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SENATE—*Thursday, November 20, 2003*

The Senate met at 9:30 a.m. and was called to order by the President pro tempore (Mr. STEVENS).

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

O Lord most holy, Who has found us wanting and yet has not forsaken us, deliver us from insincerity and thoughtlessness.

Help the leaders of this body to be strong and courageous. Keep them from deviating from the path of integrity and remind them of the importance of seeking Your wisdom. Give them an awareness of Your abiding presence and supply their needs. Help them never to fail to do what they can to establish peace and justice among nations.

Lord, make each of us instruments of Your peace, carving tunnels of hope through mountains of despair. May we remember that You have determined our path and You direct our steps. We pray this in Your powerful Name. Amen.

PLEDGE OF ALLEGIANCE

The PRESIDENT pro tempore led the Pledge of Allegiance, as follows:

> I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. FRIST. Mr. President, this morning, the Senate will resume consideration of the Energy conference report. A number of Senators came to the floor to speak on the Energy conference report yesterday. We had a good debate, good discussion, and the Senate will continue this debate throughout today's session.

I do remind my colleagues that a cloture motion was filed on the conference report during yesterday's session, and that cloture vote will occur on Friday morning.

As we all know, we are scheduled to consider several major pieces of legislation over the next few days. In addition to the appropriations measures and the Medicare reform package, there will be other conference reports that will become available for Senate consideration, and we will attempt to clear those measures for Senate action as they arrive.

In addition to that, we will also continue to work through nominations on the Executive Calendar. There are some roadblocks right now, but we are doing our very best to address those. There are a number of important nominations that are ready for confirmation, including judicial nominees who should be cleared, the Department of Homeland Security positions, a number of ambassadors, Health and Human Services officials, and the list goes on and on. They are ready for confirmation.

I understand there are Members who are objecting to all of those nominations. I urge my colleagues to allow us to schedule votes on at least the noncontroversial nominations. Some of these nominations are being held up by colleagues who say nothing is going to go through. At least let the noncontroversial nominations proceed. It is clear we can't, in these final few days, be held hostage to unrelated matters on these important nominations.

I mentioned the Senate will need to work this weekend in order for us to finish all of our business. We will have a clearer picture as to what to expect over the course of the weekend as this day progresses. I do alert everyone that the likelihood of being in Saturday is very high and possibly for a period of time on Sunday as well.

RECOGNITION OF THE MINORITY LEADER

The PRESIDENT pro tempore. The minority leader is recognized.

Mr. DASCHLE. Mr. President, the majority leader has been consulting with us with regard to the schedule. I share his view that there is an opportunity here for us to complete our work, if we can find a way to resolve the remaining issues before the Senate. We have a lot of work to do on conference reports, on the omnibus legislation, and on certain nominations.

I will say there are a number of holds on the nominations in part because of a misunderstanding perhaps with the White House on a particular nominee that has to be resolved if we are to move forward on these nominations. I am hopeful that can be done perhaps as early as today. That is one of the major obstacles to addressing successfully a number of other nominees.

This is going to be a busy week. I certainly urge our colleagues not to make plans for Saturday or Sunday until we know better what the scheduling entails. I think it would be important for us to give our Members adequate notice with regard to the schedule, perhaps once or twice a day updating people as to what the schedule may hold. We will certainly work with the majority leader in attempting to address the many challenges we face with regard to the legislative schedule yet before us.

I yield the floor.

The PRESIDENT pro tempore. The majority leader.

Mr. FRIST. Mr. President, the Democratic leader and I have been in consultation and will continue to be in consultation over the course of the day—as he suggested, pretty much every few hours—to facilitate what is going to be a challenge in moving in a reasonably orderly way all that we have on the table.

I do want to mention in my opening comments that we are very close to addressing Healthy Forests. I plead with everyone, hopefully over the course of this morning, to resolve whatever remaining issues there are in terms of holding up that legislation. If we go to conference quickly, that very important legislation will be addressed. I think we are just about there. We were just about there last night. If we can

● This "bullet" symbol identifies statements or insertions which are not spoken by a member of the Senate on the floor.

get that over the goal line this morning, that would be helpful.

The PRESIDENT pro tempore. The minority leader.

Mr. DASCHLE. Mr. President, I am pleased the majority leader mentioned Healthy Forests. I would have done it if I had remembered. Of course, Senator COCHRAN and I had a very good conversation yesterday. Based on that conversation and his assurances that extraneous material would not be included in conference, we are prepared to go to conference now.

We have had good success in reaching agreement on the forest health provisions of the bill. There are other issues that still remain to be addressed. I share the view of the majority leader that we are now at a moment where I think we ought to try to complete our work. It would be great if at the end of the day we could set aside the pending legislation and pass that conference report. I think we are going to get a good broad bipartisan vote on the legislation. I applaud those who have taken us to this point. This is good legislation. It deserves support. I look forward to finishing work on that bill as well.

I yield the floor.

RESERVATION OF LEADER TIME

The PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

ENERGY POLICY ACT OF 2003—CONFERENCE REPORT

The PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of the conference report accompanying H.R. 6, which the clerk will report.

The legislative clerk read as follows:

> Conference report to accompany H.R. 6, an act to enhance energy conservation and research and development, to provide for security and diversity in the energy supply for the American people, and for other purposes.

Mrs. FEINSTEIN addressed the Chair.

The PRESIDENT pro tempore. The Chair is in doubt. Under the previous order, the Senator from New Mexico was to be recognized first.

Under the previous order, the Senator from California is now recognized for 60 minutes.

Mr. REID. Mr. President, we received word Senator DOMENICI would not be here this morning. Of course, he is managing this bill. Whenever he comes, we will work him into the order.

The PRESIDENT pro tempore. The Chair thanks the Senator from Nevada.

(Mr. SMITH assumed the chair.)

Mrs. FEINSTEIN. Mr. President, I have come to the floor as a Californian to say there is very little in this Energy bill for California. There is very little to prevent future blackouts. There is nothing to protect consumers from manipulation and gaming of the system that we experienced a few years ago.

There is nothing to improve our Nation's energy security by increasing fuel economy standards. In short, from a California perspective, I see this bill as one giant giveaway to special interests, particularly the ethanol, the MTBE, the oil, the gas, and the nuclear power industries of this country.

I had hoped that this Congress, and in particular the Energy Committee on which I serve, following the Western energy crisis and last summer's blackout in the Northeast, would pass a sensible bill that would improve our Nation's energy supply while protecting consumers, the environment, and the economy. But as I read this bill, that is not the case. This Energy bill was drafted behind closed doors, without any input from Democratic conferees or from those of us on my side of the aisle on the Energy Committee. Simply put, it is one of the worst pieces of legislation I have seen in my time in the Senate.

It is interesting that today on every Member's desk is a summary of editorials. There are over 100 editorials from newspapers, large and small, all across this great country saying "oppose this bill." In fact, 100 newspapers around the country have come out opposed to the bill and editorialized against it. I will quote from one of them. Let me begin with the newspaper whose editorial policy is generally very conservative, and that is the Wall Street Journal. Let me read what the Wall Street Journal says about this legislation:

> We realize that making legislation is never pretty, but this exercise is uglier than most. The fact that it's being midwifed by Republicans, who claim to be free marketers, arguably makes it worse. By claiming credit for passing this comprehensive energy reform, Republicans are now taking political ownership of whatever blackouts and energy shortages ensue. Good luck.

Now I will go to yesterday's Denver Post. The editorial is entitled "Energy Bill Full of Pork."

> The bill does include funds for energy conservation, including some incentives for "green" construction, but some sound suspicious. Some $180 million will pay for a development in Shreveport, LA. That project will use federal tax money to subsidize the city's first-ever Hooters restaurant. What a new Hooters has to do with America's energy situation may be best known to U.S. Rep. Bill Tauzin, a Louisiana Congressman and key player in the secret conference committee talks.
>
> The bill provides no real vision, represents no real improvement in policies and laws. It is vexing that Congress did not seize an opportunity to improve the national energy picture. Congress should start over next year.

Let me now go to the Northeast, a large newspaper, the New York Times:

> The oil and gas companies were particularly well rewarded—hardly surprising in a bill that had its genesis partly in Vice President Dick Cheney's secret task force. Though they did not win permission to drill in the Arctic National Wildlife Refuge, they got a lot of other things, not only tax breaks but also exemptions from the Clean Water Act, protection against lawsuits for fouling underground water and an accelerated process for leasing and drilling in sensitive areas at the expense of environmental reviews and public participation. Meanwhile, the bill imposes new reliability standards on major electricity producers, but it is not clear whether it would encourage new and badly needed investment in the power grid.

Now let me go to the Midwest to the Chicago area, the Chicago Tribune.

> Despite all the years of partisan haggling that preceded it, the approximately 1,400-page energy bill that Republicans unveiled over the weekend, and which Congress is expected to vote on this week, is no masterpiece of compromise or even effective legislation.
>
> It is more like a jigsaw puzzle with hundreds of unrelated pieces crammed together. A few initiatives are worthwhile, most look more like a laundry list of special-interest subsidies. Together, they don't add up to a policy that will promote energy self-sufficiency or stable prices.

Then let's go to one of the Chair's own newspapers, the Anchorage Daily News, which states:

> What's left is a grab bag of lesser measures and pet projects patched together in hopes of gaining enough votes to pass in the House and Senate. The result is an energy bill that likely will pass—but not a coherent energy policy for a nation critically dependent on imported energy supplies.

Then let's go to the Houston Chronicle, and I will not read it all:

> The most pressing problem facing the Nation is its increasing reliance on imported oil and gas. Yet the bill ignores several obvious avenues for progress.
>
> The Republican draft of the bill set no standard for renewable sources of power, such as solar and wind. The latter will provide 2 percent of Texas' electricity supply and one day could spell the difference between air conditioning and brownout. There is no reason for Congress to ignore these pollution-free, alternative energy sources, and the conference committee should adopt a Senate amendment requiring expanded production of renewable energy.

Now, let me take a moment here to elaborate on this point. On Monday, during the Energy Conference, I was pleased an amendment requiring utilities to generate 10 percent of their energy from renewable sources was included in the bill. Unfortunately, this provision was stripped out of the conference report by the House just hours later. Although the bill does have requirements for renewable energy in government buildings, that is not enough. We need to encourage the use of this clean technology at a national level.

Finally, I would like to move to the west coast, to the largest newspaper, the Los Angeles Times. Their editorial is entitled "An Energy Throwback." They say:

It's clear why Republican leaders in Congress kept their national energy policy bill locked up in a conference committee room for the last month, safe from review by the public. Taxpayers, had they been given time to digest the not-so-fine print in the pork-laden legislation, would have revolted.

Let me begin my impression of the bill with its costs. The editorials from around the country show that this bill increases energy production at the expense of both the taxpayers and the environment. A group called the Taxpayers for Common Sense has estimated that this bill will cost $72 billion in authorized spending, and $23 billion in tax giveaways. That is $95 billion in spending over the next 10 years.

I ask unanimous consent to have that report printed in the RECORD following my remarks.

The PRESIDENT pro tempore. Without objection, it is so ordered.

(See exhibit 1.)

Mrs. FEINSTEIN. Taxpayers for Common Sense points out that there is nearly $13 billion for the oil and gas industry, $5.4 billion for coal, $1.4 billion for the nuclear power industry, $4.16 billion for ethanol, $4.9 billion in energy efficiency, $1.7 billion for auto efficiency and fuels—that includes ethanol—$11 billion for LIHEAP and weatherization, $21 billion for science research and development, $2.15 billion for freedom car and hydrogen research, and $764 million for miscellaneous provisions.

Now, I am in favor of some of these programs, but the cost of this is enormous. The Senate should think twice about these massive spending increases, especially given our rising Federal deficit. I do not want to leave my children and my grandchildren saddled with these debts.

Let's also consider the fact that this bill does not deal with global warming, does not deal with fuel efficiency standards, does not deal with consumer protections, and does not deal with energy security.

From a western perspective, and particularly a California perspective, we have to look at the western energy crisis and ask the question: Will this bill help in the future? My analysis of the bill leaves me with the conclusion that the answer is no.

I have often pointed out in this Chamber that the cost of energy directly before the crisis was $7 billion. That was in 1999. It rose to $27 billion in 2000, and $26.7 billion in 2001. In 1 year, the cost went up 400 percent in California. There are Members of this body who said: Oh, California, it is your fault, you have a broken system, you don't have adequate supply to meet demand. A 400 percent increase is not the product of supply and demand, it is the product of gaming and manipulation.

Now, 3 years later and after $45 billion in costs, we have learned how the energy markets were gamed and abused. In March of 2003, the Federal Energy Regulatory Commission issued its final report on price manipulation in the western markets, and what did it find? It confirmed that there was widespread and pervasive fraud and manipulation during the western energy crisis.

The abuse in our energy markets was in fact pervasive and unlawful. So you would think an Energy bill coming out a few years after this crisis would take a look and say we ought to prevent this from ever happening again, we ought to put policies and those procedures in this bill to prevent it, we ought to strengthen the Federal Energy Regulatory Commission's ability to produce just and reasonable rates and ensure that rates remain just and reasonable across this Nation. But this bill does not do this. Rather, this bill actually impedes the ability of Federal and State agencies to investigate and prosecute fraud and price manipulation in energy markets. These provisions would make it easier to manipulate energy markets, not harder to manipulate energy markets.

This bill sends this country in the wrong direction. Rather than preventing Enron-type schemes, such as Fat Boy, Ricochet, Death Star, and Get Shorty, this bill weakens the oversight over energy markets. It guts the Federal Energy Regulatory Commission's ability to enforce just and reasonable rates.

Between now and 2007, the FERC will be in court, litigating the meaning of this electricity title rather than enforcing the State administration of just and reasonable rates to electricity customers. FERC will be powerless to respond to market crises like the one that occurred in the West between 2000 and 2001.

I am also particularly concerned about the provision in the bill which directly affects the so-called sanctity of contract provision. California was overcharged by as much as $9 billion for the cost of energy as a result of long-term electricity contracts that were entered into under desperate circumstances at the height of a gamed energy crisis. These contracts were not based on just and reasonable rates, they were based on rates that were inflated as a result of gaming and manipulation. California has filed at FERC for refunds.

This sanctity of contract provision, however, would mean FERC would never provide any further refund in the California case. So it shuts out California from any further recourse. No one from California should vote for this Energy bill. The provision places the importance of the physical contract above the importance of enforcing just and reasonable rates. In other words, it says even if you signed a contract in a situation that has been gamed and manipulated by fraud, you are still bound to that fraud-inspired contract. That is what we are doing in this bill.

In my view, this is simply absurd. We need to be strengthening FERC's ability to enforce just and reasonable rates, particularly in a deregulated market, not weakening it. And the irony is that FERC recently announced a settlement in which El Paso Corporation and its subsidiaries would pay $1.6 billion to resolve a complaint that the company withheld supplies of natural gas into California, driving up prices for gas and electricity during the State's energy crises in 2000 and 2001.

This was precisely the incident about which I tried to see the President—he wouldn't see me at that time—because we knew that the price from San Juan, NM, to southern California, which should have been $1 per dekatherm, was $60 per dekatherm, which was a manipulated price based on the withholding of space in the El Paso pipeline. We now know that that was correct because El Paso has paid $1.6 billion: Fact.

This bill does nothing to prevent gaming and manipulation in the natural gas market. The bill does increase penalties for electricity gaming and fraud, but does nothing to increase the low penalties for manipulation of the natural gas market. It is estimated that El Paso's price manipulation cost consumers and businesses $3.7 billion, yet this bill fails to give the FERC the power it needs to ensure that this kind of price manipulation does not happen again.

Now I would like to speak about what should be for the east coast and the west coast one of the most egregious provisions in the bill, and that is this ethanol mandate. This mandate is essentially a hidden gas tax. It will increase automobile emissions in the most polluted areas of the country and will not reduce our dependence on oil. Not only is this mandate unnecessary but it may have serious unintended environmental consequences because the environmental studies on ethanol have not been done. Yet this bill forces consumption of ethanol beyond that which is needed. So this bill is pushing an untested product that States such as mine don't need to meet clean air standards.

There are several reasons I am adamantly opposed to mandating the increase in ethanol consumption from 3.1 billion gallons a year to 5 billion gallons over the next 7 years. Not only do I believe the mandate is unnecessary but I am concerned about unintended environmental consequences. Let me tell you why. This is not just off the top of my head. This summer, for the first time, 70 percent of southern California's gasoline was blended with ethanol. Partially as a result, southern California endured its worst smog season since 1998. Why? Ethanol produces smog.

For the first time in 5 years, southern California experienced a stage 1 smog alert. As of September, the greater Los Angeles metropolitan area had experienced 63 days of unhealthy air quality, when ozone levels exceeded Federal standards. That number far exceeds the 49 days of unhealthy air quality during 2002 and the 36 days in 2001.

That is with 70 percent of its gasoline blended with ethanol. So the air got worse; it didn't get better.

The number of unhealthy days this year was almost more than twice that of two other of the smoggiest areas of the country, the San Joaquin Valley and Houston, TX, which exceeded the Federal health standards for 32 days and 25 days, respectively. What ethanol has done for southern California is make it more smoggy, not less smoggy. It is a culprit. It is worsening smog. I think we are mandating it in this bill willy-nilly because of greed.

The Secretary of the California EPA concluded, and this is his direct quote:

> Our best estimate is that the increase in the use of ethanol-blended gasoline has likely resulted in a 1-percent increase in emissions of volatile organic gases in the South Coast Air Quality Management District in the summer of 2003. Given the very poor air quality in the region, and the great difficulty of reaching the current Federal ozone standard by the required attainment date of 2010, an increase of this magnitude is of great concern. Clearly, these emission increases have resulted in higher ozone levels this year than what would have otherwise occurred and are responsible for at least some of the rise of ozone levels that have been observed.

Not only does this bill do harm to California, it increases the use of ethanol-blended gasoline, and that will threaten my State's long-term trend toward cleaner air. It will make it more difficult, and it may well make it impossible.

Without major emission reduction in the next several years, air quality officials warn that the region may miss a 2010 clean air deadline to virtually eliminate smoggy days. If the deadline isn't met, the Los Angeles region could face Federal sanctions amounting to billions of dollars.

That is why I oppose this ethanol mandate. That is why I say to those who are supporting it that you are doing us grievous injury.

Furthermore, the bill as written threatens the highway trust fund, the funding stream that allows States to construct and maintain our roads.

Let me tell you how. Gasoline taxes generate about $20 billion per year for the highway trust fund, and they comprise about 90 percent of the overall money for the fund. Because this bill subsidizes ethanol with transportation dollars, any increase in the use of ethanol will mean a decrease in the amount of money going into the highway trust fund. In fact, California will lose approximately $900 million over the next 7 years just because of this provision. The loss of highway funds for the entire country will amount to $10 billion over the next 7 years because of this ethanol mandate. It is egregious public policy.

I am also concerned about the price impact this mandate will have on the cost of gasoline at the pump.

Proponents of the ethanol mandate argue that gas price increases will be minimum, but the projections don't take into consideration the real world infrastructure constraints and concentration in the marketplace that can lead to high price hikes. We all know that when one entity controls most of the marketplace, that entity can move price as it sees fit. And that is the situation we have here.

Everyone outside of the Midwest will have to grapple with how to bring ethanol to their States in amounts prescribed and mandated since the Midwest controls most of the ethanol production. California has done more analysis than any other State on what it will take to get ethanol to our State. The bottom line is that it can't happen without raising gas prices. Our analysis shows that we can't bring ethanol to our State without increasing gas prices.

As I said, California has done more analysis on what it will take to bring the required amount of ethanol to our State than any other State, and has found that it will have cost consequences at the pump. Proponents of the ethanol mandate argue that gas price increases will be minimal. But the projections don't take into consideration the infrastructure and strength and the concentration in the marketplace that exists. Everyone outside of the Midwest will have to grapple with how to bring ethanol to their States since the Midwest controls most of the production.

I am also concerned about the limited number of ethanol suppliers in the market today. This high market concentration will leave consumers vulnerable to price hikes as it did when electricity and natural gas prices soared in the West because of a few out-of-State generating firms dominating the market.

As I have watched all of this, every time you have out-of-State companies dealing with an unregulated energy-related marketplace you have problems. I don't know why. But I suspect there really isn't the connection with the consumer. Many of the companies driving the energy crisis in California weren't in California. I wonder if they would do the same thing to their State that they did to our State. I am not a fan of the way the marketplace is structured today. And into this lack of structure and lack of price responsibility, we bring a whole new component. That component is that one company is the dominant producer in the highly concentrated ethanol market.

ADM today controls 46 percent of the ethanol market. That is only what is produced today. The company has an even greater control over how ethanol is distributed and marketed. ADM does not have a sterling record. It is an admitted price fixer and three of its executives have served prison time for colluding with competitors. I cannot look at ADM and say we have a pristine corporate citizen who controls this marketplace, its production, its distribution and will have any compassion for price responsibility. I do not believe giving firms such as this, this kind of control, is good public policy.

One could ask, Do I have any more grievous complaints? The answer is yes. The list goes on and on.

Let me take up MTBE. In this bill, there is a liability waiver so nobody can sue for the fact that MTBE has been found to be defective by a court of law. Not only that, it is a retroactive liability protection for MTBE producers. This provision offers them immunity from claims that the additive is defective in design or manufacture. It makes this liability protection retroactive to September 5 of this year thereby wiping out hundreds of lawsuits brought by local jurisdictions all across America. This retroactive immunity is a perverse incentive to those who pollute because it says to them, OK, you have done all of this damage; nonetheless, it does not really matter. You do not really have any liability. All these suits will be wiped out.

This bill does not ban MTBE nationwide despite what has happened in huge numbers of States, including my own. It gives MTBE producers $2 billion in what is called "transition assistance" to transition out of a product they are allowed to continue to produce and export. So they can accept $2 billion and continue to produce a flawed product that we know contaminates ground water, that we know leaches out of ground water wells, creates plumes of benzene, could possibly be carcinogenic, and pollutes drinking water so it is undrinkable and what do they get for doing this? $2 billion in this bill. Now I ask, is that good public policy? Remember, the courts have already found it to be a defective product. This is not me speaking; it is the courts.

I first learned about MTBE when the mayor of Santa Monica came to see me and told me that one-half of their entire water supply was contaminated with MTBE and could not be used. As I delved into it and investigated the claims further, I came to learn there were at least 10,000 sites contaminated in California. Since then, about a year ago, it is now 15,000 sites in California.

California is not alone. Last year the EPA estimated there are 15,051 sites in California. Nationally there are 153,000 contaminated ground water sites.

The States with the most pollution include California and Florida. Florida has 20,273 contaminated ground water sites—more than California. Florida is heavily impacted with MTBE pollution. Illinois has 9,546 contaminated sites. Michigan has 9,087 sites. Texas has 5,678 sites. Wisconsin has 5,567 sites. New York has 3,290 polluted sites. Pennsylvania has 4,723. It is State after State after State. They total 153,000 polluted drinking water sites. This bill does not make MTBE illegal; this bill gives MTBE $2 billion, and they cut out the ability of local jurisdictions to sue to be able to clean up these sites with the money. If that is not perverse public policy, if that does not create an incentive to do bad things, I don't know what does.

As I said, the courts ruled that MTBE is a defective product. Actually, this relates to a case in my State so I think it is relevant to mention this case. It is a case brought by the South Lake Tahoe Public Utility District. The court held Shell, Texaco, Tosco, Lyondell Chemical, which is ARCO Chemical, and Equilon Enterprises liable for selling a defective product, gasoline with MTBE, while failing to warn of its pollution hazard. The court forced these MTBE producers to pay the water district of South Lake Tahoe $60 million to clean up the mess.

The industry, in fact, knew of the problems with MTBE yet decided to include it in gasoline. They deny all of this, but a court has found it to be the case. In fact, let me read a comment from Exxon employee Barbara Mickelson from 1984:

> Based on higher mobility and at the same time/odor characteristics of MTBE, Exxon's experience with contaminations in Maryland, and our knowledge of Shell's experience with MTBE contamination incidents, the number of well contamination incidents is estimated to increase three times following the widespread introduction of MTBE into Exxon gasoline.

This is 1984. The company went ahead and included it in their gasoline. Now, no one can sue them for a defective product in this bill.

Let me also give you an excerpt from a 1987 memorandum circulated within the Environmental Protection Agency:

> Concern about MTBE in drinking water surfaced after the Interagency Testing Committee report was published. Known cases of drinking water contamination have been reported in 4 states. These cases affect individual families as well as towns of up to 20,000 people. It is possible that this program could rapidly mushroom due to leaking underground storage tanks at service stations. The tendency for MTBE to separate from the gasoline mixture into ground water could lead to widespread drinking water contamination.

That is what indeed happened as illustrated by the fact that today we have 153,000 drinking water sites contaminated with MTBE across this Nation. This bill does not make its use illegal. It gives the companies $2 billion, and it prevents water districts from suing because the product was knowingly defective. There is no way you can look at a provision like this and not say this is a bad bill.

What adds insult to injury is this bill says they can continue to produce MTBE and export it to other countries so the drinking water of other countries can be polluted. How perverse can public policy be?

I am also disappointed that the conference report does nothing to increase fuel economy standards of our Nation's fleet of automobiles. We have an Energy bill. The largest contributor to global warming is carbon dioxide. The largest producer of carbon dioxide is the automobile. This bill does nothing to make automobiles more fuel efficient. What kind of an energy policy is that? In fact, the bill, again, perversely, makes it more difficult for the Department of Transportation to encourage fuel efficiency standards in the future by including a new list of criteria the Department must consider when revising standards.

I believe increasing the fuel economy of SUVs and light trucks is the single easiest step the Nation can take to reduce the emission of carbon dioxide into the atmosphere. It is the biggest single shot at reducing global warming. Yet we refuse to do it.

Earlier this year, Senator SNOWE and I introduced bipartisan legislation to close what is called the SUV loophole. We were unable to offer this legislation as an amendment to the Senate version of the Energy bill when it was on the floor.

But our bill had been evaluated by the National Academy of Sciences, that has released a study on this issue, and said it was technologically feasible to do this, and that over the next 10 years it would save the United States a million barrels of oil a day and reduce our dependence on foreign oil by 10 percent. It said it would prevent 240 million tons of carbon dioxide, the top greenhouse gas, as I have said, from entering the atmosphere each year, and it would save SUV and light-duty truck owners hundreds of dollars, ranging anywhere from $300 a year to $600 a year at the pump in the cost of gasoline.

CAFE standards were first established in 1975. They were fought by Detroit, just as seatbelts were fought by Detroit. At that time light trucks made up only a small percentage of the vehicles on the road. They were used mostly for agriculture and commerce. Today they are used mostly as passenger cars. Our roads look much different. SUVs and light-duty trucks comprise more than half of new car sales in the United States.

As a result, the overall fuel economy of our Nation's fleet is the lowest it has been in two decades, largely because fuel economy standards for SUVs and light trucks are so much lower than they are for other passenger vehicles. They are 22 miles per gallon. We could have them equal to sedans and have all the savings I have just cited.

Additionally, what is interesting is that others are moving rapidly to retrofit automobiles with new fuel savings technology that is available today for use by car manufacturers. Toyota recently announced improvements in its hybrid vehicle, the Prius, making it more powerful and more fuel efficient. Toyota has announced a hybrid version of its Lexus RX 330 SUV, which is scheduled to be released in early next year.

Meanwhile, instead of moving forward, some U.S. automakers are moving backward. I was very disappointed by the announcement made by the Ford Motor Company stating Ford would not be meeting its self-imposed goal of raising the fuel economy in its SUVs by 25 percent by 2005. Additionally, Ford announced it is delaying the sale of its hybrid SUV, the Escape, another year until 2004.

Yet China has announced it is going to move quickly on imposing fuel efficiency standards on its automobiles. Of course, any American companies that produce for Chinese consumption will have to conform.

I am so disappointed to see this Energy bill does not address global climate change. We are 5 percent of the world's population. We use 25 percent of its energy. We produce the world's most greenhouse gas emissions. We are the most significant culprit driving global warming.

Despite the fact that climate change threatens our environment and our economy, this bill does nothing to address it. I think that is a major mistake. Energy and climate are inextricably linked. A truly comprehensive energy policy cannot ignore that issue. As a nation, we ignore it at our peril.

The scientific evidence of global warming is real. The problem is getting worse. People are seeing mosquitos in areas of the Arctic for the first time. Glaciers are melting around the world, from Glacier National Park to the slopes of Mount Kilimanjaro. The largest ice shelf in the Arctic is disintegrating. This ice shelf covers 150 square miles. It is 100 feet thick.

The hole in the ozone layer, which decreased in size last year, grew to its largest level earlier this year.

Climate change is also affecting some of our most treasured places. Over a century ago, 150 magnificent glaciers could be seen on the high cliffs and jagged peaks of the surrounding mountains of Glacier National Park. Today, there are only 35. The 35 glaciers that remain today are disintegrating so quickly that scientists estimate the park will have no glaciers in 30 years.

Glaciers in the Sierra Nevada, in my State, are disappearing. Many of these have been there for the last thousand years.

We are seeing similar melting around the world, from Mount Kilimanjaro in Tanzania to the ice fields beneath Mount Everest in the Himalayas.

Dwindling glaciers offer a clear and visible sign of climate change in America and the rest of the world. We are seeing these changes. Scientists tell us to expect more. Yet this bill is silent.

We have reports from the National Academy of Sciences, the Intergovernmental Panel on Climate Change, and the Congressional Budget Office.

Let me quote the CBO report in May:

> Scientists generally agree that continued population growth and economic development . . . will result in substantially more greenhouse gas emissions and further warming unless actions are taken to control those emissions.

The place to take those actions is in an Energy bill, and yet this conference report is silent.

Let me tell you what the actual effect is in my State.

Sea level has risen 6 inches in San Francisco since 1850, with the greatest change happening since 1925. As sea level rises, the salt water permeates into the delta, contaminating drinking water and ground water further upstream.

Even without climate change, it would be a struggle to supply enough water for all of the people that live in California. But report, after report, after report indicates that climate change will further threaten a water supply that is already tight.

Models from NASA, the Lawrence Livermore National Laboratories, and the Union of Concerned Scientists all indicate that climate change is likely to increase winter rain and decrease snowfall in my State.

More winter rain means winter flooding. Less snow means less water for the rest of the year. California's water supply depends on gradual snow runoff. We have spent billions of dollars on water infrastructure that depends on this runoff, and yet we still have to struggle to provide enough water for our farms, our cities, our fish, and our wildlife. This bill does nothing to help California's situation.

In 1910, half of the Sacramento River's annual runoff took place between April and July. Today that number is 35 percent, and it is continuing to decline. We can't count on this runoff. It is clearly in our best interest to address climate change. Our environment is clearly at risk. Our relations with our allies are at risk because of our reluctance to address it.

The Foreign Relations Committee has recognized the need for the United States to act. We should do so in this bill. Yet we do not. How can I, representing the largest State in the Union, support a bill that does nothing for my State—nothing?

Let me now deal with the sensitive issue of coastal protection. On the positive side, the bill no longer includes another inventory of oil and gas resources on the Outer Continental Shelf. However, this conference report takes away the States' input into an important set of energy development projects, including liquefied natural gas facilities and other oil- and gas-related projects. These States need input into these decisions. For coastal States, this is a significant weakness in this bill, particularly States such as Florida and California and for your own State of Oregon, Mr. President. Time after time, we have said we do not want offshore energy development. This bill opens that door, and it reduces the States' input into decisions which directly affect our coastal zone waters.

The Energy bill also fails to include the renewable portfolio provision which was included in the Senate-passed bill. I heartened when the ranking member, the Senator from New Mexico, announced earlier this week that it was in. Apparently, it is now out. Solar, wind, geothermal, and biomass are generating electricity for homes and businesses nationwide. It is working in California. We need an energy policy that not only provides tax incentives for their continued development but also requires their use. I believe it is in the public interest for our Nation to require a greater development of renewable resources.

The tax provision of this bill implies that nuclear power is a form of renewable power, and it places this form of power on an equal footing in the Tax Code with traditional renewables. This production tax credit for nuclear power is the largest energy tax credit in the bill and would be the largest one in the code, equaling $6 billion. As a nation, we still can't properly dispose of nuclear waste. This waste has a half-life of an eternity, yet we are going to produce more of it. I strongly believe this is a mistake.

This bill also weakens the Clean Air Act. Upon reviewing the bill, I was most disappointed to learn that the legislation that has really cleaned up our air, the Clean Air Act, is weakened. The 1990 amendments to the Clean Air Act, signed by the first President Bush, implemented timelines for cities to clean their air. This bill undermines the intent of those amendments by no longer requiring communities to clean up their air if they can claim that part of its pollution is a result of transported air pollution.

Most of California—all the inland areas—is a product of transported, to some degree, air pollution. Seventy percent of our State does not meet national air quality standards. So California is probably more adversely impacted by this than any other State because of strong prevailing westerly winds which drive the pollution from the big coastal areas into the valley areas. This will result in a major weakening of the Clean Air Act. Huge areas of the State, such as the Central Valley and the Inland Empire, will have reduced cleanup requirements.

Our Nation needs an energy policy that will protect consumers, reduce our dependence on foreign oil, and produce new energy development while protecting our environment. This bill does not do that. This bill deserves to be defeated. This bill is a bad bill.

I strongly urge my colleagues to vote against this poorly crafted legislation.

EXHIBIT 1

TAXPAYERS FOR COMMON $ENSE

Type or industry	Authorized spending
Oil and Gas (including MTBE/LUST)	$12.971 billion (includes $414 million scoring of royalty provisions).
Coal	$5.434 billion.
Nuclear	$5.735 billion.
Utilities	$1.355 billion.
Renewables (including R&D)	$4.164 billion.
Energy Efficiency (including R&D)	$4.931 billion.
Auto Efficiency and fuels (including Ethanol)	$1.698 billion.
LIHEAP and Weatherization Assistance	$11.425 billion.
Science Research and Development	$21.850 billion.
Freedom CAR and Hydrogen Research	$2.149 billion.
Miscellaneous	$764 million.
Total Authorization	$72.476 billion.

BREAKDOWN OF COST ESTIMATES

Oil and Gas

Title III—$949 million (direct and royalty exemptions).

Title IX Research and Development—Fossil Fuel $1.997 billion.

Title XIV Miscellaneous, Subtitle B Coastal Programs— $5 billion.

Title XV Ethanol—MTBE and other provisions—$5.025 billion.

=$12.971 billion.

Coal

Title IV Coal—$3.925 billion.

Title IX Research and Development—Fossil fuels $1.509 billion (specifically allocated to coal).

=$5.434 billion.

Nuclear

Title VI Nuclear Matters—$1.186 billion.

HEALTHY FORESTS RESTORATION ACT OF 2003

Mr. FRIST. Mr. President, I ask the Chair lay before the Senate a message from the House of Representatives on the bill (H.R. 1904), to improve the capacity of the Secretary of Agriculture and the Secretary of the Interior to conduct hazardous fuels reduction projects on National Forest System lands and Bureau of Land Management lands aimed at protecting communities, watersheds, and certain other at-risk lands from catastrophic wildfire, to enhance efforts to protect watersheds and address threats to forest and rangeland health, including catastrophic wildfire, across the landscape, and for other purposes.

The Presiding Officer laid before the Senate the following message from the House of Representatives:

Resolved, That the House disagree to the amendments of the Senate to the bill (H.R.

1904) entitled "An Act to improve the capacity of the Secretary of Agriculture and the Secretary of the Interior to plan and conduct hazardous fuels reduction projects on National Forest System lands and Bureau of Land Management lands aimed at protecting communities, watersheds, and certain other at-risk lands from catastrophic wildfire, to enhance efforts to protect watersheds and address threats to forest and rangeland health, including catastrophic wildfire, across the landscape, and for other purposes", and ask a conference with the Senate on the disagreeing votes of the two Houses thereon.

Ordered, That the following Members be the managers of the conference on the part of the House:

From the Committee on Agriculture, for consideration of the House bill and the Senate amendments, and modifications committed to conference: Mr. Goodlatte, Mr. Boehner, Mr. Jenkins, Mr. Gutknecht, Mr. Hayes, Mr. Stenholm, Mr. Peterson of Minnesota, and Mr. Dooley of California.

From the Committee on Resources, for consideration of the House bill and the Senate amendments, and modifications committed to conference: Mr. Pombo, Mr. McInnis, Mr. Walden of Oregon, Mr. Renzi, Mr. George Miller of California, and Mr. Inslee.

From the Committee on the Judiciary, for consideration of sections 106 and 107 of the House bill, and sections 105, 106, 1115, and 1116 of the Senate amendment and modifications committed to conference: Mr. Sensenbrenner, Mr. Smith of Texas, and Mr. Conyers.

Mr. FRIST. Mr. President, I ask unanimous consent the Senate insist on its amendments and agree to the request of the House on a conference of the disagreeing votes of the two Houses thereon, and the Chair be authorized to appoint conferees on behalf of the Senate with a ratio of 4 to 3.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Presiding Officer (Mr. SMITH) appointed Mr. COCHRAN, Mr. McCONNELL, Mr. CRAPO, Mr. DOMENICI, Mr. HARKIN, Mr. LEAHY and Mr. DASCHLE conferees on the part of the Senate.

The PRESIDING OFFICER. The Senator from California.

Mrs. FEINSTEIN. Mr. President, I thank the leader. It, indeed, is good news that this bill is coming over. It is my understanding that we have had successful negotiations. I am very hopeful there will be a bill before us shortly.

I yield the floor.

ENERGY POLICY ACT OF 2003—CONFERENCE REPORT—Continued

The PRESIDING OFFICER (Mr. ENSIGN). The Senator from New Mexico.

Mr. BINGAMAN. Mr. President, I see no other Senators seeking recognition so I will speak for a few moments about one aspect of this bill.

First, I thank my colleague from California for her statement. She has been extremely involved in these issues from the beginning as a member of the Energy Committee. She has taken a leadership role on many aspects of the legislation in trying to see that the provisions we came up with were good for her State and good for the country.

Let me try to talk about one part of the bill. There are 16 titles to the legislation. It does go on for 11 or 12 hundred pages. I want to talk about one of those 16 titles; that is, title XII, which relates to electricity generation and transmission and distribution.

That is a very important part of the bill and one that is complicated and difficult for us to understand but one we need to focus on because of the extreme importance it has to our economy. In my view, some of the biggest changes in law that are contained in the bill are located in the electricity title. I would also argue that the biggest retreats we are making from consumer protections are perhaps in this section as well.

During the last few years, there have been three very notable publicized developments or events in the electricity industry that have come to our attention as a nation. Not in chronological order, but first, at least in what is on the front page today and what is most immediately in mind when we think about electricity, is the blackout we experienced in the eastern part of the United States and some of the Midwest that shut down nearly a third of our Nation; the problems of how to have a reliable system for transmitting electricity and ensuring that if there is a failure somewhere, it does not cascade to the 18 States that were affected by this blackout, for example. So reliability is a serious issue, and we were made very aware of that. The President's phrase was that this was a wake-up call. I would suggest that this was a wake-up call we have not heeded adequately in the bill. I will go into why I believe that.

A second issue, of course, is what happened in California and the west coast, Oregon and Washington in particular, a couple of years ago when they had the market meltdown there and prices spiraled out of control and people saw their utility bills go up very substantially. Unfortunately, those bills have remained very high. It has had a significant impact on the economy of that part of our country. Some of that, of course, was due to manipulation of those markets, ineffective market rules. That is another area of concern that clearly should be addressed in this legislation.

The third area of concern that I cite is the financial collapse of many utilities, due in large part to the investments they have made in markets that are not central to the business of producing and selling electricity. That financial collapse has become a serious problem for many in our country as well.

This bill, in my opinion, fails to adequately address each of these problems, whether it is a liability or protection of the consumer. In the conference report before us, it blocks implementation of market rules that could prevent market manipulation. There, I am thinking about the provisions in the bill that delay FERC's ability to act not only to issue a standard market design rule, but to issue other orders of general applicability within the scope of that standard market.

It also addresses only one form of market manipulation—round-trip trading. I will get into more of a description about that, but there are other types of market manipulation we should be prohibiting in this bill. It fails to do so, and it repeals the Public Utility Holding Company Act, which was passed back in the 1930s, without providing the necessary level of protection for consumers, by strengthening the Federal Energy Regulatory Commission's authority to oversee mergers and acquisitions of other entities. It makes the likelihood of blackouts greater by stalling the Federal Energy Regulatory Commission's attempts to create regional transmission entities through the delay of this standard market design, or any other order of general applicability within the scope of that rule, it discourages the construction of needed transmission, and it discourages regional transmission organization formation by imposing an unwise pricing policy called participant funding. I will try to explain the effect of the language related to participant funding and why that has become such a central part of the concern about the bill.

First, let me talk a little about the effects the bill would have on reliability; that is, the blackout problem. The United States-Canada Power System Outage Task Force yesterday released its interim report. The report dealt with the causes of the August 14 blackout both in the United States and Canada. Secretary Abraham had a press conference. I saw him last night on Jim Lehrer's show explaining it again. He has been very aggressive in trying to explain what this report includes.

The report contains no recommendations at this point. It is the first of several reports. It is an interim report. It is primarily technical in nature. It tries to establish a timeline for the events that led up to the blackout and then during the blackout. The report tells the story of a day when the power system was not unusually overloaded, but on which a series of events that you could expect to be controllable led to an outage that cascaded through 18 States in the United States and a number of Canadian provinces. It shut down power to tens of millions of customers, paralyzed our major cities—New York, Cleveland, Detroit. Some areas were blacked out for as long as 3 days, and the economic cost of this was enormous, as we would expect it to be.

I could go into some detail about what the report found, but I am sure everybody can read that in their morning paper. The report doesn't draw many conclusions or make many recommendations. In my reading of it, it is clear that the lack of communication, the lack of coordination of response, the lack of consistency of rules and equipment were major causes of what occurred. If anything is clear, it is that the major transmission system that we depended upon is a large regional machine that is not bound by political borders but is only bound by physics and by commerce. What happens in one part of the country has far-reaching effects on areas that are very far from the initial occurrence. That fact leads to the inescapable conclusion that the control and management of that transmission system needs to be on a regional basis if it is going to respond to events that happen across these regions.

This event cascaded across two countries, 18 States, 4 transmission regions, 4 reliability councils, and it did all of that in 7 minutes. The FERC, which is the Federal agency that is authorized to oversee this enormously complex part of our economy, has been trying to encourage voluntary regional control and management of the transmission system for nearly 6 years now, since the issuance of order No. 888 in 1998. If the Midwest ISO—independent system operator—is the result of the voluntary process that has been going on over this period—and it is—then it is clear that voluntary process has not worked as it should.

The Midwest ISO is the best that could be negotiated in the voluntary program for this region. It still has 23 different control areas, inadequate communication, inadequate coordination to respond to a series of events such as those that occurred during a 7-minute period on August 14. The FERC has more recently tried to take some stronger steps to be sure that the regional transmission organizations, such as the Midwest ISO, are up to the task of ensuring the reliability of the system. The standard market and design rule that was proposed by the FERC proposed that we have mandatory regional transmission organizations; that is, that FERC could require utilities to join these regional transmission organizations. This bill stops that effort in its tracks. This bill doesn't have any suggestions as to what should be done to accomplish regional transmission control, except further encouragement of these utilities to do it on a voluntary basis. But it stops the effort that is underway today to require utilities to take these steps.

I think the report gives one more strong piece of evidence that the electricity title, as proposed, is unwise and inadequate. The participant funding provisions—let me talk about those because that is an abstruse but important part of this legislation. It is one about which there is substantial controversy. When we wrote the Energy bill in the last Congress, there was substantial controversy about it in the development of this conference report. It is an issue that we need to try to do right.

In my view, provisions in the bill related to participant funding will also have a negative impact on reliability. Let me explain how I conclude that.

This provision in the bill would require that the Commission, FERC, approve participant funding for the expansion of transmission by a regional transmission organization, or by any utility. Now, what participant funding means is that the participant in the market who wants the transmission constructed, or the expansion of transmission constructed, has to pay the full freight for getting it done. The Commission may not authorize the recovery of costs on a rolled-in basis, or it may not rule that the costs should be shared among those who will benefit from the upgrade in transmission, or the expansion of transmission. Unless the native load ratepayers have stated they require the transmission, they are not to be charged for it. This amendment takes the mantle of consumer protection by supposedly protecting retail ratepayers from bearing the costs of transmission system expansions that are built in order to ship power to a far distant region of the country. In reality, there are very few transmission system expansions that are for the benefit only of one user.

In a properly planned system, expansions that take place are ones that support the entire load in the region, including the need to export power from the region where that exists. This provision has three problems.

First, it would cause customers to have to pay for costs they did not cause and for benefits they are not receiving.

Second, it would deprive local customers of the rights to the lines that are built in their area.

Third, it is not always clear or true that only one participant is creating the need for new transmission and benefiting from that transmission.

The restriction on allocating costs to Native load ratepayers sounds good at first blush. The effect, however, is to shift the cost to other ratepayers for facilities that the Native load ratepayers in question are able to use and, in many cases, are benefiting from without having to pay.

One simple example, to try to bring this home to people, is each of us has a couple of filling stations we go to, to fill up our vehicles. If we were asked, Do you need another filling station in your part of the city, most of us would say: No, we don't; we found a way to do this. But if one is built that is convenient for our use, we will use it; we will benefit from it.

The question is, Does everyone hold back and say, I will not suggest the need for expansion of a transmission facility because I am going to be stuck with the whole bill; I will wait until someone else suggests the need and then, of course, I can get the benefit without having to pay my share?

This is supposed to be aimed at generators who want to sell into the competitive market. The real victims, in my view, are the consumers who buy electricity from municipal or cooperative utilities or from utilities other than the ones that are required to pay under this participant funding language.

The likely effect of this policy is that needed transmission would not get built. If customers who need transmission expansion have to pay for the full cost of the expansion, those who need the transmission expansion may not be able to finance either the purchase or the sale they are contemplating because it becomes prohibitively expensive.

The transmission either doesn't get built or, if it does, it is at a cost that gives the incumbent utility a competitive advantage.

The second effect is the utilities would be encouraged not to join regional transmission organizations or, if they are already members of regional transmission organizations, to leave those, and they are perfectly free to do so under the legislation. This is not my conclusion. This is the conclusion of many experts who have written to us in opposition to this participant funding language.

If the utilities gain this kind of competitive advantage and get their transmission built at no cost to themselves, why should they join a regional transmission organization and talk to others about the need to cooperate and share costs?

This proposal on participant funding is anticompetitive and it is antireliability, in my view. If transmission construction is needed to relieve bottlenecks to prevent blackouts, this provision discourages that.

Under current policy, which the Federal Energy Regulatory Commission issued in 1995, new transmission is paid for by those who benefit from the transmission. If there is a single entity or single group of ratepayers who benefit, then they are the ones who pay. If the system as a whole benefits, then everyone shares in the cost. Often, there is a combination of the two and there is a sharing of the cost. The single beneficiary pays for part of the cost; the rest is rolled into the rates for all of those who use the system.

This provision that is in the bill assumes there is always a single beneficiary rather than there is a benefit to many, as is the case in most circumstances. The provision requires something FERC already has the authority to do. As I said, it can allocate the total cost to one participant. But we should not be legislating the way FERC has to deal with these issues. They should be able to deal with them on a case-by-case basis. The provision prevents them from doing that.

We have letters in opposition to this participation funding language from a great many people. I will cite a few: Public service commissions of Michigan, Minnesota, Wisconsin, Indiana, Pennsylvania, and many other States; utilities in California, Indiana, Ohio, Maryland, Pennsylvania, Delaware, West Virginia, New Jersey, Oregon, Utah, Arizona, Colorado, and many other areas of the country. We have many organizations that have come out in opposition to this provision—from APPA, NRECA, Elcon—Electric Consumers Resource Council, the large industrial customers group including General Motors, Dow Chemical, Air Products, steel companies, aluminum companies—Louisiana, Energy Users Group, the American Chemical Council, the American Forest and Paper Association, American Iron and Steel Institute, Council of Industrial Boiler Owners, Portland Cement Association, Electric Power Supply Association, Consumers for Fair Competition National Grid, American Transmission Company, International Transmission Company, Electric Power Supply Association, many individual municipal and cooperative utilities, and many others.

Congress, in my view, should not be meddling in this area. It is too complex. It is too dependent upon the facts of individual cases for us to try to be writing legislation directing how FERC allocates cost. We should not legislate what they do in this area. In my view, that is counterproductive.

The bill also contains a delay in the issuance of the standard market design rulemaking which I mentioned before. The delay is until January of 2007. That is a much longer delay than I think is wise. That is over 3 years from now. Clearly, in my view, the Federal Energy Regulatory Commission may well have circumstances to which they need to respond. They may well identify problems for which they need to issue rules of general applicability in that period, and we should not be tying their hands.

The bill would prohibit under its current language "rule or general order of applicability on matters within the scope of the standard market design rule."

The truth is, the standard market design rule covers everything but the kitchen sink. So if you are saying you cannot issue rules of general applicability on matters that are within the scope of that rule, you are basically saying you are blocked from issuing orders for the next 3 years.

What kind of actions could this prevent? It could prevent the Commission from doing its job in many respects. FERC currently has a rule in process on interconnections to the transmission grid. No matter what that rule said, the Federal Energy Regulatory Commission would be prohibited from issuing it.

Other matters that are dealt with in the rule that FERC would be prevented from dealing with in a generic manner are such things as market oversight, market mitigation, transmission pricing, scope of the regional transmission organizations, the adequacy of rules for transactions across regional transmission organization boundaries, and, in short, just about anything the Commission does about transmission or markets, because this standard market design rule, which we are blocking the implementation of, touches on all of those items. All of those subjects are within the scope of that rule, and we are legislating a prohibition not only against the rule but against any rule of general applicability within the scope of standard marketing.

I also believe some of the orders FERC issued in the western market crisis would be defined as orders of general applicability and would have been prohibited had this language been on the books at the time FERC was trying to deal with that crisis.

If another crisis occurs in the next 2 or 3 years, would we not want FERC to bring order to the market to deal with the crisis? Hopefully, we will not wind up legislating a prohibition on their doing that.

I offered amendments to try to correct this language on the Senate floor. They failed. I offered another amendment when we had our one meeting of the conference on Monday of this week.

That was agreed to by a majority of Senate conferees but was rejected by the House. Then, of course, the Senate conferees receded to that. So I think this is a serious problem that undermines our efforts as a nation to ensure reliability of the system.

Let me go on to this issue of the crisis in western markets, and any possible future market crises that we may face. It is surprising to me how soon we can forget. Just over a year ago, maybe 2 years ago now, we were in the middle of a daily diet of newspaper stories and headlines about the excesses of Enron and other power marketers and their manipulation of California and other western markets. Now it seems as though those shocking stories, that public outcry for Government to do something about that, is all gone, and we are on to other matters.

We have outlined many times before, and many of my colleagues in their statements have outlined, a parade of horrible schemes, deceitful schemes, that were put in place to defraud utilities and to ultimately defraud consumers. The names are well known to all of us: Get Shorty, DeathStar, Ricochet, Black Widow, wash trades. This conference report prohibits wash trades or roundtrip trades, and that is good. I favor that prohibition.

By doing so, the bill acknowledges that the Federal Power Act should protect consumers against fraudulent and deceptive practices, but we only mention one such practice: Roundtrip trading, these wash trades. That is a circumstance where two participants in the market sell to each other the same amount of electricity at the same price in order to make it appear they have more volume of transactions than they really have; there is more going on. This also creates a sales volume for both the sellers. This can be used to pad the reports of stockholders and analysts and make the company look as if it is a better place to invest. This practice should be prohibited.

The other practices involve creating artificial congestion on transmission lines so that one can claim to have relieved the congestion in order to collect a congestion rent. There were a number of colorfully named practices that were of this nature. Those clearly should be prohibited as well.

Some would argue that we do not need to prohibit those; they are prohibited elsewhere. I do not believe that. When FERC commissioners came before the committee last year, they told us these practices were not prohibited, that there was not much they could do to deal with them. When other Senators seemed not to be concerned about giving this authority, I could not really understand that point of view. Clearly, there can always be other prosecutions for fraud, general fraud and all, but FERC, the agency with responsibility for overseeing this sector of our industry, should have the authority to impose penalties and prohibit these practices. We need to give regulators who are charged with controlling these markets the tools they need to do the job that needs to be done.

Senator CANTWELL from Washington offered, and the Senate approved by a vote of 57 to 39, an amendment that bans all forms of manipulation. Unfortunately, the conference report does not contain that language now, language which was strongly supported in the Senate.

The other problem I mentioned when I started my comments, that I want to say a few more words about, is the problem of the financial meltdowns that we saw as a result of unwise investments by utilities in nonutility ventures and the risk that brings to ratepayers.

The conference report repeals the Public Utility Holding Company Act. I have supported repealing the Public Utility Holding Company Act, and I will explain why. But this conference report repeals that act without providing adequate protection for consumers to replace the necessary protections that were in that act. I have always taken the position that we should repeal the Public Utility Holding Company Act because it is no longer a useful device, but at the same time we should add authority to the Federal Energy Regulatory Commission to review mergers and to review dispositions of property by utilities so we can be sure consumers and ratepayers are protected.

The conference report purports to contain such strengthening of authority, but I would argue that, in fact, it weakens the authority of FERC to review mergers.

There are three problem areas that I see with this language. One is, the jurisdiction over mergers; second, the failure to guard against cross-subsidies, which I think is very important and which was in the bill we passed through the Senate earlier; and third, the language which shifts the burden from the company to the Government if a merger that is occurring is going to be stopped. It automatically occurs if the Government does not act to keep it from occurring under this language, and I think that is bad public policy.

FERC's merger authority is essential in this industry, which has been based on a system of local and regional monopolies but which is moving toward depending almost entirely on a competitive wholesale market for electricity generation.

The industry is highly concentrated. Consolidation of generation and distribution of transmission can prevent the development of a competitive market. One of the key failures in the bill, as I see it, is that the bill does not make the generation of energy or power a subject that is under the jurisdiction of the Federal Energy Regulatory Commission. Without authority over this generation of power, FERC would have to stand by and watch while this industry or parts of it reconcentrate. A single company could acquire every generator in the United States and the Federal Energy Regulatory Commission would have no authority under this act to deal with that problem. Or a single company could acquire every generator in a particular region and the Federal Energy Regulatory Commission would be unable to deal with it. This is surely incompatible with the idea that we want to develop competitive markets.

Even when the transaction is only the sale of a facility, there are serious issues at stake. Many of the utilities that are in the headlines lately are there because they are facing deep financial problems that have come as a result of the utilities spinning off their generation capacity, their powerplants, to affiliates which then are in the unregulated electricity market. Companies such as Xcel and Allegheny are experiencing extreme financial distress because of the activities of their generation and marketing affiliates.

A second failure of the proposal is that it does not require FERC to create real protections against cross-subsidy and encumbrance of assets in the new merged company. In the bill that we passed in the Senate, we had protections against cross-subsidy. We said the Federal Energy Regulatory Commission must determine that if someone is going to buy something that is not part of their utility business, they are not going to be cross-subsidizing some kind of nonutility activity.

Now, that is an essential protection for ratepayers. Otherwise, the ratepayers find their electricity rates going up because the company is losing money in some unrelated business. Clearly, we should protect consumers against that.

The provisions we had in the Senate bill, the one we sent to conference, required that the transaction do no harm either to competition, consumers, or the capacity of regulators to regulate, and it required that the Federal Energy Regulatory Commission determine that there would not be a cross-subsidy to an affiliate company and there would not be an encumbrance of the assets of the utility for the benefit of some affiliate. That is a very important provision which, unfortunately, has been dropped from the bill.

In the past, all generation was owned by utility companies. Clearly, that was under the jurisdiction of the Federal Energy Regulatory Commission. If a utility merged with another utility, the merger was under the jurisdiction of the Federal Energy Regulatory Commission under the Federal Power Act.

But we are in a new world now, and generation can be separated from the utility company, either sold to a stand-alone generation company or spun off to an affiliate of a holding company that owns the utility, and such sales or spinoffs would not be under their jurisdiction either under the Federal Power Act, since the generation facilities are not under the jurisdiction of FERC, or of course under PUHCA, since we are going to repeal PUHCA, the Public Utility Holding Company Act. So mergers of stand-alone generation companies would not be something FERC could look at.

A third key weakness of the proposal is that it requires FERC to act on a merger within a certain timeframe. It says that within 180 days, FERC needs to act. If FERC determines that is not enough time, it can extend that for another 180 days. But if it does not rule against the merger at the end of the second 180 days, then the merger is approved. That is putting the burden on the wrong end, in my view. I favor requiring FERC to issue an order approving the merger, as is current law. This is a major weakening of current law we are being presented with here.

These are only some of the problems in the electricity title. I have also expressed concerns about the provisions that give the Commodity Futures Trading Commission a role in monitoring markets that cut the Federal Energy Regulatory Commission and States out of such activities; also, over a provision that raises the bar for the Federal Energy Regulatory Commission review on whether contracts are resulting in rates that are just and reasonable. I know others are going to address those problems in their comments.

We have tried, at every opportunity during the long course of this legislation, to correct these problems. We tried to offer amendments that would strengthen the Federal Energy Regulatory Commission's merger authority, amendments to ban all forms of market manipulation, amendments to clarify FERC's authority and to strike participant funding language. We have not succeeded in making those changes. As a consequence, we have a bill that in my view, I regret to conclude but I do conclude, weakens consumer protections and reliability protections with regard to electricity.

There are others here seeking the floor, wishing to speak. I yield the floor.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. THOMAS. Mr. President, I would like to take some time on this bill. I think we should perhaps divide the time up a little bit here.

Mr. JEFFORDS. Mr. President, if I may? I ask unanimous consent that I be allowed to follow the Senator from Wyoming.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. THOMAS. Mr. President, I think we need to take a little time to talk about the purpose of this bill. All we have heard, frankly, is criticism. All we have heard is people being negative about the things that are there. The fact is, what we need in this Congress, and in this country, is a policy. We had a policy last year, you will recall, that had almost all the things about which the Senator from New Mexico talked. It did not pass. We do not have an energy policy with all those things he insists upon getting in there.

We hear from the Senator from California about the problems that happened there. We need to go back and recollect some of the reasons they happened in California. That was because the State didn't allow for the development of energy, it didn't bring any transmission to get it into California, and they had some price controls on the retail but not on the wholesale.

We need to go back and focus a little bit on what our real opportunity and obligation is here, and that is to have an energy policy, a policy that deals with conservation, that deals with alternative sources of energy, that deals with research, so we can continue to use the energy we have now, but which also focuses on domestic production.

We can talk all we want about where we are going to be in the future, and I hope we are with more alternatives and more renewables, but the fact is we will not have those for several years. The immediate need is to make sure we do not become even more dependent on imported oil and gas from places such as the Middle East and Iraq.

I want to take a minute and talk about some of the things that are very positive here because there are very positive aspects to this energy policy, keeping in mind it is an energy policy, keeping in mind, also, that most of us would like to recognize the differences between the regions in the country.

The idea of having FERC control all the details of operations doesn't work. It is not acceptable. That is why it has changed this year, so we can put emphasis on regional organizations so States can concentrate on having things work the way they work in one region that don't work in another region.

That is one of the reasons that standard market design was not acceptable to most people. It has been modified in this bill so it is not laid on the country originally. There are certainly opportunities for FERC to exercise their responsibilities, as they should, but after the States have had an opportunity to work as States and then to work as regions. This is the direction we are seeking to go.

Let me go back just a moment to some of the things we seldom hear people talking about in the Chamber about which, it seems to me, we should be talking. One is energy efficiency. We require a 20 percent reduction in Federal building energy use by 2013. There is an effort to do something about it in the conservation area. The bill authorizes $3.4 billion for low-income housing, to be able to assist that housing in being more energy efficient. Our demand for energy—the production of coal, for example, in the last 5 years has doubled our energy. We are continuing to increase our demand, yet we are becoming more restrictive on our production.

We have to balance these things. That is what is done here, is to seek to get more energy efficiency. We seek to establish new energy efficiency standards for commercial and consumer uses of products, such as stoves and refrigerators and those kinds of things. We need to do that.

We also emphasize renewables. The talk here is we don't give enough attention to renewables. As a matter of fact, we do. There are incentive programs authorizing $300 million for solar programs with the goal of installing 20,000 solar rooftop systems in Federal buildings.

It authorizes over a half billion dollars for biomass projects. These are things that have potential but have not been moved. This is designed to provide incentives so those things can move forward. It authorizes $100 million in increased hydropower production to increase efficiency of dams.

So we have goals of increasing renewables by 75 percent over just a few years.

Clean coal technology—coal is our largest resource of fossil fuel. It now produces nearly 60 percent of the electricity in this country. It ought to be used as opposed to gas, for example, because we are going to have more of that and gas is more flexible for other uses. But what we want to do is perfect and increase and make better the generation facilities so we can have clean air, so we can protect the environment at the same time that we use this fuel.

The Senator from New Mexico was talking about transmission. Certainly you are going to have to have more of that. You have to start where the fuel is and go to the marketplace. That takes transmission. That takes movement of that kind. So we need to prepare for that, and that is what regional transmission organizations are for, so you can move interstate as you move in regions.

The States can agree on what we do there.

We talk about vehicles and fuels. Advanced vehicle programs: $200 million for that; and clean schoolbus programs. We are putting a great deal of money into the development of hydrogen for use in automobiles and elsewhere.

This idea that all we are doing is giving credits for production of coal, oil, and gas is not true. That just isn't the case. There are lots of other things in here, as a matter of fact.

We continue to increase funding for the Department of Transportation to work on improving CAFE standards so we will get better mileage out of the cars. I mentioned hydrogen. It is one of the real opportunities.

As I said, this is a broad policy. It follows what the administration began several years ago to have a policy for the future of energy production for this country. We need to deal with it in a broad way. This bill does.

I understand the people who seem to be concerned about it pick out those little things, and that is all they talk about. But we need to take a look at the broad bill and what it does. One of them, of course, is it gives some incentives for increasing production. That is what we need to do if we are going to continue to have the lights on and continue to drive our cars in the years to come.

We have to have production. We have ways to do that. I happen to come from a production State. We can produce more. At the same time, we can protect the environment.

These are issues that we talk about here in terms of transporting. For instance, we can produce more natural gas in Wyoming, and we can have a pipeline to get it to the marketplace. We are in the process of doing that. This helps considerably. The same thing is true with electric transmission.

There are a great many details which we could go into here. A lot of people have talked about the cost. There is a cost.

Let me tell you very briefly, from a conservation standpoint, that there are tax credits for energy efficiency. That is a pretty good thing to be doing—tax credits for producing electricity from certain renewables. I believe that is the direction we want to move—and fuel-efficient vehicles. Some of these tax credits are going to create more conservation.

We have talked about reliability in relation to the California situation.

There are some incentives for accelerating depreciation; and natural gas-gathering lines so we continue to produce.

These are a great many things of that kind.

Production by marginal wells is one of the areas that needs to be visited. A lot of older wells only produce a few barrels a day. There has to be some incentive to continue to do that. But it is a very important production aspect so we are not totally reliable on imports.

I see others on the floor who are going to be more positive than we have heard for a while. So I will slow down here. But I do suggest that we take a look at our demand for energy and take a look at the growth of demand for energy. Look around in your own family, in your own business, and in your own place where you are sitting right now. How much increased demand do we have for energy? Then take a little look at where we are going to be in 10 or 15 years from now. How are we going to deal with that? That is really what policy is about.

Take a little look at this bill and you will find we are talking about conservation, renewables, and domestic production so we can meet the needs on which all of us would agree.

I yield the floor.

Mr. CRAIG. Mr. President, will the Senator yield for a unanimous consent request?

Mr. THOMAS. Yes.

Mr. CRAIG. Mr. President, I understand Senator JEFFORDS will follow the Senator from Wyoming.

The PRESIDING OFFICER. The Senator is correct.

Mr. CRAIG. The chairman of the full committee has just come to the floor. Senator CORNYN is on the floor ready to speak. Senator JEFFORDS has such time as he will consume. I was going to offer a unanimous consent to allow Senator CORNYN to speak, to be followed by Senator DOMENICI. Is there any objection to that?

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. CRAIG. I thank the Chair.

Mr. THOMAS. Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. JEFFORDS. Mr. President, on Monday, I addressed the Senate to share my concerns about the environmental impact of the Energy conference report. These provisions are a direct reflection of the manner in which this bill was developed and the flawed conference process used to produce it.

Nearly 100 sections of this bill are in the jurisdiction of the Environment and Public Works Committee. We were not consulted on any of these provisions—not on any of them.

In some cases, such as on the issue of nuclear security, the Environment and Public Works Committee reported legislation on a bipartisan basis. The Senate could have taken up the reported bill and passed it.

Instead, they stuck the provisions of the original introduced version of this bill in this report. Now my committee will likely have to go back and clean up this language if the bill becomes law. This could have been avoided, if the conferees had spoken to my committee in the first place.

I am deeply concerned that the conference report before us does not represent the kind of forward-looking, balanced energy policy that our Nation needs. As I mentioned earlier this week, it does not go far enough in reducing our reliance on imported oil. Further, the bill fails to provide appropriate and adequate remedies to prevent a recurrence of the electricity blackout the Northeast experienced this summer or the crisis that the West experienced 3 years ago.

The Energy legislation fails to address other important issues such as a renewable portfolio standard or climate change.

The bill contains waivers of environmental laws, and it provides for unjustified subsidies and porkbarrel programs. But, worst of all, this bill seriously harms our environment.

On November 7, 2003, I wrote all Members of the Senate listing seven of what I believe to be the most troubling environmental provisions of this conference report. The Environment and Public Works Committee has jurisdiction over all of these items. Six of the seven items outlined in my letter are now in the bill. The bill has not one but two provisions extending compliance deadlines for Federal ozone pollution standards.

I also mentioned in my letter that I was concerned the bill would delay our new Federal mercury emission standards for utilities. It doesn't do that. Instead, it authorizes $1.5 billion in compliance assistance grants for the utilities. Instead, the bill proposes to pay up to 50 percent of these compliance costs. This is poor policy.

I would like to review the status of some of the other provisions I described in my November 7 letter in more detail.

First, I would like to let colleagues know that the renewable fuels title in the conference report differs significantly from the language reported by the Environment and Public Works Committee in the 107th Congress. The provisions that my committee reported were ones contained in the energy legislation that the Senate passed this year and last year.

This conference report will shield companies that make, use, or market toxic gasoline additive MTBE from Federal and State product liability lawsuits.

Let me repeat that. It will shield companies that make, use, or market the toxic gasoline additive MTBE from Federal and State product liability lawsuits.

MTBE has contaminated ground water in every State of this Nation. This provision was not included in the Senate-passed bill. This provision shifts an estimated $29 billion in cleanup costs from oil and chemical companies to State and local American taxpayers.

The General Accounting Office estimates that there are at least 150,000 MTBE-contaminated sites nationwide.

Vermont has 851 of those sites. Public and private drinking water systems in my State have been polluted by MTBE. If the water right here in the Capitol building was contaminated with MTBE, we would ban this toxin today.

Even though we know MTBE is environmentally harmful, the conference report dramatically extends the time that this product can be added to our gasoline before we pull it off the market. In fact, it may be extended forever.

Besides the MTBE problem, the renewable fuels provisions in this conference report are deeply flawed.

The Senate's renewable fuels title was a carefully drafted package which balanced regional interests. Now, it is unbalanced in so many ways.

For instance, the Senate put positive environmental provisions into our renewable fuels package. One provision allowed Northeastern States to require reformulated gasoline statewide.

We also provided the Environmental Protection Agency with the authority to better regulate fuel additives to prevent future MTBE-like situations.

We provided States with authority to reduce the emissions from fuels if too much ethanol was being used. These are all gone.

Although I support renewable fuels and ethanol, this package has changed so dramatically that it is harmful to the air and water. I cannot support using the fuels provisions of the Clean Air Act to damage air quality.

A second item from my letter is the treatment of ozone pollution standards in the conference report.

The conferees have agreed to include an extraneous new provision amending the ozone nonattainment designation process in Title I of the Clean Air Act.

This is the part of the act that officially tells the public how dirty or clean the air is. It tells the public whether their area meets the health-based ozone standards and it determines what must be done to help clean up the air in that area and for its downwind areas.

This is an entirely new provision, it was not considered by either the Senate or the House of Representatives.

This provision, inserted in the secret conference, would allow polluted areas off the hook for controlling ozone pollution for years at a time. It would extend the deadline for compliance with the ozone standard almost indefinitely for many areas.

It would also reach back in time and declare some cities with serious air quality problems as "clean." This whole provision is a direct attack on the Clean Air Act and bad for public health.

As a result, people downwind will suffer. The air of the communities downwind of these "extended compliance" or "reclassified" areas will get dirtier. There will be more asthma and more respiratory problems.

This provision is not the answer to transported pollution. The answer is for this administration to get cracking on protecting air quality.

Changing cities' ozone compliance deadlines under the Clean Air Act does not increase our Nation's alternative energy supplies.

This provision is not an energy policy measure. It does not offer an energy-related solution to compliance with ozone pollution standards, and does not belong in this bill.

The changes put in here by a Congressman from Texas are also unfair to States and cities that have already achieved compliance with the national ozone standards. These States and cities have worked hard and invested resources in controlling their pollution. All their work will have been for naught.

There are other cities that have been "bumped up" or classified as having more serious ozone problems. EPA has already asked them to undertake more stringent ozone control efforts.

These stronger measures are already required and being implemented in numerous cities throughout the Nation including: Chicago, Milwaukee, Baltimore, Philadelphia, New York, Wilmington, Trenton, Los Angeles, and Sacramento.

Mr. President, in addition to this general assault on public health, the conferees have included one other little gem. EPA is prohibited from imposing any requirements of the Clean Air Act on an area of Southwest Michigan for 2 years.

Obviously, this provision was also not contained in either the Senate or House bills. Nor is it good public health policy.

Not only is the Clean Air Act substantially amended in this bill, but the Clean Water Act is as as well. The conferees have included language similar to a provision in the House-passed bill that exempts oil and gas exploration and production activities from the Clean Water Act stormwater program.

The Clean Water Act requires permits for stormwater discharges associated with industrial activity. The conference report exempts oil and gas construction sites from stormwater pollution control requirements.

The scope of the provision is extremely broad. Stormwater runoff typically contains pollutants such as oil and grease, chemicals, nutrients, metals, bacteria, and particulates.

According to EPA estimates, this change would exempt at least 30,000 small oil and gas sites from clean water requirements. That is a terrible rollback of current law.

Another troubling section of this bill is the leaking underground storage tank provisions. This issue is also in the Environment and Public Works Committee jurisdiction.

This is another case where my committee unanimously passed a bill that is stronger than the provisions in this conference report.

The conference report's inspection provisions are so lax that a tank last inspected in 1999 may not be reinspected until 2009. The bill my committee passed, and that I supported, would require inspections of all tanks every 2 years.

While the underground tank program needs reform, the conference report takes a step backward. It allows leaking tanks to remain undetected for years. And, in many cases, it allows the polluter off the hook for cleaning up his own mess.

Let's review what we are debating today: An energy bill. Actually, it is an energy producers' bill; an energy polluters' bill; an energy profiteers' bill.

The three Ps: Producers, polluters, profiteers.

I would like to focus briefly on the polluters.

A senior member of the conference committee reported that, yes, this bill will not reduce our reliance on polluting sources of energy. But it will secure our energy independence.

I agree with the first statement, that with this bill our Nation becomes more addicted to energy sources that pollute. In fact, I would say that this energy bill equals pollution.

Four words and a numeric symbol say it all here on my chart.

Energy bill equals pollution.

This bill pollutes our surface and groundwater by exempting oil and gas development from provisions of the Clean Water Act.

This bill pollutes our drinking water by allowing MTBE, a toxic fuel additive, to seep into our public and private drinking water systems.

This bill pollutes our land by allowing unlimited development of energy installations on public lands, including parks, wildlife refuges, and sensitive areas.

And this bill pollutes our air in so many different ways; primarily by extending pollution compliance deadlines and continuing to avoid serious progress in cleaning up our air.

Pollution, that is what we are voting on in this legislation.

A vote for this bill is a vote for greater pollution.

This is wrong. The American people do not want energy security at the expense of the environment. The word "conservation" and the word "conservative" are closely related. I am an independent Senator, but I consider myself to be a careful legislator.

I seek to be conservative. I try not to support legislation that exploits our natural resources and pollutes our environment. This bill abandons that approach. It is an aggressive, overreaching measure. I oppose this bill, and all other Senators should as well.

Mr. President, one last thing I should note for interested Members is that this Barton ozone provision is not the same as the former Clinton "bump-up" policy. That policy was a case-by-case basis and it applied only to the outgoing 1-hour ozone standard.

Also, the areas receiving the benefit of not being "bumped-up" to a higher nonattainment status under the Clinton policy had to demonstrate that their emissions did not cause problems downwind. That protection appears nowhere in Barton.

This Barton provision completely disrupts the Clean Air Act's designation process and appears to do it indefinitely.

I hope the Congressman from Texas is willing to pay the hospital and doctor bills of all the children whose health he and his Congress will damage if this bad bill becomes law. Every person who votes for cloture and for this bill should also be held responsible.

I ask unanimous consent to have printed in the RECORD a one-page explanation of how the Barton provision is different from the former Clinton policy.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

Barton's Ozone Extension Provision Is Far Different Than 1994 Clinton "Bump-Up" Policy

The 1994 policy explicitly states that the policy should apply only where "transport from an area with a later attainment date makes it practicably impossible to attain the standard by its own attainment date."

The 1994 policy says that in this situation where it is "impossible" to meet clean air standards due to transport, the attainment date may be extended, but the new attainment date must be "as soon as practicable based on the maximum acceleration practicable for emissions reductions in the downwind area and in the upwind area."

Barton's provision (Section 1443 of H.R. 6) is not limited to situations where transport makes attainment of clean air "impossible." It applies wherever there is a "significant contribution" due to transport.

What does "significant contribution" mean? It is undefined in Barton's provision, but typically significant means "able to be detected or measured." That is a much, much less restrictive standard than the approach under the Clinton administration's 1994 policy.

And unlike the 1994 policy which discusses "maximum acceleration practicable for emissions reductions" in upwind areas, section 1443 does nothing to address upwind sources of air pollution.

Another big difference between the Clinton administration policy and Section 1443 is that Section 1443 is not limited to the one-hour ozone standard. Section 1443 also applies to the eight-hour ozone standard.

In 1998, when EPA revised their transport policy, they knew it would be short-lived. EPA had promulgated a new eight-hour standard in 1997. By applying this policy to the eight-hour ozone standard, Section 1443 will likely have adverse affects on air quality for years and years to come.

EPA has done no analysis regarding the public health impacts of expanding this policy from the one-hour standard to the eight-hour standard.

However, Abt Associates, a leading air pollution consulting firm, found that delaying action meet the 8-hour ozone standard for even one year would result in: Over 387,400 asthma attacks; almost 4,900 hospitalizations due to respiratory distress; and over 573,300 missed school days.

Rep. Barton has contended that this provision would just give EPA the discretion to grant a deadline extension if appropriate and that it would not require a deadline extension. However, the language is mandatory. If section 1443 is enacted, then it creates a new section 181(d)(2) of the Clean Air Act which says EPA "shall extend the attainment date" for downwind areas.

The PRESIDING OFFICER. The Senator from Texas.

Mr. CORNYN. Mr. President, I want to speak for a few minutes about the Energy bill conference report that is before this body, and specifically address some of the criticisms that have been made against a clean fuel additive that was mandated by Congress under the Clean Air Act, and which was specifically certified for use by the Environmental Protection Agency.

But, first, let me just speak more generally about the need for a national energy policy in this country. We are a country that likes to consume a lot of energy—whether it is gasoline, natural gas, coal—because it improves our quality of life and because it is key to growth in our economy and our prosperity, which, in turn, creates jobs so people can provide for their families.

At the same time, we are a country that loves and cherishes our environment, whether it is clean water or clean air. We know that by consuming energy we need to also take necessary steps to protect our air and our water and our environment at the same time. We do not want to be forced to choose one or the other. We want, and I believe we can have, both. We can have the energy we need in order to maintain our quality of life and our prosperity and to fuel our economy, and we can also have that energy supply produced and consumed in a way that protects the environment against unreasonable damage.

The reason I support this Energy bill is not because I believe it is perfect. I do not believe there is such a bill, unless the person talking happens to be the author of that bill. That is probably the only bill any of us would agree was perfect, the one that we were able to write by ourselves. But, of course, that is not the way it happens. That is not the way the Founding Fathers conceived of legislation passing.

So what we have is a bill that has some strengths and some weaknesses. But, on the whole, I support this bill because I believe, for the first time in at least 10 years, it means America has the hope for a national energy policy that not only serves our economic interests but serves our national security interests as well.

About 60 percent of the fuel we consume in this country is imported. Over the years, as we have consumed more and more energy, we have also become more and more dependent on imports from other parts of the world. We know one of those locations in the world is the Middle East, which is the subject, of course, of daily news reports. We know how troubled it is. We know how volatile that area of the world is. It means our energy supply is in jeopardy. Thank goodness we have been able to secure a steady supply of fuel, but it is at risk—as much at risk as the next headline, the next news flash, where we learn that some terrorist activity or some disruption of our energy supply is caused by other governments and other people beyond our control.

So I think what we need to do, and what this Energy bill does, is encourage innovation and increase productivity here in America so we are less dependent on imported energy. I think that is a good thing.

What we have right now is a schizophrenic energy policy in this country, one that squanders our strength in terms of our natural resources. It discourages innovation, and it leaves consumers too vulnerable.

There are specifically some interests that relate to my State of Texas in this bill that I want to talk about, but this is a bill that is not just good for Texas, this is a bill that is good for the entire Nation. It moves us one step forward, and it is one that I believe is in the best interests of the American people.

There has been some criticism of the provisions of this bill as they relate to a chemical called MTBE. The technical term is methyl tertiary-butyl ether.

Now, people may wonder why we are talking about MTBEs, and why it is so important. Well, the truth is, this was mandated, the use of reformulated gasoline, in the Clean Air Act about 20 years ago because what Congress recognized was that unless we could find ways to burn gasoline in a cleaner, more environmentally friendly way, then we were going to have dirtier air.

So Congress mandated the use of reformulated gasoline. American enterprise, as it does so well, innovated, created this product, which has then been used over the last 20 years and has enabled literally millions of people with lung disease, asthma, and the elderly to breathe easier. In other words, this oxygenate, as it is called, this chemical compound, has improved the public health in this country over the last 20 years. We are a better and healthier Nation for it.

As a result of this Federal mandate that reformulated gasoline be used, and that something be innovated and created to allow gasoline to burn cleaner so we may breathe easier, people in my State and around the country began to produce MTBE. And you do not do that overnight. It takes a lot of infrastructure. It takes a lot of investment to produce this particular product.

Indeed, 70 percent of MTBE is produced in the State of Texas and, not coincidentally, it creates a lot of jobs in our State. It is used in parts of the United States which are among the most polluted because we universally recognize that the use of reformulated gasoline and this particular oxygenate is important to reducing pollution and improving the public health.

Well, the problem is—that this Energy bill seeks to identify—in some places we have seen that people who store MTBE in storage tanks have not kept those tanks in good repair and they have leaked this oxygenate into the surrounding environment.

But rather than address their ire and their concern—a concern which I share—at those who maintain leaking tanks, we have people focusing on this chemical compound—which has not been shown to be harmful to public health but which, indeed, has improved the quality of the air we breath over these last 20 years—people who want to opportunistically claim that this chemical is somehow dangerous, when, in fact, the fault lies with those who do not maintain the tank in which this chemical is stored.

We realize—and common sense would tell us—that whether it is gasoline or whatever the product is, if it is in a leaky tank, once it gets out of that tank into the surrounding environment, it can cause some harm. Common sense tells us that. But rather than focus on the leaky tanks and the people who have negligently allowed those tanks to leak, we have people who want to aim their crosshairs at the people who produce MTBE, which has improved public health and air quality.

What this bill simply does is provide a safe harbor provision for those who have produced this product, which has improved the public health, and says: We are not going to stab you in the back for doing what the Federal Government asked you to do in the first place.

In other words, the Federal Government said: Please invest your money, Mr. Businessman. Please create this infrastructure to produce this reformulated gas additive that allows our air to be cleaner.

We are not going to let that happen and then years later, when perhaps memories dim and when someone has another idea, to say: Yes, we have you. Now you are going to be liable for money damages because you have done what Congress and the EPA asked you to do. We don't care about the benefit to the public health by producing clean air because now all we are concerned about is getting the people who have, perhaps, the deep pockets.

What we are discussing, in terms of the safe harbor, is a provision that ensures fairness, that preserves the trust that is so important to guaranteeing that we in this country have the benefits of the innovation that the free enterprise system provides and that improves all of our lives.

I hope we are not going to say to those who place their trust in Uncle Sam, when Uncle Sam says, please, Mr. Businessman, innovate and create a product that is going to improve public health, we are not going to allow that to be turned into a liability. There are some who want it to turn into a liability. In fundamental fairness, as well as our collective interest in the innovation that comes in the free enterprise system, when people step up and produce a product from which we all benefit, we should not let that innovation and we should not let that commitment and that trust suffer as a result of this legislation.

I congratulate Chairman DOMENICI and the conference committee for standing strong in the interest of fairness. It is true that over the next 15 years, MTBE will be phased out. There will be other products that will step in to provide cleaner burning gasoline, those that are based on ethanol. But, frankly, unless the safe harbor provision stays in this bill, if I were someone who was going to produce an ethanol-based gasoline additive to produce a cleaner burning fuel, I would be very skeptical about investing the money, about developing a product that will clean our air, because I would worry that just as those who are targeting MTBE, we would be back here 10 or 15 years from now, saying: We caught you. And what are you guilty of? You are guilty of trusting Uncle Sam and Congress. Now we are going to let entrepreneurial lawyers and others make claims regarding the very product that you designed in order to meet the needs of the American people. They are going to sue you for it and try to take everything you have and more.

I don't think that would be fair. I don't think that would be right. Frankly, I wanted to come out here and talk a little bit about how we got to this place because I think anybody who understands the complete story would understand that while this bill phases out MTBE use over the next 15 years, it also, at the same time, preserves the trust that is so important to getting investment in innovative products that make the public health better.

Manufacturers will be extremely reluctant to invest in other additives without some confidence that the Federal Government will not allow those investments to become the basis of future liability.

In short, the bill Chairman DOMENICI and the conference committee have crafted ensures that clean alternative fuels will not be regarded as unreasonably dangerous simply because they comply with Federal mandates. It is important to say, though, that if someone is negligent, whether it is maintaining a leaky tank that contains MTBE or any other product, and it causes harm, they are not protected by the language in this bill in any way. There is no defense or immunity from a suit for negligent conduct.

I have heard some say that MTBE is a threat to public health. As I said, MTBE on the whole has benefited public health. The truth is, it is one of the most widely studied chemicals in commerce, including the pharmaceutical industry. The overwhelming majority of scientific evaluations to date have not identified a single health-related risk from the intended use of MTBE in gasoline. Numerous government and world-renowned independent health organizations to date have found no compelling reason to classify MTBE as even a possible cause of harm to human beings. Because MTBE manufacturers have complied with the requirements of the federally mandated program, MTBE should receive the equivalent legal treatment as ethanol for the reasons I have mentioned: for reasons of fairness and sound energy and consumer policy, and to encourage the kind of investment that ultimately will improve and maintain the public health.

The facts that demonstrate the need for a comprehensive energy policy that this bill represents are overwhelming. Gas prices are at $1.50 and above in most areas of the country. Natural gas prices at the burner tip are more than $9 per 1,000 cubic feet. This summer, as we will recall, 20 percent of the Nation faced a total blackout which lasted more than 8 hours. If now is not the time to pass comprehensive energy legislation, I ask my colleagues: When is? If now is not the time to pass comprehensive energy legislation where America can again have a coherent and comprehensive energy policy that protects our economy and our national security, when will we pass such a bill and embrace such a policy? We should do so without any hesitation and without any further delay.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Mr. President, I was going to go next, but I note the attendance of the distinguished Senator from Louisiana. He would like to speak, and I will yield to him.

Let me make one or two observations regarding the speech just delivered. First, I thank the Senator from Texas for the reasonableness, the rationality of his discussion. He would not believe, the people who have listened to the debate over the last couple of days would not believe the facts as you have described them, which are the facts, with reference to MTBE. This bill does not say if somebody misuses MTBE, negligently spills it, if they have tanks that leak, if they are not careful to keep it where it is supposed to be, it doesn't say those kinds of actions are rendered nonactionable in tort liability.

The safe harbor is very narrow. It says the producer of the product, which has been determined by the Government and to date determined by scientists to be totally safe and very effective, it says those who made the product are not liable for the mere fact of making it and selling it. They are not liable. If it causes harm because of other actions with reference to it, then the hold harmless does not apply. That is what the Senator has been telling us today; plus, he has enlightened us that, even as we speak today, contrary to the elaborate statements regarding people who have been damaged and hurt, the scientists in the Government still say, as a product, it is safe; as a product, it is tremendously effective; and as a product, the Government isn't even considering doing anything about it. They are not out there saying we want to stop it. I have not heard that from the EPA or anyone else—I think because they would have no evidence—that there is anything wrong with the product.

I say to everybody in this country who wants ethanol, ethanol may prove, as an additive, in 15 years to cause some damage. Are we going to go back 15 years and say to the farmers who grew the crops that went into ethanol: You are collectively, as the farmers of America, liable for producing the corn that produced ethanol that produced a problem 15 years later? I doubt it, because I don't think anybody would be down here saying we want to stick all these hundreds of thousands of farmers. But right now we are saying: Have at it, trial lawyers, we hope you can get after these guys because somebody got hurt. Sue the companies that produced it. People are saying: After all, they are rich companies.

That is not the American judicial system. Liability is not based on whether you have a successful company. As a matter of fact, one of the reasons some people are upset about this safe harbor is that they think the ones with money are the ones that are going to be in this safe harbor; namely, those that produced a product. They don't think there is going to be enough money for them out there in the marketplace where other things have gone wrong. They don't want to have to look for people who had leaky tanks and sue them and their insurance companies. They want to leave that to somebody else, right? They want to go after one of these companies—I don't know which one—and a number of them are in Texas. People will say: There is that old Texas again.

Well, Texas has about 13 companies that produce various products related to this whole area, not just this. Some of them produce this product. If I were the Senator from Texas, I would be right here doing what he is doing. The Senator is not opposed to those companies, right, or embarrassed by them? He is saying: Good luck. He is not embarrassed that they are making money. I assume they pay a salary to people in his State. I assume these towns like them. They are not doing anything to these towns. There is no pollution in the towns where it is being produced.

Those who would kill this bill over this issue have said to the farmers of the United States who want to use their crops to produce ethanol—if you vote this bill down based on this MTBE issue, you are saying to the farmers in your States—there are 12 or 15 of them—that have lots of corn and soybeans: We are taking the trial lawyers over you. You are saying: We have a choice to make and tomorrow morning we will make it, and we will choose the trial lawyers; we want to help them and forget about the farmers. That is the issue, as I see it. This will not end because we are going to go into MTBE today in a little more detail.

I yield to the Senator from Louisiana.

(Mr. GRAHAM from South Carolina assumed the chair.)

Mr. BREAUX. Mr. President, I thank the chairman for the work he has done on this legislation. It has been difficult and time-consuming, and it has occupied a great deal of his time. It seems to me that everything the Energy bill does in terms of traditional oil and gas exploration and development, and what it does in geothermal, encouraging wind power and alternate fuels, has sort of become secondary to the question of MTBE.

I guess Americans who are watching this debate where we are talking about an Energy bill might say the whole thing will rise or fall on what Congress does with MTBE. They would say: What are you talking about? Energy security, energy efficiency, and lessening our dependence upon foreign imports; that is all part of this legislation. It does a good job in that area. Could it do more? Of course. But it does a good, solid job in working with the issues of electricity and traditional oil and gas development and alternative fuels.

So the question now comes down, for many on my side of the aisle, to what Congress is doing with MTBE. I thought I would try, in a limited way and in a limited amount of time, to explain what I think the issue is.

The legislation establishes for MTBE—which is a fuel additive, to make fuel burn cleaner, like ethanol—the same standards for liability for one who produces it and misuses it as it does for ethanol. What does it mean? The legislation simply says you cannot sue a manufacturer of this fuel additive because it is a defective product if it is made according to the standards to which the Government told them to make it. Congress mandated that people produce MTBE to be a fuel additive so that gasoline would burn cleaner. You can add ethanol or you can add MTBE, and the results are that you have a cleaner product.

Some in this country say: Well, if MTBE gets into the drinking water, the ground water, we ought to be able to sue the manufacturers because they have produced a defective product—even though they have nothing to do with the injuries or the damage that occurred.

What I mean by that is this. Here is an example. Suppose somebody goes down to the local Exxon station and they buy 100 gallons of gasoline, and then that person takes the 100 gallons of gasoline and dumps it into the drinking water system of their hometown. Should someone be able to sue Exxon because they have made a product that this person dumped into the river system or the drinking water system? Of course not. They would be laughed out of court. If the Exxon service station took the 100 gallons of their gasoline and dumped it into the river system, then Exxon, the seller and manufacturer of that product, would be negligent and would be responsible, and you could sue them.

But there are numerous lawsuits brought against the manufacturers of MTBE, not because they did anything wrong with the product they make; the product is made to be put into gasoline to make it burn cleaner. It is made according to the standards set up and required by the Federal Government.

So the legislation says: Wait a minute, you cannot sue the manufacturer for doing what Congress told them to do in making a product that, if used in a correct manner, is very efficient, effective, and helps clean up the environment.

Some say: No, we want to sue them because it is a defective product. The product is only defective if someone misuses it. Then they ought to be able to be sued. They should be responsible.

Somebody gave me the analogy of a company that makes baseball bats. If somebody buys a baseball bat and takes it home and beats up his wife or his children, or the wife beats up her husband, then someone should not be able to sue the manufacturer of the baseball bat. Of course not.

The bat, if used for its intended purpose to play the game of baseball, is not a defective product. That is the purpose for which it was manufactured. If someone uses it to cause harm, they should be responsible, not the manufacturer of the bat, not the manufacturer of the product.

If MTBE is used as it is supposed to be used and made according to the standards Congress told it to be made by, it is not a defective product; it is a very valuable product. The legislation simply says if the product is used according to how it should be used, you can't sue the manufacturer because someone else misuses it.

The important thing is that it does not deny an injured person redress or the opportunity to sue if damage is done. The proposed language in the chairman's bill makes it abundantly clear that any claims of negligence or spills or drinking water contamination can go forward in the judicial process. That is part of the chairman's legislation. The only claim that is restricted is suing someone who makes a product according to the formula they are supposed to make it; they cannot be sued for making something that we told them to make in the first place. Not only is that common sense, it is good judicial sense. That is what the bill says.

I read the legislation. I said: What is everybody talking about? Because it can't possibly be true. Guess what. It is not. The lawsuits that are still available to proceed against misuse of these areas are substantial. It specifically maintains claims for environmental remediation costs. You can still sue for drinking water contamination. You can still sue for negligence, for spills, or other reasonably foreseeable events. You can still sue for public or private nuisance. You can still sue for trespass. You can still sue for breach of warranty. You can still sue for breach of contract. And you can still sue for any other liability, other than a liability based on the claim that you made a bad product and, therefore, you ought to be liable for damages. I think that is something no reasonable person would say is needed or necessary.

I was reading the language. You can talk about papers and this group sent out this piece of paper and that group sent out this piece of paper, and we get all this material about "vote against this" and "vote for it." Every now and then it becomes important, I say to the chairman, to actually read the legislation. You cannot put a spin on the words of the legislation. Legislation is not a political document from the Democratic Policy Committee nor a political document from the Republican Policy Committee. It is the language on which we are going to be voting.

The language says very clearly that "nothing in this subsection"—in the bill—"shall be construed to affect the liability of any person for environmental remediation costs, for drinking water contamination, for negligence, for spills, or other reasonably foreseeable events, public or private nuisance, or trespass, or breach of warranty, or breach of contract, or any other liability other than the liability based on the fact that it is a defective product."

MTBE is not a defective product. If you misuse it, it can cause problems. If you drink it, it could kill you. That is not its intended purpose. If you drink gasoline, it will kill you. That is not its intended purpose. Its intended purpose is to run engines for the economy of this country.

I am well satisfied that we have crafted a section on MTBE liability that is reasonable; it makes legal sense, and it just makes common sense. There may be other reasons not to be for the Energy bill, but it should not be on this particular issue which has been misconstrued by those who say they have concern.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Mr. President, I struck an agreement with a couple of Senators who have been waiting to speak. Senator NICKLES would like to follow me. I ask unanimous consent that he follow me. Secondly, the Senator from California, who was just here a bit ago, asked that she proceed next, and I ask unanimous consent she proceed next.

The PRESIDING OFFICER. Is there objection?

Mr. LEAHY. Reserving the right to object.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. LEAHY. Let me see what this means. Are we doing this under a particular time?

Mr. DOMENICI. No, we are not.

Mr. LEAHY. The Senator from Vermont would like to speak on two different issues: the energy issue and wants his experiences here in Washington at the time of President Kennedy's assassination. I want to get some idea of time.

Mr. DOMENICI. The Senator can speak after the Senator from California. That is fine. She is right here.

Mr. LEAHY. Mr. President, Senator DOMENICI was saying the Senator from Oklahoma and then the Senator from California. Might I ask the Senator from Oklahoma—I am not going to object—how long will the Senator speak?

Mr. NICKLES. Twenty or thirty minutes.

Mr. LEAHY. The Senator from California?

Mrs. BOXER. Fifteen to twenty minutes.

Mr. DOMENICI. And I am going to speak for 20 minutes now.

Mr. LEAHY. I wonder if I might ask, to make sure in case Senators wish to speak longer, to amend the unanimous consent request so the senior Senator from Vermont could be recognized at a quarter of 2 for up to 20 minutes.

Mr. DOMENICI. I have no objection, but I would like to add, with that agreement, that the distinguished Senator from the State of Kentucky would like to speak, and he will either speak before the Senator from Vermont, if the quarter of 2 has not yet arrived, or after the Senator from Vermont speaks.

Mr. LEAHY. But at quarter of 2, the Senator from Vermont is to be recognized.

Mr. DOMENICI. That is the junior Senator from Kentucky who is asking for time.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DOMENICI. Mr. President, I sure hope the people in this country and those who have written about MTBE were privileged to hear the few remarks that took place this morning about the issue from the distinguished junior Senator from Texas and the Senator from Louisiana. I don't plan to speak anymore about MTBE now, but before the afternoon is finished, I will speak to it with a little more detail so people will understand that the House asked us to do this, and they didn't ask us for anything unreasonable. This is a very valid approach to a problem that cries out for a solution, other than to turn it loose and let anybody sue however they would like and see what happens.

Having said that, I wish to talk about this bill that is before us from the standpoint of what is going to happen if those who have come to the floor and been so critical of the bill prevail and we don't have this bill.

I don't want to go back and spend a lot of time duplicating the words that have been used about this bill. Suffice it to say, there have been enough negative words used about this bill that one might consider it is the worst thing that ever happened.

I would like to tell each and every one of the Senators and each and every American who is concerned what is going to happen if this bill doesn't pass.

The impression is this is just a big bill that somebody put together that has a lot of pieces to it. We don't like some of them and some of them we think are giveaways, so we ought to just kill it. I am going to use the word "kill" for a little while because I assume those people who have gotten up and talked that way would like to kill the bill.

First, if we kill this bill, fuel diversity efforts that will help reduce our dependency on foreign oil and gas will be killed along with it. In other words, this bill is a conscientious effort to help American industry, large and small, produce alternative sources of energy for America and, in many instances, to do that, they have been given a tax incentive. All of those alternatives will be dead when this bill is killed, if it is.

The ethanol program, which many have wanted for years—a few in this body don't like it, but let's just take it for what it is—everybody should know the ethanol program is dead, killed, gone, out the window.

Now, there are some who would applaud it, but the overwhelming number of people, and the entire agribelt of America, is cheering that we pass it, not that we defeat it. I, frankly, do not see any way, I say to all the farmers in this country, of ever getting an ethanol bill anywhere like this if this bill is killed.

So to repeat, for those who think we need ethanol to provide an alternative 5 billion gallons a year to the use of crude oil gasoline, and for farmers who want an alternative crop, kill the bill and you have killed that forever.

The renewable fuels provision would replace 5 billion gallons of oil with 5 billion of domestic-produced ethanol. I have alluded to it. It will die with the death of this bill.

Over 800,000 job opportunities for our citizens will go out the window, dead, killed, for those who relish speaking about killing this bill.

Clean coal initiatives, which for the first time say to America, America, you are king, K-I-N-G, King Coal, and we want to provide some incentives so you might use some of that coal. Well, for those who want to kill this bill, "King Coal" will remain a dead product. We can inventory it, we can take note of it, and we can brag that America has coal that will run the country for—I do not know how long. The last time I read something, it would run it for 500 or 600 years. Out the window, no chance to use it because we will be using every other fuel led by natural gas and we will soon be importing liquefied natural gas because there is no way we are going to use our coal.

So let me repeat in simple phrases, "King Coal" will remain dormant but for the small amount being used. Not a new powerplant will be built using coal. It is dead.

Yesterday there was a report by a commission. The commission worked since the Northeastern blackout. They issued a report, and the summary of the report is two or three pages long. What they have concluded, I say to my colleagues, is that the principal reason for the Northeast blackout is that some companies were not following the voluntary reliability standards. Then those who made the study conclude that if this bill is passed, there should not be another blackout because the reliability standards are made mandatory and they will be enforced by criminal penalties. So nobody is going to run around taking a chance with overloading and breaching the reliability standards. Reliability means that one is doing what is prudent and there is no more reference to the use of these lines.

So let us summarize that one. For the time being, and I think for some time to come, the blackouts in America will remain alive and possible because we will have thrown out the window the reliability standards that are in this bill because some want to make the case on an issue such as MTBE or the like which we are talking about today.

There is regulatory certainty required for the utility industry. If we fail to provide that, FERC, with congressional direction on issues such as standard market design and transmission pricing, will be gone. They will be dead. The repeal of the Public Utility Holding Company Act will be killed.

Some people have said if nothing else was in this bill, the repeal of PUHCA, a 1935 vestige that hangs around over the utility industry, prohibiting investment over some kind of fear that is no longer a reality—and look how long we have been waiting to get rid of PUHCA—I think it would be fair that I could say if this bill is killed, PUHCA is here forever. So industry that is waiting for an injection of money, they can sit by and eke out investment because the principal impediment will still be there. The repeal will have been killed.

There are some who say because their States have had some unlucky or unfortunate situations, such as Enron, that consumer protections are necessary and then, of course, they look at this bill and say, I know what protections I want and they are not exactly the way I want them in the bill, so they come to the floor and say there are no protections. But I say if this bill is killed, you kill the consumer protections in this bill which are against fraud, manipulation, which force increased transparency, which increase penalties for violation of the Federal Power Act and Natural Gas Act, and they close the Enron fraud loophole.

Now, you can throw all of those out the window for people who want to find fault and want to talk about a turkey and want to talk about the goodies in this bill, but I am telling you what you lose when you lose this bill. I am ready for anybody to come and say it is not true.

How are we going to get these if this bill dies? Will the House come marching down the aisle, just having gone through this exercise, and say, oh, well, let's just start next week and do another one? Does the Chair think so? I think not. Do my colleagues think this Senator spent the better part of a year on it, and do they think I am going to march to my committee and start hearings and saying, oh, well, we did the best we could but we better just start over again because we heard so many speeches? Not on your life. The speeches had little to do with the important provisions in this legislation. They had to do with things that were put in the legislation, as everyone knows, when it is run through both the House and the Senate and individual bodies and then through a conference.

Tax credits—let me say I am aware of the tax credit game, and this bill is filled with tax credits that people wanted and needed and on which I am sure some of my good friends are quite certain we were too generous. I note the presence of my great friend Senator NICKLES and I am sure he is not going to get up and speak about MTBE and we ought to take it out, but he is going to wonder whether we put in too many tax credits.

For every newspaper article and editorial that said: let's kill this bill, it is no good, there are hundreds of letters of support from the people affected. They do not write editorials. They write and tell us their problem.

The people who build and sell windmills and have giant windmill projects going, they are very clear. This is the best thing that ever could have happened to them. We have made permanent the production tax credit that is sending windmills soaring in the United States, and I do not mean soaring in the air, I mean soaring in numbers.

Some ask: Do you really want those, Senator? And I sometimes chuckle. I drive around and see some of them, and I am not sure. But they will build them pretty before they are finished. They will even be good looking. Right now, some people write us letters and say: We don't want any more of those. Some people in Massachusetts wanted us to put something in this bill saying the local community could stop them if they didn't want them. We couldn't get that done if we tried. In any event, the credits for that are gone. If we pass the bill, we will see it soar.

Regarding solar, we received all kinds of congratulations and support from the solar industry, saying it will finally go now. It will go, but it is dead in its tracks when this bill dies, if it dies. I don't think it is going to. At least I hope not.

You can go right on through. Biomass and all the others are anxiously waiting so they can begin to produce alternatives, adding to the totality of what we will use for energy in America.

We have been so bold that we say the next generation, economically speaking, will be the hydrogen generation. I am not sure about that, but this bill starts us down that path. I don't know where we are going to pick up a bill that will put together the kinds of things that are involved, such as $1.6 billion to start joint ventures with the automobile companies to build this.

Then there is nuclear. France leads the world. While we tremble, they build. While we worry, they have 78 percent of their electricity from nuclear power. While we run around worrying where are we going to put this waste product, do you want to take a trip to France? They will show you where they put theirs. It is a building that looks just like a schoolhouse.

You walk into it and look around and you ask: Where is the spent fuel?

They say: You are standing on it.

What?

It is right there. It is encased and they put in solvent and put in water, glass put upon it, and they are smart enough to say that will be safe for 50 to 100 years. Guess what. They say: We will find a solution or a use for it in that period of time.

We stopped producing nuclear powerplants, one of the reasons being we don't know what to do with the waste. An engineering problem, and nothing more, has killed nuclear power in America. We have said maybe somebody would like to try it and we will give them some incentive to get around the difficulties involved. I hope we do it this way. Because if we don't, I think we can probably say, during my lifetime—I am not sure about the lifetime of the occupant of the chair, who is a very young Senator and very much waiting around to see this happen. You may see it, but I don't think I will, because you have to give some incentives to get started and then the public will see the new generation, something we ought to have going on in our country.

I could go on. Before I stop, though, I want to talk about Alaska and natural gas. First there was a program—it is not in this bill—to capture crude oil that is in ANWR. We were told: If you put it in the bill, it will be filibustered. Isn't that interesting, Senator NICKLES? You weren't for taking it out; you wanted it in. Now we have left it out and we have somebody filibustering because of the MTBE hold harmless clause.

I wish we had known we were going to have cloture votes down here. Maybe we should have put it in and had cloture on a lot of things, including ANWR. But we didn't put it in, in good faith, because the minority leader said he had enough votes to kill it. So we left it out.

Alaska is loaded with energy. What do we do in this bill if we can't utilize some of their energy? We tried very hard to assure the delivery of natural gas to the lower 48 because it will not be longer than 10 years until we will be short of natural gas and we will be using it from other countries. Won't it be interesting? With a State of ours loaded with natural gas, America, which is using natural gas like it went out of style, will be importing LNG from all over the world. We will say: Here we are again. Instead of getting independent, we are getting dependent.

But we did try our best. This bill says bring it down through a certain area and bring it to Chicago. We said we will help the companies that will build it. We did what we could by way of credits and accelerated depreciation, but as of today we have no assurance that it will be done. We have hope, and at least we have done what we could, and it may happen. If you throw this bill out, that is not going to happen either. I don't know how long before you get anything going in Alaska, with the kind of fear and trepidation that happens every time you mention capturing some of their resources.

There are many other provisions in this bill. There are all kinds of great research programs. They are misunderstood because they are not paid for; they are authorized. They are saying if, in the future, Congress wants to pay for some additional research in—let's just pick one—nanotechnology, this gives them authority but doesn't pay for it. That is one. If you add it up, you will say this bill costs all these things, but it doesn't cost those things, because those are part of—like when you fund an education bill, you fund it for a lot more than you need and later on you pay for what you can afford.

I could go through some more, but my good friend Senator NICKLES wants to speak. He will be to the point. He will cite some problems with the bill, I am sure, and will also tell us some of the things that are reasonably good about it.

I am glad people have not come down here and made a lot of noise about the whistleblower protection because we did continue protection of whistleblowers, contrary to what some of their main groups are saying. They just wanted more, not continued protection. But we have continued them.

There are at least 10 other major issues we have done that I truly don't believe will get done in the near future. They are more or less moribund—that means dead—if we finish this bill by not voting for cloture and voting for the bill.

I thank the Senator for listening. To the extent there are programs in here that others have worked hard to get in here and are very proud of and I haven't mentioned, please understand I did not mention everything. I mentioned what I could. What I didn't, I am glad, in our spare time, to get on the phone and suggest to others the rest of the things that are here.

I close by saying there are a lot of ways we could have done this bill. We have been chastised, we have been ridiculed, we have been put upon because of the way we put the bill together. All I want to say to my fellow Senators is we got a bill. We tried this before. We have gone through a year, year and a half and got nothing. I started this with the idea we would get a bill and it would be reasonably close to what we would have gotten had we spent much more time collaboratively with many more scriveners, many more writers, than we had. I think that is the case. Most people who were interested saw the product long before it came to the floor.

You notice I did not mention electricity reform, other than indirectly. But I will say for those who want FERC to run the entire grid, they will have that if this bill fails. For States that think we ought to have FERC doing it, they can be gleeful.

We thought we ought to phase it in and we thought we ought to let some States provide differently for themselves, but we made sure they couldn't close out investors who wanted to come into their States and put in utilities. We didn't make it simple, but we let it happen and we let them get their money back, too.

Those are tough issues. You don't get the bill, and you might get what some people like, or you might get that chairman over there who thinks he knows how to run it all by himself. You might get that. I didn't think that is the right way to go. But I didn't have the luxury of writing four versions. We had to write one version the best we could for everybody. We did that.

I yield the floor. I thank the Senate.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I compliment Senator DOMENICI, the chairman of the committee. He stated at the beginning of the year that he was going to produce a very comprehensive Energy bill, and he has done it. I have been in the Senate for 23 years. I have been on the Energy Committee with Senator DOMENICI for 23 years. This is the most comprehensive piece of energy legislation we have had in that entire time. We have had a lot of people say we need a comprehensive bill, but until now, that hasn't happened.

A couple of years ago, there was an Energy bill on the Senate floor, but the Energy Committee didn't have a markup. Senator DOMENICI, as chairman, decided that wasn't the way to go. He rightly felt the entire Energy Committee should be involved in marking up this bill. We marked it up over a period of months, and took several weeks in committee to report it out. For this open and inclusive committee process I compliment Senator DOMENICI for his methodology in reporting out this legislation which helped insure a solid and bipartisan product. I know he has been criticized for the way the Conference process, but he did allow the committee to work its will, and now we have brought back a very comprehensive piece of legislation to the Senate floor.

I tell my very good friend from New Mexico that I agree with a lot that is in the bill. But I disagree with some of the things in the bill. I am going to support the bill on the whole because I think positive energy legislation is very critical if we want to have a growing economy. You cannot have a growing economy if you do not have viable, sustainable and reasonably priced sources of energy. It is very important that we pass a good bill.

I would like to share with my colleagues that I ran for the Senate back in 1980 because of misguided energy policy that passed the Congress during the Carter administration which I found personally infuriating. In the midst of an energy crisis, the Carter administration proposed and passed, under a Democratic controlled Congress, several energy measures at that time which only served to worsen the energy related problems afflicting our nation. As a business man living in Ponca City, OK, I thought: What in the world is Congress doing? Everything they were doing, in my opinion, was very shortsighted. Maybe they had good, laudable goals, but they were very shortsighted if you happen to believe in free market principles. The one bill they passed that probably had more to do with me running for the Senate than anything was the windfall profits tax, which Congress passed in 1980. I was a State senator who happened to believe in free markets. The knowledge that my government would pass a law which so disincentivised the production of the very commodity we were most in need of at that time led me to conclude these people were completely out of touch with reality.

Then Congress passed a bill that said we are going to tax domestic production, but we do not tax imports. The net impact of that is you discourage domestic production and you encourage imports. That was about as antifree enterprise as any piece of legislation I could conceive.

I was so irritated that I ran for office, and ended up serving in the Senate.

I might mention that one of the highlights of my legislative career was when we repealed the windfall profits tax in 1988. Frankly, I was embarrassed it took so long to get it repealed. I introduced legislation every year I was in the Senate to repeal the windfall profits tax. We didn't get it repealed until after it robbed the taxpayers of $79 billion, but we got it repealed.

We repealed several other pieces of the mistaken energy policy of the Carter era.

In a short sighted attempt to artificially incentivise renewables while ignoring market principals the fuel use tax said you couldn't burn natural gas in utilities and big powerplants. It passed in 1978. We repealed it in 1987.

The Natural Gas Policy Act of 1978 had dozens of different class categories for natural gas. I was pleased to be the principal cosponsor of the 1987 legislation to basically deregulate natural gas. That was a very significant piece of legislation that some people had worked on for decades, and we were finally able to get it through.

I might mention that at that time Bennett Johnson was chairman of the committee. He and Wendell Ford worked in bipartisan ways to basically deregulate natural gas.

I also might tell my colleagues that many people on this floor and many people who have not retired from this Senate said if we do deregulate natural gas, terrible things will happen; natural gas prices will explode. They did just the opposite. Gas prices went down. Oil prices went down after we deregulated oil.

Also, during the Carter administration they passed the bill creating the Synthetic Fuels Corporation to subsidize the creation of synthetic fuel from coal and shale oil. That was passed in 1980, and it expired—thank goodness—I believe in the 1986, but not before it wasted billions of the taxpayers dollars.

It is important that we not pass bad legislation. But it is very important that we pass energy legislation. We are far too dependent on unreliable sources that can choke and strangle our economy. We have seen that happen in 1993. We have seen it happen in other years. We can't allow that to happen. We have become far too dependent on foreign oil. We import over 50 percent, and it is growing towards about two-thirds dependency on foreign oil. That is not acceptable. What can and could and should be done?

The bill that we have before us has a blend of a lot of things. It encourages production and it encourages conservation. It also does a couple of other things—talking about some fixes on the books that need to be replaced.

It reforms PURPA, the Public Utility Regulatory Policy Act. I believe that passed in 1978 as well. We are finally going to repeal it. That required utilities to pay for avoided costs for energy and basically increased utility prices, in many cases by—I was going to say hundreds of millions of dollars. It might be hundreds of millions of dollars for one powerplant over the life of that powerplant or those contracts. I compliment Senator LANDRIEU who worked with me on that. If there is competition, we will repeal it. I appreciate her work.

We are also finally getting rid of PUHCA, the Public Utility Holding Company Act. This passed in the 1930s. Maybe it made sense in the 1930s. It makes no sense, and, frankly, it hasn't made sense for the last couple of decades. We are finally going to get rid of it. By getting rid of that, we will open up, frankly, investment for utilities and energy projects in the billions of dollars. It received almost no attention and no debate. But anybody who has looked at it—it has been mentioned by, I think, everybody from Alan Greenspan to many of the regulators—said get rid of PUHCA. We are finally going to get rid of that regulatory maze that is long overdue.

It is also notable to see what we didn't do in the bill that many of our friends, primarily on the other side of the aisle, wanted to put in this bill. We don't have renewable portfolio standards. If we did, the price of electricity would go up dramatically all across the country. They tried to do it even in the markup earlier this week. We were successful in defeating that. That is a real win for consumers. They forgot to tell you that if you had the renewable portfolio standards of 10 percent, if you do not meet the standard, there is tax. It says you have to pay a tax of 1.5 cents per kilowatt hour—about 50 percent of the wholesale price of electricity, if you do not meet this standard. That means if you don't make 10 percent, you could have your electricity prices go up by 5 or 10 percent. We defeated that.

We defeated a very onerous corporate average fuel economy standard that people wanted to enact. It would have mandated automobiles to average 40 miles per gallon. That would have eviscerated consumer choice and resulted in our citizens being forced to buy an economy-sized automobile which could prove very unsafe. It would have been a very expensive provision as well in terms of consumer costs and lost jobs in our auto industry. We didn't do that.

We didn't put in the global warming provision that would have greatly increased every person's utility costs, devastated our economy and would have made us uncompetitive internationally. We didn't do those things. I am pleased about that.

We did do some positive electricity provisions that will encourage regional transmission organizations, that will mandate reliability standards which will help us avoid curtailment in the future. It is not fail-safe, but it certainly is a positive step in the right direction.

Senator DOMENICI mentioned several other things in the nuclear field and other provisions in coal that should help us broaden and diversify our energy sources. He mentioned the tax provisions. I voted against the tax portion of this bill when it came out of the Finance Committee. If we were voting on the tax portion of this bill standing alone, I would vote against it now.

On the tax provisions, the administration requested $8 billion. The Senate Finance Committee reported out $15 billion, and this bill is $23.5 billion.

Mr. GREGG. Mr. President, will the Senator yield for a question on that point?

Mr. NICKLES. I would be glad to yield.

Mr. GREGG. I was wondering if the tax provisions as scored violate the budget on that point.

Mr. NICKLES. To answer my colleague's question, the budget points of order lie against the spending, and I expect the tax provisions as well.

Mr. GREGG. I thank the chairman of the committee.

Mr. NICKLES. Mr. President, we scored in the budget, I believe, $18 billion for this bill. This bill will score close to $30 billion, for the information of the Senator. It scores that way for a couple of reasons.

One, the tax provision. Also, there is a provision that says brownfield projects can be funded by bonds that cost about $2 billion, which I think is a terrible way to be financing projects. This is not an appropriations bill.

Senator DOMENICI also mentioned a lot of things are authorized. I hope and pray not everything will be spent that is authorized. I will tell my colleagues that is always the case. We authorize a lot more money than we appropriate, and thank goodness for that.

I'll mention just a couple of other things. There is also direct spending in this bill. I tell my friend from New Hampshire that this Senator, at least, questions the wisdom of doing it. By direct spending there are new entitlements for two or three items that are created. Coastal impact has an estimated cost of $1 billion. I predict it will cost a lot more than $1 billion over the next 10 years. I am sympathetic with those who live on the coast and they have drilling offshore and say they do not get anything. That money goes into general revenue. It should be subject to appropriation. The coastal State should receive some consideration, maybe some compensation. But to have it set up as an entitlement for 10 years and then subject to appropriation is a very poor manner of doing it.

There is deepwater research, $150 million that is direct entitlement spending for the next 10 years. Again, I don't think that is the way this committee should operate. This is not an Appropriations Committee. The same thing for Denali. They get about $500 million over the 10 years. That is $3 billion of direct or entitlement spending that, frankly, should not be in this bill.

Let me touch on a couple of other things that are in the bill that are critically important, and at least in my opinion, if you add this together, make the bill worthwhile. One is the Alaska natural gas pipeline. If you go back historically and read the debates that occurred in this Congress, this Senate, for the Alaska oil pipeline, it was one of the most contentious issues this body had seen in a long time. This Alaska gas pipeline could have been as contentious, but it is not. It is in this bill. It is a $20 billion project, maybe the largest project in the United States in our history, certainly one of the largest projects ever. It is in this bill with expedited procedures which make that pipeline viable, in my opinion.

We also have a provision that allows the pipeline to be amortized over a shorter period of time, 7 years. That will encourage the construction of the pipeline. That is jobs. That is energy. We have a very significant serious natural gas challenge or shortage or potential shortage and deliverability shortage, getting the product to the consumers in the next several years. Getting this gas that basically is stuck in the northern plains of Alaska to the lower 48 will help alleviate that shortage to the tune of trillions of cubic feet of gas. It is absurd to leave that gas in Alaska, in northern Alaska, untapped, unutilized. This bill will authorize and expedite the construction of that pipeline.

That, to me, is probably the best thing we have in this bill, the most pro-energy item in the bill. We also have some other things that make good sense, that do encourage production. I compliment our colleagues for putting those in the bill.

On balance, we need an energy package. The administration should be complimented for the fact that Vice President CHENEY led a task force and recommended many of these things. They are now in this bill. He has taken a lot of heat for it but, frankly, this country for decades has needed a comprehensive energy package. Vice President CHENEY and President Bush have led the effort to make that happen. Now we are within a day or so of actually passing a bill to do that.

While this bill is far from perfect, while this bill actually does cost too much, while the tax provisions in this bill are far too numerous, in this Senator's opinion, with way too many tax credits—I believe there are 19 new tax credits in the code, and I hate to see the Tax Code cluttered and confused and complicated, substituting the wisdom of tax writers over the free market—I still think on balance the country needs a bill, needs an energy package. I believe this is the best one that this Congress can write, at least at this time. I encourage my colleagues to support this bill.

I yield the floor.

Mr. REID. Mr. President, it is my understanding that it works better if people know when they are supposed to come. The order locked in now is Senator LEAHY will be recognized at 1:45; is that right?

The PRESIDING OFFICER. Senator BOXER has 15 to 20 minutes by unanimous consent.

Mrs. BOXER. There is no particular time set.

The PRESIDING OFFICER. Senator BOXER, Senator LEAHY, 1:45, and Senator BUNNING, either before or after Senator LEAHY.

Mr. REID. That is now the order before the Senate.

The PRESIDING OFFICER (Mr. BUNNING). That is correct.

Mr. REID. The only other Senator I know, either Democrat or Republican, who wishes to speak is Senator DURBIN. I ask that he follow Senator BUNNING.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from California.

Mrs. BOXER. Mr. President, there is so much to say about this Energy bill, I hope I am able to be coherent on why I think it ought to be defeated.

It is a bill, first of all, that is a tax giveaway to the biggest corporations in this country. Actually, the multinational corporations—$30 billion is the size of the giveaway; $30 billion of debt. When this administration came into power, we had a surplus. Now we are reaching a $500 billion deficit. This is adding $30 billion to it.

The attitude around here is, just let our kids and grandkids pick up that deficit. It is absolutely the wrong policy for right now.

This bill is an unfunded mandate because it gives a free ride to the makers of a poisonous chemical called MTBE that never was mandated by any government and was the oxygenate of choice of the oil companies. They knew it was poisonous and they kept on putting it into the gasoline. It has contaminated water systems all over this country. By walking away from this problem and giving a pass to the people who polluted our areas, in my opinion—and this is just my own words—I think it is immoral. That is why we have the cities of this country against this bill, the counties of this country against this bill, the water agencies of this country against this bill.

The more we let this bill hang out there, the more it smells. MTBE smells. This bill has a similar smell, a sour smell, a bad smell, a poison smell.

The chairman of the committee wrote this bill with one other person in a locked room. It is extraordinary. I thought when I went to school that I learned a bill becomes a law this way: They pass a bill in the House, they pass a bill in the Senate. If they are different, there is a conference committee. The conference committee is made up of people from both sides of the aisle, both bodies. They cannot add new and extraneous things into the bill that were not at least in one of the bodies—the Senate or the House. Then it goes back to each respective House of Congress. If it is passed, it goes on to the President's desk. We have a bill, therefore, that would be a compromise, that would be genuine, which would reflect the broad views of the conferees and, therefore, by extension, all sides of the debate reflected among the American people.

What did we have in this case? Two people of the same party from big oil States sitting in a room having a party. And what we are going to have if this bill passes is one huge party, with the biggest corporations in this country, the oil companies, nuclear—believe me, they will not be drinking water tainted with MTBE. They will be drinking the bubbly stuff, and it might even be imported. But it will be expensive. This bill is expensive. Thirty billion dollars is added on to our debt from the very people who say we have to be fiscally responsible.

Then the chairman of the committee says, in a most angry fashion, and it is his right—I am angry, a little bit different type of anger—says in his angry way: If you do not take this, you will never have another Energy bill because I am not going to do it.

This is a government of laws, not men. We can have a good Energy bill if we defeat this bill. We can have one that looks toward the future. We can have an Energy bill that is a 21st century Energy bill, not an Energy bill that is a 20th century Energy bill.

So the sky will not fall for my friends who want ethanol. And I understand they want that. By the way, there are some good provisions in there for my State regarding making ethanol out of rice straw. I worked for those provisions.

I am going to go through this bill: What is good in the bill, what is bad in it, and what is left out. I worked hard to examine this bill. But when all is said and done, it is an Energy bill that is a giveaway to the special interests of this country. It is an Energy bill which turns its back on people on the west coast who suffered from companies that ripped us off and owe us $9 billion just in California alone. It is an Energy bill that really just gives a wink and a nod to some of the possible ways that we can work ourselves out of dependence on foreign oil.

Now, again, the chairman of the committee is very ecstatic about this bill, and it is his right. Why wouldn't he be? He wrote it. He likes big oil. He is defending the makers of MTBE. He loves nuclear energy. The last I checked, we still do not have a safe way to dispose of the waste from nuclear powerplants. The last time I checked, in some places in Europe they are beginning to close down nuclear powerplants. Oh, but we are going to build a new one—we, the taxpayers, $1 billion, as I understand it—in Idaho.

Now we have reports—we were going to send all of our nuclear waste to Yucca Mountain—and now we hear, in Nevada, a new scientific report saying, watch out, that material can leak.

So this is not the time to be subsidizing the building of nuclear powerplants. My God, you would think this is the 1940s after World War II, "Atoms for Peace." It does not work.

By the way, I hope taxpayers understand that what is also in this bill is a 20-year extension of the Price-Anderson Act. What is that, you ask? That takes the nuclear companies off the hook if there is a nuclear accident. They pay for some of the damage but the mammoth amount of damage, which could go escalating to God knows where, you taxpayers are picking up the tab. So first you are building them the nuclear powerplant. Then, if there is an accident, you have to pick up the tab.

This is some Energy bill. This is the worst bill. I cannot think of the names—let's hear what some of the editorials are saying from around the country for this great Energy bill.

USA Today: "Congress forgets promises made in blackout's wake." The Brattleboro Reformer: "It's time to shift gears." The Billings Gazette: "Energy bill lacks critical balance." The Boston Globe: "A polluted energy bill." The Brunswick Times Record: "This energy bill is appalling." That was their word.

The Buffalo News: "Oil and grease. Energy bill fails country as it dispenses favors to the industry." The Cape Cod Times: "Misused energy." Des Moines Register—now imagine, this is in a place where they love the ethanol issue, and even with that, this is what they say: "The MTBE outrage." And I will go into how the MTBE outrage impacts my State.

The Fort Worth Star Telegram: "Coming up short." The Great Falls Tribune: "Senate should stall Energy Policy Act of 2003." Absolutely they are right. Count me in. I am going to try to stall this bill. I am going to try to kill this bill. I am going to try to stop this bill in every single way I can because it is bad for the people I represent and it is not the kind of bill we want for this country at this time.

Jackson Clarion-Ledger: "A 'P' Perfect Bill: Pork, Politics, Pollution." That is a good one. Lakeland Ledger: "Senate, derail the energy bill." The Los Vegas Sun: "Mixed bag on national energy plan." The Lewiston Sun: "Proposed law is lousy legislation." Their words.

Memphis Commercial Appeal: "Pork barrel bill, not worth the energy." Missoula Missoulian: "Energy bill uses tax dollars for fuel. Legislation larded with massive subsidies is a parity of effective energy legislation." That is from the Deep South.

The Nashua Telegram: "Rushing energy bill is a bad way to set policy." New Jersey Star Ledger: "Defeat GOP energy bill." Orange County Register—and this is in a part of my State that is predominantly Republican—do you know what they write? "Energy bill is a waste."

Palm Beach Post: "A powerless public." The Phoenix Arizona Republic: "Energy overload. Overstuffed bill has it all, except coherent national policy."

I just have to say, the more this bill is subjected to the light of day, out of that closed-door conference committee, with two people from the same party, from big oil States—the longer that bill sees the light of day, the more people will see it.

Now, yes, there are a few good things in this bill. I am going to tell you what they are. I am going to show you what they are. Then I am going to show you what was left out of it. And then I am going to talk about the bad things in the bill.

A good thing: Drilling in the Arctic Refuge in Alaska is not in this bill. As the person who wrote the amendment that stopped it before, I say thank you to all my colleagues on both sides of the aisle who stood tall and said: We will never allow this to be put in an Energy bill. Thank you. That is a good thing.

No offshore inventory of oil—I thank the House on that one. My friend LOIS CAPPS over there was fighting hard. You cannot go into a pristine coastline that is supposed to have a moratorium on it and then drill to see how much oil there is in it. Either it is pristine and it is left alone, and there is a moratorium to keep it left alone, or you might as well just go in and destroy it. The conferees said no to that because that would have been a poison pill, too. So thank you. It is not in there.

Something that is in there that I wrote has to do with incentives for making ethanol from agricultural waste. Now, this is something that is forward looking because we have rice straw and biowaste and sugar waste from beets and we know we can use that waste to compete with corn ethanol. We think it is exciting. If we can develop those industries in our State, then we do not have to ship that corn ethanol all the way across from the Midwest. That kind of shipping is going to add to the price of gasoline for my people who need to have their cars to go to work.

Energy efficiency by the Federal Government—I am very pleased we have that in this bill. That is an important thing to undertake.

Hybrid car tax credit—ditto. It is good.

Increased funding for energy assistance in LIHEAP—for the poorest of the poor. That is good.

I understand there are some solar tax credits in there, which I think are very important, to put solar energy on some kind of equilibrium. These provisions are very small.

Now, this is what is missing from this bill which would have made it at least relevant to what has happened in our country.

There are no refunds for the people of my State. We have been told by the Federal Energy Regulatory Commission that we have been ripped off, robbed. They have stolen our money with phony schemes to create artificial shortages. You all remember some of those schemes. The fact is, FERC, which can order these refunds, has refused to do so. This administration refuses to order FERC to get those refunds back to our people. Our new Governor has his hands full with tremendous deficits. That is our money, and we want it back. No, they would not go there.

No. 2, there are no long-term contract renegotiations for my State or other States on the west coast. What does that mean? These thieving companies, as they were robbing us blind, and had us over a barrel, negotiated long-term contracts for the future. They said: Oh, we are giving you a good deal. We are going to charge you a lot less than the spot price. Well, we were negotiating with them under duress. It was a phony price. A phony price was out there, and our Governor was trying to get the best deal.

Yes, he got a lot lower than the current price, but it was way over what the market is today. So we are asking for new long-term contracts. We want to do away with those. No, they didn't do that.

No end to electricity market manipulation schemes: Ron Wyden was very good on that point. We had schemes that had every name in the book. They made up names that you can't even believe. The one I hated the most was Get Shorty. Because I am a little person, I hated the name. But they were shorting us of electricity. They were doing all these things, and they were giving them all these names. By the way, why isn't someone in jail on all of that Enron stuff? No, we didn't go there.

No CAFE standards: Unbelievable. It has been pointed out that even China, that has a bad environmental record—I went there; they are building dams that are destroying mountains and homes and valleys,

I just got sick to see it—has set CAFE standards because they know pollution is bad for their people.

When cars pollute, kids get asthma, workers get sick. And if you can't work, that hurts productivity. It is just common sense. Forget the fact that it is the right thing to do to have CAFE standards and spare the air. No, they couldn't do this.

There is a huge SUV loophole. It was about $25,000, and in the last tax bill it went up to $100,000. The Senate tried to bring it back to $25,000 but the House rejected that effort.

No increased use of renewable sources for electricity: They walked away from the formula that Senator BINGAMAN had gotten into the Senate bill.

By the way, any resemblance between this Energy bill that is before us and the Energy bill the Senate wrote is purely coincidental. This is a completely different bill, written by two people from big oil States, who love nuclear energy and have walked away from fighting for the consumer. It is a sad thing. This is what is missing from the bill.

Now let me tell you what is bad about the bill. Unfortunately, it is a long list. We talked about giveaways to the oil industry. I want to give you a few examples of that: $10.5 billion in tax breaks would be provided to the oil and gas industries. The bill provides millions of dollars' worth of subsidies to the oil industry by reducing the amount of royalties—that is kind of like rent—that they have to pay to drill off our coasts and on our Federal lands. So they use our Federal land that all the American people own. They are supposed to pay royalties when they find oil there.

This bill provides royalty relief for marginal oil and gas wells or wells that are relatively less productive. They give this royalty relief to oil and gas development off the coast of Alaska as well as deep wells and deep water operations in the Gulf of Mexico.

Wake up, America. If you want to count, listen to these things. One of the things that I find happens, I went on TV and I did an interview on one of the issues we are going to be talking about, MTBE. The person interviewing me said: I know this is very complex but let's discuss it.

It isn't complex. It is pretty simple. This bill is a giveaway to the biggest companies. It walks away from the consumers. It lets the polluters go free. It is a 20th century Energy bill.

People say it is confusing; it is complicated. It is not so complicated. That is the way to say to people: You better tune out the argument; it is too complicated.

America, tune in. It is your future. It is your kids who are going to have to pay this $30 billion. It is your kids who are going to have to breathe the dirty air. It is your kids and your cities that are going to have to pick up the tab to clean up MTBE. So listen.

The bill would also reimburse energy companies for their costs to reclaim abandoned wells on Federal lands under a new program forcing taxpayers to pay these costs rather than industry. It would provide a broad liability waiver to oil and gas operators reclaiming sites on Federal lands. So they go on the Federal lands. They mess them up. They pollute them. They walk away.

These are our lands. The bill will take $150 million from royalties and fund research on ultradeep wells, unconventional natural gas petroleum, and the Federal Government may well give $50 million extra to this fund. This research would be done to benefit the industry.

You know what, let them pay for their own R&D. They get a great tax break. I am all for it. I give big tax breaks for R&D. We don't have to give them cash on the barrel.

Giveaways to the nuclear industry: I mentioned before the Price Anderson Act. If there is a nuclear catastrophe, don't worry about it, we will pick up the tab. Your children will pick up the tab, my children, my grandchildren. Not the nuclear industry, a 20-year extension.

If it is so safe, why can't they get insurance in the private sector for the possible damage it would do? I believe in checks and balances. The insurance companies are checks and balances. If a nuclear person comes in to an insurance company and sits down and says: Well, I might have an accident.

What would it cost?

Oh, $100 billion.

Well, I won't cover you for more than $10 billion. It would just break our back.

Oh, OK.

Maybe that is a signal, Uncle Sam, that this isn't safe yet. No, we are going to back up the nuclear industry for another 20 years. It raises the cap, which is a good thing, but it is still a cap nonetheless. They don't have to pay full insurance premiums. Why should they? This bill is for them. It is not for us.

If there were an accident, nuclear companies don't have to pay the costs of the damages because the taxpayers are on the hook. That is a great idea.

A $6 billion production tax break is in here for utility companies that operate new nuclear reactors. So while they are closing down nuclear reactors in Europe and while we are reading reports that Yucca Mountain is not safe, we are going to give tax incentives for new nuclear reactors.

It goes on on the nuclear side, but I will move on to one more point here: public health and the environment.

The placing of these nuclear plants is just not going to live up to the highest level of protection. There is concern to me in terms of dumping the waste and the injuries that could occur due to the fact that we don't know what to do with the waste. These people want to give tax breaks for dirty industry—$29 billion in tax incentives for the energy industry, and more than 70 percent of the tax breaks go to polluting and mature industries, including coal, oil, gas, and nuclear.

Yes, we gave some tax benefits to some of the new and clean energy but very small in comparison. It is $1.8 billion for the clean technologies versus $28 billion; it is about 28 to 1. That is a 20th century Energy bill. Now, we repealed consumer protections in the electricity market. That is another thing that is bad. The most eloquent Senator I have heard on this of all time is Senator MARIA CANTWELL. I am sure if she hasn't spoken already, she will explain to you what this means. I have to say that the Senator from New Mexico, who wrote this bill, with the Congressman from Louisiana, a big oil, big nuclear power State—he said: This is your last chance. You will never get to repeal the Public Utility Holding Company Act if you don't do it today.

I have one word for that: Wrong. We are going to be here every day. If he doesn't like PUHCA, you can try to do it another day, just like he can try to get his nuclear money another day, just like he can do tax giveaways another day, just like he can give a liability waiver to his big oil friends another day. You don't have to pass this bill today. That is the biggest bunch of baloney I have ever heard. We are supposed to be working here all year. We don't have to pass this today or tomorrow or the next day. I hope we will not because this Public Utility Holding Company Act is the main law to protect consumers from market manipulation and fraud and abuse in the electricity sector.

It is unbelievable that we have uncovered evidence about what Enron did, and we are repealing the one law that could help us in the future. It is, to me, outrageous. Again, I will leave that for Senator MARIA CANTWELL to talk about.

We see drilling and development of our public lands. In my State, I have to tell you that this bill has a special interest provision to site a high voltage electricity transmission line through the Cleveland National Forest. The State of California, through the PUC, said, no, it is not needed and not wanted. I wonder why, in the midst of the terrible fire that we just had, we are now going to put a high voltage line through a national forest. Can someone tell me why? Can someone tell me why we would permit the siting of a high voltage electricity transmission line through a national forest?

I will tell you why. It is a special interest provision, and the State didn't want it and the local people didn't want it. The State said no, but somebody put that into the bill. The more you read the bill, the more you learn. The bill would also put the Department of Energy in charge of permitting rights of way across public lands for utility corridors.

The bill would require the Department of the Interior to process applications for permits to drill for oil and gas on Federal lands within 30 days, even though people said we need more time to look at the facts.

So the USGS would be required to identify restrictions and impediments to oil and gas development. They are allowed to look at fish and wildlife, cultural and historic values, and other public resources. In other words, they can call these things "restrictions" and "impediments" when, in fact, the law has always said they should be respected. Now they are impediments.

Diminished protection for our coasts: The first provision would grant the Secretary of the Interior broad new authority to permit energy development and support facilities anywhere on the Outer Continental Shelf. Authorized facilities would include those that support exploration, development, production, transportation, or storage of oil and gas. There are no standards for issuing or revoking easements, and the provision does not require consultation with the Secretary of Commerce.

There is no requirement that the Secretary of the Interior even consult with the States before making this decision on the Outer Continental Shelf.

I will explain the Outer Continental Shelf. The first 3 miles off of the coast are State waters. Where does the Outer Continental Shelf start? It starts after that. So you can, as a State, put all the restrictions on damaging projects that would occur because you believe your coastline is God-given. You believe your coastline is also an economic resource. You believe that your coastline and your ocean is important to protect the fish because, in fact, it is a big industry in my State. You do all these protective things.

Now they are going to say it is 4 miles out, or 3 miles plus an inch, and they are going to start looking on that Outer Continental Shelf and destroying it. This is what is in there.

They weaken the coastal zone, which is important to weigh in on what should be done.

Section 325 of the Energy bill erodes States' rights to review and respond to Federal decisions affecting coastal waters. Section 330 would also reduce States' rights to review and comment on pipelines and other energy-related projects off their coast by limiting appeals.

It is taking me a long time to tell you what is bad in this bill. There are more things, but I want to give you a sense of some of them.

Clean air rollbacks: Actually, they have amended the Clean Air Act. They have amended the Clean Air Act in this Energy bill. "Great news" for the American people. I am sure they are dancing in the streets that the Clean

Air Act has been rolled back in this bill that was written by two people of the same party from big oil States, behind closed doors, who are threatening that we will never see the light of day on any Energy bill if we don't pass their "masterpiece." The last I heard, every Senator is equal to every other Senator.

There is a provision tucked into this conference report designed to delay cleaning ozone pollution in some of the most polluted areas of our country. Under the Clean Air Act, the schedule is established for areas to clean up their air. How much they have to do, and in what timeframe, depends on how dirty or clean their air is. If these deadlines are missed, an area is bumped up into the worst air quality category. When this happens, a greater amount of air pollution must be reduced and additional requirements are imposed, but on a longer timeframe.

This provision will allow areas to avoid the additional requirement if some of the air pollution comes from upwind areas. Why this provision and why now? Because the Republicans are trying to overturn several court decisions holding that this type of an extension is illegal under the Clean Air Act. Their argument says it is unfair for a community to be forced to clean up air pollution coming from somewhere else.

Unfortunately, it appears that every community with poor air quality can meet this test because ozone pollution travels in the air. Somebody is going to be able to say we don't have to clean up our air because it is coming from somewhere else. Who gets hurt? The people who breathe the air.

Why would we delay cleaning up the air as it gets worse and worse? Do you think a child who is in a hospital because of asthma—do you think the mom will say: Why does my kid have asthma?

And the doctor will say: Because the air is filthy dirty.

And she will say: Oh, my God. That is awful. I am going to write my Senator.

Then the Senator writes and says: Your kid has asthma from dirty air, but it wasn't coming from your community. It came from another community, so please forgive us.

Wrong. This is what is done in this bill. Remember, this was written by two people of the same party from big oil States.

(Mr. SUNUNU assumed the Chair.)

Mrs. BOXER. Mr. President, the net result of this could be that no one will ever have to clean up the air until someone else cleans it up. It is unacceptable. Ozone pollution must be cleaned up. There are 130 million Americans living in communities that violate ozone smog clean air safeguards. Inhalation of smog is linked to respiratory illness, such as asthma, especially for children.

There you have that mother, as a matter of fact, in the hospital with her child because hospital admissions for children due to asthma alone increased 30 percent between 1980 and 1999. Overall admissions for respiratory problems increased 20 percent in the same time period. We had a 30-percent increase in asthma admissions in hospitals, but only a 20-percent increase for other things.

Let me say to all my colleagues who might be listening, and even to those who might read my remarks, go to any school in your State—it could be a public school, it could be a private school, it matters not—ask the children to raise their hands if they have asthma. Ask them to keep their hands up or new hands for someone who knows someone who has asthma or someone in their family, and you will see almost 40 percent of the children in that classroom respond.

In California alone, there will be 42,000 additional asthma attacks, 499 additional hospital admissions, and 68,000 lost schools days. What are we doing in an Energy bill to help those children? Are we going to clean energy? Of course not. Are we even moving to increase the fuel economy of our cars by 2 miles per gallon or 3 or 4 or 5? Are we? No, of course not. This is a bill for big oil. We do a little bit for hybrid vehicles. I am glad. We do a little bit for solar. But $28 billion to $1 billion in favor of big oil, big nuclear—big, big, big, big, dirty.

Clean water rollbacks: This might surprise you. This is an Energy bill. We have clean water rollbacks in this bill. The oil and gas industry is exempted from storm water runoff cleanup. This conference report contains language exempting oil and gas construction activities, including roads, drill pads, pipelines, and refineries from obtaining a permit and controlling their pollution runoff as required under the Clean Water Act.

Explain to me why this is necessary. Are these some poor startup companies that need our help and, oh, for a while we will let them be free of these requirements? No, these are multinational big companies that have fought so hard that we no longer have a real, important Superfund Program anymore because they don't even want to be taxed a tiny bit to clean up the mess they made. This bill gives them more rollbacks. They don't have to worry about clean air and clean water.

What is going on here? Then the chairman of the committee says: Oh, there will never be another bill; kill this bill and you will never see another Energy bill. Forget about ethanol. Forget about tax breaks for the things you believe in that might work because you will never get them. You are going to have to swallow all this bad stuff to get a bill.

I want to talk about some more of the bad items, and I will close on the MTBE issue.

Here is a picture of our country. All the States in black—and, Mr. President, I know this is an issue that is near and dear to you—all the States in black are the States that have either ground water contamination from MTBE or drinking water contamination. The ones with the little orange stickers have drinking water contamination.

Sad to say, my State has an orange sticker. When this came to me, I was stunned to hear that my town of Santa Monica in southern California had lost one-half of its drinking water. When the town tried to figure out what to do about it, they found out it would cost millions of dollars—$200 million to $400 million to clean up. This is a small city, relatively speaking in terms of California. We are a big State, but it is a relatively small city—$200 million.

They said: Oh, my God, what are we going to do? They did what every other city, every other county, every other water agency is going to have to do, be they in New Hampshire, be they in Minnesota, be they in Iowa, be they in Nebraska, be they in Nevada. They went to court. They filed a lawsuit, and they made a claim and said: Please, to the people who put this in our gasoline and it got into our water, please, help us clean it up. That is Santa Monica.

Many of you know of Lake Tahoe. It is a magnificent lake and a beautiful lake. It was getting polluted with MTBE. MTBE was leaking from the boats that were on the water into the lake. They went to court. They tried to sue under three grounds—nuisance, negligence, defective product liability. The judge in that case said on the nuisance claim: You haven't proved nuisance because you have to prove who did what to whom, when, and what day. Negligence, same thing. You have to find the people, you have to track the people. But defective product liability, that makes sense because in discovery they learned—that is a legal term when they are getting ready for the court case—they learned that the makers of MTBE knew this product was bad. As a matter of fact, they joked about it. I forget what exactly they said. One of them said: Major threat to better earnings, MTBE, because they knew some day the truth would come out. They joked about it. We found that out.

Here is the jury verdict on the Lake Tahoe case. They found the makers of MTBE knew beforehand that this was bad. This is the verdict: MTBE was defective in design because they failed to warn of its environmental risks. Gasoline containing MTBE refined by the other defendants at trial was defective in design because the environmental risks from MTBE outweighed the benefits and refiners failed to warn of its known risks. The refiners failed to warn, failure to warn. There is clear and convincing evidence that the companies acted with malice—acted with malice—as they developed, promoted, and distributed their defective MTBE product.

I say in the strongest of terms, when you are told and I am told that these companies acted with malice, why on God's green Earth would we give them a get-out-of-jail-free card in this bill? They acted with malice. They knew it was poison, and now this bill is saying, this bill that was written by two people of the same party behind closed doors from big oil States: You are off the hook.

I also want to tell you that the cost of MTBE contamination—this is a 2-year old estimate—is $29 billion. That is what this cost 2 years ago. We are looking at probably 50, 75, to 100 because all those States I showed you before are just now beginning to understand how dangerous this contamination is.

This bill is an unfunded mandate on New Hampshire. This bill is an unfunded mandate on California. This bill is an unfunded mandate on 43 out of our 50 States that have MTBE contamination.

Now, you can dress it up, you can make it look pretty, you can put lipstick on it and rouge, but the bottom line is, it is ugly. It is an ugly thing to do to the people.

I will show my colleagues our little "get out of jail free card." Here it is: MTBE producers not responsible for pollution, get out of jail free.

Is this why I came to the Senate? No. It certainly is not why the Senator from New Hampshire came, and it should not be why any of us came—to give a "get out of jail free card" to the very polluters who have harmed our people.

Senator DOMENICI talks about how many people are for this bill. I understand that. But the fact is that the League of Cities are against this bill, the National Association of Counties are against this bill, the Water Agency is against this bill, the Association of Metropolitan Water Districts, the U.S. Conference of Mayors, and the list goes on.

This bill should not be passed. This bill should never be passed. This bill is a giveaway to the biggest multinational corporations, to encourage them to do things they should not be doing. This bill rolls back environmental laws.

In summation, there were jokes on the floor about those of us who want to stop this bill because of MTBE, that we are taking some small step here, that this is not important. Well, this is important. When people cannot drink the water coming out of their tap and they have to go buy bottled water, this is important. This is important when people are fearful that their kids are going to get cancer from MTBE.

Remember, no matter what they say, the Government never mandated MTBE. The Government mandated an oxygenate. The oil companies picked MTBE and they kept using it after they knew it was dangerous. By the way, they even used it before an oxygenate was mandated.

If we can just put up that map one more time, I would like the Senator from Vermont to see this because he has not seen it as clearly as this. His State of Vermont has MTBE, as he knows, in the ground water; luckily, we do not think in the drinking water yet, but who knows. The orange shows the States where it is actually in the drinking water. My friend from Vermont, who stands every day for justice, for the people of this country, understands why we have to stop this bill.

I thank the Chair for his hard work in representing his State so well on this really tough issue, and I hope we have a chance to stop this bill in its tracks, send it back and have it come back without some of these provisions that are so harmful to the very people we are supposed to help, the people of the United States of America.

I yield the floor.

The PRESIDING OFFICER. Under the previous order, the hour of 1:45 having arrived, the Senator from Vermont is recognized.

Mr. LEAHY. I thank the Chair, my neighbor across the Connecticut River in the great State of New Hampshire.

Those of us who have wiled away the time sometimes on long airplane trips reading a bad book, we know a lot of bad books have ghostwriters. Well, a lot of bad bills that come before the Congress also have ghost writers.

If one reads through this 1,100-page Energy bill, they can tell actually who the ghostwriters were: The oil, the gas, the coal, and the ethanol industries that—surprise, surprise—are going to get almost $200 billion in tax subsidies from this bill. The voices of those ghostwriters echo throughout the bill.

The cost to the taxpayers does not stop there. If taxpayers feel their wallets are getting lighter this week, it is because this bill will cost them another $70-plus billion in other subsidies over the next 10 years. Unfortunately, the 1,100 pages of this bill are full of special interest giveaways, but they are empty of innovative and sustainable energy policy, a policy that would ensure Americans a clean, reliable, and affordable policy in the future.

Some of our colleagues are trying to sell this bill to the American public as a balanced energy plan, something that would give our Nation energy security over the decades to come. It is not that. It only increases our reliance on unsustainable petroleum-based energy sources. It undercuts recent progress in developing renewable energy sources and technologies that reduce pollution. It undermines the reliability of our electricity markets by opening the door to more manipulation and mergers in stalling regional efforts to improve the transmission grid.

The Senate sent a decent Energy bill to conference. What did we get back? We got a frog. We went from the prince to the frog, not the other way around. The roster of squandered taxpayers' dollars and squandered opportunities in this bill is breathtaking to behold.

Now the American people might have expected us to learn from this summer's blackout. After all, it should be fresh in our experiences and our minds. It cost governments and businesses billions of dollars. We could have used this bill to address what went wrong. We could have used it to build upon what is right. Incredibly, the bill does the opposite.

New England, where we rely on energy—as all parts of the country do—is also a part of the country where we can get 10, 20, 30 below zero sometimes. We have already created a regional organization to increase reliability of our transmission lines. In fact, that was able to stop the blackout from cascading further into Vermont and other States. Instead of using an organization that we know works as a model, this bill actually discourages utilities in other regions of the country from joining regional organizations. It would also discourage badly needed new investment in the transmission grid.

Apparently, we can only invest in transmission grids if they are in Iraq. We cannot invest in them when they are in our own country.

There is also no prohibition on the price gouging schemes employed by companies such as Enron, even though the Senate, on a wide margin, voted for that.

The bill repeals a 70-year-old law to restrict mergers of utility companies with other companies where they have no expertise. In the past, that has caused financial troubles for utilities and consequently the ratepayers.

One might have hoped the bill could have done more to emphasize technological innovation, promote clean and sustainable energy, but it does not. Instead of working to advance technologies to create jobs and reduce pollution, we have a bill that gives oil, gas, ethanol, and nuclear companies enormous subsidies.

One of the things it does, in my own State of Vermont, is it hands Vermont drivers a double whammy by mandating the use of 5 billion gallons of ethanol by 2012 while threatening deep revenue losses in the highway trust fund. Under this bill, Vermonters and drivers in other States can expect higher prices at the pump due to this mandate and more potholes in the road due to the trust fund cuts.

We have heard talk about MTBE producers. We know this protects producers of the gasoline additive MTBE from liability, but in Vermont and around the country States and communities face multimillion-dollar bills for cleaning up the MTBE that is already in the ground water. And, to stop the cases filed, the Energy bill makes the provision retroactive. It wipes out cases filed in September by several New York communities, cases filed by the State of the distinguished Presiding Officer, New Hampshire. The list goes on and on but so do the echoes of the ghostwriter's voice in this bill.

This turkey would waive environmental analyses for energy projects on public lands, exempt them from the Clean Water Act, Safe Drinking Water Act, open coastal areas to oil and gas development, reduce support for clean coal technology, and this bill will simply mean that more toxic pollutants like mercury will get dumped on Vermont's forests and our lakes and our rivers.

Shortly after the administration entered the White House, it closed the doors to the public and they started to put together the energy industry's wish list of subsidies—environmental and consumer protection rollbacks. If we pass this bill, we are going to say Christmas came before Thanksgiving for these special interests.

I don't see how, at a time when we are justifying drastic cuts to vital social programs, we can push through a $100 billion counterproductive budget buster for the energy industry.

As I said, many a bad book has a ghostwriter, and so do many bad bills. When you read through this 1,100-page energy bill, it is clear who the ghostwriter were: the oil, gas, coal and ethanol industries that—surprise, surprise—would reap almost $20 billion tax subsidies from this bill. The voices of these ghostwriters echo throughout this bill.

But the cost to taxpayers does not stop there. If taxpayers feel their wallets getting lighter this week it's because this bill will cost them another seventy-plus billion dollars in other subsidies over the next 10-years.

Unfortunately, the 1,100 pages are full of special interest giveaways but empty of innovative and sustainable energy policy that will ensure Americans clean, reliable and affordable power in the future.

Some of our Republican colleagues are trying to sell this bill to the American public as a balanced energy plan to give our Nation energy security over the decades to come. It is not.

It will only increase our reliance on unsustainable, petroleum-based energy sources. It undercuts recent progress in developing renewable energy sources and technologies that reduce pollution. It undermines the reliability of our electricity markets by opening the door to more manipulation and mergers and stalling regional efforts to improve the transmission grid.

The Senate sent a decent energy bill to conference, and we got back a frog. The roster of squandered taxpayers' dollars and squandered opportunities in this bill is breathtaking to behold.

The American people could have expected that we could have learned from this summer's blackout—still fresh in our experience and on our minds—and used this bill to address what went wrong and build upon what went right.

Incredibly, this bill does the opposite. In New England, we have already created a regional organization to increase reliability of our transmission liens. It was able to stop the blackout from cascading farther into Vermont and other States. Instead of using this organization as a model, this bill actually discourages utilities in other regions of the country from joining regional organizations. It could also discourage badly needed new investment in the transmission grid.

The bill also does not do enough to protect consumers and ratepayers from manipulation of energy markets. There is no prohibition on the price-gouging schemes employed by companies like Enron, even through the Senate supported such protections by a wide margin.

The bill repeals a 70-year-old law to restrict mergers of utility companies with other companies where they have no expertise. In the past, this practice has caused financial troubles for utilities and consequently, the ratepayers.

The American people could have hoped that this bill would do more to emphasize technological innovation that would promote clean and sustainable energy. Instead, it barely holds on to the status quo in incentives for renewable and energy efficiency. If we are going to avoid future blackouts, we have to decrease demand on the electricity grid as well as make improvements to it.

But instead of working to advance technologies to create jobs and reduce pollution, we have a bill that gives oil, gas, ethanol and nuclear companies enormous subsidies.

At the same time, this bill fails to address one of the biggest energy and environmental issues facing our country: how to improve fuel efficiency standards for cars and trucks. In fact, the bill actually would enlarge a loophole for huge SUVs that will actually encourage more people to buy these gas guzzlers. We all have heard of the SUV dealerships that actually use the existing tax loophole in their TV ads.

The bill also hands Vermont drivers a double whammy by mandating the use of 5 billion gallons of ethanol by 2012, while threatening deep revenue losses to the Highway Trust Fund. Under this bill, Vermonters and drivers in other States could expect higher prices at the pump due to this mandate, and more potholes in their roads due to the Trust Fund cuts.

While the bill fails to take any steps forward on energy policy, it takes a giant step backward on environmental protections. When the Clinton administration strengthened the requirements for reducing smog around cities, it was hailed as a major step toward reducing asthma and other chronic illnesses. Well, by postponing these ozone attainment targets, no one will be breathing easier after this bill except the special interests.

Although you won't be able to see much through the smog when you're looking up, you might see more when you're looking down, and what you see will be unwelcome.

This bill includes several new provisions that let polluters off the hook when it comes to reducing contaminates in groundwater and drinking water. It protects producers of the gasoline additive MTBE from liability if their product is found to be defective. In Vermont and around the country, States and communities face multimillion dollar bills for cleaning up the MTBE that already has leached into the groundwater.

At least one court has already found MTBE producers liable for these cleanup costs because of product defects, and several other cases are pending. To make sure these cases are stopped, the energy bill makes the provision retroactive, wiping out cases filed in September by several New York communities and New Hampshire.

The list goes on and on, and so do the echoes of the ghostwriters' voice in this bill. This turkey would waive environmental analysis for energy projects on public lands. It would exempt oil and gas drilling from requirements of the Clean Water Act and Safe Drinking Water Act. It would open coastal areas to oil and gas development. It also would reduce support for clean-coal technology in favor of the conventional dirty power plants.

This will simply mean that more toxic pollutants like mercury will get dumped on Vermont's forests, lakes and rivers.

Days after this administration entered the White House, they closed the doors to the public and started to put together the energy industry's wish list of subsidies and environmental and consumer protection rollbacks. Well, Christmas came early this year for the special interests.

The energy bill now before Congress is stuffed with everything on that wish list, plus just about everything else that these special interests could dream up when they were given the chance.

The bill before us now costs three times more than the proposal that the administration first put on the table 2 years ago.

When you look at the list of special-interest giveaways, it is no wonder the bill was written behind closed doors.

The President and the Congress had a real opportunity to produce a bill that would lead the Nation toward balanced, sustainable, clean energy production. This bill fails on all counts.

Instead, we have 1,100 pages worth of policies that will increase our dependence on fossil fuels, prop up wealthy energy corporations, repeal consumer protections and threaten environmental and public health. I do not see how my Republican colleagues can any longer justify their drastic cuts to vital social programs while pushing through this $100 billion, counterproductive budget-buster for the energy industry.

TRIBUTE TO JOHN FITZGERALD KENNEDY

I would like to talk for a moment about a more personal matter. Here we are today, November 20, 2003, just two days away from November 22. I think back to 40 years ago on November 22, 1963. I was living in Washington, D.C., at that time, as a young law student. My wife, Marcelle, and I were living in a small basement apartment. She was working as a nurse at the VA hospital, then called Mount Alto, up on Wisconsin Avenue, where the Russian Embassy is now. I was going to Georgetown Law School downtown here in Washington.

They say that anybody who was old enough to remember on that November 22 remembers exactly where they were when they heard the news about President Kennedy's assassination. That is true of anybody I have ever spoken with.

I was in the law school library and one of my classmates, who was not a supporter of President Kennedy, came in and told me the President had been shot. I told him this was really not funny, and then I realized he was crying. He was a person who had never voted for President Kennedy but realized the enormity of what had happened. When I saw his tears, I knew it had to be true.

My wife and I did not own a car at the time. I went outside and hailed a cab to head back to our apartment. My wife had worked the whole night before, and she was home asleep. I did not want to call her. I wanted to tell her in person what had happened.

I think I probably got in the only cab in all of Washington that did not have a radio. You can imagine my frustration as we started through the Washington traffic. As we drove down K Street, where many stockbrokers have their offices, we could see the screen that normally displayed stock prices was blank. That was an obvious signal that they had closed the markets in New York.

I saw Mrs. Kennedy's brother-in-law. As he would be chauffeured in a Rolls-Royce to his brokerage house each morning, I would watch with envy from the bus as I went to work. I saw him running into the street, frantic, trying to hail a cab. I saw a police officer directing traffic with tears coming down his face.

When I got to our apartment, I banged on the door and woke up my wife. We turned on the television to see the now famous announcement by Walter Cronkite—taking off his horn-rimmed glasses, announcing the President was dead.

Just a short time before, President Kennedy had given a speech at American University, a speech that I thought laid out his focus for that term and what most people believed would be a second term. That was the speech in which he said, "We must make the world safe for diversity." I would like to include a copy of this speech with my statement.

We should think about this quote these days. President Kennedy said, "make the world safe for diversity." He did not say we should make the world an exact copy of the United States. If everybody knew they could follow their beliefs and they could follow their system of government, it would be a safer world. But that was not to be.

I remember the next day when my wife and I stood on Pennsylvania Avenue with a half a million people watching as the cortege went from the White House up to the Capitol. It was silent. It was so silent that as we stood there, we could hear the traffic lights. Even though the street was blocked off, the traffic lights were still operating, and from eight lanes away, you could hear the click of the lights as they changed. This is with half a million or more people on that street.

Where we were standing, near the National Art Gallery, almost from the moment the cortege left the White House, we could hear the noise of the drums and the horses. I remember vividly the riderless horse, the boots turned backwards. It was a very spirited horse. I recall his name was Blackjack. He was skittering, his feet dancing on the pavement. I can still hear the click, click of his hooves. I remember a car going by with then-Attorney General Robert Kennedy in it, his chin on his hand, just staring straight ahead, not seeing any of the crowd. And, of course, I remember the coffin being brought here to lie in state in the Rotunda.

We heard the distinguished majority leader at that time, Mike Mansfield, a very close friend of John Kennedy, give a eulogy. He spoke of President Kennedy's and Jacqueline Kennedy's wedding rings. She took her husband's ring from his finger. It was 40 years ago, but I remember it so well.

I did not meet Senator Mansfield until more than 10 years later when I was the Senator-elect from Vermont. I got to know him well and realized the depth of his affection and his friendship for President Kennedy, with whom he had served in the Senate. It must have been so difficult for him to give that eulogy.

For two days, there were people—not just officials from Washington, D.C., but people from all over the country—who were stretched literally for miles, waiting to pay their respects. I can still see them huddled in their coats with frost from their breath in the air as they stood in line all night.

We stayed at our apartment to watch the funeral, because we were expecting our first child. We felt the crowd would have made it too difficult to go back downtown.

At the funeral, there were heads of state marching from 1600 Pennsylvania Avenue to St. Matthews. There were Prime Ministers, Presidents, Kings, Princes, and dictators. Someone came up with the idea of having the representatives march based on the name of their country. The head of France marched next to head of Ethiopia. Emperor Haile Selassie of Ethiopia marched next to Charles de Gaulle.

The interesting thing about this is the way the world came together. In fact, for a while there was a rumor that Premier Khrushchev might come. Remember, this was the height of the Cold War. This was when President Kennedy and Premier Khrushchev had stared across oceans at each other during the Cuban missile crisis. Khrushchev was dissuaded from coming by security considerations. Instead, he personally went to the American Embassy to sign the book of condolences. This was the kind of unity that was felt around the world.

Actually, I cannot think of any time when we felt that kind of unity and support for the United States, until the tragedy, 38 years later, of September 11.

Everybody watched the television, listened to the radio, or stood downtown to watch the funeral. We saw on television planes fly by in a missing man formation followed by Air Force One tipping its wing in salute. We ran outside just in time to see the planes which we had seen seconds before on television fly over our heads.

Looking around, everybody else had run outside too. We stood there, neighbors and strangers.

At that time, there was so much optimism, so much hope, even though it was at the height of the Cold War, and even though we had just experienced the Cuban missile crisis. After the death of President Kennedy, we felt so much of this optimism was lost.

I saw the unity come back after September 11. I don't know if the optimism will ever came back fully. We were optimistic of many things.

In my lifetime, we have seen so many wonderful advances in science. When I was young, we had to worry about polio. Our children and my two grandchildren will never have to worry about those kinds of things. Our country has had many wonderful advances and much to be optimistic about. There was unity and support from around the world for the United States right after that event, as there was right after September 11. We are now in a time where that unity is missing. I hope it will come back.

I hope this weekend all Members of this body—most of us are old enough to remember that day—I hope we stop and think what is best for this country. It is time to start working together more closely, with more support for each other and the country, and it is time to help restore some of the optimism. We are a great country. We have survived world wars, civil wars, Presidential assassinations, and terrorist attacks. We can survive much more—if not for ourselves, for our children and for our grandchildren.

Mr. President, I ask unanimous consent to print President Kennedy's 1963 commencement address delivered at American University.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

REMARKS OF PRESIDENT JOHN F. KENNEDY AT AMERICAN UNIVERSITY, WASHINGTON D.C., JUNE 10, 1963

President Anderson, members of the faculty, Board of Trustees, distinguished guests, my old colleague, Senator Bob Byrd, who has earned his degree through many years of attending night law school, while I am earning mine in the next 30 minutes, ladies and gentlemen:

It is with great pride that I participate in this ceremony of the American University, sponsored by the Methodist Church, founded by Bishop John Fletcher Hurst, and first opened by President Woodrow Wilson in 1914. This is a young and growing university, but it has already fulfilled Bishop Hurst's enlightened hope for the study of history and public affairs in a city devoted to the making of history and to the conduct of the public's business. By sponsoring this institution of higher learning for all who wish to learn whatever their color or their creed, the Methodists of this area and the nation deserve the nation's thanks, and I commend all those who are today graduating.

Professor Woodrow Wilson once said that every man sent out from a university should be a man of his nation as well as a man of his time, and I am confident that the men and women who carry the honor of graduating from this institution will continue to give from their lives, from their talents, a high measure of public service and public support.

"There are few earthly things more beautiful than a University," wrote John Masefield, in his tribute to the English Universities—and his words are equally true here. He did not refer to spires and towers, to campus greens and ivied walls. He admired the splendid beauty of the University, he said, because it was "a place where those who hate ignorance may strive to know, where those who perceive truth may strive to make others see."

I have, therefore, chose this time and this place to discuss a topic on which ignorance too often abounds and the truth is to rarely perceived—yet it is the most important topic on earth: world peace.

What kind of peace do I mean? What kind of peace do we seek? Not a Pax Americana enforced on the world by American weapons of war. Not the peace of the grave or the security of the slave. I am talking about genuine peace—the kind of peace that makes life on earth worth living—the kind that enables man and nations to grow and to hope and to build a better life for their children—not merely peace for Americans but peace for all men and women—not merely peace in our time but peace for all time.

I speak of peace because of the new face of war. Total war makes no sense in an age when great powers can maintain large and relatively invulnerable nuclear forces and refuse to surrender without resort to those forces. It makes no sense in an age when a single nuclear weapon contains almost ten times the explosive force delivered by all of the allied air forces in the Second World War. It makes no sense in an age when the deadly poisons produced by a nuclear exchange would be carried by the wind and water and soil and seed to the far corners of the globe and to generations unborn.

Today the expenditure of billions of dollars every year on weapons acquired for the purpose of making sure we never need to use them is essential to keeping the peace. But surely the acquisition of such idle stockpiles—which can only destroy and never create—is not the only, much less the most efficient, means of assuring peace.

I speak of peace, therefore, as the necessary rational end of rational men. I realize that the pursuit of peace is not as dramatic as the pursuit of war—and frequently the words of the pursuer fall on deaf ears. But we have no more urgent task.

Some say that it is useless to speak of world peace or world law or world disarmament—and that it will be useless until the leaders of the Soviet Union adopt a more enlightened attitude. I hope they do. I believe we can help them do it. But I also believe that we must re-examine our own attitude—as individuals and as a Nation—for our attitude is as essential as theirs. And every graduate of this school, every thoughtful citizen who despairs of war and wishes to bring peace, should begin by looking inward—by examining his own attitude toward the possibilities of peace, toward the Soviet Union, toward the course of the Cold War and toward freedom and peace here at home.

First: Let us examine our attitude toward peace itself. Too many of us think it is impossible. Too many of us think it is unreal. But that is dangerous, defeatist belief. It leads to the conclusion that war is inevitable—that mankind is doomed—that we are gripped by forces we cannot control.

We need not accept that view. Our problems are manmade—therefore, they can be solved by man. And man can be as big as he wants. No problem of human destiny is beyond human beings. Man's reason and spirit have often solved the seemingly unsolvable—and we believe they can do it again.

I am not referring to the absolute, infinite concept of universal peace and good will of which some fantasies and fanatics dream. I do not deny the values of hopes and dreams but we merely invite discouragement and incredulity by making that our only and immediate goal.

Let us focus instead on a more practical, more attainable peace—based not on a sudden revolution in human nature but on a gradual evolution in human institutions—on a series of concrete actions and effective agreements which are in the interest of all concerned. There is no single, simple key to this peace—no grand or magic formula to be adopted by one or two powers. Genuine peace must be the product of many nations, the sum of many acts. It must be dynamic, not static, changing to meet the challenge of each new generation. For peace is a process—a way of solving problems.

With such a peace, there will still be quarrels and conflicting interests, as there are within families and nations. World peace, like community peace, does not require that each man love his neighbor—it requires only that they live together in mutual tolerance, submitting their disputes to a just and peaceful settlement. And history teaches us that enmities between nations, as between individuals, do not last forever. However fixed our likes and dislikes may seem the tide of time and events will often bring surprising changes in the relations between nations and neighbors.

So let us persevere. Peace need not be impracticable—and war need not be inevitable. By defining our goal more clearly—by making it seem more manageable and less remote—we can help all peoples to see it, to draw hope from it, and to move irresistibly toward it.

Second: Let us re-examine our attitude toward the Soviet Union. It is discouraging to think that their leaders may actually believe what their propagandists write. It is discouraging to read a recent authoritative Soviet text on Military Strategy and find, on page after page, wholly baseless and incredible claims—such as the allegation that "American imperialist circles are preparing to unleash different types of wars . . . that there is a very real threat of a preventive war being unleashed by American imperialists against the Soviet Union . . . (and that) the political aims of the American imperialists are to enslave economically and politically the European and other capitalist countries . . . (and) to achieve world domination.

Truly, as it was written long ago: "The wicked flee when no man pursueth." Yet it is sad to read these Soviet statements—to realize the extent of the gulf between us. But it is also a warning—a warning to the American people not to fall into the same trap as the Soviets, not to see only a distorted and desperate view of the other side, not to see conflict as inevitable, accommodations as impossible and communication as nothing more than an exchange of threats.

No government or social system is so evil that its people must be considered as lacking in virtue. As Americans, we find communism profoundly repugnant as a negation of personal freedom and dignity. But we can still hail the Russian people for their many achievements—in science and space, in economic and industrial growth, in culture and in acts of courage.

Among the many traits the peoples of our two countries have in common, none is stronger than our mutual abhorrence of war. Almost unique, among the major world powers, we have never been at war with each other. And no nation in the history of battle ever suffered more than the Soviet Union suffered in the course of the Second World War. At least 20 million lost their lives. Countless millions of homes and farms were burned or sacked. A third of the nation's territory, including nearly two thirds of its industrial base, was turned into a wasteland—a loss equivalent to the devastation of this country east of Chicago.

Today, should total war ever break out again—no matter how—our two countries would become the primary targets. It is an ironical but accurate fact that the two strongest powers are the two in the most danger of devastation. All we have built, all we have worked for, would be destroyed in the first 24 hours. And even in the Cold War, which brings burdens and dangers to so many countries, including this Nation's closest allies—our two countries bear the heaviest burdens. For we are both devoting massive sums of money to weapons that could be better devoted to combating ignorance, poverty and disease. We are both caught up in a vicious and dangerous cycle in which suspicion on the other, and new weapons beget counter-weapons.

In short, both the United States and its allies, and the Soviet Union and its allies, have a mutually deep interest in a just and genuine peace and in halting the arms race. Agreements to this end are in the interests of the Soviet Union as well as ours—and even the most hostile nations can be relied upon to accept and keep those treaty obligations, and only those treaty obligations, which are in their own interest.

So, let us not be blind to our differences—but let us also direct attention to our common interests and to means by which those differences can be resolved. And if we cannot end now our differences, at least we can help make the world safe for diversity. For, in the final analysis, our most basic common link is that we all inhabit this plant. We all breathe the same air. We all cherish our children's future. And we are all mortal.

Third: Let us re-examine our attitude toward the Cold War, remembering that we are not engaged in a debate, seeking to pile up debating points. We are not here distributing blame or pointing the finger of judgment. We must deal with the world as it is, and not as it might have been had history of the last eighteen years been different.

We must, therefore, preserve in the search for peace in the hope that constructive changes within the Communist bloc might bring within reach solutions which now seem beyond us. We must conduct our affairs in such a way that it becomes in the Communists' interest to agree on a genuine peace. Above all, while defending our vital interest, nuclear powers must avert those confrontations which bring an adversary to a choice of either a humiliating retreat or a nuclear war. To adopt that kind of course in the nuclear age would be evidence only of the bankruptcy of our policy—or of a collective death-wish for the world.

To secure these ends, America's weapons are non-provocative, carefully controlled, designed to deter and capable of selective use. Our military forces are committed to peace and disciplines in self-restraint. Our diplomats are instructed to avoid unnecessary irritants and purely rhetorical hostility.

For we can seek a relaxation of tensions without relaxing our guard. And, for our part, we do not need to use threats to prove that we are resolute. We do not need to jam foreign broadcasts out of fear our faith will be eroded. We are unwilling to impose our system on any unwilling people—but we are willing and able to engage in peaceful competition with any people on earth.

Meanwhile, we seek to strengthen the United Nations, to help solve its financial problems, to make it a more effective instrument of peace, to develop it into a genuine world security system—a system capable of resolving disputes on the basis of law, of insuring the security of the large and the small, and of creating conditions under which arms can finally be abolished.

At the same time we seek to keep peace inside the non-communist world, where many nations, all of them our friends, are divided over issues which weaken western unity, which invite communist intervention or which threaten to erupt into war. Our efforts in West New Guinea, in the Congo, in the Middle East and in the Indian subcontinent, I have been persistent and patient despite criticism from both sides. We have also tried to set an example for others—by seeking to adjust small but significant differences with our own closest neighbors in Mexico and in Canada.

Speaking of other nations, I wish to make one point clear. We are bound to many nations by alliances. These alliances exist because our concern and theirs substantially overlap. Our commitment to defend Western Europe and West Berlin for example, stands undiminished because of the identity of our vital interests. The United States will make no deal with the Soviet Union at the expense of other nations and other peoples, not merely because they are our partners, but also because their interests and ours converge.

Our interests converge, however, not only in defending the frontiers of freedom, but in pursuing the paths of peace. It is our hope—and the purpose of Allied policies—to convince the Soviet Union that she, too, should let each nation choose its own future, so long as that choice does not interfere with the choices of others. The communist drive to impose their political and economic system on others is the primary cause of world tension today. For there can be no doubt that if all nations could refrain from interfering in the self-determination of others, then peace would be much more assured.

This will require a new effort to achieve world law—a new context for world discussions. It will require increased understanding between the Soviets and ourselves. And increased understanding will require increased contact and communications. One step in this direction is the proposed arrangement for a direct line between Moscow and Washington, to avoid on each side the dangerous delays, misunderstandings, and misreadings of the other's actions which might occur at a time of crisis.

We have also been talking in Geneva about other first-step measures of arms control, designed to limit the intensity of the arms race and to reduce the risks of accidental war. Our primary long-range interest in Geneva, however, is general and complete disarmament—designed to take place by stages, permitting parallel political developments to build the new institutions of peace which would take the place of arms. The pursuit of disarmament has been an effort of this Government since the 1920's. It has been urgently sought by the past three Administrations. And however dim the prospects may be today, we intend to continue this effort—to continue it in order that all countries, including our own, can better grasp what the problems and possibilities of disarmament are.

The one major area of these negotiations where the end is in sight—yet where a fresh start is badly needed—is in a treaty to outlaw nuclear tests. The conclusion of such a treaty—so near and yet so far—would check the spiraling arms race in one of its most dangerous areas. It would place the nuclear powers in a position to deal more effectively with one of the greatest hazards which man faces in 1963, the further spread of nuclear arms. It would increase our security—it would decrease the prospects of war. Surely this goal is sufficiently important to require our steady pursuit, yielding neither to the temptation to give up the whole effort nor the temptation to give up our insistence on vital and responsible safeguards.

I am taking this opportunity, therefore, to announce two important decisions in this regard.

First: Chairman Khrushchev, Prime Minister Macmillan and I have agreed that high-level discussions will shortly begin in Moscow looking toward early agreement on a comprehensive test ban treaty. Our hopes must be tempered with the caution of history—but with our hopes go the hopes of all mankind.

Second: To make clear our good faith and solemn convictions on the matter, I now declare that the United States does not propose to conduct nuclear tests in the atmosphere so long as other states do not do so. We will not be the first to resume. Such a declaration is no substitute for a formal binding treaty—but I hope it will help us achieve one. Nor would such a treaty be a substitute for disarmament—but I hope it will help us achieve it.

Finally, my fellow Americans, let us examine our attitude toward peace and freedom here at home. The quality and spirit of our own society must justify and support our efforts abroad. We must show it in the dedication of our own lives—as many of you who are graduatng today will have a unique opportunity to do, by serving without pay in the Peace Corps abroad or in the proposed National Service Corps here at home.

But wherever we are, we must all, in our daily lives, live up to the age-old faith that peace and freedom walk together. In too many of our duties today, the peace is not secure because freedom is incomplete.

It is the responsibility of the Executive Branch at all levels of government—local, state and national—to provide and protect that freedom for all of our citizens by all means within their authority. It is the responsibility of the Legislative Branch at all levels, wherever that authority is not now adequate, to make it adequate. And it is the responsibility of all citizens in all sections of this country to respect the rights of all others and to respect the law of the land.

All this is not unrelated to world peace. "When a man's ways please the Lord," the Scriptures tell us, "he maketh even his enemies to be at peace with him." And is not peace, in the last analysis, basically a matter of human rights—the right to live out our lives without fear of devastation—the right to breathe air as nature provided it—the right of future generations to a healthy existence?

While we proceed to safeguard our national interests, let us also safeguard human interests. And the elimination of war and arms is clearly in the interest of both. No treaty, however much it may be to the advantage of all, however tightly it may be worded, can provide absolute security against the risks of deception and evasion. But it can—if it is sufficiently effective in its enforcement and if it is sufficiently in the interests of its signers—offer far more security and far fewer risks than an unabated, uncontrolled, unpredictable arms race.

The United States, as the world knows, will never start a war. We do not want a war. We do not now expect a war. This generation of Americans has already had enough—more than enough—of war and hate and oppression. We shall be prepared if others wish it. We shall be alert to try to stop it. But we shall also do our part to build a world of peace where the weak are safe and the strong are just. We are not helpless before that task or hopeless of its success. Confident and unafraid, we labor on—not toward a strategy of annihilation but toward a strategy of peace.

The PRESIDING OFFICER (Mr. ALEXANDER). The Senator from Kentucky is recognized.

Mr. BUNNING. Mr. President, I thank you.

I rise to talk about the Energy conference report and urge my fellow Senators to support this bill. We have waited for a comprehensive Energy bill for too long. I am pleased that we have before us a good energy policy bill which we can send to the President of the United States.

The conference bill is not perfect. I don't believe I have voted for a perfect bill in the last 17 years. But no bill we ever pass around here is perfect. But it is a good compromise that will help our country meet its future energy needs. This agreement will mean more jobs and more money in American's pocketbooks and create more than a million jobs across this country. We are already on the upturn of an economic recession. This bill will help kick our economy into high gear.

A good energy policy must strike a balance between energy production and conservation. This bill does just that by including increased energy production while also doing more to encourage conservation and smarter energy use.

I know this bill was difficult to get out of conference. I watched my chairman for almost 2 months suffer with this bill. Under his leadership and the leadership of Senator GRASSLEY, we have before the Senate a solid piece of legislation that provides energy policy and tax incentives to promote production and energy efficiencies throughout and the use of cleaner burning fuels.

In the wake of our ongoing problems in the Middle East, now more than ever a sound energy policy is a critical part of our national security. We must have a reliable source of energy and we must cut our reliance on foreign oil. Presently we depend on foreign nations, including the Middle East, for nearly 60 percent of our Nation's oil supply. While we appear to be moving away from combat in Iraq, we still have many problems there. There is still a lot of uncertainty in the Middle East. We need to increase our own production of energy because it is more important than ever right now. It is too important and there is too much instability in the world not to pass this bill. We do not want the United States of America at the mercy of other countries just to keep our engines running and our lights on. This Energy bill will help increase our energy independence by increasing domestic production of energy and reducing our reliance on foreign sources.

This bill allows for and encourages through tax credits more oil and more natural gas exploration. The bill also includes clean coal provisions that I helped write, to increase domestic production, while also improving environmental production soundness. In my home State this means jobs, a lot of jobs, and a cleaner place to live.

Clean coal technology will result in a significant reduction in emissions and a sharp increase in energy efficiency.

I am proud to be from a coal State. Generations of Kentuckians have made their living in the coal fields and coal mines of Kentucky. For the last decade, coal in Kentucky was on the downturn because of legislative and regulatory policies from the Federal Government which forced electricity generation to invest in natural gas-fired facilities instead of coal.

I am glad to see we have turned things around and are taking steps to make sure coal continues to play a vital role in meeting our future energy needs. This focus on clean coal is good for the environment. It is certainly good for the economy and for putting folks back to work.

The Energy bill encourages research and development of clean coal technology by authorizing nearly $2.6 billion in appropriations for the Department of Energy to conduct programs to advance new technologies. Almost $2 billion will be used for the clean coal power initiatives where the DOE will work with industry to advance efficiencies, environmental performance, and cost competitiveness of new clean coal technologies.

The energy tax package includes $2.5 billion for coal-fired companies to invest in clean coal technologies and pollution control equipment. I am pleased to see that the bill also authorized an additional $2 billion for clean air programs which will encourage the use of pollution control equipment and the next generation of clean coal generators.

The 21st century economy will require increased amounts of reliable, clean, and affordable electricity to keep our Nation running. This bill recognizes that coal must play an important role in our energy future.

Today, more than half our Nation's electricity is generated from an abundant low-cost domestic coal. We have over 275 billion tons of recoverable coal reserves. This is nearly 30 percent of the world's coal supply. That is enough coal to supply us with energy for more than 250 years.

This Energy bill also includes fuel provisions that I pushed hard for that will help make fuel burn cleaner. The bill requires the use of 5 billion gallons per year of renewable fuels such as ethanol and biodiesel in gasoline by the year 2012. The bill also provides tax credits to encourage the use of these fuels. Increasing the use of alternative fuels will help farmers while also increasing domestic energy production and lessening our dependence on foreign oil.

The bill also addresses electricity. Kentucky is the second lowest electric rate State in the Union. It just fell below Idaho. Much of Kentucky's low rates come as a result of our coal production. The low rates also come from Kentucky's decision to put Kentucky consumers first before consumers outside of the State.

I do not believe this bill goes far enough to prevent FERC from implementing SMD permanently or preventing mandatory RTOs. I do believe this bill is a good compromise. The bill delays until 2007 FERC's plan to create its SMD and allows companies to participate in RTOs voluntarily.

Some of the electric provisions are especially good for Kentucky. More than one-third of Kentucky's electricity comes from rural electric cooperative distributors. This bill will help the consumer-owners of Kentucky's 26 electric cooperatives to stay in business and maintain the State's status as having the lowest residential or second lowest residential rates in the country.

I worked hard in the Senate Energy Committee to ensure that the small rural electric cooperatives in Kentucky are not subject to expensive FERC jurisdiction that could raise consumers' rates without improving the reliability of the electric utility system. This is a big issue for our cooperatives in Kentucky that serve only a few thousand customers and do not have bulk transmission.

This bill specifically codifies RUS borrowers' existing exemption from FERC regulation and expands the exemption to include small electric cooperatives that sell less than 4 million megawatts of electricity per year. This is also called the small utility exemption.

The bill also minimizes other new regulatory burdens on cooperatives. I am pleased to see this bill does not include new regulatory programs such as environmental mandates that would have raised consumers' electric rates.

I hope the Senate passes the Energy bill this week so we can make our environment, economy, and national security stronger.

Thank you, Mr. President, for the time, and I yield the floor.

Mr. DOMENICI addressed the Chair.

The PRESIDING OFFICER. Under the previous order, the Senator from Illinois is to be recognized.

Mr. DURBIN. Mr. President, I am happy to yield to the Senator from New Mexico, who has asked permission to speak for a few moments.

I say to the Senator, whatever time you would like, I would be happy to yield for that purpose.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from New Mexico.

Mr. DOMENICI. Thank you, Mr. President. I will not take too long.

I wish to speak a moment to the Senator from Kentucky.

First, I say to the Senator, I chair the Energy Committee, and I am very pleased that Kentucky has contributed you to the committee. You bring to us an enthusiastic approach to America's self-sufficiency, not the gloom and doom of: We can't make it, we can't do it. You are always there saying: We ought to do it. Why don't we do it?

I am very pleased we were able to put in this new law a series of provisions that permit the Senator to come to the floor and speak with optimism about coal of the future, coal and America's future. Of course it is parochial but it is national.

The Senator's State is a coal producer but it is a part of America. Kentucky is a State in the Union. Your State does not want to go down in coal. As I understand it, you want coal to go up. You do not want "King Coal" dead. You want "King Coal" alive.

The first thing I want to do is say to the Senator, it is very interesting to see how you interpret this and how others interpret it—that all these coal provisions are a giveaway to big business. I did not hear the Senator mention big business once, not because they are not going to be involved, but I think it is because the Senator understands you are not going to produce new, clean coal generators with nonprofit organizations.

I guess the Senator assumes, as I do, that some coal company is going to apply to the Department of Energy to do this. Is that not right, I ask the Senator?

Mr. BUNNING. Absolutely. The Senator is absolutely right.

Mr. DOMENICI. So one can stand up and say: There must have been great lobbying from the coal companies.

Well, the coal companies did not have to lobby. All we had to do was have a brain and to know there is coal and say: Well, what are we going to do so somebody will invest money in coal, servicing our country in a bigger and better way?

If it turns out some choose to come to the floor and label that indecent lobbying by a big company, I am sorry, we could have done this if no coal company ever visited us, I assure you.

I say to the Senator, we have Senators like you who told us about it.

Mr. BUNNING. I assure the Senator from New Mexico that I was not lobbied by coal companies. But I sure was lobbied by the small electric producers in Kentucky.

Mr. DOMENICI. Absolutely. The truth is, whatever you lobbied for as a Senator, that is your privilege. Nobody could say you should not work for coal in this bill, that you ought to just abandon it, that you should not do that because that is representing an interest. Of course. Well, if there are no interests, there is nothing going on. Right? We just as well might go to sleep and forget about it.

Another thing that is interesting, we have had at least three Senators come to the floor, including my cohort from New Mexico, saying they are against electricity provisions because they wanted FERC to have more power.

Now, I did not have the luxury of making speeches about FERC. I had to write something. And here we have one Senator saying FERC should have run the whole electric system in the country. Right?

Then we have this Senator. He is over here saying: You almost went too far, where we skinnied back on FERC's power. We said it can phase in over time. Right?

You were not sure of that. If you had been writing it, and did not have anybody else pressuring you, you would have written it more in favor of your State. But, you see, I did not have the luxury of writing one for each State, one that affects you up the road.

Then there is another State—such as Pennsylvania—saying: We don't do business like they do. We want a whole different electricity provision. I heard that. I could not write one for them, too. Right?

Mr. BUNNING. Fifty different ones.

Mr. DOMENICI. The last time they used to write two was before the Civil War. They wrote one for the South and one for the North. But I told them: Why don't you cut it in four pieces and we will write four of them? Right? But there aren't four countries; there are just the States. So we did the best we could. I think it is a good provision.

Now, what else about it? I share with you, right now, on the electric provision that here is the study. So everybody can see it—it is the first time it has been on the floor of the Senate. It is entitled "Interim Report: The Causes of the August 14th Blackout in the United States and Canada." I do not think I will ask that it be printed in the RECORD. I will refer to it. We have gone through it and we have looked at what they said.

Let me say to my friend, it says that the principal reason we had a blackout was that all of the States, with their various utility systems, had what are called reliability standards.

Now, I am not a technician, but reliability means something pretty common and ordinary. I can talk reliability at home in an evening with my wife. We talk a lot about this, and she should know what that is. Reliability standards means that you appropriately and prudently load your electric wires so they are not so overloaded that something happens, or that they are clean and they do not have things imposing upon their reliability.

This said it was nothing dramatic. It was not that we have an old, wornout system. Somebody said we had a Third World system. No, no, we do not. We have a first world system, not a third world system. When we have a blackout, it is big news. That is because we have a first-rate system. You know the third-rate systems nobody cares about because they are not working anyway.

So the truth is, this little report says the biggest reason it went out was reliability.

Well, guess what. For all the things we did so wrong in this bill, one of the principal things we provided was mandatory reliability standards. No more cheating, fudging, hiding a little, and overloading the lines during heavy use, and saying: Well, nobody will do anything—except when it blows out. Then we all find out.

So I say to everybody, we did the report. You wondered what happened. You got the study. You got a bill. The bill says, if you pass this bill, it is fixed. Right?

Mr. BUNNING. Right.

Mr. DOMENICI. Contrary-wise, do what some have suggested, throw the bill out, and you are right back where we were. You are right back where we were. You can sit around and wait for a blackout, just playing with your hands, worrying, sweating, saying: When will it occur?

At least this bill says we know why it occurred, and we are not going to let it occur again. The Feds are going to fine anybody who is lazy and loafs around and doesn't clean up the lines. In fact, the report is pretty good that they are going to be on them to get the trees off the lines. That would be good news; we don't have to go out there line by line. But that is part of the reliability.

The point I make is, for every issue people have raised on the floor that this bill doesn't do or fails to do, on the other hand it does and it doesn't fail to. Every time people say "we don't like it because," there is something in it to say, "but we do like it because." I regret that it can't be every single Senator taking the floor and saying: Everything in it is precisely what I want.

I am glad we have people such as the Senator from Kentucky who knows that can't happen.

Mr. BUNNING. I thank the Chair.

Mr. DOMENICI. I yield the floor.

The PRESIDING OFFICER. Under the previous order, the Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, obviously, I am in opposition to this Energy bill. The Senator from New Mexico is my friend. We go nose to nose and toe to toe and fight on a lot of issues. We are in real disagreement over this bill. But I respect him and like him very much. When we do come together on issues such as mental health parity, it is a wonderful feeling for us to be on the same side fighting together. Unfortunately, today that may not be the case, but tomorrow I hope it is. I have a great deal of respect for him and for all the hard work he and his staff and so many others put into this legislation.

What I like about Senator DOMENICI—I guess most of all—is his candor.

He tends to play cards with the cards face up. You know what you are dealing with. He is very honest and plainspoken. That is a refreshing virtue and quality in this world of politics. He was quoted on the floor the other day, talking about this Energy bill:

> We know that as soon as you start reading the language, we are duck soup.

That is what he said. I have to say to the Senator from New Mexico that I have read some of the language. It looks like a duck, it walks like a duck, and it sounds like a duck. It is a duck. And we are in the soup if we enact it.

There are provisions in this bill that are very good for America and very good for my home State, provisions which I have long fought for throughout my congressional career: Expanding the use of ethanol, expanding the use of biodiesel. These are positive steps to help farmers, rural communities, to clean up air pollution in a sensible way, to provide energy resources which are not being used as much as they should. You might not expect to hear that from a Senator from Illinois because we have the largest ethanol production in the Nation. I have been honored to represent a congressional district that includes Decatur, IL, home of Archer Daniels Midland, the largest single ethanol producer in the Nation.

I came to this issue with some knowledge and with an inclination to try my best to expand ethanol. Throughout my public career, I have done it. I have been chairman of the congressional alcohol fuels caucus. I have introduced legislation, sponsored it. I have led efforts with letters and speeches, just about all you can do to promote ethanol. If it is enacted, the ethanol provision in the bill will be the most dramatic expansion in the Nation's history. I certainly support it.

To all of my friends in the farm community back home who are disappointed because I oppose this bill, trust that my commitment to ethanol is not going to change. I am just going to hope that the next venue, the next opportunity to discuss ethanol, will be in a much different bill, a much better bill.

Sadly, what is included in this bill, beyond the ethanol provisions and the biodiesel provisions and efforts to look for new ways to burn coal in an environmentally safe way, many of the provisions are very bad, very troublesome.

Tomorrow we will have a vote. That vote will decide whether this bill goes forward to final passage. It really is the key vote. It is going to be close, probably within one or two Senators' votes. They will decide what happens to this Energy bill. It is my hope that the Senators who are on the fence now or worried about the vote will consider several things.

First, we can do better. If this is supposed to be an Energy bill for America's future, we can do so much better. Take any family in your State, wherever you are from—Tennessee, Illinois, New Mexico, or Delaware—sit down with them and say: When it comes to the energy future of America, what is the first thing we ought to look at? My guess is that most of those individuals, with no particular scientific or technical knowledge, will say: How about all the gasoline we are burning in our cars and trucks? That is the most obvious use of energy in America.

It is the No. 1 use of imported petroleum products, conversion into gasoline to fuel our cars and trucks. So you would assume that in this lengthy bill, the first chapter of the bill would relate to how we can burn this gasoline more efficiently, how we can reduce our consumption of gasoline, how we can make our cars and trucks more fuel efficient so there is less pollution and less dependence on foreign oil.

Most Americans would assume that.

Well, there is bad news. You can search this new law that is being proposed, page after page after page for 1,400 pages, and find precious little, if any, reference to fuel efficiency and fuel economy of America's cars and trucks. Why? How can we in good faith say to the American people that we are concerned about our energy security and energy independence without addressing the fuel efficiency of our cars and trucks?

There was a time, in 1975, when the average fuel efficiency was about 14 miles a gallon. Congress passed a law that almost doubled that fuel efficiency to 27.5 miles a gallon by 1985. That was 18 years ago. You ask yourself: How good are we today? Have we improved on that mark? Are we doing better than 27.5 miles a gallon on average? The answer, sadly, is no. We have gone in the opposite direction. We are closer now to 22 miles a gallon.

What has happened in 18 years? No leadership—not from Congress, not from the President—no leadership that leads us to more fuel efficiency. Instead, we have left it to the forces of the marketplace. There are many here who believe that is all we need to worry about; let the market work its will.

The market has worked its will and, as a result, we are selling cars that are less and less fuel efficient. We are importing more oil from overseas and burning it to fuel heavier, less fuel-efficient vehicles. In fact, this Congress, if it has shown any leadership, has gone in the opposite direction. We have created tax incentives for people to buy the most inefficient cars and SUVs in America, these monstrous Humvees that come rolling down the highway. We are going to give you a great big tax credit if you will buy those. Do you know why? Those big old monsters get between 9 and 15 miles a gallon. We will give you an incentive to buy those.

Yet when it comes to incentives to buy fuel-efficient cars, hybrid vehicles, we are going to have to phase that out. We do have a deficit.

Isn't that upside down? Shouldn't we be thinking about encouraging more fuel-efficient vehicles if we truly want to lessen our dependence on Saudi Arabia and Middle Eastern oil? That is obvious to most people in the State I represent. It is obvious to most Americans. It certainly was not obvious to the sponsors of this Energy bill. They wrote this bill listening to Detroit. The automobile manufacturers in Detroit—I have worked with them on a number of issues—are just plain wrong on this. They have fought tooth and nail every proposal to bring more fuel-efficient vehicles to America.

Do you want to hear the irony of this situation? The irony was brought out by a disclosure—quoting here from the Baltimore Sun of November 19, 2003. Listen to what they wrote:

> Chinese leaders are worried about their nation's growing dependence on imported oil. What's more, pollution from such fossil fuels threatens to become a parallel concern as China's booming economy matures.
>
> So they've hit upon an obvious energy strategy that somehow has eluded U.S. lawmakers: conservation.
>
> In what should be an embarrassing juxtaposition for leaders here, China is moving to impose tighter fuel-efficiency rules on cars and SUVs than the U.S. requires, while Congress is adopting an opposite approach—boosting domestic production of fossil fuels to meet all-but-unchecked demand.
>
> . . . adds insult to injury by subsidizing the purchase of monster gas-guzzlers, such as the Humvee.

They conclude:

> The Senate still has a chance to stop this monstrosity [the Energy bill]. It should take a cue from China and prepare for the future, instead of squandering precious resources trying to maintain an unsustainable past.

Chinese thinking on energy is very clear, I might say. It is the thinking of American politicians that is inscrutable. How in the world can we be talking about energy independence and ignore fuel efficiency for the cars and trucks we drive? That, sadly, is the reality of this legislation. That is why it cannot be taken seriously. You cannot believe this is the best the Congress in America can produce to deal with energy, without addressing that issue.

There is another issue here which I think goes to questions of justice and fairness, maybe even morality. I hate to raise that question, but we hear a lot about morality and virtue and values on the floor of the Senate. Occasionally, we should apply those same words to the legislation we consider. That relates to section 1502 of this legislation.

Section 1502 of this legislation has created a "get out of jail free card" for the producers of MTBE. What is MTBE? It is a substance that has been added to gasoline for years in America to reduce the tailpipe emissions and to make your engine run more smoothly. It is what is called an oxygenate. You probably didn't even know it was there. But it is blended with gasoline for those purposes, as an oxygenate. It is a product of waste products of the oil-processing procedure. So it is a pretty cheap commodity. It has been blended, for years, with gasoline in the United States. Other oxygenates include ethanol, which I referred to earlier, and, like alcohol, it is benign and doesn't really threaten the environment.

But MTBE—this additive—turns out to be extraordinarily dangerous. It is a poison, a toxic substance which, if it leeches into a water supply, can make it undrinkable, at best, and dangerous, at worst, leading those who consume it to a greater likelihood of serious illness and disease, even the potential of cancer.

So what has happened across the United States is that the oil companies that use MTBE as an additive learned that when the underground storage tank at your gas station started to leak—little drips day after day—ultimately, that MTBE-blended gasoline would reach the water table under the ground, and the water supply of the community where the gas station was located. As it reached the water supply, it didn't biodegrade but continued to be toxic and lethal. As a result, the consumers, the families, the children, and the schools that consume this water were at a public health risk.

Well, this contamination has now spread across the United States. It is in Illinois and in many other States. Let me show you how bad this is.

Here is a map showing States with MTBE contamination in ground drinking water. The Presiding Officer's State of Tennessee does not have contamination in drinking water but does have contamination sites. Tennessee has 1,394 MTBE contamination sites. Illinois, where I live, has 9,546 MTBE contamination sites. Look at this map of America. You can see that where MTBE has reached the ground water, and now the drinking water, we have the public health hazard that has swept across America. Only six States in the continental United States have not been touched by this. Hawaii has not but Alaska has. Alaska's drinking water has been contaminated as well.

Why is this important? Because, for the first time in my memory, and I have asked my legal staff to keep looking—I may be wrong—we have decided to put into legislation protection from liability for product liability cases that are filed against MTBE producers. If you are an oil company that had MTBE blended with your gasoline and it ended up contaminating drinking water, causing a public health hazard, this bill, in section 1502, says, for you, you are in luck, you get a "get out of jail free card."

How can we do this? How can we, in all fairness, say the corporations and businesses that made a conscious decision to use this additive, and because of the use of this dangerous substance are endangering the public health and lives of Americans, will somehow be free of liability?

One of the first things we decided in America—those who sat down and, in their wisdom, created our Constitution—was that we would do away with royalty; we weren't going to give people titles such as "princes" and "viscounts" and whatever it happened to be in the old country. No, in America it is different. There is no royalty. We are all the same. People are treated the same. The highest and the lowest in rank in America are held accountable.

But that is not the case when it comes to this Energy bill because if you happen to be an oil company with MTBE contamination, we are going to treat you like royalty with a "get out of jail free card." We are going to say that you are not going to be held responsible as will the business next door selling another product. That is just plain wrong.

Senator DOMENICI came to the floor and said repeatedly—understand, he turns the cards over so there is no doubt what is going on. He says: Understand what this bargain was. If you want ethanol, you want to sell more ethanol—the oil companies hate ethanol; they don't make ethanol. In order for them to go along with this bill, in order for the oil company giants to agree to promoting ethanol in America, we had to give them this MTBE waiver of liability. Those are not my words. I think they are an accurate paraphrase of Senator DOMENICI's words, repeated many times on the floor of the Senate. He said: If you don't give the oil companies this protection from liability for their own wrongdoing, from product liability lawsuits, frankly, there is going to be no ethanol in your future.

Isn't it a sad outcome that we would turn our backs on 153,858 MTBE contamination sites in America and say to the communities, to the towns and cities, the subdivisions and the families, to the individuals who are harmed by this MTBE: We are sorry, you will not have a day in court. You will not be able to hold the people accountable who ended up endangering your family. Why? Because we had to strike a political deal. We had to say that when it came to using ethanol—which is a benign substance, environmentally acceptable—we had to swallow hard and say to the makers of MTBE and the oil producers that we are going to let them off the hook.

Do you know what else is in this bill? It is not just a protection from liability. Imagine this, if you will. We provided in this bill that you can continue to sell MTBE in the United States until 2014. Now, here is a substance that we know is damaging the environment in 153,858 contaminated sites, and this bill gives the companies the express permission to continue to sell it in America. It goes on to say that any Governor or the President can stop the MTBE ban for any State or region, which means 2014 is not a real deadline. Then, to add the ultimate insult, it gives to the industry $2 billion to transition away from MTBE.

My mind is spinning to think that Congressman DELAY of Texas, who supposedly is the author of this, was so audacious as to walk into the conference and say: Here is the deal, my friends. This lethal chemical in gasoline can continue to be sold in this country for 11 or 12 more years, and any Governor or President can extend the sale of that beyond that period; any company that wants to stop selling it is going to get a Federal subsidy to a total tune of $2 billion; and, furthermore, while this MTBE additive continues to contaminate water supplies and endanger public health, we are going to make sure that those who are injured, the innocent victims across America, cannot go to court and sue under a product liability claim.

How can we do this? How can we in good conscience do this? How can we ignore this section of the bill, this outrageous section of the bill?

Frankly, this is good reason to say to our friends who have worked long and hard on this conference report: Enough; send this bill back for more work. Remove this outrageous section about MTBE. Protect innocent American families and communities, and do it now.

There are those who argue, frankly, that there are other lawsuits that can be filed, that you don't have to use the product liability theory. Here is a lawsuit that was filed in Lake Tahoe, CA, South Tahoe Utility District v. ARCO, Atlantic Richfield Company. Here is what the jury verdict was in the case.

Lyondell—the maker of the MTBE additive—Lyondell's MTBE was defective in design because Lyondell failed to warn of the environmental risks.

They went on to say: Gasoline containing MTBE refined by the other defendants at trial was defective in design because the environmental risks of MTBE outweigh the benefits and the refiners failed to warn of its risks.

They went on to say: There is clear and convincing evidence that Lyondell and Shell acted with malice as they developed, promoted, and distributed their defective MTBE products.

What this tells us is that the companies which were sued knew they had a dangerous product, they continued to make it, continued to sell it, and continued to endanger people. Not only are they clearly guilty under a product liability standard, they are guilty, I think, in the worst scenario. As I recall from law school, it is whether they knew or should have known. This is not a "should have known" situation. The wrongdoers with MTBE actually were found, in this case, to have known it was a dangerous product.

Yesterday, I came to the floor and talked about this MTBE issue. I no sooner left the floor than the oil industry decided to put out a rebuttal to the remarks I had made on the floor. It is a lengthy rebuttal, but I would like to address the elements in it.

Frankly, they were plain wrong and the record should be set straight. I stated in my floor statement yesterday and I repeat again today, there were alternatives to MTBEs in the 1990s. Some would have you believe we had no choice when it came to oxygenate; it was MTBE or nothing. But listen to this: The MTBE manufacturers knew conclusively by 1984 that MTBE was a dangerous product that could contaminate water wells throughout the United States. They misled the Environmental Protection Agency in direct responses to inquiries in 1986 when they claimed they were unaware of MTBE water contamination.

Because of this deception by the MTBE companies about the dangers of their product and their efforts to discredit anybody who said otherwise, the industry increased its production at the expense of the alternative oxygenate, ethanol.

It should be noted, MTBE, as I said earlier, is a waste product, cheaper than ethanol. Had the manufacturers of MTBE disclosed the truth about MTBE contamination, the ethanol industry would have done quite well, and Congress might or could have prohibited this product at a very early stage. But because of the active deception of the MTBE industry, starting with their knowledge in the 1980s of the danger of their product, this didn't happen.

I went on to say that MTBE was found to be a probable cause of cancer. I spent a lot of my years on Capitol Hill fighting the tobacco companies. I know how they work. The MTBE gang is up to the same bag of tricks. They are now starting to dispute medical evidence as to whether MTBE is dangerous.

The industry, in rebuttal to my remarks, said:

> MTBE is one of the most widely studied chemicals in commerce, including pharmaceuticals, and that the overwhelming majority of scientific evaluations to date have not identified any health-related risk to humans from the intended use of MTBE in gasoline.

Then they go on to cite "numerous government" and "world-renowned independent health organizations" having found no sufficiently compelling reason to classify MTBE as carcinogenic.

Let me tell you, the MTBE industry, like the tobacco industry, when it comes to playing games with medical evidence, is plain wrong. The University of California at Davis concluded that MTBE is a known animal carcinogen.

In addition, the director of the General Accounting Office's Office of Natural Resources and Environment testified before Congress in May 2002 and stated:

> An interagency assessment of potential health risks associated with fuel additives to gasoline, primarily MTBE, concluded that while available data did not fully determine risk, MTBE should be regarded as a potential carcinogenic risk to humans. . . . A primary rule in epidemiology is "Absence of evidence of risk is not evidence of absence of risk."

The data has been coming in leading community after community, jury after jury, to conclude that this dangerous product might or could have endangered the health of Americans.

The removal of MTBE, as I said yesterday, is a growing problem. Their industry spokesman said:

> It's more water soluble and can be transported more readily in soil and water than other gasoline constituents.

I will tell you this: The largest MTBE manufacturer in the United States, Lyondell, has already been forced to revise its product safety bulletin and state, in their own industry safety bulletin:

> A relatively small amount of MTBE, less than 1 part per billion, can impart a displeasing taste and odor to water.

The U.S. Geological Survey has determined MTBE is the second most frequently detected pollutant in the United States, second only to chlorine, which is intentionally added to water, to give you an idea of how pervasive this issue is.

I also stated that the defective product claim is the most effective to secure relief against MTBE. The industry denies it. Yet what we have found is this: We have had to, in most communities across America, dig up gasoline storage tanks because they leaked. It was through the Leaking Underground Storage Trust Fund—the LUST fund—that a lot of this was paid for. We did it because we found this leaking gasoline was contaminating underground wells and aquifers.

The point I make is this: Despite our best efforts to dig up these underground storage tanks, the problem across America has not abated. About half of the States have reported finding MTBE they can still attribute to leaking tanks and suspect it came from other sources, even above-ground tanks to store fuels.

The point I would like to make is this, for those who are attempting to rebut my remarks of yesterday: The problem with MTBE has not gone away and is not likely to go away soon. What this legislation is designed to do is to hold those wrongdoers, those producers of MTBE, harmless from liability in product liability lawsuits for selling an inherently dangerous and defective product, a product which the industry has known since 1984 would contaminate water supplies and endanger public health.

This, in my mind, is the ultimate in irresponsibility. Frankly, I would like to say to my friends in the farm community who have said to me, You have to look the other way; we have to allow ethanol to expand even if it means endangering the lives of people from contaminated water in public water supplies—I would like to say to them, remember what you said yourself.

The president of the Illinois Farm Bureau, Ron Warfield, a good friend of mine, called and spoke to me about this issue. He has testified before Congress, and he said:

> We recognize the urgency of ending MTBE use to protect drinking water supplies.

Mr. Warfield went on to state:

> MTBE has adverse human health and environmental impacts.

He went on to state:

> The farm bureau's belief—

This is the Illinois Farm Bureau—

> that any legislation that addresses MTBE must be national in scope. Allowing States that have different programs will not allow us to achieve our national energy goals.

This bill goes directly against the Illinois Farm Bureau's position. This bill says, when it comes to MTBE we are going to allow them to escape liability. We, who have said for years that MTBE was a dangerous contaminant, cannot forget our own word.

My colleague in the Senate, Senator FITZGERALD, I believe in 2002, introduced legislation to ban the use of MTBE and to move toward the use of a safer oxygenate, specifically the use of ethanol. My colleagues in the House of Representatives, Congressman SHIMKUS from Illinois, and Congressman Ganske, introduced similar legislation.

Senator FITZGERALD said in his press release, March 6, 2000: Despite relatively limited MTBE use in Illinois, the Illinois EPA reports that at least 25 communities across the State have detected the chemical in their water supply, and three towns have had to discontinue use of wells as a result of MTBE contamination.

That is a quote from Senator FITZGERALD's press release in March of 2000. He understood the seriousness of this risk. He understood the danger to Illinois and its communities. Frankly, the situation has not gotten better. It is worse.

Taking a look at this chart, we can see that in Illinois we have 9,546 contaminated MTBE sites, including drinking water sites. So for my colleagues, Senator FITZGERALD, Congressman SHIMKUS, my friends at the Illinois Farm Bureau, and other farm organizations, I hope they can understand how this bill, frankly, makes a mockery of what we have said in the past.

If we have said, under oath at times, that MTBE is dangerous to the public health, how can we in good conscience now support this bill, which includes section 1502, which lets the producers of MTBE off the hook? How can we say to the communities and families of Illinois, or any other State affected, that we are going to limit their opportunity to come to court?

Yesterday, Senator DOMENICI likened lawsuits against MTBE producers to lawsuits against McDonald's because a woman was scalded when hot coffee was spilled on her lap. I might say to the Senator, there is all the difference in the world between the two of them. The lawsuit against the MTBE producers is a lawsuit based on the fact that this industry had knowledge, almost 20 years ago, that what they were selling was environmentally dangerous. They continued to sell it. They deceived the Government. They secreted information away from the public, and now they are trying to escape liability for their fraud and trickery.

Why should we be party to their fraud? Why should we say that they will not be held accountable for their wrongdoing? Is it not a premise of law and the rule of law in America that each and every individual and business will be held accountable for their wrongdoing? Why, then, do we cut this wide swath and say that these contaminants, the companies that made them, and the lawsuits that might come from them, should somehow be changed by this law? That is fundamentally unfair. Why would we do that at the same time that we offer $2 billion in taxpayer money to these companies as they phase out the use and production of that product?

I can think of plenty of businesses in my State of Illinois, or the States of New Mexico, West Virginia, and Texas, that are struggling to survive, that could use a Federal subsidy to get through a transition. We are not giving them a subsidy, but we are giving a subsidy to the oil and chemical companies that make MTBE a $2 billion subsidy. That, to me, is unconscionable, unreasonable, and indefensible. It is good reason for us to stand and oppose this bill.

When we look at the States that are affected by this—New Mexico, 1,126 contaminated sites; the State of West Virginia, 1,333 contaminated sites; Texas, 5,678 contaminated MTBE sites, and the list goes on and on—it says to each one of us that this crisis is not over. This crisis will continue. If we fail to hold the wrongdoers accountable, others will pay the price. There will be injured individuals and families who will have to bear the brunt of this environmental crime. There will be cities, towns, villages, and States which will have to pay to put infiltration systems in, new water systems and cleanup because of these polluters.

Why is it that this administration, and its friends in Congress, are dedicated to polluter protection instead of the basic principle that polluters should pay?

Polluters should pay for their own pollution. This is a classic example. Section 1502, which absolves in product liability lawsuits MTBE manufacturers from their responsibility and their liability, I think that is classic in terms of special interest legislation.

As I mentioned at the outset, Senator DOMENICI said there was a real danger—and let me quote him directly: We know as you start reading the language, we are duck soup. That is what Senator DOMENICI said on the Senate floor.

Well, we have read the language and, as we read it, we are saddened and troubled that in the Senate we would have such an egregious carve-out, such a blatant effort to reward one special interest group. I understand Congressman TOM DELAY's political strength, his persuasive ability, but to think that he could walk into a conference and force this provision into this conference committee is something that I do not think we should accept.

This is what we have to face. Those of us from States with MTBE contamination cannot walk away from our responsibility. We have to acknowledge that this bill, so long as it contains this provision, needs to be defeated. This bill must be stopped in its tracks. We must say to those who spent so much time on it, they need to go back and tell Congressman DELAY, the oil companies, and those who are pushing for this provision, that this is patently unacceptable and it is, frankly, unprecedented in American law that we would exempt one company from its own wrongdoing. But that is exactly what we are doing.

Once we have removed this offensive provision, we need to sit down and write a real Energy bill, an Energy bill which tries to encourage alternative fuels and renewable fuels, an Energy bill which focuses once and for all on "conservation," which seems to be a blasphemous word in this administration, in this Congress, but one that most Americans understand. We need an Energy bill that deals with fuel efficiency and fuel economy. Sadly, this bill does not.

We need an Energy bill that looks to reducing our dependence on imported oil in the future. Maybe we should invite the Chinese to come over and give us some guidance on how we could move toward conservation and fuel economy and less dependence on foreign oil because, frankly, they understand it far better than we do. We need an Energy bill that does not have to get passed by being larded up with a gusher of giveaways. If one wants to talk about oil exploration, there is a gusher of giveaways in this bill, giveaways to cities, towns, States, Congressmen, and Senators. Is that what it takes to develop an energy policy in America? I hope it does not.

I am no newcomer to Capitol Hill, and I understand that sometimes one has to keep the process moving along and they have to help one State or this region or one industry or that industry, but when it goes to this extreme, when it goes to the extreme of absolving a polluting and contaminating industry from their legal liability in products liability lawsuits for contamination of 153,000 sites across America, then it has gone entirely too far.

I urge my colleagues to join me in opposing the motion for cloture. If that motion is stopped, this bill is stopped. When it is, it can go back to conference.

Let us hope that for the first time we will have an open process. This whole energy policy started when Vice President CHENEY created a secret task force with secret meetings, producing a secret bill, leading to the administration's energy policy. It continued apace through the congressional process and returned to secrecy when two individuals, my friend the Senator from New Mexico and the Congressman from Louisiana, Mr. TAUZIN, sat down in a room without other Members and without anyone from the minority party and wrote this bill.

The reason there is such resistance today is the fact that this was not an open process. It should have been more open. Had it been more open, I do not believe anyone could, in good conscience, have proposed this MTBE exclusion from liability. You could not have brought this out in public with a straight face. But in private you can, and that is what happened.

Now the bill is on the floor and America gets a chance to read it. Having read it, I urge those who happen to be from the States with contamination of MTBE—and I put this map up here for those who are following the debate, for my colleagues to note. If your State is in black on this map, you know you have MTBE contamination. If it has one of those gold circles as well, it is contamination of drinking water.

If you vote for this legislation, you are saying to the people living in your State and your communities: We are closing the opportunity for you to go and hold the people accountable who have created this environmental disaster in your State.

I wouldn't want to go home and try to explain that. And I am not, because, frankly, I am going to oppose this bill so long as it contains this provision.

I yield the floor.

The PRESIDING OFFICER (Mr. CRAPO). The Senator from New Mexico.

Mr. DOMENICI. Under the order, the distinguished Senator from Texas is next; is that correct?

The PRESIDING OFFICER. There is no order.

Mr. DOMENICI. She has been waiting. I assume she asks she be next. Will the Senator let me use 5 minutes before she proceeds?

Mrs. HUTCHISON. Certainly.

Mr. DOMENICI. Mr. President, I want to take 5 minutes on the issue my good friend from Illinois raised here today. Has anybody thought how in the world there would be MTBE being used in all these different parts of the United States even today, even today? Has anybody wondered why it is still being used? Because it is still valid according to the laws of our land, and it is approved by the Environmental Protection Agency. This MTBE product was produced because the U.S. Government sought an additive to be applied to gasoline so it would be cleaner than gasoline without it.

I want to assure everybody in this country. The Senator makes it sound as if the product is an illegal product. If he doesn't, then I would sure say, if per se this product is this dangerous, it ought to be banned. But isn't it interesting?

He could say it should be, but the truth is, it is not. It has not been, and there has only been a little ripple of talking around here about perhaps shutting it down.

Why has there been none? Why is the Environmental Protection Agency, not just this one, the one in the Clinton and the one before that—why did they not do something about it? The reason is there is nothing wrong with the product. The product is being used. If it is used right, it is a good product. We are going to do better when we do ethanol.

But the good Senator from Illinois—I don't know how many times he will come back to the floor, how many times the Senator from Illinois will return to the floor to speak about MTBE. But his State is the second largest producer of corn in America, and the reason he is down here talking about MTBE is because he is scared of his farmers because he is not going to vote for the thing they want more than anything else—ethanol. That is what they want. He has been working on it. I have been working on it. Everybody has been working on it. And this Senator has decided, the Senator who just spoke, from Illinois, decided he would rather defend the trial lawyers who want to go after the companies that produce MTBE.

I also assure you that the language in this bill does not say that anybody is immune from liability. It merely says you can't sue the producer of the product just because they produced the product.

What is happening is it is being used improperly. When it is used improperly, it is producing all these ill effects across the country.

Does that mean we sue the people who produced it? I repeat, it is a legal product that has been approved by the Environmental Protection Agency. The United States of America approved it and now it is being used but people don't use it right. Underground tanks leak and it leaks into the water system. Does that mean the company 2,000 miles away that manufactured the product should be responsible to clean up those water systems? Of course not.

But I guarantee they are chomping at the bit to do it—do what? Not to sue the people whose tanks leaked because they are not fat enough. They are chomping to sue the big oil company that manufactured it for the last 20 years.

Now I want to read the statute. The statute says: No product shall be deemed defective—

> if it does not violate a control or prohibition imposed by the Administrator of the Environmental Protection Agency (hereinafter referred to as the "Administrator") under section 211 of such Act, and the manufacturer is in compliance with all requests for information under subsection (b) of such section 211 of such Act. . . . If the safe harbor provided by this section does not apply, the existence of a claim of defective product shall be determined under otherwise applicable law. Nothing in this subsection shall be construed to affect the liability of any person for environmental remediation costs—

Clean up the water, sewer systems and water systems.

It says:

> Nothing in this subsection shall be construed to affect the liability of any person for environmental remediation costs, drinking water contamination, negligence for spills or other reasonably foreseeable events, public or private nuisance, trespass, breach of warranty, breach of contract, or any other liability other than liability based upon a claim of defective product.

Frankly, there is no defective product. You can go on saying where it is all over America and that is because it is legal to use it. But it is not legal to abuse it. When people abuse it, should we really, as a nation, say the people who manufactured it are liable for all the consequences? I think not. That is all we did in this legislation.

If the distinguished Senator is so worried about this, I suggest he ought to vote for this bill and take care of the ethanol producers in his State and other States. He may be the deciding vote that decides we are not going to have ethanol. I wouldn't like to be in that position, I tell you, not on a weak proposition that the reason I did it was to protect the big lawyers who want to file these lawsuits. I say to all of them: File your lawsuits. When this thing is over with, file your lawsuits. It is just that you will not be able to sue the company that made the product which is legal and allowed. You can sue anybody else who caused the damage.

It is like somebody who drinks some soup in a restaurant and somebody in the restaurant, instead of putting soup in the bowl, they put some poison in it. You drank it and got sick.

Do you sue Campbell's Soup Company for producing the soup or do you go look for the people who put the poison in it?

The truth is, maybe we would all like to see MTBE go away. But that is not the issue. The issue is whether or not we should deny the passage of an Energy bill and ethanol for the farmers of this country, a great, giant substitute for the crude oil that we are going to use; whether we are going to do that or not.

If we are not, we surely ought not do it based upon the excuse that a valid product licensed by the United States improperly used is causing damage to people and we don't want to let them sue the people who produced the product but let them sue anybody else—the leaking tank owner, the distributor who distributed it wrongly, or anybody else who caused this—just because you made a legal product and somebody got hurt later on down the line, go back and sue the company that made it legally, validly, under what one might say is almost a license from the Federal Government.

I thank the Senator from Texas for yielding. I yield the floor.

The PRESIDING OFFICER. The Senator from Texas.

Mrs. HUTCHISON. Mr. President, I thank the Senator from New Mexico for shepherding this very important and very complicated bill to the floor.

I have to say I have been in the Senate for 10 years, and I have tried to get an Energy bill through the Senate during all of that time. We have never been able to do that until the Senator from New Mexico became chairman of the committee. What he has produced is a balanced bill. There are many things in it that I don't like. There are many things in it that I am sure every one of us in this Chamber would do a little differently. But we are a legislative body, and people have the right to have differing views and come together in compromises.

When we are making the decisions about how we are going to vote on legislation, we have to determine if the good outweighs the bad and if the bad is going to be unchangeable or more harmful than we should allow. I think the good definitely outweighs the bad in this bill.

I was going to talk about the MTBE issue. I couldn't talk about it any better than the Senator from New Mexico. People forget that MTBE was a mandate from the Federal Government. It came as a result of a mandate to produce oxygenated gasoline to try to reduce smog in our country and reduce pollution. The manufacturers came forward with MTBE. It is a perfectly safe product if used properly. In fact, it did have the intended consequences of reducing pollution.

The reason it is going to be phased out is that it has been misused, it has leaked into water supplies, all of which is very bad. But I don't think making the manufacturers of a product that was produced at the insistence and mandate of the Federal Government is good public policy. I think the MTBE issue has been used as a stalking horse for people who do not like other parts of the bill.

In fact, I think this is a good Energy bill. We must have an energy policy that addresses the issue of self-sufficiency for our country.

Between 1950 and 2000—50 years—overall energy consumption in the United States increased three-fold. We currently account for 24 percent of consumption worldwide. Yet, while demand has drastically increased, domestic exploration and the development of renewable sources have not kept pace. What we are doing today and tomorrow and as long as it takes to pass this bill, I hope, is promoting conservation, promoting increased efficiency, promoting reduced consumption, and promoting increased production from traditional sources. Some forms of energy are limited. They will exhaust themselves over time. But others are replaceable.

In this bill, we encourage the replaceable sources. Geothermal technology offers a clean, sustainable energy created by the harnessing the Earth's heat. Geothermal resources can be found in shallow ground or in hot water and rock miles below the Earth's surface. Hydropower, currently the largest source of renewable power in the United States, yields electricity from flowing water. Solar energy harnesses sunlight to generate electricity, provide hot water to heat and cool, and light buildings. Wind energy is created by 16-ton turbine engines capturing the wind with two or three giant blades to generate electricity. These turbines can be seen on hilltops where there is strong wind and not too much turbulence.

These are becoming increasingly a common sight in my home State of Texas, one of the Nation's leaders in wind energy production.

All of these sources are clean, natural, and renewable, and they can play a greater role in our Nation's energy policy. This legislation provides incentives for nuclear power. This has been overlooked in recent decades.

Since 1978, no new nuclear plants have been built in our country. Fear of accident and extraordinary insurance costs have made nuclear energy a costly venture. While European nations have safely developed sophisticated nuclear capability, the United States has let development of this important source lag. By encouraging the development of nuclear energy, we will give American companies a kick start that will create the high-paying technology and construction jobs and provide probably the biggest source of clean energy to meet our high demand.

One of the parts of the bill that I wrote is tax credits for marginal wells. Marginal wells are the 10-barrel-a-day wells, or less. When there are wells that produce a million barrels, thousands of barrels, a 10-barrel-a-day well is a small well. It takes a lot of capital to go out and drill a well. If a producer believes it is going to be a very small well, that producer is going to be less likely to incur the costs of drilling. But in fact, these little bitty wells, if they are going at full capacity in our country, and if we encourage them, can bring up the same amount of oil and gas as we import from Saudi Arabia every day. These little wells can be drilled by small business people. They can create jobs in the oil fields, and they can become a significant source of oil and gas for our country.

We have tax credits for these small wells if the price goes below $18 a barrel. These people will go out of business at $18 a barrel. They cannot make it. They can't break even. They will have to close the well, which is also expensive, and let their people go. So you have a loss of jobs. With a credit for marginal wells, when the price goes below $18 a barrel, you can encourage these people to go ahead and drill the well, put people to work and keep producing oil and gas for our country. Hopefully, the price goes back up—and, of course, the price is up right now. So it wouldn't even take effect right now. But it gives that floor so that the little guys will take the chance to go ahead and drill that well.

This provision was modeled after a Texas law that has also been quite successful in waiving certain State taxes for the little guy to keep those wells going.

The other thing it does is allow expensing for delayed rental costs, and G and G—which is the geological and geothermal exploration. These are expenses that are incurred, and in any other business they are able to be written off. They would be able to in this bill as well.

It encourages deep drilling in the Gulf of Mexico, which is quite expensive. We have had incentives over the last few years for this deep drilling. It has become the largest source of oil and gas we have in our country except for Alaska. Of course, we are not able to drill in ANWR. So this is a very significant resource for us, the Gulf of Mexico.

All of these are provisions I put in the bill because I believe that keeping the small businesses in business is a very important part of energy self-sufficiency in our country and creating jobs.

There is a national security issue. When 60 percent of our oil is imported—and we know how volatile the largest sources of those imports are in the Middle East—we know our country is going to be in a very bad fix if we lose those resources because of volatility or the war on terrorism. Our economy will be affected adversely. That will affect our jobs. It will affect our factories. It will affect our small business costs if we don't have our own sources of energy. That is why the Senator from New Mexico and the people on the committee who worked to forge this bill were addressing our national security interests as much as those who work on the defense issues.

If we are energy self-sufficient, that means our economy will not be in upheaval if we have a huge loss in the ability to import foreign oil, and therefore the price goes up and it becomes prohibitively expensive. We need to have our own sources of energy. We need to be dependent on ourselves. We need to keep the jobs for energy in our own country. That is why this bill is a good bill. It is not a perfect bill. No one said it is. I would not have written it this exact way, but it is a good bill. It will make us more energy self-sufficient, which also means we will be more secure in our country, more secure in our economy, and we will keep the jobs coming which are so important to keeping our economy strong and to have the recovery we have all been looking for to occur in the next year.

I support this bill. I hope people will look at the big picture. I hope people will look at the rhetoric on MTBE and overlook some of the things they do not like in the bill by looking at the good things that will increase production, increase the renewable energy sources, increase the clean energy, and decrease our consumption all at the same time so we will have a better energy policy for our country.

We have been working on this for over 10 years. The time has come. We will be able to fix things that do not work. We always do that with major legislation that is passed. The time has come. We have the capability to act now. I hope we will not lose it.

I yield the floor.

The PRESIDING OFFICER (Ms. MURKOWSKI). The Senator from West Virginia.

Mr. BYRD. Madam President, we have before the Senate the long-awaited Energy bill. For the more than 3 years of its making, we have been led to believe this was to be the piece of legislation that would go a long way toward solving our Nation's energy problems. But instead of providing for our Nation's energy security and stability, this bill does little more than codify back-room bargaining, underwrite the administration's corporate contributions, and further deepen our deficit ditch.

This bill is a monstrosity of gifts for special interests. Its passage will mean another lost opportunity to shore up our Nation's energy security, provide for future economic growth, and protect consumer interests.

The White House and Republican advocates may argue that this bill is national, comprehensive, and strategic. It is not. Advocates argue that this is a premier jobs bill and that hundreds of thousands of new jobs will be magically created because of the Pixie dust that is sprinkled throughout the bill. But these are empty assertions. This Energy bill will be neither an economic shot in the arm nor a jobs booster.

The White House and its secretive energy task force have done their utmost to dictate the terms of energy legislation for more than 3 years now. This energy conference bill is that dismal result. The Republican energy bill negotiators took a page out of the Vice President's playbook by not undertaking their deliberations in an open, transparent, and bipartisan manner. When well-placed corporate heads have a greater voice at the conference table than the minority Members of Congress, then we have truly sold our Nation's energy policy to the highest bidder. This conference was a shameful example of how the big moneyed interests who are bosom pals of this administration, continue to elbow out the best interests of the American people.

The American people should also know that the White House and Republican proponents who have so often avowed the free market system and fiscal responsibility are essentially ignoring those policies in this bill today. During the deliberations on energy legislation, the White House raised concerns about unrealistic authorizations and indicated its support for only $8 billion in tax incentives. But now the Bush administration wholeheartedly welcomes and strongly supports this bill regardless of its budgetary impact.

The Congressional Budget Office estimates that the deficit will be deepened to the tune of $25.7 billion because of mandatory spending and unbalanced tax incentives. This Energy bill, like so many bills that Congress has passed, is another empty promise. The White House's only major goal is to tick off a campaign pledge, regardless of its contents or lack thereof.

Furthermore, this bill is replete with unrealistic new authorizations that go far beyond the reality of our limited and shrinking budgetary resources.

Passage of this bill is far from a guarantee that the money will flow. How many authorization bills have been passed during the tenure of the Bush administration pledging huge sums of moneys that never came into being? How easy it is to vote to authorize funding, to make a splash in the headlines, and raise hopes about the funds that will flow from Washington, but when it comes to actually putting money in the budget and supporting the promised funding levels in the appropriations bills, this administration jumps ship again and again and again. One need only look at the No Child Left Behind program to see how this game of bait and switch is practiced and played.

What complicates the matter further is the number of new programs that have been created in this bill. In a perfect world I would like nothing better than to be able to support a plethora of energy programs that truly advance our neighbor's ability to produce and use energy more cleanly and efficiently. But realistically, this legislation only creates more programs that will have to compete for the same pot of money, and that pot of money is ever dwindling. Instead of focusing on our Nation's highest energy priority needs, longstanding programs—programs that are working—could well be severely fractured and diluted for years to come. That is not progress. In the end, this bill will just be another empty soapbox for the President to stand upon even though the necessary resources to carry out our energy programs will never materialize.

I certainly recognize that there are several important and useful provisions that have been included in this legislation, including a number of specific clean coal programs which I have supported. These and several other provisions have had bipartisan support in the Senate in both the 107th and 108th Congresses. Yet, in the aggregate, this bill will not help us to achieve our energy, economic, and environmental goals and, in many cases, will create even bigger problems down the road.

I have long advocated developing a complimentary approach toward our energy and environmental policies. Yet I have serious concerns about this bill's liability waivers, exemptions, and alterations to longstanding environmental laws, and limited consumer protection provisions. Furthermore, like several major tax cut bills and the homeland security legislation, special deals have been stuffed into the nooks and crannies of this bill. Yet some of the matters that rightfully should have been dealt with in this legislation are glaringly absent.

I speak, for example, of the coal miners Combined Benefit Fund. Nearly 50,000 retired coal miners and their dependents are facing an imminent crisis. These miners, who live in every State, are in danger of having their health care benefits cut due to a financial emergency in the fund, created by law, to pay those benefits. These are elderly men and women—women for the most part. Most of these are elderly widows who are truly among America's most vulnerable citizens. Yet among all the billions of dollars to help oodles of special, corporate interests in this bill, I find not a penny—not one penny—to help these elderly Americans, most of whom, as I say, are widows.

For the past 2 years, as the ranking member of the Appropriations Committee, as the Senator who has been on that Appropriations Committee longer than any other Senator in history, I have come to the aid by providing relief to that fund through several appropriations transfers of funds.

The Appropriations Committee was not the committee of jurisdiction. Other committees in the Senate are the committees of jurisdiction, not the Appropriations Committee. But I have come to the aid, with the support of my friends on both sides of the aisle in that committee, and especially I remember the support that was rendered on my behalf and on behalf of the coal miners and retired miners by Senator TED STEVENS, my Republican friend.

These were transfers that did not cost any State any money to clean up its abandoned mine lands. Yet these retirees and their dependents, most of them probably in very ill health and frail health—I believe the average age of these retirees is in the high seventies, probably near eighty—are being held hostage in some cold-hearted game of chicken. There was a chance in this bill to help them. There was a chance to provide a fix for the program that Congress designed to fulfill our promise to them, but the conferees failed to make that fix. The effort was killed by too many greedy hands grabbing for their own piece of the pie.

I hope the Senate and House committees of jurisdiction—not the Appropriations Committee; the Appropriations Committee has helped time and again—I will act next year to ensure that our Government keeps its promise to these retired miners. Certainly, compassion for the old and the sick should prevail over greed.

It pains me to conclude that this energy conference report, in its totality does not fully integrate four fundamental principles of good energy policy; namely, energy security, fiscal soundness, consumer protection, and environmental balance.

Despite its rhetoric, this White House's lip service and corporate coddling have been the sum total of this White House's energy policy. It began with the Vice President's National Energy Policy plan and concluded with the exclusion of Democrats from the energy conference.

As the Sun begins to shine on this leviathan, I hope that Americans will understand that this Energy bill will do little to resolve our energy problems, and if it passes, it could very well turn out to be a Pandora's Box.

Madam President, this legislation comes to us at the end of a session, and the Republican majority is attempting to serve up this elaborate and expensive dessert. But these are just empty calories—a delicious photo opportunity for the President, rich filling for industry lobbyists, but, in the end, only empty calories and heartburn for the American taxpayers. Sadly, when all is said and done, the American people will continue to stand in the bread line, hungry for a comprehensive national energy strategy.

Madam President, I yield the floor and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. INHOFE. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. INHOFE. Madam President, I have listened very carefully to the distinguished Senator from West Virginia and his characterization of this legislation. I have to come to a different conclusion because I believe this legislation before us today is a first giant step. We have been talking about this now for not months but years. I can tell you right now that the problem we are having with energy in America is a very serious problem.

I am from a State that is a production State. We have produced shallow and marginal wells for a long period of time. Sometimes people don't realize how significant this source of energy is. Statistically this is true: If we had all of the marginal wells that have been plugged in the last year flowing today, it would equal more than we are currently importing from Saudi Arabia. That is a huge amount.

I started out, before most of the people in this Chamber were born, in the industry, in the oil business. I was a tool dresser on a cable tool rig. That is the way we used to go after oil, particularly shallow oil, where you would have to take a bit out. You would stand with it, white hot, and sledgehammers on both sides, sharpen it, and then go back and pound. We pulled a lot of oil out of the ground at that time.

If you think about the economy that resulted from all that production, there were good jobs. In the Osage area of my State of Oklahoma, northeastern Oklahoma, we had a lot of shallow wells. I can remember going in to Pawhuska, OK, at noontime to eat lunch. You would have to wait in line 15 minutes to pay your bill. It was because this industry was so viable. Today it is almost a ghost town.

With the passage of this bill, there are incentives in here. Nobody talks about them. There are some things I wish were in this bill. No one is more familiar with the necessity to get into some of the drilling at ANWR, and certainly we need to be doing that. But just look at some of the opportunities that are in the bill.

This bill has an incentive to get back into marginal well production, and that could open up a huge domestic supply of oil and lessen our reliance upon foreign countries. That reminds me of something I often say: Our reliance upon foreign countries for our oil supply is not an energy issue. It is a national security issue.

I remember back many years ago, during the Reagan administration, when Don Hodel was Secretary of Energy and later Secretary of the Interior. He and I had a little dog and pony show. We would go around the country and talk to them about how the outcome of every conflict, every war back to and including the First World War was dependent on who was in control of the energy supply. We talked about the Malay Peninsula. We talked about the submarines coming into the Caribbean to knock down the ships so we could not get to our refineries.

This is something I thought surely people would understand. They didn't understand it. By the way, the fact that we are looking at an energy policy today, this should not really be a partisan issue. I kind of laugh when I hear some of my colleagues on the other side of the aisle saying we don't need an energy policy. I tried to get Ronald Reagan to have an energy policy. He didn't do it. I tried with the first President Bush. I said: Let's get an energy policy. Let's have, as a cornerstone of that policy, a maximum amount that we are willing to depend on foreign countries for our ability to fight a war. He didn't do it. We didn't do it during the Clinton administration. But this President is.

I talked to this President when he was running for office. I said: Will you commit to an energy policy so we can lessen our dependence on foreign countries for our ability to fight a war? Back when Don Hodel and I were going around, we were 38-percent dependent upon foreign countries. Now it is approaching 60 percent. So it is very serious.

Why is it people wouldn't realize that after the Persian Gulf War in 1991, why wouldn't it be indelibly imprinted upon the hearts of every American that we could no longer be dependent upon the Middle East for our ability to fight a war? Yet it didn't seem to help. We picked up a few extra votes but not enough to get a real policy.

I chair the Environment and Public Works Committee. There are a lot of issues that are within the jurisdiction of my committee that are very significant and that are in this bill. One is, it allows hydraulic fracturing to be used by not just Oklahoma but by all States. This is a way of extracting oil out of tight formations. It is something we need to be addressing. It is addressed in this bill.

This clarifies the exemption for oil and gas production from storm water discharge permits. Congress provided this exemption years ago, and a misinterpretation of the exemption had threatened to stop a lot of the small, local production. This clarifies that and will get us back into producing.

This provides a 5 billion gallon ethanol requirement for motor fuel. If anyone ever says there is is not enough renewable energy in this bill, they have not really read this title of the bill. I started working on this issue over 5 years ago, and I am glad to see that a compromise was developed to increase the amount of renewables while ensuring that our Nation's refineries are not adversely affected.

In my committee, we had the renewal of the Price-Anderson bill. We passed it. It is now a part of this bill. So a lot of the things that would otherwise have been on individual bills or have been on a comprehensive bill from my committee are in this bill.

It is necessary to have reauthorization of Price-Anderson in order to provide the protections so we can go after the other sources of oil such as nuclear sources. This establishes a nuclear security program. I think we all, after 9/11, recognize that.

In the committee I chair, we had all the security bills. We had a wastewater security bill. We had a nuclear security bill. We had a chemical security bill. They are all there for the purpose of protecting those vital elements of our economy from a potential terrorist attack. We went ahead and put the nuclear security bill in this. If we don't pass this, it is going to certainly heighten the risk that is out there on something happening to a nuclear plant. So after a lot of effort, we finally have that in here.

This bill provides $300 million for the EPA's clean schoolbus program, another one that came out of my committee.

I am saying there is a lot more to this bill. It doesn't go far enough. I can't look at the lovely acting President in the chair without thinking about ANWR and about going up there. I just wish people who are so concerned about disrupting the environment or something up there in those slopes would go up and look at it. It is not a pristine wilderness. It is a mud flat. All the local people want it.

Here we are down here—we are a lot smarter here in Washington—saying no, in spite of the fact it would alleviate some of our reliance upon foreign countries for our ability to fight a war. We are smarter than they are up in Alaska. We know what is good for them in spite of what they want.

I am very proud of both Senators from the State of Alaska for understanding this, for explaining it. I feel sorry for them that we have such arrogance in this body that we feel we know more about their business than they do.

Our Nation is at the point where access is prohibited to almost every major reserve of oil and gas on our Nation's shores. Furthermore, extremist environmentalists have declared war on oil and gas wells in the interior of our Nation.

I have had occasion, as I am sure the manager of this bill, Senator DOMENICI, has had numerous occasions to debate people on the other side. We know we have a crisis in energy in this country. Yet there are those on the other side who say: We don't want nuclear energy. We don't want fossil fuels. We don't want oil. We don't want coal. Now they don't even want windmills because they will disturb some migratory bird path.

We have to have it. Look at the flight of industry and business that is going overseas. Right now we have chemical companies that fear they are going to end up not being able to use coal as a source of energy, one that we are depending upon for more than 50 percent of our energy in America today. They have gone over into other countries such as western Europe where they have nuclear energy, where some of the countries, 80 percent of their energy comes from nuclear sources..

This bill is a modest start. But if we don't do this, after being rejected since 1980 and before having an energy policy in America, this crisis we are facing right now is going to be even more serious. It is a modest beginning and one on which certainly, at the very least—I say this to the Republicans—we should at least have a chance procedurally to have an up-or-down vote.

Let's remember what we went through last week for some 39 hours. The big debate there was, let's just get to the point where we can have an up-or-down vote. That is all we want on this, an up-or-down vote. I would hope that some of those individuals who may not be in support of this legislation will at least vote to allow us to have that up-or-down vote.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GREGG. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GREGG. Madam President, I wish to continue what I think has been a fairly lively and informative discussion on the Energy bill which is before us. A lot of the time has been focused, of course, on the language which exempts the manufacturers of MTBEs from liability and which does it in a retroactive way which is extremely penal to those States that decided to use their rights to try to protect the ground water of the populace by bringing lawsuits and, as a result, will now be barred from those lawsuits, not only prospectively but actually ex post facto.

That seems to be an outrage in and of itself, of course, coupled with the fact an additional $2 billion is going to be spent to subsidize the companies that are producing the MTBE. That just adds insult to injury. The list of issues involving MTBE goes on and on, and they have been explored at considerable length on the floor.

I want to return to another element of this bill that concerns me, and that is the fact that it is extremely profligate in its use of Federal tax dollars and especially the manner in which those tax dollars are used.

It would be appropriate to have an energy policy in this country. That is absolutely necessary, in fact. If we are going to have an energy policy, it ought to be based on three basic purposes: One, it should be based on reducing consumption through, hopefully, conservation; two, it should be based on producing renewables that can be used over and over and, therefore, reduce our reliance on international oil; and, three, it should be based on the need to create more production of resources that can be used for energy.

All of those elements should have some sort of marketplace relevance. In other words, you can't suddenly go out and pervert the marketplace by essentially saying you are going to pick a winner and that winner, even though it may not be commercially viable and even though it may not be even environmentally viable, will be given a dramatic increase in support from the Federal Government simply because it happens to be the item of the day for those folks who happen to be writing this bill.

Unfortunately, that is the way this bill is put together. It is a hodgepodge of little interests—some of them rather large interests, some of them extremely large interests—that were able to get to the table and get their interests taken care of but not in an orderly way, not in a way that had an overarching theme, such as creating conservation, creating renewables, and creating production but, rather, in a manner that says we are going to pick winners and losers; certain segments are going to be the winners, and certain segments are going to be the losers; certain regions are going to be winners to the detriment of other regions; and essentially we are going to try to logroll this bill through the Senate even though on its face it has no relationship to national energy policy.

The list is quite long of items which you have to say, if you are going to try to be kind, are arbitrary—arbitrary at best—but they invade the taxpayers' wallet.

Let me read a few of them: $2 billion for companies in Texas and Louisiana to compensate for their phaseout of the gasoline additive MTBE. I find that to be one of the most outrageous since those companies are also, at the same time, demanding they be held basically free of any liability for having produced MTBE which is such a huge detriment to the country—$2 billion in tax deductions for oil and gas companies for purposes of geological and geophysical expenditures; $500 million for a new loan program for the oil and gas industry to demonstrate and encourage new technology. The program leaves it to the discretion of the Secretary and the loan recipients to establish interest rates and loan repayment schedules.

You have to admit, that is creative. The last time I went into a bank, I, as the borrower, did not get to pick my loan payment rate and my repayment schedule. These are very creative people who sat around this table taking care of your tax dollars.

There is $2 billion in taxpayers' money to be used for cleaning up gasoline and chemical spills from leaking underground storage tanks, a worthy goal, until one learns this fund will even fund cases where the polluter can be identified, letting the polluting individual or company off the hook and putting the hook into the American taxpayer.

There is $2.9 billion in corporate welfare for some of the wealthiest corporations in the fossil fuel industry; $800 million for a loan to build a coal gasification plant in Minnesota; $1.1 billion for the first-ever production tax credit for coal.

The bill expands the solar energy and geothermal investment tax credit to include clean coal investment. That is a unique view of renewables. That is creative use of the term "renewables"—to throw solar and geothermal in with clean coal; $1.5 billion for loan guarantees for coal plants, more than $1.4 billion over the next 5 years.

The bill establishes a federally funded research and development program to ensure coal remains a cost-competitive source of electrical generation as a chemical feedstock and for transportation fuels. This is a classic example of trying to control the marketplace arbitrarily with tax dollars.

Basically, what we are saying is even if it doesn't work competitively, we are going to subsidize it, and we are going to force it to work in the marketplace to the tune of these billions and billions of dollars. That list goes on.

One of the most interesting ones is what they did with the abandoned mines land fund. This fund collects fees on all coal mines in the United States to clean up the dangerous mines abandoned before 1977. That is an extremely worthy goal. Obviously, we don't want the mines out there, and the damage they do to the environment is significant.

Over $6 billion is needed to mitigate the environmental damage from these abandoned mines, but there is only $1 billion in the fund today. This proposal would reauthorize the fund for another 15 years, reduce the fee to mining companies by 20 percent, and transfer $275 million from the fund to address the deficit in the United Mine Workers Combined Benefit Fund and direct 10 percent of the Federal mineral leasing moneys to address the money owed from the AMI fund to Wyoming and Montana.

Over the next 3 years, the proposal would cost approximately $1.4 billion, but the mines would not get cleaned up because the money would have been siphoned off for these special projects. That is what is called special interest governance. Two billion dollars in the provision could defray some of the costs incurred by utility companies in installing pollution control equipment in old coal-burning plants to comply with the clean air bill. That sounds reasonable except for the fact we have to realize that these plants have been exempt from the Clean Air Act now for over a decade and they were given the exemption so they could work their way into being clean.

Other plants have come online, with the consumer paying the costs of having those plants be clean-air-producing plants. So consumers are paying for new plants but now they are going to get to pay twice—not the local consumers but the region of the whole country is going to get to pay twice for the old plants that do not meet the responsibility and have refused to upgrade their responsibility. Picking winners and losers again in the marketplace in a way that is extremely arbitrary and simply reflects the fact that certain interests were at the table that had the ear of the people who were effective in developing the bill.

Ethanol is a program that has taken on a life of its own. Regrettably, that life is paid for by the whole country, especially by parts of the country which see no significant benefit from this product, at an extraordinarily high cost.

Since 1978, the U.S. Government has granted a multitude of tax incentives and subsidies to promote the growth of the domestic ethanol industry. The industry and its supporters, including suppliers of ethanol—the primary input, corn—maintain that ethanol is an effective and environmentally sound way to substitute for gasoline. However, the huge subsidies given out year after year have benefited few besides the corn growers and the ethanol producers, which are often very large companies.

Despite the claims, ethanol has neither reduced our dependence on foreign oil nor has it significantly reduced pollution. Taxpayers' repeated payments in the form of subsidies to corn growers and ethanol producers, and the opportunity it costs, serves no other purpose than to artificially prop up the price of corn and the ethanol industry.

The list of subsidies that have been developed over the years is rather staggering. In the last farm bill, we put $26 billion into that bill over a 6-year period to assist people who grow corn. This is independent of the ethanol issue. That is $4.3 billion a year. Maybe that is legitimate. The farm program has some serious problems, but maybe that $4.3 billion was legitimate.

It turns out that is just the beginning, because this bill doubles the mandate for the minimum use of ethanol to 5 billion per year, costing the American taxpayer, because ethanol is not an efficient way to produce energy, an extra $6 billion. That means that $6 billion comes from taxpayers across the country in the form of higher prices to pay for an ethanol product which was already subsidized under the farm bill to the tune of $26 billion. Then on top of that, we have to pay to create two new research programs in this bill for ethanol.

One would think, after we had put $26 billion in the farm bill and $6 billion out of the taxpayers' pockets through the direct subsidy of the gasoline, they would have at least had the courtesy to pay for their own research. That is what most market-oriented products do; they go out and they research and determine whether they can produce the product. And they do not charge that research to the Federal Government. They charge it to their end product users, which is us again and we have to pay for it. But, no, that is not the case. We have to pay $12 million in this bill to create two new research initiatives.

Then, on top of the $5.9 billion in subsidies, and the $26 billion in farm subsidies, we also have to give $750 million to the ethanol producers for the cost of building their production facilities.

This is the most incredible program. First, we underwrite the raw material with tax dollars, probably to a point where we actually see the net income of the people who are actually producing the raw materials. That otherwise would be described as a national socialist approach to an economy, certainly not a market economy. Then we have to get people to pay to subsidize the purchase of the product to the tune of $6 billion, and then we have to pay $750 million to build the facilities to produce the product. The list just goes on and on.

On top of all of this, there is another $2 billion of tax credit which goes to the producers of this product in this bill. They were not happy with the fact that the small producers were going to get this tax credit so they had to expand it, so they picked up a whole group of new producers which are much bigger people in the way of income. They essentially doubled the small producer language in this bill. So we now have fairly significant people getting this huge credit. On top of the farm subsidy, on top of the subsidy for purchasing the gas, on top of the subsidy for building the production facilities, on top of the subsidy for researching the production facilities, we have a tax credit.

It is truly an amazing act of largess on the part of the American taxpayer. We all feel very good about this, I am sure. We have been able to pursue a policy in this bill that is essentially spending these types of dollars on our friends who produce this product and manufacture this product. The problem is that by doing this type of a commitment to this product and the producers of the product and the manufacturers of the product, we have totally perverted the marketplace.

We have essentially picked a winner, ethanol, and we have said that winner is going to get so heavily subsidized, and then require that the product be used, plus used in a way that is extremely detrimental to an area such as New England because in New England ethanol cannot be shipped in. It does not transport through pipelines because it is too corrosive in the pipelines. It does not transport by truck or train because it is too explosive. So it has to be put on a ship in the gulf and taken around the Gulf of Mexico and brought up the coast into the ports in the Northeast. So on top of all of the other subsidy that is in this product, we pay a much higher price for this product which we are forced to buy under this bill. It is truly not energy policy. It is simply an initiative to take care of an interest group that may be very legitimate and they are very nice people, and they certainly have good representatives in the Senate and in the Congress generally, but they cannot defend this product as being a competitive product in the arena of what we should be looking at for various options for fuel with this type of subsidy level. There are no market forces at all involved in this product. It is totally a subsidized event, subsidized by all the taxpayers in the United States for the benefit of the few who produce the product. Truly, it is a classic example of how not to do an Energy bill because it totally takes the market out of the exercise.

Then you get into the special interest projects in this bill. We have heard a little discussion of those. We have these green bond proposals. I think the Senator from Arizona pointed out that one of them would build a Hooters restaurant somewhere in Louisiana. That is paid for in this bill with taxpayers' money. You have $1 billion for coastal impact, almost all of which flows to Louisiana. That is basically a special interest initiative. You have a hydrogen research project for a Freedom Car, which is $2.1 billion. The President asked for $1.2 billion, but the lobbyists and somebody decided that just wasn't enough to take care of this interest group.

That sort of reflects this whole bill. The President asked for $8 billion in tax credits, a reasonable number. It was within the budget. I want to come back to that. Instead, we ended up with a $25 billion tax credit bill, three times the price the President asked, and we don't end up with a better energy policy. We didn't get three times better energy policy than what the President proposed because those tax credits are all being used basically to artificially manage the marketplace and to create events within the marketplace which were not able to stand on their own, and as soon as the tax credit goes away, you will not have that production capability because those products are not viable and they are not competitive for the most part.

In a speech I earlier gave on this bill, I pointed out I went through this once before. We all went through this in the 1980s. At the end of the oil crisis and an embargo in the 1970s, we tried subsidizing different forms of energy at extremely high levels to see if we could not bring them on line and make them competitive commercially. We did shale oil and solar and wind and geothermal. We even did something, I forget the name of it, where we put a ship out in the ocean and ran a pipe in the water and the pipe got cold and we piped it back around. There was some technical name for that. We were building ships to do that.

None of these technologies, except maybe solar and wind, survived, and solar and wind survived in a much different framework than the direction the initial tax incentives pushed them. That is because they were not competitive because, even with those subsidies, they could not compete in the marketplace with the products that were out there beside them.

So, once again, we are seeing that in this bill. It is not energy policy. It is picking winners and losers for the purpose of gaining economic advantage for one sector of the economy over another, one group of people over another, one manufacturing group over another. We have the $1.1 billion proposal to construct an advanced reactor hydrogen cogeneration project in Idaho—$500 million is for the construction, and then we pay $635 million, or as much as is necessary, in order to operate the plant. It is bad enough that we are going to pay to build the plant. But on the face of it, if you are going to have to spend $635 million to operate the plant, you have to conclude the plant isn't too viable as an exercise.

We went through this all, by the way. Idaho had another one of these projects which I suspect is interrelated to this, although I don't know it, which didn't fly because it was too heavily subsidized.

The window is open at the bank of the American taxpayer and their checkbook, with item after item of fairly questionable attempts to try to pick winners and losers in the nuclear industry and to do some things which are of questionable value. I could go through the list, but the list has become fairly public and it probably isn't necessary to review it.

There are a couple of other specific ones. It has been reported that the bill for some reason effectively mandates permanent use of the controversial Cross Sound Cable between Connecticut and Long Island. You tell me what that has to do with energy policy. That is an issue between Connecticut and Rhode Island, and Connecticut is a little upset that we are suddenly stepping into their jurisdiction and making that decision for them.

The Energy bill would build a project on the Iron Range, a $1 billion plus Excel Energy Powerplant for the Iron Range. Well, it is $800 million of loan guarantees for that project. It is probably a good project, but it is hard to understand why we should have picked that project, to put that level of tax dollars into this bill.

The list goes on and on, regrettably, to the point of excess in the area of picking winners and losers, and doing it in a way which has no comprehensible relationship to what one might consider to be producing an energy policy that had a rationale behind it, versus an exercise in simply going into a room and listening to the people who are whispering in your ear on the day when you are writing the bill.

That is a big problem, the fact that the bill is not structured very well as an energy policy bill and doesn't address in a thoughtful way or a comprehensive way consumption of renewables or production.

There are some production initiatives in this bill which do make sense. I think the Alaska pipeline initiative would probably be very good for this country. I wish they had included ANWR.

But overall this bill is just a hodgepodge, and it is excessive. The fact is that it exceeds the President's request by almost three times, which brings me to the next point. This bill is in violation of at least four budget points of order. That is how excessive it is. The bill violates a spending point of order, it violates a tax point of order, it violates a pay-go point of order, to say nothing of the fact that it violates rule XXVIII.

Why? Because it is totally out of touch with our own budget as a Federal Government. We put in place a Federal budget. We put in place a plan for how much we could spend in developing an energy policy, and then we ignore it in this bill. There is no fiscal responsibility at all reflected in this bill but just the opposite in the way it spends money and in the way it treats the budget which we have passed as a Congress. It is hard for me to understand how the administration could endorse a bill which exceeds their level of spending and tax policy by such a significant number.

We have heard numerous complaints about Congress overspending in a variety of areas. This bill just drives through that barrier as if it weren't even there and proceeds on down the road.

The bill has a lot of problems. It has the problem that it is an attack on a region, New England specifically, in the MTBE language. It has the problem that it is not comprehensive in its approach, or at least coordinated in its approach. It is a hodgepodge of various interest initiatives, some of which may score well, some of which may not, but there is certainly no coherence with them.

It is filled with initiatives which are clearly counterproductive to using a marketplace approach, which I think should be the approach we as Republicans would want to use, where we test the product and determine whether or not it can compete in the market, and then we give it support to draw it into the market. But we don't say you don't have to worry at all about the market, as we do in this bill, with a number of different initiatives and production capabilities.

It is expensive. It exceeds the budget by a significant number.

It is hard to defend a bill like this, it seems to me. So that is why I hope when we get around to the issue of cloture, or even the issue of points of order, people will take a very serious look at the failures of this bill on those various accounts.

Madam President, I yield the floor and make a point of order a quorum is not present.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. FEINGOLD. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. FEINGOLD. Madam President, I rise today to share my concerns about this Energy bill. An Energy bill is a serious matter. I strongly believe the country needs to achieve a balanced national energy policy.

I did not make my decision to oppose this bill lightly, but unfortunately this bill is even worse than the Senate version. I cannot support it.

Although my remarks will be very brief, my reservations about this bill run deep.

I oppose this bill for several reasons. For one thing, the price tag of this bill troubles me. According to the Congressional Budget Office, this bill will cost the taxpayers $31 billion and is not offset anywhere else in the budget. Our national deficit has ballooned over the past several years, so it is even more imperative that we be fiscally responsible with taxpayers dollars.

In addition to the bill's fiscal implications, I am deeply concerned that the bill repeals the Public Utility Holding Company Act. This critical act protects consumers against abuses in the utility industry. Repeal of PUHCA would leave rate-payers vulnerable and spur further consolidation in an industry that has already seen a number of mergers. Two large holding companies have been created in Wisconsin alone in recent years. Furthermore, the bill does not protect consumers from Enron-style electricity trading practices and market manipulation. The Senate recently went on record in support of an amendment by Senator CANTWELL to bar such abusive practices and I am disappointed that the bill fails to include similar protections. I also doubt that the bill will prevent blackouts like that we experienced last August—this is one of the country's most pressing energy problems, yet the bill does little to address it.

In the area of boutique fuels, the bill also falls badly short. Everyone in my state of Wisconsin is familiar with price spikes during the shift from the spring to winter fuel supply. Wisconsin has pushed for national standards for federally mandated reformulated gasoline blends, or RFGs, to try to broaden the supply and reduce price hikes during RFG shortages. The current bill will just authorize a study about the problem, not solve it. We had a genuine bipartisan effort to try to do this. I cannot understand for the life of me why this was not included in the conference report.

Also, the bill has serious and unwelcome environmental impacts. For example, the bill undercuts the Clean Air Act by postponing ozone attainment standards across the country. This issue was never considered in the House or Senate bill, but it was inserted in the conference report. This rewrite of the Clean Air Act is not fair to cities like Milwaukee that have devoted significant resources to reducing ozone and cleaning up their air. And, as asthma rates across the country increase, this provision could severely undercut efforts to safeguard the air quality of our citizens.

In addition to undermining air quality protection, the bill allows for siting of transmission lines in national parks, grants exemptions from the Clean Water Act and Safe Drinking Water Act for oil and gas companies, and pays oil and gas companies for their costs of compliance with the National Environmental Policy Act. I am also concerned that the liability exemption for MTBE is retroactive to September 5, 2003, which will nullify about 100 ongoing lawsuits. MTBE is found in all 50 States, and high levels are affecting drinking water systems all over the Midwest, including 5,567 wells in 29 communities in Wisconsin, even though the state only used MTBE gasoline for the first few weeks of the phase I program that began in January 1995. As a result of this bill, taxpayers are going to have to foot the $29 billion bill for the national MTBE cleanup.

This bill fails to reduce our reliance on fossil fuels. The Senate energy bill contained a requirement that power companies provide at least 10 percent of their power from renewable energy sources like wind, water, and solar power. The technical term is a renewable portfolio standard. The current bill doesn't contain any renewable portfolio. standard. There's no doubt that we can and should do better on renewable energy to reduce our dependence on foreign fossil fuels.

Although, I support many of the renewable fuel provisions in the bill regarding ethanol, I am troubled by the fact that the bill also depletes vital highway funds for States by siphoning money from the volumetric ethanol excise tax credit.

The content of the bill is problematic, but so is the process of how it was written. My Democratic colleagues who served on the conference had only 48 hours to review the 1,700-page report before the Monday conference meeting. They were virtually shut out of the negotiation process. I regret that the manner in which the current bill was drafted—in secret, closed meetings, without adequate time to review it. This is no way to come up with a balanced national energy policy.

For these reasons, I oppose this bill and I will oppose cloture. I appreciate the need to develop a new energy strategy for this country. I disagree strongly, however, with the measures taken in this bill. This is a bad bill, it's bad for Wisconsin, and it's bad for the Nation's taxpayers.

I thank my colleagues from Oregon and my colleague from New Jersey for their courtesy in letting me give my remarks.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oregon.

UNANIMOUS CONSENT REQUEST

Mr. WYDEN. Madam President, on behalf of myself, Chairman GRASSLEY, Chairman LOTT, and Senator BYRD, I ask unanimous consent the Rules Committee be discharged from consideration of S. Res. 216; that the Senate proceed to its immediate consideration; the resolution be agreed to, and the motion to reconsider be laid upon the table, without any intervening action or debate.

Mr. BURNS. Madam President, reserving the right to object, and I will object, this is mistimed to be considering this rule change on this piece of legislation. On behalf of some Senators on this side of the aisle I will have to object to the Senator's request.

The PRESIDING OFFICER. The objection is heard.

Mr. WYDEN. Has the Senator objected? I was under the impression you reserved the right to object.

Mr. BURNS. I reserved the right to object, and I did object.

Mr. WYDEN. Madam President, in light of the objection, on behalf of myself, Chairman GRASSLEY, Chairman LOTT, and Senator BYRD, I ask unanimous consent that no later than March 1 of 2004 the Rules Committee be discharged from further consideration of S. Res. 216, if not reported, and that the Senate proceed to the consideration of S. Res. 216 at a time determined by the majority leader following consultation with the Democratic leader.

Mr. BURNS. I object.

The PRESIDING OFFICER. The objection is heard.

MORNING BUSINESS

Mr. WYDEN. Madam President, I ask unanimous consent there now be a period of up to 20 minutes of morning business under my control to discuss S. Res. 216.

The PRESIDING OFFICER. Without objection, it is so ordered.

ENDING SECRET HOLDS

Mr. WYDEN. Madam President, my good friend from Montana and I have worked together on so many issues. He has objected to this bipartisan resolution which would give the Senate a chance to end one of the most pernicious practices in Washington, DC, and that is the practice of secret holds.

Walk down Main Street anywhere in the United States, and I bet you would not find one out of a million Americans who know what a secret hold is. The hold does not appear anywhere in the dictionary. It is not even in the Senate rules. Yet it is one of the most powerful weapons that any U.S. Senator has. It is, of course, a senatorial courtesy whereby one Senator can block action on a bill or nomination by telling the respective Democrat or Republican leader that he or she would object. The objection does not have to be written down, and it does not have to be made public.

It is a little bit like the seventh inning stretch in baseball. There is no official rule or regulation that talks about it, but it has been observed for so long that it has become a tradition.

Now, the capacity to use this hold, which is in secret—there is no transparency, no accountability—the prospect of using these secret holds is notorious and has given birth to several intriguing offspring: The hostage hold, the rolling hold, and the May West hold. Suffice it to say, at this time of the year secret holds are more common than acorns around an oak tree.

Senator GRASSLEY and I have been working on this for almost 7 years. I am extremely proud that the chairman of the Rules Committee, Senator LOTT, has joined us on this matter. Senator

BYRD is a cosponsor. There is no one in this body who has a better understanding of the rules than Senator BYRD, and Senator BYRD has made it clear this practice is out of hand. It is out of hand because the rules are designed to expedite the business of the Senate and not hold it up.

What we heard earlier in the objection to the effort to end secret holds is emblematic of what has happened. The objection was based on the idea that now was not a good time for the Senate to address this. It is never a good time to address it if you are in favor of doing business behind closed doors. If you are in favor of doing the public's business without accountability, it is never a good time. If you are in favor of doing business in secret, of course, we are never going to bring it up in the Senate.

The minority leader, Senator DASCHLE, has been supportive of this effort from the very beginning. From the very first day I went to him to discuss this, he said: You are right. The hold is an important power for a member of the Senate, but it ought to be exercised with some accountability.

So there was no objection from this side of the aisle. Unfortunately, we had an objection from the other side. I think it is unfortunate because I have sought throughout—throughout—to make this a bipartisan effort.

Chairman GRASSLEY and Chairman LOTT deserve an extraordinary amount of credit for the effort to work with me and with others on this issue. The fact is, during this time of the session, one Member of the Senate can spend days asking all 99 other Senators whether they have a secret hold, only to find that Senator does not even know about the secret hold because it was generated by staff.

The Senator who can successfully track down and lift the last secret hold almost feels around here as if they have won the national title.

Every Senator has a favorite example of torturous search for the sponsor of a secret hold. My favorite was during the Rules Committee hearing on holds, Senator DODD—by the way, who, is very supportive, like Chairman LOTT, of this proposal—we heard about the chairman trying to call Senators in airports around the country, trying to find out who had a hold on a bill. Senator DODD was concerned about this when he was faced with his election reform bill.

I went through the very same exercise on the spam bill where I had to literally go from desk to desk in the Senate to find out who was holding up a measure that everybody was for. Everybody said they were against spam but there were holds, and we had to try to figure out where they were.

The same thing happened on the Internet tax bill. At one time there were seven holds on the Internet tax bill. When I tried to find out which Senators had the holds, I was told that this information would not be shared with me.

Think about the consequences of not dealing with that issue. I say to my colleagues, we may have a virtual "Grinch" visiting the consumers of this country because the Senate has not dealt with the Internet tax issue. Come the holiday season, if some States and localities choose to do it, they can go out and tax e-mail, they can go out and tax Internet services that are delivered through wireless devices or DSL because the Senate has not updated the law. I believe it has not updated the law because there was not the opportunity to have a real debate, and we were held up because there were secret holds.

I am very pleased that the distinguished chairman of the Rules Committee has come to the Chamber to join me in this effort. Perhaps more than any other Member of this body, he understands the implications of this because of his service as chairman of the Rules Committee as well as having served as the distinguished majority leader of this body. He has held hearings on this issue. He reached out to Senator BYRD and Senator GRASSLEY.

We have been working on this issue for years and years. At this time of the session, the secret hold is all powerful. It is one of the most powerful weapons that a Member of Congress has. We do not seek to have it stripped from the Senate. We do not come together on a bipartisan basis to say, let us outlaw the holds. We come together—Chairman LOTT, Senator GRASSLEY, Senator BYRD, and myself—to say: There ought to be some sunshine.

Our proposal is for sunshine holds, for saying that the powers exercised by a Member of the Senate should be accompanied by some accountability. You ought to be straight with your constituents.

My good friend, the chairman of the committee, is here. I would like, without losing the remainder of our time, to yield to the distinguished chairman of the Rules Committee, who has been so supportive of the effort to end secret holds, so he could make his remarks, knowing he has a very busy schedule.

The PRESIDING OFFICER (Mr. CORNYN). Without objection, it is so ordered. The Senator from Mississippi.

Mr. LOTT. Mr. President, could I inquire about what time remains for Senator WYDEN?

The PRESIDING OFFICER. Twelve minutes twenty seconds are remaining.

Mr. LOTT. Thank you very much, Mr. President.

I believe this is an issue whose time has come in the Senate. It is an issue I am very familiar with because I have dealt with holds, both as a Senator as a leader. I have placed holds, and probably over the years some of them have been anonymous, not so much out of intent, just that is the way it was.

I remember talking to Senator WYDEN years ago, and Senator GRASSLEY, about what we could do to have a better understanding of what a hold is and how it works and what could we do to stop the anonymous holds. Senator DASCHLE and I even got together on a letter and tried to clarify how holds should be handled, and what they mean, and how Members should deal with them, by telling the committee chairman or the sponsor of legislation that they had a hold. But there was no enforcement mechanism, so it did not happen.

At this time of year, holds are particularly a problem for the leadership. Republican or Democrat, this is not a partisan issue because when they pop up right at the end of the session, it could be unrelated to the nominee, unrelated to the bill. They can be a part of a rolling hold. But with all the warts of the hold, it is something Senators prize, maybe even treasure. But I do not see how anybody can defend them being anonymous.

If there is a secret hold on a bill or a nominee, and it is just at this time of year, it is almost impossible for the leadership to deal with it. The leader, he tries to track down who has the hold, and sometimes the staff will not even tell you who has the hold because they have a problem.

I can remember tracking down Senators in their hideouts, finding Senators in airports, saying: Please, this is the Deputy Secretary of State or this is a Commissioner who needs to be confirmed.

It is not good for the institution. I think someday we should even look at the whole practice of holds. You have an institution where one Senator—one Senator alone—particularly at the end of a session, can defeat a nominee or a bill anonymously. There is something wrong with that. You are putting your constituency or the constituencies of others and 99 Senators at the mercy of one.

There is this feeling here in the institution that we cannot touch the traditions or the precedents or the rules of the Senate. They are sacrosanct. They are holy. How do you think they got there? Changes were made. Improvements were made. Or problems were created.

So that is why I do commend Senator WYDEN and Senator GRASSLEY for being doggedly persistent on this issue. I do not wish to be a part of a process or an effort that causes difficulty for the leaders. They have enough problems now. They are concerned with the Energy bill, the omnibus bill, the Medicare prescription drug bill, the FAA bill—you name it. So I do not want to contribute to their problems.

But I do think something needs to be done here. I think we need to address the overall issue of holds, but at the very minimum we should have some way to deal with secret holds.

When we sent the letter, as I suggested earlier, we required Members to notify the sponsor of the legislation, the committee of jurisdiction, and the leaders of their hold. It had a little effect for a little while. Senators sort of said: Oh, yeah. OK.

By the way, what is a hold? A hold is a notice by the Senator—to the staff, usually—that before a nominee or bill is brought up, they want to be notified so they can debate it or so they can reserve all rights to amendments. That is all it really is.

Now, if it is anonymous, that makes it even more damaging. But it is a problem for the leader because you try to get the work completed, and the threat of a filibuster or endless amendments basically kills it. So since there was no enforcement mechanism, it just did not accomplish what we wanted it to accomplish.

This resolution would place a greater responsibility on Senators to make their holds public. It creates a standing order that would stay in effect until the end of this Congress. This is something that Senator BYRD had suggested, that maybe was the solution that would do the job. We can see how it works. Let's make it a standing order, not change the rules. Let's make it apply to the rest of this Congress, which would be next year. If it works, great, we might want to build on it. If it does not, it is dead.

The order requires that the majority and the minority leaders can only recognize a hold that is provided in writing. I put a hold on a nominee today. I said: Please put a hold on this nominee. Letter will follow. So I put it in writing and it is not a secret thing.

Moreover, for the hold to be honored, the Senator objecting would have to publish his objection in the CONGRESSIONAL RECORD three days after the notice is provided to the leader. That is critical: notice. That is all really we are looking for here: Understand what a hold is; put it in writing; and make it well known.

A hold should be left to the wrestling ring, not to the Senate, and it certainly should not be in secret.

I hope the leadership, Senator FRIST and Senator DASCHLE, will work with Senator WYDEN and Senator GRASSLEY to find a solution that will allow us to do this. The light of day always has a purifying effect. This is getting to be very moldy. We need to deal with it. Again, I emphasize, I am for this because I think it would be good for the institution. I am for it because I think it is the right thing to do. I am not for it because I am trying to cause problems with the leaders. Heaven forbid, I don't want to do that. Actually, we are trying to help them deal with a problem. They are hesitant to do it because I know Senators are going to slip up next to them and say: Wait a minute, you may not want to change anything here. This is the way it has been done.

I challenge the Senators to stand up here and say they should not at least make it public. We can't have cowardice on something that is affecting people's lives and on legislation that affects our country.

I guess I am getting a little carried away. I agree with the Senator. I am going to continue to work to try to find a way to be helpful in getting this issue addressed because I think it is time we do it.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. WYDEN. Mr. President, how much time remains under my control?

The PRESIDING OFFICER. Twelve minutes 20 seconds remain.

Mr. WYDEN. I thank the Chair.

Mr. KYL. Will the Senator yield for a question?

Mr. WYDEN. I am happy to yield without losing my time.

Mr. KYL. Mr. President, I ask unanimous consent that following the Senator from Oregon, at the conclusion of his remarks, the order of speaking be Senator SUNUNU for 15 minutes, Senator LAUTENBERG for 15 minutes, Senator MURKOWSKI for 15 minutes, Senator CANTWELL for 30 minutes, and Senator KYL for 10 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Oregon.

Mr. WYDEN. Mr. President, before he leaves the floor, I thank the distinguished chairman of the Rules Committee for his eloquent statement. He has been so supportive of this effort. Essentially what he and I and Senator GRASSLEY have been talking about is the quaint notion that the public's business ought to be done in public. This is not a complicated idea.

As I have mentioned earlier, I am sure the vast majority of Americans have no idea what a secret hold is. It is not written down anywhere. This is something you wouldn't find 1 of 1,000 people having any idea about. But this is, in fact, one of the most powerful weapons, one of the most significant tools a Member of this body could possibly have. It is utilized without any accountability whatsoever.

The distinguished chairman of the Rules Committee pointed out in hearings, and we heard it echoed by Senator DODD, the bizarre kind of process of trying to track down Senators who are thousands of miles away from Capitol Hill and still claiming to have an objection when, in a lot of instances, they may not even know about it; their staff will have objected to it.

So what we have sought to do in this effort is to not limit the powers of any Member of the Senate but simply to say that power ought to be accompanied by responsibility. Yes, there should be rights. There ought to be rights of every Member of the Senate to stand up and be heard on matters important to their constituents and to this country. But there also ought to be responsibilities.

Chairman LOTT has addressed this issue very eloquently by saying one of our most important responsibilities is to let the public see what we are up to. Yes, sunlight is the best disinfectant, but it is especially important, as Chairman LOTT has noted, at the end of a session.

If someone exercises a hold in the beginning of a session, there is an opportunity, as the distinguished chairman of the committee has noted, for the leaders to come together with the chairs and work out an effort to resolve a matter in a process that is fair to all sides.

When you are down to the last few days of a session and you are talking about a measure that may involve billions of dollars, the well-being of millions of our citizens, someone can exercise the power to hold up the public's business without any accountability whatsoever. What happens is then the leaders and the chairs traipse all over here, practically going almost the equivalent of door to door, desk to desk on the Senate floor. It got to a point, when I was trying to deal with one particularly exasperating hold, where a Senator came up to me and apologized because he was told there was a hold about which I was concerned. He said: I knew nothing about it. It was put on by a staff person. I asked for its removal.

There are a variety of technical issues on which Chairman LOTT and Chairman GRASSLEY and Senator BYRD and I have worked. There is a difference between a consult and a hold. A consult, in effect, is just a request to be informed when a measure is going to be brought up. A hold is something different. A hold is when you want to shut down the effort to go forward and examine an important issue altogether. It is all powerful in the last few days of a session, as the distinguished chairman of the Rules Committee, Senator LOTT, has noted.

There is something very wrong with the process when, in effect, you have to traipse all over the Senate trying to figure out whether or not your measure is going to see the light of day.

We have had an objection to our bipartisan effort today, but I think I speak for all of the sponsors when I say we are going to be back at it. Chairman LOTT has initiated a very important process in the Rules Committee to examine some of the antiquated practices of the Senate. The holds is one that we see working great injury in the last days of a session. But under the leadership of Chairman LOTT, we are going to be looking at other practices in the Rules Committee. I think that is long overdue. I have great confidence that the chairs, Chairman LOTT, Chairman GRASSLEY, Senator BYRD, who knows more about the rules of the Senate than I could ever dream of knowing, are going to be able to work with us on a bipartisan basis to address this responsibly.

We have done that. We have asked only that this be done for the rest of this session. I personally do not believe Western civilization is going to come to an end because a Member of the Senate has to be clear about whether or not they are holding up the public's business. But to make it absolutely clear what would transpire, we have in effect a test period, as Chairman LOTT has described it, to examine the effect of our sunshine holds, a process that would end some of the stealth and secrecy that surround this issue.

I ask unanimous consent to add Senator DAYTON as a cosponsor of S. Res. 216.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. WYDEN. I see Senator LOTT and other colleagues have other business to attend to. I will wrap up only by quoting the foremost authority on Senate rules who served as majority leader of the 95th, 96th and 100th Congresses; that is, our friend and colleague, Senator ROBERT C. BYRD. In chapter 28, "Reflections of a Party Leader," volume 2 of his publication in the Senate, Senator BYRD wrote:

> To me, the Senate's rules were to be used when necessary to advance and to expedite the Senate's business.

Giving the sunshine hold a place in the Senate's rules, creating sunshine holds so as to ensure that there is new openness and new accountability in the way the Senate does its business, seems to me to be an ideal way for the Senate to honor those eloquent words of Senator BYRD.

We have not been successful today, despite the best effort of Chairman LOTT, Senator GRASSLEY, and others. But we will be back. This practice is continuing to increase. Even when I came to the Senate, I found it used frequently but not to the extent it is being used today. It is time to do the public's business in public. We will stay at this effort to accomplish just that.

I yield the floor.

Mr. GRASSLEY. Mr. President, I rise in support of the resolution to end secret holds in the Senate. Senator WYDEN and I have worked long and hard on this issue and it is time for the Senate to act decisively to reject the practice of placing anonymous holds.

A hold, which allows a single Senator to prevent a bill or nomination from coming to the floor, is a very powerful tool. Holds are a function of the rules and traditions of the Senate and they can be used for legitimate purposes. However, I believe in the principle of open government. Lack of transparency in the public policy process leads to cynicism and distrust of public officials. I would maintain that the use of secret holds damages public confidence in the institution of the Senate.

Our resolution would establish a standing order for the remainder of this Congress that holds must be disclosed publicly. For my colleagues who might be apprehensive of this change in doing business, I would point out that this measure would only be in effect for the current Congress and would not formally amend the Senate rules. Nevertheless, a standing order has essentially the same force and effect in practice as a Senate rule. I have no doubt that, once instituted, this reform will be found to be sound and no reason will be found why it shouldn't be renewed in subsequent Congresses.

For several years now, I have made it my practice to publicly disclose any hold I place in the CONGRESSIONAL RECORD, along with a short explanation. It's quick, easy and painless, I assure my colleagues. Our proposed standing order would provide for a simple form to fill out, like adding a cosponsor to a bill. The hold will then be published in the CONGRESSIONAL RECORD and the Senate calendar. It is as simple as that.

I am very pleased to have the support of Chairman LOTT and Senator BYRD on this initiative to require public disclosure of holds. Earlier this year, Chairman LOTT held a hearing in the Rules Committee on the Grassley-Wyden resolution to require disclosure of holds. Since that time, my staff has worked together with staff members for Senators WYDEN, LOTT, and BYRD to come up with what I think is a very well thought out proposal to require public disclosure of holds on legislation or nominations in the Senate. I think it says a lot that this proposal was written with the help and support of Senator LOTT and Senator BYRD. As the chairman of the Rules Committee and a former majority leader, Senator LOTT brings valuable perspective and experience. It is also a great honor to be able to work on this issue with Senator BYRD, who is also a former majority leader and an expert on Senate rules and procedure.

I am disappointed that we cannot move forward with this resolution now, but I would urge my colleagues to join the growing coalition of Senators who are working to shed some sunlight on some of the most shadowy parts of this body so that we can ensure open and honest debate on the issues before the American people. I believe that the more we talk about secret holds, the more the consensus grows that this is an issue that must ultimately be addressed by the full Senate. You can be assured that we will keep pushing forward until that happens.

The PRESIDING OFFICER. The Senator from New Hampshire is recognized for 15 minutes.

ENERGY POLICY ACT OF 2003—CONFERENCE REPORT—Continued

Mr. SUNUNU. Mr. President, I rise to add my voice to the very spirited debate we have had about the Energy bill. A number of Members have come to the floor to talk about specific provisions—the concern for the liability waiver for MTBE, in particular.

I want to step back and talk about the bigger picture—about the financial health of our country and the impact that this Energy bill, given its enormous size, will have on the long-term health of our budget, as well as our economy.

During the budget debates, we hear a great deal about fiscal responsibility. People love to talk about fiscal responsibility in the abstract. When you are looking out 10 years and are talking about surpluses or deficits, or more broadly about revenues or spending, it is all about fiscal responsibility. But they don't like to talk about it as much when we have a specific piece of legislation on the Senate floor, as we have now, that will draw from the Federal Treasury and start spending that money in a way that I don't think is very well thought out. I certainly don't think it will have a very positive effect on our economy.

In particular, if we look at the Energy bill and its scope and size, it not only breaks the budget that was agreed to just 6 months ago, it not only violates the budget once or twice or three times, it is in violation of the Budget Act in four different ways. In fact, in one area in particular, on spending, it violates the Budget Act three different times. A point of order, as has been indicated by the budget chairman himself, lies against this bill. It violates the budget caps, busts the budget by over $800 million next year alone, by more than $3.4 billion over the next 5 years, and by $4.3 billion over a 10-year period. It breaks the budget cap, breaks the budget agreement, and violates the Budget Act. That is a lot of money—800 million dollars, $3.4 billion, and $4.3 billion over the next 10 years.

I think at a certain point we have to draw the line. We have to say energy is important to the country, markets are important to the country, competitiveness is important to the country, but we can achieve these things without violating the budget agreement that was just put into place several months ago.

The bill includes new mandatory spending, which is effectively on automatic pilot, where once the bill is signed into law, the spending will take place automatically, without appropriations and without any new legislation passed. So it is $3.7 billion in mandatory spending over the next 5 years,

$5.4 billion in new mandatory spending over the next 10 years. In addition to that, we have all the authorized spending in the bill—over $70 billion in spending is authorized over the next 10 years.

Looking at the authorization language, the different programs—dozens and dozens of different programs—total over $70 billion. These programs are effectively picking and choosing among different ideas and innovations and areas of the energy industry, picking winners and losers among the different competing forces. That is where we need to be very careful about the impact a bill like this would have. Why should any legislator, or bureaucrat, for that matter, be trying to pick the winning or the losing energy technology or innovation 5 or 10 years out into the future? We are not experts in this area. We are not scientists. We don't dedicate our lives to understanding the nuances of new energy technology. We certainly should not be writing legislation that picks those winners and losers in the marketplace.

If you read through—just to touch on a few to get a sense of what I am talking about—$250 million is in the bill for photovoltaic energy commercialization, the use of photovoltaic energy in public buildings. Photovoltaics is an interesting technology, perhaps a promising one. But to spend $250 million to try to commercialize this in public buildings suggests that we know, as Senators, that this is the right energy source to use in public buildings for the foreseeable future.

Why not let the market compete? Why not let investors step forward to build or renovate or improve public buildings, to use energy more efficiently in public buildings, pick the best contractor, the best product, the product which delivers the best value for the public? Why do we have to spend $250 million biasing the marketplace? There is $125 million for a coal technology loan. It turns out this particular one will actually go to convert a clean coal technology plant into a traditional coal-fired generation plant.

Elsewhere in the bill, we have a couple of billion dollars to subsidize the clean coal technology industry. So this is a case where maybe we are just not sure what the winner is going to be, and we are trying to hedge our bets. There is nearly $100 million in the bill for the reduction of enginizing heavy-duty vehicles; reduce the amount of heavy duty vehicles' idle—I suppose in traffic, or sitting at the truck stop, or wherever else it might be. Energy efficiency in heavy-duty trucks is a great idea. Somebody tells me that those who build, manufacture, and own and operate heavy-duty trucks have a financial incentive not to waste the diesel fuel they use to drive the trucks all over the country. I don't think they need a subsidy of $100 million for us to do the job that they ought to be doing to make themselves more competitive and ultimately earn more money in the marketplace.

Engine testing program, $25 million. Why should we be subsidizing the testing of commercial engines that companies or industries use to operate and earn a good living, as they should?

Here is another very interesting one. The next generation of lighting initiative; $250 million for the next generation of lighting. We have next generation Internet. I am still not sure why we put a billion dollars or $2 billion into that. The Internet is probably the one area of our economy that has attracted more capital faster than any other idea in our history. Why the Federal Government should be subsidizing that, I don't know. Why we should be subsidizing new lighting technologies, I certainly don't know. There are wonderful companies that make great lighting products, such as halogen lights, neon lights. I could name a few companies, but I am sure I will leave some out.

When we go to the Home Depot to buy lighting products or to the local hardware store or COSTCO and buy lighting products, we know who the competitors are. Why does the Federal Government need to spend $250 million to help develop better or newer lighting?

Somebody might say we are working on more efficient lighting. If you build a better light bulb that is less expensive to use and/or less expensive to sell, I bet customers will recognize that value. It is a mature industry, a well-understood industry. You don't need a Ph.D. to understand why you would use a light bulb, how you use one, how much it costs, and what the value is. That is the classic example of an industry that certainly doesn't need a taxpayer subsidy.

Let's recognize that all of this spending—$250 million for lighting, $125 million for a coal loan, $2 billion for MTBE producers—is not money just being printed out in a back room somewhere. These are dollars that we are collecting from working families, men and women who work very hard. We collect their Federal taxes and we have an obligation to be fiscally responsible and to do a thoughtful job in the way this money is spent in Washington.

We have new mandatory spending, we have authorized spending, and then we get to the tax subsidies, some $25 billion. The President recommended only $8 billion. The Senate recommended $18 billion. It comes out of conference with the House and Senate at nearly $25 billion in tax subsidies, loan guarantees for diesel fuel plants, loan guarantees for three new coal plants. A loan guarantee to build any of these new plants effectively puts the taxpayer on the hook for all, or a very significant part, of that facility.

Again, I think the coal industry is a terrific industry, and also the oil and gas industry, electricity generation, wind power, hydropower, solar power. What we ought to be working toward, however, is a level playing field where these competing ideas and competing technologies can provide electricity, can provide power, can provide energy so consumers and investors can make good decisions about where to put their money and which one of these competing technologies to buy.

There are certainly some good provisions in this legislation. I think the electricity title takes important steps. I support repeal of the Public Utility Holding Company Act. We have better reliability standards in this legislation for our electric grid. We have regulatory reform which I think is important for building out the electric infrastructure and avoiding future crises, shortages, or blackouts. But we can do all of these things without busting the budget. We can do all of these things without violating the Budget Act. We can do all of these things without coming back with a bill that has three times the tax subsidies the President proposed.

Like so many Energy bills I have seen in my short time working in Congress, this bill is full of some very grandiose pipedreams. One of my favorites is the hydrogen car—$2 billion for the hydrogen car. We are just coming off a $2 billion bender known as the Partnership for the Next Generation Vehicle. Mr. President, $2 billion of taxpayers' money was spent to try to develop an electric car that was going to be a hybrid electric car, a hybrid combustion engine and, at the end of the day, it was a failure—$2 billion later. It had no material impact on the delivery of more energy efficient vehicles into the marketplace.

Someone somewhere suddenly decided: It turns out the car of the future is not an electric car, the car of the future is really a hydrogen car. We must have gotten that whole electric car thing wrong. Forget about that Partnership for the Next Generation Vehicle; it is really the hydrogen car, and we only need $2 billion to do it.

I don't know if hydrogen is going to propel vehicles in the future. It would be terrific if it did. I think the right way to get the answer is to let the marketplace decide, to let competing technologies and ideas in the marketplace decide; put those ideas out, attract capital, attract investment, do the research and development, and, believe me, if somebody develops a cost-competitive electric car, let alone a hydrogen car, they are going to make a lot of money because there is a demand for that in the marketplace.

People are willing to pay for a cheaper vehicle. People are willing to support initiatives that not only fulfill the needs in their daily lives traveling around but also help keep our environment a little cleaner by reducing emissions.

We have coal gasification, at $1 billion or so—nearly $1 billion for a coal gasification initiative. Twenty years ago, it was all about synthetic oil. That was clearly going to be the energy of the future—the fossil fuel energy at least. I guess we must have gotten that one wrong because we spent $4 billion, $5 billion on that, and it turns out it is really not cost competitive. So we are going to go with coal gasification. Maybe that is what we meant to say or we learned a little bit since then.

Now we can see the future much more clearly, and we are going to start out with a little bit less than $1 billion, but you can be assured that over time it is going to be a lot more than that.

These are pipedreams. These are important visions for scientists or technologists to have, and we want them to put some funding or risk some capital for these ideas. The question isn't whether they are interesting ideas or whether they are even worthy of investment but whether they are worthy of taking Federal money, taxpayer money, and putting that money at risk in a marketplace that should be able to stand on its own, compete on a level playing field, and continue to deliver the innovation and technology of which I think most Americans would and should be very proud.

We can do a lot better than this bill. We can do better than a bill that busts the budget. We can do better than a bill that has a $25 billion grab bag of tax subsidies that distort the marketplace of ideas and the marketplace of capital. We can do better in terms of legislation that should be promoting a very competitive environment and, therefore, a stronger, more robust economy, but instead, in distorting the marketplace, I think we will do great damage to our economy.

Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. The Senator's time has expired.

Mr. SUNUNU. I ask unanimous consent for 1 minute.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SUNUNU. Mr. President, we can do better than this legislation. Frankly, we need to do better than this legislation because if we don't, I am afraid if we adopt this conference report, this will become the standard method of operation, the standard way we approach science, technology, and energy: That we get together in a room in a conference or in a committee, and we sit down as Senators and we try to pick the winners and the losers; that we distribute subsidies in the way of spending or we distribute—in some ways this is even worse—subsidies in the way of added complexity to the Tax Code. Instead of ending up with an economy that is robust, an economy that is the envy of the world, an economy that encourages new ideas and innovation, we end up with some sort of variant of what has already been defeated in the Eastern European countries and in the former Soviet Union—a manipulated government-subsidized enterprise or government-run economy where bureaucrats or elected officials try to pull the strings, but to no avail, degrading the economy, making it less efficient, making it less robust, and not discovering those very entrepreneurs we know are the heart and soul of the prosperity we enjoy.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. LAUTENBERG. Mr. President, I ask unanimous consent that following the statement of Senator KYL, Senator GRAHAM of Florida be recognized for 20 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LAUTENBERG. Mr. President, I rise to join many of my colleagues in strongly opposing this Energy bill. The opposition is not reserved to only Democrats; the opposition is for those people who think about the implications of this bill and the serious concerns it raises.

For one thing, it is terribly lopsided. It is out of balance. It is heavily weighted toward the industry because it was written by just a few select individuals with almost no conference input by Democrats.

The bill is an embarrassing example of the public's worst fears about Washington power politics, and those power sources are the oil and gas lobbyists downtown. Though it is called the Energy Policy Act of 2003, this bill promotes the outdated policies of a generation ago. It should be called actually the Energy Policy Act of 1903. The policy here is simple: Drill for oil, drill for natural gas, dig for coal.

While the country needs oil, natural gas, and coal, we also need leaders with a vision to promote clean sources of energy that won't harm the health of our children, our grandchildren, and future generations. It is the 21st century, and we have the technology to do better.

According to the Congressional Research Service, between 1948 and 1998 the Federal Government subsidized the energy industry by well over $100 billion. Unfortunately, less than $1 in $10 was used to promote renewable energy, that which you can find relatively easily and without the pollution that our present energy sources convey to the public.

Now, in this single bill, we are being asked to spend another $50 billion to $100 billion on tax credits and loan guarantees to the oil, gas, and nuclear industries. How will all of those taxpayer dollars be spent? They will be spent on a long list of brazen giveaways to polluting uranium companies, Archer Daniels Midland, to MTBE producers, and for a smattering of goodies and pet projects.

Taking care of special interests has become a hallmark of this Congress. Peter Jennings highlighted it in a perfect example on the evening news the other night. He reported that taxpayers have so far contributed $1.3 billion to subsidize wealthy individuals who buy the biggest gas guzzlers sold in America. As he pointed out, one couple received $17,000 in tax breaks on their new SUV and boast: "We have decided to take two extra vacations this year with the money we saved." But for the energy they used, they pose a whole different kind of issue.

Why is the answer around here always to hand over cash to rich people and successful companies? Can we really justify turning over the hard-earned tax dollars of Americans, who do not earn enough to benefit much from the Bush tax cuts, to companies flush with cash?

Here is an issue that was announced August 1, 2003: "Chevron Quadruples Profits." It goes on to say:

> Oil giant Chevron Texaco increased quarterly profits four times to $1.6 billion.

Their revenues soared to $29 billion in the quarter. Do these companies really sound as if they need Government subsidies to do their job? Not to me.

We have the perfect opportunity to guide the country toward clean, renewable energy. Yet most of the bill's tax credits for efficiency and renewables last only 2 or 3 years. Any business person knows this is not a sufficient time period to encourage significant investments and technology development.

We Americans have always set ourselves apart by our ingenuity and creativity. Today, amid an avalanche of promising scientific discoveries in the field of energy, the majority can see no further than the lobbyists' interests which this bill follows to the letter.

Recently, I read that in Amsterdam, a major European chip manufacturer has discovered a new way to produce solar cells that will generate electricity 20 times cheaper than today's solar panels. ST-Microelectronics, Europe's largest semiconductor maker, says that by the end of next year it expects to have the first stable prototypes ready. If a decade ago we had been serious about promoting renewable energy, that discovery could have been made by an American company, but such breakthroughs are unlikely with the minimal incentives offered in this bill for development of better ways to be less dependent on the energy sources we have now.

It is also disheartening that this bill grants exemption after exemption to the Clean Water Act, the Clean Air Act, and other protective laws. I do not really understand it. Is boosting the profits of giant companies really more important to the bill's authors than the health of the American people?

Let us talk about just one of the riders slipped in by House Republicans without a vote from either the House or the Senate. This was snuck in during conference. This rider amends the Clean Air Act, gives cities an easy out if they find meeting the new ozone standard is difficult due to transboundary pollution. It requires EPA to grant them an automatic extension. It does not say for how long. It fails to define the conditions that would precipitate such an extension.

The result of this rider, of delaying implementation of the ozone standard for just 1 year, is severe. That rider is estimated to cause 390,000 more asthma attacks, 44,000 of those in my State, 5,000 more hospitalizations, and 570,000 more missed schooldays. That is the result of just one of the many exceptions carved out of our environmental laws by this bill.

Among my nine grandchildren, I have two who are asthmatic. The rate of asthma among juveniles is growing substantially. I lost my sister to an asthma attack. It was obviously a devastating event in our family's history. To those who see kids with asthma get fatigued after participating in sports or otherwise, it is the kind of anguish that drives parents to all kinds of anxieties.

The bill fails the American people on every level. It fails to boost our energy security, it fails to safeguard electricity consumers, and it fails to protect the environment.

It is astounding to look at what this bill does not do. While automobiles account for a whopping 40 percent of our Nation's growing oil addiction, the bill does not address fuel economy at all. The bill comes at the very time when fuel efficiency has arguably never been more important. America's fuel economy is at a 22-year low. Today, the United States spends $200,000 every minute on foreign oil. But the economic costs of weak fuel efficiency requirements go far beyond just the cost of oil. If we include the major oil price shocks of the last 30 years and the resulting economic recessions, the cost goes up at least $7 trillion.

Given these hard facts, one would naturally expect a national energy policy to aggressively pursue decreases in oil. It does not. Just the opposite. It generously promotes increases in oil use while tossing what I would call petty cash toward energy conservation, energy efficiency, and renewable energy.

We never hear a word—and this has happened in Democratic as well as Republican administrations—about sacrifice, conserve, think about what happens when more fuel is ground into toxic emissions. It is terrible that we cannot understand there is a mission attached to saving oil and gasoline use.

It is amazing what this bill fails to do on electric policy. This bill contains only one of three provisions the country must enact to prevent another massive blackout such as the Northeast experienced last August. We are being asked to support a dirty Energy bill in order to get one of the fundamental regulatory reforms to our electric grid system. I say the bad outweighs the good, and I cannot support it.

Around here, it is often said that the perfect is the enemy of the good, but I say the bad far outweighs the good as an alternative.

The administration's energy and environmental policies reflected in this bill are so utterly transparent in their goal of more corporate welfare that the consultant, Frank Luntz, warned the party:

> Watch your language—

And here he is, the fat cat—

> A caricature has taken hold in the public imagination: Republicans seemingly in the pockets of corporate fat cats who rub their hands together and chuckle maniacally as they plot to pollute corporate America for fun and profit.

Unfortunately for many, that is no caricature. From where I am standing, that picture is pretty accurate. If one wants proof, look at this bill. It is filled with little but big breaks for those who need them the least. Yet rather than change their policies, Luntz offers them protecting language. He wrote a memo to Republicans instructing them on how to use the language tested on focus groups to hide their deplorable environmental record.

This Energy bill is a great disappointment. It might have been acceptable at the beginning of the 20th century, but it is indefensible at the beginning of the 21st century.

Mr. President, you know true patriotism is more than waving flags. It means putting the interests of the American people before the powerful special interests, the very thing this Energy bill fails to do. I urge my colleagues to oppose this bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Alaska.

Ms. MURKOWSKI. Mr. President, I rise today to speak also to the Energy conference report. Unlike some of the previous speakers I listened to in the past 2 hours that I have been in the Chamber, I stand in support of the agreement that was reached in conference. It has been pointed out that this is not a perfect bill. I would be the first to chime in and say I agree with that. But in an effort to achieve the perfect, I don't think we should overlook the good in the conference report.

Because of the hard work of Chairman DOMENICI and his staff, working with the others on the conference agreement, and spending many, many hours to reach the consensus we have before us, I think we can truly say this is a good bill and a bill that should be signed into law. There has been a great deal of talk, not just during this legislative session but in years previous: We need to have an energy policy for this country. We need to have the framework for an energy policy.

It seems to me that so often what we do is react to situations, whether it is the blackout we experienced in August, or when the price of gasoline increases to a level where it gets our attention. We only respond when there is something that gets our attention and focuses the Nation on energy.

Quite honestly, most Americans don't pay attention to energy. They don't pay attention to how they get their lights to turn on, or how we keep the temperature cool or warm. I have said many times as I talk about energy, most Americans ascribe to the immaculate conception theory of energy: It just happens. We know that is not the case. It doesn't just happen. It takes innovation. It takes incentives. It takes capital. It takes the desire to do something.

But without the energy we have in this country, we would not have the freedoms or the liberties we take for granted—the ability to do what we want, to go where we want to go. We need to recognize that energy is something that has built our country and made us strong. We need to continue with that sound policy. I believe the conference report we have in front of us is a good first step toward that sound policy.

As I say that in very general terms, I have to start off that this is not my perfect bill. At the top of my list for an energy policy for this country would be the opening of ANWR. We don't see that coming out of the conference report. Congress had the opportunity to include language that would have generated over 1 million jobs for American workers by allowing for oil and gas exploration on just 2,000 acres of Alaska's North Slope.

I know we tried to keep ANWR in the conference report. The chairman was working hard. But we were threatened with that constant threat of a filibuster. You can't put ANWR in the Energy bill or it will be filibustered. It seems a little ironic to be standing here tonight. ANWR is not in the Energy bill yet we are still slowed in the task of getting to a vote on the Energy bill.

The House adopted ANWR and wanted it in the conference report but there were continued objections, primarily from the environmental groups, that have kept us and will keep us this year from moving forward with jobs that truly could have been promised with the opening of ANWR.

I have made the invitation to the Senators here on the floor and I know my counterpart, Senator STEVENS, has made the effort to invite all Senators to visit ANWR and see what this dispute over opening the Coastal Plain of ANWR to oil and gas exploration is all about. We want you to see Prudhoe Bay. We want you to see the developments in Alpine and the technology we have utilized to provide for the exploration and development of oil up on the North Slope. We want you to see the minimal impact to the environment, and how technology has helped us to advance.

I get a few takers, primarily in the summertime. But I encourage you to come up in the wintertime. This is when we do the production up there. I know that is kind of a chilly invitation to some, but I think it would help to understand what we are dealing with in Alaska, how vast our spaces are, and just how small of an area the Coastal Plain of ANWR, the 1002 area, really is, in comparison.

I agree with those of my colleagues who would argue we cannot drill our way to independence from foreign oil. They are absolutely right. We have to have the incentives for renewable energy sources. We have to have greater technological efficiency. We have to decrease our energy consumption. Those efforts need to be part of this comprehensive energy package. But we must also have increased domestic production. I suggest to you again, if you are going to argue that we need to have energy security, if we want to reduce our reliance on foreign oil, the first place we should be looking is ANWR.

But I am not going to go into any further discussion about ANWR at this time. You have certainly heard the debate before. It will be an issue that we will revisit. We will continue to push for opening ANWR.

I want to take one more second to remind folks that we had an opportunity here for over one million jobs across the Nation, at a time when millions are unemployed in our country. But some Members have declined to accept that offer. Instead, we are talking about extending unemployment benefits.

I suggest to you that the unemployed people in my State, if given a choice, would certainly prefer to have a job than more unemployment benefits.

But when we speak about jobs, I should not be talking exclusively in the negative here because all is not lost. We have an incredible opportunity in Alaska with our natural gas. Several very important provisions are included in this bill that will promote the construction of a natural gas pipeline to transport the vast quantities of natural gas that we have up on our North Slope, to bring it to market in the lower 48, be it down the Alaska Canadian Highway or through LNG tankers to the west coast. We have 35 trillion cubic feet of gas up there now.

You have heard Members in the Chamber talking about the fact that right now that gas is stranded up there. Right now that gas is being reinjected instead of being shipped down here to the lower 48, where we need it. We have provisions in the Energy bill to get that gas where it is needed: We have guaranteed loans, expedited judicial and environmental reviews, and a program to train pipeline workers—again, talking about the jobs aspect. The pipeline, if constructed, could provide over one million jobs, direct and indirect jobs, through the construction of this pipeline alone.

But the key here is, if this pipeline is constructed, there are no guarantees. We have done a great deal in this legislation to encourage the construction of the line.

There is one provision that generated a great deal of attention and focus but is not included. There would have been a production credit to ensure the economic viability and provide a safety net in the event the price of gas drops to very low levels. That is not included in the legislation.

This is a huge project. People need to understand how huge. This is a $20 billion project, 3,500 miles in length, 5 million tons of steel, delivering billions of cubic feet of gas per day to a nation that is starved right now for natural gas. And the situation is just getting worse.

It would be the biggest construction project of its kind in the country. It is something that we can only imagine. When we imagine huge projects like this, every now and again they take a little bit of a boost to get going. What we have done in the Energy bill is to provide that boost, to provide the incentives to encourage the construction.

Again, what we are providing is grants to authorize training of the crews and workers who will construct and operate the pipeline.

We limit the period of time to bring a claim, if a claim should arrive, and we expedite the claim so the project doesn't get bogged down in the courts.

We authorize the construction of the pipeline. We have loan guarantees of up to 80 percent of the cost of the project. It would be an $18 billion Federal loan guarantee—probably the largest loan guarantee we have ever seen given to a project here in the United States.

We have also included a 15-percent enhanced oil recovery credit for the $2.6 billion gas handling plant that will be required on the North Slope.

We have provided for accelerated depreciation on the project, again helping to provide that incentive which we need to encourage construction of this line.

This only happens, the jobs only come, if the construction happens, if we can get moving with the line, if we convince the producers that it is timely, it is necessary, and that the demand is there. I think we have established that the demand is clearly there.

I am going to be working with the State of Alaska and the industry to examine the options and to pursue those possibilities as we push this project to completion. It is imperative that we in Congress, through the passage of this bill, make our intent known that this is a priority for the country. It is a priority for Alaska. But it must be a priority for this Nation as well.

I have been talking about the Alaska component in the bill. We are pleased with what I have spoken to so far. But we should be reminded about the other good things in the Energy bill that apply throughout the country.

Authorized annual funding for the Low-Income Home Energy Assistance Program, LIHEAP, is increased from $2 billion to $3.4 billion.

There is $550 million in grants for biomass production, and it provides money for communities under 50,000 in population to improve the commercial value of their biomass.

A couple of weeks ago, I stood on the floor during the debate on the Healthy Forests legislation and I showed a picture of Alaska Chugach Forest on the Kenai Peninsula where as far as the eye can see the standing trees are dead, killed by the spruce bark beetle. With the help of grants that we are seeing in the Energy bill, those trees can be converted into a biomass fuel providing a new source of energy for low-income communities.

There is money for clean coal power energy for those projects that demonstrate the advanced technology that achieves significant emission reductions.

I need to point out that there has been discussion on this floor that through the Energy bill perhaps we are not putting enough focus on clean air, clean water, and concern for the environment. We need to understand that our environment is only going to be helped. We are only going to get cleaner air and cleaner water when we have the advanced technology instead of the old stuff we had in the past. Those technologies might take some upfront money.

I know there are programs that have already been spoken about—such as the clean schoolbuses—$100 million to retrofit existing diesel buses with new pollution control technology, $200 million in grants to replace older schoolbuses with clean alternative fuels and ultra-low sulfur fuel buses.

Also, as has been referenced, there is funding for hydropowered automobiles that the President has made such a big push for.

I might remind the body, though, that in order for us to make headway on this particular initiative, it will increase the demand for our natural gas. Again, the imperative is to move forward with a natural gas pipeline.

The bill contains language to make permanent the United States' commitment to the energy security of Israel ensuring, if Israel is unable to independently secure its own supply of oil, that the United States will procure the necessary oil to meet Israel's needs.

There is much in this Energy bill that provides the incentives and the technology to move forward. We have language that will help in the rural areas of the nation—certainly those in my State. Not only do we not have affordable energy in parts of rural Alaska, we don't have any energy to speak of. We have a long way to go, but it is only with the assistance we are seeing through the Energy bill that we will get there.

While I may suggest that Congress has missed an opportunity on certain topics, such as ANWR, this bill does offer new programs to improve our energy efficiency, increase the development and use of renewable energy resources, and promote domestic production.

It doesn't go as far as it could in reducing America's dependence on unstable foreign sources of oil, but it is the beginning of a comprehensive energy policy for this country. It is a policy that has been lacking for many, many years, and one that I feel is badly needed.

I would like to take this opportunity to thank Chairman DOMENICI and his counterpart in the House, Chairman TAUZIN. I appreciate their hard work and their leadership. Again, this is not a perfect bill, but it is a good bill. I urge my colleagues to support its adoption so we can move forward with a sound energy policy for the country.

Thank you, Mr. President. I yield the floor.

The PRESIDING OFFICER (Mr. CHAMBLISS). The Senator from Washington.

Ms. CANTWELL. Mr. President, I commend the Senator from Alaska for bringing up an important issue of jobs in this bill, because clearly one of the key components that we in the Northwest are interested in is that this bill might move us forward on an energy policy that would create jobs and diversify Northwest power.

When we ran into a drought in 2000 and ended up having to go out on the spot market and buy electricity, we certainly were gouged by some manipulated contracts. But one of the things that could provide us some long-term relief in the near term from future droughts and overreliance on the hydrosystem would be a natural gas pipeline from Alaska down to the continental United States which would help us in diversifying and protecting against such incidents in the future.

But let us be clear. This bill doesn't get the job done. The Alaska pipeline that we have all talked about as it relates to natural gas doesn't have the framework within this legislation to move forward.

I commend the Senator from Alaska for focusing on job issues. I agree with her that an energy policy must accomplish two things. It must set a policy for us to get off our dependence on foreign oil and again for America to have an advantage in job creation as we move on a 21st century energy policy. But this bill does nothing to help us diversify in the short term on natural gas that is available to us in Canada and Alaska. It does very little to help us in the future with the hydrogen fuel economy which, it is estimated, could create 750,000 jobs over the next 10 years. That is not just the kind of activity that would make us a leader in the United States; it is the kind of activity that would make us a global leader in the energy system of the future.

I will take a few minutes to talk about where we are with the Energy bill and where we have been because yesterday I spent quite a bit of time talking about the overall aspects of the bill. Something of great concern to me, being a member of the Energy and Natural Resources Committee, I wanted to make sure, given the fact this bill has been drafted mostly in secret, starting with the Vice President's energy task force. That left many Americans out of the process of understanding what the administration's energy proposal would be, which led to a conference report that was done in secret by the Republican Party. Yesterday I needed to spend my time talking about the various aspects of this bill in a comprehensive way that would give my colleagues a perspective of someone from the Energy and Natural Resources Committee who has dealt with some of the challenges and problems.

Clearly, this 2003 Energy bill is becoming known as the bill about Hooters, polluters, and about the looting of America that has happened, particularly on the west coast, particularly in my State.

Americans are trying to understand this. I have had phone calls to my office: I don't understand. I understand conservation. I understand renewable energy, I understand incentivizing. What does Hooters have to do with an energy policy?

In this legislation we have included green bond projects; that is, we would help in the public financing of proposals to various developers in Colorado, New York, Iowa, and Louisiana, with $2 billion in private bonds to build energy-efficient developments. I am for energy efficiency, but last I heard Hooters had its own airline, was doing quite well and probably could borrow any money it needed to invest in energy efficiency.

I have small businesses all over the State of Washington that got smacked with the energy crisis. They had to conserve; they had to shut down. Employees were coming up with all sorts of creativity: nobody got to borrow money from the Federal Government that would allow them to have a line item in a bill that said specifically, this project is for you.

Broad tax credits for conservation programs in which all companies can apply for some of the incentives to get America to conserve—because conservation is a great program, particularly in times of less supply—is a very good idea. But that is not what Hooters got. This particular project, and the three others mentioned in this legislation, specifically include a line item for particular projects. What qualifies them? I find it very hard to explain to my constituents. I know there is a daiquiri bar in and an energy efficient bowling alley and a movie theater and everything else as part of this Hooters restaurant development. But I don't understand why they should get some sort of line item for bonds, for money that needs to be borrowed for fuel efficiency when everyone else in the country has had to do their own jobs, to turn out the lights and conserve. What is so special about this particular restaurant?

As far as the polluters, obviously, my colleagues have done a great job talking about the MTBE provision and the fact that people who have been involved with that product are seeking relief from being liable for cleanup. I have heard from elected officials all over the State of Washington that they do not want to be the deep pocket. Cities have asked: Why is it that you are going to let these particular polluters in this bill off the hook and stick us with the cleanup cost of this particular product? It is very unfair that that is the approach we would take. My colleague, the Senator from Illinois, and everyone else has been very articulate on that issue.

I am also amazed, as we look at the other aspects of the bill, particularly relating to clean water and the Clean Water Act. Why would my colleagues would want to say, under the Clean Water Act, this is legislation that would somehow say to any coal-producing, oil, or gas company producer in the future under this bill, the 2003 Energy bill, that you do not have to comply with clean water runoff standards. Why should they be exempt? I cannot understand that. You build a shopping center. Guess what. You have to comply with runoff standards from the Clean Water Act. If you build a hotel, you have to comply with getting a runoff permit and saying how you are going to deal with runoff. Why? Because there are two sources of pollution. We have the source point pollution and then we have pollution that occurs from the runoff. We want to control that.

We are demanding every other business in America has to get a permit when they go through development to deal with runoff, to make sure we have clean water. But somehow we are going to allow certain types of industries in the Energy bill, particularly oil, gas, and coal, to be exempt? What kind of policy is that?

The most famous person on this chart is Ken Lay. Why is he the most famous person on this chart to people in Washington State? My constituents want to know why, when they have been gouged with higher energy prices, why this man is not in jail. I don't have a very good answer.

This bill is about pollution. It is about special deals. It is about allowing a part of our country to be looted, to allow special interests to stick their hands in the pockets of ratepayers. That is what I will focus on tonight. This bill takes a drastic step backward. While complex to understand, it is critically important for my colleagues to know they cannot take the drastic steps in this measure that will overturn 70 years of case law, protecting consumers with just and reasonable rates.

I talked a little bit about the Clean Water Act. I don't know that I have to go over that again, but I ask my colleagues, why make every other business in America comply with the Clean Water Act? There are probably lots of other industries in the country; yet they have to comply—if they want to develop—with runoff standards. Yet we will let oil, gas, and coal companies off the hook. They do not have to get a permit anymore.

What is the price gouging that has gone on in this legislation? It is significant, and I will talk about that price gouging because it is very important to understand.

I see my colleague from Florida, and I agreed to yield him some time. Would the Senator like that time now?

Mr. NELSON of Florida. If the Senator from the State of Washington would yield.

Ms. CANTWELL. How much time does the Senator from Florida need?

Mr. NELSON of Florida. Five minutes.

Ms. CANTWELL. I yield, from my half hour, 5 minutes to the Senator from Florida.

The PRESIDING OFFICER. The Senator from Florida is recognized for 5 minutes.

Mr. NELSON of Florida. I rise in the Senate to tell the Senate that I have concluded after studying this matter considerably that I will vote against this Energy bill, and I will vote against the motion for cloture because I have concluded that it is clearly against the interests of the State of Florida.

I am going to try to point out two particular areas of the bill that violate what everyone should consider in supporting the interests of the people of the State of Florida. This is a map of Florida with stars on it in dark colors. Each one of the dark-colored stars represents a hazardous material spill and an MTBE spill. There are 30,000 hazardous material spills in our State. There are over 20,000 MTBE spills.

In the dark of night, in a conference committee that was closely controlled, a provision was inserted in this conference report that has come back to us for consideration, that all liability of the oil companies would be removed forever on any of the contamination that came as a result of those MTBE spills.

That simply is not right. It is not right to wipe out the ability of 18 counties and cities in Florida that are presently contemplating suit to sue for those oil spills with MTBE, nor is it right that you would wipe out Escambia County's present suit—Escambia County, up here on the map, the cradle of naval aviation, Pensacola—that you would wipe out their present suit against the oil companies because of the damage that has been done to the water supply from the MTBE leeching.

There is a lot in this Energy bill that I would like to support. There is a lot in this Energy bill that I have helped put in and that I will continue to support, such as the incentives for wind energy. That is certainly desirable. There is a major Florida investor-owned utility that has wind energy in other parts of the country. I want to help encourage that renewable source of energy.

But I cannot take the good parts of this bill and overlook the kinds of things such as this: wiping out any liability of oil companies for the harm they have caused to the environment.

Now, there is another major part I have considerable objection to, and that is the coastal parts of this bill. Under section 321, the Secretary of the Interior will be given broad new authority to grant leases, easements, or rights-of-way on the Outer Continental Shelf in areas where there is a moratorium against oil and gas exploration.

It is the "Holy Grail" of Florida that we do not want oil and gas drilling off of our shores, not only for environmental reasons but for an economic reason. We have a $50 billion a year tourism industry, a lot of which depends on the pristine, sugary white beaches that we have in Florida.

The PRESIDING OFFICER. The Senator's 5 minutes have expired.

Mr. NELSON of Florida. Mr. President, may I ask the Senator for 2 additional minutes just to complete my statement?

Ms. CANTWELL. Mr. President, I yield the Senator 2 additional minutes.

The PRESIDING OFFICER. The Senator is recognized for 2 additional minutes.

Mr. NELSON of Florida. I thank the Senator from Washington.

Mr. President, I simply cannot support an Energy bill that suddenly eases the process of permitting or weakens the Coastal Zone Management Act, weakens the process of a State to object to the Federal Government doing anything having to do with oil and gas leasing off of the coast or with regard to the permitting process with regard to oil and gas pipelines.

That is inimical to the interests of Florida and causes me to come down on the side that even though there are lots of meritorious parts of this bill, which I will continue to work for, at the bottom line, this is clearly not in the interest of my constituency.

So I thank the Senator for yielding so that I could state my position, after a very deliberate consideration of this complicated legislation. That is the way I will vote when these issues are brought up tomorrow.

I thank the Senator for yielding.

The PRESIDING OFFICER. The Senator from Washington.

Ms. CANTWELL. Mr. President, I thank the Senator from Florida for his solid statement about the challenges facing us in drafting an Energy bill. The Outer Continental Shelf areas are somehow thrown up in the open as to whether they are going to be part of the policy discussion, whether States have rights, whether the development along those coastal areas is going to go through the normal process or whether industry is going to be able to just run roughshod over that.

So I appreciate the Senator's statement.

Mr. President, how much time remains?

The PRESIDING OFFICER. The Senator has 12½ minutes remaining.

Ms. CANTWELL. Mr. President, I will try to be brief to explain why I have a major objection to this legislation as it relates to what we are doing or failing, I should say, to do to protect consumers from the Enron price gouging that has happened. I think it is an amazing story.

Some of my colleagues were on the Senate floor earlier today talking about how part of the California crisis was that in California they did not pass on the cost of electricity to the retail side and somehow artificially suppressed demand. They asserted maybe that would have worked everything out.

Well, let me tell you, in Washington State we paid the cost at the retail level because we have a lot of public power in Washington State. And we had a drought. It was the second worst drought in the history of our State. It just so happened when that drought occurred it was the same time that California had deregulated, and the spot market was going crazy, and the Federal Energy Regulatory Commission, which has oversight of these issues, was failing to do anything about it.

But public power has a requirement that they have an obligation to serve. So that obligation to serve meant they had to go find power somewhere. Now, they had reserves. They had alternative plans. But they went to the marketplace to buy power and found out the power was selling at exorbitant rates because of the deregulation that happened in California and the fact that the Federal Energy Regulatory Commission was failing to take action.

In fact, it got so bad in our State because of the high rates that we had, in the county I live in, 14,000 people basically lost their electricity that year. We had a 44-percent increase in the disconnect rate in Snohomish County, my home county, that year because of the high cost of energy. People could not pay their bills.

Now, I know some people think: Well, bad decisions were made by a company, and that may not happen again, or somebody did not plan for enough power in the future. But we all know now that Enron manipulated these rates. They have admitted to manipulating the rates. The Federal Energy Regulatory Commission has said they manipulated those rates. So we all know what has gone on in those situations. But I don't think America knows that people in my State are still paying on those manipulated rates.

And my consumers are mad. They are furious. They are furious that this Energy bill not only fails to recognize we need stricter guidelines against market manipulation to prevent that from occurring in the future, but somehow this bill actually goes further in condoning those acts by saying it is going to try to preserve those Enron contracts resulting from manipulation.

Let me give you an idea of what consumers have said to me.

One of my constituents writes:

> We are writing to express our extreme concern regarding our latest electricity bill. We have done everything in our power to conserve, and that is reflected in our usage, which has been down to a very minimal level. We have lived at this address since 1979, and we cannot continue to live in Snohomish County because the electricity bills are almost greater than our mortgage payments. We are currently considering moving.

Another constituent writes:

> I just received my bill today. I tried to prepare myself before opening the envelope, but, guess what, I didn't prepare myself 6,000 times enough because my bill was $800. That's absolutely crazy. We have lived at this address for 23 years, and we have tried our best at conserving. Where is it going to end?

So my constituents—and I could read many more. I could tell you how the Everett School District in Snohomish County ended up having a million-dollar increase in their energy budget, how small businesses have had huge increases in their energy budgets.

It includes the grocery industry in the State of Washington—everybody knows that grocery stores operate on slim margins and use a lot of electricity. Do you know what they have said to me? "We are not going to build another grocery store in Snohomish County because your rates are too high."

And our rates are too high because we continue to have to pay on Enron contracts that Enron admitted they manipulated. Why is it that we have to continue to pay on these contracts?

You would think that at least at a minimum the Energy bill would take a step forward and say: Let's prevent the kind of Enron manipulation from happening again. But we are not doing that.

In this bill, originally Senator DOMENICI's proposal, roundtrip trading is prohibited. But there are other things we proposed: basically making sure people don't dodge price caps; making sure people don't falsify demand schedules, like the load shifting that happened in California; people who would go out of the region and then sell power back into the region; obviously, under the scheme Fat Boy, people were hiding some of the energy supply that they had—all those things are still allowed under this Energy bill.

As much as my colleagues have tried to articulate this on the floor, somehow the other side of the aisle wants to ignore the reality: This bill is not dealing with the Enron manipulation schemes and blocking them from happening again. I don't see, just on this issue alone—if there was nothing else in the Energy bill—why people would support this Energy bill because of this policy.

I ask my colleagues, I know it may not seem to you like an issue because it didn't happen to your State, but find me a Member on the other side of the aisle who would accept having a 50 percent rate increase for their consumers, not just for 1 year but for the next 5 years because that is what we are paying. And we are paying on those contracts to Enron. I have a letter from a woman. I will not go into the details, but she basically ended up losing her job and having to move to a different area because of this.

What is the real issue? These contracts have been manipulated. These rate are the increases. These are the numbers from 2002, but as I said, almost a 50 percent rate increase in Snohomish County where I live. Seattle City Light had a 60 percent increase. So we are talking about real dollars that my constituents are paying on these Enron contracts.

Enron admitted they manipulated contracts. They admitted that they weren't just and reasonable rates and that they used all these schemes. You would think my utilities could get out of those contracts. You would think my utilities could reform those contracts. In fact, I am amazed: the Department of Justice actually went after Enron and got them to reform a contract as it related to a Federal entity, the Bonneville Power Administration, because they had the power of the DOJ behind them. But when my little utilities, which don't have the Department of Justice working on their side, tried to go to court and get those contracts reformed—no luck. They were sent to the Federal Energy Regulatory Commission, which got on a conference call with Wall Street investors, told the Enron company and their interests, don't do anything to negotiate and reform those contracts because basically we are going to rule in your favor.

That is in a Wall Street Journal article. I ask unanimous consent to have it printed in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From the Wall Street Journal, Mar. 31, 2003]

POWER POINTS: SECOND THOUGHTS ON FERC'S CALIFORNIA D-DAY

(By Mark Golden)

NEW YORK.—Even though the Federal Energy Regulatory Commission's big day on California began Wednesday with a 400-page catalog of bad behavior by energy companies, the second look by Wall Street was that things weren't so bad.

FERC staff reported to Congress that Reliant Resources (RRI) was significantly responsible for the high prices for natural gas in southern California in the winter of 2000–2001, which may have cost consumers billions of dollars.

Reliant and BP PLC (BP) did sham electricity trades, the staff alleged, and dozens of companies used trading strategies like the infamous "Get Shorty" stuff that Enron Corp. (ENRNQ) used in California's power market. That was illegal, staff said, and all those companies should be forced to cough up any related profits. Refunds due California for overpriced crisis-era power sales could be increased.

But the "D" in what one Wall Street analyst has been calling "D-Day" turned out to stand for "dirt": A lot of ugly stuff that will make it hard for energy companies to continue claiming as they have that there wasn't much funny business during the crisis, but which isn't that horrible from a financial or legal perspective for most of the companies involved.

Reliant's "churning" of the gas market, for example, wasn't illegal, FERC staff said, and the conclusion that the practice caused prices to rise required a leap of faith. The Reliant-BP trades may cause BP to wonder if its trader rigged a higher bonus, but they had nothing to do with the soaring prices that prevailed during the crisis.

FERC staff exonerated Williams Cos. (WMB) from claims it manipulated the California gas market. And FERC commissioners said they were going to take some time to decide whether their staff was right about the Enron-like trades being illegal.

During the public meeting, the stock prices of several companies named in the investigation fell hard. Most recovered Thursday and again Friday as the smoke cleared.

MIXED MESSAGES

FERC's Donald Gelinas, who headed the investigation into market manipulation for the past year, presented his findings in the well-attended public meeting.

After the meeting and a press conference, FERC Chairman Pat Wood and Commissioner Nora Mead Brownell, the commission's two Republicans, held a password-protected conference call with a select group of

Wall Street analysts. According to several of those present, the commissioners conveyed the message that the staff findings weren't that bad.

According to one analyst on the call, the split approach makes sense, FERC wants to present a public image as a tough cop on the beat so that states and the U.S. Congress support its push for advancing electricity deregulation. On the other hand, FERC doesn't want to scare away more investment from the decapitalized electricity sector, which is in desperate need of new transmission lines and will need more power plants soon in some regions of the country.

"It was the typical thing they've been doing—trying to please Wall Street at the same time they are trying to please California, and they end up not pleasing anybody," that analyst said.

Brownell discussed the prospects for the commission's decision—expected but postponed on Wednesday—on whether to abrogate long-term power contracts signed during the crisis. She said there are likely two votes against abrogation on the three-member commission, and that the commission will hopefully issue an order in the next couple of weeks, according to one analyst on the call, who took notes.

Brownell's comments on the contracts were similar to what was said in the public meeting, even if the latter tone was more assuring to investors.

Schwab Capital Markets energy stock analyst Christine Tezak didn't agree that the commission has presented different messages to different audiences. Instead, their discussion with the analysts reflected the audience's primarily financial concerns.

"For Wall Street, the whole blame game thing isn't that interesting to us," she said. "We want to know what actions they took and what it's going to cost and when."

FERC APPROACH DEFENDED

Observers shouldn't necessarily expect the messages of the staff report and the commissioner's discussion with analysts to be consistent, a FERC spokesman said.

"The intent was to get an independent fact-finding analysis about whether Enron or any other company had the ability to manipulate the markets for power and gas in the western states in 2000 and 2001," spokesman Bryan Lee said.

Chairman Wood wouldn't try to influence the outcome of that investigation, nor does the investigation reflect his opinion on the matters, Lee said.

Still, a press release issued at the time of the report promised "tough action" from commissioners based on the report. Wood said that any doubts about FERC's role as effective "cop on the beat" should be dispelled.

Ms. CANTWELL. Enron is actually suing consumers across America. They are suing consumers in my State, in Washington, in Oregon, California, Nevada, Idaho, in the Midwest, in the East. The States on this map, those are States in which Enron is saying to utilities and to consumers and ratepayers: I am taking you to court to make sure you continue to pay on manipulated contracts because really you are going to be the deep pocket for these energy prices.

It is just plain wrong. It is plain wrong that that is what America is dealing with and that this particular bill does nothing about it.

Since the beginning of these contracts in my area, I have probably paid $700 on my own energy bill—$700 more than I would have paid if we would have had normal rates. Here is a check from me. It is not really my bank. It obviously doesn't have my bank number on there. But that is what I am going to next pay to Enron because of the fact that my utility can't get out of those manipulated contracts. My utility can't get out of those contracts. That is what everyone in Snohomish is going to have to pay, $370 more, even though we have already paid $796 more since the crisis began.

There is another example of a woman in Snohomish County, where I live, who was trying to take care of her mother. Basically, she got laid off from Boeing. She got a utility bill for $605, nearly double the last bill she had. Her mother got a bill for $747. Her mother is on a fixed income. She only has $1,500 a month from Social Security, and she is supposed to pay 747 of those dollars out to Enron to foot the bill for manipulated contracts. And this body can't do any better than to condone those contracts and further protect them under this bill? It is amazing. It is truly amazing.

So where are we on this problem and this issue? Just look at what ratepayers in my region have had to pay since 2001. The total my ratepayers have had to pay is $1.5 billion, over and above the amount they otherwise would have had to pay in the Northwest, all because they are stuck with long-term Enron contracts. It is unfair. It is unjust. It certainly isn't reasonable.

What is the problem with this legislation in front of us? Again, you would say: That is an issue of manipulated contracts. You ought to go to court. You should figure out what the court has to say about those contracts.

Actually, many of my constituents did go to court. Snohomish County PUD went to court. Enron turned around and countersued. Basically, the court said: You don't have standing here because this isn't a decision before our courts. You have to go to the Federal Energy Regulatory Commission. They are the people who oversee these issues.

So when they went to the Federal Energy Regulatory Commission, they said: There is market manipulation, but we are not going to do anything about it. And, frankly, it is a problem, but our report only is going to demonstrate that there was manipulation and we are not going to do anything.

So what we have had to do is really push on the fact that the Federal Power Act says there should be just and reasonable rates.

This bill further amends the Power Act, and it basically says that these contracts should stand. It basically gives the contracts sanctity. It goes one step further than 70 years of case law and says: Even though the Power Act requires just and reasonable rates, we are going to guarantee these contracts. And FERC and the courts don't have to reform them ever, unless somehow someone can prove that a failure to do so is somehow contrary to the public interest.

We are setting a whole new legal standard in this bill. We are failing to correct the Enron manipulations. We are failing to give direction in a key area of consumer protection. Not only that, we are changing 70 years of case law and saying it is OK to manipulate contracts.

It is time to defeat this bill which supports Hooters, polluters, and the Enron looters that are gouging American ratepayers.

I yield the floor.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. KYL. Mr. President, I congratulate Chairman PETE DOMENICI and his staff for bringing a comprehensive Energy bill to the Senate floor. It has many positive features. Unfortunately, on balance, the provisions he was not primarily responsible for, those that came out of the Finance Committee, are far too heavily weighted towards subsidies and mandates and require that I respectfully oppose the bill.

Let me first mention some of the good in the bill. This is the part that came out of the Energy Committee. First, on the subject of reliability, since the year 2000, Congress has attempted to pass mandatory reliability standards. For some time it has been known that the voluntary reliability standards that currently exist were not adequate. This point was brought home in August with the blackout that hit New England and the Midwest.

We know from the United States-Canada Power Outage System Task Force interim report on the causes of the blackout that First Energy failed to follow at least six voluntary reliability standards. The mandatory reliability standards in this bill will ensure that utilities cannot ignore the responsibility they each owe to maintaining the grid. It will go a long way toward keeping the lights on for millions of Americans.

SMD delay, standard market design, the Government knows best, a one-size-fits-all prescription for Federal domination at the expense of States and the market: This had to be stopped in its tracks before it cost consumers billions of dollars.

The same bureaucrats who approved the plan that brought blackouts and skyrocketing prices to California, obviously, didn't learn their lesson.

So we included a strong SMD delay provision in the bill. The message to the Federal Energy Regulatory Commission, FERC, is very plain: When Congress says no, it means no; and it says no rule before 2007. By that, we mean you cannot just slap another label on SMD, such as WMP, or use a different legal basis, such as "just and reasonable rates," rather than discrimination, and then send the same straitjacket kind of a rule out the door. The same goes for standards of conduct rulemaking, a supply margin assessment test, or some other Federal Government regulatory scheme.

Native load: The current stormy debates over how wholesale electricity should move and be traded in this country will mean nothing if we cannot guarantee retail customers, the families and businesses that pay their electricity bills every month, that when they flip the switch the lights will go on. The native load provision that I worked on with Senator DOMENICI guarantees Arizona's transmission lines will first be used to serve Arizonans and not just sold to the highest bidder. These are some of the good things in the bill. They are all in the electric portion of the bill that Senator DOMENICI presented.

The bad comes from the Finance Committee on which I also sit, primarily in the form of tax subsidies. The conference agreement includes nearly $24 billion in tax incentives; most are tax credits. I advise my colleagues that the negotiating compromise process here was a curious one. The energy tax provisions in the Finance Committee this year totaled $15 billion over 10 years. The House tax incentives total $17 billion over 10 years.

Mr. President, you would think that, between $15 billion and $17 billion, there is a fairly obvious number there—$16 billion might have been the compromise between the House and Senate. That is not the way it works. The compromise between $15 billion and $17 billion was $24 billion. Guess who lost in the compromise? The American taxpayers. How did you get to $24 billion? Well, obviously, there were a lot of votes that needed to be gained and that is how we got to $24 billion.

Maybe there is another formula. The administration only asked for $8 billion in energy tax incentives. This is three times that amount. Maybe that is the new formula for compromise in a conference committee. So that is not an appropriate number. It is way out of bounds. It is too much of a burden on American taxpayers for benefits that are dubious at best.

Tax credits are not the most efficient way to set policy. They can be inefficient and wasteful. We should use them very sparingly. Tax credits distort the market and cause individuals or businesses to undertake unproductive economic activity that they probably would not do absent the inducement. They are, in effect, appropriations through the Tax Code; they are a way to give Federal subsidies, disguised as tax cuts, to favored constituencies.

Here are some examples of tax subsidies in this agreement:

Section 45, renewable energy tax credit: Cost, $3 billion over 10 years. The conference agreement extends and expands the production tax credit for energy from wind and closed-loop biomass. It also extends credit to new forms of energy, such as solar, open-loop biomass, geothermal, small irrigation, and municipal solid waste. This provision includes energy produced from livestock waste and animal carcasses—so save your Thanksgiving turkey.

Energy-efficient improvements to existing homes, $352 million, for 10 years.

Energy-efficient new homes, $409 million, for 10 years.

Credit for energy-efficient appliances, $255 million, for 10 years. That is for washing machines, refrigerators, and the like.

Extend and modify the section 29 credit for producing fuel from nonconventional energy sources, $3.1 billion, 10 years. Often, companies that claim this credit are not even energy companies. There is one I have familiarity with because Arizona tried something similar.

Alternative motor vehicles incentives: Cost, $2.5 billion, 10 years.

This agreement deletes a requirement that was in the Senate bill I got in for a study. Why did I do that? We found that the Arizona experience could have cost the State of Arizona hundreds of millions of dollars. I wanted to prevent that from happening here. We had a disastrous experience with alternative fuel vehicle incentives. This is a quote from the Arizona Republic when the Arizona Legislature repealed its alternative fuel program:

> Lawmakers gutted the disastrous alternative fuel vehicle program . . . in a volatile and dramatic House vote, ending a debacle that outraged taxpayers, panicked buyers, and brought down one of the State's most powerful politicians.

The repealed law, incidentally, paid for up to 50 percent of the cost of a car equipped to burn alternative fuels. The program could have cost Arizona $½ billion if it hadn't been repealed—11 percent of the State's budget. When proposed, the cost of the program was projected to be between $3 million and $10 million—less than 10 percent of its true cost. So the question I wanted to study was, are we confident about the revenue estimates for our congressional provision?

I have talked a little about some of the good and a little about some of the bad. Let me conclude by talking about the truly ugly.

Ethanol: The ethanol provisions of the conference report are truly remarkable. They mandate that Americans use 5 billion gallons of ethanol annually by the year 2012. We use 1.7 million gallons now. For what purpose, I ask, does Congress so egregiously manipulate the national market for vehicle fuel? No proof exists that the ethanol mandate will make our air cleaner. In fact, in Arizona—and this is a critical point—the State Department of Environmental Quality found that more ethanol use will degrade air quality, which will probably force areas in Arizona out of attainment under the Clean Air Act. Arizonans will suffer as a result.

Furthermore, according to the Energy Information Administration, this mandate, costing between $6.7 billion and $8 billion a year, will force Americans to pay more for gasoline. Nor is an ethanol mandate needed to keep the ethanol industry alive. That industry already receives a hefty amount of the Federal largess. CRS estimates that the ethanol and corn industries have gotten more than $29 billion in subsidies since 1996. Yet this bill not only mandates that we more than double our ethanol use, it provides even more subsidies for the industry—as much as $26 billion over the next 5 years.

Professor David Pimental, of the College of Agriculture and Life Sciences at Cornell, has studied ethanol. He is a true expert on the "corn-to-car" fuel process. His verdict, in a recent study: "Abusing our precious croplands to grow corn for an energy-inefficient process that yields low-grade automobile fuel amounts to unsustainable, subsidized food burning." It isn't efficient. The fuel is low-grade. And what is more, Congress, by going in for "unsustainable, subsidized food burning," will impede the natural innovation in clean fuels that would occur with a competitive market, free of the Government's manipulation. These ethanol provisions, alone, dictate that I vote against the bill.

So, Mr. President, in conclusion, while this bill includes several meritorious provisions, especially those negotiated by Chairman DOMENICI, I must vote against it because of the $24 billion in tax subsidies and the bill's irresponsible manipulation of the energy markets through the Tax Code and the ethanol mandate.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. REID. Mr. President, it is my understanding that we are expecting Senator GRAHAM as part of an order.

The PRESIDING OFFICER. Senator GRAHAM has 20 minutes under that agreement.

Mr. REID. I will speak for a few minutes until he comes.

Mr. SCHUMER. Mr. President, will the Senator yield?

Mr. REID. I am happy to yield.

Mr. SCHUMER. May I be put in line after Senator GRAHAM?

Mr. REID. Will the Chair announce the schedule before the Senate as to what speakers will appear.

The PRESIDING OFFICER. Senator GRAHAM is the last speaker under the agreement, with 20 minutes.

Mr. REID. I ask unanimous consent that following Senator GRAHAM, the majority be recognized if they desire, and then following that, Senator SCHUMER have an opportunity to speak.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, as we look around the world today, we see blackouts and we see wild price spikes in electricity markets. We see turmoil in the Middle East. We see global warming caused by fossil fuel emissions. We see air pollution that contributes to asthma attacks among our smallest citizens—our children. We see our parks that are smog-ridden. We see all these things, and we realize the United States needs a national energy policy with a purpose and a vision.

We don't need more of the same old thing—more drilling, more burning, more shortages, more blackouts, more price spikes, and ever larger vehicles with inefficient engines. We need a national energy strategy that will protect our environment, provide a reliable supply of electricity for our consumers, and bolster our national security.

Instead, we get a $75 billion grab bag that I believe has serious problems with the three P's—process, pork, and policy.

The process of this bill was fatally flawed. The genesis of the bill, I believe, was hatched in secret almost 3 years ago by the Cheney task force and completed in secret just a few days ago.

The usual policy—and we have tried to live up to that—is the Senate does a bill, the House does a bill, and both parties—that is the Senators from the Senate and Congressmen from the House, Democrats and Republicans—sit down together to try to work out an arrangement. In this instance, the ranking member of the committee, Senator BINGAMAN, who was also the former chairman of the committee, was not consulted. The first he saw the bill was when it was printed. The distinguished Senator from Vermont, the ranking member and former chairman of the Environment and Public Works Committee, Senator JEFFORDS, was not consulted, even though 100 titles of this legislation that is now before the Senate were under the jurisdiction of the Environment and Public Works Committee.

The pork was best summed up by Senator MCCAIN's description of this bill: Leave no lobbyist behind. It is shameful that two-thirds of the tax incentives in this bill go to oil, gas, coal, and nuclear energy. This is an investment in the past, not an investment in the future.

This bill will lavish more than $55 billion of taxpayer money on some of the wealthiest corporations in the world; namely, oil, gas, and coal companies. It would be better if the companies were all U.S. companies, but some of them are not even U.S. companies getting these benefits.

The most disappointing aspect about this bill is its failure to enact a policy with vision. After pouring billions of dollars into oil and natural gas, we need to invest in clean technology, in a clean energy future. Sadly, this bill is more of the same old, same old. It endangers the environment; it does nothing to help consumers; and it will not break our dependence on foreign oil, a dependence that jeopardizes our national security.

Let's start with the assaults on the environment that are included in this bill.

There have been hours of speeches given in the last 2 days of how it endangers our water supply by granting MTBE producers immunity from claims that the additive is defective in design or manufacture and by weakening the leaking underground storage tank regulations.

It allows large metropolitan areas to extend deadlines for ozone nonattainment areas to comply with the Clean Air Act, and it relaxes regulatory requirements for energy production on Indian reservations and public lands.

It is beyond my ability to comprehend how anyone who is supportive of tribal sovereignty, reservations, and economic development with our Indian tribes could support this legislation.

This bill also falls short of the real steps needed to guide America toward energy independence.

For example, it is a great disappointment to me that higher fuel efficiency standards have not been included in this bill. If all cars, trucks and sport utility vehicles had a CAFE standard of 27.5 miles per gallon, the country would save more oil in 3 years than could be recovered economically from the entire Arctic National Wildlife Refuge. A comprehensive energy strategy must include conservation, efficiency, and expand generating capacity.

Certainly our Nation must promote the responsible production of oil and gas, but that doesn't mean we should sacrifice the environmental protections of our public lands.

We can't drill our way to energy independence. America only has 3 percent of the world's oil reserved, but we use 25 percent of the world's supply.

This bill also fails to protect consumers.

In the past few years, people in my home State and other Western States have experienced severe spikes in the price of electricity. The policies of the past are not the answer. Like Dorothy in the Wizard of Oz, the solution is literally right at our feet—under the ground, in the wind around us, and emanating from the Sun. In Nevada and other Western States, we have the potential to generate enormous amounts of electricity with geothermal, wind, and solar power. That is why I am disappointed this energy bill does not contain a renewable portfolio standard requiring that a growing percentage of the Nation's power supply come from renewable energy resources.

I am proud that my home State of Nevada has adopted one of the most aggressive renewable portfolio standards of any State. It requires us to produce 5 percent of our electricity with renewable sources, not counting hydropower, by the end of this year. In 10 years, the goal jumps to 15 percent. We already have developed 200 megawatts of geothermal power, with a long-term potential of more than 2,500 megawatts.

Utilities in Nevada have also signed contracts to provide 205 megawatts of wind power in 2 years, and an additional 90 megawatts is proposed. By some estimates, we could potentially produce more than 5,700 megawatts from wind power—meaning we could meet our entire electricity needs with geothermal and wind. So I wish this bill included a Renewable Portfolio Standard.

Thankfully, it does extend and expand the production tax credit on renewable energy resources from wind and poultry waste to include geothermal, solar, and open-loop biomass. I have spent years fighting for this tax credit, because it will give businesses the certainty they need to invest in geothermal and solar generating facilities. We know the production tax credit will work because it already has. With the benefit of the existing production tax credit, wind energy is the fastest growing renewable energy source. In 1990, the cost of wind energy was 22.5 cents per kilowatt hour. Today, with new technology and the help of a modest production tax credit, wind is a competitive energy source at 3 to 4 cents per kilowatt hour. I applaud the fact that wind, geothermal, and solar energy will receive a production tax credit of 1.8 cents per kilowatt hour.

I had hoped the bill would provide geothermal and solar energy the same 10-year tax credit that wind energy enjoys, but a 5-year credit is a good start. The facilities to develop these energy resources are very capital intensive, and a 10-year tax incentive is needed to fully realize our renewable energy potential.

Developing these renewable resources will not only help consumers, it will create thousands of jobs. And many of these jobs will be in rural areas that are desperate for economic growth. A report from the Tellus Institute, "Clean Energy: Jobs for America's Future," found that investment in renewable energy could lead to a net annual employment increase of more than 700,000 jobs in 2010, rising to approximately 1.3 billion by 2020, and that each State would experience a positive net job impact. This is why we must be bold. We must not cling to the fossil fuel technology of the past. We must explore and seize the potential of the future.

I opened my remarks a few minutes ago by talking about all of the problems we see if we look around the world today. But I also see much that could be positive. I see renewable energy resources—the brilliance of the sun, the power of the wind, the eternal heat within the Earth. And I see the good old American ingenuity to unlock that enormous potential.

With a little bit of incentive and investment, we can develop the technologies to efficiently develop our renewable resources. And as fantastic as it sounds, with the use of hydrogen fuel cells, oil will eventually be phased out as the primary transportation fuel.

If we choose to invest in energy efficient and renewable technologies, we will create thousands of new jobs, we will protect our environment, we will provide consumers with reliable sources of energy, and we will bolster our national security. That is the vision our Nation needs. That is the leadership we must provide.

The PRESIDING OFFICER. The Senator from Florida is recognized for 20 minutes.

Mr. GRAHAM of Florida. I thank the Chair. Mr. President, the Energy bill before the Senate today is the newest chapter in the book that we have been writing throughout this year. The title of that book is "At War With Our Children." This legislation would represent another example of this generation taking the benefits of our profligate behavior and then asking our children and grandchildren to pay the cost.

This chapter begins with the addition of over $30 billion in sanctioned appropriations and some $70 billion in authorized appropriations. This will be added to an already gigantic deficit. If it had been added to this year's deficit, it would have increased it by approximately 7 to 8 percent. This cost will be paid by our children. But this goes beyond just adding to the financial burdens of our future. It adds to the vulnerability of our children and grandchildren—a vulnerability that will be occasioned by the fundamental philosophy of this legislation, which is to drain America first.

There are some small vows to conservation and alternative sources of energy, but the principle that lies behind this bill is to extract as much of our national treasure as quickly as possible and to accelerate the date when we will have depleted our domestic source of petroleum and other critical natural resources.

Our generation gets whatever short-term benefits—physical maintenance of low prices of gasoline, the benefits to the oil and gas industry—that will come from this bill. But we again declare war on our children because they will end up paying for it.

The great philosopher Yogi Berra once said:

> If you don't know where you are going, you will wind up somewhere else.

He can very well have been defining this energy legislation. For nearly three years Congress has been laboring to write a comprehensive energy bill and to deliver on our promise to give Americans certainty and security related to our energy future. Certainly none of us ever thought it would be an easy task, even under the best conditions, but I do not believe that we have made it any easier to achieve our goal because we have ignored what should be the guiding principles of this or any comprehensive public policy.

We must start with a clear idea of where we are going, a map to guide us to that destination, and standards by which to measure our success. I would submit that if you look through the almost 12,000 pages of this bill to try to find what is our goal, where is the map that will guide us and by what standards you will measure our success towards that goal, you would find it an unrewarding effort. There are no such statements of vision, of means of achieving that vision, or of measurements of achieving that vision.

At the beginnings of the hearings of the State Energy hearing, I advocated that we develop such a set of visions, maps, and measurements as we commenced our work on a comprehensive energy bill. There is simply no other way to draft a bill of such magnitude, importance, and promise. Without a specific purpose, this energy bill is lost in the wilderness.

We can say that we have provided America with energy security, but what does that mean? Is energy security drilling America first and conserving fuel last? Is energy security ignoring the need for fuel efficiency while espousing the idea of decreasing dependence on foreign oil? Is energy security investing in targeted alternative technologies without setting timetables and goals and, at the same time, ignoring other promising technologies?

Let me suggest what I think should be some goals of a reasonable, comprehensive energy policy. These would be illustrative of the kind of long-term goals that should be but, regrettably, are not the focus of this Energy bill. As an example, my goal No. 1 was that we must take a long-term approach to energy policy, establishing goals to reach for the next 50 years with milestones for each decade to guide our progress. We cannot be the generation that sets our national energy policy on a course which will inevitably result in totally depleting our domestic energy reserves by the time our grandchildren are adults.

The United States is the model to the rest of the world. We should lead by example, using energy conservation and efficiency measures. We should husband our domestic reserves, particularly of petroleum, for times of international turmoil.

Goal No. 2: We must wean ourselves from our unhealthy dependence on petroleum, both foreign and domestic. Current estimates show that the United States is consuming between 19 and 20 million barrels of oil each day. From the mid-1970s into the 1980s, use of petroleum sharply dropped in the United States. I propose we return to that path and aim to decrease the use of petroleum by approximately 10 percent over the next decade, with the ultimate goal of finding a cleaner and more efficient way of operating automobiles and expanding our transportation options such as high-speed rail.

Goal No. 3: We must reduce our importation of foreign oil, which currently accounts for about 65 percent of the oil we consume. We must conserve our current use of domestic oil and gas in order to stretch their availability as far as possible.

Under current levels of extraction and projected levels of use, in approximately 50 to 75 years, about the time our grandchildren will be our age, we will have exhausted our domestic petroleum reserves at current economic and technological levels of extraction.

This is not a new problem, it is one that has been pointed out to us for more than half a century. In 1946, James Forrestal, then-Secretary of the Navy, said this:

> If we ever go into another world war, it is quite possible that we would not have access to reserves held in the Middle East. But in the meantime, the use of those reserves would prevent depletion of our own, a depletion which may be serious within the next 15 years.

Secretary Forrestal's statement is remarkable for a couple of reasons. First, he was looking far over the horizon, beyond the short term, and trying to see what would be happening over the next 50 years. Second, he did not succumb to the mantra of independence from foreign oil through draining America first. Rather, he viewed use of foreign oil as a method of husbanding our domestic reserves.

This Energy bill, with its drain-America-first policy, is a step backward from Forrestal's policy. It will assure that we deplete our own resources in the near future. Forrestal sets the examples of the kind of policy we should be making in this energy Bill today.

Goal No. 4: We must increase the amount of renewable and alternative energy we use. This would include wind, solar, hydro, geothermal power, and municipal solid waste. It should also include clean coal and nuclear as alternatives to current fossil fuel use.

Goal No. 5: We must eliminate our overreliance on a single source of power for electric energy generation. I am becoming increasingly concerned about our tendency to turn to natural gas to solve all of our energy woes. Clearly, natural gas has some significant advantages in terms of emission reduction, but we as a nation, in my judgment, would be foolish to have only a single or even a single dominant source of fuels for our electric supply.

The National Association of State Energy Officials estimates that natural gas used for electricity generation will increase by 54 percent between 2000 and 2015 as new powerplants are built and older plants are converted to natural gas.

In contrast, our friends in Europe are making great strides in expanding their energy portfolios to include renewables. Denmark, for example, has a plan to eventually generate about 20 percent of its energy needs from wind power. The United States should take serious steps to include all available energy sources. One way to accomplish this would be to establish a national renewable portfolio standard. This simple measure would go a long way in putting us on the path to a sustainable energy future, by encouraging innovation in renewable energy technologies and by increasing the demand which would have the result of more efficient production. It would create jobs in America for Americans.

Unfortunately, the Energy bill we are considering today ignores the renewable portfolio outright, even though Senator BINGAMAN's amendment to this effect was accepted by a strong bipartisan vote by the Senate conferees.

Goal No. 6: We must provide Americans with a reliable electricity system. We all know that millions of people were affected by the blackouts of this past summer. What we do not know is how to prevent it from happening again. I am pleased that this bill begins the process, although distressed that this bill does not go as far as the Federal Energy Regulatory Commission has recommended to give us greater reassurance about the avoidance of August 14 calamities in the future.

But there is even a more basic step we should be taking, and that is to accomplish the goal of a reliable electric grid, we must gather data about the current state of reliability.

It is shocking to realize there is presently no national reporting of outages, which makes it difficult to determine the scope of the problem and the range of solutions. Electricity customers have the means to find information about the price of their electricity should we have such national data. They do not have such an opportunity today.

I propose that consumers should also have the means to judge the reliability of the system that provides them their electricity.

Goal No. 7: We should reduce the impacts of the use of energy on our environment. In the 1990s we proved that the American economy could grow while making meaningful progress to improve our environment. This means we should not drill America first without considering real conservation and real efficiency standards, as well as the effects of such drilling on the depletion of our domestic energy reserves. It also means striving to reduce carbon emissions.

This bill does neither: It focuses, with laser-like precision, at giving big oil every item on its wish list while running roughshod over the rights of the States that depend on, for instance, healthy coasts for their economic security. Section 325 weakens the consistency guidelines of the Coastal Zone Management Act.

Currently, States have the right to review proposed offshore projects and object if they find that these projects are inconsistent with the State's plans or policy. This Energy bill would impose severely restrictive guidelines and deadlines for decisions appealing States' consistency determinations. The practical effect of this would be to limit opportunities for States to comment and provide important information on issues which directly affect their coastal zones.

Coastal States deserve to have a say in the fates of their shores. This is the basis upon which the Coastal Zone Management Act became law. This Energy bill includes provisions to get every drop of oil out of domestic reserves while refusing to improve CAFE standards for SUVs. With advances in technology, it is not difficult to improve the efficiency of vehicles while providing the other features that drivers want. Yet this bill creates the likelihood that fuel efficiency standards will continue to lag. We should resolve to move to at least the 35 miles per gallon level for new cars within this decade.

The National Academy of Sciences says this is a reasonable goal. If we pursued this goal, we would lessen the impact of any oil interruption, we would sharply reduce the amount of money going to areas of the world where the cash might support undesirable activity, and, in addition, we would also make a significant dent in reducing greenhouse gases, an issue which is also ignored by this Energy bill. Any comprehensive Energy bill that doesn't commit to at least some reductions in the emission of greenhouse gases is not worthy of passage.

Furthermore, this Energy bill goes one step further and actually rolls back important environmental standards. One example of this is the exemption of the hydraulic fracturing process from the Safe Drinking Water Act protection for drinking water sources. I have grave concerns about this action from public health, environmental, and legal perspectives.

Hydraulic fracturing is a means by which certain energy sources are retrieved through the use of a heavy hydraulic process. The consequence of this is that after the useful materials have been recovered, there is a significant amount of water laden with materials which contain potentially serious carcinogenic and toxic substances. There are potential serious consequences for drinking water quality in areas where this hydraulic fracturing occurs. In many cases, the fracturing fluids being pumped from ground water contain toxins and carcinogenic chemicals. Diesel fuel is a common component of fractured fluids.

The Energy bill before this conference permanently exempts the oil and gas industry from storm water pollution activities at construction sites. Since 1990, large construction sites have been required to control storm water runoff in order to prevent pollution from entering adjacent waterways, harming wildlife and impairing water quality.

The irony of this is that the Senate will soon consider the transportation bill, the Surface Transportation Act. This act was amended in the Environment and Public Works Committee to mandate that States earmark at least 2 percent of their highway funds to deal with storm water runoff. While we are doing this to our public agencies, requiring them to devote substantial funds and attention to storm water runoff, we are permanently exempting the oil and gas industry at its construction sites from doing so.

Mr. President, I ask unanimous consent for an additional 3 minutes to complete my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRAHAM of Florida. Mr. President, in the year 2003—this year—smaller sites were to have been required to adopt the same pollution controls which, since 1990, have applied to large projects. Under industry pressure, the EPA issued a 2-year extension for the oil and gas industry. All other sectors, including small municipalities, still have to comply. This section of the Energy bill adopts a permanent exemption for all construction at oil and gas sites, including those sites that held permits for over 10 years.

These are only some of the examples of environmental rollbacks in this Energy bill related to clean water, clean air, the National Environmental Protection Act, and other important enactments designed to protect the environment and the public health.

The Energy bill we have before us today cannot guarantee Americans that their energy future is secure. Returning to the illuminating remark of Yogi Berra, if we look at this legislation, we begin to get some sense of where we are headed.

With this Energy bill, we have written the next chapter in the book "War On Our Children," and it describes the next battle: Drain America First, overlook conservation measures, ignore strategies to reduce depletion of domestic reserves.

The residue of these outdated ideas will undoubtedly stain the future. Our children and grandchildren will live in an America where water is more contaminated, where air is further clogged with pollution, where access to clean rivers and streams for drinking, swimming, and fishing will be diminished.

The cost of this destruction is not only economic or environmental, it is societal. Future generations will be forced to fix our mistakes instead of focusing on a better tomorrow for their children and grandchildren.

For these reasons, I strongly oppose this legislation and will vote no.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. VOINOVICH. Mr. President, I rise today in support of the conference report accompanying the Energy bill. As I have often stated, we sorely need to develop a long overdue comprehensive energy policy for our Nation. The United States has a responsibility to develop a policy that harmonizes the needs of our economy and our environment.

These are not competing needs. A sustainable environment is critical to a strong economy and a sustainable economy is critical to providing the funding necessary to improve our environment. We need to enact a policy that broadens our base of energy resources to create stability, guarantee reasonable prices, and protect America's security. It has to be a policy that will keep energy affordable. Finally, it has to be a policy that will not cripple the engines of commerce that fund the research that will yield environmental protection technologies for the future.

The legislation we are discussing today is the key element in our effort to construct a viable energy policy. It will provide a tremendous boost to our economy, protect our environment, and create hundreds of thousands of jobs. Let me say this again. Passage of this bill will provide a tremendous boost to our economy, protect our environment, and create hundreds of thousands of jobs.

There are four huge reasons that my constituents in Ohio need this bill: Ethanol, natural gas, electricity and jobs.

The fuel title in this bill will triple the use of renewable fuels over the next decade, up to 5 billion gallons by 2012. It will also reduce our national trade deficit by more than $34 billion, increase the U.S. gross domestic product by $156 billion by 2012, create more than 214,000 new jobs, expand household incomes by an additional $51.7 billion, and save taxpayers $2 billion annually in reduced Government subsidies due to the creation of new markets for corn. In other words, we will not have to use the subsidies to farms to the tune of $2 billion with this 5 billion gallons of ethanol.

The benefits to the farm economy are even more pronounced. Ohio is sixth in the Nation in terms of corn production and is among the highest in the Nation in putting ethanol into gas tanks. Over 40 percent of all gasoline sold in Ohio contains ethanol.

An increase in the use of ethanol across the Nation means an economic boost to thousands of farm families across my State.

Currently, ethanol production provides 192,000 jobs and $4.5 billion to net farm income nationwide. Passage of this bill will increase net farm income by nearly $6 billion. Passage of this bill will create $5.3 billion of new private sector investment in renewable fuel production capacity, and expanding the use of ethanol will also protect our environment by reducing auto emissions which will mean cleaner air and improved public health.

The use of ethanol reduces emissions of carbon monoxide and hydrocarbons by 20 percent. The use of ethanol also reduces emissions of particulates by 40 percent. The use of ethanol helped move Chicago into attainment of their Federal ozone standard, the only RFG area to see such an improvement.

In 2002, ethanol use in the United States reduced greenhouse gas emissions by 4.3 million tons. That is the equivalent of removing more than 630,000 vehicles from the roads.

Simply stated, this legislation is critical to our farm economy, especially in agricultural States such as Ohio. We need to get this bill finished.

We are in the midst of a natural gas crisis in the United States. Over the last decade, use of natural gas in electricity generation has risen significantly while domestic supplies of natural gas have fallen. The result is predictable: tightening supplies of natural gas, higher natural gas prices, and higher electricity prices.

Home heating prices are up dramatically, forcing folks on low incomes to choose between heating their homes and paying for other necessities such as food or medicine.

Donald Mason, a commissioner of the Ohio Public Utilities Commission, testified earlier here in Congress:

> In real terms, the home heating cost this winter will increase by at least $220 per household. That might sound not significant, but during the winter season of 2002 to 2001, one gas company in Ohio saw residential nonpayments jump from $10 million a year to $26 million a year.

As a result of these heating cost increases, 50 percent more residential customers were disconnected from gas service last year than in 2001.

I have personally seen my own natural gas costs go from $4 an mcf to over $8 an mcf. Projections indicate that this winter could be devastating on the elderly and low-income families who are already struggling to survive.

At a hearing last year, Thomas Mullen of Catholic Charities and Health and Human Services of Cleveland, OH, described the impact of significant increases of energy prices on those who are less fortunate.

He said:

> In Cleveland, over one-fourth of all children live in poverty and are in a family of a single female head of household. These children suffer further loss of basic needs as their moms are forced to make a choice of whether to pay the rent, or live in a shelter; pay the heating bill, or see their child freeze; buy food, or risk the availability of a hunger center. These are not choices that any senior citizen, child, or for that matter, person in America should make.

Manufacturers that use natural gas as a feedstock are getting hammered due to the doubling and even tripling of their natural gas costs and are either leaving the country or closing their doors.

Lubrizol, a chemical company located in Wickliffe, OH, which was at a manufacturers' listening session that I conducted a couple of weeks ago, is moving part of its workforce to France due to the tripling of natural gas prices in Ohio.

The president of Zaclon, Inc., a chemical manufacturer based in Cleveland, testified earlier this year that increased natural gas costs have resulted in loss of sales revenues and increased total energy costs.

The president of one major international pharmaceutical company stopped by my office—a company that has 22,000 employees in the U.S.—and basically said: Unless you do something about natural gas prices, we are moving most of these jobs to Europe.

Due to the natural gas crisis, the Dow Chemical Company, which is headquartered in Michigan, will be forced to shut down several plants, and they are going to eliminate 3,000 to 4,000 jobs.

The American Iron Steel Institute reported that an integrated steel mill could pay as much as $73 million for natural gas this year, up from $37 million last year.

An east Texas poultry producer reported that his poultry house heating bill jumped from $3,900 to $12,000 in 1 month, forcing him to decide between paying the bank or the gas company.

High natural gas prices have resulted in the permanent closure of almost 20 percent of the U.S. nitrogen fertilizer production capacity and the idling of an additional 25 percent.

The Potash Corporation, one of the world's largest fertilizer producers, has announced layoffs at its Louisiana and Tennessee plants due to high natural gas prices.

The company spends $2 million per day on natural gas.

I could go on and on and on about the natural gas prices. This bill is going to provide more opportunity to increase the supply of natural gas and help limit the exacerbating needs for natural gas in this country because of the fuel switching that is going on. The end result is a drag on our economy.

Don't take my word for it. Federal Reserve Chairman Alan Greenspan has testified before the Senate Energy Committee, the House Energy Committee, the Commerce Committee, and the Congressional Joint Economic Committee on the supply and price of natural gas. He did it this year. He stated:

> I am quite surprised at how little attention the natural gas problem has been getting because it is a very serious problem.

This Energy bill includes several provisions to increase domestic production of natural gas and to ensure that we have a healthy, vital fuel mix for electric generation.

It is vitally important for us to finish this debate and pass this bill in order to relieve the pressure on our natural gas supply.

This bill helps provide money for clean coal technology and use a 250-year supply of coal. There are some people in this country who want to shut down coal and force our utilities to use more natural gas. This bill will increase the use of coal using clean coal technology and take the pressure off of energy companies fuel switching to natural gas.

Electricity is another issue for the people of Ohio. There has been a lot of conversation here on the floor over the last couple of days about the electricity title of the bill. Several of my colleagues have talked about the need to prevent blackouts such as the one we experienced in August. Let me say that as a Senator from Ohio where the blackout was triggered, I know about the need to prevent more blackouts. In fact, I held a hearing on this exact topic this morning in the Oversight of Government Management Subcommittee. The electricity title in this bill explicitly provides the Federal Energy Regulatory Commission with the authority to establish and enforce with penalties new national reliability standards that will be critical in helping to prevent future blackouts.

For my colleagues who are having a problem with this bill, I remind them that this title is so needed if we are going to prevent future blackouts.

It also provides the Federal Energy Regulatory Commission with new authority to site transmission lines, encourages utilities to invest in increased transmission capacity, and encourages utilities to invest in new clean coal technologies that will allow more electricity to be put into the grid without increasing the pollution put into the air.

At the oversight hearing that I held this morning, I asked the panel of electricity experts from the Federal Energy Regulatory Commission, the Department of Energy, and the North American Electric Reliability Council what we need in order to prevent future blackouts. Their response was overwhelming: Enact the provisions in the Energy bill, especially the reliability standards.

Finally, I want to talk about jobs created by this legislation. The Energy bill saves jobs. It will create nearly 1 million new jobs. The Energy bill will prevent the loss of hundreds of thousands of jobs, like the jobs lost in the manufacturing sector in the past 3 years, in part due to high energy costs, which I have discussed, and the devastating impact it has in my State, particularly manufacturing jobs, but jobs in all sectors, including manufacturing, construction, and technology.

Where are these other jobs going to come from? Natural gas and coal, more than 400,000 direct and indirect new jobs will be created through the construction of the Alaska national gas pipeline, while at the same time bringing an affordable energy supply to the lower 48 States. America's substantial investment in clean coal technology creates 62,000 jobs and ensures Americans new electricity that is abundant, reliable, affordable, and cleaner than ever before; 40,000 new construction jobs created by the construction of approximately 27 large clean coal plants; 12,000 full time permit jobs related to plant operation; 10,000 research jobs in the fields of math, engineering, physics, and science, with an estimated annual salary of $125,000. A lot of the research jobs will be created right in my State of Ohio.

The renewable fuel standard in the bill will create more than 214,000 new jobs and expand household income by an additional $51.7 billion over the next decade.

Building a first of its kind nuclear reactor to cogenerate hydrogen will create 3,000 construction jobs and 500 long-term high-paying, high-tech jobs.

A nuclear production tax credit will spur the construction of approximately four light-water nuclear reactors for a total of 6,000 megawatts of clean and affordable energy. This construction will create between 8,000 and 12,000 jobs. Running the plants will create 6,000 high-paying, high-tech jobs. The Price-Anderson renewal in this bill will protect 61,800 jobs and 103 plants nationwide.

Again, renewables, incentives for geothermal energy will bring between 300 and 500 megawatts of clean and renewable geothermal energy on line over the next 3 years that will create between 750 and 1,000 direct jobs and between 7,500 and 10,000 indirect jobs.

The fact is, this is a jobs bill. It will also do something else: It will prevent the loss of jobs. Mississippi Chemical and Yazoo City, MS, filed for chapter 11 bankruptcy protection in May due to financial losses attributed to the combination of depression in the agricultural sector and extreme volatility in the domestic natural gas area. In other words, plants are shutting down because of the high cost of natural gas. This will produce more natural gas in this country and take the heat off the rising cost of electricity in our country.

I have heard a number of my colleagues during the debate savage this bill, claiming it will devastate the environment, that it gives oil companies a free pass for MTBE contamination, and that it contains porkbarrel funding for energy companies. Unfortunately, this rhetoric is just another example of the old adage, you cannot let the facts get in the way of good judgment or a good argument. I will address a few of those most outrageous claims we have heard.

The first complaint raised by many of my friends is that the bill is bad for the environment. What are the facts? Here are the environmental benefits to this bill. By promoting greater efficiency and cleaner energy technology, the Energy bill will improve air quality, reduce greenhouse gasses, protect our natural resources, and provide a cleaner, healthier environment for the American people. The Energy bill will reduce environmental impacts by improving energy efficiency, conserving energy, and improving air quality to renew energy efficiency standards for energy-efficient products such as consumer electronics and commercial appliances.

It will provide tax incentives for energy-efficient appliances, hybrid and fuel cell vehicles, and combine heat and power products. It will authorize $1.2 billion over the next 3 years for weatherization assistance programs to help low-income families to make their homes more energy efficient and permanently reduce their energy bills. And it will increase dramatically the LIHEAP money that we will need during the next couple of years for the poor and the elderly so that they are not literally out in the cold.

It expands the use of renewable energy, requiring the Federal Government to purchase up to 5 percent of its electricity from renewable sources and encouraging the installation of solar panels on public buildings. It increases production of renewable energy resources, such as geothermal on Federal and tribal lands. It provides tax incentives for production of electricity from renewable energy such as wind, solar, biomass, and landfill.

Under this bill, the tax credits include $5.6 billion of tax incentives for thermal and for solar energy. We are going to see, as many of my colleagues have asked for the last couple of years, a lot more windmills and a lot more solar panels built as a result of this legislation.

It reduces the use of oil for transportation. It authorizes over $2.1 billion for the President's Freedom Car and hydrogen fuel initiatives to help reduce the use of oil for transportation needs.

This is a big issue in this piece of legislation. I have heard some of my colleagues say it will not do anything to reduce their reliance on oil. I have already talked about the contribution of reducing reliance on oil in terms of renewable fuels such as ethanol, but what it also does is invests substantial money in fuel cells that need to be moved along in this country.

As a Senator and as cochairman of the auto caucus, I have been in automobiles powered by hydrogen and that use fuel cells. This bill will start us on the way to a situation where my children, and for sure my grandchildren, will not be using oil to power their motor vehicles. We have to get on with it and get serious.

It creates new markets for renewable fuels for transportation such as ethanol and biodiesel to reduce the dependence on foreign oil. Expanding use of cleaner energy technologies is another issue in this bill, and modernizing our electricity grid with policies that promote the use of efficient distribution generation combined with heat and power and renewable energy technology. It authorizes a 10-year clean coal power initiative to enable the use of plentiful domestic coal resources with fewer environmental impacts.

It also improves the hydroelectric relicensing process to help maintain this nonemitting source of energy while preserving environmental goals.

The second complaint we have heard about is it contains provisions that give MTBE a free pass from any liability. Now, what are the facts? First of all, Congress has considered liability protections in a variety of settings, including medical care and educational institutions. This provision recognizes that when Congress mandates the use of fuel components and when those components have been studied and approved by the EPA, it is reasonable to disallow a case where the mere presence of a removable system fuel makes it a defective product. The safe harbor provision is intended to offer some protection to refiners that have been required to use oxygenated fuels under the Clean Air Act. They are being required to do it. We told them to do it. The safe harbor provision will not affect cleanup costs; it will not affect claims based on the wrongful release of renewable fuel into the environment such as a spill.

The suggestion is with the spills that are going on, we will not be able to sue those people responsible. Anyone harmed by a wrongful release would retain all rights under current law and would be able to recover cleanup costs just as they do now. Those responsible for releasing oxygenated fuels will be responsible for cleaning them up.

Federal and State environmental statutes such as underground storage tank laws will still apply if gasoline is released and gets into a well or contaminates a drinking water supply.

Critics have charged that this bill will throw all MTBE lawsuits out of court. They could not be more wrong. The safe harbor only applies to product liability claims and does not affect any claims that have been filed prior to September 5, 2003. In fact, at a hearing that I chaired on this topic in March of this year, we spent a significant amount of time discussing current litigation going on in Santa Monica, CA. The facts in this case are pretty clear. MTBE has contaminated the city's water, and the city has had to undergo costly remediation to clean up the contamination.

In that litigation it is worth noting that the oil companies have paid millions and millions of dollars for the cost of remediation and to bring in uncontaminated water to that community. I understand Santa Monica litigation is moving forward. Most importantly, this legislation will not change any aspect of that case. It will not cause any claims to be kicked out and will most certainly not cause the case to be dismissed.

Let me state this again: The safe harbor does not apply in cases such as this. It does not let the oil companies off the hook. It does not throw any litigation out of court. And it does not give anyone a free pass.

Now, a number of my colleagues have come to the floor during this debate and announced they will vote no on this bill because this safe harbor provision is contained in the fuels title. These Members are announcing they oppose the ethanol package purely for this reason. Cynically, I would like to say that, in my opinion, such an announcement is a statement that some of these Members have picked trial lawyers over farmers.

The third complaint that critics of this bill have lodged against it is that it contains unreasonable handouts for big energy and oil companies. What were the facts?

The authorizations and tax incentives contained in the bill are geared to promote the kinds of energy that our friends across the aisle and on this side of the aisle are calling for.

The bill includes incentives for renewable energy—$5.6 billion worth—such as wind energy, solar energy, and the use of biomass. As I mentioned, over 26 percent of all the tax incentives in this bill go to renewable energy.

The bill includes incentives for clean-burning natural gas production.

The bill includes incentives for clean coal technologies. These are the technologies that will allow utilities to continue to use coal without continuing to emit pollution into the air.

The bill includes incentives for increased energy efficiency and conservation.

I would like to read a letter that was sent to Senator DOMENICI. It is from the American Wind Energy Association, the Geothermal Energy Association, the National Hydropower Association, and the Solar Industries Association:

> Dear Senator, on behalf of the leading renewable energy trade associations, we are writing to urge your support for passage of H.R. 6. H.R. 6 contains several important provisions vital to the future of our industries. Its passage will help expand renewable energy production and spur job growth in the United States in the immediate future. We ask that you support the bill and vote in favor of any cloture motion filed on the conference report.

What is the downside of promoting clean-burning and renewable energy? Aren't these the same things that many have been attacking us for not including in the bill? This criticism is one more example of overheated rhetoric that, frankly, does not stand up to scrutiny.

If we do not pass this legislation, we will continue to see the hemorrhaging of jobs in America, especially in States such as mine, and we will lose all of the potential jobs that I have just outlined.

This is the largest jobs bill we have seen on the Senate floor in decades. It is my hope and expectation that the Senate will pass it. These issues have been in front of us for far too long—far too long.

Last year, when this was brought up, I spent 6 weeks on the floor of the Senate debating the Energy bill. We finally passed it in the Senate, and it died.

This year, we started out for 2 or 3 weeks and finally were able to enter into a compromise with the other side of the aisle and pass the bill that we passed last year so it could go into conference.

We have worked very hard on this piece of legislation. It is not perfect. There are people who have problems with it. But, overall, it is a very good piece of legislation. The result of not passing it—God only knows what would happen.

For example, this morning, when I had the hearing with the folks who are trying to do something about the blackout problem in this country, they indicated the only salvation for them is this Energy bill. They said: Please pass it, we need it now.

If we do not pass it now, then when are we going to get to mandatory renewable standards, with penalties, and get on with making sure we do not have more blackouts in the United States of America?

As I said, these issues have been in front of us for too long. Now that we are so close to the finish line, I ask my colleagues to vote for cloture on this bill, prevent a filibuster that will hurt our economy, cost us jobs, and hurt our environment. Most importantly—most importantly—we have never had an energy policy in this country. It is long overdue. It is long overdue. We need to move on with this for the future of our economy, for our environment, and for our national security.

Mr. President, I suggest the absence of a quorum.

Mr. SCHUMER addressed the Chair.

The PRESIDING OFFICER. The Senator from New York is recognized.

Mr. SCHUMER. Thank you, Mr. President.

Mr. President, I appreciate that this debate is now coming to a close, and we will, evidently, vote on cloture tomorrow morning at about 10:30. It has been a long debate. It has been a good debate. I think it has been an elucidating debate. I think the longer we debate this bill, the more unfavorably it is looked upon by the American people.

I would like to make one general comment about the process before getting into the substance of the bill. I have tremendous respect for my friend from New Mexico, Senator DOMENICI. He is a fine man. We have worked together on legislation. I think he works hard. I think he is dedicated.

I have a very fond relationship with my former colleague from the House of Representatives, Congressman TAUZIN, head of the House Energy Committee. We came into the Congress together in 1980.

But no matter who it is, you cannot negotiate a bill with only two people in the room. Our ranking member from New Mexico, Senator BINGAMAN, was excluded. The Democratic side in the House was excluded. But it was not just the Democrats who were excluded; too, too many of the Members were excluded.

Why is it that those of us in the Northeast, Democrats and Republicans, think this bill is so bad for our region and our communities? Well, maybe it is because when you have a Senator from New Mexico and a Congressman from Louisiana negotiating the whole bill, there is not enough input from other parts of the country.

The beauty of the system that the Founding Fathers created—and that we have carried forward in our own fashion 215 years later—is that it understood those things, and it understood that we should not have a major bill negotiated by two people behind closed doors.

The fact that this bill is teetering on the edge of survival right now, I think, in part, is because of the process by which it was constructed. I hope we will not do it again.

If we should win our vote tomorrow, those of us who are arguing against cloture, I hope that the lesson will be learned. I hope we will have real debate and real conference committees.

I also hope that, even here, we do not make the same mistake of passing last year's bill and then just saying, "Let it go to conference," which was a mistake, I think, made on our side as well.

The process works. It is long and slow and laborious, but it works.

Again, a bill that has so many goodies for so many people—that such a bill should be teetering on the edge of extinction, I think shows we ought to go back to the process, the open process, the process that has Members of various parts of the country represented, the process of debate and refinement, because that ends up making better legislation.

Now, I have a whole lot to say about this bill, but the hour is late. So I will just put my comments into two categories: one, what the bill contains; and, two, what the bill does not contain—neither of which makes me happy.

What the bill contains: There are some good provisions in this bill. I am not going to get up here and do a diatribe against these little narrow things that are there for everybody. There are a few in there for my State, too. I think those sometimes are the grease that makes good legislation move forward, but alone they are not enough to carry a bill, alone they are not enough to justify a bill.

Some of the bad things contained in this bill, as well as some of the things that are so missing from this bill, make a complete case against the bill.

To me, the two things that are in the bill that should not be, more than anything else, are the ethanol provisions and the MTBE provisions.

On the ethanol provisions, I would say this to my colleagues: We do have to find a substitute for MTBE. We do have to keep our air clean. And ethanol is a good way to do it. I am not against ethanol per se. What I am against is mandating ethanol for every region in the country whether it fits or not. Ethanol would be a good standard to meet the oxygenate requirements in areas where there is abundant corn and abundant ethanol manufacturing facilities. But in many regions of the country, particularly on the coasts, there is not. And there are better ways to meet the clean air standards.

Refiners in my area say that by changing the blend and changing the method of refining, they can do just that without ethanol. And they will do that to meet the oxygenate clean air standards. But this bill has the nerve—that is the only way you can put it—to require them to buy ethanol anyway or at least buy ethanol credits. I have never quite seen anything like it.

Ethanol is a very subsidized product with many different types of advantages. Corn growers get all sorts of subsidies. I am not against those subsidies. I think we need to have a farming community. And just as we need dairy farmers in New York, we need corn growers in the Midwest and other places. But I wouldn't dare require people in the Midwest to buy some kind of dairy product made in New York for some other purpose. I might subsidize the product and say: Go out in the free market and make it work. But I wouldn't force them to do it. This goes a step beyond anything we have ever done in this Chamber.

If we wanted to help the corn growers and we are not helping them enough through the Agriculture bill, then let the Government do it. But the ethanol bill says to the traveling salesmen in upstate New York: You are going to do it. It will raise the price of gasoline 4 to 10 cents a gallon in my area.

How can anyone in this Chamber ask those of us from the Northeast and the West to impose that kind of gas tax on our constituents? It is just unfair. It is just wrong. I, for one, resent it. Again, if you want to subsidize the corn growers, do it. But not in this inefficient, unfair, regionally slanted way. Therefore, I very much oppose the ethanol provision.

My folks can't afford another 4 to 10 cents a gallon, likely to be 7 or 8 cents a gallon. Gasoline is high enough. We should be doing things to lower the price of gasoline. In that one fell swoop, all the good in terms of trying to produce alternative fuels will be undone.

Probably even worse in terms of its egregiousness, in terms of its arrogance, in terms of its nerve, its gall, is the MTBE provision. Parenthetically, I say to my friend from Ohio who said it doesn't stop lawsuits, it certainly does. It doesn't stop lawsuits if the little gas station on the corner was negligent. But if you have lost your home to MTBEs, you are not going to get anything out of that little gas station.

We know the only way that homeowners are going to get recompense here. It is through the oil companies, the producers of MTBEs. And those suits are prohibited.

So it is small comfort to the thousands of citizens in Fort Montgomery or in Hyde Park or in Plainview, NY, different communities in different parts of our State who have lost use of water in their home.

This is not just some environmental fetish. I have visited these homes. I feel for these people. Every time your child wants a bath or shower, you have to get in the car and drive a mile. You must use bottled water. For most of the people I know—these are middle class people, not rich people—the value of their home has been it. All they have been able to do is save for their home, and it is gone.

Now you say: Well, we are just going after the oil companies because they have deep pockets. Bunk. The bottom line is, the oil companies knew, the producers knew this was harmful. And here is the rub: They didn't tell a soul. It is not simply that they didn't produce it, but they didn't tell a soul. When they sold the gasoline with MTBE to the gas station down the street, they didn't say: Be careful. They didn't say: If you sit on top of an aquifer or a well, maybe you shouldn't use it. They didn't say: Make sure your tanks don't have leaks because this is dangerous stuff if it leaks into the water. They didn't say any of that.

Had the oil companies, the MTBE producers, come clean and let people know that this might be harmful and that they ought to take remediation the minute there is a spill and deal with prevention so there wouldn't be spills, we would not be asking that they be sued.

The analogy is to the cigarette industry in the sense not that the product was harmful, not even that people might have known it was harmful—that is probably true in each case—but, rather, that it was kept secret. It was concealed. People didn't have the ability, the choice, to prevent the harm from occurring.

The suits have been successful. My friend from Ohio just mentioned the suit in Santa Monica. Hundreds and hundreds of suits like that will be stopped if we pass this legislation.

I wish every one of my colleagues had come with me to Fort Montgomery, a little community in the hills overlooking the Hudson, a few miles south of West Point. The people there are mostly retired soldiers, not generals, rather, they are captains and majors and sergeants. It is a modest community. They worked hard for their country and they served their country. All they have is these little homes. And look at their faces. They all gathered one fall afternoon on someone's front lawn and talked to me. They are lovely people. They said: We don't want any money; we are not suing for money.

This isn't one of these lawsuits where they say, "Give us millions of dollars," and claim some alleged damage. I don't like those lawsuits. In fact, right now we are trying to put together a class action bill that would make the lawsuits fairer. But the lawsuits were their recourse. The oil companies were beginning to negotiate with them, either to put filters on their water or to help build a new system.

If this bill passes, these people will have two terrible choices: Sell their home at maybe the half the value it was a few years back before MTBE leached into their water supply, or spend thousands and thousands and thousands of dollars each year, each taxpayer, to build a whole water system.

Who is more to blame? The company that produced the MTBE and didn't tell people it was harmful, although they knew it, or these majors and sergeants and captains who served their country for years and have lost just about everything they have had?

That story can be repeated in many parts of New York and many parts of California and many parts of New Hampshire and many parts of Iowa and many parts of America. We should not allow it to happen.

As I said, I am not the leading advocate on our side of the aisle of lawsuits as a solution to everything. I would much rather see government regulation than lawsuits. But if there was ever a situation where lawsuits are justified, it is here.

What is infuriating is we are giving the MTBE industry $2 billion for closing. My friend talked about the money for LIHEAP. It is good that it is in the bill, but it is an authorization. Every time we do the appropriations bill, we don't come close to the authorization level. That is not real money. Put that $2 billion into LIHEAP, real money. But here we are, instead, giving it to the MTBE producers for closing down.

Do we give money to the little drycleaner shop that has to close down even though the blood and sweat and tears of the person who ran it are real? Do we give money to other businesses that have closed down, the thousands in my State, because maybe our country has not done enough to defend them from unfair trade practices? No. But not only do we give this industry $2 billion as recompense for closing down, but then we protect them from liability. This bill chooses those companies over tens of thousands of innocent homeowners. It is an egregious decision, and it shall not pass—if we have anything to do with it.

Those two provisions are at the top of my list as the most egregious in the bill. I will tell you what bothers me just about as much. It is not just what is in the bill, it is what is not in the bill. As everybody who has come to the floor to speak has said, we need an energy policy in America. This bill is a hodgepodge of little things, without much of an energy policy. It is a stitching together of a coalition of individual ideas. I like the tax deductions for the renewables. The reliability provisions don't go far enough, as far as I am concerned, but at least there is a step forward there. But there is no real energy policy.

Mr. President, 9/11 showed us many things, and one thing it showed us is that we have to be independent of Middle Eastern oil. The best and quickest way to do that is by some measure of conservation, and it is MIA in this bill. When China can pass CAFE standards more significant, more stringent than our own, this country is headed for a fall. If we cannot tighten our belts now, before there is a crisis, then something is wrong with the way our country is governing itself. Yet there is virtually nothing in terms of oil independence and conservation. Even the rather modest provisions that the Senator from Louisiana put in the Senate bill are gone. Again, on issue after issue, that occurred—issue after issue after issue.

There is no real conservation measures, at a time when we cry out. If you ask experts what is most needed in terms of our energy policy, it is conservation. We can increase production, and we can try to do experiments with coal or nuclear or hydrogen or whatever you want, but those are 10, 15 years down the road. We can talk about the timetables. I disagree with my friend from Ohio on that. The quickest way to do it is by conservation. We are not doing it.

Then we have the blackout in the Northeast. It cried out for a national grid to make our electricity system like our highway system, where the Government has direct and fairly strict oversight of the means of transportation—in one case of cars, and in another of electricity. And we do the most modest of steps—after we got a huge warning.

The report yesterday showed how little oversight there is, how little coordination there is. One energy company in Ohio and one voluntary organization in part of Ohio dropped the ball. My view is simple. This ought to all be done not by the electricity companies, which have a dramatic interest against spending the money to make the transmission wires work because that is not where they want to make money. It is not a cost that brings them a big rate of return. We should turn that over to FERC and let them set the standards and require the companies to meet it.

This bill doesn't come close to that. Once again, a shot across the bow, so close to us, and we do virtually nothing. The special interests—the Southeast doesn't want to be part of a national grid. Fine. They don't want to give up any rights or be governed by rules that might be good for the common good. Fine. The grid provisions here, better than much of the bill, leave so much to be desired and are emblematic of this bill. The special interests say jump and the bill says, How high? No energy policy. And the same with the problems we have had with deregulation and the sale of electricity out in California and in the West. I am not an expert on that, but my colleagues from California and Washington State have talked about that. We are MIA.

So instead of a coherent energy policy, which the times cry out for, we have a mishmash of goodies, of nods in the direction of the best parts of the bill, and away from some very bad things that hurt many parts of our country.

It is no wonder, Mr. President, that editorial pages across the country have condemned this bill in a way we have not seen in a long time. There is virtually no division. Frankly, I have not seen one article, one editorial—I have probably missed it—that defends this bill. The New York Times—probably the leading liberal editorial page—and the Wall Street Journal—the leading conservative editorial page—I think on the same day said, "Don't vote for this bill." And they are joined by about everybody in between. That is not just the media ranting and raving and not understanding the realities, or being too much in their ivory tower, or on their high horse, which I will be the first to admit happens all the time. That is because there is something wrong with this bill.

So it is my view that we are better off going back to the drawing board, open up the process, include the ranking member from New Mexico of the committee, and include the members of the committee, debate the bill even if it takes a few weeks. I guarantee you that we will get a much better bill.

This bill is an overall negative for what it contains and for what it doesn't. We can and must do a lot better. If we defeat cloture tomorrow, we will.

I yield the floor and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

MORNING BUSINESS

Mr. FRIST. Mr. President, I ask unanimous consent that there now be a period for morning business with Senators permitted to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

REGARDING SOUTH AFRICA'S NEW HIV/AIDS POLICY

Mr. DASCHLE. Mr. President. I rise to express my strong support for a decision taken over the last several days in South Africa.

On Wednesday, South Africa's cabinet approved a plan for government-sponsored HIV/AIDS treatment programs. Though late in coming, the decision had to be received as good news by South Africa's five million people infected with HIV. In a country where 600 people a day die of complications from AIDS, this is a life-saving announcement.

Many of us feared we might not ever see this day. In August 2002, I sat with President Mbeki in Pretoria. His response to the AIDS crisis in his country was disheartening, even disconcerting. But he and his government have come a long way.

We must be sure that we do our part now, Mr. President. I gather that the Foreign Operations and Labor-HHS conferences have agreed to provide $2.4 billion in global AIDS funding for FY 04. That is welcome and positive news. But it is still less than we promised the world, and given that 16,000 people a day contract this deadly virus we cannot afford to break that promise again next year.

We will also have to take a look at the assumptions that are underlying our current AIDS policy. The President laid out an ambitious emergency AIDS program for the 14 countries hit hardest by this virus. With a robust prevention and treatment program coupled with aggressive recruitment, training and retention of qualified medical personnel, we will make a difference in those countries.

But this pandemic is moving. While we act aggressively in these 14 countries, we cannot afford to maintain just the status quo in the countries who are threatened with the next wave of this crisis. Recent studies in India suggest that the epidemic in that one country could match if not overwhelm the suffering we have already seen in Africa. In China, government mismanagement and poverty are contributing to an acceleration of the pandemic, and eastern Europe and Russia are seeing alarming rates of infection that threaten to overwhelm the weak health care infrastructures in those tenuous democracies.

This is a huge challenge. We have begun to take some important steps to address it, but we are a long way from done.

TRIBUTE TO UNIVERSITY OF LOUISVILLE ATHLETIC DIRECTOR TOM JURICH

Mr. McCONNELL. Mr. President, November 5, 2003, brought many reasons for celebration in Kentucky. First, my friend, Ernie Fletcher was celebrating his victory in the gubernatorial election, making him the first Republican to hold that office in 32 years. The same day, the University of Louisville, my alma mater, was celebrating its acceptance into the Big East Conference. On that day, my local paper, The Courier-Journal, highlighted both of these achievements on the front page—a great day to be a Republican and a Cardinal.

The man who orchestrated U of L's rise to the Big East is my friend, Tom Jurich, the university's athletic director. Since his arrival in 1997, Tom has worked diligently to improve Louisville's athletic department. In recent years, he has hired two outstanding coaches, football coach Bobby Petrino and basketball coach Rick Pitino. He also has secured U of L's place as one of the top athletic programs in the country. Tom's hard work and dedication should be commended.

I close by quoting Tom from the November 5, 2003 edition of The Courier-Journal. He said:

> It's a wonderful day to be a U of L fan. And it's a wonderful day to be a Cardinal student-athlete. But it's a hell of a great day to be the athletic director at the University of Louisville. This has been a six-year work in progress This puts us on a level playing field.

This U of L alum is one happy fan, and I thank my friend for all he has done for the University of Louisville Athletic Department. I ask unanimous consent that the following article from The Courier-Journal be printed in the CONGRESSIONAL RECORD to document this historic day: "Under Tom Jurich, Louisville's star has risen in the East."

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Courier-Journal, Nov. 5, 2003]

UNDER TOM JURICH, LOUISVILLE'S STAR HAS RISEN IN THE EAST

(By Pat Forde)

At 10 o'clock yesterday morning, a wrinkled Big East Conference banner was stretched across a table in Kenny Klein's office at the University of Louisville.

The worst-kept secret in college athletics was literally—and finally—on the table. Welcome to a banner day on Planet Red.

Klein, the associate athletic director for media relations, is in his 21st year at U of L. He has been a loyal soldier through the glory and the gory—from an NCAA championship to NCAA probation, from the Fiesta Bowl to 1–10. He ranks yesterday among his very proudest days on the job.

"For the whole, encompassing factor of the athletic department and university, it's as big as anything we've done," Klein said. "We're poised to make an absolute leap, I think.

"It's really neat because you work so hard to build something, a total department, and to see it come to fruition is just a great feeling. Until now you've had that little stigma, even though we knew we can compete. The stigma's gone."

After six years of unwavering effort by athletic director Tom Jurich, the stigma is gone. After some of the most skillful, steely and inspired personnel moves in recent college sports history reinvigorated football and men's basketball, the stigma is gone. After a committed campaign to improve U of L's shady NCAA-compliance image, low-budget facilities and neglected non-revenue sports, the stigma is gone.

The news that U of L will leave Conference USA in 2005 (at the latest) for the Big East did not pack the focused emotional wallop of beating UCLA in Indianapolis in 1980, Kentucky in Knoxville in '83, Duke in Dallas in '86 or Alabama in Tempe in '91. But those were ephemeral moments, followed (eventually) by hard times. This victory could have a permanent effect on exposure, recruiting, finances and winning—if the Bowl Championship Series situation works itself out.

That's a significant "if," but Jurich expressed confidence that the new Big East won't lose its place at the big table. And if there is one thing Cards fans have learned to do, it's to trust Jurich's vision.

"He really had to change the culture for six years to make this happen," said senior associate athletic director Julie Hermann. "This is a benchmark, a defining moment."

The defining moments keep piling up for Jurich. The man who hired John L. Smith, Rick Pitino and Bobby Petrino now has brought the entire athletic department up to a level it has strived to reach forever.

Jurich took over on Oct. 21, 1997. Yesterday he jokingly said his first call to Big East headquarters came the following day. In reality he took a few months getting a grip on the U of L program, then put in a call to see where the Cardinals stood.

"It fell on deaf ears," he said.

There is a cure for deafness: persistence, a plan and the power of Pitino.

"We just kept at it and kept at it," Jurich said. "And when we got Rick, I think the possibilities became a lot clearer."

The possibilities could become crystal-clear probabilities by 2005. Pitino is pointing for a Final Four-level season in 2004–05 and could move the Cards immediately to the top of a 16-team Big East megaheap. Football coach Bobby Petrino will be in his third year, with a number of today's young talents in starring roles. If the non-revenue sports step up—most notably women's basketball—U of L could enter the Big East on a serious roll.

The trajectory of Louisville's climb grew steeper in recent years, but the gradual ascent began decades before. This is a school that once was a member of the Ohio Valley Conference, just another regional athletic program in a state owned by Big Blue. This is a school that once gave away football tickets with a tank of gas at convenience stores, a school that once had non-revenue facilities that would embarrass some high schools.

"It's been a slow progression, but this is a great day for the athletic department," U of L trustee and 1970s basketball hero Junior Bridgeman said. "It's not a culmination, just the next step. But it's a great time, and everyone should share in the joy."

Said Charlie Tyra, a basketball star from the 1950s: "This is another step in the direction they want to get. Hopefully, this is the big step."

It's big enough to say that Louisville is now officially Big. Big enough for the Big East. Big enough for the big boys of college athletics. Big enough to have something Big Brother in Lexington lacks: membership in what will be the best basketball conference going.

This is a league big enough to find on every map. Trips to Hattiesburg, Birmingham and Greenville are out. Philadelphia, Washington and the Big Apple are in.

It's big enough to find every March. As recently as 1994, Louisville was playing in the Metro Conference Tournament in the Mississippi Coast Coliseum in Biloxi. Now it has signed on to play its league tourney on the most famous hardwood in the world at Madison Square Garden.

It's big enough to keep a football coach happy. U of L lost the two best it ever had—Howard Schnellenberger and John L. Smith—because of conference affiliation. Today Petrino, a star-in-the-making, believes he has everything he needs to chase what had been unattainable: a national championship.

Schnellenberger, Denny Crum and Bill Olsen vaulted Louisville athletics forward dramatically in the 1980s and early '90s. That shouldn't be forgotten today when measuring how far the Cards have come. But by the time Jurich arrived, the school's isolationist athletic stance had outlived its usefulness.

As the conference landscape had begun to change, U of L hadn't changed with it. Hogging TV and postseason revenue and pipe-dreaming of football independent status wasn't helping make the Cards an attractive modern program. In fact, it nearly cost them membership in C–USA at a time when, as Jurich pointed out, "Louisville needed Conference USA much more than Conference USA needed Louisville."

Today Louisville is easily the most vibrant, viable and attractive school in the league. And in 2005 it will commence aiming even higher.

You want billboard material? You've got it. Louisville might not be the Best College Sports Town in America, but it's a better one today than it ever has been.

Before the official announcement yesterday, Klein stood at a podium in the U of L football complex, preparing to make introductions. Someone flipped a switch, and behind him a projection screen rolled up.

Behind the screen was the Big East banner that had been sitting on the table in his office earlier in the day. The symbolic wrinkles had been ironed out. And as the screen rolled up, Klein couldn't help but smile.

TRIBUTE TO MONA VANNATTER

Mr. McCONNELL. Mr. President, I rise today to honor Mona Vannatter. On December 31, 2003, Mona will be retiring after 20 years of service at the Kentucky Rural Development State Office.

Raised in Anderson, IN, Mona graduated from Ball State University with an associate's degree. However, in 1978, she moved to the Bluegrass State with her husband, Steve, and their two daughters, Kristi and Sheri. Though a Hoosier by birth, Mona is a Wildcat at heart.

In 1983, Mona became the secretary to the State director of the Kentucky Rural Development State Office. Since that time, she has proven to be a dedicated and talented employee. Her colleagues praise her as a wonderful representative of the office who genuinely cares about the Kentuckians with whom she interacts. In 2003, Mona was recognized for exemplary performance as secretary to the State director. For the past several years, she has also donated her time and energy to coordinating the United Way Combined Federal Campaign for the agency and successfully reaching the Rural Department goals.

Mona brings the same enthusiasm and energy to her life outside of work. An active member of Broadway Christian Church, Mona served as secretary for her Sunday school class and co-coordinator for God's Pantry. She taught a self-improvement class at the Women's Federal Prison Camp, bringing a positive influence and an optimistic outlook to those who need it most.

For two decades, she has been a dedicated employee of the Kentucky Rural Development State Office. Mona continually proves to be a positive influence in both her workplace and her community. I ask each of my colleagues to join me in thanking Mona Vannatter for all that she has done for her community, the commonwealth of Kentucky, and this great Nation.

HONORING OUR ARMED FORCES

Mr. GRASSLEY. Mr. President, I rise today in honor of a fellow Iowan and a great American, CWO4 Bruce A. Smith, who recently gave his life in service to his country as a pilot in Operation Iraqi Freedom. Chief Warrant Officer Smith was killed on November 2, 2003, after his helicopter was attacked by a surface-to-air missile 40 miles west of Baghdad in central Iraq. He is survived by his wife Oliva, his 15-year-old daughter Savannah, his 12-year-old son Nathan, his sisters Carol and Brenda, and his brother Brian, as well as numerous other family members, friends, and loved ones. Our deepest sympathies go out to the members of Chief Warrant Officer Smith's family and to all those who have been touched by his untimely passing.

Our Nation's strength resides in the hearts of the men and the women who serve in its defense. The liberties we prize and the freedoms we cherish would not exist if it were not for those who courageously risk their lives while serving in our Nation's Armed Forces. Although our history books are filled with the names of those great patriots whose actions defined our Nation's founding, and although we stand in awe of our fathers and our grandfathers for the heroism they displayed during the great wars of the 20th century, from time to time we are reminded that men and women of such stature can still be found defending our Nation and our way of life.

Today, we pay tribute to one such man, CWO4 Bruce A. Smith. Chief Warrant Officer Smith enlisted in the Iowa Army National Guard as a senior in high school, serving his Nation with distinction for more than 23 years, first as a medic and then as a pilot, before losing his life in Iraq. Chief Warrant Officer Smith's exemplary career in the National Guard, his commitment to his family, and his sense of duty attest to his character as an outstanding American.

As I stand before you today to honor a fallen patriot, I would also like to use this opportunity to extend my deepest sympathies to Chief Warrant Officer Smith's loved ones. While we share their grief, we cannot possibly fully understand their sense of loss. We owe them a debt that can never be repaid and I know they will be in the thoughts and prayers of many Americans

CWO4 Bruce A. Smith has entered the ranks of our Nation's great patriots, and his courage, his dedication to duty, and his sacrifice are all testaments to his status as a true American hero. Let us always remember Chief Warrant Officer Smith's service to our Nation.

I also speak today in honor of a fellow Iowan and a great American, SGT Paul F. "Ringo" Fisher, who recently gave his life in service to his country as part of Operation Iraqi Freedom. On November 2, 2003, the helicopter in which Sergeant Fisher was riding was forced to make a crash landing about

40 miles west of Baghdad after being struck by a shoulder-fired missile. Sergeant Fisher sustained multiple injuries in the crash, which ultimately led to his death 4 days later on November 6, 2003, at the Homburg University Klinikum in Homburg, Germany. Sergeant Fisher is survived by his wife Karen, his stepson Jason, his mother Mary, his sister Brenda, and his brother David, as well as numerous other family members, friends, and loved ones.

I ask my colleagues in the Senate and my fellow citizens across our great Nation to join me today in paying tribute to Sergeant Fisher for his bravery, for his dedication to the cause of freedom, and for his sacrifice in defense of the liberties we all so dearly prize. The selflessness of a soldier is unmatched in the history of human endeavors, and mankind knows no greater act of courage than that displayed by the individual upon sacrificing his life for his countrymen, their liberty, and their way of life.

Although we honor Sergeant Fisher as a fallen patriot, we must also pay special tribute to his loved ones whose grief we share, but whose sense of loss we cannot possibly fully understand. My deepest sympathy goes out to the members of Sergeant Fisher's family, to his friends, and to all those who have been touched by his untimely passing. Although there is nothing I can offer that will ever compensate for their loss, I hope they will find some comfort in the thoughts and prayers of a grateful Nation who will be forever in their debt.

Our national history is filled with ordinary men and women who sacrificed their lives in service to our country. An avid student of history, Sergeant Fisher enjoyed learning about the heroes who preceded him, especially those who brought our Nation through the great wars of the 20th century. It is thus with great solemnity that we today pay tribute to SGT Paul F. "Ringo" Fisher, who has himself attained heroic status, having joined the ranks of our Nation's greatest patriots and history's most courageous souls.

SENATOR ROBERT C. BYRD, FDR, FREEDOM FROM FEAR, AND COURTING YOUR GIRL WITH ANOTHER BOY'S BUBBLE GUM

Mr. KENNEDY. Mr. President, it is an honor to take the floor now to join all Senators on both sides of the aisle in extending our warmest birthday wishes to the Senator who in so many ways is respected as Mr. United States Senate by us all, our friend and eminent colleague from the State of West Virginia, Senator ROBERT C. BYRD.

Senator BYRD is 86 years young today, with the emphasis on "young," because he truly is young in the same best sense we regard our Nation itself as young, inspiring each new generation to uphold its fundamental ideals of freedom and opportunities and justice for all.

Senator BYRD's personal story is the very essence of the American dream, born to a hard life in the coal mines of West Virginia, rising to the high position of majority leader, a copy of the Constitution in his pocket and in his heart, insisting with great eloquence and equally great determination, day in and day out, year in and year out, that the Senate, our Senate, live up to the ideals and responsibilities that those who created the Senate gave us. Washington, Adams, Jefferson, Madison, Franklin, Webster, Clay, Calhoun—they each live on today in Senator ROBERT BYRD, and they would be proud of all he has done in our day and generation to make the Senate the Senate it is intended to be.

On a personal note, I am always very touched on this day in remembering the unusual coincidence that Senator BYRD was born on the same day as my brother Robert Kennedy and in the same year as my brother, President Kennedy, and was married on President Kennedy's birthday.

In the many years we have served together, he has taught me many things about the Senate, especially how to count votes. He did me one of the biggest favors of my life, although I did not feel that way at the time. On that occasion over 30 years ago, we were each certain we had a majority of democratic votes. We couldn't both be right, and Senator BYRD was right. All these years later, like so many others among us, I still learn from his eloquence whenever he takes the floor and reminds the Senate to be more vigilant about living up to our constitutional trust.

Senator BYRD has received many honors in his brilliant career, and the honor he received last Saturday in Hyde Park in New York was among the highest. He was honored with The Freedom from Fear Award by The Franklin and Eleanor Roosevelt Institute. The award is named for one of the Four Freedoms—freedom of speech, freedom of worship, freedom from want, and freedom from fear—in President Roosevelt's famous State of the Union Address to Congress in 1942, a few weeks after the Second World War began. The award also harks back to FDR's First Inaugural Address in 1933, in which he rallied the Nation from the depths of the Great Depression with the famous words, "The only thing we have to fear is fear itself."

In his address accepting the award, Senator BYRD emphasized the importance of renewing our dedication to the Nation's ideals in the very difficult times we face today, when the temptations are so great once again to put aside our freedoms in order to safeguard our security. As Senator Byrd said so eloquently, in a lesson each of us should hear and heed:

> Carry high the banner of this Republic, else we fall into the traps of censorship and repression. The darkness of fear must never be allowed to extinguish the precious light of liberty.

Senator BYRD's address in Hyde Park also contains a very beautiful and moving passage about the person who has been his lifelong best friend and strongest supporter all through these years, the coal miner's daughter he married 66 years ago, his wife Erma.

I wish them both many, many happy returns on this special day, and I ask unanimous consent that Senator BYRD's extraordinary address on receiving the Roosevelt "Freedom from Fear" Award be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

COURAGE FROM CONVICTION

I thank Ann Roosevelt and William "Bill" vanden Heuvel (the Great!) and the Board of the Roosevelt Institute for this distinct, unique honor. I also thank my colleague, a colleague sui generis. Yes, Senator Hillary Clinton came to my office and she said that she wanted to be a good senator. And she said, "How shall I do it? How shall I go about it? I want to work for the people of New York. I want to be a good senator." And I did say, "Be a work horse, not a show horse." She took that to heart, and she has been a fine senator. She has never forgotten that admonition. She has been a good senator and I am delighted to be here in her state this morning. This is an extraordinary award, for which she recommended me so graciously.

I am humbled to be deemed a practitioner of President Roosevelt's great vision. I am proud to be associated once again with my friend and quondam colleague, former Senator and Senate Majority Leader George Mitchell. Ah, what a shame, as we have witnessed the lowering of the Senate's standards. And how proud I would be to be able to vote for a great federal judge to grace the Supreme Court of the United States, George Mitchell. I would have no doubt that he would honor this Constitution of the United States of America. And I hope that, I trust that, the Great Physician, the Great Lawgiver, might bless me so that I might live to see that day.

I congratulate the other exceptional laureates, and I am proud to be their colleague. I am proud to be numbered with the previous Four Freedom recipients.

Franklin Delano Roosevelt—ah, the voice! I can hear it. I can hear it yet as it wafted its way through the valleys, up the creeks and down the hollows in the coal camps of Southern West Virginia. That voice—there was nothing like it. Franklin Roosevelt was a man of tremendous courage. A leader of uncommon vision and optimism. An orator of compelling passion. He looms large, oh so large, in my boyhood memory. I grew up in the home a of coal miner. I married a coal miner's daughter. I thank her today for her guidance, her advice, her constant confidence in me that she has always shown.

Studs (Terkel), I tell you how I won the hand of that coal miner's daughter some 66 years ago. We had in my high school class a lad named Julius Takach. He was of a Hungarian family. His father owned a little store down in Cooktown, about 4 miles from

Stotesbury, where I grew up. And each morning, Julius Takach would come to school with his pockets full of candy and chewing gum from his ~~father's~~ store's shelves. I always made it my business to greet Julius Takach at the schoolhouse door upon his arrival! And he would give me some of that candy and chewing gum. I never ate the candy. I never chewed the chewing gum. I proudly walked the halls of Mark Twain High School to see my sweetheart as the classes changed, and I gave her that candy and chewing gum. Now do you think I told her that Julius Takach gave me that candy and that chewing gum? Why, no! Studs, that's how you court your girl with another boy's bubble gum!

The stock market crashed in October 1929. I was 12 years old. I had $7 that I had saved up selling the Cincinnati Post. I had that $7 in the bank at Matoaka, West Virginia. The bank went under, and I haven't seen my $7 since. I struggled to find my first job working at a gas station during the Great Depression. I was 24 when the Japanese bombed Pearl Harbor.

I can remember the voice of President Roosevelt on the radio in those days. His voice carried over the crackle and static of my family's old Philco set. President Roosevelt understood the nation. He understood its history. He understood its character, its ethos. He understood the Constitution. He respected the Constitution.

In Marietta, Ohio, in 1938, President Franklin Delano Roosevelt said: "Let us not be afraid to help each other—let us never forget that government is ourselves and not an alien power over us. The ultimate rulers of our democracy are not a President and senators and congressmen and government officials, but the voters of this country." President Roosevelt was right.

Especially in these days, when we find ourselves in dangerous waters, I remind the nation of President's Roosevelt's charge: the government is ourselves. I have called on my colleagues in Congress to stand as the Framers intended.

I saw them tearing a building down
A group of men in a busy town
With a "Ho, Heave, Ho" and a lusty yell
They swung a beam and the sidewall fell.

I said to the foreman, "Are these men skilled?
The type you would hire if you had to build?"
He laughed, and then he said, "No indeed,
Just common labor is all I need;
I can easily wreck in a day or two,
That which takes builders years to do."

I said to myself as I walked away,
"Which of these roles am I trying to play?
Am I a builder who works with care,
Building my life by the rule and square?
Am I shaping my deeds by a well-laid plan,
Patiently building the best I can?
Or am I a wrecker who walks the town
Content with the labor of tearing down?"

That's what we see today. I call on my colleagues to stand as the Framers intended, as a check against an overreaching executive. I have urged the people of America to awaken to what is happening and to speak out against those who would tear down the fabric of Constitutional liberty. To speak out, for it is the duty of each citizen to be vigilant to what his or her government is doing, and to be critical, if need be. It is not unpatriotic to speak out. It is not unpatriotic to ask questions. It is not unpatriotic to disagree. Speak out, lest the right of dissent, the right to disagree, be trampled underfoot by misguided zealotry and extreme partisanship.

I have been in Congress now close to 51 years, longer than any other person—out of 11,707 individual persons who have served in the House or Senate or both—with the exception of two. And I have never seen such extreme partisanship; such bitter partisanship; such forgetfulness of the faith of our fathers, and of the Constitution. Never have I seen the equal of what I have seen in these last three years.

But let us not fear. The individual mind remains an unassailable force. The individual voice can inspire other to act. A single act of bravery can lead an army against great odds. At a time when dissent is labeled unpatriotic, the strength of a single individual can give hope to the hopeless, voice to the voiceless, power to the powerless.

"The iron will of one stout heart shall make a thousand quail. A feeble dwarf, dauntlessly resolved, will return the tide of battle, and rally to nobler strife the giants that had fled (Martin F. Tupper, 1810–1889)."

During these troubled times, the legacy of Franklin Eleanor Roosevelt is not forgotten. Again, I thank Ann Roosevelt and the inimitable William vanden Heuvel (the Great!), and the Board of the Roosevelt Institute for this great honor. I thank again my protege in whom I have great pride, Senator Hillary Clinton. And I thank each of you here this morning. This day has inspired me to carry on with new energy.

I close with words from President Roosevelt's first inaugural address: "[T]he only thing we have to fear is fear itself—nameless, unreasoning, unjustified terror which paralyzes needed efforts to convert retreat into advance."

If I may be so bold as to add, let us take courage from conviction. Carry high the banner of this Republic, else we fall into the trap of censorship and repression. The darkness of fear must never be allowed to extinguish the precious light of liberty.

May we remember the words of the Scripture (Proverbs 22:28): "Remove not the ancient landmark, which thy fathers have set."

EXPANSION OF NATIONAL SECURITY LETTER AUTHORITY IN INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 2004

Mr. LEAHY. Mr. President, yesterday saw passage of yet another example of this Administration's secret efforts to further expand secret powers of the FBI. The FBI can now use National Security Letters, NSLs, which do not require approval by a court, grand jury, or prosecuting attorney, to demand confidential financial records from car dealers, pawn brokers, travel and real estate agents, and other businesses, and to prohibit the business from disclosing that the records have been sought or obtained.

There is no requirement that the FBI demonstrate a need for such records. It need only assert that the records are "sought for" an intelligence or terrorism investigation. Nor are there sufficient limits on what the FBI may do with the records or how it must store them. For example, information obtained through NSLs may be stored electronically and used for large-scale data mining operations.

Congress last expanded the FBI's NSL authority in October 2001, as part of the comprehensive antiterrorism package known as the USA PATRIOT Act. Incredibly, the Intelligence Committee forced passage of this latest expansion without consulting the Judiciary Committee, which oversees both the FBI and the implementation of the PATRIOT Act. Indeed, the Committee is in the midst of holding a series of oversight hearings on the PATRIOT Act, including the very provision that has now been significantly modified.

What is even more incredible is the fact that this very provision is the target of sunset legislation that I and other members of the Judiciary Committee, both Democratic and Republican, have introduced. There is no doubt that we would have meaningfully and thoroughly explored further expansion of the NSL authority had we been given the opportunity to do so.

This is what the new law has done. Under the PATRIOT Act, the FBI was permitted to use NSLs to obtain records from banks and other similar financial institutions if they were "sought for" an intelligence or terrorism investigation. Now the term "financial institution" has been expanded to include a host of other businesses that have nothing to do with the business of banking, and the term "financial record" has been expanded to include any record held by any such business that pertains to a customer.

The FBI has long had the power to obtain this sort of information, whether through a judicial subpoena or a search warrant. But with the stealth amendment of the NSL authority, the FBI can now obtain a vast amount of personal and highly confidential information without obtaining court approval, and without any other independent check on the validity or scope of the inquiry. The privacy rights of all Americans have been compromised as a result.

LOCAL LAW ENFORCEMENT ACT OF 2003

Mr. SMITH. Mr. President, I rise today to speak about the need for hate crimes legislation. On May 1, 2003, Senator KENNEDY and I introduced the Local Law Enforcement Enhancement Act, a bill that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society.

Today marks the fifth annual Transgender Day of Remembrance and this year, we mourn with 37 families who lost their loved ones to antitransgender violence. My home State of Oregon has also lost a citizen to this form of hatred. In August 2001, Lorenzo "Loni" Okaruru died after being savagely beaten about the head and face with a blunt instrument. Detectives believe that the crime was most likely committed by a man who picked up Okaruru, who he thought was a women, and was angered to find out Okaruru was a biological male. Law enforcement officials believe that Okaruru was killed because of his sexual orientation and gender identity and have classified the crime as a hate crime. The Portland community and civil rights groups rallied together to denounce this horrible crime.

I believe that Government's first duty to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

CONSEQUENCES OF THE NO CHILD LEFT BEHIND ACT FOCUS ON STUDENT TESTING

Mr. FEINGOLD. Mr. President, this month public school students around Wisconsin are sharpening their No. 2 pencils and settling in to take a series of annual tests called the Wisconsin Knowledge and Concepts Examinations. These exams, given to students in grades four, eight, and ten, test students' knowledge of reading, language arts, math, science, and social studies.

These tests—and their results—have taken on new meaning for schools around my State as students and teachers in Wisconsin settle into their second school year under the No Child Left Behind Act. This law, the centerpiece of the President's domestic agenda, requires that students in grades three through eight and in one high school grade be tested annually in reading and math beginning in the 2005–2006 school year, with annual science tests to be added 2 years later. Thus, Wisconsin will be required to expand the WKCEs, and the already-existing annual third grade Wisconsin Reading Comprehension Test, to include new reading tests for students in grades five, six and seven; and new math tests for students in grades three, five, six, and seven.

As I travel around Wisconsin, I hear time and again from frustrated parents, teachers, administrators, and school board members about their concerns with the ongoing implementation of the NCLB. I began to hear such comments more than 2 years ago when the President first proposed his education initiative, and this drumbeat of concern has increased as my constituents continue to learn first-hand what this new law means for them and for their students and children. While Wisconsinites support holding schools accountable for results, they are concerned about the focus on standardized testing included in the President's approach.

I opposed the President's education bill in large part because of this new annual testing mandate. The comments I have heard from people across Wisconsin about this new program have been almost universally negative. Parents, teachers, administrators, and others in the education community have told me that they are concerned about the effect that over-testing will have on Wisconsin's public school students. They oppose another layer of federally mandated testing for many reasons, including the cost of developing and implementing the additional tests, the loss of teaching time every year to prepare for and take the tests, and the unnecessary pressure that these additional tests will place on students, teachers, schools, and school districts.

The pressure to do well on annual tests is already weighing on the teachers and schools in Wisconsin, even with 2 years to go before the additional tests are required. The stakes are very high for schools and school districts. The results on these annual tests are a central part of the complicated formula that determines whether a school is meeting or exceeding its "adequate yearly progress" goals. Failure to meet AYP goals in two or more consecutive years will lead to sanctions for the schools and districts in question. I have heard from many constituents about the complex AYP system, and what being determined to be a "school in need of improvement" or a school that "has not met AYP" will mean for—and how these designations will be interpreted by—parents, students, school personnel, and the general public.

In order to measure AYP, Wisconsin and other States are required under NCLB to look at four indicators for each school and district: test participation, graduation and attendance criteria, reading achievement, and math achievement. Three of these four criteria are based on the annual standardized tests. This is troubling because the future of individual schools and school districts is riding on student participation in and success on just two exams—reading and math. These core subjects are important, to be sure, but I am concerned that this exclusive focus on testing—which is a top-down mandate from the Federal Government—may be detrimental to the successful education of our children, who could benefit from a more flexible approach.

As a recent editorial in the La Crosse Tribune points out, "the stakes on the schools are high. Buy what about students? The test result doesn't appear on their transcript and it doesn't count toward a grade or graduation." And what if a student had a bad day? Or what if the required amount of students don't take the tests, and the school fails to meet the 95 percent participation rate required by the NCLB? A missed participation rate 2 years in a row would mean that the school is "in need of improvement," even if the students who took the tests did well on them.

In addition, some of my constituents are concerned about the value of these tests to students, parents, and teachers. According to one teacher, the existing tests don't have any meaning to students and have little meaning to classroom teachers. And the Federal Government has mandated that students take even more tests without developing a system that makes these new tests, or the existing ones for that matter, meaningful to students.

The impact of these standardized tests on students varies. Some students already have test anxiety and that anxiety may well increase unnecessarily. As the stakes increase for schools, the increased stress level is sure to filter down from administrators to teachers to students. For example, members of the Wisconsin School Counselors Association told me that they have been handing out apple-shaped "stress balls" for anxious third graders to squeeze while taking their reading tests.

While some students experience stress out about tests, others simply do not care about the tests at all, and fill in random answers or turn in blank test sheets—after all, there's no penalty if they do so. For students who are struggling, however, a low test score on a standardized test can be demoralizing. According to one Wisconsin teacher, "Students are being evaluated on one single test. What if the student has a bad day? . . . [T]he truly scary part is that standardized tests ensure that half of our students will always be 'below average.' How can we meet the benchmark that everyone will score proficient and advanced when the tests are designed to never let that happen? . . . Taking more tests is not going to improve learning."

Most students, of course, try their best. But they are confused about why they are taking tests that do not count toward their grades, and many students and parents are confused by the results of these tests.

With the stakes rising for schools and districts, some schools in Wisconsin have resorted to offering what amounts to bribes to encourage the students to participate in the WKCEs and to do well on them. Since the tests have little consequences for individual students, but very serious consequences for schools and districts, some schools are pulling out all of the stops to get students to take these tests seriously.

According to a recent article in the Milwaukee Journal Sentinel, some schools are offering prizes to students who show up and complete their exams. These prizes range from movie tickets to gift certificates for a local mall to big ticket items such as a television and a DVD player. Some schools are offering exemptions from end-of-semester exams for students who do well on the WKCEs. One elementary school is promising students additional recess periods, snacks, and movies. One teacher told my staff that her school is allowing students to engage in one of the ultimate school no-nos chewing gum in the classroom in order to help to relieve the stress of taking the tests.

I will ask that the complete text of the two articles that I have referenced be printed in the RECORD.

Mr. President, schools in my State are already feeling the pressure to compel students to participate in and succeed on annual tests 2 years before the additional, federally mandated tests are added to the mix. I am concerned about the implications that this pressure, and the resulting scramble to get students to take these tests seriously, will have on public education in my State. I am not saying that schools should not be required to be successful or to show improvement in student performance. Of course, all schools should strive to ensure that they are successful and that their students show improvement.

But these examples from my State are clear evidence of one of the basic problems with the NCLB—its exclusive focus on test scores as the main measure of student achievement. When schools feel compelled to hand out goodies to get students to take tests seriously, those tests are not serving their intended purpose. Certainly, tests have their place in education. But tests should be used as one of multiple measures of student achievement, not as the sole means of determining the success or failure of a school.

I am extremely concerned that the new Federal testing mandate will not achieve the desired result of better schools with qualified teachers and successful students. I fear that this new mandate will curtail actual teaching time and real learning in favor of an environment where teaching to the test becomes the norm. The unfortunate result of this would be to show our children that education is not about preparing for their futures, but rather about preparing for tests—that education is really about sharp No. 2 pencils and test sheets, about making sure that little round bubbles are filled in completely, and, if their school districts and States have enough money, maybe about exam booklets for short answer and essay questions. I am also deeply concerned that this focus on testing will rob teachers of valuable teaching time and will squelch efforts to be innovative and creative, both with lesson plans and with ways of measuring student performance.

For these reasons, earlier this year I introduced the Student Testing Flexibility Act, a bill that would return a measure of the local control that was taken from States and local school districts with the enactment of the NCLB. This bill would allow States and school districts that have demonstrated academic success for 2 consecutive years the flexibility to apply to waive the new annual testing requirements in the NCLB. States and school districts with waivers would still be required to administer high-quality tests to students in, at a minimum, reading or language arts and mathematics at least once in grades 3–5, 6–9, and 10–12 as required under the law.

This bill is cosponsored by Senators JEFFORDS, DAYTON, and LEAHY. I am pleased that this legislation is supported by the American Association of School Administrators; the National Education Association; National PTA; the National Association of Elementary School Principals; the National Association of Secondary School Principals; the School Social Work Association of America; the National Council of Teachers of English; the Wisconsin Department of Public Instruction; the Wisconsin Education Association Council; the Wisconsin Association of School Boards; the Milwaukee Teachers' Education Association; the Wisconsin School Social Workers Association; and the Wisconsin School Administrators Alliance, which includes the Association of Wisconsin School Administrators, the Wisconsin Association of School District Administrators, the Wisconsin Association of School Business Officials, and the Wisconsin Council for Administrators of Special Services.

I would also like to take a moment to discuss the recently released National Assessment on Educational Progress scores. In addition to a massive new annual testing requirement, the NCLB also requires States to participate in the previously voluntary NAEP tests for fourth grade reading and math, which are given every 2 years. Proponents of high-stakes testing argue that NAEP participation will help to ensure that the results of State-administered tests are valid, and that States are not "dumbing down" their tests in order to avoid Federal sanctions.

The NAEP scores that were released last week are the results of the first round of required testing under the NCLB, and, for the first time, include scores from all 50 States, the District of Columbia, and 2 schools run by the Department of Defense. While the nation-wide test results are an improvement over the NAEP administered 2 years ago, I am deeply concerned about the lingering racial disparities in the test results.

I am particularly concerned that the test scores for the approximately 25,000 Wisconsin eighth graders who took this test lead the Nation in the gap between White and African-American students on both the reading and the math tests. While the NAEP was taken by only a small percentage of students in my State and around the country, we cannot ignore the racial disparities in the test scores and the need to do more to ensure that all students have an equal opportunity for a quality education.

The Secretary of Education heralded the NAEP results, saying, "These results show that the education revolution that No Child Left Behind promised has begun." If these test scores prove anything, it is that too many children are being left behind. Study after study has shown that disadvantaged students lag behind their peers on standardized tests.

I regret that the President and the Congress have not done more to ensure that schools have the resources to help these students catch up with their peers before students are required to take additional annual tests that will have serious consequences for their schools. If we fail to provide adequate resources to these schools and these students, we run the risk of setting disadvantaged children up for failure on these tests—failure which could damage the self-esteem of our most vulnerable students.

Instead of focusing resources on those students and schools needing the most help, I am afraid that the testing provisions in the President's bill will punish those very schools with sanctions that will actually take badly needed funding away from them.

I would like to note that my constituents have raised a number of other concerns about the NCLB that I hope will be addressed by Congress. I continue to hear about complex guidelines and a lack of flexibility from the Department of Education. I hear about the unique challenges that the new tutoring, public school transfer, and other requirements pose for rural districts. My constituents often ask when the Federal Government is going to provide the funding it promised for education programs. I share my constituents' concern about imposing new sanctions on schools that do not meet yearly goals even though the programs that would help students and schools to meet those goals are not fully funded.

I will continue to monitor closely the implementation of the NCLB and its effect on public school students in Wisconsin.

I ask unanimous consent the articles to which I referred be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Milwaukee Journal Sentinel, Nov. 9, 2003]

TAKE A TEST, GET A PRIZE

(By Amy Hetzner)

Some day soon, teams of Case High School sophomores could be sitting in a Racine movie theater and thanking President Bush.

In an attempt to boost the number of students taking the State's standardized test this week, Case High School will be handing out movie passes to every 10th-grader who completes the battery of exams.

It's just one of many efforts, which include a TV giveaway at another school, to improve student performance and participation on the Wisconsin Knowledge and Concepts Examinations, or WKCEs.

In many Wisconsin schools, the testing began for fourth-, eighth- and 10th-graders last week and will continue until Nov. 21. The tests cover reading, language arts, mathematics, science and social studies.

If nothing else, the new incentives show the growing importance that President Bush's No Child Left Behind Act has placed on annual state testing.

If students slip up, they could cause their school to be labeled as needing improvement and sent on a path to escalating sanctions imposed by the Federal law. If, for example, less than 95% of students take the tests two years in a row, a school may have to allow students to transfer elsewhere.

But the students themselves have little incentive to put forward an effort. The exam doesn't count toward a grade or graduation and won't appear on any transcript.

As Larry Black, principal of Big Foot High School in Walworth, puts it: "For schools, they're high-stakes tests. For students, they're low stakes. . . . And that's a bad match."

ROLLING OUT THE REWARDS

To help surmount that obstacle and hopefully avoid being labeled for improvement, two Racine high schools are rolling out the rewards just to get students to take the tests.

In addition to free movie passes, Case students can qualify for $10 cash awards, Regency Mall gift certificates, school-spirit wear and other prizes—simply by showing up this week and answering the exam's questions.

At Racine's Horlick High School, the goodies are even bigger. The school is planning several raffles for each of the two days of testing this week, at which students can win a television set, DVD player and CDs, Principal Nola Starling-Ratliff said.

The incentives are geared to increase both schools' test participation rates, which last year fell below the required 95% of students.

Miss that goal for a second year and both schools would have to allow students to transfer to other district schools under the federal law. A third year of missing their target would force the schools to offer extra tutoring in math and reading.

The high schools facing the threat of sanctions aren't the only ones proffering perks this year, however.

Gifford Elementary School in Racine also dangled the prospect of an extra recess, movie privileges and anonymous treats before any fourth-grade class that had perfect attendance during the week of testing.

"It's made a huge difference," Gifford Principal Steve Russo said. "Every morning we talk about testing with the kids. We encourage them to do the best job, to take pride in their work."

CRITIC PANS REWARD SYSTEM

But Alfie Kohn, a national opponent of high-stakes testing, called such rewards "coercive" and "disrespectful" toward students. "Even if higher test scores were a good idea, you don't treat children like pets by dangling the equivalent of doggie biscuits before them when they perform to your liking," said Kohn, a Massachusetts-based author of the book, "Punished by Rewards."

School officials, however, say there's nothing wrong with giving students a little push.

Five years ago at Arrowhead High School in Waukesha County, test scores took a serious dip when about 80 sophomores refused to complete the exams, instead turning in blank forms in protest of a test they felt was meaningless. If a school's students were to do the same today, their action could have more serious consequences for their school in addition to giving it a public black eye.

"We never want to fall into the category where the school's 'in need of improvement' just because students didn't take the test seriously," said Arrowhead Superintendent David Lodes.

A REASON TO TRY

So this year, Arrowhead will give its students a reason not only to take the test but also to try.

The school is offering its students a chance to skip final semester examinations in their regular classes if they do well on their WKCEs—scoring at least at the proficient or advanced level in the subject area that corresponds with the class exam they want to avoid.

It's the first year Arrowhead High School has made such an offer, which has been announced to students but is still waiting for formal approval from the School Board.

Arrowhead students who do exceptionally well on the WKCE—scoring at the advanced level on all the tests—also will be allowed to spend their junior-year study hall classes in the senior commons in the pilot effort.

Other schools in the state offering exam exemptions include Big Foot High School, Hartford Union High School and Pulaski High School near Green Bay. Bay Port High School in the Howard-Suamico School District gives students a chance to drop a low-scoring test with a proficient score in the subject area.

"I think we should be able to come up with a way where we can get our students to give their best effort," Lodes said. "Everybody needs to do as best as they possibly can. Yet everybody wants to be rewarded."

Arrowhead students say they can see a difference.

"I'm actually trying a little harder now," said Zack Olson, a 15-year-old sophomore at Arrowhead, where testing began last week.

Previously, Olson said he might not have studied for the test at all. But with the lure of getting out of final exams and a nicer study hall environment, he said he's been doing the practice work that teachers have offered.

Another Arrowhead sophomore, Adam Moir, said he was even a little nervous the night before testing began because he wasn't sure what to expect.

He said a lot of students will be motivated to try to get out of their final exams. "But, in the same way, there are some students that could care less about school," Moir said. "I'm not one of them."

[From the La Crosse Tribune]

OUR VIEW: MAKE FEDERAL TESTING FIT WITH CURRICULUM

(By Tribune editorial staff)

Why are some school districts offering movie tickets and other prizes as an inducement to take the tests required under President Bush's "No Child Left Behind" law?

They are doing it because students have little incentive to participate in the testing, even though a bad result can result in a Federal Government listing as a failed school.

Under the Federal legislation, schools are required to subject students to testing once a year. If students do not participate, the school could face sanctions. For instance, if less than 95 percent of the students show up for testing two years in a row, the school could have to allow students to transfer elsewhere.

So, the stakes on the schools are high. But what about students? The test result doesn't appear on their transcript and it doesn't count toward a grade or graduation.

A story in Sunday's Milwaukee Journal Sentinel said that the Racine, Wis., School District gives away movie tickets to get kids to show up. Another, unnamed, district is giving away a television set. Still another district—Arrowhead schools in Hartland, Wis., is letting students who take the test opt out of some final exams.

None of this sounds like it is educationally sound, but school administrators say they have little other incentive to get students to take the test. Isn't there a better way to judge school performance than using a test that has no other meaning than providing a potential for Federal punishment? Are there no other valid measurements of student performance?

Giving prizes as an inducement to take a test seems of dubious value. But maybe we ought to be looking for ways to reconcile the federal government's need for performance data with schools' existing curriculum and practices.

SYRIA ACCOUNTABILITY ACT

Mr. GRAHAM of Florida. Mr. President, the Syria Accountability and Lebanese Sovereignty Restoration Act takes important and valuable steps, and I would have voted for it had I been present, but I am concerned that it may not go far enough.

Syria has long been recognized as a state sponsor of terrorism. In fact, the Syrians themselves openly speak of their support for terrorist organizations such as Hezbollah, Hamas, and the Palestinian Islamic Jihad. Intelligence reports and terrorism experts tell us that the next generation of terrorists is being trained in a network of training facilities that exist in Syria and the Syrian-controlled parts of Lebanon. These international terrorist organizations that run these camps already have the capacity to kill Americans, and they have state sponsors with access to weapons of mass destruction. Prior to 9/11, Hezbollah was responsible for the deaths of more Americans than any other terrorist group.

On September 18, 2001, the Senate passed S.J. Res 23, which authorized the President to use "all necessary and appropriate force" against those responsible for the attacks of 9/11. This authorization for the use of force is therefore limited to al-Qaeda. We ignore other terrorist networks at our peril—and at one point, President Bush recognized that. Nine days after the terrorist attack of September 11, the President declared:

"Our war on terror begins with al-Qaeda but it does not end there. It will not end until every terrorist group of global reach has been found, stopped and defeated."

In his State of the Union speech on January 29, 2002, President bush restated our priorities:

> Our nation will continue to be steadfast and patient and persistent in the pursuit of two great objectives. First, we will shut down terrorist camps, disrupt terrorist plans, and bring terrorists to justice. And, second, we must prevent the terrorists and regimes who seek chemical, biological or nuclear weapons from threatening the United States and the world.

I supported those statements and hoped to help the President carry out his pledge. Last October, Congress authorized the use of force against Iraq. I voted against this authorization because I believed it was a distraction from the war on terrorism. At that time, I attempted to amend the resolution to provide the president the authorization to use force against other terrorist organizations that met the following criteria: they have a state sponsor with access to weapons of mass destruction; they have a history of killing Americans; and they have the ability to strike inside the United States.

I remain concerned that the President does not have the necessary authorization to use force against these additional terrorist organizations. Without such authorization, he cannot fulfill the commitment he made in his January 2002 State of the Union speech.

I hope the administration will take this occasion to review its existing authorities and report back to Congress on where there may be deficiencies in its authorities to carry out the war on terrorism. Only then will we be able to hold Syria and similar states that sponsor or harbor terrorists truly accountable.

BUSINESS CLIMATE IN UKRAINE

Mr. CAMPBELL. Mr. President, as Co-Chairman of the Commission on Security and Cooperation in Europe, I have closely followed developments in Ukraine including aspects of the human, security and economic dimensions. My desire is that Ukraine consolidate its independence by strengthening democratic institutions, including the judiciary, and undertaking reforms to improve the business climate essential to attracting much-needed foreign investment. Twelve years after independence, the people of Ukraine deserve to enjoy the fruits of freedom and prosperity, but obstacles remain. Bringing Ukraine more fully into Europe is both essential to the country's long-term economic success and important for European security. Accelerating Ukraine's movement toward Europe is timely and needed. While high-ranking Ukrainian officials pay lipservice to such integration, the jury is still out as to whether they are prepared to take the bold steps that will be required to advance such integration. An important barometer for the future will be the extent to which the country's moves to confront the corruption and crime that retard the process of democratization and economic liberalization and erode Ukraine's security and independence.

While those at the top say the right things, there is justified skepticism as to their sincerity. This is certainly the case concerning Ukraine's current President, Leonid Kuchma. The controversies surrounding Kuchma undercut his credibility with respect to the issue of combating corruption. Nevertheless, this should not detract from the urgency of tackling corruption in the lead up to critical parliamentary elections slated for next year, and presidential elections to select Kuchma's successor in 2004.

Meanwhile, those serious about rooting out corruption and corrupt officials should take a hard look at the handling—or more accurately, mishandling—of Ukrainian and foreign owned businesses. For example, United States-owned businesses have been victimized through expropriations, asset thefts, extortion and the like perpetrated or abetted by corrupt officials and courts in Ukraine. While new cases continue to occur, longstanding cases remain unresolved with investors unable to obtain the relief to which they are entitled under Ukrainian and international law.

Although the State Department has made repeated representations about these cases at senior levels of the Kuchma administration, Kyiv rebuffed repeated requests to resolve them in accordance with the law. At the same time it refuses to punish the perpetrators of the criminal acts or take corrective measures to prevent similar cases from arising.

If the victims are to ever achieve a measure of justice, it is essential that U.S. officials raise these cases at every appropriate opportunity.

In one especially egregious and illustrative case, well-connected individuals in Ukraine were able to orchestrate the seizure of all the assets of a successful pharmaceutical joint venture which was half owned by United States investors. When, 6 years after the theft the Ukrainian appeals courts finally dismissed the spurious claims to the assets on grounds that they were based entirely on forged and falsely fabricated documents, senior Ukrainian officials launched into action. Within weeks of these judicial decisions, the Ukrainian President reportedly convened a meeting of senior officials, including the cognizant senior judges and his own senior law enforcement and national security cabinet level officers, at which he made clear that he did not want the stolen assets restored to their rightful American owners.

The courts quickly complied, without explanation, and in disregard of the copious evidence before them, the judges reversed the decisions taken just two months earlier and held in favor of the claimants. Several months later longstanding criminal charges against the same individuals were dropped.

The circumstances surrounding this case and others involving United States investors are indicative of the far reaching scope of corruption and the rule of law deficit in Ukraine today. While the matter was repeatedly raised by the State Department several years ago, I am concerned that the Ukrainian side might assume that the matter is a closed case. I urge officials at the Departments of State and Commerce to disabuse Ukrainian Government officials of such an impression.

If the Kuchma administration is serious about rooting out corruption and advancing democracy and the rule of law, these cases provide a good starting point. Only time will tell if they are up to the challenge.

CONGRATULATING THE PEOPLE OF GUATEMALA ON THEIR RECENT ELECTIONS

Mr. COLEMAN. Mr. President, the people of Guatemala went to the polls on November 9 to elect a new President, Members of the Guatemalan Parliament, local officials, and representatives to the Central American Parliament.

These elections attracted attention, in large part, due to the candidacy of Efrain Rios Montt, a former coup leader who under the Guatemalan constitution should have been banned from running for the Presidency all together. Rios Montt presided over a troubled part of Guatemala's history, during which time too many innocent lives were lost.

Now these elections were not perfect. Long lines and confusion over where to vote made it difficult for many Guatemalans to express their political views. Some polling stations stayed open for as long as 5 hours after they were scheduled to close; other did not. The time period leading up to the elections was marked by violence and intimidation linked to some Rios Montt supporters.

But in the end, these were important and hopeful elections for a number of reasons. Rios Montt was defeated in the ballot box—and he accepted defeat. The willingness of losers to accept defeat is one sign of a maturing democracy. And the result of this defeat for Rios Montt should not be overlooked; he will lose his immunity from prosecution for crimes committed under his watch.

There is much more to the story than Rios Montt's candidacy, however. Approximately 60 percent of Guatemala's 5 million voters went to the polls on

Sunday—the largest turnout since 1985. By turning out in such numbers, Guatemalans showed they understand the power of the ballot box. As one woman put it, "You have to vote if you want things to change."

Overall, these elections were fair and open. Ballots were not rigged, and vehicles carrying them were monitored by satellite.

Violence on election day was isolated. In spite of an insecure climate during the campaign season, threats of violence were not carried out on a large scale over the weekend. The violence many had feared—and some observers have come to expect from elections of this sort—did not take place. In the words of Guatemalan Nobel Prize winner Rigoberta Menchu: "This first round was about saying no to violence."

These elections also marked the first time a nation-wide network of over 3,000 independent election observers, Mirador Electoral, monitored Guatemalan elections—no easy feat in a country ravaged by 40 years of civil war. The group was so highly regarded, they were asked by the Guatemalan election commission to release their "quick count" projections of the winners. And the results of Mirador Electoral matched those reached by the election commission.

Guatemalans will go to the polls again on December 28, and will choose between top vote-getters Oscar Berger and Alvaro Colon to be the next President. I would call upon the Guatemalan Government to maintain their commitment to fairness, and to make adjustments to better prepare for a high turn-out of Guatemalans.

While Guatemala still has many problems, these elections give me hope for the future. I congratulate the Guatemalan people for their commitment to democracy.

ADDITIONAL STATEMENTS

CONGRATULATING EDITH MILLER

• Mr. JEFFORDS. Mr. President, today I recognize the outstanding contributions made by Edith Miller, outgoing Executive Director for the Vermont School Boards Association, VSBA.

Edie, as she is known to her colleagues, friends, and family, joined the Vermont School Boards Association in December 1997 after previously serving for many years as the director of the University of Vermont's Continuing Education Program.

Edie also served with great distinction on numerous boards dedicated to the arts and community welfare. Her participation in local government is noteworthy. She has worn many hats, from holding positions on the town zoning and planning commissions to her current role as Chair of the East Montpelier Select Board.

I also had the pleasure and benefit of having her husband, Martin Miller, on staff during my tenure as Vermont Attorney General from 1969 through 1972.

Over the years, various individuals have described Edie Miller as a strong and articulate voice in support of public education. She possesses a tireless work ethic and an ability to identify critical issues, analyze the information, and communicate that information not only to the VSBA members, but also to local State and Federal officials.

Edie was a driving force in the creation and implementation of the Vermont Education Leadership Alliance Project, VELA. She worked diligently with her colleagues in the Vermont Superintendents Association and the Vermont Principals' Association to address the critical shortage of principals, superintendents and school board members in Vermont. The program was designed to train and certify school leaders, thereby increasing their effectiveness and reducing turnover. Although VELA is now under the capable leadership of David Ford, Edie still remains very active on its Board of Directors.

Her remarkable skill at working with a broad constituency has earned Edie enormous respect within Vermont's education community. Edie is not afraid to pursue any idea that she believes will improve outcomes for Vermont's children.

To underscore my efforts to increase funding of special education, Edie met with members of every school board throughout Vermont, convincing them to sign a petition asking the federal government to fully fund the Individuals with Disabilities Education Act. This was not an easy task, but she persevered. These petitions were presented to me in Vermont, bound in a red ribbon. During Senate debate of the various special education funding proposals I have sponsored, I take these petitions with me to the chamber. I can tell you that those petitions have made a deep impression on my colleagues.

I have been very fortunate to work closely with Edie on a number of education issues. I have always appreciated her keen insight and her insistence on carefully weighing all aspects of proposals before making a policy decision.

For Edie, it is important to increase educational opportunities for all students. For Edie, first and foremost, it is and always will be about the kids.

Edie has left an indelible mark on Vermont's education landscape. Though she may be stepping away from her responsibilities at VSBA, I know she will not be stepping away from education.

So, it is with great pleasure that I offer my congratulations to Edie Miller on her stellar accomplishments as executive director for the Vermont School Boards Association and her unyielding commitment to the education of Vermont's children.•

CHARLES D. "CHUCK" ANDERSON

• Mr. KYL. Mr. President, I was recently advised of the upcoming retirement of Mr. Charles D. "Chuck" Anderson after a long and faithful career in the defense industry. Mr. Anderson is retiring from Raytheon as the company's vice president of the Air-to-Air Missiles Division in Tucson, AZ.

Chuck began his career in the 1950s as a paratrooper with the California National Guard, then earned his bachelor of science degree in mathematics and physics from California State Polytechnic University. He went on to earn a master of science degree in Systems Engineering from the University of Southern California in 1972.

For the last 10 years, Mr. Anderson has been with Raytheon, and it is my understanding that he has been responsible for all AMRAAM, Sparrow AIM-9M, AIM-9X, and ASRAAM efforts, including development, testing, and production. He also played key roles in the design and manufacture of the Standard Missile, Standard Arm, DIVAD, Stinger, Advanced Cruise Missile, and Phalanx.

Prior to his years at Raytheon, Chuck served in a variety of capacities with General Dynamics, and over the years he has earned a number of awards: the Winner of the 1998 Department of Defense Logistics Life Cycle Cost Reduction Award; the 1999 Outstanding Contracting Team Award; and the 2000 Secretary of the Air Force Lightening Bolt Award, to name just a few.

Chuck Anderson has spent a career dedicated to keeping America strong. I wish him and his wife, Carolyn, best wishes as they venture into the next chapter of their lives.•

TRIBUTE TO PAUL UNGER

• Mr. DEWINE. Mr. President, today I pay tribute to a remarkable Ohioan—a man of great vision and great compassion. Paul Unger is the founder of the Unger Croatia Institute for Public Administration, an organization that provides professional training, education, and technical assistance to Croatian Government administrators and university officials. On January 23, 2004, he will receive the Outstanding Citizen Achievement Award from the U.S. Agency for International Development for his tireless dedication to fostering democracy and freedom in Croatia.

Paul Unger, a fellow Ohioan who is a native of Cleveland, first arrived in Zagreb for a Christmas party one wintry December night in 1945. He was en route from his post as commandant of a United Nations refugee camp for Croatians in Egypt to his new assignment as administrator for the United Nations relief program in Yugoslavia. That evening, he met Sonja Franz, a Croatian architect-engineer, who became his wife by the next holiday season. Soon after they married, the Ungers left Croatia for the United States.

As the decades passed, the Ungers kept close contact with their family, friends, and colleagues who had remained overseas, committed to a free, democratic Croatia. In 1997, Paul Unger assembled an advisory group of 45 American and Croatian banking, education, and government leaders to found the Unger Croatia Institute for Public Administration to help reform-minded leaders ease Croatia's transition from the devastating war to a more efficient, democratic government.

As a first step, Mr. Unger created a fellowship program to assist senior Croatian officials in the development of improved practices in government. This program was to be administered by his alma mater, Harvard University. The Unger Croatia Program was created within the John F. Kennedy School of Government, and the Institute Advisory Group was charged with nominating and selecting candidates. Between 1998–2001, the Ungers personally sponsored 22 Fellows at the Kennedy School, including deputy prime ministers, cabinet ministers and deputies, national bank governors, parliamentary committee chairs, ambassadors, and a Presidential candidate.

To build a program that could provide similar services for locally elected officials, Mr. Unger turned to the Maxine Goodman Levin College of Urban Affairs at Cleveland State University, CSU. In 2001, the Unger Croatia Center for Local Government Leadership was established within CSU's Levin College.

The success of the Cleveland seminars inspired Mr. Unger to create an educational alliance between CSU and the University of Rijeka, which was formalized in 2002. This collaboration continues to blossom. Over the past 2 years, the Unger Croatia Center at CSU has worked closely with the Economics faculty in Rijeka to develop their professional courses. Last summer, the University of Rijeka hosted the first seminar for public officials in Croatia, and this spring, the University will introduce its first programs in public administration and public health administration—an important step toward the eventual realization of the first-ever Croatian Graduate School of Public Administration.

As Mr. Unger continues to work toward a vision for a prosperous Croatia, government is being transformed. Program participants have returned home and implemented the techniques learned through their studies, creating an environment where Croatians have become increasingly involved in local government and have taken an active role in setting budget priorities and guiding community development.

Beyond his extraordinary efforts abroad, Mr. Unger also has contributed much to our home State of Ohio. It is here that he and Sonja raised a family and achieved prominence through a successful business, volunteer service, and community activism. Among his many accomplishments, Mr. Unger served as president/CEO of the Unger Company, a national food packaging company headquartered in Cleveland; chairman of the Urban Renewal Task Force for the Mayor of Cleveland; president of the Cleveland chapter of the American Civil Liberties Union; and chairman of the Ohio's International Trade Council. He has been widely-recognized, notably by the Cleveland Heights High School Hall of Fame, the Cleveland Blue Book, and the City Club of Cleveland Hall of Fame.

Finally, Paul Unger has remained steadfast in moving Cleveland into the international arena. He has helped lead the Cleveland-Miskole Sister City Committee and the Cleveland Council on World Affairs. He also has sponsored the "Cleveland in the World" lecture series at the City Club of Cleveland. Sonja has been a local civic and political leader in her own right and was the first woman to be honored with a Golden Door Award by Cleveland's Nationality Services Center for her dedication as a social worker and interpreter.

In January 2004, the USAID's Bureau for Europe and Eurasia will honor Paul Unger with the Outstanding Citizen Achievement Award, which recognizes Americans who have made exceptional contributions to international development through volunteerism. I congratulate Mr. Unger for all his work at home and abroad and express my thanks to him and to his wife Sonja for their leadership, dedication, and commitment to democracy in Croatia.•

HONORING DR. DONALD PINKEL AND PROFESSOR DR. HANSJÖRG RIEHM

• Mrs. BOXER. Mr. President, I rise to pay homage to the remarkable contributions of Dr. Donald Pinkel and Professor Dr. Hansjörg Riehm to the cure of childhood acute lymphoblastic leukemia, or ALL, once an invariably lethal disease. On December 4, 2003, distinguished colleagues from 12 nations will honor these outstanding physicians in San Diego, CA.

ALL is the most common cancer in children. Forty years ago, very few children were cured. Since that time, the cure rate has improved dramatically. I am informed that thanks in part to the leadership and vision of Dr. Pinkel and Professor Dr. Hansjörg Riehm, about 80 percent of ALL patients are now cured in developed nations. Dr. Pinkel's development of effective presymptomatic central nervous system therapy and Professor Dr. Hansjörg Riehm's development of effective post induction intensification halved the number of relapses and deaths. Tens of thousands of children, their families, friends and neighbors in many countries have benefitted. Dr. Pinkel and Professor Dr. Riehm stand united in their desire that effective therapy be available to children with ALL, both in the developed world and in the developing world.

I am informed that during his years at St. Jude Children's Research Hospital in the 1960s, Dr. Pinkel introduced the concept of presymptomatic central nervous system therapy and cured one-half of children with ALL. Previously, many children had achieved temporary remission from leukemia, only to suffer return of leukemia or relapse in the central nervous system, subsequent bone marrow relapse, and death. Presymptomatic central nervous system therapy remains a cornerstone of ALL therapy throughout the world.

Professor Dr. Hansjörg Riehm and his colleagues in the Berlin Frankfurt Münster Group introduced effective postinduction intensification in the late 1970s. This concept involves implementing stronger therapy after the patient is in remission. Previously, patients received brief intensive induction therapy followed by presymptomatic central nervous system therapy and prolonged mild maintenance therapy. Most patients achieved remission, but many suffered leukemic relapse and death. With application of effective post induction intensification, the number of relapses fell and the chance for cure increased. Professor Riehm's strategy of post induction intensification has been applied throughout the world with similar success.

We know how tragic it is when children and their families struggle with life-threatening disease. The dramatic improvement in the cure rate of ALL gives children and those who cherish them just cause for greater hope. Literally tens of thousands of children in many nations have survived and grown up to realize their hopes and dreams due to the remarkable contributions of Dr. Pinkel and Professor Dr. Riehm. I am certain that children's lives are ample thanks, but I would like to add California's thanks for these physicians' lifetimes of accomplishments. Our Nation and world are fortunate to have benefitted from their work.•

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mr. Thomas, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGES FROM THE HOUSE

At 2:27 p.m., a message from the House of Representatives, delivered by Mr. Hays, one of its reading clerks, announced that the House has passed the following bills, without amendment:

S. 117. An act to authorize the Secretary of Agriculture to sell or exchange certain land in the State of Florida, and for other purposes;

S. 286. An act to revise and extend the Birth Defects Prevention Act of 1998;

S. 650. An act to amend the Federal Food, Drug, and Cosmetic Act to authorize the Food and Drug Administration to require certain research into drugs used in pediatric patients;

S. 1685. An act to extend and expand the basic pilot program for employment eligibility verification, and for other purposes; and

S. 1720. An act to provide for Federal court proceedings in Plano, Texas.

The message also announced that the House has agreed to the following concurrent resolution, without amendment:

S. Con. Res. 48. Concurrent resolution supporting the goals and idelas of "National Epilepsy Awareness Month" and urging support for epilepsy research and service programs.

The message further announced that the House passed the following bills and joint resolution in which it requests the concurrence of the Senate:

H.R. 421. An act to reauthorize the United States Institute for Environmental Conflict Resolution, and for other purposes;

H.R. 1006. An act to amend the Lacey Act Amendments of 1981 to further the conservation of certain wildlife species;

H.R. 2218. An act to amend the Federal Food, Drug, and Cosmetic Act to provide for the regulation of all contact lenses as medical devices, and for other purposes;

H.R. 2420. An act to improve transparency relating to the fees and costs that mutual fund investors incur and to improve corporate governance of mutual funds;

H.R. 3140. An act to provide for availability of contact lens prescriptions to patients, and for other purposes;

H.R. 3491. An act to establish within the Smithsonian Institution the National Museum of African American History and Culture, and for other purposes; and

H.J. Res. 78. An act making further continuing appropriations for the fiscal year 2004, and for other purposes.

The message also announced that the House has agreed to the following concurrent resolutions in which it requests the concurrence of the Senate:

H. Con. Res. 83. Concurrent resolution honoring the victims of the Cambodian genocide that took place from April 1975 to January 1979;

H. Con. Res. 288. Concurrent resolution honoring Seeds of Peace for its promotion of understanding, reconciliation, acceptance, coexistence, and peace among youth from the Middle East and other regions of conflict; and

H. Con. Res. 320. Concurrent resolution expressing the sense of the Congress regarding the importance of motorsports.

The message further announced that the House agree to the report of the committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2417) to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes.

At 6:51 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House agree to the amendment of the Senate to the bill (H.R. 2297) to amend title 38, United States Code, to improve benefits under laws administered by the Secretary of Veterans Affairs, and for other purposes.

The message also announced that the House agree to the amendments of the Senate to the resolution (H.J. Res. 63) to approve the "Compact of Free Association, as amended between the Government of the United States of America and the Government of the Federated States of Micronesia", and the "Compact of Free Association, as amended between the Government of the United States of America and the Government of the Republic of the Marshall Islands", and otherwise to amend Public Law 99–239, and to appropriate for the purposes of amended Public Law 99–239 for fiscal years ending on or before September 30, 2023, and for other purposes.

ENROLLED BILLS SIGNED

The following enrolled bills, previously signed by the Speaker, were signed on today, November 20, 2003, by the President pro tempore (Mr. STEVENS):

S. 254. An act to revise the boundary of the Kaloko-Honokohau National Historical Park in the State of Hawaii, and for other purposes;

S. 864. An act to designate the facility of the United States Postal Service located at 710 Wick Lane in Billings, Montana, as the "Ronald Reagan Post Office Building"; and

S. 1718. An act to designate the facility of the United States Postal Service located at 3710 West 73rd Terrace in Prairie Village, Kansas, as the "Senator James B. Pearson Post Office".

H.R. 23. An act to amend the Housing and Community Development Act of 1974 to authorize communities to use community development block grant funds for construction of tornado-safe shelters in manufactured home parks.

H.R. 1588. An act to authorize appropriations for fiscal year 2004 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe personnel strengths for such fiscal year for the Armed Forces, and for other purposes.

H.R. 2744. An act to designate the facility of the United States Postal Service located at 514 17th Street in Moline, Illinois, as the "David Bybee Post Office Building".

H.R. 2754. An act making appropriations for energy and water development for the fiscal year ending September 30, 2004, and for other purposes.

H.R. 3175. An act to designate the facility of the United States Postal Service located at 2650 Cleveland Avenue, NW in Canton, Ohio, as the "Richard D. Watkins Post Office Building".

H.R. 3379. An act to designate the facility of the United States Postal Service located at 3210 East 10th Street in Bloomington, Indiana, as the "Francis X. McCloskey Post Office Building".

MEASURES REFERRED

The following bill was read the first and the second times by unanimous consent, and referred as indicated:

H.R. 2420. An act to improve transparency relating to the fees and costs that mutual fund investors incur and to improve corporate governance of mutual funds; to the Committee on Banking, Housing, and Urban Affairs.

The following concurrent resolutions were read, and referred as indicated:

H. Con. Res. 83. Concurrent resolution honoring the victims of the Cambodian genocide that took place from April 1975 to January 1979; to the Committee on Foreign Relations.

H. Con. Res. 288. Concurrent resolution honoring Seeds of Peace for its promotion of understanding, reconciliation, acceptance, coexistence, and peace among youth from the Middle East and other regions of conflict; to the Committee on the Judiciary.

ENROLLED BILL PRESENTED

The Secretary of the Senate reported that on November 20, 2003, she had presented to the President of the United States the following enrolled bills:

S. 254. An act to revise the boundary of the Kaloko-Honokohau National Historical Park Addition Act of 2003;

S. 867. An act to designate the facility of the United States Postal Service located at 710 Wicks Lane in Billings, Montana, as the "Ronald Reagan Post Office Building"; and

S. 1718. An act to designate the facility of the United States Postal Service located at 3710 West 73rd Terrace in Prairie Village, Kansas, as the "Senator James B. Pearson Post Office."

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–5325. A communication from the Secretary of Transportation, transmitting, a report relative to the Convention on International Interests in Mobile Equipment and the Protocol on Matters Specific to Aircraft Equipment; to the Committee on Commerce, Science, and Transportation.

EC–5326. A communication from the Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service, transmitting, pursuant to law, the report of a rule entitled "Fisheries Off West Coast States and in the Western Pacific; Pacific Coast Groundfish Fishery; Whiting Closure for the Catcher/Processor Sector" (ID101003F) received on November 20, 2003; to the Committee on Commerce, Science, and Transportation.

EC–5327. A communication from the Chief, Regulations and Administrative Law, Coast Guard, transmitting, pursuant to law, the report of a rule entitled "Drawbridge Regulations: [CGD07–02–160], Canaveral Barge Canal, Cape Canaveral, Brevard County, FL" (RIN1625–AA00) received on November 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–5328. A communication from the Chief, Regulations and Administrative Law, Coast Guard, transmitting, pursuant to law, the report of a rule entitled "Drawbridge Regulations: [CGD08–03–042], Mississippi River, Iowa, and Illinois" (RIN1625–AA09) received on November 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–5329. A communication from the Chief, Regulations and Administrative Law, Coast Guard, transmitting, pursuant to law, the report of a rule entitled "Drawbridge Regulations: [CGD08–03–045], St. Croix River, Prescott, WI" (RIN1625–AA09) received on November 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–5330. A communication from the Chief, Regulations and Administrative Law, Coast Guard, transmitting, pursuant to law, the report of a rule entitled "Safety/Security Zone Regulations: (Including 2 Regulations), [CGD07–03–144], [COTP San Diego 03–033]" (RIN1625–AA09) received on November 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–5331. A communication from the Chief, Regulations and Administrative Law, Coast Guard, transmitting, pursuant to law, the report of a rule entitled "Regulated Navigation Area: (Including 2 Regulations), [CGD07–03–069], [CGD09–03–214]" (RIN1625–AA11) received on November 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–5332. A communication from the Director, Executive Office of the President, Office of Management and Budget, transmitting, pursuant to law, a report on direct spending or receipts legislation dated October 24, 2001; to the Committee on Appropriations.

EC–5333. A communication from the Acting Under Secretary of Defense for Acquisition, Technology, and Logistics, transmitting, pursuant to law, a report relative to the EA–18G; to the Committee on Armed Services.

EC–5334. A communication from the Under Secretary of Agriculture for Natural Resources and Environment, transmitting, pursuant to law, a report relative to contracts involving the National Recreation Reservation System; to the Committee on Agriculture, Nutrition, and Forestry.

EC–5335. A communication from the Director, Regulatory Review Group, Commodity Credit Corporation, transmitting, pursuant to law, the report of a rule entitled "Removal of Obsolete Regulations" (RIN0560–AH04) received on November 20, 2003; to the Committee on Agriculture, Nutrition, and Forestry.

EC–5336. A communication from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled "National Poultry Improvement Plan and Auxiliary Provisions" (Doc. No. 03–017–2) received on November 19, 2003; to the Committee on Agriculture, Nutrition, and Forestry.

EC–5337. A communication from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled "Veterinary Services User Fees; Pet Food Facility Inspection and Approval Fees" (Doc. No. 03–036–2) received on November 19, 2003; to the Committee on Agriculture, Nutrition, and Forestry.

EC–5338. A communication from the Deputy Secretary, Division of Market Regulation, Securities and Exchange Commission, transmitting, pursuant to law, the report of a rule entitled "Interpretation of Rule 3b–3" (Release No. 34–48795) received on November 19, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–5339. A communication from the Chief Counsel, Office of Foreign Assets Control, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled "31 CFR Part 575—Authorization for U.S. Financial Institutions to Transfer Certain Claims Against the Government of Iraq" received on November 20, 2003; to the Committee on Banking, Housing, and Urban Affairs.

EC–5340. A communication from the Director, Executive Office of the President, Office of Management and Budget, transmitting, pursuant to law, a report on direct spending or receipts legislation dated October 24, 2001; to the Committee on the Budget.

EC–5341. A communication from the Assistant Secretary for Civil Works, Department of the Army, transmitting, pursuant to law, a report relative to the Port of Los Angeles Channel Deepening Project, California; to the Committee on Environment and Public Works.

EC–5342. A communication from the Director, Office of Congressional Affairs, Office of Nuclear Reactor Regulation, transmitting, pursuant to law, the report of a rule entitled "Direct Final Rule on Decommissioning Trust Provisions" (RIN3150–AH32) received on November 19, 2003; to the Committee on Environment and Public Works.

EC–5343. A communication from the Assistant Secretary, Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of a proposed license for the export of defense articles or defense services sold commercially under a contract in the amount of $100,000,000 or more to Australia; to the Committee on Foreign Relations.

EC–5344. A communication from the Assistant Secretary, Legislative Affairs, Department of State, transmitting, pursuant to the Arms Export Control Act, the report of a proposed manufacturing agreement of the manufacture of significant military equipment abroad and the license for the export of defense articles or defense services sold commercially under a contract in the amount of $50,000,000 or more to the Republic of Korea; to the Committee on Foreign Relations.

EC–5345. A communication from the Director, Executive Office of the President, Office of Management and Budget, transmitting, pursuant to law, a report on direct spending or receipts legislation dated October 24, 2001; to the Committee on Foreign Relations.

EC–5346. A communication from the Acting Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting, pursuant to law, the report of a rule entitled "Appeals Settlement Guidelines: Forest Products—Losses of Timber for Epidemic for Southern Pine Beetles" (UIL165.19–00) received on November 20, 2003; to the Committee on Finance.

EC–5347. A communication from the Acting Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting, pursuant to law, the report of a rule entitled "October–December 2003 Bond Fund Amounts" (Rev. Rul. 2003–117) received on November 20, 2003; to the Committee on Finance.

EC–5348. A communication from the Acting Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting, pursuant to law, the report of a rule entitled "Transfers to Provide for Satisfaction of Contested Liabilities" (RIN1545–BA91) received on November 20, 2003; to the Committee on Finance.

EC–5349. A communication from the Acting Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting, pursuant to law, the report of a rule entitled "Transfers to Provide for Satisfaction of Contested Liabilities" (RIN1545–BA91) received on November 20, 2003; to the Committee on Finance.

EC–5350. A communication from the Acting Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting, pursuant to law, the report of a rule entitled "Applicable Federal Rates--December 2003" (Rev. Rul. 2003–122) received on November 20, 2003; to the Committee on Finance.

EC–5351. A communication from the Acting Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting, pursuant to law, the report of a rule entitled "Transfers to Trusts to Provide for the Satisfaction of Contested Liabilities" (Notice 2003–77) received on November 20, 2003; to the Committee on Finance.

EC–5352. A communication from the Procurement Executive, Department of State, transmitting, pursuant to law, the report of a rule entitled "Governmentwide Debarment and Suspension (Nonprocurement) and Governmentwide Requirements for Drug-Free Workplace" (RIN1400–AB83) received on November 19, 2003; to the Committee on Governmental Affairs.

PETITIONS AND MEMORIALS

The following petitions and memorials were laid before the Senate and were referred or ordered to lie on the table as indicated:

POM–326. A resolution adopted by the General Assembly of the State of New Jersey relative to the federal tax code; to the Committee on Armed Services.

ASSEMBLY RESOLUTION NO. 292

Whereas, The President of the United States has authorized the Secretary of Defense to mobilize select members of the National Guard to active duty in response to the continuing global war on terrorism, armed conflict with Iraq, and heightened tensions with North Korea, additionally, state governors have mobilized National Guard members for state active duty to protect airports, nuclear power plants and interstate bridges and tunnels; and

Whereas, Members of the National Guard activated by the President of the United States are entitled to certain exemptions from income taxation that members of the National Guard activated by a Governor are not; and

Whereas, Members of the National Guard activated during the current crises, whether activated by the President of the United States or a Governor, are serving vital interests for which they deserve the full support of our government; and

Whereas, Many of the National Guard members and their families will suffer short and long-term hardships due to their state activation during the crises; and

Whereas, It is fitting and proper that the United States government recognize the sacrifice that these mobilized National Guard members and their families are making; and

Whereas, Part of this recognition should consist of the enactment of federal legislation establishing the same tax treatment for allowances received by members of the National Guard on state active duty as exists for allowances received by such members on federal active duty: Now, therefore, be it

Resolved by the General Assembly of the State of New Jersey:

1. The President of the United States and the Congress of the United States are respectfully urged to enact legislation to amend the provisions of the federal tax code to exempt from taxable income of National Guard members on state active duty allowances received for housing and subsistence.

2. Duly authenticated copies of this resolution, signed by the Speaker of the General Assembly and attested by the Clerk thereof, shall be transmitted to the President of the United States, the Majority and Minority Leaders of the United States Senate, the Speaker and Minority Leader or the United States House of Representatives, and each member of Congress elected from the State of New Jersey.

POM-327. A resolution adopted by the General Assembly of the State of New Jersey relative to trade relations with Taiwan; to the Committee on Finance.

Assembly Resolution No. 228

Whereas, The United States and the Republic of China, commonly known as Taiwan, maintain an important trade relationship, with Taiwan being among the largest trading partners of the United States and the United States being one of the largest exporters to Taiwan; and

Whereas, Taiwan, the fourteenth largest trading nation in the world, is a center for international trade which is vital to the economic prosperity of this State and the United States in general; and

Whereas, The State of New Jersey and Taiwan established a sister-state relationship in 1989 symbolizing the close friendship between the people of New Jersey and the people of Taiwan; and

Whereas, This State seeks to encourage and expand mutually beneficial commercial relationships with Taiwan; and

Whereas, Taiwan is a modern democracy that routinely holds free and fair elections and has dramatically improved its record on human rights; and

Whereas, Taiwan's 23,000,000 people are not represented in the United Nations; and

Whereas, Taiwan has in recent years repeatedly expressed its strong desire to participate in the United Nations and has much to contribute to the work and funding of the United Nations; and

Whereas, Taiwan's participation in the United Nations will help maintain peace and stability in Asia and the Pacific: Now, therefore, be it

Resolved by the General Assembly of the State of New Jersey:

1. The Congress and the President of the United States are respectfully memorialized to strengthen trade relations with the Republic of China (Taiwan) and to support the participation of the Republic of China (Taiwan) in the United Nations.

2. Duly authenticated copies of this resolution, signed by the Speaker of the General Assembly and attested by the Clerk thereof, shall be transmitted to the President of the United States, the President of the United States Senate, the Speaker of the United States House of Representatives, the United States Trade Representative, and every member of the New Jersey Congressional delegation.

POM-328. A resolution adopted by the General Assembly of the State of New Jersey relative to a Medicare prescription drug benefit; to the Committee on Finance.

Assembly Resolution No. 318

Whereas, Some senior citizens in New Jersey have prescription drug coverage through the "Pharmaceutical Assistance to the Aged and Disabled" and Medicaid programs, Medicare supplemental insurance policies or retirement benefit plans; however, according to the federal government, approximately one-third of senior citizens in the nation do not have any insurance coverage for prescription drugs; and

Whereas, Prescription drugs and medication therapy management services are essential components of medical treatment, yet the Medicare program does not offer a comprehensive prescription drug and service benefit to senior citizens who need prescription drug and service coverage in order to be able to afford their medications and comply with prescription medication regimes; and

Whereas, Proper utilization of prescriptions drugs can be one of the most cost-effective medical interventions available in the health care system and medication therapy management services would assist senior citizens in proper medication utilization, which can help reduce adverse medication events that oftentimes result in increased spending of Medicare funds for nursing home stays and hospital, physician and emergency room visits; and

Whereas, Proper utilization of prescription drugs can meet the needs of special populations with chronic diseases and those with co-morbidities through coordinating care with disease management, drug utilization review and patient education program, all of which aid in ameliorating medical errors; and

Whereas, Promoting greater access to prescription drugs through the inclusion of a prescription benefit in the Medicare program would reduce the incidence of senior citizens employing unsafe cost-saving methods, such as splitting pills and staggering the days on which medications are taken; and

Whereas, Comprehensive reform of the Medicare program would coordinate care for this population and offer more choices of quality coverage for senior citizens, while maintaining the financial sustainability of the program; and

Whereas, A voluntary, comprehensive Medicare prescription drug benefit program, which provides eligible enrollees with covered outpatient prescription drugs, medication preparation services and medication therapy management services, would ensure senior citizens access to necessary prescription drugs and services: Now, therefore, be it

Resolved by the Assembly of the State of New Jersey:

1. This House respectfully memorializes Congress to enact, and the President of the United States to sign into law, a financially sustainable, voluntary, universal and comprehensive prescription drug benefit in the Medicare program, which would ensure senior citizens access to necessary prescription drugs and services.

2. Duly authenticated copies of this resolution, signed by the Speaker of the General Assembly and attested by the Clerk of the General Assembly, shall be forwarded to the President of the United States, the Secretary of Health and Human Services of the United States, the presiding officers of the United States Senate and the House of Representatives, and each of the members of the Congress of the United States elected from the State of New Jersey.

POM-329. A resolution adopted by the Commission of the City of Miami of the State of Florida relative to tax-exempt governmental facilities; to the Committee on Finance.

POM-330. A resolution adopted by the House of Representatives of the General Assembly of the Commonwealth of Pennsylvania relative to steel tariffs; to the Committee on Finance.

House Resolution No. 348

Whereas, The Commonwealth of Pennsylvania is the birthplace of the American steel industry and home to the country's largest steel producer, United States Steel Corporation, and to the United Steelworkers of America; and

Whereas, The House of Representatives of the Commonwealth of Pennsylvania unanimously passed House Resolution 429 on February 12, 2002, calling upon the President to maintain the Section 201 steel tariffs; and

Whereas, The Senate of the Commonwealth of Pennsylvania adopted Senate Resolution 165 on February 12, 2002, calling upon the President to maintain the Section 201 steel tariffs; and

Whereas, As set forth in House Resolution 429 and Senate Resolution 165, the domestic steel industry and the United Steelworkers of America have worked cooperatively and made difficult decisions to ensure that the steel industry's restructuring occur in order to advance a globally competitive United States steel industry; and

Whereas, The President of the United States imposed steel tariffs on March 5, 2003, which have been vitally important to allow for the restructuring of the steel industry; and

Whereas, Since the imposition of the Section 201 tariffs, imports and domestic production of steel have increased; and

Whereas, Steel prices in the United States are still lower than in most other major steel-consuming markets around the world, and any inquiry suffered by steel-consuming industries is unrelated to the President's steel program; and

Whereas, The overall competitiveness of the United States manufacturing industries relies on the ability to maintain a steady domestic steel supply; and

Whereas, Maintaining a steady domestic steel supply is critical to the overall competitiveness of the United States manufacturing industries in the global marketplace; and

Whereas, Steel is essential to the manufacturing and infrastructure sectors, the mainstays of every advanced economy, and no major industrialized nation has been able to function without the ability to produce steel; and

Whereas, The steel tariffs the President imposed in 2002 have provided relief for the domestic steel industry; the tariffs have stopped the hemorrhaging and the steel industry is seeing signs of real recovery; the industry has begun the process of significant restructuring to adjust to the current import competition situation; and continued relief for the full three-year term is necessary so that the industry can undertake vital capital investments that it was forced to postpone due to the import crisis; therefore be it

Resolved (the Senate concurring), That the General Assembly urge the President to maintain the Section 201 steel tariffs for the three-year duration and provide all available assistance to ease the hardship which was resulted for thousands of retired steelworkers as a result of bankruptcies and restructuring; and be it further

Resolved, That a copy of this resolution be transmitted to the President of the United States, to Vice President Dick Cheney, to the members of Congress and to Pennsylvania Governor Edward G. Rendell.

POM–331. A resolution adopted by the House of Representatives of the General Assembly of the Commonwealth of Pennsylvania relative to the Medicare program; to the Committee on Finance.

House Resolution No. 255

Whereas, The mammogram is the medical standard in early breast cancer detection, reducing mortality due to breast cancer by at least 30%; and

Whereas, In the past year and a half, low Medicare and private insurance reimbursement rates for mammograms have contributed to a crisis in mammography; and

Whereas, The average cost of a mammogram is between $90 and $100 and Medicare only reimburses $69 for the procedure; and

Whereas, The private insurance reimbursement is between $50 and $60; and

Whereas, As payments from the Medicare program have not kept pace with rising health care costs, hundreds of radiology clinics have been forced to close their doors and radiologists have been unable to provide mammography services because health care providers are not adequately reimbursed; and

Whereas, The current mammography crisis is causing an increasing shortage of qualified radiologists to administer mammograms; and

Whereas, United States Senators Tom Harkin and Olympia Snowe introduced Senate Bill No. 548, which would be known as the Assure Access to Mammography Act; and

Whereas, Senate Bill No. 548 would increase:

(1) The reimbursement rate of mammography services under the Medicare program to $90.

(2) The Medicare graduate medical education funding for added radiology residency slots, some of which are required to specialize in mammography.

(3) The funding for allied health profession loan programs in order to increase the supply of qualified radiological technicians available to conduct mammograms; therefore be it

Resolved, That the House of Representatives of the Commonwealth of Pennsylvania memorialize the Congress of the United States to pass Senate Bill No. 548 to provide enhanced reimbursements for and expanded capacity to mammography services under the Medicare program; and be it further

Resolved, That copies of this resolution be transmitted to the President of the United States, the Secretary of Health and Human Services, the presiding officers of each house of Congress and to each member of Congress from Pennsylvania.

POM–332. A resolution adopted by the House of Representatives of the General Assembly of the Commonwealth of Pennsylvania relative to the Federal Unemployment Tax Act; to the Committee on Finance.

House Resolution No. 53

Whereas, the Federal Unemployment Tax Act (FUTA) requires that every employer pay an excise tax of 6.2% on the first $7,000 of total wages paid to each employee; and

Whereas, FUTA includes corporate officers within the scope of covered employment by defining these persons as "employees" of a corporation (26 U.S.C. §3121(d)(1)); and

Whereas, Pennsylvania employers, including corporate officers, can, to the extent provided by law, take a tax credit against the FUTA tax of the unemployment contributions that were paid into Pennsylvania's unemployment compensation fund; and

Whereas, FUTA establishes that employers may take a maximum credit of 5.4% against the FUTA tax; and

Whereas, after the offset credit is applied, Pennsylvania employers who pay into the State unemployment system are left to pay 0.8% FUTA tax on the first $7,000 in wages paid to each employee; and

Whereas, Pennsylvania's Unemployment Compensation Law requires that corporate officers pay unemployment compensation taxes, although they generally are not eligible to collect unemployment compensation benefits should they become unemployed; and

Whereas, Pennsylvania corporate officers have expressed frustration because they are required to pay into the State's unemployment compensation sysetm but are subsequently denied unemployment benefits when they become unemployed; and

Whereas, the payment of unemployment compensation taxes is especially burdensome for small, incorporated businesses; and

Whereas, exempting Pennsylvania corporate officers from State unemployment contribution liability would be futile because such officers would then be required to pay the full 6.2% FUTA tax on their wages instead of the net 0.8% rate normally paid with the 5.4% offset credit permitted for State unemployment taxes paid; and

Whereas, such an exemption would not provide any real tax relief to corporate officers, but would merely result in the Federal Government benefiting from additional tax revenue at the expense of Pennsylvania's unemployment compensation fund: Therefore be it

Resolved (the senate concurring) That the General Assembly of the Commonwealth of Pennsylvania urge the Congress to reexamine the FUTA tax as it relates to corporate officers and reevaluate the need for such a tax; and be it further

Resolved, That copies of this resolution be transmitted to the presiding officers of each house of Congress and to each member of Congress from Pennsylvania.

POM–333. A resolution adopted by the House of Representatives of the General Assembly of the Commonwealth of Pennsylvania relative to the war against terrorism; to the Committee on Foreign Relations.

House Resolution No. 373

Whereas, nineteen terrorists hijacked four commercial airplanes on September 11, 2001, crashing two planes into the twin towers of the World Trade Center in New York City, one into the Pentagon, in Washington, D.C., and one in Pennsylvania, resulting in the loss of life of thousands of innocent people; and

Whereas, the events of September 11 led President George W. Bush to initiate a war against terrorism that is being fought at home and abroad through multiple operations including diplomatic, military, financial, investigative, homeland security and humanitarian actions; and

Whereas, the United States is enforcing a doctrine which makes plain that terrorists will be held responsible for their actions and governments which harbor, feed, house and hide terrorists will be held accountable for these acts; and

Whereas, the United States has moved to block the assets of 62 organizations and individuals associated with two investment and money-moving networks of terror; and

Whereas, the coalition of countries supporting the financial war against terrorism now stands at 195 countries; and

Whereas, the United States has issued orders blocking the access of 150 known terrorists, terrorist organizations and terrorist financial centers to United States financial systems; and

Whereas, the United States Department of Defense has airdropped 1,725,840 Humanitarian Daily Rations totaling approximately $120 million into Afghanistan; and

Whereas, the United Nations reports that since November 1, 2001, nearly 12,000 refugees have spontaneously returned to Afghanistan from refugee camps in Iran, representing only a small portion of the estimated number of Afghan refugees in Pakistan and Iran, and it is apparent that humanitarian efforts must continue and be encouraged; and

Whereas, the people of Afghanistan have suffered extensively under the rule of the repressive Taliban regime, with girls denied access to schooling; women prohibited from working, accessing medical care and leaving their home unescorted; women required to wear the enveloping burqa; and other restrictive measures imposed on all Afghan people, including restrictions on smiling, laughing, listening to music and other normal activities of daily living; and

Whereas, talks are under way in Bonn, Germany, among various parties in Afghanistan to establish an agreement leading to a stable, cohesive and broad-based government which is loyal to the people of Afghanistan and respects its international obligations: Therefore be it

Resolved, That the House of Representatives of the Commonwealth of Pennsylvania support and encourage the continued efforts of the President and Congress of the United States to bring those responsible for the September 11, 2001, attack on America to justice; and be it further

Resolved, That the House of Representatives of the Commonwealth of Pennsylvania support and encourage efforts currently under way to establish a stable government in Afghanistan and enable Afghanistan to become a peaceful participant in world nations; and be it further

Resolved, That the House of Representatives of the Commonwealth of Pennsylvania encourage national and international efforts to bring humanitarian aid and relief to the people of Afghanistan; and be it further

Resolved, That copies of this resolution be transmitted to the President of the United States, to the presiding officers of each house of Congress and to each member of Congress from Pennsylvania.

POM–334. A resolution adopted by the General Assembly of the State of New Jersey relative to funding for the Head Start program; to the Committee on Health, Education, Labor, and Pensions.

ASSEMBLY RESOLUTION NO. 307

Whereas, the Federal Head Start project in the Department of Health and Human Services has been one of the most successful of the Great Society anti-poverty programs; and

Whereas, New Jersey's Head Start programs have played a highly successful and valuable multi-faceted role in fighting poverty, creating economic opportunity and educating low-income children in New Jersey since 1965; and

Whereas, New Jersey's Head Start programs have graduated over 1.5 million children and made them education-ready for kindergarten; and

Whereas, New Jersey Head Start programs currently educate over 16,000 children in New Jersey and build the capacity of thousands of parents and staff; and

Whereas, Head Start programs nationwide and in New Jersey are under attack with a threatened loss of funding and virtual elimination of Federal performance standards that include social services benefits to families; and

Whereas, the Federal Government is proposing to move funding that goes to Head Start programs from the Department of Health and Human Services to the Department of Education; and

Whereas, the Federal Government is also proposing to block grant the Federal funding that goes to Head Start programs to the individual states; and

Whereas, the Department of Education has no experience in supervising comprehensive anti-poverty, social service and education programs for preschoolers and families; and

Whereas, evidence makes clear that block granting to the states the funds that now go directly from Federal to local Head Start programs would undermine the consistent quality of Head Start nationwide; and

Whereas, studies show that Federal funds are 8 times more likely than State funds to reach the neediest children, including the General Accounting Office 1998 Report "State and Federal Efforts to Target Poor Children"; and

Whereas, it is inconsistent for the Federal Government to push for national outcomes for Head Start children and simultaneously erase the mechanisms to help achieve them; and

Whereas, currently, Head Start funds only 6 slots out of every 10 for eligible children and Early Head start has only enough funding to serve 3% of all eligible children; and

Whereas, the New Jersey Supreme Court has already accepted the argument that expanded preschool for low-income children in poor school districts is essential to help combat the disadvantages they experience relative to children living in wealthier school districts; and

Whereas, New Jersey has this nation's most segregated housing system and school districts, and loss of Head Start means low-income and black and Latino children would be disappropriately affected; and

Whereas, over $131 million in Head Start funds comes to local programs in New Jersey, which leverages those funds and invests in local businesses within the local Head Start community; and

Whereas, many community-based Head Start programs in New Jersey are able to build preschool facilities more economically and efficiently within the community than the State and public schools; and

Whereas, over 1,060 of Head Start's 3,400 employees in New Jersey are former Head Start parents and from the local community; and

Whereas, Head Start's mission includes a commitment to help parents become economically viable and better advocates for children and also to strengthen the community and engage in economic development activities; and

Whereas, block granting would undermine the New Jersey Supreme Court's Abbott v. Burk decision and allow the State to use the Federal funds to pay for its expenses rather than provide the supplemental funds that the Head Start programs need to meet the Supreme Court mandates: Now, therefore, be it

Resolved by the General Assembly of the State of New Jersey:

1. This House expresses its opposition to the move of Head Start funding by the Federal Government from the Department of Health and Human Services to the Department of Education and also expresses its opposition to provide Head Start funding on a block grant basis.

2. Duly authenticated copies of this resolution, signed by the Speaker of the General Assembly and attested by the Clerk, shall be transmitted to the President and Vice-President of the United States, the Speaker of the House of Representatives, the Secretaries of Education and Health and Human Services, and every member of Congress elected from this State.

POM–335. A resolution adopted by the House of Representatives of the General Assembly of the Commonwealth of Pennsylvania relative to consolidation loans; to the Committee on Health, Education, Labor, and Pensions.

HOUSE RESOLUTION NO. 388

Whereas, the 1998 Amendments to the Higher Education Act of 1965 (Public Law 105–244) provided for Federal consolidation loans to help students and graduates by reducing the cost of repaying the money that they borrowed to finance their higher education; and

Whereas, the law provides that a borrower who has a Federal consolidation loan is not eligible for a subsequent Federal consolidation loan except in the narrower circumstances in which he or she has obtained another eligible loan that is to be consolidated with the existing consolidation loan; and

Whereas, many students and graduates would benefit from the ability to refinance their student loans more than once in order to secure a lower rate of interest: Therefore, be it

Resolved, That the House of Representatives of the Commonwealth of Pennsylvania memorialize the Congress to amend the 1998 Amendments to the Higher Education Act of 1965 to allow for subsequent Federal consolidation loans regardless of whether the borrower has obtained a new eligible loan; and be it further

Resolved, That copies of this resolution be transmitted to the President of the United States, to the presiding officers of each house of Congress and to each member of Congress from Pennsylvania.

POM–336. A resolution adopted by the House of Representatives of the Legislature of the State of Michigan relative to confirmation hearings on the Michigan nominees to the United States 6th Circuit Court of Appeals; to the Committee on the Judiciary.

SENATE RESOLUTION NO. 127

Whereas, the Senate of the United States is perpetuating a grave injustice and endangering the well-being of countless Americans, putting our system of justice in jeopardy in Michigan and the states of the Sixth Circuit of the federal court system; and

Whereas, the Senate of the United States is allowing the continued, intentional obstruction of the judicial nominations of four fine Michigan jurists: Judges Henry W. Saad, Susan B. Neilson, David W. McKeague, and Richard A. Griffin, all nominated by the President of the United States to serve on the United States 6th Circuit Court of Appeals; and

Whereas, this obstruction is not only harming the lives and careers of good, qualified judicial nominees, but it is also prolonging a dire emergency in the administration of justice. This emergency has brought home to numerous Americans the truth of the phrase "justice delayed is justice denied"; and

Whereas, both of Michigan's Senators continue to block the Judiciary Committee of the United States from holding hearings regarding these nominees. This refusal to allow the United States to complete its constitutional duty of advice and consent is denying the nominees the opportunity to address any honest objections to their records or qualifications. It is also denying other Senators the right to air the relevant issues and vote according to their consciences. This is taking place during an emergency in the United States 6th Circuit Court of Appeals with the backlog of cases; and

Whereas, we join with the members of Michigan's congressional delegation who wrote Chairman Orrin Hatch on February 26, 2003, to express their concern that "if the President's nominations are permitted to be held hostage, for reasons not personal to any nominee, then these judicial seats traditionally held by judges representing the citizens of Michigan may be filled with nominees from other states within the Sixth Circuit. This would be an injustice to the many citizens who support these judges and who have given much to their professions and government in Michigan"; and

Whereas, we are concerned about the Sixth Circuit as a whole, a circuit understaffed, with 4 of its 16 seats vacant, knowing that the Sixth Circuit ranks next to last out of the 12 circuit courts in the time it takes to complete its cases. Since 1996, each active judge has had to increase his or her number of decisions by 46%—more than three times the national average. In the recent past, the Sixth Circuit has taken as long as 15.3 months to reach a final disposition of an appeal. With the national average at only 10.9 months, this means the Sixth Circuit takes over 40% longer than the national average to process a case; and

Whereas, the last time the Sixth Circuit was this understaffed, former Chief Judge Gilbert S. Merritt said that it was handling "a caseload that is excessive by any standard." Judge Merritt also wrote that the court was "rapidly deteriorating, understaffed and unable to properly carry out their responsibilities"; and

Whereas, decisions from the Sixth Circuit are slower in coming, based on less careful deliberation, and, as a result, are less likely to be just and predictable. The effects on our people, our society, and our economy are far-reaching, including transaction costs. Litigation increases as people strive to continue doing business when the lines of swift justice and clear precedent are being blurred; and

Whereas, President Bush has done his part to alleviate this judicial crisis. Over the past two years, he has nominated eight qualified people to the Sixth Circuit Court of Appeals, with three of them designated to address judicial emergencies. Four of these nominees continue to languish without hearings because of the obstruction of the two Michigan Senators: Now, therefore, be it

Resolved by the senate, That we memorialize the United States Senate and Michigan's United States Senators to act to continue the confirmation hearings and to have a vote by the full Senate on the Michigan nominees to the United States 6th Circuit Court of Appeals; and be it further

Resolved, That copies of this resolution be transmitted to Michigan's United States Senators and to the President of the United States Senate.

POM–337. A resolution adopted by the Senate of the Legislature of the State of Michigan relative to confirmation hearings on the Michigan nominees to the United States 6th Circuit Court of Appeals; to the Committee on the Judiciary.

HOUSE RESOLUTION NO. 108

Whereas, the Senate of the United States is perpetuating a grave injustice and endangering the well-being of countless Americans, putting our system of justice in jeopardy in Michigan and the states of the Sixth Circuit of the federal court system; and

Whereas, the Senate of the United States is allowing the continued, intentional obstruction of the judicial nominations of four fine Michigan jurists: Judges Henry W. Saad, Susan B. Neilson, David W. McKeague, and Richard A. Griffin, all nominated by the President of the United States to serve on the United States 6th Circuit Court of Appeals; and

Whereas, this obstruction is not only harming the lives and careers of good, qualified judicial nominees, but it is also prolonging a dire emergency in the administration of justice. This emergency has brought home to numerous Americans the truth of the phrase "justice delayed is justice denied"; and

Whereas, both of Michigan's Senators continue to block the Judiciary Committee of the United States Senate from holding hearings regarding these nominees. This refusal to allow the United States Senate to complete its constitutional duty of advice and consent is denying the nominees the opportunity to address any honest objections to their records or qualifications. It is also denying other Senators the right to air the relevant issues and vote according to their consciences. This is taking place during an emergency in the United States 6th Circuit Court of Appeals with the backlog of cases; and

Whereas, we join with the members of Michigan's congressional delegation who wrote Chairman Orrin Hatch on February 26, 2003, to express their concern that "if the President's nominations are permitted to be held hostage, for reasons not personal to any nominee, then these judicial seats traditionally held by judges representing the citizens of Michigan may be filled with nominees from other states within the Sixth Circuit. This would be an injustice to the many citizens who support these judges and who have give much to their professions and government in Michigan"; and

Whereas, we are concerned about the Sixth Circuit as a whole, a circuit court understaffed, with 4 of its 16 seats vacant, knowing that the Sixth Circuit ranks next to last out of the 12 circuit courts in the time it takes to complete its cases. Since 1996, each active judge has had to increase his or her number of decisions by 46%—more than three times the national average. In the recent past, the Sixth Circuit has taken as long as 15.3 months to reach a final disposition of an appeal. With the national average at only 10.9 months, this means the Sixth Circuit takes over 40% longer than the national average to process a case; and

Whereas, the last time the Sixth Circuit was this understaffed, former Chief Judge Gilbert S. Merritt said that it was handling "a caseload that is excessive by any standard." Judge Merritt also wrote that the court was "rapidly deteriorating, understaffed and unable to properly carry out their responsibilities"; and

Whereas, decisions from the Sixth Circuit are slower in coming, based on less careful deliberation, and as a result, are less likely to be just and predictable. The effects on our people, our society, and our economy are far-reaching, including transaction costs. Litigation increases as people strive to continue doing business when the lines of swift justice and clear precedent are being blurred; and

Whereas, President Bush has done his part to alleviate this judicial crisis. Over the past two years, he has nominated eight qualified people to the Sixth Circuit Court of Appeals, with three of them designated to address judicial emergencies. Four of these nominees continue to languish without hearings because of the obstruction of the two Michigan Senators: Now, therefore, be it

Resolved by the house of representatives, That we memorialize the United States Senate and Michigan's United States Senators to act to begin the confirmation hearings on the Michigan nominees to the United States 6th Circuit Court of Appeals; and be it further

Resolved, That copies of this resolution be transmitted to Michigan's United States Senators and to the President of the United States Senate.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Ms. COLLINS, from the Committee on Governmental Affairs, without amendment:

S. 1741. A bill to provide a site for the National Women's History Museum in the District of Columbia (Rept. No. 108–204).

By Mr. INHOFE, from the Committee on Environment and Public Works, with an amendment:

S. 1425. A bill to amend the Safe Drinking Water Act to reauthorize the New York City Watershed Protection Program (Rept. No. 108–205).

By Ms. COLLINS, from the Committee on Governmental Affairs, with an amendment in the nature of a substitute:

S. 1567. A bill to amend title 31, United States Code, to improve the financial accountability requirements applicable to the Department of Homeland Security, and for other purposes.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Ms. SNOWE:

S. 1897. A bill to amend title XVIII of the Social Security Act to provide a clarification of congressional intent regarding the counting of residents in a nonprovider setting for purposes making payment for medical education under the medicare program; to the Committee on Finance.

By Mr. COLEMAN:

S. 1898. A bill to amend the Internal Revenue Code of 1986 to allow tax-payers to designate part or all of any income tax refund to support reservists and National Guard members; to the Committee on Finance.

By Mr. BROWNBACK (for himself and Mr. GREGG):

S. 1899. A bill to improve data collection and dissemination, treatment, and research relating to cancer, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. LUGAR:

S. 1900. A bill to amend the African Growth and Opportunity Act to expand certain trade benefits to eligible sub-Saharan African countries, and for other purposes; to the Committee on Finance.

By Mr. BAYH:

S. 1901. A bill to amend the Internal Revenue Code of 1986 to provide for tax credit for offering employer-based health insurance coverage and to provide for the establishment of health insurance purchasing pools; to the Committee on Finance.

By Mr. REED (for himself, Mr. SPECTER, Mr. DURBIN, and Mr. ALLEN):

S. 1902. A bill to establish a National Commission on Digestive Diseases; to the Committee on Health, Education, Labor, and Pensions.

By Mr. BROWNBACK (for himself and Mr. BAYH):

S. 1903. A bill to promote human rights, democracy, and development in North Korea, to promote overall security on the Korean Peninsula and establish a more peaceful world environment, and for other purposes; to the Committee on the Judiciary.

By Mr. GRAHAM of Florida (for himself and Mr. NELSON of Florida):

S. 1904. A bill to designate the United States courthouse located at 400 North Miami Avenue in Miami, Florida, as the "Wilkie D. Ferguson, Jr. United States Courthouse"; to the Committee on Environment and Public Works.

By Ms. MURKOWSKI (for herself and Mr. CAMPBELL):

S. 1905. A bill to provide habitable living quarters for teachers, administrators, other school staff, and their households in rural areas of Alaska located in or near Alaska Native Villages; to the Committee on Indian Affairs.

By Mr. SESSIONS (for himself and Mr. MILLER):

S. 1906. A bill to provide for enhanced Federal, State, and local enforcement of the immigration laws, and for other purposes; to the Committee on the Judiciary.

By Mr. DASCHLE (for himself, Mr. JOHNSON, Mr. LEAHY, Mr. NELSON of Nebraska, Mr. PRYOR, Mr. BAUCUS, Mr. DAYTON, Mr. HARKIN, Mr. FEINGOLD, Mr. BINGAMAN, Mr. JEFFORDS, Mr. EDWARDS, and Mr. SCHUMER):

S. 1907. A bill to promote rural safety and improve rural law enforcement; to the Committee on the Judiciary.

By Mr. CORNYN:

S. 1908. A bill to allow certain Mexican nationals to be admitted as nonimmigrant visitors for a period of 6 months; to the Committee on the Judiciary.

By Mr. COCHRAN (for himself and Mr. KENNEDY):

S. 1909. A bill to amend the Public Health Service Act to improve stroke prevention, diagnosis, treatment, and rehabilitation; to the Committee on Health, Education, Labor, and Pensions.

By Mr. WYDEN:

S. 1910. A bill to direct the Secretary of Agriculture to carry out an inventory and management program for forests derived from public domain land; to the Committee on Energy and Natural Resources.

By Mr. HATCH (for himself and Mr. LEAHY):

S. 1911. A bill to amend the provisions of title III of the Trade Act of 1974 relating to violations of the TRIPS Agreement, and for other purposes; to the Committee on Finance.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. LEVIN (for himself, Ms. COLLINS, Mr. LIEBERMAN, Mr. REED, Mr. LAUTENBERG, Mr. DODD, Mr. WYDEN, Mr. JEFFORDS, and Mr. KENNEDY):

S. Res. 269. A resolution urging the Government of Canada to end the commercial seal hunt that opened on November 15, 2003; to the Committee on Foreign Relations.

By Mr. COLEMAN (for himself and Mr. DAYTON):

S. Res. 270. A resolution congratulating John Gagliardi, football coach of St. John's University, on the occasion of his becoming the all-time winningest coach in collegiate history; considered and agreed to.

ADDITIONAL COSPONSORS

S. 560

At the request of Mr. CRAIG, the name of the Senator from Maryland (Mr. SARBANES) was added as a cosponsor of S. 560, a bill to impose tariff-rate quotas on certain casein and milk protein concentrates.

S. 595

At the request of Mr. HATCH, the name of the Senator from Texas (Mrs. HUTCHISON) was added as a cosponsor of S. 595, a bill to amend the Internal Revenue Code of 1986 to repeal the required use of certain principal repayments on mortgage subsidy bond financings to redeem bonds, to modify the purchase price limitation under mortgage subsidy bond rules based on median family income, and for other purposes.

S. 674

At the request of Ms. COLLINS, the name of the Senator from New York (Mrs. CLINTON) was added as a cosponsor of S. 674, a bill to amend the National Maritime Heritage Act of 1994 to reaffirm and revise the designation of America's National Maritime Museum, and for other purposes.

S. 811

At the request of Mr. ALLARD, the name of the Senator from Alaska (Ms. MURKOWSKI) was added as a cosponsor of S. 811, a bill to support certain housing proposals in the fiscal year 2003 budget for the Federal Government, including the downpayment assistance initiative under the HOME Investment Partnership Act, and for other purposes.

S. 1006

At the request of Mr. BURNS, the name of the Senator from Vermont (Mr. JEFFORDS) was added as a cosponsor of S. 1006, a bill to reduce temporarily the duty on certain articles of natural cork.

S. 1177

At the request of Mr. JOHNSON, his name was withdrawn as a cosponsor of S. 1177, a bill to ensure the collection of all cigarette taxes, and for other purposes.

S. 1266

At the request of Mrs. CLINTON, the names of the Senator from Illinois (Mr. FITZGERALD), the Senator from Pennsylvania (Mr. SPECTER), the Senator from Colorado (Mr. CAMPBELL) and the Senator from Wyoming (Mr. ENZI) were added as cosponsors of S. 1266, a bill to award a congressional gold medal to Dr. Dorothy Height, in recognition of her many contributions to the Nation.

S. 1298

At the request of Mr. AKAKA, the name of the Senator from Rhode Island (Mr. CHAFEE) was added as a cosponsor of S. 1298, a bill to amend the Farm Security and Rural Investment Act of 2002 to ensure the humane slaughter of non-ambulatory livestock, and for other purposes.

S. 1354

At the request of Ms. MURKOWSKI, the name of the Senator from Idaho (Mr. CRAPO) was added as a cosponsor of S. 1354, a bill to resolve certain conveyances and provide for alternative land selections under the Alaska Native Claims Settlement Act related to Cape Fox Corporation and Sealaska Corporation, and for other purposes.

S. 1411

At the request of Mr. KERRY, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 1411, a bill to establish a National Housing Trust Fund in the Treasury of the United States to provide for the development of decent, safe, and affordable housing for low-income families, and for other purposes.

S. 1500

At the request of Mr. CONRAD, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 1500, a bill to amend the Internal Revenue Code of 1986 to modify the tax credit for holders of qualified zone academy bonds.

S. 1619

At the request of Mrs. MURRAY, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of S. 1619, a bill to amend the Individuals with Disabilities Education Act to ensure that children with disabilities who are homeless or are wards of the State have access to special education services, and for other purposes.

S. 1758

At the request of Mr. VOINOVICH, the name of the Senator from South Carolina (Mr. GRAHAM) was added as a cosponsor of S. 1758, a bill to require the Secretary of the Treasury to analyze and report on the exchange rate policies of the People's Republic of China, and to require that additional tariffs be imposed on products of that country on the basis of the rate of manipulation by that country of the rate of exchange between the currency of that country and the United States dollar.

S. 1781

At the request of Mr. DORGAN, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of S. 1781, a bill to authorize the Secretary of Health and Human Services to promulgate regulations for the reimportation of prescription drugs, and for other purposes.

S. 1879

At the request of Ms. MIKULSKI, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 1879, a bill to amend the Public Health Service Act to revise and extend provisions relating to mammography quality standards.

S. 1890

At the request of Mr. ENZI, the name of the Senator from Washington (Ms. CANTWELL) was added as a cosponsor of S. 1890, a bill to require the mandatory expensing of stock options granted to executive officers, and for other purposes.

S. CON. RES. 81

At the request of Mrs. FEINSTEIN, the name of the Senator from Georgia (Mr. MILLER) was added as a cosponsor of S. Con. Res. 81, a concurrent resolution expressing the deep concern of Congress regarding the failure of the Islamic Republic of Iran to adhere to its obligations under a safeguards agreement with the International Atomic Energy Agency and the engagement by Iran in activities that appear to be designed to develop nuclear weapons.

S. RES. 202

At the request of Mr. CAMPBELL, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. Res. 202, a resolution expressing the sense of the Senate regarding the genocidal Ukraine Famine of 1932–33.

S. RES. 216

At the request of Mr. LOTT, the name of the Senator from Minnesota (Mr. DAYTON) was added as a cosponsor of S. Res. 216, a resolution establishing as a standing order of the Senate a requirement that a Senator publicly discloses a notice of intent to object to proceeding to any measure or matter.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. COLEMAN:

S. 1898. A bill to amend the Internal Revenue Code of 1986 to allow taxpayers to designate part or all of any income tax refund to support reservists and National Guard members; to the Committee on Finance.

Mr. COLEMAN. Mr. President, I ask unanimous consent that the bill I introduce today—the Voluntary Support for Reservists and National Guard Members Act, which creates a voluntary check-off on tax returns to support the income lost to reservists who are called to active duty—be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1898

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Voluntary Support for Reservists and National Guard Members Act".

SEC. 2. DESIGNATION OF OVERPAYMENTS TO SUPPORT RESERVISTS.

(a) DESIGNATION.—

(1) IN GENERAL.—Subchapter A of chapter 61 of the Internal Revenue Code of 1986 is amended by adding at the end the following new part:

"PART IX—DESIGNATION OF OVERPAYMENTS TO SUPPORT RESERVISTS

"Sec. 6097. Designation.

"SEC. 6097. DESIGNATION.

"(a) IN GENERAL.—In the case of an individual, with respect to each taxpayer's return for the taxable year of the tax imposed by chapter 1, such taxpayer may designate that a specified portion (not less than $1) of any overpayment of tax for such taxable year be paid over to the Reservist Income Differential Trust Fund.

"(b) MANNER AND TIME OF DESIGNATION.—A designation under subsection (a) may be made with respect to any taxable year only at the time of filing the return of the tax imposed by chapter 1 for such taxable year. Such designation shall be made in such manner as the Secretary prescribes by regulations except that such designation shall be made either on the first page of the return or on the page bearing the taxpayer's signature.

"(c) OVERPAYMENTS TREATED AS REFUNDED.—For purposes of this title, any portion of an overpayment of tax designated under subsection (a) shall be treated as—

"(1) being refunded to the taxpayer as of the last date prescribed for filing the return of tax imposed by chapter 1 (determined without regard to extensions) or, if later, the date the return is filed, and

"(2) a contribution made by such taxpayer on such date to the United States.".

(2) TRANSFERS TO RESERVIST INCOME DIFFERENTIAL TRUST FUND.—The Secretary of the Treasury shall, from time to time, transfer to the Reservist Income Differential Trust Fund the amounts designated under section 6097 of the Internal Revenue Code of 1986.

(3) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 61 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

"Part IX. Designation of overpayments to support reservists.".

(b) RESERVIST INCOME DIFFERENTIAL TRUST FUND.—

(1) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to trust fund code) is amended by adding at the end the following new section:

"SEC. 9511. RESERVIST INCOME DIFFERENTIAL TRUST FUND.

"(a) ESTABLISHMENT.—There is established in the Treasury of the United States a trust fund to be known as the 'Reservist Income Differential Trust Fund', consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section or section 9602(b).

"(b) TRANSFERS TO TRUST FUND.—There are hereby appropriated to the Reservist Income Differential Trust Fund amounts equivalent to the amounts designated under section 6097 (relating to designation of overpayments to support reservists).

"(c) EXPENDITURES.—Amounts in the Reservist Income Differential Trust Fund shall be available for making distributions to eligible members of reserve components in accordance with section 212 of title 37, United States Code.".

(2) CLERICAL AMENDMENT.—The table of sections for such subchapter is amended by adding at the end the following new item:

"Sec. 9511. Reservist Income Differential Trust Fund.".

(c) EFFECTIVE DATES.—

(1) SUBSECTION (a).—The amendments made by subsection (a) shall apply to taxable years beginning after December 31, 2003.

(2) SUBSECTION (b).—The amendments made by subsection (b) shall take effect on the date of the enactment of this Act.

SEC. 3. PAY DIFFERENTIAL FOR MOBILIZED RESERVES.

(a) AUTHORITY.—

(1) IN GENERAL.—Chapter 3 of title 37, United States Code, is amended by adding at the end the following new section:

"§ 212. Reserves on active duty: pay differential for service in support of a contingency operation

"(a) AUTHORITY.—To the extent provided in appropriations Acts, the Secretary of a military department shall pay an eligible member of a reserve component of the armed forces a pay differential computed under subsection (c).

"(b) ELIGIBLE MEMBER.—A member of a reserve component is eligible for a pay differential for each month during which the member is serving on active duty for a period of more than 30 days pursuant to a call or order to active duty under a provision of law referred to in section 101(a)(13)(B) of title 10.

"(c) AMOUNT.—(1) Subject to paragraphs (2) and (3), the amount of a pay differential paid under this section for a month to a member called or ordered to active duty as described in subsection (b) shall be equal to the excess of—

"(A) the monthly rate of the salary, wage, or similar form of compensation that applied to the member in the member's position of employment (if any) for the last full month before the month in which the member either commenced the period of active duty to which called or ordered or commenced the performance of duties for the armed forces in another duty status in preparation for the performance of the active duty to which called or ordered, over

"(B) the monthly rate of basic pay payable to the member under section 204 of this title for such month of active-duty service.

"(2) The Secretary concerned may pay a member a pay differential under this section for a month in an amount less than the amount computed under paragraph (1) if the Secretary concerned determines that it is necessary to do so on the basis of the availability of funds for such purpose.

"(3) A member may not be paid more than a total of $25,000 under this section.

"(d) FUNDING.—(1) Pay differentials under this section shall be paid out of funds that are transferred from the Reservist Income Differential Trust Fund to military personnel accounts for the purposes of this section.

"(2) The Secretary of Defense and the Secretary of the Treasury shall jointly prescribe regulations providing for transfers of funds in the Reservist Income Differential Trust Fund to the appropriate military personnel accounts to make payments under this section.

"(3) In this section, the term 'Reservist Income Differential Trust Fund' means the Reservist Income Differential Trust Fund referred to in section 6097 of the Internal Revenue Code.".

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by adding at the end the following new item:

"212. Reserves on active duty: pay differential for service in support of a contingency operation.".

(b) EFFECTIVE DATE.—Section 212 of title 37, United States Code, shall take effect on October 1, 2004, and shall apply with respect to months that begin on or after that date.

By Mr. BROWNBACK (for himself and Mr. GREGG):

S. 1899. A bill to improve data collection and dissemination, treatment, and research relating to cancer, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. BROWNBACK. Mr. President, ours is a remarkable Nation.

America is the home to 90 of the top 100 universities. Americans work an average of 300 hours more per year than our friends in Europe. More patents are applied for in this Nation each year than in all of the EU member states combined. We lead the world in research and development. Perhaps the area in which our labor and investment will have the most profound impact, is in field of the life sciences.

This year our Nation met a remarkable goal. In the span of the last 5 years we have doubled our financial commitment to basic health research funding. Those funds will go toward saving and extending the lives of, and improving the quality of life for, people around the world.

Our history has proven that when this Nation is resolute and determined, we can achieve remarkable things.

In 1939, the United States was producing 800 military airplanes per year. At the onset of World War II, President Roosevelt challenged the Nation to increase manufacturing to 4,000 planes per month. By the end of 1943, in perhaps the greatest industrial feat in history, the United States was producing 8,000 military aircraft per month.

On May 5, 1961, the United States launched Mercury 3 and Alan Shepard became the first American in space, spending a total of 15 minutes and 28 seconds in sub-orbit. Twenty days later President Kennedy addressed a joint session of Congress and proposed that our Nation land a man on the moon before the end of the decade. Only July 29, 1969, four days after leaving the launch pad, Neil Armstrong stepped from the lunar module to the surface of the moon in perhaps the greatest engineering and technological feat in history.

Between 1996 and 1997, for the first time, the total number of cancer deaths in the United States did not rise. That trend has continued to this very day. Today, there are at least 50 compounds under investigation for efficacy as cancer preventives and untold research is being performed in search of new cures and treatments for cancer. This is the time for our Nation to become resolute and determined to achieve what may be the greatest scientific feat in history—to win the war on cancer.

Our Nation began its commitment to the War on Cancer with the passage of the National Cancer Institute Act of 1937. In 1971, Congress committed itself to win the war with the passage of the National Cancer Act. Today, I am joined by the Chairman of the Health, Education, Labor, and Pensions Committee JUDD GREGG in beginning the next campaign of this war, with the introduction of the National Cancer Act of 2003. With this bill we renew our commitment to the fight, and join NCI Director Dr. Andrew Von Eshenbach in his commitment to make cancer survivorship the rule and cancer deaths rare by 2015.

Major provisions within the legislation include: Enhancing our current cancer registry system; enhancing our existing screening mechanisms; creating a new Patient Education Program; enhancing NCI Designated Comprehensive Cancer Centers; elevating the importance of pain management and survivorship throughout the nation's cancer programs; authorizing the Office of Survivorship within NCI; freeing the NCI to engage private entities to further cancer research; and providing patients with greater access to experimental therapies.

In the coming months, I look forward to working with the Chairman, the Administration and other members interested committed to winning the War on Cancer, to get this bill to markup, to the floor and to the President's desk.

By Mr. LUGAR:

S. 1900. A bill to amend the African Growth and Opportunity Act to expand certain trade benefits to eligible sub-Saharan African countries, and for other purposes; to the Committee on Finance.

Mr. LUGAR. Mr. President, I rise today to introduce the "United States-Africa Partnership Act." This bill builds on the important trade and investment initiatives that were contained in the African Growth and Opportunity Act (AGOA) passed in 2000.

The original African Growth and Opportunity Act and the expansion of AGOA that I am introducing today emphasize the need to elevate the African private sector. The AGOA legislation offers enhanced trade benefits, more U.S. private sector investment, and a higher level dialogue with African governments. It envisions a new economic partnership between the United States and African nations.

To gain these benefits, African countries are expected to undertake sustained economic reform, abide by international human rights practices, and strengthen good goverance. These standards have been used by the U.S. to stimulate reforms in Asia, Latin America, Eastern Europe and elsewhere. There is no reason to expect that they will not be successful in Africa as well.

Private investment tends to follow good governance and economic reform, but the private sector takes cues from government policies and involvement. It is very much in our interest to play a constructive role in the evolving political and economic transition in Africa. A stable and prosperous Africa will be better equipped to cooperate on a range of shared global problems such as weapons proliferation, terrorism, narcotics, the environment and contagious diseases. African economic success also can create new markets for American exports. If jobs are created and foreign exchange is earned through enhanced exports, Africa will have greater capacity to buy goods and services from abroad. They will likely purchase machinery, electronics, financial services, agricultural products, and many other goods and services from U.S. suppliers.

If we had ignored Taiwan and Korea in the 1960s when they were at stages of economic development comparable to many African societies today, we would have missed out on enormous opportunities in East Asia. Years from now, I hope we can look back and say that we were present at a crucial juncture in Africa's growth and development and that we played a constructive role in that change.

In an effort to reverse the persistent under-performance by African economies and to stimulate American involvement in Africa, I introduced the African Growth and Opportunity Act in the United States Senate in 1999. Since its enactment in 2000, AGOA has been a positive economic force in Africa. In 2002, 94 percent of U.S. imports from AGOA-eligible countries entered duty-free. The United States imported $9 billion in merchandise duty-free under AGOA in 2002, a 10 percent increase from 2001.

Imports from African countries, not counting oil, jumped 50 percent last year. In South Africa, sub-Sahara's most important economy, exports of automobiles have increased sixteenfold in the past two years. The tiny country of Lesotho, population 2.2 million, generated $318 million in AGOA exports in 2002. New export-oriented garment factories have created 25,000 jobs. For the first time in its history, private sector manufacturing employment—thanks to trade—exceeds government employment.

Performances like this, which occurred despite the recent slowdown in world trade, are the direct result of AGOA. The legislation lets African countries export some 1,800 products duty-free, without quotas, to the United States. It is a direct response to developing countries' long-time plea; trade, not aid, is the real key to ending poverty and bringing about sustainable, long term economic growth.

Despite these signs of progress, many Africa economies remain in bad shape. Of the 64 least developed countries in the world, 38 are in Africa. Per capita output of goods and services actually dropped during the 1990s, according to the World Bank, and with only 1.4 percent of world trade in 2001, sub-Saharan Africa has been falling behind the rest of the world. During the 1990s, global gross domestic product grew a robust 44 percent; the figure for Africa was only 8.5 percent. From 1990 to 2001, gross national income per capita in sub-Saharan Africa actually declined by .2 percent.

Africa is in need of help, and expanding AGOA should be a part of the development strategy for the continent. The experience of AGOA has taught us valuable lessons about the path to enhanced investment and economic development and has confirmed some of the key principles that proponents of market-based development have used to guide policy. First, AGOA has demonstrated that a commitment to good governance and a positive investment climate is important to economic growth. Countries such as Lesotho, which has made significant efforts in recent years to promote economic reform and stable democracy, have derived the most benefit from the AGOA provisions. Second, the experience of AGOA has demonstrated that regional integration is as essential to development as access to the U.S. and other foreign markets. Using the infrastructure and economic stability of South Africa as a base, neighboring southern African countries have worked together to take advantage of the benefits under AGOA.

AGOA should not be seen as an end in itself. Rather, it is an initial step designed to expand development and decrease poverty by promoting greater integration of Africa into the global trading community. Achieving these goals will require both enhancements to the AGOA framework and additional steps to address the compelling problems facing Africa. Our trade efforts must be part of a broader American partnership with the often-neglected countries of Africa.

This partnership starts with three issues. First, we must help address the HIV/AIDS crisis in Africa. In addition to the human tragedy that HIV/AIDS has created in Africa, the epidemic severely limits the economic growth that would reduce Africa's poverty. When workers are forced to call in sick more days than they are able to work, when government positions are experiencing regular turnover, and when scarce capital must be diverted from investment to dealing with the AIDS crisis, it is nearly impossible to build a stable economy.

Earlier this year, Congress passed legislation establishing a program under which the United States will contribute $15 billion over the next 5 years to address the HIV/AIDS crisis in Africa. The President signed this bill into law and has placed his prestige behind its effective implementation. It is my hope that this leadership and much needed funding will start to turn the tide in the fight against the HIV/AIDS epidemic.

Second, we have begun an effort to rethink the way that aid is delivered to the world's poorest countries, most of which are in Africa. Earlier this year, the Senate Foreign Relations Committee took action on the President's Millennium Challenge Corporation initiative. This initiative would deliver up to $8 billion over the next three years to the world's poorest countries, and it would condition that aid on the development of policies by the recipient countries that will make that aid more effective. These policies include a commitment to just and democratic governance and economic freedom. The Millennium Challenge Corporation would build on the lessons of AGOA, which has demonstrated that private investment will flow to countries that build a stable, predictable investment climate. The incentives provided by Millennium Challenge Corporation dollars would help to establish conditions that will cause private investment dollars to flow to the poorest countries.

Third, we need to move forward with enhancements to AGOA itself. That is my purpose in introducing the United States Africa Partnership Act (USAPA)—also known as "AGAO III."' The current AGOA expires in 2008. My bill would extend AGOA benefits until 2015. This coincides with the goal of the World Trade Organizations to have a "tariff free world" by 2015. We should take action on this extension soon so that investors will have the certainty they need when making investment decisions involving Africa.

AGOA contains a provision that allows least developed countries (LDCs) to export capped quantities of apparel made from third country fabric to the U.S. duty free. All other countries must use U.S. or African fabric inputs in order to receive duty-free treatment. This "special rule" for LDCs expires on September 30, 2004. USAPA would extend this provision for four additional years until September 30, 2008.

It also would eliminate the import sensitivity test with respect to African products and nuisance provisions in the rule of origin for apparel. The AGOA rule of origin is modified so that it applies only to the essential components of apparel. USAPA also clarifies the definitions of certain fabrics for customs purposes, including hand-loomed folklore articles.

USAPA would develop initiatives to provide technical and capacity building experience. In the area of agriculture, it directs the Secretary of Agriculture to develop a comprehensive plan to increase import and export abilities in agricultural trade. It also provides that 20 full-time personnel of the Animal and Plant Health Inspection Service be stationed in at least 10 AGOA eligible countries to provide technical assistance in meeting U.S. import requirements and trade capacity building.

In an effort to stimulate business partnerships, the bill I introduce today also addresses investment incentives and encourages the Overseas Private Investment Corporation, the Export-Import Bank, and the Foreign Agricultural Service to facilitate investment in AGOA eligible countries. It directs the Secretary of the Treasury to seek negotiations regarding tax treaties with eligible countries.

In addition, it encourages U.S. private investment in African transportation, energy and telecommunications and increases coordination between U.S. and African transportation entities to reduce transit times and costs between the United States and Africa.

Finally, the bill grants funding for the continuation of the AGOA forums and establishes an AGOA task force to facilitate the goals of the Act.

The original African Growth and Opportunity Act launched an effort to formulate a new American strategy towards Africa. It sought to establish the foundation for a more mature economic relationship with those countries in Africa that undertake serious economic and political reforms. That effort was supported by virtually all sub-Saharan African nations, and it had wide support among American businesses and non-governmental organizations. We should now seize the opportunity to further integrate African countries into the world economy.

The United States-Africa Partnership Act that I introduce today recognizes the enormous potential for economic growth and development in sub-Saharan Africa. It embraces the vast diversity of people, cultures, economies, and potential among forty-eight countries and nearly 700 million people. A stable and economically prosperous Africa can provide new partnerships that will contribute greatly to our commercial and security interests. I urge all members to support the United States-Africa Partnership Act so that we can achieve the mutual long-term benefits that it would bring to Africa and to our country.

By Mr. REED (for himself, Mr. SPECTER, Mr. DURBIN, and Mr. ALLEN):

S. 1902. A bill to establish a National Commission on Digestive Diseases; to the Committee on Health, Education, Labor, and Pensions.

Mr. REED. Mr. President, I rise today, along with my colleague, Senator SPECTER of Pennsylvania, to introduce the National Commission on Digestive Diseases Act.

It is estimated that over 62 million Americans presently suffer from a range of painful, debilitating and in some cases, fatal digestive diseases. Conditions such as inflammatory bowel disease (IBD), irritable bowel syndrome (IBS), colorectal cancer, gastroesophageal reflux disease impact the lives of our friends, loved ones and neighbors. These diseases produce total estimated direct and indirect costs in excess of $40 billion annually. Of course, these figures do not take into account the serious physical and emotional toll digestive diseases have on those afflicted.

Thanks to significant advances in medical science, we are now on the brink of some major scientific breakthroughs in the area of digestive disease research. However, in other areas of this diverse field, we still lack even a basic understanding of the condition itself, let alone effective methods of treatment and prevention.

The bill I am proposing today would call upon the Secretary of the Department of Health and Human Services (HHS) to establish a Commission of scientific and health care providers with expertise in the field, as well as persons suffering from digestive ailments, to assess the state of digestive disease research and develop a long range plan to direct our scientific research agenda with regard to digestive disease. The Commission would submit their report to Congress in 18 months.

This legislation would build upon the successes of a digestive disease commission that was assembled roughly 25 years ago with a similar goal. The 1976 Commission's findings directed significant progress in the area of digestive disease research.

While the plan set forth by the first Commission has certainly accomplished a great deal, the burden of digestive diseases in this country remains substantial and advancements in genetics and medical technology compel the assembly of a new commission to guide our research efforts well into the 21st century.

I look forward to working with my colleagues towards expeditious passage of this important, bipartisan legislation.

Mr. SPECTER. Mr. President, I have sought recognition today to join my colleague Senator REED of Rhode Island to introduce the National Commission on Digestive Diseases Act.

Each year, more than 62 million Americans are diagnosed with digestive diseases and disorders. These conditions, such as colorectal, liver and pancreatic cancers, inflammatory bowel disease, irritable bowel syndrome, gastroesophageal reflux disease (GERD) and chronic hepatitis C require patients to undergo rigorous courses of medical therapies and treatment. As Chairman of the Labor, Health and Human Services, and Education Appropriations Subcommittee, I am acutely aware that while promising research developments have been made in these areas, the causes of many of these diseases are unknown and their incidence is on the rise.

In 2001, the Lewin Group conducted a study of the economic burden to our society resulting from the direct and indirect costs associated with just 17 of the over several hundred digestive diseases. The results of this study revealed that the total costs associated with physician care, inpatient and outpatient hospital care as well as loss of work for patients with digestive disorders was $42 billion in the year 2000. It is clear from this study and the findings of digestive disease specialists around the country that these disorders represent enormous health and economic consequences for the nation.

The National Commission on Digestive Diseases Act would address the burden of digestive diseases in a comprehensive and coordinated manner. This legislation would create a panel of scientists in the relevant disciplines, patient representatives, employers and other appropriate experts to conduct a comprehensive study on the current state of scientific and clinical knowledge in digestive diseases. The commission would then be charged with evaluating the resources necessary to expedite the discovery of treatments and cures for patients with these diseases and develop a 5–10 year long-range plan for effectively addressing these needs.

In 1976, Congress created a Commission on Digestive Diseases Research which serves as the successful model for this new initiative. Following 18 months of deliberations, the 1970s commission created a long-range plan and recommendations that laid the groundwork for significant progress in the area of digestive diseases research. The state of scientific knowledge has changed substantially since the late 1970s, however, and the advent of genetics and genomics research, as well as the discovery of additional digestive diseases, compels us to look anew at the challenges that digestive diseases present to patients and those who care for them.

It is my hope that this legislation will advance our understanding of the causes, effective treatments, possible prevention, and cures for digestive diseases. I look forward to working with my colleagues to enact this important bipartisan legislation.

By Ms. MURKOWSKI (for herself and Mr. CAMPBELL):

S. 1905. A bill to provide habitable living quarters for teachers, administrators, other school staff, and their households in the rural areas of Alaska located in or near Alaska Native Villages; to the Committee on Indian Affairs.

Ms. MURKOWSKI. Mr. President, I rise to introduce a bill that will have a profound effect on the retention of teachers, administrators, and other school staff in remote and rural areas of Alaska. I am pleased to have Mr. CAMPBELL join me in introducing this bill.

In rural areas of Alaska, school districts face the challenge of recruiting and retaining teachers, administrators and other school staff due to the lack of housing. In the Lower Kuskokwim School District in western Alaska, they hire one teacher for every six who decide not to accept job offers. Half of the applicants not accepting a teaching position in that district indicated that their decision as related to the lack of housing.

Earlier this year, I traveled through rural Alaska with Education Secretary Rod Paige. I wanted him to see the challenges of educating children in such a remote and rural environment. At the village school in Savoonga, the principal slept in a broom closet in the school due to the lack of housing in that village. The special education teacher slept in her classroom, bringing a mattress out each evening to sleep on the floor. The other teachers shared housing in a single home. Needless to say, there is not enough room for the teachers' spouses. Unfortunately, Savoonga is not an isolated example of the teacher housing situation in rural Alaska.

Rural Alaskan school districts experience a high rate of teacher turnover due to the lack of housing. Turnover is as high as 30 percent each year in some rural areas with housing issues being a major factor. How can we expect our children to receive a quality education when the good teachers don't stay? How can we meet the mandates of No Child Left Behind in such an educational environment? Clearly, the lack of teacher housing in rural Alaska is an issue that must be addressed in order to ensure that children in rural Alaska receive the same level of education as their peers in more urban settings.

My bill authorizes the Department of Housing and Urban Development to provide teacher housing funds to the Alaska Housing Finance Corporation, which is a State agency. In turn, the corporation is authorized to provide grant and loan funds to rural school districts in Alaska for teacher housing projects.

This legislation will allow school districts in rural Alaska to address the housing shortage in the following ways: construct housing units; purchase housing units; lease housing units; rehabilitate housing units; purchase or lease property on which housing units will be constructed, purchased or rehabilitated; repay loans secured for teacher housing projects; provide funding to fill any gaps not previously funded by loans or other forms of financing; and conduct any other activities normally related to the construction, purchase, or rehabilitation of teacher housing projects.

Eligible school districts that accept funds under this legislation will be required to provide the housing to teachers, administrators, other school staff, and members of their households.

It is imperative that we address this important issue immediately and allow the flexibility for the disbursement of funds to be handled at the local level. The quality of education of our rural students is at stake.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1905

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Rural Teacher Housing Act of 2003".

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—Congress finds that—

(1) housing for teachers, administrators, other school staff, and their households in remote and rural areas of Alaska is often substandard, if available at all;

(2) as a consequence, teachers, administrators, other school staff, and their households are often forced to find alternate shelter, sometimes even in school buildings; and

(3) rural school districts in Alaska are facing increased challenges, including meeting the mandates of the No Child Left Behind Act, in recruiting employees due to the lack of affordable, quality housing.

(b) PURPOSE.—The purpose of this Act is to provide habitable living quarters for teachers, administrators, other school staff, and their households in rural areas of Alaska located in or near Alaska Native Villages.

SEC. 3. DEFINITIONS.

In this Act, the following definitions shall apply:

(1) ALASKA HOUSING FINANCE CORPORATION.—The term "Alaska Housing Finance Corporation" means the State housing authority for the State of Alaska, created

under the laws of the State of Alaska, or any successor thereto.

(2) ELEMENTARY SCHOOL.—The term "elementary school" has the meaning given that term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(3) ELIGIBLE SCHOOL DISTRICT.—The term "eligible school district" means a public school district (as defined under the laws of the State of Alaska) located in the State of Alaska that operates one or more schools in a qualified community.

(4) NATIVE VILLAGE.—The term "Native Village"—

(A) has the meaning given that term in section 3 of the Alaska Native Claims Settlement Act (43 U.S.C 1602); and

(B) includes the Metlakatla Indian Community of the Annette Islands Reserve.

(5) OTHER SCHOOL STAFF.—The term "other school staff" means pupil services personnel, librarians, career guidance and counseling personnel, education aides, and other instructional and administrative school personnel.

(6) QUALIFIED COMMUNITY.—

(A) IN GENERAL.—The term "qualified community" means a home rule or general law city incorporated under the laws of the State of Alaska, or an unincorporated community (as defined under the laws of the State of Alaska) in the State of Alaska situated outside the limits of such a city, with respect to which, the Alaska Housing Finance Corporation has determined that the city or unincorporated community—

(i) has a population of 6,500 or fewer individuals;

(ii) is situated within or near a Native Village, as determined by the Alaska Housing Finance Corporation; and

(iii) is not connected by road or railroad to the municipality of Anchorage, Alaska.

(B) CONNECTED BY ROAD.—In this paragraph, the term "connected by road" does not include a connection by way of the Alaska Marine Highway System, created under the laws of the State of Alaska, or a connection that requires travel by road through Canada.

(7) SECONDARY SCHOOL.—The term "secondary school" has the meaning given that term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(8) SECRETARY.—The term "Secretary" means the Secretary of Housing and Urban Development.

(9) TEACHER.—The term "teacher" means an individual who is employed as a teacher in a public elementary or secondary school, and meets the teaching certification or licensure requirements of the State of Alaska.

(10) TRIBALLY DESIGNATED HOUSING ENTITY.—The term "tribally designated housing entity" has the meaning given that term in section 4 of the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4103).

(11) VILLAGE CORPORATION.—The term "Village Corporation" has the meaning given that term in section 3 of the Alaska Native Claims Settlement Act (43 U.S.C. 1602), and includes urban and group corporations, as defined in that section.

SEC. 4. RURAL TEACHER HOUSING PROGRAM.

(a) GRANTS AND LOANS AUTHORIZED.—The Secretary shall provide funds to the Alaska Housing Finance Corporation in accordance with the regulations promulgated under section 5, to be used as provided under subsection (b).

(b) USE OF FUNDS.—

(1) IN GENERAL.—Funds received pursuant to subsection (a) shall be used by the Alaska Housing Finance Corporation to make grants or loans to eligible school districts, to be used as provided in paragraph (2).

(2) USE OF FUNDS BY ELIGIBLE SCHOOL DISTRICTS.—Grants or loans received by an eligible school district pursuant to paragraph (1) shall be used for—

(A) the construction of new housing units within a qualified community;

(B) the purchase and rehabilitation of existing structures to be used as housing units within a qualified community;

(C) the rehabilitation of housing units within a qualified community;

(D) the leasing of housing units within a qualified community;

(E) purchasing or leasing real property on which housing units will be constructed, purchased, or rehabilitated within a qualified community;

(F) the repayment of a loan used for the purposes of constructing, purchasing, or rehabilitating housing units, or for purchasing real property on which housing units will be constructed, purchased, or rehabilitated, within a qualified community, or any activity under subparagraph (G);

(G) any other activities normally associated with the construction, purchase, or rehabilitation of housing units within a qualified community, including—

(i) connecting housing units to various utilities;

(ii) preparation of construction sites;

(iii) transporting all equipment and materials necessary for the construction or rehabilitation of housing units to and from the site on which such housing units exist or will be constructed; and

(iv) environmental assessment and remediation of construction sites or sites where housing units exist; and

(H) the funding of any remaining costs for the construction, purchase, or rehabilitation of housing units within a qualified community, the purchase of real property within a qualified community, or any activity listed under subparagraph (G) that is not financed by loans or other sources of funding.

(c) OWNERSHIP OF HOUSING AND LAND.—

(1) IN GENERAL.—All housing units constructed, purchased, or rehabilitated, or real property purchased, with grant or loan funds provided under this Act, or with respect to which funds under this Act have been expended, shall be owned by the relevant eligible school district, municipality (as defined under the laws of the State of Alaska), Village Corporation, the Metlakatla Indian Community of the Annette Islands Reserve, or a tribally designated housing entity. Ownership of housing units and real property may be transferred between such entities.

(d) OCCUPANCY OF HOUSING UNITS.—

(1) IN GENERAL.—Except as provided under paragraphs (2) and (3), each housing unit constructed, purchased, rehabilitated, or leased with grant or loan funds under this Act, or with respect to which funds awarded under this Act have been expended, shall be provided to teachers, administrators, other school staff, and members of their households.

(2) NON-SESSION MONTHS.—A housing unit constructed, purchased, rehabilitated, or leased with grant or loan funds under this Act, or with respect to which funds awarded under this Act have been expended, may be occupied by individuals other than teachers, administrators, other school staff, or members of their household, only during those times in which school is not in session.

(3) TEMPORARY OCCUPANTS.—A vacant housing unit constructed, purchased, rehabilitated, or leased with grant or loan funds under this Act, or with respect to which funds awarded under this Act have been expended, may be occupied by a contractor or guest of an eligible school district for a maximum period of time, to be determined by the Alaska Housing Finance Corporation.

(e) COMPLIANCE WITH LAW.—Each eligible school district receiving a grant or loan under this Act shall ensure that all housing units constructed, purchased, rehabilitated, or leased with such grant or loan funds, or with respect to which funds awarded under this Act have been expended, meet all applicable laws, regulations, and ordinances.

(f) PROGRAM POLICIES.—

(1) IN GENERAL.—The Alaska Housing Finance Corporation, after consulting with eligible school districts, shall establish policies governing the administration of grant and loan funds made available under this Act. Such policies shall include a methodology for ensuring that funds provided under this Act are made available on an equitable basis to eligible school districts.

(2) REVISIONS.—Not less than every 3 years, the Alaska Housing Finance Corporation shall, in consultation with eligible school districts, consider revisions to the policies established under paragraph (1).

SEC. 5. REGULATIONS.

Not later than 1 year after the date of enactment of this Act, the Secretary shall promulgate such regulations as are necessary to carry out this Act.

SEC. 6. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated to the Department of Housing and Urban Development such sums as are necessary for each of the fiscal years 2005 through 2014, to carry out this Act.

(b) LIMITATION.—The Secretary and the Alaska Housing Finance Corporation shall each use not more than 5 percent of the funds appropriated in any fiscal year to carry out this Act for administrative expenses associated with the implementation of this Act.

By Mr. SESSIONS (for himself and Mr. MILLER):

S. 1906. A bill to provide for enhanced Federal, State, and local enforcement of the immigration laws, and for other purposes; to the Committee on the Judiciary.

Mr. SESSIONS. Mr. President, I rise today to introduce the Homeland Security Enhancement Act of 1003. Senator MILLER and I have taken the lead in encouraging a culture of cooperation of all levels of immigration law enforcement—Federal, State, and local—and seek to build an immigration law enforcement system that uses unified databases for information sharing from one level to another.

The subject matter of the bill introduced today is one I care very deeply about—the ability of State and local law enforcement to voluntarily aid the Federal Government in the Enforcement of immigration law. Let me be clear, this bill is not about the commandeering of State and local police forces or about forcing them to dedicate resources toward immigration law enforcement, it is simply about their authority to participate in immigration law enforcement if they so choose.

I am convinced that our ability to successfully enforce our immigration laws is a test of whether we will be a Nation governed by laws.

Many of the immigration reforms enacted by this Congress since 9/11 have been aimed at fixing the first half of our broken immigration system, the visa issuance process that allowed terrorists to enter our country under the guise of legality.

It is now time to look at the second half of our broken immigration system—the half that allows people to remain here illegally for indefinite time periods, regardless of how they came here.

We know that Americans strongly value our heritage as a Nation of immigrants. Americans openly welcome legal immigrants and new citizens with character, ability, decency, and a strong work ethic. However, it is also clear Americans do not feel the same way about illegal immigration. The fact is that a large majority of Americans feel that State and local governments should be aiding the Federal Government in stopping illegal immigration.

A RoperASW poll published in March of this year titled "Americans Talk About Illegal Immigration" found that 88 percent of Americans agree, and 68 percent "strongly" agree, that Congress should require State and local government agencies to notify the INS, now ICE, and their local law enforcement when they determine that a person is here illegally or has presented fraudulent documentation. Additionally, 85 percent of Americans agree, and 62 percent "strongly" agree that Congress should pass a law requiring State and local governments and law enforcement agencies, to apprehend and turn over to the INS, now ICE, illegal immigrants with whom they come in contact.

Those numbers speak volumes about the desires of the American population. It is important to note that those numbers were collected on requiring state and local action. It is very likely that a poll on this bill, a bill that is about volunteer State and local action would yield even stronger support.

America's strength is based on its commitment to the rule of law. Inscribed on the front of the Supreme Court Building just down the street are the words, "Equal Justice Under Law."

In the world of immigration laws, a facade of enforcement that holds no real consequences for law breakers is both dangerous and irresponsible. If the only real consequence of coming to this country illegally is a social label, then our immigration laws are but a brightly painted sepulcher full of dead bones, for it is impossible to be a Nation governed by the rule of law, if our laws have no real effect on the lives of the people they govern.

Our illegal alien population is at a record high. The lack of immigration enforcement in our country's interior has resulted in 8–10 million illegal aliens living in the U.S. with another estimated 800,000 illegal aliens joining them every year—that is on top of the more than 1 million that legally immigrate each year. These numbers make it easy for criminal aliens to disappear inside our borders.

Of the 8–10 million illegal aliens present today, the Department of Homeland Security has estimated that 450,000 are "alien absconders"—people that have been issued final deportation orders but have not shown up for their hearings.

An estimated 86,000 of them are criminal illegal aliens—people convicted of crimes they committed in the U.S. who should have been deported, but have slipped through the cracks and are still here.

The next number is perhaps the most concerning—3,000 of the "alien absconders" within our borders are from one of the countries that the State Department has designated to be a "state sponsor of terrorism."

The number of illegal aliens outweighs the number of federal agents whose job it is to find them within our borders by 5,000 to 1. The enforcement arm of the old INS, now called The Bureau of Immigration and Customs Enforcement (ICE) has a mere 2,000 interior agents inside the borders. Leaving the job of interior immigration enforcement solely to them will guarantee failure.

State and local police, a force 650,000 strong, are the eyes and ears of our communities. They are sworn to uphold the law. They police our streets and neighborhoods every day. Their role is critical to the success of our immigration system.

For that critical role to be effective, a few very important things need to happen: 1. State and local law enforcement need clear authority to voluntarily act; 2. the NCIC needs to contain critical immigration related information that can be accessed on the roadside; 3. Federal immigration officials have to take custody of illegal aliens apprehended by State officers, they can not continue to tell them to just let them go; 4. the Institutional Removal Program has to be expanded so that criminal aliens are detained after their State sentences until deportation, they can't be released back into the community just to be searched for by federal officials at a later date; and 5. critically needed federal bedspace has to be given to DHS for they can not guarantee effective removal without adequate detention space.

The Homeland Security Enhancement Act that Senator MILLER and I are introducing today will do all of those things.

Let me tell you about a few of the problems in immigration enforcement that started my interest in this area and prompted me to author this bill.

A few years ago, police chiefs and sheriffs in Alabama began to tell me that they had been shut out of the system and felt powerless to do anything about Alabama's growing illegal immigrant population.

As I went to town hall meetings and conferences with police, I heard the same story—"we have given up calling the INS because INS tells us we have to have 15 or more illegal aliens in custody or they will not even come pick them up."

Even worse is that Alabama police were told that the aliens could not be detained until the INS could manage to send someone. They were told they had to just let them go! They were being told this, even though I thought the legal authority of State and local officers to voluntarily act on violations of immigration law was clear. If there is any doubt that State and local officers have this authority, Congress needs to fix that, which is what this bill will do.

Only two circuits have expressly ruled on State and local law enforcement authority to make an arrest on an immigration law violation. In 1983, the Ninth Circuit, while not mentioning a preexisting general authority, held that nothing in federal law precludes the police from enforcing the criminal provisions of the Immigration and Naturalization Act. See *Gonzales* v. *City of Peoria*, 722 F.2d 468 (9th Cir. 1983).

The Tenth Circuit has reviewed this question on several occasions, concluding squarely that a "State trooper has general investigatory authority to inquire into possible immigration violations." *United States* v. *Salinas-Calderon*, 728 f.2d 1298, 1301 n.3 (10th Cir. 1984).

As the Tenth Circuit has described it, there is a "preexisting general authority of State or local police officers to investigate and make arrests for violations of federal law, including immigration laws.," *United States* v. *Vasquez-Alvares*, 176 F.3d 1294, 1295 (10th Cir. 1999). And again, in 2001, the Tenth Circuit reiterated that "State and local police officers [have] implicit authority within their respective jurisdictions 'to investigate and make arrests for violations of federal law, including immigration laws.'" *United States* v. *Santana-Garcia*, 264 F.3d 1188, 1194 (citing *United States* v. *Vasquez-Alvarez*, 176 F.3d 1294, 1295).

None of these Tenth Circuit holdings drew any distinction between criminal violations of the INA and civil provisions that render an alien deportable. It appears that the Ninth Circuit started the confusion regarding the distinction between civil and criminal violations in Gonzales v. City of Peoria by asserting in dicta that the civil provisions of the INA are a persuasive regulatory scheme, and therefore only the federal government has the power to enforce civil violations. See *Gonzales* v. *City of Peoria*, 722 F.2d 468 (9th Cir. 1983).

This confusion was, to some extent, fostered by an erroneous 1996 opinion of the Office of Legal Counsel (OLC) of the department of Justice, the relevant part of which has since been withdrawn by OLC.

Why was the Federal agency responsible for immigration enforcement telling my police chiefs in Alabama to just let illegal aliens go?

To be fair, ICE probably does not have the manpower or detention space to take custody and detain all illegal aliens. With less than 20,000 appropriated detention beds, ICE tells my office that they do not have the bed space to detain all the illegal aliens that they apprehend; instead, they have to give first priority to detaining the worst of the worst—individuals such as convicted felon aliens.

It is shocking to me that even though we know that detention is a key element of effective removal, we do not even detail all illegal aliens that have been convicted of crimes, even convicted of felonies, before removal. Last February, in a report titled "the Immigration and Naturalization Service's Removal of Aliens Issued Final Orders" the Department of Justice Inspector General found that 87 percent of those not detained before removal never get deported. Even in high risk categories, the IG found that only fractions of non-detained violators are ever removed—35 percent of those with criminal records and 6 percent of those from "state sponsors of terrorism."

These percentages have not changed substantially since 1996, when the last IG report issued on the ability to remove aliens found that 89 percent of aliens with final deportation orders that are not detained are never removed.

But we cannot lay all the blame on DHS—they can only detain illegal aliens that they have space to detain. They are using all of the bedspace that they have and are releasing people that should be detained because there is no more room. The Homeland Security Enhancement Act would add the critical bedspace DHS needs to fulfill its mission of interior enforcement.

The third problem that has been brought to my attention is the inadequate way we share immigration information with State and local police. We have databases full or information on criminal aliens and aliens with final deportation orders, but that information is not directly available to state and local police. They have to make a special second inquiry to the immigration center in Vermont just to see if an illegal alien is a wanted by DHS.

Without easy access to immigration database information, and with ICE unwilling to come and identify every suspected illegal alien, State and local police cannot quickly and accurately identify who they have detained and who they will be releasing back into the community if they follow ICE's instruction to "just let them go."

State and local police are accustomed to checking for criminal information in the NCIC (National Crime Information Center) database, which is maintained by the FBI. They can and routinely do access the NCIC on the roadside when they pull over a car or stop a suspect.

An NCIC check, which takes just minutes, includes information about individuals with outstanding warrants. Even fugitives that use false identification can be identified on the roadside through use of the NCIC when, as is often the case, a police officer has access to an instant fingerprint scanner in his car.

Separately, ICE operates the Law Enforcement Support Center, which makes immigration information available to State and local police, but requires a second additional check after NCIC that most State and local police either don't know about or don't have the time to perform.

The Hart Rudman Report, "America Still Unprepared—America Still In Danger," found that one problem America still confronts is "650,000 local and State police officials continue to operate in a virtual intelligence vacuum, without access to terrorist watchlists." The first recommendation of the report was to "tap the eyes and ears of local and State law enforcement officers in preventing attacks." On page 19, the report specifically cited the burden of finding hundreds of thousands of fugitive aliens living among the population of more than 8.5 million illegal aliens living in the U.S. and suggested that the burden could and should be shared with 650,000 local, county, and State law enforcement officers if they could be brought out of the information void.

If State and local police are not accessing the immigration information we have worked hard to make available, we must find a way to get the information to them, through systems that are used to using. Our bill will get information to them through the system that are already using—the NCIC.

As part of its Alien Absconder Initiative, ICE tells us that it is in the process of entering information on the estimated 450,000 alien absconders into NCIC. As of October 31, only information on 15,200 alien absconders had been entered into NCIC. That number is totally unacceptable and is shocking to me.

This should only be the beginning. At the least, the NCIC should contain information on all illegal aliens who have received final orders of departure and all illegal aliens who have signed voluntary departure agreements. In truth, the NCIC should contain information on all violations of law.

Our bill will ensure that when a NCIC roadside check is done on an individual pulled over for speeding, police will know immediately if the individual has already been ordered to leave the country, has signed a legal document promising to leave, or has overstayed their visa.

Understanding the value of getting immigration information to State and local police comes from understanding that they are the ones who will come into contact with the dangerous illegal aliens on a day-to-day basis.

Three 9/11 hijackers were stopped by State and local police in the weeks proceeding 9/11. Hijacker Mohammad Atta, believed to have piloted American Airlines Flight 77 into the World Trade Center's north tower, was stopped twice by police in Florida. Hijacker Ziad S. Jarrah was stopped for speeding by Maryland State Police two days before 9/11. And, Hani Hanjour, who was on the flight that crashed into the Pentagon, was stopped for speeding by police in Arlington, VA. Local police can be our most powerful tool in the war against terrorism.

The D.C. Snipers were caught because of the fingerprint collected by local police. John Lee Malvo was identified when the fingerprint collected from a magazine at the scene of the liquor store murder and robbery in Montgomery, Alabama matched with the fingerprints collected by INS agents in Washington State. Had both law enforcement entities not done their job by taking prints, it is possible that the identity of John Lee Malvo could have been a mystery for weeks longer.

In February, a 42-year-old woman sitting on a park bench in New York with her boyfriend was dragged away and gang-raped by five deportable illegal immigrants. Although 4 of the 5 had State criminal convictions and 2 had served jail time, the INS claims they were never told about them—thus, they were not deported as the law requires.

Fifty-six illegal aliens were caught by State and local police, and convicted of molestation and child abuse, long before ICE's "Operation Predator" found them a few weeks ago living in New York and Northern New Jersey after they should have been deported. Of the 56 arrested, one had raped his 10-year-old niece; another has sexually assaulted a 6-year-old boy; one had raped his 7-year-old niece; and another has sexually assaulted a 2-year-old.

The 9/11 hijacker cases, the D.C. sniper cases, and a multitude of criminal alien cases clearly illustrate that our State and local police are on the front lines in combating alien crime. To cut them out of the system, as we do now, whether intentionally or unintentionally, is to eliminate our most effective weapon against criminal and terrorist aliens.

The opponents of this bill will say that we don't want immigrants to succeed and that we don't want people to come here. That is absolutely not true. We believe in the rule of law. We believe that people should come here to be citizens of this country under the color of law. We want people to come here and reach their fullest potential. But, we believe that a Nation has the right to set the standards by which it accepts people, and if it sets those standards it ought to create a legal system to enforce those standards. This bill will work to enforce the immigration standards our Nation has created.

The opposition will say that State and local police can not adequately respect the civil rights of illegal aliens, and that enforcement will cost too much and will discourage the reporting of crimes. It is curious logic to say that we trust our police to enforce laws against citizens but not against noncitizens here illegally.

I know that State and local police are trained to protect the civil rights of all types of suspects and defendants and that they do so every day in this country. In Alabama, State troopers receive annual training on racial profiling. In New York, the NYC Police Department operations order #11 strictly prohibits racial profiling in law enforcement actions. If Alabama and New York are consistent in how they instruct and train their State and local police with regards to racial profiling, it is safe to assume that the rest of the Nation does as well.

Under this bill, State and local police will have to respect the civil rights of illegal aliens the same way they respect the civil rights of all people against whom they enforce the law. State and local police will continue to be held responsible for violations of civil rights; this bill does not change that fact.

The opposition will say that this bill is expensive; that it costs too much. It is always expensive to enforce the law. I do not think this bill is overly expensive. We have made it as cost affordable as we can by electing to efficiently use resources already available to us. Law enforcement is not an area where it pays to pinch pennies. In immigration enforcement, I believe that it costs us too much not to enforce the law. I believe it is time that Congress take responsibility for providing DHS with the resources they need to do the job we have given them.

When it comes to immigration enforcement in America, the rule of law is not prevailing. If we are serious about securing the homeland, we simply must get serious about immigration enforcement.

It is time to talk about the big picture—time to be honest about what it will really take to fix our broken immigration system. In most cases, we don't need tougher immigration laws, we just need to utilize our existing resources and use some new resources to enforce the laws we already have.

If State and local police are confused about their authority to enforce immigration laws, that authority needs to be clarified. This bill will do that. If State and local police can not access immigration background information on individuals quickly enough, we should change that. This bill makes that information more accessible. If DHS is not taking custody of the illegal aliens being apprehended by State and local police, we need to make it possible for them to do so. This bill will address the practice of "catching and releasing" illegal aliens. If we do not have enough detection space to hold people that break the law, then we need more detention space. This bill gives DHS 50 percent more bedspace to use in immigration enforcement. If illegal aliens are being released back into the community after their prison sentences instead of being deported, we need to fix the system that releases them. This bill will extend the Institutional Removal Program to ensure that custody is transferred from the state prison to federal officials at the end of the alien's prison sentence.

Once again I would like to thank Senator MILLER for joining with me to introduce this legislation. It is imperative that we take critical steps toward regaining control of our out-of-control immigration system. This bill is a critical step in the right direction. I encourage my colleagues to study this bill and to join Senator MILLER and I as we work to pass the Homeland Security Act of 2003.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1906

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Homeland Security Enhancement Act of 2003".

TITLE I—ENHANCING FEDERAL, STATE, AND LOCAL ENFORCEMENT OF THE IMMIGRATION LAWS

SEC. 101. FEDERAL AFFIRMATION OF IMMIGRATION LAW ENFORCEMENT BY STATES AND POLITICAL SUBDIVISIONS OF STATES.

Notwithstanding any other provision of law and reaffirming the existing inherent authority of States, law enforcement personnel of a State or a political subdivision of a State have the inherent authority of a sovereign entity to apprehend, arrest, detain, or transfer to Federal custody aliens in the United States (including the transportation of such aliens across State lines to detention centers), in the enforcement of the immigration laws of the United States. This State authority has never been displaced or preempted by Congress.

SEC. 102. STATE AUTHORIZATION FOR ENFORCEMENT OF FEDERAL IMMIGRATION LAWS ENCOURAGED.

(a) IN GENERAL.—Effective 2 years after the date of enactment of this Act, a State (or political subdivision of a State) that has in effect a statute, policy, or practice that prohibits law enforcement officers of the State, or of a political subdivision within the State, from enforcing Federal immigration laws or from assisting or cooperating with Federal immigration law enforcement in the course of carrying out the officers' law enforcement duties shall not receive any of the funds that would otherwise be allocated to the State under section 241(i) of the Immigration and Nationality Act (8 U.S.C. 1231(i)).

(b) REALLOCATION OF FUNDS.—Any funds that are not allocated to a State due to the failure of the State to comply with this section shall be reallocated to States that comply with this section.

SEC. 103. CIVIL AND CRIMINAL PENALTIES FOR ALIENS UNLAWFULLY PRESENT IN THE UNITED STATES.

(a) ALIENS UNLAWFULLY PRESENT.—Title II of the Immigration and Nationality Act (8 U.S.C. 1151 et seq.) is amended by adding after section 275 the following:

"CRIMINAL PENALTIES AND FORFEITURE FOR UNLAWFUL PRESENCE IN THE UNITED STATES

"SEC. 275A. (a) In addition to any other violation, an alien present in the United States in violation of this Act shall be guilty of a misdemeanor and shall be fined under title 18, United States Code, imprisoned not more than 1 year, or both. The assets of any alien present in the United States in violation of this Act shall be subject to forfeiture under title 18, United States Code.

"(b) It shall be an affirmative defense to a violation of subsection (a) that the alien overstayed the time allotted under the visa due to an exceptional and extremely unusual hardship or physical illness that prevented the alien from leaving the United States by the required date.".

(b) INCREASE IN CRIMINAL PENALTIES FOR ILLEGAL ENTRY.—Section 275(a) of the Immigration and Nationality Act (8 U.S.C. 1325(a)) is amended by striking "6 months," and inserting "1 year,".

(c) PERMISSION TO DEPART VOLUNTARILY.—Section 240B of the Immigration and Nationality Act (8 U.S.C. 1229c) is amended—

(1) by striking "Attorney General" each place that term appears and inserting "Secretary of Homeland Security"; and

(2) in subsection (a)(2)(A), by striking "120" and inserting "30".

SEC. 104. LISTING OF IMMIGRATION VIOLATORS IN THE NATIONAL CRIME INFORMATION CENTER DATABASE.

(a) PROVISION OF INFORMATION TO THE NCIC.—Not later than 180 days after the date of enactment of this Act, the Under Secretary for Border and Transportation Security of the Department of Homeland Security shall provide the National Crime Information Center of the Department of Justice with such information as the Director may have on any and all aliens against whom a final order of removal has been issued, any and all aliens who have signed a voluntary departure agreement, and any and all aliens who have overstayed their visa. Such information shall be provided to the National Crime Information Center regardless of whether or not the alien received notice of a final order of removal and even if the alien has already been removed.

(b) INCLUSION OF INFORMATION IN THE NCIC DATABASE.—Section 534(a) of title 28, United States Code, is amended—

(1) in paragraph (3), by striking "and" at the end;

(2) by redesignating paragraph (4) as paragraph (5); and

(3) by inserting after paragraph (3) the following:

"(4) acquire, collect, classify, and preserve records of violations of the immigration laws of the United States, regardless of whether or not the alien has received notice of the violation and even if the alien has already been removed; and".

SEC. 105. STATE AND LOCAL LAW ENFORCEMENT PROVISION OF INFORMATION ABOUT APPREHENDED ILLEGAL ALIENS.

(a) Provision of Information.—

(1) In general.—In order to receive funds under the State Criminal Alien Assistance Program described in section 241(i) of the Immigration and Nationality Act (8 U.S.C. 1231(i)), States and localities shall provide to the Department of Homeland Security the information listed in subsection (b) on each alien apprehended in the jurisdiction of the State or locality who is believed to be in violation of an immigration law of the United States.

(2) Time limitation.—Not later than 10 days after an alien described in paragraph (1) is apprehended, information required to be provided under paragraph (1) must be provided in such form and in such manner as the Secretary of Homeland Security may, by regulation or guideline, require.

(b) Information Required.—The information listed in this subsection is as follows:

(1) The alien's name.

(2) The alien's address or place of residence.

(3) A physical description of the alien.

(4) The date, time, and location of the encounter with the alien and reason for stopping, detaining, apprehending, or arresting the alien.

(5) If applicable, the alien's driver's license number and the State of issuance of such license.

(6) If applicable, the type of any other identification document issued to the alien, any designation number contained on the identification document, and the issuing entity for the identification document.

(7) If applicable, the license plate number, make, and model of any automobile registered to, or driven by, the alien.

(8) A photo of the alien, if available or readily obtainable.

(9) The alien's fingerprints, if available or readily obtainable.

(c) Reimbursement.—The Department of Homeland Security shall reimburse States and localities for all reasonable costs, as determined by the Secretary of Homeland Security, incurred by that State or locality as a result of providing information required by this section.

(d) Authorization of Appropriations.—There is authorized to be appropriated such sums as necessary to carry out this Act.

SEC. 106. INCREASED FEDERAL DETENTION SPACE.

(a) Construction or Acquisition of Detention Facilities.—

(1) In general.—The Secretary of Homeland Security shall construct or acquire, in addition to existing facilities for the detention of aliens, 20 detention facilities in the United States, with 500 beds per facility, for aliens detained pending removal or a decision on removal of such alien from the United States.

(2) Additional facilities.—Whenever the capacity of any detention facility remains within a 1 percent range of full capacity for longer than 1 year, the Secretary of Homeland Security shall construct or acquire additional detention facilities beyond the number authorized in paragraph (1) as are appropriate to eliminate that condition.

(3) Determinations.—The need for, or location of, any detention facility built or acquired in accordance with this subsection shall be determined by the detention trustee within the Bureau of Immigration and Customs Enforcement.

(4) Use of installations under base closure laws.—In acquiring detention facilities under this subsection, the Secretary of Homeland Security shall consider the transfer of appropriate portions of military installations approved for closure or realignment under the Defense Base Closure and Realignment Act of 1990 (part A of title XXIX of Public Law 101-510; 10 U.S.C. 2687 note) for use in accordance with subsection (a)(1).

(b) Authorization of Appropriations.—There are authorized to be appropriated such sums as necessary to carry out this section.

(c) Technical and Conforming Amendment.—Section 241(g)(1) of the Immigration and Nationality Act (8 U.S.C. 1231(g)(1)) shall be amended by striking "may expend" and inserting "shall expend".

SEC. 107. FEDERAL CUSTODY OF ILLEGAL ALIENS APPREHENDED BY STATE OR LOCAL LAW ENFORCEMENT.

(a) In General.—Title II of the Immigration and Nationality Act (8 U.S.C. 1151 et seq.) is amended by adding after section 240C the following:

"CUSTODY OF ILLEGAL ALIENS

"Sec. 240D.

"(a) If the chief executive officer of a State (or, if appropriate, a political subdivision of the State) exercising authority with respect to the apprehension of an illegal alien submits a request to the Secretary of Homeland Security that the alien be taken into Federal custody, the Secretary of Homeland Security—

"(1) shall—

"(A) not later than 48 hours after the conclusion of the State charging process or dismissal process, or if no State charging or dismissal process is required, not later than 48 hours after the illegal alien is apprehended, take the illegal alien into the custody of the Federal Government and incarcerate the alien; or

"(B) request that the relevant State or local law enforcement agency temporarily incarcerate or transport the illegal alien for transfer to Federal custody; and

"(2) shall designate a Federal, State, or local prison or jail or a private contracted prison or detention facility within each State as the central facility for that State to transfer custody of the criminal or illegal aliens to the Department of Homeland Security.".

"(b) The Department of Homeland Security shall reimburse States and localities for all reasonable expenses, as determined by the Secretary of Homeland Security, incurred by a State or locality in the incarceration and transportation of an illegal alien as described in subparagraphs (A) and (B) of subsection (a)(1). Compensation provided for costs incurred under subparagraphs (A) and (B) of subsection (a)(1) shall be the average cost of incarceration of a prisoner in the relevant State, as determined by the chief executive officer of a State (or, as appropriate, a political subdivision of the State) plus the cost of transporting the criminal or illegal alien from the point of apprehension, to the place of detention, and to the custody transfer point if the place of detention and place of custody are different.

"(c) The Secretary of Homeland Security shall ensure that illegal aliens incarcerated in Federal facilities pursuant to this subsection are held in facilities which provide an appropriate level of security.

"(d)(1) In carrying out this section, the Secretary of Homeland Security may establish a regular circuit and schedule for the prompt transfer of apprehended illegal aliens from the custody of States and political subdivisions of States to Federal custody.

"(2) The Secretary of Homeland Security may enter into contracts with appropriate State and local law enforcement and detention officials to implement this subsection.

"(e) For purposes of this section, the term 'illegal alien' means an alien who—

"(1) entered the United States without inspection or at any time or place other than that designated by the Secretary of Homeland Security;

"(2) was admitted as a nonimmigrant and who, at the time the alien was taken into custody by the State or a political subdivision of the State, had failed to—

"(A) maintain the nonimmigrant status in which the alien was admitted or to which it was changed under section 248; or

"(B) comply with the conditions of any such status;

"(3) was admitted as an immigrant and has subsequently failed to comply with the requirements of that status; or

"(4) failed to depart the United States under a voluntary departure agreement or under a final order of removal.".

(b) Authorization of Appropriations for the Detention and Transportation to Federal Custody of Aliens Not Lawfully Present.—There is authorized to be appropriated $500,000,000 for the detention and removal of aliens not lawfully present in the United States under the Immigration and Nationality Act (8 U.S.C. 1101 et seq.) for fiscal year 2004 and each subsequent fiscal year.

SEC. 108. TRAINING OF STATE AND LOCAL LAW ENFORCEMENT PERSONNEL RELATING TO THE ENFORCEMENT OF IMMIGRATION LAWS.

(a) Training Manual and Pocket Guide.—

(1) Establishment.—Not later than 180 days after the date of enactment of this Act, the Secretary of Homeland Security shall establish—

(A) a training manual for law enforcement personnel of a State or political subdivision of a State to train such personnel in the investigation, identification, apprehension, arrest, detention, and transfer to Federal custody of aliens in the United States (including the transportation of such aliens across State lines to detention centers and identification of fraudulent documents); and

(B) an immigration enforcement pocket guide for law enforcement personnel of a State or political subdivision of a State to provide a quick reference for such personnel in the course of duty.

(2) Availability.—The training manual and pocket guide established in accordance with paragraph (1) shall be made available to all State and local law enforcement personnel.

(3) Applicability.—Nothing in this subsection shall be construed to require State or local law enforcement personnel to carry the training manual or pocket guide established in accordance with paragraph (1) with them while on duty.

(4) Costs.—The Department of Homeland Security shall be responsible for any costs incurred in establishing the training manual and pocket guide under this subsection.

(b) TRAINING FLEXIBILITY.—

(1) IN GENERAL.—The Department of Homeland Security shall make training of State and local law enforcement officers available through as many means as possible, including residential training at Federal facilities, onsite training held at State or local police agencies or facilities, online training courses by computer, teleconferencing, and videotape, or the digital video display (DVD) of a training course or courses.

(2) FEDERAL PERSONNEL TRAINING.—The training of State and local law enforcement personnel under this section shall not displace or otherwise adversely affect the training of Federal personnel.

(c) ADMINISTRATION FEES.—The Secretary of Homeland Security may charge a fee for training under subsection (b) that shall be an amount equal to not more than half the actual costs of providing such training.

(d) CLARIFICATION.—Nothing in this Act or any other provision of law shall be construed as making any immigration-related training a requirement for, or prerequisite to, any State or local law enforcement officer exercising that officer's inherent authority to apprehend, arrest, detain, or transfer to Federal custody illegal aliens during the normal course of carrying out their law enforcement duties.

(e) TRAINING LIMITATION.—Section 287(g) of the Immigration and Nationality Act (8 U.S.C. 1357(g)) is amended—

(1) by striking "Attorney General" each place that term appears and inserting "Secretary of Homeland Security"; and

(2) in paragraph (2), by adding at the end the following: "Such training shall not exceed 14 days or 80 hours, whichever is longer.".

[S20NO3-497]{S15297}SEC. 109.

SEC. 109. IMMUNITY.

(a) PERSONAL IMMUNITY.—Notwithstanding any other provision of law, a law enforcement officer of a State or local law enforcement agency shall be immune, to the same extent as a Federal law enforcement officer, from personal liability arising out of the enforcement of any immigration law, provided the officer is acting within the scope of the officer's official duties.

(b) AGENCY IMMUNITY.—Notwithstanding any other provision of law, a State or local law enforcement agency shall be immune from any claim for money damages based on Federal, State, or local civil rights law for an incident arising out of the enforcement of any immigration law, except to the extent that the law enforcement officer of that agency, whose action the claim involves, committed a violation of Federal, State, or local criminal law in the course of enforcing such immigration law.

SEC. 110. PLACES OF DETENTION FOR ALIENS ARRESTED PENDING EXAMINATION AND DECISION ON REMOVAL.

(a) IN GENERAL.—Section 241(g) of the Immigration and Nationality Act (8 U.S.C. 1231(g)) is amended by adding at the end the following:

"(3) POLICY ON DETENTION IN STATE AND LOCAL DETENTION FACILITIES.—In carrying out paragraph (1), the Secretary of Homeland Security shall ensure that an alien arrested under section 287(a) is detained, pending the alien's being taken for the examination described in that section, in a State or local prison, jail, detention center, or other comparable facility, if—

"(A) such a facility is the most suitably located Federal, State, or local facility available for such purpose under the circumstances;

"(B) an appropriate arrangement for such use of the facility can be made; and

"(C) such facility satisfies the standards for the housing, care, and security of persons held in custody of a United States marshal.".

(b) DETENTION FACILITY SUITABILITY.—Notwithstanding any other provision of law, a facility described in section 241(g)(3)(C) of the Immigration and Nationality Act, as added by subsection (a), is adequate for detention of persons being held for immigration related violations.

(c) TECHNICAL AND CONFORMING AMENDMENT.—Section 241 of the Immigration and Nationality Act (8 U.S.C. 1231) is amended by striking "Attorney General" each place that term appears and inserting "Secretary of Homeland Security".

SEC. 111. INSTITUTIONAL REMOVAL PROGRAM.

(a) CONTINUATION.—

(1) IN GENERAL.—The Department of Homeland Security shall continue to operate and implement the program known as the Institutional Removal Program (IRP) which—

(A) identifies removable criminal aliens in Federal and State correctional facilities;

(B) ensures such aliens are not released into the community; and

(C) removes such aliens from the United States after the completion of their sentences.

(2) EXPANSION.—The Institutional Removal Program shall be extended to all States. Any State that receives Federal funds for the incarceration of criminal aliens shall—

(A) cooperate with Federal Institutional Removal Program officials;

(B) expeditiously and systematically identify criminal aliens in its prison and jail populations; and

(C) promptly convey such information to Federal IRP authorities as a condition for receiving such funds.

(b) AUTHORIZATION FOR DETENTION AFTER COMPLETION OF STATE OR LOCAL PRISON SENTENCE.—Law enforcement officers of a State or political subdivision of a State have the authority to—

(1) hold an illegal alien for a period of up to 14 days after the alien has completed the alien's State prison sentence in order to effectuate the transfer of the alien to Federal custody when the alien is removable or not lawfully present in the United States; or

(2) issue a detainer that would allow aliens who have served a State prison sentence to be detained by the State prison until personnel from the Bureau of Immigration and Customs Enforcement can take the alien into custody.

(c) TECHNOLOGY USAGE.—Technology such as videoconferencing shall be used to the maximum extent possible in order to make the Institutional Removal Program (IRP) available in remote locations. Mobile access to Federal databases of aliens, such as IDENT, and live scan technology shall be used to the maximum extent practicable in order to make these resources available to State and local law enforcement agencies in remote locations.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out the Institutional Removal Program—

(1) $10,000,000 for fiscal year 2004;

(2) $20,000,000 for fiscal year 2005;

(3) $30,000,000 for fiscal year 2006;

(4) $40,000,000 for fiscal year 2007;

(5) $50,000,000 for fiscal year 2008;

(6) $60,000,000 for fiscal year 2009;

(7) $70,000,000 for fiscal year 2010; and

(8) $80,000,000 for fiscal year 2011.

TITLE II—ENHANCING ENFORCEMENT OF THE IMMIGRATION AND NATIONALITY ACT IN THE INTERIOR THROUGH IMPROVED DOCUMENT SECURITY

SEC. 201. DRIVERS LICENSES.

(a) EXPIRATION DATE FOR CERTAIN ALIENS.—

(1) IN GENERAL.—Section 656 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (5 U.S.C. 301 note) is amended by inserting after subsection (a) the following:

"(b) STATE-ISSUED DRIVER'S LICENSES EXPIRATION DATE.—A Federal agency may not accept for any identification-related purpose a driver's license issued by a State unless, if the driver's license is issued to an alien who is in lawful status but who is not an alien lawfully admitted for permanent residence, the period of validity of the license expires on the date on which the alien's authorization to remain in the United States expires.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect beginning on October 1, 2007, but shall apply only to licenses issued to an individual for the first time and to replacement or renewal licenses issued according to State law.

(b) CONDITION OF FUNDS.—Section 402(b)(1) of title 23, United States Code, is amended—

(1) in subparagraph (C), by striking "and" at the end;

(2) in subparagraph (D), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following:

"(E) prohibit aliens who are not in lawful status, as determined under the Immigration and Nationality Act (8 U.S.C. 1101 et seq.), from being issued a driver's license in that State.".

SEC. 202. SECURE AND VERIFIABLE IDENTIFICATION REQUIRED FOR FEDERAL PUBLIC BENEFITS.

(a) IN GENERAL.—In the provision in the United States of a Federal public benefit or service that requires the recipient to produce identification, no Federal agency, commission, or other entity within the executive, legislative, or judicial branch of the Federal Government may accept, recognize, or rely on (or authorize the acceptance or recognition of, or the reliance on) any identification document, unless—

(1) the document was issued by a United States Federal or State authority and is subject to verification by a United States Federal law enforcement, intelligence, or homeland security agency; or

(2) the recipient—

(A) is lawfully present in the United States;

(B) is in possession of a passport; and

(C) is a citizen of a country for which the visa requirement for entry into the United States is waived if the alien possesses a passport from such country.

(b) IMMUNITY.—An elected or appointed official, employee, or other contractor or agent of the Federal Government who takes an action inconsistent with subsection (a) is deemed to be acting beyond the scope of authority granted by law and shall not be immune from liability for such action, unless such immunity is conferred by the Constitution and cannot be waived.

By Mr. DASCHLE (for himself, Mr. JOHNSON, Mr. LEAHY, Mr. NELSON of Nebraska, Mr. PRYOR, Mr. BAUCUS, Mr. DAYTON, Mr. HARKIN, Mr. FEINGOLD, Mr. BINGAMAN, Mr. JEFFORDS, Mr. EDWARDS, and Mr. SCHUMER):

S. 1907. A bill to promote rural safety and improve rural law enforcement; to the Committee on the Judiciary.

Mr. DASCHLE. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Rural Safety Act of 2003".

TITLE I—SMALL COMMUNITY LAW ENFORCEMENT IMPROVEMENT GRANTS

SEC. 101. SMALL COMMUNITY GRANT PROGRAM.

Section 1703 of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796dd-2) is amended by adding at the end the following:

"(d) RETENTION GRANTS.—

"(1) IN GENERAL.—The Attorney General may make grants to units of local government and tribal governments located outside a Standard Metropolitan Statistical Area, which grants shall be targeted specifically for the retention for 1 additional year of police officers funded through the COPS Universal Hiring Program, the COPS FAST Program, the Tribal Resources Grant Program-Hiring, or the COPS in Schools Program.

"(2) PREFERENCE.—In making grants under this subsection, the Attorney General shall give preference to grantees that demonstrate financial hardship or severe budget constraint that impacts the entire local budget and may result in the termination of employment for police officers described in paragraph (1).

"(3) LIMIT ON GRANT AMOUNTS.—The total amount of a grant made under this subsection shall not exceed 20 percent of the original grant to the grantee.

"(4) AUTHORIZATION OF APPROPRIATIONS.—

"(A) IN GENERAL.—There are authorized to be appropriated to carry out this subsection $15,000,000 for each of fiscal years 2005 through 2009.

"(B) SET-ASIDE.—Of the amount made available for grants under this subsection for each fiscal year, 10 percent shall be awarded to tribal governments.".

SEC. 102. SMALL COMMUNITY TECHNOLOGY GRANT PROGRAM.

Section 1701 of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796dd) is amended by striking subsection (k) and inserting the following:

"(k) LAW ENFORCEMENT TECHNOLOGY PROGRAM.—

"(1) IN GENERAL.—Grants made under subsection (a) may be used to assist the police departments of units of local government and tribal governments located outside a Standard Metropolitan Statistical Area, in employing professional, scientific, and technological advancements that will help those police departments to—

"(A) improve police communications through the use of wireless communications, computers, software, videocams, databases, and other hardware and software that allow law enforcement agencies to communicate and operate more effectively; and

"(B) develop and improve access to crime solving technologies, including DNA analysis, photo enhancement, voice recognition, and other forensic capabilities.

"(2) COST SHARE REQUIREMENT.—A recipient of a grant made under subsection (a) and used in accordance with this subsection shall provide matching funds from non-Federal sources in an amount equal to not less than 10 percent of the total amount of the grant made under this subsection, subject to a waiver by the Attorney General for extreme hardship.

"(3) ADMINISTRATION.—The COPS Office shall administer the grant program under this subsection.

"(4) NO SUPPLANTING.—Federal funds provided under this subsection shall be used to supplement and not to supplant local funds allocated to technology.

"(5) AUTHORIZATION OF APPROPRIATIONS.—

"(A) IN GENERAL.—There are authorized to be appropriated $40,000,000 for each of fiscal years 2005 through 2009 to carry out this subsection.

"(B) SET-ASIDE.—Of the amount made available for grants under this subsection for each fiscal year, 10 percent shall be awarded to tribal governments.".

SEC. 103. RURAL 9-1-1 SERVICE.

(a) PURPOSE.—The purpose of this section is to provide access to, and improve a communications infrastructure that will ensure a reliable and seamless communication between, law enforcement, fire, and emergency medical service providers in units of local government and tribal governments located outside a Standard Metropolitan Statistical Area and in States.

(b) AUTHORITY TO MAKE GRANTS.—The Office of Justice Programs of the Department of Justice shall make grants, in accordance with such regulations as the Attorney General may prescribe, to units of local government and tribal governments located outside a Standard Metropolitan Statistical Area for the purpose of establishing or improving 9-1-1 service in those communities. Priority in making grants under this section shall be given to communities that do not have 9-1-1 service.

(c) DEFINITION.—In this section, the term "9-1-1 service" refers to telephone service that has designated 9-1-1 as a universal emergency telephone number in the community served for reporting an emergency to appropriate authorities and requesting assistance.

(d) LIMIT ON GRANT AMOUNT.—The total amount of a grant made under this section shall not exceed $250,000.

(e) FUNDING.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out this section $25,000,000 for fiscal year 2005, to remain available until expended.

(2) SET-ASIDE.—Of the amount made available for grants under this section, 10 percent shall be awarded to tribal governments.

SEC. 104. JUVENILE OFFENDER ACCOUNTABILITY.

(a) PURPOSES.—The purposes of this section are to—

(1) hold juvenile offenders accountable for their offenses;

(2) involve victims and the community in the juvenile justice process;

(3) obligate the offender to pay restitution to the victim and to the community through community service or through financial or other forms of restitution; and

(4) equip juvenile offenders with the skills needed to live responsibly and productively.

(b) AUTHORITY TO MAKE GRANTS.—The Office of Justice Programs of the Department of Justice shall make grants, in accordance with such regulations as the Attorney General may prescribe, to units of rural local governments and tribal governments located outside a Standard Metropolitan Statistical Area to establish restorative justice programs, such as victim and offender mediation, family and community conferences, family and group conferences, sentencing circles, restorative panels, and reparative boards, as an alternative to, or in addition to, incarceration.

(c) PROGRAM CRITERIA.—A program funded by a grant made under this section shall—

(1) be fully voluntary by both the victim and the offender (who must admit responsibility), once the prosecuting agency has determined that the case is appropriate for this program;

(2) include as a critical component accountability conferences, at which the victim will have the opportunity to address the offender directly, to describe the impact of the offense against the victim, and the opportunity to suggest possible forms of restitution;

(3) require that conferences be attended by the victim, the offender and, when possible, the parents or guardians of the offender, and the arresting officer; and

(4) provide an early, individualized assessment and action plan to each juvenile offender in order to prevent further criminal behavior through the development of appropriate skills in the juvenile offender so that the juvenile is more capable of living productively and responsibly in the community.

(d) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out this section—

(A) $10,000,000 for fiscal year 2005 for grants to establish programs; and

(B) $5,000,000 for each of fiscal years 2006 and 2007 to continue programs established in fiscal year 2005.

(2) SET-ASIDE.—Of the amount made available for grants under this section for each fiscal year, 10 percent shall be awarded to tribal governments.

TITLE II—CRACKING DOWN ON METHAMPHETAMINE

SEC. 201. METHAMPHETAMINE TREATMENT PROGRAMS IN RURAL AREAS.

Subpart I of part B of title V of the Public Health Service Act (42 U.S.C. 290bb et seq.) is amended by inserting after section 509 the following:

"SEC. 510. METHAMPHETAMINE TREATMENT PROGRAMS IN RURAL AREAS.

"(a) IN GENERAL.—The Secretary, acting through the Director of the Center for Substance Abuse Treatment, shall make grants to community-based public and nonprofit private entities for the establishment of substance abuse (particularly methamphetamine) prevention and treatment pilot programs in units of local government and tribal governments located outside a Standard Metropolitan Statistical Area.

"(b) ADMINISTRATION.—Grants made in accordance with this section shall be administered by a single State agency designated by a State to ensure a coordinated effort within that State.

"(c) APPLICATION.—To be eligible to receive a grant under subsection (a), a public or nonprofit private entity shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

"(d) USE OF FUNDS.—A recipient of a grant under this section shall use amounts received under the grant to establish a methamphetamine abuse prevention and treatment pilot program that serves one or more rural areas. Such a pilot program shall—

"(1) have the ability to care for individuals on an in-patient basis;

"(2) have a social detoxification capability, with direct access to medical services within 50 miles;

"(3) provide neuro-cognitive skill development services to address brain damage caused by methamphetamine use;

"(4) provide after-care services, whether as a single-source provider or in conjunction with community-based services designed to continue neuro-cognitive skill development to address brain damage caused by methamphetamine use;

"(5) provide appropriate training for the staff employed in the program; and

"(6) use scientifically-based best practices in substance abuse treatment, particularly in methamphetamine treatment.

"(e) AMOUNT OF GRANTS.—The amount of a grant under this section shall be at least $19,000 but not greater than $100,000.

"(f) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—There is authorized to be appropriated $2,000,000 to carry out this section.

"(2) SET-ASIDE.—Of the amount made available for grants under this section, 10 percent shall be awarded to tribal governments to ensure the provision of services under this section.".

SEC. 202. METHAMPHETAMINE PREVENTION EDUCATION.

Section 519E of the Public Health Service Act (42 U.S.C. 290bb–25e) is amended—

(1) in subsection (c)(1)—

(A) in subparagraph (F), by striking "and" at the end;

(B) in subparagraph (G), by striking the period and inserting "; and"; and

(C) by adding at the end the following:

"(H) to fund programs that educate rural communities, particularly parents, teachers, and others who work with youth, concerning the early signs and effects of methamphetamine use, however, as a prerequisite to receiving funding, these programs shall—

"(i) prioritize methamphetamine prevention and education;

"(ii) have past experience in community coalition building and be part of an existing coalition that includes medical and public health officials, educators, youth-serving community organizations, and members of law enforcement;

"(iii) utilize professional prevention staff to develop research and science-based prevention strategies for the community to be served;

"(iv) demonstrate the ability to operate a community-based methamphetamine prevention and education program;

"(v) establish prevalence of use through a community needs assessment;

"(vi) establish goals and objectives based on a needs assessment; and

"(vii) demonstrate measurable outcomes on a yearly basis.";

(2) in subsection (e)—

(A) by striking "subsection (a), $10,000,000" and inserting "subsection (a)—

"(1) $10,000,000";

(B) by striking the period at the end and inserting "; and"; and

(C) by adding at the end the following:

"(2) $5,000,000 for each of fiscal years 2005 through 2009 to carry out the programs referred to in subsection (c)(1)(H)."; and

(3) by adding at the end the following:

"(f) SET-ASIDE.—Of the amount made available for grants under this section, 10 percent shall be used to assist tribal governments.

"(g) AMOUNT OF GRANTS.—The amount of a grant under this section, with respect to each rural community involved, shall be at least $19,000 but not greater than $100,000.".

SEC. 203. METHAMPHETAMINE CLEANUP.

(a) IN GENERAL.—The Attorney General shall, through the Department of Justice or through grants to States or units of local government and tribal governments located outside a Standard Metropolitan Statistical Area, in accordance with such regulations as the Attorney General may prescribe, provide for—

(1) the cleanup of methamphetamine laboratories and related hazardous waste in units of local government and tribal governments located outside a Standard Metropolitan Statistical Area; and

(2) the improvement of contract-related response time for cleanup of methamphetamine laboratories and related hazardous waste in units of local government and tribal governments located outside a Standard Metropolitan Statistical Area by providing additional contract personnel, equipment, and facilities.

(b) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There is authorized to be appropriated $20,000,000 for fiscal year 2005 to carry out this section.

(2) FUNDING ADDITIONAL.—Amounts authorized by this section are in addition to amounts otherwise authorized by law.

(3) SET-ASIDE.—Of the amount made available for grants under this section, 10 percent shall be awarded to tribal governments.

TITLE III—LAW ENFORCEMENT TRAINING

SEC. 301. SMALL TOWN AND RURAL TRAINING PROGRAM.

(a) IN GENERAL.—There is established a Rural Policing Institute, which shall be administered by the National Center for State and Local Law Enforcement Training of the Federal Law Enforcement Training Center (FLETC) as part of the Small Town and Rural Training (STAR) Program to—

(1) assess the needs of law enforcement in units of local government and tribal governments located outside a Standard Metropolitan Statistical Area;

(2) develop and deliver expert training programs regarding topics such as drug enforcement, airborne counterdrug operations, domestic violence, hate and bias crimes, computer crimes, law enforcement critical incident planning related to school shootings, and other topics identified in the training needs assessment to law enforcement officers in units of local government and tribal governments located outside a Standard Metropolitan Statistical Area; and

(3) conduct outreach efforts to ensure that training programs under the Rural Policing Institute reach law enforcement officers in units of local government and tribal governments located outside a Standard Metropolitan Statistical Area.

(b) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated $10,000,000 for fiscal year 2005, and $5,000,000 for each of fiscal years 2006 through 2009 to carry out this section, including contracts, staff, and equipment.

(2) SET-ASIDE.—Of the amount made available for grants under this section for each fiscal year, 10 percent shall be awarded to tribal governments.

By Mr. COCHRAN (for himself and Mr. KENNEDY):

S. 1909. A bill to amend the Public Health Service Act to improve stroke prevention, diagnosis, treatment, and rehabilitation; to the Committee on Health, Education, Labor, and Pensions.

Mr. KENNEDY. Mr. President, it is a privilege to join with Senator COCHRAN in supporting the Stroke Treatment and Ongoing Prevention Act of 2003. The STOP Stroke Act is a vital first step in building a national network of effective care to diagnose and quickly treat victims of stroke.

For over 20 years, stroke has consistently been the third leading cause of death in our country. Every 45 seconds, another American suffers a stroke. Every 3 minutes, another American dies. Few families today are untouched by this cruel, debilitating, and often fatal disease that strikes indiscriminately, robbing us of our loved ones.

More than ever today, help is available. Modern medicine is generating new scientific advances that increase the chance of survival and partial or even full recovery following a stroke. We are learning how to manage this disease more effectively, and we are also learning how to prevent it from happening in the first place.

But science doesn't save lives and protect health by itself. We have to put new discoveries into action. We need to educate as many people as possible about the warning signs of stroke, so that they know enough to seek medical attention. We need to train doctors and nurses in the best techniques of care. We need better ways to treat victims as quickly and as effectively as possible—so that they have the best chance of full recovery.

Our bill provides grants to States to develop statewide programs for stroke care, so that the most effective care will be available to patients as quickly and efficiently as possible to reduce the level of disability caused by stroke.

Stroke systems will rely on information sharing among agencies and individuals involved in the study and provision of care, in addition to training for health professionals on the signs of stroke and guidelines on best practices.

The bill also authorizes the Secretary of HHS, acting through CDC, to operate the Paul Coverdell National Acute Stroke Registry to develop and collect data and analyze the care of acute stroke patients. Funds were appropriated for the registry at the end of the last Congress, but the registry has not yet been authorized. In fact, the Senate passed the act unanimously last year, and it came very close to House passage. Literally millions of our fellow citizens will benefit from the lives saved and the better care they will receive as a result of this legislation. It's long past time for Congress to act.

By Mr. HATCH (for himself and Mr. LEAHY):

S. 1911. A bill to amend the provisions of title III of the Trade Act of 1974 relating to violations of the TRIPS Agreement, and for other purposes; to the Committee on Finance.

Mr. LEAHY. Mr. President, today I introduce an important, bipartisan piece of legislation that will amend the Trade Act of 1974 to help ensure that America's intellectual property rights are properly protected by our trading partners and that disputes between America and other governments can be investigated and resolved in a quick and sensible manner.

This bill makes commonsense changes to three important aspects of the Trade Act of 1974. First, this bill makes certain that our partners who benefit from trade with the United States adequately protect American intellectual property. The TRIPS standards (Trade Related Aspects of Intellectual Property) that the World Trade Organization uses today in order to determine if a country is protecting intellectual property laws were written in the early 1990s—before digital piracy had become widespread. Our legislation will codify the necessity on the part of other nations to keep intellectual property protections current with technology.

In addition, this measure will establish a petition process for bringing intellectual property claims against trade partners in the Caribbean Basin who fail to enforce intellectual property rights while benefiting from profitable trading programs. Under current law, there is no provision for parties to petition the United States Trade Representative to investigate whether or not one of our Caribbean partners is meeting the criterion of "fair and effective" enforcement of intellectual property rights in order to benefit from special trade programs. This legislation invests the USTR with the power to ensure that beneficiaries of favorable trading programs will not be rewarded for failing to protect intellectual property in a meaningful way.

Finally, this bill will correct an undesirable and unintended technical deficiency of the Trade Act of 1974 when applied to the dispute mechanisms of the World Trade Organization. Current timelines for investigating intellectual property violations under the Trade Act force the USTR to designate certain countries as failing to protect intellectual property before a complete investigation can be completed and make it virtually impossible to negotiate with that country or bring a WTO dispute settlement case in order to resolve a dispute. This bill amends Section 301 of the Trade Act to make sure that investigations can proceed before policy is made.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 269—URGING THE GOVERNMENT OF CANADA TO END THE COMMERCIAL SEAL HUNT THAT OPENED ON NOVEMBER 15, 2003

Mr. LEVIN (for himself, Ms. COLLINS, Mr. LIEBERMAN, Mr. REED, Mr. LAUTENBERG, Mr. DODD, Mr. WYDEN, Mr. JEFFORDS, and Mr. KENNEDY) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 269

Whereas on November 15, 2003, the Government of Canada opened a commercial hunt on seals in the waters off the east coast of Canada;

Whereas an international outcry regarding the plight of the seals hunted in Canada resulted in the 1983 ban by the European Union of whitecoat and blueback seal skins, and the subsequent collapse of the commercial seal hunt in Canada;

Whereas the Marine Mammal Protection Act of 1972 (16 U.S.C. 1361 et seq.) bars the import into the United States of any seal products;

Whereas in February 2003, the Ministry of Fisheries and Oceans in Canada authorized the highest quota for harp seals in Canadian history, allowing nearly 1,000,000 seals to be killed over a 3-year period;

Whereas harp seal pups can be legally hunted in Canada as soon as they have begun to molt their white coats at approximately 12 days of age;

Whereas 97 percent of the seals culled in the 2003 slaughter were pups between just 12 days and 12 weeks of age, most of which had not yet eaten their first solid meal or learned to swim;

Whereas a 2001 report by an independent team of veterinarians invited to observe the hunt by the International Fund for Animal Welfare concluded that the seal hunt failed to comply with basic animal welfare regulations in Canada and that governmental regulations regarding humane killing were not being respected or enforced;

Whereas the 2001 veterinary report concluded that as many as 42 percent of the seals studied were likely skinned while alive and conscious;

Whereas the commercial slaughter of seals in the Northwest Atlantic is inherently cruel, whether the killing is conducted by clubbing or by shooting;

Whereas many seals are shot in the course of the hunt, but escape beneath the ice where they die slowly and are never recovered, and these seals are not counted in official kill statistics, making the actual kill level far higher than the level that is reported;

Whereas the commercial hunt for harp and hooded seals is not conducted by indigenous peoples of Canada, but is a commercial slaughter carried out by nonnative people from the East Coast of Canada for seal fur, oil, and penises (used as aphrodisiacs in some Asian markets);

Whereas the fishing and sealing industries in Canada continue to justify the expanded seal hunt on the grounds that the seals in the Northwest Atlantic are preventing the recovery of cod stocks, despite the lack of any credible scientific evidence to support this claim;

Whereas 2 Canadian Government marine scientists reported in 1994 that the true cause of cod depletion in the North Atlantic was over-fishing, and the consensus among the international scientific community is that seals are not responsible for the collapse of cod stocks;

Whereas harp and hooded seals are a vital part of the complex ecosystem of the Northwest Atlantic, and because the seals consume predators of commercial cod stocks, removing the seals might actually inhibit recovery of cod stocks;

Whereas certain ministries of the Government of Canada have stated clearly that there is no evidence that killing seals will help groundfish stocks to recover; and

Whereas the persistence of this cruel and needless commercial hunt is inconsistent with the well-earned international reputation of Canada: Now, therefore, be it

Resolved, That the Senate urges the Government of Canada to end the commercial hunt on seals that opened in the waters off the east coast of Canada on November 15, 2003.

Mr. LEVIN. Mr. President, today I am joined by a number of my colleagues in submitting a resolution in the hope that the Canadian government will cease its support of the slaughter of seals. The images from this senseless slaughter are difficult to view but even harder to accept: skinning of live animals, some no older than 12 days, and the dragging of live seals across the ice using steel hooks.

On November 15, 2003, the Government of Canada opened a commercial hunt on seals in the waters off the east coast of Canada. This hunt is supported by millions of dollars of subsidies to the sealing industry every year from the Canadian Government. These subsidies facilitate the slaughter of innocent animals and artificially extend the life of an industry that has ceased to exist in most developed countries. These subsides can not be justified and should be ended.

Few would argue that this industry still serves a legitimate purpose. Two years ago, an economic analysis of the Canadian sealing industry concluded that it provided the equivalent on only 100 to 150 full-time jobs each year. In addition, the analysis found that these jobs cost Canadian taxpayers nearly $30,000 each. The report concluded that when the cost of government subsidies provided to the industry was weighed against the landed value of the seals each year, the net value of the sealing industry was close to zero.

There is little about the Canadian sealing industry that is self-sustaining. The operating budget of the Canadian Sealers Association continues to be paid by the Canadian government; their rent each month is paid by the provincial government of Newfoundland and Labrador; seal processing companies continue to receive subsidies through the Atlantic Canada Opportunities Agency; Human Resources Development Canada, and other federal funding programs for staffing and capital costs. The sealing industry, through the Sealing Industry Development Council and other bodies, receives assistance for product research and development, and for product marketing initiatives, both overseas and domestically. All the costs of the seal hunt for ice breaking services and for search and rescue, provided by the Canadian Coast Guard, are underwritten by Canadian taxpayers.

Many believe that subsidizing an industry that only operates for a few weeks a year and employs only a few hundred people on a seasonal, part-time basis is simply a bad investment on the part of the Canadian government. The HSUS has already called upon the Canadian government to end these archaic subsidies and instead work to diversify the economy in the Atlantic region by facilitating long-term jobs and livelihoods.

The clubbing of baby seals can't be defended or justified, and Canada should end it just as we ended the Alaska baby seal massacre 20 years ago. I urge my colleagues to support this resolution.

SENATE RESOLUTION 270—CONGRATULATING JOHN GAGLIARDI, FOOTBALL COACH OF ST. JOHN'S UNIVERSITY, ON THE OCCASION OF HIS BECOMING THE ALL-TIME WINNINGEST COACH IN COLLEGIATE HISTORY

Mr. COLEMAN (for himself and Mr. DAYTON) submitted the following resolution; which was considered and agreed to:

S. RES. 270

Whereas John Gagliardi began his coaching career in 1943 at the age of 16 when his high school football coach was drafted and John Gagliardi was asked to take over the position;

Whereas John Gagliardi won 4 conference titles during the 6 years he coached high school football;

Whereas John Gagliardi graduated from Colorado College in 1949 and began coaching football, basketball, and baseball at Carroll College in Helena, Montana, winning titles in all 3 sports;

Whereas John Gagliardi took over the football program at St. John's University in Collegeville, Minnesota, in 1953 and the football team won the Minnesota Intercollegiate Athletic Conference title in his first year as coach;

Whereas by the end of the 2002 season, John Gagliardi had won 3 national championships, coached 22 conference title teams, appeared in 45 post-season games and compiled a 376–108–10 record during his 50 years at St. John's University;

Whereas under the leadership of John Gagliardi, St. John's University has been nationally ranked 37 times in the past 39 years, and the university set a record with a 61.5 points per game average in 1993;

Whereas over 150 students participate in the St. John's University football program each year and every player dresses for home games;

Whereas John Gagliardi's coaching methods follow the "Winning with No's" theory: no blocking sleds or dummies, no whistles, no tackling in practices, no athletic scholarships, and no long practices;

Whereas John Gagliardi has coached over 5,000 players during his 50 years at St. John's University, and no player has failed to graduate and most have graduated in 4 years;

Whereas, in 1993, the John Gagliardi trophy was unveiled, and it is given each year to the most outstanding Division III football player;

Whereas on November 1, 2003, John Gagliardi tied Grambling University coach Eddie Robinson's record of 408 wins with a 15 to 12 victory over the University of St. Thomas;

Whereas on November 8, 2003, John Gagliardi broke Eddie Robinson's record with a 29 to 26 victory over Bethel College;

Whereas John Gagliardi is admired by his players, as well as by the students, faculty, and fans of St. John's University for his ability to motivate and inspire;

Whereas students who take his course, Theory of Football, credit John Gagliardi for teaching them more about life than about football;

Whereas those closest to John Gagliardi will tell you that football is only part of his life—he values the time he spends with Peg, his wife of 47 years, and their 4 children; and

Whereas the on- and off-the-field accomplishments of John Gagliardi have placed him in an elite club that includes the best coaches in history: Now, therefore, be it

Resolved, That the Senate—

(1) congratulates John Gagliardi, football coach of St. John's University in Collegeville, Minnesota, on becoming the all-time winningest coach in collegiate football history; and

(2) directs the Secretary of the Senate to transmit an enrolled copy of this resolution to John Gagliardi and St. John's University.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2207. Mr. FRIST (for Mr. MCCAIN) proposed an amendment to the bill S. 1152, to reauthorize the United States Fire Administration, and for other purposes.

SA 2208. Mr. FRIST proposed an amendment to the joint resolution H.J. Res. 78, making further continuing appropriations for the fiscal year 2004, and for other purposes.

TEXT OF AMENDMENTS

SA 2207. Mr. FRIST (for Mr. MCCAIN) proposed an amendment to the bill S. 1152, to reauthorize the United States Fire Administration, and for other purposes; as follows:

TITLE I—UNITED STATES FIRE ADMINISTRATION REAUTHORIZATION

SEC. 101. SHORT TITLE.

This title may be cited as the "United States Fire Administration Reauthorization Act of 2003".

SEC. 102. RE-ESTABLISHMENT OF POSITION OF UNITED STATES FIRE ADMINISTRATOR.

Section 1513 of the Homeland Security Act of 2002 (6 U.S.C. 553) does not apply to the position or office of Administrator of the United States Fire Administration, who shall continue to be appointed and compensated as provided by section 5(b) of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2204(b)).

SEC. 103. AUTHORIZATION OF APPROPRIATIONS.

Section 17(g)(1) of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2216(g)) is amended by striking subparagraphs (A) through (K) and inserting the following:

"(A) $63,000,000 for fiscal year 2005, of which $2,266,000 shall be used to carry out section 8(f);

"(B) $64,850,000 for fiscal year 2006, of which $2,334,000 shall be used to carry out section 8(f);

"(C) $66,796,000 for fiscal year 2007, of which $2,404,000 shall be used to carry out section 8(f); and

"(D) $68,800,000 for fiscal year 2008, of which $2,476,000 shall be used to carry out section 8(f).".

TITLE II—FIREFIGHTING RESEARCH AND COORDINATION

SEC. 201. SHORT TITLE.

This title may be cited as the "Firefighting Research and Coordination Act".

SEC. 202. NEW FIREFIGHTING TECHNOLOGY.

Section 8 of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2207) is amended—

(1) by redesignating subsection (e) as subsection (g); and

(2) by inserting after subsection (d) the following:

"(e) ASSISTANCE TO OTHER FEDERAL AGENCIES.—At the request of other Federal agencies, including the Department of Agriculture and the Department of the Interior, the Administrator may provide assistance in fire prevention and control technologies, including methods of containing insect-infested forest fires and limiting dispersal of resultant fire particle smoke, and methods of measuring and tracking the dispersal of fine particle smoke resulting from fires of insect-infested fuel.

"(f) TECHNOLOGY EVALUATION AND STANDARDS DEVELOPMENT.—

"(1) IN GENERAL.—In addition to, or as part of, the program conducted under subsection (a), the Administrator, in conjunction with the National Institute of Standards and Technology, the InterAgency Board for Equipment Standardization and Inter-Operability, the National Institute for Occupational Safety and Health, the Directorate of Science and Technology of the Department of Homeland Security, national voluntary consensus standards development organizations, interested Federal, State, and local agencies, and other interested parties, shall—

"(A) develop new, and utilize existing, measurement techniques and testing methodologies for evaluating new firefighting technologies, including—

"(i) personal protection equipment;

"(ii) devices for advance warning of extreme hazard;

"(iii) equipment for enhanced vision;

"(iv) devices to locate victims, firefighters, and other rescue personnel in above-ground and below-ground structures;

"(v) equipment and methods to provide information for incident command, including the monitoring and reporting of individual personnel welfare;

"(vi) equipment and methods for training, especially for virtual reality training; and

"(vii) robotics and other remote-controlled devices;

"(B) evaluate the compatibility of new equipment and technology with existing firefighting technology; and

"(C) support the development of new voluntary consensus standards through national voluntary consensus standards organizations for new firefighting technologies based on techniques and methodologies described in subparagraph (A).

"(2) STANDARDS FOR NEW EQUIPMENT.

(A) The Administrator shall, by regulation, require that new equipment or systems purchased through the assistance program established by the first section 3 3 meet or exceed applicable voluntary consensus standards for such equipment or systems for which applicable voluntary consensus standards have been established. The Administrator may waive the requirement under this subparagraph with respect to specific standards.

"(B) If an applicant for a grant under the first section 33 proposes to purchase, with assistance provided under the grant, new equipment or systems that do not meet or exceed applicable voluntary consensus standards, the applicant shall include in the application an explanation of why such equipment or systems will serve the needs of the applicant better than equipment or systems that do meet or exceed such standards.

"(C) In making a determination whether or not to waive the requirement under subparagraph (A) with respect to a specific standard, the Administrator shall, to the greatest extent practicable—

"(i) consult with grant applicants and other members of the fire services regarding the impact on fire departments of the requirement to meet or exceed the specific standard;

"(ii) take into consideration the explanation provided by the applicant under subparagraph (B); and

"(iii) seek to minimize the impact of the requirement to meet or exceed the specific standard on the applicant, particularly if meeting the standard would impose additional costs.

"(D) Applicants that apply for a grant under the terms of subparagraph (B) may include a second grant request in the application to be considered by the Administrator in the event that the Administrator does not approve the primary grant request on the grounds of the equipment not meeting applicable voluntary consensus standards.".

SEC. 203. COORDINATION OF RESPONSE TO NATIONAL EMERGENCY.

(a) IN GENERAL.—Section 10 of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2209) is amended—

(1) by redesignating subsection (b) as subsection (c); and

(2) by inserting after subsection (a) the following:

"(b) MUTUAL AID SYSTEMS.

"(1) IN GENERAL.—The Administrator shall provide technical assistance and training to State and local fire service officials to establish nationwide and State mutual aid systems for dealing with national emergencies that—

"(A) include threat assessment and equipment deployment strategies;

"(B) include means of collecting asset and resource information to provide accurate and timely data for regional deployment; and

"(C) are consistent with the Federal Response Plan.

"(2) MODEL MUTUAL AID PLANS.—The Administrator shall develop and make available to State and local fire service officials model mutual aid plans for both intrastate and interstate assistance.".

(b) REPORT ON STRATEGIC NEEDS.—Within 90 days after the date of enactment of this Act, the Administrator of the United States Fire Administration shall report to the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committee on Science on the need for a strategy concerning deployment of volunteers and emergency response personnel (as defined in section 6 of the Firefighters' Safety Study Act 15 U.S.C. 2223e)), including a national credentialing system, in the event of a national emergency.

(c) REPORT ON FEDERAL RESPONSE PLAN.—Within 30 days after the date of enactment of this Act, the Department of Homeland Security shall transmit a report to the Senate Committee on Commerce, Science, and Transportation, the Senate Committee on Governmental Affairs, and the House of Representatives Committee on Science describing plans for revisions to the Federal Response Plan and its integration into the National Response Plan, including how the revised plan will address response to terrorist attacks, particularly in urban areas, including fire detection and suppression and related emergency services.

SEC. 204. TRAINING.

(a) IN GENERAL.—Section 7(d)(1) of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2206(d)(1)) is amended—

(1) by striking "and" after the semicolon in subparagraph (E);

(2) by redesignating subparagraph (F) as subparagraph (N); and

(3) by inserting after subparagraph (E) the following:

"(F) strategies for building collapse rescue;

"(G) the use of technology in response to fires, including terrorist incidents and other national emergencies;

"(H) response, tactics, and strategies for dealing with terrorist-caused national catastrophes;

"(I) use of and familiarity with the Federal Response Plan;

"(J) leadership and strategic skills, including integrated management systems operations and integrated response;

"(K) applying new technology and developing strategies and tactics for fighting forest fires;

"(L) integrating the activities of terrorism response agencies into national terrorism incident response systems;

"(M) response tactics and strategies for fighting fires at United States ports, including fires on the water and aboard vessels; and".

(b) CONSULTATION ON FIRE ACADEMY CLASSES.—The Superintendent of the National Fire Academy may consult with other Federal, State, and local agency officials in developing curricula for classes offered by the Academy.

(c) COORDINATION WITH OTHER PROGRAMS TO AVOID DUPLICATION.—The Administrator of the United States Fire Administration shall coordinate training provided under section 7(d)(1) of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2206(d)(1)) with the Attorney General, the Secretary of Health and Human Services, and the heads of other Federal agencies

(1) to ensure that such training does not duplicate existing courses available to fire service personnel; and

(2) to establish a mechanism for eliminating duplicative training programs.

(d) COURSES AND TRAINING ASSISTANCE.—Section 7(1) of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2206(1)) is amended by adding at the end the following: "The Superintendent shall offer, at the Academy and at other sites, courses and training assistance as necessary to accommodate all geographic regions and needs of career and volunteer firefighters.".

SEC. 205. FIREFIGHTER ASSISTANCE GRANTS PROGRAM.

(a) ADMINISTRATION.—The first section 33 of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2229) is amended—

(1) by striking subsection (b)(2) and inserting the following:

"(2) ADMINISTRATIVE ASSISTANCE.—The Director shall establish specific criteria for the selection of recipients of assistance under this section and shall provide grant-writing assistance to applicants."; and

(2) by striking "operate the office established under subsection (b)(2) and" in subsection (e)(2).

(b) Maritime Firefighting.—Subsection (b)(3)(B) of the first section 33 of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2229(b)(3)(B)) is amended by inserting "maritime firefighting," after "arson prevention and detection,".

(c) FIREFIGHTING IN REMOTE AREAS.—The first section 33 of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2229) is amended—

(1) by inserting "equipment for fighting fires with foam in remote areas without access to water, and" after "including" in subsection (b)(3)(H); and

(2) by inserting "Of the amounts authorized in this paragraph, $3,000,000 shall be made available each year through fiscal year 2008 for foam firefighting equipment." at the end of subsection (e)(1).

SEC. 206. NATIONAL FALLEN FIREFIGHTERS FOUNDATION.

(a) MEMBERS.—Section 151303(b) of title 36, United States Code, is amended—

(1) by striking "9" in paragraph (2) and inserting "12";

(2) by striking "six" in subparagraph (D) of paragraph (2) and inserting "nine"; and

(3) by striking "3 members" in paragraph (3) and inserting "4 members".

(b) COMPENSATION.—Section 151304(b)(3) of title 36, United States Code, is amended by inserting "15 percent above" after "more than".

(c) PERIOD OF AUTHORIZED ASSISTANCE.—Section 151307 of title 36, United States Code, is amended in subsection (a)(1), by striking "During the 10-year period beginning on the date of the enactment of the Fire Administration Authorization Act of 2000, the" and inserting "The".

SA 2208. Mr. FRIST proposed an amendment to the joint resolution H.J. Res. 78, making further continuing appropriations for the fiscal year 2004, and for other purposes; as follows:

On page 2, line 7, strike "23" and insert "24".

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. DOMENICI. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on Thursday, November 20, 2003, at 3 p.m., in closed session, to receive a briefing on assessment of the current situation in Iraq.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. DOMENICI. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on November 20, 2003, at 10 a.m., to conduct a vote on the nomination of Ms. Alicia R. Castaneda, of the District of Columbia, to be a member of the Board of Directors of the Federal Housing Finance Board; the nomination of Mr. Thomas J. Curry, of Massachusetts, to be a member of the Board of Directors of the Federal Deposit Insurance Corporation; and S. 1531, the "Chief Justice

John Marshall Commemorative Coin Act."

Following the votes, the committee will conduct a hearing on "Improving the Corporate Governance of the New York Stock Exchange."

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. DOMENICI. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on Thursday, November 20, 2003, at 2 p.m., to conduct a hearing on the "Review of Current Investigations and Regulatory Actions Regarding the Mutual Fund Industry."

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. DOMENICI. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet on Thursday, November 20, 2003, at 9:30 a.m., on Drug Importation.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. DOMENICI. Mr. President, I ask unanimous consent that the Committee on Governmental Affairs be authorized to meet on Thursday, November 20, 2003 at a time and location to be determined to hold a business meeting to consider the nominations of James M. Loy to be Deputy Secretary of Homeland Security, Department of Homeland Security; and Scott J. Bloch to be Special Counsel, Office of Special Counsel.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT, THE FEDERAL WORKFORCE AND THE DISTRICT OF COLUMBIA

Mr. DOMENICI. Mr. President, I ask unanimous consent that the Committee on Governmental Affairs Subcommittee on Oversight of Government Management, the Federal Workforce and the District of Columbia, be authorized to meet on Thursday, November 20, 2003 at 10 a.m. for a hearing entitled, "Keeping the Lights on: The Federal Role in Managing the Nation's Electricity, Part Two."

The PRESIDING OFFICER. Without objection, it is so ordered.

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

Mr. DOMENICI. Mr. President, I ask unanimous consent that the Permanent Subcommittee on Investigations of the Committee on Governmental Affairs be authorized to meet on Thursday, November 20, 2003, at 9 a.m., for a hearing entitled "U.S. Tax Shelter Industry: The Role of Accountants, Lawyers and Financial Professionals."

The PRESIDING OFFICER. Without objection, it is so ordered.

MEASURE READ THE FIRST TIME—H.R. 1274

Mr. FRIST. I understand that H.R. 1274, which was just received from the House, is at the desk and I now ask for its first reading.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (H.R. 1274) to direct the Administrator of General Services to convey to Fresno County, California, the existing Federal courthouse in that county.

Mr. FRIST. I now ask for its second reading and object to my own request.

The PRESIDING OFFICER. The bill will receive its second reading on the next legislative day.

HUGH GREGG POST OFFICE BUILDING

Mr. FRIST. I ask unanimous consent that the Senate now proceed to consideration of Calendar No. 397, H.R. 3185.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (H.R. 3185) to designate the facility of the United States Postal Service located at 38 Spring Street in Nashua, New Hampshire, as the Hugh Gregg Post Office Building.

There being no objection, the Senate proceeded to consider the bill.

Mr. FRIST. I ask unanimous consent that the bill be read a third time and passed, the motion to reconsider be laid upon the table, and any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (H.R. 3185) was read the third time and passed.

JOHN G. DOW POST OFFICE BUILDING

Mr. FRIST. I ask unanimous consent that the Senate now proceed to consideration of Calendar No. 367, H.R. 3166.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (H.R. 3166) to designate the facility of the United States Postal Service located at 57 Old Tappan Road in Tappan, New York, as the John G. Dow Post Office Building.

There being no objection, the Senate proceeded to consider the bill.

Mr. FRIST. I ask unanimous consent that the bill be read a third time and passed, the motion to reconsider be laid upon the table, and any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (H.R. 3166) was read the third time and passed.

CORRECTION OF HEALTH CARE SAFETY NET AMENDMENTS ACT OF 2003

Mr. FRIST. I ask unanimous consent that the HELP Committee be discharged from further consideration of H.R. 3038 and the Senate proceed to its immediate consideration.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (H.R. 3038) to make certain technical and conforming amendments to correct the Health Care Safety Net Amendments Act of 2002.

There being no objection, the Senate proceeded to consider the bill.

Mr. FRIST. I ask unanimous consent that the bill be read a third time and passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (H.R. 3038) was read the third time and passed.

EXPRESSING THE SENSE OF THE SENATE WITH RESPECT TO POLIO

Mr. FRIST. I ask unanimous consent that the HELP Committee be discharged from further consideration of S. Res. 266 and the Senate proceed to its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 266) expressing the sense of the Senate with respect to Polio.

There being no objection, the Senate proceeded to consider the resolution.

Mr. FRIST. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, and any statements relating to the resolution be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 266) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 266

Whereas polio has caused millions of casualties through history, paralyzing millions and killing untold numbers of others;

Whereas polio remains a public health threat in today's world, despite being easily preventable by vaccination;

Whereas polio is now limited to 10 countries, with the distinct possibility that it can be once and forever extinguished as an affliction on mankind by ensuring the vaccination of all children in these countries under the age of 5;

Whereas a Global Polio Eradication Initiative exists that seeks to once and forever end polio as an illness, which includes efforts underway by the Centers for Disease Control and Prevention; and

Whereas the United States has the capacity to act to speed the eradication of polio by assisting in the targeting of its few remaining reservoirs: Now, therefore, be it

Resolved, That the Senate—

(1) expresses serious concern about the continuing threat posed by polio;

(2) encourages the United Nations and its component agencies, the private sector, private voluntary organizations and non-governmental organizations, concerned States, and international financial institutions to act with haste and manifold dedication to eradicate polio as soon as possible; and

(3) calls upon the United States government to continue its contribution to the multilateral effort to eradicate polio, including closely monitoring laboratory stocks of the polio virus.

ESTABLISHING THE NATIONAL MUSEUM OF AFRICAN AMERICAN HISTORY AND CULTURE

Mr. FRIST. I ask unanimous consent that the Senate now proceed to the immediate consideration of H.R. 3491, which is at the desk.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (H.R. 3491) to establish within the Smithsonian Institution the National Museum of African American History and Culture, and for other purposes.

There being no objection, the Senate proceeded to consider the bill.

Mr. BROWNBACK. Mr. President, over 200 years ago, there was a dream that was America for a group of individuals who were brought to our shores in shackles. A dream so powerful that compelled a race of people to fight for the liberty of others when they were in bondage themselves. A dream that not only served as a catalyst for physical liberation in the African-American community but removed societal shackles from our culture and enabled us to realize the ideals set before us in the Constitution—that all men are created equal under God.

Today, I am proud to stand here with my colleagues, from both the House and the Senate, and announce the passage of the National Museum of African-American History and Culture Act. After over 70 years, we have finally created a museum to honor—nationally—the contributions and sacrifice of African Americans in this country.

I would specifically like to thank Senator DODD, who was committed to honoring this history and has worked hard to get us to this point today.

I would also like to thank Senator TRENT LOTT for his unwavering support to move this bill through the Committee of Jurisdiction. As well as Senator TED STEVENS for his leadership and commitment to this project.

Additionally, I would like to recognize Senator SANTORUM for his continued unwavering commitment to this bill as well as the majority leader of the Senate, Senator BILL FRIST. It means a great deal to have such widespread support and I am grateful.

Perhaps most important, I would like to thank Representative JOHN LEWIS for championing this bill for over 15 years. It has been a pleasure for me to work with you, JOHN, on this bill.

With the creation of this museum, we will celebrate a rich and magnificent history. A history of a people's quest for freedom that shaped this Nation into a symbol of freedom and democracy around the world. I am proud to stand here today with my colleagues and celebrate the passage of this wonderful bill.

Perhaps most important, I believe that this museum will be a catalyst for needed racial reconciliation in this country. There will be many tears shed at this museum—tears that cleanse the soul and that transcend race, creed, and color.

I remember when I met with the dean of the Afro-American Studies at Howard University. He told me of a story about his grandfather who finished a bowl the day the Emancipation Proclamation was authorized.

His grandfather decided to keep the bowl because it no longer was the property of a slave master but the man who made it—his grandfather. The dean has this bowl in his home—an incredible piece of history and I am sure there are many more pieces out there waiting for a home—a national home and today we have ensured that there will indeed be a home for such artifacts.

Specifically, this bill creates this museum within the Smithsonian Institution—America's premier museum complex. We have worked very hard with the Smithsonian Institution to craft a bill that will compliment their programs—and indeed we have done just that.

The legislation outlines a museum that is very similar to the American Indian Museum, slated to open next year. And I know that the Smithsonian Institution will create another national treasure, one that tells the story of African Americans in this country—a proud history, a rich history.

This bill charges the Board of Regents of the Smithsonian Institution along with the Council of the National Museum to plan, build and construct a museum dedicated to celebrating nationally African-American history—which is American history.

In addition, this bill charges the board of regents with choosing a site on or adjacent to the National Mall for the location of the museum.

Additionally, the bill instructs the director of the museum to create and oversee an education and program liaison section designed to work with educational institutions and museums across the country in order to promote African-American history.

Finally, the bill sets fourth a federal-private partnership for funding the museum and creates a council for the museum, which will be comprised from a mixture of leading African Americans from the museum, historical, and business communities.

I do not pretend that this museum is a panacea for racial reconciliation. It is, however, a productive step in recognizing the important contributions African Americans have made to this country.

Dr. Martin Luther King, Jr. once expressed his desire for this Nation, "That the dark clouds of [misconceptions] will soon pass away and the deep fog of misunderstanding will be lifted from our fear-drenched communities and in some not too distant tomorrow the radiant stars of love and brotherhood will shine over our great Nation with all their scintillating beauty." We are one step closer today—God bless.

Mr. DODD. Mr. President, today is a truly historic day. After nearly three-quarters of a century of trying, a national museum dedicated to telling the story of the African American struggle and contribution to the founding and development of this country is about to be realized with passage of H.R. 3491, legislation to create a National Museum of African American History and Culture.

Many individuals are to be congratulated and thanked for their efforts to bring this dream to fruition. In the Senate, my distinguished colleague and author of legislation this Congress to authorize the African American Museum, Senator SAM BROWNBACK, has been a champion of this effort for the past two Congresses. I was pleased to be his coauthor on this measure.

As chairman of the Senate Rules Committee last Congress, it was my great honor to work with him to produce legislation to create the Presidential Commission, whose report underpinned the legislation we introduced earlier this year. We would not be voting on this matter today but for the continuing efforts of Senator BROWNBACK.

In the House, my good friend, Congressman BOB NEY, and my friend and colleague from Connecticut, Congressman JOHN LARSON, worked with us to find a compromise that could be supported in the House and shepherded this legislation to passage on the House suspension calendar on Wednesday by an overwhelming vote of 409 to 9. Their diligence and dedication to this effort was tireless.

But no one deserves more credit for helping to realize this dream than does my dear friend from Georgia, Congressman JOHN LEWIS. This bill is truly his dream, his inspiration, his vision, his mission.

For nearly 12 years JOHN LEWIS has made creation of this museum his personal crusade. It has been a labor of love and while the road has been long and filled with bumps, the victory today is his victory. I salute JOHN LEWIS for his courage and tireless dedication to this cause.

But the ultimate winner today is not just a handful of Members, it is our Nation as a whole. For today, Congress has acted to heal old wounds of the past and formally acknowledge that the stories and contributions of African Americans to the birth and growth of this great Nation must be told to complete our history.

Since 1929, efforts have been made to recognize the contributions and unique history of Americans of African descent. It is past time that we publicly acknowledge and incorporate the African American experience into our collective identity.

This legislation will help ensure that the compelling stories and invaluable contributions of African Americans to our national fabric will no longer be ignored, but shared with all Americans, indeed, all peoples of the world.

With the creation of the National Museum of African American History and Culture, Americans of all races, ethnic backgrounds, and personal histories can come together to celebrate the contributions of all Americans to the rich heritage and culture that is the American melting pot.

That is the essence of this legislation—the completion of the American story of our quest for freedom and truth through the public incorporation of the experiences and contributions of African Americans to that struggle. This Museum offers the promise and hope that all Americans can come to understand the full story of how this nation was formed.

The House bill before us is virtually identical to the bill Senator BROWNBACK and I introduced in May of this year, S. 1157, which the Senate passed on June 23rd.

This legislation directs the Smithsonian Institution to establish a museum known as the National Museum of African American History and Culture. Within 12 months of enactment, the Smithsonian Board of Regents will choose a site for this Museum from among four sites listed in the bill.

With regard to the sites available for selection, the House bill deletes the Capitol grounds site contained in the Senate-passed bill and substitutes a fourth site, known as the "Banneker Overlook site" located on 10th Street Southwest at the foot of the L'Enfant Plaza promenade on axis with the Smithsonian Castle.

The bill directs that, prior to the selection of the site, the Board of Regents will consult with the chair of the National Capital Planning Commission and the chair of the Commission on Fine Arts, as well as the chairman of the Presidential Commission, Congressional oversight committees and others.

In the meantime, the Smithsonian Board of Regents will appoint a 19 member council, comprised of leaders within the African American community and others, to advise the Regents on the development, design and construction of the Museum.

With regard to the selection of these council members, I was disappointed that the House deleted a provision in the Senate-passed bill which would have required that at least 9 members of the council be of African American descent.

This important provision in the Senate-passed bill was modeled on provisions of the act which created the National Museum of the American Indian. As in the case of that Museum, this language was intended to ensure that the sensitivities and perspectives of those individuals whose stories this Museum will tell are properly considered and portrayed.

Although I regret that the House deleted this provision, the bill still requires that, in appointing 17 of the 19 members of the council, the Board of Regents take into consideration individuals recommended by organizations and entities that are committed to the advancement of knowledge of African American life, art, history, and culture.

Although this change weakens the Senate version of this bill some, the Smithsonian Institution can still ensure the integrity of the content of this museum by appointing members to the council in keeping with the Senate's original intent. As the ranking member of the Rules Committee which has oversight jurisdiction over the Smithsonian, I look forward to working with the Smithsonian to see that this happens.

This Museum will include exhibits and programs relating to all aspects of African American life, art, history, and culture from the time of slavery through present day and will provide leadership to other museums and will collaborate with historically Black colleges and universities and educational organizations to ensure the integrity of the exhibits and programming and to broaden the reach of its story and mission.

The House compromise also retains provisions of the Senate-passed bill which authorizes a grant program within the National Institute of Museum and Library Services. This program is intended to support organizations dedicated to expanding the knowledge of the African American experience and slavery by providing support for improving operations, care of collections, and intern and scholarship programs.

Equally important is a provision which will provide grants to nonprofit organizations whose primary purpose is to promote the study of the African American diaspora. Such grants can be used to increase existing endowment funds for the purpose of enhancing education programs and maintaining and operating traveling exhibits.

In Connecticut, we are fortunate to have such an organization in Amistad America, Inc. Amistad America is a national, non-profit educational organization dedicated to promoting the legacies of the Amistad incident of 1839 through the traveling exhibit of the freedom schooner *Amistad*.

The *Amistad* is literally a floating classroom which celebrates and teaches the historic lessons of perseverance, leadership, cooperation, justice, and freedom inherent in the Amistad Incident. Although its home port is New Haven, CT, the freedom schooner *Amistad* travels to both national and international ports to bring the story of our collective history and the continuing struggle for equality and human rights to school children and adults around the globe.

It is through the efforts of such organizations as Amistad America, with the support of the new Museum of African American History and Culture and the National Institute of Museum and Library Services, that we can ensure that the lessons of the past are not lost on current or future generations.

In short, this legislation offers the hope that through knowledge and education, the history of the struggles for freedom and equality of some Americans becomes the interwoven history of all Americans and ensures that future generations will not have to repeat such struggles.

I was honored to be the lead Democratic sponsor of this legislation in the Senate, and I am honored to stand before the Senate today to urge my colleagues to adopt this compromise which the House has passed and send this measure to the President for his signature.

We would not be at this point today without the dedication and assistance of many people, including the staff who labor many hours and late into the night to facilitate the legislative process. At the risk of leaving someone off the list, I want to recognize those staff for their considerable contributions to this measure, including LaRochelle Young of Senator BROWNBACK's staff; Michael Collins and Tammy Boyd of Congressman JOHN LEWIS's staff; Paul Vinovich and George Hagijski of Congressman BOB NEY's House Administration Committee staff; George Shevlin and Matt Pinkus of Congressman JOHN LARSON's House Administration Committee staff; Susan Brita of Congressman JAMES OBERSTAR's House Transportation and Infrastructure Committee staff; Dan Mathews of Congressman STEVEN LATOURETTE's Transportation and Infrastructure Committee staff; Bill Johnson of Congressman JACK KINGSTON's staff; and Kennie Gill of my Rules Committee staff.

The action we take today is historic not only in its ability to unify this nation, but in its message to the world that we recognize and cherish the contributions of all Americans to the creation of this great democracy.

Mr. FRIST. I ask unanimous consent that the bill be read the third time and passed, the motion to reconsider be laid upon the table, and any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (H.R. 3491) was read the third time and passed.

Mr. FRIST. I want to take just one moment and comment on the unanimous consent agreement and the establishment within the Smithsonian Institution of the National Museum of African American History and Culture, which we just approved.

This has been a fairly long journey, to come to the point of the establishment of this African American History and Culture Museum. It really goes back to the time of African-American history, when it began in 1619 in Jamestown, VA. It was there a Dutch slave trader exchanged his cargo of Africans for food. Over the next 400 years, the descendants of men and women brought to America in chains would seek and find freedom. They would transform the American consciousness. They would permanently revolutionize American culture, American music, American art, and American literature.

We are on the cusp of really a momentous event, and that is the enshrining of these events in a national museum devoted to African-American history and culture. With this, visitors from around the world will learn about 400 years of struggle and progress.

The museum will house priceless artifacts, it will house documents, it will house recordings—all commemorating that 400-year history. It will serve as a wellspring of inspiration and scholarship. With the action of just a few moments ago, we will be sending the President a bill to fulfill this vision.

What the African American Museum of History and Culture Act does is establish this museum within the Smithsonian. It is a Federal-private partnership. It authorizes $17 million for the first year in order to launch this museum.

The Board of Regents will have 12 months to designate a site and the legislation lays out four possibilities for that site. Once that site is selected, the Board will set to work raising up this new national institution. America will finally have a museum worthy of the generations of men and women who have sacrificed so much and given so deeply to the cause of freedom.

I do commend my colleagues, Senator BROWNBACK, Senator DODD, Senator LOTT, Senator SANTORUM, Senator STEVENS, and on the House side especially Representative JOHN LEWIS of Georgia and Representative J.C. Watts for their hard work and their leadership in coming to this point.

Indeed, the African-American journey is America's journey and tonight we take another major step forward.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. If the Senator has finished his comment on the passage of this important legislation, I would like to briefly say JOHN LEWIS's name was mentioned, and rightfully so. Everyone the distinguished majority leader mentioned has played a significant role in this legislation before us, but when JOHN LEWIS came to Washington, this became a personal crusade of his.

JOHN LEWIS is one of my heroes. I have such great admiration and respect for him. I think this is the culmination of a dream he started many years ago. I want the record to be clear as to how much this means to him, the people of Georgia, and this country.

The PRESIDING OFFICER. The majority leader.

Mr. FRIST. I, again, want to second that. When this bill passed the House of Representatives—I think it was 2 nights ago—I immediately called Representative LEWIS the next morning for exactly the same reason.

I have not been around Washington quite as long to be able to build upon the shoulders of somebody like Representative LEWIS, who had this vision of a museum, but we are now taking that major step forward. As museums are approved and money is put forward, it takes a while, but to see that dream really becoming concrete, I want to tell him thank you for me, for this body, for America, and for all the millions of people who will benefit from that vision he had.

CONGRATULATING COACH JOHN GAGLIARDI

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate proceed to the consideration of S. Res. 270, submitted by Senators COLEMAN and DAYTON earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 270) congratulating John Gagliardi, football coach of St. Johns University, on the occasion of his becoming the all-time winningest coach in collegiate football history.

There being no objection, the Senate proceeded to consider the resolution.

Mr. DASCHLE. Mr. President, I rise in strong support of S. Res. 270, congratulating John Gagliardi on becoming the winningest college football coach in history. He is a truly remarkable coach and an even better man.

While thousands of his players have known this for years, the rest of the country has come to learn over the last several weeks that it not just John's 410 wins which make him special. In an era when collegiate student athletes are pressured to avoid academics, John Gagliardi consistently coaches teams with graduation rates at or close to 100 percent. He values sportsmanship, hard work and humility. And he treats his players and opponents with respect.

I am proud that several South Dakotans have contributed to John's success over the years. This year's conference championship team includes three fine student athletes from South Dakota: Aaron Babb, of Sioux Falls; Jason Hardie, of Beresford; and Dana Kinsella, also of Sioux Falls.

There have been other fine South Dakotans before them. While there are dozens, I will name just a couple. Sean Dailey, an all-conference defensive end, is now an accomplished chemist. And Jay Conzemius, an All-American running back was until recently the Chancellor of the Catholic Diocese of Sioux Falls.

It is right and fitting for the Senate to honor John Gagliardi for his historic accomplishments. It is unlikely that anyone will ever win as many games as he has, and maybe even more unlikely that any coach will so positively impact the lives of so many young men. I yield the floor.

Mr. FRIST. Mr. President, I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motion to reconsider be laid upon the table, and any statements relating to the resolution be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 270) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 270

Whereas John Gagliardi began his coaching career in 1943 at the age of 16 when his high school football coach was drafted and John Gagliardi was asked to take over the position;

Whereas John Gagliardi won 4 conference titles during the 6 years he coached high school football;

Whereas John Gagliardi graduated from Colorado College in 1949 and began coaching football, basketball, and baseball at Carroll College in Helena, Montana, winning titles in all 3 sports;

Whereas John Gagliardi took over the football program at St. John's University in Collegeville, Minnesota, in 1953 and the football team won the Minnesota Intercollegiate Athletic Conference title in his first year as coach;

Whereas by the end of the 2002 season, John Gagliardi had won 3 national championships, coached 22 conference title teams, appeared in 45 post-season games and compiled a 376–108–10 record during his 50 years at St. John's University;

Whereas under the leadership of John Gagliardi, St. John's University has been nationally ranked 37 times in the past 39 years, and the university set a record with a 61.5 points per game average in 1993;

Whereas over 150 students participate in the St. John's University football program each year and every player dresses for home games;

Whereas John Gagliardi's coaching methods follow the "Winning with No's" theory: no blocking sleds or dummies, no whistles, no tackling in practices, no athletic scholarships, and no long practices;

Whereas John Gagliardi has coached over 5,000 players during his 50 years at St. John's University, and no player has failed to graduate and most have graduated in 4 years;

Whereas, in 1993, the John Gagliardi trophy was unveiled, and it is given each year to the most outstanding Division III football player;

Whereas on November 1, 2003, John Gagliardi tied Grambling University coach Eddie Robinson's record of 408 wins with a 15 to 12 victory over the University of St. Thomas;

Whereas on November 8, 2003, John Gagliardi broke Eddie Robinson's record with a 29 to 26 victory over Bethel College;

Whereas John Gagliardi is admired by his players, as well as by the students, faculty, and fans of St. John's University for his ability to motivate and inspire;

Whereas students who take his course, Theory of Football, credit John Gagliardi for teaching them more about life than about football;

Whereas those closest to John Gagliardi will tell you that football is only part of his life—he values the time he spends with Peg, his wife of 47 years, and their 4 children; and

Whereas the on- and off-the-field accomplishments of John Gagliardi have placed him in an elite club that includes the best coaches in history: Now, therefore, be it

Resolved, That the Senate—

(1) congratulates John Gagliardi, football coach of St. John's University in Collegeville, Minnesota, on becoming the all-time winningest coach in collegiate football history; and

(2) directs the Secretary of the Senate to transmit an enrolled copy of this resolution to John Gagliardi and St. John's University.

RECOGNITION OF THE EVOLUTION AND IMPORTANCE OF MOTORSPORTS

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 395, S. Res. 253.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 253) to recognize the evolution and importance of motorsports.

There being no objection, the Senate proceeded to consider the resolution.

Mr. FRIST. Mr. President, I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motion to reconsider be laid upon the table with no intervening action or debate, and that any statements relating to this resolution be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 253) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 253

Whereas on March 26, 1903, an automotive race was held on a beach in Volusia County, Florida, inaugurating 100 years of motorsports;

Whereas 100 years later, motorsports are the fastest growing sports in the country;

Whereas races occur at hundreds of motorsport facilities in all 50 States;

Whereas racing fans can enjoy a wide variety of motorsports sanctioned by organizations that include Championship Auto Racing Teams (CART), Grand American Road Racing (Grand Am), Indy Racing League (IRL), International Motorsports Association (IMSA), National Association for Stock Car Automobile Racing (NASCAR), National Hot Rod Association (NHRA), Sports Car Club of America (SCCA), and United States Auto Club (USAC);

Whereas the research and development of vehicles used in motorsports have directly contributed to improvements in safety and technology for the automobiles and motor vehicles used by hundreds of millions of Americans;

Whereas 13,000,000 fans will attend NASCAR races alone in 2003;

Whereas fans of all ages spend days at motorsport facilities participating in a variety of interactive theme and amusement activities surrounding races;

Whereas motorsport facilities that provide these theme and amusement activities contribute millions of dollars into local economies;

Whereas motorsports make a significant contribution to the national economy; and

Whereas tens of millions of people in the United States enjoy the excitement and speed of motorsports every week: Now, therefore, be it

Resolved, That the Senate recognizes the evolution of motorsports and honors those who have helped create and build this great American pastime.

EXPRESSING THE IMPORTANCE OF MOTORSPORTS

Mr. FRIST. Mr. President, I ask unanimous consent the Senate proceed to the immediate consideration of H. Con. Res. 320, which is at the desk.

The PRESIDING OFFICER. The clerk will report the concurrent resolution by title.

The legislative clerk read as follows:

A concurrent resolution (H. Con. Res. 320) expressing the sense of the Congress regarding the importance of motorsports.

There being no objection, the Senate proceeded to consider the concurrent resolution.

Mr. FRIST. Mr. President, I ask unanimous consent that the concurrent resolution be agreed to, the preamble be agreed to, the motion to reconsider be laid upon the table, and that any statements relating to the concurrent resolution be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The concurrent resolution (H. Con. Res. 320) was agreed to.

The preamble was agreed to.

UNITED STATES FIRE ADMINISTRATION REAUTHORIZATION ACT OF 2003

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 250, S. 1152.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 1152) to reauthorize the United States Fire Administration, and for other purposes.

There being no objection, the Senate proceeded to consider the bill which has been reported from the Committee on Commerce, Science, and Transportation, with amendments, as follows:

[Strike the part shown in black brackets and insert the part shown in italic.]

S. 1152

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

[SECTION 1. SHORT TITLE.

[This Act may be cited as the "United States Fire Administration Reauthorization Act of 2003".

[SEC. 2. RE-ESTABLISHMENT OF POSITION OF UNITED STATES FIRE ADMINISTRATOR.

[Section 1513 of the Homeland Security Act of 2002 does not apply to the position or office of Administrator of the United States Fire Administration, who shall continue to be appointed and compensated as provided by section 5(b) of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2204(b)) after the functions vested by law in the Federal Emergency Management Agency have been transferred to the Directorate of Emergency Preparedness and Response in accordance with section 503 of the Homeland Security Act of 2002.

[SEC. 3. AUTHORIZATION OF APPROPRIATIONS.

[Section 17(g)(1) of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2216(g)(1)) is amended to read as follows: "(1) Except as otherwise specifically provided with respect to the payment of claims under section 11 of this Act, there are authorized to be appropriated to carry out the purposes of this Act—

["(A) $52,000,000 for fiscal year 2004;

["(B) $53,560,000 for fiscal year 2005; and

["(C) $55,166,800 for fiscal year 2006.".]

TITLE I—UNITED STATES FIRE ADMINISTRATION REAUTHORIZATION

SECTION 101. SHORT TITLE.

This title may be cited as the "United States Fire Administration Reauthorization Act of 2003".

SEC. 102. RE-ESTABLISHMENT OF POSITION OF UNITED STATES FIRE ADMINISTRATOR.

Section 1513 of the Homeland Security Act of 2002 does not apply to the position or office of Administrator of the United States Fire Administration, who shall continue to be appointed and compensated as provided by section 5(b) of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2204(b)) after the functions vested by law in the Federal Emergency Management Agency have been transferred to the Directorate of Emergency Preparedness and Response in accordance with section 503 of the Homeland Security Act of 2002.

SEC. 103. AUTHORIZATION OF APPROPRIATIONS.

Section 17(g) of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2216(g)) is amended—

(1) by striking subparagraphs (A) through (K) of paragraph (1) and inserting the following:

"(A) $63,200,000 for fiscal year 2004, of which $2,200,000 shall be used to carry out section 8(e);

"(B) $65,096,000 for fiscal year 2005, of which $2,266,000 shall be used to carry out section 8(e);

"(C) $67,049,000 for fiscal year 2006, of which $2,334,000 shall be used to carry out section 8(e);

"(D) $69,060,000 for fiscal year 2007, of which $2,404,000 shall be used to carry out section 8(e); and

"(E) $71,132,000 for fiscal year 2008, of which $2,476,000 shall be used to carry out section 8(e)."; and

(2) by adding at the end the following:

"(3) Of the funds authorized by paragraph (1) for fiscal years 2004 through 2006, $3,000,000 annually shall be made available for grants for fire fighting equipment necessary to fight fires using foam in remote areas without access to water."

TITLE II—FIREFIGHTING RESEARCH AND COORDINATION

SECTION 201. SHORT TITLE.

This title may be cited as the "Firefighting Research and Coordination Act".

SEC. 202. NEW FIREFIGHTING TECHNOLOGY.

In General.—Section 8 of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2207) is amended—

(1) by striking "and" after the semicolon in paragraph (9) of subsection (a);

(2) by striking "section." in paragraph (9) of subsection (a) and inserting "section;";

(3) by adding at the end of subsection (a) the following:

"(9) methods of containing insect infested forest fires and limiting disbursal of resultant fine particle smoke; and

"(10) methods of measuring and tracking the disbursal of fine particle smoke resulting from fires of insect infested fuel.";

(4) by redesignating subsection (e) as subsection (f); and

(5) by inserting after subsection (d) the following:

"(e) Development of New Technology.—

"(1) In general.—In addition to, or as part of, the program conducted under subsection (a), the Administrator, in consultation with the National Institute of Standards and Technology, the Inter-Agency Board for Equipment Standardization and Inter-Operability, the National Institute for Occupational Safety and Health, the Directorate of Science and Technology of the Department of Homeland Security, national voluntary consensus standards development organizations, interested Federal, State, and local agencies, and other interested parties, shall—

"(A) develop new, and utilize existing, measurement techniques and testing methodologies for evaluating new firefighting technologies, including—

"(i) personal protection equipment;

"(ii) devices for advance warning of extreme hazard;

"(iii) equipment for enhanced vision;

"(iv) devices to locate victims, firefighters, and other rescue personnel in above-ground and below-ground structures;

"(v) equipment and methods to provide information for incident command, including the monitoring and reporting of individual personnel welfare;

"(vi) equipment and methods for training, especially for virtual reality training; and

"(vii) robotics and other remote-controlled devices;

"(B) evaluate the compatibility of new equipment and technology with existing firefighting technology; and

"(C) support the development of new voluntary consensus standards through national voluntary consensus standards organizations for new firefighting technologies based on techniques and methodologies described in subparagraph (A).

"(2) New equipment must meet standards.—For equipment for which applicable voluntary consensus standards have been established, the Administrator shall, by regulation, require that equipment or systems purchased through the assistance program established by section 33 meet or exceed applicable voluntary consensus standards.".

SEC. 203. COORDINATION OF RESPONSE TO NATIONAL EMERGENCY.

(a) In General.—Section 10 of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2209) is amended—

(1) by redesignating subsection (b) as subsection (c); and

(2) by inserting after subsection (a) the following:

"(b) Mutual Aid Systems.—

"(1) In general.—The Administrator, after consultation with the Under Secretary for Emergency Preparedness and Response, shall provide technical assistance and training to State and local fire service officials to establish nationwide and State mutual aid systems for dealing with national emergencies that—

"(A) include threat assessment and equipment deployment strategies;

"(B) include means of collecting asset and resource information to provide accurate and timely data for regional deployment; and

"(C) are consistent with the Federal Response Plan.

"(2) Model mutual aid plans.—The Administrator, in consultation with the Under Secretary for Emergency Preparedness and Response, shall develop and make available to State and local fire service officials model mutual aid plans for both intrastate and interstate assistance.".

(b) Report on Strategic Needs.—Within 90 days after the date of enactment of this Act, the Administrator of the United States Fire Administration shall report to the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committee on Science on the need for a strategy concerning deployment of volunteers and emergency response personnel (as defined in section 6 of the Firefighters' Safety Study Act (15 U.S.C. 2223e), including a national credentialing system, in the event of a national emergency.

(c) Update of Federal Response Plan.—Within 180 days after the date of enactment of this Act, the Under Secretary of Emergency Preparedness and Response shall—

(1) revise the Federal Response Plan to incorporate plans for responding to terrorist attacks, particularly in urban areas, including fire detection and suppression and related emergency services; and

(2) transmit a report to the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committee on Science describing the action taken to comply with paragraph (1).

SEC. 204. TRAINING.

(a) In General.—Section 8(d)(1) of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2206(d)(1)) is amended—

(1) by striking "and" after the semicolon in subparagraph (E);

(2) by redesignating subparagraph (F) as subparagraph (N); and

(3) by inserting after subparagraph (E) the following:

"(F) strategies for building collapse rescue;

"(G) the use of technology in response to fires, including terrorist incidents and other national emergencies;

"(H) response, tactics, and strategies for dealing with terrorist-caused national catastrophes;

"(I) use of and familiarity with the Federal Response Plan;

"(J) leadership and strategic skills, including integrated management systems operations and integrated response;

"(K) applying new technology and developing strategies and tactics for fighting forest fires;

"(L) integrating terrorism response agencies into the national terrorism incident response system;

"(M) response tactics and strategies for fighting fires at United States ports, including fires on the water and aboard vessels; and".

(b) Consultation on Fire Academy Classes.—The Superintendent of the National Fire Academy may consult with other Federal, State, and local agency officials in developing curricula for classes offered by the Academy.

(c) Coordination With Other Programs To Avoid Duplication.—The Administrator of the United States Fire Administration shall coordinate training provided under section 8(d)(1) of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2206(d)(1)) with the Attorney General, the Secretary of Health and Human Services, and the heads of other Federal agencies—

(1) to ensure that such training does not duplicate existing courses available to fire service personnel; and

(2) to establish a mechanism for eliminating duplicative training programs.

Mr. McCAIN. Mr. President, I am pleased the Senate will now consider S. 1152, the United States Fire Administration Act of 2003. I am pleased to offer a substitute amendment which includes the provisions of S. 321, the Firefighting Research and Coordination Act.

I thank Senators HOLLINGS, BROWNBACK, BREAUX, BIDEN, DEWINE, CANTWELL, LINDSEY GRAHAM, CARPER, and SNOWE for their support of these two bills. I also thank Representative CAMP for his leadership in the House on the companion bill to S. 321. In addition, I thank Chairman BOEHLERT and ranking member HALL of the House Science Committee, and Chairman NICK SMITH of the Research Subcommittee for their work on this legislation.

The purpose of this legislation is to address many of the pressing needs of our fire services. As we face a war against terrorism, we must remember that firefighters are among the first to respond to any domestic terrorist event. In addition, today's firefighters must be prepared to deal with a host of other hazards caused by urban and wild land fires, natural disasters, hazardous materials spills, and other accidents. This legislation is designed to ensure that our Nation's first-responders are adequately prepared and trained to take action against these myriad threats.

This legislation will reauthorize funding for the U.S. Fire Administration, USFA, for fiscal year 2005 through fiscal year 2008. The USFA's important mission is to reduce the loss of life and property due to fire and related emergencies. The agency utilizes a number of tools to fulfill its mission. The National Fire Academy, NFA, is the premiere training academy of the fire services, and has trained over 1.4 million firefighters and other first-responders in emergency management, fire prevention, and anti-terrorism. In addition, the USFA engages in research, testing, and evaluation activities with public and private entities to promote and improve fire and life safety.

This legislation also would reestablish the position of U.S. Fire Administrator at USFA. The U.S. Fire Administrator plays a critical role in our Nation's fire control policy and homeland security initiatives by serving as the point-of-contact for the fire services. This position was eliminated in last year's legislation that established the Department of Homeland Security. On April 30, 2003, the Senate Committee on Commerce, Science, and Transportation heard testimony from many of the major fire service organizations regarding the importance of the U.S. Fire Administrator, and the need for the administrator to serve as a representative of the fire services within the new Department of Homeland Security.

The legislation would address a major issue that fire departments face in equipping themselves. Today's firefighters use a variety of technologies including thermal imaging equipment; devices for locating firefighters and victims; and state-of-art protective suits to fight fires, clean up chemical and hazardous waste spills, and contend with potential terrorist devices. Unfortunately, there are no uniform technical standards for new equipment used in combating fires. Without such standards, local fire companies may purchase equipment that is faulty or that does not satisfy their needs. A January 2003, Consumer Reports article reported that much of the emergency equipment sold today is not tested or certified by the government or independent labs. The article states that "the confusion will get worse, emergency departments say, as new equipment floods the market in response to increased government funding."

The legislation would help to resolve this problem by authorizing the U.S. Fire Administrator to work with other Federal agencies and interested parties to support the development of voluntary consensus standards for new firefighting technology. Fire departments would use these standards when buying equipment through the federal Assistance to Firefighters Grant Program. In the rare case where a standard is out of date, the U.S. Fire Administrator would be allowed to grant a waiver.

The legislation also would address many of the coordination challenges that firefighters face during national emergencies. It would direct the U.S. Fire Administrator to provide assistance to State and local fire services in developing mutual aid plans, and report on a strategy for deployment of volunteers and other emergency response personnel.

Additionally, the legislation would authorize the National Fire Academy to train firefighters on technologies and strategies to respond to future terrorist attacks. It also would authorize the U.S. Fire Administrator to work with other federal agencies to coordinate training programs to prevent duplication.

The bill also would authorize the U.S. Fire Administrator to work with the Department of Agriculture and Department of the Interior to provide assistance in fire prevention and control technologies, including methods of containing insect-infested forest fires as well as measuring, tracking, and limiting the dispersal of the resulting smoke. In addition, the legislation would expand the Board of Directors of the National Fallen Firefighters Foundation from nine members to 12. And, it would allow local fire departments to purchase equipment for fighting fires with foam in remote areas without access to water under the Assistance to Firefighters Grant Program.

This legislation is supported by the National Volunteer Fire Council; the Congressional Fire Services Institute; the National Fire Protection Association; the International Association of Fire Chiefs; the International Association of Fire Fighters; the International Association of Arson Investigators; International Society of Fire Service Instructors; North American Fire Training Directors and the International Fire Service Training Association.

I urge my colleagues to support swift passage of this important legislation.

I ask unanimous consent to print the letter of endorsement in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

NOVEMBER 6, 2003.

Hon. JOHN MCCAIN,
Chairman, Senate Committee, Science and Transportation Committee, Dirksen Senate Office Building, Washington, DC.

DEAR SENATOR MCCAIN: We are writing in strong support of S. 1151/H.R. 2692, the United States Fire Administration Reauthorization Act of 2003. Through a cooperative effort between both the leaders of the authorizing committees and our organizations, this legislation charts a course for the United States Fire Administration to prepare our nation's fire service for the many challenges it faces in a post 9-11 world.

Of particular importance to the fire service is the reinstatement of the United States Fire Administrator position as a Senate-confirmed position. As you are aware, the Homeland Security Act of 2002 (Public Law 107-296) inadvertently eliminated the position of U.S. Fire Administrator. The Fire Administrator is the lead advocate for the fire service within a presidential administration. In a display of nonpartisanship, the nation's fire service, several members of Congress, and Secretary Tom Ridge agreed that the position needed to be reinstated.

Like you, we have taken a keen interest in the development of new technologies for first responders. While the emergence of new technologies will certainly benefit the readiness of local first responders, attention must be given to its performance capabilities. Otherwise we could jeopardize the safety of our first responders. For this reason, we support the Firefighter Research and Coordination Act (S. 321/H.R. 545) as an amendment to the reauthorization measure. Many new technologies have the potential to improve the capabilities of our first responders; however we must ensure that these technologies serve their intended purpose and protect our firefighters and emergency medical personnel through the requirement that equipment purchased with the FIRE Grant program must meet voluntary consensus standards.

We also support the other sections of the legislation calling for coordination of response to national emergencies and for increased training. These are critical to the effective deployment and safety of first responders at major incidents.

Lastly, there is one issue not included in your legislation that we encourage both the Congress and the U.S. Fire Administration to help us advance: the installation of automatic fire sprinklers in both homes and the workplace. We can significantly reduce the number of deaths caused by fire by providing incentives and encouragement to the public to stall automatic sprinkler systems in their homes and businesses. Until the 108th session adjourns, we will continue to call on Congress to support the Fire Sprinkler Incentives Act, sponsored by Congressman Curt Weldon and Senator Jon Corzine and any other measures that promote the use of sprinklers.

We look forward to working with you in advancing this legislation through Congress quickly. Again, we thank you for your continued support.

Sincerely,
Congressional Fire Service Institute, International Association of Arson Investigators, International Association of Fire Chiefs, International Association of Fire Fighters, International Fire Service Training Association, International Society of Fire Service Instructors, National Fire Protection Association, National Volunteer Fire Council, North American Fire Training Directors.

Ms. SNOWE. Mr. President, I rise today in support of S. 1152, the U.S. Fire Administration Reauthorization Act of 2003 that reestablishes the position of U.S. Fire Administrator and incorporates the provisions of S. 321, the Firefighting and Research Coordination Act which I cosponsored.

As we prepare to reauthorize the U.S. Fire Administration for the first time since fiscal year 2000, we do so in a vastly changed environment. In that time, the term "first responder" has entered the lexicon and is now a part of our national consciousness. Americans have always understood and were assured that in the event of an emergency, units of the U.S. Fire Service would respond, render aid to the suffering, and protect our property and resources. However, we had gotten to the point that we were taking the Fire Service for granted.

All of that changed, as did many things in America, on September 11, 2001. On that day, we watched in horror as those tragic events unfolded in New York, Pennsylvania and at the Pentagon, and we saw over and over the bravery and sacrifice of those proud men and women of the United States Fire Service as they worked tirelessly and without regard for their personal safety to help their fellow Americans. On that day, all of America once again became aware of those who live in our midst—our neighbors, our friends, and our relatives—who daily stand on the front lines to protect us from harm.

Since that time we embarked on an immense reorganization of the Government as we stood up the Department of Homeland Security. There were many views about the relative pros and cons of such a Department and which Federal agencies should be included in the Department and which were better left outside. This proposal will reauthorize just one agency within that organization, the United States Fire Administration. Most importantly, it will reestablish the U.S. Fire Administrator position as a separate entity appointed by the President and ensure that it is not subsumed as the Director of the Preparedness Division within the Department of Homeland Security.

In testimony earlier this year before the Commerce Committee, we heard from representatives from the International Association of Fire Chiefs, the National Fire Protection Association and the National Volunteer Fire Council who were united in their call to reestablish the position of United States Fire Administrator because of the importance of having an independent voice within the administration. As one example, they cited the need to have the Fire Administrator oversee the Firefighter Investment and Response Enhancement, FIRE, Act grants program to ensure funds were properly focused on the entirety of the fire service mission and not expended on strictly counterterrorism efforts.

I have always believed the FIRE grant program was one of the most successful competitive grant programs run by the Federal Government. In fiscal year 2002, my home State of Maine received a little over $4.3 million in grants, most of which went to the smallest communities in the State. In fact, the largest single recipient was the smaller South Berwick Fire Department, not the larger Portland or Bangor departments.

I have the honor and privilege of representing the Great State of Maine which has 5,300 miles of coastline and a long and proud maritime tradition. I am particularly pleased that this measure amends the FIRE grant process to include maritime firefighting so that those responsible for the protection of our ports and vessels at sea have the opportunity to acquire the tools and equipment they need to accomplish that mission.

Beyond simply directing the FIRE Act program, the bill also authorizes the U.S. Fire Administrator, in consultation with the National Institute of Standards and Technology, the Inter-Agency Board for Equipment Standardization and Interoperability, the Directorate of the Science and Technology at the Department of Homeland Security, national voluntary consensus standards development organizations and other interested parties, to develop the measurement techniques and testing methodologies to assess new firefighting technologies.

Such standards would support the development of voluntary consensus standards for evaluating the performance and compatibility of new firefighting technology, including thermal imaging equipment; early warning fire detection devices; personal protection equipment for firefighting; victim detection equipment; and devices to locate firefighters in buildings.

The U.S. Fire Administration Reauthorization Act also ensures that equipment purchased under the FIRE grant program will be required to meet or exceed those applicable voluntary consensus standards unless waived by the Fire Administrator in accordance with very specific guidelines.

Furthermore, under this legislation, the Fire Administrator is tasked with acting as a resource for State and local governments in developing mutual aid plans, updating the Federal Response Plan, and reporting on the need for a strategy for deploying volunteers, including a national credentialing system. New training programs at the National Fire Academy to improve tactics for using new firefighting technology and responding to terrorist attacks will be authorized under this measure.

I want to stress that the report on our strategic needs for the deployment of volunteers and emergency response personnel would be required within 90 days of enactment and a report describing plans to revise the Federal Response Plan to address responses to terrorism attacks would be due 180 days after enactment. These times are critical because it is imperative we complete the planning our national response so the Fire Service can more effectively protect our fellow citizens.

Successful implementation of those plans require that our firefighters undergo comprehensive training to understand and use the Federal Response Plan, to use new technologies and to develop the strategies and tactics to fight fires wherever they occur—in buildings, in forests or on the water. This legislation also encourages the Superintendent of the National Fire Academy to coordinate with Federal, State and local agencies to develop the curricula to accomplish that training and ensure that it is available in all geographic regions to both career and volunteer firefighters.

In conclusion, I would just say that this reauthorization of the Fire Administration is vital to those who risk their own lives every day in this nation to protect our citizens and our resources. It provides them with the leadership, the tools, the planning and the training they need to effectively accomplish that mission and I urge my colleagues to support passage of this measure.

Mr. FRIST. Mr. President, I ask unanimous consent that the McCain substitute at the desk be agreed to, the committee substitute, as amended, be agreed to, the bill, as amended, be read a third time and passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 2207) was agreed to.

(The amendment is printed in today's RECORD under "Text of Amendments.")

The committee amendment in the nature of a substitute, as amended, was agreed to.

The bill (S. 1152), as amended, was read the third time and passed.

PRESERVATION OF EXISTING JUDGESHIPS ON THE SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

Mr. FRIST. Mr. President, I ask unanimous consent the Senate proceed to the immediate consideration of Calendar No. 399, S. 1561.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 1561) to preserve existing judgeships on the Superior Court of the District of Columbia.

There being no objection, the Senate proceeded to consider the bill.

Mr. FRIST. I ask unanimous consent that the bill be read the third time and passed, the motion to reconsider be laid upon the table, and any statements related to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (S. 1561) was read the third time and passed, as follows:

S. 1561

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. COMPOSITION OF SUPERIOR COURT.

Section 903 of title 11 of the District of Columbia Code is amended by striking "fifty-eight" and inserting "61".

FAIRNESS TO CONTACT LENS CONSUMERS ACT

Mr. FRIST. I ask unanimous consent the Senate proceed to consideration of H.R. 3140, which is at the desk.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (H.R. 3140) to provide for availability of contact lens prescriptions to patients, and for other purposes.

There being no objection, the Senate proceeded to consider the bill.

Mr. FRIST. I ask unanimous consent the bill be read the third time and passed, the motion to reconsider be laid upon the table, and any statements related to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (H.R. 3140) was read the third time and passed.

MAKING FURTHER CONTINUING APPROPRIATIONS FOR FISCAL YEAR 2004

Mr. FRIST. I ask unanimous consent the Senate proceed to the consideration of H.J. Res. 78, which is at the desk.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A joint resolution (H.J. Res. 78) making further continuing appropriations for the fiscal year 2004, and for other purposes.

There being no objection, the Senate proceeded to consider the resolution.

Mr. FRIST. I ask the amendment at the desk be agreed to, the joint resolution, as amended, be read the third time and passed, the motion to reconsider be laid upon the table, and any statements relating to the joint resolution be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 2208) was agreed to, as follows:

On page 2, line 7, strike "23" and insert "24".

The joint resolution (H.J. Res. 78), as amended, was read the third time and passed.

ORDERS FOR FRIDAY, NOVEMBER 21, 2003

Mr. FRIST. I ask unanimous consent when the Senate completes its business today, it adjourn until 9:30 a.m. Friday, November 21. I further ask that following the prayer and pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day, and the Senate then resume consideration of the conference report to accompany H.R. 6, the Energy Policy Act, and that there then be 60 minutes equally divided between the chairman and ranking member of the Energy and Natural Resources Committee; provided that the final 10 minutes be divided between Senator BINGAMAN or his designee in control of the first 5 minutes, and the chairman or his designee in control of the final 5 minutes on the motion to invoke cloture on the conference report.

Mr. REID. Reserving the right to object, I appreciate the majority leader allowing the full 60 minutes after the prayer and pledge.

I ask, so there is no confusion on this side—this has been cleared with Senator BINGAMAN—the time on our side be allotted as follows: Senator LIEBERMAN, 4 minutes; Senator MCCAIN, 4 minutes; Senator CANTWELL, 3 minutes; Senator SCHUMER, 4 minutes; Senator JEFFORDS, 4 minutes; Senator COLLINS, 4 minutes; and the final 5 minutes, as pursuant to the intended order be Senator BINGAMAN.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. FRIST. Tomorrow morning there will be 1 hour of debate prior to a cloture vote on the energy conference report. I hope the Senate will be able to invoke cloture on this long overdue issue. It is important that the Senate invoke cloture to allow the Senate to have an up-or-down vote on the bill that will strengthen the Nation's energy security by establishing a national energy policy.

I would also announce that the conference committee on the Medicare reform legislation has finished its work. That conference report will be filed in the House. We hope to consider and complete that measure just as soon as possible.

In addition, we have the Appropriations Committee which is completing its work on the appropriations process. And we will shortly consider that conference report as well.

Having said that, we will have rollcall votes tomorrow. A number of people have asked about the weekend schedule, and we have been very clear over the last week and a half that we will be in session this weekend. But the specifics of the weekend schedule, hopefully, we will be able to announce sometime midday tomorrow.

ORDER FOR ADJOURNMENT

Mr. FRIST. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment under the previous order, following the remarks of Senator GRASSLEY and Senator DODD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Iowa.

ENERGY POLICY ACT OF 2003

Mr. GRASSLEY. Mr. President, I am going to discuss the legislation before the Senate, the Energy bill. In order to secure our country's economic and national security, we need to have a balanced energy plan that protects the environment, supports the needs of our growing economy, and reduces our dependence on foreign sources of energy.

Balance has been my guiding light as I worked legislation through the Finance Committee, which I chair, for tax incentives for energy. I wanted to make sure we had a very balanced piece of legislation. By balanced, I mean balanced between fossil fuels, conservation, and renewable fuels.

We do have in the finance provisions of this Energy bill very balanced provisions for fossil fuels, for near-term energy needs, but we also legislate for the future as we have emphasis upon renewable fuels, wind energy, biomass, biodiesel, ethanol, and things of that nature. We have tax incentives for that.

Then we also have tax incentives for conservation. It is my belief that a well-balanced piece of energy legislation, with tax incentives for fossil fuels, for renewable fuels, and for conservation, is not only good for such policy, but I have come to the conclusion that is the sort of legislation we have to have to get the bipartisanship it takes to get a bill through the Senate.

Now, the other body, in writing similar legislation out of their finance committee—over there it is called the Ways and Means Committee—it seemed to me it was very tilted toward fossil fuels. It was my job, representing the Senate, to make sure from the conference with the House of Representatives we came out with a balance. I think we did come out with that balance.

I commend that balance to this body, to think about that as you vote on cloture tomorrow. Give us an opportunity to vote this bill up or down, and consider that my committee, in bringing this balance—for conservation, for renewable fuels, and for fossil fuels—tried to do what we could to get a majority vote in this body.

Now, of course, we need a supermajority vote, and that supermajority vote is to stop a Democrat filibuster against this bill. In a time like this, when the energy needs of our country are so great, and we are in a crisis situation, we should not tolerate a filibuster against this bill.

Every man, woman, and child in the United States is a stakeholder when it comes to developing a responsible, balanced, stable, and long-term energy policy.

The events of September 11 have made very clear to Americans how important it is to enhance our energy independence. We can no longer afford to allow our dangerous reliance on foreign sources of oil to continue.

But somehow we can wait; and we do wait. We should not wait, but we seem to wait in a way that causes that wait to make "too good of an impact." It has been over 10 years since we passed energy legislation in this body. But if we wait until we get that perfect piece of legislation, we may be waiting forever. And by waiting forever, we will suffer the consequences of less supply and higher prices.

I do not know about folks in all parts of the country, but I know I was brought up in the State of Iowa just to have dependence upon our sources of energy. When you go to the gas pump, you put the hose in your car, you move the lever, you expect to get gasoline. When you flip the light switch, you expect the lights to come on.

In order for that to happen, and for the price to be stable, just a small percentage at the margins of supply is necessary in order for us to have that stability and that certainty.

Some people in this country believe that one way to change American lifestyle is to force down the supply of energy. I happen to believe that Americans ought to have a massive amount of choice; that we do not need a bunch of bureaucrats or interest groups in Washington dictating to us that somehow, through an energy policy, by cutting back on the amounts of energy, they are going to bring about their "perfect" society.

This bill is obviously not perfect. And to those who complain about various provisions, I just remind them, if they drafted a "perfect" bill—and there probably would never be one—it would not pass the House or the Senate.

Some say the process has not been perfect. But if the process had been perfect for some, it would not have been perfect in the view of others. And that is fairly common in any legislating process.

While we are talking about process, I would like to clarify the role the Senate Finance Committee, which I chair, played in this bill. We have heard a lot about Republicans shutting Democrats out of the conference process. Well, that is not the way I operate as chairman. That is not the way my Democrat counterpart, Senator BAUCUS, operated when he was chairman of this committee when the Democrats were in the majority in the last Congress.

With respect to the tax provisions of the bill, the process was open. Senator BAUCUS attended conference committee meetings. Finance Committee Democratic staff worked side by side with my Republican staff in the conference negotiations.

I might add, they were a key asset for us in the protracted negotiations with the House Ways and Means Committee. Conferee staff on both sides of the aisle was informed as the process moved forward.

If it is "perfection" you are insisting upon, then you are in the wrong business. Legislating is neither a perfect process nor does it produce perfect products.

The Energy Security Act of 1992—the last one that Congress passed—was not perfect. That quickly became clear.

In 1995, after extensive interagency review and analysis, under provisions of section 232 of the Trade Expansion Act of 1962, the Clinton administration concluded that oil imports threatened our national security.

Such a finding, under this law, gave him the authority to impose quotas and import fees on oil. But he chose to do nothing because he believed that import adjustments would be too harmful to the economy.

Within 3 years of passing what was called an Energy Security Act, the fact is, our national security only worsened. When national security is not in good shape, it is probably because our economic security has worsened.

So what do we do? Do we do nothing? Do we wait for a perfect piece of legislation? Do we wait for market forces to save us? We heard earlier today criticism of this Energy bill because it fails, in so many words, to allow the free market to work its magic. The bill is not perfect, it has been argued, because it favors one energy source over another. You can go on and on and on. I would like to talk about that favoritism, and I would like to talk about the marketplace.

During the debate on the 1992 Energy Security Act, the chairman of the Energy Committee at that time, former Senator Bennett Johnston of Louisiana, stated that each barrel of imported oil was subsidized by the taxpayers to the tune of $200 per barrel. That is outrageous. Anybody listening to that says I had to misquote something.

But again, let me explain from this leading Senate expert on energy, as Senator Johnston was, he is telling us that imported oil is subsidized $200 for each and every barrel. Is that favoritism, when we subsidize imported oil at $200 a barrel? Are we picking winners and losers? What does that tell us about the so-called free market system? How can our domestic energy producers compete with that? It makes a mockery of the argument that we must sit idly by and let the marketplace control our energy policy.

How absurd can we be? On one hand, we subsidize imported oil, and we do that through the military expense it takes to protect the trail of oil from the Middle East to our shore or what we are doing in the Middle East now to preserve peace over there, cutting down on terrorism as part of that. But on the one hand we subsidize imported oil, and then we wonder why we become dangerously dependent upon that foreign oil. The Government, through a massive interagency review, declares that our national security is at risk because of imported oil but then declines to do anything about it because we might disrupt our domestic economy. So any way you look at it, we are in a box that we need not be in, if we can get this legislation passed.

The marketplace won't save us because we stacked the deck in favor of foreign oil. Again, I ask: What do we do in response to this imperfect world in which we find ourselves? Pass a bill that picks winners and losers? The answer is a definite yes. The winners we pick in this bill are all Americans, all of whom have a stake in reducing our dependence upon foreign sources of oil. We do this by favoring domestic producers over foreign producers. That is true of oil and natural gas, but it is also true of our supply of renewable fuels.

It is well past time that we get serious about implementing energy efficiency and conservation efforts, investing in alternative renewable fuels, and improving domestic production of traditional resources. I support a comprehensive energy policy consisting of conservation efforts on the one hand, the development of renewable and alternative energy sources on the other hand, and on the third hand, domestic production of traditional sources of energy.

As my colleagues well know, I have long been a supporter of alternative and renewable sources of energy as a way of protecting our environment, increasing our energy independence. That started with my work with former Senator Robert Dole on legislation for tax incentives for ethanol. It was my own work in 1992, developing the wind energy tax credit, that has increased our production of electricity by wind. My State of Iowa, for instance, is third of the 50 States in the production of wind energy, as an example. So obviously, you know I strongly support the production of renewable domestic fuels. I particularly emphasize, in addition to ethanol, biodiesel made from soybeans. As domestic renewable sources of energy, ethanol and biodiesel can increase fuel supplies, reduce our dependence upon foreign oil, and increase our national economic security.

For the first time we have a tax incentive in this legislation for production of virgin and recycled biodiesel. This is a new market for soybean farmers and yet another source of renewable energy. The renewable fuels standard, supported by a broad coalition, is good for America's farmers, obviously good for the environment, good for our consumers, good for creating jobs in our cities in the production of this fuel, and good for our national security, as we are less dependent upon foreign sources of oil.

A key reform in this Senate bill deals with the treatment of ethanol-blended fuels for highway trust fund purposes. Tax incentives for ethanol are unique in terms of their treatment in the Tax Code. Unlike incentives for other energy sources such as oil and gas, the revenue for ethanol incentives comes out of the highway trust fund because it simply is not paid into the trust fund in the first place. This bill makes it clear that those incentives will be treated like all other energy incentives: The revenue will be made up to the highway fund from the general fund.

We didn't get all of the Senate reform in this conference agreement. A gesture to the House was that we would defer repealing the partial tax exemption these fuels get until the next highway bill, which is early next year. The same is true with respect to the transfer of the 2.5 cents fuel tax that ethanol-blended fuels do pay. That highway bill will be before us early next year. The current highway trust fund spending authority runs out on February 29 next. So we have to get it passed early.

My friend Senator BAUCUS has made this highway trust fund reform a priority of his. Together, he and I will ensure that the highway trust fund is made whole for the gap between now and February 29. I have the assurance of the leadership of both bodies that our deferral will not prejudice the highway community.

As chairman of the Senate Finance Committee, I worked closely with ranking member Senator BAUCUS to develop a tax title that strikes a good balance between conventional energy sources, alternative and renewable energy, and conservation. Among other things, it includes provisions for the development of renewable sources of energy such as wind and biomass, incentives for energy-efficient appliances in homes, and incentives as well for the production of nonconventional sources of traditional oil and gas.

This bill reflects the broad diversity of energy resources in the United States. There are new benefits for clean coal technology. Our colleagues from the Rocky Mountains and the Ohio Valley produce and use this abundant source for the generation of electricity.

Burning coal for electricity can lead to environmental problems. This bill goes a long way toward remedying the pollution problems associated with coal use. In the heartland, agriculture is a key part of our economy. Agricultural activities result in food that our people in the cities eat. There is also waste that results from farming. New technology has given us a twofer in the farm community. I am talking about equipment and processes that convert animal waste to energy. This technology needs a bit of a lift to get off the ground, so we have tax benefits to get these new technologies started.

Now we have heard some big city folks and big city papers ridicule some of the tax benefits for this new technology. I guess I would ask these folks from the big cities just a couple questions: Do you think it is wise to address these environmental problems? Do you think it is wise to ignore a new source of energy?

I believe the Senate Finance Committee did a good job in addressing our Nation's energy security in a balanced and comprehensive way. I believe the Congress has finally gotten to the point of addressing an issue with such a direct impact on our national economic security. For the sake of our children and grandchildren, we must implement conservation efforts, invest in alternative and renewable energy, and improve the development and production of domestic oil and natural gas resources. We must do it now. That is what this legislation does.

Before we get to an up-or-down vote on this legislation, we have to face the issue of a Democrat filibuster against this legislation, and that filibuster is going to keep us from voting, if we don't get 60 votes tomorrow. We have to have those Senators of both parties that represent primarily the grain-growing regions of the country, from Ohio west to Nebraska, and from Arkansas north to the Canadian border, stick together tomorrow on what we call the cloture vote, to get 60 votes. We are going to lose six Republicans from the Northeast. We have to pick up about 15 Democrats to get this job done. I expect that we can, because most of the bulwark of support of the last 20 years for renewable fuels—meaning ethanol, biodiesel but also including wind energy, geothermal, things such as that—have come from people within the Democrat Party, but particularly from what I call the upper Midwest of the United States, the grain-producing regions of the country. If we all stick together, I think we can produce these votes.

There is tremendous leadership from that part of the country. Senate Democratic Leader TOM DASCHLE, from South Dakota, has always been a leader in the production of renewable fuels, and particularly ethanol. He can claim a lot of credit for what we have done in that area over the past. I know he is not supporting cloture, but I also know, as Democrat leader, he has an opportunity to use a lot of muscle in his efforts as leader to produce the votes we need.

We cannot afford to lose votes on this issue if we are going to get the job done. I think there are a lot of other people who ought to be concerned about it. Senators on the other side of the aisle are concerned about conservation of energy, and rightly so. I pointed out how I felt, that we need a balanced bill between fossil fuel, renewables, and conservation.

There are a lot of conservation provisions in the tax provisions of my legislation that ought to get support from the other side. There has been some talk, particularly from the other side, that some people have tried to twist the arms of our colleagues to be against cloture, which means to keep the bill from coming to a final vote, arguing that we can refer this back to conference and get certain provisions taken out. That is not going to work under the Senate rules. This cannot be referred back to conference. Once it passed the other body, conference doesn't exist.

There has been some talk, when it comes to the important provisions I have talked about and have been a part of—I even complimented Senator DASCHLE for being a proponent of these for a long period of time—what we call the renewable portions of it, or this part of our legislation that makes up for the road fund. The money lost to the road fund can be made up from the general fund. That is all in this bill.

We have tax incentives for ethanol until the year 2010. We have an ethanol-like tax incentive for biodiesel. We have the renewable fuels standard, which mandates 5 billion gallons of ethanol to be used every year, phased in over a few years. That is 20 percent of our corn crop. Just think how that will benefit agriculture, cut down on taxpayers' subsidies to farmers over the long haul, and clean up the environment at the same time.

But all of these provisions are in this bill. It was not something that was easy for me to get through conference. If it had not been for the intervention of the Vice President in offering a compromise that the House of Representatives did not want to accept, we would not have such a perfect piece of legislation for renewable fuels in this bill.

As I started to say, there has been talk on the other side that somehow we can get this all done in a conference on transportation next year when the highway bill comes up. Well, all you have to do is sit in conference with members of the Ways and Means Committee and find out how they love fossil fuels. God only made so much fossil fuel; it is a finite quantity. But on the other side of this Capitol Building, the idea is there is no end to it. You don't need to worry about renewable fuels.

So they come to conference with heavy emphasis upon fossil fuels, not wanting to give tax credits to biodiesel, and to wind and ethanol, and they don't like the renewable fuels standard mandate of 5 billion gallons. Some people are being told it is just a simple process of getting this done next February, so you can vote against cloture and kill this bill.

If you knew how hard it is to negotiate this, this is the last train to leave town. If you want good provisions for biodiesel, good provisions for ethanol, good tax incentives for conservation, that is the wave of the future for energy. But if this bill is filibustered to death, don't count on me bringing back ideal provisions on renewables. I cannot guarantee that. Nobody else can guarantee it. We don't know what next January and February is going to be like.

When we have a bird in the hand, it is worth two in the bush. I hope my colleagues, particularly the Democrats who are filibustering this, and particularly anybody from the grain-producing parts of the United States, where they benefit from renewable fuels, will work hard to produce the votes and help us to get the 60 votes so we can pass this bill in an overwhelming way.

Don't tell me you are for ethanol, don't tell me you are for biodiesel, don't tell me you are for putting general fund money into the road fund to make up for lost revenue from ethanol—and this bill does that.

Don't tell me those things if you are not going to help us fight hard to get the 60 votes necessary to break the filibuster.

I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. Mr. President, I know the hour is late, and I appreciate the indulgence of the staff on the floor of the Senate. It has been a long day for them in the Senate to listen to a lot of speeches predominantly about the Energy bill, although I gather there has been some discussion about the Medicare prescription drug bill as well. I apologize to those who have been around here a long time today to have to listen to yet one more Member of this institution express his views on the matter we will be voting on tomorrow morning at around 10:30 a.m.—and that is the Energy bill.

I listened with great interest to my good friend from Iowa, with whom I have served now in the institutions of the Senate and the House of Representatives for about 30 years. We have been through a lot of battles, both together and on opposite sides. I always find his remarks compelling, interesting, and admire him immensely. He has been a very effective Member of this body for a long time. I appreciate his work.

He has been through a lot in the last couple of years. He is chairman of the Finance Committee, and he has an awful lot of matters with which to deal. I appreciate his service. I regret on the matter before us we have a different point of view on the Energy bill. I care deeply about the subject matter. I know my colleague from Iowa does. Certainly, he raises some very significant issues as they pertain to renewable energy resources. Were this a bill about just that question, he would have my unyielding support.

Unfortunately, there is more to this bill—it is more than 1,100 pages. My Governor—a Republican Governor—of the State of Connecticut and most of the membership of the State legislature have taken a different view because of the adverse impacts on my State, just as it has positive impacts on the State of Iowa and the grain-producing States. That is a major reason many of our colleagues, both Democrats and Republicans, are opposed to the bill.

They must understand, for those of us who come from other parts of the country, we have to evaluate a bill such as this and take a look at what it does to our economy, our environment, our energy needs, as well as the health of our people. For those reasons, on a bipartisan basis in my State, there have been strong expressions of opposition to this bill. I wish to take a few minutes to outline those reasons.

Tomorrow morning at 10:30 o'clock, there will be bipartisan opposition to invoking cloture. This is not a question where, on many issues, Democrats and Republicans line up very neatly on one side of the aisle or the other. There will be Democrats who will oppose cloture; there will be Democrats who will support cloture; there will be Republicans who oppose cloture; there will be Republicans who support cloture. This is a matter of people looking at legislation that evolved in the conference committee.

My respect for the Senator from New Mexico, Mr. PETE DOMENICI, as he knows, is tremendous. I have great regard for him. I admire his leadership in the Senate. I have enjoyed working with him on numerous occasions. He has been a very fine Senator for many years. I know he put a lot of work into this bill. If I were to vote on this measure exclusively on the basis of friendship, I would be a strong supporter of this bill because I happen to like PETE DOMENICI a great deal. But I cannot, in all good conscience, vote for something that does such damage to my State, to my region, to my country.

This legislation would have been better crafted at the end of the 19th century and the beginning of the 20th century than the beginning of the 21st century. This is a 20th century Energy bill, not a 21st century Energy bill. It is important, with the few hours remaining between tonight and tomorrow morning, to know what this bill may do to the country and the people of this country might express to their elected representatives their strong feelings about what is in this bill.

Like any other legislation in my 24 years here, there are good pieces to this. I am not going to stand here and suggest everything in this bill is wrong. It is not. The Senator from Iowa has already mentioned the idea of using some of our natural resources to provide a renewable source of energy.

As a Senator from Connecticut, I tried to be very sympathetic and supportive of those kinds of issues. If this bill were exclusively about that, I would not have any real difficulties with it. But no Member ought to vote for a bill such as this for the simple reason that one provision of this bill is good for their State. You must take into consideration all the damage that can be done to the very people of that State if we adopt the measures included in this bill.

This is not, as I say, a 21st century energy policy. Let me quote the Orlando Sentinel of November 18. This is not a Connecticut newspaper, it is a Florida newspaper. Listen to what they say:

> Start Over: The Energy bill before Congress is worse than what exists.

They continue:

> Two-thirds of the tax breaks would go to the oil, natural-gas and coal industries, helping to perpetuate the country's dependence on fossil fuels. Less than a quarter of the breaks would promote the use and development of renewable energy sources, and less than a tenth would reward energy efficiency or conservation.

Tonight there are literally thousands of young Americans who are stationed in a place called Iraq. I don't believe they are there exclusively, as some do, because of the oil issue, because of the dependency that this Nation and the Western alliance has on the Middle East for its energy supplies. I also don't think it is not a reason. It is certainly part of the reason. I know there are others who believe it is the whole reason. I don't subscribe to that. If I did, I would never have supported the authorization of use of force by the President to go into Iraq, for which I voted. I believe it is part of the reason. I believe we are over there trying to protect the economic and energy interests of the United States in part because of our dependency on that part of the world.

Why at a moment such as this, when our country is at such risk, particularly over its future economic policy, would we pass an Energy bill such as this? Now more than ever, this bill ought to be doing everything in its power to support energy resources that are truly renewable, such as the Senator from Iowa suggested, balanced with other resources that have been supported by other Members of this Chamber. And it certainly should do more on conservation and efficiency.

As the Orlando Sentinel pointed out, as I mentioned a moment ago, less than a tenth of this bill would reward energy efficiency or conservation—less than one-tenth of this bill. Here we are in 2003, with all of the problems we face in the Middle East and elsewhere, and one-tenth of this bill is dedicated to energy conservation and efficiencies, and only a quarter of the tax breaks would be to promote the use and development of renewable energy sources. On that basis alone, this bill ought to be reconsidered before we go forward.

The Governor of my State, John Rowland, has served as the president of the Republican Governors Association during his tenure as Governor. John Rowland and I have significant differences on a lot of issues. But on this issue, he has written to all members of our delegation in response to what is in this bill. I want to read into the RECORD some of the comments of the Republican Governor of Connecticut, shared, I might add, by many Governors all across this country.

This is a bipartisan notion of caution about what we are about to do. He mentions five or six reasons why this bill ought to be reconsidered. I ask unanimous consent that the full text of this letter be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

STATE OF CONNECTICUT,
EXECUTIVE CHAMBERS,
Hartford, CT, November 18, 2003.

Hon. CHRISTOPHER J. DODD,
U.S. Senate, Russell Senate Office Building, Washington, DC.

Hon. JOSEPH I. LIEBERMAN,
U.S. Senate, Hart Office Building, Washington, DC.

GENTLEMEN: Yesterday, the House and Senate energy conferees approved of a multibillion dollar omnibus energy bill. The energy bill passed the House just moments ago and, as such, the Senate may hold a vote on the bill as early as tomorrow.

While this office is presently engaged in reviewing the finer details of this legislation, a couple of noteworthy items have already come to light that are especially disconcerting.

First, this bill undermines the delicate balance of federal and state rights. It gives unprecedented authority and standards of review exclusively to the federal appeals court in the District of Columbia to review actions required for the construction of a natural gas pipeline. State environmental and siting laws would essentially be reduced to a process of rubber stamping Federal Energy Regulatory Commission ("FERC") certificates of public convenience and necessity. In addition, any delay, however well founded it may be, such as considering ways to protect the state's natural resources, may be grounds for an appeal and federal override of a state's ruling. State courts would be stripped of jurisdiction over matters arising in the state that not only affect the state, but also relate to the interpretation of state statutes and regulations.

Second, this proposed legislation would codify a Department of Energy Order that resulted in the operation of the Cross Sound Cable that runs from New Haven to Brookhaven. You may recall that the Cross Sound Cable was not operational before the August 14, 2003, blackout because the cable failed to meet federal and state permitting requirements concerning its depth. Section 1441 of the bill states that "Department of Energy Order No. 202-03-2, issued by the Secretary of Energy on August 28, 2003, shall remain in effect unless rescinded by Federal statute." This sets a bad precedent.

Third, the bill generally limits the time frame for development of Coastal Zone Management consistency appeal records, constraining the states and the Secretary of Commerce in making informed decisions. In the same vein, this legislation limits the record on consistency appeals addressing pipelines to the record developed by the FERC. Historically, FERC's record has been inadequate to evaluate and protect the state's natural resources. The legislation deprives Connecticut and other coastal states of the tools they need to manage their coastal resources.

Fourth, this legislation authorizes the postponement of ozone attainment standards across the country when the problems are shown to have originated outside the state. This not only hinders Connecticut's progress toward improving air quality, but also likely has significant health ramifications for Connecticut's residents. Contrary to general practice, this language was added behind closed doors, without meaningful opportunity for public debate.

Fifth, the bill contains language that would preempt a state's siting process in areas of interstate congestion, if the FERC were to find that the state delayed or denied a project. State siting authorities may very well be justified, however, in delaying approval or imposing condition for reasons such as public safety or environmental protection. It may also be that the more complex the project, the more time that may be needed to review its complexities. In addition, the applicant may need an extension of time in which to compile additional information for submittal to the siting authority or to negotiate with adverse parties. The existing language fails to take these reasons into account.

Finally, the proposed legislation provides immunity, retroactive to September 5, 2003, to MTBE producers from defective product liability arising from groundwater contamination by MTBE. It also provides $2 billion in transition assistance to producers, in preparation for an MTBE ban effective in 2014. It is precisely because of groundwater contamination caused by MTBE that Connecticut has banned its use as a gasoline additive effective January 1, 2004. MTBE has been proven to be especially harmful; we likely do not yet know how much damage it has done and perhaps will do. It may be premature at this time to provide such immunity.

While improvements are clearly needed to spur investment in energy-related projects to enhance reliability in the power grid, I would urge you to reject this proposed legislation and return it to the House and Senate energy conferees for further deliberation. I would be happy to assist Congress in any way possible to further address these items of particular concern. Thank you for your consideration.

Sincerely,

JOHN G. ROWLAND,
Governor.

Mr. DODD. I also ask unanimous consent that a letter from the attorney general of the State of Connecticut expressing other reasons to oppose this legislation also be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

STATE OF CONNECTICUT,
Hartford, CT, November 18, 2003.

Hon. CHRISTOPHER J. DODD,
U.S. Senator, Russell Senate Office Bldg., Washington, DC.

DEAR SENATOR DODD: Yesterday I wrote to you about some pressing concerns about outrageous provisions of the Administration's Energy Bill, and urged you to filibuster it. I write again today to inform you of another assault on well-accepted state powers to protect our citizens—a provision buried in this Bill, discovered during my review.

This provision, Subtitle D, new Section 1442, gives the Federal Energy Regulatory Commission dictatorial power to preempt and override all other federal agencies and all state laws and officials in approving natural gas pipelines. It would have the clear effect of forcing approval of construction of the disastrous Islander East gas pipeline project through the middle of the pristine Thimble Islands area of Long Island Sound.

The Islander East pipeline is, as I have said, the worst case in the worst possible place—an absolute environmental disaster. Every state and federal regulatory agency responsible for reviewing this proposal—the Connecticut Department of Environmental Protection (DEP), the United States Environmental Protection Agency (EPA), and the National Marine Fisheries Service—has found that this project will cause pervasive, enduring harm to the marine environment in this uniquely valuable part of the Sound. Even the Federal Energy Regulatory Commission's (FERC) own staff concluded that there was a clearly environmentally preferable alternative route, if any pipeline should be built across the Sound.

While FERC ignored the facts and voted to approve the proposal anyway, the facts arrayed against this proposal are so compelling that we are strongly positioned to stop it in court, because it is insupportable environmentally. Section 1442 is plainly intended to strangle our challenge to this project in court, no doubt because we were likely to succeed. Section 1442 drastically changes current law by providing that the courts must accept FERC's determination, although every other state and federal agency disapproves of the project.

The breathtaking sweep and far reaching ramifications of Section 1442 would extend well beyond Connecticut. This provision completely and permanently dismembers a carefully crafted system of state and federal checks and balances for all major gas pipeline projects. Under existing law, pipelines require not only the approval of FERC, but state approval for water quality issues, and for effects on the coastal zone environment. State disapprovals on these important environmental grounds are now generally sufficient to bar the proposals. Under this amendment, FERC approval of a project would effectively eliminate all state environmental oversight. One of the other projects that will apparently be rushed to final construction under this bill is the Millenium Pipeline project in Westchester County, New York, which is proposed to run through various minority neighborhoods and under a section of the Hudson River. Senators SCHUMER and CLINTON, among many other New York state officials, have expressed grave concerns about the millenium proposal.

This Bill contains many inexcusable giveaways to the energy industry. Even among those giveaways, this one is especially abhorrent, since it grants one federal agency supreme dictatorial power to preempt enforcement of environmental and consumer protection by all other state and federal authorities. It would cause wanton lasting destruction of Long Island Sound. If this Bill is passed, our environment will suffer severe permanent damage, which is absolutely and indisputably unnecessary to any legitimate public interest. Once again, I urge to take a stand against this injustice.

Very truly yours,

RICHARD BLUMENTHAL.

Mr. DODD. I will not get into the introduction of the letter and so forth, but I will quote from the Governor of a New England State. First, the Governor says the bill undermines the delicate balance of Federal and States rights. Under this legislation, this bill gives unprecedented authority and standards of review exclusively to the Federal appeals court in the District of Columbia to review actions required for the construction of a natural gas pipeline. State environmental and siting laws would essentially be reduced to a process of rubberstamping the Federal Energy Regulatory Commission certificates of public convenience and necessity.

The letter goes on:

> In addition, any delay, however well founded it may be, such as considering ways to protect the State's natural resources, may be grounds for an appeal and Federal override of a State's ruling. State courts would be stripped of jurisdiction over matters arising in the State that not only affect the State, but also relate to the interpretation of State statutes and regulations.

Now, I have historically opposed a State's right to veto important national efforts, and I include energy as one of them. So I know there have been efforts in the past to say States ought to be able to veto matters that come before them affecting energy policy, but as strongly as I have felt that States ought not to have exclusive veto power, I do not think the Federal Government ought to also have veto power when it comes to States needs and necessities.

I do not care where one lives in America, but they should pay attention to this provision. This is an incredible overreaching by the Federal Government. To come in and strip a State's ability to protect its own citizens when it comes to natural resources and the energy needs they may have, or a variety of other issues, and to shove those matters up to an appeals court in the District of Columbia, whether one is from Georgia, Connecticut, or anywhere else, I think would be highly offensive to most people in this country.

That is not to say we have it all right. We do not. Lord knows our States can make very parochial decisions, particularly when it comes to energy policy, but the idea that the Federal Government could go into any State in this country, regardless of our needs, our concerns, our well-being, and say, I am sorry, you lose, you have no rights at all in these matters. My Governor is right on that issue alone. This bill ought to be sent back to the conference.

We are about to adopt something that overreaches beyond what I think most of my colleagues would support in any other area of law, and yet they are going to do it here. If a precedent is set here, it will happen in other areas as well?

My Governor goes on to explain that there are other reasons:

> The bill generally limits the time frame for development of Coastal Zone Management consistency appeal records, constraining the States and the Secretary of Commerce in making informed decisions. In the same vein, this legislation limits the record on consistency appeals addressing pipelines to the record developed by the FERC. Historically, FERC's record has been inadequate to evaluate and protect the State's natural resources. The legislation deprives Connecticut and other coastal States of the tools they need to manage their coastal resources.

I mention this because the Presiding Officer—we share a lot of things in common, not the least of which we share is having an Atlantic coastline. All of the States on the eastern seaboard, the gulf, the west coast, if they care about coastal zone management—and I know how important that is all along the Atlantic coast—and wanting a say in determining how those very delicate and fragile resources will be managed, this bill makes it more difficult for our States to continue in that vein.

Reading from the letter:

> The legislation authorizes the postponement of ozone attainment standards across the country when the problems are shown to have originated outside of the State. This not only hinders Connecticut's progress towards improving our air quality, but also likely has significant health ramifications for Connecticut's residents. Contrary to general practice, this language was added behind closed doors, without meaningful opportunity for public debate.

It would be one thing if this bill were just about energy policy. To be able to now postpone the ozone attainment requirements written in law, there are literally hundreds of thousands of people in this country who suffer from significant ailments affecting their respiratory functions. I know of what I speak. I have family members who suffer from asthma. To roll back the provisions of the ozone attainment standards in States such as mine and elsewhere is a major health setback for people.

I suspect that various health organizations around the country will have strong feelings about this. If no other provision to this bill moves one to reconsider whether or not we ought to be moving forward, the idea that we could do such great damage to the health of American citizens is enough. We know what causes these problems—and in my State of Connecticut we suffer because of the prevailing southwesterly winds for most of the year. So we get a lot of the poor air quality coming out of other States. So we have to live with the pollution that exists elsewhere. We are trying to stop that on a national level. This legislation will make it very difficult for that to happen in the future.

My Governor goes on and says:

> The bill contains language that would permit a State's siting process in areas of interstate congestion, if the FERC were to find that the State delayed or denied a project. State siting authorities may very well be justified, however, in delaying approval or imposing condition for reasons such as public safety or environmental protection. It may also be that the more complex the project, the more time that may be needed to review its complexities. In addition, the applicant may need an extension of time in which to compile additional information for submittal to the siting authority or to negotiate with adverse parties. The existing language [in this bill] fails to take those reasons into account.

Again, this goes right back to the first point I made earlier, where one can come in and basically shove these matters up to the Federal appeals court in Washington. Again, I am not suggesting that States ought to have outright veto power. But the idea that this legislation would say, as categorically as it does, that the FERC could come in if they find that a State denied a project or delayed a project to gather more information, and just roll right over you.

Listen to this. The Governor goes on to say:

> The proposed legislation provides immunity, retroactive to September 5, 2003, to the MTBE producers from defective product liability arising from groundwater contamination of MTBE. It also provides $2 billion in transition assistance to producers, in preparation for an MTBE ban effective in 2014. It is precisely because of groundwater contamination caused by MTBE that Connecticut has banned its use as a gasoline additive effective January 1, 2004. MTBE has been proven to be especially harmful; we likely do not yet know how much damage it has done or perhaps will do [to people]. It may be premature at this time to provide such immunity.

There is a growing body of evidence that this gasoline additive could have caused great damage to people and now we are going to reach back to September 5 of this year and provide immunity to the producers of this product to the great detriment of maybe millions of people in this country. What is that doing in this bill? We talk about tort reform, and here we are providing immunity.

The idea in this bill that we would provide immunity from recovery for people who get sick and suffer as a result of being exposed to MTBE, I think is outrageous.

I am confident my colleague from New York, Senator SCHUMER, has spoken eloquently on this subject matter. I heard him address the matter the other day in a closed meeting of Senators, and I was moved by the evidence that he provided to us. I am confident he has or will lay it out again here. So I will not dwell on it.

It's bad enough we provide immunity, but now we are going to provide MTBE producers with $2 billion in assistance, in preparation for a ban effective 11 years from now.

Lastly, I mention a rather parochial matter and I don't want to make my opposition to this bill based on parochial issues. But my constituents are very concerned about a provision in this bill that was written into the bill in conference—never in the House bill, never in the Senate bill—and really tramples all over States rights. It would codify a Department of Energy order that resulted in the operation of the Cross Long Island Sound Cable that runs from New Haven, CT to Brookhaven.

This Cross Sound Cable was not operational before the August 14 blackout because the cable failed to meet the Federal and State permitting requirements concerning its depth. Section 1441 of the bill states:

> The Department of Energy order No. 202-03-2, issued by the Secretary of Energy on August 28, shall remain in effect unless rescinded by Federal statute.

You may say, "I am sorry that has happened to your State, Senator," but it could be yours next.

We didn't argue during the blackout about allowing that cable to be used, but its continued operation violates state and federal permitting requirements. But that emergency is over. Yet, written into statutory law, now it says, whether we like it or not, this temporary order is now permanent and it will require a Federal statute to overturn it. Not even FERC can overturn it. I have to pass a bill in the Senate to overturn it.

I grant you it is a local issue, but you ought to be worried about it. That is what happens around here: The precedent gets set.

These are several of the reasons why I believe this bill deserves to be sent back.

It is November. We have another session of Congress coming up. Why can't we go back and do some work on this? I have to believe that most Members think that this bill is just too tilted in one direction. It is not in the best interest of our country to be adopting this type of energy policy.

As I mentioned earlier, knowing how important it is for our economy, for our energy self-sufficiency, for our environment, and for health reasons, this legislation deserves reconsideration. It is not balanced.

So I hope when the hour arrives tomorrow morning, our colleagues respond. This is the kind of bill we will spend a good part of the next decade undoing. When people discover what is really in this bill, they will want to make changes. I think a wiser course of action would be to go back and correct the legislation now and have a bill that would enjoy broad bipartisan support. Instead, there will be broad bipartisan opposition to invoking cloture tomorrow.

These new provisions giving extraordinary power to the Federal Energy Regulatory Commission are really stunning in their scope and breadth. I am rather amazed that there has not been more outspoken opposition to this, in more predictable quarters, when States rights are involved.

I mentioned earlier the issue of health. I pointed out that dirty air from outside our State impacts our air quality. It is a major cause of asthma and may play a role in the development of that disease.

An estimated 86,000 of Connecticut children have asthma that's 10.4 percent of the children in my state. And 7.3 percent of the adult population, approximately 180,000, have it as well. I represent a small State, about 3.5 million people. These are significant numbers.

The fact that this bill rolls back the provisions on air quality is going to mean that people in Connecticut are going to suffer. If for no other reason, this bill ought to be sent back.

We are going to debate Medicare in a few days and talk about how to keep down costs. Asthma doesn't go away. In fact, there is nothing worse than an adult onset of asthma. I know because my wife has it and she didn't have it as a kid. It is crippling. Anybody who has it or has a family member with it knows what I am talking about.

There is time left to do this bill right. I hope this institution would take a moment to do so.

I yield the floor.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

The PRESIDING OFFICER. The Senate stands in adjournment until 9:30 a.m. tomorrow.

Whereupon, the Senate, at 9:38 p.m., adjourned until Friday, November 21, 2003, at 9:30 a.m.

NOMINATIONS

Executive nominations received by the Senate November 20, 2003:

DEPARTMENT OF STATE

STUART W. HOLLIDAY, OF TEXAS, TO BE AN ALTERNATE REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE SESSIONS OF THE GENERAL ASSEMBLY OF THE UNITED NATIONS DURING HIS TENURE OF SERVICE AS ALTERNATE REPRESENTATIVE OF THE UNITED STATES OF AMERICA FOR SPECIAL POLITICAL AFFAIRS IN THE UNITED NATIONS.

DEPARTMENT OF EDUCATION

JONATHAN BARON, OF MARYLAND, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE NATIONAL BOARD FOR EDUCATION SCIENCES FOR A TERM OF THREE YEARS. (NEW POSITION)

ELIZABETH ANN BRYAN, OF TEXAS, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE NATIONAL BOARD FOR EDUCATION SCIENCES FOR A TERM OF FOUR YEARS. (NEW POSITION)

JAMES R. DAVIS, OF MISSISSIPPI, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE NATIONAL BOARD FOR EDUCATION SCIENCES FOR A TERM OF TWO YEARS. (NEW POSITION)

ROBERT C. GRANGER, OF NEW JERSEY, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE NATIONAL BOARD FOR EDUCATION SCIENCES FOR A TERM OF FOUR YEARS. (NEW POSITION)

FRANK PHILIP HANDY, OF FLORIDA, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE NATIONAL BOARD FOR EDUCATION SCIENCES FOR A TERM OF THREE YEARS. (NEW POSITION)

ERIC ALAN HANUSHEK, OF CALIFORNIA, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE NATIONAL BOARD FOR EDUCATION SCIENCES FOR A TERM OF TWO YEARS. (NEW POSITION)

CAROLINE M. HOXBY, OF MASSACHUSETTS, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE NATIONAL BOARD FOR EDUCATION SCIENCES FOR A TERM OF FOUR YEARS. (NEW POSITION)

GERALD LEE, OF PENNSYLVANIA, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE NATIONAL BOARD FOR EDUCATION SCIENCES FOR A TERM OF FOUR YEARS. (NEW POSITION)

ROBERTO IBARRA LOPEZ, OF TEXAS, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE NATIONAL BOARD FOR EDUCATION SCIENCES FOR A TERM OF TWO YEARS. (NEW POSITION)

RICHARD JAMES MILGRAM, OF NEW MEXICO, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE NATIONAL BOARD FOR EDUCATION SCIENCES FOR A TERM OF THREE YEARS. (NEW POSITION)

SALLY EPSTEIN SHAYWITZ, OF CONNECTICUT, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE NATIONAL BOARD FOR EDUCATION SCIENCES FOR A TERM OF THREE YEARS. (NEW POSITION)

JOSEPH K. TORGESEN, OF FLORIDA, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE NATIONAL BOARD FOR EDUCATION SCIENCES FOR A TERM OF FOUR YEARS. (NEW POSITION)

HERBERT JOHN WALBERG, OF ILLINOIS, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE NATIONAL BOARD FOR EDUCATION SCIENCES FOR A TERM OF THREE YEARS. (NEW POSITION)

NATIONAL LABOR RELATIONS BOARD

RONALD E. MEISBURG, OF VIRGINIA, TO BE A MEMBER OF THE NATIONAL LABOR RELATIONS BOARD FOR THE TERM OF FIVE YEARS EXPIRING AUGUST 27, 2008, VICE RENE ACOSTA, RESIGNED.

IN THE AIR FORCE

THE FOLLOWING AIR NATIONAL GUARD OF THE UNITED STATES OFFICERS FOR APPOINTMENT IN THE RESERVE OF THE AIR FORCE TO THE GRADES INDICATED UNDER TITLE 10, U.S.C., SECTION 12203:

To be major general

BRIGADIER GENERAL ROGER P LEMPKE, 1663
BRIGADIER GENERAL ALBERT P RICHARDS JR., 7550
BRIGADIER GENERAL ALBERT H WILKENING, 1471

To be brigadier general

COLONEL TERRY L BUTLER, 3060
COLONEL JOHN A CAPUTO, 8283
COLONEL RICHARD H CLEVENGER, 3395
COLONEL MICHAEL D DUBIE, 9845
COLONEL JERALD L ENGELMAN, 2506
COLONEL WILLIAM H ETTER, 7521
COLONEL EDWARD R FLORA, 6867
COLONEL RUFUS L FORREST JR., 4375
COLONEL RICHARD M GREEN, 5413
COLONEL TERRY P HEGGEMEIER, 5899
COLONEL ROBERT A KNAUFF, 5052
COLONEL VERGEL L LATTIMORE, 6016
COLONEL DUANE J LODRIGE, 8683
COLONEL MARIA A MORGAN, 8913
COLONEL JAMES K ROBINSON, 7562
COLONEL MICHAEL J SHIRA, 1194
COLONEL JAMES P TOSCANO, 9542
COLONEL JAMES T WILLIAMS, 4240

THE FOLLOWING AIR NATIONAL GUARD OF THE UNITED STATES OFFICER FOR APPOINTMENT IN THE RESERVE OF THE AIR FORCE TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 12203:

To be brigadier general

COL. JAMES E. HEARON, 7278

IN THE ARMY

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT IN THE RESERVE OF THE ARMY TO THE GRADES INDICATED UNDER TITLE 10, U.S.C., SECTION 12203:

To be major general

BRIG. GEN. GREGORY J. HUNT, 9933

To be brigadier general

COL. JOSE M. VALLEJO, 0856

THE FOLLOWING NAMED ARMY NATIONAL GUARD OF THE UNITED STATES OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTIONS 12203 AND 12211:

To be colonel

JOHN R. ANGELLOZ JR., 6900
MICHAEL C. MCDANIEL, 5186

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES ARMY AND FOR REGULAR APPOINTMENT UNDER TITLE 10, U.S.C., SECTIONS 624 AND 531:

To be major

JAMES R. WARD, 6254

IN THE NAVY

THE FOLLOWING NAMED OFFICERS FOR REGULAR APPOINTMENT IN THE GRADES INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTIONS 531 AND 5582:

To be commander

TAB E AUSTIN, 1847
DAVID J CROSBY, 0183
ROBERT J HALLMARK, 2804
THOMAS S ODONNELL, 4746
JAMES K RADIKE, 9351
DAVID K WEISS, 2405

To be lieutenant commander

BRIAN E BEHARRY, 9217
GINA K BLAKEMAN, 0381
DANIEL L BOWER, 7443
STEPHEN C BRAWLEY, 6580
KATHRYN A BUNTING, 9725
MARGARET CALLOWAY, 3549
PAUL T CAMARDELLA, 8062
DAVID R CLARK, 1348
JAMES E CLARK, 9927
SCOTT A COTA, 5746
STEVEN H DAVIS, 4854
MARK D ERHARDT, 2980
KAREN M ERNEST, 6583
MARK J FLYNN, 5072
BRADLEY R GARBER, 5872
MARK A GERSCHOFFER, 8863
WALTER M GREENHALGH, 5141
GEORGE P HAIG, 4611
LAURIE A HALE, 2180
SCOTT A HAMLIN, 2309
CHRISTOPHER M HENRY, 2281
BRIAN M HERSHEY, 4470
DERRICK HUTCHINSON, 2566
THOMAS L JACKSON, 4380
GREGORY W JONES, 5166
JEFFREY JONES, 5888
DANIEL F MAHER, 4237
MARIA MAHMOODI, 6204
ERLE MARION, 9309
MICHAEL B MCGINNIS, 0275
GEORGE F MIZE, 1757
VINCENT J MOORE, 6171
TIMOTHY F MOTT, 1528
SCOTT W PYNE, 4636
KENT E RUSHING, 5125
DOUGLAS J SIEMONSMA, 9065
JEFFREY A STUART, 7374
CHARLES A P TURNER, 9891
PETER G WOODSON, 0183

To be lieutenant

PAUL H ABBOTT, 6952
ALEXEY A ABRAHAMS, 4419
JACOB J ABRAMS, 9812
CHARLES J ACKERKNECHT, 9059
DAVID J ADAMS, 6982
JAMES G ADAMS, 0654
JEFFREY W ADAMS, 0627
SAMUEL L ADAMS II, 1753
THOMAS M ADAMS, 4921
EVERETT M ALCORN JR., 0548
ERIC J ALDERMAN, 5927
BRENTON J ALEXANDER, 6603
CHRISTOPHER N ALEXANDER, 0842
JONATHAN L ALEXANDER, 5918
MARK R ALEXANDER, 7493
MARTY J ALEXANDER, 2051
TIMOTHY J ALIM, 6474
TIMOTHY N ALLAR, 2219
HENRY J ALLEN, 5397
JARED R ALLEN, 2227
TIMOTHY E ALLEN, 6516
PAUL M ALLGEIER, 8373
WALTER H ALLMAN III, 3892
JOHNNY J ALSTON, 1241
MARIA D ALVAREZ, 0792
BEN P AMMERMAN, 7381
THOMAS J ANDERSEN JR., 2653
ROBERT J ANDERSON, 8029
TODD A ANDERSON, 1673
PETER D ANDREOLI III, 7109
GARLAND H ANDREWS, 0549
MARTIN J ANERINO, 1831
RYAN W ANGOLD, 5707
GABRIEL A ANSEEUW, 8410
MICHAEL F ANZALOTTI, 1054
MARC A ARAGON, 9480
JOHN W ARBUCKLE, 5545
MARK E ARCHER, 2702
PAUL W ARCHER II, 4190
RICHARD S ARDOLINO, 7478
MATTHEW W AREL, 5945
ROBERT C ARMANDI, 7264
JACOB ARMIJO, 0896
ALBERT E ARMSTRONG, 6691
ISAAC C ARMSTRONG IV, 7856
DAVID R ARNING, 7926
CHRISTOPHER S ARNOLD, 8714
DOUGLAS J ARNOLD, 8653
DANIEL ARREDONDO, 8230
KIMBERLEY A ARRINGTON, 5924
PENNY A ARRINGTON, 3675
ARTURO A ASEO, 0979
IMELDA F ASHMAN, 9524
RANDY E ASHMAN, 0295
KELVIN J ASKEW, 1701
LEO E ASMAN, 2528
BENJAMIN F ATON, 7069
VICTOR H AULD JR., 2889
DAVID C AUSIELLO, 6072
JULIA F AUSTIN, 2281
PAUL R AUSTIN, 1222
THOMAS B AYDT, 2019
KIRBY M BADGER, 4565
JAMES J BAE, 6013
CHRISTOPHER M BAHNER, 6310
TODD S BAIER, 7691
AARON W BAILEY, 9245
CHRISTOPHER E BAILEY, 8367
NATHANIEL A BAILEY, 1312
BRIAN P BAKER, 1537
CHRISTOPHER M BAKER, 1751
KELLY S BAKER, 4322
KIRBY R BAKER, 4198
SARAH C BAKER, 1585
JAMES A BALCIUS, 2656
FRANCISCO X BALDERAS, 5985
JOSEPH E BALDETTI, 2815
TRACY K BALDWIN, 7158
ROBERT S BALLARD, 1719
BRIAN M BALLER, 2067
DAVID R BALSIGER, 4269
MARK G BANKS, 6995
KEITH A BARAVIK, 3232
ALEXANDER Y BARBARA, 8653
ALONZO BARBER III, 7168
MAZIE J BARCUS, 3134
RICHARD L BARGAS, 9729
WILLIAM J BARICH, 8761
COREY B BARKER, 1056
ANDREW R BARLOW, 8905
DEWAINE M BARNES, 3595
RAYMOND F BARNES JR., 6154
STERLEN D BARNES, 9288
RAUL BARRAGAN, 9014
JEFFERY A BARRETT, 0202
OLIVER L BARRETT, 2268
WILLIAM P BARRIE IV, 4332
MICHAEL J BARRIERE, 6984
JOHN S BARSANO, 8282
BRIAN J BARTLETT, 8795
JACOB M BARTON, 3233
PATRICK T BARTON, 9741
BRIAN P BASS, 4360
CURTIS S BASSO, 2664
RYAN G BATCHELOR, 6646
ANDREW D BATES, 9820
KHARY A BATES, 1950
SHARON G BATTISTE, 9208
BRIAN F BATTLE, 9349
DAVID A BAUCOM, 6191
STEPHEN W BAUGH, 6010
THOMAS A BAUMSTARK, 2949
ANDREW M BAXTER, 4686
PATRICK T BAYER, 1284
KYLE R BEAHAN, 9772
PATRICK J BEAM, 8968
AARON J BEATTIE IV, 1426
RICHIA L BEAUFORT, 4109
KRISTIN N BECK, 8955
ZACHARY A BEEHNER, 2034
JUSTIN C BEELER, 1590
DAVID A BEHNKE, 3590
ROBERT C BELCHER, 5790
DAVID H BELEW, 1090
KIMBERLY L BELL, 2266
THOMAS A BELL, 2405
MATTHEW W BELVER, 7689
ERIKA B BENFIELD, 9498
DAVID A BENHAM, 9426
JOHN O BENNETT, 5498
JEFFERY W BENSON, 3763
ROBERT J BERG JR., 4416
WALLACE S BERG, 7244
EFREN T BERMUDO, 7957
JEFFREY S BERNHARD, 8858
THOMAS J BERRES II, 5855
DAVID S BERRO, 6116
GEOFFREY S BERRY, 9709
MICHAEL S BERRY, 1224
PAUL E BERRYMAN, 9650
KARIN H BERZINS, 0384
ROBERT T BIBEAU, 6649
STEPHEN R BIDWELL, 4583
JASON H BIEGELSON, 9444
ERIK M BIELIK, 2281
JAY A BIESZKE, 0177
JAMES E BIGGERS, 3150
RICHARD A BILLINGSLEY, 1767
STEPHEN G BIRD, 8619
JULIE P BISHOP, 0966
CHRISTOPHER D BIZZANO, 6242
LARS T BJORN, 1980
BRIAN J BLAIR, 8272
KATHLEEN M BLAKEY, 1112
HEATHER M BLANCH, 1140
CHERIE L BLANK, 4645
SUSANNE E BLANKENBAKER, 3101
BENJAMIN G BLAZADO, 8652
RYAN J BLAZEVICH, 4378
GORDON R BLIGHTON, 3847
JAMES B BOEHNKE, 1431
JAMES W BOERNER, 1238
HOWARD J BOGAC, 5906
CURTIS L BOGETTO, 8884
THEODORE A BOHL, 6252
KURT H BOHLKEN, 8765
EUGENE N BOLTON, 5132
WILLIAM W BONIFANT JR., 3371
DERRICK D BOOM, 3690
LAURA L BOOTH, 1620
SCOTT M BOOTHROYD, 6502
JENNIFER L BOSSLER, 7544
ERNEST S BOST, 3869
WILLIAM E BOUCEK, 2805
DAVID S BOUGH, 0260
KRISTEN D BOWDEN, 9826
GIDGET BOWERS, 4596
DONALD W BOWKER, 0230
RICHARD L BOWLES, 4182
GEOFFREY P BOWMAN, 8914
COLIN K BOYNTON, 9720
THOMAS BOZARTH, 8594
STEVEN P BRABEC, 0738
NATHAN E BRACE, 9429
ENID S BRACKETT, 9906
JOHN S BRADDOCK, 7172
JOHN F BRADFORD, 1604
DIVINA O BRADSHAW, 8477
COLLEEN N BRADY, 8622
FLINT J BRADY, 6551
RYAN K BRADY, 6099
JORI S BRAJER, 2601
JOHN S BRAMBLETT, 7913
JEFFREY D BRANCHEAU, 8416
BENJAMIN A BRANDT, 1848
MICHAEL D BRASSEUR, 9953
DAVID S BREEDING, 0267
DEREK D BREEDING, 9006
DANIEL J BRETON, 4842
KEVIN M BRINK, 0282
LUIS D BRIONES, 3840
JON D BRISAR, 8490
CARL W BROBST JR., 4921
GINALYN N BROCK, 4251
ERIC M BRONSON, 5383
KERTRECK V BROOKS, 4895
GREGG A BROUGH, 3727
BOBBY E BROWN JR., 3999
CALEB C BROWN, 9608
CHAWN T BROWN, 3412
CHRISTOPHER R BROWN, 2760
COREY W BROWN, 6931
DERECK C BROWN, 8530
DEREK R BROWN, 0862
GABRIEL N BROWN, 7671
GREGORY E BROWN, 6076
JANEL T BROWN, 0442
JASON R BROWN, 2963
MARK A BROWN, 6778
NATHANIEL H BROWN, 8767
SEIHO P BROWN, 8675
STEVEN B BROWN, 5149
WILLIAM F BROWN III, 3842
JOHN D BRUBAKER, 3374
ROBERT C BRUCE, 5891
TIMOTHY J BRUEHWILER, 0123
BARRY M BRUMMETT, 4403
JOSEPH R BRUNSON, 2087
BENJAMIN L BRYANT, 0667
HOWARD M BRYANT, 1546
KEVIN D BRYANT, 5034
ELAINE A BRYE, 1536
RYAN J BUCCHIANERI, 9928
SCOTT J BUCHAR, 2361
KURT A BUCKENDORF, 8858
JASON A BUCKLEY, 2014
JOSEPH M BUCZKOWSKI, 3903
DOUGLAS J BURFIELD, 3519
MAUREEN M BURGESS, 8911
MONICA BURGESS, 1103
ROBERT A BURGESS JR., 9295
GERALD F BURKE, 3916
SEAN K BURKE, 0112
CLARENCE A BURKETT JR., 4468
CHRISTOPHER M BURKHART, 5656
PAUL R BURKHART, 2627
CHRISTOPHER D BURKS, 0385
DAVID A BURMEISTER, 2609
KEVIN J BURNS, 1078
MARK C BURNS, 4532
BRIAN P BURROW, 6675
BRIAN J BURTON, 4205
CHARLES W BURTON, 6733
STEPHEN J BURY, 9258
BRIAN R BUSBY, 7557
JEFFREY P BUSCHMANN, 3048
JOHN B BUSHKELL, 7956
RAOUL J BUSTAMANTE, 5670
NATHAN R BUTIKOFER, 0752
DONALD S BUTLER, 1031
KATRINA M BUTLER, 8675
MAURICE D BUTLER, 5633
EDWARD K BYERS, 5250
MATTHEW C BYRNE, 0033
JEFFREY J CADMAN, 3380
KEVIN H CADY, 8951
MARCELO H CALERO, 0540
ALEXANDER J CALLAHAN III, 4388
CARLIN A CALLAWAY, 8464
DONALD L CAMPBELL, 7756
MARIE A CAMPBELL, 9945
MATTHEW M CAMPBELL, 0266
SCOTT I CAMPBELL, 5681
JACOB CANDELARIA, 5103
JAMES R CAPPELMANN, 9234
ROBERT L CAPRARO, 5806
RUSSELL A CARBONARA, 7106
MATTHEW W CAREY, 3880
JOHN W CARLS, 1796
KEVIN R CARLSON, 9672
CHRISTOPHER K CARLTON, 6044
BRIAN E CARMAN, 0686
MATTHEW R CARMONA, 1905
LENN E CARON, 9184
TROY D CARR, 9569
JASON P CARRANZA, 5005
JAMES M CARRASCO, 4035
JAMES N CARROLL, 9887
SCOTT G CARTER, 1839
JOSEPH J CASALE, 7424
RODOLFO CASALS III, 0561
CHARLES J CASE, 7991
BRICE D CASEY, 1916

JASON L CASHMAN, 3162
JUAN F CASIAS, 0332
DAVID M CASS, 9647
JASON T CASSELL, 6949
KELSEY D CASSELLIUS, 1568
ANTHONY J CASSINO, 4198
BENJAMIN M CAST, 9185
GLORY B CASTANEDA, 6127
JAMES L CASTLEBERRY, 1613
TIMOTHY L CASTRO, 9588
JEFFREY S CATHCART IV, 0866
MALLORY M CAWLFIELD, 5500
STEPHEN C CAZALAS, 8956
HECTOR A CERVANTES, 3894
GLEN M CESARI, 0553
DAWNE H CHAMBERS, 8614
BRIAN R CHAMPINE, 0335
BENJAMIN D CHANCE, 3769
BLAKE L CHANEY, 9939
ROLANDO J CHANG, 5537
JEFFREY C CHAPMAN, 0232
LEONARD W CHAPMAN II, 2028
RODNEY CHAPMAN, 5229
STEPHEN A CHAPMAN, 9234
MEGER D CHAPPELL, 1723
WILLIAM J CHARAMUT II, 9776
GARY M CHASE, 8336
SERGIO CHAVEZ, 0342
BOBBY W CHERRY, 8361
RAYMOND P CHESNEY, 7376
VICTOR V CHISTIAKOV, 0432
JAMES J H CHO, 2326
CHARLES M CHOATE III, 0325
KENNETH Y CHONG, 6567
ERIC J CHOWNING, 4752
CORY C CHRISTENSEN, 7739
JASEN P CHRISTENSEN, 2942
KENNETH A CHRISTIAN, 3635
WILLIAM H CHRISTIAN, 2091
KIRK A CHRISTOFFERSON, 8195
JASON L CHUDEREWICZ, 8222
DOUGLAS S CHUMNEY, 9315
JASON CHUNG, 9312
BRUCE J CICCONE JR., 9473
VICTOR J CINTRON, 6762
JAMES J CIRCLE, 0737
JACQUELINE CIVITARESE, 2736
BRYAN L CLAIRMONT, 8827
BENJAMIN T CLAMMER, 4538
NATHANIEL R CLARK, 5952
SEAN P CLARK, 7754
SHANNON M CLARK, 2798
WILLIAM CLARK, 3078
SANDRA Y CLARY, 1851
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JONATHAN W CLEMENS, 6285
JOHN J CLENDANIEL, 0172
PAUL D CLIFFORD, 8809
SKYLER T CLINKSCALES, 1822
ROBERT T CLOUD, 1102
CHRISTOPHER M COATS, 9939
DANIEL COBIAN, 9552
SCOTT D COCKRUM, 7710
MICHAEL J COEN, 1291
MATTHEW L COHN, 1727
HEATHER M COLLAZO, 0989
TRAVIS P COLLERAN, 3053
NICHLAS W COLLINGWOOD, 5422
JOHN P COLLINS V, 5478
JONATHAN S COLLINS, 1489
NOAH S COLLINS, 4481
RYAN D COLLINS, 2864
ANTOLINO J COLON, 4502
WILLIAM P COLSTON, 1363
JOHN D COMERFORD, 7052
MICHAEL CONCANNON, 4288
ALVIN C CONCEPCION, 2577
MATTHEW T CONERLY, 2984
CHAD J CONEWAY, 3342
BRIAN D CONNOLLY, 6298
SUSANNE M CONNOLLY, 9860
BRENDAN M CONROY, 5685
RITA CONTRERAS, 2499
SEAN P CONVOY, 5439
LORIE A T CONZA, 6478
WILLIAM W COOK, 7011
JOHN O COOKE, 1464
SAMUEL L COOPER, 0698
JESUS M CORDEROVILA, 5597
CHRISTOPHER B CORNWALL, 1016
JOHN D CORREA, 7638
ANDREW R CORSO, 8790
CHRISTOPHER F COSBY, 5922
TODD M COSKY, 2779
MATTHEW S COSNER, 4105
LOUIS A COSTA, 3022
JESUS M COTA, 8126
JASON P COURNOYER, 1172
OISIN P COURTNEY, 8021
RONALD M COUTURE, 9807
BRIAN COWELL, 4717
RYAN G COX, 3014
TIMOTHY A CRADDOCK, 3351
DOUGLAS M CRANE, 1534
PATRICK D CRONYN, 2636
DON B CROSS, 8004
JAMES P CROWE, 2990
MATTHEW J CRUM, 0922
RAYMOND D CRUMP, 3946
RANDY C CRUZ, 5573
JENNY M CULBERTSON, 0441
KENNETH L CULBREATH, 0670
TONY J CULIC, 3564
ANNA M CULPEPPER, 4305
ADAM R CUNNINGHAM, 2085
TIMOTHY J J CUNNINGHAM, 8802
KELLY A CURRAN, 0066
KENNETH M CURTIN, 4647
STEPHEN CUSSEN, 5362
DAVID J CUTHBERT, 7594
ERIK L CYRE, 5914
JOHN D CZOHARA, 0925
MICHAEL J DAIGLE JR., 7727
GLORIA E DALBEC, 1998
BRIAN M DALTON, 5614
TUAN Q DANG, 3132
WILLIAM A DANIELS, 5725
PAIGE J DANLUCK, 9680
KARSTEN F DAPONTE, 1812
ANTHONY J DAPP, 5950
MICHAEL J DARCY, 3560
SHAWN W DARK, 9300
PAUL J DATKA, 2925
JEFFREY M DAUDERT, 0158
WESLEY S DAUGHERTY, 3467
DANIEL A DAURORA, 1187
JOSEPH R DAVENPORT, 7624
MICHAEL B DAVES, 3902
BRADLEY D DAVIS, 3524
BRANDON W DAVIS, 2473
DAVID DAVIS, 4855
DERRICK L DAVIS, 3521
JERRY W DAVIS, 2390
JULIE A DAVIS, 7811
KEVIN J DAVIS, 6893
RAYMOND C DAVIS, 8748
RICHARD M DAVIS, 4665
SAMUEL J DAVIS, 8491
THERON C DAVIS, 3271
WILLIAM M DAVIS, 6347
DEREK B DAWSON, 3209
GRANT W DAWSON, 1826
MICHELE M DAY, 5133
KATHRYN A DECOURSEY, 9382
PAUL J DEE, 5213
TEENA M DEERING, 1800
DAVID S DEES, 0582
HANS D DEFOR, 4251
EDWARD N DEGUIA, 4776
BRYAN K DEHNER, 1988
GUY R DELAHOUSSAYE JR., 3512
JOHN C DELARODERIE, 3022
ROMADEL E DELASALAS, 5083
LIBERTY P DELEON, 4385
GERALD T DELONG, 9336
MARC A DEMANIGOLD, 4200
MICHAEL A DEMATTIA, 6133
PAUL W DEMEYER, 7744
NATHAN J DENMAN, 8375
LEROY P DENNIS III, 1967
MARK E DENNISON, 0861
BART L DENNY, 7934
DENNIS T DERLEY, 9947
JOSEPH L DESAMERO, 9577
SEAN C DESMOND, 8115
GREGG C DEWAELE, 2309
ALTHEA C DEWAR, 0571
CHRISTOPHER N DEWEESE, 8074
SHAWN T DEWEY, 4350
STANLEY G DICKERSON, 3327
MIGUEL DIEGUEZ, 8214
SHANE C DIETRICH, 8660
DARRIK J DINNEEN, 7841
WELDON R DISEKER, 2286
NATHANIEL J DISHMAN, 1124
JEFFREY S DIXON, 7764
RICHARD J DIXON JR., 3898
ALAN M DJOCK, 4264
STEVEN V DJUNAEDI, 2066
BRIAN D DOHERTY, 4494
GEORGE M DOLAN, 9744
CHRISTOPHER T DOLLARD, 7892
ALEX F DOMINO, 5187
ELIZABETH A DOMINO, 3294
BENJAMIN W DOMOTO, 5135
THOMAS J DONOHUE, 5436
GARY W DOSS, 5384
JOHN D DOTSON, 4855
GORDON M DOTY, 6452
CARL W DOUD, 1740
KEITH P DOUGLAS JR., 3401
MICHAEL S DOUMITT, 3527
SHANE G DOVER, 9129
JUSTIN A DOWD, 8916
JOSEPH E DOWDING, 5253
ERIK P DOYE, 4757
ERIC C DOYLE, 9935
MARC A DRAGE, 0233
JENNIFER L DRAKE, 8144
WADE A DRAWDY, 1535
JAMES P DREW, 8406
JODY A DREYER, 9216
NICOLE I DRISCOLL, 8834
FRANKIE S DUARTE, 1594
SUSAN M DUBENDORFER, 1850
MICHAEL R DUBUQUE, 0701
JARED J DUCKWORTH, 0243
MICHAEL G DUDAS, 9646
MOLLY J DUERKOP, 3273
GRADY G DUFFEY JR., 7067
LYDIA J DUFFEY, 4140
PATRICK J DUFFY, 4246
STEVEN P DUFFY, 1760
MARTIN J DUGAL, 4211
WILLIAM F DUKES JR., 7015
KATHARINE O DULL, 6514
MARK D DUNBAR, 7572
ROBERT A DUNCAN, 1993
MARC N DUNIVAN, 5769
HALLE D DUNN, 2347
ROBERT S DURKEE, 4591
DAVID P DURKIN, 1478
SHANNON H DURRETT, 3304
JASON T DUTCHER, 5552
ALEXANDER C DUTKO, 1589
ADAM M DWORKIN, 6025
MICHAEL D DYSART, 7173
GILBERT L DYSICO, 6210
VICTOR K DYSON, 1429
IRA S EADIE, 0649
DAVID T EARP, 7724
CHRISTOPHER S EASTERLING, 1491
PAUL N EASTERLING, 9755
CHARLES E EATON, 8079
JENNIFER L EATON, 0723
MATTHEW J EBERHARDT, 1574
CHARLES B ECKHART, 7220
HUGH B EDMONDSON, 1926
JENNIFER A EDMONDSON, 5764
MICHAEL A EDWARDS, 9744
MOTALE E EFIMBA, 5730
WILLIAM R EHRET JR., 5247
BLAKE D EIKENBERRY, 5165
MATTHEW G ELDER, 3714
LUIS R ELIZA, 8779
DAVID C ELLIS, 7606
TIMOTHY R ELMORE, 0985
HAROLD W EMPSON, 1835
JASON W ENDRESS, 4684
ADAM M ENGEL, 8258
SUSAN K ENGEL, 4695
BRIAN D ENGESSER, 1221
CHRISTOPHER S ENGLAND, 0606
JASON C ENGLISH, 4571
SANDRA M ENNOR, 7341
MICHAEL O ENRIQUEZ, 3130
EVERETTE T ENTZMINGER, 6041
TIMOTHY A ERICKSON, 9331
KEVIN L ERNEST, 6680
JOSEPH G ERTEL, 7102
BRENT A ESCOLA, 9603
RICKSON E EVANGELISTA, 3931
JASON T EVANS, 0390
JOHN E EVANS, 4908
WILLIAM M EVANS, 1260
ZACHARY J EVANS, 8247
KEITH E EVEN, 9635
STEPHEN A EVERAGE, 9781
THERESA P EVEREST, 7601
MICHAEL C EXUM, 4056
SCOTT EYSENBACH, 4876
RAFAEL C FACUNDO, 3477
LEMUEL D FAGAN, 4493
TRACY L FAHEY, 2192
BARRI D FARNES, 2997
CHRISTOPHER M FARRICKER, 8212
LISA L FARRIS, 1948
JUSTIN T FAUNTLEROY, 6761
BENJAMIN P FAY, 4034
REGINA T FAZIO, 9585
RICK A FEESE, 6527
PETER F FEHER, 2620
PAUL J FELINI, 4972
DANIEL X FELIZ, 3617
KEITH A FELKER, 1669
PAUL J FENECH, 5481
DANIEL E FENG, 9676
SHANE P FENTRESS, 7275
MARK A FERLEY, 3252
CONSTANCE R S FERNANDEZ, 8088
MARK N FERRARA, 1872
NICHOLAS P FERRATELLA JR., 5198
WILLIAM C FERRELL, 0625
ROBERT C FESSELE, 8840
RICHARD A FICARELLI, 0025
CHRISTOPHER S FICKE, 3255
DAVID C FIELDS, 2620
ABIGAIL FIGUEROA, 8723
JOSE O FIKES, 5451
JOSEPH M FIKSMAN, 8683
DAVID W FILANOWICZ, 7580
MITCHELL E FILDES, 5356
MICHAEL D FILES, 0757
JAMES B FILLIUS, 0012
DONALD S FINKLESTINE, 2820
BENJAMIN H FINNEY, 8239
JEREMY T FISCHER, 7255
JEB A FISHER, 0[illegible]10
STANFORD E FISHER III, 3302
STEPHEN M FISHER, 4025
JOSEPH A FITZPATRICK, 3166
DEREK R FIX, 1794
WILLIAM A FLECK II, 3908
ERIK B FLEMING, 5411
JASON M FLEMISH, 6197
DAVID W FLEMMING, 5831
KELLY T FLETCHER, 8682
JOSE D FLORES, 0577
PAUL N FLORES, 8562
SIDNEY G FOOSHEE, 6936
PATRICK J FORD, 1031
RANCE N FORD, 1925
CINDY L FORDHAM, 0644
JACOB A FORET, 1618
LESTER R FORTNEY, 8794
JASON M FOSTER, 8049

TONI O FOSTER, 4893
MATTHEW W FOSTER, 2986
CHRISTOPHER A FOTOS, 2340
ERIK L FOX, 4199
TIMOTHY W FOX, 6058
JEFFREY M FOXX, 4453
MICHAEL D FRANCE, 8115
ANA I FRANCO, 1138
CRAIG S FRANGENTE, 8255
JOHN W FRANKLIN, 9561
JAMES D FRASER, 3129
MATTHEW T FRAUENZIMMER, 2651
DANIEL L FREEDMAN, 6597
CARLTON Q FREEMAN, 1431
DAVID B FREEMAN, 1300
DAVID P FRIEDLER, 6288
THOMAS E FRIES, 3958
STEPHEN M FROEHLICH, 0958
ERIC B FROSTAD, 8744
MARIA P FUENTEBELLA, 4711
DAVID E FULCHER, 5243
JEFFREY A FULLER, 3641
RUSSELL W FUSCO, 6753
MATTHEW T GABAY, 8696
SAMUEL D GAGE, 1166
JOHN J GAGLIANO, 4245
SETH C GAGLIARDI, 8483
MICHAEL T GAGNON, 9889
BRIE GALLAGHER, 7980
SHAWN G GALLAHER, 7381
KEVIN S GALLOWAY, 8851
JAMES R GALYEAN IV, 5938
ROBERT W GAMBLE, 7346
DAVID M GANDT, 8385
WILLIAM K GANTT JR., 2963
ROLANDO GARCES III, 9157
ALAIN R GARCIA, 4387
ISMAEL L GARCIA, 7369
BRETT M GARLAND, 1444
JASON M GARRETT, 5244
ROBERTA T GARVIN, 4477
JOSE L GARZA, 5115
ELIAS T GATES, 9774
BERNARDO GAUNA, 7965
JASON M GEDDES, 7754
PATRICK E GENDRON, 7343
RICHARD T GENGLER, 7712
DARREN R GENSTIL, 0026
MICHAEL H GENTNER, 9334
JASON C GERMAN, 5464
WILLIAM J GETCHIUS, 2280
TAREY M GETTYS, 5539
STEVEN F GIANNINI, 9550
JAMES E GIBB, 9791
WILLIAM E GIBSON, 5759
MICHAEL F GILBERT, 8408
ROBERT S GILBERT, 6610
MATTHEW S GILCHRIST, 0984
JANE E GILHOOLY, 9820
CHARLES P GILKISON, 3562
NICOLE L GILL, 0129
JOHN C GILLON, 0718
ANDREW P GLADIEUX, 0766
DEWEY C GLADNEY, 9282
JEFFREY A GLASER, 1686
DAVID M GLASSMAN, 5910
BOGOMIR T GLAVAN, 3697
KURT L GLENNON, 8209
TODD P GLIDDEN, 3321
TAMARA D GLOVER, 5126
HAROLD K GODWIN, 6072
FRANK T GOERTNER, 4431
CARLOS A GOMEZ JR., 3968
SONYA M GONNELLA, 4575
CESAR S GONZALEZ, 9768
JAVIER GONZALEZOCASIO, 3887
KATY K GOOD, 5555
NATALIE C GOOD, 8570
JOSHUA GORDON, 7904
GEOFFREY A GORMAN, 6948
ABIGAIL D GOSS, 2741
DANIEL B GOUGH, 9467
ANDREW P GRABUS, 2490
AMY L GRACZYK, 5709
WILLIAM E GRADY, 5058
KRISTOFOR E GRAF, 5795
AMY E GRAHAM, 9118
BRIAN D GRAHAM, 3208
MICHAEL J GRANDE, 8690
JENNY A GRASER, 4030
JOHN M GRAVER, 1407
MARY C GRAVES, 8340
IRVIN GRAY, 9911
JONATHAN GRAY, 3191
LAGENA K GRAY, 2723
CHARLES F GRAYSON III, 0244
JOHN F GREBETA, 1973
DARRYL E GREEN, 3323
MICHAEL S GREEN JR., 1104
RONA D GREEN, 7338
RAEFORD M GREENE, 4246
MICHAEL J GREGONIS, 1986
CURTIS J GREGORY, 6141
DALE M GREGORY JR., 7765
JEFFREY G GROMATZKY, 2366
LARRY B GROSSMAN, 8173
GARY C GROTHE JR., 2761
JASON P GROWER, 3800
SEAN T GRUNWELL, 9226
ERIC C GRYN, 5236
JASON J GUARNERI, 6246
ADAM A GUENTHER, 5546
KENNETH P GUERIN, 0327
BRIAN J GUERRIERI, 9816
DIANA GUGLIELMO, 5485
STEPHEN L GUIDRY, 6586
KEITH J GUILLORY, 5632
ROGER W GUNTER, 3511
MICHELLE A GUST, 5781
JUAN J GUTIERREZ, 3966
JOHN S HAAS, 8980
JON M HAGER, 0934
CLAYTON P HAHS, 6597
LESLIE C HAIR, 1199
DAVID A HALDANE, 2350
JOHN W HALE, 4321
PATRICK K HALEY, 3664
CHRISTOPHER W HALL, 8955
JASON S HALL, 3172
MATTHEW H HALL, 0042
MICHAEL D HALL, 3492
SCOTT F HALL, 5714
SHAWN D HALL, 6132
EDWARD L HALMAN JR., 7685
RICHARD C HAM, 8802
JAMES W HAMILTON III, 7115
PAUL M HAN, 9588
ADAM C HANCOCK, 9108
JEREMY R HANKINS, 4115
ERIC M HANKS, 7355
RICHARD T HANNA JR., 5203
THOMAS S HANRAHAN, 4304
KENNETH L HANSEN, 3913
MICHAEL H HANSEN, 2422
ROBERT D HARBISON, 5506
WILLIAM E HARGREAVES, 8856
KEITH J HARNETIAUX, 9867
KENNETH M HARPER, 2307
GREGG M HARRINGTON, 6380
ASHLEY M HARRIS, 4272
MARK R HARRIS, 8331
RICO R HARRIS, 5431
LAURA B HARTJEN, 3804
MATTHEW J HARTLEY, 0684
PAIGE E HARTRANFT, 9213
JUSTIN L HARTS, 1260
GEORGE N HARTWELL, 1093
MICHAEL C HARVEY, 1257
SCOTT D HARVEY, 5516
SEAN M HARZ, 1486
KEVIN G HAUG, 4858
JUSTIN T HAWKINS, 3118
IAN D HAWLEY, 6547
JOHN D HAYMORE, 4391
JOHN J HAYS III, 4666
THOMAS L HEAD, 4232
ASTOR H HEAVEN III, 6701
GABRIEL J HELMS, 0771
RICHARD M HEMENWAY, 3428
KERMIT F HEMMERT, 0374
JEFFREY HENDERSON, 4340
WILLIAM L HENDRICKS, 6172
MATTHEW S HENDRICKSON, 5645
JEREMY J HENRICH, 0777
WESLEY E HENRIE, 1535
SCOTT A HENRIKSON, 1465
JIMMY J HENRY, 9824
TIMOTHY S HENRY, 7356
WILLIAM M HENSON, 0244
COREY A HENTON, 4568
THOMAS R HEPTIG, 8685
MICHAEL W HERMANSON, 3967
INDALECIO M HERNANDEZ, 1878
MANUEL HERNANDEZ, 5354
MANUEL A HERNANDEZ, 3673
MICHELE L HERNANDEZ, 8175
THOMAS C HERR, 8639
JOE D HERRE, 6110
BURKE A HERRON, 2754
MICHAEL W HERYFORD, 3946
BRIAN M HESS, 9729
ERIK M HESS, 9897
JOHN I HEUISLER, 8122
TRAVIS N HICKS, 1257
ROSS C HIERS, 6043
FREDERICK D HIGGS, 4010
GENAIA T HILL, 8407
JEFFREY W HILL, 0090
MARK W HILL, 8593
MARTIN J HILL III, 3624
ROBERT M HILL, 6513
YERO B A HILTS, 5412
KELLY A HINDERER, 3032
BRIAN E HINER, 7288
MICHAEL S HINGST, 5154
WILLIAM T HIPPS, 3272
JOSHUA A HIPSHER, 2029
LEONID L HMELEVSKY, 9776
ANDREW C HOBURG, 2117
KRISTIN R HODAPP, 9138
ARTHUR A HODGE, 9252
BRIDGET A HODGES, 1593
JUSTIN R HODGES, 9411
SIDNEY W HODGSON III, 3046
PETERJR HOEGEL, 9262
JAMES R HOFFMAN, 1769
BRAD E HOGAN, 9941
WILLIAM H HOGE III, 3533
TODD K HOLBECK, 1636
GERALDINE M HOLDEN, 3908
RUSSELL L HOLDERNESS, 8972
GARY C HOLLAND, 1118
MICHAEL C HOLLAND, 4416
MICHAEL P HOLLENBACH, 6348
WILLIAM J HOLLIS, 6386
BRIAN L HOLMES, 2553
GREGORY K HOLMES, 6539
KELLY J HOLMES, 2338
KERRY B HOLMES, 2447
PETER J HOLTON, 6170
CHAD R HOLZAPFEL, 5006
DONNA L HOOD, 3035
ALBERT L HORNYAK, 4242
KITJA HORPAYAK, 9938
CHRISTOPHER R HORTON, 7850
LONNIE S HOSEA, 7478
CHAD R HOULLIS, 7932
SHARON L HOUSE, 8641
DUANE W HOUSER, 0285
JOHN F HOUSER, 9260
JOYCE R HOUSTON, 1870
KIMBERLY K HOWARD, 5117
DAVID E HOWE, 0755
KEITH C HOWLAND, 0575
JUSTIN S HSU, 8911
RICHARD R HUBBARD, 2784
PAUL L HUDGENS, 0509
BRYAN L HUDSON, 0152
FRANK E HUDSON, 5578
NICHOLAS A HUDSON, 9146
PAVAO A HULDISCH, 5118
GARY HULING, 8173
MATTHEW G HUMPHREY, 1111
ANDREW R HUNT, 3044
DAVID C HUNT, 6391
CHRISTOPHER M HUNTER, 4351
TERESA A HURD, 6654
JASON P HURLEY, 1949
DEAN HUSTIC, 3588
MARIANGEL IBARRA, 4803
MIKE N IBRAHIM, 1598
ALAIN M ILIRIA, 6824
ERIC P ILLSTON, 9257
STEPHEN J ILTERIS, 6707
JOHN W INGERSOLL, 8982
PATRICK J INGMAN, 5038
CHRISTOPHER S IRWIN, 2952
CARY J ISAACSON, 5122
JAMES D ISON, 1164
BRIAN D IVESON, 5427
CHRISTOPHER A JABS, 7999
TODD D JACK, 6116
JOANNA C JACKOBY, 8262
ADAM M JACKSON, 3427
JONATHAN W JACKSON, 6951
SCOTT R JACKSON, 0212
SHIKINA M JACKSON, 8856
TIMOTHY S JACKSON, 2831
JARED T JACOBS, 2858
SANTIAGO A JAMBORA III, 2668
BRIAN E JAMERSON, 6532
CORY L JAMES, 3730
MICHAEL F JAMES, 3140
JASON A JAMISON, 1943
KENNETH D JANETSKY, 9365
JOSEPH P JANKOWSKI, 7788
JESSE W JANS, 8654
TAMMY K JANSEN, 2968
DAVID M JAYNE, 7292
ERIC A JENKINS, 4519
THOMAS D JENKINS, 0484
CHRISTIAN L JENSEN, 8062
BRIAN T JETER, 8480
CARL D JEWETT, 1447
AARON D JOHNSON, 6101
ALLEN P JOHNSON, 7004
ANDREW F JOHNSON, 7597
CHARLES E JOHNSON, 8982
CHRISTOPHER E JOHNSON, 4393
CHRISTOPHER M JOHNSON, 0655
DALE F JOHNSON, 1284
DENNIS N JOHNSON, 7440
EDWARD D JOHNSON, 1002
JEROME M JOHNSON, 2221
JOHN D JOHNSON, 2023
MICHAEL D JOHNSON, 8162
SUZANNE M JOHNSON, 6528
TEDDI M JOHNSON, 5374
WESLEY P JOHNSON, 0222
SEBRINA C JOHNSONPOWELL, 7594
COREY S JOHNSTON, 8184
NATHAN C JOHNSTON, 2575
BRYAN R JONES, 1173
ERIC D JONES, 7421
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BRIAN S JORDAN, 7573
JESSICA J JORGENSON, 7621
JOHN G JOSEPH, 4855
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JEFFREY JUERGENS, 0046
BARTOLOME R R JUMAOAS, 3884
KAMBRA R JUVE, 9699
WILLIAM H JUZWIAK, 5303
ELLEN M KAATZ, 2197
JOHN J KAELIN JR., 3697
DAVID I KANG, 0743
JEFFERY M KARGOL, 0503
SHAWN B KASE, 8005
GERALD M KASHUBA, 3243
KRISTIAN P KEARTON, 2847
THOMAS B KEEFER JR., 1629
JULIE A KEEGAN, 6224
KERRI L KEEHN, 1400
SCOTT D KEENAN, 5973
THOMAS M KEENAN, 6816

STEPHEN G KEENE, 2952
AARON B KEFFLER, 0356
AMY E KEILLER, 6520
CHRISTOPHER E KEITH, 9793
DARRELL L KELLER JR., 2693
THOMAS H KELLEY II, 8045
ROBERT M KELLNER, 7872
ANNETTE KELLY, 0452
ANTHONY S KELLY, 1103
DANIEL J KELLY, 0106
BRUCE D KENNEDY, 0246
CRAIG K KENNEDY, 0062
DOUGLAS E KENNEDY, 4540
MARC A KENNEDY, 1548
STEPHEN M KENNEY, 5368
ROBERT L KENT JR., 8801
KRISTEN S KERN, 0780
JOSEPH P KERNER, 9242
KRISTIN R KERSH, 8289
JASON T KETELSEN, 0315
IAN P KIBLER, 7237
DANIEL C KIDD, 5116
CHRISTOPHER W KIDNEY, 2084
JOHN C KIEFABER, 7065
ROBERT M KIHM, 9598
MICHAEL J KILLIAN, 7080
HAROLD M KIM, 6501
DANIEL W KIMBERLY, 5991
ANDREW M KING, 8760
BRIAN A KING, 3345
MICHELLE L KING, 7468
NATHAN J KING, 0366
SANDRA M KING, 6257
SHAUNA R KINGANDERSON, 1617
GEORGE P KINGSLEY V, 6159
BERTRAM Y KINZEY IV, 1239
CHRISTOPHER E KIRBY, 2369
KARL M KIRKEBY, 6984
SHAWN C KIRLIN, 2367
ANDREW T KLEEMAN, 6255
ARIEL S KLEIN, 0569
AMY S Y KLEINBERG, 8266
JEFFREY J KLINGER, 6721
BRADLEY C KLUEGEL, 2570
JASON S KNAPP, 1948
DAVID H KNIGHT, 5515
BRIAN C KNOLL, 2193
BRADLEY T KNOPE, 4306
MELVIN L KNOX III, 7548
JAY C KOCH, 8900
JOHN S KOCHIS, 6720
KENNETH S KOELBL, 8117
LEE M KOERNER, 6412
DANIEL R KOMAR, 6397
CORDELL R KOOPMAN, 1832
PETER M KOPROWSKI, 8754
DUSTIN K KORITKO, 2999
STEPHEN M KOSLOSKI JR., 7043
CHAD C KOSTER, 8208
CHRISTOS A KOUTSOGIANNAKIS, 8694
CHRISTOPHER T KOVACK, 0917
ANDREA K KOWAL, 9201
DAVID T KOZMINSKI, 2756
EUGENE T KRAMER, 9253
GREGORY M KRAUS, 0433
ADAM G KRAUSE, 8105
KATHRYN J KRAUSE, 5108
BRET J KREIZENBECK, 2303
ANDREW G KREMER, 0158
JEFFREY W KREMER II, 2924
TIMOTHY J KREPP, 8019
JUDD A KRIER, 6625
HENRY KRIGBAUM, 2871
DAVID KRITSCHGAU, 6733
JEFFREY D KRONE, 6758
NEIL A KRUEGER, 5960
ANTHONY E KUCIA, 1300
CHRISTA L KUEHLER, 0544
AMANDA K KUEHNE, 4319
ROBERT F KUFFEL, 5911
MARTY D KUHL, 6665
DAVID A KUMMINGS, 4311
DAVID E KUNSELMAN JR., 3448
DAWN A KUPSKI, 2718
WILLIAM E KUPSKI, 3248
MARK C KUTIS, 2936
LISA J KYMPTON, 1902
LAURA LABELLA, 9725
LISA S LABERMEYER, 9367
BRADLEY C LACOUR, 3628
HERBERT E LACY, 4077
MICHAEL J LAGARDE, 0574
MICHELLE V LAGUENS, 0784
TEAGUE R LAGUENS, 0932
ALEX C LAM, 5216
JOSEPH E LAMOUREUX JR., 3384
NATHAN G LAMPERT, 7432
JASON R LANE, 1333
ERIC E LANG, 1973
JOEL B LANG, 5722
SUSAN A LANG, 3619
DOUGLAS M LANGENBERG, 4670
MATTHEW S LANGLEY, 8423
LAUREN M LANIER, 7545
JODY P LAPHAM, 6872
CARA G LAPOINTE, 8815
MATTHEW E LAPOINTE, 4159
DAVID W LARK, 0494
GARY S LARSON, 0152
JOHN E LARSON JR., 6864
ERIC S LASER, 3450
MATTHEW P LASER, 2485
DAVID F LASPISA, 7726
MARK A LAUBACH, 0772
TODD J LAUBY, 5457
JOSEPH J LAUHON, 0381
LUIGI L LAZZARI, 6123
DAVID A LEAVITT, 7271
JAMES A LECOUNTE, 4265
AARON M LEE, 0761
CHRISTIAN D LEE, 0839
CHRISTOPHER J LEE, 9336
EDDIE D LEE, 4200
KAYLA L LEE, 5143
KIRK A LEE, 7128
MICHAEL D LEE, 0858
STEVEN W LEEHE, 3461
BRIAN E LEGAN, 3084
BRYCE T LEHNA, 6855
MICHAEL C LEHRFELD, 6666
DANA M LEINBERGER, 8637
JASON B LEMLEY, 5718
JAMES J LEMMON, 7581
JAMES S LEO, 5043
PETER R LEO, 1981
DANIEL J LEONARD, 0497
JOHN A LEONAS, 2431
JOHN C LEPAK, 8239
JADE L LEPKE, 4372
CHRISTOPHER J LESUER, 4078
BRADY C LEVANDER, 5781
WALTER R LEVANTOVICH, 6375
JAMES F LEVINESS JR., 2349
ERICA J LEVITT, 7252
JASON A LEWANDOWSKI, 5180
ANDREW J LEWIS, 9902
CAMERON P LEWIS, 0122
JAMES C LEWIS, 1035
JASON T LEWIS, 4350
MARY J LEWIS, 2171
ROBERT C LEWIS, 9282
TANYA E LEWIS, 9233
MIGUEL A LEYVA, 4126
LORELEI J LICHAY, 8629
ALBERT S LICUP, 4821
KATHERINE E LICUP, 1750
KENNETH R LIEBERMAN, 1431
CHRISTOPHER J LIEDQUIST, 0467
MARK E LIERSCH, 0110
RYAN J LILLEY, 4686
JON R LINDSAY, 6086
RODRICK D LINDSEY, 3448
COREY J LITTEL, 1720
TOMMY L LIVEOAK, 6385
LAURENCE L LIVINGSTON, 5889
NILO M LLAGAS, 9018
DENNIS S LLOYD, 8312
KEVIN R LOCK, 4533
PRICE J LOCKARD, 8750
TOMMY F LOCKE JR., 2712
DALE F LOCKLAR, 3811
MICHAEL A LOEFFLER, 5735
MICHAEL P LOHAN, 7121
TERRY D LOHNES, 2914
ERIK B LOHRKE, 9785
ANGELENE M LOMAX, 2484
RICHARD T LOMBARDI JR., 5952
DANIEL J LOMBARDO, 6894
JUSTIN A LONG, 7798
LAURA H LONG, 3875
ERNEST J LONGAZEL, 5716
DANIEL LOPEZ, 5185
JOSHUA J LORDEN, 7672
DAVID M LOSHBAUGH, 98 8
ALBERT C LOUI, 5401
DWAYNE M LOUIS, 3220
AARON M LOWE, 7527
KEVIN N LOWE, 7527
RAYMOND P LOWMAN III, 8403
BRET M LOWRY, 4390
KEVIN LUFT, 6829
MANUEL X LUGO, 2045
PHUONG M LUI, 4067
STEPHEN T LUMPKIN, 1740
DAVID C LUNDAHL JR., 1466
BRYAN C LUNDGREN, 8480
ROBERT D LUSK, 0899
RYAN M LUZAK, 1520
JAMES B LYNCH, 6482
MELONY A LYNCH, 9280
ROBERT M LYNCH, 4822
NOEL B LYNN, 4205
THOMAS J LYONS III, 2302
STEPHEN M LYTLE, 4004
ALEX T MABINI, 0176
JOHN W MABRY III, 8566
AMANDA A MACALPIN, 6482
THOMAS J MACK, 4591
JOSEPH R MACKAY, 1963
JASON A MACKEN, 9053
ADAM J MACKIE, 6543
NEIL A MACMILLAN, 2946
ROBERT J MACRI, 7049
KEVIN W MACY, 3377
RICO N MAGBANUA, 3330
EDWARD F MAGGIO, 6880
BRIAN A MAI, 8167
WALTER C MAINOR, 2339
KEITH L MAJOR, 9231
CHRISTOPHER S MALFANT, 3892
SUSAN E MALIONEK, 1018
CHRISTOPHER J MALLON, 0022
RONALDO M MANALANG, 8912
CHRISTOPHER J MANDERNACH, 5411
RONNIE P MANGSAT, 0326
JOHN M MANN, 3534
TRAVIS R MANN, 8948
MICAH D MANNINGHAM, 6884
JASON S MANSE, 3299
JAMES C MANSELL, 5886
NICOLAS V MANTALVANOS, 4205
RYAN C MAPESO, 2129
DAVID A MARCINSKI, 1944
CRISTINA S MARECZ, 9084
JEROD L MARKLEY, 7940
EARL A MARKS, 9197
CHRISTOPHER D MARRS, 1024
JOHN A MARSH, 1512
NICOLE D MARSHALL, 9470
RAYMOND S MARSHALL, 0243
SAMUEL I MARSHALL, 1261
ADAM P MARTIN, 8001
BENJAMIN P MARTIN, 6058
GREGORY S MARTIN, 5210
KEVIN J MARTIN, 2820
GREGORY T MARTY, 9414
ANANDA MASON, 0432
DENISE N MASON, 7714
TONY G MASSEY, 5155
JOSHUA J MASTERSON, 5446
KIRK J MASTERSON, 3451
JOSEPH S MATISON, 9126
PATRICK J MATTES, 0995
RICHARD E MATTHEWS JR., 5240
WALTER M MATTHEWS, 5989
MATTHEW M MATTHIAS, 5135
MATTHEW P MATTRO, 0859
CLEODIS MAY, 3787
THOMAS A MAYS, 4478
TRACEY M MAYS, 5734
ROBERT S MAZZARELLA, 9797
GEOFFREY P MCALWEE, 2360
JUSTIN J MCANEAR, 0180
SHAWN M MCBRIDE, 4649
WILLIAM J MCCABE, 2370
GINA L MCCAINE, 9785
MATTHEW MCCANN, 8446
CHRISTOPHER L MCCARTY, 6023
WILLIAM R MCCAULEY, 7515
MARISA L MCCLURE, 1430
JOHN B MCCOMBS, 5363
MICHAEL C MCCORMACK, 6573
PATRICK W MCCORMICK, 2709
JASON C MCCOY, 7012
JEFFREY E MCCOY, 8295
ANDREW C MCCRONE, 2168
JOANN M MCDOUGAL, 0773
STEVEN R MCDOWELL, 3084
ELIZABETH A MCGAULEY, 7071
CHARLES C MCGILL, 0888
SCOTT J MCGINNIS, 4270
KEVIN J MCGOWAN, 3151
MICHAEL M MCGREEVY JR., 0905
DENNIS M MCGUGAN, 9557
MATTHEW E MCGUIRE, 5567
KEVIN MCHUGH, 5108
STEPHEN R MCJESSY, 7659
SCOTT E MCKELLAR, 4422
CINDY L MCKENNA, 8072
PAMELA Y MCKENZIE, 3812
JENNIFER K MCKINNEY, 6136
SCOTT R MCLAIN, 5302
ANDREA J MCLEMORE, 2535
ERIC L MCMULLEN, 3674
CHRISTOPHER R MCNAMARA, 5392
BRADLEY S MCNARY, 9040
ZACHARY J MCNEILL, 9885
DAVID A MCNUTT, 5157
RALPH L MCQUEEN III, 2729
DANIEL P MCRAE, 2293
DANIEL S MCSEVENEY, 9001
MARK M MEADE, 4794
DOUGLAS K MEAGHER, 0308
MICHAEL B MEASON, 9374
KYLE A MEER, 0351
TERENCE N MEJOS, 3127
CYRIL T MELLET, 5089
JASON D MENARCHIK, 1894
GREGORY D MENDENHALL, 5289
JASON J MENDEZ, 4944
AMELIA A MENDONCA, 5632
MATTHEW D MENZA, 0183
MICHAEL W MERRILL, 6818
STEPHEN M MERRITT, 3016
BARBARA J MERTZ, 9376
FREDERICK A MESSING II, 3587
ROBERT D METCALF, 9859
ROBERT D MEYER JR., 6590
MEGHAN A MICHAEL, 1462
BLAKE K MICHAELSON, 6819
WILLIAM G MICHAU, 3095
RENEIL A MILEWSKI, 1295
BROCK A MILLER, 6195
CHRISTINE A MILLER, 5005
JASON A MILLER, 4831
JEFFREY M MILLER, 3905
ROBERT E MILLER III, 5169
ROBERT R MILLER, 8447
JOHN D MILLINOR, 5401
RONALD C MIMS, 0506
STEPHEN J MINIHANE, 6696
DANIEL M MIRELEZ, 5971
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REED C MITCHELL, 8874
JOEL T MLINAR, 4366
BENJAMIN S MOGLEN, 5324

TIMOTHY R MOHR, 1324
KEVIN O MOLLER, 1526
MICHAEL R MOLLINEAUX, 0493
MICHAEL J MONAHAN, 7644
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ANTHONY I MONELL, 1080
JEFFREY H MONTAGUE, 4365
GARY G MONTALVO JR., 9266
JOSE F MONTES, 2414
JEFFREY MONTGOMERY, 1502
EDNA E MOORE, 6264
JOSHUA P MOORE, 4589
NATHAN A MOORE, 7932
PETER W MOORE, 1104
ROBERT A MOORE, 5273
SHANNON L MOORE, 6746
TERRI F MORACA, 9651
OSCAR R MORENO, 4439
BRIAN C MORGAN, 1156
MATTHEW P MORGAN, 7009
JEFFREY V MORGANTHALER, 5311
MAUREEN A MORONEY, 3865
ESTHER G MORRIS, 4046
LISA M MORRIS, 1760
PAUL W MORRIS, 8353
DONALD L MORRISON JR., 0166
TROY C MORSE, 9113
KARALEE G MORTENSEN, 2314
PETER J MORTON, 0785
ZACHARY V MOSEDALE, 3230
DONALD L MOSELEY JR., 0694
SCOTT A MOSEMAN, 9548
THOMAS A MOSKO, 1976
AARON M MOSKOWITZ, 0553
JAMES P MOSMAN, 2423
KENNETH M MOTOLENICHSALAS, 3775
TIMOTHY F MOTSCH, 2745
STEPHEN E MOTTER, 8785
JEREMY B MOYA, 6915
SHAWN P MOYER, 2904
CHRISTOPHER L MOYLAN, 8899
BRIAN M MOYNIHAN, 5374
MICHAEL C MRSTIK, 1477
DANA M MUCHOW, 2550
JOHN K MUES, 6175
KATHLEEN A MULLEN, 1560
INGRID T MULLER, 9854
TIMOTHY D MULLER, 5915
DARRIN R MULLINS, 7578
PAUL B MULLINS JR., 0242
ANDREW J MURPHY, 5129
CHRISTOPHER J MURPHY, 9425
JAMES H MURPHY, 6717
JAMES P MURPHY, 5841
JOHN E MURPHY, 6416
LAURA G MURPHY, 5124
DAVID S MURRAY, 8744
KELLY J MURRAY, 4763
ERICA A MUSELER, 7595
THOMAS D MUTTY, 0129
ANTHONY M MYERS, 5329
LARRY A MYERS JR., 1518
PAUL S NAGY, 8362
MELVYN N NAIDAS, 7288
MICHELLE L NAKAMURA, 7772
DEREK F NALEWAJKO, 5679
MICHAEL D NASH, 9799
MICHAEL L NASON, 8675
FERNANDO NAVARRO, 8763
DUANE E NEAL, 9909
JASON A NEAL, 3713
TYLER Y NEKOMOTO, 1551
CAMERON R NELSON, 7579
DEREK A NELSON, 5965
ERIC G NELSON, 6302
LAURA J N NELSON, 5580
YOHANCE O NELSON, 8766
IAN R NESBITT, 3587
WOODROW M NESBITT JR., 3095
JON K NEUHALFEN, 0790
MARK P NEVITT, 4363
ANDREW T NEWSOME, 6595
MICAH D NEWTON, 4329
DAVID K NG, 8389
DAMIAN N NGO, 2449
DOROTHY H NGUYEN, 7499
TUAN NGUYEN, 2332
DANIEL A NICHOLS, 2961
DANA L NIEMELA, 9672
ROSLYN B NIEVES, 5277
JEREMY P NILES, 0591
SEAN P NILES, 5478
ROGER D NISBETT, 3467
DAVID W NOLAND, 5154
LUKE P NORRIS, 1755
AMY L NOYES, 3437
EDUARDO E NUNEZ, 9118
LUIS A NUNEZ JR., 9541
RICHARD A NYE, 4175
MICHAEL K OBEIRNE, 0027
SALEE J P OBOZA, 5713
BRENDAN T OBRIEN, 2075
PHILIP A OCAMPO, 3609
PAUL J ODEN, 6772
ERIK ODOM, 1797
KENNETH C ODONNELL, 0126
IKE OFODILE, 2178
IRENE R OGBURN, 3338
EDWARD J OGRADY III, 6142
ARTHUR J OKEEFE, 2805
JOHN P OLIVER II, 1414
SUSAN M OLIVER, 2096
KAZVIN I OLMEDA, 3604
BRIAN M OLSON, 6417
THOMAS P OMALLEY, 5453
THOMAS J ONEGLIA, 9139
JAMES F ONEIL, 1746
LANCE P ONEILL, 8288
TERRANCE D ONEILL, 8985
SEAN D OPITZ, 2739
JEFFERY R ORR, 0774
JAMES D OSBORNE, 0269
MATTHEW E OSBORNE, 0920
TIMOTHY A OSWALT, 6491
KANAN C OTT, 2618
MICHAEL V OWEN, 1097
JASON C OWENS, 6623
TRAVIS J OWENS, 0109
ALDRITH L OXENDINE, 7857
ERIC G PACHECO, 5569
IAN B PADDOCK, 5962
CESAR PADILLA, 3459
CARRINE N PALM, 1430
WILLIAM B PALMER II, 6957
ANTHONY D PAPP, 6756
JASON P PAPP, 1379
WILLIAM R PAQUETTE, 2806
RAJEEV V PAREKH, 1338
DAVID C PARKER, 9893
JAMIE C PARKER, 2197
SHERI B PARKER, 5954
WILLIAM F PARMENTIER, 4787
ERIC S PARTIN, 4026
DAVID R PARTRIDGE, 0932
KAMYAR PASHNEHTAL, 763
NIRAV V PATEL, 0704
PAUL L PATILLO, 3564
JOHN P PATRIARCH, 7359
HADEN U PATRICK, 3568
DOUGLAS A PATTERSON, 3247
GEOFFRY W PATTERSON, 2017
JOSHUA T PATTON, 5830
DEREK M PAUL, 7591
MICHAEL J PAUL, 4467
ALEXEI M PAWLOWSKI, 4673
MARK J PEACE, 6712
ROBERT S PEARSON, 5560
AARON G PEASE, 6890
WALTER T PEASLEY, 5230
ANDREW M PENCE, 9794
JAMES M PENDERGAST, 6558
CLAYTON M PENDERGRASS, 7764
BARBARA E PENFOLD, 3034
DANIEL W PENROD, 0781
NIKKI N PEOPLES, 2628
MATTHEW J PERCY, 3173
PATRICK F PERDUE, 4606
WINFORD A PEREGRINO, 3185
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FRANK H PERRY JR., 4761
MICHAEL PERRY, 1921
NOLAN K PERRY JR., 1559
DAVID C PERSON, 4108
JENNIFER A PETERS, 1199
RYAN D PETERSEN, 0999
THOMAS A PETERSEN, 8138
DOUGLAS M PETERSON, 9910
BRIAN L PETRY, 1913
JEFFREY M PFEIL, 2145
MATTHEW D PHANEUF, 8255
BENJAMIN A PHELPS, 1292
VANNAVONG PHETSOMPHOU, 1640
ISAAC A PHILIPS, 1027
MIKAL J PHILLIPS, 1469
RICHARD A PHILLIPS, 4932
TODD K PHILLIPS, 7669
WILLARD L PHILLIPS, 1420
MICHAEL A PICCIANO, 5910
SCOTT A PICHETTE, 3197
JAMES M PICKENS, 3507
DANIEL C PIERCE, 7761
GLENN D PIERCE, 1920
KENNETH L PIERCE, 0474
CLARENCE D PINCKNEY, 9421
THOMAS J PINER, 5141
JACQUELINE M PIOTROWSKI, 4093
JOEL P PITEL, 8884
RICHARD C PLEASANTS, 6966
MATTHEW J PLODINEC, 9612
STEVEN G PLONKA, 0164
MICHAEL J PODBERESKY, 7944
CHRISTOPHER J POLK, 5731
JOHN C POLK, 1677
MATTHEW V POLZIN, 7623
CHRISTOPHER J POMMERER, 3305
DENISE L PONTZER, 5475
RITA A POPE, 9116
STEPHEN B POPERNIK, 1736
HEATHER E POSEY, 2729
MICHAEL M POSEY, 8195
ROBERT W POSEY II, 9330
LEA G POTTS, 2502
DONNA POULIN, 3953
CHRISTOPHER W POULOS, 5132
CALEB POWELL JR., 1465
GLENN D POWELL, 2594
JOSHUA F POWELL, 6844
KEITH M POWELL, 8399
MICHAEL W POWELL, 2797
GREGORY R POZUN, 1265
SEAN A PRADIA, 9002
JASON W PRATT, 0864
ANDREW L PRESBY, 4044
WILLIAM G PRESSLEY, 7805
MAEGEN G PRICE, 4082
SAMMIE PRINGLE II, 4691
COREY L PRITCHARD, 0651
JACK R PRITCHETT, 4743
ROBERT B PROPES, 7993
BERTRAM L PROSSER, 5564
GREGORY J PROVENCHER, 8375
PAUL W PRUDEN, 1790
EMMETT S PUGH IV, 7838
CHARLES J PUGLIA, 3534
KRISHNA C PULGAR, 2811
ERIC J PURVIS, 5108
CHARLOTTE K PUTTROFF, 8955
JAMES A QUARESIMO, 8312
JOHN Q QUARTEY II, 9374
JOSEPH QUAST, 0737
CHRISTOPHER V QUICK, 9787
BRYAN D QUINDT, 2437
DANIEL T QUINN, 3903
BRIAN N RACCIATO, 8284
ROBERT L RADAK JR., 9149
ROBERT J RADCLIFFE, 7961
JOSEPH P RADELL, 4942
JEREMY A RAILSBACK, 0526
IAN A RAINEY, 5289
RONALD A RALLS, 2597
ROBERT E RALPHS, 8138
KEVIN W RALSTON, 4183
MICHAEL RAMSEY, 5483
JAMES F RANKIN, 3939
WILLIAM M RANNEY, 7727
CLARK J RASCO, 3942
TARIQ M RASHID, 9673
TRAVIS M RAUCH, 9327
DAVID W RAUENHORST, 0279
RICHARD B RAY, 5791
CHRISTOPHER M READY, 4735
MATTHEW G REAMS, 8003
LAURENCE D REAY, 5572
CHARLES B REDMOND JR., 6425
BITHIAH R REED, 4074
KELAND T REGAN, 7746
RODNEY E REGISTER JR., 2930
CHRISTY J REICHARDT, 6045
TIMOTHY P REIDY JR., 3136
WILLIAM R REILEIN, 3626
DAVID S REILLY, 7673
PAUL B REINHARDT, 1448
JASON S RELLER, 5343
ALFREDO R RENDON, 7102
HENRY L RENDON, 7302
JOSEPH H RENIERS, 7756
JONATHAN R RETZKE, 0097
NATHANIEL A REUS, 0473
JOSEPH F RHEKER III, 3377
DANIEL B RHOADES, 3357
ERIC A RICE, 4525
KENNETH W RICE, 8598
BRIAN A RICH, 9041
JOSHUA A RICH, 3098
CHRISTOPHER A RICHARD, 7549
ANDREW P RICHARDS, 1309
JAMES M RICHARDS, 4136
ANTONY M RICHARDSON, 8474
DESIREE RICHARDSON, 2210
MARK W RICHARDSON, 3999
SCOTT T RICHERT, 9190
JEFFREY A RICHTER, 3182
DUSTIN B RIDER, 5505
STEPHEN L RIGGS, 3940
KYLE P RILEY, 4475
MICHAEL A RINALDI, 3125
ROBERT M RINAS, 2360
ANDREW H RING, 0995
RAUL RIOS, 1333
BRIAN D RIVERA, 1985
JULIE H RIVERA, 4238
RICKY RIVERA, 9893
BRYAN J ROACH, 8725
ROBERT P ROBBINS, 0253
AARON D ROBERTS, 5454
MEGAN E ROBERTSON, 9664
MARK A ROBINSON, 7742
MICHAEL L ROBINSON, 8744
DUNELEY A ROCHINO, 0787
NANCY B RODDA, 0126
DAVID L RODDY, 8684
ANNE E RODEHEAVER, 6172
STEVEN L RODENBAUGH, 7959
TONY M RODGERS, 4902
EDWARD A RODRIGUEZ, 4887
ERIC W ROE, 8160
JAMES M ROGERS, 5229
MARGARET R ROGERS, 6269
PATRICK V ROGERS, 8987
ROGER L ROGERS, 4138
KURT L ROHLMEIER, 6682
CHRISTOPHER F ROHRBACH, 5218
ROANNE U ROMERO, 7331
KENNETH R ROMO, 7018
SEAN RONGERS, 9282
COLIN J ROONEY, 4218
ARNOLD I ROPER, 7122
LANI H RORRER, 7860
BRIAN V ROSA, 7867
SCOTT D ROSE, 8893
BRIAN P ROSEMARK, 4612
MATTHEW B ROSS, 2361
DOUGLAS L ROUSH, 0107
ANDRE N ROWE, 8850
JON J ROWE, 8144
KEITH M ROXO, 7757

ROBERT A ROY, 5645
ERIC J ROZEK, 0446
JOHN G RUANE, 8228
PAUL S RUBEN, 7088
JOHN A RUBINO, 2696
KARL L RUBIS, 2861
DAVID J RUETER, 5784
MATTHEW S RUETTGERS, 9232
MELISSA L RUFF, 8438
LINDA K RUMBAUGH, 1115
ANDREW J RUMPEL, 2956
SETH D RUMSEY, 2363
CHRISTIE M RUSHING, 3352
DALE W RUSSELL, 6872
MARK S RUSSELL, 1663
MATTHEW D RUSSELL, 0422
MICHAEL A RUTH, 3440
MATTHEW F RUTHERFORD, 6175
WILLIAM S RUTHERFURD, 1613
JENNIFER M RYAN, 7016
WILLIAM J RYAN, 2062
PETER G RYBSKI JR., 6551
THOMAS A RYNO, 9323
VAN E RYPEL, 3807
LISA M SAAR, 4807
JEFFREY R SABADOS, 6476
JONATHAN P SAGASER, 4345
ZACHARY SALAS, 5422
STEVEN P SALATA, 3636
JARED T SALAZAR, 8223
ROMMEL J SALGADO, 3424
JASON A SALINAS, 5991
ROMAN P SALM III, 4565
RICHARD SALSBURY, 6205
RODRIGO A SALVADOR, 8688
ROLANDOJR SALVATIERRA, 9297
PAUL C SAMEIT, 2233
CHRISTOPHER SAMMARRO, 7351
SCOTT F SAMO, 9259
CHARLEESE R SAMPA, 9163
RICHARD P SAMPLES, 6009
CLAIRE O SAMPSON, 8534
JEFFERY D SAMPSON, 1654
ADAM M SAMUELS, 5330
XAVIER J E SAMUELS, 0086
RODNEY A SANCHEZ, 0329
RUSSEL B SANCHEZ, 0879
BRIAN J SANDBERG, 6501
WALTER G SANDELL, 3446
KARREY D SANDERS, 2617
BRETT E SANDMAN, 4419
DANIEL J SANTOS, 5707
KEVIN A SAPP, 3328
JEFFERSON P SARGENT, 3336
JUSTIN R SAUER, 3275
BOBBY B SAVANH, 7203
PATRICK C SAXTON, 5368
JENNIFER A SAYLES, 6905
MATTHEW O SCANLAN, 8197
KERRY L SCHABACKER, 1326
STEVEN W SCHABACKER, 8691
BRENDA K SCHEIBMEIR, 1646
CORY D SCHEMM, 3498
PATRICK K SCHENCK, 5286
PAUL S SCHIERMEIER, 6439
EDWARD C SCHILLO III, 5677
CRAIG J SCHLOTTKE, 4862
FREDERICK K SCHMIDT, 3461
TORSTEN SCHMIDT, 0541
JESSE A SCHMIDTMANN, 0035
ADRIA R SCHNECKSCOTT, 2359
WILLIAM M SCHOMER, 4460
SARAH A SCHOPP, 3823
DANIEL M SCHORMANN, 9254
ERICH J SCHUBERT, 2106
ADAM T SCHULTZ, 5853
MARK P SCHUMANN, 0625
JASON W SCHWARZKOPF, 8419
THOMAS B SCHWEERS, 2273
AUGUSTUS V SCIULLA, 3896
LEON B SCORATOW, 4696
SCOT W SCORTIA, 5266
BRANDON M SCOTT, 3067
JOSEPH R SCOTT, 8253
DEAN L SCRIVENER, 8616
GAIL M SEAMAN, 7022
ALBERT C SEEMAN, 7977
KURT M SELLERBERG, 1917
MICHAEL I SELLERS, 0942
REED G SELWYN, 5450
CHRISTOPHER C SEROW, 4848
ANDREW W SEVERSON, 5875
CHRISTOPHER J SEWADE, 2426
ANDREW J SEXTON, 5896
KEITH E SHADMAN, 8995
MATTHEW S SHAFFER, 0892
CHRISTIAN L SHALTERS, 3990
DOUGLAS K SHAMLIN, 2377
CHARLES E SHAMONSKY, 0678
KARL SHANK, 1213
RYAN P SHANN, 6854
JOHN D SHANNON, 1607
ISAAC SHAREEF, 9782
PETER J SHEEHY, 6607
MARK SHEFFIELD, 4805
JAMES P SHELL, 4919
SOJOURN D SHELTON, 2492
NATHAN S SHENCK, 1688
LAMAL D SHEPPARD, 0195
JASON J SHERMAN, 7515
JEFFREY W SHERWOOD, 8625
PATRICK H SHERWOOD III, 7717
RALPH B SHIELD, 9724
NATHAN D SHIFLETT, 5757
KEVIN R SHILLING, 4686
CHRISTOPHER K SHIPE, 3664
WILLIAM H SHIPP, 1204
JOHN R SHIRLEY, 3075
LISA M SHIROMA, 8752
DAMON W SHIVVERS, 5130
COLLEEN M SHOOK, 7097
GARRETT W SHOOK, 9749
BARRY J SHUEMAKER, 9858
PATRICK S SHUSTER, 5545
THOMAS P SICOLA, 0228
DAVID K SIDEWAND, 9159
DON C SIDWELL, 8154
PETER V SIEGEL, 5291
JENNY L SIGEL, 5109
MARK F SILBERNAGEL, 8796
LEWIS P SILVERMAN, 0110
CHRIS E SILVIA, 7333
MICHAEL S SIMMONS, 7693
ROBERT M SIMMS, 8861
THOMAS A SIMMS IV, 0659
JOSEPH F SIMONE, 4265
MICHAEL C SIMPSON, 5924
PHILLIP T SIMPSON, 1309
CODY S SINCLAIR, 5724
KELLY A SINGLETON, 4933
ERIC J SINIBALDI, 1695
ROBERT G SINRAM, 8661
JAMES R SISCO JR., 7740
PETER M SIWEK, 3619
BARRY C SKELTON, 4917
SHARN R SKELTON, 0446
JOSEPH S SLADE, 0875
KARLA M SLATER, 6151
KENDALL SLATTON, 8478
PAGE E SMALL, 3339
VALERIE L SMALL, 9547
ROBERT G SMALLWOOD III, 8124
ANTHONY F SMITH, 2559
ANTHONY P SMITH, 4879
CHRISTOPHER H SMITH, 3223
CHRISTOPHER T SMITH, 4858
DAVID J SMITH, 9598
DIRKLAND T SMITH, 0737
DOROTHY M SMITH, 4034
GERALD N SMITH, 4160
HEATHER A SMITH, 5153
JEFFREY J SMITH JR., 8017
MATTHEW C SMITH, 8341
MATTHEW N SMITH, 7553
MELVIN R SMITH JR., 9971
NATHAN I SMITH, 7673
ROBERT S SMITH, 5715
WILLIE J SMITH JR., 5068
JEFFREY A SNIDER, 2256
MATTHEW M SNIFFIN, 5089
MICHELLE SNYDER, 9717
WILLIAM S SNYDER JR., 0639
DARRYL B SOL, 9808
EDWARD V SON III, 4363
RONALD T SOROKA JR., 1598
VICTOR SORRENTINO, 6513
MICHELLE G SOUTHARD, 2499
JEFFREY D SOWERS, 1880
ASHLEY A SPALDING, 3093
JASON L SPARKS, 0141
ROBERT W SPATH, 6157
GEORGE A SPENCER, 8976
JON D SPIERS, 2632
BRIAN D SPRAGUE, 8467
KEVIN J SPROGE, 7591
LAWRENCE A SPROUL, 2276
JACOB V SPRUANCE, 0073
TIMOTHY K STACKS, 0325
JOHN W STAFFORD, 6712
CHARLES H STAHL IV, 2410
JASON R STAHL, 3564
KEIR D STAHLHUT, 6598
JONATHAN A STALEY, 2422
JULIETTE H STANCHFIELD, 1207
CHARLES T STANFORD, 9448
MATT T STANTON, 6681
JOHN B STAPLETON, 9467
CHRISTOPHER STARKWEATHER, 5363
JASON W STARMER, 8273
FRANCIS J STAVISH, 1694
MICHAEL W STEELE, 7699
BENJAMIN J STEFANO, 0726
GARY C STENSON, 8553
JONATHAN T STEPHENS, 3572
THOMAS S STEPHENS, 9172
HEATHER A STERNISHA, 2278
AARON M STETLER, 6517
MICHAEL E STEVENS JR., 9965
WILLIAM F STEVENS JR., 4534
JAMES W STEWART, 8809
BRETT A STGEORGE, 0308
JASON W STICHT, 9036
TONY L STILLINGS, 6017
MANSFIELD L STINSON, 3545
KELSEY P STLOUIS, 4834
ROBERT T STOCKTON JR., 2509
DANIEL A STOKES, 4781
GHISLAINE W STONAKER, 7957
KRISTOPHER W STONAKER, 5157
WENDY L STONE, 6509
GREGORY M STORCH, 7041
CHRISTOPHER J STOREY, 0514
RONALD L STOWE, 4718
JASON STRACQUALURSI, 1671
DONALD W STRASSER, 4937
THOMAS STRENGE, 0349
ANDRE J STRIDIRON III, 7763
SHANE P STROHL, 6423
MICHAEL R STRONG, 5434
MICHAEL E STUKER, 8689
JASON R STUMPF, 1668
JARROD W STUNDAHL, 1005
JEFFREY D STURM, 8974
LUKE C SUBER, 6944
RONALD J SUCHARSKI, 3311
BARBARA A SULFARO, 3474
JONATHAN B SULLIVAN, 0267
JAMES T SULTENFUSS, 9408
LUCIANA SUNG, 0033
STEVEN J SUSALLA, 0973
GREGORY E SUTTON, 1782
SCOTT A SWAGLER, 7967
THOMAS B SWAIM, 3884
MATTHEW R SWANSON, 8125
NED L SWANSON, 1857
JEREMIAH SWARTZLENDER, 7331
WILLIAM F SWINFORD, 8978
GLENN D SWITTS, 8324
CHRISTOPHER M SYLVESTER, 6400
ALEJANDRO C TAAG, 2677
SALEEM K TAFISH, 7557
OLAF O TALBERT, 6358
LEONARD A TALBOT, 7967
NANCY E TALBOT, 7468
SCOTT T TASIN, 4236
BRENT H TAWNEY, 3542
CORA C TAYLOR, 0016
JASON S TAYLOR, 4793
KELLY E TAYLOR, 2951
CARRIE A TEMPLE, 8884
RODOLFO N TERRAZAS, 9361
DANTE R TERRONEZ, 7626
KEVIN M TEST, 4337
MONTEY A THAMES JR., 2245
CARLA A THARRINGTON, 4029
ERIC J THEUS, 9661
REGINA I THIGPEN, 9750
GREGORY B THOMAS, 7725
JOHNETTA C THOMAS, 2255
MATTHEW C THOMAS, 0230
DARCY L THOMPSON, 0305
MARK D THOMPSON, 3440
SHEA S THOMPSON, 0394
SUSAN E THOMPSON, 0964
TIMOTHY M THOMPSON, 4236
JAMES T THORP, 0696
PETER THRIFT, 7680
LAURA P TILLINGHAST, 7773
ROLAND R TINK, 7763
TROY A TINKHAM, 4065
MARK I TIPTON, 9653
LYNDEN R TOLIVER JR., 0419
JASON L TOMASOVIC, 3672
JOHN J TOMON, 3439
BLAINE K TOMPKINS, 6408
SCOTT P TOMPKINS, 7753
NATHAN M TOOTHMAN, 7334
MICHAEL G TORIBIO, 5171
BRYAN A TOTH, 1110
DANIEL R TOVAR JR., 9280
LE B TRAN, 6605
NICOLE M TREEMAN, 5648
MICHAEL W TREST, 3629
JOSEPH C TREVINO, 3373
SHAWN M TRIGGS, 0626
JARA D TRIPIANO, 0094
MARK D TRIPIANO, 6445
SAM P TRONGKAMSATAYA, 8766
ALLAN C TUAZON, 5488
LOUIS B TUCKER, 3444
MATTHEW B TUCKER, 4973
DAVID L TULLISON, 7975
DANIEL W TURBEVILLE, 5226
DENNIS J TURNER, 8244
MICHAEL E TURNER, 4897
MICHAEL E TWAROG, 3786
ELIZABETH H UNANGST, 2206
DUDE L UNDERWOOD, 3499
CARLOS URBIZU, 0710
MEGAN H URFFER, 8679
MICHAEL R VAAS, 5298
ELISABETH A VAGNARELLI, 9630
STEPHEN M VAJDA, 4793
VIDAL VALENTIN, 2376
ELMER D VALLE JR., 9794
BRIAN D VANCE, 1724
ERIC J VANDYKE, 8809
JOEL W VANESSEN, 3497
JAMES K VANHAO, 6823
SHAWN T VANMETER, 8092
CLARENCE W VANMILDER, 9394
DANIEL M VANTRUMP, 2672
ADONIRAM J VARGAS, 7672
WILFREDO VARGAS, 1115
CRAIG T VASS, 8773
MAGNUM O VASSELL, 0358
JAMES O VEGA, 8922
FRANK W VEGERITA II, 6781
CHRISTOPHER W VELEZ, 2590
APRIL D VELTRY, 6017
FRANK P VENIS, 6840
MARK A VENZOR, 7936
DANIEL V VICARIO, 4929
JEFFREY R VIGNERY, 8793
PAUL S VILLAIRE, 6812
DANTE J VILLECCO, 3536

IVAN J VILLESCAS, 0086
KELLI H VOELSING, 6558
VICTORIA A VOGEL, 6190
VANESSA L VOGL, 7266
THOMAS S VOGLESONGER, 8522
JOHN A VOIGHT, 0969
JONATHAN J VOJE, 7596
JOHN T VOLPE, 1680
PATRICIA A VOOGD, 9336
TUAN A VU, 7235
SHERRY M WACLAWSKI, 6501
STEVEN A WAGGONER, 7311
HOLGER M WAGNER, 8452
JAMES C WAINWRIGHT III, 8253
TIMOTHY L WAITS, 1082
DENNIS J WAJDA, 6639
STEPHAN E WALBORN, 0446
CHRISTOPHER A WALDRON, 3886
JASON M WALDRON, 3764
WILLIAM R WALDRON, 2727
DANIEL C WALENT, 9364
SCOTT A WALGREN, 2113
BRIAN D WALKER, 0959
JASON K WALKER, 3540
JEANETTE C WALKER, 4439
TIMOTHY J WALKER, 3341
YVONNE B WALKER, 6569
DIALLO S WALLACE, 6838
PAMELA D WALLACE, 6128
PHILLIP S WALLACE, 0888
TONY M WALTON, 6188
TOMMY L WARD, 4232
JASON C WARNER, 9349
SAMUEL G WARTELL, 4026
GARY L WASHBURN, 1612
ALICIA M WASHINGTON, 2851
ANNETTE H WATKINS, 4665
EDDI L WATSON, 2790
JACOB H WATSON, 4578
JAMES J WATSON, 9774
MARK A WATSON, 2773
WARREN D WATTLES, 1783
HARRELL WATTS, 8715
ANDREW L WATTULA, 6341
LENORA B P WEATHERFORD, 4313
JOHN F WEBB, 9753
SKY R WEBB, 3120
DANIEL WEBSTER, 1893
MICHELLE E WEDDLE, 7735
JOHN W WEIDNER JR., 1104
JAMES F WELCH, 1729
SUSAN M WELLMAN, 5471
DAVID S WELLS, 7112
ROBERT S WELLS, 0475
CHARLOTTE A WELSCH, 1239
MICHAEL J WENTZEL, 4465
DANIELLE M WENZEL, 4691
DAVID M WERNER, 2559
KEITH W WESELI, 9890
AMANDA B WESTLAKE, 5227
ROBERT A WESTLUND, 5074
MARK R WESTMORELAND, 2343
DONALD G WETHERBEE, 3777
MICHAEL J WEYENBERG, 9193
MICHAEL G WHEELER, 0667
DOUGLAS B WHIMPEY, 3398
CHARLES D WHITE, 0274
GERARD J WHITE, 8644
JOEL A WHITE, 6607
THERESA D WHITE, 2513
BRIAN P WHITESIDE, 3949
RYAN W WHITESITT, 4598
JENNIFER L WHITMORE, 5876
CAROLYN H WHITNEY, 1653
CARL B WHORTON, 6927
ARCELIA WICKER, 2208
JEFFREY M WIDENHOFER, 8078
BRIAN C WIECHOWSKI, 3338
PATRICK W WIEGLEB, 1185
JULIE K WIELENGA, 2274
CRAIG M WIESEN, 6311
ASHLEY D WILBUR, 2544
DANIEL E WILBURN, 8345
MATTHEW D WILDER, 0667
RICHARD B WILDERMAN JR., 6415
JASON W WILLENBERG, 4796
MATTHEW D WILLER, 8844
AARON J WILLIAMS, 2748
ANTHONY S WILLIAMS, 6048
CHRISTOPHER J WILLIAMS, 7025
DONNELL L WILLIAMS, 5134
ERIC L WILLIAMS, 8484
KEVIN W WILLIAMS, 8987
KRISTINA K WILLIAMS, 7142
MATTHEW J WILLIAMS, 8394
PATRICK S WILLIAMS, 1981
WARREN T WILLIAMS, 9664
JASON J WILLIAMSON, 6005
JAMES A WILLSEY, 7463
ANDRE R WILSON, 8609
BRIAN S WILSON, 3535
CHARLES J WILSON, 0003
CRAIG B WILSON, 0557
DAVEN J WILSON, 6005
ELY C WILSON, 6538
ENID WILSON, 7231
STANLEY P WILSON, 4568
PAUL H WILT, 7724
DENA M WINDER, 6937
ROBERT A WINDOM, 5453
JEFEREY A WINSLOW, 6881
GARY WINTON, 9667
SUSAN M WISCH, 8825
MICHAEL P WISCHNEWSKI, 1300
ROBERT C WISE, 8986
GREGORY R WISEMAN, 9370
STEVEN T WISNOSKI, 0203
THADDEUS S WITHERS, 2464
RONALD L WITHROW, 0996
CHERYL WOEHR, 7506
KENNETH A WOFFORD, 3676
MICHAEL F WOLNER, 0436
DAVID P WOLYNSKI, 7216
DARREN J WOMACKS, 7787
JAMES Y WONG, 1688
ROBERT G WONG, 1768
SARAH C WOOD, 6340
SHANNON J WOOD, 7027
MILES A WOODARD, 7382
NORMAN B WOODCOCK, 9136
AMY E WOODS, 0973
CASEY L WOODS, 7767
DANIELLE M WOOTEN, 0819
SEAN P WOOTEN, 0608
MICHAEL W WOROSZ, 7787
CHRISTOPHER D WORRALL, 1854
CRAIG E WORTHAM, 9671
LAURENCE R WRATHALL, 8934
FELICIA B WRAY, 7215
GRAHAM L WRIGHT III, 3029
MARK E WRIGHT, 6978
HEATHER G WYCKOFF, 0916
ANDREW J WYLIE, 1251
ROY A WYLIE, 5146
COLLIN A WYNTER, 4005
JASON T YAUMAN, 8260
VINCENT E YEALDHALL, 9415
JAMES A YEATS, 5863
SEAN P YEMM, 3308
JOHN T YI, 5996
DIANA A YORTY, 9531
DANA K YOUNG, 5218
JASON P YOUNG, 3776
WILLIAM A YOUNG, 0536
HAROLD YU, 8202
THERESA E ZACH, 0273
SAMUEL L ZAGER, 7631
DEIRDRE A ZALLNICK, 0522
MATTHEW A ZAVALA, 5692
CHRISTOPHER R ZEGLEY, 9516
TODD C ZENNER, 4164
THOMAS J ZERR, 3438
JASON A ZIEBOLD, 8725
DAVID M ZIELINSKI, 7569
JESSE J ZIMBAUER, 2351
ANTHONY D ZIMMERMAN, 9864
BRIAN T ZIMMERMAN, 9538
SCOTT B ZIMMERMAN, 5583
BENJAMIN D ZITTERE, 3411
REBECCA A ZUWALLACK, 5448

To be lieutenant junior grade

MICHAEL C ABERNATHY, 5780
DANIEL R ALCORN, 5316
VICTOR ALLENDE, 4791
LORA M ANDERSON, 5729
ANTHONY C ASP, 8099
JONATHAN M AVIS, 9164
ANDREW F BALL, 0280
ROGER L BARAJAS JR., 2554
SHARON D BARNES, 7647
JASON D BARTHOLOMEW, 6944
NELSON BATTLE, 3536
STEPHEN N BENSON, 7378
ANTHONY D BERMUDEZ, 7556
MATTHEW L BOLLS, 9573
JOSEPH A CACCIOLA, 2320
ROLANDO C CALVO, 1889
PETER P CHRAPKIEWICZ, 5709
CHRISTOPHER C COFFEY, 1636
BRENT E COWER, 6321
BAKARI P DALE, 3547
DANILO I DANTES, 4348
SCOTT E DANTZSCHER, 3333
GABRIEL T DENNIS, 6181
RORKE T DENVER, 6665
MICHAEL G DULONG, 2772
JEAN J DUPINDESAINTCYR, 4340
AMELIA EBHARDT, 6610
ROBERT R ELLISON III, 0066
KEITH B FAHLENKAMP, 2591
ANDREW D FLEISHER, 3049
JOHN A FLEMING, 6228
JONATHAN M FLOYD, 6713
SAMUEL V A FONTE, 0553
SCOTT M FRANCIS, 2894
WILLIAM D FRANCIS, 3289
JENNIFER H FRASER, 2230
CANDACE A GAINES, 6533
ALFONZO E GARCIA, 3124
MICHAEL A GIGLIO, 8289
ROBERT D GOAD, 8716
JASON GRABELLE, 6517
ANGELIN M GRAHAM, 4257
ELAINE A GRAHAM, 7502
DAVID A GUNN, 3407
BRIAN A HARDING, 8508
PAUL G HAVENS, 1430
AMY D HECK, 4536
MELISSA J HILER, 4857
WILLIAM G HODGE III, 6530
MICHAEL W HOSKINS, 2766
JEFFERY A HURLEY, 7081
TODD A JACOBS, 1128
BRIAN M JOHNSON, 6648
DOUGLAS M JOHNSON, 8043
JAMMAL L JONES, 2091
MARK C JONES, 0653
SEAN V JOSLIN, 6545
JAMIE L KARBACKA, 5816
DAWN A KETCHUM, 6231
CARL V KIRAR, 9710
RICK W LENTZ, 8896
BENJAMIN D LEPPARD, 5279
MATTHEW R MAASDAM, 5596
MIGUEL S MACIAS, 0426
JORGE A MALAVET, 4924
CLAYTON B MASSEY, 2543
SIMON R MCLAREN, 6392
RAFAEL A MIRANDA, 1806
CHRISTOPHER J MITCHELL, 1683
MICHAEL S MITCHELL, 4709
JOHNATHAN H MOEN, 2327
THOMAS P MOORE, 6104
JARROD L MOSLEY, 2259
JACQUELINE A NATTER, 5321
WILLIAM R PARRISH, 0101
DOUGLAS B PERKINS, 4446
BENJAMIN W RAYBURG, 1147
ELIZABETH A REGOLI, 4940
LAWRENCE M REPASS, 5375
TIMOTHY L RHATIGAN, 4991
SHANE D RICE, 0878
RYAN W ROBISON, 6824
LAURA J ROLLINS, 6343
WILLIAM M RUSHING, 4565
FRANCISCO P SANTOS, 9256
RYAN C SCHLEICHER, 9171
ERIC M SCHMIDT, 2193
MICHAEL J SCHORP, 0039
JODI E SEWELL, 6934
JEFFREY S SHULL, 5327
JOHN J SIMONSON III, 4007
ROBERT J SMITH, 1176
ROBERT S SMITH, 5900
MICHAEL A SNYDER, 9397
TRISHA N STANFORD, 4461
AARON C TAFF, 1730
OSMAY TORRES, 6982
CHAD E TREVETT, 4212
GERALD L TRITZ, 2455
JASON C TURSE, 0679
ZALDY M VALENZUELA, 4620
NOLASCO L VILLANUEVA, 3692
JARROD M WARREN, 3799
MATTHEW S WELLMAN, 9870
CHARLES E WESTERHAUS, 2526
KIERSTEN S WHITACRE, 7327
JUSTIN K WHITT, 3070
LINDA L WILLIAMS, 5816
JIMMIE I WISE, 8738

To be ensign

JIAN M MEI, 3317
SABRINA M STEDMAN, 3841

HOUSE OF REPRESENTATIVES—*Thursday, November 20, 2003*

The House met at 10 a.m. and was called to order by the Speaker pro tempore (Mr. BASS).

DESIGNATION OF THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore laid before the House the following communication from the Speaker:

WASHINGTON, DC,
November 20, 2003.

I hereby appoint the Honorable CHARLES F. BASS to act as Speaker pro tempore on this day.

J. DENNIS HASTERT,
Speaker of the House of Representatives.

PRAYER

The Reverend Monsignor Barry Knestout, Archdiocese of Washington, D.C., offered the following prayer:

Lord God, we bless You and praise You for Your generous gifts of life and love. Lead us to love one another in humility.

O Lord our God, we beseech You and ask for the gifts we need. Help this Congress in its deliberations and decisions. Renew us in the spirit of cooperation. Show us the course we are to take.

Let Your Spirit guide and strengthen us to always perform what is for the true and lasting good of this great Nation. Help us to find ways, in word and deed, to defend the innocent, to deliver the oppressed, to pity the insignificant, and show generosity to the needy. Help us this day and each day to keep Your commands and to ever rejoice in Your glorious and life-giving presence. Amen.

THE JOURNAL

The SPEAKER pro tempore. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

PLEDGE OF ALLEGIANCE

The SPEAKER pro tempore. Will the gentleman from Oregon (Mr. DEFAZIO) come forward and lead the House in the Pledge of Allegiance.

Mr. DEFAZIO led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Monahan, one of its clerks, announced that the Senate has passed without amendment a concurrent resolution of the House of the following title:

H. Con. Res. 313. Concurrent resolution to urge the President, on behalf of the United States, to present the Presidential Medal of Freedom to His Holiness, Pope John Paul II, in recognition of his significant, enduring, and historic contributions to the causes of freedom, human dignity, and peace and to commemorate the Silver Jubilee of His Holiness' inauguration of his ministry as Bishop of Rome and Supreme Pastor of the Catholic Church.

The message also announced that the Senate has passed a bill of the following title in which the concurrence of the House is requested:

S. 1895. An act to temporarily extend the programs under the Small Business Act and the Small Business Investment Act of 1958 through March 15, 2004, and for other purposes.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair will entertain 10 one-minutes from each side.

IN SUPPORT OF MEDICARE REFORM BILL

(Mr. FOLEY asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. FOLEY. Mr. Speaker, I learned in the real estate business, you never leave the negotiations for fear they may fail and you do not get your commission. Today, I understand the Democrats are planning a walkout from this floor to protest Medicare legislation. Yesterday, uniquely, the Democrats were burning their AARP cards down the street. The only thing missing from that scene was Jane Fonda.

Mr. Speaker, the seniors of our country deserve a Medicare program that is updated for the 21st century, including prescription drugs. It is an opportunity to help our seniors with new technology, diagnostic tests for osteoporosis, cardiovascular disease, diabetes. But no. If the Democrats do not get their way, they take the highway. That is discouraging for American seniors. And for them to ridicule and criticize AARP that just last week was the gold standard for senior lobbying organizations is somewhat a tremendous stain on the Democratic Party. Where are the leaders like Claude Pepper and Franklin Roosevelt?

I urge them to come to the floor today and work on Medicare legislation. Let us pass a bill for all seniors.

A RUBE GOLDBERG MEDICARE REFORM BILL

(Mr. DEFAZIO asked and was given permission to address the House for 1 minute.)

Mr. DEFAZIO. Mr. Speaker, the gentleman before me waxed eloquent about a $400 billion Rube Goldberg complete with subsidies for the pharmaceutical industry, the insurance industry and price fixing. It is going to guarantee that there will be no reduction in the extortionate price of prescription drugs. Americans will still continue to pay the highest prices in the developed world despite the fact that the drugs are manufactured here by American companies who often receive the benefit of taxpayer-funded research.

We could provide a much more meaningful benefit for substantially less and that would be if we did two simple things: Negotiate lower prices like every other nation in the world has done, but this bill prohibits the government from negotiating lower prices on behalf of Americans or Medicare beneficiaries. And, secondly, we could just engage in free trade, allow the reimportation of U.S.-manufactured, FDA-approved drugs. That would substantially lower the price. Many American seniors have already resorted to that, but this bill will prohibit the reimportation of drugs but instead it will engage in subsidizing private insurance, subsidizing the pharmaceutical industry, price fixing and protectionism. They are violating every principle they say they believe in.

IN SUPPORT OF MEDICARE PRESCRIPTION DRUG BILL

(Ms. DUNN asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. DUNN. Mr. Speaker, later this week we will have an opportunity to keep our promises to seniors. For too long our parents and our grandparents have been paying too much for prescription drugs. This problem is much more acute for low-income seniors, especially women. Women represent more than half the seniors with incomes that are less than 135 percent of

☐This symbol represents the time of day during the House proceedings, e.g., ☐1407 is 2:07 p.m.
Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

the poverty level. They live longer than men, they spend more on health care, and they are more likely to suffer from chronic medical conditions. In essence, women need more drugs for a longer period of time but are least likely to be able to afford them.

This prescription drug bill will help those on fixed incomes. A woman with an income of less than $13,000 today will receive full assistance. No premiums, no deductibles, no gap in coverage. Furthermore, disease management programs will help women who are suffering from multiple chronic diseases. It will help them receive better care from health professionals who can coordinate their medical needs.

Mr. Speaker, it is time to end the rhetoric and deliver on a promise.

CONGRESS PUNTS ON PRESCRIPTION DRUG BILL

(Mr. EMANUEL asked and was given permission to address the House for 1 minute.)

Mr. EMANUEL. Mr. Speaker, as we address the issue of prescription drugs and as speaker after speaker is speaking about prescription drugs, there are three attempts to deal with out-of-control prices of prescription drugs that are going up on average 20 percent a year:

One is through the free market principle of reimportation, allowing Americans to buy drugs in either Europe or Canada. Second, bulk negotiation, creating a Sam's Club using the power of 40 million seniors to purchase drugs at reduced prices like they do in Europe and in Canada. And, third, through speedy introduction of generic medications to market to bring competition to price.

In all three areas, the pharmaceutical industry got what they want, and this Congress punted on getting the price reduction as it relates to pharmaceutical prices. We need to offer the taxpayers who are about to be asked to spend $400 billion of their money, $400 billion of taxpayer money, we owe them the common decency and courtesy to get them the best price, either through the free market principle, through creating negotiation bulk prices to get prices reduced, or generics. In each area, this Congress punted on behalf of the pharmaceutical industry.

PEER-TO-PEER SOFTWARE IS A REAL DANGER TO OUR KIDS

(Mr. PITTS asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. PITTS. Mr. Speaker, the British newspaper The Guardian has found that demand for child pornography through the use of file-sharing programs, like Kazaa, is leading to more abuse of children. The sale of peer-to-peer traffic in illegal images of children now dwarfs any other pedophile network they have found.

David Wilson, professor of criminology at Central England, said, "Peer-to-peer facilitates the most extreme, aggressive and reprehensible types of behavior that the Internet will allow." Programs that are used by kids to find songs or pictures of cartoons are delivering our children right into the clutches of these predators.

And what are we doing about it? Nothing. Every day innocent kids are victimized on peer-to-peer file-trading software and our inaction allows them to walk right into the trap set by sexual predators. The time to act has come.

I urge my colleagues to cosponsor my bill, H.R. 2885, so that we can move forward in protecting our kids online.

AWARDING CONGRESSIONAL GOLD MEDAL TO PRESIDENT JOSE MARIA AZNAR

(Mr. GIBBONS asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. GIBBONS. Mr. Speaker, I rise today to again encourage my colleagues to cosponsor H.R. 2131, a resolution that will bestow President of the Government of Spain, Jose Maria Aznar, with the Congressional Gold Medal.

Shortly after the September 11 attacks on the United States, President Aznar made the following comment: "Our battle is a battle for the same ideas, for the same freedoms, for the same society and civilizations, and we will share all those efforts as long as it is necessary."

President Aznar of Spain has stood by the United States and, despite heavy political pressure, has never wavered from his staunch commitment to the ideals of freedom, liberty and democracy.

I urge my fellow Members to join me and over 100 cosponsors of H.R. 2131, a bill to award the Congressional Gold Medal to President Aznar. Join us in honoring a man who is a great leader in global democracy, a great leader in the war on terrorism, a notable ally of the United States, and a champion of freedom.

IN OPPOSITION TO LATEST NEW GOVERNMENT ENTITLEMENT

(Mr. PENCE asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. PENCE. Mr. Speaker, earlier this week I came to the House floor to announce my opposition to the largest new entitlement since 1965, the Medicare prescription drug bill that we will consider this week. As my voice has weakened, strong voices in opposition have emerged, including the venerable Heritage Foundation which has been a beacon of limited government for over three decades. And today, the editorial page of the Wall Street Journal in a piece entitled "Entitlements Are Forever" makes a powerful case that Congress should reconsider before we create this massive new government entitlement. The Wall Street Journal says the GOP's Medicare bill trades certain spending for speculative reform. The bottom line is that the bill would add a universal drug entitlement to a largely unreformed Medicare program and warns of fiscal disaster. They conclude that Republicans are offering the certainty of trillions in new entitlements in return for a mere promise of future reform and that is too expensive a gamble for principled conservatives to support.

With my very last breath, I would say, "I agree." Oppose the Medicare prescription drug entitlement.

HEALTH SAVINGS ACCOUNTS

(Mr. WILSON of South Carolina asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. WILSON of South Carolina. Mr. Speaker, I rise today in support of the conference report for H.R. 1, an historic bill that will include the creation of health savings accounts, a breakthrough program that gives control back to patients. The voluntary health savings accounts provide care that is affordable, flexible and portable. They restore the doctor-patient relationship, allowing Americans the freedom to choose their own doctor and their own care. Also, contributions, earnings and medical payments from these accounts are all tax-free.

Health savings accounts will lower health insurance costs for millions of Americans and allow for price competition of doctor and hospital services. Moreover, these accounts stay with a person throughout their lives as they are portable from one job to the other. They also can be used during retirement to pay for retiree health care, Medicare expenses and prescription drugs.

I strongly encourage my colleagues to support health savings accounts by voting in favor of H.R. 1 and give health care freedom to millions of Americans.

In conclusion, God bless our troops. We will not forget September 11.

IN HONOR OF RECENT BRONZE STAR RECIPIENTS

(Mr. BOOZMAN asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BOOZMAN. Mr. Speaker, I recently had the honor of handing out Bronze Star Medals to 58 World War II veterans from the Third District of Arkansas. These veterans did not previously receive their medals because of an oversight when they returned home after the war.

The Bronze Star is awarded to World War II veterans who earned the Combat Infantry Badge or the Combat Medical Badge. The award of these badges is considered as a citation in orders of exemplary conduct in ground combat against an armed enemy.

The hard work of the Northwest Arkansas Veterans Task Force who brought this oversight to my attention made this ceremony a reality. They are constantly looking out for veterans in our community, and their commitment to our veterans ought to be commended.

Mr. Speaker, each one of these veterans has a story to tell. Theirs is a special generation, the greatest generation, and we all owe them a debt of gratitude.

IN SUPPORT OF CONFERENCE REPORT ON MEDICARE MODERNIZATION BILL

(Mr. SULLIVAN asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SULLIVAN. Mr. Speaker, I rise today in support of the conference committee report on the Medicare prescription drug coverage bill. This long-awaited legislation will provide a tangible, real and meaningful benefit to American seniors.

□ 1015

Senior Americans are tired of the talk. It is time for action. This bill will put a drug discount card in their hands in May, 2004; and it will help them save between 15 and 25 percent right off the bat. It also provides structure for Medicare. It includes an affordable deductible and catastrophic coverage, in responsible manner, to help the neediest seniors. Those who currently have prescription drug coverage can keep their coverage because this plan is voluntary. This is reasonable legislation that will not only improve and prolong lives of our seniors but will do the same for the Medicare program.

Provisions for reimportation are in this legislation, ensuring safety and accountability. And it also includes an update for oncology drugs that is critical to cancer patients nationwide.

In conclusion, I would remind my colleagues that this bill provides structure; helps seniors get the prescription drugs they need when they need them by putting a discount card in their hands; is voluntary; and is tangible. It ensures accountability for reimportation and, more importantly, makes Members accountable to their constituents. I urge my colleagues to vote for H.R. 1.

PEACE IN THE MIDDLE EAST

(Mr. WOLF asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. WOLF. Mr. Speaker, the President gave an amazing speech yesterday in England, and everyone should read it. Consistent with that speech, I would now ask the administration to appoint a special envoy to the Middle East to focus like a laser beam on bringing peace to the Middle East.

Envoys for peace have succeeded in the past. Senator Mitchell succeeded in Ireland. Senator Danforth has helped push the peace in Sudan. Three people that come to mind immediately for the Middle East are the President's father, George H.W. Bush or Secretary James A. Baker III or former Secretary George Shultz. Each would bring a unique ability to sharply focus, using the administration's road map for peace, on bringing peace to the Middle East.

PROVIDING FOR CONSIDERATION OF MOTIONS TO SUSPEND THE RULES

Mr. SESSIONS. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 449 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 449

Resolved, That it shall be in order at any time on the legislative day of Thursday, November 20, 2003, for the Speaker to entertain motions that the House suspend the rules. The Speaker or his designee shall consult with the Minority Leader or her designee on the designation of any matter for consideration pursuant to this resolution.

The SPEAKER pro tempore (Mr. BASS). The gentleman from Texas (Mr. SESSIONS) is recognized for 1 hour.

Mr. SESSIONS. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentlewoman from New York (Ms. SLAUGHTER), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

This rule provides that suspensions will be in order at any time on the legislative day of Thursday, November 20, 2003. It also provides that the Speaker, or his designee, will consult with the minority leader, or her designee, on any suspension considered under the rule.

Mr. Speaker, the Republican leadership of this House has set out an aggressive legislative plan for this week on behalf of the American people. The goal of this plan is to pass a number of bills over the next few days that will dramatically improve the quality of life for all Americans. This week we have already succeeded in passing an energy conference report that will bring our Nation's outdated energy policy into the 21st century through comprehensive legislation that promotes conservation, reduces America's growing dependence on foreign oil, and creates new jobs.

For the balance of the week we are slated to consider legislation among the following things: number one, to authorize spending levels for intelligence activities needed to win the war on terrorism; number two, to reform Medicare to make sure that more of our seniors have prescription drug coverage that they need while also giving them more and better choices for their health care coverage, also to allow all Americans to begin planning for their health needs through savings accounts that can be purchased, can grow, and can be used on a tax-free basis; and, number three, to provide for a uniform national credit recording system that ensures that consumers are protected from identity theft while giving them access to the fast and reliable credit that makes our economy the envy of the rest of the world.

I understand that Members on both sides of the aisle may have different views about how to address these issues, and we will have the opportunity to hear a great deal of debate from both sides over the next few days on each of these issues and many others. However, a great deal of legislation that the Republican House leadership has also scheduled for consideration on behalf of all Americans has broad support from both the majority and the minority. And in an attempt to make sure that this important work is finished by the end of this legislative week as well, we are here to pass a rule to provide for consideration of these bills.

This balanced rule provides the minority with an ability to consult with the Speaker on any suspension that is offered, ensuring that their input and views are duly considered before any legislation is considered under this rule brought to the floor.

Mr. Speaker, I encourage my colleagues on both sides of the aisle to support this noncontroversial, balanced rule.

Mr. Speaker, I reserve the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, I yield myself such time as I may consume, and I thank the gentleman from Texas for yielding me 30 minutes.

Mr. Speaker, this unusual move to allow for consideration of motions to suspend the rules provides this body with a great opportunity. Many pieces of legislation important to our constituents are awaiting consideration. With this rule we have a wonderful chance to address some of these significant issues. We should consider legislation to extend Federal unemployment benefits for an additional 6 months; I believe that would pass unanimously. Currently unemployment benefits are set to expire on December 31. We should not allow the millions of Americans still desperately looking for work to begin the next year in the lurch.

I am particularly concerned about the loss of 44,000 manufacturing jobs in Upstate New York since 2002. In Rochester alone, manufacturing employment is down 20 percent. In these tough economic times, it is our duty to help; and since we are rushing to adjournment this week, this is our last opportunity.

Mr. Speaker, I would also like to use this golden opportunity to pass the genetic nondiscrimination legislation. Since 1995 I have led the fight to pass this nonpartisan, noncontroversial, and widely supported legislation. The bill currently has 236 cosponsors from both sides of the aisle, the support of over 200 outside organizations, and the support of the President of the United States. Last month the other body unanimously passed the legislation which prohibits genetic discrimination. This is critical to the health of the country, something we have talked about all week. If we do not pass this legislation to prohibit genetic discrimination, we are in danger of bringing much of the research that we are so proud of in the United States to a halt.

Discrimination is already taking place. We have lots of evidence of it both in employment and insurance. If we want to continue to be on the forefront of science and to be able to make our residents and citizens the healthiest in the world, this bill should be passed. I want to urge the Speaker of the House today to put this bill on the suspension calendar, let us pass it, let the President sign it, and let us all move toward better health.

Mr. Speaker, I yield 2 minutes to the gentlewoman from Florida (Ms. CORRINE BROWN).

Ms. CORRINE BROWN of Florida. Mr. Speaker, I thank the gentlewoman for yielding me this time.

I had not planned to come to the floor this morning, but I was sitting in my office and I heard my colleague from Florida mention Claude Pepper's name in relationship to this Medicare bill. Claude Pepper would be turning over in his grave by this bill. It was an insult to all of the fine work that Claude Pepper did in this House, and he would be on this floor speaking against this horrible bill.

This Republican Medicare bill is a slap in the face for every senior struggling to pay for needed medicine. The leadership of this House is not pushing this bill because they care about seniors. In fact, they would end the program altogether. In 1995 the majority leader called Medicare "a program I would have no part of." Another leader said "a program that I hope will wither on the vine." Now they want us to believe the spin that they really care about Medicare.

A zebra cannot change its stripes, Mr. Speaker, and the American people are not buying this sham. America's seniors are happy with the Medicare program, and we should provide for a prescription drug benefit the same way we provide for doctor visits through Medicare and not through a private program that even the insurance industry says will not work. This is a life-and-death issue for many of our seniors, and this hollow bill does nothing for that.

And I want to close quoting the only black Supreme Court Justice we ever had, Thurgood Marshall. He said: "A snake is a snake. It does not matter whether it is black or white; if it bites you, it is the same." And I can say that for the Republicans on this bill, and I can also say that for AARP, who has left the people.

Mr. SESSIONS. Mr. Speaker, I yield myself such time as I may consume.

It is early in the morning in Washington, and we are back at it again talking about this wonderful opportunity that we have to come down to the floor of the House of Representatives and speak our minds. And it is no surprise to the American public that the Democrat Party and its Members oppose reform in Medicare. It is no surprise to the American public that we recognize that the Democrat Party is not only opposed to reform but also to competition, which is what is in this bill; and it is no surprise to the American public that what will happen in the next day or two as the debate gets closer is that the American public will hear and find out about how the market reforms and things and ideas that will come from this bill will make life better for millions of Americans.

What is surprising is to hear the Democrat Party lambast AARP. The AARP is that organization for senior citizens all across this country who I think has made a very wise and careful decision to look at this prescription drug plan, and they have very clearly said that the Republican Party is right on the policy and they are right on what will give long-term success to this great Nation.

But we have heard very clearly this morning what the Democrat Party intends to do. They intend to keep Medicare exactly the way it is, in trouble financially and will very soon go bankrupt.

Reform is necessary if we are going to save this system, but reform is also necessary for the millions of Americans who today are without the ability to purchase health care solely because of money. What we are going to do is make it easier for Americans, not just people who go to work but some of them who are just now entering the marketplace, to be able to save money for health care on a pretax and tax-free basis, an opportunity for them to save this money and, when they are younger, to put that money away and to grow it tax free to be able to use it for health care, to make sure that they will be able to make wiser decisions in their future, that they will be able to make the wise decisions for their family at a time when they need that money most of all.

So what Republicans really stand for once again is reform and making sure that the most critical systems that are in place in our country are not only strengthened, but we make sure that they will survive the onslaught as times change and we have so many people retiring, but we need to make sure that our children and grandchildren have that same opportunity that we have had to have a system, an underpinning in this country that takes care of people.

So I am very pleased today, as we begin our work and debate in Washington. It is no surprise that here we are on this beautiful day in Washington, D.C., we begin with the debate on the floor to talk about the activities for the week, and I am so proud that not only what the Republican majority stands for but that the reform and the things we are going to bring to the American public will include opportunities for them to save for their own health care, because the most important part is, just like my family, I have a chance then to make a decision, to be a decision-maker in the health care needs of my family.

□ 1030

I have a beautiful wife of 19 years. I have a son who is 14 years old and a Down's Syndrome son who is 9. If there is one thing that I am passionate about, it is that I want a system in this country where families have an opportunity to make their decisions about health care, and we can do that when we have money in our own pockets. And that is what this reform is about, to make sure not just my family, but millions of other families across this great Nation have that same opportunity. That is what this health care savings account is going to be about. That is what Medicare reform is all about. I am proud of what we are doing.

Mr. Speaker, I reserve the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, had the gentleman from Texas (Mr. SESSIONS), my good friend, yielded to me, I simply wanted to ask him if he is aware that the administration has just given AARP a $20 million grant and ask if he wondered if that had anything to do with their decision.

Mr. Speaker, I yield back the balance of my time.

Mr. SESSIONS. Mr. Speaker, at this time I would like to thank the gentlewoman from New York for engaging us this morning on this very important rule which will allow us to continue our work. I urge my colleagues to join me in supporting this rule as I am sure they do.

Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered.

The resolution was agreed to.

A motion to reconsider was laid on the table.

WAIVING POINTS OF ORDER AGAINST CONFERENCE REPORT ON H.R. 2417, INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 2004

Mr. GOSS. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 451 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 451

Resolved, That upon adoption of this resolution it shall be in order to consider the conference report to accompany the bill (H.R. 2417) to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes. All points of order against the conference report and against its consideration are waived. The conference report shall be considered as read.

The SPEAKER pro tempore. The gentleman from Florida (Mr. GOSS) is recognized for 1 hour.

Mr. GOSS. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentleman from Florida (Mr. HASTINGS), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only on this matter.

Mr. Speaker, the Committee on Rules has granted the customary rule for consideration of conference reports to H.R. 2417, the Intelligence Authorization Act of Fiscal Year 2004. This is standard procedure. The rule is fair and without controversy as far as I know, and it does allow ample time for consideration of conference matters that have come up.

Mr. Speaker, as in past years, we thought it best to allow Members ample opportunity to review the bill and debate the issues they feel are important to our Nation's security. This was certainly exhibited earlier this summer when we passed, with overwhelming bipartisan support, the Intelligence Authorization Act in the House. Our classified annex and staff have been made available to any Member of Congress interested in reviewing the underlying bill and the reports thereto.

Today we are at the culmination of this process. The conference report on H.R. 2417 is critical, it is must-do legislation.

The bill authorizes appropriations for fiscal year 2004 intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement Account and Disability system.

In the past 2 years, our country has made very strong steps to improve our Nation's intelligence-gathering capabilities, as well as the analysis of the results of those intelligence-gathering capabilities. With that said, the attacks this morning in Istanbul are yet again a painful reminder that every day, we must not let down our guard. Rather, it emphasizes work that remains to be accomplished. We need to strengthen our intelligence capabilities and align them to deal with the threats that we face today.

This legislation convincingly moves us in the right direction by enhancing the depth and the capacity of all facets of our intelligence community. The bill provides for improved intelligence analysis and coordination. It continues the effort to increase our human intelligence resources, an area vital to the security of our Nation during the war on terrorism, as we have seen discussed virtually every day.

In addition, H.R. 2417 augments the information shared between Federal, State, and local governments and encourages strong cooperation in the pursuit of joint counterterrorism activities to keep our homeland safe.

Mr. Speaker, this bill makes possible the important work performed by dedicated intelligence professionals, people who are out and about right now taking very high risks to get us vital information so the right decisions can be made to nip terrorism in the bud before it strikes us again. It is the product of a bipartisan agreement that we deal with today and, as I stated previously, another prudent step in the right direction for developing our capabilities in the intelligence community.

For these reasons, I urge my colleagues to vote in support of this rule that will provide them with a fair forum for debate on this matter.

Mr. Speaker, I reserve the balance of my time.

Mr. HASTINGS of Florida. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, first, let me thank my good friend, the gentleman from Sanibel, Florida (Mr. GOSS) for yielding me this time. It is a pleasure to serve with the gentleman on both the Committee on Rules and the Permanent Select Committee on Intelligence and, as I said last night, not in a self-serving way, I do not know of any two committees which work harder or more diligently than the two on which the gentleman and I serve. It turns out that we are the only two Members on both of those committees, and what I said last night is we must be gluttons for punishment.

Mr. Speaker, I rise in support of this rule, providing for the consideration of the conference report to accompany H.R. 2417, the Intelligence Authorization Act for Fiscal Year 2004. This bill authorizes classified amounts in fiscal year 2004 for 14 United States intelligence agencies and intelligence-related activities of the United States Government, including the Central Intelligence Agency and the National Security Agency, as well as foreign intelligence activities of the Defense Department, FBI, State Department, Homeland Security Department, and other agencies.

Members who wish to do so, and I urge Members to do this if they have concerns, can go to the Permanent Select Committee on Intelligence office to examine the classified schedule of authorizations for the programs and activities of the intelligence and intelligence-related activities of the national intelligence program. As I said, this includes authorizations for the CIA, as well as the foreign intelligence and counterintelligence programs within, among others, the Department of Defense, NSA, Department of State, Treasury and Energy, and the FBI. Also included in the classified documents are the authorizations for the tactical intelligence and related activities and joint military intelligence program of the Department of Defense.

The measure covers specific and general intelligence operations including all of our operations that we put forward in any manner. Today, more than ever, we must make the creation of a strong and flexible intelligence apparatus one of the highest priorities of this body. The terrorist attacks of September 11, combined with the continuing threat of further attacks, underscore the importance of this legislation. I am pleased that it has been brought to the floor in a truly bipartisan manner. Thanks to the gentlewoman from California (Ms. HARMAN), the ranking member, and the gentleman from Florida (Chairman GOSS) and all of the members of the Permanent Select Committee on Intelligence and the specific subcommittees, a good job has been done on behalf of this country.

Let me say though, Mr. Speaker, that just because this is brought here in a bipartisan manner does not mean that it is a perfect bill; far from it. There are several areas that many of us would have liked to have seen improved. One of them that we have an exacting concern about is the expansion of the executive authorities under section 374, the amendment of the National Financial Services Act. We feel that that bears further scrutiny and certainly, without judicial review in that section, could pose problems at some point in our future. It is something that many of us will continue to review.

We also felt very strongly, and I thank my colleague, the gentleman from New Jersey (Mr. HOLT) who will speak specifically to it, that we should emphasize the area of language ability in a more dramatic fashion.

Mr. Speaker, this bill provides authorizations and appropriations for some of the most important national security programs in this great country. Any hesitation by this body in passing it would be a disservice to the American people. I urge my colleagues to support this rule and the underlying conference report.

Mr. HASTINGS of Florida. Mr. Speaker, I am pleased to yield 3 minutes to the gentleman from New Jersey (Mr. HOLT), my good friend.

Mr. HOLT. Mr. Speaker, I thank my friend, the gentleman from Florida for yielding me this time, and I thank him for his good work not only on the Committee on Rules, but also on the Permanent Select Committee on Intelligence.

As he said, I would welcome the opportunity later to speak about the need to have better training in critical languages here in the United States, but at the moment, I would like to talk about something that is relevant to the rule and to the Committee on Rules.

Here in Congress we have a responsibility, not only to appropriate funds, to authorize those funds, but also to oversee their expenditure. It is a sacred responsibility to deal with other people's money. It is a difficult job.

Now, in the areas of transportation and the Department of the Interior and other areas, we are assisted by millions of engaged citizens who keep an eye out for waste or misguided programs or programs that are less than well-thought-out. We do not, in classified programs, have that advantage, so it falls to us and our staff. We have an excellent staff that keeps tabs on the multifarious programs of the intelligence community. We are blessed with a chairman who has an agreeable personality and demeanor and wields his gavel with equanimity, and an excellent ranking member who keeps us on track. But we have a difficult job under the best of circumstances to oversee the intelligence programs.

It is made almost impossible when large fractions of the intelligence budget come through special appropriations, not through the normal course, not through the normal authorization and appropriation process, when in emergency allocations, money is put in without any previous oversight.

So as I speak in favor of the authorization bill that we are considering today and hope that we approve the rule so that we can get to the debate and approval of this authorization bill, I would ask the Committee on Rules to use its considerable influence in the future to see that we do not appropriate large sums of money for intelligence and other operations without going through the customary and necessary authorization process. We have done that over and over again in recent years, and it is a disservice to the intelligence community and a disservice to the American people. So again, I ask the Committee on Rules to use its considerable influence to see that we not fall into that problem.

Mr. GOSS. Mr. Speaker, I am pleased to yield such time as he may consume to the gentleman from Nevada (Mr. GIBBONS), the distinguished chairman of our Subcommittee on Human Intelligence, Analysis and Counterintelligence.

Mr. GIBBONS. Mr. Speaker, I thank my colleague for yielding me this time.

I want to rise in strong support of the rule for the authorization of the intelligence bill, H.R. 2417. I want to take just a moment to explain the issue of compensation reform which I think is important and critical to the future of the intelligence community.

Over the years we have had a system of pay for the men and women who are doing the hard work of gathering intelligence for the people of this country.

□ 1045

And yet we have not been able to find a way to adequately compensate them. These are individuals who are dedicated to this mission. They are not there because they want more money. They are there because they like what they do. They feel it is important for the future of this country and for the security of the American people. We have opportunities now to make sure that when we pay these individuals, we pay them correctly, we pay them adequately for their services. It is important that Congress continue this oversight.

We have an important part of this bill that addresses the issue of compensation reform. I am hoping that all our colleagues will rise and support this bill because of the important aspect of compensation reform for the men and women who are doing the valiant job of representing this country in faraway places in the dark of night, doing things that most other people would not do. These are true heroes in the American legend. We should all stand up and thank them for the work they have done. And I thank the gentleman from Florida (Chairman GOSS) for the opportunity to speak out on this rule and hope that everyone will support the rule.

Mr. HASTINGS of Florida. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from Texas (Mr. REYES), my good friend.

Mr. REYES. Mr. Speaker, I thank the gentleman from Florida (Mr. HASTINGS) for yielding, and I also want to commend our chairmen and ranking members for the great job that they do under what, I think, are very difficult circumstances. And I would also associate myself with the comments of my colleague, the gentleman from Nevada (Mr. GIBBONS), about giving good compensation for great work that is being done around the world for our national security by the intelligence community employees.

Having said that, I also want to state that I rise in strong support of this rule for H.R. 2417, but I also want to note that there are many of us that have concerns about issues that are vitally important to our national security, the lack of diversity in the intelligence community, and certainly the lack of a good solid plan to diversify and understand and recruit people that know and understand and speak different languages and come from different cultures. Those are critical and important in light of the attacks of September 11.

I would urge everyone to support this rule, but at the same time I also think it is vitally important that we continue to focus. And as my colleague, the gentleman from New Jersey (Mr. HOLT), made mention, it is difficult in this environment because we operate in a closed oversight manner and we do not have the benefit of outside input and scrutiny. So it is critical.

And I know that our chairman, the gentleman from Florida (Mr. GOSS), and the ranking member are committed to continue to work in these two critical areas, diversity and language proficiency. So with that, Mr. Speaker, I appreciate the opportunity to share my thoughts.

Mr. HASTINGS of Florida. Mr. Speaker, I have no further speakers, and I yield back the balance of my time.

Mr. GOSS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I certainly want to associate myself with the remarks of the gentleman from New Jersey (Mr. HOLT), his remarks about a concern about disenfranchising authorizing committees by the use of supplemental appropriations and other such matters as has sometimes happened. I do believe that the authorizing committees provide a critical contribution, a valuable contribution to the legislation of this institution. And I think it is unfortunate that sometimes in the press of business that we sometimes bypass that wisdom and that contribution because of urgency or other matters, which are understandable, but which should be an aberration rather than the practice.

And I can assure the gentleman from New Jersey (Mr. HOLT) and others who are interested that I am going to be spending some time and, hopefully, get a point or two across on the Committee on Rules that our view is that regular order is a whole lot better than supplemental appropriations.

The second thing I wanted to point out, very briefly, I am well aware this is not a perfect bill. The gentlewoman from California (Ms. HARMAN) and I and the members of the committee have worked very hard. We have excellent staff. This is not a perfect bill. It is a very, very good bill. It deserves the attention of the Members on the floor today. Certainly the rule is appropriate to bring it forward.

I think I can promise on behalf of the gentlewoman from California (Ms. HARMAN) and all the Members that the minute this authorization bill passes we start on the next authorization bill. And there is plenty to be done.

There are a number of things we will hear about in the debate later today. These are things that we already have taken aboard, and we will be pushing hard on. So I am convinced that from the legislative perspective we are doing the job that the people of this country have asked us to take on in the oversight, and I am very proud to be part of that effort.

Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered.

The resolution was agreed to.

A motion to reconsider was laid on the table.

PROVIDING FOR CONSIDERATION OF H.J. RES. 78, FURTHER CONTINUING APPROPRIATIONS, FISCAL YEAR 2004

Mr. LINDER. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 450 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 450

Resolved, That upon the adoption of this resolution it shall be in order without intervention of any point of order to consider in the House the joint resolution (H.J. Res. 78) making further continuing appropriations for the fiscal year 2004, and for other purposes. The joint resolution shall be considered as read for amendment. The previous question shall be considered as ordered on the joint resolution to final passage without intervening motion except: (1) one hour of debate on the joint resolution equally divided and controlled by the chairman and ranking minority member of the Committee on Appropriations; and (2) one motion to recommit.

The SPEAKER pro tempore (Mr. BASS). The gentleman from Georgia (Mr. LINDER) is recognized for 1 hour.

Mr. LINDER. Mr. Speaker, for purposes of debate only, I yield the customary 30 minutes to the gentleman from Texas (Mr. FROST), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Mr. Speaker, H. Res. 450 is a closed rule that provides for the consideration of H.J. Res. 78, a continuing resolution that will ensure further appropriations for fiscal year 2004.

The rule provides for 1 hour of debate in the House equally divided and controlled by the chairman and ranking minority member of the Committee on Appropriations. The rule waives all points of order against consideration of the joint resolution and provides for one motion to recommit.

Mr. Speaker, the provisions of the most recent continuing resolution, H.J. Res. 75, are scheduled to expire this Friday, November 21. The House Committee on Appropriations continues to work hard to complete the unfinished appropriations business of Congress, and we are hopeful that this work can be completed in the coming days. The resolution before us today, H.J. Res. 78, ensures funding through this weekend until November 23.

The House of Representatives passed all of its fiscal year 2004 appropriations bills long ago. We should complete Foreign Operations, Transportation-Treasury appropriate bills in the very near future. In addition, negotiations are under way to complete Agriculture, VA–HUD, Commerce-Justice-State, Labor-HHS, and the District of Columbia appropriations bills as well. However, to ensure that essential government services continue to operate while the omnibus appropriations bill is completed, this rule makes in order another continuing resolution to give us the additional time to complete the appropriations process in an orderly manner.

Mr. Speaker, under the joint resolution that H.J. Res. 450 makes in order, the provisions of the most recent continuing resolution will be extended for 2 more days. The Committee on Rules approved this rule last night. I urge my colleagues to join me in supporting its passage.

Mr. Speaker, I reserve the balance of my time.

Mr. FROST. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, here we go again. Another month has passed and this Republican government still refuses to do its most basic job, funding the Federal Government that they control. That is why we are here, once again, to pass yet another short-term continuing resolution to keep Republican incompetence from shutting down the Federal Government.

Mr. Speaker, I do not know why Republicans refuse to do the job taxpayers pay them for, especially while millions of those same taxpayers cannot find jobs on their own. Perhaps they are so busy twisting arms to dismantle Medicare and force seniors into HMOs that they cannot be bothered with deciding how badly to shortchange education in this year's spending bills. Or maybe the White House has been consumed with spending their expensive efforts to rebuild Iraq that they do not have time to worry about America. Who knows. But it is clear that this Republican government has stopped working for the American people.

Mr. Speaker, I do not know if you watched "West Wing" last night on television, but actually the subject of the "West Wing" program was this exact issue, a continuing resolution. And at that point you had a Republican Congress trying to blame a Democratic President for closing down the government. But here, of course, we have a Republican Congress and a Republican President. So what is going on here? Republican President, Republican Congress, and we still have to have a short-term continuing resolution because those folks cannot do their job.

Just take a look at the record. Today, millions of hard-working Americans no longer share in the prosperity that they enjoyed during the Democratic-led economic boon of the 1990s. In fact, since the Republican Party took over the government nearly 3 years ago, more than 3 million American jobs have been lost in the private sector. Or to put it another way, since George W. Bush got his job, millions of Americans have lost their jobs. That is the worst jobs record of any President since Herbert Hoover in the Great Depression.

Over the same period, Republican fiscal irresponsibility has turned record surpluses into astronomical and out-of-control deficits, increasing the death tax on all Americans and threatening the future of Medicare and Social Security. In the private sector, Mr. Speaker, that kind of failure would get you fired. But Republicans are counting on their special interest friends to save their political skins. And they have spared no taxpayer expense to do their work.

Take, for example, the small elite group of big contributors who fund Republican campaigns like the Bush campaign Pioneers and now the Bush campaign Rangers. They are undoubtedly happy because this Republican government has drained the U.S. Treasury by repeatedly passing expensive tax breaks for the wealthiest few. And earlier this week Republicans gave big polluters a pass to keep fouling the air of some of America's major metropolitan areas, including my home in north Texas.

Now, Mr. Speaker, Republicans are desperately trying to pull the wool over the eyes of America's seniors so that they can shower billions of dollars on HMOs, insurance companies, and the big drug companies. Under the Republican plan, millions of senior citizens would pay more and get less for Medicare. Up to one in four Medicare beneficiaries would actually pay more for prescription drugs than they do right now. Up to 7 million seniors would be forced to join an HMO and give up their choice of doctor or pay higher Medicare premiums. Between 2 and 3 million retirees would lose the drug coverage they now get from their former employers. And millions of seniors would go without drug coverage for months each year and be forced to pay premiums year round even when they are not getting any drug benefits.

While seniors lose under the Republican plan, drug companies and HMOs win big. Republicans are giving insurance companies a $12 billion slush fund. They are giving big drug companies $139 billion in windfall profits because they are actually making it illegal for Medicare to negotiate lower prescription prices for seniors. That is right, Mr. Speaker, Republicans can find billions of dollars for HMOs and drug companies, but they cannot afford year-round drug coverage for senior citizens. No wonder Republicans do not want their plan to take effect until after the 2004 elections. They are afraid that once seniors sit down and do the math they will see the Republicans have sold them a bill of goods.

This kind of outrage, Mr. Speaker, is simply business as usual under this Republican government. Nothing gets done for the American people, but Republicans and their allies do plenty of harm to the American people. It is a shameless abuse of power, Mr. Speaker; and the American public are the victims.

Meanwhile, we have before us another 2-day continuing resolution, which is the subject of this rule today.

Mr. Speaker, I reserve the balance of my time.

□ 1100

Mr. LINDER. Mr. Speaker, I reserve the balance of my time.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentleman from Wisconsin (Mr. OBEY), the ranking member of the Committee on Appropriations.

Mr. OBEY. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, I simply take the time to indicate that the House has no choice but to proceed to pass the short-term CR in hopes that the House will come closer to finishing its work by the time we have to pass another one. But let me also say that I would hope that we would use the time constructively so that Members still can get out of here for the year on a reasonable schedule.

I note last night, for instance, that we are within a hair's breadth of having total agreement on the VA-HUD appropriations and on the CJ bill. The transportation bill has already been filed, and it is hoped that the foreign ops bill will be filed and acted upon also. That would mean that we could reduce considerably the number of bills that would have to go into the omnibus. I have no particular ax to grind about whether they do or they do not, but it would seem to me that it would be one way to at least assist on unsnarling what remains to be done before we finish.

With that, I would simply say when the CR comes, I hope that we could dispose of it in a favorable fashion so we can get on with the remainder of our work for this week.

Mr. LINDER. Mr. Speaker, I have no further speakers. I reserve the balance of my time.

Mr. FROST. Mr. Speaker, I yield myself such time as I may consume.

Let us be very clear about what is going on here. The current continuing resolution runs out tomorrow. The Republican leadership is giving itself another 2 days. So by passing this next CR, that takes us through Sunday. They will not tell us when the next CR, how far it will go, whether we will be here Saturday, Sunday, Monday, Tuesday, Wednesday of next week doing the people's business. They will not tell us when the omnibus bill is going to come to the floor or whether it will come to the floor. They will not tell us how long the next CR will run, whether it will run to December 8 or whether it will run until some time in February. Either they simply do not know, or they will not tell. Either way, they make it very difficult to legislate in an orderly fashion.

We would all like to wind up the business for this year. I would hope that the Republican leadership can finally get their act together, bring the remaining appropriations bills or an omnibus bill to the floor in an orderly way, so that we can conclude the people's business this year and not continue to operate on a 2- or 3-day CR while the Republicans try and figure out what their next step is.

Mr. Speaker, I yield back the balance of my time.

Mr. LINDER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, let me just say to the gentleman from Texas (Mr. FROST) that it is not that we do not want to inform them. It is that we do not know.

We are dealing with people in the other body who have not given us any indication of when they are prepared to move. But I will say that I agree 100 percent with the gentleman from Wisconsin (Mr. OBEY). We are moving piece by piece on these. And our side would like very much to pass them one at a time and get out of here Friday night or Saturday. I do not think it will be that soon on Friday night, but we are very close to getting our work done on the appropriations process so we would like to do that one at a time.

Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered.

The SPEAKER pro tempore (Mr. BASS). The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. FROST. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

Pursuant to clause 8 of rule XX, this 15-minute vote on House Resolution 450 will be followed by 5-minute votes on the following motions to suspend the rules:

S. 286, by the yeas and nays;

S. 686, by the yeas and nays.

The vote was taken by electronic device, and there were—yeas 406, nays 2, not voting 26, as follows:

[Roll No. 645]

YEAS—406

Ackerman
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Costello
Crane
Crenshaw
Crowley
Culberson
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Flake
Foley
Forbes
Ford
Frank (MA)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler

Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Israel
Issa
Istook
Jackson (IL)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Paul
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauzin
Taylor (MS)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NAYS—2

Filner
Jackson-Lee (TX)

NOT VOTING—26

Abercrombie
Aderholt
Clay
Cox
Cramer
Cubin
Cummings
Engel
Fletcher
Fossella
Franks (AZ)
Gephardt
Herger
Isakson
Jones (OH)
Lewis (GA)
Markey
Meek (FL)
Nethercutt
Radanovich
Rogers (AL)
Sherman
Tauscher
Taylor (NC)
Wexler
Whitfield

☐ 1125

Ms. JACKSON-LEE of Texas changed her vote from "yea" to "nay."

Mr. MORAN of Virginia changed his vote from "nay" to "yea."

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. FOSSELLA. Mr. Speaker, on rollcall No. 645 I was unavoidably detained. Had I been present, I would have voted "yea."

BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES PREVENTION ACT OF 2003

The SPEAKER pro tempore (Mr. BASS). The unfinished business is the question of suspending the rules and passing the Senate bill, S. 286.

The Clerk read the title of the Senate bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Florida (Mr. BILIRAKIS) that the House suspend the rules and pass the Senate bill, S. 286, on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 415, nays 1, not voting 18, as follows:

[Roll No. 646]

YEAS—415

Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Costello
Cramer
Crane
Crenshaw
Crowley
Culberson
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Filner
Flake
Foley
Forbes
Ford
Fossella
Frank (MA)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NAYS—1

Paul

NOT VOTING—18

Abercrombie
Clay
Cox
Cubin
Cummings
Engel
Fletcher
Franks (AZ)
Gephardt
Herger
Isakson
Markey
McDermott
Radanovich
Rogers (AL)
Sherman
Taylor (NC)
Wexler

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. BASS) (during the vote). Members are advised that 2 minutes remain in this vote.

□ 1135

Mr. SMITH of Michigan changed his vote from "nay" to "yea."

So (two-thirds having voted in favor thereof) the rules were suspended and the Senate bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

POISON CONTROL CENTER ENHANCEMENT AND AWARENESS ACT AMENDMENTS OF 2003

The SPEAKER pro tempore. The unfinished business is the question of suspending the rules and passing the Senate bill, S. 686, as amended.

The Clerk read the title of the Senate bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Florida (Mr. BILIRAKIS) that the House suspend the rules and pass the Senate bill, S. 686, as amended, on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 420, nays 1, not voting 13, as follows:

[Roll No. 647]

YEAS—420

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Filner
Flake
Foley
Forbes
Ford
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NAYS—1

Paul

NOT VOTING—13

Clay
Cubin
Cummings
Engel
Fletcher
Gephardt
Herger
Isakson
Olver
Radanovich
Rogers (AL)
Sherman
Wexler

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised that 2 minutes remain in this vote.

□ 1146

So (two-thirds having voted in favor thereof) the rules were suspended and the Senate bill, as amended, was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. YOUNG of Florida. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and that I may include tabular and extraneous material on H.J. Res. 78.

The SPEAKER pro tempore (Mr. BASS). Is there objection to the request of the gentleman from Florida?

There was no objection.

FURTHER CONTINUING APPROPRIATIONS, FISCAL YEAR 2004

Mr. YOUNG of Florida. Mr. Speaker, pursuant to House Resolution 450, I call up the joint resolution (H.J. Res. 78) making further continuing appropriations for the fiscal year 2004, and for other purposes, and ask for its consideration.

The Clerk read the title of the joint resolution.

The text of House Joint Resolution 78 is as follows:

H.J. RES. 78

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That Public Law 108–84 is amended by striking the date specified in section 107(c) and inserting "November 23, 2003".

SEC. 2. Section 8144(b) of the Department of Defense Appropriations Act, 2003 (Public Law 107–248), as amended by Public Law 108–84, is further amended by striking "November 21, 2003" and inserting "November 23, 2003".

The SPEAKER pro tempore. Pursuant to House Resolution 450, the gentleman from Florida (Mr. YOUNG) and the gentleman from Wisconsin (Mr. OBEY) each will control 30 minutes.

The Chair recognizes the gentleman from Florida (Mr. YOUNG).

Mr. YOUNG of Florida. Mr. Speaker, I yield myself such time as I may consume.

And I will not consume very much time because this continuing resolution simply extends the existing CR until midnight Sunday, this weekend. All conditions, by the way, of the original CR would still exist on this CR. We are reaching the point where we can conclude the appropriations process. Most of the appropriations issues have already been solved and are prepared to be written into a final bill. There are some outstanding issues at a level higher than the Committee on Appropriations that we are trying to apply a little pressure to get settled. Other than that, Mr. Speaker, I would give the House the word that I think we can get this done by Sunday evening, but maybe not. We will do the very best that we can.

As one can imagine, there are an awful lot of issues that we have resolved and are continuing to resolve. We are working steadily. We had a good conference last night. We cleared up a lot of the issues. So, Mr. Speaker, not much more can be said about this.

Mr. Speaker, I reserve the balance of my time.

Mr. OBEY. Mr. Speaker, I simply urge a "yes" vote, and I yield back the balance of my time.

Mr. YOUNG of Florida. Mr. Speaker, I ask for a "yes" vote, and I yield back the balance of my time.

The SPEAKER pro tempore. All time for debate has expired.

The joint resolution is considered read for amendment.

Pursuant to House Resolution 450, the previous question is ordered.

The question is on engrossment and third reading of the joint resolution.

The joint resolution was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the joint resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. OBEY. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this question will be postponed.

GENERAL LEAVE

Mr. GOSS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on the conference report on H.R. 2471.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Florida?

There was no objection.

CONFERENCE REPORT ON H.R. 2417, INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 2004

Mr. GOSS. Mr. Speaker pursuant, to House Resolution 451, I call up the conference report on the bill (H.R. 2417) to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes, and ask for its immediate consideration.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Pursuant to House Resolutions 451, the conference report is considered as having been read.

(For conference report and statement, see proceedings of the House of November 19, 2003, at page H 11605.)

The SPEAKER pro tempore. The gentleman from Florida (Mr. GOSS) and the gentlewoman from California (Ms. HARMAN) each will control 30 minutes.

The Chair recognizes the gentleman from Florida (Mr. GOSS).

Mr. GOSS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I am pleased to bring before the House the conference report for H.R. 2417, the Intelligence Authorization Act for Fiscal Year 2004. And I want to personally thank members and staff of the committee for their industry, their skill, their professionalism, and their dedication in crafting what I believe is a strong nonpartisan bill which will see us well through the year.

Perhaps the job was made a bit more difficult this year given the attempts by some in the media and elsewhere to throw American intelligence capabilities into the meatgrinder of partisan Presidential politics, but I am confident that a review of this legislation will show just how successful the members of the House Permanent Select Committee on Intelligence have been in putting the Nation's security needs first, rejecting the divisiveness, the partisan trickery and treachery that has been elsewhere.

H.R. 2417 authorizes funding for all intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement Disability System. Generally speaking, we have authorized funding for the National Foreign Intelligence Program in fiscal year 2004 at a level slightly above the President's request and substantially equal to that provided in the appropriations process.

There is much in the bill to recommend it to Members of the House. I would like to mention just a few of the important provisions and highlights.

First and foremost, this conference report supports the men and women in the intelligence community who are dedicated to protecting our Nation's citizens and their freedom, many of whom do this work under a shroud of secrecy, carrying out very tough tasks and, in fact, heroic deeds with little, if any, recognition.

Intelligence is the fundamental element of the global war on terrorism. It is crucial to America's efforts in the hot parts of the war such as Afghanistan and Iraq, just as it is essential to protecting Americans overseas and at home, that is, offense and defense. This conference report funds many important counterterrorism programs.

Also of note in the fight against terrorism, we are witnessing history being made this day. This is the first intelligence bill to authorize funds for the intelligence functions of the new Department of Homeland Security. We on the committee are acutely aware of the vital need for intelligence community resources to be effectively marshaled in protecting the homeland. In the past year, the Federal Government has moved to realign national resources to better leverage capabilities in the war on terrorism. We have been hard at work on that. In addition to the establishment of the Information Analysis and Infrastructure Protection Directorate over at the Homeland Security, the Terrorist Threat Integration Center was created and is under the control of the Director of Central Intelligence, and a new Terrorist Screening Center is being established and put to work at the FBI.

These resources, among others that we have been working on previously, will require continued investment and strong leadership to overcome a number of challenges including, by the way, the challenge of being the first of their kind. Our committee will continue to be actively engaged in defining how the intelligence community is evolving to meet the challenges of homeland security. We actually have no greater obligation.

Counterterrorism and counterintelligence are the driving forces behind section 374 of the conference report. This provision brings the definition of "financial institution" up to date with the reality of the financial industry. The current definition in the Right to Financial Privacy Act was crafted back in 1978. That was a quarter of a century ago. This provision will allow those tracking terrorists and spies to "follow the money" more effectively and thereby protect the people of the United States more effectively.

This conference report contains a provision that has received some degree of attention, section 405 dealing with the Central Intelligence Agency's compensation reform proposal. The conferees support the idea that improvements can be made, should be made, in the old GS system of pay and promotion. I certainly feel we can do better by the officers at CIA. However, it is important to replace the outdated system with a better one, not just a new one. So section 405 will assist CIA management in finding the right system by allowing important fine-tuning and workforce buy-in.

The conferees were concerned that CIA managers were rushing a bit into the implementation of an undertested and unevaluated compensation system. To address this concern, section 405 delays slightly the implementation of CIA's compensation reform plan to allow time for the review, evaluation, and for adjustment, where needed, of the compensation program currently being tested in a congressionally mandated pilot program which we have all been very interested in and are following very closely. I think the final result will be a better system for managers and employees alike and a significant improvement for the institution. If it takes a month longer to get there, I think it is going to be well worth the investment.

I could go on for some time detailing many other worthy provisions, but I will conclude my opening remarks here with the observation that this conference report reflects the committee's view that the U.S. intelligence community is making progress in many areas. In the past 3 years, it has recovered to a degree from the devastating cutbacks and budget personnel capabilities and frankly flagging political support that occurred during the mid-1990s. But as I have said, it will be a long road to recovery, and it takes time to build intelligence capability. It will take years of sustained effort and attention and reinvigorated political backing to rebuild a fully capable intelligence community that does all the things we need it to do for us. We are on the road to recovery. I am proud of that. Investment in timely intelligence is the best investment for our homeland and national security, and I hope most Members agree with that.

This conference report represents progress on that road, and I urge the House to adopt it.

Mr. Speaker, I reserve the balance of my time.

Ms. HARMAN. Mr. Speaker, I yield myself such time as I may consume.

I rise in support of H.R. 2417. Earlier today, several large truck bombs exploded in Istanbul killing the British Consul General and dozens of others, wounding at least 450, and causing substantial property damage. The attacks appear to have the earmarks of al Qaeda, and they make today's action even more pressing.

This bill is not perfect, but it represents a lot of hard work to come to bipartisan agreement on tough issues. In the past 2 years, the Permanent Select Committee on Intelligence has completed a joint 9–11 inquiry and is currently reviewing prewar Iraq intelligence. These two reviews, among other activities we have undertaken, have pinpointed deficiencies in collection, analysis, and dissemination of intelligence that cannot be fixed one brick at a time; nor can meaningful intelligence improvements be made simply in response to the latest crisis. This bill represents progress; but, Mr. Speaker, systemic transformation is needed, and it hopefully will be the committee's primary focus in the coming year.

I am particularly satisfied that this bill requires a lessons learned study on Iraq intelligence as soon as possible and no later than a year from now. This House, just 2 days ago on a virtually unanimous basis, instructed the conferees to include this language, and we did. In the course of 6 months of review, the House Permanent Select Committee on Intelligence on a bipartisan basis has identified serious shortcomings in the prewar intelligence on Iraq's weapons of mass destruction and ties to terrorism. A bipartisan letter earlier this fall details the preliminary view that the gentleman from Florida (Chairman GOSS) and I hold. My own view is that estimates were substantially wrong and at a minimum the intelligence community overstated the strength of underlying data supporting its conclusions. Asking the intelligence community to do an introspective study is not an unreasonable request to ensure the credibility of our national security strategies. It will also ensure our troops and our leaders are served by the best intelligence.

In intelligence collection, the bill funds initiatives to improve technical and human collection. It pushes the intelligence community to hire and develop officers who speak foreign languages and who have deep experience in other countries and cultures, important issues raised in an unprecedented public hearing a few weeks ago.

□ 1200

In intelligence analysis and dissemination, the bill provides a new infusion of resources to modernize analyst infrastructure, including new information technology tools, training, and hiring new analytic expertise. There is also strong support for improving information-sharing across the IC and with State and local law enforcement partners.

The bill provides funds to support integration of watch list efforts across the Terrorist Threat Information Center, the Department of Homeland Security, the Terrorist Screening Center, and other relevant players. The bill also authorizes the Secretary of Homeland Security, working with the Director of Central Intelligence and the Attorney General, to establish a training program to help local and private sector officials identify threats and report information to Federal partners. Information-sharing, as we have shown again and again and again, was a primary intelligence failure pre-9/11. This bill goes a long way to fix it.

I am pleased that the bill addresses the development of data mining efforts for fighting terrorism, while maintaining adequate privacy protections for U.S. persons. The defense appropriations conference report, which we have already voted on, terminated DOD's Terrorist Information Awareness program, but it transferred funds and projects from that program to the intelligence community. For these programs, there are restrictions on mining databases containing information on U.S. persons, and I applaud those restrictions. But data mining, properly applied, is an excellent way to isolate who the bad guys are. It is also important to ensure that research and development on data mining tools continues, even while deployment awaits the full development of policies, guidelines, and procedures for use of these tools.

Let me be clear: I do not support deployment without limitations, but I think that R&D continues to be important. Responsible, respected groups like the Markle Foundation Task Force on National Security in the Information Age and the Center for Democracy and Technology, along with scholars at the Brookings Institution and the Heritage Foundation, all have concluded that data mining tools can be enormously beneficial for our national security, and that these operations can be done in a way that preserves privacy and protects civil liberties.

But it will not happen automatically. It will require real work from the administration, especially in view of the hole it dug for itself over the TIA project. The bill tasks the administration to come to grips with the policy issues posed by advanced data mining technology, requiring the administration to report to Congress with proposed modifications to laws and policies, and I hope the administration will embrace this opportunity.

The bill contains a provision to expand the definition of "financial institution" in the context of the FBI's authority to issue national security letters which compel the production of financial records without a warrant. The expanded definition closes a potentially significant loophole in the government's ability to track terrorist financing. I agree with the gentleman from Florida (Chairman GOSS) on this point. On the other hand, however, I worry that language in the bill is not as clear as it needs to be that this authority to obtain records only pertains to the customer's financial relationship with institutions. I would have preferred this clarification to be in the statute. It is in the report language. I would have preferred the report language to be even stronger, and I remain concerned that the expanded definition leaves the potential, hopefully that will never be realized, for abuse in a classic fishing expedition.

The bill authorizes new personal services contracting for the FBI to allow it to more efficiently and flexibly surge capabilities against new missions. These powers granted to the FBI must not become a substitute for hiring full-time employees for the Bureau's long-term strategic needs or lead to other abuses in hiring practices. I spoke earlier this week with FBI Director Mueller and received his assurances that he will personally review this program and be sensitive to potential abuses. It is important to have strong standards and criteria alongside the increased flexibility.

The gentleman from Florida (Chairman GOSS) has said, and I agree, that intelligence community reform, or transformation, must be a central focus of the committee next year.

Issues raised by our Iraq review and the Joint 9/11 Inquiry point to systemic challenges and raise fundamental questions of roles, missions, capabilities, and organization. These include whether the intelligence community should be headed by a Director of National Intelligence; whether the Nation would be best served by a domestic intelligence agency; the shortcomings of budgeting by supplemental; and our committee member, the gentleman from New Jersey (Mr. HOLT), made this point I thought quite effectively in our previous debate on the rule for this conference report. Also, strengthening the quality of HUMINT and other collection on hard targets; the roles and authorities of the Department of Defense in intelligence activities; and the roles and responsibilities of policy officials and intelligence analysts regarding objectivity of intelligence products.

Transforming the IC's approach to language and cultural expertise will also require special attention. I note the work of the gentleman from New Jersey (Mr. HOLT) and the gentleman from New York (Mr. BOEHLERT), two committee members, and strongly support the gentleman from Florida's (Chairman GOSS) proposal for a major initiative focused on building these skill sets.

In conclusion, Mr. Speaker, the best intelligence is key to stopping the insurgency and permitting reconstruction in Iraq today. It is key to addressing threats in Afghanistan today. It is key to countering threats from terrorism in Turkey and elsewhere today, and to addressing challenges in Iran and North Korea today and tomorrow. To produce less than our best intelligence is to protect national security less than is needed.

Mr. Speaker, it is an honor to serve as ranking member of this committee. Our 2004 authorization conference report was approved unanimously by our Members, and I urge its strong support.

Mr. Speaker, I reserve the balance of my time.

Mr. GOSS. Mr. Speaker, I am very pleased to yield 3 minutes to the distinguished gentleman from Nebraska (Mr. BEREUTER), the distinguished vice chairman of the committee who is also chairman of our Subcommittee on Intelligence Policy and National Security. He is indeed a busy man.

Mr. BEREUTER. Mr. Speaker, I rise in strong support of the authorization legislation, and I thank the chairman for yielding me this time.

The conference report takes important steps to strengthen the intelligence community's ability to provide global analysis. I think it is an excellent report and an excellent effort on the part of the chairman, ranking member, and all Members and our staffs.

We are all aware that we are waging an aggressive war against terrorism. In addition, U.S. military forces are fighting the remnants of the former regime of Saddam Hussein. Yet we have global interests, for despite the immediate threats that we face, we must not devote all of our intelligence energies to Iraq and al Qaeda.

Mr. Speaker, I want to focus my remarks on two primary points. The first is related to human intelligence. The gentleman from Nevada (Mr. GIBBONS), I am sure, will cover that subject very well, since it is a primary responsibility of the subcommittee he chairs, so I will move to the second area. This relates to attacking the terrorists' finances. The gentlewoman from California talked about that to some extent just a few minutes ago. The distinguished gentleman from Florida (Mr. GOSS) has been very supportive in the progress that is being made in this legislation through his leadership. I think the important point is what we have done through this legislation within the Treasury Department.

Terrorist networks like al Qaeda obviously cannot function without significant financial backing. These terrorists, supported by (A) a shadowy network of fund-raisers, money lenders and shakedown artists; (B) businesses and charities serving as front organizations; and (C) unscrupulous facilitators and middlemen.

Now, prior to the attacks of September 11, the Treasury Department was not organized or equipped to take steps such as the freezing of terrorist bank accounts or assets. Frankly, it has never been as high a priority in Treasury as it should have been. H.R. 2417, this bill, creates an Office of Intelligence and Analysis within the Department of Treasury headed by an Assistant Secretary and tasked with the receipt, analysis, and dissemination of relevant foreign intelligence and counterintelligence information. In short, the conference report makes the Department of Treasury a real player, which can be an effective partner agency, in the global war on terrorism. This Members extends his appreciation to the chairman and the ranking member of the Committee on Financial Services for working in a constructive manner to include this important provision in our legislation today. This Member also congratulates the staff for the exceptional work here.

I think that the leadership presented by the gentleman from Florida (Mr. GOSS), the chairman, and the distinguished gentlewoman from California (Ms. HARMAN), the ranking member, has been demonstrated in bringing forth a genuinely bipartisan product. The conference report is a very serious effort to improve our intelligence capacity. Each and every member of the committee and its staff dedicated long hours to the drafting of this legislation. Each member recognizes the importance of our actions and responsibilities and things yet to come. This body can justifiably, I believe, be proud of the efforts of the HPSCI in this case and, in particular, the leadership of the gentleman from Florida (Mr. GOSS) and the gentlewoman from California (Ms. HARMAN).

Mr. Speaker, this Member urges strong adoption of the conference report to H.R. 2417.

Together, these endeavors have severely tested the capabilities of our intelligence resources. However, America's interests remain global, and we must not devote all our energies to Iraq and al Qa'ida. The Intelligence Community must continue to provide timely, actionable intelligence on a host of potential threats—from nuclear proliferation threats on the Korean peninsula, to narco-traffickers in the jungles of Colombia, to collapsing regimes in West Africa.

Mr. Speaker, we live in a new world, and face new and more terrible threats. In many ways, information gathering was easier when the threat was the Soviet Union. Frankly, the Intelligence Community has been slow in adapting to this new environment. Our intelligence services did not reach out aggressively to recruit the "human intelligence" sources that could have provided us invaluable information. We lost far too many of the skilled analysts whose job is to provide early warning. H.R. 2417 provides much-needed funding to rebuild a dynamic, wide-ranging, global analytic capability. But we should be under no illusions—it takes years to develop skilled analysts who are able to "connect the dots" and provide our policymakers with timely information.

Ms. HARMAN. Mr. Speaker, it is my pleasure to yield 2½ minutes to the gentleman from Texas (Mr. REYES), a senior member of our committee.

Mr. REYES. Mr. Speaker, I thank the gentlewoman for yielding me this time.

First, Mr. Speaker, I would like to thank the chairman of our committee and ranking member for their commitment to working in a bipartisan manner on the very important work that this committee has to do.

I rise today in strong support of the conference report for H.R. 2417, the Intelligence Authorization Act of 2004. Conferees and staff worked together closely to craft a bill that provides new and better capabilities to fight the war in Iraq and the war on terrorism, as well as to address a range of global intelligence challenges that we, as a country, face today.

I want to highlight two features of this very important bill. The first one is the requirement that the Director of Central Intelligence submit an Iraq Lessons Learned Report to the intelligence committees as soon as possible. Tuesday we debated the merits of the lessons learned in Iraq. I argued that Iraq must not become another Vietnam. We need to know from the intelligence community what has and what has not worked, and what has and what has not gone well in Iraq. Better intelligence is essential to defeating the expanding insurgency that we are seeing there today. I am pleased that the bill underscores the urgency of intelligence lessons learned.

This bill also establishes a pilot project within the intelligence community to enhance the recruitment of individuals with diverse ethnic and cultural backgrounds, skill sets, and language proficiency. The House Permanent Select Committee on Intelligence recently held a rare public hearing on this very issue of diversity. A panel of experts highlighted the capabilities that a diverse workforce bestows upon the intelligence community. It brings added language capability and better understanding of foreign cultures. I am pleased that this bill encourages diversity in the intelligence community.

In a similar vein, this bill also fences a portion of the funds authorized for the community management account until the Director of Central Intelligence submits a report to this committee outlining his plan to improve diversity throughout the intelligence community.

I tried also to include in this bill conference language urging that the Drug Enforcement Agency to make funds available for the El Paso Intelligence Center's Open Connectivity project. That language unfortunately was not included. Nonetheless, I still feel that EPIC has an important role to play in countering terrorism, and I hope that it is recognized for that role in this committee and others in the near future.

Mr. GOSS. Mr. Speaker, I am pleased to yield 3 minutes to the distinguished gentleman from Nevada (Mr. GIBBONS), the chairman of our Subcommittee on Human Intelligence, Analysis and Counterintelligence, and a man who has carried some of the more difficult projects that we have had to deal with in this bill.

Mr. GIBBONS. Mr. Speaker, I rise in strong support of the Intelligence Authorization bill, and I want to thank my friend and colleague, the gentleman from Florida (Mr. GOSS), for granting me this time to speak on it.

This is a very good bill, Mr. Speaker. It represents a lot of hard work by very dedicated staffs on both sides of the aisle. It addresses intelligence needs that this committee has highlighted for many years. The good news is, Mr. Speaker, that some of the most crucial needs of our intelligence community, the human intelligence and analysis, are getting the funding and attention that they deserve. We are fighting a war on terrorism, and I cannot overemphasize how important human intelligence, also known under the acronym of HUMINT, is to the security of the American people and to our national interests.

The satellites of the Cold War were key intelligence collectors, and our current reconnaissance vehicles are even better today than they have ever been in the past. However, in the world we live in right now, an overreliance on overhead photography and other technical programs would be a mistake. They cannot provide America with plans and intentions of terrorists who plot in secret, hide in civilian populations, and communicate with messengers.

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What you have to have is HUMINT, collected by professionals possessing foreign language skills, foreign cultural knowledge, and specialized training necessary for success. This committee encourages the enhancement of these critical skills areas. And this bill authorizes essential funding needed to accomplish these goals.

The second crucial area in the war on terrorism is analysis. Our committee has expressed time and again the importance of a well-trained, experienced analytic cadre. Like the HUMINT capability, building a truly professional analytical cadre takes years of investment in people, technology, and training. The critical skill sets and professional cadres are still too thin and still too few in number. We are still paying the price for the mistakes of the mid-1990s. The good news is, Mr. Speaker, that this bill commits great resources to correct those mistakes.

CIA, FBI, Homeland Security, and other intelligence and law enforcement agencies desperately need qualified analysts. It takes years to develop them, but the development is under way. This committee has seen to that. And this bill is a key measure.

In conclusion, I want to emphasize that the bill before you will significantly help the intelligence agencies increase and sharpen their effectiveness, especially against terrorist groups.

I strongly support this measure, Mr. Speaker. I urge its passage and once again thank the chairman and the ranking member for their leadership in this.

Ms. HARMAN. Mr. Speaker, I yield 2 minutes and 10 seconds to the gentleman from Iowa (Mr. BOSWELL), our committee member who is the ranking member on the Subcommittee on Human Intelligence, Analysis and Counterintelligence.

Mr. BOSWELL. Mr. Speaker, I thank the gentleman from Florida (Chairman GOSS) and the gentlewoman from California (Ms. HARMAN), the ranking member, for their leadership and untiring efforts to work together and produce this very meaningful bill. Plus I have never seen better and more dedicated staff than I have seen on this committee, and I appreciate them very much.

It is basic: we have to have the best possible intelligence to enable our troops and protect our Nation again a basic must-do. So I rise in support of H.R. 2417, the Intelligence Authorization Act of Fiscal Year 2004. What is the bottom line of this bill? The bottom line is that it funds important new intelligence capabilities while demanding accountability and improvement in certain areas.

Here are three examples: first, the conference report requires the intelligence community to conduct a review of lessons learned for military operations in Iraq. Based on the committee's reviews so far of prewar intelligence on Iraq, there were some serious deficiencies in collection and analysis that needed to be fixed, must be fixed. The lessons learned provision is essential and will identify new tools and techniques needed.

Second, as the ranking member of the Subcommittee on Human Intelligence, Analysis and Counterintelligence, I want to strengthen HUMINT collection efforts around the world. In our efforts and briefings and in our committee members' oversight trips to Baghdad and other places, members have talked to dozens of intelligence officers who are fighting the war on terrorism and fighting to win the peace in Iraq. I admire their bravery, their patriotism, and their selfless dedication to duty.

This conference report provides them with tools they need to accomplish their mission. It expands language and cultural expertise in the intelligence agencies. It asks the administration to set up a process for reviewing the laws and guidelines associated with data mining. And it supports new tools for sharing information through the Terrorist Threat Integration Center and with local officials to the Department of Homeland Security and local FBI joint task force on terrorism.

Finally, the conference report includes measures that will strengthen the capabilities of defense human intelligence. Through further transformation and reform, defense HUMINT will become more flexible, agile, readily responsive to the Department of Defense intelligence requirements. This is a good bill that will protect Americans. I am pleased to support it.

Mr. GOSS. Mr. Speaker, I yield 4 minutes to the distinguished gentleman from Illinois (Mr. LAHOOD) who is the chairman of our Subcommittee on Terrorism and Homeland Security. And that subcommittee has, indeed, been hard at work.

Mr. LAHOOD. Mr. Speaker, I rise in support of the Intelligence Authorization Act for fiscal year 2004 and thank our chairman, the gentleman from Florida (Mr. GOSS), for yielding me this time.

I want to compliment the gentleman from Florida (Mr. GOSS) for his extraordinary leadership and the outstanding job that he does and also compliment our ranking member, the gentlewoman from California (Ms. HARMAN), for the good work that she does and the way in which both the chairman and the ranking member are able to work together. I too want to compliment our staff. I think they do a terrific job and work long hours on behalf of really tying to improve intelligence gathering and really keeping the Members posted on what is happening.

Never before have we needed or have we demanded so much of crucial importance from our intelligence community. The intelligence community provides the eyes, ears, and analytical brain power necessary to identify and prevent terrorist attacks. The cataclysmic events of September 11, 2001, provide a unique and compelling mandate for strong leadership and constructive change throughout the intelligence community. This bill adds to that impetus for change.

I believe our committee has authored legislation that strives to fully invest in and engage those economic, military, foreign policy, and law enforcement elements of our intelligence community in the war on terrorism. It strives to employ, integrate, and enhance the capability of the intelligence community to track down and destroy terrorist organizations both overseas and within the United States.

For instance, this legislation supports the attack on international financial support for terrorism, supports the unique analytical capabilities of the Office of Foreign Assets Control at the Treasury Department and further develops these capabilities by establishing the Office of Intelligence Analysis within the Treasury Department. The last measure will streamline and centralize the U.S. Government's capability to track terrorist financial networks around the globe.

As chairman of the Subcommittee on Terrorism and Homeland Security, I am acutely aware of the vital need for our intelligence resources to be marshaled not only on the international front but also in our homeland.

In order to defeat terrorism threats to our Nation, all elements of government must communicate and coordinate more effectively among themselves. The conference report supports efforts to encourage the flow of information, measures including FBI efforts to make internal, structural, and technological changes to improve and expand the use of data mining and other cutting-edge analytical tools; authority for the FBI director to enter into contracts for needed services like language skills, intelligence analysis, and other high-value requirements relate to the flow of information not already available; the creation and nurturing of the Terrorism Threat Integration Center as a central office to monitor threats to the Nation; the inauguration of the Department of Homeland Security's office of Information Analysis and Infrastructure Protection to facilitate timely sharing of relevant information with all appropriate Federal and State and, very importantly, local first responder authorities.

Our committees will continue to encourage the intelligence community development of clear policies and guidelines by which no resource is wasted, no credible terrorist threat left undetected, and threats to our homeland continue to diminish.

The House Permanent Select Committee on Intelligence is very proud of the men and women that serve in the war on terrorism. I am convinced that the bill will make them more effective in their efforts to defend our country. I urge our colleagues to support this legislation.

I would be remiss, though, if I did not say something about what has taken place in what I would characterize as the politicizing of the intelligence gathering in the other body. Specifically, the Senate Select Committee on Intelligence has, I believe, tried to use intelligence gathering as a political vehicle for nothing other than political gain against the President and his team. This is wrong and I decry those who want to use the intelligence efforts of this country for political gain.

These political efforts are unprecedented and I hope the embarrassment brought to bear on the Senate Select Committee on Intelligence will put an end to the charade that has taken place.

Mr. Speaker, at this point I will enter into the RECORD the memo that has been made public that came from the Senate Select Committee on Intelligence.

We have carefully reviewed our options under the rules and believe we have identified the best approach. Our plan is as follows:

(1) Pull the majority along as far as we can on issues that may lead to major new disclosures regarding improper or questionable conduct by Administration officials. We are having some success in that regard. For example, in addition to the President's State of the Union speech, the Chairman has agreed to look at the activities of the Office of the Secretary of Defense (e.g. Rumsfeld, Feith and Wolfowitz) as well as Secretary Bolton's office at the State Department. The fact that the Chairman supports our investigations into these offices, and cosigns our requests for information, is helpful and potentially crucial. We don't know what we will find, but our prospects for getting the access we seek is far greater when we have the backing of the Majority. (Note: We can verbally mention some of the intriguing leads we are pursuing).

(2) Assiduously prepare Democratic "additional views" to attach to any interim or final reports the committee may release. Committee rules provide this opportunity and we intend to take full advantage of it. In that regard, we have already compiled all the public statements on Iraq made by senior Administration officials. We will identify the most exaggerated claims and contrast them with the intelligence estimates that have since been declassified. Our additional views will also, among other things, castigate the majority for seeking to limit the scope of the inquiry. The Democrats will then be in a strong position to reopen the question of establishing an independent commission (i.e. the Corzine amendment).

(3) Prepare to launch an Independent investigation when it becomes clear we have exhausted the opportunity to usefully collaborate with the Majority. We can pull the trigger on an independent investigation of the Administration's use of intelligence at any time—but we can only do so once. The best time to do so will probably be next year either:

(A) After we have already released our additional views on an interim report—thereby providing as many as three opportunities to make our case to the public: (1) Additional views on the interim report; (2) announcement of our independent investigation; and (3) additional views on the final investigation; or

(B) Once we identify solid leads the Majority does not want to pursue. We would attract more coverage and have greater credibility in that context than one in which we simply launch an independent investigation based on principled but vague notions regarding the "use" of intelligence.

In the meantime, even without a specifically authorized independent investigation, we continue to act independently when we encounter foot-dragging on the part of the Majority. For example, the FBI Niger investigation was done solely at the request of the Vice Chairman; we have independently submitted written questions to DoD; and we are preparing further independent requests for information.

Summary

Intelligence issues are clearly secondary to the public's concern regarding the insurgency in Iraq. Yet, we have an important role to play in revealing the misleading—if not flagrantly dishonest methods and motives—of the senior Administration officials who made the case for a unilateral, preemptive war. The approach outline above seems to offer the best prospect for exposing the

Administration's dubious motives and motives.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LATOURETTE). The Chair would remind all Members it is not appropriate during debate to characterize the actions or inactions in the other body.

Ms. HARMAN. Mr. Speaker, I yield 2½ minutes to the gentlewoman from California (Ms. ESHOO), my colleague and classmate, the ranking member on our Subcommittee on Intelligence Policy and National Security.

Ms. ESHOO. Mr. Speaker, I rise in support of this conference report. And I want to express in the beginning of my comments my appreciation for the hard work, the cooperation of all of my colleagues on the committee, of course, our distinguished chairman and, most particularly, the gentlewoman from California (Ms. HARMAN), who I think really leads us so well on our side and really brings such credit to the work that we do. To the staff of our committee, and, certainly, from where I speak, the minority staff; The word "intelligence" is used all the time—I think it resides first with them. They are second to none. And I really salute them for the work they do day in and day out.

This legislation was prepared with our minds still focused on the lessons of September 11 and as the drama in Iraq was unfolding. By these yardsticks this conference report reflects important progress in many areas. One of the most significant lessons to emerge from the joint congressional inquiry into the 9/11 tragedy is the need to improve information-sharing through the extension of modern information technology. Sounds like a no-brainer. But what we have found is that simply was not the case.

The Permanent Select Committee on Intelligence made a concerted effort this year to chart a path to bring the information revolution to the intelligence community. So it is imperative for the Congress to sustain the pressure next year and for the executive branch to embrace this vision.

Regarding so-called data mining of government and private sector databases, this is an extraordinarily large issue, and it contains extensive information on U.S. persons. And this conference report strikes what we believe is the right balance between security and privacy protection for the American people. The American people care about this. The conference report authorizes continued development of data mining tools, but it prohibits their use against domestic databases. It calls for the administration to begin defining the policies, the procedures, and the technologies necessary to safeguard this privacy.

I would like to turn just briefly to the problem of prewar intelligence. The intelligence community has to face up to the problems and the shortcomings in its Iraq estimates. That is why I strongly support the conference report's requirement for the intelligence community to report on lessons learned.

I want to again thank the committee, the committee staff, my colleagues, most especially our gifted leader, the vice chairman of the House Permanent Select Committee on Intelligence.

Mr. GOSS. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Michigan (Mr. HOEKSTRA) who is chairman of the Subcommittee on Technical and Tactical Intelligence and, obviously, a critical member of the team who has also been one of our world travelers to places that not everybody wants to go to.

Mr. HOEKSTRA. Mr. Speaker, I rise today in support of H.R. 2417 and the conference report to accompany the 2004 intelligence authorization bill.

Mr. Speaker, I am proud to serve as a member of the Permanent Select Committee on Intelligence. It is my pleasure to commend the leadership and direction of the gentleman from Florida (Chairman GOSS) and the ranking member, the gentlewoman from California (Ms. HARMAN), on this nonpartisan bill at a time in this country's history when it is needed most.

This bill addresses the critical need to review the Nation's imagery capabilities and the intelligence community's strategic plan for an imagery architecture. It is imperative that the community sees into the future with a utility of a cohesive imagery structure that focuses on each technical collection system and how it fits uniquely or with intentional redundancy into this broader framework we call an imagery architecture strategy. I think we have a fair spending plan here that provides the support that is needed, yet challenges the community to see more clearly a comprehensive vision of a much-needed cohesive architecture. Just like an architect, we must have a blueprint.

Mr. Speaker, on that note I would also like to express my disappointment that the choices presented to us in this conference report require us to fund a particular classified collection system within this bill. This system does not fit into what we hope will be our Nation's well-conceived architecture. In fact, it is a transgression. It may perpetuate a series of problems.

I would like to commend my colleague, the gentleman from Nevada (Mr. GIBBONS), for his efforts in spearheading a committee campaign to educate all members of the committee on the pros and cons of this program and to praise him for the impact that he had on the authorization for the program in this bill.

Mr. Speaker, the intelligence community is building a number of tools. I believe we need to use them and use them jointly and across services and agencies. I am glad to say that this bill addresses the need for greater emphasis on tasking, processes, exploitation, and dissemination practices within the intelligence community.

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These intelligence systems are becoming so proprietary and so complex and so autonomous that neatly networking them is becoming equally as difficult. It is very important that we observe collectively how these systems are used and by whom for greatest benefit. I believe this bill enforces that concern.

Mr. Speaker, H.R. 2417 supports our intelligence community as it supports our country's defense. Most visibly our intelligence community is fully supporting our military and other personnel in Operation Iraqi Freedom, in Operation Enduring Freedom, at Guantanamo Bay and here in homeland security operations. Mr. Speaker, intelligence is our Nation's first line of defense. We needs to support it and our intelligence professionals who continue to do heroic, but unheralded, work around the globe.

Mr. Speaker, I am pleased that this bill properly supports the intelligence community as it proves our best and first line of defense for America. I urge my colleagues to support H.R. 2417.

Ms. HARMAN. Mr. Speaker, how much time remains?

The SPEAKER pro tempore (Mr. LATOURETTE). The gentlewoman from California (Ms. HARMAN) has 13 minutes remaining. The gentleman from Florida (Mr. GOSS) has 11 minutes remaining.

Ms. HARMAN. Mr. Speaker, I yield 3 minutes to the gentleman from New Jersey (Mr. HOLT), another committee member.

Mr. HOLT. Mr. Speaker, as many of my colleagues have already done, I would like to compliment the chairman on his commitment to bipartisanship within the committee, not only in the presentation of this bill but in so many of the committee's activities. The two sides may not see eye to eye on every issue, but the two sides do share a commitment to national security.

I especially want to thank the ranking member, the gentlewoman from California (Ms. HARMAN), for her leadership and bipartisanship. She brings to her position a vigorous commitment to the Nation's intelligence.

Mr. Speaker, I rise in support of H.R. 2417. The bill enhances our Nation's intelligence capabilities in several important ways: In all source analysis, in foreign language capabilities, in human intelligence, in counter-terrorism watchlists and in particular programs. It is a step forward in what is I think a long-term transformation of the intelligence community.

The bill is based on a good measure of oversight, but as I spoke earlier today here, it is difficult to provide the kind of full oversight of such a multifaceted and secretive undertaking, but it is essential that we do so.

Intelligence, like law enforcement and policing, is essential to an orderly society; but like policing, it has great potential for misuse, challenging personal rights and civil liberties and abroad it can harm as well as advance our interests.

It is also essential that we, as a committee, support and stand behind the dedicated people and very talented people who sacrifice so much, sometimes even their lives, to keep alive American ideals.

We know that our intelligence is not perfect. We have a particularly good example of that in the intelligence that led up to and into the war with Iraq. I hope the committee will continue to scrutinize the way in which intelligence on Iraq's threat or perceived threat to the United States may have been deficient and to draw lessons for the future. The committee's oversight of this issue will be especially important if the long-term transformation of the intelligence community is to result in better intelligence.

I hope we will continue to move toward more use of understanding of unclassifieds and open sources. There is often, in fact, more useful knowledge in open sources than from the secret sources that the intelligence community sometimes so depends on.

I am disappointed that this bill does not include my proposal to authorize $10 million for two programs designed to increase language proficiency in America. Inadequate language capabilities actually threaten our national security. We must invest more in the creation of a workforce possessing requisite language skills; and to do this we must build greater proficiency throughout the country. We must increase the pool. There is bipartisan agreement on that, I believe, in the committee.

I appreciate the chairman's commitment to finding a comprehensive solution to intelligence community deficiencies, indeed, national deficiencies in our language capabilities. I look forward to doing that with the chairman in the next session on, as in so many things in this committee, a bipartisan basis.

Mr. GOSS. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from California (Mr. CUNNINGHAM), a very dedicated member of our committee who is well known for other capabilities as well.

Mr. CUNNINGHAM. Mr. Speaker, I thank the chairman and the ranking member. This is a good bill. It is a bipartisan effort. The members, the people that have been on the committee and the new members I think have done a good job, and especially the staffs. Everybody should vote for this bill. It is good however, I have some concerns that I would like to bring up, not about the bill, but about the intelligence process.

For years, our military has been drawn and cut down in half. If you look at the Air Wings, the number of services, the number of tanks, the number of ships, the number of Marine Corps, the number of Air Wings that we have, it has almost been cut in half, but yet we ask our military to do almost four times what they did during previous years.

Now, how does that effect the intelligence community? Because every time DOD is deployed, our intelligence agents have to deploy with them. We spread them thin. And there are Members in this body and the other body that continually, through their liberal views, choose to cut defense and intel to pay for social programs.

Now, those in many cases are the same Members that I have heard get up on this floor and in the other body talk about, oh, how devastating it is that we do not have enough body armor for our troops or we cannot upgrade Humvees or that George Tenent should be replaced. But in some cases, those same Members have voted to cut the funding necessary to give those individuals the tools they need to do their job, and that is wrong.

You will not see that portion in any report that we have done either in this body or the other body, because I do not think they have got the guts to put it in there. They will not point at themselves, because they won't give our kids and our intel folks the funding that they need.

We have older systems that have been drawn out. In the previous administration, we went into Haiti and Somalia. Those places are the hell holes of the Earth, and they are still there. Look at Kosovo, the number of missions. You know how many tanks we sunk in Kosovo? Five. We destroyed a country, but we had five kills and we wore out our equipment. Guess what? CIA and intel and NSA, they were all involved in that, and we spread them thin. So I would caution the Members who chastise Mr. Tenent or any of the other leadership that we put in those positions because we need to give them the tools to do their job. They are hard working, dedicated individuals, spread to thin.

The other thing that I would bring up that upsets me is that there have been some memos using this committee in the other body as a partisanship tool to take a majority and the White House. That is wrong. During a time of war, Mr. Speaker, that does disservice to this Nation, to this committee and to the American people.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair would again remind Members it is not appropriate during the debate to characterize actions or inactions in the other body.

Ms. HARMAN. Mr. Speaker, I yield myself 10 seconds.

I would just point out that Members on our side strongly support the women and men in the field who work in our intelligence community. I assume the prior speaker is aware of that.

We also, to my knowledge, have not produced any memos around here that could be characterized as divisive. We are all pulling in the same direction, and that is, hopefully, to enhance our national security.

Mr. Speaker, I yield 3 minutes to the gentleman from Florida (Mr. HASTINGS), a senior member of our committee and a senior member of the Committee on Rules.

Mr. HASTINGS of Florida. Mr. Speaker, I thank my friend, the ranking member, and she is my friend, for yielding me time.

Mr. Speaker, I regret that the gentleman from California (Mr. CUNNINGHAM), our colleague on the other side who just spoke, has left the room. For I did want to remind him what the ranking member just has said and that is every member of the House Permanent Select Committee on Intelligence vigorously and actively supports the intelligence community in its entirety and fully recognizes the extraordinary and dangerous work that they do on behalf of this great Nation.

I rise in support of this measure. As ranking member of the Subcommittee on Terrorism and Homeland Security, I have had the privilege to meet many talented and dedicated intelligence professionals. I sincerely appreciate the sacrifices they have made to ensure that United States interests both in our homeland and abroad are protected. We must make a continued investment in human resources, our greatest intelligence assets. This bill does that by increasing funds available for language proficiency maintenance and awards initiatives and providing specialized training for collectors and analysts.

I am pleased that this bill also includes a provision similar to one I offered on the House floor. It requires the intelligence community to establish a pilot project to recruit people of diverse ethnic and cultural backgrounds and those proficient in critical foreign languages. Annual statistics, and the committee's November 5 public diversity hearing demonstrate that the intelligence community continues to lag behind the Federal workforce and the private sector in the number of women and minorities in its ranks, especially in core mission areas. Clearly, more must be done to increase diversity across the intelligence community. I believe that this pilot project is another important step in this regard.

Finally, it is important to note that this bill authorizes only part of the operating funds for the intelligence community. A huge portion of intelligence funds were provided in the $87 billion Iraqi counterterrorism supplemental and in the supplementals that proceeded it. I am extremely concerned about our government's increasing overreliance on supplemental appropriations.

Budgeting by supplementals greatly undermines the committees's ability to effectively oversee how funds appropriated by Congress are spent. I fear this trend may lead to less accountability in the budget building and accounting process, a perhaps unintended, but nonetheless unacceptable, consequence.

On balance, this bill does much to enhance our Nation's international security efforts. For this reason, I urge my colleagues to support it. I am prepared at this time to support this measure.

Mr. GOSS. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Nebraska (Mr. BEREUTER), the vice chairman of the committee.

Mr. BEREUTER. Mr. Speaker, I thank the chairman for yielding me additional time.

I did want to mention in response to what the gentleman from New Jersey (Mr. HOLT) said about the language issue, I have been charged with the responsibility, with the help of the gentlewoman from California (Ms. ESHOO), for taking on this subject and seeking broadly the sources of information to give us the best product. My hope is that we will have a separate bill on the subject of language training and recruitment before the House some 4 to 6 months after the next session of Congress is convened.

I also wanted to speak further on the HUMIT issue. Our distinguished colleague from Nevada (Mr. GIBBONS) has emphasized the importance of this issue very well, but I want to bring up a couple of other points.

I mentioned, of course, that we are focussed heavily on the terrorist conflicts that create so many problems for us in places like Afghanistan and Iraq. However, we do have global responsibilities. So the intelligence community needs to continue to provide timely, actionable intelligence on a host of potential threats from nuclear proliferation threats on the Korean peninsula, from narcotraffickers in the jungles of Colombia, from collapsing regimes in West Africa.

Mr. Speaker, I would emphasize for our colleagues, and all Americans, that we live in a new world and face new and more terrible threats. In many ways, information gathering was easier when the threat was the Soviet Union. Frankly, the intelligence community has been slow in adapting to this new environment.

In the judgment of this Member, our intelligence service did not reach out aggressively to recruit the human intelligence sources that would have provided us with valuable information.

In our previous authorization bill, we corrected one of the reasons for that failure in asset recruitment. Also, because of budgetary restraints, the intelligence community in the mid-1990s lost far too many of its skilled analysts whose job was to provide early warning. This legislation provides much-needed funding to further rebuild a dynamic, wide-ranging global analytical capability. But we should be under no illusion. It takes years to develop skilled analysts who are able to connect the dots and provide our policy makers with timely information.

☐ 1245

Mr. Speaker, we have made a start here. This is good legislation. I urge its support and I thank the chairman for yielding me this time.

Ms. HARMAN. Mr. Speaker, my understanding is there is an additional speaker on the other side, and then the gentleman from Florida (Chairman GOSS) obviously has the right to close. I would reserve our time until all speakers but the chairman have spoken.

Mr. GOSS. Mr. Speaker, I am pleased to yield 2 minutes to the distinguished gentleman from Idaho (Mr. OTTER).

Mr. OTTER. Mr. Speaker, I thank the chairman for this time that he has offered me today.

I rise in deep concern over a provision in this legislation. Like most of my colleagues, I supported H.R. 2417 when it came before the House in June; but after tertiary review, I find that there is a provision in the bill that potentially has long-reaching effects on civil liberties. H.R. 2417 includes a provision that would expand the FBI's power to demand financial records, without a judge's approval, to a large range of businesses, vastly wider than their current authority.

Right now the FBI has the authority to serve subpoenas to traditional financial institutions when investigating terrorism and counterintelligence without having to seek a judge's approval. The law understands the phrase "financial institutions" as we do: banks, loan companies, savings associations and credit unions. Currently, these are the types of institutions subject to administrative subpoenas.

The provision in this bill, however, uses a definition of financial institutions to decide what organizations are subject to administrative subpoenas. Under this bill, not only are the traditional financial institutions like banks and credit unions affected but so are pawnbrokers, casinos, vehicle salesmen, real estate agents, telegraph companies, travel agencies, the U.S. Postal Service, just to name but a few.

Winning the war against terrorism is indeed vital, Mr. Speaker, and we must make sure that our law enforcement officials have the tools necessary to engage this war and win these battles. The FBI's need for authority to subpoena these groups in order to track and find and shut down terrorist operations is not in question, and I do not question that. However, under these provisions, the FBI no longer needs a court order to serve such a subpoena on a new and lengthy laundry list of financial institutions. With this legislation, we eliminate the judicial oversight that was built into our system for a reason, to make sure that our precious liberties are protected.

In our fight for our Nation to make the world a safe place, we must not turn our backs on our own freedoms. Expanding the use of administrative subpoenas and threatening our system of checks and balance is a step in the wrong direction.

Ms. HARMAN. Mr. Speaker, how much time remains?

The SPEAKER pro tempore (Mr. LATOURETTE). The gentlewoman from California (Ms. HARMAN) has 7 minutes remaining, and the gentleman from Florida (Mr. GOSS) has 4 minutes remaining.

Ms. HARMAN. Mr. Speaker, I am the concluding speaker on our side, and I yield myself such time as I may consume.

Let me say first that the views of the prior speaker are views I share. I am sad to hear that he will oppose the bill, but I certainly agree that we need to be sure we are narrowing the reach of these national security letters and limiting them only to financial transactions. It is important that we find terrorists.

It is important that we track terrorist financing; but it is, by my lights, risky to fail to include additional language in the bill or the report that would make clear what our intent is. I hope this new authority will not be abused. I will certainly be watching it carefully, and I do appreciate the fact that the prior speaker expanded on what abuses could potentially occur.

Mr. Speaker, first I would like to thank the women and men who work in our intelligence community around the world. I have been to austere places all over the world, and I have met women and men who work in the most dangerous conditions who put our security first, ahead of theirs, and who leave their families at home and take enormous risks for our country. I salute them. I know how dangerous their jobs are. I appreciate what they do every single day.

And particularly, let me say today to our intelligence community in Iraq and in Turkey and places that are under siege, I really appreciate what they are doing. I thank them very much.

I also want to say thank you to the members of this committee. All of them work hard. There is bipartisanship in this committee, and I thank the gentleman from Florida (Mr. GOSS) for the partnership we have had over some years now.

Let me thank the hardworking staff on a bipartisan basis. Every one of them works enormously hard, and I would just like to recognize the eight minority staffers, most of whom are sitting around me right now: Suzanne Spaulding, the minority chief of staff; Bob Emmett; John Keefe; Beth Larson; Marcel Lettre; Kirk McConnell; Wyndee Parker; and Ilene Romack. Thank you every day for what you do.

Let me just make three concluding points. First, facing tough issues. It is absolutely critical at a time when security risks are expanding around the world that we face tough issues; that Congress face tough issues and ask tough questions; and that the intelligence community, which tries hard but has not always delivered perfect products, face tough issues, go through this lessons learned exercise and learn from wrong judgments that were made or inadequate collection that occurred so that the next products that are prepared by good people can be the best possible products. Please let us face tough issues.

Second of all, I want to make the point that our oversight in this committee on a bipartisan basis requires constructive criticism of the intelligence community. We have done this over the years. Last year, we issued a tough report. The Subcommittee on Terrorism and Homeland Security, of which I was ranking member and Mr. CHAMBLISS, who is now in the other body, was chairman, issued a tough report on some of the problems in intelligence leading up to 9/11. That report was constructive criticism. Some of the recommendations we made have been heeded; some have not. Constructive criticism, asking tough questions are things we properly should do.

Finally, let me suggest again to the intelligence community that it is important to engage in dialogue with this committee. Shrill press releases are not dialogue. Quiet conversations, talking about how we see things, what we think can be improved, why it needs to be improved, will get the job done.

This bill provides many new resources, many, many new resources, and is carefully crafted to suggest best directions for the intelligence community. We have confidence in the people who work there. We are proud of them. We thank them. We are trying to help them do better.

I urge support of this authorization conference report.

Mr. Speaker, I yield back the balance of my time.

Mr. GOSS. Mr. Speaker, I yield myself the remaining time.

I just want to take a few minutes to congratulate my ranking member for the superb job that she has done on her side of the aisle in this conference report and throughout the year. To say she is hardworking and dedicated does not quite get it. I have words here that say her determination is fierce and she is definitely a force to be reckoned with. That does not quite say it either. She is a very valuable asset, and we are very grateful for her energies and suggestions and leadership and the way she goes about her business.

This is her very first conference report as ranking member I think, if I have got my history right; and she obviously was of significant importance in bringing the report through for the authorization bill that the House did, but she was also significantly helpful in the negotiations with the other body which I am not allowed to mention.

I would also like to thank each and every member of HPSCI for their undying dedication to the security of our Nation and the protection of the people of the United States. That is what we do. Each member works very hard learning the business of intelligence, and it is not an easy subject. What they come to understand in that process is that this Nation is far better off with our intelligence professionals than we would be without them. I know sometimes the debate rages about whether intelligence is an appropriate thing for gentlemen to be discussing in a civilized society. Well, I can tell my colleagues we could not exist without it.

The rank-and-file employees of the intelligence community every day, as the gentlewoman has said, protect the very liberties we cherish. They do it day in and day out; and as they go about gathering the secrets and information necessary for our policy-makers to make the very tough decisions they have to make, they incur a lot of risk. The members of the HPSCI understand this pretty clearly. That is because we have been out and about and talking to them. We do travel a lot. We go to the places that not everybody wants to go to. We get into the issues not everybody wants to fool around with. Frankly, that is why it is easy to leave partisanship outside the door of the committee chamber.

Finally, I want to thank committee staff, all HPSCI staff, all sides, both together, including, obviously, Democratic members and Republican members and those who do not want to declare either side who we call our support staff. Without staff support, it is obviously their expertise, their dedication, our committee would not do much of anything.

They do work late hours. I know that occasionally when I work late hours I find them there. I find them occasionally when I come in early I find them there. They do wonderful things for us, and they get very little recognition. I know a lot of the work is tedious and mundane and a lot of it is exciting, and I appreciate their contributions in all of those areas.

The other thing I know for sure is the work space up there leaves a lot to be desired, and I promise we are going to work on a lavatory soon. We do feel the days have come when there is indoor plumbing, and we should acknowledge that on the Permanent Select Committee on Intelligence.

Everybody deserves congratulatory words today, and I want to thank everybody, and I mean that very sincerely.

There is one person on the committee I am going to single out today, though, who serves as the committee's budget director who is entitled, I think, for specific recognition this year. Mike Meermans has served the government for now, I am told, 30 years, in fact something in excess of that. Among other jobs in the United States he served in the United States Air Force, and he has been engaged by the government as an Arab linguist. Mike has been with HPSCI since 1995. This is his 8th year on the committee.

It has been a very trying year for Mike, whose college-age son early in the year was diagnosed with cancer. Throughout his son's course of treatment, Mike was by his side, I know, every step of the way, being a great father, and all the while managing the committee's authorization process, crunching numbers, writing the report language, negotiating with the executive branch and with the other body, and frankly, getting into mysteries in the intelligence community that I find too complex to understand. He did all of this with energy, with fortitude and aplomb. He is the manifestation of the wonderful and professional staff which HPSCI is blessed with and is well served by.

I just wanted to say to Mike that he is appreciated not just for his legislative talents but more so because he is a good guy. He is a nice guy, a great father. His only purpose in serving HPSCI is actually to make America stronger, and this year when he had family duties, he understood those as well and met them.

To his wife, Lois, and their family, especially their son Brian, I thank them for allowing him to work so hard for us, and I am sorry we had to take him away so much of the time. We are better and the Nation is stronger because of him, and their pride in him is very well deserved. We share that pride.

Mike, for you, thank you for all your hard work in years past, this year especially. You made an extremely difficult year for you personally a successful year for the committee. You made it seem routine. We are all extremely happy to hear your son is on the mend and recently received more good news from the doctors. Our prayers for continuous good news are with you. You deserve our gratitude, and we express it here now.

I also want to say that about a year ago we were just packaging up the joint inquiry product. We had an extensive effort with our colleagues in the other body to understand 9/11, what went wrong. We came up with a good report. It was a long one. I think it steered us in some directions that corrections have already been taken. It also created a follow-on commission, the national commission, which is at work now under the leadership of Governor Kean and former member Lee Hamilton, for whom we have great admiration. I think that I should point out to the people in the United States of America that we are part of the review they are doing. We have invited them to conduct oversight of how we do oversight. So the American people can be reassured that there is oversight of the intelligence community, and some of the things we cannot talk about are indeed watched by others.

My time has come to an end. We have had a good year. We look for a better year ahead dealing with capabilities to make sure our country is safer.

Mr. OXLEY. Mr. Speaker, I rise in support of the conference report for H.R. 2417, the Intelligence Authorization Act for Fiscal Year 2004, and to note the Financial Services Committee's interest in three sections of the report. All of the sections seek to improve this country's ability to fight the financing of terrorists, and I wholeheartedly support them.

Section 105 of the report establishes an Office of Intelligence and Analysis within the Department of the Treasury, headed by an Assistant Secretary appointed by the President after consultation with the Director of Central Intelligence. Formation of the office is necessary because the Treasury's Office of Foreign Assets Control and its Financial Crimes Enforcement Network are essential tools in the fight against the funding of terrorism, but today lack access to some "secure" information essential to that effort. Establishment of the office creates a secure channel for that information to flow, as necessary, to FinCEN and OFAC, and for them to send back appropriate information.

Section 374 modernizes the definition of financial institutions that may be served administrative subpoenas, as rigidly controlled by the existing Right to Financial Privacy Act. When that Act was written, banks were really the only "financial Institutions" a terrorist might have used to stash or transfer money. As our efforts to stamp out terror financing have become more successful, a lot of that activity has moved over into other, less-traditional sorts of financial-services businesses—even, for example, to dealers in precious commodities such as gold or diamonds. The USA PATRIOT Act appropriately expanded the definition of "financial institution" to include these other financial-services businesses. This section establishes parity in the definition of "financial institution" between the PATRIOT Act and the RFPA, allowing the judicious use of administrative subpoenas in terror cases to reflect this larger universe of businesses that might be exploited. Here I must note my discomfort that the conference report ignores the Financial Services Committee's request that Section 374 include the right to injunctive relief as provided for in Section 1118 of the Right to Financial Privacy Act.

Section. 376 allows for the "in camera" review of sensitive information that leads to imposition of "special measures" isolating rogue countries or banks, as defined under Sec. 311 of the PATRIOT Act. Under the previous version of Sec 311, there is no ability to protect this sensitive information should it be necessary for the imposition of the "special measures," and that omission argues against use of the powers as effectively as we would like. For example, if the Central Intelligence Agency should have information that a bank were doing business with a terrorist, it quite possibly would be counterproductive to expose the CIA's sources and methods to indict individuals or shut down the bank, but the Treasury's "special measures" under Sec. 311 could effectively isolate the bank if the sensitive information could be used "in camera." This section merely provides protection of that sensitive information that might be used to support the imposition of those measures.

Mr. Speaker, these three sections are all important tools in the fight against terrorism, and I strongly support their inclusion. I regret that Section 1118 was not reference in the report's Section 374, and the Financial Services Committee reserves the right to address that issue later. Meanwhile, I support the conference report and ask for its immediate passage.

Mr. CONYERS. Mr. Speaker, I rise to state my opposition to a provision in this conference report that intrudes on our civil liberties and will do little, if anything, to protect us from terrorism.

I think it is important that law enforcement have the powers it needs to investigate acts of money laundering that are connected to terrorism and espionage, but we must ensure those powers are reasonable and appropriately crafted. Current law already gives the FBI the ability to obtain financial records from various financial institutions, which are defined as banks, savings and loans, thrifts, and credit unions, with little or no judicial oversight. In fact, the government can delay notification to a court that it has sought such records if it merely certifies in writing that it required emergency access to the documents.

Now, the FBI is seeking investigative authorities beyond what are necessary for terrorism and intelligence investigations. Section 374 of the conference report would give the FBI even more unfettered authority by subjecting a broader group of "financial institutions" to the FBI's special investigative authorities. The FBI would be able to seek financial records not only from traditional financial institutions but also from pawnbrokers, travel agencies, car dealers, boat sellers, telegraph companies, and persons engaged in real estate transactions, among others.

The record of the Bush administration demonstrates that this provision is a significant intrusion on our civil liberties that will not be used to protect us from terrorism. In the days after September 11, the administration demanded from Congress expanded powers to root out terrorist activity. Congress granted much of those powers in the form of the USA PATRIOT Act, but the administration has yet to justify how it has used those powers to find the planners of the 2001 attacks or to thwart other, planned attacks. Instead, the administration returns to Congress with requests for more authorities, such as this one, in a grab for power.

For these reasons, I urge my colleagues to vote "no" on this conference report.

Mr. KUCINICH. Mr. Speaker, I stand today strongly opposed to the Conference Report on H.R. 2417, the Intelligence Authorization Act for FY 2004.

Although the House of Representatives recently voted in a bi-partisan and overwhelming fashion to repeal Section 213 of the PATRIOT Act, a provision that threatens Americans' rights by allowing for "sneak and peak searches", it appears the administration is poised to move ahead with further actions that endanger civil liberties by slipping an expanded PATRIOT Act power in the Intelligence Conference Report.

The hidden measure would significantly expand the FBI's power to acquire financial records without judicial oversight from car dealers, pawnbrokers, travel agencies, and many other businesses. Traditional financial institutions like banks and credit unions are already subject to such demands, but this dramatic expansion of government authority will mean that records created by average citizens who purchase cars, plan vacations, or buy gifts will be subject to government seizure and analysis without the important requirements of probable cause or judicial review.

This provision initially appeared in a leaked draft of so-called "PATRIOT II", a proposal the American public and Members on both sides of the aisle in the House and Senate publicly rejected. It is now clear the administration's strategy is to pass PATRIOT II in separate pieces with little public debate and surreptitiously attached to other legislation. This is far from an appropriate or democratic way to handle issues that affect the fundamental liberties and freedoms of Americans.

I urge the administration and the Attorney General to openly and honestly return to Congress to discuss options that curtail, not expand, the PATRIOT Act to make it consistent with the United States Constitution. I also urge my colleagues to vote against the Intelligence Conference Report and this unnecessary and dangerous expansion of the government's assault on civil liberties.

Mr. GOSS. Mr. Speaker, I yield back the balance of my time, and I move the previous question on the conference report.

The previous question was ordered.

The SPEAKER pro tempore. The question is on the conference report.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. GOSS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this question will be postponed.

FURTHER MESSAGE FROM THE SENATE

A further message from the Senate by Mr. Monahan, one of its clerks, announced that the Senate has passed without amendment a bill of the House of the following title:

H.R. 3182. An act to reauthorize the adoption incentive payments program under part E of title IV of the Social Security Act, and for other purposes.

The message also announced that the Senate insists upon its amendments to the bill (H.R. 1904) "An Act to improve the capacity of the Secretary of Agriculture and the Secretary of the Interior to plan and conduct hazardous fuels reduction projects on National Forest System lands and Bureau of Land Management lands aimed at protecting communities, watersheds, and certain other at-risk lands from catastrophic wildfire, to enhance efforts to protect watersheds and address threats to forest and rangeland health, including catastrophic wildfire, across the landscape, and for other purposes," disagreed to by the House and agrees to the conference asked by the House on the disagreeing votes of the two Houses thereon, and appoints Mr. COCHRAN, Mr. MCCONNELL, Mr. CRAPO, Mr. DOMENICI, Mr. HARKIN, Mr. LEAHY, and Mr. DASCHLE, to be the conferees on the part of the Senate.

□ 1300

RECESS

The SPEAKER pro tempore (Mr. LATOURETTE). Pursuant to clause 12(a) of rule I, the Chair declares the House in recess subject to the call of the Chair.

Accordingly (at 1 p.m.), the House stood in recess subject to the call of the Chair.

□ 1335

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. LATOURETTE) at 1 o'clock and 35 minutes p.m.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, proceedings will resume on questions previously postponed. Votes will be taken in the following order:

House Joint Resolution 78, by the yeas and nays;

conference report on H.R. 2417, by the yeas and nays;

motion to instruct on H.R. 1, by the yeas and nays; and

motion to instruct on H.R. 2660, by the yeas and nays.

The first electronic vote will be conducted as a 15-minute vote. Remaining electronic votes will be conducted as 5-minute votes.

FURTHER CONTINUING APPROPRIATIONS, FISCAL YEAR 2004

The SPEAKER pro tempore. The pending business is the vote on the passage of the joint resolution, H.J. Res. 78, on which the yeas and nays are ordered.

The Clerk read the title of the joint resolution.

The SPEAKER pro tempore. The question is on the passage of the joint resolution.

The vote was taken by electronic device, and there were—yeas 410, nays 10, not voting 14, as follows:

[Roll No. 648]

YEAS—410

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Calvert
Camp
Cannon
Cantor
Capito
Capps
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeGette
Delahunt
DeLauro
DeLay
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Foley
Forbes
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NAYS—10

Berry
Capuano
DeFazio
Filner
Flake
Ford
Jackson-Lee (TX)
Kucinich
Miller, George
Paul

NOT VOTING—14

Berman
Blackburn
Buyer
Cubin
Davis (FL)
DeMint
Fletcher
Gephardt
Kaptur
Maloney
Nunes
Ruppersberger
Sherman
Sullivan

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LATOURETTE) (during the vote). Members are advised there are 2 minutes remaining in this vote.

Mr. TERRY changed his vote from "nay" to "yea."

□ 1358

So the joint resolution was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Mrs. BLACKBURN. Mr. Speaker, on rollcall No. 648, I was unavoidably detained. Had I been present, I would have voted "yea."

Mr. RUPPERSBERGER. Mr. Speaker, on November 20, 2003, I was attending the funeral of my long time friend and one of my dearest colleagues, Maryland State Delegate Howard P. Rawlings, chairman of the Maryland's House Appropriations Committee. Because of the services, I was unable to make rollcall vote 648.

If I were present, on rollcall vote 648, I would have voted "yea."

CONFERENCE REPORT ON H.R. 2417, INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 2004

The SPEAKER pro tempore. The pending business is the question of agreeing to the conference report on the bill, H.R. 2417, on which the yeas and nays are ordered.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the conference report.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 264, nays 163, not voting 7, as follows:

[Roll No. 649]

YEAS—264

Aderholt
Akin
Alexander
Andrews
Bachus
Baker
Ballenger
Barrett (SC)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (GA)
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boyd
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Calvert
Camp
Cannon
Cantor
Capito
Cardin
Cardoza
Carson (OK)
Carter
Castle
Chabot
Chocola
Clay
Coble
Cole
Collins
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cunningham
Davis (AL)
Davis (CA)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dooley (CA)
Doolittle
Dreier
Dunn
Edwards
Ehlers
Emerson
English
Eshoo
Evans
Everett
Feeney
Ferguson
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hinojosa
Hobson
Hoekstra
Holt
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Isakson
Israel
Issa
Istook
Janklow
Jenkins
John
Johnson (CT)
Johnson, Sam
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Lantos
Latham
LaTourette
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lowey
Lucas (KY)
Marshall
Matheson
McCarthy (NY)
McCotter
McCrery
McHugh
McInnis
McIntyre
McKeon
Meeks (NY)
Menendez
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Ortiz
Osborne
Ose
Oxley
Pearce
Pelosi
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pomeroy
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ruppersberger
Ryan (WI)
Ryun (KS)
Saxton
Schiff
Schrock
Scott (GA)
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Skelton
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Stenholm
Sullivan
Sweeney
Tancredo
Tauscher
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Turner (TX)
Upton
Vitter
Walden (OR)
Walsh
Weiner
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Wu
Young (AK)
Young (FL)

NAYS—163

Abercrombie
Ackerman
Allen
Baca
Baird
Baldwin
Ballance
Bartlett (MD)
Becerra
Bell
Berkley
Berman
Berry
Bishop (NY)
Blumenauer
Boucher
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Carson (IN)
Case
Clyburn
Conyers
Cooper
Costello
Cummings
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dingell
Doggett
Doyle
Duncan
Emanuel
Engel
Etheridge
Farr
Fattah
Filner
Flake
Ford
Frank (MA)
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Hill
Hinchey
Hoeffel
Holden
Honda
Hooley (OR)
Inslee
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson (IL)
Johnson, E. B.
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Larsen (WA)
Larson (CT)
Leach
Lee
Levin
Lewis (GA)
Lofgren
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Matsui
McCarthy (MO)
McCollum
McDermott
McGovern
McNulty
Meehan
Meek (FL)
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Otter
Owens
Pallone
Pascrell
Pastor
Paul
Payne
Pence
Pombo
Price (NC)
Rahall
Rangel
Ross
Rothman
Roybal-Allard
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Scott (VA)
Serrano
Simpson
Slaughter
Solis
Spratt
Stark
Stearns
Strickland
Stupak
Tanner
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Wamp
Waters
Watson
Watt
Waxman
Wexler
Woolsey
Wynn

NOT VOTING—7

Buyer
Cubin
Davis (FL)
DeMint
Fletcher
Gephardt
Sherman

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LATOURETTE) (during the vote). Members are advised there are 2 minutes remaining in this vote.

□ 1415

Ms. JACKSON-LEE of Texas, Ms. McCOLLUM, Ms. McCARTHY of Missouri, Ms. BERKLEY, Messrs. KENNEDY of Rhode Island, BAIRD, ACKERMAN, JEFFERSON, OBEY, HOEFFEL, Mrs. CAPPS, Messers. VAN HOLLEN, WYNN, PENCE, THOMPSON of Mississippi, PALLONE, LANGEVIN, Ms. HOOLEY of Oregon, Mr. TANNER, Ms. LORETTA SANCHEZ of California, Messrs. BISHOP of New York, JONES of North Carolina, MANZULLO, LAMPSON, DINGELL, LEACH, HOLDEN, ROTHMAN, Ms. LINDA T. SÁNCHEZ of California, Messrs. KIND, BALLANCE, McNULTY, JOHNSON of Illinois, MATSUI, GREEN of Texas, TAYLOR of Mississippi, HILL, GONZALEZ, COOPER, SANDLIN, CASE of Hawaii, ROSS, PRICE of North Carolina, MILLER of North Carolina, ETHERIDGE, Ms. ROYBAL-ALLARD, Mr. SPRATT, Mr. MOORE and Mr. BACA changed their vote from "yea" to "nay."

So the conference report was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

MOTION TO INSTRUCT CONFEREES ON H.R. 1, MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003

The SPEAKER pro tempore. The unfinished business is the question on the motion to instruct conferees on H.R. 1.

The Clerk will designate the motion.

The Clerk designated the motion.

The SPEAKER pro tempore. The question is on the motion to instruct conferees offered by the gentlewoman from Oregon (Ms. HOOLEY) on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 201, nays 222, not voting 11, as follows:

[Roll No. 650]

YEAS—201

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boehlert
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Capps

Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Leach
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McHugh
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Skelton
Smith (WA)
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NAYS—222

Aderholt
Akin
Bachus
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Hall
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McInnis
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NOT VOTING—11

Baker
Buyer
Cubin
Davis (FL)
Davis (IL)
DeMint
Fletcher
Gephardt
Herger
Sherman
Slaughter

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. TERRY) (during the vote). Members are advised there are 2 minutes remaining in this vote.

□ 1423

Mr. ROYCE changed his vote from "yea" to "nay."

So the motion to instruct was rejected.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Ms. SLAUGHTER. Mr. Speaker, I was unable to be present for rollcall vote 650. Had I been present, I would have voted "yea" on rollcall vote 650.

MOTION TO INSTRUCT CONFEREES ON H.R. 2660, DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2004

The SPEAKER pro tempore. The unfinished business is the question on the motion to instruct conferees on H.R. 2660.

The Clerk will designate the motion.

The Clerk designated the motion.

The SPEAKER pro tempore. The question is on the motion to instruct offered by the gentleman from Michigan (Mr. KILDEE).

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 360, nays 64, not voting 10, as follows:

[Roll No. 651]

YEAS—360

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baldwin
Ballance
Ballenger
Barrett (SC)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burns
Burr
Burton (IN)
Calvert
Camp
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Cole
Conyers
Cooper
Costello
Cox
Cramer
Crenshaw
Crowley
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Diaz-Balart, L.
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Farr
Fattah
Ferguson
Filner
Foley
Forbes
Ford
Fossella
Frank (MA)
Frelinghuysen
Frost
Gallegly
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Houghton
Hoyer
Hulshof
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (NY)
Kirk
Kleczka
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi

Peterson (MN)
Peterson (PA)
Petri
Pickering
Platts
Pombo
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Serrano
Shaw
Shays
Sherwood
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tanner
Tauscher
Tauzin
Taylor (MS)
Terry
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wolf
Woolsey
Wu
Wynn

NAYS—64

Baker
Bartlett (MD)
Barton (TX)
Biggert
Blackburn
Bonner
Burgess
Cannon
Cantor
Coble
Collins
Crane
Culberson
DeLay
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Everett
Feeney
Flake
Franks (AZ)
Garrett (NJ)
Goss
Hart
Hefley
Hensarling
Herger
Hoekstra
Hostettler
Hunter
Hyde
Johnson, Sam
Jones (NC)
King (IA)
Kingston
Linder
Miller, Gary
Musgrave
Nunes
Oxley
Paul
Pence
Pitts
Radanovich
Rohrabacher
Sensenbrenner
Sessions
Shadegg
Shimkus
Smith (MI)
Souder
Stearns
Tancredo
Taylor (NC)
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Weldon (FL)
Wilson (SC)
Young (AK)
Young (FL)

NOT VOTING—10

Buyer
Carson (OK)
Cubin
Davis (FL)
Davis (IL)
DeMint
Fletcher
Gephardt
Pomeroy
Sherman

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised there are 2 minutes left in this vote.

☐ 1430

Mr. TERRY changed his vote from "nay" to "yea."

So the motion to instruct was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. TERRY). Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote is objected to under clause 6 of rule XX.

Record votes on postponed questions will be taken later.

21ST CENTURY NANOTECHNOLOGY RESEARCH AND DEVELOPMENT ACT

Mr. BOEHLERT. Mr. Speaker, I move to suspend the rules and pass the Senate bill (S. 189) to authorize appropriations for nanoscience, nanoengineering, and nanotechnology research, and for other purposes.

The Clerk read as follows:

S. 189

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "21st Century Nanotechnology Research and Development Act".

SEC. 2. NATIONAL NANOTECHNOLOGY PROGRAM.

(a) NATIONAL NANOTECHNOLOGY PROGRAM.—The President shall implement a National Nanotechnology Program. Through appropriate agencies, councils, and the National Nanotechnology Coordination Office established in section 3, the Program shall—

(1) establish the goals, priorities, and metrics for evaluation for Federal nanotechnology research, development, and other activities;

(2) invest in Federal research and development programs in nanotechnology and related sciences to achieve those goals; and

(3) provide for interagency coordination of Federal nanotechnology research, development, and other activities undertaken pursuant to the Program.

(b) PROGRAM ACTIVITIES.—The activities of the Program shall include—

(1) developing a fundamental understanding of matter that enables control and manipulation at the nanoscale;

(2) providing grants to individual investigators and interdisciplinary teams of investigators;

(3) establishing a network of advanced technology user facilities and centers;

(4) establishing, on a merit-reviewed and competitive basis, interdisciplinary nanotechnology research centers, which shall—

(A) interact and collaborate to foster the exchange of technical information and best practices;

(B) involve academic institutions or national laboratories and other partners, which may include States and industry;

(C) make use of existing expertise in nanotechnology in their regions and nationally;

(D) make use of ongoing research and development at the micrometer scale to support their work in nanotechnology; and

(E) to the greatest extent possible, be established in geographically diverse locations, encourage the participation of Historically Black Colleges and Universities that are part B institutions as defined in section 322(2) of the Higher Education Act of 1965 (20 U.S.C. 1061(2)) and minority institutions (as defined in section 365(3) of that Act (20 U.S.C. 1067k(3))), and include institutions located in States participating in the Experimental Program to Stimulate Competitive Research (EPSCoR);

(5) ensuring United States global leadership in the development and application of nanotechnology;

(6) advancing the United States productivity and industrial competitiveness through stable, consistent, and coordinated investments in long-term scientific and engineering research in nanotechnology;

(7) accelerating the deployment and application of nanotechnology research and development in the private sector, including startup companies;

(8) encouraging interdisciplinary research, and ensuring that processes for solicitation and evaluation of proposals under the Program encourage interdisciplinary projects and collaborations;

(9) providing effective education and training for researchers and professionals skilled in the interdisciplinary perspectives necessary for nanotechnology so that a true interdisciplinary research culture for nanoscale science, engineering, and technology can emerge;

(10) ensuring that ethical, legal, environmental, and other appropriate societal concerns, including the potential use of nanotechnology in enhancing human intelligence and in developing artificial intelligence which exceeds human capacity, are considered during the development of nanotechnology by—

(A) establishing a research program to identify ethical, legal, environmental, and other appropriate societal concerns related to nanotechnology, and ensuring that the results of such research are widely disseminated;

(B) requiring that interdisciplinary nanotechnology research centers established under paragraph (4) include activities that address societal, ethical, and environmental concerns;

(C) insofar as possible, integrating research on societal, ethical, and environmental concerns with nanotechnology research and development, and ensuring that advances in nanotechnology bring about improvements in quality of life for all Americans; and

(D) providing, through the National Nanotechnology Coordination Office established in section 3, for public input and outreach to be integrated into the Program by the convening of regular and ongoing public discussions, through mechanisms such as citizens' panels, consensus conferences, and educational events, as appropriate; and

(11) encouraging research on nanotechnology advances that utilize existing processes and technologies.

(c) PROGRAM MANAGEMENT.—The National Science and Technology Council shall oversee the planning, management, and coordination of the Program. The Council, itself or through an appropriate subgroup it designates or establishes, shall—

(1) establish goals and priorities for the Program, based on national needs for a set of broad applications of nanotechnology;

(2) establish program component areas, with specific priorities and technical goals, that reflect the goals and priorities established for the Program;

(3) oversee interagency coordination of the Program, including with the activities of the Defense Nanotechnology Research and Development Program established under section 246 of the Bob Stump National Defense Authorization Act for Fiscal Year 2003 (Public Law 107-314) and the National Institutes of Health;

(4) develop, within 12 months after the date of enactment of this Act, and update every 3 years thereafter, a strategic plan to guide the activities described under subsection (b), meet the goals, priorities, and anticipated outcomes of the participating agencies, and describe—

(A) how the Program will move results out of the laboratory and into application for the benefit of society;

(B) the Program's support for long-term funding for interdisciplinary research and development in nanotechnology; and

(C) the allocation of funding for interagency nanotechnology projects;

(5) propose a coordinated interagency budget for the Program to the Office of Management and Budget to ensure the maintenance of a balanced nanotechnology research portfolio and an appropriate level of research effort;

(6) exchange information with academic, industry, State and local government (including State and regional nanotechnology programs), and other appropriate groups conducting research on and using nanotechnology;

(7) develop a plan to utilize Federal programs, such as the Small Business Innovation Research Program and the Small Business Technology Transfer Research Program, in support of the activity stated in subsection (b)(7);

(8) identify research areas that are not being adequately addressed by the agencies' current research programs and address such research areas;

(9) encourage progress on Program activities through the utilization of existing manufacturing facilities and industrial infrastructures such as, but not limited to, the employment of underutilized manufacturing facilities in areas of high unemployment as production engineering and research testbeds; and

(10) in carrying out its responsibilities under paragraphs (1) through (9), take into consideration the recommendations of the Advisory Panel, suggestions or recommendations developed pursuant to subsection (b)(10)(D), and the views of academic, State, industry, and other appropriate groups conducting research on and using nanotechnology.

(d) ANNUAL REPORT.—The Council shall prepare an annual report, to be submitted to the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committee on Science, and other appropriate committees, at the time of the President's budget request to Congress, that includes—

(1) the Program budget, for the current fiscal year, for each agency that participates in the Program, including a breakout of spending for the development and acquisition of research facilities and instrumentation, for each program component area, and for all activities pursuant to subsection (b)(10);

(2) the proposed Program budget for the next fiscal year, for each agency that participates in the Program, including a breakout of spending for the development and acquisition of research facilities and instrumentation, for each program component area, and for all activities pursuant to subsection (b)(10);

(3) an analysis of the progress made toward achieving the goals and priorities established for the Program;

(4) an analysis of the extent to which the Program has incorporated the recommendations of the Advisory Panel; and

(5) an assessment of how Federal agencies are implementing the plan described in subsection (c)(7), and a description of the amount of Small Business Innovative Research and Small Business Technology Transfer Research funds supporting the plan.

SEC. 3. PROGRAM COORDINATION.

(a) IN GENERAL.—The President shall establish a National Nanotechnology Coordination Office, with a Director and full-time staff, which shall—

(1) provide technical and administrative support to the Council and the Advisory Panel;

(2) serve as the point of contact on Federal nanotechnology activities for government organizations, academia, industry, professional societies, State nanotechnology programs, interested citizen groups, and others to exchange technical and programmatic information;

(3) conduct public outreach, including dissemination of findings and recommendations of the Advisory Panel, as appropriate; and

(4) promote access to and early application of the technologies, innovations, and expertise derived from Program activities to agency missions and systems across the Federal Government, and to United States industry, including startup companies.

(b) FUNDING.—The National Nanotechnology Coordination Office shall be funded through interagency funding in accordance with section 631 of Public Law 108–7.

(c) REPORT.—Within 90 days after the date of enactment of this Act, the Director of the Office of Science and Technology Policy shall report to the Senate Committee on Commerce, Science, and Transportation, and the House of Representatives Committee on Science on the funding of the National Nanotechnology Coordination Office. The report shall include—

(1) the amount of funding required to adequately fund the Office;

(2) the adequacy of existing mechanisms to fund this Office; and

(3) the actions taken by the Director to ensure stable funding of this Office.

SEC. 4. ADVISORY PANEL.

(a) IN GENERAL.—The President shall establish or designate a National Nanotechnology Advisory Panel.

(b) QUALIFICATIONS.—The Advisory Panel established or designated by the President under subsection (a) shall consist primarily of members from academic institutions and industry. Members of the Advisory Panel shall be qualified to provide advice and information on nanotechnology research, development, demonstrations, education, technology transfer, commercial application, or societal and ethical concerns. In selecting or designating an Advisory Panel, the President may also seek and give consideration to recommendations from the Congress, industry, the scientific community (including the National Academy of Sciences, scientific professional societies, and academia), the defense community, State and local governments, regional nanotechnology programs, and other appropriate organizations.

(c) DUTIES.—The Advisory Panel shall advise the President and the Council on matters relating to the Program, including assessing—

(1) trends and developments in nanotechnology science and engineering;

(2) progress made in implementing the Program;

(3) the need to revise the Program;

(4) the balance among the components of the Program, including funding levels for the program component areas;

(5) whether the program component areas, priorities, and technical goals developed by the Council are helping to maintain United States leadership in nanotechnology;

(6) the management, coordination, implementation, and activities of the Program; and

(7) whether societal, ethical, legal, environmental, and workforce concerns are adequately addressed by the Program.

(d) REPORTS.—The Advisory Panel shall report, not less frequently than once every 2 fiscal years, to the President on its assessments under subsection (c) and its recommendations for ways to improve the Program. The first report under this subsection shall be submitted within 1 year after the date of enactment of this Act. The Director of the Office of Science and Technology Policy shall transmit a copy of each report under this subsection to the Senate Committee on Commerce, Science, and Technology, the House of Representatives Committee on Science, and other appropriate committees of the Congress.

(e) TRAVEL EXPENSES OF NON-FEDERAL MEMBERS.—Non-Federal members of the Advisory Panel, while attending meetings of the Advisory Panel or while otherwise serving at the request of the head of the Advisory Panel away from their homes or regular places of business, may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for individuals in the government serving without pay. Nothing in this subsection shall be construed to prohibit members of the Advisory Panel who are officers or employees of the United States from being allowed travel expenses, including per diem in lieu of subsistence, in accordance with existing law.

(f) EXEMPTION FROM SUNSET.—Section 14 of the Federal Advisory Committee Act shall not apply to the Advisory Panel.

SEC. 5. TRIENNIAL EXTERNAL REVIEW OF THE NATIONAL NANOTECHNOLOGY PROGRAM.

(a) IN GENERAL.—The Director of the National Nanotechnology Coordination Office shall enter into an arrangement with the National Research Council of the National Academy of Sciences to conduct a triennial evaluation of the Program, including—

(1) an evaluation of the technical accomplishments of the Program, including a review of whether the Program has achieved the goals under the metrics established by the Council;

(2) a review of the Program's management and coordination across agencies and disciplines;

(3) a review of the funding levels at each agency for the Program's activities and the ability of each agency to achieve the Program's stated goals with that funding;

(4) an evaluation of the Program's success in transferring technology to the private sector;

(5) an evaluation of whether the Program has been successful in fostering interdisciplinary research and development;

(6) an evaluation of the extent to which the Program has adequately considered ethical, legal, environmental, and other appropriate societal concerns;

(7) recommendations for new or revised Program goals;

(8) recommendations for new research areas, partnerships, coordination and management mechanisms, or programs to be established to achieve the Program's stated goals;

(9) recommendations on policy, program, and budget changes with respect to nanotechnology research and development activities;

(10) recommendations for improved metrics to evaluate the success of the Program in accomplishing its stated goals;

(11) a review of the performance of the National Nanotechnology Coordination Office

and its efforts to promote access to and early application of the technologies, innovations, and expertise derived from Program activities to agency missions and systems across the Federal Government and to United States industry;

(12) an analysis of the relative position of the United States compared to other nations with respect to nanotechnology research and development, including the identification of any critical research areas where the United States should be the world leader to best achieve the goals of the Program; and

(13) an analysis of the current impact of nanotechnology on the United States economy and recommendations for increasing its future impact.

(b) Study on Molecular Self-Assembly.—As part of the first triennial review conducted in accordance with subsection (a), the National Research Council shall conduct a one-time study to determine the technical feasibility of molecular self-assembly for the manufacture of materials and devices at the molecular scale.

(c) Study on the Responsible Development of Nanotechnology.—As part of the first triennial review conducted in accordance with subsection (a), the National Research Council shall conduct a one-time study to assess the need for standards, guidelines, or strategies for ensuring the responsible development of nanotechnolgy, including, but not limited to—

(1) self-replicating nanoscale machines or devices;

(2) the release of such machines in natural environments;

(3) encryption;

(4) the development of defensive technologies;

(5) the use of nanotechnology in the enhancement of human intelligence; and

(6) the use of nanotechnology in developing artificial intelligence.

(d) Evaluation to be Transmitted to Congress.—The Director of the National Nanotechnology Coordination Office shall transmit the results of any evaluation for which it made arrangements under subsection (a) to the Advisory Panel, the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committee on Science upon receipt. The first such evaluation shall be transmitted no later than June 10, 2005, with subsequent evaluations transmitted to the Committees every 3 years thereafter.

SEC. 6. AUTHORIZATION OF APPROPRIATIONS.

(a) National Science Foundation.—There are authorized to be appropriated to the Director of the National Science Foundation to carry out the Director's responsibilities under this Act—

(1) $385,000,000 for fiscal year 2005;
(2) $424,000,000 for fiscal year 2006;
(3) $449,000,000 for fiscal year 2007; and
(4) $476,000,000 for fiscal year 2008.

(b) Department of Energy.—There are authorized to be appropriated to the Secretary of Energy to carry out the Secretary's responsibilities under this Act—

(1) $317,000,000 for fiscal year 2005;
(2) $347,000,000 for fiscal year 2006;
(3) $380,000,000 for fiscal year 2007; and
(4) $415,000,000 for fiscal year 2008.

(c) National Aeronautics and Space Administration.—There are authorized to be appropriated to the Administrator of the National Aeronautics and Space Administration to carry out the Administrator's responsibilities under this Act—

(1) $34,100,000 for fiscal year 2005;
(2) $37,500,000 for fiscal year 2006;
(3) $40,000,000 for fiscal year 2007; and
(4) $42,300,000 for fiscal year 2008.

(d) National Institute of Standards and Technology.—There are authorized to be appropriated to the Director of the National Institute of Standards and Technology to carry out the Director's responsibilities under this Act—

(1) $68,200,000 for fiscal year 2005;
(2) $75,000,000 for fiscal year 2006;
(3) $80,000,000 for fiscal year 2007; and
(4) $84,000,000 for fiscal year 2008.

(e) Environmental Protection Agency.—There are authorized to be appropriated to the Administrator of the Environmental Protection Agency to carry out the Administrator's responsibilities under this Act—

(1) $5,500,000 for fiscal year 2005;
(2) $6,050,000 for fiscal year 2006;
(3) $6,413,000 for fiscal year 2007; and
(4) $6,800,000 for fiscal year 2008.

SEC. 7. DEPARTMENT OF COMMERCE PROGRAMS.

(a) NIST Programs.—The Director of the National Institute of Standards and Technology shall—

(1) as part of the Program activities under section 2(b)(7), establish a program to conduct basic research on issues related to the development and manufacture of nanotechnology, including metrology; reliability and quality assurance; processes control; and manufacturing best practices; and

(2) utilize the Manufacturing Extension Partnership program to the extent possible to ensure that the research conducted under paragraph (1) reaches small- and medium-sized manufacturing companies.

(b) Clearinghouse.—The Secretary of Commerce or his designee, in consultation with the National Nanotechnology Coordination Office and, to the extent possible, utilizing resources at the National Technical Information Service, shall establish a clearinghouse of information related to commercialization of nanotechnology research, including information relating to activities by regional, State, and local commercial nanotechnology initiatives; transition of research, technologies, and concepts from Federal nanotechnology research and development programs into commercial and military products; best practices by government, universities and private sector laboratories transitioning technology to commercial use; examples of ways to overcome barriers and challenges to technology deployment; and use of manufacturing infrastructure and workforce.

SEC. 8. DEPARTMENT OF ENERGY PROGRAMS.

(a) Research Consortia.—

(1) Department of energy program.—The Secretary of Energy shall establish a program to support, on a merit-reviewed and competitive basis, consortia to conduct interdisciplinary nanotechnology research and development designed to integrate newly developed nanotechnology and microfluidic tools with systems biology and molecular imaging.

(2) Authorization of appropriations.—Of the sums authorized for the Department of Energy under section 6(b), $25,000,000 shall be used for each fiscal year 2005 through 2008 to carry out this section. Of these amounts, not less than $10,000,000 shall be provided to at least 1 consortium for each fiscal year.

(b) Research Centers and Major Instrumentation.—The Secretary of Energy shall carry out projects to develop, plan, construct, acquire, operate, or support special equipment, instrumentation, or facilities for investigators conducting research and development in nanotechnology.

SEC. 9. ADDITIONAL CENTERS.

(a) American Nanotechnology Preparedness Center.—The Program shall provide for the establishment, on a merit-reviewed and competitive basis, of an American Nanotechnology Preparedness Center which shall—

(1) conduct, coordinate, collect, and disseminate studies on the societal, ethical, environmental, educational, legal, and workforce implications of nanotechnology; and

(2) identify anticipated issues related to the responsible research, development, and application of nanotechnology, as well as provide recommendations for preventing or addressing such issues.

(b) Center for Nanomaterials Manufacturing.—The Program shall provide for the establishment, on a merit reviewed and competitive basis, of a center to—

(1) encourage, conduct, coordinate, commission, collect, and disseminate research on new manufacturing technologies for materials, devices, and systems with new combinations of characteristics, such as, but not limited to, strength, toughness, density, conductivity, flame resistance, and membrane separation characteristics; and

(2) develop mechanisms to transfer such manufacturing technologies to United States industries.

(c) Reports.—The Council, through the Director of the National Nanotechnology Coordination Office, shall submit to the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committee on Science—

(1) within 6 months after the date of enactment of this Act, a report identifying which agency shall be the lead agency and which other agencies, if any, will be responsible for establishing the Centers described in this section; and

(2) within 18 months after the date of enactment of this Act, a report describing how the Centers described in this section have been established.

SEC. 10. DEFINITIONS.

In this Act:

(1) Advisory panel.—The term "Advisory Panel" means the President's National Nanotechnology Advisory Panel established or designated under section 4.

(2) Nanotechnology.—The term "nanotechnology" means the science and technology that will enable one to understand, measure, manipulate, and manufacture at the atomic, molecular, and supramolecular levels, aimed at creating materials, devices, and systems with fundamentally new molecular organization, properties, and functions.

(3) Program.—The term "Program" means the National Nanotechnology Program established under section 2.

(4) Council.—The term "Council" means the National Science and Technology Council or an appropriate subgroup designated by the Council under section 2(c).

(5) Advanced technology user facility.—The term "advanced technology user facility" means a nanotechnology research and development facility supported, in whole or in part, by Federal funds that is open to all United States researchers on a competitive, merit-reviewed basis.

(6) Program component area.—The term "program component area" means a major subject area established under section 2(c)(2) under which is grouped related individual projects and activities carried out under the Program.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from

New York (Mr. BOEHLERT) and the gentleman from Texas (Mr. HALL) each will control 20 minutes.

The Chair recognizes the gentleman from New York (Mr. BOEHLERT).

GENERAL LEAVE

Mr. BOEHLERT. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on S. 189.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New York?

There was no objection.

Mr. BOEHLERT. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of S.189, the Nanotechnology and Research Development Act. This bill began its life in the House as H.R. 766, which I introduced with my colleague, the gentleman from California (Mr. HONDA) and which the House passed back in May by the overwhelming margin of 405 to 19.

The text before us today reflects 2 months of negotiations with the Senate to come up with a final version of the bill. The Senate amended S. 189 with the text of that agreement, and it is that compromise we will be sending on to the President today.

This bill is endorsed by a wide variety of high technology and academic organizations including the National Association of Manufacturers, the Semiconductor Industry Association, Intel, IBM, Hewlett-Packard, and the Association of American Universities.

The idea behind this bill is simple yet powerful. The American economy will grow bigger if America's scientists and engineers focus on things that are smaller. The U.S. is the leader in nanotechnology and New York under Governor Pataki is in the front ranks of that world leadership. We must remain in the front as this new field starts remaking the marketplace.

This bill has four salient aspects designed to help ensure continued U.S. leadership: It authorizes the President's National Nanotechnology Initiative; it emphasizes the need for broad interagency participation and stronger interagency coordination, especially in the presentation of program budgets; it underscores the need for interdisciplinary research and for shepherding research from the laboratory to the marketplace; and it ensures that research and public discussion on the societal and ethical consequences of nanotechnology will go on concurrent with, and as part of technology research and development.

The nanotechnology program will be a model of government, industry, university, cooperation, coordination and interdisciplinary research with public involvement.

I wanted to thank the many Members who helped contribute to this bill but particularly to my cosponsor, the gentleman from California (Mr. HONDA) and my partner, the ranking member, the gentleman from Texas (Mr. HALL), as well as the chairman of our Subcommittee on Research, the gentleman from Michigan (Mr. SMITH) and his ranking member, the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON).

Last but not least, I want to thank my staff who labored so long and hard on this bill and on the many hearings on the subject. Peter Rooney, Dan Byers and Elizabeth Grossman deserve special recognition, but the entire staff of the committee minority and majority has been actively engaged.

Mr. Speaker, I reserve the balance of my time.

Mr. HALL. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I, of course, rise in support of the Nanotechnology Research and Development Act, Senate 189, which as the chairman has so ably set forth, authorizes the National Nanotechnology Initiative as part of the President's budget request. This interagency research program is going to have enormous consequences for the future of our entire Nation.

S. 189 is a compromise measure worked out with the other body. It is largely based on H.R. 766 which passed the House in May by a vote of 405 to 19. The bipartisan House bill was introduced by Committee on Science chairman, the gentleman from New York (Mr. BOEHLERT) and the gentleman from California (Mr. HONDA) and cosponsored by Members from both sides of the aisle.

I want to acknowledge the leadership of the chairman, the gentleman from New York (Mr. BOEHLERT) and the gentleman from California (Mr. HONDA) in crafting the original version of the legislation. I want to thank the gentleman from New York (Mr. BOEHLERT) for working cooperatively day in and day with Democratic Members in developing the bill and arriving at the final bicameral compromise.

I also want to thank my colleague, the gentleman from California (Mr. HONDA) for his hard work on the bill. His efforts have led to a strengthening of the outside advisory mechanism for this research and also led to a process to help facilitate the transfer of research innovations to commercial applications.

The potential reach and impact of nanotechnology argues for careful attention to how it might affect society, and in particular, attention to potential downsides of the technology.

I believe it is important for the successful development of nanotechnology that problems be addressed from the beginning in a straightforward and open way.

Consequently, I am pleased that the bill imposes requirements to provide understanding of potential problems arising from the nanotechnology applications. I particularly want to compliment my colleague, the gentleman from California (Mr. SHERMAN) and my colleague, the gentleman from Texas (Mr. BELL) for championing provisions to address this issue, including annual reporting requirements to allow Congress to track the agencies' activities that are related to societal and ethical concerns.

This annual report will include a description of the nature of the activities being supported and how the activities relate to the overall objectives of the research initiative. An important goal of the bill is to integrate research on societal and ethical concerns with research and development efforts to advance nanotechnology.

The bill also addresses the need to open lines of communication between the research community and the public to make clear that potential safety risks of nanotechnology are being explored and not ignored.

I want to especially acknowledge the efforts of my colleague, the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON) who introduced provisions that will provide for input from and outreach to the public from such mechanisms as citizen panels and consensus conferences.

Senate 189 authorizes appropriations over 4 years for nanotechnology research and development at five agencies: The National Science Foundation, the Department of Energy, NASA, National Institute of Standards and Technology, and EPA. In addition to setting funding goals, the bill puts in place mechanisms for planning and coordinating and implementation of the interagency research program.

The bill also includes provisions for outside, expert advice to help guide the research program and ensure its relevance to emerging technological opportunities and to the industry. The advisory committee required by the bill is charged to review the goals, content, implementation and administration of the nanotechnology initiative.

Mr. Speaker, we now stand at the threshold of an age in which materials and devices can be fashioned atom by atom. The capability will have enormous consequences for the information industry, for manufacturing, and for medicine and health. Indeed, the scope of this technology is so broad as to leave virtually no product untouched.

The measure before us will help ensure that the Nation maintains a vigorous research effort in a technology area that is emerging as increasingly important for the economy and also for national security. It enjoys widespread support from the research community and industry. I urge my colleagues to support its final passage.

Mr. Speaker, I reserve the balance of my time.

Mr. BOEHLERT. Mr. Speaker, I yield 3 minutes to the gentlewoman from Illinois (Mrs. BIGGERT), the distinguished chair of the Subcommittee on Energy.

Mrs. BIGGERT. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, as an original cosponsor of H.R. 766, the Nanotechnology Research and Development Act that was approved by the House last May, I rise to express my strong support for this compromise legislation negotiated by the House Committee on Science.

I want to commend the chairman of the Committee on Science, the gentleman from New York (Mr. BOEHLERT) for working with the Senate to develop such a comprehensive and forward-looking piece of legislation as S. 189, the 21st Century Nanotechnology Research and Development Act.

Unlike so many other complex scientific concepts, nanotechnology is actually something that we should all be able to grasp. Most Americans learn in grade school and high school that atoms are the building blocks of nature. In the years since I have been in school, incredible machines have allowed to us see every one of those atoms.

The challenge now is to develop the tools, equipment and expertise to manipulate those atoms, and build new materials and new machines, one molecule at a time.

This bill takes up that challenge, ensuring coordination and collaboration among the many Federal agencies engaged in nanotech research. Unlike other research efforts, some of which are undertaken for the sake of science and our understanding of it, the broad and practical applications of nanotechnology, and its benefits, can be described in layman's terms.

Here are just a few benefits: Sensing the presence of unwanted pathogens in blood; improving the efficiency of electricity distribution; dispensing medications; cleaning polluted soil and water, or building the next generation of space craft.

I do not think I am being overly optimistic. Just consider how far we have come since the creation of the first microchip. Sixty percent of Americans now own a personal computer or a laptop, and 90 percent of them use the Internet. The public, private, and nonprofit sectors invested in research that reduced the size of the microchip while increasing its speeds exponentially.

This investment was made because the applications were many and the possibilities endless. After all, microchips are now found in cars, pacemakers, watches, sewing machines, and just about every household appliance.

With all its potential applications, nanotechnology could have an equal, if not greater, impact than the microchip on our lives, our wealth, our health and safety, our environment, and our security at home and abroad.

All levels of government, academia, and the industry recognize the potential of nanotechnology, as well as the benefits of collaborating to realize that potential. Nanotechnology could very well be the catalyst for national competitiveness for the next 50 years. In countless ways, our lives will be better as a result of coordinated investment in nanoscience R&D.

I urge my colleagues to join me in supporting this nanotechnology research and development legislation.

Mr. HALL. Mr. Speaker, I yield 3 minutes to the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON), the ranking member on Subcommittee on Research.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I thank the leadership of the committee and the subcommittee. I want to express my appreciation for the camaraderie of which we work together on the committee. I rise together in support of S. 189, the Nanotechnology Research and Development Act.

The emerging fields of nanoscale science, engineering and technology are leading to unprecedented understanding and control over the basic building blocks of properties of all natural and man-made things.

□ 1445

Nanotechnology has the potential for enormous consequences, both technological and societal. This technology could result in new materials with prescribed properties not otherwise possible, information processing that far exceeds our current capabilities, and medical devices that could provide revolutionary advances in health care and dramatically increase our lifespan.

Nanotechnology has a great potential for America's leadership around the world. As America enters the 21st century, it is important that we lead the world in developing and commercializing new technologies and perhaps restore many of the jobs that we have lost.

I am very pleased that this bill includes an amendment that I introduced when we voted on H.R. 766 back in May. This amendment, under program "activities on societal and ethical concerns," requires public input and outreach to the public to be integrated into the program through regular and ongoing public discussions, including citizens panels, consensus conferences, and educational events.

The views of the general public, who will bear the brunt of the consequences, both good and bad, should have input in the planning and execution of the research program. Taxpayers are paying for development of this technology. They have a right to have a voice in the research agenda.

I agree with that assessment that nanotechnology is one of the most promising and exciting fields of science today.

I am proud to be a cosponsor of this legislation and proud to say that I believe that the area which I represent will have some leading research in this area, with Nobel laureates. As I vote for its approval, I would urge my colleagues to do the same.

Mr. BOEHLERT. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Michigan (Mr. SMITH), the chairman of the Subcommittee on Research.

Mr. SMITH of Michigan. Mr. Speaker, first, let me compliment the gentleman from California (Mr. HONDA) and the chairman for introducing this legislation. Nanotechnology is the science of the very small, and I thought I might use a visual aid today. So if my colleagues would take a hair out of their heads and pretend that it is hollow, they could fit 100,000 strands of nano-technology inside that hollow hair. It is amazing technology.

Nanotechnology is exciting to me because it has so much potential for the future. Already today, computers and disk drives contain nanotechnology. Soon, most computers and telecommunications hardware will be based on it. In the not-too-distant future, nanotechnology will begin to transform biology, medicine, military systems, energy systems.

Nanotechnology is poised to become the next great vehicle of growth for the American economy; and like biotechnology was 10, 12, 15 years ago, nanotechnology has reached a critical growth stage. The 21st Century Research and Development Act intensifies Federal support for nanoresearch and experimentation and will prove, I think, critical to unlocking the tremendous potential that nanotechnology presents.

In conclusion, let me just say that nanotechnology holds incredible promise in a wide range of scientific disciplines; and while there are some nanotechnology products on the market today, the industry is very close to achieving several important breakthroughs that include revolutionary new applications in materials science, in manufacturing. So if we are going to stay competitive in the world market, and that means having our standard of living above everybody else, then we are going to have to take advantage of this kind of technology that can improve the way we produce products, but also improve those products that we are selling and allow us to be competitive on a world market.

In conclusion, I would hope everybody would unanimously not only support this bill but the kind of funding that is necessary to make sure that the United States stays on top in nanoresearch.

I thank the chairman for yielding me the time.

Mr. HALL. Mr. Speaker, I yield 4 minutes to the gentleman from California (Mr. HONDA), who is an original

Democratic cosponsor of the House bill.

Mr. HONDA. Mr. Speaker, I rise in support of S. 189, the 21st Century Nanotechnology Research and Development Act. I thank the distinguished leaders of the Committee on Science, the gentleman from New York (Chairman BOEHLERT) and the gentleman from Texas (Ranking Member HALL) for working with me on the House version of this bipartisan bill, as well as Senators ALLEN and WYDEN for their leadership on the Senate version of this legislation.

I would also like to thank my personal staff and the committee staff for all their hard work in ironing out the differences with the other body that has allowed us to get to where we are today on this important legislation.

Nanotechnology, which is the ability of scientists and engineers to manipulate matter at the level of single atoms and molecules, can be revolutionary because it is an enabling technology and fundamentally changes the way many items are designed and manufactured. Most Members of this body had probably never heard of the word "nanotechnology" before we first considered legislation in May, but their support for the bill then and in the following months suggests that they have come to appreciate the impact this field will have.

The long-term, sometimes high-risk nature of the research that will be needed to bring nanotechnology to maturity requires the support of, and significant investment by, the Federal Government. This bill provides three things. It puts the National Technology Initiative into law and authorizes $3.7 billion in spending over the next 4 years for the program.

This investment in the future is critical because experts agree that investing in innovation is the key to a vibrant U.S. manufacturing base and continued generation of new jobs. Nanotechnology is one of the areas of innovation most worthy of investment, as it has the potential to create entirely new industries and radically transform the basis of competition in others.

The bill also contains a number of other provisions to make improvements in our national technology initiative. It requires the creation of research centers, education training efforts, research into the societal and ethical consequence of nanotechnology, and efforts to transfer technology into the marketplace. Importantly, the bill includes a series of coordination offices, advisory committees and regular programming to ensure that taxpayer money is being spent wisely and efficiently.

This is an excellent bill that I am proud to have had the chance to work on, and I urge my colleagues to support it.

Once again, let me again repeat my gratitude and thanks to the leadership of the gentleman from New York (Mr. BOEHLERT), our chairman, and the gentleman from Texas (Mr. HALL), our ranking member.

Mr. BOEHLERT. Mr. Speaker, let me say I want to thank the gentleman from California (Mr. HONDA) for his partnership, and it has been a cooperative effort; and all of the efforts on the Committee on Science reflect that cooperation.

Mr. Speaker, it is my pleasure to yield 3 minutes to the distinguished gentleman from Texas (Mr. BURGESS), who has been a real leader for our side on this issue of nanotechnology.

Mr. BURGESS. Mr. Speaker, I thank my chairman for yielding me time.

It is indeed a pleasure to be here this afternoon to support Senate bill 189, the 21st Century National Nanotechnology Research and Development Act.

Nanotechnology is a very promising future technology. From materials to computers, medicine, defense, energy, the possibilities are limitless. We are moving from an age of miniaturization to an age of self-replication.

The House overwhelmingly approved this bill's companion, H.R. 766, and I am hopeful that the House will once again make a bipartisan commitment to increasing resources for nanotechnology research and development. The development of nanotechnology is not only important to my corner of the country but for every human on the planet.

The National Science Foundation estimates that in a little over a decade nanotechnology will positively impact the global market by approximately $1 trillion. This bill will ensure that the United States continues to be a leader in nanotechnology research.

This bill is especially important to my academic institutions in my district, especially the University of North Texas. Mr. Speaker, as the ranking member knows, everything is bigger in Texas unless it is better to be smaller, in which case everything is smaller in Texas.

Beginning last fall, the University of North Texas began laboratory renovation and equipment purchases for the Department of Material Science, including research space for their Laboratory for Electronic Materials and Devices and the establishment of a nanometrology laboratory, the first in the Nation.

This center, the Center for Advanced Research and Technology, is a unique collaboration between academic and corporate partners in the north Texas area, designed to develop new nanotechnology applications. The development of the nanometrology laboratory will provide remote access by researchers throughout the United States through state-of-the-art materials characterization.

These facility and research capabilities are important to the future competitiveness and the value of American materials worldwide, and this bill will help further those developments.

This comprehensive approach taken by Senate bill 189 to raise the profile of nanometrology and nanotechnology among the general public and increased resources for academic institutions will ensure that our country, America, is the leader in this field for years to come.

Mr. HALL. Mr. Speaker, I yield 3 minutes to the gentlewoman from California (Ms. LOFGREN), a long-time leader in high-tech issues from the Silicon Valley.

Ms. LOFGREN. Mr. Speaker, I am happy to strongly support S. 189, the 21st Century Nanotechnology Research and Development Act.

I represent, as the gentleman from Texas (Mr. HALL) just said, an area, Silicon Valley, that often leads this Nation in fostering cutting-edge research in technology and in manufacturing. Indeed, a great deal of much important research involving nanotechnology is being done right now at NASA Ames Research Park in California.

Mr. Speaker, I would like to take this opportunity to remind us all of the importance of supporting scientific research and its interaction with our society and our economy. With that in mind, Mr. Speaker, S. 189 is an important first step that will ensure that the United States will continue to play a pioneering role in the area of nanotechnology and its revolutionary potential to transform the manufacturing sector in our Nation, not to mention energy, health care, and areas that we can only dream of today.

I congratulate the gentleman from New York (Mr. BOEHLERT) and my Bay Area colleague, the gentleman from California (Mr. HONDA), for their bipartisan efforts in drafting and perfecting and passing H.R. 766 in the House which in large part forms the basis of this bill that we are about to pass.

The future benefits of research in nanotechnology, fusion energy, and other types of research depend on us acting with great foresight. S. 189 represents a great first step on that path; and as my colleague, the gentleman from California (Mr. HONDA), said recently at a nanotechnology conference that he helped organize at NASA Ames Research Park, nanotechnology is the next big thing.

Mr. HALL. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. BOEHLERT. Mr. Speaker, I have no further requests for time; but before I yield back, I urge everyone to take the enlightened approach and support this very important initiative. I yield back the balance of my time.

The SPEAKER pro tempore (Mr. TERRY). The question is on the motion offered by the gentleman from New York (Mr. BOEHLERT) that the House suspend the rules and pass the Senate bill, S. 189.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the Senate bill was passed.

A motion to reconsider was laid on the table.

□ 1500

VETERANS BENEFITS ACT OF 2003

Mr. SMITH of New Jersey. Mr. Speaker, I move to suspend the rules and concur in the Senate amendment to the bill (H.R. 2297) to amend title 38, United States Code, to improve benefits under laws administered by the Secretary of Veterans Affairs, and for other purposes.

The Clerk read as follows:

Senate amendment:

Strike out all after the enacting clause and insert:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Veterans Benefits Act of 2003".

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. References to title 38, United States Code.

TITLE I—SURVIVOR BENEFITS

Sec. 101. Retention of certain veterans survivor benefits for surviving spouses remarrying after age 57.
Sec. 102. Benefits for children with spina bifida of veterans of certain service in Korea.
Sec. 103. Alternative beneficiaries for National Service Life Insurance and United States Government Life Insurance.
Sec. 104. Payment of benefits accrued and unpaid at time of death.

TITLE II—BENEFITS FOR FORMER PRISONERS OF WAR AND FOR FILIPINO VETERANS

SUBTITLE A—FORMER PRISONERS OF WAR

Sec. 201. Presumptions of service-connection relating to diseases and disabilities of former prisoners of war.

SUBTITLE B—FILIPINO VETERANS

Sec. 211. Rate of payment of benefits for certain Filipino veterans and their survivors residing in the United States.
Sec. 212. Burial benefits for new Philippine Scouts residing in the United States.
Sec. 213. Extension of authority to maintain regional office in the Republic of the Philippines.

TITLE III—EDUCATION BENEFITS, EMPLOYMENT PROVISIONS, AND RELATED MATTERS

Sec. 301. Expansion of Montgomery GI Bill education benefits for certain self-employment training.
Sec. 302. Increase in rates of survivors' and dependents' educational assistance.
Sec. 303. Restoration of survivors' and dependents' education benefits of individuals being ordered to full-time National Guard duty.
Sec. 304. Rounding down of certain cost-of-living adjustments on educational assistance.
Sec. 305. Authorization for State approving agencies to approve certain entrepreneurship courses.
Sec. 306. Repeal of provisions relating to obsolete education loan program.
Sec. 307. Six-year extension of the Veterans' Advisory Committee on Education.
Sec. 308. Procurement program for small business concerns owned and controlled by service-disabled veterans.
Sec. 309. Outstationing of Transition Assistance Program personnel.

TITLE IV—HOUSING BENEFITS AND RELATED MATTERS

Sec. 401. Authorization to provide adapted housing assistance to certain disabled members of the Armed Forces who remain on active duty.
Sec. 402. Increase in amounts for certain adaptive benefits for disabled veterans.
Sec. 403. Permanent authority for housing loans for members of the Selected Reserve.
Sec. 404. Reinstatement of minimum requirements for sale of vendee loans.
Sec. 405. Adjustment to home loan fees.
Sec. 406. One-year extension of procedures on liquidation sales of defaulted home loans guaranteed by the Department of Veterans Affairs.

TITLE V—BURIAL BENEFITS

Sec. 501. Burial plot allowance.
Sec. 502. Eligibility of surviving spouses who remarry for burial in national cemeteries.
Sec. 503. Permanent authority for State cemetery grants program.

TITLE VI—EXPOSURE TO HAZARDOUS SUBSTANCES

Sec. 601. Radiation Dose Reconstruction Program of Department of Defense.
Sec. 602. Study on disposition of Air Force Health Study.
Sec. 603. Funding of Medical Follow-Up Agency of Institute of Medicine of National Academy of Sciences for epidemiological research on members of the Armed Forces and veterans.

TITLE VII—OTHER MATTERS

Sec. 701. Time limitations on receipt of claim information pursuant to requests of Department of Veterans Affairs.
Sec. 702. Clarification of applicability of prohibition on assignment of veterans benefits to agreements requiring payment of future receipt of benefits.
Sec. 703. Six-year extension of Advisory Committee on Minority Veterans.
Sec. 704. Temporary authority for performance of medical disabilities examinations by contract physicians.
Sec. 705. Forfeiture of benefits for subversive activities.
Sec. 706. Two-year extension of round-down requirement for compensation cost-of-living adjustments.
Sec. 707. Codification of requirement for expeditious treatment of cases on remand.
Sec. 708. Technical and clerical amendments.

SEC. 2. REFERENCES TO TITLE 38, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

TITLE I—SURVIVOR BENEFITS

SEC. 101. RETENTION OF CERTAIN VETERANS SURVIVOR BENEFITS FOR SURVIVING SPOUSES REMARRYING AFTER AGE 57.

(a) EXCEPTION TO TERMINATION OF BENEFITS UPON REMARRIAGE.—Section 103(d)(2)(B) is amended by striking "The remarriage after age 55" and inserting "The remarriage after age 57 of the surviving spouse of a veteran shall not bar the furnishing of benefits specified in paragraph (5) to such person as the surviving spouse of the veteran. Notwithstanding the previous sentence, the remarriage after age 55".

(b) COORDINATION OF BENEFITS.—Section 1311 is amended by adding at the end the following new subsection:

"(e) In the case of an individual who is eligible for dependency and indemnity compensation under this section by reason of section 103(d)(2)(B) of this title who is also eligible for benefits under another provision of law by reason of such individual's status as the surviving spouse of a veteran, then, notwithstanding any other provision of law (other than section 5304(b)(3) of this title), no reduction in benefits under such other provision of law shall be made by reason of such individual's eligibility for benefits under this section.".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall take effect on January 1, 2004.

(d) RETROACTIVE BENEFITS PROHIBITED.—No benefit may be paid to any person by reason of the amendments made by subsections (a) and (b) for any period before the effective date specified in subsection (c).

(e) APPLICATION FOR BENEFITS.—In the case of an individual who but for having remarried would be eligible for benefits under title 38, United States Code, by reason of the amendment made by subsection (a) and whose remarriage was before the date of the enactment of this Act and after the individual had attained age 57, the individual shall be eligible for such benefits by reason of such amendment only if the individual submits an application for such benefits to the Secretary of Veterans Affairs not later than the end of the one-year period beginning on the date of the enactment of this Act.

(f) TECHNICAL CORRECTION.—Section 101(b) of the Veterans Benefits Act of 2002 (Public Law 107–330; 116 Stat. 2821; 38 U.S.C. 103 note) is amended by striking "during the 1-year period" and all that follows through "(c)" and inserting "before the end of the one-year period beginning on the date of the enactment of the Veterans Benefits Act of 2003".

SEC. 102. BENEFITS FOR CHILDREN WITH SPINA BIFIDA OF VETERANS OF CERTAIN SERVICE IN KOREA.

(a) IN GENERAL.—Chapter 18 is amended—

(1) by redesignating subchapter III, and sections 1821, 1822, 1823, and 1824, as subchapter IV, and sections 1831, 1832, 1833, and 1834, respectively; and

(2) by inserting after subchapter II the following new subchapter III:

"SUBCHAPTER III—CHILDREN OF CERTAIN KOREA SERVICE VETERANS BORN WITH SPINA BIFIDA

"§ 1821. Benefits for children of certain Korea service veterans born with spina bifida

"(a) BENEFITS AUTHORIZED.—The Secretary may provide to any child of a veteran of covered service in Korea who is suffering from spina bifida the health care, vocational training and rehabilitation, and monetary allowance required to be paid to a child of a Vietnam veteran who is suffering from spina bifida under subchapter I of this chapter as if such child of a veteran of covered service in Korea were a child of a Vietnam veteran who is suffering from spina bifida under such subchapter.

"(b) Spina Bifida Conditions Covered.—This section applies with respect to all forms and manifestations of spina bifida, except spina bifida occulta.

"(c) Veteran of Covered Service in Korea.—For purposes of this section, a veteran of covered service in Korea is any individual, without regard to the characterization of that individual's service, who—

"(1) served in the active military, naval, or air service in or near the Korean demilitarized zone (DMZ), as determined by the Secretary in consultation with the Secretary of Defense, during the period beginning on September 1, 1967, and ending on August 31, 1971; and

"(2) is determined by the Secretary, in consultation with the Secretary of Defense, to have been exposed to a herbicide agent during such service in or near the Korean demilitarized zone.

"(d) Herbicide Agent.—For purposes of this section, the term 'herbicide agent' means a chemical in a herbicide used in support of United States and allied military operations in or near the Korean demilitarized zone, as determined by the Secretary in consultation with the Secretary of Defense, during the period beginning on September 1, 1967, and ending on August 31, 1971.".

(b) Child Defined.—Section 1831, as redesignated by subsection (a) of this section, is amended by striking paragraph (1) and inserting the following new paragraph (1):

"(1) The term 'child' means the following:

"(A) For purposes of subchapters I and II of this chapter, an individual, regardless of age or marital status, who—

"(i) is the natural child of a Vietnam veteran; and

"(ii) was conceived after the date on which that veteran first entered the Republic of Vietnam during the Vietnam era.

"(B) For purposes of subchapter III of this chapter, an individual, regardless of age or marital status, who—

"(i) is the natural child of a veteran of covered service in Korea (as determined for purposes of section 1821 of this title); and

"(ii) was conceived after the date on which that veteran first entered service described in subsection (c) of that section.".

(c) Nonduplication of Benefits.—Subsection (a) of section 1834, as redesignated by subsection (a) of this section, is amended by adding at the end the following new sentence: "In the case of a child eligible for benefits under subchapter I or II of this chapter who is also eligible for benefits under subchapter III of this chapter, a monetary allowance shall be paid under the subchapter of this chapter elected by the child.".

(d) Conforming Amendments.—(1) Section 1811(1)(A) is amended by striking "section 1821(1)" and inserting "section 1831(1)".

(2) The heading for chapter 18 is amended to read as follows:

"CHAPTER 18—BENEFITS FOR CHILDREN OF VIETNAM VETERANS AND CERTAIN OTHER VETERANS".

(e) Clerical Amendments.—(1) The table of sections at the beginning of chapter 18 is amended by striking the items relating to subchapter III and sections 1821, 1822, 1823, and 1824 and inserting the following new items:

"SUBCHAPTER III—CHILDREN OF CERTAIN KOREA SERVICE VETERANS BORN WITH SPINA BIFIDA

"1821. Benefits for children of certain Korea service veterans born with spina bifida.

"SUBCHAPTER IV—GENERAL PROVISIONS

"1831. Definitions.

"1832. Applicability of certain administrative provisions.

"1833. Treatment of receipt of monetary allowance and other benefits.

"1834. Nonduplication of benefits.".

(2) The table of chapters at the beginning of title 38, United States Code, and at the beginning of part II, are each amended by striking the item relating to chapter 18 and inserting the following new item:

"18. Benefits for Children of Vietnam Veterans and Certain Other Veterans .... 1802".

SEC. 103. ALTERNATIVE BENEFICIARIES FOR NATIONAL SERVICE LIFE INSURANCE AND UNITED STATES GOVERNMENT LIFE INSURANCE.

(a) National Service Life Insurance.—Section 1917 is amended by adding at the end the following new subsection:

"(f)(1) Following the death of the insured and in a case not covered by subsection (d)—

"(A) if the first beneficiary otherwise entitled to payment of the insurance does not make a claim for such payment within two years after the death of the insured, payment may be made to another beneficiary designated by the insured, in the order of precedence as designated by the insured, as if the first beneficiary had predeceased the insured; and

"(B) if, within four years after the death of the insured, no claim has been filed by a person designated by the insured as a beneficiary and the Secretary has not received any notice in writing that any such claim will be made, payment may (notwithstanding any other provision of law) be made to such person as may in the judgment of the Secretary be equitably entitled thereto.

"(2) Payment of insurance under paragraph (1) shall be a bar to recovery by any other person.".

(b) United States Government Life Insurance.—Section 1952 is amended by adding at the end the following new subsection:

"(c)(1) Following the death of the insured and in a case not covered by section 1950 of this title—

"(A) if the first beneficiary otherwise entitled to payment of the insurance does not make a claim for such payment within two years after the death of the insured, payment may be made to another beneficiary designated by the insured, in the order of precedence as designated by the insured, as if the first beneficiary had predeceased the insured; and

"(B) if, within four years after the death of the insured, no claim has been filed by a person designated by the insured as a beneficiary and the Secretary has not received any notice in writing that any such claim will be made, payment may (notwithstanding any other provision of law) be made to such person as may in the judgment of the Secretary be equitably entitled thereto.

"(2) Payment of insurance under paragraph (1) shall be a bar to recovery by any other person.".

(c) Effective Date.—The amendments made by subsections (a) and (b) shall take effect on October 1, 2004.

(d) Transition Provision.—In the case of a person insured under subchapter I or II of chapter 19 of title 38, United States Code, who dies before the effective date of the amendments made by subsections (a) and (b), as specified by subsection (c), the two-year and four-year periods specified in subsection (f)(1) of section 1917 of title 38, United States Code, as added by subsection (a), and subsection (c)(1) of section 1952 of such title, as added by subsection (b), as applicable, shall for purposes of the applicable subsection be treated as being the two-year and four-year periods, respectively, beginning on the effective date of such amendments, as so specified.

SEC. 104. PAYMENT OF BENEFITS ACCRUED AND UNPAID AT TIME OF DEATH.

(a) Repeal of Two-Year Limitation on Payment.—Section 5121(a) is amended by striking "for a period not to exceed two years" in the matter preceding paragraph (1).

(b) Payment Recipients for Beneficiaries Under Chapter 18.—Such section is further amended—

(1) by striking "and" at the end of paragraph (4);

(2) by redesignating paragraph (5) as paragraph (6); and

(3) by inserting after paragraph (4) the following new paragraph (5):

"(5) Upon the death of a child claiming benefits under chapter 18 of this title, to the surviving parents.".

(c) Technical Amendments.—Such section is further amended—

(1) in the matter preceding paragraph (1), by striking the comma after "or decisions";

(2) by striking the semicolon at the end of paragraphs (1), (2), (3), and (4), and at the end of subparagraphs (A) and (B) of paragraph (2), and inserting a period.

(d) Effective Date.—The amendments made by subsections (a) and (b) shall apply with respect to deaths occurring on or after the date of the enactment of this Act.

TITLE II—BENEFITS FOR FORMER PRISONERS OF WAR AND FOR FILIPINO VETERANS

Subtitle A—Former Prisoners of War

SEC. 201. PRESUMPTIONS OF SERVICE-CONNECTION RELATING TO DISEASES AND DISABILITIES OF FORMER PRISONERS OF WAR.

Subsection (b) of section 1112 is amended to read as follows:

"(b)(1) For the purposes of section 1110 of this title and subject to the provisions of section 1113 of this title, in the case of a veteran who is a former prisoner of war—

"(A) a disease specified in paragraph (2) which became manifest to a degree of 10 percent or more after active military, naval, or air service shall be considered to have been incurred in or aggravated by such service, notwithstanding that there is no record of such disease during the period of service; and

"(B) if the veteran was detained or interned as a prisoner of war for not less than thirty days, a disease specified in paragraph (3) which became manifest to a degree of 10 percent or more after active military, naval, or air service shall be considered to have been incurred in or aggravated by such service, notwithstanding that there is no record of such disease during the period of service.

"(2) The diseases specified in this paragraph are the following:

"(A) Psychosis.

"(B) Any of the anxiety states.

"(C) Dysthymic disorder (or depressive neurosis).

"(D) Organic residuals of frostbite, if the Secretary determines that the veteran was detained or interned in climatic conditions consistent with the occurrence of frostbite.

"(E) Post-traumatic osteoarthritis.

"(3) The diseases specified in this paragraph are the following:

"(A) Avitaminosis.

"(B) Beriberi (including beriberi heart disease).

"(C) Chronic dysentery.

"(D) Helminthiasis.

"(E) Malnutrition (including optic atrophy associated with malnutrition).

"(F) Pellagra.

"(G) Any other nutritional deficiency.

"(H) Cirrhosis of the liver.

"(I) Peripheral neuropathy except where directly related to infectious causes.

"(J) Irritable bowel syndrome.

"(K) Peptic ulcer disease.".

Subtitle B—Filipino Veterans

SEC. 211. RATE OF PAYMENT OF BENEFITS FOR CERTAIN FILIPINO VETERANS AND THEIR SURVIVORS RESIDING IN THE UNITED STATES.

(a) RATE OF PAYMENT.—Section 107 is amended—

(1) in the second sentence of subsection (b), by striking "Payments" and inserting "Except as provided in subsection (c), payments"; and

(2) in subsection (c)—

(A) by inserting "and subchapter II of chapter 13 (except section 1312(a)) of this title" after "chapter 11 of this title";

(B) by striking "in subsection (a)" and inserting "in subsection (a) or (b)"; and

(C) by striking "of subsection (a)" and inserting "of the applicable subsection".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to benefits paid for months beginning after the date of the enactment of this Act.

SEC. 212. BURIAL BENEFITS FOR NEW PHILIPPINE SCOUTS RESIDING IN THE UNITED STATES.

(a) BENEFIT ELIGIBILITY.—Section 107, as amended by section 211 of this Act, is amended—

(1) in subsection (b)(2)—

(A) by striking "and" and inserting a comma; and

(B) by inserting ", 23, and 24 (to the extent provided for in section 2402(8))" after "(except section 1312(a))";

(2) in the second sentence of subsection (b), as so amended, by inserting "or (d)" after "subsection (c)";

(3) in subsection (d)(1), by inserting "or (b), as otherwise applicable," after "subsection (a)"; and

(4) in subsection (d)(2), by inserting "or whose service is described in subsection (b) and who dies after the date of the enactment of the Veterans Benefits Act of 2003," after "November 1, 2000,".

(b) NATIONAL CEMETERY INTERMENT.—Section 2402(8) is amended by striking "section 107(a)" and inserting "subsection (a) or (b) of section 107".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to deaths occurring on or after the date of the enactment of this Act.

SEC. 213. EXTENSION OF AUTHORITY TO MAINTAIN REGIONAL OFFICE IN THE REPUBLIC OF THE PHILIPPINES.

Section 315(b) is amended by striking "December 31, 2003" and inserting "December 31, 2009".

TITLE III—EDUCATION BENEFITS, EMPLOYMENT PROVISIONS, AND RELATED MATTERS

SEC. 301. EXPANSION OF MONTGOMERY GI BILL EDUCATION BENEFITS FOR CERTAIN SELF-EMPLOYMENT TRAINING.

(a) DEFINITION OF TRAINING ESTABLISHMENT.—Section 3452(e) is amended by striking "means any" and all that follows and inserting "means any of the following:

"(1) An establishment providing apprentice or other on-job training, including those under the supervision of a college or university or any State department of education.

"(2) An establishment providing self-employment on-job training consisting of full-time training for a period of less than six months that is needed or accepted for purposes of obtaining licensure to engage in a self-employment occupation or required for ownership and operation of a franchise that is the objective of the training.

"(3) A State board of vocational education.

"(4) A Federal or State apprenticeship registration agency.

"(5) A joint apprenticeship committee established pursuant to the Act of August 16, 1937, popularly known as the 'National Apprenticeship Act' (29 U.S.C. 50 et seq.).

"(6) An agency of the Federal Government authorized to supervise such training.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is six months after the date of the enactment of this Act and shall apply to self-employment on-job training approved and pursued on or after that date.

SEC. 302. INCREASE IN RATES OF SURVIVORS' AND DEPENDENTS' EDUCATIONAL ASSISTANCE.

(a) SURVIVORS' AND DEPENDENTS' EDUCATIONAL ASSISTANCE.—Section 3532 is amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking "at the monthly rate of" and all that follows and inserting "at the monthly rate of $788 for full-time, $592 for three-quarter-time, or $394 for half-time pursuit."; and

(B) in paragraph (2), by striking "at the rate of" and all that follows and inserting "at the rate of the lesser of—

"(A) the established charges for tuition and fees that the educational institution involved requires similarly circumstanced nonveterans enrolled in the same program to pay; or

"(B) $788 per month for a full-time course.";

(2) in subsection (b), by striking "$670" and inserting "$788"; and

(3) in subsection (c)(2), by striking "shall be" and all that follows and inserting "shall be $636 for full-time, $477 for three-quarter-time, or $319 for half-time pursuit.".

(b) CORRESPONDENCE COURSES.—Section 3534(b) is amended by striking "$670" and inserting "$788".

(c) SPECIAL RESTORATIVE TRAINING.—Section 3542(a) is amended—

(1) by striking "$670" and inserting "$788"; and

(2) by striking "$210" each place it appears and inserting "$247".

(d) APPRENTICESHIP TRAINING.—Section 3687(b)(2) is amended by striking "shall be $488 for the first six months" and all that follows and inserting "shall be $574 for the first six months, $429 for the second six months, $285 for the third six months, and $144 for the fourth and any succeeding six-month period of training.".

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on July 1, 2004, and shall apply with respect to educational assistance allowances payable under chapter 35 and section 3687(b)(2) of title 38, United States Code, for months beginning on or after that date.

SEC. 303. RESTORATION OF SURVIVORS' AND DEPENDENTS' EDUCATION BENEFITS OF INDIVIDUALS BEING ORDERED TO FULL-TIME NATIONAL GUARD DUTY.

(a) DELIMITING DATE.—Section 3512(h) is amended by inserting "or is involuntarily ordered to full-time National Guard duty under section 502(f) of title 32," after "title 10,".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as of September 11, 2001.

SEC. 304. ROUNDING DOWN OF CERTAIN COST-OF-LIVING ADJUSTMENTS ON EDUCATIONAL ASSISTANCE.

(a) BASIC EDUCATIONAL ASSISTANCE UNDER MONTGOMERY GI BILL.—Section 3015(h) is amended—

(1) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively;

(2) by inserting "(1)" after "(h)";

(3) by striking "(rounded to the nearest dollar)";

(4) in subparagraph (B), as so redesignated, by striking "paragraph (1)" and inserting "subparagraph (A)"; and

(5) by adding at the end the following new paragraph:

"(2) Any increase under paragraph (1) in a rate with respect to a fiscal year after fiscal year 2004 and before fiscal year 2014 shall be rounded down to the next lower whole dollar amount. Any such increase with respect to a fiscal year after fiscal year 2013 shall be rounded to the nearest whole dollar amount.".

(b) SURVIVORS' AND DEPENDENTS' EDUCATIONAL ASSISTANCE.—Section 3564 is amended—

(1) by inserting "(a)" before "With";

(2) by striking "(rounded to the nearest dollar)"; and

(3) by adding at the end the following new subsection:

"(b) Any increase under subsection (a) in a rate with respect to a fiscal year after fiscal year 2004 and before fiscal year 2014 shall be rounded down to the next lower whole dollar amount. Any such increase with respect to a fiscal year after fiscal year 2013 shall be rounded to the nearest whole dollar amount.".

SEC. 305. AUTHORIZATION FOR STATE APPROVING AGENCIES TO APPROVE CERTAIN ENTREPRENEURSHIP COURSES.

(a) APPROVAL OF ENTREPRENEURSHIP COURSES.—Section 3675 is amended by adding at the end the following new subsection:

"(c)(1) A State approving agency may approve the entrepreneurship courses offered by a qualified provider of entrepreneurship courses.

"(2) For purposes of this subsection, the term 'entrepreneurship course' means a non-degree, non-credit course of business education that enables or assists a person to start or enhance a small business concern (as defined pursuant to section 3(a) of the Small Business Act (15 U.S.C. 632(a))).

"(3) Subsection (a) and paragraphs (1) and (2) of subsection (b) shall not apply to—

"(A) an entrepreneurship course offered by a qualified provider of entrepreneurship courses; and

"(B) a qualified provider of entrepreneurship courses by reason of such provider offering one or more entrepreneurship courses.".

(b) BUSINESS OWNERS NOT TREATED AS ALREADY QUALIFIED.—Section 3471 is amended by inserting before the last sentence the following: "The Secretary shall not treat a person as already qualified for the objective of a program of education offered by a qualified provider of entrepreneurship courses solely because such person is the owner or operator of a business.".

(c) INCLUSION OF ENTREPRENEURSHIP COURSES IN DEFINITION OF PROGRAM OF EDUCATION.—Subsection (b) of section 3452 is amended by adding at the end the following: "Such term also includes any course, or combination of courses, offered by a qualified provider of entrepreneurship courses.".

(d) INCLUSION OF QUALIFIED PROVIDER OF ENTREPRENEURSHIP COURSES IN DEFINITION OF EDUCATIONAL INSTITUTION.—Subsection (c) of section 3452 is amended by adding at the end the following: "Such term also includes any qualified provider of entrepreneurship courses.".

(e) DEFINITION OF QUALIFIED PROVIDER OF ENTREPRENEURSHIP COURSES.—Section 3452 is further amended by adding at the end the following new subsection:

"(h) The term 'qualified provider of entrepreneurship courses' means any of the following entities insofar as such entity offers, sponsors, or cosponsors an entrepreneurship course (as defined in section 3675(c)(2) of this title):

"(1) Any small business development center described in section 21 of the Small Business Act (15 U.S.C. 648).

"(2) The National Veterans Business Development Corporation (established under section 33 of the Small Business Act (15 U.S.C. 657c)).".

(f) Effective Date.—The amendments made by this section shall apply to courses approved by State approving agencies after the date of the enactment of this Act.

SEC. 306. REPEAL OF PROVISIONS RELATING TO OBSOLETE EDUCATION LOAN PROGRAM.

(a) Termination of Program.—The Secretary of Veterans Affairs may not make a loan under subchapter III of chapter 36 of title 38, United States Code, after the date of the enactment of this Act.

(b) Discharge of Liabilities.—Effective as of the date of the transfer of funds under subsection (c)—

(1) any liability on an education loan under subchapter III of chapter 36 of title 38, United States Code, that is outstanding as of such date shall be deemed discharged; and

(2) the right of the United States to recover an overpayment declared under section 3698(e)(1) of such title that is outstanding as of such date shall be deemed waived.

(c) Termination of Loan Fund.—(1) Effective as of the day before the date of the repeal under this section of subchapter III of chapter 36 of title 38, United States Code, all monies in the revolving fund of the Treasury known as the "Department of Veterans Affairs Education Loan Fund" shall be transferred to the Department of Veterans Affairs Readjustment Benefits Account, and the revolving fund shall be closed.

(2) Any monies transferred to the Department of Veterans Affairs Readjustment Benefits Account under paragraph (1) shall be merged with amounts in that account and shall be available for the same purposes, and subject to the same conditions and limitations, as amounts in that account.

(d) Use of Entitlement to Veterans Educational Assistance for Education Loan Program.—Section 3462(a) is amended by striking paragraph (2).

(e) Repeal of Education Loan Program.—Subchapter III of chapter 36 is repealed.

(f) Conforming Amendments.—(1) Section 3485(e)(1) is amended by striking "(other than an education loan under subchapter III)".

(2) Section 3512 is amended by striking subsection (f).

(g) Clerical Amendment.—The table of sections at the beginning of chapter 36 is amended by striking the items relating to subchapter III and sections 3698 and 3699.

(h) Effective Dates.—(1) The amendments made by subsection (d) shall take effect on the date of the enactment of this Act.

(2) The amendments made by subsections (e), (f), and (g) shall take effect 90 days after the date of the enactment of this Act.

SEC. 307. SIX-YEAR EXTENSION OF THE VETERANS' ADVISORY COMMITTEE ON EDUCATION.

(a) Membership.—Subsection (a) of section 3692 is amended in the second sentence by inserting ", to the maximum extent practicable," after "The committee shall also".

(b) Extension.—Subsection (c) of that section is amended by striking "December 31, 2003" and inserting "December 31, 2009".

(c) Technical Amendments.—That section is further amended—

(1) in subsections (a) and (b), by striking "chapter 106" each place it appears and inserting "chapter 1606"; and

(2) in subsection (b), by striking "chapter 30" and inserting "chapters 30".

SEC. 308. PROCUREMENT PROGRAM FOR SMALL BUSINESS CONCERNS OWNED AND CONTROLLED BY SERVICE-DISABLED VETERANS.

The Small Business Act (15 U.S.C. 631 et seq.) is amended by redesignating section 36 as section 37 and by inserting after section 35 the following new section:

"SEC. 36. PROCUREMENT PROGRAM FOR SMALL BUSINESS CONCERNS OWNED AND CONTROLLED BY SERVICE-DISABLED VETERANS.

"(a) Sole Source Contracts.—In accordance with this section, a contracting officer may award a sole source contract to any small business concern owned and controlled by service-disabled veterans if—

"(1) such concern is determined to be a responsible contractor with respect to performance of such contract opportunity and the contracting officer does not have a reasonable expectation that 2 or more small business concerns owned and controlled by service-disabled veterans will submit offers for the contracting opportunity;

"(2) the anticipated award price of the contract (including options) will not exceed—

"(A) $5,000,000, in the case of a contract opportunity assigned a standard industrial classification code for manufacturing; or

"(B) $3,000,000, in the case of any other contract opportunity; and

"(3) in the estimation of the contracting officer, the contract award can be made at a fair and reasonable price.

"(b) Restricted Competition.—In accordance with this section, a contracting officer may award contracts on the basis of competition restricted to small business concerns owned and controlled by service-disabled veterans if the contracting officer has a reasonable expectation that not less than 2 small business concerns owned and controlled by service-disabled veterans will submit offers and that the award can be made at a fair market price.

"(c) Relationship to Other Contracting Preferences.—A procurement may not be made from a source on the basis of a preference provided under subsection (a) or (b) if the procurement would otherwise be made from a different source under section 4124 or 4125 of title 18, United States Code, or the Javits-Wagner-O'Day Act (41 U.S.C. 46 et seq.).

"(d) Enforcement; Penalties.—Rules similar to the rules of paragraphs (5) and (6) of section 8(m) shall apply for purposes of this section.

"(e) Contracting Officer.—For purposes of this section, the term 'contracting officer' has the meaning given such term in section 27(f)(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 423(f)(5)).".

SEC. 309. OUTSTATIONING OF TRANSITION ASSISTANCE PROGRAM PERSONNEL.

(a) In General.—(1) Chapter 41 is amended by adding at the end the following new section:

"§4113. Outstationing of Transition Assistance Program personnel

"(a) Stationing of TAP Personnel at Overseas Military Installations.—(1) The Secretary—

"(A) shall station employees of the Veterans' Employment and Training Service, or contractors under subsection (c), at each veterans assistance office described in paragraph (2); and

"(B) may station such employees or contractors at such other military installations outside the United States as the Secretary, after consultation with the Secretary of Defense, determines to be appropriate or desirable to carry out the purposes of this chapter.

"(2) Veterans assistance offices referred to in paragraph (1)(A) are those offices that are established by the Secretary of Veterans Affairs on military installations pursuant to the second sentence of section 7723(a) of this title.

"(b) Functions.—Employees (or contractors) stationed at military installations pursuant to subsection (a) shall provide, in person, counseling, assistance in identifying employment and training opportunities, help in obtaining such employment and training, and other related information and services to members of the Armed Forces who are being separated from active duty, and the spouses of such members, under the Transition Assistance Program and Disabled Transition Assistance Program established in section 1144 of title 10.

"(c) Authority to Contract With Private Entities.—The Secretary, consistent with section 1144 of title 10, may enter into contracts with public or private entities to provide, in person, some or all of the counseling, assistance, information and services under the Transition Assistance Program required under subsection (a).".

(2) The table of sections at the beginning of such chapter is amended by adding at the end the following new item:

"4113. Outstationing of Transition Assistance Program personnel.".

(b) Deadline for Implementation.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Labor shall implement section 4113 of title 38, United States Code, as added by subsection (a), and shall have employees of the Veterans' Employment and Training Service, or contractors, to carry out that section at the military installations involved by such date.

(c) Additional Amendment.—(1) The second sentence of section 7723(a) is amended by inserting "and taking into account recommendations, if any, of the Secretary of Labor" after "Secretary of Defense"

(2) The amendment made by paragraph (1) shall apply with respect to offices established after the date of the enactment of this Act.

TITLE IV—HOUSING BENEFITS AND RELATED MATTERS

SEC. 401. AUTHORIZATION TO PROVIDE ADAPTED HOUSING ASSISTANCE TO CERTAIN DISABLED MEMBERS OF THE ARMED FORCES WHO REMAIN ON ACTIVE DUTY.

Section 2101 is amended by adding at the end the following new subsection:

"(c)(1) The Secretary may provide assistance under subsection (a) to a member of the Armed Forces serving on active duty who is suffering from a disability described in paragraph (1), (2), or (3) of that subsection if such disability is the result of an injury incurred or disease contracted in or aggravated in line of duty in the active military, naval, or air service. Such assistance shall be provided to the same extent as assistance is provided under that subsection to veterans eligible for assistance under that subsection and subject to the requirements of the second sentence of that subsection.

"(2) The Secretary may provide assistance under subsection (b) to a member of the Armed Forces serving on active duty who is suffering from a disability described in subparagraph (A) or (B) of paragraph (1) of that subsection if such disability is the result of an injury incurred or disease contracted in or aggravated in line of duty in the active military, naval, or air service. Such assistance shall be provided to the same extent as assistance is provided under that subsection to veterans eligible for assistance under that subsection and subject to the requirements of paragraph (2) of that subsection.".

SEC. 402. INCREASE IN AMOUNTS FOR CERTAIN ADAPTIVE BENEFITS FOR DISABLED VETERANS.

(a) Increase in Assistance Amount for Specially Adapted Housing.—Section 2102 is amended—

(1) in the matter preceding paragraph (1) of subsection (a), by striking "$48,000" and inserting "$50,000"; and

(2) in subsection (b)(2), by striking "$9,250" and inserting "$10,000".

(b) INCREASE IN AMOUNT OF ASSISTANCE FOR AUTOMOBILE AND ADAPTIVE EQUIPMENT FOR CERTAIN DISABLED VETERANS.—Section 3902(a) is amended by striking "$9,000" and inserting "$11,000".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply with respect to assistance furnished on or after the date of the enactment of this Act.

SEC. 403. PERMANENT AUTHORITY FOR HOUSING LOANS FOR MEMBERS OF THE SELECTED RESERVE.

Section 3702(a)(2)(E) is amended by striking "For the period" and all that follows through "each" and inserting "Each".

SEC. 404. REINSTATEMENT OF MINIMUM REQUIREMENTS FOR SALE OF VENDEE LOANS.

(a) REINSTATEMENT.—Subsection (a) of section 3733 is amended by adding at the end the following new paragraph:

"(7) During the period that begins on the date of the enactment of the Veterans' Benefits Act of 2003 and ends on September 30, 2013, the Secretary shall carry out the provisions of this subsection as if—

"(A) the references in the first sentence of paragraph (1) to '65 percent' and 'may be financed' were references to '85 percent' and 'shall be financed', respectively;

"(B) the second sentence of paragraph (1) were repealed; and

"(C) the reference in paragraph (2) to 'September 30, 1990,' were a reference to 'September 30, 2013,'.".

(b) STYLISTIC AMENDMENTS.—Such section is further amended—

(1) by striking "of this subsection" after—

(A) "paragraph (1)" in subsections (a)(4)(A), (a)(5), (a)(6), and (c)(2); and

(B) "paragraph (5)" in subsection (a)(4)(B)(i); and

(2) by striking "of this paragraph" each place it appears in subsection (a)(4).

SEC. 405. ADJUSTMENT TO HOME LOAN FEES.

Effective January 1, 2004, paragraph (2) of section 3729(b) is amended to read as follows:

"(2) The loan fee table referred to in paragraph (1) is as follows:

"LOAN FEE TABLE

Type of loan	Active duty veteran	Reservist	Other obligor
(A)(i) Initial loan described in section 3710(a) to purchase or construct a dwelling with 0-down, or any other initial loan described in section 3710(a) other than with 5-down or 10-down (closed before January 1, 2004)	2.00	2.75	NA
(A)(ii) Initial loan described in section 3710(a) to purchase or construct a dwelling with 0-down, or any other initial loan described in section 3710(a) other than with 5-down or 10-down (closed on or after January 1, 2004, and before October 1, 2004)	2.20	2.40	NA
(A)(iii) Initial loan described in section 3710(a) to purchase or construct a dwelling with 0-down, or any other initial loan described in section 3710(a) other than with 5-down or 10-down (closed on or after October 1, 2004, and before October 1, 2011)	2.15	2.40	NA
(A)(iv) Initial loan described in section 3710(a) to purchase or construct a dwelling with 0-down, or any other initial loan described in section 3710(a) other than with 5-down or 10-down (closed on or after October 1, 2011)	1.40	1.65	NA
(B)(i) Subsequent loan described in section 3710(a) to purchase or construct a dwelling with 0-down, or any other subsequent loan described in section 3710(a) (closed before January 1, 2004)	3.00	3.00	NA
(B)(ii) Subsequent loan described in section 3710(a) to purchase or construct a dwelling with 0-down, or any other subsequent loan described in section 3710(a) (closed on or after January 1, 2004, and before October 1, 2011)	3.30	3.30	NA
(B)(iii) Subsequent loan described in section 3710(a) to purchase or construct a dwelling with 0-down, or any other subsequent loan described in section 3710(a) (closed on or after October 1, 2011 and before October 1, 2013)	2.15	2.15	NA
(B)(iv) Subsequent loan described in section 3710(a) to purchase or construct a dwelling with 0-down, or any other subsequent loan described in section 3710(a) (closed on or after October 1, 2013)	1.25	1.25	NA
(C)(i) Loan described in section 3710(a) to purchase or construct a dwelling with 5-down (closed before October 1, 2011)	1.50	1.75	NA
(C)(ii) Loan described in section 3710(a) to purchase or construct a dwelling with 5-down (closed on or after October 1, 2011)	0.75	1.00	NA
(D)(i) Initial loan described in section 3710(a) to purchase or construct a dwelling with 10-down (closed before October 1, 2011)	1.25	1.50	NA
(D)(ii) Initial loan described in section 3710(a) to purchase or construct a dwelling with 10-down (closed on or after October 1, 2011)	0.50	0.75	NA
(E) Interest rate reduction refinancing loan	0.50	0.50	NA
(F) Direct loan under section 3711	1.00	1.00	NA
(G) Manufactured home loan under section 3712 (other than an interest rate reduction refinancing loan)	1.00	1.00	NA
(H) Loan to Native American veteran under section 3762 (other than an interest rate reduction refinancing loan)	1.25	1.25	NA
(I) Loan assumption under section 3714	0.50	0.50	0.50
(J) Loan under section 3733(a)	2.25	2.25	2.25".

SEC. 406. ONE-YEAR EXTENSION OF PROCEDURES ON LIQUIDATION SALES OF DEFAULTED HOME LOANS GUARANTEED BY THE DEPARTMENT OF VETERANS AFFAIRS.

Section 3732(c)(11) is amended by striking "October 1, 2011" and inserting "October 1, 2012".

TITLE V—BURIAL BENEFITS

SEC. 501. BURIAL PLOT ALLOWANCE.

(a) IN GENERAL.—Section 2303(b) is amended—

(1) in the matter preceding paragraph (1), by striking "a burial allowance under such section 2302, or under such subsection, who was discharged from the active military, naval, or air service for a disability incurred or aggravated in line of duty, or who is a veteran of any war" and inserting "burial in a national cemetery under section 2402 of this title"; and

(2) in paragraph (2), by striking "(other than a veteran whose eligibility for benefits under this subsection is based on being a veteran of any war)" and inserting "is eligible for a burial allowance under section 2302 of this title or under subsection (a) of this section, or was discharged from the active military, naval, or air

service for a disability incurred or aggravated in line of duty, and such veteran''.

(b) CONFORMING AMENDMENT.—Section 2307 is amended in the last sentence by striking ''and (b)'' and inserting ''and (b)(2)''.

SEC. 502. ELIGIBILITY OF SURVIVING SPOUSES WHO REMARRY FOR BURIAL IN NATIONAL CEMETERIES.

(a) ELIGIBILITY.—Section 2402(5) is amended by striking ''(which for purposes of this chapter includes an unremarried surviving spouse who had a subsequent remarriage which was terminated by death or divorce)'' and inserting ''(which for purposes of this chapter includes a surviving spouse who had a subsequent remarriage)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to deaths occurring on or after January 1, 2000.

SEC. 503. PERMANENT AUTHORITY FOR STATE CEMETERY GRANTS PROGRAM.

(a) PERMANENT AUTHORITY.—Subsection (a) of section 2408 is amended—

(1) by striking ''(1)''; and

(2) by striking paragraph (2).

(b) CONFORMING AMENDMENT.—Subsection (e) of such section is amended by striking ''Sums appropriated under subsection (a) of this section'' and inserting ''Amounts appropriated to carry out this section''.

(c) TECHNICAL AMENDMENT TO REPEAL OBSOLETE PROVISION.—Subsection (d)(1) of such section is amended by striking ''on or after November 21, 1997,''.

TITLE VI—EXPOSURE TO HAZARDOUS SUBSTANCES

SEC. 601. RADIATION DOSE RECONSTRUCTION PROGRAM OF DEPARTMENT OF DEFENSE.

(a) REVIEW OF MISSION, PROCEDURES, AND ADMINISTRATION.—(1) The Secretary of Veterans Affairs and the Secretary of Defense shall jointly conduct a review of the mission, procedures, and administration of the Radiation Dose Reconstruction Program of the Department of Defense.

(2) In conducting the review under paragraph (1), the Secretaries shall—

(A) determine whether any additional actions are required to ensure that the quality assurance and quality control mechanisms of the Radiation Dose Reconstruction Program are adequate and sufficient for purposes of the program; and

(B) determine the actions that are required to ensure that the mechanisms of the Radiation Dose Reconstruction Program for communication and interaction with veterans are adequate and sufficient for purposes of the program, including mechanisms to permit veterans to review the assumptions utilized in their dose reconstructions.

(3) Not later than 90 days after the date of the enactment of this Act, the Secretaries shall jointly submit to Congress a report on the review under paragraph (1). The report shall set forth—

(A) the results of the review;

(B) a plan for any actions determined to be required under paragraph (2); and

(C) such other recommendations for the improvement of the mission, procedures, and administration of the Radiation Dose Reconstruction Program as the Secretaries jointly consider appropriate.

(b) ON-GOING REVIEW AND OVERSIGHT.—The Secretaries shall jointly take appropriate actions to ensure the on-going independent review and oversight of the Radiation Dose Reconstruction Program, including the establishment of the advisory board required by subsection (c).

(c) ADVISORY BOARD.—(1) In taking actions under subsection (b), the Secretaries shall jointly appoint an advisory board to provide review and oversight of the Radiation Dose Reconstruction Program.

(2) The advisory board under paragraph (1) shall be composed of the following:

(A) At least one expert in historical dose reconstruction of the type conducted under the Radiation Dose Reconstruction Program.

(B) At least one expert in radiation health matters.

(C) At least one expert in risk communications matters.

(D) A representative of the Department of Veterans Affairs.

(E) A representative of the Defense Threat Reduction Agency.

(F) At least three veterans, including at least one veteran who is a member of an atomic veterans group.

(3) The advisory board under paragraph (1) shall—

(A) conduct periodic, random audits of dose reconstructions under the Radiation Dose Reconstruction Program and of decisions by the Department of Veterans Affairs on claims for service connection of radiogenic diseases;

(B) assist the Department of Veterans Affairs and the Defense Threat Reduction Agency in communicating to veterans information on the mission, procedures, and evidentiary requirements of the Radiation Dose Reconstruction Program; and

(C) carry out such other activities with respect to the review and oversight of the Radiation Dose Reconstruction Program as the Secretaries shall jointly specify.

(4) The advisory board under paragraph (1) may make such recommendations on modifications in the mission or procedures of the Radiation Dose Reconstruction Program as the advisory board considers appropriate as a result of the audits conducted under paragraph (3)(A).

SEC. 602. STUDY ON DISPOSITION OF AIR FORCE HEALTH STUDY.

(a) STUDY REQUIRED.—The Secretary of Veterans Affairs shall, in accordance with this section, carry out a study to determine the appropriate disposition of the Air Force Health Study, an epidemiologic study of Air Force personnel who were responsible for conducting aerial spray missions of herbicides during the Vietnam era.

(b) STUDY THROUGH NATIONAL ACADEMY OF SCIENCES.—Not later than 60 days after the date of the enactment of this Act, the Secretary shall seek to enter into an agreement with the National Academy of Sciences, or another appropriate scientific organization, to carry out the study required by subsection (a).

(c) ELEMENTS.—Under the study under subsection (a), the National Academy of Sciences, or other appropriate scientific organization, shall address the following:

(1) The scientific merit of retaining and maintaining the medical records, other study data, and laboratory specimens collected in the course of the Air Force Health Study after the currently-scheduled termination date of the study in 2006.

(2) Whether or not any obstacles exist to retaining and maintaining the medical records, other study data, and laboratory specimens referred to in paragraph (1), including privacy concerns.

(3) The advisability of providing independent oversight of the medical records, other study data, and laboratory specimens referred to in paragraph (1), and of any further study of such records, data, and specimens, and, if so, the mechanism for providing such oversight.

(4) The advisability of extending the Air Force Health Study, including the potential value and relevance of extending the study, the potential cost of extending the study, and the Federal or non-Federal entity best suited to continue the study if extended.

(5) The advisability of making the laboratory specimens of the Air Force Health Study available for independent research, including the potential value and relevance of such research, and the potential cost of such research.

(d) REPORT.—Not later than 120 days after entering into an agreement under subsection (b), the National Academy of Sciences, or other appropriate scientific organization, shall submit to the Secretary and Congress a report on the results of the study under subsection (a). The report shall include the results of the study, including the matters addressed under subsection (c), and such other recommendations as the Academy, or other appropriate scientific organization, considers appropriate as a result of the study.

SEC. 603. FUNDING OF MEDICAL FOLLOW-UP AGENCY OF INSTITUTE OF MEDICINE OF NATIONAL ACADEMY OF SCIENCES FOR EPIDEMIOLOGICAL RESEARCH ON MEMBERS OF THE ARMED FORCES AND VETERANS.

(a) FUNDING.—(1) The Secretary of Veterans Affairs and the Secretary of Defense shall each make available to the National Academy of Sciences in each of fiscal years 2004 through 2013 the amount of $250,000 for the Medical Follow-Up Agency of the Institute of Medicine of the Academy for purposes of epidemiological research on members of the Armed Forces and veterans.

(2) The Secretary of Veterans Affairs shall make available amounts under paragraph (1) for a fiscal year from amounts available for the Department of Veterans Affairs for that fiscal year.

(3) The Secretary of Defense shall make available amounts under paragraph (1) for a fiscal year from amounts available for the Department of Defense for that fiscal year.

(b) USE OF FUNDS.—The Medical Follow-Up Agency shall use funds made available under subsection (a) for epidemiological research on members of the Armed Forces and veterans.

(c) SUPPLEMENT NOT SUPPLANT.—Amounts made available to the Medical Follow-Up Agency under this section for a fiscal year for the purposes referred to in subsection (b) are in addition to any other amount made available to the Agency for that fiscal year for those purposes.

TITLE VII—OTHER MATTERS

SEC. 701. TIME LIMITATIONS ON RECEIPT OF CLAIM INFORMATION PURSUANT TO REQUESTS OF DEPARTMENT OF VETERANS AFFAIRS.

(a) INFORMATION TO COMPLETE CLAIMS APPLICATIONS.—Section 5102 is amended by adding at the end the following new subsection:

''(c) TIME LIMITATION.—(1) If information that a claimant and the claimant's representative, if any, are notified under subsection (b) is necessary to complete an application is not received by the Secretary within one year from the date such notice is sent, no benefit may be paid or furnished by reason of the claimant's application.

''(2) This subsection shall not apply to any application or claim for Government life insurance benefits.''.

(b) CONSTRUCTION OF LIMITATION ON INFORMATION TO SUBSTANTIATE CLAIMS.—Section 5103(b) is amended—

(1) in paragraph (1), by striking ''if such'' and all that follows through ''application'' and inserting ''such information or evidence must be received by the Secretary within one year from the date such notice is sent''; and

(2) by adding at the end the following new paragraph:

''(3) Nothing in paragraph (1) shall be construed to prohibit the Secretary from making a decision on a claim before the expiration of the period referred to in that subsection.''.

(c) Effective Date.—The amendments made by this section shall take effect as if enacted on November 9, 2000, immediately after the enactment of the Veterans Claims Assistance Act of 2000 (Public Law 106–475; 114 Stat. 2096).

(d) Procedures for Readjudication of Certain Claims.—(1) The Secretary of Veterans Affairs shall readjudicate a claim of a qualified claimant if the request for such readjudication is received not later than the end of the one-year period that begins on the date of the enactment of this Act.

(2) For purposes of this subsection, a claimant is qualified within the meaning of paragraph (1) if the claimant—

(A) received notice under section 5103(a) of title 38, United States Code, requesting information or evidence to substantiate a claim;

(B) did not submit such information or evidence within a year after the date such notice was sent;

(C) did not file a timely appeal to the Board of Veterans' Appeals or the United States Court of Appeals for Veterans Claims; and

(D) submits such information or evidence during the one-year period referred to in paragraph (1).

(3) If the decision of the Secretary on a readjudication under this subsection is in favor of the qualified claimant, the award of the grant shall take effect as if the prior decision by the Secretary on the claim had not been made.

(4) Nothing in this subsection shall be construed to establish a duty on the part of the Secretary to identify or readjudicate any claim that—

(A) is not submitted during the one-year period referred to in paragraph (1); or

(B) has been the subject of a timely appeal to the Board of Veterans' Appeals or the United States Court of Appeals for Veterans Claims.

(e) Construction on Providing Renotification.—Nothing in this section, or the amendments made by this section, shall be construed to require the Secretary of Veterans Affairs—

(1) to provide notice under section 5103(a) of such title with respect to a claim insofar as the Secretary has previously provided such notice; or

(2) to provide for a special notice with respect to this section and the amendments made by this section.

SEC. 702. CLARIFICATION OF APPLICABILITY OF PROHIBITION ON ASSIGNMENT OF VETERANS BENEFITS TO AGREEMENTS REQUIRING PAYMENT OF FUTURE RECEIPT OF BENEFITS.

Section 5301(a) is amended—

(1) by inserting "(1)" after "(a)";

(2) by designating the last sentence as paragraph (2); and

(3) by adding at the end the following new paragraph:

"(3)(A) This paragraph is intended to clarify that, in any case where a beneficiary entitled to compensation, pension, or dependency and indemnity compensation enters into an agreement with another person under which agreement such other person acquires for consideration the right to receive such benefit by payment of such compensation, pension, or dependency and indemnity compensation, as the case may be, except as provided in subparagraph (B), and including deposit into a joint account from which such other person may make withdrawals, or otherwise, such agreement shall be deemed to be an assignment and is prohibited.

"(B) Notwithstanding subparagraph (A), nothing in this paragraph is intended to prohibit a loan involving a beneficiary under the terms of which the beneficiary may use the benefit to repay such other person as long as each of the periodic payments made to repay such other person is separately and voluntarily executed by the beneficiary or is made by preauthorized electronic funds transfer pursuant to the Electronic Funds Transfers Act (15 U.S.C. 1693 et seq.).

"(C) Any agreement or arrangement for collateral for security for an agreement that is prohibited under subparagraph (A) is also prohibited and is void from its inception.".

SEC. 703. SIX-YEAR EXTENSION OF ADVISORY COMMITTEE ON MINORITY VETERANS.

Section 544(e) is amended by striking "December 31, 2003" and inserting "December 31, 2009".

SEC. 704. TEMPORARY AUTHORITY FOR PERFORMANCE OF MEDICAL DISABILITIES EXAMINATIONS BY CONTRACT PHYSICIANS.

(a) Authority.—Using appropriated funds, other than funds available for compensation and pension, the Secretary of Veterans Affairs may provide for the conduct of examinations with respect to the medical disabilities of applicants for benefits under laws administered by the Secretary by persons other than Department of Veterans Affairs employees. The authority under this section is in addition to the authority provided in section 504(b) of the Veterans' Benefits Improvement Act of 1996 (Public Law 104–275; 38 U.S.C. 5101 note).

(b) Performance by Contract.—Examinations under the authority provided in subsection (a) shall be conducted pursuant to contracts entered into and administered by the Under Secretary for Benefits.

(c) Expiration.—The authority in subsection (a) shall expire on December 31, 2009. No examination may be carried out under the authority provided in that subsection after that date.

(d) Report.—Not later than four years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the use of the authority provided in subsection (a). The Secretary shall include in the report an assessment of the effect of examinations under that authority on the cost, timeliness, and thoroughness of examinations with respect to the medical disabilities of applicants for benefits under laws administered by the Secretary.

SEC. 705. FORFEITURE OF BENEFITS FOR SUBVERSIVE ACTIVITIES.

(a) Addition of Certain Offenses.—Paragraph (2) of section 6105(b) is amended—

(1) by inserting "175, 229," after "sections"; and

(2) by inserting "831, 1091, 2332a, 2332b," after "798,".

(b) Effective Date.—The amendments made by subsection (a) shall apply to claims filed after the date of the enactment of this Act.

SEC. 706. TWO-YEAR EXTENSION OF ROUND-DOWN REQUIREMENT FOR COMPENSATION COST-OF-LIVING ADJUSTMENTS.

Sections 1104(a) and 1303(a) are each amended by striking "2011" and inserting "2013".

SEC. 707. CODIFICATION OF REQUIREMENT FOR EXPEDITIOUS TREATMENT OF CASES ON REMAND.

(a) Cases Remanded by Board of Veterans' Appeals.—(1) Chapter 51 is amended by adding at the end of subchapter I the following new section:

"§5109B. Expedited treatment of remanded claims

"The Secretary shall take such actions as may be necessary to provide for the expeditious treatment by the appropriate regional office of the Veterans Benefits Administration of any claim that is remanded to a regional office of the Veterans Benefits Administration by the Board of Veterans' Appeals.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 5109A the following new item:

"5109B. Expedited treatment of remanded claims.".

(b) Cases Remanded by Court of Appeals for Veterans Claims.—(1) Chapter 71 is amended by adding at the end the following new section:

"§7112. Expedited treatment of remanded claims

"The Secretary shall take such actions as may be necessary to provide for the expeditious treatment by the Board of any claim that is remanded to the Secretary by the Court of Appeals for Veterans Claims.".

(2) The table of sections at the beginning of such chapter is amended by adding at the end the following new item:

"7112. Expedited treatment of remanded claims.".

(c) Repeal of Source Section.—Section 302 of the Veterans' Benefits Improvement Act of 1994 (Public Law 103–446; 108 Stat. 4658; 38 U.S.C. 5101 note) is repealed.

SEC. 708. TECHNICAL AND CLERICAL AMENDMENTS.

(a) Miscellaneous Amendments.—(1) Section 103(d) is amended—

(A) in paragraph (4)—

(i) in the matter preceding subparagraph (A), by striking "this subsection" and inserting "paragraph (2)(A) or (3)"; and

(ii) in subparagraph (A), by striking "paragraph (2)" and inserting "paragraph (2)(A)"; and

(B) in paragraph (5), by striking "Paragraphs (2)" and inserting "Paragraphs (2)(A)".

(2) Section 1729A is amended—

(A) in subsection (b), by striking "after June 30, 1997," in the matter preceding paragraph (1);

(B) in subsection (c), by striking paragraph (3);

(C) by striking subsection (e); and

(D) by redesignating subsection (f) as subsection (e).

(3) Section 1804(c)(2) is amended by striking "subsection" and inserting "section".

(4) Section 1974(a)(5) is amended by striking "Secretary of Transportation" and inserting "Secretary of Homeland Security".

(b) Amendments Relating to the Jobs for Veterans Act.—(1)(A) Subsection (c)(2)(B)(ii) of section 4102A is amended by striking "October 1, 2002" and inserting "October 1, 2003".

(B) The amendment made by subparagraph (A) shall take effect as if included in the enactment of section 4(a) of the Jobs for Veterans Act (Public Law 107–288; 116 Stat. 2038).

(2) Subsection (f)(1) of section 4102A is amended by striking "6 months after the date of the enactment of this section," and inserting "May 7, 2003,".

(c) Amendments Relating to the Establishment of Social Security Administration as an Independent Agency.—(1) Section 1322 is amended—

(A) in subsection (a), by striking "Secretary of Health and Human Services" and all that follows through the period and inserting "Commissioner of Social Security, and shall be certified by the Commissioner to the Secretary upon request of the Secretary."; and

(B) in subsection (b)—

(i) by striking "Secretary of Health and Human Services" in the first sentence and inserting "Commissioner of Social Security";

(ii) by striking "the two Secretaries" and inserting "the Secretary and the Commissioner"; and

(iii) by striking "Secretary of Health and Human Services" in the second sentence and inserting "Commissioner".

(2) Section 5101(a) is amended by striking "Secretary of Health and Human Services" and inserting "Commissioner of Social Security".

(3) Section 5317 is amended by striking "Secretary of Health and Human Services" in subsections (a), (b), and (g) and inserting "Commissioner of Social Security".

(4)(A) Section 5318 is amended—

(i) in subsection (a), by striking "Department of Health and Human Services" and inserting "Social Security Administration"; and

(ii) in subsection (b)—

(I) by striking "Department of Health and Human Services" and inserting "Social Security Administration";

(II) by striking "Secretary of Health and Human Services" the first place it appears and inserting "Commissioner of Social Security";

(III) by striking "Secretary of Health and Human Services" the second place it appears and inserting "Commissioner"; and

(IV) by striking "such Secretaries" and inserting "the Secretary and the Commissioner".

(B)(i) The heading of such section is amended to read as follows:

"§5318. Review of Social Security Administration death information".

(ii) The item relating to that section in the table of sections at the beginning at chapter 53 is amended to read as follows:

"5318. Review of Social Security Administration death information.".

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New Jersey (Mr. SMITH) and the gentleman from Maine (Mr. MICHAUD) each will control 20 minutes.

The Chair recognizes the gentleman from New Jersey (Mr. SMITH).

Mr. SMITH of New Jersey. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the Senate amendment to H.R. 2297 reflects an agreement with the other body on comparable House and Senate bills. The Veterans Benefits Act of 2003 includes almost all of the provisions that were contained in the bill when the House originally considered it, as well as several other worthwhile provisions contained in S. 1136, which the Senate passed on October 31.

Mr. Speaker, the Chairman of our Subcommittee on Benefits, the distinguished gentleman from South Carolina, will describe several of those important provisions, some seven titles in all, approximately 40 provisions, and I will yield to him in just a moment to do so. But let me briefly touch on the benefits this bill contains and who will be affected by it.

Mr. Speaker, many surviving spouses of veterans who die of a service-related cause will qualify for restoration of benefits taken away when they remarry. Former prisoners of war will find it easier to qualify for veterans benefits that they so richly deserve. Disabled veterans who own businesses will find it easier to sell their goods and services to the Federal Government. The surviving children of those killed in the line of duty will now receive a college-assisted payment that is 13 percent higher than the current benefit. Reservists who want to use the VA home loan program will now be charged a lower fee.

Mr. Speaker, following on the heels of our historic enactment of legislation to provide concurrent receipt benefits to over 250,000 severely disabled military retirees, this bill is a further testament to Congress' commitment to aiding those who serve our country in the Armed Forces. There are many other important provisions in this measure, and I do urge my colleagues to review them. And, again, my good friend and colleague, as well as the ranking member, will be going into further detail.

I would especially like to congratulate the Chair and Ranking Member of our Subcommittee on Benefits, the gentleman from South Carolina (Mr. BROWN) and the gentleman from Maine (Mr. MICHAUD) for holding hearings this year on a variety of important issues affecting veterans. I am pleased that their efforts on the subcommittee pulled together in truly bipartisan fashion all of these disparate elements into this omnibus bill to advance the needs of our veterans.

And, again, I always like to thank, because we work hand in glove, my good friend and colleague, the gentleman from Illinois (Mr. EVANS), for his work on this legislation as well.

Mr. Speaker, I reserve the balance of my time.

Mr. MICHAUD. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in strong support of H.R. 2297, as amended, the Veterans Benefits Act of 2003. I would like to thank the chairman, the gentleman from New Jersey (Mr. SMITH) and the ranking member, the gentleman from Illinois (Mr. EVANS), for their leadership on the full committee and their successful negotiations with the Senate. I also would like to personally thank my good friend, the chairman of the subcommittee, the gentleman from South Carolina (Mr. BROWN), for his leadership and bipartisan spirit shown in considering these bills assigned to our subcommittee. It definitely has been a pleasure working with Chairman BROWN and his staff.

The Veterans Benefits Act of 2003 includes provisions drawn from many bills introduced by Members of both sides of the aisle. Our Nation's servicemembers and veterans have earned and their families deserve all the benefits provided under H.R. 2297 and, indeed, they certainly deserve much, much more.

Mr. Speaker, I am proud to be a sponsor and cosponsor of many of these measures that have been incorporated in H.R. 2297, including provisions aimed to make the home loan benefit for members of the Guard and Reserves permanent, to improve veterans education benefits, enhance self-employment opportunities, and expand employment counseling and job search assistance for servicemembers returning to civilian life after separating from military installations overseas.

H.R. 2297 provides for more equitable and rational treatment for surviving spouses and Filipino World War II veterans, of which I also fully support. It allows former prisoners of war to qualify for certain presumption of service connection and adds sclerosis of the liver to the diseases considered presumptively disabling for POWs. The Gold Star wives will benefit from our efforts to allow them to remarry after age 57 without losing the dependency and indemnity compensation, educational, and home loan benefits that they currently receive. This measure is long overdue and represents substantial progress.

I also support provisions brought forth by the other body which will increase education benefits for the spouses, surviving spouses, and dependent children for totally and permanently disabled and deceased servicemembers.

Mr. Speaker, the provisions in this package will benefit servicemembers and veterans from my State of Maine as well as their families. It will help others all around the country as well. I fully support H.R. 2297, as amended, and urge my colleagues to do the same.

Mr. Speaker, I rise today in strong support of H.R. 2297, as amended, the Veterans Benefits Package of 2003.

I would like to thank Chairman SMITH and Ranking Member LANE EVANS for their leadership on the full committee and their successful negotiations with the Senate.

I would also like to personally thank Chairman BROWN and his staff for the cooperative manner shown in introducing and considering bills assigned to our subcommittee. It has been a pleasure working with him and his staff.

As is the custom of the House Committee on Veterans Affairs, a large number of bills considered by the Subcommittee on Benefits have been included in the Veterans Benefits Act of 2003.

I am pleased that H.R. 2294 which I introduced to extend the Veterans' Advisory Committee on Education is included as section 307 of H.R. 2297, as amended. The Veterans Advisory Committee provides useful information to the Congress and should be continued.

I am also pleased that H.R. 3239 which I introduced to extend the Veterans' Advisory Committee on Minority Veterans is included as section 703 of H.R. 2297, as amended. This committee brings to the attention of the Congress specific issues of concern to African-American, Native America, Hispanic American, and Asian-Pacific Island American veterans. I know that the Native American veterans of Maine, as well as all minority veterans, will continue to benefit from the counsel and advice provided by this committee.

I am original cosponsor of H.R. 761 introduced by our ranking Democratic member of the full committee, LANE EVANS, to permit seriously disabled servicemembers to apply for grants to adapt their homes before being discharged from military service. This provision included as section 401 will enable seriously disabled servicemembers to begin the process of obtaining suitable housing while on active duty.

I joined our Ranking Democratic Member LANE EVANS in introducing H.R. 1257 to make the home loan program of the Department of Veterans Affairs for members of the Select Reserve a permanent program. This provision is included as section 403 of H.R. 2297, as amended. That bill also provided for an equalization of the fees paid by reservists and active duty veterans. Although the fees were not equalized in the final bill, I note that the rates have been reduced to a nominal amount of 0.25 percent above that charged to active duty servicemembers and veterans. As we know, reservists are an integral part of this Nation's total force. Making their home loan benefits permanent and reducing the fees they must pay acknowledges their service in a tangible way.

I am an original cosponsor of H.R. 1460 introduced by Mr. RENZI to provide additional opportunities for service-disabled veterans to contract with the Federal Government. Unfortunately, the record of contracts awarded to service-disabled veterans by Federal agencies is dismal and getting worse. Provisions from H.R. 1460 are included in section 308 of H.R. 2297, as amended. I hope that Federal agencies will take seriously their responsibility to contract with small businesses owned or controlled by service-disabled veterans. Under the provision, the committees expect that the Small Business Administration will accept the determinations of the Secretary of Veterans Affairs with respect to the definition of service-connection.

I joined my good friend and neighbor Mr. BRADLEY in introducing H.R. 2164 to provide an extension in the period of eligibility for educational benefits provided to certain children of disabled and deceased veterans, when those children are called to full time duty in the National Guard. This provision is included in section 303 of H.R. 2297, as amended.

I am an original cosponsor of H.R. 2285 introduced by Mr. SIMPSON to require the Secretary of Labor to provide staffing at overseas locations to servicemembers who are separating from active duty. This provision is included as section 309 of H.R. 2297, as amended. It is unfortunate that the Secretary of Labor has not followed the lead of the Secretary of Veterans Affairs in making these services available at overseas locations. This bill will require the Secretary of Labor to do so.

I joined our chairman on the full committee, CHRIS SMITH, our ranking Democratic member on the full committee. LANE EVANS and our subcommittee chairman, HENRY BROWN, in introducing H.R. 2297 which provided the basis for this larger bill. I appreciate the efforts made by the chairman of the full committee as well as Chairman BROWN to operate in a bipartisan manner.

Although H.R. 3392, introduced by our Democratic Ranking Member LANE EVANS and myself to improve the adjudication of claims for benefits was not considered by the House committee during this session, I note that provisions similar to that bill are included as section 701 of H.R. 2297, as amended.

I am also a cosponsor of many other bills included in H.R. 2297, as amended. As a freshman Member of Congress, I am proud to have been able to introduce and cosponsor legislation which will improve the lives of our Nation's veterans.

The House Committee on Veterans Affairs has a reputation of serving veterans in a bipartisan manner. This bill reflects that spirit of cooperation.

Our Nation's servicemembers and veterans have earned—and their families deserve—all the benefits provided under H.R. 2297, as amended.

Indeed, they deserve so much more.

Mr. Speaker, the provisions in this package will benefit servicemembers and veterans from my State of Maine as well as their families. It will help others around the country as well.

I fully support H.R. 2297, as amended, and urge my colleagues to do the same.

Mr. Speaker, I reserve the balance of my time.

Mr. SMITH of New Jersey. Mr. Speaker, I yield such time as he may consume to the gentleman from South Carolina (Mr. BROWN), the distinguished chairman of our Subcommittee on Benefits.

Mr. BROWN of South Carolina. Mr. Speaker, I thank the gentleman for yielding me this time, and I am pleased we are here today to consider the Veterans Benefits Act of 2003, a bipartisan effort with no less than 37 substantive provisions.

Mr. Speaker, I would like to highlight five of the provisions of this comprehensive bill which provides more than a billion dollars in improved benefits over 10 years.

Section 101 of the bill is long overdue. After years of trying to find the offsets, we are finally able to bring equity to those surviving spouses who lose their Dependency and Indemnity Compensation upon remarrying later in life. Section 101 would allow a surviving spouse who remarries after age 57 to retain DIC, as well as home loan and educational benefits. The gentleman from Florida (Mr. BILIRAKIS) has championed this cause for almost 15 years now, and I appreciate his dedication.

Small business is the bedrock of our economy. Section 301 of the bill would expand the Montgomery GI bill while authorizing educational assistance benefits for on-the-job training of less than 6 months in various types of self-employment training programs. Similarly, section 305 would allow, for the first time, servicemembers, veterans and certain dependents to enroll in entrepreneurship and pre-entrepreneurship courses offered by the Small Business Development Centers and the Veterans Business Development Corporation. I applaud the gentleman from Arizona (Mr. RENZI) for this provision, as well as provisions giving Federal agencies and departments new discretionary contracting authority to assist service-disabled veteran-owned businesses, another first.

Indeed, we, as a Nation, should accord veterans who become disabled in their service to this Nation a full opportunity to participate in the free enterprise system they have fought so hard to defend.

Section 309 would require the Department of Labor to go where its customers are to provide in-person Transitional Assistance Program services overseas, as VA has done since about 1992. I applaud the gentleman from Idaho (Mr. SIMPSON) and the gentleman from Texas (Mr. REYES) for their longstanding work on this provision.

Lastly, section 402 of the bill increases the adapted housing and automobile allowances for disabled servicemembers. I applaud the chairman of the Senate Committee on Veterans' Affairs, Mr. SPECTER, along with the ranking member, Mr. GRAHAM, for their many excellent contributions to this bill. I also applaud the former ranking member of the Senate Committee on Veterans' Affairs, Mr. ROCKEFELLER, for his continued assistance.

In closing, I commend Chairman SMITH, Ranking Member EVANS, and Subcommittee on Benefits' Ranking Member MICHAUD for their leadership and diligent work on this bill, as well as the support they have given to me my first term as chairman of the Subcommittee on Benefits. I also want to recognize the good folks who make up the committee staff, many of whom put in long hours so we could consider this bill before we adjourned.

I wholeheartedly support H.R. 2297, as amended, and encourage the full House to support it as well.

Mr. MICHAUD. Mr. Speaker, I yield 2 minutes to the gentleman from Illinois (Mr. EVANS), who has fought for veterans for a number of years.

Mr. EVANS. Mr. Speaker, I want to thank the gentleman for yielding me this time and for his fine work on the Subcommittee on Benefits this year.

We have really defined the impact that we have had by working on a bipartisan basis to achieve this. We have worked on a nonpartisan basis with our chairman, and the ranking members of other subcommittees, such as the gentleman from Maine (Mr. MICHAUD) and the gentleman from South Carolina (Mr. BROWN), have worked with the other body in finalizing this legislation, and I think they deserve a strong salute from veterans across the country.

I am very proud to be an original cosponsor of many of the provisions contained in this act. I am especially pleased for children of veterans who were exposed to herbicides in Korea, and who now are suffering from spina bifida, like a lot of the kids that were exposed in the Vietnam War. We must realize we have an obligation to those children and their families, and I think we have started down that road as well.

The bill recognizes the contributions made by the Guard and Reserve in making their home loan program permanent and reducing the funding fees that they are charged. I am most pleased we are providing long-term benefits to our Gold Star wives of the Filipino Veterans. This bill also includes important veterans education benefits and extends business opportunities for veterans.

H.R. 2297 is a good bill, and I urge all my colleagues to show their support for our troops and Veterans by voting for it.

Mr. MICHAUD. Mr. Speaker, I yield 4 minutes to the gentleman from California (Mr. FILNER).

Mr. FILNER. Mr. Speaker, I thank the gentleman for yielding me this time, and we are, of course, supporting H.R. 2297, a bill that incorporates many provisions that have been discussed at the House Committee on Veterans' Affairs and in the Senate Committee on Veterans' Affairs, and it includes provisions that upgrade benefits in many, many areas.

I would suspect, Mr. Speaker, that if this bill was taken one by one in terms of the provisions in there and the health bill that we hope will follow sometime later today, veterans across the Nation would understand that we are really keeping our promise to our Nation's veterans in both our benefits and our health provisions.

I would say to the chairman of the full committee, the gentleman from New Jersey (Mr. SMITH) and to the ranking member, the gentleman from Illinois (Mr. EVANS), the combination of the benefit and the health bill probably represents one of the most productive years in the history of this Congress in terms of veterans' benefits and veterans' health care. So I thank the chairman, and I thank the ranking member for bringing all these provisions together and working so hard and allowing Members from both sides of the aisle to contribute. There are provisions in these bills that represent both Democratic and Republican contributions, and I think that is the way we ought to behave here, and that is what this bill represents.

I just want to add a few comments to what has been stated previously. Two provisions which I helped to write are in the bill. The first involves a cause for which I have been fighting ever since I became a Member of Congress, and it is exceptionally gratifying to see progress on an important issue, and that is restoring the rightful benefits to Filipino World War II veterans.

Many of us know that after being drafted into service by President Franklin Delano Roosevelt, after bravely fighting alongside soldiers from the U.S. mainland, many Filipino veterans were deprived of their promised benefits by the Congress of 1946. In the intervening years, many of these veterans have emigrated to the United States and have become American citizens. This bill will increase the compensation received by one part of the Filipino Armed Forces, and that is the new Filipino Scouts.

They had been given what is called the "peso rate" in their disability compensation. That is one-half of what an American soldier would get. And they have been receiving that peso rate since the end of the war, whether they have lived in the United States or in the Philippines. For these that live in the United States, their cost of living is equal to the veterans here, and paying half is just simply not acceptable. Upon the passage of this bill, the widows of the Filipino World War II veterans will also receive the full amount of their DIC benefits, and burial benefits for the new Scouts will also be restored. So this is justice restored after almost 60 years of being denied.

There is another provision which I am pleased to see in this bill, and that involves life insurance policies. The VA currently holds about 4,000 insurance policies, valued at about $23 million, on which payment has not been made because the VA has not been able to locate the identified beneficiary.

What will happen after this bill passes is that the VA can pay secondary benefits if we cannot locate the primary beneficiary. And if no beneficiary files within 4 years, the VA secretary may pay another appropriate relative. It is a shame to have Veterans paying for life insurance throughout their lifetimes only to have their insurance unclaimed. So this will benefit the families of many of our veterans in this country.

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Mr. Speaker, these are just two portions of the bill. There are many, many provisions which have been described by my colleagues. Again, I think it is a great advance for veterans to be able to receive the benefits that are in H.R. 2297, so I urge Members to support this bill.

Mr. SMITH of New Jersey. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I want to thank the gentleman from California (Mr. FILNER) for his kind remarks and also point out that he has been indefatigable in fighting for the Filipino veterans, and thank the gentleman for his hard work, which has been incorporated in this bill.

Mr. Speaker, I yield 2 minutes to the gentlewoman from Florida (Ms. GINNY BROWN-WAITE).

Ms. GINNY BROWN-WAITE of Florida. Mr. Speaker, I rise today to offer my support for H.R. 2297, the legislation that the Committee on Veterans' Affairs has worked so hard to pass this year. I want to commend the gentleman from New Jersey (Chairman SMITH); the ranking member, the gentleman from Illinois (Mr. EVANS); and the gentleman from South Carolina (Mr. BROWN) for their steadfast leadership on veterans issues.

I also want to recognize the efforts of the gentleman from Arizona (Mr. RENZI) in drafting the Veterans Entrepreneurship Act of 2003, which is included in this legislation. Obviously, this bill will increase the opportunity afforded to veterans who spent their youth serving our country. Federal agencies will have the discretionary authority to sole source contracts for disabled veteran-owned businesses. Additionally, disabled veterans enrolled in school under a VA vocational rehab program will be allowed to declare self-employment as a vocational goal. Certainly this encourages entrepreneurship and business ownership. It clearly establishes a level playing field for those who have been wounded or injured while defending our freedom.

Very important to a lot of widows back home is that it addresses an injustice which has been suffered by military widows whose spouses died while on active duty or of a service-connected condition. They will no longer be denied the benefits earned by their first husband if they choose to remarry later in life. A military spouse already faces a life of sacrifice and hardship and should not be stripped of earned benefits because of a new-found love and companionship. We should not as a government be discouraging people to get married, and this bill corrects that injustice.

In a time of war, it is critically important that our servicemen and -women see that when they return home they will be welcomed by an eternally grateful Nation. This bill helps to express the gratitude that Congress has for our veterans of wars past and present.

Mr. MICHAUD. Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. STRICKLAND), who has fought for veterans issues for a number of years.

Mr. STRICKLAND. Mr. Speaker, I thank the gentleman for yielding me this time, and I thank him for his work on this legislation that offers important benefits to very deserving veterans and their families.

There are many excellent provisions in this bill, and we should all support these provisions, including benefits to POWs and Filipino veterans. I would particularly like to thank the gentleman from Illinois (Mr. EVANS) and his staff and the staff of the Committee on Veterans' Affairs for their work in putting an end to lending schemes that target our Nation's veterans.

Recently, I introduced legislation on making this type of predatory lending illegal, and I am happy to have this language incorporated into this legislation. Predatory lenders are preying on veterans by manipulating them into surrendering their veterans benefits for lump sums, lump sums that these lenders then charge interest rates on ranging from 39 to 106 percent. It is embarrassing that companies would prey on our Nation's veterans and seize the benefits that these veterans have earned through their service to our country. I am grateful that these provisions have been included in this legislation which make it clear that such practices are illegal and that predatory lenders who trick our veterans into surrendering their VA benefits will be in violation of the law.

Again, I would like to thank the gentleman from New Jersey (Mr. SMITH), the chairman of the full committee, and the gentleman from Illinois (Mr. EVANS), our ranking member, for their work; and I would especially like to thank the staffs on both the Republican and Democratic sides who worked so closely together to do those things which can make life better for our veterans.

Mr. SMITH of New Jersey. Mr. Speaker, I reserve the balance of my time.

Mr. MICHAUD. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, in closing, I would like to once again thank the gentleman from New Jersey (Mr. SMITH) and the ranking member, the gentleman from Illinois (Mr. EVANS), for all their work, as well as the chairman of the Subcommittee on Benefits, the gentleman from South Carolina (Mr. BROWN). I think our servicemen, our veterans in this country, can be very proud of the way the Committee on Veterans' Affairs has handled itself this year in a bipartisan manner, looking out for veterans in this country for all the work that they do as well.

I would also like to thank staff on both the Republican and Democratic side for working together in a bipartisan way. The only way we are ever going to move forward and get veterans issues addressed in Congress is by working together in a bipartisan manner. I wish actually some other committees here in Congress would look at the way the Committee on Veterans' Affairs operates and act as bipartisanly.

Mr. Speaker, I yield back the balance of my time.

Mr. SMITH of New Jersey. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I thank our colleagues on the other side of the aisle, all of the staff who have worked for days, weeks and months on this legislation through the hearing process. There are seven titles and close to 40 provisions in this bill. It is a very comprehensive omnibus bill, and so many Members made a difference in its content.

I would like to say we break a lot of new ground in this legislation, including the legislation dealing with veterans' businesses so that set-asides, sole source procurements, and the benefits accruing thereon will go to veterans themselves. In the past, veterans have gotten so little of the Federal procurement dollars—only 0.13 of 1 percent—which is unconscionable. This legislation now gives discretionary authority government-wide so we can again facilitate these important businesses.

Let me also point out that provision, just like the whole bill which is backed by virtually every veteran service organization in the country—that particular provision—on veterans' businesses has 36 military and veterans organizations backing it from a broad spectrum. From the largest Hispanic organization to the Black Veterans for Social Justice, we have a good cross-spectrum of people backing this provision because our veterans who have served so ably and are disabled are absolutely deserving of this legislation.

I thank the gentleman from Arizona (Mr. RENZI) for his leadership on this particular provision. He actually introduced the bill which is incorporated here in our final product. Mr. RENZI has been a champion of veterans benefits, and I thank him.

Mr. Speaker, I also thank Senator ROCKEFELLER, who was instrumental in encouraging a strong text for this provision. I also thank our counterparts in the Senate, Senator GRAHAM and the chairman of the Committee on Veterans' Affairs, Senator SPECTER, for their work on this legislation and their spirit of cooperation.

Mr. Speaker, I include for the RECORD a joint explanatory statement describing all of the provisions including the compromise agreement that we have reached with the other body.

EXPLANATORY STATEMENT ON SENATE AMENDMENT TO HOUSE BILL, H.R. 2297, AS AMENDED

H.R. 2297, as amended, the Veterans Benefits Act of 2003, reflects a Compromise Agreement reached by the House and Senate Committees on Veterans' Affairs ("the Committees") on the following bills considered in the House and Senate during the 108th Congress: H.R. 1257; H.R. 1460, as amended; H.R. 2297, as amended ("House Bill"); and S. 1132, as amended ("Senate Bill"). H.R. 1257 passed the House on May 22, 2003; H.R. 1460, as amended, passed the House on June 24, 2003; H.R. 2297, as amended, passed the House on October 8, 2003; S. 1132, as amended, passed the Senate on October 31, 2003.

The House and Senate Committees on Veterans' Affairs have prepared the following explanation of H.R. 2297, as amended ("Compromise Agreement"). Differences between the provisions contained in the Compromise Agreement and the related provisions of H.R. 1257, H.R. 1460, as amended, H.R. 2297, as amended, and S. 1132, as amended, are noted in this document, except for clerical corrections, conforming changes made necessary by the Compromise Agreement, and minor drafting, technical, and clarifying changes.

TITLE I: SURVIVOR BENEFITS

RETENTION OF CERTAIN VETERANS SURVIVOR BENEFITS FOR SURVIVING SPOUSES REMARRYING AFTER AGE 57

Current Law

Section 103(d) of title 38, United States Code, prohibits a surviving spouse who has remarried from receiving dependency and indemnity compensation ("DIC") and related housing and education benefits during the course of the remarriage. This benefit may be reinstated in the event the subsequent marriage is terminated. Public Law 107–330 extended to surviving spouses who remarry after age 55 continuing eligibility under the Civilian Health and Medical Program of the Department of Veterans Affairs ("CHAMPVA").

House Bill

Section 6 of H.R. 2297, as amended, would allow a surviving spouse who remarries after attaining age 55 to retain the DIC benefit. Spouses who remarry at age 55 or older prior to enactment of the bill would have one year from the date of enactment to apply for reinstatement of DIC benefits. The amount of DIC would be paid with no reduction of certain other Federal benefits to which the surviving spouse might be entitled.

Senate Bill

The Senate Bill contains no comparable provision.

Compromise Agreement

Section 101 of the Compromise Agreement would provide that a surviving spouse upon remarriage after attaining age 57 would retain DIC, home loan, and educational benefits eligibility. Surviving spouses who remarried after attaining age 57 prior to enactment of the Compromise Agreement would have one year to apply for reinstatement of these benefits.

BENEFITS FOR CHILDREN WITH SPINA BIFIDA OF VETERANS OF CERTAIN SERVICE IN KOREA

Current Law

Chapter 18 of title 38, United States Code, authorizes the Department of Veterans Affairs ("VA") to provide benefits and services to those children born with spina bifida whose natural parent (before the child was conceived) served in the Republic of Vietnam between January 9, 1962 and May 7, 1975. Benefits and services are authorized due to the association between exposure to dioxin and the incidence of spina bifida in the children of those exposed. Children born with spina bifida whose parent was exposed to dioxin and other herbicides during military service in locations other than the Republic of Vietnam do not qualify for VA benefits and services.

House Bill

Section 12 of H.R. 2297, as amended, would permit children born with spina bifida whose parent (before the child was conceived) served in an area of Korea near the demilitarized zone ("DMZ") between October 1, 1967 and May 7, 1975, to qualify for benefits in the same manner as children whose parent served in the Republic of Vietnam.

Senate Bill

Section 101 of S. 1132, as amended, would permit children with spina bifida whose parent (before the child was conceived) served in or near the DMZ in Korea during the period beginning on January 1, 1967, and ending on December 31, 1969, to qualify for benefits in the same manner as children whose parent served in the Republic of Vietnam. The Senate Bill would require the Secretary of Veterans Affairs to make determinations of exposure to herbicides in Korea in consultation with the Secretary of Defense.

Compromise Agreement

Section 102 of the Compromise Agreement would generally follow the Senate language. However, under the Compromise Agreement, the time period for qualifying service in or near the DMZ is changed to service which occurred during the period beginning on September 1, 1967, and ending on August 31, 1971.

The Committees note that although use of herbicides in Vietnam ceased in 1971, Vietnam-era veterans who served until May 7, 1975, are presumed to have been exposed to residuals. Similarly, even though herbicide use in or near the Korean DMZ ended in 1969, the Committees believe it is appropriate to extend the qualifying service period beyond 1969 to account for residual exposure.

The Committees also note that the Secretary of Defense has identified the following units as those assigned or rotated to areas near the DMZ where herbicides were used between 1968 and 1969: combat brigades of the 2nd Infantry Division (1–38 Infantry, 2–38 Infantry, 1–23 Infantry, 2–23 Infantry, 3–23 Infantry, 3–32 Infantry, 1–9 Infantry, 2–9 Infantry, 1–72 Armor, and 2–72 Armor); Division Reaction Force (4–7th Cavalry, Counter Agent Company); 3rd Brigade of the 7th Infantry Division (1–17th Infantry, 2–17 Infantry, 1–73 Armor and 2–10th Cavalry); and Field Artillery, Signal and Engineer support personnel.

ALTERNATE BENEFICIARIES FOR NATIONAL SERVICE LIFE INSURANCE AND UNITED STATES GOVERNMENT LIFE INSURANCE

Current Law

Section 1917 of title 38, United States Code, gives veterans insured under the VA's National Service Life Insurance ("NSLI") program the right to designate the beneficiary or beneficiaries of insurance policies maturing on or after August 1, 1946. It also specifies the modes of payment to beneficiaries when an insured dies, and sets forth the procedure to be followed when a beneficiary has not been designated or dies before the insured.

Section 1949 of title 38, United States Code, gives veterans insured under the United States Government Life Insurance ("USGLI") program the right to change beneficiaries, and sections 1950 through 1952 of title 38 set out the modes of payment to designated beneficiaries and sets forth the procedure to be followed when a beneficiary either has not been designated or dies before the insured.

For the NSLI and USGLI programs, the law does not specify the course of action VA is to take when no beneficiary can be found.

House Bill

The House Bill contains no comparable provision.

Senate Bill

Section 102 of S. 1132, as amended, would authorize the payment of NSLI and USGLI to alternate beneficiaries, in order of precedence and as designated by the insured veteran, if no claim is made by the primary beneficiary within two years of the insured veteran's death. If four years have elapsed since the death of the insured and no claim has been filed by a person designated by the insured as a beneficiary, section 102 would authorize VA to make payment to a person VA determines to be equitably entitled to such payment.

Compromise Agreement

Section 103 of the Compromise Agreement follows the Senate language.

PAYMENT OF BENEFITS ACCRUED AND UNPAID AT TIME OF DEATH

Current Law

Section 5121 of title 38, United States Code, restricts specified classes of survivors to receiving no more than two years of accrued benefits if a veteran dies while a claim for VA periodic monetary benefits (other than insurance and servicemen's indemnity) is being adjudicated. Public Law 104–275 extended the retroactive payment from one year to two years.

House Bill

Section 6 of H.R. 1460, as amended, would repeal the two-year limitation on accrued benefits so that a veteran's survivor may receive the full amount of award for accrued benefits.

Senate Bill

Section 105 of S. 1132, as amended, contains an identical provision.

Compromise Agreement

Section 104 of the Compromise Agreement contains this provision.

TITLE II: BENEFITS FOR FORMER PRISONERS OF WAR AND FOR FILIPINO VETERANS

Subtitle A—Former Prisoners of War

PRESUMPTIONS OF SERVICE-CONNECTION RELATING TO DISEASES AND DISABILITIES OF FORMER PRISONERS OF WAR

Current Law

Section 1112(b) of title 38, United States Code, specifies a list of 15 disabilities that VA presumes are related to military service for former prisoners of war ("POWs") who were held captive for not less than 30 days. If a former POW was interned for less than 30 days, he or she must establish that the disability was incurred or aggravated during military service in order for service connection to be granted.

The list in section 1112(b) of title 38, United States Code, does not include cirrhosis of the liver; however, on July 18, 2003, VA published a regulation adding cirrhosis of the liver to the list of conditions presumptively service-connected for former POWs. (68 Fed. Reg. 42,602).

House Bill

Section 11 of H.R. 2297, as amended, would eliminate the 30-day requirement for psychosis, any anxiety states, dysthymic disorders, organic residuals of frostbite and post-traumatic arthritis. Section 11 would also codify cirrhosis of the liver as a disability which is presumptively service-connected for a former POW who was interned for at least 30 days.

Senate Bill

Section 302 of S. 1132, as amended, contains an identical provision.

Compromise Agreement

Section 201 of the Compromise Agreement contains this provision.

Subtitle B—Filipino Veterans

RATE OF PAYMENT OF BENEFITS FOR CERTAIN FILIPINO VETERANS AND THEIR SURVIVORS RESIDING IN THE UNITED STATES

Current Law

Section 107(a) of title 38, United States Code, generally provides that service before July 1, 1946, in the organized military forces of the Government of the Commonwealth of the Philippines, including organized guerilla units ("Commonwealth Army veterans"), may in some circumstances be a basis for entitlement to disability compensation, dependency and indemnity compensation, monetary burial benefits, and certain other benefits under title 38, United States Code, and that payment of such benefits will be at the rate of $0.50 for each dollar authorized. Section 107(b) of title 38, United States Code, generally provides that service in the Philippine Scouts under section 14 of the Armed Forces Voluntary Recruitment Act of 1945 (i.e., service in the "new Philippine Scouts"), may be a basis for entitlement to disability compensation, DIC, and certain other benefits under title 38, United States Code, but payment of such benefits will be at the rate of $0.50 for each dollar authorized.

House Bill

Section 16 of H.R. 2297, as amended, would provide the full amount of compensation and DIC to eligible members of the new Philippine Scouts, as well as the full amount of DIC paid by reason of service in the organized military forces of the Commonwealth of the Philippines, including organized guerilla units, if the individual to whom the benefit is payable resides in the United States and is either a citizen of the U.S. or an alien lawfully admitted for permanent residence.

Senate Bill

Section 321 of S. 1132, as amended, contains an identical provision.

Compromise Agreement

Section 211 of the Compromise Agreement contains this provision.

BURIAL BENEFITS FOR NEW PHILIPPINE SCOUTS RESIDING IN THE UNITED STATES

Current Law

Section 107 of title 38, United States Code, provides that persons who served in the organized military forces of the Government of the Commonwealth of the Philippines, including organized guerilla units ("Commonwealth Army veterans"), who lawfully reside in the United States are eligible for burial in a VA national cemetery and VA monetary burial benefits at the full-dollar rate if, at the time of death, they are receiving VA disability compensation or would have been receiving VA pension but for their lack of qualifying service.

House Bill

Section 17 of H.R. 2297, as amended, would extend eligibility for burial in a national cemetery to new Philippine Scouts, as well as eligibility for VA burial benefits, to those who lawfully reside in the United States.

Senate Bill

Section 322 of S. 1132, as amended, contains an identical provision.

Compromise Agreement

Section 212 of the Compromise Agreement contains this provision.

EXTENSION OF AUTHORITY TO MAINTAIN REGIONAL OFFICE IN THE REPUBLIC OF THE PHILIPPINES

Current Law

Section 315(b) of title 38, United States Code, authorizes the Secretary of Veterans Affairs to operate a regional office in the Republic of the Philippines until December 31, 2003. Congress last extended this authority in Public Law 106–117.

House Bill

Section 18 of H.R. 2297, as amended, would extend the Secretary's authority to operate a regional office in the Republic of the Philippines through December 31, 2009.

Senate Bill

Section 323 of S. 1132, as amended, would extend the Secretary's authority to operate a regional office in the Republic of the Philippines through December 31, 2008.

Compromise Agreement

Section 213 of the Compromise Agreement follows the House language.

TITLE III: EDUCATION BENEFITS, EMPLOYMENT PROVISIONS, AND RELATED MATTERS

EXPANSION OF MONTGOMERY GI BILL EDUCATION BENEFITS FOR CERTAIN SELF-EMPLOYMENT TRAINING

Current Law

Section 3452(e) of title 38, United States Code, furnishes various legal definitions used in the administration of VA's educational assistance programs. Self-employment training is not included among the current definitions.

House Bill

Section 2 of H.R. 2297, as amended, would expand the Montgomery GI Bill program by authorizing educational assistance benefits for on-job training of less than six months in certain self-employment training programs, to include: (1) an establishment providing apprentice or other on-job training, including programs under the supervision of a college or university or any State department of education; (2) an establishment providing self-employment training consisting of full-time training for less than six months that is needed for obtaining licensure to engage in a self-employment occupation or required for ownership and operation of a franchise; (3) a State board of vocational education; (4) a Federal or State apprenticeship registration agency; (5) a joint apprenticeship committee established pursuant to the National Apprenticeship Act, title 29, United States Code; or (6) an agency of the Federal Government authorized to supervise such training.

Senate Bill

The Senate Bill contains no comparable provision.

Compromise Agreement

Section 301 of the Compromise Agreement follows the House language.

INCREASE IN RATES OF SURVIVORS' AND DEPENDENTS' EDUCATIONAL ASSISTANCE

Current Law

Chapter 35 of title 38, United States Code, specifies the eligibility criteria, programs of education and training, and payment amounts applicable under VA's Survivors' and Dependents' Educational Assistance ("DEA") benefits program. Generally, those eligible for DEA benefits are the spouses and dependents of: veterans with total and permanent service-connected ratings; veterans who died as a result of service-related injuries; or servicemembers who died while on active duty. Currently, monthly benefit rates for eligible DEA beneficiaries are $695 for full-time study, $522 for three-quarter-time study, and $347 for half-time study. Monthly DEA benefits are also available for beneficiaries pursuing programs of education on a less-than-half-time basis, through farm cooperative programs, correspondence courses, special restorative training programs, or programs of apprenticeship or other approved on-job training programs.

House Bill

The House Bill contains no comparable provision.

Senate Bill

Section 104 of S. 1132, as amended, would raise monthly DEA benefits by 13.4 percent over current levels. The new rates would be set at $788 for full-time study, $592 for three-quarter time study, and $394 for half-time study. A 13.4 percent increase would also be made to benefits paid to eligible persons pursuing a program of education on a less than half-time basis, through institutional courses, farm cooperative programs, correspondence courses, special restorative training programs, or programs of apprenticeship or other approved on-job training programs. The increases would take effect on July 1, 2004.

Compromise Agreement

Section 302 of the Compromise Agreement follows the Senate language.

RESTORATION OF SURVIVORS' AND DEPENDENTS' EDUCATION BENEFITS OF INDIVIDUALS BEING ORDERED TO FULL-TIME NATIONAL GUARD DUTY

Current Law

Section 3512(h) of title 38, United States Code, provides for an extension of Survivors' and Dependents' Educational Assistance only to reservists called to active duty after September 11, 2001, for an amount of time equal to that period of full-time duty, plus 4 months.

House Bill

Section 3 of H.R. 2297, as amended, would provide that National Guard members who qualify for survivors' and dependents' education benefits under chapter 35 of title 38, United States Code, and are involuntarily ordered to full-time duty under title 32, United States Code, after September 11, 2001, would have their eligibility extended by an amount of time equal to that period of full-time duty, plus 4 months.

Senate Bill

Section 103 of S. 1132, as amended, contains an identical provision.

Compromise Agreement

Section 303 of the Compromise Agreement contains this provision.

ROUNDING DOWN OF CERTAIN COST-OF-LIVING ADJUSTMENTS ON EDUCATIONAL ASSISTANCE

Current Law

Sections 3015(h) and 3564 of title 38, United States Code, provide for annual cost-of-living adjustments to both the Montgomery GI Bill and Survivors' and Dependents' Educational Assistance programs. Each section specifies that percentage increases be "rounded to the nearest dollar."

House Bill

The House Bill contains no comparable provision.

Senate Bill

Section 304 of S. 1132, as amended, would require annual percentage adjustments under sections 3015(h) and 3564 to be rounded down to the nearest dollar. This section would first apply to adjustments made at the start of fiscal year 2005.

Compromise Agreement

Section 304 of the Compromise Agreement follows the Senate language. However, the Compromise Agreement specifies that the changes made by the Senate language shall be effective only through September 30, 2013.

AUTHORIZATION FOR STATE APPROVING AGENCIES TO APPROVE CERTAIN ENTREPRENEURSHIP COURSES

Current Law

Section 3675 of title 38, United States Code, establishes requirements for approval of accredited courses offered by educational institutions. Section 3452 of title 38, United States Code, furnishes various legal definitions used in the administration of VA educational assistance programs. Section 3471 of title 38, United States Code, establishes general requirements which must be met by educational institutions before VA may approve applications for educational assistance from veterans or eligible persons. There is no provision in current law authorizing the approval of entrepreneurship courses.

House Bill

Section 2 of H.R 1460, as amended, would allow State approving agencies to approve non-degree, non-credit entrepreneurship courses offered by a Small Business Development Center ("SBDC") or the National Veterans Business Development Corporation for the training of veterans, disabled veterans, dependent spouses and children of certain disabled or deceased veterans, and members of the National Guard and Selected Reserve. VA would also be prohibited from considering a beneficiary as already qualified for the objective of a program of education offered by a qualified provider of an entrepreneurship course solely because he or she is the owner or operator of a small business.

Senate Bill

The Senate Bill contains no comparable provision.

Compromise Agreement

Section 305 of the Compromise Agreement follows the House language.

REPEAL OF PROVISIONS RELATING TO OBSOLETE EDUCATION LOAN PROGRAM

Current Law

Subchapter III of chapter 36 of title 38, United States Code, establishes VA's education loan program, states policy regarding eligibility, amount, condition, and interest rates of loans, and establishes a revolving fund and insurance against defaults as part of its administration. This program has been in effect since January 1, 1975.

House Bill

Section 5 of H.R. 2297, as amended, would, effective on the date of enactment, repeal the VA education loan program and waive any existing repayment obligations of a veteran, including overpayments due to default on these loans.

Senate Bill

Section 305 of S. 1132, as amended, contains a comparable provision, but terminates the program 90 days after date of enactment.

Compromise Agreement

Section 306 of the Compromise Agreement follows the Senate language.

SIX-YEAR EXTENSION OF VETERANS' ADVISORY COMMITTEE ON EDUCATION

Current Law

Section 3692 of title 38, United States Code, requires the Secretary of Veterans Affairs to administer a Veterans' Advisory Committee on Education. It requires the Secretary to consult with and seek the advice of the Advisory Committee from time to time with respect to the administration of chapters 30, 32, and 35 of title 38, United States Code, and chapter 1606 of title 10, United States Code. The Advisory Committee's authorization expires on December 31, 2003.

House Bill

Section 4 of H.R. 2297, as amended, would extend, through December 31, 2009, the Veterans' Advisory Committee on Education, as well as amend the language to eliminate the requirement that veterans from certain periods—World War II, Korean conflict era, or post-Korean conflict era—be required to participate as members of the Advisory Committee.

Senate Bill

Section 342 of S. 1132, as amended, would extend the Veterans' Advisory Committee on Education through December 31, 2013, and maintain the existing membership requirements, as practicable.

Compromise Agreement

Section 307 of the Compromise Agreement follows the Senate language with regard to membership, and the House language with regard to extending the Advisory Committee's authorization date through December 31, 2009.

PROCUREMENT PROGRAM FOR SMALL BUSINESS CONCERNS OWNED AND CONTROLLED BY QUALIFIED SERVICE-DISABLED VETERANS

Current Law

Sections 631 through 657 of title 15, United States Code, establish policies with respect to aid to small businesses. Section 637 specifies Small Business Administration ("SBA") authorities regarding procurement matters. Section 637(a) specifies SBA authorities with respect to procurement contracts and subcontracts to disadvantaged small business concerns. Section 637(d) establishes policies regarding performance of contracts by small business concerns ("SBC"), as described in title 15, United States Code. Section 637(h) establishes policies regarding award of contracts, procedures other than competitive ones, and exceptions.

House Bill

Section 3 of H.R. 1460, as amended, would provide Federal agencies discretionary authority to create "sole-source" contracts for service-disabled veteran-owned and controlled small businesses, up to $5 million for manufacturing contract awards and up to $3 million for non-manufacturing contract awards.

This section would provide Federal agencies discretionary authority to restrict certain contracts to service-disabled veteran-owned and controlled small businesses if at least two such concerns are qualified to bid on the contract.

Section 3 would establish a contracting priority that places restricted and "sole source" contracts for service-disabled veteran-owned and controlled small businesses immediately below the priority for socially and economically disadvantaged firms (known as "8(a)" program contracts) for all Federal departments and agencies except VA. Such priorities for service-disabled veteran-owned and controlled small businesses would rank above priorities for HUBZone and women-owned businesses. HUBZones are SBCs located in historically underutilized business zones. However, a contracting officer would procure from a source on the basis of a preference provided under any provision of this legislation unless the contracting officer had determined the procurement could be made by a contracting authority having a higher priority. Lastly, procurement could not be made from a source on the basis of preference provided under this legislation if the procurement could otherwise be made from a different source under section 4124 or 4125 of title 18, United States Code, or the Javits-Wagner-O'Day Act.

Section 3 would establish a four-year pilot program in the Department of Veterans Affairs in which service-disabled veteran-owned and controlled small businesses would have the same contracting priority as the 8(a) program.

This section would define "qualified service-disabled veteran" as any veteran who (1) has one or more disabilities that are service-connected as defined in section 101(16) of title 38, United States Code, and are rated at 10 percent or more by the Secretary of Veterans Affairs, or (2) is entitled to benefits under section 1151 of title 38, United States Code.

Section 3 would define "small business concerns owned and controlled by qualified service-disabled veterans" as (1) one in which not less than 51 percent of which is owned by one or more qualified service-disabled veterans or, in the case of any publicly-owned businesses, not less than 51 percent of the stock of which is owned by one or more qualified service-disabled veterans, and (2) the management and daily business operations of which are controlled by one or more qualified service-disabled veterans or, in the case of a veteran with permanent and severe disability, the spouse or permanent care giver of the veteran.

Section 3 would define the term "certified small business concerns owned and controlled any qualified service-disabled veterans" as any small business concern owned and controlled by qualified service-disabled veterans that is certified by the Administrator of the Small Business Administration as being such a concern.

Senate Bill

The Senate Bill contains no comparable provision.

Compromise Agreement

Section 308 of the Compromise Agreement would provide Federal contracting officials the discretionary authority to award sole source contracts (limited to contracts of up to $5 million for manufacturing and $3 million for non-manufacturing) to SBCs owned and controlled by service-disabled veterans. This section would also provide Federal contracting officials, in certain circumstances, the discretionary authority to award contracts on a restricted competition basis to SBCs owned and controlled by service-disabled veterans. This provision would not supercede any existing procurement preference established under law. Specifically, it would not accord service-disabled veteran small business owners priority over procurement preferences under the Federal Prison Industries, Javits-Wagner-O'Day, SBA 8(a), Women's, or HubZone programs. Rather, the Committees intend the provision to provide Federal contracting officials a means to improve their results with respect to contracting with service-disabled veterans. The Committees note that in 1999, Public Law 106–50 established a 3 percent government-wide goal for procurement from service-disabled veteran-owned small businesses. To date, all Federal agencies fall far short of reaching this procurement goal.The Committees intend that a determination of service-connection by the Secretary of Veterans Affairs would be binding on the SBA for purposes of participation in this program. The Committees also urge the SBA and the Office of Federal Procurement Policy to expeditiously and transparently implement this program, perform outreach, and provide the necessary resources to improve results with respect to SBCs owned and operated by service-disabled veterans.

OUTSTATIONING OF TRANSITION ASSISTANCE PROGRAM PERSONNEL

Current Law

Section 1144 of title 10, United States Code, authorizes the Secretary of Labor to place staff in veterans' assistance offices on military installations, both foreign and domestic, to help transitioning servicemembers obtain civilian jobs.

House Bill

Section 19 of H.R. 2297, as amended, would require the Department of Labor to place staff in veterans' assistance offices where VA staff are located at overseas military installations 90 days after enactment. It would also authorize the Department of Labor to exceed the number of VA locations and place staff in additional locations abroad.

Senate Bill

The Senate Bill contains no comparable provision.

Compromise Agreement

Section 309 of the Compromise Agreement follows the House language with a technical modification.

TITLE IV: HOUSING BENEFITS AND RELATED MATTERS

AUTHORIZATION TO PROVIDE ADAPTED HOUSING ASSISTANCE TO CERTAIN DISABLED MEMBERS OF THE ARMED FORCES WHO REMAIN ON ACTIVE DUTY

Current Law

Section 2101 of title 38, United States Code, provides for grants to adapt or acquire suitable housing for certain severely disabled veterans, including veterans who are unable to ambulate without assistance. Severely disabled servicemembers who have not yet been processed for discharge from military service, but who will qualify for the benefit upon discharge due to the severity of their disabilities, are not allowed to apply for or receive the grant until they are actually discharged from military service.

House Bill

Section 4 of H.R. 1460, as amended, would permit a member of the Armed Forces to apply for and receive a grant prior to actually being discharged from military service.

Senate Bill

The Senate Bill contains no comparable provision.

Compromise Agreement

Section 401 of the Compromise Agreement follows the House language.

INCREASE IN AMOUNTS FOR CERTAIN ADAPTIVE BENEFITS FOR DISABLED VETERANS

Current Law

The Secretary of Veterans Affairs is authorized in chapter 21 of title 38, United States Code, to assist eligible veterans in acquiring suitable housing and adaptations with special fixtures made necessary by the nature of the veteran's service-connected disability, and with the necessary land. The maximum amount authorized for a severely disabled veteran is $48,000. The maximum amount authorized for less severely disabled veterans is $9,250.

Section 3902(a) of title 38, United States Code, authorizes the Secretary to pay up to $9,000 to an eligible disabled servicemember or veteran to purchase an automobile (including all state, local, and other taxes).

House Bill

Section 10(a) of H.R. 2297, as amended, would increase the specially adapted housing grants for the most severely disabled veterans from $48,000 to $50,000, and from $9,250 to $10,000 for less severely disabled veterans.

Section 10(b) would increase the specially adapted automobile grant from $9,000 to $11,000.

Senate Bill

The Senate Bill contains no comparable provision.

Compromise Agreement

Section 402 of the Compromise Agreement follows the House language.

PERMANENT AUTHORITY FOR HOUSING LOANS FOR MEMBERS OF THE SELECTED RESERVE

Current Law

Under section 3702(a)(2)(E) of title 38, United States Code, members of the Selected

Reserve qualify for a VA home loan if the reservist has served for a minimum of six years. Eligibility for reservists under this program is scheduled to expire on September 30, 2009.

House Bill

Section 13 of H.R. 2297, as amended, would make the Selected Reserve home loan program permanent.

Senate Bill

The Senate Bill contains no comparable provision.

Compromise Agreement

Section 403 of the Compromise Agreement follows the House language.

REINSTATEMENT OF MINIMUM REQUIREMENTS FOR SALE OF VENDEE LOANS

Current Law

Section 3733 of title 38, United States Code, generally establishes property management policies for real property acquired by the Department of Veterans Affairs as a result of a default on a loan that VA has guaranteed.

House Bill

Section 15 of H.R. 2297, as amended, would reinstate the vendee loan program which VA administratively terminated on January 31, 2003. It would increase from 65 percent to 85 percent the maximum number of purchases of real property the Secretary may finance in a fiscal year. It would change the vendee loan program from a discretionary to a mandatory one.

Senate Bill

Section 308 of S. 1132, as amended, contains an identical provision.

Compromise Agreement

Section 404 of the Compromise Agreement contains this provision. However, the Compromise Agreement specifies that the changes made under this provision shall expire after September 30, 2013.

ADJUSTMENT TO HOME LOAN FEES AND UNIFORMITY OF FEES FOR QUALIFYING RESERVE MEMBERS WITH FEES FOR ACTIVE DUTY VETERANS

Current Law

Section 3729(a) of title 38, United States Code, requires that a fee shall be collected from each person (1) obtaining a housing loan guaranteed, insured, or made under chapter 37; and (2) assuming a loan to which section 3714 (concerning loan assumptions) applies. The fee may be included in the loan.

Section 3729(b) of title 38, United States Code, determines the amount of the home loan fees expressed as a percentage of the total amount of the loan guaranteed, insured, or made, or, in the case of a loan assumption, the unpaid principal balance of the loan on the date of the transfer of the property.

Section 3729(b)(2) requires that veterans who served in the Selected Reserve pay 75 basis points more than veterans with active duty service.

House Bill

Section 14 of H.R. 2297, as amended, would make four revisions to the Loan Fee Table. First, it would provide uniformity in the funding fees for VA-guaranteed home loans charged to those who served in the Selected Reserve and veterans with active duty service. Second, beginning in fiscal year 2004, it would increase the fee charged for loans made with no down payment by 15 basis points. Third, it would increase the fee charged for repeated use of the home loan benefit, i.e., for a second or subsequent loan, by 30 basis points for the fiscal year 2004–2011 period and by 90 basis points in fiscal years 2012 and 2013. Fourth, it would replace the existing range of fees for hybrid adjustable rate mortgages under the current pilot program with a flat fee of 1.25 percent.

Senate Bill

Section 307 of S. 1132, as amended, would increase the funding fees for subsequent use of a guaranty by 50 basis points, but only between fiscal years 2005 and 2011.

Compromise Agreement

Section 405 of the Compromise Agreement would follow the House language, except that a funding fee for members of the Selected Reserve would, for initial use of a guaranty, be set 25 basis points higher than applicable funding fees set for veterans with active duty service. Further, for the period January 1, 2004 through September 30, 2004 only, in the case of active-duty veterans making initial loans with zero dollars down, the fee would be increased from 2.15 percent to 2.20 percent. In addition, the Compromise Agreement would not effect a 1.25 percent flat fee for hybrid adjustable rate mortgage loans.

ONE-YEAR EXTENSION OF PROCEDURES ON LIQUIDATION SALES OF DEFAULTED HOME LOANS GUARANTEED BY THE DEPARTMENT OF VETERANS AFFAIRS

Current Law

Section 3732 of title 38, United States Code, defines the procedures for a liquidation sale of a property acquired by VA in the event of a default on a VA-guaranteed home loan. The procedures direct VA to follow a formula, defined in statute, which mandates VA consider losses it might incur when selling properties acquired through foreclosure. Ultimately, after considering the loss VA can make a determination whether to, in fact, acquire the property or simply pay the guaranty on the loan used to purchase the property. The authority for these procedures is currently set to expire on October 1, 2011.

House Bill

The House Bill contains no comparable provision.

Senate Bill

The Senate Bill contains no comparable provision.

Compromise Agreement

Section 406 of the Compromise Agreement would extend the application of the liquidation sale procedures through October 1, 2012.

TITLE V: BURIAL BENEFITS

BURIAL PLOT ALLOWANCE

Current Law

Veterans who are discharged from active duty service as a result of a service-connected disability, veterans who are entitled to disability compensation or VA pension, and veterans who die in a VA facility are eligible for a $300 VA "plot allowance" if they are not buried in a national cemetery. Section 2303(b)(1) of title 38, United States Code, allows state cemeteries to receive the $300 plot allowance payment for the interment of such veterans, and the interment of veterans of any war, if the cemeteries are used solely for the burial of veterans. However, states may not receive a plot allowance for burial of veterans who die as a result of a service-connected disability and whose survivors seek reimbursement of funeral expenses under section 2307 of title 38, United States Code (which currently authorizes a $2,000 funeral expense benefit).

House Bill

The House Bill contains no comparable provision.

Senate Bill

Section 201 of S. 1132, as amended, would expand existing law to allow states to receive the $300 plot allowance for the interment of veterans who did not serve during a wartime period and for the interment of veterans who died as a result of service-connected disabilities and whose survivors sought reimbursement of funeral expenses under section 2307 of title 38, United States Code.

Compromise Agreement

Section 501 of the Compromise Agreement follows the Senate language.

ELIGIBILITY OF SURVIVING SPOUSES WHO REMARRY FOR BURIAL IN NATIONAL CEMETERIES

Current Law

Section 2402(5) of title 38, United States Code, prohibits a surviving spouse of a veteran who has remarried from being buried with the veteran spouse in a national cemetery if the remarriage is in effect when the veteran's surviving spouse dies. Public Law 103–466 revised eligibility criteria for burial in a national cemetery to reinstate burial eligibility for a surviving spouse of an eligible veteran whose subsequent remarriage was terminated by death or divorce.

House Bill

Section 7 of H.R. 2297, as amended, would allow the surviving spouse of a veteran to be eligible for burial in a VA national cemetery based on his or her marriage to the veteran, regardless of the status of the subsequent marriage. This eligibility revision would be effective January 1, 2000.

Senate Bill

Section 202 of S. 1132, as amended, contains a similar provision, with the eligibility revision being effective on date of enactment.

Compromise Agreement

Section 502 of the Compromise Agreement follows the House language. Despite the inclusion of an additional group of persons (i.e., remarried spouses) eligible for national cemetery burial under the Compromise Agreement, the Secretary retains the authority under section 2402(6) of title 38, United States Code, to grant or deny national cemetery burial for other persons, or classes of persons, not explicitly granted eligibility in statute. It has come to the Committees' attention that VA's record-keeping system concerning which persons are granted or denied waivers for burial in national cemeteries is, at best, incomplete. Adequate records on burial waivers are necessary to ensure that the Secretary's judgment on waiver cases is being applied uniformly to all applicants. The Committees direct VA to rectify gaps in its waiver-accounting system so that basic information, such as which persons are denied burial waivers and the reasons for the denial, will be available.

PERMANENT AUTHORITY FOR STATE CEMETERY GRANTS PROGRAM

Current Law

Section 2408(a)(2) of title 38, United States Code, authorizes appropriations, through fiscal year 2004, for VA to make grants to States to assist them in establishing, expanding, or improving state veterans' cemeteries.

House Bill

Section 8 of H.R. 2297, as amended, would make the State Cemetery Grants Program permanent.

Senate Bill

Section 203 of S. 1132, as amended, contains a similar provision with an additional technical change.

Compromise Agreement

Section 503 of the Compromise Agreement follows the Senate language.

TITLE VI: EXPOSURE TO HAZARDOUS SUBSTANCES

RADIATION DOSE RECONSTRUCTION PROGRAM OF DEPARTMENT OF DEFENSE

Current Law

Section 3.311 of title 38, Code of Federal Regulations, sets out procedures for the adjudication of claims by VA for benefits premised on a veteran's exposure to ionizing radiation in service. For veterans who claim radiation exposure due to participation in nuclear atmospheric testing from 1945 through 1962, or due to occupation duty in Hiroshima and Nagasaki prior to July 1, 1946, dose data are requested from the Department of Defense ("DOD"). DOD's Defense Threat Reduction Agency ("DTRA") pays a private contractor to estimate radiation exposure through a process called radiation dose reconstruction.

There is no entity under existing law which provides independent oversight of DTRA's radiation dose reconstruction process.

House Bill

The House Bill contains no comparable provision.

Senate Bill

Section 331 of S. 1132, as amended, would require VA and DOD to review, and report on the mission, procedures, and administration of the radiation dose reconstruction program. It would also require VA and DOD to establish an advisory board to oversee the program.

Compromise Agreement

Section 601 of the Compromise Agreement follows the Senate language.

STUDY ON DISPOSITION OF AIR FORCE HEALTH STUDY

Current Law

The Air Force Health Study ("AFHS") was initiated by DOD in 1982 to examine the effects of herbicide exposure and health, mortality, and reproductive outcomes in veterans of Operation Ranch Hand, the activity responsible for aerial spraying of herbicides during the Vietnam Conflict. The study will conclude in 2006.

House Bill

The House Bill contains no comparable provision.

Senate Bill

Section 332 of S. 1132, as amended, would direct VA to enter into an agreement with the National Academy of Sciences ("NAS") under which NAS would report on the following: (1) the scientific merit of retaining AFHS data after the Ranch Hand study is terminated; (2) obstacles to retaining the AFHS data which may exist; (3) the advisability of providing independent oversight of the data; (4) the advisability and prospective costs of extending the study and the identity of an entity which would be suited to continue the study; and (5) the advisability of making laboratory specimens from the study available for independent research.

Compromise Agreement

Section 602 of the Compromise Agreement follows the Senate language, but the reporting deadline is extended to 120 days.

FUNDING OF MEDICAL FOLLOW-UP AGENCY OF INSTITUTE OF MEDICINE OF NATIONAL ACADEMY OF SCIENCES FOR EPIDEMIOLOGICAL RESEARCH ON MEMBERS OF THE ARMED FORCES AND VETERANS

Current Law

Public Law 102–585 requires that VA and DOD each contribute $250,000 in annual core funding to the Medical Follow-Up Agency ("MFUA") for a period of 10 years. MFUA is a panel of the Institute of Medicine which researches military health issues.

House Bill

The House Bill contains no comparable provision.

Senate Bill

Section 333 of S. 1132, as amended, would mandate VA and DOD funding for MFUA, at current levels, from fiscal year 2004 through 2013.

Compromise Agreement

Section 603 of the Compromise Agreement follows the Senate language.

TITLE VII: OTHER MATTERS

TIME LIMITATIONS ON RECEIPT OF CLAIM INFORMATION PURSUANT TO REQUESTS OF DEPARTMENT OF VETERANS AFFAIRS

Current Law

Section 5102(b) of title 38, United States Code, requires that VA, in cases where it receives an application for benefits that is not complete, notify the applicant of the information that is necessary to complete the application for benefits. Similarly, section 5103(a) of title 38, United States Code, requires that VA, when it receives a complete or a substantially complete application for benefits, notify the applicant of any information or evidence necessary to substantiate the claim. Section 5103(b) of title 38, United States Code, states that if information or evidence requested under section 5103(a) is not received within one year of the date of such notification, no benefit may be paid by reason of that application for benefits.

House Bill

The House Bill contains no comparable provision.

Senate Bill

Section 310 of S. 1132, as amended, would require that claimants who have submitted an incomplete application under section 5102(b) of title 38, United States Code, and who have been notified that information is required to complete the application, submit the information within one year of the date of notification or else no benefit would be paid by reason of the application. It would also clarify section 5103(b) by stating that that subsection would not be construed to prohibit VA from making a decision on a claim before the expiration of the one-year period. Section 310 would be effective as if enacted on November 9, 2000, immediately after the enactment of the Veterans Claims Assistance Act of 2000.

Compromise Agreement

Section 701 of the Compromise Agreement would follow the Senate language, but would make a further amendment to section 5103(b) of title 38, United States Code, to remove the statutory bar to payment of benefits when information or evidence, requested of the claimant by VA, is not submitted within one year of the notification requesting such information or evidence. If a matter is on appeal and evidence is received beyond the one-year period relating to the original claim, it should be considered.

Section 701(d)(1) of the Compromise Agreement would require VA to readjudicate the original claim when a claimant adequately asserts he or she was misled upon receiving notification from VA of the information or evidence needed to substantiate the claim. However, section 701(d)(4) specifies that the Secretary is not required to identify or readjudicate any claim based upon the authority given to the Secretary under this section when information or evidence was submitted during the one-year period following the notification or when the claim has been the subject of a timely appeal to the Board of Veterans' Appeals or the United States Court of Appeals for Veterans Claims.

CLARIFICATION OF APPLICABILITY OF PROHIBITION ON ASSIGNMENT OF VETERANS BENEFITS TO AGREEMENTS ON FUTURE RECEIPT OF CERTAIN BENEFITS

Current Law

Section 5301 of title 38, United States Code, prohibits the assignment of VA benefits and exempts such benefits from taxation and from the claims of creditors.

House Bill

The House Bill contains no comparable provision.

Senate Bill

Section 311 of S. 1132, as amended, would clarify current statutory language prohibiting the assignment of benefits and specify that any agreement under which a VA beneficiary might purport to transfer to another person or entity the right to receive direct or indirect payments of compensation, pension, or DIC benefits shall be deemed to be a prohibited assignment. Section 311 would also make it clear that such prohibitory language would not bar loans to VA beneficiaries which might be repaid with funds derived from VA, so long as each periodic payment made under the loan is separately and voluntarily executed by the beneficiary at the time the payment is made.

Compromise Agreement

Section 702 of the Compromise Agreement would follow the Senate language but would modify it to state that payments on loans are explicitly allowed when made by preauthorized electronic funds transfers pursuant to the Electronic Funds Transfers Act ("EFTA"). The EFTA defines a characteristic of these transfers as allowing the beneficiary to direct his or her financial institution to cease payments upon the beneficiary's notice. It is the Committees' intent to ensure that methods of loan repayment would not be limited for disabled veterans. The Compromise Agreement would also eliminate the section that specifies the effective date of the provision. It is the Committees' intent that prohibition against assignment shall be enforced through coordination with appropriate authorities.

SIX-YEAR EXTENSION OF ADVISORY COMMITTEE ON MINORITY VETERANS

Current Law

Section 544 of title 38, United States Code, mandates that VA establish an Advisory Committee on Minority Veterans. The Secretary of Veterans Affairs must, on a regular basis, consult with and seek the advice of the Advisory Committee with respect to issues relating to the administration of benefits for minority group veterans. The Secretary must also consult with and seek the advice of the Committee with respect to reports and studies pertaining to such veterans, and the needs of such veterans for compensation, health care, rehabilitation, outreach, and other benefits and programs administered by VA. The Advisory Committee is required to submit an annual report providing its assessment of the needs of minority veterans, VA programs designed to meet those needs, and any recommendations the Advisory Committee considers appropriate. The authorization for the Advisory Committee expires on December 31, 2003.

House Bill

The House Bill contains no comparable provision.

Senate Bill

Section 341 of S. 1132, as amended, would extend the authorization of the Advisory Committee on Minority Veterans until December 31, 2007.

Compromise Agreement

Section 703 of the Compromise Agreement would extend the authorization of the Advisory Committee until December 31, 2009.

TEMPORARY AUTHORITY FOR PERFORMANCE OF MEDICAL DISABILITIES EXAMINATIONS BY CONTRACT PHYSICIANS

Current Law

Section 504 of Public Law 104–275 authorized VA to carry out a contract disability examination pilot program at 10 VA regional offices. The law specifies that VA draw funds for the program from amounts available to the Secretary of Veterans Affairs for compensation and pensions.

House Bill

The House Bill contains no comparable provision.

Senate Bill

Section 343 of S. 1132, as amended, would authorize VA, using funds subject to appropriation, to contract for disability examinations from non-VA providers at all VA regional offices. Such examinations would be conducted pursuant to contracts entered into and administered by the Under Secretary for Benefits. The Secretary's authority under this section would expire on December 31, 2009. No later than four years after the section's enactment, the Secretary would be required to submit a report assessing the cost, timeliness, and thoroughness of disability examinations performed under this section.

Compromise Agreement

Section 704 of the Compromise Agreement follows the Senate language, but adds a technical modification that would clarify that the authority granted the Secretary under section 704 of the Compromise Agreement is in addition to the authority already granted the Secretary under Section 504 of Public Law 104–275. Thus, it is the Committees' intent that VA's existing contract for disability examinations under the authority of Public Law 104–275 remain in force. It is also the Committees' intent that the Secretary's ability to enter into contracts in the future under the strictures of Section 504 of Public Law 104–275 remain in force as well.

FORFEITURE OF BENEFITS FOR SUBVERSIVE ACTIVITIES

Current Law

Section 6105 of title 38, United States Code, provides that an individual convicted after September 1, 1959, of any of several specified offenses involving subversive activities shall have no right to gratuitous benefits (including the right to burial in a national cemetery) under laws administered by the Secretary of Veterans Affairs. No other person shall be entitled to such benefits on account of such individual.

House Bill

Section 20 of H.R. 2297, as amended, would amend current law to supplement the list of serious Federal criminal offenses for which a veteran's conviction results in a bar to VA benefits, including burial in a national cemetery. The following criminal offenses from title 18, United States Code, would be added: section 175, prohibited activities with respect to biological weapons; section 229, prohibited activities with respect to chemical weapons; section 831, prohibited transactions involving nuclear materials; section 1091, genocide; section 2332a, use of certain weapons of mass destruction; and section 2332b, acts of terrorism transcending national boundaries. All of these offenses, which involve serious threats to national security, were added to title 18, United States Code, after the enactment of the provisions in section 6105 of title 38, United States Code.

Senate Bill

Section 313 of S. 1132, as amended, contains an identical provision.

Compromise Agreement

Section 705 of the Compromise Agreement contains this provision.

TWO-YEAR EXTENSION OF ROUND-DOWN REQUIREMENT FOR COMPENSATION COST-OF-LIVING ADJUSTMENTS

Current Law

Sections 1104(a) and 1303(a) of title 38, United States Code, mandate that yearly cost-of-living adjustments made to rates of compensation and dependency and indemnity compensation be rounded down to the nearest whole dollar amount. This authority expires on September 30, 2011.

House Bill

The House Bill contains no comparable provision.

Senate Bill

Section 301 of S. 1132, as amended, would extend the round-down authority under sections 1104(a) and 1303(a) through fiscal year 2013.

Compromise Agreement

Section 706 of the Compromise Agreement follows the Senate language.

CODIFICATION OF REQUIREMENT FOR EXPEDITIOUS TREATMENT OF CASES ON REMAND

Current Law

Section 302 of Public Law 103–446 requires the Secretary of Veterans Affairs to provide for the expeditious treatment by the Board of Veterans' Appeals and by regional offices of the Veterans Benefits Administration of claims remanded by the Board of Veterans' Appeals or the United States Court of Appeals for Veterans Claims.

House Bill

The House Bill contains no comparable provision.

Senate Bill

The Senate Bill contains no comparable provision.

Compromise Agreement

Section 707 of the Compromise Agreement would codify the provisions of section 302 of Public Law 103–446. Expedited treatment of decisions of the Board of Veterans' Appeals would be codified in chapter 51 of title 38, United States Code. Expedited treatment of decisions of the United States Court of Appeals for Veterans Claims would be codified in chapter 71 of title 38, United States Code.

LEGISLATIVE PROVISIONS NOT ADOPTED

CLARIFICATION OF NOTICE OF DISAGREEMENT FOR APPELLATE REVIEW OF DEPARTMENT OF VETERANS AFFAIRS ACTIVITIES

Current Law

Claimants for VA benefits who disagree with an initial decision rendered by VA may initiate an appeals process by submitting a written notice of disagreement ("NOD") within one year after the claimant was notified of the initial decision. Section 7105(b) of title 38, United States Code, states that an NOD "must be in writing and filed with the activity which entered the determination with which disagreement is expressed." Upon the timely filing of an NOD, VA is required to provide appellate review of its initial benefits rating decision.

VA has promulgated regulations to implement section 7105 of title 38, United States Code, which state that "while special wording is not required, the Notice of Disagreement must be in terms which can be reasonably construed as disagreement with the determination and [expressing a] desire for appellate review." 38 CFR §20.201 (2002).

House Bill

The House Bill contains no comparable provision.

Senate Bill

Section 314 of S. 1132, as amended, would clarify section 7105(b) of title 38, United States Code, by requiring that VA deem any written document which expresses disagreement with a VA decision to be an NOD unless VA finds that the claimant has disavowed a desire for appellate review. This section would be effective with respect to documents filed on or after the date of enactment, and with respect to documents filed before the date of enactment and not treated by VA as an NOD pursuant to part 20.201 of title 38, Code of Federal Regulations. Furthermore, a document filed as an NOD after March 15, 2002, and rejected by the Secretary as insufficient would, at VA motion or at the request of a claimant within one year of enactment, be deemed to be an NOD if the document expresses disagreement with a decision and VA finds that the claimant has not disavowed a desire for appellate review.

PROVISION OF MARKERS FOR PRIVATELY MARKED GRAVES

Current Law

Section 502 of Public Law 107–103, the Veterans Education and Benefits Expansion Act of 2001, authorizes VA to furnish a government headstone or marker for the grave of an eligible veteran buried in a non-veterans' cemetery irrespective of whether the grave was already marked with a private marker. The law applies to veterans whose deaths occurred on or after December 27, 2001. Public Law 107–330 extended this authority to include deaths occurring on or after September 11, 2001.

House Bill

The House Bill contains no comparable provision.

Senate Bill

Section 204 of S. 1132, as amended, would amend the Veterans Education and Benefits Expansion Act of 2001 to authorize VA to furnish a government headstone or marker for the grave of an eligible veteran buried in a private cemetery, irrespective of whether the grave was already marked with a private marker, for deaths occurring on or after November 1, 1990.

TERMINATION OF AUTHORITY TO GUARANTEE LOANS TO PURCHASE MANUFACTURED HOMES AND LOTS

Current Law

Section 3712 of title 38, United States Code, authorizes VA to guarantee loans for the purchase of a manufactured home and a lot on which it is sited.

House Bill

The House Bill contains no comparable provision.

Senate Bill

Section 306 of S. 1132, as amended, would eliminate VA's authority to guarantee loans to purchase a manufactured home and the lot on which it is sited.

REINSTATEMENT OF VETERANS VOCATIONAL TRAINING PROGRAM FOR CERTAIN PENSION RECIPIENTS

Current Law

Section 1524 of title 38, United States Code, authorized a pilot program of vocational training to certain nonservice-connected pension recipients. The initial pilot program was in place from February 1, 1985, through January 31, 1992. Public Law 102-562 extended the program through December 31, 1995.

House Bill

Section 9 of H.R. 2297, as amended, would reinstate the VA pilot program for five years beginning on the date of enactment to provide vocational training to newly eligible VA nonservice-connected pension recipients. The program would be open to those veterans age 45 years or younger. The Department of Veterans Affairs would be required to ensure that the availability of vocational training is made known through various outreach methods. Not later than two years after the date of enactment, and each year thereafter, the Secretary would be required to submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the operation of the pilot program. The report would include an evaluation of the vocational training provided, an analysis of the cost-effectiveness of the training provided, and data on the entered-employment rate of veterans participating in the program.

Senate Bill

The Senate Bill contains no comparable provision.

THREE-YEAR EXTENSION OF INCOME VERIFICATION AUTHORITY

Current Law

Section 5317 of title 38, United States Code, directs VA to notify applicants for needs-based VA benefits that information collected from the applicants may be compared with income-related information obtained by VA from the Internal Revenue Service and the Department of Health and Human Services. The authority of the Secretary of Veterans Affairs to obtain such information expires on September 30, 2008.

Section 6103(l)(7)(D)(viii) of the Internal Revenue Code authorizes the release of income information by the Internal Revenue Service to VA. This authority expires on September 30, 2008.

House Bill

The House Bill contains no comparable provision.

Senate Bill

Section 312 of S. 1132, as amended, would extend until September 30, 2011, the authority of the Secretary to obtain income information under section 5317 of title 38, United States Code, and the authority of the Internal Revenue Service to share income information under section 6103(l)(7)(D)(viii) of the Internal Revenue Code.

Mr. BILIRAKIS. Mr. Speaker, I rise in strong support of H.R. 2297, the Veterans' Benefits Act of 2003. This bill addresses an issue that I have been working on for a number of years. Dependency and Indemnity Compensation (DIC) is the benefit accorded to the surviving dependents of those members of the Armed Forces who died while on active duty or of a service-connected cause.

DIC is the only federal annuity program that does not allow a widow who is receiving compensation to remarry at an older age and retain her annuity. Earlier this year, I reintroduced legislation which provides that the remarriage of the surviving spouse of a veteran after age 55 shall not result in termination of Dependency and Indemnity Compensation.

I was pleased that my legislation was incorporated into H.R. 2297 when it passed the House in October. The bill that we are considering today, which was worked out with the Senate, slightly modifies my original provision to provide that a surviving spouse upon remarriage after age 57 would retain DIC, home loan and educational benefits eligibility. Surviving spouses who remarried after attaining age 57 prior to enactment of the Compromise Agreement would have one year to apply for reinstatement of these benefits.

I think it is a wonderful thing if an older person finds companionship, falls in love and decides to marry. I don't think we should be discouraging such marriages by making them financially burdensome. In these circumstances, it is often the case that both partners are living on fixed incomes. the prospect of one partner losing financial benefits as a result of the marriage is a real disincentive.

Once again, I would like to thank Chairman SMITH, Ranking Member EVANS, Benefits Subcommittee Chairman BROWN and Subcommittee Ranking Member MICHAUD for working with me to include a DIC remarriage provision in H.R. 2297.

I urge my colleagues to support the bill before us today.

Mr. SMITH of New Jersey. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. TERRY). The question is on the motion offered by the gentleman from New Jersey (Mr. SMITH) that the House suspend the rules and concur in the Senate amendment to the bill, H.R. 2297.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the Senate amendment was concurred in.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. SMITH of New Jersey. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on H.R. 2297.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

COMPACT OF FREE ASSOCIATION AMENDMENTS ACT OF 2003

Mr. LEACH. Mr. Speaker, I move to suspend the rules and concur in the Senate amendments to the joint resolution (H.J. Res. 63) to approve the "Compact of Free Association, as amended between the Government of the United States of America and the Government of the Federated States of Micronesia", and the "Compact of Free Association, as amended between the Government of the United States of America and the Government of the Republic of the Marshall Islands," and otherwise to amend Public Law 99-239, and to appropriate for the purposes of amended Public Law 99-239 for fiscal years ending on or before September 30, 2023, and for other purposes.

The Clerk read as follows:

Senate amendments:

Strike out all after the resolving clause and insert:

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—This joint resolution, together with the table of contents in subsection (b) of this section, may be cited as the "Compact of Free Association Amendments Act of 2003".

(b) TABLE OF CONTENTS.—The table of contents for this joint resolution is as follows:

Sec. 1. Short title and table of contents.

TITLE I—APPROVAL OF U.S.-FSM COMPACT AND U.S.-RMI COMPACT; INTERPRETATION OF, AND U.S. POLICIES REGARDING, U.S.-FSM COMPACT AND U.S.-RMI COMPACT; SUPPLEMENTAL PROVISIONS

Sec. 101. Approval of U.S.-FSM Compact of Free Association and the U.S.-RMI Compact of Free Association; references to subsidiary agreements or separate agreements.
  (a) Federated States of Micronesia.
  (b) Republic of the Marshall Islands.
  (c) References to the Compact, the U.S.-FSM Compact and the U.S.-RMI Compact; References to Subsidiary Agreements or Separate Agreements.
  (d) Amendment, Change, or Termination in the U.S.-FSM Compact, the U.S.-RMI Compact and Certain Agreements.
  (e) Subsidiary Agreements Deemed Bilateral.
  (f) Entry Into Force of Future Amendments to Subsidiary Agreements.
Sec. 102. Agreements With Federated States of Micronesia.
  (a) Law Enforcement Assistance.
  (b) Agreement on Audits.
Sec. 103. Agreements With and Other Provisions Related to the Republic of the Marshall Islands.
  (a) Law Enforcement Assistance.
  (b) EJIT.
  (c) Section 177 Agreement.
  (d) Nuclear Test Effects.
  (e) Espousal Provisions.
  (f) DOE Radiological Health Care Program; USDA Agricultural and Food Programs.
  (g) Rongelap.
  (h) Four Atoll Health Care Program.
  (i) Enjebi Community Trust Fund.
  (j) Bikini Atoll Cleanup.
  (k) Agreement on Audits.
  (l) Kwajalein.
Sec. 104. Interpretation of and United States Policy Regarding U.S.-FSM Compact and U.S.-RMI Compact.
  (a) Human Rights.
  (b) Immigration and Passport Security.
  (c) Nonalienation of Lands.
  (d) Nuclear Waste Disposal.
  (e) Impact of the U.S.-FSM Compact and the U.S.-RMI Compact on the State of Hawaii, Guam, the Commonwealth of the Northern Mariana Islands and American Samoa; Related Authorization and Continuing Appropriation.

(f) Foreign Loans.
(g) Sense of Congress Concerning Funding of Public Infrastructure.
(h) Reports and Reviews.
(i) Construction of Section 141(f).
(j) Inflation adjustment.
(k) Participation by secondary schools in the Armed Services Vocational Aptitude Battery (ASVAB) Student Testing Program.
Sec. 105. Supplemental Provisions.
(a) Domestic Program Requirements.
(b) Relations With the Federated States of Micronesia and the Republic of the Marshall Islands.
(c) Continuing Trust Territory Authorization.
(d) Survivability.
(e) Noncompliance Sanctions; Actions Incompatible With United States Authority.
(f) Continuing Programs and Laws.
(g) College of Micronesia.
(h) Trust Territory Debts to U.S. Federal Agencies.
(i) Judicial Training.
(j) Technical Assistance.
(k) Prior Service Benefits Program.
(l) Indefinite Land Use Payments.
(m) Communicable Disease Control Program.
(n) User Fees.
(o) Treatment of Judgments of Courts of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.
(p) Establishment of Trust Funds; Expedition of Process.
Sec. 106. Construction Contract Assistance.
(a) Assistance to U.S. Firms.
(b) Authorization of Appropriations.
Sec. 107. Prohibition.
Sec. 108. Compensatory Adjustments.
(a) Additional Programs and Services.
(b) Further Amounts.
Sec. 109. Authorization and Continuing Appropriation.
Sec. 110. Payment of Citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau Employed by the Government of the United States in the Continental United States.

TITLE II—COMPACTS OF FREE ASSOCIATION WITH THE FEDERATED STATES OF MICRONESIA AND THE REPUBLIC OF THE MARSHALL ISLANDS

Sec. 201. Compacts of Free Association, as Amended Between the Government of the United States of America and the Government of the Federated States of Micronesia and Between the Government of the United States of America and the Government of the Republic of the Marshall Islands.
(a) Compact of Free Association, as amended, between the Government of the United States of America and the Government of the Federated States of Micronesia.

TITLE ONE—GOVERNMENTAL RELATIONS

Article I—Self-Government.
Article II—Foreign Affairs.
Article III—Communications.
Article IV—Immigration.
Article V—Representation.
Article VI—Environmental Protection.
Article VII—General Legal Provisions.

TITLE TWO—ECONOMIC RELATIONS

Article I—Grant Assistance.
Article II—Services and Program Assistance.
Article III—Administrative Provisions.
Article IV—Trade.
Article V—Finance and Taxation.

TITLE THREE—SECURITY AND DEFENSE RELATIONS

Article I—Authority and Responsibility.
Article II—Defense Facilities and Operating Rights.
Article III—Defense Treaties and International Security Agreements.
Article IV—Service in Armed Forces of the United States.
Article V—General Provisions.

TITLE FOUR—GENERAL PROVISIONS

Article I—Approval and Effective Date.
Article II—Conference and Dispute Resolution.
Article III—Amendment.
Article IV—Termination.
Article V—Survivability.
Article VI—Definition of Terms.
Article VII—Concluding Provisions.
(b) Compact of Free Association, as amended, between the Government of the United States of America and the Government of the Republic of the Marshall Islands.

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TITLE I—APPROVAL OF U.S.-FSM COMPACT AND U.S.-RMI COMPACT; INTERPRETATION OF, AND U.S. POLICIES REGARDING, U.S.-FSM COMPACT AND U.S.-RMI COMPACT; SUPPLEMENTAL PROVISIONS

SEC. 101. APPROVAL OF U.S.-FSM COMPACT OF FREE ASSOCIATION AND THE U.S.-RMI COMPACT OF FREE ASSOCIATION; REFERENCES TO SUBSIDIARY AGREEMENTS OR SEPARATE AGREEMENTS.

(a) FEDERATED STATES OF MICRONESIA.—The Compact of Free Association, as amended with respect to the Federated States of Micronesia and signed by the United States and the Government of the Federated States of Micronesia and set forth in Title II (section 201(a)) of this joint resolution, is hereby approved, and Congress hereby consents to the subsidiary agreements and amended subsidiary agreements listed in section 462 of the U.S.-FSM Compact. Subject to the provisions of this joint resolution, the President is authorized to agree, in accordance with section 411 of the U.S.-FSM Compact, to an effective date for and thereafter to implement such U.S.-FSM Compact.

(b) REPUBLIC OF THE MARSHALL ISLANDS.—The Compact of Free Association, as amended with respect to the Republic of the Marshall Islands and signed by the United States and the Government of the Republic of the Marshall Islands and set forth in Title II (section 201(b)) of this joint resolution, is hereby approved, and Congress hereby consents to the subsidiary agreements and amended subsidiary agreements listed in section 462 of the U.S.-RMI Compact. Subject to the provisions of this joint resolution, the President is authorized to agree, in accordance with section 411 of the U.S.-RMI Compact, to an effective date for and thereafter to implement such U.S.-RMI Compact.

(c) REFERENCES TO THE COMPACT, THE U.S.-FSM COMPACT, AND THE U.S.-RMI COMPACT; REFERENCES TO SUBSIDIARY AGREEMENTS OR SEPARATE AGREEMENTS.—

(1) Any reference in this joint resolution (except references in Title II) to "the Compact" shall be treated as a reference to the Compact of Free Association set forth in title II of Public Law 99–239, January 14, 1986, 99 Stat. 1770. Any reference in this joint resolution to the "U.S.-FSM Compact" shall be treated as a reference to the Compact of Free Association, as amended between the Government of the United States of America and the Government of the Federated States of Micronesia and set forth in Title II (section 201(a)) of this joint resolution. Any reference in this joint resolution to the "U.S.-RMI Compact" shall be treated as a reference to the Compact of Free Association, as amended between the Government of the United States of America and the Government of the Republic of the Marshall Islands and set forth in Title II (section 201(b)) of this joint resolution.

(2) Any reference to the term "subsidiary agreements" or "separate agreements" in this joint resolution shall be treated as a reference to agreements listed in section 462 of the U.S.-FSM Compact and the U.S.-RMI Compact, and any other agreements that the United States may from time to time enter into with either the Government of the Federated States of Micronesia or the Government of the Republic of the Marshall Islands, or with both such governments in accordance with the provisions of the U.S.-FSM Compact and the U.S.-RMI Compact.

(d) AMENDMENT, CHANGE, OR TERMINATION IN THE U.S.-FSM COMPACT AND U.S.-RMI COMPACT AND CERTAIN AGREEMENTS.—

(1) Any amendment, change, or termination by mutual agreement or by unilateral action of the Government of the United States of all or any part of the U.S.-FSM Compact or U.S.-RMI Compact shall not enter into force until after Congress has incorporated it in an Act of Congress.

(2) The provisions of paragraph (1) shall apply—

(A) to all actions of the Government of the United States under the U.S.-FSM Compact or U.S.-RMI Compact including, but not limited to, actions taken pursuant to sections 431, 441, or 442;

(B) to any amendment, change, or termination in the Agreement Between the Government of the United States and the Government of the Federated States of Micronesia Regarding Friendship, Cooperation and Mutual Security Concluded Pursuant to Sections 321 and 323 of the Compact of Free Association referred to in section 462(a)(2) of the U.S.-FSM Compact and the Agreement Between the Government of the United States and the Government of the Marshall Islands Regarding Mutual Security Concluded Pursuant to Sections 321 and 323 of the Compact of Free Association referred to in section 462(a)(5) of the U.S.-RMI Compact;

(C) to any amendment, change, or termination of the agreements concluded pursuant to Compact section 177, and section 215(a) of the U.S.-FSM Compact and section 216(a) of the U.S.-RMI Compact, the terms of which are incorporated by reference into the U.S.-FSM Compact and the U.S.-RMI Compact; and

(D) to the following subsidiary agreements, or portions thereof:

(i) Articles III, IV, and X of the agreement referred to in section 462(b)(6) of the U.S.-RMI Compact:

(ii) Article III and IV of the agreement referred to in section 462(b)(6) of the U.S.-FSM Compact.

(iii) Articles VI, XV, and XVII of the agreement referred to in section 462(b)(7) of the U.S.-FSM Compact and U.S.-RMI Compact.

(e) SUBSIDIARY AGREEMENTS DEEMED BILATERAL.—For purposes of implementation of the U.S.-FSM Compact and the U.S.-RMI Compact and this joint resolution, the Agreement Concluded Pursuant to Section 234 of the Compact of Free Association and referred to in section 462(a)(1) of the U.S.-FSM Compact and section 462(a)(4) of the U.S.-RMI Compact shall be deemed to be a bilateral agreement between the United States and each other party to such subsidiary agreement. The consent or concurrence of any other party shall not be required for the effectiveness of any actions taken by the United States in conjunction with either the Federated States of Micronesia or the Republic of the Marshall Islands which are intended to affect the implementation, modification, suspension, or termination of such subsidiary agreement (or any provision thereof) as regards the mutual responsibilities of the United States and the party in conjunction with whom the actions are taken.

(f) ENTRY INTO FORCE OF FUTURE AMENDMENTS TO SUBSIDIARY AGREEMENTS.—No agreement between the United States and the government of either the Federated States of Micronesia or the Republic of the Marshall Islands which would amend, change, or terminate any subsidiary agreement or portion thereof, other than those set forth in subsection (d) of this section shall enter into force until 90 days after the President has transmitted such agreement to the President of the Senate and the Speaker of the House of Representatives together with an explanation of the agreement and the reasons therefor. In the case of the agreement referred to in section 462(b)(3) of the U.S.-FSM Compact and the U.S.-RMI Compact, such transmittal shall include a specific statement by the Secretary of Labor as to the necessity of such amendment, change, or termination, and the impact thereof.

SEC. 102. AGREEMENTS WITH FEDERATED STATES OF MICRONESIA.

(a) LAW ENFORCEMENT ASSISTANCE.—Pursuant to sections 222 and 224 of the U.S.-FSM Compact, the United States shall provide nonreimbursable technical and training assistance as appropriate, including training and equipment for postal inspection of illicit drugs and other contraband, to enable the Government of the Federated States of Micronesia to develop and adequately enforce laws of the Federated States of Micronesia and to cooperate with the United States in the enforcement of criminal laws of the United States. Funds appropriated pursuant to section 105(j) of this title may be used to reimburse State or local agencies providing such assistance.

(b) AGREEMENT ON AUDITS.—The Comptroller General (and his duly authorized representatives) shall have the authorities necessary to carry out his responsibilities under section 232 of the U.S.-FSM Compact and the agreement referred to in section 462(b)(4) of the U.S.-FSM Compact, including the following authorities:

(1) GENERAL AUTHORITY OF THE COMPTROLLER GENERAL TO AUDIT.—

(A) The Comptroller General of the United States (and his duly authorized representatives) shall have the authority to audit—

(i) all grants, program assistance, and other assistance provided to the Government of the Federated States of Micronesia under Articles I and II of Title Two of the U.S.-FSM Compact; and

(ii) any other assistance provided by the Government of the United States to the Government of the Federated States of Micronesia.

Such authority shall include authority for the Comptroller General to conduct or cause to be conducted any of the audits provided for in section 232 of the U.S.-FSM Compact. The authority provided in this paragraph shall continue for at least three years after the last such grant has been made or assistance has been provided.

(B) The Comptroller General (and his duly authorized representatives) shall also have authority to review any audit conducted by or on behalf of the Government of the United States. In this connection, the Comptroller General shall have access to such personnel and to such records, documents, working papers, automated data and files, and other information relevant to such review.

(2) COMPTROLLER GENERAL ACCESS TO RECORDS.—

(A) In carrying out paragraph (1), the Comptroller General (and his duly authorized representatives) shall have such access to the personnel and (without cost) to records, documents, working papers, automated data and files, and other information relevant to such audits. The Comptroller General may duplicate any such records, documents, working papers, automated data and files, or other information relevant to such audits.

(B) Such records, documents, working papers, automated data and files, and other information regarding each such grant or other assistance shall be maintained for at least five years after the date such grant or assistance was provided and in a manner that permits such grants, assistance, and payments to be accounted for distinct from any other funds of the Government of the Federated States of Micronesia.

(3) STATUS OF COMPTROLLER GENERAL REPRESENTATIVES.—The Comptroller General and his duly authorized representatives shall be immune from civil and criminal process relating to words spoken or written and all acts performed by them in their official capacity and falling within their functions, except insofar as such immunity may be expressly waived by the Government of the United States. The Comptroller General and his duly authorized representatives shall not be liable to arrest or detention pending trial, except in the case of a grave crime and pursuant to a decision by a competent judicial authority, and such persons shall enjoy immunity from seizure of personal property, immigration restrictions, and laws relating to alien registration, fingerprinting, and the registration of foreign agents. Such persons shall enjoy the same taxation exemptions as are set forth in Article 34 of the Vienna Convention on Diplomatic Relations. The privileges, exemptions and immunities accorded under this paragraph are not for the personal benefit of the individuals concerned but are to safeguard the independent exercise of their official functions. Without prejudice to those privileges, exemptions and immunities, it is the duty of all such persons to respect the laws and regulations of the Government of the Federated States of Micronesia.

(4) AUDITS DEFINED.—As used in this subsection, the term "audits" includes financial, program, and management audits, including determining—

(A) whether the Government of the Federated States of Micronesia has met the requirements set forth in the U.S.-FSM Compact, or any related agreement entered into under the U.S.-FSM Compact, regarding the purposes for which such grants and other assistance are to be used; and

(B) the propriety of the financial transactions of the Government of the Federated States of Micronesia pursuant to such grants or assistance.

(5) COOPERATION BY FEDERATED STATES OF MICRONESIA.—The Government of the Federated States of Micronesia will cooperate fully with the Comptroller General of the United States in the conduct of such audits as the Comptroller General determines necessary to enable the Comptroller General to fully discharge his responsibilities under this joint resolution.

SEC. 103. AGREEMENTS WITH AND OTHER PROVISIONS RELATED TO THE REPUBLIC OF THE MARSHALL ISLANDS.

(a) LAW ENFORCEMENT ASSISTANCE.—Pursuant to sections 222 and 224 of the U.S.-RMI Compact, the United States shall provide nonreimbursable technical and training assistance as appropriate, including training and equipment for postal inspection of illicit drugs and other contraband, to enable the Government of the Marshall Islands to develop and adequately enforce laws of the Marshall Islands and to cooperate with the United States in the enforcement of criminal laws of the United States. Funds appropriated pursuant to section 105(j) of this title may be used to reimburse State or local agencies providing such assistance.

(b) EJIT.—

(1) In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that the President of the United States shall negotiate with the Government of the Marshall Islands an agreement whereby, without prejudice as to any claims which have been or may be asserted by any party as to rightful title and ownership of any lands on Ejit, the Government of the Marshall Islands shall assure that lands on Ejit used as of January 1, 1985, by the people of Bikini, will continue to be available without charge for their use, until such time as Bikini is restored and inhabitable and the continued use of Ejit is no longer necessary, unless a Marshall Islands court of competent jurisdiction finally determines that there are legal impediments to continued use of Ejit by the people of Bikini.

(2) In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that if the impediments described in paragraph (1) do arise, the United States will cooperate with the Government of the Marshall Islands in assisting any person adversely affected by such judicial determination to remain on Ejit, or in locating suitable and acceptable alternative lands for such person's use.

(3) In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that paragraph (1) shall not be applied in a manner which would prevent the Government of the Marshall Islands from acting in accordance with its constitutional processes to resolve title and ownership claims with respect to such lands or from taking substitute or additional measures to meet the needs of the people of Bikini with their democratically expressed consent and approval.

(c) SECTION 177 AGREEMENT.—

(1) In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that in furtherance of the purposes of Article I of the Subsidiary Agreement for Implementation of Section 177 of the Compact, the payment of the amount specified therein shall be made by the United States under Article I of the Agreement between the Government of the United States and the Government of the Marshall Islands for the Implementation of section 177 of the Compact (hereafter in this subsection referred to as

the "Section 177 Agreement") only after the Government of the Marshall Islands has notified the President of the United States as to which investment management firm has been selected by such Government to act as Fund Manager under Article I of the Section 177 Agreement.

(2) In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that in the event that the President determines that an investment management firm selected by the Government of the Marshall Islands does not meet the requirements specified in Article I of the Section 177 Agreement, the United States shall invoke the conference and dispute resolution procedures of Article II of Title Four of the Compact. Pending the resolution of such a dispute and until a qualified Fund Manager has been designated, the Government of the Marshall Islands shall place the funds paid by the United States pursuant to Article I of the Section 177 Agreement into an interest-bearing escrow account. Upon designation of a qualified Fund Manager, all funds in the escrow account shall be transferred to the control of such Fund Manager for management pursuant to the Section 177 Agreement.

(3) In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that if the Government of the Marshall Islands determines that some other investment firm should act as Fund Manager in place of the firm first (or subsequently) selected by such Government, the Government of the Marshall Islands shall so notify the President of the United States, identifying the firm selected by such Government to become Fund Manager, and the President shall proceed to evaluate the qualifications of such identified firm.

(4) In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that at the end of 15 years after the effective date of the Compact, the firm then acting as Fund Manager shall transfer to the Government of the Marshall Islands, or to such account as such Government shall so notify the Fund Manager, all remaining funds and assets being managed by the Fund Manager under the Section 177 Agreement.

(d) NUCLEAR TEST EFFECTS.—In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that in approving the Compact, the Congress understands and intends that the peoples of Bikini, Enewetak, Rongelap, and Utrik, who were affected by the United States nuclear weapons testing program in the Marshall Islands, will receive the amounts of $75,000,000 (Bikini); $48,750,000 (Enewetak); $37,500,000 (Rongelap); and $22,500,000 (Utrik), respectively, which amounts shall be paid out of proceeds from the fund established under Article I, section 1 of the subsidiary agreement for the implementation of section 177 of the Compact. The amounts specified in this subsection shall be in addition to any amounts which may be awarded to claimants pursuant to Article IV of the subsidiary agreement for the implementation of Section 177 of the Compact.

(e) ESPOUSAL PROVISIONS.—

(1) In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that it is the intention of the Congress of the United States that the provisions of section 177 of the Compact of Free Association and the Agreement between the Government of the United States and the Government of the Marshall Islands for the Implementation of Section 177 of the Compact (hereafter in this subsection referred to as the "Section 177 Agreement") constitute a full and final settlement of all claims described in Articles X and XI of the Section 177 Agreement, and that any such claims be terminated and barred except insofar as provided for in the Section 177 Agreement.

(2) In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that in furtherance of the intention of Congress as stated in paragraph (1) of this subsection, the Section 177 Agreement is hereby ratified and approved. It is the explicit understanding and intent of Congress that the jurisdictional limitations set forth in Article XII of such Agreement are enacted solely and exclusively to accomplish the objective of Article X of such Agreement and only as a clarification of the effect of Article X, and are not to be construed or implemented separately from Article X.

(f) DOE RADIOLOGICAL HEALTH CARE PROGRAM; USDA AGRICULTURAL AND FOOD PROGRAMS.—

(1) MARSHALL ISLANDS PROGRAM.—Notwithstanding any other provision of law, upon the request of the Government of the Republic of the Marshall Islands, the President (either through an appropriate department or agency of the United States or by contract with a United States firm) shall continue to provide special medical care and logistical support thereto for the remaining members of the population of Rongelap and Utrik who were exposed to radiation resulting from the 1954 United States thermo-nuclear "Bravo" test, pursuant to Public Laws 95–134 and 96–205.

(2) AGRICULTURAL AND FOOD PROGRAMS.—

(A) IN GENERAL.—In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that notwithstanding any other provision of law, upon the request of the Government of the Marshall Islands, for the first fifteen years after the effective date of the Compact, the President (either through an appropriate department or agency of the United States or by contract with a United States firm or by a grant to the Government of the Republic of the Marshall Islands which may further contract only with a United States firm or a Republic of the Marshall Islands firm, the owners, officers and majority of the employees of which are citizens of the United States or the Republic of the Marshall Islands) shall provide technical and other assistance—

(i) without reimbursement, to continue the planting and agricultural maintenance program on Enewetak, as provided in subparagraph (C); and

(ii) without reimbursement, to continue the food programs of the Bikini and Enewetak people described in section 1(d) of Article II of the Subsidiary Agreement for the Implementation of Section 177 of the Compact and for continued waterborne transportation of agricultural products to Enewetak including operations and maintenance of the vessel used for such purposes.

(B) POPULATION CHANGES.—The President shall ensure the assistance provided under these programs reflects the changes in the population since the inception of such programs.

(C) PLANTING AND AGRICULTURAL MAINTENANCE PROGRAM.—

(i) IN GENERAL.—The planting and agricultural maintenance program on Enewetak shall be funded at a level of not less than $1,300,000 per year, as adjusted for inflation under section 218 of the U.S.-RMI Compact.

(ii) AUTHORIZATION AND CONTINUING APPROPRIATION.—There is hereby authorized and appropriated to the Secretary of the Interior, out of any funds in the Treasury not otherwise appropriated, to remain available until expended, for each fiscal year from 2004 through 2023, $1,300,000, as adjusted for inflation under section 218 of the U.S.-RMI Compact, for grants to carry out the planting and agricultural maintenance program.

(3) PAYMENTS.—In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that payments under this subsection shall be provided to such extent or in such amounts as are necessary for services and other assistance provided pursuant to this subsection. It is the sense of Congress that after the periods of time specified in paragraphs (1) and (2) of this subsection, consideration will be given to such additional funding for these programs as may be necessary.

(g) RONGELAP.—

(1) In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that because Rongelap was directly affected by fallout from a 1954 United States thermonuclear test and because the Rongelap people remain unconvinced that it is safe to continue to live on Rongelap Island, it is the intent of Congress to take such steps (if any) as may be necessary to overcome the effects of such fallout on the habitability of Rongelap Island, and to restore Rongelap Island, if necessary, so that it can be safely inhabited. Accordingly, it is the expectation of the Congress that the Government of the Marshall Islands shall use such portion of the funds specified in Article II, section 1(e) of the subsidiary agreement for the implementation of section 177 of the Compact as are necessary for the purpose of contracting with a qualified scientist or group of scientists to review the data collected by the Department of Energy relating to radiation levels and other conditions on Rongelap Island resulting from the thermonuclear test. It is the expectation of the Congress that the Government of the Marshall Islands, after consultation with the people of Rongelap, shall select the party to review such data, and shall contract for such review and for submission of a report to the President of the United States and the Congress as to the results thereof.

(2) In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that the purpose of the review referred to in paragraph (1) of this subsection shall be to establish whether the data cited in support of the conclusions as to the habitability of Rongelap Island, as set forth in the Department of Energy report entitled: "The Meaning of Radiation for Those Atolls in the Northern Part of the Marshall Islands That Were Surveyed in 1978", dated November 1982, are adequate and whether such conclusions are fully supported by the data. If the party reviewing the data concludes that such conclusions as to habitability are fully supported by adequate data, the report to the President of the United States and the Congress shall so state. If the party reviewing the data concludes that the data are inadequate to support such conclusions as to habitability or that such conclusions as to habitability are not fully supported by the data, the Government of the Marshall Islands shall contract with an appropriate scientist or group of scientists to undertake a complete survey of radiation and other effects of the nuclear testing program relating to the habitability of Rongelap Island. Such sums as are necessary for such survey and report concerning the results thereof and as to steps needed to restore the habitability of Rongelap Island are authorized to be made available to the Government of the Marshall Islands.

(3) In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that it is the intent of Congress that such steps (if any) as are necessary to restore the habitability of Rongelap Island and return the Rongelap people to their homeland will be taken by the United States in consultation with the Government of the Marshall Islands and, in accordance with its authority under the Constitution of the Marshall Islands, the Rongelap local government council.

(4) There are hereby authorized and appropriated to the Secretary of the Interior, out of any funds in the Treasury not otherwise appropriated, to remain available until expended, for fiscal year 2005, $1,780,000; for fiscal year 2006,

$1,760,000; and for fiscal year 2007, $1,760,000, as the final contributions of the United States to the Rongelap Resettlement Trust Fund as established pursuant to Public Law 102–154 (105 Stat. 1009), for the purposes of establishing a food importation program as a part of the overall resettlement program of Rongelap Island.

(h) FOUR ATOLL HEALTH CARE PROGRAM.—

(1) In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that services provided by the United States Public Health Service or any other United States agency pursuant to section 1(a) of Article II of the Agreement for the Implementation of Section 177 of the Compact (hereafter in this subsection referred to as the "Section 177 Agreement") shall be only for services to the people of the Atolls of Bikini, Enewetak, Rongelap, and Utrik who were affected by the consequences of the United States nuclear testing program, pursuant to the program described in Public Law 95–134 (91 Stat. 1159) and Public Law 96–205 (94 Stat. 84) and their descendants (and any other persons identified as having been so affected if such identification occurs in the manner described in such public laws). Nothing in this subsection shall be construed as prejudicial to the views or policies of the Government of the Marshall Islands as to the persons affected by the consequences of the United States nuclear testing program.

(2) In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that at the end of the first year after the effective date of the Compact and at the end of each year thereafter, the providing agency or agencies shall return to the Government of the Marshall Islands any unexpended funds to be returned to the Fund Manager (as described in Article I of the Section 177 Agreement) to be covered into the Fund to be available for future use.

(3) In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that the Fund Manager shall retain the funds returned by the Government of the Marshall Islands pursuant to paragraph (2) of this subsection, shall invest and manage such funds, and at the end of 15 years after the effective date of the Compact, shall make from the total amount so retained and the proceeds thereof annual disbursements sufficient to continue to make payments for the provision of health services as specified in paragraph (1) of this subsection to such extent as may be provided in contracts between the Government of the Marshall Islands and appropriate United States providers of such health services.

(i) ENJEBI COMMUNITY TRUST FUND.—In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that notwithstanding any other provision of law, the Secretary of the Treasury shall establish on the books of the Treasury of the United States a fund having the status specified in Article V of the subsidiary agreement for the implementation of Section 177 of the Compact, to be known as the "Enjebi Community Trust Fund" (hereafter in this subsection referred to as the "Fund"), and shall credit to the Fund the amount of $7,500,000. Such amount, which shall be ex gratia, shall be in addition to and not charged against any other funds provided for in the Compact and its subsidiary agreements, this joint resolution, or any other Act. Upon receipt by the President of the United States of the agreement described in this subsection, the Secretary of the Treasury, upon request of the Government of the Marshall Islands, shall transfer the Fund to the Government of the Marshall Islands, provided that the Government of the Marshall Islands agrees as follows:

(1) ENJEBI TRUST AGREEMENT.—In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that the Government of the Marshall Islands and the Enewetak Local Government Council, in consultation with the people of Enjebi, shall provide for the creation of the Enjebi Community Trust Fund and the employment of the manager of the Enewetak Fund established pursuant to the Section 177 Agreement as trustee and manager of the Enjebi Community Trust Fund, or, should the manager of the Enewetak Fund not be acceptable to the people of Enjebi, another United States investment manager with substantial experience in the administration of trusts and with funds under management in excess of $250,000,000.

(2) MONITOR CONDITIONS.—In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that upon the request of the Government of the Marshall Islands, the United States shall monitor the radiation and other conditions on Enjebi and within one year of receiving such a request shall report to the Government of the Marshall Islands when the people of Enjebi may resettle Enjebi under circumstances where the radioactive contamination at Enjebi, including contamination derived from consumption of locally grown food products, can be reduced or otherwise controlled to meet whole body Federal radiation protection standards for the general population, including mean annual dose and mean 30-year cumulative dose standards.

(3) RESETTLEMENT OF ENJEBI.—In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that in the event that the United States determines that the people of Enjebi can within 25 years of January 14, 1986, resettle Enjebi under the conditions set forth in paragraph (2) of this subsection, then upon such determination there shall be available to the people of Enjebi from the Fund such amounts as are necessary for the people of Enjebi to do the following, in accordance with a plan developed by the Enewetak Local Government Council and the people of Enjebi, and concurred with by the Government of the Marshall Islands to assure consistency with the government's overall economic development plan:

(A) Establish a community on Enjebi Island for the use of the people of Enjebi.

(B) Replant Enjebi with appropriate food-bearing and other vegetation.

(4) RESETTLEMENT OF OTHER LOCATION.—In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that in the event that the United States determines that within 25 years of January 14, 1986, the people of Enjebi cannot resettle Enjebi without exceeding the radiation standards set forth in paragraph (2) of this subsection, then the fund manager shall be directed by the trust instrument to distribute the Fund to the people of Enjebi for their resettlement at some other location in accordance with a plan, developed by the Enewetak Local Government Council and the people of Enjebi and concurred with by the Government of the Marshall Islands, to assure consistency with the government's overall economic development plan.

(5) INTEREST FROM FUND.—In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that prior to and during the distribution of the corpus of the Fund pursuant to paragraphs (3) and (4) of this subsection, the people of Enjebi may, if they so request, receive the interest earned by the Fund on no less frequent a basis than quarterly.

(6) DISCLAIMER OF LIABILITY.—In the joint resolution of January 14, 1986 (Public Law 99–239) Congress provided that neither under the laws of the Marshall Islands nor under the laws of the United States, shall the Government of the United States be liable for any loss or damage to person or property in respect to the resettlement of Enjebi by the people of Enjebi, pursuant to the provision of this subsection or otherwise.

(j) BIKINI ATOLL CLEANUP.—

(1) DECLARATION OF POLICY.—In the joint resolution of January 14, 1986 (Public Law 99–239), the Congress determined and declared that it is the policy of the United States, to be supported by the full faith and credit of the United States, that because the United States, through its nuclear testing and other activities, rendered Bikini Atoll unsafe for habitation by the people of Bikini, the United States will fulfill its responsibility for restoring Bikini Atoll to habitability, as set forth in paragraph (2) and (3) of this subsection.

(2) CLEANUP FUNDS.—The joint resolution of January 14, 1986 (Public Law 99–239) authorized to be appropriated such sums as necessary to implement the settlement agreement of March 15, 1985, in The People of Bikini, et al. against United States of America, et al., Civ. No. 84–0425 (D. Ha.).

(3) CONDITIONS OF FUNDING.—In the joint resolution of January 14, 1986 (Public Law 99–239) the Congress provided that the funds referred to in paragraph (2) were to be made available pursuant to Article VI, Section 1 of the Compact Section 177 Agreement upon completion of the events set forth in the settlement agreement referred to in paragraph (2) of this subsection.

(k) AGREEMENT ON AUDITS.—The Comptroller General (and his duly authorized representatives) shall have the authorities necessary to carry out his responsibilities under section 232 of the U.S.-RMI Compact and the agreement referred to in section 462(b)(4) of the U.S.-RMI Compact, including the following authorities:

(1) GENERAL AUTHORITY OF THE COMPTROLLER GENERAL TO AUDIT.—

(A) The Comptroller General of the United States (and his duly authorized representatives) shall have the authority to audit—

(i) all grants, program assistance, and other assistance provided to the Government of the Republic of the Marshall Islands under Articles I and II of Title Two of the U.S.-RMI Compact; and

(ii) any other assistance provided by the Government of the United States to the Government of the Republic of the Marshall Islands.

Such authority shall include authority for the Comptroller General to conduct or cause to be conducted any of the audits provided for in section 232 of the U.S.-RMI Compact. The authority provided in this paragraph shall continue for at least three years after the last such grant has been made or assistance has been provided.

(B) The Comptroller General (and his duly authorized representatives) shall also have authority to review any audit conducted by or on behalf of the Government of the United States. In this connection, the Comptroller General shall have access to such personnel and to such records, documents, working papers, automated data and files, and other information relevant to such review.

(2) COMPTROLLER GENERAL ACCESS TO RECORDS.—

(A) In carrying out paragraph (1), the Comptroller General (and his duly authorized representatives) shall have such access to the personnel and (without cost) to records, documents, working papers, automated data and files, and other information relevant to such audits. The Comptroller General may duplicate any such records, documents, working papers, automated data and files, or other information relevant to such audits.

(B) Such records, documents, working papers, automated data and files, and other information regarding each such grant or other assistance shall be maintained for at least five years after the date such grant or assistance was provided and in a manner that permits such grants, assistance and payments to be accounted for distinct from any other funds of the Government of the Republic of the Marshall Islands.

(3) STATUS OF COMPTROLLER GENERAL REPRESENTATIVES.—The Comptroller General and his duly authorized representatives shall be immune from civil and criminal process relating to words spoken or written and all acts performed by them in their official capacity and falling within their functions, except insofar as such immunity may be expressly waived by the Government of the United States. The Comptroller General and his duly authorized representatives shall not be liable to arrest or detention pending trial, except in the case of a grave crime and pursuant to a decision by a competent judicial authority, and such persons shall enjoy immunity from seizure of personal property, immigration restrictions, and laws relating to alien registration, fingerprinting, and the registration of foreign agents. Such persons shall enjoy the same taxation exemptions as are set forth in Article 34 of the Vienna Convention on Diplomatic Relations. The privileges, exemptions and immunities accorded under this paragraph are not for the personal benefit of the individuals concerned but are to safeguard the independent exercise of their official functions. Without prejudice to those privileges, exemptions and immunities, it is the duty of all such persons to respect the laws and regulations of the Government of the Republic of the Marshall Islands.

(4) AUDITS DEFINED.—As used in this subsection, the term "audits" includes financial, program, and management audits, including determining—

(A) whether the Government of the Republic of the Marshall Islands has met the requirements set forth in the U.S.-RMI Compact, or any related agreement entered into under the U.S.-RMI Compact, regarding the purposes for which such grants and other assistance are to be used; and

(B) the propriety of the financial transactions of the Government of the Republic of the Marshall Islands pursuant to such grants or assistance.

(5) COOPERATION BY THE REPUBLIC OF THE MARSHALL ISLANDS.—The Government of the Republic of the Marshall Islands will cooperate fully with the Comptroller General of the United States in the conduct of such audits as the Comptroller General determines necessary to enable the Comptroller General to fully discharge his responsibilities under this joint resolution.

(l) KWAJALEIN.—

(1) STATEMENT OF POLICY.—It is the policy of the United States that payment of funds by the Government of the Marshall Islands to the landowners of Kwajalein Atoll in accordance with the land use agreement dated October 19, 1982, or as amended or superseded, and any related allocation agreements, is required in order to ensure that the Government of the United States will be able to fulfill its obligation and responsibilities under Title Three of the U.S.-RMI Compact and the subsidiary agreements concluded pursuant to the U.S.-RMI Compact.

(2) FAILURE TO PAY.—

(A) IN GENERAL.—If the Government of the Marshall Islands fails to make payments in accordance with paragraph (1), the Government of the United States shall initiate procedures under section 313 of the U.S.-RMI Compact and consult with the Government of the Marshall Islands with respect to the basis for the nonpayment of funds.

(B) RESOLUTION.—The United States shall expeditiously resolve the matter of any nonpayment of funds required under paragraph (1) pursuant to section 313 of the U.S.-RMI Compact and the authority and responsibility of the Government of the United States for security and defense matters in or relating to the Marshall Islands. This paragraph shall be enforced, as may be necessary, in accordance with section 105(e).

(3) DISPOSITION OF INCREASED PAYMENTS PENDING NEW LAND USE AGREEMENT.—Until such time as the Government of the Marshall Islands and the landowners of Kwajalein Atoll have concluded an agreement amending or superseding the land use agreement reflecting the terms of and consistent with the Military Use Operating Rights Agreement dated October 19, 1982, any amounts paid by the United States to the Government of the Marshall Islands in excess of the amounts required to be paid pursuant to the land use agreement dated October 19, 1982, shall be paid into, and held in, an interest bearing escrow account in a United States financial institution by the Government of the Republic of the Marshall Islands. At such time, the funds and interest held in escrow shall be paid to the landowners of Kwajalein in accordance with the new land use agreement. If no such agreement is concluded by the date which is five years after the date of enactment of this resolution, then such funds and interest shall, unless otherwise mutually agreed between the Government of the United States of America and the Government of the Republic of the Marshall Islands, be returned to the U.S. Treasury.

(4) NOTIFICATIONS AND REPORT.—

(A) The Government of the Republic of the Marshall Islands shall notify the Government of the United States of America when an agreement amending or superseding the land use agreement dated October 19, 1982, is concluded.

(B) If no agreement amending or superseding the land use agreement dated October 19, 1982 is concluded by the date five years after the date of enactment of this resolution, then the President shall report to Congress on the intentions of the United States with respect to the use of Kwajalein Atoll after 2016, on any plans to relocate activities carried out on Kwajalein Atoll, and on the disposition of the funds and interest held in escrow under paragraph (3).

(5) ASSISTANCE.—The President is authorized to make loans and grants to the Government of the Marshall Islands to address the special needs of the community at Ebeye, Kwajalein Atoll, and other Marshallese communities within the Kwajalein Atoll, pursuant to development plans adopted in accordance with applicable laws of the Marshall Islands. The loans and grants shall be subject to such other terms and conditions as the President, in the discretion of the President, may determine are appropriate.

SEC. 104. INTERPRETATION OF AND UNITED STATES POLICY REGARDING U.S.-FSM COMPACT AND U.S.-RMI COMPACT.

(a) HUMAN RIGHTS.—In approving the U.S.-FSM Compact and the U.S.-RMI Compact, Congress notes the conclusion in the Statement of Intent of the Report of The Future Political Status Commission of the Congress of Micronesia in July, 1969, that "our recommendation of a free associated state is indissolubly linked to our desire for such a democratic, representative, constitutional government" and notes that such desire and intention are reaffirmed and embodied in the Constitutions of the Federated States of Micronesia and the Republic of the Marshall Islands. Congress also notes and specifically endorses the preamble to the U.S.-FSM Compact and the U.S.-RMI Compact, which affirms that the governments of the parties to the U.S.-FSM Compact and the U.S.-RMI Compact are founded upon respect for human rights and fundamental freedoms for all. The Secretary of State shall include in the annual reports on the status of internationally recognized human rights in foreign countries, which are submitted to Congress pursuant to sections 116 and 502B of the Foreign Assistance Act of 1961, "22 U.S.C. 2151n, 2304" a full and complete report regarding the status of internationally recognized human rights in the Federated States of Micronesia and the Republic of the Marshall Islands.

(b) IMMIGRATION AND PASSPORT SECURITY.—

(1) NATURALIZED CITIZENS.—The rights of a bona fide naturalized citizen of the Federated States of Micronesia or the Republic of the Marshall Islands to enter the United States, to lawfully engage therein in occupations, and to establish residence therein as a nonimmigrant, to the extent such rights are provided under section 141 of the U.S.-FSM Compact and U.S.-RMI Compact, shall not be deemed to extend to any such naturalized citizen with respect to whom circumstances associated with the acquisition of the status of a naturalized citizen are such as to allow a reasonable inference, on the part of appropriate officials of the United States and subject to United States procedural requirements, that such naturalized status was acquired primarily in order to obtain such rights.

(2) PASSPORTS.—It is the sense of Congress that up to $250,000 of the grant assistance provided to the Federated States of Micronesia pursuant to section 211(a)(4) of the U.S.-FSM Compact, and up to $250,000 of the grant assistance provided to the Republic of the Marshall Islands pursuant to section 211(a)(4) of the U.S.-RMI Compact (or a greater amount of the section 211(a)(4) grant, if mutually agreed between the Government of the United States and the government of the Federated States of Micronesia or the government of the Republic of the Marshall Islands), be used for the purpose of increasing the machine-readability and security of passports issued by such jurisdictions. It is further the sense of Congress that such funds be obligated by September 30, 2004 and in the amount and manner specified by the Secretary of State in consultation with the Secretary of Homeland Security and, respectively, with the government of the Federated States of Micronesia and the government of the Republic of the Marshall Islands. The United States Government is authorized to require that passports used for the purpose of seeking admission under section 141 of the U.S.-FSM Compact and the U.S.-RMI Compact contain the security enhancements funded by such assistance.

(3) INFORMATION-SHARING.—It is the sense of Congress that the governments of the Federated States of Micronesia and the Republic of the Marshall Islands develop, prior to October 1, 2004, the capability to provide reliable and timely information as may reasonably be required by the Government of the United States in enforcing criminal and security-related grounds of inadmissibility and deportability under the Immigration and Nationality Act, as amended, and shall provide such information to the Government of the United States.

(4) TRANSITION; CONSTRUCTION OF SECTIONS 141(a)(3) AND 141(a)(4) OF THE U.S.-FSM COMPACT AND U.S.-RMI COMPACT.—The words "the effective date of this Compact, as amended" in sections 141(a)(3) and 141(a)(4) of the U.S.-FSM Compact and the U.S.-RMI Compact shall be construed to read, "on the day prior to the enactment by the United States Congress of the Compact of Free Association Amendments Act of 2003.".

(c) NONALIENATION OF LANDS.—Congress endorses and encourages the maintenance of the policies of the Government of the Federated States of Micronesia and the Government of the Republic of the Marshall Islands to regulate, in accordance with their Constitutions and laws, the alienation of permanent interests in real property so as to restrict the acquisition of such interests to persons of Federated States of Micronesia citizenship and the Republic of the Marshall Islands citizenship, respectively.

(d) NUCLEAR WASTE DISPOSAL.—In approving the U.S.-FSM Compact and the U.S.-RMI Compact, Congress understands that the Government of the Federated States of Micronesia and the Government of the Republic of the Marshall

Islands will not permit any other government or any nongovernmental party to conduct, in the Republic of the Marshall Islands or in the Federated States of Micronesia, any of the activities specified in subsection (a) of section 314 of the U.S.-FSM Compact and the U.S.-RMI Compact.

(e) IMPACT OF THE U.S.-FSM COMPACT AND THE U.S.-RMI COMPACT ON THE STATE OF HAWAII, GUAM, THE COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS AND AMERICAN SAMOA; RELATED AUTHORIZATION AND CONTINUING APPROPRIATION.—

(1) STATEMENT OF CONGRESSIONAL INTENT.—In reauthorizing the U.S.-FSM Compact and the U.S.-RMI Compact, it is not the intent of Congress to cause any adverse consequences for an affected jurisdiction.

(2) DEFINITIONS.—For the purposes of this title—

(A) the term "affected jurisdiction" means American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, or the State of Hawaii; and

(B) the term "qualified nonimmigrant" means a person, or their children under the age of 18, admitted or resident pursuant to section 141 of the U.S.-RMI or U.S.-FSM Compact, or section 141 of the Palau Compact who, as of a date referenced in the most recently published enumeration is a resident of an affected jurisdiction. As used in this subsection, the term "resident" shall be a person who has a "residence," as that term is defined in section 101(a)(33) of the Immigration and Nationality Act, as amended.

(3) AUTHORIZATION AND CONTINUING APPROPRIATION.—There is hereby authorized and appropriated to the Secretary of the Interior, out of any funds in the Treasury not otherwise appropriated, to remain available until expended, for each fiscal year from 2004 through 2023, $30,000,000 for grants to affected jurisdictions to aid in defraying costs incurred by affected jurisdictions as a result of increased demands placed on health, educational, social, or public safety services or infrastructure related to such services due to the residence in affected jurisdictions of qualified nonimmigrants from the Republic of the Marshall Islands, the Federated States of Micronesia, or the Republic of Palau. The grants shall be—

(A) awarded and administered by the Department of the Interior, Office of Insular Affairs, or any successor thereto, in accordance with regulations, policies and procedures applicable to grants so awarded and administered, and

(B) used only for health, educational, social, or public safety services, or infrastructure related to such services, specifically affected by qualified nonimmigrants.

(4) ENUMERATION.—The Secretary of the Interior shall conduct periodic enumerations of qualified nonimmigrants in each affected jurisdiction. The enumerations—

(A) shall be conducted at such intervals as the Secretary of the Interior shall determine, but no less frequently than every five years, beginning in fiscal year 2003;

(B) shall be supervised by the United States Bureau of the Census or such other organization as the Secretary of the Interior may select; and

(C) after fiscal year 2003, shall be funded by the Secretary of the Interior by deducting such sums as are necessary, but not to exceed $300,000 as adjusted for inflation pursuant to section 217 of the U.S. FSM Compact with fiscal year 2003 as the base year, per enumeration, from funds appropriated pursuant to the authorization contained in paragraph (3) of this subsection.

(5) ALLOCATION.—The Secretary of the Interior shall allocate to the government of each affected jurisdiction, on the basis of the results of the most recent enumeration, grants in an aggregate amount equal to the total amount of funds appropriated under paragraph (3) of this subsection, as reduced by any deductions authorized by subparagraph (C) of paragraph (4) of this subsection, multiplied by a ratio derived by dividing the number of qualified nonimmigrants in such affected jurisdiction by the total number of qualified nonimmigrants in all affected jurisdictions.

(6) AUTHORIZATION FOR HEALTH CARE REIMBURSEMENT.—There are hereby authorized to be appropriated to the Secretary of the Interior such sums as may be necessary to reimburse health care institutions in the affected jurisdictions for costs resulting from the migration of citizens of the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau to the affected jurisdictions as a result of the implementation of the Compact of Free Association, approved by Public Law 99–239, or the approval of the U.S.-FSM Compact and the U.S.-RMI Compact by this resolution.

(7) USE OF DOD MEDICAL FACILITIES AND NATIONAL HEALTH SERVICE CORPS.—

(A) DOD MEDICAL FACILITIES.—The Secretary of Defense shall make available, on a space available and reimbursable basis, the medical facilities of the Department of Defense for use by citizens of the Federated States of Micronesia and the Republic of the Marshall Islands who are properly referred to the facilities by government authorities responsible for provision of medical services in the Federated States of Micronesia, the Republic of the Marshall Islands, the Republic of Palau and the affected jurisdictions.

(B) NATIONAL HEALTH SERVICE CORPS.—The Secretary of Health and Human Services shall continue to make the services of the National Health Service Corps available to the residents of the Federated States of Micronesia and the Republic of the Marshall Islands to the same extent and for so long as such services are authorized to be provided to persons residing in any other areas within or outside the United States.

(C) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this paragraph such sums as are necessary for each fiscal year.

(8) REPORTING REQUIREMENT.—Not later than one year after the date of enactment of this joint resolution, and at one year intervals thereafter, the Governors of Guam, the State of Hawaii, the Commonwealth of the Northern Mariana Islands, and American Samoa may provide to the Secretary of the Interior by February 1 of each year their comments with respect to the impacts of the Compacts on their respective jurisdiction. The Secretary of the Interior, upon receipt of any such comments, shall report to the Congress not later than May 1 of each year to include the following:

(A) The Governor's comments on the impacts of the Compacts as well as the Administration's analysis of such impact.

(B) The Administration views on any recommendations for corrective action to eliminate those consequences as proposed by such Governors.

(C) With regard to immigration, statistics concerning the number of persons availing themselves of the rights described in section 141(a) of the Compact during the year covered by each report.

(D) With regard to trade, an analysis of the impact on the economy of American Samoa resulting from imports of canned tuna into the United States from the Federated States of Micronesia, and the Republic of the Marshall Islands.

(9) RECONCILIATION OF UNREIMBURSED IMPACT EXPENSES.—

(A) IN GENERAL.—Notwithstanding any other provision of law, the President, to address previously accrued and unreimbursed impact expenses, may at the request of the Governor of Guam or the Governor of the Commonwealth of the Northern Mariana Islands, reduce, release, or waive all or part of any amounts owed by the Government of Guam or the Government of the Commonwealth of the Northern Mariana Islands (or either government's autonomous agencies or instrumentalities), respectively, to any department, agency, independent agency, office, or instrumentality of the United States.

(B) TERMS AND CONDITIONS.—

(i) SUBSTANTIATION OF IMPACT COSTS.—Not later than 120 days after the date of the enactment of this resolution, the Governor of Guam and the Governor of the Commonwealth of the Northern Mariana Islands shall each submit to the Secretary of the Interior a report, prepared in consultation with an independent accounting firm, substantiating unreimbursed impact expenses claimed for the period from January 14, 1986, through September 30, 2003. Upon request of the Secretary of the Interior, the Governor of Guam and the Governor of the Commonwealth of the Northern Mariana Islands shall submit to the Secretary of the Interior copies of all documents upon which the report submitted by that Governor under this clause was based.

(ii) CONGRESSIONAL NOTIFICATION.—The President shall notify Congress of his intent to exercise the authority granted in subparagraph (A).

(iii) CONGRESSIONAL REVIEW AND COMMENT.—Any reduction, release, or waiver under this Act shall not take effect until 60 days after the President notifies Congress of his intent to approve a request of the Governor of Guam or the Governor of the Commonwealth of the Northern Mariana Islands. In exercising his authority under this section and in determining whether to give final approval to a request, the President shall take into consideration comments he may receive after Congressional review.

(iv) EXPIRATION.—The authority granted in subparagraph (A) shall expire on February 28, 2005.

(10) AUTHORIZATION OF APPROPRIATIONS FOR GRANTS.—There are hereby authorized to the Secretary of the Interior for each of fiscal years 2004 through 2023 such sums as may be necessary for grants to the governments of Guam, the State of Hawaii, the Commonwealth of the Northern Mariana Islands, and American Samoa, as a result of increased demands placed on educational, social, or public safety services or infrastructure related to service due to the presence in Guam, Hawaii, the Commonwealth of the Northern Mariana Islands, and American Samoa of qualified nonimmigrants from the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

(f) FOREIGN LOANS.—Congress hereby reaffirms the United States position that the United States Government is not responsible for foreign loans or debt obtained by the Governments of the Federated States of Micronesia and the Republic of the Marshall Islands.

(g) SENSE OF CONGRESS CONCERNING FUNDING OF PUBLIC INFRASTRUCTURE.—It is the sense of Congress that not less than 30 percent of the United States annual grant assistance provided under section 211 of the Compact of Free Association, as amended, between the Government of the United States of America and the Government of the Federated States of Micronesia, and not less than 30 percent of the total amount of section 211 funds allocated to each of the States of the Federated States of Micronesia, shall be invested in infrastructure improvements and maintenance in accordance with section 211(a)(6). It is further the sense of Congress that not less than 30 percent of the United States annual grant assistance provided under section 211 of the Compact of Free Association, as amended, between the Government of the United States of America and the Government of the Republic of

the Marshall Islands, shall be invested in infrastructure improvements and maintenance in accordance with section 211(d).

(h) REPORTS AND REVIEWS.—

(1) REPORT BY THE PRESIDENT.—Not later than the end of the first full calendar year following enactment of this resolution, and not later than December 31 of each year thereafter, the President shall report to Congress regarding the Federated States of Micronesia and the Republic of the Marshall Islands, including but not limited to—

(A) general social, political, and economic conditions, including estimates of economic growth, per capita income, and migration rates;

(B) the use and effectiveness of United States financial, program, and technical assistance;

(C) the status of economic policy reforms including but not limited to progress toward establishing self-sufficient tax rates;

(D) the status of the efforts to increase investment including: the rate of infrastructure investment of U.S. financial assistance under the U.S.-FSM Compact and the U.S.-RMI Compact; non-U.S. contributions to the trust funds, and the level of private investment; and

(E) recommendations on ways to increase the effectiveness of United States assistance and to meet overall economic performance objectives, including, if appropriate, recommendations to Congress to adjust the inflation rate or to adjust the contributions to the Trust Funds based on non-U.S. contributions.

(2) REVIEW.—During the year of the fifth, tenth, and fifteenth anniversaries of the date of enactment of this resolution, the Government of the United States shall review the terms of the respective Compacts and consider the overall nature and development of the U.S.-FSM and U.S.-RMI relationships including the topics set forth in subparagraphs (A) through (E) of paragraph (1). In conducting the reviews, the Government of the United States shall consider the operating requirements of the Government of the Federated States of Micronesia and the Government of the Republic of the Marshall Islands and their progress in meeting the development objectives set forth in their respective development plans. The President shall include in the annual reports to Congress for the years following the reviews the comments of the Government of the Federated States of Micronesia and the Government of the Republic of the Marshall Islands on the topics described in this paragraph, the President's response to the comments, the findings resulting from the reviews, and any recommendations for actions to respond to such findings.

(3) BY THE COMPTROLLER GENERAL.—Not later than the date that is three years after the date of enactment of this joint resolution, and every 5 years thereafter, the Comptroller General of the United States shall submit to Congress a report on the Federated States of Micronesia and the Republic of the Marshall Islands including the topics set forth in paragraphs (1) (A) through (E) above, and on the effectiveness of administrative oversight by the United States.

(i) CONSTRUCTION OF SECTION 141(f).—Section 141(f)(2) of the Compact of Free Association, as amended, between the Government of the United States of America and the Government of the Federated States of Micronesia and of the Compact of Free Association, as amended, between the Government of the United States of America and the Government of the Republic of the Marshall Islands, shall be construed as though, after "may by regulations prescribe", there were included the following: ", except that any such regulations that would have a significant effect on the admission, stay and employment privileges provided under this section shall not become effective until 90 days after the date of transmission of the regulations to the Committee on Energy and Natural Resources and the Committee on the Judiciary of the Senate and the Committee on Resources, the Committee on International Relations, and the Committee on the Judiciary of the House of Representatives".

(j) INFLATION ADJUSTMENT.—As of Fiscal Year 2015, if the United States Gross Domestic Product Implicit Price Deflator average for Fiscal Years 2009 through 2013 is greater than United States Gross Domestic Product Implicit Price Deflator average for Fiscal Years 2004 through 2008 (as reported in the Survey of Current Business or subsequent publication and compiled by the Department of Interior), then section 217 of the U.S.-FSM Compact, paragraph 5 of Article II of the U.S.-FSM Fiscal Procedures Agreement, section 218 of the U.S.-RMI Compact, and paragraph 5 of Article II of the U.S.-RMI Fiscal Procedures Agreement shall be construed as if "the full" appeared in place of "two-thirds of the" each place those words appear. If an inflation adjustment is made under this subsection, the base year for calculating the inflation adjustment shall be fiscal year 2014.

(k) PARTICIPATION BY SECONDARY SCHOOLS IN THE ARMED SERVICES VOCATIONAL APTITUDE BATTERY (ASVAB) STUDENT TESTING PROGRAM.—In furtherance of the provisions of Title Three, Article IV, Section 341 of the U.S.-FSM and the U.S.-RMI Compacts, the purpose of which is to establish the privilege to volunteer for service in the U.S. Armed Forces, it is the sense of Congress that, to facilitate eligibility of FSM and RMI secondary school students to qualify for such service, the Department of Defense may extend the Armed Services Vocational Aptitude Battery (ASVAB) Student Testing Program (STP) and the ASVAB Career Exploration Program to selected secondary Schools in the FSM and the RMI to the extent such programs are available to Department of Defense Dependent Schools located in foreign jurisdictions.

SEC. 105. SUPPLEMENTAL PROVISIONS.

(a) DOMESTIC PROGRAM REQUIREMENTS.—Except as may otherwise be provided in this joint resolution, all United States Federal programs and services extended to or operated in the Federated States of Micronesia or the Republic of the Marshall Islands are and shall remain subject to all applicable criteria, standards, reporting requirements, auditing procedures, and other rules and regulations applicable to such programs when operating in the United States (including its territories and commonwealths).

(b) RELATIONS WITH THE FEDERATED STATES OF MICRONESIA AND THE REPUBLIC OF THE MARSHALL ISLANDS.—

(1) Appropriations made pursuant to Article I of Title Two and subsection (a)(2) of section 221 of article II of Title Two of the U.S.-FSM Compact and the U.S.-RMI Compact shall be made to the Secretary of the Interior, who shall have the authority necessary to fulfill his responsibilities for monitoring and managing the funds so appropriated consistent with the U.S.-FSM Compact and the U.S.-RMI Compact, including the agreements referred to in section 462(b)(4) of the U.S.-FSM Compact and U.S.-RMI Compact (relating to Fiscal Procedures) and the agreements referred to in section 462(b)(5) of the U.S.-FSM Compact and the U.S.-RMI Compact (regarding the Trust Fund).

(2) Appropriations made pursuant to subsections (a)(1) and (a)(3) through (6) of section 221 of Article II of Title Two of the U.S.-FSM Compact and subsection (a)(1) and (a)(3) through (5) of the U.S.-RMI Compact shall be made directly to the agencies named in those subsections.

(3) Appropriations for services and programs referred to in subsection (b) of section 221 of Article II of Title Two of the U.S.-FSM Compact or U.S.-RMI Compact and appropriations for services and programs referred to in sections 105(f) and 108(a) of this joint resolution shall be made to the relevant agencies in accordance with the terms of the appropriations for such services and programs.

(4) Federal agencies providing programs and services to the Federated States of Micronesia and the Republic of the Marshall Islands shall coordinate with the Secretaries of the Interior and State regarding provision of such programs and services. The Secretaries of the Interior and State shall consult with appropriate officials of the Asian Development Bank and with the Secretary of the Treasury regarding overall economic conditions in the Federated States of Micronesia and the Republic of the Marshall Islands and regarding the activities of other donors of assistance to the Federated States of Micronesia and the Republic of the Marshall Islands.

(5) United States Government employees in either the Federated States of Micronesia or the Republic of the Marshall Islands are subject to the authority of the United States Chief of Mission, including as elaborated in section 207 of the Foreign Service Act and the President's Letter of Instruction to the United States Chief of Mission and any order or directive of the President in effect from time to time.

(6) INTERAGENCY GROUP ON FREELY ASSOCIATED STATES' AFFAIRS.—

(A) IN GENERAL.—The President is hereby authorized to appoint an Interagency Group on Freely Associated States' Affairs to provide policy guidance and recommendations on implementation of the U.S.-FSM Compact and the U.S.-RMI Compact to Federal departments and agencies.

(B) SECRETARIES.—It is the sense of Congress that the Secretary of State and the Secretary of the Interior shall be represented on the Interagency Group.

(7) UNITED STATES APPOINTEES TO JOINT COMMITTEES.—

(A) JOINT ECONOMIC MANAGEMENT COMMITTEE.—

(i) IN GENERAL.—The three United States appointees (United States chair plus two members) to the Joint Economic Management Committee provided for in section 213 of the U.S.-FSM Compact and Article III of the U.S.-FSM Fiscal Procedures Agreement referred to in section 462(b)(4) of the U.S.-FSM Compact shall be United States Government officers or employees.

(ii) DEPARTMENTS.—It is the sense of Congress that 2 of the 3 appointees should be designated from the Department of State and the Department of the Interior, and that U.S. officials of the Asian Development Bank shall be consulted in order to properly coordinate U.S. and Asian Development Bank financial, program, and technical assistance.

(iii) ADDITIONAL SCOPE.—Section 213 of the U.S.-FSM Compact shall be construed to read as though the phrase, "the implementation of economic policy reforms to encourage investment and to achieve self-sufficient tax rates," were inserted after "with particular focus on those parts of the plan dealing with the sectors identified in subsection (a) of section 211".

(B) JOINT ECONOMIC MANAGEMENT AND FINANCIAL ACCOUNTABILITY COMMITTEE.—

(i) IN GENERAL.—The three United States appointees (United States chair plus two members) to the Joint Economic Management and Financial Accountability Committee provided for in section 214 of the U.S.-RMI Compact and Article III of the U.S.-RMI Fiscal Procedures Agreement referred to in section 462(b)(4) of the U.S.-RMI Compact shall be United States Government officers or employees.

(ii) DEPARTMENTS.—It is the sense of Congress that 2 of the 3 appointees should be designated from the Department of State and the Department of the Interior, and that U.S. officials of

the Asian Development Bank shall be consulted in order to properly coordinate U.S. and Asian Development Bank financial, program, and technical assistance.

(iii) ADDITIONAL SCOPE.—Section 214 of the U.S.-RMI Compact shall be construed to read as though the phrase, "the implementation of economic policy reforms to encourage investment and to achieve self-sufficient tax rates," were inserted after "with particular focus on those parts of the framework dealing with the sectors and areas identified in subsection (a) of section 211".

(8) OVERSIGHT AND COORDINATION.—It is the sense of Congress that the Secretary of State and the Secretary of the Interior shall ensure that there are personnel resources committed in the appropriate numbers and locations to ensure effective oversight of United States assistance, and effective coordination of assistance among United States agencies and with other international donors such as the Asian Development Bank.

(9) The United States voting members (United States chair plus two or more members) of the Trust Fund Committee appointed by the Government of the United States pursuant to Article 7 of the Trust Fund Agreement implementing section 215 of the U.S.-FSM Compact and referred to in section 462(b)(5) of the U.S.-FSM Compact and any alternates designated by the Government of the United States shall be United States Government officers or employees. The United States voting members (United States chair plus two or more members) of the Trust Fund Committee appointed by the Government of the United States pursuant to Article 7 of the Trust Fund Agreement implementing section 216 of the U.S.-RMI Compact and referred to in section 462(b)(5) of the U.S.-RMI Compact and any alternates designated by the Government of the United States shall be United States Government officers or employees. It is the sense of Congress that the appointees should be designated from the Department of State, the Department of the Interior, and the Department of the Treasury.

(10) The Trust Fund Committee provided for in Article 7 of the U.S.-FSM Trust Fund Agreement implementing section 215 of the U.S.-FSM Compact shall be a nonprofit corporation incorporated under the laws of the District of Columbia. To the extent that any law, rule, regulation or ordinance of the District of Columbia, or of any State or political subdivision thereof in which the Trust Fund Committee is incorporated or doing business, impedes or otherwise interferes with the performance of the functions of the Trust Fund Committee pursuant to this joint resolution, such law, rule, regulation, or ordinance shall be deemed to be preempted by this joint resolution. The Trust Fund Committee provided for in Article 7 of the U.S.-RMI Trust Fund Agreement implementing section 216 of the U.S.-RMI Compact shall be a non-profit corporation incorporated under the laws of the District of Columbia. To the extent that any law, rule, regulation or ordinance of the District of Columbia, or of any State or political subdivision thereof in which the Trust Fund Committee is incorporated or doing business, impedes or otherwise interferes with the performance of the functions of the Trust Fund Committee pursuant to this joint resolution, such law, rule, regulation, or ordinance shall be deemed to be preempted by this joint resolution.

(c) CONTINUING TRUST TERRITORY AUTHORIZATION.—The authorization provided by the Act of June 30, 1954, as amended (68 Stat. 330) shall remain available after the effective date of the Compact with respect to the Federated States of Micronesia and the Republic of the Marshall Islands for the following purposes:

(1) Prior to October 1, 1986, for any purpose authorized by the Compact or the joint resolution of January 14, 1986 (Public Law 99–239).

(2) Transition purposes, including but not limited to, completion of projects and fulfillment of commitments or obligations; termination of the Trust Territory Government and termination of the High Court; health and education as a result of exceptional circumstances; ex gratia contributions for the populations of Bikini, Enewetak, Rongelap, and Utrik; and technical assistance and training in financial management, program administration, and maintenance of infrastructure.

(d) SURVIVABILITY.—In furtherance of the provisions of Title Four, Article V, sections 452 and 453 of the U.S.-FSM Compact and the U.S.-RMI Compact, any provisions of the U.S.-FSM Compact or the U.S.-RMI Compact which remain effective after the termination of the U.S.-FSM Compact or U.S.-RMI Compact by the act of any party thereto and which are affected in any manner by provisions of this title shall remain subject to such provisions.

(e) NONCOMPLIANCE SANCTIONS; ACTIONS INCOMPATIBLE WITH UNITED STATES AUTHORITY.—Congress expresses its understanding that the Governments of the Federated States of Micronesia and the Republic of the Marshall Islands will not act in a manner incompatible with the authority and responsibility of the United States for security and defense matters in or related to the Federated States of Micronesia or the Republic of the Marshall Islands pursuant to the U.S.-FSM Compact or the U.S.-RMI Compact, including the agreements referred to in sections 462(a)(2) of the U.S.-FSM Compact and 462(a)(5) of the U.S.-RMI Compact. Congress further expresses its intention that any such act on the part of either such Government will be viewed by the United States as a material breach of the U.S.-FSM Compact or U.S.-RMI Compact. The Government of the United States reserves the right in the event of such a material breach of the U.S.-FSM Compact by the Government of the Federated States of Micronesia or the U.S.-RMI Compact by the Government of the Republic of the Marshall Islands to take action, including (but not limited to) the suspension in whole or in part of the obligations of the Government of the United States to that Government.

(f) CONTINUING PROGRAMS AND LAWS.—

(1) FEDERATED STATES OF MICRONESIA AND REPUBLIC OF THE MARSHALL ISLANDS.—In addition to the programs and services set forth in section 221 of the Compact, and pursuant to section 222 of the Compact, the programs and services of the following agencies shall be made available to the Federated States of Micronesia and to the Republic of the Marshall Islands:

(A) CONTINUATION OF THE PROGRAMS AND SERVICES OF THE FEDERAL EMERGENCY MANAGEMENT AGENCY.—Except as provided in clauses (ii) and (iii), the programs and services of the Department of Homeland Security, Federal Emergency Management Agency shall continue to be available to the Federated States of Micronesia and the Republic of the Marshall Islands to the same extent as such programs and services were available in fiscal year 2003.

(i) Paragraph (a)(6) of section 221 of the U.S.-FSM Compact and paragraph (a)(5) of the U.S.-RMI Compact shall each be construed as though the paragraph reads as follows: "the Department of Homeland Security, United States Federal Emergency Management Agency."

(ii) Subsection (d) of section 211 of the U.S.-FSM Compact and subsection (e) of section 211 of the U.S.-RMI Compact shall each be construed as though the subsection reads as follows: "Not more than $200,000 (as adjusted for inflation pursuant to section 217 of the U.S.-FSM Compact and section 218 of the U.S.-RMI Compact) shall be made available by the Secretary of the Interior to the Department of Homeland Security, Federal Emergency Management Agency to facilitate the activities of the Federal Emergency Management Agency in accordance with and to the extent provided in the Federal Programs and Services Agreement."

(iii) The Secretary of State, in consultation with the Department of Homeland Security and the Federal Emergency Management Agency, shall immediately undertake negotiations with the Government of the Federated States of Micronesia and the Government of the Republic of the Marshall Islands regarding disaster assistance and shall report to the appropriate committees of Congress no later than June 30, 2004, on the outcome of such negotiations, including recommendations for changes to law regarding disaster assistance under the U.S.-FSM Compact and the U.S.-RMI Compact, and including subsidiary agreements as needed to implement such changes to law. If an agreement is not concluded, and legislation enacted which reflects such agreement, before the date which is five years after the date of enactment of this Joint Resolution, the following provisions shall apply:

"Paragraph (a)(6) of section 221 of the U.S.-FSM Compact and paragraph (a)(5) of section 221 of the U.S.-RMI Compact shall each be construed and applied as if each provision reads as follows:

"The U.S. Agency for International Development shall be responsible for the provision of emergency and disaster relief assistance in accordance with its statutory authorities, regulations and policies. The Republic of the Marshall Islands and the Federated States of Micronesia may additionally request that the President make an emergency or major disaster declaration. If the President declares an emergency or major disaster, the Department of Homeland Security (DHS), the Federal Emergency Management Agency (FEMA) and the U.S. Agency for International Development shall jointly (a) assess the damage caused by the emergency or disaster and (b) prepare a reconstruction plan including an estimate of the total amount of Federal resources that are needed for reconstruction. Pursuant to an interagency agreement, FEMA shall transfer funds from the Disaster Relief Fund in the amount of the estimate, together with an amount to be determined for administrative expenses, to the U.S. Agency for International Development, which shall carry out reconstruction activities in the Republic of the Marshall Islands and the Federated States of Micronesia in accordance with the reconstruction plan. For purposes of Disaster Relief Fund appropriations, the funding of the activities to be carried out pursuant to this paragraph shall be deemed to be necessary expenses in carrying out the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121 et seq).

"DHS may provide to the Republic of the Marshall Islands and the Federated States of Micronesia preparedness grants to the extent that such assistance is available to the States of the United States. Funding for this assistance may be made available from appropriations made to DHS for preparedness activities.".

(B) TREATMENT OF ADDITIONAL PROGRAMS.—

(i) CONSULTATION.—The United States appointees to the committees established pursuant to section 213 of the U.S.-FSM Compact and section 214 of the U.S.-RMI Compact shall consult with the Secretary of Education regarding the objectives, use, and monitoring of United States financial, program, and technical assistance made available for educational purposes.

(ii) CONTINUING PROGRAMS.—The Government of the United States—

(I) shall continue to make available to the Federated States of Micronesia and the Republic of the Marshall Islands for fiscal years 2004 through 2023, the services to individuals eligible for such services under the Individuals with

Disabilities Education Act (20 U.S.C. 1400 et seq.) to the extent that such services continue to be available to individuals in the United States; and

(II) shall continue to make available to eligible institutions in the Federated States of Micronesia and the Republic of the Marshall Islands, and to students enrolled in such institutions, and in institutions in the United States and its territories, for fiscal years 2004 through 2023, grants under subpart 1 of part A of title IV of the Higher Education Act of 1965 (20 U.S.C. 1070a et seq.) to the extent that such grants continue to be available to institutions and students in the United States.

(iii) SUPPLEMENTAL EDUCATION GRANTS.—In lieu of eligibility for appropriations under part A of title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311 et seq.), title I of the Workforce Investment Act of 1998 (29 U.S.C. 2801 et seq.), other than subtitle C of that Act (29 U.S.C. 2881 et seq.) (Job Corps), title II of the Workforce Investment Act of 1998 (20 U.S.C. 9201 et seq.; commonly known as the Adult Education and Family Literacy Act), title I of the Carl D. Perkins Vocational and Technical Education Act of 1998 (20 U.S.C. 2321 et seq.), the Head Start Act (42 U.S.C. 9831 et seq.), and subpart 3 of part A, and part C, of title IV of the Higher Education Act of 1965 (20 U.S.C. 1070b et seq., 42 U.S.C. 2751 et seq.), there are authorized to be appropriated to the Secretary of Education to supplement the education grants under section 211(a)(1) of the U.S.-FSM Compact and section 211(a)(1) of the U.S.-RMI Compact, respectively, the following amounts:

(I) $12,230,000 for the Federated States of Micronesia for fiscal year 2005 and an equivalent amount, as adjusted for inflation under section 217 of the U.S.-FSM Compact, for each of fiscal years 2005 through 2023; and

(II) $6,100,000 for the Republic of the Marshall Islands for fiscal year 2005 and an equivalent amount, as adjusted for inflation under section 218 of the U.S.-RMI Compact, for each of fiscal years 2005 through 2023,

except that citizens of the Federated States of Micronesia and the Republic of the Marshall Islands who attend an institution of higher education in the United States or its territories, the Federated States of Micronesia, or the Republic of the Marshall Islands on the date of enactment of this joint resolution may continue to receive assistance under such subpart 3 of part A or part C, for not more than 4 academic years after such date to enable such citizens to complete their program of study.

(iv) FISCAL PROCEDURES.—Appropriations made pursuant to clause (iii) shall be used and monitored in accordance with an agreement between the Secretary of Education, the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Interior, and in accordance with the respective Fiscal Procedures Agreements referred to in section 462(b)(4) of the U.S.-FSM Compact and section 462(b)(4) of the U.S.-RMI Compact. The agreement between the Secretary of Education, the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Interior shall provide for the transfer, not later than 60 days after the appropriations made pursuant to clause (iii) become available to the Secretary of Education, the Secretary of Labor, and the Secretary of Health and Human Services, from the Secretary of Education, the Secretary of Labor, and the Secretary of Health and Human Services, to the Secretary of the Interior for disbursement.

(v) FORMULA EDUCATION GRANTS.—For fiscal years 2005 through 2023, except as provided in clause (ii) and the exception provided under clause (iii), the Governments of the Federated States of Micronesia and the Republic of the Marshall Islands shall not receive any grant under any formula-grant program administered by the Secretary of Education or the Secretary of Labor, nor any grant provided through the Head Start Act (42 U.S.C. 9831 et seq.) administered by the Secretary of Health and Human Services.

(vi) TRANSITION.—For fiscal year 2004, the Governments of the Federated States of Micronesia and the Republic of the Marshall Islands shall continue to be eligible for appropriations and to receive grants under the provisions of law specified in clauses (ii) and (iii).

(vii) TECHNICAL ASSISTANCE.—The Federated States of Micronesia and the Republic of the Marshall Islands may request technical assistance from the Secretary of Education, the Secretary of Health and Human Services, or the Secretary of Labor the terms of which, including reimbursement, shall be negotiated with the participation of the appropriate cabinet officer for inclusion in the Federal Programs and Services Agreement.

(viii) CONTINUED ELIGIBILITY FOR COMPETITIVE GRANTS.—The Governments of the Federated States of Micronesia and the Republic of the Marshall Islands shall continue to be eligible for competitive grants administered by the Secretary of Education, the Secretary of Health and Human Services, and the Secretary of Labor to the extent that such grants continue to be available to State and local governments in the United States.

(ix) APPLICABILITY.—The Republic of Palau shall remain eligible for appropriations and to receive grants under the provisions of law specified in clauses (ii) and (iii) until the end of fiscal year 2007, to the extent the Republic of Palau was so eligible under such provisions in fiscal year 2003.

(C) The Legal Services Corporation.

(D) The Public Health Service.

(E) The Rural Housing Service (formerly, the Farmers Home Administration) in the Marshall Islands and each of the four States of the Federated States of Micronesia: Provided, That in lieu of continuation of the program in the Federated States of Micronesia, the President may agree to transfer to the Government of the Federated States of Micronesia without cost, the portfolio of the Rural Housing Service applicable to the Federated States of Micronesia and provide such technical assistance in management of the portfolio as may be requested by the Federated States of Micronesia).

(2) TORT CLAIMS.—The provisions of section 178 of the U.S.-FSM Compact and the U.S.-RMI Compact regarding settlement and payment of tort claims shall apply to employees of any Federal agency of the Government of the United States (and to any other person employed on behalf of any Federal agency of the Government of the United States on the basis of a contractual, cooperative, or similar agreement) which provides any service or carries out any other function pursuant to or in furtherance of any provisions of the U.S.-FSM Compact or the U.S.-RMI Compact or this joint resolution, except for provisions of Title Three of the Compact and of the subsidiary agreements related to such Title, in such area to which such Agreement formerly applied.

(3) PCB CLEANUP.—The programs and services of the Environmental Protection Agency regarding PCBs shall, to the extent applicable, as appropriate, and in accordance with applicable law, be construed to be made available to such islands for the cleanup of PCBs imported prior to 1987. The Secretary of the Interior and the Secretary of Defense shall cooperate and assist in any such cleanup activities.

(g) COLLEGE OF MICRONESIA.—Until otherwise provided by Act of Congress, or until termination of the U.S.-FSM Compact and the U.S.-RMI Compact, the College of Micronesia shall retain its status as a land-grant institution and its eligibility for all benefits and programs available to such land-grant institutions.

(h) TRUST TERRITORY DEBTS TO U.S. FEDERAL AGENCIES.—Neither the Government of the Federated States of Micronesia nor the Government of the Marshall Islands shall be required to pay to any department, agency, independent agency, office, or instrumentality of the United States any amounts owed to such department, agency, independent agency, office, or instrumentality by the Government of the Trust Territory of the Pacific Islands as of the effective date of the Compact. There is authorized to be appropriated such sums as may be necessary to carry out the purposes of this subsection.

(i) JUDICIAL TRAINING.—

(1) IN GENERAL.—In addition to amounts provided under section 211(a)(4) of the U.S.-FSM Compact and the U.S.-RMI Compact, the Secretary of the Interior shall annually provide $300,000 for the training of judges and officials of the judiciary in the Federated States of Micronesia and the Republic of the Marshall Islands in cooperation with the Pacific Islands Committee of the Ninth Circuit Judicial Council and in accordance with and to the extent provided in the Federal Programs and Services Agreement and the Fiscal Procedure Agreement, as appropriate.

(2) AUTHORIZATION AND CONTINUING APPROPRIATION.—There is hereby authorized and appropriated to the Secretary of the Interior, out of any funds in the Treasury not otherwise appropriated, to remain available until expended, for each fiscal year from 2004 through 2023, $300,000, as adjusted for inflation under section 218 of the U.S.-FSM Compact and the U.S.-RMI Compact, to carry out the purposes of this section.

(j) TECHNICAL ASSISTANCE.—Technical assistance may be provided pursuant to section 224 of the U.S.-FSM Compact or the U.S.-RMI Compact by Federal agencies and institutions of the Government of the United States to the extent such assistance may be provided to States, territories, or units of local government. Such assistance by the Forest Service, the Natural Resources Conservation Service, the Fish and Wildlife Service, the National Marine Fisheries Service, the United States Coast Guard, and the Advisory Council on Historic Preservation, the Department of the Interior, and other agencies providing assistance under the National Historic Preservation Act (80 Stat. 915; 16 U.S.C. 470–470t), shall be on a nonreimbursable basis. During the period the U.S.-FSM Compact and the U.S.-RMI Compact are in effect, the grant programs under the National Historic Preservation Act shall continue to apply to the Federated States of Micronesia and the Republic of the Marshall Islands in the same manner and to the same extent as prior to the approval of the Compact. Any funds provided pursuant to sections 102(a), 103(a), 103(b), 103(f), 103(g), 103(h), 103(j), 105(c), 105(g), 105(h), 105(i), 105(j), 105(k), 105(l), and 105(m) of this joint resolution shall be in addition to and not charged against any amounts to be paid to either the Federated States of Micronesia or the Republic of the Marshall Islands pursuant to the U.S.-FSM Compact, the U.S.-RMI Compact, or their related subsidiary agreements.

(k) PRIOR SERVICE BENEFITS PROGRAM.—Notwithstanding any other provision of law, persons who on January 1, 1985, were eligible to receive payment under the Prior Service Benefits Program established within the Social Security System of the Trust Territory of the Pacific Islands because of their services performed for the United States Navy or the Government of the Trust Territory of the Pacific Islands prior to

July 1, 1968, shall continue to receive such payments on and after the effective date of the Compact.

(l) INDEFINITE LAND USE PAYMENTS.—There are authorized to be appropriated such sums as may be necessary to complete repayment by the United States of any debts owed for the use of various lands in the Federated States of Micronesia and the Marshall Islands prior to January 1, 1985.

(m) COMMUNICABLE DISEASE CONTROL PROGRAM.—There are authorized to be appropriated for grants to the Government of the Federated States of Micronesia, the Government of the Republic of the Marshall Islands, and the governments of the affected jurisdictions, such sums as may be necessary for purposes of establishing or continuing programs for the control and prevention of communicable diseases, including (but not limited to) cholera, tuberculosis, and Hansen's Disease. The Secretary of the Interior shall assist the Government of the Federated States of Micronesia, the Government of the Republic of the Marshall Islands and the governments of the affected jurisdictions in designing and implementing such a program.

(n) USER FEES.—Any person in the Federated States of Micronesia or the Republic of the Marshall Islands shall be liable for user fees, if any, for services provided in the Federated States of Micronesia or the Republic of the Marshall Islands by the Government of the United States to the same extent as any person in the United States would be liable for fees, if any, for such services in the United States.

(o) TREATMENT OF JUDGMENTS OF COURTS OF THE FEDERATED STATES OF MICRONESIA, THE REPUBLIC OF THE MARSHALL ISLANDS, AND THE REPUBLIC OF PALAU.—No judgment, whenever issued, of a court of the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau, against the United States, its departments and agencies, or officials of the United States or any other individuals acting on behalf of the United States within the scope of their official duty, shall be honored by the United States, or be subject to recognition or enforcement in a court in the United States, unless the judgment is consistent with the interpretation by the United States of international agreements relevant to the judgment. In determining the consistency of a judgment with an international agreement, due regard shall be given to assurances made by the Executive Branch to Congress of the United States regarding the proper interpretation of the international agreement.

(p) ESTABLISHMENT OF TRUST FUNDS; EXPEDITION OF PROCESS.—

(1) IN GENERAL.—The Trust Fund Agreement executed pursuant to the U.S.-FSM Compact and the Trust Fund Agreement executed pursuant to the U.S.-RMI Compact each provides for the establishment of a trust fund.

(2) METHOD OF ESTABLISHMENT.—The trust fund may be established by—

(A) creating a new legal entity to constitute the trust fund; or

(B) assuming control of an existing legal entity including, without limitation, a trust fund or other legal entity that was established by or at the direction of the Government of the United States, the Government of the Federated States of Micronesia, the Government of the Republic of the Marshall Islands, or otherwise for the purpose of facilitating or expediting the establishment of the trust fund pursuant to the applicable Trust Fund Agreement.

(3) OBLIGATIONS.—For the purpose of expediting the commencement of operations of a trust fund under either Trust Fund Agreement, the trust fund may, but shall not be obligated to, assume any obligations of an existing legal entity and take assignment of any contract or other agreement to which the existing legal entity is party.

(4) ASSISTANCE.—Without limiting the authority that the United States Government may otherwise have under applicable law, the United States Government may, but shall not be obligated to, provide financial, technical, or other assistance directly or indirectly to the Government of the Federated States of Micronesia or the Government of the Republic of the Marshall Islands for the purpose of establishing and operating a trust fund or other legal entity that will solicit bids from, and enter into contracts with, parties willing to serve in such capacities as trustee, depositary, money manager, or investment advisor, with the intention that the contracts will ultimately be assumed by and assigned to a trust fund established pursuant to a Trust Fund Agreement.

SEC. 106. CONSTRUCTION CONTRACT ASSISTANCE.

(a) ASSISTANCE TO U.S. FIRMS.—In order to assist the Governments of the Federated States of Micronesia and of the Republic of the Marshall Islands through private sector firms which may be awarded contracts for construction or major repair of capital infrastructure within the Federated States of Micronesia or the Republic of the Marshall Islands, the United States shall consult with the Governments of the Federated States of Micronesia and the Republic of the Marshall Islands with respect to any such contracts, and the United States shall enter into agreements with such firms whereby such firms will, consistent with applicable requirements of such Governments—

(1) to the maximum extent possible, employ citizens of the Federated States of Micronesia and the Republic of the Marshall Islands;

(2) to the extent that necessary skills are not possessed by citizens of the Federated States of Micronesia and the Republic of the Marshall Islands, provide on the job training, with particular emphasis on the development of skills relating to operation of machinery and routine and preventative maintenance of machinery and other facilities; and

(3) provide specific training or other assistance in order to enable the Government to engage in long-term maintenance of infrastructure.

Assistance by such firms pursuant to this section may not exceed 20 percent of the amount of the contract and shall be made available only to such firms which meet the definition of United States firm under the nationality rule for suppliers of services of the Agency for International Development (hereafter in this section referred to as "United States firms"). There are authorized to be appropriated such sums as may be necessary for the purposes of this subsection.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to cover any additional costs incurred by the Government of the Federated States of Micronesia or the Republic of the Marshall Islands if such Governments, pursuant to an agreement entered into with the United States, apply a preference on the award of contracts to United States firms, provided that the amount of such preference does not exceed 10 percent of the amount of the lowest qualified bid from a non-United States firm for such contract.

SEC. 107. PROHIBITION.

All laws governing conflicts of interest and post-employment of Federal employees shall apply to the implementation of this Act.

SEC. 108. COMPENSATORY ADJUSTMENTS.

(a) ADDITIONAL PROGRAMS AND SERVICES.—In addition to the programs and services set forth in section 221 of the U.S.-FSM Compact and the U.S.-RMI Compact, and pursuant to section 222 of the U.S.-FSM Compact and the U.S.-RMI Compact, the services and programs of the following United States agencies shall be made available to the Federated States of Micronesia and the Republic of the Marshall Islands: the Small Business Administration, Economic Development Administration, the Rural Utilities Services (formerly Rural Electrification Administration); the programs and services of the Department of Labor under subtitle C of title I of the Workforce Investment Act of 1998 (29 U.S.C. 2881 et seq.; relating to Job Corps); and the programs and services of the Department of Commerce relating to tourism and to marine resource development.

(b) FURTHER AMOUNTS.—

(1) The joint resolution of January 14, 1986 (Public Law 99–239) provided that the governments of the Federated States of Micronesia and the Marshall Islands may submit to Congress reports concerning the overall financial and economic impacts on such areas resulting from the effect of title IV of that joint resolution upon Title Two of the Compact. There were authorized to be appropriated for fiscal years beginning after September 30, 1990, such amounts as necessary, but not to exceed $40,000,000 for the Federated States of Micronesia and $20,000,000 for the Marshall Islands, as provided in appropriation acts, to further compensate the governments of such islands (in addition to the compensation provided in subsections (a) and (b) of section 111 of the joint resolution of January 14, 1986 (Public Law 99–239) for adverse impacts, if any, on the finances and economies of such areas resulting from the effect of title IV of that joint resolution upon Title Two of the Compact. The joint resolution of January 14, 1986 (Public Law 99–239) further provided that at the end of the initial fifteen-year term of the Compact, should any portion of the total amount of funds authorized in section 111 of that resolution not have been appropriated, such amount not yet appropriated may be appropriated, without regard to divisions between amounts authorized in section 111 for the Federated States of Micronesia and for the Marshall Islands, based on either or both such government's showing of such adverse impact, if any, as provided in that subsection.

(2) The governments of the Federated States of Micronesia and the Republic of the Marshall Islands may each submit no more than one report or request for further compensation under section 111 of the joint resolution of January 14, 1986 (Public Law 99–239) and any such report or request must be submitted by September 30, 2009. Only adverse economic effects occurring during the initial 15-year term of the Compact may be considered for compensation under section 111 of the joint resolution of January 14, 1986 (Public Law 99–239).

SEC. 109. AUTHORIZATION AND CONTINUING APPROPRIATION.

(a) There are authorized and appropriated to the Department of the Interior, out of any funds in the Treasury not otherwise appropriated, to remain available until expended, such sums as are necessary to carry out the purposes of sections 105(f)(1) and 105(i) of this Act, sections 211, 212(b), 215, and 217 of the U.S.-FSM Compact, and sections 211, 212, 213(b), 216, and 218 of the U.S.-RMI Compact, in this and subsequent years.

(b) There are authorized to be appropriated to the Departments, agencies, and instrumentalities named in paragraphs (1) and (3) through (6) of section 221(a) of the U.S.-FSM Compact and paragraphs (1) and (3) through (5) of section 221(a) of the U.S.-RMI Compact, such sums as are necessary to carry out the purposes of sections 221(a) of the U.S.-FSM Compact and the U.S.-RMI Compact, to remain available until expended.

SEC. 110. PAYMENT OF CITIZENS OF THE FEDERATED STATES OF MICRONESIA, THE REPUBLIC OF THE MARSHALL ISLANDS, AND THE REPUBLIC OF PALAU EMPLOYED BY THE GOVERNMENT OF THE UNITED STATES IN THE CONTINENTAL UNITED STATES.

Section 605 of Public Law 107–67 (the Treasury and General Government Appropriations Act, 2002) is amended by striking "or the Republic of the Philippines," in the last sentence and inserting the following: "the Republic of the Philippines, the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau,".

TITLE II—COMPACTS OF FREE ASSOCIATION WITH THE FEDERATED STATES OF MICRONESIA AND THE REPUBLIC OF THE MARSHALL ISLANDS

SEC. 201. COMPACTS OF FREE ASSOCIATION, AS AMENDED BETWEEN THE GOVERNMENT OF THE UNITED STATES OF AMERICA AND THE GOVERNMENT OF THE FEDERATED STATES OF MICRONESIA AND BETWEEN THE GOVERNMENT OF THE UNITED STATES OF AMERICA AND THE GOVERNMENT OF THE REPUBLIC OF THE MARSHALL ISLANDS.

(a) COMPACT OF FREE ASSOCIATION, AS AMENDED, BETWEEN THE GOVERNMENT OF THE UNITED STATES OF AMERICA AND THE GOVERNMENT OF THE FEDERATED STATES OF MICRONESIA.—The Compact of Free Association, as amended, between the Government of the United States of America and the Government of the Federated States of Micronesia is as follows:

PREAMBLE

THE GOVERNMENT OF THE UNITED STATES OF AMERICA AND THE GOVERNMENT OF THE FEDERATED STATES OF MICRONESIA

Affirming that their Governments and their relationship as Governments are founded upon respect for human rights and fundamental freedoms for all, and that the people of the Federated States of Micronesia have the right to enjoy self-government; and

Affirming the common interests of the United States of America and the Federated States of Micronesia in creating and maintaining their close and mutually beneficial relationship through the free and voluntary association of their respective Governments; and

Affirming the interest of the Government of the United States in promoting the economic advancement and budgetary self-reliance of the Federated States of Micronesia; and

Recognizing that their relationship until the entry into force on November 3, 1986 of the Compact was based upon the International Trusteeship System of the United Nations Charter, and in particular Article 76 of the Charter; and that pursuant to Article 76 of the Charter, the people of the Federated States of Micronesia have progressively developed their institutions of self-government, and that in the exercise of their sovereign right to self-determination they, through their freely-expressed wishes, have adopted a Constitution appropriate to their particular circumstances; and

Recognizing that the Compact reflected their common desire to terminate the Trusteeship and establish a government-to-government relationship which was in accordance with the new political status based on the freely expressed wishes of the people of the Federated States of Micronesia and appropriate to their particular circumstances; and

Recognizing that the people of the Federated States of Micronesia have and retain their sovereignty and their sovereign right to self-determination and the inherent right to adopt and amend their own Constitution and form of government and that the approval of the entry of the Government of the Federated States of Micronesia into the Compact by the people of the Federated States of Micronesia constituted an exercise of their sovereign right to self-determination; and

Recognizing the common desire of the people of the United States and the people of the Federated States of Micronesia to maintain their close government-to-government relationship, the United States and the Federated States of Micronesia:

NOW, THEREFORE, MUTUALLY AGREE to continue and strengthen their relationship of free association by amending the Compact, which continues to provide a full measure of self-government for the people of the Federated States of Micronesia; and

FURTHER AGREE that the relationship of free association derives from and is as set forth in this Compact, as amended, by the Governments of the United States and the Federated States of Micronesia; and that, during such relationship of free association, the respective rights and responsibilities of the Government of the United States and the Government of the Federated States of Micronesia in regard to this relationship of free association derive from and are as set forth in this Compact, as amended.

TITLE ONE

GOVERNMENTAL RELATIONS

Article I

Self-Government

Section 111

The people of the Federated States of Micronesia, acting through the Government established under their Constitution, are self-governing.

Article II

Foreign Affairs

Section 121

(a) The Government of the Federated States of Micronesia has the capacity to conduct foreign affairs and shall do so in its own name and right, except as otherwise provided in this Compact, as amended.

(b) The foreign affairs capacity of the Government of the Federated States of Micronesia includes:

(1) the conduct of foreign affairs relating to law of the sea and marine resources matters, including the harvesting, conservation, exploration or exploitation of living and non-living resources from the sea, seabed or subsoil to the full extent recognized under international law;

(2) the conduct of its commercial, diplomatic, consular, economic, trade, banking, postal, civil aviation, communications, and cultural relations, including negotiations for the receipt of developmental loans and grants and the conclusion of arrangements with other governments and international and intergovernmental organizations, including any matters specially benefiting its individual citizens.

(c) The Government of the United States recognizes that the Government of the Federated States of Micronesia has the capacity to enter into, in its own name and right, treaties and other international agreements with governments and regional and international organizations.

(d) In the conduct of its foreign affairs, the Government of the Federated States of Micronesia confirms that it shall act in accordance with principles of international law and shall settle its international disputes by peaceful means.

Section 122

The Government of the United States shall support applications by the Government of the Federated States of Micronesia for membership or other participation in regional or international organizations as may be mutually agreed.

Section 123

(a) In recognition of the authority and responsibility of the Government of the United States under Title Three, the Government of the Federated States of Micronesia shall consult, in the conduct of its foreign affairs, with the Government of the United States.

(b) In recognition of the foreign affairs capacity of the Government of the Federated States of Micronesia, the Government of the United States, in the conduct of its foreign affairs, shall consult with the Government of the Federated States of Micronesia on matters that the Government of the United States regards as relating to or affecting the Government of the Federated States of Micronesia.

Section 124

The Government of the United States may assist or act on behalf of the Government of the Federated States of Micronesia in the area of foreign affairs as may be requested and mutually agreed from time to time. The Government of the United States shall not be responsible to third parties for the actions of the Government of the Federated States of Micronesia undertaken with the assistance or through the agency of the Government of the United States pursuant to this section unless expressly agreed.

Section 125

The Government of the United States shall not be responsible for nor obligated by any actions taken by the Government of the Federated States of Micronesia in the area of foreign affairs, except as may from time to time be expressly agreed.

Section 126

At the request of the Government of the Federated States of Micronesia and subject to the consent of the receiving state, the Government of the United States shall extend consular assistance on the same basis as for citizens of the United States to citizens of the Federated States of Micronesia for travel outside the Federated States of Micronesia, the United States and its territories and possessions.

Section 127

Except as otherwise provided in this Compact, as amended, or its related agreements, all obligations, responsibilities, rights and benefits of the Government of the United States as Administering Authority which resulted from the application pursuant to the Trusteeship Agreement of any treaty or other international agreement to the Trust Territory of the Pacific Islands on November 2, 1986, are, as of that date, no longer assumed and enjoyed by the Government of the United States.

Article III

Communications

Section 131

(a) The Government of the Federated States of Micronesia has full authority and responsibility to regulate its domestic and foreign communications, and the Government of the United States shall provide communications assistance as mutually agreed.

(b) On May 24, 1993, the Government of the Federated States of Micronesia elected to undertake all functions previously performed by the Government of the United States with respect to domestic and foreign communications, except for those functions set forth in a separate agreement entered into pursuant to this section of the Compact, as amended.

Section 132

The Government of the Federated States of Micronesia shall permit the Government of the United States to operate telecommunications services in the Federated States of Micronesia to the extent necessary to fulfill the obligations of the Government of the United States under this Compact, as amended, in accordance with the terms of separate agreements entered into pursuant to this section of the Compact, as amended.

Article IV

Immigration

Section 141

(a) In furtherance of the special and unique relationship that exists between the United States and the Federated States of Micronesia, under the Compact, as amended, any person in the following categories may be admitted to, lawfully engage in occupations, and establish residence as a nonimmigrant in the United States and its territories and possessions (the "United States") without regard to paragraph (5) or (7)(B)(i)(II) of section 212(a) of the Immigration and Nationality Act, as amended, 8 U.S.C. 1182(a)(5) or (7)(B)(i)(II):

(1) a person who, on November 2, 1986, was a citizen of the Trust Territory of the Pacific Islands, as defined in Title 53 of the Trust Territory Code in force on January 1, 1979, and has become and remains a citizen of the Federated States of Micronesia;

(2) a person who acquires the citizenship of the Federated States of Micronesia at birth, on or after the effective date of the Constitution of the Federated States of Micronesia;

(3) an immediate relative of a person referred to in paragraphs (1) or (2) of this section, provided that such immediate relative is a naturalized citizen of the Federated States of Micronesia who has been an actual resident there for not less than five years after attaining such naturalization and who holds a certificate of actual residence, and further provided, that, in the case of a spouse, such spouse has been married to the person referred to in paragraph (1) or (2) of this section for at least five years, and further provided, that the Government of the United States is satisfied that such naturalized citizen meets the requirement of subsection (b) of section 104 of Public Law 99–239 as it was in effect on the day prior to the effective date of this Compact, as amended;

(4) a naturalized citizen of the Federated States of Micronesia who was an actual resident there for not less than five years after attaining such naturalization and who satisfied these requirements as of April 30, 2003, who continues to be an actual resident and holds a certificate of actual residence, and whose name is included in a list furnished by the Government of the Federated States of Micronesia to the Government of the United States no later than the effective date of the Compact, as amended, in form and content acceptable to the Government of the United States, provided, that the Government of the United States is satisfied that such naturalized citizen meets the requirement of subsection (b) of section 104 of Public Law 99–239 as it was in effect on the day prior to the effective date of this Compact, as amended; or

(5) an immediate relative of a citizen of the Federated States of Micronesia, regardless of the immediate relative's country of citizenship or period of residence in the Federated States of Micronesia, if the citizen of the Federated States of Micronesia is serving on active duty in any branch of the United States Armed Forces, or in the active reserves.

(b) Notwithstanding subsection (a) of this section, a person who is coming to the United States pursuant to an adoption outside the United States, or for the purpose of adoption in the United States, is ineligible for admission under the Compact and the Compact, as amended. This subsection shall apply to any person who is or was an applicant for admission to the United States on or after March 1, 2003, including any applicant for admission in removal proceedings (including appellate proceedings) on or after March 1, 2003, regardless of the date such proceedings were commenced. This subsection shall have no effect on the ability of the Government of the United States or any United States State or local government to commence or otherwise take any action against any person or entity who has violated any law relating to the adoption of any person.

(c) Notwithstanding subsection (a) of this section, no person who has been or is granted citizenship in the Federated States of Micronesia, or has been or is issued a Federated States of Micronesia passport pursuant to any investment, passport sale, or similar program has been or shall be eligible for admission to the United States under the Compact or the Compact, as amended.

(d) A person admitted to the United States under the Compact, or the Compact, as amended, shall be considered to have the permission of the Government of the United States to accept employment in the United States. An unexpired Federated States of Micronesia passport with unexpired documentation issued by the Government of the United States evidencing admission under the Compact or the Compact, as amended, shall be considered to be documentation establishing identity and employment authorization under section 274A(b)(1)(B) of the Immigration and Nationality Act, as amended, 8 U.S.C. 1324a(b)(1)(B). The Government of the United States will take reasonable and appropriate steps to implement and publicize this provision, and the Government of the Federated States of Micronesia will also take reasonable and appropriate steps to publicize this provision.

(e) For purposes of the Compact and the Compact, as amended:

(1) the term "residence" with respect to a person means the person's principal, actual dwelling place in fact, without regard to intent, as provided in section 101(a)(33) of the Immigration and Nationality Act, as amended, 8 U.S.C. 1101(a)(33), and variations of the term "residence," including "resident" and "reside," shall be similarly construed;

(2) the term "actual residence" means physical presence in the Federated States of Micronesia during eighty-five percent of the five-year period of residency required by section 141(a)(3) and (4);

(3) the term "certificate of actual residence" means a certificate issued to a naturalized citizen by the Government of the Federated States of Micronesia stating that the citizen has complied with the actual residence requirement of section 141(a)(3) or (4);

(4) the term "nonimmigrant" means an alien who is not an "immigrant" as defined in section 101(a)(15) of such Act, 8 U.S.C. 1101(a)(15); and

(5) the term "immediate relative" means a spouse, or unmarried son or unmarried daughter less than 21 years of age.

(f) The Immigration and Nationality Act, as amended, shall apply to any person admitted or seeking admission to the United States (other than a United States possession or territory where such Act does not apply) under the Compact or the Compact, as amended, and nothing in the Compact or the Compact, as amended, shall be construed to limit, preclude, or modify the applicability of, with respect to such person:

(1) any ground of inadmissibility or deportability under such Act (except sections 212(a)(5) and 212(a)(7)(B)(i)(II) of such Act, as provided in subsection (a) of this section), and any defense thereto, provided that, section 237(a)(5) of such Act shall be construed and applied as if it reads as follows: "any alien who has been admitted under the Compact, or the Compact, as amended, who cannot show that he or she has sufficient means of support in the United States, is deportable";

(2) the authority of the Government of the United States under section 214(a)(1) of such Act to provide that admission as a nonimmigrant shall be for such time and under such conditions as the Government of the United States may by regulations prescribe;

(3) Except for the treatment of certain documentation for purposes of section 274A(b)(1)(B) of such Act as provided by subsection (d) of this section of the Compact, as amended, any requirement under section 274A, including but not limited to section 274A(b)(1)(E);

(4) Section 643 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Public Law 104–208, and actions taken pursuant to section 643; and

(5) the authority of the Government of the United States otherwise to administer and enforce the Immigration and Nationality Act, as amended, or other United States law.

(g) Any authority possessed by the Government of the United States under this section of the Compact or the Compact, as amended, may also be exercised by the Government of a territory or possession of the United States where the Immigration and Nationality Act, as amended, does not apply, to the extent such exercise of authority is lawful under a statute or regulation of such territory or possession that is authorized by the laws of the United States.

(h) Subsection (a) of this section does not confer on a citizen of the Federated States of Micronesia the right to establish the residence necessary for naturalization under the Immigration and Nationality Act, as amended, or to petition for benefits for alien relatives under that Act. Subsection (a) of this section, however, shall not prevent a citizen of the Federated States of Micronesia from otherwise acquiring such rights or lawful permanent resident alien status in the United States.

Section 142

(a) Any citizen or national of the United States may be admitted, to lawfully engage in occupations, and reside in the Federated States of Micronesia, subject to the rights of the Government of the Federated States of Micronesia to deny entry to or deport any such citizen or national as an undesirable alien. Any determination of inadmissibility or deportability shall be based on reasonable statutory grounds and shall be subject to appropriate administrative and judicial review within the Federated States of Micronesia. If a citizen or national of the United States is a spouse of a citizen of the Federated States of Micronesia, the Government of the Federated States of Micronesia shall allow the United States citizen spouse to establish residence. Should the Federated States of Micronesia citizen spouse predecease the United States citizen spouse during the marriage, the Government of the Federated States of Micronesia shall allow the United States citizen spouse to continue to reside in the Federated States of Micronesia.

(b) In enacting any laws or imposing any requirements with respect to citizens and nationals of the United States entering the Federated States of Micronesia under subsection (a) of this section, including any grounds of inadmissibility or deportability, the Government of the Federated States of Micronesia shall accord to such citizens and nationals of the United States treatment no less favorable than that accorded to citizens of other countries.

(c) Consistent with subsection (a) of this section, with respect to citizens and nationals of the United States seeking to engage in employment or invest in the Federated States of Micronesia, the Government of the Federated States of Micronesia shall adopt immigration-related procedures no less favorable than those adopted by the Government of the United States with respect to citizens of the Federated States of Micronesia seeking employment in the United States.

Section 143

Any person who relinquishes, or otherwise loses, his United States nationality or citizenship, or his Federated States of Micronesia citizenship, shall be ineligible to receive the privileges set forth in sections 141 and 142. Any such person may apply for admission to the United States or the Federated States of Micronesia, as the case may be, in accordance with any other applicable laws of the United States or the Federated States of Micronesia relating to immigration of aliens from other countries. The laws of the Federated States of Micronesia or the United States, as the case may be, shall dictate the terms and conditions of any such person's stay.

Article V
Representation

Section 151

Relations between the Government of the United States and the Government of the Federated States of Micronesia shall be conducted in accordance with the Vienna Convention on Diplomatic Relations. In addition to diplomatic missions and representation, the Governments may establish and maintain other offices and designate other representatives on terms and in locations as may be mutually agreed.

Section 152

(a) Any citizen or national of the United States who, without authority of the United States, acts as the agent of the Government of the Federated States of Micronesia with regard to matters specified in the provisions of the Foreign Agents Registration Act of 1938, as amended (22 U.S.C. 611 et seq.), that apply with respect to an agent of a foreign principal shall be subject to the requirements of such Act. Failure to comply with such requirements shall subject such citizen or national to the same penalties and provisions of law as apply in the case of the failure of such an agent of a foreign principal to comply with such requirements. For purposes of the Foreign Agents Registration Act of 1938, the Federated States of Micronesia shall be considered to be a foreign country.

(b) Subsection (a) of this section shall not apply to a citizen or national of the United States employed by the Government of the Federated States of Micronesia with respect to whom the Government of the Federated States of Micronesia from time to time certifies to the Government of the United States that such citizen or national is an employee of the Federated States of Micronesia whose principal duties are other than those matters specified in the Foreign Agents Registration Act of 1938, as amended, that apply with respect to an agent of a foreign principal. The agency or officer of the United States receiving such certifications shall cause them to be filed with the Attorney General, who shall maintain a publicly available list of the persons so certified.

Article VI
Environmental Protection

Section 161

The Governments of the United States and the Federated States of Micronesia declare that it is their policy to promote efforts to prevent or eliminate damage to the environment and biosphere and to enrich understanding of the natural resources of the Federated States of Micronesia. In order to carry out this policy, the Government of the United States and the Government of the Federated States of Micronesia agree to the following mutual and reciprocal undertakings.

(a) The Government of the United States:

(1) shall continue to apply the environmental controls in effect on November 2, 1986 to those of its continuing activities subject to section 161(a)(2), unless and until those controls are modified under sections 161(a)(3) and 161(a)(4);

(2) shall apply the National Environmental Policy Act of 1969, 83 Stat. 852, 42 U.S.C. 4321 et seq., to its activities under the Compact, as amended, and its related agreements as if the Federated States of Micronesia were the United States;

(3) shall comply also, in the conduct of any activity requiring the preparation of an Environmental Impact Statement under section 161(a)(2), with standards substantively similar to those required by the following laws of the United States, taking into account the particular environment of the Federated States of Micronesia: the Endangered Species Act of 1973, as amended, 87 Stat. 884, 16 U.S.C. 1531 et seq.; the Clean Air Act, as amended, 77 Stat. 392, 42 U.S.C. Supp. 7401 et seq.; the Clean Water Act (Federal Water Pollution Control Act), as amended, 86 Stat. 896, 33 U.S.C. 1251 et seq.; Title I of the Marine Protection, Research and Sanctuaries Act of 1972 (the Ocean Dumping Act), 33 U.S.C. 1411 et seq.; the Toxic Substances Control Act, as amended, 15 U.S.C. 2601 et seq.; the Solid Waste Disposal Act, as amended, 42 U.S.C. 6901 et seq.; and such other environmental protection laws of the United States and of the Federated States of Micronesia, as may be mutually agreed from time to time with the Government of the Federated States of Micronesia; and

(4) shall develop, prior to conducting any activity requiring the preparation of an Environmental Impact Statement under section 161(a)(2), written standards and procedures, as agreed with the Government of the Federated States of Micronesia, to implement the substantive provisions of the laws made applicable to U.S. Government activities in the Federated States of Micronesia, pursuant to section 161(a)(3).

(b) The Government of the Federated States of Micronesia shall continue to develop and implement standards and procedures to protect its environment. As a reciprocal obligation to the undertakings of the Government of the United States under this Article, the Federated States of Micronesia, taking into account its particular environment, shall continue to develop and implement standards for environmental protection substantively similar to those required of the Government of the United States by section 161(a)(3) prior to its conducting activities in the Federated States of Micronesia, substantively equivalent to activities conducted there by the Government of the United States and, as a further reciprocal obligation, shall enforce those standards.

(c) Section 161(a), including any standard or procedure applicable thereunder, and section 161(b) may be modified or superseded in whole or in part by agreement of the Government of the United States and the Government of the Federated States of Micronesia.

(d) In the event that an Environmental Impact Statement is no longer required under the laws of the United States for major Federal actions significantly affecting the quality of the human environment, the regulatory regime established under sections 161(a)(3) and 161(a)(4) shall continue to apply to such activities of the Government of the United States until amended by mutual agreement.

(e) The President of the United States may exempt any of the activities of the Government of the United States under this Compact, as amended, and its related agreements from any environmental standard or procedure which may be applicable under sections 161(a)(3) and 161(a)(4) if the President determines it to be in the paramount interest of the Government of the United States to do so, consistent with Title Three of this Compact, as amended, and the obligations of the Government of the United States under international law. Prior to any decision pursuant to this subsection, the views of the Government of the Federated States of Micronesia shall be sought and considered to the extent practicable. If the President grants such an exemption, to the extent practicable, a report with his reasons for granting such exemption shall be given promptly to the Government of the Federated States of Micronesia.

(f) The laws of the United States referred to in section 161(a)(3) shall apply to the activities of the Government of the United States under this Compact, as amended, and its related agreements only to the extent provided for in this section.

Section 162

The Government of the Federated States of Micronesia may bring an action for judicial review of any administrative agency action or any activity of the Government of the United States pursuant to section 161(a) for enforcement of the obligations of the Government of the United States arising thereunder. The United States District Court for the District of Hawaii and the United States District Court for the District of Columbia shall have jurisdiction over such action or activity, and over actions brought under section 172(b) which relate to the activities of the Government of the United States and its officers and employees, governed by section 161, provided that:

(a) Such actions may only be civil actions for any appropriate civil relief other than punitive damages against the Government of the United States or, where required by law, its officers in their official capacity; no criminal actions may arise under this section.

(b) Actions brought pursuant to this section may be initiated only by the Government of the Federated States of Micronesia.

(c) Administrative agency actions arising under section 161 shall be reviewed pursuant to the standard of judicial review set forth in 5 U.S.C. 706.

(d) The United States District Court for the District of Hawaii and the United States District Court for the District of Columbia shall have jurisdiction to issue all necessary processes, and the Government of the United States agrees to submit itself to the jurisdiction of the court; decisions of the United States District Court shall be reviewable in the United States Court of Appeals for the Ninth Circuit or the United States Court of Appeals for the District of Columbia, respectively, or in the United States Supreme Court as provided by the laws of the United States.

(e) The judicial remedy provided for in this section shall be the exclusive remedy for the judicial review or enforcement of the obligations of the Government of the United States under this Article and actions brought under section 172(b) which relate to the activities of the Government of the United States and its officers and employees governed by section 161.

(f) In actions pursuant to this section, the Government of the Federated States of Micronesia shall be treated as if it were a United States citizen.

Section 163

(a) For the purpose of gathering data necessary to study the environmental effects of activities of the Government of the United States subject to the requirements of this Article, the Government of the Federated States of Micronesia shall be granted access to facilities operated by the Government of the United States in the Federated States of Micronesia, to the extent necessary for this purpose, except to the extent such access would unreasonably interfere with the exercise of the authority and responsibility of the Government of the United States under Title Three.

(b) The Government of the United States, in turn, shall be granted access to the Federated States of Micronesia for the purpose of gathering data necessary to discharge its obligations

under this Article, except to the extent such access would unreasonably interfere with the exercise of the authority and responsibility of the Government of the Federated States of Micronesia under Title One, and to the extent necessary for this purpose shall be granted access to documents and other information to the same extent similar access is provided the Government of the Federated States of Micronesia under the Freedom of Information Act, 5 U.S.C. 552.

(c) The Government of the Federated States of Micronesia shall not impede efforts by the Government of the United States to comply with applicable standards and procedures.

Article VII

General Legal Provisions

Section 171

Except as provided in this Compact, as amended, or its related agreements, the application of the laws of the United States to the Trust Territory of the Pacific Islands by virtue of the Trusteeship Agreement ceased with respect to the Federated States of Micronesia on November 3, 1986, the date the Compact went into effect.

Section 172

(a) Every citizen of the Federated States of Micronesia who is not a resident of the United States shall enjoy the rights and remedies under the laws of the United States enjoyed by any non-resident alien.

(b) The Government of the Federated States of Micronesia and every citizen of the Federated States of Micronesia shall be considered to be a "person" within the meaning of the Freedom of Information Act, 5 U.S.C. 552, and of the judicial review provisions of the Administrative Procedure Act, 5 U.S.C. 701–706, except that only the Government of the Federated States of Micronesia may seek judicial review under the Administrative Procedure Act or judicial enforcement under the Freedom of Information Act when such judicial review or enforcement relates to the activities of the Government of the United States governed by sections 161 and 162.

Section 173

The Governments of the United States and the Federated States of Micronesia agree to adopt and enforce such measures, consistent with this Compact, as amended, and its related agreements, as may be necessary to protect the personnel, property, installations, services, programs and official archives and documents maintained by the Government of the United States in the Federated States of Micronesia pursuant to this Compact, as amended, and its related agreements and by the Government of the Federated States of Micronesia in the United States pursuant to this Compact, as amended, and its related agreements.

Section 174

Except as otherwise provided in this Compact, as amended, and its related agreements:

(a) The Government of the Federated States of Micronesia, and its agencies and officials, shall be immune from the jurisdiction of the court of the United States, and the Government of the United States, and its agencies and officials, shall be immune from the jurisdiction of the courts of the Federated States of Micronesia.

(b) The Government of the United States accepts responsibility for and shall pay:

(1) any unpaid money judgment rendered by the High Court of the Trust Territory of the Pacific Islands against the Government of the United States with regard to any cause of action arising as a result of acts or omissions of the Government of the Trust Territory of the Pacific Islands or the Government of the United States prior to November 3, 1986;

(2) any claim settled by the claimant and the Government of the Trust Territory of the Pacific Islands but not paid as of the November 3, 1986; and

(3) settlement of any administrative claim or of any action before a court of the Trust Territory of the Pacific Islands or the Government of the United States, arising as a result of acts or omissions of the Government of the Trust Territory of the Pacific Islands or the Government of the United States.

(c) Any claim not referred to in section 174(b) and arising from an act or omission of the Government of the Trust Territory of the Pacific Islands or the Government of the United States prior to the effective date of the Compact shall be adjudicated in the same manner as a claim adjudicated according to section 174(d). In any claim against the Government of the Trust Territory of the Pacific Islands, the Government of the United States shall stand in the place of the Government of the Trust Territory of the Pacific Islands. A judgment on any claim referred to in section 174(b) or this subsection, not otherwise satisfied by the Government of the United States, may be presented for certification to the United States Court of Appeals for the Federal Circuit, or its successor courts, which shall have jurisdiction therefore, notwithstanding the provisions of 28 U.S.C. 1502, and which court's decisions shall be reviewable as provided by the laws of the United States. The United States Court of Appeals for the Federal Circuit shall certify such judgment, and order payment thereof, unless it finds, after a hearing, that such judgment is manifestly erroneous as to law or fact, or manifestly excessive. In either of such cases the United States Court of Appeals for the Federal Circuit shall have jurisdiction to modify such judgment.

(d) The Government of the Federated States of Micronesia shall not be immune from the jurisdiction of the courts of the United States, and the Government of the United States shall not be immune from the jurisdiction of the courts of the Federated States of Micronesia in any civil case in which an exception to foreign state immunity is set forth in the Foreign Sovereign Immunities Act (28 U.S.C. 1602 et seq.) or its successor statutes.

Section 175

(a) A separate agreement, which shall come into effect simultaneously with this Compact, as amended, and shall have the force of law, shall govern mutual assistance and cooperation in law enforcement matters, including the pursuit, capture, imprisonment and extradition of fugitives from justice and the transfer of prisoners, as well as other law enforcement matters. In the United States, the laws of the United States governing international extradition, including 18 U.S.C. 3184, 3186 and 3188–95, shall be applicable to the extradition of fugitives under the separate agreement, and the laws of the United States governing the transfer of prisoners, including 18 U.S.C. 4100–15, shall be applicable to the transfer of prisoners under the separate agreement; and

(b) A separate agreement, which shall come into effect simultaneously with this Compact, as amended, and shall have the force of law, shall govern requirements relating to labor recruitment practices, including registration, reporting, suspension or revocation of authorization to recruit persons for employment in the United States, and enforcement for violations of such requirements.

Section 176

The Government of the Federated States of Micronesia confirms that final judgments in civil cases rendered by any court of the Trust Territory of the Pacific Islands shall continue in full force and effect, subject to the constitutional power of the courts of the Federated States of Micronesia to grant relief from judgments in appropriate cases.

Section 177

Section 177 of the Compact entered into force with respect to the Federated States of Micronesia on November 3, 1986 as follows:

"(a) The Government of the United States accepts the responsibility for compensation owing to citizens of the Marshall Islands, or the Federated States of Micronesia, or Palau for loss or damage to property and person of the citizens of the Marshall Islands, or the Federated States of Micronesia, resulting from the nuclear testing program which the Government of the United States conducted in the Northern Marshall Islands between June 30, 1946, and August 18, 1958.

"(b) The Government of the United States and the Government of the Marshall Islands shall set forth in a separate agreement provisions for the just and adequate settlement of all such claims which have arisen in regard to the Marshall Islands and its citizens and which have not as yet been compensated or which in the future may arise, for the continued administration by the Government of the United States of direct radiation related medical surveillance and treatment programs and radiological monitoring activities and for such additional programs and activities as may be mutually agreed, and for the assumption by the Government of the Marshall Islands of responsibility for enforcement of limitations on the utilization of affected areas developed in cooperation with the Government of the United States and for the assistance by the Government of the United States in the exercise of such responsibility as may be mutually agreed. This separate agreement shall come into effect simultaneously with this Compact and shall remain in effect in accordance with its own terms.

"(c) The Government of the United States shall provide to the Government of the Marshall Islands, on a grant basis, the amount of $150 million to be paid and distributed in accordance with the separate agreement referred to in this Section, and shall provide the services and programs set forth in this separate agreement, the language of which is incorporated into this Compact."

The Compact, as amended, makes no changes to, and has no effect upon, Section 177 of the Compact, nor does the Compact, as amended, change or affect the separate agreement referred to in Section 177 of the Compact including Articles IX and X of that separate agreement, and measures taken by the parties thereunder.

Section 178

(a) The Federal agencies of the Government of the United States that provide the services and related programs in the Federated States of Micronesia pursuant to Title Two are authorized to settle and pay tort claims arising in the Federated States of Micronesia from the activities of such agencies or from the acts or omissions of the employees of such agencies. Except as provided in section 178(b), the provisions of 28 U.S.C. 2672 and 31 U.S.C. 1304 shall apply exclusively to such administrative settlements and payments.

(b) Claims under section 178(a) that cannot be settled under section 178(a) shall be disposed of exclusively in accordance with Article II of Title Four. Arbitration awards rendered pursuant to this subsection shall be paid out of funds under 31 U.S.C. 1304.

(c) The Government of the United States and the Government of the Federated States of Micronesia shall, in the separate agreement referred to in section 231, provide for:

(1) the administrative settlement of claims referred to in section 178(a), including designation of local agents in each State of the Federated States of Micronesia; such agents to be empowered to accept, investigate and settle such claims, in a timely manner, as provided in such separate agreements; and

(2) arbitration, referred to in section 178(b), in a timely manner, at a site convenient to the claimant, in the event a claim is not otherwise settled pursuant to section 178(a).

(d) The provisions of section 174(d) shall not apply to claims covered by this section.

(e) Except as otherwise explicitly provided by law of the United States, neither the Government of the United States, its instrumentalities, nor any person acting on behalf of the Government of the United States, shall be named a party in any action based on, or arising out of, the activity or activities of a recipient of any grant or other assistance provided by the Government of the United States (or the activity or activities of the recipient's agency or any other person or entity acting on behalf of the recipient).

Section 179

(a) The courts of the Federated States of Micronesia shall not exercise criminal jurisdiction over the Government of the United States, or its instrumentalities.

(b) The courts of the Federated States of Micronesia shall not exercise criminal jurisdiction over any person if the Government of the United States provides notification to the Government of the Federated States of Micronesia that such person was acting on behalf of the Government of the United States, for actions taken in furtherance of section 221 or 224 of this amended Compact, or any other provision of law authorizing financial, program, or service assistance to the Federated States of Micronesia.

TITLE TWO

ECONOMIC RELATIONS

Article I

Grant Assistance

Section 211 - Sector Grants

(a) In order to assist the Government of the Federated States of Micronesia in its efforts to promote the economic advancement, budgetary self-reliance, and economic self-sufficiency of its people, and in recognition of the special relationship that exists between the Federated States of Micronesia and the United States, the Government of the United States shall provide assistance on a sector grant basis for a period of twenty years in the amounts set forth in section 216, commencing on the effective date of this Compact, as amended. Such grants shall be used for assistance in the sectors of education, health care, private sector development, the environment, public sector capacity building, and public infrastructure, or for other sectors as mutually agreed, with priorities in the education and health care sectors. For each year such sector grant assistance is made available, the proposed division of this amount among these sectors shall be certified to the Government of the United States by the Government of the Federated States of Micronesia and shall be subject to the concurrence of the Government of the United States. In such case, the Government of the United States shall disburse the agreed upon amounts and monitor the use of such sector grants in accordance with the provisions of this Article and the Agreement Concerning Procedures for the Implementation of United States Economic Assistance Provided in the Compact, as Amended, of Free Association Between the Government of the United States of America and the Government of the Federated States of Micronesia ("Fiscal Procedures Agreement") which shall come into effect simultaneously with this Compact, as amended. The provision of any United States assistance under the Compact, as amended, the Fiscal Procedures Agreement, the Trust Fund Agreement, or any other subsidiary agreement to the Compact, as amended, shall constitute "a particular distribution . . . required by the terms or special nature of the assistance" for purposes of Article XII, section 1(b) of the Constitution of the Federated States of Micronesia.

(1) EDUCATION.—United States grant assistance shall be made available in accordance with the plan described in subsection (c) of this section to support and improve the educational system of the Federated States of Micronesia and develop the human, financial, and material resources necessary for the Government of the Federated States of Micronesia to perform these services. Emphasis should be placed on advancing a quality basic education system.

(2) HEALTH.—United States grant assistance shall be made available in accordance with the plan described in subsection (c) of this section to support and improve the delivery of preventive, curative and environmental care and develop the human, financial, and material resources necessary for the Government of the Federated States of Micronesia to perform these services.

(3) PRIVATE SECTOR DEVELOPMENT.—United States grant assistance shall be made available in accordance with the plan described in subsection (c) of this section to support the efforts of the Government of the Federated States of Micronesia to attract foreign investment and increase indigenous business activity by vitalizing the commercial environment, ensuring fair and equitable application of the law, promoting adherence to core labor standards, and maintaining progress toward privatization of state-owned and partially state-owned enterprises, and engaging in other reforms.

(4) CAPACITY BUILDING IN THE PUBLIC SECTOR.—United States grant assistance shall be made available in accordance with the plan described in subsection (c) of this section to support the efforts of the Government of the Federated States of Micronesia to build effective, accountable and transparent national, state, and local government and other public sector institutions and systems.

(5) ENVIRONMENT.—United States grant assistance shall be made available in accordance with the plan described in subsection (c) of this section to increase environmental protection; conserve and achieve sustainable use of natural resources; and engage in environmental infrastructure planning, design construction and operation.

(6) PUBLIC INFRASTRUCTURE.—

(i) U.S. annual grant assistance shall be made available in accordance with a list of specific projects included in the plan described in subsection (c) of this section to assist the Government of the Federated States of Micronesia in its efforts to provide adequate public infrastructure.

(ii) INFRASTRUCTURE AND MAINTENANCE FUND.—Five percent of the annual public infrastructure grant made available under paragraph (i) of this subsection shall be set aside, with an equal contribution from the Government of the Federated States of Micronesia, as a contribution to an Infrastructure Maintenance Fund (IMF). Administration of the Infrastructure Maintenance Fund shall be governed by the Fiscal Procedures Agreement.

(b) HUMANITARIAN ASSISTANCE.—Federated States of Micronesia Program. In recognition of the special development needs of the Federated States of Micronesia, the Government of the United States shall make available to the Government of the Federated States of Micronesia, on its request and to be deducted from the grant amount made available under subsection (a) of this section, a Humanitarian Assistance - Federated States of Micronesia ("HAFSM") Program with emphasis on health, education, and infrastructure (including transportation), projects. The terms and conditions of the HAFSM shall be set forth in the Agreement Regarding the Military Use and Operating Rights of the Government of the United States in the Government of the Federated States of Micronesia Concluded Pursuant to Sections 321 and 323 of the Compact of Free Association, as Amended which shall come into effect simultaneously with the amendments to this Compact.

(c) DEVELOPMENT PLAN.—The Government of the Federated States of Micronesia shall prepare and maintain an official overall development plan. The plan shall be strategic in nature, shall be continuously reviewed and updated through the annual budget process, and shall make projections on a multi-year rolling basis. Each of the sectors named in subsection (a) of this section, or other sectors as mutually agreed, shall be accorded specific treatment in the plan. Insofar as grants funds are involved, the plan shall be subject to the concurrence of the Government of the United States.

(d) DISASTER ASSISTANCE EMERGENCY FUND.—An amount of two hundred thousand dollars ($200,000) shall be provided annually, with an equal contribution from the Government of the Federated States of Micronesia, as a contribution to a "Disaster Assistance Emergency Fund (DAEF)." Any funds from the DAEF may be used only for assistance and rehabilitation resulting from disasters and emergencies. The funds will be accessed upon declaration by the Government of the Federated States of Micronesia, with the concurrence of the United States Chief of Mission to the Federated States of Micronesia. The Administration of the DAEF shall be governed by the Fiscal Procedures Agreement.

Section 212 - Accountability

(a) Regulations and policies normally applicable to United States financial assistance to its state and local governments, as reflected in the Fiscal Procedures Agreement, shall apply to each sector grant described in section 211, and to grants administered under section 221 below, except as modified in the separate agreements referred to in section 231 of this Compact, as amended, or by United States law. The Government of the United States, after annual consultations with the Federated States of Micronesia, may attach reasonable terms and conditions, including annual performance indicators that are necessary to ensure effective use of United States assistance and reasonable progress toward achieving program objectives. The Government of the United States may seek appropriate remedies for noncompliance with the terms and conditions attached to the assistance, or for failure to comply with section 234, including withholding assistance.

(b) The Government of the United States shall, for each fiscal year of the twenty years during which assistance is to be provided on a sector grant basis under section 211, grant the Government of the Federated States of Micronesia an amount equal to the lesser of (i) one half of the reasonable, properly documented cost incurred during each fiscal year to conduct the annual audit required under Article VIII (2) of the Fiscal Procedures Agreement or (ii) $500,000. Such amount will not be adjusted for inflation under section 217 or otherwise.

Section 213—Joint Economic Management Committee

The Governments of the United States and the Federated States of Micronesia shall establish a Joint Economic Management Committee, composed of a U.S. chair, two other members from the Government of the United States and two members from the Government of the Federated States of Micronesia. The Joint Economic Management Committee shall meet at least once each year to review the audits and reports required under this Title, evaluate the progress made by the Federated States of Micronesia in meeting the objectives identified in its plan described in subsection (c) of section 211, with particular focus on those parts of the plan dealing with the sectors identified in subsection (a) of section 211, identify problems encountered, and recommend ways to increase the effectiveness of U.S. assistance made available under this Title. The establishment and operations of the Joint Economic Management Committee shall be governed by the Fiscal Procedures Agreement.

Section 214 - Annual Report

The Government of the Federated States of Micronesia shall report annually to the President of the United States on the use of United States sector grant assistance and other assistance and progress in meeting mutually agreed program and economic goals. The Joint Economic Management Committee shall review and comment on the report and make appropriate recommendations based thereon.

Section 215 - Trust Fund

(a) The United States shall contribute annually for twenty years from the effective date of this Compact, as amended, in the amounts set forth in section 216 into a Trust Fund established in accordance with the Agreement Between the Government of the United States of America and the Government of the Federated States of Micronesia Implementing Section 215 and Section 216 of the Compact, as Amended, Regarding a Trust Fund ("Trust Fund Agreement"). Upon termination of the annual financial assistance under section 211, the proceeds of the fund shall thereafter be used for the purposes described in section 211 or as otherwise mutually agreed.

(b) The United States contribution into the Trust Fund described in subsection(a) of this section is conditioned on the Government of the Federated States of Micronesia contributing to the Trust Fund at least $30 million, prior to September 30, 2004. Any funds received by the Federated States of Micronesia under section 111 (d) of Public Law 99–239 (January 14, 1986), or successor provisions, would be contributed to the Trust Fund as a Federated States of Micronesia contribution.

(c) The terms regarding the investment and management of funds and use of the income of the Trust Fund shall be set forth in the separate Trust Fund Agreement described in subsection (a) of this section. Funds derived from United States investment shall not be subject to Federal or state taxes in the United States or the Federated States of Micronesia. The Trust Fund Agreement shall also provide for annual reports to the Government of the United States and to the Government of the Federated States of Micronesia. The Trust Fund Agreement shall provide for appropriate distributions of trust fund proceeds to the Federated States of Micronesia and for appropriate remedies for the failure of the Federated States of Micronesia to use income of the Trust Fund for the annual grant purposes set forth in section 211. These remedies may include the return to the United States of the present market value of its contributions to the Trust Fund and the present market value of any undistributed income on the contributions of the United States. If this Compact, as amended, is terminated, the provisions of sections 451 through 453 of this Compact, as amended, shall govern treatment of any U.S. contributions to the Trust Fund or accrued interest thereon.

Section 216 - Sector Grant Funding and Trust Fund Contributions

The funds described in sections 211, 212(b) and 215 shall be made available as follows:

[In millions of dollars]

Fiscal year	Annual Grants Section 211	Audit Grant Section 212(b) (amount up to)	Trust Fund Section 215	Total
2004	76.2	.5	16	92.7
2005	76.2	.5	16	92.7
2006	76.2	.5	16	92.7
2007	75.4	.5	16.8	92.7
2008	74.6	.5	17.6	92.7
2009	73.8	.5	18.4	92.7
2010	73	.5	19.2	92.7
2011	72.2	.5	20	92.7
2012	71.4	.5	20.8	92.7
2013	70.6	.5	21.6	92.7
2014	69.8	.5	22.4	92.7
2015	69	.5	23.2	92.7
2016	68.2	.5	24	92.7
2017	67.4	.5	24.8	92.7
2018	66.6	.5	25.6	92.7
2019	65.8	.5	26.4	92.7
2020	65	.5	27.2	92.7
2021	64.2	.5	28	92.7
2022	63.4	.5	28.8	92.7
2023	62.6	.5	29.6	92.7

Section 217 - Inflation Adjustment

Except for the amounts provided for audits under section 212(b), the amounts stated in this Title shall be adjusted for each United States Fiscal Year by the percent that equals two-thirds of the percent change in the United States Gross Domestic Product Implicit Price Deflator, or 5 percent, whichever is less in any one year, using the beginning of Fiscal Year 2004 as a base.

Section 218 - Carry-Over of Unused Funds

If in any year the funds made available by the Government of the United States for that year pursuant to this Article are not completely obligated by the Government of the Federated States of Micronesia, the unobligated balances shall remain available in addition to the funds to be provided in subsequent years.

Article II

Services and Program Assistance

Section 221

(a) SERVICES.—The Government of the United States shall make available to the Federated States of Micronesia, in accordance with and to the extent provided in the Federal Programs and Services Agreement referred to in section 231, the services and related programs of:

(1) the United States Weather Service;

(2) the United States Postal Service;

(3) the United States Federal Aviation Administration;

(4) the United States Department of Transportation;

(5) the Federal Deposit Insurance Corporation (for the benefit only of the Bank of the Federated States of Micronesia), and

(6) the Department of Homeland Security, and the United States Agency for International Development, Office of Foreign Disaster Assistance.

Upon the effective date of this Compact, as amended, the United States Departments and Agencies named or having responsibility to provide these services and related programs shall have the authority to implement the relevant provisions of the Federal Programs and Services Agreement referred to in section 231.

(b) PROGRAMS.—

(1) With the exception of the services and programs covered by subsection (a) of this section, and unless the Congress of the United States provides otherwise, the Government of the United States shall make available to the Federated States of Micronesia the services and programs that were available to the Federated States of Micronesia on the effective date of this Compact, as amended, to the extent that such services and programs continue to be available to State and local governments of the United States. As set forth in the Fiscal Procedures Agreement, funds provided under subsection (a) of section 211 will be considered to be local revenues of the Government of the Federated States of Micronesia when used as the local share required to obtain Federal programs and services.

(2) Unless provided otherwise by U.S. law, the services and programs described in paragraph (1) of this subsection shall be extended in accordance with the terms of the Federal Programs and Services Agreement referred to in section 231.

(c) The Government of the United States shall have and exercise such authority as is necessary to carry out its responsibilities under this Title and the separate agreements referred to in amended section 231, including the authority to monitor and administer all service and program assistance provided by the United States to the Federated States of Micronesia. The Federal Programs and Services Agreement referred to in amended section 231 shall also set forth the extent to which services and programs shall be provided to the Federated States of Micronesia.

(d) Except as provided elsewhere in this Compact, as amended, under any separate agreement entered into under this Compact, as amended, or otherwise under U.S. law, all Federal domestic programs extended to or operating in the Federated States of Micronesia shall be subject to all applicable criteria, standards, reporting requirements, auditing procedures, and other rules and regulations applicable to such programs and services when operating in the United States.

(e) The Government of the United States shall make available to the Federated States of Micronesia alternate energy development projects, studies, and conservation measures to the extent provided for the Freely Associated States in the laws of the United States.

Section 222

The Government of the United States and the Government of the Federated States of Micronesia may agree from time to time to extend to the Federated States of Micronesia additional United States grant assistance, services and programs, as provided under the laws of the United States. Unless inconsistent with such laws, or otherwise specifically precluded by the Government of the United States at the time such additional grant assistance, services, or programs are extended, the Federal Programs and Services Agreement referred to section 231 shall apply to any such assistance, services or programs.

Section 223

The Government of the Federated States of Micronesia shall make available to the Government of the United States at no cost such land as may be necessary for the operations of the services and programs provided pursuant to this Article, and such facilities as are provided by the Government of the Federated States of Micronesia at no cost to the Government of the United States as of the effective date of this Compact, as amended, or as may be mutually agreed thereafter.

Section 224

The Government of the Federated States of Micronesia may request, from time to time, technical assistance from the Federal agencies and institutions of the Government of the United States, which are authorized to grant such technical assistance in accordance with its laws. If technical assistance is granted pursuant to such a request, the Government of the United States shall provide the technical assistance in a manner which gives priority consideration to the Federated States of Micronesia over other recipients not a part of the United States, its territories or possessions, and equivalent consideration to the Federated States of Micronesia with respect to other states in Free Association with the United States. Such assistance shall be made available on a reimbursable or non-reimbursable basis to the extent provided by United States law.

Article III

Administrative Provisions

Section 231

The specific nature, extent and contractual arrangements of the services and programs provided for in section 221 of this Compact, as amended, as well as the legal status of agencies of the Government of the United States, their civilian employees and contractors, and the dependents of such personnel while present in the Federated States of Micronesia, and other arrangements in connection with the assistance, services, or programs furnished by the Government of the United States, are set forth in a Federal Programs and Services Agreement which shall come into effect simultaneously with this Compact, as amended.

Section 232

The Government of the United States, in consultation with the Government of the Federated States of Micronesia, shall determine and implement procedures for the periodic audit of all grants and other assistance made under Article I of this Title and of all funds expended for the services and programs provided under Article II of this Title. Further, in accordance with the Fiscal Procedures Agreement described in subsection (a) of section 211, the Comptroller General of the United States shall have such powers and authorities as described in sections 102 (c) and 110 (c) of Public Law 99–239, 99 Stat. 1777–78, and 99 Stat. 1799 (January 14, 1986).

Section 233

Approval of this Compact, as amended, by the Government of the United States, in accordance with its constitutional processes, shall constitute a pledge by the United States that the sums and amounts specified as sector grants in section 211 of this Compact, as amended, shall be appropriated and paid to the Federated States of Micronesia for such period as those provisions of this Compact, as amended, remain in force, subject to the terms and conditions of this Title and related subsidiary agreements.

Section 234

The Government of the Federated States of Micronesia pledges to cooperate with, permit, and assist if reasonably requested, designated and authorized representatives of the Government of the United States charged with investigating whether Compact funds, or any other assistance authorized under this Compact, as amended, have, or are being, used for purposes other than those set forth in this Compact, as amended, or its subsidiary agreements. In carrying out this investigative authority, such United States Government representatives may request that the Government of the Federated States of Micronesia subpoena documents and records and compel testimony in accordance with the laws and Constitution of the Federated States of Micronesia. Such assistance by the Government of the Federated States of Micronesia to the Government of the United States shall not be unreasonably withheld. The obligation of the Government of the Federated States of Micronesia to fulfill its pledge herein is a condition to its receiving payment of such funds or other assistance authorized under this Compact, as amended. The Government of the United States shall pay any reasonable costs for extraordinary services executed by the Government of the Federated States of Micronesia in carrying out the provisions of this section.

Article IV

Trade

Section 241

The Federated States of Micronesia is not included in the customs territory of the United States.

Section 242

The President shall proclaim the following tariff treatment for articles imported from the Federated States of Micronesia which shall apply during the period of effectiveness of this title:

(a) Unless otherwise excluded, articles imported from the Federated States of Micronesia, subject to the limitations imposed under section 503(b) of title V of the Trade Act of 1974 (19 U.S.C. 2463(b)), shall be exempt from duty.

(b) Only tuna in airtight containers provided for in heading 1604.14.22 of the Harmonized Tariff Schedule of the United States that is imported from the Federated States of Micronesia and the Republic of the Marshall Islands during any calendar year not to exceed 10 percent of apparent United States consumption of tuna in airtight containers during the immediately preceding calendar year, as reported by the National Marine Fisheries Service, shall be exempt from duty; but the quantity of tuna given duty-free treatment under this paragraph for any calendar year shall be counted against the aggregated quantity of tuna in airtight containers that is dutiable under rate column numbered 1 of such heading 1604.14.22 for that calendar year.

(c) The duty-free treatment provided under subsection (a) shall not apply to—

(1) watches, clocks, and timing apparatus provided for in Chapter 91, excluding heading 9113, of the Harmonized Tariff Schedule of the United States;

(2) buttons (whether finished or not finished) provided for in items 9606.21.40 and 9606.29.20 of such Schedule;

(3) textile and apparel articles which are subject to textile agreements; and

(4) footwear, handbags, luggage, flat goods, work gloves, and leather wearing apparel which were not eligible articles for purposes of title V of the Trade Act of 1974 (19 U.S.C. 2461, et seq.) on April 1, 1984.

(d) If the cost or value of materials produced in the customs territory of the United States is included with respect to an eligible article which is a product of the Federated States of Micronesia, an amount not to exceed 15 percent of the appraised value of the article at the time it is entered that is attributable to such United States cost or value may be applied for duty assessment purposes toward determining the percentage referred to in section 503(a)(2) of title V of the Trade Act of 1974.

Section 243

Articles imported from the Federated States of Micronesia which are not exempt from duty under subsections (a), (b), (c), and (d) of section 242 shall be subject to the rates of duty set forth in column numbered 1-general of the Harmonized Tariff Schedule of the United States (HTSUS).

Section 244

(a) All products of the United States imported into the Federated States of Micronesia shall receive treatment no less favorable than that accorded like products of any foreign country with respect to customs duties or charges of a similar nature and with respect to laws and regulations relating to importation, exportation, taxation, sale, distribution, storage or use.

(b) The provisions of subsection (a) shall not apply to advantages accorded by the Federated States of Micronesia by virtue of their full membership in the Pacific Island Countries Trade Agreement (PICTA), done on August 18, 2001, to those governments listed in Article 26 of PICTA, as of the date the Compact, as amended, is signed.

(c) Prior to entering into consultations on, or concluding, a free trade agreement with governments not listed in Article 26 of PICTA, the Federated States of Micronesia shall consult with the United States regarding whether or how subsection (a) of section 244 shall be applied.

Article V

Finance and Taxation

Section 251

The currency of the United States is the official circulating legal tender of the Federated States of Micronesia. Should the Government of the Federated States of Micronesia act to institute another currency, the terms of an appropriate currency transitional period shall be as agreed with the Government of the United States.

Section 252

The Government of the Federated States of Micronesia may, with respect to United States persons, tax income derived from sources within its respective jurisdiction, property situated therein, including transfers of such property by gift or at death, and products consumed therein, in such manner as the Government of the Federated States of Micronesia deems appropriate. The determination of the source of any income, or the situs of any property, shall for purposes of this Compact be made according to the United States Internal Revenue Code.

Section 253

A citizen of the Federated States of Micronesia, domiciled therein, shall be exempt from estate, gift, and generation-skipping transfer taxes imposed by the Government of the United States, provided that such citizen of the Federated States of Micronesia is neither a citizen nor a resident of the United States.

Section 254

(a) In determining any income tax imposed by the Government of the Federated States of Micronesia, the Government of the Federated

States of Micronesia shall have authority to impose tax upon income derived by a resident of the Federated States of Micronesia from sources without the Federated States of Micronesia, in the same manner and to the same extent as the Government of the Federated States of Micronesia imposes tax upon income derived from within its own jurisdiction. If the Government of the Federated States of Micronesia exercises such authority as provided in this subsection, any individual resident of the Federated States of Micronesia who is subject to tax by the Government of the United States on income which is also taxed by the Government of the Federated States of Micronesia shall be relieved of liability to the Government of the United States for the tax which, but for this subsection, would otherwise be imposed by the Government of the United States on such income. However, the relief from liability to the United States Government referred to in the preceding sentence means only relief in the form of the foreign tax credit (or deduction in lieu thereof) available with respect to the income taxes of a possession of the United States, and relief in the form of the exclusion under section 911 of the Internal Revenue Code of 1986. For purposes of this section, the term "resident of the Federated States of Micronesia" shall be deemed to include any person who was physically present in the Federated States of Micronesia for a period of 183 or more days during any taxable year.

(b) If the Government of the Federated States of Micronesia subjects income to taxation substantially similar to that imposed by the Trust Territory Code in effect on January 1, 1980, such Government shall be deemed to have exercised the authority described in section 254(a).

Section 255

For purposes of section 274(h)(3)(A) of the United States Internal Revenue Code of 1986, the term "North American Area" shall include the Federated States of Micronesia.

TITLE THREE

SECURITY AND DEFENSE RELATIONS

Article I

Authority and Responsibility

Section 311

(a) The Government of the United States has full authority and responsibility for security and defense matters in or relating to the Federated States of Micronesia.

(b) This authority and responsibility includes:

(1) the obligation to defend the Federated States of Micronesia and its people from attack or threats thereof as the United States and its citizens are defended;

(2) the option to foreclose access to or use of the Federated States of Micronesia by military personnel or for the military purposes of any third country; and

(3) the option to establish and use military areas and facilities in the Federated States of Micronesia, subject to the terms of the separate agreements referred to in sections 321 and 323.

(c) The Government of the United States confirms that it shall act in accordance with the principles of international law and the Charter of the United Nations in the exercise of this authority and responsibility.

Section 312

Subject to the terms of any agreements negotiated in accordance with sections 321 and 323, the Government of the United States may conduct within the lands, waters and airspace of the Federated States of Micronesia the activities and operations necessary for the exercise of its authority and responsibility under this Title.

Section 313

(a) The Government of the Federated States of Micronesia shall refrain from actions that the Government of the United States determines, after appropriate consultation with that Government, to be incompatible with its authority and responsibility for security and defense matters in or relating to the Federated States of Micronesia.

(b) The consultations referred to in this section shall be conducted expeditiously at senior levels of the two Governments, and the subsequent determination by the Government of the United States referred to in this section shall be made only at senior interagency levels of the Government of the United States.

(c) The Government of the Federated States of Micronesia shall be afforded, on an expeditious basis, an opportunity to raise its concerns with the United States Secretary of State personally and the United States Secretary of Defense personally regarding any determination made in accordance with this section.

Section 314

(a) Unless otherwise agreed, the Government of the United States shall not, in the Federated States of Micronesia:

(1) test by detonation or dispose of any nuclear weapon, nor test, dispose of, or discharge any toxic chemical or biological weapon; or

(2) test, dispose of, or discharge any other radioactive, toxic chemical or biological materials in an amount or manner which would be hazardous to public health or safety.

(b) Unless otherwise agreed, other than for transit or overflight purposes or during time of a national emergency declared by the President of the United States, a state of war declared by the Congress of the United States or as necessary to defend against an actual or impending armed attack on the United States, the Federated States of Micronesia or the Republic of the Marshall Islands, the Government of the United States shall not store in the Federated States of Micronesia or the Republic of the Marshall Islands any toxic chemical weapon, nor any radioactive materials nor any toxic chemical materials intended for weapons use.

(c) Radioactive, toxic chemical, or biological materials not intended for weapons use shall not be affected by section 314(b).

(d) No material or substance referred to in this section shall be stored in the Federated States of Micronesia except in an amount and manner which would not be hazardous to public health or safety. In determining what shall be an amount or manner which would be hazardous to public health or safety under this section, the Government of the United States shall comply with any applicable mutual agreement, international guidelines accepted by the Government of the United States, and the laws of the United States and their implementing regulations.

(e) Any exercise of the exemption authority set forth in section 161(e) shall have no effect on the obligations of the Government of the United States under this section or on the application of this subsection.

(f) The provisions of this section shall apply in the areas in which the Government of the Federated States of Micronesia exercises jurisdiction over the living resources of the seabed, subsoil or water column adjacent to its coasts.

Section 315

The Government of the United States may invite members of the armed forces of other countries to use military areas and facilities in the Federated States of Micronesia, in conjunction with and under the control of United States Armed Forces. Use by units of the armed forces of other countries of such military areas and facilities, other than for transit and overflight purposes, shall be subject to consultation with and, in the case of major units, approval of the Government of the Federated States of Micronesia.

Section 316

The authority and responsibility of the Government of the United States under this Title may not be transferred or otherwise assigned.

Article II

Defense Facilities and Operating Rights

Section 321

(a) Specific arrangements for the establishment and use by the Government of the United States of military areas and facilities in the Federated States of Micronesia are set forth in separate agreements, which shall remain in effect in accordance with the terms of such agreements.

(b) If, in the exercise of its authority and responsibility under this Title, the Government of the United States requires the use of areas within the Federated States of Micronesia in addition to those for which specific arrangements are concluded pursuant to section 321(a), it may request the Government of the Federated States of Micronesia to satisfy those requirements through leases or other arrangements. The Government of the Federated States of Micronesia shall sympathetically consider any such request and shall establish suitable procedures to discuss it with and provide a prompt response to the Government of the United States.

(c) The Government of the United States recognizes and respects the scarcity and special importance of land in the Federated States of Micronesia. In making any requests pursuant to section 321(b), the Government of the United States shall follow the policy of requesting the minimum area necessary to accomplish the required security and defense purpose, of requesting only the minimum interest in real property necessary to support such purpose, and of requesting first to satisfy its requirement through public real property, where available, rather than through private real property.

Section 322

The Government of the United States shall provide and maintain fixed and floating aids to navigation in the Federated States of Micronesia at least to the extent necessary for the exercise of its authority and responsibility under this Title.

Section 323

The military operating rights of the Government of the United States and the legal status and contractual arrangements of the United States Armed Forces, their members, and associated civilians, while present in the Federated States of Micronesia are set forth in separate agreements, which shall remain in effect in accordance with the terms of such agreements.

Article III

Defense Treaties and International Security Agreements

Section 331

Subject to the terms of this Compact, as amended, and its related agreements, the Government of the United States, exclusively, has assumed and enjoys, as to the Federated States of Micronesia, all obligations, responsibilities, rights and benefits of:

(a) Any defense treaty or other international security agreement applied by the Government of the United States as Administering Authority of the Trust Territory of the Pacific Islands as of November 2, 1986.

(b) Any defense treaty or other international security agreement to which the Government of the United States is or may become a party which it determines to be applicable in the Federated States of Micronesia. Such a determination by the Government of the United States shall be preceded by appropriate consultation with the Government of the Federated States of Micronesia.

Article IV

Service in Armed Forces of the United States

Section 341

Any person entitled to the privileges set forth in Section 141 (with the exception of any person described in section 141(a)(5) who is not a citizen of the Federated States of Micronesia) shall be eligible to volunteer for service in the Armed Forces of the United States, but shall not be subject to involuntary induction into military service of the United States as long as such person has resided in the United States for a period of less than one year, provided that no time shall count towards this one year while a person admitted to the United States under the Compact, or the Compact, as amended, is engaged in full-time study in the United States. Any person described in section 141(a)(5) who is not a citizen of the Federated States of Micronesia shall be subject to United States laws relating to selective service.

Section 342

The Government of the United States shall have enrolled, at any one time, at least one qualified student from the Federated States of Micronesia, as may be nominated by the Government of the Federated States of Micronesia, in each of:

(a) The United States Coast Guard Academy pursuant to 14 U.S.C. 195.

(b) The United States Merchant Marine Academy pursuant to 46 U.S.C. 1295(b)(6), provided that the provisions of 46 U.S.C. 1295b(b)(6)(C) shall not apply to the enrollment of students pursuant to section 342(b) of this Compact, as amended.

Article V

General Provisions

Section 351

(a) The Government of the United States and the Government of the Federated States of Micronesia shall continue to maintain a Joint Committee empowered to consider disputes arising under the implementation of this Title and its related agreements.

(b) The membership of the Joint Committee shall comprise selected senior officials of the two Governments. The senior United States military commander in the Pacific area shall be the senior United States member of the Joint Committee. For the meetings of the Joint Committee, each of the two Governments may designate additional or alternate representatives as appropriate for the subject matter under consideration.

(c) Unless otherwise mutually agreed, the Joint Committee shall meet annually at a time and place to be designated, after appropriate consultation, by the Government of the United States. The Joint Committee also shall meet promptly upon request of either of its members. The Joint Committee shall follow such procedures, including the establishment of functional subcommittees, as the members may from time to time agree. Upon notification by the Government of the United States, the Joint Committee of the United States and the Federated States of Micronesia shall meet promptly in a combined session with the Joint Committee established and maintained by the Government of the United States and the Republic of the Marshall Islands to consider matters within the jurisdiction of the two Joint Committees.

(d) Unresolved issues in the Joint Committee shall be referred to the Governments for resolution, and the Government of the Federated States of Micronesia shall be afforded, on an expeditious basis, an opportunity to raise its concerns with the United States Secretary of Defense personally regarding any unresolved issue which threatens its continued association with the Government of the United States.

Section 352

In the exercise of its authority and responsibility under Title Three, the Government of the United States shall accord due respect to the authority and responsibility of the Government of the Federated States of Micronesia under Titles One, Two and Four and to the responsibility of the Government of the Federated States of Micronesia to assure the well-being of its people.

Section 353

(a) The Government of the United States shall not include the Government of the Federated States of Micronesia as a named party to a formal declaration of war, without that Government's consent.

(b) Absent such consent, this Compact, as amended, is without prejudice, on the ground of belligerence or the existence of a state of war, to any claims for damages which are advanced by the citizens, nationals or Government of the Federated States of Micronesia, which arise out of armed conflict subsequent to November 3, 1986, and which are:

(1) petitions to the Government of the United States for redress; or

(2) claims in any manner against the government, citizens, nationals or entities of any third country.

(c) Petitions under section 353(b)(1) shall be treated as if they were made by citizens of the United States.

Section 354

(a) The Government of the United States and the Government of the Federated States of Micronesia are jointly committed to continue their security and defense relations, as set forth in this Title. Accordingly, it is the intention of the two countries that the provisions of this Title shall remain binding as long as this Compact, as amended, remains in effect, and thereafter as mutually agreed, unless earlier terminated by mutual agreement pursuant to section 441, or amended pursuant to Article III of Title Four. If at any time the Government of the United States, or the Government of the Federated States of Micronesia, acting unilaterally, terminates this Title, such unilateral termination shall be considered to be termination of the entire Compact, in which case the provisions of section 442 and 452 (in the case of termination by the Government of the United States) or sections 443 and 453 (in the case of termination by the Government of the Federated States of Micronesia), with the exception of paragraph (3) of subsection (a) of section 452 or paragraph (3) of subsection (a) of section 453, as the case may be, shall apply.

(b) The Government of the United States recognizes, in view of the special relationship between the Government of the United States and the Government of the Federated States of Micronesia, and in view of the existence of the separate agreement regarding mutual security concluded with the Government of the Federated States of Micronesia pursuant to sections 321 and 323, that, even if this Title should terminate, any attack on the Federated States of Micronesia during the period in which such separate agreement is in effect, would constitute a threat to the peace and security of the entire region and a danger to the United States. In the event of such an attack, the Government of the United States would take action to meet the danger to the United States and to the Federated States of Micronesia in accordance with its constitutional processes.

(c) As reflected in Article 21(1)(b) of the Trust Fund Agreement, the Government of the United States and the Government of the Federated States of Micronesia further recognize, in view of the special relationship between their countries, that even if this Title should terminate, the Government of the Federated States of Micronesia shall refrain from actions which the Government of the United States determines, after appropriate consultation with that Government, to be incompatible with its authority and responsibility for security and defense matters in or relating to the Federated States of Micronesia or the Republic of the Marshall Islands.

TITLE FOUR

GENERAL PROVISIONS

Article I

Approval and Effective Date

Section 411

Pursuant to section 432 of the Compact and subject to subsection (e) of section 461 of the Compact, as amended, the Compact, as amended, shall come into effect upon mutual agreement between the Government of the United States and the Government of the Federated States of Micronesia subsequent to completion of the following:

(a) Approval by the Government of the Federated States of Micronesia in accordance with its constitutional processes.

(b) Approval by the Government of the United States in accordance with its constitutional processes.

Article II

Conference and Dispute Resolution

Section 421

The Government of the United States shall confer promptly at the request of the Government of the Federated States of Micronesia and that Government shall confer promptly at the request of the Government of the United States on matters relating to the provisions of this Compact, as amended, or of its related agreements.

Section 422

In the event the Government of the United States or the Government of the Federated States of Micronesia, after conferring pursuant to section 421, determines that there is a dispute and gives written notice thereof, the two Governments shall make a good faith effort to resolve the dispute between themselves.

Section 423

If a dispute between the Government of the United States and the Government of the Federated States of Micronesia cannot be resolved within 90 days of written notification in the manner provided in section 422, either party to the dispute may refer it to arbitration in accordance with section 424.

Section 424

Should a dispute be referred to arbitration as provided for in section 423, an Arbitration Board shall be established for the purpose of hearing the dispute and rendering a decision which shall be binding upon the two parties to the dispute unless the two parties mutually agree that the decision shall be advisory. Arbitration shall occur according to the following terms:

(a) An Arbitration Board shall consist of a Chairman and two other members, each of whom shall be a citizen of a party to the dispute. Each of the two Governments which is a party to the dispute shall appoint one member to the Arbitration Board. If either party to the dispute does not fulfill the appointment requirements of this section within 30 days of referral of the dispute to arbitration pursuant to section 423, its member on the Arbitration Board shall be selected from its own standing list by the other party to the dispute. Each Government shall maintain a standing list of 10 candidates. The parties to the dispute shall jointly appoint a Chairman within 15 days after selection of the other members of the Arbitration Board. Failing agreement on a Chairman, the Chairman shall be chosen by lot from the standing lists of the parties to the dispute within 5 days after such failure.

(b) Unless otherwise provided in this Compact, as amended, or its related agreements, the Arbitration Board shall have jurisdiction to hear and render its final determination on all disputes arising exclusively under Articles I, II, III, IV and V of Title One, Title Two, Title Four, and their related agreements.

(c) Each member of the Arbitration Board shall have one vote. Each decision of the Arbitration Board shall be reached by majority vote.

(d) In determining any legal issue, the Arbitration Board may have reference to international law and, in such reference, shall apply as guidelines the provisions set forth in Article 38 of the Statute of the International Court of Justice.

(e) The Arbitration Board shall adopt such rules for its proceedings as it may deem appropriate and necessary, but such rules shall not contravene the provisions of this Compact, as amended. Unless the parties provide otherwise by mutual agreement, the Arbitration Board shall endeavor to render its decision within 30 days after the conclusion of arguments. The Arbitration Board shall make findings of fact and conclusions of law and its members may issue dissenting or individual opinions. Except as may be otherwise decided by the Arbitration Board, one-half of all costs of the arbitration shall be borne by the Government of the United States and the remainder shall be borne by the Government of the Federated States of Micronesia.

Article III

Amendment

Section 431

The provisions of this Compact, as amended, may be further amended by mutual agreement of the Government of the United States and the Government of the Federated States of Micronesia, in accordance with their respective constitutional processes.

Article IV

Termination

Section 441

This Compact, as amended, may be terminated by mutual agreement of the Government of the Federated States of Micronesia and the Government of the United States, in accordance with their respective constitutional processes. Such mutual termination of this Compact, as amended, shall be without prejudice to the continued application of section 451 of this Compact, as amended, and the provisions of the Compact, as amended, set forth therein.

Section 442

Subject to section 452, this Compact, as amended, may be terminated by the Government of the United States in accordance with its constitutional processes. Such termination shall be effective on the date specified in the notice of termination by the Government of the United States but not earlier than six months following delivery of such notice. The time specified in the notice of termination may be extended. Such termination of this Compact, as amended, shall be without prejudice to the continued application of section 452 of this Compact, as amended, and the provisions of the Compact, as amended, set forth therein.

Section 443

This Compact, as amended, shall be terminated by the Government of the Federated States of Micronesia, pursuant to its constitutional processes, subject to section 453 if the people represented by that Government vote in a plebiscite to terminate the Compact, as amended, or by another process permitted by the FSM constitution and mutually agreed between the Governments of the United States and the Federated States of Micronesia. The Government of the Federated States of Micronesia shall notify the Government of the United States of its intention to call such a plebiscite, or to pursue another mutually agreed and constitutional process, which plebiscite or process shall take place not earlier than three months after delivery of such notice. The plebiscite or other process shall be administered by the Government of the Federated States of Micronesia in accordance with its constitutional and legislative processes. If a majority of the valid ballots cast in the plebiscite or other process favors termination, the Government of the Federated States of Micronesia shall, upon certification of the results of the plebiscite or other process, give notice of termination to the Government of the United States, such termination to be effective on the date specified in such notice but not earlier than three months following the date of delivery of such notice. The time specified in the notice of termination may be extended.

Article V

Survivability

Section 451

(a) Should termination occur pursuant to section 441, economic and other assistance by the Government of the United States shall continue only if and as mutually agreed by the Governments of the United States and the Federated States of Micronesia, and in accordance with the parties' respective constitutional processes.

(b) In view of the special relationship of the United States and the Federated States of Micronesia, as reflected in subsections (b) and (c) of section 354 of this Compact, as amended, and the separate agreement entered into consistent with those subsections, if termination occurs pursuant to section 441 prior to the twentieth anniversary of the effective date of this Compact, as amended, the United States shall continue to make contributions to the Trust Fund described in section 215 of this Compact, as amended.

(c) In view of the special relationship of the United States and the Federated States of Micronesia described in subsection (b) of this section, if termination occurs pursuant to section 441 following the twentieth anniversary of the effective date of this Compact, as amended, the Federated States of Micronesia shall be entitled to receive proceeds from the Trust Fund described in section 215 of this Compact, as amended, in the manner described in those provisions and the Trust Fund Agreement governing the distribution of such proceeds.

Section 452

(a) Should termination occur pursuant to section 442 prior to the twentieth anniversary of the effective date of this Compact, as amended, the following provisions of this Compact, as amended, shall remain in full force and effect until the twentieth anniversary of the effective date of this Compact, as amended, and thereafter as mutually agreed:

(1) Article VI and sections 172, 173, 176 and 177 of Title One;

(2) Sections 232 and 234 of Title Two;

(3) Title Three; and

(4) Articles II, III, V and VI of Title Four.

(b) Should termination occur pursuant to section 442 before the twentieth anniversary of the effective date of the Compact, as amended:

(1) Except as provided in paragraph (2) of this subsection and subsection (c) of this section, economic and other assistance by the United States shall continue only if and as mutually agreed by the Governments of the United States and the Federated States of Micronesia.

(2) In view of the special relationship of the United States and the Federated States of Micronesia, as reflected in subsections (b) and (c) of section 354 of this Compact, as amended, and the separate agreement regarding mutual security, and the Trust Fund Agreement, the United States shall continue to make contributions to the Trust Fund described in section 215 of this Compact, as amended, in the manner described in the Trust Fund Agreement.

(c) In view of the special relationship of the United States and the Federated States of Micronesia, as reflected in subsections 354(b) and (c) of this Compact, as amended, and the separate agreement regarding mutual security, and the Trust Fund Agreement, if termination occurs pursuant to section 442 following the twentieth anniversary of the effective date of this Compact, as amended, the Federated States of Micronesia shall continue to be eligible to receive proceeds from the Trust Fund described in section 215 of this Compact, as amended, in the manner described in those provisions and the Trust Fund Agreement.

Section 453

(a) Should termination occur pursuant to section 443 prior to the twentieth anniversary of the effective date of this Compact, as amended, the following provisions of this Compact, as amended, shall remain in full force and effect until the twentieth anniversary of the effective date of this Compact, as amended, and thereafter as mutually agreed:

(1) Article VI and sections 172, 173, 176 and 177 of Title One;

(2) Sections 232 and 234 of Title Two;

(3) Title Three; and

(4) Articles II, III, V and VI of Title Four.

(b) Upon receipt of notice of termination pursuant to section 443, the Government of the United States and the Government of the Federated States of Micronesia shall promptly consult with regard to their future relationship. Except as provided in subsection (c) and (d) of this section, these consultations shall determine the level of economic and other assistance, if any, which the Government of the United States shall provide to the Government of the Federated States of Micronesia for the period ending on the twentieth anniversary of the effective date of this Compact, as amended, and for any period thereafter, if mutually agreed.

(c) In view of the special relationship of the United States and the Federated States of Micronesia, as reflected in subsections 354(b) and (c) of this Compact, as amended, and the separate agreement regarding mutual security, and the Trust Fund Agreement, if termination occurs pursuant to section 443 prior to the twentieth anniversary of the effective date of this Compact, as amended, the United States shall continue to make contributions to the Trust Fund described in section 215 of this Compact, as amended, in the manner described in the Trust Fund Agreement.

(d) In view of the special relationship of the United States and the Federated States of Micronesia, as reflected in subsections 354(b) and (c) of this Compact, as amended, and the separate agreement regarding mutual security, and the Trust Fund Agreement, if termination occurs pursuant to section 443 following the twentieth anniversary of the effective date of this Compact, as amended, the Federated States of Micronesia shall continue to be eligible to receive proceeds from the Trust Fund described in section 215 of this Compact, as amended, in the manner described in those provisions and the Trust Fund Agreement.

Section 454

Notwithstanding any other provision of this Compact, as amended:

(a) The Government of the United States reaffirms its continuing interest in promoting the economic advancement and budgetary self-reliance of the people of the Federated States of Micronesia.

(b) The separate agreements referred to in Article II of Title Three shall remain in effect in accordance with their terms.

Article VI

Definition of Terms

Section 461

For the purpose of this Compact, as amended, only, and without prejudice to the views of the Government of the United States or the Government of the Federated States of Micronesia as to the nature and extent of the jurisdiction of either of them under international law, the following terms shall have the following meanings:

(a) "Trust Territory of the Pacific Islands" means the area established in the Trusteeship Agreement consisting of the former administrative districts of Kosrae, Yap, Ponape, the Marshall Islands and Truk as described in Title One, Trust Territory Code, section 1, in force on January 1, 1979. This term does not include the area of Palau or the Northern Mariana Islands.

(b) "Trusteeship Agreement" means the agreement setting forth the terms of trusteeship for the Trust Territory of the Pacific Islands, approved by the Security Council of the United Nations April 2, 1947, and by the United States July 18, 1947, entered into force July 18, 1947, 61 Stat. 3301, T.I.A.S. 1665, 8 U.N.T.S. 189.

(c) "The Federated States of Micronesia" and "the Republic of the Marshall Islands" are used in a geographic sense and include the land and water areas to the outer limits of the territorial sea and the air space above such areas as now or hereafter recognized by the Government of the United States.

(d) "Compact" means the Compact of Free Association Between the United States and the Federated States of Micronesia and the Marshall Islands, that was approved by the United States Congress in section 201 of Public Law 99–239 (Jan. 14, 1986) and went into effect with respect to the Federated States of Micronesia on November 3, 1986.

(e) "Compact, as amended" means the Compact of Free Association Between the United States and the Federated States of Micronesia, as amended. The effective date of the Compact, as amended, shall be on a date to be determined by the President of the United States, and agreed to by the Government of the Federated States of Micronesia, following formal approval of the Compact, as amended, in accordance with section 411 of this Compact, as amended.

(f) "Government of the Federated States of Micronesia" means the Government established and organized by the Constitution of the Federated States of Micronesia including all the political subdivisions and entities comprising that Government.

(g) "Government of the Republic of the Marshall Islands" means the Government established and organized by the Constitution of the Republic of the Marshall Islands including all the political subdivisions and entities comprising that Government.

(h) The following terms shall be defined consistent with the 1998 Edition of the Radio Regulations of the International Telecommunications Union as follows:

(1) "Radiocommunication" means telecommunication by means of radio waves.

(2) "Station" means one or more transmitters or receivers or a combination of transmitters and receivers, including the accessory equipment, necessary at one location for carrying on a radiocommunication service, or the radio astronomy service.

(3) "Broadcasting Service" means a radiocommunication service in which the transmissions are intended for direct reception by the general public. This service may include sound transmissions, television transmissions or other types of transmission.

(4) "Broadcasting Station" means a station in the broadcasting service.

(5) "Assignment (of a radio frequency or radio frequency channel)" means an authorization given by an administration for a radio station to use a radio frequency or radio frequency channel under specified conditions.

(6) "Telecommunication" means any transmission, emission or reception of signs, signals, writings, images and sounds or intelligence of any nature by wire, radio, optical or other electromagnetic systems.

(i) "Military Areas and Facilities" means those areas and facilities in the Federated States of Micronesia reserved or acquired by the Government of the Federated States of Micronesia for use by the Government of the United States, as set forth in the separate agreements referred to in section 321.

(j) "Tariff Schedules of the United States" means the Tariff Schedules of the United States as amended from time to time and as promulgated pursuant to United States law and includes the Tariff Schedules of the United States Annotated (TSUSA), as amended.

(k) "Vienna Convention on Diplomatic Relations" means the Vienna Convention on Diplomatic Relations, done April 18, 1961, 23 U.S.T. 3227, T.I.A.S. 7502, 500 U.N.T.S. 95.

Section 462

(a) The Government of the United States and the Government of the Federated States of Micronesia previously have concluded agreements pursuant to the Compact, which shall remain in effect and shall survive in accordance with their terms, as follows:

(1) Agreement Concluded Pursuant to Section 234 of the Compact;

(2) Agreement Between the Government of the United States and the Government of the Federated States of Micronesia Regarding Friendship, Cooperation and Mutual Security Concluded Pursuant to Sections 321 and 323 of the Compact of Free Association; and

(3) Agreement between the Government of the United States of America and the Federated States of Micronesia Regarding Aspects of the Marine Sovereignty and Jurisdiction of the Federated States of Micronesia.

(b) The Government of the United States and the Government of the Federated States of Micronesia shall conclude prior to the date of submission of this Compact, as amended, to the legislatures of the two countries, the following related agreements which shall come into effect on the effective date of this Compact, as amended, and shall survive in accordance with their terms, as follows:

(1) Federal Programs and Services Agreement Between the Government of the United States of America and the Government of the Federated States of Micronesia Concluded Pursuant to Article III of Title One, Article II of Title Two (including Section 222), and Section 231 of the Compact of Free Association, as amended which includes:

(i) Postal Services and Related Programs;

(ii) Weather Services and Related Programs;

(iii) Civil Aviation Safety Service and Related Programs;

(iv) Civil Aviation Economic Services and Related Programs;

(v) United States Disaster Preparedness and Response Services and Related Programs;

(vi) Federal Deposit Insurance Corporation Services and Related Programs; and

(vii) Telecommunications Services and Related Programs.

(2) Agreement Between the Government of the United States of America and the Government of the Federated States of Micronesia on Extradition, Mutual Assistance in Law Enforcement Matters and Penal Sanctions Concluded Pursuant to Section 175(a) of the Compact of Free Association, as amended;

(3) Agreement Between the Government of the United States of America and the Government of the Federated States of Micronesia on Labor Recruitment Concluded Pursuant to Section 175(b) of the Compact of Free Association, as amended;

(4) Agreement Concerning Procedures for the Implementation of United States Economic Assistance Provided in the Compact of Free Association, as Amended, of Free Association Between the Government of the United States of America and Government of the Federated States of Micronesia;

(5) Agreement Between the Government of the United States of America and the Government of the Federated States of Micronesia Implementing Section 215 and Section 216 of the Compact, as Amended, Regarding a Trust Fund;

(6) Agreement Regarding the Military Use and Operating Rights of the Government of the United States in the Federated States of Micronesia Concluded Pursuant to Sections 211(b), 321 and 323 of the Compact of Free Association, as Amended; and the

(7) Status of Forces Agreement Between the Government of the United States of America and the Government of the Federated States of Micronesia Concluded Pursuant to Section 323 of the Compact of Free Association, as Amended.

Section 463

(a) Except as set forth in subsection (b) of this section, any reference in this Compact, as amended, to a provision of the United States Code or the Statutes at Large of the United States constitutes the incorporation of the language of such provision into this Compact, as amended, as such provision was in force on the effective date of this Compact, as amended.

(b) Any reference in Articles IV and Article VI of Title One and Sections 174, 175, 178 and 342 to a provision of the United States Code or the Statutes at Large of the United States or to the Privacy Act, the Freedom of Information Act, the Administrative Procedure Act or the Immigration and Nationality Act constitutes the incorporation of the language of such provision into this Compact, as amended, as such provision was in force on the effective date of this Compact, as amended, or as it may be amended thereafter on a non-discriminatory basis according to the constitutional processes of the United States.

Article VII

Concluding Provisions

Section 471

Both the Government of the United States and the Government of the Federated States of Micronesia shall take all necessary steps, of a general or particular character, to ensure, no later than the entry into force date of this Compact, as amended, the conformity of its laws, regulations and administrative procedures with the provisions of this Compact, as amended, or in the case of subsection (d) of section 141, as soon as reasonably possible thereafter.

Section 472

This Compact, as amended, may be accepted, by signature or otherwise, by the Government of the United States and the Government of the Federated States of Micronesia.

IN WITNESS WHEREOF, the undersigned, duly authorized, have signed this Compact of Free Association, as amended, which shall enter into force upon the exchange of diplomatic notes by which the Government of the United States of America and the Government of the Federated States of Micronesia inform each other about the fulfillment of their respective requirements for entry into force.

DONE at Pohnpei, Federated States of Micronesia, in duplicate, this fourteenth (14) day of May, 2003, each text being equally authentic.

Signed (May 14, 2003) **For the Government of the United States of America:**	**Signed (May 14, 2003)** **For the Government of the Federated States of Micronesia:**

(b) COMPACT OF FREE ASSOCIATION, AS AMENDED, BETWEEN THE GOVERNMENT OF THE UNITED STATES OF AMERICA AND THE GOVERNMENT OF THE REPUBLIC OF THE MARSHALL ISLANDS.—The Compact of Free Association, as amended, between the Government of the United States of America and the Government of the Republic of the Marshall Islands is as follows:

PREAMBLE

THE GOVERNMENT OF THE UNITED STATES OF AMERICA AND THE GOVERNMENT OF THE REPUBLIC OF THE MARSHALL ISLANDS

Affirming that their Governments and their relationship as Governments are founded upon respect for human rights and fundamental freedoms for all, and that the people of the Republic of the Marshall Islands have the right to enjoy self-government; and

Affirming the common interests of the United States of America and the Republic of the Marshall Islands in creating and maintaining their close and mutually beneficial relationship through the free and voluntary association of their respective Governments; and

Affirming the interest of the Government of the United States in promoting the economic advancement and budgetary self-reliance of the Republic of the Marshall Islands; and

Recognizing that their relationship until the entry into force on October 21, 1986 of the Compact was based upon the International Trusteeship System of the United Nations Charter, and in particular Article 76 of the Charter; and that pursuant to Article 76 of the Charter, the people of the Republic of the Marshall Islands have progressively developed their institutions of self-government, and that in the exercise of their sovereign right to self-determination they, through their freely-expressed wishes, have adopted a Constitution appropriate to their particular circumstances; and

Recognizing that the Compact reflected their common desire to terminate the Trusteeship and establish a government-to-government relationship which was in accordance with the new political status based on the freely expressed wishes of the people of the Republic of the Marshall Islands and appropriate to their particular circumstances; and

Recognizing that the people of the Republic of the Marshall Islands have and retain their sovereignty and their sovereign right to self-determination and the inherent right to adopt and amend their own Constitution and form of government and that the approval of the entry of the Government of the Republic of the Marshall Islands into the Compact by the people of the Republic of the Marshall Islands constituted an exercise of their sovereign right to self-determination; and

Recognizing the common desire of the people of the United States and the people of the Republic of the Marshall Islands to maintain their close government-to-government relationship, the United States and the Republic of the Marshall Islands:

NOW, THEREFORE, MUTUALLY AGREE to continue and strengthen their relationship of free association by amending the Compact, which continues to provide a full measure of self-government for the people of the Republic of the Marshall Islands; and

FURTHER AGREE that the relationship of free association derives from and is as set forth in this Compact, as amended, by the Governments of the United States and the Republic of the Marshall Islands; and that, during such relationship of free association, the respective rights and responsibilities of the Government of the United States and the Government of the Republic of the Marshall Islands in regard to this relationship of free association derive from and are as set forth in this Compact, as amended.

TITLE ONE

GOVERNMENTAL RELATIONS

Article I

Self-Government

Section 111

The people of the Republic of the Marshall Islands, acting through the Government established under their Constitution, are self-governing.

Article II

Foreign Affairs

Section 121

(a) The Government of the Republic of the Marshall Islands has the capacity to conduct foreign affairs and shall do so in its own name and right, except as otherwise provided in this Compact, as amended.

(b) The foreign affairs capacity of the Government of the Republic of the Marshall Islands includes:

(1) the conduct of foreign affairs relating to law of the sea and marine resources matters, including the harvesting, conservation, exploration or exploitation of living and non-living resources from the sea, seabed or subsoil to the full extent recognized under international law;

(2) the conduct of its commercial, diplomatic, consular, economic, trade, banking, postal, civil aviation, communications, and cultural relations, including negotiations for the receipt of developmental loans and grants and the conclusion of arrangements with other governments and international and intergovernmental organizations, including any matters specially benefiting its individual citizens.

(c) The Government of the United States recognizes that the Government of the Republic of the Marshall Islands has the capacity to enter into, in its own name and right, treaties and other international agreements with governments and regional and international organizations.

(d) In the conduct of its foreign affairs, the Government of the Republic of the Marshall Islands confirms that it shall act in accordance with principles of international law and shall settle its international disputes by peaceful means.

Section 122

The Government of the United States shall support applications by the Government of the Republic of the Marshall Islands for membership or other participation in regional or international organizations as may be mutually agreed.

Section 123

(a) In recognition of the authority and responsibility of the Government of the United States under Title Three, the Government of the Republic of the Marshall Islands shall consult, in the conduct of its foreign affairs, with the Government of the United States.

(b) In recognition of the foreign affairs capacity of the Government of the Republic of the Marshall Islands, the Government of the United States, in the conduct of its foreign affairs, shall consult with the Government of the Republic of the Marshall Islands on matters that the Government of the United States regards as relating to or affecting the Government of the Republic of the Marshall Islands.

Section 124

The Government of the United States may assist or act on behalf of the Government of the Republic of the Marshall Islands in the area of foreign affairs as may be requested and mutually agreed from time to time. The Government of the United States shall not be responsible to third parties for the actions of the Government of the Republic of the Marshall Islands undertaken with the assistance or through the agency of the Government of the United States pursuant to this section unless expressly agreed.

Section 125

The Government of the United States shall not be responsible for nor obligated by any actions taken by the Government of the Republic of the Marshall Islands in the area of foreign affairs, except as may from time to time be expressly agreed.

Section 126

At the request of the Government of the Republic of the Marshall Islands and subject to the consent of the receiving state, the Government of the United States shall extend consular assistance on the same basis as for citizens of the United States to citizens of the Republic of the Marshall Islands for travel outside the Republic of the Marshall Islands, the United States and its territories and possessions.

Section 127

Except as otherwise provided in this Compact, as amended, or its related agreements, all obligations, responsibilities, rights and benefits of the Government of the United States as Administering Authority which resulted from the application pursuant to the Trusteeship Agreement of any treaty or other international agreement to the Trust Territory of the Pacific Islands on October 20, 1986, are, as of that date, no longer assumed and enjoyed by the Government of the United States.

Article III

Communications

Section 131

(a) The Government of the Republic of the Marshall Islands has full authority and responsibility to regulate its domestic and foreign communications, and the Government of the United States shall provide communications assistance as mutually agreed.

(b) The Government of the Republic of the Marshall Islands has elected to undertake all functions previously performed by the Government of the United States with respect to domestic and foreign communications, except for those functions set forth in a separate agreement entered into pursuant to this section of the Compact, as amended.

Section 132

The Government of the Republic of the Marshall Islands shall permit the Government of the United States to operate telecommunications services in the Republic of the Marshall Islands to the extent necessary to fulfill the obligations of the Government of the United States under this Compact, as amended, in accordance with the terms of separate agreements entered into pursuant to this section of the Compact, as amended.

Article IV

Immigration

Section 141

(a) In furtherance of the special and unique relationship that exists between the United States and the Republic of the Marshall Islands, under the Compact, as amended, any person in the following categories may be admitted to lawfully engage in occupations, and establish residence as a nonimmigrant in the United States and its territories and possessions (the "United States") without regard to paragraphs (5) or (7)(B)(i)(II) of section 212(a) of the Immigration and Nationality Act, as amended, 8 U.S.C. 1182(a)(5) or (7)(B)(i)(II):

(1) a person who, on October 21, 1986, was a citizen of the Trust Territory of the Pacific Islands, as defined in Title 53 of the Trust Territory Code in force on January 1, 1979, and has become and remains a citizen of the Republic of the Marshall Islands;

(2) a person who acquires the citizenship of the Republic of the Marshall Islands at birth, on or after the effective date of the Constitution of the Republic of the Marshall Islands;

(3) an immediate relative of a person referred to in paragraphs (1) or (2) of this section, provided that such immediate relative is a naturalized citizen of the Republic of the Marshall Islands who has been an actual resident there for not less than five years after attaining such naturalization and who holds a certificate of actual residence, and further provided, that, in the case of a spouse, such spouse has been married to the person referred to in paragraph (1) or

(2) of this section for at least five years, and further provided, that the Government of the United States is satisfied that such naturalized citizen meets the requirement of subsection (b) of section 104 of Public Law 99–239 as it was in effect on the day prior to the effective date of this Compact, as amended;

(4) a naturalized citizen of the Republic of the Marshall Islands who was an actual resident there for not less than five years after attaining such naturalization and who satisfied these requirements as of April 30, 2003, who continues to be an actual resident and holds a certificate of actual residence, and whose name is included in a list furnished by the Government of the Republic of the Marshall Islands to the Government of the United States no later than the effective date of the Compact, as amended, in form and content acceptable to the Government of the United States, provided, that the Government of the United States is satisfied that such naturalized citizen meets the requirement of subsection (b) of section 104 of Public Law 99–239 as it was in effect on the day prior to the effective date of this Compact, as amended; or

(5) an immediate relative of a citizen of the Republic of the Marshall Islands, regardless of the immediate relative's country of citizenship or period of residence in the Republic of the Marshall Islands, if the citizen of the Republic of the Marshall Islands is serving on active duty in any branch of the United States Armed Forces, or in the active reserves.

(b) Notwithstanding subsection (a) of this section, a person who is coming to the United States pursuant to an adoption outside the United States, or for the purpose of adoption in the United States, is ineligible for admission under the Compact and the Compact, as amended. This subsection shall apply to any person who is or was an applicant for admission to the United States on or after March 1, 2003, including any applicant for admission in removal proceedings (including appellate proceedings) on or after March 1, 2003, regardless of the date such proceedings were commenced. This subsection shall have no effect on the ability of the Government of the United States or any United States State or local government to commence or otherwise take any action against any person or entity who has violated any law relating to the adoption of any person.

(c) Notwithstanding subsection (a) of this section, no person who has been or is granted citizenship in the Republic of the Marshall Islands, or has been or is issued a Republic of the Marshall Islands passport pursuant to any investment, passport sale, or similar program has been or shall be eligible for admission to the United States under the Compact or the Compact, as amended.

(d) A person admitted to the United States under the Compact, or the Compact, as amended, shall be considered to have the permission of the Government of the United States to accept employment in the United States. An unexpired Republic of the Marshall Islands passport with unexpired documentation issued by the Government of the United States evidencing admission under the Compact or the Compact, as amended, shall be considered to be documentation establishing identity and employment authorization under section 274A(b)(1)(B) of the Immigration and Nationality Act, as amended, 8 U.S.C. 1324a(b)(1)(B). The Government of the United States will take reasonable and appropriate steps to implement and publicize this provision, and the Government of the Republic of the Marshall Islands will also take reasonable and appropriate steps to publicize this provision.

(e) For purposes of the Compact and the Compact, as amended:

(1) the term "residence" with respect to a person means the person's principal, actual dwelling place in fact, without regard to intent, as provided in section 101(a)(33) of the Immigration and Nationality Act, as amended, 8 U.S.C. 1101(a)(33), and variations of the term "residence," including "resident" and "reside," shall be similarly construed;

(2) the term "actual residence" means physical presence in the Republic of the Marshall Islands during eighty-five percent of the five-year period of residency required by section 141(a)(3) and (4);

(3) the term "certificate of actual residence" means a certificate issued to a naturalized citizen by the Government of the Republic of the Marshall Islands stating that the citizen has complied with the actual residence requirement of section 141(a)(3) or (4);

(4) the term "nonimmigrant" means an alien who is not an "immigrant" as defined in section 101(a)(15) of such Act, 8 U.S.C. 1101(a)(15); and

(5) the term "immediate relative" means a spouse, or unmarried son or unmarried daughter less than 21 years of age.

(f) The Immigration and Nationality Act, as amended, shall apply to any person admitted or seeking admission to the United States (other than a United States possession or territory where such Act does not apply) under the Compact or the Compact, as amended, and nothing in the Compact or the Compact, as amended, shall be construed to limit, preclude, or modify the applicability of, with respect to such person:

(1) any ground of inadmissibility or deportability under such Act (except sections 212(a)(5) and 212(a)(7)(B)(i)(II) of such Act, as provided in subsection (a) of this section), and any defense thereto, provided that, section 237(a)(5) of such Act shall be construed and applied as if it reads as follows: "any alien who has been admitted under the Compact, or the Compact, as amended, who cannot show that he or she has sufficient means of support in the United States, is deportable;"

(2) the authority of the Government of the United States under section 214(a)(1) of such Act to provide that admission as a nonimmigrant shall be for such time and under such conditions as the Government of the United States may by regulations prescribe;

(3) except for the treatment of certain documentation for purposes of section 274A(b)(1)(B) of such Act as provided by subsection (d) of this section of the Compact, as amended, any requirement under section 274A, including but not limited to section 274A(b)(1)(E);

(4) section 643 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Public Law 104–208, and actions taken pursuant to section 643; and

(5) the authority of the Government of the United States otherwise to administer and enforce the Immigration and Nationality Act, as amended, or other United States law.

(g) Any authority possessed by the Government of the United States under this section of the Compact or the Compact, as amended, may also be exercised by the Government of a territory or possession of the United States where the Immigration and Nationality Act, as amended, does not apply, to the extent such exercise of authority is lawful under a statute or regulation of such territory or possession that is authorized by the laws of the United States.

(h) Subsection (a) of this section does not confer on a citizen of the Republic of the Marshall Islands the right to establish the residence necessary for naturalization under the Immigration and Nationality Act, as amended, or to petition for benefits for alien relatives under that Act. Subsection (a) of this section, however, shall not prevent a citizen of the Republic of the Marshall Islands from otherwise acquiring such rights or lawful permanent resident alien status in the United States.

Section 142

(a) Any citizen or national of the United States may be admitted to lawfully engage in occupations, and reside in the Republic of the Marshall Islands, subject to the rights of the Government of the Republic of the Marshall Islands to deny entry to or deport any such citizen or national as an undesirable alien. Any determination of inadmissibility or deportability shall be based on reasonable statutory grounds and shall be subject to appropriate administrative and judicial review within the Republic of the Marshall Islands. If a citizen or national of the United States is a spouse of a citizen of the Republic of the Marshall Islands, the Government of the Republic of the Marshall Islands shall allow the United States citizen spouse to establish residence. Should the Republic of the Marshall Islands citizen spouse predecease the United States citizen spouse during the marriage, the Government of the Republic of the Marshall Islands shall allow the United States citizen spouse to continue to reside in the Republic of the Marshall Islands.

(b) In enacting any laws or imposing any requirements with respect to citizens and nationals of the United States entering the Republic of the Marshall Islands under subsection (a) of this section, including any grounds of inadmissibility or deportability, the Government of the Republic of the Marshall Islands shall accord to such citizens and nationals of the United States treatment no less favorable than that accorded to citizens of other countries.

(c) Consistent with subsection (a) of this section, with respect to citizens and nationals of the United States seeking to engage in employment or invest in the Republic of the Marshall Islands, the Government of the Republic of the Marshall Islands shall adopt immigration-related procedures no less favorable than those adopted by the Government of the United States with respect to citizens of the Republic of the Marshall Islands seeking employment in the United States.

Section 143

Any person who relinquishes, or otherwise loses, his United States nationality or citizenship, or his Republic of the Marshall Islands citizenship, shall be ineligible to receive the privileges set forth in sections 141 and 142. Any such person may apply for admission to the United States or the Republic of the Marshall Islands, as the case may be, in accordance with any other applicable laws of the United States or the Republic of the Marshall Islands relating to immigration of aliens from other countries. The laws of the Republic of the Marshall Islands or the United States, as the case may be, shall dictate the terms and conditions of any such person's stay.

Article V

Representation

Section 151

Relations between the Government of the United States and the Government of the Republic of the Marshall Islands shall be conducted in accordance with the Vienna Convention on Diplomatic Relations. In addition to diplomatic missions and representation, the Governments may establish and maintain other offices and designate other representatives on terms and in locations as may be mutually agreed.

Section 152

(a) Any citizen or national of the United States who, without authority of the United States, acts as the agent of the Government of the Republic of the Marshall Islands with regard to matters specified in the provisions of the Foreign Agents Registration Act of 1938, as amended (22 U.S.C. 611 et seq.), that apply with respect to an agent of a foreign principal shall

be subject to the requirements of such Act. Failure to comply with such requirements shall subject such citizen or national to the same penalties and provisions of law as apply in the case of the failure of such an agent of a foreign principal to comply with such requirements. For purposes of the Foreign Agents Registration Act of 1938, the Republic of the Marshall Islands shall be considered to be a foreign country.

(b) Subsection (a) of this section shall not apply to a citizen or national of the United States employed by the Government of the Republic of the Marshall Islands with respect to whom the Government of the Republic of the Marshall Islands from time to time certifies to the Government of the United States that such citizen or national is an employee of the Republic of the Marshall Islands whose principal duties are other than those matters specified in the Foreign Agents Registration Act of 1938, as amended, that apply with respect to an agent of a foreign principal. The agency or officer of the United States receiving such certifications shall cause them to be filed with the Attorney General, who shall maintain a publicly available list of the persons so certified.

Article VI

Environmental Protection

Section 161

The Governments of the United States and the Republic of the Marshall Islands declare that it is their policy to promote efforts to prevent or eliminate damage to the environment and biosphere and to enrich understanding of the natural resources of the Republic of the Marshall Islands. In order to carry out this policy, the Government of the United States and the Government of the Republic of the Marshall Islands agree to the following mutual and reciprocal undertakings:

(a) The Government of the United States:

(1) shall, for its activities controlled by the U.S. Army at Kwajalein Atoll and in the Mid-Atoll Corridor and for U.S. Army Kwajalein Atoll activities in the Republic of the Marshall Islands, continue to apply the Environmental Standards and Procedures for United States Army Kwajalein Atoll Activities in the Republic of the Marshall Islands, unless and until those Standards or Procedures are modified by mutual agreement of the Governments of the United States and the Republic of the Marshall Islands;

(2) shall apply the National Environmental Policy Act of 1969, 83 Stat. 852, 42 U.S.C. 4321 et seq., to its activities under the Compact, as amended, and its related agreements as if the Republic of the Marshall Islands were the United States;

(3) in the conduct of any activity not described in section 161(a)(1) requiring the preparation of an Environmental Impact Statement under section 161(a)(2), shall comply with standards substantively similar to those required by the following laws of the United States, taking into account the particular environment of the Republic of the Marshall Islands; the Endangered Species Act of 1973, as amended, 16 U.S.C. 1531 et seq.; the Clean Air Act, as amended, 42 U.S.C. 7401 et seq.; the Clean Water Act (Federal Water Pollution Control Act), as amended, 33 U.S.C. 1251 et seq.; Title I of the Marine Protection, Research and Sanctuaries Act of 1972 (the Ocean Dumping Act), 33 U.S.C. 1411 et seq.; the Toxic Substances Control Act, as amended, 15 U.S.C. 2601 et seq.; the Solid Waste Disposal Act, as amended, 42 U.S.C. 6901 et seq.; and such other environmental protection laws of the United States and the Republic of the Marshall Islands as may be agreed from time to time with the Government of the Republic of the Marshall Islands;

(4) shall, prior to conducting any activity not described in section 161(a)(1) requiring the preparation of an Environmental Impact Statement under section 161(a)(2), develop, as agreed with the Government of the Republic of the Marshall Islands, written environmental standards and procedures to implement the substantive provisions of the laws made applicable to U.S. Government activities in the Republic of the Marshall Islands, pursuant to section 161(a)(3).

(b) The Government of the Republic of the Marshall Islands shall continue to develop and implement standards and procedures to protect its environment. As a reciprocal obligation to the undertakings of the Government of the United States under this Article, the Republic of the Marshall Islands, taking into account its particular environment, shall continue to develop and implement standards for environmental protection substantively similar to those required of the Government of the United States by section 161(a)(3) prior to its conducting activities in the Republic of the Marshall Islands, substantively equivalent to activities conducted there by the Government of the United States and, as a further reciprocal obligation, shall enforce those standards.

(c) Section 161(a), including any standard or procedure applicable thereunder, and section 161(b) may be modified or superseded in whole or in part by agreement of the Government of the United States and the Government of the Republic of the Marshall Islands.

(d) In the event that an Environmental Impact Statement is no longer required under the laws of the United States for major Federal actions significantly affecting the quality of the human environment, the regulatory regime established under sections 161(a)(3) and 161(a)(4) shall continue to apply to such activities of the Government of the United States until amended by mutual agreement.

(e) The President of the United States may exempt any of the activities of the Government of the United States under this Compact, as amended, and its related agreements from any environmental standard or procedure which may be applicable under sections 161(a)(3) and 161(a)(4) if the President determines it to be in the paramount interest of the Government of the United States to do so, consistent with Title Three of this Compact, as amended, and the obligations of the Government of the United States under international law. Prior to any decision pursuant to this subsection, the views of the Government of the Republic of the Marshall Islands shall be sought and considered to the extent practicable. If the President grants such an exemption, to the extent practicable, a report with his reasons for granting such exemption shall be given promptly to the Government of the Republic of the Marshall Islands.

(f) The laws of the United States referred to in section 161(a)(3) shall apply to the activities of the Government of the United States under this Compact, as amended, and its related agreements only to the extent provided for in this section.

Section 162

The Government of the Republic of the Marshall Islands may bring an action for judicial review of any administrative agency action or any activity of the Government of the United States pursuant to section 161(a) for enforcement of the obligations of the Government of the United States arising thereunder. The United States District Court for the District of Hawaii and the United States District Court for the District of Columbia shall have jurisdiction over such action or activity, and over actions brought under section 172(b) which relate to the activities of the Government of the United States and its officers and employees, governed by section 161, provided that:

(a) Such actions may only be civil actions for any appropriate civil relief other than punitive damages against the Government of the United States or, where required by law, its officers in their official capacity; no criminal actions may arise under this section.

(b) Actions brought pursuant to this section may be initiated only by the Government of the Republic of the Marshall Islands.

(c) Administrative agency actions arising under section 161 shall be reviewed pursuant to the standard of judicial review set forth in 5 U.S.C. 706.

(d) The United States District Court for the District of Hawaii and the United States District Court for the District of Columbia shall have jurisdiction to issue all necessary processes, and the Government of the United States agrees to submit itself to the jurisdiction of the court; decisions of the United States District Court shall be reviewable in the United States Court of Appeals for the Ninth Circuit or the United States Court of Appeals for the District of Columbia, respectively, or in the United States Supreme Court as provided by the laws of the United States.

(e) The judicial remedy provided for in this section shall be the exclusive remedy for the judicial review or enforcement of the obligations of the Government of the United States under this Article and actions brought under section 172(b), which relate to the activities of the Government of the United States and its officers and employees governed by section 161.

(f) In actions pursuant to this section, the Government of the Republic of the Marshall Islands shall be treated as if it were a United States citizen.

Section 163

(a) For the purpose of gathering data necessary to study the environmental effects of activities of the Government of the United States subject to the requirements of this Article, the Government of the Republic of the Marshall Islands shall be granted access to facilities operated by the Government of the United States in the Republic of the Marshall Islands, to the extent necessary for this purpose, except to the extent such access would unreasonably interfere with the exercise of the authority and responsibility of the Government of the United States under Title Three.

(b) The Government of the United States, in turn, shall be granted access to the Republic of the Marshall Islands for the purpose of gathering data necessary to discharge its obligations under this Article, except to the extent such access would unreasonably interfere with the exercise of the authority and responsibility of the Government of the Republic of the Marshall Islands under Title One, and to the extent necessary for this purpose shall be granted access to documents and other information to the same extent similar access is provided the Government of the Republic of the Marshall Islands under the Freedom of Information Act, 5 U.S.C. 552.

(c) The Government of the Republic of the Marshall Islands shall not impede efforts by the Government of the United States to comply with applicable standards and procedures.

Article VII

General Legal Provisions

Section 171

Except as provided in this Compact, as amended, or its related agreements, the application of the laws of the United States to the Trust Territory of the Pacific Islands by virtue of the Trusteeship Agreement ceased with respect to the Marshall Islands on October 21, 1986, the date the Compact went into effect.

Section 172

(a) Every citizen of the Republic of the Marshall Islands who is not a resident of the United States shall enjoy the rights and remedies under the laws of the United States enjoyed by any non-resident alien.

(b) The Government of the Republic of the Marshall Islands and every citizen of the Republic of the Marshall Islands shall be considered to be a "person" within the meaning of the Freedom of Information Act, 5 U.S.C. 552, and of the judicial review provisions of the Administrative Procedure Act, 5 U.S.C. 701–706, except that only the Government of the Republic of the Marshall Islands may seek judicial review under the Administrative Procedure Act or judicial enforcement under the Freedom of Information Act when such judicial review or enforcement relates to the activities of the Government of the United States governed by sections 161 and 162.

Section 173

The Governments of the United States and the Republic of the Marshall Islands agree to adopt and enforce such measures, consistent with this Compact, as amended, and its related agreements, as may be necessary to protect the personnel, property, installations, services, programs and official archives and documents maintained by the Government of the United States in the Republic of the Marshall Islands pursuant to this Compact, as amended, and its related agreements and by the Government of the Republic of the Marshall Islands in the United States pursuant to this Compact, Compact, as amended, and its related agreements.

Section 174

Except as otherwise provided in this Compact, as amended, and its related agreements:

(a) The Government of the Republic of the Marshall Islands, and its agencies and officials, shall be immune from the jurisdiction of the court of the United States, and the Government of the United States, and its agencies and officials, shall be immune from the jurisdiction of the courts of the Republic of the Marshall Islands.

(b) Any the Government of the United States accepts responsibility for and shall pay:

(1) any unpaid money judgment rendered by the High Court of the Trust Territory of the Pacific Islands against the Government of the United States with regard to any cause of action arising as a result of acts or omissions of the Government of the Trust Territory of the Pacific Islands or the Government of the United States prior to October 21, 1986;

(2) any claim settled by the claimant and the Government of the Trust Territory of the Pacific Islands but not paid as of October 21, 1986; and

(3) settlement of any administrative claim or of any action before a court of the Trust Territory of the Pacific Islands or the Government of the United States, arising as a result of acts or omissions of the Government of the Trust Territory of the Pacific Islands or the Government of the United States.

(c) Any claim not referred to in section 174(b) and arising from an act or omission of the Government of the Trust Territory of the Pacific Islands or the Government of the United States prior to the effective date of the Compact shall be adjudicated in the same manner as a claim adjudicated according to section 174(d). In any claim against the Government of the Trust Territory of the Pacific Islands, the Government of the United States shall stand in the place of the Government of the Trust Territory of the Pacific Islands. A judgment on any claim referred to in section 174(b) or this subsection, not otherwise satisfied by the Government of the United States, may be presented for certification to the United States Court of Appeals for the Federal Circuit, or its successor courts, which shall have jurisdiction therefore, notwithstanding the provisions of 28 U.S.C. 1502, and which court's decisions shall be reviewable as provided by the laws of the United States. The United States Court of Appeals for the Federal Circuit shall certify such judgment, and order payment thereof, unless it finds, after a hearing, that such judgment is manifestly erroneous as to law or fact, or manifestly excessive. In either of such cases the United States Court of Appeals for the Federal Circuit shall have jurisdiction to modify such judgment.

(d) The Government of the Republic of the Marshall Islands shall not be immune from the jurisdiction of the courts of the United States, and the Government of the United States shall not be immune from the jurisdiction of the courts of the Republic of the Marshall Islands in any civil case in which an exception to foreign state immunity is set forth in the Foreign Sovereign Immunities Act (28 U.S.C. 1602 et seq.) or its successor statutes.

Section 175

(a) A separate agreement, which shall come into effect simultaneously with this Compact, as amended, and shall have the force of law, shall govern mutual assistance and cooperation in law enforcement matters, including the pursuit, capture, imprisonment and extradition of fugitives from justice and the transfer of prisoners, as well as other law enforcement matters. In the United States, the laws of the United States governing international extradition, including 18 U.S.C. 3184, 3186, and 3188–95, shall be applicable to the extradition of fugitives under the separate agreement, and the laws of the United States governing the transfer of prisoners, including 18 U.S.C. 4100–15, shall be applicable to the transfer of prisoners under the separate agreement; and

(b) A separate agreement, which shall come into effect simultaneously with this Compact, as amended, and shall have the force of law, shall govern requirements relating to labor recruitment practices, including registration, reporting, suspension or revocation of authorization to recruit persons for employment in the United States, and enforcement for violations of such requirements.

Section 176

The Government of the Republic of the Marshall Islands confirms that final judgments in civil cases rendered by any court of the Trust Territory of the Pacific Islands shall continue in full force and effect, subject to the constitutional power of the courts of the Republic of the Marshall Islands to grant relief from judgments in appropriate cases.

Section 177

Section 177 of the Compact entered into force with respect to the Marshall Islands on October 21, 1986 as follows:

"(a) The Government of the United States accepts the responsibility for compensation owing to citizens of the Marshall Islands, or the Federated States of Micronesia, (or Palau) for loss or damage to property and person of the citizens of the Marshall Islands, or the Federated States of Micronesia, resulting from the nuclear testing program which the Government of the United States conducted in the Northern Marshall Islands between June 30, 1946, and August 18, 1958.

"(b) The Government of the United States and the Government of the Marshall Islands shall set forth in a separate agreement provisions for the just and adequate settlement of all such claims which have arisen in regard to the Marshall Islands and its citizens and which have not as yet been compensated or which in the future may arise, for the continued administration by the Government of the United States of direct radiation related medical surveillance and treatment programs and radiological monitoring activities and for such additional programs and activities as may be mutually agreed, and for the assumption by the Government of the Marshall Islands of responsibility for enforcement of limitations on the utilization of affected areas developed in cooperation with the Government of the United States and for the assistance by the Government of the United States in the exercise of such responsibility as may be mutually agreed. This separate agreement shall come into effect simultaneously with this Compact and shall remain in effect in accordance with its own terms.

"(c) The Government of the United States shall provide to the Government of the Marshall Islands, on a grant basis, the amount of $150 million to be paid and distributed in accordance with the separate agreement referred to in this Section, and shall provide the services and programs set forth in this separate agreement, the language of which is incorporated into this Compact."

The Compact, as amended, makes no changes to, and has no effect upon, Section 177 of the Compact, nor does the Compact, as amended, change or affect the separate agreement referred to in Section 177 of the Compact including Articles IX and X of that separate agreement, and measures taken by the parties thereunder.

Section 178

(a) The Federal agencies of the Government of the United States that provide services and related programs in the Republic of the Marshall Islands pursuant to Title Two are authorized to settle and pay tort claims arising in the Republic of the Marshall Islands from the activities of such agencies or from the acts or omissions of the employees of such agencies. Except as provided in section 178(b), the provisions of 28 U.S.C. 2672 and 31 U.S.C. 1304 shall apply exclusively to such administrative settlements and payments.

(b) Claims under section 178(a) that cannot be settled under section 178(a) shall be disposed of exclusively in accordance with Article II of Title Four. Arbitration awards rendered pursuant to this subsection shall be paid out of funds under 31 U.S.C. 1304.

(c) The Government of the United States and the Government of the Republic of the Marshall Islands shall, in the separate agreement referred to in section 231, provide for:

(1) the administrative settlement of claims referred to in section 178(a), including designation of local agents in each State of the Republic of the Marshall Islands; such agents to be empowered to accept, investigate and settle such claims, in a timely manner, as provided in such separate agreements; and

(2) arbitration, referred to in section 178(b), in a timely manner, at a site convenient to the claimant, in the event a claim is not otherwise settled pursuant to section 178(a).

(d) The provisions of section 174(d) shall not apply to claims covered by this section.

(e) Except as otherwise explicitly provided by law of the United States, this Compact, as amended, or its related agreements, neither the Government of the United States, its instrumentalities, nor any person acting on behalf of the Government of the United States, shall be named a party in any action based on, or arising out of, the activity or activities of a recipient of any grant or other assistance provided by the Government of the United States (or the activity or activities of the recipient's agency or any other person or entity acting on behalf of the recipient).

Section 179

(a) The courts of the Republic of the Marshall Islands shall not exercise criminal jurisdiction over the Government of the United States, or its instrumentalities.

(b) The courts of the Republic of the Marshall Islands shall not exercise criminal jurisdiction over any person if the Government of the United States provides notification to the Government of the Republic of the Marshall Islands that such person was acting on behalf of the Government of the United States, for actions taken in furtherance of section 221 or 224 of this amended

Compact, or any other provision of law authorizing financial, program, or service assistance to the Republic of the Marshall Islands.

TITLE TWO
ECONOMIC RELATIONS
Article I
Grant Assistance
Section 211 - Annual Grant Assistance

(a) In order to assist the Government of the Republic of the Marshall Islands in its efforts to promote the economic advancement and budgetary self-reliance of its people, and in recognition of the special relationship that exists between the Republic of the Marshall Islands and the United States, the Government of the United States shall provide assistance on a grant basis for a period of twenty years in the amounts set forth in section 217, commencing on the effective date of this Compact, as amended. Such grants shall be used for assistance in education, health care, the environment, public sector capacity building, and private sector development, or for other areas as mutually agreed, with priorities in the education and health care sectors. Consistent with the medium-term budget and investment framework described in subsection (f) of this section, the proposed division of this amount among the identified areas shall require the concurrence of both the Government of the United States and the Government of the Republic of the Marshall Islands, through the Joint Economic Management and Financial Accountability Committee described in section 214. The Government of the United States shall disburse the grant assistance and monitor the use of such grant assistance in accordance with the provisions of this Article and an Agreement Concerning Procedures for the Implementation of United States Economic Assistance Provided in the Compact, as Amended, of Free Association Between the Government of the United States of America and the Government of the Republic of the Marshall Islands ("Fiscal Procedures Agreement") which shall come into effect simultaneously with this Compact, as amended.

(1) EDUCATION.—United States grant assistance shall be made available in accordance with the strategic framework described in subsection (f) of this section to support and improve the educational system of the Republic of the Marshall Islands and develop the human, financial, and material resources necessary for the Republic of the Marshall Islands to perform these services. Emphasis should be placed on advancing a quality basic education system.

(2) HEALTH.—United States grant assistance shall be made available in accordance with the strategic framework described in subsection (f) of this section to support and improve the delivery of preventive, curative and environmental care and develop the human, financial, and material resources necessary for the Republic of the Marshall Islands to perform these services.

(3) PRIVATE SECTOR DEVELOPMENT.—United States grant assistance shall be made available in accordance with the strategic framework described in subsection (f) of this section to support the efforts of the Republic of the Marshall Islands to attract foreign investment and increase indigenous business activity by vitalizing the commercial environment, ensuring fair and equitable application of the law, promoting adherence to core labor standards, maintaining progress toward privatization of state-owned and partially state-owned enterprises, and engaging in other reforms.

(4) CAPACITY BUILDING IN THE PUBLIC SECTOR.—United States grant assistance shall be made available in accordance with the strategic framework described in subsection (f) of this section to support the efforts of the Republic of the Marshall Islands to build effective, accountable and transparent national and local government and other public sector institutions and systems.

(5) ENVIRONMENT.—United States grant assistance shall be made available in accordance with the strategic framework described in subsection (f) of this section to increase environmental protection; establish and manage conservation areas; engage in environmental infrastructure planning, design construction and operation; and to involve the citizens of the Republic of the Marshall Islands in the process of conserving their country's natural resources.

(b) KWAJALEIN ATOLL.—

(1) Of the total grant assistance made available under subsection (a) of this section, the amount specified herein shall be allocated annually from fiscal year 2004 through fiscal year 2023 (and thereafter in accordance with the Agreement between the Government of the United States and the Government of the Republic of the Marshall Islands Regarding Military Use and Operating Rights) to advance the objectives and specific priorities set forth in subsections (a) and (d) of this section and the Fiscal Procedures Agreement, to address the special needs of the community at Ebeye, Kwajalein Atoll and other Marshallese communities within Kwajalein Atoll. This United States grant assistance shall be made available, in accordance with the medium-term budget and investment framework described in subsection (f) of this section, to support and improve the infrastructure and delivery of services and develop the human and material resources necessary for the Republic of the Marshall Islands to carry out its responsibility to maintain such infrastructure and deliver such services. The amount of this assistance shall be $3,100,000, with an inflation adjustment as provided in section 218, from fiscal year 2004 through fiscal year 2013 and the fiscal year 2013 level of funding, with an inflation adjustment as provided in section 218, will be increased by $2 million for fiscal year 2014. The fiscal year 2014 level of funding, with an inflation adjustment as provided in section 218, will be made available from fiscal year 2015 through fiscal year 2023 (and thereafter as noted above).

(2) The Government of the United States shall also provide to the Government of the Republic of the Marshall Islands, in conjunction with section 321(a) of this Compact, as amended, an annual payment from fiscal year 2004 through fiscal year 2023 (and thereafter in accordance with the Agreement between the Government of the United States and the Government of the Republic of the Marshall Islands Regarding Military Use and Operating Rights) of $1.9 million. This grant assistance will be subject to the Fiscal Procedures Agreement and will be adjusted for inflation under section 218 and used to address the special needs of the community at Ebeye, Kwajalein Atoll and other Marshallese communities within Kwajalein Atoll with emphasis on the Kwajalein landowners, as described in the Fiscal Procedures Agreement.

(3) Of the total grant assistance made available under subsection (a) of this section, and in conjunction with section 321(a) of the Compact, as amended, $200,000, with an inflation adjustment as provided in section 218, shall be allocated annually from fiscal year 2004 through fiscal year 2023 (and thereafter as provided in the Agreement between the Government of the United States and the Government of the Republic of the Marshall Islands Regarding Military Use and Operating Rights) for a grant to support increased participation of the Government of the Republic of the Marshall Islands Environmental Protection Authority in the annual U.S. Army Kwajalein Atoll Environmental Standards Survey and to promote a greater Government of the Republic of the Marshall Islands capacity for independent analysis of the Survey's findings and conclusions.

(c) HUMANITARIAN ASSISTANCE—REPUBLIC OF THE MARSHALL ISLANDS PROGRAM.—In recognition of the special development needs of the Republic of the Marshall Islands, the Government of the United States shall make available to the Government of the Republic of the Marshall Islands, on its request and to be deducted from the grant amount made available under subsection (a) of this section, a Humanitarian Assistance—Republic of the Marshall Islands ("HARMI") Program with emphasis on health, education, and infrastructure (including transportation), projects and such other projects as mutually agreed. The terms and conditions of the HARMI shall be set forth in the Agreement Regarding the Military Use and Operating Rights of the Government of the United States in the Republic of the Marshall Islands Concluded Pursuant to Sections 321 and 323 of the Compact of Free Association, as Amended, which shall come into effect simultaneously with the amendments to this Compact.

(d) PUBLIC INFRASTRUCTURE.—

(1) Unless otherwise agreed, not less than 30 percent and not more than 50 percent of U.S. annual grant assistance provided under this section shall be made available in accordance with a list of specific projects included in the infrastructure improvement and maintenance plan prepared by the Government of the Republic of the Marshall Islands as part of the strategic framework described in subsection (f) of this section.

(2) INFRASTRUCTURE MAINTENANCE FUND.—Five percent of the annual public infrastructure grant made available under paragraph (1) of this subsection shall be set aside, with an equal contribution from the Government of the Republic of the Marshall Islands, as a contribution to an Infrastructure Maintenance Fund. Administration of the Infrastructure Maintenance Fund shall be governed by the Fiscal Procedures Agreement.

(e) DISASTER ASSISTANCE EMERGENCY FUND.—Of the total grant assistance made available under subsection (a) of this section, an amount of two hundred thousand dollars ($200,000) shall be provided annually, with an equal contribution from the Government of the Republic of the Marshall Islands, as a contribution to a Disaster Assistance Emergency Fund ("DAEF"). Any funds from the DAEF may be used only for assistance and rehabilitation resulting from disasters and emergencies. The funds will be accessed upon declaration of a State of Emergency by the Government of the Republic of the Marshall Islands, with the concurrence of the United States Chief of Mission to the Republic of the Marshall Islands. Administration of the DAEF shall be governed by the Fiscal Procedures Agreement.

(f) BUDGET AND INVESTMENT FRAMEWORK.—The Government of the Republic of the Marshall Islands shall prepare and maintain an official medium-term budget and investment framework. The framework shall be strategic in nature, shall be continuously reviewed and updated through the annual budget process, and shall make projections on a multi-year rolling basis. Each of the sectors and areas named in subsections (a), (b), and (d) of this section, or other sectors and areas as mutually agreed, shall be accorded specific treatment in the framework. Those portions of the framework that contemplate the use of United States grant funds shall require the concurrence of both the Government of the United States and the Government of the Republic of the Marshall Islands.

Section 212—Kwajalein Impact and Use

The Government of the United States shall provide to the Government of the Republic of the Marshall Islands in conjunction with section 321(a) of the Compact, as amended, and the agreement between the Government of the

United States and the Government of the Republic of the Marshall Islands regarding military use and operating rights, a payment in fiscal year 2004 of $15,000,000, with no adjustment for inflation. In fiscal year 2005 and through fiscal year 2013, the annual payment will be the fiscal year 2004 amount ($15,000,000) with an inflation adjustment as provided under section 218. In fiscal year 2014, the annual payment will be $18,000,000 (with no adjustment for inflation) or the fiscal year 2013 amount with an inflation adjustment under section 218, whichever is greater. For fiscal year 2015 through fiscal year 2023 (and thereafter in accordance with the Agreement between the Government of the United States and the Government of the Republic of the Marshall Islands Regarding Military Use and Operating Rights) the annual payment will be the fiscal year 2014 amount, with an inflation adjustment as provided under section 218.

Section 213 - Accountability

(a) Regulations and policies normally applicable to United States financial assistance to its state and local governments, as set forth in the Fiscal Procedures Agreement, shall apply to each grant described in section 211, and to grants administered under section 221 below, except as modified in the separate agreements referred to in section 231 of this Compact, as amended, or by U.S. law. As set forth in the Fiscal Procedures Agreement, reasonable terms and conditions, including annual performance indicators that are necessary to ensure effective use of United States assistance and reasonable progress toward achieving program objectives may be attached. In addition, the United States may seek appropriate remedies for noncompliance with the terms and conditions attached to the assistance, or for failure to comply with section 234, including withholding assistance.

(b) The Government of the United States shall, for each fiscal year of the twenty years during which assistance is to be provided on a sector grant basis under section 211 (a), grant the Government of the Republic of the Marshall Islands an amount equal to the lesser of (i) one half of the reasonable, properly documented cost incurred during such fiscal year to conduct the annual audit required under Article VIII (2) of the Fiscal Procedures Agreement or (ii) $500,000. Such amount will not be adjusted for inflation under section 218 or otherwise.

Section 214 - Joint Economic Management and Financial Accountability Committee

The Governments of the United States and the Republic of the Marshall Islands shall establish a Joint Economic Management and Financial Accountability Committee, composed of a U.S. chair, two other members from the Government of the United States and two members from the Government of the Republic of the Marshall Islands. The Joint Economic Management and Financial Accountability Committee shall meet at least once each year to review the audits and reports required under this Title and the Fiscal Procedures Agreement, evaluate the progress made by the Republic of the Marshall Islands in meeting the objectives identified in its framework described in subsection (f) of section 211, with particular focus on those parts of the framework dealing with the sectors and areas identified in subsection (a) of section 211, identify problems encountered, and recommend ways to increase the effectiveness of U.S. assistance made available under this Title. The establishment and operations of the Joint Economic Management and Financial Accountability Committee shall be governed by the Fiscal Procedures Agreement.

Section 215 - Annual Report

The Government of the Republic of the Marshall Islands shall report annually to the President of the United States on the use of United States sector grant assistance and other assistance and progress in meeting mutually agreed program and economic goals. The Joint Economic Management and Financial Accountability Committee shall review and comment on the report and make appropriate recommendations based thereon.

Section 216 - Trust Fund

(a) The United States shall contribute annually for twenty years from the effective date of the Compact, as amended, in the amounts set forth in section 217 into a trust fund established in accordance with the Agreement Between the Government of the United States of America and the Government of the Republic of the Marshall Islands Implementing Section 216 and Section 217 of the Compact, as Amended, Regarding a Trust Fund ("Trust Fund Agreement"), which shall come into effect simultaneously with this Compact, as amended. Upon termination of the annual grant assistance under section 211 (a), (d) and (e), the earnings of the fund shall thereafter be used for the purposes described in section 211 or as otherwise mutually agreed.

(b) The United States contribution into the Trust Fund described in subsection (a) of this section is conditioned on the Government of the Republic of the Marshall Islands contributing to the Trust Fund at least $25,000,000, on the effective date of the Trust Fund Agreement or on October 1, 2003, whichever is later, $2,500,000 prior to October 1, 2004, and $2,500,000 prior to October 1, 2005. Any funds received by the Republic of the Marshall Islands under section 111(d) of Public Law 99–239 (January 14, 1986), or successor provisions, would be contributed to the Trust Fund as a Republic of the Marshall Islands' contribution.

(c) The terms regarding the investment and management of funds and use of the income of the Trust Fund shall be governed by the Trust Fund Agreement. Funds derived from United States investment shall not be subject to Federal or state taxes in the United States or any taxes in the Republic of the Marshall Islands. The Trust Fund Agreement shall also provide for annual reports to the Government of the United States and to the Government of the Republic of the Marshall Islands. The Trust Fund Agreement shall provide for appropriate distributions of trust fund proceeds to the Republic of the Marshall Islands and for appropriate remedies for the failure of the Republic of the Marshall Islands to use income of the Trust Fund for the annual grant purposes set forth in section 211. These remedies may include the return to the United States of the present market value of its contributions to the Trust Fund and the present market value of any undistributed income on the contributions of the United States. If this Compact, as amended, is terminated, the provisions of sections 451–453 of the Compact, as amended, and the Trust Fund Agreement shall govern treatment of any U.S. contributions to the Trust Fund or accrued income thereon.

Section 217 - Annual Grant Funding and Trust Fund Contributions

The funds described in sections 211, 212, 213(b), and 216 shall be made available as follows:

[In millions of dollars]

Fiscal year	Annual Grants Section 211	Audit Grant Section 213(b)	Trust Fund Section 216 (a&c)	Kwajalein Impact Section 212	Total
2004	35.2	.5	7	15.0	57.7
2005	34.7	.5	7.5	15.0	57.7
2006	34.2	.5	8	15.0	57.7
2007	33.7	.5	8.5	15.0	57.7
2008	33.2	.5	9	15.0	57.7
2009	32.7	.5	9.5	15.0	57.7
2010	32.2	.5	10	15.0	57.7
2011	31.7	.5	10.5	15.0	57.7
2012	31.2	.5	11	15.0	57.7
2013	30.7	.5	11.5	15.0	57.7
2014	32.2	.5	12	18.0	62.7
2015	31.7	.5	12.5	18.0	62.7
2016	31.2	.5	13	18.0	62.7
2017	30.7	.5	13.5	18.0	62.7
2018	30.2	.5	14	18.0	62.7
2019	29.7	.5	14.5	18.0	62.7
2020	29.2	.5	15	18.0	62.7
2021	28.7	.5	15.5	18.0	62.7
2022	28.2	.5	16	18.0	62.7
2023	27.7	.5	16.5	18.0	62.7

Section 218 - Inflation Adjustment

Except as otherwise provided, the amounts stated in this Title shall be adjusted for each United States Fiscal Year by the percent that equals two-thirds of the percent change in the United States Gross Domestic Product Implicit Price Deflator, or 5 percent, whichever is less in any one year, using the beginning of Fiscal Year 2004 as a base.

Section 219 - Carry-Over of Unused Funds

If in any year the funds made available by the Government of the United States for that year *pursuant to this Article are not completely obligated by the Government of the Republic of the Marshall Islands, the unobligated balances shall remain available in addition to the funds to be provided in subsequent years.*

Article II

Services and Program Assistance

Section 221

(a) SERVICES.—The Government of the United States shall make available to the Republic of the Marshall Islands, in accordance with and to the extent provided in the Federal Programs and Services Agreement referred to in Section 231, the services and related programs of:

(1) the United States Weather Service;

(2) the United States Postal Service;

(3) the United States Federal Aviation Administration;

(4) the United States Department of Transportation; and

(5) the Department of Homeland Security, and the United States Agency for International Development, Office of Foreign Disaster Assistance.

Upon the effective date of this Compact, as amended, the United States Departments and Agencies named or having responsibility to provide these services and related programs shall have the authority to implement the relevant provisions of the Federal Programs and Services Agreement referred to in section 231.

(b) PROGRAMS.—

(1) Other than the services and programs covered by subsection (a) of this section, and to the extent authorized by the Congress of the United States, the Government of the United States shall make available to the Republic of the Marshall Islands the services and programs that were available to the Republic of the Marshall Islands on the effective date of this Compact, as amended, to the extent that such services and programs continue to be available to State and local governments of the United States. As set forth in the Fiscal Procedures Agreement, funds provided under subsection (a) of section 211 shall be considered to be local revenues of the Government of the Republic of the Marshall Islands when used as the local share required to obtain Federal programs and services.

(2) Unless provided otherwise by U.S. law, the services and programs described in paragraph (1) of this subsection shall be extended in accordance with the terms of the Federal Programs and Services Agreement.

(c) The Government of the United States shall have and exercise such authority as is necessary to carry out its responsibilities under this Title and the Federal Programs and Services Agreement, including the authority to monitor and administer all service and program assistance provided by the United States to the Republic of the Marshall Islands. The Federal Programs and Services Agreement shall also set forth the extent to which services and programs shall be provided to the Republic of the Marshall Islands.

(d) Except as provided elsewhere in this Compact, as amended, under any separate agreement entered into under this Compact, as amended, or otherwise under U.S. law, all Federal domestic programs extended to or operating in the Republic of the Marshall Islands shall be subject to all applicable criteria, standards, reporting requirements, auditing procedures, and other rules and regulations applicable to such programs and services when operating in the United States.

(e) The Government of the United States shall make available to the Republic of the Marshall Islands alternate energy development projects, studies, and conservation measures to the extent provided for the Freely Associated States in the laws of the United States.

Section 222

The Government of the United States and the Government of the Republic of the Marshall Islands may agree from time to time to extend to the Republic of the Marshall Islands additional United States grant assistance, services and programs, as provided under the laws of the United States. Unless inconsistent with such laws, or otherwise specifically precluded by the Government of the United States at the time such additional grant assistance, services, or programs are extended, the Federal Programs and Services Agreement shall apply to any such assistance, services or programs.

Section 223

The Government of the Republic of the Marshall Islands shall make available to the Government of the United States at no cost such land as may be necessary for the operations of the services and programs provided pursuant to this Article, and such facilities as are provided by the Government of the Republic of the Marshall Islands at no cost to the Government of the United States as of the effective date of this Compact, as amended, or as may be mutually agreed thereafter.

Section 224

The Government of the Republic of the Marshall Islands may request, from the time to time, technical assistance from the Federal agencies and institutions of the Government of the United States, which are authorized to grant such technical assistance in accordance with its laws. If technical assistance is granted pursuant to such a request, the Government of the United States shall provide the technical assistance in a manner which gives priority consideration to the Republic of the Marshall Islands over other recipients not a part of the United States, its territories or possessions, and equivalent consideration to the Republic of the Marshall Islands with respect to other states in Free Association with the United States. Such assistance shall be made available on a reimbursable or non-reimbursable basis to the extent provided by United States law.

Article III

Administrative Provisions

Section 231

The specific nature, extent and contractual arrangements of the services and programs provided for in section 221 of this Compact, as amended, as well as the legal status of agencies of the Government of the United States, their civilian employees and contractors, and the dependents of such personnel while present in the Republic of the Marshall Islands, and other arrangements in connection with the assistance, services, or programs furnished by the Government of the United States, are set forth in a Federal Programs and Services Agreement which shall come into effect simultaneously with this Compact, as amended.

Section 232

The Government of the United States, in consultation with the Government of the Republic of the Marshall Islands, shall determine and implement procedures for the periodic audit of all grants and other assistance made under Article I of this Title and of all funds expended for the services and programs provided under Article II of this Title. Further, in accordance with the Fiscal Procedures Agreement described in subsection (a) of section 211, the Comptroller General of the United States shall have such powers and authorities as described in sections 103(m) and 110(c) of Public Law 99–239, 99 Stat. 1777–78, and 99 Stat. 1799 (January 14, 1986).

Section 233

Approval of this Compact, as amended, by the Government of the United States, in accordance with its constitutional processes, shall constitute a pledge by the United States that the sums and amounts specified as grants in section 211 of this Compact, as amended, shall be appropriated and paid to the Republic of the Marshall Islands for such period as those provisions of this Compact, as amended, remain in force, provided that the Republic of the Marshall Islands complies with the terms and conditions of this Title and related subsidiary agreements.

Section 234

The Government of the Republic of the Marshall Islands pledges to cooperate with, permit, and assist if reasonably requested, designated and authorized representatives of the Government of the United States charged with investigating whether Compact funds, or any other assistance authorized under this Compact, as amended, have, or are being, used for purposes other than those set forth in this Compact, as amended, or its subsidiary agreements. In carrying out this investigative authority, such United States Government representatives may request that the Government of the Republic of the Marshall Islands subpoena documents and records and compel testimony in accordance with the laws and Constitution of the Republic of the Marshall Islands. Such assistance by the Government of the Republic of the Marshall Islands to the Government of the United States shall not be unreasonably withheld. The obligation of the Government of the Marshall Islands to fulfill its pledge herein is a condition to its receiving payment of such funds or other assistance authorized under this Compact, as amended. The Government of the United States shall pay any reasonable costs for extraordinary services executed by the Government of the Marshall Islands in carrying out the provisions of this section.

Article IV

Trade

Section 241

The Republic of the Marshall Islands is not included in the customs territory of the United States.

Section 242

The President shall proclaim the following tariff treatment for articles imported from the Republic of the Marshall Islands which shall apply during the period of effectiveness of this title:

(a) Unless otherwise excluded, articles imported from the Republic of the Marshall Islands, subject to the limitations imposed under section 503(b) of title V of the Trade Act of 1974 (19 U.S.C. 2463(b)), shall be exempt from duty.

(b) Only tuna in airtight containers provided for in heading 1604.14.22 of the Harmonized Tariff Schedule of the United States that is imported from the Republic of the Marshall Islands and the Federated States of Micronesia during any calendar year not to exceed 10 percent of apparent United States consumption of tuna in airtight containers during the immediately preceding calendar year, as reported by the National Marine Fisheries Service, shall be exempt from duty; but the quantity of tuna given duty-free treatment under this paragraph for any calendar year shall be counted against the aggregated quantity of tuna in airtight containers that is dutiable under rate column numbered 1 of such heading 1604.14.22 for that calendar year.

(c) The duty-free treatment provided under subsection (a) shall not apply to:

(1) watches, clocks, and timing apparatus provided for in Chapter 91, excluding heading 9113, of the Harmonized Tariff Schedule of the United States;

(2) buttons (whether finished or not finished) provided for in items 9606.21.40 and 9606.29.20 of such Schedule;

(3) textile and apparel articles which are subject to textile agreements; and

(4) footwear, handbags, luggage, flat goods, work gloves, and leather wearing apparel which were not eligible articles for purposes of title V

of the Trade Act of 1974 (19 U.S.C. 2461, et seq.) on April 1, 1984.

(d) If the cost or value of materials produced in the customs territory of the United States is included with respect to an eligible article which is a product of the Republic of the Marshall Islands, an amount not to exceed 15 percent of the appraised value of the article at the time it is entered that is attributable to such United States cost or value may be applied for duty assessment purposes toward determining the percentage referred to in section 503(a)(2) of title V of the Trade Act of 1974.

Section 243

Articles imported from the Republic of the Marshall Islands which are not exempt from duty under subsections (a), (b), (c), and (d) of section 242 shall be subject to the rates of duty set forth in column numbered 1-general of the Harmonized Tariff Schedule of the United States (HTSUS).

Section 244

(a) All products of the United States imported into the Republic of the Marshall Islands shall receive treatment no less favorable than that accorded like products of any foreign country with respect to customs duties or charges of a similar nature and with respect to laws and regulations relating to importation, exportation, taxation, sale, distribution, storage or use.

(b) The provisions of subsection (a) shall not apply to advantages accorded by the Republic of the Marshall Islands by virtue of their full membership in the Pacific Island Countries Trade Agreement (PICTA), done on August 18, 2001, to those governments listed in Article 26 of PICTA, as of the date the Compact, as amended, is signed.

(c) Prior to entering into consultations on, or concluding, a free trade agreement with governments not listed in Article 26 of PICTA, the Republic of the Marshall Islands shall consult with the United States regarding whether or how subsection (a) of section 244 shall be applied.

Article V

Finance and Taxation

Section 251

The currency of the United States is the official circulating legal tender of the Republic of the Marshall Islands. Should the Government of the Republic of the Marshall Islands act to institute another currency, the terms of an appropriate currency transitional period shall be as agreed with the Government of the United States.

Section 252

The Government of the Republic of the Marshall Islands may, with respect to United States persons, tax income derived from sources within its respective jurisdiction, property situated therein, including transfers of such property by gift or at death, and products consumed therein, in such manner as the Government of the Republic of the Marshall Islands deems appropriate. The determination of the source of any income, or the situs of any property, shall for purposes of this Compact, as amended, be made according to the United States Internal Revenue Code.

Section 253

A citizen of the Republic of the Marshall Islands, domiciled therein, shall be exempt from estate, gift, and generation-skipping transfer taxes imposed by the Government of the United States, provided that such citizen of the Republic of the Marshall Islands is neither a citizen nor a resident of the United States.

Section 254

(a) In determining any income tax imposed by the Government of the Republic of the Marshall Islands, the Government of the Republic of the Marshall Islands shall have authority to impose tax upon income derived by a resident of the Republic of the Marshall Islands from sources without the Republic of the Marshall Islands, in the same manner and to the same extent as the Government of the Republic of the Marshall Islands imposes tax upon income derived from within its own jurisdiction. If the Government of the Republic of the Marshall Islands exercises such authority as provided in this subsection, any individual resident of the Republic of the Marshall Islands who is subject to tax by the Government of the United States on income which is also taxed by the Government of the Republic of the Marshall Islands shall be relieved of liability to the Government of the United States for the tax which, but for this subsection, would otherwise be imposed by the Government of the United States on such income. However, the relief from liability to the United States Government referred to in the preceding sentence means only relief in the form of the foreign tax credit (or deduction in lieu thereof) available with respect to the income taxes of a possession of the United States, and relief in the form of the exclusion under section 911 of the Internal Revenue Code of 1986. For purposes of this section, the term "resident of the Republic of the Marshall Islands" shall be deemed to include any person who was physically present in the Republic of the Marshall Islands for a period of 183 or more days during any taxable year.

(b) If the Government of the Republic of the Marshall Islands subjects income to taxation substantially similar to that which was imposed by the Trust Territory Code in effect on January 1, 1980, such Government shall be deemed to have exercised the authority described in section 254(a).

Section 255

For purposes of section 274(h)(3)(A) of the U.S. Internal Revenue Code of 1986, the term "North American Area" shall include the Republic of the Marshall Islands.

TITLE THREE

SECURITY AND DEFENSE RELATIONS

Article I

Authority and Responsibility

Section 311

(a) The Government of the United States has full authority and responsibility for security and defense matters in or relating to the Republic of the Marshall Islands.

(b) This authority and responsibility includes:

(1) the obligation to defend the Republic of the Marshall Islands and its people from attack or threats thereof as the United States and its citizens are defended;

(2) the option to foreclose access to or use of the Republic of the Marshall Islands by military personnel or for the military purposes of any third country; and

(3) the option to establish and use military areas and facilities in the Republic of the Marshall Islands, subject to the terms of the separate agreements referred to in sections 321 and 323.

(c) The Government of the United States confirms that it shall act in accordance with the principles of international law and the Charter of the United Nations in the exercise of this authority and responsibility.

Section 312

Subject to the terms of any agreements negotiated in accordance with sections 321 and 323, the Government of the United States may conduct within the lands, waters and airspace of the Republic of the Marshall Islands the activities and operations necessary for the exercise of its authority and responsibility under this Title.

Section 313

(a) The Government of the Republic of the Marshall Islands shall refrain from actions that the Government of the United States determines, after appropriate consultation with that Government, to be incompatible with its authority and responsibility for security and defense matters in or relating to the Republic of the Marshall Islands.

(b) The consultations referred to in this section shall be conducted expeditiously at senior levels of the two Governments, and the subsequent determination by the Government of the United States referred to in this section shall be made only at senior interagency levels of the Government of the United States.

(c). The Government of the Republic of the Marshall Islands shall be afforded, on an expeditious basis, an opportunity to raise its concerns with the United States Secretary of State personally and the United States Secretary of Defense personally regarding any determination made in accordance with this section.

Section 314

(a) Unless otherwise agreed, the Government of the United States shall not, in the Republic of the Marshall Islands:

(1) test by detonation or dispose of any nuclear weapon, nor test, dispose of, or discharge any toxic chemical or biological weapon; or

(2) test, dispose of, or discharge any other radioactive, toxic chemical or biological materials in an amount or manner that would be hazardous to public health or safety.

(b) Unless otherwise agreed, other than for transit or overflight purposes or during time of a national emergency declared by the President of the United States, a state of war declared by the Congress of the United States or as necessary to defend against an actual or impending armed attack on the United States, the Republic of the Marshall Islands or the Federated States of Micronesia, the Government of the United States shall not store in the Republic of the Marshall Islands or the Federated States of Micronesia any toxic chemical weapon, nor any radioactive materials nor any toxic chemical materials intended for weapons use.

(c) Radioactive, toxic chemical, or biological materials not intended for weapons use shall not be affected by section 314(b).

(d) No material or substance referred to in this section shall be stored in the Republic of the Marshall Islands except in an amount and manner which would not be hazardous to public health or safety. In determining what shall be an amount or manner which would be hazardous to public health or safety under this section, the Government of the United States shall comply with any applicable mutual agreement, international guidelines accepted by the Government of the United States, and the laws of the United States and their implementing regulations.

(e) Any exercise of the exemption authority set forth in section 161(e) shall have no effect on the obligations of the Government of the United States under this section or on the application of this subsection.

(f) The provisions of this section shall apply in the areas in which the Government of the Republic of the Marshall Islands exercises jurisdiction over the living resources of the seabed, subsoil or water column adjacent to its coasts.

Section 315

The Government of the United States may invite members of the armed forces of other countries to use military areas and facilities in the Republic of the Marshall Islands, in conjunction with and under the control of United States Armed Forces. Use by units of the armed forces of other countries of such military areas and facilities, other than for transit and overflight purposes, shall be subject to consultation with and, in the case of major units, approval of the Government of the Republic of the Marshall Islands.

Section 316

The authority and responsibility of the Government of the United States under this Title may not be transferred or otherwise assigned.

Article II

Defense Facilities and Operating Rights

Section 321

(a) Specific arrangements for the establishment and use by the Government of the United States of military areas and facilities in the Republic of the Marshall Islands are set forth in separate agreements, which shall remain in effect in accordance with the terms of such agreements.

(b) If, in the exercise of its authority and responsibility under this Title, the Government of the United States requires the use of areas within the Republic of the Marshall Islands in addition to those for which specific arrangements are concluded pursuant to section 321(a), it may request the Government of the Republic of the Marshall Islands to satisfy those requirements through leases or other arrangements. The Government of the Republic of the Marshall Islands shall sympathetically consider any such request and shall establish suitable procedures to discuss it with and provide a prompt response to the Government of the United States.

(c) The Government of the United States recognizes and respects the scarcity and special importance of land in the Republic of the Marshall Islands. In making any requests pursuant to section 321(b), the Government of the United States shall follow the policy of requesting the minimum area necessary to accomplish the required security and defense purpose, of requesting only the minimum interest in real property necessary to support such purpose, and of requesting first to satisfy its requirement through public real property, where available, rather than through private real property.

Section 322

The Government of the United States shall provide and maintain fixed and floating aids to navigation in the Republic of the Marshall Islands at least to the extent necessary for the exercise of its authority and responsibility under this Title.

Section 323

The military operating rights of the Government of the United States and the legal status and contractual arrangements of the United States Armed Forces, their members, and associated civilians, while present in the Republic of the Marshall Islands are set forth in separate agreements, which shall remain in effect in accordance with the terms of such agreements.

Article III

Defense Treaties and International Security Agreements

Section 331

Subject to the terms of this Compact, as amended, and its related agreements, the Government of the United States, exclusively, has assumed and enjoys, as to the Republic of the Marshall Islands, all obligations, responsibilities, rights and benefits of:

(a) Any defense treaty or other international security agreement applied by the Government of the United States as Administering Authority of the Trust Territory of the Pacific Islands as of October 20, 1986.

(b) Any defense treaty or other international security agreement to which the Government of the United States is or may become a party which it determines to be applicable in the Republic of the Marshall Islands. Such a determination by the Government of the United States shall be preceded by appropriate consultation with the Government of the Republic of the Marshall Islands.

Article IV

Service in Armed Forces of the United States

Section 341

Any person entitled to the privileges set forth in Section 141 (with the exception of any person described in section 141(a)(5) who is not a citizen of the Republic of the Marshall Islands) shall be eligible to volunteer for service in the Armed Forces of the United States, but shall not be subject to involuntary induction into military service of the United States as long as such person has resided in the United States for a period of less than one year, provided that no time shall count towards this one year while a person admitted to the United States under the Compact, or the Compact, as amended, is engaged in full-time study in the United States. Any person described in section 141(a)(5) who is not a citizen of the Republic of the Marshall Islands shall be subject to United States laws relating to selective service.

Section 342

The Government of the United States shall have enrolled, at any one time, at least one qualified student from the Republic of the Marshall Islands, as may be nominated by the Government of the Republic of the Marshall Islands, in each of:

(a) The United States Coast Guard Academy pursuant to 14 U.S.C. 195.

(b) The United States Merchant Marine Academy pursuant to 46 U.S.C. 1295(b)(6), provided that the provisions of 46 U.S.C. 1295b(b)(6)(C) shall not apply to the enrollment of students pursuant to section 342(b) of this Compact, as amended.

Article V

General Provisions

Section 351

(a) The Government of the United States and the Government of the Republic of the Marshall Islands shall continue to maintain a Joint Committee empowered to consider disputes arising under the implementation of this Title and its related agreements.

(b) The membership of the Joint Committee shall comprise selected senior officials of the two Governments. The senior United States military commander in the Pacific area shall be the senior United States member of the Joint Committee. For the meetings of the Joint Committee, each of the two Governments may designate additional or alternate representatives as appropriate for the subject matter under consideration.

(c) Unless otherwise mutually agreed, the Joint Committee shall meet annually at a time and place to be designated, after appropriate consultation, by the Government of the United States. The Joint Committee also shall meet promptly upon request of either of its members. The Joint Committee shall follow such procedures, including the establishment of functional subcommittees, as the members may from time to time agree. Upon notification by the Government of the United States, the Joint Committee of the United States and the Republic of the Marshall Islands shall meet promptly in a combined session with the Joint Committee established and maintained by the Government of the United States and the Government of the Federated States of Micronesia to consider matters within the jurisdiction of the two Joint Committees.

(d) Unresolved issues in the Joint Committee shall be referred to the Governments for resolution, and the Government of the Republic of the Marshall Islands shall be afforded, on an expeditious basis, an opportunity to raise its concerns with the United States Secretary of Defense personally regarding any unresolved issue which threatens its continued association with the Government of the United States.

Section 352

In the exercise of its authority and responsibility under Title Three, the Government of the United States shall accord due respect to the authority and responsibility of the Government of the Republic of the Marshall Islands under Titles One, Two and Four and to the responsibility of the Government of the Republic of the Marshall Islands to assure the well-being of its people.

Section 353

(a) The Government of the United States shall not include the Government of the Republic of the Marshall Islands as a named party to a formal declaration of war, without that Government's consent.

(b) Absent such consent, this Compact, as amended, is without prejudice, on the ground of belligerence or the existence of a state of war, to any claims for damages which are advanced by the citizens, nationals or Government of the Republic of the Marshall Islands, which arise out of armed conflict subsequent to October 21, 1986, and which are:

(1) petitions to the Government of the United States for redress; or

(2) claims in any manner against the government, citizens, nationals or entities of any third country.

(c) Petitions under section 353(b)(1) shall be treated as if they were made by citizens of the United States.

Section 354

(a) The Government of the United States and the Government of the Republic of the Marshall Islands are jointly committed to continue their security and defense relations, as set forth in this Title. Accordingly, it is the intention of the two countries that the provisions of this Title shall remain binding as long as this Compact, as amended, remains in effect, and thereafter as mutually agreed, unless earlier terminated by mutual agreement pursuant to section 441, or amended pursuant to Article III of Title Four. If at any time the Government of the United States, or the Government of the Republic of the Marshall Islands, acting unilaterally, terminates this Title, such unilateral termination shall be considered to be termination of the entire Compact, as amended, in which case the provisions of section 442 and 452 (in the case of termination by the Government of the United States) or sections 443 and 453 (in the case of termination by the Government of the Republic of the Marshall Islands), with the exception of paragraph (3) of subsection (a) of section 452 or paragraph (3) of subsection (a) of section 453, as the case may be, shall apply.

(b) The Government of the United States recognizes, in view of the special relationship between the Government of the United States and the Government of the Republic of the Marshall Islands, and in view of the existence of the separate agreement regarding mutual security concluded with the Government of the Republic of the Marshall Islands pursuant to sections 321 and 323, that, even if this Title should terminate, any attack on the Republic of the Marshall Islands during the period in which such separate agreement is in effect, would constitute a threat to the peace and security of the entire region and a danger to the United States. In the event of such an attack, the Government of the United States would take action to meet the danger to the United States and to the Republic of the Marshall Islands in accordance with its constitutional processes.

(c) As reflected in Article 21(1)(b) of the Trust Fund Agreement, the Government of the United States and the Government of the Republic of the Marshall Islands further recognize, in view of the special relationship between their countries, that even if this Title should terminate, the Government of Republic of the Marshall Islands shall refrain from actions which the Government of the United States determines, after appropriate consultation with that Government, to be incompatible with its authority and responsibility for security and defense matters in *or relating to the Republic of the Marshall Islands or the Federated States of Micronesia.*

TITLE FOUR

GENERAL PROVISIONS

Article I

Approval and Effective Date

Section 411

Pursuant to section 432 of the Compact and subject to subsection (e) of section 461 of the Compact, as amended, the Compact, as amended, shall come into effect upon mutual agreement between the Government of the United States and the Government of the Republic of the Marshall Islands subsequent to completion of the following:

(a) Approval by the Government of the Republic of the Marshall Islands in accordance with its constitutional processes.

(b) Approval by the Government of the United States in accordance with its constitutional processes.

Article II

Conference and Dispute Resolution

Section 421

The Government of the United States shall confer promptly at the request of the Government of the Republic of the Marshall Islands and that Government shall confer promptly at the request of the Government of the United States on matters relating to the provisions of this Compact, as amended, or of its related agreements.

Section 422

In the event the Government of the United States or the Government of the Republic of the Marshall Islands, after conferring pursuant to section 421, determines that there is a dispute and gives written notice thereof, the two Governments shall make a good faith effort to resolve the dispute between themselves.

Section 423

If a dispute between the Government of the United States and the Government of the Republic of the Marshall Islands cannot be resolved within 90 days of written notification in the manner provided in section 422, either party to the dispute may refer it to arbitration in accordance with section 424.

Section 424

Should a dispute be referred to arbitration as provided for in section 423, an Arbitration Board shall be established for the purpose of hearing the dispute and rendering a decision which shall be binding upon the two parties to the dispute unless the two parties mutually agree that the decision shall be advisory. Arbitration shall occur according to the following terms:

(a) An Arbitration Board shall consist of a Chairman and two other members, each of whom shall be a citizen of a party to the dispute. Each of the two Governments that is a party to the dispute shall appoint one member to the Arbitration Board. If either party to the dispute does not fulfill the appointment requirements of this section within 30 days of referral of the dispute to arbitration pursuant to section 423, its member on the Arbitration Board shall be selected from its own standing list by the other party to the dispute. Each Government shall maintain a standing list of 10 candidates. The parties to the dispute shall jointly appoint a Chairman within 15 days after selection of the other members of the Arbitration Board. Failing agreement on a Chairman, the Chairman shall be chosen by lot from the standing lists of the parties to the dispute within 5 days after such failure.

(b) Unless otherwise provided in this Compact, as amended, or its related agreements, the Arbitration Board shall have jurisdiction to hear and render its final determination on all disputes arising exclusively under Articles I, II, III, IV and V of Title One, Title Two, Title Four, and their related agreements.

(c) Each member of the Arbitration Board shall have one vote. Each decision of the Arbitration Board shall be reached by majority vote.

(d) In determining any legal issue, the Arbitration Board may have reference to international law and, in such reference, shall apply as guidelines the provisions set forth in Article 38 of the Statute of the International Court of Justice.

(e) The Arbitration Board shall adopt such rules for its proceedings as it may deem appropriate and necessary, but such rules shall not contravene the provisions of this Compact, as amended. Unless the parties provide otherwise by mutual agreement, the Arbitration Board shall endeavor to render its decision within 30 days after the conclusion of arguments. The Arbitration Board shall make findings of fact and conclusions of law and its members may issue dissenting or individual opinions. Except as may be otherwise decided by the Arbitration Board, one-half of all costs of the arbitration shall be borne by the Government of the United States and the remainder shall be borne by the Government of the Republic of the Marshall Islands.

Article III

Amendment

Section 431

The provisions of this Compact, as amended, may be further amended by mutual agreement of the Government of the United States and the Government of the Republic of the Marshall Islands, in accordance with their respective constitutional processes.

Article IV

Termination

Section 441

This Compact, as amended, may be terminated by mutual agreement of the Government of the Republic of the Marshall Islands and the Government of the United States, in accordance with their respective constitutional processes. Such mutual termination of this Compact, as amended, shall be without prejudice to the continued application of section 451 of this Compact, as amended, and the provisions of the Compact, as amended, set forth therein.

Section 442

Subject to section 452, this Compact, as amended, may be terminated by the Government of the United States in accordance with its constitutional processes. Such termination shall be effective on the date specified in the notice of termination by the Government of the United States but not earlier than six months following delivery of such notice. The time specified in the notice of termination may be extended. Such termination of this Compact, as amended, shall be without prejudice to the continued application of section 452 of this Compact, as amended, and the provisions of the Compact, as amended, set forth therein.

Section 443

This Compact, as amended, shall be terminated by the Government of the Republic of the Marshall Islands, pursuant to its constitutional processes, subject to section 453 if the people represented by that Government vote in a plebiscite to terminate the Compact. The Government of the Republic of the Marshall Islands shall notify the Government of the United States of its intention to call such a plebiscite, which shall take place not earlier than three months after delivery of such notice. The plebiscite shall be administered by the Government of the Republic of the Marshall Islands in accordance with its constitutional and legislative processes, but the Government of the United States may send its own observers and invite observers from a mutually agreed party. If a majority of the valid ballots cast in the plebiscite favors termination, the Government of the Republic of the Marshall Islands shall, upon certification of the results of the plebiscite, give notice of termination to the Government of the United States, such termination to be effective on the date specified in such notice but not earlier than three months following the date of delivery of such notice. The time specified in the notice of termination may be extended.

Article V

Survivability

Section 451

(a) Should termination occur pursuant to section 441, economic and other assistance by the Government of the United States shall continue only if and as mutually agreed by the Governments of the United States and the Republic of the Marshall Islands, and in accordance with the countries' respective constitutional processes.

(b) In view of the special relationship of the United States and the Republic of the Marshall Islands, as reflected in subsections (b) and (c) of section 354 of this Compact, as amended, and the separate agreement entered into consistent with those subsections, if termination occurs pursuant to section 441 prior to the twentieth anniversary of the effective date of this Compact, as amended, the United States shall continue to make contributions to the Trust Fund described in section 216 of this Compact, as amended.

(c) In view of the special relationship of the United States and the Republic of the Marshall Islands described in subsection (b) of this section, if termination occurs pursuant to section 441 following the twentieth anniversary of the effective date of this Compact, as amended, the Republic of the Marshall Islands shall be entitled to receive proceeds from the Trust Fund described in section 216 of this Compact, as amended, in the manner described in those provisions and the Trust Fund Agreement.

Section 452

(a) Should termination occur pursuant to section 442 prior to the twentieth anniversary of the effective date of this Compact, as amended, the following provisions of this amended Compact shall remain in full force and effect until the twentieth anniversary of the effective date of this Compact, as amended, and thereafter as mutually agreed:

(1) Article VI and sections 172, 173, 176 and 177 of Title One;

(2) Article One and sections 232 and 234 of Title Two;

(3) Title Three; and

(4) Articles II, III, V and VI of Title Four.

(b) Should termination occur pursuant to section 442 before the twentieth anniversary of the effective date of this Compact, as amended:

(1) Except as provided in paragraph (2) of this subsection and subsection (c) of this section, economic and other assistance by the United States shall continue only if and as mutually agreed by the Governments of the United States and the Republic of the Marshall Islands.

(2) In view of the special relationship of the United States and the Republic of the Marshall Islands, as reflected in subsections (b) and (c) of section 354 of this Compact, as amended, and the separate agreement regarding mutual security, and the Trust Fund Agreement, the United States shall continue to make contributions to the Trust Fund described in section 216 of this Compact, as amended, in the manner described in the Trust Fund Agreement.

(c) In view of the special relationship of the United States and the Republic of the Marshall Islands, as reflected in subsections 354(b) and (c) of this Compact, as amended, and the separate agreement regarding mutual security, and

the Trust Fund Agreement, if termination occurs pursuant to section 442 following the twentieth anniversary of the effective date of this Compact, as amended, the Republic of the Marshall Islands shall continue to be eligible to receive proceeds from the Trust Fund described in section 216 of this Compact, as amended, in the manner described in those provisions and the Trust Fund Agreement.

Section 453

(a) Should termination occur pursuant to section 443 prior to the twentieth anniversary of the effective date of this Compact, as amended, the following provisions of this Compact, as amended, shall remain in full force and effect until the twentieth anniversary of the effective date of this Compact, as amended, and thereafter as mutually agreed:

(1) Article VI and sections 172, 173, 176 and 177 of Title One;

(2) Sections 232 and 234 of Title Two;

(3) Title Three; and

(4) Articles II, III, V and VI of Title Four.

(b) Upon receipt of notice of termination pursuant to section 443, the Government of the United States and the Government of the Republic of the Marshall Islands shall promptly consult with regard to their future relationship. Except as provided in subsections (c) and (d) of this section, these consultations shall determine the level of economic and other assistance, if any, which the Government of the United States shall provide to the Government of the Republic of the Marshall Islands for the period ending on the twentieth anniversary of the effective date of this Compact, as amended, and for any period thereafter, if mutually agreed.

(c) In view of the special relationship of the United States and the Republic of the Marshall Islands, as reflected in subsections 354(b) and (c) of this Compact, as amended, and the separate agreement regarding mutual security, and the Trust Fund Agreement, if termination occurs pursuant to section 443 prior to the twentieth anniversary of the effective date of this Compact, as amended, the United States shall continue to make contributions to the Trust Fund described in section 216 of this Compact, as amended.

(d) In view of the special relationship of the United States and the Republic of the Marshall Islands, as reflected in subsections 354(b) and (c) of this Compact, as amended, and the separate agreement regarding mutual security, and the Trust Fund Agreement, if termination occurs pursuant to section 443 following the twentieth anniversary of the effective date of this Compact, as amended, the Republic of the Marshall Islands shall continue to be eligible to receive proceeds from the Trust Fund described in section 216 of this Compact, as amended, in the manner described in those provisions and the Trust Fund Agreement.

Section 454

Notwithstanding any other provision of this Compact, as amended:

(a) The Government of the United States reaffirms its continuing interest in promoting the economic advancement and budgetary self-reliance of the people of the Republic of the Marshall Islands.

(b) The separate agreements referred to in Article II of Title Three shall remain in effect in accordance with their terms.

Article VI

Definition of Terms

Section 461

For the purpose of this Compact, as amended, only, and without prejudice to the views of the Government of the United States or the Government of the Republic of the Marshall Islands as to the nature and extent of the jurisdiction of either of them under international law, the following terms shall have the following meanings:

(a) "Trust Territory of the Pacific Islands" means the area established in the Trusteeship Agreement consisting of the former administrative districts of Kosrae, Yap, Ponape, the Marshall Islands and Truk as described in Title One, Trust Territory Code, section 1, in force on January 1, 1979. This term does not include the area of Palau or the Northern Mariana Islands.

(b) "Trusteeship Agreement" means the agreement setting forth the terms of trusteeship for the Trust Territory of the Pacific Islands, approved by the Security Council of the United Nations April 2, 1947, and by the United States July 18, 1947, entered into force July 18, 1947, 61 Stat. 3301, T.I.A.S. 1665, 8 U.N.T.S. 189.

(c) "The Republic of the Marshall Islands" and "the Federated States of Micronesia" are used in a geographic sense and include the land and water areas to the outer limits of the territorial sea and the air space above such areas as now or hereafter recognized by the Government of the United States.

(d) "Compact" means the Compact of Free Association Between the United States and the Federated States of Micronesia and the Marshall Islands, that was approved by the United States Congress in section 201 of Public Law 99–239 (Jan. 14, 1986) and went into effect with respect to the Republic of the Marshall Islands on October 21, 1986.

(e) "Compact, as amended" means the Compact of Free Association Between the United States and the Republic of the Marshall Islands, as amended. The effective date of the Compact, as amended, shall be on a date to be determined by the President of the United States, and agreed to by the Government of the Republic of the Marshall Islands, following formal approval of the Compact, as amended, in accordance with section 411 of this Compact, as amended.

(f) "Government of the Republic of the Marshall Islands" means the Government established and organized by the Constitution of the Republic of the Marshall Islands including all the political subdivisions and entities comprising that Government.

(g) "Government of the Federated States of Micronesia" means the Government established and organized by the Constitution of the Federated States of Micronesia including all the political subdivisions and entities comprising that Government.

(h) The following terms shall be defined consistent with the 1978 Edition of the Radio Regulations of the International Telecommunications as follows:

(1) "Radiocommunication" means telecommunication by means of radio waves.

(2) "Station" means one or more transmitters or receivers or a combination of transmitters and receivers, including the accessory equipment, necessary at one location for carrying on a radiocommunication service, or the radio astronomy service.

(3) "Broadcasting Service" means a radiocommunication service in which the transmissions are intended for direct reception by the general public. This service may include sound transmissions, television transmissions or other types of transmission.

(4) "Broadcasting Station" means a station in the broadcasting service.

(5) "Assignment (of a radio frequency or radio frequency channel)" means an authorization given by an administration for a radio station to use a radio frequency or radio frequency channel under specified conditions.

(6) "Telecommunication" means any transmission, emission or reception of signs, signals, writings, images and sounds or intelligence of any nature by wire, radio, optical or other electromagnetic systems.

(i) "Military Areas and Facilities" means those areas and facilities in the Republic of the Marshall Islands reserved or acquired by the Government of the Republic of the Marshall Islands for use by the Government of the United States, as set forth in the separate agreements referred to in section 321.

(j) "Tariff Schedules of the United States" means the Tariff Schedules of the United States as amended from time to time and as promulgated pursuant to United States law and includes the Tariff Schedules of the United States Annotated (TSUSA), as amended.

(k) "Vienna Convention on Diplomatic Relations" means the Vienna Convention on Diplomatic Relations, done April 18, 1961, 23 U.S.T. 3227, T.I.A.S. 7502, 500 U.N.T.S. 95.

Section 462

(a) The Government of the United States and the Government of the Republic of the Marshall Islands previously have concluded agreements, which shall remain in effect and shall survive in accordance with their terms, as follows:

(1) Agreement Between the Government of the United States and the Government of the Marshall Islands for the Implementation of Section 177 of the Compact of Free Association;

(2) Agreement Between the Government of the United States and the Government of the Marshall Islands by Persons Displaced as a Result of the United States Nuclear Testing Program in the Marshall Islands;

(3) Agreement Between the Government of the United States and the Government of the Marshall Islands Regarding the Resettlement of Enjebi Island;

(4) Agreement Concluded Pursuant to Section 234 of the Compact; and

(5) Agreement Between the Government of the United States and the Government of the Marshall Islands Regarding Mutual Security Concluded Pursuant to Sections 321 and 323 of the Compact of Free Association.

(b) The Government of the United States and the Government of the Republic of the Marshall Islands shall conclude prior to the date of submission of this Compact to the legislatures of the two countries, the following related agreements which shall come into effect on the effective date of this Compact, as amended, and shall survive in accordance with their terms, as follows:

(1) Federal Programs and Services Agreement Between the Government of the United States of America and the Government of the Republic of the Marshall Islands Concluded Pursuant to Article III of Title One, Article II of Title Two (including Section 222), and Section 231 of the Compact of Free Association, as Amended, which include:

(i) Postal Services and Related Programs;

(ii) Weather Services and Related Programs;

(iii) Civil Aviation Safety Service and Related Programs;

(iv) Civil Aviation Economic Services and Related Programs;

(v) United States Disaster Preparedness and Response Services and Related Programs; and

(vi) Telecommunications Services and Related Programs.

(2) Agreement Between the Government of the United States of America and the Government of the Republic of the Marshall Islands on Extradition, Mutual Assistance in Law Enforcement Matters and Penal Sanctions Concluded Pursuant to Section 175 (a) of the Compact of Free Association, as Amended;

(3) Agreement Between the Government of the United States of America and the Government of the Republic of the Marshall Islands on Labor Recruitment Concluded Pursuant to Section 175 (b) of the Compact of Free Association, as Amended;

(4) Agreement Concerning Procedures for the Implementation of United States Economic Assistance Provided in the Compact, as Amended,

of Free Association Between the Government of the United States of America and the Government of the Republic of the Marshall Islands;

(5) Agreement Between the Government of the United States of America and the Government of the Republic of the Marshall Islands Implementing Section 216 and Section 217 of the Compact, as Amended, Regarding a Trust Fund;

(6) Agreement Regarding the Military Use and Operating Rights of the Government of the United States in the Republic of the Marshall Islands Concluded Pursuant to Sections 321 and 323 of the Compact of Free Association, as Amended; and,

(7) Status of Forces Agreement Between the Government of the United States of America and the Government of the Republic of the Marshall Islands Concluded Pursuant to Section 323 of the Compact of Free Association, as Amended.

Section 463

(a) Except as set forth in subsection (b) of this section, any reference in this Compact, as amended, to a provision of the United States Code or the Statutes at Large of the United States constitutes the incorporation of the language of such provision into this Compact, as amended, as such provision was in force on the effective date of this Compact, as amended.

(b) Any reference in Article IV and VI of Title One, and Sections 174, 175, 178 and 342 to a provision of the United States Code or the Statutes at Large of the United States or to the Privacy Act, the Freedom of Information Act, the Administrative Procedure Act or the Immigration and Nationality Act constitutes the incorporation of the language of such provision into this Compact, as amended, as such provision was in force on the effective date of this Compact, as amended, or as it may be amended thereafter on a non-discriminatory basis according to the constitutional processes of the United States.

Article VII

Concluding Provisions

Section 471

Both the Government of the United States and the Government of the Republic of the Marshall Islands shall take all necessary steps, of a general or particular character, to ensure, no later than the entry into force date of this Compact, as amended, the conformity of its laws, regulations and administrative procedures with the provisions of this Compact, as amended, or, in the case of subsection (d) of section 141, as soon as reasonably possible thereafter.

Section 472

This Compact, as amended, may be accepted, by signature or otherwise, by the Government of the United States and the Government of the Republic of the Marshall Islands.

IN WITNESS WHEREOF, the undersigned, duly authorized, have signed this Compact of Free Association, as amended, which shall enter into force upon the exchange of diplomatic notes by which the Government of the United States of America and the Government of the Republic of the Marshall Islands inform each other about the fulfillment of their respective requirements for entry into force.

DONE at Majuro, Republic of the Marshall Islands, in duplicate, this thirtieth (30) day of April, 2003, each text being equally authentic.

Signed (May 14, 2003)	***Signed (May 14, 2003)***
For the Government of the United States of America:	***For the Government of the Federated States of Micronesia:***

Approved _______, 2003.

Strike out the preamble and insert:

Whereas the United States (in accordance with the Trusteeship Agreement for the Trust Territory of the Pacific Islands, the United Nations Charter, and the objectives of the international trusteeship system of the United Nations) fulfilled its obligations to promote the development of the people of the Trust Territory toward self-government or independence as appropriate to the particular circumstances of the Trust Territory and its peoples and the freely expressed wishes of the peoples concerned;

Whereas the United States, the Federated States of Micronesia, and the Republic of the Marshall Islands entered into the Compact of Free Association set forth in title II of Public Law 99–239, January 14, 1986, 99 Stat. 1770, to create and maintain a close and mutually beneficial relationship;

Whereas the United States, in accordance with section 231 of the Compact of Free Association entered into negotiations with the Governments of the Federated States of Micronesia and the Republic of the Marshall Islands to provide continued United States assistance and to reaffirm its commitment to this close and beneficial relationship; and

Whereas these negotiations, in accordance with section 431 of the Compact, resulted in the "Compact of Free Association, as amended between the Government of the United States of America and the Government of the Federated States of Micronesia", and the "Compact of Free Association, as amended between the Government of the United States of America and the Government of the Republic of the Marshall Islands", which, together with their related agreements, were signed by the Government of the United States and the Governments of the Federated States of Micronesia and the Republic of the Marshall Islands on May 14, and April 30, 2003, respectively: Now, therefore, be it

Amend the title so as to read: "A joint resolution to approve the Compact of Free Association, as amended, between the Government of the United States of America and the Government of the Federated States of Micronesia, and the Compact of Free Association, as amended, between the Government of the United States of America and the Government of the Republic of the Marshall Islands, and to appropriate funds to carry out the amended Compacts.".

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Iowa (Mr. LEACH) and the gentleman from California (Mr. LANTOS) each will control 20 minutes.

The Chair recognizes the gentleman from Iowa (Mr. LEACH).

GENERAL LEAVE

Mr. LEACH. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on the joint resolution under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Iowa?

There was no objection.

Mr. LEACH. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of House Joint Resolution 63, legislation that reauthorizes the Compact of Free Association of the Federated States of Micronesia and the Republic of the Marshall Islands.

Mr. Speaker, the text of H.J. Res. 63 which is before us is substantially identical to the extensive bill passed by this body 3 weeks ago. The few changes it incorporates were the result of the bipartisan, bicameral consultations prior to passage in the other body, and in my judgment represent further improvements to this legislative product. Specifically, these include an amendment to the education section which ensures retention within the islands of eligibility for participation in U.S. special education programs; a modification of the disaster assistance provisions based primarily on a recent proposal from the administration which envisions continuing roles for both the Federal Emergency Management Agency and the U.S. Agency for International Development's Office of Foreign Disaster Assistance; and the inclusion of $5.3 million for the final U.S. contribution to the trust fund established to assist in the resettlement of Rongelap Island, the locale for the U.S. thermonuclear tests in the 1940s and 1950s.

It would be my hope that we could finalize this noncontroversial package today and send it to the President for signature before the end of the session. As my colleagues may be aware, the economic assistance provisions of the current Compact with Micronesia and the Marshall Islands expired in 2001, but were extended for 2 years while the United States renegotiated the expiring provisions with the island countries. These negotiations were only completed this spring, leaving Congress relatively little time to act on a host of difficult substantive and jurisdictional issues before those authorities expired on September 30, 2003. Because Congress was not able to reauthorize the compacts prior to the end of the fiscal year, the basic authorities for U.S. assistance to the islands have been extended temporarily by continuing resolution.

In closing, I would like to thank again the chairmen and ranking members of the Committees on Resources, Education and the Work Force, Budget, Ways and Means, and the Committee on International Relations, particularly the gentleman from California (Mr. LANTOS), for their assistance and cooperation in developing and supporting this important legislation which further advances relations with our stalwart friends in the freely associated states and protects key U.S. interests in the Western Pacific. I urge support for the resolution.

Mr. Speaker, I reserve the balance of my time.

Mr. LANTOS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in strong support of this legislation. I am very pleased that the House is taking final action today on renewal of the Compact of Free Association with the Federated States of Micronesia and the Republic of the Marshall Islands.

With final approval of these compacts, the United States will further solidify our relationship with these Western Pacific nations, both of which are close allies and make an ongoing contribution to our national defense.

□ 1530

To understand the importance of renewing the compacts, Mr. Speaker, we must remember our Nation's history in the region. During the Second World War, American soldiers liberated the Pacific, island by island, in brutal and bloody battles. After the war, the United States administered Micronesia and the Marshalls, and we have maintained a vitally important military base on Kwajalein Atoll.

In the 1940s and 1950s, the United States used the Marshall Islands as a nuclear testing ground. The Marshallese people were dramatically affected by these nuclear tests, and entire islands remain uninhabitable, even today. Since the independence of the Marshalls and Micronesia in 1986, the ties between our nations have grown even stronger. When Congress approved the Compact of Free Association in 1986, we received a very good bargain. Funds would flow to the island nations in return for strategic denial and a defense veto. The Kwajalein Army Base is vitally important to American missile tests, and as a listening post to the world. With approval of the compacts, the United States advanced our national security interests. However, our government inadequately monitored the expenditure of funds and ignored the need to promote economic development in the islands.

The compacts before the House today ensure that funds will be well spent in the future, will promote sound economic development, and will focus on the all-important subjects of education and health care. They also establish trust funds for both nations to ensure that they can become self-sufficient in 20 years.

Mr. Speaker, H.J. Res. 63 promotes our Nation's national security interests and furthers our already excellent relationship with the Marshalls and Micronesia. I urge its approval.

Mr. Speaker, I reserve the balance of my time.

Mr. LEACH. Mr. Speaker, I reserve the balance of my time.

Mr. LANTOS. Mr. Speaker, it gives me extraordinary pleasure to yield 5 minutes to the gentlewoman from California (Ms. WATSON), our former distinguished Ambassador to Micronesia.

Ms. WATSON. Mr. Speaker, I would like to thank the gentleman from California (Mr. LANTOS), the gentleman from Iowa (Mr. LEACH) and all those who had a very active part in bringing this bill to the floor. I was privileged and honored to represent the United States as the Ambassador to the Federated States of Micronesia, and I have a deep and abiding respect for the island nations who are struggling to build their democracy following the American model. I am pleased that we have advanced the new compact legislation out of Congress to this point.

Although most of the contentious issues in the compact have been addressed, the funding allocated for education still continues to concern me. I visited many of the schools, and I can tell my colleagues that they need a lot of help. We have to take them from the past into the present, and we have to see that they have the technology in their classrooms to make them a part of our new global economy. The RMI and FSM children have only just begun to benefit from the establishment of an integrated education system, and I am very pleased to know that authorization for educational programs is included in the bill.

In my former profession of teaching, I have witnessed the impact of early structured education. Young children are much better equipped to enter the educational system when they are exposed to education at an early age. Our Head Start program over there is the Cadillac program of the island. Everyone clamors to get their children in there whether they qualify or not. The educational appropriations that Chairman REGULA has offered to support is critical to keep these effective programs in place and give these children of these distant Pacific islands an opportunity.

I also strongly support those provisions in this compact that provide for continued Pell Grant eligibility for the FAS. It will bolster the ability of the FAS to cultivate education. If we were to eliminate the Pell Grant assistance, we would have decimated the college system in the Federated States of Micronesia. A large portion of the operating funds for the college are obtained through Pell Grants. When you see these young people able to do 2 years in their college and then come here to the United States and then come back home and lend their expertise to this new emerging government, it really fills your heart with glee, and we should be so proud.

One other important area that I would like to point out is the reinstatement of FEMA assistance. It has been placed back into the compact for infrastructure purposes and major catastrophes. USAID is not equipped to deal with all of the problems that arise on small islands nor do they have the ready response to help in a timely fashion. The FEMA assistance is absolutely critical because being surrounded by water and spread out over a million miles of ocean, we are always in line for some kind of natural catastrophe.

As we move forward with our unique relationship with the Freely Associated States, I hope the United States Congress will continue to be supportive and receptive of the needs of our new democratic friends.

I urge my colleagues to understand the importance of the FAS, and I fully support this piece of legislation.

Mr. LANTOS. Mr. Speaker, I want to thank my friend for her eloquent and powerful statement.

Mr. Speaker, I yield 5 minutes to the distinguished gentlewoman from Guam (Mr. BORDALLO).

Ms. BORDALLO. Mr. Speaker, I thank the gentleman from California (Mr. LANTOS) and the gentleman from Iowa (Mr. LEACH) for this opportunity. I want to take this time to thank the leadership for their work on the Compact of Free Association Amendments Act. This piece of legislation is vital to the Pacific region and so important to the people of Guam. Guam is the closest American neighbor to the Freely Associated States. We have witnessed the progress that the Federated States of Micronesia and the Republic of the Marshall Islands have made under the original compact since 1986. Today this House will approve a renewal of this compact and recommit the United States of America to friendship with steadfast allies in the Pacific. Over the past 2 years, a lot of work has been exerted in renegotiating the terms of the original compact, and today we consider this measure for the final time before it makes its way to the White House. I am pleased that we are able to come to agreement in a bipartisan effort on matters that are so important to the Freely Associated States. Continuation of their eligibility for Pell Grants, Job Corps and programs under the Individuals with Disabilities Education Act is protected by H.J. Res. 63. This legislation also provides for an improved process to address the impact the immigration provisions have on affected U.S. jurisdictions. Annual mandatory funding in the amount of $30 million is provided for by this bill to be shared by Guam, Hawaii, the Commonwealth of the Northern Mariana Islands and American Samoa to help defray costs associated with immigration. The legislation includes my provision for compact-impact reconciliation to address the unreimbursed compact costs over the past 17 years.

I want to recognize the work of the U.S. negotiating teams, most particularly the contributions of the chief U.S. negotiators, Al Stayman in the early phase and Colonel Al Short under the Bush administration. I congratulate the leadership of the Federated States of Micronesia and the Republic of the Marshall Islands for their successful efforts. I want to acknowledge and thank the united efforts of Guam's leaders on the provisions important to our island. Governor Camacho and Speaker Pangelinan traveled thousands of miles to Washington in July to testify before the House Committee on Resources. Additionally, Mr. Speaker, I want to thank the gentlemen from Hawaii (Mr. ABERCROMBIE) and (Mr. CASE) for their efforts. I also want to thank the gentleman from Iowa (Mr. LEACH), the gentleman from Illinois (Mr. HYDE), the gentleman from California (Mr. POMBO), the gentleman from Ohio (Mr. BOEHNER) and the gentleman from

Wisconsin (Mr. SENSENBRENNER) for their leadership in crafting this legislation as well as the gentleman from Iowa (Mr. NUSSLE), the gentleman from Ohio (Mr. REGULA) and the gentleman from California (Mr. THOMAS) for their input on matters under their committee's jurisdictions. I also want to thank the gentleman from California (Mr. LANTOS), the gentleman from West Virginia (Mr. RAHALL), the gentleman from California (Mr. GEORGE MILLER), the gentleman from Michigan (Mr. CONYERS), the gentleman from South Carolina (Mr. SPRATT), the gentleman from Wisconsin (Mr. OBEY), and the gentleman from New York (Mr. RANGEL) for their help in addressing matters of concern as this bill moved through the process, and to thank the staff serving on these committees.

Lastly, Mr. Speaker, I want to make special mention of the work the gentleman from American Samoa (Mr. FALEOMAVAEGA) has put into the legislation. His service is invaluable to this institution and the people of the Pacific islands hold him in high esteem. This is indeed, Mr. Speaker, an historic day for the Pacific islands. I urge adoption of H.J. Res. 63.

Mr. LANTOS. Mr. Speaker, I am very pleased to yield 2 minutes to the distinguished gentleman from Hawaii (Mr. ABERCROMBIE).

Mr. ABERCROMBIE. Mr. Speaker, our colleague and friend from Guam has made manifest in her remarks the debt of gratitude that is owed to many individuals, some of whom are here and are represented, I think, on the whole by our colleagues who are in charge of the bill on the floor.

This is an issue of little note for many Members. It would be easy, I expect, to say that the compact for Micronesia represents an area of forgotten people, but that would be incorrect, Mr. Speaker, because in many instances this is an area of the never noticed. It is something that is difficult for many people in the United States, let alone in the rest of the world, to comprehend that we have here a colonial vestige, a post-World War II anachronism. We have a situation in which responsibility exists for the United States which is scarcely understood, let alone taken into account, not because of design but rather by the default and omission of elementary understanding.

Those of us who live in the Pacific, those of us who are aware of the human dimension that is involved here are particularly grateful to all of the individuals and committee staff members that have been noted by my good friend from Guam. I want to pay particular notice to my chairman on the Committee on Resources, the gentleman from California (Mr. POMBO) who has assumed these duties with this Congress. Some of the other Members mentioned are long familiar with the compact. The gentleman from California has exhibited a particular sensitivity and quest for understanding that I think has aided immeasurably in the accomplishment of dealing with what is, in fact, an unfunded mandate. The compact requires us to meet certain standards and, as has been mentioned by my good friend from Guam, Guam, Hawaii and the Marianas bear the brunt of the financial side of this as well.

Free association means that people are able to travel freely and as a result of this compact, Mr. Speaker, I think we have taken an enormous step forward, and my gratitude and aloha to all those who helped to provide it and get us to this step today. Mahalo to all.

Mr. LANTOS. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. LEACH. Mr. Speaker, I yield myself such time as I may consume. In conclusion, let me thank each of the contributors to today's discussion. Obviously, the gentleman from California (Mr. LANTOS) has played a seminal role in this process; so have the gentlewoman from California (Ms. WATSON), the gentleman from American Samoa (Mr. FALEOMAVAEGA), the gentleman from Hawaii (Mr. ABERCROMBIE), and I would like to note with regard to the gentlewoman from Guam (Ms. BORDALLO), how appreciative we are of her help in this endeavor, and how appreciative I am that she has referenced all the people from the outside that have contributed to the development of this particular agreement.

I might say that Congress has put a slightly modified stamp on what was negotiated by the executive branch. This modified stamp is tilted towards generosity.

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This is particularly appropriate because this is the people's body, and we are in the fortunate position of having nothing but feelings of enormous goodwill towards the people of the freely associated states.

This is a tangible agreement, but it is what is intangible that is so much more important. So as we in this House pass this agreement, I would just like to say that I am confident I speak for this entire body when I suggest that we are proud of our friends in the Pacific and we hope to maintain warm relationships for decades and decades to come.

Mr. ABERCROMBIE. Mr. Speaker, I would like to express my wholehearted support for the final passage of H.J. Res. 63, the Compact of Free Association Amendments Act of 2003. Years of negotiations and the cooperative work of many people has brought us to this point, the reauthorization of the Compact by Congress.

For the past 17 years, the United States has had a secure relationship with the Freely Associated States (FAS). The Federated States of Micronesia (FSM) and the Republic of the Marshall Islands (RMI) have been able to transition from a United Nations trusteeship to sovereign governments. At the same time, the United States has had its security and defense interests in the Pacific fulfilled. H.J. Res. 63 will not only allow this critical economic and military relationship to continue, but will improve upon its successes and ensure that FAS citizens get the maximum benefit possible from this agreement.

H.J. Res. 63 extends our military commitments in the Pacific by retaining certain defense rights as well as providing for continued access to Kwajalein Atoll, home of the Ronald Reagan Ballistic Missile Defense Test Site.

This legislation also includes provisions affecting the health, education, and welfare of FAS citizens. They will continue to be eligible for funds from the Pell Grant Program and from the Individuals with Disabilities Education Act, resources which are integral to their development of a competent and effective education system. They will also be eligible for funds to combat the spread of communicable diseases such as tuberculosis, cholera and Hansen's disease. FAS citizens can have complicated and severe health care needs and this grant money will go a long way toward easing these health difficulties.

The Compact also allows FAS citizens to enter the United States and its territories as nonimmigrants. These provisions are being enhanced to include security measures and more dependable passports. In addition, due to the ability to freely migrate, Compact migrants have been entering the United States in ever increasing numbers. This migration is having an enormous impact on the education, health, public safety and social service systems of the areas receiving these compact migrants. These costs have a very tangible impact and collectively, are fast approaching the $100 million per year level. For the State of Hawaii alone, more than $32 million was expended in 2002 in order to support Compact migrants and help ensure their health and well-being.

H.J. Res. 63 addresses this effect by creating a mandatory funding stream of $30 million a year in compensation for Hawaii, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa. These areas have borne the brunt of this impact since 1986 and although these funds will be divided among the four jurisdictions, it will be the largest compensation any of these jurisdictions has received to date. In addition, health care providers will also be eligible for the reimbursement of expenses arising from the treatment of Compact migrants. While these funds will surely cover only a portion of the total impact cost, its yearly distribution will undoubtedly have a great effect on the state and territorial departments and agencies that have spent untold resources and labor in providing for the Compact migrants.

The scope of this Compact assures that every FAS citizen will be affected in some way and that is why I applaud the efforts to produce a bipartisan compromise with the input of all affected parties. Chairman POMBO of the House Resources Committee has been especially willing to listen to the voices of people in the Pacific and has bent over backwards to be fair and just. Chairman HYDE, Chairman BOEHNER and Chairman NUSSLE have also accomplished tremendous work in bringing this bill to the floor. Thanks to their efforts, I have no doubt that our relationship with these Pacific nations will continue to be productive and mutually beneficial. I urge my colleagues to support this important measure.

Mr. FALEOMAVAEGA. Mr. Speaker, I would like to extend my gratitude to Chairman HYDE and Ranking Member LANTOS of the International Relations Committee, Chairman POMBO and Ranking Member RAHALL of the Resources Committee and my good friend, Chairman JIM LEACH of the International Relations Subcommittee on Asia and the Pacific for working so diligently these past several months to address some of the very important concerns raised by the RMI and FSM as it relates to the Compact of Free Association.

The Compacts of Free Association commenced in 1986 between the Federated States of Micronesia and the Republic of the Marshall Islands and the United States. In brief, the United States agrees to provide federal funding to the FSM and RMI and in turn both agree to provide the U.S. with certain defense rights now including use of eleven defense sites on Kwajalein Atoll where the U.S. Department of Defense has established a multi-billion dollar anti-ballistic missile testing facility.

In October 2001, portions of the Compact expired and representatives from the FSM, RMI and the Department of the Interior began negotiating an extension of these provisions. Earlier this year, DOI sent Congress the negotiated product to be considered as the re-authorization of the Compacts of Free Association. However, key provisions, including funding for Pell Grants and FEMA assistance were excluded from the agreement and, over the last several months, my colleagues and I have been working closely with representatives from both the FSM and RMI to address these concerns.

Mr. Speaker, the good people of the Federated States of Micronesia and the Republic of the Marshall Islands are in need of and, indeed, deserve U.S. support and assistance in building local capacity. As you know, education is invaluable to building self-sufficiency and local capacity and ultimately will contribute to bolstering the economy of these developing nations. This is why I am pleased that the bill before us today now provides the Freely Associated States with Pell Grants assistance and also recognizes the importance of FEMA assistance to these islands.

The truth is, the Freely Associated States have made many sacrifices and contributions on behalf of the United States. In fact, the U.S. used the Marshall Islands as a nuclear testing ground and detonated more than 67 nuclear bombs, including the first hydrogen bomb which was 1,000 times more powerful than the bombs dropped on Hiroshima and Nagasaki during World War II. The results were and continue to be devastating.

As a Pacific Islander, I am pleased that H.J. Res 63 acknowledges the contributions and sacrifices made by the FAS and also addresses the needs and concerns of the people of the FSM and RMI. I am also pleased that my colleagues have worked closely with me to make sure that American Samoa's tuna industry was protected in the process of these negotiations. The outcome of H.J. Res 63 will determine our relationship with the FSM and RMI for the next twenty years and will also affect American Samoa's tuna industry for generations to come.

I urge my colleagues to honor our pledge to the people of the FAS to assist them in maintaining a democratic government and supporting the principles that contribute to economic development and self-sufficiency. I also urge my colleagues to support American Samoa's interests by voting yes for H.J. Res 63.

Mr. LEACH. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. TERRY). The question is on the motion offered by the gentleman from Iowa (Mr. LEACH) that the House suspend the rules and concur in the Senate amendments to the joint resolution, H.J. Res. 63.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. LANTOS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

COMMENDING THE SIGNING OF THE UNITED STATES-ADRIATIC CHARTER

Mr. BEREUTER. Mr. Speaker, I move to suspend the rules and concur in the Senate amendments to the concurrent resolution (H. Con. Res. 209) commending the signing of the United States-Adriatic Charter, a charter of partnership among the United States, Albania, Croatia, and Macedonia.

The Clerk read as follows:

Senate amendments:

(1)Page 3, line 4, after "and" the second time it appears insert: *The Former Yugoslav Republic of*

(2)Page 3, line 8, after "and" insert: *The Former Yugoslav Republic of*

(3)Page 3, line 14, after "and" insert: *The Former Yugoslav Republic of*

(4)Page 3, line 16, after "and" insert: *The Former Yugoslav Republic of*

Amend the preamble as follows:

(5)Page 1, unnumbered line 6, after "and" insert: *The Former Yugoslav Republic of*

(6)Page 2, unnumbered line 4, after "and" insert: *The Former Yugoslav Republic of*

(7)Page 2, unnumbered line 11, strike out all after "Powell," down to an including "Minister" in unnumbered line 13 and insert: *Albania Foreign Minister Ilir Meta, Croatia Foreign Minister Tonino Picula, and The Former Yugoslav Republic of Macedonia Foreign Minister*

(8)Page 2, unnumbered line 15, after "and" the first time it appears insert: *The Former Yugoslav Republic of*

(9)Page 2, unnumbered line 29, strike out all after "Whereas" over to an including "Macedonia" in unnumbered line 2 on page 3 and insert: *75 special forces troops of Albania were sent to Iraq as part of the coalition forces during Operation Iraqi Freedom, 29 special forces troops of The Former Yugoslav Republic of Macedonia were sent to Iraq as part of the post-war stabilization force, and Albania, Croatia, and The Former Yugoslav Republic of Macedonia*

Amend the title so as to read: "Concurrent resolution commending the signing of the United States-Adriatic Charter, a charter of partnership among the United States, Albania, Croatia, and The Former Yugoslav Republic of Macedonia.".

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Nebraska (Mr. BEREUTER) and the gentleman from California (Mr. LANTOS) each will control 20 minutes.

The Chair recognizes the gentleman from Nebraska (Mr. BEREUTER).

GENERAL LEAVE

Mr. BEREUTER. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on the concurrent resolution under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Nebraska?

There was no objection.

Mr. BEREUTER. Mr. Speaker, I yield myself such time as I may consume.

The resolution before the House expresses the support of the Congress for the Adriatic Charter. The charter was signed on May 2 in the Albanian capital of Tirana by Secretary of State Powell and the foreign ministers of Albania, Croatia, and the Former Yugoslav Republic of Macedonia, the three currently remaining NATO aspirant countries which have not yet been accepted for NATO membership.

The resolution, introduced by the distinguished gentleman from New York (Mr. ENGEL), is virtually identical to the one that was agreed to in this Chamber on June 23 by a 381 to 1 vote. When the Senate passed this concurrent resolution in July, it made a minor change in the name of one of the countries being recognized, changing the word "Macedonia," which was used in the Adriatic Charter itself, to "Former Yugoslav Republic of Macedonia," which is the name by which this country is internationally recognized by most countries.

The Adriatic Charter pledges the United States to support efforts by Albania, Croatia, and Macedonia to join Euro-Atlantic institutions like NATO and the European Union.

In this agreement, the three aspirant nations commit themselves to accelerate their democratic reforms, protect human rights, implement market-oriented economic policies, and enhance their mutual cooperation. Also very importantly, under the Adriatic Charter, the United States and these three countries pledge to consult whenever the security of one of them is threatened. For their part, the aspirant countries promise to continue defense reforms and to undertake steps to enhance border security so they can contribute to regional stability.

Mr. Speaker, this Member urges the House to agree to this resolution.

Mr. Speaker, I reserve the balance of my time.

Mr. LANTOS. Mr. Speaker, I yield myself such time as I may consume.

I rise in strong support of this resolution. First, Mr. Speaker, I want to commend the gentleman from New York (Mr. ENGEL), the gentleman from Nebraska (Mr. BEREUTER), and the gentleman from Florida (Mr. WEXLER) for their leadership on this important resolution and the gentleman from Illinois (Chairman HYDE) for moving it forward so expeditiously.

Mr. Speaker, this resolution celebrates cooperation and forward thinking among the nations of the Balkans, a region that just a few years ago was engulfed in bloody ethnic violence and strife. The United States has an enduring interest in the independence, territorial integrity, and security of Albania, Croatia, and Macedonia. We must make every effort to support their full integration into the community of democratic Euro-Atlantic states.

The Adriatic Charter affirms the commitment of Albania, Croatia, and Macedonia to the values and principles of NATO and to joining the alliance at the earliest possible time. Albania, Croatia, and Macedonia have taken positive steps to advance their integration into Europe and have already contributed to European security and to the peace and security of southeast Europe through the resolution of conflicts in the region. Croatia has announced its intention to join the European Union and is moving steadily in that direction. Albania has been making important progress in its transition to democracy and as a candidate for NATO membership. Both Macedonia and Croatia are also candidates for NATO membership, and all three nations are fully committed to the Membership Action Plan agreed upon by NATO.

Mr. Speaker, the Adriatic Charter is a milestone in this region, where very recently people were skeptical about the fate of democracy and human rights. Many argue that the American emphasis upon democracy in the region was misplaced and that our Nation's efforts would fail. We proved the skeptics wrong.

If the Speaker will allow a personal word, it was not too many years ago that my wife and I were the first American officials to visit Albania, at the time still a communist dictatorship; and the head of Albania asked me to carry a letter to our President asking for the reestablishment of diplomatic relations between Albania and the United States of America. I did so and the rest is history.

Mr. Speaker, I again commend all of my colleagues who have worked so hard on this legislation, and I urge all of my colleagues to support this resolution.

Mr. Speaker, I reserve the balance of my time.

Mr. BEREUTER. Mr. Speaker, I have no further requests for time, and I reserve the balance of my time.

Mr. LANTOS. Mr. Speaker, I yield 5 minutes to the distinguished gentleman from New York (Mr. ENGEL), who has played such a pivotal role in bringing peace and democracy to this whole region.

Mr. ENGEL. Mr. Speaker, I thank my friend and colleague from California for his kind words, and I thank him as always for his help on matters such as these. We all look to him for guidance. I want to thank the gentleman from Nebraska (Mr. BEREUTER), as well, for really being with me every step of the way in bringing this to fruition and the gentleman from Florida (Mr. WEXLER), as well, for working with me on this.

I rise in support of H. Con. Res. 209, which commends the signing of the U.S.-Adriatic Charter. As the author of H. Con. Res. 209, I am honored that the Senate has passed this measure and the House is now considering this important resolution for final passage.

On May 2, 2003, the U.S.-Adriatic Charter was signed in Tirana, Albania, by Secretary of State Colin Powell and the Foreign Ministers of Albania, Croatia, and the Former Yugoslav Republic of Macedonia. As Secretary Powell noted when he signed the document, it is remarkable that the agreement was signed in Albania, a country once known only for its isolation and distance from Western principles.

I can say, Mr. Speaker, as the chairman of the Albanian Issues Caucus in this Congress, I am absolutely delighted that Albania and the United States continue to work closely together and look at this charter as an important step in bringing Albania and the United States even closer together. Today, Tirana is a capital filled with energy as it continues its opening to Europe. Macedonia and Croatia have seen similar changes as well.

Mr. Speaker, as NATO has expanded through other countries of Europe, several Balkan nations in South Central Europe were excluded. They just were not ready for membership at that time. Today, three of those nations, Albania, Croatia, and the Former Yugoslav Republic of Macedonia, are now moving to make the needed changes in reforms so that they can join the North Atlantic structures including NATO. I have long been a strong supporter of Albanian membership in NATO.

The U.S.-Adriatic Charter embodies a commitment by Albania, Croatia, and the Former Yugoslav Republic of Macedonia to the values and principles of NATO and a declaration of their intent to join NATO as soon as they meet alliance standards. I certainly support all of their efforts to advance toward NATO membership, and having Secretary Powell sign the charter puts the United States firmly in support of their efforts to join NATO when they are ready, and as far as I am concerned, sooner rather than later.

By passing this resolution today, as amended in the Senate, and it is a House resolution, Congress adds its voice by "urging NATO to invite Albania, Croatia, and Macedonia to join NATO as soon as these countries demonstrate the ability to assume the responsibilities of NATO membership."

H. Con. Res. 209 also welcomes and supports the aspirations of Albania, Croatia, and Macedonia to join the European Union at the earliest opportunity and recognizes that the three countries are making important strides to bring their economic, military, and political institutions into conformance with the standards of NATO and other Euro-Atlantic institutions. Finally, our resolution also commends Secretary Powell for his strong personal support of the resolution, as demonstrated by his travel to the region to sign the document.

Mr. Speaker, as a sponsor of H. Con. Res. 209, I think this is an appropriate forum to publicly thank Albania and the Former Yugoslav Republic of Macedonia for sending forces to fight alongside our troops in Afghanistan. It is my hope that Albania, one of only three European countries to send ground troops to fight in the war, would be high on the Defense Department's list when it considers the realignment of, and new bases for, American forces around the world. I have often thought that Albania is a perfect country for the United States to put new bases into.

Finally, again I would like to thank the gentleman from Nebraska (Mr. BEREUTER), chairman of the Subcommittee on Europe, and his staff for the cooperation and support as we drafted this concurrent resolution, H. Con. Res. 209. I would like to thank the gentleman from Florida (Mr. WEXLER), the ranking member of the subcommittee, for his support; and the Senate for its adoption of the measure; the gentleman from Illinois (Mr. HYDE), our chairman; and the gentleman from California (Mr. LANTOS), our ranking member. All played important roles, and I strongly support this resolution and urge my colleagues to also support it.

Mr. LANTOS. Mr. Speaker, we have no further requests for time, and I yield back the balance of my time.

Mr. BEREUTER. Mr. Speaker, I yield myself such time as I may consume.

I have just a couple of concluding remarks. I would begin by first thanking the distinguished gentleman from New York (Mr. ENGEL) for his initiative in introducing this legislation in the first place and for working with us to ensure its final action here today.

During the past several weeks, I have had the occasion to have Foreign Ministry leaders of these three countries in my office. No doubt that has happened with a number of us, and I must say that the progress that they are making is very dramatic. And in part that progress is driven by the fact that both the European Union and NATO have formal and informal criteria for membership, and it is pushing them along to make some of the important changes that mean we are going to have peace and stability, economic progress, civilian control of the military, transparency in military budgets, and so on. Those kinds of things that are extremely important.

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Most importantly, to move these countries along towards a rule of law and towards democratic institutions.

So, Mr. Speaker, I think we can take some pleasure in their accomplishments and continue to urge them to make all the efforts necessary for membership, because I certainly want to see these three countries become members of the European Union, and especially NATO, as soon as possible.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. TERRY). The question is on the motion offered by the gentleman from Nebraska (Mr. BEREUTER) that the House suspend the rules and concur in the Senate amendments to the concurrent resolution, H. Con. Res. 209.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. LANTOS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

SYRIAN ACCOUNTABILITY AND LEBANESE SOVEREIGNTY RESTORATION ACT OF 2003

Ms. ROS-LEHTINEN. Mr. Speaker, I move to suspend the rules and concur in the Senate amendments to the bill (H.R. 1828) to halt Syrian support for terrorism, end its occupation of Lebanon, and stop its development of weapons of mass destruction, and by so doing hold Syria accountable for the serious international security problems it has caused in the Middle East.

The Clerk read as follows:

Senate amendments:

⟨1⟩Page 2, strike out lines 8 through 15

⟨2⟩Page 2, line 16 strike out [(2)] and insert: *(1)*

⟨3⟩Page 2, line 20 strike out [(3)] and insert: *(2)*

⟨4⟩Page 3, line 3 strike out [(4)] and insert: *(3)*

⟨5⟩Page 3, line 11 strike out [(5)] and insert: *(4)*

⟨6⟩Page 3, line 18 strike out [(6)] and insert: *(5)*

⟨7⟩Page 4, line 1 strike out [(7)] and insert: *(6)*

⟨8⟩Page 4, line 7 strike out [(8)] and insert: *(7)*

⟨9⟩Page 4, line 12 strike out [(9)] and insert: *(8)*

⟨10⟩Page 4, line 16 strike out [(10)] and insert: *(9)*

⟨11⟩Page 4, line 21 strike out [(11)] and insert: *(10)*

⟨12⟩Page 5, line 1 strike out [(12)] and insert: *(11)*

⟨13⟩Page 5, line 6 strike out [(13)] and insert: *(12)*

⟨14⟩Page 5, line 16 strike out [(14)] and insert: *(13)*

⟨15⟩Page 5, line 20 strike out [(15)] and insert: *(14)*

⟨16⟩Page 6, line 3 strike out [(16)] and insert: *(15)*

⟨17⟩Page 6, line 14 strike out [(17)] and insert: *(16)*

⟨18⟩Page 6, line 20 strike out [(18)] and insert: *(17)*

⟨19⟩Page 6, line 23 strike out [(19)] and insert: *(18)*

⟨20⟩Page 7, line 6 strike out [(20)] and insert: *(19)*

⟨21⟩Page 7, line 10 strike out [(21)] and insert: *(20)*

⟨22⟩Page 7, line 23 strike out [(22)] and insert: *(21)*

⟨23⟩Page 8, line 9 strike out [(23)] and insert: *(22)*

⟨24⟩Page 8, line 19 strike out [(24)] and insert: *(23)*

⟨25⟩Page 9, line 3 strike out [(25)] and insert: *(24)*

⟨26⟩Page 9, line 7 strike out [(26)] and insert: *(25)*

⟨27⟩Page 9, line 14 strike out [(27)] and insert: *(26)*

⟨28⟩Page 9, line 18 strike out [(28)] and insert: *(27)*

⟨29⟩Page 9, strike out lines 21 through 24

⟨30⟩Page 10, line 1 strike out [(30)] and insert: *(28)*

⟨31⟩Page 10, line 10 strike out [(31)] and insert: *(29)*

⟨32⟩Page 10, line 18 strike out [(32)] and insert: *(30)*

⟨33⟩Page 10, line 24 strike out [(33)] and insert: *(31)*

⟨34⟩Page 11, line 4 strike out [(34)] and insert: *(32)*

⟨35⟩Page 11, line 9 strike out [(35)] and insert: *(33)*

⟨36⟩Page 12, line 1 strike out [(36)] and insert: *(34)*

⟨37⟩Page 15, line 1 strike out [will be held responsible] and insert: *should bear responsibility*

⟨38⟩Page 15, line 6, strike out all after "States" down to and including "ity" in line 7 and insert: *will work to deny Syria the ability*

⟨39⟩Page 15, strike out lines 18 through 20

⟨40⟩Page 15, line 21 strike out [(5)] and insert: *(4)*

⟨41⟩Page 16, line 1 strike out [(6)] and insert: *(5)*

⟨42⟩Page 16, line 6 strike out [(7)] and insert: *(6)*

⟨43⟩Page 16, line 11 strike out [(8)] and insert: *(7)*

⟨44⟩Page 16, line 15 strike out [(9)] and insert: *(8)*

⟨45⟩Page 16, line 17, after "Iraq" insert: *if the Government of Syria is found to be responsible*

⟨46⟩Page 16, line 20 strike out [(10)] and insert: *(9)*

⟨47⟩Page 18, strike lines 15 through 20 and insert:

(b) WAIVER.—The President may waive the application of subsection (a)(1), (a)(2), or both if the President determines that it is in the national security interest of the United States to do so and submits to the appropriate congressional committees a report containing the reasons for the determination.

⟨48⟩Page 20, line 6, strike out all after "has" down to and including "Lebanon" in line 8 and insert: *ended its occupation of Lebanon described in section 2(7) of this Act*

⟨49⟩Page 21, line 15, strike out all after "and" down to and including "other" in line 17

⟨50⟩Page 21, line 20, strike out all after "Hizballah" down to and including "al Qaeda" in line 21 and insert: *and other terrorist organizations supported by Syria*

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from Florida (Ms. ROS-LEHTINEN) and the gentleman from California (Mr. LANTOS) each will control 20 minutes.

The Chair recognizes the gentlewoman from Florida (Ms. ROS-LEHTINEN).

GENERAL LEAVE

Ms. ROS-LEHTINEN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Florida?

There was no objection.

Ms. ROS-LEHTINEN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, just 2 weeks ago, the Senate amended and overwhelmingly passed H.R. 1828, the Syria Accountability and the Lebanese Sovereignty Restoration Act.

The overwhelming support that the House-passed Syria bill received in the Senate and in the House clearly demonstrates a unity of purpose and an approach to the terrorist regime in Damascus. Even antisanctions advocates in the Senate recognize the serious threat that Syria poses to U.S. national security and to our interests and allies in the region.

This bill seeks to hold Syria accountable for its weapons program, its continued illegal occupation of Lebanon, and its terrorist activities, including its facilitation of attacks against Americans in Iraq.

The Syrian Foreign Minister has been quoted as saying that the requirements of this bill and of the U.S. in general for Syria to cease and desist on these three fronts are "unreasonable and unrealistic" demands. In fact, the Syrian Foreign Minister believes that "America has too many demands."

Meanwhile, just a few days ago, on Tuesday of this week, a French news source published an interview with a former member of Saddam Hussein's nefarious Secret Service. This former Saddam agent and current leader of the militias inside Iraq said that Syria is "definitely" working alongside Iraqi intelligence and other Saddam loyalists. He said that there is cooperation between Syria and his forces inside Iraq, and that "It began before the war, through trade, which was only a cover."

"Armed Syrians," he added, "even joined our Iraqi militia groups. And well before the war, we had forged passports that enabled us to go to that country," meaning Syria. He added that this coordination continues to this day.

Thus, regardless of how some will spin it, the Syrian regime has the blood of Americans on its hands, and they must be held responsible for their deaths, as well as those of scores of innocent human beings murdered by Syrian-sponsored terrorists.

Fully implemented, H.R. 1828 would help deny Syria the resources to continue its deplorable activities and will help prevent U.S. complicity in them. It seeks to do so by prohibiting U.S. exports of military, dual-use, and other items, as well as by prohibiting investments in key sectors that provide an economic windfall for the Syrian economy. We have every faith and confidence in President Bush's commitment to use the range of U.S. policy options, including the sanctions provided for in H.R. 1828, to hold Syria accountable for its unacceptable behavior.

As the President and the Secretary of State have clearly stated, Syria is on the wrong side of history. And now, it is time for it to suffer the consequences.

I ask my colleagues to concur with the Senate amendments to the House-passed bill.

Mr. Speaker, I reserve the balance of my time.

Mr. LANTOS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in strong support of this resolution. Mr. Speaker, among the many Members who deserve commendation for the bill before us, I would like to single out for recognition my friend, the gentleman from New York (Mr. ENGEL) who first introduced this bill in the 107th Congress; my good friend, the gentlewoman from Florida (Ms. ROS-LEHTINEN) for her superb chairmanship of the Subcommittee on the Middle East and Central Asia who joined the gentleman from New York (Mr. ENGEL), in initiating this bill in the 108th Congress; and my friend, the gentleman from New York (Mr. ACKERMAN), the ranking member of the Subcommittee on the Middle East and Central Asia, who has been a tireless fighter for tough-minded U.S. policies towards State sponsors of terrorism.

Mr. Speaker, for years, our government has favored Syria over other State sponsors of terrorism. We allow more trade with Syria than with the others, and we maintain normal diplomatic ties with Syria. This legislation, the Syria Accountability and Lebanese Sovereignty Restoration Act of 2003, will end this special treatment, this inequity. It will make our Syria policy more like our policies toward other State sponsors of terrorism. With this legislation, Syria's support for terrorism, as well as Syria's illegal occupation of Lebanon, will become the central focus of our bilateral relations, rather than just an afterthought.

Mr. Speaker, Syrian-sponsored terrorism was responsible for the worst pre-September 11 terrorist incident in American history: the cold-blooded murder of 241 of our Marines by a suicide bomber in Lebanon a few years ago. Now, Syrian behavior is resulting in more American military being killed, this time in Iraq.

Recently, as my colleagues know, I visited Syria and met with President Bashar al-Asad. I warned him that the Syria Accountability Act would soon be on its way to passage unless Syria changed its ways. My words to him were both a prediction and a pledge. Asad understood me perfectly. The Secretary of State, Colin Powell, delivered a very similar message to him one week after my visit.

Yet, Syria's unacceptable and menacing behavior has not changed. Palestinian terrorists still populate Damascus. Hezbollah still occupies the south of Lebanon, its military arsenal regularly replenished, both by arms from Syria and Iran. Lebanon continues to remain under Syria's thumb. There are some 17,000 Syrian occupation troops in Lebanon, and countless additional thousands of Syrian intelligence officers controlling Lebanon. Anti-U.S. incitement continues in the Syrian media. Dissident Syrian parliamentarians and academicians, who want only freedom, languish in prison. Terrorists and Jahadists are allowed to cross the Syrian border into Iraq for the purpose of killing our own fighting men and women.

Mr. Speaker, I wish that this legislation had not been necessary, but the Syrian regime has made it so. Despite warning after warning, it has refused to heed the dictates of common sense. Now, Syria will pay the consequences.

The door to good relations with the United States has been wide open to Syria. Secretary of State Powell, myself, and others beckoned Syria to enter, but the Syrian regime has contemptuously slammed the door shut. Mr. Speaker, even now, as this legislation makes clear, our Nation would welcome good relations with Syria just as soon as the Syrian regime conforms to the minimal norms of civilized international conduct. Until then, I urge my colleagues to support H.R. 1828.

Mr. LANTOS. Mr. Speaker, I am very pleased to yield 7½ minutes to the gentleman from New York (Mr. ENGEL), the originator of this legislation.

Mr. ENGEL. Mr. Speaker, I thank my friend, the gentleman from California (Mr. LANTOS), who has been supportive every step of the way.

It has been a long road. Two years ago, when we sat down in my office and drafted this bill, we could hardly have dreamed the overwhelming support that this bill would have picked up, bipartisan support, I might add, in both the House and the Senate. In the previous Congress, the 107th Congress, I approached the then majority leader, Mr. Armey, about sponsoring this bill with me, and he very graciously agreed to do so. Our sponsors in the other body were Senator SANTORUM and Senator BOXER, and they, in the 108th Congress, continued to be the sponsors of the bill. In the 108th Congress, I spoke with my good friend and the chair of our subcommittee, the gentlewoman from Florida (Ms. ROS-LEHTINEN), and she joined with me in sponsoring this bill in the 108th Congress, and it has been a pleasure to work with her. I want to also thank our chairman, the gentleman from Illinois (Mr. HYDE), and all of the people who have worked so hard to bring this to fruition.

This is a very important bill. Syria is prominently listed by the U.S. State Department as a nation which supports terror. In 1979, the U.S. State Department put forth a list of countries which support terrorism and Syria was a charter member of that list. Syria has been on that State Department list, unabated, for 24 years, and now, in 2003, Syria is the only nation currently on that list with which we have normal diplomatic relations. It never made any sense to me, it still does not, and this bill is an important step in saying to Syria, enough is enough. No longer are you going to get away with supporting terrorism. No longer are you going to get away with your weapons of mass destruction. No longer are you going to get away with your occupation and strangulation of the sovereign nation of Lebanon and, certainly, no longer will we allow you to get away with allowing terrorists to cross over your border into Iraq to do harm to U.S. troops, and weapons crossing over from Syria to Iraq to kill U.S. troops.

□ 1615

Numerous terrorist groups, including Hezbollah, Hamas, and the Palestinian Islamic Jihad, maintain offices or training camps in Syria or areas of Syrian-occupied Lebanon with impunity under Syrian control and guidance.

Syria is in clear violation of U.N. Security Council Resolution 1373, which directs all states to refrain from providing any form of support for terrorists. Indeed, even after Secretary of State Powell's meeting with President Assad earlier this year, Hamas, Islamic Jihad, and other terrorist groups still remain active in Damascus and all over Syria and Lebanon.

Hezbollah is the group which killed more than 200 U.S. Marines in Beirut 20 years ago. Hezbollah continues to attack and wreak havoc in Israel's northern border. Hezbollah continues to kill American citizens. And yet Syria continues to play these duplicitous games. As General Aoun, the former leader of Lebanon, said, Syria plays a game where she is both the arsonist and the fireman. She starts the fire and then helps to put it out and expects accolades. Syria can no longer throw us crumbs and support terrorism at the same time and expect our accolades. She does not deserve it.

I think it is also interesting to note, Mr. Speaker, that several days ago the bombings in Turkey and Istanbul, and there were other horrible bombings this morning, but the bombing of the two synagogues in Istanbul the other day were carried out by two cousins. And the mastermind of the bombings, a brother of one of the cousins, fled to Syria after the bombings.

Syria, of course, is safe haven for terrorists around the world. Now, not only does Syria undermine regional stability by harboring terrorist groups, its 20,000-strong occupation force has denied Lebanon its internationally guaranteed sovereignty and political independence. As called for in U.N. Security Council Resolution 520, it is time that Lebanon is run by the Lebanese, not by the Assad regime in Damascus.

I cannot tell you how many Lebanese Americans have called me and called my office and commended us for this bill because people of Lebanese descent in this country are tired of seeing the stranglehold on Lebanon by Syria.

I am also concerned about Syrian efforts to field chemical and biological weapons in its development of long-range ballistic missiles. Considering the close ties Syria maintains with terrorist organizations, Syrian weapons of mass destruction programs are of grave concern. At a recent hearing of our Middle East subcommittee, the State Department confirmed that Syria is continuing to permit volunteers and others to enter Iraq from Syria to attack and kill Americans. This is totally unacceptable.

The broad spectrum of organizations which supports H.R. 1828 recognizes Syria as a major destabilizing factor in the region and see this bill as an essential tool to send a clear message to the Assad regime. The bill has 297 bipartisan cosponsors in the House and 76 in the Senate, a majority in both Houses in both parties.

The legislation imposes a variety of penalties upon Syria until it ends its support of terrorism, withdraws its armed forces from Lebanon, halts development of weapons of mass destruction and ballistic missiles, and stops facilitating terrorism in Iraq and stops allowing people to cross the border to do harm to U.S. troops.

This act is a measured and flexible approach to deal with the challenge emanating from Syria. It clearly states that we will not accept Syria's support of terrorism and we call for a free and sovereign Lebanon. This is the right step in America's Middle East policy.

And, finally, I want to say the national security waiver authority in this bill, which was put in by the Senate, is to be taken very seriously by the President; and its provisions are not to be waived except in instances truly affecting the national security interest of the United States.

Let me just say, as Syria is still supporting terrorism, occupying Lebanon, procuring weapons of mass destruction, and permitting guerillas to enter Iraq to attack and kill our troops, I want to say to the White House that any waiver would have to outweigh those most dangerous transgressions.

I find it very hard to imagine what factor would be more important to the national security of the U.S. than those matters. The administration should be aware that any waiver will be given the strictest scrutiny by Congress. And I would hope that the President in signing this bill would understand that the full implementation of this bill ought to be put into effect right away.

Mr. LANTOS. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey (Mr. PALLONE), my good friend and distinguished colleague.

Mr. PALLONE. Mr. Speaker, I rise today as an original cosponsor of H.R. 1828, the Syria Accountability and Lebanese Sovereignty Restoration Act. I urge all my colleagues to continue their support for this important legislation. The United States must show Syria that there are consequences for supporting terrorism and undermining peace in the region.

H.R. 1828 holds Syria accountable for its continued support of terrorism, occupation of Lebanon, and possession and development of weapons of mass destruction. It gives the President the tools he needs to impose penalties on Syria unless Syria corrects its behavior immediately.

Syria is listed on the State Department's list of countries who harbor and support terrorism. Syria has proven to be a destabilizing force in the Middle East, continuing to develop and stockpile chemical weapons and the missiles to deliver them and remaining the occupying power in Lebanon. Syria offered support to Iraq even as U.S. and coalition forces were engaged in combat and has turned a blind eye to militants who slip across their borders into Iraq to kill American soldiers.

Mr. Speaker, yet Syria is subject to fewer U.S. sanctions than any other country considered a state sponsor of terrorism.

I would like to take this opportunity to commend my colleagues, the gentleman from New York (Mr. ENGEL) and also the gentlewoman from Florida (Ms. ROS-LEHTINEN), for introducing this legislation. I just want to urge my colleagues on a bipartisan basis to fully support and pass this bill as amended in the Senate.

Mr. LANTOS. Mr. Speaker, I yield 2 minutes to the gentleman from Illinois (Mr. EMANUEL).

Mr. EMANUEL. Mr. Speaker, as a cosponsor of the Syrian Accountability Act, I am proud to rise in strong support of this legislation. It is a remedy for the absence of a consistent, clear, and strong policy towards Syria today. And while we pass this bill today, we are sending a strong signal by passing this bill that Syria will be treated like other state sponsors of terrorist organizations.

Today, over in Iraq the Iraqi council, with the American administration support, buys electricity in a swap deal for energy and oil, inconsistent with both the principles and the values embedded in this policy. On the northern border of Iraq, we have opened up in dialogue with Syria a free trade zone, again inconsistent especially with the policy of this act and the values and the principles embedded here.

It is my hope here we not only send a signal to Syria when it comes to being a state sponsor of terrorism but to the administration that we must have a consistent policy, not one that says as a state sponsor of terrorism that you have penalties but on the other side we will continue to do trade as it relates to electricity, continue to do trade as it relates to opening up a trade zone between Iraq and Syria. If we want to buy electricity, there are sources like Turkey, Jordan, countries that are partners with America.

So it is my hope that we support this bill which is a good first step to sending a signal to Syria that its days of sponsoring terrorism are coming to an end and that the administration should announce a policy that sends a strong, consistent, unambiguous signal we will not do business with states that sponsor terrorism.

Once again, I want to associate myself with my colleagues who have worked so hard on this and for their great work. Again, it crosses both parties because it represents the values of all of those in the House and other democratic nations in the fight against terrorism.

Mr. LANTOS. Mr. Speaker, I have no additional speakers, and I yield back the balance of my time.

Ms. ROS-LEHTINEN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, in closing, I would like to take a moment to express my appreciation to those without whom this day would not have been possible. Of course, first and foremost, the gentleman from New York (Mr. ENGEL), with whom it has been a pleasure to work for passage of this bill, the second time we pass it in just a few short weeks. Our impressive leadership here in the House, very particularly our majority leader whose unwavering commitment to U.S. national security and, thus, to this bill, were instrumental in moving this legislation. So thank you to the gentleman from Texas (Mr. DELAY), my distinguished chairman, the gentleman from Illinois (Mr. HYDE) for his support and his assistance throughout this process, the ranking member of the Committee on International Relations, the gentleman from California (Mr. LANTOS) who is always an inspiration to us all, to Tony Haddad and the Lebanese American community whose passion on these issues have served as a source of energy for us all.

And I would also like to pay special thanks to Yleem Poblete, committee staff director of our Subcommittee on the Middle East and Central Asia. This will be the last piece of legislation that she will be handling for our subcommittee because she is awaiting White House approval in a State Department job working with Secretary John Bolton. And I thank Yleem for being a valuable member of my family, my legislative family for many, many years. I remember when Yleem and I first met and she was Miss Teen Florida. That was not so long ago. But she has been a wonderful friend and a part of my family for a long time. And we wish her God speed and much success.

And I would also like to ask my colleagues to reflect on the suffering of the Syrian and Lebanese people today and on the lives and the sacrifice of American, Israeli, and so many other victims of terrorist attacks supported by or facilitated by the Syrian regime. This bill is also for them. We look forward to working closely with President Bush toward expeditious enactment and implementation of this bill.

Time has clearly run out for the Syrian regime. It had a choice to make, and it chose terrorism. That was the wrong choice. We have a choice to make. We have demonstrated it by our overwhelming vote in support of this bill, what our will is with respect to Syria's regime. Let us again send a strong, unequivocal message to this pariah state and concur in the Senate amendment to the Syria Accountability and Lebanese Sovereignty Restoration Act.

Mr. ENGEL. Mr. Speaker, will the gentlewoman yield?

Ms. ROS-LEHTINEN. I yield to the gentleman from New York.

Mr. ENGEL. Mr. Speaker, I want to again personally thank her for being my partner in this bill. This whole Congress, it could not have been done without her. And it was a pleasure to work with her. I want to state that for the record.

I also want to thank the gentleman who is to my left who is my chief of staff, Jason Steinbaum. When I say that we wrote the bill in my office, he is the man who did all the writing. And I want to acknowledge his role and his work and thank him. It is very difficult when you have a concept and then you want to put the concept into writing and then you want to pass it through all the channels that it needs to be passed through. But as you mentioned, our staffs do a magnificent job. We could not do what we do if it were not for the good work of our staff.

Ms. ROS-LEHTINEN. Mr. Speaker, we look forward to working on the Saudi Arabia Accountability Act and the Iran Accountability Act. We have only just begun.

Mr. McDERMOTT. Mr. Speaker, a little over a month ago, this Act came before the House and I voted for it.

I believe that Syria's occupation of Lebanon and questionable policies toward terrorist groups are reprehensible. I also believe it is important for the Syrian government to realize that Americans of every political stripe (including those who, like me, opposed the U.S. invasion of Iraq) are aware of and disapprove of many of Syria's actions.

I believe it is entirely appropriate for the United States to apply political and economic pressure on Syria to change its policies. However, I have decided to vote against the Syria Accountability Act tonight.

I am concerned about the increasing bellicose statements we have been hearing from London. I am concerned that our President may be setting the stage for the imposition of his vision of democracy in more and more places, and that he may use the many findings, senses of Congress, and statements of policy in this Act to promote actions that are contrary to the best interests of the United States.

This act is filled with nonbinding provisions that build a case against Syria, based on soft intelligence and reasonable, but undocumented, assumptions.

Ultimately, I fear that those provisions could be used to build a case for a military intervention against Syria.

For example, the bill before us contains language that speaks of "hostile actions" by Syria against U.S.-led forces in Iraq as though this is something we firmly know to be true. It is certainly possible that it is true. Yet there is no conclusive evidence as to the role of the Government of Syria in the attacks that have been carried out against our troops in Iraq. It is just this kind of poorly sourced insinuation that I fear might be used to build the case for a preemptive invasion of Syria.

It is unfortunate that the dangerous doctrine of preemption to which President Bush so obdurately subscribes makes members like me, who are truly concerned about wrongdoing by Syria, fearful of supplying the Administration with language like this to wield.

I remember that similar language regarding Iraq was misused by the Administration. We meant to express concerns and admonish the Iraqi government, but our words ended up being used as evidence for military action.

The standard of proof for a House expression of concern is and should be lower than the standard of proof for an invasion—but I don't think any of us can count on the Bush Administration to draw that distinction. Therefore, I must vote "no."

Ms. ROS-LEHTINEN. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. CULBERSON). The question is on the motion offered by the gentlewoman from Florida (Ms. ROS-LEHTINEN) that the House suspend the rules and concur in the Senate amendments to the bill, H.R. 1828.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Ms. ROS-LEHTINEN. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

□ 1630

TAX RELIEF EXTENSION ACT OF 2003

Mr. McCRERY. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3521) to amend the Internal Revenue Code of 1986 to extend certain expiring provisions, and for other purposes, as amended.

The Clerk read as follows:

H.R. 3521

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; REFERENCES; ETC.

(a) SHORT TITLE.—This Act may be cited as the "Tax Relief Extension Act of 2003".

(b) AMENDMENT OF 1986 CODE.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

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Sec. 3187. Certain children's products.
Sec. 3188. Certain optical instruments used in children's products.
Sec. 3189. Cases for certain children's products.
Sec. 3190. 2,4-dichloroaniline.
Sec. 3191. Ethoprop.
Sec. 3192. Foramsulfuron.
Sec. 3193. Certain epoxy molding compounds.
Sec. 3194. Dimethyldicyane.
Sec. 3195. Triacetone diamine.
Sec. 3196. Triethylene glycol bis[3-(3-tert-butyl-4-hydroxy-5-methylphenyl) propionate.
Sec. 3197. Certain power weaving textile machinery.
Sec. 3198. Certain filament yarns.
Sec. 3199. Certain other filament yarns.
Sec. 3200. Certain ink-jet textile printing machinery.
Sec. 3201. Certain other textile printing machinery.
Sec. 3203. D-mannose.
Sec. 3204. Benzamide, N-methyl-2-[[3-[(1E)-2-(2-pyridinyl)-ethenyl]-1H-indazol-6-yl)thio]-.
Sec. 3205. 1(2h)-quinolinecarboxylic acid, 4-[[[3,5-bis-(trifluoromethyl)phenyl] methyl](methoxycarbonyl)amino]-2-ethyl- 3,4-dihydro-6-(trifluoromethyl)-, ethyl ester, (2R,4S)-(9CI).
Sec. 3206. Disulfide,bis(3,5-dichlorophenyl)(9C1).
Sec. 3207. Pyridine, 4-[[4-(1-methylethyl)-2-[(phenylmethoxy)methyl]-1H-midazol-1-yl] methyl]-ethanedioate (1:2).
Sec. 3208. Paclobutrazole technical.
Sec. 3209. Paclobutrazole 2SC.
Sec. 3210. Methidathion technical.
Sec. 3211. Vanguard 75 WDG.
Sec. 3212. Wakil XL.
Sec. 3213. Mucochloric acid.
Sec. 3214. Azoxystrobin technical.
Sec. 3215. Flumetralin technical.
Sec. 3216. Cyprodinil technical.
Sec. 3217. Mixtures of lambda-cyhalothrin.
Sec. 3218. Primisulfuron methyl.
Sec. 3219. 1,2-cyclohexanedione.
Sec. 3220. Difenoconazole.
Sec. 3221. Certain refracting and reflecting telescopes.
Sec. 3222. Phenylisocyanate.
Sec. 3223. Bayowet FT-248.
Sec. 3224. P-phenylphenol.
Sec. 3225. Certain rubber riding boots.
Sec. 3226. Chemical RH water-based.
Sec. 3227. Chemical NR ethanol-based.
Sec. 3228. Tantalum capacitor ink.
Sec. 3229. Certain sawing machines.
Sec. 3230. Certain sector mold press manufacturing equipment.
Sec. 3231. Certain manufacturing equipment used for molding.
Sec. 3232. Certain extruders.
Sec. 3233. Certain shearing machines.
Sec. 3234. Thermal release plastic film.
Sec. 3235. Certain silver paints and pastes.
Sec. 3236. Polymer masking material for aluminum capacitors (upicoat).
Sec. 3237. OBPA.
Sec. 3238. Macroporous ion-exchange resin.
Sec. 3239. Copper 8-quinolinolate.
Sec. 3240. Ion-exchange resin.
Sec. 3241. Ion-exchange resin crosslinked with ethenylbenzene, aminophosponic acid.

Sec. 3242. Ion-exchange resin crosslinked with divinylbenzene, sulphonic acid.
Sec. 3243. 3-[(4 amino-3-methoxyphenyl) azo]-benzene sulfonic acid.
Sec. 3244. 2-methyl-5-nitrobenzenesulfonic acid.
Sec. 3245. 2-amino-6-nitro-phenol-4-sulfonic acid.
Sec. 3246. 2-amino-5-sulfobenzoic acid.
Sec. 3247. 2,5 bis [(1,3 dioxobutyl) amino] benzene sulfonic acid.
Sec. 3248. P-aminoazobenzene 4 sulfonic acid, monosodium salt.
Sec. 3249. P-aminoazobenzene 4 sulfonic acid.
Sec. 3250. 3-[(4 amino-3-methoxyphenyl) azo]-benzene sulfonic acid, monosodium salt.
Sec. 3251. ET-743 (ecteinascidin).
Sec. 3252. 2,7-naphthalenedisulfonic acid, 5-[[4-chloro-6-[[2-[[4-fluoro-6-[[5-hydroxy-6-[(4-methoxy-2-sulfophenyl)azo]-7-sulfo-2-naphthalenyl]amino]-1,3,5-triazin-2-yl] amino]-1-methylethyl]amino]-1,3,5-triazin-2-yl]amino]-3-[[4-(ethenylsulfonyl)phenyl]azo]-4-hydrox′-, sodium salt.
Sec. 3253. 1,5-naphthalenedisulfonic acid, 3-[[2-(acetylamino)-4-[[4-[[2-[2-(ethenylsulfonyl)ethoxy]ethyl] amino]-6-fluoro-1,3,5-triazin-2-yl]amino]phenyl]azo]-, disodium salt.
Sec. 3254. 7,7′-[1,3-propanediylbis[imino(6-fluoro-1,3,5-triazine-4,2-diyl)imino[2-[(aminocarbonyl)amino]-4,1-phenylene]azo]]bis-, sodium salt.
Sec. 3255. Cuprate(3-), [2-[[[[3-[[4-[[2-[2-(ethenylsulfonyl)ethoxy]ethyl]amino]-6-fluoro-1,3,5-triazin-2-yl]amino]-2-(hydroxy-.kappa.o)-5-sulfophenyl]azo-.kappa.n2]phenylmethyl]azo-.kappa.n1]-4-sulfobenzoato(5-)-.kappa.o], trisodium.
Sec. 3256. 1,5-naphthalenedisulfonic acid, 2-[[8-[[4-[[3-[[[2-(ethenylsulfonyl) ethyl]amino]carbonyl] phenyl]amino]-6-fluoro-1,3,5-triazin-2-yl]amino]-1-hydroxy-3,6-disulfo-2-naphthalenyl]azo]-, tetrasodium salt.
Sec. 3257. PTFMBA.
Sec. 3258. Benzoic acid, 2-amino-4-[[(2,5-dichlorophenyl) amino]carbonyl]-, methyl ester.
Sec. 3259. Imidacloprid pesticides.
Sec. 3260. Beta-cyfluthrin.
Sec. 3261. Imidacloprid technical.
Sec. 3262. bayleton technical.
Sec. 3263. Propoxur technical.
Sec. 3264. MKH 6561 isocyanate.
Sec. 3265. Propoxy methyl triazolone.
Sec. 3266. Nemacur VL.
Sec. 3267. Methoxy methyl triazolone.
Sec. 3268. Levafix golden yellow E-G.
Sec. 3269. Levafix blue CA/remazol blue CA.
Sec. 3270. Remazol yellow RR gran.
Sec. 3271. Indanthren blue CLF.
Sec. 3272. indanthren yellow F3GC.
Sec. 3273. acetyl chloride.
Sec. 3274. 4-methoxy-phenacychloride.
Sec. 3275. 3-methoxy-thiophenol.
Sec. 3276. Levafix brilliant red E-6BA.
Sec. 3277. Remazol BR. Blue BB 133 percent.
Sec. 3278. Fast navy salt RA.
Sec. 3279. Levafix royal blue E-FR.
Sec. 3280. P-chloroaniline.
Sec. 3281. Esters and sodium esters of parahydroxybenzoic acid.
Sec. 3282. Santolink EP 560.
Sec. 3283. Phenodur VPW 1942.
Sec. 3284. Phenodur PR 612.
Sec. 3285. Phenodur PR 263.
Sec. 3286. Macrynal SM 510 and 516.
Sec. 3287. Alftalat AN 725.
Sec. 3288. RWJ 241947.
Sec. 3289. RWJ 394718.
Sec. 3290. RWJ 394720.
Sec. 3291. 3,4-DCBN.
Sec. 3292. Cyhalofop.
Sec. 3293. Asulam.
Sec. 3294. Florasulam.
Sec. 3295. Propanil.
Sec. 3296. Halofenozide.
Sec. 3297. Ortho-phthalaldehyde.
Sec. 3298. Trans 1,3-dichloropentene.
Sec. 3299. Methacrylamide.
Sec. 3300. Cation exchange resin.
Sec. 3301. Gallery.
Sec. 3302. Necks used in cathode ray tubes.
Sec. 3303. Polytetramethylene ether glycol.
Sec. 3304. Leaf alcohol.
Sec. 3305. Combed cashmere and camel hair yarn.
Sec. 3306. Certain carded cashmere yarn.
Sec. 3307. Sulfur black 1.
Sec. 3308. Reduced vat blue 43.
Sec. 3309. Fluorobenzene.
Sec. 3310. Certain rayon filament yarn.
Sec. 3311. Certain tire cord fabric.
Sec. 3312. Direct black 184.
Sec. 3313. Black 263 stage.
Sec. 3314. Magenta 364.
Sec. 3315. Thiamethoxam technical.
Sec. 3316. Cyan 485 stage.
Sec. 3317. Direct blue 307.
Sec. 3318. Direct violet 107.
Sec. 3319. Fast black 286 stage.
Sec. 3320. Mixtures of fluazinam.
Sec. 3321. Prodiamine technical.
Sec. 3322. Carbon dioxide cartridges.
Sec. 3323. 12-hydroxyoctadecanoic acid, reaction product with *N*,*N*-dimethyl, 1,3-propanediamine, dimethyl sulfate, quaternized.
Sec. 3324. 40 percent polymer acid salt/polymer amide, 60 percent butyl acetate.
Sec. 3325. 12-hydroxyoctadecanoic acid, reaction product with *N*,*N*-dimethyl- 1,3-propanediamine, dimethyl sulfate, quaternized, 60 percent solution in toluene.
Sec. 3326. Polymer acid salt/polymer amide.
Sec. 3327. 50 percent amine neutralized phosphated polyester polymer, 50 percent solvesso 100.
Sec. 3328. 1-octadecanaminium, *N*,*N*-di-methyl-*N*-octadecyl-, (SP-4-2)-[29H,31H-phthalocyanine-2-sulfonato(3-)-.kappa.n29,.kappa.n30,. Kappa.n31,.kappa. n32]cuprate(1-).
Sec. 3329. Chromate(1-)-bis{1- {(5-chloro–2-hydroxyphenyl) azo}–2-napthal enolato(2-)}-,hydrogen.
Sec. 3330. Bronate advanced.
Sec. 3331. N-cyclohexylthiophthalimide.
Sec. 3332. Certain high-performance loudspeakers.
Sec. 3333. Bio-set injection RCC.
Sec. 3334. Penta amino aceto nitrate cobalt III (coflake 2).
Sec. 3335. Oxasulfuron technical.
Sec. 3336. Certain manufacturing equipment.
Sec. 3337. 4-aminobenzamide.
Sec. 3338. FOE hydroxy.
Sec. 3339. Magenta 364 liquid feed.
Sec. 3340. Tetrakis.
Sec. 3341. Palmitic acid.
Sec. 3342. Phytol.
Sec. 3343. Chloridazon.
Sec. 3344. Disperse orange 30, disperse blue 79:1, disperse red 167:1, disperse yellow 64, disperse red 60, disperse blue 60, disperse blue 77, disperse yellow 42, disperse red 86, and disperse red 86:1.
Sec. 3345. Disperse blue 321.
Sec. 3346. Direct black 175.
Sec. 3347. Disperse red 73 and disperse blue 56.
Sec. 3348. Acid black 132.
Sec. 3349. Acid black 132 and acid black 172.
Sec. 3350. Acid black 107.
Sec. 3351. Acid yellow 219, acid orange 152, acid red 278, acid orange 116, acid orange 156, and acid blue 113.
Sec. 3352. Europium oxides.
Sec. 3353. Luganil brown NGT powder.
Sec. 3354. Thiophanate-methyl.
Sec. 3355. Mixtures of thiophanate-methyl and application adjuvants.
Sec. 3356. Hydrated hydroxypropyl methylcellulose.
Sec. 3357. C 12–18 alkenes, polymers with 4-methyl-1-pentene.
Sec. 3358. Certain 12-volt batteries.
Sec. 3359. Certain prepared or preserved artichokes.
Sec. 3360. Certain other prepared or preserved artichokes.
Sec. 3361. Ethylene/tetrafluoroethylene copolymer (ETFE).
Sec. 3362. Acetamiprid.
Sec. 3363. Certain manufacturing equipment.
Sec. 3364. Triticonazole.
Sec. 3365. Certain textile machinery.
Sec. 3366. 3-sulfinobenzoic acid.
Sec. 3367. Polydimethylsiloxane.
Sec. 3368. Baysilone fluid.
Sec. 3369. Ethanediamide, N- (2-ethoxyphenyl)-N′- (4-isodecylphenyl)-.
Sec. 3370. 1-acetyl-4-(3-dodecyl-2, 5-dioxo-1-pyrrolidinyl)-2,2,6,6-tetramethyl-piperidine.
Sec. 3371. Aryl phosphonite.
Sec. 3372. Mono octyl malionate.
Sec. 3373. 3,6,9-trioxaundecanedioic acid.
Sec. 3374. Crotonic acid.
Sec. 3375. 1,3-benzenedicarboxamide, N, N′-bis-(2,2,6,6-tetramethyl-4-piperidinyl)-.
Sec. 3376. 3-dodecyl-1-(2,2,6,6-tetramethyl-4-piperidinyl)-2,5-pyrrolidinedione.
Sec. 3377. Oxalic anilide.
Sec. 3378. N-methyl diisopropanolamine.
Sec. 3379. 50 percent homopolymer, 3-(dimethylamino) propyl amide, dimethyl sulfate-quaternized 50 percent polyricinoleic acid.
Sec. 3380. Black CPW stage.
Sec. 3381. Fast black 287 NA paste.
Sec. 3382. Fast black 287 NA liquid feed.
Sec. 3383. Fast yellow 2 stage.
Sec. 3384. Cyan 1 stage.
Sec. 3385. Yellow 1 stage.
Sec. 3386. Yellow 746 stage.
Sec. 3387. Black SCR stage.
Sec. 3388. Magenta 3B-OA stage.
Sec. 3389. Yellow 577 stage.
Sec. 3390. Cyan 485/4 stage.
Sec. 3391. Low expansion laboratory glass.
Sec. 3392. Stoppers, lids, and other closures.
Sec. 3393. Triflusulfuron methyl formulated product.
Sec. 3394. Agrumex (o-t-butyl cyclohexanol).
Sec. 3395. Trimethyl cyclo hexanol (1-methyl-3,3-dimethylcyclohexanol-5).
Sec. 3396. Myclobutanil.
Sec. 3397. Methyl cinnamate (methyl-3-phenylpropenoate).

Sec. 3398. Acetanisole (anisyl methyl ketone).
Sec. 3399. Alkylketone.
Sec. 3400. Iprodione 3-(3-5, dicholorophenyl)-N-(1-methylethyl)-2,4-dioxo-1-imidazolidinecarboxamide.
Sec. 3401. Dichlorobenzidine dihydrochloride.
Sec. 3402. Kresoxim-methyl.
Sec. 3403. MKH 6562 isocyanate.
Sec. 3404. Certain rayon filament yarn.
Sec. 3405. Benzenepropanal, 4-(1,1-dimethylethyl)-alpha-methyl.
Sec. 3406. 3,7-dichloro-8-quinoline carboxylic acid.
Sec. 3407. 3-(1-methylethyl)-1h-2,1,3-benzothiadiazin-4(3h)-one 2,2 dioxide, sodium salt.
Sec. 3408. 3,3′,4-4′-biphenyltetracarboxylic dianhydride, oda, odpa, pmda, and 1,3-bis(4-aminophenoxy)benzene.
Sec. 3409. Oryzalin.
Sec. 3410. Tebufenozide.
Sec. 3411. Endosulfan.
Sec. 3412. Ethofumesate.
Sec. 3413. Night vision monoculars.
Sec. 3414. Solvent yellow 163.
Sec. 3415. Railway car body shells for EMU's.
Sec. 3416. Railway passenger coaches.
Sec. 3417. Railway electric multiple unit (EMU) gallery commuter coaches of stainless steel.
Sec. 3418. Snowboard boots.
Sec. 3419. Hand-held radio scanners.
Sec. 3420. Mobile and base radio scanners that are combined with a clock.
Sec. 3421. Mobile and base radio scanners that are not combined with a clock.
Sec. 3422. Certain fine animal hair of kashmir (cashmere) goats not processed.
Sec. 3423. Certain fine animal hair of kashmir (cashmere) goats.
Sec. 3424. Certain r-core transformers.
Sec. 3425. Decorative plates.
Sec. 3426. Bispyribac sodium.
Sec. 3427. Fenpropathrin.
Sec. 3428. Pyriproxyfen.
Sec. 3429. Uniconazole-P.
Sec. 3430. Flumioxazin.
Sec. 3431. Night vision monoculars.
Sec. 3432. 2,4-xylidine.
Sec. 3433. R118118 salt.
Sec. 3434. NMSBA.
Sec. 3435. Certain satellite radio broadcasting apparatus.
Sec. 3436. Acephate.
Sec. 3437. Magnesium aluminum hydroxide carbonate hydrate.
Sec. 3438. Certain footwear.

SUBCHAPTER B—EXISTING DUTY SUSPENSIONS AND REDUCTIONS

Sec. 3451. Extension of certain existing duty suspensions.
Sec. 3452. Effective date.

CHAPTER 2—OTHER TARIFF PROVISIONS

SUBCHAPTER A—LIQUIDATION OR RELIQUIDATION OF CERTAIN ENTRIES

Sec. 3501. Certain tramway cars.
Sec. 3502. Liberty Bell replica.
Sec. 3503. Certain entries of cotton gloves.
Sec. 3504. Certain entries of posters.
Sec. 3505. Certain entries of posters entered in 1999 and 2000.
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Sec. 3507. Neoprene synchronous timing belts.
Sec. 3508. Liquidation of certain entries of roller chain.
Sec. 3509. Reliquidation of drawback claim relating to juices entered in April 1993.
Sec. 3510. Reliquidation of drawback claim relating to juices entered in March 1994.
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Sec. 3524. Vessel repair duties.
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Sec. 3526. Duty drawback for certain articles.
Sec. 3527. Unused merchandise drawback.
Sec. 3528. Treatment of certain footwear under Caribbean Basin Economic Recovery Act.
Sec. 3529. Designation of San Antonio International Airport for customs processing of certain private aircraft arriving in the United States.
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Sec. 3531. Designation of foreign law enforcement officers.
Sec. 3532. Amendments to United States insular possession program.
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Sec. 3601. Termination of application of title IV of the Trade Act of 1974 to Armenia.
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CHAPTER 2—TECHNICAL AMENDMENTS RELATING TO ENTRY AND PROTEST

Sec. 3701. Entry of merchandise.
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TITLE I—EXTENSION OF CERTAIN EXPIRING PROVISIONS

SEC. 1001. ALLOWANCE OF NONREFUNDABLE PERSONAL CREDITS AGAINST REGULAR AND MINIMUM TAX LIABILITY.

(a) IN GENERAL.—Paragraph (2) of section 26(a) is amended—

(1) by striking "RULE FOR 2000, 2001, 2002, AND 2003.—" and inserting "RULE FOR TAXABLE YEARS 2000 THROUGH 2004.—", and

(2) by striking "or 2003," and inserting "2003, or 2004,".

(b) CONFORMING PROVISIONS.—

(1) Section 904(h) is amended by striking "or 2003" and inserting "2003, or 2004".

(2) The amendments made by sections 201(b), 202(f), and 618(b) of the Economic Growth and Tax Relief Reconciliation Act of 2001 shall not apply to taxable years beginning during 2004.

(3) The amendments made by section 1346 of the Energy Tax Policy Act of 2003 shall not apply to taxable years beginning during 2004.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2003.

SEC. 1002. WORK OPPORTUNITY CREDIT.

(a) IN GENERAL.—Subparagraph (B) of section 51(c)(4) is amended by striking "December 31, 2003" and inserting "December 31, 2004".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to individuals who begin work for the employer after December 31, 2003.

SEC. 1003. WELFARE-TO-WORK CREDIT.

(a) IN GENERAL.—Subsection (f) of section 51A is amended by striking "December 31, 2003" and inserting "December 31, 2004".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to individuals who begin work for the employer after December 31, 2003.

SEC. 1004. CERTAIN EXPENSES OF ELEMENTARY AND SECONDARY SCHOOL TEACHERS.

(a) IN GENERAL.—Subparagraph (D) of section 62(a)(2) (relating to certain trade and business deductions of employees) is amended by striking "or 2003" and inserting ", 2003, or 2004".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 2003.

SEC. 1005. CHARITABLE CONTRIBUTIONS OF COMPUTER TECHNOLOGY AND EQUIPMENT USED FOR EDUCATIONAL PURPOSES.

(a) IN GENERAL.—Subparagraph (G) of section 170(e)(6) (relating to special rule for contributions of computer technology and equipment for educational purposes) is amended by striking "December 31, 2003" and inserting "December 31, 2004".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 2003.

SEC. 1006. EXPENSING OF ENVIRONMENTAL REMEDIATION COSTS.

(a) IN GENERAL.—Subsection (h) of section 198 (relating to termination) is amended by striking "December 31, 2003" and inserting "December 31, 2004".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to expenditures paid or incurred after December 31, 2003.

SEC. 1007. 5-YEAR CARRYBACK OF CERTAIN NET OPERATING LOSSES.

(a) IN GENERAL.—Subparagraph (H) of section 172(b)(1) is amended—

(1) by inserting "5-YEAR CARRYBACK OF CERTAIN LOSSES.—" after "(H)", and

(2) by striking "or 2002" and inserting ", 2002, or 2003".

(b) TEMPORARY SUSPENSION OF LIMITATION ON ALTERNATIVE MINIMUM TAXABLE INCOME FOR CERTAIN NOL CARRYBACKS.—Subclause (I) of section 56(d)(1)(A)(ii) is amended—

(1) by striking "or 2002" and inserting ", 2002, or 2003", and

(2) by striking "and 2002" and inserting ", 2002, or 2003".

(c) TECHNICAL CORRECTIONS.—

(1) Subparagraph (H) of section 172(b)(1) is amended by striking "a taxpayer which has".

(2) Section 102(c)(2) of the Job Creation and Worker Assistance Act of 2002 (Public Law 107–147) is amended by striking "before January 1, 2003" and inserting "after December 31, 1990".

(3)(A) Subclause (I) of section 56(d)(1)(A)(i) is amended by striking "attributable to carryovers".

(B) Subclause (I) of section 56(d)(1)(A)(ii) is amended—

(i) by striking "for taxable years" and inserting "from taxable years", and

(ii) by striking "carryforwards" and inserting "carryovers".

(d) Effective Dates.—

(1) In general.—Except as provided in paragraph (2), the amendments made by this section shall apply to net operating losses for taxable years ending after December 31, 2002.

(2) Technical corrections.—The amendments made by subsection (c) shall take effect as if included in the amendments made by section 102 of the Job Creation and Worker Assistance Act of 2002.

(3) Election.—In the case of a net operating loss for a taxable year ending during 2003—

(A) any election made under section 172(b)(3) of such Code may (notwithstanding such section) be revoked before April 15, 2004, and

(B) any election made under section 172(j) of such Code shall (notwithstanding such section) be treated as timely made if made before April 15, 2004.

SEC. 1008. AVAILABILITY OF MEDICAL SAVINGS ACCOUNTS.

(a) In General.—Paragraphs (2) and (3)(B) of section 220(i) (defining cut-off year) are each amended by striking "2003" each place it appears in the text and headings and inserting "2004".

(b) Conforming Amendments.—

(1) Paragraph (2) of section 220(j) is amended—

(A) in the text by striking "or 2002" each place it appears and inserting "2002, or 2003", and

(B) in the heading by striking "OR 2002" and inserting "2002, OR 2003".

(2) Subparagraph (A) of section 220(j)(4) is amended by striking "and 2002" and inserting "2002, and 2003".

(c) Effective Date.—The amendments made by this section shall take effect on January 1, 2004.

(d) Time for Filing Reports, Etc.—

(1) The report required by section 220(j)(4) of the Internal Revenue Code of 1986 to be made on August 1, 2003, shall be treated as timely if made before the close of the 90-day period beginning on the date of the enactment of this Act.

(2) The determination and publication required by section 220(j)(5) of such Code shall be treated as timely if made before the close of the 120-day period beginning on such date. If the determination under the preceding sentence is that 2003 is a cut-off year under section 220(i) of such Code, the cut-off date under such section 220(i) shall be the last day of such 120-day period.

SEC. 1009. TEMPORARY SPECIAL RULES FOR TAXATION OF LIFE INSURANCE COMPANIES.

(a) In General.—Subsection (j) of section 809 (relating to reduction in certain deductions of mutual life insurance companies) is amended by striking "or 2003" and inserting "2003, or 2004".

(b) Effective Date.—The amendment made by this section shall apply to taxable years beginning after December 31, 2003.

SEC. 1010. QUALIFIED ZONE ACADEMY BONDS.

(a) In General.—Paragraph (1) of section 1397E(e) is amended by striking "and 2003" and inserting "2003, and 2004".

(b) Effective Date.—The amendment made by subsection (a) shall apply to obligations issued after the date of the enactment of this Act.

SEC. 1011. DISTRICT OF COLUMBIA.

(a) District of Columbia Enterprise Zone.—Subsection (f) of section 1400 is amended by striking "December 31, 2003" both places it appears and inserting "December 31, 2004".

(b) Tax-Exempt Economic Development Bonds.—Subsection (b) of section 1400A is amended by striking "December 31, 2003" and inserting "December 31, 2004".

(c) Zero Percent Capital Gains Rate.—

(1) Section 1400B is amended by striking "January 1, 2004" each place it appears and inserting "January 1, 2005".

(2) Subsections (e)(2) and (g)(2) of section 1400B are each amended by striking "2008" each place it appears in the headings and text and inserting "2009".

(3) Subsection (d) of section 1400F is amended by striking "December 31, 2008" and inserting "December 31, 2009".

(d) First-Time Homebuyer Credit.—Subsection (i) of section 1400C is amended by striking "January 1, 2004" and inserting "January 1, 2005".

(e) Effective Dates.—

(1) In general.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on the date of the enactment of this Act.

(2) Tax-exempt economic development bonds.—The amendment made by subsection (b) shall apply to obligations issued after December 31, 2003.

SEC. 1012. WORK OPPORTUNITY CREDIT WITH RESPECT TO NEW YORK LIBERTY ZONE.

(a) In General.—Subclause (I) of section 1400L(a)(2)(D)(iv) (defining qualified wages) is amended by striking "or 2003" and inserting ", 2003, or 2004".

(b) Effective Date.—The amendment made by subsection (a) shall apply with respect to work performed after December 31, 2003.

SEC. 1013. DISCLOSURES RELATING TO TERRORIST ACTIVITIES.

(a) In General.—Clause (iv) of section 6103(i)(3)(C) and subparagraph (E) of section 6103(i)(7) are both amended by striking "December 31, 2003" and inserting "December 31, 2004".

(b) Disclosure of taxpayer identity to law enforcement agencies investigating terrorism.—Subparagraph (A) of section 6103(i)(7) is amended by adding at the end the following new clause:

"(v) Taxpayer identity.—For purposes of this subparagraph, a taxpayer's identity shall not be treated as taxpayer return information.".

(c) Effective Dates.—

(1) In general.—The amendments made by subsection (a) shall apply to disclosures after December 31, 2003.

(2) Subsection (b).—The amendment made by subsection (b) shall take effect as if included in section 201 of the Victims of Terrorism Tax Relief Act of 2001.

SEC. 1014. COVER OVER OF TAX ON DISTILLED SPIRITS.

(a) In General.—Paragraph (1) of section 7652(f) is amended by striking "January 1, 2004" and inserting "January 1, 2005".

(b) Effective Date.—The amendment made by subsection (a) shall apply to articles brought into the United States after December 31, 2003.

SEC. 1015. PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS.

(a) In General.—Paragraph (2) of section 9812(f) is amended by striking "December 31, 2003" and inserting "December 31, 2004".

(b) ERISA.—Section 712(f) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a(f)) is amended by striking "on or after December 31, 2003" and inserting "after December 31, 2004".

(c) PHSA.—Section 2705(f) of the Public Health Service Act (42 U.S.C. 300gg-5(f)) is amended by striking "on or after December 31, 2003" and inserting "after December 31, 2004".

(d) Effective Date.—The amendments made by this section shall apply to benefits for services furnished on or after December 31, 2003.

SEC. 1016. COMBINED EMPLOYMENT TAX REPORTING PROJECT.

(a) In General.—Paragraph (1) of section 976(b) of the Taxpayer Relief Act of 1997 (111 Stat. 898) is amended by striking "for a period ending with the date which is 5 years after the date of the enactment of this Act" and inserting "during the period ending before the date that is one year after the date of enactment of the Tax Relief Extension Act of 2003". .

(b) Effective Date.—The amendment made by subsection (a) shall apply to disclosures on or after the date of the enactment of this Act.

TITLE II—PROVISIONS RELATING TO PENSIONS

SEC. 2001. TEMPORARY REPLACEMENT OF 30-YEAR TREASURY RATE.

(a) Employee Retirement Income Security Act of 1974.—

(1) Determination of permissible range.—

(A) In general.—Clause (ii) of section 302(b)(5)(B) of the Employee Retirement Income Security Act of 1974 is amended by redesignating subclause (II) as subclause (III) and by inserting after subclause (I) the following new subclause:

"(II) Special rule for years 2004 and 2005.—In the case of plan years beginning after December 31; 2003, and before January 1, 2006, the term 'permissible range' means a rate of interest which is not above, and not more than 10 percent below, the weighted average of the rates of interest on amounts invested conservatively in long-term investment grade corporate bonds during the 4-year period ending on the last day before the beginning of the plan year. Such rates shall be determined by the Secretary on the basis of one or more indices selected periodically by the Secretary, and the Secretary shall make the permissible range publicly available.".

(B) Secretarial authority.—Subclause (III) of section 302(b)(5)(B)(ii) of such Act, as redesignated by subparagraph (A), is amended—

(i) by inserting "or (II)" after "subclause (I)" the first place it appears, and

(ii) by striking "subclause (I)" the second place it appears and inserting "such subclause".

(C) Conforming amendment.—Subclause (I) of section 302(b)(5)(B)(ii) of such Act is amended by inserting "or (III)" after "subclause (II)".

(2) Determination of current liability.—Clause (i) of section 302(d)(7)(C) of such Act is amended by adding at the end the following new subclause:

"(IV) SPECIAL RULE FOR 2004 AND 2005.—For plan years beginning in 2004 or 2005, notwithstanding subclause (I), the rate of interest used to determine current liability under this subsection shall be the rate of interest under subsection (b)(5).".

(3) CONFORMING AMENDMENT.—Paragraph (7) of section 302(e) of such Act is amended to read as follows:

"(7) SPECIAL RULE FOR 2002.—In any case in which the interest rate used to determine current liability is determined under subsection (d)(7)(C)(i)(III), for purposes of applying paragraphs (1) and (4)(B)(ii) for plan years beginning in 2002, the current liability for the preceding plan year shall be redetermined using 120 percent as the specified percentage determined under subsection (d)(7)(C)(i)(II).".

(4) PBGC.—Clause (iii) of section 4006(a)(3)(E) of such Act is amended by adding at the end the following new subclause:

"(V) In the case of plan years beginning after December 31, 2003, and before January 1, 2006, the annual yield taken into account under subclause (II) shall be the annual rate of interest determined by the Secretary of the Treasury on amounts invested conservatively in long-term investment grade corporate bonds for the month preceding the month in which the plan year begins. For purposes of the preceding sentence, the Secretary of the Treasury shall determine such rate of interest on the basis of one or more indices selected periodically by the Secretary, and the Secretary shall make such yield publicly available.".

(b) INTERNAL REVENUE CODE OF 1986.—

(1) DETERMINATION OF PERMISSIBLE RANGE.—

(A) IN GENERAL.—Clause (ii) of section 412(b)(5)(B) is amended by redesignating subclause (II) as subclause (III) and by inserting after subclause (I) the following new subclause:

"(II) SPECIAL RULE FOR YEARS 2004 AND 2005.—In the case of plan years beginning after December 31, 2003, and before January 1, 2006, the term 'permissible range' means a rate of interest which is not above, and not more than 10 percent below, the weighted average of the rates of interest on amounts invested conservatively in long-term investment grade corporate bonds during the 4-year period ending on the last day before the beginning of the plan year. Such rates shall be determined by the Secretary on the basis of one or more indices selected periodically by the Secretary, and the Secretary shall make the permissible range publicly available.".

(B) SECRETARIAL AUTHORITY.—Subclause (III) of section 412(b)(5)(B)(ii), as redesignated by subparagraph (A), is amended—

(i) by inserting "or (II)" after "subclause (I)" the first place it appears, and

(ii) by striking "subclause (I)" the second place it appears and inserting "such subclause".

(C) CONFORMING AMENDMENT.—Subclause (I) of section 412(b)(5)(B)(ii) is amended by inserting "or (III)" after "subclause (II)".

(2) DETERMINATION OF CURRENT LIABILITY.—Clause (i) of section 412(l)(7)(C) is amended by adding at the end the following new subclause:

"(IV) SPECIAL RULE FOR 2004 AND 2005.—For plan years beginning in 2004 or 2005, notwithstanding subclause (I), the rate of interest used to determine current liability under this subsection shall be the rate of interest under subsection (b)(5).".

(3) CONFORMING AMENDMENT.—Paragraph (7) of section 412(m) is amended to read as follows:

"(7) SPECIAL RULE FOR 2002.—In any case in which the interest rate used to determine current liability is determined under subsection (l)(7)(C)(i)(III), for purposes of applying paragraphs (1) and (4)(B)(ii) for plan years beginning in 2002, the current liability for the preceding plan year shall be redetermined using 120 percent as the specified percentage determined under subsection (l)(7)(C)(i)(II).".

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to plan years beginning after December 31, 2003.

(2) LOOKBACK RULES.—For purposes of applying subsections (l)(9)(B)(ii) and (m)(1) of section 412 of the Internal Revenue Code of 1986 and subsections (d)(9)(B)(ii) and (e)(1) of section 302 of the Employee Retirement Income Security Act of 1974 to plan years beginning after December 31, 2003, the amendments made by this section may be applied as if such amendments had been in effect for all prior plan years. The Secretary of the Treasury (or the Secretary's delegate) may prescribe simplified assumptions which may be used in applying the amendments made by this section to such prior plan years.

SEC. 2002. FUNDING REQUIREMENTS FOR DEFINED BENEFIT PLANS OF COMMERCIAL PASSENGER AIRLINES.

(a) INTERNAL REVENUE CODE OF 1986.—Subsection (l) of section 412 (relating to additional funding requirements for plans which are not multiemployer plans) is amended by adding at the end the following new paragraph:

"(12) SPECIAL RULE FOR COMMERCIAL PASSENGER AIRLINES.—In the case of a defined benefit plan established and maintained by a commercial passenger airline, the increased amount under paragraph (1) for plan years beginning after December 27, 2003, and before December 28, 2005, shall be 20 percent of the increased amount under paragraph (1) determined without regard to this paragraph.".

(b) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—Subsection (d) of section 302 of Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new paragraph:

"(12) In the case of a defined benefit plan established and maintained by a commercial passenger airline, the increased amount under paragraph (1) for plan years beginning after December 27, 2003, and before December 28, 2005, shall be 20 percent of the increased amount under paragraph (1) determined without regard to this paragraph.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after December 27, 2003.

TITLE III—MISCELLANEOUS TRADE AND TECHNICAL CORRECTIONS

SEC. 3001. SHORT TITLE.

This title may be cited as the "Miscellaneous Trade and Technical Corrections Act of 2003".

Subtitle A—Tariff Provisions

SEC. 3101. REFERENCE; EXPIRED PROVISIONS.

(a) REFERENCE.—Except as otherwise expressly provided, whenever in this subtitle an amendment or repeal is expressed in terms of an amendment to, or repeal of, a chapter, subchapter, note, additional U.S. note, heading, subheading, or other provision, the reference shall be considered to be made to a chapter, subchapter, note, additional U.S. note, heading, subheading, or other provision of the Harmonized Tariff Schedule of the United States (19 U.S.C. 3007).

(b) EXPIRED PROVISIONS.—Subchapter II of chapter 99 is amended by striking the following headings:

9902.29.06
9902.29.09
9902.29.11
9902.29.12
9902.29.15
9902.29.18
9902.29.19
9902.29.20
9902.29.21
9902.29.23
9902.29.24
9902.29.28
9902.29.29
9902.29.32
9902.29.36
9902.29.43
9902.29.44
9902.29.45
9902.29.46
9902.29.50
9902.29.51
9902.29.52
9902.29.53
9902.29.54
9902.29.57
9902.29.60
9902.29.65
9902.29.66
9902.29.67
9902.29.72
9902.29.74
9902.29.95
9902.30.04
9902.30.16
9902.30.17
9902.30.18
9902.30.19
9902.30.31
9902.30.58
9902.30.63
9902.30.64
9902.30.65
9902.30.90
9902.30.91
9902.30.92
9902.31.12
9902.31.13
9902.31.14
9902.31.21
9902.32.01
9902.32.08
9902.32.11
9902.32.13
9902.32.14
9902.32.16
9902.32.29
9902.32.30
9902.32.31
9902.32.33
9902.32.34
9902.32.35
9902.32.36
9902.32.37
9902.32.38
9902.32.39
9902.32.40
9902.32.41
9902.32.42
9902.32.43
9902.32.45
9902.32.51
9902.32.54
9902.32.56
9902.32.70
9902.32.94
9902.32.95
9902.33.01
9902.33.02
9902.33.03
9902.33.04
9902.33.05
9902.33.06
9902.33.07
9902.33.08
9902.33.09
9902.33.10
9902.33.11
9902.33.12
9902.33.16
9902.33.19
9902.33.66
9902.33.90
9902.34.02
9902.38.08
9902.38.11
9902.38.12
9902.38.25
9902.38.26
9902.38.28
9902.39.04
9902.39.12
9902.61.00
9902.64.04
9902.64.05
9902.84.10
9902.84.12
9902.84.20
9902.84.43
9902.84.46
9902.84.77
9902.84.79
9902.84.81
9902.84.83
9902.84.85
9902.84.87
9902.84.89
9902.84.91
9902.85.20
9902.85.21
9902.98.03
9902.98.04
9902.98.05
9902.98.08

Chapter 1—Temporary Duty Suspensions and Reductions

Subchapter A—New Duty Suspensions and Reductions

SEC. 3111. BITOLYLENE DIISOCYANATE (TODI).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.01	Bitolylene diisocyanate (TODI) (CAS No. 91-97-4) (provided for in subheading 2929.10.20)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3112. 2-METHYLIMIDAZOLE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.02	2-Methylimidazole (CAS No. 693–98–1) (provided for in subheading 2933.29.90)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3113. HYDROXYLAMINE FREE BASE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.03	Hydroxylamine (CAS No. 7803–49–8) (provided for in subheading 2825.10.00)	0.6%	No change	No change	On or before 12/31/2006	".

SEC. 3114. PRENOL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.04	3-Methyl-2-buten-1-ol (CAS No. 556–82–1) (provided for in subheading 2905.29.90)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3115. 1-METHYLIMADAZOLE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.05	1-Methylimidazole (CAS No. 616–47–7) (provided for in subheading 2933.29.90)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3116. FORMAMIDE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.06	Formamide (CAS No. 75–12–7) (provided for in subheading 2924.19.10)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3117. MICHLER'S ETHYL KETONE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.07	4,4′-Bis-(diethylamino)-benzophenone (CAS No. 90–93–7) (provided for in subheading 2922.39.45)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3118. VINYL IMIDAZOLE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.08	1-Ethenyl-1H-imidazole (CAS No. 1072–63–5) (provided for in subheading 2933.29.90)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3119. DISPERSE BLUE 27.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.09	Disperse blue 27 (9,10-anthracenedione, 1,8-dihydroxy-4-[[4-(2-hydroxyethyl)phenyl]amino]-5-nitro-) (CAS No. 15791–78–3) (provided for in subheading 3204.11.50)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3120. ACID BLACK 244.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.10	Acid black 244 (chromate(2-), [3-(hydroxy-.kappa.O)-4-[[2-(hydroxy-.kappa.O)-1-naphthalenyl]azo-.kappa.N2]-1-naphthalenesulfonato(3-)] [1-[[2-(hydroxy-.kappa.O)-5-[4-methoxyphenyl)-azo]phenyl]azo-.kappa.N2]-2-naphthalenesulfonato(2-)-.kappa.O]-, disodium) (CAS No. 30785–74–1) (provided for in subheading 3204.12.45)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3121. REACTIVE ORANGE 132.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.11	Reactive orange 132 (benzenesulfonic acid, 2,2′-[(1-methyl-1,2-ethanediyl)-bis[imino(6-fluoro-1,3,5-triazine-4,2-diyl)imino[2-[(aminocarbonyl)- amino]-4,1-phenylene]azo]]bis[5-[(4-sulfophenyl)azo]-, sodium salt) (CAS No. 149850-31–7) (provided for in subheading 3204.16.30)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3122. MIXTURES OF ACID RED 337, ACID RED 266, AND ACID RED 361.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.12	Mixtures of acid red 337 (2-naphthalenesulfonic acid, 6-amino-5-[[2-[(cyclohexylmethylamino)-sulfonyl]phenyl]azo]-4-hydroxy-, monosodium salt) (CAS No. 32846–21–2), acid red 266 (2-naphthalenesulfonic acid, 6-amino-5-[[4-chloro-2-(trifluoromethyl)phenyl]azo]-4-hydroxy-, monosodium salt) (CAS No. 57741–47–6), and acid red 361 (2-naphthalenesulfonic acid, 6-amino-4-hydroxy-5-[[2-(trifluoromethyl)phenyl]azo]-, monosodium salt) (CAS No. 67786–14–5) (provided for in subheading 3204.12.45)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3123. VAT RED 13.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.13	Vat red 13 ([3,3′-bianthra[1,9-cd]pyrazole]-6,6′(1H,1′H)-dione, 1,1′-diethyl-) (CAS No. 4203–77–4) (provided for in subheading 3204.15.80)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3124. 5-METHYLPYRIDINE-2,3-DICARBOXYLIC ACID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.14	5-Methylpyridine-2,3-dicarboxylic acid (CAS No. 53636–65–0) (provided for in subheading 2933.39.61)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3125. 5-METHYLPYRIDINE-2,3-DICARBOXYLIC ACID DIETHYLESTER.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.15	5-Methylpyridine-2,3-dicarboxylic acid, diethyl ester (CAS No. 112110–16–4) (provided for in subheading 2933.39.61)	1.8%	No change	No change	On or before 12/31/2006	”.

SEC. 3126. 5-ETHYLPYRIDINE DICARBOXYLIC ACID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.16	5-Ethylpyridine-2,3-dicarboxylic acid (CAS No. 102268–15–5) (provided for in subheading 2933.39.61)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3127. (E)-O(2,5-DIMETHYLPHENOXY METHYL)-2-METHOXY-IMINO-N-METHYLPHENYLACETAMIDE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.17	(E)-O-(2,5-Dimethylphenoxy- methyl)-2-methoxyimino-N-methylphenylacet-amide (dimoxystrobin) (CAS No. 145451–07–6) (provided for in subheading 2928.00.25)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3128. 2-CHLORO-N-(4′CHLOROBIPHENYL-2-YL) NICOTINAMIDE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.18	2-Chloro-N-(4′-chloro-[1,1′-biphenyl]-2-yl)-nicotinamide (nicobifen) (CAS No. 188425–85–6) (provided for in subheading 2933.39.21)	4.4%	No change	No change	On or before 12/31/2006	”.

SEC. 3129. VINCLOZOLIN.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.19	3-(3,5-Dichlorophenyl)-5-ethenyl-5-methyl-2,4-oxazolidinedione (vinclozolin) (CAS No. 50471–44–8) (provided for in subheading 2934.99.12)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3130. DAZOMET.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.20	Tetrahydro-3,5-dimethyl-2H-1,3,5-thiadiazine-2-thione (CAS No. 533–74–4) (dazomet) (provided for in subheading 2934.99.90)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3131. PYRACLOSTROBIN.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.21	Methyl N-(2-[[1-(4-chlorophenyl)-1H-pyrazol-3-yl]oxymethyl]-phenyl) N-methoxy- carbanose (pyra- clostrobin) (CAS No. 175013–18–0) (provided for in subheading 2933.19.23)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3132. 1,3-BENZENEDICARBOXYLIC ACID, 5-SULFO-1,3-DIMETHYL ESTER SODIUM SALT.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.22	1,3-Benzenedicarboxylic acid, 5-sulfo-1,3-dimethyl ester, sodium salt (CAS No. 3965–55–7) (provided for in subheading 2917.39.30)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3133. SACCHAROSE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.23	Saccharose to be used other than in food for human consumption and not for nutritional purposes (provided for in subheading 1701.99.50)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3134. (2-BENZOTHIAZOLYTHIO) BUTANEDIOIC ACID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:heading:

“	9902.01.25	(Benzothiazol-2-ylthio)succinic acid (CAS No. 95154–01–1) (provided for in subheading 2934.20.40)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3135. 60–70 PERCENT AMINE SALT OF 2-BENZO-THIAZOLYTHIO SUCCINIC ACID IN SOLVENT.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.26	(Benzothiazol-2-ylthio)succinic acid (60–70 percent) in solvent (provided for in subheading 3824.90.28)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3136. 4-METHYL-g-OXO-BENZENEBUTANOIC ACID COMPOUNDED WITH 4-ETHYLMORPHOLINE (2:1).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.27	4-Methyl-g-oxo-benzenebutanoic acid compounded with 4-ethylmorpholine (2:1) (CAS No. 171054–89–0) (provided for in subheading 3824.90.28)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3137. MIXTURES OF RIMSULFURON, NICOSULFURON, AND APPLICATION ADJUVANTS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.28	Mixtures of rimsulfuron (N-[[(4,6-dimethoxypyrimidin-2-yl)-amino]carbonyl]-3-(ethylsulfonyl)-2-pyridinesulfonamide (CAS No. 122931–48–0), nicosulfuron (2-(((((4,6-dimethoxypyrimidin-2-yl)-amino)carbonyl)-amino)sulfonyl)-N,N-dimethyl-3-pyridinecarboxamide (CAS No. 111991–09–4), and application adjuvants (provided for in subheading 3808.30.15)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3138. MIXTURES OF THIFENSULFURON METHYL, TRIBENURON METHYL AND APPLICATION ADJUVANTS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.29	Mixtures of thifensulfuron methyl (methyl 3-[[[[(4-methoxy-6-methyl-1,3,5-triazin-2-yl)- amino]carbonyl]- amino]sulfonyl]- 2-thiophenecar- boxylate (CAS No. 79277–27–3), tribenuron methyl (methyl 2-[[[[(4-methoxy-6-methyl-1,3,5-triazin-2-yl)-methylamino]-carbonyl]- amino]sulfonyl]-benzoate) (CAS No. 101200–48–0) and application adjuvants (provided for in subheading 3808.30.15)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3139. MIXTURES OF THIFENSULFURON METHYL AND APPLICATION ADJUVANTS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.30	Mixtures of thifensulfuron methyl (methyl 3-[[[[(4-methoxy-6-methyl-1,3,5-triazin-2-yl)- amino]carbonyl]- amino]sulfonyl]-2-thiophenecarboxylate) (CAS No. 79277–27–3) and application adjuvants (provided for in subheading 3808.30.15)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3140. MIXTURES OF TRIBENURON METHYL AND APPLICATION ADJUVANTS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.31	Mixtures of tribenuron methyl (methyl 2-[[[[(4-methoxy-6-methyl-1,3,5-triazin-2-yl)methylamino]- carbonyl]amino]-sulfonyl]-benzoate) (CAS No. 101200–48–0) and application adjuvants (provided for in subheading 3808.30.15)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3141. MIXTURES OF RIMSULFURON, THIFENSULFURON METHYL AND APPLICATION ADJUVANTS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.32	Mixtures of rimsulfuron (N-[(4,6-dimethoxypyrimidin-2-yl)-aminocarbonyl]-3-(ethylsulfonyl)-2-pyridinesulfonamide) (CAS No. 122931–48–0); thifensulfuron methyl (methyl 3-[[[[(4-methoxy-6-methyl-1,3,5- triazin-2-yl)-amino]carbonyl]- amino]sulfonyl]-2-thiophenecarboxylate) (CAS No. 79277-27–3); and application adjuvants (provided for in subheading 3808.30.15)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3142. VAT BLACK 25.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.33	Anthra[2,1,9-mna]naphth[2,3-h]acridine-5,10,15(16H)-trione, 3-[(9,10-dihydro-9,10-dioxo-1-anthracenyl)- amino]- (Vat black 25) (CAS No. 4395–53–3) (provided for in subheading 3204.15.80)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3143. CYCLOHEXANEPROPANOIC ACID, 2-PROPENYL ESTER.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.34	Cyclohexanepro-panoic acid, 2-propenyl ester (CAS No. 2705–87–5) (provided for in subheading 2916.20.50)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3144. NEOHELIOPAN HYDRO (2-PHENYLBENZIMIDAZOLE-5-SULFONIC ACID).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.35	2-Phenylbenzimidazole-5-sulfonic acid) (CAS No. 27503–81–7) (provided for in subheading 2933.99.79)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3145. SODIUM METHYLATE POWDER (NA METHYLATE POWDER).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.36	Methanol, sodium salt (CAS No. 124–41–4) (provided for in subheading 2905.19.00)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3146. GLOBANONE (CYCLOHEXADEC-8-EN-1-ONE).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.37	Cyclohexadec-8-en-1-one (CAS No. 3100-36-5) (provided for in subheading 2914.29.50)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3147. METHYL ACETOPHENONE-PARA (MELILOT).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.38	p-Methyl acetophenone (CAS No. 122-00-9) (provided for in subheading 2914.39.90)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3148. MAJANTOL (2,2-DIMETHYL-3-(3-METHYLPHENYL)PROPANOL).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.39	2,2-Dimethyl-3-(3-methylphenyl)- propanol (CAS No. 103694-68-4) (provided for in subheading 2906.29.20)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3149. NEOHELIOPAN MA (MENTHYL ANTHRANILATE).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.40	Menthyl anthranilate (CAS No. 134-09-8) (provided for in subheading 2922.49.37)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3150. ALLYL ISOSULFOCYANATE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.41	Allyl isothiocyanate (CAS No. 57-06-7) (provided for in subheading 2930.90.90)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3151. FRESCOLAT.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.42	5-Methyl-2-(1-methylethyl)-cyclohexyl-2-hydroxypropanoate (lactic acid, menthyl ester) (Frescolat) (CAS No. 59259-38-0) (provided for in subheading 2918.11.50)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3152. THYMOL (ALPHA-CYMOPHENOL).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.43	Thymol (CAS No. 89-83-8) (provided for in subheading 2907.19.40)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3153. BENZYL CARBAZATE.

Subchapter II of chapter 99 is amended by inserting in the numerical sequence the following new heading:

"	9902.01.44	Benzyl carbazate (Hydrazine- carboxylic acid, phenylmethyl ester (CAS No. 5331-43-1) (provided for in subheading 2928.00.25)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3154. ESFENVALERATE TECHNICAL.

Subchapter II of chapter 99 is amended by inserting in the numerical sequence the following new heading:

"	9902.01.45	(S)-Cyano(3-phenoxyphenyl)- methyl (S)-4-chloro-α-(1-methylethyl- benzeneacetate (Esfenvalerate) (CAS No. 66230-04-4) (provided for in subheading 2926.90.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3155. AVAUNT AND STEWARD.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.46	Mixtures of indoxacarb ((S)-methyl 7-chloro-2,5-dihydro-2-[[(methoxycarbonyl)[4-(trifluoromethoxy)-phenyl]amino]carbonyl]indeno- [1,2-e][1,3,4]- oxadiazine-4a-(3H)carboxylate) (CAS No. 173584-44-6) and application adjuvants (provided for in subheading 3808.10.25)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3156. HELIUM.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.47	Helium (provided for in subheading 2804.29.00)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3157. ETHYL PYRUVATE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.48	Ethyl pyruvate (CAS No. 617-35-6) (provided for in subheading 2918.30.90)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3158. DELTAMETHRIN.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.49	(S)-α-Cyano-3-phenoxybenzyl (1R,3R)-3-(2,2-dibromovinyl)-2,2-dimethylcyclopropanecarb- oxylate (Deltamethrin) (CAS No. 52918-63-5) in bulk or unmixed in forms or packings for retail sale (provided for in subheading 2926.90.30 or 3808.10.25)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3159. ASULAM SODIUM SALT.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.50	Mixtures of methyl sulfanilycarbam- ate, sodium salt (Asulam sodium salt) (CAS No. 2302-17-2) and application adjuvants (provided for in subheading 3808.30.15)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3160. TRALOMETHRIN.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.52	Tralomethrin (1R,3S)3[(1′RS)- (1′,2′,2′,2′-tetrabromoethyl)]-2.2-dimethylcyclopropanecarboxylic acid, (S)-alpha-cyano-3-phenoxybenzyl ester (CAS No. 66841-25-6) in bulk or in forms or packages for retail sale (provided for in subheading 2926.90.30 or 3808.10.25)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3161. N-PHENYL-N′-(1,2,3-THIADIAZOL-5-YL)-UREA.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.53	N-Phenyl-N′-1,2,3-thiadiazol-5-ylurea (thidiazuron) in bulk or in forms or packages for retail sale (CAS No. 51707–55–2) (provided for in subheading 2934.99.15 or 3808.30.15)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3162. BENZENEPROPANOIC ACID, ALPHA-2-DICHLORO-5-[4 (DIFLUOROMETHYL)-4,5-DIHYDRO-3-METHYL-5-OXO-1H-1,2,4-TRIAZOL-1-YL]-4-FLUORO-ETHYL ESTER.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.54	alpha-2- Dichloro-5-[4- (difluoromethyl)-4,5-dihydro-3-methyl-5-oxo-1H-1,2,4-triazol-1-yl]-4-fluorobenzenepropanoic acid, ethyl ester (carfentazone-ethyl) (CAS No. 128639-02–1) (provided for in subheading 2933.99.22)	4.9%	No change	No change	On or before 12/31/2006	”.

SEC. 3163. (Z)-(1RS, 3RS)-3-(2-CHLORO-3,3,3 TRIFLOURO-1-PROPENYL)-2,2-DIMETHYL-CYCLOPROPANE CARBOXYLIC ACID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.55	(Z)-(1RS,3RS)-3-(2-Chloro-3,3,3-trifluro-1-propenyl)-2,2-dimethylcyclopropanecarboxylic acid (CAS No. 68127–59–3) (provided for in subheading 2916.20.50)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3164. 2-CHLOROBENZYL CHLORIDE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.56	2-Chlorobenzyl chloride (CAS No. 611–19–8) (provided for in subheading 2903.69.70)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3165. (S)-ALPHA-HYDROXY-3-PHENOXYBENZENEACETONITRILE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.57	(S)-alpha-Hydroxy-3-phenoxybenzeneacetonitrile (CAS No. 61826–76–4) (provided for in subheading 2926.90.43)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3166. 4-PENTENOIC ACID, 3,3-DIMETHYL-, METHYL ESTER.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.58	4-Pentenoic acid, 3,3-dimethyl-, methyl ester (CAS No. 63721–05–1) (provided for in subheading 2916.19.50)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3167. TERRAZOLE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.59	Etridiazole [5-ethoxy-3- (trichloromethyl)-1,2,4-thiadiazole] (CAS No. 2593-15-9) (provided for in subheading 2934.99.90) and any mixtures (preparations) containing Etridiazole as the active ingredient (provided for in subheading 3808.20.50)	Free	Free	No change	On or before 12/31/2006	".

SEC. 3168. 2-MERCAPTOETHANOL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.60	2-Mercaptoethanol (CAS No. 60-24-2) (provided for in subheading 2930.90.90)	Free	Free	No change	On or before 12/31/2006	".

SEC. 3169. BIFENAZATE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.61	Bifenazate (Hydrazinecarb- oxylic acid, 2-(4-methoxy-[1,1- biphenyl]-3-yl)-1-methylethyl ester (CAS No. 149877-41-8) (provided for in subheading 2928.00.25)	Free	Free	No change	On or before 12/31/2006	".

SEC. 3170. A CERTAIN POLYMER.

(a) IN GENERAL.—Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.62	Fluoropolymers containing 95 percent or more by weight of the monomer units tetrafluoroethylene, hexafluoropropylene, and vinylidene fluoride (provided for in subheading 3904.69.50)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3171. PARA ETHYLPHENOL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.63	p-Ethylphenol (CAS No. 123-07-9) (provided for in subheading 2907.19.20)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3172. EZETIMIBE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.64	2-Azetidinone, 1-(4-fluorophenyl)-3-[(3S)-3-(4-fluorophenyl)-3-hydroxypropyl]-4-(4-hydroxyphenyl)-, (3R,4S)-(Ezetimibe) (CAS No. 163222-33-1) (provided for in subheading 2933.79.08)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3173. P-CRESIDINESULFONIC ACID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.65	p-Cresidinesulfonic acid (4-amino-5-methoxy-2-methylbenzene- sulfonic acid) (CAS No. 6471-78-9) (provided for in subheading 2922.29.80)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3174. 2,4 DISULFOBENZALDEHYDE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.66	2,4- Disulfobenzaldehyde (CAS No. 88-39-1) (provided for in subheading 2913.00.40)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3175. M-HYDROXYBENZALDEHYDE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.67	m-Hydroxybenzal- dehyde (CAS No. 100–83–4) (provided for in subheading 2912.49.25)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3176. N-ETHYL-N-(3-SULFOBENZYL)ANILINE, BENZENESULFONIC ACID, 3[(ETHYLPHENYLAMINO)METHYL].

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.68	N-Ethyl-N-(3-sulfobenzyl)aniline (benzenesulfonic acid, 3-[(ethylphenylamino)-methyl]-) (CAS No. 101–11–1) (provided for in subheading 2921.42.90)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3177. ACRYLIC FIBER TOW.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.69	Acrylic fiber tow (polyacrylonitrile tow) consisting of 6 sub-bundles crimped together, each containing 45,000 filaments (plus or minus 0.06) and 2–8 percent water, such acrylic fiber containing by weight a minimum of 92 percent acrylonitrile, not more than 0.1 percent zinc and average filament denier of either 1.48 decitex (plus or minus 0.08) or 1.32 decitex (plus or minus 0.089) (provided for in subheading 5501.30.00)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3178. YTTRIUM OXIDES.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.21	Yttrium oxides having a purity of at least 99.9 percent (CAS No. 1314–36–9) (provided for in subheading 2846.90.80)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3179. HEXANEDIOIC ACID, POLYMER WITH 1,3-BENZENEDIMETHANAMINE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.71	Hexanedioic acid, polymer with 1,3-benzene-dimethanamine (CAS No. 25718–70–1) (provided for in subheading 3908.10.00)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3180. N1-[(6-CHLORO-3-PYRIDYL)METHYL]-N2-CYANO-N1-METHYLACETAMIDINE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.72	(E)-N1-[(6-Chloro-3-pyridyl)methyl]-N2-cyano-N1-methylacetamidine (Acetamiprid) (CAS No. 135410–20–7) whether or not mixed with application adjuvants (provided for in subheading 2933.39.27 or 3808.10.25)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3181. ALUMINUM TRIS (O-ETHYL PHOSPHONATE).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.73	Aluminum tris- (O-ethylphosphon- ate) (CAS No. 39148–24–8) (provided for in subheading 2920.90.50)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3182. MIXTURE OF DISPERSE BLUE 77 AND DISPERSE BLUE 56.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.74	Mixtures of disperse blue 77 (9,10-anthracenedione, 1,8-dihydroxy-4-nitro-5-(phenylamino)-) (CAS No. 20241–76–3) and disperse blue 56 (9,10-anthracenedione, 1,5-diaminochloro-4,8-dihydroxy-) (CAS No. 12217–79–7) (provided for in subheading 3204.11.35)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3183. ACID BLACK 194.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.75	Acid black 194 (chromate(3-), bis[3-(hydroxy-.kappa.O)-4-[[2-(hydroxy.kappa.O)-1-naphthalenyl]azo- .kappa. N1]-7-nitro-1-naphthalenesulfonato(3-)]-, trisodium) (CAS No. 57693–14–8) (provided for in subheading 3204.12.20)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3184. MIXTURE OF 9,10-ANTHRACENEDIONE, 1,5-DIHYDROXY-4-NITRO-8-(PHENYLAMINO)-AND DISPERSE BLUE 77.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.76	Mixtures of 9,10-anthracenedione, 1,5-dihydroxy-4-nitro-8-(phenylamino)- (CAS No. 3065–87–0) and 9,10-anthracenedione, 1,8-dihydroxy-4-nitro-5-(phenylamino)-(Disperse blue 77) (CAS No. 20241–76–3) (provided for in subheading 3204.11.35)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3185. COPPER PHTHALOCYANINE SUBSTITUTED WITH 15 OR 16 GROUPS WHICH COMPRISE 8-15 THIOARYL AND 1-8 ARYLAMINO GROUPS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.77	A copper phthalocyanine substituted with 15 or 16 groups which comprise 8-15 thioaryl and 1-8 arylamino groups (provided for in subheading 3204.19.40)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3186. BAGS FOR CERTAIN TOYS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.78	Bags (provided for in subheading 4202.92.45) for transporting, storing, or protecting goods of headings 9502-9504, inclusive, imported and sold with such articles therein	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3187. CERTAIN CHILDREN'S PRODUCTS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.79	Image projectors (provided for in subheading 9008.30.00) capable of projecting images from circular mounted sets of stereoscopic photographic transparencies, such mounts measuring approximately 8.99 cm in diameter	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3188. CERTAIN OPTICAL INSTRUMENTS USED IN CHILDREN'S PRODUCTS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.80	Optical instruments (provided for in subheading 9013.80.90) designed for the viewing of circular mounted sets of stereoscopic photographic transparencies, such mounts measuring approximately 8.99 cm in diameter	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3189. CASES FOR CERTAIN CHILDREN'S PRODUCTS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.81	Cases or containers (provided for in subheading 4202.92.90) specially designed or fitted for circular mounts for sets of stereoscopic photographic transparencies, such mounts measuring approximately 8.99 cm in diameter the foregoing imported and sold with such articles therein	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3190. 2,4-DICHLOROANILINE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.82	2,4-Dichloroaniline (CAS No. 554–00–7) (provided for in subheading 2921.42.18)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3191. ETHOPROP.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.83	O-Ethyl S,S-dipropyl- phosphorodithioate (Ethoprop) (CAS No. 13194–48–4) (provided for in subheading 2930.90.44)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3192. FORAMSULFURON.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.84	Mixtures of benzamide, 2-[[[[(4,6-dimethoxy-2- pyrimidinyl)- amino] carbonyl]- amino]sulfonyl]-4- (formylamino)-N,N-methyl- (foramsulfuron) (CAS No. 173159–57–4) and application adjuvants (provided for in subheading 3808.30.15).	3%	No change	No change	On or before 12/31/2006	”.

SEC. 3193. CERTAIN EPOXY MOLDING COMPOUNDS.

(a) IN GENERAL.—Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.85	Epoxy molding compounds, of a kind used for encapsulating integrated circuits (provided for in subheading 3907.30.00)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3194. DIMETHYLDICYANE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.86	Dimethyldicyane (2,2′-dimethyl-4,4′-methylenebis- (cyclohexylamine)) (CAS No. 6864–37–5) (provided for in subheading 2921.30.30)	Free	Free	No change	On or before 12/31/2006	”.

SEC. 3195. TRIACETONE DIAMINE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.87	2,2,6,6-Tetra-methyl-4-pip-eridinamine (Triacetone diamine) (CAS No. 36768-62-4) (provided for in subheading 2933.39.61)	Free	Free	No change	On or before 12/31/2006	".

SEC. 3196. TRIETHYLENE GLYCOL BIS[3-(3-TERT-BUTYL-4-HYDROXY-5-METHYLPHENYL) PROPIONATE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new subheading:

"	9902.01.88	Triethylene glycol bis[3-(3-tert-butyl-4-hydroxy-5-methylphenyl)propionate] (CAS No. 36443-68-2) (provided for in subheading 2918.90.43)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3197. CERTAIN POWER WEAVING TEXTILE MACHINERY.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.89	Power weaving machines (looms), shuttle type, for weaving fabrics of a width exceeding 30 cm but not exceeding 4.9 m, entered without off-loom or large loom take-ups, drop wires, heddles, reeds, harness frames, or beams (provided for in subheading 8446.21.50)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3198. CERTAIN FILAMENT YARNS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.90	Synthetic filament yarn (other than sewing thread) not put up for retail sale, single, of decitex sizes of 23 to 850, with between 4 and 68 filaments, with a twist of 100 to 300 turns/m, of nylon or other polyamides, containing 10 percent or more by weight of nylon 12 (provided for in subheading 5402.51.00)	Free	Free	No change	On or before 12/31/2006	".

SEC. 3199. CERTAIN OTHER FILAMENT YARNS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.91	Synthetic filament yarn (other than sewing thread) not put up for retail sale, single, of decitex sizes of 23 to 850, with between 4 and 68 filaments, untwisted, of nylon or other polyamides, containing 10 percent or more by weight of nylon 12 (provided for in subheading 5402.41.90)	Free	Free	No change	On or before 12/31/2006	".

SEC. 3200. CERTAIN INK-JET TEXTILE PRINTING MACHINERY.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.92	Ink-jet textile printing machinery (provided for in subheading 8443.51.10)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3201. CERTAIN OTHER TEXTILE PRINTING MACHINERY.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.93	Textile printing machinery (provided for in subheading 8443.59.10)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3203. D-MANNOSE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following heading:

"	9902.01.94	D-Mannose (CAS No. 3458-28-4) (provided for in subheading 2940.00.60)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3204. BENZAMIDE, N-METHYL-2-[[3-[(1E)-2-(2-PYRIDINYL)-ETHENYL]-1H-INDAZOL-6-YL)THIO]-.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.95	Benzamide, N-methyl-2-[[3-[(1E)-2-(2-pyridinyl)-ethenyl]-1H-indazol-6-yl)thio]-(CAS No. 319460-85-0) (provided for in subheading 2933.99.79)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3205. 1(2H)-QUINOLINECARBOXYLIC ACID, 4-[[[3,5-BIS-(TRIFLUOROMETHYL) PHENYL] METHYL] (METHOXYCARBONYL) AMINO]-2-ETHYL- 3,4-DIHYDRO-6-(TRIFLUOROMETHYL)-, ETHYL ESTER, (2R,4S)-(9CI).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.96	1(2H)-Quinolinecarboxylic acid, 4-[[[3,5-bis-(trifluoromethyl)- phenyl]methyl]-(methoxycarb- onyl)amino]-2-ethyl-3,4-dihydro-6-(trifluoromethyl)- ethyl ester, (2R,4S)- (CAS No. 262352-17-0) (provided for in subheading 2933.49.26).	Free	No change	No change	On or before 12/31/2006	".

SEC. 3206. DISULFIDE,BIS(3,5-DICHLOROPHENYL)(9C1).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.97	Bis(3,5-dichlorophenyl) disulfide (CAS No. 137897-99-5) (provided for in subheading 2930.90.29)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3207. PYRIDINE, 4-[[4-(1-METHYLETHYL)-2-[(PHENYLMETHOXY)METHYL]-1H-MIDAZOL-1-YL] METHYL]-ETHANEDIOATE (1:2).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.98	Pyridine, 4-[[4-(1-methylethyl)-2-[(phenylmethoxy)- methyl]-1H-imidazol-1-yl]- methyl]-ethanedioate (1:2) (CAS No. 280129-82-0) (provided for in subheading 2933.39.61)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3208. PACLOBUTRAZOLE TECHNICAL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.01.99	(RS,3RS)-1-(4-Chlorophenyl)-4,4-dimethyl-2-(1H-1,2,4-triazol-1-yl)pentan-3-ol (paclobutrazol) (CAS No. 76738-62-0) (provided for in subheading 2933.99.22)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3209. PACLOBUTRAZOLE 2SC.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.01	Mixtures of (RS,3RS)-1-(4-chlorophenyl)-4,4-dimethyl-2-(1H-1,2,4-triazol-1-yl)pentan-3-ol (paclobutrazol) (CAS No. 76738–62–0) and application adjuvants (provided for in subheading 3808.30.15)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3210. METHIDATHION TECHNICAL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.02	S-[(5-Methoxy-2-oxo-1,3,4-thiadiazol-3(2H)-yl)methyl] O,O-dimethyl phosphorodithioate (CAS No. 950–37–8) (provided for in subheading 2934.99.90)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3211. VANGUARD 75 WDG.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.03	Mixtures of 2-pyrimidinamine, 4-cyclopropyl-6-methyl-N-phenyl-(cyprodinil) (CAS No. 121552–61–2) and application adjuvants (provided for in subheading 3808.20.15)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3212. WAKIL XL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.04	Mixtures of (R)-2-[(2,6-dimethylphenyl-methoxy)acetyl-amino]propionic acid, methyl ester (mefenoxam) (CAS No. 70630–17–0), 4-(2,2-difluoro-1,3-benzodioxol-4-yl)-1H-pyrrole-3-carbonitrile (fludioxonil) (CAS No. 131341–86–1), and 2-cyano-2-methoxyimino-N-(ethylcarbamoyl)acetamide (cymoxanil) (CAS No. 57966–95–7) with application adjuvants (the foregoing mixtures provided for in subheading 3808.20.15)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3213. MUCOCHLORIC ACID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.05	2-Butenoic acid, 2,3-dichloro-4-oxo-(mucochloric acid) (CAS No. 87–56–9) (provided for in subheading 2918.30.90)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3214. AZOXYSTROBIN TECHNICAL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.06	Benzeneacetic acid, (E)-2-[[6-(2-cyanophenoxy)-4-pyrimidinyl]oxy]-alpha-(methoxymethyl- ene)-, methyl ester (pyroxystrobin) (CAS No. 131860–33–8) (provided for in subheading 2933.59.15)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3215. FLUMETRALIN TECHNICAL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.07	2-Chloro-N-[2,6-dinitro-4-(trifluoromethyl)-phenyl]-N-ethyl-6-fluorobenzenemethanamine (flumetralin) (CAS No. 62924–70–3) (provided for in subheading 2921.49.45)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3216. CYPRODINIL TECHNICAL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.08	2-Pyrimidinamine, 4-cyclopropyl-6-methyl-N-phenyl- (cyprodinil) (CAS No. 121552–61–2) (provided for in subheading 2933.59.15)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3217. MIXTURES OF LAMBDA-CYHALOTHRIN.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.09	Mixtures of cyhalothrin (cyclopropanecarboxylic acid, 3-(2-chloro-3,3,3-trifluoro-1-propenyl)-2,2-dimethyl-, cyano(3-phenoxyphenyl)-methyl ester, [1.alpha. (S*),3.alpha. (Z)]-(.+-.)-) (CAS No. 91465–08–6) and application adjuvants (provided for in subheading 3808.10.25)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3218. PRIMISULFURON METHYL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.10	Benzoic acid, 2-[[[[[4,6-bis-(difluoromethoxy)-2-pyrimidinyl]-amino]carbonyl]- amino]sulfonyl]-, methyl ester (primisulfuron methyl) (CAS No. 86209–51–0) (provided for in subheading 2935.00.75)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3219. 1,2-CYCLOHEXANEDIONE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.11	1,2- Cyclohexanedione (CAS No. 765–87–7) (provided for in subheading 2914.29.50)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3220. DIFENOCONAZOLE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.12	1H-1,2,4-Triazole, 1-[[2-[2-chloro-4-(4-chlorophenoxy)-phenyl]-4-methyl-1,3-dioxolan-2-yl]methyl]- (difenoconazole) (CAS No. 119446–68–3) (provided for in subheading 2934.99.12)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3221. CERTAIN REFRACTING AND REFLECTING TELESCOPES.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.13	Refracting telescopes with 50 mm or smaller lenses and reflecting telescopes with 76 mm or smaller lenses (provided for in subheading 9005.80.40)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3222. PHENYLISOCYANATE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.14	Phenylisocyanate (CAS No. 103–71–9) (provided for in subheading 2929.10.80)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3223. BAYOWET FT-248.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.15	Tetraethylammonium perfluoroctanesulfonate (CAS No. 56773–42–3) (provided for in subheading 2923.90.00)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3224. P-PHENYLPHENOL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.16	p-Phenylphenol (CAS No. 92–69–3) (provided for in subheading 2907.19.80)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3225. CERTAIN RUBBER RIDING BOOTS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.17	Horseback riding boots with soles and uppers of rubber, such boots extending above the ankle and below the knee, specifically designed for horseback riding, and having a spur rest on the heel counter (provided for in subheading 6401.92)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3226. CHEMICAL RH WATER-BASED.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.18	Chemical RH water-based (iron toluene sulfonate) (comprising 75 percent water, 25 percent p-toluenesulfonic acid (CAS No. 6192–52–5) and 5 percent ferric oxide (CAS No. 1309–37–1)) (provided for in subheading 2904.10.10)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3227. CHEMICAL NR ETHANOL-BASED.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.19	Chemical NR ethanol-based (iron toluene sulfonate) (comprising 60 percent ethanol (CAS No. 63–17–5), 33 percent p-toluenesulfonic acid (CAS No. 6192–52–5), and 7 percent ferric oxide (CAS No. 1309–37–1)) (provided for in subheading 2912.12.00 or 3824.90.28)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3228. TANTALUM CAPACITOR INK.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.20	Tantalum capacitor ink: graphite ink P7300 of 85 percent butyl acetate, 8 percent graphite, and the remaining balance of non-hazardous resins; and graphite paste P5900 of 92-96 percent water, 1-3 percent graphite (CAS No. 7782–42–5), 0.5-2 percent ammonia (CAS No. 7664–41–7), and less than 1 percent acrylic resin (CAS No. 9003–32–1) (provided for in subheading 3207.30.00)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3229. CERTAIN SAWING MACHINES.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.84.91	Sawing machines certified for use in production of radial tires, designed for off-the-highway use, and for use on a rim measuring 63.5 cm or more in diameter (provided for in subheading 4011.20.10, 4011.61.00, 4011.63.00, 4011.69.00, 4011.92.00, 4011.94.40, or 4011.99.45), numerically controlled, or parts thereof (provided for in subheading 8465.91.00 or 8466.92.50) –	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3230. CERTAIN SECTOR MOLD PRESS MANUFACTURING EQUIPMENT.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.84.89	Sector mold press machines to be used in production of radial tires designed for off-the highway use with a rim measuring 63.5 cm or more in diameter (provided for in subheading 4011.20.10, 4011.61.00, 4011.63.00, 4011.69.00, 4011.92.00, 4011.94.40, or 4011.99.45), numerically controlled, or parts thereof (provided for in subheading 8477.51.00 or 8477.90.85)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3231. CERTAIN MANUFACTURING EQUIPMENT USED FOR MOLDING.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.84.88	Machinery for molding, or otherwise forming uncured, unvulcanized rubber to be used in production of radial tires designed for off-the-highway use with a rim measuring 63.5 cm or more in diameter (provided for in subheading 4011.20.10, 4011.61.00, 4011.63.00, 4011.69.00, 4011.92.00, 4011.94.40, or 4011.99.45), numerically controlled, or parts thereof (provided for in subheading 8477.51.00 or 8477.90.85)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3232. CERTAIN EXTRUDERS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.84.85	Extruders to be used in production of radial tires designed for off-the-highway use with a rim measuring 63.5 cm or more in diameter (provided for in subheading 4011.20.10, 4011.61.00, 4011.63.00, 4011.69.00, 4011.92.00, 4011.94.40, or 4011.99.45), numerically controlled, or parts thereof (provided for in subheading 8477.20.00 or 8477.90.85)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3233. CERTAIN SHEARING MACHINES.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.84.81	Shearing machines used to cut metallic tissue certified for use in production of radial tires designed for off-the highway use with a rim measuring 63.5 cm or more in diameter (provided for in subheading 4011.20.10, 4011.61.00, 4011.63.00, 4011.69.00, 4011.92.00, 4011.94.40, or 4011.99.45), numerically controlled, or parts thereof (provided for in subheading 8462.31.00 or 8466.94.85)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3234. THERMAL RELEASE PLASTIC FILM.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.26	Thermal release plastic film (with a substrate of polyolefin-based PET/conductive acrylic polymer, release liner of polyethylene terephthalate PET/polysiloxane, pressure sensitive adhesive of acrylic ester-based copolymer, and core of acrylonitrile-butadiene-styrene copolymer) (provided for in subheading 3919.10.20)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3235. CERTAIN SILVER PAINTS AND PASTES.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.27	Mixtures comprising 42 to 52 percent by weight of silver metal, 7.5 to 15 percent by weight of epoxy resin, and solvent (butyl 2-ethoxyethanol acetate); mixtures comprising 53 percent by weight of silver metal, 7 percent by weight of viton resin, and solvent (isoamyl acetate); and paste adhesive preparations comprising 62 percent by weight of silver metal, 8.4 percent by weight of viton resin, and solvent (composed of 1 part butyl 2-ethoxyethanol acetate and 9 parts isoamyl acetate); (all the foregoing provided for in subheading 7115.90.40)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3236. POLYMER MASKING MATERIAL FOR ALUMINUM CAPACITORS (UPICOAT).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.28	Dispersions (60 percent) of polymide resins in 2,2′-oxydiethanol, dimethyl ether (provided for in subheading 3911.90.35 or 3911.90.90)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3237. OBPA.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.29	10, 10′- Oxybisphenoxarsine (CAS No. 58–36–6) (provided for in subheading 2934.99.18)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3238. MACROPOROUS ION-EXCHANGE RESIN.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.30	Macroporous ion-exchange resin comprising a copolymer of styrene crosslinked with divinylbenzene, thiol functionalized (CAS No. 113834–91–6) (provided for in subheading 3914.00.60)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3239. COPPER 8-QUINOLINOLATE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.31	Copper 8-quinolinolate (oxine-copper) (CAS No. 10380–28–6) (provided for in subheading 2933.49.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3240. ION-EXCHANGE RESIN.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.32	Ion-exchange resin comprising a copolymer of styrene crosslinked with divinylbenzene, iminodiacetic acid, sodium form (CAS No. 244203–30–3) (provided for in subheading 3914.00.60)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3241. ION-EXCHANGE RESIN CROSSLINKED WITH ETHENYLBENZENE, AMINOPHOSPONIC ACID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.33	Ion-exchange resin comprising a copolymer of styrene crosslinked with ethenylbenzene, aminophosphonic acid, sodium form (CAS No. 125935–42–4) (provided for in subheading 3914.00.60)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3242. ION-EXCHANGE RESIN CROSSLINKED WITH DIVINYLBENZENE, SULPHONIC ACID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.34	Ion-exchange resin comprising a copolymer of styrene crosslinked with divinylbenzene, sulfonic acid, sodium form (CAS No. 63182–08–1) (provided for in subheading 3914.00.60)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3243. 3-[(4 AMINO-3-METHOXYPHENYL) AZO]-BENZENE SULFONIC ACID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.35	3-[(Amino-3-methoxyphenyl)-azo]-benzenesulfonic acid (CAS No. 138–28–3) (provided for in subheading 2927.00.50)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3244. 2-METHYL-5-NITROBENZENESULFONIC ACID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.36	2-Methyl-5-nitrobenzenesulfonic acid (CAS No. 121–03–9) (provided for in subheading 2904.90.20)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3245. 2-AMINO-6-NITRO-PHENOL-4-SULFONIC ACID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.37	2-Amino-6-nitro- phenol-4-sulfonic acid (CAS No. 96–93–5) (provided for in subheading 2922.29.60)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3246. 2-AMINO-5-SULFOBENZOIC ACID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.38	2-Amino-5- sulfobenzoic acid (CAS No. 3577–63–7) (provided for in subheading 2922.49.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3247. 2,5 BIS [(1,3 DIOXOBUTYL) AMINO] BENZENE SULFONIC ACID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.39	2,5-Bis[(1,3- dioxobutyl)- amino]benzenesulfonic acid (CAS No. 70185–87–4) (provided for in subheading 2924.29.71)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3248. P-AMINOAZOBENZENE 4 SULFONIC ACID, MONOSODIUM SALT.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.40	4-[(4-Amino- phenyl)azo]- benezenesulfonic acid, monosodium salt (CAS No. 2491-71-6) (provided for in subheading 2927.00.50)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3249. P-AMINOAZOBENZENE 4 SULFONIC ACID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.41	4-[(4-Amino- phenyl)azo]- benzenesulfonic acid (CAS No. 104-23-4) (provided for in subheading 2927.00.50)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3250. 3-[(4 AMINO-3-METHOXYPHENYL) AZO]-BENZENE SULFONIC ACID, MONO-SODIUM SALT.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.42	3-[(4-Amino-3- methoxyphenyl)-azo]benzenesul- fonic acid, monosodium salt (CAS No. 6300-07-8) (provided for in subheading 2927.00.50)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3251. ET-743 (ECTEINASCIDIN).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.43	[6R-(6a.6ab,7b, 13b,14b,16a, 20R*)]-5-Acetyloxy-3′,4′, 6.6a.7.13.14.16-octahydro-6′,8,14-trihydroxy-7′,9-dimethoxy- 4,10,23-trimethylspiro[6, 16-b][3]benzazocine-20,1′(2H)-isoquinolin-19-one (ecteinascidin) (CAS No. 114899-77-3) (provided for in subheading 2934.99.30)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3252. 2,7-NAPHTHALENEDISULFONIC ACID, 5-[[4-CHLORO-6-[[2-[[4-FLUORO-6-[[5-HYDROXY-6-[(4-METHOXY-2-SULFOPHENYL)AZO]-7-SULFO-2-NAPHTHALENYL]AMINO]-1,3,5-TRIAZIN-2-YL] AMINO]-1-METHYLETHYL]AMINO]-1,3,5-TRIAZIN-2-YL]AMINO]-3-[[4-(ETHENYLSULFONYL)PHENYL]AZO]-4-HYDROX′-, SODIUM SALT.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.44	2,7-Naphthalene- disulfonic acid, 5-[[4-chloro-6-[[2-[[4-fluoro-6-[[5-hydroxy-6-[(4-methoxy-2-sulfophenyl)azo]-7-sulfo-2-naphthalenyl]-amino]-1,3,5-triazin-2-yl]- amino]-1-methylethyl]-amino]-1,3,5-triazin-2-yl]-amino]-3-[[4-(ethenylsulfonyl)-phenyl]azo]-4-hydroxy, sodium salt (CAS No. 168113-78-8) (provided for in subheading 3204.16.30)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3253. 1,5-NAPHTHALENE DISULFONIC ACID, 3-[[2-(ACETYLAMINO)-4-[[4-[[2-[2-(ETHENYLSULFONYL) ETHOXY] ETHYL] AMINO]-6-FLUORO-1,3, 5-TRIAZIN-2-YL]AMINO] PHENYL]AZO]-, DISODIUM SALT.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.45	1,5-Naphthalenedi- sulfonic acid, 3-[[2-(acetylamino)-4-[[4-[[2-[2-(ethenylsulfonyl)- ethoxy]-ethyl]amino]-6-fluoro-1,3,5-triazin-2-yl]-amino]- phenyl]azo]-, disodium salt (CAS No. 98635–31–5) (provided for in subheading 3204.16.30)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3254. 7,7′-[1,3-PROPANEDIYLBIS[IMINO(6-FLUORO-1,3,5-TRIAZINE-4,2-DIYL)IMINO[2-[(AMINOCARBONYL)AMINO]-4,1-PHENYLENE]AZO]]BIS-, SODIUM SALT.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.46	7,7′-[1,3-Propanediylbis- [imino(6-fluoro-1,3,5-triazine-4,2-diyl)imino[2-[(aminocarbonyl)-amino]-4,1-phenylene]azo]]bis-, sodium salt (CAS No. 143683–24–3) (provided for in subheading 3204.16.30)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3255. CUPRATE(3-), [2-[[[[3-[[4-[[2-[2-(ETHENYLSULFONYL) ETHOXY] ETHYL]AMINO]-6-FLUORO- 1,3,5-TRIAZIN-2- YL]AMINO]-2- (HYDROXY-.KAPPA.O)- 5-SULFOPHENYL]AZO-.KAPPA.N2] PHENYLMETHYL]AZO-.KAPPA.N1]-4-SULFOBENZOATO(5-)-.KAPPA.O], TRISODIUM.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.47	Cuprate(3-), [2-[[[[3-[[4-[[2-[2-(ethenylsulfonyl)- ethoxy]-ethyl]amino]-6-fluoro-1,3,5-triazin-2-yl]-amino]-2-(hydroxy-.kappa.O)-5-sulfophenyl]azo-.kappa.N2]-phenylmethyl]azo-.kappa.N1]-4-sulfobenzoato(5-)-.kappa.O], trisodium (CAS No. 106404–06–2) (provided for in subheading 3204.16.30)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3256. 1,5-NAPHTHALENEDI SULFONIC ACID, 2-[[8-[[4-[[3-[[[2-(ETHENYLSULFONYL) ETHYL]AMINO] CARBONYL]PHENYL]AMINO]- 6-FLUORO-1,3,5- TRIAZIN-2-YL]AMINO]- 1-HYDROXY-3,6- DISULFO-2-NAPHTHAL ENYL]AZO]-, TETRASODIUM SALT.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.48	1,5-Naphthalenedi- sulfonic acid, 2-[[8-[[4-[[3-[[[2- (ethenylsulfonyl)- ethyl]-amino]carbonyl]- phenyl]amino]-6-fluoro-1,3,5-triazin-2-yl]amino]-1-hydroxy-3,6-disulfo-2-naphthalenyl]-azo]-, tetrasodium salt (CAS No. 116912-36-8) (provided for in subheading 3204.16.30)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3257. PTFMBA.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.49	p-(Trifluoro-methyl)benzaldehyde (CAS No. 455–19–6) (provided for in subheading 2913.00.40)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3258. BENZOIC ACID, 2-AMINO-4-[[(2,5-DICHLOROPHENYL) AMINO]CARBONYL]-, METHYL ESTER.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.51	Benzoic acid, 2-amino-4-[[(2,5-dichlorophenyl)- amino]carbonyl]-, methyl ester (CAS No. 59673-82-4) (provided for in subheading 2924.29.71)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3259. IMIDACLOPRID PESTICIDES.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.52	Mixtures of imidacloprid (1-[(6-Chloro-3-pyridinyl)methyl]-*N*-nitro-2- imidazolidinimine) (CAS No. 138261-41-3) with application adjuvants (provided for in subheading 3808.10.25)	5.7%	No change	No change	On or before 12/31/2006	".

SEC. 3260. BETA-CYFLUTHRIN.

(a) IN GENERAL.—Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.54	beta-Cyfluthrin (CAS No. 68359-37-5) (provided for in subheading 2926.90.30)	4.3%	No change	No change	On or before 12/31/2006	".

SEC. 3261. IMIDACLOPRID TECHNICAL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.55	Imidacloprid (1-[(6-Chloro-3-pyridinyl)methyl]-*N*-nitro-2-imidazolidinimine) (CAS No. 138261-41-3) (provided for in subheading 2933.39.27)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3262. BAYLETON TECHNICAL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.56	Triadimefon (1-(4-chlorophenoxy)-3,3-dimethyl-1-(1*H*-1,2,4-triazol-1-yl)-2-butanone) (CAS No. 43121-43-3) (provided for in subheading 2933.99.22)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3263. PROPOXUR TECHNICAL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.57	Propoxur (2-(1-methylethoxy)-phenol methylcarbamate) (CAS No. 114-26-1) (provided for in subheading 2924.29.47)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3264. MKH 6561 ISOCYANATE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.58	A mixture of 30 percent 2-(carbomethoxy)-benzenesulfonyl isocyanate (CAS No. 13330-20-7) and 70 percent xylenes (provided for in subheading 3824.90.28)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3265. PROPOXY METHYL TRIAZOLONE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.59	A mixture of 20 percent propoxymethyltriazolone (3H-1,2,4-triazol-3-one, 2,4- dihydro-4-methyl-5-propoxy-) (CAS No. 1330-20-7) and triazolone (3H-1,2,4-triazol-3-one, 2,4- dihydro-4-methyl-5-propoxy-) (CAS No. 1330-2-7) (provided for in subheading 3824.90.28)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3266. NEMACUR VL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.60	Fenamiphos (ethyl 4-(methylthio)-m-tolyl-isospropylphos- phoramidate) (CAS No. 22224–92–6) (provided for in subheading 2930.90.10)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3267. METHOXY METHYL TRIAZOLONE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.61	2,4-Dihydro-5-methoxy-4-methyl-3*H*-1,2,4-triazol-3-one (CAS No. 135302–13–5) (provided for in subheading 2933.99.97)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3268. LEVAFIX GOLDEN YELLOW E-G.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.62	Reactive yellow 27 (1H-Pyrazole-3-carboxylic acid, 4-[[4-[[(2,3-dichloro-6-quinoxalinyl)carbonyl]amino]-2- sulfophenyl]- azo]-4,5-dihydro-5-oxo-1- (4-sulfophenyl)-, trisodium salt) (CAS No. 75199–00–7) (provided for in subheading 3204.16.20)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3269. LEVAFIX BLUE CA/REMAZOL BLUE CA.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.63	Cuprate(4-), [2-[[3-[[substituted]-1,3,5-triazin-2-yl]amino]-2-hydroxy-5- sulfophenyl]- .(substituted)azo], sodium salt (CAS No. 156830–72–7) (provided for in subheading 3204.16.30)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3270. REMAZOL YELLOW RR GRAN.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.64	Benzenesulfonic- acid, 2-amino-4-(cyanoamino)-6-[(3-sulfo- phenyl)amino]- 1,3,5-triazin-2-yl]amino]-5-[[4-[[2-(sulfoxy)- ethyl]sulfonyl]- phenyl]azo]-, lithium/sodium salt (CAS No. 189574–45–6) (provided for in subheading 3204.16.30)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3271. INDANTHREN BLUE CLF.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.65	Vat blue 66 (9,10-Anthra- cenedione, 1,1′-[(6-phenyl-1,3,5- triazine-2,4-diyl)diimino]-bis[3-acetyl-4- amino-) (CAS No. 32220–82–9) (provided for in subheading 3204.15.30)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3272. INDANTHREN YELLOW F3GC.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.66	Vat yellow 33 ([1,1′-Biphenyl]- 4-carboxamide, 4′,4‴-azobis[N- (9,10-dihydro-9,10-dioxo-1- anthracenyl)-) (CAS No. 12227–50–8) (provided for in subheading 3204.15.80)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3273. ACETYL CHLORIDE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.67	Acetyl chloride (CAS No. 75-36-5) (provided for in subheading 2915.90.50)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3274. 4-METHOXY-PHENACYCHLORIDE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.68	4-Methoxyphena- cyl chloride (CAS No. 2196-99-8) (provided for in subheading 2914.70.40)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3275. 3-METHOXY-THIOPHENOL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.69	3-Methoxy-thiophenol (CAS No. 15570-12-4) (provided for in subheading 2930.90.90)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3276. LEVAFIX BRILLIANT RED E-6BA.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.70	Reactive red 159 (2,7-naphthalenedisulfonic acid, 5-(benzoylamino)- 3-[[5-[[(5- chloro-2,6-difluoro-4-pyrimidinyl)-amino]methyl]- 1-sulfo-2- naphthalenyl]-azo]-4-hydroxy-, lithium sodium salt) (CAS No. 83400-12-8) (provided for in subheading 3204.16.20)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3277. REMAZOL BR. BLUE BB 133 PERCENT.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.71	Reactive blue 220 (cuprate(4-), [4,5-dihydro-4- [[8-hydroxy-7- [[2-hydroxy-5- methoxy-4-[[2- (sulfoxy)ethyl]- sulfonyl]- phenyl]azo]-6- sulfo-2-naphthal- enyl]azo]-5-oxo- 1-(4-sulfophenyl)-1H-pyrazole-3- carboxylato(6-)]-, sodium) (CAS No. 90341-71-2) (provided for in subheading 3204.16.30)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3278. FAST NAVY SALT RA.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.72	Benzenediazonium, 4-[(2,6- dichloro-4-nitrophenyl)azo]- 2,5-dimethoxy-, (T-4)-tetra- chlorozincate(2-) (2:1) (CAS No. 63224-47-5) (provided for in subheading 2927.00.30)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3279. LEVAFIX ROYAL BLUE E-FR.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.73	Reactive blue 224 (ethanol, 2,2′-[[6,13-dichloro-3,10- bis[[2-sulfoxy)- ethyl]amino]-triphenodioxazinediyl]bis(sul- fonyl)]bis-, bis(hydrogen sulfate) ester, potassium sodium salt (CAS No. 108692-09-7) (provided for in subheading 3204.16.30)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3280. P-CHLOROANILINE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.74	p-Chloroaniline (CAS No. 106–47–8) (provided for in subheading 2921.42.90)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3281. ESTERS AND SODIUM ESTERS OF PARAHYDROXYBENZOIC ACID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.75	Methyl 4-hydroxybenzoate (CAS No. 99–76–3); propyl 4-hydroxybenzoate (CAS No. 94–13–3); ethyl 4-hydroxybenzoate (CAS No. 120–47–8); butyl 4-hydroxybenzoate (CAS No. 94–26–8); benzyl 4-hydroxybenzoate (CAS No. 94–18–8); methyl 4-hydroxybenzoate, sodium salt (CAS No. 5026–62–0); propyl 4-hydroxybenzoate, sodium salt (CAS No. 35285–69–9); ethyl 4-hydroxybenzoate, sodium salt (CAS No. 35285–68–8); and butyl 4-hydroxybenzoate, sodium salt (CAS No. 36457–20–2) (all the foregoing provided for in subheading 2918.29.65 or 2918.29.75)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3282. SANTOLINK EP 560.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.76	Phenol-formaldehyde polymer, butylated (CAS No. 96446–41–2) (provided for in subheading 3909.40.00)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3283. PHENODUR VPW 1942.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.77	Phenol, 4,4′-(1-methylethylidene)bis-, polymer with (chloromethyl)-oxirane and phenol polymer with formaldehyde modified with chloroacetic acid (provided for in subheading 3909.40.00)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3284. PHENODUR PR 612.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.78	Formaldehyde, polymer with 2-methylphenol, butylated (CAS No. 118685–25–9) (provided for in subheading 3909.40.00)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3285. PHENODUR PR 263.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.79	Phenol, polymer with formaldehyde (CAS No. 126191–57–9) and urea, polymer with formaldehyde (CAS No. 68002–18–6) dissolved in a mixture of isobutanol and n-butanol (provided for in subheading 3909.40.00)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3286. MACRYNAL SM 510 AND 516.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.80	Neodecanoic acid, oxiranylmethyl ester, polymer with ethenylbenzene, 2-hydroxyethyl 2-methyl-2-propenoate, methyl 2-methyl-2-propenoate and 2-propenoic acid (CAS No. 98613–27–5) (provided for in subheading 3906.90.50)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3287. ALFTALAT AN 725.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.81	1,3-Benzenedicarboxylic acid, polymer with 1,4-benzenedicarboxylic acid and 2,2-dimethyl-1,3-propanediol (CAS No. 25214–38–4) (provided for in subheading 3907.99.00)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3288. RWJ 241947.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.82	(+)-5-[[6-[(2-Fluorophenyl)- methoxy]-2-naphthalenyl]-methyl]-2,4-thiazolidinedione (CAS No. 161600–01–7) (provided for in subheading 2934.10.10)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3289. RWJ 394718.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.83	1-Propanone, 3-(5-benzofuranyl)-1-[2-hydroxy-6-[[6-O-(methoxycarbonyl-beta-D-glucopyranosyl]-oxy]-4-methylphenyl- (CAS No. 209746–59–8) (provided for in subheading 2932.99.61)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3290. RWJ 394720.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.84	3-(5-Benzofuranyl)-1-[2-β-D-glucopyranosyloxy- 6-hydroxy-4-methylphenyl]-1-propanone (CAS No. 209746–56–5) (provided for in subheading 2932.99.61)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3291. 3,4-DCBN.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.85	3,4-Dichlorobenzonitrile (CAS No. 6574–99–8) (provided for in subheading 2926.90.12)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3292. CYHALOFOP.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.86	Propanoic acid, 2-[4-(cyano-2-fluorophenoxy)-phenoxy]butyl ester(2R) (CAS No. 122008–85–9) (provided for in subheading 2926.90.25)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3293. ASULAM.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.87	Methyl sulfanilylcarbamate, sodium salt (asulam sodium salt) (CAS No. 2302–17–2) imported in bulk form (provided for in subheading 2935.00.75), or imported in forms or packings for retail sale or mixed with application adjuvants (provided for in subheading 3808.30.15)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3294. FLORASULAM.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.88	Mixtures of florasulam ([1,2,4]- triazolo[1,5-c]- pyrimidine-2-sulfonamide, N-(2,6-difluorophenyl)-8-fluoro-5-methoxy-) (CAS No. 145701–23–1) and application adjuvants (provided for in subheading 3808.30.15)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3295. PROPANIL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.89	Propanamide, N-(3,4-dichlorophenyl)- (CAS No. 709–98–8) (provided for in subheading 2924.29.47)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3296. HALOFENOZIDE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.90	Benzoic acid, 4-chloro-2-benzoyl-2-(1,1-dimethylethyl)- hydrazide (halofenozide) (CAS No. 112226–61–6) (provided for in subheading 2928.00.25)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3297. ORTHO-PHTHALALDEHYDE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.92	1,2-Benzenedicarboxaldehyde (CAS No. 643–79–8) (provided for in subheading 2912.29.60)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3298. TRANS 1,3-DICHLOROPENTENE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new subheading:

"	9902.02.93	Mixed cis and trans isomers of 1,3-dichloro-propene (CAS No. 10061–02–6) (provided for in subheading 2903.29.00)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3299. METHACRYLAMIDE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.94	Methacrylamide (CAS No. 79–39–0) (provided for in subheading 2924.19.10)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3300. CATION EXCHANGE RESIN.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.95	2-Propenoic acid, polymer with diethenylbenzene (CAS No. 9052–45–3) (provided for in subheading 3914.00.60)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3301. GALLERY.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.96	N-[3-(1-Ethyl-1-methylpropyl)-5-isoxazolyl]-2,6-dimethoxybenzamide (isoxaben) (CAS No. 82558-50-7) (provided for in subheading 2934.99.15)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3302. NECKS USED IN CATHODE RAY TUBES.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.97	Necks of a kind used in cathode ray tubes (provided for in subheading 7011.20.80)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3303. POLYTETRAMETHYLENE ETHER GLYCOL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new subheading:

"	9902.02.98	Polytetramethylene ether glycol (tetrahydro-3-methylfuran, polymer with tetrahydrofuran) (CAS No. 38640-26-5) (provided for in subheading 3907.20.00)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3304. LEAF ALCOHOL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new subheading:

"	9902.02.99	cis-3-Hexen-1-ol (CAS No. 928-96-1) (provided for in subheading 2905.29.90)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3305. COMBED CASHMERE AND CAMEL HAIR YARN.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.01	Yarn of combed cashmere or yarn of camel hair (provided for in subheading 5108.20.60)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3306. CERTAIN CARDED CASHMERE YARN.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.02	Yarn of carded cashmere of 6 run or finer (equivalent to 19.35 metric yarn system) (provided for in subheading 5108.10.60)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3307. SULFUR BLACK 1.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.03	Sulfur black 1 (CAS No. 1326-82-5) (provided for in subheading 3204.19.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3308. REDUCED VAT BLUE 43.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.04	Reduced vat blue 43 (CAS No. 85737-02-6) (provided for in subheading 3204.15.40)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3309. FLUOROBENZENE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.05	Fluorobenzene (CAS No. 462–06–6) (provided for in subheading 2903.69.70)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3310. CERTAIN RAYON FILAMENT YARN.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.06	High tenacity multiple (folded) or cabled yarn of viscose rayon (provided for in subheading 5403.10.60)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3311. CERTAIN TIRE CORD FABRIC.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.07	Tire cord fabric of high tenacity yarn of viscose rayon (provided for in subheading 5902.90.00)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3312. DIRECT BLACK 184.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.08	Direct black 184 (provided for in subheading 3204.14.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3313. BLACK 263 STAGE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.09	5-[4-(7-Amino-1-hydroxy-3-sulfonaphthalen-2-ylazo)-2,5-bis(2-hydroxyethoxy)-phenylazo]isophthalic acid, lithium salt (provided for in subheading 3204.14.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3314. MAGENTA 364.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.10	5-[4-(4,5-Dimethyl-2-sulfo-phenylamino)-6-hydroxy-[1,3,5]triazin-2-ylamino]-4-hydroxy-3-(1-sulfonaphthalen-2-ylazo)naphthalene-2,7-disulfonic acid, sodium salt (provided for in subheading 3204.14.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3315. THIAMETHOXAM TECHNICAL.

(a) CALENDAR YEAR 2004.—Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.11	Thiamethoxam (3-[(2-chloro-5-thiazolyl)methyl)- tetrahydro-5-methyl-N-nitro-1,3,5-oxadiazin-4-imine) (CAS No. 153719–23–4) (provided for in subheading 2934.10.90)	2.6%	No change	No change	On or before 12/31/2004	".

(b) CALENDAR YEAR 2005.—

(1) IN GENERAL.—Heading 9902.03.11, as added by subsection (a), is amended—

(A) by striking "2.6%" and inserting "2.54%"; and

(B) by striking "On or before 12/31/2004" and inserting "On or before 12/31/2005".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on January 1, 2005.

(c) CALENDAR YEAR 2006.—

(1) IN GENERAL.—Heading 9902.03.11, as added by subsection (a) and amended by this section, is further amended—

(A) by striking "2.54%" and inserting "3.2%"; and

(B) by striking "On or before 12/31/2005" and inserting "On or before 12/31/2006".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on January 1, 2006.

SEC. 3316. CYAN 485 STAGE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.12	2-[(Hydroxyethyl- sulfamoyl)-sulfophthalocyaninato] copper (II), mixed isomers (provided for in subheading 3204.14.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3317. DIRECT BLUE 307.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.14	Direct blue 307 (provided for in subheading 3204.14.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3318. DIRECT VIOLET 107.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.16	Direct violet 107 (provided for in subheading 3204.14.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3319. FAST BLACK 286 STAGE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.17	1,3-Benzenedicarboxylic acid, 5-[[4-[(7-amino-1-hydroxy-3-sulfo-2-naphthalenyl)-azo]-6-sulfo-1-naphthalenyl]-azo]-, sodium salt (CAS No. 201932–24–3) (provided for in subheading 3204.14.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3320. MIXTURES OF FLUAZINAM.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.18	Mixtures of fluazinam (3-chloro-N-(3-chloro-2,6- dinitro-4-(trifluoromethyl)-phenyl-5-(trifluoromethyl)-2-pyridinamine) (CAS No. 79622–59–6) and application adjuvants (provided for in subheading 3808.20.15)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3321. PRODIAMINE TECHNICAL.

(a) CALENDAR YEAR 2004.—Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.19	Prodiamine (2,6-dinitro-N1,N1-dipropyl-4-(trifluoromethyl)-1,3-benzenediamine (CAS No. 29091–21–2) (provided for in subheading 2921.59.80)	0.53%	No change	No change	On or before 12/31/2004	".

(b) CALENDAR YEARS 2005 AND 2006.—

(1) IN GENERAL.—Heading 9902.03.19, as added by subsection (a), is amended—

(A) by striking "0.53%" and inserting "Free"; and

(B) by striking "On or before 12/31/2004" and inserting "On or before 12/31/2006".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on January 1, 2005.

SEC. 3322. CARBON DIOXIDE CARTRIDGES.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.20	Carbon dioxide in threaded 12-, 16-, and 25-gram non-refillable cartridges (provided for in subheading 2811.21.00)	Free	Free	No change	On or before 12/31/2006	".

SEC. 3323. 12-HYDROXYOCTADECANOIC ACID, REACTION PRODUCT WITH N,N-DIMETHYL, 1,3-PROPANEDIAMINE, DIMETHYL SULFATE, QUATERNIZED.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.21	12-Hydroxyoctadecanoic acid, reaction product with *N,N*-dimethyl- 1,3-propanediamine, dimethyl sulfate, quaternized (CAS No. 70879–66–2) (provided for in subheading 3824.90.40)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3324. 40 PERCENT POLYMER ACID SALT/POLYMER AMIDE, 60 PERCENT BUTYL ACETATE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.22	2-Oxepanone, polymer with aziridine and tetrahydro-2H-pyran-2-one, dodecanoate ester, 40 percent solution in N-butyl acetate (provided for in subheading 3208.90.00)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3325. 12-HYDROXYOCTADECANOIC ACID, REACTION PRODUCT WITH N,N-DIMETHYL- 1,3-PROPANEDIAMINE, DIMETHYL SULFATE, QUATERNIZED, 60 PERCENT SOLUTION IN TOLUENE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.03.23	12-Hydroxyoctadecanoic acid, reaction product with *N,N*-dimethyl- 1,3-propanediamine, dimethyl sulfate, quaternized (CAS No. 70879–66–2), 60 percent solution in toluene (provided for in subheading 3824.90.28)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3326. POLYMER ACID SALT/POLYMER AMIDE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.03.24	2-Oxepanone, polymer with aziridine and tetrahydro-2H-pyran-2-one, dodecanoate ester (provided for in subheading 3824.90.91)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3327. 50 PERCENT AMINE NEUTRALIZED PHOSPHATED POLYESTER POLYMER, 50 PERCENT SOLVESSO 100.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.03.25	50 percent amine neutralized phosphated polyester polymer, 50 percent solvesso 100 (CAS Nos. P–99–1218, 64742–95–6, 95–63–6, 108–67–8, 98–82–8, and 1330–20–7) (provided for in subheading 3907.99.00)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3328. 1-OCTADECANAMINIUM, N,N-DIMETHYL-N-OCTADECYL-, (SP-4-2)-[29H,31H-PHTHALOCYANINE-2-SULFONATO(3-)-.KAPPA.N29,.KAPPA.N30,.KAPPA.N31,.KAPPA.N32]CUPRATE(1-).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.03.26	1-Octa- decanaminium, *N,N*-dimethyl-*N*-octadecyl-, (Sp-4-2)-[29H,31H-phthalocyanine-2-sulfonato(3-)-.kappa.N29, .kappa.N30, .kappa.N31, .kappa.N32] cuprate(1-) (CAS No. 70750-63-9) (provided for in subheading 3824.90.28)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3329. CHROMATE(1-)-BIS[1-[(5-CHLORO–2-HYDROXYPHENYL)AZO]–2-NAPTHALENOLATO(2-)]-,HYDROGEN.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.03.27	Chromate(1-)- bis[1-[(5-chloro-2- hydroxyphenyl)azo]-2- naphthalenolato- (2-)]-, hydrogen (CAS No. 31714–55–3) (provided for in subheading 2942.00.10)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3330. BRONATE ADVANCED.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.03.29	Mixtures of bromoxynil octanoate (3,5-dibromo-4-hydroxybenzo-nitrile octanoate (CAS No. 1689–99–2) with application adjuvants (provided for in subheading 3808.30.15)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3331. N-CYCLOHEXYLTHIOPHTHALIMIDE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.03.30	N-Cyclohexylthiophthalimide (CAS No. 17796–82–6) (provided for in subheading 2930.90.24)	3%	No change	No change	On or before 12/31/2006	”.

SEC. 3332. CERTAIN HIGH-PERFORMANCE LOUDSPEAKERS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.85.20	Loudspeakers not mounted in their enclosures (provided for in subheading 8518.29.80), the foregoing which meet a performance standard of not more than 1.5 dB for the average level of 3 or more octave bands, when such loudspeakers are tested in a reverberant chamber	Free	No change	No change	On or before 12/31/2006	".

SEC. 3333. BIO-SET INJECTION RCC.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following heading:

"	9902.03.33	Polymeric apparatus, comprising a removable cap, an injection port attached to an air vent filter and a fixed needle of plastics and a base for attaching the whole to a vial with a 13 mm or 20 mm flange, of a kind used for transferring diluent from a prefilled syringe (without needle) to a vial containing a powdered or lyophilized medicament and, after mixing, transferring the medicament back to the syringe for subsequent administration to the patient (provided for in subheading 3923.50.00)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3334. PENTA AMINO ACETO NITRATE COBALT III (COFLAKE 2).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.34	Mixtures of (acetato)pent-ammine cobalt dinitrate (CAS No. 14854–63–8) with a polymeric or paraffinic carrier (provided for in subheading 3815.90.50)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3335. OXASULFURON TECHNICAL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.35	Benzoic acid, 2-[[[[(4.6-dimethyl-2-pyrimidinyl)-amino]carbonyl]-amino]sulfonyl]-, 3-oxetanyl ester (CAS No. 144651–06–9) (provided for in subheading 2935.00.75)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3336. CERTAIN MANUFACTURING EQUIPMENT.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.84.83	Machine tools for working wire of iron or steel, certified for use in production of radial tires designed for off-the-highway use and for use on a rim measuring 63.5 cm or more in diameter (provided for in subheading 4011.20.10, 4011.61.00, 4011.63.00, 4011.69.00, 4011.92.00, 4011.94.40, or 4011.99.45), numerically controlled, or parts thereof (provided for in subheading 8463.30.00 or 8466.94.85)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3337. 4-AMINOBENZAMIDE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.37	4-Aminobenzamide (CAS No. 2835–68–9) (provided for in subheading 2924.29.76)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3338. FOE HYDROXY.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.38	N-(4-Fluorophenyl)-2-hydroxy-N-(1-methylethyl)-acetamide (CAS No. 54041–17–7) (provided for in subheading 2924.29.71)	5.2%	No change	No change	On or before 12/31/2006	".

SEC. 3339. MAGENTA 364 LIQUID FEED.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.39	5-[4-(4,5-Dimethyl-2-sulfo- phenylamino)-6-hydroxy-[1,3,5]triazin-2-ylamino]-4-hydroxy-3-(1-sulfonaphthalen-2-ylazo)naphthalene-2,7-disulfonic acid, sodium ammonium salt (provided for in subheading 3204.14.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3340. TETRAKIS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.40	Tetrakis ((2,4-di-tert-butylphenyl)-4,4-biphenylene diphosphonite) (CAS No. 38613–77–3) (provided for in subheading 2835.29.50)	Free	Free	No change	On or before 12/31/2006	".

SEC. 3341. PALMITIC ACID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.41	Palmitic acid, with a purity of 90 percent or more (CAS No. 57–10–3) (provided for in subheading 2915.70.00)	Free	Free	No change	On or before 12/31/2006	".

SEC. 3342. PHYTOL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.42	3,7,11,15-Tetramethylhexadec-2-en-1-ol (CAS No. 7541–49–3) (provided for in subheading 2905.22.50)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3343. CHLORIDAZON.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.43	Chloridazon (5-Amino-4-chloro-2- phenyl-3(2H)-pyridazinone) (CAS No. 1698–60–8) put up in forms or packings for retail sale or mixed with application adjuvants (provided for in subheading 3808.30.15)	Free	Free	No change	On or before 12/31/2006	".

SEC. 3344. DISPERSE ORANGE 30, DISPERSE BLUE 79:1, DISPERSE RED 167:1, DISPERSE YELLOW 64, DISPERSE RED 60, DISPERSE BLUE 60, DISPERSE BLUE 77, DISPERSE YELLOW 42, DISPERSE RED 86, AND DISPERSE RED 86:1.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.45	Propanenitrile, 3-[[2-(acetyloxy)- ethyl]-[4-[(2,6-dichloro-4-nitro- phenyl)azo]-phenyl]amino]- (disperse orange 30) (CAS No. 5261–31–4) (provided for in subheading 3204.11.50)	Free	No change	No change	On or before 12/31/2006
"	9902.03.46	Acetamide, N-[5-[bis[2-(acetyloxy)-ethyl]amino]-2-[(2-bromo-4,6-dinitrophenyl)- azo]-4-methoxyphenyl]-(disperse blue 79:1) (CAS No. 3618–72–2) (provided for in subheading 3204.11.50)	Free	No change	No change	On or before 12/31/2006

“	9902.03.47	Acetamide, N-[5-[bis[2-(acetyloxy)-ethyl]amino]-2-[(2-chloro-4-nitrophenyl)-azo]phenyl]- (disperse red 167:1) (CAS No. 1533–78–4) (provided for in subheading 3204.11.50)	Free	No change	No change	On or before 12/31/2006	
“	9902.03.48	1H-Indene-1,3(2H)-dione, 2-(4-bromo-3-hydroxy-2-quinol-inyl)- (disperse yellow 64) (CAS No. 10319–14–9) (provided for in subheading 3204.11.50)	Free	No change	No change	On or before 12/31/2006	
“	9902.03.49	9,10-Anthra- cenedione, 1-amino-4-hydroxy-2-phenoxy- (disperse red 60) (CAS No. 17418–58–5) (provided for in subheading 3204.11.50)	Free	No change	No change	On or before 12/31/2006	
“	9902.03.50	1H-Naphth[2,3-f]isoindole-1,3,5,10(2H)-tetrone, 4,11-diamino-2-(3-methoxypropyl)-(disperse blue 60) (CAS No. 12217–80–0) (provided for in subheading 3204.11.50)	Free	No change	No change	On or before 12/31/2006	
“	9902.03.51	9,10-Anthracenedione, 1,8-dihydroxy-4-nitro-5-(phenylamino)- (disperse blue 77) (CAS No. 20241–76–3) (provided for in subheading 3204.11.50)	Free	No change	No change	On or before 12/31/2006	
“	9902.03.52	Benzenesulfonamide, 3-nitro-N-phenyl-4-(phenylamino)- (disperse yellow 42) (CAS No. 5124–25–4) (provided for in subheading 3204.11.50)	Free	No change	No change	On or before 12/31/2006	
“	9902.03.53	Benzenesulfonamide, N-(4-amino-9,10-dihydro-3-methoxy-9,10-dioxo-1-anthracenyl)-4-methyl- (disperse red 86) (CAS No. 81–68–5) (provided for in subheading 3204.11.50)	Free	No change	No change	On or before 12/31/2006	
“	9902.03.54	Benzenesulfonamide, N-(4-amino-9,10-dihydro-3-methoxy-9,10-dioxo-1-anthracenyl)- (disperse red 86:1) (CAS No. 69563–51–5) (provided for in subheading 3204.11.50)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3345. DISPERSE BLUE 321.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.03.55	1-Naphthalenamine, 4-[(2-bromo-4,6-dinitrophenyl)- azo]-N-(3-methoxypropyl)- (disperse blue 321) (CAS No. 70660–55–8) (provided for in subheading 3204.11.35)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3346. DIRECT BLACK 175.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.03.56	Cuprate(4-), [m-[5-[(4,5-dihydro-3-methyl-5-oxo- 1-phenyl-1H-pyrazol-4-yl)azo]-3-[[4′-[[3,6-disulfo-2-hydroxy.kappa.O-1-naphthalenyl]azo-.kappa.N1]-3,3′-di(hydroxy-.kappa.O)[1,1′-biphenyl]-4-yl]azo-.kappa.N1]-4-(hydroxy-.kappa.O)-2,7-naphtha- lenedisulf-onato(8-)]]di-, tetrasodium (direct black 175) (CAS No. 66256–76–6) (provided for in subheading 3204.12.50)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3347. DISPERSE RED 73 AND DISPERSE BLUE 56.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new headings:

“	9902.03.57	Benzonitrile, 2-[[4-[(2-cyanoethyl)-ethylamino]- phenyl]azo]-5-nitro- (disperse red 73) (CAS No. 16889–10–4) (provided for in subheading 3204.11.10)	Free	No change	No change	On or before 12/31/2006	”.
“	9902.03.58	9,10-Anthra- cenedione, 1,5-diaminochloro-4,8-dihydroxy- (disperse blue 56) (CAS No. 12217–79–7) (provided for in subheading 3204.11.10)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3348. ACID BLACK 132.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.59	[3-(Hydroxy-.kappa.O)-4-[[2-(hydroxy-.kappa.O)-1-naphthalenyl]azo-.kappa.N1]-1-naphthal-enesulfonato (3-)]-[1-[[2-(hydroxy-.kappa.O)-5-[(2-methoxyphenyl]-azophenyl]-azo-.kappa.N1]-2-naphthalenolato (2-).kappa.O]-, disodium (acid black 132) (CAS No. 27425–58–7) (provided for in subheading 3204.12.20)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3349. ACID BLACK 132 AND ACID BLACK 172.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new headings:

"	9902.03.59	[3-(Hydroxy- kO)-4- [[2-(hydroxy-.kappa.O)-1-naphthalenyl]azo-.kappa.N1]-1-naphthal-enesulfonato (3)]-[1-[[2-(hydroxy-.kappa.O)-5-[(2-methoxyphenyl)-azo]phenyl]-azo-kappa.N1]-2-naphthalenolato (2-)-.kappa.O]-, disodium (acid black 132) (CAS No. 57693–14–8) (provided for in subheading 3204.12.45)	Free	No change	No change	On or before 12/31/2006	".
"	9902.03.60	Chromate(3-), bis[3-(hydroxy- .kappa.O)-4-[[2-(hydroxy-.kappa.O)-1-naphthalenyl]azo-.kappa.N1]-7-nitro-1-naphthal-enesulfonato(3-)]-, trisodium (acid black 172) (CAS No. 57693–14–8) (provided for in subheading 3204.12.45)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3350. ACID BLACK 107.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.61	Chromate(2-), [1-[[2-(hydroxy-.kappa.O)-3,5-dinitro- phenyl]azo-.kappa.N1]-2-naphthal-enolato(2-)-.kappa.O][3-(hydroxy.kappa.O)-4-[[2 (hydroxy-.kappa.O)-1-naphthalenyl]azo-.kappa.N1]-7- nitro-1-naphthalenesulfonato(3-)]-, sodium hydrogen (acid black 107) (CAS No. 12218–96–1) (provided for in subheading 3204.12.45)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3351. ACID YELLOW 219, ACID ORANGE 152, ACID RED 278, ACID ORANGE 116, ACID ORANGE 156, AND ACID BLUE 113.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.62	Benzenesulfonic acid, 3-[[3-methoxy-4-[(4-methoxyphenyl)- azo]phenyl]azo]-, sodium salt (acid yellow 219) (CAS No. 71819–57–3) (provided for in subheading 3204.12.50)	Free	No change	No change	On or before 12/31/2006	".
"	9902.03.63	Benzenesulfonic acid, 3-[[4-[[4-(2-hydroxybut-oxy)phenyl]azo]-5-methoxy-2-methyl-phenyl]azo]-, monolithium salt (acid orange 152) (CAS No. 71838–37–4) (provided for in subheading 3204.12.50)	Free	No change	No change	On or before 12/31/2006	".
"	9902.03.64	Chromate(1-), bis[3-[4-[[5-chloro-2-(hydroxy.kappa.O)- phenyl]azo-.kappa.N1]-4,5-dihydro-3-methyl-5-(oxo-.kappa.O)-1H-pyrazol-1-yl]benzenesul- fonamidato(2-)]-, sodium (acid red 278) (CAS No. 71819–56–2) (provided for in subheading 3204.12.50)	Free	No change	No change	On or before 12/31/2006	".
"	9902.03.65	Benzenesulfonic acid, 3-[[4-[(2-ethoxy-5-methylphenyl)- azo]-1-naphthal- enyl]azo]-, sodium salt (acid orange 116) (CAS No. 12220–10–9) (provided for in subheading 3204.12.50)	Free	No change	No change	On or before 12/31/2006	".
"	9902.03.66	Benzenesulfonic acid, 4-[[5-meth- oxy-4-[(4-methoxy- phenyl)azo]-2-methyl-phenyl]azo]-, sodium salt (acid orange 156) (CAS No. 68555–86–2) (provided for in subheading 3204.12.50)	Free	No change	No change	On or before 12/31/2006	".

“	9902.03.67	1-Naphthalene- sulfonic acid, 8-(phenylamino)-5-[[4-[(3- sulfophenyl)- azo]-1-naphthalenyl]-azo]-, disodium salt (acid blue 113) (CAS No. 3351-05-1) (provided for in subheading 3204.12.50)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3352. EUROPIUM OXIDES.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.22	Europium oxides having a purity of at least 99.99 percent (CAS No. 1308-96-7) (provided for in subheading 2846.90.80)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3353. LUGANIL BROWN NGT POWDER.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.03.76	Acid brown 290 (CAS No. 12234-74-1) (provided for in subheading 3204.12.20)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3354. THIOPHANATE-METHYL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.03.77	4,4′-*o*-Phenylenebis-(3-thioallophanic acid), dimethyl ester (thiophanate-methyl) (CAS No. 23564-05-8) (provided for in subheading 2930.90.10)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3355. MIXTURES OF THIOPHANATE-METHYL AND APPLICATION ADJUVANTS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new subheading:

“	9902.03.79	Mixtures of 4,4′-o-Phenylenebis-(3-thioallophanic acid), dimethyl ester (Thiophanate-methyl) (CAS No. 23564-05-8) and application adjuvants (provided for in subheading 3808.20.15)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3356. HYDRATED HYDROXYPROPYL METHYLCELLULOSE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.03.80	2-Hydroxypropyl methyl cellulose (CAS No. 9004-65-3)(provided for in subheading 3912.39.00)	0.4%	No change	No change	On or before 12/31/2006	”.

SEC. 3357. C 12-18 ALKENES, POLYMERS WITH 4-METHYL-1-PENTENE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.03.86	C 12-18 alkenes, polymers with 4-methyl-1-pentene (CAS No. 68413-03-6) (provided for in subheading 3902.90.00)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3358. CERTAIN 12-VOLT BATTERIES.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.03.87	12V Lead-acid storage batteries, of a kind used for the auxiliary source of power for burglar or fire alarms and similar apparatus of subheading 8531.10.00 (provided for in subheading 8507.20.80)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3359. CERTAIN PREPARED OR PRESERVED ARTICHOKES.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.89	Artichokes, prepared or preserved otherwise than by vinegar or acetic acid, not frozen (provided for in subheading 2005.90.80)	13.8%	No change	No change	On or before 12/31/2006	".

SEC. 3360. CERTAIN OTHER PREPARED OR PRESERVED ARTICHOKES.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.90	Artichokes, prepared or preserved by vinegar or acetic acid (provided for in subheading 2001.90.25)	7.5%	No change	No change	On or before 12/31/2006	".

SEC. 3361. ETHYLENE/TETRAFLUOROETHYLENE COPOLYMER (ETFE).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.91	Ethylene-tetra- fluoroethylene copolymers (ETFE) (provided for in subheading 3904.69.50)	4.9%	No change	No change	On or before 12/31/2006	".

SEC. 3362. ACETAMIPRID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.92	N1-[(6-Chloro-3-pyridyl)methyl]-N2-cyano-N1-methylacetamidine (CAS No. 135410-20-7) (provided for in subheading 2933.39.27)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3363. CERTAIN MANUFACTURING EQUIPMENT.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new headings:

"	9902.84.94	Extruders, screw type, suitable for processing polyester thermoplastics in a cast film production line (provided for in subheading 8477.20.00)	Free	No change	No change	On or before 12/31/2006	
	9902.84.95	Casting machinery suitable for processing polyester thermoplastics into a sheet in a cast film production line (provided for in subheading 8477.80.00)	Free	No change	No change	On or before 12/31/2006	
	9902.84.96	Transverse direction orientation tenter machinery, suitable for processing polyester film in a cast film production line (provided for in subheading 8477.80.00)	Free	No change	No change	On or before 12/31/2006	
	9902.84.97	Winder machinery suitable for processing polyester film in a cast film production line (provided for in subheading 8477.80.00)	Free	No change	No change	On or before 12/31/2006	
	9902.84.98	Slitting machinery suitable for processing polyester film in a cast film production line (provided for in subheading 8477.80.00)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3364. TRITICONAZOLE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.99	E-5-(4-Chlorobenzylidene)-2,2-dimethyl-1-(1H-1,2,4-triazol-1-ylmethyl)cyclopentanol. (CAS No.131983-72-7) (provided for in subheading 2933.99.12)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3365. CERTAIN TEXTILE MACHINERY.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.03.88	Weaving machines (looms), shuttleless type, for weaving fabrics of a width exceeding 30 cm but not exceeding 4.9 m, entered without off-loom or large loom take-ups, drop wires, heddles, reeds, harness frames, or beams (provided for in subheading 8446.30.50)	2.7%	No change	No change	On or before 12/31/2006	".

SEC. 3366. 3-SULFINOBENZOIC ACID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.01	3-Sulfinobenzoic acid (CAS No. 15451–00–0) (provided for in subheading 2930.90.29)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3367. POLYDIMETHYLSILOXANE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.02	Polydimethylsiloxane (CAS No. 63148–62–9) (provided for in subheading 3910.00.00)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3368. BAYSILONE FLUID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.03	An alkyl modified polydimethylsiloxane (CAS No. 102782–93–4) (provided for in subheading 3910.00.00)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3369. ETHANEDIAMIDE, N-(2-ETHOXYPHENYL)-N′-(4-ISODECYLPHENYL)-.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.05	Preparations based on ethanediamide, N-(2-ethoxyphenyl)-N′-(4-isodecylphenyl)-(CAS No. 82493–14–9) (provided for in subheading 3812.30.60)	Free	Free	No change	On or before 12/31/2006	".

SEC. 3370. 1-ACETYL-4-(3-DODECYL-2, 5-DIOXO-1-PYRROLIDINYL)-2,2,6,6-TETRAMETHYL-PIPERIDINE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.06	1-Acetyl-4-(3-dodecyl-2,5-dioxo-1-pyrrolidinyl)-2,2,6,6-tetramethylpiperidine (CAS No. 106917–31–1) (provided for in subheading 2933.39.61)	Free	Free	No change	On or before 12/31/2006	".

SEC. 3371. ARYL PHOSPHONITE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.07	Reaction products of phosphorus trichloride with 1,1′-biphenyl and 2,4-bis(1,1-dimethylethyl)phenol (CAS No. 119345–01–6) (provided for in subheading 3812.30.60)	Free	Free	No change	On or before 12/31/2006	".

SEC. 3372. MONO OCTYL MALIONATE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.08	mono-2-Ethylhexyl maleate (CAS No. 7423–42–9) (provided for in subheading 2917.19.20)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3373. 3,6,9-TRIOXAUNDECANEDIOIC ACID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.04.09	3,6,9-Trioxaundecanedioic acid (CAS No. 13887–98–4) (provided for in subheading 2918.90.50)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3374. CROTONIC ACID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.04.10	(E)-2-Butenoic acid (Crotonic acid) (CAS No. 107–93–7) (provided for in subheading 2916.19.30)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3375. 1,3-BENZENEDICARBOXAMIDE, N, N′-BIS-(2,2,6,6-TETRAMETHYL-4-PIPERIDINYL)-.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.04.11	1,3-Benzenedicarboxamide, N,N′-bis-(2,2,6,6-tetramethyl-4-piperidinyl)- (CAS No. 42774–15–2) (provided for in subheading 2933.39.61)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3376. 3-DODECYL-1-(2,2,6,6-TETRAMETHYL-4-PIPERIDINYL)-2,5-PYRROLIDINEDIONE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.04.12	3-Dodecyl-1-(2,2,6,6-tetramethyl-4-piperidinyl)-2,5-pyrrolidinedione (CAS No. 79720–19–7) (provided for in subheading 2933.39.61)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3377. OXALIC ANILIDE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.04.13	Ethanediamide, N-(2-ethoxyphenyl)-N′-(2-ethylphenyl)- (CAS No. 23949–66–8) (provided for in subheading 2924.29.76)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3378. N-METHYL DIISOPROPANOLAMINE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.04.14	1,1′-(Methylamino)dipropan-2-ol (CAS No. 4402–30–6) (provided for in subheading 2922.19.95)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3379. 50 PERCENT HOMOPOLYMER, 3-(DIMETHYLAMINO) PROPYL AMIDE, DIMETHYL SULFATE-QUATERNIZED 50 PERCENT POLYRICINOLEIC ACID.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.04.15	Mixture (1:1) of polyricinoleic acid homopolymer, 3-(dimethylamino) propylamide, dimethyl sulfate, quaternized and polyricinoleic acid (provided for in subheading 3824.90.40)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3380. BLACK CPW STAGE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.16	2,7-Naphthalenedisulfonic acid, 4-amino-3-[[4-[[-4-[(2- or 4-amino-4 or 2-hydroxyphenyl)azo]phenyl]amino]-3-sulfophenyl]azo]-5-hydroxy-6-(phenylazo), trisodium salt) (CAS No. 85631–88–5) (provided for in subheading 3204.14.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3381. FAST BLACK 287 NA PASTE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.17	1,3-Benzenedicarboxylic acid, 5-[[4-[(7-amino-1-hydroxy-3-sulfo-2-naphthalenyl)azo]-1-naphthalenyl]azo]-, trisodium salt, in paste form (provided for in subheading 3204.14.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3382. FAST BLACK 287 NA LIQUID FEED.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.18	1,3-Benzenedicarboxylic acid, 5-[[4-[(7-amino-1-hydroxy-3-sulfo-2-naphthalenyl)azo]-1-naphthalenyl]azo]-, trisodium salt, in liquid form (provided for in subheading 3204.14.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3383. FAST YELLOW 2 STAGE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.19	1,3-Benzenedicarboxylic acid, 5,5′- [[6-(4-morpholinyl)-1,3,5-triazine-2,4-diyl]bis(imino-4,1-phenyleneazo)]bis-, ammonium/sodium/hydrogen salt (direct yellow 173) (provided for in either subheading 3204.14.30 or 3215.19.00.)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3384. CYAN 1 STAGE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.21	Copper [29H,31H-phthalo- cyaninato(2-)-N29,N30,N31,N32]-, aminosulfonylsulfo derivatives, tetramethylammonium salts (provided for in subheading 3204.14.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3385. YELLOW 1 STAGE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.24	1,5-Naphthalenedisulfonic acid, 3,3′- [[6-[(2-hydroxyethyl)amino]-1,3,5-triazine-2,4-diyl]bis[imino(2-methyl-4,1-phenylene)azo]]bis-, tetrasodium salt (CAS No. 50925-42–3) (provided for in subheading 3204.14.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3386. YELLOW 746 STAGE.

Subchapter II of chapter 99 of is amended by inserting in numerical sequence the following new heading:

"	9902.04.26	1,3-Bipyridirium, 3-carboxy-5′-[(2-carboxy-4-sulfophenyl)azo]-1′,2′-dihydro-6′-hydroxy-4′-methyl-2′-oxo-, inner salt, lithium/sodium salt (provided for in subheading 3204.14.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3387. BLACK SCR STAGE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.27	2,7-Naphthalenedi- sulfonic acid, 4-amino-3-[[4-[[-4-[(2 or 4-amino-4 or 2-hydroxyphenyl)-azo]- phenyl]amino]-3-sulfophenyl]- azo]-5-hydroxy-6-(phenylazo)-, trisodium salt (CAS No. 85631–88–5) (provided for in subheading 3204.14.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3388. MAGENTA 3B-OA STAGE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.28	2-[[4-Chloro-6-[[8-hydroxy-3,6-disulfonate-7-[(1-sulfo-2-naphthalenyl)azo]-1-naphthalenyl]amino]-1,3,5-triazin-2-yl]amino]-5-sulfobenzoic acid, sodium/lithium salts (CAS No. 12237–00–2) (provided for in subheading 3204.16.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3389. YELLOW 577 STAGE.

(a) Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.29	5-[4-[4-[4-(4,8-Disulfonaphthalen-2-ylazo)-phenylamino]-6-(2-sulfoethylamino)-1,3,5-triazin-2-ylamino]- phenylazo-[isophthalic acid, sodium salt (provided for in subheading 3204.14.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3390. CYAN 485/4 STAGE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.30	Copper, [29H,31H-phthalo-cyaninato(2-)-xN29,xN30,xN31,xN32]-aminosulfonyl-[(2-hydroxyethyl)amino]-sulfonylsulfo derivatives, sodium salt (provided for in subheading 3204.14.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3391. LOW EXPANSION LABORATORY GLASS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.32	Laboratory, hygienic, or pharmaceutical glassware, whether or not graduated or calibrated, of low expansion borosilicate glass or alumino-borosilicate glass, having a linear coefficient of expansion not exceeding 3.3 x 10^{-7} per Kelvin within a temperature range of 0 to 300°C (provided for in subheadings 7017.20.00 and 7020.00.60).	Free	No change	No change	On or before 12/31/2006	".

SEC. 3392. STOPPERS, LIDS, AND OTHER CLOSURES.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.33	Stoppers, lids, and other closures of low expansion borosilicate glass or alumino-borosilicate glass, having a linear coefficient of expansion not exceeding 3.3 x 10^{-7} per Kelvin within a temperature range of 0 to 300°C, produced by automatic machine (provided for in subheading 7010.20.20) or produced by hand (provided for in subheading 7010.20.30).	Free	No change	No change	On or before 12/31/2006	".

SEC. 3393. TRIFLUSULFURON METHYL FORMULATED PRODUCT.

(a) CALENDAR YEARS 2004 AND 2005.—Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.05.01	Mixtures of methyl 2-[[[[[4-(dimethylamino)- 6-(2,2,2-trifluoroethoxy)-1,3,5-triazin-2-yl]-amino]carbonyl]-amino]sulfonyl]-3-methylbenzoate (CAS No. 126535-15-7) and application adjuvants (provided for in subheading 3808.30.15)	1%	No change	No change	On or before 12/31/2006	”.

(b) CALENDAR YEAR 2006.—

(1) IN GENERAL.—Heading 9902.05.01, as added by subsection (a), is amended—

(A) by striking “1%” and inserting “Free”; and

(B) by striking “On or before 12/31/2005” and inserting “On or before 12/31/2007”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on January 1, 2006.

SEC. 3394. AGRUMEX (O-T-BUTYL CYCLOHEXANOL).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.05.02	o-tert-Butyl-cyclohexanol (CAS No. 13491-79-7) (provided for in subheading 2915.39.45)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3395. TRIMETHYL CYCLO HEXANOL (1-METHYL-3,3-DIMETHYLCYCLOHEXANOL-5).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.05.03	3,3,5-Trimethyl-cyclohexan-1-ol (CAS No. 116-02-9) (provided for in subheading 2906.19.50)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3396. MYCLOBUTANIL.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.91	alpha-Butyl-alpha-(4-chlorophenyl)-1H-1,2,4-triazole-1-propanenitrile (myclobutanil) (CAS No. 88671-89-0) (provided for in subheading 2933.99.06)	1.9%	No change	No change	On or before 12/31/2006	”.

SEC. 3397. METHYL CINNAMATE (METHYL-3-PHENYLPROPENOATE).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.05.04	Methyl cinnamate (methyl-3-phenylpropenoate) (CAS No. 103-26-4) (provided for in subheading 2916.39.20)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3398. ACETANISOLE (ANISYL METHYL KETONE).

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.05.05	p-Acetanisole (CAS No. 100-06-1) (provided for in subheading 2914.50.30)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3399. ALKYLKETONE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.02.53	1-(4-Chlorophenyl)- 4,4-dimethyl-3-pentanone (CAS No. 66346-01-8) (provided for in subheading 2914.70.40)	3.5%	No change	No change	On or before 12/31/2006	”.

SEC. 3400. IPRODIONE 3-(3-5, DICHOLOROPHENYL)-N-(1-METHYLETHYL)-2,4-DIOXO-1-IMIDAZOLIDINECARBOXAMIDE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.01.51	Iprodione (3-(3,5-dicholorophenyl)-N-(1-methylethyl)-2,4-dioxo-1-imidazolidinecarboxamide) (CAS No. 36734-19-7) (provided for in subheading 2933.21.00)	4.1%	No change	No change	On or before 12/31/2006	”.

SEC. 3401. DICHLOROBENZIDINE DIHYDROCHLORIDE.

(a) CALENDAR YEAR 2004.—Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.03.28	3,3′-Dichlorobenzi-dine dihydrochloride (CAS No. 612–83–9) (provided for in subheading 2921.59.80)	6.3% + 0.2 cents/kg	No change	No change	On or before 12/31/2004	”.

(b) CALENDAR YEARS 2005 AND 2006.—

(1) IN GENERAL.—Heading 9902.03.28, as added by subsection (a), is amended—

(A) by striking “6.3% + 0.2 cents/kg” and inserting “5.1%”; and

(B) by striking “On or before 12/31/2004” and inserting “On or before 12/31/2006”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on January 1, 2005.

SEC. 3402. KRESOXIM-METHYL.

(a) CALENDAR YEAR 2004.—Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.03.78	Methyl (E)- methoxyimino- [alpha-(o-tolyloxy)-o-tolyl]- acetate (kresoxim methyl) (CAS No. 143390–89–0) (provided for in subheading 2925.20.60)	3.3%	No change	Free	On or before 12/31/2004	”.

(b) CALENDAR YEARS 2005 AND 2006.—

(1) IN GENERAL.—Heading 9902.03.78, as added by subsection (a), is amended—

(A) by striking “3.3%” and inserting “2.4%”; and

(B) by striking “On or before 12/31/2004” and inserting “On or before 12/31/2006”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on January 1, 2005.

SEC. 3403. MKH 6562 ISOCYANATE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.05.06	2-(Trifluoro- methoxy)-benzenesulfonyl isocyanate (CAS No. 99722–81–3) (provided for in subheading 2930.90.29)	0.7%	No change	No change	On or before 12/31/2006	”.

SEC. 3404. CERTAIN RAYON FILAMENT YARN.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.05.07	High tenacity single yarn of viscose rayon (provided for in subheading 5403.10.30) with a decitex equal to or greater than 1,000	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3405. BENZENEPROPANAL, 4-(1,1-DIMETHYLETHYL)-ALPHA-METHYL.

(a) CALENDAR YEAR 2004.—Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.05.08	Benzenepropanal, 4-(1,1-dimethylethyl)-alpha-methyl- (CAS No. 80–54–6) (provided for in subheading 2912.29.60)	2.3%	No change	Free	On or before 12/31/2004	”.

(b) CALENDAR YEARS 2005 AND 2006.—

(1) IN GENERAL.—Heading 9902.05.08, as added by subsection (a), is amended—

(A) by striking “2.3%” and inserting “1.7%”; and

(B) by striking “On or before 12/31/2004” and inserting “On or before 12/31/2006”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on January 1, 2005.

SEC. 3406. 3,7-DICHLORO-8-QUINOLINE CARBOXYLIC ACID.

(a) CALENDAR YEAR 2004.—Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.05.09	3,7-Dichloro-8-quinolinecarb-oxylic acid (quinclorac) (CAS No. 84087–01–4) (provided for in subheading 2933.49.30)	3.9%	No change	Free	On or before 12/31/2004	”.

(b) CALENDAR YEARS 2005 AND 2006.—

(1) IN GENERAL.—Heading 9902.05.09, as added by subsection (a), is amended—

(A) by striking “3.9%” and inserting “3.3%”; and

(B) by striking “On or before 12/31/2004” and inserting “On or before 12/31/2006”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on January 1, 2005.

SEC. 3407. 3-(1-METHYLETHYL)-1H-2,1,3-BENZOTHIADIAZIN-4(3H)-ONE 2,2 DIOXIDE, SODIUM SALT.

(a) CALENDAR YEAR 2004.—Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.05.10	3-(1-Methyl- ethyl)-1H-2,1,3-benzothiadiazin-4(3H)-one-2,2-dioxide, sodium salt (bentazon, sodium salt) (CAS No. 50723–80–3) (provided for in subheading 2934.99.15)	1.8%	No change	Free	On or before 12/31/2004	”.

(b) CALENDAR YEARS 2005 AND 2006.—

(1) IN GENERAL.—Heading 9902.05.10, as added by subsection (a), is amended—

(A) by striking “1.8%” and inserting “2.6%”; and

(B) by striking “On or before 12/31/2004” and inserting “On or before 12/31/2006”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on January 1, 2005.

SEC. 3408. 3,3′,4-4′-BIPHENYLTETRACARBOXYLIC DIANHYDRIDE, ODA, ODPA, PMDA, AND 1,3-BIS(4-AMINOPHENOXY)BENZENE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new headings:

“	9902.05.11	3,3′,4,4′-Biphenyltetracarboxylic dianhydride (CAS No. 2420–87–3) (provided for in subheading 2917.39.30)	Free	No change	No change	On or before 12/31/2006	
“	9902.05.12	4,4′-Oxydianiline (CAS No. 101–80–4) (provided for in subheading 2922.29.80)	1.5%	No change	No change	On or before 12/31/2006	
“	9902.05.13	4,4′-Oxydiphthalic anhydride (CAS No. 1823–59–2) (provided for in subheading 2918.90.43)	Free	No change	No change	On or before 12/31/2006	
“	9902.05.14	Pyromellitic dianhydride (CAS No. 89–32–7) (provided for in subheading 2917.39.70)	Free	No change	No change	On or before 12/31/2006	
“	9902.05.15	1,3-Bis(4-aminophenoxy)- benzene (CAS No. 2479–46–1) (provided for in subheading 2922.29.29 or 2922.29.60)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3409. ORYZALIN.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.05.16	Oryzalin (benzenesulfonamide, 4-(dipropylamino)-3,5-dinitro-) (CAS No. 19044–88–3) (provided for in subheading 2935.00.95)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3410. TEBUFENOZIDE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.05.17	N-tert-Butyl-N′-(4-ethylbenzoyl)-3,5-dimethylbenzoylhydrazide (tebufenozide) (CAS No. 112410–23–8) (provided for in subheading 2928.00.25)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3411. ENDOSULFAN.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.05.18	6,7,8,9,10,10-Hexachloro-1,5,5a,6,9,9a-hexahydro-6,9-methano-2,4,3-benzodioxathiepin-3-oxide (thiosulfan) (CAS No. 115–29–7) (provided for in subheading 2920.90.10)	Free	Free	No change	On or before 12/31/2006	”.

SEC. 3412. ETHOFUMESATE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

“	9902.05.19	2-Ethoxy-2,3-dihydro-3,3-di-methyl-5-benzofuranyl-methanesulfonate (ethofumesate) (CAS No. 26225–79–6) in bulk or mixed with application adjuvants (provided for in subheading 2932.99.08 or 3808.30.15)	Free	Free	No change	On or before 12/31/2006	”.

SEC. 3413. NIGHT VISION MONOCULARS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.05.21	Hand-held night vision monoculars, other than those containing a micro-channel plate to amplify electrons or having a photocathode containing gallium arsenide (provided for in subheading 9005.80.60)	Free	Free	No change	On or before 12/31/2006	".

SEC. 3414. SOLVENT YELLOW 163.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.05.27	Solvent yellow 163 (CAS No. 13676-91-0) (provided for in subheading 3204.19.20)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3415. RAILWAY CAR BODY SHELLS FOR EMU'S.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following heading:

"	9902.86.09	Railway car body shells for electric multiple unit (EMU) commuter coaches of stainless steel, the foregoing which are designed for passenger coaches each having an aggregate passenger seating capacity up to 156 (including flip-up seating and wheelchair spaces) on two levels (provided for in subheading 8607.99.50)	Free	No change	No change	On or before 12/31/05	".

SEC. 3416. RAILWAY PASSENGER COACHES.

(a) IN GENERAL.—Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.86.10	Railway passenger coaches of stainless steel: one cab control and one trailer coach (pursuant to contract), gallery type coaches manufactured to contract specifications, each having an aggregate seating capacity of 130–150 seats (including flip-up seats and wheelchair spaces) on two levels (provided for in subheading 8605.00.00)	Free	No change	No change	On or before 12/31/06	".

SEC. 3417. RAILWAY ELECTRIC MULTIPLE UNIT (EMU) GALLERY COMMUTER COACHES OF STAINLESS STEEL.

Subchapter II of chapter 99 is amended by inserting in the numerical sequence the following new heading:

"	9902.86.11	Railway electric multiple unit (EMU) commuter coaches of stainless steel; the foregoing consisting of two finished EMU gallery-type coaches manufactured to contract specifications each, having an aggregate seating capacity of up to 156 seats (including flip-up seats and wheelchair spaces) on two levels. (provided for in subheading 8603.10.00)	Free	No change	No change	On or before 12/31/06	".

SEC. 3418. SNOWBOARD BOOTS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following subheading:

"	9902.64.04	Snowboard boots with uppers of textile materials (provided for in subheading 6404.11.90)	4%	No change	No change	On or before 12/31/06	".

SEC. 3419. HAND-HELD RADIO SCANNERS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.23	Electrical radiobroadcast receivers, intended to be hand-held, valued over $40 each, the foregoing designed to receive and monitor publicly transmitted radio communications (provided for in subheading 8527.19.50)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3420. MOBILE AND BASE RADIO SCANNERS THAT ARE COMBINED WITH A CLOCK.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.24	Electrical radiobroadcast receivers designed to receive and monitor publicly transmitted radio communications, valued at over $40 each, that are combined with a clock, and that are either mounted on a base or designed for use in an automobile or boat (provided for in subheading 8527.32.50)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3421. MOBILE AND BASE RADIO SCANNERS THAT ARE NOT COMBINED WITH A CLOCK.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.02.25	Electrical radiobroadcast receivers designed to receive and monitor publicly transmitted radio communications, valued at over $40 each, that are not combined with a clock, and that are either mounted on a base or designed for use in an automobile or boat (provided for in subheading 8527.39.00)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3422. CERTAIN FINE ANIMAL HAIR OF KASHMIR (CASHMERE) GOATS NOT PROCESSED.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.51.15	Fine animal hair of Kashmir (cashmere) goats; not processed in any manner beyond the degreased or carbonized condition (provided for in subheading 5102.11.10)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3423. CERTAIN FINE ANIMAL HAIR OF KASHMIR (CASHMERE) GOATS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.51.16	Fine animal hair of Kashmir (cashmere) goats (provided for in subheading 5102.11.90)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3424. CERTAIN R-CORE TRANSFORMERS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.85.04	120 volt/60 Hz electrical transformers (the foregoing and parts thereof provided for in subheading 8504.31.40 or 8504.90.95), with dimensions not exceeding 88 mm by 88 mm by 72 mm but at least 82 mm by 69 mm by 43 mm and each containing a layered and uncut round core with two balanced bobbins, the foregoing rated as less than 40 VA but greater than 32.2 VA with a rating number of R25	Free	No change	No change	On or before 12/31/2006	".

SEC. 3425. DECORATIVE PLATES.

(a) IN GENERAL.—Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.99	Decorative plates, whether or not with decorative rim or attached sculpture; decorative sculptures, each with plate or plaque attached; decorative plaques each not over 7.65 cm in thickness; architectural miniatures, whether or not put up in sets; all the foregoing of resin materials and containing agglomerated stone, put up for mail order retail sale, whether for wall or tabletop display and each weighing not over 1.36 kg together with their retail packaging (provided for in subheading 3926.40.00)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3426. BISPYRIBAC SODIUM.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.05.20	Sodium 2,6-bis[(4,6-dimethoxypyrimidin-2-yl)oxy]benzoate (Bispyribac-sodium) (CAS No. 125401–92–5) (provided for in subheading 2933.59.10)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3427. FENPROPATHRIN.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.05.22	α-Cyano-3-phenoxybenzyl 2,2,3,3-tetramethylcyclopropanecarboxylate (fenpropathrin) (CAS No. 39515–41–8) (provided for in subheading 2926.90.30)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3428. PYRIPROXYFEN.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.05.23	2-[1-Methyl-2-(4-phenoxyphenoxy)ethoxy]pyridine (Pyriproxyfen) (CAS No. 95737–68–1) (provided for in subheading 2933.39.27)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3429. UNICONAZOLE-P.

Subchapter II is amended by inserting in numerical sequence the following new heading:

"	9902.05.24	(E)-(+)-(S)-1-(4-Chlorophenyl)-4,4-dimethyl-2-(1,2,4-triazol-1-yl)-pent-1-ene-3-ol (Uniconazole) (CAS No. 83657–22–1), mixed with application adjuvants (provided for in subheading 3808.30.15)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3430. FLUMIOXAZIN.

Subchapter II is amended by inserting in numerical sequence the following new heading:

"	9902.05.25	2-[7-fluoro-3,4-dihydro-3-oxo-4-(2-propynl)-2*H*-1,4-benzoxazin-6-yl]-4,5,6,7-tetrahydro-1*H*-isoindole-1,3-(2*H*)-dione (Flumioxazin) (CAS No. 103361–09–7) (provided for in subheading 2934.99.15)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3431. NIGHT VISION MONOCULARS.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.05.26	Hand-held night vision monoculars, other than those containing a micro-channel plate to amplify electrons or having a photocathode containing gallium arsenide (provided for in subheading 9005.80.40)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3432. 2,4-XYLIDINE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.05.28	2,4-Xylidine (CAS No. 95–68–1) (provided for in subheading 2921.49.10)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3433. R118118 SALT.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.05.29	R118118 Salt - benzoic acid, 3-[2-chloro-4-(trifluoromethyl) phenoxy]-(CAS No. 63734–62–3) (provided in subheading 2918.90.20)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3434. NMSBA.

(a) CALENDAR YEAR 2004.—Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.05.30	4-(Methylsulfonyl)-2-nitrobenzoic acid (CAS No. 110964–79–9) (provided for in subheading 2916.39.45)	0.28%	No change	No change	On or before 12/31/2004	".

(b) CALENDAR YEAR 2005.—

(1) IN GENERAL.—Heading 9902.29.82, as added by subsection (a), is amended—

(A) by striking "0.28%" and inserting "0.16%"; and

(B) by striking "On or before 12/31/2004" and inserting "On or before 12/31/2005".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on January 1, 2005.

(c) CALENDAR YEARS 2006 THROUGH 2008.—

(1) IN GENERAL.—Heading 9902.29.82, as added by subsection (a) and amended by subsection (b), is further amended—

(A) by striking "0.16%" and inserting "1.1%"; and

(B) by striking "On or before 12/31/2005" and inserting "On or before 12/31/2008".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on January 1, 2006.

SEC. 3435. CERTAIN SATELLITE RADIO BROADCASTING APPARATUS.

(a) CALENDAR YEAR 2004.—Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.04.35	Reception apparatus for satellite radio broadcasting, other than satellite radio broadcast receivers described in subheading 8527.21.40 (provided in subheading 8527.90.95)	5.2%	No change	No change	On or before 12/31/2004	".

(b) CALENDAR YEAR 2005.—

(1) IN GENERAL.—Heading 9902.04.35, as added by subsection (a), is amended—

(A) by striking "5.2%" and inserting "5.4%"; and

(B) by striking "On or before 12/31/2004" and inserting "On or before 12/31/2005".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on January 1, 2005.

(c) CALENDAR YEAR 2006.—

(1) IN GENERAL.—Heading 9902.04.35, as added by subsection (a) and amended by this section, is further amended—

(A) by striking "5.4%" and inserting "5.5%"; and

(B) by striking "On or before 12/31/2005" and inserting "On or before 12/31/2006".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on January 1, 2006.

SEC. 3436. ACEPHATE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new heading:

"	9902.05.31	O,S-Dimethyl acetylphosphoramidothioate (Acephate) (CAS No. 30560–19–1) (provided for in subheading 2930.90.44)	Free	No change	No change	On or before 12/31/2006	".

SEC. 3437. MAGNESIUM ALUMINUM HYDROXIDE CARBONATE HYDRATE.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new subheading:

“	9902.05.32	Magnesium aluminum hydroxide carbonate hydrate (CAS No. 11097-59-9) (provided for in subheading 2842.90.00)	Free	No change	No change	On or before 12/31/2006	”.

SEC. 3438. CERTAIN FOOTWEAR.

Subchapter II of chapter 99 is amended by inserting in numerical sequence the following new subheading:

“	9902.05.35	Footwear consisting of an outer sole affixed to an incomplete or unfinished upper to which additional upper parts or material must be affixed to permit the footwear to be held to the foot, such footwear having a bottom of vulcanized rubber and produced by the hand-laid assembly process or hand made, the foregoing footwear of a type that is not designed to be worn over other footwear (provided for in subheadings 6401.99.30 and 6401.99.60	17%	No change	No change	On or before 12/31/2006	”.

Subchapter B—Existing Duty Suspensions and Reductions

SEC. 3451. EXTENSION OF CERTAIN EXISTING DUTY SUSPENSIONS.

(a) EXISTING DUTY SUSPENSIONS.—Each of the following headings is amended by striking out the date in the effective period column and inserting “12/31/2006”:

(1) Heading 9902.30.90 (relating to 3-amino-2′-(sulfato-ethyl sulfonyl) ethyl benzamide).

(2) Heading 9902.32.91 (relating to MUB 738 INT).

(3) Heading 9902.30.31 (relating to 5-amino-N-(2-hydroxyethyl)-2,3-xylenesulfonamide).

(4) Heading 9902.29.46 (relating to 2-amino-5-nitrothiazole).

(5) Heading 9902.32.14 (relating to 2-methyl-4,6-bis[(octylthio) methyl]phenol).

(6) Heading 9902.32.30 (relating to 4-[[4,6-bis(octylthio)-1,3,5-triazin-2-yl]amino]-2,6-bis(1,1-dimethylethyl)phenol).

(7) Heading 9902.32.16 (relating to calcium bis[monoethyl(3,5-di-tert-butyl-4-hydroxybenzyl) phosphonate]).

(8) Heading 9902.38.69 (relating to nicosulfuron formulated product (“Accent”)).

(9) Heading 9902.33.63 (relating to DPX-E9260).

(10) Heading 9902.33.59 (relating to DPX-E6758).

(11) Heading 9902.33.61 (relating to carbamic acid (U-9069)).

(12) Heading 9902.29.35 (relating to 1N-N5297).

(13) Heading 9902.28.19 (relating to an ultraviolet dye).

(14) Heading 9902.32.07 (relating to certain organic pigments and dyes).

(15) Heading 9902.29.07 (relating to 4-hexylresorcinol).

(16) Heading 9902.29.37 (relating to certain sensitizing dyes).

(17) Heading 9902.85.42 (relating to certain cathode-ray tubes).

(18) Heading 9902.30.14 (relating to a fluorinated compound).

(19) Heading 9902.29.55 (relating to a certain light absorbing photo dye).

(20) Heading 9902.32.55 (relating to methyl thioglycolate).

(21) Heading 9902.29.62 (relating to chloro amino toluene).

(22) Headings 9902.28.08, 9902.28.09, and 9902.28.10 (relating to bromine-containing compounds).

(23) Heading 9902.32.62 (relating to filter blue green photo dye).

(24) Heading 9902.32.99 (relating to 5-[(3,5-dichlorophenyl)-thio]-4-(1-methylethyl-1)-(4-pyridin lmethyl)-1H-imidazole-2-methanol carbamate).

(25) Heading 9902.32.97 (relating to (2E,4S)-4-(((2R,5S)-2-((4-fluorophenyl)-methyl)-6-methyl-5-((5-methyl-3-isoxazolyl)-carbonyl y)amino)-1,4-dioxoheptyl)-amino)-5-((3S)-2-oxo-3-pyrrolidinyl)-2-pentenoic acid, ethyl ester).

(26) Heading 9902.29.87 (relating to Baytron M).

(27) Heading 9902.39.15 (relating to Baytron P).

(28) Heading 9902.39.30 (relating to certain ion-exchange resins).

(29) Heading 9902.28.01 (relating to thionyl chloride).

(30) Heading 9902.32.12 (relating to DEMT).

(31) Heading 9902.29.03 (relating to p-hydroxybenzoic acid).

(32) Headings 9902.29.83 and 9902.38.10 (relating to iminodisuccinate).

(33) Heading 9902.38.14 (relating to mesamoll).

(34) Heading 9902.38.15 (relating to Baytron C-R).

(35) Heading 9902.29.25 (relating to ortho-phenylphenol (OPP)).

(36) Heading 9902.38.31 (relating to Vulkalent E/C).

(37) Heading 9902.31.14 (relating to desmedipham).

(38) Heading 9902.31.13 (relating to phenmedipham).

(39) Heading 9902.30.16 (relating to diclofop methyl).

(40) Heading 9902.33.40 (relating to R115777).

(41) Heading 9902.29.10 (relating to imazalil).

(42) Heading 9902.29.22 (relating to Norbloc 7966).

(43) Heading 9902.38.09 (relating to Fungaflor 500 EC).

(44) Heading 9902.32.73 (relating to Solvent Blue 124).

(45) Heading 9902.29.73 (relating to 4-amino-2,5-dimethoxy-N-phenylbenzene sulfonamide).

(46) Heading 9902.32.72 (relating to Solvent Blue 104).

(47) Heading 9902.34.01 (relating to sodium petroleum sulfonate).

(48) Heading 9902.29.71 (relating to isobornyl acetate).

(49) Heading 9902.29.70 (relating to certain TAED chemicals).

(50) Heading 9902.29.58 (relating to diethyl phosphorochidothioate).

(51) Heading 9902.29.17 (relating to 2,6-dichloroaniline).

(52) Heading 9902.29.59 (relating to benfluralin).

(53) Heading 9902.29.26 (relating to 1,3-diethyl-2-imidazolidinone).

(54) Heading 9902.29.06 (relating to diphenyl sulfide).

(55) Heading 9902.32.93 (relating to methoxyfenozide).

(56) Heading 9902.32.89 (relating to triazamate).

(57) Heading 9902.29.80 (relating to propiconazole).

(58) Heading 9902.32.92 (relating to β-Bromo-β-nitrostyrene).

(59) Heading 9902.29.61 (relating to quinoline).

(60) Heading 9902.29.25 (relating to 2-phenylphenol).

(61) Heading 9902.29.08 (relating to 3-amino-5-mercapto-1,2,4-triazole).

(62) Heading 9902.29.16 (relating to 4,4-dimethoxy-2-butanone).

(63) Heading 9902.32.87 (relating to fenbuconazole).

(64) Heading 9902.32.90 (relating to diiodomethyl-*p*-tolylsulfone).

(65) Heading 9902.28.16 (relating to propiophenone).

(66) Heading 9902.28.17 (relating to meta-chlorobenzaldehyde).

(67) Heading 9902.28.15 (relating to 4-bromo-2-fluoroacetanilide).

(68) Heading 9902.32.82 (relating to 2,6, dichlorotoluene).

(69) Heading 9902.80.05 (relating to cobalt boron).

(70) Heading 9902.72.02 (relating to ferroboron).

(71) Heading 9902.32.85 (relating to 4,4′ difluorobenzophenone).

(72) Heading 9902.29.34 (relating to certain light absorbing photo dyes).

(73) Heading 9902.29.38 (relating to certain imaging chemicals).

(74) Heading 9902.28.18 (relating to 3,5-dibromo-4-hydoxybenzonitril).

(75) Heading 9902.29.64 (relating to cyclanilide technical).

(76) Heading 9902.29.98 (relating to fipronil technical).

(77) Heading 9902.38.04 (relating to 3,5-dibromo-4-hydoxybenzonitril ester and inerts).

(78) Heading 9902.29.23 (relating to P-nitro toluene-o-sulfonic acid).

(79) Heading 9902.28.20 (relating to ammonium bifluoride).

(80) Heading 9902.39.01 (relating to poly(vinyl chloride) (PVC) self-adhesive sheets.

(81) Heading 9902.32.49 (relating to 11-aminoundecanoic acid).

(b) OTHER MODIFICATIONS.—

(1) CERTAIN CATHODE-RAY TUBES.—Heading 9902.85.41 is amended—

(A) by striking "1%" and inserting "Free"; and

(B) in the effective period column, by striking the date contained therein and inserting "12/31/2006".

(2) ETHALFLURALIN.—Heading 9902.30.49 is amended—

(A) by striking "3.5%" and inserting "Free"; and

(B) in the effective period column, by striking the date contained therein and inserting "12/31/2006".

(3) DMDS.—Heading 9902.33.92 is amended—

(A) by striking "2933.59.80" and inserting "2933.59.95"; and

(B) in the effective period column, by striking the date contained therein and inserting "12/31/2006".

(4) CERTAIN POLYAMIDES.—Heading 9902.39.08 is amended—

(A) by striking "forms of polyamide-6, polyamide-12, and polyamide-6,12 powders (CAS Nos. 25038-54-4, 25038-74-8, and 25191-04-1) (provided for in subheading 3908.10.00)" and inserting "ORGASOL® polyamide powders (provided for in subheading 3908.10.00 or 3908.90.70)"; and

(B) in the effective period column, by striking the date contained therein and inserting "12/31/2006".

(5) BUTRALIN.—Heading 9902.38.00 is amended by striking "3808.31.15" and inserting "3808.30.15".

(6) PRO-JET CYAN 1 RO FEED; PRO-JET FAST BLACK 287 NA PASTE/LIQUID FEED.—

(A) IN GENERAL.—Paragraph (2) in each of sections 1222(c) and 1223(c) of the Tariff Suspension and Trade Act of 2000 are amended by striking "January 1, 2001" and inserting "January 1, 2002".

(B) EFFECTIVE DATE.—The amendments made by subparagraph (A) shall take effect as if such amendments had been enacted immediately after the enactment of the Tariff Suspension and Trade Act of 2000.

(7) 2-METHYL-4-CHLOROPHENOXYACETIC ACID.—Heading 9902.29.81 is amended—

(A) in the general rate of duty column, by striking "2.6%" and inserting "1.8%"; and

(B) in the effective period column, by striking the date contained therein and inserting "12/31/2006".

(8) STARANE F.—Heading 9902.29.77 is amended—

(A) in the general rate of duty column, by striking "Free" and inserting "1.5%"; and

(B) in the effective period column, by striking the date contained therein and inserting "12/31/2006".

(9) TRIFLURALIN.—Heading 9902.29.02 is amended—

(A) by striking "3.3%" and inserting "Free"; and

(B) in the effective period column, by striking the date contained therein and inserting "12/31/2006".

(10) CERTAIN REDESIGNATIONS.—(A) The second heading 9902.29.02 (as added by section 1144 of the Tariff Suspension and Trade Act of 2000) is amended by redesignating such heading as heading 9902.05.33 and placing such heading in numerical sequence.

(B) The second heading 9902.39.07 (as added by section 1248 of the Tariff Suspension and Trade Act of 2000) by redesignating such heading as heading 9902.05.34 and placing such heading in numerical sequence.

(11) CERTAIN RAILWAY CAR BODY SHELLS.—(A) Heading 9902.86.07 is amended—

(i) in the article description, by striking "138" and inserting "up to 150"; and

(ii) in the effective period column, by striking the date contained therein and inserting "12/31/2006".

(B) Heading 9902.86.08 is amended—

(i) in the article description, by striking "148" and inserting "140"; and

(ii) in the effective period column, by striking the date contained therein and inserting "12/31/2006".

SEC. 3452. EFFECTIVE DATE.

Except as otherwise provided in this subchapter, the amendments made by this subchapter apply to goods entered, or withdrawn from warehouse for consumption, on or after January 1, 2004.

Chapter 2—Other Tariff Provisions

Subchapter A—Liquidation or Reliquidation of Certain Entries

SEC. 3501. CERTAIN TRAMWAY CARS.

(a) IN GENERAL.—Notwithstanding section 514 of the Tariff Act of 1930 (19 U.S.C. 1514) or any other provision of law, upon proper request filed with the United States Customs Service within 180 days after the date of the enactment of this Act, the Customs Service shall liquidate or reliquidate the entry described in subsection (c) as free of duty.

(b) REFUND OF AMOUNTS OWED.—Any amounts owed by the United States pursuant to a request for a liquidation or reliquidation of the entry under subsection (a) shall be refunded with interest within 180 days after the date on which request is made.

(c) AFFECTED ENTRY.—The entry referred to in subsection (a) is the entry on July 5, 2002, of 2 tramway cars (provided for in subheading 8603.10.00) manufactured in Plzen, Czech Republic, for the use of the city of Portland, Oregon (Entry number 529-0032191-1).

SEC. 3502. LIBERTY BELL REPLICA.

The Secretary of the Treasury shall admit free of duty a replica of the Liberty Bell imported from the Whitechapel Bell Foundry of London, England, by the Liberty Memorial Association of Green Bay and Brown County, Wisconsin, for use by the city of Green Bay, Wisconsin and Brown County, Wisconsin.

SEC. 3503. CERTAIN ENTRIES OF COTTON GLOVES.

(a) IN GENERAL.—Notwithstanding section 514 of the Tariff Act of 1930 (19 U.S.C. 1514) or any other provision of law, upon proper request filed with the United States Customs Service within 180 days after the date of the enactment of this Act, the Customs Service—

(1) shall reliquidate each entry described in subsection (c) containing any merchandise which, at the time of original liquidation, had been classified under subheading 6116.92.64 or subheading 6116.92.74; and

(2) shall reliquidate such merchandise under subheading 6116.92.88 at the rate of duty then applicable under such subheading.

(b) REFUND OF AMOUNTS OWED.—Any amounts owed by the United States pursuant to a request for the reliquidation of an entry under subsection (a) shall be refunded with interest within 180 days after the date on which request is made.

(c) AFFECTED ENTRIES.—The entries referred to in subsection (a) are as follows:

Entry number	Date of entry
0397329-2	02/02/00
0395844-2	12/15/99
0394509-2	09/27/99
0393293-4	08/11/99
0391942-8	06/21/99
0389842-4	04/01/99
0387094-4	12/21/98
0386845-0	12/16/98
0385488-0	10/28/98
0384053-3	09/01/98
0382090-7	06/04/98
0381125-5	04/11/98
0289673-4	01/26/98
0288778-2	12/10/97
0288085-2	11/07/97
0386624-0	08/02/97
0284468-4	04/29/97
0283060-0	03/10/97
0281394-5	11/27/96
0274823-2	01/10/96
0274523-8	12/22/95
0274113-8	11/30/95
0273038-8	10/13/95
0272524-8	09/14/95
0272128-8	08/23/95
0271540-5	07/27/95
0270995-2	07/03/95
0270695-8	06/09/95
0269959-1	05/09/95
0269276-0	04/04/95
0265832-4	11/02/94
0264841-6	09/08/94

SEC. 3504. CERTAIN ENTRIES OF POSTERS.

(a) IN GENERAL.—Notwithstanding section 514 of the Tariff Act of 1930 (19 U.S.C. 1514) or any other provision of law and subject to the provisions of subsection (b), the United States Customs Service shall, not later than 90 days after the receipt of the request described in subsection (b), liquidate or reliquidate each entry described in subsection (d) containing any merchandise which, at the time of the original liquidation, was classified under subheading 4911.91.20 at the rate of duty that would have been applicable to such merchandise if the merchandise had been liquidated or reliquidated under subheading 4911.91.40 on the date of entry.

(b) REQUESTS.—Reliquidation may be made under subsection (a) with respect to an entry described in subsection (c) only if a request therefor is filed with the Customs Service within 90 days after the date of the enactment of this Act.

(c) PAYMENT OF AMOUNTS OWED.—Any amounts owed by the United States pursuant to the liquidation or reliquidation of an entry under subsection (a) shall be paid not later than 90 days after the date of such liquidation or reliquidation.

(d) AFFECTED ENTRIES.—The entries referred to in subsection (a) are as follows:

Entry number	Date of entry
F1126496605	09/24/00
F1117735656	10/18/00
90100999235	02/14/01
90101010321	04/23/01
90101001700	02/28/01
28100674408	04/25/01
28100671081	04/09/01
28100670398	04/06/01
F1126187352	06/19/00
F1126530833	10/05/00
28100678433	05/18/01
90100999235	04/14/01
90101001700	02/28/01

SEC. 3505. CERTAIN ENTRIES OF POSTERS ENTERED IN 1999 AND 2000.

(a) IN GENERAL.—Notwithstanding section 514 of the Tariff Act of 1930 (19 U.S.C. 1514) or any other provision of law and subject to the provisions of subsection (b), the United States Customs Service shall—

(1) not later than 90 days after the receipt of the request described in subsection (b), liquidate or reliquidate each entry described in subsection (c) containing any merchandise which, at the time of the original liquidation, was classified under subheading 4911.91.20 at the rate of duty that would have been applicable to such merchandise if the merchandise had been liquidated or reliquidated under subheading 4911.91.40 on the date of entry; and

(2) within 90 days after such liquidation or reliquidation—

(A) refund any excess duties paid with respect to such entries, including interest from the date of entry; or

(B) relieve the importer of record of any excess duties, penalties, or fines associated with the excess duties.

(b) REQUESTS.—Reliquidation may be made under subsection (a) with respect to any entry described in subsection (c) only if a request therefor is filed with the Customs Service within 90 days after the date of the enactment of this Act.

(c) ENTRIES.—The entries referred to in subsection (a) are as follows:

Entry number	Date of entry
582-0002495-7	September 2, 1999
582-0093847-9	November 19, 1999
582-8905213-4	March 8, 1999
582-2250697-3	February 21, 2000
582-0197509-0	February 18, 2000
582-1296965-2	February 20, 2000
582-0212609-9	March 1, 2000
582-0215607-0	March 3, 2000
582-0242091-4	March 24, 2000
582-0046610-9	October 12, 1999
582-0251198-5	March 31, 2000
582-0002495-7	September 2, 1999
528-0088559-7	November 16, 1999
582-0093847-9	November 19, 1999
582-0068164-0	October 29, 1999
582-0163876-3	January 20, 2000
582-0136646-4	December 22, 1999
582-0126598-9	December 15, 1999
582-0111417-9	December 3, 1999
445-2163068-9	November 14, 1999
445-2161190-3	September 6, 1999
445-2163176-0	November 18, 1999
445-2164563-8	January 13, 2000
445-2166869-7	April 12, 2000
445-2162118-3	October 10, 1999
U16-0101858-7	May 2, 2000
182-0167758-2	November 1, 2000

SEC. 3506. CERTAIN ENTRIES OF 13-INCH TELEVISIONS.

(a) IN GENERAL.—Notwithstanding section 514 of the Tariff Act of 1930 (19 U.S.C. 1514) or any other provision of law and subject to the provisions of subsection (b), the United States Customs Service shall, not later than 180 days after the receipt of the request described in subsection (b), liquidate or reliquidate each entry described in subsection (d) containing any merchandise which, at the time of the original liquidation, was classified under the following subheadings with respect to which there would have been no duty or a lesser duty if the amendments made by section 1003 of the Miscellaneous Trade and Technical Corrections Act of 1999 had applied to such entry or withdrawal:

(1) Subheading 8528.12.12.
(2) Subheading 8528.12.20.
(3) Subheading 8528.12.62.
(4) Subheading 8528.12.68.
(5) Subheading 8528.12.76.
(6) Subheading 8528.12.84.
(7) Subheading 8528.21.16.
(8) Subheading 8528.21.24.
(9) Subheading 8528.21.55.
(10) Subheading 8528.21.65.
(11) Subheading 8528.21.75.
(12) Subheading 8528.21.85.
(13) Subheading 8528.30.62.
(14) Subheading 8528.30.66.
(15) Subheading 8540.11.24.
(16) Subheading 8540.11.44.

(b) REQUESTS.—Reliquidation may be made under subsection (a) with respect to an entry described in subsection (d) only if a request therefor is filed with the Customs Service within 90 days after the date of the enactment of this Act, and the request contains sufficient information to enable the Customs Service to locate the entry or reconstruct the entry if it cannot be located.

(c) PAYMENT OF AMOUNTS OWED.—Any amounts owed by the United States pursuant to the liquidation or reliquidation of an entry under subsection (a) shall be paid not later than 180 days after the date of such liquidation or reliquidation.

(d) AFFECTED ENTRIES.—The entries referred to in subsection (a), are as follows:

Entry number	Date of entry	Date of liquidation
110-17072538	11/03/98	09/17/99
110-17091314	11/23/98	10/08/99
110-17091322	11/23/98	10/08/99
110-17216804	12/31/98	11/12/99
110-20748215	04/20/99	03/03/00
110-20762802	04/28/99	03/10/00
110-20848544	05/12/99	03/31/00
110-20848569	05/18/99	03/31/00
110-20988456	06/22/99	05/04/00
110-20993563	06/22/99	05/15/00
110-20997705	06/22/99	05/05/00
110-63822017	06/09/97	05/05/00
110-63822041	06/09/97	
110-63822082	06/09/97	
110-68575370	07/11/97	05/22/98
110-68575610	07/11/97	05/22/98
110-15093163	10/05/98	08/20/99
110-15173551	11/02/98	09/17/99
110-17091132	11/07/98	09/24/99
110-17217265	12/05/98	10/15/99
110-20762364	04/12/99	02/18/00
110-63822025	06/09/97	
110-75485118	02/12/98	12/28/98
110-75492643	02/12/98	12/28/98
110-75793447	07/07/98	05/21/99
110-20993704	06/20/99	05/05/00
110-66600972	06/07/97	04/17/98
110-66603414	06/14/97	
110-66603448	06/07/97	04/17/98
110-66617810	06/21/97	05/01/98
110-66618099	06/23/97	05/08/98
110-68156429	07/12/97	05/22/98
110-68165818	07/19/97	05/29/98
110-68165826	07/19/97	05/29/98
110-68171576	07/26/97	06/05/98
110-68175767	08/02/97	06/12/98
110-68177029	08/02/97	06/12/98
110-68217833	08/16/97	06/26/98
110-68220167	08/16/97	07/06/98
110-68220183	08/19/97	07/06/98
110-68233418	08/24/97	07/10/98
110-68234424	08/25/97	07/10/98
110-70008550	09/20/97	07/31/98
110-70014707	09/20/97	07/31/98
110-70014723	09/20/97	07/31/98
110-70014731	09/30/97	07/31/98
110-70014756	09/20/97	07/31/98
110-70014798	09/20/97	07/31/98
110-70100464	10/11/97	08/21/98
110-70106651	10/19/97	09/04/98
110-70106669	10/19/97	09/04/98
110-70112584	10/25/97	09/04/98
110-70113970	10/25/97	09/04/98
110-70113996	10/25/97	09/04/98
110-70115199	10/25/97	09/04/98
110-70190978	11/08/97	09/18/98
110-70192990	11/08/97	09/18/98
110-70198906	11/15/97	09/25/98
110-70198914	11/15/97	09/25/98
110-70204233	11/29/97	10/09/98
110-70204266	11/22/97	10/02/98
110-75399046	12/19/97	10/30/98
110-75399103	01/04/98	11/20/98
110-75481455	01/24/98	12/04/98
110-75485563	01/24/98	12/04/98
110-75494953	02/07/98	12/18/98
110-04901383	07/11/97	05/22/98
110-33326985	07/07/97	05/22/98
110-63019333	07/11/97	05/22/98
110-63821993	06/07/97	04/17/98
110-66600378	06/20/97	05/01/98
110-66601004	06/20/97	05/01/98
110-66603380	06/20/97	05/01/98
110-66625441	07/07/97	05/22/98
110-66626951	07/07/97	05/22/98
110-68175825	08/04/97	06/19/98
110-68182938	08/11/97	06/26/98
110-68184140	08/11/97	06/26/98
110-68184918	08/11/97	06/26/98
110-68184926	08/11/97	06/26/98
110-68184934	08/11/97	06/26/98
110-68184942	08/11/97	06/26/98
110-68229994	09/08/97	07/24/98
110-68230000	09/08/97	07/24/98
110-68230232	09/03/97	07/17/98
110-70009715	09/22/97	08/07/98
110-70024698	10/07/98	08/21/98
110-70028764	10/13/97	08/28/98
110-70028772	10/13/97	08/28/98
110-70103625	10/30/98	09/11/98
110-70186810	11/13/97	09/25/98
110-70190937	11/26/97	10/09/98
110-70192362	11/19/97	10/02/98
110-70199151	11/26/97	10/09/98
110-70204555	12/04/97	10/16/98
110-70204563	12/04/97	10/16/98
110-70206360	12/06/97	10/23/98
110-75399079	01/07/98	11/20/98
110-75492627	02/11/98	12/28/98
110-75492635	02/11/98	12/28/98
110-14975204	09/15/98	07/30/99
110-20848643	05/19/99	05/31/00
110-20988472	06/20/99	05/05/00
110-20993589	06/20/99	05/05/00
110-75485126	02/11/98	12/28/98
110-75793405	07/16/98	05/28/99
110-75793611	08/04/98	06/18/99
110-75931278	08/16/98	07/02/99
110-75938893	08/16/98	07/23/99

SEC. 3507. NEOPRENE SYNCHRONOUS TIMING BELTS.

(a) IN GENERAL.—Notwithstanding sections 514 and 520 of the Tariff Act of 1930 (19 U.S.C. 1514 and 1520), or any other provision of law, the United States Customs Service shall, not later than 90 days after the date of the enactment of this Act, liquidate or reliquidate the entries described in subsection (c).

(b) PAYMENT OF AMOUNTS OWED.—Any amounts owed by the United States pursuant to the liquidation or reliquidation of the entries under subsection (a), with interest accrued from the date of entry, shall be paid by the Customs Service within 90 days after such liquidation or reliquidation.

(c) ENTRIES.—The entries referred to in subsection (a) are the following:

Entry number	Date of entry	Date of liquidation
469/00133193	07/06/89	11/22/91
469/00136022	07/28/89	11/22/91
469/00143135	09/26/89	02/09/90
469/00148969	11/08/89	03/02/90
469/00152565	12/06/89	03/30/90
469/00154785	12/28/89	11/29/91
469/00159461	02/01/90	11/22/91
469/00161921	02/26/90	11/22/91
469/00170237	04/24/90	11/22/91
469/00173546	05/21/90	11/22/91
469/00176218	06/06/90	03/13/92
469/00137038	08/08/89	11/29/91
469/00152599	12/06/89	03/30/90
469/00152607	12/06/89	04/06/90
469/0015961C	02/06/90	11/29/91
469/00169205	04/17/90	08/10/90

SEC. 3508. LIQUIDATION OF CERTAIN ENTRIES OF ROLLER CHAIN.

(a) LIQUIDATION OR RELIQUIDATION OF ENTRIES.—Notwithstanding sections 514 and 520 of the Tariff Act of 1930 (19 U.S.C. 1514 and 1520) or any other provision of law, the United States Customs Service shall, not later than 90 days after the date of the enactment of this Act, liquidate or reliquidate the entries listed in subsection (b) without assessment of interest acrrued after December 31, 1994, and shall refund any such interest which was previously paid.

(b) AFFECTED ENTRIES.—The entries referred to in subsections (a) and (b) are the following:

Entry number	Date of entry	Port
12606577	05/04/89	Columbia-Snake River (Portland, Oregon)
12606593	05/08/89	Columbia-Snake River (Portland, Oregon)
12607492	05/30/89	Columbia-Snake River (Portland, Oregon)
12608680	06/09/89	Columbia-Snake River (Portland, Oregon)
00054863	07/28/89	Columbia-Snake River (Portland, Oregon)
00056181	08/21/89	Columbia-Snake River (Portland, Oregon)
00057973	09/25/89	Columbia-Snake River (Portland, Oregon)
25761120	11/20/89	Columbia-Snake River (Portland, Oregon)
25767150	03/12/90	Columbia-Snake River (Portland, Oregon)
25767762	03/22/90	Columbia-Snake River (Portland, Oregon)
85-4232312	04/09/85	Columbia-Snake River (Portland, Oregon)
85-4237582	07/18/85	Columbia-Snake River (Portland, Oregon)
85-4238086	07/25/85	Columbia-Snake River (Portland, Oregon)
85-4238976	08/19/85	Columbia-Snake River (Portland, Oregon)
85-4464818	09/11/85	Columbia-Snake River (Portland, Oregon)
85-4466722	09/27/85	Columbia-Snake River (Portland, Oregon)
86-4307787	10/30/85	Columbia-Snake River (Portland, Oregon)
86-4310389	11/21/85	Columbia-Snake River (Portland, Oregon)
86-4311715	12/31/85	Columbia-Snake River (Portland, Oregon)
86-4312109	01/10/86	Columbia-Snake River (Portland, Oregon)
86-4317078	02/28/86	Columbia-Snake River (Portland, Oregon)
86-4318349	03/17/86	Columbia-Snake River (Portland, Oregon)
85-4235937	06/15/85	Columbia-Snake River (Portland, Oregon)
36074057	09/12/96	Columbia-Snake River (Portland, Oregon)
36071137	05/08/96	Columbia-Snake River (Portland, Oregon)
36078074	03/26/97	Columbia-Snake River (Portland, Oregon)
85-4464177	08/26/85	Columbia-Snake River (Portland, Oregon)
36077688	03/11/97	Columbia-Snake River (Portland, Oregon)
36072788	07/18/96	Columbia-Snake River (Portland, Oregon)
36074990	11/06/96	Columbia-Snake River (Portland, Oregon)
81-4139170	06/30/81	Columbia-Snake River (Portland, Oregon)
81-4139992	07/23/81	Columbia-Snake River (Portland, Oregon)
81-4140868	08/06/81	Columbia-Snake River (Portland, Oregon)
81-4140871	08/07/81	Columbia-Snake River (Portland, Oregon)
81-4141469	08/28/81	Columbia-Snake River (Portland, Oregon)
81-4142219	09/23/81	Columbia-Snake River (Portland, Oregon)
82-4139364	11/03/81	Columbia-Snake River (Portland, Oregon)
82-4140939	12/02/81	Columbia-Snake River (Portland, Oregon)
82-4141598	12/15/81	Columbia-Snake River (Portland, Oregon)
82-4142571	01/14/82	Columbia-Snake River (Portland, Oregon)
82-4143499	03/02/82	Columbia-Snake River (Portland, Oregon)
82-4145390	04/01/82	Columbia-Snake River (Portland, Oregon)
82-4146179	04/22/82	Columbia-Snake River (Portland, Oregon)
82-4147932	06/02/82	Columbia-Snake River (Portland, Oregon)
82-4148601	06/22/82	Columbia-Snake River (Portland, Oregon)
82-4149626	07/29/82	Columbia-Snake River (Portland, Oregon)
82-4150291	08/10/82	Columbia-Snake River (Portland, Oregon)
82-4151203	09/14/82	Columbia-Snake River (Portland, Oregon)
83-4124149	10/07/82	Columbia-Snake River (Portland, Oregon)
83-4124547	10/14/82	Columbia-Snake River (Portland, Oregon)
83-4125342	11/08/82	Columbia-Snake River (Portland, Oregon)
83-4125407	11/15/82	Columbia-Snake River (Portland, Oregon)
83-4126011	12/08/82	Columbia-Snake River (Portland, Oregon)
094126448	12/21/82	Columbia-Snake River (Portland, Oregon)
83-4126927	12/29/82	Columbia-Snake River (Portland, Oregon)
83-4127191	01/10/83	Columbia-Snake River (Portland, Oregon)
83-4129050	02/28/83	Columbia-Snake River (Portland, Oregon)
83-4129678	03/17/83	Columbia-Snake River (Portland, Oregon)
83-4129937	03/30/83	Columbia-Snake River (Portland, Oregon)
83-4131491	04/29/83	Columbia-Snake River (Portland, Oregon)
83-4133460	06/15/83	Columbia-Snake River (Portland, Oregon)
84-4154743	11/29/83	Columbia-Snake River (Portland, Oregon)
84-4161972	04/18/84	Columbia-Snake River (Portland, Oregon)
84-4163543	05/22/84	Columbia-Snake River (Portland, Oregon)
84-4164568	06/13/84	Columbia-Snake River (Portland, Oregon)
84-4161972	06/18/84	Columbia-Snake River (Portland, Oregon)
84-4165758	07/06/84	Columbia-Snake River (Portland, Oregon)
84-4421214	07/30/84	Columbia-Snake River (Portland, Oregon)

Entry number	Date of entry	Port
84-4421366	08/06/84	Columbia-Snake River (Portland, Oregon)
84-4421418	08/22/84	Columbia-Snake River (Portland, Oregon)
84-4424389	09/21/84	Columbia-Snake River (Portland, Oregon)
85-4220094	10/03/84	Columbia-Snake River (Portland, Oregon)
85-4220816	10/11/84	Columbia-Snake River (Portland, Oregon)
85-4221527	10/25/84	Columbia-Snake River (Portland, Oregon)
85-4222199	11/07/84	Columbia-Snake River (Portland, Oregon)
85-4222856	11/15/84	Columbia-Snake River (Portland, Oregon)
85-4224126	12/10/84	Columbia-Snake River (Portland, Oregon)
85-4225413	01/15/85	Columbia-Snake River (Portland, Oregon)
85-4230071	02/28/85	Columbia-Snake River (Portland, Oregon)
85-4231070	03/18/85	Columbia-Snake River (Portland, Oregon)
85-4234828	05/21/85	Columbia-Snake River (Portland, Oregon)
85-4237524	07/15/85	Columbia-Snake River (Portland, Oregon)
12561053	05/13/87	Columbia-Snake River (Portland, Oregon)
12563349	06/20/87	Columbia-Snake River (Portland, Oregon)
12564826	07/19/87	Columbia-Snake River (Portland, Oregon)
12567126	08/20/87	Columbia-Snake River (Portland, Oregon)
12568835	09/18/87	Columbia-Snake River (Portland, Oregon)
12570963	10/21/87	Columbia-Snake River (Portland, Oregon)
12574346	12/15/87	Columbia-Snake River (Portland, Oregon)
12574619	12/23/87	Columbia-Snake River (Portland, Oregon)
12577752	02/03/88	Columbia-Snake River (Portland, Oregon)
25768422	04/09/90	Columbia-Snake River (Portland, Oregon)
25768752	04/16/90	Columbia-Snake River (Portland, Oregon)
25770750	05/15/90	Columbia-Snake River (Portland, Oregon)
25770758	05/22/90	Columbia-Snake River (Portland, Oregon)
25772333	06/26/90	Columbia-Snake River (Portland, Oregon)
25773828	07/25/90	Columbia-Snake River (Portland, Oregon)
20281783	08/22/90	Columbia-Snake River (Portland, Oregon)
20281809	08/24/90	Columbia-Snake River (Portland, Oregon)
20288762	10/08/90	Columbia-Snake River (Portland, Oregon)
20291360	11/01/90	Columbia-Snake River (Portland, Oregon)
20296245	11/29/90	Columbia-Snake River (Portland, Oregon)
20300369	01/04/91	Columbia-Snake River (Portland, Oregon)
20305772	02/19/91	Columbia-Snake River (Portland, Oregon)
83-4130751	04/18/83	Columbia-Snake River (Portland, Oregon)
83-4131365	05/04/83	Columbia-Snake River (Portland, Oregon)
83-4132649	06/02/83	Columbia-Snake River (Portland, Oregon)
83-4133486	06/23/83	Columbia-Snake River (Portland, Oregon)
83-4134935	07/27/83	Columbia-Snake River (Portland, Oregon)
83-4135617	08/15/83	Columbia-Snake River (Portland, Oregon)
83-4136056	08/30/83	Columbia-Snake River (Portland, Oregon)
83-4137178	09/23/83	Columbia-Snake River (Portland, Oregon)
84-4152253	10/12/83	Columbia-Snake River (Portland, Oregon)
84-4153689	11/04/83	Columbia-Snake River (Portland, Oregon)
84-4154662	11/29/83	Columbia-Snake River (Portland, Oregon)
84-4156110	12/29/83	Columbia-Snake River (Portland, Oregon)
84-4156709	01/13/84	Columbia-Snake River (Portland, Oregon)
84-4157245	01/25/84	Columbia-Snake River (Portland, Oregon)
84-4158419	02/13/84	Columbia-Snake River (Portland, Oregon)
84-4158956	02/27/84	Columbia-Snake River (Portland, Oregon)
84-4160672	03/29/84	Columbia-Snake River (Portland, Oregon)
85-4236596	06/28/85	Columbia-Snake River (Portland, Oregon)
12581978	04/06/88	Columbia-Snake River (Portland, Oregon)
12586944	06/22/88	Columbia-Snake River (Portland, Oregon)
12588411	07/14/88	Columbia-Snake River (Portland, Oregon)
12590052	08/10/88	Columbia-Snake River (Portland, Oregon)
12591464	08/31/88	Columbia-Snake River (Portland, Oregon)
12592843	09/21/88	Columbia-Snake River (Portland, Oregon)
12594153	10/06/88	Columbia-Snake River (Portland, Oregon)
12594526	10/12/88	Columbia-Snake River (Portland, Oregon)
12595051	10/21/88	Columbia-Snake River (Portland, Oregon)
12600166	01/11/89	Columbia-Snake River (Portland, Oregon)
12604259	03/25/89	Columbia-Snake River (Portland, Oregon)
85-4221705	10/29/84	Columbia-Snake River (Portland, Oregon)
85-4422876	05/25/85	Los Angeles, California
81-1328861	09/28/81	Honolulu, Hawaii
85-1340139	11/19/84	Honolulu, Hawaii
83-1310040	10/21/82	Honolulu, Hawaii
84-1326082	11/16/83	Honolulu, Hawaii
86-1129340	10/17/85	Honolulu, Hawaii
86-1135525	03/11/86	Honolulu, Hawaii

Entry number	Date of entry	Port
85-2326987	04/22/85	San Francisco, California
31585289	04/02/96	San Francisco, California
31594950	12/02/96	San Francisco, California
82-1627918	04/27/82	San Francisco, California
83-1668145	10/19/82	San Francisco, California
83-1671640	11/05/82	San Francisco, California
83-1689496	12/23/82	San Francisco, California
07202257	05/23/90	San Francisco, California
07204287	09/05/90	San Francisco, California
84-2390622	07/12/84	Seattle, Washington

SEC. 3509. RELIQUIDATION OF DRAWBACK CLAIM RELATING TO JUICES ENTERED IN APRIL 1993.

(a) IN GENERAL.—Notwithstanding section 514 of the Tariff Act of 1930 (19 U.S.C. 1514) or any other provision of law, the United States Customs Service shall, not later than 90 days after the date of the enactment of this Act, reliquidate the entry described in subsection (c) at the full amount claimed in such entry.

(b) PAYMENT OF AMOUNTS OWED.—Any amounts owed by the United States pursuant to the reliquidation under subsection (a) shall be paid by the Customs Service within 90 days after such reliquidation.

(c) AFFECTED ENTRY.—The entry referred to in subsection (a) is as follows:

Entry Number	Date of Entry	Date of Liquidation
032-0001141-3	04/28/93	06/25/99

SEC. 3510. RELIQUIDATION OF DRAWBACK CLAIM RELATING TO JUICES ENTERED IN MARCH 1994.

(a) IN GENERAL.—Notwithstanding section 514 of the Tariff Act of 1930 (19 U.S.C. 1514) or any other provision of law, the United States Customs Service shall, not later than 90 days after the date of the enactment of this Act, reliquidate the entry described in subsection (c) at the full amount claimed in such entry.

(b) PAYMENT OF AMOUNTS OWED.—Any amounts owed by the United States pursuant to the reliquidation under subsection (a) shall be paid by the Customs Service within 90 days after such reliquidation.

(c) AFFECTED ENTRY.—The entry referred to in subsection (a) is as follows:

Entry Number	Date of Entry	Date of Liquidation
032-0001138-9	03/30/94	06/25/99

SEC. 3511. CERTAIN ENTRIES PREMATURELY LIQUIDATED IN ERROR.

(a) IN GENERAL.—Notwithstanding sections 514 and 520 of the Tariff Act of 1930 (19 U.S.C. 1514 and 1520), or any other provision of law, the United States Customs Service shall, not later than 90 days after the date of the enactment of this Act, reliquidate those entries described in subsection (c), in accordance with the final decision of the International Trade Administration of the Department of Commerce, and the final results of the administrative reviews, for entries made on or after December 1, 1993, and before April 1, 2001.

(b) PAYMENT OF AMOUNTS OWED.—Any amounts owed by the United States pursuant to the liquidation or reliquidation of an entry under subsection (a) shall be paid by the Customs Service within 90 days after such liquidation or reliquidation.

(c) ENTRY LIST.—The entries referred to in subsection (a), are as follows:

Entry number	Date of entry	Date of liquidation
669-26046013	02/09/94	07/12/96
112-62707166	02/12/94	05/14/99
669-26046716	03/05/94	07/12/96
669-26046997	03/16/94	07/12/96
669-26047094	03/22/94	07/12/96
669-26047508	04/03/94	07/12/96
225-41000430	04/11/94	07/29/94
669-26047862	04/19/94	07/12/96
669-26048027	04/22/94	07/12/96
669-26048050	04/22/94	07/12/96
669-26048068	04/22/94	07/12/96
669-26049199	06/05/94	07/12/96
051-01380045	06/14/94	06/21/96
225-21019541	07/02/94	Unknown
669-26050742	07/20/94	07/12/96
669-26051294	08/16/94	07/19/96
669-26051377	08/17/94	07/12/96
669-26051401	08/23/94	07/19/96
051-01378452	09/01/94	08/16/96
669-26051906	09/06/94	07/19/96
669-26052714	10/05/94	07/19/96
669-26054629	01/02/95	07/12/96
669-26054918	01/21/95	07/12/96
669-00985582	02/17/95	09/17/99
225-41030148	05/01/95	01/20/95
112-85106669	06/07/95	02/25/00
112-80968196	08/03/95	11/17/95
669-26059347	09/02/95	07/12/96
112-79650961	09/27/95	12/29/95
669-28017335	10/06/95	06/14/96
112-05038720	05/01/96	08/02/96
112-17629326	01/06/97	04/18/97
112-17629326	03/12/97	04/18/97
669-01225053	06/12/97	10/15/99
669-01223637	06/25/97	10/08/99
669-01225418	06/25/97	10/08/99
669-01225913	06/27/97	10/08/99
669-01227380	07/03/97	10/08/99
669-01232166	07/07/97	10/08/99
669-01230533	07/09/97	10/08/99
669-01236357	07/30/97	10/08/99
100-47966294	08/08/97	08/26/99
669-01241811	08/13/97	10/08/99
669-01245838	08/27/97	10/08/99
669-01247933	09/04/97	10/15/99
669-01251448	09/21/97	10/08/99
669-01254020	09/24/97	10/08/99
669-01256801	10/01/97	10/08/99
669-01259466	10/15/97	10/08/99
669-01260753	10/15/97	10/08/99
669-01261363	10/16/97	10/08/99
669-01262650	10/22/97	10/08/99
669-01263856	10/24/97	10/08/99
669-01267337	11/06/97	10/08/99
669-01269200	11/12/97	10/08/99
669-01271784	11/20/97	10/08/99
669-01271800	11/23/97	10/08/99
669-01272907	11/30/97	10/08/99
669-01273673	11/30/97	10/08/99
669-01274119	11/30/97	10/08/99
669-01276585	12/04/97	10/08/99
669-01278763	12/14/97	10/15/99
669-01283441	12/30/97	10/08/99
669-01296948	01/09/98	10/08/99
669-01292186	01/22/98	10/08/99
669-04201964	01/23/98	10/08/99
112-14206987	01/23/98	02/22/99
669-01295130	02/01/98	10/08/99
669-01296955	02/05/98	10/08/99
669-01297649	02/12/98	10/08/99
669-01298530	02/12/98	10/08/99
669-01302126	02/21/98	10/08/99
669-01302134	02/21/98	10/08/99
669-01302530	02/21/98	10/08/99
669-01303546	02/21/98	10/08/99
669-01304569	02/27/98	10/08/99
669-01305947	03/05/98	10/08/99
669-01306978	03/07/98	10/08/99
669-01306986	03/07/98	10/08/99
669-01307554	03/12/98	10/08/99
669-01312711	03/14/98	10/08/99
669-28050047	03/20/98	04/02/99
669-01312703	03/21/98	10/08/99
669-01318072	04/07/98	10/08/99
669-01324781	04/24/98	10/08/99
669-01325218	04/25/98	10/08/99
669-01327586	04/30/98	10/08/99
669-01330283	May-98	10/08/99
669-01332081	May-98	10/08/99
112-35098876	05/08/98	04/02/99
669-01332081	05/16/98	10/08/99
669-01335357	05/26/98	10/08/99
700-07050910	05/30/98	03/24/00
110-54366892	06/03/98	04/16/99
112-38590861	09/09/98	07/23/99
112-01742119	04/20/99	08/09/96
110-64694523	10/07/99	10/01/99

SEC. 3512. CERTAIN POSTERS ENTERED DURING 2000 AND 2001.

(a) IN GENERAL.—Notwithstanding section 514 of the Tariff Act of 1930 (19 U.S.C. 1514) or any other provision of law and subject to the provisions of subsection (b), the United States Customs Service shall, not later than 90 days after the receipt of the request described in subsection (b), liquidate or reliquidate each entry described in subsection (d) containing any merchandise which, at the time of the original liquidation, was classified under subheading 4911.91.20 of the Harmonized Tariff Schedule of the United States at the rate of duty that would have been applicable to such merchandise if the merchandise had been liquidated or reliquidated under subheading 4911.91.40 of the Harmonized Tariff Schedule of the United States on the date of entry.

(b) REQUESTS.—Reliquidation may be made under subsection (a) with respect to an entry described in subsection (d) only if a request therefor is filed with the Customs Service within 90 days after the date of the enactment of this Act.

(c) PAYMENT OF AMOUNTS OWED.—Any amounts owed by the United States pursuant to the liquidation or reliquidation of an entry under subsection (a) shall be paid not later than 90 days after the date of such liquidation or reliquidation.

(d) AFFECTED ENTRIES.—The entries referred to in subsection (a) are as follows:

Entry number	Date of entry
F1126496605	09-24-00
F1117735656	10-18-00
90100999235	02-14-01
90101010321	04-23-01
90101001700	02-28-01
28100674408	04-25-01
28100671081	04-09-01
28100670398	04-06-01
F1126187352	06-19-00
F1126530833	10-05-00
28100678433	05-18-01
90100999235	04-14-01
90101001700	02-28-01

SEC. 3513. LIQUIDATION OR RELIQUIDATION OF CERTAIN ENTRIES.

(a) IN GENERAL.—Notwithstanding section 514 of the Tariff Act of 1930 (19 U.S.C. 1514) or any other provision of law, and subject to subsection (b), the United States Customs Service shall, not later than 180 days after the receipt of the request described in subsection (b), liquidate or reliquidate each entry described in subsection (d) by applying the column 1 general rate of duty of the Harmonized Tariff Schedule of the United States to each entry that is liquidated or reliquidated, regardless of whether the entry was made under the column 1 special rate of duty of such schedule.

(b) REQUESTS.—Liquidation or reliquidation may be made under subsection (a) with respect to an entry described in subsection (d) only upon a request therefor is filed with the Customs Service.

(c) PAYMENT OF AMOUNTS DUE.—Any amounts due to the United States pursuant to the liquidation or reliquidation of an entry under subsection (a) shall be paid not later than 180 days after the date of such liquidation or reliquidation.

(d) AFFECTED ENTRIES.—The entries referred to in subsection (a), filed at the ports of Laredo, Texas (designated as port of entry 2304), Hidalgo, Texas (designated as port of entry 2305), and Wilmington, Delaware (designated as port of entry 1103), are as follows:

Entry number	Port of Entry	Date of Entry
95300618568	2305	02/22/95
95300618576	2305	02/22/95
95300619236	2305	02/27/95
95300619277	2305	02/27/95
95300619806	2305	03/02/95
95300619871	2305	03/02/95
95300620142	2305	03/07/95
95300620176	2305	03/03/95
95300620184	2305	03/03/95
95300620911	2305	03/07/95
95300635133	2305	04/07/95
95300635141	2305	04/07/95
95300635950	2305	04/12/95
95300635968	2305	04/12/95
95300636370	2305	04/14/95
95300636388	2305	04/14/95
95300640554	2305	05/09/95
95300640653	2305	05/10/95
95300656592	2304	11/05/95
95300657665	2304	11/29/95
95300657756	2304	12/02/95
95300658358	2304	12/16/95
95300658408	2304	12/17/95
95300658572	2304	12/19/95
95300658648	2304	12/22/95
95300658754	2304	12/22/95
95300658945	2304	12/27/95
95300659018	2304	12/28/95
95300659117	2304	12/29/95
95300659208	2304	01/02/96
95300659398	2304	01/05/96
95300659513	2304	01/08/96
95300659547	2304	01/09/96
95300659679	2304	01/11/96
95300659737	2304	01/14/96
95300659794	2304	01/13/96
95300659810	2304	01/14/96
95300659844	2304	01/15/96
95300659851	2304	01/15/96
95300659901	2304	01/16/96
95300659919	2304	01/16/96
95300659935	2304	01/17/96
95300660065	2304	01/18/96
95300660107	2304	01/19/96
95300660172	2304	01/22/96
95300660180	2304	01/22/96
95300660248	2304	01/22/96
95300660362	2304	01/23/96
95300660388	2304	01/24/96
95300660560	2304	01/25/96
95300660743	2304	01/27/96
95300660818	2304	01/29/96
95300660826	2304	01/29/96
95300704053	2305	05/16/95
95300704061	2305	05/16/95
95300704889	2305	05/22/95
95300704897	2305	05/22/95
95300705886	2305	05/31/95
95300705969	2305	05/30/95
95300706900	2305	06/09/95
95300706926	2305	06/09/95
95300752656	2305	02/02/96
95300752698	2305	02/04/96
95300752805	2305	02/05/96
95300752813	2305	02/05/96
95300752870	2305	02/06/96
95300752904	2305	02/06/96
95300753001	2305	02/07/96
95300753076	2305	02/09/96
R7410350736	1103	11/29/95
R7410350769	1103	11/29/95
R7410350801	1103	11/29/95
R7410350835	1103	11/29/95
T8500081575	2305	06/16/95
T8500081591	2305	06/16/95
T8500081716	2305	06/20/95
T8500081724	2305	06/20/95
T8500081815	2305	06/27/95
T8500081823	2305	06/28/95
T8500081922	2305	06/27/95
T8500081930	2305	06/27/95
T8500082052	2305	07/01/95
T8500082060	2305	07/01/95
T8500082326	2305	07/14/95
T8500082342	2305	07/14/95
T8500082458	2305	07/22/95
T8500082482	2305	07/22/95
T8500082508	2305	07/24/95
T8500082516	2305	07/24/95
T8500082581	2305	07/30/95
T8500082599	2305	07/30/95
T8500082656	2305	08/03/95
T8500082664	2305	08/03/95
T8500082748	2305	08/09/95
T8500082797	2305	08/10/95
T8500082839	2305	08/14/95
T8500082847	2305	08/14/95
T8500084462	2305	10/22/95

SEC. 3514. CERTAIN RAILWAY PASSENGER COACHES.

(a) IN GENERAL.—Notwithstanding section 514 of the Tariff Act of 1930 (19 U.S.C. 1514) or any other provision of law, upon proper request filed with the United States Customs Service within 180 days after the date of the enactment of this Act, the Customs Service shall liquidate or reliquidate the entry described in subsection (c) as free of duty.

(b) REFUND OF AMOUNTS OWED.—Any amounts owed by the United States pursuant to a request for a liquidation or reliquidation of the entry under subsection (a) shall be refunded with interest within 180 days after the date on which request is made.

(c) AFFECTED ENTRY.—The entry referred to in subsection (a) is the entry on July 12, 2002, of railway passenger coaches (provided for in subheading 8605.00.00) (Entry number 2210888343–4).

Subchapter B—Miscellaneous Provisions

SEC. 3521. HAIR CLIPPERS.

(a) IN GENERAL.—Heading 8510 of chapter 85 is amended—

(1) by striking subheading 8510.20.00 and inserting the following, with the article description for subheading 8510.20 having the same degree of indentation as the article description for subheading 8510.10.00, and with the article descriptions for subheadings 8510.20.10 and 8510.20.90 having the same degree of indentation as the article description for subheading 8510.90.55:

"	8510.20 8510.20.10	Hair clippers: Hair clippers to be used for agricultural or horticultural purposes	4%	Free (A, CA, E, IL, J, JO, MX)	45%	
	8510.20.90	Other	4%	Free (A, CA, E, IL, J, JO, MX)	45%	";

and

(2) by striking subheading 8510.90.30 and inserting the following subheadings and superior text thereto, with such superior text having the same degree of indentation as the article description for subheading 8510.90.55:

"		Parts of hair clippers:				
	8510.90.30	Parts of hair clippers to be used for agricultural or horticultural purposes	4%	Free (A,CA,E, IL,J,JO,MX)	45%	
	8510.90.40	Other parts of hair clippers	4%	Free (A,CA,E, IL,J,JO,MX)	45%	".

(b) STAGED RATE REDUCTIONS.—Any staged reduction of a rate of duty proclaimed by the President before the date of the enactment of this Act, that—

(1) would take effect on or after such date of enactment, and

(2) would, but for the amendments made by subsection (a), apply to subheading 8510.20.00 or subheading 8510.90.30 of the Harmonized Tariff Schedule of the United States,

applies to the corresponding rate of duty set forth in subheading 8510.20.10, 8510.20.90, or 8510.90.40 of such Schedule (as added by subsection (a)).

SEC. 3522. TRACTOR BODY PARTS.

(a) CERTAIN TRACTOR PARTS.—Heading 8708 is amended by striking subheading 8708.29.20 and inserting the following subheadings and superior text thereto, with such superior text having the same degree of indentation as the article description for subheading 8708.29.15:

"		Body stampings:				
	8708.29.21	For tractors suitable for agricultural use	Free		Free	
	8708.29.25	Other	2.5%	Free (A, B, CA, E, IL, J, JO, MX)	25%	";

(b) STAGED RATE REDUCTIONS.—Any staged reduction of a rate of duty proclaimed by the President before the date of the enactment of this Act, that—

(1) would take effect on or after such date of enactment, and

(2) would, but for the amendment made by subsection (a), apply to subheading 8708.29.20 of the Harmonized Tariff Schedule of the United States,

applies to the corresponding rate of duty set forth in subheading 8708.29.25 of such Schedule (as added by subsection (a)).

SEC. 3523. FLEXIBLE MAGNETS AND COMPOSITE GOODS CONTAINING FLEXIBLE MAGNETS.

Heading 8505 is amended—

(1) by striking subheading 8505.19.00 and inserting the following new subheadings, with the article description for subheadings 8505.19.10, 8505.19.20, and 8505.19.30 having the same degree of indentation as the article description for subheading 8505.11.00:

"	8505.19.10	Flexible magnet	4.9%	Free (A, CA, E, IL, J, JO, MX)	45%	
	8505.19.20	Composite goods containing flexible magnet	4.9%	Free (A, CA, E, IL, J, JO, MX)	45%	
	8505.19.30	Other	4.9%	Free (A, CA, E, IL, J, MX)	45%	".

(b) STAGED RATE REDUCTIONS.—Any staged reduction of a rate of duty proclaimed by the President before the date of the enactment of this Act, that—

(1) would take effect on or after such date of enactment, and

(2) would, but for the amendment made by subsection (a), apply to subheading 8505.19.00 of the Harmonized Tariff Schedule of the United States,

applies to the corresponding rate of duty set forth in subheadings 8505.19.10, 8505.19.20, and 8505.19.30 of such Schedule (as added by subsection (a)).

SEC. 3524. VESSEL REPAIR DUTIES.

(a) EXEMPTION.—Section 466(h) of the Tariff Act of 1930 (19 U.S.C. 1466(h)) is amended—

(1) in paragraph (1), by striking the comma at the end and inserting a semicolon;

(2) in paragraph (2), by striking ", or" at the end and inserting a semicolon;

(3) in paragraph (3), by striking the period at the end and inserting "; or"; and

(4) by adding at the end the following:

"(4) the cost of equipment, repair parts, and materials that are installed on a vessel documented under the laws of the United States and engaged in the foreign or coasting trade, if the installation is done by members of the regular crew of such vessel while the vessel is on the high seas.

Declaration and entry shall not be required with respect to the installation, equipment, parts, and materials described in paragraph (4).".

(b) AMENDMENT TO HTS.—Subchapter XVIII of chapter 98 of the Harmonized Tariff Schedule of the United States is amended by striking "U.S. Note" and inserting "U.S. Notes" and by adding after U.S. note 1 the following new note:

"2. Notwithstanding the provisions of subheadings 9818.00.03 through 9818.00.07, no duty shall apply to the cost of equipment, repair parts, and materials that are installed in a vessel documented under the laws of the United States and engaged in the foreign or coasting trade, if the installation is done by members of the regular crew of such vessel while the vessel is on the high seas, and declaration and entry shall not be required with respect to such installation, equipment, parts, and materials.".

(c) EFFECTIVE DATE.—The amendments made by this section apply to vessel equipment, repair parts, and materials installed on or after April 25, 2001.

SEC. 3525. DUTY-FREE TREATMENT FOR HAND-KNOTTED OR HAND-WOVEN CARPETS.

(a) AMENDMENT OF THE TRADE ACT OF 1974.—Section 503(b) of the Trade Act of 1974 (19 U.S.C. 2463(b)) is amended by adding at the end the following new paragraph:

"(4) CERTAIN HAND-KNOTTED OR HAND-WOVEN CARPETS.—Notwithstanding paragraph (1)(A), the President may designate as an eligible article or articles under subsection (a) carpets or rugs which are hand-loomed, hand-woven, hand-hooked, hand-tufted, or hand-knotted, and classifiable under subheading 5701.10.16, 5701.10.40, 5701.90.10, 5701.90.20, 5702.10.90, 5702.42.20, 5702.49.10, 5702.51.20, 5702.91.30, 5702.92.00, 5702.99.10, 5703.10.00, 5703.20.10, or 5703.30.00 of the Harmonized Tariff Schedule of the United States.".

(b) CONFORMING AMENDMENT.—Section 503(b)(1)(A) of the Trade Act of 1974 (19 U.S.C. 2463(b)(1)(A)) is amended by striking "Textile" and inserting "Except as provided in paragraph (4), textile".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to any article entered, or withdrawn from warehouse for consumption, on or after the date on which the President makes a designation with respect to the article under section 503(b)(4) of the Trade Act of 1974, as added by subsection (a).

SEC. 3526. DUTY DRAWBACK FOR CERTAIN ARTICLES.

Section 313 of the Tariff Act of 1930 (19 U.S.C. 1313) is amended by adding at the end the following new subsection:

"(y) ARTICLES SHIPPED TO THE UNITED STATES INSULAR POSSESSIONS.—Articles described in subsection (j)(1) shall be eligible for drawback under this section if duty was paid on the merchandise upon importation into the United States and the person claiming the drawback demonstrates that the merchandise has entered the customs territory of the United States Virgin Islands, American Samoa, Wake Island, Midway Islands, Kingman Reef, Guam, Canton Island, Enderbury Island, Johnston Island, or Palmyra Island.".

SEC. 3527. UNUSED MERCHANDISE DRAWBACK.

(a) IN GENERAL.—Section 313(j) of the Tariff Act of 1930 (19 U.S.C. 1313(j)) is amended—

(1) in paragraph (1), by striking "because of its" and inserting "upon entry or"; and

(2) in paragraph (2)—

(A) in the matter preceding subparagraph (A), by striking "because of its" and inserting "upon entry or"; and

(B) in the matter following subparagraph (C)(ii)(II)—

(i) by striking "then upon" and inserting "then, notwithstanding any other provision of law, upon"; and

(ii) by striking "shall be refunded as drawback" and inserting "shall be refunded as drawback under this subsection".

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act, and shall apply to any drawback claim filed on or after that date and to any drawback entry filed before that date if the liquidation of the entry is not final on that date.

SEC. 3528. TREATMENT OF CERTAIN FOOTWEAR UNDER CARIBBEAN BASIN ECONOMIC RECOVERY ACT.

Section 213(b) of the Caribbean Basin Economic Recovery Act (19 U.S.C. 2703(b)) is amended as follows:

(1) By amending paragraph (1)(B) to read as follows:

"(B) footwear provided for in any of subheadings 6401.10.00, 6401.91.00, 6401.92.90, 6401.99.30, 6401.99.60, 6401.99.90, 6402.30.50, 6402.30.70, 6402.30.80, 6402.91.50, 6402.91.80, 6402.91.90, 6402.99.20, 6402.99.80, 6402.99.90, 6403.59.60, 6403.91.30, 6403.99.60, 6403.99.90, 6404.11.90, and 6404.19.20 of the HTS that was not designated at the time of the effective date of this title as eligible articles for the purpose of the generalized system of preferences under title V of the Trade Act of 1974;".

(2) In paragraph (3)(A)—

(A) in clause (i), by striking "Subject to clause (ii)" and inserting "Subject to clauses (ii) and (iii)"; and

(B) by adding at the end the following:

"(iii) CERTAIN FOOTWEAR.—Notwithstanding paragraph (1)(B) and clause (i) of this subparagraph, footwear provided for in any of subheadings 6403.59.60, 6403.91.30, 6403.99.60, and 6403.99.90 of the HTS shall be eligible for the duty-free treatment provided for under this title if—

"(I) the article of footwear is the growth, product, or manufacture of a CBTPA beneficiary country; and

"(II) the article otherwise meets the requirements of subsection (a), except that in applying such subsection, 'CBTPA beneficiary country' shall be substituted for 'beneficiary country' each place it appears.".

SEC. 3529. DESIGNATION OF SAN ANTONIO INTERNATIONAL AIRPORT FOR CUSTOMS PROCESSING OF CERTAIN PRIVATE AIRCRAFT ARRIVING IN THE UNITED STATES.

(a) IN GENERAL.—Section 1453(a) of the Tariff Suspension and Trade Act of 2000 is amended by striking "2-year period" and inserting "6-year period".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall be effective as of November 9, 2002.

SEC. 3530. AUTHORITY FOR THE ESTABLISHMENT OF INTEGRATED BORDER INSPECTION AREAS AT THE UNITED STATES-CANADA BORDER.

(a) FINDINGS.—Congress makes the following findings:

(1) The increased security and safety concerns that developed in the aftermath of the terrorist attacks in the United States on September 11, 2001, need to be addressed.

(2) One concern that has come to light is the vulnerability of the international bridges and tunnels along the United States borders.

(3) It is necessary to ensure that potentially dangerous vehicles are inspected prior to crossing these bridges and tunnels; however, currently these vehicles are not inspected until after they have crossed into the United States.

(4) Establishing Integrated Border Inspection Areas (IBIAs) would address these concerns by inspecting vehicles before they gained access to the infrastructure of international bridges and tunnels joining the United States and Canada.

(b) CREATION OF INTEGRATED BORDER INSPECTION AREAS.—

(1) IN GENERAL.—The Commissioner of the Customs Service, in consultation with the

Canadian Customs and Revenue Agency (CCRA), shall seek to establish Integrated Border Inspection Areas (IBIAs), such as areas on either side of the United States-Canada border, in which United States Customs officers can inspect vehicles entering the United States from Canada before they enter the United States, or Canadian Customs officers can inspect vehicles entering Canada from the United States before they enter Canada. Such inspections may include, where appropriate, employment of reverse inspection techniques.

(2) ADDITIONAL REQUIREMENT.—The Commissioner of Customs, in consultation with the Administrator of the General Services Administration when appropriate, shall seek to carry out paragraph (1) in a manner that minimizes adverse impacts on the surrounding community.

(3) ELEMENTS OF THE PROGRAM.—Using the authority granted by this section and under section 629 of the Tariff Act of 1930, the Commissioner of Customs, in consultation with the Canadian Customs and Revenue Agency, shall seek to—

(A) locate Integrated Border Inspection Areas in areas with bridges or tunnels with high traffic volume, significant commercial activity, and that have experienced backups and delays since September 11, 2001;

(B) ensure that United States Customs officers stationed in any such IBIA on the Canadian side of the border are vested with the maximum authority to carry out their duties and enforce United States law;

(C) ensure that United States Customs officers stationed in any such IBIA on the Canadian side of the border shall possess the same immunity that they would possess if they were stationed in the United States; and

(D) encourage appropriate officials of the United States to enter into an agreement with Canada permitting Canadian Customs officers stationed in any such IBIA on the United States side of the border to enjoy such immunities as permitted in Canada.

SEC. 3531. DESIGNATION OF FOREIGN LAW ENFORCEMENT OFFICERS.

(a) MISCELLANEOUS PROVISIONS.—Section 401(i) of the Tariff Act of 1930 (19 U.S.C. 1401(i)) is amended by inserting ", including foreign law enforcement officers," after "or other person".

(b) INSPECTIONS AND PRECLEARANCE IN FOREIGN COUNTRIES.—Section 629 of the Tariff Act of 1930 (19 U.S.C. 1629) is amended—

(1) in subsection (a), by inserting ", or subsequent to their exit from," after "prior to their arrival in";

(2) in subsection (c)—

(A) by inserting "or exportation" after "relating to the importation"; and

(B) by inserting "or exit" after "port of entry";

(3) by amending subsection (e) to read as follows:

"(e) STATIONING OF FOREIGN CUSTOMS AND AGRICULTURE INSPECTION OFFICERS IN THE UNITED STATES.—The Secretary of State, in coordination with the Secretary and the Secretary of Agriculture, may enter into agreements with any foreign country authorizing the stationing in the United States of customs and agriculture inspection officials of that country (if similar privileges are extended by that country to United States officials) for the purpose of insuring that persons and merchandise going directly to that country from the United States, or that have gone directly from that country to the United States, comply with the customs and other laws of that country governing the importation or exportation of merchandise. Any foreign customs or agriculture inspection official stationed in the United States under this subsection may exercise such functions, perform such duties, and enjoy such privileges and immunities as United States officials may be authorized to perform or are afforded in that foreign country by treaty, agreement, or law."; and

(4) by adding at the end the following:

"(g) PRIVILEGES AND IMMUNITIES.—Any person designated to perform the duties of an officer of the Customs Service pursuant to section 401(i) of this Act shall be entitled to the same privileges and immunities as an officer of the Customs Service with respect to any actions taken by the designated person in the performance of such duties.".

(c) CONFORMING AMENDMENT.—Section 127 of the Treasury Department Appropriations Act, 2003, is hereby repealed.

(d) EFFECTIVE DATE.—This section, and the amendments made by this section, take effect on the date of the enactment of this Act.

SEC. 3532. AMENDMENTS TO UNITED STATES INSULAR POSSESSION PROGRAM.

(a) PRODUCTION CERTIFICATES.—Additional U.S. Note 5(h) to chapter 91 is amended—

(1) by amending subparagraphs (i) and (ii) to read as follows:

"(i) In the case of each of calendar years 2003 through 2015, the Secretaries jointly, shall—

"(A) verify—

"(1) the wages paid by each producer to permanent residents of the insular possessions during the preceding calendar year (including the value of usual and customary health insurance, life insurance, and pension benefits); and

"(2) the total quantity and value of watches and watch movements produced in the insular possessions by that producer and imported free of duty into the customs territory of the United States; and

"(B) issue to each producer (not later than 60 days after the end of the preceding calendar year) a certificate for the applicable amount.

"(ii) For purposes of subparagraph (i), except as provided in subparagraphs (iii) and (iv), the term 'applicable amount' means an amount equal to the sum of—

"(A) 90 percent of the producer's creditable wages (including the value of usual and customary health insurance, life insurance, and pension benefits) on the assembly during the preceding calendar year of the first 300,000 units; plus

"(B) the applicable graduated declining percentage (determined each year by the Secretaries) of the producer's creditable wages (including the value of usual and customary health insurance, life insurance, and pension benefits) on the assembly during the preceding calendar year of units in excess of 300,000 but not in excess of 750,000; plus

"(C) the difference between the duties that would have been due on each producer's watches and watch movements (excluding digital watches and excluding units in excess of the 750,000 limitation of this subparagraph) imported into the customs territory of the United States free of duty during the preceding calendar year if the watches and watch movements had been subject to duty at the rates set forth in column 1 under this chapter that were in effect on January 1, 2001, and the duties that would have been due on the watches and watch movements if the watches and watch movements had been subject to duty at the rates set forth in column 1 under this chapter that were in effect for such preceding calendar year."; and

(2) by amending subparagraph (v) to read as follows:

"(v) Any certificate issued under subparagraph (i) shall entitle the certificate holder to secure a refund of duties equal to the face value of the certificate on any articles that are imported into the customs territory of the United States by the certificate holder. Such refunds shall be made under regulations issued by the Treasury Department. Not more than 5 percent of such refunds may be retained as a reimbursement to the Customs Service for the administrative costs of making the refunds.".

(b) JEWELRY.—Additional U.S. Note 3 to chapter 71 is amended—

(1) by redesignating paragraphs (b), (c), (d), and (e) as paragraphs (c), (d), (e), and (f), respectively;

(2) by inserting after paragraph (a) the following new paragraph:

"(b) Notwithstanding additional U.S. Note 5(h)(ii)(B) to chapter 91, articles of jewelry subject to this note shall be subject to a limitation of 10,000,000 units."; and

(3) by striking paragraph (f), as so redesignated, and inserting the following:

"(f) Notwithstanding any other provision of law, any article of jewelry provided for in heading 7113 that is assembled in the Virgin Islands, Guam, or American Samoa by a jewelry manufacturer or jewelry assembler that commenced jewelry manufacturing or jewelry assembly operations in the Virgin Islands, Guam, or American Samoa after August 9, 2001, shall be treated as a product of the Virgin Islands, Guam, or American Samoa for purposes of this note and General Note 3(a)(iv) of this Schedule if such article is entered no later than 18 months after such jewelry manufacturer or jewelry assembler commenced jewelry manufacturing or jewelry assembly operations in the Virgin Islands, Guam, or American Samoa.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to goods imported into the customs territory of the United States on or after January 1, 2003.

SEC. 3533. MODIFICATION OF PROVISIONS RELATING TO DRAWBACK CLAIMS.

(a) MERCHANDISE NOT CONFORMING TO SAMPLE OR SPECIFICATIONS.—Section 313(c) of the Tariff Act of 1930 (19 U.S.C. 1313(c)) is amended to read as follows:

"(c) MERCHANDISE NOT CONFORMING TO SAMPLE OR SPECIFICATIONS.—

"(1) CONDITIONS FOR DRAWBACK.—Upon the exportation or destruction under the supervision of the Customs Service of articles or merchandise—

"(A) upon which the duties have been paid,

"(B) which has been entered or withdrawn for consumption,

"(C) which is—

"(i) not conforming to sample or specifications, shipped without the consent of the consignee, or determined to be defective as of the time of importation, or

"(ii) ultimately sold at retail by the importer, or the person who received the merchandise from the importer under a certificate of delivery, and for any reason returned to and accepted by the importer, or the person who received the merchandise from the importer under a certificate of delivery, and

"(D) which, within 3 years after the date of importation or withdrawal, as applicable, has been exported or destroyed under the supervision of the Customs Service,

the full amount of the duties paid upon such merchandise, less 1 percent, shall be refunded as drawback.

"(2) DESIGNATION OF IMPORT ENTRIES.—For purposes of paragraph (1)(C)(ii), drawback may be claimed by designating an entry of merchandise that was imported within 1 year before the date of exportation or destruction of the merchandise described in paragraph (1) (A) and (B) under the supervision of the Customs Service. The merchandise designated for drawback must be identified in the import documentation with the same eight-digit classification number and specific product identifier (such as part number, SKU, or product code) as the returned merchandise.

"(3) When drawback certificates not required.—For purposes of this subsection, drawback certificates are not required if the drawback claimant and the importer are the same party, or if the drawback claimant is a drawback successor to the importer as defined in subsection (s)(3).".

(b) Time Limitation on Exportation or Destruction.—Section 313(i) of the Tariff Act of 1930 (19 U.S.C. 1313(i)), is amended—

(1) by striking "No" and inserting "Unless otherwise provided for in this section, no"; and

(2) by inserting ", or destroyed under the supervision of the Customs Service," after "exported".

(c) Use of Domestic Merchandise Acquired in Exchange for Imported Merchandise of Same Kind and Quality.—Section 313(k) of the Tariff Act of 1930 (19 U.S.C. 1313(k)), is amended—

(1) by striking "(k)" and inserting "(k)(1)"; and

(2) by adding at the end the following new paragraph:

"(2) For purposes of subsections (a) and (b), the use of any domestic merchandise acquired in exchange for a drawback product of the same kind and quality shall be treated as the use of such drawback product if no certificate of delivery or certificate of manufacture and delivery pertaining to such drawback product is issued, other than that which documents the product's manufacture and delivery. As used in this paragraph, the term 'drawback product' means any domestically produced product, manufactured with imported merchandise or any other merchandise (whether imported or domestic) of the same kind and quality, that is subject to drawback.".

(d) Packaging Material.—Section 313(q) of the Tariff Act of 1930 (19 U.S.C. 1313(q)), is amended to read as follows:

"(q) Packaging Material.—

"(1) Packaging material under subsections (c) and (j).—Packaging material, whether imported and duty paid, and claimed for drawback under either subsection (c) or (j)(1), or imported and duty paid, or substituted, and claimed for drawback under subsection (j)(2), shall be eligible for drawback, upon exportation, of 99 percent of any duty, tax, or fee imposed under Federal law on such imported material.

"(2) Packaging material under subsections (a) and (b).—Packaging material that is manufactured or produced under subsection (a) or (b) shall be eligible for drawback, upon exportation, of 99 percent of any duty, tax, or fee imposed under Federal law on the imported or substituted merchandise used to manufacture or produce such material.

"(3) Contents.—Packaging material described in paragraphs (1) and (2) shall be eligible for drawback whether or not they contain articles or merchandise, and whether or not any articles or merchandise they contain are eligible for drawback.

"(4) Employing packaging material for its intended purpose prior to exportation.—The use of any packaging material for its intended purpose prior to exportation shall not be treated as a use of such material prior to exportation for purposes of applying subsection (a), (b), or (c), or paragraph (1)(B) or (2)(C)(i) of subsection (j).".

(e) Limitation on Liquidation.—Section 504 of the Tariff Act of 1930 (19 U.S.C. 1504) is amended—

(1) by striking subsections (a) and (b) and inserting the following:

"(a) Liquidation.—

"(1) Entries for consumption.—Unless an entry of merchandise for consumption is extended under subsection (b) of this section or suspended as required by statute or court order, except as provided in section 751(a)(3), an entry of merchandise for consumption not liquidated within 1 year from—

"(A) the date of entry of such merchandise,

"(B) the date of the final withdrawal of all such merchandise covered by a warehouse entry,

"(C) the date of withdrawal from warehouse of such merchandise for consumption if, pursuant to regulations issued under section 505(a), duties may be deposited after the filing of any entry or withdrawal from warehouse, or

"(D) if a reconciliation is filed, or should have been filed, the date of the filing under section 484 or the date the reconciliation should have been filed,

shall be deemed liquidated at the rate of duty, value, quantity, and amount of duties asserted at the time of entry by the importer of record. Notwithstanding section 500(e), notice of liquidation need not be given of an entry deemed liquidated.

"(2) Entries or claims for drawback.—

"(A) In general.—Except as provided in subparagraph (B) or (C), unless an entry or claim for drawback is extended under subsection (b) or suspended as required by statute or court order, an entry or claim for drawback not liquidated within 1 year from the date of entry or claim shall be deemed liquidated at the drawback amount asserted by the claimant at the time of entry or claim. Notwithstanding section 500(e), notice of liquidation need not be given of an entry deemed liquidated.

"(B) Unliquidated imports.—An entry or claim for drawback whose designated or identified import entries have not been liquidated and become final within the 1-year period described in subparagraph (A), or within the 1-year period described in subparagraph (C), shall be deemed liquidated upon the deposit of estimated duties on the unliquidated imported merchandise, and upon the filing with the Customs Service of a written request for the liquidation of the drawback entry or claim. Such a request must include a waiver of any right to payment or refund under other provisions of law. The Secretary of the Treasury shall prescribe any necessary regulations for the purpose of administering this subparagraph.

"(C) Exception.—An entry or claim for drawback filed before the date of the enactment of this paragraph, the liquidation of which is not final as of the date of the enactment of this paragraph, shall be deemed liquidated on the date that is 1 year after the date of the enactment of this paragraph at the drawback amount asserted by the claimant at the time of the entry or claim.

"(3) Payments or refunds.—Payment or refund of duties owed pursuant to paragraph (1) or (2) shall be made to the importer of record or drawback claimant, as the case may be, not later than 90 days after liquidation.

"(b) Extension.—The Secretary of the Treasury may extend the period in which to liquidate an entry if—

"(1) the information needed for the proper appraisement or classification of the imported or withdrawn merchandise, or for determining the correct drawback amount, or for ensuring compliance with applicable law, is not available to the Customs Service; or

"(2) the importer of record or drawback claimant, as the case may be, requests such extension and shows good cause therefor.

The Secretary shall give notice of an extension under this subsection to the importer of record or drawback claimant, as the case may be, and the surety of such importer of record or drawback claimant. Notice shall be in such form and manner (which may include electronic transmittal) as the Secretary shall by regulation prescribe. Any entry the liquidation of which is extended under this subsection shall be treated as having been liquidated at the rate of duty, value, quantity, and amount of duty asserted at the time of entry by the importer of record, or the drawback amount asserted at the time of entry by the drawback claimant, at the expiration of 4 years from the applicable date specified in subsection (a).";

(2) in subsection (c)—

(A) by inserting "or drawback claimant, as the case may be," after "to the importer of record"; and

(B) by inserting "or drawback claimant" after "of such importer of record"; and

(3) in subsection (d), by striking the period at the end and inserting "or (in the case of a drawback entry or claim) at the drawback amount asserted at the time of entry by the drawback claimant.".

(f) Penalties for False Drawback Claims.—Section 593A(h) of the Tariff Act of 1930 (19 U.S.C. 1593a(h)) is amended by striking "subsection (g)" and inserting "subsections (c) and (g)".

(g) Effective Date.—

(1) In general.—The amendments made by subsections (a), (b), (c), (d), and (f) shall take effect on the date of the enactment of this Act, and shall apply to—

(A) any drawback entry filed on and after such date of enactment; and

(B) any drawback entry filed before such date of enactment if the liquidation of the entry is not final on such date of enactment.

(2) Subsection (e).—The amendments made by subsection (e) shall take effect on the date of the enactment of this Act, and shall apply to—

(A) any entry of merchandise for consumption or entry or claim for drawback filed on and after such date of enactment; and

(B) any entry or claim for drawback filed before such date of enactment if the liquidation of the entry or claim is not final on such date of enactment.

Chapter 3—Effective Date

SEC. 3551. EFFECTIVE DATE.

Except as otherwise provided in this subtitle, the amendments made by this subtitle shall apply with respect to goods entered, or withdrawn from warehouse, for consumption, on or after the 15th day after the date of the enactment of this Act.

Subtitle B—Other Trade Provisions

Chapter 1—Miscellaneous Provisions

SEC. 3601. TERMINATION OF APPLICATION OF TITLE IV OF THE TRADE ACT OF 1974 TO ARMENIA.

(a) Findings.—Congress makes the following findings:

(1) Armenia has been found to be in full compliance with the freedom of emigration

requirements under title IV of the Trade Act of 1974.

(2) Armenia acceded to the World Trade Organization on February 5, 2003.

(3) Since declaring its independence from the Soviet Union in 1991, Armenia has made considerable progress in enacting free-market reforms.

(4) Armenia has demonstrated a strong desire to build a friendly and cooperative relationship with the United States and has concluded many bilateral treaties and agreements with the United States.

(5) Total United States-Armenia bilateral trade for 2002 amounted to more than $134,200,000.

(b) Presidential Determinations and Extensions of Nondiscriminatory Treatment.—Notwithstanding any provision of title IV of the Trade Act of 1974 (19 U.S.C. 2431 et seq.), the President may—

(1) determine that such title should no longer apply to Armenia; and

(2) after making a determination under paragraph (1) with respect to Armenia, proclaim the extension of nondiscriminatory treatment (normal trade relations treatment) to the products of that country.

(c) Termination of Application of Title IV.—On and after the effective date of the extension under subsection (b)(2) of nondiscriminatory treatment to the products of Armenia, title IV of the Trade Act of 1974 shall cease to apply to that country.

SEC. 3602. MODIFICATION TO CELLAR TREATMENT OF NATURAL WINE.

(a) In general.—Subsection (a) of section 5382 of the Internal Revenue Code of 1986 (relating to cellar treatment of natural wine) is amended to read as follows:

“(a) Proper cellar treatment.—

“(1) In general.—Proper cellar treatment of natural wine constitutes—

“(A) subject to paragraph (2), those practices and procedures in the United States, whether historical or newly developed, of using various methods and materials to stabilize the wine, or the fruit juice from which it is made, so as to produce a finished product acceptable in good commercial practice in accordance with regulations prescribed by the Secretary; and

“(B) subject to paragraph (3), in the case of wine produced and imported subject to an international agreement or treaty, those practices and procedures acceptable to the United States under such agreement or treaty.

“(2) Recognition of continuing treatment.—For purposes of paragraph (1)(A), where a particular treatment has been used in customary commercial practice in the United States, it shall continue to be recognized as a proper cellar treatment in the absence of regulations prescribed by the Secretary finding such treatment not to be proper cellar treatment within the meaning of this subsection.

“(3) Certification of practices and procedures for imported wine.—

“(A) In general.—In the case of imported wine produced after December 31, 2004, the Secretary shall accept the practices and procedures used to produce such wine, if, at the time of importation—

“(i) the Secretary has on file or is provided with a certification from the government of the producing country, accompanied by an affirmed laboratory analysis, that the practices and procedures used to produce the wine constitute proper cellar treatment under paragraph (1)(A),

“(ii) the Secretary has on file or is provided with such certification, if any, as may be required by an international agreement or treaty under paragraph (1)(B), or

“(iii) in the case of an importer that owns or controls or that has an affiliate that owns or controls a winery operating under a basic permit issued by the Secretary, the importer certifies that the practices and procedures used to produce the wine constitute proper cellar treatment under paragraph (1)(A).

“(B) Affiliate defined.—For purposes of this paragraph, the term ‘affiliate’ has the meaning given such term by section 117(a)(4) of the Federal Alcohol Administration Act (27 U.S.C. 211(a)(4)) and includes a winery's parent or subsidiary or any other entity in which the winery's parent or subsidiary has an ownership interest.”.

(b) Effective Date.—The amendment made by this section shall take effect on January 1, 2005.

SEC. 3603. ARTICLES ELIGIBLE FOR PREFERENTIAL TREATMENT UNDER THE ANDEAN TRADE PREFERENCE ACT.

(a) In General.—Notwithstanding section 514 of the Tariff Act of 1930 or any other provision of law, and subject to subsection (c)—

(1) with respect to any article described in section 204(b)(1)(D) of the Andean Trade Preference Act (as amended by section 3103(a)(2) of the Trade Act of 2002) for which the President proclaims duty free treatment pursuant to section 204(b)(1) of the Andean Trade Preference Act, the entry of any such article on or after August 6, 2002, and before the date on which the President so proclaims duty free treatment for such article shall be subject to the rate of duty applicable on August 5, 2002; and

(2) such entries shall be liquidated or reliquidated as if the reduced duty preferential treatment applied, and the Secretary of the Treasury shall refund any excess duties paid with respect to such entry.

(b) Entry.—As used in this subsection, the term “entry” includes a withdrawal from warehouse for consumption.

(c) Requests.—Liquidation or reliquidation may be made under paragraph (1) with respect to an entry only if a request therefor is filed with the Customs Service, within 180 days after the date of the enactment of this Act, and such request contains sufficient information to enable the Customs Service—

(1) to locate the entry; or

(2) to reconstruct the entry if it cannot be located.

SEC. 3604. TECHNICAL AMENDMENTS.

(a) Trade Act of 2002.—(1) Section 2(a)(4) of the Trade Act of 2002 is amended by striking “and Other Provisions”.

(2) The table of contents of the Trade Act of 2002 is amended—

(A) in the item relating to section 342, by striking “customs service” and inserting “Customs Service”; and

(B) by amending the item relating to section 3107 to read as follows:

“3107. Trade benefits under the Caribbean Basin Economic Recovery Act.”.

(3) The amendment made by section 111(b) of the Trade Act of 2002 shall be deemed never to have been enacted.

(4) Section 221(a)(2)(A) of the Trade Act of 1974 (19 U.S.C. 2271(a)(2)(A)) is amended by striking “assistance, and appropriate” and inserting “assistance and appropriate”.

(5) Section 222(b) of the Trade Act of 1974 (19 U.S.C. 2272(b)) is amended—

(A) by striking the subsection heading and inserting the following: “Adversely Affected Secondary Workers”; and

(B) in the matter preceding paragraph (1), by inserting “pursuant to a petition filed under section 221” after “under this chapter”.

(6) Section 238(b)(1) of the Trade Act of 1974 is amended by striking “Secretary,” and inserting “Secretary)”.

(7) Section 246 of the Trade Act of 1974 is amended—

(A) in subsection (a)(3)(B)(iii), by striking “and” after the semicolon;

(B) in subsection (a)(5), by striking “section 238(a)(2)(B)” and inserting “paragraph (2)(B)”; and

(C) in subsection (b)(2), by striking “provided that” and inserting “if”.

(8) The table of contents of the Trade Act of 1974 is amended by striking

“246. Supplemental wage allowances demonstration projects.”.

(9) Section 296 of the Trade Act of 1974 is amended—

(A) in subsection (a)(1)—

(i) in the matter preceding subparagraph (A)—

(I) by striking “trade adjustment allowance” and inserting “adjustment assistance under this chapter”; and

(II) by striking “such allowance” and inserting “such assistance”; and

(ii) in subparagraph (A), by striking “subsection (a)” and inserting “this subsection”; and

(B) in subsection (b)(2), by striking “paragraph (1) except” and inserting “paragraph (1), except”.

(10) Section 141(b) of the Trade Act of 2002 is amended by striking “title” and inserting “subtitle”.

(11) Section 142 of the Trade Act of 2002 is amended—

(A) in subsection (a)(1)—

(i) by striking “284(a)” and “2395(a)” and inserting “284” and “2395”, respectively; and

(ii) in subparagraph (A), by inserting “in subsection (a),” after “(A)”; and

(B) in subsection (b), by striking “, as amended by subparagraph (A),”.

(12) Section 583(c)(1) of the Tariff Act of 1930 (19 U.S.C. 1583(c)(1)) is amended by moving the matter preceding subparagraph (A) and subparagraphs (A) through (K) 2 ems to the right.

(13) Section 371(b) of the Trade Act of 2002 is amended by striking “1330(e)(2)” and inserting “1330(e)”.

(14) Section 336 of the Trade Act of 2002 is amended to read as follows:

“SEC. 336. STUDY AND REPORT RELATING TO CUSTOMS USER FEES.

“(a) Study.—The Comptroller General shall conduct a study on the extent to which the amount of each customs user fee imposed under section 13031(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(a)) approximates the cost of services provided by the Customs Service relating to the fee so imposed.

“(b) Report.—Not later than 180 days after the date of the enactment of the Miscellaneous Trade and Technical Corrections Act of 2003, the Comptroller General shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report containing—

“(1) the results of the study conducted under subsection (a); and

“(2) recommendations for the appropriate amount of the customs user fees if such results indicate that the fees are not commensurate with the level of services provided by the Customs Service.

Notwithstanding any other provision of law, the report or its contents may only be disclosed by the Comptroller General to the committees or Members of Congress and the Customs Service and shall not be disclosed to the public.".

(15) Section 141(b)(2) of the Trade Act of 1974 (19 U.S.C. 2171(b)(2)) is amended by moving the paragraph 2 ems to the left.

(16) Section 2102(c) of the Trade Act of 2002 is amended—

(A) in paragraph (8), by striking "this Act" and inserting "this title"; and

(B) in paragraph (12), by striking "government engaged" and inserting "government is engaged".

(17) Section 2103 of the Trade Act of 2002 is amended—

(A) in subsection (a)(1)(A), by striking "June 1" each place it appears and inserting "July 1";

(B) in subsection (b)(1)(C), by striking "June 1" each place it appears and inserting "July 1" and

(C) in subsection (c)—

(i) in paragraph (1)(B)(ii), by striking "June 1" and inserting "July 1";

(ii) in paragraph (2), by striking "March 1" and inserting "April 1"; and

(iii) in paragraph (3), by striking "May 1" each place it appears and inserting "June 1".

(18) Section 2105(c) of the Trade Act of 2002 is amended by striking "aand" and inserting "and".

(19) Section 2113 of the Trade Act of 2002 is amended—

(A) in the first paragraph designated "(2)", by striking "101(d)(12)" and "3511(d)(12)" and inserting "101(d)(13)" and "3511(d)(13)", respectively; and

(B) in the second paragraph designated "(2)"—

(i) by redesignating such paragraph as paragraph (3); and

(ii) by striking "101(d)(13)" and "3511(d)(13)" and inserting "101(d)(12)" and "3511(d)(12)", respectively.

(20) Section 4101(b)(1) of the Trade Act of 2002 is amended—

(A) in the matter preceding subparagraph (A), by striking "entry—" and inserting "entry of any article—"; and

(B) in subparagraph (A), by striking "of any article".

(21) U.S. Note 15 to subchapter II of chapter 99 of the Harmonized Tariff Schedule of the United States is amended by striking the comma after "9902.51.11".

(22) U.S. Note 16 to subchapter II of chapter 99 of the Harmonized Tariff Schedule of the United States is amended by striking the comma after "9902.51.12".

(23) Section 151(a) of the Trade Act of 2002 is amended by striking "and 141(b)" and inserting ", 141(b), 201(d), and 202(e)".

(24) Paragraph (4) of section 6103(p) of the Internal Revenue Code of 1986, as amended by section 202(b)(2)(B) of the Trade Act of 2002 (Public Law 107–210; 116 Stat. 961), is amended by striking "or (17)" after "any other person described in subsection (l)(16)" each place it appears and inserting "or (18)".

(b) Apparel Articles Under African Growth and Opportunity Act.—(1) Section 112(b)(1) of the African Growth and Opportunity Act (19 U.S.C. 3721(b)(1)) is amended by striking "(including" and inserting "or both (including".

(2) Section 112(b)(3) of the African Growth and Opportunity Act (19 United States Code 3721(b)(3)) is amended in the matter preceding subparagraph (A)—

(A) by striking "either in the United States or one or more beneficiary sub-Saharan African countries" each place it appears and inserting "in the United States or one or more beneficiary sub-Saharan African countries, or both"; and

(B) by striking "subject to the following:" and inserting "whether or not the apparel articles are also made from any of the fabrics, fabric components formed, or components knit-to-shape described in paragraph (1) or (2) (unless the apparel articles are made exclusively from any of the fabrics, fabric components formed, or components knit-to-shape described in paragraph (1) or (2)), subject to the following:".

(3) Section 112(b)(5)(A) of the African Growth and Opportunity Act (19 U.S.C. 3721(b)(5)(A)) is amended to read as follows:

"(A) In general.—Apparel articles that are both cut (or knit-to-shape) and sewn or otherwise assembled in one or more beneficiary sub-Saharan African countries, to the extent that apparel articles of such fabrics or yarns would be eligible for preferential treatment, without regard to the source of the fabrics or yarns, under Annex 401 to the NAFTA."

(c) Apparel Articles Under Caribbean Basin Economic Recovery Act.—(1) Section 213(b)(2)(A) of the Caribbean Basin Economic Recovery Act (19 U.S.C. 2703(b)(2)(A)) is amended—

(A) in clause (i), by striking "(including" and inserting "or both (including";

(B) in clause (v), by striking ", from fabrics or yarn that is not formed in the United States or in one or more CBTPA beneficiary countries"; and

(C) in clause (vii)(IV), by striking "(i) or (ii)" and inserting "(i), (ii), or (ix)".

(2) Section 3107(a)(1)(B) of the Trade Act of 2002 is amended by striking "(B) by adding at the end the following:" and inserting "(B) by amending the last two sentences to read as follows:".

(d) Tariff Act of 1930.—Section 505(a) of the Tariff Act of 1930 is amended—

(1) in the first sentence—

(A) by inserting "referred to in this subsection" after "periodic payment"; and

(B) by striking "10 working days" and inserting "12 working days"; and

(2) in the second sentence, by striking "a participating" and all that follows through the end of the sentence and inserting the following: "the Secretary shall promulgate regulations, after testing the module, permitting a participating importer of record to deposit estimated duties and fees for entries of merchandise, other than merchandise entered for warehouse, transportation, or under bond, no later than the 15 working days following the month in which the merchandise is entered or released, whichever comes first.".

(e) Additional Technical Amendments.—(1) The second and third U.S. notes 6 to subchapter XVII 14 of chapter 98 of the Harmonized Tariff Schedule of the United States (as added by sections 1433(b) and 1456(b) of the Tariff Suspension and Trade Act of 2000, respectively) are redesignated as U.S. notes 7 and 8 to subchapter XVII of such chapter 98, respectively.

(2) U.S. notes 4 and 12 to subchapter II of chapter 99 of the Harmonized Tariff Schedule of the United States are hereby repealed.

(3) Section 421(b) of the Trade Act of 1974 (19 U.S.C. 2451(b)) is amended by striking "subtitle" each place it appears and inserting "chapter".

(4) Section 422(j) of the Trade Act of 1974 (19 U.S.C. 2451a(j)) is amended by striking "(1)".

(5) Section 337(a) of the Tariff Act of 1930 (19 U.S.C. 1337) is amended—

(A) in paragraph (1), by aligning the text of subparagraph (E) with the text of subparagraph (D); and

(B) in paragraph (2), by striking "and (D)" and inserting "(D), and (E)".

(6) Section 313(n)(1)(B) of the Tariff Act of 1930 (19 U.S.C. 1313(n)(1)(B)) is amended by adding a semicolon after "Act".

(7) Section 202(d)(1) of the United States-Chile Free Trade Agreement Implementation Act (19 U.S.C. 3805 note) is amended by striking "subsection (a)(2)" and inserting "subsection (a)(1)(B)".

(8)(A) Subheading 9804.00.70 of the Harmonized Tariff Schedule of the United States is amended in the article description column—

(i) by striking "$1200" and inserting "$1600";

(ii) by striking "$400" and inserting "$800"; and

(iii) by striking "or up to $600 of which have been acquired in one or more beneficiary countries".

(B) Subheading 9804.00.72 of the Harmonized Tariff Schedule of the United States is amended in the article description column—

(i) by striking "$600" and inserting "$800"; and

(ii) by striking "not more than $400 of which shall have been acquired elsewhere than in beneficiary countries".

(f) United States Vessels.—Section 204(b)(4)(B)(i) of the Andean Trade Preference Act is amended to read as follows:

"(i) United states vessel.—A 'United States vessel' is—

"(I) a vessel that has a certificate of documentation with a fishery endorsement under chapter 121 of title 46, United States Code; or

"(II) in the case of a vessel without a fishery endorsement, a vessel that is documented under the laws of the United States and for which a license has been issued pursuant to section 9 of the South Pacific Tuna Act of 1988 (16 U.S.C. 973g).".

(g) Customs User Fees.—(1) Section 13031(b)(9)(A) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(b)(9)(A)) is amended by striking "less than $2,000" and inserting "$2,000 or less".

(2) Section 13031(b)(9)(A)(ii) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(b)(9)(A)(ii)) is amended to read as follows:

"(ii) Notwithstanding subsection (e)(6) and subject to the provisions of subparagraph (B), in the case of an express consignment carrier facility or centralized hub facility—

"(I) $.66 per individual airway bill or bill of lading; and

"(II) if the merchandise is formally entered, the fee provided for in subsection (a)(9), if applicable.".

(3) Section 13031(b)(9)(B) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(b)(9)(B)) is amended—

(A) by moving the margins for subparagraph (B) 4 ems to the left; and

(B) in clause (ii), by striking "subparagraph (A)(ii)" and inserting "subparagraph (A)(ii) (I) or (II)".

(4) Section 13031(f)(1)(B) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(f)(1)(B)) is amended by moving the subparagraph 2 ems to the left.

(h) Entries of Certain Apparel Articles Pursuant to the Caribbean Basin Economic Recovery Act or the African Growth and Opportunity Act.—

(1) In general.—Notwithstanding section 514 of the Tariff Act of 1930 (19 U.S.C. 1514) or any other provision of law, the Customs Service shall liquidate or reliquidate as free of duty and free of any quantitative restrictions, limitations, or consultation levels entries of articles described in paragraph (4) made on or after October 1, 2000.

(2) Requests.—Liquidation or reliquidation may be made under paragraph (1) with respect to an entry described in paragraph (4) only if a request therefor is filed with the Customs Service within 90 days after the date of the enactment of this Act and the request contains sufficient information to enable the Customs Service to locate the entry or reconstruct the entry if it cannot be located.

(3) Payment of amounts owed.—Any amounts owed by the United States pursuant to the liquidation or reliquidation of any entry under paragraph (1) shall be paid not later than 180 days after the date of such liquidation or reliquidation.

(4) Entries.—The entries referred to in paragraph (1) are—

(A) entries of apparel articles (other than socks provided for in heading 6115 of the Harmonized Tariff Schedule of the United States) that meet the requirements of section 213(b)(2)(A) of the Caribbean Basin Economic Recovery Act (as amended by section 3107(a) of the Trade Act of 2002 and subsection (c) of this section); and

(B) entries of apparel articles that meet the requirements of section 112(b) of the African Growth and Opportunity Act (as amended by section 3108 of the Trade Act of 2002 and subsection (b) of this section).

(i) Labeling Requirements.—

(1) In general.—Section 4 of the Textile Fiber Products Identification Act (15 U.S.C. 70b) is amended by adding at the end the following new subsection:

“(k) Marking of Certain Sock Products.—

“(1) Notwithstanding any other provision of law, socks provided for in subheading 6115.92.90, 6115.93.90, 6115.99.18, 6111.20.60, 6111.30.50, or 6111.90.50 of the Harmonized Tariff Schedule of the United States, as in effect on September 1, 2003, shall be marked as legibly, indelibly, and permanently as the nature of the article or package will permit in such a manner as to indicate to the ultimate consumer in the United States the English name of the country of origin of the article. The marking required by this subsection shall be on the front of the package, adjacent to the size designation of the product, and shall be set forth in such a manner as to be clearly legible, conspicuous, and readily accessible to the ultimate consumer.

“(2) Exceptions.—Any package that contains several different types of goods and includes socks classified under subheading 6115.92.90, 6115.93.90, 6115.99.18, 6111.20.60, 6111.30.50, or 6111.90.50 of the Harmonized Tariff Schedule of the United States, as in effect on September 1, 2003, shall not be subject to the requirements of paragraph (1).”.

(2) Effective date.—The amendment made by paragraph (1) shall take effect on the date that is 15 months after the date of enactment of this Act, and on and after the date that is 15 months after such date of enactment, any provision of part 303 of title 16, Code of Federal Regulations, that is inconsistent with such amendment shall not apply.

Chapter 2—Technical Amendments Relating to Entry and Protest

SEC. 3701. ENTRY OF MERCHANDISE.

(a) In General.—Section 484(a) of the Tariff Act of 1930 (19 U.S.C. 1484) is amended—

(1) by amending paragraph (1)(A) to read as follows:

“(A) make entry therefor by filing with the Customs Service—

“(i) such documentation; or

“(ii) pursuant to an electronic data interchange system, such information as is necessary to enable the Customs Service to determine whether the merchandise may be released from customs custody; and”;

(2) in paragraph (1)(B), by inserting after “entry” the following: “, or substitute 1 or more reconfigured entries on an import activity summary statement,”; and

(3) in paragraph (2)(A)—

(A) by inserting after “statements” the following: “and permit the filing of reconfigured entries,”; and

(B) by adding at the end the following: “Entries filed under paragraph (1)(A) shall not be liquidated if covered by an import activity summary statement, but instead each reconfigured entry in the import activity summary statement shall be subject to liquidation or reliquidation pursuant to section 500, 501, or 504.”.

(b) Reconciliation.—Section 484(b)(1) of the Tariff Act of 1930 (19 U.S.C. 1484(b)(1)) is amended by striking “15 months” and inserting “21 months”.

SEC. 3702. LIMITATION ON LIQUIDATIONS.

Section 504 of the Tariff Act of 1930 (19 U.S.C. 1504) is amended—

(1) in subsection (a)—

(A) by striking “or” at the end of paragraph (3);

(B) in paragraph (4), by striking “filed;” and inserting “filed, whichever is earlier; or”; and

(C) by inserting after paragraph (4) the following:

“(5) if a reconfigured entry is filed under an import activity summary statement, the date the import activity summary statement is filed or should have been filed, whichever is earlier;”; and

(2) by striking “at the time of entry” each place it appears.

SEC. 3703. PROTESTS.

Section 514 of the Tariff Act of 1930 (19 U.S.C. 1514) is amended—

(1) in subsection (a)—

(A) in the matter preceding paragraph (1), by striking “(relating to refunds and errors) of this Act” and inserting “(relating to refunds), any clerical error, mistake of fact, or other inadvertence, whether or not resulting from or contained in an electronic transmission, adverse to the importer, in any entry, liquidation, or reliquidation, and”;

(B) in paragraph (5), by inserting “, including the liquidation of an entry, pursuant to either section 500 or section 504;” after “thereof”; and

(C) in paragraph (7), by striking “(c) or”; and

(2) in subsection (c)—

(A) in paragraph (1), in the sixth sentence, by striking “A protest may be amended,” and inserting “Unless a request for accelerated disposition is filed under section 515(b), a protest may be amended,”;

(B) in paragraph (3)(A), by striking “notice of” and inserting “date of”; and

(C) in paragraph (3)—

(i) by striking “ninety days” and inserting “180 days”; and

(ii) by striking “90 days” and inserting “180 days” .

SEC. 3704. REVIEW OF PROTESTS.

Section 515(b) of the Tariff Act of 1930 (19 U.S.C 1515(b)) is amended by striking “after ninety days” and inserting “concurrent with or”.

SEC. 3705. REFUNDS AND ERRORS.

Section 520(c) of the Tariff Act of 1930 (19 U.S.C 1520(c)) is repealed.

SEC. 3706. DEFINITIONS AND MISCELLANEOUS PROVISIONS.

Section 401 of the Tariff Act of 1930 (19 U.S.C 1401) is amended by adding at the end the following:

“(t) Reconfigured Entry.—The term ‘reconfigured entry’ means an entry filed on an import activity summary statement which substitutes for all or part of 1 or more entries filed under section 484(a)(1)(A) or filed on a reconciliation entry that aggregates the entry elements to be reconciled under section 484(b) for purposes of liquidation, reliquidation, or protest.”.

SEC. 3707. VOLUNTARY RELIQUIDATIONS.

Section 501 of the Tariff Act of 1930 (19 U.S.C 1501) is amended by inserting “or 504” after “section 500”.

SEC. 3708. EFFECTIVE DATE.

The amendments made by this chapter shall apply to merchandise entered, or withdrawn from warehouse for consumption, on or after the 15th day after the date of the enactment of this Act.

Chapter 3—Protection of Intellectual Property Rights

SEC. 3751. USTR DETERMINATIONS IN TRIPS AGREEMENT INVESTIGATIONS.

(a) In General.—Section 304(a)(2)(A) of the Trade Act of 1974 (19 U.S.C. 2414(a)(2)(A)) is amended by inserting after “agreement,” the following: “except an investigation initiated pursuant to section 302(b)(2)(A) involving rights under the Agreement on Trade-Related Aspects of Intellectual Property Rights (referred to in section 101(d)(15) of the Uruguay Round Agreements Act) or the GATT 1994 (as defined in section 2(1)(B) of that Act) relating to products subject to intellectual property protection,”.

(b) Timeframe for TRIPS Agreement Determinations.—Section 304(a)(3)(A) of the Trade Act of 1974 is amended to read as follows:

“(3)(A) If an investigation is initiated under this chapter by reason of section 302(b)(2) and—

“(i) the Trade Representative considers that rights under the Agreement on Trade-Related Aspects of Intellectual Property Rights or the GATT 1994 relating to products subject to intellectual property protection are involved, the Trade Representative shall make the determination required under paragraph (1) not later than 30 days after the date on which the dispute settlement procedure is concluded; or

“(ii) the Trade Representative does not consider that a trade agreement, including the Agreement on Trade-Related Aspects of Intellectual Property Rights, is involved or does not make a determination described in subparagraph (B) with respect to such investigation, the Trade Representative shall make the determinations required under paragraph (1) with respect to such investigation not later than the date that is 6 months after the date on which such investigation is initiated.”.

(c) Conforming Amendment.—Section 305(a)(2)(B) of the Trade Act of 1974 is amended by striking “section 304(a)(3)(A)” and inserting “section 304(a)(3)(A)(ii)”.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Louisiana (Mr. McCrery) and the gentleman from Michigan (Mr. Levin) each will control 20 minutes.

The Chair recognizes the gentleman from Louisiana (Mr. McCrery).

Mr. McCRERY. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, to begin this explanation of the bill, the bill before us is very straightforward. It includes many elements which have passed this House before, in some cases numerous times.

The Tax Relief Extension Act of 2003 extends a number of important tax incentives strongly supported by Members on both sides of the aisle including incentives which create jobs and encourage restoration of brownfields.

One extension provision ensures that the benefits of individual tax credits are not lost to the bite of the alternative minimum tax. Those credits do little good if they are countered by the effects of the AMT. And the bill promotes economic growth by extending a provision first enacted in the 2002 stimulus bill allowing companies to carry back net operating losses up to 5 years.

The measure before us allows two important provisions related to defined benefit pension plans which must set aside enough money today to pay promised benefits tomorrow. As a result of declining rates on 30-year Treasury notes, plans are forced to assume that plan assets will grow more slowly than we know will be the case. This assumption results in employers having to set aside additional funds in their pension plan today, depriving them of money needed to expand their businesses and create more jobs.

The bill temporarily replaces the 30-year Treasury rate as the benchmark used for these calculations with an index based on high-grade corporate debt. The provision in this bill mirrors H.R. 3108, a bill approved last month in this Chamber by a vote of 397 to 2.

Further, the bill provides relief for embattled airlines facing burdensome mandatory contributions. This industry has been hard hit by the recession, a post-9/11 suspension in air travel and the resulting reduced passenger loads, and the higher costs of security resulting from terrorist fears.

Airlines are generally either in bankruptcy, coming out of bankruptcy or teetering on bankruptcy's brink. Forcing them to make billions of dollars in additional pension contributions at this time could be disastrous.

Accordingly, the bill before us contains relief which allows airlines to pay 20 percent of what current law would require into their plans during the next 2 years.

Together, these provisions will give Congress the time to develop long-term solutions to pension funding issues.

Finally, the bill includes several trade-related provisions. It includes the provisions of the Miscellaneous Trade and Technical Corrections Act, a compendium of bipartisan trade-related items, duty suspensions, and technical corrections drawn largely from legislation introduced by individual Members.

These duty suspensions are critical to many American employers since they are paying unnecessarily high prices for supplies which are not made here in the United States.

The House passed a substantially similar version of this bill in March of 2003 by a vote of 415 to 11.

The legislation before the House today includes several additional trade provisions, including an extension of Permanent Normal Trade Relations status to Armenia and an increase from $1,200 to $1,600 in the personal duty exemption for travellers returning to the United States from the Virgin Islands.

Like the tax provisions outlined above, the trade provisions included in this bipartisan bill are noncontroversial, small in cost and will help United States companies better compete.

Mr. Speaker, I urge my colleagues to support this package.

Mr. Speaker, I reserve the balance of my time.

Mr. LEVIN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of this legislation. I want to, though, at the beginning talk about process and then I will discuss the substance of the bill.

There have been some process issues. One of them relates to the Senate. The bill here has some provisions that have been over in the Senate and they have been held up by the action, as I understand it, of one Member of the Senate. It relates to a labelling requirement and essentially would, if that effort succeeded, roll back a provision that we have favored. And I just want everyone to understand that I think trade issues should not be handled that way.

Secondly, I want to say a word about the Armenia PNTR. We have been discussing this, but not directly in the committee or the Subcommittee on Trade for a number of months. A bill was introduced to grant Armenia PNTR, and I very much have favored that happening. Unfortunately, the bill was not sent through the subcommittee or the full committee, and I think that really deprived us of a chance to add to this bill some references to certain issues that Armenia has faced and that we think other countries should confront, especially as they are going to accede to the WTO which has already happened in the case of Armenia and receive the extension of PNTR by the United States.

For example, we have been trying to introduce into this bill references to the implementation by Armenia of some important aspect of the Helsinki Act, citing that some progress, although not full, has been made in the area of human rights. This would include treatment of minorities, religious minorities and others, providing protection to minorities from violence based on discrimination of any kind, hostility or hatred, including anti-Semitism. Also, reference to the fact that Armenia has demonstrated a commitment to enforcing internationally recognized core labor standards and has been working to improve its enforcement of those laws, as well as implementing some important market reforms.

Well, this bill suddenly included the Armenia PNTR, which I have favored, but there is resistance from some on the majority to allow us to insert into this bill these references to progress by Armenia in important areas that had reference, and should have reference, to other countries; and so I very much regret that.

But as said, this bill has some important provisions including the PNTR, provisions that extend important aspects of our tax laws. The extension of the work opportunity tax credits, the welfare-to-work tax credits, the AMT provision that the gentleman from Louisiana (Mr. McCRERY) mentioned, as well as several others including tax incentives for the District of Columbia.

Also in this bill are some pension-related provisions. One of them relates to the 30-year Treasury rate. This is an important provision for large numbers of companies and their workers, and we needed to find a way to introduce this into legislation and to implement it, and this bill does exactly that. And is another reason to favor this bill.

There is also, as the gentleman from Louisiana (Mr. McCRERY) mentioned, a provision relating to airlines and a 2-year provision to help them out. So this is a bill that has some miscellaneous provisions in it, but some of them are not very miscellaneous. Some of them are very important provisions. Some that are called technical, for example, would suspend or reduce import duties on numerous items for which there are no American competitors. And it would correct instances where Customs has overcharged for import duties. These are provisions that are important for domestic manufacturers and for their employees and for consumers.

One other provision that I should mention, since I have been so much involved with it with others, is the Reverse Customs Program at the northern border. This bill has references to that. These references are essentially relating to jurisdiction of committees. They do not change the basic provisions and do not in any way disturb the pace by which Customs will implement this important experiment in Reverse Customs Programs so that we can expedite the transportation of goods and passengers across the northern border, keeping in mind security considerations.

So, all in all, I believe this is a bill that deserves support with the caveats I mentioned. I have discussed earlier today, and the gentleman from Maryland, Mr. CARDIN, did with the chairman of the committee, the issue of Armenia and the need not for anybody to consider it a precedent either in terms of how PNTR is handled, other countries are handled, or the provisions relating to them. And we have received those verbal reassurances that the way the Armenia PNTR has been handled, it will not be a precedent in terms of committee or subcommittee consideration.

When my turn next comes I am going to yield many minutes to the gentleman from Maryland (Mr. CARDIN) who is going to talk about one issue that is not in this bill where there is an opportunity to place it and is so critical to hundreds of thousands of the citizens of the United States of America, and that is unemployment compensation, and I will do that at the appropriate time.

Mr. Speaker, I reserve the balance of my time.

Mr. McCRERY. Mr. Speaker, I yield 2 minutes to the gentleman from Pennsylvania (Mr. ENGLISH), a distinguished member of the Committee on Ways and Means.

Mr. ENGLISH. Mr. Speaker, I want to thank the gentleman for yielding me time.

As this institution moves forward to complete its business for the year, I think it is particularly important that we pause to pass this legislation that provides very critical tax relief and other important continuations of policy that I think reflect where this institution has been going, not only on tax policy but also on economic policy generally.

Mr. Speaker, I want to call attention to a couple of very important provisions that have been folded into this bill. I think one of the most important things we could do right now is to extend our tax treatment of net operating losses for companies, particularly in the wake of the long period, hopefully ending now, of companies having to attack against an ocean of red ink. I think it is particularly important now, particularly as our economy is beginning to grow again and beginning to grow again at a significant rate, that we give companies the relief they need on their net operating losses.

We have an opportunity here, I think, to give an additional boost to a lot of tax sensitive manufacturing concerns. And particularly, I wanted to say as chairman of the Congressional Steel Caucus, at a time when we are concerning ourselves with the health of the steel industry, it would be most helpful if we could liberalize the treatment of net operating losses and help not only steel companies, but also manufacturers generally in this economy trying to bounce back from an extended recession.

Mr. Speaker, I would also like to note as the gentleman on the other side of the aisle did, that this bill contains a very important provision providing Permanent Normal Trade Relations for the Republic of Armenia. Armenia emerged from the wreck of the Soviet Union with great potential, and they have done an enormous amount to liberalize their society and liberalize their economy. This institution needs to recognize that and take the additional step of stripping away those outdated Jackson-Vanik restrictions.

With that, I would urge that my colleagues pass this legislation and send a strong message that this body is prepared to go forward on the tax front and the trade front and do what it needs to do.

Mr. LEVIN. Mr. Speaker, I yield 5 minutes to the gentleman from Maryland (Mr. CARDIN).

Mr. CARDIN. Mr. Speaker, let me thank my friend, the gentleman from Michigan (Mr. LEVIN) for yielding me time.

Mr. Speaker, first let me say that there are some very important provisions in this bill. I see my friend, the gentleman from Ohio (Mr. PORTMAN) on the floor, and I know that we are both pleased that the 30-year Treasury replacement is included in this bill.

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I think we are both very disappointed that it is not for a longer period of time and does not include other provisions and legislation that we filed earlier that would have also helped preserve defined benefit plans properly funded for the workers of America, but at least there is some relief in this bill that is needed, and I am glad to see that is included in the legislation.

Let me say I appreciate the way the gentleman from Michigan (Mr. LEVIN) has presented the Armenian situation because I think he said it exactly right. There are human rights problems within Armenia. The Armenia Assembly of America, a respected group in this body, said the people of Armenia deserve nothing less than the declared aim of their government for free, fair, and transparent elections. As reported in depth by the OSCE, this achievable standard was not met.

The gentleman from New Jersey (Mr. SMITH), the chairman of our Helsinki Commission, and myself as ranking Democrat sent the letter to the Committee on Ways and Means in April of 2003. I just want to quote one line from that letter where we said: The underlining intent of the Jackson-Vanik language is to foster democratization and protect human rights. Our commission puts a very high premium to carry out the responsibility of this body to make human rights development in these emerging democracies a top priority. We are disappointed that more progress has not been made.

In Armenia's case, they do have normal trade relations, and I thank the gentleman from Michigan (Mr. LEVIN) very much for the understanding that the process that was used in Armenia's elevation will not be the process used as we consider other countries for elevation on normal trade relations; and clearly, we will be looking at the progress on human rights issues.

Mr. Speaker, let me, if I might, spend the remainder of my time on the unemployment insurance issue. I must tell my colleagues I am extremely disappointed that the majority did not include an extension of the unemployment insurance benefits in this extender bill. We are going to be faced with the same thing that happened last year. The Christmas present to our unemployed will be that they are not going to get any additional benefits. The present program expires at the end of December. We might be out of session by the end of the week, and yet the majority sees no urgency in extending the unemployment insurance. Eighty thousand to 90,000 workers every week will lose their Federal unemployment benefits if we do not extend this program.

The majority leader, the gentleman from Texas (Mr. DELAY), said, and I am quoting from today's paper, "I see no reason to be extending unemployment compensation since every economic indicator is better than in 1993 when the Democrats ended the Federal unemployment program."

Mr. Speaker, that is just not true. The extended benefit program in the early 1990s did not end until the economy had created nearly 3 million jobs, compared to the pre-recession levels. The current program is scheduled to end when the economy is still suffering a deficit of 2.4 million jobs. The current unemployment rate, 6 percent, has risen since the extended program was established in March of 2002. While starting at a higher level, the unemployment dropped substantially in the 1990s before we terminated the program.

The number of the long-term unemployed had dropped significantly before the 1990 extended program had expired. Today, the number of long-term unemployed, 2 million, has remained at a high level. The percentage of workers exhausting their unemployment benefits is higher today, 43 percent, than when the 1990 program ended, 39 percent. There are more people receiving unemployment today, 3.5 million, compared to the 1990s, 3.1 million.

Mr. Speaker, I just give those numbers because all we have to do is be in the trenches to know that people are hurting, people cannot find jobs, where every person seeking a job, there is only one job available. People want jobs, but cannot find them.

We need to extend the unemployment insurance Federal program. We have always done that in a bipartisan manner. We have always done it in every recession until we are on the road to recovery where people can find employment. That is not the case today. By every indicator that we have ever used in prior recessions, we should be extending the unemployment insurance program in this legislation. We should not be putting at jeopardy the needs of the people of our Nation.

So I am extremely disappointed; and I hope, Mr. Speaker, that the majority will allow us the chance to vote on the extension of unemployment insurance benefits before we adjourn this session of Congress. I know that there is support on the other side of the aisle for these programs. There have been two bills that have been filed. One has been filed by the gentlewoman from Washington (Ms. DUNN). I filed one. There has been legislation filed on both sides of the aisle. It is important that we consider it. It is important that we consider it as quickly as possible, and I hope that we will find a way to bring this up. Maybe the other body will include it in this legislation. I think we missed an opportunity to include it in this bill, and I am disappointed about that, and I urge my colleagues to figure out a way that we could address this issue before we adjourn.

Mr. MCCRERY. Mr. Speaker, I yield 2 minutes to the gentleman from Illinois (Mr. WELLER), another member of the Committee on Ways and Means.

Mr. WELLER. Mr. Speaker, we have had some good news since July. We have seen 286,000 new jobs created as a result of the Jobs and Economic Growth Act that was signed into law in May. That is good news; and really, this legislation we have before us today is another step in our effort to continue growing this economy and creating jobs, because one of the most important factors that affects the investment and the creation of jobs is certainty; and when a tax provision expires and there is doubt, uncertainty about whether that tax provision is going to be extended, those who invest, business and others, hold back and that affects our economy.

Passage of this legislation, with bipartisan support, is very important as we work to continue growing our economy. There are several very important economic growth provisions in this legislation that will be extended for another year, a 12-month extension, legislation that provides a tax incentive to clean up brownfields, abandoned industrial sites that require some environmental cleanup. Of course, we are extending the incentive to help business recover the cost of that environmental cleanup and create new jobs, recycling those industrial sites.

We recognize that there are many small- and medium-size manufacturers and other companies that have lost money this year. They need capital to invest in the creation of jobs to participate in the economic growth that we are currently beginning to enjoy; and by allowing them to go back over the last 5 years, find a profitable year, take this year's loss and essentially apply for a tax refund, that will give them capital to create new jobs.

Third, we all want those who are currently unemployed to have an opportunity to get a job. We also want those who are on welfare to have an opportunity to get a job; and the work opportunity tax credit is a tremendous program that has worked so well to give those who have been on welfare the opportunity for a job, a chance, in many cases the first chance that they have ever had for a good-paying job.

Let us extend these. This legislation deserves unanimous, bipartisan support. I urge an "aye" vote.

Mr. MCCRERY. Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. CAMP), another distinguished member of the Committee on Ways and Means.

Mr. CAMP. Mr. Speaker, I thank the chairman for yielding me the time.

There are a lot of important provisions in this legislation. I would like to address my remarks particularly to the airline pension relief provisions and why airlines face a pension funding crisis.

At the end of 1999, the airline industry's defined benefit pension plans on average were funded at 102 percent. At the end of 2002, that average level of funding fell to 54 percent, and the decline is a result of three factors. For the first time since World War II, the equity markets declined for 3 consecutive years. Market interest rates, which are used to define pension liabilities, are at 40-year lows. This pension funding crisis occurred at a time when the airline industry was in its worst financial situation due to the global recession, September 11, SARS, the Iraq war, and increased security costs.

There are also problems with current funding rules with regard to airlines. There is mandatory contribution provisions which tightened the funding rules in two inflexible ways which mandated the use of the 30-year Treasury rate, which this legislation addresses, and secondly, dramatically shortened the amortization period. That legislation was tightened in many ways in 1994.

During the last 3 years, the mandatory contribution funding requirements have been stress-tested by sustained economic downturns; and so between the enactment in 1987 and the beginning of the 3-year market collapse, the stock market had declined previously only in 1 year and then only by about 3 percent.

So in the face of this recent economic downturn and the simultaneous collapse of asset values, this mandatory contribution has proved to be onerous and inflexible, particularly to a highly cyclical industry like the airline industry.

This legislation affects zero tax dollars. It would temporarily defer contributions required by the mandatory contribution law for just a period of 2 years. Forcing airlines to contribute billions of dollars more over and above their regular pension contributions at this time would be disastrous. This gives us time to develop long-term solutions in this area. This is why unions and management came together to save pension plans for workers. If we do not address this issue, airlines will go bankrupt, as U.S. Airways has, and terminate their plans. Please support this legislation.

Mr. LEVIN. Mr. Speaker, it is my pleasure to yield 2 minutes to the gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Speaker, I rise in support of this tax extension bill. It includes, as has been mentioned, H.R. 528, a bill to extend normal trade relations to Armenia. As co-chair of the Congressional Caucus on Armenian Issues, I introduced this legislation with my fellow co-chair, the gentleman from Michigan (Mr. KNOLLENBERG), and our bipartisan bill has garnered 112 cosponsors during the course of this year; and it has been included in this bill thanks to the gentleman from California (Chairman THOMAS), the gentleman from New York (Ranking Member RANGEL), and also the gentleman from Michigan (Ranking Member LEVIN).

Mr. Speaker, Armenia has been consistently found in full compliance with Jackson-Vànik since 1997, and the passage of this legislation will go a long way to establishing closer relations between the United States and Armenia. Since the fall of the Soviet Union, the Republic of Armenia has consistently made strides towards a free and open economic system; and like many former Soviet republics in the last decade, Armenia has seen considerable diversity in this last decade.

Unlike most, though, Armenia has vigorously pursued free-market reforms within a democratic framework. On February 5, Armenia was acceded to the World Trade Organization, and its recent accession supports its noted progress in adopting and implementing economic and trade reforms. In fact, Armenia is consistently ranked the most economically free nation in the region. It is truly amazing that all this has been achieved considering that Armenia continues to suffer dual blockades by its neighbors to the east and west, both Azerbaijan and Turkey respectively.

I wanted to mention the comments that the gentleman from Michigan (Mr. LEVIN) and the gentleman from Maryland (Mr. CARDIN) made about human rights violations and strides towards democracy in Armenia. I know that, although Armenia continues to make great strides in these areas, more needs to be done; and I do acknowledge that. In fact, I do intend when I visit Armenia in 2 weeks, I wanted to mention to my colleagues that I will be talking to the President and the leaders there, and I will indicate to them that while we are very thrilled with the fact that the PNTR legislation has now passed the House that more needs to be done with regard to democracy and human rights.

But I want to point out that this will further strengthen our ties and lead to greater strides in these areas.

Mr. McCRERY. Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. PORTMAN), a member of the Committee on Ways and Means, a gentleman who has done tremendous work on the pension elements that are contained in this bill and will continue, I am sure, to provide leadership in this area.

Mr. PORTMAN. Mr. Speaker, I thank the gentleman from Louisiana (Mr. McCRERY) for giving me some time. I want to congratulate him for getting this extender bill to the floor. It is extremely important that we extend so many of these important tax provisions. I would like to think that over time we can make some of them permanent because they make so much sense, and after all, this is a 1-year extension. We are likely to extend them again and again. So I would hope that we could work toward that, but it is a very important bill; and it is extremely important we do it this year. If we do not, then we will have a situation where there will be a gap and companies and those individuals who want to take advantage of these good public policy tax provisions will not be able to plan. So not to have them be retroactive but do it at this point is extremely important, and I commend him and the gentleman from California (Chairman THOMAS) for getting us to this point.

I rise today also very strongly in support of a specific provision here that helps with regard to our defined pension plans. As all of us know, defined pension plans are in trouble. In the last few years, we have actually gone down in our pension coverage by about 19 percent. In fact, in the past 18 years we have gone from about 114,000 defined pension plans that are guaranteed by the Pension Benefit Guaranty Corporation to about 32,000 plans, dramatic decreases.

Many of the reasons that people are no longer offering plans and why this year we think that about 20 percent of plans are freezing their plans for participants is because we have a broken system with regard to what the interest rate is which is charged to these pension plans for their contributions.

What we do in this legislation is we provide for a 2-year fix, a short-term replacement for the currently and defunct 30-year Treasury rate, and that is extremely important. It allows employers to calculate the amount of money to set aside for their employee benefit plans in a more reasonable way and a more accurate way.

□ 1700

It strengthens, therefore, our defined benefit system dramatically in the short-term while we take a look at this whole system.

I see the gentleman from Ohio (Mr. BOEHNER), chairman of the Committee on Education and the Workforce, is here, and I look forward to working with him, as well as with the gentleman from California (Mr. THOMAS), chairman of the Committee on Ways and Means, the gentleman from Louisiana (Mr. McCRERY), the chairman of the subcommittee, and others, including the gentleman from Maryland (Mr. CARDIN), who spoke earlier about this issue, to come up with longer-term solutions to our pension funding rules, pension accounting rules to be sure that we can indeed continue to have these important defined benefit plans.

I think they are extremely important as a part of our overall security system, working with our Social Security System and our defined contribution system, such as the 401(k) plan. Without a permanent solution, these plans will be a thing of the past, and we will not have this guaranteed benefit for millions of Americans.

I strongly support the legislation before us and urge my colleagues on both sides of the aisle to do the same.

Mr. LEVIN. Mr. Speaker, it is my pleasure to yield 2 minutes to the distinguished Delegate, the gentlewoman from the District of Columbia (Ms. NORTON).

Ms. NORTON. Mr. Speaker, I thank my good friend, the gentleman from Michigan, for yielding me this time and for his assistance on this bill.

I strongly support the many provisions of H.R. 3521, but I rise to speak particularly about the D.C. tax incentives because the Members of this body have seen what these tax incentives have done with their own eyes. They have seen the District of Columbia rise from the dust with the amount of building we see downtown and in the neighborhoods, and that is due in no small part to the tax incentives that are in this extender.

I want to thank the Speaker, who has worked with me to assure me that these tax incentives would be extended. He promised me 2 years ago. He has continued to say this is going to happen. I appreciate that the gentleman from Texas (Mr. DELAY) and the gentleman from California (Mr. THOMAS) have kept on this. I know there were some difficulties. And I particularly appreciate my good friend, the ranking member in the minority, the gentleman from New York (Mr. RANGEL).

I appreciate that the tax incentives have been so effective that the President actually put them in his budget. I think it is because these tax incentives are the essence of how bipartisan tax work can help revive our Nation's Capital. The District had difficulty in the 1990s, the way New York and Philadelphia did. They had States, we did not, and I thought it was more important to get the businesses and the residents to revive the city than to keep asking the Congress for money. And, in fact, these tax incentives have recouped many times over for the Treasury.

There is a $5,000 homebuyer credit if you buy a house in the District of Columbia. This has reversed the flight from the District of Columbia, and we have seen a 50 percent increase in homebuying over the last 5 years. Many of them are staff from the House and Senate who are always talking to me about it. According to the studies, the majority of this homebuyer energy comes from the tax credit and not only from increased employment and declining mortgage rates.

There is a wage credit, which has been an incentive for many employers to remain in our city, and particularly for our tourist industry. There is the EZ Bonds that have brought us retail businesses of the kind that used to flee from the District, like K Mart. The zero capital gains can be seen in the $200 million Gallery Place development downtown.

So I, therefore, want to thank my colleagues for all this bill has done for our City, and I strongly urge its passage.

Mr. McCRERY. Mr. Speaker, I yield 2½ minutes to the gentleman from Ohio (Mr. BOEHNER), the distinguished chairman of the Committee on Education and the Workforce.

Mr. BOEHNER. Mr. Speaker, the significant pension underfunding problems that we face in this country have critical implications on the retirement security of American workers. Traditional defined benefit pension plans promise workers a set monthly benefit at retirement, and we have a responsibility to ensure that these important pension benefits for millions of American workers will be there when they retire.

The tax extension package that we have before us today includes a key pension funding change that was included in the Pension Funding Equity Act, the bipartisan measure that passed the House previously on October the 8th. It would have replaced the current 30-year Treasury bond interest rate that is used by many employers to calculate the amount of money they must set aside in their pension plans with a blend of corporate bond index rates for the next 2 years, through 2005. Because the current fix expires at the end of 2003, there is an urgency on the part of employers, unions, and workers to address this issue.

Let me explain why this change, I think, is so important. Strengthening the funding of defined benefit pension plans in the short-term will reduce the likelihood that the Federal Government will have to step in and pay benefits for underfunded plans, often at lower benefit levels for American workers. Moreover, employers who are making major short-term financial decisions need greater certainty to make key decisions about how to allocate scarce resources. Doing nothing could jeopardize employers' willingness to continue their defined benefit programs that provide a stable and secure pension benefit to workers during their retirement. Doing nothing is not an option, and for the good of our economy and for the good of American workers we need to act.

This measure also includes an additional item that would reduce additional payments that airlines must make to their pension plan when their funding falls below 90 percent of liabilities, called deficit reduction contributions, and we would reduce those contributions by 80 percent for just the next 2 years.

I remain concerned about the possible consequences of reducing deficit reduction contributions. Certainly, it is a last-resort approach. I would prefer not to single out any one industry for special relief, but enough of our colleagues in the other body feel differently, and we are nearly out of time. So I am pleased the DRC relief included in this measure is limited to 2 years, and I plan to support this measure for the good of our economy and the overall health of our Nation's pension system.

I am committed to ensuring that any DRC relief we enact is responsible and limited in scope to avoid compromising the defined benefit system as we look at broader, long-term reforms in both the Committee on Ways and Means and the Committee on Education and the Workforce.

Mr. LEVIN. Mr. Speaker, it is my pleasure to yield 2 minutes to the gentleman from California (Mr. GEORGE MILLER).

Mr. GEORGE MILLER of California. Mr. Speaker, I thank the gentleman for yielding me this time, and while I support this stopgap, short-term bill, I must say this legislation really does nothing to address the well-documented, serious and worsening pension crisis that threatens the retirement security of millions of Americans, and I provide my support for this legislation acknowledging the promise of my chairman, the gentleman from Ohio (Mr. BOEHNER), that we will, in fact, have detailed hearings and comprehensive hearings on this matter in the coming session of Congress.

Once again, this House is going to adjourn for the year without enacting much-needed comprehensive pension reform. As a result, the already precarious security of millions of seniors and working Americans is likely to worsen. The Congress and the Bush administration have been warned for 2 years about this deepening crisis. Yet as scandals, bankruptcies, and deficits have skyrocketed, there has been virtually no response. In fact, all we have seen from this administration is a plan to allow companies to convert cash balance plans that could cut some retirees pensions in half. Fortunately, it looks as if we may be able to prevent this from happening, no thanks to that administration.

Let no one be fooled, we are in a severe pension crisis in this country. Over the past 2 years, the underfunding of pensions has skyrocketed from $26 billion to $400 billion, the largest in history. The reserves of the Pension Benefits Guaranty Corporation, which takes over pension responsibilities for failed corporations, has gone from a $7.7 billion surplus to a deficit of almost $9 billion, threatening its future financial stability. According to the PBGC, the $11 billion loss in fiscal year 2002 is more than five times larger than any previous 1-year loss in the Agency's 29-year history.

For the past 18 months, the Bush administration and the Republican leadership in Congress have repeatedly ignored our urgent requests to wake up to the serious problem of pension underfunding. As the administration dithered, the deficits continued to balloon and the Government Accounting Office put the Pension Benefits Guaranty Corporation on its list of high-risk Federal Government programs, meaning the pensions of millions of Americans are in grave jeopardy.

As of today, the administration has yet to submit to Congress its reform plan. In testimony before our committee last month, the GAO demonstrated the severity of this problem in our pension laws, and I hope that we will be able to address in the next session of Congress that comprehensive solution.

Mr. McCRERY. Mr. Speaker, I yield 2½ minutes to the gentleman from Michigan (Mr. KNOLLENBERG).

Mr. KNOLLENBERG. Mr. Speaker, I thank the gentleman for yielding me this time, and I rise today in support of this very important bill. I hope all of our colleagues on both sides will join in supporting the bill because there are so many provisions that are important to our economy and to our foreign policy.

Airlines relief has been mentioned, replacement for the 30-year Treasury benchmark to allow companies to make more accurate contributions to their pension plans is something that we desperately need, and it is great to see that is provided here.

One provision in particular that I want to highlight is the Permanent Normal Trade Relations for Armenia. I am a sponsor of H.R. 528, a bill to provide PNTR for Armenia, which, as already has been indicated, was introduced by myself and my cochair of the Congressional Caucus on Armenian Issues, the gentleman from New Jersey (Mr. PALLONE). The bill currently has 112 cosponsors, a broad bipartisan group which includes many members of the Committee on Ways and Means and the ranking member, the gentleman from New York (Mr. RANGEL). I want to commend the chairman, the gentleman from California (Mr. THOMAS), and the subcommittee chairman, the gentleman from Louisiana (Mr. McCRERY), for their work to ensure that this is included in the bill.

Since declaring its independence from the Soviet Union in 1991, Armenia has made some great strides in developing a stable Democratic and open society. This includes an adherence to the fundamental principle of free emigration. Armenia is found to be in full compliance with the Jackson-Vanik requirement regarding free emigration under title IV of the Trade Act of 1974. The time has now come for Armenia to be graduated from this annual review.

On December 10, 2002, the World Trade Organization voted to include Armenia in its membership. However, neither Armenia nor the United States will be able to receive the full benefit of Armenia's inclusion in the WTO unless Congress passes PNTR. Passage of H.R. 528 will not only enhance trade and investment between the U.S. and Armenia, but will also deepen the strong relationship between our two countries. Approximately 70 U.S.-owned firms currently do business in Armenia. In total, United States-Armenia bilateral trade for 2002 amounted to over $134 million.

And, again, in closing, I want to thank everyone for working together to bring this about, and I want to urge my colleagues again to support this important bill.

Mr. LEVIN. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, I want to make two points. First of all, this bill is not paid for, $7 billion, and I hope that the Senate will rectify that. It is our understanding that they will. And I think that gives people on our side some reassurance that this will not be a further addition to an already escalating atrociously high deficit.

Secondly, I simply want to reinforce, on the issue of unemployment compensation, that when the gentleman from Texas (Mr. DELAY) said, "I see no reason to be extending unemployment compensation since every economic indicator is better than in 1993, when the Democrats ended the Federal unemployment program," that, as the gentleman from Maryland (Mr. CARDIN) pointed out, that is really an inaccurate statement.

If we do not extend this program, every week after Christmas about 90,000 people are going to be out on the street without any benefits. Now, we went through this the last Christmas. If my colleagues want us to come back here this Christmas, the three of us who came last time, and object, we will do that, but we should not have to do that. The unemployment program should be extended, period. And I hope that the majority in this House will step up to the plate on what is if not life and death, it is survival decently for tens of thousands of our fellow and sister citizens.

Mr. McCRERY. Mr. Speaker, I yield the balance of my time to the gentleman from Florida (Mr. FOLEY), a respected member of the Committee on Ways and Means, who will close the debate on this bipartisan bill.

Mr. FOLEY. Mr. Speaker, I thank the gentleman for yielding me this time, and for his outstanding presentation on the floor today and for going over some of the most relevant and important topics of this extension of expiring tax provisions.

I want to call to the attention of my colleagues on both sides of the aisle some very, very important substantial pieces of legislative tax work that are here in the bill. The Work Opportunity Tax Credit, a credit for employers equal to 40 percent of wages for hiring certain disadvantaged individuals. Targeted groups include TANF families, high-risk youth, certain ex-felons, summer youth, certain Veterans, and families on food stamps. This is a very important provision in this bill.

□ 1715

Welfare to work, again an experiment which has yielded tremendous results in Palm Beach County, the county in which I live, provides a tax credit for employers hiring targeted groups equal to 35 percent of wages.

These are interesting and important provisions to help people get back on their feet, to maintain a work ethic, and contribute to themselves, their families and our Nation.

The gentleman from Michigan (Mr. CAMP) and I authored an important provision relevant to elementary and secondary school teachers. My father is a retired teacher and principal, and that is a $250 above-the-line deduction for teachers purchasing classroom supplies. It was first enacted in the 2002 stimulus bill, and it continues today.

Qualified zone academy bonds. These are targeted tax credit bonds for school construction in economically targeted areas. This is very important for Florida with the rapid growth of the population and the need for school construction, once again a mechanism by which localities can seek tax credits for bonds to help with that opportunity.

Charitable contributions of computer technology used for educational purposes. We have seen a blossoming of computers in the classroom in educational settings, most due to the generosity of companies with excess equipment. This extends for 1 year the current law which encourages donation of computer technology and related equipment for educational purposes, providing donors with a higher basis and, therefore, larger deductions.

The gentleman from Illinois (Mr. WELLER) mentioned the brownfields remediations cost. Again, those are in my district and districts throughout the country.

The Archer medical savings account, which will be a provision contained also in our Medicare bill which will be brought to the floor tomorrow or Saturday, all of these issues contained in this extension provide some great opportunities for constituents throughout all 50 States and the territories.

Finally, for D.C. residents, the gentlewoman from the District of Columbia (Ms. NORTON) has worked extensively in reviving the fortunes of the city, and extends for 1 year a range of tax incentives for activities in the District of Columbia, including an important $5,000 tax credit for first-time home buyers. Anyone who lives on Capitol Hill has noticed a refurbishing, a reinvigoration of one of our most important cities. Visitors from around the world come to see where we work and where democracy flourishes.

Thanks to this provision, a $5,000 tax credit, we are starting to see the fruits of the labor of this bill, increasing homeownership and increasing opportunities: zero capital gains for D.C. on long-term capital gains held in the District, rental real estate buildings, things of that nature, getting people to reinvest in the capital city; and I thank the gentlewoman from the District of Columbia (Ms. NORTON) for helping the Mayor of this city and bringing some of these opportunities forward.

I encourage passage of the expiring tax provisions and urge adoption of this bill.

Mr. LANTOS. Mr. Speaker, I rise today to offer some observations regarding H.R. 3521, which includes the text of H.R. 528 that would establish normal trade relations for the Republic of Armenia.

First, I wish to make clear I have supported conditionally terminating the application of the Jackson-Vanik amendment, known as Title IV, to the Soviet successor states, starting with the Kyrgyz Republic and the Republic of Georgia in 2000.

In the case of this legislation, I support granting permanent normal trade relations (PNTR) status to Armenia. I believe that graduation from Jackson-Vanik will contribute to economic growth in Armenia. Starting in 1989, Armenia had been receiving annual Jackson-Vanik waivers, first as part of the Soviet Union and then as an independent country. It's time to make this process permanent.

However, I also strongly believe that the graduation for any successor state must be conditioned upon the development of a legal structure that guarantees internationally recognized human rights for its Jewish citizens, and members of other religious, national and ethnic minorities. In the absence of such conditions, there is in my opinion no possibility of establishing democratic institutions applicable to all citizens.

Twice in the past, in the case of the Republic of Georgia and the Republic of Kyrgyzstan, Congress has prudently determined that graduation from Jackson-Vanik would require more than the mere opening of a country's doors to emigration. The legislation prudently noted the advances made in other areas prior to waiving Jackson-Vanik, including the ability of Jews and other minorities to identify with their cultural heritage, restitution of communal property, rigorous governmental responses to anti-Semitism an xenophobia, and commitments on the implementation of laws and practices ensuring minority protection.

I believe that we do a disservice to the Republic of Armenia and to the Armenian diaspora—Armenia's greatest resource and asset—by not including the same standards to this legislation.

The findings that we believe should be included in this legislation are as follows:

The Congress of the United States finds that Armenia—

Registered significant progress in developing a system of governance in accordance with the provisions of the Final Act of the Conference on Security and Cooperation in Europe (also known as the "Helsinki Final Act") regarding human rights and humanitarian affairs;

Addressed issues related to its national and religious minorities through the relevant articles of its Constitution, and as a member state of the Organization for Security and Cooperation in Europe (OSCE), ensured that persons belonging to national minorities have full equality individually as well as in community with other members of their group;

Provided protection against incitement to violence against persons or groups based on national, racial, ethnic, or religious discrimination, hostility, or hatred, including anti-Semitism;

[Append the following to finding in H.R. 528 related to enacting free-market reforms] And is committed to making additional reforms to its economy;

Concluded a bilateral trade agreement with the United States, which entered into force on April 7, 1992, and a bilateral investment treaty, which entered into force on March 29, 1996;

Demonstrated a commitment to enforcing internationally recognized core labor standards and to continue to improve effective enforcement of its laws reflecting such standards; and

Acceded to the World Trade Organization on February 5, 2003, and the extension of unconditional normal trade relations treatment to the products of Armenia will enable the United States to avail itself of all rights under the World Trade Organization with respect to Armenia.

Armenia's small Jewish community is relatively well-treated and maintains a good working relationship with the government. I hope that the Armenian government will make available to the Jewish community an appropriate public space as symbolic compensation for communal properties destroyed during the Soviet period.

Although Armenia has gained accession to the World Trade Organization, the decision to graduate a country from the Jackson-Vanik amendment should be based upon those issues which motivated the original enactment of this law: religious freedom and human rights. Adoption of PNTR for Armenia by this House in the context as part of a larger, unrelated tax measure without this language should not be seen as any precedent for any future graduation.

In any case, I look forward to working with the gentleman from California and the gentleman from New York on incorporating language along these lines in the final bill regarding this legislation.

The SPEAKER pro tempore (Mr. SWEENEY). The question is on the motion offered by the gentleman from Louisiana (Mr. MCCRERY) that the House suspend the rules and pass the bill, H.R. 3521, as amended.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

FLOOD INSURANCE REFORM ACT OF 2003

Mr. NEY. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 253) to amend the National Flood Insurance Act of 1968 to reduce losses to properties for which repetitive flood claim payments have been made, as amended.

The Clerk read as follows:

H.R. 253

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Flood Insurance Reform Act of 2003".

SEC. 2. CONGRESSIONAL FINDINGS.

The Congress finds that—

(1) the national flood insurance program (A) identifies the flood risk, (B) provides flood risk information to the public, (C) encourages State and local governments to make appropriate land use adjustments to constrict the development of land which is exposed to flood damage and minimize damage caused by flood losses, and (D) makes flood insurance available on a nationwide basis that would otherwise not be available, to accelerate recovery from floods, mitigate future losses, save lives, and reduce the personal and national costs of flood disasters;

(2) the national flood insurance program insures approximately 4,400,000 policyholders;

(3) approximately 48,000 properties currently insured under the program have experienced, within a 10-year period, two or more flood losses where each such loss exceeds the amount $1,000;

(4) approximately 10,000 of these repetitive-loss properties have experienced either two or three losses that cumulatively exceed building value or four or more losses, each exceeding $1,000;

(5) repetitive-loss properties constitute a significant drain on the resources of the national flood insurance program, costing about $200,000,000 annually;

(6) repetitive-loss properties comprise approximately one percent of currently insured properties but are expected to account for 25 to 30 percent of claims losses;

(7) the vast majority of repetitive-loss properties were built before local community implementation of floodplain management standards under the program and thus are eligible for subsidized flood insurance;

(8) while some property owners take advantage of the program allowing subsidized flood insurance without requiring mitigation action, others are trapped in a vicious cycle of suffering flooding, then repairing flood damage, then suffering flooding, without the means to mitigate losses or move out of harm's way;

(9) mitigation of repetitive-loss properties through buyouts, elevations, relocations, or flood-proofing will produce savings for policyholders under the program and for Federal taxpayers through reduced flood insurance losses and reduced Federal disaster assistance;

(10) a strategy of making mitigation offers aimed at high-priority repetitive-loss properties and shifting more of the burden of recovery costs to property owners who choose to remain vulnerable to repetitive flood damage can encourage property owners to take appropriate actions that reduce loss of life and property damage and benefit the financial soundness of the program; and

(11) the method for addressing repetitive-loss properties should be flexible enough to take into consideration legitimate circumstances that may prevent an owner from taking a mitigation action.

SEC. 3. EXTENSION OF PROGRAM AND CONSOLIDATION OF AUTHORIZATIONS.

The National Flood Insurance Act of 1968 is amended as follows:

(1) BORROWING AUTHORITY.—In the first sentence of section 1309(a) (42 U.S.C. 4016(a)), by striking "through December" and all that follows through ", and" and inserting the following: "through the date specified in section 1319, and".

(2) AUTHORITY FOR CONTRACTS.—In section 1319 (42 U.S.C. 4026), by striking "after" and all that follows and inserting "after September 30, 2008.".

(3) EMERGENCY IMPLEMENTATION.—In section 1336(a) (42 U.S.C. 4056(a)), by striking "during the period" and all that follows through "in accordance" and inserting "during the period ending on the date specified in section 1319, in accordance".

(4) AUTHORIZATION OF APPROPRIATIONS FOR STUDIES.—In section 1376(c) (42 U.S.C. 4127(c)), by striking "through" and all that follows and inserting the following: "through the date specified in section 1319, for studies under this title.".

SEC. 4. ESTABLISHMENT OF PILOT PROGRAM FOR MITIGATION OF SEVERE REPETITIVE LOSS PROPERTIES.

(a) IN GENERAL.—The National Flood Insurance Act of 1968 is amended by inserting after section 1361 (42 U.S.C. 4102) the following new section:

"PILOT PROGRAM FOR MITIGATION OF SEVERE REPETITIVE LOSS PROPERTIES

"SEC. 1362. (a) AUTHORITY.—To the extent amounts are made available for use under this section, the Director may, subject to the limitations of this section, provide financial assistance to States and communities for taking actions with respect to severe repetitive loss properties (as such term is defined in subsection (b)) to mitigate flood damage to such properties and losses to the National Flood Insurance Fund from such properties.

"(b) SEVERE REPETITIVE LOSS PROPERTY.—For purposes of this section, the term 'severe repetitive loss property' has the following meaning:

"(1) SINGLE-FAMILY PROPERTIES.—In the case of a property consisting of one to four residences, such term means a property that—

"(A) is covered under a contract for flood insurance made available under this title; and

"(B) has incurred flood-related damage—

"(i) for which four or more separate claims payments have been made under flood insurance coverage under this title before the date of the enactment of the Flood Insurance Reform Act of 2003, with the amount of each such claim exceeding $5,000, and with the cumulative amount of such claims payments exceeding $20,000;

"(ii) for which four or more separate claims payments have been made under flood insurance coverage under this title after the date of the enactment of the Flood Insurance Reform Act of 2003, with the amount of each such claim exceeding $3,000, and with the cumulative amount of such claims payments exceeding $15,000; or

"(iii) for which at least two separate claims payments have been made under such coverage, with the cumulative amount of such claims exceeding the value of the property.

"(2) MULTIFAMILY PROPERTIES.—In the case of a property consisting of five or more residences, such term shall have such meaning as the Director shall by regulation provide.

"(c) ELIGIBLE ACTIVITIES.—Amounts provided under this section to a State or community may be used only for the following activities:

"(1) MITIGATION ACTIVITIES.—To carry out mitigation activities that reduce flood damages to severe repetitive loss properties, including elevation, relocation, demolition, and floodproofing of structures, and minor physical localized flood control projects.

"(2) PURCHASE.—To purchase severe repetitive loss properties, subject to subsection (f).

"(d) MATCHING REQUIREMENT.—

"(1) IN GENERAL.—Except as provided in paragraph (2), the Director may not provide assistance under this section to a State or community in an amount exceeding 3 times the amount that the State or community certifies, as the Director shall require, that the State or community will contribute from non-Federal funds for carrying out the eligible activities to be funded with such assistance amounts.

"(2) WAIVER.—

"(A) AUTHORITY.—Subject to subparagraph (B), the Director may waive the limitation under paragraph (1) for any State, and for the communities located in that State, with respect to a year, if, for such year—

"(i) 5 percent or more of the total number of severe repetitive loss properties in the United States are located in such State; and

"(ii) the State submits a plan to the Director specifying how the State intends to reduce the number of severe repetitive loss properties and the Director determines, after consultation with State and technical experts, that the State has taken actions to reduce the number of such properties.

"(B) LIMITATION.—In each waiver under subparagraph (A), the Director may waive the limitation under paragraph (1) only to the extent that the State or community involved is required to contribute, for each severe repetitive loss property for which grant amounts are provided, not less than 10 percent of the cost of the activities for such properties that are to be funded with grant amounts.

"(3) NON-FEDERAL FUNDS.—For purposes of this subsection, the term 'non-Federal funds' includes State or local agency funds, in-kind contributions, any salary paid to staff to carry out the eligible activities of the recipient, the value of the time and services contributed by volunteers to carry out such activities (at a rate determined by the Director), and the value of any donated material or building and the value of any lease on a building.

“(e) STANDARDS FOR MITIGATION OFFERS.—The program under this section for providing assistance for eligible activities for severe repetitive loss properties shall be subject to the following limitations:

“(1) PRIORITY.—In determining the properties for which to provide assistance for eligible activities under subsection (c), the Director shall provide assistance for properties in the order that will result in the greatest amount of savings to the National Flood Insurance Fund in the shortest period of time.

“(2) OFFERS.—The Director shall provide assistance in a manner that permits States and communities to make offers to owners of severe repetitive loss properties to take eligible activities under subsection (c) as soon as is practicable.

“(3) NOTICE.—Upon making an offer to provide assistance with respect to a property for any eligible activity under subsection (c), the State or community shall notify each holder of a recorded interest on the property of such offer and activity.

“(f) PURCHASE OFFERS.—A State or community may take action under subsection (c)(2) to purchase a severe repetitive loss property only if the following requirements are met:

“(1) USE OF PROPERTY.—The State or community enters into an agreement with the Director that provides assurances that the property purchased will be used in a manner that is consistent with the requirements of clauses (i) and (ii) of section 404(b)(2)(B) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5170c(b)(2)(B)) for properties acquired, accepted, or from which a structure will be removed pursuant to a project provided property acquisition and relocation assistance under such section 404(b).

“(2) PURCHASE PRICE.—The amount of purchase offer is not less than the greatest of—

“(A) the amount of the original purchase price of the property, when purchased by the holder of the current policy of flood insurance under this title;

“(B) the total amount owed, at the time the offer to purchase is made, under any loan secured by a recorded interest on the property;

“(C) an amount equal to the fair market value of the property immediately before the most recent flood event affecting the property; and

“(D) an amount equal to the replacement value of the property immediately before the most recent flood event affecting the property, except that this subparagraph shall apply in the case only of a property for which the State or community taking action under subsection (c)(2) determines, and the Director concurs, that the fair market value referred to in subparagraph (C) of the property is less than the purchase price of a replacement primary residence that is of comparable value, functionally equivalent, and located in the same community or market area but not in an area having special flood hazards.

“(g) INCREASED PREMIUMS IN CASES OF REFUSAL TO MITIGATE.—

“(1) IN GENERAL.—In any case in which the owner of a severe repetitive loss property refuses an offer to take action under paragraph (1) or (2) of subsection (c) with respect to such property, the Director shall—

“(A) notify each holder of a recorded interest on the property of such refusal; and

“(B) notwithstanding subsections (a) through (c) of section 1308, thereafter the chargeable premium rate with respect to the property shall be the amount equal to 150 percent of the chargeable rate for the property at the time that the offer was made, as adjusted by any other premium adjustments otherwise applicable to the property and any subsequent increases pursuant to paragraph (2) and subject to the limitation under paragraph (3).

“(2) INCREASED PREMIUMS UPON SUBSEQUENT FLOOD DAMAGE.—Notwithstanding subsections (a) through (c) of section 1308, if the owner of a severe repetitive loss property does not accept an offer to take action under paragraph (1) or (2) of subsection (c) with respect to such property and a claim payment exceeding $1,500 is made under flood insurance coverage under this title for damage to the property caused by a flood event occurring after such offer is made, thereafter the chargeable premium rate with respect to the property shall be the amount equal to 150 percent of the chargeable rate for the property at the time of such flood event, as adjusted by any other premium adjustments otherwise applicable to the property and any subsequent increases pursuant to this paragraph and subject to the limitation under paragraph (3).

“(3) LIMITATION ON INCREASED PREMIUMS.—In no case may the chargeable premium rate for a severe repetitive loss property be increased pursuant to this subsection to an amount exceeding the applicable estimated risk premium rate for the area (or subdivision thereof) under section 1307(a)(1).

“(4) TREATMENT OF DEDUCTIBLES.—Any increase in chargeable premium rates required under this subsection for a severe repetitive loss property may be carried out, to the extent appropriate, as determined by the Director, by adjusting any deductible charged in connection with flood insurance coverage under this title for the property.

“(5) NOTICE OF CONTINUED OFFER.—Upon each renewal or modification of any flood insurance coverage under this title for a severe repetitive loss property, the Director shall notify the owner that the offer made pursuant to subsection (c) is still open.

“(6) APPEALS.—

“(A) IN GENERAL.—Any owner of a severe repetitive loss property may appeal a determination of the Director to take action under paragraph (1)(B) or (2) with respect to such property, based only upon the following grounds:

“(i) As a result of such action, the owner of the property will not be able to purchase a replacement primary residence of comparable value and that is functionally equivalent.

“(ii) As a result of such action, the preservation or maintenance of any prehistoric or historic district, site, building, structure, or object included in, or eligible for inclusion in, the National Register of historic places will be interfered with, impaired, or disrupted.

“(iii) The flooding that resulted in the flood insurance claims described in subsection (b)(2) for the property resulted from significant actions by a third party in violation of Federal, State, or local law, ordinance, or regulation.

“(iv) In purchasing the property, the owner relied upon flood insurance rate maps of the Federal Emergency Management Agency that were current at the time and did not indicate that the property was located in an area having special flood hazards.

“(B) PROCEDURE.—An appeal under this paragraph of a determination of the Director shall be made by filing, with the Director, a request for an appeal within 90 days after receiving notice of such determination. Upon receiving the request, the Director shall select, from a list of independent third parties compiled by the Director for such purpose, a party to hear such appeal. Within 90 days after filing of the request for the appeal, such third party shall review the determination of the Director and shall set aside such determination if the third party determines that the grounds under subparagraph (A) exist. During the pendency of an appeal under this paragraph, the Director shall stay the applicability of the rates established pursuant to paragraph (1)(B) or (2), as applicable.

“(C) EFFECT OF FINAL DETERMINATION.—In an appeal under this paragraph—

“(i) if a final determination is made that the grounds under subparagraph (A) exist, the third party hearing such appeal shall make a determination of how much to reduce the chargeable risk premium rate for flood insurance coverage for the property involved in the appeal from the amount required under paragraph (1)(B) or (2) and the Director shall promptly reduce the chargeable risk premium rate for such property by such amount; and

“(ii) if a final determination is made that the grounds under subparagraph (A) do not exist, the Director shall promptly increase the chargeable risk premium rate for such property to the amount established pursuant to paragraph (1)(B) or (2), as applicable, and shall collect from the property owner the amount necessary to cover the stay of the applicability of such increased rates during the pendency of the appeal.

“(D) COSTS.—If the third party hearing an appeal under this paragraph is compensated for such service, the costs of such compensation shall be borne—

“(i) by the owner of the property requesting the appeal, if the final determination in the appeal is that the grounds under subparagraph (A) do not exist; and

“(ii) by the National Flood Insurance Fund, if such final determination is that the grounds under subparagraph (A) do exist.

“(E) REPORT.—Not later than 6 months after the date of the enactment of the Flood Insurance Reform Act of 2003, the Director shall submit a report to the House of Representatives and the Senate describing the rules, procedures, and administration for appeals under this paragraph.

“(h) DISCRETIONARY ACTIONS IN CASES OF FRAUDULENT CLAIMS.—If the Director determines that a fraudulent claim was made under flood insurance coverage under this title for a severe repetitive loss property, the Director may—

“(1) cancel the policy and deny the provision to such policyholder of any new flood insurance coverage under this title for the property; or

“(2) refuse to renew the policy with such policyholder upon expiration and deny the provision of any new flood insurance coverage under this title to such policyholder for the property.

“(i) FUNDING.—Pursuant to section 1310(a)(8), the Director may use amounts from the National Flood Insurance Fund to provide assistance under this section in each of fiscal years 2004, 2005, 2006, 2007, and 2008, except that the amount so used in each such fiscal year may not exceed $40,000,000 and shall remain available until expended. Notwithstanding any other provision of this title, amounts made available pursuant to this subsection shall not be subject to offsetting collections through premium rates for flood insurance coverage under this title.

“(j) TERMINATION.—The Director may not provide assistance under this section to any

State or community after September 30, 2008.".

(b) Availability of National Flood Insurance Fund Amounts.—Section 1310(a) of the National Flood Insurance Act of 1968 (42 U.S.C. 4017(a)) is amended—

(1) in paragraph (7), by striking "and" at the end; and

(2) by striking paragraph (8) and inserting the following new paragraph:

"(8) for financial assistance under section 1362 to States and communities for taking actions under such section with respect to severe repetitive loss properties, but only to the extent provided in section 1362(i); and".

SEC. 5. AMENDMENTS TO EXISTING FLOOD MITIGATION ASSISTANCE PROGRAM.

(a) Standard for Approval of Mitigation Plans.—Section 1366(e)(3) of the National Flood Insurance Act of 1968 (42 U.S.C. 4104(c) is amended by adding at the end the following new sentence: "The Director may approve only mitigation plans that give priority for funding to such properties, or to such subsets of properties, as are in the best interest of the National Flood Insurance Fund.".

(b) Priority for Mitigation Assistance.—Section 1366(e) of the National Flood Insurance Act of 1968 (42 U.S.C. 4104c) is amended by striking paragraph (4) and inserting the following new paragraph:

"(4) Priority for mitigation assistance.—In providing grants under this subsection for mitigation activities, the Director shall give first priority for funding to such properties, or to such subsets of such properties as the Director may establish, that the Director determines are in the best interests of the National Flood Insurance Fund and for which matching amounts under subsection (f) are available.".

(c) Coordination With States and Communities.—Section 1366 of the National Flood Insurance Act of 1968 (42 U.S.C. 4104c) is amended by adding at the end the following new subsection:

"(m) Coordination With States and Communities.—The Director shall, in consultation and coordination with States and communities take such actions as are appropriate to encourage and improve participation in the national flood insurance program of owners of properties, including owners of properties that are not located in areas having special flood hazards but are located within the 100-year floodplain.".

(d) Funding.—Section 1367(b) of the National Flood Insurance Act of 1968 (42 U.S.C. 4104d(b)) is amended by striking paragraph (1) and inserting the following new paragraph:

"(1) in each fiscal year, amounts from the National Flood Insurance Fund not exceeding $40,000,000;".

SEC. 6. FEMA AUTHORITY TO FUND MITIGATION ACTIVITIES FOR INDIVIDUAL REPETITIVE CLAIMS PROPERTIES.

(a) In General.—Chapter I of the National Flood Insurance Act of 1968 (42 U.S.C. 4011 et seq.) is amended by adding at the end the following new section:

"GRANTS FOR REPETITIVE INSURANCE CLAIMS PROPERTIES

"Sec. 1323. (a) In General.—General.—The Director may provide funding for mitigation actions that reduce flood damages to individual properties for which one or more claim payments for losses have been made under flood insurance coverage under this title, but only if the Director determines that—

"(1) such activities are in the best interest of the National Flood Insurance Fund; and

"(2) such activities can not be funded under the program under section 1366 because—

"(A) the requirements of section 1366(g) are not being met by the State or community in which the property is located; or

"(B) the State or community does not have the capacity to manage such activities.

"(b) Priority for Worst-Case Properties.—In determining the properties for which funding is to be provided under this section, the Director shall consult with the States in which such properties are located and provide assistance for properties in the order that will result in the greatest amount of savings to the National Flood Insurance Fund in the shortest period of time.".

(b) Availability of National Flood Insurance Fund Amounts.—Section 1310(a) of the National Flood Insurance Act of 1968 (42 U.S.C. 4017(a)) is amended by adding at the end the following new paragraph:

"(9) for funding, not to exceed $10,000,000 in any fiscal year, for mitigation actions under section 1323, except that, notwithstanding any other provision of this title, amounts made available pursuant to this paragraph shall not be subject to offsetting collections through premium rates for flood insurance coverage under this title.".

SEC. 7. ACTUARIAL RATE PROPERTIES.

(a) In General.—Section 1308 of the National Flood Insurance Act of 1968 (42 U.S.C. 4015) is amended by striking subsection (c) and inserting the following new subsection:

"(c) Actuarial Rate Properties.—Subject only to the limitations provided under paragraphs (1) and (2), the chargeable rate shall not be less than the applicable estimated risk premium rate for such area (or subdivision thereof) under section 1307(a)(1) with respect to the following properties:

"(1) Post-firm properties.—Any property the construction or substantial improvement of which the Director determines has been started after December 31, 1974, or started after the effective date of the initial rate map published by the Director under paragraph (2) of section 1360 for the area in which such property is located, whichever is later, except that the chargeable rate for properties under this paragraph shall be subject to the limitation under subsection (e).

"(2) Certain leased coastal and river properties.—Any property leased from the Federal Government (including residential and nonresidential properties) that the Director determines is located on the river-facing side of any dike, levee, or other riverine flood control structure, or seaward of any seawall or other coastal flood control structure.".

(b) Inapplicability of Annual Limitations on Premium Increases.—Section 1308(e) of the National Flood Insurance Act of 1968 (42 U.S.C. 4015(e)) is amended by striking "Notwithstanding" and inserting "Except with respect to properties described under paragraph (2) or (3) of subsection (c) and notwithstanding".

SEC. 8. ELECTRONIC DATABASE OF REPETITIVE LOSS PROPERTIES.

Section 1364 of the National Flood Insurance Act of 1968 (42 U.S.C. 4104a) is amended by adding at the end the following new subsection:

"(d) Electronic Database of Repetitive Claims Properties.—The Director may, if the Director determines such action is feasible, establish and maintain a database identifying by location and address all repetitive loss structures (as such term is defined in section 1370) and severe repetitive loss properties (as such term is defined in section 1362(b)). If established, the Director shall make the database available to the public in a format that may be searched electronically. Such a database shall not include any information regarding ownership of properties.".

SEC. 9. REPLACEMENT OF MOBILE HOMES ON ORIGINAL SITES.

Section 1315 of the National Flood Insurance Act of 1968 (42 U.S.C. 4022) is amended by adding at the end the following new subsection:

"(c) Replacement of Mobile Homes on Original Sites.—

"(1) Community participation.—The placement of any mobile home on any site shall not affect the eligibility of any community to participate in the flood insurance program under this title and the Flood Disaster Protection Act of 1973 (notwithstanding that such placement may fail to comply with any elevation or flood damage mitigation requirements), if—

"(A) such mobile home was previously located on such site;

"(B) such mobile home was relocated from such site because of flooding that threatened or affected such site; and

"(C) such replacement is conducted not later than the expiration of the 180-day period that begins upon the subsidence (in the area of such site) of the body of water that flooded to a level considered lower than flood levels.

"(2) Definition.—For purposes of this subsection, the term 'mobile home' has the meaning given such term in the law of the State in which the mobile home is located.".

SEC. 10. REITERATION OF FEMA RESPONSIBILITY TO MAP MUDSLIDES.

As directed in section 1360(b) of the National Flood Insurance Act of 1968 (42 U.S.C. 4101(b)), the Director of the Federal Emergency Management Agency is again directed to accelerate the identification of risk zones within flood-prone and mudslide-prone areas, as provided by subsection (a)(2) of such section 1360, in order to make known the degree of hazard within each such zone at the earliest possible date.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Ohio (Mr. Ney) and the gentleman from Massachusetts (Mr. Frank) each will control 20 minutes.

The Chair recognizes the gentleman from Ohio (Mr. Ney).

GENERAL LEAVE

Mr. NEY. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and insert extraneous material on this legislation.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Ohio?

There was no objection.

Mr. NEY. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, today I rise in support of H.R. 253, a reauthorization of the National Flood Insurance Program. I am pleased that an arrangement this afternoon could be worked out between all of the interested parties so this bill could come up under suspension. We can all agree that this is a fiscally responsible bipartisan piece of legislation.

Floods have been and continue to be one of the most destructive and costly natural hazards to our country. The National Flood Insurance Program is a valuable tool in addressing the losses incurred throughout this country due to floods. It ensures that businesses and families have access to affordable flood insurance that would not be available on the national market. The National Flood Insurance Program was established in 1968 with the passage of the National Flood Insurance Act.

Prior to that time, insurance companies generally did not offer coverage for flood disasters because of the high risk involved. Today almost 20,000 communities participate in the National Flood Insurance Program. More than 90 insurance companies sell and service flood policies. There are approximately 4.4 million policies covering a total of $620 billion. In order to participate in the program, communities must agree to abide by certain hazard mitigation provisions. These provisions include adopting building codes that require new floodplain structures to be protected against flooding, or elevated above the 100-year flood plain. The National Flood Insurance Program is administered by FEMA. It is worth noting that on November 25, 2002, President Bush signed into law the Homeland Security Act of 2002 which brought FEMA under the new Department of Homeland Security.

The NFIP authorization expired on November 21, 2002. Unfortunately, Congress adjourned without extending the program. This situation was quickly remedied in the 108th Congress on January 13, 2003. President Bush signed into law a bill to reauthorize the program for 1 year retroactively to January 1, 2003. This 1-year reauthorization will give us the time necessary to determine how best to go about reforming the existing program.

This is a good day for the National Food Insurance Program and a good day for American taxpayers. I applaud all Members for reaching agreement and give credit to the gentleman from Ohio (Mr. OXLEY), the gentleman from Louisiana (Mr. BAKER), the gentleman from Nebraska (Mr. BEREUTER), the gentleman from Massachusetts (Mr. FRANK), the gentleman from Louisiana (Mr. TAUZIN), the gentlewoman from California (Ms. WATERS), and the gentleman from Oregon (Mr. BLUMENAUER).

Also, I want to note that a correction was made that was a terrible situation for many people in that if they moved a trailer off a property, they could not take it back in; and they were forced to build expensive, tall walls and it hurt a lot of poor people. That correction was made after 5 years of injustice on that. I urge my colleagues to support this initiative.

Mr. Speaker, I reserve the balance of my time.

Mr. FRANK of Massachusetts. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I am pleased with this legislation and, frankly, with the cooperative spirit that has brought it before us as a suspension. Members may note, there was a change in plans. Originally, we had a unanimous consent agreement to bring this up as a bill with an amendment. We have had conversations. As a result, we have an agreement to go forward with this bill with an amendment. It is a modification that will make the impact a little easier on some people in some areas of the country and will make it in part something of an experiment because we will have to revisit it after a few years, but it will change the essence of the bill.

Our hope is, as a result of the spirit of compromise and flexibility that was shown on this side, when the bill goes elsewhere in this Capitol, there will be a hospitable attitude. There was, frankly, the prospect before that of a possible deadlock between the branches. We believe we have taken a step, well, more than a step, to help avoid that.

The substance is very important, and I want to pay particular tribute to the gentleman from Nebraska (Mr. BEREUTER) and the gentleman from Oregon (Mr. BLUMENAUER). One is a member of the committee, the gentleman from Nebraska (Mr. BEREUTER); and one is not, the gentleman from Oregon (Mr. BLUMENAUER), because they took the initiative. Yes, people who have built in areas that are likely to flood should get some help from the Federal Government. The poor old Federal Government gets denounced a lot in general; but in particular, almost everybody finds some reason to want to substitute it for the pure market forces in some cases.

There is a consensus here that the market does not work for some people with regard to flood insurance. Our position was, however, that we were too little reliant on economic factors. That is, we have had a situation where people could build, be flooded, get compensated through a Federal program; build, get flooded, and get compensated through a Federal program indefinitely. Neither in fiscal terms nor from an environmental standpoint was that a good idea.

This bill is an effort, without cutting people off, to reform that situation. It is widely supported by virtually all of the taxpayer groups that worry about what they think is excessive spending, and it is supported by environmentalists. It is something of a compromise. I hope we can go forward with it and see it adopted.

I should note, this program, the Federal Flood Insurance Program, expired last year. The gentleman from Ohio (Chairman NEY) and I collaborated earlier this year and retroactively extended it. I believe it was the first act this Congress took, was to make sure people were protected. No one is indifferent to the fate of these people.

We did, however, say, and I thank the gentleman for his leadership, that we could not simply continue to extend this program. It had to be reformed. The gentleman from Nebraska (Mr. BEREUTER) and the gentleman from Oregon (Mr. BLUMENAUER) did us a great service by taking the initiative there. It was supported by the gentleman from Ohio (Chairman NEY) and the gentlewoman from California (Ms. WATERS), who is the ranking member; and that is where we are.

We have now got a further compromise. I understand that is not yet something they have had a chance to review in the Senate. My hope is what we will do, and I believe there is agreement on this, is to pass a 3-month extension in an appropriate vehicle here, which would then be accepted in the Senate. That would give us until March 31 of next year with the program fully in effect to be able to work out in the Senate what we believe we have successfully worked out here, namely, a reasonable compromise. It is in that spirit that I go forward with this.

Mr. Speaker, I reserve the balance of my time.

Mr. NEY. Mr. Speaker, I yield such time as he may consume to the gentleman from Ohio (Mr. OXLEY).

Mr. OXLEY. Mr. Speaker, let me thank the gentleman from Ohio (Mr. NEY) for his leadership on this issue. I certainly share the sentiments expressed by the gentleman from Massachusetts (Mr. FRANK) regarding the need to really get at reforming this flood insurance program. The 1-year extensions year after year were something that I think grated on a lot of folks, the taxpayer groups and the environmental groups. Had it not been for the gentleman from Oregon (Mr. BLUMENAUER) and the gentleman from Nebraska (Mr. BEREUTER), we probably would not be here today. I want to give them particular acknowledgment for their efforts to craft a compromise, and it was not easy. We have been through this I do not know how many years.

These two gentlemen have toiled in the vineyards trying to get this legislation passed, and it is a real tribute to their perseverance that we are here today. And I also thank the gentleman from Massachusetts (Mr. FRANK) for his incisive leadership as well, as well as the gentleman from Louisiana (Mr. BAKER) because he was an integral part of forming the compromise that led to a unanimous vote in the subcommittee as well as the full committee and bringing this to the floor today.

This program is vital. We proved that by letting it expire some time for the first part of the year and then came back and made it retroactive as indicated, but we found out very quickly it was incredibly important from a lot of housing groups that we needed to move and move fast. It was, I think, the first bill that was passed in the last year to make up that difference.

□ 1730

This gives us an opportunity to really reform this program in the right way. We hopefully are in a situation where the other body can take a look at this. We would, of course, agree to a short-term extension but at the same time get some assurances that we can really address this problem. There are too many people out there who depend on this program, there are too many taxpayers who have been ripped off over the years by the abuse of this program, and that is what the reform really does.

From the environmental side, from the taxpayer side, this is good legislation, crafted by the committee and made better by the gentleman from Louisiana (Mr. BAKER) and his efforts. I want to thank all of them for their efforts. Also I see the gentleman from Texas (Mr. GREEN) who has also been a participant in this and has some very important issues to raise in terms of property values that have arisen in his Houston district. We were pleased to add that language to the legislation as well.

Mr. FRANK of Massachusetts. Mr. Speaker, I yield 2 minutes to the gentlewoman from Oregon (Ms. HOOLEY).

Ms. HOOLEY of Oregon. Mr. Speaker, I rise in support of this legislation which will take important steps towards reforming the National Flood Insurance Program that will, in the end, benefit taxpayers, the environment, and people who suffer from frequent flooding by improving mitigation programs.

Mitigation is important both in terms of saving lives and in terms of saving dollars. There is a great example of a success in one of the counties in my district, Tillamook County. Five rivers flow into Tillamook Bay, leading to frequent floods during rainy Oregon winters. Realizing the repeated problem with flooding they face, the county and local businesses and residents have stepped up to address the issue. From the earliest days of their participation in Project Impact, Tillamook has been involved in flood mitigation before anyone else knew what that meant, and they have reduced the damages caused by flooding significantly. While floods still come frequently, they no longer cause million upon millions of dollars in damages to residents and businesses thanks to the great work done in Tillamook County. In this regard, I believe it is important to make sure the Federal Government is a partner in these efforts and does not penalize Tillamook and other localities for their hard work. One part of this is ensuring that local communities, who are knowledgeable about the local businesses, are the ones making the decisions instead of a Federal agency like FEMA. Based on communications with the gentleman from Oregon (Mr. BLUMENAUER) and FEMA, local communities will indeed have the decision-making authority under this legislation.

I have spoken with many local governments and civic leaders from Oregon, including mayors, county commissioners, city council members and local flood plain managers. Each have expressed their support for the creation of a better mitigation program to prevent flood damage from ever happening. This bill accomplishes that goal.

I rise in support of the gentleman from Oregon's and the gentleman from Nebraska's legislation and urge my colleagues to vote in favor of it.

Mr. NEY. Mr. Speaker, I yield 3 minutes to the gentleman from Louisiana (Mr. TAUZIN).

Mr. TAUZIN. Mr. Speaker, let me first pay special thanks and appreciation to the gentleman from Louisiana (Mr. BAKER) who has worked tirelessly this week to try to find some rational amendment to this bill that made it somewhat better for those of us who represent districts that are literally so low along the coast of this country, mine included. You can imagine living in coastal Louisiana and most of the Cajuns I represent live there, very poor people in many cases who live and have lived there for centuries almost in that same area, to try to make this a little better.

Let me explain the problem that coastal communities face, particularly coastal Louisiana, with a bill like this. First of all, the flood insurance program is kind of special in America. Flood victims are the only ones who are obliged to belong to an insurance program. We do not have an earthquake insurance program. We do not have a fire insurance program for the homes in California that were damaged by these fires. We do not have violence insurance programs for the urban city. What we have is a flood insurance program that we are mandated to join. Unlike the other disasters that strike America, whether it is tornadoes, earthquakes or other fire disasters out West, when those disasters come, this Congress, this government, responds fully to assist those victims through FEMA. In flood-prone areas, we are obliged to put up our premiums in a flood insurance program and that Flood Insurance Program, I am told, has not lost a dime. It is not paid by taxpayers. The flood losses are paid, instead, by the premiums that go into that fund.

Louisiana happens to drain 43 States. Forty-three States of America, from the Appalachians to the Rockies, drain right through Louisiana. Coming from the North are tons of water, coming from the South is the Gulf of Mexico, and we are eroding at 35 square miles a year.

Do we get help? Sometimes, yes, we get some levees built once in a while. Mostly we get resistance from the Federal Government in building levees to protect those poor Cajuns who live in coastal Louisiana. And now comes a bill that says, well, if you're unlucky enough to get flooded too often, you just might have to sell your home to the Federal Government, and then you can't do anything with your property anymore. You have to move out. We got kicked out of Nova Scotia in 1755, and we came to America, and we settled in Louisiana. You are not going to kick us out of Louisiana, not with this bill or any other bill.

What is wrong with this notion is that it penalizes flood victims unlike it penalizes any other victims in America. First, you have to buy the insurance. Second, if you get flooded too many times, the government can take your house because you cannot pay the mitigation. You cannot afford to lift an old family home up 14 feet in the air. Thirty-five square miles of loss in erosion every year. FEMA predicts right now that if the folks who live in New Orleans get hit by a Category 4 hurricane coming through Lake Borgne or Barataria Bay, 27 feet of water in New Orleans. It comes down to luck in some cases. If the storm hits you too often and you get flooded too often, you get penalized under this bill. If you are living in the lowest part in New Orleans, but you did not get flooded yet, the levees have held, you are okay. You do not have to sell your home, you do not have to mitigate, you do not have to pay excessive premiums.

Mr. Speaker, I thank the gentleman from Louisiana (Mr. BAKER) for helping this bill get better, but it is still a bad bill.

Mr. FRANK of Massachusetts. Mr. Speaker, I yield 6 minutes to the gentleman from Oregon (Mr. BLUMENAUER), one of the main coauthors.

Mr. BLUMENAUER. Mr. Speaker, I appreciate the gentleman's courtesy in permitting me to speak on this, and I appreciate the leadership that has been shown by the committee, the gentleman from Ohio (Mr. OXLEY), the gentleman from Massachusetts (Mr. FRANK), the principal lead sponsor the gentleman from Nebraska (Mr. BEREUTER) who has been working on this for a number of years.

I am afraid the gentleman from Louisiana (Mr. TAUZIN) fundamentally misses the point for why we have a flood insurance program. I find no small amount of irony that it was the late Hale Boggs who was one of the first three sponsors of the flood insurance program in 1968 precisely because the people in Louisiana needed a program like this. I have encouraged my friends from Louisiana who were skeptical to maybe look at the facts. It is the people in Louisiana who are actually paying more money, and I wish the gentleman from Louisiana was still here so that we could engage in a little bit of a colloquy at some point, but they have paid more than $200 million in premiums above what they have gotten back. There are a few of the Cajuns who are part of the 10,000 people who are flooded repeatedly, in many cases being paid more than the price of the property value. This bill would help these people. We have in our files correspondence from people who are trapped because of the repetitive flood loss. They cannot sell their property.

This bill, contrary to what my friend from Louisiana says, would not force anybody to sell their property. It would, for the first time, provide adequate mitigation on an ongoing basis so that they would have a choice. They could floodproof the property, raise it if it is cost-effective or they could relocate. Thanks to the gentleman from Texas (Mr. GREEN), there is extra provision to make sure that some of these low-income properties are dealt with. One of the problems is that under this program, other people in Louisiana would be paying much higher rates over time to pay for a few repetitive flood loss properties.

Mr. Speaker, I think this bill is coming at exactly the right time. We are going to be able to take care of the 1 percent of the property that is costing thousands of policyholders in Louisiana more than they are putting in, and if we would take the approach of my friend from Louisiana, unfortunately, they would be paying even more in premium while other people are trapped in this repetitive flood loss cycle. This bill signals a higher profile and greater interest in a commonsense solution.

One of the reasons the business community is so interested in it is because it will help make sure that the properties here can be financed. It will make sure that we cut down the long-term burden for 4.5 million policyholders across the country who are paying year after year more money. It is not just the people in Louisiana that are being disadvantaged, but millions of policyholders around the country who are paying higher premiums than are necessary. If we are able under this program to defer just one 10 percent premium increase, it will mean a savings for policyholders across the country of $165 million each and every year on into the future. And there are tax dollars involved here, because there are countless times where the Federal Government steps in with disaster relief. With this program and its mitigation, we will be spending fewer of these tax dollars.

Mr. Speaker, this is sound environmentally, it is sound in terms of economic development, it is sound in terms of helping these people in harm's way, and it sends the right pricing signals. It does not force them out of their home but it says if you are going to stay there, you are going to start paying a little bit more so that the rest of the people in Louisiana and Mississippi and Missouri and Oregon, God forbid, do not have to pay a disproportionate amount unnecessarily. But part of the advantage of this bill cannot have a price put on it. It is going to save lives.

Looking in today's paper, there were three people killed yesterday in Maryland. I do not know what the loss is in Louisiana or Mississippi or Oregon. We have seen them time and time again. This is a proposal that is going to help get these people out of being trapped and I think not just save money but it is going to stop the disruption of business and it is going to save lives. It is right for the environment, it is right for the economy, it is right for the Federal taxpayers and it is right even for my colleague's Cajun friends who are going to end up being out of this flooding cycle and more people in Louisiana are going to save in premium dollars.

Mr. NEY. Mr. Speaker, in a calmer, non-Cajun moment, I yield 5 minutes to the gentleman from Nebraska (Mr. BEREUTER).

Mr. BEREUTER. Mr. Speaker, I first want to thank the distinguished gentlemen from Ohio (Mr. OXLEY) and (Mr. NEY) the chairman and subcommittee chairman, and the distinguished gentleman from Massachusetts (Mr. FRANK) for his tenaciousness and support for quite a number of years on this issue. I think I have been working on it approximately 14 or 16 years now, first with Congressman Joe Kennedy of Massachusetts, but in recent years with the help of the gentleman from Oregon (Mr. BLUMENAUER), who has been a partner in this effort and a tireless advocate of reform of the NFIP.

I want to say that the bill is better coming through committee because of the work of the gentleman from Louisiana (Mr. BAKER). He constantly brought issues to me and particular circumstances in his constituency and individually or collectively we worked out solutions which made the bill better. And he has helped today here in the process of addressing a couple of other concerns that I think are helping to make the bill better.

This bill will give FEMA the needed tools to reduce the number of repetitive loss properties which cost the NFIP about $200 million annually. These properties, while comprising approximately 1 percent of the currently insured properties, are expected to account for 25 to 30 percent of the claims paid. The vast majority of repetitive loss properties are receiving flood insurance premiums at a cost that are below their actuarial risk.

As far as the contents, this legislation authorizes two programs which address repetitive loss properties. First, it authorizes a new pilot program. Second, the bill uses FEMA's existing flood management assistance to provide assistance to repetitive claims properties. At the outset, I think it is important to note that no property owner under this bill is ever denied Federal flood insurance except for fraudulent claims.

This Member will give a brief description of these two programs. The pilot program authorizes up to $40 million a year to be transferred from the National Flood Insurance Fund over 5 years for mitigation assistance to severe repetitive loss properties. The pilot program which expires on September 30, 2008, under this legislation addresses these properties in a simple, straightforward manner. The owners of a severe repetitive loss property will be charged something closer to the actuarial, risk-based rates for a progressive period on their national flood insurance policy. That is a change we made just today in response to concerns brought to us.

The first condition is that there has to be a severe repetitive loss property. The second condition is that the owner of the property must have refused a mitigation measure from a State or locality such as an elevation of the structure or buyout of the property. Furthermore, this bill would allow the director of FEMA to reduce the non-Federal cost share under the pilot program from the current 25 percent to as low as 10 percent in any State that has 5 percent or more of the total number of severe loss properties in the U.S.

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In 2002, for example, this benefit would be qualified for Louisiana, Texas, New Jersey, Florida, North Carolina, New York. So in other words, the non-Federal share is reduced from 25 percent to as low as 10 percent because these States have a number of these repetitive-loss properties.

So we are trying this new step to accommodate those particular costs. This legislation also allows any owner of a severe repetitive-loss property to appeal and increase to anything approaching an actuarial rate of insurance to an independent third party, and one of the grounds for appeal is that the owner of the property will not be able to purchase a replacement primary residence of comparable value that is functionally equivalent to their current residence.

I think it is important to note the broad coalition of groups which are supportive of the legislation: the Heritage Foundation, the National Taxpayers Union, Citizens Against Government Waste, Taxpayers for Common Sense, the National Association of Realtors, America's Community Bankers, The National Association of Professional Insurance Agents, the Independent Insurance Agents and Brokers of America, the Mortgage Bankers Association, the American Bankers Association, the Association of State Floodplain Managers, the American Planning Association, the National Wildlife Federation, Friends of the Earth, the U.S. Public Interest Research Group, American Rivers, The Ocean Conservancy, and the Coast Alliance. And that is a pretty broad coalition.

I want to bring three other things to the attention of the body. First of all, a provision in this bill was deleted which would otherwise have unintentionally provided no Federal disaster assistance to be given to severe and repetitive-loss properties or repetitive-claims properties if the owner refused to accept mitigation. This change was done in our legislation upon the very constructive suggestion of the distinguished gentleman from Louisiana (Mr. TAUZIN).

Lastly, a provision was included in H.R. 253 which was offered by the gentleman from Texas (Mr. GREEN). His provision addresses the issue of the amount of the buyout offer. Under this bill, the buyout offered by the States or locality would be the highest of three differential rates. And, finally, third, we have changed the title to more accurately reflect the reality that in the process of compromise, only one of these two programs has anything to do with two floods.

I thank the gentleman for yielding me this time.

This bill was introduced by this Member on January 8, 2003. It both authorizes the NFIP through September 30, 2008, and makes essential changes to the program as it relates to the mitigation of repetitive loss properties. The NFIP is set to expire on December 31, 2003. This legislation passed the House Financial Services Committee, as amended, without noted dissent by a bipartisan voice vote on July 23, 2003.

This Member believes that it is important that one final public policy point be made. Under the NFIP, a very large regional cross-shifting of the cost of flood insurance is occurring; the policyholders in nonrepetitive loss areas of the country by their higher than appropriate premiums are subsidizing the policyholders in repetitive loss areas of the country. This bill will give FEMA the needed tools to substantially reduce the dramatic cases of this cost-shifting to other NFIP policyholders.

Mr. Speaker, in closing, we need to stop the very expensive treading through the water of repetitive loss after repetitive loss. Passing this legislation is the right thing to do at the right time. This Member urges his colleagues to support H.R. 253.

Mr. FRANK of Massachusetts. Mr. Speaker, I yield 3 minutes to the gentleman from Texas (Mr. GREEN), who came to us earlier and mentioned a particular problem affecting his State and is responsible, with the support of others from Texas, for a very constructive change in this program.

Mr. GREEN of Texas. Mr. Speaker, I thank our ranking member and the chairman of the committee for working with us on this.

The National Flood Insurance Program is absolutely essential for the financial security and quality of life for millions of Americans who live near our coasts and rivers, and it is vital to our flood-prone areas. And I can relate to the gentleman from Louisiana's (Chairman TAUZIN) concern because being a neighbor of Louisiana, we have a problem with flooding too, although we in Texas were not thrown out of Nova Scotia. We were typically run off, though, because we owed somebody in some other State. That is why we ended up in Texas originally.

So I am pleased that this legislation has been changed to reflect a more realistic definition of repetitive-loss properties, four strikes instead of the punitive two strikes in the original legislation.

And my community will also be glad to know that people who refused a buyout for whatever reason will not be denied Federal disaster assistance should they find their lives ruined by a future event.

As for folks who reach the definition of repetitive-loss properties and do receive a buyout offer from the Federal Government, the Bereuter substitute now allows for communities conducting these buyouts to offer replacement values when appropriate.

I want to express my appreciation again to the chairman and ranking member of the Committee on Financial Services and the subcommittee and also to the gentleman from Nebraska for their support of this important provision. I also want to note the gentleman from Houston, Texas (Mr. BELL) also assisted in this.

When FEMA came in to do a large number of buyouts after Tropical Storm Allison in Harris County in 2001, which flooded a total of 72,500 homes in Houston, Harris County, we had problems finding money so folks getting bought out could afford another home.

FEMA realized the necessity of replacement value in certain cases in my area and other areas. FEMA had to scramble to find funding from other programs, HUD programs and other sources, which is not ideal.

Some of my constituents, and again I do not have a wealthy area, actually received offers of $12,000 for their property because that was fair market value, which was completely inadequate for them to purchase anything outside the floodplain.

So I am pleased that the legislation incorporates our provision allowing communities to offer replacement value to flood victims when they realize that the fair market value is inadequate and FEMA agrees with that assessment. Without this provision, FEMA would have to deal with more homeowner appeals of buyout offers, and the time and the cost for repetitive-loss buyout projects would increase.

Again, the bill has so many good things about it, not just a typical extension of the authorization. And again I want to thank the chairman and ranking member for working with me on the legislation and being willing to address the needs of the flood victims. I am proud to support H.R. 253.

The SPEAKER pro tempore (Mr. SWEENEY). The Chair would advise Members the gentleman from Ohio (Mr. NEY) has 5½ minutes remaining, and the gentleman from Massachusetts (Mr. FRANK) has 5 minutes remaining.

Mr. NEY. Mr. Speaker, I yield 3 minutes to the gentleman from Louisiana (Mr. BAKER).

Mr. BAKER. Mr. Speaker, I thank the chairman for yielding me this time.

This is very difficult work. I want to start out by stating appreciation to the gentleman from Nebraska (Mr. BEREUTER) for over a decade-long effort. It seems as though a lot of meaningful reforms around here take a decade or better. But he has been persistent, yet very cooperative in reaching agreements that make sense.

It has been difficult work because we have a unique State that is a beneficiary of this program to a great extent over others; but as the gentleman from Oregon (Mr. BLUMENAUER) pointed out, we also make larger contributions than just about anybody else because our people participate. We pay a premium. The premium goes into a bank account. The bank account pays the claim. If we do not have enough money in the bank, we have a line of credit. In the history of the program, anytime a line of credit has been extended, we not only pay it back, we pay it back with interest. There is no other pre-need program of this sort in the country. It does work and provides a valuable resource to hard-working people who live in regions of the country who suffer from persistent flooding.

But we do not defend, and we are not here today to say, that people who abuse the program, who repetitively make claims on the program, who intentionally buy property for the sake of gaming the system, should be protected. And the bill we have before us today, to the gentleman from Ohio's (Chairman OXLEY) credit, to the gentleman from Nebraska's (Mr. BEREUTER) credit, the gentleman from Massachusetts (Mr. FRANK), the gentleman from Oregon (Mr. BLUMENAUER), will preclude that practice from being encouraged in the future.

And for those folks who happen to be listening to the debate from back home in Louisiana, there are some assets to this proposal which are very meaningful. When they finally get that designation, if it does occur, there is now a provision for mitigation, a new and unique system, where the government can actually help them. There are many people back home today who are trapped in these properties. They cannot sell them. They are below market value. Worse yet, they may be below in value what they owe on the property because of repetitive claims. Now we have the ability for the government to either buy the property at a reasonable price or to provide a mechanism to reduce the likelihood of flooding by simply elevating the home, and we do that with a new 90/10 program where 90 percent of the money will be provided by the government with the homeowner putting up only 10 percent. It is new landmark assistance that has never existed before.

When we get these repetitive-loss problems off the books, I think the program cash flows very well; and I will continue, as I have pledged to the gentleman from Louisiana (Mr. TAUZIN), who has expressed his deep concerns about where this program might be going, that in the months and years ahead we will continue to work to protect the interests of hard-working people in Louisiana to make sure that equity is the rule of the day. If we are going to write checks and not expect repayment for a California earthquake or a mudslide in the Northeast or a tornado in Oklahoma or a fire somewhere else and say that that is okay to use taxpayer money for that purpose, we have a justifiable reason in this case to say in Louisiana we are paying our way. We think equity cries out that we preserve this program. Ask us to pay the premium, run it properly, and hold others to account the way hard-working Louisianans are held to account, and all will be well with us.

Mr. FRANK of Massachusetts. Mr. Speaker, I did want to enter my Russian grandparents in the "they got run out" contest, but I will do that later.

Mr. Speaker, I yield 30 seconds to the gentleman from Oregon (Mr. BLUMENAUER).

Mr. BLUMENAUER. Mr. Speaker, I just wanted to comment briefly because it is hard to get through things very quickly, but one of the things that was in my notes that I wanted to acknowledge was that this bill is a very different bill because of the contribution the gentleman from Louisiana (Mr. BAKER) made. I personally learned a lot about the flood insurance program in a broader context in terms of some of the history, in terms of some of the dynamics and some of the perceptions that we need to build. My good friend from Nebraska mentioned the name change. It is not just symbolic. I think it is something that really reflects a better approach, and it would not have happened without the gentleman from Louisiana (Mr. BAKER), and I appreciate it.

Mr. FRANK of Massachusetts. Mr. Speaker, I yield 3 minutes to the gentleman from California (Mr. THOMPSON).

Mr. THOMPSON of California. Mr. Speaker, I thank the gentleman for yielding me this time.

I think it is very important that in the reauthorization of the National Flood Insurance Program that we include provisions that are much more forward looking and provide opportunities to communities to avoid catastrophic problems that a little advanced work could, in fact, avoid. A really good example of this can be seen in my district out in the Napa Valley out in California when after the major floods in 1995 that caused about $85 million worth of damages, ruined about 27 businesses and nearly 1,000 residential properties, the community came together, came together and changed the way that we do flood protection, recognizing that we need to build regional programs that will allow us to protect these properties that continually are damaged by flood with somewhat unconventional methods.

The Army Corps of Engineers, resource agencies, the wine industry, the conservation community all came together to develop a innovative flood protection plan for Napa, which includes 100-year flood protection with the creation of a 600-acre tidal wetlands while also protecting the reconstruction of existing structures to prevent future flood damages.

I want to commend everyone who worked so hard on this bill, and particularly the gentleman from Oregon (Mr. BLUMENAUER), who brought this particular emphasis to the debate. I know that we will all be better off. We will save businesses. We will save residential properties. We will save money, and we will save lives.

Mr. NEY. Mr. Speaker, I yield 1 minute to the gentleman from Maryland (Mr. GILCHREST).

Mr. GILCHREST. Mr. Speaker, I thank the gentleman for yielding me this time. And I thank all of the Members and the staff that have worked on this piece of legislation because I think fundamentally this brings many disparate Federal programs that are often paid for by taxpayers at cross-purposes into clearer focus.

I want to make three points. One, many taxpayers pay to restore environmental degradation. Taxpayers provide incentives to keep people out of harm's way. Taxpayers pay to provide incentives to degradate the environment under many circumstances. Taxpayers provide incentives to put people in harm's way. What this legislation does is clearly view the problems of disparate Federal programs and provide an incentive to move in the right direction.

The third point I want to make, though, I came from England to live in the Chesapeake Bay. I was run out of England around the time of John Smith. We live in a region where there are a number of storms and a number of people that are in harm's way. Keep in mind my perspective that the Federal Flood Insurance Program, the premiums paid into it fundamentally only pay a tiny fraction of the cost of these problems because we have to pay for the police, the fire department, the National Guard, residences where people must live. So this legislation brings into clear focus the needs of this problem.

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Mr. FRANK of Massachusetts. Mr. Speaker, I yield myself the remainder of my time.

Mr. Speaker, I want to again express my appreciation to the people working on this, and I should acknowledge, as others have, we do recognize that Louisiana, because of geography and history, has different problems and I am pleased that we were able, and I understand we were not able to get everybody together, but I think it was a good thing that because of the gentleman from Louisiana (Mr. BAKER) and the gentleman from Louisiana (Mr. TAUZIN), the bill is different than it would have been. They did call to our attention special problems that they have; we cannot always resolve everything. But I appreciate that we were able to move in that spirit.

I also wanted at this point, Mr. Speaker, to say that I know the gentlewoman from California who has been working on this from my subcommittee as well as others has some concerns, and I yield to the gentlewoman from California (Ms. WATERS).

Ms. WATERS. Mr. Speaker, I would like to say that I am pleased that this bill has been reauthorized for at least 5 years. I want to say that the gentleman from Louisiana (Mr. BAKER) makes a very good point. Reform is always very difficult, and we need to recognize that there are things that fall outside of the traditional thinking about some of these floodplains.

For example, in my own city, in my district, there was flash flooding, the first time it ever happened in the history of the State, and we had this flooding and all of these little homes were damaged, they will not meet the FEMA assessment requirements, and we need to find ways in which we deal with that kind of freak of nature also. So I would like very much to continue to work on this.

Mr. FRANK of Massachusetts. Mr. Speaker, reclaiming my time, I thank the gentlewoman. Let me say, first of all, she talked about encouraging thinking outside the traditional. For me she has picked a good week in which to do this. I have been spending a lot of time talking about some nontraditional thinking this week in my State Supreme Court on Tuesday. But in the particular issue that she mentioned, that she has alerted us to it, she is absolutely right. The people in her district were hit by some natural disaster that no one could have predicted. We need to have a capacity to help communities respond to the unpredictable as well as the predictable. And I would assure her that it is my intention, now that she has brought this to our attention, to see that the committee addresses that to the extent that we can next year.

I also just want to say in closing, Mr. Speaker, that I am very pleased that we are where we are, but I should reiterate, we are at a point where we are, I believe, going to agree to a 3-month extension of this program. I hope no one thinks that simply by inaction, they are going to be able to coerce us, and I do not mean anybody in this room or who votes in this room; I just do not want anyone to think that inaction will force us to continue to do year-by-year extensions that the chairman had talked about. We made a serious, good-faith compromise here. I believe it ought to be generally acceptable. I hope that early next year, when Congress reconvenes after our recess, we will be able to come forward with this bill with maybe some minor changes and get some further study, and it will become law. I hope that everyone understands that this is our chance to put this on the kind of indefinite footing it ought to be on.

Mr. NEY. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. FOLEY).

Mr. FOLEY. Mr. Speaker, I want to commend the gentleman from Louisiana (Chairman TAUZIN) for recommending the Louisiana Purchase to Thomas Jefferson. It was a good deal then, and it remains a good deal today. I particularly thank my colleagues, the gentleman from Louisiana (Chairman BAKER), the gentleman from Ohio (Chairman NEY), the gentleman from Nebraska (Chairman BEREUTER), and the gentleman from Ohio (Chairman OXLEY). My friend from Louisiana was very, very helpful in crafting amendments that have been incorporated in the bill to bring some fairness to policyholders that I believe were lacking in the original bill.

I represent Floridians at both the Atlantic Ocean and the Gulf of Mexico, and we certainly see our fair share of hurricanes and tropical storms. The base bill would have punished people for choosing to live there. Does the Federal Government discriminate against people who choose to live in the areas that are prone to earthquakes or tornadoes? Of course not. Some people who live in coastal areas should not be punished either.

So reauthorizing the National Flood Insurance Program is extremely important. I would have preferred a cleaner reauthorization, but I am thrilled it is for 5 years. Of course, failure to reauthorize this program would have disastrous consequences to policyholders, as well as to the banking and real estate industry in my State. I thank all for their cooperation, and I look forward to passage of this important legislation.

Mr. NEY. Mr. Speaker, I yield myself the remaining time.

In closing, I want to thank everybody involved with this bill. I want to mention the supporters of H.R. 253 include National Taxpayers Union, Citizens Against Government Waste, Heritage Foundation, Taxpayers for Common Sense, American Bankers Association, National Association of Realtors, America's Community Bankers, Mortgage Bankers Association, National Association of Homebuilders, National Association of Professional Insurance Agents, Independent Insurance Agents and Brokers of America, American Planning Association, the Association of State Floodplain Managers.

Mr. FRANK of Massachusetts. Mr. Speaker, will the gentleman yield?

Mr. NEY. I yield to the gentleman from Massachusetts.

Mr. FRANK of Massachusetts. Mr. Speaker, the first group the gentleman read, the Heritage Foundation and that group, would you send them a note reminding them where I was on this bill, that I helped on this bill?

Mr. NEY. Mr. Speaker, I will do that, and then I will make a phone call too, and if the gentleman wants, we will bring them to his office for a chat.

Mr. OSBORNE. Mr. Speaker, I rise in support of H.R. 253, which is a reauthorization of the National Flood Insurance Program, introduced by my colleagues Congressmen DOUG BEREUTER and EARL BLUMENAUER.

The legislation reauthorizes the National Flood Insurance Program and reforms it to ensure the availability of flood insurance while reducing the amount of money spent on frequently flooded properties.

H.R. 253 creates a pilot program to mitigate the severe repetitive loss properties in the National Flood Insurance Program and sets up an equitable process for the treatment of policyholders who refuse mitigation. This legislation also uses the existing Flood Mitigation Assistance Program to further mitigate repetitive claims properties.

H.R. 253 authorizes funds to be transferred from the National Flood Insurance Fund into the National Mitigation Fund for both the pilot program and the FMA program for purposes of mitigation.

Mr. Speaker, numerous communities in my district participate in the National Flood Insurance Program, including the community of North Platte, NE.

This community is surrounded by the North and South Platte rivers which merge together to form the Platte River east of North Platte.

The citizens in North Platte have been paying substantial premiums for flood insurance without experiencing the flood events that other communities encounter.

In fact, collectively they have paid over a $1 million in premiums each year, but collected a total of $26,000 in settlements.

While the citizens of North Platte are grateful the program exists in the event that the 100-year flood does come, many residents are upset with the skyrocketing premiums for flood insurance.

A $170,000 home in 1993 would have had a flood insurance premium of over $200.

In 2003, that same property is costing over $1,000 in flood insurance premiums.

Mr. Speaker, I believe this legislation will reduce the number of repetitive claims in areas that are frequently flooded, so communities like North Platte will not continue to subsidize those communities by paying higher premiums.

I ask that my colleagues support this important legislation.

Mr. RAHALL. Mr. Speaker, I rise today in opposition to this bill.

In these waning hours of the first session of the 108th Congress, it is absolutely true that we need to reauthorize the National Flood Insurance Program, which is due to expire at the end of this year. However, this is not the bill with which to do so.

I should note that there is much in this bill that I support. As an example, this bill will offer a multi-year reauthorization, which will definitely help with municipal planning. But, this bill could harm many of my unfortunate constituents in Southern West Virginia who have already suffered so much in flood damage over the last several years. They already have to buy flood insurance, in the first place. Now, their burden is going to be increased, again, under this proposal.

Under the pilot program, which I fear may wind up covering too many of my constituents, this bill will disallow more than four separate claims payments under flood insurance if the amounts exceed $3,000 each or just $15,000 in total. If an individual exceeds these limits, as many of my constituents may, they could be forced to accept mitigation. At worse, mitigation means having to move to a new residence or else face increased insurance premiums that many of my constituents just can't afford.

Mr. Speaker, my constituents in West Virginia who are suffering disaster aren't people who are losing beachfront vacation homes. These are people who are losing their livelihoods. Many of them live in homes built long before flood risks were even known, and their land is sacred to them. For many, their properties have been in the family for generations, and being told that you have to move is not consolation.

Southern West Virginia has suffered massive, unpreventable, and unanticipated flooding since 2001. The U.S. Geologic Survey said the 2001 flooding in the cities of Pineville and Mullens, West Virginia even exceeded the 100-year flood level, the estimated maximum expected to occur in a 100-year period, as the Guyandotte and Tug Rivers rose to record levels. The Governor's helicopter actually had to be used to rescue people off of rooftops.

In McDowell County, we actually experienced two different 100-year floods in consecutive years.

We have even experienced two floods just this week due to the severe weather conditions. The most recent storm damaged more homes and businesses across the region, and caused Governor Bob Wise to extend a state of emergency to 29 counties, many of which are in my district.

Mr. Speaker, I have been working tirelessly with the U.S. Army Corps of Engineers, the Appalachian Regional Commission, and state and local authorities to combat our flood damage while seeking to prevent future flooding. I have even worked with the U.S. Library of Congress to replace books, electronic employment, and furniture destroyed at the McDowell Public Library. In addition, we are updating flood maps in the region to be able to better gauge where future flooding would be likely to occur.

But, my constituents can't hold back the weather, and they need relief. Unfortunately, this bill, instead, seeks to limit that relief and maybe even force some West Virginians to have to surrender their dearly-held property.

The SPEAKER pro tempore (Mr. SWEENEY). The question is on the motion offered by the gentleman from Ohio (Mr. NEY) that the House suspend the rules and pass the bill, H.R. 253, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. VITTER. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

* * *

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause of 8 of rule XX, proceedings will resume on motions to suspend the rules previously postponed. Votes will be taken in the following order:

Concur in Senate amendments to House Joint Resolution 63, by the yeas and nays;

Concur in Senate amendments to House Concurrent Resolution 209, by the yeas and nays;

Concur in Senate amendments to H.R. 1828, by the yeas and nays, and

H.R. 253, by the yeas and nays.

The first electronic vote will be conducted as a 15-minute vote. Remaining electronic votes will be conducted as 5-minute votes.

COMPACT OF FREE ASSOCIATION AMENDMENTS ACT OF 2003

The SPEAKER pro tempore. The pending business is the question of suspending the rules and concurring in the Senate amendments to the joint resolution, H.J. Res. 63.

The Clerk read the title of the joint resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Iowa (Mr. LEACH) that the House suspend the rules and concur in the Senate amendments to the joint resolution, H.J. Res. 63 on which the yeas and nays are ordered.

The vote was taken by electronic device, and there were—yeas 417, nays 2, not voting 15, as follows:

[Roll No. 652]

YEAS—417

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burton (IN)
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Cole
Collins
Conyers
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Filner
Flake
Foley
Forbes
Ford
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NAYS—2

Coble
Paul

NOT VOTING—15

Burr
Buyer
Cubin
Davis (FL)
Davis (IL)
DeMint
Fletcher
Gephardt
Holden
Hunter
Lewis (GA)
Quinn
Sherman
Smith (MI)
Weiner

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SWEENEY) (during the vote). Members are advised there are 2 minutes remaining in this vote.

☐ 1829

So (two-thirds having voted in favor thereof) the rules were suspended and the Senate amendments were concurred in.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the Chair announces that he will reduce to a minimum of 5 minutes the period of time within which a vote by electronic device will be taken on each additional motion to suspend the rules on which the Chair has postponed further consideration.

COMMENDING THE SIGNING OF THE UNITED STATES-ADRIATIC CHARTER

The SPEAKER pro tempore. The pending business is the question of suspending the rules and concurring in the Senate amendments to the concurrent resolution, H. Con. Res. 209.

The Clerk read the title of the concurrent resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Nebraska (Mr. BEREUTER) that the House suspend the rules and concur in the Senate amendments to the concurrent resolution, H. Con. Res. 209, on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 416, nays 1, not voting 17, as follows:

[Roll No. 653]

YEAS—416

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burton (IN)
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Filner
Flake
Foley
Forbes
Ford
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NAYS—1

Paul

NOT VOTING—17

Ballenger
Burr
Buyer
Cubin
Davis (FL)
Davis (IL)
DeMint
Fletcher
Gephardt
Holden
Hunter
Jenkins
Lewis (GA)
Oxley
Quinn
Sherman
Weiner

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SWEENEY) (during the vote). Members are advised that 2 minutes remain in this vote.

□ 1839

So (two-thirds having voted in favor thereof) the rules were suspended and the Senate amendments were concurred in.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

SYRIA ACCOUNTABILITY AND LEBANESE SOVEREIGNTY RESTORATION ACT OF 2003

The SPEAKER pro tempore. The pending business is the question of suspending the rules and concurring in the Senate amendments to the bill, H.R. 1828.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from Florida (Ms. ROS-LEHTINEN) that the House suspend the rules and concur in the Senate amendments to the bill, H.R. 1828, on which the yeas and nays are ordered.

This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 408, nays 8, answered "present" 1, not voting 17, as follows:

[Roll No. 654]

YEAS—408

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burton (IN)
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay

Clyburn
Coble
Cole
Collins
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Filner
Foley
Forbes
Ford
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinojosa
Hobson
Hoeffel
Hoekstra
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Price (NC)
Pryce (OH)
Putnam
Radanovich
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Solis
Souder
Spratt
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NAYS—8

Conyers
Dingell
Flake
Kucinich
McDermott
Paul
Rahall
Stark

ANSWERED "PRESENT"—1

Hinchey

NOT VOTING—17

Ballenger
Burr
Buyer
Cubin
Davis (FL)
Davis (IL)
DeMint
Fletcher
Gephardt
Holden
Hunter
John
Lewis (GA)
Portman
Quinn
Sherman
Weiner

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised that 2 minutes remain in this vote.

□ 1849

Mr. HILL changed his vote from "nay" to "yea."

So (two-thirds having voted in favor thereof) the rules were suspended and the Senate amendments were concurred in.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

FLOOD INSURANCE REFORM ACT OF 2003

The SPEAKER pro tempore (Mr. OSE). The pending business is the question of suspending the rules and passing the bill, H.R. 253, as amended.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Ohio (Mr. NEY) that the House suspend the rules and pass the bill, H.R. 253, as amended, on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 352, nays 67, not voting 15, as follows:

[Roll No. 655]

YEAS—352

Abercrombie
Ackerman
Aderholt
Akin
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Barrett (SC)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Biggert
Bishop (GA)
Bishop (NY)
Blackburn
Blumenauer
Boehlert
Boehner
Bonilla
Bono
Boozman
Boswell
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burton (IN)
Calvert
Camp
Cantor
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Dreier
Edwards
Ehlers
Emanuel
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Filner
Flake
Foley
Forbes
Ford
Fossella
Frank (MA)
Frost
Gallegly
Garrett (NJ)
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hayes
Hayworth
Hefley
Hensarling
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holt
Honda
Hooley (OR)
Houghton
Hoyer
Hunter
Hyde
Inslee
Isakson
Israel
Istook
Jackson (IL)
Jackson-Lee (TX)
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (KY)
Linder
Lipinski
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McIntyre
McNulty
Meehan
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Myrick
Nadler
Napolitano
Neal (MA)
Neugebauer
Ney
Northup
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Owens
Oxley
Pallone
Pascrell
Pastor
Payne
Pelosi
Pence
Petri
Pickering
Pitts
Platts
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Radanovich
Ramstad
Rangel
Regula
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Shimkus
Simmons
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Strickland
Sullivan
Tancredo
Tanner
Tauscher
Taylor (MS)
Taylor (NC)

Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu

NAYS—67

Alexander
Bartlett (MD)
Barton (TX)
Berry
Bilirakis
Bishop (UT)
Blunt
Bonner
Boucher
Boyd
Cannon
Capito
Costello
Deutsch
Doolittle
Duncan
Dunn
Emerson
Ferguson
Franks (AZ)
Frelinghuysen
Gerlach
Gibbons
Hastings (FL)
Hastings (WA)
Herger
Hostettler
Hulshof
Issa
Janklow
Jefferson
John
Larsen (WA)
Lewis (CA)
LoBiondo
McInnis
McKeon
Meek (FL)
Miller (FL)
Mollohan
Musgrave
Nethercutt
Norwood
Nunes
Ose
Otter
Paul
Pearce
Peterson (MN)
Peterson (PA)
Pombo
Rahall
Rehberg
Rohrabacher
Saxton
Sherwood
Shuster
Simpson
Skelton
Stenholm
Stupak
Sweeney
Tauzin
Visclosky
Vitter
Young (AK)
Young (FL)

NOT VOTING—15

Ballenger
Burr
Buyer
Cubin
Davis (FL)
Davis (IL)
DeMint
Fletcher
Gephardt
Holden
Lewis (GA)
Quinn
Sherman
Weiner
Wynn

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised 2 minutes remain in this vote.

□ 1857

Mr. GERLACH changed his vote from "yea" to "nay."

So (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

TEMPORARY EXTENSION OF PROGRAMS UNDER SMALL BUSINESS ACT AND SMALL BUSINESS INVESTMENT ACT OF 1958 THROUGH MARCH 15, 2004

Mr. SCHROCK. Mr. Speaker, I ask unanimous consent to take from the Speaker's table the Senate bill (S. 1895) to temporarily extend the programs under the Small Business Act and the Small Business Investment Act of 1958 through March 15, 2004, and for other purposes, and ask for its immediate consideration in the House.

The Clerk read the title of the Senate bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Virginia?

There was no objection.

The Clerk read the Senate bill, as follows:

S. 1895

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. EXTENSION OF PROGRAM AUTHORITY.

(a) IN GENERAL.—Any program, authority, or provision, including any pilot program, authorized under the Small Business Act (15 U.S.C. 631 et seq.) or the Small Business Investment Act of 1958 (15 U.S.C. 661 et seq.) as of September 30, 2003, that is scheduled to expire on or after September 30, 2003 and before March 15, 2004, shall remain authorized through March 15, 2004, under the same terms and conditions in effect on September 30, 2003.

(b) EXCEPTION.—Notwithstanding subsection (a), section 303(g)(2) of the Small Business Investment Act of 1958 (15 U.S.C. 683(g)(2)) is amended by striking "1.38 percent" and inserting "1.46 percent".

The Senate bill was ordered to be read a third time, was read the third time, and passed, and a motion to reconsider was laid on the table.

ANNOUNCEMENT OF INTENTION TO OFFER MOTION TO INSTRUCT CONFEREES ON H.R. 2660, DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2004

Mr. MARKEY. Mr. Speaker, pursuant to clause 7(c) of House rule XXII, I hereby notify the House of my intention tomorrow to offer the following motion to instruct on House conferees on H.R. 2660, the fiscal year 2004 Labor-HHS-Education and Related Agencies Appropriations Act.

The form of the motion is as follows:

Mr. MARKEY moves that the managers on the part of the House at the conference on the disagreeing votes of the two Houses on the Senate amendment to the bill H.R. 2660 be instructed to recede to the Senate funding level for the Low Income Home Energy Assistance Program (LIHEAP).

□ 1900

ANNOUNCEMENT OF INTENTION TO OFFER MOTION TO INSTRUCT CONFEREES ON H.R. 2660, DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 2004

Mr. POMEROY. Mr. Speaker, pursuant to clause 7(c) of the House rule XXII, I hereby notify the House of my intention tomorrow to offer the following motion to instruct House conferees on H.R. 2660, the Departments of Health and Human Services, Education, and Related Agencies Appropriations Act of 2004.

The form of the motion is as follows:

I move that the managers on the part of the House at the conference on the disagreeing votes of the two Houses on the bill, H.R. 2660, be instructed to agree a level of $8,410,000,000 for the Limitation on Administrative Expenses of the Social Security Administration, as proposed by the Senate.

MOTION TO INSTRUCT CONFEREES ON H.R. 1, MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003

Mr. INSLEE. Mr. Speaker, I offer a motion to instruct.

The Clerk read as follows:

Mr. INSLEE moves that the managers on the part of the House at the conference on the disagreeing votes of the two Houses on the Senate amendment to the bill H.R. 1 be instructed as follows:

(1) To reject the provisions of subtitle C of title II of the House bill.

(2) To reject the provisions of section 231 of the Senate amendment.

(3) Within the scope of conference, to increase payments by an amount equal to the amount of savings attributable to the rejection of the aforementioned provisions to—

(A) raise the average standardized amount for hospitals in rural and other urban areas to the level of the rate for those in larger urban areas; and

(B) to raise the physicians' work geographic index for any locality in which such index is less than 1.0 to a work geographic index of 1.0.

(4) To insist upon section 601 of the House bill.

The SPEAKER pro tempore (Mr. OSE). Pursuant to clause 7 of rule XXII, the gentleman from Washington (Mr. INSLEE) and the gentleman from Florida (Mr. BILIRAKIS) each will control 30 minutes.

The Chair recognizes the gentleman from Washington (Mr. INSLEE).

Mr. INSLEE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, we are bringing a motion today on this most important of issues in an effort to give seniors what they deserve, which is a real guaranteed prescription drug benefit under Medicare. Unfortunately, unless we pass this motion, or some equivalent motion, the generation that fulfilled their duties on Iwo Jima, that is The Greatest Generation, will not get a first class double-A rated guaranteed prescription drug benefit under Medicaid. They will get something approaching the flimflam that they have had for so long from the United States Congress.

Mr. Speaker, we are here to offer a motion which will boldly instruct the conferees to cure both a sin of commission and a sin of omission in their plan. Now, let me address those sins of commission and omissions.

First, there are multiple sins of omission from the proposal of the conferees we have heard to date, one of which is their abject and total failure to do anything for America's senior citizens to restrict the incredible rise in drug prices they have been experiencing. And, Mr. Speaker, certain other motions will address that issue. But it is amazing to me that at the moment in time when our seniors are yelling, and justifiably so, about the incredible rise in their drug prices, that not only does this conference report refuse to do anything affirmative about it, it has actually shackled Uncle Sam from doing anything about it and from negotiating better drug prices. That is a sin of omission that other motions have dealt with.

Mr. Speaker, this motion deals with two other fundamental ones that need to be remedied. One is to prevent this conference report from driving a dagger through the heart of Medicare by privatizing this entire system, which this conference report would result in as sure as God made little green apples. And it would do so slowly but surely by this nefarious plan to force every single senior citizen to either accept a privatized system in the morass of the insurance industry, or to accept essentially higher premiums and less coverage. That is a sin of commission.

But there is a sin of omission as well that our motion would cure, and that is the fact that we are not providing adequate reimbursement to physicians, to providers, to nurses, to physical therapists, to oncologists who treat our senior citizens. And as a result of these low payments, as a result of these low payments now in the State of Washington, over 50 percent of the physicians are no longer taking new Medicare patients. Why not? They cannot afford to under the reimbursement rates. And are we fixing this problem in this bill? No.

Over 50 percent of the people in the State of Washington now go to try to get their physicians and they are not being accepted. And, frankly, a prescription drug benefit that does not solve this problem is not going to be a solution to the problem. It does no good to have a prescription drug benefit if you cannot get into a physician to have a prescription written for you. Half the doctors in the State cannot afford to do it right now, because under the Republican plan, in order to fund the tax cuts for Enron, we are adopting measures to screw down Medicare and to screw down benefits over the long term under the Medicare system.

Now, there is a tricky little effort that slowly but surely will accomplish former Representative Newt Gingrich's great dream, which is to see Medicare wither on the vine. And it will accomplish it by saying a few years out from now, people who want to stay in the Medicare system to get a guaranteed benefit would be forced either to go into a privatized system at the whim of the insurance industry or accept less effective coverage from Medicare. How do I know that? Well, I know that because the experts in the field have evaluated it.

Let me just quote two fellows. Henry Aarons of The Brookings Institution, and CBO Director Robert Reischauer, two people who essentially were the originators of the idea of premium support, because in the right circumstances perhaps it would have some justification. They said the GOP plan could result in Medicare experiencing a "death spiral," and said that it is too risky to adopt. And the reason they said that is that the authors of this plan, the people who have been trying to shrink Medicare since it started in the 1960s, and who actually tried to prevent it from starting in the first place, know that under their plan what will happen is that private insurance companies will cherry pick the healthiest among Americans. And as they cherry pick the healthiest Americans, they will leave the sick in Medicare, who will have to pay higher premiums under this nefarious proposal.

Mr. Speaker, this motion will instruct the conferees to come back without that provision, without that little thing that is the poison in this little trap for our senior citizens. That is why we have people calling every single office in Congress urging us not to adopt this for our senior citizens, because they are not going to be snookered by this plan.

Mr. Speaker, I yield 3 minutes to the gentleman from Washington (Mr. McDERMOTT), who is a great physician from Seattle.

Mr. McDERMOTT. Mr. Speaker, I only want to make two points. The reason that this is a bad bill is that it does not take into account what is in the common good. The idea of Medicare is that everybody pays into the pot and then, if God forbid you get sick, you take money out to pay for your health care. Everybody in the United States who is over 65 is covered. Everybody gets the same benefits. It does not make any difference where you live, Alabama, Arizona, or wherever, you get the same benefits. And what this bill does is change the basic concept.

What this bill says is we are going to guarantee that you have enough money individually as Americans to go out and buy your own bill. Now, everybody who is 65 and older in this country is not in the same health status, and they are going to get different coverage depending on their health status, depending on where they live, and how much money it costs in their area. Everybody is going to get something different. And the fairness in this program will be gone. Now, that is the first thing that is wrong with this; that we have taken away the idea of a common good, where we take care of each other.

Now, they will say, oh, but you can stay in the old Medicare program. Let me tell you what is wrong with that. What they say is that the old Medicare program has to compete with these private insurance companies. So if you do not want to take your voucher and go out to a private insurance company, you can stay in the old Medicare program. Now, we have already heard my colleague, the gentleman from Washington (Mr. INSLEE) say that the insurance companies, in meeting the enrollment criteria for their program, they will find some way to figure out where the healthy old people are. They are not going after the 95-year-old mother that I have living in a retirement home in Seattle. They will not be going and recruiting her to get into their health care plans. They want to leave her over here with this bunch.

Now, what will happen is the old and the sick will be over here and the young and the healthy will be on this side. And, of course, the costs will be less over here. So if this side has to compete with that side, and the costs are higher, they are going to stick the ones who stay in the old health care, in the old Medicare, with higher premiums. So not only is my mother not going to have the same benefits, she is going to get a higher premium. I, because I am younger and in better shape than she is, will be on this side, and I will get a deal with some insurance company, and I will do much better than my mother.

Is that fair? Is that what we want to do? Do we want to separate out the healthy old people from the sick old people and say to the sick ones, well, you are kind of on your own, folks. Hope it works out. Hope you have some kids to pick up the difference. Because my mother has four kids to help her, but not everybody has four kids to help them. So you are setting up a situation where you are saying to grandma, here is your voucher, good luck.

Vote "no" tomorrow.

Mr. Speaker, I want to talk about the Medicare bill that we will soon consider. This is one of the most important bills in the 16 years I have been in the Congress because we are dealing with an issue that is about the question of what is in the common good.

The way Medicare works is, everyone pays money into the pot, and if someone gets sick, then their health care is paid for. So the only people who cost money are those who get sick and need health care.

Nobody wants to get sick, but it's good to know that Medicare is there to take care of us.

But if we allow this Medicare plan to go into effect, the Republicans would change Medicare into a voucher system, where seniors pay private insurance companies to provide them with health care coverage.

And if we use private, for-profit health insurance, we—the government and the taxpayers—are going to pay them money every single month to "cover" our seniors, but not necessarily to provide health care. Because if somebody does not get sick or use health care, the insurance company keeps the money. So the insurance company has every reason to not provide health care and every reason to want to get only the healthiest among us in their plan.

And that will leave us in the situation where we're paying insurance companies to do little, and they will leave the oldest and sickest

Medicare beneficiaries in the traditional Medicare plan.

Now, it gets even worse. Because the Republicans want the oldest and the sickest to pay more. They want traditional Medicare to "compete" with these private insurance companies based on their costs. But we know the insurance companies will get the cheapest people into their plans. They'll advertise at health clubs, at the top of the stairs. They've done this before; they're good at it.

So for those who stay in traditional Medicare, their premiums will go up because the insurance companies will only target and recruit the people who wouldn't use health care. The Republicans will let the insurance companies take just who they want and leave the most vulnerable amongst us on their own.

We already know this will happen, because this is exactly what happened before. Back in 1997, we set up this big program, "Medicare plus Choice". The Republicans believed then, as they do now, that it would be better to break Medicare up into private managed care plans—to put everyone in an HMO. They said it would be cheaper, and better.

Well, we know what happened. Every year since the Medicare Plus Choice plans came into existence, they have pulled out and left seniors scrambling back into traditional Medicare. In 1999, there were about 7 million people in these M+C plans. Now there are about 4.6 million people in these plans. So nearly 3 million seniors have already been abandoned by these private plans.

But the plans were happy to take our money first.

We know the private plans take the healthiest seniors, and we know that these people would be cheaper to insure if they stayed in traditional Medicare.

We know that these very healthy seniors are 16 percent less costly. These are the healthy people the private plans are trying to get. And the insurance companies are making money on them, hand over fist. They are either making a ton of money for doing nothing, or they are so inefficient that they are losing this 16-percentage point spread. Either way, they aren't very good for us.

In their new plan, the Republicans throw even more money to the insurance companies. The insurance companies will be paid even more per person then they already get, probably 10 t0 15 percent more. And we know how these plans operate, they will do their best to get the healthy folks in, the ones they can make money on.

And for those who want to stay in traditional Medicare, the price per person is going to go up, so they are going to raise the premium on anybody who stays in the regular program. This is not thinking about the common good. It is wrong, it is un-American, and it is undermining the whole concept of Medicare.

Republicans have tried for many years to shift Medicare away from a program of real benefits to a voucher program. This time around, the Republicans call this a "demonstration project," they say it will just be a test. But it could involve 6 million or more seniors, and could be expanded to cover the whole country after six years. And this "demonstration" is not something you can volunteer for, or decide not to do—if they pick your city, you're in, whether you like it or not, you're a guinea pig.

Don't be fooled. This is not an experiment, this is not a test—this is the first step towards privatizing Medicare, pushing all our seniors into the private market and telling them to make it on their own. This is not insurance, this is throwing them to the wolves.

The Republican plan to use the promise of much-needed prescription drug coverage in order to push their agenda of privatizing Medicare is just wrong. We can't do this to our seniors. We can't just give them all a voucher and say, "good luck finding coverage, good luck finding something you can afford."

And, just in case you're wondering if this is all, here are a few more things wrong with their Medicare bill:

1. Millions of seniors will lose their existing—and better—retirement benefits. Companies will use Medicare providing a drug benefit as an opportunity to eliminate coverage they currently provide for their retirees. At least 2 million Medicare beneficiaries will lose their current benefit, which is almost certainly better than the scant coverage provided under this plan. This will make these beneficiaries worse off.

2. The drug coverage provided is weak and inconsistent. Seniors will pay a premium of at least $35 a month, and many will pay more into the program than they will get back.

The Republican plan contains a large coverage gap—after $2,200 in total costs, there is no coverage until a senior has paid $3,600 out of pocket, and purchased $5,044 worth of prescription drugs.

This means that of the first $5,000 a person spends, only $1,000 of it will come from their insurance. They will pay $4,000 of it on their own. This is not much of a benefit.

This means that seniors who spend more than $180 per month on medications will have many months in the year when they pay 100% of their drug costs but will still pay a premium every month.

Seniors will only be eligible for drug coverage through private insurance companies that will have wide latitude in setting premiums and deductibles.

Private insurance companies will also be able to make decisions about which drugs are covered, as well as which pharmacies seniors can use.

3. This bill is designed to protect an increase drug companies' and insurance companies' profits.

The pharmaceutical industry will reap about $140 billion in profits over eight years if this bill becomes law.

The bill explicitly prohibits the Secretary of Health and Human Services from negotiating lower drug prices on behalf of America's 40 million Medicare beneficiaries.

And, the bill does not allow Americans to import drugs from countries where prices are lower.

Insurance companies receive tens of billions of dollars in subsidies to take Medicare's business.

We take the risk and the insurance companies take the profits. If insurance companies lose money on Medicare, this bill says we, the government, will pay for it.

4. Their "Cost-containment" measure is designed to hurt Medicare beneficiaries and providers. Under their plan, Medicare's financing will be unstable and under assault. If general tax revenues account for more than 45 percent of Medicare spending, Congress would have to consider cost-control measures. We know this will probably happen by 2016, or even earlier. Congress could reduce benefits, increase beneficiary premiums, raise payroll taxes or reduce payments to providers.

Mr. BILIRAKIS. Mr. Speaker, I yield myself such time as I may consume, and I rise in opposition to the motion to instruct offered by the gentleman from Washington (Mr. INSLEE).

Mr. Speaker, I would say at the outset, through the Chair, that the only air of omission is that the gentleman's party was in charge so very many years did not see fit to decide that prescription drugs were necessary for our poor seniors. Now, all of a sudden, when the Republicans are doing it, they are taking issue with it.

This motion to instruct, Mr. Speaker, no longer serves any purpose, no longer serves any purpose, since a bipartisan group of Medicare conferees has already reached, as the gentleman knows, reached an agreement that will greatly improve the Medicare program, and most notably through the addition of a long-awaited prescription drug benefit.

□ 1915

In fact, I can assure the gentleman from Washington (Mr. INSLEE) that the provisions he seeks to strike in his motion to instruct were not included in the bipartisan Medicare conference agreement.

Additionally, the three positions that the gentleman is advocating, insuring that all hospitals receive the large urban standardized rate, that there be a floor on the work component on the physician fee schedule, and that the conference report include increases in reimbursements to physicians, are all already in the conference report.

I have led the opposition to a number of motions to instruct Medicare conferees over the past couple of months; and in doing so, I continually urge my colleagues to allow the bipartisan negotiations that I was a part of to play out. As Members know, these negotiations have run their course, and the result is a bipartisan agreement that is endorsed by a number of organizations, including the AARP.

That is why this motion no longer has any meaning, Mr. Speaker. It seeks to strike provisions not included in the final agreement and direct these nonexistent funds towards provider-payment increases that are already included in a bipartisan Medicare conference agreement.

In fact, the American Medical Association has strongly opposed previous motions to instruct that attempt to move money from patients to providers. In fact, the AMA forwarded me a statement earlier this week in response to a motion which took place, I believe, a couple of nights ago to instruct that said it strongly opposes the Berkley motion to instruct and urges Congress to pass the pending Medicare conference report before we adjourn.

I support reimbursing physicians and hospitals fairly for the valuable services they provide. I have been particularly passionate about fixing the formula that the Centers for Medicare and Medicaid use to annually update Medicare physician payments. In fact, I introduced a bill in late 2001, I believe it was jointly with the ranking member of my Subcommittee on Health, the gentleman from Ohio (Mr. BROWN), that would have prevented the 5.4 percent cut in physician reimbursements under Medicare that went into effect in 2002.

Physicians were slated to receive another cut, this time a 4.4 percent, if not for congressional action that corrected flawed data in the update formula and provided physicians with a 1.6 percent update for 2003.

However, persistent flaws in the update formula mean that physicians are looking at a 4.5 percent cut next year and further negative updates through 2007. It makes no sense, does it, that we would be cutting payments to our Nation's doctors at the same time their costs are rising. That is why the bipartisan Medicare conference agreement contains provisions that will ensure that physicians see their reimbursements under Medicare increased by 1.5 percent in fiscal years 2004 and 2005. Rather than the 4.5 percent cut, we are talking about a 1.5 percent increase, a 5.9 percent swing.

This will provide Congress with the time that it needs to make long-term reforms to the Medicare physician payment update formula so that physicians can count on predictable, rational payments from Medicare; and it will also avoid a major physician access problem for Medicare beneficiaries.

I would note that a number of organizations representing America's health care providers, including the American Medical Association, the American Osteopathic Organization, the American Hospital Association, and the Federation of American Hospitals, all strongly support the bipartisan Medicare conference agreement.

Mr. Speaker, over the past few months, I have had to listen to an awful lot of rhetoric about how Congress was privatizing Medicare or implementing a voucher system or handing Medicare over to the HMOs. That was not true then, and it certainly is not true now. What the bipartisan Medicare conference agreement does do is improve the Medicare+Choice program and set up a new system that will encourage regional plans to offer seniors another choice besides traditional Medicare.

It is a voluntary thing. Seniors can choose to retain traditional Medicare, something that they are accustomed to, something I would recommend to my parents if they were still alive, retain it and then go ahead and purchase a private drug prescription plan to add to it. It is my hope that this will extend new choices to folks in rural areas who have not had a choice in Medicare before.

The bipartisan Medicare conference agreement also includes a limited pilot project that will test a new system that could help put Medicare on sound financial footing for future generations. It is a pilot program. I think conferees came to a solid compromise. It is bipartisan, and it will help us fulfill our promise to America's seniors, and that is why I am so pleased that AARP strongly endorsed this agreement.

I can attest to the gentleman that a bipartisan group of conferees worked around the clock to reach this compromise. Soon Congress, I suppose tomorrow, will vote on a conference report that will add a new prescription drug benefit that will be available to all Medicare beneficiaries and that will provide seniors with new choices under Medicare and will reimburse our health care providers, including physicians, fairly so that beneficiaries will continue to have access to high-quality care; and I would also throw in at this point that under this bipartisan Medicare conference agreement, as under the original House-passed bill, seniors retain complete freedom to choose a private plan or to remain, as I have already said, in the traditional fee-for-service program. Medicare will continue to offer every beneficiary access to Medicare's defined benefit.

I hope Members will join me in supporting the conference report tomorrow and rejecting this motion to instruct which is meaningless because the conference agreement has already taken place.

Mr. Speaker, I reserve the balance of my time.

Mr. INSLEE. Mr. Speaker, I yield 1 minute to the gentleman from Ohio (Mr. STRICKLAND).

Mr. STRICKLAND. Mr. Speaker, I would just like to take a moment and direct a question to the gentleman from Florida (Mr. BILIRAKIS). The gentleman has said over and over in his statement that this was a bipartisan conference report. I ask a question: Was any House Democratic Member included in the conference negotiations? Were any of the Democrats included in the conference negotiations?

Mr. BILIRAKIS. Mr. Speaker, will the gentleman yield?

Mr. STRICKLAND. I yield to the gentleman from Florida.

Mr. BILIRAKIS. Mr. Speaker, every House Democratic Member who showed an interest in having a piece of legislation rather than an issue in November was invited into this coalition. It was bipartisan because there were two Democratic Senators who did have enough dedication who wanted to have a bill who were invited to participate, and I am here to tell Members that their comments and their recommendations probably took up 50 percent of the time over a period of months.

Mr. STRICKLAND. But the gentleman from Florida knows that our appointed conferees were the gentleman from New York (Mr. RANGEL), the gentleman from Michigan (Mr. DINGELL), and the gentleman from Arkansas (Mr. BERRY), and those three individuals were not included in the negotiations. I do not understand how the gentleman can stand and say to the American people that this was a bipartisan effort. It was not. Our Members were shut out of these negotiations.

Mr. INSLEE. Mr. Speaker, I yield 2 minutes to the gentleman from Wisconsin (Mr. KIND).

Mr. KIND. Mr. Speaker, I thank the gentleman from Washington (Mr. INSLEE) for yielding me time on this important motion. I commend the gentleman for this motion and for his efforts on the prescription drug bill that we have before us tomorrow.

This motion speaks to a fundamental problem that has existed in rural America in particular for many, many years; and coming from western Wisconsin, the Third Congressional District that I represent, I have devoted a lot of my time to try to deal with the inadequacies of Medicare reimbursement that have adversely affected my rural hospitals.

This motion would ask for raising the average standardized amount for hospitals in rural areas, as well as raise the physicians' work geographic index. Why is this important? Well, rural hospitals have been suffering for a long time. Sixty percent of the rural hospitals in my district and throughout the country are not receiving adequate Medicare reimbursement to cover the costs of treating Medicare recipients. Over the last 25 years, we have lost 475 rural hospitals which have gone out of business, partly due to the fact of the inadequacy of the Medicare reimbursement formula.

On average, my rural hospitals receive about 25 percent less than the average Medicare reimbursement throughout the country. This is a serious issue that needs serious attention.

The bill before us tomorrow I feel has a very good provider aspect with it, but the provider aspect is paid for. There are offsets found in the budget in order to pay for that. One of the chief concerns I have with the Medicare bill that is going to come before us tomorrow is there is no cost containment, and these costs are going to explode in future years. As a way of dealing with the rising prices of prescription drugs, one is allowing generics to enter the market on a competitive basis when the patents on brand-names expire. Another is to allow the Federal Government to negotiate prices with the pharmaceutical companies, even though there is specific language in this bill that specifically prohibits any price negotiation. Finally, is to allow the reimportation of FDA-approved drugs in a country like Canada back into the United States, something that many of my seniors in Wisconsin are already doing.

Mr. Speaker, if we are concerned about the costs of this bill, we would implement these practical measures. The easiest thing to do in the world of politics is to pass a bill we do not pay for and stick it to our kids and our grandchildren in future years, and that is exactly going to be the outcome of this bill tomorrow if we do not come to grips with the cost factor of rising medications.

Mr. BILIRAKIS. Mr. Speaker, I yield myself 1 minutes.

Mr. Speaker, to respond to the gentleman's statements, the regulatory reform portion of this bill, the electronic prescribing portion of this bill, the medication therapy management portion of this bill, and many of the provider issues were worked out on a bipartisan basis by all of the staffs, even prior to the conference. They were not discussed as part of the conference because they were already worked out. I just wanted to point that out.

Mr. Speaker, I yield such time as he may consume to the gentleman from Georgia (Mr. GINGREY).

Mr. GINGREY. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, once again we are debating a motion to instruct Medicare conferees. I find it odd that we are doing so after a bipartisan group of Medicare conferees has reached an agreement that has been strongly endorsed by numerous organizations, including AARP and 35 million seniors.

This motion to instruct conferees, as the gentleman from Florida (Mr. BILIRAKIS) said, like so many that the minority has offered before, serves no useful purpose in this debate. It is a solution in desperate search of a problem. They are simply political tools used in a desperate attempt to divert attention away from the fact that the Republican House will, in a matter of days, deliver on its commitment to providing seniors with access to meaningful, affordable, and comprehensive prescription drug coverage.

Mr. Speaker, I support properly reimbursing physicians and hospitals. The House bill does that, as does the bipartisan Medicare conference agreement, which is why it is supported by a number of organizations, including the American Medical Association, the American Hospital Association, and the Federation of American Hospitals.

I also believe it is a false choice to suggest that we need to choose between properly reimbursing providers and finding a way to ensure Medicare's long-term financial viability, because this bill does both. The AMA agrees with me, and here are some of its thoughts on a motion that was offered earlier this week by the gentlewoman from Nevada (Ms. BERKLEY).

□ 1930

"The American Medical Association strongly supports passage of the Medicare prescription drug conference report, which currently includes historic and critical provisions for improving choice and access for Medicare seniors and disabled patients.

"In addition, the conference report would halt 2 years of impending Medicare payment cuts to physicians and other health professionals and replace these cuts with payment increases of at least 1.5 percent per year.

"Because the Medicare conference report includes these critical provisions for improving choice and access, the AMA strongly opposes the Berkley motion to instruct and urges Congress to pass the pending Medicare conference report before they adjourn."

Let me just say this, Mr. Speaker. If the gentleman from Washington is serious about wanting to help our Nation's providers, let me suggest and urge to him to reconsider his opposition to medical liability reform legislation, tort reform, such as H.R. 5, the HEALTH Act, a bill that was strongly supported by the American Medical Association. Mr. Speaker, I am sure that the physicians in the State of Washington would be very appreciative of that support.

While we should all be pleased about the fact that we are about to provide our seniors with Medicare prescription drug coverage, I would note for my colleagues that spending on Medicare is projected to nearly double over the next decade just as our baby boomers begin to retire. Social Security, Medicare and Medicaid currently comprise more than 40 percent of the Federal budget. By the year 2030, the General Accounting Office estimates that these three programs, once again Social Security, Medicare and Medicaid, could consume 75 percent of the Federal budget if we make no changes and we keep Medicare as we know it. This level of entitlement spending is unsustainable and it will crowd out other essential functions of government. Reforms must be made to ensure that Medicare continues to exist for future generations, the children and the grandchildren that the gentleman from Washington was talking about. As we add a $400 billion drug benefit to a program that already has $13 trillion in unfunded liabilities, we must enact real reforms that will place the program on sound financial footing for the future.

To modernize Medicare and ensure its long-term fiscal viability, the bipartisan Medicare conference agreement will provide for a limited pilot project that will help test to see if the competitive reforms included in the House bill will help to ensure the long-term viability of this program. Under the bipartisan Medicare conference agreement as under the original House-passed bill, seniors retain complete freedom to choose a private plan or remain in the traditional as we know it fee-for-service program. Medicare will continue to offer every beneficiary with access to Medicare's defined benefit.

Mr. Speaker, I strongly support the bipartisan Medicare conference agreement which we will soon consider on the House floor. This motion to instruct no longer serves any purpose and the gentleman from Washington knows that. Indeed, the provisions relating to Medicare competition that the gentleman references in his motion are not even part of the final conference report.

I urge my colleagues to join me in rejecting this motion to instruct and supporting in a bipartisan fashion the final Medicare conference agreement.

Mr. INSLEE. Mr. Speaker, I yield myself such time as I may consume.

I appreciate the gentleman's advice, but we take it with not great credence from a group that have run us up into a $500 billion deficit because of their fiscal irresponsibility. So I appreciate the gentleman's advice, but I do not think it is going to have a lot of sway with the American people from a group that has given us the largest deficits in the universe's history.

Mr. Speaker, I yield 2½ minutes to the gentleman from Ohio (Mr. BROWN).

Mr. BROWN of Ohio. I thank the gentleman from Washington for yielding time.

Mr. Speaker, night after night we come down here. We talk about Medicare. I hear my friends on the other side of the aisle over and over say that of course they care about Medicare, that they believe in it. I know the gentleman from Florida (Mr. BILIRAKIS) does, because I have worked with him regularly. But I also know that his leadership does not. All you have got to do is look at the Republican history of Medicare. In 1965, when Medicare came in front of the United States Congress, when the creation of Medicare happened and President Johnson signed it, July 1965, only 13 out of 140 Republicans in this body voted to create Medicare. The other 127 voted no. Gerald Ford voted no; Bob Michel voted no; John Rhodes voted no; Bob Dole voted no; Senator Strom Thurmond voted no; and Donald Rumsfeld voted no.

The first time in these years since 1965 when the Republicans actually could weaken Medicare, they tried to.

Newt Gingrich, the new Speaker of the House in 1995, the first thing he did was proposed to cut $270 billion from Medicare in order to give a tax cut to the most privileged people in this society. Speaker Gingrich said, "We don't want to get rid of Medicare in round one because we don't think that's politically smart, but we believe it's going to wither on the vine."

Bob Dole, who had been around 30 years earlier to try to defeat Medicare, bragged to a conservative group in 1996, "I was there fighting the fight trying to stop Medicare from happening." They are not the only ones. JOHN LINDER told the House Rules Committee he did not like Medicare because it was a Soviet-style program. Dick Armey, former majority leader, said he did not like Medicare. He said, "It's something you wouldn't have in a free society." And Bill Novelli, the AARP CEO, wrote a preface to Newt Gingrich's book calling him a big idea person because of his efforts to privatize Medicare. Bill Novelli, making $700,000 a year working for the insurance company that we call AARP. AARP has made, according to the Milwaukee Journal and Capital News Services, literally $100 million a year from insurance sales, that organization. Sure they endorse this bill because that organization is going to make tons of money in the insurance business.

But the fact is my friends on the other side of the aisle simply do not like Medicare. They voted against its creation and every single time they have had a chance, they have done what they could to cripple it. They cut its funding, they try to privatize it, they take options away from seniors, all in the name of choice.

Mr. Speaker, the Inslee motion makes sense. Support the Inslee motion to instruct.

Mr. BILIRAKIS. Mr. Speaker, I yield such time as he may consume to the gentleman from Texas (Mr. BURGESS).

Mr. BURGESS. I thank the gentleman for yielding me this time.

Mr. Speaker, once again this was a bad motion earlier this week, it was a bad motion last week, it is a bad motion this week, and now it is irrelevant. It is irrelevant because the Medicare conferees have come to an agreement on these provisions. In fact, the final conference agreement does not even contain the Medicare competition provisions referenced in this motion.

The Medicare conference agreement has been endorsed by a number of organizations that would be directly affected by this motion to instruct conferees, such as AARP, the American Medical Association, and the American Hospital Association. So while the minority continues to try to score political points, and in fact they are just trying to scare people, the House is on the cusp of delivering a Medicare prescription drug bill to our Nation's seniors.

However, in the best interest of today's debate, let me describe what this motion intended to accomplish. It directs conferees to strip out important competitive reforms in the House and Senate-passed Medicare bills and redirect the funds toward increasing reimbursements for physicians and hospitals. This House certainly understands the importance of properly reimbursing physicians. That is why, unlike the Senate, the House included a provision that will provide physicians with positive payment updates in 2004 and 2005. This provision is included in the bipartisan Medicare conference agreement. While this is not a permanent solution, Mr. Speaker, it will provide Congress with the time it needs to make long-term, substantive changes to the Medicare physician payment update formula.

The bipartisan Medicare conference agreement also increases reimbursements for physicians practicing in rural areas as part of the most robust Medicare rural package this Congress has ever considered. Finally, the conference agreement will ensure that all hospitals receive the large urban standardized rate which means billions of dollars in additional funding for our Nation's hospitals.

Mr. Speaker, it is not lost on me that the supporters of this motion are attempting to portray this as a choice between HMOs or doctors. It is a false choice and they know it.

One of the aspects of the conference report that will be presented later this week that I find particularly attractive is the enactment of health savings accounts, a far cry from yesterday's HMOs. But do not take my word for it. We were very fortunate today to have the president-elect of the American Medical Association here on Capitol Hill, Dr. John Nelson, an OB-GYN like the gentleman from Georgia (Mr. GINGREY) and myself. The American Medical Association last week when this motion to instruct was offered yet one more time said they strongly support the passage of the Medicare prescription drug conference report which currently includes historic and critical provisions for improving choice and access to America's seniors and America's disabled.

In addition to increasing Medicare reimbursements to our Nation's physicians, the bipartisan Medicare conference agreement also provides seniors with more choices under Medicare and will begin to test some long-term competitive reforms that will ensure that Medicare is available and on sound financial footing for generations to come. That is an important point. Let me stress it. Ensure that Medicare is on sound financial footing for generations to come. I want to emphasize that neither the bipartisan Medicare conference agreement nor the House-passed Medicare bill would ever require that Medicare beneficiaries leave traditional Medicare.

A traditional Medicare will have a new patient prescription drug benefit available to its beneficiaries. Anyone who says otherwise either does not understand this legislation or prefers to avoid the facts.

Medicare conferees have worked through some very difficult issues. We owe them all a debt of gratitude for what they have done. They have produced a consensus agreement that this House will vote on later this week. The time to offer irrelevant, meaningless motions to instruct is over. The time to provide America's seniors with a Medicare prescription drug benefit is now. I urge my colleagues to vote "no" on the motion to instruct.

Mr. INSLEE. Mr. Speaker, I yield myself such time as I may consume.

When this premium support kicks in, no senior in America will have any choice about the matter. You will be subject to a provision that you will have to pay more money out of pocket when the HMOs take the healthy people into the private sector and leave the rest of our senior citizens in the more expensive Medicare pool. The group that said that last July was the AARP which said it will require beneficiaries to pay even more out of pocket. One hundred percent of Medicare recipients will be subject to this provision. You have no choice whatsoever. And everybody in this Chamber knows it.

Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. RYAN).

Mr. RYAN of Ohio. Mr. Speaker, I have noticed as I sat here tonight and throughout this debate some contradictions in the arguments from the other side which has not been unusual in my short time here. We hear a lot about privatization. We hear a lot about how the free markets need to work. But I am a little confused when we want to free-trade pharmaceuticals. The same day we were sitting here passing free trade agreements with Singapore and Chile, we refused to free trade pharmaceuticals with Canada, to lower the prices here. The same day. Actually, it was early into the next morning. I am wondering where all the capitalists and free traders were for that vote. Now, we have pharmacy benefit managers who for the private insurance companies will be allowed to negotiate down the drug prices. But we are tying the hands of the Secretary of Health and Human Services and explicitly say he is not allowed to negotiate lower drug prices.

These are complete contradictions in the argument. We hear about smaller government and free trade is great and we need the private markets to work, we need to be able to allow the free markets to work, and they are not working because they are not allowed to work if somehow they are going to improve this program and allow the government to be able to run a program that will benefit all of the seniors who will be eligible. People think they are going to wake up and get a Christmas gift this year, and they are going to find out in the end they are going to get coal in their stockings.

Mr. BILIRAKIS. Mr. Speaker, I yield myself 1 minute to respond to a point just made by the gentleman from Washington regarding premium support because that was the point. I am reading from the AARP endorsement, this insurance company as it was referred to a few minutes ago:

AARP is pleased by the improvements made to the conference report in recent days. A new structure called premium support—their words—which required competition between traditional Medicare and private plans was downsized to a limited test starting in 2010 which has significant protections—their words—significant protections for those in traditional Medicare.

I should think they would know at least as much about this as many of you gentlemen over there do. The government will provide coverage in areas where private plans fail to offer coverage. The integrity of Medicare will be protected.

Mr. Speaker, I yield such time as he may consume to the gentleman from Kentucky (Mr. WHITFIELD).

□ 1945

Mr. WHITFIELD. Mr. Speaker, I am glad that we are having this debate this evening on such an important topic as Medicare. It is quite obvious that this bill is not an ideal bill. There are shortcomings in this bill. But this Congress for 5 or 6 years has been having discussions about providing a prescription drug benefit for senior citizens, and that is precisely what this legislation does.

The previous speaker talked about the importance of being able to reimport drugs from Canada. If we pass this bill, those seniors who need it most are not going to have to be concerned about the cost of medicine because if they want to, and the option is theirs, they do not have to, they can stay with the Medicare program they have today; but if they want to, they can come into this program, and if their income is 135 percent of the poverty level and below, they do not have to pay a monthly premium to participate. They do not have to pay any deductible to participate, and their only out-go would be a $1 co-pay for a generic drug, a $3 co-pay for a brand-name drug, and they can reimport all the drugs they want to; and it is not going to be less than that. So they are going to be better off under this program than they would be worrying about reimportation of drugs from Canada.

If they are 135 percent of the poverty level and higher, instead of paying a $1 co-pay, they are going to pay a $2 co-pay. Instead of paying a $3 co-pay for brand names, they are going to pay a $5 co-pay for brand names. And I can tell the Members, the 35 counties that I represent in rural western Kentucky, the senior citizens there are going to be delighted with this bill because most of them are going to be able to walk away and not pay a premium, not pay a deductible, but have a prescription drug program that they can afford. It is not the ideal bill. There are some shortcomings. There is no question about that.

I would also like to make this comment about this argument about privatization, which I think is frequently used to scare senior citizens, and I understand that. We all like to play that game. But I think it is important to know that under the existing Medicare program that has been in effect for all these years, HCFA already contracts with private companies in all 12 regions of this country to administer the program. So we are already dealing with private companies. There is nothing unusual about that. But it does sound good if they want to try to scare senior citizens. But overall I think this bill is a good beginning.

And I would make one other comment, although I certainly do not agree with Newt Gingrich on everything, but people always talk about his comment of letting it wither on the vine. He was not talking about Medicare as a program. He was talking about HCFA, the entity that administers Medicare; and if people talk to any health care provider in this country, whether it be a physician, hospital, whatever, they will complain and express concern about the bureaucracy at HCFA on reimbursements, on all sorts of issues. I have had more than one town meeting in my district with health care providers complaining about the bureaucracy at HCFA. Obviously, HCFA is trying to do a good job, but Newt Gingrich's comment was simply about trying to modernize it to provide a better program, more efficient program, more productive program with a faster reimbursement for health care providers.

So, Mr. Speaker, I know it has been a difficult chore, and I know that the Democrats on the other side have contributed to this program. They have worked to help us devise a program that is a good starting point, and I think this is a good starting point, and I think the thing that really tells the story about this program, about this bill that we probably will be voting on tomorrow, is that the AARP, which is the premier senior citizen association in the country, is now endorsing this bill, it is my understanding. So I hope that we will vote against the gentleman from Washington's motion to instruct, and I hope that tomorrow we can pass this bill and provide our seniors with a prescription drug bill that they will be able to afford.

Mr. INSLEE. Mr. Speaker, I yield myself such time as I may consume.

AARP, that is the organization that also endorsed the catastrophic drug plan some time ago, that, when seniors found what was in it, rampaged and forced this Congress to repeal it. And, yes, seniors are concerned about this, and that is why they are calling us by the score in every one of our offices, and no doubt in yours too, because they understand when we tried to do this privatization experiment in the State of Washington for these profit-driven insurances companies that come in, tens of thousands of people without coverage were left without coverage when they left a year and a half later. It did not work. It is an experiment that already failed, and we are doing it again because people want to have Medicare wither on the vine.

Mr. Speaker, I yield 2 minutes to the gentleman from New Mexico (Mr. UDALL).

Mr. UDALL of New Mexico. Mr. Speaker, I thank the gentleman from Washington (Mr. INSLEE) for his leadership on this motion to instruct, and it is badly needed because we can see from the other side how the deceptions flow out. We are hearing over and over here again about a bipartisan conference. The fact of the matter is, and they know it, that we were locked out of the conference. Absolutely unprecedented. Democrats locked out and a secret agreement crafted, which we most of us have not even seen yet. We have not seen it. But it is going to be rammed through despite the fact it is supposed to sit on the table here for 3 days at a minimum for us to study.

But this is a bad bill. It is a bad bill for seniors, and it is a bad bill for the future of Medicare. The key thing that a prescription drug bill should do is get control of the cost. This bill does not get control of costs in any respect. In fact, it has a prohibition in the bill that specifically says the Department of Health and Social Services, the agency that runs Medicare, cannot negotiate with the drug companies. I will bet the drug companies love that provision.

Also the House of Representatives passed a reimportation provision. Reimportation allows us in the United States to bring in the cheaper drugs where they are safely manufactured. But they did not want that in the bill; so they junked that also. So there is nothing in this bill to control costs, and we are headed down a road of creating a program which is going to bankrupt our grandchildren.

The only way, the only way we are going to get control of costs is allow the government, allow the government to negotiate. With that, let me urge all my colleagues to support the very wise motion of the gentleman from Washington (Mr. INSLEE).

Mr. Speaker, I rise today with great disappointment in the conference agreement that has been brought to the floor. I sincerely hoped that the bill that passed the House in July would have been moderated with provisions included in the other Chamber's bill.

Unfortunately, instead of considering legislation today that would have modernized the Medicare program to provide prescription drug cost relief and coverage for seniors throughout this great Nation, we have this agreement that is geared toward dismantling one of the most successful government programs ever implemented. Instead of considering legislation to modernize the Medicare formulas to fix the inequities between rural and urban areas, we are considering an agreement that wraps these crucial fixes in with a prescription drug benefit that is designed to achieve the ideologically extreme goal of privatizing Medicare.

I will certainly admit that the provider package included in this agreement is excellent. For years doctors, hospital administrators, and other health care providers have suffered under the unfair Medicare formulas that severely hampered their ability to provide care to Medicare beneficiaries. The labor share revision, the geographic physician payment adjustment, equalizing the Medicare disproportionate share payments, increasing home health services furnished in rural areas, critical access hospital improvements—these are all incredibly important provisions that I strongly support in order to help strengthen the health care system in rural areas. The physician fee formula update is another provision that is incredibly important. Without this fix, physicians will have no other choice but to stop seeing Medicare beneficiaries, which will lead to the total breakdown of a system that is already badly strained to its limits.

I recognize the importance of these provisions. I understand the difficulties that those in the health care industry are facing. I understand the difficulties seniors are facing in trying to purchase and pay for their medications. That is why I have cosponsored legislation to fix the disproportionate share provisions, I have cosponsored legislation to fix the Medicare physician payment updates, I have written letters supporting these provisions and urging Chairman THOMAS to include these rural fixes in the legislation, I have written a letter to conferees asking them to retain these provisions, and, when this bill passed in July, I voted in favor of the Democratic alternative that not only included stronger rural provisions than those included in the Majority's bill, but also contained a real prescription drug benefit—not a benefit engineered to bring about the demise of the Medicare program.

Let's be clear about what our goal was supposed to be. We were supposed to create a new prescription drug benefit in Medicare. That's what we were supposed to be doing with this important legislation.

Unfortunately, we are doing much more than that, and a lot of it is terrible. We were supposed to be reducing the costs of drugs for seniors. Yet this plan prohibits the federal government from using its clout to force down the price of medicine.

We were supposed to help seniors keep their current drug coverage if they are fortunate enough to have it. Yet this plan may force up to three million seniors out of their current employer-based plans.

We were supposed to be strengthening the Medicare program by adding a voluntary benefit for prescription drug coverage. Yet this plan, under the guise of a premium support demonstration, weakens the Medicare program by forcing beneficiaries to pay more for Medicare if they don't give up their doctor and join an HMO.

We were supposed to help low-income seniors who get additional assistance from Medicaid afford their prescriptions. Yet this plan not only forces 6 million low-income seniors to pay more for their medications, but also imposes an unfair assets test that disqualifies seniors if they have modest savings.

We were supposed to be providing a prescription drug benefit that would ease the cost and emotional burden seniors face in dealing with medication purchases. Yet this plan leaves millions of seniors without drug coverage for part of the year due to the $2800 gap in coverage.

Mr. Speaker, I am extremely disappointed with this agreement. I am disappointed because what should have been a straightforward approach took a wrong-turn along the way. I think this is a terrible way to spend $400 billion dollars on a supposed prescription drug benefit, and I will be forced to vote against this measure. I urge my colleagues to reject this shameless assault on Medicare.

Mr. BILIRAKIS. Mr. Speaker, I reserve the balance of my time.

Mr. INSLEE. Mr. Speaker, I yield 2 minutes to the gentlewoman from Texas (Ms. JACKSON-LEE).

Ms. JACKSON-LEE of Texas. Mr. Speaker, I thank the distinguished gentleman from Washington for yielding me this time, and I thank the gentleman from Florida (Mr. BILIRAKIS) as well.

There are several points that I think are very important this evening. I have heard the words, and I guess it was not ridiculous, but I heard the fact that this is an outdated motion, it is unnecessary, it is without timeliness. I beg to differ with my colleagues. If we can do anything to educate the American public and our colleagues who may not be here this evening about the failures and the fallacies of the legislation that we might see tomorrow, Mr. Speaker, if we could pass a real guaranteed Medicare prescription drug benefit and as well provide for our private hospitals and our doctors, this legislation would be passed 435 to zero. If we could actually do what we have debated and argued for almost 10 years through the Clinton administration and now the Bush administration, there would be no need to have a motion to instruct.

But, Mr. Speaker, I stand here tonight because there is little time to educate our colleagues as well as the American public because tomorrow we will have 632 pages that will never have been read and that will be forced down our throats and we will be asked to vote for something that truly will destroy Medicare as we know it.

We will be asked to give $12 billion to the HMOs without any explanation. We will be asked to tell the government that they cannot negotiate lower pharmaceutical prices, drug prices, for the Medicare program. What an outrage. We will be telling the government to spend all the money that is needed and not require it to get the best deal. We will not be giving the hospitals, all of the hospitals, the kind of moneys that they need as it relates to reimbursement. We will not be doing what the gentleman from Washington (Mr. INSLEE) has asked for identification payment.

We will, in fact, not allow seniors to reimport drugs where they have been doing it all along. And in actuality, to my good friends at AARP, and I consider them my good friends, I thought it was called now the "American Association of Rich People," I would say to them the reason why they have 35 million members is because in 1965 President Johnson passed Medicare to give an extended life to those seniors who are now living.

So what this bill will do tomorrow when we vote on it is it will eliminate the sickest of our seniors, the oldest of our seniors, and the calculation is that by 2006 those seniors will be dead. So we will not to have to worry about them.

This is a bad bill; and to the American public, no matter how long we are on this floor, I thank the gentleman from Washington (Mr. INSLEE) for his leadership. We are educating 35 million AARP members. We will tell them the truth that this is a bad bill and the only reason they are still alive to have an AARP card is because we passed Medicare in 1965.

Mr. BILIRAKIS. Mr. Speaker, I reserve the balance of my time.

Mr. INSLEE. Mr. Speaker, I yield 1½ minutes to the gentleman from Ohio (Mr. STRICKLAND).

Mr. STRICKLAND. Mr. Speaker, I thank my friend for yielding me this time.

I continue to object to my friends on the other side referring to this as a bipartisan bill. They know that no Democratic Member of this House was allowed to participate in the negotiations.

And it is your bill, and you are going to have to live with it. The gentleman from Michigan (Mr. DINGELL), the gentleman from New York (Mr. RANGEL), the gentleman from Arkansas (Mr. BERRY), our representatives, were shut out; and you ought to recognize that. I think it is intellectually dishonest to refer to it as a bipartisan bill.

This bill was written by the pharmaceutical companies. Let me give the Members an example of why I say that. Two days ago, Secretary Thompson and the two Senators that participated, the Democratic Senators, met with the Blue Dogs in this House; and in that meeting they were asked why there is specific language in this bill that prohibits the Secretary from negotiating cheaper prices for our senior citizens. And one of those seniors spoke up and said it is in there because PhRMA insisted that it be in there.

□ 2000

Think of that. I hope the American people are paying attention, because this bill was written for and by the pharmaceutical companies and, sadly, my friends on the Republican side are supporting it, and they are going to have to live with it. I have gotten over 100 calls in my office today; only two of them have been in support of this flawed bill.

Mr. BILIRAKIS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I would remind the gentleman through the Chair that I am not sure what his definition of bipartisanship is, but a few years ago, we had a tort reform bill on the floor, and the most elderly Member in terms of service of this House had the bill on that side. He had one Republican cosponsor of that bill and continually, continually harped on it being bipartisan, bipartisan, bipartisan. I should think that two United States Senators, two United States Senators, I think one, maybe both ranking members of the appropriate committees, two out of 12 would be considered every bit as bipartisan as one out of 435.

I would also, additionally, remind the gentleman through the Chair that in addition to the other areas that I said that have been worked out on a bipartisan basis by all of the staffs, there were the Hatch-Waxman reforms and the reimportation and whatnot, and the gentleman from Michigan's (Mr. DINGELL) staffers were at every one of certainly the Hatch-Waxman reforms and the reimportations, as I understand it.

The point was made regarding the catastrophic. If memory serves me correctly, I believe I voted for that bill. How many of us, 400-some of us did. It turned out to have been the wrong thing to do, but 400 some. Bipartisan? My colleagues better believe it. I would suggest that if the gentleman were here at that time, he probably would have been part of the 400 and some that voted for that particular bill. That was a mandatory thing. This is voluntary. That was mandating on these people. This is voluntary.

I would just finish up my comments, Mr. Speaker, by reminding the people over there through the Chair of the AARP endorsement. AARP believes that millions of older Americans and their families will be helped by this legislation. Though far from perfect, the bill represents an historic breakthrough and an important milestone in the Nation's commitment to strengthen and expand health security for its citizens at a time when it is sorely needed. The bill will provide prescription drug coverage at little cost to those who need it most: people with low incomes, including those who depend on Social Security for all or most of their income. It will provide substantial relief for those with very high drug costs. It will provide modest relief for millions more.

It also provides a substantial increase in protections, protections for retiree benefits and maintains fairness by upholding the health benefit protections of the Age Discrimination and Employment Act.

The gentleman from Ohio who most recently spoke talked about some sort of a meeting which was held with PhRMA. I really do not know about that. I do not deny it took place. But I will tell my colleagues that there was a meeting held in the last couple of days where AARP appeared with the two Democratic Senators, and they wrote many of the provisions of this bill. I would not call this an AARP bill, I would not call this a Republican bill nor a Democratic bill. It is a bipartisan bill.

Mr. Speaker, I reserve the balance of my time.

Mr. INSLEE. Mr. Speaker, I yield myself such time as I may consume.

We have tremendous respect for the gentleman from Florida (Mr. BILIRAKIS). But what we are saying is the seniors of the greatest generation simply deserve better than this bill, and we ought to be capable of doing better, so that we do not have a bill that is too little and too late, we believe both.

Mr. BILIRAKIS. Mr. Speaker, will the gentleman yield?

Mr. INSLEE. I yield to the gentleman from Florida.

Mr. BILIRAKIS. Mr. Speaker, I agree with the gentleman, they deserve better. I agree with the gentleman, it is not perfect. But I would simply say to the gentleman that it will help an awful lot of seniors in the meantime. In the meantime, it will help a lot of seniors. The alternative is zero.

Mr. INSLEE. Mr. Speaker, reclaiming my time, we believe the alternative is a real Medicare prescription drug plan which we Democrats have offered and voted for.

Mr. Speaker, I yield 2 minutes to the gentlewoman from Ohio (Mrs. JONES).

Mrs. JONES of Ohio. Mr. Speaker, I too have a lot of respect for the gentleman from Florida (Mr. BILIRAKIS), and he has been very helpful in letting the issue of uterine fibroid research be heard, and I thank him for that.

But I have to differ with him on a few things, and one of those would be we are discussing this prescription drug benefit like it is going to happen tomorrow. I want seniors, if the bill passes, to understand it will not happen until 2006, so we are clear on that.

Mr. Speaker, I had a town hall meeting for my seniors and what they said to me is, they wanted a prescription drug benefit that would be fair, that would be guaranteed, and that would be affordable. I have been talking and talking about how I want it to be fair, guaranteed, and affordable and, as I review this bill, it is not that.

I am here talking on a motion to instruct because as a new member of the Committee on Ways and Means, I thought that my ranking member would have a chance to be in the meeting. Now, the reality is, the Democratic House Members were not included. We went to a meeting with the chairman, the gentleman from California (Mr. THOMAS), and he said, only those who are Members of the willing, or however the heck he described it, get to come to the private meetings of the conference committee. Our conference folks would get invited to the official meetings of the conference, but they would not be invited to the meetings where things that were accomplished in this bill were included.

History taught me that there is a Senate and then there is a House of Representatives and, true, those two Senators sat down with the Republicans, and they call it bipartisan, but they are not my Senators. We stand up as Members of the House, and we are entitled to participate in the process.

Mr. Speaker, I had Tom Scully in my district because I am truly concerned about what is happening in health care, and he came in and talked to my hospitals, and my colleagues heard what the hospitals said, and they got more money. And the doctors sat with Tom Scully, and my colleagues heard what they said, and they got more money.

My son Mervin is 20 years old and he uses the term, "I ain't mad." And I "ain't mad" at the hospitals that they got money to be able to provide services. And I "ain't mad" at the doctors because I thought they should be paid more. But I am mad because my seniors are not getting what I thought they were entitled to, which is a guaranteed, affordable benefit. There is a gap in coverage, there are all kinds of things. I am running out of time, but I am here to speak on behalf of the 11th Congressional District. I ain't voting for this bill, and I ain't mad.

Mr. BILIRAKIS. Mr. Speaker, the gentleman has the right to close, as I understand it. I have no further speakers, so I yield back the balance of my time.

Mr. INSLEE. Mr. Speaker, I yield myself the remaining time.

I want to express my respect for the leadership of the gentleman from Florida (Mr. BILIRAKIS) on organ donation issues, which is an important matter as well. We appreciate his leadership of trying to improve the access of organs in organ transplant procedures. So we agree on quite a number of issues.

But I think we agree on a goal perhaps and not a direction in that he has indicated that he believes seniors do deserve better. And we believe seniors, in the bottom line of this debate, deserve better than this proposal for a couple of fundamental reasons. Reason number 1: this short-term, extremely modest potential benefit that may potentially help a few seniors includes the seeds of destruction potentially of the very foundation of their health care that this Nation has come to embrace since the early 1960s, and that is Medicare. In the premium support provision, which sounds like innocuous language that is in the bill, it is in the bill, and we all agree on that; it will be in bill. We do not know what page, because nobody has read this. It is going to be hundreds of pages and nobody will have read this probably until we are forced to vote on it less than 24 hours after the bill is passed; but nonetheless, that little innocuous provision carries the potential of the seeds of destruction of the guarantee of the Medicare program.

The reason I say that is it will, ultimately, foist on every senior, whether they want it or not, if it is implemented, under this bill, to face a situation where they will have to pay more and have less coverage than those in the private plans. And since the private insurance companies are extremely adept at marketing, they can have all kinds of bells and whistles to lure the healthiest people into their population, leaving the sickest in Medicare, those most in need of security and peace of mind, leaving their premiums to skyrocket and Medicare to go into a death spiral, as the analysts have predicted.

I am getting to a certain age; I am not as old as my dad and mom who I love dearly, but I think aging is tough enough. American seniors should not have to worry about the loss of the guarantee of Medicare. We should pass a Medicare prescription drug program that we have suggested on this side of the aisle, and work with my Republican colleagues to pass a true bipartisan bill.

The SPEAKER pro tempore (Mr. ROGERS of Alabama). Without objection, the previous question is ordered on the motion to instruct.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to instruct offered by the gentleman from Washington (Mr. INSLEE).

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. BILIRAKIS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, and the Chair's prior announcement, further proceedings on this motion will be postponed.

MOTION TO INSTRUCT CONFEREES ON H.R. 2989, TRANSPORTATION, TREASURY, AND INDEPENDENT AGENCIES APPROPRIATIONS ACT, 2004

Mr. HASTINGS of Florida. Mr. Speaker, I offer a motion to instruct.

The SPEAKER pro tempore. The Clerk will report the motion.

The Clerk read as follows:

> Mr. HASTINGS of Florida moves that the managers on the part of the House at the conference on the disagreeing votes of the two Houses on the Senate amendments to the bill H.R. 2989 be instructed to recede from disagreement with Senate Amendment 1928 (relating to the provision of $1,500,000,000 for grants to assist State and local efforts to improve election technology and the administration of Federal elections, as authorized by the Help America Vote Act of 2002).

The SPEAKER pro tempore. Pursuant to clause 7 of rule XXII, the gentleman from Florida (Mr. HASTINGS) and a Member of the majority each will control 30 minutes.

The Chair recognizes the gentleman from Florida (Mr. HASTINGS).

GENERAL LEAVE

Mr. HASTINGS of Florida. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on this motion to instruct conferees.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Florida?

There was no objection.

Mr. HASTINGS of Florida. Mr. Speaker, I yield myself such time as I may consume.

Before I begin, Mr. Speaker, I want to take a moment to acknowledge the great work of so many Members to make election reform a reality in the 107th and 108th Congresses. First, the American people owe a large debt of gratitude to the Democratic whip, the gentleman from Maryland (Mr. HOYER), and the chairman of the Committee on House Administration, the gentleman from Ohio (Mr. NEY). Without them, the Help America Vote Act never would have passed and the possibility of $1.5 billion in 2004 would never be possible.

I also want to acknowledge the gentleman from Florida (Chairman YOUNG) and the gentleman from Oklahoma (Mr. ISTOOK) and the ranking members, the gentleman from Wisconsin (Mr. OBEY) and the gentleman from Massachusetts (Mr. OLVER) for their commitment to funding the Help America Vote Act. I would like also to thank the Black Caucus and the Hispanic Caucus and specifically, the gentleman from Rhode Island (Mr. LANGEVIN), the gentlewoman from California (Ms. WATERS), the gentleman from Michigan (Mr. CONYERS), the gentleman from New Jersey (Mr. HOLT), the gentleman from Pennsylvania (Mr. FATTAH), the gentleman from Florida (Mr. JIM DAVIS), the gentlewoman from Florida (Ms. CORRINE BROWN), the gentleman from Florida (Mr. MEEK) and his mother, former Representative Carrie Meek, and many more, such as the gentlewoman who just spoke, the gentlewoman from Ohio (Mrs. JONES), and countless Members here in the House who were instrumental in getting us where we are today.

Mr. Speaker, I rise to offer this motion to instruct conferees on H.R. 2989, the Transportation, Treasury and Independent Agencies Appropriations bill. This motion instructs House conferees to accept the provision from the Senate-passed bill providing a total of $1.5 billion in election reform assistance to States and local communities.

When the House considered this legislation last month, it appropriated only $500 million. Since Congress passed the Help America Vote Act, States, including my own, have struggled in implementing the requirements of the new election laws, largely because Congress has not fulfilled its financial commitment.

□ 2015

In 2003, the Congress provided only $1.5 billion of the $2.16 billion that was authorized for that year. $830 million of that amount has yet to reach the States. And while the Help America Vote Act authorized $1 billion for fiscal year 2004, the House only appropriated half of that amount. In contrast, the Senate-passed bill appropriates $1.5 billion, covering the full fiscal year 2004 authorization as well as making up for a significant portion of last year's funding shortfall.

Mr. Speaker, I am aware that the current draft of the Transportation-Treasury Appropriations conference report includes $500 million for election reform. That is for the whole United States. I am also aware that a possible agreement exists to provide additional election reform funding in the omnibus, perhaps as much as $1 billion. One of the reasons I highlighted the $500 million for the whole United States, the State of Florida has funded $200 million. And that is substantially 40 percent of the total amount that we did for the whole United States. However, what I am not aware of in this measure is why the majority is unwilling to fund all $1.5 billion in the proper spending measure. The majority has stated that the budget does not allow for an additional $1 billion. And the President will veto anything over the already agreed amount.

The reality is, Mr. Speaker, the majority is going to violate the budget agreement when it passes an omnibus in 3 days or whatever day it is that we leave here with the $1 billion in the bill. Every penny appropriated in the next 4 days or the final days of this portion of the session is going to be spent in fiscal year 2004 regardless of what bill we included it in. The budget is going to go bust. So if we are going to bust it, at least fund something which will benefit all Americans.

Next week I am scheduled to travel to Maastricht, Holland, and on to Moscow in my capacity as vice president of the organization for security and cooperation in Europe's parliamentary assembly. I will represent the United States as an observer to the upcoming Russian elections.

While I am certainly honored by the task, the irony of the situation is striking. Imagine an elected official from the United States, Florida, advising another country on how to run its elections. Perhaps the OSCE ought to be sending election monitors to the United States. In fact, I plan to invite them to do just that next year.

Realize, when I attend the international meetings of the OSCE, America's ability to conduct fair and reliable elections is often mocked. Parliamentarians from around the world question our election results while Americans are faced to deal with the harsh and unfortunate reality that the Supreme Court may be the only place in the Nation where votes actually matter.

We are spending billions of dollars to bring democracy to Iraq and Afghanistan. Yet we are hesitant about spending $1 billion to protect our own. Congress must continue to strive to identify methods and practices to encourage and increase participation in America's electoral process. As a country, we must work toward a day where fairness and transparency are manifest in our elections process and cut-throat politics are forever overwhelmed.

Fully funding the Help America Vote Act is the next step that Congress must take to ensure that we never again find ourselves questioning the methods by which we choose our leaders.

In approving my motion to instruct, the House will send a clear message that it supports funding a fair and reliable election system in America, no matter what it costs. I ask for my colleagues' support.

Mr. Speaker, I reserve the balance of my time.

Mr. SHUSTER. Mr. Speaker, I reserve the balance of my time.

Mr. HASTINGS of Florida. Mr. Speaker, I yield 5 minutes to the gentleman from Maryland (Mr. HOYER), distinguished whip and my good friend, who I earlier noticed in my remarks. But for him and the gentleman from Ohio (Chairman NEY), this measure would not have passed.

Mr. HOYER. Mr. Speaker, I thank the distinguished gentleman from Florida (Mr. HASTINGS) for yielding me the time.

I rise in strong support of this motion to instruct. I would add, Mr. Speaker, however, that I appreciate his giving me and the gentleman from Ohio (Mr. NEY), the chairman of the Committee on House Administration, credit. We worked hard on this.

Mr. Speaker, this was the most bipartisan bill in the last Congress. But substantial credit is also due the Speaker of the House, the gentleman from Illinois (Mr. HASTERT), as well as Republicans in the Senate, Senator MCCONNELL, Senator BOND, and Senator DODD. It was, in my opinion, an example of how the Congress ought to work. We sat down together, we talked about the problem, and we tried to solve it.

In 347 days, on November 2, 2004, the American people will again go to the polling places. And every State in this Nation will exercise the most fundamental right in any democracy, which is, of course, the right to vote. And when they do, they will be reminded of one of the most painful episodes in American history, the disenfranchisement of an estimated 6 million Americans in the election of November 2000.

Mr. Speaker, in my opinion, we have a moral obligation to ensure that the election problems that plagued us 3 years ago and which undermined this great democracy in the eyes of the world, and indeed in the eyes of many of our citizens, will not be repeated. That is precisely the point of this important motion made by the gentleman from Florida (Mr. HASTINGS). It instructs the House to recede to the $1.5 billion in spending for election reform in fiscal year 2004 called for by the other body.

Mr. Speaker, I mentioned the gentleman from Illinois (Mr. HASTERT). I also want to mention the gentleman from Florida (Mr. YOUNG), the chairman of the Committee on Appropriations. Without the gentleman from Florida, we would not have received the funding of approximately $1.5 billion that we included in last year's bill. But in the HAVA, the Help America Vote Act, we promised the States that they would receive assistance from the Federal Government to achieve the reforms we felt essential.

That bill, proclaimed as the most important election reform legislation since the adoption of the Voting Rights Act of 1965, established minimum Federal standards for Federal elections. Properly funded HAVA will improve the security and accuracy of this Nation's election and registration system and prevent a repeat of the 2000 debacle.

Despite HAVA's enormous promise, however, States have had considerable difficulty implementing the law's requirements because Congress provided only $1.5 billion of the $2.16 billion authorized in fiscal year 2003. In other words, Mr. Speaker, we are over $600 million behind as of this date.

HAVA also authorized $1 billion for this year. However, the House only appropriated $500 million in the Transportation-Treasury bill. Recently, the other body, in a bipartisan way, added a billion dollars to the transportation bill which already included $500 million. This amount not only fully funds HAVA at the fiscal year 2004 authorized level, but it also covers the shortfall from fiscal year 2003.

This motion should attract the support of every Member of this body. It is consistent with the numerous pledges made by the Speaker, the gentleman from Florida (Chairman YOUNG), the White House, and this Congress in a bipartisan way.

Through HAVA, Mr. Speaker, we can make sure that the States have resources to make election reform a reality. And we can restore the public's confidence in our election system. We must do so. And this motion calls upon us to effect that end.

In closing, Mr. Speaker, let me say that I talked to the gentleman from Florida (Mr. YOUNG), the chairman of the Committee on Appropriations, and I have talked to the gentleman from Ohio (Mr. NEY). It is my understanding the administration has pledged to include in the 2005 budget the $800-plus million left on this Congress's pledge to the States to ensure that every American not only has the right to vote but every American is encouraged to vote, every American is facilitated in casting their vote, every American will have an opportunity to check that they voted correctly and that every American's vote will be counted accurately.

Mr. SHUSTER. Mr. Speaker, I reserve the balance of my time.

Mr. HASTINGS of Florida. Mr. Speaker, I yield 4 minutes to the gentlewoman from Texas (Ms. JACKSON-LEE), my good friend from Houston.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I thank the distinguished proponent of this motion, and I recognize the journey that we have traveled in getting to this point. Let me acknowledge both the gentleman from Maryland (Mr. HOYER) and the gentleman from Ohio (Mr. NEY) on working with so many of us in the Congressional Black Caucus, Hispanic Caucus, members of the Democratic Caucus, and members of the Republican conference on a concept that every single vote of every single American must count.

I believe that this is a very important motion because I think it has potential. It is a motion that would give the broadest of consensus by both Republicans and Democrats, that it is important to fully fund the legislation that allows and provides an opportunity for local communities and State communities to be able to ensure that every vote is counted. Election reform was long overdue.

And certainly the crisis of 2000, where millions of voters were denied both access to the voting polls, some who were racially profiled and kept away from voting, students who were intimidated and told that they could not vote, and individuals who were charged with being convicted felons when they were not and therefore denied to vote. That was a scenario in the State of Florida, but Florida is not the only example.

Time after time when there is an election, we find that there are individuals who have been denied the right to vote. This past election in Houston, Texas, I traveled to many polls, local municipal elections, to come upon instances where many of our voting officials did not have all of the knowledge of the law, turned people away, did not understand the process of an affidavit where you would allow people to sign an affidavit, thereby being allowed to vote. So we know that voting resources or election resources are extremely important.

And one factor that has never been fully addressed, the question of whether or not there is a paper trail for the new electronic voting, is a question that is raised in many local municipalities, and I believe that we should address it. This full funding of about $1.5 billion, I believe, will help, I do not want to say complete the story, but it will put us on the right journey to make the journey that we started an effective one by ensuring that our State and local governments in particular will have the resources as we approach the 2004 very important Presidential elections.

□ 2030

So I rise today to support this motion to instruct because we are on the eve of those Presidential elections, now four years later. Most would wonder how time has flown, but it would be, I guess, an undermining of the commitment we all made after 2000, Republicans and Democrats alike, if we could not see, by 2004, a full funding of this legislative initiative so that as we approach the Presidential elections, the primaries, in fact, every single State in this union and every local municipality would not have as an excuse for denying an American their right to vote, the lack of resources, the lack of trained voting officials, the lack of equipment, the lack of the knowledge of the law, and certainly no matter what color you were, how your history started in this Nation, whether or not your voting rights were enhanced only in 1965 with the Voting Rights Act of 1965, whether or not you have just become a citizen, every single American would know in their hearts and know by the laws that guided them that we had the resources to ensure that their votes were counted.

I thank the gentleman from Florida (Mr. HASTINGS) for his leadership on this matter for bringing this very instructive, very vital and very important motion to instruct to our colleagues. And I ask my colleagues in unanimity to vote for this motion, so that we would have a successful instruction to be able to provide for those who want to vote.

Mr. SHUSTER. Mr. Speaker, I reserve the balance of my time.

Mr. HASTINGS of Florida. Mr. Speaker, I yield 4 minutes to the gentleman from Rhode Island (Mr. LANGEVIN) and to make the further comment that he has been extremely instrumental in causing us to get this far.

Mr. LANGEVIN. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, I am pleased to join my good friend and colleague, the gentleman from Florida (Mr. HASTINGS) in support of this motion to instruct conferees. He has been an outspoken advocate for improving our Nation's election systems and voting administration, and I thank him for his leadership. I also thank my good friends, the gentleman from Ohio (Mr. NEY) and the gentleman from Maryland (Mr. HOYER) for their consistent support and unwaivering dedication to the issue of election reform.

Mr. Speaker, just over a year ago, I joined a group of my colleagues as the President signed into law the Help America Vote Act. The result of more than a year of hard work and bipartisan cooperation, the legislation was called the first civil rights legislation of the 21st century because it ensured that all Americans could participate fully in our democracy by being guaranteed the fundamental right to vote. I am particularly pleased that the legislation contained groundbreaking provisions to make our Nation's polling places and voting equipment accessible to people with disabilities. This change will enable millions of Americans to cast a ballot independently for the very first time in their lives.

At the signing ceremony, President Bush said that thanks to the reforms contained in HAVA, "the Federal Government will help State and local officials to conduct elections that have the confidence of all Americans."

Well, Mr. Speaker, unfortunately, we have yet to reach that level of confidence because we have not provided sufficient resources to implement the law. States are eager to enact HAVA's reforms but they lack the funds promised to them. Congress provided only $1.5 billion of the $2.16 billion authorized in fiscal year 2003, and the House included only $500 million of the $1 billion authorized for fiscal year 2004. The Senate approved $1.5 billion in its version of the Transportation-Treasury bill, which will meet this year's shortfall. I joined the gentleman from Florida (Mr. HASTINGS) in organizing a letter to conferees to endorse the Senate funding levels, an effort that garnered the support of 60 Members, and I am pleased to continue that more here today.

In the 1990s, as Secretary of State of Rhode Island, I led the effort to upgrade our State's voting equipment, and I know firsthand the benefits that modernized election systems can have on voter turnout and civic participation. I encourage my colleagues to support this motion to instruct so that we can realize the vision of the Help America Vote Act and restore confidence in our Nation's elections.

Mr. Speaker, I thank the gentleman for yielding me time.

Mr. SHUSTER. Mr. Speaker, I reserve the balance of my time.

Mr. HASTINGS of Florida. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I would like to thank my good friend, the gentleman from Rhode Island (Mr. LANGEVIN) for his comments and my thanks for his extraordinary work on behalf of America and all of us. And I apologize for the faux pas. I guess I had the primary on the brain and did not recognize the great State of Rhode Island but no offense was meant.

Mr. Speaker, I did not offer this motion to instruct to rehash the 2000 election debacle. We have plenty of opportunity to do that in 2004. But I did offer the motion to highlight and remind Members of the commitment that this body made last year to reform our country's election system. I offered this motion so that the thousands of my constituents and others around the U.S. who were demonized, demoralized and disenfranchised after the 2000 election can go to bed tonight knowing that Congress is serious about ensuring their votes are not only counted but actually count.

I have already introduced the next generations of election reform in the form of the Voter Outreach and Turnout Expansion Act. The VOTE Act allows no excuse absentee voting, requires early voting opportunities, not less than 3 weeks prior to the general election day, requires adequate notification to voters who submit incomplete voter registration forms by mail, treat election day as a Federal holiday, and provides leave time for private employees to vote on Election Day.

These are the ideas of the present, and we task ourselves in making them the realities of the future.

Mr. Speaker, States are eager to implement the improvements required by the law, but they have insufficient resources to meet these goals. Today, we will reaffirm our commitment and appropriate the necessary funding to the Help America Vote Act that Congress guaranteed to States last year.

A dependable and reliable election system remains the linchpin in the integrity of our democracy, and we have no choice but to protect it. I urge my colleagues to vote yes on this motion to instruct.

Mr. Speaker, I yield back the balance of my time.

Mr. SHUSTER. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. ROGERS of Alabama). Without objection, the previous question is ordered on the motion to instruct.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to instruct offered by the gentleman from Florida (Mr. HASTINGS).

The motion to instruct was agreed to.

A motion to reconsider was laid on the table.

SPECIAL ORDERS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 7, 2003, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

SENIORS DESERVE BETTER PRESCRIPTION DRUG COVERAGE

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Indiana (Mr. BURTON) is recognized for 5 minutes.

Mr. BURTON of Indiana. Mr. Speaker, last night I took a special order, and I talked about what seniors are going to pay under the new Medicare prescription drug program if it is passed in its present form; and I understand it is coming out of committee just a little bit different than that we said last night, but the end result is the same. They are changing the annual deductible from $275 to $250, but the seniors will be paying 25 percent of the next $2,250 minus the annual deductible. So the seniors for $1,500 in coverage will be paying $1,170, and that is not well known by most of the seniors with whom I have talked. And then there is a doughnut hole which goes up to $5,100, and seniors will pay an additional $2,850 with no coverage for that.

That means seniors up to $5,100 under the new prescription drug benefit will pay $4,020 and the government will pay $1,500.

Now, that is not what I think seniors are expecting. I think they are expecting coverage that is much broader than that; and I think they are going to be very unpleasantly surprised when they realize that they will be paying a tremendous amount of money for very small amount of coverage.

Now, above the $5,000 level, the catastrophic health care benefit kicks in, and that is 95 percent of that. But the average senior pays about $1,800 year in prescription drug costs, and they will not reach that level. There will be very few that reach that level. So most seniors, if they pay $5,000 for their prescription drugs in a given year, the average senior, they will pay $4,020 and the Federal Government will pay $1,500. I think they will be very angry when they find out that is the case.

I believe we should pass a bill that takes care of those who are uninsured, who do not have prescription drug coverage. Right now, 76 percent of American seniors have some form of prescription drug coverage. And the program that we are talking about in most cases is going to give them less coverage than what they already have. Now, the 24 percent of the seniors that do not have coverage, we should deal with them. We should help them. Those who are indigent, those who have health problems where they cannot get coverage, we need to take care of those. But those who are already covered, I do not believe our government should start taking care of.

The cost of this program is estimated to be somewhere around $400 billion over 10 years. I have another chart which I am not bring forward right now, but it shows what happened with Medicare. Medicare when it was passed in 1965 cost $3 billion. Two years ago in the year 2001, Medicare cost $241 billion. That is an 80 times increase.

□ 2045

It went up 80 times since 1964. The Medicaid program which we passed in Indiana under duress started out, we thought, costing a few million. We estimated a top figure of $20 million. It has cost well over $1 billion just for Indiana's share, and it has gone up about 70 times since 1969.

Anybody who thinks that this donut hole is not going to be a big issue to seniors is sorely mistaken, in my opinion; and I believe that they will demand that this donut hole, this $2,850 that is not covered, will shrink. When that happens, there is going to be a tremendous increase in the cost of this program. I believe the $400 billion price tag for 10 years is very low. I believe it will be more than double that, maybe up to $1 trillion over 10 years, but only time will tell.

The other thing that really concerns me is we are paying $70 billion to American industry so that they will not dump their retired employees on the Federal Government program. The fact of the matter is I believe long term the businessmen and industrialists in this country are going to say we do not know what Congress is going to do tomorrow, and they are going to start dumping their employees on the Federal program anyhow; and when that happens, the retirees are going to see the program that they are under with their previous employer go out the window, and they are going to be put on the government program.

Their coverage right now under their retired benefits with their previous employer is probably much, much better. In fact, I am sure it is much better than what they are going to get on the Federal program, and so the $70 billion buyout or payout they are going to give to industry I do not think is going to stop the dumping of employees on to this program out of independent industrial programs that are covered by private industry and companies.

I think it is very realistic to believe those people will be put on the government program. So that is another cost that will be added to this program over the next 10 years.

This is an open-ended entitlement. The floor, the floor is $400 billion. There is no ceiling. They will tell you there are some cost controls in it, but the fact of the matter is there really will not be, not over the long period of time; and the ultimate result of this is going to be an entitlement that is going to be like Medicare, like Medicaid. It is going to be out of control. It is not going to provide the benefits that the seniors anticipate, and I think they are going to be very, very angry.

So I would just like to say to my colleagues, tomorrow or the next day when we decide to vote on this bill, think about what the seniors' reaction is going to be. In 1988 we passed a catastrophic health care bill. Only 11 Members, as I recall, voted against it. I was one of the 11, and 1 year later we repealed it because the seniors were so angry when they found out what was in it. I think they are going to be angry with this bill as well, and I hope my colleagues will take that into consideration.

DISAPPOINTMENT AND OUTRAGE OVER RECENT RULING OF FCC

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Virginia (Mrs. JO ANN DAVIS) is recognized for 5 minutes.

Mrs. JO ANN DAVIS of Virginia. Mr. Speaker, today I rise to express my disappointment and outrage with the recent ruling by the Federal Communications Commission deeming the use of obscene language acceptable on television. Last month, the FCC ruled the use of what has been termed the "F word" in a live interview was not inappropriate, and its use in this case was deemed acceptable. While I understand this FCC ruling addresses a specific instance, I strongly caution my colleagues to the dangerous precedent that this ruling sets.

This profane word has long been deemed inappropriate by American society and consequently has not been permitted on broadcast television and radio, and its use factors into movie ratings. However, with this recent FCC ruling, we are opening the door to a whole new world of what is deemed acceptable for television audiences.

I ask my colleagues, then, what are our standards? Where do we draw the line? If the use of this expletive is appropriate in this one instance, what is to deter additional uses of it in similar instances, and at what point does it remain inappropriate?

Again, I urge my colleagues to tread carefully and be mindful of what this ruling means for the future. We are sending the children of America mixed signals about what is decent behavior when we make exceptions to our standards, and I certainly do not think that we need to further complicate the complex period of childhood and adolescence.

Mr. Speaker, I ask then, why do we even have an FCC if they are not going to uphold rules of decency? Why do we even as a society even make laws if they are not going to be followed? Turning a blind eye to this assault on decency will do a great disservice to America and damage the integrity of our airwaves.

Mr. Speaker, the American public is currently under siege in their own homes. Every day, the Internet brings unsolicited and inappropriate material into the household through the dissemination of pornography. Our e-mail accounts are flooded with pornographic spam, making it necessary to utilize various controls and software to protect our children from being exposed to such obscene material.

I am encouraged by the Attorney General's efforts in combatting this problem, specifically the recent increased number of prosecutions for adult obscenity and pornography. Additionally, my colleagues in Congress are actively working on language to curb spam solicitations and to further protect Americans from unsolicited e-mails. In doing so, we will stop not only those annoying advertisements but also keep indecent images out of sight of our children. It is through such efforts that we are able to take important steps against the onslaught of sexual offenses that so often stem from obscenity and pornography.

The common decency of America is being tested, as little by little we are broadening the definition of acceptable and decent behavior. It is imperative that we now pause to carefully examine the decisions being made today that will ultimately impact the accepted standards of tomorrow.

PRICE AND AFFORDABILITY OF PRESCRIPTION DRUGS

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Illinois (Mr. EMANUEL) is recognized for 5 minutes.

Mr. EMANUEL. Mr. Speaker, this week we will be taking up the prescription drug bill, and what I find interesting, a number of us on both sides of the aisle have worked on the issue of bringing the cost of medications down to a level that our grandparents and parents could get the medications they need at the prices they can afford.

There are three ways to address the issue of price and affordability. One is through the issue of market mechanisms and free markets, allowing competition, people to buy their medications in Canada, Italy, France, Germany, having it brought into the United States at the prices where they are 40 to 50 percent cheaper and bringing that competition to bear on the price of medications. We have a closed market as it relates to pharmaceutical products. We are not allowed to have competition. Therefore, Americans pay the highest prices in the world. If we brought competition in, medications like Lipitor, Zocor, seeing what we see all over on our TV would be at the same prices that people in France, Germany, Canada, and England are paying at a 40 to 50 percent discount of what we see in our corner grocery store.

The second way we would bring prices down would be to allow the Secretary of Health and Human Services, Republican former Governor Tommy Thompson, to negotiate and create a Sam's Club out of Medicare. Like all the Sam's Clubs throughout the country, using the power of 41 million seniors, we can negotiate lower prices and bring bulk and the purchasing power of our seniors down. That is what a Sam's Club does. That is what everybody does and the private insurance business does.

This legislation prohibits the free market from operating, prohibits Sam's Clubs from being created under Medicare and also does a very weak job of allowing generics in the market to compete at a generic price versus a name-brand price.

In these areas we could get competition, bring the prices down to an affordable level so our parents and grandparents could afford the medications they need whether that be blood thinner, cholesterol medication, medication for their heart. In each area, Members of the Republican Congress in this body and the other body chose to ignore the free market and chose to keep prices artificially high here in America.

This is not only unfair to the seniors. What is worse, it is unfair to the taxpayers. I think we owe the common courtesy and decency to the taxpayers to get them the best price rather than the most expensive and premium price that they are paying today. If we are going to borrow $400 billion in the largest expansion of an entitlement in over 40 years, do my colleagues not think we owe the common courtesy and decency to the taxpayers to get them the best price, not the premium price?

Today, Americans pay the most of any industrialized country for pharmaceutical products. Yet on each of the areas, market access and competition, bulk purchasing, or in generics, the conference took a punch. I understand why. I am not naive to politics. I understand who benefits.

There was an article in The Washington Post showing that the pharmaceutical industry would garner $132 billion in additional revenue from this legislation, and who do my colleagues think is going to give that $132 billion? Our parents, grandparents, and the taxpayers. That is the way the system works, but in each of these cases we could have done something to lower prices and make the needed medications more affordable and more accessible, and we chose not to.

That is why I am opposing this legislation. It does nothing to affect the price of prescription drugs that on average has gone up 15 to 20 percent a year as the cause of inflation. Prescription drugs are one of the single reasons for the rise of inflation in health care in general. We could do something to affect the prices of medications and we chose not to.

I think it is important to know, as somebody whose life was saved by types of medications, what the pharmaceutical industry does is very important. The research they do is very important. We Americans are the leaders in the world in new pharmaceutical research, and the reason is because the pharmaceutical industry here in the United States is the beneficiary of the generosity of the taxpayers. The research and development tax credit, all the research and development of new medications, life-saving medication is paid for by the taxpayers.

SUPPORT FOR THE CONFERENCE REPORT ON THE MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Pennsylvania (Mr. SHUSTER) is recognized for 5 minutes.

Mr. SHUSTER. Mr. Speaker, I rise tonight in support of the conference report for the Medicare Prescription Drug and Modernization Act. Tomorrow, this body is poised to pass historic legislation that will provide millions of seniors access to a responsible and affordable prescription drug benefit. Almost 40 years ago, a promise was made to seniors, a promise that they could depend on Medicare for affordable, reliable, and quality health care.

With passage of this conference report, we will achieve numerous goals that will strengthen the current Medicare program and will protect the most vulnerable seniors. Low-income seniors and those with extremely high prescription drug costs are given specific consideration.

While at the same time bringing much-needed fiscal relief in the overall cost of prescription drugs to all seniors, by adding a voluntary prescription drug benefit and modernizing the program to give seniors more choice in their overall health plans, Congress has an opportunity to improve the quality of health care being provided in the

Medicare program for millions of seniors.

As a Member that represents a rural district, I am also very pleased with many of the rural provider provisions contained in this report. Under this legislation, unequal payments for equal work will no longer be status quo for rural America's health care providers.

Hospitals are important to rural communities for three reasons. First and foremost, they provide health care services for the residents. Second, hospitals are an economic engine in rural communities, and in my district they are the first or second largest employer, providing good-paying jobs. Third, hospitals are an economic development tool. Without adequate access to health care, it is difficult for a community to retain and attract businesses. A strong health care system is vital to the strength and stability of any community.

I am also pleased that this conference report also contains a provision to establish health savings accounts. This will help not only seniors but all Americans to better afford their health care. Health savings accounts will allow individuals to save, grow and spend their hard-earned dollars tax free for necessary out-of-pocket medical expenses. These accounts will go a long way in helping to make health care more affordable for families and individuals of all ages.

Mr. Speaker, when I first ran for office 3 years ago, I committed myself to working toward adding a prescription drug benefit in Medicare. I am pleased to support this conference report which I believe will move Medicare into the 21st century, and I urge all my colleagues to do the same.

□ 2100

CASTRO SEEKS TO KILL PEACEFUL CUBAN DISSIDENT DR. OSCAR ELIAS BISCET

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Florida (Mr. LINCOLN DIAZ-BALART) is recognized for 5 minutes.

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, I try to come to this floor every week to highlight the existence of the individual cases of political prisoners on an island only 90 miles away from the United States, thousands of political prisoners, thousands upon thousands. Tonight, I speak of perhaps the most, or certainly one of the most respected of the political prisoners in the enslaved island of Cuba, Dr. Oscar Elias Bisect.

Dr. Biscet, prisoner of conscience, declared a prisoner of conscience by Amnesty International, is an extraordinary man. He maintains a philosophy of nonviolence, and yet his nonviolence has been responded to continuously by the violence of what is without any doubt a gangster regime run by the gangster in chief, the totalitarian tyrant of Cuba.

Now, Dr. Biscet was sentenced to 3 years in the Cuban gulag. He was sentenced in 1998 to 3 years in a Cuban gulag. When he was released last October, October of 2002, he was out of prison only a few weeks when he was rounded up again and sentenced this time for "association with enemies of the State," and he was sentenced, along with over 75 other peaceful dissidents and independent journalists, to 25 years in the Cuban gulag.

A few weeks ago, they told Dr. Biscet that he was going to be placed with a serial killer, someone who was a common criminal and who had murdered many, many people. He objected to that. As a consequence of his objection, Dr. Biscet has been placed in what is called the tomb. He is underground in solitary confinement, in a punishment cell. And so that he fully understood the dimension of his punishment, a serial killer was placed along with him in the tomb. So Dr. Biscet is at this moment in a tomb in the Cuban gulag because he believes in freedom and democracy, and he has espoused support for Mahatma Gandhi and for Martin Luther King and the peaceful methods to achieve the change that those great leaders represent.

The question I ask this evening, the one question which begs to be asked of our colleagues, is how can they come here time and time again to this floor and in the other House to ask for measures that would provide additional revenue to that dictatorship; some of them after having received one of the 8-hour or 10-hour banquets that the Cuban dictator likes to offer to his friends, they have come here and been zealous advocates for someone who they consider so charming, so admirable, so intelligent? In fact, one of our colleagues was so impressed with the Cuban tyrant when Castro told him that his shoes were dirty, that he should shine his shoes, that he melted in admiration before the charming tyrant, who has such interesting comments, this tyrant who maintains thousands of men and women in the gulag because of their support of men and women believing in freedom and democracy.

Another question is begged, Mr. Speaker: Where is the free press that we enjoy in this country and in the international community and in the community of democracies? Where are the reporters, the members of the media who are talking about what is happening to Dr. Biscet? Is there not an elemental, an elemental duty and responsibility to talk about these facts by the free press? There is. They know it, and they are failing in that elemental duty.

EXCHANGE OF SPECIAL ORDER TIME

Mr. PALLONE. Mr. Speaker, I ask unanimous consent to take the time of the gentleman from California (Mr. SCHIFF).

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

MISTREATMENT OF CUBAN POLITICAL PRISONER, DR. OSCAR BISCET

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New Jersey (Mr. PALLONE) is recognized for 5 minutes.

Mr. PALLONE. Mr. Speaker, I rise today to draw attention to the continued plight and mistreatment of political prisoners locked in Cuban jails, and obviously joining with my colleagues from Florida, and I thank also my other colleague from New Jersey, specifically paying attention to Dr. Oscar Biscet.

I have spoken on numerous occasions here on the House floor of the crushing campaign Castro waged against the Cuban pro-democracy movement earlier this year. Over the course of a few weeks in late March and early April, Castro's regime arrested an array of political opposition leaders and pro-democracy advocates. Inside of a month, the dissidents were arrested, arraigned, tried, and sentenced.

Dr. Biscet, already in state custody at the time, was tried in tandem with the other dissidents, and in April was sentenced for 25 years for "serving as a mercenary to a foreign state."

Dr. Biscet is a 42-year-old physician. He is President of the Lawton Foundation for Human Rights. He is a well-known follower of Ghandi and Martin Luther King, and is heralded for his religious and civic leadership. Just last week, on November 11, at Prison Kilo Cinco y Medio, Dr. Biscet peacefully protested with six other political prisoners the cruel treatment given by prison authorities to the family of another fellow prisoner during their scheduled visit. Fearing that Dr. Biscet was becoming a leader among the other prisoners, he was transferred the next day to another maximum security prison in the province of Pinar del Rio, called Kilo 8.

In Kilo 8, Dr. Biscet has been confined in a punishment cell that he has referred to as a dungeon with another prisoner who has committed 12 violent criminal assaults, a blatant attempt to put Dr. Biscet's life in danger. His wife and parents traveled to Kilo 8 this Monday, November 17, for their assigned family visit. When they arrived, prison authorities informed them that Dr. Biscet was punished for 21 days without family visits. They told his family he is currently being confined in a cell with no sunlight that literally measures four feet by four feet. They told his family that he had been denied food supplies and toiletries and is without writing or reading materials.

Upon hearing this news, his mother required medical attention from the prison staff due to a sudden rise in her blood pressure and the horror of her son's living conditions. Mr. Speaker, compelled by circumstances and the persistence of Dr. Biscet's wife, prison authorities allowed his mother to see her son, but only for 10 minutes. Dr. Biscet asked his mother to alert international public opinion, since he had broken no prison rule, and they were forcing him to share a cell with a violent criminal intentionally placing his life in danger.

So I join my colleagues here on the House floor to inform Congress and the American public of the inhumane treatment of Dr. Biscet. I ask all my colleagues to join us here on the floor and to demand the unconditional and immediate release of Dr. Oscar Elias Biscet and all those prisoners whose only crime is a desire for basic human rights. We must send a strong message to Castro that his abuse of Cuban political prisoners has not gone unnoticed and will not be allowed to continue.

DR. OSCAR BISCET

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New Jersey (Mr. SMITH) is recognized for 5 minutes.

Mr. SMITH of New Jersey. Mr. Speaker, I rise with my colleagues today in support of one of the most courageous men of peace on the planet today, an advocate for freedom, Dr. Oscar Biscet. A long-time human rights activist and pro-life doctor in Cuba, Dr. Biscet had already spent some 3 years, unjustly, 3 years in Castro's gulag for speaking out against the death penalty in Cuba and for calling for the release of all political prisoners.

After his release, Mr. Speaker, in the fall of 2002, he remained undaunted by his oppressors, Castro and the brutal thugs who run his regime, and continued to attempt to peacefully organize human rights' supporters. Dr. Biscet was redetained with 16 other dissidents after they attempted to simply meet in a home in Havana to discuss human rights last September. Just think about that, my colleagues, just simply meeting, gathering together, and in come the thugs to take you away.

When police prevented him from entering that home, Dr. Biscet and others, just like Dr. Martin Luther King, sat down in the street and protested, uttering slogans like "long live human rights," and "freedom for political prisoners." For that, he received a draconian 25-year prison sentence in April. That was during the same time when there was a massive crackdown that Amnesty International pointed out, reminiscent of what happened during the early years of Castro's brutal regime when massive numbers of people were arrested and given long prison sentences, many of those, 75 of them, some of the bravest and brightest in Cuba today: Independent journalists and democracy activists, who now themselves languishing in prison.

Mr. Speaker, while reports of Dr. Biscet's actions in prison continue to be heroic, and the word does get out, this is a man of conscience, a man of courage, the reports of his mistreatment, however, have been equally horrific. He is heroic; the mistreatment is horrific. For months, we know that he has endured solitary confinement for refusing to wear the prisoner's uniform. He has lived with insufficient light, and now no light at all, no running water and no bed. His benign and peaceful protest on November 11 on behalf of the cruel treatment of another prisoner, even though he is suffering so much, Mr. Speaker, he speaks out and tries to lend a hand to other prisoners who are being mistreated, for that he was moved to a punishment cell, as my colleagues have pointed out, the gentleman from Florida (Mr. LINCOLN DIAZ-BALART), who spoke so eloquently a moment ago, to a cell known as the dungeon.

This man, this peaceful man, this Martin Luther King of Cuba is now languishing in a dungeon, a small confined area with no light. He has been put into a prison cell, this dungeon, with a man who on 12 different occasions has committed assault.

I remember during the years of Nicolae Ceausescu, the brutal thug in Romania, what he used to do. He would put people who committed crimes in with peaceful activists, political prisoners, and political prisoners of conscience with the hope and the thought that these men of violence would commit violence against these peaceful activists, and God forbid that that happens. We will continue to speak out, and, hopefully, nothing will happen as a result of this emplacement of this thug in with Dr. Biscet.

Let me just point out to my colleagues that in the spring Dr. Biscet, and this just shows the heart of this great man, stated "I am innocent of the charges for which I was condemned, which is why I will maintain my ideological position. A true man cannot betray himself, so I can only appeal to the living God and pray to our Lord. And he is not neutral and never abandons his flock." What a faith. Here is a man crying out from prison, praying to God above, asking that he not be forgotten in a way that is reminiscent of our Lord when he said, why have I been abandoned? Well, in this case he is saying despite his ordeal that God will not abandon him.

Mr. Speaker, we cannot abandon him, and that is why we are speaking out and speaking out so strongly tonight. We cannot allow this prisoner of conscience, and there are hundreds, as the gentleman from Florida (Mr. LINCOLN DIAZ-BALART) said so ably earlier, hundreds who live likewise in Castro's gulag. His wife, Elsa Morejon, has said his crimes are honoring the universal declaration of human rights: Opposing abortion and the death penalty and organizing civil rights movements through nonviolent civil disobedience to reclaim the rights of fellow Cubans that he believes are being violated. For that, 25 years being mistreated and being treated in a way that we would not even treat our animals.

Let me just conclude, Mr. Speaker. After months of brutal treatment, his health is very poor. We have to speak out. There are Members who take to the floor here and say we need to have an expansion of travel and trade and the like. Well, not until these individuals, starting with Dr. Biscet, are released. Otherwise, the blame and the crime of complicity rests at your doorstep.

EXCHANGE OF SPECIAL ORDER TIME

Mr. BROWN of Ohio. Mr. Speaker, I ask unanimous consent to take the time of the gentleman from Illinois (Mr. DAVIS).

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Ohio?

There was no objection.

☐ 2115

ENERGY BILL LEAVES NO ENERGY COMPANY BEHIND

The SPEAKER pro tempore (Mr. BRADLEY of New Hampshire). Under a previous order of the House, the gentleman from Ohio (Mr. BROWN) is recognized for 5 minutes.

Mr. BROWN of Ohio. Mr. Speaker, it has been a great week for the most influential, the most well-heeled lobbyists in Washington. Earlier in the week the House passed an energy bill which one very prominent leader of this country called the "no lobbyist left behind" bill. This energy legislation was full of benefits for oil companies, for natural gas companies, and for electric utility companies. As I said, it was a great week for some of the most well-heeled, most influential lobbyists in Washington.

The energy policy started with bad process as Vice President CHENEY convened a secret group of energy lobbyists to draft the administration's energy plan. Citizen after citizen, group after group have tried to find out who attended these meetings with Vice President CHENEY, what was discussed, and what they were all about. Vice President CHENEY refused; but we should not be surprised that he would bring energy executives into the Vice President's office to secretly write an energy bill. After all, Vice President CHENEY himself was an oil company executive, or should I say still is. He still receives $3,000 a week from Halliburton, one of the major energy companies in the United States. The Vice President is meeting secretly with energy company, oil company executives, and is still receiving $3,000 a week from Halliburton, that company that is making billions of dollars in unbid contracts in Iraq given by the administration, and kicking back or contributing large numbers of dollars to the Bush reelection campaign.

So CHENEY is meeting with the energy companies to draft legislation that one prominent Republican said was a no lobbyist left behind bill. It was an early Christmas present for the energy industry, and for oil, gas and utilities, and some have estimated as much as $100 billion.

Some of the corporate giveaways that harm consumers in this bill were granting Enron's last wish to repeal the consumer-oriented, Public Utility Holding Companies Act, making taxpayers rather than corporate polluters pay to clean up leaking underground storage tanks, even when we know exactly which corporation is responsible for the pollution; allowing power companies to charge consumers more, ostensibly to finance system upgrades without any assurance that the resulting changes will actually benefit consumers; making taxpayers pay to clean up nuclear accidents and compensate victims even when the accidents result from a private contractor's intentional misconduct; deleting bipartisan provisions to ensure the safety and security of crosscountry nuclear shipments. All of those provisions were in there as gifts to the oil and gas and electric companies that Vice President CHENEY still represents, amazingly enough as Vice President.

At the same time, that energy bill was loaded up with all kinds of tax breaks, all kinds of tax provisions helping those energy companies. At the same time this legislation, this early corporate Christmas present for which they give great thanks, included all kinds of harm to the environment. It allows oil companies to pump diesel fuels and other toxics underground and expand their operations without regard to the Clean Water Act groundwater runoff requirements, opening Federal lands to powerlines and mineral developments, and exempting significant segments of our communities and our industries from Clean Air Act requirements.

Now, Mr. Speaker, Congress earlier in the week passed one major corporate giveaway to the energy industry, to oil, gas and electric utilities. Tomorrow Congress is going to attempt, Republican leadership is going to attempt to do their second major corporate giveaway of tax dollars, and that is the so-called prescription drug Medicare bill. This is not a prescription drug bill; this is a Medicare privatization, insurance company/drug company giveaway bill.

The prescription drug companies under this legislation stand in the next few years to profit $139 billion more than they already have. And already for 20 years running, the drug industry has been the most profitable industry in America, by any measurement: return on investment, return on sales, return on equity, while enjoying the lowest tax rate of any industry in America.

Mr. Speaker, the second part of this bill gives a $20 billion gift, $8 billion this year, $12 billion in 2006, to the large insurance companies and HMOs in order to get them to offer private drug insurance.

What most of us say is let us do the Medicare bill right, give the drug benefit directly to seniors; do not do it by enriching the drug companies and enriching the insurance companies.

Mr. Speaker, it has been a good week for big business in Washington and for corporate lobbyists, and a bad week for America's consumers.

INHUMANE TREATMENT OF DR. OSCAR E. BISCET GONZALEZ

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Florida (Ms. ROS-LEHTINEN) is recognized for 5 minutes.

Ms. ROS-LEHTINEN. Mr. Speaker, I stand here today to speak on an issue dear to my heart. At the same moment that our fellow colleagues deliberated on a decision to weaken the vital and necessary sanctions against the ruthless Castro regime, at that same moment human rights and liberty were hurriedly moved to what is now one of the worst prisons on the island; that is what happened to Dr. Oscar E. Biscet Gonzalez.

At the same time we were going to lift sanctions on Castro, Castro was putting Dr. Biscet in a dungeon. Even as we meet here today, courageous advocates suffer in jail for speaking their minds and advocating for liberty and freedom, and it is a crime to do that in Fidel Castro's Cuba. People such as Dr. Oscar E. Biscet Gonzalez are serving horrific prison sentences for promoting democratic values.

Dr. Biscet is a leader, as Members have heard from the gentleman from Florida (Mr. LINCOLN DIAZ-BALART), the gentleman from New Jersey (Mr. SMITH), the gentleman from New Jersey (Mr. PALLONE), and we will hear from the gentleman from Florida (Mr. MARIO DIAZ-BALART) in a moment, is a leader in the Cuban opposition movement. He is a follower of Ghandi and Martin Luther King, and he was arrested earlier this year and has been arbitrarily detained over 26 times in the past 18 months. His body may be weak, rapidly deteriorating; but his courage, his spirit, his commitment to see a free Cuba from its enslavement, they are stronger than ever. Dr. Biscet sits in a jail where prisoners are tortured so intensely that their skulls are cracked, their faces are disfigured, and their bodies are dragged down rugged stairs feet first. But we are going to lift the sanctions against his jailer.

Mr. Speaker, Dr. Biscet, together with an incalculable number of victims of a bloody and terrorist regime illustrates the reason why our government, the great United States of America, must remain vigilant against tyrannical regimes. Dr. Biscet's torture and cowardly imprisonment is an attempt to break the spirit of liberty from the minds of Cubans who long for a free Cuba, and there are 11 million of those Cubans on the island.

Dr. Biscet previously served 3 years in prison. He was released October 31 of last year only to be rearrested on December 6 as he was to meet with human rights activists. That is a crime in Cuba. On April 7 of this year, he was summarily tried during a Cuban regime crackdown, along with 75 other activists and independent journalists, and was sentenced to 25 years for serving as a mercenary to a foreign state.

Mr. Speaker, our esteemed halls of democracy have welcomed many distinguished speakers. We have received countless heroes and people of the highest honor, and these are the same caliber and fiber such as Dr. Biscet, who is one of Cuba's many unsung heroes. I would like to quote his most recent note to his wife and have his words ring loudly in these Halls so we may all understand the true brutal nature of the Cuban regime and the reasons why we must bring an end to the misery of the Cuban people.

Dr. Biscet writes, "I don't know why I am in this dismal place. I will not grieve nor be afraid for being punished in this dungeon. I will face life's difficulties in order to enjoy the germination of love. I know I will succeed, for the darker the place, the brighter and more intense the light."

Every day more and more opposition leaders such as Dr. Biscet are sentenced to languish in squalid jail cells subjected to the most inhumane and degrading treatment. We must not be silent. We cannot and we must not be indifferent to the anguish and misery endured by the Cuban people, just 90 miles from our shores, at the hands of this depraved dictator and his agents of terror.

Mr. Speaker, indifference breeds evil. Indifference is the enemy of freedom. Indifference helps cloak the deplorable actions of tyrants.

Mr. Speaker, I would say to Dr. Biscet, inside your jail cell I know you cannot hear our words, but we want to express our profound admiration for you and the just cause that you are fighting for. We support you and we support all of Cuba's independent internal opposition in your struggle to be free. Let us not become indifferent to the plight of our fellow Cuban brothers and sisters. Dr. Biscet, vamos a continuar luchando hasta que usted y el pueblo de Cuba sea libre.

WRONGFUL IMPRISONMENT OF CUBAN DISSIDENTS

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Florida (Mr. MARIO DIAZ-BALART) is recognized for 5 minutes.

Mr. MARIO DIAZ-BALART of Florida. Mr. Speaker, we have heard tonight the plight of Dr. Oscar E. Biscet Gonzalez and the situation that he finds himself in today, in a dungeon where he is not able to receive light and barely has enough air to breathe, where he has been placed with another person who is a violent person to see if that violent person can do harm to Dr. Biscet. Why is he serving under those conditions? Because he has asked for the one thing that the Castro dictatorship, just 90 miles away from the United States, that that thug fears the most. What Dr. Biscet continues to ask for is freedom. That is it. Freedom to associate, freedom of religion and freedom to speak out and elect one's leaders; and for that, he has been sentenced to 25 years in prison.

There are those that apologize for the Castro dictatorship, and they say we have to normalize relationships with the Castro dictatorship and we should treat Castro as if we were dealing with the government of Costa Rica or Paraguay because he is not that bad. He is ailing. He is an older, ailing individual; and, therefore, we should treat him nicely, while he has people like Dr. Biscet and many others rotting in prison because all they want is to be free.

As my colleague, the gentleman from Florida (Mr. LINCOLN DIAZ-BALART) said, Where is the outrage?

From time to time we see miniseries on those expensive movie networks glorifying Castro, showing him as a great leader. Where is the news coverage of Dr. Biscet and the story of Dr. Biscet's suffering? Where are the stories of any of the other political prisoners suffering in Castro's prisons? Where are they? Why does the press refuse to cover the plight of these people?

Mr. Speaker, despite the fact that the press has total indifference, that still gives excuse after excuse as to why we need to deal with Castro as if he were a normal human being, not the animal or the murderer that he is, despite all that, we will continue to speak out because the Cuban people deserve to be free and the American people understand more than anybody else how valuable freedom is, which is why the American people have always stood fast and have always supported people like Dr. Biscet.

And until the day that Dr. Biscet is free, we will continue to speak, despite those that want to apologize for Castro, and despite those who want to help the regime and go to Cuba to have sexual tourism with little boys and little girls, we will continue to speak up for those that cannot be heard, and they will ultimately win. They will ultimately be heard, and the Cuban people will be free and the American people will feel very proud that they stood by the people of Cuba in their darkest moments by not treating Castro as if he were a normal human being, by keeping the pressure and making sure that the world understands that Castro is what he is: he is a crazy, sick, senile, murdering animal. And until the day he is gone, we will continue to speak for those like Dr. Biscet who cannot speak.

REGARDING RETIREMENT OF HOUSE RADIO-TV GALLERY DEPUTY DIRECTOR BEVERLY BRAUN

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Maryland (Mr. HOYER) is recognized for 5 minutes.

Mr. HOYER. Mr. Speaker, when we come back for the second session of the 108th Congress, there will be a new face in the House Radio-TV Gallery. That is because, after 20 years of service, the Deputy Director Beverly Braun is retiring December 12th.

When Braun came to the Gallery in 1983, she and her colleagues sat up there in the southeast corner of the House chamber taking notes on floor proceedings by hand because they didn't have a computer, and the television reporters who covered out activities had to physically transport tapes to their bureaus. Beverly has shepherded the staff from learning to use a single 10K floppy disk drive machine to having individual 60 Gig hard drive laptops, and has helped incorporate technical developments that now afford the broadcasters use of fiber optic transmission lines.

In the past 20 years Beverly Braun has worked under five speakers, under both Democratic and Republican control of the House and has been involved in coverage arrangements of many diverse events. Some were annual like State of the Union Addresses, St. Patrick's Day luncheons and Christmas Tree lightings. Some were periodic like mock swearing-ins of new members. Some were joyful like the joint meeting to celebrate Harry Truman's 100th birthday. Some were tragic like that lying in honor for Officers Chestnut and Gibson, and September 11th. Some were historical hearings such as Iran-Contra and Waco. Some were historical visits such as those by Queen Elizabeth, Nelson Mandella, Vaclav Havel, and most special to Braun, the Dalai Lama.

As part of her regular Gallery work Braun worked with many Congressional staffers and committee members, but in recent years has primarily served as liaison to the Ways and Means, Financial Services and Rules Committees. In addition to her regular Gallery work, Braun helped with broadcast arrangements for 10 Democratic and Republican national political nominating conventions and provided on site assistance in San Francisco, Dallas, Atlanta, New Orleans, New York City, Houston, San Diego, Chicago, Philadelphia and Los Angeles.

Braun was born to Phyllis (Lawson) and Ray Nicholas in Warren, Ohio in 1942, attended Ohio University and graduated from St. Vincent School of Medical Technology in Cleveland in 1961. She and her first husband Roland Braun lived in Pittsburgh PA where her son Stephen was born in 1964, and in Ramsey NJ where her daughter Leslie de Vries was born in 1966. They moved to Minnesota in 1967 where Braun became active in politics and women's rights organizations and where she ran unsuccessfully for a state senate seat in 1972. She later served as Communications Director for the Minnesota Bicentennial Commission, Director of the Small Business Division of the Minnesota Department of Economic Development and managed a Small Business Development Center for Control Data Corporation.

Braun and her second husband, Skip Loescher, moved to Washington, D.C. twice, staying here since their second move in 1981. After spending 20 years with WCCO–TV and a short stint with Senator and Vice President Walter Mondale, Loescher has been the Washington correspondent for CNN Newsource for the past 12 years. Prior to her employment with the Gallery, Braun worked in Washington with the National Women's Education Fund and later founded a business which provided services to companies that did not have a Washington Office.

Braun and Loescher's families are spread all across the country. Braun's mother Phyllis Beadle lives in Queensbury NY. Braun's son Stephen and his wife Anne live in Columbia MD. He has a son Nicolas and daughter Katie. Braun's daughter Leslie and her husband Jackson Griffith live in Sacramento CA with daughters Emma and Ellie and son Will. Loescher's son Jeff lives in Portland OR with wife Carol, daughter Nicole and son Tyler. Loescher's son Mick and wife Erin live in Peabody MA with sons Sean and Christian. Loescher's daughter Suzy and husband Jeff Quinlan live in Covington GA with son Alex and daughter Kate. Both Braun and Loescher are also blessed with aunts, uncles, cousins, former classmates and friends in almost every other state represented by the members in this chamber.

After leaving Congress, Braun plans on possibly teaching, writing and doing more gardening at her home in Annapolis where she and her husband moved after 19 years on Capitol Hill. She also wants to address end of life issues. She and her husband hope to eventually pursue training and taking therapy dogs in hospitals, nursing homes and hospices . . . and spending more time with all those adorable grandchildren.

Braun has always been a helpful and cheerful professional and she will be missed. So at the end of her career with us, let us say to

Beverly as we have heard her say at the end of many a photo op . . . "Thank you . . . lights!"

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THE HEALTH CARE CRISIS

The SPEAKER pro tempore (Mr. BRADLEY of New Hampshire). Under the Speaker's announced policy of January 7, 2003, the gentleman from Maryland (Mr. CUMMINGS) is recognized for 60 minutes as the designee of the minority leader.

GENERAL LEAVE

Mr. CUMMINGS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on the subject of my Special Order.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Maryland?

There was no objection.

Mr. CUMMINGS. Mr. Speaker, I rise this evening with my fellow members of the Congressional Black Caucus to address the health care crisis in America. While millions of Americans lack adequate health insurance, the rights of the uninsured continue to increase. In addition, the cost of prescription medication is placing an enormous financial burden on consumers. And our seniors, many of whom are living on fixed wages, are in desperate need of relief.

Mr. Speaker, the late Senator and former Vice President, Hubert Humphrey, once said, " . . . the moral test of government is how it treats those in the dawn of life, the children; those in the twilight of life, the elderly; and those in the shadows of life, the sick, the needy, and the handicapped." As a Nation we have failed that test on all three counts.

Currently, my colleagues on the other side of the aisle are offering a bill to overhaul the Federal Medicare program under the guise of a much-needed prescription drug benefit for this Nation's seniors. This bill, if passed, would cost our children over $400 billion. Mr. Speaker, I say it will cost our children because the government is currently operating in a deficit. We simply do not have the money. Therefore, it is the younger generations and those yet unborn who will have to shoulder the financial burden required by this legislation.

Mr. Speaker, let us not be mistaken. Every dollar being spent worth saving or improving one's quality of life is a dollar well worth spending. However, this bill directs billions of dollars towards enhancing the financial well-being of corporations at the expense of the physical well-being of those who need it the most.

This Nation's seniors have practically begged us, as their congressional representatives, to work together in drafting a comprehensive bill that would provide prescription drug coverage and enhance the current Medicare program. Quite frankly, this bill is an inadequate response to their plea.

Let me boil it down to the very basics. The Medicare conference agreement prohibits the Secretary of Health and Human Services from negotiating lower drug prices on behalf of the 40 million Medicare beneficiaries. In other words, this legislation says that the Secretary of Health and Human Services cannot negotiate lower prices although we have millions of Medicare beneficiaries buying medicines or obtaining medicines from these pharmaceuticals.

This proposed legislation also creates a gap of $2,844 that would be impossible for lower-income seniors to bridge and disallows lower-income seniors the ability to receive coverage under both Medicare and Medicaid. And further, Mr. Speaker, the bill could have disastrous effects on my home State of Maryland. 59,640 Maryland Medicare beneficiaries could lose their retiree health benefits and 75,800 Maryland Medicaid beneficiaries could pay more for the prescription drugs that they need. Mr. Speaker, that is simply unacceptable. We can and we must do better for our seniors.

The Congressional Black Caucus is extremely concerned about the health care needs of the 26 million people of every color that we represent. Therefore, providing affordable, high-quality health care for every American is a top priority. And I emphasize the fact that the Congressional Black Caucus represents not only African American people but we represent people of all colors. As a matter of fact, many of our districts do not have a majority African American population, and we have consistently found that we have spoken for Americans who are merely feeling as if they have no voice in this Chamber.

Some have said that we have been the conscience of the Congress. I would submit that we have been the conscience of this Nation. To this end, the Congressional Black Caucus, the Asian Pacific American Caucus, the Hispanic Caucus, and the Native American Caucus introduced the Healthcare Equality and Accountability Act of 2003. This comprehensive and ambitious legislation will improve the lives and livelihoods of all Americans and signifies a historic milestones towards providing equal access to affordable and quality health care.

The gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN), who will be addressing us a little bit later, played a very significant role in leading the Black Caucus and the other caucuses to create this very important legislation.

Mr. Speaker, let me say why it is so important to communities of color that this Congress create an affordable prescription drug benefit under Medicare and work to pass the Healthcare Equality and Accountability Act. The state of health care within communities of color is particularly disturbing. According to a recent report released by the National Urban League, "African Americans are more likely to be among Medicare's lower-income beneficiaries . . . 65 percent of African American beneficiaries fall below 200 percent of the poverty level and 33 percent have incomes that actually fall below the poverty level itself."

Minorities are also disproportionately among the uninsured, representing more than half of all uninsured Americans. Hispanic Americans, 35 percent; Native Americans, 27 percent; African Americans, 20 percent; and Asian-Pacific Islanders, 19 percent. All have substantially higher uninsured rates than white Americans, which is 12 percent. Conversely, the health care needs of minority Americans are often greater than those of nonminorities. Our communities disproportionately suffer from numerous chronic diseases: diabetes, heart disease and stroke, and many forms of cancer.

Racial and ethnic minorities are also more likely to receive unequal treatment than white Americans. According to the National Academies' Institute of Medicine Report of 2002, racial and ethnic minorities tend to receive inferior care in comparison to white Americans even when insurance status, income, age, and severity of conditions are comparable.

Communities of color are less likely to receive preventative care and face a greater risk of misdiagnosis, inadequate treatment, and even premature death. The state of health care in minority communities is nothing short of alarming.

Mr. Speaker, consider the following statistics: The death rates from heart disease among African American adults is 29 percent higher than white adults, and the death rate from stroke is 40 percent higher. Compared with whites, Native Americans are 2.5 times more likely to have diagnosed diabetes, while African Americans and Latinos are 2 and 1.8 times more likely, respectively.

African American women are more likely to die of breast cancer than women of any other race or ethnicity. The infant death rate among African Americans is more than twice as high as it is for white Americans. African Americans and Latinos account for 68 percent of new adult and adolescent AIDS cases. Americans of Asian and Pacific Islander descent have the highest rate of hepatitis B of all U.S. ethnic groups. Older African Americans are 3.6 times more likely to have lower limbs amputated as a result of diabetes. African American seniors are more than two times less likely to receive treatment for prostate cancer.

In general, the health of minority Americans continues to lag far behind that of white Americans, creating a health care divide between communities of color and the rest of America.

Mr. Speaker, as the richest Nation in the world with an average gross domestic product in the trillions, the United States spends a greater percentage of its GDP on health care than any other G–8 or Scandinavian nation.

On a per capita basis, the United States spends far more on health care than any other country in the world, $3,935 or 13 percent in 1997, while the median Organization for Economic Cooperation and Development country spent $1,728 or 7.5 percent. Yet the United States had the largest percentage of citizens without government-assured health insurance coverage.

In addition to having the largest number of uninsured, we rank 12th among 13 countries on 16 available health indicators. The United States ranked 13th for low-birth-weight percentages, 11th for life expectancy at 1 year for females, 12th for males, and 13th for neonatal mortality and infant mortality overall.

Mr. Speaker, through the Healthcare Equality and Accountability Act of 2003, the Congressional Black Caucus, the Hispanic Caucus, the Asian Pacific American Caucus, and Native American Caucuses confront the issue of disparate minority health care head on. Our bill addresses the shortage of minority health care providers and improves workforce diversity through the expansion of such successful programs as the Health Career Opportunities Program and the Minority Centers of Excellence. Our bill would help patients from diverse backgrounds, including those with limited English proficiency, with provisions such as codifying existing standards for culturally and linguistically appropriate health care, assisting health care professionals provide cultural and language services, and increasing Federal reimbursement for these services.

Mr. Speaker, I would like to take this opportunity to thank my colleagues in the Congressional Black Caucus, the Congressional Hispanic Caucus, the Congressional Asian Pacific American Caucus, and the Native American Caucus for their diligence in drafting this important piece of legislation.

I would also again like to extend my special recognition to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN), the chair of the Congressional Black Caucus Health Braintrust; the gentlewoman from California (Ms. SOLIS), chair of the CHC Health Task Force; the gentleman from California (Mr. HONDA), chair of the CAPAC Health Caucus; and the gentleman from New Jersey (Mr. PALLONE), chair of the Native American Health Caucus; Senate Democratic leader Daschle; and the gentlewoman from California (Ms. PELOSI), House Democratic leader, for their leadership.

I also appreciate the support of my congressional colleagues who continue to stand firmly by our side in our efforts to make universal health care a reality.

Mr. Speaker, as Members of the greatest national legislature in the world, our social contract is clear. We have a moral responsibility to promote the general welfare of all of our citizens regardless of race, age, ethnicity, or social economic status. We must work to accomplish this goal by providing comprehensive health care coverage to all of our citizens and meaningful prescription drug coverage to our seniors. We should not rest nor recess until this task is done.

Mr. Speaker, I yield to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

Mrs. CHRISTENSEN. Mr. Speaker, I thank the gentleman from Maryland (Mr. CUMMINGS) for yielding, and I thank him for hosting this Special Order today.

I would have come here to primarily discuss H.R. 3459, the Healthcare Equality and Accountability Act of 2003, which is a very important piece of legislation that the four caucuses that we have heard have introduced with our Democratic leadership in both this and the other body.

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The bill, which I call the Heal America Act, would do just that: heal America, because the health of people of color is inextricably linked to that of all Americans. So the provisions that are included, which would expand Medicaid to include pregnant women, young people to the age of 20, and legal immigrants, which provides that Federal program set standards and pay for translation services; that includes programs for young people of color to enter the health professions at all levels, and even for older ones to enter the health professions by changing their profession as long as they practice in underserved communities; which would strengthen the safety net facilities like our hospitals and our community health centers; fully funds and strengthens the Office of Civil Rights within the Department of Health and Human Services, as well as the Office of Minority Health which creates empowerment zones so the communities themselves, which face high disparities, will get the resources and technical assistance that they need to address their health care challenges. This bill would finally bring this country to the top of the list of nations in the world for our health, reverse the global statistics that we have heard from our chairman and, instead of being the thirty-ninth of all of the nations of the world, it would reduce the premature deaths and disabilities that exist in the people of color here; would begin to reduce the skyrocketing health care costs, and also to restore the greatness of this country, which has indeed been tarnished by our recent history here and in the world.

But tonight I want to focus more on an imminent threat to the equality and accountability in health care for millions of Americans. After years of promising a prescription drug benefit, and my knowing from experience as a family physician how badly it is needed, it is a painful task to come to this floor this evening to oppose what we understand is going to be brought to the floor as a Medicare reform bill, perhaps tomorrow. I, like many of my physician colleagues, was tempted to support it, just so we could get something done to alleviate the burden of health care for our patients. But the lives, the health, and the needs of our seniors and the disabled people in this country are too important to just take anything, no matter how defective it might be, just to do something. It would not be fulfilling our promise of a comprehensive prescription drug benefit; it would be reneging on that promise.

We who are here tonight have too much respect for our constituents. We know that we have to continually earn the trust that they have placed in us with their vote. So we are here tonight to oppose the Medicare conference agreement, and to tell our colleagues why.

Despite all of the carrots; for example, the rural provisions which themselves seem to be little more than smoke and mirrors, and the increased payments for physicians which, if the leadership believes, as I do, that it needs to be done, we can do that separately. The bottom line for me is that this bill begins to destroy a program that has provided real health security, that has kept many seniors and disabled persons out of poverty, and which has provided access to health care for them for over 30 years. I cannot in good conscience be a part of dismantling this important safety net program. Yes, I know that some provisions, like premium support, are just demonstration programs, but that is opening a door that should just remain shut.

This conference report goes against what we have been working towards in our caucus: the elimination of disparities in health care for African Americans and other people of color. African Americans are 8 percent of Medicare recipients, and 32 percent of African Americans who have some insurance, have Medicare. While 40 percent of all Medicare beneficiaries are below 200 percent of poverty, 65 percent of African American beneficiaries are. Thirty-three percent are below the poverty level period.

We are then disproportionately among the very poor, and this bill will increase cost-sharing for people who fall in that category. While it may start out relatively low in the first year, it can be counted on to increase with increasing drug prices which average 10 percent an increase a year.

I am also very concerned that there is a very strict means test that will be applied to even these poor beneficiaries: $6,000 for individuals and $9,000 for a couple, which means that many seniors and disabled who need this benefit will be left out.

All of this will mean that even the little that the bill does to provide for low-income Medicare beneficiaries will not be available for as many as up to 2.8 million individuals. This is not, Mr. Speaker, what we promised.

Let us look at what happens to beneficiaries who have prescription drug coverage. Not only will this bill jeopardize the retiree prescription drug benefit, and 22 percent of African Americans with Medicare have a retiree prescription drug benefit, as well as 17 percent of Latino beneficiaries, but how could we, in good conscience, also worsen the already bad situation this report would create for the very poor dual-eligible who would also lose benefits that they have under Medicaid because this bill would eliminate the wrap-around provisions.

Lastly, let me mention the potential cap on Medicaid, the potential cap on this Medicare prescription drug benefit if we pass the conference report. It goes to cost containment. We all know what cost containment has done for us thus far. It has filled the coffers of managed care corporations and, for the most part, has done so by reducing access to needed medical care for those who are enrolled and, virtually, it has left out the sicker, many of whom are poor, who are people of color, or who live in our rural areas. And has the cost of health care gone down in this country because of that cost containment? No, it has not. Have insurance premiums gone down or even stayed steady? No. They are increasing in double digits. So what we would be likely to see would be the rationing of care where we have just begun to see some minor changes. Cost containment would just expand the 2- and 3-tiered health care system where the sickest get the least care. This is not what we promised.

I want to take this opportunity to answer one of my constituents, Rosalee Dance from Saint Thomas. She asked the question, because she is confused like many seniors are in this country. She asks me two questions. She asks, is it true that the bill creates a situation where people either pay sharply increased premiums to stay in traditional Medicare where they can choose their doctors, or be forced out into an HMO?

Ms. Dance, the answer is yes, that is what the conference report would do.

The second question she asks: is it true that it would require that people who want the prescription drug coverage that it is advertised to provide to buy such coverage that they would have to buy it from private insurance plans?

Again, the answer is yes. This is not Medicare as it needs to be.

All of these aspects reduce access of poor and minority seniors more than others to needed medication, which would otherwise maintain good health, prevent complications, prevent disabilities, and also prevent excess and preventable deaths. What we are doing, or what the Republican leadership is attempting to have us do is continue the same wrong-headed policies that have created the health care crisis that we are now in, through denying good prevention and health maintenance to all of the seniors and the disabled who are most in need and to most of the 16 percent of Medicare beneficiaries of racial and ethnic minority backgrounds. We would diminish the quality of services if we do this and increase the cost, continue to increase the cost of care for all.

Mr. Speaker, it is time that we actually do what H.R. 3459 says, which is begin to heal our country, to heal America, and we can begin to do that by voting no on the Medicare proposal that will be coming before this House tomorrow.

Mr. CUMMINGS. Mr. Speaker, I yield to the gentlewoman from California (Ms. LEE).

Ms. LEE. Mr. Speaker, first, let me thank the chairman of the Congressional Black Caucus, once again, the gentleman from Maryland, (Mr. CUMMINGS), for his continued leadership and for ensuring that the Congressional Black Caucus continues to have the opportunity to wake up America, and for continuing to stand up for our seniors' rights to an affordable, quality, and guaranteed prescription drug benefit. Also, to really protect Medicare as a vital institution. So I just want to thank the gentleman again for giving us this opportunity.

Now, I did not come to Congress to dismantle Medicare, and I will not stand by quietly while my Republican colleagues do just that.

Last night, I came to the floor and detailed my very strong opposition to the Republican prescription privatization plan, which does represent a giant kickback to the pharmaceutical and insurance industries. Tonight I come to the floor again to reiterate my opposition and to discuss the other inadequacies in our health care system that are addressed in the Health Care Equality and Accountability Act, H.R. 3459, a bill which my colleague, the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN), has guided and has led and has brought us together through her tireless work to introduce on behalf of America. I just want to thank the gentlewoman for her leadership in providing us a real vision and a real alternative and a real roadmap to quality health care for all of our communities in America; specifically, our communities of color.

Now, our constituents realize that the cost of prescription drugs are really crippling our seniors, and this Republican prescription drug bill is a real joke, a cruel joke on seniors and the disabled. This bill will only raise false hopes that real help is on the way from the drug prices that are currently crushing our seniors. But nothing could be further from the truth.

This bill not only weakens benefits by creating major gaps in coverage; it actually prohibits, mind you, it prohibits the Secretary of Health and Human Services from negotiating lower drug prices on behalf of America's 40 million Medicare beneficiaries. It is a shame that not only will the government be prohibited from lowering the prices of medicines, senior citizens cannot even benefit from lower prices through drug reimportation, which this body actually passed. But, of course, any measure to reduce the cost of prescription drugs does not meet the approval of the pharmaceutical companies. So, quite frankly, these provisions are not in this bill, which really is their bill.

Now, in California, almost 250,000 Medicare beneficiaries are projected to lose their retiree health benefits. Nearly 300,000 fewer seniors in my State will not qualify for low-income protections because of the assets test and qualifying income levels.

When we get right down to it, the 300,000 low-income seniors will disproportionately be older women who, as we all know, have fewer financial assets, tend to live longer, have more chronic health conditions than men, and ultimately are more dependent on Medicare than men in their later years.

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And, of course, women are more than twice as likely as men to face poverty in retirement and account for more than 70 percent of the elderly poor.

This bill is harmful to the poorest and the sickest. And their out-of-pocket costs would increase above what Medicaid currently allows, and co-payments would dramatically increase further in future years.

A constituent from Oakland wrote to me and said, and I quote, "I am on Medicare and do not like this bill. I cannot understand why Congress will not allow anyone to bargain for better rates. I don't understand why Medicare must be privatized. The proposed deductible is too much. And I will not be able to afford medication for my disabilities if this bill passes. This bill amounts to another Republican publicity thing.'' I agree with her. H.R. 1 punishes people for getting older and for needing to use prescription drugs and for being disabled.

In 2002, for example, the Kaiser Family Foundation found more than 33 percent of seniors without drug coverage did not fill the prescriptions that their doctors prescribed. That is a rate twice as high as those with coverage. Lower-income Americans really do deserve better.

On July 24 of this year, the Wall Street Journal reported that black Medicare beneficiaries are more than twice as likely as white beneficiaries to go without a prescription drug because they could not afford it. Nearly 40 percent of elderly African Americans lived in poverty in 2001 compared with 10 percent of whites. As a result of the disparities in our health care system, African American seniors are more likely to be in poor health and to report having one or more chronic health conditions, while only 26 percent of whites on Medicare report their health status to be fair or poor.

While the Republicans punish seniors, particularly women and minorities, with this bill, California drug companies will make out like bandits. More than 860,000 Medicaid beneficiaries pay more for the prescription drugs that they need, pay more. This bill is really not just, however, a gift to the drug companies, it is the beginning of the end of Medicare. And it is the beginning of the privatization of Medicare.

Under this Republican bill, beneficiaries dropped from one plan may face a period of noncoverage before they are picked up by traditional Medicare or another private plan, if one is available at all. During this time, all beneficiaries lose continuity of care and may not even be able to get the care that they need.

Secondly, beneficiaries even in a new private plan may not be able to use the same doctors, services, and prescriptions due to the plan limitations. African Americans face a disproportionate risk under such a coverage gap since they are more likely to have serious health problems.

Prescription drugs are not a luxury for our seniors; they are a necessity. And our seniors cannot afford to pay more than the outlandish prices for prescription drugs that they are already paying. Also seniors with income levels below the poverty level are nearly three times as likely as those with incomes of more than $17,000 to go without prescription drugs. The pharmaceutical companies cannot continue to get rich off the poorest of the poor.

Let us be clear, this bill really is a fraud and really is an embarrassment. We stand here today with a Republican bill that is not affordable, is not comprehensive, and is not guaranteed. On behalf of all people who see through this bill, I call on my colleagues to join us in opposing the sad attempt to pull the wool over the eyes of our nation's Medicare beneficiaries.

Further, I think that the President and the Republicans should really look at how to really provide a meaningful benefit and also to get at other pressing issues facing our health care system today: the cost of drugs, the lack of access to any health care at all, and the horrific disparities in access and the quality of care for communities of color and the needs to move forward with the system where health care is a basic human right provided for all.

Today African American Medicare beneficiaries are more than twice as likely as white beneficiaries to go without prescription drugs because they could not afford it. Nowhere in H.R. 1 are these beneficiaries considered.

So now is the time to expand the health care safety net which will increase the availability, quality and affordability of health care coverage options. The Healthcare Equality and Accountability Act, as I mentioned earlier, H.R. 3459, reminds us that now is the time for diversification of the health care workforce which will reflect the communities that have been neglected while incorporating a real understanding of the backgrounds, experiences, languages, and cultures of minority people.

H.R. 3459 reminds us that now is the time for an aggressive collection of data and dissemination of data on people of color so that that becomes a priority in terms of the health care of our communities. And H.R. 3459 reminds us that now is the time for a complete assault on HIV and AIDS and other diseases that are disproportionately killing minority communities.

So now is the time for Congress to take a real look at our health care system, diagnose our weaknesses and our illnesses, and prescribe a system where everyone will have quality universal guaranteed health care.

Again, as I said, I did not come to Congress to dismantle Medicare, and I cannot stand quietly while that happens. So I just want to thank our chairman again, the gentleman from Maryland (Mr. CUMMINGS), for giving us this opportunity to really allow our senior citizens and the entire country to hear our views in spite of what AARP has told individuals with regard to this very terrible bill. I want to thank the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN) once again for her leadership to ensure that we have an alternative that makes sense for universal health care.

Mr. CUMMINGS. Mr. Speaker, I want to thank the gentlewoman from California (Ms. LEE). It is indeed interesting a lot of times when people hear the Congressional Black Caucus talk on issues they have a tendency sometimes to think, oh, here are some liberals standing up and being against a certain provision or being for something. One of the most interesting things that came to my attention today is that there are many conservative organizations who are against this bill.

And one of them being the Heritage Foundation issued these comments within the last 2 or 3 days. And I quote, now, this is the Heritage Foundation, they say, "The agreement contains an unworkable and potentially unpopular drug benefit with millions of Americans losing part of their existing coverage. Instead of targeting benefits to seniors who need them, the Medicare conferees are insisting on creating a universal drug entitlement to be delivered through the vehicle of stand-alone insurance. In the process, according to both the Congressional Budget Office and recent independent economic analysis, more than 4 million seniors with existing private coverage are bound to lose it or have it scaled back. Meanwhile, the politically engineered premiums and deductibles coupled with their odd combination of donut holes or gaps in drug coverage are likely to be unpopular with seniors." That is dated November 17, 2003. And that is from the Heritage Foundation.

Now, the fact is that we all agree, maybe for a little different reason at times, that this is not an appropriate bill. But it is just interesting because I want to make it clear to everybody who may be listening to us tonight that it is just not the Congressional Black Caucus that is standing up against this legislation.

Ms. LEE. Mr. Speaker, I am glad that the gentleman from Maryland (Mr. CUMMINGS) raised that because this legislation is bad for America. I am glad that he cited the Heritage Foundation's comments and their opposition because I believe that we need to make sure that America understands that in spite of the leadership of AARP and in spite of the fact that the pharmaceuticals and the insurance industry for the most part wrote this bill, that there are, all of us, primarily, with the exception of a few, those who really believe that this will begin to dismantle Medicare and privatize Medicare. And if no one believes us, they sure should believe the Heritage Foundation. But I think that the Congressional Black Caucus, our tri-caucus has an unbelievable track record in telling the truth. So I am glad that the Heritage Foundation has joined us in that tonight.

Mr. CUMMINGS. Mr. Speaker, it is so interesting that when we talk about Medicare, Medicare is so important to so many people. If we did not have Medicare, we would have to invent it because it touches the lives of so many. And I have often said that if I were sick and did not have a way to get well, I think that would make me sicker.

I think that we are, with the way this conference report is structured, it seems as if we are pushing more and more people out into the cold and placing them in a position where they will not be able to get available, accessible and affordable health care.

Ms. LEE. Well, Mr. Speaker, I think the gentleman from Maryland (Mr. CUMMINGS) has summarized what this bill does. And I think our senior citizens understand that Medicare has been that safety net and has provided the foundation for really the quality of life that they deserve in their golden years. And to see that safety net being tampered with and to see it put up on the chopping block at the whims of the insurance industry and pharmaceuticals is very shameful and very disgraceful. And I think that all of us have the duty and responsibility to fight against this. Because this is, I think, a basic value that America holds dear, and that is protecting and ensuring, I would say, the comfort of our senior citizens. And we cannot play around with that.

Mr. CUMMINGS. I want to thank the gentlewoman from California (Ms. LEE).

Mr. Speaker, I yield such time as he may consume to my colleague from the great State of New York (Mr. OWENS).

Mr. OWENS. Mr. Speaker, I want to congratulate and thank the gentleman from Maryland (Mr. CUMMINGS) for this Special Order. Nothing could be more timely than our focus tonight on the Republican Medicare Prescription Drug conference report that will be before us for a vote soon.

We also are concerned about the tri-caucus minority health bill, H.R. 3459, which I think is very significant; but that is in the works, and we will not be having a vote on that any time soon. And it will be very much jeopardized if we have the awful fate of having the Medicare prescription drug conference report of the Republicans passed tomorrow or the next day. It is impossible to move forward with a minority health bill which is of any great significance and impact if you do not have the envelope of Medicare.

Medicare and Medicaid are the beach heads for providing universal care in America. And all of us are hopeful we will move forward and provide health care to all those 43 million people who tonight have any health care and that some plan would be developed which is based on Medicare as a start. But what the Republicans have done here is started a slow and tortuous assassination of Medicare.

In the beginning when Medicare was first proposed and passed, very few Republicans voted for it. Over the years Republicans have repeatedly talked about liquidating Medicare. Former Speaker Gingrich made no bones about it. He wanted Medicare to fade away. His phrase was, "We should make it fade away."

So we are in the process now under this guise and camouflage of providing a prescription drug benefit of sticking Medicare in the back with a dagger for a slow bleed to death. That is what will happen. The introduction of privatization, the build-up of HMOs, and the role that the pharmaceutical companies have played in this legislation is such that you know we may be discussing the beginning of the end of Medicare. We cannot do that. Nothing else in the area of health care would be go forward unless we have Medicare to build on. We need that very much.

The tri-caucus minority health bill would have talked more about adapting and refining the health care program to make certain that we deal with some of the basic problems in the African American community and the Hispanic community and other minority committees with respect to health care.

I want to bring in a very important event that took place, not many people have heard about, last Saturday. We had, last Friday night and Saturday, a conference on saving young black males. The gentleman from Maryland (Mr. CUMMINGS) kicked off the conference on Friday night. And I came on Saturday expecting to stay maybe half a day, but I was so impressed with the audience, the participants who showed up, that I got locked in the whole day and I did not leave until 6:00 because they were so serious, the people who came to participate. Counselors, principals, Boy Scout masters, Girl Scout masters, all kinds of folks who were interested in young people were there.

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They were serious because, usually, on these weekends we have a serious panel. You can only hold people's attention an hour and a half. If you are good you go two hours. They came at 8:30 in the morning. They filled up the place. At noon when we had the address by Mr. DAVIS, of course, the place was packed, and they stayed. And I looked out in the audience at 5:30 and it was still packed. People began to drift home at 5:30. If they are willing to go from 8:30 to 5:30, you can imagine what a great deal of interest and how deeply people feel about saving the black males.

Again and again during that day the problem of health care came up. Some people who are getting the least amount of health care they need are black males. The alienation factor that sets in very early, where they do not feel the system is for them, drives them away from even seeking help in many cases. Then they focus in on the tremendous mental health problem. Studies have showed that the suicide rate among black males is far higher than most people realize because of the recklessness of some automobile accidents and the recklessness of confrontations with the police or other authorities, the number of ways that black males end up dying is driven by the fact that they have a suicide wish. And the hopelessness and the kind anxiety of black males was talked about in terms of nobody is out there to deal with that mental health concern.

I will not diverge too much here, but the fact that large numbers of them are incarcerated, we keep focusing on that. It was 25 percent 5 years ago, and now a greater percentage of black males are in the criminal justice system somewhere, parole, probation or prison. And a large number of those who are in that system, about half are in the system as nonviolent offenders. They are in the system because of drug use.

The problem that we have been trying to address in terms of the use of drugs and the way in which our society criminalizes the drug user, not necessarily the drug sellers or dealer but the user, has led to this tremendous percentage of incarcerated black males.

I must say that the way that Rush Limbaugh has been dealt with in terms of his problem, he had an addiction problem, a pain problem. Whether it is mental or physical, we are not sure whether it is just mental or just physical. Maybe it was both. Whatever it was he used large number of drugs and they were purchased in a way which obviously is suspect. And people have shown a great deal of sympathy for Rush Limbaugh who makes $35 million a year. He certainly does not have the anxieties that black males who have tremendous anxieties about employment and adjusting to a world which is impacted heavily with racism.

Here is a man with anxieties in pain and he used illegal methods to seek relief. I will go so far to say that I think it is clearly illegal. He is hustled off to a treatment center. He is back on the air now seeking sympathy. And the same man has said and his friends have said that we should put people who use drugs into jail. They have the harshest words for them.

So the mental health of black males is not considered in the same league of the mental and physical health of Rush Limbaugh. So racism is a factor that we are concerned with, the racism that drives our society, whether it is the criminal justice system or health care system is still a problem.

In health care racism is a problem. The Tri-Caucus Minority Health Bill is aimed to do a number of things, but one of the things it has to deal with is the disparate health care treatment. And my colleagues have spoken about being too poor to afford Medicare and the kind of drugs they need; but the disparate health care treatment studies have shown that even when middle class blacks have health plans that pay for everything that white middle class persons are entitled to, the system is so racist that they are not offered the same procedures. They are not offered the same treatment. They are not offered the same medications.

Three studies have documented this. It is alarming. Money is not the factor, but somebody along the way decides that minorities do not deserve first class health treatment. This is sometimes decided by nurses, sometimes decided by technicians, the doctor's diagnosis and the determination of whether you get a heart bypass or whether you get a pill indicates the disparity in treatment.

So racism is a factor. It will become more of a factor as we struggle and compete for the existing health care that is out there now. If we do not go forward with Medicare and beyond Medicare, a universal health program based upon Medicare as a beginning, then we will have even more difficulty, and racism will play an even bigger role in determining the poor health care that minorities receive.

There is adequate health care treatment and inadequate health care treatment. Class does not come in and should not be considered as a factor.

Our first step is to make sure that we maintain Medicare as it is. The bill on the floor tomorrow goes far beyond dealing with prescription drugs. It sets up a situation for privatization, for a number of factors which will mean the end of Medicare. And when Medicare ends then minorities in general, poor and middle class, answer to the poor, we will have nowhere to turn. We must fight to the very end to see to it that our colleagues understand how decisive this action will be tomorrow in terms of determining the future of health care in America.

Mr. CUMMINGS. Mr. Speaker, I want to thank the gentleman for his outstanding statement. I really appreciate it.

I now yield to the distinguished gentlewoman from the great State of Texas (Ms. JACKSON-LEE).

Ms. JACKSON-LEE of Texas. Mr. Speaker, I thank the distinguished chairman for yielding to me, and I thank him for bringing this important special order. Because one of the tragedies of the next 24 hours, and I do believe that this debate, this discussion and ultimate decision on Medicare, can in fact be a bipartisan decision. And I look forward to working with my friends on the other side of the aisle who have the same common goals. And that is to strengthen Medicare and to provide the best package possible within a fiscally responsible presentation Medicare, to save Medicare as we know it, to preserve the safety net as we know it. And frankly, Mr. Speaker, I do believe that there are Republicans who believe this same way.

I hope the opportunity that I have this evening and my colleagues have had from the Congressional Black Caucus that we have might share some of these thoughts sufficiently enough that our friends on the other side of the aisle might work with us tomorrow in this shortened time frame, limited debated, to do what is right. And that is to send this legislation back to the drawing board and really do what we have been asked to do.

I think there are two things that are creating problems and maybe even three as it relates to the Medicare system. The first one is what we have debated and discussed for at least the almost 10 years that I have been here and that is to give a real guaranteed Medicare prescription drug benefit to our seniors in the Medicare system.

The second and third have to do with providing the compensation for providers whether they be physicians or whether they be, in fact, our hospitals, both urban and rural areas, that they can provide the kind of care that is necessary for all Americans who are senior citizens and who have access and are qualified for Medicare. I think that is really the crux of what we have been trying to do now for 10 years.

Many people are rushing to judgment feeling that we are desperate that we are at our wits ends, this is the last opportunity, and I would just say to my friend, it is not. The Congressional Black Caucus stands on this floor tonight to let you know that our districts now have become so diverse that whether or not you happen to represent a conservative Republican district, moderate, liberal, Democratic district as it may be so designated, you can be assured that there are people of all economic levels, races, color and creed and religion in your district.

That means if you cavalierly vote for a bill that will be on the floor of the House, 634 pages tomorrow, that rule destroys Medicare as we know it, that gets rid of the Medicare premise, the safety net for all Americans, you will have made a very big mistake. Once seniors begin to understand one that the vote tomorrow does not give them any benefit, it does not take effect until 2006, for the fiscally conservative and responsible Members of this House, for them to realize that this is more than a budget buster, this is a budget imploder. Because in actuality, because we have had to try to sweeten the pot for every constituency possible we really do not know what the cost of this bill is going to be. It is more than the $400 billion that we surmise that it might be based upon the fact that the President gave that as a number.

In fact, what it does is it throws seniors of all accounts into a private system that may fall on its own weight. It insists on creating a prescription drug benefit not under Medicare; but under a private HMO system, which if it is not beneficial or prosperous or has a good profit margin just like we found in the HMO's crisis of about 5 or 6 years ago, you will see HMO's closing every single place in the Nation, including the districts of my friends across the aisle.

So if you think you are doing something for your seniors, take a second look. This is not a prescription drug benefit. It is, in fact, a prescription drug booster. And what it does is it causes the Social Security increases to not match up with the prescription drug increases.

Let me just bring several points to a close, Mr. Speaker. First of all, for those of us who have seniors who are on Medicaid, it is going to be a higher co-pay for them. And the HMOs rather than the doctors are going to determine what drugs, what prescription drugs are going to be paid for under this plan. Then I will say there will be no reimportation allowed, and I know there will be a number of those who supported the reimportation. I will say one of the greatest shams of this bill is that it does not allow, Mr. Chairman, it does not allow the government to negotiate lower prices for prescription drugs under Medicare.

What an insult. It does not allow the government to save money. The reason for that is, and let me say I have no argument with the pharmaceutical companies. They do great work. I say that in terms of research and finding prescription drugs or drugs that will allow us to live longer or cure our ailments, but their participation in this kind of misfortune, in this legislation of tying the hands of government is a travesty.

So I would simply say that we will not have the time that we need to debate this tomorrow on the floor of the House. I know this is going to hurt Hispanics and African Americans. And I would just simply argue the point, Mr. Speaker, that this is a bad bill. Send it back as the Congressional Black Caucus would like you to do and put forward something that is reasonable and that works to help all Americans of which tomorrow's legislation will not do.

Mr. CUMMINGS. Mr. Speaker, I will close by simply thanking the Members of Congressional Black Caucus for being here tonight and being a part of all of this. I have often said that a hundred years ago, none of us were here. A hundred years from now, none of us will be here. The critical question is what do we do while we are here to lift each other up.

The fact is that we have a bill on the floor of this House tomorrow which is supposed to be a prescription benefit bill when, in fact, it does much more harm than good. And I think that when all the dust settles, when everything is laid out very clearly, the question becomes, Have we lifted our seniors up? So many of them have begged for relief. So many of them have cut pills in half and in quarters. So many of them have gone from one drug store to another begging for prescriptions.

□ 2230

So many of them have almost broken out in tears when they found out that their doctor did not have the sample prescription drugs that they needed, and so we stand here tonight not only saying that we consider the prescription drug bill to be bad, bad news, but we also on the other hand, Mr. Speaker, offer our HealthCare Equality Accountability Act of 2003 to say that we have a piece of legislation that does not cure everything but certainly it helps; but on the other hand, we have another piece of legislation, the prescription drug bill which does so much harm.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF MOTIONS TO SUSPEND THE RULES

Ms. PRYCE of Ohio (during the Special Order of Mr. CUMMINGS) from the Committee on Rules, submitted a privileged report (Rept. No. 108–387) on the resolution (H. Res. 456) providing for consideration of motions to suspend the rules, which was referred to the House Calendar and ordered to be printed.

REPORT ON RESOLUTION WAIVING POINTS OF ORDER AGAINST CONFERENCE REPORT ON H.R. 1904, HEALTHY FORESTS RESTORATION ACT OF 2003

Ms. PRYCE of Ohio (during the Special Order of Mr. CUMMINGS) from the Committee on Rules, submitted a privileged report (Rept. No. 108–388) on the resolution (H. Res. 457) waiving points of order against the conference report to accompany the bill (H.R. 1904) to improve the capacity of the Secretary of Agriculture and the Secretary of the Interior to plan and conduct hazardous fuels reduction projects on National Forest System lands and Bureau of Land Management lands aimed at protecting communities, watersheds, and certain other at-risk lands from catastrophic wildfire, to enhance efforts to protect watersheds and address threats to forest and rangeland health, including catastrophic wildfire, across the landscape, and for other purposes, which was referred to the House Calendar and ordered to be printed.

REPORT ON RESOLUTION WAIVING REQUIREMENT OF CLAUSE 6(a) OF RULE XIII WITH RESPECT TO CONSIDERATION OF CERTAIN RESOLUTIONS

Ms. PRYCE of Ohio (during the Special Order of Mr. CUMMINGS) from the Committee on Rules, submitted a privileged report (Rept. No. 108–389) on the resolution (H. Res. 458) waiving a requirement of clause 6(a) of rule XIII with respect to consideration of certain resolutions reported from the Committee on Rules, which was referred to the House Calendar and ordered to be printed.

REPORT ON RESOLUTION WAIVING REQUIREMENT OF CLAUSE 6(a) OF RULE XIII WITH RESPECT TO CONSIDERATION OF CERTAIN RESOLUTIONS

Ms. PRYCE of Ohio (during the Special Order of Mr. CUMMINGS) from the Committee on Rules, submitted a privileged report (Rept. No. 108–390) on the resolution (H. Res. 459) waiving a requirement of clause 6(a) of rule XIII with respect to consideration of certain resolutions reported from the Committee on Rules, which was referred to the House Calendar and ordered to be printed.

MEDICARE PRESCRIPTION DRUG BILL

The SPEAKER pro tempore (Mr. ROGERS of Alabama). Under the Speaker's announced policy of January 7, 2003, the gentleman from Georgia (Mr. GINGREY) is recognized for 60 minutes as the designee of the majority leader.

Mr. GINGREY. Mr. Speaker, it is good to be back tonight to talk on an issue that is really very, very dear to my heart. We have got an exciting day. In fact, I do not think I could even, though it is a late hour, I do not think I could go home and sleep tonight in anticipation of a historic moment tomorrow when we will finally deliver on a promise that has been made to our seniors, and that is a prescription drug benefit under Medicare.

Mr. Speaker, I would like to start out by maybe addressing some of the remarks that I just heard made from the other side, and it is the kind of remarks which I would really refer to as "Mediscare" comments. I just heard the gentlewoman from Texas refer to the government not being able to set prices. I think that is exactly what the Democrats tried to do in 1993 under "Hillary care." They wanted the government to set prices. They wanted a one-size-fits-all, essentially a national health insurance program, and the people of this great country rejected that.

Another comment I have heard them say just repeatedly is this business about, well, who is going to benefit from this prescription drug availability for our seniors, who is going to benefit the most, and they keep saying, well, it is the drug companies, the evil, greedy drug companies. Well, of course, no duh. Who makes the drugs? Who has made this country the greatest Nation on Earth in regard to having access to life-saving drugs? The pharmaceutical industry. Who do we expect? Who does the other side expect to provide these drugs? The chocolate cookie company or the potato chip factory? No, it is the pharmaceutical industry, of course.

Did they say the same thing in 1965, 40 years ago when Medicare was first enacted, that gosh, you know, we cannot do this, this program because who is going to benefit the most from Medicare part A, the evil hospitals, the evil skilled nursing homes; or who is going to benefit the most from Medicare part B, the doctors? Absolutely the doctors. They are the ones that provide health care.

So this argument about the drug company being the big beneficiary, it is absolutely bogus. Sure they are going to provide drug coverage, sell more drugs certainly, but the price of those drugs, Mr. Speaker, is going to come down. Their profit margin per sale is going to be drastically reduced. So, again, we hear these arguments over and over again, and it truly is nothing but "Mediscare."

Another argument we hear, and we have been hearing it today, we will probably hear it all day tomorrow and as long as this debate goes on, is the Republicans want to take Medicare away; they want to destroy Medicare as we know it. Of course, they like to throw in the infamous "P" word. As far as destroying Medicare as we know it, let us talk just a little bit about Medicare as we know it and what my seniors in the 11th Congressional District of Georgia have told me about Medicare as we know it.

It is a good program. It served us well, but it is not 21st-century medicine; and I say that, Mr. Speaker, because, first and foremost, there has never been a prescription drug benefit under Medicare. There has really never been any real meaningful, preventive care under Medicare. It is all episodic. If you get sick, you get to go to the doctor, and the visit is paid for. If something catastrophic happens to you, like a heart attack or a stroke, you get to go to the hospital, and you certainly have the benefit of that hospital stay. If you have a family history of heart disease or you have high cholesterol and you develop coronary artery disease, sure, you get admitted to the hospital; and there is some coverage for you to have that open heart surgery.

It is the same thing for a diabetic patient who unfortunately under Medicare, many of those patients cannot afford to buy their insulin, cannot take their medication, glucophage, something to lower that blood sugar, to keep that disease under control. So they end up going to the hospital; and, yeah, it is paid for, if they have to have a leg cut off or they have to go on dialysis for years because of end-stage renal disease that probably would not have occurred if that diabetes had been checked with timely medication.

So when my colleagues talk about destroying Medicare as we know it, I want to just say to my colleagues on the other side of the aisle and who are opposed to this bill in contradistinction to the opinion and the feeling of 35 million seniors who are members of the American Association of Retired People, the AARP, of which I am proudly a member, they can talk all they want to about burning their membership cards and sounds like back in the 1960s, the people burning their draft card or burning the flag. I mean, if they want to do that, that is fine, but I will guarantee my colleagues that the seniors in this country respect that organization, as we all do and should, because they have certainly delivered for seniors and have a proven track record, and we are not talking about an organization, Mr. Speaker, that is necessarily a bastion of conservatism, that is known for their deep and unending support of Republican issues. That is not true at all. We all know that. The other side knows that, but they are talking about again "Mediscare," trying to scare people when clearly what we are trying to do is not destroy Medicare, but just improve it, improve it with a prescription drug benefit that is long overdue.

The other way we are going to improve it, Mr. Speaker, is we are going to finally put some emphasis on preventive care. We are going to give our seniors a chance to get into a managed care system, an HMO or a PPO, really very similar, in fact, exactly what 435 Members of this House of Representatives and probably 100 Senators in other Chamber, the kind of health care they have. It would be interesting to take a poll and see what they do have. I will guarantee my colleagues, it will be 95 percent or higher have that kind of a coverage where they can go in or their wives or their spouse can go in and have screening tests done for high cholesterol, elevated lipids, osteoporosis screening, colonoscopies, timely mammograms. These are the kinds of things that until just recently none of that was covered under Medicare as we know it, and there still is not really any catastrophic coverage for part A and part B.

Unfortunately, a senior goes into the hospital in any one episode of illness and can only stay a certain number of days. There is a very high copay, but once you have exhausted those days in the hospital or, God forbid, in a skilled nursing home, it happens so often, if a patient has had a stroke, then what happens to our seniors who have worked all of their lives to save up and hope and pray that they will be able to leave a little something to their children or more likely their grandchildren, so that their lives would be a little easier? For the seniors to lose all of that and end up in poverty and end up basically as a ward of the respective States because they have gone broke because of a long stay in a hospital or skilled nursing home, Mr. Speaker, there is something wrong with that picture.

Democrats on the other side of the aisle, they can complain all they want to and try to scare our seniors and talk about taking away Medicare as we know it. We are not taking away Medicare. Traditional Medicare, fee-for-service, that option will remain. It will be there for our seniors, and I am sure there are some that kind of get used to the old system, and they may not want to change. I think we all understand that. Do not for a minute think that they will not have the option to also get this prescription drug benefit if they stay in traditional Medicare.

That is what the other side is trying to do. They are trying to scare seniors into thinking that if they do not move into managed care or Medicare+Choice or advantage type program, that they will not be eligible; they will not get the prescription drug benefit. Mr. Speaker, we know on this side of the aisle, we absolutely know that that is not true.

Again, this is one of the greatest times of my life, and I am so much looking forward tomorrow to this historic piece of legislation and voting enthusiastically for it and for its passage. Make no mistake, I feel every confident that it will pass, and I think at the end of the day we are going to have our colleagues from the other side, no, not all of them, but I think this will be a bipartisan-supported bill because I know that they love the seniors as much as I do.

I am often asked in the districts, Dr. Gingrey, you had a great medical practice and you delivered all those babies, and do you miss it? The answer is, of course I miss it, absolutely. In fact, just yesterday on the floor of this House, my cell phone rang on the silent mode, on the vibrate mode, and I went out to take the call, and it was from the husband of one of my patients whose two children I had delivered. She is now pregnant with their third in about 8½ months and was starting to have some problems, and he just wanted to call Dr. Phil, even though she has got a great doctor, one of my former partners, back home in Marietta, Georgia. I talked to him, an old friend and a patient about his wife. It, of course, made me realize once again how much I do miss that, but this opportunity to come to the Congress of the United States, this 108th Congress and be a part of this great body and have an opportunity tomorrow to cast a vote, to give finally a prescription benefit and to modernize Medicare for 40 million seniors, a third of whom are probably living right at or below the poverty level, who have nothing, nothing, Mr. Speaker, to live on other than Social Security and no health care except basic Medicare. They cannot afford Medigap or their former employer did not offer a health care plan.

So that is what it is all about. That is why I am so excited to be here, and even though I miss my practice, I feel in many ways that this is a high calling, and I am really proud to be here, proud of being part of this majority and working with the leadership of this Congress, with our great Speaker and our great leader and answering the call of President George W. Bush when he said, Men and women of the Congress, we have got to keep this promise.

We tried so hard last year to do that, tried so hard to pass this bill last year, and it did pass the House with the Republican leadership, but what happened on the Senate side? It gets over to the Senate where the Democrats had control, and again, I heard one of my colleagues just a few minutes ago talking about, well, we need to send this bill back for more study, it needs more study. Well, we can study things to death. That is exactly what they did last year. They studied it to death, and we had no bill until we finally now have the leadership in both the House and the Senate, and I think we are going to get the job done this time.

It is like the president of AARP, Mr. Bill Novelli, said, We cannot wait for a perfect bill. There are no perfect bills. Seniors need our help now. They have been needing it for a long, long time.

□ 2245

And this business about waiting for the perfect bill is a total farce. This is a good bill. It is not perfect, but it absolutely is a good bill.

Mr. Speaker, I would now like to yield to one of my colleagues and good friends, the gentleman from Colorado (Mr. BEAUPREZ), who has worked very hard on this bill, and I know he is just as excited about its impending passage as I am.

Mr. BEAUPREZ. I thank the gentleman, Mr. Speaker, and he is unnecessarily kind. The gentleman from Georgia is admired by every Member of this House for his tenacity and his dedication and his intelligence and understanding about this bill that we are going to consider on the floor here very shortly.

And the gentleman is correct, I agree with him completely, that this is an historic moment. The gentleman knows full well the history of Medicare, founded with the greatest of intention and the greatest of purpose about 40 years ago. And for most of those 40 years, there has essentially been a very little change in modernization with the bill, with Medicare, with the program, to keep up with the rapidly changing nature of health care and medicine as we deliver it. And that is the dilemma we are in right now.

I am proud that the gentleman is a Member of my class. I am proud he is a Member of this 108th Congress with me. And I am also proud that, as I take a little bit of pride in myself, in coming to this Chamber the gentleman has some real-world experience. I had some experience running businesses before, a family dairy farm, and later on a community bank. And as a community banker, I came in contact with a great number of individuals with a whole lot of different experience. And when I wanted some information about something in particular, I usually went to someone with that particular type experience.

So for me it is especially valuable and important that at a time when we are really talking about making some important reform and modernization to something as personal as important to especially our senior population as their health care, that we have someone like yourself, a doctor, who has supplied that health care to individuals and that we can ask for counsel.

For me, and I expect, for my colleague, because he just related a great story, a great testimony to how personal this issue is for him with his patients, I have two parents at home. And I am fortunate that I still have them. My dad is 85, and mom is 83. They both live in assisted living.

I believe mom has eight prescriptions a day, dad is on nine, and both suffering with some of the things that come with getting a little bit older. But, again, I am grateful that I have them. But their health care, how it is delivered, their insurance coverage, Medicare, is critically important to them. Right now, they do not have a prescription drug plan for Medicare. They had to go get a supplemental plan. And they are at a point in life where any change in how they are doing things is difficult for them to comprehend and understand.

I have a brother, hard to imagine, but I have a brother that is about eligible himself, and it is not going to be very long until some of the rest of us are going to be there too. So it becomes real personal real fast.

And, certainly, as I talk to my constituents back home, as I asked them to give me this job of representing them here so that we could come back here and collectively give them what Medicare has denied them, a prescription drug coverage option, I came back here after listening to folks back in my district who said they wanted prescription drug coverage, yes, but they did not want to be forced into anything.

They wanted to make sure it especially took care of the poorest among us. And I have to admire a lot of the seniors, at least in my district, who recognized that we probably cannot provide everything to everybody 100 percent of the time and pay 100 percent of the cost out of the government. They said, we will pay some of the cost of that, but we want to make sure that for the poorest it is there, and especially for those times in life, those last few weeks, months, maybe years when their health deteriorates and the costs really escalate that we as a Nation are there for them, for what I think most of us call the catastrophic coverage.

Mr. GINGREY. Reclaiming my time, Mr. Speaker, for just a moment, I wanted to touch on that point and maybe get the gentleman to elaborate, because I think he really, really hit the key point here, and that is that the major emphasis, as we understand the bill, the major emphasis is on those who need it most.

Mr. BEAUPREZ. I thank the gentleman, for emphasizing that, Mr. Speaker, and I am delighted to hear that, because that is consistently what I heard from our seniors. And not surprisingly, I think our seniors are some of our best citizens. They are the most experienced, and they have lived a full life. They know what it means to be a good citizen and a good American, and they are willing to do their share. But they also want to know that when necessary, if it becomes necessary, that this Nation will be there for them. When they do pass on, they want to be able to pass on in dignity, and they want that same thing for their fellow Americans.

If the gentleman would be so inclined, because I do rely on his expertise, his experience and understanding, especially of this critical issue, which candidly is far too complicated for most of us in this Chamber to fully comprehend, so we have to rely, I think, on experts, and I consider the gentleman one.

Mr. GINGREY. Well, Mr. Speaker, I appreciate the gentleman stating that, but, of course, it works both ways, and the gentleman from Colorado is a former farmer and very successful banker and successful businessman. Of course, we physicians need to understand that we are businessmen and women, but far too few of us do understand that.

I will be glad to answer any questions on the medical issues that the gentleman might have, but I am going to ask him some business questions, particularly in regard to the health savings accounts. And he knows a lot about that, having employed a lot of folks. But, yes, I will be happy to respond to any questions the gentleman might have on medical issues.

Mr. BEAUPREZ. Well, I look forward to a few minutes of a colloquy here. And if I might begin, one of the issues I heard consistently, and especially from the doctor community, as well as from their patients, was this issue that surrounds the doctor reimbursement rates that we have been dealing with; and the fact that because of apparently low reimbursement rates, many doctors have literally been forced to not accept any more Medicare patients, against their own better wishes, their own training, the oath I think they took.

They simply found themselves, I am told, in a position that they cannot take any more patients. I even had a constituent recently tell me that when her husband became Medicare eligible, he was told he would have to go find someone else to be his doctor. Now, is that the case? And if indeed it is the case, I ask the gentleman, are we addressing it in this legislation?

Mr. GINGREY. Well, the gentleman is so right, Mr. Speaker, and physicians who take Medicare patients really do so out of great compassion. I do not think they would be doctors if they did not love people and want to care for them. But, of course, as I just mentioned a few minutes ago, they are businessmen and women and they have got practice overhead, not the least of which, as the gentleman knows, is the high cost of malpractice insurance.

We tried to address that issue, did we not, earlier, way back in February or March; trying to get some meaningful tort reform; just trying to balance the playing field? And we got practically no help from the other side. And with those kinds of escalating expenses and decreases in Medicare reimbursement, as the gentleman knows, I think the physicians were scheduled in 2004 and 2005 to take another 4.5 percent cut in Medicare reimbursement for each of those 2 years, on top of what has already happened in a downward trend when their practice expenses are going up.

I have often said to people that ask me about this, the excitement about getting a prescription benefit under Medicare, and the reason why we cannot just do that as a stand-alone part D of Medicare, if you will, run by the government and price setting by the government, the reason we cannot do that is because we just cannot afford it. We literally cannot afford that. And if we do that, and we continue to cut the reimbursements to the physicians, what will happen is there will be no physicians out there, except in Medicare patients.

The primary care physicians, the general internists, and these are the physicians who are on the lowest income scale of our profession, they are just going to throw up their hands and say we cannot continue to lose money doing this, and all of a sudden our patients, our seniors, have prescription benefits but nobody to write the prescriptions.

So I am so glad the gentleman asked the question, because in this bill that is part of the modernization piece. We are going to make sure that we keep these doctors in the system.

Are they getting rich off of Medicare patients? Absolutely not. The other side wants to suggest that there are winners and losers in this modernization of Medicare and the prescription drug benefit. I suggest to them that we are all winners. Very modest winners. The major one, of course, as it should be, are our seniors, and especially our neediest seniors.

Mr. BEAUPREZ. Well, the gentleman has already acknowledged, Mr. Speaker, that I have been a community banker, and as a community banker, I, of course, see financial statements from various people, some of them doctors. And I know full well that while it may appear that they have significant revenue, so too do they have significant expense. My own personal physician back home told me, a very compassionate man, that, unfortunately, he could not take any more Medicare patients, and that grieved him greatly.

Let me ask the gentleman very specifically, because this question has come up a lot. Cancer docs: A growing population and a growing need out there. They seem to be quite concerned about what this bill does to them or does not do to them. Have we addressed that critical issue in this legislation?

Mr. GINGREY. Well, Mr. Speaker, the gentleman is asking a great question. And, of course, what they are saying too, as the gentleman from Colorado has asked, is what is it going to do; what is this bill going to do to their patients? Not so much their bottom line, but the patients who are stricken with cancer.

And, of course, a lot of those cancer patients have been here, have been to Washington, and some of them, God bless them, in the midst of their chemotherapy; having lost their hair and maybe not looking as good as they would like to look physically. They got on that plane, flew up to Washington, and a lot of them came along with their doctors and talked to us about that. They wanted to make sure that we understood that, yes, they agree that certain changes needed to be made in regard to how they were reimbursed for cancer care, but they wanted to make sure, though, that they could keep their offices open and continue to provide that community cancer care. Because if they could not, if they had to close their doors and be denied the opportunity to see those patients, where would they go? Would they go back to the hospital? I am not sure. I think it is very likely that many of them would not get care; would not get care in a timely fashion.

So we have worked very closely with and we have listened to these patients, patients suffering from leukemia and breast cancer and bone cancer. We know, of course, that today there are medications that in some instances can yield a long remission for these patients and, with the help of God, occasionally a cure. Here again, years ago, when Medicare first started, there was no cancer chemotherapy. That just did not exist. And it would be a shame today if one of these seniors who is receiving chemotherapy, and that is actually one of few drugs that is covered under current Medicare Part B, because it is administered by a physician in an intravenous fashion, but if we did not have these kinds of benefits, what would happen? These patients would die, pure and simple.

So we have listened to the doctors, we have listened to their patients, and the answer to the question the gentleman from Colorado is asking is, I think they are pretty satisfied. They are going to take a significant hit on this bill, but I think they understand that for the overall good, for the greater good, they are willing to make those sacrifices. So I think they are going to be fairly pleased with the bill.

□ 2300

Mr. BEAUPREZ. Mr. Speaker, I thank the gentleman for that comprehensive answer. Once again, that issue is very personal as cancer has touched members of my family, as it has probably touched members of almost every family in this great Nation.

I would like to pursue one more issue regarding reimbursement rates and that is in regard to our hospitals, and even more specifically rural hospitals because it has become apparent to me that we do have a significant issue with the tens of thousands of usually small, more rural hospitals around this great land. And I believe in the gentleman's opening comments he made reference to an issue I am also aware of, and that is from the patient's side how Medicare up to now has treated extended hospital stays.

I would like the gentleman to address that greater issue of hospitals, specifically rural hospitals, and then extended stay for patients and how Medicare does or does not take care of them currently and what this legislation would provide.

Mr. GINGREY. Mr. Speaker, I am glad that the gentleman asked about that because in the hospital payment system, there has been this disparity for a long time. The rural hospitals and the rural physicians, those doctors who are practicing in an area outside of a metropolitan service area or a big city, they are reimbursed for the exact same service at a lower rate than a doctor who might be practicing in Boston or Atlanta or Denver, and there is just something wrong with that system. Again, that has been addressed.

In fact, if the gentleman will allow me to read here, there are hospitals referred to as disproportionate share facilities, by that I mean a disproportionate share of Medicare and Medicaid patients in their population. Some of these hospitals are in small towns, and I know in my district and probably the gentleman's district, but I know for sure in southwest and northwest Georgia, the 17 counties that I represent, in some of the towns in the county, the hospital is the major employer in town. It is the only source of revenue and health care. When they are seeing mostly Medicare and Medicaid patients, and there is not much industry so there is not much good, private health insurance, they do not have full pay rather than deeply discounted pay that we have under Medicare and Medicaid, and if we continue to treat them in an unfair manner, not only does health care go away, but jobs go away as well.

Here is one thing that I wanted to read in regard to what we are doing about this problem: "The bipartisan agreement modifies Medicare's payments for those hospitals that furnish care to a disproportionate share of low-income and uninsured patients. Currently, the disproportionate share hospital adjustment paid to rural and small urban hospitals is capped at 5.25 percent. The bipartisan agreement increases the rural and small urban cap to 12 percent."

Mr. BEAUPREZ. Mr. Speaker, I thank the gentleman for that, and as I think about Colorado and the eastern plains and smaller mountain communities, that is good news for many folks back home because I am sure they will fit in that category.

If I can shift gears a little bit and continue this probing of the gentleman's wealth of knowledge and personal experience, let us talk a little bit, a big evolution in the past 40 years in medicine has been the importance placed on preventive medicine. My doctor tells me get your physical, exercise and watch your nutrition; and it is my understanding that as we age, preventive medicine is even more important, and yet another glaring weakness in Medicare, at least at the moment, has been a lack of coverage for many preventive medicines that most of us think of as fairly routine. I believe the gentlewoman from Connecticut (Mrs. JOHNSON) who is an expert in this field as well has been a big proponent of incorporating preventive health care within Medicare. And my question is: Have we managed to accomplish that?

Mr. GINGREY. As Members know, the gentlewoman from Connecticut (Mrs. JOHNSON) is the chairman of the Subcommittee on Health on the Committee on Ways and Means. What many Members may not know is her husband is a retired OB–GYN physician. She is very knowledgeable about this issue. I have told Members if they do not understand the bill, and it is 1,100 pages, parts of it are arcane, and it is not necessary for every Member to understand every bit of minutia, but of course they need to understand the things that are important, and the gentlewoman has been a great resource to me.

In regard to medication, let me get personal. I had open heart surgery right after I won my election, just a month before we were sworn in. I think back and wonder if a senior, I am not there yet, I am getting pretty close, but if a senior at age 65 who was used to managed care and that attention, which has been described as prevention, not just episodic, let us say that they had the same kind of coverage that most Members of Congress have today, all of a sudden they turn 65 and Medicare, as we know it, and we have heard it before, we will hear it tomorrow, I am sure, and Medicare as we know it is taking over their care, and they have been on a cholesterol-lowering drug, we call them statins, or maybe they have been on something to prevent osteoporosis, and then all of a sudden they do not get that. All of a sudden they are on Medicare, and Medicare is primary. They do not have Medigap. Their employer did not give them health care in their retirement, and all of a sudden they are on Medicare and they have no coverage. Those are the very patients that were getting the benefit of the drug for osteoporosis prevention or to lower cholesterol. I am telling Members within 5 to 10 years, they will end up with coronary artery blockage. And when they go in the hospital then, sure, it will pay for open heart surgery. Or if they fall and break their hip and have an extended stay in the hospital, it will pay for that, but who wants that? That is why I have said a lot of times about this bill in commending the President for bringing this to us, this is compassionate conservatism, and I emphasize compassionate in its finest hour.

Mr. BEAUPREZ. I think the gentleman puts that very well. Not only does it make fiscal sense, as we have an obligation in this body to exercise, spending the taxpayers' money wisely, but we are providing better quality of life and better health care to our seniors, especially in this case, by allowing them to have access to preventive care which is less expensive earlier in life rather than taking care of the manifestation of disease later in life. Would that be a fair statement?

Mr. GINGREY. Mr. Speaker, that is exactly right. The gentleman was talking about rural hospitals, and we talked about the disproportionate share, and I explained that, but let me just read a letter that was written to our Speaker from the Rural Hospital Coalition in regard to the gentleman's question earlier: " Dear Speaker HASTERT, The Rural Hospital Coalition, which is comprised of more than 150 rural hospitals in America, applauds your leadership in working in a bipartisan fashion to achieve a compromise Medicare bill. We support your efforts to modernize Medicare and give senior citizens a prescription drug benefit that they deserve.

□ 2310

"Most importantly, this bill strengthens health care in rural America. For that alone, you should be proud.

"We urge all Members of Congress to support the compromise Medicare Prescription Drug and Modernization bill. It reforms a Medicare system that has for far too long reimbursed rural hospitals at a lower rate than their urban counterparts for the exact same services. Passage of this conference report will give rural physicians, nurses, clinics, and hospitals a fair shake when it comes to the Medicare payments. It will create a financially stronger hospital for rural communities, provide more jobs, and provide more services.

"Thank you again for your leadership to get this legislation this far. The Rural Hospital Coalition appreciates your strong leadership on rural health care issues and looks forward to working with you to see it is enacted into law in the very near future.

"On behalf of the Rural Hospital Coalition, sincerely yours, William F. Carpenter, senior vice president."

This is really exactly where we are. And I said when we began our colloquy that I wanted to ask the gentleman from Colorado (Mr. BEAUPREZ) an important question as well. As a businessman, having been in the banking business and very successful in what he does, I wanted to get his opinion about the health savings accounts. There are a lot of things in this bill that people do not want to talk about; they do not want to talk about the good. They want to just kind of confuse folks with, as I say, "Mediscare" rhetoric; but there are so many things in this bill, we could probably talk about it for 2 hours. But would the gentleman tell us a little bit about health savings accounts and what he thinks that will mean to the uninsured in this country.

Mr. BEAUPREZ. Mr. Speaker, I am attempting to not overstate or overemphasize my enthusiasm for health savings accounts. But I honestly believe that this may be as revolutionary an action that this body has considered in a very long time. The concept is a fairly simple and straightforward one, but it is so revolutionary that I think it bears some very careful consideration, and I thank the gentleman for his question.

This is simply a personal account whereby an individual can make a tax-free, before-tax, contribution to that account, year after year, skip if they like, but an account that can accrue over time. It is again tax free going in. The earnings, the interest that is accrued on that account is tax free, and the real key is on the back end as long as they spend it for health care, it is likewise tax free. What that means is that over time that account can grow, and I think we are all familiar with 401(k)s and IRAs and those incentive mechanisms that this great body in previous Congresses has enacted to encourage us to save for retirement.

Likewise, this encourages us to save, but coming out the back end, it is still tax free. They never ever pay a dime of tax on the money going in, the earnings on that money over however extended a period of time it happens to be, nor on the money as it comes out to pay for long-term health care, for specialty surgery, for catastrophic care, for whatever that individual finds himself in a situation to want or need in their advanced years.

What this really does in my mind is what has been lacking in much of our health care system, and I am talking about the larger system now, and that is the empowering of the individual to control their own destiny, their money, their choices, their decision. It puts the patient and the doctor, as we have said for years, ever closer together and the patient in control of their dollars. Further, it provides an enormous incentive, and I do not know how we provide a larger incentive, an enormous incentive for individuals to do this.

Now, perhaps the biggest component of this is not only can individuals deposit into these accounts, so too can family members. So if I want to contribute to my parents in their advanced years as they certainly contributed to me in my younger years, that is not only allowed, it is incented and invited. Because I get to do that tax free as well. Further, if I wanted to downstream it, I have a grandson, a 3-year-old grandson, who is about to have a birthday next week. A nice birthday present might be to make a contribution to his health savings account which will grow and grow and grow over the young man's life.

Mr. GINGREY. Mr. Speaker, it is my understanding too that in these accounts, that money that the gentleman described is growing at compound interest, the tax on that is deferred, and that this money of course can be used, as I understand it, for anything related to health. I mean, it can do the things that a lot of people are now spending money on for the so-called Medigap insurance. It could take care of that. It is my understanding also that one could pay for long-term care, to purchase a long-term care policy out of that account. Is that also the gentleman's understanding?

Mr. BEAUPREZ. Mr. Speaker, that is exactly my understanding and exactly correct, and I think even more to the point, it gets at health care as it is provided today, the long-term care, the assisted living facilities, exactly what my parents are going through.

Now, there is one additional item. Before I came to this body, I was an employer. The gentleman cited that. I had about 160 employees. And we provided not only the normal salary compensation, but benefits as well, health care being one of those. 401(k) matching contribution being one of those. And we were also looking for other ways to take care, if the gentleman will, to compensate, provide benefits to our employees. This health savings account allows an employer to make tax-free contributions as well to this health savings account. So what we have is the opportunity for funds from multiple directions incented, inspired to help out an individual, a particular individual, that will be there for them later in life when they most need it; and if it is unused, it can be passed on to their heirs tax free.

Mr. GINGREY. Mr. Speaker, as the gentleman points out, we are saying that this Medicare Prescription Drug and Modernization conference committee report of 2003, which we are going to vote on tomorrow, it is not just to the benefit of our seniors. Of course that is very important to provide this prescription drug benefit, as the gentleman pointed out, especially to the neediest. But it helps our younger workers as well, does it not? I think there are maybe 40 million, maybe it is 43 million now uninsured. I started to say unemployed, but the truth is 65 percent of the uninsured, no health insurance, are employed. They have got jobs. They are working hard. They go to work every day. But their employer, maybe it is a small shop, five, 10, 15 people, they cannot go out in the marketplace and afford to buy that policy, that first dollar coverage or $500 deductible. It is just too expensive, and they cannot individually afford to do it either.

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But this opportunity the gentleman describes is going to be a tremendous help to our workers at whatever age and, finally, they are going to get an opportunity to get health care. As the gentleman pointed out, or I heard someone say earlier in the week that in the history of the rental car industry, nobody has ever paid to have their oil changed. And, of course, what they are implying is that if you do not have some ownership, you are not going to be as good a shopper, you are not going to do the due diligence, you are not going to take care of yourself quite as well as if it is your money and it is growing and it is in that account, and you know that later on you might need that for, as the gentleman pointed out, long-term health insurance. So you are going to shop. You are going to go out in the market. You are going to make sure that you find the best doctors and the best hospitals. And just because they are lower-priced, that does not mean they are not good. In many instances, lower is better.

Mr. BEAUPREZ. Mr. Speaker, I think that the doctor says it very well. This addresses a good conservative principle. We as the Federal Government are willing to forego some tax revenue from individuals, but believing in individuals to manage their own funds and then make their own choices, rather than have choices made for them by government. I think that is good conservative principle. I think it will help us hold down eventually the cost of health care. But it is such a powerful incentive for folks all over the age spectrum from again, my grandson, who is going to be 3 years old next week, to my parents, who are in their 80s.

Mr. Speaker, might I pursue at least one or two more questions with the gentleman, if he has time.

Mr. GINGREY. Of course, certainly.

Mr. BEAUPREZ. Mr. Speaker, the question of prescription drugs, if I can return to it, the question exists of choice and whether it is voluntary or not voluntary. I will cite my parents again. They, obviously, do not have prescription drug coverage in Medicare now, so they have gone out and purchased their own policy. Frankly, I do not think they would like it very much if I told them, well, the policy you have now does not exist any more because you have to take Medicare.

Are we forcing anybody to take this prescription drug plan, or do they have a choice?

Mr. GINGREY. Mr. Speaker, absolutely. The gentleman is asking about the choice issue, and that is what is so important.

Mr. Speaker, back in 1988, we were not here. We just got here as freshmen. But I do remember when there was some attempt to include catastrophic coverage under Medicare. I think that was an important thing to look at. But the mistake that Congress made at that time is they passed a law that included, for the first time, catastrophic coverage. But there was no choice. All seniors had to have that coverage. Their Part B, Medicare Part B premiums just went through the roof. And there was much, much concern about that. We learn lessons.

This program, this Medicare modernization and prescription drug program, is all about choice. It is all about choice. In fact, a senior, and I am sure some will, will decide to stay in traditional Medicare, something they have been used to; maybe they turned 65 20 years ago and they just do not want to go to the trouble, if you will, and get out of their comfort zone. They may decide not to even take the prescription drug benefit. Certainly they can; they have that option, as well as the option to remain in the Medicare fee-for-service, the traditional Medicare program.

But as the gentleman points out, and I am so glad he asked the question, it is all about choice. We know that a third of our 40 million plus Medicare beneficiaries, they do not have any health insurance. They do not have that employer plan. They are not retired military. They do not have Tricare. They cannot afford Medigap insurance. Their only income is a Social Security check, and their only health coverage is your basic, traditional fee-for-service Medicare.

So we are giving them the opportunity, and I think under the circumstances it is so important that the gentleman brings that up. That is what is going to make this program so successful. It is not a one-size-fits-all. We are not forcing anybody into anything.

Now, certainly, I would love to see seniors, and when I turn 65, I am going to look very carefully at a managed care, Medicare advantage where I know that I can go and get disease management benefits and a lot of screening for things and, hopefully, some catastrophic coverage.

So the gentleman is absolutely right. The keystone of this thing is choice, from start to finish.

Mr. BEAUPREZ. Mr. Speaker, I thank the gentleman for this opportunity for this colloquy and certainly for his expertise. I am certainly comfortable with this bill. The gentleman said it earlier. It may not be perfect; only history will determine whether or not it is perfect. But I certainly think it is good enough. I think we have made huge strides in the direction that my seniors and my own intuition tell me we need to step, and I will be comfortable in supporting the passage of this bill.

Mr. GINGREY. Mr. Speaker, I thank the gentleman from Colorado for being with us and helping to bring a little bit sharper focus on this bill. Because our seniors need to know, they need to be well-informed, and I think they are going to feel a lot better, those who have a little insomnia tonight and maybe had an opportunity to watch this late-night show on the medicare modernization and prescription drug act.

Mr. Speaker, there are so many people that are supporting this bill, so many organizations. As I mentioned earlier, the AARP and 35 million seniors; the American Medical Association, which represents 330,000 physicians. But even more important than that, they treat 280 million Americans and lots of seniors.

Listen to this letter. I want to real briefly read this letter. Real quickly, this is one from the United States Chamber of Commerce. Here is what they say:

The United States Chamber of Commerce applauded word that House and Senate leaders, along with the administration, have reached an agreement to bring a Medicare conference bill to the floor for a final vote. Quote: "With employers being the source of retirement health care for 12 million seniors, it is critical this bill allows businesses the flexibility to integrate the new prescription drug benefit to their existing retiree health benefits, while allowing opportunities to partner with Medicare. The Chamber is pleased this bill is nearing final approval and welcomes congressional and administration action to modernize the Medicare program and ensure its long-term viability for future generations. The final Medicare conference report is expected to include significant reforms to modernize the Medicare program structure and delivery system by emphasizing quality care, establish a much-needed prescription drug benefit, and offer preventive health care services and disease management."

Mr. Speaker, in conclusion, as I said last night, this bill, this bipartisan effort; and yes, it is bipartisan, and we will have support on both sides of the aisle, this is all about compassion. We hear concerns about cost and certainly we are all concerned about cost and wanting to keep that down as much as we can. But this $400 billion new benefit under Medicare, I say this: it is going to only cost $400 billion if it does not work, and this is what I mean by that. You spend the money on taking timely prescription medications, and some of our neediest seniors need three or four pills a day, could be spending $600, $700 a month on prescription drugs. But if that will keep them out of the hospital, if that will prevent them from having a stroke; we heard earlier tonight from the Congressional Black Caucus talking about the fact that African Americans are more prone to have high blood pressure. Well, they ought to be so enthusiastic about this bill, we ought to have 100 percent support from the Congressional Black Caucus, because it is true, it is true that they suffer, particularly African American males, more from hypertension. And what happens? They end up in too many cases, far too many cases suffering from a stroke. What kind of life is that, no matter how long they live after, possibly not able to move one side of their body or utter a word.

☐ 2330

So as this President has said to us, Mr. Speaker, this is all about compassion and caring, and caring for the most precious seniors that are so important to all of us. So, yes, I am very excited. I will probably leave here in a few minutes and go home and lay awake for another couple of hours because I cannot wait to vote for this bill tomorrow. I am an OB/GYN physician, and I want to be able to say to my constituents and to the seniors of America, The real Dr. Phil, he delivered.

Mr. Speaker, I yield back the balance of my time.

THE WAR IN IRAQ

The SPEAKER pro tempore (Mr. ROGERS of Alabama). Under the Speaker's announced policy of January 7, 2003, the gentleman from Massachusetts (Mr. DELAHUNT) is recognized for half the time to midnight, which is 15 minutes. If the Majority Leader does not claim the remainder of the time, the Chair will recognize the gentleman from Massachusetts for an additional 15 minutes.

Mr. DELAHUNT. Mr. Speaker, I am joined here tonight by the gentleman from Washington (Mr. McDERMOTT), and I anticipate that another colleague of ours, the gentleman from Washington (Mr. INSLEE), will also be here. We are here tonight to discuss the situation, the mess, if you will, that unfortunately we find ourselves mired in, not just in Iraq, but in Afghanistan.

But before we proceed, I think, in response to what I heard from Dr. Phil, the gentleman from Georgia (Mr. GINGREY), my dear friend, I think we should warn the seniors that if this bill passes tomorrow, they better stay healthy because that prescription drug benefit will not take effect this year, it will not take effect in 2004, nor will it take effect in 2005. So make sure that if you are unhealthy, you go visit your State services; see if there is a program at the State level that can get you through to 2006. Because when you go to your druggist in the next several months or in 2004 and 2005, they are going to tell you, sorry, sorry, you do not have the benefit. And we hope that you do have the benefit in 2006, but, of course, if the Republican leadership and the White House continue to pass large, massive tax cuts for the wealthiest Americans, maybe you will not even have it then.

Mr. Speaker, I yield to the gentleman from Washington (Mr. McDERMOTT), my friend and colleague.

Mr. McDERMOTT. Mr. Speaker, I want to thank the gentleman from Massachusetts (Mr. DELAHUNT) for having this session tonight. I come out here, it is 11:35 at night. You ask yourself, why does a Congressman come into the well at 11:30 at night to talk about Iraq. Well, today was an absolutely stunning day. And I will submit into the RECORD an article in the Guardian Newspaper from Thursday, November 20, entitled, "War Critics Astonished as U.S. Hawk Admits Invasion was Illegal."

Mr. Speaker, now in an absolutely stunning statement today, Richard Perle, who has been the chairman of the Defense Policy Board, this is the board that talks to the President about what he should do with defense, today he said, "I think in this case international law stood in the way of doing the right thing." Now, consider what that means. International law says what we are doing is illegal, but we are going to go ahead and do it anyway because we made the decision that what we think is more important than international law.

[From The Guardian, Nov. 20, 2003]

WAR CRITICS ASTONISHED AS U.S. HAWK ADMITS INVASION WAS ILLEGAL

(By Oliver Burkeman and Julian Borger)

International lawyers and anti-war campaigners reacted with astonishment yesterday after the influential Pentagon hawk Richard Perle conceded that the invasion of Iraq had been illegal.

In a startling break with the official White House and Downing Street lines, Mr. Perle told an audience in London: "I think in this case international law stood in the way of doing the right thing."

President George Bush has consistently argued that the war was legal either because of existing UN security council resolutions on Iraq—also the British government's publicly stated view—or as an act of self-defence permitted by international law.

But Mr. Perle, a key member of the defence policy board, which advises the US defence secretary, Donald Rumsfeld, said that "international law . . . would have required us to leave Saddam Hussein alone", and this would have been morally unacceptable. French intrasigence, he added, meant there had been "no practical mechanism consistent with the rules of the UN for dealing with Saddam Hussein".

Mr. Perle, who was speaking at an event organised by the Institute of Contemporary Arts in London, had argued loudly for the toppling of the Iraqi dictator since the end of the 1991 Gulf war.

They're just not interested in international law, are they?" said Linda Hugl, a spokeswoman for the Campaign for Nuclear Disarmament, which launched a high court challenge to the war's legality last year. "It's only when the law suits them that they want to use it."

Mr. Perle's remarks bear little resemblance to official justifications for war, according to Rabinder Singh QC, who represented CND and also participated in Tuesday's event.

Certainly the British government, he said, "has never advanced the suggestion that it is entitled to act, or right to act, contrary to international law in relation to Iraq".

The Pentagon adviser's views, he added, underlined "a divergence of view between the British government and some senior voices in American public life [who] have expressed the view that, well, if it's the case that international law doesn't permit unilateral pre-emptive action without the authority of the UN, then the defect is in international law".

Mr. Perle's view is not the official one put forward by the White House. Its main argument has been that the invasion was justified under the UN charter, which guarantees the right of each state to self-defence, including pre-emptive self-defence. On the night bombing began, in March, Mr. Bush reiterated America's "sovereign authority to use force" to defeat the threat from Baghdad. The UN secretary general, Kofi Annan, has questioned that justification, arguing that the security . . .

Mr. DELAHUNT. Mr. Speaker, if I could interrupt, I think that is not only damning, but diminishes the prestige of the United States in terms of the world. There was a French man by the name of Alexis de Tocqueville that years ago as he was traveling through our Nation, our country, made the observation that America is great because America is good. And implicit in that observation is the acknowledgment that the United States respects the rule of law. If we do not have the rule of law, we have a jungle. And just imagine in this time where weapons of mass destruction are a threat to every human being, we just abrogate conventions, treaties, and ignore it is a national law. To me that is a profoundly damning statement.

Mr. McDERMOTT. Mr. Speaker, I think that says a lot about why we are in the problem we are in. Because Perle went on to say that international law would have required us to leave Saddam Hussein alone. He admits it. International law would have required us to leave Saddam Hussein alone.

Now, how can the President of the United States come before us and present this as an imminent danger and all this stuff when the law says you cannot do it? He did not want to go to the United Nations. We understand why he did not want to go to the United Nations. Why? If he had had to stand up to international law, he would never have been able to do this.

Perle went on to say, this is unbelievable, really, when you think about it, he said, "A divergence of view between the British Government and some senior voices in American public life who have expressed the view that, well, if it is the case that international law does not permit unilateral preemptive action without authority of the U.N., then the defect is in the international law."

Now, that is like driving down the highway and saying, well, I am in a hurry, and the speed says I can only go 40. The defect is in that sign. It is in the ordinance. I should be able to go 60 when I am in a hurry. I should not have to pay any attention. This country was hell bent to get into war. And they got into war.

Mr. DELAHUNT. Mr. Speaker, I think it is important to be very clear it was not this Nation, hopefully not even our President. But it was some within the administration that had a plan, a plan that would bring democracy, if you will, to the Middle East. And therefore, in the aftermath of 9/11, they were looking for a rationale that would somehow create a situation where the United States would intervene militarily in Iraq. That is, at least, my opinion. And I know that is shared by others.

Mr. McDERMOTT. Mr. Speaker, well, I think you and I and the gentleman from Washington (Mr. INSLEE) all voted no on this. So when I say our "country," I was really referring to the President. You are absolutely right. It was he and his advisors, a very small group around him known as neocons who believed from the day after 9/11, on 9/12 they started talking about how they could go to war in Iraq. And they had the most powerful military in the world and they knew they were going to win the battle, so to speak. But they had no plan for what they would do after that. They did not have one generator, one water purifier, one policeman, one anything ready to put on the ground to bring security and civil society back in Iraq.

□ 2340

And the mess we are into now is really about this. That is why it is so good that the gentleman brought this up tonight.

Mr. DELAHUNT. Let me just say this, I think all of us voted to intervene militarily in Afghanistan. And I know that the gentleman from Washington (Mr. INSLEE) did because we did have a right to intervene militarily there. We knew that al Qaeda had found a safe haven provided for bit extremist Taliban government. We had every right. Unfortunately, because of the impetus to intervene in Iraq and the decision to intervene militarily in Iraq, we now find ourselves with a real mess, parts of that $87 billion mess in Iraq. And the comments from both sides of the aisle, from people like Senator HAGEL, Senator LUGAR, people such as the chair of the Committee on Appropriations, Subcommittee on Defense, the gentleman from California (Mr. LEWIS), and others respected, deplore and have articulated their profound concern about the fact that Afghanistan, where we should be with substantial force, is on the verge of once again becoming a failed state.

When the question is posed, did we ever win the war on terror, I fear that the answer will be we won it and then we lost it in Afghanistan. And I would request or ask my friend, the gentleman from Washington (Mr. INSLEE) if he wishes to comment.

Mr. INSLEE. Mr. Speaker, I do. And I have come here based on some conversations I have had in the last couple of weeks with the father of a soldier who was killed in Iraq, the wife of a soldier who was killed in Iraq from the State of Washington. I met about a week and a half ago with a soldier with a shattered leg over in Walter Reed, actually two soldiers with shattered legs; and that is one of the great, unfortunately, hidden tragedies of this war the number of terrible injuries that have come out of it. That has been kind of hidden, and I think it is unfortunate that folks do not understand how terrible these young men are being injured. In part because of our tremendous medical care, we have saved people that never would have lived in previous wars, but they come away with some terrible injuries.

But the reason I came here tonight is just to say that the U.S. Congress owes it to these men and women in uniform who are serving proudly tonight to not ignore them and not give up trying to help resolve this mess, and that silence is not an option for the U.S. Congress. We took a vote but that was only the start of our obligation to these people who are serving in Iraq tonight. And I just have two messages that I hope the administration would listen to to try to get out of this mess.

One is to finally develop a meaningful plan, to develop a recognizable, credible Iraqi government so that the Iraqi people could have some credibility in the government, so that hopefully at some point we can bring our men and women home; and they are still on the wrong path failing in that fundamental obligation. Our mission is doomed there until this administration has a workable plan to develop a credible government in Iraq. They have failed in that fundamental mission, in a stumbling, bumbling mechanism.

I will state, we stood in a meeting room about a hundred yards from here very shortly before the war started and said, Where is your plan for postwar Iraq? Where is your plan for establishing a credible government in Iraq so that we can bring our troops home?

Do you know what their answer was? We are starting to think about that. And that is not too much of a paraphrase of what they told us. And now they still are making a fundamental mistake of thinking that we can establish a government by our order as to who will be the governing authority without the involvement of the international community.

We still need to get international folks of other countries involved in there to help develop a credible government. And until we do that, we are not going to win the hearts and minds of the people no matter how many thousand-pound bombs we drop.

Mr. McDERMOTT. The gentleman raises the question about what the plan was before the war. There was a lot of talk in the government that they wanted to use a guy named Chalabi. And I asked some Iraqis in the United States here about whether Chalabi would be the right guy. They said he is hated by the Kurds. He is hated by the Sunnis. He is hated by the Shia. Maybe it is a good idea to put him in there because he is gone. We are putting all our eggs in Chalabi's basket.

Mr. DELAHUNT. Mr. Speaker, I have some very bad news for the gentleman then. If we accept the idea or the conclusion that he is gone, because Ahmed Chalabi is not gone. There was a report today in the New York Times, and let me vote quote the relevant portion.

The SPEAKER pro tempore (Mr. ROGERS of Alabama). The gentleman from Massachusetts (Mr. DELAHUNT) is recognized for an additional 15 minutes.

Mr. DELAHUNT. Mr. Speaker, I am quoting from today's New York Times regarding this new temporary, tentative, possible plan.

Another possibility some in the administration say is that Iraq could evolve towards a political compromise forced by the exile Ahmed Chalabi, Chalabi might manage to stitch together pro-Iranian groups, Kurds and others into a government, a top administration official predicted recently that in that event Mr. Chalabi, who set up an office for his opposition group in Tehran before the American invasion of Iraq, could become the first prime minister.

Well, I guess the question is, who is Ahmed Chalabi? Well, to go back to the comments that the gentleman made earlier regarding Mr. Perle, he and Mr. Perle are very close, are allied together. They have had a long relationship. Mr. Perle some believe is the, if you will, the author or the architect of this policy, described Mr. Chalabi in the most effusive of terms, as if he were going to be the George Washington of Iraq.

What the American people are unaware of, however, is that Mr. Chalabi fled Iraq, went to Jordan, got into the banking business, and was convicted of the crime of embezzling some $70 million.

Now, I am not particularly conversant with the Jordanian legal system, but I know this, that Mr. Chalabi has a sentence hanging over his head from a Jordanian court of some 22 years.

Now, our relationship with Jordan has been a positive one, and we see some incipient signs of democracy there. When King Abdallah came here, I inquired of him, Were you ever consulted by the Department of State or anyone in the White House about the appointment of this convicted felon according to Jordanian law in terms of his appointment to the Iraqi governing council? And he said, No, Mr. Congressman, I was not.

What a great way to create good will among our allies in the war against terrorism. Who is Ahmed Chalabi? And top administration is suggesting that he might be the next prime minister when he has absolutely no support among the Iraqi people, none at all. He lived in London after he fled Jordan for decades.

I am really concerned about the mess we are in.

Mr. INSLEE. If I may inquire, basically what we have is it sounds like the only international support the administration has had to try to help establish a new Iraqi government is a fellow from London, Mr. Chalabi, and that is not what we think we need when it comes to international support to try and establish a government. Because we know that ultimately to bring our men and women home, we are going to have to be in a position where there is a secure government that has some degree of trust to the Iraqi people. And the one thing we know is a decision, a unilateral decision by the United States to decide who that is is not working at the moment.

□ 2350

We believe and have been arguing now since the beginning of hostilities that involving the international community to help establish a definition who is going to be at the table when the constitution is adopted, when the elections are set up, are going to help get the hearts and minds of the Iraqi people which ultimately we need to succeed in this mission.

So we are here again tonight urging the administration to learn from past problems and indeed mistakes. One of those mistakes has been acting with such unilateralism, and unilateralism to date has resulted in folks allegedly running Iraq with no security and no credibility. So we will continue to beat that drum, and we hope at some point the administration will learn from these past errors.

I want to mention another thing, too, that I hope that Congress does not lose sight of its responsibility to the men and women in Iraq tonight. Those men and women deserve to know why Americans did not get the straight scoop before this war started, and we just began just the baby step for Congress to start to get to the root of why Americans were told things that were not true before this war started. We owe this to the people in the field right now in Iraq, and we are going to call on the administration to stop stonewalling on that investigation.

We have been trying to get multiple documents. We are not getting that, and it is interesting to me, when a true patriot, Joe Wilson, who was an ambassador, who was called a hero by the first President Bush for serving as the last counselor in Iraq, who stood up to Saddam Hussein and maybe saved hundreds of Americans before the first Persian Gulf War, when he helped blow the whistle and indicate there had been a mistake in the State of the Union address that came from that podium out to the American people, when he helped demonstrate that there had been a mistake made by the President as to what he said when he said that there was this uranium in Africa, what did the administration do? Instead of thanking Mr. Wilson for helping correct a mistake that the President had made on a pivotal issue and on which they had hung the hat to start this war, instead somebody in the administration, and we better darn well find out who blew the cover on Mr. Wilson's wife as a CIA agent, and that is the type of attitude to date this administration has in getting to the bottom of why we did not get the truth before this war started.

Mr. McDERMOTT. My colleagues are both lawyers. My understanding is they broke a law. It is a felony. Somebody broke the law.

Mr. INSLEE. It appears that there could have been a felony committed; but even if there was not a felony committed, this administration, instead of thanking Mr. Wilson for correcting this grievous mistake that the President made in the State of the Union address, I do not recall he has ever thanked Mr. Wilson. Instead, they have hunkered down and they have refused to recognize that this war was started on the basis of false information given to the American people, and we need to know and the people serving in Iraq tonight deserve to know how and why that happened because it should not happen again.

Now, if, in fact, it was a simple failure of intelligence by the CIA, and that the White House, all they did was convey to us the purest, most virginal intelligence given to them by the CIA, we need to know that; but if, in fact, that was not the case, if, in fact, it was the case that they took information and exaggerated it, stretched it, fudged it, told us things were certain when there was doubt, we need to know that, too; and this Congress has an obligation to get to the bottom of it. I hope that we have just started that process.

With that, I need to bid adieu.

Mr. DELAHUNT. Mr. Speaker, I thank the gentleman for joining us tonight and thank him for his input. I think he goes to the issue of credibility.

Recently, there was a report by a conservative magazine, the Weekly Standard, that said case closed. They established a memorandum that was leaked. Somehow, in their calculation, it was conclusive as to links between Saddam Hussein and Osama bin Laden.

The gentleman from Washington (Mr. McDERMOTT) circulated a memorandum to all of us here in the House with a statement from the Department of Defense. If the gentleman wants to give us a synopsis, I would be fascinated, and I hope those who are listening would pay attention.

Mr. McDERMOTT. It basically absolutely contradicted what has come out of this Weekly Standard article, and in fact, the Weekly Standard is really the mouthpiece for the neocons, Perle and Wolfowitz and all these people who have been involved in this, and the Defense Department came out and said, this is wrong. I mean, they are trying to bury it. They are trying to stonewall it, and that is why we are out here tonight.

Mr. DELAHUNT. Mr. Speaker, I want to compliment the White House for finally being honest with the American people as it relates to Afghanistan. Again, from this week, Wednesday, November 19, the new ambassador to Afghanistan, Ambassador Kahlizad, gave the administration's bleakest assessment yet of security conditions in Afghanistan, saying that a regrouping of the Taliban and al Qaeda, increased drug trafficking and even common criminals are hampering President Karzai and the transition to democracy. Taliban rebels have dramatically stepped up operations in recent months and, the ambassador said, common criminals and al Qaeda followers are increasingly active. This is most disturbing news.

There was an interesting and, again, unfortunate story coming from the United Nations. This week reported in the New York Times, the United Nations refugee agency announced Tuesday that it was temporarily pulling 30 foreign staff members out of large areas of southern and eastern Afghanistan and closing refugee reception centers in four provinces, officials said. The suspension of operations comes after three attacks on the United Nations offices and staff members in the last week by suspected Taliban fighters.

Mr. McDERMOTT. Mr. Speaker, what the gentleman is doing is shining the light on the fact that we never finished the job..

Mr. DELAHUNT. We never finished the job in Afghanistan.

Mr. McDERMOTT. They never put up a sign that said mission accomplished for Afghanistan.

Mr. DELAHUNT. The gentleman is absolutely right.

Mr. McDERMOTT. And left a mess and went on to Iraq, and now we have got two messes on our hands. The gentleman is absolutely right, what is happening in Afghanistan is a terrible mess.

Mr. DELAHUNT. To think that our military, as it has in Iraq, performed so professionally and admirably in Afghanistan, and now we are on the verge of seeing Afghanistan becoming a failed state.

Nicolas Kristoff, a columnist in the New York Times, says, and again it is this week, in the 2 years since the war in Afghanistan, opium production, and he has given us three choices, virtually been eliminated, declined 30 percent, soared 19-fold and become the major source of the world's heroin. That is what is happening in Afghanistan today.

In two provinces that are religiously conservative parts of Afghanistan, the number of children going to school has quintupled, has risen 40 percent, has plummeted as poor security has closed nearly all the schools there. The right answer is the last one.

This is truly potentially a disaster. President Karzai's brother, Ahmed Karzai, who represents the government in one of the southern provinces, was very blunt to an AP reporter this past Monday: it is like I am seeing the same movie twice, and no one is trying to fix the problem. What was promised to Afghans with the collapse of the Taliban was a new life of hope and change. Those are the words of President Bush, but what was delivered, nothing. There had been no significant changes for people. Karzai says he does not know what to say to people anymore.

We better pay attention to Afghanistan because with the focus now on Iraq, the media is taking the glare of the cameras away from a totally, potentially disastrous situation. They are scheduled to have elections in Afghanistan next June. It is estimated that the need would be for 70,000 police security forces. Does my colleague know how many have been trained? Does the gentleman know how many have been trained? Seven thousand, 7,000. This is, again, a potential foreign policy disaster, not just for this President but for this country.

With that, if the gentleman has anything further to say.

Mr. McDERMOTT. Mr. Speaker, I think we have said enough for tonight, but this issue will not go away.

One fact that I will finish with, this week now, more people have died in Iraq since the war began than died in the first 3 full years in Vietnam. So if we do not think we have got a developing mess on our hands, just remember how we eased into Vietnam, and this is where we are going if this administration does not begin to develop a plan.

Mr. DELAHUNT. Twenty-six people died today in Turkey, the victims of an act of terrorism. Some 400 were wounded. In the northern part of Iraq, not in the so-called Sunni Triangle, 12 died as a result of acts of terrorism in northern Iraq.

We are in a mess. Let us get our act together. Let us support our President, but let us do it in consultation and make sure that America can continue to be proud and claim that it is great because it is good and it has a moral compass.

RECESS

The SPEAKER pro tempore (Mr. ROGERS of Alabama). Pursuant to clause 12(a) of rule I, the Chair declares the House in recess subject to the call of the Chair.

Accordingly (at midnight), the House stood in recess subject to the call of the Chair.

☐ 0117

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. NUNES) at 1 o'clock and 17 minutes a.m.

CONFERENCE REPORT ON H.R. 1, MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003

Mr. THOMAS submitted the following conference report and statement on the bill (H.R. 1) to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes:

CONFERENCE REPORT (H. REPT. 108-391)

The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 1), to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment, insert the following.

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BIPA AND SECRETARY; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003".

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in division A of this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) BIPA; SECRETARY.—In this Act:

(1) BIPA.—The term "BIPA" means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106–554.

(2) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(d) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references to BIPA and Secretary; table of contents.

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Sec. 101. Medicare prescription drug benefit.

"PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

"Subpart 1—Part D Eligible Individuals and Prescription Drug Benefits

"Sec. 1860D–1. Eligibility, enrollment, and information.
"Sec. 1860D–2. Prescription drug benefits.
"Sec. 1860D–3. Access to a choice of qualified prescription drug coverage.
"Sec. 1860D–4. Beneficiary protections for qualified prescription drug coverage.

"Subpart 2—Prescription Drug Plans; PDP Sponsors; Financing

"Sec. 1860D–11. PDP regions; submission of bids; plan approval.

"Sec. 1860D–12. Requirements for and contracts with prescription drug plan (PDP) sponsors.
"Sec. 1860D–13. Premiums; late enrollment penalty.
"Sec. 1860D–14. Premium and cost-sharing subsidies for low-income individuals.
"Sec. 1860D–15. Subsidies for part D eligible individuals for qualified prescription drug coverage.
"Sec. 1860D–16. Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.

"Subpart 3—Application to Medicare Advantage Program and Treatment of Employer-Sponsored Programs and Other Prescription Drug Plans

"Sec. 1860D–21. Application to Medicare Advantage program and related managed care programs.
"Sec. 1860D–22. Special rules for employer-sponsored programs.
"Sec. 1860D–23. State pharmaceutical assistance programs.
"Sec. 1860D–24. Coordination requirements for plans providing prescription drug coverage.

"Subpart 4—Medicare Prescription Drug Discount Card and Transitional Assistance Program

"Sec. 1860D–31. Medicare prescription drug discount card and transitional assistance program.

"Subpart 5—Definitions and Miscellaneous Provisions

"Sec. 1860D–41. Definitions; treatment of references to provisions in part C.
"Sec. 1860D–42. Miscellaneous provisions.
Sec. 102. Medicare Advantage conforming amendments.
Sec. 103. Medicaid amendments.
Sec. 104. Medigap amendments.
Sec. 105. Additional provisions relating to medicare prescription drug discount card and transitional assistance program.
Sec. 106. State Pharmaceutical Assistance Transition Commission.
Sec. 107. Studies and reports.
Sec. 108. Grants to physicians to implement electronic prescription drug programs.
Sec. 109. Expanding the work of medicare Quality Improvement Organizations to include parts C and D.
Sec. 110. Conflict of interest study.
Sec. 111. Study on employment-based retiree health coverage.

TITLE II—MEDICARE ADVANTAGE

Subtitle A—Implementation of Medicare Advantage Program

Sec. 201. Implementation of Medicare Advantage program.

Subtitle B—Immediate Improvements

Sec. 211. Immediate improvements.

Subtitle C—Offering of Medicare Advantage (MA) Regional Plans; Medicare Advantage Competition

Sec. 221. Establishment of MA regional plans.
Sec. 222. Competition program beginning in 2006.
Sec. 223. Effective date.

Subtitle D—Additional Reforms

Sec. 231. Specialized MA plans for special needs individuals.
Sec. 232. Avoiding duplicative State regulation.
Sec. 233. Medicare MSAs.
Sec. 234. Extension of reasonable cost contracts.
Sec. 235. 2-year extension of municipal health service demonstration projects.
Sec. 236. Payment by PACE providers for medicare and medicaid services furnished by noncontract providers.
Sec. 237. Reimbursement for Federally qualified health centers providing services under MA plans.
Sec. 238. Institute of Medicine evaluation and report on health care performance measures.

Subtitle E—Comparative Cost Adjustment (CCA) Program

Sec. 241. Comparative Cost Adjustment (CCA) program.

TITLE III—COMBATTING WASTE, FRAUD, AND ABUSE

Sec. 301. Medicare secondary payor (MSP) provisions.
Sec. 302. Payment for durable medical equipment; competitive acquisition of certain items and services.
Sec. 303. Payment reform for covered outpatient drugs and biologicals.
Sec. 304. Extension of application of payment reform for covered outpatient drugs and biologicals to other physician specialties.
Sec. 305. Payment for inhalation drugs.
Sec. 306. Demonstration project for use of recovery audit contractors.
Sec. 307. Pilot program for national and State background checks on direct patient access employees of long-term care facilities or providers.

TITLE IV—RURAL PROVISIONS

Subtitle A—Provisions Relating to Part A Only

Sec. 401. Equalizing urban and rural standardized payment amounts under the medicare inpatient hospital prospective payment system.
Sec. 402. Enhanced disproportionate share hospital (DSH) treatment for rural hospitals and urban hospitals with fewer than 100 beds.
Sec. 403. Adjustment to the medicare inpatient hospital prospective payment system wage index to revise the labor-related share of such index.
Sec. 404. More frequent update in weights used in hospital market basket.
Sec. 405. Improvements to critical access hospital program.
Sec. 406. Medicare inpatient hospital payment adjustment for low-volume hospitals.
Sec. 407. Treatment of missing cost reporting periods for sole community hospitals.
Sec. 408. Recognition of attending nurse practitioners as attending physicians to serve hospice patients.
Sec. 409. Rural hospice demonstration project.
Sec. 410. Exclusion of certain rural health clinic and federally qualified health center services from the prospective payment system for skilled nursing facilities.
Sec. 410A. Rural community hospital demonstration program.

Subtitle B—Provisions Relating to Part B Only

Sec. 411. 2-year extension of hold harmless provisions for small rural hospitals and sole community hospitals under the prospective payment system for hospital outpatient department services.
Sec. 412. Establishment of floor on work geographic adjustment.
Sec. 413. Medicare incentive payment program improvements for physician scarcity.
Sec. 414. Payment for rural and urban ambulance services.
Sec. 415. Providing appropriate coverage of rural air ambulance services.
Sec. 416. Treatment of certain clinical diagnostic laboratory tests furnished to hospital outpatients in certain rural areas.
Sec. 417. Extension of telemedicine demonstration project.
Sec. 418. Report on demonstration project permitting skilled nursing facilities to be originating telehealth sites; authority to implement.

Subtitle C—Provisions Relating to Parts A and B

Sec. 421. 1-year increase for home health services furnished in a rural area.
Sec. 422. Redistribution of unused resident positions.

Subtitle D—Other Provisions

Sec. 431. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.
Sec. 432. Office of Rural Health Policy improvements.
Sec. 433. MedPAC study on rural hospital payment adjustments.
Sec. 434. Frontier extended stay clinic demonstration project.

TITLE V—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

Sec. 501. Revision of acute care hospital payment updates.
Sec. 502. Revision of the indirect medical education (IME) adjustment percentage.
Sec. 503. Recognition of new medical technologies under inpatient hospital prospective payment system.
Sec. 504. Increase in Federal rate for hospitals in Puerto Rico.
Sec. 505. Wage index adjustment reclassification reform.
Sec. 506. Limitation on charges for inpatient hospital contract health services provided to Indians by medicare participating hospitals.
Sec. 507. Clarifications to certain exceptions to medicare limits on physician referrals.
Sec. 508. 1-Time appeals process for hospital wage index classification.

Subtitle B—Other Provisions

Sec. 511. Payment for covered skilled nursing facility services.
Sec. 512. Coverage of hospice consultation services.
Sec. 513. Study on portable diagnostic ultrasound services for beneficiaries in skilled nursing facilities.

TITLE VI—PROVISIONS RELATING TO PART B

Subtitle A—Provisions Relating to Physicians' Services

Sec. 601. Revision of updates for physicians' services.
Sec. 602. Treatment of physicians' services furnished in Alaska.
Sec. 603. Inclusion of podiatrists, dentists, and optometrists under private contracting authority.
Sec. 604. GAO study on access to physicians' services.
Sec. 605. Collaborative demonstration-based review of physician practice expense geographic adjustment data.
Sec. 606. MedPAC report on payment for physicians' services.

Subtitle B—Preventive Services

Sec. 611. Coverage of an initial preventive physical examination.

Sec. 612. Coverage of cardiovascular screening blood tests.
Sec. 613. Coverage of diabetes screening tests.
Sec. 614. Improved payment for certain mammography services.

Subtitle C—Other Provisions

Sec. 621. Hospital outpatient department (HOPD) payment reform.
Sec. 622. Limitation of application of functional equivalence standard.
Sec. 623. Payment for renal dialysis services.
Sec. 624. 2-year moratorium on therapy caps; provisions relating to reports.
Sec. 625. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.
Sec. 626. Payment for services furnished in ambulatory surgical centers.
Sec. 627. Payment for certain shoes and inserts under the fee schedule for orthotics and prosthetics.
Sec. 628. Payment for clinical diagnostic laboratory tests.
Sec. 629. Indexing part B deductible to inflation.
Sec. 630. 5-year authorization of reimbursement for all medicare part B services furnished by certain Indian hospitals and clinics.

Subtitle D—Additional Demonstrations, Studies, and Other Provisions

Sec. 641. Demonstration project for coverage of certain prescription drugs and biologicals.
Sec. 642. Extension of coverage of Intravenous Immune Globulin (IVIG) for the treatment of primary immune deficiency diseases in the home.
Sec. 643. MedPAC study of coverage of surgical first assisting services of certified registered nurse first assistants.
Sec. 644. MedPAC study of payment for cardiothoracic surgeons.
Sec. 645. Studies relating to vision impairments.
Sec. 646. Medicare health care quality demonstration programs.
Sec. 647. MedPAC study on direct access to physical therapy services.
Sec. 648. Demonstration project for consumer-directed chronic outpatient services.
Sec. 649. Medicare care management performance demonstration.
Sec. 650. GAO study and report on the propagation of concierge care.
Sec. 651. Demonstration of coverage of chiropractic services under medicare.

TITLE VII—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

Sec. 701. Update in home health services.
Sec. 702. Demonstration project to clarify the definition of homebound.
Sec. 703. Demonstration project for medical adult day care services.
Sec. 704. Temporary suspension of OASIS requirement for collection of data on non-medicare and non-medicaid patients.
Sec. 705. MedPAC study on medicare margins of home health agencies.
Sec. 706. Coverage of religious nonmedical health care institution services furnished in the home.

Subtitle B—Graduate Medical Education

Sec. 711. Extension of update limitation on high cost programs.
Sec. 712. Exception to initial residency period for geriatric residency or fellowship programs.
Sec. 713. Treatment of volunteer supervision.

Subtitle C—Chronic Care Improvement

Sec. 721. Voluntary chronic care improvement under traditional fee-for-service.
Sec. 722. Medicare Advantage quality improvement programs.
Sec. 723. Chronically ill medicare beneficiary research, data, demonstration strategy.

Subtitle D—Other Provisions

Sec. 731. Improvements in national and local coverage determination process to respond to changes in technology.
Sec. 732. Extension of treatment of certain physician pathology services under medicare.
Sec. 733. Payment for pancreatic islet cell investigational transplants for medicare beneficiaries in clinical trials.
Sec. 734. Restoration of medicare trust funds.
Sec. 735. Modifications to Medicare Payment Advisory Commission (MedPAC).
Sec. 736. Technical amendments.

TITLE VIII—COST CONTAINMENT

Subtitle A—Cost Containment

Sec. 801. Inclusion in annual report of medicare trustees of information on status of medicare trust funds.
Sec. 802. Presidential submission of legislation.
Sec. 803. Procedures in the House of Representatives.
Sec. 804. Procedures in the Senate.

Subtitle B—Income-Related Reduction in Part B Premium Subsidy

Sec. 811. Income-related reduction in part B premium subsidy.

TITLE IX—ADMINISTRATIVE IMPROVEMENTS, REGULATORY REDUCTION, AND CONTRACTING REFORM

Sec. 900. Administrative improvements within the Centers for Medicare & Medicaid Services (CMS).

Subtitle A—Regulatory Reform

Sec. 901. Construction; definition of supplier.
Sec. 902. Issuance of regulations.
Sec. 903. Compliance with changes in regulations and policies.
Sec. 904. Reports and studies relating to regulatory reform.

Subtitle B—Contracting Reform

Sec. 911. Increased flexibility in medicare administration.
Sec. 912. Requirements for information security for medicare administrative contractors.

Subtitle C—Education and Outreach

Sec. 921. Provider education and technical assistance.
Sec. 922. Small provider technical assistance demonstration program.
Sec. 923. Medicare Beneficiary Ombudsman.
Sec. 924. Beneficiary outreach demonstration program.
Sec. 925. Inclusion of additional information in notices to beneficiaries about skilled nursing facility benefits.
Sec. 926. Information on medicare-certified skilled nursing facilities in hospital discharge plans.

Subtitle D—Appeals and Recovery

Sec. 931. Transfer of responsibility for medicare appeals.
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TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

SEC. 101. MEDICARE PRESCRIPTION DRUG BENEFIT.

(a) IN GENERAL.—Title XVIII is amended—

(1) by redesignating part D as part E; and

(2) by inserting after part C the following new part:

"PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

"Subpart 1—Part D Eligible Individuals and Prescription Drug Benefits

"ELIGIBILITY, ENROLLMENT, AND INFORMATION

"SEC. 1860D–1. (a) PROVISION OF QUALIFIED PRESCRIPTION DRUG COVERAGE THROUGH ENROLLMENT IN PLANS.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this part, each part D eligible individual (as defined in paragraph (3)(A)) is entitled to obtain qualified prescription drug coverage (described in section 1860D–2(a)) as follows:

"(A) FEE-FOR-SERVICE ENROLLEES MAY RECEIVE COVERAGE THROUGH A PRESCRIPTION DRUG PLAN.—A part D eligible individual who is not enrolled in an MA plan may obtain qualified prescription drug coverage through enrollment in a prescription drug plan (as defined in section 1860D–41(a)(14)).

"(B) MEDICARE ADVANTAGE ENROLLEES.—

"(i) ENROLLEES IN A PLAN PROVIDING QUALIFIED PRESCRIPTION DRUG COVERAGE RECEIVE COVERAGE THROUGH THE PLAN.—A part D eligible individual who is enrolled in an MA–PD plan obtains such coverage through such plan.

"(ii) LIMITATION ON ENROLLMENT OF MA PLAN ENROLLEES IN PRESCRIPTION DRUG PLANS.—Except as provided in clauses (iii) and (iv), a part D eligible individual who is enrolled in an MA plan may not enroll in a prescription drug plan under this part.

"(iii) PRIVATE FEE-FOR-SERVICE ENROLLEES IN MA PLANS NOT PROVIDING QUALIFIED PRESCRIPTION DRUG COVERAGE PERMITTED TO ENROLL IN A PRESCRIPTION DRUG PLAN.—A part D eligible individual who is enrolled in an MA private fee-for-service plan (as defined in section 1859(b)(2)) that does not provide qualified prescription drug coverage may obtain qualified prescription drug coverage through enrollment in a prescription drug plan.

"(iv) ENROLLEES IN MSA PLANS PERMITTED TO ENROLL IN A PRESCRIPTION DRUG PLAN.—A part D eligible individual who is enrolled in an MSA plan (as defined in section 1859(b)(3)) may obtain qualified prescription drug coverage through enrollment in a prescription drug plan.

"(2) COVERAGE FIRST EFFECTIVE JANUARY 1, 2006.—Coverage under prescription drug plans and MA–PD plans shall first be effective on January 1, 2006.

"(3) DEFINITIONS.—For purposes of this part:

"(A) PART D ELIGIBLE INDIVIDUAL.—The term 'part D eligible individual' means an individual who is entitled to benefits under part A or enrolled under part B.

"(B) MA PLAN.—The term 'MA plan' has the meaning given such term in section 1859(b)(1).

"(C) MA–PD PLAN.—The term 'MA–PD plan' means an MA plan that provides qualified prescription drug coverage.

"(b) ENROLLMENT PROCESS FOR PRESCRIPTION DRUG PLANS.—

"(1) ESTABLISHMENT OF PROCESS.—

"(A) IN GENERAL.—The Secretary shall establish a process for the enrollment, disenrollment, termination, and change of enrollment of part D eligible individuals in prescription drug plans consistent with this subsection.

"(B) APPLICATION OF MA RULES.—In establishing such process, the Secretary shall use rules similar to (and coordinated with) the rules for enrollment, disenrollment, termination, and change of enrollment with an MA–PD plan under the following provisions of section 1851:

"(i) RESIDENCE REQUIREMENTS.—Section 1851(b)(1)(A), relating to residence requirements.

"(ii) EXERCISE OF CHOICE.—Section 1851(c) (other than paragraph (3)(A) of such section), relating to exercise of choice.

"(iii) COVERAGE ELECTION PERIODS.—Subject to paragraphs (2) and (3) of this subsection, section 1851(e) (other than subparagraphs (B) and (C) of paragraph (2) and the second sentence of paragraph (4) of such section), relating to coverage election periods, including initial periods, annual coordinated election periods, special election periods, and election periods for exceptional circumstances.

"(iv) COVERAGE PERIODS.—Section 1851(f), relating to effectiveness of elections and changes of elections.

"(v) GUARANTEED ISSUE AND RENEWAL.—Section 1851(g) (other than paragraph (2) of such section and clause (i) and the second sentence of clause (ii) of paragraph (3)(C) of such section), relating to guaranteed issue and renewal.

"(vi) MARKETING MATERIAL AND APPLICATION FORMS.—Section 1851(h), relating to approval of marketing material and application forms.

In applying clauses (ii), (iv), and (v) of this subparagraph, any reference to section 1851(e) shall be treated as a reference to such section as applied pursuant to clause (iii) of this subparagraph.

"(C) SPECIAL RULE.—The process established under subparagraph (A) shall include, in the case of a part D eligible individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) who has failed to enroll in a prescription drug plan or an MA–PD plan, for the enrollment in a prescription drug plan that has a monthly beneficiary premium that does not exceed the premium assistance available under section 1860D–14(a)(1)(A)). If there is more than one such plan available, the Secretary shall enroll such an individual on a random basis among all such plans in the PDP region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.

"(2) INITIAL ENROLLMENT PERIOD.—

"(A) PROGRAM INITIATION.—In the case of an individual who is a part D eligible individual as of November 15, 2005, there shall be an initial enrollment period that shall be the same as the annual, coordinated open election period described in section 1851(e)(3)(B)(iii), as applied under paragraph (1)(B)(iii).

"(B) CONTINUING PERIODS.—In the case of an individual who becomes a part D eligible individual after November 15, 2005, there shall be an initial enrollment period which is the period under section 1851(e)(1), as applied under paragraph (1)(B)(iii) of this section, as if 'entitled to benefits under part A or enrolled under part B' were substituted for 'entitled to benefits under part A and enrolled under part B', but in no case shall such period end before the period described in subparagraph (A).

"(3) ADDITIONAL SPECIAL ENROLLMENT PERIODS.—The Secretary shall establish special enrollment periods, including the following:

"(A) INVOLUNTARY LOSS OF CREDITABLE PRESCRIPTION DRUG COVERAGE.—

"(i) IN GENERAL.—In the case of a part D eligible individual who involuntarily loses creditable prescription drug coverage (as defined in section 1860D–13(b)(4)).

"(ii) NOTICE.—In establishing special enrollment periods under clause (i), the Secretary shall take into account when the part D eligible individuals are provided notice of the loss of creditable prescription drug coverage.

"(iii) FAILURE TO PAY PREMIUM.—For purposes of clause (i), a loss of coverage shall be treated as voluntary if the coverage is terminated because of failure to pay a required beneficiary premium.

"(iv) REDUCTION IN COVERAGE.—For purposes of clause (i), a reduction in coverage so that the coverage no longer meets the requirements under section 1860D–13(b)(5) (relating to actuarial equivalence) shall be treated as an involuntary loss of coverage.

"(B) ERRORS IN ENROLLMENT.—In the case described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B.

"(C) EXCEPTIONAL CIRCUMSTANCES.—In the case of part D eligible individuals who meet such exceptional conditions (in addition to those conditions applied under paragraph (1)(B)(iii)) as the Secretary may provide.

"(D) MEDICAID COVERAGE.—In the case of an individual (as determined by the Secretary) who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)).

"(E) DISCONTINUANCE OF MA–PD ELECTION DURING FIRST YEAR OF ELIGIBILITY.—In the case of a part D eligible individual who discontinues enrollment in an MA–PD plan under the second sentence of section 1851(e)(4) at the time of the election of coverage under such sentence under the original medicare fee-for-service program.

"(4) INFORMATION TO FACILITATE ENROLLMENT.—

"(A) IN GENERAL.—Notwithstanding any other provision of law but subject to subparagraph (B), the Secretary may provide to each PDP sponsor and MA organization such identifying information about part D eligible individuals as the Secretary determines to be necessary to facilitate efficient marketing of prescription drug plans and MA–PD plans to such individuals and enrollment of such individuals in such plans.

"(B) LIMITATION.—

"(i) PROVISION OF INFORMATION.—The Secretary may provide the information under subparagraph (A) only to the extent necessary to carry out such subparagraph.

"(ii) USE OF INFORMATION.—Such information provided by the Secretary to a PDP sponsor or an MA organization may be used by such sponsor or organization only to facilitate marketing of, and enrollment of part D eligible individuals in, prescription drug plans and MA–PD plans.

"(5) REFERENCE TO ENROLLMENT PROCEDURES FOR MA–PD PLANS.—For rules applicable to enrollment, disenrollment, termination, and change of enrollment of part D eligible individuals in MA–PD plans, see section 1851.

"(6) REFERENCE TO PENALTIES FOR LATE ENROLLMENT.—Section 1860D–13(b) imposes a late enrollment penalty for part D eligible individuals who—

"(A) enroll in a prescription drug plan or an MA–PD plan after the initial enrollment period described in paragraph (2); and

"(B) fail to maintain continuous creditable prescription drug coverage during the period of non-enrollment.

"(c) PROVIDING INFORMATION TO BENEFICIARIES.—

"(1) ACTIVITIES.—The Secretary shall conduct activities that are designed to broadly disseminate information to part D eligible individuals (and prospective part D eligible individuals) regarding the coverage provided under this part. Such activities shall ensure that such information is first made available at least 30 days prior *to the initial enrollment period described in subsection (b)(2)(A).*

“(2) REQUIREMENTS.—The activities described in paragraph (1) shall—

“(A) be similar to the activities performed by the Secretary under section 1851(d), including dissemination (including through the toll-free telephone number 1–800–MEDICARE) of comparative information for prescription drug plans and MA–PD plans; and

“(B) be coordinated with the activities performed by the Secretary under such section and under section 1804.

“(3) COMPARATIVE INFORMATION.—

“(A) IN GENERAL.—Subject to subparagraph (B), the comparative information referred to in paragraph (2)(A) shall include a comparison of the following with respect to qualified prescription drug coverage:

“(i) BENEFITS.—The benefits provided under the plan.

“(ii) MONTHLY BENEFICIARY PREMIUM.—The monthly beneficiary premium under the plan.

“(iii) QUALITY AND PERFORMANCE.—The quality and performance under the plan.

“(iv) BENEFICIARY COST-SHARING.—The cost-sharing required of part D eligible individuals under the plan.

“(v) CONSUMER SATISFACTION SURVEYS.—The results of consumer satisfaction surveys regarding the plan conducted pursuant to section 1860D–4(d).

“(B) EXCEPTION FOR UNAVAILABILITY OF INFORMATION.—The Secretary is not required to provide comparative information under clauses (iii) and (v) of subparagraph (A) with respect to a plan—

“(i) for the first plan year in which it is offered; and

“(ii) for the next plan year if it is impracticable or the information is otherwise unavailable.

“(4) INFORMATION ON LATE ENROLLMENT PENALTY.—The information disseminated under paragraph (1) shall include information concerning the methodology for determining the late enrollment penalty under section 1860D–13(b).

“PRESCRIPTION DRUG BENEFITS

“SEC. 1860D–2. (a) REQUIREMENTS.—

“(1) IN GENERAL.—For purposes of this part and part C, the term ‘qualified prescription drug coverage’ means either of the following:

“(A) STANDARD PRESCRIPTION DRUG COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard prescription drug coverage (as defined in subsection (b)) and access to negotiated prices under subsection (d).

“(B) ALTERNATIVE PRESCRIPTION DRUG COVERAGE WITH AT LEAST ACTUARIALLY EQUIVALENT BENEFITS AND ACCESS TO NEGOTIATED PRICES.—Coverage of covered part D drugs which meets the alternative prescription drug coverage requirements of subsection (c) and access to negotiated prices under subsection (d), but only if the benefit design of such coverage is approved by the Secretary, as provided under subsection (c).

“(2) PERMITTING SUPPLEMENTAL PRESCRIPTION DRUG COVERAGE.—

“(A) IN GENERAL.—Subject to subparagraph (B), qualified prescription drug coverage may include supplemental prescription drug coverage consisting of either or both of the following:

“(i) CERTAIN REDUCTIONS IN COST-SHARING.—

“(I) IN GENERAL.—A reduction in the annual deductible, a reduction in the coinsurance percentage, or an increase in the initial coverage limit with respect to covered part D drugs, or any combination thereof, insofar as such a reduction or increase increases the actuarial value of benefits above the actuarial value of basic prescription drug coverage.

“(II) CONSTRUCTION.—Nothing in this paragraph shall be construed as affecting the application of subsection (c)(3).

“(ii) OPTIONAL DRUGS.—Coverage of any product that would be a covered part D drug but for the application of subsection (e)(2)(A).

“(B) REQUIREMENT.—A PDP sponsor may not offer a prescription drug plan that provides supplemental prescription drug coverage pursuant to subparagraph (A) in an area unless the sponsor also offers a prescription drug plan in the area that only provides basic prescription drug coverage.

“(3) BASIC PRESCRIPTION DRUG COVERAGE.—For purposes of this part and part C, the term ‘basic prescription drug coverage’ means either of the following:

“(A) Coverage that meets the requirements of paragraph (1)(A).

“(B) Coverage that meets the requirements of paragraph (1)(B) but does not have any supplemental prescription drug coverage described in paragraph (2)(A).

“(4) APPLICATION OF SECONDARY PAYOR PROVISIONS.—The provisions of section 1852(a)(4) shall apply under this part in the same manner as they apply under part C.

“(5) CONSTRUCTION.—Nothing in this subsection shall be construed as changing the computation of incurred costs under subsection (b)(4).

“(b) STANDARD PRESCRIPTION DRUG COVERAGE.—For purposes of this part and part C, the term ‘standard prescription drug coverage’ means coverage of covered part D drugs that meets the following requirements:

“(1) DEDUCTIBLE.—

“(A) IN GENERAL.—The coverage has an annual deductible—

“(i) for 2006, that is equal to $250; or

“(ii) for a subsequent year, that is equal to the amount specified under this paragraph for the previous year increased by the percentage specified in paragraph (6) for the year involved.

“(B) ROUNDING.—Any amount determined under subparagraph (A)(ii) that is not a multiple of $5 shall be rounded to the nearest multiple of $5.

“(2) BENEFIT STRUCTURE.—

“(A) 25 PERCENT COINSURANCE.—The coverage has coinsurance (for costs above the annual deductible specified in paragraph (1) and up to the initial coverage limit under paragraph (3)) that is—

“(i) equal to 25 percent; or

“(ii) actuarially equivalent (using processes and methods established under section 1860D–11(c)) to an average expected payment of 25 percent of such costs.

“(B) USE OF TIERS.—Nothing in this part shall be construed as preventing a PDP sponsor or an MA organization from applying tiered copayments under a plan, so long as such tiered copayments are consistent with subparagraph (A)(ii).

“(3) INITIAL COVERAGE LIMIT.—

“(A) IN GENERAL.—Except as provided in paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes (including the annual deductible)—

“(i) for 2006, that is equal to $2,250; or

“(ii) for a subsequent year, that is equal to the amount specified in this paragraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved.

“(B) ROUNDING.—Any amount determined under subparagraph (A)(ii) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

“(4) PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES.—

“(A) IN GENERAL.—

“(i) IN GENERAL.—The coverage provides benefits, after the part D eligible individual has incurred costs (as described in subparagraph (C)) for covered part D drugs in a year equal to the annual out-of-pocket threshold specified in subparagraph (B), with cost-sharing that is equal to the greater of—

“(I) a copayment of $2 for a generic drug or a preferred drug that is a multiple source drug (as defined in section 1927(k)(7)(A)(i)) and $5 for any other drug; or

“(II) coinsurance that is equal to 5 percent.

“(ii) ADJUSTMENT OF AMOUNT.—For a year after 2006, the dollar amounts specified in clause (i)(I) shall be equal to the dollar amounts specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved. Any amount established under this clause that is not a multiple of a 5 cents shall be rounded to the nearest multiple of 5 cents.

“(B) ANNUAL OUT-OF-POCKET THRESHOLD.—

“(i) IN GENERAL.—For purposes of this part, the ‘annual out-of-pocket threshold’ specified in this subparagraph—

“(I) for 2006, is equal to $3,600; or

“(II) for a subsequent year, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved.

“(ii) ROUNDING.—Any amount determined under clause (i)(II) that is not a multiple of $50 shall be rounded to the nearest multiple of $50.

“(C) APPLICATION.—In applying subparagraph (A)—

“(i) incurred costs shall only include costs incurred with respect to covered part D drugs for the annual deductible described in paragraph (1), for cost-sharing described in paragraph (2), and for amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3), but does not include any costs incurred for covered part D drugs which are not included (or treated as being included) in the plan's formulary; and

“(ii) such costs shall be treated as incurred only if they are paid by the part D eligible individual (or by another person, such as a family member, on behalf of the individual), under section 1860D–14, or under a State Pharmaceutical Assistance Program and the part D eligible individual (or other person) is not reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement (other than under such section or such a Program) for such costs.

“(D) INFORMATION REGARDING THIRD-PARTY REIMBURSEMENT.—

“(i) PROCEDURES FOR EXCHANGING INFORMATION.—In order to accurately apply the requirements of subparagraph (C)(ii), the Secretary is authorized to establish procedures, in coordination with the Secretary of the Treasury and the Secretary of Labor—

“(I) for determining whether costs for part D eligible individuals are being reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement; and

“(II) for alerting the PDP sponsors and MA organizations that offer the prescription drug plans and MA–PD plans in which such individuals are enrolled about such reimbursement arrangements.

“(ii) AUTHORITY TO REQUEST INFORMATION FROM ENROLLEES.—A PDP sponsor or an MA organization may periodically ask part D eligible individuals enrolled in a prescription drug plan or an MA–PD plan offered by the sponsor or organization whether such individuals have or expect to receive such third-party reimbursement. A material misrepresentation of the information described in the preceding sentence by an individual (as defined in standards set by the Secretary and determined through a process established by the Secretary) shall constitute grounds

for termination of enrollment in any plan under section 1851(g)(3)(B) (and as applied under this part under section 1860D–1(b)(1)(B)(v)) for a period specified by the Secretary.

"(5) CONSTRUCTION.—Nothing in this part shall be construed as preventing a PDP sponsor or an MA organization offering an MA–PD plan from reducing to 0 the cost-sharing otherwise applicable to preferred or generic drugs.

"(6) ANNUAL PERCENTAGE INCREASE.—The annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered part D drugs in the United States for part D eligible individuals, as determined by the Secretary for the 12-month period ending in July of the previous year using such methods as the Secretary shall specify.

"(c) ALTERNATIVE PRESCRIPTION DRUG COVERAGE REQUIREMENTS.—A prescription drug plan or an MA–PD plan may provide a different prescription drug benefit design from standard prescription drug coverage so long as the Secretary determines (consistent with section 1860D–11(c)) that the following requirements are met and the plan applies for, and receives, the approval of the Secretary for such benefit design:

"(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT COVERAGE.—

"(A) ASSURING EQUIVALENT VALUE OF TOTAL COVERAGE.—The actuarial value of the total coverage is at least equal to the actuarial value of standard prescription drug coverage.

"(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard prescription drug coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage exceeds the actuarial value of the subsidy payments under section 1860D–15 with respect to such coverage.

"(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization, to provide for the payment, with respect to costs incurred that are equal to the initial coverage limit under subsection (b)(3) for the year, of an amount equal to at least the product of—

"(i) the amount by which the initial coverage limit described in subsection (b)(3) for the year exceeds the deductible described in subsection (b)(1) for the year; and

"(ii) 100 percent minus the coinsurance percentage specified in subsection (b)(2)(A)(i).

"(2) MAXIMUM REQUIRED DEDUCTIBLE.—The deductible under the coverage shall not exceed the deductible amount specified under subsection (b)(1) for the year.

"(3) SAME PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES.—The coverage provides the coverage required under subsection (b)(4).

"(d) ACCESS TO NEGOTIATED PRICES.—

"(1) ACCESS.—

"(A) IN GENERAL.—Under qualified prescription drug coverage offered by a PDP sponsor offering a prescription drug plan or an MA organization offering an MA–PD plan, the sponsor or organization shall provide enrollees with access to negotiated prices used for payment for covered part D drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of a deductible or other cost-sharing or an initial coverage limit (described in subsection (b)(3)).

"(B) NEGOTIATED PRICES.—For purposes of this part, negotiated prices shall take into account negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations, for covered part D drugs, and include any dispensing fees for such drugs.

"(C) MEDICAID-RELATED PROVISIONS.—The prices negotiated by a prescription drug plan, by an MA–PD plan with respect to covered part D drugs, or by a qualified retiree prescription drug plan (as defined in section 1860D–22(a)(2)) with respect to such drugs on behalf of part D eligible individuals, shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

"(2) DISCLOSURE.—A PDP sponsor offering a prescription drug plan or an MA organization offering an MA–PD plan shall disclose to the Secretary (in a manner specified by the Secretary) the aggregate negotiated price concessions described in paragraph (1)(B) made available to the sponsor or organization by a manufacturer which are passed through in the form of lower subsidies, lower monthly beneficiary prescription drug premiums, and lower prices through pharmacies and other dispensers. The provisions of section 1927(b)(3)(D) apply to information disclosed to the Secretary under this paragraph.

"(3) AUDITS.—To protect against fraud and abuse and to ensure proper disclosures and accounting under this part and in accordance with section 1857(d)(2)(B) (as applied under section 1860D–12(b)(3)(C)), the Secretary may conduct periodic audits, directly or through contracts, of the financial statements and records of PDP sponsors with respect to prescription drug plans and MA organizations with respect to MA–PD plans.

"(e) COVERED PART D DRUG DEFINED.—

"(1) IN GENERAL.—Except as provided in this subsection, for purposes of this part, the term 'covered part D drug' means—

"(A) a drug that may be dispensed only upon a prescription and that is described in subparagraph (A)(i), (A)(ii), or (A)(iii) of section 1927(k)(2); or

"(B) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section and medical supplies associated with the injection of insulin (as defined in regulations of the Secretary),

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered part D drug for a medically accepted indication (as defined in section 1927(k)(6)).

"(2) EXCLUSIONS.—

"(A) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) of such section (relating to smoking cessation agents), or under section 1927(d)(3).

"(B) MEDICARE COVERED DRUGS.—A drug prescribed for a part D eligible individual that would otherwise be a covered part D drug under this part shall not be so considered if payment for such drug as so prescribed and dispensed or administered with respect to that individual is available (or would be available but for the application of a deductible) under part A or B for that individual.

"(3) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug plan or an MA–PD plan may exclude from qualified prescription drug coverage any covered part D drug—

"(A) for which payment would not be made if section 1862(a) applied to this part; or

"(B) which is not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to subsections (g) and (h), respectively, of section 1860D–4.

"ACCESS TO A CHOICE OF QUALIFIED PRESCRIPTION DRUG COVERAGE

"SEC. 1860D–3. (a) ASSURING ACCESS TO A CHOICE OF COVERAGE.—

"(1) CHOICE OF AT LEAST TWO PLANS IN EACH AREA.—The Secretary shall ensure that each part D eligible individual has available, consistent with paragraph (2), a choice of enrollment in at least 2 qualifying plans (as defined in paragraph (3)) in the area in which the individual resides, at least one of which is a prescription drug plan. In any such case in which such plans are not available, the part D eligible individual shall be given the opportunity to enroll in a fallback prescription drug plan.

"(2) REQUIREMENT FOR DIFFERENT PLAN SPONSORS.—The requirement in paragraph (1) is not satisfied with respect to an area if only one entity offers all the qualifying plans in the area.

"(3) QUALIFYING PLAN DEFINED.—For purposes of this section, the term 'qualifying plan' means—

"(A) a prescription drug plan; or

"(B) an MA–PD plan described in section 1851(a)(2)(A)(i) that provides—

"(i) basic prescription drug coverage; or

"(ii) qualified prescription drug coverage that provides supplemental prescription drug coverage so long as there is no MA monthly supplemental beneficiary premium applied under the plan, due to the application of a credit against such premium of a rebate under section 1854(b)(1)(C).

"(b) FLEXIBILITY IN RISK ASSUMED AND APPLICATION OF FALLBACK PLAN.—In order to ensure access pursuant to subsection (a) in an area—

"(1) the Secretary may approve limited risk plans under section 1860D–11(f) for the area; and

"(2) only if such access is still not provided in the area after applying paragraph (1), the Secretary shall provide for the offering of a fallback prescription drug plan for that area under section 1860D–11(g).

"BENEFICIARY PROTECTIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE

"SEC. 1860D–4. (a) DISSEMINATION OF INFORMATION.—

"(1) GENERAL INFORMATION.—

"(A) APPLICATION OF MA INFORMATION.—A PDP sponsor shall disclose, in a clear, accurate, and standardized form to each enrollee with a prescription drug plan offered by the sponsor under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan, insofar as the Secretary determines appropriate with respect to benefits provided under this part, and including the information described in subparagraph (B).

"(B) DRUG SPECIFIC INFORMATION.—The information described in this subparagraph is information concerning the following:

"(i) Access to specific covered part D drugs, including access through pharmacy networks.

"(ii) How any formulary (including any tiered formulary structure) used by the sponsor functions, including a description of how a part D eligible individual may obtain information on the formulary consistent with paragraph (3).

"(iii) Beneficiary cost-sharing requirements and how a part D eligible individual may obtain information on such requirements, including tiered or other copayment level applicable to each drug (or class of drugs), consistent with paragraph (3).

"(iv) The medication therapy management program required under subsection (c).

"(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of a part D eligible individual who is eligible to enroll in a prescription drug plan, the PDP sponsor offering such plan shall provide information similar (as determined by the Secretary) to the information described in subparagraphs (A), (B), and (C) of section 1852(c)(2) to such individual.

"(3) PROVISION OF SPECIFIC INFORMATION.—

"(A) RESPONSE TO BENEFICIARY QUESTIONS.—Each PDP sponsor offering a prescription drug plan shall have a mechanism for providing specific information on a timely basis to enrollees upon request. Such mechanism shall include access to information through the use of a toll-free telephone number and, upon request, the provision of such information in writing.

"(B) AVAILABILITY OF INFORMATION ON CHANGES IN FORMULARY THROUGH THE INTERNET.—A PDP sponsor offering a prescription drug plan shall make available on a timely basis through an Internet website information on specific changes in the formulary under the plan (including changes to tiered or preferred status of covered part D drugs).

"(4) CLAIMS INFORMATION.—A PDP sponsor offering a prescription drug plan must furnish to each enrollee in a form easily understandable to such enrollees—

"(A) an explanation of benefits (in accordance with section 1806(a) or in a comparable manner); and

"(B) when prescription drug benefits are provided under this part, a notice of the benefits in relation to—

"(i) the initial coverage limit for the current year; and

"(ii) the annual out-of-pocket threshold for the current year.

Notices under subparagraph (B) need not be provided more often than as specified by the Secretary and notices under subparagraph (B)(ii) shall take into account the application of section 1860D–2(b)(4)(C) to the extent practicable, as specified by the Secretary.

"(b) ACCESS TO COVERED PART D DRUGS.—

"(1) ASSURING PHARMACY ACCESS.—

"(A) PARTICIPATION OF ANY WILLING PHARMACY.—A prescription drug plan shall permit the participation of any pharmacy that meets the terms and conditions under the plan.

"(B) DISCOUNTS ALLOWED FOR NETWORK PHARMACIES.—For covered part D drugs dispensed through in-network pharmacies, a prescription drug plan may, notwithstanding subparagraph (A), reduce coinsurance or copayments for part D eligible individuals enrolled in the plan below the level otherwise required. In no case shall such a reduction result in an increase in payments made by the Secretary under section 1860D–15 to a plan.

"(C) CONVENIENT ACCESS FOR NETWORK PHARMACIES.—

"(i) IN GENERAL.—The PDP sponsor of the prescription drug plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (consistent with rules established by the Secretary).

"(ii) APPLICATION OF TRICARE STANDARDS.—The Secretary shall establish rules for convenient access to in-network pharmacies under this subparagraph that are no less favorable to enrollees than the rules for convenient access to pharmacies included in the statement of work of solicitation (#MDA906–03–R–0002) of the Department of Defense under the TRICARE Retail Pharmacy (TRRx) as of March 13, 2003.

"(iii) ADEQUATE EMERGENCY ACCESS.—Such rules shall include adequate emergency access for enrollees.

"(iv) CONVENIENT ACCESS IN LONG-TERM CARE FACILITIES.—Such rules may include standards with respect to access for enrollees who are residing in long-term care facilities and for pharmacies operated by the Indian Health Service, Indian tribes and tribal organizations, and urban Indian organizations (as defined in section 4 of the Indian Health Care Improvement Act).

"(D) LEVEL PLAYING FIELD.—Such a sponsor shall permit enrollees to receive benefits (which may include a 90-day supply of drugs or biologicals) through a pharmacy (other than a mail order pharmacy), with any differential in charge paid by such enrollees.

"(E) NOT REQUIRED TO ACCEPT INSURANCE RISK.—The terms and conditions under subparagraph (A) may not require participating pharmacies to accept insurance risk as a condition of participation.

"(2) USE OF STANDARDIZED TECHNOLOGY.—

"(A) IN GENERAL.—The PDP sponsor of a prescription drug plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrollee to assure access to negotiated prices under section 1860D–2(d).

"(B) STANDARDS.—

"(i) IN GENERAL.—The Secretary shall provide for the development, adoption, or recognition of standards relating to a standardized format for the card or other technology required under subparagraph (A). Such standards shall be compatible with part C of title XI and may be based on standards developed by an appropriate standard setting organization.

"(ii) CONSULTATION.—In developing the standards under clause (i), the Secretary shall consult with the National Council for Prescription Drug Programs and other standard setting organizations determined appropriate by the Secretary.

"(iii) IMPLEMENTATION.—The Secretary shall develop, adopt, or recognize the standards under clause (i) by such date as the Secretary determines shall be sufficient to ensure that PDP sponsors utilize such standards beginning January 1, 2006.

"(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If a PDP sponsor of a prescription drug plan uses a formulary (including the use of tiered cost-sharing), the following requirements must be met:

"(A) DEVELOPMENT AND REVISION BY A PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—

"(i) IN GENERAL.—The formulary must be developed and reviewed by a pharmacy and therapeutic committee. A majority of the members of such committee shall consist of individuals who are practicing physicians or practicing pharmacists (or both).

"(ii) INCLUSION OF INDEPENDENT EXPERTS.—Such committee shall include at least one practicing physician and at least one practicing pharmacist, each of whom—

"(I) is independent and free of conflict with respect to the sponsor and plan; and

"(II) has expertise in the care of elderly or disabled persons.

"(B) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall—

"(i) base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and on such other information as the committee determines to be appropriate; and

"(ii) take into account whether including in the formulary (or in a tier in such formulary) particular covered part D drugs has therapeutic advantages in terms of safety and efficacy.

"(C) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES AND CLASSES.—

"(i) IN GENERAL.—The formulary must include drugs within each therapeutic category and class of covered part D drugs, although not necessarily all drugs within such categories and classes.

"(ii) MODEL GUIDELINES.—The Secretary shall request the United States Pharmacopeia to develop, in consultation with pharmaceutical benefit managers and other interested parties, a list of categories and classes that may be used by prescription drug plans under this paragraph and to revise such classification from time to time to reflect changes in therapeutic uses of covered part D drugs and the additions of new covered part D drugs.

"(iii) LIMITATION ON CHANGES IN THERAPEUTIC CLASSIFICATION.—The PDP sponsor of a prescription drug plan may not change the therapeutic categories and classes in a formulary other than at the beginning of each plan year except as the Secretary may permit to take into account new therapeutic uses and newly approved covered part D drugs.

"(D) PROVIDER AND PATIENT EDUCATION.—The PDP sponsor shall establish policies and procedures to educate and inform health care providers and enrollees concerning the formulary.

"(E) NOTICE BEFORE REMOVING DRUG FROM FORMULARY OR CHANGING PREFERRED OR TIER STATUS OF DRUG.—Any removal of a covered part D drug from a formulary and any change in the preferred or tiered cost-sharing status of such a drug shall take effect only after appropriate notice is made available (such as under subsection (a)(3)) to the Secretary, affected enrollees, physicians, pharmacies, and pharmacists.

"(F) PERIODIC EVALUATION OF PROTOCOLS.—In connection with the formulary, the sponsor of a prescription drug plan shall provide for the periodic evaluation and analysis of treatment protocols and procedures.

The requirements of this paragraph may be met by a PDP sponsor directly or through arrangements with another entity.

"(c) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

"(1) IN GENERAL.—The PDP sponsor shall have in place, directly or through appropriate arrangements, with respect to covered part D drugs, the following:

"(A) A cost-effective drug utilization management program, including incentives to reduce costs when medically appropriate, such as through the use of multiple source drugs (as defined in section 1927(k)(7)(A)(i)).

"(B) Quality assurance measures and systems to reduce medication errors and adverse drug interactions and improve medication use.

"(C) A medication therapy management program described in paragraph (2).

"(D) A program to control fraud, abuse, and waste.

Nothing in this section shall be construed as impairing a PDP sponsor from utilizing cost management tools (including differential payments) under all methods of operation.

"(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

"(A) DESCRIPTION.—

"(i) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management that may be furnished by a pharmacist and that is designed to assure, with respect to targeted beneficiaries described in clause (ii), that covered part D drugs under the prescription drug plan are appropriately used to optimize therapeutic outcomes through improved medication use, and to reduce the risk of adverse events, including adverse drug interactions. Such a program may distinguish between services in ambulatory and institutional settings.

"(ii) TARGETED BENEFICIARIES DESCRIBED.—Targeted beneficiaries described in this clause are part D eligible individuals who—

"(I) have multiple chronic diseases (such as diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure);

"(II) are taking multiple covered part D drugs; and

"(III) are identified as likely to incur annual costs for covered part D drugs that exceed a level specified by the Secretary.

"(B) ELEMENTS.—Such program may include elements that promote—

"(i) enhanced enrollee understanding to promote the appropriate use of medications by enrollees and to reduce the risk of potential adverse events associated with medications, through beneficiary education, counseling, and other appropriate means;

"(ii) increased enrollee adherence with prescription medication regimens through medication refill reminders, special packaging, and other compliance programs and other appropriate means; and

"(iii) detection of adverse drug events and patterns of overuse and underuse of prescription drugs.

"(C) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—Such program shall be developed in cooperation with licensed and practicing pharmacists and physicians.

"(D) COORDINATION WITH CARE MANAGEMENT PLANS.—The Secretary shall establish guidelines for the coordination of any medication therapy management program under this paragraph with respect to a targeted beneficiary with any care management plan established with respect to such beneficiary under a chronic care improvement program under section 1807.

"(E) CONSIDERATIONS IN PHARMACY FEES.—The PDP sponsor of a prescription drug plan shall take into account, in establishing fees for pharmacists and others providing services under such plan, the resources used, and time required to, implement the medication therapy management program under this paragraph. Each such sponsor shall disclose to the Secretary upon request the amount of any such management or dispensing fees. The provisions of section 1927(b)(3)(D) apply to information disclosed under this subparagraph.

"(d) CONSUMER SATISFACTION SURVEYS.—In order to provide for comparative information under section 1860D–1(c)(3)(A)(v), the Secretary shall conduct consumer satisfaction surveys with respect to PDP sponsors and prescription drug plans in a manner similar to the manner such surveys are conducted for MA organizations and MA plans under part C.

"(e) ELECTRONIC PRESCRIPTION PROGRAM.—

"(1) APPLICATION OF STANDARDS.—As of such date as the Secretary may specify, but not later than 1 year after the date of promulgation of final standards under paragraph (4)(D), prescriptions and other information described in paragraph (2)(A) for covered part D drugs prescribed for part D eligible individuals that are transmitted electronically shall be transmitted only in accordance with such standards under an electronic prescription drug program that meets the requirements of paragraph (2).

"(2) PROGRAM REQUIREMENTS.—Consistent with uniform standards established under paragraph (3)—

"(A) PROVISION OF INFORMATION TO PRESCRIBING HEALTH CARE PROFESSIONAL AND DISPENSING PHARMACIES AND PHARMACISTS.—An electronic prescription drug program shall provide for the electronic transmittal to the prescribing health care professional and to the dispensing pharmacy and pharmacist of the prescription and information on eligibility and benefits (including the drugs included in the applicable formulary, any tiered formulary structure, and any requirements for prior authorization) and of the following information with respect to the prescribing and dispensing of a covered part D drug:

"(i) Information on the drug being prescribed or dispensed and other drugs listed on the medication history, including information on drug-drug interactions, warnings or cautions, and, when indicated, dosage adjustments.

"(ii) Information on the availability of lower cost, therapeutically appropriate alternatives (if any) for the drug prescribed.

"(B) APPLICATION TO MEDICAL HISTORY INFORMATION.—Effective on and after such date as the Secretary specifies and after the establishment of appropriate standards to carry out this subparagraph, the program shall provide for the electronic transmittal in a manner similar to the manner under subparagraph (A) of information that relates to the medical history concerning the individual and related to a covered part D drug being prescribed or dispensed, upon request of the professional or pharmacist involved.

"(C) LIMITATIONS.—Information shall only be disclosed under subparagraph (A) or (B) if the disclosure of such information is permitted under the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

"(D) TIMING.—To the extent feasible, the information exchanged under this paragraph shall be on an interactive, real-time basis.

"(3) STANDARDS.—

"(A) IN GENERAL.—The Secretary shall provide consistent with this subsection for the promulgation of uniform standards relating to the requirements for electronic prescription drug programs under paragraph (2).

"(B) OBJECTIVES.—Such standards shall be consistent with the objectives of improving—

"(i) patient safety;

"(ii) the quality of care provided to patients; and

"(iii) efficiencies, including cost savings, in the delivery of care.

"(C) DESIGN CRITERIA.—Such standards shall—

"(i) be designed so that, to the extent practicable, the standards do not impose an undue administrative burden on prescribing health care professionals and dispensing pharmacies and pharmacists;

"(ii) be compatible with standards established under part C of title XI, standards established under subsection (b)(2)(B)(i), and with general health information technology standards; and

"(iii) be designed so that they permit electronic exchange of drug labeling and drug listing information maintained by the Food and Drug Administration and the National Library of Medicine.

"(D) PERMITTING USE OF APPROPRIATE MESSAGING.—Such standards shall allow for the messaging of information only if it relates to the appropriate prescribing of drugs, including quality assurance measures and systems referred to in subsection (c)(1)(B).

"(E) PERMITTING PATIENT DESIGNATION OF DISPENSING PHARMACY.—

"(i) IN GENERAL.—Consistent with clause (ii), such standards shall permit a part D eligible individual to designate a particular pharmacy to dispense a prescribed drug.

"(ii) NO CHANGE IN BENEFITS.—Clause (i) shall not be construed as affecting—

"(I) the access required to be provided to pharmacies by a prescription drug plan; or

"(II) the application of any differences in benefits or payments under such a plan based on the pharmacy dispensing a covered part D drug.

"(4) DEVELOPMENT, PROMULGATION, AND MODIFICATION OF STANDARDS.—

"(A) INITIAL STANDARDS.—Not later than September 1, 2005, the Secretary shall develop, adopt, recognize, or modify initial uniform standards relating to the requirements for electronic prescription drug programs described in paragraph (2) taking into consideration the recommendations (if any) from the National Committee on Vital and Health Statistics (as established under section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k))) under subparagraph (B).

"(B) ROLE OF NCVHS.—The National Committee on Vital and Health Statistics shall develop recommendations for uniform standards relating to such requirements in consultation with the following:

"(i) Standard setting organizations (as defined in section 1171(8))

"(ii) Practicing physicians.

"(iii) Hospitals.

"(iv) Pharmacies.

"(v) Practicing pharmacists.

"(vi) Pharmacy benefit managers.

"(vii) State boards of pharmacy.

"(viii) State boards of medicine.

"(ix) Experts on electronic prescribing.

"(x) Other appropriate Federal agencies.

"(C) PILOT PROJECT TO TEST INITIAL STANDARDS.—

"(i) IN GENERAL.—During the 1-year period that begins on January 1, 2006, the Secretary shall conduct a pilot project to test the initial standards developed under subparagraph (A) prior to the promulgation of the final uniform standards under subparagraph (D) in order to provide for the efficient implementation of the requirements described in paragraph (2).

"(ii) EXCEPTION.—Pilot testing of standards is not required under clause (i) where there already is adequate industry experience with such standards, as determined by the Secretary after consultation with effected standard setting organizations and industry users.

"(iii) VOLUNTARY PARTICIPATION OF PHYSICIANS AND PHARMACIES.—In order to conduct the pilot project under clause (i), the Secretary shall enter into agreements with physicians, physician groups, pharmacies, hospitals, PDP sponsors, MA organizations, and other appropriate entities under which health care professionals electronically transmit prescriptions to dispensing pharmacies and pharmacists in accordance with such standards.

"(iv) EVALUATION AND REPORT.—

"(I) EVALUATION.—The Secretary shall conduct an evaluation of the pilot project conducted under clause (i).

"(II) REPORT TO CONGRESS.—Not later than April 1, 2007, the Secretary shall submit to Congress a report on the evaluation conducted under subclause (I).

"(D) FINAL STANDARDS.—Based upon the evaluation of the pilot project under subparagraph (C)(iv)(I) and not later than April 1, 2008, the Secretary shall promulgate uniform standards relating to the requirements described in paragraph (2).

"(5) RELATION TO STATE LAWS.—The standards promulgated under this subsection shall supersede any State law or regulation that—

"(A) is contrary to the standards or restricts the ability to carry out this part; and

"(B) pertains to the electronic transmission of medication history and of information on eligibility, benefits, and prescriptions with respect to covered part D drugs under this part.

"(6) ESTABLISHMENT OF SAFE HARBOR.—The Secretary, in consultation with the Attorney General, shall promulgate regulations that provide for a safe harbor from sanctions under paragraphs (1) and (2) of section 1128B(b) and an exception to the prohibition under subsection (a)(1) of section 1877 with respect to the provision of nonmonetary remuneration (in the form of hardware, software, or information technology and training services) necessary and used solely to receive and transmit electronic prescription information in accordance with the standards promulgated under this subsection—

"(A) in the case of a hospital, by the hospital to members of its medical staff;

"(B) in the case of a group practice (as defined in section 1877(h)(4)), by the practice to prescribing health care professionals who are members of such practice; and

"(C) in the case of a PDP sponsor or MA organization, by the sponsor or organization to pharmacists and pharmacies participating in the network of such sponsor or organization, and to prescribing health care professionals.

"(f) GRIEVANCE MECHANISM.—Each PDP sponsor shall provide meaningful procedures for hearing and resolving grievances between the sponsor (including any entity or individual through which the sponsor provides covered benefits) and enrollees with prescription drug plans of the sponsor under this part in accordance with section 1852(f).

"(g) COVERAGE DETERMINATIONS AND RECONSIDERATIONS.—

"(1) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—A PDP sponsor shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug plan it offers under this part in the same manner as such requirements apply to an MA organization with respect to benefits it offers under an MA plan under part C.

"(2) REQUEST FOR A DETERMINATION FOR THE TREATMENT OF TIERED FORMULARY DRUG.—In the case of a prescription drug plan offered by a PDP sponsor that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, a part D eligible individual who is enrolled in the plan may request an exception to the tiered cost-sharing structure. Under such an exception, a nonpreferred drug could be covered under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both. A PDP sponsor shall have an exceptions process under this paragraph consistent with guidelines established by the Secretary for making a determination with respect to such a request. Denial of such an exception shall be treated as a coverage denial for purposes of applying subsection (h).

"(h) APPEALS.—

"(1) IN GENERAL.—Subject to paragraph (2), a PDP sponsor shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to benefits (including a determination related to the application of tiered cost-sharing described in subsection (g)(2)) in a manner similar (as determined by the Secretary) to the manner such requirements apply to an MA organization with respect to benefits under the original medicare fee-for-service program option it offers under an MA plan under part C. In applying this paragraph only the part D eligible individual shall be entitled to bring such an appeal.

"(2) LIMITATION IN CASES ON NONFORMULARY DETERMINATIONS.—A part D eligible individual who is enrolled in a prescription drug plan offered by a PDP sponsor may appeal under paragraph (1) a determination not to provide for coverage of a covered part D drug that is not on the formulary under the plan only if the prescribing physician determines that all covered part D drugs on any tier of the formulary for treatment of the same condition would not be as effective for the individual as the nonformulary drug, would have adverse effects for the individual, or both.

"(3) TREATMENT OF NONFORMULARY DETERMINATIONS.—If a PDP sponsor determines that a plan provides coverage for a covered part D drug that is not on the formulary of the plan, the drug shall be treated as being included on the formulary for purposes of section 1860D–2(b)(4)(C)(i).

"(i) PRIVACY, CONFIDENTIALITY, AND ACCURACY OF ENROLLEE RECORDS.—The provisions of section 1852(h) shall apply to a PDP sponsor and prescription drug plan in the same manner as it applies to an MA organization and an MA plan.

"(j) TREATMENT OF ACCREDITATION.—Subparagraph (A) of section 1852(e)(4) (relating to treatment of accreditation) shall apply to a PDP sponsor under this part with respect to the following requirements, in the same manner as it applies to an MA organization with respect to the requirements in subparagraph (B) (other than clause (vii) thereof) of such section:

"(1) Subsection (b) of this section (relating to access to covered part D drugs).

"(2) Subsection (c) of this section (including quality assurance and medication therapy management).

"(3) Subsection (i) of this section (relating to confidentiality and accuracy of enrollee records).

"(k) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—

"(1) IN GENERAL.—A PDP sponsor offering a prescription drug plan shall provide that each pharmacy that dispenses a covered part D drug shall inform an enrollee of any differential between the price of the drug to the enrollee and the price of the lowest priced generic covered part D drug under the plan that is therapeutically equivalent and bioequivalent and available at such pharmacy.

"(2) TIMING OF NOTICE.—

"(A) IN GENERAL.—Subject to subparagraph (B), the information under paragraph (1) shall be provided at the time of purchase of the drug involved, or, in the case of dispensing by mail order, at the time of delivery of such drug.

"(B) WAIVER.—The Secretary may waive subparagraph (A) in such circumstances as the Secretary may specify.

"Subpart 2—Prescription Drug Plans; PDP Sponsors; Financing

"PDP REGIONS; SUBMISSION OF BIDS; PLAN APPROVAL

"SEC. 1860D–11. (a) ESTABLISHMENT OF PDP REGIONS; SERVICE AREAS.—

"(1) COVERAGE OF ENTIRE PDP REGION.—The service area for a prescription drug plan shall consist of an entire PDP region established under paragraph (2).

"(2) ESTABLISHMENT OF PDP REGIONS.—

"(A) IN GENERAL.—The Secretary shall establish, and may revise, PDP regions in a manner that is consistent with the requirements for the establishment and revision of MA regions under subparagraphs (B) and (C) of section 1858(a)(2).

"(B) RELATION TO MA REGIONS.—To the extent practicable, PDP regions shall be the same as MA regions under section 1858(a)(2). The Secretary may establish PDP regions which are not the same as MA regions if the Secretary determines that the establishment of different regions under this part would improve access to benefits under this part.

"(C) AUTHORITY FOR TERRITORIES.—The Secretary shall establish, and may revise, PDP regions for areas in States that are not within the 50 States or the District of Columbia.

"(3) NATIONAL PLAN.—Nothing in this subsection shall be construed as preventing a prescription drug plan from being offered in more than one PDP region (including all PDP regions).

"(b) SUBMISSION OF BIDS, PREMIUMS, AND RELATED INFORMATION.—

"(1) IN GENERAL.—A PDP sponsor shall submit to the Secretary information described in paragraph (2) with respect to each prescription drug plan it offers. Such information shall be submitted at the same time and in a similar manner to the manner in which information described in paragraph (6) of section 1854(a) is submitted by an MA organization under paragraph (1) of such section.

"(2) INFORMATION DESCRIBED.—The information described in this paragraph is information on the following:

"(A) COVERAGE PROVIDED.—The prescription drug coverage provided under the plan, including the deductible and other cost-sharing.

"(B) ACTUARIAL VALUE.—The actuarial value of the qualified prescription drug coverage in the region for a part D eligible individual with a national average risk profile for the factors described in section 1860D–15(c)(1)(A) (as specified by the Secretary).

"(C) BID.—Information on the bid, including an actuarial certification of—

"(i) the basis for the actuarial value described in subparagraph (B) assumed in such bid;

"(ii) the portion of such bid attributable to basic prescription drug coverage and, if applicable, the portion of such bid attributable to supplemental benefits;

"(iii) assumptions regarding the reinsurance subsidy payments provided under section 1860D–15(b) subtracted from the actuarial value to produce such bid; and

"(iv) administrative expenses assumed in the bid.

"(D) SERVICE AREA.—The service area for the plan.

"(E) LEVEL OF RISK ASSUMED.—

"(i) IN GENERAL.—Whether the PDP sponsor requires a modification of risk level under clause (ii) and, if so, the extent of such modification. Any such modification shall apply with respect to all prescription drug plans offered by a PDP sponsor in a PDP region. This subparagraph shall not apply to an MA–PD plan.

"(ii) RISK LEVELS DESCRIBED.—A modification of risk level under this clause may consist of one or more of the following:

"(I) INCREASE IN FEDERAL PERCENTAGE ASSUMED IN INITIAL RISK CORRIDOR.—An equal percentage point increase in the percents applied under subparagraphs (B)(i), (B)(ii)(I), (C)(i), and (C)(ii)(I) of section 1860D–15(e)(2). In no case shall the application of previous sentence prevent the application of a higher percentage under section 1869D–15(e)(2)(B)(iii).

"(II) INCREASE IN FEDERAL PERCENTAGE ASSUMED IN SECOND RISK CORRIDOR.—An equal percentage point increase in the percents applied under subparagraphs (B)(ii)(II) and (C)(ii)(II) of section 1860D–15(e)(2).

"(III) DECREASE IN SIZE OF RISK CORRIDORS.—A decrease in the threshold risk percentages specified in section 1860D–15(e)(3)(C).

"(F) ADDITIONAL INFORMATION.—Such other information as the Secretary may require to carry out this part.

"(3) PAPERWORK REDUCTION FOR OFFERING OF PRESCRIPTION DRUG PLANS NATIONALLY OR IN MULTI-REGION AREAS.—The Secretary shall establish requirements for information submission under this subsection in a manner that promotes the offering of such plans in more than one PDP region (including all regions) through the filing of consolidated information.

"(c) ACTUARIAL VALUATION.—

"(1) PROCESSES.—For purposes of this part, the Secretary shall establish processes and methods for determining the actuarial valuation of prescription drug coverage, including—

"(A) an actuarial valuation of standard prescription drug coverage under section 1860D–2(b);

"(B) actuarial valuations relating to alternative prescription drug coverage under section 1860D–2(c)(1);

"(C) an actuarial valuation of the reinsurance subsidy payments under section 1860D–15(b);

"(D) the use of generally accepted actuarial principles and methodologies; and

"(E) applying the same methodology for determinations of actuarial valuations under subparagraphs (A) and (B).

"(2) ACCOUNTING FOR DRUG UTILIZATION.—Such processes and methods for determining actuarial valuation shall take into account the effect that providing alternative prescription drug coverage (rather than standard prescription drug coverage) has on drug utilization.

"(3) RESPONSIBILITIES.—

"(A) PLAN RESPONSIBILITIES.—PDP sponsors and MA organizations are responsible for the preparation and submission of actuarial valuations required under this part for prescription drug plans and MA–PD plans they offer.

"(B) USE OF OUTSIDE ACTUARIES.—Under the processes and methods established under paragraph (1), PDP sponsors offering prescription drug plans and MA organizations offering MA–PD plans may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values.

"(d) REVIEW OF INFORMATION AND NEGOTIATION.—

"(1) REVIEW OF INFORMATION.—The Secretary shall review the information filed under subsection (b) for the purpose of conducting negotiations under paragraph (2).

"(2) NEGOTIATION REGARDING TERMS AND CONDITIONS.—Subject to subsection (i), in exercising the authority under paragraph (1), the Secretary—

"(A) has the authority to negotiate the terms and conditions of the proposed bid submitted and other terms and conditions of a proposed plan; and

"(B) has authority similar to the authority of the Director of the Office of Personnel Management with respect to health benefits plans under chapter 89 of title 5, United States Code.

"(e) APPROVAL OF PROPOSED PLANS.—

"(1) IN GENERAL.—After review and negotiation under subsection (d), the Secretary shall approve or disapprove the prescription drug plan.

"(2) REQUIREMENTS FOR APPROVAL.—The Secretary may approve a prescription drug plan only if the following requirements are met:

"(A) COMPLIANCE WITH REQUIREMENTS.—The plan and the PDP sponsor offering the plan comply with the requirements under this part, including the provision of qualified prescription drug coverage.

"(B) ACTUARIAL DETERMINATIONS.—The Secretary determines that the plan and PDP sponsor meet the requirements under this part relating to actuarial determinations, including such requirements under section 1860D–2(c).

"(C) APPLICATION OF FEHBP STANDARD.—

"(i) IN GENERAL.—The Secretary determines that the portion of the bid submitted under subsection (b) that is attributable to basic prescription drug coverage is supported by the actuarial bases provided under such subsection and reasonably and equitably reflects the revenue requirements (as used for purposes of section 1302(8)(C) of the Public Health Service Act) for benefits provided under that plan, less the sum (determined on a monthly per capita basis) of the actuarial value of the reinsurance payments under section 1860D–15(b).

"(ii) SUPPLEMENTAL COVERAGE.—The Secretary determines that the portion of the bid submitted under subsection (b) that is attributable to supplemental prescription drug coverage pursuant to section 1860D–2(a)(2) is supported by the actuarial bases provided under such subsection and reasonably and equitably reflects the revenue requirements (as used for purposes of section 1302(8)(C) of the Public Health Service Act) for such coverage under the plan.

"(D) PLAN DESIGN.—

"(i) IN GENERAL.—The Secretary does not find that the design of the plan and its benefits (including any formulary and tiered formulary structure) are likely to substantially discourage enrollment by certain part D eligible individuals under the plan.

"(ii) USE OF CATEGORIES AND CLASSES IN FORMULARIES.—The Secretary may not find that the design of categories and classes within a formulary violates clause (i) if such categories and classes are consistent with guidelines (if any) for such categories and classes established by the United States Pharmacopeia.

"(f) APPLICATION OF LIMITED RISK PLANS.—

"(1) CONDITIONS FOR APPROVAL OF LIMITED RISK PLANS.—The Secretary may only approve a limited risk plan (as defined in paragraph (4)(A)) for a PDP region if the access requirements under section 1860D–3(a) would not be met for the region but for the approval of such a plan (or a fallback prescription drug plan under subsection (g)).

"(2) RULES.—The following rules shall apply with respect to the approval of a limited risk plan in a PDP region:

"(A) LIMITED EXERCISE OF AUTHORITY.—Only the minimum number of such plans may be approved in order to meet the access requirements under section 1860D–3(a).

"(B) MAXIMIZING ASSUMPTION OF RISK.—The Secretary shall provide priority in approval for those plans bearing the highest level of risk (as computed by the Secretary), but the Secretary may take into account the level of the bids submitted by such plans.

"(C) NO FULL UNDERWRITING FOR LIMITED RISK PLANS.—In no case may the Secretary approve a limited risk plan under which the modification of risk level provides for no (or a de minimis) level of financial risk.

"(3) ACCEPTANCE OF ALL FULL RISK CONTRACTS.—There shall be no limit on the number of full risk plans that are approved under subsection (e).

"(4) RISK-PLANS DEFINED.—For purposes of this subsection:

"(A) LIMITED RISK PLAN.—The term 'limited risk plan' means a prescription drug plan that provides basic prescription drug coverage and for which the PDP sponsor includes a modification of risk level described in subparagraph (E) of subsection (b)(2) in its bid submitted for the plan under such subsection. Such term does not include a fallback prescription drug plan.

"(B) FULL RISK PLAN.—The term 'full risk plan' means a prescription drug plan that is not a limited risk plan or a fallback prescription drug plan.

"(g) GUARANTEEING ACCESS TO COVERAGE.—

"(1) SOLICITATION OF BIDS.—

"(A) IN GENERAL.—Separate from the bidding process under subsection (b), the Secretary shall provide for a process for the solicitation of bids from eligible fallback entities (as defined in paragraph (2)) for the offering in all fallback service areas (as defined in paragraph (3)) in one or more PDP regions of a fallback prescription drug plan (as defined in paragraph (4)) during the contract period specified in paragraph (5)).

"(B) ACCEPTANCE OF BIDS.—

"(i) IN GENERAL.—Except as provided in this subparagraph, the provisions of subsection (e) shall apply with respect to the approval or disapproval of fallback prescription drug plans. The Secretary shall enter into contracts under this subsection with eligible fallback entities for the offering of fallback prescription drug plans so approved in fallback service areas.

"(ii) LIMITATION OF 1 PLAN FOR ALL FALLBACK SERVICE AREAS IN A PDP REGION.—With respect to all fallback service areas in any PDP region for a contract period, the Secretary shall approve the offering of only 1 fallback prescription drug plan.

"(iii) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into a contract under this subsection. The provisions of subsection (d) of section 1874A shall apply to a contract under this section in the same manner as they apply to a contract under such section.

"(iv) TIMING.—The Secretary shall approve a fallback prescription drug plan for a PDP region in a manner so that, if there are any fallback service areas in the region for a year, the fallback prescription drug plan is offered at the same time as prescription drug plans would otherwise be offered.

"(V) NO NATIONAL FALLBACK PLAN.—The Secretary shall not enter into a contract with a single fallback entity for the offering of fallback plans throughout the United States.

"(2) ELIGIBLE FALLBACK ENTITY.—For purposes of this section, the term 'eligible fallback entity' means, with respect to all fallback service areas in a PDP region for a contract period, an entity that—

"(A) meets the requirements to be a PDP sponsor (or would meet such requirements but for the fact that the entity is not a risk-bearing entity); and

"(B) does not submit a bid under section 1860D–11(b) for any prescription drug plan for any PDP region for the first year of such contract period.

For purposes of subparagraph (B), an entity shall be treated as submitting a bid with respect to a prescription drug plan if the entity is acting as a subcontractor of a PDP sponsor that is offering such a plan. The previous sentence shall not apply to entities that are subcontractors of an MA organization except insofar as such organization is acting as a PDP sponsor with respect to a prescription drug plan.

"(3) FALLBACK SERVICE AREA.—For purposes of this subsection, the term 'fallback service area' means, for a PDP region with respect to a year, any area within such region for which the Secretary determines before the beginning of the year that the access requirements of the first sentence of section 1860D–3(a) will not be met for part D eligible individuals residing in the area for the year.

"(4) FALLBACK PRESCRIPTION DRUG PLAN.—For purposes of this part, the term 'fallback prescription drug plan' means a prescription drug plan that—

"(A) only offers the standard prescription drug coverage and access to negotiated prices described in section 1860D–2(a)(1)(A) and does not include any supplemental prescription drug coverage; and

"(B) meets such other requirements as the Secretary may specify.

"(5) PAYMENTS UNDER THE CONTRACT.—

"(A) IN GENERAL.—A contract entered into under this subsection shall provide for—

"(i) payment for the actual costs (taking into account negotiated price concessions described in section 1860D–2(d)(1)(B)) of covered part D drugs provided to part D eligible individuals enrolled in a fallback prescription drug plan offered by the entity; and

"(ii) payment of management fees that are tied to performance measures established by the Secretary for the management, administration, and delivery of the benefits under the contract.

"(B) PERFORMANCE MEASURES.—The performance measures established by the Secretary pursuant to subparagraph (A)(ii) shall include at least measures for each of the following:

"(i) COSTS.—The entity contains costs to the Medicare Prescription Drug Account and to part D eligible individuals enrolled in a fallback prescription drug plan offered by the entity *through mechanisms such as generic substitution and price discounts.*

"(ii) QUALITY PROGRAMS.—The entity provides such enrollees with quality programs that avoid adverse drug reactions and overutilization and reduce medical errors.

"(iii) CUSTOMER SERVICE.—The entity provides timely and accurate delivery of services and pharmacy and beneficiary support services.

"(iv) BENEFIT ADMINISTRATION AND CLAIMS ADJUDICATION.—The entity provides efficient and effective benefit administration and claims adjudication.

"(6) MONTHLY BENEFICIARY PREMIUM.—Except as provided in section 1860D–13(b) (relating to late enrollment penalty) and subject to section 1860D–14 (relating to low-income assistance), the monthly beneficiary premium to be charged under a fallback prescription drug plan offered in all fallback service areas in a PDP region shall be uniform and shall be equal to 25.5 percent of an amount equal to the Secretary's estimate of the average monthly per capita actuarial cost, including administrative expenses, under the fallback prescription drug plan of providing coverage in the region, as calculated by the Chief Actuary of the Centers for Medicare & Medicaid Services. In calculating such administrative expenses, the Chief Actuary shall use a factor that is based on similar expenses of prescription drug plans that are not fallback prescription drug plans.

"(7) GENERAL CONTRACT TERMS AND CONDITIONS.—

"(A) IN GENERAL.—Except as may be appropriate to carry out this section, the terms and conditions of contracts with eligible fallback entities offering fallback prescription drug plans under this subsection shall be the same as the terms and conditions of contracts under this part for prescription drug plans.

"(B) PERIOD OF CONTRACT.—

"(i) IN GENERAL.—Subject to clause (ii), a contract approved for a fallback prescription drug plan for fallback service areas for a PDP region under this section shall be for a period of 3 years (except as may be renewed after a subsequent bidding process).

"(ii) LIMITATION.—A fallback prescription drug plan may be offered under a contract in an area for a year only if that area is a fallback service area for that year.

"(C) ENTITY NOT PERMITTED TO MARKET OR BRAND FALLBACK PRESCRIPTION DRUG PLANS.—An eligible fallback entity with a contract under this subsection may not engage in any marketing or branding of a fallback prescription drug plan.

"(h) ANNUAL REPORT ON USE OF LIMITED RISK PLANS AND FALLBACK PLANS.—The Secretary shall submit to Congress an annual report that describes instances in which limited risk plans and fallback prescription drug plans were offered under subsections (f) and (g). The Secretary shall include in such report such recommendations as may be appropriate to limit the need for the provision of such plans and to maximize the assumption of financial risk under section subsection (f).

"(i) NONINTERFERENCE.—In order to promote competition under this part and in carrying out this part, the Secretary—

"(1) may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors; and

"(2) may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs.

"(j) COORDINATION OF BENEFITS.—A PDP sponsor offering a prescription drug plan shall permit State Pharmaceutical Assistance Programs and Rx plans under sections 1860D–23 and 1860D–24 to coordinate benefits with the plan and, in connection with such coordination with such a Program, not to impose fees that are unrelated to the cost of coordination.

"REQUIREMENTS FOR AND CONTRACTS WITH PRESCRIPTION DRUG PLAN (PDP) SPONSORS

"SEC. 1860D–12. (a) GENERAL REQUIREMENTS.—Each PDP sponsor of a prescription drug plan shall meet the following requirements:

"(1) LICENSURE.—Subject to subsection (c), the sponsor is organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a prescription drug plan.

"(2) ASSUMPTION OF FINANCIAL RISK FOR UNSUBSIDIZED COVERAGE.—

"(A) IN GENERAL.—Subject to subparagraph (B), to the extent that the entity is at risk the entity assumes financial risk on a prospective basis for benefits that it offers under a prescription drug plan and that is not covered under section 1860D–15(b).

"(B) REINSURANCE PERMITTED.—The plan sponsor may obtain insurance or make other arrangements for the cost of coverage provided to any enrollee to the extent that the sponsor is at risk for providing such coverage.

"(3) SOLVENCY FOR UNLICENSED SPONSORS.—In the case of a PDP sponsor that is not described in paragraph (1) and for which a waiver has been approved under subsection (c), such sponsor shall meet solvency standards established by the Secretary under subsection (d).

"(b) CONTRACT REQUIREMENTS.—

"(1) IN GENERAL.—The Secretary shall not permit the enrollment under section 1860D–1 in a prescription drug plan offered by a PDP sponsor under this part, and the sponsor shall not be eligible for payments under section 1860D–14 or 1860D–15, unless the Secretary has entered into a contract under this subsection with the sponsor with respect to the offering of such plan. Such a contract with a sponsor may cover more than one prescription drug plan. Such contract shall provide that the sponsor agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

"(2) LIMITATION ON ENTITIES OFFERING FALLBACK PRESCRIPTION DRUG PLANS.—The Secretary shall not enter into a contract with a PDP sponsor for the offering of a prescription drug plan (other than a fallback prescription drug plan) in a PDP region for a year if the sponsor—

"(A) submitted a bid under section 1860D–11(g) for such year (as the first year of a contract period under such section) to offer a fallback prescription drug plan in any PDP region;

"(B) offers a fallback prescription drug plan in any PDP region during the year; or

"(C) offered a fallback prescription drug plan in that PDP region during the previous year.

For purposes of this paragraph, an entity shall be treated as submitting a bid with respect to a prescription drug plan or offering a fallback prescription drug plan if the entity is acting as a subcontractor of a PDP sponsor that is offering such a plan. The previous sentence shall not apply to entities that are subcontractors of an MA organization except insofar as such organization is acting as a PDP sponsor with respect to a prescription drug plan.

"(3) INCORPORATION OF CERTAIN MEDICARE ADVANTAGE CONTRACT REQUIREMENTS.—Except as otherwise provided, the following provisions of section 1857 shall apply to contracts under this section in the same manner as they apply to contracts under section 1857(a):

"(A) MINIMUM ENROLLMENT.—Paragraphs (1) and (3) of section 1857(b), except that—

"(i) the Secretary may increase the minimum number of enrollees required under such paragraph (1) as the Secretary determines appropriate; and

"(ii) the requirement of such paragraph (1) shall be waived during the first contract year with respect to an organization in a region.

"(B) CONTRACT PERIOD AND EFFECTIVENESS.—Section 1857(c), except that in applying paragraph (4)(B) of such section any reference to payment amounts under section 1853 shall be deemed payment amounts under section 1860D–15.

"(C) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—Section 1857(d).

"(D) ADDITIONAL CONTRACT TERMS.—Section 1857(e); except that section 1857(e)(2) shall apply as specified to PDP sponsors and payments under this part to an MA–PD plan shall be treated as expenditures made under part D.

"(E) INTERMEDIATE SANCTIONS.—Section 1857(g) (other than paragraph (1)(F) of such section), except that in applying such section the reference in section 1857(g)(1)(B) to section 1854 is deemed a reference to this part.

"(F) PROCEDURES FOR TERMINATION.—Section 1857(h).

"(c) WAIVER OF CERTAIN REQUIREMENTS TO EXPAND CHOICE.—

"(1) AUTHORIZING WAIVER.—

"(A) IN GENERAL.—In the case of an entity that seeks to offer a prescription drug plan in a State, the Secretary shall waive the requirement of subsection (a)(1) that the entity be licensed in that State if the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in paragraph (2) have been met.

"(B) APPLICATION OF REGIONAL PLAN WAIVER RULE.—In addition to the waiver available under subparagraph (A), the provisions of section 1858(d) shall apply to PDP sponsors under this part in a manner similar to the manner in which such provisions apply to MA organizations under part C, except that no application shall be required under paragraph (1)(B) of such section in the case of a State that does not provide a licensing process for such a sponsor.

"(2) GROUNDS FOR APPROVAL.—

"(A) IN GENERAL.—The grounds for approval under this paragraph are—

"(i) subject to subparagraph (B), the grounds for approval described in subparagraphs (B), (C), and (D) of section 1855(a)(2); and

"(ii) the application by a State of any grounds other than those required under Federal law.

"(B) SPECIAL RULES.—In applying subparagraph (A)(i)—

"(i) the ground of approval described in section 1855(a)(2)(B) is deemed to have been met if the State does not have a licensing process in effect with respect to the PDP sponsor; and

"(ii) for plan years beginning before January 1, 2008, if the State does have such a licensing process in effect, such ground for approval described in such section is deemed to have been met upon submission of an application described in such section.

"(3) APPLICATION OF WAIVER PROCEDURES.—With respect to an application for a waiver (or a waiver granted) under paragraph (1)(A) of this subsection, the provisions of subparagraphs (E), (F), and (G) of section 1855(a)(2) shall apply, except that clauses (i) and (ii) of such subparagraph (E) shall not apply in the case of a State that does not have a licensing process described in paragraph (2)(B)(i) in effect.

"(4) REFERENCES TO CERTAIN PROVISIONS.—In applying provisions of section 1855(a)(2) under paragraphs (2) and (3) of this subsection to prescription drug plans and PDP sponsors—

"(A) any reference to a waiver application under section 1855 shall be treated as a reference to a waiver application under paragraph (1)(A) of this subsection; and

"(B) any reference to solvency standards shall be treated as a reference to solvency standards established under subsection (d) of this section.

"(d) SOLVENCY STANDARDS FOR NON-LICENSED ENTITIES.—

“(1) ESTABLISHMENT AND PUBLICATION.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall establish and publish, by not later than January 1, 2005, financial solvency and capital adequacy standards for entities described in paragraph (2).

“(2) COMPLIANCE WITH STANDARDS.—A PDP sponsor that is not licensed by a State under subsection (a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Secretary shall establish certification procedures for such sponsors with respect to such solvency standards in the manner described in section 1855(c)(2).

“(e) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that a PDP sponsor is licensed in accordance with subsection (a)(1) or has a waiver application approved under subsection (c) does not deem the sponsor to meet other requirements imposed under this part for a sponsor.

“(f) PERIODIC REVIEW AND REVISION OF STANDARDS.—

“(1) IN GENERAL.—Subject to paragraph (2), the Secretary may periodically review the standards established under this section and, based on such review, may revise such standards if the Secretary determines such revision to be appropriate.

“(2) PROHIBITION OF MIDYEAR IMPLEMENTATION OF SIGNIFICANT NEW REGULATORY REQUIREMENTS.—The Secretary may not implement, other than at the beginning of a calendar year, regulations under this section that impose new, significant regulatory requirements on a PDP sponsor or a prescription drug plan.

“(g) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES; RELATION TO STATE LAWS.—The provisions of sections 1854(g) and 1856(b)(3) shall apply with respect to PDP sponsors and prescription drug plans under this part in the same manner as such sections apply to MA organizations and MA plans under part C.

“PREMIUMS; LATE ENROLLMENT PENALTY

“SEC. 1860D–13. (a) MONTHLY BENEFICIARY PREMIUM.—

“(1) COMPUTATION.—

“(A) IN GENERAL.—The monthly beneficiary premium for a prescription drug plan is the base beneficiary premium computed under paragraph (2) as adjusted under this paragraph.

“(B) ADJUSTMENT TO REFLECT DIFFERENCE BETWEEN BID AND NATIONAL AVERAGE BID.—

“(i) ABOVE AVERAGE BID.—If for a month the amount of the standardized bid amount (as defined in paragraph (5)) exceeds the amount of the adjusted national average monthly bid amount (as defined in clause (iii)), the base beneficiary premium for the month shall be increased by the amount of such excess.

“(ii) BELOW AVERAGE BID.—If for a month the amount of the adjusted national average monthly bid amount for the month exceeds the standardized bid amount, the base beneficiary premium for the month shall be decreased by the amount of such excess.

“(iii) ADJUSTED NATIONAL AVERAGE MONTHLY BID AMOUNT DEFINED.—For purposes of this subparagraph, the term ‘adjusted national average monthly bid amount’ means the national average monthly bid amount computed under paragraph (4), as adjusted under section 1860D–15(c)(2).

“(C) INCREASE FOR SUPPLEMENTAL PRESCRIPTION DRUG BENEFITS.—The base beneficiary premium shall be increased by the portion of the PDP approved bid that is attributable to supplemental prescription drug benefits.

“(D) INCREASE FOR LATE ENROLLMENT PENALTY.—The base beneficiary premium shall be increased by the amount of any late enrollment penalty under subsection (b).

“(E) DECREASE FOR LOW-INCOME ASSISTANCE.—The monthly beneficiary premium is subject to decrease in the case of a subsidy eligible individual under section 1860D–14.

“(F) UNIFORM PREMIUM.—Except as provided in subparagraphs (D) and (E), the monthly beneficiary premium for a prescription drug plan in a PDP region is the same for all part D eligible individuals enrolled in the plan.

“(2) BASE BENEFICIARY PREMIUM.—The base beneficiary premium under this paragraph for a prescription drug plan for a month is equal to the product—

“(A) the beneficiary premium percentage (as specified in paragraph (3)); and

“(B) the national average monthly bid amount (computed under paragraph (4)) for the month.

“(3) BENEFICIARY PREMIUM PERCENTAGE.—For purposes of this subsection, the beneficiary premium percentage for any year is the percentage equal to a fraction—

“(A) the numerator of which is 25.5 percent; and

“(B) the denominator of which is 100 percent minus a percentage equal to—

“(i) the total reinsurance payments which the Secretary estimates are payable under section 1860D–15(b) with respect to the coverage year; divided by

“(ii) the sum of—

“(I) the amount estimated under clause (i) for the year; and

“(II) the total payments which the Secretary estimates will be paid to prescription drug plans and MA–PD plans that are attributable to the standardized bid amount during the year, taking into account amounts paid by the Secretary and enrollees.

“(4) COMPUTATION OF NATIONAL AVERAGE MONTHLY BID AMOUNT.—

“(A) IN GENERAL.—For each year (beginning with 2006) the Secretary shall compute a national average monthly bid amount equal to the average of the standardized bid amounts (as defined in paragraph (5)) for each prescription drug plan and for each MA–PD plan described in section 1851(a)(2)(A)(i). Such average does not take into account the bids submitted for MSA plans, MA private fee-for-service plan, and specialized MA plans for special needs individuals, PACE programs under section 1894 (pursuant to section 1860D–21(f)), and under reasonable cost reimbursement contracts under section 1876(h) (pursuant to section 1860D–21(e)).

“(B) WEIGHTED AVERAGE.—

“(i) IN GENERAL.—The monthly national average monthly bid amount computed under subparagraph (A) for a year shall be a weighted average, with the weight for each plan being equal to the average number of part D eligible individuals enrolled in such plan in the reference month (as defined in section 1858(f)(4)).

“(ii) SPECIAL RULE FOR 2006.—For purposes of applying this paragraph for 2006, the Secretary shall establish procedures for determining the weighted average under clause (i) for 2005.

“(5) STANDARDIZED BID AMOUNT DEFINED.—For purposes of this subsection, the term ‘standardized bid amount’ means the following:

“(A) PRESCRIPTION DRUG PLANS.—

“(i) BASIC COVERAGE.—In the case of a prescription drug plan that provides basic prescription drug coverage, the PDP approved bid (as defined in paragraph (6)).

“(ii) SUPPLEMENTAL COVERAGE.—In the case of a prescription drug plan that provides supplemental prescription drug coverage, the portion of the PDP approved bid that is attributable to basic prescription drug coverage.

“(B) MA–PD PLANS.—In the case of an MA–PD plan, the portion of the accepted bid amount that is attributable to basic prescription drug coverage.

“(6) PDP APPROVED BID DEFINED.—For purposes of this part, the term ‘PDP approved bid’ means, with respect to a prescription drug plan, the bid amount approved for the plan under this part.

“(b) LATE ENROLLMENT PENALTY.—

“(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, in the case of a part D eligible individual described in paragraph (2) with respect to a continuous period of eligibility, there shall be an increase in the monthly beneficiary premium established under subsection (a) in an amount determined under paragraph (3).

“(2) INDIVIDUALS SUBJECT TO PENALTY.—A part D eligible individual described in this paragraph is, with respect to a continuous period of eligibility, an individual for whom there is a continuous period of 63 days or longer (all of which in such continuous period of eligibility) beginning on the day after the last date of the individual’s initial enrollment period under section 1860D–1(b)(2) and ending on the date of enrollment under a prescription drug plan or MA–PD plan during all of which the individual was not covered under any creditable prescription drug coverage.

“(3) AMOUNT OF PENALTY.—

“(A) IN GENERAL.—The amount determined under this paragraph for a part D eligible individual for a continuous period of eligibility is the greater of—

“(i) an amount that the Secretary determines is actuarially sound for each uncovered month (as defined in subparagraph (B)) in the same continuous period of eligibility; or

“(ii) 1 percent of the base beneficiary premium (computed under subsection (a)(2)) for each such uncovered month in such period.

“(B) UNCOVERED MONTH DEFINED.—For purposes of this subsection, the term ‘uncovered month’ means, with respect to a part D eligible individual, any month beginning after the end of the initial enrollment period under section 1860D–1(b)(2) unless the individual can demonstrate that the individual had creditable prescription drug coverage (as defined in paragraph (4)) for any portion of such month.

“(4) CREDITABLE PRESCRIPTION DRUG COVERAGE DEFINED.—For purposes of this part, the term ‘creditable prescription drug coverage’ means any of the following coverage, but only if the coverage meets the requirement of paragraph (5):

“(A) COVERAGE UNDER PRESCRIPTION DRUG PLAN OR MA–PD PLAN.—Coverage under a prescription drug plan or under an MA–PD plan.

“(B) MEDICAID.—Coverage under a medicaid plan under title XIX or under a waiver under section 1115.

“(C) GROUP HEALTH PLAN.—Coverage under a group health plan, including a health benefits plan under chapter 89 of title 5, United States Code (commonly known as the Federal employees health benefits program), and a qualified retiree prescription drug plan (as defined in section 1860D–22(a)(2)).

“(D) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage under a State pharmaceutical assistance program described in section 1860D–23(b)(1).

“(E) VETERANS’ COVERAGE OF PRESCRIPTION DRUGS.—Coverage for veterans, and survivors and dependents of veterans, under chapter 17 of title 38, United States Code.

“(F) PRESCRIPTION DRUG COVERAGE UNDER MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)).

“(G) MILITARY COVERAGE (INCLUDING TRICARE).—Coverage under chapter 55 of title 10, United States Code.

"(H) OTHER COVERAGE.—Such other coverage as the Secretary determines appropriate.

"(5) ACTUARIAL EQUIVALENCE REQUIREMENT.—Coverage meets the requirement of this paragraph only if the coverage is determined (in a manner specified by the Secretary) to provide coverage of the cost of prescription drugs the actuarial value of which (as defined by the Secretary) to the individual equals or exceeds the actuarial value of standard prescription drug coverage (as determined under section 1860D–11(c)).

"(6) PROCEDURES TO DOCUMENT CREDITABLE PRESCRIPTION DRUG COVERAGE.—

"(A) IN GENERAL.—The Secretary shall establish procedures (including the form, manner, and time) for the documentation of creditable prescription drug coverage, including procedures to assist in determining whether coverage meets the requirement of paragraph (5).

"(B) DISCLOSURE BY ENTITIES OFFERING CREDITABLE PRESCRIPTION DRUG COVERAGE.—

"(i) IN GENERAL.—Each entity that offers prescription drug coverage of the type described in subparagraphs (B) through (H) of paragraph (4) shall provide for disclosure, in a form, manner, and time consistent with standards established by the Secretary, to the Secretary and part D eligible individuals of whether the coverage meets the requirement of paragraph (5) or whether such coverage is changed so it no longer meets such requirement.

"(ii) DISCLOSURE OF NON-CREDITABLE COVERAGE.—In the case of such coverage that does not meet such requirement, the disclosure to part D eligible individuals under this subparagraph shall include information regarding the fact that because such coverage does not meet such requirement there are limitations on the periods in a year in which the individuals may enroll under a prescription drug plan or an MA–PD plan and that any such enrollment is subject to a late enrollment penalty under this subsection.

"(C) WAIVER OF REQUIREMENT.—In the case of a part D eligible individual who was enrolled in prescription drug coverage of the type described in subparagraphs (B) through (H) of paragraph (4) which is not creditable prescription drug coverage because it does not meet the requirement of paragraph (5), the individual may apply to the Secretary to have such coverage treated as creditable prescription drug coverage if the individual establishes that the individual was not adequately informed that such coverage did not meet such requirement.

"(7) CONTINUOUS PERIOD OF ELIGIBILITY.—

"(A) IN GENERAL.—Subject to subparagraph (B), for purposes of this subsection, the term 'continuous period of eligibility' means, with respect to a part D eligible individual, the period that begins with the first day on which the individual is eligible to enroll in a prescription drug plan under this part and ends with the individual's death.

"(B) SEPARATE PERIOD.—Any period during all of which a part D eligible individual is entitled to hospital insurance benefits under part A and—

"(i) which terminated in or before the month preceding the month in which the individual attained age 65; or

"(ii) for which the basis for eligibility for such entitlement changed between section 226(b) and section 226(a), between 226(b) and section 226A, or between section 226A and section 226(a),

shall be a separate continuous period of eligibility with respect to the individual (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this paragraph).

"(c) COLLECTION OF MONTHLY BENEFICIARY PREMIUMS.—

"(1) IN GENERAL.—Subject to paragraphs (2) and (3), the provisions of section 1854(d) shall apply to PDP sponsors and premiums (and any late enrollment penalty) under this part in the same manner as they apply to MA organizations and beneficiary premiums under part C, except that any reference to a Trust Fund is deemed for this purpose a reference to the Medicare Prescription Drug Account.

"(2) CREDITING OF LATE ENROLLMENT PENALTY.—

"(A) PORTION ATTRIBUTABLE TO INCREASED ACTUARIAL COSTS.—With respect to late enrollment penalties imposed under subsection (b), the Secretary shall specify the portion of such a penalty that the Secretary estimates is attributable to increased actuarial costs assumed by the PDP sponsor or MA organization (and not taken into account through risk adjustment provided under section 1860D–15(c)(1) or through reinsurance payments under section 1860D–15(b)) as a result of such late enrollment.

"(B) COLLECTION THROUGH WITHHOLDING.—In the case of a late enrollment penalty that is collected from a part D eligible individual in the manner described in section 1854(d)(2)(A), the Secretary shall provide that only the portion of such penalty estimated under subparagraph (A) shall be paid to the PDP sponsor or MA organization offering the part D plan in which the individual is enrolled.

"(C) COLLECTION BY PLAN.—In the case of a late enrollment penalty that is collected from a part D eligible individual in a manner other than the manner described in section 1854(d)(2)(A), the Secretary shall establish procedures for reducing payments otherwise made to the PDP sponsor or MA organization by an amount equal to the amount of such penalty less the portion of such penalty estimated under subparagraph (A).

"(3) FALLBACK PLANS.—In applying this subsection in the case of a fallback prescription drug plan, paragraph (2) shall not apply and the monthly beneficiary premium shall be collected in the manner specified in section 1854(d)(2)(A) (or such other manner as may be provided under section 1840 in the case of monthly premiums under section 1839).

"PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS

"SEC. 1860D–14. (a) INCOME-RELATED SUBSIDIES FOR INDIVIDUALS WITH INCOME UP TO 150 PERCENT OF POVERTY LINE.—

"(1) INDIVIDUALS WITH INCOME BELOW 135 PERCENT OF POVERTY LINE.—In the case of a subsidy eligible individual (as defined in paragraph (3)) who is determined to have income that is below 135 percent of the poverty line applicable to a family of the size involved and who meets the resources requirement described in paragraph (3)(D) or who is covered under this paragraph under paragraph (3)(B)(i), the individual is entitled under this section to the following:

"(A) FULL PREMIUM SUBSIDY.—An income-related premium subsidy equal to—

"(i) 100 percent of the amount described in subsection (b)(1), but not to exceed the premium amount specified in subsection (b)(2)(B); plus

"(ii) 80 percent of any late enrollment penalties imposed under section 1860D--13(b) for the first 60 months in which such penalties are imposed for that individual, and 100 percent of any such penalties for any subsequent month.

"(B) ELIMINATION OF DEDUCTIBLE.—A reduction in the annual deductible applicable under section 1860D–2(b)(1) to $0.

"(C) CONTINUATION OF COVERAGE ABOVE THE INITIAL COVERAGE LIMIT.—The continuation of coverage from the initial coverage limit (under paragraph (3) of section 1860D–2(b)) for expenditures incurred through the total amount of expenditures at which benefits are available under paragraph (4) of such section, subject to the reduced cost-sharing described in subparagraph (D).

"(D) REDUCTION IN COST-SHARING BELOW OUT-OF-POCKET THRESHOLD.—

"(i) INSTITUTIONALIZED INDIVIDUALS.—In the case of an individual who is a full-benefit dual eligible individual and who is an institutionalized individual or couple (as defined in section 1902(q)(1)(B)), the elimination of any beneficiary coinsurance described in section 1860D–2(b)(2) (for all amounts through the total amount of expenditures at which benefits are available under section 1860D–2(b)(4)).

"(ii) LOWEST INCOME DUAL ELIGIBLE INDIVIDUALS.—In the case of an individual not described in clause (i) who is a full-benefit dual eligible individual and whose income does not exceed 100 percent of the poverty line applicable to a family of the size involved, the substitution for the beneficiary coinsurance described in section 1860D–2(b)(2) (for all amounts through the total amount of expenditures at which benefits are available under section 1860D–2(b)(4)) of a copayment amount that does not exceed $1 for a generic drug or a preferred drug that is a multiple source drug (as defined in section 1927(k)(7)(A)(i)) and $3 for any other drug, or, if less, the copayment amount applicable to an individual under clause (iii).

"(iii) OTHER INDIVIDUALS.—In the case of an individual not described in clause (i) or (ii), the substitution for the beneficiary coinsurance described in section 1860D–2(b)(2) (for all amounts through the total amount of expenditures at which benefits are available under section 1860D–2(b)(4)) of a copayment amount that does not exceed the copayment amount specified under section 1860D–2(b)(4)(A)(i)(I) for the drug and year involved.

"(E) ELIMINATION OF COST-SHARING ABOVE ANNUAL OUT-OF-POCKET THRESHOLD.—The elimination of any cost-sharing imposed under section 1860D–2(b)(4)(A).

"(2) OTHER INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF POVERTY LINE.—In the case of a subsidy eligible individual who is not described in paragraph (1), the individual is entitled under this section to the following:

"(A) SLIDING SCALE PREMIUM SUBSIDY.—An income-related premium subsidy determined on a linear sliding scale ranging from 100 percent of the amount described in paragraph (1)(A) for individuals with incomes at or below 135 percent of such level to 0 percent of such amount for individuals with incomes at 150 percent of such level.

"(B) REDUCTION OF DEDUCTIBLE.—A reduction in the annual deductible applicable under section 1860D–2(b)(1) to $50.

"(C) CONTINUATION OF COVERAGE ABOVE THE INITIAL COVERAGE LIMIT.—The continuation of coverage from the initial coverage limit (under paragraph (3) of section 1860D–2(b)) for expenditures incurred through the total amount of expenditures at which benefits are available under paragraph (4) of such section, subject to the reduced coinsurance described in subparagraph (D).

"(D) REDUCTION IN COST-SHARING BELOW OUT-OF-POCKET THRESHOLD.—The substitution for the beneficiary coinsurance described in section 1860D–2(b)(2) (for all amounts above the deductible under subparagraph (B) through the total amount of expenditures at which benefits are available under section 1860D–2(b)(4)) of coinsurance of '15 percent' instead of coinsurance of '25 percent' in section 1860D–2(b)(2).

"(E) REDUCTION OF COST-SHARING ABOVE ANNUAL OUT-OF-POCKET THRESHOLD.—Subject to subsection (c), the substitution for the cost-sharing imposed under section 1860D–2(b)(4)(A) of a copayment or coinsurance not to exceed the copayment or coinsurance amount specified under section 1860D–2(b)(4)(A)(i)(I) for the drug and year involved.

"(3) DETERMINATION OF ELIGIBILITY.—

"(A) SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this part, subject to subparagraph (F), the term 'subsidy eligible individual' means a part D eligible individual who—

"(i) is enrolled in a prescription drug plan or MA–PD plan;

"(ii) has income below 150 percent of the poverty line applicable to a family of the size involved; and

"(iii) meets the resources requirement described in subparagraph (D) or (E).

"(B) DETERMINATIONS.—

"(i) IN GENERAL.—The determination of whether a part D eligible individual residing in a State is a subsidy eligible individual and whether the individual is described in paragraph (1) shall be determined under the State plan under title XIX for the State under section 1935(a) or by the Commissioner of Social Security. There are authorized to be appropriated to the Social Security Administration such sums as may be necessary for the determination of eligibility under this subparagraph.

"(ii) EFFECTIVE PERIOD.—Determinations under this subparagraph shall be effective beginning with the month in which the individual applies for a determination that the individual is a subsidy eligible individual and shall remain in effect for a period specified by the Secretary, but not to exceed 1 year.

"(iii) REDETERMINATIONS AND APPEALS THROUGH MEDICAID.—Redeterminations and appeals, with respect to eligibility determinations under clause (i) made under a State plan under title XIX, shall be made in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under such plan for purposes of medical assistance under such title.

"(iv) REDETERMINATIONS AND APPEALS THROUGH COMMISSIONER.—With respect to eligibility determinations under clause (i) made by the Commissioner of Social Security—

"(I) redeterminations shall be made at such time or times as may be provided by the Commissioner; and

"(II) the Commissioner shall establish procedures for appeals of such determinations that are similar to the procedures described in the third sentence of section 1631(c)(1)(A).

"(v) TREATMENT OF MEDICAID BENEFICIARIES.—Subject to subparagraph (F), the Secretary—

"(I) shall provide that part D eligible individuals who are full-benefit dual eligible individuals (as defined in section 1935(c)(6)) or who are recipients of supplemental security income benefits under title XVI shall be treated as subsidy eligible individuals described in paragraph (1); and

"(II) may provide that part D eligible individuals not described in subclause (I) who are determined for purposes of the State plan under title XIX to be eligible for medical assistance under clause (i), (iii), or (iv) of section 1902(a)(10)(E) are treated as being determined to be subsidy eligible individuals described in paragraph (1).

Insofar as the Secretary determines that the eligibility requirements under the State plan for medical assistance referred to in subclause (II) are substantially the same as the requirements for being treated as a subsidy eligible individual described in paragraph (1), the Secretary shall provide for the treatment described in such subclause.

"(C) INCOME DETERMINATIONS.—For purposes of applying this section—

"(i) in the case of a part D eligible individual who is not treated as a subsidy eligible individual under subparagraph (B)(v), income shall be determined in the manner described in section 1905(p)(1)(B), without regard to the application of section 1902(r)(2); and

"(ii) the term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

Nothing in clause (i) shall be construed to affect the application of section 1902(r)(2) for the determination of eligibility for medical assistance under title XIX.

"(D) RESOURCE STANDARD APPLIED TO FULL LOW-INCOME SUBSIDY TO BE BASED ON THREE TIMES SSI RESOURCE STANDARD.—The resources requirement of this subparagraph is that an individual's resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed—

"(i) for 2006 three times the maximum amount of resources that an individual may have and obtain benefits under that program; and

"(ii) for a subsequent year the resource limitation established under this clause for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year.

Any resource limitation established under clause (ii) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

"(E) ALTERNATIVE RESOURCE STANDARD.—

"(i) IN GENERAL.—The resources requirement of this subparagraph is that an individual's resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed—

"(I) for 2006, $10,000 (or $20,000 in the case of the combined value of the individual's assets or resources and the assets or resources of the individual's spouse); and

"(II) for a subsequent year the dollar amounts specified in this subclause (or subclause (I)) for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year.

Any dollar amount established under subclause (II) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

"(ii) USE OF SIMPLIFIED APPLICATION FORM AND PROCESS.—The Secretary, jointly with the Commissioner of Social Security, shall—

"(I) develop a model, simplified application form and process consistent with clause (iii) for the determination and verification of a part D eligible individual's assets or resources under this subparagraph; and

"(II) provide such form to States.

"(iii) DOCUMENTATION AND SAFEGUARDS.—Under such process—

"(I) the application form shall consist of an attestation under penalty of perjury regarding the level of assets or resources (or combined assets and resources in the case of a married part D eligible individual) and valuations of general classes of assets or resources;

"(II) such form shall be accompanied by copies of recent statements (if any) from financial institutions in support of the application; and

"(III) matters attested to in the application shall be subject to appropriate methods of verification.

"(iv) METHODOLOGY FLEXIBILITY.—The Secretary may permit a State in making eligibility determinations for premium and cost-sharing subsidies under this section to use the same asset or resource methodologies that are used with respect to eligibility for medical assistance for medicare cost-sharing described in section 1905(p) so long as the Secretary determines that the use of such methodologies will not result in any significant differences in the number of individuals determined to be subsidy eligible individuals.

"(F) TREATMENT OF TERRITORIAL RESIDENTS.—In the case of a part D eligible individual who is not a resident of the 50 States or the District of Columbia, the individual is not eligible to be a subsidy eligible individual under this section but may be eligible for financial assistance with prescription drug expenses under section 1935(e).

"(4) INDEXING DOLLAR AMOUNTS.—

"(A) COPAYMENT FOR LOWEST INCOME DUAL ELIGIBLE INDIVIDUALS.—The dollar amounts applied under paragraph (1)(D)(ii)—

"(i) for 2007 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year; or

"(ii) for a subsequent year shall be the dollar amounts specified in this clause (or clause (i)) for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year.

Any amount established under clause (i) or (ii), that is based on an increase of $1 or $3, that is not a multiple of 5 cents or 10 cents, respectively, shall be rounded to the nearest multiple of 5 cents or 10 cents, respectively.

"(B) REDUCED DEDUCTIBLE.—The dollar amount applied under paragraph (2)(B)—

"(i) for 2007 shall be the dollar amount specified in such paragraph increased by the annual percentage increase described in section 1860D–2(b)(6) for 2007; or

"(ii) for a subsequent year shall be the dollar amount specified in this clause (or clause (i)) for the previous year increased by the annual percentage increase described in section 1860D–2(b)(6) for the year involved.

Any amount established under clause (i) or (ii) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

"(b) PREMIUM SUBSIDY AMOUNT.—

"(1) IN GENERAL.—The premium subsidy amount described in this subsection for a subsidy eligible individual residing in a PDP region and enrolled in a prescription drug plan or MA–PD plan is the low-income benchmark premium amount (as defined in paragraph (2)) for the PDP region in which the individual resides or, if greater, the amount specified in paragraph (3).

"(2) LOW-INCOME BENCHMARK PREMIUM AMOUNT DEFINED.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'low-income benchmark premium amount' means, with respect to a PDP region in which—

"(i) all prescription drug plans are offered by the same PDP sponsor, the weighted average of the amounts described in subparagraph (B)(i) for such plans; or

"(ii) there are prescription drug plans offered by more than one PDP sponsor, the weighted average of amounts described in subparagraph (B) for prescription drug plans and MA–PD plans described in section 1851(a)(2)(A)(i) offered in such region.

"(B) PREMIUM AMOUNTS DESCRIBED.—The premium amounts described in this subparagraph are, in the case of—

"(i) a prescription drug plan that is a basic prescription drug plan, the monthly beneficiary premium for such plan;

"(ii) a prescription drug plan that provides alternative prescription drug coverage the actuarial value of which is greater than that of standard prescription drug coverage, the portion of the monthly beneficiary premium that is attributable to basic prescription drug coverage; and

"(iii) an MA–PD plan, the portion of the MA monthly prescription drug beneficiary premium that is attributable to basic prescription drug benefits (described in section 1852(a)(6)(B)(ii)).

The premium amounts described in this subparagraph do not include any amounts attributable to late enrollment penalties under section 1860D–13(b).

"(3) ACCESS TO 0 PREMIUM PLAN.—In no case shall the premium subsidy amount under this subsection for a PDP region be less than the lowest monthly beneficiary premium for a prescription drug plan that offers basic prescription drug coverage in the region.

"(c) ADMINISTRATION OF SUBSIDY PROGRAM.—

"(1) IN GENERAL.—The Secretary shall provide a process whereby, in the case of a part D eligible individual who is determined to be a subsidy eligible individual and who is enrolled in a prescription drug plan or is enrolled in an MA–PD plan—

"(A) the Secretary provides for a notification of the PDP sponsor or the MA organization offering the plan involved that the individual is eligible for a subsidy and the amount of the subsidy under subsection (a);

"(B) the sponsor or organization involved reduces the premiums or cost-sharing otherwise imposed by the amount of the applicable subsidy and submits to the Secretary information on the amount of such reduction;

"(C) the Secretary periodically and on a timely basis reimburses the sponsor or organization for the amount of such reductions; and

"(D) the Secretary ensures the confidentiality of individually identifiable information.

In applying subparagraph (C), the Secretary shall compute reductions based upon imposition under subsections (a)(1)(D) and (a)(2)(E) of unreduced copayment amounts applied under such subsections.

"(2) USE OF CAPITATED FORM OF PAYMENT.—The reimbursement under this section with respect to cost-sharing subsidies may be computed on a capitated basis, taking into account the actuarial value of the subsidies and with appropriate adjustments to reflect differences in the risks actually involved.

"(d) RELATION TO MEDICAID PROGRAM.—For special provisions under the medicaid program relating to medicare prescription drug benefits, see section 1935.

"SUBSIDIES FOR PART D ELIGIBLE INDIVIDUALS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE

"SEC. 1860D–15. (a) SUBSIDY PAYMENT.—In order to reduce premium levels applicable to qualified prescription drug coverage for part D eligible individuals consistent with an overall subsidy level of 74.5 percent for basic prescription drug coverage, to reduce adverse selection among prescription drug plans and MA–PD plans, and to promote the participation of PDP sponsors under this part and MA organizations under part C, the Secretary shall provide for payment to a PDP sponsor that offers a prescription drug plan and an MA organization that offers an MA–PD plan of the following subsidies in accordance with this section:

"(1) DIRECT SUBSIDY.—A direct subsidy for each part D eligible individual enrolled in a prescription drug plan or MA–PD plan for a month equal to—

"(A) the amount of the plan's standardized bid amount (as defined in section 1860D–13(a)(5)), adjusted under subsection (c)(1), reduced by

"(B) the base beneficiary premium (as computed under paragraph (2) of section 1860D–13(a) and as adjusted under paragraph (1)(B) of such section).

"(2) SUBSIDY THROUGH REINSURANCE.—The reinsurance payment amount (as defined in subsection (b)).

This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this section.

"(b) REINSURANCE PAYMENT AMOUNT.—

"(1) IN GENERAL.—The reinsurance payment amount under this subsection for a part D eligible individual enrolled in a prescription drug plan or MA–PD plan for a coverage year is an amount equal to 80 percent of the allowable reinsurance costs (as specified in paragraph (2)) attributable to that portion of gross covered prescription drug costs as specified in paragraph (3) incurred in the coverage year after such individual has incurred costs that exceed the annual out-of-pocket threshold specified in section 1860D–2(b)(4)(B).

"(2) ALLOWABLE REINSURANCE COSTS.—For purposes of this section, the term 'allowable reinsurance costs' means, with respect to gross covered prescription drug costs under a prescription drug plan offered by a PDP sponsor or an MA–PD plan offered by an MA organization, the part of such costs that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or organization or by (or on behalf of) an enrollee under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were basic prescription drug coverage, or, in the case of a plan providing supplemental prescription drug coverage, if such coverage were standard prescription drug coverage.

"(3) GROSS COVERED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term 'gross covered prescription drug costs' means, with respect to a part D eligible individual enrolled in a prescription drug plan or MA–PD plan during a coverage year, the costs incurred under the plan, not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year and costs relating to the deductible. Such costs shall be determined whether they are paid by the individual or under the plan, regardless of whether the coverage under the plan exceeds basic prescription drug coverage.

"(4) COVERAGE YEAR DEFINED.—For purposes of this section, the term 'coverage year' means a calendar year in which covered part D drugs are dispensed if the claim for such drugs (and payment on such claim) is made not later than such period after the end of such year as the Secretary specifies.

"(c) ADJUSTMENTS RELATING TO BIDS.—

"(1) HEALTH STATUS RISK ADJUSTMENT.—

"(A) ESTABLISHMENT OF RISK ADJUSTORS.—The Secretary shall establish an appropriate methodology for adjusting the standardized bid amount under subsection (a)(1)(A) to take into account variation in costs for basic prescription drug coverage among prescription drug plans and MA–PD plans based on the differences in actuarial risk of different enrollees being served. Any such risk adjustment shall be designed in a manner so as not to result in a change in the aggregate amounts payable to such plans under subsection (a)(1) and through that portion of the monthly beneficiary prescription drug premiums described in subsection (a)(1)(B) and MA monthly prescription drug beneficiary premiums.

"(B) CONSIDERATIONS.—In establishing the methodology under subparagraph (A), the Secretary may take into account the similar methodologies used under section 1853(a)(3) to adjust payments to MA organizations for benefits under the original medicare fee-for-service program option.

"(C) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require—

"(i) PDP sponsors to submit data regarding drug claims that can be linked at the individual level to part A and part B data and such other information as the Secretary determines necessary; and

"(ii) MA organizations that offer MA–PD plans to submit data regarding drug claims that can be linked at the individual level to other data that such organizations are required to submit to the Secretary and such other information as the Secretary determines necessary.

"(D) PUBLICATION.—At the time of publication of risk adjustment factors under section 1853(b)(1)(B)(i)(II), the Secretary shall publish the risk adjusters established under this paragraph for the succeeding year.

"(2) GEOGRAPHIC ADJUSTMENT.—

"(A) IN GENERAL.—Subject to subparagraph (B), for purposes of section 1860D–13(a)(1)(B)(iii), the Secretary shall establish an appropriate methodology for adjusting the national average monthly bid amount (computed under section 1860D–13(a)(4)) to take into account differences in prices for covered part D drugs among PDP regions.

"(B) DE MINIMIS RULE.—If the Secretary determines that the price variations described in subparagraph (A) among PDP regions are de minimis, the Secretary shall not provide for adjustment under this paragraph.

"(C) BUDGET NEUTRAL ADJUSTMENT.—Any adjustment under this paragraph shall be applied in a manner so as to not result in a change in the aggregate payments made under this part that would have been made if the Secretary had not applied such adjustment.

"(d) PAYMENT METHODS.—

"(1) IN GENERAL.—Payments under this section shall be based on such a method as the Secretary determines. The Secretary may establish a payment method by which interim payments of amounts under this section are made during a year based on the Secretary's best estimate of amounts that will be payable after obtaining all of the information.

"(2) REQUIREMENT FOR PROVISION OF INFORMATION.—

"(A) REQUIREMENT.—Payments under this section to a PDP sponsor or MA organization are conditioned upon the furnishing to the Secretary, in a form and manner specified by the Secretary, of such information as may be required to carry out this section.

"(B) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to subparagraph (A) may be used by officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section.

"(3) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Medicare Prescription Drug Account.

"(4) APPLICATION OF ENROLLEE ADJUSTMENT.—The provisions of section 1853(a)(2) shall apply to payments to PDP sponsors under this section in the same manner as they apply to payments to MA organizations under section 1853(a).

"(e) PORTION OF TOTAL PAYMENTS TO A SPONSOR OR ORGANIZATION SUBJECT TO RISK (APPLICATION OF RISK CORRIDORS).—

"(1) COMPUTATION OF ADJUSTED ALLOWABLE RISK CORRIDOR COSTS.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'adjusted allowable risk corridor costs' means, for a plan for a coverage year (as defined in subsection (b)(4))—

"(i) the allowable risk corridor costs (as defined in subparagraph (B)) for the plan for the year, reduced by

"(ii) the sum of (I) the total reinsurance payments made under subsection (b) to the sponsor of the plan for the year, and (II) the total subsidy payments made under section 1860D–14 to the sponsor of the plan for the year.

"(B) ALLOWABLE RISK CORRIDOR COSTS.—For purposes of this subsection, the term 'allowable risk corridor costs' means, with respect to a prescription drug plan offered by a PDP sponsor or an MA–PD plan offered by an MA organization,

the part of costs (not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year) incurred by the sponsor or organization under the plan that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or organization under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were basic prescription drug coverage, or, in the case of a plan providing supplemental prescription drug coverage, if such coverage were basic prescription drug coverage taking into account the adjustment under section 1860D–11(c)(2). In computing allowable costs under this paragraph, the Secretary shall compute such costs based upon imposition under paragraphs (1)(D) and (2)(E) of section 1860D–14(a) of the maximum amount of copayments permitted under such paragraphs.

"(2) ADJUSTMENT OF PAYMENT.—

"(A) NO ADJUSTMENT IF ADJUSTED ALLOWABLE RISK CORRIDOR COSTS WITHIN RISK CORRIDOR.—If the adjusted allowable risk corridor costs (as defined in paragraph (1)) for the plan for the year are at least equal to the first threshold lower limit of the risk corridor (specified in paragraph (3)(A)(i)), but not greater than the first threshold upper limit of the risk corridor (specified in paragraph (3)(A)(iii)) for the plan for the year, then no payment adjustment shall be made under this subsection.

"(B) INCREASE IN PAYMENT IF ADJUSTED ALLOWABLE RISK CORRIDOR COSTS ABOVE UPPER LIMIT OF RISK CORRIDOR.—

"(i) COSTS BETWEEN FIRST AND SECOND THRESHOLD UPPER LIMITS.—If the adjusted allowable risk corridor costs for the plan for the year are greater than the first threshold upper limit, but not greater than the second threshold upper limit, of the risk corridor for the plan for the year, the Secretary shall increase the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount equal to 50 percent (or, for 2006 and 2007, 75 percent or 90 percent if the conditions described in clause (iii) are met for the year) of the difference between such adjusted allowable risk corridor costs and the first threshold upper limit of the risk corridor.

"(ii) COSTS ABOVE SECOND THRESHOLD UPPER LIMITS.—If the adjusted allowable risk corridor costs for the plan for the year are greater than the second threshold upper limit of the risk corridor for the plan for the year, the Secretary shall increase the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount equal to the sum of—

"(I) 50 percent (or, for 2006 and 2007, 75 percent or 90 percent if the conditions described in clause (iii) are met for the year) of the difference between the second threshold upper limit and the first threshold upper limit; and

"(II) 80 percent of the difference between such adjusted allowable risk corridor costs and the second threshold upper limit of the risk corridor.

"(iii) CONDITIONS FOR APPLICATION OF HIGHER PERCENTAGE FOR 2006 AND 2007.—The conditions described in this clause are met for 2006 or 2007 if the Secretary determines with respect to such year that—

"(I) at least 60 percent of prescription drug plans and MA–PD plans to which this subsection applies have adjusted allowable risk corridor costs for the plan for the year that are more than the first threshold upper limit of the risk corridor for the plan for the year; and

"(II) such plans represent at least 60 percent of part D eligible individuals enrolled in any prescription drug plan or MA–PD plan.

"(C) REDUCTION IN PAYMENT IF ADJUSTED ALLOWABLE RISK CORRIDOR COSTS BELOW LOWER LIMIT OF RISK CORRIDOR.—

"(i) COSTS BETWEEN FIRST AND SECOND THRESHOLD LOWER LIMITS.—If the adjusted allowable risk corridor costs for the plan for the year are less than the first threshold lower limit, but not less than the second threshold lower limit, of the risk corridor for the plan for the year, the Secretary shall reduce the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount (or otherwise recover from the sponsor or organization an amount) equal to 50 percent (or, for 2006 and 2007, 75 percent) of the difference between the first threshold lower limit of the risk corridor and such adjusted allowable risk corridor costs.

"(ii) COSTS BELOW SECOND THRESHOLD LOWER LIMIT.—If the adjusted allowable risk corridor costs for the plan for the year are less the second threshold lower limit of the risk corridor for the plan for the year, the Secretary shall reduce the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount (or otherwise recover from the sponsor or organization an amount) equal to the sum of—

"(I) 50 percent (or, for 2006 and 2007, 75 percent) of the difference between the first threshold lower limit and the second threshold lower limit; and

"(II) 80 percent of the difference between the second threshold upper limit of the risk corridor and such adjusted allowable risk corridor costs.

"(3) ESTABLISHMENT OF RISK CORRIDORS.—

"(A) IN GENERAL.—For each plan year the Secretary shall establish a risk corridor for each prescription drug plan and each MA–PD plan. The risk corridor for a plan for a year shall be equal to a range as follows:

"(i) FIRST THRESHOLD LOWER LIMIT.—The first threshold lower limit of such corridor shall be equal to—

"(I) the target amount described in subparagraph (B) for the plan; minus

"(II) an amount equal to the first threshold risk percentage for the plan (as determined under subparagraph (C)(i)) of such target amount.

"(ii) SECOND THRESHOLD LOWER LIMIT.—The second threshold lower limit of such corridor shall be equal to—

"(I) the target amount described in subparagraph (B) for the plan; minus

"(II) an amount equal to the second threshold risk percentage for the plan (as determined under subparagraph (C)(ii)) of such target amount.

"(iii) FIRST THRESHOLD UPPER LIMIT.—The first threshold upper limit of such corridor shall be equal to the sum of—

"(I) such target amount; and

"(II) the amount described in clause (i)(II).

"(iv) SECOND THRESHOLD UPPER LIMIT.—The second threshold upper limit of such corridor shall be equal to the sum of—

"(I) such target amount; and

"(II) the amount described in clause (ii)(II).

"(B) TARGET AMOUNT DESCRIBED.—The target amount described in this paragraph is, with respect to a prescription drug plan or an MA–PD plan in a year, the total amount of payments paid to the PDP sponsor or MA–PD organization for the plan for the year, taking into account amounts paid by the Secretary and enrollees, based upon the standardized bid amount (as defined in section 1860D–13(a)(5) and as risk adjusted under subsection (c)(1)), reduced by the total amount of administrative expenses for the year assumed in such standardized bid.

"(C) FIRST AND SECOND THRESHOLD RISK PERCENTAGE DEFINED.—

"(i) FIRST THRESHOLD RISK PERCENTAGE.—Subject to clause (iii), for purposes of this section, the first threshold risk percentage is—

"(I) for 2006 and 2007, and 2.5 percent;

"(II) for 2008 through 2011, 5 percent; and

"(III) for 2012 and subsequent years, a percentage established by the Secretary, but in no case less than 5 percent.

"(ii) SECOND THRESHOLD RISK PERCENTAGE.—Subject to clause (iii), for purposes of this section, the second threshold risk percentage is—

"(I) for 2006 and 2007, 5 percent;

"(II) for 2008 through 2011, 10 percent; and

"(III) for 2012 and subsequent years, a percentage established by the Secretary that is greater than the percent established for the year under clause (i)(III), but in no case less than 10 percent.

"(iii) REDUCTION OF RISK PERCENTAGE TO ENSURE 2 PLANS IN AN AREA.—Pursuant to section 1860D–11(b)(2)(E)(ii), a PDP sponsor may submit a bid that requests a decrease in the applicable first or second threshold risk percentages or an increase in the percents applied under paragraph (2).

"(4) PLANS AT RISK FOR ENTIRE AMOUNT OF SUPPLEMENTAL PRESCRIPTION DRUG COVERAGE.—A PDP sponsor and MA organization that offers a plan that provides supplemental prescription drug benefits shall be at full financial risk for the provision of such supplemental benefits.

"(5) NO EFFECT ON MONTHLY PREMIUM.—No adjustment in payments made by reason of this subsection shall affect the monthly beneficiary premium or the MA monthly prescription drug beneficiary premium.

"(f) DISCLOSURE OF INFORMATION.—

"(1) IN GENERAL.—Each contract under this part and under part C shall provide that—

"(A) the PDP sponsor offering a prescription drug plan or an MA organization offering an MA–PD plan shall provide the Secretary with such information as the Secretary determines is necessary to carry out this section; and

"(B) the Secretary shall have the right in accordance with section 1857(d)(2)(B) (as applied under section 1860D–12(b)(3)(C)) to inspect and audit any books and records of a PDP sponsor or MA organization that pertain to the information regarding costs provided to the Secretary under subparagraph (A).

"(2) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to the provisions of this section may be used by officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section.

"(g) PAYMENT FOR FALLBACK PRESCRIPTION DRUG PLANS.—In lieu of the amounts otherwise payable under this section to a PDP sponsor offering a fallback prescription drug plan (as defined in section 1860D–3(c)(4)), the amount payable shall be the amounts determined under the contract for such plan pursuant to section 1860D–11(g)(5).

"MEDICARE PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

"SEC. 1860D–16. (a) ESTABLISHMENT AND OPERATION OF ACCOUNT.—

"(1) ESTABLISHMENT.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Medicare Prescription Drug Account' (in this section referred to as the 'Account').

"(2) FUNDING.—The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), accrued interest on balances in the Account, and such amounts as may be deposited in, or appropriated to, such Account as provided in this part.

"(3) SEPARATE FROM REST OF TRUST FUND.—Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund, but shall be invested, and such investments redeemed, in the same manner as all other funds and investments within such Trust Fund.

“(b) PAYMENTS FROM ACCOUNT.—

“(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments to operate the program under this part, including—

“(A) payments under section 1860D–14 (relating to low-income subsidy payments);

“(B) payments under section 1860D–15 (relating to subsidy payments and payments for fallback plans);

“(C) payments to sponsors of qualified retiree prescription drug plans under section 1860D–22(a); and

“(D) payments with respect to administrative expenses under this part in accordance with section 201(g).

“(2) TRANSFERS TO MEDICAID ACCOUNT FOR INCREASED ADMINISTRATIVE COSTS.—The Managing Trustee shall transfer from time to time from the Account to the Grants to States for Medicaid account amounts the Secretary certifies are attributable to increases in payment resulting from the application of section 1935(b).

“(3) PAYMENTS OF PREMIUMS WITHHELD.—The Managing Trustee shall make payment to the PDP sponsor or MA organization involved of the premiums (and the portion of late enrollment penalties) that are collected in the manner described in section 1854(d)(2)(A) and that are payable under a prescription drug plan or MA–PD plan offered by such sponsor or organization.

“(4) TREATMENT IN RELATION TO PART B PREMIUM.—Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1839.

“(c) DEPOSITS INTO ACCOUNT.—

“(1) LOW-INCOME TRANSFER.—Amounts paid under section 1935(c) (and any amounts collected or offset under paragraph (1)(C) of such section) are deposited into the Account.

“(2) AMOUNTS WITHHELD.—Pursuant to sections 1860D–13(c) and 1854(d) (as applied under this part), amounts that are withheld (and allocated) to the Account are deposited into the Account.

“(3) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Account, an amount equivalent to the amount of payments made from the Account under subsection (b) plus such amounts as the Managing Trustee certifies is necessary to maintain an appropriate contingency margin, reduced by the amounts deposited under paragraph (1) or subsection (a)(2).

“(4) INITIAL FUNDING AND RESERVE.—In order to assure prompt payment of benefits provided under this part and the administrative expenses thereunder during the early months of the program established by this part and to provide an initial contingency reserve, there are authorized to be appropriated to the Account, out of any moneys in the Treasury not otherwise appropriated, such amount as the Secretary certifies are required, but not to exceed 10 percent of the estimated total expenditures from such Account in 2006.

“(5) TRANSFER OF ANY REMAINING BALANCE FROM TRANSITIONAL ASSISTANCE ACCOUNT.—Any balance in the Transitional Assistance Account that is transferred under section 1860D–31(k)(5) shall be deposited into the Account.

“Subpart 3—Application to Medicare Advantage Program and Treatment of Employer-Sponsored Programs and Other Prescription Drug Plans

“APPLICATION TO MEDICARE ADVANTAGE PROGRAM AND RELATED MANAGED CARE PROGRAMS

“SEC. 1860D–21. (a) SPECIAL RULES RELATING TO OFFERING OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

“(1) IN GENERAL.—An MA organization on and after January 1, 2006—

“(A) may not offer an MA plan described in section 1851(a)(2)(A) in an area unless either that plan (or another MA plan offered by the organization in that same service area) includes required prescription drug coverage (as defined in paragraph (2)); and

“(B) may not offer prescription drug coverage (other than that required under parts A and B) to an enrollee—

“(i) under an MSA plan; or

“(ii) under another MA plan unless such drug coverage under such other plan provides qualified prescription drug coverage and unless the requirements of this section with respect to such coverage are met.

“(2) QUALIFYING COVERAGE.—For purposes of paragraph (1)(A), the term ‘required coverage’ means with respect to an MA–PD plan—

“(A) basic prescription drug coverage; or

“(B) qualified prescription drug coverage that provides supplemental prescription drug coverage, so long as there is no MA monthly supplemental beneficiary premium applied under the plan (due to the application of a credit against such premium of a rebate under section 1854(b)(1)(C)).

“(b) APPLICATION OF DEFAULT ENROLLMENT RULES.—

“(1) SEAMLESS CONTINUATION.—In applying section 1851(c)(3)(A)(ii), an individual who is enrolled in a health benefits plan shall not be considered to have been deemed to make an election into an MA–PD plan unless such health benefits plan provides any prescription drug coverage.

“(2) MA CONTINUATION.—In applying section 1851(c)(3)(B), an individual who is enrolled in an MA plan shall not be considered to have been deemed to make an election into an MA–PD plan unless—

“(A) for purposes of the election as of January 1, 2006, the MA plan provided as of December 31, 2005, any prescription drug coverage; or

“(B) for periods after January 1, 2006, such MA plan is an MA–PD plan.

“(3) DISCONTINUANCE OF MA–PD ELECTION DURING FIRST YEAR OF ELIGIBILITY.—In applying the second sentence of section 1851(e)(4) in the case of an individual who is electing to discontinue enrollment in an MA–PD plan, the individual shall be permitted to enroll in a prescription drug plan under part D at the time of the election of coverage under the original medicare fee-for-service program.

“(4) RULES REGARDING ENROLLEES IN MA PLANS NOT PROVIDING QUALIFIED PRESCRIPTION DRUG COVERAGE.—In the case of an individual who is enrolled in an MA plan (other than an MSA plan) that does not provide qualified prescription drug coverage, if the organization offering such coverage discontinues the offering with respect to the individual of all MA plans that do not provide such coverage—

“(i) the individual is deemed to have elected the original medicare fee-for-service program option, unless the individual affirmatively elects to enroll in an MA–PD plan; and

“(ii) in the case of such a deemed election, the disenrollment shall be treated as an involuntary termination of the MA plan described in subparagraph (B)(ii) of section 1882(s)(3) for purposes of applying such section.

The information disclosed under section 1852(c)(1) for individuals who are enrolled in such an MA plan shall include information regarding such rules.

“(c) APPLICATION OF PART D RULES FOR PRESCRIPTION DRUG COVERAGE.—With respect to the offering of qualified prescription drug coverage by an MA organization under this part on and after January 1, 2006—

“(1) IN GENERAL.—Except as otherwise provided, the provisions of this part shall apply under part C with respect to prescription drug coverage provided under MA–PD plans in lieu of the other provisions of part C that would apply to such coverage under such plans.

“(2) WAIVER.—The Secretary shall waive the provisions referred to in paragraph (1) to the extent the Secretary determines that such provisions duplicate, or are in conflict with, provisions otherwise applicable to the organization or plan under part C or as may be necessary in order to improve coordination of this part with the benefits under this part.

“(3) TREATMENT OF MA OWNED AND OPERATED PHARMACIES.—The Secretary may waive the requirement of section 1860D–4(b)(1)(C) in the case of an MA–PD plan that provides access (other than mail order) to qualified prescription drug coverage through pharmacies owned and operated by the MA organization, if the Secretary determines that the organization's pharmacy network is sufficient to provide comparable access for enrollees under the plan.

“(d) SPECIAL RULES FOR PRIVATE FEE-FOR-SERVICE PLANS THAT OFFER PRESCRIPTION DRUG COVERAGE.—With respect to an MA plan described in section 1851(a)(2)(C) that offers qualified prescription drug coverage, on and after January 1, 2006, the following rules apply:

“(1) REQUIREMENTS REGARDING NEGOTIATED PRICES.—Subsections (a)(1) and (d)(1) of section 1860D–2 and section 1860D–4(b)(2)(A) shall not be construed to require the plan to provide negotiated prices (described in subsection (d)(1)(B) of such section), but shall apply to the extent the plan does so.

“(2) MODIFICATION OF PHARMACY ACCESS STANDARD AND DISCLOSURE REQUIREMENT.—If the plan provides coverage for drugs purchased from all pharmacies, without charging additional cost-sharing, and without regard to whether they are participating pharmacies in a network or have entered into contracts or agreements with pharmacies to provide drugs to enrollees covered by the plan, subsections (b)(1)(C) and (k) of section 1860D–4 shall not apply to the plan.

“(3) DRUG UTILIZATION MANAGEMENT PROGRAM AND MEDICATION THERAPY MANAGEMENT PROGRAM NOT REQUIRED.—The requirements of subparagraphs (A) and (C) of section 1860D–4(c)(1) shall not apply to the plan.

“(4) APPLICATION OF REINSURANCE.—The Secretary shall determine the amount of reinsurance payments under section 1860D–15(b) using a methodology that—

“(A) bases such amount on the Secretary's estimate of the amount of such payments that would be payable if the plan were an MA–PD plan described in section 1851(a)(2)(A)(i) and the previous provisions of this subsection did not apply; and

“(B) takes into account the average reinsurance payments made under section 1860D–15(b) for populations of similar risk under MA–PD plans described in such section.

“(5) EXEMPTION FROM RISK CORRIDOR PROVISIONS.—The provisions of section 1860D–15(e) shall not apply.

“(6) EXEMPTION FROM NEGOTIATIONS.—Subsections (d) and (e)(2)(C) of section 1860D–11 shall not apply and the provisions of section 1854(a)(5)(B) prohibiting the review, approval, or disapproval of amounts described in such section shall apply to the proposed bid and terms and conditions described in section 1860D–11(d).

"(7) TREATMENT OF INCURRED COSTS WITHOUT REGARD TO FORMULARY.—The exclusion of costs incurred for covered part D drugs which are not included (or treated as being included) in a plan's formulary under section 1860D–2(b)(4)(B)(i) shall not apply insofar as the plan does not utilize a formulary.

"(e) APPLICATION TO REASONABLE COST REIMBURSEMENT CONTRACTORS.—

"(1) IN GENERAL.—Subject to paragraphs (2) and (3) and rules established by the Secretary, in the case of an organization that is providing benefits under a reasonable cost reimbursement contract under section 1876(h) and that elects to provide qualified prescription drug coverage to a part D eligible individual who is enrolled under such a contract, the provisions of this part (and related provisions of part C) shall apply to the provision of such coverage to such enrollee in the same manner as such provisions apply to the provision of such coverage under an MA–PD local plan described in section 1851(a)(2)(A)(i) and coverage under such a contract that so provides qualified prescription drug coverage shall be deemed to be an MA–PD local plan.

"(2) LIMITATION ON ENROLLMENT.—In applying paragraph (1), the organization may not enroll part D eligible individuals who are not enrolled under the reasonable cost reimbursement contract involved.

"(3) BIDS NOT INCLUDED IN DETERMINING NATIONAL AVERAGE MONTHLY BID AMOUNT.—The bid of an organization offering prescription drug coverage under this subsection shall not be taken into account in computing the national average monthly bid amount and low-income benchmark premium amount under this part.

"(f) APPLICATION TO PACE.—

"(1) IN GENERAL.—Subject to paragraphs (2) and (3) and rules established by the Secretary, in the case of a PACE program under section 1894 that elects to provide qualified prescription drug coverage to a part D eligible individual who is enrolled under such program, the provisions of this part (and related provisions of part C) shall apply to the provision of such coverage to such enrollee in a manner that is similar to the manner in which such provisions apply to the provision of such coverage under an MA–PD local plan described in section 1851(a)(2)(A)(ii) and a PACE program that so provides such coverage may be deemed to be an MA–PD local plan.

"(2) LIMITATION ON ENROLLMENT.—In applying paragraph (1), the organization may not enroll part D eligible individuals who are not enrolled under the PACE program involved.

"(3) BIDS NOT INCLUDED IN DETERMINING STANDARDIZED BID AMOUNT.—The bid of an organization offering prescription drug coverage under this subsection is not be taken into account in computing any average benchmark bid amount and low-income benchmark premium amount under this part.

"SPECIAL RULES FOR EMPLOYER-SPONSORED PROGRAMS

"SEC. 1860D–22. (a) SUBSIDY PAYMENT.—

"(1) IN GENERAL.—The Secretary shall provide in accordance with this subsection for payment to the sponsor of a qualified retiree prescription drug plan (as defined in paragraph (2)) of a special subsidy payment equal to the amount specified in paragraph (3) for each qualified covered retiree under the plan (as defined in paragraph (4)). This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this section.

"(2) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN DEFINED.—For purposes of this subsection, the term 'qualified retiree prescription drug plan' means employment-based retiree health coverage (as defined in subsection (c)(1)) if, with respect to a part D eligible individual who is a participant or beneficiary under such coverage, the following requirements are met:

"(A) ATTESTATION OF ACTUARIAL EQUIVALENCE TO STANDARD COVERAGE.—The sponsor of the plan provides the Secretary, annually or at such other time as the Secretary may require, with an attestation that the actuarial value of prescription drug coverage under the plan (as determined using the processes and methods described in section 1860D–11(c)) is at least equal to the actuarial value of standard prescription drug coverage.

"(B) AUDITS.—The sponsor of the plan, or an administrator of the plan designated by the sponsor, shall maintain (and afford the Secretary access to) such records as the Secretary may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage and the accuracy of payments made under this section. The provisions of section 1860D–2(d)(3) shall apply to such information under this section (including such actuarial value and attestation) in a manner similar to the manner in which they apply to financial records of PDP sponsors and MA organizations.

"(C) PROVISION OF DISCLOSURE REGARDING PRESCRIPTION DRUG COVERAGE.—The sponsor of the plan shall provide for disclosure of information regarding prescription drug coverage in accordance with section 1860D–13(b)(6)(B).

"(3) EMPLOYER AND UNION SPECIAL SUBSIDY AMOUNTS.—

"(A) IN GENERAL.—For purposes of this subsection, the special subsidy payment amount under this paragraph for a qualifying covered retiree for a coverage year enrolled with the sponsor of a qualified retiree prescription drug plan is, for the portion of the retiree's gross covered retiree plan-related prescription drug costs (as defined in subparagraph (C)(ii)) for such year that exceeds the cost threshold amount specified in subparagraph (B) and does not exceed the cost limit under such subparagraph, an amount equal to 28 percent of the allowable retiree costs (as defined in subparagraph (C)(i)) attributable to such gross covered prescription drug costs.

"(B) COST THRESHOLD AND COST LIMIT APPLICABLE.—

"(i) IN GENERAL.—Subject to clause (ii)—

"(I) the cost threshold under this subparagraph is equal to $250 for plan years that end in 2006; and

"(II) the cost limit under this subparagraph is equal to $5,000 for plan years that end in 2006.

"(ii) INDEXING.—The cost threshold and cost limit amounts specified in subclauses (I) and (II) of clause (i) for a plan year that ends after 2006 shall be adjusted in the same manner as the annual deductible and the annual out-of-pocket threshold, respectively, are annually adjusted under paragraphs (1) and (4)(B) of section 1860D–2(b).

"(C) DEFINITIONS.—For purposes of this paragraph:

"(i) ALLOWABLE RETIREE COSTS.—The term 'allowable retiree costs' means, with respect to gross covered prescription drug costs under a qualified retiree prescription drug plan by a plan sponsor, the part of such costs that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or by or on behalf of a qualifying covered retiree under the plan.

"(ii) GROSS COVERED RETIREE PLAN-RELATED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term 'gross covered retiree plan-related prescription drug costs' means, with respect to a qualifying covered retiree enrolled in a qualified retiree prescription drug plan during a coverage year, the costs incurred under the plan, not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year. Such costs shall be determined whether they are paid by the retiree or under the plan.

"(iii) COVERAGE YEAR.—The term 'coverage year' has the meaning given such term in section 1860D–15(b)(4).

"(4) QUALIFYING COVERED RETIREE DEFINED.—For purposes of this subsection, the term 'qualifying covered retiree' means a part D eligible individual who is not enrolled in a prescription drug plan or an MA–PD plan but is covered under a qualified retiree prescription drug plan.

"(5) PAYMENT METHODS, INCLUDING PROVISION OF NECESSARY INFORMATION.—The provisions of section 1860D–15(d) (including paragraph (2), relating to requirement for provision of information) shall apply to payments under this subsection in a manner similar to the manner in which they apply to payment under section 1860D–15(b).

"(6) CONSTRUCTION.—Nothing in this subsection shall be construed as—

"(A) precluding a part D eligible individual who is covered under employment-based retiree health coverage from enrolling in a prescription drug plan or in an MA–PD plan;

"(B) precluding such employment-based retiree health coverage or an employer or other person from paying all or any portion of any premium required for coverage under a prescription drug plan or MA–PD plan on behalf of such an individual;

"(C) preventing such employment-based retiree health coverage from providing coverage—

"(i) that is better than standard prescription drug coverage to retirees who are covered under a qualified retiree prescription drug plan; or

"(ii) that is supplemental to the benefits provided under a prescription drug plan or an MA–PD plan, including benefits to retirees who are not covered under a qualified retiree prescription drug plan but who are enrolled in such a prescription drug plan or MA–PD plan; or

"(D) preventing employers to provide for flexibility in benefit design and pharmacy access provisions, without regard to the requirements for basic prescription drug coverage, so long as the actuarial equivalence requirement of paragraph (2)(A) is met.

"(b) APPLICATION OF MA WAIVER AUTHORITY.—The provisions of section 1857(i) shall apply with respect to prescription drug plans in relation to employment-based retiree health coverage in a manner similar to the manner in which they apply to an MA plan in relation to employers, including authorizing the establishment of separate premium amounts for enrollees in a prescription drug plan by reason of such coverage and limitations on enrollment to part D eligible individuals enrolled under such coverage.

"(c) DEFINITIONS.—For purposes of this section:

"(1) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs (whether provided by voluntary insurance coverage or pursuant to statutory or contractual obligation) for part D eligible individuals (or for such individuals and their spouses and dependents) under a group health plan based on their status as retired participants in such plan.

"(2) SPONSOR.—The term 'sponsor' means a plan sponsor, as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974, in relation to a group health plan, except that, in the case of a plan maintained jointly by one employer and an employee organization and with respect to which the employer is the primary source of financing, such term means such employer.

"(3) GROUP HEALTH PLAN.—The term 'group health plan' includes such a plan as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 and also includes the following:

"(A) FEDERAL AND STATE GOVERNMENTAL PLANS.—Such a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing, including a health benefits plan offered under chapter 89 of title 5, United States Code.

"(B) COLLECTIVELY BARGAINED PLANS.—Such a plan established or maintained under or pursuant to one or more collective bargaining agreements.

"(C) CHURCH PLANS.—Such a plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code of 1986.

"STATE PHARMACEUTICAL ASSISTANCE PROGRAMS

"SEC. 1860D–23. (a) REQUIREMENTS FOR BENEFIT COORDINATION.—

"(1) IN GENERAL.—Before July 1, 2005, the Secretary shall establish consistent with this section requirements for prescription drug plans to ensure the effective coordination between a part D plan (as defined in paragraph (5)) and a State Pharmaceutical Assistance Program (as defined in subsection (b)) with respect to—

"(A) payment of premiums and coverage; and

"(B) payment for supplemental prescription drug benefits,

for part D eligible individuals enrolled under both types of plans.

"(2) COORDINATION ELEMENTS.—The requirements under paragraph (1) shall include requirements relating to coordination of each of the following:

"(A) Enrollment file sharing.

"(B) The processing of claims, including electronic processing.

"(C) Claims payment.

"(D) Claims reconciliation reports.

"(E) Application of the protection against high out-of-pocket expenditures under section 1860D–2(b)(4).

"(F) Other administrative processes specified by the Secretary.

Such requirements shall be consistent with applicable law to safeguard the privacy of any individually identifiable beneficiary information.

"(3) USE OF LUMP SUM PER CAPITA METHOD.—Such requirements shall include a method for the application by a part D plan of specified funding amounts from a State Pharmaceutical Assistance Program for enrolled individuals for supplemental prescription drug benefits.

"(4) CONSULTATION.—In establishing requirements under this subsection, the Secretary shall consult with State Pharmaceutical Assistance Programs, MA organizations, States, pharmaceutical benefit managers, employers, representatives of part D eligible individuals, the data processing experts, pharmacists, pharmaceutical manufacturers, and other experts.

"(5) PART D PLAN DEFINED.—For purposes of this section and section 1860D–24, the term 'part D plan' means a prescription drug plan and an MA–PD plan.

"(b) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—For purposes of this part, the term 'State Pharmaceutical Assistance Program' means a State program—

"(1) which provides financial assistance for the purchase or provision of supplemental prescription drug coverage or benefits on behalf of part D eligible individuals;

"(2) which, in determining eligibility and the amount of assistance to part D eligible individuals under the Program, provides assistance to such individuals in all part D plans and does not discriminate based upon the part D plan in which the individual is enrolled; and

"(3) which satisfies the requirements of subsections (a) and (c).

"(c) RELATION TO OTHER PROVISIONS.—

"(1) MEDICARE AS PRIMARY PAYOR.—The requirements of this section shall not change or affect the primary payor status of a part D plan.

"(2) USE OF A SINGLE CARD.—A card that is issued under section 1860D–4(b)(2)(A) for use under a part D plan may also be used in connection with coverage of benefits provided under a State Pharmaceutical Assistance Program and, in such case, may contain an emblem or symbol indicating such connection.

"(3) OTHER PROVISIONS.—The provisions of section 1860D–24(c) shall apply to the requirements under this section.

"(4) SPECIAL TREATMENT UNDER OUT-OF-POCKET RULE.—In applying section 1860D–2(b)(4)(C)(ii), expenses incurred under a State Pharmaceutical Assistance Program may be counted toward the annual out-of-pocket threshold.

"(5) CONSTRUCTION.—Nothing in this section shall be construed as requiring a State Pharmaceutical Assistance Program to coordinate or provide financial assistance with respect to any part D plan.

"(d) FACILITATION OF TRANSITION AND COORDINATION WITH STATE PHARMACEUTICAL ASSISTANCE PROGRAMS.—

"(1) TRANSITIONAL GRANT PROGRAM.—The Secretary shall provide payments to State Pharmaceutical Assistance Programs with an application approved under this subsection.

"(2) USE OF FUNDS.—Payments under this section may be used by a Program for any of the following:

"(A) Educating part D eligible individuals enrolled in the Program about the prescription drug coverage available through part D plans under this part.

"(B) Providing technical assistance, phone support, and counseling for such enrollees to facilitate selection and enrollment in such plans.

"(C) Other activities designed to promote the effective coordination of enrollment, coverage, and payment between such Program and such plans.

"(3) ALLOCATION OF FUNDS.—Of the amount appropriated to carry out this subsection for a fiscal year, the Secretary shall allocate payments among Programs that have applications approved under paragraph (4) for such fiscal year in proportion to the number of enrollees enrolled in each such Program as of October 1, 2003.

"(4) APPLICATION.—No payments may be made under this subsection except pursuant to an application that is submitted and approved in a time, manner, and form specified by the Secretary.

"(5) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated for each of fiscal years 2005 and 2006, $62,500,000 to carry out this subsection.

"COORDINATION REQUIREMENTS FOR PLANS PROVIDING PRESCRIPTION DRUG COVERAGE

"SEC. 1860D–24. (a) APPLICATION OF BENEFIT COORDINATION REQUIREMENTS TO ADDITIONAL PLANS.—

"(1) IN GENERAL.—The Secretary shall apply the coordination requirements established under section 1860D–23(a) to Rx plans described in subsection (b) in the same manner as such requirements apply to a State Pharmaceutical Assistance Program.

"(2) APPLICATION TO TREATMENT OF CERTAIN OUT-OF-POCKET EXPENDITURES.—To the extent specified by the Secretary, the requirements referred to in paragraph (1) shall apply to procedures established under section 1860D–2(b)(4)(D).

"(3) USER FEES.—

"(A) IN GENERAL.—The Secretary may impose user fees for the transmittal of information necessary for benefit coordination under section 1860D–2(b)(4)(D) in a manner similar to the manner in which user fees are imposed under section 1842(h)(3)(B), except that the Secretary may retain a portion of such fees to defray the Secretary's costs in carrying out procedures under section 1860D–2(b)(4)(D).

"(B) APPLICATION.—A user fee may not be imposed under subparagraph (A) with respect to a State Pharmaceutical Assistance Program.

"(b) RX PLAN.—An Rx plan described in this subsection is any of the following:

"(1) MEDICAID PROGRAMS.—A State plan under title XIX, including such a plan operating under a waiver under section 1115, if it meets the requirements of section 1860D–23(b)(2).

"(2) GROUP HEALTH PLANS.—An employer group health plan.

"(3) FEHBP.—The Federal employees health benefits plan under chapter 89 of title 5, United States Code.

"(4) MILITARY COVERAGE (INCLUDING TRICARE).—Coverage under chapter 55 of title 10, United States Code.

"(5) OTHER PRESCRIPTION DRUG COVERAGE.—Such other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of prescription drug coverage on behalf of part D eligible individuals as the Secretary may specify.

"(c) RELATION TO OTHER PROVISIONS.—

"(1) USE OF COST MANAGEMENT TOOLS.—The requirements of this section shall not impair or prevent a PDP sponsor or MA organization from applying cost management tools (including differential payments) under all methods of operation.

"(2) NO AFFECT ON TREATMENT OF CERTAIN OUT-OF-POCKET EXPENDITURES.—The requirements of this section shall not affect the application of the procedures established under section 1860D–2(b)(4)(D).

"Subpart 4—Medicare Prescription Drug Discount Card and Transitional Assistance Program

"MEDICARE PRESCRIPTION DRUG DISCOUNT CARD AND TRANSITIONAL ASSISTANCE PROGRAM

"SEC. 1860D–31. (a) ESTABLISHMENT OF PROGRAM.—

"(1) IN GENERAL.—The Secretary shall establish a program under this section—

"(A) to endorse prescription drug discount card programs that meet the requirements of this section in order to provide access to prescription drug discounts through prescription drug card sponsors for discount card eligible individuals throughout the United States; and

"(B) to provide for transitional assistance for transitional assistance eligible individuals enrolled in such endorsed programs.

"(2) PERIOD OF OPERATION.—

"(A) IMPLEMENTATION DEADLINE.—The Secretary shall implement the program under this section so that discount cards and transitional assistance are first available by not later than 6 months after the date of the enactment of this section.

"(B) EXPEDITING IMPLEMENTATION.—The Secretary shall promulgate regulations to carry out the program under this section which may be effective and final immediately on an interim basis as of the date of publication of the interim final regulation. If the Secretary provides for an interim final regulation, the Secretary shall provide for a period of public comments on such regulation after the date of publication. The Secretary may change or revise such regulation after completion of the period of public comment.

"(C) TERMINATION AND TRANSITION.—

"(i) IN GENERAL.—Subject to clause (ii)—

"(I) the program under this section shall not apply to covered discount card drugs dispensed after December 31, 2005; and

"(II) transitional assistance shall be available after such date to the extent the assistance relates to drugs dispensed on or before such date.

"(ii) TRANSITION.—In the case of an individual who is enrolled in an endorsed discount card program as of December 31, 2005, during the individual's transition period (if any) under clause (iii), in accordance with transition rules specified by the Secretary—

"(I) such endorsed program may continue to apply to covered discount card drugs dispensed to the individual under the program during such transition period;

"(II) no annual enrollment fee shall be applicable during the transition period;

"(III) during such period the individual may not change the endorsed program plan in which the individual is enrolled; and

"(IV) the balance of any transitional assistance remaining on January 1, 2006, shall remain available for drugs dispensed during the individual's transition period.

"(iii) TRANSITION PERIOD.—The transition period under this clause for an individual is the period beginning on January 1, 2006, and ending in the case of an individual who—

"(I) is enrolled in a prescription drug plan or an MA–PD plan before the last date of the initial enrollment period under section 1860D–1(b)(2)(A), on the effective date of the individual's coverage under such part; or

"(II) is not so enrolled, on the last day of such initial period.

"(3) VOLUNTARY NATURE OF PROGRAM.—Nothing in this section shall be construed as requiring a discount card eligible individual to enroll in an endorsed discount card program under this section.

"(4) GLOSSARY AND DEFINITIONS OF TERMS.—For purposes of this section:

"(A) COVERED DISCOUNT CARD DRUG.—The term 'covered discount card drug' has the meaning given the term 'covered part D drug' in section 1860D–2(e).

"(B) DISCOUNT CARD ELIGIBLE INDIVIDUAL.—The term 'discount card eligible individual' is defined in subsection (b)(1)(A).

"(C) ENDORSED DISCOUNT CARD PROGRAM; ENDORSED PROGRAM.—The terms 'endorsed discount card program' and 'endorsed program' mean a prescription drug discount card program that is endorsed (and for which the sponsor has a contract with the Secretary) under this section.

"(D) NEGOTIATED PRICE.—Negotiated prices are described in subsection (e)(1)(A)(ii).

"(E) PRESCRIPTION DRUG CARD SPONSOR; SPONSOR.—The terms 'prescription drug card sponsor' and 'sponsor' are defined in subsection (h)(1)(A).

"(F) STATE.—The term 'State' has the meaning given such term for purposes of title XIX.

"(G) TRANSITIONAL ASSISTANCE ELIGIBLE INDIVIDUAL.—The term 'transitional assistance eligible individual' is defined in subsection (b)(2).

"(b) ELIGIBILITY FOR DISCOUNT CARD AND FOR TRANSITIONAL ASSISTANCE.—For purposes of this section:

"(1) DISCOUNT CARD ELIGIBLE INDIVIDUAL.—

"(A) IN GENERAL.—The term 'discount card eligible individual' means an individual who—

"(i) is entitled to benefits, or enrolled, under part A or enrolled under part B; and

"(ii) subject to paragraph (4), is not an individual described in subparagraph (B).

"(B) INDIVIDUAL DESCRIBED.—An individual described in this subparagraph is an individual described in subparagraph (A)(i) who is enrolled under title XIX (or under a waiver under section 1115 of the requirements of such title) and is entitled to any medical assistance for outpatient prescribed drugs described in section 1905(a)(12).

"(2) TRANSITIONAL ASSISTANCE ELIGIBLE INDIVIDUAL.—

"(A) IN GENERAL.—Subject to subparagraph (B), the term 'transitional assistance eligible individual' means a discount card eligible individual who resides in one of the 50 States or the District of Columbia and whose income (as determined under subsection (f)(1)(B)) is not more than 135 percent of the poverty line (as defined in section 673(2) of the Community Services Block Grant Act, 42 U.S.C. 9902(2), including any revision required by such section) applicable to the family size involved (as determined under subsection (f)(1)(B)).

"(B) EXCLUSION OF INDIVIDUALS WITH CERTAIN PRESCRIPTION DRUG COVERAGE.—Such term does not include an individual who has coverage of, or assistance for, covered discount card drugs under any of the following:

"(i) A group health plan or health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act), other than coverage under a plan under part C and other than coverage consisting only of excepted benefits (as defined in such section).

"(ii) Chapter 55 of title 10, United States Code (relating to medical and dental care for members of the uniformed services).

"(iii) A plan under chapter 89 of title 5, United States Code (relating to the Federal employees' health benefits program).

"(3) SPECIAL TRANSITIONAL ASSISTANCE ELIGIBLE INDIVIDUAL.—The term 'special transitional assistance eligible individual' means a transitional assistance eligible individual whose income (as determined under subsection (f)(1)(B)) is not more than 100 percent of the poverty line (as defined in section 673(2) of the Community Services Block Grant Act, 42 U.S.C. 9902(2), including any revision required by such section) applicable to the family size involved (as determined under subsection (f)(1)(B)).

"(4) TREATMENT OF MEDICAID MEDICALLY NEEDY.—For purposes of this section, the Secretary shall provide for appropriate rules for the treatment of medically needy individuals described in section 1902(a)(10)(C) as discount card eligible individuals and as transitional assistance eligible individuals.

"(c) ENROLLMENT AND ENROLLMENT FEES.—

"(1) ENROLLMENT PROCESS.—The Secretary shall establish a process through which a discount card eligible individual is enrolled and disenrolled in an endorsed discount card program under this section consistent with the following:

"(A) CONTINUOUS OPEN ENROLLMENT.—Subject to the succeeding provisions of this paragraph and subsection (h)(9), a discount card eligible individual who is not enrolled in an endorsed discount card program and is residing in a State may enroll in any such endorsed program—

"(i) that serves residents of the State; and

"(ii) at any time beginning on the initial enrollment date, specified by the Secretary, and before January 1, 2006.

"(B) USE OF STANDARD ENROLLMENT FORM.—An enrollment in an endorsed program shall only be effected through completion of a standard enrollment form specified by the Secretary. Each sponsor of an endorsed program shall transmit to the Secretary (in a form and manner specified by the Secretary) information on individuals who complete such enrollment forms and, to the extent provided under subsection (f), information regarding certification as a transitional assistance eligible individual.

"(C) ENROLLMENT ONLY IN ONE PROGRAM.—

"(i) IN GENERAL.—Subject to clauses (ii) and (iii), a discount card eligible individual may be enrolled in only one endorsed discount card program under this section.

"(ii) CHANGE IN ENDORSED PROGRAM PERMITTED FOR 2005.—The Secretary shall establish a process, similar to (and coordinated with) the process for annual, coordinated elections under section 1851(e)(3) during 2004, under which an individual enrolled in an endorsed discount card program may change the endorsed program in which the individual is enrolled for 2005.

"(iii) ADDITIONAL EXCEPTIONS.—The Secretary shall permit an individual to change the endorsed discount card program in which the individual is enrolled in the case of an individual who changes residence to be outside the service area of such program and in such other exceptional cases as the Secretary may provide (taking into account the circumstances for special election periods under section 1851(e)(4)). Under the previous sentence, the Secretary may consider a change in residential setting (such as placement in a nursing facility) or enrollment in or disenrollment from a plan under part C through which the individual was enrolled in an endorsed program to be an exceptional circumstance.

"(D) DISENROLLMENT.—

"(i) VOLUNTARY.—An individual may voluntarily disenroll from an endorsed discount card program at any time. In the case of such a voluntary disenrollment, the individual may not enroll in another endorsed program, except under such exceptional circumstances as the Secretary may recognize under subparagraph (C)(iii) or during the annual coordinated enrollment period provided under subparagraph (C)(ii).

"(ii) INVOLUNTARY.—An individual who is enrolled in an endorsed discount card program and not a transitional assistance eligible individual may be disenrolled by the sponsor of the program if the individual fails to pay any annual enrollment fee required under the program.

"(E) APPLICATION TO CERTAIN ENROLLEES.—In the case of a discount card eligible individual who is enrolled in a plan described in section 1851(a)(2)(A) or under a reasonable cost reimbursement contract under section 1876(h) that is offered by an organization that also is a prescription discount card sponsor that offers an endorsed discount card program under which the individual may be enrolled and that has made an election to apply the special rules under subsection (h)(9)(B) for such an endorsed program, the individual may only enroll in such an endorsed discount card program offered by that sponsor.

"(2) ENROLLMENT FEES.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, a prescription drug card sponsor may charge an annual enrollment fee for each discount card eligible individual enrolled in an endorsed discount card program offered by such sponsor. The annual enrollment fee for either 2004 or 2005 shall not be prorated for portions of a year. There shall be no annual enrollment fee for a year after 2005.

"(B) AMOUNT.—No annual enrollment fee charged under subparagraph (A) may exceed $30.

"(C) UNIFORM ENROLLMENT FEE.—A prescription drug card sponsor shall ensure that the annual enrollment fee (if any) for an endorsed discount card program is the same for all discount card eligible individuals enrolled in the program and residing in the State.

"(D) COLLECTION.—The annual enrollment fee (if any) charged for enrollment in an endorsed program shall be collected by the sponsor of the program.

"(E) PAYMENT OF FEE FOR TRANSITIONAL ASSISTANCE ELIGIBLE INDIVIDUALS.—Under subsection (g)(1)(A), the annual enrollment fee (if any) otherwise charged under this paragraph with respect to a transitional assistance eligible individual shall be paid by the Secretary on behalf of such individual.

"(F) OPTIONAL PAYMENT OF FEE BY STATE.—

"(i) IN GENERAL.—The Secretary shall establish an arrangement under which a State may

provide for payment of some or all of the enrollment fee for some or all enrollees who are not transitional assistance eligible individuals in the State, as specified by the State under the arrangement. Insofar as such a payment arrangement is made with respect to an enrollee, the amount of the enrollment fee shall be paid directly by the State to the sponsor.

“(ii) NO FEDERAL MATCHING AVAILABLE UNDER MEDICAID OR SCHIP.—Expenditures made by a State for enrollment fees described in clause (i) shall not be treated as State expenditures for purposes of Federal matching payments under title XIX or XXI.

“(G) RULES IN CASE OF CHANGES IN PROGRAM ENROLLMENT DURING A YEAR.—The Secretary shall provide special rules in the case of payment of an annual enrollment fee for a discount card eligible individual who changes the endorsed program in which the individual is enrolled during a year.

“(3) ISSUANCE OF DISCOUNT CARD.—Each prescription drug card sponsor of an endorsed discount card program shall issue, in a standard format specified by the Secretary, to each discount card eligible individual enrolled in such program.a card that establishes proof of enrollment and that can be used in a coordinated manner to identify the sponsor, program, and individual for purposes of the program under this section.

“(4) PERIOD OF ACCESS.—In the case of a discount card eligible individual who enrolls in an endorsed program, access to negotiated prices and transitional assistance, if any, under such endorsed program shall take effect on such date as the Secretary shall specify.

“(d) PROVISION OF INFORMATION ON ENROLLMENT AND PROGRAM FEATURES.—

“(1) SECRETARIAL RESPONSIBILITIES.—

“(A) IN GENERAL.—The Secretary shall provide for activities under this subsection to broadly disseminate information to discount card eligible individuals (and prospective eligible individuals) regarding—

“(i) enrollment in endorsed discount card programs; and

“(ii) the features of the program under this section, including the availability of transitional assistance.

“(B) PROMOTION OF INFORMED CHOICE.—In order to promote informed choice among endorsed prescription drug discount card programs, the Secretary shall provide for the dissemination of information which—

“(i) compares the annual enrollment fee and other features of such programs, which may include comparative prices for covered discount card drugs; and

“(ii) includes educational materials on the variability of discounts on prices of covered discount card drugs under an endorsed program.

The dissemination of information under clause (i) shall, to the extent practicable, be coordinated with the dissemination of educational information on other medicare options.

“(C) SPECIAL RULE FOR INITIAL ENROLLMENT DATE UNDER THE PROGRAM.—To the extent practicable, the Secretary shall ensure, through the activities described in subparagraphs (A) and (B), that discount card eligible individuals are provided with such information at least 30 days prior to the initial enrollment date specified under subsection (c)(1)(A)(ii).

“(D) USE OF MEDICARE TOLL-FREE NUMBER.—The Secretary shall provide through the toll-free telephone number 1–800–MEDICARE for the receipt and response to inquiries and complaints concerning the program under this section and endorsed programs.

“(2) PRESCRIPTION DRUG CARD SPONSOR RESPONSIBILITIES.—

“(A) IN GENERAL.—Each prescription drug card sponsor that offers an endorsed discount card program shall make available to discount card eligible individuals (through the Internet and otherwise) information that the Secretary identifies as being necessary to promote informed choice among endorsed discount card programs by such individuals, including information on enrollment fees and negotiated prices for covered discount card drugs charged to such individuals.

“(B) RESPONSE TO ENROLLEE QUESTIONS.—Each sponsor offering an endorsed discount card program shall have a mechanism (including a toll-free telephone number) for providing upon request specific information (such as negotiated prices and the amount of transitional assistance remaining available through the program) to discount card eligible individuals enrolled in the program. The sponsor shall inform transitional assistance eligible individuals enrolled in the program of the availability of such toll-free telephone number to provide information on the amount of available transitional assistance.

“(C) INFORMATION ON BALANCE OF TRANSITIONAL ASSISTANCE AVAILABLE AT POINT-OF-SALE.—Each sponsor offering an endorsed discount card program shall have a mechanism so that information on the amount of transitional assistance remaining under subsection (g)(1)(B) is available (electronically or by telephone) at the point-of-sale of covered discount card drugs.

“(3) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—

“(A) IN GENERAL.—A prescription drug card sponsor offering an endorsed discount card program shall provide that each pharmacy that dispenses a covered discount card drug shall inform a discount card eligible individual enrolled in the program of any differential between the price of the drug to the enrollee and the price of the lowest priced generic covered discount card drug under the program that is therapeutically equivalent and bioequivalent and available at such pharmacy.

“(B) TIMING OF NOTICE.—

“(i) IN GENERAL.—Subject to clause (ii), the information under subparagraph (A) shall be provided at the time of purchase of the drug involved, or, in the case of dispensing by mail order, at the time of delivery of such drug.

“(ii) WAIVER.—The Secretary may waive clause (i) in such circumstances as the Secretary may specify.

“(e) DISCOUNT CARD FEATURES.—

“(1) SAVINGS TO ENROLLEES THROUGH NEGOTIATED PRICES.—

“(A) ACCESS TO NEGOTIATED PRICES.—

“(i) IN GENERAL.—Each prescription drug card sponsor that offers an endorsed discount card program shall provide each discount card eligible individual enrolled in the program with access to negotiated prices.

“(ii) NEGOTIATED PRICES.—For purposes of this section, negotiated prices shall take into account negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations, for covered discount card drugs, and include any dispensing fees for such drugs.

“(B) ENSURING PHARMACY ACCESS.—Each prescription drug card sponsor offering an endorsed discount card program shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than solely by mail order) drugs directly to enrollees to ensure convenient access to covered discount card drugs at negotiated prices (consistent with rules established by the Secretary). The Secretary shall establish convenient access rules under this clause that are no less favorable to enrollees than the standards for convenient access to pharmacies included in the statement of work of solicitation (#MDA906–03–R–0002) of the Department of Defense under the TRICARE Retail Pharmacy (TRRx) as of March 13, 2003.

“(C) PROHIBITION ON CHARGES FOR REQUIRED SERVICES.—

“(i) IN GENERAL.—Subject to clause (ii), a prescription drug card sponsor (and any pharmacy contracting with such sponsor for the provision of covered discount card drugs to individuals enrolled in such sponsor's endorsed discount card program) may not charge an enrollee any amount for any items and services required to be provided by the sponsor under this section.

“(ii) CONSTRUCTION.—Nothing in clause (i) shall be construed to prevent—

“(I) the sponsor from charging the annual enrollment fee (except in the case of a transitional assistance eligible individual); and

“(II) the pharmacy dispensing the covered discount card drug, from imposing a charge (consistent with the negotiated price) for the covered discount card drug dispensed, reduced by the amount of any transitional assistance made available.

“(D) INAPPLICABILITY OF MEDICAID BEST PRICE RULES.—The prices negotiated from drug manufacturers for covered discount card drugs under an endorsed discount card program under this section shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

“(2) REDUCTION OF MEDICATION ERRORS AND ADVERSE DRUG INTERACTIONS.—Each endorsed discount card program shall implement a system to reduce the likelihood of medication errors and adverse drug interactions and to improve medication use.

“(f) ELIGIBILITY PROCEDURES FOR ENDORSED PROGRAMS AND TRANSITIONAL ASSISTANCE.—

“(1) DETERMINATIONS.—

“(A) PROCEDURES.—The determination of whether an individual is a discount card eligible individual or a transitional assistance eligible individual or a special transitional assistance eligible individual (as defined in subsection (b)) shall be determined under procedures specified by the Secretary consistent with this subsection.

“(B) INCOME AND FAMILY SIZE DETERMINATIONS.—For purposes of this section, the Secretary shall define the terms ‘income’ and ‘family size’ and shall specify the methods and period for which they are determined. If under such methods income or family size is determined based on the income or family size for prior periods of time, the Secretary shall permit (whether through a process of reconsideration or otherwise) an individual whose income or family size has changed to elect to have eligibility for transitional assistance determined based on income or family size for a more recent period.

“(2) USE OF SELF-CERTIFICATION FOR TRANSITIONAL ASSISTANCE.—

“(A) IN GENERAL.—Under the procedures specified under paragraph (1)(A) an individual who wishes to be treated as a transitional assistance eligible individual or a special transitional assistance eligible individual under this section (or another qualified person on such individual's behalf) shall certify on the enrollment form under subsection (c)(1)(B) (or similar form specified by the Secretary), through a simplified means specified by the Secretary and under penalty of perjury or similar sanction for false statements, as to the amount of the individual's income, family size, and individual's prescription drug coverage (if any) insofar as they relate to eligibility to be a transitional assistance eligible individual or a special transitional assistance eligible individual. Such certification shall be deemed as consent to verification of respective eligibility under paragraph (3). A certification under this paragraph may be provided before, on, or after the time of enrollment under an endorsed program.

“(B) TREATMENT OF SELF-CERTIFICATION.—The Secretary shall treat a certification under

subparagraph (A) that is verified under paragraph (3) as a determination that the individual involved is a transitional assistance eligible individual or special transitional assistance eligible individual (as the case may be) for the entire period of the enrollment of the individual in any endorsed program.

"(3) VERIFICATION.—

"(A) IN GENERAL.—The Secretary shall establish methods (which may include the use of sampling and the use of information described in subparagraph (B)) to verify eligibility for individuals who seek to enroll in an endorsed program and for individuals who provide a certification under paragraph (2).

"(B) INFORMATION DESCRIBED.—The information described in this subparagraph is as follows:

"(i) MEDICAID-RELATED INFORMATION.—Information on eligibility under title XIX and provided to the Secretary under arrangements between the Secretary and States in order to verify the eligibility of individuals who seek to enroll in an endorsed program and of individuals who provide certification under paragraph (2).

"(ii) SOCIAL SECURITY INFORMATION.—Financial information made available to the Secretary under arrangements between the Secretary and the Commissioner of Social Security in order to verify the eligibility of individuals who provide such certification.

"(iii) INFORMATION FROM SECRETARY OF THE TREASURY.—Financial information made available to the Secretary under section 6103(l)(19) of the Internal Revenue Code of 1986 in order to verify the eligibility of individuals who provide such certification.

"(C) VERIFICATION IN CASES OF MEDICAID ENROLLEES.—

"(i) IN GENERAL.—Nothing in this section shall be construed as preventing the Secretary from finding that a discount card eligible individual meets the income requirements under subsection (b)(2)(A) if the individual is within a category of discount card eligible individuals who are enrolled under title XIX (such as qualified medicare beneficiaries (QMBs), specified low-income medicare beneficiaries (SLMBs), and certain qualified individuals (QI–1s)).

"(ii) AVAILABILITY OF INFORMATION FOR VERIFICATION PURPOSES.—As a condition of provision of Federal financial participation to a State that is one of the 50 States or the District of Columbia under title XIX, for purposes of carrying out this section, the State shall provide the information it submits to the Secretary relating to such title in a manner specified by the Secretary that permits the Secretary to identify individuals who are described in subsection (b)(1)(B) or are transitional assistance eligible individuals or special transitional assistance eligible individuals.

"(4) RECONSIDERATION.—

"(A) IN GENERAL.—The Secretary shall establish a process under which a discount card eligible individual, who is determined through the certification and verification methods under paragraphs (2) and (3) not to be a transitional assistance eligible individual or a special transitional assistance eligible individual, may request a reconsideration of the determination.

"(B) CONTRACT AUTHORITY.—The Secretary may enter into a contract to perform the reconsiderations requested under subparagraph (A).

"(C) COMMUNICATION OF RESULTS.—Under the process under subparagraph (A) the results of such reconsideration shall be communicated to the individual and the prescription drug card sponsor involved.

"(g) TRANSITIONAL ASSISTANCE.—

"(1) PROVISION OF TRANSITIONAL ASSISTANCE.—An individual who is a transitional assistance eligible individual (as determined under this section) and who is enrolled with an endorsed program is entitled—

"(A) to have payment made of any annual enrollment fee charged under subsection (c)(2) for enrollment under the program; and

"(B) to have payment made, up to the amount specified in paragraph (2), under such endorsed program of 90 percent (or 95 percent in the case of a special transitional assistance eligible individual) of the costs incurred for covered discount card drugs obtained through the program taking into account the negotiated price (if any) for the drug under the program.

"(2) LIMITATION ON DOLLAR AMOUNT.—

"(A) IN GENERAL.—Subject to subparagraph (B), the amount specified in this paragraph for a transitional assistance eligible individual—

"(i) for costs incurred during 2004, is $600; or

"(ii) for costs incurred during 2005, is—

"(I) $600, plus

"(II) except as provided in subparagraph (E), the amount by which the amount available under this paragraph for 2004 for that individual exceeds the amount of payment made under paragraph (1)(B) for that individual for costs incurred during 2004.

"(B) PRORATION.—

"(i) IN GENERAL.—In the case of an individual not described in clause (ii) with respect to a year, the Secretary may prorate the amount specified in subparagraph (A) for the balance of the year involved in a manner specified by the Secretary.

"(ii) INDIVIDUAL DESCRIBED.—An individual described in this clause is a transitional assistance eligible individual who—

"(I) with respect to 2004, enrolls in an endorsed program, and provides a certification under subsection (f)(2), before the initial implementation date of the program under this section; and

"(II) with respect to 2005, is enrolled in an endorsed program, and has provided such a certification, before February 1, 2005.

"(C) ACCOUNTING FOR AVAILABLE BALANCES IN CASES OF CHANGES IN PROGRAM ENROLLMENT.—In the case of a transitional assistance eligible individual who changes the endorsed discount card program in which the individual is enrolled under this section, the Secretary shall provide a process under which the Secretary provides to the sponsor of the endorsed program in which the individual enrolls information concerning the balance of amounts available on behalf of the individual under this paragraph.

"(D) LIMITATION ON USE OF FUNDS.—Pursuant to subsection (a)(2)(C), no assistance shall be provided under paragraph (1)(B) with respect to covered discount card drugs dispensed after December 31, 2005.

"(E) NO ROLLOVER PERMITTED IN CASE OF VOLUNTARY DISENROLLMENT.—Except in such exceptional cases as the Secretary may provide, in the case of a transitional assistance eligible individual who voluntarily disenrolls from an endorsed plan, the provisions of subclause (II) of subparagraph (A)(ii) shall not apply.

"(3) PAYMENT.—The Secretary shall provide a method for the reimbursement of prescription drug card sponsors for assistance provided under this subsection.

"(4) COVERAGE OF COINSURANCE.—

"(A) WAIVER PERMITTED BY PHARMACY.—Nothing in this section shall be construed as precluding a pharmacy from reducing or waiving the application of coinsurance imposed under paragraph (1)(B) in accordance with section 1128B(b)(3)(G).

"(B) OPTIONAL PAYMENT OF COINSURANCE BY STATE.—

"(i) IN GENERAL.—The Secretary shall establish an arrangement under which a State may provide for payment of some or all of the coinsurance under paragraph (1)(B) for some or all enrollees in the State, as specified by the State under the arrangement. Insofar as such a payment arrangement is made with respect to an enrollee, the amount of the coinsurance shall be paid directly by the State to the pharmacy involved.

"(ii) NO FEDERAL MATCHING AVAILABLE UNDER MEDICAID OR SCHIP.—Expenditures made by a State for coinsurance described in clause (i) shall not be treated as State expenditures for purposes of Federal matching payments under title XIX or XXI.

"(iii) NOT TREATED AS MEDICARE COST-SHARING.—Coinsurance described in paragraph (1)(B) shall not be treated as coinsurance under this title for purposes of section 1905(p)(3)(B).

"(C) TREATMENT OF COINSURANCE.—The amount of any coinsurance imposed under paragraph (1)(B), whether paid or waived under this paragraph, shall not be taken into account in applying the limitation in dollar amount under paragraph (2).

"(5) ENSURING ACCESS TO TRANSITIONAL ASSISTANCE FOR QUALIFIED RESIDENTS OF LONG-TERM CARE FACILITIES AND AMERICAN INDIANS.—

"(A) RESIDENTS OF LONG-TERM CARE FACILITIES.—The Secretary shall establish procedures and may waive requirements of this section as necessary to negotiate arrangements with sponsors to provide arrangements with pharmacies that support long-term care facilities in order to ensure access to transitional assistance for transitional assistance eligible individuals who reside in long-term care facilities.

"(B) AMERICAN INDIANS.—The Secretary shall establish procedures and may waive requirements of this section to ensure that, for purposes of providing transitional assistance, pharmacies operated by the Indian Health Service, Indian tribes and tribal organizations, and urban Indian organizations (as defined in section 4 of the Indian Health Care Improvement Act) have the opportunity to participate in the pharmacy networks of at least two endorsed programs in each of the 50 States and the District of Columbia where such a pharmacy operates.

"(6) NO IMPACT ON BENEFITS UNDER OTHER PROGRAMS.—The availability of negotiated prices or transitional assistance under this section shall not be treated as benefits or otherwise taken into account in determining an individual's eligibility for, or the amount of benefits under, any other Federal program.

"(7) DISREGARD FOR PURPOSES OF PART C.—Nonuniformity of benefits resulting from the implementation of this section (including the provision or nonprovision of transitional assistance and the payment or waiver of any enrollment fee under this section) shall not be taken into account in applying section 1854(f).

"(h) QUALIFICATION OF PRESCRIPTION DRUG CARD SPONSORS AND ENDORSEMENT OF DISCOUNT CARD PROGRAMS; BENEFICIARY PROTECTIONS.—

"(1) PRESCRIPTION DRUG CARD SPONSOR AND QUALIFICATIONS.—

"(A) PRESCRIPTION DRUG CARD SPONSOR AND SPONSOR DEFINED.—For purposes of this section, the terms 'prescription drug card sponsor' and 'sponsor' mean any nongovernmental entity that the Secretary determines to be appropriate to offer an endorsed discount card program under this section, which may include—

"(i) a pharmaceutical benefit management company;

"(ii) a wholesale or retail pharmacy delivery system;

"(iii) an insurer (including an insurer that offers medicare supplemental policies under section 1882);

"(iv) an organization offering a plan under part C; or

"(v) any combination of the entities described in clauses (i) through (iv).

"(B) ADMINISTRATIVE QUALIFICATIONS.—Each endorsed discount card program shall be operated directly, or through arrangements with an

affiliated organization (or organizations), by one or more entities that have demonstrated experience and expertise in operating such a program or a similar program and that meets such business stability and integrity requirements as the Secretary may specify.

"(C) ACCOUNTING FOR TRANSITIONAL ASSISTANCE.—The sponsor of an endorsed discount card program shall have arrangements satisfactory to the Secretary to account for the assistance provided under subsection (g) on behalf of transitional assistance eligible individuals.

"(2) APPLICATIONS FOR PROGRAM ENDORSEMENT.—

"(A) SUBMISSION.—Each prescription drug card sponsor that seeks endorsement of a prescription drug discount card program under this section shall submit to the Secretary, at such time and in such manner as the Secretary may specify, an application containing such information as the Secretary may require.

"(B) APPROVAL; COMPLIANCE WITH APPLICABLE REQUIREMENTS.—The Secretary shall review the application submitted under subparagraph (A) and shall determine whether to endorse the prescription drug discount card program. The Secretary may not endorse such a program unless—

"(i) the program and prescription drug card sponsor offering the program comply with the applicable requirements under this section; and

"(ii) the sponsor has entered into a contract with the Secretary to carry out such requirements.

"(C) TERMINATION OF ENDORSEMENT AND CONTRACTS.—An endorsement of an endorsed program and a contract under subparagraph (B) shall be for the duration of the program under this section (including any transition applicable under subsection (a)(2)(C)(ii)), except that the Secretary may, with notice and for cause (as defined by the Secretary), terminate such endorsement and contract.

"(D) ENSURING CHOICE OF PROGRAMS.—

"(i) IN GENERAL.—The Secretary shall ensure that there is available to each discount card eligible individual a choice of at least 2 endorsed programs (each offered by a different sponsor).

"(ii) LIMITATION ON NUMBER.—The Secretary may limit (but not below 2) the number of sponsors in a State that are awarded contracts under this paragraph.

"(3) SERVICE AREA ENCOMPASSING ENTIRE STATES.—Except as provided in paragraph (9), if a prescription drug card sponsor that offers an endorsed program enrolls in the program individuals residing in any part of a State, the sponsor must permit any discount card eligible individual residing in any portion of the State to enroll in the program.

"(4) SAVINGS TO MEDICARE BENEFICIARIES.—Each prescription drug card sponsor that offers an endorsed discount card program shall pass on to discount card eligible individuals enrolled in the program negotiated prices on covered discount card drugs, including discounts negotiated with pharmacies and manufacturers, to the extent disclosed under subsection (i)(1).

"(5) GRIEVANCE MECHANISM.—Each prescription drug card sponsor shall provide meaningful procedures for hearing and resolving grievances between the sponsor (including any entity or individual through which the sponsor carries out the endorsed discount card program) and enrollees in endorsed discount card programs of the sponsor under this section in a manner similar to that required under section 1852(f).

"(6) CONFIDENTIALITY OF ENROLLEE RECORDS.—

"(A) IN GENERAL.—For purposes of the program under this section, the operations of an endorsed program are covered functions and a prescription drug card sponsor is a covered entity for purposes of applying part C of title XI and all regulatory provisions promulgated thereunder, including regulations (relating to privacy) adopted pursuant to the authority of the Secretary under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

"(B) WAIVER AUTHORITY.—In order to promote participation of sponsors in the program under this section, the Secretary may waive such relevant portions of regulations relating to privacy referred to in subparagraph (A), for such appropriate, limited period of time, as the Secretary specifies.

"(7) LIMITATION ON PROVISION AND MARKETING OF PRODUCTS AND SERVICES.—The sponsor of an endorsed discount card program—

"(A) may provide under the program—

"(i) a product or service only if the product or service is directly related to a covered discount card drug; or

"(ii) a discount price for nonprescription drugs; and

"(B) may, to the extent otherwise permitted under paragraph (6) (relating to application of HIPAA requirements), market a product or service under the program only if the product or service is directly related to—

"(i) a covered discount card drug; or

"(ii) a drug described in subparagraph (A)(ii) and the marketing consists of information on the discounted price made available for the drug involved.

"(8) ADDITIONAL PROTECTIONS.—Each endorsed discount card program shall meet such additional requirements as the Secretary identifies to protect and promote the interest of discount card eligible individuals, including requirements that ensure that discount card eligible individuals enrolled in endorsed discount card programs are not charged more than the lower of the price based on negotiated prices or the usual and customary price.

"(9) SPECIAL RULES FOR CERTAIN ORGANIZATIONS.—

"(A) IN GENERAL.—In the case of an organization that is offering a plan under part C or enrollment under a reasonable cost reimbursement contract under section 1876(h) that is seeking to be a prescription drug card sponsor under this section, the organization may elect to apply the special rules under subparagraph (B) with respect to enrollees in any plan described in section 1851(a)(2)(A) that it offers or under such contract and an endorsed discount card program it offers, but only if it limits enrollment under such program to individuals enrolled in such plan or under such contract.

"(B) SPECIAL RULES.—The special rules under this subparagraph are as follows:

"(i) LIMITATION ON ENROLLMENT.—The sponsor limits enrollment under this section under the endorsed discount card program to discount card eligible individuals who are enrolled in the part C plan involved or under the reasonable cost reimbursement contract involved and is not required nor permitted to enroll other individuals under such program.

"(ii) PHARMACY ACCESS.—Pharmacy access requirements under subsection (e)(1)(B) are deemed to be met if the access is made available through a pharmacy network (and not only through mail order) and the network used by the sponsor is approved by the Secretary.

"(iii) SPONSOR REQUIREMENTS.—The Secretary may waive the application of such requirements for a sponsor as the Secretary determines to be duplicative or to conflict with a requirement of the organization under part C or section 1876 (as the case may be) or to be necessary in order to improve coordination of this section with the benefits under such part or section.

"(i) DISCLOSURE AND OVERSIGHT.—

"(1) DISCLOSURE.—Each prescription drug card sponsor offering an endorsed discount card program shall disclose to the Secretary (in a manner specified by the Secretary) information relating to program performance, use of prescription drugs by discount card eligible individuals enrolled in the program, the extent to which negotiated price concessions described in subsection (e)(1)(A)(ii) made available to the entity by a manufacturer are passed through to enrollees through pharmacies or otherwise, and such other information as the Secretary may specify. The provisions of section 1927(b)(3)(D) shall apply to drug pricing data reported under the previous sentence (other than data in aggregate form).

"(2) OVERSIGHT; AUDIT AND INSPECTION AUTHORITY.—The Secretary shall provide appropriate oversight to ensure compliance of endorsed discount card programs and their sponsors with the requirements of this section. The Secretary shall have the right to audit and inspect any books and records of a prescription discount card sponsor (and of any affiliated organization referred to in subsection (h)(1)(B)) that pertain to the endorsed discount card program under this section, including amounts payable to the sponsor under this section.

"(3) SANCTIONS FOR ABUSIVE PRACTICES.—The Secretary may implement intermediate sanctions or may revoke the endorsement of a program offered by a sponsor under this section if the Secretary determines that the sponsor or the program no longer meets the applicable requirements of this section or that the sponsor has engaged in false or misleading marketing practices. The Secretary may impose a civil money penalty in an amount not to exceed $10,000 for conduct that a party knows or should know is a violation of this section. The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(j) TREATMENT OF TERRITORIES.—

"(1) IN GENERAL.—The Secretary may waive any provision of this section (including subsection (h)(2)(D)) in the case of a resident of a State (other than the 50 States and the District of Columbia) insofar as the Secretary determines it is necessary to secure access to negotiated prices for discount card eligible individuals (or, at the option of the Secretary, individuals described in subsection (b)(1)(A)(i)).

"(2) TRANSITIONAL ASSISTANCE.—

"(A) IN GENERAL.—In the case of a State, other than the 50 States and the District of Columbia, if the State establishes a plan described in subparagraph (B) (for providing transitional assistance with respect to the provision of prescription drugs to some or all individuals residing in the State who are described in subparagraph (B)(i)), the Secretary shall pay to the State for the entire period of the operation of this section an amount equal to the amount allotted to the State under subparagraph (C).

"(B) PLAN.—The plan described in this subparagraph is a plan that—

"(i) provides transitional assistance with respect to the provision of covered discount card drugs to some or all individuals who are entitled to benefits under part A or enrolled under part B, who reside in the State, and who have income below 135 percent of the poverty line; and

"(ii) assures that amounts received by the State under this paragraph are used only for such assistance.

"(C) ALLOTMENT LIMIT.—The amount described in this subparagraph for a State is equal to $35,000,000 multiplied by the ratio (as estimated by the Secretary) of—

"(i) the number of individuals who are entitled to benefits under part A or enrolled under part B and who reside in the State (as determined by the Secretary as of July 1, 2003), to

"(ii) the sum of such numbers for all States to which this paragraph applies.

"(D) CONTINUED AVAILABILITY OF FUNDS.—Amounts made available to a State under this paragraph which are not used under this paragraph shall be added to the amount available to that State for purposes of carrying out section 1935(e).

"(k) FUNDING.—

"(1) ESTABLISHMENT OF TRANSITIONAL ASSISTANCE ACCOUNT.—

"(A) IN GENERAL.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Transitional Assistance Account' (in this subsection referred to as the 'Account').

"(B) FUNDS.—The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), accrued interest on balances in the Account, and such amounts as may be deposited in, or appropriated to, the Account as provided in this subsection.

"(C) SEPARATE FROM REST OF TRUST FUND.—Funds provided under this subsection to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund, but shall be invested, and such investments redeemed, in the same manner as all other funds and investments within such Trust Fund.

"(2) PAYMENTS FROM ACCOUNT.—

"(A) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments for transitional assistance provided under subsections (g) and (j)(2).

"(B) TREATMENT IN RELATION TO PART B PREMIUM.—Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1839.

"(3) APPROPRIATIONS TO COVER BENEFITS.—There are appropriated to the Account in a fiscal year, out of any moneys in the Treasury not otherwise appropriated, an amount equal to the payments made from the Account in the year.

"(4) FOR ADMINISTRATIVE EXPENSES.—There are authorized to be appropriated to the Secretary such sums as may be necessary to carry out the Secretary's responsibilities under this section.

"(5) TRANSFER OF ANY REMAINING BALANCE TO MEDICARE PRESCRIPTION DRUG ACCOUNT.—Any balance remaining in the Account after the Secretary determines that funds in the Account are no longer necessary to carry out the program under this section shall be transferred and deposited into the Medicare Prescription Drug Account under section 1860D–16.

"(6) CONSTRUCTION.—Nothing in this section shall be construed as authorizing the Secretary to provide for payment (other than payment of an enrollment fee on behalf of a transitional assistance eligible individual under subsection (g)(1)(A)) to a sponsor for administrative expenses incurred by the sponsor in carrying out this section (including in administering the transitional assistance provisions of subsections (f) and (g)).

"Subpart 5—Definitions and Miscellaneous Provisions

"DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN PART C

"SEC. 1860D–41. (a) DEFINITIONS.—For purposes of this part:

"(1) BASIC PRESCRIPTION DRUG COVERAGE.—The term 'basic prescription drug coverage' is defined in section 1860D–2(a)(3).

"(2) COVERED PART D DRUG.—The term 'covered part D drug' is defined in section 1860D–2(e).

"(3) CREDITABLE PRESCRIPTION DRUG COVERAGE.—The term 'creditable prescription drug coverage' has the meaning given such term in section 1860D–13(b)(4).

"(4) PART D ELIGIBLE INDIVIDUAL.—The term 'part D eligible individual' has the meaning given such term in section 1860D–1(a)(4)(A).

"(5) FALLBACK PRESCRIPTION DRUG PLAN.—The term 'fallback prescription drug plan' has the meaning given such term in section 1860D–11(g)(4).

"(6) INITIAL COVERAGE LIMIT.—The term 'initial coverage limit' means such limit as established under section 1860D–2(b)(3), or, in the case of coverage that is not standard prescription drug coverage, the comparable limit (if any) established under the coverage.

"(7) INSURANCE RISK.—The term 'insurance risk' means, with respect to a participating pharmacy, risk of the type commonly assumed only by insurers licensed by a State and does not include payment variations designed to reflect performance-based measures of activities within the control of the pharmacy, such as formulary compliance and generic drug substitution.

"(8) MA PLAN.—The term 'MA plan' has the meaning given such term in section 1860D–1(a)(4)(B).

"(9) MA–PD PLAN.—The term 'MA–PD plan' has the meaning given such term in section 1860D–1(a)(4)(C).

"(10) MEDICARE PRESCRIPTION DRUG ACCOUNT.—The term 'Medicare Prescription Drug Account' means the Account created under section 1860D–16(a).

"(11) PDP APPROVED BID.—The term 'PDP approved bid' has the meaning given such term in section 1860D–13(a)(6).

"(12) PDP REGION.—The term 'PDP region' means such a region as provided under section 1860D–11(a)(2).

"(13) PDP SPONSOR.—The term 'PDP sponsor' means a nongovernmental entity that is certified under this part as meeting the requirements and standards of this part for such a sponsor.

"(14) PRESCRIPTION DRUG PLAN.—The term 'prescription drug plan' means prescription drug coverage that is offered—

"(A) under a policy, contract, or plan that has been approved under section 1860D–11(e); and

"(B) by a PDP sponsor pursuant to, and in accordance with, a contract between the Secretary and the sponsor under section 1860D–12(b).

"(15) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'qualified prescription drug coverage' is defined in section 1860D–2(a)(1).

"(16) STANDARD PRESCRIPTION DRUG COVERAGE.—The term 'standard prescription drug coverage' is defined in section 1860D–2(b).

"(17) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—The term 'State Pharmaceutical Assistance Program' has the meaning given such term in section 1860D–23(b).

"(18) SUBSIDY ELIGIBLE INDIVIDUAL.—The term 'subsidy eligible individual' has the meaning given such term in section 1860D–14(a)(3)(A).

"(b) APPLICATION OF PART C PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C under this part with respect to a prescription drug plan and a PDP sponsor, unless otherwise provided in this part such provisions shall be applied as if—

"(1) any reference to an MA plan included a reference to a prescription drug plan;

"(2) any reference to an MA organization or a provider-sponsored organization included a reference to a PDP sponsor;

"(3) any reference to a contract under section 1857 included a reference to a contract under section 1860D–12(b);

"(4) any reference to part C included a reference to this part; and

"(5) any reference to an election period under section 1851 were a reference to an enrollment period under section 1860D–1.

"MISCELLANEOUS PROVISIONS

"SEC. 1860D–42. (a) ACCESS TO COVERAGE IN TERRITORIES.—The Secretary may waive such requirements of this part, including section 1860D–3(a)(1), insofar as the Secretary determines it is necessary to secure access to qualified prescription drug coverage for part D eligible individuals residing in a State (other than the 50 States and the District of Columbia).

"(b) APPLICATION OF DEMONSTRATION AUTHORITY.—The provisions of section 402 of the Social Security Amendments of 1967 (Public Law 90–248) shall apply with respect to this part and part C in the same manner it applies with respect to parts A and B, except that any reference with respect to a Trust Fund in relation to an experiment or demonstration project relating to prescription drug coverage under this part shall be deemed a reference to the Medicare Prescription Drug Account within the Federal Supplementary Medical Insurance Trust Fund.".

(b) SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this title and title II.

(c) STUDY ON TRANSITIONING PART B PRESCRIPTION DRUG COVERAGE.—Not later than January 1, 2005, the Secretary shall submit a report to Congress that makes recommendations regarding methods for providing benefits under subpart 1 of part D of title XVIII of the Social Security Act for outpatient prescription drugs for which benefits are provided under part B of such title.

(d) REPORT ON PROGRESS IN IMPLEMENTATION OF PRESCRIPTION DRUG BENEFIT.—Not later than March 1, 2005, the Secretary shall submit a report to Congress on the progress that has been made in implementing the prescription drug benefit under this title. The Secretary shall include in the report specific steps that have been taken, and that need to be taken, to ensure a timely start of the program on January 1, 2006. The report shall include recommendations regarding an appropriate transition from the program under section 1860D–31 of the Social Security Act to prescription drug benefits under subpart 1 of part D of title XVIII of such Act.

(e) ADDITIONAL CONFORMING CHANGES.—

(1) CONFORMING REFERENCES TO PREVIOUS PART D.—Any reference in law (in effect before the date of the enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part E of such title (as in effect after such date).

(2) CONFORMING AMENDMENT PERMITTING WAIVER OF COST-SHARING.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(A) by striking "and" at the end of subparagraph (E);

(B) by striking the period at the end of subparagraph (F) and inserting "; and"; and

(C) by adding at the end the following new subparagraph:

"(G) the waiver or reduction by pharmacies (including pharmacies of the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations) of any cost-sharing imposed under part D of title XVIII, if the conditions described in clauses (i) through (iii) of section 1128A(i)(6)(A) are met with respect to the waiver or reduction (except that, in the case of such a waiver or reduction on behalf of a subsidy eligible individual (as defined in section 1860D–14(a)(3)), section 1128A(i)(6)(A) shall be applied without regard to clauses (ii) and (iii) of that section).".

(3) MEDICARE PRESCRIPTION DRUG ACCOUNT.—

(A) Section 201(g) (42 U.S.C. 401(g)) is amended—

(i) in paragraph (1)(B)(i)(V), by inserting "(and, of such portion, the portion of such costs which should have been borne by the Medicare Prescription Drug Account in such Trust Fund)" after "Trust Fund"; and

(ii) in paragraph (1)(B)(ii)(III), by inserting "(and, of such portion, the portion of such costs which should have been borne by the Medicare Prescription Drug Account in such Trust Fund)" after "Trust Fund".

(B) Section 201(i)(1) (42 U.S.C. 401(i)(1)) is amended by inserting "(and for the Medicare Prescription Drug Account and the Transitional Assistance Account in such Trust Fund)" after "Federal Supplementary Medical Insurance Trust Fund".

(C) Section 1841 (42 U.S.C. 1395t) is amended—

(i) in the last sentence of subsection (a)—

(I) by striking "and" before "such amounts"; and

(II) by inserting before the period the following: ", and such amounts as may be deposited in, or appropriated to, the Medicare Prescription Drug Account established by section 1860D–16";

(ii) in subsection (g), by adding at the end the following: "The payments provided for under part D, other than under section 1860D–31(k)(2), shall be made from the Medicare Prescription Drug Account in the Trust Fund.";

(iii) in subsection (h), by inserting "or pursuant to section 1860D–13(c)(1) or 1854(d)(2)(A) (in which case payments shall be made in appropriate part from the Medicare Prescription Drug Account in the Trust Fund)" after "1840(d)"; and

(iv) in subsection (i), by inserting after "and section 1842(g)" the following: "and pursuant to sections 1860D–13(c)(1) and 1854(d)(2)(A) (in which case payments shall be made in appropriate part from the Medicare Prescription Drug Account in the Trust Fund)".

(D) Section 1853(f) (42 U.S.C. 1395w–23(f)) is amended—

(i) in the heading by striking "TRUST FUND" and inserting "TRUST FUNDS"; and

(ii) by inserting after the first sentence the following: "Payments to MA organizations for statutory drug benefits provided under this title are made from the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.".

(4) APPLICATION OF CONFIDENTIALITY FOR DRUG PRICING DATA.—Section 1927(b)(3)(D) (42 U.S.C. 1396r–8(b)(3)(D)) is amended by adding after and below clause (iii) the following:

"The previous sentence shall also apply to information disclosed under section 1860D–2(d)(2) or 1860D–4(c)(2)(E).".

(5) CLARIFICATION OF TREATMENT OF PART A ENROLLEES.—Section 1818(a) (42 U.S.C. 1395i–2(a)) is amended by adding at the end the following: "Except as otherwise provided, any reference to an individual entitled to benefits under this part includes an individual entitled to benefits under this part pursuant to an enrollment under this section or section 1818A.".

(6) DISCLOSURE.—Section 6103(l)(7)(D)(ii) of the Internal Revenue Code of 1986 is amended by inserting "or subsidies provided under section 1860D–14 of such Act" after "Social Security Act".

(7) EXTENSION OF STUDY AUTHORITY.—Section 1875(b) (42 U.S.C. 1395ll(b)) is amended by striking "the insurance programs under parts A and B" and inserting "this title".

(8) CONFORMING AMENDMENTS RELATING TO FACILITATION OF ELECTRONIC PRESCRIBING.—

(A) Section 1128B(b)(3)(C) (42 U.S.C. 1320a–7b(b)(3)(C)) is amended by inserting "or in regulations under section 1860D–3(e)(6)" after "1987".

(B) Section 1877(b) (42 U.S.C. 1395nn(b)) is amended by adding at the end the following new paragraph:

"(5) ELECTRONIC PRESCRIBING.—An exception established by regulation under section 1860D–3(e)(6).".

(9) OTHER CHANGES.—Section 1927(g)(1)(B)(i) (42 U.S.C. 1396r–8(g)(1)(B)(i)) is amended—

(A) by adding "and" at the end of subclause (II); and

(B) by striking subclause (IV).

SEC. 102. MEDICARE ADVANTAGE CONFORMING AMENDMENTS.

(a) CONFORMING AMENDMENTS TO ENROLLMENT PROCESS.—

(1) EXTENDING OPEN ENROLLMENT PERIODS.—Section 1851(e) (42 U.S.C. 1395w–21(e)) is amended—

(A) in paragraph (2), by striking "2004" and "2005" and inserting "2005" and "2006" each place it appears; and

(B) in paragraph (4), by striking "2005" and inserting "2006" each place it appears.

(2) ESTABLISHMENT OF SPECIAL ANNUAL, COORDINATED ELECTION PERIOD FOR 6 MONTHS BEGINNING NOVEMBER 15, 2005.—Section 1851(e)(3)(B) (42 U.S.C. 1395w–21(e)(3)(B)) is amended to read as follows:

"(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term 'annual, coordinated election period' means—

"(i) with respect to a year before 2002, the month of November before such year;

"(ii) with respect to 2002, 2003, 2004, and 2005, the period beginning on November 15 and ending on December 31 of the year before such year;

"(iii) with respect to 2006, the period beginning on November 15, 2005, and ending on May 15, 2006; and

"(iv) with respect to 2007 and succeeding years, the period beginning on November 15 and ending on December 31 of the year before such year.".

(3) SPECIAL INFORMATION CAMPAIGN.—Section 1851(e)(3) (42 U.S.C. 1395w–21(e)(3)) is amended—

(A) in subparagraph (C), by inserting "and during the period described in subparagraph (B)(iii)" after "(beginning with 1999)"; and

(B) in subparagraph (D)—

(i) in the heading by striking "CAMPAIGN IN 1998" and inserting "CAMPAIGNS"; and

(ii) by adding at the end the following: "During the period described in subparagraph (B)(iii), the Secretary shall provide for an educational and publicity campaign to inform MA eligible individuals about the availability of MA plans (including MA–PD plans) offered in different areas and the election process provided under this section.".

(4) COORDINATING INITIAL ENROLLMENT PERIODS.—Section 1851(e)(1) (42 U.S.C. 1395w–21(e)(1)) is amended by adding at the end the following new sentence: "If any portion of an individual's initial enrollment period under part B occurs after the end of the annual, coordinated election period described in paragraph (3)(B)(iii), the initial enrollment period under this part shall further extend through the end of the individual's initial enrollment period under part B.".

(5) COORDINATION OF EFFECTIVENESS OF ELECTIONS DURING ANNUAL COORDINATED ELECTION PERIOD FOR 2006.—Section 1851(f)(3) (42 U.S.C. 1395w–21(f)(3)) is amended by inserting ", other than the period described in clause (iii) of such subsection" after "subsection (e)(3)(B)".

(6) LIMITATION ON ONE-CHANGE RULE TO SAME TYPE OF PLAN.—Section 1851(e)(2) (42 U.S.C. 1395w–21(e)(2)) is amended—

(A) in subparagraph (B)(i), by inserting ", subparagraph (C)(iii)," after "clause (ii)";

(B) in subparagraph (C)(i), by striking "clause (ii)" and inserting "clauses (ii) and (iii)"; and

(C) by adding at the end of subparagraph (C) the following new clause:

"(iii) LIMITATION ON EXERCISE OF RIGHT WITH RESPECT TO PRESCRIPTION DRUG COVERAGE.—Effective for plan years beginning on or after January 1, 2006, in applying clause (i) (and clause (i) of subparagraph (B)) in the case of an individual who—

"(I) is enrolled in an MA plan that does provide qualified prescription drug coverage, the individual may exercise the right under such clause only with respect to coverage under the original fee-for-service plan or coverage under another MA plan that does not provide such coverage and may not exercise such right to obtain coverage under an MA–PD plan or under a prescription drug plan under part D; or

"(II) is enrolled in an MA–PD plan, the individual may exercise the right under such clause only with respect to coverage under another MA–PD plan (and not an MA plan that does not provide qualified prescription drug coverage) or under the original fee-for-service plan and coverage under a prescription drug plan under part D.".

(b) PROMOTION OF E-PRESCRIBING BY MA PLANS.—Section 1852(j) (42 U.S.C. 1395w–22(j)) is amended by adding at the end the following new paragraph:

"(7) PROMOTION OF E-PRESCRIBING BY MA PLANS.—

"(A) IN GENERAL.—An MA–PD plan may provide for a separate payment or otherwise provide for a differential payment for a participating physician that prescribes covered part D drugs in accordance with an electronic prescription drug program that meets standards established under section 1860D–4(e).

"(B) CONSIDERATIONS.—Such payment may take into consideration the costs of the physician in implementing such a program and may also be increased for those participating physicians who significantly increase—

"(i) formulary compliance;

"(ii) lower cost, therapeutically equivalent alternatives;

"(iii) reductions in adverse drug interactions; and

"(iv) efficiencies in filing prescriptions through reduced administrative costs.

"(C) STRUCTURE.—Additional or increased payments under this subsection may be structured in the same manner as medication therapy management fees are structured under section 1860D–4(c)(2)(E).".

(c) OTHER CONFORMING AMENDMENTS.—

(1) Section 1851(a)(1) (42 U.S.C. 1395w–21(a)(1)) is amended—

(A) by inserting "(other than qualified prescription drug benefits)" after "benefits";

(B) by striking the period at the end of subparagraph (B) and inserting a comma; and

(C) by adding after and below subparagraph (B) the following:

"and may elect qualified prescription drug coverage in accordance with section 1860D–1.".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply on and after January 1, 2006.

SEC. 103. MEDICAID AMENDMENTS.

(a) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME SUBSIDIES.—

(1) REQUIREMENT.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(A) by striking "and" at the end of paragraph (64);

(B) by striking the period at the end of paragraph (65) and inserting "; and"; and

(C) by inserting after paragraph (65) the following new paragraph:

"(66) provide for making eligibility determinations under section 1935(a).".

(2) NEW SECTION.—Title XIX is further amended—

(A) by redesignating section 1935 as section 1936; and

(B) by inserting after section 1934 the following new section:

"SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

"SEC. 1935. (a) REQUIREMENTS RELATING TO MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES AND MEDICARE TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a), a State shall do the following:

"(1) INFORMATION FOR TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE VERIFICATION.—The State shall provide the Secretary with information to carry out section 1860D–31(f)(3)(B)(i).

"(2) ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—The State shall—

"(A) make determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D–14;

"(B) inform the Secretary of such determinations in cases in which such eligibility is established; and

"(C) otherwise provide the Secretary with such information as may be required to carry out part D, other than subpart 4, of title XVIII (including section 1860D–14).

"(3) SCREENING FOR ELIGIBILITY, AND ENROLLMENT OF, BENEFICIARIES FOR MEDICARE COST-SHARING.—As part of making an eligibility determination required under paragraph (2) for an individual, the State shall make a determination of the individual's eligibility for medical assistance for any medicare cost-sharing described in section 1905(p)(3) and, if the individual is eligible for any such medicare cost-sharing, offer enrollment to the individual under the State plan (or under a waiver of such plan).

"(b) REGULAR FEDERAL SUBSIDY OF ADMINISTRATIVE COSTS.—The amounts expended by a State in carrying out subsection (a) are expenditures reimbursable under the appropriate paragraph of section 1903(a).

(b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES FOR DUALLY ELIGIBLE INDIVIDUALS.—Section 1935, as inserted by subsection (a)(2), is amended by adding at the end the following new subsection:

"(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY ELIGIBLE INDIVIDUALS.—

"(1) PHASED-DOWN STATE CONTRIBUTION.—

"(A) IN GENERAL.—Each of the 50 States and the District of Columbia for each month beginning with January 2006 shall provide for payment under this subsection to the Secretary of the product of—

"(i) the amount computed under paragraph (2)(A) for the State and month;

"(ii) the total number of full-benefit dual eligible individuals (as defined in paragraph (6)) for such State and month; and

"(iii) the factor for the month specified in paragraph (5).

"(B) FORM AND MANNER OF PAYMENT.—Payment under subparagraph (A) shall be made in a manner specified by the Secretary that is similar to the manner in which State payments are made under an agreement entered into under section 1843, except that all such payments shall be deposited into the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.

"(C) COMPLIANCE.—If a State fails to pay to the Secretary an amount required under subparagraph (A), interest shall accrue on such amount at the rate provided under section 1903(d)(5). The amount so owed and applicable interest shall be immediately offset against amounts otherwise payable to the State under section 1903(a), in accordance with the Federal Claims Collection Act of 1996 and applicable regulations.

"(D) DATA MATCH.—The Secretary shall perform such periodic data matches as may be necessary to identify and compute the number of full-benefit dual eligible individuals for purposes of computing the amount under subparagraph (A).

"(2) AMOUNT.—

"(A) IN GENERAL.—The amount computed under this paragraph for a State described in paragraph (1) and for a month in a year is equal to—

"(i) $\frac{1}{12}$ of the product of—

"(I) the base year state medicaid per capita expenditures for covered part D drugs for full-benefit dual eligible individuals (as computed under paragraph (3)); and

"(II) a proportion equal to 100 percent minus the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State for the fiscal year in which the month occurs; and

"(ii) increased for each year (beginning with 2004 up to and including the year involved) by the applicable growth factor specified in paragraph (4) for that year.

"(B) NOTICE.—The Secretary shall notify each State described in paragraph (1) not later than October 15 before the beginning of each year (beginning with 2006) of the amount computed under subparagraph (A) for the State for that year.

"(3) BASE YEAR STATE MEDICAID PER CAPITA EXPENDITURES FOR COVERED PART D DRUGS FOR FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

"(A) IN GENERAL.—For purposes of paragraph (2)(A), the 'base year State medicaid per capita expenditures for covered part D drugs for full-benefit dual eligible individuals' for a State is equal to the weighted average (as weighted under subparagraph (C)) of—

"(i) the gross per capita medicaid expenditures for prescription drugs for 2003, determined under subparagraph (B); and

"(ii) the estimated actuarial value of prescription drug benefits provided under a capitated managed care plan per full-benefit dual eligible individual for 2003, as determined using such data as the Secretary determines appropriate.

"(B) GROSS PER CAPITA MEDICAID EXPENDITURES FOR PRESCRIPTION DRUGS.—

"(i) IN GENERAL.—The gross per capita medicaid expenditures for prescription drugs for 2003 under this subparagraph is equal to the expenditures, including dispensing fees, for the State under this title during 2003 for covered outpatient drugs, determined per full-benefit-dual-eligible-individual for such individuals not receiving medical assistance for such drugs through a medicaid managed care plan.

"(ii) DETERMINATION.—In determining the amount under clause (i), the Secretary shall—

"(I) use data from the Medicaid Statistical Information System (MSIS) and other available data;

"(II) exclude expenditures attributable to covered outpatient prescription drugs that are not covered part D drugs (as defined in section 1860D–2(e)); and

"(III) reduce such expenditures by the product of such portion and the adjustment factor (described in clause (iii)).

"(iii) ADJUSTMENT FACTOR.—The adjustment factor described in this clause for a State is equal to the ratio for the State for 2003 of—

"(I) aggregate payments under agreements under section 1927; to

"(II) the gross expenditures under this title for covered outpatient drugs referred to in clause (i).

Such factor shall be determined based on information reported by the State in the medicaid financial management reports (form CMS–64) for the 4 quarters of calendar year 2003 and such other data as the Secretary may require.

"(C) WEIGHTED AVERAGE.—The weighted average under subparagraph (A) shall be determined taking into account—

"(i) with respect to subparagraph (A)(i), the average number of full-benefit dual eligible individuals in 2003 who are not described in clause (ii); and

"(ii) with respect to subparagraph (A)(ii), the average number of full-benefit dual eligible individuals in such year who received in 2003 medical assistance for covered outpatient drugs through a medicaid managed care plan.

"(4) APPLICABLE GROWTH FACTOR.—The applicable growth factor under this paragraph for—

"(A) each of 2004, 2005, and 2006, is the average annual percent change (to that year from the previous year) of the per capita amount of prescription drug expenditures (as determined based on the most recent National Health Expenditure projections for the years involved); and

"(B) a succeeding year, is the annual percentage increase specified in section 1860D–2(b)(6) for the year.

"(5) FACTOR.—The factor under this paragraph for a month—

"(A) in 2006 is 90 percent;

"(B) in 2007 is 88-$\frac{1}{3}$ percent;

"(C) in 2008 is 86-$\frac{2}{3}$ percent;

"(D) in 2009 is 85 percent;

"(E) in 2010 is 83-$\frac{1}{3}$ percent;

"(F) in 2011 is 81-$\frac{2}{3}$ percent;

"(G) in 2012 is 80 percent;

"(H) in 2013 is 78-$\frac{1}{3}$ percent;

"(I) in 2014 is 76-$\frac{2}{3}$ percent; or

"(J) after December 2014, is 75 percent.

"(6) FULL-BENEFIT DUAL ELIGIBLE INDIVIDUAL DEFINED.—

"(A) IN GENERAL.—For purposes of this section, the term 'full-benefit dual eligible individual' means for a State for a month an individual who—

"(i) has coverage for the month for covered part D drugs under a prescription drug plan under part D of title XVIII, or under an MA–PD plan under part C of such title; and

"(ii) is determined eligible by the State for medical assistance for full benefits under this title for such month under section 1902(a)(10)(A) or 1902(a)(10)(C), by reason of section 1902(f), or under any other category of eligibility for medical assistance for full benefits under this title, as determined by the Secretary.

"(B) TREATMENT OF MEDICALLY NEEDY AND OTHER INDIVIDUALS REQUIRED TO SPEND DOWN.—In applying subparagraph (A) in the case of an individual determined to be eligible by the State for medical assistance under section 1902(a)(10)(C) or by reason of section 1902(f), the individual shall be treated as meeting the requirement of subparagraph (A)(ii) for any month if such medical assistance is provided for in any part of the month.".

(c) MEDICAID COORDINATION WITH MEDICARE PRESCRIPTION DRUG BENEFITS.—Section 1935, as so inserted and amended, is further amended by adding at the end the following new subsection:

"(d) COORDINATION OF PRESCRIPTION DRUG BENEFITS.—

"(1) MEDICARE AS PRIMARY PAYOR.—In the case of a part D eligible individual (as defined in section 1860D–1(a)(3)(A)) who is described in subsection (c)(6)(A)(ii), notwithstanding any other provision of this title, medical assistance is not available under this title for such drugs (or for any cost-sharing respecting such drugs), and the rules under this title relating to the provision of medical assistance for such drugs shall not apply. The provision of benefits with respect to such drugs shall not be considered as the provision of care or services under the plan under this title. No payment may be made under section 1903(a) for prescribed drugs for which medical assistance is not available pursuant to this paragraph.

“(2) COVERAGE OF CERTAIN EXCLUDABLE DRUGS.—In the case of medical assistance under this title with respect to a covered outpatient drug (other than a covered part D drug) furnished to an individual who is enrolled in a prescription drug plan under part D of title XVIII or an MA–PD plan under part C of such title, the State may elect to provide such medical assistance in the manner otherwise provided in the case of individuals who are not full-benefit dual eligible individuals or through an arrangement with such plan.”.

(d) TREATMENT OF TERRITORIES.—

(1) IN GENERAL.—Section 1935, as so inserted and amended, is further amended—

(A) in subsection (a) in the matter preceding paragraph (1), by inserting “subject to subsection (e)” after “section 1903(a)”;

(B) in subsection (c)(1), by inserting “subject to subsection (e)” after “1903(a)(1)”; and

(C) by adding at the end the following new subsection:

“(e) TREATMENT OF TERRITORIES.—

“(1) IN GENERAL.—In the case of a State, other than the 50 States and the District of Columbia—

“(A) the previous provisions of this section shall not apply to residents of such State; and

“(B) if the State establishes and submits to the Secretary a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to part D eligible individuals), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be increased by the amount for the fiscal period specified in paragraph (3).

“(2) PLAN.—The Secretary shall determine that a plan is described in this paragraph if the plan—

“(A) provides medical assistance with respect to the provision of covered part D drugs (as defined in section 1860D–2(e)) to low-income part D eligible individuals;

“(B) provides assurances that additional amounts received by the State that are attributable to the operation of this subsection shall be used only for such assistance and related administrative expenses and that no more than 10 percent of the amount specified in paragraph (3)(A) for the State for any fiscal period shall be used for such administrative expenses; and

“(C) meets such other criteria as the Secretary may establish.

“(3) INCREASED AMOUNT.—

“(A) IN GENERAL.—The amount specified in this paragraph for a State for a year is equal to the product of—

“(i) the aggregate amount specified in subparagraph (B); and

“(ii) the ratio (as estimated by the Secretary) of—

“(I) the number of individuals who are entitled to benefits under part A or enrolled under part B and who reside in the State (as determined by the Secretary based on the most recent available data before the beginning of the year); to

“(II) the sum of such numbers for all States that submit a plan described in paragraph (2).

“(B) AGGREGATE AMOUNT.—The aggregate amount specified in this subparagraph for—

“(i) the last 3 quarters of fiscal year 2006, is equal to $28,125,000;

“(ii) fiscal year 2007, is equal to $37,500,000; or

“(iii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by annual percentage increase specified in section 1860D–2(b)(6) for the year involved.

“(4) REPORT.—The Secretary shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Secretary deems appropriate.”.

(2) CONFORMING AMENDMENT.—Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting “and section 1935(e)(1)(B)” after “Subject to subsection (g)”.

(e) AMENDMENT TO BEST PRICE.—

(1) IN GENERAL.—Section 1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)) is amended—

(A) by striking “and” at the end of subclause (III);

(B) by striking the period at the end of subclause (IV) and inserting a semicolon; and

(C) by adding at the end the following new subclauses:

“(V) the prices negotiated from drug manufacturers for covered discount card drugs under an endorsed discount card program under section 1860D–31; and

“(VI) any prices charged which are negotiated by a prescription drug plan under part D of title XVIII, by an MA–PD plan under part C of such title with respect to covered part D drugs or by a qualified retiree prescription drug plan (as defined in section 1860D–22(a)(2)) with respect to such drugs on behalf of individuals entitled to benefits under part A or enrolled under part B of such title.”.

(2) IN GENERAL.—Section 1927(c)(1)(C)(i)(VI) of the Social Security Act, as added by paragraph (1), shall apply to prices charged for drugs dispensed on or after January 1, 2006.

(f) EXTENSION OF MEDICARE COST-SHARING FOR PART B PREMIUM FOR QUALIFYING INDIVIDUALS THROUGH SEPTEMBER 2004.—

(1) IN GENERAL.—Section 1902(a)(10)(E)(iv) (42 U.S.C. 1396a(a)(10)(E)(iv)), as amended by section 401(a) of Public Law 108–89, is amended by striking “ending with March 2004” and inserting “ending with September 2004”.

(2) TOTAL AMOUNT AVAILABLE FOR ALLOCATION.—Section 1933(g) (42 U.S.C. 1396u–3(g)), as added by section 401(c) of Public Law 108–89, is amended—

(A) in the matter preceding paragraph (1), by striking “March 31, 2004” and inserting “September 30, 2004”; and

(B) in paragraph (2), by striking “$100,000,000” and inserting “$300,000,000”.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to calendar quarters beginning on or after April 1, 2004.

(g) OUTREACH BY THE COMMISSIONER OF SOCIAL SECURITY.—Section 1144 (42 U.S.C. 1320b–14) is amended—

(1) in the section heading, by inserting “AND SUBSIDIES FOR LOW-INCOME INDIVIDUALS UNDER TITLE XVIII” after “COST-SHARING”;

(2) in subsection (a)—

(A) in paragraph (1)—

(i) in subparagraph (A), by inserting “for the transitional assistance under section 1860D–31(f), or for premium and cost-sharing subsidies under section 1860D–14” before the semicolon; and

(ii) in subparagraph (B), by inserting “, program, and subsidies” after “medical assistance”; and

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by inserting “, the transitional assistance under section 1860D–31(f), or premium and cost-sharing subsidies under section 1860D–14” after “assistance”; and

(ii) in subparagraph (A), by striking “such eligibility” and inserting “eligibility for medicare cost-sharing under the medicaid program”; and

(3) in subsection (b)—

(A) in paragraph (1)(A), by inserting “, for transitional assistance under section 1860D–31(f), or for premium and cost-sharing subsidies for low-income individuals under section 1860D–14” after “1933”; and

(B) in paragraph (2), by inserting “, program, and subsidies” after “medical assistance”.

SEC. 104. MEDIGAP AMENDMENTS.

(a) RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—

(1) IN GENERAL.—Section 1882 (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

“(v) RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—

“(1) PROHIBITION ON SALE, ISSUANCE, AND RENEWAL OF NEW POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—

“(A) IN GENERAL.—Notwithstanding any other provision of law, on or after January 1, 2006, a medigap Rx policy (as defined in paragraph (6)(A)) may not be sold, issued, or renewed under this section—

“(i) to an individual who is a part D enrollee (as defined in paragraph (6)(B)); or

“(ii) except as provided in subparagraph (B), to an individual who is not a part D enrollee.

“(B) CONTINUATION PERMITTED FOR NON-PART D ENROLLEES.—Subparagraph (A)(ii) shall not apply to the renewal of a medigap Rx policy that was issued before January 1, 2006.

“(C) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the offering on and after January 1, 2006, of ‘H’, ‘I’, and ‘J’ policies described in paragraph (2)(D)(i) if the benefit packages are modified in accordance with paragraph (2)(C).

“(2) ELIMINATION OF DUPLICATIVE COVERAGE UPON PART D ENROLLMENT.—

“(A) IN GENERAL.—In the case of an individual who is covered under a medigap Rx policy and enrolls under a part D plan—

“(i) before the end of the initial part D enrollment period, the individual may—

“(I) enroll in a medicare supplemental policy without prescription drug coverage under paragraph (3); or

“(II) continue the policy in effect subject to the modification described in subparagraph (C)(i); or

“(ii) after the end of such period, the individual may continue the policy in effect subject to such modification.

“(B) NOTICE REQUIRED TO BE PROVIDED TO CURRENT POLICYHOLDERS WITH MEDIGAP RX POLICY.—No medicare supplemental policy of an issuer shall be deemed to meet the standards in subsection (c) unless the issuer provides written notice (in accordance with standards of the Secretary established in consultation with the National Association of Insurance Commissioners) during the 60-day period immediately preceding the initial part D enrollment period, to each individual who is a policyholder or certificate holder of a medigap Rx policy (at the most recent available address of that individual) of the following:

“(i) If the individual enrolls in a plan under part D during the initial enrollment period under section 1860D–1(b)(2)(A), the individual has the option of—

“(I) continuing enrollment in the individual’s current plan, but the plan’s coverage of prescription drugs will be modified under subparagraph (C)(i)· or

“(II) enrolling in another medicare supplemental policy pursuant to paragraph (3).

“(ii) If the individual does not enroll in a plan under part D during such period, the individual may continue enrollment in the individual’s current plan without change, but—

“(I) the individual will not be guaranteed the option of enrollment in another medicare supplemental policy pursuant to paragraph (3); and

“(II) if the current plan does not provide creditable prescription drug coverage (as defined in section 1860D–13(b)(4)), notice of such fact and that there are limitations on the periods in a year in which the individual may enroll under

a part D plan and any such enrollment is subject to a late enrollment penalty.

“(iii) Such other information as the Secretary may specify (in consultation with the National Association of Insurance Commissioners), including the potential impact of such election on premiums for medicare supplemental policies.

“(C) MODIFICATION.—

“(i) IN GENERAL.—The policy modification described in this subparagraph is the elimination of prescription coverage for expenses of prescription drugs incurred after the effective date of the individual’s coverage under a part D plan and the appropriate adjustment of premiums to reflect such elimination of coverage.

“(ii) CONTINUATION OF RENEWABILITY AND APPLICATION OF MODIFICATION.—No medicare supplemental policy of an issuer shall be deemed to meet the standards in subsection (c) unless the issuer—

“(I) continues renewability of medigap Rx policies that it has issued, subject to subclause (II); and

“(II) applies the policy modification described in clause (i) in the cases described in clauses (i)(II) and (ii) of subparagraph (A).

“(D) REFERENCES TO RX POLICIES.—

“(i) H, I, AND J POLICIES.—Any reference to a benefit package classified as ‘H’, ‘I’, or ‘J’ (including the benefit package classified as ‘J’ with a high deductible feature, as described in subsection (p)(11)) under the standards established under subsection (p)(2) shall be construed as including a reference to such a package as modified under subparagraph (C) and such packages as modified shall not be counted as a separate benefit package under such subsection.

“(ii) APPLICATION IN WAIVERED STATES.—Except for the modification provided under subparagraph (C), the waivers previously in effect under subsection (p)(2) shall continue in effect.

“(3) AVAILABILITY OF SUBSTITUTE POLICIES WITH GUARANTEED ISSUE.—

“(A) IN GENERAL.—The issuer of a medicare supplemental policy—

“(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as ‘A’, ‘B’, ‘C’, or ‘F’ (including the benefit package classified as ‘F’ with a high deductible feature, as described in subsection (p)(11)), under the standards established under subsection (p)(2), or a benefit package described in subparagraph (A) or (B) of subsection (w)(2) and that is offered and is available for issuance to new enrollees by such issuer;

“(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

“(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy, in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the effective date of the individual’s coverage under a part D plan.

“(B) INDIVIDUAL COVERED.—An individual described in this subparagraph with respect to the issuer of a medicare supplemental policy is an individual who—

“(i) enrolls in a part D plan during the initial part D enrollment period;

“(ii) at the time of such enrollment was enrolled in a medigap Rx policy issued by such issuer; and

“(iii) terminates enrollment in such policy and submits evidence of such termination along with the application for the policy under subparagraph (A).

“(C) SPECIAL RULE FOR WAIVERED STATES.—For purposes of applying this paragraph in the case of a State that provides for offering of benefit packages other than under the classification referred to in subparagraph (A)(i), the references to benefit packages in such subparagraph are deemed references to comparable benefit packages offered in such State.

“(4) ENFORCEMENT.—

“(A) PENALTIES FOR DUPLICATION.—The penalties described in subsection (d)(3)(A)(ii) shall apply with respect to a violation of paragraph (1)(A).

“(B) GUARANTEED ISSUE.—The provisions of paragraph (4) of subsection (s) shall apply with respect to the requirements of paragraph (3) in the same manner as they apply to the requirements of such subsection.

“(5) CONSTRUCTION.—Any provision in this section or in a medicare supplemental policy relating to guaranteed renewability of coverage shall be deemed to have been met with respect to a part D enrollee through the continuation of the policy subject to modification under paragraph (2)(C) or the offering of a substitute policy under paragraph (3). The previous sentence shall not be construed to affect the guaranteed renewability of such a modified or substitute policy.

“(6) DEFINITIONS.—For purposes of this subsection:

“(A) MEDIGAP RX POLICY.—The term ‘medigap Rx policy’ means a medicare supplemental policy—

“(i) which has a benefit package classified as ‘H’, ‘I’, or ‘J’ (including the benefit package classified as ‘J’ with a high deductible feature, as described in subsection (p)(11)) under the standards established under subsection (p)(2), without regard to this subsection; and

“(ii) to which such standards do not apply (or to which such standards have been waived under subsection (p)(6)) but which provides benefits for prescription drugs.

Such term does not include a policy with a benefit package as classified under clause (i) which has been modified under paragraph (2)(C)(i).

“(B) PART D ENROLLEE.—The term ‘part D enrollee’ means an individual who is enrolled in a part D plan.

“(C) PART D PLAN.—The term ‘part D plan’ means a prescription drug plan or an MA–PD plan (as defined for purposes of part D).

“(D) INITIAL PART D ENROLLMENT PERIOD.—The term ‘initial part D enrollment period’ means the initial enrollment period described in section 1860D–1(b)(2)(A).”.

(2) CONFORMING CURRENT GUARANTEED ISSUE PROVISIONS.—

(A) EXTENDING GUARANTEED ISSUE POLICY FOR INDIVIDUALS ENROLLED IN MEDIGAP RX POLICIES WHO TRY MEDICARE ADVANTAGE.—Subsection (s)(3)(C)(ii) of such section is amended—

(i) by striking “(ii) Only” and inserting “(ii)(I) Subject to subclause (II), only”; and

(ii) by adding at the end the following new subclause:

“(II) If the medicare supplemental policy referred to in subparagraph (B)(v) was a medigap Rx policy (as defined in subsection (v)(6)(A)), a medicare supplemental policy described in this subparagraph is such policy in which the individual was most recently enrolled as modified under subsection (v)(2)(C)(i) or, at the election of the individual, a policy referred to in subsection (v)(3)(A)(i).”.

(B) CONFORMING AMENDMENT.—Section 1882(s)(3)(C)(iii) is amended by inserting “and subject to subsection (v)(1)” after “subparagraph (B)(vi)”.

(b) DEVELOPMENT OF NEW STANDARDS FOR MEDIGAP POLICIES.—

(1) IN GENERAL.—Section 1882 (42 U.S.C. 1395ss) is further amended by adding at the end the following new subsection:

“(w) DEVELOPMENT OF NEW STANDARDS FOR MEDICARE SUPPLEMENTAL POLICIES.—

“(1) IN GENERAL.—The Secretary shall request the National Association of Insurance Commissioners to review and revise the standards for benefit packages under subsection (p)(1), taking into account the changes in benefits resulting from enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and to otherwise update standards to reflect other changes in law included in such Act. Such revision shall incorporate the inclusion of the 2 benefit packages described in paragraph (2). Such revisions shall be made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the ‘1991 NAIC Model Regulation’ deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law (and subsection (v)) and the reference to ‘date of enactment of this subsection’ deemed a reference to the date of enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. To the extent practicable, such revision shall provide for the implementation of revised standards for benefit packages as of January 1, 2006.

“(2) NEW BENEFIT PACKAGES.—The benefit packages described in this paragraph are the following (notwithstanding any other provision of this section relating to a core benefit package):

“(A) FIRST NEW BENEFIT PACKAGE.—A benefit package consisting of the following:

“(i) Subject to clause (ii), coverage of 50 percent of the cost-sharing otherwise applicable under parts A and B, except there shall be no coverage of the part B deductible and coverage of 100 percent of any cost-sharing otherwise applicable for preventive benefits.

“(ii) Coverage for all hospital inpatient coinsurance and 365 extra lifetime days of coverage of inpatient hospital services (as in the current core benefit package).

“(iii) A limitation on annual out-of-pocket expenditures under parts A and B to $4,000 in 2006 (or, in a subsequent year, to such limitation for the previous year increased by an appropriate inflation adjustment specified by the Secretary).

“(B) SECOND NEW BENEFIT PACKAGE.—A benefit package consisting of the benefit package described in subparagraph (A), except as follows:

“(i) Substitute ‘75 percent’ for ‘50 percent’ in clause (i) of such subparagraph.

“(ii) Substitute ‘$2,000’ for ‘$4,000’ in clause (iii) of such subparagraph.”.

(2) CONFORMING AMENDMENTS.—Section 1882 (42 U.S.C. 1395ss) is amended—

(A) in subsection (g)(1), by inserting “a prescription drug plan under part D or” after “but does not include”; and

(B) in subsection (o)(1), by striking “subsection (p)” and inserting “subsections (p), (v), and (w)”.

(c) RULE OF CONSTRUCTION.—

(1) IN GENERAL.—Nothing in this Act shall be construed to require an issuer of a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395rr) to participate as a PDP sponsor under part D of title XVIII of such Act, as added by section 101, as a condition for issuing such policy.

(2) PROHIBITION ON STATE REQUIREMENT.—A State may not require an issuer of a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395rr) to participate as a PDP sponsor under such part D as a condition for issuing such policy.

SEC. 105. ADDITIONAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG DISCOUNT CARD AND TRANSITIONAL ASSISTANCE PROGRAM.

(a) EXCLUSION OF COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839(g) (42 U.S.C. 1395r(g)) is amended—

(1) by striking “attributable to the application of section” and inserting “attributable to—

"(1) the application of section";

(2) by striking the period and inserting "; and"; and

(3) by adding at the end the following new paragraph:

"(2) the medicare prescription drug discount card and transitional assistance program under section 1860D–31.".

(b) APPLICATION OF CONFIDENTIALITY FOR DRUG PRICING DATA.—The last sentence of section 1927(b)(3)(D) (42 U.S.C. 1396r–8(b)(3)(D)), as added by section 101(e)(4), is amended by inserting "and drug pricing data reported under the first sentence of section 1860D–31(i)(1)" after "section 1860D–4(c)(2)(E)".

(c) RULES FOR IMPLEMENTATION.—The following rules shall apply to the medicare prescription drug discount card and transitional assistance program under section 1860D–31 of the Social Security Act, as added by section 101(a):

(1) In promulgating regulations pursuant to subsection (a)(2)(B) of such section 1860D–31—

(A) section 1871(a)(3) of the Social Security Act (42 U.S.C. 1395hh(a)(3)), as added by section 902(a)(1), shall not apply;

(B) chapter 35 of title 44, United States Code, shall not apply; and

(C) sections 553(d) and 801(a)(3)(A) of title 5, United States Code, shall not apply.

(2) Section 1857(c)(5) of the Social Security Act (42 U.S.C. 1395w–27(c)(5)) shall apply with respect to section 1860D–31 of such Act, as added by section 101(a), in the same manner as it applies to part C of title XVIII of such Act.

(3) The administration of such program shall be made without regard to chapter 35 of title 44, United States Code.

(4)(A) There shall be no judicial review of a determination not to endorse, or enter into a contract, with a prescription drug card sponsor under section 1860D–31 of the Social Security Act.

(B) In the case of any order issued to enjoin any provision of section 1860D–31 of the Social Security Act (or of any provision of this section), such order shall not affect any other provision of such section (or of this section) and all such provisions shall be treated as severable.

(d) CONFORMING AMENDMENTS TO FEDERAL SMI TRUST FUND FOR TRANSITIONAL ASSISTANCE ACCOUNT.—Section 1841 (42 U.S.C. 1395t), as amended by section 101(e)(3)(C), is amended—

(1) in the last sentence of subsection (a), by inserting after "section 1860D–16" the following: "or the Transitional Assistance Account established by section 1860D–31(k)(1)"; and

(2) in subsection (g), by adding at the end the following: "The payments provided for under section 1860D–31(k)(2) shall be made from the Transitional Assistance Account in the Trust Fund.".

(e) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF PROVIDING TRANSITIONAL ASSISTANCE UNDER MEDICARE DISCOUNT CARD PROGRAM.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to disclosure of returns and return information for purposes other than tax administration) is amended by adding at the end the following new paragraph:

"(19) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF PROVIDING TRANSITIONAL ASSISTANCE UNDER MEDICARE DISCOUNT CARD PROGRAM.—

"(A) IN GENERAL.—The Secretary, upon written request from the Secretary of Health and Human Services pursuant to carrying out section 1860D–31 of the Social Security Act, shall disclose to officers, employees, and contractors of the Department of Health and Human Services with respect to a taxpayer for the applicable year—

"(i)(I) whether the adjusted gross income, as modified in accordance with specifications of the Secretary of Health and Human Services for purposes of carrying out such section, of such taxpayer and, if applicable, such taxpayer's spouse, for the applicable year, exceeds the amounts specified by the Secretary of Health and Human Services in order to apply the 100 and 135 percent of the poverty lines under such section, (II) whether the return was a joint return, and (III) the applicable year, or

"(ii) if applicable, the fact that there is no return filed for such taxpayer for the applicable year.

"(B) DEFINITION OF APPLICABLE YEAR.—For the purposes of this subsection, the term 'applicable year' means the most recent taxable year for which information is available in the Internal Revenue Service's taxpayer data information systems, or, if there is no return filed for such taxpayer for such year, the prior taxable year.

"(C) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under this paragraph may be used only for the purposes of determining eligibility for and administering transitional assistance under section 1860D–31 of the Social Security Act."

(2) CONFIDENTIALITY.—Paragraph (3) of section 6103(a) of such Code is amended by striking "or (16)" and inserting "(16), or (19)".

(3) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Subsection (p)(4) of section 6103 of such Code is amended by striking "(l)(16) or (17)" each place it appears and inserting "(l)(16), (17), or (19)".

(4) UNAUTHORIZED DISCLOSURE OR INSPECTION.—Paragraph (2) of section 7213(a) of such Code is amended by striking "or (16)" and inserting "(16), or (19)".

SEC. 106. STATE PHARMACEUTICAL ASSISTANCE TRANSITION COMMISSION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is established, as of the first day of the third month beginning after the date of the enactment of this Act, a State Pharmaceutical Assistance Transition Commission (in this section referred to as the "Commission") to develop a proposal for addressing the unique transitional issues facing State pharmaceutical assistance programs, and program participants, due to the implementation of the voluntary prescription drug benefit program under part D of title XVIII of the Social Security Act, as added by section 101.

(2) DEFINITIONS.—For purposes of this section:

(A) STATE PHARMACEUTICAL ASSISTANCE PROGRAM DEFINED.—The term "State pharmaceutical assistance program" means a program (other than the medicaid program) operated by a State (or under contract with a State) that provides as of the date of the enactment of this Act financial assistance to medicare beneficiaries for the purchase of prescription drugs.

(B) PROGRAM PARTICIPANT.—The term "program participant" means a low-income medicare beneficiary who is a participant in a State pharmaceutical assistance program.

(b) COMPOSITION.—The Commission shall include the following:

(1) A representative of each Governor of each State that the Secretary identifies as operating on a statewide basis a State pharmaceutical assistance program that provides for eligibility and benefits that are comparable or more generous than the low-income assistance eligibility and benefits offered under section 1860D–14 of the Social Security Act.

(2) Representatives from other States that the Secretary identifies have in operation other State pharmaceutical assistance programs, as appointed by the Secretary.

(3) Representatives of organizations that have an inherent interest in program participants or the program itself, as appointed by the Secretary but not to exceed the number of representatives under paragraphs (1) and (2).

(4) Representatives of Medicare Advantage organizations, pharmaceutical benefit managers, and other private health insurance plans, as appointed by the Secretary.

(5) The Secretary (or the Secretary's designee) and such other members as the Secretary may specify. The Secretary shall designate a member to serve as Chair of the Commission and the Commission shall meet at the call of the Chair.

(c) DEVELOPMENT OF PROPOSAL.—The Commission shall develop the proposal described in subsection (a) in a manner consistent with the following principles:

(1) Protection of the interests of program participants in a manner that is the least disruptive to such participants and that includes a single point of contact for enrollment and processing of benefits.

(2) Protection of the financial and flexibility interests of States so that States are not financially worse off as a result of the enactment of this title.

(3) Principles of medicare modernization under this Act.

(d) REPORT.—By not later than January 1, 2005, the Commission shall submit to the President and Congress a report that contains a detailed proposal (including specific legislative or administrative recommendations, if any) and such other recommendations as the Commission deems appropriate.

(e) SUPPORT.—The Secretary shall provide the Commission with the administrative support services necessary for the Commission to carry out its responsibilities under this section.

(f) TERMINATION.—The Commission shall terminate 30 days after the date of submission of the report under subsection (d).

SEC. 107. STUDIES AND REPORTS.

(a) STUDY REGARDING REGIONAL VARIATIONS IN PRESCRIPTION DRUG SPENDING.—

(1) IN GENERAL.—The Secretary shall conduct a study that examines variations in per capita spending for covered part D drugs under part D of title XVIII of the Social Security Act among PDP regions and, with respect to such spending, the amount of such variation that is attributable to—

(A) price variations (described in section 1860D–15(c)(2) of such Act); and

(B) differences in per capita utilization that is not taken into account in the health status risk adjustment provided under section 1860D–15(c)(1) of such Act.

(2) REPORT AND RECOMMENDATIONS.—Not later than January 1, 2009, the Secretary shall submit to Congress a report on the study conducted under paragraph (1). Such report shall include—

(A) information regarding the extent of geographic variation described in paragraph (1)(B);

(B) an analysis of the impact on direct subsidies under section 1860D–15(a)(1) of the Social Security Act in different PDP regions if such subsidies were adjusted to take into account the variation described in subparagraph (A); and

(C) recommendations regarding the appropriateness of applying an additional geographic adjustment factor under section 1860D–15(c)(2) that reflects some or all of the variation described in subparagraph (A).

(b) REVIEW AND REPORT ON CURRENT STANDARDS OF PRACTICE FOR PHARMACY SERVICES PROVIDED TO PATIENTS IN NURSING FACILITIES.—

(1) REVIEW.—

(A) IN GENERAL.—Not later than 12 months after the date of the enactment of this Act, the Secretary shall conduct a thorough review of the current standards of practice for pharmacy services provided to patients in nursing facilities

(B) SPECIFIC MATTERS REVIEWED.—In conducting the review under subparagraph (A), the Secretary shall—

(i) assess the current standards of practice, clinical services, and other service requirements generally used for pharmacy services in long-term care settings; and

(ii) evaluate the impact of those standards with respect to patient safety, reduction of medication errors and quality of care.

(2) REPORT.—

(A) IN GENERAL.—Not later than the date that is 18 months after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the study conducted under paragraph (1)(A).

(B) CONTENTS.—The report submitted under subparagraph (A) shall contain—

(i) a description of the plans of the Secretary to implement the provisions of this Act in a manner consistent with applicable State and Federal laws designed to protect the safety and quality of care of nursing facility patients; and

(ii) recommendations regarding necessary actions and appropriate reimbursement to ensure the provision of prescription drugs to medicare beneficiaries residing in nursing facilities in a manner consistent with existing patient safety and quality of care standards under applicable State and Federal laws.

(c) IOM STUDY ON DRUG SAFETY AND QUALITY.—

(1) IN GENERAL.—The Secretary shall enter into a contract with the Institutes of Medicine of the National Academies of Science (such Institutes referred to in this subsection as the ''IOM'') to carry out a comprehensive study (in this subsection referred to as the ''study'') of drug safety and quality issues in order to provide a blueprint for system-wide change.

(2) OBJECTIVES.—

(A) The study shall develop a full understanding of drug safety and quality issues through an evidence-based review of literature, case studies, and analysis. This review will consider the nature and causes of medication errors, their impact on patients, the differences in causation, impact, and prevention across multiple dimensions of health care delivery-including patient populations, care settings, clinicians, and institutional cultures.

(B) The study shall attempt to develop credible estimates of the incidence, severity, costs of medication errors that can be useful in prioritizing resources for national quality improvement efforts and influencing national health care policy.

(C) The study shall evaluate alternative approaches to reducing medication errors in terms of their efficacy, cost-effectiveness, appropriateness in different settings and circumstances, feasibility, institutional barriers to implementation, associated risks, and the quality of evidence supporting the approach.

(D) The study shall provide guidance to consumers, providers, payers, and other key stakeholders on high-priority strategies to achieve both short-term and long-term drug safety goals, to elucidate the goals and expected results of such initiatives and support the business case for them, and to identify critical success factors and key levers for achieving success.

(E) The study shall assess the opportunities and key impediments to broad nationwide implementation of medication error reductions, and to provide guidance to policy-makers and government agencies (including the Food and Drug Administration, the Centers for Medicare & Medicaid Services, and the National Institutes of Health) in promoting a national agenda for medication error reduction.

(F) The study shall develop an applied research agenda to evaluate the health and cost impacts of alternative interventions, and to assess collaborative public and private strategies for implementing the research agenda through AHRQ and other government agencies.

(3) CONDUCT OF STUDY.—

(A) EXPERT COMMITTEE.—In conducting the study, the IOM shall convene a committee of leading experts and key stakeholders in pharmaceutical management and drug safety, including clinicians, health services researchers, pharmacists, system administrators, payer representatives, and others.

(B) COMPLETION.—The study shall be completed within an 18-month period.

(4) REPORT.—A report on the study shall be submitted to Congress upon the completion of the study.

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary.

(d) STUDY OF MULTI-YEAR CONTRACTS.—

(1) IN GENERAL.—The Secretary shall provide for a study on the feasibility and advisability of providing for contracting with PDP sponsors and MA organizations under parts C and D of title XVIII on a multi-year basis.

(2) REPORT.—Not later than January 1, 2007, the Secretary shall submit to Congress a report on the study under paragraph (1). The report shall include such recommendations as the Secretary deems appropriate.

(e) GAO STUDY REGARDING IMPACT OF ASSETS TEST FOR SUBSIDY ELIGIBLE INDIVIDUALS.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine the extent to which drug utilization and access to covered part D drugs under part D of title XVIII of the Social Security Act by subsidy eligible individuals differs from such utilization and access for individuals who would qualify as such subsidy eligible individuals but for the application of section 1860D–14(a)(3)(A)(iii) of such Act.

(2) REPORT.—Not later than September 30, 2007, the Comptroller General shall submit a report to Congress on the study conducted under paragraph (1) that includes such recommendations for legislation as the Comptroller General determines are appropriate.

(f) STUDY ON MAKING PRESCRIPTION PHARMACEUTICAL INFORMATION ACCESSIBLE FOR BLIND AND VISUALLY-IMPAIRED INDIVIDUALS.—

(1) STUDY.—

(A) IN GENERAL.—The Secretary shall undertake a study of how to make prescription pharmaceutical information, including drug labels and usage instructions, accessible to blind and visually-impaired individuals.

(B) STUDY TO INCLUDE EXISTING AND EMERGING TECHNOLOGIES.—The study under subparagraph (A) shall include a review of existing and emerging technologies, including assistive technology, that makes essential information on the content and prescribed use of pharmaceutical medicines available in a usable format for blind and visually-impaired individuals.

(2) REPORT.—

(A) IN GENERAL.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the study required under paragraph (1).

(B) CONTENTS OF REPORT.—The report required under paragraph (1) shall include recommendations for the implementation of usable formats for making prescription pharmaceutical information available to blind and visually-impaired individuals and an estimate of the costs associated with the implementation of each format.

SEC. 108. GRANTS TO PHYSICIANS TO IMPLEMENT ELECTRONIC PRESCRIPTION DRUG PROGRAMS.

(a) IN GENERAL.—The Secretary is authorized to make grants to physicians for the purpose of assisting such physicians to implement electronic prescription drug programs that comply with the standards promulgated or modified under section 1860D–4(e) of the Social Security Act, as inserted by section 101(a).

(b) AWARDING OF GRANTS.—

(1) APPLICATION.—No grant may be made under this section except pursuant to a grant application that is submitted and approved in a time, manner, and form specified by the Secretary.

(2) CONSIDERATIONS AND PREFERENCES.—In awarding grants under this section, the Secretary shall—

(A) give special consideration to physicians who serve a disproportionate number of medicare patients; and

(B) give preference to physicians who serve a rural or underserved area.

(3) LIMITATION ON GRANTS.—Only 1 grant may be awarded under this section with respect to any physician or group practice of physicians.

(c) TERMS AND CONDITIONS.—

(1) IN GENERAL.—Grants under this section shall be made under such terms and conditions as the Secretary specifies consistent with this section.

(2) USE OF GRANT FUNDS.—Funds provided under grants under this section may be used for any of the following:

(A) For purchasing, leasing, and installing computer software and hardware, including handheld computer technologies.

(B) Making upgrades and other improvements to existing computer software and hardware to enable e-prescribing.

(C) Providing education and training to eligible physician staff on the use of technology to implement the electronic transmission of prescription and patient information.

(3) PROVISION OF INFORMATION.—As a condition for the awarding of a grant under this section, an applicant shall provide to the Secretary such information as the Secretary may require in order to—

(A) evaluate the project for which the grant is made; and

(B) ensure that funding provided under the grant is expended only for the purposes for which it is made.

(4) AUDIT.—The Secretary shall conduct appropriate audits of grants under this section.

(5) MATCHING REQUIREMENT.—The applicant for a grant under this section shall agree, with respect to the costs to be incurred by the applicant in implementing an electronic prescription drug program, to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that is not less than 50 percent of such costs. Non-Federal contributions under the previous sentence may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $50,000,000 for fiscal year 2007 and such sums as may be necessary for each of fiscal years 2008 and 2009.

SEC. 109. EXPANDING THE WORK OF MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS TO INCLUDE PARTS C AND D.

(a) APPLICATION TO MEDICARE MANAGED CARE AND PRESCRIPTION DRUG COVERAGE.—Section 1154(a)(1) (42 U.S.C. 1320c–3(a)(1)) is amended by inserting '', to Medicare Advantage organizations pursuant to contracts under part C, and to prescription drug sponsors pursuant to contracts under part D'' after ''under section 1876''.

(b) PRESCRIPTION DRUG THERAPY QUALITY IMPROVEMENT.—Section 1154(a) (42 U.S.C. 1320c–

3(a)) is amended by adding at the end the following new paragraph:

"(17) The organization shall execute its responsibilities under subparagraphs (A) and (B) of paragraph (1) by offering to providers, practitioners, Medicare Advantage organizations offering Medicare Advantage plans under part C, and prescription drug sponsors offering prescription drug plans under part D quality improvement assistance pertaining to prescription drug therapy. For purposes of this part and title XVIII, the functions described in this paragraph shall be treated as a review function.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply on and after January 1, 2004.

(d) IOM STUDY OF QIOS.—

(1) IN GENERAL.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to conduct an evaluation of the program under part B of title XI of the Social Security Act. The study shall include a review of the following:

(A) An overview of the program under such part.

(B) The duties of organizations with contracts with the Secretary under such part.

(C) The extent to which quality improvement organizations improve the quality of care for medicare beneficiaries.

(D) The extent to which other entities could perform such quality improvement functions as well as, or better than, quality improvement organizations.

(E) The effectiveness of reviews and other actions conducted by such organizations in carrying out those duties.

(F) The source and amount of funding for such organizations.

(G) The conduct of oversight of such organizations.

(2) REPORT TO CONGRESS.—Not later than June 1, 2006, the Secretary shall submit to Congress a report on the results of the study described in paragraph (1), including any recommendations for legislation.

(3) INCREASED COMPETITION.—If the Secretary finds based on the study conducted under paragraph (1) that other entities could improve quality in the medicare program as well as, or better than, the current quality improvement organizations, then the Secretary shall provide for such increased competition through the addition of new types of entities which may perform quality improvement functions.

SEC. 110. CONFLICT OF INTEREST STUDY.

(a) STUDY.—The Federal Trade Commission shall conduct a study of differences in payment amounts for pharmacy services provided to enrollees in group health plans that utilize pharmacy benefit managers. Such study shall include the following:

(1) An assessment of the differences in costs incurred by such enrollees and plans for prescription drugs dispensed by mail-order pharmacies owned by pharmaceutical benefit managers compared to mail-order pharmacies not owned by pharmaceutical benefit managers, and community pharmacies.

(2) Whether such plans are acting in a manner that maximizes competition and results in lower prescription drug prices for enrollees.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study conducted under subsection (a). Such report shall include recommendations regarding any need for legislation to ensure the fiscal integrity of the voluntary prescription drug benefit program under part D of title XVIII, as added by section 101, that may be appropriated as the result of such study.

(c) EXEMPTION FROM PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to the collection of information under subsection (a).

SEC. 111. STUDY ON EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.

(a) STUDY.—The Comptroller General of the United States shall conduct an initial and final study under this subsection to examine trends in employment-based retiree health coverage (as defined in 1860D–22(c)(1) of the Social Security Act, as added by section 101), including coverage under the Federal Employees Health Benefits Program (FEHBP), and the options and incentives available under this Act which may have an effect on the voluntary provision of such coverage.

(b) CONTENT OF INITIAL STUDY.—The initial study under this section shall consider the following:

(1) Trends in employment-based retiree health coverage prior to the date of the enactment of this Act.

(2) The opinions of sponsors of employment-based retiree health coverage concerning which of the options available under this Act they are most likely to utilize for the provision of health coverage to their medicare-eligible retirees, including an assessment of the administrative burdens associated with the available options.

(3) The likelihood of sponsors of employment-based retiree health coverage to maintain or adjust their levels of retiree health benefits beyond coordination with medicare, including for prescription drug coverage, provided to medicare-eligible retirees after the date of the enactment of this Act.

(4) The factors that sponsors of employment-based retiree health coverage expect to consider in making decisions about any changes they may make in the health coverage provided to medicare-eligible retirees.

(5) Whether the prescription drug plan options available, or the health plan options available under the Medicare Advantage program, are likely to cause employers and other entities that did not provide health coverage to retirees prior to the date of the enactment of this Act to provide supplemental coverage or contributions toward premium expenses for medicare-eligible retirees who may enroll in such options in the future.

(c) CONTENTS OF FINAL STUDY.—The final study under this section shall consider the following:

(1) Changes in the trends in employment-based retiree health coverage since the completion of the initial study by the Comptroller General.

(2) Factors contributing to any changes in coverage levels.

(3) The number and characteristics of sponsors of employment-based retiree health coverage who receive the special subsidy payments under section 1860D–22 of the Social Security Act, as added by section 101, for the provision of prescription drug coverage to their medicare-eligible retirees that is the same or greater actuarial value as the prescription drug coverage available to other medicare beneficiaries without employment-based retiree health coverage.

(4) The extent to which sponsors of employment-based retiree health coverage provide supplemental health coverage or contribute to the premiums for medicare-eligible retirees who enroll in a prescription drug plan or an MA–PD plan.

(5) Other coverage options, including tax-preferred retirement or health savings accounts, consumer-directed health plans, or other vehicles that sponsors of employment-based retiree health coverage believe would assist retirees with their future health care needs and their willingness to sponsor such alternative plan designs.

(6) The extent to which employers or other entities that did not provide employment-based retiree health coverage prior to the date of the enactment of this Act provided some form of coverage or financial assistance for retiree health care needs after the date of the enactment of this Act.

(7) Recommendations by employers, benefits experts, academics, and others on ways that the voluntary provision of employment-based retiree health coverage may be improved and expanded.

(d) REPORTS.—The Comptroller General shall submit a report to Congress on—

(1) the initial study under subsection (b) not later than 1 year after the date of the enactment of this Act; and

(2) the final study under subsection (c) not later than January 1, 2007.

(e) CONSULTATION.—The Comptroller General shall consult with sponsors of employment-based retiree health coverage, benefits experts, human resources professionals, employee benefits consultants, and academics with experience in health benefits and survey research in the development and design of the initial and final studies under this section.

TITLE II—MEDICARE ADVANTAGE

Subtitle A—Implementation of Medicare Advantage Program

SEC. 201. IMPLEMENTATION OF MEDICARE ADVANTAGE PROGRAM.

(a) IN GENERAL.—There is hereby established the Medicare Advantage program. The Medicare Advantage program shall consist of the program under part C of title XVIII of the Social Security Act (as amended by this Act).

(b) REFERENCES.—Subject to subsection (c), any reference to the program under part C of title XVIII of the Social Security Act shall be deemed a reference to the Medicare Advantage program and, with respect to such part, any reference to "Medicare+Choice" is deemed a reference to "Medicare Advantage" and "MA".

(c) TRANSITION.—In order to provide for an orderly transition and avoid beneficiary and provider confusion, the Secretary shall provide for an appropriate transition in the use of the terms "Medicare+Choice" and "Medicare Advantage" (or "MA") in reference to the program under part C of title XVIII of the Social Security Act. Such transition shall be fully completed for all materials for plan years beginning not later than January 1, 2006. Before the completion of such transition, any reference to "Medicare Advantage" or "MA" shall be deemed to include a reference to "Medicare+Choice".

Subtitle B—Immediate Improvements

SEC. 211. IMMEDIATE IMPROVEMENTS.

(a) EQUALIZING PAYMENTS WITH FEE-FOR-SERVICE.—

(1) IN GENERAL.—Section 1853(c)(1) (42 U.S.C. 1395w–23(c)(1)) is amended by adding at the end the following:

"(D) 100 PERCENT OF FEE-FOR-SERVICE COSTS.—

"(i) IN GENERAL.—For each year specified in clause (ii), the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) and adjusted as appropriate for the purpose of risk adjustment, for the MA payment area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1886(h).

"(ii) PERIODIC REBASING.—The provisions of clause (i) shall apply for 2004 and for subsequent years as the Secretary shall specify (but not less than once every 3 years).

"(iii) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that *would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.*

(2) CONFORMING AMENDMENT.—Such section is further amended, in the matter before subparagraph (A), by striking ''or (C)'' and inserting ''(C), or (D)''.

(b) CHANGE IN BUDGET NEUTRALITY FOR BLEND.—Section 1853(c) (42 U.S.C. 1395w–23(c)) is amended—

(1) in paragraph (1)(A), by inserting ''(for a year other than 2004)'' after ''multiplied''; and

(2) in paragraph (5), by inserting ''(other than 2004)'' after ''for each year''.

(c) INCREASING MINIMUM PERCENTAGE INCREASE TO NATIONAL GROWTH RATE.—

(1) IN GENERAL.—Section 1853(c)(1) (42 U.S.C. 1395w–23(c)(1)) is amended—

(A) in subparagraph (A), by striking ''The sum'' and inserting ''For a year before 2005, the sum'';

(B) in subparagraph (B)(iv), by striking ''and each succeeding year'' and inserting '', 2003, and 2004'';

(C) in subparagraph (C)(iv), by striking ''and each succeeding year'' and inserting ''and 2003''; and

(D) by adding at the end of subparagraph (C) the following new clause:

''(v) For 2004 and each succeeding year, the greater of—

''(I) 102 percent of the annual MA capitation rate under this paragraph for the area for the previous year; or

''(II) the annual MA capitation rate under this paragraph for the area for the previous year increased by the national per capita MA growth percentage, described in paragraph (6) for that succeeding year, but not taking into account any adjustment under paragraph (6)(C) for a year before 2004.''.

(2) CONFORMING AMENDMENT.—Section 1853(c)(6)(C) (42 U.S.C. 1395w–23(c)(6)(C)) is amended by inserting before the period at the end the following: '', except that for purposes of paragraph (1)(C)(v)(II), no such adjustment shall be made for a year before 2004''.

(d) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES IN CALCULATION OF PAYMENT RATES.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)) is amended—

(1) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (E)''; and

(2) by adding at the end the following new subparagraph:

''(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific MA capitation rate under subparagraph (A) for a year (beginning with 2004), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.

(e) EXTENDING SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS TO REHABILITATION HOSPITALS AND LONG-TERM CARE HOSPITALS.—

(1) IN GENERAL.—Section 1853(g) (42 U.S.C. 1395w–23(g)) is amended—

(A) in the matter preceding paragraph (1), by inserting '', a rehabilitation hospital described in section 1886(d)(1)(B)(ii) or a distinct part rehabilitation unit described in the matter following clause (v) of section 1886(d)(1)(B), or a long-term care hospital (described in section 1886(d)(1)(B)(iv))'' after ''1886(d)(1)(B))''; and

(B) in paragraph (2)(B), by inserting ''or other payment provision under this title for inpatient services for the type of facility, hospital, or unit involved, described in the matter preceding paragraph (1), as the case may be,'' after ''1886(d)''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to contract years beginning on or after January 1, 2004.

(f) MEDPAC STUDY OF AAPCC.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study that assesses the method used for determining the adjusted average per capita cost (AAPCC) under section 1876(a)(4) of the Social Security Act (42 U.S.C. 1395mm(a)(4)) as applied under section 1853(c)(1)(A) of such Act (as amended by subsection (a)). Such study shall include an examination of—

(A) the bases for variation in such costs between different areas, including differences in input prices, utilization, and practice patterns;

(B) the appropriate geographic area for payment of MA local plans under the Medicare Advantage program under part C of title XVIII of such Act; and

(C) the accuracy of risk adjustment methods in reflecting differences in costs of providing care to different groups of beneficiaries served under such program.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study conducted under paragraph (1).

(g) REPORT ON IMPACT OF INCREASED FINANCIAL ASSISTANCE TO MEDICARE ADVANTAGE PLANS.—Not later than July 1, 2006, the Secretary shall submit to Congress a report that describes the impact of additional financing provided under this Act and other Acts (including the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and BIPA) on the availability of Medicare Advantage plans in different areas and its impact on lowering premiums and increasing benefits under such plans.

(h) MEDPAC STUDY AND REPORT ON CLARIFICATION OF AUTHORITY REGARDING DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-SHARING.—

(1) STUDY.—The Medicare Payment Advisory Commission, in consultation with beneficiaries, consumer groups, employers, and organizations offering plans under part C of title XVIII of the Social Security Act, shall conduct a study to determine the extent to which the cost-sharing structures under such plans affect access to covered services or select enrollees based on the health status of eligible individuals described in section 1851(a)(3) of the Social Security Act (42 U.S.C. 1395w–21(a)(3)).

(2) REPORT.—Not later than December 31, 2004, the Commission shall submit a report to Congress on the study conducted under paragraph (1) together with recommendations for such legislation and administrative actions as the Commission considers appropriate.

(i) IMPLEMENTATION OF PROVISIONS.—

(1) ANNOUNCEMENT OF REVISED MEDICARE ADVANTAGE PAYMENT RATES.—Within 6 weeks after the date of the enactment of this Act, the Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties) MA capitation rates under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for 2004, revised in accordance with the provisions of this section.

(2) TRANSITION TO REVISED PAYMENT RATES.—The provisions of section 604 of BIPA (114 Stat. 2763A–555) (other than subsection (a)) shall apply to the provisions of subsections (a) through (d) of this section for 2004 in the same manner as the provisions of such section 604 applied to the provisions of BIPA for 2001.

(3) SPECIAL RULE FOR PAYMENT RATES IN 2004.—

(A) JANUARY AND FEBRUARY.—Notwithstanding the amendments made by subsections (a) through (d), for purposes of making payments under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for January and February 2004, the annual capitation rate for a payment area shall be calculated and the excess amount under section 1854(f)(1)(B) of such Act (42 U.S.C. 1395w–24(f)(1)(B)) shall be determined as if such amendments had not been enacted.

(B) MARCH THROUGH DECEMBER.—Notwithstanding the amendments made by subsections (a) through (d), for purposes of making payments under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for March through December 2004, the annual capitation rate for a payment area shall be calculated and the excess amount under section 1854(f)(1)(B) of such Act (42 U.S.C. 1395w–24(f)(1)(B)) shall be determined, in such manner as the Secretary estimates will ensure that the total of such payments with respect to 2004 is the same as the amounts that would have been if subparagraph (A) had not been enacted.

(C) CONSTRUCTION.—Subparagraphs (A) and (B) shall not be taken into account in computing such capitation rate for 2005 and subsequent years.

(4) PLANS REQUIRED TO PROVIDE NOTICE OF CHANGES IN PLAN BENEFITS.—In the case of an organization offering a plan under part C of title XVIII of the Social Security Act that revises its submission of the information described in section 1854(a)(1) of such Act (42 U.S.C. 1395w–23(a)(1)) for a plan pursuant to the application of paragraph (2), if such revision results in changes in beneficiary premiums, beneficiary cost-sharing, or benefits under the plan, then by not later than 3 weeks after the date the Secretary approves such submission, the organization offering the plan shall provide each beneficiary enrolled in the plan with written notice of such changes.

(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869 or section 1878 of the Social Security Act (42 U.S.C. 1395ff and 1395oo), or otherwise of any determination made by the Secretary under this subsection or the application of the payment rates determined pursuant to this subsection.

(j) ADDITIONAL AMENDMENTS.—Section 1852(d)(4) (42 U.S.C. 1395w–22(d)(4)) is amended—

(1) in subparagraph (B), by inserting ''(other than deemed contracts or agreements under subsection (j)(6))'' after ''the plan has contracts or agreements''; and

(2) in the last sentence, by inserting before the period at the end the following: '', except that, if a plan entirely meets such requirement with respect to a category of health care professional or provider on the basis of subparagraph (B), it may provide for a higher beneficiary copayment in the case of health care professionals and providers of that category who do not have contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) to provide covered services under the terms of the plan''.

Subtitle C—Offering of Medicare Advantage (MA) Regional Plans; Medicare Advantage Competition

SEC. 221. ESTABLISHMENT OF MA REGIONAL PLANS.

(a) OFFERING OF MA REGIONAL PLANS.—

(1) IN GENERAL.—Section 1851(a)(2)(A) is amended—

(A) by striking ''COORDINATED CARE PLANS.—Coordinated'' and inserting the following: ''COORDINATED CARE PLANS (INCLUDING REGIONAL PLANS).—

''(i) IN GENERAL.—Coordinated'';

(B) by inserting "regional or local" before "preferred provider organization plans"; and

(C) by inserting " (including MA regional plans)" after "preferred provider organization plans".

(2) MORATORIUM ON NEW LOCAL PREFERRED PROVIDER ORGANIZATION PLANS.—The Secretary shall not permit the offering of a local preferred provider organization plan under part C of title XVIII of the Social Security Act during 2006 or 2007 in a service area unless such plan was offered under such part (including under a demonstration project under such part) in such area as of December 31, 2005.

(b) DEFINITION OF MA REGIONAL PLAN; MA LOCAL PLAN.—

(1) IN GENERAL.—Section 1859(b) (42 U.S.C. 1395w–29(b)) is amended by adding at the end the following new paragraphs:

"(4) MA REGIONAL PLAN.—The term 'MA regional plan' means an MA plan described in section 1851(a)(2)(A)(i)—

"(A) that has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

"(B) that provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

"(C) the service area of which is one or more entire MA regions.

"(5) MA LOCAL PLAN.—The term 'MA local plan' means an MA plan that is not an MA regional plan.".

(2) CONSTRUCTION.—Nothing in part C of title XVIII of the Social Security Act shall be construed as preventing an MSA plan or MA private fee-for-service plan from having a service area that covers one or more MA regions or the entire nation.

(c) RULES FOR MA REGIONAL PLANS.—Part C of title XVIII (42 U.S.C. 1395w–21 et seq.) is amended by inserting after section 1857 the following new section:

"SPECIAL RULES FOR MA REGIONAL PLANS

"SEC. 1858. (a) REGIONAL SERVICE AREA; ESTABLISHMENT OF MA REGIONS.—

"(1) COVERAGE OF ENTIRE MA REGION.—The service area for an MA regional plan shall consist of an entire MA region established under paragraph (2) and the provisions of section 1854(h) shall not apply to such a plan.

"(2) ESTABLISHMENT OF MA REGIONS.—

"(A) MA REGION.—For purposes of this title, the term 'MA region' means such a region within the 50 States and the District of Columbia as established by the Secretary under this paragraph.

"(B) ESTABLISHMENT.—

"(i) INITIAL ESTABLISHMENT.—Not later than January 1, 2005, the Secretary shall first establish and publish MA regions.

"(ii) PERIODIC REVIEW AND REVISION OF SERVICE AREAS.—The Secretary may periodically review MA regions under this paragraph and, based on such review, may revise such regions if the Secretary determines such revision to be appropriate.

"(C) REQUIREMENTS FOR MA REGIONS.—The Secretary shall establish, and may revise, MA regions under this paragraph in a manner consistent with the following:

"(i) NUMBER OF REGIONS.—There shall be no fewer than 10 regions, and no more than 50 regions.

"(ii) MAXIMIZING AVAILABILITY OF PLANS.—The regions shall maximize the availability of MA regional plans to all MA eligible individuals without regard to health status, especially those residing in rural areas.

"(D) MARKET SURVEY AND ANALYSIS.—Before establishing MA regions, the Secretary shall conduct a market survey and analysis, including an examination of current insurance markets, to determine how the regions should be established.

"(3) NATIONAL PLAN.—Nothing in this subsection shall be construed as preventing an MA regional plan from being offered in more than one MA region (including all regions).

"(b) APPLICATION OF SINGLE DEDUCTIBLE AND CATASTROPHIC LIMIT ON OUT-OF-POCKET EXPENSES.—An MA regional plan shall include the following:

"(1) SINGLE DEDUCTIBLE.—Any deductible for benefits under the original medicare fee-for-service program option shall be a single deductible (instead of a separate inpatient hospital deductible and a part B deductible) and may be applied differentially for in-network services and may be waived for preventive or other items and services.

"(2) CATASTROPHIC LIMIT.—

"(A) IN-NETWORK.—A catastrophic limit on out-of-pocket expenditures for in-network benefits under the original medicare fee-for-service program option.

"(B) TOTAL.—A catastrophic limit on out-of-pocket expenditures for all benefits under the original medicare fee-for-service program option.

"(c) PORTION OF TOTAL PAYMENTS TO AN ORGANIZATION SUBJECT TO RISK FOR 2006 AND 2007.—

"(1) APPLICATION OF RISK CORRIDORS.—

"(A) IN GENERAL.—This subsection shall only apply to MA regional plans offered during 2006 or 2007.

"(B) NOTIFICATION OF ALLOWABLE COSTS UNDER THE PLAN.—In the case of an MA organization that offers an MA regional plan in an MA region in 2006 or 2007, the organization shall notify the Secretary, before such date in the succeeding year as the Secretary specifies, of—

"(i) its total amount of costs that the organization incurred in providing benefits covered under the original medicare fee-for-service program option for all enrollees under the plan in the region in the year and the portion of such costs that is attributable to administrative expenses described in subparagraph (C); and

"(ii) its total amount of costs that the organization incurred in providing rebatable integrated benefits (as defined in subparagraph (D)) and with respect to such benefits the portion of such costs that is attributable to administrative expenses described in subparagraph (C) and not described in clause (i) of this subparagraph.

"(C) ALLOWABLE COSTS DEFINED.—For purposes of this subsection, the term 'allowable costs' means, with respect to an MA regional plan for a year, the total amount of costs described in subparagraph (B) for the plan and year, reduced by the portion of such costs attributable to administrative expenses incurred in providing the benefits described in such subparagraph.

"(D) REBATABLE INTEGRATED BENEFITS.—For purposes of this subsection, the term 'rebatable integrated benefits' means such non-drug supplemental benefits under subclause (I) of section 1854(b)(1)(C)(ii) pursuant to a rebate under such section that the Secretary determines are integrated with the benefits described in subparagraph (B)(i).

"(2) ADJUSTMENT OF PAYMENT.—

"(A) NO ADJUSTMENT IF ALLOWABLE COSTS WITHIN 3 PERCENT OF TARGET AMOUNT.—If the allowable costs for the plan for the year are at least 97 percent, but do not exceed 103 percent, of the target amount for the plan and year, there shall be no payment adjustment under this subsection for the plan and year.

"(B) INCREASE IN PAYMENT IF ALLOWABLE COSTS ABOVE 103 PERCENT OF TARGET AMOUNT.—

"(i) COSTS BETWEEN 103 AND 108 PERCENT OF TARGET AMOUNT.—If the allowable costs for the plan for the year are greater than 103 percent, but not greater than 108 percent, of the target amount for the plan and year, the Secretary shall increase the total of the monthly payments made to the organization offering the plan for the year under section 1853(a) by an amount equal to 50 percent of the difference between such allowable costs and 103 percent of such target amount.

"(ii) COSTS ABOVE 108 PERCENT OF TARGET AMOUNT.—If the allowable costs for the plan for the year are greater than 108 percent of the target amount for the plan and year, the Secretary shall increase the total of the monthly payments made to the organization offering the plan for the year under section 1853(a) by an amount equal to the sum of—

"(I) 2.5 percent of such target amount; and

"(II) 80 percent of the difference between such allowable costs and 108 percent of such target amount.

"(C) REDUCTION IN PAYMENT IF ALLOWABLE COSTS BELOW 97 PERCENT OF TARGET AMOUNT.—

"(i) COSTS BETWEEN 92 AND 97 PERCENT OF TARGET AMOUNT.—If the allowable costs for the plan for the year are less than 97 percent, but greater than or equal to 92 percent, of the target amount for the plan and year, the Secretary shall reduce the total of the monthly payments made to the organization offering the plan for the year under section 1853(a) by an amount (or otherwise recover from the plan an amount) equal to 50 percent of the difference between 97 percent of the target amount and such allowable costs.

"(ii) COSTS BELOW 92 PERCENT OF TARGET AMOUNT.—If the allowable costs for the plan for the year are less than 92 percent of the target amount for the plan and year, the Secretary shall reduce the total of the monthly payments made to the organization offering the plan for the year under section 1853(a) by an amount (or otherwise recover from the plan an amount) equal to the sum of—

"(I) 2.5 percent of such target amount; and

"(II) 80 percent of the difference between 92 percent of such target amount and such allowable costs.

"(D) TARGET AMOUNT DESCRIBED.—For purposes of this paragraph, the term 'target amount' means, with respect to an MA regional plan offered by an organization in a year, an amount equal to—

"(i) the sum of—

"(I) the total monthly payments made to the organization for enrollees in the plan for the year that are attributable to benefits under the original medicare fee-for-service program option (as defined in section 1852(a)(1)(B));

"(II) the total of the MA monthly basic beneficiary premium collectable for such enrollees for the year; and

"(III) the total amount of the rebates under section 1854(b)(1)(C)(ii) that are attributable to rebatable integrated benefits; reduced by

"(ii) the amount of administrative expenses assumed in the bid insofar as the bid is attributable to benefits described in clause (i)(I) or (i)(III).

"(3) DISCLOSURE OF INFORMATION.—

"(A) IN GENERAL.—Each contract under this part shall provide—

"(i) that an MA organization offering an MA regional plan shall provide the Secretary with such information as the Secretary determines is necessary to carry out this subsection; and

"(ii) that, pursuant to section 1857(d)(2)(B), the Secretary has the right to inspect and audit any books and records of the organization that pertain to the information regarding costs provided to the Secretary under paragraph (1)(B).

"(B) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to the provisions of this subsection may be used by *officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this subsection.*

"(d) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS.—

"(1) IN GENERAL.—In the case of an MA organization that is offering an MA regional plan in an MA region and—

"(A) meets the requirements of section 1855(a)(1) with respect to at least one such State in such region; and

"(B) with respect to each other State in such region in which it does not meet requirements, it demonstrates to the satisfaction of the Secretary that it has filed the necessary application to meet such requirements,

the Secretary may waive such requirement with respect to each State described in subparagraph (B) for such period of time as the Secretary determines appropriate for the timely processing of such an application by the State (and, if such application is denied, through the end of such plan year as the Secretary determines appropriate to provide for a transition).

"(2) SELECTION OF APPROPRIATE STATE.—In applying paragraph (1) in the case of an MA organization that meets the requirements of section 1855(a)(1) with respect to more than one State in a region, the organization shall select, in a manner specified by the Secretary among such States, one State the rules of which shall apply in the case of the States described in paragraph (1)(B).

"(e) STABILIZATION FUND.—

"(1) ESTABLISHMENT.—The Secretary shall establish under this subsection an MA Regional Plan Stabilization Fund (in this subsection referred to as the 'Fund') which shall be available for 2 purposes:

"(A) PLAN ENTRY.—To provide incentives to have MA regional plans offered in each MA region under paragraph (3).

"(B) PLAN RETENTION.—To provide incentives to retain MA regional plans in certain MA regions with below-national-average MA market penetration under paragraph (4).

"(2) FUNDING.—

"(A) INITIAL FUNDING.—

"(i) IN GENERAL.—There shall be available to the Fund, for expenditures from the Fund during the period beginning on January 1, 2007, and ending on December 31, 2013, a total of $10,000,000,000.

"(ii) PAYMENT FROM TRUST FUNDS.—Such amount shall be available to the Fund, as expenditures are made from the Fund, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in the proportion specified in section 1853(f).

"(B) ADDITIONAL FUNDING FROM SAVINGS.—

"(i) IN GENERAL.—There shall also be made available to the Fund, 50 percent of savings described in clause (ii).

"(ii) SAVINGS.—The savings described in this clause are 25 percent of the average per capita savings described in section 1854(b)(4)(C) for which monthly rebates are provided under section 1854(b)(1)(C) in the fiscal year involved that are attributable to MA regional plans.

"(iii) AVAILABILITY.—Funds made available under this subparagraph shall be transferred into a special account in the Treasury from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in the proportion specified in section 1853(f) on a monthly basis.

"(C) OBLIGATIONS.—Amounts in the Fund shall be available in advance of appropriations to MA regional plans in qualifying MA regions only in accordance with paragraph (5).

"(D) ORDERING.—Expenditures from the Fund shall first be made from amounts made available under subparagraph (A).

"(3) PLAN ENTRY FUNDING.—

"(A) IN GENERAL.—Funding is available under this paragraph for a year only as follows:

"(i) NATIONAL PLAN.—For a national bonus payment described in subparagraph (B) for the offering by a single MA organization of an MA regional plan in each MA region in the year, but only if there was not such a plan offered in each such region in the previous year. Funding under this clause is only available with respect to any individual MA organization for a single year, but may be made available to more than one such organization in the same year.

"(ii) REGIONAL PLANS.—Subject to clause (iii), for an increased amount under subparagraph (C) for an MA regional plan offered in an MA region which did not have any MA regional plan offered in the prior year.

"(iii) LIMITATION ON REGIONAL PLAN FUNDING IN CASE OF NATIONAL PLAN.—In no case shall there be any payment adjustment under subparagraph (C) for a year for which a national payment adjustment is made under subparagraph (B).

"(B) NATIONAL BONUS PAYMENT.—The national bonus payment under this subparagraph shall—

"(i) be available to an MA organization only if the organization offers MA regional plans in every MA region;

"(ii) be available with respect to all MA regional plans of the organization regardless of whether any other MA regional plan is offered in any region; and

"(iii) subject to amounts available under paragraph (5) for a year, be equal to 3 percent of the benchmark amount otherwise applicable for each MA regional plan offered by the organization.

"(C) REGIONAL PAYMENT ADJUSTMENT.—

"(i) IN GENERAL.—The increased amount under this subparagraph for an MA regional plan in an MA region for a year shall be an amount, determined by the Secretary, based on the bid submitted for such plan (or plans) and shall be available to all MA regional plans offered in such region and year. Such amount may be based on the mean, mode, or median, or other measure of such bids and may vary from region to region. The Secretary may not limit the number of plans or bids in a region.

"(ii) MULTI-YEAR FUNDING.—

"(I) IN GENERAL.—Subject to amounts available under paragraph (5), funding under this subparagraph shall be available for a period determined by the Secretary.

"(II) REPORT.—If the Secretary determines that funding will be provided for a second consecutive year with respect to an MA region, the Secretary shall submit to the Congress a report that describes the underlying market dynamics in the region and that includes recommendations concerning changes in the payment methodology otherwise provided for MA regional plans under this part.

"(iii) APPLICATION TO ALL PLANS IN A REGION.—Funding under this subparagraph with respect to an MA region shall be made available with respect to all MA regional plans offered in the region.

"(iv) LIMITATION ON AVAILABILITY OF PLAN RETENTION FUNDING IN NEXT YEAR.—If an increased amount is made available under this subparagraph with respect to an MA region for a period determined by the Secretary under clause (ii)(I), in no case shall funding be available under paragraph (4) with respect to MA regional plans offered in the region in the year following such period.

"(D) APPLICATION.—Any additional payment under this paragraph provided for an MA regional plan for a year shall be treated as if it were an addition to the benchmark amount otherwise applicable to such plan and year, but shall not be taken into account in the computation of any benchmark amount for any subsequent year.

"(4) PLAN RETENTION FUNDING.—

"(A) IN GENERAL.—Funding is available under this paragraph for a year with respect to MA regional plans offered in an MA region for the increased amount specified in subparagraph (B) but only if the region meets the requirements of subparagraphs (C) and (E).

"(B) PAYMENT INCREASE.—The increased amount under this subparagraph for an MA regional plan in an MA region for a year shall be an amount, determined by the Secretary, that does not exceed the greater of—

"(i) 3 percent of the benchmark amount applicable in the region; or

"(ii) such amount as (when added to the benchmark amount applicable to the region) will result in the ratio of—

"(I) such additional amount plus the benchmark amount computed under section 1854(b)(4)(B)(i) for the region and year, to the adjusted average per capita cost for the region and year, as estimated by the Secretary under section 1876(a)(4) and adjusted as appropriate for the purpose of risk adjustment; being equal to

"(II) the weighted average of such benchmark amounts for all the regions and such year, to the average per capita cost for the United States and such year, as estimated by the Secretary under seotion 1876(a)(4) and adjusted as appropriate for the purpose of risk adjustment.

"(C) REGIONAL REQUIREMENTS.—The requirements of this subparagraph for an MA region for a year are as follows:

"(i) NOTIFICATION OF PLAN EXIT.—The Secretary has received notice (in such form and manner as the Secretary specifies) before a year that one or more MA regional plans that were offered in the region in the previous year will not be offered in the succeeding year.

"(ii) REGIONAL PLANS AVAILABLE FROM FEWER THAN 2 MA ORGANIZATIONS IN THE REGION.—The Secretary determines that if the plans referred to in clause (i) are not offered in the year, fewer than 2 MA organizations will be offering MA regional plans in the region in the year involved.

"(iii) PERCENTAGE ENROLLMENT IN MA REGIONAL PLANS BELOW NATIONAL AVERAGE.—For the previous year, the Secretary determines that the average percentage of MA eligible individuals residing in the region who are enrolled in MA regional plans is less than the average percentage of such individuals in the United States enrolled in such plans.

"(D) APPLICATION.—Any additional payment under this paragraph provided for an MA regional plan for a year shall be treated as if it were an addition to the benchmark amount otherwise applicable to such plan and year, but shall not be taken into account in the computation of any benchmark amount for any subsequent year.

"(E) 2-CONSECUTIVE-YEAR LIMITATION.—

"(i) IN GENERAL.—In no case shall any funding be available under this paragraph in an MA region in a period of consecutive years that exceeds 2 years.

"(ii) REPORT.—If the Secretary determines that funding will be provided under this paragraph for a second consecutive year with respect to an MA region, the Secretary shall submit to the Congress a report that describes the underlying market dynamics in the region and that includes recommendations concerning changes in the payment methodology otherwise provided for MA regional plans under this part.

"(5) FUNDING LIMITATION.—

"(A) IN GENERAL.—The total amount expended from the Fund as a result of the application of this subsection through the end of a calendar year may not exceed the amount available

to the Fund as of the first day of such year. For purposes of this subsection, amounts that are expended under this title insofar as such amounts would not have been expended but for the application of this subsection shall be counted as amounts expended as a result of such application.

"(B) APPLICATION OF LIMITATION.—The Secretary may obligate funds from the Fund for a year only if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund at the beginning of the year sufficient amounts to cover all such obligations incurred during the year consistent with subparagraph (A). The Secretary shall take such steps, in connection with computing additional payment amounts under paragraphs (3) and (4) and including limitations on enrollment in MA regional plans receiving such payments, as will ensure that sufficient funds are available to make such payments for the entire year. Funds shall only be made available from the Fund pursuant to an apportionment made in accordance with applicable procedures.

"(6) SECRETARY REPORTS.—Not later than April 1 of each year (beginning in 2008), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

"(A) a detailed description of—

"(i) the total amount expended as a result of the application of this subsection in the previous year compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

"(ii) the projections of the total amount that will be expended as a result of the application of this subsection in the year in which the report is submitted compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

"(iii) amounts remaining within the funding limitation specified in paragraph (5); and

"(iv) the steps that the Secretary will take under paragraph (5)(B) to ensure that the application of this subsection will not cause expenditures to exceed the amount available in the Fund; and

"(B) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the description provided under subparagraph (A) is reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

"(7) BIENNIAL GAO REPORTS.—Not later than January 1 of 2009, 2011, 2013, and 2015, the Comptroller General of the United States shall submit to the Secretary and Congress a report on the application of additional payments under this subsection. Each report shall include—

"(A) an evaluation of—

"(i) the quality of care provided to individuals enrolled in MA regional plans for which additional payments were made under this subsection;

"(ii) the satisfaction of such individuals with benefits under such a plan;

"(iii) the costs to the medicare program for payments made to such plans; and

"(iv) any improvements in the delivery of health care services under such a plan;

"(B) a comparative analysis of the performance of MA regional plans receiving payments under this subsection with MA regional plans not receiving such payments; and

"(C) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.

"(f) COMPUTATION OF APPLICABLE MA REGION-SPECIFIC NON-DRUG MONTHLY BENCHMARK AMOUNTS.—

"(1) COMPUTATION FOR REGIONS.—For purposes of section 1853(j)(2) and this section, subject to subsection (e), the term 'MA region-specific non-drug monthly benchmark amount' means, with respect to an MA region for a month in a year, the sum of the 2 components described in paragraph (2) for the region and year. The Secretary shall compute such benchmark amount for each MA region before the beginning of each annual, coordinated election period under section 1851(e)(3)(B) for each year (beginning with 2006).

"(2) 2 COMPONENTS.—For purposes of paragraph (1), the 2 components described in this paragraph for an MA region and a year are the following:

"(A) STATUTORY COMPONENT.—The product of the following:

"(i) STATUTORY REGION-SPECIFIC NON-DRUG AMOUNT.—The statutory region-specific non-drug amount (as defined in paragraph (3)) for the region and year.

"(ii) STATUTORY NATIONAL MARKET SHARE.—The statutory national market share percentage, determined under paragraph (4) for the year.

"(B) PLAN-BID COMPONENT.—The product of the following:

"(i) WEIGHTED AVERAGE OF MA PLAN BIDS IN REGION.—The weighted average of the plan bids for the region and year (as determined under paragraph (5)(A)).

"(ii) NON-STATUTORY MARKET SHARE.—1 minus the statutory national market share percentage, determined under paragraph (4) for the year.

"(3) STATUTORY REGION-SPECIFIC NON-DRUG AMOUNT.—For purposes of paragraph (2)(A)(i), the term 'statutory region-specific non-drug amount' means, for an MA region and year, an amount equal the sum (for each MA local area within the region) of the product of—

"(A) MA area-specific non-drug monthly benchmark amount under section 1853(j)(1)(A) for that area and year; and

"(B) the number of MA eligible individuals residing in the local area, divided by the total number of MA eligible individuals residing in the region.

"(4) COMPUTATION OF STATUTORY MARKET SHARE PERCENTAGE.—

"(A) IN GENERAL.—The Secretary shall determine for each year a statutory national market share percentage that is equal to the proportion of MA eligible individuals nationally who were not enrolled in an MA plan during the reference month.

"(B) REFERENCE MONTH DEFINED.—For purposes of this part, the term 'reference month' means, with respect to a year, the most recent month during the previous year for which the Secretary determines that data are available to compute the percentage specified in subparagraph (A) and other relevant percentages under this part.

"(5) DETERMINATION OF WEIGHTED AVERAGE MA BIDS FOR A REGION.—

"(A) IN GENERAL.—For purposes of paragraph (2)(B)(i), the weighted average of plan bids for an MA region and a year is the sum, for MA regional plans described in subparagraph (D) in the region and year, of the products (for each such plan) of the following:

"(i) MONTHLY MA STATUTORY NON-DRUG BID AMOUNT.—The unadjusted MA statutory non-drug monthly bid amount for the plan.

"(ii) PLAN'S SHARE OF MA ENROLLMENT IN REGION.—The factor described in subparagraph (B) for the plan.

"(B) PLAN'S SHARE OF MA ENROLLMENT IN REGION.—

"(i) IN GENERAL.—Subject to the succeeding provisions of this subparagraph, the factor described in this subparagraph for a plan is equal to the number of individuals described in subparagraph (C) for such plan, divided by the total number of such individuals for all MA regional plans described in subparagraph (D) for that region and year.

"(ii) SINGLE PLAN RULE.—In the case of an MA region in which only a single MA regional plan is being offered, the factor described in this subparagraph shall be equal to 1.

"(iii) EQUAL DIVISION AMONG MULTIPLE PLANS IN YEAR IN WHICH PLANS ARE FIRST AVAILABLE.—In the case of an MA region in the first year in which any MA regional plan is offered, if more than one MA regional plan is offered in such year, the factor described in this subparagraph for a plan shall (as specified by the Secretary) be equal to—

"(I) 1 divided by the number of such plans offered in such year; or

"(II) a factor for such plan that is based upon the organization's estimate of projected enrollment, as reviewed and adjusted by the Secretary to ensure reasonableness and as is certified by the Chief Actuary of the Centers for Medicare & Medicaid Services.

"(C) COUNTING OF INDIVIDUALS.—For purposes of subparagraph (B)(i), the Secretary shall count for each MA regional plan described in subparagraph (D) for an MA region and year, the number of individuals who reside in the region and who were enrolled under such plan under this part during the reference month.

"(D) PLANS COVERED.—For an MA region and year, an MA regional plan described in this subparagraph is an MA regional plan that is offered in the region and year and was offered in the region in the reference month.

"(g) ELECTION OF UNIFORM COVERAGE DETERMINATION.—Instead of applying section 1852(a)(2)(C) with respect to an MA regional plan, the organization offering the plan may elect to have a local coverage determination for the entire MA region be the local coverage determination applied for any part of such region (as selected by the organization).

"(h) ASSURING NETWORK ADEQUACY.—

"(1) IN GENERAL.—For purposes of enabling MA organizations that offer MA regional plans to meet applicable provider access requirements under section 1852 with respect to such plans, the Secretary may provide for payment under this section to an essential hospital that provides inpatient hospital services to enrollees in such a plan where the MA organization offering the plan certifies to the Secretary that the organization was unable to reach an agreement between the hospital and the organization regarding provision of such services under the plan. Such payment shall be available only if—

"(A) the organization provides assurances satisfactory to the Secretary that the organization will make payment to the hospital for inpatient hospital services of an amount that is not less than the amount that would be payable to the hospital under section 1886 with respect to such services; and

"(B) with respect to specific inpatient hospital services provided to an enrollee, the hospital demonstrates to the satisfaction of the Secretary that the hospital's costs of such services exceed the payment amount described in subparagraph (A).

"(2) PAYMENT AMOUNTS.—The payment amount under this subsection for inpatient hospital services provided by a subsection (d) hospital to an enrollee in an MA regional plan shall be, subject to the limitation of funds under paragraph (3), the amount (if any) by which—

"(A) the amount of payment that would have been paid for such services under this title if the enrollees were covered under the original medicare fee-for-service program option and the hospital were a critical access hospital; exceeds

"(B) the amount of payment made for such services under paragraph (1)(A).

"(3) AVAILABLE AMOUNTS.—There shall be available for payments under this subsection—

"(A) in 2006, $25,000,000; and

"(B) in each succeeding year the amount specified in this paragraph for the preceding year increased by the market basket percentage increase (as defined in section 1886(b)(3)(B)(iii)) for the fiscal year ending in such succeeding year.

Payments under this subsection shall be made from the Federal Hospital Insurance Trust Fund.

"(4) ESSENTIAL HOSPITAL.—In this subsection, the term 'essential hospital' means, with respect to an MA regional plan offered by an MA organization, a subsection (d) hospital (as defined in section 1886(d)) that the Secretary determines, based upon an application filed by the organization with the Secretary, is necessary to meet the requirements referred to in paragraph (1) for such plan.".

(d) CONFORMING AMENDMENTS.—

(1) RELATING TO MA REGIONS.—Section 1853(d) (42 U.S.C. 1395w–23(d)) is amended—

(A) by amending the heading to read as follows: "MA PAYMENT AREA; MA LOCAL AREA; MA REGION DEFINED";

(B) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively;

(C) by amending paragraph (1) to read as follows:

"(1) MA PAYMENT AREA.—In this part, except as provided in this subsection, the term 'MA payment area' means—

"(A) with respect to an MA local plan, an MA local area (as defined in paragraph (2)); and

"(B) with respect to an MA regional plan, an MA region (as established under section 1858(a)(2)).";

(D) by inserting after paragraph (1) the following new paragraph:

"(2) MA LOCAL AREA.—The term 'MA local area' means a county or equivalent area specified by the Secretary."; and

(E) in paragraph (4), as so redesignated—

(i) in subparagraph (A), by inserting "for MA local plans" after "paragraph (1)";

(ii) in subparagraph (A)(iii), by striking "paragraph (1)" and inserting "paragraph (1)(A)"; and

(iii) in subparagraph (B)—

(I) by inserting "with respect to MA local plans" after "established under this section";

(II) by inserting "for such plans" after "payments under this section"; and

(III) by inserting "for such plans" after "made under this section".

(2) MA LOCAL AREA DEFINED.—Section 1859(c) (42 U.S.C. 1395w–29(c)) is amended by adding at the end the following:

"(5) MA LOCAL AREA.—The term 'MA local area' is defined in section 1853(d)(2).".

(3) APPLICATION OF SPECIAL BENEFIT RULES TO PPOS AND REGIONAL PLANS.—Section 1852(a) (42 U.S.C. 1395w–22(a)) is amended—

(A) in paragraph (1), by inserting "and except as provided in paragraph (6) for MA regional plans" after "MSA plans"; and

(B) by adding at the end the following new paragraph:

"(6) SPECIAL BENEFIT RULES FOR REGIONAL PLANS.—In the case of an MA plan that is an MA regional plan, benefits under the plan shall include the benefits described in paragraphs (1) and (2) of section 1858(b).".

(4) APPLICATION OF CAPITATION RATES TO LOCAL AREAS.—Section 1853(c)(1) (42 U.S.C. 1395w–23(c)(1)) is amended by inserting "that is an MA local area" after "for a Medicare+Choice payment area".

(5) NETWORK ADEQUACY HOSPITAL PAYMENTS.—Section 1851(i)(2) (42 U.S.C. 1395w–21(i)(2)) is amended by inserting "1858(h)," after "1857(f)(2),".

SEC. 222. COMPETITION PROGRAM BEGINNING IN 2006.

(a) SUBMISSION OF BIDDING AND REBATE INFORMATION BEGINNING IN 2006.—

(1) IN GENERAL.—Section 1854 (42 U.S.C. 1395w–24) is amended—

(A) by amending paragraph (1) of subsection (a) to read as follows:

"(1) IN GENERAL.—

"(A) INITIAL SUBMISSION.—Not later than the second Monday in September of 2002, 2003, and 2004 (or the first Monday in June of each subsequent year), each MA organization shall submit to the Secretary, in a form and manner specified by the Secretary and for each MA plan for the service area (or segment of such an area if permitted under subsection (h)) in which it intends to be offered in the following year the following:

"(i) The information described in paragraph (2), (3), (4), or (6)(A) for the type of plan and year involved.

"(ii) The plan type for each plan.

"(iii) The enrollment capacity (if any) in relation to the plan and area.

"(B) BENEFICIARY REBATE INFORMATION.—In the case of a plan required to provide a monthly rebate under subsection (b)(1)(C) for a year, the MA organization offering the plan shall submit to the Secretary, in such form and manner and at such time as the Secretary specifies, information on—

"(i) the manner in which such rebate will be provided under clause (ii) of such subsection; and

"(ii) the MA monthly prescription drug beneficiary premium (if any) and the MA monthly supplemental beneficiary premium (if any).

"(C) PAPERWORK REDUCTION FOR OFFERING OF MA REGIONAL PLANS NATIONALLY OR IN MULTI-REGION AREAS.—The Secretary shall establish requirements for information submission under this subsection in a manner that promotes the offering of MA regional plans in more than one region (including all regions) through the filing of consolidated information."; and

(B) by adding at the end of subsection (a) the following:

"(6) SUBMISSION OF BID AMOUNTS BY MA ORGANIZATIONS BEGINNING IN 2006.—

"(A) INFORMATION TO BE SUBMITTED.—For an MA plan (other than an MSA plan) for a plan year beginning on or after January 1, 2006, the information described in this subparagraph is as follows:

"(i) The monthly aggregate bid amount for the provision of all items and services under the plan, which amount shall be based on average revenue requirements (as used for purposes of section 1302(8) of the Public Health Service Act) in the payment area for an enrollee with a national average risk profile for the factors described in section 1853(a)(1)(C) (as specified by the Secretary).

"(ii) The proportions of such bid amount that are attributable to—

"(I) the provision of benefits under the original medicare fee-for-service program option (as defined in section 1852(a)(1)(B));

"(II) the provision of basic prescription drug coverage; and

"(III) the provision of supplemental health care benefits.

"(iii) The actuarial basis for determining the amount under clause (i) and the proportions described in clause (ii) and such additional information as the Secretary may require to verify such actuarial bases and the projected number of enrollees in each MA local area.

"(iv) A description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(4)(A).

"(v) With respect to qualified prescription drug coverage, the information required under section 1860D–4, as incorporated under section 1860D–11(b)(2), with respect to such coverage.

In the case of a specialized MA plan for special needs individuals, the information described in this subparagraph is such information as the Secretary shall specify.

"(B) ACCEPTANCE AND NEGOTIATION OF BID AMOUNTS.—

"(i) AUTHORITY.—Subject to clauses (iii) and (iv), the Secretary has the authority to negotiate regarding monthly bid amounts submitted under subparagraph (A) (and the proportions described in subparagraph (A)(ii)), including supplemental benefits provided under subsection (b)(1)(C)(ii)(I) and in exercising such authority the Secretary shall have authority similar to the authority of the Director of the Office of Personnel Management with respect to health benefits plans under chapter 89 of title 5, United States Code.

"(ii) APPLICATION OF FEHBP STANDARD.—Subject to clause (iv), the Secretary may only accept such a bid amount or proportion if the Secretary determines that such amount and proportions are supported by the actuarial bases provided under subparagraph (A) and reasonably and equitably reflects the revenue requirements (as used for purposes of section 1302(8) of the Public Health Service Act) of benefits provided under that plan.

"(iii) NONINTERFERENCE.—In order to promote competition under this part and part D and in carrying out such parts, the Secretary may not require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services under this title or require a particular price structure for payment under such a contract to the extent consistent with the Secretary's authority under this part.

"(iv) EXCEPTION.—In the case of a plan described in section 1851(a)(2)(C), the provisions of clauses (i) and (ii) shall not apply and the provisions of paragraph (5)(B), prohibiting the review, approval, or disapproval of amounts described in such paragraph, shall apply to the negotiation and rejection of the monthly bid amounts and the proportions referred to in subparagraph (A).".

(2) DEFINITION OF BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—Section 1852(a)(1) (42 U.S.C. 1395w–22(a)(1)) is amended—

(A) by striking "IN GENERAL.—Except" and inserting "REQUIREMENT.—

"(A) IN GENERAL.—Except"; and

(B) by striking "title XI" and all that follows and inserting the following: "title XI, benefits under the original medicare fee-for-service program option (and, for plan years before 2006, additional benefits required under section 1854(f)(1)(A)).

"(B) BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION DEFINED.—

"(i) IN GENERAL.—For purposes of this part, the term 'benefits under the original medicare fee-for-service program option' means those items and services (other than hospice care) for which benefits are available under parts A and B to individuals entitled to benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B or an actuarially equivalent level of cost-sharing as determined in this part.

"(ii) SPECIAL RULE FOR REGIONAL PLANS.—In the case of an MA regional plan in determining an actuarially equivalent level of cost-sharing with respect to benefits under the original medicare fee-for-service program option, there shall only be taken into account, with respect to the application of section 1858(b)(2), such expenses only with respect to subparagraph (A) of such section.".

(3) CONFORMING AMENDMENT RELATING TO SUPPLEMENTAL HEALTH BENEFITS.—Section 1852(a)(3) (42 U.S.C. 1395w–22(a)(3)) is amended by adding at the end the following: "Such benefits may include reductions in cost-sharing

below the actuarial value specified in section 1854(e)(4)(B).".

(b) PROVIDING FOR BENEFICIARY SAVINGS FOR CERTAIN PLANS.—

(1) BENEFICIARY REBATES.—Section 1854(b)(1) (42 U.S.C. 1395w–24(b)(1)) is amended—

(A) in subparagraph (A), by striking "The monthly amount" and inserting "Subject to the rebate under subparagraph (C), the monthly amount (if any)"; and

(B) by adding at the end the following new subparagraph:

"(C) BENEFICIARY REBATE RULE.—

"(i) REQUIREMENT.—The MA plan shall provide to the enrollee a monthly rebate equal to 75 percent of the average per capita savings (if any) described in paragraph (3)(C) or (4)(C), as applicable to the plan and year involved.

"(ii) FORM OF REBATE.—A rebate required under this subparagraph shall be provided through the application of the amount of the rebate toward one or more of the following:

"(I) PROVISION OF SUPPLEMENTAL HEALTH CARE BENEFITS AND PAYMENT FOR PREMIUM FOR SUPPLEMENTAL BENEFITS.—The provision of supplemental health care benefits described in section 1852(a)(3) in a manner specified under the plan, which may include the reduction of cost-sharing otherwise applicable as well as additional health care benefits which are not benefits under the original medicare fee-for-service program option, or crediting toward an MA monthly supplemental beneficiary premium (if any).

"(II) PAYMENT FOR PREMIUM FOR PRESCRIPTION DRUG COVERAGE.—Crediting toward the MA monthly prescription drug beneficiary premium.

"(III) PAYMENT TOWARD PART B PREMIUM.—Crediting toward the premium imposed under part B (determined without regard to the application of subsections (b), (h), and (i) of section 1839).

"(iii) DISCLOSURE RELATING TO REBATES.—The plan shall disclose to the Secretary information on the form and amount of the rebate provided under this subparagraph or the actuarial value in the case of supplemental health care benefits.

"(iv) APPLICATION OF PART B PREMIUM REDUCTION.—Insofar as an MA organization elects to provide a rebate under this subparagraph under a plan as a credit toward the part B premium under clause (ii)(III), the Secretary shall apply such credit to reduce the premium under section 1839 of each enrollee in such plan as provided in section 1840(i).".

(2) REVISION OF PREMIUM TERMINOLOGY.—Section 1854(b)(2) (42 U.S.C. 1395w–24(b)(2)) is amended—

(A) in the heading, by inserting "AND BID" after "PREMIUM";

(B) by redesignating subparagraph (C) as subparagraph (D);

(C) by striking subparagraphs (A) and (B) and inserting the following:

"(A) MA MONTHLY BASIC BENEFICIARY PREMIUM.—The term 'MA monthly basic beneficiary premium' means, with respect to an MA plan—

"(i) described in section 1853(a)(1)(B)(i) (relating to plans providing rebates), zero; or

"(ii) described in section 1853(a)(1)(B)(ii), the amount (if any) by which the unadjusted MA statutory non-drug monthly bid amount (as defined in subparagraph (E)) exceeds the applicable unadjusted MA area-specific non-drug monthly benchmark amount (as defined in section 1853(j)).

"(B) MA MONTHLY PRESCRIPTION DRUG BENEFICIARY PREMIUM.—The term 'MA monthly prescription drug beneficiary premium' means, with respect to an MA plan, the base beneficiary premium (as determined under section 1860D–13(a)(2) and as adjusted under section 1860D–13(a)(1)(B)), less the amount of rebate credited toward such amount under section 1854(b)(1)(C)(ii)(II).

"(C) MA MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The term 'MA monthly supplemental beneficiary premium' means, with respect to an MA plan, the portion of the aggregate monthly bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under clause (ii)(III) of such subsection to the provision of supplemental health care benefits, less the amount of rebate credited toward such portion under section 1854(b)(1)(C)(ii)(I)."; and

(D) by adding at the end the following:

"(E) UNADJUSTED MA STATUTORY NON-DRUG MONTHLY BID AMOUNT.—The term 'unadjusted MA statutory non-drug monthly bid amount' means the portion of the bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under clause (ii)(I) of such subsection to the provision of benefits under the original medicare fee-for-service program option (as defined in section 1852(a)(1)(B)).".

(3) COMPUTATION OF SAVINGS.—Section 1854(b) (42 U.S.C. 1395w–24(b)) is further amended by adding at the end the following new paragraphs:

"(3) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS FOR LOCAL PLANS.—For purposes of paragraph (1)(C)(i), the average per capita monthly savings referred to in such paragraph for an MA local plan and year is computed as follows:

"(A) DETERMINATION OF STATEWIDE AVERAGE RISK ADJUSTMENT FOR LOCAL PLANS.—

"(i) IN GENERAL.—Subject to clause (iii), the Secretary shall determine, at the same time rates are promulgated under section 1853(b)(1) (beginning with 2006) for each State, the average of the risk adjustment factors to be applied under section 1853(a)(1)(C) to payment for enrollees in that State for MA local plans.

"(ii) TREATMENT OF STATES FOR FIRST YEAR IN WHICH LOCAL PLAN OFFERED.—In the case of a State in which no MA local plan was offered in the previous year, the Secretary shall estimate such average. In making such estimate, the Secretary may use average risk adjustment factors applied to comparable States or applied on a national basis.

"(iii) AUTHORITY TO DETERMINE RISK ADJUSTMENT FOR AREAS OTHER THAN STATES.—The Secretary may provide for the determination and application of risk adjustment factors under this subparagraph on the basis of areas other than States or on a plan-specific basis.

"(B) DETERMINATION OF RISK ADJUSTED BENCHMARK AND RISK-ADJUSTED BID FOR LOCAL PLANS.—For each MA plan offered in a local area in a State, the Secretary shall—

"(i) adjust the applicable MA area-specific non-drug monthly benchmark amount (as defined in section 1853(j)(1)) for the area by the average risk adjustment factor computed under subparagraph (A); and

"(ii) adjust the unadjusted MA statutory non-drug monthly bid amount by such applicable average risk adjustment factor.

"(C) DETERMINATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—The average per capita monthly savings described in this subparagraph for an MA local plan is equal to the amount (if any) by which—

"(i) the risk-adjusted benchmark amount computed under subparagraph (B)(i); exceeds

"(ii) the risk-adjusted bid computed under subparagraph (B)(ii).

"(4) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS FOR REGIONAL PLANS.—For purposes of paragraph (1)(C)(i), the average per capita monthly savings referred to in such paragraph for an MA regional plan and year is computed as follows:

"(A) DETERMINATION OF REGIONWIDE AVERAGE RISK ADJUSTMENT FOR REGIONAL PLANS.—

"(i) IN GENERAL.—The Secretary shall determine, at the same time rates are promulgated under section 1853(b)(1) (beginning with 2006) for each MA region the average of the risk adjustment factors to be applied under section 1853(a)(1)(C) to payment for enrollees in that region for MA regional plans.

"(ii) TREATMENT OF REGIONS FOR FIRST YEAR IN WHICH REGIONAL PLAN OFFERED.—In the case of an MA region in which no MA regional plan was offered in the previous year, the Secretary shall estimate such average. In making such estimate, the Secretary may use average risk adjustment factors applied to comparable regions or applied on a national basis.

"(iii) AUTHORITY TO DETERMINE RISK ADJUSTMENT FOR AREAS OTHER THAN REGIONS.—The Secretary may provide for the determination and application of risk adjustment factors under this subparagraph on the basis of areas other than MA regions or on a plan-specific basis.

"(B) DETERMINATION OF RISK-ADJUSTED BENCHMARK AND RISK-ADJUSTED BID FOR REGIONAL PLANS.—For each MA regional plan offered in a region, the Secretary shall—

"(i) adjust the applicable MA area-specific non-drug monthly benchmark amount (as defined in section 1853(j)(2)) for the region by the average risk adjustment factor computed under subparagraph (A); and

"(ii) adjust the unadjusted MA statutory non-drug monthly bid amount by such applicable average risk adjustment factor.

"(C) DETERMINATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—The average per capita monthly savings described in this subparagraph for an MA regional plan is equal to the amount (if any) by which—

"(i) the risk-adjusted benchmark amount computed under subparagraph (B)(i); exceeds

"(ii) the risk-adjusted bid computed under subparagraph (B)(ii).".

(c) COLLECTION OF PREMIUMS.—Section 1854(d) (42 U.S.C. 1395w–24(d)) is amended—

(1) by striking "PREMIUMS.—Each" and inserting "PREMIUMS.—

"(1) IN GENERAL.—Each"; and

(2) by adding at the end the following new paragraphs:

"(2) BENEFICIARY'S OPTION OF PAYMENT THROUGH WITHHOLDING FROM SOCIAL SECURITY PAYMENT OR USE OF ELECTRONIC FUNDS TRANSFER MECHANISM.—In accordance with regulations, an MA organization shall permit each enrollee, at the enrollee's option, to make payment of premiums (if any) under this part to the organization through—

"(A) withholding from benefit payments in the manner provided under section 1840 with respect to monthly premiums under section 1839;

"(B) an electronic funds transfer mechanism (such as automatic charges of an account at a financial institution or a credit or debit card account); or

"(C) such other means as the Secretary may specify, including payment by an employer or under employment-based retiree health coverage (as defined in section 1860D–22(c)(1)) on behalf of an employee or former employee (or dependent).

All premium payments that are withheld under subparagraph (A) shall be credited to the appropriate Trust Fund (or Account thereof), as specified by the Secretary, under this title and shall be paid to the MA organization involved. No charge may be imposed under an MA plan with respect to the election of the payment option described in subparagraph (A). The Secretary shall consult with the Commissioner of Social Security and the Secretary of the Treasury regarding methods for allocating premiums withheld under subparagraph (A) among the appropriate Trust Funds and Account.

"(3) INFORMATION NECESSARY FOR COLLECTION.—In order to carry out paragraph (2)(A) with respect to an enrollee who has elected such paragraph to apply, the Secretary shall transmit to the Commissioner of Social Security—

"(A) by the beginning of each year, the name, social security account number, consolidated monthly beneficiary premium described in paragraph (4) owed by such enrollee for each month during the year, and other information determined appropriate by the Secretary, in consultation with the Commissioner of Social Security; and

"(B) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

"(4) CONSOLIDATED MONTHLY BENEFICIARY PREMIUM.—In the case of an enrollee in an MA plan, the Secretary shall provide a mechanism for the consolidation of—

"(A) the MA monthly basic beneficiary premium (if any);

"(B) the MA monthly supplemental beneficiary premium (if any); and

"(C) the MA monthly prescription drug beneficiary premium (if any).".

(d) COMPUTATION OF MA AREA-SPECIFIC NON-DRUG BENCHMARK.—Section 1853 (42 U.S.C. 1395w–23) is amended by adding at the end the following new subsection:

"(j) COMPUTATION OF BENCHMARK AMOUNTS.—For purposes of this part, the term 'MA area-specific non-drug monthly benchmark amount' means for a month in a year—

"(1) with respect to—

"(A) a service area that is entirely within an MA local area, an amount equal to 1/12 of the annual MA capitation rate under section 1853(c)(1) for the area for the year, adjusted as appropriate for the purpose of risk adjustment; or

"(B) a service area that includes more than one MA local area, an amount equal to the average of the amounts described in subparagraph (A) for each such local MA area, weighted by the projected number of enrollees in the plan residing in the respective local MA areas (as used by the plan for purposes of the bid and disclosed to the Secretary under section 1854(a)(6)(A)(iii)), adjusted as appropriate for the purpose of risk adjustment; or

"(2) with respect to an MA region for a month in a year, the MA region-specific non-drug monthly benchmark amount, as defined in section 1858(f) for the region for the year.".

(e) PAYMENT OF PLANS BASED ON BID AMOUNTS.—

(1) IN GENERAL.—Section 1853(a)(1) (42 U.S.C. 1395w–23(a)(1)) (42 U.S.C. 1395w–23) is amended—

(A) by redesignating subparagraph (B) as subparagraph (H); and

(B) in subparagraph (A), by striking "in an amount" and all that follows and inserting the following: "in an amount determined as follows:

"(i) PAYMENT BEFORE 2006.—For years before 2006, the payment amount shall be equal to 1/12 of the annual MA capitation rate (as calculated under subsection (c)(1)) with respect to that individual for that area, adjusted under subparagraph (C) and reduced by the amount of any reduction elected under section 1854(f)(1)(E).

"(ii) PAYMENT FOR ORIGINAL FEE-FOR-SERVICE BENEFITS BEGINNING WITH 2006.—For years beginning with 2006, the amount specified in subparagraph (B).

"(B) PAYMENT AMOUNT FOR ORIGINAL FEE-FOR-SERVICE BENEFITS BEGINNING WITH 2006.—

"(i) PAYMENT OF BID FOR PLANS WITH BIDS BELOW BENCHMARK.—In the case of a plan for which there are average per capita monthly savings described in section 1854(b)(3)(C) or 1854(b)(4)(C), as the case may be, the amount specified in this subparagraph is equal to the unadjusted MA statutory non-drug monthly bid amount, adjusted under subparagraph (C) and (if applicable) under subparagraphs (F) and (G), plus the amount (if any) of any rebate under subparagraph (E).

"(ii) PAYMENT OF BENCHMARK FOR PLANS WITH BIDS AT OR ABOVE BENCHMARK.—In the case of a plan for which there are no average per capita monthly savings described in section 1854(b)(3)(C) or 1854(b)(4)(C), as the case may be, the amount specified in this subparagraph is equal to the MA area-specific non-drug monthly benchmark amount, adjusted under subparagraph (C) and (if applicable) under subparagraphs (F) and (G).

"(iii) PAYMENT OF BENCHMARK FOR MSA PLANS.—Notwithstanding clauses (i) and (ii), in the case of an MSA plan, the amount specified in this subparagraph is equal to the MA area-specific non-drug monthly benchmark amount, adjusted under subparagraph (C).

"(C) DEMOGRAPHIC ADJUSTMENT, INCLUDING ADJUSTMENT FOR HEALTH STATUS.—The Secretary shall adjust the payment amount under subparagraph (A)(i) and the amount specified under subparagraph (B)(i), (B)(ii), and (B)(iii) for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, including adjustment for health status under paragraph (3), so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such adjustment factors if such changes will improve the determination of actuarial equivalence.

"(D) SEPARATE PAYMENT FOR FEDERAL DRUG SUBSIDIES.—In the case of an enrollee in an MA–PD plan, the MA organization offering such plan also receives—

"(i) subsidies under section 1860D–15 (other than under subsection (g)); and

"(ii) reimbursement for premium and cost-sharing reductions for low-income individuals under section 1860D–14(c)(1)(C).

"(E) PAYMENT OF REBATE FOR PLANS WITH BIDS BELOW BENCHMARK.—In the case of a plan for which there are average per capita monthly savings described in section 1854(b)(3)(C) or 1854(b)(4)(C), as the case may be, the amount specified in this subparagraph is the amount of the monthly rebate computed under section 1854(b)(1)(C)(i) for that plan and year (as reduced by the amount of any credit provided under section 1854(b)(1)(C)(iv)).

"(F) ADJUSTMENT FOR INTRA-AREA VARIATIONS.—

"(i) INTRA-REGIONAL VARIATIONS.—In the case of payment with respect to an MA regional plan for an MA region, the Secretary shall also adjust the amounts specified under subparagraphs (B)(i) and (B)(ii) in a manner to take into account variations in MA local payment rates under this part among the different MA local areas included in such region.

"(ii) INTRA-SERVICE AREA VARIATIONS.—In the case of payment with respect to an MA local plan for a service area that covers more than one MA local area, the Secretary shall also adjust the amounts specified under subparagraphs (B)(i) and (B)(ii) in a manner to take into account variations in MA local payment rates under this part among the different MA local areas included in such service area.

"(G) ADJUSTMENT RELATING TO RISK ADJUSTMENT.—The Secretary shall adjust payments with respect to MA plans as necessary to ensure that—

"(i) the sum of—

"(I) the monthly payment made under subparagraph (A)(ii); and

"(II) the MA monthly basic beneficiary premium under section 1854(b)(2)(A); equals

"(ii) the unadjusted MA statutory non-drug monthly bid amount, adjusted in the manner described in subparagraph (C) and, for an MA regional plan, subparagraph (F).".

(f) CONFORMING CHANGES TO ANNUAL ANNOUNCEMENT PROCESS.—Section 1853(b) (42 U.S.C. 1395w–23(b)(1)) is amended—

(1) by amending paragraph (1) to read as follows:

"(1) ANNUAL ANNOUNCEMENTS.—

"(A) FOR 2005.—The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), not later than the second Monday in May of 2004, with respect to each MA payment area, the following:

"(i) MA CAPITATION RATES.—The annual MA capitation rate for each MA payment area for 2005.

"(ii) ADJUSTMENT FACTORS.—The risk and other factors to be used in adjusting such rates under subsection (a)(1)(C) for payments for months in 2005.

"(B) FOR 2006 AND SUBSEQUENT YEARS.—For a year after 2005—

"(i) INITIAL ANNOUNCEMENT.—The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), not later than the first Monday in April before the calendar year concerned, with respect to each MA payment area, the following:

"(I) MA CAPITATION RATES; MA LOCAL AREA BENCHMARK.—The annual MA capitation rate for each MA payment area for the year.

"(II) ADJUSTMENT FACTORS.—The risk and other factors to be used in adjusting such rates under subsection (a)(1)(C) for payments for months in such year.

"(ii) REGIONAL BENCHMARK ANNOUNCEMENT.—The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), on a timely basis before the calendar year concerned, with respect to each MA region and each MA regional plan for which a bid was submitted under section 1854, the MA region-specific non-drug monthly benchmark amount for that region for the year involved."; and

(2) in paragraph (3), by striking "in the announcement" and all that follows and inserting "in such announcement.".

(g) OTHER AMENDMENTS RELATING TO PREMIUMS AND BID AMOUNTS.—

(1) IN GENERAL.—Section 1854 (42 U.S.C. 1395w–24) is amended—

(A) by amending the section heading to read as follows:

"PREMIUMS AND BID AMOUNTS";

(B) in the heading of subsection (a), by inserting ", BID AMOUNTS," after "PREMIUMS";

(C) in subsection (a)(2)—

(i) by inserting "BEFORE 2006" after "FOR COORDINATED CARE PLANS"; and

(ii) by inserting "for a year before 2006" after "section 1851(a)(2)(A)";

(D) in subsection (a)(3), by striking "described" and inserting "for any year";

(E) in subsection (a)(4)—

(i) by inserting "BEFORE 2006" after "FOR PRIVATE FEE-FOR-SERVICE PLANS"; and

(ii) by inserting "for a year before 2006" after "section 1852(a)(1)(A)";

(F) in subsection (a)(5)(A), by inserting "paragraphs (2) and (4) of" after "filed under";

(G) in subsection (a)(5)(B), by inserting after "paragraph (3) or" the following: ", in the case of an MA private fee-for-service plan,"; and

(H) in subsection (b)(1)(A) by striking "and" and inserting a comma and by inserting before the period at the end the following: ", and, if the plan provides qualified prescription drug coverage, the MA monthly prescription drug beneficiary premium".

(2) UNIFORMITY.—Section 1854(c) (42 U.S.C. 1395w–24(c)) is amended to read as follows:

"(c) UNIFORM PREMIUM AND BID AMOUNTS.—Except as permitted under section 1857(i), the

MA monthly bid amount submitted under subsection (a)(6), the amounts of the MA monthly basic, prescription drug, and supplemental beneficiary premiums, and the MA monthly MSA premium charged under subsection (b) of an MA organization under this part may not vary among individuals enrolled in the plan.".

(3) PREMIUMS.—Section 1854(d)(1) (42 U.S.C. 1395w–24(d)(1)), as amended by subsection (c)(1), is amended by inserting ", prescription drug," after "basic".

(4) LIMITATION ON ENROLLEE LIABILITY.—Section 1854(e) (42 U.S.C. 1395w–24(e)) is amended—

(A) in paragraph (1), by striking ".—In" and inserting "BEFORE 2006.—For periods before 2006, in";

(B) in paragraph (2), by striking ".—If" and insert "BEFORE 2006.—For periods before 2006, if";

(C) in paragraph (3), by striking "or (2)" and inserting ", (2), or (4)"; and

(D) in paragraph (4)—

(i) by inserting "AND FOR BASIC BENEFITS BEGINNING IN 2006" after "PLANS";

(ii) in the matter before subparagraph (A), by inserting "and for periods beginning with 2006, with respect to an MA plan described in section 1851(a)(2)(A)" after "MSA plan)";

(iii) in subparagraph (A), by striking "required benefits described in section 1852(a)(1)" and inserting "benefits under the original medicare fee-for-service program option"; and

(iv) in subparagraph (B), by inserting "with respect to such benefits" after "would be applicable".

(5) MODIFICATION OF ACR PROCESS.—Section 1854(f) (42 U.S.C. 1395w–24(f)) is amended—

(A) in the heading, by inserting "BEFORE 2006" after "ADDITIONAL BENEFITS"; and

(B) in paragraph (1)(A), by striking "Each" and inserting "For years before 2006, each".

(h) PLAN INCENTIVES.—Section 1852(j)(4) (42 U.S.C. 1395w–22(j)(4)) is amended—

(1) by inserting "the organization provides assurances satisfactory to the Secretary that" after "unless";

(2) in clause (ii)—

(A) by striking "the organization—" and all that follows through "(I) provides" and inserting "the organization provides";

(B) by striking ", and" and inserting a period; and

(C) by striking subclause (II); and

(3) by striking clause (iii).

(i) CONTINUATION OF TREATMENT OF ENROLLEES WITH END-STAGE RENAL DISEASE.—Section 1853(a)(1)(H), as redesignated under subsection (d)(1)(A), is amended—

(1) by amending the second sentence to read as follows: "Such rates of payment shall be actuarially equivalent to rates that would have been paid with respect to other enrollees in the MA payment area (or such other area as specified by the Secretary) under the provisions of this section as in effect before the date of the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003."; and

(2) by adding at the end the following new sentence: "The Secretary may apply the competitive bidding methodology provided for in this section, with appropriate adjustments to account for the risk adjustment methodology applied to end stage renal disease payments.".

(j) FACILITATION OF EMPLOYER SPONSORSHIP OF MA PLANS.—Section 1857(i) (42 U.S.C. 1395w–27(i)) is amended—

(1) by designating the matter following the heading as a paragraph (1) with the heading "CONTRACTS WITH MA ORGANIZATIONS.—" and appropriate indentation; and

(2) by adding at the end the following new paragraph:

"(2) EMPLOYER SPONSORED MA PLANS.—To facilitate the offering of MA plans by employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such MA plans. Notwithstanding section 1851(g), an MA plan described in the previous sentence may restrict the enrollment of individuals under this part to individuals who are beneficiaries and participants in such plan.".

(k) EXPANSION OF MEDICARE BENEFICIARY EDUCATION AND INFORMATION CAMPAIGN.—Section 1857(e)(2) (42 U.S.C. 1395w–27(e)(2)) is amended—

(1) in subparagraph (A) by inserting "and a PDP sponsor under part D" after "organization";

(2) in subparagraph (B)—

(A) by inserting "and each PDP sponsor with a contract under part D" after "contract under this part";

(B) by inserting "or sponsor's" after "organization's"; and

(C) by inserting ", section 1860D–1(c)," after "information)";

(3) in subparagraph (C)—

(A) by inserting "and ending with fiscal year 2005" after "beginning with fiscal year 2001";

(B) by inserting "and for each fiscal year beginning with fiscal year 2006 an amount equal to $200,000,000," after "$100,000,000,"; and

(C) by inserting "and section 1860D–12(b)(3)(D)" after "under this paragraph";

(4) in subparagraph (D)—

(A) in clause (i) by inserting "and section 1860D–1(c)" after "section 1851";

(B) in clause (ii)(III), by striking "and" at the end of subclause (III);

(C) in clause (ii)(IV), by striking "each succeeding fiscal year." and inserting "each succeeding fiscal year before fiscal year 2006; and"; and

(D) in clause (ii), by adding at the end the following new subclause:

"(V) the applicable portion (as defined in subparagraph (F)) of $200,000,000 in fiscal year 2006 and each succeeding fiscal year."; and

(5) by adding at the end the following new subparagraph:

"(F) APPLICABLE PORTION DEFINED.—In this paragraph, the term 'applicable portion' means, for a fiscal year—

"(i) with respect to MA organizations, the Secretary's estimate of the total proportion of expenditures under this title that are attributable to expenditures made under this part (including payments under part D that are made to such organizations); or

"(ii) with respect to PDP sponsors, the Secretary's estimate of the total proportion of expenditures under this title that are attributable to expenditures made to such sponsors under part D.".

(l) CONFORMING AMENDMENTS.—

(1) PROTECTION AGAINST BENEFICIARY SELECTION.—Section 1852(b)(1)(A) (42 U.S.C. 1395w–22(b)(1)(A)) is amended by adding at the end the following: "The Secretary shall not approve a plan of an organization if the Secretary determines that the design of the plan and its benefits are likely to substantially discourage enrollment by certain MA eligible individuals with the organization.".

(2) RELATING TO REBATES.—

(A) Section 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended by striking "80 percent of any reduction elected under section 1854(f)(1)(E)" and inserting "any credit provided under section 1854(b)(1)(C)(ii)(III)".

(B) The first sentence of section 1840(i) (42 U.S.C. 1395s(i)) is amended by inserting "and to reflect any credit provided under section 1854(b)(1)(C)(iv)" after "section 1854(f)(1)(E)".

(C) Section 1844(c) (42 U.S.C. 1395w(c)) is amended by inserting "or any credits provided under section 1854(b)(1)(C)(iv)" after "section 1854(f)(1)(E)".

(3) OTHER CONFORMING AND TECHNICAL AMENDMENTS.—

(A) Section 1851(b)(1) (42 U.S.C. 1395w–21(b)(1)) is amended—

(i) in subparagraph (B), by striking "a plan" and inserting "an MA local plan";

(ii) in subparagraph (B), by striking "basic benefits described in section 1852(a)(1)(A)" and inserting "benefits under the original medicare fee-for-service program option"; and

(iii) in subparagraph (C), by striking "in a Medicare+Choice plan" and inserting "in an MA local plan".

(B) Section 1851(d) (42 U.S.C. 1395w–21(d)) is amended—

(i) in paragraph (3), by adding at the end the following new subparagraph:

"(F) CATASTROPHIC COVERAGE AND SINGLE DEDUCTIBLE.—In the case of an MA regional plan, a description of the catastrophic coverage and single deductible applicable under the plan.";

(ii) in paragraph (4)(A)(ii), by inserting ", including information on the single deductible (if applicable) under section 1858(b)(1)" after "cost sharing";

(iii) in paragraph (4)(B)(i), by striking "Medicare+Choice monthly basic" and all that follows and inserting "monthly amount of the premium charged to an individual."; and

(iv) by amending subparagraph (E) of subsection (d)(4) to read as follows:

"(E) SUPPLEMENTAL BENEFITS.—Supplemental health care benefits, including any reductions in cost-sharing under section 1852(a)(3) and the terms and conditions (including premiums) for such benefits.".

(C) Section 1857(d)(1) (42 U.S.C. 1395w–27(d)(1)) is amended by striking ", costs, and computation of the adjusted community rate" and inserting "and costs, including allowable costs under section 1858(c)".

(D) Section 1851(a)(3)(B)(ii) (42 U.S.C. 1395w–21(a)(3)(B)(ii)) is amended by striking "section 1851(e)(4)(A)" and inserting "subsection (e)(4)(A)".

(E) Section 1851(f)(1) (42 U.S.C. 1395w–21(f)(1)) is amended by striking "subsection (e)(1)(A)" and inserting "subsection (e)(1)".

SEC. 223. EFFECTIVE DATE.

(a) EFFECTIVE DATE.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1, 2006.

(b) ISSUANCE OF REGULATIONS.—The Secretary shall revise the regulations previously promulgated to carry out part C of title XVIII of the Social Security Act to carry out the provisions of this Act.

Subtitle D—Additional Reforms

SEC. 231. SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.

(a) TREATMENT AS COORDINATED CARE PLAN.—Section 1851(a)(2)(A) (42 U.S.C. 1395w–21(a)(2)(A)), as amended by section 221(a), is amended by adding at the end the following new clause:

"(ii) SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—Specialized MA plans for special needs individuals (as defined in section 1859(b)(6)) may be any type of coordinated care plan.".

(b) SPECIALIZED MA PLAN FOR SPECIAL NEEDS INDIVIDUALS DEFINED.—Section 1859(b) (42 U.S.C. 1395w–29(b)), as amended by section 221(b), is amended by adding at the end the following new paragraph:

"(6) SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—

"(A) IN GENERAL.—The term 'specialized MA plan for special needs individuals' means an MA plan that exclusively serves special needs individuals (as defined in subparagraph (B)).

"(B) SPECIAL NEEDS INDIVIDUAL.—The term 'special needs individual' means an MA eligible individual who—

"(i) is institutionalized (as defined by the Secretary);

"(ii) is entitled to medical assistance under a State plan under title XIX; or

"(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized MA plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.

The Secretary may waive application of section 1851(a)(3)(B) in the case of an individual described in clause (i), (ii), or (iii) of this subparagraph and may apply rules similar to the rules of section 1894(c)(4) for continued eligibility of special needs individuals.".

(c) RESTRICTION ON ENROLLMENT PERMITTED.—Section 1859 (42 U.S.C. 1395w–29) is amended by adding at the end the following new subsection:

"(f) RESTRICTION ON ENROLLMENT FOR SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—In the case of a specialized MA plan for special needs individuals (as defined in subsection (b)(6)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2009, the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs individuals.".

(d) AUTHORITY TO DESIGNATE OTHER PLANS AS SPECIALIZED MA PLANS.—In promulgating regulations to carry out section 1851(a)(2)(A)(ii) of the Social Security Act (as added by subsection (a)) and section 1859(b)(6) of such Act (as added by subsection (b)), the Secretary may provide (notwithstanding section 1859(b)(6)(A) of such Act) for the offering of specialized MA plans for special needs individuals by MA plans that disproportionately serve special needs individuals.

(e) REPORT TO CONGRESS.—Not later than December 31, 2007, the Secretary shall submit to Congress a report that assesses the impact of specialized MA plans for special needs individuals on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the medicare program as a result of amendments made by subsections (a), (b), and (c).

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsections (a), (b), and (c) shall take effect upon the date of the enactment of this Act.

(2) DEADLINE FOR ISSUANCE OF REQUIREMENTS FOR SPECIAL NEEDS INDIVIDUALS; TRANSITION.—No later than 1 year after the date of the enactment of this Act, the Secretary shall issue final regulations to establish requirements for special needs individuals under section 1859(b)(6)(B)(iii) of the Social Security Act, as added by subsection (b).

SEC. 232. AVOIDING DUPLICATIVE STATE REGULATION.

(a) IN GENERAL.—Section 1856(b)(3) (42 U.S.C. 1395w–26(b)(3)) is amended to read as follows:

"(3) RELATION TO STATE LAWS.—The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part.".

(b) CONFORMING AMENDMENT.—Section 1854(g) (42 U.S.C. 1395w–24(g)) is amended by inserting "or premiums paid to such organizations under this part" after "section 1853".

(c) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

SEC. 233. MEDICARE MSAS.

(a) EXEMPTION FROM REPORTING REQUIREMENT.—

(1) IN GENERAL.—Section 1852(e)(1) (42 U.S.C. 1395w–22(e)(1)) is amended by inserting "(other than MSA plans)" after "plans".

(2) CONFORMING AMENDMENTS.—Section 1852 (42 U.S.C. 1395w–22) is amended—

(A) in subsection (c)(1)(I), by inserting before the period at the end the following: ", if required under such section"; and

(B) in subsection (e)(2)(A), by striking ", a non-network MSA plan,"; and

(C) in subsection (e)(2)(B), by striking ", NON-NETWORK MSA PLANS," and ", a non-network MSA plan,".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply on and after the date of the enactment of this Act but shall not apply to contract years beginning on or after January 1, 2006.

(b) MAKING PROGRAM PERMANENT AND ELIMINATING CAP.—Section 1851(b)(4) (42 U.S.C. 1395w–21(b)(4)) is amended—

(1) in the heading, by striking "ON A DEMONSTRATION BASIS";

(2) by striking the first sentence of subparagraph (A); and

(3) by striking the second sentence of subparagraph (C).

(c) APPLYING LIMITATIONS ON BALANCE BILLING.—Section 1852(k)(1) (42 U.S.C. 1395w–22(k)(1)) is amended by inserting "or with an organization offering an MSA plan" after "section 1851(a)(2)(A)".

(d) ADDITIONAL AMENDMENT.—Section 1851(e)(5)(A) (42 U.S.C. 1395w–21(e)(5)(A)) is amended—

(1) by adding "or" at the end of clause (i);

(2) by striking ", or" at the end of clause (ii) and inserting a semicolon; and

(3) by striking clause (iii).

SEC. 234. EXTENSION OF REASONABLE COST CONTRACTS.

Subparagraph (C) of section 1876(h)(5) (42 U.S.C. 1395mm(h)(5)) is amended to read as follows:

"(C)(i) Subject to clause (ii), a reasonable cost reimbursement contract under this subsection may be extended or renewed indefinitely.

"(ii) For any period beginning on or after January 1, 2008, a reasonable cost reimbursement contract under this subsection may not be extended or renewed for a service area insofar as such area during the entire previous year was within the service area of—

"(I) 2 or more MA regional plans described in clause (iii); or

"(II) 2 or more MA local plans described in clause (iii).

"(iii) A plan described in this clause for a year for a service area is a plan described in section 1851(a)(2)(A)(i) if the service area for the year meets the following minimum enrollment requirements:

"(I) With respect to any portion of the area involved that is within a Metropolitan Statistical Area with a population of more than 250,000 and counties contiguous to such Metropolitan Statistical Area, 5,000 individuals.

"(II) With respect to any other portion of such area, 1,500 individuals.".

SEC. 235. 2-YEAR EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

The last sentence of section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as amended by section 6135 of the Omnibus Budget Reconciliation Act of 1989, section 13557 of the Omnibus Budget Reconciliation Act of 1993, section 4017 of BBA, section 534 of BBRA (113 Stat. 1501A–390), and section 633 of BIPA, is amended by striking "December 31, 2004" and inserting "December 31, 2006".

SEC. 236. PAYMENT BY PACE PROVIDERS FOR MEDICARE AND MEDICAID SERVICES FURNISHED BY NONCONTRACT PROVIDERS.

(a) MEDICARE SERVICES.—

(1) MEDICARE SERVICES FURNISHED BY PROVIDERS OF SERVICES.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended—

(A) by striking "part C or" and inserting "part C, with a PACE provider under section 1894 or 1934, or";

(B) by striking "(i)";

(C) by striking "and (ii)";

(D) by inserting "(or, in the case of a PACE provider, contract or other agreement)" after "have a contract"; and

(E) by striking "members of the organization" and inserting "members of the organization or PACE program eligible individuals enrolled with the PACE provider,".

(2) MEDICARE SERVICES FURNISHED BY PHYSICIANS AND OTHER ENTITIES.—Section 1894(b) (42 U.S.C. 1395eee(b)) is amended by adding at the end the following new paragraphs:

"(3) TREATMENT OF MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

"(A) APPLICATION OF MEDICARE ADVANTAGE REQUIREMENT WITH RESPECT TO MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—Section 1852(k)(1) (relating to limitations on balance billing against MA organizations for noncontract physicians and other entities with respect to services covered under this title) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract or other agreement establishing payment amounts for services furnished to such an individual in the same manner as such section applies to MA organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

"(B) REFERENCE TO RELATED PROVISION FOR NONCONTRACT PROVIDERS OF SERVICES.—For the provision relating to limitations on balance billing against PACE providers for services covered under this title furnished by noncontract providers of services, see section 1866(a)(1)(O).

"(4) REFERENCE TO RELATED PROVISION FOR SERVICES COVERED UNDER TITLE XIX BUT NOT UNDER THIS TITLE.—For provisions relating to limitations on payments to providers participating under the State plan under title XIX that do not have a contract or other agreement with a PACE provider establishing payment amounts for services covered under such plan (but not under this title) when such services are furnished to enrollees of that PACE provider, see section 1902(a)(66).".

(b) MEDICAID SERVICES.—

(1) REQUIREMENT UNDER STATE PLAN.—Section 1902(a) (42 U.S.C. 1396a(a)), as amended by section 103(a), is amended—

(A) in paragraph (65), by striking "and" at the end;

(B) in paragraph (66), by striking the period at the end and inserting "; and"; and

(C) by inserting after paragraph (66) the following new paragraph:

"(67) provide, with respect to services covered under the State plan (but not under title XVIII) that are furnished to a PACE program eligible individual enrolled with a PACE provider by a provider participating under the State plan that does not have a contract or other agreement with the PACE provider that establishes payment amounts for such services, that such participating provider may not require the PACE provider to pay the participating provider an amount greater than the amount that would otherwise be payable for the service to the participating provider under the State plan for the State where the PACE provider is located (in accordance with regulations issued by the Secretary).".

(2) APPLICATION UNDER MEDICAID.—Section 1934(b) (42 U.S.C. 1396u–4(b)) is amended by adding at the end the following new paragraphs:

"(3) TREATMENT OF MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

"(A) APPLICATION OF MEDICARE ADVANTAGE REQUIREMENT WITH RESPECT TO MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—Section 1852(k)(1) (relating to limitations on balance billing against MA organizations for noncontract physicians and other entities with respect to services covered under title XVIII) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract or other agreement establishing payment amounts for services furnished to such an individual in the same manner as such section applies to MA organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

"(B) REFERENCE TO RELATED PROVISION FOR NONCONTRACT PROVIDERS OF SERVICES.—For the provision relating to limitations on balance billing against PACE providers for services covered under title XVIII furnished by noncontract providers of services, see section 1866(a)(1)(O).

"(4) REFERENCE TO RELATED PROVISION FOR SERVICES COVERED UNDER THIS TITLE BUT NOT UNDER TITLE XVIII.—For provisions relating to limitations on payments to providers participating under the State plan under this title that do not have a contract or other agreement with a PACE provider establishing payment amounts for services covered under such plan (but not under title XVIII) when such services are furnished to enrollees of that PACE provider, see section 1902(a)(67).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2004.

SEC. 237. REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS PROVIDING SERVICES UNDER MA PLANS.

(a) REIMBURSEMENT.—Section 1833(a)(3) (42 U.S.C. 1395l(a)(3)) is amended to read as follows:

"(3) in the case of services described in section 1832(a)(2)(D)—

"(A) except as provided in subparagraph (B), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs; or

"(B) with respect to the services described in clause (ii) of section 1832(a)(2)(D) that are furnished to an individual enrolled with a MA plan under part C pursuant to a written agreement described in section 1853(a)(4), the amount (if any) by which—

"(i) the amount of payment that would have otherwise been provided under subparagraph (A) (calculated as if '100 percent' were substituted for '80 percent' in such subparagraph) for such services if the individual had not been so enrolled; exceeds

"(ii) the amount of the payments received under such written agreement for such services (not including any financial incentives provided for in such agreement such as risk pool payments, bonuses, or withholds),

less the amount the Federally qualified health center may charge as described in section 1857(e)(3)(B);".

(b) CONTINUATION OF MONTHLY PAYMENTS.—

(1) IN GENERAL.—Section 1853(a) (42 U.S.C. 1395w–23(a)) is amended by adding at the end the following new paragraph:

"(4) PAYMENT RULE FOR FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—If an individual who is enrolled with an MA plan under this part receives a service from a Federally qualified health center that has a written agreement with the MA organization that offers such plan for providing such a service (including any agreement required under section 1857(e)(3))—

"(A) the Secretary shall pay the amount determined under section 1833(a)(3)(B) directly to the Federally qualified health center not less frequently than quarterly; and

"(B) the Secretary shall not reduce the amount of the monthly payments under this subsection as a result of the application of subparagraph (A).".

(2) CONFORMING AMENDMENTS.—

(A) Section 1851(i) (42 U.S.C. 1395w–21(i)) is amended—

(i) in paragraph (1), by inserting "1853(a)(4)," after "Subject to sections 1852(a)(5),"; and

(ii) in paragraph (2), by inserting "1853(a)(4)," after "Subject to sections".

(B) Section 1853(c)(5) is amended by striking "subsections (a)(3)(C)(iii) and (i)" and inserting "subsections (a)(3)(C)(iii), (a)(4), and (i)".

(c) ADDITIONAL CONTRACT REQUIREMENTS.—Section 1857(e) (42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

"(3) AGREEMENTS WITH FEDERALLY QUALIFIED HEALTH CENTERS.—

"(A) PAYMENT LEVELS AND AMOUNTS.—A contract under this section with an MA organization shall require the organization to provide, in any written agreement described in section 1853(a)(4) between the organization and a Federally qualified health center, for a level and amount of payment to the Federally qualified health center for services provided by such health center that is not less than the level and amount of payment that the plan would make for such services if the services had been furnished by a entity providing similar services that was not a Federally qualified health center.

"(B) COST-SHARING.—Under the written agreement referred to in subparagraph (A), a Federally qualified health center must accept the payment amount referred to in such subparagraph plus the Federal payment provided for in section 1833(a)(3)(B) as payment in full for services covered by the agreement, except that such a health center may collect any amount of cost-sharing permitted under the contract under this section, so long as the amounts of any deductible, coinsurance, or copayment comply with the requirements under section 1854(e).".

(d) SAFE HARBOR.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)), as amended by section 101(f)(2), is amended—

(1) in subparagraph (F), by striking "and" after the semicolon at the end;

(2) in subparagraph (G), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(H) any remuneration between a Federally qualified health center (or an entity controlled by such a health center) and an MA organization pursuant to a written agreement described in section 1853(a)(4).".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided on or after January 1, 2006, and contract years beginning on or after such date.

SEC. 238. INSTITUTE OF MEDICINE EVALUATION AND REPORT ON HEALTH CARE PERFORMANCE MEASURES.

(a) EVALUATION.—

(1) IN GENERAL.—Not later than the date that is 2 months after the date of the enactment of this Act, the Secretary shall enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences (in this section referred to as the "Institute") shall conduct an evaluation of leading health care performance measures in the public and private sectors and options to implement policies that align performance with payment under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) SPECIFIC MATTERS EVALUATED.—In conducting the evaluation under paragraph (1), the Institute shall—

(A) catalogue, review, and evaluate the validity of leading health care performance measures;

(B) catalogue and evaluate the success and utility of alternative performance incentive programs in public or private sector settings; and

(C) identify and prioritize options to implement policies that align performance with payment under the medicare program that indicate—

(i) the performance measurement set to be used and how that measurement set will be updated;

(ii) the payment policy that will reward performance; and

(iii) the key implementation issues (such as data and information technology requirements) that must be addressed.

(3) SCOPE OF HEALTH CARE PERFORMANCE MEASURES.—The health care performance measures described in paragraph (2)(A) shall encompass a variety of perspectives, including physicians, hospitals, other health care providers, health plans, purchasers, and patients.

(4) CONSULTATION WITH MEDPAC.—In evaluating the matters described in paragraph (2)(C), the Institute shall consult with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6).

(b) REPORT.—Not later than the date that is 18 months after the date of enactment of this Act, the Institute shall submit to the Secretary and appropriate committees of jurisdiction of the Senate and House of Representatives a report on the evaluation conducted under subsection (a)(1) describing the findings of such evaluation and recommendations for an overall strategy and approach for aligning payment with performance, including options for updating performance measures, in the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act, the Medicare Advantage program under part C of such title, and any other programs under such title XVIII.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for purposes of conducting the evaluation and preparing the report required by this section.

Subtitle E—Comparative Cost Adjustment (CCA) Program

SEC. 241. COMPARATIVE COST ADJUSTMENT (CCA) PROGRAM.

(a) IN GENERAL.—Part C of title XVIII is amended by adding at the end the following new section:

"COMPARATIVE COST ADJUSTMENT (CCA) PROGRAM

"SEC. 1860C–1. (a) ESTABLISHMENT OF PROGRAM.—

"(1) IN GENERAL.—The Secretary shall establish a program under this section (in this section referred to as the 'CCA program') for the application of comparative cost adjustment in CCA areas selected under this section.

"(2) DURATION.—The CCA program shall begin January 1, 2010, and shall extend over a period of 6 years, and end on December 31, 2015.

“(3) REPORT.—Upon the completion of the CCA program, the Secretary shall submit a report to Congress. Such report shall include the following, with respect to both this part and the original medicare fee-for-service program:

“(A) An evaluation of the financial impact of the CCA program.

“(B) An evaluation of changes in access to physicians and other health care providers.

“(C) Beneficiary satisfaction.

“(D) Recommendations regarding any extension or expansion of the CCA program.

“(b) REQUIREMENTS FOR SELECTION OF CCA AREAS.—

“(1) CCA AREA DEFINED.—

“(A) IN GENERAL.—For purposes of this section, the term ‘CCA area’ means an MSA that meets the requirements of paragraph (2) and is selected by the Secretary under subsection (c).

“(B) MSA DEFINED.—For purposes of this section, the term ‘MSA’ means a Metropolitan Statistical Area (or such similar area as the Secretary recognizes).

“(2) REQUIREMENTS FOR CCA AREAS.—The requirements of this paragraph for an MSA to be a CCA area are as follows:

“(A) MA ENROLLMENT REQUIREMENT.—For the reference month (as defined under section 1858(f)(4)(B)) with respect to 2010, at least 25 percent of the total number of MA eligible individuals who reside in the MSA were enrolled in an MA local plan described in section 1851(a)(2)(A)(i).

“(B) 2 PLAN REQUIREMENT.—There will be offered in the MSA during the annual, coordinated election period under section 1851(e)(3)(B) before the beginning of 2010 at least 2 MA local plans described in section 1851(a)(2)(A)(i) (in addition to the fee-for-service program under parts A and B), each offered by a different MA organization and each of which met the minimum enrollment requirements of paragraph (1) of section 1857(b) (as applied without regard to paragraph (3) thereof) as of the reference month.

“(c) SELECTION OF CCA AREAS.—

“(1) GENERAL SELECTION CRITERIA.—The Secretary shall select CCA areas from among those MSAs qualifying under subsection (b) in a manner that—

“(A) seeks to maximize the opportunity to test the application of comparative cost adjustment under this title;

“(B) does not seek to maximize the number of MA eligible individuals who reside in such areas; and

“(C) provides for geographic diversity consistent with the criteria specified in paragraph (2).

“(2) SELECTION CRITERIA.—With respect to the selection of MSAs that qualify to be CCA areas under subsection (b), the following rules apply, to the maximum extent feasible:

“(A) MAXIMUM NUMBER.—The number of such MSAs selected may not exceed the lesser of (i) 6, or (ii) 25 percent of the number of MSAs that meet the requirement of subsection (b)(2)(A).

“(B) ONE OF 4 LARGEST AREAS BY POPULATION.—At least one such qualifying MSA shall be selected from among the 4 such qualifying MSAs with the largest total population of MA eligible individuals.

“(C) ONE OF 4 AREAS WITH LOWEST POPULATION DENSITY.—At least one such qualifying MSA shall be selected from among the 4 such qualifying MSAs with the lowest population density (as measured by residents per square mile or similar measure of density).

“(D) MULTISTATE AREA.—At least one such qualifying MSA shall be selected that includes a multi-State area. Such an MSA may be an MSA described in subparagraph (B) or (C).

“(E) LIMITATION WITHIN SAME GEOGRAPHIC REGION.—No more than 2 such MSAs shall be selected that are, in whole or in part, within the same geographic region (as specified by the Secretary) of the United States.

“(F) PRIORITY TO AREAS NOT WITHIN CERTAIN DEMONSTRATION PROJECTS.—Priority shall be provided for those qualifying MSAs that do not have a demonstration project in effect as of the date of the enactment of this section for medicare preferred provider organization plans under this part.

“(d) APPLICATION OF COMPARATIVE COST ADJUSTMENT.—

“(1) IN GENERAL.—In the case of a CCA area for a year—

“(A) for purposes of applying this part with respect to payment for MA local plans, any reference to an MA area-specific non-drug monthly benchmark amount shall be treated as a reference to such benchmark computed as if the CCA area-specific non-drug monthly benchmark amount (as defined in subsection (e)(1)) were substituted for the amount described in section 1853(j)(1)(A) for the CCA area and year involved, as phased in under paragraph (3); and

“(B) with respect to months in the year for individuals residing in the CCA area who are not enrolled in an MA plan, the amount of the monthly premium under section 1839 is subject to adjustment under subsection (f).

“(2) EXCLUSION OF MA LOCAL AREAS WITH FEWER THAN 2 ORGANIZATIONS OFFERING MA PLANS.—

“(A) IN GENERAL.—In no case shall an MA local area that is within an MSA be included as part of a CCA area unless for 2010 (and, except as provided in subparagraph (B), for a subsequent year) there is offered in each part of such MA local area at least 2 MA local plans described in section 1851(a)(2)(A)(i) each of which is offered by a different MA organization.

“(B) CONTINUATION.—If an MA local area meets the requirement of subparagraph (A) and is included in a CCA area for 2010, such local area shall continue to be included in such CCA area for a subsequent year notwithstanding that it no longer meets such requirement so long as there is at least one MA local plan described in section 1851(a)(2)(A)(i) that is offered in such local area.

“(3) PHASE-IN OF CCA BENCHMARK.—

“(A) IN GENERAL.—In applying this section for a year before 2013, paragraph (1)(A) shall be applied as if the phase-in fraction under subparagraph (B) of the CCA non-drug monthly benchmark amount for the year were substituted for such fraction of the MA area-specific non-drug monthly benchmark amount.

“(B) PHASE-IN FRACTION.—The phase-in fraction under this subparagraph is—

“(i) for 2010 ¼; and

“(ii) for a subsequent year is the phase-in fraction under this subparagraph for the previous year increased by ¼, but in no case more than 1.

“(e) COMPUTATION OF CCA BENCHMARK AMOUNT.—

“(1) CCA NON-DRUG MONTHLY BENCHMARK AMOUNT.—For purposes of this section, the term ‘CCA non-drug monthly benchmark amount’ means, with respect to a CCA area for a month in a year, the sum of the 2 components described in paragraph (2) for the area and year. The Secretary shall compute such benchmark amount for each such CCA area before the beginning of each annual, coordinated election period under section 1851(e)(3)(B) for each year (beginning with 2010) in which the CCA area is so selected.

“(2) 2 COMPONENTS.—For purposes of paragraph (1), the 2 components described in this paragraph for a CCA area and a year are the following:

“(A) MA LOCAL COMPONENT.—The product of the following:

“(i) WEIGHTED AVERAGE OF MEDICARE ADVANTAGE PLAN BIDS IN AREA.—The weighted average of the plan bids for the area and year (as determined under paragraph (3)(A)).

“(ii) NON-FFS MARKET SHARE.—1 minus the fee-for-service market share percentage, determined under paragraph (4) for the area and year.

“(B) FEE-FOR-SERVICE COMPONENT.—The product of the following:

“(i) FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG AMOUNT.—The fee-for-service area-specific non-drug amount (as defined in paragraph (5)) for the area and year.

“(ii) FEE-FOR-SERVICE MARKET SHARE.—The fee-for-service market share percentage, determined under paragraph (4) for the area and year.

“(3) DETERMINATION OF WEIGHTED AVERAGE MA BIDS FOR A CCA AREA.—

“(A) IN GENERAL.—For purposes of paragraph (2)(A)(i), the weighted average of plan bids for a CCA area and a year is, subject to subparagraph (D), the sum of the following products for MA local plans described in subparagraph (C) in the area and year:

“(i) MONTHLY MEDICARE ADVANTAGE STATUTORY NON-DRUG BID AMOUNT.—The accepted unadjusted MA statutory non-drug monthly bid amount.

“(ii) PLAN'S SHARE OF MEDICARE ADVANTAGE ENROLLMENT IN AREA.—The number of individuals described in subparagraph (B), divided by the total number of such individuals for all MA plans described in subparagraph (C) for that area and year.

“(B) COUNTING OF INDIVIDUALS.—The Secretary shall count, for each MA local plan described in subparagraph (C) for an area and year, the number of individuals who reside in the area and who were enrolled under such plan under this part during the reference month for that year.

“(C) EXCLUSION OF PLANS NOT OFFERED IN PREVIOUS YEAR.—For an area and year, the MA local plans described in this subparagraph are MA local plans described in section 1851(a)(2)(A)(i) that are offered in the area and year and were offered in the CCA area in the reference month.

“(D) COMPUTATION OF WEIGHTED AVERAGE OF PLAN BIDS.—In calculating the weighted average of plan bids for a CCA area under subparagraph (A)—

“(i) in the case of an MA local plan that has a service area only part of which is within such CCA area, the MA organization offering such plan shall submit a separate bid for such plan for the portion within such CCA area; and

“(ii) the Secretary shall adjust such separate bid (or, in the case of an MA local plan that has a service area entirely within such CCA area, the plan bid) as may be necessary to take into account differences between the service area of such plan within the CCA area and the entire CCA area and the distribution of plan enrollees of all MA local plans offered within the CCA area.

“(4) COMPUTATION OF FEE-FOR-SERVICE MARKET SHARE PERCENTAGE.—The Secretary shall determine, for a year and a CCA area, the proportion (in this subsection referred to as the ‘fee-for-service market share percentage’) equal to—

“(A) the total number of MA eligible individuals residing in such area who during the reference month for the year were not enrolled in any MA plan; divided by

“(B) the sum of such number and the total number of MA eligible individuals residing in such area who during such reference month were enrolled in an MA local plan described in section 1851(a)(2)(A)(i),

or, if greater, such proportion determined for individuals nationally.

“(5) FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG AMOUNT.—

"(A) IN GENERAL.—For purposes of paragraph (2)(B)(i) and subsection (f)(2)(A), subject to subparagraph (C), the term 'fee-for-service area-specific non-drug amount' means, for a CCA area and a year, the adjusted average per capita cost for such area and year involved, determined under section 1876(a)(4) and adjusted as appropriate for the purpose of risk adjustment for benefits under the original medicare fee-for-service program option for individuals entitled to benefits under part A and enrolled under part B who are not enrolled in an MA plan for the year, but adjusted to exclude costs attributable to payments under section 1886(h).

"(B) USE OF FULL RISK ADJUSTMENT TO STANDARDIZE FEE-FOR-SERVICE COSTS TO TYPICAL BENEFICIARY.—In determining the adjusted average per capita cost for an area and year under subparagraph (A), such costs shall be adjusted to fully take into account the demographic and health status risk factors established under section 1853(a)(1)(A)(iv) so that such per capita costs reflect the average costs for a typical beneficiary residing in the CCA area.

"(C) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under subparagraph (A) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.

"(f) PREMIUM ADJUSTMENT.—

"(1) APPLICATION.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), in the case of an individual who is enrolled under part B, who resides in a CCA area, and who is not enrolled in an MA plan under this part, the monthly premium otherwise applied under part B (determined without regard to subsections (b), (f), and (i) of section 1839 or any adjustment under this subsection) shall be adjusted in accordance with paragraph (2), but only in the case of premiums for months during the period in which the CCA program under this section for such area is in effect.

"(B) NO PREMIUM ADJUSTMENT FOR SUBSIDY ELIGIBLE BENEFICIARIES.—No premium adjustment shall be made under this subsection for a premium for a month if the individual is determined to be a subsidy eligible individual (as defined in section 1860D–14(a)(3)(A)) for the month.

"(2) AMOUNT OF ADJUSTMENT.—

"(A) IN GENERAL.—Under this paragraph, subject to the exemption under paragraph (1)(B) and the limitation under subparagraph (B), if the fee-for-service area-specific non-drug amount (as defined in section (e)(5)) for a CCA area in which an individual resides for a month—

"(i) does not exceed the CCA non-drug monthly benchmark amount (as determined under subsection (e)(1)) for such area and month, the amount of the premium for the individual for the month shall be reduced, by an amount equal to 75 percent of the amount by which such CCA benchmark exceeds such fee-for-service area-specific non-drug amount; or

"(ii) exceeds such CCA non-drug benchmark, the amount of the premium for the individual for the month shall be adjusted to ensure, that—

"(I) the sum of the amount of the adjusted premium and the CCA non-drug benchmark for the area; is equal to

"(II) the sum of the unadjusted premium plus the amount of such fee-for-service area-specific non-drug amount for the area.

"(B) LIMITATION.—In no case shall the actual amount of an adjustment under subparagraph (A) for an area and month in a year result in an adjustment that exceeds the maximum adjustment permitted under subparagraph (C) for the area and year, or, if less, the maximum annual adjustment permitted under subparagraph (D) for the area and year.

"(C) PHASE-IN OF ADJUSTMENT.—The amount of an adjustment under subparagraph (A) for a CCA area and year may not exceed the product of the phase-in fraction for the year under subsection (d)(3)(B) multiplied by the amount of the adjustment otherwise computed under subparagraph (A) for the area and year, determined without regard to this subparagraph and subparagraph (D).

"(D) 5-PERCENT LIMITATION ON ADJUSTMENT.—The amount of the adjustment under this subsection for months in a year shall not exceed 5 percent of the amount of the monthly premium amount determined for months in the year under section 1839 without regard to subsections (b), (f), and (i) of such section and this subsection.".

(b) CONFORMING AMENDMENTS.—

(1) MA LOCAL PLANS.—

(A) Section 1853(j)(1)(A) (42 U.S.C. 1395w–23(j)(1)(A)), as added by section 222(d), is amended by inserting "subject to section 1860C–1(d)(2)(A)," after "within an MA local area,".

(B) Section 1853(b)(1)(B), as amended by section 222(f)(1), is amended by adding at the end the following new clause:

"(iii) BENCHMARK ANNOUNCEMENT FOR CCA LOCAL AREAS.—The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), on a timely basis before the calendar year concerned, with respect to each CCA area (as defined in section 1860C–1(b)(1)(A)), the CCA non-drug monthly benchmark amount under section 1860C–1(e)(1) for that area for the year involved.".

(2) PREMIUM ADJUSTMENT.—

(A) Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following new subsection:

"(h) POTENTIAL APPLICATION OF COMPARATIVE COST ADJUSTMENT IN CCA AREAS.—

"(1) IN GENERAL.—Certain individuals who are residing in a CCA area under section 1860C–1 who are not enrolled in an MA plan under part C may be subject to a premium adjustment under subsection (f) of such section for months in which the CCA program under such section is in effect in such area.

"(2) NO EFFECT ON LATE ENROLLMENT PENALTY OR INCOME-RELATED ADJUSTMENT IN SUBSIDIES.—Nothing in this subsection or section 1860C–1(f) shall be construed as affecting the amount of any premium adjustment under subsection (b) or (i). Subsection (f) shall be applied without regard to any premium adjustment referred to in paragraph (1).

"(3) IMPLEMENTATION.—In order to carry out a premium adjustment under this subsection and section 1860C–1(f) (insofar as it is effected through the manner of collection of premiums under section 1840(a)), the Secretary shall transmit to the Commissioner of Social Security—

"(A) at the beginning of each year, the name, social security account number, and the amount of the premium adjustment (if any) for each individual enrolled under this part for each month during the year; and

"(B) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.".

(B) Section 1844(c) (42 U.S.C. 1395w(c)) is amended by inserting "and without regard to any premium adjustment effected under sections 1839(h) and 1860C–1(f)" before the period at the end.

(c) NO CHANGE IN MEDICARE'S DEFINED BENEFIT PACKAGE.—Nothing in this part (or the amendments made by this part) shall be construed as changing the entitlement to defined benefits under parts A and B of title XVIII of the Social Security Act.

TITLE III—COMBATTING WASTE, FRAUD, AND ABUSE

SEC. 301. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(1) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)"; and

(2) in subparagraph (B)—

(A) by redesignating clauses (i) through (v) as clauses (ii) through (vi), respectively; and

(B) by inserting before clause (ii), as so redesignated, the following new clause:

"(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.".

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)), as amended by subsection (a), is amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.";

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(A)—

(A) by striking the first sentence and inserting the following: "A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means."; and

(B) in the final sentence, by striking "on the date such notice or other information is received" and inserting "on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received"; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(A), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any

such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.”.

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking “such” before “paragraphs”.

(d) EFFECTIVE DATES.—The amendments made by this section shall be effective—

(1) in the case of subsection (a), as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98–369); and

(2) in the case of subsections (b) and (c), as if included in the enactment of section 953 of the Omnibus Reconciliation Act of 1980 (Public Law 96–499; 94 Stat. 2647).

SEC. 302. PAYMENT FOR DURABLE MEDICAL EQUIPMENT; COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES.

(a) QUALITY ENHANCEMENT AND FRAUD REDUCTION.—

(1) ESTABLISHMENT OF QUALITY STANDARDS AND ACCREDITATION REQUIREMENTS FOR DURABLE MEDICAL EQUIPMENT SUPPLIERS.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended—

(A) by transferring paragraph (17), as added by section 4551(c)(1) of the Balanced Budget Act of 1997 (111 Stat. 458), to the end of such section and redesignating such paragraph as paragraph (19); and

(B) by adding at the end the following new paragraph:

“(20) IDENTIFICATION OF QUALITY STANDARDS.—

“(A) IN GENERAL.—Subject to subparagraph (C), the Secretary shall establish and implement quality standards for suppliers of items and services described in subparagraph (D) to be applied by recognized independent accreditation organizations (as designated under subparagraph (B)) and with which such suppliers shall be required to comply in order to—

“(i) furnish any such item or service for which payment is made under this part; and

“(ii) receive or retain a provider or supplier number used to submit claims for reimbursement for any such item or service for which payment may be made under this title.

“(B) DESIGNATION OF INDEPENDENT ACCREDITATION ORGANIZATIONS.—Not later than the date that is 1 year after the date on which the Secretary implements the quality standards under subparagraph (A), notwithstanding section 1865(b), the Secretary shall designate and approve one or more independent accreditation organizations for purposes of such subparagraph.

“(C) QUALITY STANDARDS.—The quality standards described in subparagraph (A) may not be less stringent than the quality standards that would otherwise apply if this paragraph did not apply and shall include consumer services standards.

“(D) ITEMS AND SERVICES DESCRIBED.—The items and services described in this subparagraph are the following items and services, as the Secretary determines appropriate:

“(i) Covered items (as defined in paragraph (13)) for which payment may otherwise be made under this subsection.

“(ii) Prosthetic devices and orthotics and prosthetics described in section 1834(h)(4).

“(iii) Items and services described in section 1842(s)(2).

“(E) IMPLEMENTATION.—The Secretary may establish by program instruction or otherwise the quality standards under this paragraph, after consultation with representatives of relevant parties. Such standards shall be applied prospectively and shall be published on the Internet website of the Centers for Medicare & Medicaid Services.”.

(2) ESTABLISHMENT OF CLINICAL CONDITIONS OF COVERAGE STANDARDS FOR ITEMS OF DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(1) (42 U.S.C. 1395m(a)(1)) is amended by adding at the end the following new subparagraph:

“(E) CLINICAL CONDITIONS FOR COVERAGE.—

“(i) IN GENERAL.—The Secretary shall establish standards for clinical conditions for payment for covered items under this subsection.

“(ii) REQUIREMENTS.—The standards established under clause (i) shall include the specification of types or classes of covered items that require, as a condition of payment under this subsection, a face-to-face examination of the individual by a physician (as defined in section 1861(r)(1)), a physician assistant, nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) and a prescription for the item.

“(iii) PRIORITY OF ESTABLISHMENT OF STANDARDS.—In establishing the standards under this subparagraph, the Secretary shall first establish standards for those covered items for which the Secretary determines there has been a proliferation of use, consistent findings of charges for covered items that are not delivered, or consistent findings of falsification of documentation to provide for payment of such covered items under this part.

“(iv) STANDARDS FOR POWER WHEELCHAIRS.—Effective on the date of the enactment of this subparagraph, in the case of a covered item consisting of a motorized or power wheelchair for an individual, payment may not be made for such covered item unless a physician (as defined in section 1861(r)(1)), a physician assistant, nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) has conducted a face-to-face examination of the individual and written a prescription for the item.

“(v) LIMITATION ON PAYMENT FOR COVERED ITEMS.—Payment may not be made for a covered item under this subsection unless the item meets any standards established under this subparagraph for clinical condition of coverage.”.

(b) COMPETITIVE ACQUISITION.—

(1) IN GENERAL.—Section 1847 (42 U.S.C. 1395w–3) is amended to read as follows:

“COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES

“SEC. 1847. (a) ESTABLISHMENT OF COMPETITIVE ACQUISITION PROGRAMS.—

“(1) IMPLEMENTATION OF PROGRAMS.—

“(A) IN GENERAL.—The Secretary shall establish and implement programs under which competitive acquisition areas are established throughout the United States for contract award purposes for the furnishing under this part of competitively priced items and services (described in paragraph (2)) for which payment is made under this part. Such areas may differ for different items and services.

“(B) PHASED-IN IMPLEMENTATION.—The programs—

“(i) shall be phased in among competitive acquisition areas in a manner so that the competition under the programs occurs in—

“(I) 10 of the largest metropolitan statistical areas in 2007;

“(II) 80 of the largest metropolitan statistical areas in 2009; and

“(III) additional areas after 2009; and

“(ii) may be phased in first among the highest cost and highest volume items and services or those items and services that the Secretary determines have the largest savings potential.

“(C) WAIVER OF CERTAIN PROVISIONS.—In carrying out the programs, the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

“(2) ITEMS AND SERVICES DESCRIBED.—The items and services referred to in paragraph (1) are the following:

“(A) DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES.—Covered items (as defined in section 1834(a)(13)) for which payment would otherwise be made under section 1834(a), including items used in infusion and drugs (other than inhalation drugs) and supplies used in conjunction with durable medical equipment, but excluding class III devices under the Federal Food, Drug, and Cosmetic Act.

“(B) OTHER EQUIPMENT AND SUPPLIES.—Items and services described in section 1842(s)(2)(D), other than parenteral nutrients, equipment, and supplies.

“(C) OFF-THE-SHELF ORTHOTICS.—Orthotics described in section 1861(s)(9) for which payment would otherwise be made under section 1834(h) which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit to the individual.

“(3) EXCEPTION AUTHORITY.—In carrying out the programs under this section, the Secretary may exempt—

“(A) rural areas and areas with low population density within urban areas that are not competitive,, unless there is a significant national market through mail order for a particular item or service; and

“(B) items and services for which the application of competitive acquisition is not likely to result in significant savings.

“(4) SPECIAL RULE FOR CERTAIN RENTED ITEMS OF DURABLE MEDICAL EQUIPMENT AND OXYGEN.—In the case of a covered item for which payment is made on a rental basis under section 1834(a) and in the case of payment for oxygen under section 1834(a)(5), the Secretary shall establish a process by which rental agreements for the covered items and supply arrangements with oxygen suppliers entered into before the application of the competitive acquisition program under this section for the item may be continued notwithstanding this section. In the case of any such continuation, the supplier involved shall provide for appropriate servicing and replacement, as required under section 1834(a).

“(5) PHYSICIAN AUTHORIZATION.—

“(A) IN GENERAL.—With respect to items or services included within a particular HCPCS code, the Secretary may establish a process for certain items and services under which a physician may prescribe a particular brand or mode of delivery of an item or service within such code if the physician determines that use of the particular item or service would avoid an adverse medical outcome on the individual, as determined by the Secretary.

“(B) NO EFFECT ON PAYMENT AMOUNT.—A prescription under subparagraph (A) shall not affect the amount of payment otherwise applicable for the item or service under the code involved.

“(6) APPLICATION.—For each competitive acquisition area in which the program is implemented under this subsection with respect to items and services, the payment basis determined under the competition conducted under subsection (b) shall be substituted for the payment basis otherwise applied under section 1834(a), section 1834(h), or section 1842(s), as appropriate.

“(b) PROGRAM REQUIREMENTS.—

“(1) IN GENERAL.—The Secretary shall conduct a competition among entities supplying items and services described in subsection (a)(2) for each competitive acquisition area in which the program is implemented under subsection (a) with respect to such items and services.

''(2) CONDITIONS FOR AWARDING CONTRACT.—

''(A) IN GENERAL.—The Secretary may not award a contract to any entity under the competition conducted in an competitive acquisition area pursuant to paragraph (1) to furnish such items or services unless the Secretary finds all of the following:

''(i) The entity meets applicable quality standards specified by the Secretary under section 1834(a)(20).

''(ii) The entity meets applicable financial standards specified by the Secretary, taking into account the needs of small providers.

''(iii) The total amounts to be paid to contractors in a competitive acquisition area are expected to be less than the total amounts that would otherwise be paid.

''(iv) Access of individuals to a choice of multiple suppliers in the area is maintained.

''(B) TIMELY IMPLEMENTATION OF PROGRAM.—Any delay in the implementation of quality standards under section 1834(a)(20) or delay in the receipt of advice from the program oversight committee established under subsection (c) shall not delay the implementation of the competitive acquisition program under this section.

''(3) CONTENTS OF CONTRACT.—

''(A) IN GENERAL.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

''(B) TERM OF CONTRACTS.—The Secretary shall recompete contracts under this section not less often than once every 3 years.

''(4) LIMIT ON NUMBER OF CONTRACTORS.—

''(A) IN GENERAL.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts. In awarding contracts, the Secretary shall take into account the ability of bidding entities to furnish items or services in sufficient quantities to meet the anticipated needs of individuals for such items or services in the geographic area covered under the contract on a timely basis.

''(B) MULTIPLE WINNERS.—The Secretary shall award contracts to multiple entities submitting bids in each area for an item or service.

''(5) PAYMENT.—

''(A) IN GENERAL.—Payment under this part for competitively priced items and services described in subsection (a)(2) shall be based on bids submitted and accepted under this section for such items and services. Based on such bids the Secretary shall determine a single payment amount for each item or service in each competitive acquisition area.

''(B) REDUCED BENEFICIARY COST-SHARING.—

''(i) APPLICATION OF COINSURANCE.—Payment under this section for items and services shall be in an amount equal to 80 percent of the payment basis described in subparagraph (A).

''(ii) APPLICATION OF DEDUCTIBLE.—Before applying clause (i), the individual shall be required to meet the deductible described in section 1833(b).

''(C) PAYMENT ON ASSIGNMENT-RELATED BASIS.—Payment for any item or service furnished by the entity may only be made under this section on an assignment-related basis.

''(D) CONSTRUCTION.—Nothing in this section shall be construed as precluding the use of an advanced beneficiary notice with respect to a competitively priced item and service.

''(6) PARTICIPATING CONTRACTORS.—

''(A) IN GENERAL.—Except as provided in subsection (a)(4), payment shall not be made for items and services described in subsection (a)(2) furnished by a contractor and for which competition is conducted under this section unless—

''(i) the contractor has submitted a bid for such items and services under this section; and

''(ii) the Secretary has awarded a contract to the contractor for such items and services under this section.

''(B) BID DEFINED.—In this section, the term 'bid' means an offer to furnish an item or service for a particular price and time period that includes, where appropriate, any services that are attendant to the furnishing of the item or service.

''(C) RULES FOR MERGERS AND ACQUISITIONS.—In applying subparagraph (A) to a contractor, the contractor shall include a successor entity in the case of a merger or acquisition, if the successor entity assumes such contract along with any liabilities that may have occurred thereunder.

''(D) PROTECTION OF SMALL SUPPLIERS.—In developing procedures relating to bids and the awarding of contracts under this section, the Secretary shall take appropriate steps to ensure that small suppliers of items and services have an opportunity to be considered for participation in the program under this section.

''(7) CONSIDERATION IN DETERMINING CATEGORIES FOR BIDS.—The Secretary may consider the clinical efficiency and value of specific items within codes, including whether some items have a greater therapeutic advantage to individuals.

''(8) AUTHORITY TO CONTRACT FOR EDUCATION, MONITORING, OUTREACH, AND COMPLAINT SERVICES.—The Secretary may enter into contracts with appropriate entities to address complaints from individuals who receive items and services from an entity with a contract under this section and to conduct appropriate education of and outreach to such individuals and monitoring quality of services with respect to the program.

''(9) AUTHORITY TO CONTRACT FOR IMPLEMENTATION.—The Secretary may contract with appropriate entities to implement the competitive bidding program under this section.

''(10) NO ADMINISTRATIVE OR JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

''(A) the establishment of payment amounts under paragraph (5);

''(B) the awarding of contracts under this section;

''(C) the designation of competitive acquisition areas under subsection (a)(1)(A);

''(D) the phased-in implementation under subsection (a)(1)(B);

''(E) the selection of items and services for competitive acquisition under subsection (a)(2); or

''(F) the bidding structure and number of contractors selected under this section.

''(c) PROGRAM ADVISORY AND OVERSIGHT COMMITTEE.—

''(1) ESTABLISHMENT.—The Secretary shall establish a Program Advisory and Oversight Committee (hereinafter in this section referred to as the 'Committee').

''(2) MEMBERSHIP; TERMS.—The Committee shall consist of such members as the Secretary may appoint who shall serve for such term as the Secretary may specify.

''(3) DUTIES.—

''(A) ADVICE.—The Committee shall provide advice to the Secretary with respect to the following functions:

''(i) The implementation of the program under this section.

''(ii) The establishment of financial standards for purposes of subsection (b)(2)(A)(ii).

''(iii) The establishment of requirements for collection of data for the efficient management of the program.

''(iv) The development of proposals for efficient interaction among manufacturers, providers of services, suppliers (as defined in section 1861(d)), and individuals.

''(v) The establishment of quality standards under section 1834(a)(20).

''(B) ADDITIONAL DUTIES.—The Committee shall perform such additional functions to assist the Secretary in carrying out this section as the Secretary may specify.

''(4) INAPPLICABILITY OF FACA.—The provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply.

''(5) TERMINATION.—The Committee shall terminate on December 31, 2009.

''(d) REPORT.—Not later than July 1, 2009, the Secretary shall submit to Congress a report on the programs under this section. The report shall include information on savings, reductions in cost-sharing, access to and quality of items and services, and satisfaction of individuals.

''(e) DEMONSTRATION PROJECT FOR CLINICAL LABORATORY SERVICES.—

''(1) IN GENERAL.—The Secretary shall conduct a demonstration project on the application of competitive acquisition under this section to clinical diagnostic laboratory tests—

''(A) for which payment would otherwise be made under section 1833(h) (other than for pap smear laboratory tests under paragraph (7) of such section) or section 1834(d)(1) (relating to colorectal cancer screening tests); and

''(B) which are furnished by entities that did not have a face-to-face encounter with the individual.

''(2) TERMS AND CONDITIONS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), such project shall be under the same conditions as are applicable to items and services described in subsection (a)(2), excluding subsection (b)(5)(B) and other conditions as the Secretary determines to be appropriate.

''(B) APPLICATION OF CLIA QUALITY STANDARDS.—The quality standards established by the Secretary under section 353 of the Public Health Service Act for clinical diagnostic laboratory tests shall apply to such tests under the demonstration project under this section in lieu of quality standards described in subsection (b)(2)(A)(i).

''(3) REPORT.—The Secretary shall submit to Congress—

''(A) an initial report on the project not later than December 31, 2005; and

''(B) such progress and final reports on the project after such date as the Secretary determines appropriate.''.

(2) CONFORMING AMENDMENTS.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking ''and (U)'' and inserting ''(U)'';

(B) by inserting before the semicolon at the end the following: '', and (V) notwithstanding subparagraphs (I) (relating to durable medical equipment), (M) (relating to prosthetic devices and orthotics and prosthetics), and (Q) (relating to 1842(s) items), with respect to competitively priced items and services (described in section 1847(a)(2)) that are furnished in a competitive area, the amounts paid shall be the amounts described in section 1847(b)(5)''; and

(C) in clause (D)—

(i) by striking ''or (ii)'' and inserting ''(ii)''; and

(ii) by adding at the end the following: ''or (iii) on the basis of a rate established under a demonstration project under section 1847(e), the amount paid shall be equal to 100 percent of such rate,''.

(3) GAO REPORT ON IMPACT OF COMPETITIVE ACQUISITION ON SUPPLIERS.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study on the impact of competitive acquisition of durable medical equipment under section 1847 of the Social Security Act, as amended by paragraph (1), on suppliers and manufacturers of such equipment and on patients. Such study shall specifically examine the impact of such competitive acquisition on access to, and quality of, such equipment and service related to such equipment.

(B) REPORT.—Not later than January 1, 2009, the Comptroller General shall submit to Congress a report on the study conducted under subparagraph (A) and shall include in the report such recommendations as the Comptroller General determines appropriate.

(c) TRANSITIONAL FREEZE.—

(1) DME.—

(A) IN GENERAL.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

(i) in subparagraph (E), by striking "and" at the end;

(ii) in subparagraph (F)—

(I) by striking "a subsequent year" and inserting "2003"; and

(II) by striking "the previous year." and inserting "2002;"; and

(iii) by adding at the end the following new subparagraphs:

"(G) for 2004 through 2006—

"(i) subject to clause (ii), in the case of class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(c)(1)(C)), the percentage increase described in subparagraph (B) for the year involved; and

"(ii) in the case of covered items not described in clause (i), 0 percentage points;

"(H) for 2007—

"(i) subject to clause (ii), in the case of class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(c)(1)(C)), the percentage change determined by the Secretary to be appropriate taking into account recommendations contained in the report of the Comptroller General of the United States under section 302(c)(1)(B) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003; and

"(ii) in the case of covered items not described in clause (i), 0 percentage points; and

"(I) for 2008—

"(i) subject to clause (ii), in the case of class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(c)(1)(C)), the percentage increase described in subparagraph (B) (as applied to the payment amount for 2007 determined after the application of the percentage change under subparagraph (H)(i)); and

"(ii) in the case of covered items not described in clause (i), 0 percentage points; and

"(J) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.".

(B) GAO REPORT ON CLASS III MEDICAL DEVICES.—Not later than March 1, 2006, the Comptroller General of the United States shall submit to Congress, and transmit to the Secretary, a report containing recommendations on the appropriate update percentage under section 1834(a)(14) of the Social Security Act (42 U.S.C. 1395m(a)(14)) for class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(a)(1)(C)) furnished to medicare beneficiaries during 2007 and 2008.

(2) PAYMENT RULE FOR SPECIFIED ITEMS.—Section 1834(a) (42 U.S.C. 1395m(a)), as amended by subsection (a), is further amended by adding at the end the following new paragraph:

"(21) SPECIAL PAYMENT RULE FOR SPECIFIED ITEMS AND SUPPLIES.—

"(A) IN GENERAL.—Notwithstanding the preceding provisions of this subsection, for specified items and supplies (described in subparagraph (B)) furnished during 2005, the payment amount otherwise determined under this subsection for such specified items and supplies shall be reduced by the percentage difference between—

"(i) the amount of payment otherwise determined for the specified item or supply under this subsection for 2002, and

"(ii) the amount of payment for the specified item or supply under chapter 89 of title 5, United States Code, as identified in the column entitled 'Median FEHP Price' in the table entitled 'SUMMARY OF MEDICARE PRICES COMPARED TO VA, MEDICAID, RETAIL, AND FEHP PRICES FOR 16 ITEMS' included in the Testimony of the Inspector General before the Senate Committee on Appropriations, June 12, 2002, or any subsequent report by the Inspector General.

"(B) SPECIFIED ITEM OR SUPPLY DESCRIBED.—For purposes of subparagraph (A), a specified item or supply means oxygen and oxygen equipment, standard wheelchairs (including standard power wheelchairs), nebulizers, diabetic supplies consisting of lancets and testing strips, hospital beds, and air mattresses, but only if the HCPCS code for the item or supply is identified in a table referred to in subparagraph (A)(ii).

"(C) APPLICATION OF UPDATE TO SPECIAL PAYMENT AMOUNT.—The covered item update under paragraph (14) for specified items and supplies for 2006 and each subsequent year shall be applied to the payment amount under subparagraph (A) unless payment is made for such items and supplies under section 1847.".

(3) PROSTHETIC DEVICES AND ORTHOTICS AND PROSTHETICS.—Section 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A)) is amended—

(A) in clause (vii), by striking "and" at the end;

(B) in clause (viii), by striking "a subsequent year" and inserting "2003"; and

(C) by adding at the end the following new clauses:

"(ix) for 2004, 2005, and 2006, 0 percent; and

"(x) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;".

(d) CONFORMING AMENDMENTS.—

(1) DURABLE MEDICAL EQUIPMENT; LIMITATION OF INHERENT REASONABLENESS AUTHORITY.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended—

(A) in paragraph (1)(B), by striking "The payment basis" and inserting "Subject to subparagraph (F)(i), the payment basis";

(B) in paragraph (1)(C), by striking "This subsection" and inserting "Subject to subparagraph (F)(ii), this subsection";

(C) by adding at the end of paragraph (1) the following new subparagraph:

"(F) APPLICATION OF COMPETITIVE ACQUISITION; LIMITATION OF INHERENT REASONABLENESS AUTHORITY.—In the case of covered items furnished on or after January 1, 2009, that are included in a competitive acquisition program in a competitive acquisition area under section 1847(a)—

"(i) the payment basis under this subsection for such items and services furnished in such area shall be the payment basis determined under such competitive acquisition program; and

"(ii) the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1847 and in the case of such adjustment, paragraph (10)(B) shall not be applied."; and

(D) in paragraph (10)(B), by inserting "in an area and with respect to covered items and services for which the Secretary does not make a payment amount adjustment under paragraph (1)(F)" after "under this subsection".

(2) OFF-THE-SHELF ORTHOTICS; LIMITATION OF INHERENT REASONABLENESS AUTHORITY.—Section 1834(h) (42 U.S.C. 1395m(h)) is amended—

(A) in paragraph (1)(B), by striking "and (E)" and inserting ", (E), and (H)(i)";

(B) in paragraph (1)(D), by striking "This subsection" and inserting "Subject to subparagraph (H)(ii), this subsection"; and

(C) by adding at the end of paragraph (1) the following new subparagraph:

"(H) APPLICATION OF COMPETITIVE ACQUISITION TO ORTHOTICS; LIMITATION OF INHERENT REASONABLENESS AUTHORITY.—In the case of orthotics described in paragraph (2)(C) of section 1847(a) furnished on or after January 1, 2009, that are included in a competitive acquisition program in a competitive acquisition area under such section—

"(i) the payment basis under this subsection for such orthotics furnished in such area shall be the payment basis determined under such competitive acquisition program; and

"(ii) the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1847, and in the case of such adjustment, paragraphs (8) and (9) of section 1842(b) shall not be applied.".

(3) OTHER ITEMS AND SERVICES; LIMITATION OF INHERENT REASONABLENESS AUTHORITY.—Section 1842(s) (42 U.S.C. 1395u(s)) is amended—

(A) in the first sentence of paragraph (1), by striking "The Secretary" and inserting "Subject to paragraph (3), the Secretary"; and

(B) by adding at the end the following new paragraph:

"(3) In the case of items and services described in paragraph (2)(D) that are included in a competitive acquisition program in a competitive acquisition area under section 1847(a)—

"(A) the payment basis under this subsection for such items and services furnished in such area shall be the payment basis determined under such competitive acquisition program; and

"(B) the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise applicable under paragraph (1) for an area that is not a competitive acquisition area under section 1847, and in the case of such adjustment, paragraphs (8) and (9) of section 1842(b) shall not be applied.".

(e) REPORT ON ACTIVITIES OF SUPPLIERS.—The Inspector General of the Department of Health and Human Services shall conduct a study to determine the extent to which (if any) suppliers of covered items of durable medical equipment that are subject to the competitive acquisition program under section 1847 of the Social Security Act, as amended by subsection (a), are soliciting physicians to prescribe certain brands or modes of delivery of covered items based on profitability. Not later than July 1, 2009, the Inspector General shall submit to Congress a report on such study.

SEC. 303. PAYMENT REFORM FOR COVERED OUTPATIENT DRUGS AND BIOLOGICALS.

(a) ADJUSTMENT TO PHYSICIAN FEE SCHEDULE.—

(1) ADJUSTMENT IN PRACTICE EXPENSE RELATIVE VALUE UNITS.—Section 1848(c)(2) (42 U.S.C. 1395w–4(c)(2)) is amended—

(A) in subparagraph (B)—

(i) in clause (ii)(II), by striking "The adjustments" and inserting "Subject to clause (iv), the adjustments"; and

(ii) by adding at the end of subparagraph (B), the following new clause:

"(iv) EXEMPTION FROM BUDGET NEUTRALITY.—The additional expenditures attributable to—

"(I) subparagraph (H) shall not be taken into account in applying clause (ii)(II) for 2004;

"(II) subparagraph (I) insofar as it relates to a physician fee schedule for 2005 or 2006 shall not be taken into account in applying clause (ii)(II) for drug administration services under

the fee schedule for such year for a specialty described in subparagraph (I)(ii)(II); and

"(III) subparagraph (J) insofar as it relates to a physician fee schedule for 2005 or 2006 shall not be taken into account in applying clause (ii)(II) for drug administration services under the fee schedule for such year."; and

(B) by adding at the end the following new subparagraphs:

"(H) ADJUSTMENTS IN PRACTICE EXPENSE RELATIVE VALUE UNITS FOR CERTAIN DRUG ADMINISTRATION SERVICES BEGINNING IN 2004.—

"(i) USE OF SURVEY DATA.—In establishing the physician fee schedule under subsection (b) with respect to payments for services furnished on or after January 1, 2004, the Secretary shall, in determining practice expense relative value units under this subsection, utilize a survey submitted to the Secretary as of January 1, 2003, by a physician specialty organization pursuant to section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 if the survey—

"(I) covers practice expenses for oncology drug administration services; and

"(II) meets criteria established by the Secretary for acceptance of such surveys.

"(ii) PRICING OF CLINICAL ONCOLOGY NURSES IN PRACTICE EXPENSE METHODOLOGY.—If the survey described in clause (i) includes data on wages, salaries, and compensation of clinical oncology nurses, the Secretary shall utilize such data in the methodology for determining practice expense relative value units under subsection (c).

"(iii) WORK RELATIVE VALUE UNITS FOR CERTAIN DRUG ADMINISTRATION SERVICES.—In establishing the relative value units under this paragraph for drug administration services described in clause (iv) furnished on or after January 1, 2004, the Secretary shall establish work relative value units equal to the work relative value units for a level 1 office medical visit for an established patient.

"(iv) DRUG ADMINISTRATION SERVICES DESCRIBED.—The drug administration services described in this clause are physicians' services—

"(I) which are classified as of October 1, 2003, within any of the following groups of procedures: therapeutic or diagnostic infusions (excluding chemotherapy); chemotherapy administration services; and therapeutic, prophylactic, or diagnostic injections;

"(II) for which there are no work relative value units assigned under this subsection as of such date; and

"(III) for which national relative value units have been assigned under this subsection as of such date.

"(I) ADJUSTMENTS IN PRACTICE EXPENSE RELATIVE VALUE UNITS FOR CERTAIN DRUG ADMINISTRATION SERVICES BEGINNING WITH 2005.—

"(i) IN GENERAL.—In establishing the physician fee schedule under subsection (b) with respect to payments for services furnished on or after January 1, 2005 or 2006, the Secretary shall adjust the practice expense relative value units for such year consistent with clause (ii).

"(ii) USE OF SUPPLEMENTAL SURVEY DATA.—

"(I) IN GENERAL.—Subject to subclause (II), if a specialty submits to the Secretary by not later than March 1, 2004, for 2005, or March 1, 2005, for 2006, data that includes expenses for the administration of drugs and biologicals for which the payment amount is determined pursuant to section 1842(o), the Secretary shall use such supplemental survey data in carrying out this subparagraph for the years involved insofar as they are collected and provided by entities and organizations consistent with the criteria established by the Secretary pursuant to section 212(a) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

"(II) LIMITATION ON SPECIALTY.—Subclause (I) shall apply to a specialty only insofar as not less than 40 percent of payments for the specialty under this title in 2002 are attributable to the administration of drugs and biologicals, as determined by the Secretary.

"(III) APPLICATION.—This clause shall not apply with respect to a survey to which subparagraph (H)(i) applies.

"(J) PROVISIONS FOR APPROPRIATE REPORTING AND BILLING FOR PHYSICIANS' SERVICES ASSOCIATED WITH THE ADMINISTRATION OF COVERED OUTPATIENT DRUGS AND BIOLOGICALS.—

"(i) EVALUATION OF CODES.—The Secretary shall promptly evaluate existing drug administration codes for physicians' services to ensure accurate reporting and billing for such services, taking into account levels of complexity of the administration and resource consumption.

"(ii) USE OF EXISTING PROCESSES.—In carrying out clause (i), the Secretary shall use existing processes for the consideration of coding changes and, to the extent coding changes are made, shall use such processes in establishing relative values for such services.

"(iii) IMPLEMENTATION.—In carrying out clause (i), the Secretary shall consult with representatives of physician specialties affected by the implementation of section 1847A or section 1847B, and shall take such steps within the Secretary's authority to expedite such considerations under clause (ii).

"(iv) SUBSEQUENT, BUDGET NEUTRAL ADJUSTMENTS PERMITTED.—Nothing in subparagraph (H) or (I) or this subparagraph shall be construed as preventing the Secretary from providing for adjustments in practice expense relative value units under (and consistent with) subparagraph (B) for years after 2004, 2005, or 2006, respectively.".

(2) TREATMENT OF OTHER SERVICES CURRENTLY IN THE NONPHYSICIAN WORK POOL.—The Secretary shall make adjustments to the nonphysician work pool methodology (as such term is used in the final rule promulgated by the Secretary in the Federal Register on December 31, 2002 (67 Fed. Reg. 251)), for the determination of practice expense relative value units under the physician fee schedule under section 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)(ii)), so that the practice expense relative value units for services determined under such methodology are not affected relative to the practice expense relative value units of services not determined under such methodology, as a result of the amendments made by paragraph (1).

(3) PAYMENT FOR MULTIPLE CHEMOTHERAPY AGENTS FURNISHED ON A SINGLE DAY THROUGH THE PUSH TECHNIQUE.—

(A) REVIEW OF POLICY.—The Secretary shall review the policy, as in effect on October 1, 2003, with respect to payment under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for the administration of more than 1 drug or biological to an individual on a single day through the push technique.

(B) MODIFICATION OF POLICY.—After conducting the review under subparagraph (A), the Secretary shall modify such payment policy as the Secretary determines to be appropriate.

(C) EXEMPTION FROM BUDGET NEUTRALITY UNDER PHYSICIAN FEE SCHEDULE.—If the Secretary modifies such payment policy pursuant to subparagraph (B), any increased expenditures under title XVIII of the Social Security Act resulting from such modification shall be treated as additional expenditures attributable to subparagraph (H) of section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as added by paragraph (1)(B), for purposes of applying the exemption to budget neutrality under subparagraph (B)(iv) of such section, as added by paragraph (1)(A).

(4) TRANSITIONAL ADJUSTMENT.—

(A) IN GENERAL.—In order to provide for a transition during 2004 and 2005 to the payment system established under the amendments made by this section, in the case of physicians' services consisting of drug administration services described in subparagraph (H)(iv) of section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as added by paragraph (1)(B), furnished on or after January 1, 2004, and before January 1, 2006, in addition to the amount determined under the fee schedule under section 1848(b) of such Act (42 U.S.C. 1395w–4(b)) there also shall be paid to the physician from the Federal Supplementary Medical Insurance Trust Fund an amount equal to the applicable percentage specified in subparagraph (B) of such fee schedule amount for the services so determined.

(B) APPLICABLE PERCENTAGE.—The applicable percentage specified in this subparagraph for services furnished—

(i) during 2004, is 32 percent; and

(ii) during 2005, is 3 percent.

(5) MEDPAC REVIEW AND REPORTS; SECRETARIAL RESPONSE.—

(A) REVIEW.—The Medicare Payment Advisory Commission shall review the payment changes made under this section insofar as they affect payment under part B of title XVIII of the Social Security Act—

(i) for items and services furnished by oncologists; and

(ii) for drug administration services furnished by other specialists.

(B) OTHER MATTERS STUDIED.—In conducting the review under subparagraph (A), the Commission shall also review such changes as they affect—

(i) the quality of care furnished to individuals enrolled under part B and the satisfaction of such individuals with that care;

(ii) the adequacy of reimbursement as applied in, and the availability in, different geographic areas and to different physician practice sizes; and

(iii) the impact on physician practices.

(C) REPORTS.—The Commission shall submit to the Secretary and Congress—

(i) not later than January 1, 2006, a report on the review conducted under subparagraph (A)(i); and

(ii) not later than January 1, 2007, a report on the review conducted under subparagraph (A)(ii).

Each such report may include such recommendations regarding further adjustments in such payments as the Commission deems appropriate.

(D) SECRETARIAL RESPONSE.—As part of the rulemaking with respect to payment for physicians services under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for 2007, the Secretary may make appropriate adjustments to payment for items and services described in subparagraph (A)(i), taking into account the report submitted under such subparagraph (C)(i).

(b) APPLICATION OF MARKET-BASED PAYMENT SYSTEMS.—Section 1842(o) (42 U.S.C. 1395u(o)) is amended—

(1) in paragraph (1), by striking "equal to 95 percent of the average wholesale price." and inserting "equal to the following:

"(A) In the case of any of the following drugs or biologicals, 95 percent of the average wholesale price:

"(i) A drug or biological furnished before January 1, 2004.

"(ii) Blood clotting factors furnished during 2004.

"(iii) A drug or biological furnished during 2004 that was not available for payment under this part as of April 1, 2003.

"(iv) A vaccine described in subparagraph (A) or (B) of section 1861(s)(10) furnished on or after January 1, 2004.

"(v) A drug or biological furnished during 2004 in connection with the furnishing of renal

dialysis services if separately billed by renal dialysis facilities.

"(B) In the case of a drug or biological furnished during 2004 that is not described in—

"(i) clause (ii), (iii), (iv), or (v) of subparagraph (A),

"(ii) subparagraph (D)(i), or

"(iii) subparagraph (F),

the amount determined under paragraph (4).

"(C) In the case of a drug or biological that is not described in subparagraph (A)(iv), (D)(i), or (F) furnished on or after January 1, 2005, the amount provided under section 1847, section 1847A, section 1847B, or section 1881(b)(13), as the case may be for the drug or biological.

"(D)(i) Except as provided in clause (ii), in the case of infusion drugs furnished through an item of durable medical equipment covered under section 1861(n) on or after January 1, 2004, 95 percent of the average wholesale price for such drug in effect on October 1, 2003.

"(ii) In the case of such infusion drugs furnished in a competitive acquisition area under section 1847 on or after January 1, 2007, the amount provided under section 1847.

"(E) In the case of a drug or biological, consisting of intravenous immune globulin, furnished—

"(i) in 2004, the amount of payment provided under paragraph (4); and

"(ii) in 2005 and subsequent years, the amount of payment provided under section 1847A.

"(F) In the case of blood and blood products (other than blood clotting factors), the amount of payment shall be determined in the same manner as such amount of payment was determined on October 1, 2003.

"(G) The provisions of subparagraphs (A) through (F) of this paragraph shall not apply to an inhalation drug or biological furnished through durable medical equipment covered under section 1861(n)."; and

(2) by adding at the end the following new paragraph:

"(4)(A) Subject to the succeeding provisions of this paragraph, the amount of payment for a drug or biological under this paragraph furnished in 2004 is equal to 85 percent of the average wholesale price (determined as of April 1, 2003) for the drug or biological.

"(B) The Secretary shall substitute for the percentage under subparagraph (A) for a drug or biological the percentage that would apply to the drug or biological under the column entitled 'Average of GAO and OIG data (percent)' in the table entitled 'Table 3.—Medicare Part B Drugs in the Most Recent GAO and OIG Studies' published on August 20, 2003, in the Federal Register (68 Fed. Reg. 50445).

"(C)(i) The Secretary may substitute for the percentage under subparagraph (A) a percentage that is based on data and information submitted by the manufacturer of the drug or biological by October 15, 2003.

"(ii) The Secretary may substitute for the percentage under subparagraph (A) with respect to drugs and biologicals furnished during 2004 on or after April 1, 2004, a percentage that is based on data and information submitted by the manufacturer of the drug or biological after October 15, 2003, and before January 1, 2004.

"(D) In no case may the percentage substituted under subparagraph (B) or (C) be less than 80 percent.".

(c) APPLICATION OF AVERAGE SALES PRICE METHODS BEGINNING IN 2005.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1847 (42 U.S.C. 1395w–3), as amended by section 302(b), the following new section:

"USE OF AVERAGE SALES PRICE PAYMENT METHODOLOGY

"SEC. 1847A. (a) APPLICATION.—

"(1) IN GENERAL.—Except as provided in paragraph (2), this section shall apply to payment for drugs and biologicals that are described in section 1842(o)(1)(C) and that are furnished on or after January 1, 2005.

"(2) ELECTION.—This section shall not apply in the case of a physician who elects under subsection (a)(1)(A)(ii) of section 1847B for that section to apply instead of this section for the payment for drugs and biologicals.

"(b) PAYMENT AMOUNT.—

"(1) IN GENERAL.—Subject to subsections (d)(3)(C) and (e), the amount of payment determined under this section for the billing and payment code for a drug or biological (based on a minimum dosage unit) is, subject to applicable deductible and coinsurance—

"(A) in the case of a multiple source drug (as defined in subsection (c)(6)(C)), 106 percent of the amount determined under paragraph (3); or

"(B) in the case of a single source drug or biological (as defined in subsection (c)(6)(D)), 106 percent of the amount determined under paragraph (4).

"(2) SPECIFICATION OF UNIT.—

"(A) SPECIFICATION BY MANUFACTURER.—The manufacturer of a drug or biological shall specify the unit associated with each National Drug Code (including package size) as part of the submission of data under section 1927(b)(3)(A)(iii).

"(B) UNIT DEFINED.—In this section, the term 'unit' means, with respect to each National Drug Code (including package size) associated with a drug or biological, the lowest identifiable quantity (such as a capsule or tablet, milligram of molecules, or grams) of the drug or biological that is dispensed, exclusive of any diluent without reference to volume measures pertaining to liquids. For years after 2004, the Secretary may establish the unit for a manufacturer to report and methods for counting units as the Secretary determines appropriate to implement this section.

"(3) MULTIPLE SOURCE DRUG.—For all drug products included within the same multiple source drug billing and payment code, the amount specified in this paragraph is the volume-weighted average of the average sales prices reported under section 1927(b)(3)(A)(iii) determined by—

"(A) computing the sum of the products (for each National Drug Code assigned to such drug products) of—

"(i) the manufacturer's average sales price (as defined in subsection (c)); and

"(ii) the total number of units specified under paragraph (2) sold; and

"(B) dividing the sum determined under subparagraph (A) by the sum of the total number of units under subparagraph (A)(ii) for all National Drug Codes assigned to such drug products.

"(4) SINGLE SOURCE DRUG OR BIOLOGICAL.—The amount specified in this paragraph for a single source drug or biological is the lesser of the following:

"(A) AVERAGE SALES PRICE.—The average sales price as determined using the methodology applied under paragraph (3) for all National Drug Codes assigned to such drug or biological product.

"(B) WHOLESALE ACQUISITION COST (WAC).—The wholesale acquisition cost (as defined in subsection (c)(6)(B)) using the methodology applied under paragraph (3) for all National Drug Codes assigned to such drug or biological product.

"(5) BASIS FOR PAYMENT AMOUNT.—The payment amount shall be determined under this subsection based on information reported under subsection (f) and without regard to any special packaging, labeling, or identifiers on the dosage form or product or package.

"(c) MANUFACTURER'S AVERAGE SALES PRICE.—

"(1) IN GENERAL.—For purposes of this section, subject to paragraphs (2) and (3), the manufacturer's 'average sales price' means, of a drug or biological for a National Drug Code for a calendar quarter for a manufacturer for a unit—

"(A) the manufacturer's sales to all purchasers (excluding sales exempted in paragraph (2)) in the United States for such drug or biological in the calendar quarter; divided by

"(B) the total number of such units of such drug or biological sold by the manufacturer in such quarter.

"(2) CERTAIN SALES EXEMPTED FROM COMPUTATION.—In calculating the manufacturer's average sales price under this subsection, the following sales shall be excluded:

"(A) SALES EXEMPT FROM BEST PRICE.—Sales exempt from the inclusion in the determination of 'best price' under section 1927(c)(1)(C)(i).

"(B) SALES AT NOMINAL CHARGE.—Such other sales as the Secretary identifies as sales to an entity that are merely nominal in amount (as applied for purposes of section 1927(c)(1)(C)(ii)(III), except as the Secretary may otherwise provide).

"(3) SALE PRICE NET OF DISCOUNTS.—In calculating the manufacturer's average sales price under this subsection, such price shall include volume discounts, prompt pay discounts, cash discounts, free goods that are contingent on any purchase requirement, chargebacks, and rebates (other than rebates under section 1927). For years after 2004, the Secretary may include in such price other price concessions, which may be based on recommendations of the Inspector General, that would result in a reduction of the cost to the purchaser.

"(4) PAYMENT METHODOLOGY IN CASES WHERE AVERAGE SALES PRICE DURING FIRST QUARTER OF SALES IS UNAVAILABLE.—In the case of a drug or biological during an initial period (not to exceed a full calendar quarter) in which data on the prices for sales for the drug or biological is not sufficiently available from the manufacturer to compute an average sales price for the drug or biological, the Secretary may determine the amount payable under this section for the drug or biological based on—

"(A) the wholesale acquisition cost; or

"(B) the methodologies in effect under this part on November 1, 2003, to determine payment amounts for drugs or biologicals.

"(5) FREQUENCY OF DETERMINATIONS.—

"(A) IN GENERAL ON A QUARTERLY BASIS.—The manufacturer's average sales price, for a drug or biological of a manufacturer, shall be calculated by such manufacturer under this subsection on a quarterly basis. In making such calculation insofar as there is a lag in the reporting of the information on rebates and chargebacks under paragraph (3) so that adequate data are not available on a timely basis, the manufacturer shall apply a methodology based on a 12-month rolling average for the manufacturer to estimate costs attributable to rebates and chargebacks. For years after 2004, the Secretary may establish a uniform methodology under this subparagraph to estimate and apply such costs.

"(B) UPDATES IN PAYMENT AMOUNTS.—The payment amounts under subsection (b) shall be updated by the Secretary on a quarterly basis and shall be applied based upon the manufacturer's average sales price calculated for the most recent calendar quarter for which data is available.

"(C) USE OF CONTRACTORS; IMPLEMENTATION.—The Secretary may contract with appropriate entities to calculate the payment amount under subsection (b). Notwithstanding any other provision of law, the Secretary may implement, by program instruction or otherwise, any of the provisions of this section.

"(6) DEFINITIONS AND OTHER RULES.—In this section:

"(A) MANUFACTURER.—The term 'manufacturer' means, with respect to a drug or biological, the manufacturer (as defined in section 1927(k)(5)).

"(B) WHOLESALE ACQUISITION COST.—The term 'wholesale acquisition cost' means, with respect to a drug or biological, the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.

"(C) MULTIPLE SOURCE DRUG.—

"(i) IN GENERAL.—The term 'multiple source drug' means, for a calendar quarter, a drug for which there are 2 or more drug products which—

"(I) are rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of 'Approved Drug Products with Therapeutic Equivalence Evaluations'),

"(II) except as provided in subparagraph (E), are pharmaceutically equivalent and bioequivalent, as determined under subparagraph (F) and as determined by the Food and Drug Administration, and

"(III) are sold or marketed in the United States during the quarter.

"(ii) EXCEPTION.—With respect to single source drugs or biologicals that are within the same billing and payment code as of October 1, 2003, the Secretary shall treat such single source drugs or biologicals as if the single source drugs or biologicals were multiple source drugs.

"(D) SINGLE SOURCE DRUG OR BIOLOGICAL.—The term 'single source drug or biological' means—

"(i) a biological; or

"(ii) a drug which is not a multiple source drug and which is produced or distributed under a new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application.

"(E) EXCEPTION FROM PHARMACEUTICAL EQUIVALENCE AND BIOEQUIVALENCE REQUIREMENT.—Subparagraph (C)(ii) shall not apply if the Food and Drug Administration changes by regulation the requirement that, for purposes of the publication described in subparagraph (C)(i), in order for drug products to be rated as therapeutically equivalent, they must be pharmaceutically equivalent and bioequivalent, as defined in subparagraph (F).

"(F) DETERMINATION OF PHARMACEUTICAL EQUIVALENCE AND BIOEQUIVALENCE.—For purposes of this paragraph—

"(i) drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity; and

"(ii) drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or, if they do present such a problem, they are shown to meet an appropriate standard of bioequivalence.

"(G) INCLUSION OF VACCINES.—In applying provisions of section 1927 under this section, 'other than a vaccine' is deemed deleted from section 1927(k)(2)(B).

"(d) MONITORING OF MARKET PRICES.—

"(1) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct studies, which may include surveys, to determine the widely available market prices of drugs and biologicals to which this section applies, as the Inspector General, in consultation with the Secretary, determines to be appropriate.

"(2) COMPARISON OF PRICES.—Based upon such studies and other data for drugs and biologicals, the Inspector General shall compare the average sales price under this section for drugs and biologicals with—

"(A) the widely available market price for such drugs and biologicals (if any); and

"(B) the average manufacturer price (as determined under section 1927(k)(1)) for such drugs and biologicals.

"(3) LIMITATION ON AVERAGE SALES PRICE.—

"(A) IN GENERAL.—The Secretary may disregard the average sales price for a drug or biological that exceeds the widely available market price or the average manufacturer price for such drug or biological by the applicable threshold percentage (as defined in subparagraph (B)).

"(B) APPLICABLE THRESHOLD PERCENTAGE DEFINED.—In this paragraph, the term 'applicable threshold percentage' means—

"(i) in 2005, in the case of an average sales price for a drug or biological that exceeds widely available market price or the average manufacturer price, 5 percent; and

"(ii) in 2006 and subsequent years, the percentage applied under this subparagraph subject to such adjustment as the Secretary may specify for the widely available market price or the average manufacturer price, or both.

"(C) AUTHORITY TO ADJUST AVERAGE SALES PRICE.—If the Inspector General finds that the average sales price for a drug or biological exceeds such widely available market price or average manufacturer price for such drug or biological by the applicable threshold percentage, the Inspector General shall inform the Secretary (at such times as the Secretary may specify to carry out this subparagraph) and the Secretary shall, effective as of the next quarter, substitute for the amount of payment otherwise determined under this section for such drug or biological the lesser of—

"(i) the widely available market price for the drug or biological (if any); or

"(ii) 103 percent of the average manufacturer price (as determined under section 1927(k)(1)) for the drug or biological.

"(4) CIVIL MONEY PENALTY.—

"(A) IN GENERAL.—If the Secretary determines that a manufacturer has made a misrepresentation in the reporting of the manufacturer's average sales price for a drug or biological, the Secretary may apply a civil money penalty in an amount of up to $10,000 for each such price misrepresentation and for each day in which such price misrepresentation was applied.

"(B) PROCEDURES.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under subparagraph (B) in the same manner as they apply to a penalty or proceeding under section 1128A(a).

"(5) WIDELY AVAILABLE MARKET PRICE.—

"(A) IN GENERAL.—In this subsection, the term 'widely available market price' means the price that a prudent physician or supplier would pay for the drug or biological. In determining such price, the Inspector General shall take into account the discounts, rebates, and other price concessions routinely made available to such prudent physicians or suppliers for such drugs or biologicals.

"(B) CONSIDERATIONS.—In determining the price under subparagraph (A), the Inspector General shall consider information from one or more of the following sources:

"(i) Manufacturers.

"(ii) Wholesalers.

"(iii) Distributors.

"(iv) Physician supply houses.

"(v) Specialty pharmacies.

"(vi) Group purchasing arrangements.

"(vii) Surveys of physicians.

"(viii) Surveys of suppliers.

"(ix) Information on such market prices from insurers.

"(x) Information on such market prices from private health plans.

"(e) AUTHORITY TO USE ALTERNATIVE PAYMENT IN RESPONSE TO PUBLIC HEALTH EMERGENCY.—In the case of a public health emergency under section 319 of the Public Health Service Act in which there is a documented inability to access drugs and biologicals, and a concomitant increase in the price, of a drug or biological which is not reflected in the manufacturer's average sales price for one or more quarters, the Secretary may use the wholesale acquisition cost (or other reasonable measure of drug or biological price) instead of the manufacturer's average sales price for such quarters and for subsequent quarters until the price and availability of the drug or biological has stabilized and is substantially reflected in the applicable manufacturer's average sales price.

"(f) QUARTERLY REPORT ON AVERAGE SALES PRICE.—For requirements for reporting the manufacturer's average sales price (and, if required to make payment, the manufacturer's wholesale acquisition cost) for the drug or biological under this section, see section 1927(b)(3).

"(g) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

"(1) determinations of payment amounts under this section, including the assignment of National Drug Codes to billing and payment codes;

"(2) the identification of units (and package size) under subsection (b)(2);

"(3) the method to allocate rebates, chargebacks, and other price concessions to a quarter if specified by the Secretary;

"(4) the manufacturer's average sales price when it is used for the determination of a payment amount under this section; and

"(5) the disclosure of the average manufacturer price by reason of an adjustment under subsection (d)(3)(C) or (e).".

(2) REPORT ON SALES TO PHARMACY BENEFIT MANAGERS.—

(A) STUDY.—The Secretary shall conduct a study on sales of drugs and biologicals to large volume purchasers, such as pharmacy benefit managers and health maintenance organizations, for purposes of determining whether the price at which such drugs and biologicals are sold to such purchasers does not represent the price such drugs and biologicals are made available for purchase to prudent physicians.

(B) REPORT.—Not later than January 1, 2006, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), and shall include recommendations on whether such sales to large volume purchasers should be excluded from the computation of a manufacturer's average sales price under section 1847A of the Social Security Act, as added by paragraph (1).

(3) INSPECTOR GENERAL REPORT ON ADEQUACY OF REIMBURSEMENT RATE UNDER AVERAGE SALES PRICE METHODOLOGY.—

(A) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study on the ability of physician practices in the specialties of hematology, hematology/oncology, and medical oncology of different sizes, especially particularly large practices, to obtain drugs and biologicals for the treatment of cancer patients at 106 percent of the average sales price for the drugs and biologicals. In conducting the study, the Inspector General shall conduct an audit of a representative sample of such practices to determine the adequacy of reimbursement under section 1847A of the Social Security Act, as added by paragraph (1).

(B) REPORT.—Not later October 1, 2005, the Inspector General shall submit to Congress a report on the study conducted under subparagraph (A), and shall include recommendations on the adequacy of reimbursement for such drugs and biologicals under such section 1847A.

(d) PAYMENT BASED ON COMPETITION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1847A, as added by subsection (c), the following new section:

"COMPETITIVE ACQUISITION OF OUTPATIENT DRUGS AND BIOLOGICALS

"SEC. 1847B. (a) IMPLEMENTATION OF COMPETITIVE ACQUISITION.—

"(1) IMPLEMENTATION OF PROGRAM.—

"(A) IN GENERAL.—The Secretary shall establish and implement a competitive acquisition program under which—

"(i) competitive acquisition areas are established for contract award purposes for acquisition of and payment for categories of competitively biddable drugs and biologicals (as defined in paragraph (2)) under this part;

"(ii) each physician is given the opportunity annually to elect to obtain drugs and biologicals under the program, rather than under section 1847A; and

"(iii) each physician who elects to obtain drugs and biologicals under the program makes an annual selection under paragraph (5) of the contractor through which drugs and biologicals within a category of drugs and biologicals will be acquired and delivered to the physician under this part.

This section shall not apply in the case of a physician who elects section 1847A to apply.

"(B) IMPLEMENTATION.—For purposes of implementing the program, the Secretary shall establish categories of competitively biddable drugs and biologicals. The Secretary shall phase in the program with respect to those categories beginning in 2006 in such manner as the Secretary determines to be appropriate.

"(C) WAIVER OF CERTAIN PROVISIONS.—In order to promote competition, in carrying out the program the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

"(D) EXCLUSION AUTHORITY.—The Secretary may exclude competitively biddable drugs and biologicals (including a class of such drugs and biologicals) from the competitive bidding system under this section if the application of competitive bidding to such drugs or biologicals—

"(i) is not likely to result in significant savings; or

"(ii) is likely to have an adverse impact on access to such drugs or biologicals.

"(2) COMPETITIVELY BIDDABLE DRUGS AND BIOLOGICALS AND PROGRAM DEFINED.—For purposes of this section—

"(A) COMPETITIVELY BIDDABLE DRUGS AND BIOLOGICALS DEFINED.—The term 'competitively biddable drugs and biologicals' means a drug or biological described in section 1842(o)(1)(C) and furnished on or after January 1, 2006.

"(B) PROGRAM.—The term 'program' means the competitive acquisition program under this section.

"(C) COMPETITIVE ACQUISITION AREA; AREA.—The terms 'competitive acquisition area' and 'area' mean an appropriate geographic region established by the Secretary under the program.

"(D) CONTRACTOR.—The term 'contractor' means an entity that has entered into a contract with the Secretary under this section.

"(3) APPLICATION OF PROGRAM PAYMENT METHODOLOGY.—

"(A) IN GENERAL.—With respect to competitively biddable drugs and biologicals which are supplied under the program in an area and which are prescribed by a physician who has elected this section to apply—

"(i) the claim for such drugs and biologicals shall be submitted by the contractor that supplied the drugs and biologicals;

"(ii) collection of amounts of any deductible and coinsurance applicable with respect to such drugs and biologicals shall be the responsibility of such contractor and shall not be collected unless the drug or biological is administered to the individual involved; and

"(iii) the payment under this section (and related amounts of any applicable deductible and coinsurance) for such drugs and biologicals—

"(I) shall be made only to such contractor; and

"(II) shall be conditioned upon the administration of such drugs and biologicals.

"(B) PROCESS FOR ADJUSTMENTS.—The Secretary shall provide a process for adjustments to payments in the case in which payment is made for drugs and biologicals which were billed at the time of dispensing but which were not actually administered.

"(C) INFORMATION FOR PURPOSES OF COST-SHARING.—The Secretary shall provide a process by which physicians submit information to contractors for purposes of the collection of any applicable deductible or coinsurance amounts under subparagraph (A)(ii).

"(4) CONTRACT REQUIRED.—Payment may not be made under this part for competitively biddable drugs and biologicals prescribed by a physician who has elected this section to apply within a category and a competitive acquisition area with respect to which the program applies unless—

"(A) the drugs or biologicals are supplied by a contractor with a contract under this section for such category of drugs and biologicals and area; and

"(B) the physician has elected such contractor under paragraph (5) for such category and area.

"(5) CONTRACTOR SELECTION PROCESS.—

"(A) ANNUAL SELECTION.—

"(i) IN GENERAL.—The Secretary shall provide a process for the selection of a contractor, on an annual basis and in such exigent circumstances as the Secretary may provide and with respect to each category of competitively biddable drugs and biologicals for an area by selecting physicians.

"(ii) TIMING OF SELECTION.—The selection of a contractor under clause (i) shall be made at the time of the election described in section 1847A(a) for this section to apply and shall be coordinated with agreements entered into under section 1842(h).

"(B) INFORMATION ON CONTRACTORS.—The Secretary shall make available to physicians on an ongoing basis, through a directory posted on the Internet website of the Centers for Medicare & Medicaid Services or otherwise and upon request, a list of the contractors under this section in the different competitive acquisition areas.

"(C) SELECTING PHYSICIAN DEFINED.—For purposes of this section, the term 'selecting physician' means, with respect to a contractor and category and competitive acquisition area, a physician who has elected this section to apply and has selected to apply under this section such contractor for such category and area.

"(b) PROGRAM REQUIREMENTS.—

"(1) CONTRACT FOR COMPETITIVELY BIDDABLE DRUGS AND BIOLOGICALS.—The Secretary shall conduct a competition among entities for the acquisition of competitively biddable drugs and biologicals. Notwithstanding any other provision of this title, in the case of a multiple source drug, the Secretary shall conduct such competition among entities for the acquisition of at least one competitively biddable drug and biological within each billing and payment code within each category for each competitive acquisition area.

"(2) CONDITIONS FOR AWARDING CONTRACT.—

"(A) IN GENERAL.—The Secretary may not award a contract to any entity under the competition conducted in a competitive acquisition area pursuant to paragraph (1) with respect to the acquisition of competitively biddable drugs and biologicals within a category unless the Secretary finds that the entity meets all of the following with respect to the contract period involved:

"(i) CAPACITY TO SUPPLY COMPETITIVELY BIDDABLE DRUG OR BIOLOGICAL WITHIN CATEGORY.—

"(I) IN GENERAL.—The entity has sufficient arrangements to acquire and to deliver competitively biddable drugs and biologicals within such category in the area specified in the contract.

"(II) SHIPMENT METHODOLOGY.—The entity has arrangements in effect for the shipment at least 5 days each week of competitively biddable drugs and biologicals under the contract and for the timely delivery (including for emergency situations) of such drugs and biologicals in the area under the contract.

"(ii) QUALITY, SERVICE, FINANCIAL PERFORMANCE AND SOLVENCY STANDARDS.—The entity meets quality, service, financial performance, and solvency standards specified by the Secretary, including—

"(I) the establishment of procedures for the prompt response and resolution of complaints of physicians and individuals and of inquiries regarding the shipment of competitively biddable drugs and biologicals; and

"(II) a grievance and appeals process for the resolution of disputes.

"(B) ADDITIONAL CONSIDERATIONS.—The Secretary may refuse to award a contract under this section, and may terminate such a contract, with an entity based upon—

"(i) the suspension or revocation, by the Federal Government or a State government, of the entity's license for the distribution of drugs or biologicals (including controlled substances); or

"(ii) the exclusion of the entity under section 1128 from participation under this title.

"(C) APPLICATION OF MEDICARE PROVIDER OMBUDSMAN.—For provision providing for a program-wide Medicare Provider Ombudsman to review complaints, see section 1868(b), as added by section 923 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

"(3) AWARDING MULTIPLE CONTRACTS FOR A CATEGORY AND AREA.—The Secretary may limit (but not below 2) the number of qualified entities that are awarded such contracts for any category and area. The Secretary shall select among qualified entities based on the following:

"(A) The bid prices for competitively biddable drugs and biologicals within the category and area.

"(B) Bid price for distribution of such drugs and biologicals.

"(C) Ability to ensure product integrity.

"(D) Customer service.

"(E) Past experience in the distribution of drugs and biologicals, including controlled substances.

"(F) Such other factors as the Secretary may specify.

"(4) TERMS OF CONTRACTS.—

"(A) IN GENERAL.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify consistent with this section.

"(B) PERIOD OF CONTRACTS.—A contract under this section shall be for a term of 3 years, but may be terminated by the Secretary or the entity with appropriate, advance notice.

"(C) INTEGRITY OF DRUG AND BIOLOGICAL DISTRIBUTION SYSTEM.—A contractor (as defined in subsection (a)(2)(D)) shall—

"(i) acquire all drug and biological products it distributes directly from the manufacturer or from a distributor that has acquired the products directly from the manufacturer; and

"(ii) comply with any product integrity safeguards as may be determined to be appropriate by the Secretary.

Nothing in this subparagraph shall be construed to relieve or exempt any contractor from the provisions of the Federal Food, Drug, and Cosmetic Act that relate to the wholesale distribution of prescription drugs or biologicals.

"(D) COMPLIANCE WITH CODE OF CONDUCT AND FRAUD AND ABUSE RULES.—Under the contract—

"(i) the contractor shall comply with a code of conduct, specified or recognized by the Secretary, that includes standards relating to conflicts of interest; and

"(ii) the contractor shall comply with all applicable provisions relating to prevention of fraud and abuse, including compliance with applicable guidelines of the Department of Justice and the Inspector General of the Department of Health and Human Services.

"(E) DIRECT DELIVERY OF DRUGS AND BIOLOGICALS TO PHYSICIANS.—Under the contract the contractor shall only supply competitively biddable drugs and biologicals directly to the selecting physicians and not directly to individuals, except under circumstances and settings where an individual currently receives a drug or biological in the individual's home or other non-physician office setting as the Secretary may provide. The contractor shall not deliver drugs and biologicals to a selecting physician except upon receipt of a prescription for such drugs and biologicals, and such necessary data as may be required by the Secretary to carry out this section. This section does not—

"(i) require a physician to submit a prescription for each individual treatment; or

"(ii) change a physician's flexibility in terms of writing a prescription for drugs or biologicals for a single treatment or a course of treatment.

"(5) PERMITTING ACCESS TO DRUGS AND BIOLOGICALS.—The Secretary shall establish rules under this section under which drugs and biologicals which are acquired through a contractor under this section may be used to resupply inventories of such drugs and biologicals which are administered consistent with safe drug practices and with adequate safeguards against fraud and abuse. The previous sentence shall apply if the physicians can demonstrate to the Secretary all of the following:

"(A) The drugs or biologicals are required immediately.

"(B) The physician could not have reasonably anticipated the immediate requirement for the drugs or biologicals.

"(C) The contractor could not deliver to the physician the drugs or biologicals in a timely manner.

"(D) The drugs or biologicals were administered in an emergency situation.

"(6) CONSTRUCTION.—Nothing in this section shall be construed as waiving applicable State requirements relating to licensing of pharmacies.

"(c) BIDDING PROCESS.—

"(1) IN GENERAL.—In awarding a contract for a category of drugs and biologicals in an area under the program, the Secretary shall consider with respect to each entity seeking to be awarded a contract the bid price and the other factors referred to in subsection (b)(3).

"(2) BID DEFINED.—In this section, the term 'bid' means an offer to furnish a competitively biddable drug or biological for a particular price and time period.

"(3) BIDDING ON A NATIONAL OR REGIONAL BASIS.—Nothing in this section shall be construed as precluding a bidder from bidding for contracts in all areas of the United States or as requiring a bidder to submit a bid for all areas of the United States.

"(4) UNIFORMITY OF BIDS WITHIN AREA.—The amount of the bid submitted under a contract offer for any competitively biddable drug or biological for an area shall be the same for that drug or biological for all portions of that area.

"(5) CONFIDENTIALITY OF BIDS.—The provisions of subparagraph (D) of section 1927(b)(3) shall apply to periods during which a bid is submitted with respect to a competitively biddable drug or biological under this section in the same manner as it applies to information disclosed under such section, except that any reference—

"(A) in that subparagraph to a 'manufacturer or wholesaler' is deemed a reference to a 'bidder' under this section;

"(B) in that section to 'prices charged for drugs' is deemed a reference to a 'bid' submitted under this section; and

"(C) in clause (i) of that section to 'this section', is deemed a reference to 'part B of title XVIII'.

"(6) INCLUSION OF COSTS.—The bid price submitted in a contract offer for a competitively biddable drug or biological shall—

"(A) include all costs related to the delivery of the drug or biological to the selecting physician (or other point of delivery); and

"(B) include the costs of dispensing (including shipping) of such drug or biological and management fees, but shall not include any costs related to the administration of the drug or biological, or wastage, spillage, or spoilage.

"(7) PRICE ADJUSTMENTS DURING CONTRACT PERIOD; DISCLOSURE OF COSTS.—Each contract awarded shall provide for—

"(A) disclosure to the Secretary the contractor's reasonable, net acquisition costs for periods specified by the Secretary, not more often than quarterly, of the contract; and

"(B) appropriate price adjustments over the period of the contract to reflect significant increases or decreases in a contractor's reasonable, net acquisition costs, as so disclosed.

"(d) COMPUTATION OF PAYMENT AMOUNTS.—

"(1) IN GENERAL.—Payment under this section for competitively biddable drugs or biologicals shall be based on bids submitted and accepted under this section for such drugs or biologicals in an area. Based on such bids the Secretary shall determine a single payment amount for each competitively biddable drug or biological in the area.

"(2) SPECIAL RULES.—The Secretary shall establish rules regarding the use under this section of the alternative payment amount provided under section 1847A to the use of a price for specific competitively biddable drugs and biologicals in the following cases:

"(A) NEW DRUGS AND BIOLOGICALS.—A competitively biddable drug or biological for which a payment and billing code has not been established.

"(B) OTHER CASES.—Such other exceptional cases as the Secretary may specify in regulations.

"(e) COST-SHARING.—

"(1) APPLICATION OF COINSURANCE.—Payment under this section for competitively biddable drugs and biologicals shall be in an amount equal to 80 percent of the payment basis described in subsection (d)(1).

"(2) DEDUCTIBLE.—Before applying paragraph (1), the individual shall be required to meet the deductible described in section 1833(b).

"(3) COLLECTION.—Such coinsurance and deductible shall be collected by the contractor that supplies the drug or biological involved. Subject to subsection (a)(3)(B), such coinsurance and deductible may be collected in a manner similar to the manner in which the coinsurance and deductible are collected for durable medical equipment under this part.

"(f) SPECIAL PAYMENT RULES.—

"(1) USE IN EXCLUSION CASES.—If the Secretary excludes a drug or biological (or class of drugs or biologicals) under subsection (a)(1)(D), the Secretary may provide for payment to be made under this part for such drugs and biologicals (or class) using the payment methodology under section 1847A.

"(2) APPLICATION OF REQUIREMENT FOR ASSIGNMENT.—For provision requiring assignment of claims for competitively biddable drugs and biologicals, see section 1842(o)(3).

"(3) PROTECTION FOR BENEFICIARY IN CASE OF MEDICAL NECESSITY DENIAL.—For protection of individuals against liability in the case of medical necessity determinations, see section 1842(b)(3)(B)(ii)(III).

"(g) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of—

"(1) the establishment of payment amounts under subsection (d)(1);

"(2) the awarding of contracts under this section;

"(3) the establishment of competitive acquisition areas under subsection (a)(2)(C);

"(4) the phased-in implementation under subsection (a)(1)(B);

"(5) the selection of categories of competitively biddable drugs and biologicals for competitive acquisition under such subsection or the selection of a drug in the case of multiple source drugs; or

"(6) the bidding structure and number of contractors selected under this section.".

(2) REPORT.—Not later than July 1, 2008, the Secretary shall submit to Congress a report on the program conducted under section 1847B of the Social Security Act, as added by paragraph (1). Such report shall include information on savings, reductions in cost-sharing, access to competitively biddable drugs and biologicals, the range of choices of contractors available to physicians, the satisfaction of physicians and of individuals enrolled under this part, and information comparing prices for drugs and biologicals under such section and section 1847A of such Act, as added by subsection (c).

(e) ADJUSTMENTS TO PAYMENT AMOUNTS FOR ADMINISTRATION OF DRUGS AND BIOLOGICALS.—

(1) ITEMS AND SERVICES RELATING TO FURNISHING OF BLOOD CLOTTING FACTORS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (b)(2), is amended by adding at the end the following new paragraph:

"(5)(A) Subject to subparagraph (B), in the case of clotting factors furnished on or after January 1, 2005, the Secretary shall, after reviewing the January 2003 report to Congress by the Comptroller General of the United States entitled 'Payment for Blood Clotting Factor Exceeds Providers Acquisition Cost', provide for a separate payment, to the entity which furnishes to the patient blood clotting factors, for items and services related to the furnishing of such factors in an amount that the Secretary determines to be appropriate. Such payment amount may take into account any or all of the following:

"(i) The mixing (if appropriate) and delivery of factors to an individual, including special inventory management and storage requirements.

"(ii) Ancillary supplies and patient training necessary for the self-administration of such factors.

"(B) In determining the separate payment amount under subparagraph (A) for blood clotting factors furnished in 2005, the Secretary shall ensure that the total amount of payments under this part (as estimated by the Secretary) for such factors under paragraph (1)(C) and such separate payments for such factors does not exceed the total amount of payments that would have been made for such factors under this part (as estimated by the Secretary) if the amendments made by section 303 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 had not been enacted.

"(C) The separate payment amount under this subparagraph for blood clotting factors furnished in 2006 or a subsequent year shall be equal to the separate payment amount determined under this paragraph for the previous year increased by the percentage increase in the consumer price index for medical care for the 12-month period ending with June of the previous year.".

(2) PHARMACY SUPPLYING FEE FOR CERTAIN DRUGS AND BIOLOGICALS.—Section 1842(o) (42 U.S.C. 1395u(o)), as previously amended, is amended by adding at the end the following new paragraph:

"(6) In the case of an immunosuppressive drug described in subparagraph (J) of section 1861(s)(2) and an oral drug described in subparagraph (Q) or (T) of such section, the Secretary shall pay to the pharmacy a supplying fee for such a drug determined appropriate by the Secretary (less the applicable deductible and coinsurance amounts).".

(f) LINKAGE OF REVISED DRUG PAYMENTS AND INCREASES FOR DRUG ADMINISTRATION.—The Secretary shall not implement the revisions in payment amounts for drugs and biologicals administered by physicians as a result of the amendments made by subsection (b) with respect to 2004 unless the Secretary concurrently makes adjustments to the practice expense payment adjustment under the amendments made by subsection (a).

(g) PROHIBITION OF ADMINISTRATIVE AND JUDICIAL REVIEW.—

(1) DRUGS.—Section 1842(o) (42 U.S.C. 1395u(o)), as previously amended, is amended by adding at the end the following new paragraph:

"(7) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under paragraphs (4) through (6).".

(2) PHYSICIAN FEE SCHEDULE.—Section 1848(i)(1)(B) (42 U.S.C. 1395w-4(i)(1)(B)) is amended by striking "subsection (c)(2)(F)" and inserting "subsections (c)(2)(F), (c)(2)(H), and (c)(2)(I)".

(3) MULTIPLE CHEMOTHERAPY AGENTS, OTHER SERVICES CURRENTLY ON THE NON-PHYSICIAN WORK POOL, AND TRANSITIONAL ADJUSTMENT.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under paragraphs (2) through (4) of subsection (a).

(h) CONTINUATION OF PAYMENT METHODOLOGY FOR RADIOPHARMACEUTICALS.—Nothing in the amendments made by this section shall be construed as changing the payment methodology under part B of title XVIII of the Social Security Act for radiopharmaceuticals, including the use by carriers of invoice pricing methodology.

(i) CONFORMING AMENDMENTS.—

(1) APPLICATION OF ASP AND COMPETITIVE BIDDING.—Section 1842(o)(2) (42 U.S.C. 1395u(o)(2)) is amended by adding at the end the following: "This paragraph shall not apply in the case of payment under paragraph (1)(C).".

(2) NO CHANGE IN COVERAGE BASIS.—Section 1861(s)(2)(A) (42 U.S.C. 1395x(s)(2)(A)) is amended by inserting "(or would have been so included but for the application of section 1847B)" after "included in the physicians' bills".

(3) PAYMENT.—(A) Section 1833(a)(1)(S) (42 U.S.C. 1395l(a)(1)(S)) is amended by inserting "(or, if applicable, under section 1847, 1847A, or 1847B)" after "1842(o)".

(B) Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)) is amended—

(i) by striking "and" at the end of subparagraph (H);

(ii) by striking the semicolon at the end of subparagraph (I) and inserting ", and"; and

(iii) by adding at the end the following new subparagraph:

"(J) in the case of a drug or biological specified in section 1847A(c)(6)(C) for which payment is made under part B that is furnished in a competitive area under section 1847B, that is not furnished by an entity under a contract under such section;".

(4) CONSOLIDATED REPORTING OF PRICING INFORMATION.—Section 1927 (42 U.S.C. 1396r–8) is amended—

(A) in subsection (a)(1), by inserting "or under part B of title XVIII" after "section 1903(a)";

(B) in subsection (b)(3)(A)—

(i) in clause (i), by striking "and" at the end and inserting a semicolon;

(ii) in clause (ii), by striking the period and inserting "; and"; and

(iii) by adding at the end the following:

"(iii) for calendar quarters beginning on or after January 1, 2004, in conjunction with reporting required under clause (i) and by National Drug Code (including package size)—

"(I) the manufacturer's average sales price (as defined in section 1847A(c)) and the total number of units specified under section 1847A(b)(2)(A);

"(II) if required to make payment under section 1847A, the manufacturer's wholesale acquisition cost, as defined in subsection (c)(6) of such section; and

"(III) information on those sales that were made at a nominal price or otherwise described in section 1847A(c)(2)(B);

for a drug or biological described in subparagraph (C), (D), (E), or (G) of section 1842(o)(1) or section 1881(b)(13)(A)(ii).

Information reported under this subparagraph is subject to audit by the Inspector General of the Department of Health and Human Services.";

(C) in subsection (b)(3)(B)—

(i) in the heading, by inserting "AND MANUFACTURER'S AVERAGE SALES PRICE" after "PRICE"; and

(ii) by inserting "and manufacturer's average sales prices (including wholesale acquisition cost) if required to make payment" after "manufacturer prices"; and

(D) in subsection (b)(3)(D)—

(i) in the matter preceding clause (i), by inserting "(other than the wholesale acquisition cost for purposes of carrying out section 1847A)" after "subsection (a)(6)(A)(ii)"; and

(ii) in clause (i), by inserting ", to carry out section 1847A (including the determination and implementation of the payment amount), or to carry out section 1847B" after "this section"..

(5) IMPLEMENTATION.—The provisions of chapter 8 of title 5, United States Code, shall not apply with respect to regulations implementing the amendments made by subsections (a), (b), and (e)(3), to regulations implementing section 304, and to regulations implementing the amendment made by section 305(a), insofar as such regulations apply in 2004.

(6) REPEAL OF STUDY.—Section 4556 of the Balanced Budget Act of 1997 (42 U.S.C. 1395u note) is amended by striking subsection (c).

(j) APPLICATION TO CERTAIN PHYSICIAN SPECIALTIES.—Insofar as the amendments made by this section apply to payments for drugs or biologicals and drug administration services furnished by physicians, such amendments shall only apply to physicians in the specialties of hematology, hematology/oncology, and medical oncology under title XVIII of the Social Security Act.

SEC. 304. EXTENSION OF APPLICATION OF PAYMENT REFORM FOR COVERED OUTPATIENT DRUGS AND BIOLOGICALS TO OTHER PHYSICIAN SPECIALTIES.

Notwithstanding section 303(j), the amendments made by section 303 shall also apply to payments for drugs or biologicals and drug administration services furnished by physicians in specialties other than the specialties of hematology, hematology/oncology, and medical oncology.

SEC. 305. PAYMENT FOR INHALATION DRUGS.

(a) IN GENERAL.—Section 1842(o)(1)(G) (42 U.S.C. 1395u(o)(1)(G)), as added by section 303(b), is amended to read as follows:

"(G) In the case of inhalation drugs or biologicals furnished through durable medical equipment covered under section 1861(n) that are furnished—

"(i) in 2004, the amount provided under paragraph (4) for the drug or biological; and

"(ii) in 2005 and subsequent years, the amount provided under section 1847A for the drug or biological.".

(b) GAO STUDY OF MEDICARE PAYMENT FOR INHALATION THERAPY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to examine the adequacy of current reimbursements for inhalation therapy under the medicare program.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 306. DEMONSTRATION PROJECT FOR USE OF RECOVERY AUDIT CONTRACTORS.

(a) IN GENERAL.—The Secretary shall conduct a demonstration project under this section (in this section referred to as the "project") to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the medicare program for services for which payment is made under part A or B of title XVIII of the Social Security Act. Under the project—

(1) payment may be made to such a contractor on a contingent basis;

(2) such percentage as the Secretary may specify of the amount recovered shall be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and

(3) the Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.

(b) SCOPE AND DURATION.—

(1) SCOPE.—The project shall cover at least 2 States that are among the States with—

(A) the highest per capita utilization rates of medicare services, and

(B) at least 3 contractors.

(2) DURATION.—The project shall last for not longer than 3 years.

(c) WAIVER.—The Secretary shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (a).

(d) QUALIFICATIONS OF CONTRACTORS.—

(1) IN GENERAL.—The Secretary shall enter into a recovery audit contract under this section with an entity only if the entity has staff that has the appropriate clinical knowledge of and experience with the payment rules and regulations under the medicare program or the entity has or will contract with another entity that has such knowledgeable and experienced staff.

(2) INELIGIBILITY OF CERTAIN CONTRACTORS.—The Secretary may not enter into a recovery audit contract under this section with an entity to the extent that the entity is a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h), a carrier under section 1842 of such Act (42 U.S.C. 1395u), or a Medicare Administrative Contractor under section 1874A of such Act.

(3) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY.—In awarding contracts to recovery audit contractors under this

section, the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, or under the medicaid program under title XIX of the Social Security Act.

(e) CONSTRUCTION RELATING TO CONDUCT OF INVESTIGATION OF FRAUD.—A recovery of an overpayment to a provider by a recovery audit contractor shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(f) REPORT.—The Secretary shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on savings to the medicare program and recommendations on the cost-effectiveness of extending or expanding the project.information' means information about a conviction for a relevant crime or a finding of patient or resident abuse.

SEC. 307. PILOT PROGRAM FOR NATIONAL AND STATE BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES OR PROVIDERS.

(a) AUTHORITY TO CONDUCT PROGRAM.—The Secretary, in consultation with the Attorney General, shall establish a pilot program to identify efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees.

(b) REQUIREMENTS.—

(1) IN GENERAL.—Under the pilot program, a long-term care facility or provider in a participating State, prior to employing a direct patient access employee that is first hired on or after the commencement date of the pilot program in the State, shall conduct a background check on the employee in accordance with such procedures as the participating State shall establish.

(2) PROCEDURES.—

(A) IN GENERAL.—The procedures established by a participating State under paragraph (1) should be designed to—

(i) give a prospective direct access patient employee notice that the long-term care facility or provider is required to perform background checks with respect to new employees;

(ii) require, as a condition of employment, that the employee—

(I) provide a written statement disclosing any disqualifying information;

(II) provide a statement signed by the employee authorizing the facility to request national and State criminal history background checks;

(III) provide the facility with a rolled set of the employee's fingerprints; and

(IV) provide any other identification information the participating State may require;

(iii) require the facility or provider to check any available registries that would be likely to contain disqualifying information about a prospective employee of a long-term care facility or provider; and

(iv) permit the facility or provider to obtain State and national criminal history background checks on the prospective employee through a 10-fingerprint check that utilizes State criminal records and the Integrated Automated Fingerprint Identification System of the Federal Bureau of Investigation.

(B) ELIMINATION OF UNNECESSARY CHECKS.—The procedures established by a participating State under paragraph (1) shall permit a long-term care facility or provider to terminate the background check at any stage at which the facility or provider obtains disqualifying information regarding a prospective direct patient access employee.

(3) PROHIBITION ON HIRING OF ABUSIVE WORKERS.—

(A) IN GENERAL.—A long-term care facility or provider may not knowingly employ any direct patient access employee who has any disqualifying information.

(B) PROVISIONAL EMPLOYMENT.—

(i) IN GENERAL.—Under the pilot program, a participating State may permit a long-term care facility or provider to provide for a provisional period of employment for a direct patient access employee pending completion of a background check, subject to such supervision during the employee's provisional period of employment as the participating State determines appropriate.

(ii) SPECIAL CONSIDERATION FOR CERTAIN FACILITIES AND PROVIDERS.—In determining what constitutes appropriate supervision of a provisional employee, a participating State shall take into account cost or other burdens that would be imposed on small rural long-term care facilities or providers, as well as the nature of care delivered by such facilities or providers that are home health agencies or providers of hospice care.

(4) USE OF INFORMATION; IMMUNITY FROM LIABILITY.—

(A) USE OF INFORMATION.—A participating State shall ensure that a long-term care facility or provider that obtains information about a direct patient access employee pursuant to a background check uses such information only for the purpose of determining the suitability of the employee for employment.

(B) IMMUNITY FROM LIABILITY.—A participating State shall ensure that a long-term care facility or provider that, in denying employment for an individual selected for hire as a direct patient access employee (including during any period of provisional employment), reasonably relies upon information obtained through a background check of the individual, shall not be liable in any action brought by the individual based on the employment determination resulting from the information.

(5) AGREEMENTS WITH EMPLOYMENT AGENCIES.—A participating State may establish procedures for facilitating the conduct of background checks on prospective direct patient access employees that are hired by a long-term care facility or provider through an employment agency (including a temporary employment agency).

(6) PENALTIES.—A participating State may impose such penalties as the State determines appropriate to enforce the requirements of the pilot program conducted in that State.

(c) PARTICIPATING STATES.—

(1) IN GENERAL.—The Secretary shall enter into agreements with not more than 10 States to conduct the pilot program under this section in such States.

(2) REQUIREMENTS FOR STATES.—An agreement entered into under paragraph (1) shall require that a participating State—

(A) be responsible for monitoring compliance with the requirements of the pilot program;

(B) have procedures by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check performed under the pilot program; and

(C) agree to—

(i) review the results of any State or national criminal history background checks conducted regarding a prospective direct patient access employee to determine whether the employee has any conviction for a relevant crime;

(ii) immediately report to the entity that requested the criminal history background checks the results of such review; and

(iii) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 1128E of the Social Security Act (42 U.S.C. 1320a–7e), report the existence of such conviction to the database established under that section.

(3) APPLICATION AND SELECTION CRITERIA.—

(A) APPLICATION.—A State seeking to participate in the pilot program established under this section, shall submit an application to the Secretary containing such information and at such time as the Secretary may specify.

(B) SELECTION CRITERIA.—

(i) IN GENERAL.—In selecting States to participate in the pilot program, the Secretary shall establish criteria to ensure—

(I) geographic diversity;

(II) the inclusion of a variety of long-term care facilities or providers;

(III) the evaluation of a variety of payment mechanisms for covering the costs of conducting the background checks required under the pilot program; and

(IV) the evaluation of a variety of penalties (monetary and otherwise) used by participating States to enforce the requirements of the pilot program in such States.

(ii) ADDITIONAL CRITERIA.—The Secretary shall, to the greatest extent practicable, select States to participate in the pilot program in accordance with the following:

(I) At least one participating State should permit long-term care facilities or providers to provide for a provisional period of employment pending completion of a background check and at least one such State should not permit such a period of employment.

(II) At least one participating State should establish procedures under which employment agencies (including temporary employment agencies) may contact the State directly to conduct background checks on prospective direct patient access employees.

(III) At least one participating State should include patient abuse prevention training (including behavior training and interventions) for managers and employees of long-term care facilities and providers as part of the pilot program conducted in that State.

(iii) INCLUSION OF STATES WITH EXISTING PROGRAMS.—Nothing in this section shall be construed as prohibiting any State which, as of the date of the enactment of this Act, has procedures for conducting background checks on behalf of any entity described in subsection (g)(5) from being selected to participate in the pilot program conducted under this section.

(d) PAYMENTS.—Of the amounts made available under subsection (f) to conduct the pilot program under this section, the Secretary shall—

(1) make payments to participating States for the costs of conducting the pilot program in such States; and

(2) reserve up to 4 percent of such amounts to conduct the evaluation required under subsection (e).

(e) EVALUATION.—The Secretary, in consultation with the Attorney General, shall conduct by grant, contract, or interagency agreement an evaluation of the pilot program conducted under this section. Such evaluation shall—

(1) review the various procedures implemented by participating States for long-term care facilities or providers to conduct background checks of direct patient access employees and identify the most efficient, effective, and economical procedures for conducting such background checks;

(2) assess the costs of conducting such background checks (including start-up and administrative costs);

(3) consider the benefits and problems associated with requiring employees or facilities or providers to pay the costs of conducting such background checks;

(4) consider whether the costs of conducting such background checks should be allocated between the medicare and medicaid programs and

if so, identify an equitable methodology for doing so;

(5) determine the extent to which conducting such background checks leads to any unintended consequences, including a reduction in the available workforce for such facilities or providers;

(6) review forms used by participating States in order to develop, in consultation with the Attorney General, a model form for such background checks;

(7) determine the effectiveness of background checks conducted by employment agencies; and

(8) recommend appropriate procedures and payment mechanisms for implementing a national criminal background check program for such facilities and providers.

(f) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out the pilot program under this section for the period of fiscal years 2004 through 2007, $25,000,000.

(g) DEFINITIONS.—In this section:

(1) CONVICTION FOR A RELEVANT CRIME.—The term “conviction for a relevant crime” means any Federal or State criminal conviction for—

(A) any offense described in section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7); and

(B) such other types of offenses as a participating State may specify for purposes of conducting the pilot program in such State.

(2) DISQUALIFYING INFORMATION.—The term “disqualifying information” means a conviction for a relevant crime or a finding of patient or resident abuse.

(3) FINDING OF PATIENT OR RESIDENT ABUSE.—The term “finding of patient or resident abuse” means any substantiated finding by a State agency under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i–3(g)(1)(C), 1396r(g)(1)(C)) or a Federal agency that a direct patient access employee has committed—

(A) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

(B) such other types of acts as a participating State may specify for purposes of conducting the pilot program in such State.

(4) DIRECT PATIENT ACCESS EMPLOYEE.—The term “direct patient access employee” means any individual (other than a volunteer) that has access to a patient or resident of a long-term care facility or provider through employment or through a contract with such facility or provider, as determined by a participating State for purposes of conducting the pilot program in such State.

(5) LONG-TERM CARE FACILITY OR PROVIDER.—

(A) IN GENERAL.—The term “long-term care facility or provider” means the following facilities or providers which receive payment for services under title XVIII or XIX of the Social Security Act:

(i) A skilled nursing facility (as defined in section 1819(a) of the Social Security Act) (42 U.S.C. 1395i–3(a)).

(ii) A nursing facility (as defined in section 1919(a) in such Act) (42 U.S.C. 1396r(a)).

(iii) A home health agency.

(iv) A provider of hospice care (as defined in section 1861(dd)(1) of such Act) (42 U.S.C. 1395x(dd)(1)).

(v) A long-term care hospital (as described in section 1886(d)(1)(B)(iv) of such Act) (42 U.S.C. 1395ww(d)(1)(B)(iv)).

(vi) A provider of personal care services.

(vii) A residential care provider that arranges for, or directly provides, long-term care services.

(viii) An intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act) 42 U.S.C. 1396d(d)).

(B) ADDITIONAL FACILITIES OR PROVIDERS.—During the first year in which a pilot program under this section is conducted in a participating State, the State may expand the list of facilities or providers under subparagraph (A) (on a phased-in basis or otherwise) to include such other facilities or providers of long-term care services under such titles as the participating State determines appropriate.

(C) EXCEPTIONS.—Such term does not include—

(i) any facility or entity that provides, or is a provider of, services described in subparagraph (A) that are exclusively provided to an individual pursuant to a self-directed arrangement that meets such requirements as the participating State may establish in accordance with guidance from the Secretary; or

(ii) any such arrangement that is obtained by a patient or resident functioning as an employer.

(6) PARTICIPATING STATE.—The term “participating State” means a State with an agreement under subsection (c)(1).

TITLE IV—RURAL PROVISIONS

Subtitle A—Provisions Relating to Part A Only

SEC. 401. EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.—Section 1886(d)(3)(A)(iv) (42 U.S.C. 1395ww(d)(3)(A)(iv)) is amended—

(1) by striking “(iv) For discharges” and inserting “(iv)(I) Subject to subclause (II), for discharges”; and

(2) by adding at the end the following new subclause:

“(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.”.

(b) CONFORMING AMENDMENTS.—

(1) COMPUTING DRG-SPECIFIC RATES.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking “IN DIFFERENT AREAS”;

(B) in the matter preceding clause (i), by striking “, each of”;

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting “for fiscal years before fiscal year 2004,” before “for hospitals”; and

(ii) in subclause (II), by striking “and” after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting “for fiscal years before fiscal year 2004,” before “for hospitals”; and

(ii) in subclause (II), by striking the period at the end and inserting “; and”; and

(E) by adding at the end the following new clause:

“(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

“(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

“(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.”.

(2) TECHNICAL CONFORMING SUNSET.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by inserting “, for fiscal years before fiscal year 1997,” before “a regional adjusted DRG prospective payment rate”; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting “, for fiscal years before fiscal year 1997,” before “a regional DRG prospective payment rate for each region,”.

(3) ADDITIONAL TECHNICAL AMENDMENT.—Section 1886(d)(3)(A)(iii) (42 U.S.C. 1395ww(d)(3)(A)(iii)) is amended by striking “in an other urban area” and inserting “in an urban area”.

(c) EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM FOR HOSPITALS IN PUERTO RICO.—

(1) IN GENERAL.—Section 1886(d)(9)(A) (42 U.S.C. 1395ww(d)(9)(A)), as amended by section 504, is amended—

(A) in clause (i), by striking “and” after the comma at the end; and

(B) by striking clause (ii) and inserting the following new clause:

“(ii) the applicable Federal percentage (specified in subparagraph (E)) of—

“(I) for discharges beginning in a fiscal year beginning on or after October 1, 1997, and before October 1, 2003, the discharge-weighted average of—

“(aa) the national adjusted DRG prospective payment rate (determined under paragraph (3)(D)) for hospitals located in a large urban area,

“(bb) such rate for hospitals located in other urban areas, and

“(cc) such rate for hospitals located in a rural area,

for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels; and

“(II) for discharges in a fiscal year beginning on or after October 1, 2003, the national DRG prospective payment rate determined under paragraph (3)(D)(iii) for hospitals located in any area for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels.

As used in this section, the term ‘subsection (d) Puerto Rico hospital’ means a hospital that is located in Puerto Rico and that would be a subsection (d) hospital (as defined in paragraph (1)(B)) if it were located in one of the 50 States.”.

(2) APPLICATION OF PUERTO RICO STANDARDIZED AMOUNT BASED ON LARGE URBAN AREAS.—Section 1886(d)(9)(C) (42 U.S.C. 1395ww(d)(9)(C)) is amended—

(A) in clause (i)—

(i) by striking “(i) The Secretary” and inserting “(i)(I) For discharges in a fiscal year after fiscal year 1988 and before fiscal year 2004, the Secretary”; and

(ii) by adding at the end the following new subclause:

“(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute an average standardized amount for hospitals located in any area of Puerto Rico that is equal to the average standardized amount computed under subclause (I) for fiscal year 2003 for hospitals in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B) for the fiscal year involved.”;

(B) in clause (ii), by inserting “(or for fiscal year 2004 and thereafter, the average standardized amount)” after “each of the average standardized amounts”; and

(C) in clause (iii)(I), by striking “for hospitals located in an urban or rural area, respectively”.

(d) IMPLEMENTATION.—

(1) IN GENERAL.—The amendments made by subsections (a), (b), and (c)(1) of this section shall have no effect on the authority of the Secretary, under subsection (b)(2) of section 402 of

Public Law 108–89, to delay implementation of the extension of provisions equalizing urban and rural standardized inpatient hospital payments under subsection (a) of such section 402.

(2) APPLICATION OF PUERTO RICO STANDARDIZED AMOUNT BASED ON LARGE URBAN AREAS.—The authority of the Secretary referred to in paragraph (1) shall apply with respect to the amendments made by subsection (c)(2) of this section in the same manner as that authority applies with respect to the extension of provisions equalizing urban and rural standardized inpatient hospital payments under subsection (a) of such section 402, except that any reference in subsection (b)(2)(A) of such section 402 is deemed to be a reference to April 1, 2004.

SEC. 402. ENHANCED DISPROPORTIONATE SHARE HOSPITAL (DSH) TREATMENT FOR RURAL HOSPITALS AND URBAN HOSPITALS WITH FEWER THAN 100 BEDS.

(a) DOUBLING THE CAP.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended by adding at the end the following new clause:

"(xiv)(I) In the case of discharges occurring on or after April 1, 2004, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subclause (I)) or under clause (viii), (x), (xi), (xii), or (xiii), the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

"(II) Under subclause (I), the disproportionate share adjustment percentage shall not exceed 12 percent for a hospital that is not classified as a rural referral center under subparagraph (C).".

(b) CONFORMING AMENDMENTS.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended—

(1) in paragraph (5)(F)—

(A) in each of subclauses (II), (III), (IV), (V), and (VI) of clause (iv), by inserting "subject to clause (xiv) and" before "for discharges occurring";

(B) in clause (viii), by striking "The formula" and inserting "Subject to clause (xiv), the formula"; and

(C) in each of clauses (x), (xi), (xii), and (xiii), by striking "For purposes" and inserting "Subject to clause (xiv), for purposes"; and

(2) in paragraph (2)(C)(iv)—

(A) by striking "or" before "the enactment of section 303"; and

(B) by inserting before the period at the end the following: ", or the enactment of section 402(a)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003".

SEC. 403. ADJUSTMENT TO THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM WAGE INDEX TO REVISE THE LABOR-RELATED SHARE OF SUCH INDEX.

(a) ADJUSTMENT.—

(1) IN GENERAL.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(A) by striking "WAGE LEVELS.—The Secretary" and inserting "WAGE LEVELS.—

"(i) IN GENERAL.—Except as provided in clause (ii), the Secretary"; and

(B) by adding at the end the following new clause:

"(ii) ALTERNATIVE PROPORTION TO BE ADJUSTED BEGINNING IN FISCAL YEAR 2005.—For discharges occurring on or after October 1, 2004, the Secretary shall substitute '62 percent' for the proportion described in the first sentence of clause (i), unless the application of this clause would result in lower payments to a hospital than would otherwise be made.".

(2) WAIVING BUDGET NEUTRALITY.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as amended by subsection (a), is amended by adding at the end of clause (i) the following new sentence: "The Secretary shall apply the previous sentence for any period as if the amendments made by section 403(a)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 had not been enacted.".

(b) APPLICATION TO PUERTO RICO HOSPITALS.—Section 1886(d)(9)(C)(iv) (42 U.S.C. 1395ww(d)(9)(C)(iv)) is amended—

(1) by inserting "(I)" after "(iv)";

(2) by striking "paragraph (3)(E)" and inserting "paragraph (3)(E)(i)"; and

(3) by adding at the end the following new subclause:

"(II) For discharges occurring on or after October 1, 2004, the Secretary shall substitute '62 percent' for the proportion described in the first sentence of clause (i), unless the application of this subclause would result in lower payments to a hospital than would otherwise be made.".

SEC. 404. MORE FREQUENT UPDATE IN WEIGHTS USED IN HOSPITAL MARKET BASKET.

(a) MORE FREQUENT UPDATES IN WEIGHTS.—After revising the weights used in the hospital market basket under section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most current data available, the Secretary shall establish a frequency for revising such weights, including the labor share, in such market basket to reflect the most current data available more frequently than once every 5 years.

(b) INCORPORATION OF EXPLANATION IN RULEMAKING.—The Secretary shall include in the publication of the final rule for payment for inpatient hospital services under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) for fiscal year 2006, an explanation of the reasons for, and options considered, in determining frequency established under subsection (a).

SEC. 405. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

(a) INCREASE IN PAYMENT AMOUNTS.—

(1) IN GENERAL.—Sections 1814(l), 1834(g)(1), and 1883(a)(3) (42 U.S.C. 1395f(l), 1395m(g)(1), and 1395tt(a)(3)) are each amended by inserting "equal to 101 percent of" before "the reasonable costs".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to payments for services furnished during cost reporting periods beginning on or after January 1, 2004.

(b) COVERAGE OF COSTS FOR CERTAIN EMERGENCY ROOM ON-CALL PROVIDERS.—

(1) IN GENERAL.—Section 1834(g)(5) (42 U.S.C. 1395m(g)(5)) is amended—

(A) in the heading—

(i) by inserting "CERTAIN" before "EMERGENCY"; and

(ii) by striking "PHYSICIANS" and inserting "PROVIDERS";

(B) by striking "emergency room physicians who are on-call (as defined by the Secretary)" and inserting "physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services"; and

(C) by striking "physicians' services" and inserting "services covered under this title".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply with respect to costs incurred for services furnished on or after January 1, 2005.

(c) AUTHORIZATION OF PERIODIC INTERIM PAYMENT (PIP).—

(1) IN GENERAL.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(A) in the matter before subparagraph (A), by inserting ", in the cases described in subparagraphs (A) through (D)" after "1986";

(B) by striking "and" at the end of subparagraph (C);

(C) by adding "and" at the end of subparagraph (D); and

(D) by inserting after subparagraph (D) the following new subparagraph:

"(E) inpatient critical access hospital services;".

(2) DEVELOPMENT OF ALTERNATIVE TIMING METHODS OF PERIODIC INTERIM PAYMENTS.—With respect to periodic interim payments to critical access hospitals for inpatient critical access hospital services under section 1815(e)(2)(E) of the Social Security Act, as added by paragraph (1), the Secretary shall develop alternative methods for the timing of such payments.

(3) AUTHORIZATION OF PIP.—The amendments made by paragraph (1) shall apply to payments made on or after July 1, 2004.

(d) CONDITION FOR APPLICATION OF SPECIAL PROFESSIONAL SERVICE PAYMENT ADJUSTMENT.—

(1) IN GENERAL.—Section 1834(g)(2) (42 U.S.C. 1395m(g)(2)) is amended by adding after and below subparagraph (B) the following:

"The Secretary may not require, as a condition for applying subparagraph (B) with respect to a critical access hospital, that each physician or other practitioner providing professional services in the hospital must assign billing rights with respect to such services, except that such subparagraph shall not apply to those physicians and practitioners who have not assigned such billing rights.".

(2) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after July 1, 2004.

(B) RULE OF APPLICATION.—In the case of a critical access hospital that made an election under section 1834(g)(2) of the Social Security Act (42 U.S.C. 1395m(g)(2)) before November 1, 2003, the amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after July 1, 2001.

(e) REVISION OF BED LIMITATION FOR HOSPITALS.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i–4(c)(2)(B)(iii)) is amended by striking "15 (or, in the case of a facility under an agreement described in subsection (f), 25)" and inserting "25".

(2) CONFORMING AMENDMENT.—Section 1820(f) (42 U.S.C. 1395i–4(f)) is amended by striking "and the number of beds used at any time for acute care inpatient services does not exceed 15 beds".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to designations made before, on, or after January 1, 2004, but any election made pursuant to regulations promulgated to carry out such amendments shall only apply prospectively.

(f) PROVISIONS RELATING TO FLEX GRANTS.—

(1) ADDITIONAL 4-YEAR PERIOD OF FUNDING.—Section 1820(j) (42 U.S.C. 1395i–4(j)) is amended by inserting before the period at the end the following: ", and for making grants to all States under paragraphs (1) and (2) of subsection (g), $35,000,000 in each of fiscal years 2005 through 2008".

(2) ADDITIONAL REQUIREMENTS AND ADMINISTRATION.—Section 1820(g) (42 U.S.C. 1395i–4(g)) is amended by adding at the end the following new paragraphs:

"(4) ADDITIONAL REQUIREMENTS WITH RESPECT TO FLEX GRANTS.—With respect to grants awarded under paragraph (1) or (2) from funds appropriated for fiscal year 2005 and subsequent fiscal years—

"(A) CONSULTATION WITH THE STATE HOSPITAL ASSOCIATION AND RURAL HOSPITALS ON THE MOST APPROPRIATE WAYS TO USE GRANTS.—A State shall consult with the hospital association of such State and rural hospitals located in such State on the most appropriate ways to use the funds under such grant.

"(B) LIMITATION ON USE OF GRANT FUNDS FOR ADMINISTRATIVE EXPENSES.—A State may not expend more than the lesser of—

"(i) 15 percent of the amount of the grant for administrative expenses; or

"(ii) the State's federally negotiated indirect rate for administering the grant.

"(5) USE OF FUNDS FOR FEDERAL ADMINISTRATIVE EXPENSES.—Of the total amount appropriated for grants under paragraphs (1) and (2) for a fiscal year (beginning with fiscal year 2005), up to 5 percent of such amount shall be available to the Health Resources and Services Administration for purposes of administering such grants.".

(g) AUTHORITY TO ESTABLISH PSYCHIATRIC AND REHABILITATION DISTINCT PART UNITS.—

(1) IN GENERAL.—Section 1820(c)(2) (42 U.S.C. 1395i–4(c)(2)) is amended by adding at the end the following:

"(E) AUTHORITY TO ESTABLISH PSYCHIATRIC AND REHABILITATION DISTINCT PART UNITS.—

"(i) IN GENERAL.—Subject to the succeeding provisions of this subparagraph, a critical access hospital may establish—

"(I) a psychiatric unit of the hospital that is a distinct part of the hospital; and

"(II) a rehabilitation unit of the hospital that is a distinct part of the hospital,

if the distinct part meets the requirements (including conditions of participation) that would otherwise apply to the distinct part if the distinct part were established by a subsection (d) hospital in accordance with the matter following clause (v) of section 1886(d)(1)(B), including any regulations adopted by the Secretary under such section.

"(ii) LIMITATION ON NUMBER OF BEDS.—The total number of beds that may be established under clause (i) for a distinct part unit may not exceed 10.

"(iii) EXCLUSION OF BEDS FROM BED COUNT.—In determining the number of beds of a critical access hospital for purposes of applying the bed limitations referred to in subparagraph (B)(iii) and subsection (f), the Secretary shall not take into account any bed established under clause (i).

"(iv) EFFECT OF FAILURE TO MEET REQUIREMENTS.—If a psychiatric or rehabilitation unit established under clause (i) does not meet the requirements described in such clause with respect to a cost reporting period, no payment may be made under this title to the hospital for services furnished in such unit during such period. Payment to the hospital for services furnished in the unit may resume only after the hospital has demonstrated to the Secretary that the unit meets such requirements.".

(2) PAYMENT ON A PROSPECTIVE PAYMENT BASIS.—Section 1814(l) (42 U.S.C. 1395f(l)) is amended—

(A) by striking "(l) The amount" and inserting "(l)(1) Except as provided in paragraph (2), the amount"; and

(B) by adding at the end the following new paragraph:

"(2) In the case of a distinct part psychiatric or rehabilitation unit of a critical access hospital described in section 1820(c)(2)(E), the amount of payment for inpatient critical access hospital services of such unit shall be equal to the amount of the payment that would otherwise be made if such services were inpatient hospital services of a distinct part psychiatric or rehabilitation unit, respectively, described in the matter following clause (v) of section 1886(d)(1)(B).".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to cost reporting periods beginning on or after October 1, 2004.

(h) WAIVER AUTHORITY.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(i)(II) (42 U.S.C. 1395i–4(c)(2)(B)(i)(II)) is amended by inserting "before January 1, 2006," after "is certified".

(2) GRANDFATHERING WAIVER AUTHORITY FOR CERTAIN FACILITIES.—Section 1820(h) (42 U.S.C. 1395i–4(h)) is amended—

(A) in the heading preceding paragraph (1), by striking "OF CERTAIN FACILITIES" and inserting "PROVISIONS"; and

(B) by adding at the end the following new paragraph:

"(3) STATE AUTHORITY TO WAIVE 35-MILE RULE.—In the case of a facility that was designated as a critical access hospital before January 1, 2006, and was certified by the State as being a necessary provider of health care services to residents in the area under subsection (c)(2)(B)(i)(II), as in effect before such date, the authority under such subsection with respect to any redesignation of such facility shall continue to apply notwithstanding the amendment made by section 405(h)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.".

SEC. 406. MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

(a) IN GENERAL.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following new paragraph:

"(12) PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.—

"(A) IN GENERAL.—In addition to any payments calculated under this section for a subsection (d) hospital, for discharges occurring during a fiscal year (beginning with fiscal year 2005), the Secretary shall provide for an additional payment amount to each low-volume hospital (as defined in subparagraph (C)(i)) for discharges occurring during that fiscal year that is equal to the applicable percentage increase (determined under subparagraph (B) for the hospital involved) in the amount paid to such hospital under this section for such discharges (determined without regard to this paragraph).

"(B) APPLICABLE PERCENTAGE INCREASE.—The Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) as follows:

"(i) The Secretary shall determine the empirical relationship for subsection (d) hospitals between the standardized cost-per-case for such hospitals and the total number of discharges of such hospitals and the amount of the additional incremental costs (if any) that are associated with such number of discharges.

"(ii) The applicable percentage increase shall be determined based upon such relationship in a manner that reflects, based upon the number of such discharges for a subsection (d) hospital, such additional incremental costs.

"(iii) In no case shall the applicable percentage increase exceed 25 percent.

"(C) DEFINITIONS.—

"(i) LOW-VOLUME HOSPITAL.—For purposes of this paragraph, the term 'low-volume hospital' means, for a fiscal year, a subsection (d) hospital (as defined in paragraph (1)(B)) that the Secretary determines is located more than 25 road miles from another subsection (d) hospital and has less than 800 discharges during the fiscal year.

"(ii) DISCHARGE.—For purposes of subparagraph (B) and clause (i), the term 'discharge' means an inpatient acute care discharge of an individual regardless of whether the individual is entitled to benefits under part A.".

(b) JUDICIAL REVIEW.—Section 1886(d)(7)(A) (42 U.S.C. 1395ww(d)(7)(A)) is amended by inserting after "to subsection (e)(1)" the following: "or the determination of the applicable percentage increase under paragraph (12)(A)(ii)".

SEC. 407. TREATMENT OF MISSING COST REPORTING PERIODS FOR SOLE COMMUNITY HOSPITALS.

(a) IN GENERAL.—Section 1886(b)(3)(I) (42 U.S.C. 1395ww(b)(3)(I)) is amended by adding at the end the following new clause:

"(iii) In no case shall a hospital be denied treatment as a sole community hospital or payment (on the basis of a target rate as such as a hospital) because data are unavailable for any cost reporting period due to changes in ownership, changes in fiscal intermediaries, or other extraordinary circumstances, so long as data for at least one applicable base cost reporting period is available.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to cost reporting periods beginning on or after January 1, 2004.

SEC. 408. RECOGNITION OF ATTENDING NURSE PRACTITIONERS AS ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS.

(a) IN GENERAL.—Section 1861(dd)(3)(B) (42 U.S.C. 1395x(dd)(3)(B)) is amended by inserting "or nurse practitioner (as defined in subsection (aa)(5))" after "the physician (as defined in subsection (r)(1))".

(b) CLARIFICATION OF HOSPICE ROLE OF NURSE PRACTITIONERS.—Section 1814(a)(7)(A)(i)(I) (42 U.S.C. 1395f(a)(7)(A)(i)(I)) is amended by inserting "(which for purposes of this subparagraph does not include a nurse practitioner)" after "attending physician (as defined in section 1861(dd)(3)(B))".

SEC. 409. RURAL HOSPICE DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary shall conduct a demonstration project for the delivery of hospice care to medicare beneficiaries in rural areas. Under the project medicare beneficiaries who are unable to receive hospice care in the facility for lack of an appropriate caregiver are provided such care in a facility of 20 or fewer beds which offers, within its walls, the full range of services provided by hospice programs under section 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)).

(b) SCOPE OF PROJECT.—The Secretary shall conduct the project under this section with respect to no more than 3 hospice programs over a period of not longer than 5 years each.

(c) COMPLIANCE WITH CONDITIONS.—Under the demonstration project—

(1) the hospice program shall comply with otherwise applicable requirements, except that it shall not be required to offer services outside of the home or to meet the requirements of section 1861(dd)(2)(A)(iii) of the Social Security Act; and

(2) payments for hospice care shall be made at the rates otherwise applicable to such care under title XVIII of such Act.

The Secretary may require the program to comply with such additional quality assurance standards for its provision of services in its facility as the Secretary deems appropriate.

(d) REPORT.—Upon completion of the project, the Secretary shall submit a report to Congress on the project and shall include in the report recommendations regarding extension of such project to hospice programs serving rural areas.

SEC. 410. EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES FROM THE PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITIES.

(a) IN GENERAL.—Section 1888(e)(2)(A) (42 U.S.C. 1395yy(e)(2)(A)) is amended—

(1) in clause (i)(II), by striking "clauses (ii) and (iii)" and inserting "clauses (ii), (iii), and (iv)"; and

(2) by adding at the end the following new clause:

"(iv) EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—Services described in this clause are—

"(I) rural health clinic services (as defined in paragraph (1) of section 1861(aa)); and

"(II) Federally qualified health center services (as defined in paragraph (3) of such section);

that would be described in clause (ii) if such services were furnished by an individual not affiliated with a rural health clinic or a Federally qualified health center.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished on or after January 1, 2005.

SEC. 410A. RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT OF RURAL COMMUNITY HOSPITAL (RCH) DEMONSTRATION PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program to test the feasibility and advisability of the establishment of rural community hospitals (as defined in subsection (f)(1)) to furnish covered inpatient hospital services (as defined in subsection (f)(2)) to medicare beneficiaries.

(2) DEMONSTRATION AREAS.—The program shall be conducted in rural areas selected by the Secretary in States with low population densities, as determined by the Secretary.

(3) APPLICATION.—Each rural community hospital that is located in a demonstration area selected under paragraph (2) that desires to participate in the demonstration program under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(4) SELECTION OF HOSPITALS.—The Secretary shall select from among rural community hospitals submitting applications under paragraph (3) not more than 15 of such hospitals to participate in the demonstration program under this section.

(5) DURATION.—The Secretary shall conduct the demonstration program under this section for a 5-year period.

(6) IMPLEMENTATION.—The Secretary shall implement the demonstration program not later than January 1, 2005, but may not implement the program before October 1, 2004.

(b) PAYMENT.—

(1) IN GENERAL.—The amount of payment under the demonstration program for covered inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is—

(A) for discharges occurring in the first cost reporting period beginning on or after the implementation of the demonstration program, the reasonable costs of providing such services; and

(B) for discharges occurring in a subsequent cost reporting period under the demonstration program, the lesser of—

(i) the reasonable costs of providing such services in the cost reporting period involved; or

(ii) the target amount (as defined in paragraph (2), applicable to the cost reporting period involved.

(2) TARGET AMOUNT.—For purposes of paragraph (1)(B)(ii), the term ''target amount'' means, with respect to a rural community hospital for a particular 12-month cost reporting period—

(A) in the case of the second such reporting period for which this subsection is in effect, the reasonable costs of providing such covered inpatient hospital services as determined under paragraph (1)(A), and

(B) in the case of a later reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase (under clause (i) of section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B))) in the market basket percentage increase (as defined in clause (iii) of such section) for that particular cost reporting period.

(c) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(d) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(e) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(f) DEFINITIONS.—In this section:

(1) RURAL COMMUNITY HOSPITAL DEFINED.—

(A) IN GENERAL.—The term ''rural community hospital'' means a hospital (as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e))) that—

(i) is located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) or treated as being so located pursuant to section 1886(d)(8)(E) of such Act (42 U.S.C. 1395ww(d)(8)(E));

(ii) subject to paragraph (2), has fewer than 51 acute care inpatient beds, as reported in its most recent cost report;

(iii) makes available 24-hour emergency care services; and

(iv) is not eligible for designation, or has not been designated, as a critical access hospital under section 1820.

(B) TREATMENT OF PSYCHIATRIC AND REHABILITATION UNITS.—For purposes of paragraph (1)(B), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital shall not be counted.

(2) COVERED INPATIENT HOSPITAL SERVICES.—The term ''covered inpatient hospital services'' means inpatient hospital services, and includes extended care services furnished under an agreement under section 1883 of the Social Security Act (42 U.S.C. 1395tt).

Subtitle B—Provisions Relating to Part B Only

SEC. 411. 2-YEAR EXTENSION OF HOLD HARMLESS PROVISIONS FOR SMALL RURAL HOSPITALS AND SOLE COMMUNITY HOSPITALS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) HOLD HARMLESS PROVISIONS.—

(1) IN GENERAL.—Section 1833(t)(7)(D)(i) (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(A) in the heading, by striking ''SMALL'' and inserting ''CERTAIN'';

(B) by inserting ''or a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) located in a rural area'' after ''100 beds''; and

(C) by striking ''2004'' and inserting ''2006''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1)(B) shall apply with respect to cost reporting periods beginning on and after January 1, 2004.

(b) STUDY; AUTHORIZATION OF ADJUSTMENT.—Section 1833(t) (42 U.S.C. 1395l(t)) is amended—

(1) by redesignating paragraph (13) as paragraph (16); and

(2) by inserting after paragraph (12) the following new paragraph:

''(13) AUTHORIZATION OF ADJUSTMENT FOR RURAL HOSPITALS.—

''(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals located in rural areas by ambulatory payment classification groups (APCs) exceed those costs incurred by hospitals located in urban areas.

''(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals located in rural areas exceed those costs incurred by hospitals located in urban areas, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs by January 1, 2006.''.

SEC. 412. ESTABLISHMENT OF FLOOR ON WORK GEOGRAPHIC ADJUSTMENT.

Section 1848(e)(1) (42 U.S.C. 1395w–4(e)(1)) is amended—

(1) in subparagraph (A), by striking ''subparagraphs (B) and (C)'' and inserting ''subparagraphs (B), (C), and (E)''; and

(2) by adding at the end the following new subparagraph:

''(E) FLOOR AT 1.0 ON WORK GEOGRAPHIC INDEX.—After calculating the work geographic index in subparagraph (A)(iii), for purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2007, the Secretary shall increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00.''.

SEC. 413. MEDICARE INCENTIVE PAYMENT PROGRAM IMPROVEMENTS FOR PHYSICIAN SCARCITY.

(a) ADDITIONAL INCENTIVE PAYMENT FOR CERTAIN PHYSICIAN SCARCITY AREAS.—Section 1833 (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

''(u) INCENTIVE PAYMENTS FOR PHYSICIAN SCARCITY AREAS.—

''(1) IN GENERAL.—In the case of physicians' services furnished on or after January 1, 2005, and before January 1, 2008—

''(A) by a primary care physician in a primary care scarcity county (identified under paragraph (4)); or

''(B) by a physician who is not a primary care physician in a specialist care scarcity county (as so identified),

in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid an amount equal to 5 percent of the payment amount for the service under this part.

''(2) DETERMINATION OF RATIOS OF PHYSICIANS TO MEDICARE BENEFICIARIES IN AREA.—Based upon available data, the Secretary shall establish for each county or equivalent area in the United States, the following:

''(A) NUMBER OF PHYSICIANS PRACTICING IN THE AREA.—The number of physicians who furnish physicians' services in the active practice of medicine or osteopathy in that county or area, other than physicians whose practice is exclusively for the Federal Government, physicians who are retired, or physicians who only provide administrative services. Of such number, the number of such physicians who are—

''(i) primary care physicians; or

''(ii) physicians who are not primary care physicians.

''(B) NUMBER OF MEDICARE BENEFICIARIES RESIDING IN THE AREA.—The number of individuals who are residing in the county and are entitled to benefits under part A or enrolled under this part, or both (in this subsection referred to as 'individuals').

''(C) DETERMINATION OF RATIOS.—

''(i) PRIMARY CARE RATIO.—The ratio (in this paragraph referred to as the 'primary care ratio') of the number of primary care physicians (determined under subparagraph (A)(i)), to the number of individuals determined under subparagraph (B).

''(ii) SPECIALIST CARE RATIO.—The ratio (in this paragraph referred to as the 'specialist care

ratio') of the number of other physicians (determined under subparagraph (A)(ii)), to the number of individuals determined under subparagraph (B).

"(3) RANKING OF COUNTIES.—The Secretary shall rank each such county or area based separately on its primary care ratio and its specialist care ratio.

"(4) IDENTIFICATION OF COUNTIES.—

"(A) IN GENERAL.—The Secretary shall identify—

"(i) those counties and areas (in this paragraph referred to as 'primary care scarcity counties') with the lowest primary care ratios that represent, if each such county or area were weighted by the number of individuals determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the individuals determined under such paragraph; and

"(ii) those counties and areas (in this subsection referred to as 'specialist care scarcity counties') with the lowest specialist care ratios that represent, if each such county or area were weighted by the number of individuals determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the individuals determined under such paragraph.

"(B) PERIODIC REVISIONS.—The Secretary shall periodically revise the counties or areas identified in subparagraph (A) (but not less often than once every three years) unless the Secretary determines that there is no new data available on the number of physicians practicing in the county or area or the number of individuals residing in the county or area, as identified in paragraph (2).

"(C) IDENTIFICATION OF COUNTIES WHERE SERVICE IS FURNISHED.—For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code is in a scarcity county identified in subparagraph (A) or revised in subparagraph (B).

"(D) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting—

"(i) the identification of a county or area;

"(ii) the assignment of a specialty of any physician under this paragraph;

"(iii) the assignment of a physician to a county under paragraph (2); or

"(iv) the assignment of a postal ZIP Code to a county or other area under this subsection.

"(5) RURAL CENSUS TRACTS.—To the extent feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)), as an equivalent area for purposes of qualifying as a primary care scarcity county or specialist care scarcity county under this subsection.

"(6) PHYSICIAN DEFINED.—For purposes of this paragraph, the term 'physician' means a physician described in section 1861(r)(1) and the term 'primary care physician' means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

"(7) PUBLICATION OF LIST OF COUNTIES; POSTING ON WEBSITE.—With respect to a year for which a county or area is identified or revised under paragraph (4), the Secretary shall identify such counties or areas as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the applicable year. The Secretary shall post the list of counties identified or revised under paragraph (4) on the Internet website of the Centers for Medicare & Medicaid Services.".

(b) IMPROVEMENT TO MEDICARE INCENTIVE PAYMENT PROGRAM.—

(1) IN GENERAL.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended—

(A) by inserting "(1)" after "(m)";

(B) in paragraph (1), as designated by subparagraph (A)—

(i) by inserting "in a year" after "In the case of physicians' services furnished"; and

(ii) by inserting "as identified by the Secretary prior to the beginning of such year" after "as a health professional shortage area"; and

(C) by adding at the end the following new paragraphs:

"(2) For each health professional shortage area identified in paragraph (1) that consists of an entire county, the Secretary shall provide for the additional payment under paragraph (1) without any requirement on the physician to identify the health professional shortage area involved. The Secretary may implement the previous sentence using the method specified in subsection (u)(4)(C).

"(3) The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the health professional shortage areas identified in paragraph (1) that consist of a partial county to facilitate the additional payment under paragraph (1) in such areas.

"(4) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, respecting—

"(A) the identification of a county or area;

"(B) the assignment of a specialty of any physician under this paragraph;

"(C) the assignment of a physician to a county under this subsection; or

"(D) the assignment of a postal zip code to a county or other area under this subsection.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to physicians' services furnished on or after January 1, 2005.

(c) GAO STUDY OF GEOGRAPHIC DIFFERENCES IN PAYMENTS FOR PHYSICIANS' SERVICES.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study of differences in payment amounts under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians' services in different geographic areas. Such study shall include—

(A) an assessment of the validity of the geographic adjustment factors used for each component of the fee schedule;

(B) an evaluation of the measures used for such adjustment, including the frequency of revisions;

(C) an evaluation of the methods used to determine professional liability insurance costs used in computing the malpractice component, including a review of increases in professional liability insurance premiums and variation in such increases by State and physician specialty and methods used to update the geographic cost of practice index and relative weights for the malpractice component; and

(D) an evaluation of the effect of the adjustment to the physician work geographic index under section 1848(e)(1)(E) of the Social Security Act, as added by section 412, on physician location and retention in areas affected by such adjustment, taking into account—

(i) differences in recruitment costs and retention rates for physicians, including specialists, between large urban areas and other areas; and

(ii) the mobility of physicians, including specialists, over the last decade.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include recommendations regarding the use of more current data in computing geographic cost of practice indices as well as the use of data directly representative of physicians' costs (rather than proxy measures of such costs).

SEC. 414. PAYMENT FOR RURAL AND URBAN AMBULANCE SERVICES.

(a) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—Section 1834(l) (42 U.S.C. 1395m(l)) is amended—

(1) in paragraph (2)(E), by inserting "consistent with paragraph (11)" after "in an efficient and fair manner"; and

(2) by redesignating paragraph (8), as added by section 221(a) of BIPA (114 Stat. 2763A–486), as paragraph (9); and

(3) by adding at the end the following new paragraph:

"(10) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In carrying out the phase-in under paragraph (2)(E) for each level of ground service furnished in a year, the portion of the payment amount that is based on the fee schedule shall be the greater of the amount determined under such fee schedule (without regard to this paragraph) or the following blended rate of the fee schedule under paragraph (1) and of a regional fee schedule for the region involved:

"(A) For 2004 (for services furnished on or after July 1, 2004), the blended rate shall be based 20 percent on the fee schedule under paragraph (1) and 80 percent on the regional fee schedule.

"(B) For 2005, the blended rate shall be based 40 percent on the fee schedule under paragraph (1) and 60 percent on the regional fee schedule.

"(C) For 2006, the blended rate shall be based 60 percent on the fee schedule under paragraph (1) and 40 percent on the regional fee schedule.

"(D) For 2007, 2008, and 2009, the blended rate shall be based 80 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule.

"(E) For 2010 and each succeeding year, the blended rate shall be based 100 percent on the fee schedule under paragraph (1).

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the nine census divisions (referred to in section 1886(d)(2)) using the methodology (used in establishing the fee schedule under paragraph (1)) to calculate a regional conversion factor and a regional mileage payment rate and using the same payment adjustments and the same relative value units as used in the fee schedule under such paragraph.".

(b) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—Section 1834(l), as amended by subsection (a), is amended by adding at the end the following new paragraph:

"(11) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—In the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2009, regardless of where the transportation originates, the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by ¼ of the payment per mile otherwise applicable to miles in excess of 50 miles in such trip.".

(c) IMPROVEMENT IN PAYMENTS TO RETAIN EMERGENCY CAPACITY FOR AMBULANCE SERVICES IN RURAL AREAS.—

(1) IN GENERAL.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by subsections (a) and (b), is amended by adding at the end the following new paragraph:

"(12) ASSISTANCE FOR RURAL PROVIDERS FURNISHING SERVICES IN LOW POPULATION DENSITY AREAS.—

"(A) IN GENERAL.—In the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2010, for which the transportation originates in a qualified rural area (identified under subparagraph (B)(iii)), the Secretary shall provide for a percent increase in the base rate of the fee schedule for a trip established under this subsection. In establishing such percent increase, the Secretary shall estimate the average cost per trip for such services (not taking into account mileage) in the lowest quartile as compared to the average cost per trip for such services (not taking into account mileage) in the highest quartile of all rural county populations.

"(B) IDENTIFICATION OF QUALIFIED RURAL AREAS.—

"(i) DETERMINATION OF POPULATION DENSITY IN AREA.—Based upon data from the United States decennial census for the year 2000, the Secretary shall determine, for each rural area, the population density for that area.

"(ii) RANKING OF AREAS.—The Secretary shall rank each such area based on such population density.

"(iii) IDENTIFICATION OF QUALIFIED RURAL AREAS.—The Secretary shall identify those areas (in subparagraph (A) referred to as 'qualified rural areas') with the lowest population densities that represent, if each such area were weighted by the population of such area (as used in computing such population densities), an aggregate total of 25 percent of the total of the population of all such areas.

"(iv) RURAL AREA.—For purposes of this paragraph, the term 'rural area' has the meaning given such term in section 1886(d)(2)(D). If feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725) as a rural area for purposes of this paragraph.

"(v) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of an area under this subparagraph.".

(2) USE OF DATA.—In order to promptly implement section 1834(l)(12) of the Social Security Act, as added by paragraph (1), the Secretary may use data furnished by the Comptroller General of the United States.

(d) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by subsections (a), (b), and (c), is amended by adding at the end the following new paragraph:

"(13) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—

"(A) IN GENERAL.—After computing the rates with respect to ground ambulance services under the other applicable provisions of this subsection, in the case of such services furnished on or after July 1, 2004, and before January 1, 2007, for which the transportation originates in—

"(i) a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section shall provide that the rate for the service otherwise established, after the application of any increase under paragraphs (11) and (12), shall be increased by 2 percent; and

"(ii) an area not described in clause (i), the fee schedule established under this subsection shall provide that the rate for the service otherwise established, after the application of any increase under paragraph (11), shall be increased by 1 percent.

"(B) APPLICATION OF INCREASED PAYMENTS AFTER 2006.—The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished after the period specified in such subparagraph.".

(e) IMPLEMENTATION.—The Secretary may implement the amendments made by this section, and revise the conversion factor applicable under section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)) for purposes of implementing such amendments, on an interim final basis, or by program instruction.

(f) GAO REPORT ON COSTS AND ACCESS.—Not later than December 31, 2005, the Comptroller General of the United States shall submit to Congress an initial report on how costs differ among the types of ambulance providers and on access, supply, and quality of ambulance services in those regions and States that have a reduction in payment under the medicare ambulance fee schedule (under section 1834(l) of the Social Security Act, as amended by this Act). Not later than December 31, 2007, the Comptroller General shall submit to Congress a final report on such access and supply.

(g) TECHNICAL AMENDMENTS.—(1) Section 221(c) of BIPA (114 Stat. 2763A-487) is amended by striking "subsection (b)(2)" and inserting "subsection (b)(3)".

(2) Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by moving subparagraph (U) 4 ems to the left.

SEC. 415. PROVIDING APPROPRIATE COVERAGE OF RURAL AIR AMBULANCE SERVICES.

(a) COVERAGE.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by subsections (a), (b), (c), and (d) of section 414, is amended by adding at the end the following new paragraph:

"(14) PROVIDING APPROPRIATE COVERAGE OF RURAL AIR AMBULANCE SERVICES.—

"(A) IN GENERAL.—The regulations described in section 1861(s)(7) shall provide, to the extent that any ambulance services (whether ground or air) may be covered under such section, that a rural air ambulance service (as defined in subparagraph (C)) is reimbursed under this subsection at the air ambulance rate if the air ambulance service—

"(i) is reasonable and necessary based on the health condition of the individual being transported at or immediately prior to the time of the transport; and

"(ii) complies with equipment and crew requirements established by the Secretary.

"(B) SATISFACTION OF REQUIREMENT OF MEDICALLY NECESSARY.—The requirement of subparagraph (A)(i) is deemed to be met for a rural air ambulance service if—

"(i) subject to subparagraph (D), such service is requested by a physician or other qualified medical personnel (as specified by the Secretary) who reasonably determines or certifies that the individual's condition is such that the time needed to transport the individual by land or the instability of transportation by land poses a threat to the individual's survival or seriously endangers the individual's health; or

"(ii) such service is furnished pursuant to a protocol that is established by a State or regional emergency medical service (EMS) agency and recognized or approved by the Secretary under which the use of an air ambulance is recommended, if such agency does not have an ownership interest in the entity furnishing such service.

"(C) RURAL AIR AMBULANCE SERVICE DEFINED.—For purposes of this paragraph, the term 'rural air ambulance service' means fixed wing and rotary wing air ambulance service in which the point of pick up of the individual occurs in a rural area (as defined in section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

"(D) LIMITATION.—

"(i) IN GENERAL.—Subparagraph (B)(i) shall not apply if there is a financial or employment relationship between the person requesting the rural air ambulance service and the entity furnishing the ambulance service, or an entity under common ownership with the entity furnishing the air ambulance service, or a financial relationship between an immediate family member of such requester and such an entity.

"(ii) EXCEPTION.—Where a hospital and the entity furnishing rural air ambulance services are under common ownership, clause (i) shall not apply to remuneration (through employment or other relationship) by the hospital of the requester or immediate family member if the remuneration is for provider-based physician services furnished in a hospital (as described in section 1887) which are reimbursed under part A and the amount of the remuneration is unrelated directly or indirectly to the provision of rural air ambulance services.".

(b) CONFORMING AMENDMENT.—Section 1861(s)(7) (42 U.S.C. 1395x(s)(7)) is amended by inserting ", subject to section 1834(l)(14)," after "but".

(c) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 2005.

SEC. 416. TREATMENT OF CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL OUTPATIENTS IN CERTAIN RURAL AREAS.

(a) IN GENERAL.—Notwithstanding subsections (a), (b), and (h) of section 1833 of the Social Security Act (42 U.S.C. 1395l) and section 1834(d)(1) of such Act (42 U.S.C. 1395m(d)(1)), in the case of a clinical diagnostic laboratory test covered under part B of title XVIII of such Act that is furnished during a cost reporting period described in subsection (b) by a hospital with fewer than 50 beds that is located in a qualified rural area (identified under paragraph (12)(B)(iii) of section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)), as added by section 414(c)) as part of outpatient services of the hospital, the amount of payment for such test shall be 100 percent of the reasonable costs of the hospital in furnishing such test.

(b) APPLICATION.—A cost reporting period described in this subsection is a cost reporting period beginning during the 2-year period beginning on July 1, 2004.

(c) PROVISION AS PART OF OUTPATIENT HOSPITAL SERVICES.—For purposes of subsection (a), in determining whether clinical diagnostic laboratory services are furnished as part of outpatient services of a hospital, the Secretary shall apply the same rules that are used to determine whether clinical diagnostic laboratory services are furnished as an outpatient critical access hospital service under section 1834(g)(4) of the Social Security Act (42 U.S.C. 1395m(g)(4)).

SEC. 417. EXTENSION OF TELEMEDICINE DEMONSTRATION PROJECT.

Section 4207 of the Balanced Budget Act of 1997 (Public Law 105–33) is amended—

(1) in subsection (a)(4), by striking "4-year" and inserting "8-year"; and

(2) in subsection (d)(3), by striking "$30,000,000" and inserting "$60,000,000".

SEC. 418. REPORT ON DEMONSTRATION PROJECT PERMITTING SKILLED NURSING FACILITIES TO BE ORIGINATING TELEHEALTH SITES; AUTHORITY TO IMPLEMENT.

(a) EVALUATION.—The Secretary, acting through the Administrator of the Health Resources and Services Administration in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall evaluate demonstration projects conducted by the Secretary under which skilled nursing facilities

(as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)) are treated as originating sites for telehealth services.

(b) REPORT.—Not later than January 1, 2005, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a). Such report shall include recommendations on mechanisms to ensure that permitting a skilled nursing facility to serve as an originating site for the use of telehealth services or any other service delivered via a telecommunications system does not serve as a substitute for in-person visits furnished by a physician, or for in-person visits furnished by a physician assistant, nurse practitioner or clinical nurse specialist, as is otherwise required by the Secretary.

(c) AUTHORITY TO EXPAND ORIGINATING TELEHEALTH SITES TO INCLUDE SKILLED NURSING FACILITIES.—Insofar as the Secretary concludes in the report required under subsection (b) that it is advisable to permit a skilled nursing facility to be an originating site for telehealth services under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), and that the Secretary can establish the mechanisms to ensure such permission does not serve as a substitute for in-person visits furnished by a physician, or for in-person visits furnished by a physician assistant, nurse practitioner or clinical nurse specialist, the Secretary may deem a skilled nursing facility to be an originating site under paragraph (4)(C)(ii) of such section beginning on January 1, 2006.

Subtitle C—Provisions Relating to Parts A and B

SEC. 421. 1-YEAR INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) IN GENERAL.—With respect to episodes and visits ending on or after April 1, 2004, and before April 1, 2005, in the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))), the Secretary shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 5 percent.

(b) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a).

(c) NO EFFECT ON SUBSEQUENT PERIODS.—The payment increase provided under subsection (a) for a period under such subsection—

(1) shall not apply to episodes and visits ending after such period; and

(2) shall not be taken into account in calculating the payment amounts applicable for episodes and visits occurring after such period.

SEC. 422. REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.

(a) IN GENERAL.—Section 1886(h) (42 U.S.C. 1395ww(h)(4)) is amended—

(1) in paragraph (4)(F)(i), by inserting "subject to paragraph (7)," after "October 1, 1997,";

(2) in paragraph (4)(H)(i), by inserting "and subject to paragraph (7)" after "subparagraphs (F) and (G)"; and

(3) by adding at the end the following new paragraph:

"(7) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

"(A) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

"(i) PROGRAMS SUBJECT TO REDUCTION.—

"(I) IN GENERAL.—Except as provided in subclause (II), if a hospital's reference resident level (specified in clause (ii)) is less than the otherwise applicable resident limit (as defined in subparagraph (C)(ii)), effective for portions of cost reporting periods occurring on or after July 1, 2005, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such otherwise applicable resident limit and such reference resident level.

"(II) EXCEPTION FOR SMALL RURAL HOSPITALS.—This subparagraph shall not apply to a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds.

"(ii) REFERENCE RESIDENT LEVEL.—

"(I) IN GENERAL.—Except as otherwise provided in subclauses (II) and (III), the reference resident level specified in this clause for a hospital is the resident level for the most recent cost reporting period of the hospital ending on or before September 30, 2002, for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

"(II) USE OF MOST RECENT ACCOUNTING PERIOD TO RECOGNIZE EXPANSION OF EXISTING PROGRAMS.—If a hospital submits a timely request to increase its resident level due to an expansion of an existing residency training program that is not reflected on the most recent settled cost report, after audit and subject to the discretion of the Secretary, the reference resident level for such hospital is the resident level for the cost reporting period that includes July 1, 2003, as determined by the Secretary.

"(III) EXPANSIONS UNDER NEWLY APPROVED PROGRAMS.—Upon the timely request of a hospital, the Secretary shall adjust the reference resident level specified under subclause (I) or (II) to include the number of medical residents that were approved in an application for a medical residency training program that was approved by an appropriate accrediting organization (as determined by the Secretary) before January 1, 2002, but which was not in operation during the cost reporting period used under subclause (I) or (II), as the case may be, as determined by the Secretary.

"(iii) AFFILIATION.—The provisions of clause (i) shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) as of July 1, 2003.

"(B) REDISTRIBUTION.—

"(i) IN GENERAL.—The Secretary is authorized to increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2005. The aggregate number of increases in the otherwise applicable resident limits under this subparagraph may not exceed the Secretary's estimate of the aggregate reduction in such limits attributable to subparagraph (A).

"(ii) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under clause (i), the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions within the first 3 cost reporting periods beginning on or after July 1, 2005, made available under this subparagraph, as determined by the Secretary.

"(iii) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under clause (i), the Secretary shall distribute the increase to programs of hospitals located in the following priority order:

"(I) First, to hospitals located in rural areas (as defined in subsection (d)(2)(D)(ii)).

"(II) Second, to hospitals located in urban areas that are not large urban areas (as defined for purposes of subsection (d)).

"(III) Third, to other hospitals in a State if the residency training program involved is in a specialty for which there are not other residency training programs in the State.

Increases of residency limits within the same priority category under this clause shall be determined by the Secretary.

"(iv) LIMITATION.—In no case shall more than 25 full-time equivalent additional residency positions be made available under this subparagraph with respect to any hospital.

"(v) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this subparagraph, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under paragraph (4)(E) for that hospital.

"(vi) CONSTRUCTION.—Nothing in this subparagraph shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6), under a demonstration project approved as of October 31, 2003, under the authority of section 402 of Public Law 90–248, or as affecting the ability of a hospital to establish new medical residency training programs under paragraph (4)(H).

"(C) RESIDENT LEVEL AND LIMIT DEFINED.—In this paragraph:

"(i) RESIDENT LEVEL.—The term 'resident level' means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under paragraph (4)), in the fields of allopathic and osteopathic medicine for the hospital.

"(ii) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph.

"(D) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, with respect to determinations made under this paragraph.".

(b) CONFORMING PROVISIONS.—(1) Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended—

(A) in the second sentence of clause (ii), by striking "For discharges" and inserting "Subject to clause (ix), for discharges";

(B) in clause (v), by adding at the end the following: "The provisions of subsection (h)(7) shall apply with respect to the first sentence of this clause in the same manner as it applies with respect to subsection (h)(4)(F)(i)."; and

(C) by adding at the end the following new clause:

"(ix) For discharges occurring on or after July 1, 2005, insofar as an additional payment amount under this subparagraph is attributable to resident positions redistributed to a hospital under subsection (h)(7)(B), in computing the indirect teaching adjustment factor under clause (ii) the adjustment shall be computed in a manner as if 'c' were equal to 0.66 with respect to such resident positions.".

(2) Chapter 35 of title 44, United States Code, shall not apply with respect to applications under section 1886(h)(7) of the Social Security Act, as added by subsection (a)(3).

(c) REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2005, the Secretary shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident limits under section 1886(h)(4)(I)(ii)(II) of the Social Security Act (as added by subsection (a)).

Subtitle D—Other Provisions

SEC. 431. PROVIDING SAFE HARBOR FOR CERTAIN COLLABORATIVE EFFORTS THAT BENEFIT MEDICALLY UNDERSERVED POPULATIONS.

(a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C. 1320a–7(b)(3)), as amended by section 101(e)(2), is amended—

(1) in subparagraph (F), by striking "and" after the semicolon at the end;

(2) in subparagraph (G), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(H) any remuneration between a health center entity described under clause (i) or (ii) of section 1905(l)(2)(B) and any individual or entity providing goods, items, services, donations, loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity.".

(b) RULEMAKING FOR EXCEPTION FOR HEALTH CENTER ENTITY ARRANGEMENTS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary shall establish, on an expedited basis, standards relating to the exception described in section 1128B(b)(3)(H) of the Social Security Act, as added by subsection (a), for health center entity arrangements to the antikickback penalties.

(B) FACTORS TO CONSIDER.—The Secretary shall consider the following factors, among others, in establishing standards relating to the exception for health center entity arrangements under subparagraph (A):

(i) Whether the arrangement between the health center entity and the other party results in savings of Federal grant funds or increased revenues to the health center entity.

(ii) Whether the arrangement between the health center entity and the other party restricts or limits an individual's freedom of choice.

(iii) Whether the arrangement between the health center entity and the other party protects a health care professional's independent medical judgment regarding medically appropriate treatment.

The Secretary may also include other standards and criteria that are consistent with the intent of Congress in enacting the exception established under this section.

(2) DEADLINE.—Not later than 1 year after the date of the enactment of this Act the Secretary shall publish final regulations establishing the standards described in paragraph (1).

SEC. 432. OFFICE OF RURAL HEALTH POLICY IMPROVEMENTS.

Section 711(b) (42 U.S.C. 912(b)) is amended—

(1) in paragraph (3), by striking "and" after the comma at the end;

(2) in paragraph (4), by striking the period at the end and inserting ", and"; and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) administer grants, cooperative agreements, and contracts to provide technical assistance and other activities as necessary to support activities related to improving health care in rural areas.".

SEC. 433. MEDPAC STUDY ON RURAL HOSPITAL PAYMENT ADJUSTMENTS.

(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study of the impact of sections 401 through 406, 411, 416, and 505. The Commission shall analyze the effect on total payments, growth in costs, capital spending, and such other payment effects under those sections.

(b) REPORTS.—

(1) INTERIM REPORT.—Not later than 18 months after the date of the enactment of this Act, the Commission shall submit to Congress an interim report on the matters studied under subsection (a) with respect only to changes to the critical access hospital provisions under section 405.

(2) FINAL REPORT.—Not later than 3 years after the date of the enactment of this Act, the Commission shall submit to Congress a final report on all matters studied under subsection (a).

SEC. 434. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas are treated as providers of items and services under the medicare program.

(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—

(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

(B) patients who need monitoring and observation for a limited period of time.

(c) SPECIFICATION OF CODES.—The Secretary shall determine the appropriate life-safety codes for such clinics that treat patients for needs referred to in subsection (b)(2).

(d) FUNDING.—

(1) IN GENERAL.—Subject to paragraph (2), there are authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, such sums as are necessary to conduct the demonstration project under this section.

(2) BUDGET NEUTRAL IMPLEMENTATION.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under the medicare program do not exceed the amount which the Secretary would have paid under the medicare program if the demonstration project under this section was not implemented.

(e) 3-YEAR PERIOD.—The Secretary shall conduct the demonstration under this section for a 3-year period.

(f) REPORT.—Not later than the date that is 1 year after the date on which the demonstration project concludes, the Secretary shall submit to Congress a report on the demonstration project, together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

(g) DEFINITIONS.—In this section, the terms "hospital" and "critical access hospital" have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

TITLE V—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

SEC. 501. REVISION OF ACUTE CARE HOSPITAL PAYMENT UPDATES.

(a) IN GENERAL.—Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(1) by striking "and" at the end of subclause (XVIII);

(2) by striking subclause (XIX); and

(3) by inserting after subclause (XVIII) the following new subclauses:

"(XIX) for each of fiscal years 2004 through 2007, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and

"(XX) for fiscal year 2008 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.".

(b) SUBMISSION OF HOSPITAL QUALITY DATA.—Section 1886(b)(3)(B) (42 U.S.C. 1395ww(b)(3)(B)) is amended by adding at the end the following new clause:

"(vii)(I) For purposes of clause (i)(XIX) for each of fiscal years 2005 through 2007, in a case of a subsection (d) hospital that does not submit data to the Secretary in accordance with subclause (II) with respect to such a fiscal year, the applicable percentage increase under such clause for such fiscal year shall be reduced by 0.4 percentage points. Such reduction shall apply only with respect to the fiscal year involved, and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i)(XIX) for a subsequent fiscal year.

"(II) Each subsection (d) hospital shall submit to the Secretary quality data (for a set of 10 indicators established by the Secretary as of November 1, 2003) that relate to the quality of care furnished by the hospital in inpatient settings in a form and manner, and at a time, specified by the Secretary for purposes of this clause, but with respect to fiscal year 2005, the Secretary shall provide for a 30-day grace period for the submission of data by a hospital.".

(c) GAO STUDY AND REPORT ON APPROPRIATENESS OF PAYMENTS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES.—

(1) STUDY.—The Comptroller General of the United States, using the most current data available, shall conduct a study to determine—

(A) the appropriate level and distribution of payments in relation to costs under the prospective payment system under section 1886 of the Social Security Act (42 U.S.C. 1395ww) for inpatient hospital services furnished by subsection (d) hospitals (as defined in subsection (d)(1)(B) of such section); and

(B) whether there is a need to adjust such payments under such system to reflect legitimate differences in costs across different geographic areas, kinds of hospitals, and types of cases.

(2) REPORT.—Not later than 24 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislative and administrative action as the Comptroller General determines appropriate.

SEC. 502. REVISION OF THE INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT PERCENTAGE.

(a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) in subclause (VI), by striking "and" after the semicolon at the end;

(2) in subclause (VII)—

(A) by inserting "and before April 1, 2004," after "on or after October 1, 2002,"; and

(B) by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new subclauses:

"(VIII) on or after April 1, 2004, and before October 1, 2004, 'c' is equal to 1.47;

"(IX) during fiscal year 2005, 'c' is equal to 1.42;

"(X) during fiscal year 2006, 'c' is equal to 1.37;

"(XI) during fiscal year 2007, 'c' is equal to 1.32; and

"(XII) on or after October 1, 2007, 'c' is equal to 1.35.".

(b) Conforming Amendment Relating to Determination of Standardized Amount.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

(1) by striking "1999 or" and inserting "1999,"; and

(2) by inserting ", or the Medicare Prescription Drug, Improvement, and Modernization Act of 2003" after "2000".

(c) Effective Date.—The amendments made by this section shall apply to discharges occurring on or after April 1, 2004.

SEC. 503. RECOGNITION OF NEW MEDICAL TECHNOLOGIES UNDER INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

(a) Improving Timeliness of Data Collection.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is amended by adding at the end the following new clause:

"(vii) Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.".

(b) Eligibility Standard for Technology Outliers.—

(1) Adjustment of threshold.—Section 1886(d)(5)(K)(ii)(I) (42 U.S.C. 1395ww(d)(5)(K)(ii)(I)) is amended by inserting "(applying a threshold specified by the Secretary that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation for the diagnosis-related group involved)" after "is inadequate".

(2) Process for public input.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as amended by subsection (a), is amended—

(A) in clause (i), by adding at the end the following: "Such mechanism shall be modified to meet the requirements of clause (viii)."; and

(B) by adding at the end the following new clause:

"(viii) The mechanism established pursuant to clause (i) shall be adjusted to provide, before publication of a proposed rule, for public input regarding whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of individuals entitled to benefits under part A as follows:

"(I) The Secretary shall make public and periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

"(II) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

"(III) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, such individuals, manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking regarding whether service or technology represents a substantial improvement.".

(c) Preference for Use of DRG Adjustment.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as amended by subsections (a) and (b), is amended by adding at the end the following new clause:

"(ix) Before establishing any add-on payment under this subparagraph with respect to a new technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology. Within such groups the Secretary shall assign an eligible new technology into a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. No add-on payment under this subparagraph shall be made with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii).".

(d) Establishment of New Funding for Hospital Inpatient Technology.—

(1) In general.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by striking "subject to paragraph (4)(C)(iii),".

(2) Not budget neutral.—There shall be no reduction or other adjustment in payments under section 1886 of the Social Security Act because an additional payment is provided under subsection (d)(5)(K)(ii)(III) of such section.

(e) Effective Date.—

(1) In general.—The Secretary shall implement the amendments made by this section so that they apply to classification for fiscal years beginning with fiscal year 2005.

(2) Reconsiderations of applications for fiscal year 2004 that are denied.—In the case of an application for a classification of a medical service or technology as a new medical service or technology under section 1886(d)(5)(K) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(K)) that was filed for fiscal year 2004 and that is denied—

(A) the Secretary shall automatically reconsider the application as an application for fiscal year 2005 under the amendments made by this section; and

(B) the maximum time period otherwise permitted for such classification of the service or technology shall be extended by 12 months.

SEC. 504. INCREASE IN FEDERAL RATE FOR HOSPITALS IN PUERTO RICO.

Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking "for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)" and inserting "the applicable Puerto Rico percentage (specified in subparagraph (E))"; and

(B) in clause (ii), by striking "for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent)" and inserting "the applicable Federal percentage (specified in subparagraph (E))"; and

(2) by adding at the end the following new subparagraph:

"(E) For purposes of subparagraph (A), for discharges occurring—

"(i) on or after October 1, 1987, and before October 1, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

"(ii) on or after October 1, 1997, and before April 1, 2004, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

"(iii) on or after April 1, 2004, and before October 1, 2004, the applicable Puerto Rico percentage is 37.5 percent and the applicable Federal percentage is 62.5 percent; and

"(iv) on or after October 1, 2004, the applicable Puerto Rico percentage is 25 percent and the applicable Federal percentage is 75 percent.".

SEC. 505. WAGE INDEX ADJUSTMENT RECLASSIFICATION REFORM.

(a) In General.—Section 1886(d) (42 U.S.C. 1395ww(d)), as amended by section 406, is amended by adding at the end the following new paragraph:

"(13)(A) In order to recognize commuting patterns among geographic areas, the Secretary shall establish a process through application or otherwise for an increase of the wage index applied under paragraph (3)(E) for subsection (d) hospitals located in a qualifying county described in subparagraph (B) in the amount computed under subparagraph (D) based on out-migration of hospital employees who reside in that county to any higher wage index area.

"(B) The Secretary shall establish criteria for a qualifying county under this subparagraph based on the out-migration referred to in subparagraph (A) and differences in the area wage indices. Under such criteria the Secretary shall, utilizing such data as the Secretary determines to be appropriate, establish—

"(i) a threshold percentage, established by the Secretary, of the weighted average of the area wage index or indices for the higher wage index areas involved;

"(ii) a threshold (of not less than 10 percent) for minimum out-migration to a higher wage index area or areas; and

"(iii) a requirement that the average hourly wage of the hospitals in the qualifying county equals or exceeds the average hourly wage of all the hospitals in the area in which the qualifying county is located.

"(C) For purposes of this paragraph, the term 'higher wage index area' means, with respect to a county, an area with a wage index that exceeds that of the county.

"(D) The increase in the wage index under subparagraph (A) for a qualifying county shall be equal to the percentage of the hospital employees residing in the qualifying county who are employed in any higher wage index area multiplied by the sum of the products, for each higher wage index area of—

"(i) the difference between—

"(I) the wage index for such higher wage index area, and

"(II) the wage index of the qualifying county; and

"(ii) the number of hospital employees residing in the qualifying county who are employed in such higher wage index area divided by the total number of hospital employees residing in the qualifying county who are employed in any higher wage index area.

"(E) The process under this paragraph may be based upon the process used by the Medicare Geographic Classification Review Board under paragraph (10). As the Secretary determines to be appropriate to carry out such process, the Secretary may require hospitals (including subsection (d) hospitals and other hospitals) and critical access hospitals, as required under section 1866(a)(1)(T), to submit data regarding the location of residence, or the Secretary may use data from other sources.

"(F) A wage index increase under this paragraph shall be effective for a period of 3 fiscal years, except that the Secretary shall establish procedures under which a subsection (d) hospital may elect to waive the application of such wage index increase.

"(G) A hospital in a county that has a wage index increase under this paragraph for a period and that has not waived the application of such an increase under subparagraph (F) is not eligible for reclassification under paragraph (8) or (10) during that period.

"(H) Any increase in a wage index under this paragraph for a county shall not be taken into account for purposes of—

"(i) computing the wage index for portions of the wage index area (not including the county) in which the county is located; or

"(ii) applying any budget neutrality adjustment with respect to such index under paragraph (8)(D).

"(I) The thresholds described in subparagraph (B), data on hospital employees used under this *paragraph, and any determination of the Secretary under the process described in subparagraph (E) shall be final and shall not be subject to judicial review.".*

(b) CONFORMING AMENDMENTS.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (R), by striking "and" at the end;

(2) in subparagraph (S), by striking the period at the end and inserting ", and"; and

(3) by inserting after subparagraph (S) the following new subparagraph:

"(T) in the case of hospitals and critical access hospitals, to furnish to the Secretary such data as the Secretary determines appropriate pursuant to subparagraph (E) of section 1886(d)(12) to carry out such section.".

(c) EFFECTIVE DATE.—The amendments made by this section shall first apply to the wage index for discharges occurring on or after October 1, 2004. In initially implementing such amendments, the Secretary may modify the deadlines otherwise applicable under clauses (ii) and (iii)(I) of section 1886(d)(10)(C) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(C)), for submission of, and actions on, applications relating to changes in hospital geographic reclassification.

SEC. 506. LIMITATION ON CHARGES FOR INPATIENT HOSPITAL CONTRACT HEALTH SERVICES PROVIDED TO INDIANS BY MEDICARE PARTICIPATING HOSPITALS.

(a) IN GENERAL.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)), as amended by section 505(b), is amended—

(1) in subparagraph (S), by striking "and" at the end;

(2) in subparagraph (T), by striking the period and inserting ", and"; and

(3) by inserting after subparagraph (T) the following new subparagraph:

"(U) in the case of hospitals which furnish inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care both—

"(i) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian tribe, or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and

"(ii) under any program funded by the Indian Health Service and operated by an urban Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in such section 4),

in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply as of a date specified by the Secretary of Health and Human Services (but in no case later than 1 year after the date of enactment of this Act) to medicare participation agreements in effect (or entered into) on or after such date.

(c) PROMULGATION OF REGULATIONS.—The Secretary shall promulgate regulations to carry out the amendments made by subsection (a).

SEC. 507. CLARIFICATIONS TO CERTAIN EXCEPTIONS TO MEDICARE LIMITS ON PHYSICIAN REFERRALS.

(a) LIMITS ON PHYSICIAN REFERRALS.—

(1) OWNERSHIP AND INVESTMENT INTERESTS IN WHOLE HOSPITALS.—

(A) IN GENERAL.—Section 1877(d)(3) (42 U.S.C. 1395nn(d)(3)) is amended—

(i) by striking ", and" at the end of subparagraph (A) and inserting a semicolon; and

(ii) by redesignating subparagraph (B) as subparagraph (C) and inserting after subparagraph (A) the following new subparagraph:

"(B) effective for the 18-month period beginning on the date of the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the hospital is not a specialty hospital (as defined in subsection (h)(7)); and".

(B) DEFINITION.—Section 1877(h) (42 U.S.C. 1395nn(h)) is amended by adding at the end the following:

"(7) SPECIALTY HOSPITAL.—

"(A) IN GENERAL.—For purposes of this section, except as provided in subparagraph (B), the term 'specialty hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B)) that is primarily or exclusively engaged in the care and treatment of one of the following categories:

"(i) Patients with a cardiac condition.

"(ii) Patients with an orthopedic condition.

"(iii) Patients receiving a surgical procedure.

"(iv) Any other specialized category of services that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section.

"(B) EXCEPTION.—For purposes of this section, the term 'specialty hospital' does not include any hospital—

"(i) determined by the Secretary—

"(I) to be in operation before November 18, 2003; or

"(II) under development as of such date;

"(ii) for which the number of physician investors at any time on or after such date is no greater than the number of such investors as of such date;

"(iii) for which the type of categories described in subparagraph (A) at any time on or after such date is no different than the type of such categories as of such date;

"(iv) for which any increase in the number of beds occurs only in the facilities on the main campus of the hospital and does not exceed 50 percent of the number of beds in the hospital as of November 18, 2003, or 5 beds, whichever is greater; and

"(v) that meets such other requirements as the Secretary may specify.".

(2) OWNERSHIP AND INVESTMENT INTERESTS IN A RURAL PROVIDER.—Section 1877(d)(2) (42 U.S.C. 1395nn(d)(2)) is amended to read as follows:

"(2) RURAL PROVIDERS.—In the case of designated health services furnished in a rural area (as defined in section 1886(d)(2)(D)) by an entity, if—

"(A) substantially all of the designated health services furnished by the entity are furnished to individuals residing in such a rural area; and

"(B) effective for the 18-month period beginning on the date of the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the entity is not a specialty hospital (as defined in subsection (h)(7)).".

(b) APPLICATION OF EXCEPTION FOR HOSPITALS UNDER DEVELOPMENT.—For purposes of section 1877(h)(7)(B)(i)(II) of the Social Security Act, as added by subsection (a)(1)(B), in determining whether a hospital is under development as of November 18, 2003, the Secretary shall consider—

(1) whether architectural plans have been completed, funding has been received, zoning requirements have been met, and necessary approvals from appropriate State agencies have been received; and

(2) any other evidence the Secretary determines would indicate whether a hospital is under development as of such date.

(c) STUDIES.—

(1) MEDPAC STUDY.—The Medicare Payment Advisory Commission, in consultation with the Comptroller General of the United States, shall conduct a study to determine—

(A) any differences in the costs of health care services furnished to patients by physician-owned specialty hospitals and the costs of such services furnished by local full-service community hospitals within specific diagnosis-related groups;

(B) the extent to which specialty hospitals, relative to local full-service community hospitals, treat patients in certain diagnosis-related groups within a category, such as cardiology, and an analysis of the selection;

(C) the financial impact of physician-owned specialty hospitals on local full-service community hospitals;

(D) how the current diagnosis-related group system should be updated to better reflect the cost of delivering care in a hospital setting; and

(E) the proportions of payments received, by type of payer, between the specialty hospitals and local full-service community hospitals.

(2) HHS STUDY.—The Secretary shall conduct a study of a representative sample of specialty hospitals—

(A) to determine the percentage of patients admitted to physician-owned specialty hospitals who are referred by physicians with an ownership interest;

(B) to determine the referral patterns of physician owners, including the percentage of patients they referred to physician-owned specialty hospitals and the percentage of patients they referred to local full-service community hospitals for the same condition;

(C) to compare the quality of care furnished in physician-owned specialty hospitals and in local full-service community hospitals for similar conditions and patient satisfaction with such care; and

(D) to assess the differences in uncompensated care, as defined by the Secretary, between the specialty hospital and local full-service community hospitals, and the relative value of any tax exemption available to such hospitals.

(3) REPORTS.—Not later than 15 months after the date of the enactment of this Act, the Commission and the Secretary, respectively, shall each submit to Congress a report on the studies conducted under paragraphs (1) and (2), respectively, and shall include any recommendations for legislation or administrative changes.

SEC. 508. 1-TIME APPEALS PROCESS FOR HOSPITAL WAGE INDEX CLASSIFICATION.

(a) ESTABLISHMENT OF PROCESS.—

(1) IN GENERAL.—The Secretary shall establish not later than January 1, 2004, by instruction or otherwise a process under which a hospital may appeal the wage index classification otherwise applicable to the hospital and select another area within the State (or, at the discretion of the Secretary, within a contiguous State) to which to be reclassified.

(2) PROCESS REQUIREMENTS.—The process established under paragraph (1) shall be consistent with the following:

(A) Such an appeal may be filed as soon as possible after the date of the enactment of this Act but shall be filed by not later than February 15, 2004.

(B) Such an appeal shall be heard by the Medicare Geographic Reclassification Review Board.

(C) There shall be no further administrative or judicial review of a decision of such Board.

(3) RECLASSIFICATION UPON SUCCESSFUL APPEAL.—If the Medicare Geographic Reclassification Review Board determines that the hospital

is a qualifying hospital (as defined in subsection (c)), the hospital shall be reclassified to the area selected under paragraph (1). Such reclassification shall apply with respect to discharges occurring during the 3-year period beginning with April 1, 2004.

(4) INAPPLICABILITY OF CERTAIN PROVISIONS.—Except as the Secretary may provide, the provisions of paragraphs (8) and (10) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) shall not apply to an appeal under this section.

(b) APPLICATION OF RECLASSIFICATION.—In the case of an appeal decided in favor of a qualifying hospital under subsection (a), the wage index reclassification shall not affect the wage index computation for any area or for any other hospital and shall not be effected in a budget neutral manner. The provisions of this section shall not affect payment for discharges occurring after the end of the 3-year-period referred to in subsection (a).

(c) QUALIFYING HOSPITAL DEFINED.—For purposes of this section, the term "qualifying hospital" means a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) that—

(1) does not qualify for a change in wage index classification under paragraph (8) or (10) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) on the basis of requirements relating to distance or commuting; and

(2) meets such other criteria, such as quality, as the Secretary may specify by instruction or otherwise.

The Secretary may modify the wage comparison guidelines promulgated under section 1886(d)(10)(D) of such Act (42 U.S.C. 1395ww(d)(10)(D)) in carrying out this section.

(d) WAGE INDEX CLASSIFICATION.—For purposes of this section, the term "wage index classification" means the geographic area in which it is classified for purposes of determining for a fiscal year the factor used to adjust the DRG prospective payment rate under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) for area differences in hospital wage levels that applies to such hospital under paragraph (3)(E) of such section.

(e) LIMITATION ON EXPENDITURES.—The aggregate amount of additional expenditures resulting from the application of this section shall not exceed $900,000,000.

(f) TRANSITIONAL EXTENSION.—Any reclassification of a county or other area made by Act of Congress for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) that expired on September 30, 2003, shall be deemed to be in effect during the period beginning on January 1, 2004, and ending on September 30, 2004.

Subtitle B—Other Provisions

SEC. 511. PAYMENT FOR COVERED SKILLED NURSING FACILITY SERVICES.

(a) ADJUSTMENT TO RUGs FOR AIDS RESIDENTS.—Paragraph (12) of section 1888(e) (42 U.S.C. 1395yy(e)) is amended to read as follows:

"(12) ADJUSTMENT FOR RESIDENTS WITH AIDS.—

"(A) IN GENERAL.—Subject to subparagraph (B), in the case of a resident of a skilled nursing facility who is afflicted with acquired immune deficiency syndrome (AIDS), the per diem amount of payment otherwise applicable (determined without regard to any increase under section 101 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, or under section 314(a) of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000), shall be increased by 128 percent to reflect increased costs associated with such residents.

"(B) SUNSET.—Subparagraph (A) shall not apply on and after such date as the Secretary certifies that there is an appropriate adjustment in the case mix under paragraph (4)(G)(i) to compensate for the increased costs associated with residents described in such subparagraph.".

(b) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after October 1, 2004.

SEC. 512. COVERAGE OF HOSPICE CONSULTATION SERVICES.

(a) COVERAGE OF HOSPICE CONSULTATION SERVICES.—Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

(1) by striking "and" at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting "; and"; and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) for individuals who are terminally ill, have not made an election under subsection (d)(1), and have not previously received services under this paragraph, services that are furnished by a physician (as defined in section 1861(r)(1)) who is either the medical director or an employee of a hospice program and that—

"(A) consist of—

"(i) an evaluation of the individual's need for pain and symptom management, including the individual's need for hospice care; and

"(ii) counseling the individual with respect to hospice care and other care options; and

"(B) may include advising the individual regarding advanced care planning.".

(b) PAYMENT.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

"(4) The amount paid to a hospice program with respect to the services under section 1812(a)(5) for which payment may be made under this part shall be equal to an amount established for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity and requiring medical decisionmaking of low complexity under the fee schedule established under section 1848(b), other than the portion of such amount attributable to the practice expense component.".

(c) CONFORMING AMENDMENT.—Section 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is amended by inserting before the comma at the end the following: "and services described in section 1812(a)(5)".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided by a hospice program on or after January 1, 2005.

SEC. 513. STUDY ON PORTABLE DIAGNOSTIC ULTRASOUND SERVICES FOR BENEFICIARIES IN SKILLED NURSING FACILITIES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of portable diagnostic ultrasound services furnished to medicare beneficiaries in skilled nursing facilities. Such study shall consider the following:

(1) TYPES OF EQUIPMENT; TRAINING.—The types of portable diagnostic ultrasound services furnished to such beneficiaries, the types of portable ultrasound equipment used to furnish such services, and the technical skills, or training, or both, required for technicians to furnish such services.

(2) CLINICAL APPROPRIATENESS.—The clinical appropriateness of transporting portable diagnostic ultrasound diagnostic and technicians to patients in skilled nursing facilities as opposed to transporting such patients to a hospital or other facility that furnishes diagnostic ultrasound services.

(3) FINANCIAL IMPACT.—The financial impact if Medicare were make a separate payment for portable ultrasound diagnostic services, including the impact of separate payments—

(A) for transportation and technician services for residents during a resident in a part A stay, that would otherwise be paid for under the prospective payment system for covered skilled nursing facility services (under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)); and

(B) for such services for residents in a skilled nursing facility after a part A stay.

(4) CREDENTIALING REQUIREMENTS.—Whether the Secretary should establish credentialing or other requirements for technicians that furnish diagnostic ultrasound services to medicare beneficiaries.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a), and shall include any recommendations for legislation or administrative change as the Comptroller General determines appropriate.

TITLE VI—PROVISIONS RELATING TO PART B

Subtitle A—Provisions Relating to Physicians' Services

SEC. 601. REVISION OF UPDATES FOR PHYSICIANS' SERVICES.

(a) UPDATE FOR 2004 AND 2005.—

(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraph:

"(5) UPDATE FOR 2004 AND 2005.—The update to the single conversion factor established in paragraph (1)(C) for each of 2004 and 2005 shall be not less than 1.5 percent.".

(2) CONFORMING AMENDMENT.—Paragraph (4)(B) of such section is amended, in the matter before clause (i), by inserting "and paragraph (5)" after "subparagraph (D)".

(3) NOT TREATED AS CHANGE IN LAW AND REGULATION IN SUSTAINABLE GROWTH RATE DETERMINATION.—The amendments made by this subsection shall not be treated as a change in law for purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)).

(b) USE OF 10-YEAR ROLLING AVERAGE IN COMPUTING GROSS DOMESTIC PRODUCT.—

(1) IN GENERAL.—Section 1848(f)(2)(C) (42 U.S.C. 1395w–4(f)(2)(C)) is amended—

(A) by striking "projected" and inserting "annual average"; and

(B) by striking "from the previous applicable period to the applicable period involved" and inserting "during the 10-year period ending with the applicable period involved".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to computations of the sustainable growth rate for years beginning with 2003.

SEC. 602. TREATMENT OF PHYSICIANS' SERVICES FURNISHED IN ALASKA.

Section 1848(e)(1) (42 U.S.C. 1395w–4(e)(1)), as amended by section 421, is amended—

(1) in subparagraph (A), by striking "subparagraphs (B), (C), (E), and (F)" and inserting "subparagraphs (B), (C), (E), (F) and (G)"; and

(2) by adding at the end the following new subparagraph:

"(G) FLOOR FOR PRACTICE EXPENSE, MALPRACTICE, AND WORK GEOGRAPHIC INDICES FOR SERVICES FURNISHED IN ALASKA.—For purposes of payment for services furnished in Alaska on or after January 1, 2004, and before January 1, 2006, after calculating the practice expense, malpractice, and work geographic indices in clauses (i), (ii), and (iii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.67 if such index would otherwise be less than 1.67.".

SEC. 603. INCLUSION OF PODIATRISTS, DENTISTS, AND OPTOMETRISTS UNDER PRIVATE CONTRACTING AUTHORITY.

Section 1802(b)(5)(B) (42 U.S.C. 1395a(b)(5)(B)) is amended by striking "section 1861(r)(1)" and inserting ''paragraphs (1), (2), (3), and (4) of section 1861(r)''.

SEC. 604. GAO STUDY ON ACCESS TO PHYSICIANS' SERVICES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on access of medicare beneficiaries to physicians' services under the medicare program. The study shall include—

(1) an assessment of the use by beneficiaries of such services through an analysis of claims submitted by physicians for such services under part B of the medicare program;

(2) an examination of changes in the use by beneficiaries of physicians' services over time; and

(3) an examination of the extent to which physicians are not accepting new medicare beneficiaries as patients.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall include a determination whether—

(1) data from claims submitted by physicians under part B of the medicare program indicate potential access problems for medicare beneficiaries in certain geographic areas; and

(2) access by medicare beneficiaries to physicians' services may have improved, remained constant, or deteriorated over time.

SEC. 605. COLLABORATIVE DEMONSTRATION-BASED REVIEW OF PHYSICIAN PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT DATA.

(a) IN GENERAL.—Not later than January 1, 2005, the Secretary shall, in collaboration with State and other appropriate organizations representing physicians, and other appropriate persons, review and consider alternative data sources than those currently used in establishing the geographic index for the practice expense component under the medicare physician fee schedule under section 1848(e)(1)(A)(i) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)(A)(i)).

(b) SITES.—The Secretary shall select two physician payment localities in which to carry out subsection (a). One locality shall include rural areas and at least one locality shall be a statewide locality that includes both urban and rural areas.

(c) REPORT AND RECOMMENDATIONS.—

(1) REPORT.—Not later than January 1, 2006, the Secretary shall submit to Congress a report on the review and consideration conducted under subsection (a). Such report shall include information on the alternative developed data sources considered by the Secretary under subsection (a), including the accuracy and validity of the data as measures of the elements of the geographic index for practice expenses under the medicare physician fee schedule as well as the feasibility of using such alternative data nationwide in lieu of current proxy data used in such index, and the estimated impacts of using such alternative data.

(2) RECOMMENDATIONS.—The report submitted under paragraph (1) shall contain recommendations on which data sources reviewed and considered under subsection (a) are appropriate for use in calculating the geographic index for practice expenses under the medicare physician fee schedule.

SEC. 606. MEDPAC REPORT ON PAYMENT FOR PHYSICIANS' SERVICES.

(a) PRACTICE EXPENSE COMPONENT.—Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the effect of refinements to the practice expense component of payments for physicians' services, after the transition to a full resource-based payment system in 2002, under section 1848 of the Social Security Act (42 U.S.C. 1395w–4). Such report shall examine the following matters by physician specialty:

(1) The effect of such refinements on payment for physicians' services.

(2) The interaction of the practice expense component with other components of and adjustments to payment for physicians' services under such section.

(3) The appropriateness of the amount of compensation by reason of such refinements.

(4) The effect of such refinements on access to care by medicare beneficiaries to physicians' services.

(5) The effect of such refinements on physician participation under the medicare program.

(b) VOLUME OF PHYSICIANS' SERVICES.—Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the extent to which increases in the volume of physicians' services under part B of the medicare program are a result of care that improves the health and well-being of medicare beneficiaries. The study shall include the following:

(1) An analysis of recent and historic growth in the components that the Secretary includes under the sustainable growth rate (under section 1848(f) of the Social Security Act (42 U.S.C. 1395w–4(f))).

(2) An examination of the relative growth of volume in physicians' services between medicare beneficiaries and other populations.

(3) An analysis of the degree to which new technology, including coverage determinations of the Centers for Medicare & Medicaid Services, has affected the volume of physicians' services.

(4) An examination of the impact on volume of demographic changes.

(5) An examination of shifts in the site of service or services that influence the number and intensity of services furnished in physicians' offices and the extent to which changes in reimbursement rates to other providers have effected these changes.

(6) An evaluation of the extent to which the Centers for Medicare & Medicaid Services takes into account the impact of law and regulations on the sustainable growth rate.

Subtitle B—Preventive Services

SEC. 611. COVERAGE OF AN INITIAL PREVENTIVE PHYSICAL EXAMINATION.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking ''and'' at the end;

(2) in subparagraph (V)(iii), by inserting ''and'' at the end; and

(3) by adding at the end the following new subparagraph:

''(W) an initial preventive physical examination (as defined in subsection (ww));''.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Initial Preventive Physical Examination

''(ww)(1) The term 'initial preventive physical examination' means physicians' services consisting of a physical examination (including measurement of height, weight, and blood pressure, and an electrocardiogram) with the goal of health promotion and disease detection and includes education, counseling, and referral with respect to screening and other preventive services described in paragraph (2), but does not include clinical laboratory tests.

''(2) The screening and other preventive services described in this paragraph include the following:

''(A) Pneumococcal, influenza, and hepatitis B vaccine and administration under subsection (s)(10).

''(B) Screening mammography as defined in subsection (jj).

''(C) Screening pap smear and screening pelvic exam as defined in subsection (nn).

''(D) Prostate cancer screening tests as defined in subsection (oo).

''(E) Colorectal cancer screening tests as defined in subsection (pp).

''(F) Diabetes outpatient self-management training services as defined in subsection (qq)(1).

''(G) Bone mass measurement as defined in subsection (rr).

''(H) Screening for glaucoma as defined in subsection (uu).

''(I) Medical nutrition therapy services as defined in subsection (vv).

''(J) Cardiovascular screening blood tests as defined in subsection (xx)(1).

''(K) Diabetes screening tests as defined in subsection (yy).''.

(c) PAYMENT AS PHYSICIANS' SERVICES.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(W),'' after ''(2)(S),''.

(d) OTHER CONFORMING AMENDMENTS.—(1) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 303(i)(3)(B), is amended—

(A) in paragraph (1)—

(i) by striking ''and'' at the end of subparagraph (I);

(ii) by striking the semicolon at the end of subparagraph (J) and inserting '', and''; and

(iii) by adding at the end the following new subparagraph:

''(K) in the case of an initial preventive physical examination, which is performed not later than 6 months after the date the individual's first coverage period begins under part B;''; a

(B) in paragraph (7), by striking ''or (H)'' and inserting ''(H), or (K)''.

(2) Clauses (i) and (ii) of section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) are each amended by inserting ''and services described in subsection (ww)(1)'' after ''services which would be physicians' services''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2005, but only for individuals whose coverage period under part B begins on or after such date.

SEC. 612. COVERAGE OF CARDIOVASCULAR SCREENING BLOOD TESTS.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by section 611(a), is amended—

(1) in subparagraph (V)(iii), by striking ''and'' at the end;

(2) in subparagraph (W), by inserting ''and'' at the end; and

(3) by adding at the end the following new subparagraph:

''(X) cardiovascular screening blood tests (as defined in subsection (xx)(1));''.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Cardiovascular Screening Blood Test

''(xx)(1) The term 'cardiovascular screening blood test' means a blood test for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) that tests for the following:

''(A) Cholesterol levels and other lipid or triglyceride levels.

''(B) Such other indications associated with the presence of, or an elevated risk for, cardiovascular disease as the Secretary may approve for all individuals (or for some individuals determined by the Secretary to be at risk for cardiovascular disease), including indications measured by noninvasive testing.

The Secretary may not approve an indication under subparagraph (B) for any individual unless a blood test for such is recommended by the United States Preventive Services Task Force.

"(2) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency for each type of cardiovascular screening blood tests, except that such frequency may not be more often than once every 2 years.".

(c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by section 611(d), is amended—

(1) by striking "and" at the end of subparagraph (J);

(2) by striking the semicolon at the end of subparagraph (K) and inserting ", and"; and

(3) by adding at the end the following new subparagraph:

"(L) in the case of cardiovascular screening blood tests (as defined in section 1861(xx)(1)), which are performed more frequently than is covered under section 1861(xx)(2);".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2005.

SEC. 613. COVERAGE OF DIABETES SCREENING TESTS.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by section 612(a), is amended—

(1) in subparagraph (W), by striking "and" at the end;

(2) in subparagraph (X), by adding "and" at the end; and

(3) by adding at the end the following new subparagraph:

"(Y) diabetes screening tests (as defined in subsection (yy));".

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x), as amended by section 612(b), is amended by adding at the end the following new subsection:

"Diabetes Screening Tests

"(yy)(1) The term 'diabetes screening tests' means testing furnished to an individual at risk for diabetes (as defined in paragraph (2)) for the purpose of early detection of diabetes, including—

"(A) a fasting plasma glucose test; and

"(B) such other tests, and modifications to tests, as the Secretary determines appropriate, in consultation with appropriate organizations.

"(2) For purposes of paragraph (1), the term 'individual at risk for diabetes' means an individual who has any of the following risk factors for diabetes:

"(A) Hypertension.

"(B) Dyslipidemia.

"(C) Obesity, defined as a body mass index greater than or equal to 30 kg/m^2.

"(D) Previous identification of an elevated impaired fasting glucose.

"(E) Previous identification of impaired glucose tolerance.

"(F) A risk factor consisting of at least 2 of the following characteristics:

"(i) Overweight, defined as a body mass index greater than 25, but less than 30, kg/m^2.

"(ii) A family history of diabetes.

"(iii) A history of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.

"(iv) 65 years of age or older.

"(3) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency of diabetes screening tests, except that such frequency may not be more often than twice within the 12-month period following the date of the most recent diabetes screening test of that individual.".

(c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by section 612(c), is amended—

(1) by striking "and" at the end of subparagraph (K);

(2) by striking the semicolon at the end of subparagraph (L) and inserting ", and"; and

(3) by adding at the end the following new subparagraph:

"(M) in the case of a diabetes screening test (as defined in section 1861(yy)(1)), which is performed more frequently than is covered under section 1861(yy)(3);".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2005.

SEC. 614. IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by inserting before the period at the end the following: "and does not include screening mammography (as defined in section 1861(jj)) and diagnostic mammography".

(b) CONFORMING AMENDMENT.—Section 1833(a)(2)(E)(i) (42 U.S.C. 1395l(a)(2)(E)(i)) is amended by inserting "and, for services furnished on or after January 1, 2005, diagnostic mammography" after "screening mammography".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply—

(1) in the case of screening mammography, to services furnished on or after the date of the enactment of this Act; and

(2) in the case of diagnostic mammography, to services furnished on or after January 1, 2005.

Subtitle C—Other Provisions

SEC. 621. HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT REFORM.

(a) PAYMENT FOR DRUGS.—

(1) SPECIAL RULES FOR CERTAIN DRUGS AND BIOLOGICALS.—Section 1833(t) (42 U.S.C. 1395l(t)), as amended by section 411(b), is amended by inserting after paragraph (13) the following new paragraphs:

"(14) DRUG APC PAYMENT RATES.—

"(A) IN GENERAL.—The amount of payment under this subsection for a specified covered outpatient drug (defined in subparagraph (B)) that is furnished as part of a covered OPD service (or group of services)—

"(i) in 2004, in the case of—

"(I) a sole source drug shall in no case be less than 88 percent, or exceed 95 percent, of the reference average wholesale price for the drug;

"(II) an innovator multiple source drug shall in no case exceed 68 percent of the reference average wholesale price for the drug; or

"(III) a noninnovator multiple source drug shall in no case exceed 46 percent of the reference average wholesale price for the drug;

"(ii) in 2005, in the case of—

"(I) a sole source drug shall in no case be less than 83 percent, or exceed 95 percent, of the reference average wholesale price for the drug;

"(II) an innovator multiple source drug shall in no case exceed 68 percent of the reference average wholesale price for the drug; or

"(III) a noninnovator multiple source drug shall in no case exceed 46 percent of the reference average wholesale price for the drug; or

"(iii) in a subsequent year, shall be equal, subject to subparagraph (E)—

"(I) to the average acquisition cost for the drug for that year (which, at the option of the Secretary, may vary by hospital group (as defined by the Secretary based on volume of covered OPD services or other relevant characteristics)), as determined by the Secretary taking into account the hospital acquisition cost survey data under subparagraph (D); or

"(II) if hospital acquisition cost data are not available, the average price for the drug in the year established under section 1842(o), section 1847A, or section 1847B, as the case may be, as calculated and adjusted by the Secretary as necessary for purposes of this paragraph.

"(B) SPECIFIED COVERED OUTPATIENT DRUG DEFINED.—

"(i) IN GENERAL.—In this paragraph, the term 'specified covered outpatient drug' means, subject to clause (ii), a covered outpatient drug (as defined in section 1927(k)(2)) for which a separate ambulatory payment classification group (APC) has been established and that is—

"(I) a radiopharmaceutical; or

"(II) a drug or biological for which payment was made under paragraph (6) (relating to pass-through payments) on or before December 31, 2002.

"(ii) EXCEPTION.—Such term does not include—

"(I) a drug or biological for which payment is first made on or after January 1, 2003, under paragraph (6);

"(II) a drug or biological for which a temporary HCPCS code has not been assigned; or

"(III) during 2004 and 2005, an orphan drug (as designated by the Secretary).

"(C) PAYMENT FOR DESIGNATED ORPHAN DRUGS DURING 2004 AND 2005.—The amount of payment under this subsection for an orphan drug designated by the Secretary under subparagraph (B)(ii)(III) that is furnished as part of a covered OPD service (or group of services) during 2004 and 2005 shall equal such amount as the Secretary may specify.

"(D) ACQUISITION COST SURVEY FOR HOSPITAL OUTPATIENT DRUGS.—

"(i) ANNUAL GAO SURVEYS IN 2004 AND 2005.—

"(I) IN GENERAL.—The Comptroller General of the United States shall conduct a survey in each of 2004 and 2005 to determine the hospital acquisition cost for each specified covered outpatient drug. Not later than April 1, 2005, the Comptroller General shall furnish data from such surveys to the Secretary for use in setting the payment rates under subparagraph (A) for 2006.

"(II) RECOMMENDATIONS.—Upon the completion of such surveys, the Comptroller General shall recommend to the Secretary the frequency and methodology of subsequent surveys to be conducted by the Secretary under clause (ii).

"(ii) SUBSEQUENT SECRETARIAL SURVEYS.—The Secretary, taking into account such recommendations, shall conduct periodic subsequent surveys to determine the hospital acquisition cost for each specified covered outpatient drug for use in setting the payment rates under subparagraph (A).

"(iii) SURVEY REQUIREMENTS.—The surveys conducted under clauses (i) and (ii) shall have a large sample of hospitals that is sufficient to generate a statistically significant estimate of the average hospital acquisition cost for each specified covered outpatient drug. With respect to the surveys conducted under clause (i), the Comptroller General shall report to Congress on the justification for the size of the sample used in order to assure the validity of such estimates.

"(iv) DIFFERENTIATION IN COST.—In conducting surveys under clause (i), the Comptroller General shall determine and report to Congress if there is (and the extent of any) variation in hospital acquisition costs for drugs among hospitals based on the volume of covered OPD services performed by such hospitals or other relevant characteristics of such hospitals (as defined by the Comptroller General).

"(v) COMMENT ON PROPOSED RATES.—Not later than 30 days after the date the Secretary promulgated proposed rules setting forth the payment rates under subparagraph (A) for 2006, the Comptroller General shall evaluate such proposed rates and submit to Congress a report regarding the appropriateness of such rates based on the surveys the Comptroller General has conducted under clause (i).

"(E) ADJUSTMENT IN PAYMENT RATES FOR OVERHEAD COSTS.—

"(i) MEDPAC REPORT ON DRUG APC DESIGN.—The Medicare Payment Advisory Commission shall submit to the Secretary, not later than

July 1, 2005, a report on adjustment of payment for ambulatory payment classifications for specified covered outpatient drugs to take into account overhead and related expenses, such as pharmacy services and handling costs. Such report shall include—

"(I) a description and analysis of the data available with regard to such expenses;

"(II) a recommendation as to whether such a payment adjustment should be made; and

"(III) if such adjustment should be made, a recommendation regarding the methodology for making such an adjustment.

"(ii) ADJUSTMENT AUTHORIZED.—The Secretary may adjust the weights for ambulatory payment classifications for specified covered outpatient drugs to take into account the recommendations contained in the report submitted under clause (i).

"(F) CLASSES OF DRUGS.—For purposes of this paragraph:

"(i) SOLE SOURCE DRUGS.—The term 'sole source drug' means—

"(I) a biological product (as defined under section 1861(t)(1)); or

"(II) a single source drug (as defined in section 1927(k)(7)(A)(iv)).

"(ii) INNOVATOR MULTIPLE SOURCE DRUGS.—The term 'innovator multiple source drug' has the meaning given such term in section 1927(k)(7)(A)(ii).

"(iii) NONINNOVATOR MULTIPLE SOURCE DRUGS.—The term 'noninnovator multiple source drug' has the meaning given such term in section 1927(k)(7)(A)(iii).

"(G) REFERENCE AVERAGE WHOLESALE PRICE.—The term 'reference average wholesale price' means, with respect to a specified covered outpatient drug, the average wholesale price for the drug as determined under section 1842(o) as of May 1, 2003.

"(H) INAPPLICABILITY OF EXPENDITURES IN DETERMINING CONVERSION, WEIGHTING, AND OTHER ADJUSTMENT FACTORS.—Additional expenditures resulting from this paragraph shall not be taken into account in establishing the conversion, weighting, and other adjustment factors for 2004 and 2005 under paragraph (9), but shall be taken into account for subsequent years.

"(15) PAYMENT FOR NEW DRUGS AND BIOLOGICALS UNTIL HCPCS CODE ASSIGNED.—With respect to payment under this part for an outpatient drug or biological that is covered under this part and is furnished as part of covered OPD services for which a HCPCS code has not been assigned, the amount provided for payment for such drug or biological under this part shall be equal to 95 percent of the average wholesale price for the drug or biological.".

(2) REDUCTION IN THRESHOLD FOR SEPARATE APCS FOR DRUGS.—Section 1833(t)(16), as redesignated section 411(b), is amended by adding at the end the following new subparagraph:

"(B) THRESHOLD FOR ESTABLISHMENT OF SEPARATE APCS FOR DRUGS.—The Secretary shall reduce the threshold for the establishment of separate ambulatory payment classification groups (APCs) with respect to drugs or biologicals to $50 per administration for drugs and biologicals furnished in 2005 and 2006.".

(3) EXCLUSION OF SEPARATE DRUG APCS FROM OUTLIER PAYMENTS.—Section 1833(t)(5) is amended by adding at the end the following new subparagraph:

"(E) EXCLUSION OF SEPARATE DRUG AND BIOLOGICAL APCS FROM OUTLIER PAYMENTS.—No additional payment shall be made under subparagraph (A) in the case of ambulatory payment classification groups established separately for drugs or biologicals.".

(4) PAYMENT FOR PASS THROUGH DRUGS.—Section 1833(t)(6)(D)(i) (42 U.S.C. 1395l(t)(6)(D)(i)) is amended by inserting after "under section 1842(o)" the following: "(or if the drug or biological is covered under a competitive acquisition contract under section 1847B, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary for purposes of this paragraph)".

(5) CONFORMING AMENDMENT TO BUDGET NEUTRALITY REQUIREMENT.—Section 1833(t)(9)(B) (42 U.S.C. 1395l(t)(9)(B)) is amended by adding at the end the following: "In determining adjustments under the preceding sentence for 2004 and 2005, the Secretary shall not take into account under this subparagraph or paragraph (2)(E) any expenditures that would not have been made but for the application of paragraph (14).".

(6) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items and services furnished on or after January 1, 2004.

(b) SPECIAL PAYMENT FOR BRACHYTHERAPY.—

(1) IN GENERAL.—Section 1833(t)(16), as redesignated by section 411(b) and as amended by subsection (a)(2), is amended by adding at the end the following new subparagraph:

"(C) PAYMENT FOR DEVICES OF BRACHYTHERAPY AT CHARGES ADJUSTED TO COST.—Notwithstanding the preceding provisions of this subsection, for a device of brachytherapy consisting of a seed or seeds (or radioactive source) furnished on or after January 1, 2004, and before January 1, 2007, the payment basis for the device under this subsection shall be equal to the hospital's charges for each device furnished, adjusted to cost. Charges for such devices shall not be included in determining any outlier payment under this subsection.".

(2) SPECIFICATION OF GROUPS FOR BRACHYTHERAPY DEVICES.—Section 1833(t)(2) (42 U.S.C. 1395l(t)(2)) is amended—

(A) in subparagraph (F), by striking "and" at the end;

(B) in subparagraph (G), by striking the period at the end and inserting "; and"; and

(C) by adding at the end the following new subparagraph:

"(H) with respect to devices of brachytherapy consisting of a seed or seeds (or radioactive source), the Secretary shall create additional groups of covered OPD services that classify such devices separately from the other services (or group of services) paid for under this subsection in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate groups for palladium-103 and iodine-125 devices.".

(3) GAO REPORT.—The Comptroller General of the United States shall conduct a study to determine appropriate payment amounts under section 1833(t)(16)(C) of the Social Security Act, as added by paragraph (1), for devices of brachytherapy. Not later than January 1, 2005, the Comptroller General shall submit to Congress and the Secretary a report on the study conducted under this paragraph, and shall include specific recommendations for appropriate payments for such devices.

SEC. 622. LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.

Section 1833(t)(6) (42 U.S.C. 1395l(t)(6)) is amended by adding at the end the following new subparagraph:

"(F) LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.—

"(i) IN GENERAL.—The Secretary may not publish regulations that apply a functional equivalence standard to a drug or biological under this paragraph.

"(ii) APPLICATION.—Clause (i) shall apply to the application of a functional equivalence standard to a drug or biological on or after the date of enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 unless—

"(I) such application was being made to such drug or biological prior to such date of enactment; and

"(II) the Secretary applies such standard to such drug or biological only for the purpose of determining eligibility of such drug or biological for additional payments under this paragraph and not for the purpose of any other payments under this title.

"(iii) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall be construed to effect the Secretary's authority to deem a particular drug to be identical to another drug if the 2 products are pharmaceutically equivalent and bioequivalent, as determined by the Commissioner of Food and Drugs.".

SEC. 623. PAYMENT FOR RENAL DIALYSIS SERVICES.

(a) INCREASE IN RENAL DIALYSIS COMPOSITE RATE FOR SERVICES FURNISHED.—The last sentence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended—

(1) by striking "and" before "for such services" the second place it appears;

(2) by inserting "and before January 1, 2005," after "January 1, 2001,"; and

(3) by inserting before the period at the end the following: ", and for such services furnished on or after January 1, 2005, by 1.6 percent above such composite rate payment amounts for such services furnished on December 31, 2004".

(b) RESTORING COMPOSITE RATE EXCEPTIONS FOR PEDIATRIC FACILITIES.—

(1) IN GENERAL.—Section 422(a)(2) of BIPA is amended—

(A) in subparagraph (A), by striking "and (C)" and inserting ", (C), and (D)";

(B) in subparagraph (B), by striking "In the case" and inserting "Subject to subparagraph (D), in the case"; and

(C) by adding at the end the following new subparagraph:

"(D) INAPPLICABILITY TO PEDIATRIC FACILITIES.—Subparagraphs (A) and (B) shall not apply, as of October 1, 2002, to pediatric facilities that do not have an exception rate described in subparagraph (C) in effect on such date. For purposes of this subparagraph, the term 'pediatric facility' means a renal facility at least 50 percent of whose patients are individuals under 18 years of age.".

(2) CONFORMING AMENDMENT.—The fourth sentence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by striking "The Secretary" and inserting "Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Secretary".

(c) INSPECTOR GENERAL STUDIES ON ESRD DRUGS.—

(1) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct two studies with respect to drugs and biologicals (including erythropoietin) furnished to end-stage renal disease patients under the medicare program which are separately billed by end stage renal disease facilities.

(2) STUDIES ON ESRD DRUGS.—

(A) EXISTING DRUGS.—The first study under paragraph (1) shall be conducted with respect to such drugs and biologicals for which a billing code exists prior to January 1, 2004.

(B) NEW DRUGS.—The second study under paragraph (1) shall be conducted with respect to such drugs and biologicals for which a billing code does not exist prior to January 1, 2004.

(3) MATTERS STUDIED.—Under each study conducted under paragraph (1), the Inspector General shall—

(A) determine the difference between the amount of payment made to end stage renal disease facilities under title XVIII of the Social Security Act for such drugs and biologicals and

the acquisition costs of such facilities for such drugs and biologicals and which are separately billed by end stage renal disease facilities, and

(B) estimate the rates of growth of expenditures for such drugs and biologicals billed by such facilities.

(4) REPORTS.—

(A) EXISTING ESRD DRUGS.—Not later than April 1, 2004, the Inspector General shall report to the Secretary on the study described in paragraph (2)(A).

(B) NEW ESRD DRUGS.—Not later than April 1, 2006, the Inspector General shall report to the Secretary on the study described in paragraph (2)(B).

(d) BASIC CASE-MIX ADJUSTED COMPOSITE RATE FOR RENAL DIALYSIS FACILITY SERVICES.—(1) Section 1881(b) (42 U.S.C. 1395rr(b)) is amended by adding at the end the following new paragraphs:

"(12)(A) In lieu of payment under paragraph (7) beginning with services furnished on January 1, 2005, the Secretary shall establish a basic case-mix adjusted prospective payment system for dialysis services furnished by providers of services and renal dialysis facilities in a year to individuals in a facility and to such individuals at home. The case-mix under such system shall be for a limited number of patient characteristics.

"(B) The system described in subparagraph (A) shall include—

"(i) the services comprising the composite rate established under paragraph (7); and

"(ii) the difference between payment amounts under this title for separately billed drugs and biologicals (including erythropoietin) and acquisition costs of such drugs and biologicals, as determined by the Inspector General reports to the Secretary as required by section 623(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003—

"(I) beginning with 2005, for such drugs and biologicals for which a billing code exists prior to January 1, 2004; and

"(II) beginning with 2007, for such drugs and biologicals for which a billing code does not exist prior to January 1, 2004,

adjusted to 2005, or 2007, respectively, as determined to be appropriate by the Secretary.

"(C)(i) In applying subparagraph (B)(ii) for 2005, such payment amounts under this title shall be determined using the methodology specified in paragraph (13)(A)(i).

"(ii) For 2006, the Secretary shall provide for an adjustment to the payments under clause (i) to reflect the difference between the payment amounts using the methodology under paragraph (13)(A)(i) and the payment amount determined using the methodology applied by the Secretary under paragraph (13)(A)(iii) of such paragraph, as estimated by the Secretary.

"(D) The Secretary shall adjust the payment rates under such system by a geographic index as the Secretary determines to be appropriate. If the Secretary applies a geographic index under this paragraph that differs from the index applied under paragraph (7) the Secretary shall phase-in the application of the index under this paragraph over a multiyear period.

"(E)(i) Such system shall be designed to result in the same aggregate amount of expenditures for such services, as estimated by the Secretary, as would have been made for 2005 if this paragraph did not apply.

"(ii) The adjustment made under subparagraph (B)(ii)(II) shall be done in a manner to result in the same aggregate amount of expenditures after such adjustment as would otherwise have been made for such services for 2006 or 2007, respectively, as estimated by the Secretary, if this paragraph did not apply.

"(F) Beginning with 2006, the Secretary shall annually increase the basic case-mix adjusted payment amounts established under this paragraph, by an amount determined by—

"(i) applying the estimated growth in expenditures for drugs and biologicals (including erythropoietin) that are separately billable to the component of the basic case-mix adjusted system described in subparagraph (B)(ii); and

"(ii) converting the amount determined in clause (i) to an increase applicable to the basic case-mix adjusted payment amounts established under subparagraph (B).

Nothing in this paragraph shall be construed as providing for an update to the composite rate component of the basic case-mix adjusted system under subparagraph (B).

"(G) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of the case-mix system, relative weights, payment amounts, the geographic adjustment factor, or the update for the system established under this paragraph, or the determination of the difference between medicare payment amounts and acquisition costs for separately billed drugs and biologicals (including erythropoietin) under this paragraph and paragraph (13).

"(13)(A) The payment amounts under this title for separately billed drugs and biologicals furnished in a year, beginning with 2004, are as follows:

"(i) For such drugs and biologicals (other than erythropoietin) furnished in 2004, the amount determined under section 1842(o)(1)(A)(v) for the drug or biological.

"(ii) For such drugs and biologicals (including erythropoietin) furnished in 2005, the acquisition cost of the drug or biological, as determined by the Inspector General reports to the Secretary as required by section 623(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Insofar as the Inspector General has not determined the acquisition cost with respect to a drug or biological, the Secretary shall determine the payment amount for such drug or biological.

"(iii) For such drugs and biologicals (including erythropoietin) furnished in 2006 and subsequent years, such acquisition cost or the amount determined under section 1847A for the drug or biological, as the Secretary may specify.

"(B)(i) Drugs and biologicals (including erythropoietin) which were separately billed under this subsection on the day before the date of the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 shall continue to be separately billed on and after such date.

"(ii) Nothing in this paragraph, section 1842(o), section 1847A, or section 1847B shall be construed as requiring or authorizing the bundling of payment for drugs and biologicals into the basic case-mix adjusted payment system under this paragraph.".

(2) Paragraph (7) of such section is amended in the first sentence by striking "The Secretary" and inserting "Subject to paragraph (12), the Secretary".

(3) Paragraph (11)(B) of such section is amended by inserting "subject to paragraphs (12) and (13)" before "payment for such item".

(e) DEMONSTRATION OF BUNDLED CASE-MIX ADJUSTED PAYMENT SYSTEM FOR ESRD SERVICES.—

(1) IN GENERAL.—The Secretary shall establish a demonstration project of the use of a fully case-mix adjusted payment system for end stage renal disease services under section 1881 of the Social Security Act (42 U.S.C. 1395rr) for patient characteristics identified in the report under subsection (f) that bundles into such payment rates amounts for—

(A) drugs and biologicals (including erythropoietin) furnished to end stage renal disease patients under the medicare program which are separately billed by end stage renal disease facilities (as of the date of the enactment of this Act); and

(B) clinical laboratory tests related to such drugs and biologicals.

(2) FACILITIES INCLUDED IN THE DEMONSTRATION.—In conducting the demonstration under this subsection, the Secretary shall ensure the participation of a sufficient number of providers of dialysis services and renal dialysis facilities, but in no case to exceed 500. In selecting such providers and facilities, the Secretary shall ensure that the following types of providers are included in the demonstration:

(A) Urban providers and facilities.

(B) Rural providers and facilities.

(C) Not-for-profit providers and facilities.

(D) For-profit providers and facilities.

(E) Independent providers and facilities.

(F) Specialty providers and facilities, including pediatric providers and facilities and small providers and facilities.

(3) TEMPORARY ADD-ON PAYMENT FOR DIALYSIS SERVICES FURNISHED UNDER THE DEMONSTRATION.—

(A) IN GENERAL.—During the period of the demonstration project, the Secretary shall increase payment rates that would otherwise apply under section 1881(b) of such Act (42 U.S.C. 1395rr(b)) by 1.6 percent for dialysis services furnished in facilities in the demonstration site.

(B) RULES OF CONSTRUCTION.—Nothing in this subsection shall be construed as—

(i) as an annual update under section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b));

(ii) as increasing the baseline for payments under such section; or

(iii) requiring the budget neutral implementation of the demonstration project under this subsection.

(4) 3-YEAR PERIOD.—The Secretary shall conduct the demonstration under this subsection for the 3-year period beginning on January 1, 2006.

(5) USE OF ADVISORY BOARD.—

(A) IN GENERAL.—In carrying out the demonstration under this subsection, the Secretary shall establish an advisory board comprised of representatives described in subparagraph (B) to provide advice and recommendations with respect to the establishment and operation of such demonstration.

(B) REPRESENTATIVES.—Representatives referred to in subparagraph (A) include representatives of the following:

(i) Patient organizations.

(ii) Individuals with expertise in end stage renal dialysis services, such as clinicians, economists, and researchers.

(iii) The Medicare Payment Advisory Commission, established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6).

(iv) The National Institutes of Health.

(v) Network organizations under section 1881(c) of the Social Security Act (42 U.S.C. 1395rr(c)).

(vi) Medicare contractors to monitor quality of care.

(vii) Providers of services and renal dialysis facilities furnishing end stage renal disease services.

(C) TERMINATION OF ADVISORY PANEL.—The advisory panel shall terminate on December 31, 2008.

(6) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, $5,000,000 in fiscal year 2006 to conduct the demonstration under this subsection.

(f) REPORT ON A BUNDLED PROSPECTIVE PAYMENT SYSTEM FOR END STAGE RENAL DISEASE SERVICES.—

(1) REPORT.—

(A) IN GENERAL.—Not later than October 1, 2005, the Secretary shall submit to Congress a report detailing the elements and features for the design and implementation of a bundled prospective payment system for services furnished by end stage renal disease facilities including, to the maximum extent feasible, bundling of drugs, clinical laboratory tests, and other items that are separately billed by such facilities. The report shall include a description of the methodology to be used for the establishment of payment rates, including components of the new system described in paragraph (2).

(B) RECOMMENDATIONS.—The Secretary shall include in such report recommendations on elements, features, and methodology for a bundled prospective payment system or other issues related to such system as the Secretary determines to be appropriate.

(2) ELEMENTS AND FEATURES OF A BUNDLED PROSPECTIVE PAYMENT SYSTEM.—The report required under paragraph (1) shall include the following elements and features of a bundled prospective payment system:

(A) BUNDLE OF ITEMS AND SERVICES.—A description of the bundle of items and services to be included under the prospective payment system.

(B) CASE MIX.—A description of the case-mix adjustment to account for the relative resource use of different types of patients.

(C) WAGE INDEX.—A description of an adjustment to account for geographic differences in wages.

(D) RURAL AREAS.—The appropriateness of establishing a specific payment adjustment to account for additional costs incurred by rural facilities.

(E) OTHER ADJUSTMENTS.—Such other adjustments as may be necessary to reflect the variation in costs incurred by facilities in caring for patients with end stage renal disease.

(F) UPDATE FRAMEWORK.—A methodology for appropriate updates under the prospective payment system.

(G) ADDITIONAL RECOMMENDATIONS.—Such other matters as the Secretary determines to be appropriate.

SEC. 624. 2-YEAR MORATORIUM ON THERAPY CAPS; PROVISIONS RELATING TO REPORTS.

(a) ADDITIONAL MORATORIUM ON THERAPY CAPS.—

(1) 2004 AND 2005.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended by striking "and 2002" and inserting "2002, 2004, and 2005".

(2) REMAINDER OF 2003.—For the period beginning on the date of the enactment of this Act and ending of December 31, 2003, the Secretary shall not apply the provisions of paragraphs (1), (2), and (3) of section 1833(g) to expenses incurred with respect to services described in such paragraphs during such period. Nothing in the preceding sentence shall be construed as affecting the application of such paragraphs by the Secretary before the date of the enactment of this Act.

(b) PROMPT SUBMISSION OF OVERDUE REPORTS ON PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY SERVICES.—Not later than March 31, 2004, the Secretary shall submit to Congress the reports required under section 4541(d)(2) of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 457) (relating to alternatives to a single annual dollar cap on outpatient therapy) and under section 221(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Appendix F, 113 Stat. 1501A–352), as enacted into law by section 1000(a)(6) of Public Law 106–113 (relating to utilization patterns for outpatient therapy).

(c) GAO REPORT IDENTIFYING CONDITIONS AND DISEASES JUSTIFYING WAIVER OF THERAPY CAP.—

(1) STUDY.—The Comptroller General of the United States shall identify conditions or diseases that may justify waiving the application of the therapy caps under section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) with respect to such conditions or diseases.

(2) REPORT TO CONGRESS.—Not later than October 1, 2004, the Comptroller General shall submit to Congress a report on the conditions and diseases identified under paragraph (1), and shall include a recommendation of criteria, with respect to such conditions and disease, under which a waiver of the therapy caps would apply.

SEC. 625. WAIVER OF PART B LATE ENROLLMENT PENALTY FOR CERTAIN MILITARY RETIREES; SPECIAL ENROLLMENT PERIOD.

(a) WAIVER OF PENALTY.—

(1) IN GENERAL.—Section 1839(b) (42 U.S.C. 1395r(b)) is amended by adding at the end the following new sentence: "No increase in the premium shall be effected for a month in the case of an individual who enrolls under this part during 2001, 2002, 2003, or 2004 and who demonstrates to the Secretary before December 31, 2004, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to premiums for months beginning with January 2004. The Secretary shall establish a method for providing rebates of premium penalties paid for months on or after January 2004 for which a penalty does not apply under such amendment but for which a penalty was previously collected.

(b) MEDICARE PART B SPECIAL ENROLLMENT PERIOD.—

(1) IN GENERAL.—In the case of any individual who, as of the date of the enactment of this Act, is eligible to enroll but is not enrolled under part B of title XVIII of the Social Security Act and is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code), the Secretary of Health and Human Services shall provide for a special enrollment period during which the individual may enroll under such part. Such period shall begin as soon as possible after the date of the enactment of this Act and shall end on December 31, 2004.

(2) COVERAGE PERIOD.—In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under part B of title XVIII of the Social Security Act shall begin on the first day of the month following the month in which the individual enrolls.

SEC. 626. PAYMENT FOR SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.

(a) REDUCTIONS IN PAYMENT UPDATES.—Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is amended to read as follows:

"(C)(i) Notwithstanding the second sentence of each of subparagraphs (A) and (B), except as otherwise specified in clauses (ii), (iii), and (iv), if the Secretary has not updated amounts established under such subparagraphs or under subparagraph (D), with respect to facility services furnished during a fiscal year (beginning with fiscal year 1986 or a calendar year (beginning with 2006)), such amounts shall be increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

"(ii) In each of the fiscal years 1998 through 2002, the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points.

"(iii) In fiscal year 2004, beginning with April 1, 2004, the increase under this subparagraph shall be the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with March 31, 2003, minus 3.0 percentage points.

"(iv) In fiscal year 2005, the last quarter of calendar year 2005, and each of calendar years 2006 through 2009, the increase under this subparagraph shall be 0 percent.".

(b) REPEAL OF SURVEY REQUIREMENT AND IMPLEMENTATION OF NEW SYSTEM.—Section 1833(i)(2) (42 U.S.C. 1395l(i)(2)) is amended—

(1) in subparagraph (A)—

(A) in the matter preceding clause (i), by striking "The" and inserting "For services furnished prior to the implementation of the system described in subparagraph (D), the"; and

(B) in clause (i), by striking "taken not later than January 1, 1995, and every 5 years thereafter,"; and

(2) by adding at the end the following new subparagraph:

"(D)(i) Taking into account the recommendations in the report under section 626(d) of Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Secretary shall implement a revised payment system for payment of surgical services furnished in ambulatory surgical centers.

"(ii) In the year the system described in clause (i) is implemented, such system shall be designed to result in the same aggregate amount of expenditures for such services as would be made if this subparagraph did not apply, as estimated by the Secretary.

"(iii) The Secretary shall implement the system described in clause (i) for periods in a manner so that it is first effective beginning on or after January 1, 2006, and not later than January 1, 2008.

"(iv) There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the classification system, the relative weights, payment amounts, and the geographic adjustment factor, if any, under this subparagraph.".

(c) CONFORMING AMENDMENT.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended by adding the following new subparagraph:

"(G) with respect to facility services furnished in connection with a surgical procedure specified pursuant to subsection (i)(1)(A) and furnished to an individual in an ambulatory surgical center described in such subsection, for services furnished beginning with the implementation date of a revised payment system for such services in such facilities specified in subsection (i)(2)(D), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by the Secretary under such revised payment system,".

(d) GAO STUDY OF AMBULATORY SURGICAL CENTER PAYMENTS.—

(1) STUDY.—

(A) IN GENERAL.—The Comptroller General of the United States shall conduct a study that compares the relative costs of procedures furnished in ambulatory surgical centers to the relative costs of procedures furnished in hospital outpatient departments under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)). The study shall also examine how accurately ambulatory payment categories reflect procedures furnished in ambulatory surgical centers.

(B) CONSIDERATION OF ASC DATA.—In conducting the study under paragraph (1), the Comptroller General shall consider data submitted by ambulatory surgical centers regarding the matters described in clauses (i) through (iii) of paragraph (2)(B).

(2) REPORT AND RECOMMENDATIONS.—

(A) REPORT.—Not later than January 1, 2005, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

(B) RECOMMENDATIONS.—The report submitted under subparagraph (A) shall include recommendations on the following matters:

(i) The appropriateness of using the groups of covered services and relative weights established under the outpatient prospective payment system as the basis of payment for ambulatory surgical centers.

(ii) If the relative weights under such hospital outpatient prospective payment system are appropriate for such purpose—

(I) whether the payment rates for ambulatory surgical centers should be based on a uniform percentage of the payment rates or weights under such outpatient system; or

(II) whether the payment rates for ambulatory surgical centers should vary, or the weights should be revised, based on specific procedures or types of services (such as ophthalmology and pain management services).

(iii) Whether a geographic adjustment should be used for payment of services furnished in ambulatory surgical centers, and if so, the labor and nonlabor shares of such payment.

SEC. 627. PAYMENT FOR CERTAIN SHOES AND INSERTS UNDER THE FEE SCHEDULE FOR ORTHOTICS AND PROSTHETICS.

(a) IN GENERAL.—Section 1833(o) (42 U.S.C. 1395l(o)) is amended—

(1) in paragraph (1)(B), by striking "no more than the limits established under paragraph (2)" and inserting "no more than the amount of payment applicable under paragraph (2)"; and

(2) in paragraph (2), to read as follows:

"(2)(A) Except as provided by the Secretary under subparagraphs (B) and (C), the amount of payment under this paragraph for custom molded shoes, extra-depth shoes, and inserts shall be the amount determined for such items by the Secretary under section 1834(h).

"(B) The Secretary may establish payment amounts for shoes and inserts that are lower than the amount established under section 1834(h) if the Secretary finds that shoes and inserts of an appropriate quality are readily available at or below the amount established under such section.

"(C) In accordance with procedures established by the Secretary, an individual entitled to benefits with respect to shoes described in section 1861(s)(12) may substitute modification of such shoes instead of obtaining one (or more, as specified by the Secretary) pair of inserts (other than the original pair of inserts with respect to such shoes). In such case, the Secretary shall substitute, for the payment amount established under section 1834(h), a payment amount that the Secretary estimates will assure that there is no net increase in expenditures under this subsection as a result of this subparagraph.".

(b) CONFORMING AMENDMENTS.—(1) Section 1834(h)(4)(C) (42 U.S.C. 1395m(h)(4)(C)) is amended by inserting "(and includes shoes described in section 1861(s)(12))" after "in section 1861(s)(9)".

(2) Section 1842(s)(2) (42 U.S.C. 1395u(s)(2)) is amended by striking subparagraph (C).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items furnished on or after January 1, 2005.

SEC. 628. PAYMENT FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

Section 1833(h)(2)(A)(ii)(IV) (42 U.S.C. 1395l(h)(2)(A)(ii)(IV)) is amended by striking "and 1998 through 2002" and inserting ", 1998 through 2002, and 2004 through 2008".

SEC. 629. INDEXING PART B DEDUCTIBLE TO INFLATION.

The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended by striking "and $100 for 1991 and subsequent years" and inserting the following: ", $100 for 1991 through 2004, $110 for 2005, and for a subsequent year the amount of such deductible for the previous year increased by the annual percentage increase in the monthly actuarial rate under section 1839(a)(1) ending with such subsequent year (rounded to the nearest $1)".

SEC. 630. 5-YEAR AUTHORIZATION OF REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

Section 1880(e)(1)(A) (42 U.S.C. 1395qq(e)(1)(A)) is amended by inserting "(and for items and services furnished during the 5-year period beginning on January 1, 2005, all items and services for which payment may be made under part B)" after "for services described in paragraph (2)".

Subtitle D—Additional Demonstrations, Studies, and Other Provisions

SEC. 641. DEMONSTRATION PROJECT FOR COVERAGE OF CERTAIN PRESCRIPTION DRUGS AND BIOLOGICALS.

(a) DEMONSTRATION PROJECT.—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which payment is made for drugs or biologicals that are prescribed as replacements for drugs and biologicals described in section 1861(s)(2)(A) or 1861(s)(2)(Q) of such Act (42 U.S.C. 1395x(s)(2)(A), 1395x(s)(2)(Q)), or both, for which payment is made under such part. Such project shall provide for cost-sharing applicable with respect to such drugs or biologicals in the same manner as cost-sharing applies with respect to part D drugs under standard prescription drug coverage (as defined in section 1860D–2(b) of the Social Security Act, as added by section 101(a)).

(b) DEMONSTRATION PROJECT SITES.—The project established under this section shall be conducted in sites selected by the Secretary.

(c) DURATION.—The Secretary shall conduct the demonstration project for the 2-year period beginning on the date that is 90 days after the date of the enactment of this Act, but in no case may the project extend beyond December 31, 2005.

(d) LIMITATION.—Under the demonstration project over the duration of the project, the Secretary may not provide—

(1) coverage for more than 50,000 patients; and

(2) more than $500,000,000 in funding.

(e) REPORT.—Not later than July 1, 2006, the Secretary shall submit to Congress a report on the project. The report shall include an evaluation of patient access to care and patient outcomes under the project, as well as an analysis of the cost effectiveness of the project, including an evaluation of the costs savings (if any) to the medicare program attributable to reduced physicians' services and hospital outpatient departments services for administration of the biological.

SEC. 642. EXTENSION OF COVERAGE OF INTRAVENOUS IMMUNE GLOBULIN (IVIG) FOR THE TREATMENT OF PRIMARY IMMUNE DEFICIENCY DISEASES IN THE HOME.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by sections 611(a) and 612(a) is amended—

(1) in subsection (s)(2)—

(A) by striking "and" at the end of subparagraph (X);

(B) by adding "and" at the end of subparagraph (Y); and

(C) by adding at the end the following new subparagraph:

"(Z) intravenous immune globulin for the treatment of primary immune deficiency diseases in the home (as defined in subsection (zz));"; and

(2) by adding at the end the following new subsection:

"Intravenous Immune Globulin

"(zz) The term 'intravenous immune globulin' means an approved pooled plasma derivative for the treatment in the patient's home of a patient with a diagnosed primary immune deficiency disease, but not including items or services related to the administration of the derivative, if a physician determines administration of the derivative in the patient's home is medically appropriate.".

(b) PAYMENT AS A DRUG OR BIOLOGICAL.—Section 1833(a)(1)(S) (42 U.S.C. 1395l(a)(1)(S)) is amended by inserting "(including intravenous immune globulin (as defined in section 1861(zz)))" after "with respect to drugs and biologicals".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items furnished administered on or after January 1, 2004.

SEC. 643. MEDPAC STUDY OF COVERAGE OF SURGICAL FIRST ASSISTING SERVICES OF CERTIFIED REGISTERED NURSE FIRST ASSISTANTS.

(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the "Commission") shall conduct a study on the feasibility and advisability of providing for payment under part B of title XVIII of the Social Security Act for surgical first assisting services furnished by a certified registered nurse first assistant to medicare beneficiaries.

(b) REPORT.—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate.

(c) DEFINITIONS.—In this section:

(1) SURGICAL FIRST ASSISTING SERVICES.—The term "surgical first assisting services" means services consisting of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care (as determined by the Secretary) furnished by a certified registered nurse first assistant (as defined in paragraph (2)) which the certified registered nurse first assistant is legally authorized to perform by the State in which the services are performed.

(2) CERTIFIED REGISTERED NURSE FIRST ASSISTANT.—The term "certified registered nurse first assistant" means an individual who—

(A) is a registered nurse and is licensed to practice nursing in the State in which the surgical first assisting services are performed;

(B) has completed a minimum of 2,000 hours of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care; and

(C) is certified as a registered nurse first assistant by an organization recognized by the Secretary.

SEC. 644. MEDPAC STUDY OF PAYMENT FOR CARDIO-THORACIC SURGEONS.

(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the "Commission") shall conduct a study on the practice expense relative values established by the Secretary of Health and Human Services under the medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians in the specialties of thoracic and cardiac surgery to determine whether such values adequately take into account the attendant costs that such physicians incur in providing clinical staff for patient care in hospitals.

(b) REPORT.—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate.

SEC. 645. STUDIES RELATING TO VISION IMPAIRMENTS.

(a) COVERAGE OF OUTPATIENT VISION SERVICES FURNISHED BY VISION REHABILITATION PROFESSIONALS UNDER PART B.—

(1) STUDY.—The Secretary shall conduct a study to determine the feasibility and advisability of providing for payment for vision rehabilitation services furnished by vision rehabilitation professionals.

(2) REPORT.—Not later than January 1, 2005, the Secretary shall submit to Congress a report on the study conducted under paragraph (1) together with recommendations for such legislation or administrative action as the Secretary determines to be appropriate.

(3) VISION REHABILITATION PROFESSIONAL DEFINED.—In this subsection, the term ''vision rehabilitation professional'' means an orientation and mobility specialist, a rehabilitation teacher, or a low vision therapist.

(b) REPORT ON APPROPRIATENESS OF A DEMONSTRATION PROJECT TO TEST FEASIBILITY OF USING PPO NETWORKS TO REDUCE COSTS OF ACQUIRING EYEGLASSES FOR MEDICARE BENEFICIARIES AFTER CATARACT SURGERY.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the feasibility of establishing a two-year demonstration project under which the Secretary enters into arrangements with vision care preferred provider organization networks to furnish and pay for conventional eyeglasses subsequent to each cataract surgery with insertion of an intraocular lens on behalf of Medicare beneficiaries. In such report, the Secretary shall include an estimate of potential cost savings to the Medicare program through the use of such networks, taking into consideration quality of service and beneficiary access to services offered by vision care preferred provider organization networks.

SEC. 646. MEDICARE HEALTH CARE QUALITY DEMONSTRATION PROGRAMS.

Title XVIII (42 U.S.C. 1395 et seq.) is amended by inserting after section 1866B the following new section:

''HEALTH CARE QUALITY DEMONSTRATION PROGRAM

''SEC. 1866C. (a) DEFINITIONS.—In this section:

''(1) BENEFICIARY.—The term 'beneficiary' means an individual who is entitled to benefits under part A and enrolled under part B, including any individual who is enrolled in a Medicare Advantage plan under part C.

''(2) HEALTH CARE GROUP.—

''(A) IN GENERAL.—The term 'health care group' means—

''(i) a group of physicians that is organized at least in part for the purpose of providing physician's services under this title;

''(ii) an integrated health care delivery system that delivers care through coordinated hospitals, clinics, home health agencies, ambulatory surgery centers, skilled nursing facilities, rehabilitation facilities and clinics, and employed, independent, or contracted physicians; or

''(iii) an organization representing regional coalitions of groups or systems described in clause (i) or (ii).

''(B) INCLUSION.—As the Secretary determines appropriate, a health care group may include a hospital or any other individual or entity furnishing items or services for which payment may be made under this title that is affiliated with the health care group under an arrangement structured so that such hospital, individual, or entity participates in a demonstration project under this section.

''(3) PHYSICIAN.—Except as otherwise provided for by the Secretary, the term 'physician' means any individual who furnishes services that may be paid for as physicians' services under this title.

''(b) DEMONSTRATION PROJECTS.—The Secretary shall establish a 5-year demonstration program under which the Secretary shall approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including—

''(1) the provision of incentives to improve the safety of care provided to beneficiaries;

''(2) the appropriate use of best practice guidelines by providers and services by beneficiaries;

''(3) reduced scientific uncertainty in the delivery of care through the examination of variations in the utilization and allocation of services, and outcomes measurement and research;

''(4) encourage shared decision making between providers and patients;

''(5) the provision of incentives for improving the quality and safety of care and achieving the efficient allocation of resources;

''(6) the appropriate use of culturally and ethnically sensitive health care delivery; and

''(7) the financial effects on the health care marketplace of altering the incentives for care delivery and changing the allocation of resources.

''(c) ADMINISTRATION BY CONTRACT.—

''(1) IN GENERAL.—Except as otherwise provided in this section, the Secretary may administer the demonstration program established under this section in a manner that is similar to the manner in which the demonstration program established under section 1866A is administered in accordance with section 1866B.

''(2) ALTERNATIVE PAYMENT SYSTEMS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include proposals for the use of alternative payment systems for items and services provided to beneficiaries by the group that are designed to—

''(A) encourage the delivery of high quality care while accomplishing the objectives described in subsection (b); and

''(B) streamline documentation and reporting requirements otherwise required under this title.

''(3) BENEFITS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include modifications to the package of benefits available under the original medicare fee-for-service program under parts A and B or the package of benefits available through a Medicare Advantage plan under part C. The criteria employed under the demonstration program under this section to evaluate outcomes and determine best practice guidelines and incentives shall not be used as a basis for the denial of medicare benefits under the demonstration program to patients against their wishes (or if the patient is incompetent, against the wishes of the patient's surrogate) on the basis of the patient's age or expected length of life or of the patient's present or predicted disability, degree of medical dependency, or quality of life.

''(d) ELIGIBILITY CRITERIA.—To be eligible to receive assistance under this section, an entity shall—

''(1) be a health care group;

''(2) meet quality standards established by the Secretary, including—

''(A) the implementation of continuous quality improvement mechanisms that are aimed at integrating community-based support services, primary care, and referral care;

''(B) the implementation of activities to increase the delivery of effective care to beneficiaries;

''(C) encouraging patient participation in preference-based decisions;

''(D) the implementation of activities to encourage the coordination and integration of medical service delivery; and

''(E) the implementation of activities to measure and document the financial impact on the health care marketplace of altering the incentives of health care delivery and changing the allocation of resources; and

''(3) meet such other requirements as the Secretary may establish.

''(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII as may be necessary to carry out the purposes of the demonstration program established under this section.

''(f) BUDGET NEUTRALITY.—With respect to the 5-year period of the demonstration program under subsection (b), the aggregate expenditures under this title for such period shall not exceed the aggregate expenditures that would have been expended under this title if the program established under this section had not been implemented.

''(g) NOTICE REQUIREMENTS.—In the case of an individual that receives health care items or services under a demonstration program carried out under this section, the Secretary shall ensure that such individual is notified of any waivers of coverage or payment rules that are applicable to such individual under this title as a result of the participation of the individual in such program.

''(h) PARTICIPATION AND SUPPORT BY FEDERAL AGENCIES.—In carrying out the demonstration program under this section, the Secretary may direct—

''(1) the Director of the National Institutes of Health to expand the efforts of the Institutes to evaluate current medical technologies and improve the foundation for evidence-based practice;

''(2) the Administrator of the Agency for Healthcare Research and Quality to, where possible and appropriate, use the program under this section as a laboratory for the study of quality improvement strategies and to evaluate, monitor, and disseminate information relevant to such program; and

''(3) the Administrator of the Centers for Medicare & Medicaid Services and the Administrator of the Center for Medicare Choices to support linkages of relevant medicare data to registry information from participating health care groups for the beneficiary populations served by the participating groups, for analysis supporting the purposes of the demonstration program, consistent with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996.''.

SEC. 647. MEDPAC STUDY ON DIRECT ACCESS TO PHYSICAL THERAPY SERVICES.

(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the ''Commission'') shall conduct a study on the feasibility and advisability of allowing medicare fee-for-service beneficiaries direct access to outpatient physical therapy services and physical therapy services furnished as comprehensive rehabilitation facility services.

(b) REPORT.—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate.

(c) DIRECT ACCESS DEFINED.—The term ''direct access'' means, with respect to outpatient physical therapy services and physical therapy services furnished as comprehensive outpatient rehabilitation facility services, coverage of and payment for such services in accordance with the provisions of title XVIII of the Social Security Act, except that sections 1835(a)(2), 1861(p), and 1861(cc) of such Act (42 U.S.C. 1395n(a)(2), 1395x(p), and 1395x(cc), respectively) shall be applied—

(1) without regard to any requirement that—

(A) an individual be under the care of (or referred by) a physician; or

(B) services be provided under the supervision of a physician; and

(2) by allowing a physician or a qualified physical therapist to satisfy any requirement for—

(A) certification and recertification; and

(B) establishment and periodic review of a plan of care.

SEC. 648. DEMONSTRATION PROJECT FOR CONSUMER-DIRECTED CHRONIC OUTPATIENT SERVICES.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, the Secretary shall establish demonstration projects (in this section referred to as "demonstration projects") under which the Secretary shall evaluate methods that improve the quality of care provided to individuals with chronic conditions and that reduce expenditures that would otherwise be made under the medicare program on behalf of such individuals for such chronic conditions, such methods to include permitting those beneficiaries to direct their own health care needs and services.

(2) INDIVIDUALS WITH CHRONIC CONDITIONS DEFINED.—In this section, the term "individuals with chronic conditions" means an individual entitled to benefits under part A of title XVIII of the Social Security Act, and enrolled under part B of such title, but who is not enrolled under part C of such title who is diagnosed as having one or more chronic conditions (as defined by the Secretary), such as diabetes.

(b) DESIGN OF PROJECTS.—

(1) EVALUATION BEFORE IMPLEMENTATION OF PROJECT.—

(A) IN GENERAL.—In establishing the demonstration projects under this section, the Secretary shall evaluate best practices employed by group health plans and practices under State plans for medical assistance under the medicaid program under title XIX of the Social Security Act, as well as best practices in the private sector or other areas, of methods that permit patients to self-direct the provision of personal care services. The Secretary shall evaluate such practices for a 1-year period and, based on such evaluation, shall design the demonstration project.

(B) REQUIREMENT FOR ESTIMATE OF BUDGET NEUTRAL COSTS.—As part of the evaluation under subparagraph (A), the Secretary shall evaluate the costs of furnishing care under the projects. The Secretary may not implement the demonstration projects under this section unless the Secretary determines that the costs of providing care to individuals with chronic conditions under the project will not exceed the costs, in the aggregate, of furnishing care to such individuals under title XVIII of the Social Security Act, that would otherwise be paid without regard to the demonstration projects for the period of the project.

(2) SCOPE OF SERVICES.—The Secretary shall determine the appropriate scope of personal care services that would apply under the demonstration projects.

(c) VOLUNTARY PARTICIPATION.—Participation of providers of services and suppliers, and of individuals with chronic conditions, in the demonstration projects shall be voluntary.

(d) DEMONSTRATION PROJECTS SITES.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall conduct a demonstration project in at least one area that the Secretary determines has a population of individuals entitled to benefits under part A of title XVIII of the Social Security Act, and enrolled under part B of such title, with a rate of incidence of diabetes that significantly exceeds the national average rate of all areas.

(e) EVALUATION AND REPORT.—

(1) EVALUATIONS.—The Secretary shall conduct evaluations of the clinical and cost effectiveness of the demonstration projects.

(2) REPORTS.—Not later than 2 years after the commencement of the demonstration projects, and biannually thereafter, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

(A) An analysis of the patient outcomes and costs of furnishing care to the individuals with chronic conditions participating in the projects as compared to such outcomes and costs to other individuals for the same health conditions.

(B) Evaluation of patient satisfaction under the demonstration projects.

(C) Such recommendations regarding the extension, expansion, or termination of the projects as the Secretary determines appropriate.

(f) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(g) AUTHORIZATION OF APPROPRIATIONS.—(1) Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

(2) There are authorized to be appropriated from such Trust Fund such sums as may be necessary for the Secretary to enter into contracts with appropriate organizations for the deign, implementation, and evaluation of the demonstration project.

(3) In no case may expenditures under this section exceed the aggregate expenditures that would otherwise have been made for the provision of personal care services.

SEC. 649. MEDICARE CARE MANAGEMENT PERFORMANCE DEMONSTRATION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a pay-for-performance demonstration program with physicians to meet the needs of eligible beneficiaries through the adoption and use of health information technology and evidence-based outcomes measures for—

(A) promoting continuity of care;

(B) helping stabilize medical conditions;

(C) preventing or minimizing acute exacerbations of chronic conditions; and

(D) reducing adverse health outcomes, such as adverse drug interactions related to polypharmacy.

(2) SITES.—The Secretary shall designate no more than 4 sites at which to conduct the demonstration program under this section, of which—

(A) 2 shall be in an urban area;

(B) 1 shall be in a rural area; and

(C) 1 shall be in a State with a medical school with a Department of Geriatrics that manages rural outreach sites and is capable of managing patients with multiple chronic conditions, one of which is dementia.

(3) DURATION.—The Secretary shall conduct the demonstration program under this section for a 3-year period.

(4) CONSULTATION.—In carrying out the demonstration program under this section, the Secretary shall consult with private sector and non-profit groups that are undertaking similar efforts to improve quality and reduce avoidable hospitalizations for chronically ill patients.

(b) PARTICIPATION.—

(1) IN GENERAL.—A physician who provides care for a minimum number of eligible beneficiaries (as specified by the Secretary) may participate in the demonstration program under this section if such physician agrees, to phase-in over the course of the 3-year demonstration period and with the assistance provided under subsection (d)(2)—

(A) the use of health information technology to manage the clinical care of eligible beneficiaries consistent with paragraph (3); and

(B) the electronic reporting of clinical quality and outcomes measures in accordance with requirements established by the Secretary under the demonstration program.

(2) SPECIAL RULE.—In the case of the sites referred to in subparagraphs (B) and (C) of subsection (a)(2), a physician who provides care for a minimum number of beneficiaries with two or more chronic conditions, including dementia (as specified by the Secretary), may participate in the program under this section if such physician agrees to the requirements in subparagraphs (A) and (B) of paragraph (1).

(3) PRACTICE STANDARDS.—Each physician participating in the demonstration program under this section must demonstrate the ability—

(A) to assess each eligible beneficiary for conditions other than chronic conditions, such as impaired cognitive ability and co-morbidities, for the purposes of developing care management requirements;

(B) to serve as the primary contact of eligible beneficiaries in accessing items and services for which payment may be made under the medicare program;

(C) to establish and maintain health care information system for such beneficiaries;

(D) to promote continuity of care across providers and settings;

(E) to use evidence-based guidelines and meet such clinical quality and outcome measures as the Secretary shall require;

(F) to promote self-care through the provision of patient education and support for patients or, where appropriate, family caregivers;

(G) when appropriate, to refer such beneficiaries to community service organizations; and

(H) to meet such other complex care management requirements as the Secretary may specify.

The guidelines and measures required under subparagraph (E) shall be designed to take into account beneficiaries with multiple chronic conditions.

(c) PAYMENT METHODOLOGY.—Under the demonstration program under this section the Secretary shall pay a per beneficiary amount to each participating physician who meets or exceeds specific performance standards established by the Secretary with respect to the clinical quality and outcome measures reported under subsection (b)(1)(B). Such amount may vary based on different levels of performance or improvement.

(d) ADMINISTRATION.—

(1) USE OF QUALITY IMPROVEMENT ORGANIZATIONS.—The Secretary shall contract with quality improvement organizations or such other entities as the Secretary deems appropriate to enroll physicians and evaluate their performance under the demonstration program under this section.

(2) TECHNICAL ASSISTANCE.—The Secretary shall require in such contracts that the contractor be responsible for technical assistance and education as needed to physicians enrolled in the demonstration program under this section for the purpose of aiding their adoption of health information technology, meeting practice standards, and implementing required clinical and outcomes measures.

(e) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for

the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary estimates would have been paid if the demonstration program under this section was not implemented.

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(g) REPORT.—Not later than 12 months after the date of completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(h) DEFINITIONS.—In this section:

(1) ELIGIBLE BENEFICIARY.—The term "eligible beneficiary" means any individual who—

(A) is entitled to benefits under part A and enrolled for benefits under part B of title XVIII of the Social Security Act and is not enrolled in a plan under part C of such title; and

(B) has one or more chronic medical conditions specified by the Secretary (one of which may be cognitive impairment).

(2) HEALTH INFORMATION TECHNOLOGY.—The term "health information technology" means email communication, clinical alerts and reminders, and other information technology that meets such functionality, interoperability, and other standards as prescribed by the Secretary.

SEC. 650. GAO STUDY AND REPORT ON THE PROPAGATION OF CONCIERGE CARE.

(a) STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on concierge care (as defined in paragraph (2)) to determine the extent to which such care—

(A) is used by medicare beneficiaries (as defined in section 1802(b)(5)(A) of the Social Security Act (42 U.S.C. 1395a(b)(5)(A))); and

(B) has impacted upon the access of medicare beneficiaries (as so defined) to items and services for which reimbursement is provided under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) CONCIERGE CARE.—In this section, the term "concierge care" means an arrangement under which, as a prerequisite for the provision of a health care item or service to an individual, a physician, practitioner (as described in section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C))), or other individual—

(A) charges a membership fee or another incidental fee to an individual desiring to receive the health care item or service from such physician, practitioner, or other individual; or

(B) requires the individual desiring to receive the health care item or service from such physician, practitioner, or other individual to purchase an item or service.

(b) REPORT.—Not later than the date that is 12 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a)(1) together with such recommendations for legislative or administrative action as the Comptroller General determines to be appropriate.

SEC. 651. DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.

(a) DEFINITIONS.—In this section:

(1) CHIROPRACTIC SERVICES.—The term "chiropractic services" has the meaning given that term by the Secretary for purposes of the demonstration projects, but shall include, at a minimum—

(A) care for neuromusculoskeletal conditions typical among eligible beneficiaries; and

(B) diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided.

(2) DEMONSTRATION PROJECT.—The term "demonstration project" means a demonstration project established by the Secretary under subsection (b)(1).

(3) ELIGIBLE BENEFICIARY.—The term "eligible beneficiary" means an individual who is enrolled under part B of the medicare program.

(4) MEDICARE PROGRAM.—The term "medicare program" means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.—

(1) ESTABLISHMENT.—The Secretary shall establish demonstration projects in accordance with the provisions of this section for the purpose of evaluating the feasibility and advisability of covering chiropractic services under the medicare program (in addition to the coverage provided for services consisting of treatment by means of manual manipulation of the spine to correct a subluxation described in section 1861(r)(5) of the Social Security Act (42 U.S.C. 1395x(r)(5))).

(2) NO PHYSICIAN APPROVAL REQUIRED.—In establishing the demonstration projects, the Secretary shall ensure that an eligible beneficiary who participates in a demonstration project, including an eligible beneficiary who is enrolled for coverage under a Medicare+Choice plan (or, on and after January 1, 2006, under a Medicare Advantage plan), is not required to receive approval from a physician or other health care provider in order to receive a chiropractic service under a demonstration project.

(3) CONSULTATION.—In establishing the demonstration projects, the Secretary shall consult with chiropractors, organizations representing chiropractors, eligible beneficiaries, and organizations representing eligible beneficiaries.

(4) PARTICIPATION.—Any eligible beneficiary may participate in the demonstration projects on a voluntary basis.

(c) CONDUCT OF DEMONSTRATION PROJECTS.—

(1) DEMONSTRATION SITES.—

(A) SELECTION OF DEMONSTRATION SITES.—The Secretary shall conduct demonstration projects at 4 demonstration sites.

(B) GEOGRAPHIC DIVERSITY.—Of the sites described in subparagraph (A)—

(i) 2 shall be in rural areas; and

(ii) 2 shall be in urban areas.

(C) SITES LOCATED IN HPSAS.—At least 1 site described in clause (i) of subparagraph (B) and at least 1 site described in clause (ii) of such subparagraph shall be located in an area that is designated under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) as a health professional shortage area.

(2) IMPLEMENTATION; DURATION.—

(A) IMPLEMENTATION.—The Secretary shall not implement the demonstration projects before October 1, 2004.

(B) DURATION.—The Secretary shall complete the demonstration projects by the date that is 2 years after the date on which the first demonstration project is implemented.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration projects—

(A) to determine whether eligible beneficiaries who use chiropractic services use a lesser overall amount of items and services for which payment is made under the medicare program than eligible beneficiaries who do not use such services;

(B) to determine the cost of providing payment for chiropractic services under the medicare program;

(C) to determine the satisfaction of eligible beneficiaries participating in the demonstration projects and the quality of care received by such beneficiaries; and

(D) to evaluate such other matters as the Secretary determines is appropriate.

(2) REPORT.—Not later than the date that is 1 year after the date on which the demonstration projects conclude, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) together with such recommendations for legislation or administrative action as the Secretary determines is appropriate.

(e) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of the medicare program to the extent and for the period the Secretary finds necessary to conduct the demonstration projects.

(f) FUNDING.—

(1) DEMONSTRATION PROJECTS.—

(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (2), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration projects under this section.

(B) LIMITATION.—In conducting the demonstration projects under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under the medicare program do not exceed the amount which the Secretary would have paid under the medicare program if the demonstration projects under this section were not implemented.

(2) EVALUATION AND REPORT.—There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (d).

TITLE VII—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

SEC. 701. UPDATE IN HOME HEALTH SERVICES.

(a) CHANGE TO CALENDAR YEAR UPDATE.—Section 1895(b) (42 U.S.C. 1395fff(b)(3)) is amended—

(1) in paragraph (3)(B)(i)—

(A) by striking "each fiscal year (beginning with fiscal year 2002)" and inserting "fiscal year 2002 and for fiscal year 2003 and for each subsequent year (beginning with 2004)"; and

(B) by inserting "or year" after "the fiscal year";

(2) in paragraph (3)(B)(ii)—

(A) in subclause (I), by striking "or" at the end;

(B) by redesignating subclause (II) as subclause (III);

(C) in subclause (III), as so redesignated, by striking "any subsequent fiscal year" and inserting "2004 and any subsequent year"; and

(D) by inserting after subclause (I) the following new subclause:

"(II) for the last calendar quarter of 2003 and the first calendar quarter of 2004, the home health market basket percentage increase; or";

(3) in paragraph (3)(B)(iii), by inserting "or year" after "fiscal year" each place it appears; and

(4) in paragraph (3)(B)(iv)—

(A) by inserting "or year" after "fiscal year" each place it appears; and

(B) by inserting "or years" after "fiscal years"; and

(5) in paragraph (5), by inserting "or year" after "fiscal year".

(b) ADJUSTMENT TO UPDATES FOR 2004, 2005, AND 2006.—Section 1895(b)(3)(B)(ii) (42 U.S.C. 1395fff(b)(3)(B)(ii)), as amended by subsection (a)(2), is amended—

(1) by striking "or" at the end of subclause (II);

(2) by redesignating subclause (III) as subclause (IV);

(3) in subclause (IV), as so redesignated, by striking "2004" and inserting "2007"; and

(4) by inserting after subclause (II) the following new subclause:

"(III) the last 3 calendar quarters of 2004, and each of 2005 and 2006 the home health market basket percentage increase minus 0.8 percentage points; or".

SEC. 702. DEMONSTRATION PROJECT TO CLARIFY THE DEFINITION OF HOMEBOUND.

(a) DEMONSTRATION PROJECT.—Not later than 180 days after the date of the enactment of this Act, the Secretary shall conduct a 2-year demonstration project under part B of title XVIII of the Social Security Act under which medicare beneficiaries with chronic conditions described in subsection (b) are deemed to be homebound for purposes of receiving home health services under the medicare program.

(b) MEDICARE BENEFICIARY DESCRIBED.—For purposes of subsection (a), a medicare beneficiary is eligible to be deemed to be homebound, without regard to the purpose, frequency, or duration of absences from the home, if—

(1) the beneficiary has been certified by one physician as an individual who has a permanent and severe, disabling condition that is not expected to improve;

(2) the beneficiary is dependent upon assistance from another individual with at least 3 out of the 5 activities of daily living for the rest of the beneficiary's life;

(3) the beneficiary requires skilled nursing services for the rest of the beneficiary's life and the skilled nursing is more than medication management;

(4) an attendant is required to visit the beneficiary on a daily basis to monitor and treat the beneficiary's medical condition or to assist the beneficiary with activities of daily living;

(5) the beneficiary requires technological assistance or the assistance of another person to leave the home; and

(6) the beneficiary does not regularly work in a paid position full-time or part-time outside the home.

(c) DEMONSTRATION PROJECT SITES.—The demonstration project established under this section shall be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

(d) LIMITATION ON NUMBER OF PARTICIPANTS.—The aggregate number of such beneficiaries that may participate in the project may not exceed 15,000.

(e) DATA.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to medicare beneficiaries that relates to quality of care, patient outcomes, and additional costs, if any, to the medicare program.

(f) REPORT TO CONGRESS.—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project using the data collected under subsection (e). The report shall include the following:

(1) An examination of whether the provision of home health services to medicare beneficiaries under the project has had any of the following effects:

(A) Has adversely affected the provision of home health services under the medicare program.

(B) Has directly caused an increase of expenditures under the medicare program for the provision of such services that is directly attributable to such clarification.

(2) The specific data evidencing the amount of any increase in expenditures that is directly attributable to the demonstration project (expressed both in absolute dollar terms and as a percentage) above expenditures that would otherwise have been incurred for home health services under the medicare program.

(3) Specific recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency, and purpose of their absences from the home to qualify for home health services without incurring additional costs to the medicare program.

(g) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(h) CONSTRUCTION.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act for acts prohibited under such titles, including penalties for false certifications for purposes of receipt of items or services under the medicare program.

(i) AUTHORIZATION OF APPROPRIATIONS.—Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

(j) DEFINITIONS.—In this section:

(1) MEDICARE BENEFICIARY.—The term "medicare beneficiary" means an individual who is enrolled under part B of title XVIII of the Social Security Act.

(2) HOME HEALTH SERVICES.—The term "home health services" has the meaning given such term in section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)).

(3) ACTIVITIES OF DAILY LIVING DEFINED.—The term "activities of daily living" means eating, toileting, transferring, bathing, and dressing.

SEC. 703. DEMONSTRATION PROJECT FOR MEDICAL ADULT DAY-CARE SERVICES.

(a) ESTABLISHMENT.—Subject to the succeeding provisions of this section, the Secretary shall establish a demonstration project (in this section referred to as the "demonstration project") under which the Secretary shall, as part of a plan of an episode of care for home health services established for a medicare beneficiary, permit a home health agency, directly or under arrangements with a medical adult day-care facility, to provide medical adult day-care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home.

(b) PAYMENT.—

(1) IN GENERAL.—Subject to paragraph (2), the amount of payment for an episode of care for home health services, a portion of which consists of substitute medical adult day-care services, under the demonstration project shall be made at a rate equal to 95 percent of the amount that would otherwise apply for such home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff). In no case may a home health agency, or a medical adult day-care facility under arrangements with a home health agency, separately charge a beneficiary for medical adult day-care services furnished under the plan of care.

(2) ADJUSTMENT IN CASE OF OVERUTILIZATION OF SUBSTITUTE ADULT DAY-CARE SERVICES TO ENSURE BUDGET NEUTRALITY.—The Secretary shall monitor the expenditures under the demonstration project and under title XVIII of the Social Security Act for home health services. If the Secretary estimates that the total expenditures under the demonstration project and under such title XVIII for home health services for a period determined by the Secretary exceed expenditures that would have been made under such title XVIII for home health services for such period if the demonstration project had not been conducted, the Secretary shall adjust the rate of payment to medical adult day-care facilities under paragraph (1) in order to eliminate such excess.

(c) DEMONSTRATION PROJECT SITES.—The demonstration project established under this section shall be conducted in not more than 5 sites in States selected by the Secretary that license or certify providers of services that furnish medical adult day-care services.

(d) DURATION.—The Secretary shall conduct the demonstration project for a period of 3 years.

(e) VOLUNTARY PARTICIPATION.—Participation of medicare beneficiaries in the demonstration project shall be voluntary. The total number of such beneficiaries that may participate in the project at any given time may not exceed 15,000.

(f) PREFERENCE IN SELECTING AGENCIES.—In selecting home health agencies to participate under the demonstration project, the Secretary shall give preference to those agencies that are currently licensed or certified through common ownership and control to furnish medical adult day-care services.

(g) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act as may be necessary for the purposes of carrying out the demonstration project, other than waiving the requirement that an individual be homebound in order to be eligible for benefits for home health services.

(h) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the clinical and cost-effectiveness of the demonstration project. Not later than 6 months after the completion of the project, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

(1) An analysis of the patient outcomes and costs of furnishing care to the medicare beneficiaries participating in the project as compared to such outcomes and costs to beneficiaries receiving only home health services for the same health conditions.

(2) Such recommendations regarding the extension, expansion, or termination of the project as the Secretary determines appropriate.

(i) DEFINITIONS.—In this section:

(1) HOME HEALTH AGENCY.—The term "home health agency" has the meaning given such term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(2) MEDICAL ADULT DAY-CARE FACILITY.—The term "medical adult day-care facility" means a facility that—

(A) has been licensed or certified by a State to furnish medical adult day-care services in the State for a continuous 2-year period;

(B) is engaged in providing skilled nursing services and other therapeutic services directly or under arrangement with a home health agency;

(C) is licensed and certified by the State in which it operates or meets such standards established by the Secretary to assure quality of care and such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the facility; and

(D) provides medical adult day-care services.

(3) MEDICAL ADULT DAY-CARE SERVICES.—The term "medical adult day-care services" means—

(A) home health service items and services described in paragraphs (1) through (7) of section 1861(m) furnished in a medical adult day-care facility;

(B) a program of supervised activities furnished in a group setting in the facility that—

(i) meet such criteria as the Secretary determines appropriate; and

(ii) is designed to promote physical and mental health of the individuals; and

(C) such other services as the Secretary may specify.

(4) MEDICARE BENEFICIARY.—The term "medicare beneficiary" means an individual entitled to benefits under part A of this title, enrolled under part B of this title, or both.

SEC. 704. TEMPORARY SUSPENSION OF OASIS REQUIREMENT FOR COLLECTION OF DATA ON NON-MEDICARE AND NON-MEDICAID PATIENTS.

(a) IN GENERAL.—During the period described in subsection (b), the Secretary may not require, under section 4602(e) of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 467) or otherwise under OASIS, a home health agency to gather or submit information that relates to an individual who is not eligible for benefits under either title XVIII or title XIX of the Social Security Act (such information in this section referred to as "non-medicare/medicaid OASIS information").

(b) PERIOD OF SUSPENSION.—The period described in this subsection—

(1) begins on the date of the enactment of this Act; and

(2) ends on the last day of the second month beginning after the date as of which the Secretary has published final regulations regarding the collection and use by the Centers for Medicare & Medicaid Services of non-medicare/medicaid OASIS information following the submission of the report required under subsection (c).

(c) REPORT.—

(1) STUDY.—The Secretary shall conduct a study on how non-medicare/medicaid OASIS information is and can be used by large home health agencies. Such study shall examine—

(A) whether there are unique benefits from the analysis of such information that cannot be derived from other information available to, or collected by, such agencies; and

(B) the value of collecting such information by small home health agencies compared to the administrative burden related to such collection.

In conducting the study the Secretary shall obtain recommendations from quality assessment experts in the use of such information and the necessity of small, as well as large, home health agencies collecting such information.

(2) REPORT.—The Secretary shall submit to Congress a report on the study conducted under paragraph (1) by not later than 18 months after the date of the enactment of this Act.

(d) CONSTRUCTION.—Nothing in this section shall be construed as preventing home health agencies from collecting non-medicare/medicaid OASIS information for their own use.

SEC. 705. MEDPAC STUDY ON MEDICARE MARGINS OF HOME HEALTH AGENCIES.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study of payment margins of home health agencies under the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff). Such study shall examine whether systematic differences in payment margins are related to differences in case mix (as measured by home health resource groups (HHRGs)) among such agencies. The study shall use the partial or full-year cost reports filed by home health agencies.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study under subsection (a).

SEC. 706. COVERAGE OF RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTION SERVICES FURNISHED IN THE HOME.

(a) IN GENERAL.—Section 1821(a) (42 U.S.C. 1395i–5(a)) is amended—

(1) in the matter preceding paragraph (1), by inserting "and for home health services furnished an individual by a religious nonmedical health care institution" after "religious nonmedical health care institution"; and

(2) in paragraph (2)—

(A) by striking "or extended care services" and inserting ", extended care services, or home health services"; and

(B) by inserting ", or receiving services from a home health agency," after "skilled nursing facility".

(b) DEFINITION.—Section 1861 (42 U.S.C. 1395x), as amended by section 642, is amended by adding at the end the following new section:

"Extended Care in Religious Nonmedical Health Care Institutions

"(aaa)(1) The term 'home health agency' also includes a religious nonmedical health care institution (as defined in subsection (ss)(1)), but only with respect to items and services ordinarily furnished by such an institution to individuals in their homes, and that are comparable to items and services furnished to individuals by a home health agency that is not religious nonmedical health care institution.

"(2)(A) Subject to subparagraphs (B), payment may be made with respect to services provided by such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations consistent with section 1821.

"(B) Notwithstanding any other provision of this title, payment may not be made under subparagraph (A)—

"(i) in a year insofar as such payments exceed $700,000; and

"(ii) after December 31, 2006.".

Subtitle B—Graduate Medical Education

SEC. 711. EXTENSION OF UPDATE LIMITATION ON HIGH COST PROGRAMS.

Section 1886(h)(2)(D)(iv) (42 U.S.C. 1395ww(h)(2)(D)(iv)) is amended—

(1) in subclause (I)—

(A) by inserting "AND 2004 THROUGH 2013" after "AND 2002"; and

(B) by inserting "or during the period beginning with fiscal year 2004 and ending with fiscal year 2013" after "during fiscal year 2001 or fiscal year 2002"; and

(2) in subclause (II)—

(A) by striking "fiscal year 2004, or fiscal year 2005," and

(B) by striking "For a" and inserting "For the".

SEC. 712. EXCEPTION TO INITIAL RESIDENCY PERIOD FOR GERIATRIC RESIDENCY OR FELLOWSHIP PROGRAMS.

(a) CLARIFICATION OF CONGRESSIONAL INTENT.—Congress intended section 1886(h)(5)(F)(ii) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(F)(ii)), as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272), to provide an exception to the initial residency period for geriatric residency or fellowship programs such that, where a particular approved geriatric training program requires a resident to complete 2 years of training to initially become board eligible in the geriatric specialty, the 2 years spent in the geriatric training program are treated as part of the resident's initial residency period, but are not counted against any limitation on the initial residency period.

(b) INTERIM FINAL REGULATORY AUTHORITY AND EFFECTIVE DATE.—The Secretary shall promulgate interim final regulations consistent with the congressional intent expressed in this section after notice and pending opportunity for public comment to be effective for cost reporting periods beginning on or after October 1, 2003.

SEC. 713. TREATMENT OF VOLUNTEER SUPERVISION.

(a) MORATORIUM ON CHANGES IN TREATMENT.—During the 1-year period beginning on January 1, 2004, for purposes of applying subsections (d)(5)(B) and (h) of section 1886 of the Social Security Act (42 U.S.C. 1395ww), the Secretary shall allow all hospitals to count residents in osteopathic and allopathic family practice programs in existence as of January 1, 2002, who are training at non-hospital sites, without regard to the financial arrangement between the hospital and the teaching physician practicing in the non-hospital site to which the resident has been assigned.

(b) STUDY AND REPORT.—

(1) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study of the appropriateness of alternative payment methodologies under such sections for the costs of training residents in non-hospital settings.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Inspector General shall submit to Congress a report on the study conducted under paragraph (1), together with such recommendations as the Inspector General determines appropriate.

Subtitle C—Chronic Care Improvement

SEC. 721. VOLUNTARY CHRONIC CARE IMPROVEMENT UNDER TRADITIONAL FEE-FOR-SERVICE.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1806 the following new section:

"CHRONIC CARE IMPROVEMENT

"SEC. 1807. (a) IMPLEMENTATION OF CHRONIC CARE IMPROVEMENT PROGRAMS.—

"(1) IN GENERAL.—The Secretary shall provide for the phased-in development, testing, evaluation, and implementation of chronic care improvement programs in accordance with this section. Each such program shall be designed to improve clinical quality and beneficiary satisfaction and achieve spending targets with respect to expenditures under this title for targeted beneficiaries with one or more threshold conditions.

"(2) DEFINITIONS.—For purposes of this section:

"(A) CHRONIC CARE IMPROVEMENT PROGRAM.—The term 'chronic care improvement program' means a program described in paragraph (1) that is offered under an agreement under subsection (b) or (c).

"(B) CHRONIC CARE IMPROVEMENT ORGANIZATION.—The term 'chronic care improvement organization' means an entity that has entered into an agreement under subsection (b) or (c) to provide, directly or through contracts with subcontractors, a chronic care improvement program under this section. Such an entity may be a disease management organization, health insurer, integrated delivery system, physician group practice, a consortium of such entities, or any other legal entity that the Secretary determines appropriate to carry out a chronic care improvement program under this section.

"(C) CARE MANAGEMENT PLAN.—The term 'care management plan' means a plan established under subsection (d) for a participant in a chronic care improvement program.

"(D) THRESHOLD CONDITION.—The term 'threshold condition' means a chronic condition, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), or other diseases or conditions, as selected by the Secretary as appropriate for the establishment of a chronic care improvement program.

"(E) TARGETED BENEFICIARY.—The term 'targeted beneficiary' means, with respect to a chronic care improvement program, an individual who—

"(i) is entitled to benefits under part A and enrolled under part B, but not enrolled in a plan under part C;

"(ii) has one or more threshold conditions covered under such program; and "(iii) has been identified under subsection (d)(1) as a potential participant in such program.

"(3) CONSTRUCTION.—Nothing in this section shall be construed as—

"(A) expanding the amount, duration, or scope of benefits under this title;

"(B) providing an entitlement to participate in a chronic care improvement program under this section;

"(C) providing for any hearing or appeal rights under section 1869, 1878, or otherwise, with respect to a chronic care improvement program under this section; or

"(D) providing benefits under a chronic care improvement program for which a claim may be submitted to the Secretary by any provider of services or supplier (as defined in section 1861(d)).

"(b) DEVELOPMENTAL PHASE (PHASE I).—

"(1) IN GENERAL.—In carrying out this section, the Secretary shall enter into agreements consistent with subsection (f) with chronic care improvement organizations for the development, testing, and evaluation of chronic care improvement programs using randomized controlled trials. The first such agreement shall be entered into not later than 12 months after the date of the enactment of this section.

"(2) AGREEMENT PERIOD.—The period of an agreement under this subsection shall be for 3 years.

"(3) MINIMUM PARTICIPATION.—

"(A) IN GENERAL.—The Secretary shall enter into agreements under this subsection in a manner so that chronic care improvement programs offered under this section are offered in geographic areas that, in the aggregate, consist of areas in which at least 10 percent of the aggregate number of medicare beneficiaries reside.

"(B) MEDICARE BENEFICIARY DEFINED.—In this paragraph, the term 'medicare beneficiary' means an individual who is entitled to benefits under part A, enrolled under part B, or both, and who resides in the United States.

"(4) SITE SELECTION.—In selecting geographic areas in which agreements are entered into under this subsection, the Secretary shall ensure that each chronic care improvement program is conducted in a geographic area in which at least 10,000 targeted beneficiaries reside among other individuals entitled to benefits under part A, enrolled under part B, or both to serve as a control population.

"(5) INDEPENDENT EVALUATIONS OF PHASE I PROGRAMS.—The Secretary shall contract for an independent evaluation of the programs conducted under this subsection. Such evaluation shall be done by a contractor with knowledge of chronic care management programs and demonstrated experience in the evaluation of such programs. Each evaluation shall include an assessment of the following factors of the programs:

"(A) Quality improvement measures, such as adherence to evidence-based guidelines and rehospitalization rates.

"(B) Beneficiary and provider satisfaction.

"(C) Health outcomes.

"(D) Financial outcomes, including any cost savings to the program under this title.

"(c) EXPANDED IMPLEMENTATION PHASE (PHASE II).—

"(1) IN GENERAL.—With respect to chronic care improvement programs conducted under subsection (b), if the Secretary finds that the results of the independent evaluation conducted under subsection (b)(6) indicate that the conditions specified in paragraph (2) have been met by a program (or components of such program), the Secretary shall enter into agreements consistent with subsection (f) to expand the implementation of the program (or components) to additional geographic areas not covered under the program as conducted under subsection (b), which may include the implementation of the program on a national basis. Such expansion shall begin not earlier than 2 years after the program is implemented under subsection (b) and not later than 6 months after the date of completion of such program.

"(2) CONDITIONS FOR EXPANSION OF PROGRAMS.—The conditions specified in this paragraph are, with respect to a chronic care improvement program conducted under subsection (b) for a threshold condition, that the program is expected to—

"(A) improve the clinical quality of care;

"(B) improve beneficiary satisfaction; and

"(C) achieve targets for savings to the program under this title specified by the Secretary in the agreement within a range determined to be appropriate by the Secretary, subject to the application of budget neutrality with respect to the program and not taking into account any payments by the organization under the agreement under the program for risk under subsection (f)(3)(B).

"(3) INDEPENDENT EVALUATIONS OF PHASE II PROGRAMS.—The Secretary shall carry out evaluations of programs expanded under this subsection as the Secretary determines appropriate. Such evaluations shall be carried out in the similar manner as is provided under subsection (b)(5).

"(d) IDENTIFICATION AND ENROLLMENT OF PROSPECTIVE PROGRAM PARTICIPANTS.—

"(1) IDENTIFICATION OF PROSPECTIVE PROGRAM PARTICIPANTS.—The Secretary shall establish a method for identifying targeted beneficiaries who may benefit from participation in a chronic care improvement program.

"(2) INITIAL CONTACT BY SECRETARY.—The Secretary shall communicate with each targeted beneficiary concerning participation in a chronic care improvement program. Such communication may be made by the Secretary and shall include information on the following:

"(A) A description of the advantages to the beneficiary in participating in a program.

"(B) Notification that the organization offering a program may contact the beneficiary directly concerning such participation.

"(C) Notification that participation in a program is voluntary.

"(D) A description of the method for the beneficiary to participate or for declining to participate and the method for obtaining additional information concerning such participation.

"(3) VOLUNTARY PARTICIPATION.—A targeted beneficiary may participate in a chronic care improvement program on a voluntary basis and may terminate participation at any time.

"(e) CHRONIC CARE IMPROVEMENT PROGRAMS.—

"(1) IN GENERAL.—Each chronic care improvement program shall—

"(A) have a process to screen each targeted beneficiary for conditions other than threshold conditions, such as impaired cognitive ability and co-morbidities, for the purposes of developing an individualized, goal-oriented care management plan under paragraph (2);

"(B) provide each targeted beneficiary participating in the program with such plan; and

"(C) carry out such plan and other chronic care improvement activities in accordance with paragraph (3).

"(2) ELEMENTS OF CARE MANAGEMENT PLANS.—A care management plan for a targeted beneficiary shall be developed with the beneficiary and shall, to the extent appropriate, include the following:

"(A) A designated point of contact responsible for communications with the beneficiary and for facilitating communications with other health care providers under the plan.

"(B) Self-care education for the beneficiary (through approaches such as disease management or medical nutrition therapy) and education for primary caregivers and family members.

"(C) Education for physicians and other providers and collaboration to enhance communication of relevant clinical information.

"(D) The use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment.

"(E) The provision of information about hospice care, pain and palliative care, and end-of-life care.

"(3) CONDUCT OF PROGRAMS.—In carrying out paragraph (1)(C) with respect to a participant, the chronic care improvement organization shall—

"(A) guide the participant in managing the participant's health (including all co-morbidities, relevant health care services, and pharmaceutical needs) and in performing activities as specified under the elements of the care management plan of the participant;

"(B) use decision-support tools such as evidence-based practice guidelines or other criteria as determined by the Secretary; and

"(C) develop a clinical information database to track and monitor each participant across settings and to evaluate outcomes.

"(4) ADDITIONAL RESPONSIBILITIES.—

"(A) OUTCOMES REPORT.—Each chronic care improvement organization offering a chronic care improvement program shall monitor and report to the Secretary, in a manner specified by the Secretary, on health care quality, cost, and outcomes.

"(B) ADDITIONAL REQUIREMENTS.—Each such organization and program shall comply with such additional requirements as the Secretary may specify.

"(5) ACCREDITATION.—The Secretary may provide that chronic care improvement programs and chronic care improvement organizations that are accredited by qualified organizations (as defined by the Secretary) may be deemed to meet such requirements under this section as the Secretary may specify.

"(f) TERMS OF AGREEMENTS.—

"(1) TERMS AND CONDITIONS.—

"(A) IN GENERAL.—An agreement under this section with a chronic care improvement organization shall contain such terms and conditions as the Secretary may specify consistent with this section.

"(B) CLINICAL, QUALITY IMPROVEMENT, AND FINANCIAL REQUIREMENTS.—The Secretary may not enter into an agreement with such an organization under this section for the operation of a chronic care improvement program unless—

"(i) the program and organization meet the requirements of subsection (e) and such clinical, quality improvement, financial, and other requirements as the Secretary deems to be appropriate for the targeted beneficiaries to be served; and

"(ii) the organization demonstrates to the satisfaction of the Secretary that the organization is able to assume financial risk for performance under the agreement (as applied under paragraph (3)(B)) with respect to payments made to the organization under such agreement through available reserves, reinsurance, withholds, or such other means as the Secretary determines appropriate.

"(2) MANNER OF PAYMENT.—Subject to paragraph (3)(B), the payment under an agreement under—

"(A) subsection (b) shall be computed on a per-member per-month basis; or

"(B) subsection (c) may be on a per-member per-month basis or such other basis as the Secretary and organization may agree.

"(3) APPLICATION OF PERFORMANCE STANDARDS.—

"(A) SPECIFICATION OF PERFORMANCE STANDARDS.—Each agreement under this section with a chronic care improvement organization shall specify performance standards for each of the factors specified in subsection (c)(2), including clinical quality and spending targets under this title, against which the performance of the chronic care improvement organization under the agreement is measured.

"(B) ADJUSTMENT OF PAYMENT BASED ON PERFORMANCE.—

"(i) IN GENERAL.—Each such agreement shall provide for adjustments in payment rates to an organization under the agreement insofar as the Secretary determines that the organization failed to meet the performance standards specified in the agreement under subparagraph (A).

"(ii) FINANCIAL RISK FOR PERFORMANCE.—In the case of an agreement under subsection (b) or (c), the agreement shall provide for a full recovery for any amount by which the fees paid to the organization under the agreement exceed the estimated savings to the programs under this title attributable to implementation of such agreement.

"(4) BUDGET NEUTRAL PAYMENT CONDITION.—Under this section, the Secretary shall ensure that the aggregate sum of medicare program benefit expenditures for beneficiaries participating in chronic care improvement programs and funds paid to chronic care improvement organizations under this section, shall not exceed the medicare program benefit expenditures that the Secretary estimates would have been made for such targeted beneficiaries in the absence of such programs.

"(g) FUNDING.—(1) Subject to paragraph (2), there are appropriated to the Secretary, in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, such sums as may be necessary to provide for agreements with chronic care improvement programs under this section.

"(2) In no case shall the funding under this section exceed $100,000,000 in aggregate increased expenditures under this title (after taking into account any savings attributable to the operation of this section) over the 3-fiscal-year period beginning on October 1, 2003.".

(b) REPORTS.—The Secretary shall submit to Congress reports on the operation of section 1807 of the Social Security Act, as added by subsection (a), as follows:

(1) Not later than 2 years after the date of the implementation of such section, the Secretary shall submit to Congress an interim report on the scope of implementation of the programs under subsection (b) of such section, the design of the programs, and preliminary cost and quality findings with respect to those programs based on the following measures of the programs:

(A) Quality improvement measures, such as adherence to evidence-based guidelines and rehospitalization rates.

(B) Beneficiary and provider satisfaction.

(C) Health outcomes.

(D) Financial outcomes.

(2) Not later than 3 years and 6 months after the date of the implementation of such section the Secretary shall submit to Congress an update to the report required under paragraph (1) on the results of such programs.

(3) The Secretary shall submit to Congress 2 additional biennial reports on the chronic care improvement programs conducted under such section. The first such report shall be submitted not later than 2 years after the report is submitted under paragraph (2). Each such report shall include information on—

(A) the scope of implementation (in terms of both regions and chronic conditions) of the chronic care improvement programs;

(B) the design of the programs; and

(C) the improvements in health outcomes and financial efficiencies that result from such implementation.

SEC. 722. MEDICARE ADVANTAGE QUALITY IMPROVEMENT PROGRAMS.

(a) IN GENERAL.—Section 1852(e) (42 U.S.C. 1395w–22(e)) is amended—

(1) in the heading, by striking "ASSURANCE" and inserting "IMPROVEMENT";

(2) by amending paragraphs (1) through (3) to read as follows:

"(1) IN GENERAL.—Each MA organization shall have an ongoing quality improvement program for the purpose of improving the quality of care provided to enrollees in each MA plan offered by such organization (other than an MA private fee-for-service plan or an MSA plan).

"(2) CHRONIC CARE IMPROVEMENT PROGRAMS.—As part of the quality improvement program under paragraph (1), each MA organization shall have a chronic care improvement program. Each chronic care improvement program shall have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions that meet criteria established by the organization for participation under the program.

"(3) DATA.—

"(A) COLLECTION, ANALYSIS, AND REPORTING.—

"(i) IN GENERAL.—Except as provided in clauses (ii) and (iii) with respect to plans described in such clauses and subject to subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality.

"(ii) APPLICATION TO MA REGIONAL PLANS.—The Secretary shall establish as appropriate by regulation requirements for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality for MA organizations with respect to MA regional plans. Such requirements may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans.

"(iii) APPLICATION TO PREFERRED PROVIDER ORGANIZATIONS.—Clause (i) shall apply to MA organizations with respect to MA local plans that are preferred provider organization plans only insofar as services are furnished by providers or services, physicians, and other health care practitioners and suppliers that have contracts with such organization to furnish services under such plans.

"(iv) DEFINITION OF PREFERRED PROVIDER ORGANIZATION PLAN.—In this subparagraph, the term 'preferred provider organization plan' means an MA plan that—

"(I) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

"(II) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

"(III) is offered by an organization that is not licensed or organized under State law as a health maintenance organization.

"(B) LIMITATIONS.—

"(i) TYPES OF DATA.—The Secretary shall not collect under subparagraph (A) data on quality, outcomes, and beneficiary satisfaction to facilitate consumer choice and program administration other than the types of data that were collected by the Secretary as of November 1, 2003.

"(ii) CHANGES IN TYPES OF DATA.—Subject to subclause (iii), the Secretary may only change the types of data that are required to be submitted under subparagraph (A) after submitting to Congress a report on the reasons for such changes that was prepared in consultation with MA organizations and private accrediting bodies.

"(iii) CONSTRUCTION.—Nothing in the subsection shall be construed as restricting the ability of the Secretary to carry out the duties under section 1851(d)(4)(D).";

(3) in paragraph (4)(B)—

(A) by amending clause (i) to read as follows:

"(i) Paragraphs (1) through (3) of this subsection (relating to quality improvement programs)."; and

(B) by adding at the end the following new clause:

"(vii) The requirements described in section 1860D–4(j), to the extent such requirements apply under section 1860D–21(c)."; and

(4) by striking paragraph (5).

(b) CONFORMING AMENDMENT.—Section 1852(c)(1)(I) (42 U.S.C. 1395w–22(c)(1)(I)) is amended to read as follows:

"(I) QUALITY IMPROVEMENT PROGRAM.—A description of the organization's quality improvement program under subsection (e).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on and after January 1, 2006.

SEC. 723. CHRONICALLY ILL MEDICARE BENEFICIARY RESEARCH, DATA, DEMONSTRATION STRATEGY.

(a) DEVELOPMENT OF PLAN.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall develop a plan to improve quality of care and reduce the cost of care for chronically ill medicare beneficiaries.

(b) PLAN REQUIREMENTS.—The plan will utilize existing data and identify data gaps, develop research initiatives, and propose intervention demonstration programs to provide better health care for chronically ill medicare beneficiaries. The plan shall—

(1) integrate existing data sets including, the Medicare Current Beneficiary Survey (MCBS), Minimum Data Set (MDS), Outcome and Assessment Information Set (OASIS), data from Quality Improvement Organizations (QIO), and claims data;

(2) identify any new data needs and a methodology to address new data needs;

(3) plan for the collection of such data in a data warehouse; and

(4) develop a research agenda using such data.

(c) CONSULTATION.—In developing the plan under this section, the Secretary shall consult with experts in the fields of care for the chronically ill (including clinicians).

(d) IMPLEMENTATION.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall implement the plan developed under this section. The Secretary may contract with appropriate entities to implement such plan.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as may be necessary in fiscal years 2004 and 2005 to carry out this section.

Subtitle D—Other Provisions

SEC. 731. IMPROVEMENTS IN NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS TO RESPOND TO CHANGES IN TECHNOLOGY.

(a) NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS.—

(1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y), as amended by sections 948 and 950, is amended—

(A) in the third sentence of subsection (a), by inserting "consistent with subsection (l)" after "the Secretary shall ensure"; and

(B) by adding at the end the following new subsection:

"(l) National and Local Coverage Determination Process.—

"(1) Factors and evidence used in making national coverage determinations.—The Secretary shall make available to the public the factors considered in making national coverage determinations of whether an item or service is reasonable and necessary. The Secretary shall develop guidance documents to carry out this paragraph in a manner similar to the development of guidance documents under section 701(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 371(h)).

"(2) Timeframe for decisions on requests for national coverage determinations.—In the case of a request for a national coverage determination that—

"(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

"(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 9 months after the date of the request.

"(3) Process for public comment in national coverage determinations.—

"(A) Period for proposed decision.—Not later than the end of the 6-month period (or 9-month period for requests described in paragraph (2)(B)) that begins on the date a request for a national coverage determination is made, the Secretary shall make a draft of proposed decision on the request available to the public through the Internet website of the Centers for Medicare & Medicaid Services or other appropriate means.

"(B) 30-day period for public comment.—Beginning on the date the Secretary makes a draft of the proposed decision available under subparagraph (A), the Secretary shall provide a 30-day period for public comment on such draft.

"(C) 60-day period for final decision.—Not later than 60 days after the conclusion of the 30-day period referred to under subparagraph (B), the Secretary shall—

"(i) make a final decision on the request;

"(ii) include in such final decision summaries of the public comments received and responses to such comments;

"(iii) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and

"(iv) in the case of a final decision under clause (i) to grant the request for the national coverage determination, the Secretary shall assign a temporary or permanent code (whether existing or unclassified) and implement the coding change.

"(4) Consultation with outside experts in certain national coverage determinations.—With respect to a request for a national coverage determination for which there is not a review by the Medicare Coverage Advisory Committee, the Secretary shall consult with appropriate outside clinical experts.

"(5) Local coverage determination process.—

"(A) Plan to promote consistency of coverage determinations.—The Secretary shall develop a plan to evaluate new local coverage determinations to determine which determinations should be adopted nationally and to what extent greater consistency can be achieved among local coverage determinations.

"(B) Consultation.—The Secretary shall require the fiscal intermediaries or carriers providing services within the same area to consult on all new local coverage determinations within the area.

"(C) Dissemination of information.—The Secretary should serve as a center to disseminate information on local coverage determinations among fiscal intermediaries and carriers to reduce duplication of effort.

"(6) National and local coverage determination defined.—For purposes of this subsection—

"(A) National coverage determination.—The term 'national coverage determination' means a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under this title.

"(B) Local coverage determination.—The term 'local coverage determination' has the meaning given that in section 1869(f)(2)(B).".

(2) Effective date.—The amendments made by paragraph (1) shall apply to national coverage determinations as of January 1, 2004, and section 1862(l)(5) of the Social Security Act, as added by such paragraph, shall apply to local coverage determinations made on or after July 1, 2004.

(b) Medicare Coverage of Routine Costs Associated With Certain Clinical Trials of Category A Devices.—

(1) In general.—Section 1862 (42 U.S.C. 1395y), as amended by subsection (a), is amended by adding at the end the following new subsection:

"(m) Coverage of Routine Costs Associated With Certain Clinical Trials of Category A Devices.—

"(1) In general.—In the case of an individual entitled to benefits under part A, or enrolled under part B, or both who participates in a category A clinical trial, the Secretary shall not exclude under subsection (a)(1) payment for coverage of routine costs of care (as defined by the Secretary) furnished to such individual in the trial.

"(2) Category A clinical trial.—For purposes of paragraph (1), a 'category A clinical trial' means a trial of a medical device if—

"(A) the trial is of an experimental/investigational (category A) medical device (as defined in regulations under section 405.201(b) of title 42, Code of Federal Regulations (as in effect as of September 1, 2003));

"(B) the trial meets criteria established by the Secretary to ensure that the trial conforms to appropriate scientific and ethical standards; and

"(C) in the case of a trial initiated before January 1, 2010, the device involved in the trial has been determined by the Secretary to be intended for use in the diagnosis, monitoring, or treatment of an immediately life-threatening disease or condition.".

(2) Effective date.—The amendment made by paragraph (1) shall apply to routine costs incurred on and after January 1, 2005, and, as of such date, section 411.15(o) of title 42, Code of Federal Regulations, is superseded to the extent inconsistent with section 1862(m) of the Social Security Act, as added by such paragraph.

(3) Rule of construction.—Nothing in the amendment made by paragraph (1) shall be construed as applying to, or affecting, coverage or payment for a nonexperimental/investigational (category B) device.

(c) Issuance of Temporary National Codes.—Not later than July 1, 2004, the Secretary shall implement revised procedures for the issuance of temporary national HCPCS codes under part B of title XVIII of the Social Security Act.

SEC. 732. EXTENSION OF TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

Section 542(c) of BIPA (114 Stat. 2763A–551) is amended by inserting ", and for services furnished during 2005 and 2006" before the period at the end.

SEC. 733. PAYMENT FOR PANCREATIC ISLET CELL INVESTIGATIONAL TRANSPLANTS FOR MEDICARE BENEFICIARIES IN CLINICAL TRIALS.

(a) Clinical Trial.—

(1) In general.—The Secretary, acting through the National Institute of Diabetes and Digestive and Kidney Disorders, shall conduct a clinical investigation of pancreatic islet cell transplantation which includes medicare beneficiaries.

(2) Authorization of appropriations.—There are authorized to be appropriated to the Secretary such sums as may be necessary to conduct the clinical investigation under paragraph (1).

(b) Medicare Payment.—Not earlier than October 1, 2004, the Secretary shall pay for the routine costs as well as transplantation and appropriate related items and services (as described in subsection (c)) in the case of medicare beneficiaries who are participating in a clinical trial described in subsection (a) as if such transplantation were covered under title XVIII of such Act and as would be paid under part A or part B of such title for such beneficiary.

(c) Scope of Payment.—For purposes of subsection (b):

(1) The term "routine costs" means reasonable and necessary routine patient care costs (as defined in the Centers for Medicare & Medicaid Services Coverage Issues Manual, section 30–1), including immunosuppressive drugs and other followup care.

(2) The term "transplantation and appropriate related items and services" means items and services related to the acquisition and delivery of the pancreatic islet cell transplantation, notwithstanding any national noncoverage determination contained in the Centers for Medicare & Medicaid Services Coverage Issues Manual.

(3) The term "medicare beneficiary" means an individual who is entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both.

(d) Construction.—The provisions of this section shall not be construed—

(1) to permit payment for partial pancreatic tissue or islet cell transplantation under title XVIII of the Social Security Act other than payment as described in subsection (b); or

(2) as authorizing or requiring coverage or payment conveying—

(A) benefits under part A of such title to a beneficiary not entitled to such part A; or

(B) benefits under part B of such title to a beneficiary not enrolled in such part B.

SEC. 734. RESTORATION OF MEDICARE TRUST FUNDS.

(a) Definitions.—In this section:

(1) Clerical error.—The term "clerical error" means a failure that occurs on or after April 15, 2001, to have transferred the correct amount from the general fund of the Treasury to a Trust Fund.

(2) Trust fund.—The term "Trust Fund" means the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t).

(b) Correction of Trust Fund Holdings.—

(1) In general.—The Secretary of the Treasury shall take the actions described in paragraph (2) with respect to the Trust Fund with the goal being that, after such actions are taken, the holdings of the Trust Fund will replicate, to the extent practicable in the judgment of the Secretary of the Treasury, in consultation with the Secretary, the holdings that would have been held by the Trust Fund if the clerical error involved had not occurred.

(2) Obligations issued and redeemed.—The Secretary of the Treasury shall—

(A) issue to the Trust Fund obligations under chapter 31 of title 31, United States Code, that bear issue dates, interest rates, and maturity dates that are the same as those for the obligations that—

(i) would have been issued to the Trust Fund if the clerical error involved had not occurred; or

(ii) were issued to the Trust Fund and were redeemed by reason of the clerical error involved; and

(B) redeem from the Trust Fund obligations that would have been redeemed from the Trust Fund if the clerical error involved had not occurred.

(c) APPROPRIATION.—There is appropriated to the Trust Fund, out of any money in the Treasury not otherwise appropriated, an amount determined by the Secretary of the Treasury, in consultation with the Secretary, to be equal to the interest income lost by the Trust Fund through the date on which the appropriation is being made as a result of the clerical error involved.

(d) CONGRESSIONAL NOTICE.—In the case of a clerical error that occurs after April 15, 2001, the Secretary of the Treasury, before taking action to correct the error under this section, shall notify the appropriate committees of Congress concerning such error and the actions to be taken under this section in response to such error.

(e) DEADLINE.—With respect to the clerical error that occurred on April 15, 2001, not later than 120 days after the date of the enactment of this Act—

(1) the Secretary of the Treasury shall take the actions under subsection (b)(1); and

(2) the appropriation under subsection (c) shall be made.

SEC. 735. MODIFICATIONS TO MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) EXAMINATION OF BUDGET CONSEQUENCES.—Section 1805(b) (42 U.S.C. 1395b–6(b)) is amended by adding at the end the following new paragraph:

"(8) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.".

(b) CONSIDERATION OF EFFICIENT PROVISION OF SERVICES.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b–6(b)(2)(B)(i)) is amended by inserting "the efficient provision of" after "expenditures for".

(c) APPLICATION OF DISCLOSURE REQUIREMENTS.—

(1) IN GENERAL.—Section 1805(c)(2)(D) (42 U.S.C. 1395b–6(c)(2)(D)) is amended by adding at the end the following: "Members of the Commission shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 2004.

(d) ADDITIONAL REPORTS.—

(1) DATA NEEDS AND SOURCES.—The Medicare Payment Advisory Commission shall conduct a study, and submit a report to Congress by not later than June 1, 2004, on the need for current data, and sources of current data available, to determine the solvency and financial circumstances of hospitals and other medicare providers of services.

(2) USE OF TAX-RELATED RETURNS.—Using return information provided under Form 990 of the Internal Revenue Service, the Commission shall submit to Congress, by not later than June 1, 2004, a report on the following:

(A) Investments, endowments, and fundraising of hospitals participating under the medicare program and related foundations.

(B) Access to capital financing for private and for not-for-profit hospitals.

(e) REPRESENTATION OF EXPERTS IN PRESCRIPTION DRUGS.—

(1) IN GENERAL.—Section 1805(c)(2)(B) (42 U.S.C. 1395b–6(c)(2)(B)) is amended by inserting "experts in the area of pharmaco-economics or prescription drug benefit programs," after "other health professionals,".

(2) APPOINTMENT.—The Comptroller General of the United States shall ensure that the membership of the Commission complies with the amendment made by paragraph (1) with respect to appointments made on or after the date of the enactment of this Act.

SEC. 736. TECHNICAL AMENDMENTS.

(a) PART A.—(1) Section 1814(a) (42 U.S.C. 1395f(a)) is amended—

(A) by striking the seventh sentence, as added by section 322(a)(1) of BIPA (114 Stat. 2763A–501); and

(B) in paragraph (7)(A)—

(i) in clause (i), by inserting before the comma at the end the following: "based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness"; and

(ii) in clause (ii), by inserting before the semicolon at the end the following: "based on such clinical judgment".

(2) Section 1814(b) (42 U.S.C. 1395f(b)), in the matter preceding paragraph (1), is amended by inserting a comma after "1813".

(3) Section 1815(e)(1)(B) (42 U.S.C. 1395g(e)(1)(B)), in the matter preceding clause (i), is amended by striking "of hospital" and inserting "of a hospital".

(4) Section 1816(c)(2)(B)(ii) (42 U.S.C. 1395h(c)(2)(B)(ii)) is amended—

(A) by striking "and" at the end of subclause (III); and

(B) by striking the period at the end of subclause (IV) and inserting ", and".

(5) Section 1817(k)(3)(A) (42 U.S.C. 1395i(k)(3)(A)) is amended—

(A) in clause (i)(I), by striking the comma at the end and inserting a semicolon; and

(B) in clause (ii), by striking "the Medicare and medicaid programs" and inserting "the programs under this title and title XIX".

(6) Section 1817(k)(6)(B) (42 U.S.C. 1395i(k)(6)(B)) is amended by striking "Medicare program under title XVIII" and inserting "program under this title".

(7) Section 1818 (42 U.S.C. 1395i–2) is amended—

(A) in subsection (d)(6)(A) is amended by inserting "of such Code" after "3111(b)"; and

(B) in subsection (g)(2)(B) is amended by striking "subsection (b)." and inserting "subsection (b)".

(8) Section 1819 (42 U.S.C. 1395i–3) is amended—

(A) in subsection (b)(4)(C)(i), by striking "at least at least" and inserting "at least";

(B) in subsection (d)(1)(A), by striking "physical mental" and inserting "physical, mental"; and

(C) in subsection (f)(2)(B)(iii), by moving the last sentence 2 ems to the left.

(9) Section 1886(b)(3)(I)(i)(I) (42 U.S.C. 1395ww(b)(3)(I)(i)(I)) is amended by striking "the the" and inserting "the".

(10) The heading of subsection (mm) of section 1861 (42 U.S.C. 1395x) is amended to read as follows:

"Critical Access Hospital; Critical Access Hospital Services".

(11) Paragraphs (1) and (2) of section 1861(tt) (42 U.S.C. 1395x(tt)) are each amended by striking "rural primary care" and inserting "critical access".

(12) Section 1865(b)(3)(B) (42 U.S.C. 1395bb(b)(3)(B)) is amended by striking "section 1819 and 1861(j)" and inserting "sections 1819 and 1861(j)".

(13) Section 1866(b)(2) (42 U.S.C. 1395cc(b)(2)) is amended by moving subparagraph (D) 2 ems to the left.

(14) Section 1867 (42 U.S.C. 1395dd) is amended—

(A) in the matter following clause (ii) of subsection (d)(1)(B), by striking "is is" and inserting "is";

(B) in subsection (e)(1)(B), by striking "a pregnant women" and inserting "a pregnant woman"; and

(C) in subsection (e)(2), by striking "means hospital" and inserting "means a hospital".

(15) Section 1886(g)(3)(B) (42 U.S.C. 1395ww(g)(3)(B)) is amended by striking "(as defined in subsection (d)(5)(D)(iii)" and inserting "(as defined in subsection (d)(5)(D)(iii))".

(b) PART B.—(1) Section 1833(h)(5)(D) (42 U.S.C. 1395l(h)(5)(D)) is amended by striking "clinic,," and inserting "clinic,".

(2) Section 1833(t)(3)(C)(ii) (42 U.S.C. 1395l(t)(3)(C)(ii)) is amended by striking "clause (iii)" and inserting "clause (iv)".

(3) Section 1861(v)(1)(S)(ii)(III) (42 U.S.C. 1395x(v)(1)(S)(ii)(III)) is amended by striking "(as defined in section 1886(d)(5)(D)(iii)" and inserting "(as defined in section 1886(d)(5)(D)(iii))".

(4) Section 1834(b)(4)(D)(iv) (42 U.S.C. 1395m(b)(4)(D)(iv)) is amended by striking "clauses (vi)" and inserting "clause (vi)".

(5) Section 1834(m)(4)(C)(ii)(III) (42 U.S.C. 1395m(m)(4)(C)(ii)(III)) is amended by striking "1861(aa)(s)" and inserting "1861(aa)(2)".

(6) Section 1838(a)(1) (42 U.S.C. 1395q(a)(1)) is amended by inserting a comma after "1966".

(7) The second sentence of section 1839(a)(4) (42 U.S.C. 1395r(a)(4)) is amended by striking "which will" and inserting "will".

(8) Section 1842(c)(2)(B)(ii) (42 U.S.C. 1395u(c)(2)(B)(ii)) is amended—

(A) by striking "and" at the end of subclause (III); and

(B) by striking the period at the end of subclause (IV) and inserting ", and".

(9) Section 1842(i)(2) (42 U.S.C. 1395u(i)(2)) is amended by striking "services, a physician" and inserting "services, to a physician".

(10) Section 1848(i)(3)(A) (42 U.S.C. 1395w–4(i)(3)(A)) is amended by striking "a comparable services" and inserting "comparable services".

(11) Section 1861(s)(2)(K)(i) (42 U.S.C. 1395x(s)(2)(K)(i)) is amended by striking "; and but" and inserting ", but".

(12) Section 1861(aa)(1)(B) (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking ",," and inserting a comma.

(13) Section 128(b)(2) of BIPA (114 Stat. 2763A–480) is amended by striking "Not later that" and inserting "Not later than" each place it appears.

(c) PARTS A AND B.—(1) Section 1812(a)(3) (42 U.S.C. 1395d(a)(3)) is amended—

(A) by striking "for individuals not" and inserting "in the case of individuals not"; and

(B) by striking "for individuals so" and inserting "in the case of individuals so".

(2)(A) Section 1814(a) (42 U.S.C. 1395f(a)) is amended in the sixth sentence by striking "leave home," and inserting "leave home and".

(B) Section 1835(a) (42 U.S.C. 1395n(a)) is amended in the seventh sentence by striking "leave home," and inserting "leave home and".

(3) Section 1891(d)(1) (42 U.S.C. 1395bbb(d)(1)) is amended by striking "subsection (c)(2)(C)(I)" and inserting "subsection (c)(2)(C)(i)(I)".

(4) Section 1861(v) (42 U.S.C. 1395x(v)) is amended by moving paragraph (8) (including clauses (i) through (v) of such paragraph) 2 ems to the left.

(5) Section 1866B(b)(7)(D) (42 U.S.C. 1395cc–2(b)(7)(D)) is amended by striking "(c)(2)(A)(ii)" and inserting "(c)(2)(B)".

(6) Section 1886(h)(3)(D)(ii)(III) (42 U.S.C. 1395ww(h)(3)(D)(ii)(III)) is amended by striking "and" after the comma at the end.

(7) Section 1893(a) (42 U.S.C. 1395ddd(a)) is amended by striking "Medicare program" and inserting "medicare program".

(8) Section 1896(b)(4) (42 U.S.C. 1395ggg(b)(4)) is amended by striking "701(f)" and inserting "712(f)".

(d) PART C.—(1) Section 1853 (42 U.S.C. 1395w–23), as amended by section 607 of BIPA (114 Stat. 2763A–558), is amended—

(A) in subsection (a)(3)(C)(ii), by striking "clause (iii)" and inserting "clause (iv)";

(B) in subsection (a)(3)(C), by redesignating the clause (iii) added by such section 607 as clause (iv); and

(C) in subsection (c)(5), by striking "(a)(3)(C)(iii)" and inserting "(a)(3)(C)(iv)".

(2) Section 1876 (42 U.S.C. 1395mm) is amended—

(A) in subsection (c)(2)(B), by striking "signifcant" and inserting "significant"; and

(B) in subsection (j)(2), by striking "this setion" and inserting "this section".

(e) MEDIGAP.—Section 1882 (42 U.S.C. 1395ss) is amended—

(1) in subsection (d)(3)(A)(i)(II), by striking "plan a medicare supplemental policy" and inserting "plan, a medicare supplemental policy";

(2) in subsection (d)(3)(B)(iii)(II), by striking "to the best of the issuer or seller's knowledge" and inserting "to the best of the issuer's or seller's knowledge";

(3) in subsection (g)(2)(A), by striking "medicare supplement policies" and inserting "medicare supplemental policies";

(4) in subsection (p)(2)(B), by striking ", and" and inserting "; and"; and

(5) in subsection (s)(3)(A)(iii), by striking "pre-existing" and inserting "preexisting".

TITLE VIII—COST CONTAINMENT

Subtitle A—Cost Containment

SEC. 801. INCLUSION IN ANNUAL REPORT OF MEDICARE TRUSTEES OF INFORMATION ON STATUS OF MEDICARE TRUST FUNDS.

(a) DETERMINATIONS OF EXCESS GENERAL REVENUE MEDICARE FUNDING.—

(1) IN GENERAL.—The Board of Trustees of each medicare trust fund shall include in the annual reports submitted under subsection (b)(2) of sections 1817 and 1841 of the Social Security Act (42 U.S.C. 1395i and 1395t)—

(A) the information described in subsection (b); and

(B) a determination as to whether there is projected to be excess general revenue medicare funding (as defined in subsection (c)) for the fiscal year in which the report is submitted or for any of the succeeding 6 fiscal years.

(2) MEDICARE FUNDING WARNING.—For purposes of section 1105(h) of title 31, United States Code, and this subtitle, an affirmative determination under paragraph (1)(B) in 2 consecutive annual reports shall be treated as a medicare funding warning in the year in which the second such report is made.

(3) 7-FISCAL-YEAR REPORTING PERIOD.—For purposes of this subtitle, the term "7-fiscal-year reporting period" means, with respect to a year in which an annual report described in paragraph (1) is made, the period of 7 consecutive fiscal years beginning with the fiscal year in which the report is submitted.

(b) INFORMATION.—The information described in this subsection for an annual report in a year is as follows:

(1) PROJECTIONS OF GROWTH OF GENERAL REVENUE SPENDING.—A statement of the general revenue medicare funding as a percentage of the total medicare outlays for each of the following:

(A) Each fiscal year within the 7-fiscal-year reporting period.

(B) Previous fiscal years and as of 10, 50, and 75 years after such year.

(2) COMPARISON WITH OTHER GROWTH TRENDS.—A comparison of the trend of such percentages with the annual growth rate in the following:

(A) The gross domestic product.

(B) Private health costs.

(C) National health expenditures.

(D) Other appropriate measures.

(3) PART D SPENDING.—Expenditures, including trends in expenditures, under part D of title XVIII of the Social Security Act, as added by section 101.

(4) COMBINED MEDICARE TRUST FUND ANALYSIS.—A financial analysis of the combined medicare trust funds if general revenue medicare funding were limited to the percentage specified in subsection (c)(1)(B) of total medicare outlays.

(c) DEFINITIONS.—For purposes of this section:

(1) EXCESS GENERAL REVENUE MEDICARE FUNDING.—The term "excess general revenue medicare funding" means, with respect to a fiscal year, that—

(A) general revenue medicare funding (as defined in paragraph (2)), expressed as a percentage of total medicare outlays (as defined in paragraph (4)) for the fiscal year; exceeds

(B) 45 percent.

(2) GENERAL REVENUE MEDICARE FUNDING.—The term "general revenue medicare funding" means for a year—

(A) the total medicare outlays (as defined in paragraph (4)) for the year; minus

(B) the dedicated medicare financing sources (as defined in paragraph (3)) for the year.

(3) DEDICATED MEDICARE FINANCING SOURCES.—The term "dedicated medicare financing sources" means the following:

(A) HOSPITAL INSURANCE TAX.—Amounts appropriated to the Hospital Insurance Trust Fund under the third sentence of section 1817(a) of the Social Security Act (42 U.S.C. 1395i(a)) and amounts transferred to such Trust Fund under section 7(c)(2) of the Railroad Retirement Act of 1974 (45 U.S.C. 231f(c)(2)).

(B) TAXATION OF CERTAIN OASDI BENEFITS.—Amounts appropriated to the Hospital Insurance Trust Fund under section 121(e)(1)(B) of the Social Security Amendments of 1983 (Public Law 98–21), as inserted by section 13215(c) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66).

(C) STATE TRANSFERS.—The State share of amounts paid to the Federal Government by a State under section 1843 of the Social Security Act (42 U.S.C. 1395v) or pursuant to section 1935(c) of such Act.

(D) PREMIUMS.—The following premiums:

(i) PART A.—Premiums paid by non-Federal sources under sections 1818 and section 1818A (42 U.S.C. 1395i–2 and 1395i–2a) of such Act.

(ii) PART B.—Premiums paid by non-Federal sources under section 1839 of such Act (42 U.S.C. 1395r), including any adjustments in premiums under such section.

(iii) PART D.—Monthly beneficiary premiums paid under part D of title XVIII of such Act, as added by section 101, and MA monthly prescription drug beneficiary premiums paid under part C of such title insofar as they are attributable to basic prescription drug coverage.

Premiums under clauses (ii) and (iii) shall be determined without regard to any reduction in such premiums attributable to a beneficiary rebate under section 1854(b)(1)(C) of such title, as amended by section 222(b)(1), and premiums under clause (iii) are deemed to include any amounts paid under section 1860D–13(b) of such title, as added by section 101.

(E) GIFTS.—Amounts received by the medicare trust funds under section 201(i) of the Social Security Act (42 U.S.C. 401(i)).

(4) TOTAL MEDICARE OUTLAYS.—The term "total medicare outlays" means total outlays from the medicare trust funds and shall—

(A) include payments made to plans under part C of title XVIII of the Social Security Act that are attributable to any rebates under section 1854(b)(1)(C) of such Act (42 U.S.C. 1395w–24(b)(1)(C)), as amended by section 222(b)(1);

(B) include administrative expenditures made in carrying out title XVIII of such Act and Federal outlays under section 1935(b) of such Act, as added by section 103(a)(2); and

(C) offset outlays by the amount of fraud and abuse collections insofar as they are applied or deposited into a medicare trust fund.

(5) MEDICARE TRUST FUND.—The term "medicare trust fund" means—

(A) the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i); and

(B) the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), including the Medicare Prescription Drug Account under such Trust Fund.

(d) CONFORMING AMENDMENTS.—

(1) FEDERAL HOSPITAL INSURANCE TRUST FUND.—Section 1817(b)(2) (42 U.S.C. 1395i(b)(2)) is amended by adding at the end the following: "Each report provided under paragraph (2) beginning with the report in 2005 shall include the information specified in section 801(a) of Medicare Prescription Drug, Improvement, and Modernization Act of 2003.".

(2) FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841(b)(2) (42 U.S.C. 1395t(b)(2)) is amended by adding at the end the following: "Each report provided under paragraph (2) beginning with the report in 2005 shall include the information specified in section 801(a) of Medicare Prescription Drug, Improvement, and Modernization Act of 2003.".

(e) NOTICE OF MEDICARE FUNDING WARNING.—Whenever any report described in subsection (a) contains a determination that for any fiscal year within the 7-fiscal-year reporting period there will be excess general revenue medicare funding, Congress and the President should address the matter under existing rules and procedures.

SEC. 802. PRESIDENTIAL SUBMISSION OF LEGISLATION.

(a) IN GENERAL.—Section 1105 of title 31, United States Code, is amended by adding at the end the following new subsection:

"(h)(1) If there is a medicare funding warning under section 801(a)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 made in a year, the President shall submit to Congress, within the 15-day period beginning on the date of the budget submission to Congress under subsection (a) for the succeeding year, proposed legislation to respond to such warning.

"(2) Paragraph (1) does not apply if, during the year in which the warning is made, legislation is enacted which eliminates excess general revenue medicare funding (as defined in section 801(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) for the 7-fiscal-year reporting period, as certified by the Board of Trustees of each medicare trust fund (as defined in section 801(c)(5) of such Act) not later than 30 days after the date of the enactment of such legislation.".

(b) SENSE OF CONGRESS.—It is the sense of Congress that legislation submitted pursuant to section 1105(h) of title 31, United States Code, in a year should be designed to eliminate excess general revenue medicare funding (as defined in section 801(c)) for the 7-fiscal-year period that begins in such year.

SEC. 803. PROCEDURES IN THE HOUSE OF REPRESENTATIVES.

(a) INTRODUCTION AND REFERRAL OF PRESIDENT'S LEGISLATIVE PROPOSAL.—

(1) INTRODUCTION.—In the case of a legislative proposal submitted by the President pursuant to

section 1105(h) of title 31, United States Code, within the 15-day period specified in paragraph (1) of such section, the Majority Leader of the House of Representatives (or his designee) and the Minority Leader of the House of Representatives (or his designee) shall introduce such proposal (by request), the title of which is as follows: "A bill to respond to a medicare funding warning." Such bill shall be introduced within 3 legislative days after Congress receives such proposal.

(2) REFERRAL.—Any legislation introduced pursuant to paragraph (1) shall be referred to the appropriate committees of the House of Representatives.

(b) DIRECTION TO THE APPROPRIATE HOUSE COMMITTEES.—

(1) IN GENERAL.—In the House, in any year during which the President is required to submit proposed legislation to Congress under section 1105(h) of title 31, United States Code, the appropriate committees shall report medicare funding legislation by not later than June 30 of such year.

(2) MEDICARE FUNDING LEGISLATION.—For purposes of this section, the term "medicare funding legislation" means—

(A) legislation introduced pursuant to subsection (a)(1), but only if the legislative proposal upon which the legislation is based was submitted within the 15-day period referred to in such subsection; or

(B) any bill the title of which is as follows: "A bill to respond to a medicare funding warning.".

(3) CERTIFICATION.—With respect to any medicare funding legislation or any amendment to such legislation to respond to a medicare funding warning, the chairman of the Committee on the Budget of the House shall certify—

(A) whether or not such legislation eliminates excess general revenue medicare funding (as defined in section 801(c)) for each fiscal year in the 7-fiscal-year reporting period; and

(B) with respect to such an amendment, whether the legislation, as amended, would eliminate excess general revenue medicare funding (as defined in section 801(c)) for each fiscal year in such 7-fiscal-year reporting period.

(c) FALLBACK PROCEDURE FOR FLOOR CONSIDERATION IF THE HOUSE FAILS TO VOTE ON FINAL PASSAGE BY JULY 30.—

(1) After July 30 of any year during which the President is required to submit proposed legislation to Congress under section 1105(h) of title 31, United States Code, unless the House of Representatives has voted on final passage of any medicare funding legislation for which there is an affirmative certification under subsection (b)(3)(A), then, after the expiration of not less than 30 calendar days (and concurrently 5 legislative days), it is in order to move to discharge any committee to which medicare funding legislation which has such a certification and which has been referred to such committee for 30 calendar days from further consideration of the legislation.

(2) A motion to discharge may be made only by an individual favoring the legislation, may be made only if supported by one-fifth of the total membership of the House (a quorum being present), and is highly privileged in the House. Debate thereon shall be limited to not more than one hour, the time to be divided in the House equally between those favoring and those opposing the motion. An amendment to the motion is not in order, and it is not in order to move to reconsider the vote by which the motion is agreed to or disagreed to.

(3) Only one motion to discharge a particular committee may be adopted under this subsection in any session of a Congress.

(4) Notwithstanding paragraph (1), it shall not be in order to move to discharge a committee from further consideration of medicare funding legislation pursuant to this subsection during a session of a Congress if, during the previous session of the Congress, the House passed medicare funding legislation for which there is an affirmative certification under subsection (b)(3)(A).

(d) FLOOR CONSIDERATION IN THE HOUSE OF DISCHARGED LEGISLATION.—

(1) In the House, not later than 3 legislative days after any committee has been discharged from further consideration of legislation under subsection (c), the Speaker shall resolve the House into the Committee of the Whole for consideration of the legislation.

(2) The first reading of the legislation shall be dispensed with. All points of order against consideration of the legislation are waived. General debate shall be confined to the legislation and shall not exceed five hours, which shall be divided equally between those favoring and those opposing the legislation. After general debate the legislation shall be considered for amendment under the five-minute rule. During consideration of the legislation, no amendments shall be in order in the House or in the Committee of the Whole except those for which there has been an affirmative certification under subsection (b)(3)(B). All points of order against consideration of any such amendment in the Committee of the Whole are waived. The legislation, together with any amendments which shall be in order, shall be considered as read. During the consideration of the bill for amendment, the Chairman of the Committee of the Whole may accord priority in recognition on the basis of whether the Member offering an amendment has caused it to be printed in the portion of the Congressional Record designated for that purpose in clause 8 of Rule XVIII of the Rules of the House of Representatives. Debate on any amendment shall not exceed one hour, which shall be divided equally between those favoring and those opposing the amendment, and no pro forma amendments shall be offered during the debate. The total time for debate on all amendments shall not exceed 10 hours. At the conclusion of consideration of the legislation for amendment, the Committee shall rise and report the legislation to the House with such amendments as may have been adopted. The previous question shall be considered as ordered on the legislation and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions. If the Committee of the Whole rises and reports that it has come to no resolution on the bill, then on the next legislative day the House shall, immediately after the third daily order of business under clause 1 of Rule XIV of the Rules of the House of Representatives, resolve into the Committee of the Whole for further consideration of the bill.

(3) All appeals from the decisions of the Chair relating to the application of the Rules of the House of Representatives to the procedure relating to any such legislation shall be decided without debate.

(4) Except to the extent specifically provided in the preceding provisions of this subsection, consideration of any such legislation and amendments thereto (or any conference report thereon) shall be governed by the Rules of the House of Representatives applicable to other bills and resolutions, amendments, and conference reports in similar circumstances.

(e) LEGISLATIVE DAY DEFINED.—As used in this section, the term "legislative day" means a day on which the House of Representatives is in session.

(f) RESTRICTION ON WAIVER.—In the House, the provisions of this section may be waived only by a rule or order proposing only to waive such provisions.

(g) RULEMAKING POWER.—The provisions of this section are enacted by the Congress—

(1) as an exercise of the rulemaking power of the House of Representatives and, as such, shall be considered as part of the rules of that House and shall supersede other rules only to the extent that they are inconsistent therewith; and

(2) with full recognition of the constitutional right of that House to change the rules (so far as they relate to the procedures of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

SEC. 804. PROCEDURES IN THE SENATE.

(a) INTRODUCTION AND REFERRAL OF PRESIDENT'S LEGISLATIVE PROPOSAL.—

(1) INTRODUCTION.—In the case of a legislative proposal submitted by the President pursuant to section 1105(h) of title 31, United States Code, within the 15-day period specified in paragraph (1) of such section, the Majority Leader and Minority Leader of the Senate (or their designees) shall introduce such proposal (by request), the title of which is as follows: "A bill to respond to a medicare funding warning." Such bill shall be introduced within 3 days of session after Congress receives such proposal.

(2) REFERRAL.—Any legislation introduced pursuant to paragraph (1) shall be referred to the Committee on Finance.

(b) MEDICARE FUNDING LEGISLATION.—For purposes of this section, the term "medicare funding legislation" means—

(1) legislation introduced pursuant to subsection (a)(1), but only if the legislative proposal upon which the legislation is based was submitted within the 15-day period referred to in such subsection; or

(2) any bill the title of which is as follows: "A bill to respond to a medicare funding warning.".

(c) QUALIFICATION FOR SPECIAL PROCEDURES.—

(1) IN GENERAL.—The special procedures set forth in subsections (d) and (e) shall apply to medicare funding legislation, as described in subsection (b), only if the legislation—

(A) is medicare funding legislation that is passed by the House of Representatives; or

(B) contains matter within the jurisdiction of the Committee on Finance in the Senate.

(2) FAILURE TO QUALIFY FOR SPECIAL PROCEDURES.—If the medicare funding legislation does not satisfy paragraph (1), then the legislation shall be considered under the ordinary procedures of the Standing Rules of the Senate.

(d) DISCHARGE.—

(1) IN GENERAL.—If the Committee on Finance has not reported medicare funding legislation described in subsection (c)(1) by June 30 of a year in which the President is required to submit medicare funding legislation to Congress under section 1105(h) of title 31, United States Code, then any Senator may move to discharge the Committee of any single medicare funding legislation measure. Only one such motion shall be in order in any session of Congress.

(2) DEBATE LIMITS.—Debate in the Senate on any such motion to discharge, and all appeals in connection therewith, shall be limited to not more than 2 hours. The time shall be equally divided between, and controlled by, the maker of the motion and the Majority Leader, or their designees, except that in the event the Majority Leader is in favor of such motion, the time in opposition thereto shall be controlled by the Minority Leader or the Minority Leader's designee. A point of order under this subsection may be made at any time. It is not in order to move to proceed to another measure or matter while such motion (or the motion to reconsider such motion) is pending.

(3) AMENDMENTS.—No amendment to the motion to discharge shall be in order.

(4) EXCEPTION IF CERTIFIED LEGISLATION ENACTED.—Notwithstanding paragraph (1), it shall not be in order to discharge the Committee from further consideration of medicare funding legislation pursuant to this subsection during a session of a Congress if the chairman of the Committee on the Budget of the Senate certifies that

medicare funding legislation has been enacted that eliminates excess general revenue medicare funding (as defined in section 801(c)) for each fiscal year in the 7-fiscal-year reporting period.

(e) CONSIDERATION.—After the date on which the Committee on Finance has reported medicare funding legislation described in subsection (c)(1), or has been discharged (under subsection (d)) from further consideration of, such legislation, it is in order (even though a previous motion to the same effect has been disagreed to) for any Member of the Senate to move to proceed to the consideration of such legislation.

(f) RULES OF THE SENATE.—This section is enacted by the Senate—

(1) as an exercise of the rulemaking power of the Senate and as such it is deemed a part of the rules of the Senate, but applicable only with respect to the procedure to be followed in the Senate in the case of a bill described in this paragraph, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(2) with full recognition of the constitutional right of the Senate to change the rules (so far as relating to the procedure of the Senate) at any time, in the same manner, and to the same extent as in the case of any other rule of the Senate.

Subtitle B—Income-Related Reduction in Part B Premium Subsidy

SEC. 811. INCOME-RELATED REDUCTION IN PART B PREMIUM SUBSIDY.

(a) IN GENERAL.—Section 1839 (42 U.S.C. 1395r), as amended by section 241(c), is amended by adding at the end the following:

"(i) REDUCTION IN PREMIUM SUBSIDY BASED ON INCOME.—

"(1) IN GENERAL.—In the case of an individual whose modified adjusted gross income exceeds the threshold amount under paragraph (2), the monthly amount of the premium subsidy applicable to the premium under this section for a month after December 2006 shall be reduced (and the monthly premium shall be increased) by the monthly adjustment amount specified in paragraph (3).

"(2) THRESHOLD AMOUNT.—For purposes of this subsection, the threshold amount is—

"(A) except as provided in subparagraph (B), $80,000, and

"(B) in the case of a joint return, twice the amount applicable under subparagraph (A) for the calendar year.

"(3) MONTHLY ADJUSTMENT AMOUNT.—

"(A) IN GENERAL.—Subject to subparagraph (B), the monthly adjustment amount specified in this paragraph for an individual for a month in a year is equal to the product of the following:

"(i) SLIDING SCALE PERCENTAGE.—The applicable percentage specified in the table in subparagraph (C) for the individual minus 25 percentage points.

"(ii) UNSUBSIDIZED PART B PREMIUM AMOUNT.—200 percent of the monthly actuarial rate for enrollees age 65 and over (as determined under subsection (a)(1) for the year).

"(B) 5-YEAR PHASE IN.—The monthly adjustment amount specified in this paragraph for an individual for a month in a year before 2011 is equal to the following percentage of the monthly adjustment amount specified in subparagraph (A):

"(i) For 2007, 20 percent.

"(ii) For 2008, 40 percent.

"(iii) For 2009, 60 percent.

"(iv) for 2010, 80 percent.

"(C) APPLICABLE PERCENTAGE.—

"(i) IN GENERAL.—

"If the modified adjusted gross income is:	***The applicable percentage is:***
More than $80,000 but not more than $100,000.	*35 percent*
More than $100,000 but not more than $150,000.	*50 percent*
More than $150,000 but not more than $200,000.	*65 percent*
More than $200,000	*80 percent.*

"(ii) JOINT RETURNS.—In the case of a joint return, clause (i) shall be applied by substituting dollar amounts which are twice the dollar amounts otherwise applicable under clause (i) for the calendar year.

"(iii) MARRIED INDIVIDUALS FILING SEPARATE RETURNS.—In the case of an individual who—

"(I) is married as of the close of the taxable year (within the meaning of section 7703 of the Internal Revenue Code of 1986) but does not file a joint return for such year, and

"(II) does not live apart from such individual's spouse at all times during the taxable year,

clause (i) shall be applied by reducing each of the dollar amounts otherwise applicable under such clause for the calendar year by the threshold amount for such year applicable to an unmarried individual.

"(4) MODIFIED ADJUSTED GROSS INCOME.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'modified adjusted gross income' means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

"(i) determined without regard to sections 135, 911, 931, and 933 of such Code; and

"(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax under such Code.

In the case of an individual filing a joint return, any reference in this subsection to the modified adjusted gross income of such individual shall be to such return's modified adjusted gross income.

"(B) TAXABLE YEAR TO BE USED IN DETERMINING MODIFIED ADJUSTED GROSS INCOME.—

"(i) IN GENERAL.—In applying this subsection for an individual's premiums in a month in a year, subject to clause (ii) and subparagraph (C), the individual's modified adjusted gross income shall be such income determined for the individual's last taxable year beginning in the second calendar year preceding the year involved.

"(ii) TEMPORARY USE OF OTHER DATA.—If, as of October 15 before a calendar year, the Secretary of the Treasury does not have adequate data for an individual in appropriate electronic form for the taxable year referred to in clause (i), the individual's modified adjusted gross income shall be determined using the data in such form from the previous taxable year. Except as provided in regulations prescribed by the Commissioner of Social Security in consultation with the Secretary, the preceding sentence shall cease to apply when adequate data in appropriate electronic form are available for the individual for the taxable year referred to in clause (i), and proper adjustments shall be made to the extent that the premium adjustments determined under the preceding sentence were inconsistent with those determined using such taxable year.

"(iii) NON-FILERS.—In the case of individuals with respect to whom the Secretary of the Treasury does not have adequate data in appropriate electronic form for either taxable year referred to in clause (i) or clause (ii), the Commissioner of Social Security, in consultation with the Secretary, shall prescribe regulations which provide for the treatment of the premium adjustment with respect to such individual under this subsection, including regulations which provide for—

"(I) the application of the highest applicable percentage under paragraph (3)(C) to such individual if the Commissioner has information which indicates that such individual's modified adjusted gross income might exceed the threshold amount for the taxable year referred to in clause (i), and

"(II) proper adjustments in the case of the application of an applicable percentage under subclause (I) to such individual which is inconsistent with such individual's modified adjusted gross income for such taxable year.

"(C) USE OF MORE RECENT TAXABLE YEAR.—

"(i) IN GENERAL.—The Commissioner of Social Security in consultation with the Secretary of the Treasury shall establish a procedures under which an individual's modified adjusted gross income shall, at the request of such individual, be determined under this subsection—

"(I) for a more recent taxable year than the taxable year otherwise used under subparagraph (B), or

"(II) by such methodology as the Commissioner, in consultation with such Secretary, determines to be appropriate, which may include a methodology for aggregating or disaggregating information from tax returns in the case of marriage or divorce.

"(ii) STANDARD FOR GRANTING REQUESTS.—A request under clause (i)(I) to use a more recent taxable year may be granted only if—

"(I) the individual furnishes to such Commissioner with respect to such year such documentation, such as a copy of a filed Federal income tax return or an equivalent document, as the Commissioner specifies for purposes of determining the premium adjustment (if any) under this subsection; and

"(II) the individual's modified adjusted gross income for such year is significantly less than such income for the taxable year determined under subparagraph (B) by reason of the death of such individual's spouse, the marriage or divorce of such individual, or other major life changing events specified in regulations prescribed by the Commissioner in consultation with the Secretary.

"(5) INFLATION ADJUSTMENT.—

"(A) IN GENERAL.—In the case of any calendar year beginning after 2007, each dollar amount in paragraph (2) or (3) shall be increased by an amount equal to—

"(i) such dollar amount, multiplied by

"(ii) the percentage (if any) by which the average of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with August of the preceding calendar year exceeds such average for the 12-month period ending with August 2006.

"(B) ROUNDING.—If any dollar amount after being increased under subparagraph (A) is not a multiple of $1,000, such dollar amount shall be rounded to the nearest multiple of $1,000.

"(6) JOINT RETURN DEFINED.—For purposes of this subsection, the term 'joint return' has the meaning given to such term by section 7701(a)(38) of the Internal Revenue Code of 1986.".

(b) CONFORMING AMENDMENTS.—

(1) Section 1839 (42 U.S.C. 1395r) is amended—

(A) in subsection (a)(2), by striking "and (f)" and inserting "(f), and (i)";

(B) in subsection (b), inserting "(without regard to any adjustment under subsection (i))" after "subsection (a)"; and

(C) in subsection (f)—

(i) by striking "and if" and inserting "if"; and

(ii) by inserting "and if the amount of the individual's premium is not adjusted for such January under subsection (i)," after "section 1840(b)(1),".

(2) Section 1844 (42 U.S.C. 1395w) is amended—

(A) in subsection (a)(1)—

(i) in subparagraph (B), by striking "plus" at the end and inserting "minus"; and

(ii) by adding at the end the following new subparagraph:

"(C) the aggregate amount of additional premium payments attributable to the application of section 1839(i); plus"; and

(B) in subsection (c), by inserting before the period at the end the following: "and without regard to any premium adjustment under section 1839(i)".

(c) REPORTING REQUIREMENTS FOR SECRETARY OF THE TREASURY.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to disclosure of returns and return information for purposes other than tax administration), as amended by section 105(e), is amended by adding at the end the following new paragraph:

"(20) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT MEDICARE PART B PREMIUM SUBSIDY ADJUSTMENT.—

"(A) IN GENERAL.—The Secretary shall, upon written request from the Commissioner of Social Security, disclose to officers, employees, and contractors of the Social Security Administration return information of a taxpayer whose premium (according to the records of the Secretary) may be subject to adjustment under section 1839(i) of the Social Security Act. Such return information shall be limited to—

"(i) taxpayer identity information with respect to such taxpayer,

"(ii) the filing status of such taxpayer,

"(iii) the adjusted gross income of such taxpayer,

"(iv) the amounts excluded from such taxpayer's gross income under sections 135 and 911 to the extent such information is available,

"(v) the interest received or accrued during the taxable year which is exempt from the tax imposed by chapter 1 to the extent such information is available,

"(vi) the amounts excluded from such taxpayer's gross income by sections 931 and 933 to the extent such information is available,

"(vii) such other information relating to the liability of the taxpayer as is prescribed by the Secretary by regulation as might indicate in the case of a taxpayer who is an individual described in subsection (i)(4)(B)(iii) of section 1839 of the Social Security Act that the amount of the premium of the taxpayer under such section may be subject to adjustment under subsection (i) of such section and the amount of such adjustment, and

"(viii) the taxable year with respect to which the preceding information relates.

"(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers, employees, and contractors of the Social Security Administration only for the purposes of, and to the extent necessary in, establishing the appropriate amount of any premium adjustment under such section 1839(i)."

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (3) of section 6103(a) of such Code, as amended by section 105(e)(1), is amended by striking "or (19)" and inserting "(19), or (20)".

(B) Paragraph (4) of section 6103(p) of such Code, as amended by section 105(e)(3), is amended by striking "(l)(16), (17), or (19)" each place it appears and inserting "(l)(16), (17), (19), or (20)".

(C) Paragraph (2) of section 7213(a) of such Code, as amended by section 105(e)(4), is amended by striking "or (19)" and inserting "(19), or (20)".

TITLE IX—ADMINISTRATIVE IMPROVEMENTS, REGULATORY REDUCTION, AND CONTRACTING REFORM

SEC. 900. ADMINISTRATIVE IMPROVEMENTS WITHIN THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS).

(a) COORDINATED ADMINISTRATION OF MEDICARE PRESCRIPTION DRUG AND MEDICARE ADVANTAGE PROGRAMS.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 721, is amended by inserting after 1807 the following new section:

"PROVISIONS RELATING TO ADMINISTRATION

"SEC. 1808. (a) COORDINATED ADMINISTRATION OF MEDICARE PRESCRIPTION DRUG AND MEDICARE ADVANTAGE PROGRAMS.—

"(1) IN GENERAL.—There is within the Centers for Medicare & Medicaid Services a center to carry out the duties described in paragraph (3).

"(2) DIRECTOR.—Such center shall be headed by a director who shall report directly to the Administrator of the Centers for Medicare & Medicaid Services.

"(3) DUTIES.—The duties described in this paragraph are the following:

"(A) The administration of parts C and D.

"(B) The provision of notice and information under section 1804.

"(C) Such other duties as the Secretary may specify.

"(4) DEADLINE.—The Secretary shall ensure that the center is carrying out the duties described in paragraph (3) by not later than January 1, 2008.".

(b) MANAGEMENT STAFF FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—Such section is further amended by adding at the end the following new subsection:

"(b) EMPLOYMENT OF MANAGEMENT STAFF.—

"(1) IN GENERAL.—The Secretary may employ, within the Centers for Medicare & Medicaid Services, such individuals as management staff as the Secretary determines to be appropriate. With respect to the administration of parts C and D, such individuals shall include individuals with private sector expertise in negotiations with health benefits plans.

"(2) ELIGIBILITY.—To be eligible for employment under paragraph (1) an individual shall be required to have demonstrated, by their education and experience (either in the public or private sector), superior expertise in at least one of the following areas:

"(A) The review, negotiation, and administration of health care contracts.

"(B) The design of health care benefit plans.

"(C) Actuarial sciences.

"(D) Compliance with health plan contracts.

"(E) Consumer education and decision making.

"(F) Any other area specified by the Secretary that requires specialized management or other expertise.

"(3) RATES OF PAYMENT.—

"(A) PERFORMANCE-RELATED PAY.—Subject to subparagraph (B), the Secretary shall establish the rate of pay for an individual employed under paragraph (1). Such rate shall take into account expertise, experience, and performance.

"(B) LIMITATION.—In no case may the rate of compensation determined under subparagraph (A) exceed the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.".

(c) REQUIREMENT FOR DEDICATED ACTUARY FOR PRIVATE HEALTH PLANS.—Section 1117(b) (42 U.S.C. 1317(b)) is amended by adding at the end the following new paragraph:

"(3) In the office of the Chief Actuary there shall be an actuary whose duties relate exclusively to the programs under parts C and D of title XVIII and related provisions of such title.".

(d) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR THE ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) IN GENERAL.—Section 5314 of title 5, United States Code, is amended by adding at the end the following:

"Administrator of the Centers for Medicare & Medicaid Services.".

(2) CONFORMING AMENDMENT.—Section 5315 of such title is amended by striking "Administrator of the Health Care Financing Administration.".

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect on January 1, 2004.

(e) CONFORMING AMENDMENTS RELATING TO HEALTH CARE FINANCING ADMINISTRATION.—

(1) AMENDMENTS TO THE SOCIAL SECURITY ACT.—The Social Security Act is amended—

(A) in section 1117 (42 U.S.C. 1317)—

(i) in the heading to read as follows:

"APPOINTMENT OF THE ADMINISTRATOR AND CHIEF ACTUARY OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES";

(ii) in subsection (a), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services"; and

(iii) in subsection (b)(1)—

(I) by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services"; and

(II) by striking "Administration" and inserting "Centers";

(B) in section 1140(a) (42 U.S.C. 1320b–10(a))—

(i) in paragraph (1), by striking "Health Care Financing Administration" both places it appears in the matter following subparagraph (B) and inserting "Centers for Medicare & Medicaid Services";

(ii) in paragraph (1)(A)—

(I) by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services"; and

(II) by striking "HCFA" and inserting "CMS"; and

(iii) in paragraph (1)(B), by striking "Health Care Financing Administration" both places it appears and inserting "Centers for Medicare & Medicaid Services";

(C) in section 1142(b)(3) (42 U.S.C. 1320b–12(b)(3)), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services";

(D) in section 1817(b) (42 U.S.C. 1395i(b))—

(i) by striking "Health Care Financing Administration", both in the fifth sentence of the matter preceding paragraph (1) and in the second sentence of the matter following paragraph (4), and inserting "Centers for Medicare & Medicaid Services"; and

(ii) by striking "Chief Actuarial Officer" in the second sentence of the matter following paragraph (4) and inserting "Chief Actuary";

(E) in section 1841(b) (42 U.S.C. 1395t(b))—

(i) by striking "Health Care Financing Administration", both in the fifth sentence of the matter preceding paragraph (1) and in the second sentence of the matter following paragraph (4), and inserting "Centers for Medicare & Medicaid Services"; and

(ii) by striking "Chief Actuarial Officer" in the second sentence of the matter following paragraph (4) and inserting "Chief Actuary";

(F) in section 1852(a)(5) (42 U.S.C. 1395w–22(a)(5)), by striking "Health Care Financing Administration" in the matter following subparagraph (B) and inserting "Centers for Medicare & Medicaid Services";

(G) in section 1853 (42 U.S.C. 1395w–23)—

(i) in subsection (b)(4), by striking "Health Care Financing Administration" in the first sentence and inserting "Centers for Medicare & Medicaid Services"; and

(ii) in subsection (c)(7), by striking "Health Care Financing Administration" in the last sentence and inserting "Centers for Medicare & Medicaid Services";

(H) in section 1854(a)(5)(A) (42 U.S.C. 1395w–24(a)(5)(A)), by striking "Health Care Financing Administration"and inserting "Centers for Medicare & Medicaid Services";

(I) in section 1857(d)(4)(A)(ii) (42 U.S.C. 1395w–27(d)(4)(A)(ii)), by striking "Health Care Financing Administration" and inserting "Secretary";

(J) in section 1862(b)(5)(A)(ii) (42 U.S.C. 1395y(b)(5)(A)(ii)), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services";

(K) in section 1927(e)(4) (42 U.S.C. 1396r–8(e)(4)), by striking "HCFA" and inserting "The Secretary";

(L) in section 1927(f)(2) (42 U.S.C. 1396r–8(f)(2)), by striking "HCFA" and inserting "The Secretary"; and

(M) in section 2104(g)(3) (42 U.S.C. 1397dd(g)(3)) by inserting "or CMS Form 64 or CMS Form 21, as the case may be," after "HCFA Form 64 or HCFA Form 21".

(2) AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.—The Public Health Service Act is amended—

(A) in section 501(d)(18) (42 U.S.C. 290aa(d)(18)), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services";

(B) in section 507(b)(6) (42 U.S.C. 290bb(b)(6)), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services";

(C) in section 916 (42 U.S.C. 299b–5)—

(i) in subsection (b)(2), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services"; and

(ii) in subsection (c)(2), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services";

(D) in section 921(c)(3)(A) (42 U.S.C. 299c(c)(3)(A)), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services";

(E) in section 1318(a)(2) (42 U.S.C. 300e–17(a)(2)), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services";

(F) in section 2102(a)(7) (42 U.S.C. 300aa–2(a)(7)), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services"; and

(G) in section 2675(a) (42 U.S.C. 300ff–75(a)), by striking "Health Care Financing Administration" in the first sentence and inserting "Centers for Medicare & Medicaid Services".

(3) AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.—Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended—

(A) in subparagraph (B), by striking "Health Care Financing Administration" in the matter preceding clause (i) and inserting "Centers for Medicare & Medicaid Services"; and

(B) in subparagraph (C)—

(i) by striking "HEALTH CARE FINANCING ADMINISTRATION" in the heading and inserting "CENTERS FOR MEDICARE & MEDICAID SERVICES"; and

(ii) by striking "Health Care Financing Administration" in the matter preceding clause (i) and inserting "Centers for Medicare & Medicaid Services".

(4) AMENDMENTS TO TITLE 10, UNITED STATES CODE.—Title 10, United States Code, is amended—

(A) in section 1086(d)(4), by striking "administrator of the Health Care Financing Administration" in the last sentence and inserting "Administrator of the Centers for Medicare & Medicaid Services"; and

(B) in section 1095(k)(2), by striking "Health Care Financing Administration" in the second sentence and inserting "Centers for Medicare & Medicaid Services".

(5) AMENDMENTS TO THE ALZHEIMER'S DISEASE AND RELATED DEMENTIAS SERVICES RESEARCH ACT OF 1992.—The Alzheimer's Disease and Related Dementias Research Act of 1992 (42 U.S.C. 11271 et seq.) is amended—

(A) in the heading of subpart 3 of part D to read as follows:

"Subpart 3—Responsibilities of the Centers for Medicare & Medicaid Services";

(B) in section 937 (42 U.S.C. 11271)—

(i) in subsection (a), by striking "National Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services";

(ii) in subsection (b)(1), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services";

(iii) in subsection (b)(2), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services"; and

(iv) in subsection (c), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services"; and

(C) in section 938 (42 U.S.C. 11272), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services".

(6) MISCELLANEOUS AMENDMENTS.—

(A) REHABILITATION ACT OF 1973.—Section 202(b)(8) of the Rehabilitation Act of 1973 (29 U.S.C. 762(b)(8)) is amended by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services".

(B) INDIAN HEALTH CARE IMPROVEMENT ACT.—Section 405(d)(1) of the Indian Health Care Improvement Act (25 U.S.C. 1645(d)(1)) is amended by striking "Health Care Financing Administration" in the matter preceding subparagraph (A) and inserting "Centers for Medicare & Medicaid Services".

(C) INDIVIDUALS WITH DISABILITIES EDUCATION ACT.—Section 644(b)(5) of the Individuals with Disabilities Education Act (20 U.S.C. 1444(b)(5)) is amended by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services".

(D) THE HOME HEALTH CARE AND ALZHEIMER'S DISEASE AMENDMENTS OF 1990.—Section 302(a)(9) of the Home Health Care and Alzheimer's Disease Amendments of 1990 (42 U.S.C. 242q–1(a)(9)) is amended by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services".

(E) THE CHILDREN'S HEALTH ACT OF 2000.—Section 2503(a) of the Children's Health Act of 2000 (42 U.S.C. 247b–3a(a)) is amended by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services".

(F) THE NATIONAL INSTITUTES OF HEALTH REVITALIZATION ACT OF 1993.—Section 1909 of the National Institutes of Health Revitalization Act of 1993 (42 U.S.C. 299a note) is amended by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services".

(G) THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990.—Section 4359(d) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1395b–3(d)) is amended by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services".

(H) THE MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000.—Section 104(d)(4) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (42 U.S.C. 1395m note) is amended by striking "Health Care Financing Administration" and inserting "Health Care".

(7) ADDITIONAL AMENDMENT.—Section 403 of the Act entitled, "An Act to authorize certain appropriations for the territories of the United States, to amend certain Acts relating thereto, and for other purposes", enacted October 15, 1977 (48 U.S.C. 1574–1; 48 U.S.C. 1421q–1), is amended by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services".

Subtitle A—Regulatory Reform

SEC. 901. CONSTRUCTION; DEFINITION OF SUPPLIER.

(a) CONSTRUCTION.—Nothing in this title shall be construed—

(1) to compromise or affect existing legal remedies for addressing fraud or abuse, whether it be criminal prosecution, civil enforcement, or administrative remedies, including under sections 3729 through 3733 of title 31, United States Code (commonly known as the "False Claims Act"); or

(2) to prevent or impede the Department of Health and Human Services in any way from its ongoing efforts to eliminate waste, fraud, and abuse in the medicare program.

Furthermore, the consolidation of medicare administrative contracting set forth in this division does not constitute consolidation of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund or reflect any position on that issue.

(b) DEFINITION OF SUPPLIER.—Section 1861 (42 U.S.C. 1395x) is amended by inserting after subsection (c) the following new subsection:

"Supplier

"(d) The term 'supplier' means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.".

SEC. 902. ISSUANCE OF REGULATIONS.

(a) REGULAR TIMELINE FOR PUBLICATION OF FINAL RULES.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraph:

"(3)(A) The Secretary, in consultation with the Director of the Office of Management and Budget, shall establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation or an interim final regulation.

"(B) Such timeline may vary among different regulations based on differences in the complexity of the regulation, the number and scope of comments received, and other relevant factors, but shall not be longer than 3 years except under exceptional circumstances. If the Secretary intends to vary such timeline with respect to the publication of a final regulation, the Secretary shall cause to have published in the Federal Register notice of the different timeline by not later than the timeline previously established with respect to such regulation. Such notice shall include a brief explanation of the justification for such variation.

"(C) In the case of interim final regulations, upon the expiration of the regular timeline established under this paragraph for the publication of a final regulation after opportunity for public comment, the interim final regulation shall not continue in effect unless the Secretary publishes (at the end of the regular timeline and, if applicable, at the end of each succeeding 1-year period) a notice of continuation of the regulation that includes an explanation of why the regular timeline (and any subsequent 1-year extension) was not complied with. If such a notice is published, the regular timeline (or such timeline as previously extended under this paragraph) for publication of the final regulation shall be treated as having been extended for 1 additional year.

"(D) The Secretary shall annually submit to Congress a report that describes the instances in which the Secretary failed to publish a final regulation within the applicable regular timeline under this paragraph and that provides an explanation for such failures.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act. The Secretary shall provide for an appropriate transition to take into account the backlog of previously published interim final regulations.

(b) LIMITATIONS ON NEW MATTER IN FINAL REGULATIONS.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)), as amended by subsection (a), is

amended by adding at the end the following new paragraph:

"(4) If the Secretary publishes a final regulation that includes a provision that is not a logical outgrowth of a previously published notice of proposed rulemaking or interim final rule, such provision shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to final regulations published on or after the date of the enactment of this Act.

SEC. 903. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh), as amended by section 902(a), is amended by adding at the end the following new subsection:

"(e)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

"(i) such retroactive application is necessary to comply with statutory requirements; or

"(ii) failure to apply the change retroactively would be contrary to the public interest.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of the enactment of this Act.

(b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE CHANGES AFTER NOTICE.—

(1) IN GENERAL.—Section 1871(e)(1), as added by subsection (a), is amended by adding at the end the following:

"(B)(i) Except as provided in clause (ii), a substantive change referred to in subparagraph (A) shall not become effective before the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

"(ii) The Secretary may provide for such a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.

"(C) No action shall be taken against a provider of services or supplier with respect to noncompliance with such a substantive change for items and services furnished before the effective date of such a change.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to compliance actions undertaken on or after the date of the enactment of this Act.

(c) RELIANCE ON GUIDANCE.—

(1) IN GENERAL.—Section 1871(e), as added by subsection (a), is further amended by adding at the end the following new paragraph:

"(2)(A) If—

"(i) a provider of services or supplier follows the written guidance (which may be transmitted electronically) provided by the Secretary or by a medicare contractor (as defined in section 1889(g)) acting within the scope of the contractor's contract authority, with respect to the furnishing of items or services and submission of a claim for benefits for such items or services with respect to such provider or supplier;

"(ii) the Secretary determines that the provider of services or supplier has accurately presented the circumstances relating to such items, services, and claim to the contractor in writing; and

"(iii) the guidance was in error;

the provider of services or supplier shall not be subject to any penalty or interest under this title or the provisions of title XI insofar as they relate to this title (including interest under a repayment plan under section 1893 or otherwise) relating to the provision of such items or service or such claim if the provider of services or supplier reasonably relied on such guidance.

"(B) Subparagraph (A) shall not be construed as preventing the recoupment or repayment (without any additional penalty) relating to an overpayment insofar as the overpayment was solely the result of a clerical or technical operational error.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act and shall only apply to a penalty or interest imposed with respect to guidance provided on or after July 24, 2003.

SEC. 904. REPORTS AND STUDIES RELATING TO REGULATORY REFORM.

(a) GAO STUDY ON ADVISORY OPINION AUTHORITY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine the feasibility and appropriateness of establishing in the Secretary authority to provide legally binding advisory opinions on appropriate interpretation and application of regulations to carry out the medicare program under title XVIII of the Social Security Act. Such study shall examine the appropriate timeframe for issuing such advisory opinions, as well as the need for additional staff and funding to provide such opinions.

(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than 1 year after the date of the enactment of this Act.

(b) REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by section 903(a)(1), is amended by adding at the end the following new subsection:

"(f)(1) Not later than 2 years after the date of the enactment of this subsection, and every 3 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

"(2) In preparing a report under paragraph (1), the Secretary shall collect—

"(A) information from individuals entitled to benefits under part A or enrolled under part B, or both, providers of services, and suppliers and from the Medicare Beneficiary Ombudsman with respect to such areas of inconsistency and conflict; and

"(B) information from medicare contractors that tracks the nature of written and telephone inquiries.

"(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.".

Subtitle B—Contracting Reform

SEC. 911. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

"CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

"SEC. 1874A. (a) AUTHORITY.—

"(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

"(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

"(A) the entity has demonstrated capability to carry out such function;

"(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

"(C) the entity has sufficient assets to financially support the performance of such function; and

"(D) the entity meets such other requirements as the Secretary may impose.

"(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

"(A) IN GENERAL.—The term 'medicare administrative contractor' means an agency, organization, or other person with a contract under this section.

"(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services or supplier (or class of such providers of services or suppliers), the 'appropriate' medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services or supplier or class of provider of services or supplier.

"(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions (including the function of developing local coverage determinations, as defined in section 1869(f)(2)(B)), provider services functions, and functions relating to services furnished to individuals entitled to benefits under part A or enrolled under part B, or both, as follows:

"(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, suppliers and individuals.

"(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

"(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Providing education and outreach to individuals entitled to benefits under part A or enrolled under part B, or both, and providing assistance to those individuals with specific issues, concerns, or problems.

"(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services or suppliers.

"(E) COMMUNICATION WITH PROVIDERS.—Communicating to providers of services and suppliers any information or instructions furnished to the medicare administrative contractor by the Secretary, and facilitating communication between such providers and suppliers and the Secretary.

"(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions relating to

provider education, training, and technical assistance.

"(G) ADDITIONAL FUNCTIONS.—Performing such other functions, including (subject to paragraph (5)) functions under the Medicare Integrity Program under section 1893, as are necessary to carry out the purposes of this title.

"(5) RELATIONSHIP TO MIP CONTRACTS.—

"(A) NONDUPLICATION OF DUTIES.—In entering into contracts under this section, the Secretary shall assure that functions of medicare administrative contractors in carrying out activities under parts A and B do not duplicate activities carried out under a contract entered into under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

"(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

"(6) APPLICATION OF FEDERAL ACQUISITION REGULATION.—Except to the extent inconsistent with a specific requirement of this section, the Federal Acquisition Regulation applies to contracts under this section.

"(b) CONTRACTING REQUIREMENTS.—

"(1) USE OF COMPETITIVE PROCEDURES.—

"(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section, taking into account performance quality as well as price and other factors.

"(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every 5 years.

"(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors consistent with the provisions of this paragraph. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide public notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred, a description of the providers of services and suppliers affected by such transfer, and contact information for the contractors involved).

"(D) INCENTIVES FOR QUALITY.—The Secretary shall provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

"(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, quality of services provided, and other matters as the Secretary finds pertinent.

"(3) PERFORMANCE REQUIREMENTS.—

"(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—

"(i) IN GENERAL.—The Secretary shall develop contract performance requirements to carry out the specific requirements applicable under this title to a function described in subsection (a)(4) and shall develop standards for measuring the extent to which a contractor has met such requirements.

"(ii) CONSULTATION.—In developing such performance requirements and standards for measurement, the Secretary shall consult with providers of services, organizations representative of beneficiaries under this title, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements.

"(iii) PUBLICATION OF STANDARDS.—The Secretary shall make such performance requirements and measurement standards available to the public.

"(B) CONSIDERATIONS.—The Secretary shall include, as one of the standards developed under subparagraph (A), provider and beneficiary satisfaction levels.

"(C) INCLUSION IN CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

"(i) shall reflect the performance requirements published under subparagraph (A), but may include additional performance requirements;

"(ii) shall be used for evaluating contractor performance under the contract; and

"(iii) shall be consistent with the written statement of work provided under the contract.

"(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

"(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

"(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

"(5) SURETY BOND.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

"(c) TERMS AND CONDITIONS.—

"(1) IN GENERAL.—A contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

"(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

"(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

"(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

"(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General of the United States) of a certifying officer designated as provided in paragraph (1) of this subsection.

"(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—

"(A) IN GENERAL.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless, in connection with such payment, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

"(B) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code.

"(4) INDEMNIFICATION BY SECRETARY.—

"(A) IN GENERAL.—Subject to subparagraphs (B) and (D), in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from or relating directly to the claims administration process under this title, the Secretary may, to the extent the Secretary determines to be appropriate and as specified in the contract with the contractor, indemnify the contractor and such persons.

"(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the judicial proceeding or by the Secretary to be criminal in nature, fraudulent, or grossly negligent. If indemnification is provided by the Secretary with respect to a contractor before a determination that such costs arose directly from such conduct, the contractor shall reimburse the Secretary for costs of indemnification.

"(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

"(D) WRITTEN APPROVAL FOR SETTLEMENTS OR COMPROMISES.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate such settlement or compromise. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement or compromise of a proceeding described in such subparagraph are conditioned upon prior written approval by the Secretary of the final settlement or compromise.

"(E) CONSTRUCTION.—Nothing in this paragraph shall be construed—

"(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

"(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulation.".

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act, as inserted by paragraph (1), the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and

applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act.

(b) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows:

"PROVISIONS RELATING TO THE ADMINISTRATION OF PART A".

(2) Subsection (a) is amended to read as follows:

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.".

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking "agreement under this section" and inserting "contract under section 1874A that provides for making payments under this part".

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking "An agreement with an agency or organization under this section" and inserting "A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part"; and

(B) by striking "such agency or organization" and inserting "such medicare administrative contractor" each place it appears.

(7) Subsection (l) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

"PROVISIONS RELATING TO THE ADMINISTRATION OF PART B".

(2) Subsection (a) is amended to read as follows:

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.".

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking "carriers" and inserting "medicare administrative contractors"; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking "Each such contract shall provide that the carrier" and inserting "The Secretary";

(ii) by striking "will" the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting "shall";

(iii) in subparagraph (B), in the matter before clause (i), by striking "to the policyholders and subscribers of the carrier" and inserting "to the policyholders and subscribers of the medicare administrative contractor";

(iv) by striking subparagraphs (C), (D), and (E);

(v) in subparagraph (H)—

(I) by striking "if it makes determinations or payments with respect to physicians' services," in the matter preceding clause (i); and

(II) by striking "carrier" and inserting "medicare administrative contractor" in clause (i);

(vi) by striking subparagraph (I);

(vii) in subparagraph (L), by striking the semicolon and inserting a period;

(viii) in the first sentence, after subparagraph (L), by striking "and shall contain" and all that follows through the period; and

(ix) in the seventh sentence, by inserting "medicare administrative contractor," after "carrier,";

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking "carrier" and inserting "medicare administrative contractor"; and

(F) in paragraph (7), by striking "the carrier" and inserting "the Secretary" each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)(A), by striking "contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B)," and inserting "contract under section 1874A that provides for making payments under this part";

(C) in paragraph (3)(A), by striking "subsection (a)(1)(B)" and inserting "section 1874A(a)(3)(B)";

(D) in paragraph (4), in the matter preceding subparagraph (A), by striking "carrier" and inserting "medicare administrative contractor"; and

(E) by striking paragraphs (5) and (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking "carrier or carriers" and inserting "medicare administrative contractor or contractors".

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking "Each carrier having an agreement with the Secretary under subsection (a)" and inserting "The Secretary"; and

(ii) by striking "Each such carrier" and inserting "The Secretary";

(B) in paragraph (3)(A)—

(i) by striking "a carrier having an agreement with the Secretary under subsection (a)" and inserting "medicare administrative contractor having a contract under section 1874A that provides for making payments under this part"; and

(ii) by striking "such carrier" and inserting "such contractor";

(C) in paragraph (3)(B)—

(i) by striking "a carrier" and inserting "a medicare administrative contractor" each place it appears; and

(ii) by striking "the carrier" and inserting "the contractor" each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking "carriers" and inserting "medicare administrative contractors" each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking "carrier" and inserting "medicare administrative contractor"; and

(B) in paragraph (2), by striking "carrier" and inserting "medicare administrative contractor".

(9) Subsection (p)(3)(A) is amended by striking "carrier" and inserting "medicare administrative contractor".

(10) Subsection (q)(1)(A) is amended by striking "carrier".

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2005, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this Act, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2011.

(2) GENERAL TRANSITION RULES.—

(A) AUTHORITY TO CONTINUE TO ENTER INTO NEW AGREEMENTS AND CONTRACTS AND WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—Prior to October 1, 2005, the Secretary may, consistent with subparagraph (B), continue to enter into agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u). The Secretary may enter into new agreements under section 1816 prior to October 1, 2005, without regard to any of the provider nomination provisions of such section.

(B) APPROPRIATE TRANSITION.—The Secretary shall take such steps as are necessary to provide for an appropriate transition from agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) AUTHORIZING CONTINUATION OF MIP FUNCTIONS UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER TRANSITION CONTRACTS.—Notwithstanding the amendments made by this section, the provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply during the period that begins on the date of the enactment of this Act and ends on October 1, 2011, and any reference in such provisions to an agreement or contract shall be deemed to include a contract under section 1874A of such Act, as inserted by subsection (a)(1), that continues the activities referred to in such provisions.

(e) REFERENCES.—On and after the effective date provided under subsection (d)(1), any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to a medicare administrative contractor (as provided under section 1874A of the Social Security Act).

(f) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(g) REPORTS ON IMPLEMENTATION.—

(1) PLAN FOR IMPLEMENTATION.—By not later than October 1, 2004, the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes the plan for implementation of the amendments made by this section. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contracts and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

SEC. 912. REQUIREMENTS FOR INFORMATION SECURITY FOR MEDICARE ADMINISTRATIVE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 911(a)(1), is amended by adding at the end the following new subsection:

"(e) REQUIREMENTS FOR INFORMATION SECURITY.—

"(1) DEVELOPMENT OF INFORMATION SECURITY PROGRAM.—A medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall implement a contractor-wide information security program to provide information security for the operation and assets of the contractor with respect to such functions under this title. An information security program under this paragraph shall meet the requirements for information security programs imposed on Federal agencies under paragraphs (1) through (8) of section 3544(b) of title 44, United States Code (other than the requirements under paragraphs (2)(D)(i), (5)(A), and (5)(B) of such section).

"(2) INDEPENDENT AUDITS.—

"(A) PERFORMANCE OF ANNUAL EVALUATIONS.—Each year a medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall undergo an evaluation of the information security of the contractor with respect to such functions under this title. The evaluation shall—

"(i) be performed by an entity that meets such requirements for independence as the Inspector General of the Department of Health and Human Services may establish; and

"(ii) test the effectiveness of information security control techniques of an appropriate subset of the contractor's information systems (as defined in section 3502(8) of title 44, United States Code) relating to such functions under this title and an assessment of compliance with the requirements of this subsection and related information security policies, procedures, standards and guidelines, including policies and procedures as may be prescribed by the Director of the Office of Management and Budget and applicable information security standards promulgated under section 11331 of title 40, United States Code.

"(B) DEADLINE FOR INITIAL EVALUATION.—

"(i) NEW CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that has not previously performed the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) as a fiscal intermediary or carrier under section 1816 or 1842, the first independent evaluation conducted pursuant to subparagraph (A) shall be completed prior to commencing such functions.

"(ii) OTHER CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that is not described in clause (i), the first independent evaluation conducted pursuant to subparagraph (A) shall be completed within 1 year after the date the contractor commences functions referred to in clause (i) under this section.

"(C) REPORTS ON EVALUATIONS.—

"(i) TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The results of independent evaluations under subparagraph (A) shall be submitted promptly to the Inspector General of the Department of Health and Human Services and to the Secretary.

"(ii) TO CONGRESS.—The Inspector General of the Department of Health and Human Services shall submit to Congress annual reports on the results of such evaluations, including assessments of the scope and sufficiency of such evaluations.

"(iii) AGENCY REPORTING.—The Secretary shall address the results of such evaluations in reports required under section 3544(c) of title 44, United States Code.".

(b) APPLICATION OF REQUIREMENTS TO FISCAL INTERMEDIARIES AND CARRIERS.—

(1) IN GENERAL.—The provisions of section 1874A(e)(2) of the Social Security Act (other than subparagraph (B)), as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(2) DEADLINE FOR INITIAL EVALUATION.—In the case of such a fiscal intermediary or carrier with an agreement or contract under such respective section in effect as of the date of the enactment of this Act, the first evaluation under section 1874A(e)(2)(A) of the Social Security Act (as added by subsection (a)), pursuant to paragraph (1), shall be completed (and a report on the evaluation submitted to the Secretary) by not later than 1 year after such date.

Subtitle C—Education and Outreach

SEC. 921. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1888 the following new section:

"PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

"SEC. 1889. (a) COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (g), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services and suppliers.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(3) REPORT.—Not later than October 1, 2004, the Secretary shall submit to Congress a report that includes a description and evaluation of the steps taken to coordinate the funding of provider education under section 1889(a) of the Social Security Act, as added by paragraph (1).

(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—

(1) IN GENERAL.—Section 1874A, as added by section 911(a)(1) and as amended by section 912(a), is amended by adding at the end the following new subsection:

"(f) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—The Secretary shall use specific claims payment error rates or similar methodology of medicare administrative contractors in the processing or reviewing of medicare claims in order to give such contractors an incentive to implement effective education and outreach programs for providers of services and suppliers.".

(2) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(f) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(3) GAO REPORT ON ADEQUACY OF METHODOLOGY.—Not later than October 1, 2004, the Comptroller General of the United States shall submit to Congress and to the Secretary a report on the adequacy of the methodology under section 1874A(f) of the Social Security Act, as added by paragraph (1), and shall include in the report such recommendations as the Comptroller General determines appropriate with respect to the methodology.

(4) REPORT ON USE OF METHODOLOGY IN ASSESSING CONTRACTOR PERFORMANCE.—Not later than October 1, 2004, the Secretary shall submit to Congress a report that describes how the Secretary intends to use such methodology in assessing medicare contractor performance in implementing effective education and outreach programs, including whether to use such methodology as a basis for performance bonuses. The report shall include an analysis of the sources of identified errors and potential changes in systems of contractors and rules of the Secretary that could reduce claims error rates.

(c) PROVISION OF ACCESS TO AND PROMPT RESPONSES FROM MEDICARE ADMINISTRATIVE CONTRACTORS.—

(1) IN GENERAL.—Section 1874A, as added by section 911(a)(1) and as amended by section 912(a) and subsection (b), is further amended by adding at the end the following new subsection:

"(g) COMMUNICATIONS WITH BENEFICIARIES, PROVIDERS OF SERVICES AND SUPPLIERS.—

"(1) COMMUNICATION STRATEGY.—The Secretary shall develop a strategy for communications with individuals entitled to benefits under part A or enrolled under part B, or both, and with providers of services and suppliers under this title.

"(2) RESPONSE TO WRITTEN INQUIRIES.—Each medicare administrative contractor shall, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries of providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

"(3) RESPONSE TO TOLL-FREE LINES.—The Secretary shall ensure that each medicare administrative contractor shall provide, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, a toll-free telephone number at which such individuals, providers of services, and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

"(4) MONITORING OF CONTRACTOR RESPONSES.—

"(A) IN GENERAL.—Each medicare administrative contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

"(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

"(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

"(B) DEVELOPMENT OF STANDARDS.—

"(i) IN GENERAL.—The Secretary shall establish and make public standards to monitor the accuracy, consistency, and timeliness of the information provided in response to written and telephone inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

"(ii) EVALUATION.—In conducting evaluations of individual medicare administrative contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under

part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

"(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.

"(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this subsection.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect October 1, 2004.

(3) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(g) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(d) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) IN GENERAL.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsections:

"(b) ENHANCED EDUCATION AND TRAINING.—

"(1) ADDITIONAL RESOURCES.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) such sums as may be necessary for fiscal years beginning with fiscal year 2005.

"(2) USE.—The funds made available under paragraph (1) shall be used to increase the conduct by medicare contractors of education and training of providers of services and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses.

"(c) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

"(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall tailor such activities to meet the special needs of small providers of services or suppliers (as defined in paragraph (2)). Such education and training activities for small providers of services and suppliers may include the provision of technical assistance (such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance).

"(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term 'small provider of services or supplier' means—

"(A) a provider of services with fewer than 25 full-time-equivalent employees; or

"(B) a supplier with fewer than 10 full-time-equivalent employees.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(e) REQUIREMENT TO MAINTAIN INTERNET WEBSITES.—

(1) IN GENERAL.—Section 1889, as added by subsection (a), and as amended by subsection (d), is further amended by adding at the end the following new subsection:

"(d) INTERNET WEBSITES; FAQS.—The Secretary, and each medicare contractor insofar as it provides services (including claims processing) for providers of services or suppliers, shall maintain an Internet website which—

"(1) provides answers in an easily accessible format to frequently asked questions, and

"(2) includes other published materials of the contractor, that relate to providers of services and suppliers under the programs under this title (and title XI insofar as it relates to such programs).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(f) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsections (d) and (e), is further amended by adding at the end the following new subsections:

"(e) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services or suppliers for the purpose of conducting any type of audit or prepayment review.

"(f) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor—

"(1) of the screens used for identifying claims that will be subject to medical review; or

"(2) of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

"(g) DEFINITIONS.—For purposes of this section, the term 'medicare contractor' includes the following:

"(1) A medicare administrative contractor with a contract under section 1874A, including a fiscal intermediary with a contract under section 1816 and a carrier with a contract under section 1842.

"(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services or supplier an entity that has no authority under this title or title IX with respect to such activities and such provider of services or supplier.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

SEC. 922. SMALL PROVIDER TECHNICAL ASSISTANCE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the "demonstration program") under which technical assistance described in paragraph (2) is made available, upon request and on a voluntary basis, to small providers of services or suppliers in order to improve compliance with the applicable requirements of the programs under medicare program under title XVIII of the Social Security Act (including provisions of title XI of such Act insofar as they relate to such title and are not administered by the Office of the Inspector General of the Department of Health and Human Services).

(2) FORMS OF TECHNICAL ASSISTANCE.—The technical assistance described in this paragraph is—

(A) evaluation and recommendations regarding billing and related systems; and

(B) information and assistance regarding policies and procedures under the medicare program, including coding and reimbursement.

(3) SMALL PROVIDERS OF SERVICES OR SUPPLIERS.—In this section, the term "small providers of services or suppliers" means—

(A) a provider of services with fewer than 25 full-time-equivalent employees; or

(B) a supplier with fewer than 10 full-time-equivalent employees.

(b) QUALIFICATION OF CONTRACTORS.—In conducting the demonstration program, the Secretary shall enter into contracts with qualified organizations (such as peer review organizations or entities described in section 1889(g)(2) of the Social Security Act, as inserted by section 921(f)(1)) with appropriate expertise with billing systems of the full range of providers of services and suppliers to provide the technical assistance. In awarding such contracts, the Secretary shall consider any prior investigations of the entity's work by the Inspector General of Department of Health and Human Services or the Comptroller General of the United States.

(c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The technical assistance provided under the demonstration program shall include a direct and in-person examination of billing systems and internal controls of small providers of services or suppliers to determine program compliance and to suggest more efficient or effective means of achieving such compliance.

(d) GAO EVALUATION.—Not later than 2 years after the date the demonstration program is first implemented, the Comptroller General, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct an evaluation of the demonstration program. The evaluation shall include a determination of whether claims error rates are reduced for small providers of services or suppliers who participated in the program and the extent of improper payments made as a result of the demonstration program. The Comptroller General shall submit a report to the Secretary and the Congress on such evaluation and shall include in such report recommendations regarding the continuation or extension of the demonstration program.

(e) FINANCIAL PARTICIPATION BY PROVIDERS.—The provision of technical assistance to a small provider of services or supplier under the demonstration program is conditioned upon the small provider of services or supplier paying an amount estimated (and disclosed in advance of a provider's or supplier's participation in the program) to be equal to 25 percent of the cost of the technical assistance.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, from amounts not otherwise appropriated in the Treasury, such sums as may be necessary to carry out this section.

SEC. 923. MEDICARE BENEFICIARY OMBUDSMAN.

(a) IN GENERAL.—Section 1808, as added and amended by section 900, is amended by adding at the end the following new subsection:

"(c) MEDICARE BENEFICIARY OMBUDSMAN.—

"(1) IN GENERAL.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals entitled to benefits under this title.

"(2) DUTIES.—The Medicare Beneficiary Ombudsman shall—

"(A) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under part A or enrolled under part B, or both, with respect to any aspect of the medicare program;

"(B) provide assistance with respect to complaints, grievances, and requests referred to in subparagraph (A), including—

"(i) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, MA organization, or the Secretary;

"(ii) assistance to such individuals with any problems arising from disenrollment from an MA plan under part C; and

"(iii) assistance to such individuals in presenting information under section 1839(i)(4)(C) (relating to income-related premium adjustment; and

"(C) submit annual reports to Congress and the Secretary that describe the activities of the

Office and that include such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate. The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

"(3) WORKING WITH HEALTH INSURANCE COUNSELING PROGRAMS.—To the extent possible, the Ombudsman shall work with health insurance counseling programs (receiving funding under section 4360 of Omnibus Budget Reconciliation Act of 1990) to facilitate the provision of information to individuals entitled to benefits under part A or enrolled under part B, or both regarding MA plans and changes to those plans. Nothing in this paragraph shall preclude further collaboration between the Ombudsman and such programs.".

(b) DEADLINE FOR APPOINTMENT.—By not later than 1 year after the date of the enactment of this Act, the Secretary shall appoint the Medicare Beneficiary Ombudsman under section 1808(c) of the Social Security Act, as added by subsection (a).

(c) FUNDING.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund, established under section 1817 of the Social Security Act (42 U.S.C. 1395i), and the Federal Supplementary Medical Insurance Trust Fund, established under section 1841 of such Act (42 U.S.C. 1395t)) to carry out section 1808(c) of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (a), such sums as are necessary for fiscal year 2004 and each succeeding fiscal year.

(d) USE OF CENTRAL, TOLL-FREE NUMBER (1–800–MEDICARE).—

(1) PHONE TRIAGE SYSTEM; LISTING IN MEDICARE HANDBOOK INSTEAD OF OTHER TOLL-FREE NUMBERS.—Section 1804(b) (42 U.S.C. 1395b–2(b)) is amended by adding at the end the following: "The Secretary shall provide, through the toll-free telephone number 1–800–MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.".

(2) MONITORING ACCURACY.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study to monitor the accuracy and consistency of information provided to individuals entitled to benefits under part A or enrolled under part B, or both, through the toll-free telephone number 1–800–MEDICARE, including an assessment of whether the information provided is sufficient to answer questions of such individuals. In conducting the study, the Comptroller General shall examine the education and training of the individuals providing information through such number.

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subparagraph (A).

SEC. 924. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the "demonstration program") under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to individuals entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both, regarding the medicare program at the location of existing local offices of the Social Security Administration.

(b) LOCATIONS.—

(1) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to paragraph (2), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by individuals referred to in subsection (a).

(2) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(c) DURATION.—The demonstration program shall be conducted over a 3-year period.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(A) utilization of, and satisfaction of those individuals referred to in subsection (a) with, the assistance provided under the program; and

(B) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local offices of the Social Security Administration.

(2) REPORT.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing medicare specialists at local offices of the Social Security Administration.

SEC. 925. INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY BENEFITS.

(a) IN GENERAL.—The Secretary shall provide that in medicare beneficiary notices provided (under section 1806(a) of the Social Security Act, 42 U.S.C. 1395b–7(a)) with respect to the provision of post-hospital extended care services under part A of title XVIII of the Social Security Act, there shall be included information on the number of days of coverage of such services remaining under such part for the medicare beneficiary and spell of illness involved.

(b) EFFECTIVE DATE.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

SEC. 926. INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS.

(a) AVAILABILITY OF DATA.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.

(b) INCLUSION OF INFORMATION IN CERTAIN HOSPITAL DISCHARGE PLANS.—

(1) IN GENERAL.—Section 1861(ee)(2)(D) (42 U.S.C. 1395x(ee)(2)(D)) is amended—

(A) by striking "hospice services" and inserting "hospice care and post-hospital extended care services"; and

(B) by inserting before the period at the end the following: "and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to discharge plans made on or after such date as the Secretary shall specify, but not later than 6 months after the date the Secretary provides for availability of information under subsection (a).

Subtitle D—Appeals and Recovery

SEC. 931. TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) TRANSITION PLAN.—

(1) IN GENERAL.—Not later than April 1, 2004, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) CONTENTS.—The plan shall include information on the following:

(A) WORKLOAD.—The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes.

(B) COST PROJECTIONS AND FINANCING.—Funding levels required for fiscal year 2005 and subsequent fiscal years to carry out the functions transferred under the plan.

(C) TRANSITION TIMETABLE.—A timetable for the transition.

(D) REGULATIONS.—The establishment of specific regulations to govern the appeals process.

(E) CASE TRACKING.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the medicare program.

(F) FEASIBILITY OF PRECEDENTIAL AUTHORITY.—The feasibility of developing a process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services addressing broad legal issues binding, precedential authority.

(G) ACCESS TO ADMINISTRATIVE LAW JUDGES.—The feasibility of—

(i) filing appeals with administrative law judges electronically; and

(ii) conducting hearings using tele- or video-conference technologies.

(H) INDEPENDENCE OF ADMINISTRATIVE LAW JUDGES.—The steps that should be taken to ensure the independence of administrative law judges consistent with the requirements of subsection (b)(2).

(I) GEOGRAPHIC DISTRIBUTION.—The steps that should be taken to provide for an appropriate geographic distribution of administrative law judges throughout the United States to carry out subsection (b)(3).

(J) HIRING.—The steps that should be taken to hire administrative law judges (and support staff) to carry out subsection (b)(4).

(K) PERFORMANCE STANDARDS.—The appropriateness of establishing performance standards for administrative law judges with respect to timelines for decisions in cases under title XVIII of the Social Security Act taking into account requirements under subsection (b)(2) for the independence of such judges and consistent with the applicable provisions of title 5, United States Code relating to impartiality.

(L) SHARED RESOURCES.—The steps that should be taken to carry out subsection (b)(6) (relating to the arrangements with the Commissioner of Social Security to share office space, support staff, and other resources, with appropriate reimbursement).

(M) TRAINING.—The training that should be provided to administrative law judges with respect to laws and regulations under title XVIII of the Social Security Act.

(3) ADDITIONAL INFORMATION.—The plan may also include recommendations for further congressional action, including modifications to the

requirements and deadlines established under section 1869 of the Social Security Act (42 U.S.C. 1395ff) (as amended by this Act).

(4) GAO EVALUATION.—The Comptroller General of the United States shall evaluate the plan and, not later than the date that is 6 months after the date on which the plan is received by the Comptroller General, shall submit to Congress a report on such evaluation.

(b) TRANSFER OF ADJUDICATION AUTHORITY.—

(1) IN GENERAL.—Not earlier than July 1, 2005, and not later than October 1, 2005, the Commissioner of Social Security and the Secretary shall implement the transition plan under subsection (a) and transfer the administrative law judge functions described in such subsection from the Social Security Administration to the Secretary.

(2) ASSURING INDEPENDENCE OF JUDGES.—The Secretary shall assure the independence of administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Centers for Medicare & Medicaid Services and its contractors. In order to assure such independence, the Secretary shall place such judges in an administrative office that is organizationally and functionally separate from such Centers. Such judges shall report to, and be under the general supervision of, the Secretary, but shall not report to, or be subject to supervision by, another officer of the Department of Health and Human Services.

(3) GEOGRAPHIC DISTRIBUTION.—The Secretary shall provide for an appropriate geographic distribution of administrative law judges performing the administrative law judge functions transferred under paragraph (1) throughout the United States to ensure timely access to such judges.

(4) HIRING AUTHORITY.—Subject to the amounts provided in advance in appropriations Acts, the Secretary shall have authority to hire administrative law judges to hear such cases, taking into consideration those judges with expertise in handling medicare appeals and in a manner consistent with paragraph (3), and to hire support staff for such judges.

(5) FINANCING.—Amounts payable under law to the Commissioner for administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund shall become payable to the Secretary for the functions so transferred.

(6) SHARED RESOURCES.—The Secretary shall enter into such arrangements with the Commissioner as may be appropriate with respect to transferred functions of administrative law judges to share office space, support staff, and other resources, with appropriate reimbursement from the Trust Funds described in paragraph (5).

(c) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to ensure timely action on appeals before administrative law judges and the Departmental Appeals Board consistent with section 1869 of the Social Security Act (42 U.S.C. 1395ff) (as amended by this Act), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund, established under section 1817 of the Social Security Act (42 U.S.C. 1395i), and the Federal Supplementary Medical Insurance Trust Fund, established under section 1841 of such Act (42 U.S.C. 1395t)) to the Secretary such sums as are necessary for fiscal year 2005 and each subsequent fiscal year to—

(1) increase the number of administrative law judges (and their staffs) under subsection (b)(4);

(2) improve education and training opportunities for administrative law judges (and their staffs); and

(3) increase the staff of the Departmental Appeals Board.

(d) CONFORMING AMENDMENT.—Section 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)) is amended by striking "of the Social Security Administration".

SEC. 932. PROCESS FOR EXPEDITED ACCESS TO REVIEW.

(a) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

(1) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)) is amended—

(A) in paragraph (1)(A), by inserting ", subject to paragraph (2)," before "to judicial review of the Secretary's final decision"; and

(B) by adding at the end the following new paragraph:

"(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

"(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or an individual entitled to benefits under part A or enrolled under part B, or both, who has filed an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)(i)) may obtain access to judicial review when a review entity (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation for a specific matter in dispute in a case of an appeal.

"(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute, and if such request is accompanied by the documents and materials as the appropriate review entity shall require for purposes of making such determination, such review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the request and such accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

"(C) ACCESS TO JUDICIAL REVIEW.—

"(i) IN GENERAL.—If the appropriate review entity—

"(I) determines that there are no material issues of fact in dispute and that the only issues to be adjudicated are ones of law or regulation that the Departmental Appeals Board does not have authority to decide; or

"(II) fails to make such determination within the period provided under subparagraph (B), then the appellant may bring a civil action as described in this subparagraph.

"(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

"(I) clause (i)(I), within 60 days of the date of the determination described in such clause; or

"(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

"(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the District Court for the District of Columbia.

"(iv) INTEREST ON ANY AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier is granted judicial review pursuant to this paragraph, the amount in controversy (if any) shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services or suppliers under this title.

"(D) REVIEW ENTITY DEFINED.—For purposes of this subsection, the term 'review entity' means an entity of up to three reviewers who are administrative law judges or members of the Departmental Appeals Board selected for purposes of making determinations under this paragraph.".

(2) CONFORMING AMENDMENT.—Section 1869(b)(1)(F)(ii) (42 U.S.C. 1395ff(b)(1)(F)(ii)) is amended to read as follows:

"(ii) REFERENCE TO EXPEDITED ACCESS TO JUDICIAL REVIEW.—For the provision relating to expedited access to judicial review, see paragraph (2).".

(b) APPLICATION TO PROVIDER AGREEMENT DETERMINATIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting "(A)" after "(h)(1)"; and

(2) by adding at the end the following new subparagraph:

"(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.".

(c) EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.—

(1) TERMINATION AND CERTAIN OTHER IMMEDIATE REMEDIES.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)), as amended by subsection (b), is amended by adding at the end the following new subparagraph:

"(C)(i) The Secretary shall develop and implement a process to expedite proceedings under this subsection in which—

"(I) the remedy of termination of participation has been imposed;

"(II) a remedy described in clause (i) or (iii) of section 1819(h)(2)(B) has been imposed, but only if such remedy has been imposed on an immediate basis; or

"(III) a determination has been made as to a finding of substandard quality of care that results in the loss of approval of a skilled nursing facility's nurse aide training program.

"(ii) Under such process under clause (i), priority shall be provided in cases of termination described in clause (i)(I).

"(iii) Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.".

(2) WAIVER OF DISAPPROVAL OF NURSE-AIDE TRAINING PROGRAMS.—Sections 1819(f)(2) and section 1919(f)(2) (42 U.S.C. 1395i–3(f)(2) and 1396r(f)(2)) are each amended—

(A) in subparagraph (B)(iii), by striking "subparagraph (C)" and inserting "subparagraphs (C) and (D)"; and

(B) by adding at the end the following new subparagraph:

"(D) WAIVER OF DISAPPROVAL OF NURSE-AIDE TRAINING PROGRAMS.—Upon application of a

nursing facility, the Secretary may waive the application of subparagraph (B)(iii)(I)(c) if the imposition of the civil monetary penalty was not related to the quality of care provided to residents of the facility. Nothing in this subparagraph shall be construed as eliminating any requirement upon a facility to pay a civil monetary penalty described in the preceding sentence.''.

(3) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund, established under section 1817 of the Social Security Act (42 U.S.C. 1395i), and the Federal Supplementary Medical Insurance Trust Fund, established under section 1841 of such Act (42 U.S.C. 1395t)) to the Secretary such additional sums for fiscal year 2004 and each subsequent fiscal year as may be necessary. The purposes for which such amounts are available include increasing the number of administrative law judges (and their staffs) and the appellate level staff at the Departmental Appeals Board of the Department of Health and Human Services and educating such judges and staffs on long-term care issues.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to appeals filed on or after October 1, 2004.

SEC. 933. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE.—

(1) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by section 932(a), is further amended by adding at the end the following new paragraph:

''(3) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE BY PROVIDERS.—A provider of services or supplier may not introduce evidence in any appeal under this section that was not presented at the reconsideration conducted by the qualified independent contractor under subsection (c), unless there is good cause which precluded the introduction of such evidence at or before that reconsideration.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(b) USE OF PATIENTS' MEDICAL RECORDS.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)) is amended by inserting ''(including the medical records of the individual involved)'' after ''clinical experience''.

(c) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)) is amended by adding at the end the following new paragraphs:

''(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS.—With respect to an initial determination insofar as it results in a denial of a claim for benefits—

''(A) the written notice on the determination shall include—

''(i) the reasons for the determination, including whether a local medical review policy or a local coverage determination was used;

''(ii) the procedures for obtaining additional information concerning the determination, including the information described in subparagraph (B); and

''(iii) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination under this section;

''(B) such written notice shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both; and

''(C) the individual provided such written notice may obtain, upon request, information on the specific provision of the policy, manual, or regulation used in making the redetermination.

''(5) REQUIREMENTS OF NOTICE OF REDETERMINATIONS.—With respect to a redetermination insofar as it results in a denial of a claim for benefits—

''(A) the written notice on the redetermination shall include—

''(i) the specific reasons for the redetermination;

''(ii) as appropriate, a summary of the clinical or scientific evidence used in making the redetermination;

''(iii) a description of the procedures for obtaining additional information concerning the redetermination; and

''(iv) notification of the right to appeal the redetermination and instructions on how to initiate such an appeal under this section;

''(B) such written notice shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both; and

''(C) the individual provided such written notice may obtain, upon request, information on the specific provision of the policy, manual, or regulation used in making the redetermination.''.

(2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)) is amended—

(A) by inserting ''be written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include (to the extent appropriate)'' after ''in writing,''; and

(B) by inserting ''and a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section'' after ''such decision,''.

(3) APPEALS.—Section 1869(d) (42 U.S.C. 1395ff(d)) is amended—

(A) in the heading, by inserting ''; NOTICE'' after ''SECRETARY''; and

(B) by adding at the end the following new paragraph:

''(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include—

''(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

''(B) the procedures for obtaining additional information concerning the decision; and

''(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.''.

(4) SUBMISSION OF RECORD FOR APPEAL.—Section 1869(c)(3)(J)(i) (42 U.S.C. 1395ff(c)(3)(J)(i)) is amended by striking ''prepare'' and inserting ''submit'' and by striking ''with respect to'' and all that follows through ''and relevant policies''.

(d) QUALIFIED INDEPENDENT CONTRACTORS.—

(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(3) (42 U.S.C. 1395ff(c)(3)) is amended—

(A) in subparagraph (A), by striking ''sufficient training and expertise in medical science and legal matters'' and inserting ''sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing''; and

(B) by adding at the end the following new subparagraph:

''(K) INDEPENDENCE REQUIREMENTS.—

''(i) IN GENERAL.—Subject to clause (ii), a qualified independent contractor shall not conduct any activities in a case unless the entity—

''(I) is not a related party (as defined in subsection (g)(5));

''(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

''(III) does not otherwise have a conflict of interest with such a party.

''(ii) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

''(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.''.

(2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—Section 1869 (42 U.S.C. 1395ff) is amended—

(A) by amending subsection (c)(3)(D) to read as follows:

''(D) QUALIFICATIONS FOR REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals).''; and

(B) by adding at the end the following new subsection:

''(g) QUALIFICATIONS OF REVIEWERS.—

''(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall assure that—

''(A) each individual conducting a review shall meet the qualifications of paragraph (2);

''(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

''(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a 'reviewing professional'), a reviewing professional meets the qualifications described in paragraph (4) and, where a claim is regarding the furnishing of treatment by a physician (allopathic or osteopathic) or the provision of items or services by a physician (allopathic or osteopathic), a reviewing professional shall be a physician (allopathic or osteopathic).

''(2) INDEPENDENCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

''(i) not be a related party (as defined in paragraph (5));

''(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

''(iii) not otherwise have a conflict of interest with such a party.

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit an individual, solely on the basis of a participation agreement with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

''(I) the individual is not involved in the provision of items or services in the case under review;

''(II) the fact of such an agreement is disclosed to the Secretary and the individual entitled to benefits under part A or enrolled under part B, or both, or such individual's authorized representative, and neither party objects; and

''(III) the individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

''(ii) prohibit an individual who has staff privileges at the institution where the treatment

involved takes place from serving as a reviewer merely on the basis of having such staff privileges if the existence of such privileges is disclosed to the Secretary and such individual (or authorized representative), and neither party objects; or

"(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

For purposes of this paragraph, the term 'participation agreement' means an agreement relating to the provision of health care services by the individual and does not include the provision of services as a reviewer under this subsection.

"(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

"(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be—

"(A) a physician (allopathic or osteopathic) who is appropriately credentialed or licensed in one or more States to deliver health care services and has medical expertise in the field of practice that is appropriate for the items or services at issue; or

"(B) a health care professional who is legally authorized in one or more States (in accordance with State law or the State regulatory mechanism provided by State law) to furnish the health care items or services at issue and has medical expertise in the field of practice that is appropriate for such items or services.

"(5) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a case under this title involving a specific individual entitled to benefits under part A or enrolled under part B, or both, any of the following:

"(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

"(B) The individual (or authorized representative).

"(C) The health care professional that provides the items or services involved in the case.

"(D) The institution at which the items or services (or treatment) involved in the case are provided.

"(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

"(F) Any other party determined under any regulations to have a substantial interest in the case involved.".

(3) REDUCING MINIMUM NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by striking "not fewer than 12 qualified independent contractors under this subsection" and inserting "a sufficient number of qualified independent contractors (but not fewer than 4 such contractors) to conduct reconsiderations consistent with the timeframes applicable under this subsection".

(4) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA (114 Stat. 2763A–534).

(5) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by paragraph (2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).

SEC. 934. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 911(a)(1) and as amended by sections 912(b), 921(b)(1), and 921(c)(1), is further amended by adding at the end the following new subsection:

"(h) CONDUCT OF PREPAYMENT REVIEW.—

"(1) CONDUCT OF RANDOM PREPAYMENT REVIEW.—

"(A) IN GENERAL.—A medicare administrative contractor may conduct random prepayment review only to develop a contractor-wide or program-wide claims payment error rates or under such additional circumstances as may be provided under regulations, developed in consultation with providers of services and suppliers.

"(B) USE OF STANDARD PROTOCOLS WHEN CONDUCTING PREPAYMENT REVIEWS.—When a medicare administrative contractor conducts a random prepayment review, the contractor may conduct such review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

"(C) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review.

"(D) RANDOM PREPAYMENT REVIEW.—For purposes of this subsection, the term 'random prepayment review' means a demand for the production of records or documentation absent cause with respect to a claim.

"(2) LIMITATIONS ON NON-RANDOM PREPAYMENT REVIEW.—

"(A) LIMITATIONS ON INITIATION OF NON-RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate non-random prepayment review of a provider of services or supplier based on the initial identification by that provider of services or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error under section 1893(f)(3)(A).

"(B) TERMINATION OF NON-RANDOM PREPAYMENT REVIEW.—The Secretary shall issue regulations relating to the termination, including termination dates, of non-random prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect 1 year after the date of the enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(h) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of the enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(h)(1)(B) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary shall specify.

(c) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(h) of the Social Security Act, as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

SEC. 935. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1893 (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

"(f) RECOVERY OF OVERPAYMENTS.—

"(1) USE OF REPAYMENT PLANS.—

"(A) IN GENERAL.—If the repayment, within 30 days by a provider of services or supplier, of an overpayment under this title would constitute a hardship (as described in subparagraph (B)), subject to subparagraph (C), upon request of the provider of services or supplier the Secretary shall enter into a plan with the provider of services or supplier for the repayment (through offset or otherwise) of such overpayment over a period of at least 6 months but not longer than 3 years (or not longer than 5 years in the case of extreme hardship, as determined by the Secretary). Interest shall accrue on the balance through the period of repayment. Such plan shall meet terms and conditions determined to be appropriate by the Secretary.

"(B) HARDSHIP.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the repayment of an overpayment (or overpayments) within 30 days is deemed to constitute a hardship if—

"(I) in the case of a provider of services that files cost reports, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services for the cost reporting period covered by the most recently submitted cost report; or

"(II) in the case of another provider of services or supplier, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services or supplier for the previous calendar year.

"(ii) RULE OF APPLICATION.—The Secretary shall establish rules for the application of this subparagraph in the case of a provider of services or supplier that was not paid under this title during the previous year or was paid under this title only during a portion of that year.

"(iii) TREATMENT OF PREVIOUS OVERPAYMENTS.—If a provider of services or supplier has entered into a repayment plan under subparagraph (A) with respect to a specific overpayment amount, such payment amount under the repayment plan shall not be taken into account under clause (i) with respect to subsequent overpayment amounts.

"(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

"(i) the Secretary has reason to suspect that the provider of services or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

"(ii) there is an indication of fraud or abuse committed against the program.

"(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

"(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

"(2) LIMITATION ON RECOUPMENT.—

"(A) IN GENERAL.—In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination under section 1869(b)(1), the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1869(b)(1) (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

"(B) COLLECTION WITH INTEREST.—Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

"(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in section 1889(g).

"(3) LIMITATION ON USE OF EXTRAPOLATION.—A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless the Secretary determines that—

"(A) there is a sustained or high level of payment error; or

"(B) documented educational intervention has failed to correct the payment error.

There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations by the Secretary of sustained or high levels of payment errors under this paragraph.

"(4) PROVISION OF SUPPORTING DOCUMENTATION.—In the case of a provider of services or supplier with respect to which amounts were previously overpaid, a medicare contractor may request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

"(5) CONSENT SETTLEMENT REFORMS.—

"(A) IN GENERAL.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

"(B) OPPORTUNITY TO SUBMIT ADDITIONAL INFORMATION BEFORE CONSENT SETTLEMENT OFFER.—Before offering a provider of services or supplier a consent settlement, the Secretary shall—

"(i) communicate to the provider of services or supplier—

"(I) that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment;

"(II) the nature of the problems identified in such evaluation; and

"(III) the steps that the provider of services or supplier should take to address the problems; and

"(ii) provide for a 45-day period during which the provider of services or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

"(C) CONSENT SETTLEMENT OFFER.—The Secretary shall review any additional information furnished by the provider of services or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

"(i) shall provide notice of such determination to the provider of services or supplier, including an explanation of the reason for such determination; and

"(ii) in order to resolve the overpayment, may offer the provider of services or supplier—

"(I) the opportunity for a statistically valid random sample; or

"(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

"(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term 'consent settlement' means an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved.

"(6) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services and suppliers, a process under which the Secretary provides for notice to classes of providers of services and suppliers served by the contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

"(7) PAYMENT AUDITS.—

"(A) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services or supplier under this title, the contractor shall provide the provider of services or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

"(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services or supplier under this title, the contractor shall—

"(i) give the provider of services or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services or supplier and permits the development of an appropriate corrective action plan;

"(ii) inform the provider of services or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary);

"(iii) give the provider of services or supplier an opportunity to provide additional information to the contractor; and

"(iv) take into account information provided, on a timely basis, by the provider of services or supplier under clause (iii).

"(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

"(8) STANDARD METHODOLOGY FOR PROBE SAMPLING.—The Secretary shall establish a standard methodology for medicare contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.".

(b) EFFECTIVE DATES AND DEADLINES.—

(1) USE OF REPAYMENT PLANS.—Section 1893(f)(1) of the Social Security Act, as added by subsection (a), shall apply to requests for repayment plans made after the date of the enactment of this Act.

(2) LIMITATION ON RECOUPMENT.—Section 1893(f)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date of the enactment of this Act.

(3) USE OF EXTRAPOLATION.—Section 1893(f)(3) of the Social Security Act, as added by subsection (a), shall apply to statistically valid random samples initiated after the date that is 1 year after the date of the enactment of this Act.

(4) PROVISION OF SUPPORTING DOCUMENTATION.—Section 1893(f)(4) of the Social Security Act, as added by subsection (a), shall take effect on the date of the enactment of this Act.

(5) CONSENT SETTLEMENT.—Section 1893(f)(5) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

(6) NOTICE OF OVERUTILIZATION.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish the process for notice of overutilization of billing codes under section 1893A(f)(6) of the Social Security Act, as added by subsection (a).

(7) PAYMENT AUDITS.—Section 1893A(f)(7) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of the enactment of this Act.

(8) STANDARD FOR ABNORMAL BILLING PATTERNS.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1893(f)(8) of the Social Security Act, as added by subsection (a).

SEC. 936. PROVIDER ENROLLMENT PROCESS; RIGHT OF APPEAL.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) by adding at the end of the heading the following: "; ENROLLMENT PROCESSES"; and

(2) by adding at the end the following new subsection:

"(j) ENROLLMENT PROCESS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

"(1) ENROLLMENT PROCESS.—

"(A) IN GENERAL.—The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this title.

"(B) DEADLINES.—The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance of medicare administrative contractors in meeting the deadlines established under this subparagraph.

"(C) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—The Secretary shall consult with providers of services and suppliers before making changes in the provider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this title.

"(2) HEARING RIGHTS IN CASES OF DENIAL OR NON-RENEWAL.—A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.".

(b) EFFECTIVE DATES.—

(1) ENROLLMENT PROCESS.—The Secretary shall provide for the establishment of the enrollment process under section 1866(j)(1) of the Social Security Act, as added by subsection (a)(2), within 6 months after the date of the enactment of this Act.

(2) CONSULTATION.—Section 1866(j)(1)(C) of the Social Security Act, as added by subsection (a)(2), shall apply with respect to changes in provider enrollment forms made on or after January 1, 2004.

(3) HEARING RIGHTS.—Section 1866(j)(2) of the Social Security Act, as added by subsection (a)(2), shall apply to denials occurring on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary specifies.

SEC. 937. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS WITHOUT PURSUING APPEALS PROCESS.

(a) CLAIMS.—The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(g) of the Social Security Act, as inserted by section 301(a)(1)) and representatives of providers of services and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services or supplier is given an opportunity to correct such an error or

omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

(b) DEADLINE.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first develop the process under subsection (a).

SEC. 938. PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES; ADVANCE BENEFICIARY NOTICES.

(a) IN GENERAL.—Section 1869 (42 U.S.C. 1395ff(b)), as amended by section 933(d)(2)(B), is further amended by adding at the end the following new subsection:

“(h) PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES.—

“(1) ESTABLISHMENT OF PROCESS.—

“(A) IN GENERAL.—With respect to a medicare administrative contractor that has a contract under section 1874A that provides for making payments under this title with respect to physicians' services (as defined in section 1848(j)(3)), the Secretary shall establish a prior determination process that meets the requirements of this subsection and that shall be applied by such contractor in the case of eligible requesters.

“(B) ELIGIBLE REQUESTER.—For purposes of this subsection, each of the following shall be an eligible requester:

“(i) A participating physician, but only with respect to physicians' services to be furnished to an individual who is entitled to benefits under this title and who has consented to the physician making the request under this subsection for those physicians' services.

“(ii) An individual entitled to benefits under this title, but only with respect to a physicians' service for which the individual receives, from a physician, an advance beneficiary notice under section 1879(a).

“(2) SECRETARIAL FLEXIBILITY.—The Secretary shall establish by regulation reasonable limits on the physicians' services for which a prior determination of coverage may be requested under this subsection. In establishing such limits, the Secretary may consider the dollar amount involved with respect to the physicians' service, administrative costs and burdens, and other relevant factors.

“(3) REQUEST FOR PRIOR DETERMINATION.—

“(A) IN GENERAL.—Subject to paragraph (2), under the process established under this subsection an eligible requester may submit to the contractor a request for a determination, before the furnishing of a physicians' service, as to whether the physicians' service is covered under this title consistent with the applicable requirements of section 1862(a)(1)(A) (relating to medical necessity).

“(B) ACCOMPANYING DOCUMENTATION.—The Secretary may require that the request be accompanied by a description of the physicians' service, supporting documentation relating to the medical necessity for the physicians' service, and any other appropriate documentation. In the case of a request submitted by an eligible requester who is described in paragraph (1)(B)(ii), the Secretary may require that the request also be accompanied by a copy of the advance beneficiary notice involved.

“(4) RESPONSE TO REQUEST.—

“(A) IN GENERAL.—Under such process, the contractor shall provide the eligible requester with written notice of a determination as to whether—

“(i) the physicians' service is so covered;

“(ii) the physicians' service is not so covered; or

“(iii) the contractor lacks sufficient information to make a coverage determination with respect to the physicians' service.

“(B) CONTENTS OF NOTICE FOR CERTAIN DETERMINATIONS.—

“(i) NONCOVERAGE.—If the contractor makes the determination described in subparagraph (A)(ii), the contractor shall include in the notice a brief explanation of the basis for the determination, including on what national or local coverage or noncoverage determination (if any) the determination is based, and a description of any applicable rights under subsection (a).

“(ii) INSUFFICIENT INFORMATION.—If the contractor makes the determination described in subparagraph (A)(iii), the contractor shall include in the notice a description of the additional information required to make the coverage determination.

“(C) DEADLINE TO RESPOND.—Such notice shall be provided within the same time period as the time period applicable to the contractor providing notice of initial determinations on a claim for benefits under subsection (a)(2)(A).

“(D) INFORMING BENEFICIARY IN CASE OF PHYSICIAN REQUEST.—In the case of a request by a participating physician under paragraph (1)(B)(i), the process shall provide that the individual to whom the physicians' service is proposed to be furnished shall be informed of any determination described in subparagraph (A)(ii) (relating to a determination of non-coverage) and the right (referred to in paragraph (6)(B)) to obtain the physicians' service and have a claim submitted for the physicians' service.

“(5) BINDING NATURE OF POSITIVE DETERMINATION.—If the contractor makes the determination described in paragraph (4)(A)(i), such determination shall be binding on the contractor in the absence of fraud or evidence of misrepresentation of facts presented to the contractor.

“(6) LIMITATION ON FURTHER REVIEW.—

“(A) IN GENERAL.—Contractor determinations described in paragraph (4)(A)(ii) or (4)(A)(iii) (relating to pre-service claims) are not subject to further administrative appeal or judicial review under this section or otherwise.

“(B) DECISION NOT TO SEEK PRIOR DETERMINATION OR NEGATIVE DETERMINATION DOES NOT IMPACT RIGHT TO OBTAIN SERVICES, SEEK REIMBURSEMENT, OR APPEAL RIGHTS.—Nothing in this subsection shall be construed as affecting the right of an individual who—

“(i) decides not to seek a prior determination under this subsection with respect to physicians' services; or

“(ii) seeks such a determination and has received a determination described in paragraph (4)(A)(ii),

from receiving (and submitting a claim for) such physicians' services and from obtaining administrative or judicial review respecting such claim under the other applicable provisions of this section. Failure to seek a prior determination under this subsection with respect to physicians' service shall not be taken into account in such administrative or judicial review.

“(C) NO PRIOR DETERMINATION AFTER RECEIPT OF SERVICES.—Once an individual is provided physicians' services, there shall be no prior determination under this subsection with respect to such physicians' services.”.

(b) EFFECTIVE DATE; SUNSET; TRANSITION.—

(1) EFFECTIVE DATE.—The Secretary shall establish the prior determination process under the amendment made by subsection (a) in such a manner as to provide for the acceptance of requests for determinations under such process filed not later than 18 months after the date of the enactment of this Act.

(2) SUNSET.—Such prior determination process shall not apply to requests filed after the end of the 5-year period beginning on the first date on which requests for determinations under such process are accepted.

(3) TRANSITION.—During the period in which the amendment made by subsection (a) has become effective but contracts are not provided under section 1874A of the Social Security Act with medicare administrative contractors, any reference in section 1869(g) of such Act (as added by such amendment) to such a contractor is deemed a reference to a fiscal intermediary or carrier with an agreement under section 1816, or contract under section 1842, respectively, of such Act.

(4) LIMITATION ON APPLICATION TO SGR.—For purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)), the amendment made by subsection (a) shall not be considered to be a change in law or regulation.

(c) PROVISIONS RELATING TO ADVANCE BENEFICIARY NOTICES; REPORT ON PRIOR DETERMINATION PROCESS.—

(1) DATA COLLECTION.—The Secretary shall establish a process for the collection of information on the instances in which an advance beneficiary notice (as defined in paragraph (5)) has been provided and on instances in which a beneficiary indicates on such a notice that the beneficiary does not intend to seek to have the item or service that is the subject of the notice furnished.

(2) OUTREACH AND EDUCATION.—The Secretary shall establish a program of outreach and education for beneficiaries and providers of services and other persons on the appropriate use of advance beneficiary notices and coverage policies under the medicare program.

(3) GAO REPORT ON USE OF ADVANCE BENEFICIARY NOTICES.—Not later than 18 months after the date on which section 1869(h) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of advance beneficiary notices under title XVIII of such Act. Such report shall include information concerning the providers of services and other persons that have provided such notices and the response of beneficiaries to such notices.

(4) GAO REPORT ON USE OF PRIOR DETERMINATION PROCESS.—Not later than 36 months after the date on which section 1869(h) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of the prior determination process under such section. Such report shall include—

(A) information concerning—

(i) the number and types of procedures for which a prior determination has been sought;

(ii) determinations made under the process;

(iii) the percentage of beneficiaries prevailing;

(iv) in those cases in which the beneficiaries do not prevail, the reasons why such beneficiaries did not prevail; and

(v) changes in receipt of services resulting from the application of such process;

(B) an evaluation of whether the process was useful for physicians (and other suppliers) and beneficiaries, whether it was timely, and whether the amount of information required was burdensome to physicians and beneficiaries; and

(C) recommendations for improvements or continuation of such process.

(5) ADVANCE BENEFICIARY NOTICE DEFINED.—In this subsection, the term “advance beneficiary notice” means a written notice provided under section 1879(a) of the Social Security Act (42 U.S.C. 1395pp(a)) to an individual entitled to benefits under part A or enrolled under part B of title XVIII of such Act before items or services are furnished under such part in cases where a provider of services or other person that would furnish the item or service believes that payment will not be made for some or all of such items or services under such title.

SEC. 939. APPEALS BY PROVIDERS WHEN THERE IS NO OTHER PARTY AVAILABLE.

(a) IN GENERAL.—Section 1870 (42 U.S.C. 1395gg) is amended by adding at the end the following new subsection:

“(h) Notwithstanding subsection (f) or any other provision of law, the Secretary shall permit a provider of services or supplier to appeal

any determination of the Secretary under this title relating to services rendered under this title to an individual who subsequently dies if there is no other party available to appeal such determination.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 940. REVISIONS TO APPEALS TIMEFRAMES AND AMOUNTS.

(a) TIMEFRAMES.—Section 1869 (42 U.S.C. 1395ff) is amended—

(1) in subsection (a)(3)(C)(ii), by striking ''30-day period'' each place it appears and inserting ''60-day period''; and

(2) in subsection (c)(3)(C)(i), by striking ''30-day period'' and inserting ''60-day period''.

(b) AMOUNTS.—

(1) IN GENERAL.—Section 1869(b)(1)(E) (42 U.S.C. 1395ff(b)(1)(E)) is amended by adding at the end the following new clause:

''(iii) ADJUSTMENT OF DOLLAR AMOUNTS.—For requests for hearings or judicial review made in a year after 2004, the dollar amounts specified in clause (i) shall be equal to such dollar amounts increased by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount determined under the previous sentence that is not a multiple of $10 shall be rounded to the nearest multiple of $10.''.

(2) CONFORMING AMENDMENTS.—(A) Section 1852(g)(5) (42 U.S.C. 1395w–22(g)(5)) is amended by adding at the end the following: ''The provisions of section 1869(b)(1)(E)(iii) shall apply with respect to dollar amounts specified in the first 2 sentences of this paragraph in the same manner as they apply to the dollar amounts specified in section 1869(b)(1)(E)(i).''.

(B) Section 1876(b)(5)(B) (42 U.S.C. 1395mm(b)(5)(B)) is amended by adding at the end the following: ''The provisions of section 1869(b)(1)(E)(iii) shall apply with respect to dollar amounts specified in the first 2 sentences of this subparagraph in the same manner as they apply to the dollar amounts specified in section 1869(b)(1)(E)(i).''.

SEC. 940A. MEDIATION PROCESS FOR LOCAL COVERAGE DETERMINATIONS.

(a) IN GENERAL.—Section 1869 (42 U.S.C. 1395ff), as amended by section 938(a), is amended by adding at the end the following new subsection:

''(i) MEDIATION PROCESS FOR LOCAL COVERAGE DETERMINATIONS.—

''(1) ESTABLISHMENT OF PROCESS.—The Secretary shall establish a mediation process under this subsection through the use of a physician trained in mediation and employed by the Centers for Medicare & Medicaid Services.

''(2) RESPONSIBILITY OF MEDIATOR.—Under the process established in paragraph (1), such a mediator shall mediate in disputes between groups representing providers of services, suppliers (as defined in section 1861(d)), and the medical director for a medicare administrative contractor whenever the regional administrator (as defined by the Secretary) involved determines that there was a systematic pattern and a large volume of complaints from such groups regarding decisions of such director or there is a complaint from the co-chair of the advisory committee for that contractor to such regional administrator regarding such dispute.''.

(b) INCLUSION IN MAC CONTRACTS.—Section 1874A(b)(3)(A)(i), as added by section 911(a)(1), is amended by adding at the end the following: ''Such requirements shall include specific performance duties expected of a medical director of a medicare administrative contractor, including requirements relating to professional relations and the availability of such director to conduct medical determination activities within the jurisdiction of such a contractor.''.

Subtitle E—Miscellaneous Provisions

SEC. 941. POLICY DEVELOPMENT REGARDING EVALUATION AND MANAGEMENT (E & M) DOCUMENTATION GUIDELINES.

(a) IN GENERAL.—The Secretary may not implement any new or modified documentation guidelines (which for purposes of this section includes clinical examples) for evaluation and management physician services under the title XVIII of the Social Security Act on or after the date of the enactment of this Act unless the Secretary—

(1) has developed the guidelines in collaboration with practicing physicians (including both generalists and specialists) and provided for an assessment of the proposed guidelines by the physician community;

(2) has established a plan that contains specific goals, including a schedule, for improving the use of such guidelines;

(3) has conducted appropriate and representative pilot projects under subsection (b) to test such guidelines;

(4) finds, based on reports submitted under subsection (b)(5) with respect to pilot projects conducted for such or related guidelines, that the objectives described in subsection (c) will be met in the implementation of such guidelines; and

(5) has established, and is implementing, a program to educate physicians on the use of such guidelines and that includes appropriate outreach.

The Secretary shall make changes to the manner in which existing evaluation and management documentation guidelines are implemented to reduce paperwork burdens on physicians.

(b) PILOT PROJECTS TO TEST MODIFIED OR NEW EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES.—

(1) IN GENERAL.—With respect to proposed new or modified documentation guidelines referred to in subsection (a), the Secretary shall conduct under this subsection appropriate and representative pilot projects to test the proposed guidelines.

(2) LENGTH AND CONSULTATION.—Each pilot project under this subsection shall—

(A) be voluntary;

(B) be of sufficient length as determined by the Secretary (but in no case to exceed 1 year) to allow for preparatory physician and medicare contractor education, analysis, and use and assessment of potential evaluation and management guidelines; and

(C) be conducted, in development and throughout the planning and operational stages of the project, in consultation with practicing physicians (including both generalists and specialists).

(3) RANGE OF PILOT PROJECTS.—Of the pilot projects conducted under this subsection with respect to proposed new or modified documentation guidelines—

(A) at least one shall focus on a peer review method by physicians (not employed by a medicare contractor) which evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to codes used for billing purposes for such services;

(B) at least one shall focus on an alternative method to detailed guidelines based on physician documentation of face to face encounter time with a patient;

(C) at least one shall be conducted for services furnished in a rural area and at least one for services furnished outside such an area; and

(D) at least one shall be conducted in a setting where physicians bill under physicians' services in teaching settings and at least one shall be conducted in a setting other than a teaching setting.

(4) STUDY OF IMPACT.—Each pilot project shall examine the effect of the proposed guidelines on—

(A) different types of physician practices, including those with fewer than 10 full-time-equivalent employees (including physicians); and

(B) the costs of physician compliance, including education, implementation, auditing, and monitoring.

(5) REPORT ON PILOT PROJECTS.—Not later than 6 months after the date of completion of pilot projects carried out under this subsection with respect to a proposed guideline described in paragraph (1), the Secretary shall submit to Congress a report on the pilot projects. Each such report shall include a finding by the Secretary of whether the objectives described in subsection (c) will be met in the implementation of such proposed guideline.

(c) OBJECTIVES FOR EVALUATION AND MANAGEMENT GUIDELINES.—The objectives for modified evaluation and management documentation guidelines developed by the Secretary shall be to—

(1) identify clinically relevant documentation needed to code accurately and assess coding levels accurately;

(2) decrease the level of non-clinically pertinent and burdensome documentation time and content in the physician's medical record;

(3) increase accuracy by reviewers; and

(4) educate both physicians and reviewers.

(d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF DOCUMENTATION FOR PHYSICIAN CLAIMS.—

(1) STUDY.—The Secretary shall carry out a study of the matters described in paragraph (2).

(2) MATTERS DESCRIBED.—The matters referred to in paragraph (1) are—

(A) the development of a simpler, alternative system of requirements for documentation accompanying claims for evaluation and management physician services for which payment is made under title XVIII of the Social Security Act; and

(B) consideration of systems other than current coding and documentation requirements for payment for such physician services.

(3) CONSULTATION WITH PRACTICING PHYSICIANS.—In designing and carrying out the study under paragraph (1), the Secretary shall consult with practicing physicians, including physicians who are part of group practices and including both generalists and specialists.

(4) APPLICATION OF HIPAA UNIFORM CODING REQUIREMENTS.—In developing an alternative system under paragraph (2), the Secretary shall consider requirements of administrative simplification under part C of title XI of the Social Security Act.

(5) REPORT TO CONGRESS.—(A) Not later than October 1, 2005, the Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

(B) The Medicare Payment Advisory Commission shall conduct an analysis of the results of the study included in the report under subparagraph (A) and shall submit a report on such analysis to Congress.

(e) STUDY ON APPROPRIATE CODING OF CERTAIN EXTENDED OFFICE VISITS.—The Secretary shall conduct a study of the appropriateness of coding in cases of extended office visits in which there is no diagnosis made. Not later than October 1, 2005, the Secretary shall submit a report to Congress on such study and shall include recommendations on how to code appropriately for such visits in a manner that takes into account the amount of time the physician spent with the patient.

(f) DEFINITIONS.—In this section—

(1) the term ''rural area'' has the meaning given that term in section 1886(d)(2)(D) of the

Social Security Act (42 U.S.C. 1395ww(d)(2)(D)); and

(2) the term "teaching settings" are those settings described in section 415.150 of title 42, Code of Federal Regulations.

SEC. 942. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY AND COVERAGE.

(a) Council for Technology and Innovation.—Section 1868 (42 U.S.C. 1395ee) is amended—

(1) by adding at the end of the heading the following: "; COUNCIL FOR TECHNOLOGY AND INNOVATION";

(2) by inserting "Practicing Physicians Advisory Council.—(1)" after "(a)";

(3) in paragraph (1), as so redesignated under paragraph (2), by striking "in this section" and inserting "in this subsection";

(4) by redesignating subsections (b) and (c) as paragraphs (2) and (3), respectively; and

(5) by adding at the end the following new subsection:

"(b) Council for Technology and Innovation.—

"(1) Establishment.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as 'CMS').

"(2) Composition.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

"(3) Duties.—The Council shall coordinate the activities of coverage, coding, and payment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

"(4) Executive coordinator for technology and innovation.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title.".

(b) Methods for Determining Payment Basis for New Lab Tests.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following:

"(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2005 (in this paragraph referred to as 'new tests').

"(B) Determinations under subparagraph (A) shall be made only after the Secretary—

"(i) makes available to the public (through an Internet website and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

"(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

"(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

"(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet website and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

"(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet website and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

"(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

"(i) set forth the criteria for making determinations under subparagraph (A); and

"(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

"(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

"(E) For purposes of this paragraph:

"(i) The term 'HCPCS' refers to the Health Care Procedure Coding System.

"(ii) A code shall be considered to be 'substantially revised' if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).".

(c) GAO Study on Improvements in External Data Collection for Use in the Medicare Inpatient Payment System.—

(1) Study.—The Comptroller General of the United States shall conduct a study that analyzes which external data can be collected in a shorter timeframe by the Centers for Medicare & Medicaid Services for use in computing payments for inpatient hospital services. The study may include an evaluation of the feasibility and appropriateness of using quarterly samples or special surveys or any other methods. The study shall include an analysis of whether other executive agencies, such as the Bureau of Labor Statistics in the Department of Commerce, are best suited to collect this information.

(2) Report.—By not later than October 1, 2004, the Comptroller General shall submit a report to Congress on the study under paragraph (1).

SEC. 943. TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) In General.—The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to medicare secondary payor provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

(b) Reference Laboratory Services Described.—Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.

SEC. 944. EMTALA IMPROVEMENTS.

(a) Payment for EMTALA-Mandated Screening and Stabilization Services.—

(1) In general.—Section 1862 (42 U.S.C. 1395y) is amended by inserting after subsection (c) the following new subsection:

"(d) For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1867 to an individual who is entitled to benefits under this title, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.".

(2) Effective date.—The amendment made by paragraph (1) shall apply to items and services furnished on or after January 1, 2004.

(b) Notification of Providers When EMTALA Investigation Closed.—Section 1867(d) (42 U.S.C. 42 U.S.C. 1395dd(d)) is amended by adding at the end the following new paragraph:

"(4) Notice upon closing an investigation.—The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.".

(c) Prior Review by Peer Review Organizations in EMTALA Cases Involving Termination of Participation.—

(1) In general.—Section 1867(d)(3) (42 U.S.C. 1395dd(d)(3)) is amended—

(A) in the first sentence, by inserting "or in terminating a hospital's participation under this title" after "in imposing sanctions under paragraph (1)"; and

(B) by adding at the end the following new sentences: "Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this title for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.".

(2) Effective date.—The amendments made by paragraph (1) shall apply to terminations of participation initiated on or after the date of the enactment of this Act.

SEC. 945. EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP.

(a) Establishment.—The Secretary shall establish a Technical Advisory Group (in this section referred to as the "Advisory Group") to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA) and its implementation. In this section, the term "EMTALA" refers to the provisions of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

(b) MEMBERSHIP.—The Advisory Group shall be composed of 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and of which—

(1) 4 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of EMTALA and at least 2 of which have not been cited for EMTALA violations;

(2) 7 shall be practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;

(3) 2 shall represent patients;

(4) 2 shall be staff involved in EMTALA investigations from different regional offices of the Centers for Medicare & Medicaid Services; and

(5) 1 shall be from a State survey office involved in EMTALA investigations and 1 shall be from a peer review organization, both of whom shall be from areas other than the regions represented under paragraph (4).

In selecting members described in paragraphs (1) through (3), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients.

(c) GENERAL RESPONSIBILITIES.—The Advisory Group—

(1) shall review EMTALA regulations;

(2) may provide advice and recommendations to the Secretary with respect to those regulations and their application to hospitals and physicians;

(3) shall solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and

(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public.

(d) ADMINISTRATIVE MATTERS.—

(1) CHAIRPERSON.—The members of the Advisory Group shall elect a member to serve as chairperson of the Advisory Group for the life of the Advisory Group.

(2) MEETINGS.—The Advisory Group shall first meet at the direction of the Secretary. The Advisory Group shall then meet twice per year and at such other times as the Advisory Group may provide.

(e) TERMINATION.—The Advisory Group shall terminate 30 months after the date of its first meeting.

(f) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary shall establish the Advisory Group notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

SEC. 946. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following:

''(D) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.

''(E) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services of a registered professional nurse and are provided non-routinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive.''.

(b) CONFORMING PAYMENT PROVISION.—Section 1814(i) (42 U.S.C. 1395f(i)), as amended by section 512(b), is amended by adding at the end the following new paragraph:

''(5) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to hospice care provided on or after the date of the enactment of this Act.

SEC. 947. APPLICATION OF OSHA BLOODBORNE PATHOGENS STANDARD TO CERTAIN HOSPITALS.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc), as amended by section 506, is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (T), by striking ''and'' at the end;

(B) in subparagraph (U), by striking the period at the end and inserting '', and''; and

(C) by inserting after subparagraph (U) the following new subparagraph:

''(V) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 (or a State occupational safety and health plan that is approved under 18(b) of such Act), to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated).''; and

(2) by adding at the end of subsection (b) the following new paragraph:

''(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(V) (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

''(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(U) by a hospital that is subject to the provisions of such Act.

''(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.''.

(b) EFFECTIVE DATE.—The amendments made by this subsection (a) shall apply to hospitals as of July 1, 2004.

SEC. 948. BIPA-RELATED TECHNICAL AMENDMENTS AND CORRECTIONS.

(a) TECHNICAL AMENDMENTS RELATING TO ADVISORY COMMITTEE UNDER BIPA SECTION 522.—(1) Subsection (i) of section 1114 (42 U.S.C. 1314)—

(A) is transferred to section 1862 and added at the end of such section; and

(B) is redesignated as subsection (j).

(2) Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the last sentence of subsection (a), by striking ''established under section 1114(f)''; and

(B) in subsection (j), as so transferred and redesignated—

(i) by striking ''under subsection (f)''; and

(ii) by striking ''section 1862(a)(1)'' and inserting ''subsection (a)(1)''.

(b) TERMINOLOGY CORRECTIONS.—(1) Section 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)) is amended—

(A) in subclause (III), by striking ''policy'' and inserting ''determination''; and

(B) in subclause (IV), by striking ''medical review policies'' and inserting ''coverage determinations''.

(2) Section 1852(a)(2)(C) (42 U.S.C. 1395w-22(a)(2)(C)) is amended by striking ''policy'' and ''POLICY'' and inserting ''determination'' each place it appears and ''DETERMINATION'', respectively.

(c) REFERENCE CORRECTIONS.—Section 1869(f)(4) (42 U.S.C. 1395ff(f)(4)) is amended—

(1) in subparagraph (A)(iv), by striking ''subclause (I), (II), or (III)'' and inserting ''clause (i), (ii), or (iii)'';

(2) in subparagraph (B), by striking ''clause (i)(IV)'' and ''clause (i)(III)'' and inserting ''subparagraph (A)(iv)'' and ''subparagraph (A)(iii)'', respectively; and

(3) in subparagraph (C), by striking ''clause (i)'', ''subclause (IV)'' and ''subparagraph (A)'' and inserting ''subparagraph (A)'', ''clause (iv)'' and ''paragraph (1)(A)'', respectively each place it appears.

(d) OTHER CORRECTIONS.—Effective as if included in the enactment of section 521(c) of BIPA, section 1154(e) (42 U.S.C. 1320c–3(e)) is amended by striking paragraph (5).

(e) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall be effective as if included in the enactment of BIPA.

SEC. 949. CONFORMING AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a–7(c)(3)(B)) is amended to read as follows: ''Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of the administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both, the Secretary may, after consulting with the Inspector General of the Department of Health and Human Services, waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.''.

SEC. 950. TREATMENT OF CERTAIN DENTAL CLAIMS.

(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by adding at the end, after the subsection transferred and redesignated by section 948(a), the following new subsection:

''(k)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

''(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of the enactment of this Act.

SEC. 951. FURNISHING HOSPITALS WITH INFORMATION TO COMPUTE DSH FORMULA.

Beginning not later than 1 year after the date of the enactment of this Act, the Secretary shall arrange to furnish to subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage under such section for that hospital for the current cost reporting year. Such data shall also be furnished to other hospitals which would qualify for additional payments under part A of title XVIII of the Social Security Act on the basis of such data.

SEC. 952. REVISIONS TO REASSIGNMENT PROVISIONS.

(a) In General.—Section 1842(b)(6)(A) (42 U.S.C. 1395u(b)(6)(A)) is amended by striking "or (ii) (where the service was provided in a hospital, critical access hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service," and inserting "or (ii) where the service was provided under a contractual arrangement between such physician or other person and an entity, to the entity if, under the contractual arrangement, the entity submits the bill for the service and the contractual arrangement meets such program integrity and other safeguards as the Secretary may determine to be appropriate,".

(b) Conforming Amendment.—The second sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by striking "except to an employer or facility as described in clause (A)" and inserting "except to an employer or entity as described in subparagraph (A)".

(c) Effective Date.—The amendments made by this section shall apply to payments made on or after the date of the enactment of this Act.

SEC. 953. OTHER PROVISIONS.

(a) GAO Reports on the Physician Compensation.—

(1) Sustainable growth rate and updates.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the appropriateness of the updates in the conversion factor under subsection (d)(3) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), including the appropriateness of the sustainable growth rate formula under subsection (f) of such section for 2002 and succeeding years. Such report shall examine the stability and predictability of such updates and rate and alternatives for the use of such rate in the updates.

(2) Physician compensation generally.—Not later than 12 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on all aspects of physician compensation for services furnished under title XVIII of the Social Security Act, and how those aspects interact and the effect on appropriate compensation for physician services. Such report shall review alternatives for the physician fee schedule under section 1848 of such title (42 U.S.C. 1395w–4).

(b) Annual Publication of List of National Coverage Determinations.—The Secretary shall provide, in an appropriate annual publication available to the public, a list of national coverage determinations made under title XVIII of the Social Security Act in the previous year and information on how to get more information with respect to such determinations.

(c) GAO Report on Flexibility in Applying Home Health Conditions of Participation to Patients Who Are Not Medicare Beneficiaries.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the implications if there were flexibility in the application of the medicare conditions of participation for home health agencies with respect to groups or types of patients who are not medicare beneficiaries. The report shall include an analysis of the potential impact of such flexible application on clinical operations and the recipients of such services and an analysis of methods for monitoring the quality of care provided to such recipients.

(d) OIG Report on Notices Relating to Use of Hospital Lifetime Reserve Days.—Not later than 1 year after the date of the enactment of this Act, the Inspector General of the Department of Health and Human Services shall submit a report to Congress on—

(1) the extent to which hospitals provide notice to medicare beneficiaries in accordance with applicable requirements before they use the 60 lifetime reserve days described in section 1812(a)(1) of the Social Security Act (42 U.S.C. 1395d(a)(1)); and

(2) the appropriateness and feasibility of hospitals providing a notice to such beneficiaries before they completely exhaust such lifetime reserve days.

TITLE X—MEDICAID AND MISCELLANEOUS PROVISIONS

Subtitle A—Medicaid Provisions

SEC. 1001. MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

(a) Temporary Increase.—Section 1923(f)(3) (42 U.S.C. 1396r–4(f)(3)) is amended—

(1) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)"; and

(2) by adding at the end the following new subparagraphs:

"(C) Special, temporary increase in allotments on a one-time, non-cumulative basis.—The DSH allotment for any State (other than a State with a DSH allotment determined under paragraph (5))—

"(i) for fiscal year 2004 is equal to 116 percent of the DSH allotment for the State for fiscal year 2003 under this paragraph, notwithstanding subparagraph (B); and

"(ii) for each succeeding fiscal year is equal to the DSH allotment for the State for fiscal year 2004 or, in the case of fiscal years beginning with the fiscal year specified in subparagraph (D) for that State, the DSH allotment for the State for the previous fiscal year increased by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

"(D) Fiscal year specified.—For purposes of subparagraph (C)(ii), the fiscal year specified in this subparagraph for a State is the first fiscal year for which the Secretary estimates that the DSH allotment for that State will equal (or no longer exceed) the DSH allotment for that State under the law as in effect before the date of the enactment of this subparagraph.".

(b) Increase in Floor for Treatment as a Low DSH State.—Section 1923(f)(5) (42 U.S.C. 1396r–4(f)(5)) is amended—

(1) in the paragraph heading, by striking "EXTREMELY";

(2) by striking "In the case of" and inserting the following:

"(A) For fiscal years 2001 through 2003 for extremely low DSH states.—In the case of";

(3) by inserting "before fiscal year 2004" after "In subsequent years"; and

(4) by adding at the end the following:

"(B) For fiscal year 2004 and subsequent fiscal years.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2000, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2003, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for the State with respect to—

"(i) fiscal year 2004 shall be the DSH allotment for the State for fiscal year 2003 increased by 16 percent;

"(ii) each succeeding fiscal year before fiscal year 2009 shall be the DSH allotment for the State for the previous fiscal year increased by 16 percent; and

"(iii) fiscal year 2009 and any subsequent fiscal year, shall be the DSH allotment for the State for the previous year subject to an increase for inflation as provided in paragraph (3)(A).".

(c) Allotment Adjustment.—Section 1923(f) (42 U.S.C. 1396r–4(f)) is amended—

(1) in paragraph (3)(A), by striking "The DSH" and inserting "Except as provided in paragraph (6), the DSH";

(2) by redesignating paragraph (6) as paragraph (7); and

(3) by inserting after paragraph (5) the following:

"(6) Allotment adjustment.—Only with respect to fiscal year 2004 or 2005, if a statewide waiver under section 1115 is revoked or terminated before the end of either such fiscal year and there is no DSH allotment for the State, the Secretary shall—

"(A) permit the State whose waiver was revoked or terminated to submit an amendment to its State plan that would describe the methodology to be used by the State (after the effective date of such revocation or termination) to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities (other than State-owned institutions or facilities), on the basis of the proportion of patients served by such hospitals that are low-income patients with special needs; and

"(B) provide for purposes of this subsection for computation of an appropriate DSH allotment for the State for fiscal year 2004 or 2005 (or both) that would not exceed the amount allowed under paragraph (3)(B)(ii) and that does not result in greater expenditures under this title than would have been made if such waiver had not been revoked or terminated.

In determining the amount of an appropriate DSH allotment under subparagraph (B) for a State, the Secretary shall take into account the level of DSH expenditures for the State for the fiscal year preceding the fiscal year in which the waiver commenced.".

(d) Increased Reporting and Other Requirements To Ensure the Appropriate Use of Medicaid DSH Payment Adjustments.—Section 1923 (42 U.S.C. 1396r–4) is amended by adding at the end the following new subsection:

"(j) Annual Reports and Other Requirements Regarding Payment Adjustments.—With respect to fiscal year 2004 and each fiscal year thereafter, the Secretary shall require a State, as a condition of receiving a payment under section 1903(a)(1) with respect to a payment adjustment made under this section, to do the following:

"(1) Report.—The State shall submit an annual report that includes the following:

"(A) An identification of each disproportionate share hospital that received a payment adjustment under this section for the preceding fiscal year and the amount of the payment adjustment made to such hospital for the preceding fiscal year.

"(B) Such other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made under this section for the preceding fiscal year.

"(2) Independent certified audit.—The State shall annually submit to the Secretary an independent certified audit that verifies each of the following:

"(A) The extent to which hospitals in the State have reduced their uncompensated care costs to reflect the total amount of claimed expenditures made under this section.

"(B) Payments under this section to hospitals that comply with the requirements of subsection (g).

"(C) Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals described in paragraph (1)(A) of such subsection are included in the calculation of the hospital-specific limits under such subsection.

"(D) The State included all payments under this title, including supplemental payments, in the calculation of such hospital-specific limits.

"(E) The State has separately documented and retained a record of all of its costs under this title, claimed expenditures under this title, uninsured costs in determining payment adjustments under this section, and any payments made on behalf of the uninsured from payment adjustments under this section.".

(e) CLARIFICATION REGARDING NON-REGULATION OF TRANSFERS.—

(1) IN GENERAL.—Nothing in section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) shall be construed by the Secretary as prohibiting a State's use of funds as the non-Federal share of expenditures under title XIX of such Act where such funds are transferred from or certified by a publicly-owned regional medical center located in another State and described in paragraph (2), so long as the Secretary determines that such use of funds is proper and in the interest of the program under title XIX.

(2) CENTER DESCRIBED.—A center described in this paragraph is a publicly-owned regional medical center that—

(A) provides level 1 trauma and burn care service;

(B) provides level 3 neonatal care services;

(C) is obligated to serve all patients, regardless of State of origin;

(D) is located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 States, including the States described in paragraph (1);

(E) serves as a tertiary care provider for patients residing within a 125 mile radius; and

(F) meets the criteria for a disproportionate share hospital under section 1923 of such Act in at least one State other than the one in which the center is located.

(3) EFFECTIVE PERIOD.—This subsection shall apply through December 31, 2005.

SEC. 1002. CLARIFICATION OF INCLUSION OF INPATIENT DRUG PRICES CHARGED TO CERTAIN PUBLIC HOSPITALS IN THE BEST PRICE EXEMPTIONS FOR THE MEDICAID DRUG REBATE PROGRAM.

(a) IN GENERAL.—Section 1927(c)(1)(C)(i)(I) (42 U.S.C. 1396r–8(c)(1)(C)(i)(I)) is amended by inserting before the semicolon the following: "(including inpatient prices charged to hospitals described in section 340B(a)(4)(L) of the Public Health Service Act)".

(b) ANTI-DIVERSION PROTECTION.—Section 1927(c)(1)(C) (42 U.S.C. 1396r–8(c)(1)(C)) is amended by adding at the end the following:

"(iii) APPLICATION OF AUDITING AND RECORDKEEPING REQUIREMENTS.—With respect to a covered entity described in section 340B(a)(4)(L) of the Public Health Service Act, any drug purchased for inpatient use shall be subject to the auditing and recordkeeping requirements described in section 340B(a)(5)(C) of the Public Health Service Act.".

SEC. 1003. EXTENSION OF MORATORIUM.

(a) IN GENERAL.—Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993 and section 4758 of the Balanced Budget Act of 1997, is amended—

(1) by striking "until December 31, 2002", and

(2) by striking "Kent Community Hospital Complex in Michigan or."

(b) EFFECTIVE DATES.—

(1) PERMANENT EXTENSION.—The amendment made by subsection (a)(1) shall take effect as if included in the amendment made by section 4758 of the Balanced Budget Act of 1997.

(2) MODIFICATION.—The amendment made by subsection (a)(2) shall take effect on the date of enactment of this Act.

Subtitle B—Miscellaneous Provisions

SEC. 1011. FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.

(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—

(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary $250,000,000 for each of fiscal years 2005 through 2008 for the purpose of making allotments under this section for payments to eligible providers in States described in paragraph (1) or (2) of subsection (b).

(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

(b) STATE ALLOTMENTS.—

(1) BASED ON PERCENTAGE OF UNDOCUMENTED ALIENS.—

(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $167,000,000 of such amount to make allotments for such fiscal year in accordance with subparagraph (B).

(B) FORMULA.—The amount of the allotment for payments to eligible providers in each State for a fiscal year shall be equal to the product of—

(i) the total amount available for allotments under this paragraph for the fiscal year; and

(ii) the percentage of undocumented aliens residing in the State as compared to the total number of such aliens residing in all States, as determined by the Statistics Division of the Immigration and Naturalization Service, as of January 2003, based on the 2000 decennial census.

(2) BASED ON NUMBER OF UNDOCUMENTED ALIEN APPREHENSION STATES.—

(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $83,000,000 of such amount to make allotments, in addition to amounts allotted under paragraph (1), for such fiscal year for each of the 6 States with the highest number of undocumented alien apprehensions for such fiscal year.

(B) DETERMINATION OF ALLOTMENTS.—The amount of the allotment for each State described in subparagraph (A) for a fiscal year shall be equal to the product of—

(i) the total amount available for allotments under this paragraph for the fiscal year; and

(ii) the percentage of undocumented alien apprehensions in the State in that fiscal year as compared to the total of such apprehensions for all such States for the preceding fiscal year.

(C) DATA.—For purposes of this paragraph, the highest number of undocumented alien apprehensions for a fiscal year shall be based on the apprehension rates for the 4-consecutive-quarter period ending before the beginning of the fiscal year for which information is available for undocumented aliens in such States, as reported by the Department of Homeland Security.

(c) USE OF FUNDS.—

(1) AUTHORITY TO MAKE PAYMENTS.—From the allotments made for a State under subsection (b) for a fiscal year, the Secretary shall pay the amount (subject to the total amount available from such allotments) determined under paragraph (2) directly to eligible providers located in the State for the provision of eligible services to aliens described in paragraph (5) to the extent that the eligible provider was not otherwise reimbursed (through insurance or otherwise) for such services during that fiscal year.

(2) DETERMINATION OF PAYMENT AMOUNTS.—

(A) IN GENERAL.—Subject to subparagraph (B), the payment amount determined under this paragraph shall be an amount determined by the Secretary that is equal to the lesser of—

(i) the amount that the provider demonstrates was incurred for the provision of such services; or

(ii) amounts determined under a methodology established by the Secretary for purposes of this subsection.

(B) PRO-RATA REDUCTION.—If the amount of funds allotted to a State under subsection (b) for a fiscal year is insufficient to ensure that each eligible provider in that State receives the amount of payment calculated under subparagraph (A), the Secretary shall reduce that amount of payment with respect to each eligible provider to ensure that the entire amount allotted to the State for that fiscal year is paid to such eligible providers.

(3) METHODOLOGY.—In establishing a methodology under paragraph (2)(A)(ii), the Secretary—

(A) may establish different methodologies for types of eligible providers;

(B) may base payments for hospital services on estimated hospital charges, adjusted to estimated cost, through the application of hospital-specific cost-to-charge ratios;

(C) shall provide for the election by a hospital to receive either payments to the hospital for—

(i) hospital and physician services; or

(ii) hospital services and for a portion of the on-call payments made by the hospital to physicians; and

(D) shall make quarterly payments under this section to eligible providers.

If a hospital makes the election under subparagraph (C)(i), the hospital shall pass on payments for services of a physician to the physician and may not charge any administrative or other fee with respect to such payments.

(4) LIMITATION ON USE OF FUNDS.—Payments made to eligible providers in a State from allotments made under subsection (b) for a fiscal year may only be used for costs incurred in providing eligible services to aliens described in paragraph (5).

(5) ALIENS DESCRIBED.—For purposes of paragraphs (1) and (2), aliens described in this paragraph are any of the following:

(A) Undocumented aliens.

(B) Aliens who have been paroled into the United States at a United States port of entry for the purpose of receiving eligible services.

(C) Mexican citizens permitted to enter the United States for not more than 72 hours under the authority of a biometric machine readable border crossing identification card (also referred to as a "laser visa") issued in accordance with the requirements of regulations prescribed under section 101(a)(6) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(6)).

(d) APPLICATIONS; ADVANCE PAYMENTS.—

(1) DEADLINE FOR ESTABLISHMENT OF APPLICATION PROCESS.—

(A) IN GENERAL.—Not later than September 1, 2004, the Secretary shall establish a process under which eligible providers located in a State may request payments under subsection (c).

(B) INCLUSION OF MEASURES TO COMBAT FRAUD AND ABUSE.—The Secretary shall include in the process established under subparagraph (A) measures to ensure that inappropriate, excessive, or fraudulent payments are not made from the allotments determined under subsection (b), including certification by the eligible provider of the veracity of the payment request.

(2) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The process established under paragraph (1) may provide for making payments under this section for each quarter of a fiscal year on the basis of advance estimates of expenditures submitted by applicants for such payments and such other investigation as the Secretary may find necessary, and for making reductions or increases in the payments as necessary to adjust for any overpayment or underpayment for prior quarters of such fiscal year.

(e) DEFINITIONS.—In this section:

(1) ELIGIBLE PROVIDER.—The term "eligible provider" means a hospital, physician, or provider of ambulance services (including an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization).

(2) ELIGIBLE SERVICES.—The term "eligible services" means health care services required by the application of section 1867 of the Social Security Act (42 U.S.C. 1395dd), and related hospital inpatient and outpatient services and ambulance services (as defined by the Secretary).

(3) HOSPITAL.—The term "hospital" has the meaning given such term in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)), except that such term shall include a critical access hospital (as defined in section 1861(mm)(1) of such Act (42 U.S.C. 1395x(mm)(1)).

(4) PHYSICIAN.—The term "physician" has the meaning given that term in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

(5) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms "Indian tribe" and "tribal organization" have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(6) STATE.—The term "State" means the 50 States and the District of Columbia.

SEC. 1012. COMMISSION ON SYSTEMIC INTEROPERABILITY.

(a) ESTABLISHMENT.—The Secretary shall establish a commission to be known as the "Commission on Systemic Interoperability" (in this section referred to as the "Commission").

(b) DUTIES.—

(1) IN GENERAL.—The Commission shall develop a comprehensive strategy for the adoption and implementation of health care information technology standards, that includes a timeline and prioritization for such adoption and implementation.

(2) CONSIDERATIONS.—In developing the comprehensive health care information technology strategy under paragraph (1), the Commission shall consider—

(A) the costs and benefits of the standards, both financial impact and quality improvement;

(B) the current demand on industry resources to implement this Act and other electronic standards, including HIPAA standards; and

(C) the most cost-effective and efficient means for industry to implement the standards.

(3) NONINTERFERENCE.—In carrying out this section, the Commission shall not interfere with any standards development of adoption processes underway in the private or public sector and shall not replicate activities related to such standards or the national health information infrastructure underway within the Department of Health and Human Services.

(4) REPORT.—Not later than October 31, 2005, the Commission shall submit to the Secretary and to Congress a report describing the strategy developed under paragraph (1), including an analysis of the matters considered under paragraph (2).

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 11 members appointed as follows:

(A) The President shall appoint 3 members, one of whom the President shall designate as Chairperson.

(B) The Majority Leader of the Senate shall appoint 2 members.

(C) The Minority Leader of the Senate shall appoint 2 members.

(D) The Speaker of the House of Representatives shall appoint 2 members.

(E) The Minority Leader of the House of Representatives shall appoint 2 members.

(2) QUALIFICATIONS.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, health plans and integrated delivery systems, reimbursement of health facilities, practicing physicians, practicing pharmacists, and other providers of health services, health care technology and information systems, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

(d) TERMS.—Each member shall be appointed for the life of the Commission.

(e) COMPENSATION.—

(1) RATES OF PAY.—Members shall each be paid at a rate not to exceed the daily equivalent of the rate of basic pay for level IV of the Executive Schedule for each day (including travel time) during which they are engaged in the actual performance of duties vested in the Commission.

(2) PROHIBITION OF COMPENSATION OF FEDERAL EMPLOYEES.—Members of the Commission who are full-time officers or employees of the United States or Members of Congress may not receive additional pay, allowances, or benefits by reason of their service on the Commission.

(3) TRAVEL EXPENSES.—Each member shall receive travel expenses, including per diem in lieu of subsistence, in accordance with applicable provisions under subchapter I of chapter 57 of title 5, United States Code.

(f) QUORUM.—A majority of the members of the Commission shall constitute a quorum but a lesser number may hold hearings.

(g) DIRECTOR AND STAFF OF COMMISSION; EXPERTS AND CONSULTANTS.—

(1) DIRECTOR.—The Commission shall have a Director who shall be appointed by the Chairperson. The Director shall be paid at a rate not to exceed the rate of basic pay for level IV of the Executive Schedule.

(2) STAFF.—With the approval of the Commission, the Director may appoint and fix the pay of such additional personnel as the Director considers appropriate.

(3) APPLICABILITY OF CERTAIN CIVIL SERVICE LAWS.—The Director and staff of the Commission may be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of that title relating to classification and General Schedule pay rates, except that an individual so appointed may not receive pay in excess of level IV of the Executive Schedule.

(4) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the Director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(5) STAFF OF FEDERAL AGENCIES.—Upon request of the Chairperson, the head of any Federal department or agency may detail, on a reimbursable basis, any of the personnel of that department or agency to the Commission to assist it in carrying out its duties under this Act.

(h) POWERS OF COMMISSION.—

(1) HEARINGS AND SESSIONS.—The Commission may, for the purpose of carrying out this Act, hold hearings, sit and act at times and places, take testimony, and receive evidence as the Commission considers appropriate.

(2) POWERS OF MEMBERS AND AGENTS.—Any member or agent of the Commission may, if authorized by the Commission, take any action which the Commission is authorized to take by this section.

(3) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this Act. Upon request of the Chairperson of the Commission, the head of that department or agency shall furnish that information to the Commission.

(4) GIFTS, BEQUESTS, AND DEVISES.—The Commission may accept, use, and dispose of gifts, bequests, or devises of services or property, both real and personal, for the purpose of aiding or facilitating the work of the Commission. Gifts, bequests, or devises of money and proceeds from sales of other property received as gifts, bequests, or devises shall be deposited in the Treasury and shall be available for disbursement upon order of the Commission. For purposes of Federal income, estate, and gift taxes, property accepted under this subsection shall be considered as a gift, bequest, or devise to the United States.

(5) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the United States.

(6) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission, on a reimbursable basis, the administrative support services necessary for the Commission to carry out its responsibilities under this Act.

(7) CONTRACT AUTHORITY.—The Commission may enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5)).

(i) TERMINATION.—The Commission shall terminate on 30 days after submitting its report pursuant to subsection (b)(3).

(j) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 1013. RESEARCH ON OUTCOMES OF HEALTH CARE ITEMS AND SERVICES.

(a) RESEARCH, DEMONSTRATIONS, AND EVALUATIONS.—

(1) IMPROVEMENT OF EFFECTIVENESS AND EFFICIENCY.—

(A) IN GENERAL.—To improve the quality, effectiveness, and efficiency of health care delivered pursuant to the programs established under titles XVIII, XIX, and XXI of the Social Security Act, the Secretary acting through the Director of the Agency for Healthcare Research and Quality (in this section referred to as the "Director"), shall conduct and support research to meet the priorities and requests for scientific evidence and information identified by such programs with respect to—

(i) the outcomes, comparative clinical effectiveness, and appropriateness of health care items and services (including prescription drugs); and

(ii) strategies for improving the efficiency and effectiveness of such programs, including the ways in which such items and services are organized, managed, and delivered under such programs.

(B) SPECIFICATION.—To respond to priorities and information requests in subparagraph (A), the Secretary may conduct or support, by grant, contract, or interagency agreement, research, demonstrations, evaluations, technology assessments, or other activities, including the provision of technical assistance, scientific expertise, or methodological assistance.

(2) PRIORITIES.—

(A) IN GENERAL.—The Secretary shall establish a process to develop priorities that will

guide the research, demonstrations, and evaluation activities undertaken pursuant to this section.

(B) INITIAL LIST.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall establish an initial list of priorities for research related to health care items and services (including prescription drugs).

(C) PROCESS.—In carrying out subparagraph (A), the Secretary—

(i) shall ensure that there is broad and ongoing consultation with relevant stakeholders in identifying the highest priorities for research, demonstrations, and evaluations to support and improve the programs established under titles XVIII, XIX, and XXI of the Social Security Act;

(ii) may include health care items and services which impose a high cost on such programs, as well as those which may be underutilized or overutilized and which may significantly improve the prevention, treatment, or cure of diseases and conditions (including chronic conditions) which impose high direct or indirect costs on patients or society; and

(iii) shall ensure that the research and activities undertaken pursuant to this section are responsive to the specified priorities and are conducted in a timely manner.

(3) EVALUATION AND SYNTHESIS OF SCIENTIFIC EVIDENCE.—

(A) IN GENERAL.—The Secretary shall—

(i) evaluate and synthesize available scientific evidence related to health care items and services (including prescription drugs) identified as priorities in accordance with paragraph (2) with respect to the comparative clinical effectiveness, outcomes, appropriateness, and provision of such items and services (including prescription drugs);

(ii) identify issues for which existing scientific evidence is insufficient with respect to such health care items and services (including prescription drugs);

(iii) disseminate to prescription drug plans and MA–PD plans under part D of title XVIII of the Social Security Act, other health plans, and the public the findings made under clauses (i) and (ii); and

(iv) work in voluntary collaboration with public and private sector entities to facilitate the development of new scientific knowledge regarding health care items and services (including prescription drugs).

(B) INITIAL RESEARCH.—The Secretary shall complete the evaluation and synthesis of the initial research required by the priority list developed under paragraph (2)(B) not later than 18 months after the development of such list.

(C) DISSEMINATION.—

(i) IN GENERAL.—To enhance patient safety and the quality of health care, the Secretary shall make available and disseminate in appropriate formats to prescription drugs plans under part D, and MA–PD plans under part C, of title XVIII of the Social Security Act, other health plans, and the public the evaluations and syntheses prepared pursuant to subparagraph (A) and the findings of research conducted pursuant to paragraph (1). In carrying out this clause the Secretary, in order to facilitate the availability of such evaluations and syntheses or findings at every decision point in the health care system, shall—

(I) present such evaluations and syntheses or findings in a form that is easily understood by the individuals receiving health care items and services (including prescription drugs) under such plans and periodically assess that the requirements of this subclause have been met; and

(II) provide such evaluations and syntheses or findings and other relevant information through easily accessible and searchable electronic mechanisms, and in hard copy formats as appropriate.

(ii) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as—

(I) affecting the authority of the Secretary or the Commissioner of Food and Drugs under the Federal Food, Drug, and Cosmetic Act or the Public Health Service Act; or

(II) conferring any authority referred to in subclause (I) to the Director.

(D) ACCOUNTABILITY.—In carrying out this paragraph, the Secretary shall implement activities in a manner that—

(i) makes publicly available all scientific evidence relied upon and the methodologies employed, provided such evidence and method are not protected from public disclosure by section 1905 of title 18, United States Code, or other applicable law so that the results of the research, analyses, or syntheses can be evaluated or replicated; and

(ii) ensures that any information needs and unresolved issues identified in subparagraph (A)(ii) are taken into account in priority-setting for future research conducted by the Secretary.

(4) CONFIDENTIALITY.—

(A) IN GENERAL.—In making use of administrative, clinical, and program data and information developed or collected with respect to the programs established under titles XVIII, XIX, and XXI of the Social Security Act, for purposes of carrying out the requirements of this section or the activities authorized under title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), such data and information shall be protected in accordance with the confidentiality requirements of title IX of the Public Health Service Act.

(B) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require or permit the disclosure of data provided to the Secretary that is otherwise protected from disclosure under the Federal Food, Drug, and Cosmetic Act, section 1905 of title 18, United States Code, or other applicable law.

(5) EVALUATIONS.—The Secretary shall conduct and support evaluations of the activities carried out under this section to determine the extent to which such activities have had an effect on outcomes and utilization of health care items and services.

(6) IMPROVING INFORMATION AVAILABLE TO HEALTH CARE PROVIDERS, PATIENTS, AND POLICYMAKERS.—Not later than 18 months after the date of enactment of this Act, the Secretary shall identify options that could be undertaken in voluntary collaboration with private and public entities (as appropriate) for the—

(A) provision of more timely information through the programs established under. titles XVIII, XIX, and XXI of the Social Security Act, regarding the outcomes and quality of patient care, including clinical and patient-reported outcomes, especially with respect to interventions and conditions for which clinical trials would not be feasible or raise ethical concerns that are difficult to address;

(B) acceleration of the adoption of innovation and quality improvement under such programs; and

(C) development of management tools for the programs established under titles XIX and XXI of the Social Security Act, and with respect to the programs established under such titles, assess the feasibility of using administrative or claims data, to—

(i) improve oversight by State officials;

(ii) support Federal and State initiatives to improve the quality, safety, and efficiency of services provided under such programs; and

(iii) provide a basis for estimating the fiscal and coverage impact of Federal or State program and policy changes.

(b) RECOMMENDATIONS.—

(1) DISCLAIMER.—In carrying out this section, the Director shall—

(A) not mandate national standards of clinical practice or quality health care standards; and

(B) include in any recommendations resulting from projects funded and published by the Director, a corresponding reference to the prohibition described in subparagraph (A).

(2) REQUIREMENT FOR IMPLEMENTATION.—Research, evaluation, and communication activities performed pursuant to this section shall reflect the principle that clinicians and patients should have the best available evidence upon which to make choices in health care items and services, in providers, and in health care delivery systems, recognizing that patient subpopulations and patient and physician preferences may vary.

(3) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to provide the Director with authority to mandate a national standard or require a specific approach to quality measurement and reporting.

(c) RESEARCH WITH RESPECT TO DISSEMINATION.—The Secretary, acting through the Director, may conduct or support research with respect to improving methods of disseminating information in accordance with subsection (a)(3)(C).

(d) LIMITATION ON CMS.—The Administrator of the Centers for Medicare & Medicaid Services may not use data obtained in accordance with this section to withhold coverage of a prescription drug..

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2004, and such sums as may be necessary for each fiscal year thereafter.

SEC. 1014. HEALTH CARE THAT WORKS FOR ALL AMERICANS: CITIZENS HEALTH CARE WORKING GROUP.

(a) FINDINGS.—Congress finds the following:

(1) In order to improve the health care system, the American public must engage in an informed national public debate to make choices about the services they want covered, what health care coverage they want, and how they are willing to pay for coverage.

(2) More than a trillion dollars annually is spent on the health care system, yet—

(A) 41,000,000 Americans are uninsured;

(B) insured individuals do not always have access to essential, effective services to improve and maintain their health; and

(C) employers, who cover over 170,000,000 Americans, find providing coverage increasingly difficult because of rising costs and double digit premium increases.

(3) Despite increases in medical care spending that are greater than the rate of inflation, population growth, and Gross Domestic Product growth, there has not been a commensurate improvement in our health status as a nation.

(4) Health care costs for even just 1 member of a family can be catastrophic, resulting in medical bills potentially harming the economic stability of the entire family.

(5) Common life occurrences can jeopardize the ability of a family to retain private coverage or jeopardize access to public coverage.

(6) Innovations in health care access, coverage, and quality of care, including the use of technology, have often come from States, local communities, and private sector organizations, but more creative policies could tap this potential.

(7) Despite our Nation's wealth, the health care system does not provide coverage to all Americans who want it.

(b) PURPOSES.—The purposes of this section are—

(1) to provide for a nationwide public debate about improving the health care system to provide every American with the ability to obtain quality, affordable health care coverage; and

(2) to provide for a vote by Congress on the recommendations that result from the debate.

(c) ESTABLISHMENT.—The Secretary, acting through the Agency for Healthcare Research and Quality, shall establish an entity to be known as the Citizens' Health Care Working Group (referred to in this section as the "Working Group").

(d) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Working Group shall be composed of 15 members. One member shall be the Secretary. The Comptroller General of the United States shall appoint 14 members.

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of the Working Group shall include—

(i) consumers of health services that represent those individuals who have not had insurance within 2 years of appointment, that have had chronic illnesses, including mental illness, are disabled, and those who receive insurance coverage through medicare and medicaid; and

(ii) individuals with expertise in financing and paying for benefits and access to care, business and labor perspectives, and providers of health care.

The membership shall reflect a broad geographic representation and a balance between urban and rural representatives.

(B) PROHIBITED APPOINTMENTS.—Members of the Working Group shall not include Members of Congress or other elected government officials (Federal, State, or local). Individuals appointed to the Working Group shall not be paid employees or representatives of associations or advocacy organizations involved in the health care system.

(e) PERIOD OF APPOINTMENT.—Members of the Working Group shall be appointed for a life of the Working Group. Any vacancies shall not affect the power and duties of the Working Group but shall be filled in the same manner as the original appointment.

(f) DESIGNATION OF THE CHAIRPERSON.—Not later than 15 days after the date on which all members of the Working Group have been appointed under subsection (d)(1), the Comptroller General shall designate the chairperson of the Working Group.

(g) SUBCOMMITTEES.—The Working Group may establish subcommittees if doing so increases the efficiency of the Working Group in completing its tasks.

(h) DUTIES.—

(1) HEARINGS.—Not later than 90 days after the date of the designation of the chairperson under subsection (f), the Working Group shall hold hearings to examine—

(A) the capacity of the public and private health care systems to expand coverage options;

(B) the cost of health care and the effectiveness of care provided at all stages of disease;

(C) innovative State strategies used to expand health care coverage and lower health care costs;

(D) local community solutions to accessing health care coverage;

(E) efforts to enroll individuals currently eligible for public or private health care coverage;

(F) the role of evidence-based medical practices that can be documented as restoring, maintaining, or improving a patient's health, and the use of technology in supporting providers in improving quality of care and lowering costs; and

(G) strategies to assist purchasers of health care, including consumers, to become more aware of the impact of costs, and to lower the costs of health care.

(2) ADDITIONAL HEARINGS.—The Working Group may hold additional hearings on subjects other than those listed in paragraph (1) so long as such hearings are determined to be necessary by the Working Group in carrying out the purposes of this section. Such additional hearings do not have to be completed within the time period specified in paragraph (1) but shall not delay the other activities of the Working Group under this section.

(3) THE HEALTH REPORT TO THE AMERICAN PEOPLE.—Not later than 90 days after the hearings described in paragraphs (1) and (2) are completed, the Working Group shall prepare and make available to health care consumers through the Internet and other appropriate public channels, a report to be entitled, "The Health Report to the American People". Such report shall be understandable to the general public and include—

(A) a summary of—

(i) health care and related services that may be used by individuals throughout their life span;

(ii) the cost of health care services and their medical effectiveness in providing better quality of care for different age groups;

(iii) the source of coverage and payment, including reimbursement, for health care services;

(iv) the reasons people are uninsured or underinsured and the cost to taxpayers, purchasers of health services, and communities when Americans are uninsured or underinsured;

(v) the impact on health care outcomes and costs when individuals are treated in all stages of disease;

(vi) health care cost containment strategies; and

(vii) information on health care needs that need to be addressed;

(B) examples of community strategies to provide health care coverage or access;

(C) information on geographic-specific issues relating to health care;

(D) information concerning the cost of care in different settings, including institutional-based care and home and community-based care;

(E) a summary of ways to finance health care coverage; and

(F) the role of technology in providing future health care including ways to support the information needs of patients and providers.

(4) COMMUNITY MEETINGS.—

(A) IN GENERAL.—Not later than 1 year after the date on which all the members of the Working Group have been appointed under subsection (d)(1) and appropriations are first made available to carry out this section the Working Group shall initiate health care community meetings throughout the United States (in this paragraph referred to as "community meetings"). Such community meetings may be geographically or regionally based and shall be completed within 180 days after the initiation of the first meeting.

(B) NUMBER OF MEETINGS.—The Working Group shall hold a sufficient number of community meetings in order to receive information that reflects—

(i) the geographic differences throughout the United States;

(ii) diverse populations; and

(iii) a balance among urban and rural populations.

(C) MEETING REQUIREMENTS.—

(i) FACILITATOR.—A State health officer may be the facilitator at the community meetings.

(ii) ATTENDANCE.—At least 1 member of the Working Group shall attend and serve as chair of each community meeting. Other members may participate through interactive technology.

(iii) TOPICS.—The community meetings shall, at a minimum, address the following questions:

(I) What health care benefits and services should be provided?

(II) How does the American public want health care delivered?

(III) How should health care coverage be financed?

(IV) What trade-offs are the American public willing to make in either benefits or financing to ensure access to affordable, high quality health care coverage and services?

(iv) INTERACTIVE TECHNOLOGY.—The Working Group may encourage public participation in community meetings through interactive technology and other means as determined appropriate by the Working Group.

(D) INTERIM REQUIREMENTS.—Not later than 180 days after the date of completion of the community meetings, the Working Group shall prepare and make available to the public through the Internet and other appropriate public channels, an interim set of recommendations on health care coverage and ways to improve and strengthen the health care system based on the information and preferences expressed at the community meetings. There shall be a 90-day public comment period on such recommendations.

(i) RECOMMENDATIONS.—Not later than 120 days after the expiration of the public comment period described in subsection (h)(4)(D), the Working Group shall submit to Congress and the President a final set of recommendations.

(j) ADMINISTRATION.—

(1) EXECUTIVE DIRECTOR.—There shall be an Executive Director of the Working Group who shall be appointed by the chairperson of the Working Group in consultation with the members of the Working Group.

(2) COMPENSATION.—While serving on the business of the Working Group (including travel time), a member of the Working Group shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the chairperson of the Working Group. For purposes of pay and employment benefits, rights, and privileges, all personnel of the Working Group shall be treated as if they were employees of the Senate.

(3) INFORMATION FROM FEDERAL AGENCIES.—The Working Group may secure directly from any Federal department or agency such information as the Working Group considers necessary to carry out this section. Upon request of the Working Group, the head of such department or agency shall furnish such information.

(4) POSTAL SERVICES.—The Working Group may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(k) DETAIL.—Not more than 10 Federal Government employees employed by the Department of Labor and 10 Federal Government employees employed by the Department of Health and Human Services may be detailed to the Working Group under this section without further reimbursement. Any detail of an employee shall be without interruption or loss of civil service status or privilege.

(l) TEMPORARY AND INTERMITTENT SERVICES.—The chairperson of the Working Group may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(m) ANNUAL REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter during the existence of the Working Group, the Working Group shall report to Congress and make public a detailed description of the expenditures of the Working Group used to carry out its duties under this section.

(n) SUNSET OF WORKING GROUP.—The Working Group shall terminate on the date that is 2

years after the date on which all the members of the Working Group have been appointed under subsection (d)(1) and appropriations are first made available to carry out this section.

(o) ADMINISTRATION REVIEW AND COMMENTS.—Not later than 45 days after receiving the final recommendations of the Working Group under subsection (i), the President shall submit a report to Congress which shall contain—

(1) additional views and comments on such recommendations; and

(2) recommendations for such legislation and administrative actions as the President considers appropriate.

(p) REQUIRED CONGRESSIONAL ACTION.—Not later than 45 days after receiving the report submitted by the President under subsection (o), each committee of jurisdiction of Congress, the Committee on Finance of the Senate, the Committee on Health, Education, Labor, and Pensions of the Senate, the Committee on Ways and Means of the House of Representatives, the Committee on Energy and Commerce of the House of Representatives, Committee on Education and the Workforce of the House of Representatives, shall hold at least 1 hearing on such report and on the final recommendations of the Working Group submitted under subsection (i).

(q) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out this section, other than subsection (h)(3), $3,000,000 for each of fiscal years 2005 and 2006.

(2) HEALTH REPORT TO THE AMERICAN PEOPLE.—There are authorized to be appropriated for the preparation and dissemination of the Health Report to the American People described in subsection (h)(3), such sums as may be necessary for the fiscal year in which the report is required to be submitted.

SEC. 1015. FUNDING START-UP ADMINISTRATIVE COSTS FOR MEDICARE REFORM.

(a) IN GENERAL.—There are appropriated to carry out this Act (including the amendments made by this Act), to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund—

(1) not to exceed $1,000,000,000 for the Centers for Medicare & Medicaid Services; and

(2) not to exceed $500,000,000 for the Social Security Administration.

(b) AVAILABILITY.—Amounts provided under subsection (a) shall remain available until September 30, 2005.

(c) APPLICATION.—From amounts provided under subsection (a)(2), the Social Security Administration may reimburse the Internal Revenue Service for expenses in carrying out this Act (and the amendments made by this Act).

(d) TRANSFER.—The President may transfer amounts provided under subsection (a) between the Centers for Medicare & Medicaid Services and the Social Security Administration. Notice of such transfers shall be transmitted within 15 days to the authorizing committees of the House of Representatives and of the Senate.

SEC. 1016. HEALTH CARE INFRASTRUCTURE IMPROVEMENT PROGRAM.

Title XVIII is amended by adding at the end the following new section:

"HEALTH CARE INFRASTRUCTURE IMPROVEMENT PROGRAM

"SEC. 1897. (a) ESTABLISHMENT.—The Secretary shall establish a loan program that provides loans to qualifying hospitals for payment of the capital costs of projects described in subsection (d).

"(b) APPLICATION.—No loan may be provided under this section to a qualifying hospital except pursuant to an application that is submitted and approved in a time, manner, and form specified by the Secretary. A loan under this section shall be on such terms and conditions and meet such requirements as the Secretary determines appropriate.

"(c) SELECTION CRITERIA.—

"(1) IN GENERAL.—The Secretary shall establish criteria for selecting among qualifying hospitals that apply for a loan under this section. Such criteria shall consider the extent to which the project for which loan is sought is nationally or regionally significant, in terms of expanding or improving the health care infrastructure of the United States or the region or in terms of the medical benefit that the project will have.

"(2) QUALIFYING HOSPITAL DEFINED.—For purposes of this section, the term 'qualifying hospital' means a hospital that—

"(A) is engaged in research in the causes, prevention, and treatment of cancer; and

"(B) is designated as a cancer center for the National Cancer Institute or is designated by the State as the official cancer institute of the State.

"(d) PROJECTS.—A project described in this subsection is a project of a qualifying hospital that is designed to improve the health care infrastructure of the hospital, including construction, renovation, or other capital improvements.

"(e) STATE AND LOCAL PERMITS.—The provision of a loan under this section with respect to a project shall not—

"(1) relieve any recipient of the loan of any obligation to obtain any required State or local permit or approval with respect to the project;

"(2) limit the right of any unit of State or local government to approve or regulate any rate of return on private equity invested in the project; or

"(3) otherwise supersede any State or local law (including any regulation) applicable to the construction or operation of the project.

"(f) FORGIVENESS OF INDEBTEDNESS.—The Secretary may forgive a loan provided to a qualifying hospital under this section under terms and conditions that are analogous to the loan forgiveness provision for student loans under part D of title IV of the Higher Education Act of 1965 (20 U.S.C. 1087a et seq.), except that the Secretary shall condition such forgiveness on the establishment by the hospital of—

"(A) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of a State or region, including residents of rural areas;

"(B) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to multiple Indian tribes; and

"(C)(i) unique research resources (such as population databases); or

"(ii) an affiliation with an entity that has unique research resources.

"(g) FUNDING.—

"(1) IN GENERAL.—There are appropriated, out of amounts in the Treasury not otherwise appropriated, to carry out this section, $200,000,000, to remain available during the period beginning on July 1, 2004, and ending on September 30, 2008.

"(2) ADMINISTRATIVE COSTS.—From funds made available under paragraph (1), the Secretary may use, for the administration of this section, not more than $2,000,000 for each of fiscal years 2004 through 2008.

"(3) AVAILABILITY.—Amounts appropriated under this section shall be available for obligation on July 1, 2004.

"(h) REPORT TO CONGRESS.—Not later than 4 years after the date of the enactment of this section, the Secretary shall submit to Congress a report on the projects for which loans are provided under this section and a recommendation as to whether the Congress should authorize the Secretary to continue loans under this section beyond fiscal year 2008.".

TITLE XI—ACCESS TO AFFORDABLE PHARMACEUTICALS

Subtitle A—Access to Affordable Pharmaceuticals

SEC. 1101. 30-MONTH STAY-OF-EFFECTIVENESS PERIOD.

(a) ABBREVIATED NEW DRUG APPLICATIONS.—Section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) is amended—

(1) in paragraph (2)—

(A) by striking subparagraph (B) and inserting the following:

"(B) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—

"(i) AGREEMENT TO GIVE NOTICE.—An applicant that makes a certification described in subparagraph (A)(vii)(IV) shall include in the application a statement that the applicant will give notice as required by this subparagraph.

"(ii) TIMING OF NOTICE.—An applicant that makes a certification described in subparagraph (A)(vii)(IV) shall give notice as required under this subparagraph—

"(I) if the certification is in the application, not later than 20 days after the date of the postmark on the notice with which the Secretary informs the applicant that the application has been filed; or

"(II) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, regardless of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

"(iii) RECIPIENTS OF NOTICE.—An applicant required under this subparagraph to give notice shall give notice to—

"(I) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

"(II) the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent (or a representative of the holder designated to receive such a notice).

"(iv) CONTENTS OF NOTICE.—A notice required under this subparagraph shall—

"(I) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, use, or sale of the drug before the expiration of the patent referred to in the certification; and

"(II) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is invalid or will not be infringed."; and

(B) by adding at the end the following subparagraph:

"(D)(i) An applicant may not amend or supplement an application to seek approval of a drug referring to a different listed drug from the listed drug identified in the application as submitted to the Secretary.

"(ii) With respect to the drug for which an application is submitted, nothing in this subsection prohibits an applicant from amending or supplementing the application to seek approval of a different strength.

"(iii) Within 60 days after the date of the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Secretary shall issue guidance defining the term 'listed drug' for purposes of this subparagraph."; and

(2) in paragraph (5)—

(A) in subparagraph (B)—

(i) by striking "under the following" and inserting "by applying the following to each certification made under paragraph (2)(A)(vii)"; and

(ii) in clause (iii)—

(I) in the first sentence, by striking "unless" and all that follows and inserting "unless, before the expiration of 45 days after the date on which the notice described in paragraph (2)(B) is received, an action is brought for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under subsection (b)(1) or (c)(2) before the date on which the application (excluding an amendment or supplement to the application), which the Secretary later determines to be substantially complete, was submitted."; and

(II) in the second sentence—

(aa) by striking subclause (I) and inserting the following:

"(I) if before the expiration of such period the district court decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity), the approval shall be made effective on—

"(aa) the date on which the court enters judgment reflecting the decision; or

"(bb) the date of a settlement order or consent decree signed and entered by the court stating that the patent that is the subject of the certification is invalid or not infringed;";

(bb) by striking subclause (II) and inserting the following:

"(II) if before the expiration of such period the district court decides that the patent has been infringed—

"(aa) if the judgment of the district court is appealed, the approval shall be made effective on—

"(AA) the date on which the court of appeals decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity); or

"(BB) the date of a settlement order or consent decree signed and entered by the court of appeals stating that the patent that is the subject of the certification is invalid or not infringed; or

"(bb) if the judgment of the district court is not appealed or is affirmed, the approval shall be made effective on the date specified by the district court in a court order under section 271(e)(4)(A) of title 35, United States Code;";

(cc) in subclause (III), by striking "on the date of such court decision." and inserting "as provided in subclause (I); or";

(dd) by inserting after subclause (III) the following:

"(IV) if before the expiration of such period the court grants a preliminary injunction prohibiting the applicant from engaging in the commercial manufacture or sale of the drug until the court decides the issues of patent validity and infringement and if the court decides that such patent has been infringed, the approval shall be made effective as provided in subclause (II)."; and

(ee) in the matter after and below subclause (IV) (as added by item (dd)), by striking "Until the expiration" and all that follows;

(B) by redesignating subparagraphs (C) and (D) as subparagraphs (E) and (F), respectively; and

(C) by inserting after subparagraph (B) the following:

"(C) CIVIL ACTION TO OBTAIN PATENT CERTAINTY.—

"(i) DECLARATORY JUDGMENT ABSENT INFRINGEMENT ACTION.—

"(I) IN GENERAL.—No action may be brought under section 2201 of title 28, United States Code, by an applicant under paragraph (2) for a declaratory judgment with respect to a patent which is the subject of the certification referred to in subparagraph (B)(iii) unless—

"(aa) the forty-five day period referred to in such subparagraph has expired;

"(bb) neither the owner of such patent nor the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brought a civil action against the applicant for infringement of the patent before the expiration of such period; and

"(cc) in any case in which the notice provided under paragraph (2)(B) relates to noninfringement, the notice was accompanied by a document described in subclause (III).

"(II) FILING OF CIVIL ACTION.—If the conditions described in items (aa), (bb), and as applicable, (cc) of subclause (I) have been met, the applicant referred to in such subclause may, in accordance with section 2201 of title 28, United States Code, bring a civil action under such section against the owner or holder referred to in such subclause (but not against any owner or holder that has brought such a civil action against the applicant, unless that civil action was dismissed without prejudice) for a declaratory judgment that the patent is invalid or will not be infringed by the drug for which the applicant seeks approval, except that such civil action may be brought for a declaratory judgment that the patent will not be infringed only in a case in which the condition described in subclause (I)(cc) is applicable. A civil action referred to in this subclause shall be brought in the judicial district where the defendant has its principal place of business or a regular and established place of business.

"(III) OFFER OF CONFIDENTIAL ACCESS TO APPLICATION.—For purposes of subclause (I)(cc), the document described in this subclause is a document providing an offer of confidential access to the application that is in the custody of the applicant under paragraph (2) for the purpose of determining whether an action referred to in subparagraph (B)(iii) should be brought. The document providing the offer of confidential access shall contain such restrictions as to persons entitled to access, and on the use and disposition of any information accessed, as would apply had a protective order been entered for the purpose of protecting trade secrets and other confidential business information. A request for access to an application under an offer of confidential access shall be considered acceptance of the offer of confidential access with the restrictions as to persons entitled to access, and on the use and disposition of any information accessed, contained in the offer of confidential access, and those restrictions and other terms of the offer of confidential access shall be considered terms of an enforceable contract. Any person provided an offer of confidential access shall review the application for the sole and limited purpose of evaluating possible infringement of the patent that is the subject of the certification under paragraph (2)(A)(vii)(IV) and for no other purpose, and may not disclose information of no relevance to any issue of patent infringement to any person other than a person provided an offer of confidential access. Further, the application may be redacted by the applicant to remove any information of no relevance to any issue of patent infringement.

"(ii) COUNTERCLAIM TO INFRINGEMENT ACTION.—

"(I) IN GENERAL.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brings a patent infringement action against the applicant, the applicant may assert a counterclaim seeking an order requiring the holder to correct or delete the patent information submitted by the holder under subsection (b) or (c) on the ground that the patent does not claim either—

"(aa) the drug for which the application was approved; or

"(bb) an approved method of using the drug.

"(II) NO INDEPENDENT CAUSE OF ACTION.—Subclause (I) does not authorize the assertion of a claim described in subclause (I) in any civil action or proceeding other than a counterclaim described in subclause (I).

"(iii) NO DAMAGES.—An applicant shall not be entitled to damages in a civil action under clause (i) or a counterclaim under clause (ii).".

(b) APPLICATIONS GENERALLY.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended—

(1) in subsection (b)—

(A) by striking paragraph (3) and inserting the following:

"(3) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—

"(A) AGREEMENT TO GIVE NOTICE.—An applicant that makes a certification described in paragraph (2)(A)(iv) shall include in the application a statement that the applicant will give notice as required by this paragraph.

"(B) TIMING OF NOTICE.—An applicant that makes a certification described in paragraph (2)(A)(iv) shall give notice as required under this paragraph—

"(i) if the certification is in the application, not later than 20 days after the date of the postmark on the notice with which the Secretary informs the applicant that the application has been filed; or

"(ii) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, regardless of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

"(C) RECIPIENTS OF NOTICE.—An applicant required under this paragraph to give notice shall give notice to—

"(i) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

"(ii) the holder of the approved application under this subsection for the drug that is claimed by the patent or a use of which is claimed by the patent (or a representative of the holder designated to receive such a notice).

"(D) CONTENTS OF NOTICE.—A notice required under this paragraph shall—

"(i) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, use, or sale of the drug before the expiration of the patent referred to in the certification; and

"(ii) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is invalid or will not be infringed."; and

(B)(i) by redesignating paragraph (4) as paragraph (5); and

(ii) by inserting after paragraph (3) the following paragraph:

"(4)(A) An applicant may not amend or supplement an application referred to in paragraph (2) to seek approval of a drug that is a different drug than the drug identified in the application as submitted to the Secretary.

"(B) With respect to the drug for which such an application is submitted, nothing in this subsection or subsection (c)(3) prohibits an applicant from amending or supplementing the application to seek approval of a different strength."; and

(2) in subsection (c)(3)—

(A) in the first sentence, by striking "under the following" and inserting "by applying the following to each certification made under subsection (b)(2)(A)";

(B) in subparagraph (C)—

(i) in the first sentence, by striking "unless" and all that follows and inserting "unless, before the expiration of 45 days after the date on which the notice described in subsection (b)(3) is received, an action is brought for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under paragraph (2) or subsection (b)(1) before the date on which the application (excluding an amendment or supplement to the application) was submitted.";

(ii) in the second sentence—

(I) by striking "paragraph (3)(B)" and inserting "subsection (b)(3)";

(II) by striking clause (i) and inserting the following:

"(i) if before the expiration of such period the district court decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity), the approval shall be made effective on—

"(I) the date on which the court enters judgment reflecting the decision; or

"(II) the date of a settlement order or consent decree signed and entered by the court stating that the patent that is the subject of the certification is invalid or not infringed;";

(III) by striking clause (ii) and inserting the following:

"(ii) if before the expiration of such period the district court decides that the patent has been infringed—

"(I) if the judgment of the district court is appealed, the approval shall be made effective on—

"(aa) the date on which the court of appeals decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity); or

"(bb) the date of a settlement order or consent decree signed and entered by the court of appeals stating that the patent that is the subject of the certification is invalid or not infringed; or

"(II) if the judgment of the district court is not appealed or is affirmed, the approval shall be made effective on the date specified by the district court in a court order under section 271(e)(4)(A) of title 35, United States Code;";

(IV) in clause (iii), by striking "on the date of such court decision." and inserting "as provided in clause (i); or";

(V) by inserting after clause (iii), the following:

"(iv) if before the expiration of such period the court grants a preliminary injunction prohibiting the applicant from engaging in the commercial manufacture or sale of the drug until the court decides the issues of patent validity and infringement and if the court decides that such patent has been infringed, the approval shall be made effective as provided in clause (ii)."; and

(VI) in the matter after and below clause (iv) (as added by subclause (V)), by striking "Until the expiration" and all that follows; and

(iii) in the third sentence, by striking "paragraph (3)(B)" and inserting "subsection (b)(3)";

(C) by redesignating subparagraph (D) as subparagraph (E); and

(D) by inserting after subparagraph (C) the following:

"(D) CIVIL ACTION TO OBTAIN PATENT CERTAINTY.—

"(i) DECLARATORY JUDGMENT ABSENT INFRINGEMENT ACTION.—

"(I) IN GENERAL.—No action may be brought under section 2201 of title 28, United States Code, by an applicant referred to in subsection (b)(2) for a declaratory judgment with respect to a patent which is the subject of the certification referred to in subparagraph (C) unless—

"(aa) the forty-five day period referred to in such subparagraph has expired;

"(bb) neither the owner of such patent nor the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brought a civil action against the applicant for infringement of the patent before the expiration of such period; and

"(cc) in any case in which the notice provided under paragraph (2)(B) relates to noninfringement, the notice was accompanied by a document described in subclause (III).

"(II) FILING OF CIVIL ACTION.—If the conditions described in items (aa), (bb), and as applicable, (cc) of subclause (I) have been met, the applicant referred to in such subclause may, in accordance with section 2201 of title 28, United States Code, bring a civil action under such section against the owner or holder referred to in such subclause (but not against any owner or holder that has brought such a civil action against the applicant, unless that civil action was dismissed without prejudice) for a declaratory judgment that the patent is invalid or will not be infringed by the drug for which the applicant seeks approval, except that such civil action may be brought for a declaratory judgment that the patent will not be infringed only in a case in which the condition described in subclause (I)(cc) is applicable. A civil action referred to in this subclause shall be brought in the judicial district where the defendant has its principal place of business or a regular and established place of business.

"(III) OFFER OF CONFIDENTIAL ACCESS TO APPLICATION.—For purposes of subclause (I)(cc), the document described in this subclause is a document providing an offer of confidential access to the application that is in the custody of the applicant referred to in subsection (b)(2) for the purpose of determining whether an action referred to in subparagraph (C) should be brought. The document providing the offer of confidential access shall contain such restrictions as to persons entitled to access, and on the use and disposition of any information accessed, as would apply had a protective order been entered for the purpose of protecting trade secrets and other confidential business information. A request for access to an application under an offer of confidential access shall be considered acceptance of the offer of confidential access with the restrictions as to persons entitled to access, and on the use and disposition of any information accessed, contained in the offer of confidential access, and those restrictions and other terms of the offer of confidential access shall be considered terms of an enforceable contract. Any person provided an offer of confidential access shall review the application for the sole and limited purpose of evaluating possible infringement of the patent that is the subject of the certification under subsection (b)(2)(A)(iv) and for no other purpose, and may not disclose information of no relevance to any issue of patent infringement to any person other than a person provided an offer of confidential access. Further, the application may be redacted by the applicant to remove any information of no relevance to any issue of patent infringement.

"(ii) COUNTERCLAIM TO INFRINGEMENT ACTION.—

"(I) IN GENERAL.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brings a patent infringement action against the applicant, the applicant may assert a counterclaim seeking an order requiring the holder to correct or delete the patent information submitted by the holder under subsection (b) or this subsection on the ground that the patent does not claim either—

"(aa) the drug for which the application was approved; or

"(bb) an approved method of using the drug.

"(II) NO INDEPENDENT CAUSE OF ACTION.—Subclause (I) does not authorize the assertion of a claim described in subclause (I) in any civil action or proceeding other than a counterclaim described in subclause (I).

"(iii) NO DAMAGES.—An applicant shall not be entitled to damages in a civil action under clause (i) or a counterclaim under clause (ii).".

(c) APPLICABILITY.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by subsections (a) and (b), apply to any proceeding under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) that is pending on or after the date of the enactment of this Act regardless of the date on which the proceeding was commenced or is commenced.

(2) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—The amendments made by subsections (a)(1) and (b)(1) apply with respect to any certification under subsection (b)(2)(A)(iv) or (j)(2)(A)(vii)(IV) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) submitted on or after August 18, 2003, in an application filed under subsection (b) or (j) of that section or in an amendment or supplement to an application filed under subsection (b) or (j) of that section.

(3) EFFECTIVE DATE OF APPROVAL.—The amendments made by subsections (a)(2)(A)(ii)(I) and (b)(2)(B)(i) apply with respect to any patent information submitted under subsection (b)(1) or (c)(2) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) on or after August 18, 2003.

(d) INFRINGEMENT ACTIONS.—Section 271(e) of title 35, United States Code, is amended by adding at the end the following:

"(5) Where a person has filed an application described in paragraph (2) that includes a certification under subsection (b)(2)(A)(iv) or (j)(2)(A)(vii)(IV) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), and neither the owner of the patent that is the subject of the certification nor the holder of the approved application under subsection (b) of such section for the drug that is claimed by the patent or a use of which is claimed by the patent brought an action for infringement of such patent before the expiration of 45 days after the date on which the notice given under subsection (b)(3) or (j)(2)(B) of such section was received, the courts of the United States shall, to the extent consistent with the Constitution, have subject matter jurisdiction in any action brought by such person under section 2201 of title 28 for a declaratory judgment that such patent is invalid or not infringed.".

SEC. 1102. FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.

(a) IN GENERAL.—Section 505(j)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)) (as amended by section 1101) is amended—

(1) in subparagraph (B), by striking clause (iv) and inserting the following:

"(iv) 180-DAY EXCLUSIVITY PERIOD.—

"(I) EFFECTIVENESS OF APPLICATION.—Subject to subparagraph (D), if the application contains a certification described in paragraph (2)(A)(vii)(IV) and is for a drug for which a first applicant has submitted an application containing such a certification, the application shall be made effective on the date that is 180 days after the date of the first commercial marketing of the drug (including the commercial marketing of the listed drug) by any first applicant.

"(II) DEFINITIONS.—In this paragraph:

"(aa) 180-DAY EXCLUSIVITY PERIOD.—The term '180-day exclusivity period' means the 180-day period ending on the day before the date on which an application submitted by an applicant other than a first applicant could become effective under this clause.

"(bb) FIRST APPLICANT.—As used in this subsection, the term 'first applicant' means an applicant that, on the first day on which a substantially complete application containing a certification described in paragraph (2)(A)(vii)(IV) is submitted for approval of a drug, submits a substantially complete application that contains and lawfully maintains a certification described in paragraph (2)(A)(vii)(IV) for the drug.

"(cc) SUBSTANTIALLY COMPLETE APPLICATION.—As used in this subsection, the term 'substantially complete application' means an application under this subsection that on its face is sufficiently complete to permit a substantive review and contains all the information required by paragraph (2)(A).

"(dd) TENTATIVE APPROVAL.—

"(AA) IN GENERAL.—The term 'tentative approval' means notification to an applicant by the Secretary that an application under this subsection meets the requirements of paragraph (2)(A), but cannot receive effective approval because the application does not meet the requirements of this subparagraph, there is a period of exclusivity for the listed drug under subparagraph (F) or section 505A, or there is a 7-year period of exclusivity for the listed drug under section 527.

"(BB) LIMITATION.—A drug that is granted tentative approval by the Secretary is not an approved drug and shall not have an effective approval until the Secretary issues an approval after any necessary additional review of the application."; and

(2) by inserting after subparagraph (C) the following:

"(D) FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.—

"(i) DEFINITION OF FORFEITURE EVENT.—In this subparagraph, the term 'forfeiture event', with respect to an application under this subsection, means the occurrence of any of the following:

"(I) FAILURE TO MARKET.—The first applicant fails to market the drug by the later of—

"(aa) the earlier of the date that is—

"(AA) 75 days after the date on which the approval of the application of the first applicant is made effective under subparagraph (B)(iii); or

"(BB) 30 months after the date of submission of the application of the first applicant; or

"(bb) with respect to the first applicant or any other applicant (which other applicant has received tentative approval), the date that is 75 days after the date as of which, as to each of the patents with respect to which the first applicant submitted and lawfully maintained a certification qualifying the first applicant for the 180-day exclusivity period under subparagraph (B)(iv), at least 1 of the following has occurred:

"(AA) In an infringement action brought against that applicant with respect to the patent or in a declaratory judgment action brought by that applicant with respect to the patent, a court enters a final decision from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the patent is invalid or not infringed.

"(BB) In an infringement action or a declaratory judgment action described in subitem (AA), a court signs a settlement order or consent decree that enters a final judgment that includes a finding that the patent is invalid or not infringed.

"(CC) The patent information submitted under subsection (b) or (c) is withdrawn by the holder of the application approved under subsection (b).

"(II) WITHDRAWAL OF APPLICATION.—The first applicant withdraws the application or the Secretary considers the application to have been withdrawn as a result of a determination by the Secretary that the application does not meet the requirements for approval under paragraph (4).

"(III) AMENDMENT OF CERTIFICATION.—The first applicant amends or withdraws the certification for all of the patents with respect to which that applicant submitted a certification qualifying the applicant for the 180-day exclusivity period.

"(IV) FAILURE TO OBTAIN TENTATIVE APPROVAL.—The first applicant fails to obtain tentative approval of the application within 30 months after the date on which the application is filed, unless the failure is caused by a change in or a review of the requirements for approval of the application imposed after the date on which the application is filed.

"(V) AGREEMENT WITH ANOTHER APPLICANT, THE LISTED DRUG APPLICATION HOLDER, OR A PATENT OWNER.—The first applicant enters into an agreement with another applicant under this subsection for the drug, the holder of the application for the listed drug, or an owner of the patent that is the subject of the certification under paragraph (2)(A)(vii)(IV), the Federal Trade Commission or the Attorney General files a complaint, and there is a final decision of the Federal Trade Commission or the court with regard to the complaint from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the agreement has violated the antitrust laws (as defined in section 1 of the Clayton Act (15 U.S.C. 12), except that the term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that that section applies to unfair methods of competition).

"(VI) EXPIRATION OF ALL PATENTS.—All of the patents as to which the applicant submitted a certification qualifying it for the 180-day exclusivity period have expired.

"(ii) FORFEITURE.—The 180-day exclusivity period described in subparagraph (B)(iv) shall be forfeited by a first applicant if a forfeiture event occurs with respect to that first applicant.

"(iii) SUBSEQUENT APPLICANT.—If all first applicants forfeit the 180-day exclusivity period under clause (ii)—

"(I) approval of any application containing a certification described in paragraph (2)(A)(vii)(IV) shall be made effective in accordance with subparagraph (B)(iii); and

"(II) no applicant shall be eligible for a 180-day exclusivity period.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) shall be effective only with respect to an application filed under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) after the date of the enactment of this Act for a listed drug for which no certification under section 505(j)(2)(A)(vii)(IV) of that Act was made before the date of the enactment of this Act.

(2) COLLUSIVE AGREEMENTS.—If a forfeiture event described in section 505(j)(5)(D)(i)(V) of that Act occurs in the case of an applicant, the applicant shall forfeit the 180-day period under section 505(j)(5)(B)(iv) of that Act without regard to when the first certification under section 505(j)(2)(A)(vii)(IV) of that Act for the listed drug was made.

(3) DECISION OF A COURT WHEN THE 180-DAY EXCLUSIVITY PERIOD HAS NOT BEEN TRIGGERED.—With respect to an application filed before, on, or after the date of the enactment of this Act for a listed drug for which a certification under section 505(j)(2)(A)(vii)(IV) of that Act was made before the date of the enactment of this Act and for which neither of the events described in subclause (I) or (II) of section 505(j)(5)(B)(iv) of that Act (as in effect on the day before the date of the enactment of this Act) has occurred on or before the date of the enactment of this Act, the term "decision of a court" as used in clause (iv) of section 505(j)(5)(B) of that Act means a final decision of a court from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken.

SEC. 1103. BIOAVAILABILITY AND BIOEQUIVALENCE.

(a) IN GENERAL.—Section 505(j)(8) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(8)) is amended—

(1) by striking subparagraph (A) and inserting the following:

"(A)(i) The term 'bioavailability' means the rate and extent to which the active ingredient or therapeutic ingredient is absorbed from a drug and becomes available at the site of drug action.

"(ii) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may assess bioavailability by scientifically valid measurements intended to reflect the rate and extent to which the active ingredient or therapeutic ingredient becomes available at the site of drug action."; and

(2) by adding at the end the following:

"(C) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may establish alternative, scientifically valid methods to show bioequivalence if the alternative methods are expected to detect a significant difference between the drug and the listed drug in safety and therapeutic effect.".

(b) EFFECT OF AMENDMENT.—The amendment made by subsection (a) does not alter the standards for approval of drugs under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

SEC. 1104. CONFORMING AMENDMENTS.

Section 505A of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355a) is amended—

(1) in subsections (b)(1)(A)(i) and (c)(1)(A)(i), by striking "(j)(5)(D)(ii)" each place it appears and inserting "(j)(5)(F)(ii)";

(2) in subsections (b)(1)(A)(ii) and (c)(1)(A)(ii), by striking "(j)(5)(D)" each place it appears and inserting "(j)(5)(F)"; and

(3) in subsections (e) and (l), by striking "505(j)(5)(D)" each place it appears and inserting "505(j)(5)(F)".

Subtitle B—Federal Trade Commission Review

SEC. 1111. DEFINITIONS.

In this subtitle:

(1) ANDA.—The term "ANDA" means an abbreviated drug application, as defined under section 201(aa) of the Federal Food, Drug, and Cosmetic Act.

(2) ASSISTANT ATTORNEY GENERAL.—The term "Assistant Attorney General" means the Assistant Attorney General in charge of the Antitrust Division of the Department of Justice.

(3) BRAND NAME DRUG.—The term "brand name drug" means a drug for which an application is approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act, including an application referred to in section 505(b)(2) of such Act.

(4) BRAND NAME DRUG COMPANY.—The term "brand name drug company" means the party that holds the approved application referred to in paragraph (3) for a brand name drug that is a listed drug in an ANDA, or a party that is the owner of a patent for which information is submitted for such drug under subsection (b) or (c) of section 505 of the Federal Food, Drug, and Cosmetic Act.

(5) COMMISSION.—The term "Commission" means the Federal Trade Commission.

(6) GENERIC DRUG.—The term "generic drug" means a drug for which an application under

section 505(j) of the Federal Food, Drug, and Cosmetic Act is approved.

(7) GENERIC DRUG APPLICANT.—The term "generic drug applicant" means a person who has filed or received approval for an ANDA under section 505(j) of the Federal Food, Drug, and Cosmetic Act.

(8) LISTED DRUG.—The term "listed drug" means a brand name drug that is listed under section 505(j)(7) of the Federal Food, Drug, and Cosmetic Act.

SEC. 1112. NOTIFICATION OF AGREEMENTS.

(a) AGREEMENT WITH BRAND NAME DRUG COMPANY.—

(1) REQUIREMENT.—A generic drug applicant that has submitted an ANDA containing a certification under section 505(j)(2)(A)(vii)(IV) of the Federal Food, Drug, and Cosmetic Act and a brand name drug company that enter into an agreement described in paragraph (2) shall each file the agreement in accordance with subsection (c). The agreement shall be filed prior to the date of the first commercial marketing of the generic drug that is the subject of the ANDA.

(2) SUBJECT MATTER OF AGREEMENT.—An agreement described in this paragraph between a generic drug applicant and a brand name drug company is an agreement regarding—

(A) the manufacture, marketing or sale of the brand name drug that is the listed drug in the ANDA involved;

(B) the manufacture, marketing, or sale of the generic drug for which the ANDA was submitted; or

(C) the 180-day period referred to in section 505(j)(5)(B)(iv) of the Federal Food, Drug, and Cosmetic Act as it applies to such ANDA or to any other ANDA based on the same brand name drug.

(b) AGREEMENT WITH ANOTHER GENERIC DRUG APPLICANT.—

(1) REQUIREMENT.—A generic drug applicant that has submitted an ANDA containing a certification under section 505(j)(2)(A)(vii)(IV) of the Federal Food, Drug, and Cosmetic Act with respect to a listed drug and another generic drug applicant that has submitted an ANDA containing such a certification for the same listed drug shall each file the agreement in accordance with subsection (c). The agreement shall be filed prior to the date of the first commercial marketing of either of the generic drugs for which such ANDAs were submitted.

(2) SUBJECT MATTER OF AGREEMENT.—An agreement described in this paragraph between two generic drug applicants is an agreement regarding the 180-day period referred to in section 505(j)(5)(B)(iv) of the Federal Food, Drug, and Cosmetic Act as it applies to the ANDAs with which the agreement is concerned.

(c) FILING.—

(1) AGREEMENT.—The parties that are required in subsection (a) or (b) to file an agreement in accordance with this subsection shall file with the Assistant Attorney General and the Commission the text of any such agreement, except that such parties are not required to file an agreement that solely concerns—

(A) purchase orders for raw material supplies;

(B) equipment and facility contracts;

(C) employment or consulting contracts; or

(D) packaging and labeling contracts.

(2) OTHER AGREEMENTS.—The parties that are required in subsection (a) or (b) to file an agreement in accordance with this subsection shall file with the Assistant Attorney General and the Commission the text of any agreements between the parties that are not described in such subsections and are contingent upon, provide a contingent condition for, or are otherwise related to an agreement that is required in subsection (a) or (b) to be filed in accordance with this subsection.

(3) DESCRIPTION.—In the event that any agreement required in subsection (a) or (b) to be filed in accordance with this subsection has not been reduced to text, each of the parties involved shall file written descriptions of such agreement that are sufficient to disclose all the terms and conditions of the agreement.

SEC. 1113. FILING DEADLINES.

Any filing required under section 1112 shall be filed with the Assistant Attorney General and the Commission not later than 10 business days after the date the agreements are executed.

SEC. 1114. DISCLOSURE EXEMPTION.

Any information or documentary material filed with the Assistant Attorney General or the Commission pursuant to this subtitle shall be exempt from disclosure under section 552 of title 5, United States Code, and no such information or documentary material may be made public, except as may be relevant to any administrative or judicial action or proceeding. Nothing in this section is intended to prevent disclosure to either body of the Congress or to any duly authorized committee or subcommittee of the Congress.

SEC. 1115. ENFORCEMENT.

(a) CIVIL PENALTY.—Any brand name drug company or generic drug applicant which fails to comply with any provision of this subtitle shall be liable for a civil penalty of not more than $11,000, for each day during which such entity is in violation of this subtitle. Such penalty may be recovered in a civil action brought by the United States, or brought by the Commission in accordance with the procedures established in section 16(a)(1) of the Federal Trade Commission Act (15 U.S.C. 56(a)).

(b) COMPLIANCE AND EQUITABLE RELIEF.—If any brand name drug company or generic drug applicant fails to comply with any provision of this subtitle, the United States district court may order compliance, and may grant such other equitable relief as the court in its discretion determines necessary or appropriate, upon application of the Assistant Attorney General or the Commission.

SEC. 1116. RULEMAKING.

The Commission, with the concurrence of the Assistant Attorney General and by rule in accordance with section 553 of title 5, United States Code, consistent with the purposes of this subtitle—

(1) may define the terms used in this subtitle;

(2) may exempt classes of persons or agreements from the requirements of this subtitle; and

(3) may prescribe such other rules as may be necessary and appropriate to carry out the purposes of this subtitle.

SEC. 1117. SAVINGS CLAUSE.

Any action taken by the Assistant Attorney General or the Commission, or any failure of the Assistant Attorney General or the Commission to take action, under this subtitle shall not at any time bar any proceeding or any action with respect to any agreement between a brand name drug company and a generic drug applicant, or any agreement between generic drug applicants, under any other provision of law, nor shall any filing under this subtitle constitute or create a presumption of any violation of any competition laws.

SEC. 1118. EFFECTIVE DATE.

This subtitle shall—

(1) take effect 30 days after the date of the enactment of this Act; and

(2) shall apply to agreements described in section 1112 that are entered into 30 days after the date of the enactment of this Act.

Subtitle C—Importation of Prescription Drugs

SEC. 1121. IMPORTATION OF PRESCRIPTION DRUGS.

(a) IN GENERAL.—Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.) is amended by striking section 804 and inserting the following:

"SEC. 804. IMPORTATION OF PRESCRIPTION DRUGS.

"(a) DEFINITIONS.—In this section:

"(1) IMPORTER.—The term 'importer' means a pharmacist or wholesaler.

"(2) PHARMACIST.—The term 'pharmacist' means a person licensed by a State to practice pharmacy, including the dispensing and selling of prescription drugs.

"(3) PRESCRIPTION DRUG.—The term 'prescription drug' means a drug subject to section 503(b), other than—

"(A) a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802));

"(B) a biological product (as defined in section 351 of the Public Health Service Act (42 U.S.C. 262));

"(C) an infused drug (including a peritoneal dialysis solution);

"(D) an intravenously injected drug;

"(E) a drug that is inhaled during surgery; or

"(F) a drug which is a parenteral drug, the importation of which pursuant to subsection (b) is determined by the Secretary to pose a threat to the public health, in which case section 801(d)(1) shall continue to apply.

"(4) QUALIFYING LABORATORY.—The term 'qualifying laboratory' means a laboratory in the United States that has been approved by the Secretary for the purposes of this section.

"(5) WHOLESALER.—

"(A) IN GENERAL.—The term 'wholesaler' means a person licensed as a wholesaler or distributor of prescription drugs in the United States under section 503(e)(2)(A).

"(B) EXCLUSION.—The term 'wholesaler' does not include a person authorized to import drugs under section 801(d)(1).

"(b) REGULATIONS.—The Secretary, after consultation with the United States Trade Representative and the Commissioner of Customs, shall promulgate regulations permitting pharmacists and wholesalers to import prescription drugs from Canada into the United States.

"(c) LIMITATION.—The regulations under subsection (b) shall—

"(1) require that safeguards be in place to ensure that each prescription drug imported under the regulations complies with section 505 (including with respect to being safe and effective for the intended use of the prescription drug), with sections 501 and 502, and with other applicable requirements of this Act;

"(2) require that an importer of a prescription drug under the regulations comply with subsections (d)(1) and (e); and

"(3) contain any additional provisions determined by the Secretary to be appropriate as a safeguard to protect the public health or as a means to facilitate the importation of prescription drugs.

"(d) INFORMATION AND RECORDS.—

"(1) IN GENERAL.—The regulations under subsection (b) shall require an importer of a prescription drug under subsection (b) to submit to the Secretary the following information and documentation:

"(A) The name and quantity of the active ingredient of the prescription drug.

"(B) A description of the dosage form of the prescription drug.

"(C) The date on which the prescription drug is shipped.

"(D) The quantity of the prescription drug that is shipped.

"(E) The point of origin and destination of the prescription drug.

"(F) The price paid by the importer for the prescription drug.

"(G) Documentation from the foreign seller specifying—

"(i) the original source of the prescription drug; and

"(ii) the quantity of each lot of the prescription drug originally received by the seller from that source.

"(H) The lot or control number assigned to the prescription drug by the manufacturer of the prescription drug.

"(I) The name, address, telephone number, and professional license number (if any) of the importer.

"(J)(i) In the case of a prescription drug that is shipped directly from the first foreign recipient of the prescription drug from the manufacturer:

"(I) Documentation demonstrating that the prescription drug was received by the recipient from the manufacturer and subsequently shipped by the first foreign recipient to the importer.

"(II) Documentation of the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

"(III)(aa) In the case of an initial imported shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(bb) In the case of any subsequent shipment, documentation demonstrating that a statistically valid sample of the shipment was tested for authenticity and degradation.

"(ii) In the case of a prescription drug that is not shipped directly from the first foreign recipient of the prescription drug from the manufacturer, documentation demonstrating that each batch in each shipment offered for importation into the United States was statistically sampled and tested for authenticity and degradation.

"(K) Certification from the importer or manufacturer of the prescription drug that the prescription drug—

"(i) is approved for marketing in the United States and is not adulterated or misbranded; and

"(ii) meets all labeling requirements under this Act.

"(L) Laboratory records, including complete data derived from all tests necessary to ensure that the prescription drug is in compliance with established specifications and standards.

"(M) Documentation demonstrating that the testing required by subparagraphs (J) and (L) was conducted at a qualifying laboratory.

"(N) Any other information that the Secretary determines is necessary to ensure the protection of the public health.

"(2) MAINTENANCE BY THE SECRETARY.—The Secretary shall maintain information and documentation submitted under paragraph (1) for such period of time as the Secretary determines to be necessary.

"(e) TESTING.—The regulations under subsection (b) shall require—

"(1) that testing described in subparagraphs (J) and (L) of subsection (d)(1) be conducted by the importer or by the manufacturer of the prescription drug at a qualified laboratory;

"(2) if the tests are conducted by the importer—

"(A) that information needed to—

"(i) authenticate the prescription drug being tested; and

"(ii) confirm that the labeling of the prescription drug complies with labeling requirements under this Act;

be supplied by the manufacturer of the prescription drug to the pharmacist or wholesaler; and

"(B) that the information supplied under subparagraph (A) be kept in strict confidence and used only for purposes of testing or otherwise complying with this Act; and

"(3) may include such additional provisions as the Secretary determines to be appropriate to provide for the protection of trade secrets and commercial or financial information that is privileged or confidential.

"(f) REGISTRATION OF FOREIGN SELLERS.—Any establishment within Canada engaged in the distribution of a prescription drug that is imported or offered for importation into the United States shall register with the Secretary the name and place of business of the establishment and the name of the United States agent for the establishment.

"(g) SUSPENSION OF IMPORTATION.—The Secretary shall require that importations of a specific prescription drug or importations by a specific importer under subsection (b) be immediately suspended on discovery of a pattern of importation of that specific prescription drug or by that specific importer of drugs that are counterfeit or in violation of any requirement under this section, until an investigation is completed and the Secretary determines that the public is adequately protected from counterfeit and violative prescription drugs being imported under subsection (b).

"(h) APPROVED LABELING.—The manufacturer of a prescription drug shall provide an importer written authorization for the importer to use, at no cost, the approved labeling for the prescription drug.

"(i) CHARITABLE CONTRIBUTIONS.—Notwithstanding any other provision of this section, section 801(d)(1) continues to apply to a prescription drug that is donated or otherwise supplied at no charge by the manufacturer of the drug to a charitable or humanitarian organization (including the United Nations and affiliates) or to a government of a foreign country.

"(j) WAIVER AUTHORITY FOR IMPORTATION BY INDIVIDUALS.—

"(1) DECLARATIONS.—Congress declares that in the enforcement against individuals of the prohibition of importation of prescription drugs and devices, the Secretary should—

"(A) focus enforcement on cases in which the importation by an individual poses a significant threat to public health; and

"(B) exercise discretion to permit individuals to make such importations in circumstances in which—

"(i) the importation is clearly for personal use; and

"(ii) the prescription drug or device imported does not appear to present an unreasonable risk to the individual.

"(2) WAIVER AUTHORITY.—

"(A) IN GENERAL.—The Secretary may grant to individuals, by regulation or on a case-by-case basis, a waiver of the prohibition of importation of a prescription drug or device or class of prescription drugs or devices, under such conditions as the Secretary determines to be appropriate.

"(B) GUIDANCE ON CASE-BY-CASE WAIVERS.—The Secretary shall publish, and update as necessary, guidance that accurately describes circumstances in which the Secretary will consistently grant waivers on a case-by-case basis under subparagraph (A), so that individuals may know with the greatest practicable degree of certainty whether a particular importation for personal use will be permitted.

"(3) DRUGS IMPORTED FROM CANADA.—In particular, the Secretary shall by regulation grant individuals a waiver to permit individuals to import into the United States a prescription drug that—

"(A) is imported from a licensed pharmacy for personal use by an individual, not for resale, in quantities that do not exceed a 90-day supply;

"(B) is accompanied by a copy of a valid prescription;

"(C) is imported from Canada, from a seller registered with the Secretary;

"(D) is a prescription drug approved by the Secretary under chapter V;

"(E) is in the form of a final finished dosage that was manufactured in an establishment registered under section 510; and

"(F) is imported under such other conditions as the Secretary determines to be necessary to ensure public safety.

"(k) CONSTRUCTION.—Nothing in this section limits the authority of the Secretary relating to the importation of prescription drugs, other than with respect to section 801(d)(1) as provided in this section.

"(l) EFFECTIVENESS OF SECTION.—

"(1) COMMENCEMENT OF PROGRAM.—This section shall become effective only if the Secretary certifies to the Congress that the implementation of this section will—

(A) pose no additional risk to the public's health and safety; and

(B) result in a significant reduction in the cost of covered products to the American consumer.

"(2) TERMINATION OF PROGRAM.—

"(A) IN GENERAL.—If, after the date that is 1 year after the effective date of the regulations under subsection (b) and before the date that is 18 months after the effective date, the Secretary submits to Congress a certification that, in the opinion of the Secretary, based on substantial evidence obtained after the effective date, the benefits of implementation of this section do not outweigh any detriment of implementation of this section, this section shall cease to be effective as of the date that is 30 days after the date on which the Secretary submits the certification.

"(B) PROCEDURE.—The Secretary shall not submit a certification under subparagraph (A) unless, after a hearing on the record under sections 556 and 557 of title 5, United States Code, the Secretary—

"(i)(I) determines that it is more likely than not that implementation of this section would result in an increase in the risk to the public health and safety;

"(II) identifies specifically, in qualitative and quantitative terms, the nature of the increased risk;

"(III) identifies specifically the causes of the increased risk; and

"(IV)(aa) considers whether any measures can be taken to avoid, reduce, or mitigate the increased risk; and

"(bb) if the Secretary determines that any measures described in item (aa) would require additional statutory authority, submits to Congress a report describing the legislation that would be required;

"(ii) identifies specifically, in qualitative and quantitative terms, the benefits that would result from implementation of this section (including the benefit of reductions in the cost of covered products to consumers in the United States, allowing consumers to procure needed medication that consumers might not otherwise be able to procure without foregoing other necessities of life); and

"(iii)(I) compares in specific terms the detriment identified under clause (i) with the benefits identified under clause (ii); and

"(II) determines that the benefits do not outweigh the detriment.

"(m) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.".

(b) CONFORMING AMENDMENTS.—The Federal Food, Drug, and Cosmetic Act is amended—

(1) in section 301(aa) (21 U.S.C. 331(aa)), by striking "covered product in violation of section 804" and inserting "prescription drug in violation of section 804"; and

(2) in section 303(a)(6) (21 U.S.C. 333(a)(6), by striking "covered product pursuant to section 804(a)" and inserting "prescription drug under section 804(b)".

SEC. 1122. STUDY AND REPORT ON IMPORTATION OF DRUGS.

The Secretary, in consultation with appropriate government agencies, shall conduct a *study on the importation of drugs into the United States pursuant to section 804 of the Federal Food, Drug, and Cosmetic Act (as added by section 1121 of this Act). Not later than 12 months after the date of the enactment of this Act, the Secretary shall submit to the appropriate committees of the Congress a report providing the findings of such study.*

SEC. 1123. STUDY AND REPORT ON TRADE IN PHARMACEUTICALS.

The President's designees shall conduct a study and report on issues related to trade and pharmaceuticals.

TITLE XII—TAX INCENTIVES FOR HEALTH AND RETIREMENT SECURITY

SEC. 1201. HEALTH SAVINGS ACCOUNTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions for individuals) is amended by redesignating section 223 as section 224 and by inserting after section 222 the following new section:

“SEC. 223. HEALTH SAVINGS ACCOUNTS.

“(a) DEDUCTION ALLOWED.—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by or on behalf of such individual to a health savings account of such individual.

“(b) LIMITATIONS.—

“(1) IN GENERAL.—The amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed the sum of the monthly limitations for months during such taxable year that the individual is an eligible individual.

“(2) MONTHLY LIMITATION.—The monthly limitation for any month is 1/12 of—

“(A) in the case of an eligible individual who has self-only coverage under a high deductible health plan as of the first day of such month, the lesser of—

“(i) the annual deductible under such coverage, or

“(ii) $2,250, or

“(B) in the case of an eligible individual who has family coverage under a high deductible health plan as of the first day of such month, the lesser of—

“(i) the annual deductible under such coverage, or

“(ii) $4,500.

“(3) ADDITIONAL CONTRIBUTIONS FOR INDIVIDUALS 55 OR OLDER.—

“(A) IN GENERAL.—In the case of an individual who has attained age 55 before the close of the taxable year, the applicable limitation under subparagraphs (A) and (B) of paragraph (2) shall be increased by the additional contribution amount.

“(B) ADDITIONAL CONTRIBUTION AMOUNT.—For purposes of this section, the additional contribution amount is the amount determined in accordance with the following table:

“For taxable years beginning in:	***The additional contribution amount is:***
2004	*$500*
2005	*$600*
2006	*$700*
2007	*$800*
2008	*$900*
2009 and thereafter	*$1,000.*

“(4) COORDINATION WITH OTHER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to an individual for any taxable year shall be reduced (but not below zero) by the sum of—

“(A) the aggregate amount paid for such taxable year to Archer MSAs of such individual, and

“(B) the aggregate amount contributed to health savings accounts of such individual which is excludable from the taxpayer's gross income for such taxable year under section 106(d) (and such amount shall not be allowed as a deduction under subsection (a)).

Subparagraph (A) shall not apply with respect to any individual to whom paragraph (5) applies.

“(5) SPECIAL RULE FOR MARRIED INDIVIDUALS.—In the case of individuals who are married to each other, if either spouse has family coverage—

“(A) both spouses shall be treated as having only such family coverage (and if such spouses each have family coverage under different plans, as having the family coverage with the lowest annual deductible), and

“(B) the limitation under paragraph (1) (after the application of subparagraph (A) and without regard to any additional contribution amount under paragraph (3))—

“(i) shall be reduced by the aggregate amount paid to Archer MSAs of such spouses for the taxable year, and

“(ii) after such reduction, shall be divided equally between them unless they agree on a different division.

“(6) DENIAL OF DEDUCTION TO DEPENDENTS.—No deduction shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

“(7) MEDICARE ELIGIBLE INDIVIDUALS.—The limitation under this subsection for any month with respect to an individual shall be zero for the first month such individual is entitled to benefits under title XVIII of the Social Security Act and for each month thereafter.

“(c) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

“(1) ELIGIBLE INDIVIDUAL.—

“(A) IN GENERAL.—The term ‘eligible individual’ means, with respect to any month, any individual if—

“(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and

“(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

“(I) which is not a high deductible health plan, and

“(II) which provides coverage for any benefit which is covered under the high deductible health plan.

“(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph (A)(ii) shall be applied without regard to—

“(i) coverage for any benefit provided by permitted insurance, and

“(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

“(2) HIGH DEDUCTIBLE HEALTH PLAN.—

“(A) IN GENERAL.—The term ‘high deductible health plan’ means a health plan—

“(i) which has an annual deductible which is not less than—

“(I) $1,000 for self-only coverage, and

“(II) twice the dollar amount in subclause (I) for family coverage, and

“(ii) the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—

“(I) $5,000 for self-only coverage, and

“(II) twice the dollar amount in subclause (I) for family coverage.

“(B) EXCLUSION OF CERTAIN PLANS.—Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B).

“(C) SAFE HARBOR FOR ABSENCE OF PREVENTIVE CARE DEDUCTIBLE.—A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care (within the meaning of section 1871 of the Social Security Act, except as otherwise provided by the Secretary).

“(D) SPECIAL RULES FOR NETWORK PLANS.—In the case of a plan using a network of providers—

“(i) ANNUAL OUT-OF-POCKET LIMITATION.—Such plan shall not fail to be treated as a high deductible health plan by reason of having an out-of-pocket limitation for services provided outside of such network which exceeds the applicable limitation under subparagraph (A)(ii).

“(ii) ANNUAL DEDUCTIBLE.—Such plan's annual deductible for services provided outside of such network shall not be taken into account for purposes of subsection (b)(2).

“(3) PERMITTED INSURANCE.—The term ‘permitted insurance’ means—

“(A) insurance if substantially all of the coverage provided under such insurance relates to—

“(i) liabilities incurred under workers' compensation laws,

“(ii) tort liabilities,

“(iii) liabilities relating to ownership or use of property, or

“(iv) such other similar liabilities as the Secretary may specify by regulations,

“(B) insurance for a specified disease or illness, and

“(C) insurance paying a fixed amount per day (or other period) of hospitalization.

“(4) FAMILY COVERAGE.—The term ‘family coverage’ means any coverage other than self-only coverage.

“(5) ARCHER MSA.—The term ‘Archer MSA’ has the meaning given such term in section 220(d).

“(d) HEALTH SAVINGS ACCOUNT.—For purposes of this section—

“(1) IN GENERAL.—The term ‘health savings account’ means a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary, but only if the written governing instrument creating the trust meets the following requirements:

“(A) Except in the case of a rollover contribution described in subsection (f)(5) or section 220(f)(5), no contribution will be accepted—

“(i) unless it is in cash, or

“(ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds the sum of—

“(I) the dollar amount in effect under subsection (b)(2)(B)(ii), and

“(II) the dollar amount in effect under subsection (b)(3)(B).

“(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

“(C) No part of the trust assets will be invested in life insurance contracts.

“(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

“(E) The interest of an individual in the balance in his account is nonforfeitable.

“(2) QUALIFIED MEDICAL EXPENSES.—

“(A) IN GENERAL.—The term ‘qualified medical expenses’ means, with respect to an account beneficiary, amounts paid by such beneficiary for medical care (as defined in section 213(d) for such individual, the spouse of such individual, and any dependent (as defined in section 152) of

such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

''(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—Subparagraph (A) shall not apply to any payment for insurance.

''(C) EXCEPTIONS.—Subparagraph (B) shall not apply to any expense for coverage under—

''(i) a health plan during any period of continuation coverage required under any Federal law,

''(ii) a qualified long-term care insurance contract (as defined in section 7702B(b)),

''(iii) a health plan during a period in which the individual is receiving unemployment compensation under any Federal or State law, or

''(iv) in the case of an account beneficiary who has attained the age specified in section 1811 of the Social Security Act, any health insurance other than a medicare supplemental policy (as defined in section 1882 of the Social Security Act).

''(3) ACCOUNT BENEFICIARY.—The term 'account beneficiary' means the individual on whose behalf the health savings account was established.

''(4) CERTAIN RULES TO APPLY.—Rules similar to the following rules shall apply for purposes of this section:

''(A) Section 219(d)(2) (relating to no deduction for rollovers).

''(B) Section 219(f)(3) (relating to time when contributions deemed made).

''(C) Except as provided in section 106(d), section 219(f)(5) (relating to employer payments).

''(D) Section 408(g) (relating to community property laws).

''(E) Section 408(h) (relating to custodial accounts).

''(e) TAX TREATMENT OF ACCOUNTS.—

''(1) IN GENERAL.—A health savings account is exempt from taxation under this subtitle unless such account has ceased to be a health savings account. Notwithstanding the preceding sentence, any such account is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

''(2) ACCOUNT TERMINATIONS.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to health savings accounts, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

''(f) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of a health savings account which is used exclusively to pay qualified medical expenses of any account beneficiary shall not be includible in gross income.

''(2) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of a health savings account which is not used exclusively to pay the qualified medical expenses of the account beneficiary shall be included in the gross income of such beneficiary.

''(3) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—

''(A) IN GENERAL.—If any excess contribution is contributed for a taxable year to any health savings account of an individual, paragraph (2) shall not apply to distributions from the health savings accounts of such individual (to the extent such distributions do not exceed the aggregate excess contributions to all such accounts of such individual for such year) if—

''(i) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

''(ii) such distribution is accompanied by the amount of net income attributable to such excess contribution. Any net income described in clause (ii) shall be included in the gross income of the individual for the taxable year in which it is received.

''(B) EXCESS CONTRIBUTION.—For purposes of subparagraph (A), the term 'excess contribution' means any contribution (other than a rollover contribution described in paragraph (5) or section 220(f)(5)) which is neither excludable from gross income under section 106(d) nor deductible under this section.

''(4) ADDITIONAL TAX ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—The tax imposed by this chapter on the account beneficiary for any taxable year in which there is a payment or distribution from a health savings account of such beneficiary which is includible in gross income under paragraph (2) shall be increased by 10 percent of the amount which is so includible.

''(B) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of section 72(m)(7) or dies.

''(C) EXCEPTION FOR DISTRIBUTIONS AFTER MEDICARE ELIGIBILITY.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account beneficiary attains the age specified in section 1811 of the Social Security Act.

''(5) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

''(A) IN GENERAL.—Paragraph (2) shall not apply to any amount paid or distributed from a health savings account to the account beneficiary to the extent the amount received is paid into a health savings account for the benefit of such beneficiary not later than the 60th day after the day on which the beneficiary receives the payment or distribution.

''(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a health savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a health savings account which was not includible in the individual's gross income because of the application of this paragraph.

''(6) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of determining the amount of the deduction under section 213, any payment or distribution out of a health savings account for qualified medical expenses shall not be treated as an expense paid for medical care.

''(7) TRANSFER OF ACCOUNT INCIDENT TO DIVORCE.—The transfer of an individual's interest in a health savings account to an individual's spouse or former spouse under a divorce or separation instrument described in subparagraph (A) of section 71(b)(2) shall not be considered a taxable transfer made by such individual notwithstanding any other provision of this subtitle, and such interest shall, after such transfer, be treated as a health savings account with respect to which such spouse is the account beneficiary.

''(8) TREATMENT AFTER DEATH OF ACCOUNT BENEFICIARY.—

''(A) TREATMENT IF DESIGNATED BENEFICIARY IS SPOUSE.—If the account beneficiary's surviving spouse acquires such beneficiary's interest in a health savings account by reason of being the designated beneficiary of such account at the death of the account beneficiary, such health savings account shall be treated as if the spouse were the account beneficiary.

''(B) OTHER CASES.—

''(i) IN GENERAL.— If, by reason of the death of the account beneficiary, any person acquires the account beneficiary's interest in a health savings account in a case to which subparagraph (A) does not apply--

''(I) such account shall cease to be a health savings account as of the date of death, and

''(II) an amount equal to the fair market value of the assets in such account on such date shall be includible if such person is not the estate of such beneficiary, in such person's gross income for the taxable year which includes such date, or if such person is the estate of such beneficiary, in such beneficiary's gross income for the last taxable year of such beneficiary.

''(ii) SPECIAL RULES.—

''(I) REDUCTION OF INCLUSION FOR PREDEATH EXPENSES.—The amount includible in gross income under clause (i) by any person (other than the estate) shall be reduced by the amount of qualified medical expenses which were incurred by the decedent before the date of the decedent's death and paid by such person within 1 year after such date.

''(II) DEDUCTION FOR ESTATE TAXES.— An appropriate deduction shall be allowed under section 691(c) to any person (other than the decedent or the decedent's spouse) with respect to amounts included in gross income under clause (i) by such person.

''(g) COST-OF-LIVING ADJUSTMENT.—

''(1) IN GENERAL.—Each dollar amount in subsections (b)(2) and (c)(2)(A) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins determined by substituting for 'calendar year 1992' in subparagraph (B) thereof—

''(i) except as provided in clause (ii), 'calendar year 1997', and

''(ii) in the case of each dollar amount in subsection (c)(2)(A), 'calendar year 2003'.

''(2) ROUNDING.—If any increase under paragraph (1) is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

''(h) REPORTS.—The Secretary may require—

''(1) the trustee of a health savings account to make such reports regarding such account to the Secretary and to the account beneficiary with respect to contributions, distributions, the return of excess contributions, and such other matters as the Secretary determines appropriate, and

''(2) any person who provides an individual with a high deductible health plan to make such reports to the Secretary and to the account beneficiary with respect to such plan as the Secretary determines appropriate.

The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by the Secretary.''.

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (18) the following new paragraph:

''(19) HEALTH SAVINGS ACCOUNTS.—The deduction allowed by section 223.''.

(c) ROLLOVERS FROM ARCHER MSAS PERMITTED.—Subparagraph (A) of section 220(f)(5) of such Code (relating to rollover contribution) is amended by inserting ''or a health savings account (as defined in section 223(d))'' after ''paid into an Archer MSA''.

(d) EXCLUSIONS FOR EMPLOYER CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS.—

(1) EXCLUSION FROM INCOME TAX.—Section 106 of such Code (relating to contributions by employer to accident and health plans) is amended by adding at the end the following new subsection:

''(d) CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS.—

''(1) IN GENERAL.—In the case of an employee who is an eligible individual (as defined in section 223(c)(1)), amounts contributed by such employee's employer to any health savings account

(as defined in section 223(d)) of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do not exceed the limitation under section 223(b) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

"(2) SPECIAL RULES.—Rules similar to the rules of paragraphs (2), (3), (4), and (5) of subsection (b) shall apply for purposes of this subsection.

"(3) CROSS REFERENCE.—

"For penalty on failure by employer to make comparable contributions to the health savings accounts of comparable employees, see section 4980G.".

(2) EXCLUSION FROM EMPLOYMENT TAXES.—

(A) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 of such Code is amended by adding at the end the following new paragraph:

"(11) HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.—The term 'compensation' shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(d).".

(B) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 of such Code is amended by striking "or" at the end of paragraph (16), by striking the period at the end of paragraph (17) and inserting "; or", and by inserting after paragraph (17) the following new paragraph:

"(18) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(d).".

(C) WITHHOLDING TAX.—Subsection (a) of section 3401 of such Code is amended by striking "or" at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting "; or", and by inserting after paragraph (21) the following new paragraph:

"(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(d).".

(3) EMPLOYER CONTRIBUTIONS REQUIRED TO BE SHOWN ON W–2.—Subsection (a) of section 6051 of such Code is amended by striking "and" at the end of paragraph (10), by striking the period at the end of paragraph (11) and inserting ", and", and by inserting after paragraph (11) the following new paragraph:

"(12) the amount contributed to any health savings account (as defined in section 223(d)) of such employee or such employee's spouse.".

(4) PENALTY FOR FAILURE OF EMPLOYER TO MAKE COMPARABLE HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.—

(A) IN GENERAL.—Chapter 43 of such Code is amended by adding after section 4980F the following new section:

"SEC. 4980G. FAILURE OF EMPLOYER TO MAKE COMPARABLE HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.

"(a) GENERAL RULE.—In the case of an employer who makes a contribution to the health savings account of any employee during a calendar year, there is hereby imposed a tax on the failure of such employer to meet the requirements of subsection (b) for such calendar year.

"(b) RULES AND REQUIREMENTS.—Rules and requirements similar to the rules and requirements of section 4980E shall apply for purposes of this section.

"(c) REGULATIONS.—The Secretary shall issue regulations to carry out the purposes of this section, including regulations providing special rules for employers who make contributions to Archer MSAs and health savings accounts during the calendar year.".

(B) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding after the item relating to section 4980F the following new item:

"Sec. 4980G. Failure of employer to make comparable health savings account contributions.".

(e) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 of such Code (relating to tax on excess contributions to certain tax-favored accounts and annuities) is amended—

(1) by striking "or" at the end of subsection (a)(3), by inserting "or" at the end of subsection (a)(4), and by inserting after subsection (a)(4) the following new paragraph:

"(5) a health savings account (within the meaning of section 223(d)),", and

(2) by adding at the end the following new subsection:

"(g) EXCESS CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS.—For purposes of this section, in the case of health savings accounts (within the meaning of section 223(d)), the term 'excess contributions' means the sum of—

"(1) the aggregate amount contributed for the taxable year to the accounts (other than a rollover contribution described in section 220(f)(5) or 223(f)(5)) which is neither excludable from gross income under section 106(d) nor allowable as a deduction under section 223 for such year, and

"(2) the amount determined under this subsection for the preceding taxable year, reduced by the sum of—

"(A) the distributions out of the accounts which were included in gross income under section 223(f)(2), and

"(B) the excess (if any) of—

"(i) the maximum amount allowable as a deduction under section 223(b) (determined without regard to section 106(d)) for the taxable year, over

"(ii) the amount contributed to the accounts for the taxable year.

For purposes of this subsection, any contribution which is distributed out of the health savings account in a distribution to which section 223(f)(3) applies shall be treated as an amount not contributed.".

(f) TAX ON PROHIBITED TRANSACTIONS.—

(1) Section 4975 of such Code (relating to tax on prohibited transactions) is amended by adding at the end of subsection (c) the following new paragraph:

"(6) SPECIAL RULE FOR HEALTH SAVINGS ACCOUNTS.—An individual for whose benefit a health savings account (within the meaning of section 223(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a health savings account by reason of the application of section 223(e)(2) to such account.".

(2) Paragraph (1) of section 4975(e) of such Code is amended by redesignating subparagraphs (E) and (F) as subparagraphs (F) and (G), respectively, and by inserting after subparagraph (D) the following new subparagraph:

"(E) a health savings account described in section 223(d),".

(g) FAILURE TO PROVIDE REPORTS ON HEALTH SAVINGS ACCOUNTS.—Paragraph (2) of section 6693(a) of such Code (relating to reports) is amended by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), respectively, and by inserting after subparagraph (B) the following new subparagraph:

"(C) section 223(h) (relating to health savings accounts),".

(h) EXCEPTION FROM CAPITALIZATION OF POLICY ACQUISITION EXPENSES.—Subparagraph (B) of section 848(e)(1) of such Code (defining specified insurance contract) is amended by striking "and" at the end of clause (iii), by striking the period at the end of clause (iv) and inserting ", and", and by adding at the end the following new clause:

"(v) any contract which is a health savings account (as defined in section 223(d)).".

(i) HEALTH SAVINGS ACCOUNTS MAY BE OFFERED UNDER CAFETERIA PLANS.—Paragraph (2) of section 125(d) (relating to cafeteria plan defined) is amended by adding at the end the following new subparagraph:

"(D) EXCEPTION FOR HEALTH SAVINGS ACCOUNTS.—Subparagraph (A) shall not apply to a plan to the extent of amounts which a covered employee may elect to have the employer pay as contributions to a health savings account established on behalf of the employee.".

(j) CLERICAL AMENDMENT.—The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

"Sec. 223. Health savings accounts.
"Sec. 224. Cross reference.".

(k) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2003.

SEC. 1202. EXCLUSION FROM GROSS INCOME OF CERTAIN FEDERAL SUBSIDIES FOR PRESCRIPTION DRUG PLANS.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 139 the following new section:

"SEC. 139A. FEDERAL SUBSIDIES FOR PRESCRIPTION DRUG PLANS.

"Gross income shall not include any special subsidy payment received under section 1860D–22 of the Social Security Act. This section shall not be taken into account for purposes of determining whether any deduction is allowable with respect to any cost taken into account in determining such payment.".

(b) ALTERNATIVE MINIMUM TAX RELIEF.—Section 56(g)(4)(B) of such Code is amended by inserting "or 139A" after "section 114".

(c) CONFORMING AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of such Code is amended by inserting after the item relating to section 139 the following new item:

"Sec. 139A. Federal subsidies for prescription drug plans.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after the date of the enactment of this Act.

SEC. 1203. EXCEPTION TO INFORMATION REPORTING REQUIREMENTS RELATED TO CERTAIN HEALTH ARRANGEMENTS.

(a) IN GENERAL.—Section 6041 of the Internal Revenue Code of 1986 (relating to information at source) is amended by adding at the end the following new subsection:

"(f) SECTION DOES NOT APPLY TO CERTAIN HEALTH ARRANGEMENTS.—This section shall not apply to any payment for medical care (as defined in section 213(d)) made under—

"(1) a flexible spending arrangement (as defined in section 106(c)(2)), or

"(2) a health reimbursement arrangement which is treated as employer-provided coverage under an accident or health plan for purposes of section 106.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to payments made after December 31, 2002.

And the Senate agree to the same.

That the House recede from its disagreement to the amendment of the Senate to the title of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment to the title of the bill insert the following: "An Act to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug coverage program under the medicare program, to modernize, strengthen, and improve the medicare program, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings accounts, to amend the Federal Food, Drug, and Cosmetic Act with respect to abbreviated applications for the approval of new drugs and the importation of prescription drugs, and for other purposes.".

And the Senate agree to the same.

BILLY TAUZIN,
WILLIAM THOMAS,
MICHAEL BILIRAKIS,
NANCY L. JOHNSON,
TOM DELAY,
Managers on the Part of the House.

CHUCK GRASSLEY,
ORRIN HATCH,
DON NICKLES,
BILL FRIST,
JON KYL,
MAX BAUCUS,
JOHN BREAUX,
Managers on the Part of the Senate.

JOINT EXPLANATION STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 1) to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The Senate amendment to the text of the bill struck all of the House bill after the enacting clause and inserted a substitute text.

The House recedes from its disagreement to the amendment of the Senate with an amendment that is a substitute for the Hose bill and the Senate amendment. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003

Short Title; Amendments to Social Security Act; References to BIPA and Secretary; Table of Contents. (Section 1 of Conference Agreement; Section 1 of House bill; Section 1 of Senate bill).

Present Law

No provision.

House Provision

The provision specifies the title of the Act as the "Medicare Prescription Drug and Modernization Act of 2003". The provision also includes a table of contents.

Senate Provision

The provision specifies the title of the Act as the "Prescription Drug and Medicare Improvement Act of 2003". The provision also includes a table of contents.

Conference Agreement

The provision specifies the title of the Act as the "Medicare Prescription Drug, Improvement and Modernization Act of 2003". The provision also includes a table of contents.

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Voluntary Prescription Drug Benefit Program (Section 101 of Conference agreement, Section 101 of House bill; Section 101 of Senate bill).

Present Law

Medicare does not cover most outpatient prescription drugs. Beneficiaries who are inpatients of hospitals or skilled nursing facilities may receive drugs as part of their treatment. Medicare payments made to the facilities cover these costs. Medicare also makes payments to physicians for drugs or biologicals which cannot be self-administered. This means that coverage is generally limited to drugs or biologicals administered by infusion or injection. However, if the injection is generally self-administered (e.g., insulin), it is not covered.

Despite the general limitation on coverage for outpatient drugs, the law specifically authorizes coverage for the following: (1) drugs used in immunosuppressive therapy (such as cyclosporin) following discharge from a hospital for a Medicare covered organ transplant; (2) erythropoietin (EPO) for the treatment of anemia for persons with chronic renal failure who are on dialysis; (3) drugs taken orally during cancer chemotherapy providing they have the same active ingredients and are used for the same indications as chemotherapy drugs which would be covered if they were not self-administered and were administered as incident to a physician's professional service; and (4) hemophilia clotting factors for hemophilia patients competent to use such factors to control bleeding without medical supervision, and items related to the administration of such factors. The program also pays for supplies (including drugs) that are necessary for the effective use of covered durable medical equipment, including those which must be put directly into the equipment (e.g., tumor chemotherapy agents used with an infusion pump). Medicare also covers pneumococcal pneumonia vaccines, hepatitis B vaccines, and influenza virus vaccines.

The Committee on Ways and Means, the Committee on Energy and Commerce and the Senate Finance Committee have held numerous hearings on providing prescription drug benefits to seniors, modernizing the program by making benefits, cost sharing and the delivery of care more rational, and strengthening Medicare financially for current and future generations.

The typical senior now takes more than 20 prescriptions a year to improve their health or manage their diseases. While seniors are taking more drugs than any other demographic group, they are often paying the highest prices because about twenty five percent of seniors have no prescription drug coverage. Similarly, low-income beneficiaries must often make unacceptable choices between life-saving medicines and other essentials.

The addition of a prescription drug benefit to Medicare, while providing seniors additional choices in how they receive their health services, is a critical modernization of the program.

Legislation to achieve these goals passed the House in 2000 (H.R. 4680, the Medicare Rx 2000 Act), in 2002 (H.R. 4954, the Medicare Modernization and Prescription Drug Act), and in 2003 (H.R. 1, the Medicare Prescription Drug and Modernization Act). The Senate passed legislation (S.1, the Prescription Drug and Medicare Improvement Act) to modernize the program and provide prescription drugs in 2003.

The conference report is the culmination of this legislative process.

House Bill

The provision would establish a new Voluntary Prescription Drug Benefit Program under a new Part D of Title XVIII of the Social Security Act. Effective January 1, 2006, a new optional benefit would be established under a new Part D. Beneficiaries could purchase either "standard coverage" or actuarially equivalent coverage. In 2006, "standard coverage" would have a $250 deductible, 20% cost-sharing for costs between $251 and $2,000, then no coverage until the beneficiary had out-of-pocket costs of $3,500 when full coverage would be provided.

The out-of-pocket limit would be higher for higher income beneficiaries. Low-income subsidies would be provided for persons with incomes below 150% of poverty. Coverage would be provided through prescription drug plans (PDPs) or Medicare Advantage (MA) Rx plans or Enhanced Fee-For-Service (EFFS) Rx plans. The program would rely on private plans to provide coverage and to bear some of the financial risk for drug costs; federal subsidies would be provided to encourage participation. Plans would determine payments and would be expected to negotiate prices. The new Medicare Benefits Administration (MBA), within the Department of Health and Human Services (HHS) would administer the benefit.

Senate Bill

Effective January 1, 2006, a new optional benefit would be established under a new Part D. Beneficiaries could purchase either "standard coverage" or actuarially equivalent coverage. In 2006, "standard coverage" would have a $275 deductible, 50% cost-sharing for costs between $276 and $4,500, then no coverage until the beneficiary had out-of-pocket costs of $3,700; and 10% cost-sharing thereafter. Individuals with incomes below 160% of poverty would receive additional assistance. The bill would rely on private plans to provide coverage and to bear a portion of the financial risk for drug costs. Federal subsidies would be provided to encourage participation. (A fallback mechanism would be provided in areas where private risk bearing plans were not available. Under the fallback mechanism, Medicare would contract with a private plan to provide the benefit in the area; the plan would not be at financial risk, except for a small portion of management fees tied to performance). Coverage would be provided through Medicare Prescription Drug Plans (PDPs) or MedicareAdvantage plans (MAs). A new Center for Medicare Choices (CMC) would be established within the Department of Health and Human Services (HHS) to administer the Part D benefit and the new MA program.

Conference Agreement

The provision establishes a new voluntary prescription drug benefit under a new Part D of Title XVIII of the Social Security Act. Effective January 1, 2006, a new optional benefit will be established under a new Part D. Beneficiaries could purchase either "standard coverage" or alternative coverage with actuarially equivalent benefits. In 2006, "standard coverage" will have a $250 deductible, 25% coinsurance for costs between $251 and $2,250, and catastrophic coverage after out of pocket expenses of $3,600. Once the beneficiary reached the catastrophic limit, the program would pay all costs except for nominal cost-sharing. Low-income subsidies would be provided for persons with incomes below 150% of poverty. Coverage would be provided through prescription drug plans or Medicare Advantage prescription drug (MA-PD) plans. The program will rely on private plans to provide coverage and to bear some of the financial risk for drug costs; federal subsidies will be provided to encourage participation. Plans will determine premiums through a bid process and will compete based on premiums and negotiated prices.

PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

Subpart 1—Eligible Beneficiaries and Prescription Drug Benefits.

Eligibility, Enrollment and Information (New Section 1860D–1 of conference agreement; New Section 1860D–1 and New Section 1860D–5 of House bill; new sections 1860D–1, 1860D–2, 1860D–3, and 1860D–4 of Senate bill).

Present Law

People generally enroll in Part B when they turn 65. Persons who have applied for Social Security or railroad retirement benefits automatically receive a Medicare card when they turn 65. Persons who have not applied for Social Security or railroad retirement benefits must file an application for Medicare benefits. An individual who becomes entitled to Medicare Part A is automatically enrolled in Part B unless he or she specifically opts out of this coverage. An aged person not entitled to Part A may still enroll in Part B.

House Bill

The new Section 1860D–1 would specify that each individual entitled to Medicare Part A or enrolled in Medicare Part B would be entitled to obtain qualified prescription drug coverage. The benefit is completely voluntary. MA organizations and EFFS plans would be required to offer plans that included qualified prescription drug coverage. An individual enrolled in an MA Rx plan or EFFS Rx plan would obtain their drug coverage through the plan. An individual not enrolled in either an MA or EFFS plan could enroll in a new prescription drug plan (PDP). The provision would specify that an individual eligible to make an election to enroll in a PDP, or with an MA Rx or EFFS Rx plan, would do so in accordance with regulations issued by the Administrator of the new Medicare Benefits Administration (MBA). Enrollments and changes in enrollment could occur only during a specified election period. The election periods would generally be the same as those established for MA and EFFS programs including annual coordinated election periods and special election periods. An individual discontinuing an MA election during the first year of eligibility would be permitted to enroll in a PDP at the same time as the election of coverage under the original fee-for-service plan.

The provision would establish initial election periods. A six month election period, beginning on October 1, 2005, would be established for persons entitled to Part A or enrolled under Part B on that date. For persons first entitled to Part A or enrolled in Part B after that date, an initial election period, which was the same as that for initial part B enrollment, would be established. The Administrator would be required to establish special election periods for persons in special circumstances to ensure no or little disruption in coverage. Specifically these would apply to: persons having and involuntarily losing prescription drug coverage; in cases of enrollment delays or non-enrollment attributable to government action; in the case of an individual meeting exceptional circumstances specified by the Administrator (including circumstances identified by the Administrator for MA enrollment); and in cases of individuals who become eligible for Medicaid drug coverage.

General information on PDP, MA Rx and EFFS Rx plans would be made available during election periods. The Administrator could provide information on individuals eligible to enroll in plans to plan sponsors and organizations.

The provision would provide that elections would take effect at the same time that elections take effect for MA plans. However, no election could take effect before January 1, 2006. The Administrator would provide for the termination of an election in the case of termination of Part A and Part B coverage or termination of an election for cause (including failure to pay the required premium).

The new Section 1860D–5 would require the Administrator to establish a process for the selection of a PDP plan or an MA Rx or EFFS Rx plan that provided qualified prescription drug coverage. The process would include the conduct of annual coordinated election periods under which individuals could change the qualifying plans through which they obtained coverage. The process would also include the active dissemination of information to promote an informed selection among qualifying plans (based on price, quality, and other features) in a manner consistent with and in coordination with the dissemination of information under MA. Further, the process would provide for the coordination of elections through filing with an entity offering a MA Rx or EFFS Rx plan or a PDP sponsor in a manner consistent with that provided under MA. The plan would have to inform each enrollee at the beginning of the year of the enrollee's annual out-of-pocket threshold.

In order to ensure no duplication of coverage, the section would specify that an MA Rx or EFFS Rx enrollee could only elect to receive drug coverage through the plan.

SENATE BILL

Under the New Section 1860D–1, the Administrator would provide for and administer a voluntary prescription drug delivery program under which each Part D eligible individual enrolled in Part D would be provided access to drug coverage. In general, MedicareAdvantage enrollees would obtain drug benefits through their MedicareAdvantage plan. Other Part D enrollees would receive their drug coverage through enrollment in a Medicare Prescription Drug Plan offered in the geographic area in which the beneficiary resides. MedicareAdvantage enrollees in MSA plans would also receive drug coverage through enrollment in a Medicare Prescription Drug plan. MedicareAdvantage enrollees in private fee-for-service plans would receive drug benefits through such plan if the plan provided qualified prescription drug coverage; otherwise they would enroll in a Medicare Prescription Drug plan. The program would begin January 1, 2006.

Under the New Section 1860D–2, the Administrator would establish an enrollment process, which would be similar to that for Part B. An initial open enrollment period would be established. For beneficiaries eligible as of November 1, 2005, this would be the 6-month period beginning November 1, 2005. Persons becoming eligible after this date would have an initial 7-month enrollment period similar to that established for Part B.

The New Section 1860D–3 would require the Administrator to establish a process through which a Part D eligible individual who was not enrolled in a MedicareAdvantage Plan (except for an MSA plan or private-fee-for-service plan not offering qualified drug coverage) could enroll in a Medicare Prescription Drug plan serving the geographic area where the beneficiary resides. The beneficiary could make an annual election to change enrollment to another plan. A beneficiary in Part D who failed to enroll in a plan would be enrolled in a plan designated by the Administrator.

The Administrator would use rules similar to the rules established for enrollment, disenrollment and termination of enrollment with MedicareAdvantage plans. Included would be requirements relating to establishment of special election periods and application of the guaranteed issue and renewal provisions. The Administrator would also coordinate enrollments, disenrollments, and terminations of enrollments under Part C with those under Part D.

The enrollment process established by the Administrator would ensure that beneficiaries who enrolled in the first open enrollment period (beginning November 2005) would be permitted to elect an eligible entity prior to January 1, 2006, in order to assure coverage was effective on that date.

In general, persons enrolled in MedicareAdvantage Plans would receive drug coverage through their MedicareAdvantage Plans and be subject to their enrollment rules. Persons enrolled in MSA plans or private-fee-for-service plans not offering qualified drug coverage would be subject to Part D enrollment rules.

The Administrator would be authorized to provide information about eligible beneficiaries to eligible entities with contracts under Part D. Such information would be provided as the Administrator determined necessary to facilitate enrollment with such entities and for only so long and to the extent necessary to carry out this objective.

The new Section 1860D–4 would require the Administrator to broadly disseminate information to beneficiaries regarding Part D coverage. Current beneficiaries would be provided such information at least 30 days prior to beginning of the first enrollment period.

Information activities would be similar to those performed for MedicareAdvantage and be coordinated with such activities. Comparative plan information would include a comparison of benefits, monthly beneficiary obligation, quality and performance, beneficiary cost-sharing, consumer satisfaction surveys, and other information specified by the Secretary.

Conference agreement

The New Section 1860D–1 of the conference agreement specifies that each individual entitled to Medicare Part A or enrolled in Medicare Part B would be entitled to obtain qualified prescription drug coverage through enrollment in a prescription drug plan. A beneficiary enrolled in a Medicare Advantage (MA) plan providing qualified prescription drug coverage (MA–PD plan) will obtain coverage through that plan. MA enrollees may not enroll in a prescription drug plan (PDP) under Part D except for: (1) Enrollees in private-fee-for service MA plans not offering qualified prescription drug coverage; and (2) Enrollees in Medicare medical savings accounts (MSAs). Coverage first begins January 1, 2006.

The Secretary is required to establish a process for enrollment, disenrollment, termination, and change of enrollment of eligible beneficiaries in prescription drug plans. The Secretary is required to use rules similar to, and coordinated with rules established for MA–PD plans relating to: residency requirements, exercise of choice, coverage election periods (including initial periods, annual coordinated election periods, special election periods, and election periods for exceptional circumstances); coverage periods (relating to effectiveness of elections and changes of elections); guaranteed issue and renewal; and marketing material and application forms.

The agreement establishes a default election process for full-benefit dual eligible beneficiaries, that is, persons eligible for both Medicare and full benefits (including prescription drugs) under the state's Medicaid program. The Secretary will enroll any full-benefit dual eligible who has not enrolled in a prescription drug plan or MA–PD plan, in a plan that has a premium equal to or below the premium subsidy amount available to persons with incomes below 135% of poverty. If more than one plan is available, the Secretary will enroll the beneficiary on a random basis among all such plans in the PDP region. Nothing prevents the beneficiary from declining enrollment or changing such enrollment.

The provision would establish a six-month initial enrollment period, beginning November 15, 2005, for all persons who are eligible beneficiaries on that date; it is the same period established for enrollment period established for MA plans for that year. An initial enrollment period will apply for individuals becoming eligible after that date; in no case can such period be less than six months, which follows the current enrollment process for Part B. Conferees intend the enrollment process to be administratively simple to encourage enrollment in the new plans.

The Secretary will establish enrollment periods for special circumstances. These include the involuntary loss of creditable prescription drug coverage such as under a group health plan, or a reduction in coverage such that it no longer meets the actuarial equivalence test. Failure to pay the required premium does not meet the definition of involuntary loss of coverage. A special enrollment period is also established for persons who discontinue their enrollment in a MA–PD plan during their first year of eligibility.

The Secretary is authorized to provide each PDP sponsor and MA organization such identifying information about eligible individuals as the Secretary determines to be necessary to facilitate efficient marketing of plans and enrollment of beneficiaries in plans. The Secretary may provide such information only to the extent necessary to carry out these activities and such PDP sponsor or MA organization may only use it to facilitate marketing and enrollment of beneficiaries in PDP and MA–PD plans. Conferees intend this provision to facilitate outreach to beneficiaries to ensure participation in the program. A consistent barrier to encouraging enrollment in the existing Medicare+Choice program is the high cost of marketing to individuals. With Secretarial assistance, Conferees expect these costs to be reduced so that plans can readily identify eligible beneficiaries and target information effectively.

The Secretary is required to conduct activities that are designed to broadly disseminate information to eligible beneficiaries and prospective eligible beneficiaries. It must be available at least 30 days prior to the initial enrollment period. The information dissemination requirements are similar to and are to be coordinated with the activities the Secretary is required to perform for MA plans.

The Conferees expect that in carrying out the annual dissemination of information requirement that the Secretary will conduct a significant public information campaign to educate beneficiaries about the new Medicare drug benefit to ensure the broad dissemination of accurate and timely information. In particular, the Conferees expect that in carrying out this public information campaign that HHS will place a priority on, and make a best and concerted effort to, ensuring that the lower income seniors are aware of the additional benefits available to them and how to enroll. Therefore, the public information campaign should include a program of outreach, information, appropriate mailings, and enrollment assistance with and through appropriate state and federal agencies, including State health insurance counseling and assistance programs, in coordination with other federal programs of assistance to low-income individuals, to maximize enrollment of eligible individuals. In addition, special outreach efforts shall be made for disadvantaged and hard-to-reach populations, including targeted efforts in historically underserved populations, and working with low-income assistance sites and a broad array of public, voluntary, and private community organizations serving Medicare beneficiaries. Materials and information shall be made available in languages other than English, where appropriate.

It is also critical that eligibility determination forms and paperwork should be as simple as possible, with mail-in or electronic filings possible. In addition, face-to-face interviews should not be required except where necessary. The Secretary shall encourage multi-year enrollment (provided eligible individuals will be required to report disqualifying income and asset changes on a timely basis). It is the desire of the Conferees that, within three years after program enactment, the Secretary shall report on best practices in the successful enrollment of low-income beneficiaries.

The Secretary is also required to disseminate comparative information to beneficiaries for the annual open enrollment period. Comparative information is to include information on benefits and formularies under a plan; monthly beneficiary premium; quality and performance; beneficiary cost-sharing; and consumer satisfaction surveys. The Secretary is not required to provide information on quality and performance or consumer satisfaction during the first plan year or the next plan year if the information is not available. The Secretary is also required to provide information concerning the methodology for determining late enrollment penalties.

To promote informed decisions, comparative information is to include information on benefits and formularies under a plan; monthly beneficiary premium; quality and performance; beneficiary cost-sharing; and consumer satisfaction surveys. The Secretary is not required to provide information on quality and performance or consumer satisfaction during the first plan year or the next plan year if the information is not available. The Secretary is also required to provide information concerning the methodology for determining late enrollment penalties.

Prescription Drug Benefits (New Section 1860D–2 of conference agreement; New Section 1860D–2 of House bill; New Sections 1860D–6, 1860D, and 1860D–1 of Senate bill).

Present Law

No provision.

House Bill

a. *Benefits.* The new Section 1860D–2 would specify the requirements for qualified prescription drug coverage. Qualified coverage would be defined as either "standard coverage" or actuarially equivalent coverage. In both cases, access would have to be provided to negotiated prices.

For 2006, "standard coverage" would be defined as having a $250 deductible; 20% coinsurance up to the initial coverage limit ($2,000); catastrophic coverage would begin after an individual incurred $3,500 in out of pocket costs. Beginning in 2007, the annual dollar amounts would be increased by the annual percentage increase in average per capita aggregate expenditures for covered outpatient drugs for Medicare beneficiaries for the 12-month period ending in July of the previous year.

Plans would be permitted to substitute cost-sharing requirements, for costs up to the initial coverage limit that were actuarially consistent with an average expected 20% coinsurance for costs up to the initial coverage limit. They could also apply tiered copayments, provided such copayments were actuarially consistent with the average 20% cost-sharing requirements.

The provision would specify incurred costs that would count toward meeting the catastrophic limit. Costs would be treated as incurred costs only if they were paid by the individual (or by another family member on behalf of the individual), paid on behalf of a low-income individual under the subsidy provisions, under the Medicaid program, or under a state pharmaceutical assistance program. Any costs for which the individual was reimbursed by insurance or otherwise would not count toward incurred costs. The Administrator would be authorized to establish procedures, in coordination with the Secretary of the Treasury and the Secretary of Labor, for determining whether costs were being reimbursed by insurance or other third-party arrangement. The procedures would provide for alerting entities in which such individuals were enrolled. Entities could also periodically ask enrolled individuals about such arrangements. A material misrepresentation by an individual (as defined in standards set by the Administrator through a process established by the Administrator) would constitute grounds for termination of Part D enrollment.

The provision would permit a PDP or MA Rx or EFFS Rx plan to offer, subject to approval by the Administrator, alternative coverage providing certain requirements were met. The actuarial value of total coverage would have to be at least equal to the actuarial value of standard coverage. The unsubsidized value of the coverage (i.e. the value of the coverage exceeding subsidy payments) would have to be equal to the unsubsidized value of standard coverage. The coverage would be designed (based on actuarially representative patterns of utilization) to provide for payment of incurred costs up to the initial coverage limit of at least the same percentage of costs provided under standard coverage. Further, stop loss protection would be the same as that under standard coverage.

Both standard coverage and actuarially equivalent coverage would have to offer access to negotiated prices. Coverage offered by a PDP plan sponsor or a MA or EFFS entity would be required to provide beneficiaries with access to negotiated prices (including applicable discounts). Access would be provided even when no benefits were payable because of the application of cost-sharing or initial coverage limits. Insofar as a state elected to use these negotiated prices for its Medicaid program, the Medicaid drug payment provisions would not apply. (Further, the negotiated prices would not be taken into account in making "best price" determinations under Medicaid.) The PDP sponsor or MA or EFFS entity would be required to disclose to the Administrator the extent to which manufacturer discounts or rebates or other remunerations or price concessions were made available to the sponsor or organization and passed through to enrollees through pharmacies and other dispensers. Manufacturers would be required to disclose pricing information to the Administrator under the same conditions currently required for Medicaid.

Qualified prescription drug coverage could include coverage exceeding that specified for standard coverage or actuarially equivalent coverage. However, any additional coverage would be limited to covered outpatient drugs. The Administrator could terminate a contract with a PDP sponsor or MA or EFFS entity if a determination was made that the sponsor or organizations engaged in activities intended to discourage enrollment of classes of eligible Medicare beneficiaries obtaining coverage through the plan on the basis of their higher likelihood of utilizing prescription drug coverage.

b. *Income-Related Out-of-Pocket threshold.* The provision would increase the annual out-of-pocket threshold for each enrollee whose adjusted gross income exceeded a specified income threshold. The portion of income exceeding this income threshold ($60,000 in 2006), but below an income threshold limit ($200,000 in 2006), would be considered in making this calculation. The increase would be calculated as follows. First, the ratio of the annual out-of- pocket limit to the income limit would be calculated and expressed as a percent. For 2006, this would be $3,500 divided by $60,000 equaling 5.8%. This percentage would be multiplied by any excess income over $60,000, or, if less, by the difference between income threshold limit and the income threshold ($140,000 in 2006). Thus, the catastrophic out-of-pocket limit would be $5,820 for an enrollee with an income of $100,000 and $11,620 for persons with incomes at $200,000 or above. Beginning in 2007, the income threshold and income threshold limits would be increased by the percentage increase in the consumer price index (CPI) for all urban consumers, rounding to the nearest $100.

The income used for making the income determination would be adjusted gross income. (Individuals filing joint returns would each be treated separately with each person considered to have an adjusted gross income equal to one-half of the total.) The determination would be the most recent return information disclosed by the Secretary of the Treasury to the Secretary of HHS, (as provided for under Section 106 of this Act) before the beginning of the year. The Secretary, in coordination with the Secretary of the Treasury, would provide a procedure under which an enrollee could elect to use more recent information, including information for a taxable year ending in the current calendar year. The process would require: (1) the enrollee to provide the Secretary with the relevant portion of the more recent return; (2) the Medicare Beneficiary Ombudsman offering assistance to the enrollees in presenting such information and the toll-free number being a point of contact for beneficiaries to inquire how to present the information; (3) verification by the Secretary of the Treasury; and (4) payment by the Secretary to the enrollee equal to the benefit payments that would have been payable under the plan if more recent information had been used. If such payments were made, the PDP sponsor would pay the Secretary the requisite amount, less the applicable reinsurance that would have applied. The payment would be credited to the Prescription Drug Account.

The Secretary would be required to provide, through the annual Medicare handbook, general information on the calculation of out-of-pocket thresholds. The Secretary would periodically transmit to the Secretary of the Treasury the names and TINs of enrollees in PDPs or MA Rx or EFFS Rx plans and request that the Secretary of the Treasury disclose information as provided for under Section 106 of this Act. The Secretary would disclose to entities offering the plan the amount of the out-of-pocket threshold that would apply to a specified taxpayer. Individuals could opt out of the Secretarial disclosure requirements, if they elected to have the maximum out-of-pocket threshold applied in a year. Criminal and civil penalties would apply to any unauthorized disclosure of information obtained pursuant to Section 106. In disclosing such information, stringent new confidentiality protections would apply.

c. *Covered Drugs.* Covered outpatient drugs would be defined to include: (1) a drug which could only be dispensed subject to a prescription and which was described in subparagraph (A)(i) or (A)(ii) of Section 1927(k)(2) of the Social Security Act (relating to drugs covered under Medicaid); (2) a biological product described in paragraph B of such subsection; (3) insulin described in subparagraph C of such section and medical supplies associated with the injection of insulin; and (4) vaccines licensed under section 351 of the Public Health Service Act. Drugs excluded from Medicaid coverage would be excluded from the definition except for smoking cessation drugs. The definition would include any use of a covered outpatient drug for a medically accepted indication. Drugs, which could be paid for under Medicare Part B, would not be covered under Part D. A plan could elect to exclude a drug, which would otherwise be covered, if the drug was excluded under the formulary and the exclusion was not successfully appealed under the new Section 1860D–3. In addition, a PDP or MA Rx or EFFS Rx plan could exclude from coverage, subject to reconsideration and appeals provisions, any drug, which would not meet Medicare's definition of medically necessary or was not prescribed in accordance with the plan or Part D.

Senate Bill

a. *Benefits.* Under the new Section 1860D–6 of the Senate bill, plans would be required to offer "qualified coverage." "Qualified coverage" would be either "standard coverage" or "actuarially equivalent coverage." Both would require access to negotiated prices. In 2006, standard coverage would be defined as having a $275 deductible, 50% cost-sharing for drug costs between $276 and the initial coverage limit of $4,500, then no coverage, except that beneficiaries would have access to negotiated drug prices, until the beneficiary had out-of-pocket costs of $3,700 ($5813 in total spending); and 10% cost-sharing thereafter. These amounts would be increased in future years by the percentage increase in average per capita expenditures for covered drugs for the year ending the previous July.

Out-of-pocket costs counting toward the limit would include costs paid by the individual (or by another individual such as a family member), paid on behalf of a low-income individual under the low-income provisions, paid under Medicaid, or paid under a state pharmaceutical assistance program. Any costs for which the individual was reimbursed by insurance or otherwise could not be counted. The Administrator would be authorized to establish procedures, in coordination with the Secretary of the Treasury and the Secretary of Labor, for determining whether costs were being reimbursed by insurance or other third-party arrangement. The procedures would provide for alerting entities in which such individuals were enrolled. Entities could also periodically ask enrolled individuals about such arrangements. A material misrepresentation by an individual (as defined in standards set by the Administrator through a process established by the Administrator) would constitute grounds for termination of Part D enrollment.

Entities could offer more generous drug coverage, if approved by the Administrator, but only if they also offered a plan providing standard coverage. Entities could offer a plan design different from standard coverage provided certain conditions were met. The actuarial value of total coverage would have to be at least equal to the actuarial value of standard coverage. The unsubsidized value of coverage would have to be at least equal to the unsubsidized value of standard coverage. Further, the coverage would be designed, based on a representative pattern of utilization, to cover the same percentage of costs up to the initial benefit limit as provided under the standard plan. The limitation on the deductible and out-of-pocket expenditures would be the same as under standard coverage. The entity would have to apply for and receive approval from the Administrator for an alternative benefit design.

The Administrator would establish processes for determining the actuarial value of prescription drug coverage. The processes would take into account any effect that providing actuarially equivalent rather than standard coverage would have on utilization.

Qualified drug plans would be required to provide beneficiaries with access to negotiated prices (including all discounts, direct or indirect subsidies, rebates, other price concessions, or direct or indirect remunerations), regardless of the fact that no benefits may be payable. The entity would be required to issue a card or other technology for this purpose. The Administrator would be required to provide for development of national standards relating to a standardized format for the card or other technology. The standards would be compatible with those provided for under the administrative simplification and electronic prescribing requirements of Title XI. The standards would be implemented no later than January 1, 2008.

The bill would exempt any prices negotiated by a Medicare Prescription Drug plan, MedicareAdvantage plan, or qualified retiree program from Medicaid's determination of "best price" for purposes of the Medicaid drug rebate program.

b. *Income-Related Out-of-Pocket Threshold.* No provision.

c. *Covered Drugs.* The New Section 1860 D would define covered drugs as drugs, biological products, and insulin (including syringes, and necessary medical supplies associated with the administration of insulin, as defined by the Administrator) which are covered under Medicaid and vaccines licensed under Section 351 of the Public Health Service Act. Coverage would be extended to any use of a covered drug for a medically accepted indication. The term would not include drugs or classes of drugs, or their medical uses, which could be excluded from coverage under Medicaid, except for smoking cessation agents. The term would not include drugs currently covered under Medicare Part A or Medicare Part B to the extent payment is available under those Parts. A drug prescribed for an individual, which would ordinarily be a covered drug, would not be covered if a plan's formulary excluded the drug and the exclusion was not successfully resolved. Further, a Medicare Prescription Drug plan or a MedicareAdvantage plan could exclude drugs which did not meet Medicare's definition of "reasonable and necessary" under Section 1862(a) of the Act or which were not prescribed in accordance with the requirements of the plan or Part D.

New Section 1860D–1 would specify that the program would provide coverage for all therapeutic categories and classes of covered drugs (though not necessarily for all drugs within such categories and classes).

Conference Agreement

a. *Benefits*. The New Section 1860D–2 specifies the requirements for qualified prescription drug coverage. Qualified coverage would be defined as either "standard prescription drug coverage" or "alternative prescription drug coverage" with at least actuarially equivalent benefits. In both cases, access would have to be provided to negotiated prices.

Qualified drug plans would be required to provide beneficiaries with access to negotiated prices (including all discounts, direct or indirect subsidies, rebates, other price concessions, or direct or indirect remunerations), regardless of the fact that no benefits may be payable. The entity would be required to issue a card or other technology for this purpose. The Administrator would be required to provide for development of national standards relating to a standardized format for the card or other technology. The standards would be compatible with those provided for under the administrative simplification and electronic prescribing requirements of Title XI.

Plans are permitted to provide supplemental prescription coverage consisting of either certain reductions in cost-sharing (i.e. reduction in deductible, reduction in coinsurance percentage, and increase in initial coverage limit) or coverage of drugs which are excluded because of application of the Medicaid definition of covered drugs. A PDP sponsor may not offer a plan that provides supplemental benefits unless it also offers a basic plan in the area.

For 2006, "standard prescription drug coverage" is defined as having a $250 deductible; 25% coinsurance up to the initial coverage limit ($2,250); and catastrophic coverage after an individual incurred $3,600 in out of pocket expenses. Once the beneficiary reached the catastrophic limit, the program would pay all costs except for nominal cost-sharing.

Once the beneficiary reached the catastrophic ("stop loss") limit, the program would pay all costs, except for nominal cost-sharing. Low-income beneficiaries would have no cost- sharing. The cost-sharing is equal to the greater of: (1) a copayment of $2 for a generic drug or preferred multiple source and $5 for any other drug; or (2) five percent coinsurance. Nothing is to be construed as preventing a PDP sponsor or MA organization from reducing the cost-sharing for preferred or generic drugs. Beginning in 2007, the annual dollar amounts would be increased by the annual percentage increase in average per capita aggregate expenditures for covered outpatient drugs for Medicare beneficiaries for the 12-month period ending in July of the previous year.

Plans would be permitted to substitute cost-sharing requirements, for costs up to the initial coverage limit that were actuarially consistent with an average expected 25% coinsurance for costs up to the initial coverage limit. They could also apply tiered copayments, provided such copayments were actuarially consistent with the average 25% cost-sharing requirements.

The agreement specifies incurred costs that count toward meeting the catastrophic limit. Costs are only considered incurred if they are incurred for the deductible, cost-sharing, benefits not paid because of application of the initial coverage limit. Incurred costs do not include amounts for which no benefits are provided because of the application of a formulary. Costs would be treated as incurred costs only if they were paid by the individual (or by another family member on behalf of the individual), paid on behalf of a low-income individual under the subsidy provisions, or under a state pharmaceutical assistance program (SPAP). Conferees intend SPAP spending to fill in beneficiary cost sharing and deductibles and have that spending count against the catastrophic. State liability will be limited to spending below the catastrophic limit, and for which there is no coverage. The state pharmacy assistance programs could use money saved from the Medicare drug benefit to extend their assistance to persons with incomes above 150% of poverty. For example, 200% of poverty or even 300% of poverty.

Any costs for which the individual was reimbursed by insurance or otherwise would not count toward incurred costs. The Secretary is authorized to establish procedures, in coordination with the Secretary of the Treasury and the Secretary of Labor, for determining whether costs were being reimbursed by insurance or other third-party arrangement. The procedures would provide for alerting entities in which such individuals were enrolled. Entities could also periodically ask enrolled individuals about such arrangements. A material misrepresentation by an individual (as defined in standards set by the Secretary through a process established by the Secretary) would constitute grounds for termination of Part D enrollment.

The provision permits a prescription drug plan or MA–PD plan to offer, subject to approval by the Secretary alternative prescription drug coverage providing certain requirements are met. The actuarial value of total coverage would have to be at least equal to the actuarial value of standard coverage. The unsubsidized value of the coverage (i.e. the value of the coverage exceeding subsidy payments) would have to be equal to the unsubsidized value of standard coverage. The coverage would be designed (based on actuarially representative patterns of utilization) to provide for payment of incurred costs up to the initial coverage limit of at least the same percentage of costs provided under standard coverage. Further, stop loss protection would be the same as that under standard coverage. The deductible could not exceed that under standard coverage.

Under the conference agreement, prescription drug plans and MA–PD plans are permitted to offer alternative coverage that is at least actuarially equivalent to the standard Part D benefit, provided that the alternative coverage includes an initial deductible that is no more than the deductible in the standard plan and provides the same threshold for catastrophic coverage under the standard Part D benefit. Within these requirements plans may change the cost sharing for the drug benefit, implement different formularies, and the benefit limit can be modified while still maintaining actuarial equivalence.

For beneficiaries who desire additional drug coverage beyond that offered in the basic Medicare benefit, MA–PD and PDP plans may also provide supplemental prescription drug coverage. Supplemental policies may be offered by a plan to its own enrollees and may provide for a reduction in the annual deductible, reductions in coinsurance or cost-sharing required, or increases in drug coverage above the benefit limit. However, the conferees recognize that the conditions under which the government provides reinsurance subsidies may create significant disincentives for private sector plans to provide supplemental prescription drug coverage.

To address this concern, the conference agreement clarifies the Secretary's current Medicare demonstration authority to include Part C and Part D with the intent that this authority be used to conduct demonstration projects to allow private sector plans maximum flexibility to design alternative prescription drug coverage. CMS's authority to conduct Medicare demonstrations is provided in section 402 of the Social Security Amendments of 1967 (42 U.S.C. §1395b–1). Under section 402(b), the Secretary is authorized to waive requirements in Title XVIII that relate to reimbursement and payment. Consistent with the Secretary's current-law demonstration authority, the Conference committee intends that any demonstration of benefit flexibility be limited to evaluate innovations in drug benefit design and to not increase total prescription drug outlays as a result of the demonstrations.

Under this authority, CMS could alter the payments to prescription drug plans, Medicare Advantage plans and regional PPOs, or some subset thereof. A number of subsections of 402 could be used as authority to demonstrate the impact of providing additional drug coverage to filling in the gap in coverage or for providing benefit flexibility, as long as the provisions being waived could reasonably be characterized as related to payment provisions.

Specifically, CMS should demonstrate the effect of filling in the gap in coverage by reimbursing participating plans a capitated payment that is actuarially equivalent to the amount that plans would otherwise receive from the government in the form of specific reinsurance when an individual plan enrollee reaches the catastrophic attachment point ($3,600). In order to demonstrate the impact of plans offering flexible benefits, CMS could alter reinsurance payments for MA plans, regional PPOs, or prescription drug plans participating in a waiver program. For example, it is expected that CMS would change the reinsurance payment methodology for a group of plans and compare spending under this alternative methodology to those plans that continue to receive payments as outlined in Title I. However, all plans would be required to at least offer the required benefits, including those required under Part D. CMS is not permitted to waive the minimum benefits provided by the plans. The conferees anticipate that CMS would use this authority to demonstrate that paying MA plans, regional PPOs or PDPs a capitated payment in lieu of specific reinsurance for prescription drug coverage increases plan efficiency and improves the quality of the services.

Consistent with current law, CMS also is also permitted to develop and engage in demonstrations to determine whether payments for non-Medicare services would result in more economical provision and more effective utilization of Medicare services provided by MA plans, regional PPOs, or prescription drug plans as long as the additional services are incident to Medicare covered services, and provided by entities that meet certain requirements (MA plans and regional PPOs would meet these conditions). Under this subsection, CMS could demonstrate that paying MA plans or regional PPOs a payment to provide non-Medicare benefits (including prescription drug coverage or preventative services not provided under Part C or Part D) results in more economical provision and more effective utilization of comprehensive health care services. Any additional benefits must be determined to be budget neutral, and it is the intention of the Conference committee that any demonstration authority be used in a manner as to not increase Medicare outlays.

The conferees fully expect that the Secretary will use this demonstration authority to conduct projects to evaluate new methods of providing reinsurance payments that remove disincentives for private sector plans to offer additional prescription drug benefits to their enrollees. In order to meet the budget neutrality requirement, it may be necessary to implement such a demonstration after implementation of the new Part D benefit for one to two years. Using the results of this type of demonstration, the Conferees would expect the Secretary to submit to Congress any recommend changes in the drug payment methodology under this Part. Both standard coverage and alternative coverage would have to offer access to negotiated prices.

Coverage offered by a PDP plan sponsor or a MA–PD entity would be required to provide beneficiaries with access to negotiated prices. Access would be provided even when no benefits were payable because of the application of cost-sharing or an initial coverage limits. Negotiated prices are to take into account negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations, for covered Part D drugs, and include dispensing fees. The negotiated prices would not be taken into account in making "best price" determinations under Medicaid. Under the current Medicaid best price policy, the largest discount a pharmaceutical manufacturer negotiates in the private market must be passed along to the Medicaid program as well. As GAO and CBO have noted, because manufacturers can only influence market share and volume in the private sector, not Medicaid, the "best price" policy has led to less discounting by manufacturers.

The PDP sponsor or MA–PD entity is required to disclose to the Secretary the aggregate negotiated price concessions made available to the sponsor or organization and passed through in the form of lower subsidies, lower monthly beneficiary premiums, and lower prices through pharmacies and other dispensers. Manufacturers would be required to disclose pricing information to the Secretary, but that information would remain confidential.

b. Income-Related Out-of-Pocket Threshold. No provision.

c. Covered Drugs. Covered outpatient drugs are defined to include: (1) a drug which could only be dispensed subject to a prescription and which was described in subparagraph A of Section 1927(k)(2) of the Social Security Act (relating to drugs covered under Medicaid); (2) a biological product described in paragraph B of such subsection; (3) insulin described in subparagraph C of such section and medical supplies associated with the injection of insulin (as defined in regulations of the Secretary); and (4) vaccines licensed under section 351 of the Public Health Service Act. It is the intent of conferees that the definition of insulin, and medical supplies associated with the administration of insulin, as a covered prescription drug shall include medical supplies that the Secretary determines to be reasonable and necessary, such as insulin, insulin syringes, and insulin delivery devices that are not otherwise covered under the durable medical equipment benefit. Drugs excluded from Medicaid coverage are excluded from the definition except for smoking cessation drugs. The definition would include any use of a covered outpatient drug for a medically accepted indication. Drugs, which can be paid for under Medicare Part B, are not covered under Part D. A PDP plan or MA–PD plan could exclude from coverage, subject to reconsideration and appeals provisions, any drug which would not meet Medicare's definition of medically necessary or was not prescribed in accordance with the plan or Part D.

Access to a Choice of Qualified Prescription Drug Coverage (New Section 1860D–3 of Conference agreement; New Section 1860D–5 of House bill; New Section 1860d–13 of Senate bill).

Present Law

No provision.

House Bill

New section 1860D–5 would require the Administrator to assure that all eligible individuals residing in the U.S. would have a choice of enrollment in at least two qualifying plan options, at least one of which was a PDP, in their area of residence. The requirement would not be satisfied if only one PDP sponsor or one MA or EFFS organization offered all the qualifying plans in the area. If necessary to ensure such access, the Administrator would be authorized to provide partial underwriting of risk for a PDP sponsor to expand its service area under an existing prescription drug plan to adjoining or additional areas, or to establish such a plan, including offering such plan on a regional or nationwide basis. The assistance would be available only so long as, and to the extent, necessary to assure the guaranteed access. However, the Administrator could never provide for the full underwriting of financial risk for any PDP sponsor. Additionally, the Administrator would be directed to seek to maximize the assumption of financial risk by PDP sponsors and entities offering MA Rx or EFFS Rx plans. The Administrator would be required to report to Congress annually on the exercise of this authority and recommendations to minimize the exercise of such authority.

Senate Bill

New Section 1860D–13 of the Senate bill would require the Administrator to approve at least 2 contracts to offer a Medicare Prescription drug Plan in an area. If the Administrator determined that at least 2 plans were not going to be available in the subsequent year, the Administrator would reduce the amount of risk required by plans in a region. This would be achieved by adjusting the percentages applicable to risk corridors established under the bill. Alternatively, the reinsurance percentage could be increased. The Administrator could not provide for the full underwriting of financial risk for any entity and could not provide for the underwriting of any financial risk for a public entity. The Administrator would seek to maximize the assumption of financial risk to ensure fair competition among plans. The authority would be used only so long as, and to the extent necessary, to assure access. The authority could not be used if 2 or more qualified bids were submitted in an area by qualified entities.

Not later than September 1 of each year, beginning in 2005, the Administrator would make a determination as to whether there were 2 approved bids. If not, the Administrator would enter into an annual fallback contract with an entity to provide Part D enrollees in the area with standard coverage (including access to negotiated prices) for the following year.

In the case of an area with only one competitively bid contract, the plan (at the plan's option) could be offered under the rules established for risk-bearing plans. Beneficiaries could enroll with such plan or with the fallback plan.

Conference Agreement

New Section 1860D–3 of the conference agreement requires the Secretary to assure that each beneficiary has available a choice of enrollment in at least 2 qualifying plans in the area in which the beneficiary resides. At least one plan has to be a prescription drug plan. The requirement is not satisfied for an area if only one PDP sponsor or one MA organization offering a MA–PD plan offers all the qualifying plans for the area. A qualifying plan is defined as a prescription drug plan or an MA–PD plan that provides either: (1) basic prescription drug coverage; or (2) qualified prescription drug coverage, so long as there is no MA monthly supplemental beneficiary premium applied (due to the application of a credit against the premium of a rebate). In any case where plans are not available, the beneficiary is given the opportunity to enroll in a fallback plan.

The conference agreement permits the Secretary, in order to assure access, to approve limited risk contracts as specified under the new Section 1860D–11. Only if access is still not provided, will the Secretary provide for the offering of a fallback plan.

Beneficiary Protections for Qualified Prescription Drug Coverage (New Section 1860D–4 of conference agreement; New Section 1860D–3 of House bill; New Section 1860D–5 and Section 121 of Senate bill).

Present Law

a. Beneficiary Protections. Medicare+Choice plans are required to meet a number of beneficiary protection requirements. They are required to disclose plan information to enrollees. They are required to have procedures relating to coverage decisions, reconsiderations, and appeals. Further, they are required to assure the confidentiality and accuracy of enrollee records.

Marketing material used by Medicare+Choice plans must be approved by the Secretary.

b. Electronic Prescription Program. Part C (Administrative Simplification) in Title XI of the Social Security Act requires the Secretary to develop transaction and security standards to support the growth of electronic record keeping and claims processing in the nation's health care system.

Section 1171 defines health care clearinghouse, health care provider, health plan, personally identifiable health information, and standard setting organization. Section 1172 specifies that the administrative simplification standards apply to individual and group health plans, health care clearinghouses, and health care providers who transmit health information electronically in a standard format in connection with one of the transactions specified in Section 1173, or who rely on third-party billing services to conduct such transactions. The Secretary is required either to adopt standards that have already been developed by standard setting organizations or to develop different standards, provided they substantially reduce administrative costs to health plans and providers. If no standard has been adopted by a standard setting organization, the Secretary must develop a new standard based on the recommendations of various specified organizations and agencies.

Section 1173 instructs the Secretary to adopt the following standards: (1) uniform electronic formats for various common transactions between health care providers and health plans (e.g., health claims, eligibility and enrollment); (2) code sets for data elements in standard electronic transactions; (3) unique health identifiers for individuals, employers, plans, and providers; (4) security standards to safeguard confidential patient information against unauthorized access, use, or disclosure; and (5) electronic signatures to verify the authenticity of transactions. Section 1174 provides a timetable for the adoption of the administrative simplification standards and permits the Secretary to modify the standards as frequently as once every 12 months.

Section 1175 requires health plans and providers that process electronic transactions to use standard formats and data elements. Plans and providers may transmit and receive such data either directly or by contracting with a clearinghouse to convert nonstandard data elements into standard transactions. Most entities covered by the administrative simplification standards have 24 months to comply. Small health plans have 36 months to comply.

Section 1176 establishes civil monetary penalties of up to $25,000 per person for violations of the standards. Section 1177 establishes criminal penalties for wrongfully obtaining or disclosing personally identifiable health information. Penalties range from a $50,000 fine and/or 1 year in prison, up to a $250,000 fine and/or up to 10 years in prison if the offense is committed with the intent to sell, transfer, or use the information for commercial advantage, personal gain, or to inflict malicious harm. Section 1178 specifies that the standards preempt contrary provisions in state law pertaining to health information. However, the standards may not preempt or limit state laws that are necessary to prevent fraud and abuse, regulate health insurance companies, or report on health care delivery and costs. Also, the standards may not limit the authority of the state to collect and report for public health purposes.

House Bill

a. Beneficiary Protections. The New Section 1860D–1 would establish guaranteed issue and community-rating requirements. The provision would specify that individuals electing qualified prescription drug coverage under a PDP plan or MA Rx or EFFS Rx plan could not be denied enrollment based on health status or other factors. MA provisions relating to priority enrollment (where capacity limits have been reached) and limitations on terminations of elections would apply to PDP sponsors. The provision would require PDP sponsors to make drug coverage available to all eligible individuals residing in the area without regard to their health or economic status or their place of residence in the area.

The New Section 1860D–3 would specify required beneficiary protections. Plans would have to comply with guaranteed issue and community-rated premium requirements specified in the new Section 1860D–1, access to negotiated prices as specified in the new Section 1860D–2, and the non-discrimination provisions specified in the new Section 1860D–6.

PDP plan sponsors would be required to disclose, to each enrolling beneficiary, information about the plan's benefit structure. The plan would have to disclose information on: (1) access to specific covered drugs, including access through pharmacy networks; (2) how any formulary used by the sponsor functioned; (3) copayment and deductible requirements (including any applicable tiered copayment requirements); and (4) grievance and appeals procedures. In addition, beneficiaries would have the right to obtain more detailed plan information. Plans would be required to have a mechanism for providing specific information to enrollees on request. The sponsor would be required to make available, through an Internet web site and, on request, in writing, information on specific changes in the formulary. Plans would be required to furnish to enrollees, at least monthly, a detailed explanation of benefits when drug benefits were provided, including information on benefits compared to the initial coverage limit and the applicable out-of-pocket threshold.

PDP sponsors and entities offering an MA Rx or EFFS Rx plan would be required to permit the participation of any pharmacy that met the plan's terms and conditions. A PDP and an MA Rx or EFFS Rx plan could reduce copayments for its enrolled beneficiaries below the otherwise applicable level for drugs dispensed through in-network pharmacies; in no case could the reduction result in an increase in subsidy payments made by the Administrator to the plan. PDP sponsors and entities offering an MA Rx or EFFS Rx plan would be required to secure participation in its network of a sufficient number of pharmacies that dispense drugs directly to patients (other than by mail order) to assure convenient access. The Administrator would establish convenient access rules that were no less favorable to enrollees than rules for convenient access established by the Secretary of Defense on June 1, 2003, for purposes of the TRICARE Retail Pharmacy program. The rules would include adequate emergency assess for enrolled beneficiaries. Sponsors would permit enrollees to receive benefits through a community pharmacy, rather than through mail-order, with any differential in cost paid by enrollees. Pharmacies could not be required to accept insurance risk as a condition of participation.

PDP sponsors and entities offering an MA Rx or EFFS Rx plan would be required to issue (and reissue as appropriate) a card or other technology that could be used by an enrolled beneficiary to assure access to negotiated prices for drugs when coverage was not otherwise provided under the plan. The Administrator would provide for the development of uniform standards relating to a standardized format for the card or other technology. These standards would be compatible with the administrative simplification requirements of Title XI of the Social Security Act.

The provision would specify that if a PDP sponsor or an MA or EFFS entity used a formulary, it would have to meet certain requirements. It would be required to establish a pharmaceutical and therapeutic committee to develop and review the formulary. The committee would include at least one physician and one pharmacist, independent and free of conflict with respect to the committee, both with expertise in the care of elderly or disabled persons. The majority of members would be physicians or pharmacists. The committee would be required, when developing and reviewing the formulary, to base clinical decisions on the strength of scientific evidence and standards of practice. This would include assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information the committee determined appropriate. The committee would also take into account whether including a particular covered drug had therapeutic advantages in terms of safety and efficacy. The formulary would have to include drugs within each therapeutic category and class of covered outpatient drugs, although not necessarily all drugs within such categories or classes. When establishing such classes, the committee would take into account the standards published in the United States Pharmacopeia Drug Information. It would be required to make available to plan enrollees, through the Internet or otherwise, the bases for the exclusion of coverage of any drug on the formulary. The committee would be required to establish policies and procedures to educate and inform health care providers and enrollees concerning the formulary. Any removal of a drug from the formulary, and any change in the preferred or tier cost-sharing status of a drug, could not occur until appropriate notice had been provided to beneficiaries and physicians. The plan would provide for periodic evaluation and analysis of treatment protocols and procedures. Further, the PDP sponsor or entity offering a MA Rx or EFFS Rx plan would be required to have, as part of its appeals process, a process for appeals of coverage denials based on application of the formulary.

The PDP sponsor would be required to have (directly, or indirectly through arrangements) an effective cost and drug utilization management program; quality assurance measures including a medication therapy management program; and a program to control waste, fraud, and abuse. Utilization management programs would be required to include medically appropriate incentives to use generic drugs and therapeutic interchange where appropriate. Medication therapy management programs would be designed to assure, for beneficiaries at risk for potential medication problems such as beneficiaries with complex or chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that drugs under the plan were appropriately used to optimize therapeutic outcomes through improved medication use and to reduce the risk of adverse events, including adverse drug interactions. The program would be developed in cooperation with licensed pharmacists and physicians. The PDP sponsor would be required, when establishing fees for pharmacists and other providers, to take into account the resources and time associated with the medication therapy management program. The sponsor or entity would disclose the amount of such fees to the Administrator upon request; the fees would be confidential.

Each PDP sponsor and entity offering a MA Rx or EFFS Rx plan would ensure that each pharmacy or other dispenser informed enrolled beneficiaries at the time of purchase, of any price differential between their prescribed drug and the price of the lowest cost generic drug covered under the plan that was therapeutically equivalent and bioequivalent.

Each PDP sponsor would be required to have meaningful procedures for the hearing and resolving of any grievances between the organization (including any entity or individual through which the organization provided covered benefits) and enrollees. Enrollees would be afforded access to expedited determinations and reconsiderations, in the same manner afforded under MA. A beneficiary in a plan that provided for tiered cost-sharing could request coverage of a nonpreferred drug on the same conditions applicable to preferred drugs, if the prescribing physician determined that the preferred drug for the treatment of the same condition was not as effective for the enrollee or had adverse effects for the enrollee.

In general, PDP plan sponsors would be required to meet the requirements for independent review and appeals of coverage denials and tiered cost-sharing in the same manner that such requirements applied to MA organizations. An individual enrolled in a PDP plan could appeal to obtain coverage for a drug not on the formulary if the prescribing physician determined that the formulary drug for treatment of the same condition was not as effective for the individual or had adverse effects for the individual. The PDP sponsor would be required to meet requirements related to confidentiality and accuracy of enrollee records in the same manner that such requirements applied to MA organizations.

b. Electronic Prescription Program. PDP sponsors and entities offering an MA Rx or EFFS Rx plan would be required, effective January 1, 2007, to have in place an electronic prescription program. The program would have to be consistent with national standards developed by the Administrator. The program would be required to provide for electronic transmittal of prescriptions (except in emergencies and exceptional cases). It would also have to provide for the electronic transmittal of information to the prescribing health professional of information that included:. (1) information (to the extent available and feasible) on the drugs being prescribed for that patient and other information relating to the medical history or condition of the patient that may be relevant to the appropriate prescription for the patient; (2) cost-effective alternatives (if any) for the prescribed drug; and (3) information on drugs included in the applicable formulary. To the extent feasible, the program would permit the prescribing health professional to provide, and be provided, information on an interactive real time basis.

The Administrator would provide for the development of uniform standards relating to the electronic prescription drug program. These standards would be compatible with the administrative simplification requirements of Title XI of the Social Security Act. The Administrator would be required to establish an advisory task force that included representatives of physicians, hospitals, pharmacies, beneficiaries, pharmacy benefit managers, individuals with expertise in information technology, and pharmacy benefit experts of the Departments of Veterans Affairs and Defense and other appropriate Federal agencies to provide recommendations to the administrator on such standards, including recommendations relating to: (1) the range of available computerized prescribing software and hardware and their costs to develop and implement; (2) the extent to which such standards and systems could be readily implemented by physicians, pharmacies, and hospitals; (3) efforts to develop uniform standards and a common software platform for the secure electronic communication of medication history, eligibility, benefit, and prescription information; (4) efforts to develop and promote universal connectivity and interoperability for the secure electronic exchange of such information; (5) the cost of implementing such systems; (6) implementation issues as they relate to the administrative simplification provisions of Title XI and current Federal and State prescribing laws and regulations and their impact on implementation of computerized prescribing. The Administrator would constitute the task force by April 1, 2004; it would submit recommendations to the Administrator by January 1, 2005. The Administrator would provide for the development and promulgation of national standards by January 1, 2006. The standards would be issued by a standards organization accredited by the American National Standards Institute and be compatible with administrative simplification standards.

Senate Bill

a. Beneficiary Protections. Eligible entities offering Medicare Prescription Drug Plans would be required to disclose plan information comparable to that required for MedicareAdvantage plans. Entities would have to disclose information on access, operation of any formulary, beneficiary cost-sharing, and grievance and appeals procedures. Further, upon request of an individual, they would be required to disclose general information on coverage, utilization, and grievance procedures. An eligible entity would be required to have a mechanism for providing specific information to enrollees, upon request, including information on coverage of specific drugs and changes in its formulary. Entities would be required to provide easily understandable explanation of benefits and a notice of benefits in relation to the initial coverage limit and the annual out-of-pocket limit. The MedicareAdvantage requirements relating to approval of marketing materials would apply to information provided by entities on drug plans.

The bill would include several provisions designed to assure beneficiary access to drugs. Eligible entities would be required to have in place procedures to ensure that beneficiaries were not charged more than the negotiated price of a covered drug. The procedures would include the issuance of a card or other technology that could be used by a beneficiary to assure access to negotiated prices for which coverage was not otherwise provided under the plan. Entities would be required to secure the participation in the network of a sufficient number of pharmacies that dispensed drugs directly to patients (other than by mail order) to ensure convenient access for beneficiaries. The Administrator would be required to establish standards to ensure convenient access, including emergency access. The standards would take into account reasonable distances to pharmacy services in both urban and rural areas and to pharmacy services and access to pharmacy services of the Indian health service and Indian tribes and tribal organizations.

An entity would be required to establish a point-of-service method of operation under which the plan would provide access to any or all pharmacies not participating in the network and could charge beneficiaries, through adjustments in cost sharing, the additional costs associated with this option. This additional cost sharing would not count toward the program's cost-sharing requirements or benefit limits. Entities would be required to permit enrollees receiving benefits (which may include a 90-day supply of drugs or biologicals) through a community pharmacy, rather than through mail order and may permit a differential amount to be paid by enrollees.

New Section 1860D–6 would permit entities to use a variety of cost control mechanisms including formularies, tiered copayments, selective contracting with drug providers, and mail order pharmacies. Under New Section 1860D–5, plans electing to use a formulary would be required to establish a pharmacy and therapeutic committee to develop and review the formulary. The pharmacy and therapeutics committee would include at least one academic expert, at least one practicing physician, and at least one practicing pharmacist, all of whom must have expertise in the care of elderly or disabled persons. The committee would base clinical decisions on the strength of scientific evidence and standards of practice. The committee would establish policies and procedures to educate and inform health care providers concerning the formulary. Drugs could not be removed from the formulary until after appropriate notice had been provided to beneficiaries, physicians, and pharmacists. An enrollee would have the right to appeal to obtain coverage for a drug not on the formulary if the prescribing physician determined that the formulary drug was not as effective for treatment of the same condition for the individual or had adverse effects for the individual. If a plan offered tiered cost-sharing for covered drugs, an enrollee would have the right to request that a nonpreferred drug be treated on terms applicable for a preferred drug if the prescribing physician determined that the preferred drug was not as effective for treatment of the same condition for the individual or had adverse effects for the individual.

The formulary would be required to include drugs within all therapeutic categories and classes of covered drugs (although not necessarily for all drugs within such categories and classes). For purposes of defining therapeutic categories and classes, the Administrator would be required to use the following compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, the DRUGEX Information System, and American Medical Association Drug Evaluations.

Eligible entities would be required to have a cost-effective drug utilization management program (including incentives to reduce costs when appropriate). They would be required to have a program to control fraud, abuse, and waste. Further, they would be required to have quality assurance measures, including a medication therapy management program, to reduce medical errors and adverse drug interactions. The medication therapy management program would be designed to assure that drugs for beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure) or multiple prescriptions were appropriately used to optimize therapeutic outcomes and reduce the risk of adverse events including adverse drug interactions. The program could include enhanced beneficiary understanding of appropriate use through education, counseling and other appropriate means; increased adherence with prescription regimens through refill reminders, special packaging and other appropriate means; and detection of patterns of overuse and underuse of drugs. The program would be developed in cooperation with pharmacists and physicians. Associated costs would be taken into account by the entity when establishing fees for pharmacists and others providing services under the medication therapy management program.

Pharmacies or other dispensers would be required to assure that beneficiaries were informed at the time of purchase of any difference between the price of the prescribed drug and the lowest cost generic drug that is therapeutically equivalent and bioequivalent and that is available at the pharmacy or other dispenser. Entities would also be required to have meaningful procedures for hearing and resolving grievances, comparable to those established for MedicareAdvantage plans. In addition, eligible entities would be required to meet MedicareAdvantage requirements relating to coverage determinations. Entities would be required to safeguard the privacy of individually identifiable beneficiary information, maintain such records in an accurate and timely manner, ensure timely access by beneficiaries, and otherwise comply with laws relating to patient privacy.

Eligible entities would be required to conduct consumer satisfaction surveys with respect to the plan and entity. The Administrator would establish uniform requirements for such survey.

b. Electronic Prescription Program. The provision would establish a new Part D in Title XI of the Social Security Act. The new Section 1180 would mandate the development or adoption of standards for transactions and data elements for such transactions, to enable the electronic transmission of medication history, eligibility, benefit and other prescription information. In developing the standards, the Secretary would be required to consult with representatives of physicians, hospitals, pharmacists, standard setting organizations, pharmacy benefit managers, beneficiaries, information exchange networks, technology experts, and representatives of the Departments of Veterans Affairs and Defense and other interested parties. The standards developed or adopted by the Secretary would be consistent with the objective of improving patient safety and improving the quality of care.

Standards would be required to comply with certain requirements. Patients could request a written prescription and not be charged for such request. The standards would accommodate the electronic transmittal of a patient's medication history, eligibility, benefit and other prescription information among prescribing and dispensing professionals at the point of care. The information that could be transmitted using the standards would include: information on the drugs prescribed for the patient; cost-effective alternatives (if any) to the drug prescribed; information on eligibility and benefits (including the drugs included in the applicable formulary and any requirements for prior authorization); information on potential drug interactions; and other information to improve the quality of care and to reduce medical errors. The standards would be designed so that, to the extent practicable, they did not impose an undue administrative burden on the practice of medicine, pharmacy, or other health professions.

The standards developed or adopted by the Secretary would be consistent with Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the 1996 Health Insurance Portability and Accountability Act (HIPAA), and would be compatible with HIPAA's Administrative Simplification standards.

The Secretary would be required to adopt standards for the appropriate data elements needed for the electronic exchange of prescription drug information among prescribers, insurers, and other entities.

The Secretary would have to adopt the standards by Jan. 1, 2006, and would be permitted to modify them, but in a manner that minimized the disruption and cost of compliance. Individuals that transmit or receive prescriptions electronically would be required to comply with the standards. However, individuals would not be required to transmit or receive electronic prescriptions. The standards would preempt state electronic prescription laws. Entities covered by the standards would have 24 months to comply. Small health plans, as defined by the Secretary, would have an additional 12 months to comply.

The Secretary would be required to consult with the Attorney General to ensure that the standards resulted in the secure electronic transmission of prescriptions for controlled substances.

Conference Agreement

a. Beneficiary Protections. New Section 1860D–4 establishes beneficiary protection requirements for qualified prescription drug plans. PDP plan sponsors are required to disclose, to each enrolling beneficiary, information about the plan's benefit structure. The plan will disclose information on: (1) access to specific covered drugs (including access through pharmacy networks); (2) how any formulary (including a tiered formulary) used by the sponsor functions, including how a beneficiary might obtain information on the formulary; (3) copayment and deductible requirements (including any applicable tiered copayment requirements; and (4) grievance and appeals procedures. In addition, beneficiaries will have the right to obtain more detailed plan information. Plans will be required to have a mechanism for providing specific information to enrollees on request. The sponsor will be required to make available, through an Internet website, information on specific changes in the formulary (including tiered or preferred status). Sponsors will be required to furnish to enrollees, a detailed explanation of benefits when drug benefits were provided, including information on benefits compared to the initial coverage limit and the applicable out-of-pocket threshold.

PDP sponsors are required to permit the participation of any pharmacy that meets the plan's terms and conditions. The conference report would require plans to accept any and all pharmacies willing to agree to the terms and conditions of the plan. A PDP could reduce copayments for its enrolled beneficiaries below the otherwise applicable level for drugs dispensed through in-network pharmacies; in no case could the reduction result in an increase in subsidy payments made by the Secretary to the plan. The PDP sponsor is required to secure participation in its network of a sufficient number of pharmacies that dispense drugs directly to patients (other than by mail order) to assure convenient access. The Secretary will establish convenient access rules that are no less favorable to enrollees than rules for convenient access established in the statement of work solicitation (#MDA906-03-R-0002) by the Department of Defense on March 13, 2003, for purposes of the TRICARE Retail Pharmacy program. The conference report adopts the House language, with the clarification that the minimum in-network pharmacy for each plan offered by a PDP or MA plan in a geographic area must provide access to pharmacies that is not less restrictive than the TRICARE access standards. These standards require that 90 percent of plan enrollees in urban areas will have access to a retail pharmacy within 2 miles; that 90 percent of suburban plan enrollees will have access to a retail pharmacy within 5 miles; and that 70 percent of rural plan enrollees will have access to a pharmacy within 15 miles. PDP sponsors or MA sponsors can offer broader networks than those meeting the TRICARE access standards.

Plan sponsors cannot create any pharmacy networks that are more restrictive than the TRICARE access standards. PDP plan sponsors or MA sponsors cannot include mail order only pharmacies. The rules would include adequate emergency access for enrolled beneficiaries. The rules may include standards with respect to access for enrollees in long-term care facilities. Sponsors will permit enrollees to receive benefits (which may include a 90-day supply) through a community pharmacy, rather than through mail-order, with any differential in charge paid by enrollees. In addition, the conference report clarifies that pharmacies could not accept insurance risk.

PDP sponsors are required to issue (and reissue as appropriate) a card or other technology that could be used by an enrolled beneficiary to assure access to negotiated prices for drugs. The Secretary will provide for the development, adoption, or recognition of standards relating to a standardized format for the card or other technology. These standards are to be compatible with the administrative simplification requirements of Title XI of the Social Security Act. The standards will be implemented by such date the Secretary determines to be sufficient to ensure PDP sponsors utilize such standards beginning January 1, 2006, and developed in consultation with the National Counsel for Prescription Drug Programs (NCPDP) and other standard setting organizations.

The provision would specify that if a PDP sponsor used a formulary, it would have to meet certain requirements. A pharmaceutical and therapeutic committee would develop and review the formulary. The committee would include at least one practicing physician and one practicing pharmacist, independent and free of conflict with respect to the committee, both with expertise in the care of elderly or disabled persons. The majority of members would be physicians or pharmacists. The committee would be required, when developing and reviewing the formulary, to base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information the committee determined appropriate. The committee would also take into account whether including a particular covered drug in the formulary (or in a particular tier in a formulary) had therapeutic advantages in terms of safety and efficacy. The formulary would have to include drugs within each therapeutic category and class of covered Part D drugs, although not necessarily all drugs within such categories or classes.

The Secretary is required to request the United States Pharmacopeia to develop a list of categories and classes that may be used by plans. The Secretary's request would also include the revision of such classification from time to time to reflect changes in therapeutic uses of covered drugs and the addition of new covered drugs. The plan sponsor cannot change therapeutic categories and classes in a formulary other than at the beginning of a plan year, except as the Secretary may permit to take into account new therapeutic uses and newly approved covered drugs. Each sponsor is required to establish policies and procedures to educate and inform health care providers and enrollees concerning the formulary. Any removal of a drug from the formulary, and any change in the preferred or tier cost-sharing status of a drug, could not occur until appropriate notice had been provided to the Secretary, beneficiaries, and physicians, pharmacies, and pharmacists. The plan must provide for periodic evaluation and analysis of treatment protocols and procedures.

The PDP sponsor would be required to have (directly, or indirectly through arrangements) a cost-effective drug utilization management program; quality assurance measures, a medication therapy management program; and a program to control fraud, waste, and abuse. A medication therapy management program is a program of drug therapy management and medication administration, that may be furnished by a pharmacist and that is designed to assure with respect to targeted beneficiaries that drugs under the plan are appropriately used to optimize therapeutic outcomes through improved medication use and to reduce the risk of adverse events, including adverse drug interactions. Targeted individuals are those with multiple chronic diseases (such as diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure) or are taking multiple drugs or are likely to incur annual costs that exceed a specified level. The program would be developed in cooperation with licensed practicing pharmacists and physicians. Such plans would be coordinated with disease management programs to the extent beneficiaries are enrolled in such programs. The PDP sponsor would be required, when establishing fees for pharmacists and other providers, to take into account the resources and time associated with the medication therapy management program. The sponsor or entity would disclose the amount of such fees to the Administrator upon request; the fees would be confidential.

The Secretary will be required to conduct consumer satisfaction surveys in order to provide comparative information during the enrollment period.

Each PDP sponsor is required to have meaningful procedures for the hearing and resolving of any grievances between the sponsor (including any entity or individual through which the sponsor provided covered benefits) and enrollees. Enrollees will be afforded access to expedited determinations and reconsiderations, in the same manner afforded under MA. A beneficiary in a plan that provides for tiered cost-sharing can request coverage of a non-preferred drug on the same conditions applicable to preferred drugs, if the prescribing physician determines that that the preferred drug for the treatment of the same condition is not as effective for the enrollee or has adverse effects for the enrollee. A PDP is required to have an exceptions process consistent with guidelines established by the Secretary.

In general, PDP plan sponsors will be required to meet the requirements for independent review and appeals of coverage denials and tiered cost-sharing in a similar manner that such requirements applied to MA organizations for fee-for-service benefits. An individual enrolled in a PDP plan may appeal to obtain coverage for a drug not on the formulary only if the prescribing physician determines that all covered Part D drugs on any tier of the formulary for treatment of the same condition would not as effective for the individual or would have adverse effects for the individual or both. The PDP sponsor will be required to meet requirements related to confidentiality and accuracy of enrollee records in the same manner that such requirements applied to MA organizations.

Each PDP sponsor will provide that each pharmacy that dispenses a covered drug shall inform enrolled beneficiaries at the time of purchase (or at the time of delivery in the case of mail order drugs) of any price differential between the price to the enrollee and the price of the lowest cost generic drug covered under the plan that is therapeutically equivalent and bioequivalent and available at the pharmacy. The Secretary is permitted to waive this requirement.

b. Electronic Prescription Program. The conference agreement requires the Secretary to develop electronic prescription standards. The standards apply to prescriptions for covered part D drugs and required information that are transmitted electronically under an electronic prescription drug program conducted by a PDP or MA plan. The program must provide for the electronic transmittal of information on eligibility and benefits (including formulary drugs, any tiered formulary structure, and prior authorization requirements), information on the drug being prescribed and other drugs listed in the patient's medication history (including drug-drug interactions), and information on the availability of lower-cost, therapeutically appropriate alternative drugs. The conferees intend for prescribing health care professionals to have ready access to neutral and unbiased information on the full range of covered outpatient drugs available. Disclosure of information must meet the requirements of the HIPAA privacy rule and, to the extent feasible, be on an interactive, real-time basis. The conferees do not intend for the provision relating to "interactive, real-time" transmission of information to preclude an individual or entity from complying with the standards under this part by virtue of such individual's or entity's inability to transmit information on an interactive, real-time basis.

The standards must be consistent with the objectives of improving patient safety and the quality and efficiency of patient care. To the extent practicable, the standards must be designed so that they do not impose an undue administrative burden on prescribing physicians and pharmacists. The standards must also be compatible with the HIPAA Administrative Simplification standards and other health information technology standards, and must permit the electronic exchange of drug labeling and drug listing information maintained by the FDA and the National Library of Medicine. Finally, the standards must accommodate the messaging of information about appropriate prescribing of drugs and allow a beneficiary (consistent with their prescription drug plan) to designate a particular pharmacy to dispense a prescribed drug.

The conference agreement requires the Secretary to promulgate initial standards by September 1, 2005, taking into account recommendations from the National Committee on Vital and Health Statistics (NCVHS). The NCVHS is required to develop such recommendations in consultation with standard setting organizations, practicing physicians, hospitals, pharmacies, practicing pharmacists, pharmacy benefit managers, state boards of pharmacy and medicine, and appropriate federal agencies. Prior to the promulgation of final standards, the Secretary must enter into voluntary agreements with physicians, pharmacies, hospitals, and PDP sponsors and MA plans to conduct a pilot project to test the initial standards. The pilot project must be conducted during the 1-year period that begins on January 1, 2006, except that pilot testing is not required where there is adequate industry experience. The Secretary must then evaluate the pilot project and report to Congress not later than April 1, 2007. Based on the evaluation and not later then April 1, 2008, the Secretary must promulgate final standards to take effect within one year. The electronic prescriptions standards shall supercede any contrary state laws.

The agreement requires the Secretary, in consultation with the Attorney General, to provide a safe harbor from both criminal sanctions under Section 1128(b)(1 and 2) of the Act and the self-referral prohibition under Section 1877 of the Act with respect to the provision of nonmonetary remuneration necessary and used solely to receive and transmit electronic prescription information in accordance with Part D standards. Nonmonetary remuneration includes hardware, software, or information technology and training services. This safe harbor is to apply: (1) in the case of a hospital by the hospital to members of its medical staff; (2) in the case of a medical group practice by the practice to prescribing health care professionals who are members of the practice; and (3) in the case of a PDP sponsor or MA organization, by the sponsor or organization to pharmacists and pharmacies participating in its network and to prescribing health processionals.

The conferees intend for electronic prescribing to serve as a vehicle to reduce medical errors and improve efficiencies in the health care system, but not for it to be used as a marketing platform or other mechanism to unduly influence the clinical decisions of physicians.

Subpart 2—Prescription Drug Plans; PDP Sponsors; Financing

PDP Regions; Submission of Bids; Plan Approval (New Section 1860D–11 of Conference Agreement; New Section 1860D–6 and New section 1860D–4 of House bill; New Section 1860D–7, 1860D–12, and 1860D–13 of Senate bill).

Present Law

a. PDP Regions. No provision.

b. Submission of Bids. No provision.

c. Plan Approval. No provision.

d. Fallback. No provision

House Bill

a. PDP Regions. The Administrator would designate at least 10 service areas in the U.S., consistent with EFFS regions, to the extent practicable.

b. Submission of Bids. The new Section 1860D–6 would require each PDP sponsor to submit to the Administrator specified information in the same manner as such information was submitted by MA organizations.

The information to be submitted would be information on the qualified drug coverage to be provided, the actuarial value of the coverage, and information on the bid and premium for the coverage. The PDP sponsor would have to include an actuarial certification of: (1) the actuarial basis for the bid and premium; (2) the portion of the bid and premium attributable to benefits in excess of the standard coverage; (3) the reduction in the premium resulting from reinsurance subsidies; (4) the reduction in the bid resulting from direct and reinsurance subsidy payments; and (5) such other information required by the Administrator.

c. Plan Approval. The Administrator would review the submitted information for purposes of conducting negotiations with the plan. The Administrator would approve the premium only if it accurately reflected the actuarial value of the benefits and the 73% average subsidy provided for under the new Section 1860D–8. The Administrator would apply actuarial principles to approval of a premium in a manner similar to that used for establishing the monthly Part B premium.. These requirements would not apply to private fee-for-service plans.

d. Fallback. No provision

Senate Bill

a. PDP Regions. New Section 1860D–10 would require the Administrator to establish by April 15, 2005, and periodically review, service areas in which plans could offer benefits. The Administrator would establish service areas so that they maximized the availability of Medicare Prescription Drug Plans to eligible beneficiaries and minimized the ability of entities offering plans to favorably select beneficiaries. In establishing the service areas, the Administrator would establish at least 10 service areas, which would have to include at least one state. The Administrator could not divide states so that portions of a state were in different service areas.

To the extent possible, the Administrator would include multi-state metropolitan statistical areas (MSAs) in a single service area. The Secretary could divide MSAs where it is necessary to establish service areas of such size and geography as to maximize plan participation. The Administrator could conform service areas to those established for preferred provider organizations under MedicareAdvantage.

Under the New Section 1860D–12, plan service areas could either be, the entire area of one of the service areas established by the Administrator or the entire area covered by Medicare. Entities could submit separate bids for multiple service areas, provided each bid was for a single service area.

b. Submission of bids. The new Section 1860D–12 of the Senate bill would require entities to submit bids to the Administrator on an annual basis. The bid would be submitted at such time in the previous year as specified by the Administrator. The bid would contain information on proposed plans including benefits, actuarial value of the qualified prescription drug coverage, the service area for the plan, and the monthly premium. Premium information would have to include an actuarial certification of the basis for the premium, the portion of the premium attributable to benefits in excess of standard coverage, and the reduction in bids attributable to reinsurance payments. Entities would also be required to provide information on whether the entity planned to use any funds in the plan stabilization reserve fund that were available to the entity for the purpose of stabilizing or reducing the monthly premium.

c. Plan Approval. The new Section 1860D–13 would prohibit the Administrator from approving a plan unless the premium, for both standard coverage and for any additional benefits, accurately reflected the actuarial value of the benefits less the actuarial value of reinsurance payments and any stabilization funds used. The bid submitted by an entity for a qualified plan must reasonably and equitably reflect the cost of benefits provided under that plan. The Administrator would have the authority to negotiate the terms and conditions of the proposed monthly premiums and other terms and conditions of proposed plans. The Administrator could disapprove, or limit enrollment in, a proposed plan based on costs to beneficiaries, the quality of coverage and benefits, the adequacy of the plan network, average aggregate projected costs of covered drugs and other factors determined appropriate by the Administrator. The Administrator could approve a plan only if it provided the required benefits and was not designed to result in a favorable selection of beneficiaries. The Administrator would approve at least 2 contracts to offer a Medicare Prescription Drug plan in an area. Contracts would be awarded for 2 years.

d. Fallback. Under New Section 1860D–13, the Administrator, not later than September 1 of each year, beginning in 2005, would make a determination as to whether there were 2 approved bids. If not, the Administrator would enter into an annual contract with an entity to provide Part D enrollees in the area with standard coverage (including access to negotiated prices) for the following year. The Administrator could enter into only 1 contract for each such area. A single entity could be awarded contracts for more than one such area. The Administrator could not enter into such a contract if the Administrator received two or more qualified bids after exercise of the authority to reduce risk for entities. Entities would be required to meet beneficiary protection requirements.

Beneficiary premiums for a fallback plan would be set at the premium amount that would apply if the plan premium equaled the national weighted average premium for the area, as adjusted for geographic differences in drug prices. The Administrator would establish a methodology for making this calculation, which could take into account geographic differences in utilization and the results of the ongoing study on spending and utilization required under the Act. The contract with the plan would provide for payments to the plans for the negotiated costs of covered drugs and payment of prescription management fees tied to performance management fees established by the Administrator. Performance requirements established by the Administrator would include the following; (1) the entity contained costs to taxpayers and to beneficiaries; (2) the entity provided quality clinical care; and (3) the entity provided quality services. The fallback plan would not be permitted to engage in any marketing or branding of the contract. Entities that submitted bids to be a qualified risk-bearing entity could not submit a bid to be a fallback plan.

Conference Agreement

a. PDP Regions. New Section 1860D–11 of the conference agreement provides for the establishment of PDP regions. The service area for a plan includes an entire PDP region. The Secretary shall establish, and may revise PDP regions in a manner that is consistent with the requirements for establishment and revision of MA regions. To the extent practicable, PDP regions shall be the same as MA regions. The Secretary may establish different regions if the Secretary determines that it would improve access to drug benefits. The Secretary will establish PDP regions for the territories. A plan can be offered in more than one PDP region, including all PDP regions.

b. Submission of Bids. Each PDP sponsor is required to submit to the Secretary specified information at the same time and in a similar manner as such information is submitted by MA organizations. The information to be submitted is: (1) information on the prescription drug coverage to be provided; (2) the actuarial value of the qualified prescription drug coverage in the region for a beneficiary with a national average risk profile; (3) information on the bid including the basis for the actuarial value, the portion of the bid attributable to basic coverage and if applicable, the portion attributable to supplemental benefits, and assumptions regarding reinsurance subsidy payments and administrative expenses; (4) service area; (5) level of risk assumed including whether the sponsor requires a modification of risk level and if so the extent of the modification; and (6) such other information required by the Secretary. A modification of risk levels applies to all PDP plans offered by a PDP sponsor in a region; it may include an increase in the federal percentage assumed in the risk corridor or decrease in the size of risk corridors. The Secretary is to establish requirements for information submission in a manner that promotes the offering of plans in more than one PDP region.

The Secretary is to establish processes and methods for determining the actuarial valuation of prescription drug coverage including: (1) an actuarial valuation of standard coverage; (2) actuarial valuations relating to alternative coverage; (3) use of generally accepted actuarial principles and methodologies; (4) applying the same methodology for determinations of alternative coverage as is used for determinations of standard coverage; and (5) actuarial valuation of reinsurance subsidies. The processes and methods are to take into account the effect that providing alternative coverage (rather than standard coverage) has on drug utilization.

PDP sponsors and MA organizations are responsible for the submission of required actuarial valuations for plans they offer. They may use actuarial opinions certified by independent, qualified actuaries.

c. Plan Approval. The Secretary will review the submitted information for purposes of conducting negotiations with the plan. The Secretary has the authority to negotiate the terms and conditions of the plans. The authority is similar to the authority the Director of the Office of Personnel Management has with respect to Federal Employee Health Benefits (FEHB) plans.

After review and negotiation, the Secretary will approve or disapprove the plan. The Secretary may only approve a plan if certain requirements are met. The plan must comply with Part D requirements, including for actuarial determinations. The Secretary must determine that the portion of the bid that is related to basic coverage is supported by the actuarial bases provided and reasonably and equitably reflects the revenue requirements (as the term is used under Section 1302(8)(c) of the Public Health Service Act) for benefits provided under the plan, less the sum of the actuarial value of the reinsurance payments provided. Similarly, the Secretary must determine that the portion of the bid that is related to supplemental coverage is supported by the actuarial bases provided and reasonably and equitably reflects the revenue requirements for coverage provided under the plan.

The Secretary can only approve a plan, if the plan and the benefits (including any formulary and tiered formulary structure) are not likely to discourage enrollment by certain beneficiaries.

The agreement provides that the Secretary may only approve a limited risk plan for a PDP region if the access requirements for the region would otherwise not be met except for the approval of a limited risk or fallback plan. Only the minimum number of limited risk plans necessary for a region to meet access requirements may be approved. The Secretary shall provide priority to those with the highest level of risk. In no case can the reduction of risk provide for no (or a de minimus) level of financial risk. There is no limit on the number of full risk plans that may be approved.

d. Fallback. The New Section 1860D–3, discussed above, establishes access requirements. If access is not provided, including through a limited risk plan, the conference agreement establishes a fallback process. The Secretary is required to establish a separate process for the solicitation of bids from eligible fallback entities for the offering in all fallback service areas in or more PDP regions of a fallback prescription drug plan during the contract period. A single fallback entity may not offer all fallback plans throughout the United States. Except as otherwise provided, the general provision relating to approval or disapproval of bids under New Section 1860D–11(e) applies with respect to fallback plans. The Secretary can only approve one fallback plan for all fallback service areas in any PDP region for a contract period. Competitive contracting provisions apply. The Secretary shall approve fallback plans so that if there are any fallback service areas in the region for the year, they are offered at the same time as prescription drug plans would otherwise be offered.

The fallback entity could not submit a bid for a prescription drug plan for any region for the first year of a contract period. A fallback service area is an area within a PDP region in which, after applying the provisions relating to limited risk plans, the access requirements will not be met. Fallback prescription drug plans are permitted to offer only standard prescription drug coverage, pass on negotiated discounts and meet such other requirements specified by the Secretary. The fallback plan would not be permitted to engage in any marketing or branding of the contract.

Under a fallback contract, the Secretary would pay actual costs of Part D covered drugs taking into account negotiated price concessions. Payment would also be made for prescription management fees tied to performance management requirements, established by the Secretary. Performance requirements established by the Secretary would include the following; (1) the entity contained costs to the Medicare Prescription Drug Account and to beneficiaries; (2) the entity provided quality clinical care, including reduction in adverse drug interactions; and (3) the entity provided timely and accurate delivery of services, including pharmacy and beneficiary support services; and (4) efficient and effective benefit administration and claims adjudication services. Beneficiary premiums under fallback plans would be uniform and equal to 26 percent of the Secretary's estimate of the average monthly per capita actuarial cost (including administrative costs) to the entity offering the fallback plan.

In general, contract requirements for fallback plans would be the same as those established for prescription drug plans. A contract for a fallback plan would be for 3 years (and be renewable after a subsequent bidding process). However, a contract could not apply in an area in any year unless the area was a fallback service area.

The Secretary will submit an annual report to Congress that describes the instances in which limited risk plans and fallback plans are offered. The secretary will include such recommendations as may be appropriate to limit the need for the provision of such plans and to maximize the assumption of financial risk.

In order to promote competition, the Secretary is prohibited from interfering with the negotiations between drug manufacturers and pharmacies and PDP sponsors. Further, the Secretary may not require a particular formulary or require a particular price structure for the reimbursement of covered drugs. Conferees expect PDPs to negotiate price concessions directly with manufacturers.

PDP sponsors shall permit State pharmaceutical assistance programs and prescription plans under Section 1860D–24 to coordinate benefits with the plan. Fees may not be imposed that are unrelated to coordination. Conferees want to ensure the new Medicare plans are required to coordinate with State plans to ensure those plans can efficiently enroll seniors without unnecessary constraints. Conferees want to ensure a seamless transition for both States and beneficiaries.

Requirements for and contracts with prescription drug plan (PDP) sponsors (new Section 1860D–12 of Conference agreement; (New Section 1860D–4 of House Bill; New Sections 1860D–7, 1860D–10, 1860D–12, and 1860D–13 of Senate Bill).

Present Law

Medicare+Choice plans are required to meet a number of financial and organizational requirements. In general they are required to be organized and licensed under state law, except that a special exception may be established for provider-sponsored organizations. In addition, entities must assume full financial risk for required services.

House Bill

New Section 1860D–4 would specify organizational plan requirements for entities seeking to become PDP plan sponsors. In general, the section would require a PDP sponsor to be licensed under state law as a risk bearing entity eligible to offer health insurance or health benefits coverage in each state in which it offers a prescription drug plan. Alternatively it could meet solvency standards established by the Administrator for entities not licensed by the state. Plans would be required to assume full financial risk on a prospective basis for covered benefits except: (1) as covered by federal subsidy payments and reinsurance payments for high cost enrollees; or (2) as covered by federal incentive payments to encourage plans to expand service areas for existing plans or establish new plans. The entity could obtain reinsurance or make other arrangements for the cost of coverage provided to enrollees.

PDP plan sponsors would be required to enter into a contract with the Administrator under which the sponsor agreed to comply both with the applicable requirements and standards and the terms and conditions of payment. The contract could cover more than one plan. Contracts would be for at least one year. The Administrator would have the same authority to negotiate the terms and conditions of the plans as the Director of the Office of Personnel Management has with respect to Federal Employee Health Benefits (FEHB) plans. The Administrator would be required to take into account subsidy payments for covered benefits in negotiating the terms and conditions regarding premiums. The Administrator would designate at least 10 service areas, consistent with EFFS regions.

The new section would incorporate, by reference, many of the contract requirements applicable to MA plans including minimum enrollment, contract periods, allowable audits to protect against fraud and abuse, intermediate sanctions, and contract terminations. Pro rata user fees could be established to help finance enrollment activities; in no case could the amount of the fee exceed 20% of the maximum fee permitted for an MA or EFFS plan.

The new Section would permit the Administrator to waive the state licensure requirements under circumstances similar to those permitted under Part C for provider sponsored organizations. In such cases, plans would be required to meet financial solvency and capital adequacy standards established by the Administrator. The Administrator would establish such standards by regulation by October 1, 2004.

The standards established under Part D would supersede any state law or regulation (other than state licensing laws or laws relating to plan solvency). In addition, states would be prohibited from imposing premium taxes or similar taxes with respect to premiums paid to PDP sponsors or payments made to such sponsors by the Administrator.

Senate Bill

Under the New Section 1860D–7, an entity eligible to offer a Medicare Prescription Drug Plan would be organized and licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each state it offers a plan. Alternatively, the Administrator could waive the requirement that the entity be licensed in the state, if the Administrator determined that grounds for approval of the application had been met. By January 1, 2005, the Administrator would, in consultation with the National Association of Insurance Commissioners, establish and publish solvency standards for non-licensed entities.

Entities would be required to assume financial risk on a prospective basis for costs of benefits in excess of amounts received from premium payments and reinsurance payments. Entities would be permitted to obtain private reinsurance for the portion of the costs for which they were at risk.

Beneficiaries could not elect a Medicare Prescription Drug Plan unless the Administrator had entered into a contract with the eligible entity for the plan. A contract with an entity could cover more than one plan.

The New Section 1860D–12 would require the Administrator, by January 1, 2005, to establish by regulation standards to implement Part D. Such standards would be periodically reviewed and revised as appropriate. Significant new regulatory requirements could only be implemented at the beginning of a calendar year. The standards would supersede any state law and regulation to the extent such law or regulation was inconsistent with such standards and in the same manner those standards were superseded for Medicare Advantage plans. Standards specifically superseded include those relating to benefits (including requirements relating to cost- sharing and the structure of formularies), premiums, requirements relating to inclusion or treatment of providers, coverage determinations (including related grievance and appeals processes), and requirements relating to marketing materials and summaries and schedules of benefits for a plan.

States would be prohibited from imposing a premium or similar tax with respect to premiums paid to the Administrator for Medicare Prescription Drug Plans and any payments made by the Administrator to eligible entities offering such a plan.

Conference Agreement

The conference agreement establishes organizational requirements for PDP sponsors under the New Section 1860D–12. In general, the section would require a PDP sponsor to be licensed under state law as a risk bearing entity eligible to offer health insurance or health benefits coverage in each state in which it offers a prescription drug plan. Alternatively it could meet solvency standards established by the Secretary for entities not licensed by the state. To the extent an entity is at risk, it must assume financial risk on a prospective basis for covered benefits that is not covered by direct subsidy payments. The entity could obtain insurance or make other arrangements for the cost of coverage provided to enrollees.

PDP plan sponsors would be required to enter into a contract with the Secretary under which the sponsor agreed to comply both with the applicable requirements and standards and the terms and conditions of payment. The contract could cover more than one plan. The Secretary may not enter into a contract with a PDP sponsor if the entity submitted a bid for the year (as the first year of the contract period) to offer a fallback plan in any region or offered a fallback plan in the region during the previous year. An entity is to be treated as submitting a bid if it is acting as a subcontractor of a PDP sponsor that is offering a plan; however this does not apply to a MA organization insofar as it is acting as a PDP sponsor.

The new section would incorporate, by reference, many of the contract requirements applicable to MA plans including minimum enrollment, contract periods, protections against fraud and abuse, intermediate sanctions, and contract terminations. Pro rata user fees may be established to help finance enrollment activities.

The new Section 1860D–12 permits the Secretary, in order to expand choice, to waive the state licensure requirement under circumstances similar to those permitted under Part C for provider sponsored organizations. In such cases, plans would be required to meet financial solvency and capital adequacy standards established by the Secretary. The Secretary, in consultation with the National Association of Insurance Commissioners, would establish and publish such standards by January 1, 2005. The Secretary may periodically review and revise the standards; however, the Secretary may not implement significant new regulatory requirements except at the beginning of a calendar year.

The standards established under Part D supersede state laws or regulations in the same manner that such laws or regulations are superseded for purposes of MA organizations and plans. In addition, states are prohibited from imposing premium taxes with respect to premiums for PDP plans.

Premiums; Late Enrollment Penalty (New Section 1860D–13 of the Conference agreement; New Section 1860D–1 and New Section 1860D–6 of House Bill; New Sections 1860D–2, 1860D–6, 1860D–14, 1860D–15, 1860D–17, and 1860D–18 of Senate bill).

Present Law

Persons who delay enrollment in Part B after their initial enrollment period are subject to a premium penalty. Certain persons, including a working individual and/or spouse of a working individual, may be able to delay enrollment in Medicare Part B without being subject to the delayed enrollment penalty.

House Bill

New Section 1860D–1 would specify that PDP sponsors and MA or EFFS organizations providing qualified prescription drug coverage could not deny, limit, or condition the coverage or provision of benefits or increase the premium based on any health-related status factor in the case of persons who maintained continuous prescription drug coverage since the date they first qualified to elect drug coverage under Part D. Individuals who did not maintain continuous coverage could be subject to an adjusted premium or a pre-existing condition exclusion in a manner reflecting the additional actuarial risk involved. Such risk would be established through an appropriate actuarial opinion. The Administrator would provide a mechanism for assisting sponsors and entities in identifying eligible individuals who had, or had not, maintained continuous coverage.

The provision would specify that an individual would be considered to have had continuous prescription drug coverage if the individual established that he or she had coverage under one of the following (and coverage in one plan occurred no more than 63 days after termination of coverage in another plan): (1) qualified prescription drug coverage under a PDP or MA Rx or EFFS Rx plan; (2) Medicaid prescription drug coverage; (3) prescription drug coverage under a group health plan, but only if benefits were at least equivalent to benefits under a qualified PDP; (4) prescription drug coverage under a Medigap plan, but only if the policy was in effect on January 1, 2006, and only if the benefits were at least equivalent to benefits under a qualified PDP; (5) state pharmaceutical assistance program, but only if benefits were at least equivalent to benefits under a qualified PDP; and (6) veterans coverage for prescription drugs, but only if benefits were at least equivalent to benefits under a qualified PDP. Individuals could apply to the Administrator to waive the requirement that such coverage be at least equivalent to benefits under a qualified prescription drug plan. They could make such application if they could establish that they were not adequately informed that the coverage did not provide such level of coverage.

New Section 1860D–6 would specify that the bid and premium for a PDP could not vary among individuals enrolled in the plan in the same service area, provided they were not subject to late enrollment penalties. A PDP sponsor would permit each enrollee to have their premiums withheld from their Social Security checks in the same manner as is currently done for Part B premiums. Beneficiaries could also make payment of the premium through an electronic funds transfer mechanism. The amount would be credited to the Medicare Prescription Drug Trust Fund. Reductions in Part B premiums attributable to enrollment in MA or EFFS plans could be used to reduce the premium otherwise applicable.

Under certain conditions, the PDP sponsor or entity offering an MA Rx or EFFS Rx plan in an area would be required to accept, for an individual eligible for a low-income premium subsidy, the reference premium amount (premium for standard coverage) as payment in full for the premium for qualified prescription coverage. This requirement would apply if there was no standard coverage available in the area.

Senate Bill

New section 1860D–2 would specify that persons enrolling in Part D after their initial enrollment period would be subject to delayed enrollment penalties. The actuarially sound increase for each 12-month period of delayed enrollment would be determined by the Administrator.

Eligible beneficiaries with creditable drug coverage could elect to continue to receive such coverage, not enroll in Part D, and subsequently enroll in Part D without penalty if the plan terminates, ceases to provide, or reduces the value of the prescription drug coverage under the plan to below the actuarial value of standard prescription drug coverage. Subject to certain conditions, creditable drug coverage would include drug coverage through Medicaid or through a Section 1115 waiver for persons who are not dual eligibles, a group health plan, state pharmaceutical assistance program, Veterans' programs, and Medigap. Entities offering creditable coverage would be required to disclose whether coverage equals or exceeds the actuarial value of standard coverage. A special enrollment period would apply for persons losing creditable coverage. In general, it would be the 63-day period beginning on the date the individual lost such coverage. Entitlement would begin the first day of the first month following enrollment.

The New Section 1860D–14 would require the Administrator to compute a monthly standard coverage premium for each Medicare Prescription Drug plan and for each Medicare Advantage plan. This would equal the value of standard coverage or actuarially equivalent coverage if the plan provided no additional benefits. If the plan offered additional benefits, the calculation would reflect only the value of standard coverage or, alternatively the approved plan premium for the required qualified coverage plan offered by the entity.

The New Section 1860D–15 would require the Administrator, each year, beginning in 2006, to compute a monthly national average premium equal to the average of the monthly standard coverage premium for each Medicare Prescription Drug plan and each Medicare Advantage plan. The calculation would be a weighted average based on the number of enrollees in the plan in the previous year. The Administrator would establish a methodology for making an adjustment to take into account differences in prices among different areas. In making this calculation, the Administrator could take into account geographic differences in utilization. Any adjustment would be budget neutral.

The Administrator would establish procedures for making the calculation for 2005.

New Section 1860D–17 would specify that if the plan's monthly approved premium for standard coverage was equal to the national monthly weighted average premium for such coverage, the beneficiary would pay: (1) the applicable percentage, established for the area, of the monthly national average. If the plan's monthly approved premium was less than the national average the beneficiary would pay: (1) the applicable percentage for the area, minus, (2) the difference between the national average and the plan's premium. If the plan's monthly premium was greater than the national average, the beneficiary would pay: (1) the applicable percentage for the area, plus (2) the difference between the national average and the plan's premium. The applicable percentage for an area would be 30% divided by 100% minus a percentage equal to: total reinsurance payments that will be made in a year (including such payments to qualified retiree plans) divided by such amount plus total payments that would be made to plans, including Medicare Advantage plans, in the year for standard coverage (or actuarially equivalent coverage).

New Section 1860D–18 would specify that premiums would be collected in the same manner as Part B premiums. The collections would be credited to the Prescription Drug Account. The Administrator would establish procedures whereby the sponsor of employment-based retiree coverage could pay the premium. The Administrator would transmit the information necessary for collection to the Commissioner of Social Security.

New section 1860D–6 would specify that premiums for a plan would not vary within a region. However, this requirement would not apply to enrollees who were enrolled in a plan pursuant to a contract between the plan and the employer or other group plan that provided employment-based retiree health coverage, if the premium amount was the same for all such enrollees under such agreement.

Conference Agreement

The conference agreement establishes a new section 1860D–13 which sets requirements for beneficiary premiums. The monthly beneficiary premium for a prescription drug plan is defined as the base beneficiary premium, as adjusted. The base beneficiary premium equals the product of the beneficiary premium percentage and the national average monthly bid amount. The beneficiary premium percentage is equal to: (1) 26%, divided by (2) 100% minus a percentage equal to total reinsurance payments divided by the sum of such reinsurance payments and total payments the Secretary estimates will be paid to prescription drug plans in a year that are attributable to the standardized bid amount (taking into account amounts paid by the Secretary and enrollees and the application of risk adjustment). The national average monthly bid amount is a weighted average of standardized bid amounts for each prescription drug plan and each MA–PD plan. It does not take into account bids submitted for MSA plans, MA private fee-for-service plans, specialized MA plans for special needs beneficiaries, PACE programs, and reasonable cost reimbursement contracts. Once the base beneficiary premium is calculated, it is adjusted up or down, as appropriate, to reflect differences between it and the geographically-adjusted national average monthly bid amount. It is further increased for any supplemental benefits and decreased if the individual is entitled to a low-income subsidy. The premium is uniform for all persons enrolled in the plan, except for those receiving low-income subsidies or those subject to a late enrollment penalty.

Late enrollment penalties would be applied to beneficiaries who failed to maintain creditable coverage for a period of 63 days (within a continuous period of eligibility), beginning on the day after the individual's initial enrollment period and ending on the date of enrollment in a prescription drug plan or MA–PD plan. The amount of the penalty is equal to the amount that is the greater of what the Secretary determines is actuarially sound or 1 percent of the national average monthly beneficiary basic premium (not geographically adjusted) for each uncovered month.

The provision specifies that an individual is considered to have had creditable prescription drug coverage if the individual establishes that he or she had coverage under one of the following: (1) prescription drug plan or MA–PD; (2) Medicaid; (3) group health plan, including a Federal Employees Health Benefits (FEHB) plan and a qualified retiree prescription drug plan; (4) state pharmaceutical assistance program; (5) veterans coverage of prescription drugs; (6) prescription drug coverage under a Medigap plan; (7) military coverage including TRICARE; and 8) other coverage the Secretary determines is appropriate. Coverage meets the definition of creditable coverage only if the actuarial value of prescription drug coverage equals or exceeds the actuarial value of such coverage under standard prescription drug coverage. Individuals could apply to the Secretary to waive the requirement that such coverage be at least equivalent to benefits under a qualified prescription drug plan if they could establish that they were not adequately informed that the coverage did not provide such level of coverage. The Secretary will establish procedures for the documentation of creditable prescription drug coverage. Entities offering creditable coverage would be required to provide disclosure that the coverage does not meet the requirement and the fact that the eligible individual could face late enrollment penalties.

Beneficiary premium payments may be paid directly to the PDP sponsor or MA organization. Alternatively the beneficiary has the option of having the amount withheld from his or her Social Security payment or having payment made through an electronic funds transfer mechanism. Payments withheld are to be paid to the PDP sponsor; however, in the case of late enrollment penalties only that portion attributable to increased actuarial costs is to be paid to the plan.

Premium and Cost-Sharing Subsidies for Low-Income Subsidy Individuals (New Section 1860D–14 of the Conference agreement; New section 1860D–7 of House bill; New Section 1860D–19 of Senate bill).

Present Law

Some low-income aged and disabled Medicare beneficiaries are also eligible for full or partial coverage under Medicaid. Medicaid is a federal-state program, which provides health insurance coverage to certain low-income individuals. Within broad federal guidelines, each state sets its own eligibility criteria, including income eligibility standards. Persons meeting the state standards are entitled to full coverage under Medicaid. Persons entitled to full Medicaid protection generally have all of their health care expenses met by a combination of Medicare and Medicaid. For these "dual eligibles," Medicare pays first for services both programs cover. Medicaid picks up Medicare cost-sharing charges and provides protection against the costs of services generally not covered by Medicare. Perhaps the most important service for the majority of dual eligibles is prescription drugs. These dual eligibles typically have comprehensive drug coverage with only nominal cost-sharing.

Federal law specifies several population groups that are entitled to more limited Medicaid protection. These are qualified Medicare beneficiaries (QMBs), specified low income beneficiaries (SLMBs), and certain qualified individuals. QMBs and SLMBs are not entitled to Medicaid's prescription drug benefit unless they are also entitled to full Medicaid coverage under their state's Medicaid program. Qualifying individuals are never entitled to Medicaid drug coverage (because, by definition, they are not eligible for full Medicaid benefits).

Qualified Medicare Beneficiaries (QMBs) are aged or disabled persons with incomes at or below the federal poverty level. In 2003, the monthly level is $769 for an individual and $1,030 for a couple. ($9,228 per year for an individual and $12,360 per year for a couple). The qualifying levels are higher than the HHS federal poverty guidelines because, by law, $20 per month of unearned income, rounded to the next dollar, is disregarded in the calculation. QMBs must also have assets below $4,000 for an individual and $6,000 for a couple. QMBs are entitled to have their Medicare cost-sharing charges, including the Part B premium, paid by the Federal-state Medicaid program. Medicaid protection is limited to payment of Medicare cost-sharing charges (i.e., the Medicare beneficiary is not entitled to coverage of Medicaid plan services unless the individual is otherwise entitled to Medicaid).

Specified Low-Income Medicare Beneficiaries (SLMBs) are persons who meet the QMB criteria, except that their income is over the QMB limit. The SLMB limit is 120% of the federal poverty level. In 2003, the monthly income limits are $918 for an individual and $1,232 for a couple ($11,016 per year for an individual and $14,784 for a couple). Medicaid protection is limited to payment of the Medicare Part B premium (i.e., the Medicare beneficiary is not entitled to coverage of Medicaid plan services unless the individual is otherwise entitled to Medicaid.)

Qualifying Individuals (QI–1s) are persons who meet the QMB criteria, except that their income is between 120% and 135% of poverty. The monthly income limit for QI–1 for an individual is $1,031 and for a couple $1,384 ($12,372 per year for an individual and $16,608 for a couple). Medicaid protection for these persons is limited to payment of the monthly Medicare Part B premium. In general, Medicaid payments are shared between the federal government and the states according to a matching formula. However, expenditures under the QI–1 program are paid 100% by the federal government (from the Part B trust fund) up to the state's allocation level. A state is only required to cover the number of persons which would bring its spending on these population groups in a year up to its allocation level. This temporary program, originally slated to end September 30, 2002, was extended through March 31, 2004 by P.L. 108–89.

Eligibility determinations for Medicaid, QMB, SLMB, and QI–1 programs are made by the states.

House Bill

The New Section 1860D–7 would provide income-related subsidies for low-income individuals. Low-income persons would receive a premium subsidy (based on the value of standard coverage). Individuals with incomes below 135% of poverty would have a subsidy equal to 100% of the value of standard drug coverage provided under the plan. For individuals between 135% and 150% of poverty, there would be a sliding scale premium subsidy ranging from 100% of such value at 135% of poverty to 0% of such value at 150% of poverty. For those with incomes under 135% of poverty, beneficiary cost-sharing for spending up to the initial coverage limit would be reduced to an amount not to exceed $2 for a multiple source or generic drug and $5 for a non-preferred drug. Sponsors and entities could not charge individuals receiving cost-sharing subsidies more than $5 per prescription. (Beginning in 2007, these amounts would be increased by the percentage increase in per capita beneficiary drug costs.) Sponsors and entities could reduce to zero the cost-sharing otherwise applicable for generic drugs.

In 2006, persons eligible for low-income subsidies would have to have resources at or below three times the level applicable for the Supplemental Security Income program (i.e. $6,000 for an individual and $9,000 for a couple). Beginning in 2007, these amounts would be increased by the annual percentage increase in the consumer price index.

The determination of whether an individual was a subsidy eligible individual, and the amount of the subsidy, would be made by the State Medicaid program or the Social Security Administration. Such funds as necessary would be appropriated to the Social Security Administration. Individuals not in the 50 states or the District of Columbia could not be subsidy eligible individuals but could be eligible for financial assistance with drug costs under new Section 1935(e) added by Section 103.

The premium subsidy amount would be defined as the benchmark premium amount for the qualified prescription drug coverage that the beneficiary selects whether offered by a PDP plan or an MA Rx or EFFS Rx plan in the area. The benchmark premium amount for a plan means the premium amount for enrollment under the plan (without regard to any subsidies or late enrollment penalties) for standard coverage (or alternative coverage if the actuarial value was equivalent). If a plan provided alternative coverage with a higher actuarial value than that for standard coverage, the benchmark amount would bear the same ratio to the total premium as the actuarial value of standard coverage was to the actuarial value of alternative coverage.

The Administrator would provide a process whereby the Administrator would notify the PDP sponsor or MA Rx or EFFS Rx entity that an individual was eligible for a subsidy and the amount of the subsidy. The sponsor or entity would reduce the premiums or cost-sharing otherwise imposed by the amount of the subsidy. The Administrator would periodically, and on a timely basis, reimburse the sponsor or entity for the amount of the reductions.

Part D benefits would be primary to any coverage available under Medicaid. The Administrator would be required to develop and implement a plan for the coordination of Part D benefits and Medicaid benefits. Particular attention would be given to coordination of payments and preventing fraud and abuse. The Administrator would be required to involve the Secretary, the States, the data processing industry, pharmacists, pharmaceutical manufacturers, and other experts in the development and administration of the plan.

Senate Bill

Medicaid beneficiaries eligible for medical and drug benefits under their state Medicaid program (including the medically needy) would continue to receive drug benefits through Medicaid. Persons meeting the definition of QMB, SLMB, or QI–1, and not eligible for Medicaid medical and drug benefits, as well as other persons below 160% of the federal poverty level, would receive their drug benefits through Part D. They would receive assistance for the Part D premium and cost-sharing charges.

QMBs, SLMBs and QI–1s would have a 100% premium subsidy for premiums provided the plan premium was at or below the national weighted average premium (or the lowest premium in the area if none was below the national weighted average).

The benefit package for the QMB population would be defined as having a zero deductible, cost-sharing of 2.5% for costs below the initial coverage limit; 5.0% cost-sharing for costs above the initial coverage limit and below the annual catastrophic limit, and 2.5% cost-sharing for costs above the catastrophic limit. The benefit package for the SLMB and QI–1 population would be defined as having a zero deductible, 5.0% cost-sharing for costs below the initial coverage limit; 10.0% cost-sharing for costs above the initial coverage limit and below the annual catastrophic limit, and 2.5% cost-sharing for costs above the catastrophic limit. Plans could waive or reduce cost-sharing otherwise applicable.

Persons with incomes below 160% of poverty, not otherwise eligible for low-income benefits would have a sliding scale premium subsidy ranging from 100% of the premium at 135% of poverty to 0% at 160% of poverty with no additional premium costs provided the plan premium was at or below the national weighted average premium (or the lowest premium in the area if none was below the national weighted average). The benefit package for this population would be defined as having a $50 deductible in 2006 (indexed in subsequent years by the annual percentage increase in average per capita Medicare drug expenditures), 10.0% cost-sharing for costs below the initial coverage limit; 20.0% cost-sharing for costs above the initial coverage limit and below the annual catastrophic limit, and 10.0% cost-sharing for costs above the catastrophic limit. Plans could waive or reduce cost-sharing otherwise applicable.

QMBs, SLMBs and QI–1s and other Part D enrollees with incomes below 160% of poverty could enroll in MedicareAdvantage and receive their low-income assistance through such plans.

Beginning November 1, 2005, eligibility for low-income individuals would be determined by states. The Administrator would implement a process to notify the eligible entity or MedicareAdvantage plan that the individual was eligible for a cost-sharing subsidy and the amount of the subsidy. The entity would reduce the applicable cost-sharing and submit information to the Administrator on the amount of the reduction. The Administrator would periodically and on a timely basis reimburse the entity or organization for the amount of the reductions.

Beginning January 1, 2009, to the extent a state had not already eliminated application of an asset test, it would be required to permit individuals to make a self-declaration that assets did not exceed $10,000 for an individual or $20,000 for a couple. In subsequent years, these amounts would be increased by the increase in the consumer price index. The Secretary would develop a model declaration form.

Conference Agreement

New Section 1860D–14 of the conference agreement provides premium and cost-sharing subsidies for low-income subsidy-eligible individuals. There are groups of subsidy eligible individuals. The first group is composed of persons who: (1) are enrolled in a prescription drug plan or MA–PD plan; (2) have incomes below 135% of poverty; and (3) have resources in 2006 below $6,000 for an individual and $9,000 for a couple (increased in future years by the percentage increase in the CPI), or (4) who is a full benefit dual eligible, regardless whether that person meets other eligibility standards. The second group of subsidy eligible individuals are persons meeting the same requirements, except that the income level is 150% of poverty and an alternative resources standard may be used; this alternative standard in 2006 is $10,000 for an individual and $20,000 for a couple (increased in future years by the percentage increase in the CPI.)

Individuals with incomes below 135% of poverty, and resources meeting the requirement for the first group, would have a premium subsidy equal to 100% of the low-income benchmark premium amount, but in no case higher than the actual premium amount for basic coverage under the plan. The low-income benchmark premium amount for a region equals either: (1) the weighted average of the basic premiums, if all prescription drug plans are offered by the same PDP sponsor; or (2) the weighted average of premiums for prescription drug plans and MA–PD plans, if plans in the region are offered by more than one PDP sponsor. Other low-income subsidy eligible persons will have a sliding scale premium subsidy ranging from 100% of such value at 135% of poverty to 0% of such value at 150% of poverty. Persons below 135% of poverty would have a premium subsidy for any late enrollment penalty equal to 80 percent for the first 60 months and 100 percent thereafter.

Beneficiaries in both groups are entitled to cost-sharing subsidies. Individuals with incomes below 135% of poverty, and resources meeting the requirement for the first group will have no deductible, cost-sharing for all costs up to the out-of-pocket threshold of $2 for a generic drug or preferred multiple source and $5 for brand name or non-preferred drug. Institutionalized dual eligibles will have no cost sharing. Full benefit dual eligibles with incomes under 100 percent of poverty will have cost sharing up to the out-of-pocket threshold of up to $1 for a generic drug or preferred multiple source and $3 for a brand name or nonpreferred drug. Other low-income subsidy eligible persons will have a $50 deductible, 15 percent cost-sharing for all costs up to the out-of-pocket limit, and cost-sharing for costs above the out-of-pocket threshold of $2 for a generic drug or preferred multiple source and $5 for brand name or non-preferred drug. The deductible and cost-sharing amounts are increased each year beginning in 2007 by the annual percentage increase in per capita beneficiary expenditures for Part D covered drugs except for $1 and $3 cost-sharing, which will increase by the percentage increase in CPI.

Eligibility determinations are to be made under the state Medicaid plan for the state or by the Commissioner of Social Security. Conferees believe that more beneficiaries will enroll in the new Part D benefit if given the option to apply at the Social Security office as well as the welfare office. Low-income subsidy applications, information, and application assistance shall be available to beneficiaries in all Social Security offices and State Medicaid offices. It is the intent of the conferees that while enrollment at the SSA offices is important, both Medicaid programs and the Social Security Administration should engage in outreach activities to encourage eligible individuals to apply for subsidies under this section. The determinations shall remain effective for a period determined by the Secretary, not to exceed one year. Redeterminations or appeals are to be made in the same manner as such redeterminations and appeals are made by state Medicaid plans or the Commissioner for the supplemental security income program, whichever is appropriate.

Full dual eligible persons are to be treated as subsidy eligible persons; the Secretary may provide that other Medicaid beneficiaries be treated as subsidy eligible. Otherwise, income is to be determined in the same manner as determinations are made for the QMB program; however, Section 1902(r)(2) which permits the use of less restive methodologies does not apply for determining whether an individual is a low-income subsidy eligible individual. However, Section 1902(r)(2) continues to apply to all state Medicaid eligibility determinations. The Secretary is to develop a model simplified application form and process for determining and verifying eligibility. The Commissioner may only require submission of statements from financial institutions for an application for low-income subsidies to be considered complete. No other documentary evidence may be required with the submission of the application. The Secretary is permitted to verify information submitted on the application.

The Secretary will provide a process whereby the Secretary will notify the PDP sponsor or MA organization that an individual is eligible for a subsidy and the amount of the subsidy. The sponsor or entity would reduce the premiums or cost-sharing otherwise imposed by the amount of the subsidy. The Administrator will periodically, and on a timely basis, reimburse the sponsor or entity for the amount of the reductions. Reimbursement for cost-sharing subsidies may be computed on a capitated basis.

The residents of the territories are not eligible for low-income subsidies. However, they may be eligible for financial assistance under the new section 1935(e), as added by Section 103.

Subsidies for All Medicare Beneficiaries for Qualified Prescription Drug Coverage (New Section 1860D–15 of Conference agreement; New Section 1860D–8 of House bill; New Sections 1860D–20, 1860D–11, and 1860D–16 of Senate bill).

House Bill

a. Subsidies. New Section 1860D–8 would provide for subsidy payments to qualifying entities. The stated purpose of such payments would be to reduce premiums for all beneficiaries consistent with an overall subsidy level of 73%, reduce adverse selection among plans, and promote the participation of PDP sponsors. Such payments would be made as direct subsidies and through reinsurance. The section would constitute budget authority in advance of appropriations and represent the obligation of the Administrator to provide for subsidy payments specified under the section.

Direct subsidies would be made for individuals enrolled in a PDP, MA Rx or EFFS Rx plan, and equal to 43% of the national weighted average monthly bid amount. Each year, the Administrator would compute a national average monthly bid amount equal to the average of the benchmark bid amounts for each drug plan (not including those offered by private-fee-for service entities) adjusted to add back in the value of reinsurance subsidies. The benchmark bid amount would be defined as the portion of the bid attributable to standard coverage or actuarial equivalent coverage. The bid amount would be a weighted average with the weight for each plan equal to the average number of beneficiaries enrolled in the plan for the previous year. (The Administrator would establish a procedure for determining the weighted average for 2005).

Reinsurance payments would be made for specified costs incurred in providing prescription drug coverage for individuals enrolled in either a PDP plan, or a MA Rx or EFFS Rx plan. The Administrator would provide for reinsurance payments to PDP sponsors, and entities offering MA Rx or EFFS Rx plans. Reinsurance payments would be provided for 30% of an individual's allowable drug costs over the initial reinsurance threshold ($1,000 in 2006) but not over the initial coverage limit ($2,000 in 2006). Reinsurance, not to exceed 80% would also be provided for costs over the out-of-pocket threshold ($3,500 in 2006). In the aggregate, reinsurance payments would equal 30% of total payments made by qualifying entities for standard coverage.

For purposes of calculating reinsurance payments, allowable costs would be defined as the portion of gross covered prescription drug costs that were actually paid by the plan (net of discounts, chargebacks, and average percentage rebates), but in no case more than the part of such costs that would have been paid by the plan if the drug coverage under the plan were standard coverage. Gross covered drug costs would be defined as costs (including administrative costs) incurred under the plan for covered prescription drugs dispensed during the year, including costs related to the deductible, whether paid by the enrollee or the plan, regardless of whether coverage under the plan exceeded standard coverage and regardless of when the payment for the drugs was made.

The Administrator would be required to estimate the total reinsurance subsidy payments that would be made during the year (including those made to qualified retiree plans) and total benefit payments to be made by qualifying entities for standard coverage during the year. The Administrator would proportionately adjust payments such that total subsidy payments during the year were equal to 30% of total payments made by qualifying plans for standard coverage during the year. The Administrator could, in a budget neutral manner, adjust direct subsidy payments in order to avoid risk selection. The payment method would be determined by the Administrator who could use an interim payment system based on estimates. Payments would be made from the Medicare Prescription Drug Trust Fund.

b. Risk corridors. No provision.

Senate Bill

a. Subsidies. New Section 1860D–20 of the Senate bill would provide for reinsurance payments on behalf of: (1) persons enrolled in a PDP; (2) MA plan (except for MSA plan or private fee-for-service plan not providing qualified coverage); (3) persons eligible for but not enrolled in Part D and covered under a qualified retiree plan; (4) persons eligible for but not enrolled in Part D and covered under a qualified state pharmaceutical assistance program. Qualified retiree plans and state pharmaceutical assistance programs would have to provide coverage at least equal to the actuarial value of standard coverage. Reinsurance payments would be made to plans in the case of individuals whose spending exceeded the out-of-pocket limit. Payments to plans would equal 80% (65% in the case of persons in a state pharmaceutical assistance program) of allowable drug costs exceeding the limit. Allowable costs would be equal to actual costs above the limit. Entities would be required to notify the Administrator of the total actual costs (if any) incurred for providing benefits for an individual after the individual exceeded the out-of-pocket threshold. Administrative costs, costs for coverage in excess of the standard benefit, and discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations would not be included. Payment methods would be determined by the Administrator. Such methods could include the use of interim payments.

Any plan sponsor that was not an employer would be required to redistribute reinsurance payments to employers contributing to the plan maintained by the sponsor; the payments would be allocated proportionately among all employers contributing to the plan.

The New Section 1860D–11 would require the Administrator to establish an appropriate method for adjusting payments to plans to take into account variations in costs based on the differences in actuarial risk of different enrollees being served. Any risk adjustment would be designed in a budget neutral manner. The Administrator could take into account similar methodologies used to adjust payments for Medicare Advantage organizations. The Administrator would be required to publish such risk adjusters not later than April 15 each year (beginning in 2005) to be used for computing payments to plans for standard coverage.

New Section 1860D–16 would require the Administrator to pay each entity offering a Medicare Prescription Drug Plan an amount equal to the full monthly approved premium, with appropriate risk adjusters. Payment terms would be determined by the Administrator and be based on terms used for Medicare Advantage plans. Payments to plans would be adjusted to account for differences in actuarial risk of different enrollees being served.

b. Risk corridors. New section 1860D–16 would require entities to notify the Administrator for each year (beginning in 2007) of the total actual costs the entity incurred in providing standard coverage in the preceding year. Total actual costs would reflect total payments made to pharmacies and other entities for coverage and the aggregate amount of discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made to the entity. The notification would not include spending for administrative costs, amounts spent for coverage in excess of standard coverage, or amounts for which the entity subsequently received reinsurance payments.

The provision would establish risk corridors, which would be defined as specified percentages above and below a target amount. The target amount would be defined as the total of plan premiums minus a percentage (negotiated between the Administrator and the entity) for administrative costs. No payment adjustment would be made if allowable costs were not more than the first threshold upper limit or less than the first threshold lower limit for the year, i.e. if the plans were within the first risk corridor. A portion of any plan spending above or below these levels would be subject to risk adjustments. If allowable costs exceeded the first threshold upper limit, then payments would be increased. If allowable costs were below the first threshold lower limit, payments would be reduced.

During 2006 and 2007, plans would be at full risk for drug spending within 2.5% above or below the target. Plans would be at risk for 25% of spending exceeding 2.5% (first threshold upper limit) and below 5% of the target (second threshold upper limit). That is their payments would equal 75% of the allowable costs for spending in this range. They would be at risk for 10% of the spending exceeding 5% of the target. That is their payments would equal 90% of the allowable costs for spending in this range. Conversely, if plans fell below the target, they would share the savings with the government. They would have to refund 75% of the savings if costs fell between 2.5% and 5% below the target level, and 90% of any amounts below 5% of the target.

A special transition corridor would be established in the first two years. The Administrator would make a payment adjustment if the Administrator determined that 60% or more of all participating plans (including Medicare Advantage plans) representing at least 60% of covered beneficiaries had allowable costs that were more than 2.5% above the target. Risk corridor payments would equal 90% of any spending greater than 2.5% of the target but below 5% of the target.

For 2008–2011, the risk corridors would be modified. Plans would be at full risk for drug spending within 5.0% above or below the target level. Plans would be at risk for 50% of spending exceeding 5.0% and below 10.0% of the target level. They would be at risk for 10% of the spending exceeding 10% of the target level. Payments would be increased by 50% of allowable costs exceeding the first threshold upper limit and 90% for costs exceeding the second threshold upper limit. Conversely, if plans fell below the target, they would share the savings with the government. They would have to refund 50% of the savings if costs fell between 5% and 10% below the target level, and 90% of any amounts below 90% of the target. For years after 2011, the Administrator would establish risk corridors. The first threshold risk percentage could not be less than 5% and the second threshold risk percentage could not be less than 10%.

Administrative costs would be not be included in the calculation of whether or nor plan spending fell within a particular risk corridor. Administrative costs would be negotiated separately, on a plan by plan basis, with the Administrator. Administrative costs would be subject to performance risk.

For purposes of making risk corridor calculations, allowable costs would be based on actual costs reported by the plan.

The Administrator could require disclosure of any data as needed to administer the benefit. The Administrator would have the right to inspect and audit any books and records of the entity pertaining to amounts reported for drug spending. Information could be used by officers and employees of the Department of Health and Human Services, but only to the extent necessary to carry out this section.

The Administrator would be required to establish a stabilization reserve fund, within the Prescription Drug Account. Amounts in this fund would be made available to eligible entities beginning with their 2008 contract year. Payments to the fund would be determined as follows. If the target amount for a plan for any year 2006–2010 exceeded applicable costs by more than 3% for the year, the entity would pay the Administrator the amount of such excess; the Administrator would deposit such amount in the fund on behalf of the entity. Applicable costs would be defined as the sum of allowable costs and the amount by which monthly payments were reduced through application of the risk corridor provisions. At appropriate intervals, the Administrator would notify a participating entity of the balances in any of its stabilization accounts. Beginning in 2008, entities would be permitted to use account funds to stabilize or reduce plan premiums. The accounts would expire after 5 years. Any amounts not used by an eligible entity or that was deposited for use by an entity that no longer had a Part D contract would revert to the use of the Prescription Drug Account.

Conference agreement

a. Subsidies. New Section 1860D–15 of the conference agreement provides for subsidy payments to qualifying entities. Such payments would reduce premiums for all beneficiaries consistent with an overall subsidy level of 74% for basic coverage, to reduce adverse selection among plans, and to promote the participation of PDP sponsors and MA organizations. Such payments would be made as direct subsidies and through insurance.

The direct monthly per capita subsidy amount is equal to the plan's standardized bid amount adjusted for health status and risk and reduced by the base beneficiary premium as adjusted to reflect the difference between the bid and the national average bid.

Reinsurance payments, equal to 80% of allowable costs, would also be provided for an enrollee whose costs exceeded the annual out-of-pocket threshold ($3,600 in 2006). For purposes of calculating reinsurance payments, allowable costs would be defined as the portion of gross covered prescription drug costs that were actually paid by the plan (net of discounts, chargebacks, and average percentage rebates), but in no case more than the part of such costs that would have been paid by the plan if the drug coverage under the plan were basic coverage or, in the case of supplemental coverage, standard coverage. Gross covered drug costs would be defined as costs (not including administrative costs) incurred under the plan for covered prescription drugs dispensed during the year, including costs related to the deductible, whether paid by the enrollee or the plan, regardless of whether coverage under the plan exceeded basic coverage and regardless of when the payment for the drugs was made.

The Secretary is required to establish an appropriate method for adjusting the standardized bid amount to take into account variations in costs for basic coverage based on the differences in actuarial risk of different enrollees being served. Any risk adjustment would be designed in a budget neutral manner. The Secretary may take into account similar methodologies used to adjust payments for MA organizations. The Secretary would require PDP sponsors and MA organizations offering MA–PD plans to submit data. The Secretary is required to publish such risk adjusters at the same time as risk adjusters are published for MA organizations.

The Secretary is required to establish an appropriate method for adjusting the national average monthly bid amount per capita subsidy amount to take into account differences. If the Secretary determines that price variations are de minimis, no adjustment is to be made. Any adjustments must be applied in a budget neutral manner.

The Secretary is to establish payment methods, which may include interim payments. Payments are conditional upon the PDP sponsor and MA organization furnishing necessary information to the Secretary. Information may be used by officers and employees of HHS only for the purposes of and to the extent necessary to carry out the section.

c. Risk corridors. New Section 1860D–15 of the conference agreement provides for the establishment of risk corridors, which are defined as specified percentages above and below a target amount. The target amount is defined as total payments paid to the plan, taking into account the amount paid by the Secretary and enrollees, based on the standardized bid amount, risk adjusted, and reduced by total administrative expenses assumed in the bid. No payment adjustments will be made if adjusted allowable costs for the plan are at least equal to the first threshold lower limit of the first risk corridor but not greater than the first threshold upper limit of the risk corridor for the year, i.e. if the plans are within the first risk corridor. A portion of any plan spending above or below these levels is subject to risk adjustment. If adjusted allowable costs exceed the first threshold upper limit, then payments are increased. If adjusted allowable costs are below the first threshold lower limit, then payments are reduced. Adjusted allowable costs are reduced by reinsurance and subsidy payments. Payment adjustments would not affect beneficiary premiums.

During 2006 and 2007, plans would be at full risk for adjusted allowable risk corridor costs within 2.5% above or below the target. Plans with adjusted allowable costs above this level would receive increased payments. If their costs were between 2.5% of the target (first threshold upper limit) and 5% of the target (second threshold upper limit), they would be at risk for 25% of the increased amount; that is their payments would equal 75% of adjusted allowable costs for spending in this range. If their costs were above 5% of the target they would be at risk for 25% of the costs between the first and second threshold upper limits and 20% of the costs above that amount. That is their payments would equal 80% of the adjusted allowable costs over the second threshold upper limit. Conversely, if plans fell below the target, they would share the savings with the government. They would have to refund 75% of the savings if costs fell between 2.5% and 5% below the target level, and 80% of any amounts below 5% of the target.

A higher risk sharing percentage would apply in 2006 and 2007 if the Secretary determines that 60 percent of prescription drug plans and MA–PD plans, representing at least 60 percent of beneficiaries enrolled in such plans have adjusted allowable costs that are more than the first threshold upper limit. In this case, payment to plans would equal 90 percent of adjusted allowable costs between the first and second upper threshold limits.

For 2008–2011, the risk corridors would be modified. Plans would be at full risk for drug spending within 5% above or below the target level. Plans would be at risk for 50% of spending exceeding 5% and below 10% of the target level. Additionally, they would be at risk for 20% of any spending exceeding 10% of the target level. Payments would be increased by 50% of adjusted allowable costs exceeding the first threshold upper limit and 80% for any costs exceeding the second threshold upper limit. Conversely, if plans fell below the target, they would share the savings with the government. They would have to refund 50% of the savings if costs fell between 5% and 10% below the target level, and 80% of any amounts below 10% of the target. For years after 2011, the Administrator would establish risk corridors. The first threshold risk percentage could not be less than 5% and the second threshold risk percentage could not be less than 10% of the target amount. Conferees intend the risk corridors to create incentives for plans to enter the market.

If allowable risk corridor costs are less than the first threshold lower limit, but not greater than the first threshold upper limit for the plan year, then no payment adjustment is made.

Plans are at full financial risk for all spending for supplemental prescription drug coverage.

The subsidy and risk corridor provisions would not apply to fallback plans.

Medicare Prescription Drug Account in the Federal Supplementary Insurance Trust Fund (New Section 1860D–16 of Conference Agreement; New Section 1860D–9 of House Bill; New Section 1860D–25 of Senate Bill).

Present Law

Medicare Part B is financed by a combination of enrollee premiums and federal general revenues. Income from these sources is credited to the Federal Supplementary Insurance Trust Fund. Payments are made from the Trust Fund for Part B benefits.

House Bill

New Section 1860D–9 would create a Medicare Prescription Drug Trust Fund. Requirements applicable to the Part B trust fund would apply in the same manner to the Drug Trust Fund as they apply to the Part B Trust Fund. The Managing Trustee would pay from the Fund, from time to time, low-income subsidy payments, subsidy payments, and payments for administrative expenses. The Managing Trustee would transfer, from time to time, to the Medicaid account amounts attributable to allowable increases in administrative costs associated with identifying and qualifying beneficiaries eligible for low-income subsidies. Amounts deposited into the Trust Fund would include the federal amount which would otherwise be payable by Medicaid except for the fact that Medicaid becomes the secondary payer of drug benefits for the dual eligibles. The provision would authorize appropriations to the Trust Fund an amount equal to the amount of payments from the Trust Fund reduced by the amount transferred to the Trust Fund.

The provision would specify that any provision of law relating to the solvency of the trust fund would take into account the Fund and the amounts received by, or payable from, the Fund.

Senate Bill

A separate account, known as the Prescription Drug Account, would be established within the Part B Trust Fund. Funds in this Account would be kept separate from other funds within the Trust Fund. Payments would be made from the Account to eligible entities and Medicare Advantage plans and for low-income subsidies, reinsurance payments, and administrative expenses. Appropriations would be made to the Account equal to the amount of payments and transfers made from the Account.

Conference Agreement

The conference agreement establishes a Medicare Prescription Drug Account in the Part B Trust Fund. Funds in this Account will be kept separate from other funds within the Trust Fund. Payments will be made from the Account for low-income subsidies, subsidy payments, payments to qualified retiree prescription drug plans, and administrative expenses. Transfers would be made to the Medicaid account for increased administrative costs. States would make payments to the Account for dual eligibles as provided for under Section 1935(c). Appropriations would be made to the Account equal to the amount of payments and transfers from the Account. In order to ensure prompt payments in the early months of the program, there are appropriated such amounts the Secretary certified as necessary, not to exceed 10% of estimated expenditures for 2006.

Subpart 3—Application to Medicare Advantage Program and Treatment of Employer-Sponsored Programs and Other Prescription Drug Plans

Application to Medicare Advantage Program and Related Managed Care Programs (New Section 1860D–21 of Conference agreement; Section 101 of House bill; Sections 201 and 205 of Senate bill).

Present Law

No provision.

House Bill

Beginning January 1, 2006, at least one MA plan offered by an MA organization in an area would be required to: (1) offer qualified drug coverage under Part D; (2) meet the beneficiary protections outlined in the new Section 1860D–3, including requirements relating to information dissemination as well as grievance and appeals; and (3) provide the same information required from prescription drug plan sponsors when submitting a bid, unless waived by the Administrator. MA organizations providing qualified drug coverage would receive low-income subsidy payments and direct and reinsurance subsidies. A single premium would be established for drug and non-drug coverage.

There would be exceptions for the prescription drug coverage offered by private fee-for-service (PFFS) plans. PFFS plans would not be required to negotiate prices or discounts; however, to the extent a plan did so, it would be required to meet related Part D requirements.

Senate Bill

In addition to current law requirements, Medicare beneficiaries would also be required to be enrolled in the new Part D (prescription drug program) in order to enroll in MA (except for PFFS).

Beginning on January 1, 2006, MA plans, other than PFFS and MSA plans, would be required to offer each enrollee qualified prescription drug coverage that met the requirements for such coverage under the MA program and under Part D of Medicare. An MA plan could offer qualified prescription drug coverage that exceeded the coverage required under Part D, as long as it also offered an MA plan in the area that provided only the required coverage. This provision would also establish payments to each MA organization offering an MA plan that provided qualified prescription drug coverage, including a low-income drug subsidy.

Conference Agreement

Beginning January 1, 2006, an MA organization cannot offer an MA plan in an area unless either that plan (or another MA plan offered by the organization in the same service area) includes required prescription drug coverage, and could not offer prescription drug coverage (other than that required under parts A and B) to an enrollee under an MSA plan or under another MA plan unless such drug coverage was qualified prescription drug coverage and unless the requirements of this section, with respect to such coverage are met. Qualified coverage is basic coverage or qualified coverage that provides supplemental drug benefits so long as there is no MA monthly supplemental beneficiary premium under the plan.

An individual enrolled in a health benefits plan would not be considered to have been deemed to make an election into an MA–PD plan, unless the plan provides prescription drug coverage. An individual enrolled in an MA plan would not be considered to have been deemed to make an election into an MA–PD plan, unless: (1) for purposes of the January 1, 2006 election, the MA plan provided as of December 31, 2005 any prescription drug coverage; or (2) for periods after January 1, 2006, such MA plan was an MA–PD plan. An individual who discontinues enrollment in an MA–PD plan during his/her first year of eligibility could enroll in a prescription drug plan under part D at the time of their election of coverage under original Medicare fee-for-service program.

If an individual is enrolled in an MA plan (other than an MSA plan) that does not provide qualified prescription drug coverage, and the organization discontinues offering all MA plans without prescription drug coverage, then the individual would be deemed to have elected the original Medicare fee-for-service program, unless the individual affirmatively enrolls in an MA–PD plan. This disenrollment would be treated as an involuntary termination of the MA plan.

The provisions of this part would apply under Part C of Medicare with respect to prescription drug coverage provided under MA–PD plans in lieu of other Part C provisions that would apply to such coverage. The Secretary could waive these provisions to the extent that they duplicate provision under Part C or as may be necessary in order to improve coordination. The Secretary may also waive the pharmacy network requirements of section 1860D–4(b)(1)(C) in the case of an MA–PD plan that provides access (other than mail order) to qualified prescription drug coverage through pharmacies owned and operated by the MA organizations. The Secretary must determine the organization's pharmacy network is sufficient to provide comparable access for enrollees under the plan.

Private fee-for-service plans (PFFS) plans would not be required to negotiate prices or discounts; however, to the extent a plan did so, it would be required to meet related Part D requirements. If the PFFS plan provided coverage for drugs purchased from all pharmacies, without additional cost-sharing, requirements for pharmacy access and public disclosure of pharmaceutical prices for equivalent drugs would not apply. For PFFS plans, the drug utilization management program and the medication therapy management program would not be required. For PFFS plans, the Secretary would determine the amount of reinsurance payment using a methodology that bases such amount on the Secretary's estimate of the amount of such payment that would be payable if the plan were an MA–PD plan and that takes into account the average reinsurance payment made for a population of similar risk under MA–PD plans. The risk corridor provisions would not apply, and plans would be exempt from negotiations on bid terms.

If an organization provides benefits under a reasonable cost reimbursement contract and also elects to provide qualified prescription drug coverage, then the provisions of this section and related provisions in part C would apply in the same manner as applied to local MA–PD plans. Individuals, who were not enrolled in the reasonable cost plan, could not enroll in the prescription drug plan. The bid of the reasonable cost plan would not be taken into account in computing any standardized bid amount under this section.

In general, the provisions of Part D and related provisions of Part C apply to PACE programs in the same manner as they apply to MA-PD plans. The organization may not enroll persons not enrolled in PACE. Bids are not taken into account in computing the standardized bid amount.

Special Rules for Employer-Sponsored Programs (New Section 1860D–22 of Conference agreement; New section 1860D–8 of House bill; New Section 1860D–21 and 1860D–22 of Senate bill).

Present Law

No provision.

House Bill

Under New section 1860D–8, special subsidy payments would be made to a "qualified retiree prescription drug plan." A qualified plan would be defined as employment-based retiree health coverage (including coverage offered pursuant to one or more collective bargaining agreements) meeting certain requirements. The Administrator would have to determine that coverage had at least the same actuarial value as standard coverage. The sponsor (and the plan) would be required to maintain and provide access to records needed to ensure the adequacy of coverage and the accuracy of payments made. Further, the sponsor would be required to provide certifications of coverage. Payment could not be made for an individual unless: the individual was covered under the retiree plan, entitled to enroll under a PDP or MA Rx or EFFS Rx plan but elected not to. Subsidy payments would equal 28% of allowable costs between $250, but not greater than $5,000, indexed annually by the percentage increase in Medicare per capita prescription drug costs. The provision would clarify that nothing in the section would be construed as precluding an individual covered under an employment-based retiree plan from enrolling in a PDP plan or MA or EFFs plan or having the employment based plan from paying the premium. Employment-based supplemental coverage would be considered the primary payer for purposes of the Medicare secondary payment provisions.

Senate Bill

New Section 1860D–21 of the Senate bill would authorize the Administrator to make direct payments to sponsors of qualified retiree prescription drug plans (as defined under New Section 1860D–20) for each beneficiary enrolled in the plan who was not enrolled in Part D. The amount of the payment would equal the direct subsidy percent of the monthly national average premium for the year, as adjusted by risk adjusters. The direct subsidy percent would be 100% minus the applicable percent as defined under the new Section 1860D–17. The applicable percentage for an area would be 30% divided by: 1) 100%, minus two) a percentage equal to total reinsurance payments that would be made in a year divided by such amount plus total payments that would be made to plans in the year for standard coverage.

The Administrator would establish payment methods, which could include interim payments. Payments would be made from the Prescription Drug Account.

New Section 1860D–22 would require the Administrator to make direct payments to sponsors of qualified state pharmaceutical assistance programs for each beneficiary enrolled in the plan who was not enrolled in Part D. The amount of the payment would be calculated in the same way that such payments were calculated for retiree plans. Further, the Administrator would provide for additional payments in behalf of each person who would otherwise qualify for a low-income subsidy, if the individual were enrolled in Part D. The payment would equal the amount the Administrator estimates would have been paid under the subsidy provisions, but in no case more than the average payment made under the subsidy provisions for an individual in the same income group.

Conference agreement

New Section 1860D–22 of the conference agreement establishes special rules for employer-sponsored programs. Under certain conditions, the Secretary is required to make special subsidy payments to sponsors of qualified retiree prescription drug plans. These payments are to be made on behalf of an individual covered under the retiree plan, entitled to enroll under a PDP or MA–PD plan but elected not to. Subsidy payments will equal 28% of gross covered retiree plan-related prescription drug costs greater than $250 but not greater than $5,000, adjusted annually by the percentage increase in Medicare per capita prescription drug costs.

Qualified retiree prescription drug plans must be employment-based group health plans. Group health plans include welfare plans defined under the Employee Retirement Income Security Act, federal and state governmental plans, including such plans as the Federal Employee Health Benefits program and CalPERS, collectively bargained plans, and church plans. Conferees expect that in the case of interpretive matters with regard to plan sponsors of group health plans, CMS will coordinate with the Department of Labor and Treasury Department for guidance. The sponsor must provide the Secretary with an attestation that the actuarial value of prescription drug coverage under the plan is at least equivalent to the actuarial value of standard prescription drug coverage. The sponsor, or administrator designated by the sponsor, shall maintain and afford the Secretary access to necessary records for the purpose of audits and other oversight activities. The sponsor is required to provide disclosure of information in accordance with disclosure of information on creditable coverage.

Nothing in the section is to be construed as precluding an individual covered under an employment-based retiree plan from enrolling in a PDP plan or MA–PD plan or having the employment-based plan from paying the premium. The PDP or MAPD plan would constitute primary coverage, not the employer. Employment-based retiree coverage may provide coverage that is better than standard coverage to retirees under a qualified retiree prescription drug plan. Employment-based retiree health coverage may provide coverage that is supplemental to benefits provided under a prescription drug plan or MA–PD plan to enrollees in such plans. Nothing is to prevent employers from providing flexibility in benefit design and pharmacy access provisions for basic drug coverage so long as actuarial equivalence requirements are met.

About one-third of Medicare beneficiaries receive coverage for prescription drugs from their former employers. Retirees are generally happy with their coverage and want to keep it. But employer plans are under increasing pressure to drop or scale back coverage. In 1988, 66% of large employers provided health benefits. In 2002, that number slipped to just 34%. Costs for retiree health coverage rose 16.0% in 2002, while prescription drug expenditures increased by 11.8% last year, and most employers predict double-digit health inflation well into the future. Conferees believe the employer retiree subsidies included in the conference report will help employers retain and enhance their prescription drug coverage so that the current erosion in coverage would plateau or even improve. Absent this assistance, many more retirees will lose their employer sponsored coverage.

State Pharmaceutical Assistance Programs (New Section 1860D–23 of Conference agreement).

Present Law

A number of states currently have programs to provide low-income persons, not qualifying for Medicaid, with financial assistance in meeting their drug costs. The state programs differ substantially in both design and coverage.

House Bill

No provision.

Senate Bill

No provision.

Conference agreement

New Section 1860D–23 of the conference agreement requires the Secretary, by July 1, 2005, to establish requirements to ensure effective coordination between a Part D plan (both a prescription drug plan and MA–PD plan) and a state pharmaceutical assistance program (SPAP). The coordination requirements relate to payment of premiums and coverage and payment for supplemental drug benefits, and assistance with cost-sharing. Requirements must be included for enrollment file-sharing, claims processing, claims reconciliation reports, application of the catastrophic out-of-pocket protection, and other administrative procedures specified by the Secretary. Requirements are to be consistent with applicable law, to safeguard the privacy of any identifiable beneficiary information. The agreement provides that the requirements must include a method for the application by a Part D plan of specified funding amounts for enrolled beneficiaries for supplemental benefits. The Secretary is required, when developing the requirements, to consult with state programs, the PDP sponsors, MA organizations, States, pharmaceutical benefit managers, employers, data processing experts, pharmacists, pharmaceutical manufacturers, and other experts.

This legislation allows state pharmacy assistance programs to act as administrative intermediaries for the purpose of facilitating enrollment of SPAP members in prescription drug plans and in the discount card program.

A state pharmaceutical program that this provision applies to is one: (1) that provides financial assistance for the purchase or provision of supplemental prescription drug coverage on behalf of eligible individuals; and (2) which, in determining program eligibility and amount of payment, provides assistance to beneficiaries in all Part D plans and does not discriminate based on the Part D plan in which the individual is enrolled. A card used under Part D may also be used for benefits under the state program.

The agreement authorizes the Secretary, based on an approved application, to provide payments to state pharmaceutical assistance programs for the purpose of educating program beneficiaries about Part D coverage, providing technical assistance to facilitate selection and enrollment in plans, and other activities to promote effective coordination. The report provides $62.5 million in mandatory spending in each fiscal year 2005 and 2006 to help promote coordination between Medicare plans and SPAPs.

Coordination Requirements for Plans Providing Prescription Drug Coverage (New Section 1860D–24 of Conference agreement).

Present Law

No provision.

House Bill

No provision.

Senate Bill

No provision.

Conference Agreement

The New Section 1860D–24 of the conference agreement requires the Secretary to apply the coordination requirements established under the New Section 1860D–23 for state pharmaceutical assistance programs, to other prescription plans including Medicaid (including a plan operating under an 1115 waiver), group health plans, federal employees health benefits plan, military coverage (including TRICARE), and other coverage specified by the Secretary.

The coordination requirements include coordination of procedures to establish third-party reimbursement of out-of-pocket costs. The provision does not change the application of these procedures. The Secretary may impose user fees for the transmittal of information necessary for benefit coordination.

Medicare Prescription Drug Discount Card and Transitional Assistance Program (New Section 1860D–31 of Conference agreement; Section 105 of House bill; Section 111 of Senate Bill).

Present Law

On July 12, 2001, the President announced a new national drug discount card program for Medicare beneficiaries. Under this program, CMS would endorse drug card programs meeting certain requirements. This program was viewed as an interim step until a legislative reform package, including both a drug benefit and other Medicare reforms, was enacted. Implementation of the drug discount card program was suspended by court action.

House Bill

The provision would require the Secretary to establish a program to: (1) endorse prescription drug discount card programs meeting certain requirements; (2) provide for prescription drug accounts; and (3) make available information on such programs to beneficiaries. The Secretary would begin operation of the endorsement program within 90 days of enactment. The account part of the program would begin no later than September 2004. The Secretary would provide for an appropriate transition and termination of the program on January 1, 2006. The program would be voluntary.

Eligible beneficiaries would be defined as persons eligible under Part A or enrolled in Part B, but not enrolled in an MA plan offering qualified prescription drug coverage. The Secretary would establish a process through which an Part D eligible individual could make an election to enroll under the new Section 1807 with an endorsed program. The beneficiary would have to enroll for a year in order to receive the benefits for the year. An individual would, in general have only one opportunity for enrollment. This would occur during an initial, general enrollment period as soon as possible after enactment, and annually thereafter. The annual open enrollment periods would be coordinated with those for MA. An individual who enrolled in the new Section 1807, subsequently enrolled in an MA plan with drug coverage, and then discontinued such MA enrollment would be permitted to reenroll under Section 1807.

In general, eligible beneficiaries would not be permitted to enroll after their initial enrollment period (as defined under Part B). The Secretary would establish an open enrollment period for current beneficiaries.

The Secretary would establish a process through which an Part D eligible individual, enrolled under the new Section 1807, would select an eligible entity to provide access to negotiated prices. The entity would be one, which had been awarded a contract and served the state in which the beneficiary resided. Eligible entities would be pharmaceutical benefit management companies, wholesale and retail pharmacy delivery systems, insurers, MA organizations, other entities, or any combination of these.

The enrollment process, established by the Secretary, would use rules similar to those established for MA. Individuals could not select more than one entity at a time and, except for unusual circumstances (including changing residential setting, such as nursing home placement.) change the selection once a year. The process would provide for selecting eligible entities for individuals who enrolled in the New Section 1807, but failed to select an entity. Entities would compete for beneficiaries on the basis of discounts, formularies, pharmacy networks, and other services.

The Secretary would broadly disseminate information to eligible beneficiaries regarding enrollment, selection of eligible entities, and the coverage made available by entities. The enrollment fee would be $30 with the 2004 fee including any portion of 2003 covered by the program. The fee would be collected in the same manner as Part B premiums are collected from social security payments, except the collection would be made only once a year. States could pay the fee for some or all low-income enrollees in the state. No federal matching payments would be available. The Secretary would make 2/3 of the fee collected available to the eligible entity.

Each eligible entity would be required to issue a card and an enrollment number to each enrolled beneficiary and to provide for electronic methods to coordinate with prescription drug accounts established under the New Section 1807A.

Beneficiary protections would be established including guaranteed issue and nondiscrimination provisions. If an eligible entity served a state, it would be required to serve the entire state. Entities would be required to disseminate, to each beneficiary who selected the entity, summary information on negotiated prices, access to such prices through pharmacy networks, and how the formulary functioned. Upon request, entities would be required to provide general coverage, utilization, and grievance information. In addition, entities would be required to have a mechanism for providing specific information upon request. The new Part D provisions relating to pharmacy access would apply to eligible entities. To the extent the Secretary determined they could be implemented on a timely basis, entities would be required to meet the new Part D provisions with respect to development and application of formularies and the requirements to have in place an effective cost and drug utilization management program, quality assurance measures and systems, and a program to control fraud, abuse and waste. Each entity would be required to have in place meaningful procedures for hearing and resolving grievances and for expedited determinations and reconsiderations of coverage determinations. Entities would be required to provide pharmaceutical support services. They would also be required to provide for confidentiality and accuracy of enrollee records and periodic reports to the Secretary.

Entities would be required to provide beneficiaries with access to negotiated prices (including applicable discounts). Such discounts would not be taken into account in establishing "best price" for purposes of Medicaid calculations. If the entity used a formulary, negotiated prices would only be available for formulary drugs. Negotiated prices could not be limited to mail order drugs. Entities and contracting pharmacies could not charge beneficiaries for any required services. Entities would be required to disclose to the Secretary the extent to which discounts, or rebates or other remuneration or price concessions made available by a manufacturer were passed through to enrollees; such information would be confidential. Entities would be required to notify enrollees at the time of purchase of the differential between any prescribed drug and the cost of the lowest cost available generic drug that was therapeutically equivalent and bioequivalent.

The Secretary would be required to establish a prescription drug account for each enrolled individual and deposit into the account the federal contribution amount. This amount would be $800 for an accountholder with income under 135% of poverty, $500 for an accountholder with income between 135% and 150% of poverty, and $100 for all other persons. Income would be determined under the state Medicaid program or by the Social Security Administration (SSA). Such sums as may be necessary would be authorized to be appropriated to the SSA. If the program was not in effect for all of 2004, the amounts would be prorated. Persons would not be eligible for a federal contribution if they were eligible for drug coverage under Medicaid, group health plan, Medigap, medical care for members of the uniformed services, Veterans' medical care, Federal Employees Health Benefits program, or the Indian Health Care Improvement Act. The provision would authorize appropriations to the Part B trust fund of an amount equal to the amount by which benefits and administrative costs exceeded the portion of enrollment fees retained by the Secretary.

The provision would establish a new Section 1807A, Prescription Drug Accounts, that would be established for each enrolled beneficiary. Contributions to the account would include federal contributions, any state contributions, private contributions (including employer and individual contributions) and spousal rollover contributions. If the accountholder was married at the time of death, the amount in the account attributable to public contributions would be credited to the account, if any, of the surviving spouse, or if the spouse was not an Part D eligible individual, into a reserve account to be held for when the spouse became an Part D eligible individual.

Costs of the voluntary prescription drug discount card program would not be considered in calculating the Part B premium.

By March 1, 2005, the Administrator would be required to submit a report to Congress on the progress made in implementing the new prescription drug benefit, including specific steps that had been taken, and need to be taken, to ensure timely start of the program on January 1, 2006.

Senate Bill

Section 111 would add a new Section 1807 to the Social Security Act, *Medicare Prescription Drug Discount Card Endorsement Program.* The Secretary would establish a program under which the Secretary would endorse card programs offered by prescription drug card sponsors meeting certain requirements and would make available information on such programs to beneficiaries. Eligible sponsors would be entities with demonstrated experience and expertise in operating a prescription drug discount card program or similar program that the Secretary determined to be appropriate to provide benefits to Medicare beneficiaries. Such entities would include pharmaceutical benefit management companies, wholesale or retail pharmacist delivery systems, insurers, other entities, or any combination of these.

Any individual entitled to Part A and enrolled in Part B would be eligible to enroll in an endorsed prescription drug card program. The Secretary would be required to establish procedures for identifying eligible beneficiaries. The Secretary would also be required to establish procedures under which beneficiaries could make an election to enroll and disenroll in an endorsed card program. A beneficiary could only be enrolled in one endorsed program at a time. Card sponsors could charge annual enrollment fees, not to exceed $25. The fee would be the same for all eligible Medicare beneficiaries enrolled in the program and would be collected by the card sponsor.

The Secretary would provide information, which compared the costs and benefits of various programs. This information dissemination, intended to promote informed choice, would be coordinated with the dissemination of other educational information on other Medicare options. Each card sponsor would make available to each beneficiary (through the Internet or otherwise) information that the Secretary identified as being necessary to provide for informed choice by beneficiaries among endorsed programs; this would include information on enrollment fees, negotiated prices, and services related to drugs offered under the program. The sponsor would have to provide information on how the formulary functioned. The Medicare toll-free number, 1–800–MEDICARE, would be used to receive and respond to inquiries and complaints.

Each endorsed drug card program would have to meet beneficiary protection requirements, including those relating to beneficiary appeals and marketing practices. They would also have to ensure that beneficiaries were not charged more than the lower of the negotiated retail price or the usual and customary price. Each card sponsor would secure the participation of a sufficient number of pharmacies that distributed drugs directly to patients to ensure convenient access (including adequate emergency access) for beneficiaries enrolled in the program. Convenient access would be determined by the Secretary and would take into account reasonable distances to pharmacy services in both urban and rural areas. Each card sponsor would be required to have in place procedures for assuring that quality service was provided to eligible beneficiaries enrolled in a prescription drug discount card program. They would also have to safeguard individually identifiable information in accordance with the Health Insurance Portability and Accountability Act (HIPAA). Sponsors would be prohibited from charging any fees, except for the annual enrollment fee. Card sponsors could not recommend switching an Part D eligible individual to a drug with a higher negotiated price, unless a licensed health professional recommended a switch based on a clinical indication. Negotiated prices could not change more than once every 60 days.

Card sponsors would provide enrolled beneficiaries with access to negotiated prices used by the sponsor for payment for prescription drugs, provided such drugs were not excluded under the program's formulary. The term negotiated price, would include all discounts, direct or indirect subsidies, rebates, price concessions, and direct or indirect remunerations. Medicaid negotiation rules, including rebate requirements, would not apply.

Each card program would be required to provide pharmaceutical support services such as education, counseling, and services to prevent adverse drug interactions. Each card sponsor would issue a discount card to program enrollees.

Sponsors seeking endorsement of a card program would submit required information to the Secretary. The Secretary would review the information and determine whether to endorse the program. A program could not be approved unless it and the sponsor complied with the requirements of the new Section 1807.

Sponsors could use a formulary. Sponsors electing to use a formulary would be required to establish a pharmaceutical and therapeutic committee (that included at least one academic expert, at least one practicing physician and at least one practicing pharmacist) to develop and review the formulary. The committee would base clinical decisions on the strength of scientific evidence and standards of practice. The formulary would have to include drugs within each therapeutic category and class of covered drugs (as defined by the Secretary) although not necessarily for all drugs within such categories and classes. The committee would establish policies and procedures to educate and inform health care providers concerning the formulary. Drugs could not be removed from the formulary until after appropriate notice had been provided to beneficiaries, physicians, and pharmacies. The Secretary would provide appropriate oversight to ensure compliance of programs; including verification of the negotiated prices and services provided. Each program sponsor would be required to report to the Secretary on program performance, use of drugs by beneficiaries, financial information of the sponsor, and other information required by the Secretary. The Secretary could not disclose any proprietary data that was reported. The Secretary could use Parts A and B claims data for purposes of conducting a drug utilization review program.

Section 111 would add a new Section 1807A to the Social Security Act, *Transitional Prescription Drug Assistance Card Program for Eligible Low-Income Beneficiaries*. The Secretary would award contracts to prescription drug card sponsors, offering a program that was endorsed by the Secretary under the new Section 1807, to offer a prescription drug card assistance program to eligible low-income beneficiaries. The program would begin no later than January 1, 2004. The Secretary would provide for a transition and discontinuation of the drug card program and the low-income assistance card program when the new Part D program became effective. The transitional programs would continue to operate at least 6 months after the date benefits first became available under Part D.

All individuals meeting the definition of QMB, SLMB, or QI–1, or those with income below 135 percent of poverty who were not eligible to receive drug benefits under Medicaid, could receive assistance with their prescription drug costs, effective January 1, 2004. In addition, those determined to have income below 135 percent of poverty could receive assistance with their prescription drug costs. These persons would have access, through a drug discount card, to up to $600 per year. The entire $600 benefit would be available for the entire year; any balance left on the card in one year could be carried forward. Beneficiaries would be subject to cost-sharing requirements, which could not be less than 5% of the negotiated price for a drug, or 10% for a transitional assistance eligible individual. Cost-sharing charges would not count against the $600. At a minimum, card sponsors would provide low-income enrollees with a minimum of a 20% discount from the average wholesale price for each covered drug.

In general, the enrollment procedures established for the drug discount card program would apply for this program. Each sponsor offering an assistance card program would be required to enroll any low-income person wishing to enroll if the program served the geographic area where the beneficiary resides. An individual enrolling in an assistance card program would be simultaneously enrolled in a discount card program offered by the sponsor. Enrollment fees would be waived for these individuals and would instead be paid by the Secretary.

Eligible beneficiaries would have to be provided the information required for the discount card program. In addition, sponsors would be required to notify low-income enrollees, on a periodic basis, of the amount of coverage remaining and on the grievance and appeals process under the program.

Each card sponsor would secure the participation of a sufficient number of pharmacies that distributed drugs directly to patients to ensure convenient access for beneficiaries enrolled in the program. The Secretary would determine whether convenient access was provided; mail order pharmacies would not be included in the determination. Further, the Secretary could not make a determination that convenient access had been provided, unless an appropriate arrangement was in place for low-income persons in long-term care facilities.

The Secretary would be required to establish procedures under which benefits under the assistance card program were coordinated with coverage under a state pharmaceutical assistance program or Medicare+Choice plan.

Drug discount card managers could establish formularies. A low-income enrollee would have the right to appeal to obtain coverage for a drug not on the formulary if the prescribing physician determined that the formulary drug was not as effective for the individual or had adverse effects for the individual. If a plan offered tiered cost-sharing for covered drugs, an enrollee would have the right to request that a nonpreferred drug be treated on terms applicable for a preferred drug if the prescribing physician determined that the preferred drug was not as effective for the individual or had adverse effects for the individual.

Sponsors offering assistance card programs would be required to process claims negotiate with brand name and generic manufacturers and others for price concessions, track individual beneficiary expenditures, and perform other functions specified by the Secretary. Each sponsor would receive data exchanges in a format specified by the Secretary.

Entities would be required to assure that low-income beneficiaries were informed at the time of purchase of any difference between the price of the prescribed drug and the lowest cost generic drug that was therapeutically equivalent and bioequivalent and that was available at the pharmacy or other dispenser. Entities would also be required to have meaningful procedures for hearing and resolving grievances, comparable to those established for Medicare+Choice plans. In addition, eligible entities would be required to meet Medicare+Choice requirements relating to coverage determinations.

Sponsors seeking to offer an assistance program would be required to submit information to the Secretary, in the manner specified by the Secretary. The Secretary could not approve a program unless the sponsor and program met the requirements of the new Section 1807A. Further, the Secretary would have to determine that the entity was appropriate to provide benefits to low-income beneficiaries, was able to manage the monetary assistance provided under the program, agreed to submit to audits by the Secretary, and provided other assurances require by the Secretary. There would be no limit on the number of sponsors who could be awarded contracts. The contract would be for the lifetime of the program and cover the same service area served by the sponsor under the card program under Section 1807. The sponsor could submit an application for endorsement under both programs simultaneously.

The Secretary would pay sponsors the amount agreed to in the contract between the sponsor and the Secretary. Payments would be made from the Part B trust fund but would not be considered in the calculation of the Part B premium.

The Secretary would implement New Sections 1807 and 1807A to assure that discounts and benefits were available no later than January 1, 2004. The Secretary would provide for an appropriate transition and discontinuation of the programs; such transition would ensure that benefits continue to operate until the first Part D enrollment period ended.

Conference Agreement

a. Establishment of Program. The conference agreement adds a new Section 1860D–31 to the Social Security Act, Medicare Prescription Drug Discount Card and Transitional Assistance Program. The Section requires the Secretary to establish a program to endorse prescription drug discount card programs meeting certain requirements. Discount card eligible individuals would receive access to prescription drug discounts through card sponsors throughout the U.S. The program will also provide transitional assistance for low-income persons enrolled in endorsed programs. The program is voluntary for eligible individuals.

The agreement requires the Secretary to implement the program so that discount cards and transitional assistance are available no later than 6 months after enactment. The Secretary is required to promulgate regulations to carry out the program. They could be promulgated on an interim final basis which could be effective on the date of issuance. In the case interim final regulations are promulgated, a public comment period would be provided. The Secretary could change or revise the regulations after conclusion of the comment period.

The conference agreement specifies that the new program would not, except as provided for during an individual's transition period, apply to covered discount card drugs dispensed after December 31, 2005. However, any transitional assistance for low income persons would be available after that date to the extent the assistance was for drugs dispensed on or before that date.

Special rules may apply for an individual in a transition period who is also enrolled under a card program as of December 31, 2005. The transition period to the new Part D is the period beginning January 1, 2006 and ending on the effective date of the individual's coverage under Part D or at the close of the individual's initial enrollment period for Part D. During this period, discounts may continue to apply for drugs dispensed to the individual, no annual enrollment fee would be applicable, the individual could not change the endorsed plan in which they were enrolled, and the balance of any transitional assistance remaining on January 1, 2006 would remain available for drugs dispensed during this period.

b. Eligibility. The conference agreement specifies that persons eligible for the discount card are those entitled to or enrolled under Part A or enrolled under Part B. However individuals enrolled in Medicaid (or under any Section 1115 Medicaid waiver) who are entitled to any medical assistance for outpatient prescribed drugs would not be a discount card eligible individual.

An individual eligible for transitional assistance is a discount card eligible individual, residing in one of the 50 states or the District of Columbia, whose income is not more than 135% of the official poverty line applicable to the family size involved. Certain persons would not be eligible for transitional assistance. These are persons who had coverage for, or assistance with, covered discount card drugs under: (1) a group health insurance plan or health insurance plan (other than coverage under a plan under Medicare Part C or coverage consisting only of excepted benefits as that term is defined under Section 2791 of the Public Health Service Act); (2) Chapter 55 of the United States Code relating to medical and dental care for members of the uniformed services; and (3) a plan under the Federal employees health benefits program.

Certain transitional eligible assistance eligible individuals may also qualify as special transitional assistance eligible individuals. These are persons with incomes below 100% of the official poverty line.

The Secretary is required to provide for appropriate rules for the treatment of medically needy persons as discount eligible individuals and as transitional assistance eligible individuals.

c. Enrollment. The conference agreement requires the Secretary to establish a process through which a discount card eligible individual is enrolled and disenrolled in a discount card program. An individual not enrolled in a card program may enroll in any card program, serving residents of the state at any time beginning on the initial enrollment date and before January 1, 2006. Completion of a standard enrollment form, specified by the Secretary, is required. Each program sponsor is required to transmit to the Secretary (in a form and manner specified by the Secretary) information on persons completing the enrollment forms. They are also required to provide certain information relating to the certification as a transitional assistance eligible individual.

The conference agreement specifies that a discount eligible individual may only be enrolled in one endorsed card program at a time. An individual enrolled in one program in 2004 could change the election for 2005. The Secretary will establish a process for making this change, which will be similar to, and coordinated with, that established for annual coordinated elections for Medicare+Choice plans under Part C. The agreement requires the Secretary to permit individuals to change programs in which they were enrolled if they changed residence outside the service area of the plan or under other exceptional circumstances. The Secretary is permitted to consider a change in residential setting (such as placement in a nursing facility) as an exceptional circumstance. Also meeting this criteria would be enrollment or disenrollment from a Medicare+Choice plan through which an individual was enrolled in an endorsed program.

An individual could voluntarily disenroll from an endorsed program at any time. Such individual could not enroll under another endorsed program except during the open enrollment period or under the exceptional circumstances specified by the Secretary. An individual, who was not a transitional assistance eligible individual, could be disenrolled by the program sponsor, if the individual failed to pay the annual enrollment fee.

A Medicare+Choice organization or organization operating under a reasonable cost contract that wishes to become a prescription drug card sponsor may elect to limit enrollment in its endorsed discount card program to eligible enrollees enrolled in the plan. If the organization elects this option, its enrollees can only enroll in the endorsed discount card program offered by that sponsor.

A card sponsor may charge an annual enrollment fee, not to exceed $30, for each enrollee. The fee for either 2004 or 2005 could not be prorated. The sponsor will ensure that the annual enrollment fee (if any) is the same for all enrollees residing in the state. The annual enrollment fee is to be collected by the program sponsor. The annual enrollment fee for a transitional assistance eligible individual is to be paid by the Secretary on the individual's behalf.

The Secretary will establish an arrangement under which a state could pay for some, or all, of the enrollment fee for some or all enrollees who are not transitional assistance eligible individuals. The payment would be paid directly by the state to the sponsor. No federal matching payments would be available.

The Secretary will establish special rules for individuals who change, during a year, the endorsed program in which they are enrolled.

Each card sponsor will issue, in a standard format specified by the Secretary, a discount card to each enrollee. The card will establish proof of enrollment. It may be used in a coordinated manner to identify the sponsor, program, and individual. The Secretary will specify the effective date that card enrollees will have access to negotiated prices and transitional assistance, if any.

d. Information. The conference agreement requires the Secretary to provide for activities that broadly disseminate information to discount card eligible individuals and prospective eligible individuals. These persons would receive information on enrollment in endorsed card programs and on the features of the drug discount card and transitional assistance program. In order to promote informed choice, the Secretary will provide for the dissemination of information, which compares the annual enrollment fee and other features of such programs, which could include comparative prices for covered drugs. To the extent practicable, this will be coordinated with the dissemination of educational material on other Medicare options. The required information will also include educational materials on the variability of discounts on covered drugs under an endorsed program. To the extent practicable, the Secretary will ensure the provision of required information at least 30 days prior to the initial enrollment date. The Secretary, through the use of 1–800–MEDICARE, will provide for the receipt and response to inquiries and complaints concerning the discount card program and endorsed programs.

The conference agreement requires each card sponsor to make available to discount card eligible individuals (through the Internet and otherwise) information the Secretary identifies as being necessary to promote informed choice. This includes information on enrollment fees and negotiated prices for covered drugs. Each sponsor is required to have a mechanism (including a toll free number) for providing, on request, specific information to individuals enrolled in the program. Specific information includes information on negotiated prices and the amount of transitional assistance remaining to the individual. The sponsor is required to inform transitional assistance eligible individuals of the availability of such toll-free numbers to provide information on the amount of available assistance to the individual. Information on the balance of transitional assistance available will have to be available at the point-of-sale, either electronically or by telephone.

The conference report requires sponsors to provide that each pharmacy that dispensed a covered discount drug to inform program enrollees of any difference between the price of the drug provided to the enrollee and the price of the lowest priced generic drug covered under the program that is therapeutically equivalent and bioequivalent and available at such pharmacy. The notice is to be provided at the time of purchase, or in the case of a mail order drug, at the time of delivery. The Secretary may waive this requirement under circumstances specified by the Secretary.

e. Discount Card Program. The conference agreement requires each card sponsor to provide each enrollee with access to negotiated prices. These negotiated prices would take into account negotiated price concessions such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations for covered drugs. Negotiated prices include any dispensing fees. Seniors currently benefit from prescription drug assistance programs offered by pharmaceutical companies. Conferees intend that these programs continue to be offered until the full implementation of the prescription drug benefit. Nothing in this conference report shall be interpreted as encouraging the discontinuation or diminution of these benefits.

Each prescription drug card sponsor must secure the participation of a sufficient number of pharmacies that dispense drugs directly to enrollees to ensure convenient access to covered drugs at negotiated prices. This requirement may only be met by entities dispensing drugs other than solely by mail order. Conferees intend for seniors to have access to a bricks and mortar pharmacy. The Secretary will establish convenient access rules that are no less favorable than standards for convenient access to pharmacies applicable under TRICARE. Applicable TRICARE standards are those specified in the statement of work solicitation (#MDA906-03-R-0002) as of March 13, 2003.

A prescription drug card sponsor (and any pharmacy contracting with the sponsor to provide covered discount card drugs) may not charge enrollees for any items and services required to be provided under the program. This prohibition would not apply to the annual enrollment fee for persons who are not transitional assistance eligible individuals or for the charge for the drug (consistent with the negotiated price) reduced by any transitional assistance.

The agreement further provides that negotiated prices will not be taken into account for purposes of making best price calculations under the Medicaid rebate program.

Each endorsed card program is required to implement a system to reduce the likelihood of medication errors and adverse drug interactions and to improve medication use.

f. Eligibility Procedures. The conference agreement requires the Secretary to establish procedures for eligibility determinations for endorsed programs and for those eligible as a transitional assistance eligible individual or a special transitional eligible individual. The Secretary is to define the terms income and family size and specify the methods and period for which they are determined. If such methods provide for use of information for prior time periods, the Secretary is required to permit an individual whose circumstances changed to have eligibility for transitional assistance determined for a more recent period. The Secretary may use a reconsideration process or other method.

An individual wishing to be treated as a transitional assistance eligible individual or special transitional eligible individual could self-certify through a simplified means as to their income, family size, and prescription drug coverage (if any). The certification could also be done by another qualified person, acting on the individual's behalf. The certification could be provided before, on or after the time of enrollment in an endorsed program. The self-certification would be deemed as consent to have the information verified by the Secretary. A verified self-certification for as a transitional assistance or special transitional assistance eligible individual would be applicable for the entire period of enrollment in any endorsed program.

The Secretary is required to establish verification methods, which could include sampling and use of information on Medicaid eligibility provided by the states, financial information from the Commissioner of Social Security, and financial information from the Secretary of the Treasury. The Secretary could find that an individual met the income requirements for transitional assistance if the individual is within a category of discount card eligible individuals who are enrolled under Medicaid (such as qualified Medicare beneficiaries, specified low-income Medicare beneficiaries, and certain qualified individuals). States will be required, as a condition of Federal Medicaid assistance to provide, on a timely basis, information that allows the Secretary to identify persons eligible for drug coverage under Medicaid, or who are transitional assistance eligible individuals, or special transitional eligible individuals. The Secretary is required to establish a reconsideration process for persons determined not to be transitional eligible or special transitional assistance eligible individuals. The results are to be communicated to the individual and drug card sponsor involved. The Secretary may enter into contracts to perform the reconsideration function.

g. Transitional Assistance. The conference agreement provides special provisions for low-income persons. A transitional assistance eligible individual will be entitled to have his or her discount card enrollment fee paid. Those individuals with incomes below 100% of poverty (special transitional assistance eligible individuals) would be liable for coinsurance charges of 5% of incurred costs up to $600 in both 2004 and 2005. Other transitional assistance eligible individuals (those with incomes between 100% and 135% of poverty) would be liable for coinsurance charges of 10% of incurred costs up to $600 in both 2004 and 2005. Thus, the program will pay 95% of a special transitional eligible individual's incurred drug costs up to $600 in 2004 and 90% of other transitional eligible individual's incurred drug costs up to $600 in 2004. Similarly, payment would be made for 95% or 90%, whichever is appropriate, of the individual's incurred drug costs up to $600 in 2005. In addition, any balance left over from 2004 may be added to the amount available in 2005, except no rollover would be permitted if the individual voluntarily disenrolled from an endorsed plan. No funds will be available under this program for covered discount card drugs dispensed after December 31, 2005. The Secretary will provide a method for the reimbursement of card sponsors for transitional assistance.

The $600 annual amount is to be prorated in 2004, for persons not enrolling in an endorsed program and providing self-certification prior to the program's initial implementation date. For 2005, the amount is to be prorated for persons not enrolling in an endorsed program and providing self-certification prior to February 1, 2005.

The conference agreement permits a pharmacy to reduce the coinsurance otherwise applicable. It also permits states to pay some or all of the coinsurance for some or all transitional assistance eligible enrollees. The payment would be made directly by the state to the pharmacy. No federal matching payments would be available for these costs; further they could not be considered as Medicare cost-sharing for purposes of the qualified Medicare beneficiary program.

The conference agreement includes provisions to ensure access to transitional assistance for qualified residents of long-tem care facilities and American Indians. It requires the Secretary to establish procedures to ensure such access for qualified residents of long-term care facilities. The Secretary could waive requirements of the new Section 1860D-31, as necessary, to negotiate arrangements with sponsors to provide arrangements with pharmacies that support long-term care facilities. The Secretary is also required to establish procedures to ensure that pharmacies operated by the Indian Health Service, Indian tribes and tribal organizations, and urban Indian organizations have the opportunity to participate in the pharmacy networks of at least two endorsed programs in each of the 50 states and the District of Columbia where such a pharmacy operates. Where necessary, the Secretary could waive requirements of the new Section 1860D-31.

The availability of negotiated prices or transitional assistance could not be taken into account in determining an individual's eligibility for or benefits under any other Federal program. Any nonuniformity of benefits resulting from the implementation of the new Section 1807 (such as the waiver of an enrollment fee) would not be taken into account in calculations of any required additional benefits under Part C.

h. Qualifications for Card Sponsors. The conference agreement defines entities eligible to be card sponsors and establishes criteria that such entities would have to meet. The agreement specifies that a card sponsor could be any nongovernmental entity that the Secretary determines is appropriate to offer an endorsed discount card program. An entity which could qualify includes a pharmaceutical benefit management company, a wholesale or retail pharmacy delivery system, an insurer (including one that offered Medigap policies), an organization under Part C, or any combination of these. Each program would have to be operated directly, or through arrangements with an affiliated organization (or organizations), by one or more organizations with demonstrated experience and expertise in operating such a program. Further, the program would have to meet business stability and integrity requirements specified by the Secretary. The sponsor will be required to have arrangements, satisfactory to the Secretary, to account for transitional assistance provided to eligible individuals.

The conference agreement requires each sponsor seeking endorsement to submit an application to the Secretary. The Secretary would review the application and determine whether to endorse the program. The Secretary could not endorse the program unless the program and sponsor comply with the applicable requirements of the new Section 1860D–31 and the sponsor enters into a contract with the Secretary to carry out such requirements. An endorsement would be for the duration of the discount card and transitional assistance program. The Secretary could make an exception for cause.

The conference agreement requires the Secretary to ensure that at least 2 endorsed programs (each offered by a different sponsor) are available to each eligible individual. The

Secretary may limit (but not below 2) the number of sponsors in a state that were awarded contracts.

Card sponsors enrolling individuals in any part of a state would be required to permit eligible individuals in all parts of the state to enroll. An exception would apply in the case of a Medicare+Choice organization, which elects to limit enrollment in its endorsed discount card program to eligible enrollees enrolled in its Medicare+Choice plan.

Each prescription drug card sponsor will be required to pass on to discount eligible enrollees the negotiated prices for covered drugs, including discounts negotiated with pharmacies and manufacturers, to the extent such discounts are disclosed under required disclosure rules. Each card sponsor will be required to provide meaningful procedures for hearing and resolving grievances between the sponsor and enrollees in a manner similar to that required for Medicare+Choice. The operations of an endorsed card program are covered functions and a card sponsor is a covered entity for purposes of applying the administrative simplification provisions established in Part C of Title XI of the Social Security Act. Included are regulations promulgated under that Part including privacy regulations. The Secretary could waive the relevant portions of privacy regulations for an appropriate limited period of time in order to promote participation of sponsors.

The sponsor of an endorsed card program may not provide or market services under the program except if the product or service is directly related to a covered discount card drug or a discount price for a nonprescription drug. Sponsors will also be required to meet additional requirements as the Secretary identifies are needed to ensure that enrollees are not charged more than the lower of the negotiated price or the usual and customary price.

Special rules apply to Medicare+Choice organizations or organizations offering enrollment under a reasonable cost contract. An organization could elect to limit enrollment in its endorsed discount card program to eligible enrollees enrolled in its plan. In this case, special rules would apply. The sponsor could not enroll individuals not enrolled in the plan. The pharmacy access requirements applicable to card sponsors would be deemed to be met if access is made available through a pharmacy network (and not only through mail order) and the network is approved by the Secretary. The Secretary could waive requirements applicable to card sponsors to the extent he determined they were duplicative or conflicted with a Medicare+Choice or cost contract requirement or were necessary in order to improve coordination of the card program with Medicare+Choice or cost contract benefits.

Each card sponsor will be required to disclose to the Secretary information relating to: (1) program performance; (2) use of drugs by card program enrollees; (3) extent to which negotiated price concessions made available by the manufacturer are passed through to enrollees through pharmacies or otherwise; and (4) other information specified by the Secretary. The Medicaid provision providing for the confidentiality of drug information will apply to any drug pricing information (other than aggregate data) disclosed under these requirements.

The Secretary will provide appropriate oversight to ensure compliance of card programs and sponsors with the requirements of the new Section 1860D–31. The Secretary would have the right to audit and inspect any books and records of sponsors (and any affiliated organization) that pertain to the card program, including amounts payable to the sponsor. The Secretary could impose sanctions for abusive practices.

i. Territories. The conference agreement provides federal assistance to territories, which establish a plan to provide transitional assistance for covered discount drugs to some or all eligible persons residing in the state. Eligible persons are those entitled to benefits under Part A or enrolled in Part B with incomes below 135% of the poverty line. The total amount of available federal assistance is $35 million. The amount available for each territory would be determined using the ratio of the total number of Medicare residents in the territory to Medicare residents in all the territories.

j. Funding. The conference agreement creates a separate Transitional Assistance Account in the Part B Trust Fund. Funds in this account are to be kept separate from other funds within the Trust fund. Payments are to be made from the Account in such amounts as the Secretary certifies are necessary to make payments for transitional assistance. Appropriations are to be made to the Account equal to the amount of payments from the Account. Such sums as are necessary would be authorized to be appropriated for the Secretary's administrative expenses. Payments could not be made to sponsors for administrative expenses, except for payment of the enrollment fee for transitional eligible individuals. Costs associated with the Medicare prescription drug card and the transitional assistance program would be excluded from the calculation of the Part B premium.

Definitions; Treatment of References to Provisions in Part C (New Section 1860D–41 of Conference agreement; *New Section 1860D–10 of House bill;* New Sections 1860D, 1860D–26 and Section 110 of Senate bill).

House Bill

New Section 1860D–10 would provide cross-references to other sections of the bill for definitions of covered outpatient drugs, initial coverage limit, Medicare Prescription Drug Trust Fund, PDP sponsor, qualified prescription drug coverage, and standard coverage. It would define a prescription drug plan as health benefits coverage that: (1) is offered under a policy, contract, or plan by a PDP sponsor pursuant to and in accordance with a contract between the Administrator and the sponsor; (2) provides qualified prescription drug coverage; and (3) meets the applicable beneficiary protection requirements. It would specify that the term "insurance risk" would, for a participating pharmacy, mean the type commonly assumed only by insurers licensed by a state and not payment variations designed to reflect performance-based measures of activities within control of the pharmacy, such as formulary compliance and generic drug substitution. The section would further provide that any reduction or waiver of cost-sharing would not be in violation of kickback and similar prohibitions.

MA and EFFS plans would be required to offer drug plans pursuant to the requirements of Sections 1851 and New Section 1860e–2(d). The provision would specify that Part C requirements relating to a drug plan or sponsor would be applied (unless otherwise specified) as if: (1) any reference to a MA or other plan included a reference to a prescription drug plan; (2) any reference to a provider-sponsored organization included a reference to a PDP sponsor; (3) any reference to a contract included a reference to a drug plan contract; and (4) any reference to Part C included a reference to Part D.

Senate Bill

New Section 1860 D would define a number of terms used in the bill. The "Administrator" would be defined as the Administrator of the new Center for Medicare Choices established under the bill.

A "Part D eligible individual" would be an individual entitled to, or enrolled for, benefits under Part A and enrolled in Part B. An "eligible entity" would be any risk bearing entity that the Administrator determined to be appropriate to provide eligible beneficiaries with benefits under a Medicare Prescription Drug Plan. Eligible entities would include pharmaceutical benefit management companies, wholesale or retail pharmacist delivery systems, insurers (including insurers that offered Medigap policies), other risk bearing entities, or any combination of these. This requirement would not preclude State pharmacy assistance programs from becoming a qualified entity if they meet the requirements.

A "Medicare Prescription Drug Plan" would offer prescription drug coverage under a policy, contract or plan by an eligible entity pursuant to and in accordance with a contract between the Administrator and the entity. The plan would have to be approved by the Administrator.

The provision would specify that Part C requirements relating to MedicareAdvantage would be applied (unless otherwise specified) as if: (1) any reference to a MedicareAdvantage plan included a reference to a Medicare Prescription Drug plan; (2) any reference to a provider-sponsored organization included a reference to an eligible entity; (3) any reference to a contract included a reference to a drug plan contract; and (4) any reference to Part C included a reference to Part D.

The provision would permit sponsors of employment-based retiree coverage that offer a prescription drug plan to restrict enrollment in the plan to eligible beneficiaries enrolled in such coverage. Sponsors could not offer enrollment in a Medicare Prescription Drug plan based on the health status of beneficiaries.

Entities offering a Medicare Prescription Drug plan or a MedicareAdvantage organization offering a MedicareAdvantage plan could enter into an agreement with a state pharmaceutical assistance program (including one established under a Section 115 waiver) to coordinate coverage.

Conference Agreement

New Section 1860D–41 provides cross references to other sections of the bill for definitions of basic prescription drug coverage, covered Part D drugs, creditable prescription drug coverage, Part D eligible individual, fallback prescription drug plan, initial coverage limit, MA plan, MA–PD plan, Medicare Prescription Drug Account, PDP approved bid, PDP region, qualified prescription drug coverage, standard prescription drug coverage, state pharmaceutical assistance program; and subsidy-Part D eligible individual. It defines the term "insurance risk" as meaning for a participating pharmacy, risk of the type commonly assumed only by insurers licensed by a state and does not include payment variations designed to reflect performance-based measures of activities within control of the pharmacy, such as formulary compliance and generic drug substitution. A PDP sponsor is defined as a nongovernmental agency that is certified under Part D as meeting Part D requirements and standards. A prescription drug plan is defined as prescription drug coverage that: is offered (1) under a policy, contract, or plan that has been approved under Part D; and (2) by a PDP sponsor pursuant to and in accordance with a contract between the Secretary and the sponsor under Part D.

The provision specifies that Part C requirements are to be applied (unless otherwise specified) as if: (1) any reference to a MA plan included a reference to a prescription drug plan; (2) any reference to a provider-sponsored organization included a reference to a PDP sponsor; (3) any reference to a contract included a reference to a drug plan contract; (4) any reference to Part C included a reference to Part D; and (5) any reference to a Part C election period is a reference to a Part D enrollment period.

Miscellaneous Provisions (New Section 1860D–42 of conference agreement; New Section 1860D–16 of House bill; Section 1860D–26 of Senate bill).

Present Law

No provision.

House Bill

The Secretary would be required to submit a legislative proposal within six months of enactment containing necessary technical and conforming amendments. Not later than January 1, 2005, the Administrator would be required to submit a report containing recommendations for providing benefits under Part D for drugs currently paid for under Part B.

Senate Bill

New Section 1860D–26 would require the Secretary, within six months of enactment, to submit a legislative proposal for any necessary technical and conforming amendments.

Conference Agreement

The agreement includes miscellaneous provisions. It permits the Secretary to waive Part D requirements, including the requirement for two plans in an area, insofar as the Secretary determines it necessary to secure access to qualified drug coverage in the territories.

The agreement requires the Secretary to submit a legislative proposal within six months of enactment containing necessary technical and conforming amendments to titles I and II of the bill. Not later than January 1, 2005, the Secretary is required to submit a report to Congress containing recommendations for providing benefits under Part D for drugs currently paid for under Part B. By March 1, 2005, the Secretary is required to submit a report to Congress on the progress made in implementing the drug benefit. The report will include specific steps taken, and that need to be taken, to ensure a timely start on January 1, 2006. The report is to include recommendations regarding an appropriate transition form the discount card and transitional assistance program.

Medicare Advantage Conforming Amendments (Section 102 of Conference agreement; Section 231 of House bill; Sections 201 and 204 of Senate bill).

Present Law

The Public Health Security and Bioterrorism Preparedness and Response Act of 2002, P.L. 107–188, made temporary changes to reporting dates and deadlines. First, CMS moved its annual announcement of M+C payment rates from no later than March 1 to no later than the 2nd Monday in May, effective only in 2003 and 2004. It also temporarily moved the deadline for plans to submit information about ACRs, M+C premiums, cost sharing, and additional benefits (if any) from no later than July 1 to no later than the 2nd Monday in September in 2002, 2003, and 2004. It also changed the annual coordinated election period from the month of November to November 15th through December 31 in 2002, 2003, and 2004. Once the temporary provision expires, the reporting dates and deadlines would return to the pre-P.L. 107–188 dates.

In addition, P.L. 107–188 will continue to allow Medicare beneficiaries to make and change election to an M+C plan on an ongoing basis through 2004. Then beginning in 2005, individuals will only be able to make changes on the more limited basis, originally scheduled to be phased in beginning in 2002. Beneficiaries can make or change elections during the annual coordinated election period. Current Medicare beneficiaries may also change their election at any time during the first 6 months of 2005 (or first 3 months of any subsequent year). Additionally, there are special enrollment rules for newly eligible aged beneficiaries as well as special enrollment periods for all enrollees under limited situations, such as an enrollee who changes place of residence.

The Secretary must provide information to Medicare beneficiaries and prospective beneficiaries on the coverage options provided under the M+C program, including open season notification, a list of plans and other general information.

House Bill

The reporting deadline for ACRs and other information would permanently move to July 1 of each year. The annual coordinated election period would be permanently changed to November 15 through December 31. The announcement of payment rates, including rates for EFFS plans, would be permanently moved to no later than the second Monday in May.

In addition to the information dissemination required under current law, the Secretary would be required to provide beneficiaries with a list of plans that are or would be available in an area, to the extent the information was available at the time the materials were prepared for mailing.

Senate Bill

Each MA organization would be required to submit information by the second Monday in September, including: (1) notice of intent and information on the service area of the plan; (2) the plan type for each plan; (3) specific information for coordinated care and PFFS plans; (4) enrollment capacity; (5) the expected mix of enrollees, by health status; and (6) other information specified by the Secretary.

Medicare beneficiaries would retain their ability to make and change elections to a Medicare+Choice plan through 2005. The current law limitation on changing elections that begins in 2005, would be delayed until 2006. Further, the annual coordinated election period for 2003 through 2006 would begin on November 15 and end on December 31. Beginning in 2007, the annual coordinated election period would be during the month of November.

In addition to the information dissemination required under current law, the Secretary would be required to provide: (1) the MA monthly basic beneficiary premium; (2) the monthly beneficiary premium for any enhanced medical benefits; (3) the MA monthly beneficiary obligation for qualified prescription drug coverage; (4) the catastrophic coverage amount (including the maximum limitation on out-of-pocket expenses) and unified deductible for the plan; (5) the outpatient prescription drug coverage benefits; (6) any beneficiary cost-sharing, including information on the unified deductible; (7) comparative information relating to prescription drug coverage; (8) if applicable, any reduction in the Medicare Part B premium; (9) whether the MA monthly premium for enhanced benefits was optional or mandatory; and (10) quality and performance indicators for prescription drug coverage, including a comparison with FFS Medicare.

Additionally, the Secretary would conduct a special information campaign to inform MA eligible beneficiaries about plans. The campaign would begin on November 15, 2005 and ending on December 31, 2005.

Conference Agreement

The conference agreement allows Medicare beneficiaries to retain their ability to make and change elections to a Medicare+Choice plan through 2006. The current law limitation on changing elections that begins in 2005, is delayed until 2006. Further, the annual coordinated election period for 2004 and 2005 begins on November 15 and ends on December 31. For 2006, the annual coordinated election period begins on November 15 and ends on May 15, 2006. Beginning in 2007, the annual coordinated election period will begin on November 15 and end on December 31.

The Secretary is to provide for an education and publicity campaign to inform MA eligible individuals about the availability of MA plans, including MA–PD plans, offered in different areas and the election process for MA plans. If any portion of an individual's initial enrollment period for Part B occurs after the end of the annual coordinated election period, their initial enrollment period would be extended through the end of their Part B initial enrollment period.

The conference agreement will limit an individual's right to change MA plans, for plan years beginning on or after January 1, 2006. This limit will not affect an individual's opportunity to make changes during the annual coordinated election period, but it will limit changes during the continuous open enrollment and disenrollment periods in a year. Individuals enrolled in an MA plan that provides qualified prescription drug coverage, may only disenroll from their plan to get coverage through FFS Medicare or through another MA plan that does not provide qualified prescription drug coverage. They may not leave their plan to obtain coverage under an MA–PD plan or under a prescription drug plan under Part D. Conversely, individuals enrolled in an MA–PD plan, may only change to another MA–PD plan or they may get coverage under FFS Medicare with coverage under a drug plan under part D. They may not enroll in an MA plan if it does not provide qualified prescription drug coverage.

An MA–PD plan could provide for a separate or differential payment for a participating physician who prescribes covered part D drugs in accordance with an electronic prescription program meeting Part D requirements. Such payment could take into consideration the implementation costs for the physician and could also be increased for those participating physicians who significantly increased: (1) formulary compliance; (2) lower cost and therapeutically equivalent alternatives; (3) reductions in adverse drug interactions; and (4) efficiencies in filing prescriptions through reduced administrative costs. Additional or increased payment could be structured in the same manner as medication therapy management fees under section 1869(D)–4(c)(2)(E).

An MA eligible individual could elect qualified prescription drug coverage in accordance with Section 1860D–1.

Medicaid Amendments (Section 103 of Conference agreement; Section 103 of House bill; Section 104 of Senate Bill).

Present Law

Some low-income aged and disabled Medicare beneficiaries are also eligible for full or partial coverage under Medicaid. Within broad federal guidelines, each state sets its own eligibility criteria, including income eligibility standards. Persons meeting the state standards are entitled to full coverage under Medicaid. Persons entitled to full Medicaid protection generally have all of their health care expenses met by a combination of Medicare and Medicaid. For these "dual eligibles" Medicare pays first for services both programs cover. Medicaid picks up Medicare cost-sharing charges and provides protection against the costs of services generally not covered by Medicare, including prescription drugs. State Medicaid programs have the option to include prescription drugs in their Medicaid benefit packages. All states include drugs for at least some of their Medicaid beneficiaries and many offer it to all program recipients entitled to full Medicaid benefits.

As noted earlier, Federal law specifies several population groups that are entitled to more limited Medicaid protection. These are qualified Medicare beneficiaries (QMBs), specified low income beneficiaries (SLIMBs), and certain qualified individuals (QI–1s). Assistance under the QI–1 program, originally available for the period January 1, 1998 to December 31, 2002, has been extended to March 31, 2004.

States make eligibility determinations for their Medicaid populations. Federal matching payments for Medicaid services in the territories is subject to an annual cap.

Current Medicaid law requires manufacturers to pay state Medicaid programs a basic rebate for single source and innovator multiple source drugs. Basic rebates are calculated by comparing the average manufacturer price for a drug (the average price paid by wholesalers) to the "best price," which is the lowest price offered by the manufacturer in the same period to any wholesaler, retailer, nonprofit, or public agency. For purposes of determining Medicaid rebates, prices paid by a number of federal and state entities are excluded from the definition of "best price."

House Bill

Section 103 would add a new Section 1935 to the Social Security Act entitled "Special Provisions Relating to Medicare Prescription Drug Benefit." The provision would require states, as a condition of receiving federal Medicaid assistance, to make eligibility determinations for low-income premium and cost-sharing subsidies, inform the Administrator of cases where eligibility has been established, and otherwise provide the Administrator with information that may be needed to carry out Part D. The provision would provide for the phased-in federal assumption of associated administrative costs. In 2005, the federal matching rate would be increased by 6⅔ percent and in 2006 by 13⅓ percent. In each subsequent year, the percent would be increased by 6⅔ percentage points (but in no case could the rate exceed 100 percent). Beginning in 2019, the federal matching rate would be 100 percent. The state would be required to provide the Administrator with the appropriate information needed to properly allocate administrative expenditures that could be made for similar eligibility determinations.

The provision would provide for the federal phase-in of the costs of premiums and cost-sharing subsidies for dual eligibles (i.e. persons eligible for Medicare and full Medicaid benefits, including drugs). Over the 2006–2020 period, the federal matching rate for these costs would be increased to cover 100% of what would otherwise be state costs. States would be required to maintain Medicaid benefits as a wrap around to Medicare benefits for dual eligibles; states could require that these persons elect Part D drug coverage.

Residents of territories would not be eligible for regular low-income subsidies. However, territories would be able to get additional Medicaid funds, beginning at $25 million in 2006 and increasing in subsequent years by the annual percentage increase in prescription drug costs for Medicare beneficiaries. In order to obtain these funds, territories would be required to formulate a plan on how they would dedicate the funds to assist low-income Medicare beneficiaries in obtaining covered outpatient prescription drugs. The Administrator would be required to report to Congress on the application of the law in the territories.

Senate Bill

Section 104 would add a new Section 1935 to the Social Security Act entitled "Special Provisions Relating to Medicare Prescription Drug Benefit." The provision would require states to make low-income eligibility determinations for low income subsidies. States would be required, for purposes of the transitional prescription drug card assistance program, to establish eligibility standards consistent with that program; establish procedures for providing presumptive eligibility determinations (similar to that which currently apply for low-income pregnant women and children); make eligibility determinations for the card program; and communicate to the Secretary information on eligibility determinations or discontinuations. For purposes of the low-income subsidies for the new Part D program, states would be required, beginning November 2005, to make eligibility determinations; inform the Administrator of cases where eligibility was established, and otherwise provide the Administrator with any information required to carry out Part D. States would be required to enter agreements with the Commissioner of Social Security to use all social security field offices in the state as information and enrollment sites for making eligibility determinations. As part of the eligibility determination process, states would also be required to screen for eligibility for Medicare cost-sharing assistance under the QMB, SLIMB, and QI–1 programs.

The federal government would pay an enhanced matching rate for administrative costs associated with making eligibility determinations. The rate would be 75% for the period January 1, 2004–September 30, 2005, 70% for fiscal year 2006, 65% for FY 2007, and 60% beginning in FY 2008. Beginning November 1, 2005, the rate would be 100% for purposes of making eligibility determinations for low-income subsidies.

In addition, states would be entitled to enhanced matching for the costs associated with designing, developing, acquiring and installing improved eligibility determination systems, including hardware and software, for low-income subsidy programs. The enhanced rate would be 90% for fiscal years 2004, 2005, and 2006. The systems would be required to comply with any standards established by the Secretary for improved eligibility systems. Further, the systems would have to be compatible with the standards established under the administrative simplification provisions of Title XI of the Social Security Act.

Medicaid beneficiaries who were eligible for drug benefits under their state Medicaid program would remain in Medicaid. Beginning January 1, 2006, states agreeing to provide a drug benefit to their dual eligible population that was at least equivalent to minimum standards would be relieved of their responsibility to pay Medicare Part B premiums for persons with incomes between the level established for the supplemental security income program and 100% of the federal poverty level. The minimum standards would be defined as follows. A state would be required to meet all current law coverage standards for dual eligibles under Medicaid, including nominal cost-sharing requirements. States would have to provide beneficiary protections equivalent to those provided under Part D. States could not place a limit on the number of prescriptions for dual eligibles. States would be permitted to cover smoking cessation drugs for this population group.

If on the date of enactment, a state provided medical assistance to aged and disabled persons up to 100% of poverty, it would be entitled to have the federal government assume the costs for Medicare Part A cost-sharing. The Part A costs would be assumed so long as the state maintained the expanded coverage. The provision would apply effective January 1, 2006.

Residents of Puerto Rico and the territories would not be eligible for low-income subsidies. Instead, if they chose to provide assistance to their low-income residents they would receive an increase in amounts otherwise paid to them under Medicaid. The aggregate amount available would be $37.5 million for the last 3 quarters of FY2006, and $50 million for FY2007. In subsequent fiscal years, the aggregate amount would be the amount available the previous year, increased by the percentage increase in prescription drug spending.

The provision would extend the QI–1 program through December 2008 with total annual allocations of $400 million through fiscal year 2008 and $100 million for the first quarter of fiscal 2009.

The provision would expand outreach requirements for the Commissioner of Social Security to include outreach activities for low-income subsidy individuals. By January 1, 2005, the Secretary would submit a report to Congress to recommend a voluntary option for dual eligibles to enroll in Part D drug plans.

The provision would exempt negotiated prices by any qualified plan offering Medicare drug coverage from the calculation of Medicaid "best price."

Conference Agreement

The conference agreement would add a new Section 1935 to the Social Security Act entitled "Special Provisions Relating to Medicare Prescription Drug Benefit." The provision establishes certain requirements, as a condition of receiving federal Medicaid assistance. States are required to provide the Secretary with Medicaid eligibility information necessary to carry out transitional prescription drug assistance verification. They are required to make eligibility determinations for low-income premium and cost-sharing subsidies, inform the Secretary of cases where eligibility has been established, and otherwise provide the Secretary with information that may be needed to carry out Part D. Further, as part of the eligibility determination process, states are required to make determinations for Medicare cost-sharing assistance. Regular federal matching applies to these activities.

The agreement provides for the federal phase-in of the costs of premiums and cost-sharing subsidies for dual eligibles (i.e., persons eligible for Medicare and full Medicaid benefits, including drugs). The agreement provides for a phased-down state contribution. For each month beginning in 2006, each state is required to provide for payment to the Secretary equal to the product of: (1) 1/12 of the product of the base year state Medicaid per capita expenditures for full-benefit dual eligibles and the state matching rate, and updated to the year involved by the applicable growth factor; (2) the total number of dual eligibles for such state for the month; and (3) the factor for the month. The base year is defined as the weighted average of gross Medicaid expenditures (including dispensing fees) for prescription drugs in 2003 and the estimated actuarial value of prescription drug benefits provided under a capitated care plan for full benefit dual eligibles in that year. The applicable growth factor in 2004, 2005, and 2006 is the average annual percent change in the per capita amount of prescription drug expenditures as determined based on the most recent National Health Expenditure projections. In subsequent years, the growth factor is the annual percentage increase average per capita expenditures under Part D. The factor under #3 is 90% in 2006, phasing down to 75% over 10 years. The Secretary is required to notify each state by October 15 of the amount computed under the formula for the following year, beginning in 2006. A state's failure to make required payments would result in interest charges and in an offset to amounts otherwise payable under Medicaid.

The agreement requires the Secretary when determining gross expenditures for 2003 to: (1) use data from the Medicaid Statistical Information System (MSIS) and other available data; (2) exclude expenditures for drugs that are not covered Part D drugs, and (3) reduce the portion of expenditures not attributable to dispensing fees by an adjustment ratio applied to such portion. The adjustment ratio for a state is equal to 1 minus the ratio in 2003 of aggregate payments under rebate agreements under section 1927 to gross expenditures under Medicaid for covered outpatient drugs.

The agreement specifies that Medicare is the primary payer for covered drugs for dual eligibles. Medicaid coverage is not available for such drugs or any cost-sharing for such drugs. States may provide coverage for drugs, other than Part D covered drugs in the manner otherwise provided for non-full benefit dual eligibles or through an arrangement with the prescription drug plan of MA–PD plan.

Residents of territories would not be eligible for regular low-income subsidies. However, territories would be able to apply for additional Medicaid funds. The total amount available is $28.125 million beginning in the last 3 quarters of 2006, $37.5 million in 2007 and increasing in subsequent years by the annual percentage increase in prescription drug costs for Medicare beneficiaries. In order to obtain these funds, territories would be required to provide assurances that additional funds would be used covered drugs and administrative costs (with no more than 10 percent of the total used for administrative expenses.) The Secretary is required to report to Congress on the application of the provision in the territories.

The agreement exempts prices negotiated from manufacturers for discount card drugs under an endorsement card program and prices negotiated by a prescription drug plan under Part D, a MA–PD plan or a qualified retiree prescription plan from the calculation of Medicaid "best price."

The agreement extends the QI–1 program through September 30, 2004. It expands outreach requirements for the Commissioner of Social Security to include outreach activities for transitional assistance and low-income subsidy individuals.

Medigap Amendments (Section 104 of Conference agreement; Section 104 of House bill; Section 103 of Senate bill).

Present Law

Most beneficiaries have some health insurance coverage in addition to basic Medicare benefits. Some individuals obtain private supplementary coverage through an individually-purchased policy, commonly referred to as a "Medigap" policy. Beneficiaries with Medigap insurance typically have coverage for Medicare's deductibles and coinsurance; they may also have coverage for some items and services not covered by Medicare. Individuals generally select from one of 10 standardized plans, though not all 10 plans are offered in all states. The 10 plans are known as Plans A through Plan J. Plan A covers a basic package of benefits. Each of the other nine plans includes the basic benefits plus a different combination of additional benefits. Plan J is the most comprehensive. Plans H, I, and J offer some drug coverage.

The law provided for the development by the National Association of Insurance Commissioners (NAIC) of standardized benefit packages. It also provides for modifications of such packages when Medicare benefit changes are enacted.

All insurers offering Medigap policies are required to offer open enrollment for 6 months from the date a person first enrolls in Medicare Part B (generally when the enrollee turns 65). The law also guarantees issuance of specified Medigap policies for certain persons whose previous supplementary coverage was terminated. Guaranteed issue also applies to certain persons who elect to try out a managed care option under the Medicare+Choice plan program.

Medicare beneficiaries buy supplemental coverage to help pay for health care costs not covered by Medicare. Almost one-quarter (24 percent) of Medicare beneficiaries purchase this coverage as individuals through the private insurance "Medigap" market. In 1990, Congress mandated the creation of 10 standardized Medigap policies through the National Association of Insurance Commissioners (NAIC). All 10 plans are required to cover beneficiaries' coinsurance—some of the costs of Medicare services for which beneficiaries are responsible, such as 20 percent of the costs of a physician visit. Nine out of 10 of those policies, which comprise more than 90 percent of the Medigap market, are required to cover the Part A inpatient hospital deductible, and the most popular Medigap policy covers both the Part A hospital deductible and the $100 Part B deductible for physician services. Insulating beneficiaries from this cost sharing incentives over utilization of health services.

Numerous studies have demonstrated that covering deductibles and coinsurance has led to higher Medicare spending because beneficiaries become insensitive to costs. Beneficiaries with Medigap consume $1,400 more in Medicare services than beneficiaries without supplemental coverage, and $500 more than beneficiaries with employer-sponsored insurance. This higher utilization drives up costs for everyone—premiums of Medicare beneficiaries without Medigap coverage and costs to taxpayers.

In addition, only the three most expensive Medigap plans cover prescription drugs, and that coverage is limited. Yet, 8 of the 10 plans are required to cover foreign travel insurance, while most beneficiaries never leave their home country.

And despite standardization, premiums continue to increase and vary widely. From 1998 to 2000, average premiums rose 16 percent for plans without drug coverage, and more than twice as fast, 37 percent, for plans with drug coverage. In addition, premiums vary dramatically for identical plans in the same location. Weiss Ratings, Inc. analyzed Medigap premiums in 2001. A 65-year old man living in Ft. Myers, Florida would pay about $3,600 for Plan J from Physicians Mutual Insurance Company, but only $2,700 with United Healthcare Insurance Company through AARP. The same gentleman living in Las Vegas would spend about $1,500 for Plan C with United American Insurance Company, but about half that amount—$778 B with the USAA Life Insurance Company for the same policy.

All of these factors lead conferees to believe Medigap policies should be restructured in light of changes to the marketplace since standardization. Conferees encourage the National Association of Insurance Commissioners (NAIC) to modernize the Medigap market by reforming first dollar coverage requirements that drive over utilization of services and premiums. Conferees believe that in developing the two new policies included in the conference report, NAIC should consider much broader changes to the Medigap market that will effectuate reduced premiums and more rational coverage policies that create incentives for appropriate utilization of services.

House Bill

The provision would prohibit, effective January 1, 2006, the issuance of new Medigap policies with prescription drug coverage. The prohibition would not apply to policies replacing another policy with drug coverage. Beneficiaries could keep their existing policies. Further, it would not apply to policies meeting new standards, as outlined below.

The provision would guarantee issuance of a substitute Medigap policy for persons, enrolling in Part D, who at the time of such enrollment were enrolled in and terminated enrollment in a Medigap policy H, I, or J. The guaranteed enrollment would be for any of the Plans A through Plan G. The guarantee would apply for enrollments occurring in the new Medigap plan within 63 days of termination of enrollment in a Medigap drug Plan H, I, or J. The insurer could not impose an exclusion based on a pre-existing condition for such individuals. Further, the insurer would be prohibited from discriminating in the pricing of such policy on the basis of the individual's health status, claims experience, receipt of health care or medical condition.

The provision would provide for the development by the NAIC of two new standardized Medigap plans and would outline the standards for these policies. The first new policy would have the following benefits (notwithstanding other provisions of law relating to core benefits): (1) coverage of 50% of the cost-sharing otherwise applicable (except coverage of 100% cost-sharing applicable for preventive benefits); (2) no coverage of the Part B deductible; (3) coverage of all hospital coinsurance for long stays (as in current core package); and (4) a limitation on annual out-of-pocket costs of $4,000 in 2006 (increased in future years by an appropriate inflation adjustment as specified by the Secretary). The second new policy would have the same benefit structure as the first new policy, except that: (1) coverage would be provided for 75%, rather than 50%, of cost-sharing otherwise applicable; and (2) the limitation on out-of-pocket costs would be $2,000, rather than $4,000. Both policies could provide for coverage of Part D cost-sharing; however, neither policy could cover the Part D deductible.

Senate Bill

Effective January 1, 2006, Medigap drug policies could not be sold, issued or renewed for Part D enrollees. Persons who had such policies could obtain Medigap coverage without drug benefits. Beneficiaries who sought to enroll during the Part D open enrollment period established for current beneficiaries would be guaranteed issuance of such non-drug policies (without an exclusion based on preexisting conditions). Medigap issuers would be required to notify individuals of these changes 60 days prior to the Part D open enrollment period.

Medigap insurers could not be required to participate as an eligible entity under the new Part D.

Conference agreement

The agreement prohibits, effective January 1, 2006, the selling, issuance, or renewal of existing Medigap policies with prescription drug coverage for Part D enrollees. The prohibition would not apply to renewal of Medigap prescription policies for persons who are not Part D enrollees. Persons enrolling under Part D during the initial enrollment period could enroll in a plan without drug coverage, or continue their previous policy as modified to exclude drugs. H, I, and J policies, modified to exclude drugs, could continue to be offered to new enrollees. Medigap issuers would be required to notify individuals of these changes 60 days prior to the initial Part D enrollment period.

The provision guarantees issuance of a substitute Medigap policy for persons, enrolling in Part D, who at the time of such enrollment were enrolled in and terminated enrollment in a Medigap policy H, I, or J or a prestandard policy that included drug coverage. Evidence of enrollment and termination would be required. The guaranteed enrollment is for any of the Plans A, B, C, and F within the same carrier of issue. The guarantee applies for enrollments occurring in the new Medigap plan within 63 days of termination of enrollment in a Medigap drug Plan H, I, or J. The insurer may not impose an exclusion based on a pre-existing condition for such individuals. Further, the insurer is prohibited from discriminating in the pricing of such policy on the basis of the individual's health status, claims experience, receipt of health care or medical condition. The conferees intend that these provisions be administered in such a manner as to avoid a break in coverage.

The conference agreement requires the Secretary to request the National Association of Insurance Commissioners to review and revise standards for benefit packages taking into account the changes in benefits resulting form the enactment of this Act and to otherwise update standards to reflect other changes in law included in the Act. To the extent practicable, the revision will provide for implementation of revised standards as of January 1, 2006.

The revision is to include 2 new benefit packages. The first new package will have the following benefits (notwithstanding other provisions of law relating to core benefits): (1) coverage of 50% of the cost-sharing otherwise applicable (except coverage of 100% cost-sharing applicable for preventive benefits); (2) no coverage of the Part B deductible; (3) coverage of all hospital coinsurance for long stays and 365 extra lifetime days of coverage (as in current core package); and (4) a limitation on annual out-of-pocket costs of $4,000 in 2006 (increased in future years by an appropriate inflation adjustment as specified by the Secretary). The second new benefit package will have the same benefit structure as the first new package except that: (1) coverage would be provided for 75%, rather than 50%, of cost-sharing otherwise applicable; and (2) the limitation on out-of-pocket costs would be $2,000, rather than $4,000.

Medigap issuers could not be required to participate as a PDP sponsor under the new Part D, nor could a State make such a requirement.

Additional Provisions Relating to Medicare Prescription Drug Discount Card and Transitional Assistance Program (Section 105 of Conference agreement).

Present Law

No provision.

House Bill

No provision.

Senate Bill

No provision.

Conference Agreement

The conference agreement includes additional provisions relating to the implementation of the Medicare prescription drug discount card and transitional assistance program. It excludes program costs from the calculation of the Part B premium. It applies Medicaid confidentiality provisions to drug pricing data reported by manufacturers under the program.

The conference agreement includes additional administrative provisions. It specifies that the following sections of law would not apply to the card program: New Section 1871(a)(3) of the Social Security Act relating to time line for publication of final rules; Chapter 35 of Title 44 of the U.S. Code relating to coordination of federal information policy; Section 553(d) of Title 5 of the U.S. Code requiring at least 30 days between issuance and effective date of a substantive rule; and Section 801(a)(3)(A) of title 5 of the U.S. Code providing 60 days for congressional review of a major rule.

The contracting authority extended to the Secretary under Medicare+Choice also applies to the Secretary with respect to the discount card program. There could be no judicial review of a determination not to endorse or enter into a contract with a card sponsor. Further, an order to enjoin any provision of the new section 1807 would not affect any other provision of the section and all provisions are to be treated as severable.

The Secretary of the Treasury, upon written request from the Secretary of HHS, is required to disclose to officers and employees of HHS certain information with respect to a taxpayer for the most recent taxable year for which information is available in the Internal Revenue Service's taxpayer data information system, or if no return was filed for that year, the year before that. Required information would consist of whether the adjusted gross income (as modified by HHS regulations) of the taxpayer, and if applicable the taxpayer's spouse, exceeds amounts that are 100 percent and 135 percent of the official poverty line. Such information may only be used to determine eligibility for the transitional low-income assistance program.

State Pharmaceutical Assistance Transition Commission (Section 106 of Conference agreement; Section 107 of House bill).

Present Law

A number of states currently have programs to provide low-income persons, not qualifying for Medicaid, with financial assistance in meeting their drug costs. The state programs differ substantially in both design and coverage.

House Bill

The provision would establish a State Pharmaceutical Assistance Transition Commission to develop a proposal for dealing with the transitional issues facing state programs and participants due to implementation of the new Part D prescription drug program. The Commission, to be established on the first day of the third month following enactment, would include: (1) a representative of each governor from each state with a program that the Secretary identified as having a benefit package comparable to or more generous than the new Part D; (2) representatives from other states that had pharmaceutical assistance programs, as appointed by the Secretary; (3) representatives (not exceeding the total under #1 and #2) of organizations that represented interests of participants, appointed by the Secretary; (4) representatives of MA organizations; and (5) the Secretary or the Secretary's designee and other members specified by the Secretary. The Commission would develop the proposal in accordance with specified principles, namely: (1) protection of the interests of program participants in the least disruptive manner; (2) protection of the financial and flexibility interests of states so they are not financially worse off; and (3) principles of Medicare modernization outlined in Title II of the Act.

The Commission would report to the President and Congress by January 1, 2005. The report would contain specific proposals including specific legislative or administrative recommendations, if any. The Commission would terminate 30 days later.

Senate Bill

No provision.

Conference agreement

The agreement establishes a State Pharmaceutical Assistance Transition Commission to develop a proposal for dealing with the transitional issues facing State programs and participants due to implementation of the new Part D prescription drug program.

The Commission, to be established as of the first day of the third month following enactment, will include: (1) a representative of each governor from each state with a program that the Secretary identifies as having a benefit package comparable to or more generous than the low-income assistance under the new Section 1860D–14; (2) representatives from other states that have pharmaceutical assistance programs, as appointed by the Secretary; (3) representatives (not exceeding the total under #1 and #2) of organizations that have an inherent interest in the participants or the program itself; appointed by the Secretary; (4) representatives of MA organizations, Pharmacy Benefit Managers and other private insurance plans; and (5) the Secretary or the Secretary's designee and other members specified by the Secretary. The Commission is to develop the proposal in accordance with specified principles, namely: (1) protection of the interests of program participants in the least disruptive manner; (2) protection of the financial and flexibility interests of states so they are not financially worse off; and (3) principles of Medicare modernization outlined in Title II of the Act.

The Commission will report to the President and Congress by January 1, 2005, including specific legislative or administrative recommendations, if any. The Commission will terminate 30 days later. The Conferees intend the Commission to play an integral role in identifying potential problems and proposing creative solutions to ensure a seamless transition for States and beneficiaries in coordinating and interacting with the new Medicare plans.

Studies and Reports (Section 107 of Conference agreement; New Section 1860D–10 of House bill; Section 102, Section 106 and Section 110 of Senate bill).

House Bill

Under the new Section 1860D–10, the Secretary, within six months of enactment, would be required to review the current standards of practice for pharmacy services provided to patients in nursing facilities. Specifically, the Secretary would assess: (1) the current standards of practice, clinical services, and other service requirements generally utilized for such pharmacy services; (2) evaluate the impact of those standards with respect to patient safety, reduction of medication errors, and quality of care; and (3) recommend necessary actions. The Secretary would submit a report to the Congress on the findings and recommendations.

Senate Bill

Section 110 would require the Secretary to conduct a thorough review of the standards of practice for pharmacy services provided to patients in nursing facilities. The Secretary would assess the current standards, clinical services and other service requirements generally used in long-tern settings and evaluate the impact of these standards with respect to patient safety, reduction of medication errors, and quality of care. Within 18 months of enactment, the Secretary would be required to submit a report to Congress on the study containing: (1) a detailed description of the Secretary's plans to implement the Act in a manner consistent with applicable state and federal laws designed to protect the safety and quality of care of nursing facility patients; and (2) recommendations regarding necessary actions and appropriate reimbursement to ensure the provision of care in such manner.

Section 102 would require the Administrator to conduct a study, and report to Congress by January 1, 2005, on allowing persons not entitled to Part A, but enrolled in Part B, to enroll in Part D.

Section 106 requires the Secretary, on an ongoing basis, would study variations in spending and drug utilization under Part D to determine the impact on premiums. The Secretary would examine the impact of geographic adjustments of the monthly national average premium on the maximization of competition and the ability of eligible entities to contain costs. The Secretary would submit an annual report to Congress beginning in 2007.

Conference Agreement

The agreement requires the Secretary to study variations in per capita spending for covered Part D drugs among PDP regions to determine the amount of such variation that is attributable to price variations and the differences in per capita utilization that is not taken into account in the health status risk adjustment made to PDP bids. The Secretary is required to submit a report to Congress on the study including information on the extent of geographic variation in per capita utilization, an analysis of the impact of direct subsidies and whether such subsidies should be adjusted to take into account such variation, and recommendations regarding the appropriateness of applying an additional geographic adjustment factor to bids.

The conference agreement requires the Secretary, within six months of enactment, to review the current standards of practice for pharmacy services provided to patients in nursing facilities. Specifically, the Secretary is to assess: (1) the current standards of practice, clinical services, and other service requirements generally utilized for such pharmacy services; and (2) evaluate the impact of those standards with respect to patient safety, reduction of medication errors, and quality of care. The report is to contain a description of the Secretary's plans to implement this Act in a manner consistent with applicable state and federal laws designed to protect the safety and quality of care of nursing facility patients. The report must also include recommendations regarding necessary actions.

The conference agreement requires the Secretary to enter into a contract with the Institute of Medicine to carry out a comprehensive study of drug safety and quality issues in order to provide a blueprint for system-wide change. The objectives of the study are to: (1) develop a full understanding of drug safety and quality issues through an evidence-based review of the literature, case studies, and analysis; (2) attempt to develop credible estimates of the incidence, severity and costs of medication errors; (3) evaluate alterative approaches to reducing medication errors; (4) provide guidance on high-priority strategies to achieve drug safety goals; (5) assess opportunities and key impediments to broad nationwide implementation of medication error reductions; and (6) develop an applied research agenda to evaluate the health and cost impacts of alternative interventions. The study is to be completed within an 18-month period. Such sums as may be necessary are authorized.

The agreement requires the Secretary to provide a study on the feasibility and advisability of providing multi-year contracts with PDP sponsors and MA organizations.

The agreement requires the GAO to conduct a study to determine the extent to which utilization and access to covered Part D drugs for low-income subsidy eligible individuals differs from that for persons who would qualify as subsidy eligible individuals except for application of the assets test. The report is due to Congress by September 30, 2007.

Grants to Physicians to Implement Electronic Prescription Programs (Section 108 of Conference agreement; Section 121 of Senate bill).

Present Law

No provision.

House Bill

No provision.

Senate Bill

The Secretary would be authorized to award grants to health care providers to implement electronic prescription programs. There would be authorized to be appropriated such sums as may be necessary for each of fiscal years 2006, 2007, and 2008.

Conference Agreement

The agreement authorizes the Secretary to make grants to physicians for the purpose of assisting them to implement electronic prescription programs in complying with the standards under the new Section 1860D–(4)(e). The Secretary, in awarding the grant shall give special consideration to physicians who serve a disproportionate number of Medicare patients and give preference to physicians who serve a rural or underserved area. Grant funds may be used for purchasing, leasing, and installing hardware and software; making upgrades and other improvements; and providing education and training to eligible physician staff on the use of technology. Grant applicants are required to provide the secretary with information necessary to evaluate the project and to ensure that funding is expended only for the purposes for which it is made. The applicant must agree to make available non-Federal contributions totaling at least 50 percent of the costs. $50 million is authorized for FY 2007, and such sums as may be necessary for FY 2008 and FY 2009.

Expanding the Work of Medicare Quality Improvement Organizations to Include Parts C and D (New section 109 of the Conference agreement).

Present Law

Quality improvement organizations (QIOs) review medical necessity and quality of services provided under Medicare.

House Bill

No provision.

Senate Bill

No provision.

Conference agreement

The conference agreement expands the work of quality improvement organizations (QIOs) to include Part C and Part D. It is required to offer providers, practitioners, MA organizations, and PDP sponsors quality improvement assistance pertaining to prescription drug therapy. The secretary is to request the Institute of Medicine of the National Academy of Sciences to conduct a study of the QIO program including an evaluation of the program and the extent to which other entities could perform similar quality improvement functions as well as or better than QIOs. The Secretary will report to Congress on such study by June 1, 2006. If the Secretary finds, based on the study, that other entities could improve quality as well as or better than QIOs, the Secretary shall provide increased competition through such entities.

Conflict of Interest Study (Section 110 of Conference agreement).

Present Law

No provision.

House Bill

No provision.

Senate Bill

No provision.

Conference Agreement

The conference agreement requires the Federal Trade Commission to conduct a study of differences in payment amounts for pharmacy services provided to enrollees in group health plans that utilize pharmacy benefit managers (PBMs). The study is to include an assessment of the differences in costs incurred by such enrollees and plans for drugs dispensed by mail order pharmacies owned by PBMs compared to those not owned by PBMs, and community pharmacies. The study is to examine whether such plans are acting in a manner that maximizes competition and results in lower prescription drug prices for enrollees. The report is due to Congress within 18 months of enactment. It is to include recommendations regarding any legislation to insure the fiscal integrity of the Part D program. Conferees note the Secretary has the authority to accept or reject bids, based, among other factors, costs associated with delivering drug benefits.

The intent of the conferees in including this assessment by the FTC is to assess whether Medicare spending is likely to be adversely affected because of the use of mail order pharmacies that are owned and operated by a PBM under contract to a prescription drug plan or MA–PD plan. Therefore, this study should evaluate to what extent prescription drug spending is likely to be affected if a PDP or MA–PD plan approves the dispensation of covered drugs from a mail-order pharmacy owned directly or indirectly by a PBM compared to drug utilization and costs if the mail-order pharmacy were independently owned. Such assessment shall take into account the following:

(1) whether mail order pharmacies that are owned by PBMs (or entities that own PBMs) dispense fewer generic drugs compared to single source drugs within the same therapeutic class when compared to mail order pharmacies that are not owned by PBMs,

(2) whether mail order pharmacies that are owned by PBMs (or entities that own PBMs) routinely switch patients from lower priced drugs to higher priced drugs (in the absence of a clinical indication) when compared to mail order pharmacies that are not owned by PBMs,

(3) whether mail order pharmacies owned by PBMs (or entities that own PBMs) sell a higher proportion of repackaged drugs than mail order pharmacies that are not owned by PBMs,

(4) whether mail order pharmacies owned by PBMs (or entities owned by PBMs) sell repackaged drugs at prices above the manufacturer's average wholesale price,

(5) Other factors deemed relevant by the FTC.

In conducting this study, the FTC shall consider whether competition or drug pricing behavior by PBMs would be affected if PBMs were to bear financial risk for drug spending. The FTC shall issue a written report within 18 months of the date of enactment.

Disclosure of Return Information for Purposes of Carrying Out Medicare Catastrophic Prescription Drug Program. (Section 106 of House Bill).

Present Law

Current law authorizes, under specified circumstances, the disclosure by the Secretary of the Treasury of returns and return information for purposes other than tax administration.

House Bill

The provision would permit the Secretary of the Treasury, upon written request from the Secretary of the Department of Health and Human Services (HHS) to disclose to officers and employees of HHS specific information with respect to a specified taxpayer for a specific tax year. The information that could be disclosed is taxpayer identity information and the adjusted gross income for the taxpayer or, if less, the income threshold limit specified under the new Part D ($200,000 in 2006). A specified taxpayer would be either: (1) an individual who had adjusted gross income for the year in question in excess of the income threshold specified in the new Part D ($60,000); or (2) an individual who elected to use more recent income information as permitted under Part D. Individuals filing joint returns would each be treated separately with each person considered to have an adjusted gross income equal to one-half of the total.

Return information disclosed, could be used by officers and employees of HHS only for administering the prescription drug benefit. They could disclose the annual out-of-pocket threshold applicable to an individual to the entity offering the individual prescription drug coverage. The sponsor could use such information only for the purposes of administering the benefit.

Senate Bill

No provision.

Conference Agreement

No provision.

Limitation on Prescription Drug Benefits of Members of Congress (Section 107 of Senate Bill).

Present Law

Members of Congress are entitled to receive health benefits through the Federal Employees Health Benefits (FEHB) program.

House Bill

No provision.

Senate Bill

During calendar year 2004, the actuarial value of the drug benefit of any Member of Congress enrolled in a FEHBP plan could not exceed the actuarial value of any prescription drug benefit under Title XVIII of the Social Security Act passed by the first session of the 108th Congress and enacted into law. The Office of Personnel Management would promulgate necessary regulations.

Conference Agreement

No provision.

Protecting Seniors With Cancer (Section 108 of Senate Bill).

Present Law

Medicaid pays Part B premiums for QMBs, SLIMBs and QI–1s. It pays Medicare cost-sharing charges for QMBs.

House Bill

No provision.

Senate Bill

The cost-sharing specified under the low-income subsidy provisions would be modified for persons diagnosed with cancer. The cost-sharing specified under New Section 1860D–19 would apply except for the following changes. The QMB population would have a full premium subsidy for at least one drug plan available in the area where the beneficiary resided. For the SLIMB and QI–1 population, there would be no premium for any plan whose premium was at or below the monthly national average premium. For other persons below 160% of poverty, only a percentage of the premium otherwise applicable. Persons with incomes above 160% of the poverty line would have, in 2006, the same cost-sharing otherwise specified under the bill.

Conference Agreement

No provision.

Protecting Seniors With Cardiovascular Disease, Cancer, or Alzheimer's Disease (Section 109 of Senate Bill).

Present Law

Medicaid pays Part B premiums for QMBs, SLIMBs and QI–1s. It pays Medicare cost-sharing charges for QMBs.

House Bill

No provision.

Senate Bill

The cost-sharing specified under the low-income subsidy provisions would be modified for persons diagnosed with cardiovascular disease, cancer, diabetes or Alzheimer's disease. The cost-sharing specified under New Section 1860D–19 would apply except for the following changes. The QMB population would have a full premium subsidy for at least one drug plan available in the area where the beneficiary resided. For the SLIMB and QI–1 population, there would be no premium for any plan whose premium was at or below the monthly national average premium. For other persons below 160% of poverty, only a percentage of the premium otherwise applicable. Persons with incomes above 160% of the poverty line would have, in 2006, the same cost-sharing otherwise specified under the bill.

Conference Agreement

No provision.

Medication Therapy Management Assessment Program (Section 110A of Senate Bill).

Present Law

No provision.

House Bill

No provision.

Senate Bill

The Secretary would be required to establish a 1-year assessment program to contract with qualified pharmacists to provide medication therapy management services to fee-for-service beneficiaries. The Secretary would designate 6 geographic areas (at least 2 rural), each containing not less than 3 sites. The program would be implemented between October 1, 2004 and January 1, 2005. Beneficiaries in an area could participate if they identified a qualified pharmacist to furnish medication therapy management services. The Secretary would enter into contracts with qualified pharmacists to provide such services. The fee established under the contract would be designed to test various payment methodologies including one that applied a relative value scale and fee schedule. Payments would be made from the Part B trust fund and be budget neutral. The Secretary would be required to make data on the program available and report to Congress within 6 months of completion of the program.

Conference Agreement

No provision.

Section 133. Pharmacy Benefit Managers Transparency Requirements (Section 133 of Senate Bill).

Present Law

No provision.

House Bill

No provision.

Senate Bill

An eligible entity offering a Medicare prescription drug plan under Part D or a MedicareAdvantage organization offering a MedicareAdvantage plan under Part C could not enter a contract with a pharmacy benefit manager (PBM) owned by a pharmaceutical manufacturing company. PBMs would be required to provide the following information, on an annual basis, to the Assistant Attorney General for Antitrust of the Department of Justice and the Inspector General for the Department of Health and Human Services: (1) aggregate amount of any and all rebates, discounts, administrative fees, promotional allowances, and other payments received or recovered from each pharmaceutical manufacturer; (2) the amount of payments received or recovered from each pharmaceutical manufacturer for each of the top 50 drugs (as measured by volume); and (3) the percentage differential between the price PBMs pay pharmacies and the price the PBM charges the PDP or MA organization. Failure to disclose could result in civil penalties; further, the U.S. district court could order compliance. No disclosed information would be made public, except as might be relevant to any judicial action or proceeding. Nothing in the provision would be intended to prevent disclosure to either body of Congress or any duly authorized committee or subcommittee.

Conference Agreement

No provision.

Office of the Medicare Beneficiary Advocate (Section 134 of Senate Bill).

Present Law

No provision.

House Bill

No provision.

Senate Bill

Within 1 year of enactment, the Secretary would be required to establish an Office of the Medicare Beneficiary Advocate within the Department of Health and Human Services. The Office would establish a toll-free number for beneficiaries to obtain information on the Medicare program, particularly with respect to Part D. It would establish a website with easily accessible information on PDPs and MA plans. From amounts appropriated to the Secretary's administrative account, $2 million could be used to establish the Office and such funds as may be necessary would be used to operate the Office.

Conference Agreement

No provision.

TITLE II—MEDICARE ADVANTAGE

Subtitle A—Implementation of Medicare Advantage Program

Sec. 201. Implementation of Medicare Advantage program

Present Law

Health maintenance organizations (HMOs) and other types of managed care plans have long participated in the Medicare program, beginning with private health plan contracts in the 1970s and the Medicare risk contract program in the 1980s. In 1997, Congress passed the Balanced Budget Act of 1997 (BBA 1997, P.L. 105–33), which replaced the risk contract program with the Medicare+Choice (M+C) program. M+C plans include coordinated care plans (HMOs, preferred provider organizations or PPOs, and provider-sponsored organizations or PSOs), private fee for service (PFFS) plans, and, on a temporary basis, medical savings accounts (MSAs).

House Bill

Section 200. Title II would establish the Medicare Enhanced Fee-for-Service (EFFS) program, under which Medicare beneficiaries would be provided access to a range of regional EFFS plans that could include preferred provider networks, beginning in 2006. It would establish the Medicare Advantage (MA) program, upon enactment, to replace the M+C program, which would continue to offer coordinated care and other plans on a county-wide basis as under current law. It would also use competitive bidding, beginning in 2010, in the same style as the Federal Employees Health Benefits program (FEHBP) for certain EFFS plans and MA plans, to promote greater efficiency and responsiveness to Medicare beneficiaries.

Senate Bill

Title II would establish the Medicare Advantage (MA) program, which would replace the M+C program, beginning in 2006. The MA program would continue to offer coordinated care and other plans on a county-wide basis as under current law. It would also establish regional PPOs, to be offered in regions. Beginning in 2008, it would establish a limited competition program, in areas designated as "highly competitive."

Conference Agreement

Section 201. The conference agreement establishes the Medicare Advantage (MA) program under Part C of Medicare. Any reference under Part C of Medicare to the "Medicare+Choice" program is deemed to be a reference to "Medicare Advantage" and "MA".

This title modernizes and revitalizes private plans under Medicare. The Balanced Budget Act (BBA) of 1997 altered payments for private plans and expanded the types of plans that could be offered under Medicare. Since payment rate changes were implemented, enrollment in private plans has fallen from 6.2 million beneficiaries in 1998 to 4.6 million beneficiaries in November 2003, and the number of plans has decreased from 346 risk plans in 1998 to 155 (151 coordinated care plans and 4 private FFS plans) in November 2003. This disruption has been due, in part, to unpredictable and insufficient payments. BBA 97 fundamentally de-linked payments to plans from FFS payment growth.

To increase beneficiary choice, Title II reforms the payment system in 2004. All plans would be paid at a rate at least as high as the rate for traditional FFS Medicare, as recommended by the Medicare Payment Advisory Commission (MedPAC). After 2004, private plans' capitation rates would grow at the same rate as FFS Medicare. To increase beneficiary choice in more rural areas, Title II would establish regional plans, which would encourage private plans to serve Medicare beneficiaries in larger regions, beginning in 2006. Both local and regional MA private plans would bid competitively against a benchmark beginning in 2006.

Once private plans became established, and enrollment in private plans increased, a demonstration of comparative cost adjustment in selected sites would begin in 2010. Plan bids from private plans and rates for traditional FFS Medicare would be averaged to create a benchmark for competitive bidding. The competitive program would encourage beneficiaries to enroll in the most efficient plan, producing savings for both beneficiaries, through reduced premiums, and for taxpayers, through relatively lower Medicare costs.

Subtitle B—Immediate Improvements

Section 211. Immediate improvements

Present Law

Under current law, Medicare+Choice (M+C) plans are paid an administered monthly payment, called the M+C payment rate, for each enrollee. The per capita rate for a payment area is set at the highest of three amounts: (1) a minimum payment (or floor) rate, (2) a rate calculated as a blend of an area-specific (local) rate and a national rate, or (3) a rate reflecting a minimum increase from the previous year's rate (currently 2%).

A budget neutrality adjustment is made so that estimated total M+C payments in a given year will be equal to the total payments that would be made if payments were based solely on area-specific rates. The budget neutrality adjustment may only be applied to the blended rates because rates cannot be reduced below the floor or minimum increase amounts. The blend payment is also adjusted to remove the direct and indirect costs of graduate medical education. The blend payment amount is based on a weighted average of local and national rates for all Medicare beneficiaries.

Each year, the three payment amounts are updated by formulas set in statute. Both the floor and the blend are updated each year by a measure of growth in program spending, the national growth percentage. The minimum increase provides for an increase of at least 2% over the previous year's amount.

If an individual is in a short-term general hospital at the time he or she elected to enroll in an M+C plan or change from one M+C plan to another, payment for such services would be made through FFS or the original plan. Conversely, if an individual terminates enrollment in an M+C plan, that organization would be responsible for payment for such services until the date of the individual's discharge.

House Bill

Section 212(a). For 2004, a 4th payment mechanism would be added and plans would receive the highest of the four payment calculations (the floor, blend, minimum percentage increase, or the new amount). The new payment amount would be 100% of fee-for-service (FFS) costs. The FFS payment would be based on the adjusted average per capita cost for the year, for an MA payment area, for services covered under Parts A and B for beneficiaries entitled to benefits under Part A, enrolled in Part B and not enrolled in an MA plan. This payment would be adjusted to remove payments for direct medical education costs and to include the additional payments that would have been made if Medicare beneficiaries entitled to benefits from facilities of the Department of Veteran Affairs (VA) and the Department of Defense (DOD) had not used those services (VA/DOD adjustment).

Section 212(b). In 2004, no adjustment would be made for budget neutrality, which would fund the blend for that year.

Section 212(c). The calculation of the minimum percentage increase would also be revised. For 2004 and beyond, the minimum percentage increase would be the greater of: (1) a 2% increase over the previous year's payment rate (as under current law), or (2) the previous year's payment increased by the national per capita MA growth percentage. For purposes of calculating the minimum percentage increase, there would be no adjustment to the national growth percentage for prior years' errors before 2004. Beginning in 2005 and each subsequent year, the payments to a plan would be based on its prior year rate increased by the revised minimum percentage increase.

Section 212(d). The area-specific MA capitation rate (the local component of the blend) would be adjusted to include the VA/DOD adjustment, beginning in 2004.

Section 212(e). Beginning January 1, 2004, the payment rule for beneficiaries in a short-term general hospital at the time they either elected to enroll in or to terminate their enrollment in an M+C plan, would be extended to a beneficiary in an inpatient rehabilitation facility.

Section 212(f). No later than 18 months after enactment of this Act, the Medicare Payment Advisory Commission would report to Congress providing an assessment of the method used for determining the adjusted average per capita cost (AAPCC). The report would examine the variation in costs between different areas, including differences in input prices, utilization and practice patterns; the appropriate geographic area for payment; and the accuracy of the risk adjustment methods in reflecting differences in the cost of providing care to different groups of beneficiaries.

Section 212(g). No later than July 1, 2006, the Administrator would submit a report to Congress that described the impact of additional financing provided under this Act and other Acts, (including the Balanced Budget Refinement Act of 1999—BBRA and the Benefits Improvement and Protection Act of 2000—BIPA) on the availability of MA plans in different areas and the impact on lowering premiums and increasing benefits under such plans.

Section 212(h). The Secretary would calculate and announce the new MA capitation rates within 6 weeks of enactment of this legislation.

Senate Bill

Section 203. [§1853(c)]. For payments before 2006, the payment would be calculated in the same manner as under current law—the highest of the blend, minimum payment (floor) rate, or minimum percentage increase. However the calculation of the minimum percentage increase would change for 2005. The minimum percentage increase for 2005 would be a 3% increase over the rate for the area for 2003. For 2006 and subsequent years, it would be a 2% increase over the previous year (but calculated as though the increase in 2005 was 2%.) Additionally, beginning in 2014, the minimum amount (floor) would be increased by the percentage increase in the CPI for all consumers, for the 12-month period ending in June of the previous year.

Section 204(b). The Secretary would conduct a study to determine the extent to which M+C cost-sharing discourages access to covered services or discriminates based on the health status of M+C eligible beneficiaries. The Secretary would submit a report to Congress, providing recommendations for legislation and administrative action, no later than December 31, 2004.

Section 210. The costs of DOD and VA military facility services would be included in the area specific M+C payment and the local fee for service rates beginning in 2006.

Conference Agreement

Section 211(a). The conference agreement makes several changes to the payments for MA plans. In some MA payment areas, the MA payment rate is lower than the costs of providing FFS care to enrollees in traditional Medicare in some parts of the country. Many private plans have seen their Medicare payment rates rise much less rapidly than the costs of FFS Medicare, as they have been held to increases of two percent annually every year since 1998, except for 2001 when a three percent increase was paid due to the BIPA. Health costs in general are running much higher than the two percent payment increases that most plans are receiving in the areas where most of the beneficiaries are enrolled in Medicare+Choice. Plans find it difficult—if not impossible—to contract with providers if FFS Medicare can reimburse providers at higher rates than private plans may offer, given their Medicare payments. If paid less than FFS Medicare, private plans may be forced to increase enrollee premiums or cost-sharing, or decrease supplemental benefits, such as prescription drug coverage. Since 1998, the number of plans participating in M+C has declined from 346 to 155.

To encourage plan entry, all private plans would be paid at a minimum of the FFS rate. In addition, private plan rates would increase at the same rate as growth in FFS Medicare. The goal is to increase beneficiary choice, by increasing private plan participation in Medicare.

For 2004, a 4th payment mechanism will be added and plans will receive the highest of the four payment calculations (the floor, blend, minimum percentage increase, or the new amount). The new payment amount is 100% of fee-for-service (FFS) costs. The FFS payment is based on the adjusted average per capita cost for the year, for an MA payment area, for services covered under Parts A and B for beneficiaries entitled to benefits under Part A, enrolled in Part B and not enrolled in an MA plan. The 4th payment mechanism, 100% fee-for-service, will be rebased no less than once every 3 years. This payment will be adjusted to: (1) remove payments for direct medical education costs, and (2) include the additional payments that would have been made if Medicare beneficiaries entitled to benefits from facilities of the Department of Veteran Affairs (VA) and the Department of Defense (DOD) had not used those services (VA/DOD adjustment).

Section 211(b). In 2004, no adjustment will be made for budget neutrality, in order to fund the blend for that year.

Section 211(c). The calculation of the minimum percentage increase will also be revised. For 2004 and beyond, the minimum percentage increase will be the greater of: (1) a 2% increase over the previous year's payment rate (as under current law); or (2) the previous year's payment increased by the national per capita MA growth percentage. For purposes of calculating the minimum percentage increase, there will be no adjustment to the national growth percentage for prior years' errors before 2004. Beginning in 2005 and each subsequent year, the payments to a plan will be based on its prior year rate increased by the revised minimum percentage increase.

Section 211(d). The area-specific MA capitation rate (the local component of the blend) will be adjusted to include the VA/DOD adjustment, beginning in 2004.

Section 211(e). Beginning January 1, 2004, the payment rule for beneficiaries in a short-term general hospital at the time they either elected to enroll in or to terminate their enrollment in an MA plan, will be extended to a beneficiary in an rehabilitation hospital, a distinct part rehabilitation unit, or a long-term care hospital. For beneficiaries leaving their MA plan while receiving these inpatient hospital services, this provision will expand the rule that disallows payment for such services under fee-for-service payments for inpatient hospitals. Under the expansion, payments will be prohibited from any type of payment provision under Medicare for inpatient services, for the type of facility, hospital, or unit involved.

Section 211(f). No later than 18 months after enactment of this Act, the Medicare Payment Advisory Commission (MedPAC) will submit a report to Congress providing an assessment of the method used for determining the adjusted average per capita cost (AAPCC). The report will examine the variation in costs between different areas, including differences in input prices, utilization and practice patterns; the appropriate geographic area for payment of local MA plans; and the accuracy of the risk adjustment methods in reflecting differences in the cost of providing care to different groups of beneficiaries.

Section 211(g). No later than July 1, 2006, the Secretary will submit a report to Congress that describes the impact of additional financing provided under this Act and other Acts, (including the Balanced Budget Refinement Act of 1999—BBRA and the Benefits Improvement and Protection Act of 2000—BIPA) on the availability of MA plans in different areas and the impact on lowering premiums and increasing benefits under such plans.

Section 211(h). The Medicare Payment Advisory Commission (MedPAC) will conduct a study to determine the extent to which MA cost-sharing affects access to covered services or selects enrollees based on the health status of MA eligible beneficiaries. MedPAC will submit a report to Congress, providing recommendations for legislation and administrative action, no later than December 31, 2004.

Section 211(i). Within 6 weeks after enactment, the Secretary will determine and announce the revised MA capitation rates. The revised payment rates will be subject to the same transition rules that applied to revised payments after the passage of the Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554), including the requirement that plans that previously announced their intention to terminate their contract or reduce their service area could rescind their notice, among other transition rules. Also for 2004, any changes to payments made under this Act will be effective beginning in March 2004, and would be adjusted to include any additional amounts plans would have received if the new payment system had been effective January 1. If a plan revises its submission of information to the Secretary, and it includes changes in beneficiary premiums, beneficiary cost-sharing, or benefits under the plan, then the plan is required to notify each enrollee in writing, within 3 weeks after the date that the Secretary approves the changes. There will be no administrative or judicial review of any determination made by the Secretary for application of this section or payment rates.

In order to clarify current law, if a private fee-for-service plan has contacts and agreements with a sufficient number and range of providers within a category of health care professionals and providers, it may charge higher beneficiary copayments to providers in that category who do not have such contracts or agreements (other than deemed contracts or agreements).

Subtitle C—Offering Medicare Advantage (MA) Regional Plan; Medicare Advantage Competition

Section 221. Establishment of MA regional plans

Present Law

M+C plans include coordinated care plans (HMOs, preferred provider organizations or

PPOs, and provider-sponsored organizations or PSOs), private fee for service (PFFS) plans, and, on a temporary basis, medical savings accounts (MSAs).

Enrollment in any individual M+C plan is open only to those beneficiaries living in a specific service area. An M+C payment area is defined as a county, or equivalent area as specified by the Secretary. Plans define a service area as a set of counties and county parts, identified at the zip code level. At a state's option, the service area could be defined as the entire state; however, to date, no state has done so.

House Bill

Section 201(a). [§1860E–1(a)] Beginning January 1, 2006, the Administrator would establish the EFFS program for EFFS eligible individuals in EFFS regions. Plans would be offered on a regional basis, in at least 10 regions established by the Administrator. Before establishing the regions, the Administrator would conduct a market survey and analysis, including an examination of current insurance markets, to determine how the regions should be established. Regions would be established to take into consideration maximizing full access for all EFFS-eligible individuals, especially those residing in rural areas. [§1860E–1(b)]. EFFS plans would be required to provide either fee-for-service (FFS) or preferred provider coverage. Under FFS coverage, plans would: (1) reimburse hospitals, physicians and other providers at a rate determined by the plan on a FFS basis, without placing providers at risk, (2) not vary rates based on the provider's utilization, and (3) not restrict the selection of providers from among those who were lawfully authorized to provide covered services and agreed to accept the plan's terms and conditions. Under preferred provider coverage, plans would: (1) have a network of providers who agreed to a contractually-specified reimbursement for covered benefits with the organization, and (2) provide for reimbursement for all covered benefits regardless of whether they were provided within the network.

[§1860E–1(c)]. EFFS plans would have to comply with existing eligibility, election, and enrollment provisions (under §1851) including guaranteed issue and renewal, but could offer cash rebates, reduced premiums, or supplemental benefits to beneficiaries if plan bids were below a specified benchmark.

[§1860E–3(a)]. The Administrator may enter into contracts with up to three EFFS organizations in any region.

Senate Bill

Section 211. [§1858(a)]. Beginning January 1, 2006, a preferred provider organization (PPO) plan would be offered to MA eligible individuals in preferred provider regions. A PPO would be an entity with a contract that met other requirements of this Act. A PPO would have a network of providers that agreed to contractually specified reimbursements for covered benefits under Parts A and B. The PPO would pay for all covered services an enrollee received, whether provided in or out of network.

[§1858(a)(3)]. There would be at least 10 regions. Each region would have to include at least one state, and could be the entire United States. The Secretary could not divide states so that portions of the state were in different regions. To the extent possible, the Secretary would include multi-state metropolitan statistical areas (MSAs) in a single region, except that he or she could divide an MSA where necessary to establish a region of such size and geography to maximize the participation of PPOs. The Secretary could use the same regions established for the prescription drug program, under Part D. The service area of a PPO would be the region.

Each plan would be offered to any MA eligible individual residing in the service area.

Section 211. [§1858(b)]. PPOs would be required to establish a sufficient number and range of health care professionals and providers willing to provide services under the plan's terms. The Secretary would consider this requirement to be met if the organization had a sufficient number of contracts and agreements with a sufficient number and range of providers. These arrangements would not restrict enrollee access to other providers for covered services. Additionally, if the plan was in a state where 25% or more of the population resided in a health professional shortage area, these arrangements would also not restrict the categories of licensed health professionals or providers from whom the enrollee could obtain covered benefits. The Secretary could disapprove any PPO believed to attract a population that is healthier than the average population of the region serviced by the plan.

Section 211. [§1858(d)]. If there were bids for more than three plans in a preferred provider region, the Secretary would limit the number of plans to the three lowest-cost credible plans that met or exceeded the quality or minimum standards.

Conference Agreement

The conference agreement establishes a new regional plan program beginning in 2006. The Secretary will establish between 10 and 50 regions across the nation. Plans wishing to participate in this program will be required to serve an entire region. By requiring plans to serve larger service areas that bring together both urban and rural areas, the program will bring greater health plan choices to areas not previously served by the Medicare+Choice program, particularly rural areas.

In establishing Medicare Advantage regions (MA regions), the Secretary will conduct a market study to determine how regions should best be constructed to maximize plan participation and availability of plans to beneficiaries. The conference agreement includes a number of provisions to provide incentives for plans to participate in the regional program. These provisions include risk corridors for plans during the first 2 years of the program, 2006 and 2007; a stabilization fund to encourage plan entry and limit plan withdrawals; a blended benchmark that will provide greater responsiveness to the market by allowing plan bids to influence the benchmark amount; and a network adequacy fund to assist plans in forming adequate networks, particularly in rural areas. While private plans have experience in serving Medicare beneficiaries at a local level, such plans have not previously operated on a region-wide basis. These provisions will assist plans as they enter this new line of business and learn the market dynamics of serving beneficiaries across larger regions.

Section 221(a). This provision establishes a 2-year moratorium on new local preferred provider organizations in order to encourage PPOs to operate at the regional level. PPOs that are in operation as of December 31, 2005, including demonstration projects, will be allowed to continue operations and expand enrollment in their existing service areas during this period; however they will not be allowed to expand their service areas. PPOs will be able to enter new or expanded service areas again beginning January 1, 2008.

Section 221(b). The conference agreement allows MA regional coordinated care plans under the MA program. An MA regional plan: (1) has a network of providers who agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan, (2) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers, and (3) has a service area of one or more MA regions. A local MA plan is an MA plan that is not an MA regional plan, and local MA areas are defined, as under current law, as a county or equivalent area specified by the Secretary. MSA and PFFS plans are defined as local plans, although nothing prevents an MSA plan or an MA PFFS plan from serving one or more regions, or the entire Nation.

Section 221(c). [§1858(a)(1)]. The service area for an MA regional plan will consist of an entire MA region and may not be segmented.

[§1858(a)(2)]. No later than January 1, 2005 the Secretary will establish and publish a list of MA regions. There will be between 10 and 50 regions within the 50 states and the District of Columbia. Before establishing the MA regions, the Secretary will conduct a market survey and analysis, including an examination of current insurance markets. The regions should maximize the availability of MA regional plans to all MA eligible individuals without regard to health status, especially beneficiaries residing in rural areas. To the extent possible, each region should include at least one State, should not divide States across regions, and should include multi-State Metropolitan Statistical Areas in a single region. The Secretary may periodically review MA regions and, based on the review, revise the regions to be more appropriate. An MA regional plan may be offered in more than one region including all regions.

Single Deductible and Catastrophic Limit

Present Law

Medicare does not have a catastrophic limit on beneficiary out-of-pocket expenses, although some M+C plans offer an out-of-pocket limit as an added benefit. The original Medicare FFS program includes a Part B deductible and a separate Part A deductible for hospital stays.

House Bill

Section 201(a). [§1860E–2(b and c)]. EFFS plans could only be offered in a region if the plan, among other requirements, included a single deductible for benefits under Parts A and B, and a catastrophic limit on out-of-pocket expenses.

Senate Bill

Section 202. [§1852(a)]. Each MA plan would have to offer a maximum limitation on out-of-pocket expenses and a unified deductible.

Conference Agreement

Section 221(c). [§1858(b)]. In order to ensure that MA regional plans are structured more like existing private market plans for the under-65 population, the conference agreement requires MA regional plans to include a single deductible for benefits under Parts A and B. The single deductible may be applied differentially for in-network services and may be waived for preventive or other items and services. MA regional plans will also be required to include two catastrophic limits—one for out-of-pocket expenditures for in-network Part A and B benefits and one for out-of-pocket expenditures for all Part A and B benefits. Payment rates to these plans are not increased to provide this coverage.

Risk Corridors

Present Law

No provision.

House Bill

No provision.

Senate Bill

Section 211. [§1858(e)]. The PPO would notify the Secretary of the total amount of costs incurred during 2007 and 2008 in providing covered benefits under Part A and B of Medicare, except that certain expenses would not be included (administrative expenses over the amount determined appropriate by the Administrator and amounts expended for enhanced medical benefits).

The Secretary would be required to establish risk corridors for the regional PPO plans for 2006 and 2007. Medicare would share risk with PPO organizations after costs fell above or below a risk corridor of 5% as follows: (1) Medicare would share 50% of the losses or profits between 105% and 110% of a target which consists of Medicare's MA payment plus the beneficiaries' contributions; and (2) Medicare would share 90% of the losses or profits above 110% of the target. PPOs would be at full risk for all enhanced medical benefits. A beneficiary's liability would not be affected by these risk corridors in the given years.

Conference Agreement

Section 221(c). [§1858(c)]. In order to encourage plans to enter the regional market and to provide assistance to these plans during the start-up phase of their business, Medicare will share risk with MA regional plans if costs fall above or below a specific risk corridor. These risk corridors will be available to plans during 2006 and 2007. The conference agreement provides that MA regional plans notify the Secretary of: (1) the total costs of providing Part A and B benefits and the portion attributable to allowable administrative expenses, and (2) the costs of providing rebatable integrated benefits and the portion of these costs attributable to allowable administrative expenses. Allowable cost is defined, with respect to an MA regional plan for a year, as the total amount of costs incurred in providing benefits under the original Medicare FFS program, and rebatable integrated benefits, reduced by administrative expenses. Rebatable integrated benefits are defined as non-drug supplemental benefits provided by a plan, as part of its required rebate to beneficiaries, that are integrated with the benefits under the original Medicare fee-for-service program. The Secretary will have discretion to evaluate whether certain rebatable benefits should be included in allowable costs for risk corridor calculations.

[§1854(c)(2)(D)]. The target amount is defined as an amount equal to the sum of: (1) the total monthly payments made to the organization for enrollees in the plan for the year that are attributable to benefits under the original Medicare FFS program; (2) the total of the MA monthly basic beneficiary premium, collectable for the enrollees for the year; and (3) the total amount of rebatable integrated benefits that the Secretary determines are appropriate for inclusion in the risk corridor calculation. The target amount does not include the cost of administrative expenses for FFS benefits or for rebatable supplemental benefits.

[§1854(c)(2)]. There will be no payment adjustment if the allowable costs for the plan are at least 97 percent, but do not exceed 103 percent of the target amount for the plan. If allowable costs for the plan are more than 103 percent but less than 108 percent of the target amount for the plan for the year, the Secretary will increase the total monthly payments made to the organization by 50 percent of the difference between 103 percent and allowable costs. If allowable costs for the plan are greater than 108 percent of the target amount, the Secretary will increase the total monthly payments to the plan by an amount equal to the sum of: (1) 2.5 percent of the target amount; and (2) 80 percent of the difference between allowable costs and 108 percent of the target. Conversely, if the allowable costs for the plan are less than 97 percent, but greater than or equal to 92 percent of the target amount, the Secretary will reduce the total monthly payment to the plan by 50 percent of the difference between 97 percent of the target amount and the allowable cost. If the allowable costs for the plan are below 92 percent of the target, the Secretary will reduce the total monthly payments to the organization by the sum of: (1) 2.5 percent of the target amount, and (2) 80 percent of the difference between 92 percent of the target and the allowable cost.

[§1854(c)(3)]. Each contract under the MA program will provide the information the Secretary deems necessary to carry out this subsection. While the Secretary has the right to inspect and audit all books and records pertaining to information provided under this section, the information disclosed or obtained may only be used to carry out this section.

Organizational and Financial Requirements

[§1854(d)]. In order to facilitate the offering of MA plans in regions that may encompass multiple states, the conference agreement establishes rules for applying licensing requirements across states. If an MA organization offering an MA regional plan is organized and licensed under State law in a state in the region but does not meet the requirements in other states in the region, the Secretary may waive such requirement for an appropriate period of time. Such a waiver can only be granted if the organization demonstrates to the Secretary's satisfaction that it has filed the necessary application to meet the other state's requirements. If an MA organization is organized and licensed under more than one state in the region, and the organization does not meet the requirements of each state, the organization may select the rules of one State and apply those rules to the entire service area until such time as the organization meets a state's requirements, in a manner specified by the Secretary.

Stabilization Fund

Present Law

No provision.

House Bill

No provision.

Senate Bill

Section 231. If an area was designated as highly competitive, benchmarks would not apply. Instead, a plan would bid the total payment it was willing to accept (not taking into account risk adjustment) for providing required Parts A and B benefits to plan enrollees residing in the service area. The Secretary would substitute the second lowest bid for the benchmark. If there were fewer than three bids, the Secretary would be required to substitute the lowest bid for the benchmark. Total funding for this provision is limited to $6 billion over 2009 through 2013.

Conference Agreement

Section 221(c). [§1858(e)]. During the past several years a number of plans have pulled out of the Medicare+Choice program due to changing market conditions and an inflexible payment formula. Plans were held to 2 percent annual payment increases while costs in the fee-for-service program were rising at a much faster rate. Under current law, the Secretary had no ability to respond quickly to these market changes, resulting in plan withdrawals which have affected millions of beneficiaries. In order to promote greater stability in the regional program and provide the Secretary with a tool to respond to market fluctuations, the conference agreement establishes an MA Regional Plan Stabilization Fund. The Fund can be used to provide incentives for plan entry in each region and plan retention in MA regions with below- average MA penetration. Initially, $10 billion will be available for expenditures from the Fund beginning on January 1, 2007 and these start-up funds will only be available until December 31, 2013. Funds will be drawn from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in a proportion that reflects the relative weight that the benefits under Parts A and B represent of the actuarial value of the total benefit. Additional funds will be available in an amount equal to 12.5% of average per capita monthly savings from regional plans that bid below the benchmark. The additional funds will be deposited on a monthly basis into a special account in the Treasury.

The Fund is designed to allow the Secretary to respond to market conditions on a temporary basis. If the Fund is used for either plan entry or retention for 2 consecutive years, the Secretary must report to Congress on the underlying market conditions in the regions. These reports will give Congress time to respond to the market conditions through changes to the regions or the underlying payment system.

[§1858(e)(2)]. The funds will be available in advance of appropriations to MA regional plans in accordance with specified funding limitations. [§1854(e)(5)]. The total amount projected to be expended from the Fund in any year may not exceed the amount available in the Fund as of the first day of that year. If the use of the stabilization fund results in increased expenditures under this title, the increased expenditures shall be counted as expenditures from the Fund. The Secretary will only obligate funds if the Secretary, the Chief Actuary of CMS, and the appropriate budget officer certifies that there are sufficient funds at the beginning of the year to cover all such obligations for that year. The Secretary will take steps to ensure that sufficient funds are available to make such payments for the entire year, which may include computing additional payment amounts or limitations on enrollment in MA regional plans receiving such payments. [§1858(e)(2)(D)]. Expenditures from the Fund will first be made from amounts made available from the initial funding.

[§1858(e)(3)]. Plan entry incentives are available for either a one-year national bonus payment or multi-year adjustments in regional payments; however in no case can there be a regional payment adjustment if there is a national bonus for that year. In order to encourage the offering of plans in all regions, the national bonus payment will be available to an MA organization that elects to offer a regional plan in each MA region in a year, but only if one of the regions did not have a plan available in the previous year. Funding is only available for a single year, but more than one organization can receive the incentive in the same year. The national bonus payment will: (1) be available to an organization only if it offers plans in every MA region; (2) be available to all MA regional plans of the organization regardless of whether any other MA regional plan is offered in any region; and (3) be equal to 3 percent of the benchmark amount otherwise applicable for each MA regional plan offered by the organization, subject to funding limitations.

[§1858(e)(3)]. If a national bonus payment is not made, a regional payment adjustment can be made. The regional payment adjustment is an increased payment for an MA regional plan offered in an MA region that did not have any MA regional plans offered in the previous year. The Secretary will determine the adjusted payment amount based solely on plans' bids in the region, and the adjusted payment amount will be available to all plans offered in the region. The amount can be based on the mean, mode, median or other measure of such bids and may vary from region to region, but the payment amount cannot be determined through a method that limits the number of plans or bids in the region. Such a payment adjustment will be treated as a change to the benchmark amount in that region for purposes of calculating individual plan payments and beneficiary rebates.

[§1858(e)(3)(C)(ii)]. Subject to funding limitations, the Secretary will determine the period of time that funds are available for regional payment changes to encourage plan entry. If funding will be provided for a second consecutive year under this provision, the Secretary is required to submit a report to Congress describing the underlying market dynamics in the region and recommending changes to the payment methodology. Multi-year funding may be made available to all MA plans offered in a region. If this multi-year increased amount is made available to MA plans in a region, funding will not be available for plan retention in the region in the following year. Regional payment adjustments will not be taken into account when computing the underlying benchmark for the subsequent year.

[§1858(e)(4)]. In addition to using the Fund to encourage plans to enter regions that might otherwise go unserved, the Secretary may also use the fund to encourage plans to remain in regions if market conditions are causing plan withdrawals. Incentives for plan retention could take the form of an increased payment to plans in regions that meet specific requirements. The requirements are: (1) one or more plans inform the Secretary that they will discontinue service in the region in the succeeding year; (2) the Secretary determines that if those plans were not offered, fewer than 2 MA regional plans, each offered by a different organization, would be offered in the region in the year; (3) for the previous year, the Secretary determines that the proportion of beneficiaries enrolled in MA regional plans in the region is less than national average of MA regional plan enrollment; (4) funds have not already been awarded for 2 consecutive years. Any additional payment amount will be treated as if it were an addition to the benchmark amount otherwise applicable, but will not be taken into account in the computation of the benchmark for any subsequent year. If plans receive funding under this part for a second year, the Secretary will submit a report to Congress that describes the underlying market dynamics in the region and includes recommendations concerning changes in the payment methodology otherwise provided for MA regional plans under this part.

[§1858(e)(4)]. The incentive for plan retention payment will be an amount determined by the Secretary, that does not exceed the greater of: (1) 3 percent of the benchmark amount applicable in the region; or (2) an amount that, when added to the benchmark, results in a ratio such that the additional amount plus the benchmark for the region divided by the adjusted average per capita cost (AAPCC) equals the weighted average of benchmarks for all regions divided by the AAPCC for the United States.

[§1858(e)(6)]. Not later than April 1 of each year beginning in 2008, the Secretary will submit a report to Congress and the Comptroller General of the United States that includes: (1) a detailed description of the total amount expended as a result of the Stabilization Fund in the previous year (and the projections for the current year) compared to the total amount that would have been expended under this title in each year if this subsection had not been enacted; (2) amounts remaining within the funding limitations; and (3) the steps the Secretary will take to ensure that the expenditures from the Stabilization Fund will not exceed the amount available. The report will include certification from the Chief Actuary of CMS that estimates are reasonable, accurate and based on generally accepted actuarial principles and methodologies.

[§1858(e)(7)]. Not later than January 1 of 2009, 2011, 2013 and 2015, the Comptroller General of the United States will submit a report to the Secretary and Congress on the application of payments from the Stabilization Fund. The reports will include an evaluation of: (1) the quality of care provided to individuals for which additional payments were made from the Stabilization Fund; (2) beneficiary satisfaction; (3) the cost of Stabilization Fund payments to the Medicare program; and (4) any improvements in service delivery. The report will also include a comparative analysis of the performance of MA regional plans receiving payments to MA regional plans not receiving Stabilization Fund payments, and recommendations for legislation or administrative action as the Comptroller General determines would be appropriate.

Regional Blended Benchmark

Present Law

Under current law, Medicare+Choice (M+C) plans are paid an administered monthly payment, called the M+C payment rate, for each enrollee. The per capita rate for a payment area is set at the highest of three amounts: (1) a minimum payment (or floor) rate, (2) a rate calculated as a blend of an area-specific (local) rate and a national rate, or (3) a rate reflecting a minimum increase from the previous year's rate (currently 2%). In general, the Secretary makes monthly payments for each M+C enrollee reduced by any Part B premium reduction, and adjusted for risk.

House Bill

Section 201. [§1860E–3(b)]. The EFFS region-specific non-drug monthly benchmark amount means an amount equal to $\frac{1}{12}$ of the average (weighted by the number of EFFS eligible individuals in each local payment area in the region) of the annual MA payment rate for payment areas within the region.

Senate Bill

Section 211. [§1858(c)(2)]. Beginning in 2006, the Secretary would calculate a benchmark amount for required services for each region equal to the average of each benchmark amount for each MA payment area within the region, weighted by the number of MA eligible individuals residing in the payment area for the year. Each year, beginning in 2005, the Secretary would publish (at the time of publication of the risk adjustors under Part D—no later than April 15) the benchmark amount for each region, factors to be used for adjusting payments under the comprehensive risk adjustment methodology and methodology used for adjustments for geographic variations within a region.

Conference Agreement

Section 221(c). [§1854(f)]. Beginning in 2006, the Secretary will compute a "blended benchmark" amount for each MA region. The blended benchmark is designed to be responsive to market conditions in the region by allowing plan bids to influence the final benchmark amount. The MA region-specific non-drug monthly benchmark amount is defined as the sum of a statutory component and a plan-bid component for the year. The statutory component is the product of the statutory region-specific non-drug amount for the region and the year, and the statutory national market share percentage. The statutory region-specific non-drug amount, the first part of the statutory component, is an amount equal to the sum, (for each local MA area within the region) of the product of the MA area-specific non-drug monthly benchmark amount for the area and the year, and the number of MA eligible individuals residing in the local area, divided by the total number of MA eligible individuals residing in the region. The statutory national market share percentage, the second part of the statutory component, is equal to the proportion of MA eligible individuals nationally who were not enrolled in an MA plan during the most recent month during the previous year for which data are available.

The plan-bid component is the product of the weighted average of MA plan bids for the region and the year and the non-statutory market share percentage. The weighted average of plan bids for an MA region is calculated as the sum across MA regional plans, of (for each plan) the products of the unadjusted MA statutory non-drug monthly bid for the plan, and the plan's share of MA enrollment in the region. Or, in the first year in which any regional plan is offered in a region, if more than one MA regional plan is offered in that year, the plan's share of MA enrollment in the region is replaced in the formula either by (1) one divided by the number of plans in the region, or (2) a share estimated by the Secretary. The non-statutory market share percentage is one minus the statutory national market share percentage.

Uniform Coverage Determination

Present Law

An M+C organization may elect to have a single local coverage policy apply to its plan when the plan's service area includes more than one local coverage policy area. The Secretary will identify the local coverage policy that is most beneficial to M+C enrollees.

House Bill

No provision.

Senate Bill

No provision.

Conference Agreement

Section 221(c). [§1854(g)]. The organization offering an MA regional plan may elect to have a local coverage determination for the entire MA plan based on the local coverage determination applied for any part of the region, as selected by the organization. These local coverage determination are may be appealed under the applicable provisions of section 1869(f) (BIPA, sec. 522).

Assurance of Network Adequacy

Present Law

An M+C organization may select the providers in its network, so long as: (1) the organization makes the benefits available and accessible to each individual within the service area with reasonable promptness and in a manner which assures continuity in the provision of benefits; (2) when medically necessary, the organization makes benefits available and accessible 24 hours a day and 7 days a week; and (3) the plan provides reimbursement for services provided outside of the network when services are medically necessary and immediately required, when the services are renal dialysis and the beneficiary is temporarily out of the plan's service area, or when the services are maintenance care or post-stabilization. The organization must provide access to appropriate providers including credentialed specialists, and must provide emergency services without regard to prior authorization.

House Bill

No provision.

Senate Bill

No provision.

Conference Agreement

Section 221(c). [§1854(h)]. All current law network adequacy requirements will remain in place under the new regional program. However, because regions may encompass areas served by a single hospital, plans may have difficulty meeting their network adequacy requirements if they are unable to reach an agreement with such a hospital. In order to facilitate the meeting of these network adequacy requirements across large regions, the conference agreement allows the Secretary to provide payment to an essential hospital that provides services to enrollees in an area, in cases in which the MA organization offering the plan was unable to reach an agreement with the hospital regarding provision of services to plan enrollees. The Secretary will make the plan payment available only if the organization makes satisfactory assurances to the Secretary that it will pay the hospital an amount not less than the Medicare Part A payment for such services, and, with respect to specific services provided to an enrollee, the hospital demonstrates that its costs exceed the Medicare Part A payment. The agreement makes $25 million available in 2006, increased each year by the growth in the market basket percentage. Subject to that limit, the payment, if any, would be the amount by which the payment for inpatient hospital services if the hospital were a critical access hospital exceeds the payment for the same service that the hospital would otherwise receive. An essential hospital would be defined as a general acute care hospital that demonstrates to the Secretary that its costs exceed the Medicare Part A payment and is determined by the Secretary to be necessary for the plan to meet its network adequacy requirements.

Section 222. Competition program beginning in 2006

Submission of bidding and rebate information

Present Law

Under current law, Medicare+Choice (M+C) plans are paid an administered monthly payment, called the M+C payment rate, for each enrollee. The per capita rate for a payment area is set at the highest of three amounts: (1) a minimum payment (or floor) rate, (2) a rate calculated as a blend of an area-specific (local) rate and a national rate, or (3) a rate reflecting a minimum increase from the previous year's rate (currently 2%). In general, the Secretary makes monthly payments for each M+C enrollee, reduced by any Part B premium reduction, and adjusted for risk.

Each year a coordinated care plan of an M+C organization submits an adjusted community rate (ACR) proposal, estimating its proposed cost to serve Medicare beneficiaries for the following contract year and comparing such costs to the estimated costs of providing Medicare services to a commercial population. To the extent that a plan's ACR is below the administered payment amount, the plan must provide additional benefits to its enrollees or reductions in the Part B premium. In submitting its proposal, the organization must include information on: (1) the ACR; (2) the M+C monthly basic beneficiary premium; (3) a description of the deductible, coinsurance and copayments under the plan (including the actuarial value of each); and (4) a description of any required additional benefits. For supplemental benefits, the organization must also include: (1) the ACR, (2) the M+C monthly supplemental beneficiary premium, and (3) a description of the deductible, coinsurance and copayments, including the actuarial value of each.

House Bill

Section 221(a). Beginning in 2006, an MA organization would be required to provide the following information: (1) the monthly bid amount for the provision of all required items and services, based on average costs for a typical enrollee residing in the area and the actuarial bases for determining such amount; (2) the proportion of the bid attributed to the provision of statutory non-drug benefits (the "unadjusted MA statutory non-drug monthly bid" amount), statutory prescription drug benefits, and non-statutory benefits (including the actuarial basis for determining these proportions); and (3) additional information as the Administrator may require.

Senate Bill

Section 204. [§1854(a)]. Each MA organization would be required to submit information by the second Monday in September, including: (1) notice of intent and information on the service area of the plan; (2) the plan type for each plan; (3) specific information for coordinated care and PFFS plans; (4) enrollment capacity; (5) the expected mix of enrollees, by health status; and (6) other information specified by the Secretary. For coordinated care plans and PFFS plans, the plans would also be required to submit the plan bid (the total amount that the plan was willing to accept for required Parts A and B benefits not taking into account the application of comprehensive risk adjustment), the assumptions used in preparing the bid with respect to the number of enrollees in each payment area and the mix by health status, and any required information for prescription drug coverage. The plan bid would also have to be based on actuarial equivalence.

For any enhanced medical benefit package a plan chooses to offer, it would be required to provide the following information: (1) the ACR, (2) the portion of the actuarial value of such benefits package, if any, that would be applied toward satisfying the requirement for additional benefits, (3) the MA monthly beneficiary premium for enhanced benefits, (4) cost-sharing requirements, (5) the description of whether the unified deductible had been lowered or if the maximum out-of-pocket limitation had been decreased, and (6) other information required by the Secretary.

[§1854(a)(5)]. Each plan bid would be required to reasonably and equitably reflect the cost of benefits provided under that plan.

Conference Agreement

Section 222(a). Under the current Medicare+Choice system, plans are paid a fixed administrative amount regardless of their efficiency or their actual costs of providing services to the Medicare population. Beginning in 2006, an MA organization (other than an MSA) will be required to submit a bid to provide services to Medicare beneficiaries on either a local or a regional level. In submitting its bid, the plan will provide the following information: (1) the monthly aggregate bid amount for the provision of all required items and services, based on average revenue requirements (as applied under Title XIII of the Public Health Service Act for Health Maintenance Organizations) in the payment area for an enrollee with a national average risk profile (including demographic risk factors and health status); (2) the proportion of the bid attributable to the provision of benefits under the original Medicare fee-for-service program, basic prescription drug coverage, and supplemental health care benefits; (3) the actuarial basis for determining the amounts and proportions, and additional information as the Secretary may require to verify such actuarial basis; (4) a description of deductibles, coinsurance and copayments applicable under the plan and their actuarial value; and (5) for qualified prescription drug coverage, the information required under Title I of this Act. In order to facilitate regional plans being offered in more than one MA region, the Secretary will establish procedures to reduce paperwork for bids in multiple regions. Use of the term "required revenue" is intended to make clear that the bids of health plans incorporate all their revenue needs, both the medical costs of providing benefits and associated administrative costs (including profits or retained earnings).

The changes made in the bidding process under Part C do not apply to PACE programs, which operate outside of Part C. However, if they wish to offer qualified prescription drug coverage, they will be treated as a MA–PD local plan and must submit a bid for drug coverage.

Plan bids for supplemental benefits, for which plans charge a premium may include reductions in the cost sharing that would otherwise apply under the plan for Part A and B services. Benefits in each of the three areas (A/B benefits, prescription drug benefits, and supplemental benefits) will be integrated together in a way that is seamless to the beneficiary and paid for through a single premium.

Acceptance and Negotiation of Bid Amounts

Present Law

The Secretary reviews the information submitted by plans and approves or disapproves the premiums, cost-sharing amounts, and benefits. The Secretary does not have the authority to review the premiums for either MSA plans or PFFS plans.

House Bill

Section 221(a)(3)(C). The Administrator would have the same authority to negotiate bid amounts that the Director of the Office of Personnel Management has with respect to the Federal Employee Health Benefits Plan. The Administrator could negotiate the bid amount and could also reject a bid amount or proportion of the bid, if it was not supported by the actuarial basis. PFFS plans would be exempt from this negotiation.

Senate Bill

Section 204(a)(5). Each bid amount would have to reasonable and equitably reflect the cost of benefits provided by the plan.

Conference Agreement

Section 222(a). The conference agreement provides the Secretary with the authority to negotiate the monthly bid amount and the proportions, including supplemental benefits. The Secretary has similar authority to negotiate bid amounts to that of the Director of the Office of Personnel Management with respect to the Federal Employees Health Benefits Program. The Secretary may only accept such a bid amount and proportion if they are supported by the actuarial bases, and reasonably and equitably reflect the revenue requirement (as applied under Title XIII of the Public Health Service Act for Health Maintenance Organizations) of benefits provided under the plan. As under current law, the Secretary does not have the authority to review the bid amounts for PFFS plans.

The Secretary may not require: (1) any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services under this title; or (2) a particular price structure for payment under such a contract to the extent consistent with the Secretary's authority.

Benefits under the original Medicare fee-for-service program option

Present Law

M+C plans are required to include all Medicare-covered services (Parts A and B benefits) except hospice care. In some circumstances, plans may also be required to offer additional benefits or reduced cost-sharing to their beneficiaries. The basic benefit package includes all of the required Medicare-covered benefits (except hospice services) as well as the additional benefits, as determined by a formula which is set in law. The adjusted community rate (ACR) mechanism is the process through which health plans determine the minimum amount of additional benefits, if any, they are required to provide to Medicare enrollees and the cost-sharing they are permitted to charge for those benefits. Medicare does not have a catastrophic limit on beneficiary out-of-pocket expenses although some M+C plans offer an out-of-pocket limit as an added benefit. The original Medicare FFS program includes a Part B deductible and a separate Part A deductible for inpatient hospital stays.

House Bill

MA organizations, other than PFFS plans, will be required to offer at least one plan in their service area that provides drug coverage as outlined in Title I. However, if an organization offers one such plan with drug coverage, they may offer alternative plans without such drug coverage. MA plans would be required to pay rebates to beneficiaries—in the form of additional benefits, reduced premiums, or cash payments—to the extent that program payments to MA plans exceeded bid amounts. MA plans would also be able to offer supplemental benefits for additional premiums.

Senate Bill

Section 202. [§1852(a)]. In addition to offering Medicare Parts A and B benefits (except hospice) and any additional required benefits, each MA plan (except MSAs, and in the case of prescription drug coverage, PFFS plans) would be required to offer: (1) qualified prescription drug coverage under Part D to beneficiaries residing in the area, and (2) a maximum limitation on out-of-pocket expenses and a unified deductible.

[§1852(a)(7)]. The unified deductible would be defined as an annual deductible amount applied in lieu of the inpatient hospital deductible and the Part B deductible. This would not prevent an MA organization from requiring coinsurance or a copayment for inpatient hospital services, after the unified deductible was satisfied, subject to statutory limitations.

[§1852(a)(2)(D)]. A PFFS plan could choose not to offer qualified prescription drug coverage under part D. Beneficiaries enrolling in such a PFFS plan could choose to enroll in an eligible entity under part D to receive their prescription drug coverage. [§1852(d)(4)]. A PFFS plan entirely meeting the access requirement for a category of providers through contracts or agreements (other than deemed contracts) could require higher beneficiary co-payments for providers who did not have such contracts or agreements.

Conference Agreement

Section 222(a). Beginning in 2006, plan bids will be compared to a benchmark amount. For MA local plans, the benchmark amount will be the MA payment rates. For MA regional plans, the benchmark amount will be the regional blended benchmark. Plans that submit bids below the benchmark will be paid their bids, plus 75 percent of the difference between the benchmark and the bid, which must be returned to beneficiaries in the form of additional benefits or reduced premiums. For plans that bid above the benchmark the government will pay the benchmark amount, and the beneficiary will pay the difference between the benchmark and the bid amount as a premium. When for an MA regional plan, in determining the actuarially equivalent level of cost-sharing for required benefits, only expenses for in-network providers will be taken into account for the application of the catastrophic limit. Supplemental benefits can include reductions in cost-sharing for A and B benefits below the actuarial value of the deductible, coinsurance and copayments that would be applicable, on average, to individuals in the original fee-for-service program.

MA organizations, other than PFFS plans, will be required to offer at least one plan in their service area that provides drug coverage as outlined in Title I. However, if an organization offers one such plan with drug coverage, it may offer alternative plans without such drug coverage.

Beneficiary Savings

Present Law

To the extent that a plan's ACR is below the administered payment amount, plans must provide reduced cost-sharing, additional benefits, or reduced Part B premiums to their Medicare enrollees. Such benefits must be valued at 100 percent of the difference between the projected cost of providing Medicare-covered services to its commercial population and the expected revenue for Medicare enrollees. Plans can choose which additional benefits to offer, however, the total cost of these benefits must at least equal the "savings" from Medicare-covered services. Plans may also place the additional funds in a stabilization fund or return funds to the Treasury.

House Bill

Section 221(b). An MA plan would be required to provide an enrollee a monthly rebate that equaled 75 percent of any average per capita savings (the amount by which the risk-adjusted benchmark exceeded the risk-adjusted bid). The rebate could be: (1) credited toward the MA monthly supplemental beneficiary premium or the prescription drug premium; (2) paid directly to the beneficiary; (3) provided by another means approved by the Administrator; (4) or any combination of the above. The remaining 25 percent of the average per capita savings would be retained by the federal government.

Benchmarks would equal one-twelfth of the annual MA capitation rate for an enrollee in that area, and would be calculated by updating the previous year's capitation rate by the annual increase in the minimum percentage increase.

Senate Bill

[§1854(c)]. If the weighted service area benchmark exceeded the plan bid, the Secretary would require the plan to provide additional benefits, and if the plan bid exceeded the weighted service area benchmark, the plan could charge an MA monthly basic beneficiary premium equal to the amount the bid exceeded the benchmark.

Section 204. [§1854(g)]. If the plan bid was lower than the weighted service area benchmark, the plan could, in addition to benefits allowed under current law, also lower the amount of the unified deductible and decrease the maximum limitation on out-of-pocket expenses. However, plans would be restricted from specifying any additional benefits that provided for the coverage of any prescription drug, other than that relating to covered drugs under Part D.

Conference Agreement

Section 222(b). The conference agreement requires an MA plan to provide an enrollee with a monthly rebate equal to 75 percent of any average per capita savings (the amount by which the risk-adjusted benchmark exceeds the risk-adjusted bid). In calculating such savings, and in order to ensure that savings are uniform for all enrollees in a plan, the benchmark and the bid will be risk adjusted according to a statewide (for local plans) or region-wide (for regional plans) risk adjuster. Alternatively, the Secretary has the discretion to risk adjust the benchmark and bid on a plan-specific basis for the purpose of calculating such savings. The beneficiary rebate can be credited toward the provision of supplemental health care benefits (including a reduction in cost-sharing, additional benefits or a credit toward any MA monthly supplemental beneficiary premium), the prescription drug premium, or the Part B premium. The plan will inform the Secretary about the form and amount of the rebate, or the actuarial value, in the case of supplemental health care benefits. The remaining 25 percent of the average per capita savings will be retained by the federal government.

Revision of Premium Terminology

Present Law

The M+C monthly basic beneficiary premium is the amount authorized to be charged for the plan based on the application of the "limitation on enrollee liability". The "limitation on enrollee liability" requires that the actuarial value of the premium, deductibles, coinsurance, and copayments applicable on average to enrollees in an M+C plan for required services does not exceed the actuarial value of deductibles, coinsurance, and copayments on average for beneficiaries in traditional Medicare. However, this average may be achieved by having higher copayments for some M+C services and lower copayments for other services. The supplemental beneficiary premium is amount authorized to be charged for the plan, such that the actuarial value of supplemental beneficiary premium, deductibles, coinsurance, and copayments for such benefits does not exceed the ACR for such benefits. These requirements do not apply to PFFS plans.

House Bill

Section 221 (d). For plans with a bid amount below the benchmark, the basic premium would be zero. For plans with bids above the benchmark, the basic premium would be equal to the amount by which the bid exceeded the benchmark.

Senate Bill

Section 204. If the weighted service area benchmark exceeded the plan bid, the plan would have to provide additional benefits. If the bid exceeded the weighted service area benchmark, the amount of the excess would be the MA monthly basic beneficiary premium.

Conference Agreement

Section 222(b). For plans providing rebates (plans that bid below the benchmark), the MA monthly basic beneficiary premium will be zero. For plans with bids above the applicable benchmark, the MA monthly basic beneficiary premium will equal the amount by which the bid exceeds the benchmark. The MA monthly prescription drug beneficiary premium is the portion of the aggregate monthly bid amount that is attributable to the provision of prescription drug benefits under Title I of this Act, less the amount of any rebate. The MA monthly supplemental beneficiary premium is the portion of the aggregate monthly bid amount that is attributable to the provision of supplemental health care benefits, less the amount of any rebate. The unadjusted MA statutory non-drug monthly bid is the portion of the bid submitted by a plan attributable to the provision of required benefits under Medicare fee-for-service.

Collection of Premiums

Present Law

Medicare beneficiaries may have their Part B premiums deducted directly from their Social Security benefits.

House Bill

Section 221(b). Enrollees would be permitted to have their MA premiums deducted directly from their Social Security benefits or through an electronic funds transfer. The Administrator would be required to provide a mechanism whereby a beneficiary who joined an MA plan and elected Part D coverage through the plan would be able to pay one consolidated premium amount.

Senate Bill

No provision.

Conference Agreement

Section 222(c). The conference agreement allows enrollees to have their MA premiums deducted directly from their Social Security benefits, through an electronic funds transfer, or such other mean as specified by the Secretary, including payment by an employer or under employment-based retiree coverage on behalf of an employee, a former employee, or a dependent. All premium payments deducted from Social Security benefits will be credited to the appropriate Trust Fund as specified by the Secretary (in consultation with the Commissioner of Social Security and the Secretary of the Treasury) and shall be paid to the MA organization involved. The MA plan may not impose a charge for individuals electing to pay their premiums through a deduction from their Social Security payments.

For individuals electing to have premiums deducted directly from Social Security benefits, the Secretary will transmit to the Commissioner of Social Security, by the beginning of each year, the name, social security account number, consolidated monthly beneficiary premium owed by the enrollee for each month during the year, and other information determined appropriate by the Secretary. Information will be periodically updated throughout the year. The Secretary will be required to provide a mechanism for the consolidation of any MA monthly basic beneficiary premium, any MA monthly supplemental beneficiary premium, and any MA monthly prescription drug beneficiary premium.

Computation of MA Benchmark and Payments of Plans Based on Bid Amounts

Present Law

Under current law, Medicare+Choice (M+C) plans are paid an administered monthly payment, called the M+C payment rate, for each enrollee. The per capita rate for a payment area is set at the highest of three amounts: (1) a minimum payment (or floor) rate, (2) a rate calculated as a blend of an area-specific (local) rate and a national rate, or (3) a rate reflecting a minimum increase from the previous year's rate (currently 2%). In general, the Secretary makes monthly payments for each M+C enrollee, reduced by any Part B premium reduction, and adjusted for risk.

House Bill

Section 221(c). For payments before 2006, the monthly payment amount would equal 1/12 of the annual MA capitation rate, for an enrollee for that area, reduced by any Part B premium reduction and adjusted for risk factors such as age, disability status, gender, institutional status and other factors the Administrator determines to be appropriate, including an adjustment for health status.

Beginning in 2006, MA payment rates would be determined by the Administrator by comparing plan bids to the benchmark. Non-drug benefits: Beginning in 2006, for plans with bids below the benchmark, the payment would equal the unadjusted MA statutory non-drug monthly bid amount, with adjustments for demographic factors (including age, disability, and gender) and health status and the monthly rebate. Conversely, for plans with bids at or above the benchmark, the payment amount would equal the MA area-specific non-drug monthly benchmark amount, with the demographic and health status adjustments. Drug benefits: Additionally, for an MA enrollee who enrolled in Part D and elected prescription drug coverage through the plan, the plan's payment would include a direct and a reinsurance subsidy payment and reimbursement for premiums and cost-sharing reductions for certain low-income beneficiaries, as outlined in Title I of this bill.

Senate Bill

Section 203. [§1853(a)]. Each MA organization would receive a separate monthly payment for: (1) benefits under FFS Medicare Parts A and B, and (2) benefits under the prescription drug program, Part D. The Secretary would ensure that payments for each enrollee would equal the MA benchmark amount for the payment area, as adjusted. The adjustments would include both a risk adjustment and an adjustment based on the ratio of the payment amount to the weighted service area benchmark.

Section 203. [§1853(c&d)]. Beginning in 2006, payments to MA plans would be determined differently, based on a comparison between plan bids and the weighted service area benchmark. The Secretary would however, continue to calculate the annual M+C capitation rates.

Plans would submit bids to the Secretary by the second Monday in September.

The Secretary would calculate the benchmark amounts as the greater of the minimum amount (floor) or the local FFS rate for the area. The local FFS rate would be calculated similarly to the adjusted average per capita cost (AAPCC), adjusted to remove the costs of indirect and direct graduate medical education.

The Secretary would calculate the weighted service area benchmark amount equal to the weighted average of the benchmark amounts for required services for the payment areas included in the service area of the plan.

The Secretary would determine the difference between each plan's bid and the weighted service area benchmark amount. For plan bids that equal or exceed the weighted service area benchmark, the MA organization would be paid the weighted service area benchmark amount. For plan bids below the weighted service area benchmark, the plan would be paid the weighted service area benchmark reduced by the amount of any premium reduction elected by the plan. The Secretary would adjust payments using the comprehensive risk adjustment methodology.

Section 205. This provision would establish the additional payments that would be made to the MA plans for the prescription drug coverage under Part D.

Conference Agreement

Section 222(d). The conference agreement defines the term MA area-specific non-drug monthly benchmark amount, for a month in a year, for a service area that is entirely within an MA local area, as an amount equal to 1/12 of the annual MA capitation rate for the area. For a service area within more than one MA local area, the amount is equal to the average of the local amounts, weighted by the projected number of enrollees in the plan residing in the respective local area. For an MA region, the MA region-specific benchmark amount for the region for the year is defined as the sum of the statutory component and the plan-bid component. The statutory component is a weighted average of the local MA benchmarks in the region.

Section 222(e). For payments before 2006, the conference agreement sets the monthly payment amount to equal 1/12 of the annual MA capitation rate, for an enrollee for that area, reduced by any Part B premium reduction and adjusted for demographic factors such as age, disability status, gender, institutional status and other factors the Secretary determines to be appropriate, including an adjustment for health status.

Beginning in 2006, MA payment rates will be determined by the Secretary by comparing plan bids to the benchmark. Non-drug benefits: Beginning in 2006, for plans with bids below the benchmark, the payment will equal the unadjusted MA statutory non-drug monthly bid amount, with adjustments for demographic factors (including age, disability, and gender) and health status, adjustments for intra-regional variation (if applicable), adjustments relating to risk adjustment, and the monthly rebate. To adjust for intra-regional variation, the Secretary will adjust the amounts to take into account variation in MA local payment rates among the different MA local areas included in a region. For adjustments relating to risk, the Secretary will adjust payments to MA plans to ensure that the sum of the monthly payment and any basic beneficiary premium equals the unadjusted MA statutory non-drug monthly bid amount, with demographic adjustments, and for an MA regional plan, adjustments for intra-regional variations. For plans with bids at or above the benchmark, the payment amount will equal the

MA area-specific non-drug monthly benchmark amount, with the demographic and health status adjustments, adjustments for intra-regional variation (if applicable), and adjustments relating to risk adjustment. The use of a risk adjustment methodology that uses demographic factors and health status factors will continue as under current law, and the Secretary will continue to have the flexibility to develop and implement new risk adjustment methodologies. Drug benefits: Additionally, for an MA enrollee in an MA–PD plan, the plan's payment will include a subsidy payment and reimbursement for premiums and cost-sharing reductions for certain low-income beneficiaries, as outlined in Title I of this bill.

In the case of an MSA plan, the payment equals the MA area-specific non-drug monthly benchmark amount, adjusted for demographics and health status.

Annual Announcement Process

Present Law

The Secretary annually determines and announces, no later than May 1 for 2003 and 2004 and March 1, thereafter (for the following year), the annual M+C capitation rate for each M+C payment area and the risk and other factors to be used in adjusting these rates.

House Bill

Section 221(e). For years before 2006, for the calendar year concerned, the Secretary would announce the annual MA capitation rate for each MA payment area for the year and the risk and other factors to be used to adjust these rates. Beginning in 2006, the Secretary would announce yearly the MA area-specific non-drug benchmark and the adjustment factors relating to demographics, end stage renal disease (ESRD), and health status in each MA plan in the area.

Senate Bill

Section 203. [§1853(a)]. Beginning April 15, 2005 (at the same time as risk adjusters for prescription drug coverage were announced), the Secretary would annually announce the benchmark for each MA payment area and the risk adjustment factors.

Conference Agreement

Section 222(f). For payments in 2005, the conference agreement requires the Secretary to determine and announce the MA capitation rates for each MA payment area for 2005, and the risk and other adjustment factors, by the 2nd Monday in May of 2004. For 2006 and subsequent years, the Secretary will determine and announce, not later than the 1st Monday in April before the calendar year concerned, the MA capitation rate for each payment area, and the risk and other factors to be used in adjusting such rates. The Secretary will determine and announce, on a timely basis before the calendar year concerned, for each MA region and MA regional plan for which a bid is submitted, the MA region-specific non-drug monthly benchmark amount.

Protection Against Beneficiary Selection

Present Law

The M+C monthly basic and supplemental beneficiary premium cannot vary among individuals enrolled in a the same plan.

House Bill

Section 221(d). The MA monthly bid amount, the MA monthly basic, prescription drug, and the supplemental beneficiary premium would not vary among enrollees in the plan. Additionally, the MA monthly MSA premium would not vary within an MSA plan.

Senate Bill

Section 204. The provision would establish the requirement that the MA monthly basic beneficiary premium, the MA monthly beneficiary obligation for qualified prescription drug coverage, and the MA monthly beneficiary premium for enhanced medical benefits could not vary among beneficiaries enrolled in the plan. Also, the MA MSA premium would not vary among beneficiaries enrolled in the MSA plan.

Conference Agreement

Section 222 (g). Except as permitted to facilitate the offering of MA plans under contracts between MA organizations and employers, labor organizations or the trustees to a fund established by one or more employers or labor organizations (as currently allowed under sec. 1857(i)), the MA monthly bid amount, the MA monthly basic, prescription drug, and the supplemental beneficiary premium may not vary among enrollees in the plan.

Adjusted Community Rates

Present Law

Each year an M+C organization submits an ACR proposal, estimating their proposed cost of serving Medicare beneficiaries for the following contract year as compared to the estimated cost of providing the same services to a commercial population. The ACR process is a mechanism through which health plans determine the minimum amount of additional benefits they are required to provide to Medicare enrollees and the cost-sharing they are permitted to charge for those benefits.

House Bill

Plan bids would replace ACRs beginning in 2006.

Senate Bill

No provision.

Conference Agreement

Plan bids will replace ACRs beginning in 2006.

Plan Incentives

Present Law

A M+C organization may not operate a physician incentive plan unless it meets the following requirements: (1) no specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided to an enrollee; or (2) if the plan places a physician or group at substantial financial risk, it must provide stop-loss protection and conduct periodic surveys of current and former enrollees to determine the degree of access and satisfaction with the quality of services. The organization must provide the Secretary with sufficient information regarding the plan, to determine whether or not the plan is in compliance with these requirements.

House Bill

No provision.

Senate Bill

No provision.

Conference Agreement

Section 222 (h). An MA organization may not operate a physician incentive plan unless it provides assurances satisfactory to the Secretary. Requirements that the organization: (1) conduct periodic surveys, and (2) provide the Secretary with sufficient information regarding the plan, to determine whether or not the plan is in compliance with these requirements are replaced. Instead, the plan must provide such information as the Secretary requires on any physician incentive plan.

Continuation of treatment of enrollees with End-Stage Renal Disease

Present Law

The Secretary established a separate rate of payment to an M+C organization for individuals with ESRD who are enrolled in an M+C plan.

House Bill

No provision.

Senate Bill

No provision.

Conference Agreement

Section 222 (i). The conference agreement requires payment rates to be actuarially equivalent to rates that would have been paid with respect to other enrollees in the MA payment area (or such other area as specified by the Secretary) under the provision of this section in effect before the enactment of this Act. The Secretary may apply the competitive bidding methodology of this section, with appropriate adjustments to account for the risk adjustment methodology applied to ESRD payments.

Facilitating employer participation

Present Law

Employers may sponsor an M+C plan or pay premiums for retirees who enroll in an M+C plan. If an M+C plan contracts with an employer group health plan (EGHP) that covers enrollees in an M+C plan, the enrollees must be provided the same benefits as all other enrollees in the M+C plan, with the EGHP benefits supplementing the M+C plan benefits. The Secretary may waive or modify requirements that hinder the ability of employer or union group health plans to offer an M+C plan option.

House Bill

No provision.

Senate Bill

Section 206. The Administrator could permit an MA plan to establish a separate premium amount for enrollees in an employer or other group health plan that provides employment-based retiree health coverage. This provision would also apply the current law requirements to regional PPOs.

Conference Agreement

Section 222(j). The conference agreement allows the Secretary to waive or modify requirements that hinder the design of, offering of, or enrollment in an MA plan offered by employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (to furnish benefits to any combination of current or former employees, or current or former members of the labor organization.) The MA plan may restrict enrollment to individuals who are beneficiaries and participants in such a plan.

Expansion of Medicare Beneficiary Education and Information Campaign

Present Law

The Secretary is authorized to collect a user fee from each M+C organization for use in carrying out enrollment information dissemination activities for the program as well as the health insurance and counseling assistance program. The fee is based on the ratio of the organization's number of Medicare enrollees to the total number of Medicare beneficiaries. There are authorized to be appropriated $1 million each year, reduced by any fees collected by the Secretary, to carry out these activities.

House Bill

No provision.

Senate Bill

No provision.

Conference Agreement

Section 222(k). The conference agreement allows the Secretary to also charge a PDP sponsor under Part D for its share of fees related to enrollment information dissemination activities. The authorization for appropriated amounts will be increased to $2 million each year, beginning in 2006.

Protection against Beneficiary Selection

Present Law

No provision.

House Bill

Section 221(d). The Administrator would not approve a plan if benefits were designed to substantially discourage enrollment by certain MA eligible individuals.

Senate Bill

Section 204. [§1854(a)]. The Secretary could disapprove a plan bid if he or she determined that the deductibles, coinsurance or copayments discouraged access to covered services or were likely to result in favorable selection of MA eligible beneficiaries.

Conference Agreement

Section 222(l). The Secretary may not approve a plan if the design of the plan and its benefits are likely to substantially discourage enrollment by certain MA eligible individuals.

Section 223. Effective date.

Present Law

No provision.

House Bill

Section 211(e). The MA program would be effective January 1, 2004. Section 21(g). The competition program would be effective January 1, 2006.

Senate Bill

Section 209. Generally effective January 1, 2006. However, the Secretary would apply payment and other rules for MSA plans, as if this title had not been enacted.

Conference Agreement

The conference agreement makes the amendments of Title II effective for plan years beginning on or after January 1, 2006, unless otherwise provided. The Secretary shall revise previously promulgated regulations for the changes due to the provisions of this Act, to carry out Part C of Medicare.

Subtitle D—Additional Reforms

Section 231. Specialized MA plans for special needs beneficiaries

Present Law

One model for providing a specialized M+C plan, EverCare, operates as a demonstration program. EverCare is designed to study the effectiveness of managing acute-care needs of nursing home residents by pairing physicians and geriatric nurse practitioners. EverCare receives a fixed capitated payment, based on a percentage of the AAPCC, for all nursing home resident Medicare enrollees.

House Bill

Section 233. A new MA option would be established—specialized MA plans for special needs beneficiaries (such as the EverCare demonstration). Special needs beneficiaries are defined as those MA eligible beneficiaries who were institutionalized, entitled to Medicaid, or met requirements determined by the Administrator. Enrollment in specialized MA plans could be limited to special needs beneficiaries until January 1, 2007. Interim final regulations would be required within 6 months of enactment. The Secretary would be permitted to offer specialized MA plans for plans that disproportionately serve beneficiaries with special needs who are the frail elderly. No later than December 31, 2005, the Administrator would be required to submit a report to Congress that assessed the impact of specialized MA plans for special needs beneficiaries on the cost and quality of services provided to enrollees.

Senate Bill

Section 222. A new M+C option would be established—specialized M+C plans for special needs beneficiaries (such as the EverCare demonstration). Special needs beneficiaries are defined as those M+C eligible beneficiaries who were institutionalized, entitled to Medicaid, or met requirements determined by the Secretary. Enrollment in specialized M+C plans could be limited to special needs beneficiaries until January 1, 2008. No later than December 31, 2006, the Secretary would be required to submit a report to Congress that assessed the impact of specialized M+C plans for special needs beneficiaries on the cost and quality of services provided to enrollees. No later than 1 year after enactment of this Act, the Secretary would be required to issue final regulations to establish requirements for special needs beneficiaries.

Conference Agreement

Section 231. The establishment of a specialized plan designation provides health plans the authority and incentives to develop targeted clinical programs to more effectively care for high-risk beneficiaries who have multiple chronic conditions or have complex medical problems. This provision designates two specific segments of the Medicare population as special needs beneficiaries, but also provides the Secretary the authority to designate other chronically ill or disabled beneficiaries as "special needs beneficiaries" to allow plans to serve additional high risk groups who would benefit from enrollment in plans that offer targeted geriatric approaches and innovations in chronic illness care. The Secretary should consider Medicare demonstrations for guidance regarding other potential special needs beneficiary designations.

The provision would establish a new Medicare Advantage option—Specialized Medicare Advantage plans for Special Needs Beneficiaries. Specialized Medicare Advantage plans are plans that exclusively serve special needs beneficiaries such as the Evercare and Wisconsin Partnership demonstrations and, at the discretion of the Secretary, those that serve a disproportionate number of such beneficiaries. Special needs beneficiaries are defined as Medicare Advantage enrollees who are institutionalized, or entitled to Medicaid, or individuals with severe and disabling conditions that the Secretary deems would benefit from a specialized plan. Specialized Medicare Advantage plans can limit enrollment to special needs beneficiaries until January 1, 2009. No later than 1 year after enactment of this act, the Secretary is required to issue final regulations to establish requirements for special needs beneficiaries. No later than December 31, 2007, the Secretary is required to submit a report to Congress that assesses the impact of Specialized Medicare Advantage plans on the cost and quality of care. The provision does not change current Medicare+Choice quality, oversight or payment rules.

The legislation also allows the Secretary to define as Specialized Medicare Advantage plans those that "disproportionately" serve special needs beneficiaries. Since there is no existing standard for measuring "disproportionate," the provision gives the Secretary discretion in promulgating this part of the regulation with a view toward establishing quantitative criteria for defining "disproportionate." The Secretary may identify such means of measuring "disproportionate" as are feasible to capture appropriate risk levels for designation as a "Specialized Medicare Advantage Plan for Special Needs Beneficiaries." The Secretary may wish to require further validation that "disproportionate" plans are 'specialized" by requiring evidence of processes or clinical programs designed to address the unique needs of the special needs beneficiaries served.

Section 232. Avoiding duplicative State regulation

Present Law

Medicare law currently preempts state law or regulation from applying to M+C plans to the extent they are inconsistent with federal requirements imposed on M+C plans, and specifically, relating to benefit requirements, the inclusion or treatment of providers, and coverage determinations (including related appeals and grievance processes).

House Bill

Section 232. Federal standards established by this legislation would supersede any state law or regulation (other than state licensure laws and state laws relating to plan solvency), with respect to MA plans offered by MA organizations.

Senate Bill

No provision.

Conference Agreement

Section 232. The conference agreement clarifies that the MA program is a federal program operated under Federal rules. State laws, do not, and should not apply, with the exception of state licensing laws or state laws related to plan solvency. There has been some confusion in recent court cases. This provision would apply prospectively; thus, it would not affect previous and ongoing litigation.

Additionally, no state may impose a premium, or similar, tax on premiums paid to MA organizations under this bill.

Section 233. Medicare Medical Savings Accounts (MSAs)

Present Law

BBA1997 authorized a demonstration for M+C MSAs. The M+C option combined a high-deductible health insurance plan with an M+C MSA. New enrollment was not allowed after January 1, 2003 or after the number of enrollees reached 390,000. No private plans have established an M+C MSA for Medicare beneficiaries. M+C plans (including MSAs) must have an ongoing quality assurance program for health care services provided to Medicare beneficiaries. The required elements of the program are specified in statute.

House Bill

Section 234. The requirement that MSAs report on enrollee encounters for an ongoing quality assurance program would be eliminated because MSAs are not plans but bank accounts. The Medicare MSA demonstration would be made a permanent option, the capacity limit would be removed and the deadline for enrollment would be eliminated. Non-contract providers furnishing services to enrollees of MSAs will be subject to the same balanced billing limitations as noncontract providers furnishing services to enrollees of coordinated care plans.

Senate Bill

Section 201. The deadline for enrollment in an MSA would be extended until December 31, 2003.

Conference Agreement

Section 233. Medicare MSAs are not being offered in the Medicare program today, despite the legislative authority granted in 1997 and despite the fact that non-Medicare MSAs are being offered. The Medicare MSA demonstration will be made a permanent option, the capacity limit will be removed and the deadline for enrollment will be eliminated. The requirement that MSAs report on enrollee encounters for an ongoing quality assurance program would be eliminated because MSAs are not plans but bank accounts. Non-contract providers furnishing services to enrollees of MSAs will be subject to the same balanced billing limitations as non-contract providers furnishing services to enrollees of coordinated care plans. The Conferees hope to encourage this additional choice for seniors through these changes.

Section 234. Extension of reasonable cost contracts

Present Law

Cost-based plans are those plans that are reimbursed by Medicare for the actual cost of furnishing covered services to Medicare beneficiaries, less the estimated value of beneficiary cost-sharing. The Secretary cannot extend or renew a reasonable cost reimbursement contract for any period beyond December 31, 2004.

House Bill

Section 235. Reasonable cost contracts could be extended or renewed indefinitely, with an exception that would begin in 2008. Beginning January 1, 2008, cost contracts could not be continued if during the entire previous year, the service area had two or more coordinated care MA plans or two or more EFFS plans, each of which met the following minimum enrollment requirements: (1) at least 5,000 enrollees for the portion of the area that is within a metropolitan statistical area having more than 250,000 people and counties contiguous to such an area, and (2) at least 1,500 enrollees for any other portion of such area.

Senate Bill

Section 221. Reasonable cost contracts could be extended or renewed until December 31, 2009. Beginning in 2004, these plans would have to comply with certain requirements of the M+C program (and beginning in 2006 the MA program), including ongoing quality assurance programs, physician incentive plan limitations, uniform premium amount requirements, premium tax restrictions, federal preemption, authority of an organization to include supplemental health care benefits, benefit filling deadlines, contract renewals and beneficiary notifications, and proposed cost-sharing subject to the Secretary's review.

The Secretary would be required to approve a new application for a group practice HMO to enter into a reasonable cost contract if the group met certain requirements of the Public Health Service Act. The requirements would be that the group practice HMO, as of January 1, 2004, provided at least 85% of the services of a physician (which are provided as basic health services) through a medical group (or groups), and met other requirements for such entities specified in statute.

Conference Agreement

Section 234. The conference agreement ends the uncertainty about the continuation of cost contracts, allowing these plans to operate indefinitely, unless two other plans of the same type (i.e., either 2 local or 2 regional plans) enter the cost contract's service area. These other plans must meet the following minimum enrollment requirements: (1) at least 5,000 enrollees for the portion of the area that is within a metropolitan statistical area having more than 250,000 people and counties contiguous to such an area, and (2) at least 1,500 enrollees for any other portion of such area. The Conferees believe that if other private plans are willing to enter the cost contract's service area, then the cost contract should be required to operate under the same provisions as these other private plans.

Section 235. 2-year extension of Municipal Health Service demonstration projects

Present Law

The Municipal Health Services Demonstration Project operates in four cities. These cities use their existing public health programs as the nucleus of a coordinated system to provide community-based health care for the underserved urban poor. The project provides comprehensive health services, including a prescription drug benefit and dental services.

BBA 97 extended the program through 2000. The BBRA extended it through 2002, and the BIPA extended it through December 31, 2004.

House Bill

Section 236. Demonstration projects would be extended through December 31, 2009, for beneficiaries who reside in the city in which the project is operated.

Senate Bill

Section 618. Demonstration projects would be extended through December 31, 2006, for beneficiaries who reside in the city in which the project is operated.

Conference Agreement

Section 235. The conference agreement extends demonstration projects through December 31, 2006, for beneficiaries who reside in the city in which the project is operated.

Section 236. Payment by Program of All-Inclusive Care for the Elderly (PACE) providers for Medicare and Medicaid services furnished by non-contract providers

Present Law

PACE was created as a demonstration project in the Omnibus Budget Reconciliation Act (OBRA 86). The Secretary was required to grant waivers of certain Medicare and Medicaid requirements to a maximum of 10 (expanded to 15 in OBRA90) community-based organizations to provide health and long-term care services on a capitated basis to frail elderly persons at risk of being institutionalized. The Balanced Budget Act 97 (BBA97) made PACE a permanent part of Medicare and a state option for the Medicaid program.

House Bill

No provision.

Senate Bill

Section 223. For the Medicare program, protections against balance billing to PACE providers and beneficiaries enrolled with such PACE providers would apply in the same manner as applies to M+C. For the Medicaid program, with respect to services covered under the State plan (but not under Medicare) that were furnished to a beneficiary enrolled in a PACE program, the PACE program would not be required to pay a provider an amount greater than required under the state plan.

Conference Agreement

Section 236. For the Medicare program, protections against balance billing to PACE providers and beneficiaries enrolled with such PACE providers apply in the same manner as applies to M+C (MA). For the Medicaid program, with respect to services covered under the State plan (but not under Medicare) that are furnished to a beneficiary enrolled in a PACE program, the PACE program is not required to pay a provider an amount greater than required under the state plan.

Section 237. Reimbursement for Federally Qualified Health Centers (FQHCs) providing services under MA plans

Present Law

Services provided by FQHCs to Medicare enrollees are reimbursed at no more than 80% of the reasonable costs of providing such services less any beneficiary cost sharing amounts collected.

People who knowingly and willfully offer or pay a kickback, a bribe, or rebate to directly or indirectly induce referrals or the provision of services under a Federal program may be subject to financial penalties and imprisonment. Certain exceptions or safe harbors that are not considered violations of the anti-kickback statute have been established.

House Bill

No provision.

Senate Bill

Section 615. FQHCs would receive a wrap-around payment for the reasonable costs of care provided to Medicare managed care patients served at such centers. The provision would raise reimbursements to FQHCs, so that when they are combined with M+C payments and cost-sharing payments from beneficiaries, they would equal 100% of the reasonable costs of providing such services.

This provision would extend the safe harbor to include any remuneration between a FQHC (or entity control by and FQHC) and an MA organization.

Conference Agreement

Section 237. FQHCs will receive a wrap-around payment for the reasonable costs of care provided to Medicare managed care patients served at such centers. The provision raises reimbursements to FQHCs, so that when they are combined with MA payments and cost-sharing payments from beneficiaries, they equal 100% of the reasonable costs of providing such services.

This provision extends the safe harbor to include any remuneration between a FQHC (or entity control by an FQHC) and an MA organization.

Section 238. Study of performance-based payment systems

Present Law

No provision.

House Bill

Section 237. The Secretary would request that the IOM conduct a study to review and evaluate public and private sector experiences in: (1) establishing performance measures and payment incentives under the Medicare program, and (2) linking performance to payment. The Secretary would also request that no later than 18 months after enactment, the Institute submit a report to the Secretary and the Congress that included a review and evaluation of incentives to encourage quality performance, as specified in the statute. The study would also examine how these measures and incentives might be applied in the Medicare MA, EFFS, and FFS programs. The report would include recommendations regarding appropriate performance measures for use in assessing and paying for quality and would identify options for updating performance measures.

Senate Bill

Section 224. Within 2 months of enactment, the Secretary would be required to enter into an arrangement with IOM to evaluate leading health care performance measures and options to implement policies that align performance with payment under the Medicare program. The information that would be catalogued, reviewed and evaluated by IOM would be specified in statute. A report would be due to the Secretary and the congressional committees of jurisdiction within 18 months of enactment. There would be $1 million authorized to be appropriated to conduct the evaluation and prepare the report.

Conference Agreement

Section 238. The conference agreement requires that within 2 months of enactment, the Secretary shall enter into an arrangement with IOM to evaluate leading health care performance measures in the public and private sectors and options to implement policies that align performance with payment under the Medicare program. The information examined by IOM includes the validity of leading health care performance measures, the success and utility of alternative performance incentive programs, and options to implement policy that aligns performance with payments. The Institute shall consult with MedPAC. A report is be due to the Secretary and the congressional committees of jurisdiction within 18 months of enactment. There will be authorized to be appropriated such sums as may be necessary to conduct the evaluation and prepare the report.

Subtitle E—Demonstration of Comparative Cost Adjustment

Establishment of Demonstration

Present Law

No provision.

House Bill

Section 241. Beginning in 2010, FEHBP-style competition would begin nationwide in competitive areas. Competitive areas would be defined as areas in which Medicare beneficiaries have access to two private plans—either two MA or two EFFS plans—along with traditional FFS Medicare; and private plan enrollment in the area that is at least as great as private plan enrollment nationwide, or 20 percent, whichever is lower. Competitive MA (CMA) areas would be limited to metropolitan statistical areas, or areas with substantial numbers of MA enrollees. To be considered a competitive area, the two private plans must be offered during the open season by different organizations, each meeting minimum enrollment requirements as of March of the previous year.

In competitive areas, private plans would submit bids and traditional FFS would calculate FFS amounts, based on the adjusted average per capita cost (AAPCC) in the area or region. The AAPCC would be adjusted to remove costs associated with direct graduate medical education, and to include costs of services provided to Medicare beneficiaries by the VA and DoD military facilities. In addition, payments would be adjusted for health status and other demographic factors.

The competitive benchmark would be set at the weighted average of the private plan bids and the FFS amount in the competitive area. In order to provide traditional FFS disproportionate influence in competitive areas, the weight of the benchmark for FFS would equal the nationwide proportion of Medicare beneficiaries enrolled in FFS, or the competitive area's proportion, if higher. The weights for all other private plans would equal the national proportion of beneficiaries enrolled in private plans, or the regional proportion if lower.

The competitive benchmark would be blended with the older, pre-2010 benchmark for the area over a 5-year period to allow for transition to a more competitive system.

Beneficiaries enrolling in plans with bids or FFS amounts below the competitive benchmark would receive 75 percent of the difference between the benchmark and bid/FFS amount, and the government would receive 25 percent of the difference. Beneficiaries enrolling in plans with bids/FFS amounts above the benchmark would pay the excess. Premium adjustments would be moderated over a 5-year period for beneficiaries remaining in traditional FFS in competitive areas. The traditional FFS beneficiary premium would be unaffected in non-competitive areas or regions.

Beginning in 2010, the MBA Administrator would announce the MA area-specific non-drug benchmark yearly. If applicable, the MBA Administrator would also announce, for the year and CMA area: the competitive MA non-drug benchmark; the national FFS market share percentage; the demographic, end-stage renal disease, and health status adjustment factors; the MA area-wide non-drug benchmark amount; the FFS area-specific non-drug amount; and MA enrollment.

To carry out this section, the MBA Administrator would transmit the name, social security number, and adjustment amount to the Commissioner of SSA at the beginning of each year and at periodic times throughout the year.

Senate Bill

No provision.

Conference Agreement

Section 241 [§1860 C–1]. In order to test whether direct competition between private plans and the original Medicare FFS program will enhance competition in Medicare, improve health care delivery for all Medicare beneficiaries, and provide for greater beneficiary savings and reductions in government costs, the conference agreement requires the Secretary to establish a demonstration for the application of comparative cost adjustment (CCA). The 6-year demonstration will begin on January 1, 2010. The first 4 years include a phase-in. Upon completion of the demonstration, the Secretary will submit a report to Congress that includes an evaluation of: (1) the financial impact on Medicare, (2) changes in access to physicians and other health care providers, and (3) beneficiary satisfaction under the demonstration and original Medicare fee-for-service. Based upon the results of the evaluation, the Secretary will provide recommendations for any extension or expansion of the demonstration. The demonstration cannot be extended unless there is a reauthorization from Congress.

Allowing for competition for enrollees, between private plans and original FFS Medicare, will level the playing field between all options available to Medicare beneficiaries. If traditional FFS Medicare is able to provide benefits at a lower cost than some or all private plans in a competitive area, then beneficiaries remaining in traditional FFS will see their premiums decline. In this case, beneficiaries enrolling in higher-cost private plans will be required to pay the extra price stemming from that decision. Likewise, if a private plan is able to offer Medicare beneficiaries coverage at a lower cost, then beneficiaries will be encouraged to enroll in the private plan by lowering the beneficiaries' costs of coverage under the private plan. In any case, beneficiaries will be entitled to the same defined benefit package and payments to plans will be fully adjusted for health and other demographic factors.

Without this stage of competition, private plans will have an incentive to shadow price their benchmarks. A floating benchmark rewards more efficient plans, and it allows these more efficient plans to lower the benchmark in future years, as their market share rises.

Several features were added in the Chairman's amendment in the nature of a substitute to allow for a smooth transition to a more competitive system in 2010 in competitive areas/regions, and to prevent shock to the current system. The competitive benchmark, based on private plan bids and traditional FFS rates, would be calculated based on the relative enrollment in FFS versus private plans nationwide (or the area/region if FFS enrollment is a larger proportion in the area/region). This feature ensures that the competitive benchmark is closer to the traditional FFS rate than would otherwise occur. Premium changes for beneficiaries remaining in traditional FFS in competitive areas would be phased-in over five years to prevent oscillations. In addition, the competitive benchmark would be phased-in over a 5-year period for private plans. This would allow for a more gradual change from the benchmarks under the pre-2010 system to the new competitive benchmark in competitive areas.

The Secretary will select CCA demonstration areas from among qualifying Metropolitan Statistical Areas (MSAs). To qualify, an MSA must have: (1) at least 25 percent of eligible Medicare beneficiaries enrolled in a local coordinated care MA plan; and (2) at least 2 coordinated MA local plans offered by different organizations, both of which meet minimum enrollment criteria. The total number of CCA areas may not exceed 6, or 25% of the total number of qualifying MSAs, whichever is lower.

To maximize the opportunity for a successful demonstration, the Secretary will select CCA demonstration areas to provide for geographic diversity and not seek to maximize the number of beneficiaries affected by the demonstration. At least one of the selected MSAs must be chosen from the 4 largest that qualify (based on the eligible MA population). At least one selected MSA must be chosen from among the 4 with the lowest population density. At least one must include a multi-State area. No more than 2 CCA areas may be located within the same geographic region. In addition, the Secretary will also grant priority to qualifying MSAs that have not had a Medicare preferred provider organization (PPO) plan demonstration.

In order to ensure that all beneficiaries residing in a CCA demonstration area have sufficient choice, a county within the MSA will be included only if it has at least 2 MA local coordinated care plans, each of which is offered by a different MA organization. An area will continue to be included as long as there is at least one MA local plan offered in the local area.

To minimize any possible disruption, the demonstration will be phased in over a four-year period between 2010 and 2013. Both the benchmark and changes to the Part B premiums under the original FFS program will be phased-in over this 4-year period.

In CCA areas, private plans would submit bids and traditional FFS would calculate FFS amounts, based on the adjusted average per capita cost (AAPCC) in the area or region. The AAPCC would be adjusted to remove costs associated with direct graduate medical education, and to include costs of services provided to Medicare beneficiaries by the VA and DoD military facilities. In addition, payments would be adjusted for health status and other demographic factors.

The CCA competitive benchmark would be set at the weighted average of the private plan bids and the FFS amount in the CCA area. In order to provide traditional FFS disproportionate influence in CCA areas, the weight of the benchmark for FFS would equal the nationwide proportion of Medicare beneficiaries enrolled in FFS, or the CCA area's proportion, if higher. The weights for all other private plans would equal the national proportion of beneficiaries enrolled in private plans, or the CCA proportion if lower.

The CCA competitive benchmark would be blended with the older, pre-2010 benchmark for the area over a 4-year period to allow for transition to a more competitive system.

Beneficiaries enrolling in plans with bids or FFS amounts below the CCA competitive benchmark would receive 75 percent of the difference between the benchmark and bid/FFS amount, and the government would receive 25 percent of the difference. Beneficiaries enrolling in plans with bids/FFS amounts above the benchmark would pay the excess. Premium adjustments would be moderated over a 4-year period for beneficiaries remaining in traditional FFS in CCA areas.

In order to test whether application of the CCA benchmark to the traditional FFS program will improve efficiency of the program, an individual residing in a CCA demonstration area who is enrolled in Part B of Medicare, but not enrolled in an MA plan, can have an adjustment to their Part B premium, either as an increase or a decrease. No premium adjustment would be made for individuals, for a month that they were eligible for a prescription drug subsidy, as defined in Title I of this Act. That is, individual with incomes below 150 percent of poverty and who also meet the assets requirements would continue to pay the Part B premium amount.

The Part B premium adjustment for FFS beneficiaries in CCA demonstration areas would be made as follows: (1) if the FFS area-specific non-drug amount for the month does not exceed the CCA non-drug benchmark, the Part B premium is reduced by 75% of the difference; and (2) if the FFS area-specific non-drug amount for the month exceeds the CCA non-drug benchmark, the Part B premium is increased by the full amount of the difference. This adjustment will be phased-in over 4 years. There is also a 5% limit to the adjustment, irrespective of whether it is an increase or a decrease.

The premium adjustment will not affect any late enrollment penalties or income-related adjustments to the Part B premiums as established under Title VIII of this Act. The Secretary will transmit to the Commissioner of Social Security at the beginning of each year, the name, social security account number and the amount the any adjustment for each individual, and periodically through the year, update the information.

Nothing in the demonstration project in any way changes the entitlement to defined benefits under Parts A and B of the Medicare program. Throughout the demonstration, beneficiaries will have complete freedom to choose either a private plan or the traditional Medicare fee-for-service program.

Other Provisions

Expanding the work of Medicare Quality Improvement Organizations (QIOs) to include parts C and D

Present Law

QIOs, formerly known as Peer Review Organizations (PROs), are responsible for working with consumers, physicians, hospitals, and other care-givers to refine care delivery.

House Bill

No provision.

Senate Bill

Section 225. The responsibilities of the QIOs would be expanded to include M+C and MA organizations, prescription drug card sponsors, and eligible entities beginning January 1, 2004. Quality improvement assistance relating to prescription drug therapy would be provided to providers, practitioners, prescription drug card sponsors, eligible entities under Part D, M+C plans, and MA plans beginning January 1, 2004.

Conference Agreement

The conference agreement does not include this provision.

Extension of demonstration for end-stage renal disease (ESRD) managed care

Present Law

Medicare beneficiaries with ESRD cannot enroll in a managed care plan. If they develop ESRD while a member of a plan they can continue their enrollment in the plan. The Deficit Reduction Act of 1984 established a demonstration project for ESRD managed care, which was subsequently extended by the Omnibus Budget Reconciliation Act of 1993.

House Bill

No provision.

Senate Bill

Section 226. The Secretary would be required to extend the demonstration project for ESRD managed care through December 31, 2007. The terms and conditions in place during 2002 would apply. The monthly capitation rate for enrollees would be set based on the reasonable medical and direct administrative costs of providing the benefits to participants.

Conference Agreement

The conference agreement does not include this provision.

MA annual coordinated election period

Present Law

The Public Health Security and Bioterrorism Preparedness and Response Act of 2002, P.L. 107–188 changed the annual coordinated election period from the month of November to November 15th through December 31st in 2002, 2003, and 2004. Once the temporary provisions expired, the reporting dates and deadlines return to the pre-P.L.107–188 dates.

In addition, P.L. 107–188 continues to allow Medicare beneficiaries to make and change election to an M+C plan on an ongoing basis through 2004. Then beginning in 2005, individuals may only make changes on the more limited basis, originally scheduled to be phased in beginning in 2002. Since the beginning of the M+C program, beneficiaries have been able to make and change election to an M+C plan on an ongoing basis. Beginning in 2005, elections and changes to elections will be available on a more limited basis. Beneficiaries can make or change elections during the annual coordinated election period. Current Medicare beneficiaries may also change their election at any time during the first 6 months of 2005 (or first 3 months of any subsequent year). Additionally, there are special enrollment rules for newly eligible aged beneficiaries as well as special enrollment periods for all enrollees under limited situations, such as an enrollee who changes place of residence.

House Bill

Section 231. The annual coordinated election period would be permanently changed to November 15 through December 31.

Senate Bill

Section 201. [§1851(e)]. Medicare beneficiaries would retain their ability to make and change elections to an M+C plan through 2005. The current law limitation on changing elections that begins in 2005, would be delayed until 2006. Further, the annual coordinated election period for 2003 through 2006 would begin on November 15 and end on December 31. Beginning in 2007, the annual coordinated election period would be during the month of November.

[§1851(e)(3)]. Additionally, the Secretary would conduct a special information campaign to inform MA eligible beneficiaries about plans. The campaign would begin on November 15, 2005 and ending on December 31, 2005.

Conference Agreement

The conference agreement does not include this provision.

Cause for intermediate sanctions

Present Law

The Secretary is authorized to carry out specific remedies in the event that an M+C organization: (1) fails substantially to provide medically necessary items and services required to be provided, if the failure adversely affects the Medicare enrollee; (2) imposes premiums on enrollees that are in excess of those allowed; (3) acts to expel or refuses to re-enroll an enrollee in violation of Federal requirements; (4) engages in any practice that would have the effect of denying or discouraging enrollment (except as permitted by law) of eligible beneficiaries whose medical condition or history indicates a need for substantial future medical services; (5) misrepresents or falsifies information to the Secretary or others; (6) fails to comply with rules regarding physician participation; or (7) employs or contracts with any individual or entity that has been excluded from participation in Medicare.

House Bill

No comparable provision.

Senate Bill

Section 208. In addition to specifications included in current law, the Secretary could also carry out remedies if an organization charged any Medicare enrollee an amount in excess of the MA monthly beneficiary obligation for qualified prescription drug coverage, provided coverage that was not qualified prescription drug coverage, offered prescription drug coverage but did not make standard prescription drug coverage available, or provided coverage for drugs other than that relating to prescription drugs covered under Part D, as an enhanced or additional benefit.

Conference Agreement

The conference agreement does not include this provision.

Evaluate fee-for-service modernization projects

Present Law

No provision.

House Bill

No explicit provision. H.R. 1 would establish chronic care improvement benefits under fee-for-service (Section 721) and under MA and EFFS (Section 722).

Senate Bill

Section 232. The Secretary would be required to review the results of the demonstrations required under Sections 442, 443, and 444 of this bill and report to Congress by January 1, 2008. [These demonstrations are the Medicare health care quality demonstration, the Medicare complex clinical care management payment demonstration, and the Medicare fee-for-service care coordination demonstration.] Beginning in 2009, the Secretary would be required to establish projects to provide Medicare beneficiaries in traditional Medicare coverage of enhanced benefits or services (preventive services not already covered under Medicare, chronic care coordination services, disease management services or other benefits determined by the Secretary). The purpose of the projects would be to evaluate whether the enhanced benefits or services improved the quality of care, improved health care delivery systems, and reduced expenditures under the Medicare program. The projects would be conducted in regions comparable to the regions designated as "highly competitive." The Secretary would be required to submit annual reports to Congress and the GAO beginning no later than April 1, 2010. The GAO would be required to report by January 1, 2011 and biennially thereafter for as long as the projects were being conducted.

Conference Agreement

The conference agreement does not include this provision.

Establish MA enrollment goal

Present Law

No provision.

House Bill

No provision.

Senate Bill

Section 241. This provision would establish an MA enrollment goal of at least 15% of Medicare beneficiaries by January 1, 2010. If the goal were not met, a bipartisan commission would be established as provided for in Section 242.

Conference Agreement

The conference agreement does not include this provision.

Establish national bipartisan commission on Medicare reform

Present Law

No provision.

House Bill

No provision.

Senate Bill

Section 242. If the enrollment goal described in Section 241 were not met, the National Bipartisan Commission on Medicare Reform would be established. The Commission would review and analyze the long-term financial condition of the Medicare program; identify problems that threaten the financial integrity of the Medicare Trust Funds; and analyze potential solutions to the identified problems. The Commission would be required to make recommendations, including issues facing Medicare, such as solvency, financing of the Medicare Trust Funds, and benefits. The Commission would have 17 members—four appointed by the President, 12 appointed by Congressional leaders, and one appointed jointly by the President and Congressional leaders to serve as Chairperson. The Commission would be required to submit a report and an implementation bill to the President and Congress no later than April 1, 2014.

Conference Agreement

The conference agreement does not include this provision.

Establish congressional consideration of reform proposals

Present Law

No provision.

House Bill

No provision.

Senate Bill

Section 243. Congressional leaders would be required to introduce the implementation bill required by Section 242. Hearings would be required by appropriate committees as well as floor consideration.

Conference Agreement

The conference agreement does not include this provision.

Authorize appropriations

Present Law

No provision.

House Bill

No provision.

Senate Bill

Section 244. Appropriations would be authorized for such sums as necessary to carry out the provisions regarding the National Bipartisan Commission on Medicare Reform for fiscal years 2012 through 2013.

Conference Agreement

The conference agreement does not include this provision.

Enhanced benefits

Present Law

M+C plans may offer supplemental benefits in addition to any required benefits under Parts A and B of Medicare and any additional required benefits.

House Bill

Section 221 (a). Plans could include supplemental benefits in their bids. The Secretary's authority to negotiate bids would include these supplemental benefits.

Senate Bill

Section 202. [§1852(a)(3)]. MA plans could choose to provide beneficiaries with enhanced medical benefits that the Secretary could approve. The Secretary could deny any submission for enhanced benefits believed to discourage enrollment by MA eligible individuals. The Secretary could not approve any enhanced medical benefit that provided for the coverage of any prescription drug, other than those relating to covered prescription drugs under Part D.

Conference Agreement

The conference agreement does not include this provision.

Incentive for Enrollment

Present Law

M+C plans cannot offer cash or monetary rebates as an inducement for enrollment.

House Bill

Section 221 (d). For MA plans, the ability to offer cash or monetary rebates would be limited to the rebates (based on the calculation of average per capita monthly savings) established under this bill.

Senate Bill

No provision.

Conference Agreement

The conference agreement does not include this provision.

TITLE III—COMBATTING WASTE, FRAUD AND ABUSE

Medicare Secondary Payor (MSP) Provisions (Section 301 of the Conference Agreement, Section 301 of the House Bill, and Section 461 of the Senate Bill).

Present Law

In certain instances, Medicare is prohibited from making payment for a health care claim if payment is expected to be made promptly under workmen's compensation law or plan, under automobile or liability insurance (including a self-insured plan) or under no-fault insurance on behalf of a beneficiary. Medicare is permitted to make a conditional payment in certain circumstances including if Medicare could reasonably expect payment to be made under a workers compensation plan or no-fault insurance claim but Medicare determines that the payment will not be made promptly, as determined in accordance with regulations).

House Bill

The Secretary would be able to make a conditional Medicare payment if a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan), or a no-fault insurance plan, has not made or cannot reasonably be expected to make prompt payment (as determined in accordance with regulations). This payment would be contingent on reimbursement by the primary plan to the Medicare Trust Funds. This provision on conditional payment would be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (P.L. 98–369) (which was contained in the Deficit Reduction Act of 1984).

The list of primary plans for which conditional payment could be made would be clarified; an entity engaging in a business, trade, or profession would be deemed as having a self-insured plan if it carries its own risk. A primary plan, as well as an entity that receives payment from a primary plan, would be required to reimburse the Medicare Trust Funds for any payment made by the Secretary if the primary plan was obligated to make payment. The Secretary's authority to recover payment from any and all responsible entities and bring action, including the collection of double damages, to recover payment under the Medicare Secondary Payer provisions also would be clarified. This provision clarifying the conditional payment provisions would be effective upon enactment.

Senate Bill

Identical provision.

Conference Agreement

The conference agreement clarifies that the Secretary may make a conditional Medicare payment if a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan), or a no-fault insurance plan, has not made or cannot reasonably be expected to make prompt payment (as determined in accordance with regulations). This payment is contingent on reimbursement by the primary plan to the Medicare Trust Funds. This provision on conditional payment is effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (P.L. 98–369) (which was contained in the Deficit Reduction Act of 1984).

The list of primary plans for which conditional payment could be made is also clarified; an entity engaging in a business, trade, or profession would be deemed as having a self-insured plan if it carries its own risk. A primary plan, as well as an entity that receives payment from a primary plan, is required to reimburse the Medicare Trust

Funds for any payment made by the Secretary if the primary plan was obligated to make payment. The Secretary's authority to recover payment from any and all responsible entities and to bring action, including the collection of double damages, to recover payment under the Medicare Secondary Payer provisions also is clarified. This provision clarifying the conditional payment provisions is effective as if included in the enactment of section 953 of the Omnibus Reconciliation Act of 1980.

Payment for Durable Medical Equipment; Competitive Acquisition of Certain Items and Services (Section 302 of the Conference Agreement, Section 302 of the House Bill, and Section 430 of the Senate Bill).

Present Law

Medicare pays for durable medical equipment (DME), using a different fee schedule for each class of covered items. Under the fee schedule, covered items are classified into six major categories, one of which is prosthetics and orthotic devices. In general, fee schedule payments are a weighted average of either local or regional prices, subject to national limits (both floors and ceilings), that are updated each year by the consumer price index for urban consumers (CPI-U) for the 12-month period ending with June of the previous year.

Medical devices are classified into three categories: Class I devices represent minimal potential for harm, and are subject to the least regulatory control (e.g., elastic bandages and enema kits). Class II devices are moderate risk (e.g., some surgical lasers). Class III devices are devices that sustain or support life, are implanted, or present potential unreasonable risk (e.g., implantable infusion pumps and heart valve replacements) and are subject to premarket approval, the most stringent regulatory control.

BBA 97 authorized the Secretary to conduct up to five demonstration projects to test competitive bidding as a way for Medicare to price and pay for Part B services other than physician services. The Secretary was required to establish up to three competitive acquisition areas for this purpose. Three competitive bidding demonstrations for durable medical equipment, prosthetics, orthotics, and supplies were implemented, two in Polk County, Florida and one in the San Antonio, Texas area.

House Bill

The Secretary would be required to establish and implement competitive acquisition programs for durable medical equipment, medical supplies, items used in infusion, drugs and supplies used in conjunction with durable medical equipment, medical supplies, home dialysis supplies, blood products, parental nutrition, and off-the-shelf orthotics (requiring minimal self-adjustment for appropriate use) that would replace the Medicare fee schedule payments. Enteral nutrients and class III devices, those that sustain or support life, are implanted, or present potential unreasonable risk (e.g., implantable infusion pumps and heart valve replacements) and are subject to premarket approval by the Food and Drug Administration would not be covered by the program.

In starting the programs, the Secretary would be required to establish competitive acquisition areas, but would be able to exempt rural areas and areas with low population density within urban areas that are not competitive, unless a significant national market exists through mail order for a particular item or service. The programs would be phased-in over 3 years with at least one-third of the areas implemented in 2005 and two-thirds of the areas implemented in 2006. High-cost items and services would be required to be phased-in first. The Secretary would be able to exempt items and services for which competitive acquisition would not be likely to result in significant savings. The Secretary would be required to establish a process where existing rental agreements for covered DME items entered into contract before implementation of this program would not be affected. The supplier would be required to provide for appropriate servicing and replacement of these rental items. Also, the Secretary may establish a process where a physician would be able to prescribe a particular brand or mode of delivery of an item or service if such item is clinically more appropriate than other similar items.

Certain requirements for the competitive acquisition program would be established. Specifically, the Secretary would be allowed to award contracts in an area only when the following conditions were met: entities met quality and financial standards specified by the Secretary or the Program Advisory and Oversight Committee; total amounts paid under the contracts would be expected to be less than would otherwise be paid; beneficiary access to multiple suppliers would be maintained; and beneficiary liability would be limited to 20% of the applicable contract award price. Contracts would be required to be re-competed at least every three years. The Secretary would be required to award contracts to multiple entities submitting bids in each area for an item or service and would also have the authority to limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for covered items and services. The similarity of the clinical efficiency and the value of specific products would be considered when establishing the categories and products that would be subject to bidding. The Secretary would not be able to pay for items furnished by a contractor unless the contractor has submitted a bid to supply the item and the contract has been awarded. The Secretary would be permitted to waive certain provisions of the Federal Acquisition Regulation that are necessary for the efficient implementation of this program, other than those relating to confidentiality of information. The Secretary would also be able to contract with an appropriate entity to address beneficiary complaints, provide beneficiary outreach and education services, and monitor the quality of items and services provided. The Secretary would be required to report to Congress annually on savings, reductions in cost-sharing, access to items and services, and beneficiary satisfaction under the competitive acquisition program.

A Program Advisory and Oversight Committee with members appointed by the Secretary would be established. The Committee would be required to provide advice and technical assistance to the Secretary regarding the implementation of the program, data collection requirements, proposals for efficient interaction among manufacturers and distributors of the items and services, providers, and beneficiaries, and other functions specified by the Secretary. The provisions of the Federal Advisory Committee Act would not apply to this Committee. The Secretary would be required to conduct a demonstration program on using competitive acquisition for clinical laboratory tests that are furnished without a face-to-face encounter between the individual and the hospital personnel or physician performing the test. The same quality and financial conditions specified for the DME competitive acquisition program would apply for clinical laboratory test competitive acquisition. An initial report to Congress would be required of the Secretary not later than December 31, 2005 with progress and final reports as the Secretary would determine appropriate.

The covered items and services included in the competitive acquisition program would be paid as determined under this program. The Secretary would be able to use this payment information to adjust the payment amounts for DME not in a competitive acquisition area. In this instance, the inherent reasonableness rule would not be applied. Orthotics in a competitive acquisition program would also be paid the amounts determined by this program. The Secretary would be able to use this payment information to adjust the payment amounts for such items. The provision would be effective upon enactment.

Senate Bill

Medicare would not increase the DME fee schedule amounts in any of the years from 2004 through 2010 and would update the amounts by the CPI-U in each subsequent year. Payments for orthotic devices that have not been custom-fabricated would be similarly affected. Class III medical devices would be exempt from the freeze in DME payments. Prosthetics, prosthetic devices, and custom-fabricated orthotics would be updated by the percentage change in the CPI-U. The provision would also subject DME companies to an accreditation and quality assurance process. The Secretary would be required to designate independent accreditation organizations no later than 6 months from enactment after consultation with an expert outside advisory panel. The application of quality standards would be phased in over a 3-year period. The provision would be effective upon enactment.

Conference Agreement

The conference agreement requires the Secretary to establish and implement quality standards for suppliers of: items and services of durable medical equipment, prosthetics and orthotics, and certain other items and services. Suppliers of the following items and services are included in the conference agreement: items of durable medical equipment, prosthetic devices, orthotics and prosthetics, medical supplies, home dialysis supplies and equipment, therapeutic shoes, parenteral and enteral nutrients, equipment, and supplies, electromyogram devices, salivation devices, blood products, and transfusion machines. The Secretary is explicitly authorized to establish the quality standards by program memorandum on a prospective basis after consultation with representatives of relevant parties. The standards are required to be posted on the Internet website of CMS. The Secretary is required to designate one or more independent accreditation organizations not later than one year after the date the quality standards are implemented. The quality standards may not be less stringent than the quality standards otherwise in place.

The Secretary is required to establish standards for clinical conditions for payment for covered durable medical equipment that include the specification of types or classes of covered items that require, as a condition of payment, a face-to-face examination and a prescription for the item. Standards are required to be established for those covered items for which there has been a proliferation of use, consistent findings of charges for covered items that are not delivered, or consistent findings of falsification of documentation to provide for payment of such covered items. Beginning with the date of enactment, payment may not be made for motorized or power wheelchairs unless a physician, physician assistant, nurse practitioner, or a clinical nurse specialist has conducted a face-to-face examination of the individual and written a prescription for the item. Medicare payment is not permitted unless the item meets the standards established for clinical condition of coverage.

The conference agreement also establishes competitive acquisition programs for durable medical equipment (including items used in infusion and drugs), medical supplies, home dialysis supplies, therapeutic shoes, enteral nutrients, equipment, and supplies, electromyogram devices, salivation devices, blood products, and transfusion medicine, and off-the-shelf orthotics (requiring minimal self-adjustment for appropriate use) that would replace the Medicare fee schedule payments. Exclusions from the competitive acquisition are: inhalation drugs; parenteral nutrients, equipment, and supplies; and class III devices, that is those that sustain or support life, are implanted, or present potential unreasonable risk (e.g., implantable infusion pumps and heart valve replacements) and are subject to premarket approval by the Food and Drug Administration.

In starting the programs, the Secretary is required to establish competitive acquisition areas, but would be able to exempt rural areas and areas with low population density within urban areas that are not competitive, unless a significant national market exists through mail order for a particular item or service. The programs will be phased-in so that competition under the programs occurs in 10 of the largest metropolitan statistical areas in 2007; 80 of the largest metropolitan statistical areas in 2009; and remaining areas after 2009. The Secretary is permitted to phase-in first items and services with the highest cost and highest volume, or those items and services that the Secretary determines have the largest savings potential. The Secretary may exempt items and services for which competitive acquisition would not be likely to result in significant savings. The Secretary is required to establish a process where existing rental agreements for covered DME items entered into contract before implementation of this program would not be affected. The supplier would be required to provide for appropriate servicing and replacement of these rental items. Also, the Secretary may establish a process where a physician would be able to prescribe a particular brand or mode of delivery of an item or service within a particular healthcare procedure code (HCPCS) if the physician determines that use of the item or service would avoid an adverse medical outcome on the beneficiary, as determined by the Secretary, although this could not affect the amount of payment otherwise applicable.

Certain requirements for the competitive acquisition program are established by the conference agreement. Specifically, the Secretary cannot award contracts in an area unless the following conditions were met: (1) entities meet quality standards established by the Secretary; (2) entities meet financial standards specified by the Secretary, taking into account the needs of small providers; (3) total amounts paid under the contracts are expected to be less than would otherwise be paid; and (4) beneficiary access to multiple suppliers would be maintained. Contracts are subject to terms and conditions that the Secretary may specify and are required to be recompeted at least every 3 years. The Secretary is required to award contracts to multiple entities submitting bids in each area for an item or service and has the authority to limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for covered items and services.

Payment for competitively priced items and services will be based on bids submitted and accepted. The Secretary is required to determine a single payment amount for each item or service in each competitive acquisition area. Medicare payment is required to be equal to 80 percent of the payment amount determined, with beneficiaries paying the remaining 20 percent (after meeting the Part B deductible). Payment for any item or services can be made only on an assignment-related basis that is the supplier bills Medicare and accepts Medicare payment as payment in full. The use of advanced beneficiary notices is not precluded by this program.

In establishing the categories and products that would be subject to bidding, the Secretary is permitted to consider the clinical efficiency and the value of specific items within HCPCs codes, including whether some items have a greater therapeutic advantage to individuals. The Secretary is required to take appropriate steps to ensure that small suppliers of items and services have an opportunity to be considered for participation in this program. The Secretary cannot pay for items furnished by a contractor unless the contractor has submitted a bid to supply the item and the contract has been awarded. The Secretary is permitted to waive certain provisions of the Federal Acquisition Regulation that are necessary for the efficient implementation of this program, other than those relating to confidentiality of information. The Secretary is permitted to contract with an appropriate entity to address beneficiary complaints, provide beneficiary outreach and education services, and monitor the quality of items and services provided. The Secretary is also permitted to contract with entities to implement the competitive bidding program. The conference agreement prohibits administrative or judicial review of the establishment of payments amounts, the awarding of contracts, the designation of competitive acquisition areas, the phased-in implementation, the selection of items and services for competitive acquisition or the bidding structure and number of contractors. The Secretary is required to report to Congress by July 1, 2009, on savings, reductions in cost-sharing, access to items and services, and beneficiary satisfaction under the competitive acquisition program.

A Program Advisory and Oversight Committee with members appointed by the Secretary is required to be established. The Committee is required to provide advice to the Secretary regarding the implementation of the program, data collection requirements, proposals for efficient interaction among manufacturers and distributors of the items and services, providers, and beneficiaries, the establishment of quality standards, and other functions specified by the Secretary. The provisions of the Federal Advisory Committee Act do not apply to this Committee. The Committee is required to end on December 31, 2009.

The Secretary is required to conduct a demonstration program on using competitive acquisition for clinical laboratory tests that are furnished without a face-to-face encounter between the individual and the hospital personnel or physician performing the test. The terms and conditions of the demonstration are to include the application of CLIA quality standards. An initial report to Congress is required of the Secretary no later than December 31, 2005, with progress and final reports as the Secretary determines appropriate.

For durable medical equipment, prosthetic devices, prosthetics and orthotics, the update will be 0 percentage points in 2004 through 2008. After 2008, for those items not included in competitive bidding the update will be the consumer price index (CPI). For 2005, the payment amount for certain items, oxygen and oxygen equipment, standard wheelchairs, nebulizers, diabetic lancets and testing strips, hospital beds and air mattresses, will be reduced. The Secretary will take the payment amount otherwise determined and reduce it by the percentage difference between the amount of payment otherwise determined for the specific item for 2002 and the amount of payment for the specific item and HCPC code under chapter 89 of title 5, United States Code (which was identified in the column entitled a median FEHBP Price in the table entitled "A Summary of Medicare Prices Compared to VA, Medicaid, Retail, and FEHP Prices for 16 Items" that was included in the Testimony of the Inspector General before the Senate Committee on Appropriations, June 12, 2002). An OIG report on oxygen will be available in the spring of 2004.

For class III medical devices the update in 2004, 2005, and 2006 is equal to the percentage increase in the consumer price index for all urban consumers (CPI–U) for the 12-month period ending with June of the previous year. In 2007 the percentage change for class III medical devices is to be determined by the Secretary after taking into account recommendations made by the Comptroller General in a report on class III medical devices. In 2008 the update is determined by the amount paid in 2007 updated by the CPI. In subsequent years the CPI is the update.

For covered items and services furnished beginning January 1, 2009, items and services included in the competitive acquisition program would be paid as determined under that program and the Secretary would be able to use this payment information to adjust the payment amounts for DME, off-the-shelf orthotics, and other items and services that are supplied in an area that is not a competitive acquisition area. The inherent reasonableness authority for DME, off-the-shelf orthotics, medical supplies, home dialysis supplies, therapeutic shoes, enteral nutrients, equipment, and supplies, electromyogram devices, salivation devices, blood products, and transfusion medicine is not eliminated but, if the Secretary uses the competitive acquisition program information to adjust payments, then inherent reasonableness authority cannot be used.

The Inspector General of the Department of Health and Human Services (the Inspector General) is required to study the extent to which (if any) suppliers of covered items of DME that are subject to the competitive acquisition program are soliciting physicians to prescribe certain brands or modes of delivery of covered items based on profitability. The report is due to Congress no later than July 1, 2009.

The provision is effective upon enactment.

Competitive Acquisition of Covered Outpatient Drugs and Biologicals (Section 303 of the Conference Agreement, Section 303 of the House Bill, and Section 432 of the Senate Bill).

Adjustment to the Physician Fee Schedule (Section 303(a) of the Conference Agreement, Section 303(a) of the House Bill and Section 432(b) of the Senate Bill).

Present Law

The relative value associated with a particular physician service is the sum of three components: physician work, practice expense, and malpractice expense. Practice expense includes both direct costs (such as clinical personnel time and medical supplies used to provide a specific service to an individual patient) as well as indirect costs such as rent, utilities, and business costs associated with running a practice). When the physician fee schedule was implemented, reimbursement for practice expenses was based on historic charges. The Social Security Act Amendments of 1994 (PL. 103–432) required the Secretary to develop a methodology for a resource based system for calculating practice expenses for use in CY1998. BBA 1997 delayed the implementation of the methodology until CY1999 and established a transition period with full implementation by CY2002. BBRA required the Secretary to establish a data collection process and data standards for determining practice expense relative values. Under this survey process, the Secretary was required to use data collected or developed outside HHS, to the maximum extent practicable, consistent with sound data collection practices.

The Secretary is required to periodically review and adjust the relative values affecting physician payment to account for changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. Under the budget-neutrality requirement, changes in these factors cannot cause expenditures to differ by more than $20 million from what would have been spent if such adjustments had not been made.

House Bill

The Secretary would be required to increase the practice expense relative value for the physician fee schedule in CY2005 using survey data that includes information on the expense associated with administering drugs and biologicals. The supplemental data provided by entities and organizations would be included if consistent with the Secretary's criteria for acceptable survey data and submitted by December 31, 2004. Using existing processes for coding considerations, the Secretary would be required to promptly evaluate existing codes for the administration of covered outpatient drugs and biologicals to ensure accurate reporting and billing for these services. Any payment increase in CY2005 that resulted from using supplemental survey data or reevaluating codes would not be subject to budget neutrality provisions, would be exempt from administrative and judicial review, and would be treated as a change in law and regulation in the sustainable growth rate determination. Nothing in this section would prevent the Secretary from providing for practice expense adjustments in subsequent years, subject to the budget neutrality provisions. The Secretary would be required to consult with the Comptroller General of the United States (GAO) and groups representing the affected physician specialties before publishing the notice of proposed rulemaking. Also, the Secretary would be required to adjust the non-physician work pool methodology so that practice expense relative values for these services are not disproportionately reduced as a result of the above changes. The provision would be effective upon enactment.

Senate Bill

The Secretary would be required to establish the practice expense relative value for the physician fee schedule in CY2004 using the survey data collected from a physician specialty organization as of January 1, 2003 if the data cover the practice expenses for oncology administration services and meet the Secretary's criteria for acceptable survey data. The Secretary would also be required to review and appropriately modify Medicare's payment policy for the administration of more than one anticancer chemotherapy agent to an individual patient on a single day. The increase in expenditures resulting from this provision would be exempt from the budget-neutrality requirement. Also, the Secretary would be required to adjust the non- physician work pool methodology so that practice expense relative values for these services are not disproportionately reduced as a result of the above changes. The provision would be effective upon enactment.

The Secretary would not be able to revise payment amounts for a category of outpatient drugs or biologicals unless the Secretary concurrently adjusts the payment amounts for administration of such category of drug or biological. The provision would be effective upon enactment.

The provisions affecting the practice expense relative values, multiple chemotherapy agents administered on a single day, and treatment of other services currently in the non-physician work pool would not be subject to administrative or judicial review under Sections 1869 and 1878 of the Social Security Act (SSA) or otherwise. The provision would be effective upon enactment.

Conference Agreement

Beginning in 2004, the Secretary is required to make adjustments in practice expense relative value units for certain drug administration services when establishing the physician fee schedule. The Secretary is required to use the survey data submitted by the American Society of Clinical Oncology (ASCO) in 2002 because it meets criteria established under the BBRA for use.

The Secretary is required to add work relative value units to certain drug administration services, equal to the work relative value units for a level 1 office medical visit for an established patient. These services are classified, as of October 1, 2003, within any of the following groups of procedures: therapeutic or diagnostic infusions (excluding chemotherapy), chemotherapy administration services, and therapeutic, prophylactic or diagnostic injections. Only those services for which national relative value units, but no work relative value units have been assigned by October 1, 2003 are included. These specified drug administration services are intended to be those classified as of October 1, 2003, within HCPCs codes 90780–90781, 96400, 96408–96425, 96520, 96530 and 90782–90788, and as subsequently may be modified by CMS, to provide work relative value units for CPT code 99211 for a level 1 office medical visit for an established patient.

Starting in 2005, the Secretary is required to use supplemental survey data to increase practice expense relative values for other drug administration services in the physician fee schedule if that supplemental survey data include information on the expense associated with administering drugs and biologicals, the survey meets criteria for acceptance, and the survey is submitted by March 1, 2004, for 2005, or March 1, 2005 for 2006. This provision will apply only to a specialty that received 40% or more of its Medicare payments in 2002 from drugs and biologicals and would not apply to the ASCO survey submitted in 2002.

The Secretary is also required to promptly evaluate existing drug administration codes for physicians' services to ensure accurate reporting and billing for these services. These codes should take into account levels of complexity of the administration and resource consumption. The Secretary is required to use existing processes for considering coding changes and for incorporating appropriate changes in the relative values for such services. As part of this process, the Secretary is required to consult with representatives of physician specialties affected by the changes in payment for drugs under this section and, within the scope of existing authority, expedite appropriate conclusions resulting from these coding evaluations.

The adjustments in practice expense relative value units for certain drug administration services based on the ASCO survey data are exempt from the budget neutrality requirements in 2004. Adjustments in practice expense relative value units for other drug administration services in 2005, 2006, or 2007 based on the surveys or coding changes described above are also exempt. Nothing in this section shall prevent the Secretary making these practice expense adjustments in subsequent years, subject to the budget neutrality provisions.

The Secretary is required to make adjustments to the non-physician work pool methodology so that the practice expense relative values for other services in the pool are not affected by the changes to practice expenses for drug administration. This provision is intended to protect the services in the non-physician work pool from payment reductions resulting from changes made to the AWP payment methodology. The budget neutrality waiver was included in this section to ensure that the increase in practice expense relative value units for drug administration services (resulting from the use of new supplemental survey data) would not be offset by decreases in the other non-physician work pool services. The Secretary is further required to review and appropriately modify Medicare's payment policy in effect on October 1, 2003, for the administration of more than one drug or biological to an individual on a single day through the push technique. The increase in expenditures resulting from this provision will be exempt from the budget-neutrality requirement in 2004. The Conferees strongly urge the Secretary to make payment for these multiple pushes.

A transitional adjustment or additional payment for services furnished from April 1, 2004, through December 31, 2005 will be made for drug administration services. This Part B payment is to be made to the physician and equals a percentage of the payment otherwise made. The percent is 32 in 2004, and 3 in 2005.

MedPAC is required to review the payment changes as they affect payments for items and services furnished by oncologists and for drug administration services furnished by other specialists. This review will also include an examination of the effect of such changes on the quality of Part B services and beneficiary satisfaction with such care. The Commission is required to submit a report to the Secretary and Congress by January 1, 2006 on oncologists' payments and by January 1, 2007 on drug administration services furnished by other specialists. The reports may include recommendations for further adjustments. The Secretary could make appropriate adjustments to payments as part of the rulemaking for physician payments for 2007.

Section 303 exempts all physician specialties, other than oncology, from the payment adjustments made to both physicians' services and expenses for the administration of drugs and biologicals in this section, and does not apply to inhalation drugs in Section 305. Section 304 requires the Secretary to disregard this exemption and apply the adjustments in section 303 to these other specialties. The intent in drafting the two sections in this manner is to segregate the savings achieved from adjustments to payments to oncologists from savings derived from other physician specialties. The specialties to which the provisions apply are the specialties as used by the carriers in administering Medicare.

Application of Market based Payment Systems (Sections 303(b) through Sections 303(d) of the Conference Agreement, Section 303(b) of the House Bill and Section 432(a) of the Senate Bill).

Present Law

Although Medicare does not currently provide an outpatient prescription drug benefit, coverage of certain outpatient drugs is authorized by statute. Specifically, under Medicare Part B, outpatient prescription drugs and biologicals are covered if they are usually not self-administered and are provided incident to a physician's services. Drugs and biologicals are also covered if they are necessary for the effective use of covered durable medical equipment. In addition, Medicare will pay for certain self-administered oral cancer and anti-nausea drugs, erythropoietin (used to treat anemia), immunosuppressive drugs after covered Medicare organ transplants and hemophilia clotting factors. Vaccines for diseases like influenza, pneumonia, and hepatitis B are considered drugs and are covered by Medicare. Payments for covered outpatient drugs are made under Medicare Part B and are generally calculated using the average wholesale price (AWP).

The AWP is intended to represent the average price used by wholesalers to sell drugs to their customers. It has been based on prices reported by drug manufacturers, that are published in industry reference publications or drug price compendia. There are no uniform criteria for reporting these numbers. Moreover, these reported prices do not reflect the discounts that manufacturers and wholesalers customarily offer to providers and physicians. AWP has never been defined in either statute or regulation, but it is used to set reimbursement amounts for drugs and biologicals covered under the Medicare Part B benefit

The Balanced Budget Act of 1997 (BBA 97, P.L. 105–33) specified that Medicare payment for covered outpatient prescription drugs would equal 95 percent of AWP. Current Medicare payment rates are 95% of AWP for brand name drugs produced by a single manufacturer (referred to single source drugs.) Medicare pays 95% of the lower of (a) the median AWP of all generic drugs or (b) the lowest brand-name product AWP for drugs with 2 or more competing brand names drugs (referred to as multisource or multiple source drugs) or those drugs with available generic equivalents. Although Medicare uses a Healthcare Common Procedure Coding System (HCPCS) code to identify and pay for physician administered drugs, AWPs are reported on the basis of national drug codes (NDC), which are maintained by the Food and Drug Administration (FDA). Every drug sold in the United States has a unique NDC that provides information on its chemical molecule, drug manufacturer, dosage, dosage from and package size. In addition, there may be several multiple source or generic drugs within a specific HCPCS code.

There is substantial evidence that indicates that AWPs for many Medicare-covered products far exceed the acquisition cost paid by suppliers and physicians. Reliance on AWP (instead of a market based price) has caused significantly increased payments, as some use AWP to inflate payments made for drugs to influence physician prescribing practices. This has resulted in Medicare paying more than $1 billion per year in excess overpayments for these products. Because Medicare beneficiaries are also required to pay coinsurance amounts equal to 20 percent of the Medicare payment amount, the increased Medicare payment amounts resulting from inflated AWPs cause Medicare beneficiaries to pay hundreds of millions of extra dollars in inflated co-payments every year.

Some physicians assert that the overpayment for drugs covers underpayment for practice expenses. They contend that Medicare does not adequately reimburse them for the practice expenses associated with providing care in outpatient settings. This section reduces the overpayment for drugs and biologics, while increasing physician practice expenses.

Since 1992, the HHS Office of the Inspector General OIG (OIG) has raised concerns about how certain drug manufacturers have established AWPs for certain of their Medicare-covered drugs that were much higher than the prices generally paid by the health care providers to those drug companies. This difference—commonly referred to by the industry and the health care community as the "spread"—results in a profit to providers each time they administer such drugs to Medicare patients. For example, in 1999, an oncologist could purchase 10 mgs of doxorubicin, a chemotherapy agent, for $10.08, while Medicare's reimbursement for that same dose was $42.92, resulting in a profit to the providers of $32.84. The OIG, based on a review of 24 of the Medicare-covered drugs, estimate that such practices result in Medicare making $750 million each year in overpayments to these providers.

Subsequently, the findings of this report were updated with more current drug pricing. This updated report found that, of the $3.7 billion Medicare spent for 24 drugs in 2000, if Medicare paid the actual wholesale prices available to physicians and suppliers for these 24 drugs, the program and its beneficiaries would have saved $887 million a year.

In addition to the financial toll on the U.S. Treasury, these large spreads also affect Medicare beneficiaries, who are often required to pay dramatically inflated co-payments for the drugs they receive. These copayments sometimes even exceed the actual price that the provider has paid for the drug. For example, leucovorin calcium, a chemotherapy agent, had a beneficiary co-payment of $3.60 per dosage, while the OIG estimated that a provider could buy the same drug for $2.94, and would receive a total reimbursement (including beneficiary co-payment) of $18.02 per dose. OIG estimated that if Medicare had paid reimbursements equal to widely available wholesale prices, beneficiaries would have paid $175 million less in coinsurance.

A September, 2001, GAO report found that physicians can obtain Medicare-covered drugs at prices significantly below current Medicare payments. GAO found that the average discount from AWP ranged from 13 percent to 34 percent, and that two drugs had discounts of 65 percent and 86 percent.

Evidence also suggests that certain types of health care providers may also be making treatment decisions based at least in part upon the amount of profit they can reap from the use of certain drugs. In one particularly disturbing example, a respiratory therapy drug, ipratropium bromide, saw its utilization skyrocket after certain drug manufacturers began to build a large spread in its price. In 1995, Medicare reimbursed providers $14 million dollars for their use of ipratropium bromide. After the spread was created, utilization increased dramatically, to the point where Medicare paid $250 million for the same drug in 1999, and over $300 million in 2000 and 2001.

In its recommendations to the Congress, the GAO urged CMS to take steps to begin reimbursing providers for Part B-covered drugs and related services at levels reflecting providers' acquisition costs using information about actual market transaction prices. The GAO also recommended that CMS should evaluate expanding competitive bidding approaches to setting payment levels, and that CMS should monitor beneficiary access to covered drugs in light of any changes to reimbursement.

The GAO also debunked some common myths generally held by many in the health care community. Specifically, the GAO found that despite concerns that the discounts available to large purchasers would not be available to physicians with a small number of drug claims, physicians with low volumes reported that their purchase prices were the same or less than the widely available prices GAO documented. GAO also believes that Medicare should pay for each service appropriately and not rely on overpayments for some services to offset inadequate payments for complementary services. The Committee shares this view, and believes the legislation achieves this goal.

The Committee on Ways and Means, the Committee on Energy and Commerce and the Senate Finance Committee have all conducted independent investigations and held public hearings on the problems associated with using AWP as a reimbursement benchmark. All three Committees have also examined the reimbursement for drug administration through the Medicare physician payment structure. Both reimbursement systems were found to have serious flaws in methodology and application.

More recently, the Centers for Medicare and Medicaid Services issued a proposed rule on August 20, 2003, to improve the way that Medicare pays for covered drugs and asked for public input on the best way to achieve that goal. The rule solicited comments on four differing approaches:

Medicare would pay the same amounts for covered drugs that private insurers pay; Medicare would apply a discount of 10 to 20 percent from the inflated average wholesale price in 2004 and then establish more reasonable payment updates in future years; Medicare would use existing sources of market-based prices and would develop additional sources to monitor market changes over time, such as drug price catalogs; or Medicare would establish a competitive .bidding process for drugs and would also require drug companies to report their average sales prices.

Because of the serious flawed reimbursement methodology in the current system, and absent a change in the statute, CMS has indicated they will move forward with the rule.

House Bill

New sections 1847A and 1847B would be established. Under 1847A, the Secretary would be required to establish a competitive acquisition program to acquire and pay for covered outpatient drugs. Under this program, at least 2 contractors would be established in each competitive acquisition area (which would be defined as an appropriate geographic region) throughout the United States. Each year, a physician would be able to select a contractor who would deliver covered drugs and biologicals to the physician; alternatively, a physician would be able to elect payment under the use of the average sales price payment methodology established by 1847B.

Under the competitive acquisition program, there would be 2 categories of drugs under this program: the oncology category (which would include drugs determined by the Secretary as typically primarily billed by oncologists or are otherwise used to treat cancer) which would be implemented beginning in 2005 and the non-oncology category which would be implemented beginning in 2006. In this case, covered drugs means certain drugs currently covered under Section 1842(o) of the SSA which are not covered as part of the competitive acquisition for durable medical equipment. Blood clotting factors, drugs and biologicals furnished as treatment for end-stage renal disease (ESRD), radiopharmaceuticals, and vaccines would not be considered covered drugs under the competitive acquisition program. The Secretary would also be able to exclude other drugs and biologicals or classes of drugs and biologicals that are not appropriate for competitive bidding or would not produce savings.

Certain contractor selection and contracting requirements for the competitive acquisition program would be established. Specifically, the Secretary would be required to establish an annual selection process for a contractor in each area for each of the 2 categories of drugs. The Secretary may not award the 2-year contract to any entity that does not have the capacity to supply covered outpatient drugs within the applicable category or does not meet quality, service, and financial performance and solvency standards established by the Secretary. Specifically the entity would be required to have (1) arrangements to ship covered drugs at least 5 days of the week and on an emergency basis; (2) procedures for the prompt response and resolution of physician and beneficiary complaints and inquiries; (3) grievance resolution procedures, including review by the Medicare Provider Ombudsman established in this legislation. The Secretary would not be able to contract with an entity that has had its license for distributing drugs (including controlled substances) suspended or revoked by the Federal or a State government or that has been excluded from program participation. A contractor would be required to comply with a specified code of conduct, including conflict of interest provisions as well as all applicable provisions relating to the prevention of fraud and abuse. A contract would be able to include the specifications with respect to secure facilities, safe and appropriate storage of covered drugs, examination of drugs, record keeping, written policies and procedures, and compliance personnel. Those contractors may be required to comply with additional product integrity safeguards for drugs susceptible to counterfeiting or diversion. Contracts would be able to be terminated by either the Secretary or the entity with appropriate advance notice. The Secretary would make the list of the available contractors accessible to physicians on an ongoing basis, through a directory posted on the Internet and provided by request.

The Secretary would be able to limit the number of qualified entities in each category and area, but not below two. The Secretary would be required to base selection on bid prices for covered drugs, bid prices for distribution of those drugs, ability to ensure product integrity, customer service, past experience with drug distribution, and other factors. This bid price would include all costs related to the delivery of the drug or biological to the selecting physician or other delivery point as well as all dispensing and shipping costs. Costs relating to the administration of the drug or biological or waste, spillage or spoilage would not be included. As part of the awarded contract, the selected contractor would be required to disclose the reasonable, net acquisition costs regularly (but not more often than once a quarter) as specified by the Secretary. The selected contractor would also be required to disclose appropriate price adjustments over the period of the contract to reflect changes in reasonable, net acquisition costs.

The Secretary would be able to reject the contract offer of an entity for a category of drugs and biologicals if the Secretary establishes that the aggregate average bid price exceeds the average sales price (as determined under Section 1847B discussed subsequently). Nothing in the section would prevent a bidder from submitting a contract offer to cover all areas of the United States; nothing would prevent requiring a bidder to submit a contract offer to cover all areas of the United States. The amount of the bid price submitted under a contract offer would be required to be the same for all portions of the area. The Secretary would be permitted to waive certain provisions of the Federal Acquisition Regulation that are necessary for the efficient implementation of this program, other than those relating to confidentiality of information.

The Secretary would be required to compute an area average of the bid prices submitted, in contract offers accepted for the category and the area, for each year or other contract period. The Secretary would apply special rules and alternative payment amounts to establish a price for specific covered drugs including new drugs and biologicals, oral anti-cancer and immunosuppressive drugs. Generally, the Secretary would not be able to adjust payments for drugs under this section unless supplemental data is used to adjust the practice expense payment adjustment. Also, if the Secretary excludes a class of drugs or biologicals or a specific item from the competitive acquisition program, Medicare's payment would be based on the average sales price methodology discussed subsequently. Beneficiary liability would be limited to 20% of the payment basis for the covered drug or biological.

The contractor supplying the physician in the area would submit the claim for the drug and would collect the cost-sharing amount from the beneficiary after administration of the drug.Both program payment and beneficiary cost sharing amounts would only be made to the contractor; would only be made upon the administration of the drug; and would be based on the average bid of prices for the drug and biological in the area. The Secretary would be required to establish a process for recovery of payments billed at the time of dispensing for drugs that were not actually administered. The Secretary would be required to establish an appeals process for physicians that is comparable to those provided to a physician who prescribes durable medical equipment or a laboratory test.

The appropriate contractor, as selected by the physician, would supply covered drugs directly to the physician, except under the circumstances when a beneficiary is presently able to receive a drug at home. The Secretary would be able to specify other non-physician office settings where a beneficiary would be able to receive a covered drug directly. However, the contractor would not be able to deliver drugs to a physician without first receiving a prescription as well as other necessary information specified by the Secretary. A physician would not be required to submit a prescription for each individual treatment. The Secretary would establish requirements, including adequate safeguards against fraud and abuse and consistent with safe drug practices, in order for a physician to maintain a supply of drugs that may be needed in emergency situations. In order to maintain such an inventory, a physician would be required to demonstrate that the drugs would be immediately required, not reasonably foreseen as immediately required, not able to be delivered by the contractor in a timely manner, and administered in an emergency situation. No applicable State requirements relating to the licensing of pharmacies would be waived.

The Secretary would be able to establish an advisory committee to assist in the implementation of this program. The Secretary would be required to report to Congress on savings, reductions in cost-sharing, access to items and services, the availability of contractors as well as beneficiary and satisfaction under the competitive acquisition program. These reports would be due each year from 2005, 2006, and 2007.

Alternatively, physicians would be able to elect payment for covered outpatient drugs under a separate methodology established in Section 1847B. Subject to the applicable beneficiary coinsurance and deductible amount, a single and multiple source drugs would be paid 112% of the applicable price in 2005 and 2006 and 100% of the price subsequently. The applicable price for all the products within multiple source drug codes would be the reported volume-weighted average of the average sales price; the applicable price for a single source drug would be the lesser of the manufacturer's average sales price for the NDC code or the reported wholesale acquisition cost. The payment amount would be determined without regard to any special packaging, labeling or identifiers on the dosage form or product or package.

Starting for calendar quarters on or after April 1, 2004, the average sales price would be calculated by NDC code each calendar quarter by dividing a manufacturer's total sales by the total number of units sold in that quarter. Certain sales would be exempt from the calculation: (1) those sales that are exempt from the Medicaid drug rebate program including those to the Indian Health Service, the Department of Veterans Affairs, a state Veterans home, the Department of Defense, or the Public Health Services as well as any price charged under the Federal Supply Schedule or used under a state pharmaceutical assistance program; and (2) those sales that do not reflect market prices, as determined by the Secretary. The average sales price would take into account volume discounts, prompt pay discounts, cash discounts, chargebacks and certain rebates. The Secretary would be able to disregard the average sales price during the first quarter of a new drug's sales if the price data is not sufficient to determine an average amount payable. The average sales price would be determined by the manufacturer on a quarterly basis; to the extent that data on rebates and chargebacks is reported on a lagged basis, the manufacturer would apply the 12-month rolling average methodology to estimate the amount of such discounts, as specified by the Secretary. The wholesale acquisition cost would be the manufacturer's list price for the drug to wholesalers or direct purchasers in the United States for the most recent available month, not including discounts or other price reductions, as reported in wholesale price guides or other pricing publications. Payment rates would be updated on a quarterly basis and based on the most recent calendar quarter. The Secretary would be able to use carriers, fiscal intermediaries or other contractors to determine the payment amounts. Certain standards would be established with respect to the definition of multiple source and single source drugs. Certain determinations of pharmaceutical equivalence and bioequivalence would be established. There would be no administrative or judicial review of the determination of the manufacturer's average sale price.

The Secretary would be able to use the wholesale acquisition cost or other reasonable measure of drug price instead of the manufacturer's average sale price in the case of certain public emergencies where there is a documented inability to access covered outpatient drugs and a related increase in price. The alternative price would be used until the price and availability of the drug or biological has stabilized and is substantially reflected in the manufacturer's average sale price.

The Secretary would be required to submit an annual report to the Committees of jurisdiction on the trends in average sales prices, the administrative costs, and total value of payment as well as a comparison of the average manufacturer's sale price with the price established under the Medicaid drug rebate program. The provision would be effective upon enactment.

Senate Bill

Drugs or biologicals furnished before January 1, 2004 would be paid at 95% of the AWP. In 2004, existing drugs and biologicals would be paid the lower of the AWP or 85% of the listed AWP as of April 1, 2003. In subsequent years, this price would be increased by change the consumer price index (CPI) for medical care for the previous year ending in June. Existing drugs and biologicals are those first available for payment on or before April 1, 2003. After January 1, 2004, payments for influenza virus, pneumococcal pneumonia, and hepatitis B vaccines would be equal to the AWP.

The Secretary would be required to establish a process to determine whether the widely available market price to physicians and suppliers for drugs and biologicals furnished in a year is different from the AWP amounts. This determination would be based on: (1) any report on market price published by the Inspector General (IG) of the Department of Health and Human Services (HHS) or GAO after December 31,1999; (2) a review of market prices by the Secretary including information from insurers, private health plans, manufacturers, wholesalers, distributors, physician supply houses, specialty pharmacies, group purchasing arrangements, physicians, suppliers or any other appropriate source as determined by the Secretary; (3) data submitted by the manufacturer of the drug or biological or by another entity; and (4) other appropriate information as determined by the Secretary. If the market price for a drug or biological determined through this process differs from the AWP amount, that market price shall be treated as the AWP amount when determining Medicare's payment for a drug or biological in 2004 and subsequently. The Secretary would be able to make subsequent determinations with respect to the widely available market price for a given drug or biological. If not, the prior market price determination will be considered as the basis for Medicare's payment amount for such an item.

If, however, the first market price determination for a given drug or biological would result in a payment amount that is 15% less than would otherwise be made, the Secretary would provide for an appropriate transition period where the price is reduced in annual increments equal to 15% of Medicare's payment amount in the previous year. At the end of the transition period, the market price (as determined) would serve as basis for Medicare's payment amount. This transition period would not apply to a drug or biological where a generic version of that drug or biological first enters the market on or after January 1, 2004. The generic version would not be required to be marketed under the chemical name of the given drug or biological.

New drugs and biologicals, those that are first available for Medicare payment after April 1, 2003, would be subject to certain requirements in order to obtain a code and receive Medicare payment. A manufacturer would be required to provide the Secretary with necessary and appropriate information on the estimated price that the manufacturer expects physicians and suppliers to pay to routinely obtain the drug or biological; the manufacturer would be able to provide the Secretary with other appropriate information as well. During the first year that the drug or biological is available for Medicare payment, the manufacturer would be required to provide the Secretary with updated information on the actual market prices paid by physicians or suppliers for such drugs and biologicals. These market prices would be equal to the lesser of the average wholesale price for the drug or biological or the amount determined by the Secretary based on information originally submitted by the manufacturer supplemented by other appropriate information. The market price of the drug or biological during the second year after becoming available for Medicare payment is subject to the same conditions as in the first year. In subsequent years, the market price would be equal to the lesser of the average wholesale price or the widely available market price as determined by the Secretary in the same fashion as for existing drugs. If no market price determination occurs, then Medicare's payment for the drug or biological in the prior year is updated by the change in the CPI for medical care for the previous year ending in June.

The provision would be effective upon enactment.

With respect to home infusion drugs and biologicals, the Secretary would be able to make separate payments for these drugs and biologicals furnished through covered DME on or after January 1, 2004, if such payments are determined to be appropriate. Total amount of payments for the infusion drugs in the year could not exceed the total amount of spending that would have occurred without enactment of this legislation. The provision would be effective upon enactment.

Conference Agreement

Certain categories of drugs and biologicals will continue to be paid at 95 percent of the AWP; these include a drug or biological furnished before January 1, 2004; blood clotting factors furnished during 2004; a drug or biological furnished during 2004 that was not available for Part B payment as of April 1, 2003; pneumococcal, influenza, and hepatitis B vaccines; and a drug or biological (other than erythropoietin) furnished in connection with renal dialysis services that are separately billed by renal dialysis facilities; and radiopharmaceuticals and blood products. In general, payments for other drugs furnished in 2004 will equal 85 percent of the average wholesale price (determined as of April 1, 2003). Beginning in 2005, drugs and biologicals, except for pneumococcal, influenza, and hepatitis B vaccines and those associated with certain renal dialysis services, will be paid using either the average sales price methodology or through the competitive acquisition program. Infusion drugs furnished through covered durable medical equipment starting January 1, 2004 will be paid at 95% of the AWP in effect on October 1, 2003; those infusion drugs which may be furnished in a competitive acquisition area starting January 1, 2007 will be paid on the competitive price. Intravenous immune globulin will be paid at 95% of AWP in 2004 and paid according to the average sales price method beginning in 2005.

The Secretary is authorized to substitute a different percent of the April 1, 2003 AWP, based on the Secretary's NPRM, but not less than 80%. Also, the Secretary may adjust the price based on data submitted by the manufacturer of the drug or biological by October 15, 2003.

New sections 1847A and 1847B are established in the Social Security Act. New Section 1847A establishes the use of the average sales price methodology for payment for drugs and biologicals (except for pneumococcal, influenza, and hepatitis B vaccines, or drugs or biologicals furnished in connection with certain renal dialysis services, blood or blood products or radiopharmaceuticals) furnished starting January 1, 2005. This methodology does not apply in the case of a physician who elects to participate in the newly established competition acquisition program established in new Section 1847B; payments for drugs and biologicals will be paid under that section instead.

Medicare's payment under the average sales price methodology will equal 106% of the applicable price for a multiple source drug or single source drug, subject to the applicable beneficiary deductible and coinsurance requirements. The manufacturer will be required to specify the unit associated with each National Drug Code (NDC) as part of its Medicaid reporting requirements. Unit is defined as the lowest identifiable quantity of the drug or biological by NDC (including package size) that is dispensed, exclusive of any diluents without reference to volume measures pertaining to liquids. After 2004, the Secretary may establish the counting method and unit for the manufacturer to report.

The applicable price for all drug products within the same multiple source drug billing and payment code is the volume-weighted average of the sales prices. The applicable price for single source drugs is the lesser of the manufacturer's average sales price for an NDC or the wholesale acquisition cost (WAC). A limited number of single source drugs and biologicals are currently included in the same HCPCs codes, along with other similar single source products. The Conferees intend to exempt these products from the definition of single source drugs or biologicals, and continue to allow these products to be treated as multiple source drugs and be included within the same

HCPCs code. The payment amount is determined without regard to any special packaging, labeling or identifiers on the dosage form or product or package. In the section, the term "payment and billing code" shall mean the HCPCs code for such drug or biological.

A manufacturer's average sales price is calculated by NDC code for each calendar quarter by dividing a manufacturer's total sales by the total number of units sold in that quarter. Certain sales are exempt from the calculation: (1) certain sales that are exempt from the Medicaid drug rebate program including those to the Indian Health Service, the Department of Veterans Affairs, a state Veteran's home, the Department of Defense, or the Public Health Services; and (2) sales that are nominal in amount, as used in the Medicaid rebate program. The average sales price will take into account volume discounts, prompt pay discounts, cash discounts, free goods that are contingent on any purchase requirement, chargebacks and certain rebates (not including Medicaid rebates). After 2004, the Secretary may include other price concessions that result in a price reduction to the purchaser as may be recommended by the Inspector General.

The Secretary will be able to disregard the average sales price during the first quarter of a new drug's sales if the price data is not sufficient to determine an average amount payable. The average sales price will be calculated by the manufacturer on a quarterly basis; to the extent that data on rebates and chargebacks is reported on a lagged basis, the manufacturer will apply the 12–month rolling average methodology to estimate the amount of such discounts, as specified by the Secretary. After 2004, the Secretary may establish a uniform methodology to estimate and apply such costs. Payment rates will be updated on a quarterly basis. The Secretary may contract with appropriate entities to determine the payment amounts. The Secretary may implement any provision of this section by program instruction or otherwise.

To monitor market prices, the Inspector General will conduct studies, which may include market surveys, to determine market prices of drugs and biologicals paid under this section. The Inspector General will compare average sales price under Medicare with the widely available market price and the average manufacturer price. The Secretary may disregard the average sales price reported by a manufacturer if this price exceeds the market price or average manufacturer price by a threshold percentage. In 2005 the threshold is 5%; in 2006 and subsequent years, the percentage threshold will be specified by the Secretary. If the Inspector General finds that the average sales price for a drug or biological exceeds the widely available market price or average manufacturer price by the applicable threshold, the Inspector General will inform the Secretary at specified times, and the Secretary will substitute a payment amount equal to the lesser of the widely available market price or 106 percent of the average manufacturer price.

The section requires that in order to have a drug covered under both Medicare and Medicaid, a manufacturer must submit information quarterly on the manufacturer's average sales price, total number of units, wholesale acquisition cost and sales made at nominal price. The Conferees intend that if a manufacturer knowingly (as defined by section 3729(b) of the False Claims Act) submits false information, that such submission be considered a "false record or statement" made or used "to get a false or fraudulent claim paid or approved by the government" for purposes of section 3729(a)(2) of title 31, United States Code, known as the False Claims Act. Thus if a manufacturer knowingly submits any false information, the manufacturer would be fully subject to liability under the False Claims Act.

The Conferees intend that that the Secretary, in making determinations to use the widely available market price, rather than the ASP, would provide a number of procedural and substantive safeguards to ensure the reliability and validity of the data used to make such determinations. These safeguards would include notice and comment rulemaking, identification of the specific sources of information used to make such determinations, and explanations of the methodology and criteria for selecting such sources.

If the Secretary determines that a manufacturer has misrepresented the average sales price of a drug, the Secretary may apply a civil monetary penalty of up to $10,000 for each price discrepancy and for each day in which the price misrepresentation was applied. In this subsection for drugs furnished in a year after 2004, the widely available market price is the price that a prudent physician or supplier would pay for a drug or biological, taking into account discounts, rebates and other price concessions routinely made available. The Secretary will consider information from one or more of the following sources including manufacturers, wholesalers, distributors, physician supply houses, specialty pharmacies, group purchasing arrangements, physician and supplier surveys as well as information on market prices from insurers and private health plans.

The Secretary will be able to use the wholesale acquisition cost or other reasonable measure of drug price instead of the manufacturer's average sale price in the case of certain public emergencies where there is a documented inability to access covered outpatient drugs and a related increase in price (which is not reflected in the manufacturer's average sale price for one or more quarters). The alternative price will be used until the price and availability of the drug or biological has stabilized and is substantially reflected in the manufacturer's average sale price.

There will be no administrative or judicial review of determinations of payment amounts including the assignment of NDCs to billing and payment codes; the identification of units and package size; the method to allocate rebates, chargebacks, and other price concessions to a quarter, the manufacturer average sales price when it is used for Medicare's price determinations, and the disclosure of the average manufacturer price under certain situations.

The Secretary will conduct a study on the sales of drugs and biologicals to large volume purchasers such as pharmacy benefit managers to determine whether the price at which drugs and biologicals are sold to these purchasers represents the price made available to physicians. The Secretary will submit a report to Congress, including recommendations, on whether sales to large volume purchasers should be excluded from the computation of the manufacturer's average sale price. Upon completion of this report, the Secretary may require that manufacturers separately report these prices, which may also then be excluded from future calculations of ASP, if the Secretary determines that doing so would be better reflect prices available to prudent physicians.

Under the new Section 1847B, the Secretary would be required to establish a competitive acquisition program to acquire and pay for competitively biddable drugs and biologicals. Under the program, competitive acquisition areas (defined as an appropriate geographic region) will be established throughout the United States. Each year, a physician would be able to select a contractor who would deliver covered drugs and biologicals to the physician; alternatively, a physician would be able to elect payment using the methodology established by Section 1847A. Conferees intend this choice to be completely voluntary on behalf of the physician. Use of this system should reduce administrative and inventory costs for physicians. In addition, because physicians do not take title to the drug, their liability is reduced.

Under the competitive acquisition program, categories of competitively biddable drugs under this program will be established, and the program will be phased in beginning in 2006. In order to promote competition and the efficient operation of the program, the Secretary would be able to waive provisions of the Federal Acquisition Regulation, other than those relating to confidentiality of information and other provisions deemed appropriate by the Secretary.

Competitively biddable drugs and biologicals exclude pneumococcal, influenza, and hepatitis B vaccines or drugs or biologicals (other than erythropoietin) furnished in connection with renal dialysis services furnished starting January 1, 2006, radiopharmaceuticals, IVIG products and blood products. Conferees do not intend to exclude therapeutic vaccines, such as new vaccines used to treat cancer that may be in development. The Secretary will be able to exclude competitively biddable drugs and biologicals including classes of such drugs and biologicals that are not appropriate for competitive bidding, if such inclusion is not likely to result in significant savings or is likely to have an adverse impact on access to the drugs and biologicals. The Secretary may provide for payment of these excluded drugs and biologicals (or class of same) using the average sale price methodology established in Section 1847A. Conferees intend the use of the exclusion authority to apply in exceptional cases. Such authority is not intended to be a system wide replacement for competitive bidding.

The contractor supplying the physician in the area will submit the claim for the drugs and biologicals and will collect the cost-sharing amount from the beneficiary after administration of the drug. Both program payment and beneficiary cost sharing amounts will only be made to the contractor and will only be made upon the administration of the drug or biological. The Secretary is required to establish a process for recovery of payments billed at the time of dispensing of drugs or biologicals that were not actually administered as well as a process by which physicians submit information to contractors for the purposes of collection of any applicable deductible or coinsurance amounts. Payment could only be made to the contractor, provided the contractor has a contract and the physician elects that contractor for such category of drug or biological for the area. Alternatively, the physician may elect Section 1847A to apply.

Certain contractor selection and contracting requirements for the competitive acquisition program are established. Specifically, the Secretary is required to establish an annual selection process for a contractor in each area for each category of drugs and biologicals. The selection of the contractor will be made at the time the physician elects to participate in the program established under Section 1847B. The Secretary will make a list of contractors in the different competitive acquisition area who are available to physicians on an ongoing basis through a directory posted on the Internet website of the Centers for Medicare & Medicaid Services, and through the annual CMS "Dear Doctor" campaign.

The Secretary will conduct a competition among entities for the acquisition of at least one competitively biddable drug or biological that is a multiple source or a single source drug or biological within each billing and payment code within each category for each area. The competition within a HCPCS code for multiple source drug products is intended to produce competitive forces that will lower bid prices for drugs. Because multiple source drugs and generics within a HCPCS code are therapeutically equivalent, such competition will ensure access to appropriate therapeutic products. The Secretary may not award the 3-year contract to any entity that does not have the capacity to supply competitively biddable drugs or biologicals within the applicable category or does not meet quality, service, and financial performance and solvency standards established by the Secretary. Specifically, the entity would be required to have (1) sufficient arrangements to ship competitively biddable drugs and biologicals at least 5 days of the week in order for the timely delivery (including for emergency situations) of such drugs and biologicals; (2) procedures for the prompt response and resolution of physician and beneficiary complaints and inquiries regarding the shipment of these drugs; and (3) a grievance and appeals process. Review of complaints by the Medicare Provider Ombudsman has been established in Section 923 of this legislation. The Secretary will not be able to contract with an entity that has had its license for distributing drugs (including controlled substances) suspended or revoked by the Federal or a State Government or that has been excluded from program participation.

The Secretary will be able to limit the number of qualified entities in each category and area, but not below 2 for any category and area. The Secretary is required to base selection on bid prices for competitively biddable drugs and biologicals, bid prices for distribution of those drugs and biologicals, ability to ensure product integrity, customer service, past experience with drug and biologic distribution, and other factors.

The contract is subject to terms and conditions that the Secretary may specify. The contract will be for a term of 3 years, but may be terminated by either the Secretary or the entity with appropriate notice. The Secretary must require that all drugs and biological products distributed by a contractor be acquired directly from the manufacturer or from a distributor that has acquired the products directly from the manufacturer. Nothing in this provision relieves or exempts any contractor from the requirements of the Federal Food, Drug, and Cosmetic Act that relate to the wholesale distribution of prescription drugs or biologicals. Conferees want to ensure the safe distribution of drugs and to ensure counterfeiting and adulteration is minimized. Such measures include includes the safe and appropriate storage of drugs and biologicals, disposition of damaged and outdated drugs and biologicals and appropriate record keeping and compliance personnel.

Contractors will be required to comply with a code of conduct and fraud and abuse rules. Specifically, the contractor will comply with standards relating to conflicts of interest and all applicable provisions and guidelines relating to the prevention of fraud and abuse established by the Department of Justice and the Inspector General.

The appropriate contractor, as selected by the physician, will supply competitively biddable drugs and biologicals directly to the physician, except under the circumstances when a beneficiary is presently able to receive a drug at home or other non-physician office settings as the Secretary may provide. The contractor shall not deliver drugs to a physician without first receiving a prescription as well as other necessary information specified by the Secretary. However, a physician would not be required to submit a prescription for each individual treatment or change a physician's flexibility in terms of writing a prescription for a single treatment or course of treatment. Conferees do not intend contractors to mix drug products prior to a patient's visit, but may do so should it be clinically advised. If specialty pharmacies mix products under the program for a specific patient, it should be done only to the benefit of the patient. Such cases may include a physician office that lacks the ability to mix Part B drugs in compliance with medical, clinical and environmental standards. In no way do conferees intend the requirements for the competition program to impair a patient's access to health treatment as a result of changes in the patient's health status, including pre-mixed drugs or biologics.

The Secretary is required to establish rules allowing physicians to use drugs or biologics from their own inventories in emergency situations consistent with safe drug practices and with adequate safeguards against fraud and abuse. In order to resupply such an inventory, a physician will be required to demonstrate that the drugs are immediately required; that the immediate need could not reasonably have been foreseen, that the drugs could not be delivered by the contractor in a timely manner, and that the drugs were administered in an emergency situation. No applicable State requirements relating to the licensing of pharmacies are waived.

The Secretary is required to base selection of the contractors on several factors including bid prices. Bid prices are those in effect and available through the entity for the contract period and includes all costs related to the delivery of the drug or biological to the selecting physician or other delivery point as well as all dispensing and shipping costs. Costs relating to the administration of the drug or biological or waste, spillage or spoilage are not included. As part of the awarded contract, the selected contractor will be required to disclose the reasonable, net acquisition costs regularly (but not more often than once a quarter) as specified by the Secretary. The selected contractor will also be required to disclose appropriate price adjustments over the period of the contract to reflect changes in reasonable, net acquisition costs.

Payments would be based upon bids submitted and accepted, and the Secretary would determine a single payment amount for each drug in an area. The Secretary will apply special rules and alternative payment amounts to establish a price for specific competitively biddable drugs and biologicals, including new drugs and biologicals (for which an average bid price has not been previously determined) and other exceptional cases specified in regulations. Medicare's payment for these drugs equals 80% of the payment amount after the Medicare beneficiary meets the applicable deductible. Generally, these coinsurance and deductible amounts will be collected by the contractor that supplies the drug or biological which may be collected in a similar manner as those collected for durable medical equipment.

Nothing in the section prevents a bidder from submitting a contract offer to cover all areas of the United States. Similarly, nothing would require a bidder to submit a contract offer to cover all areas of the United States. The amount of the bid price submitted under a contract offer is required to be the same for all portions of the area.

The Secretary will establish a procedure under which a prescribing physician has certain appeal rights that are similar to those provided to a physician who prescribes durable medical equipment or a clinical diagnostic laboratory test. Certain provisions specified in Section 1842(o)(3) with respect to assignment will also apply to claims for competitively biddable drugs and biologicals. Certain protections against liability in case of adverse medical necessity determination will apply to Medicare beneficiaries. There shall be no administrative or judicial review with respect to the establishment of payment amounts, contract awards, establishment of competitive acquisition areas, the phased in implementation, the selection of categories of competitively biddable drugs and biologicals for competitive acquisition or the bidding structure or number of contractors who are selected.

No later than July 1, 2008, the Secretary is required to report to Congress on savings, reductions in cost-sharing, access to competitively biddable drugs and biologicals, the range of choices of contractors available to providers as well as beneficiary and provider satisfaction under the competitive acquisition program. The report will also examine the information comparing prices for drugs in the competitive acquisition program and under the application of the average sales price methodology under Section 1847A.

In developing rules to implement this section, the Secretary should seek public comment on factors that disadvantage certain covered drugs based on drug forms and delivery and dispensing modes, and which may result in increased Medicare expenditures.

Items and Services Relating to Furnishing of Blood Clotting Factors (Section 303(e)(1) of the Conference Agreement and Section 303(f) of the House Bill).

Present Law

Medicare will pay for blood clotting factors for hemophilia patients who are competent to use such factors to control bleeding without medical supervision, as well as the items related to the administration of such factors.

House Bill

MedPAC would be required to submit to Congress specific recommendations with respect to payment for blood clotting factors and its administration in its 2004 annual report. The provision would be effective upon enactment.

Senate Bill

The Secretary is required to review the GAO report on payment for blood clotting factors and provide a separate payment for the administration of these factors. The total amount of payments for blood clotting factors furnished in CY2004 would not exceed the amount that would have otherwise been expended. In CY2005 and subsequently, this separate payment amount would be updated by the change in the CPI for medical care for the previous year ending in June. The provision would be effective upon enactment.

Conference Agreement

The Secretary is required to review the GAO report on payment for blood clotting factors and provide a separate payment for the administration of these factors. The payment amount may take into account the mixing (if appropriate) and delivery of factors to an individual, including special inventory management and storage requirements as well as ancillary supplies and patient training necessary for self-administration. The total amount of payments for blood clotting factors furnished in CY2005 can not exceed the amount that would have otherwise been expended. In CY2006 and subsequently, this separate payment amount would be updated by the change in the CPI for medical care for the previous year ending in June.

Pharmacy Supplying Fee for Certain Drugs and Biologicals (Section 303(e)(2), Section 303(g) of the House Bill and Section 432(b)(8) of the Senate Bill).

Present Law

Medicare pays for certain outpatient prescription drugs and biologicals. For instance, Medicare pays a dispensing fee in conjunction with inhalation therapy drugs used in nebulizers. Medicare does not pay a dispensing fee to pharmacists or providers who supply oral drugs.

House Bill

The Secretary would be required to provide for separate payments in the physician fee schedule to cover the administration and acquisition costs associated with covered drugs and biologicals furnished by a contractor under the competitive acquisition program. The provision would be effective upon enactment.

Senate Bill

Medicare would pay a dispensing fee (less the applicable deductible and coinsurance amounts) to licensed approved pharmacies for covered immunosuppressive drugs, oral anti-cancer drugs, and oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen. Medicare would be able to pay a dispensing fee (less the applicable deductible and coinsurance amounts) to licensed approved pharmacies for other drugs and biologicals. The provision would be effective upon enactment.

Conference Agreement

The Secretary is required to pay a supply fee (less the applicable deductible and coinsurance amounts) to licensed approved pharmacies for covered immunosuppressive drugs, oral anti-cancer drugs, and oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen. Such fee is not meant to be a dispensing fee. The intent of the Conferees is to not to include in such fee, amounts for cognitive services.

Linkage of Revised Drug Payments and Increases for Drug Administration (Section 303(f) of the Conference Agreement and Section 432(b)(1) of the Senate Bill).

Present Law

No provision.

House Bill

No provision.

Senate Bill

A linkage of revising drug payments to incorporate market prices and payment increases for drug administration would be established.

Conference Agreement

The Secretary cannot implement the revision in payment amount for categories of drug or biological administered by physicians unless the Secretary concurrently makes the practice expense payment adjustment on the basis of survey data as specified earlier.

Prohibition of Administrative and Judicial Review (Section 303(g) of the Conference Agreement and Section 432(d) of the Senate Bill).

Present Law

Medicare beneficiaries and, in certain circumstances, providers and suppliers of health care services may appeal adverse determinations regarding claims for benefits under Part A and Part B. Section 1869 of the SSA allows these parties who have been denied coverage of an item or service the right to appeal that decision through a series of administrative appeals and then into federal district court under certain circumstances. Section 1878 of the SSA allows providers who are dissatisfied with certain cost reporting determinations that affect their reimbursement amounts the right to appeal that decision in front of the Provider Reimbursement Review Board and then into federal district court if certain thresholds regarding the amount in dispute are met at each step of the appeals process.

House Bill

No provision.

Senate Bill

The provisions concerning Medicare's determination of payment amounts for existing and new drugs and biologicals including the administration of blood clotting factors, home infusion drugs and inhalation drugs would not be subject to administrative or judicial review under Sections 1869 and 1878 of the SSA or otherwise. The provision would be effective upon enactment.

Conference Agreement

The provisions concerning Medicare's determination of payment amounts, methods or adjustments including those with respect to a drug's widely available market price in 2004, the administration of blood clotting factors, and pharmacy supplying fees will not be subject to administrative or judicial review under Sections 1869 and 1878 of the SSA or otherwise. The provision would be effective upon enactment.

The provisions concerning Medicare's determination of the budget neutral adjustments, adjustments to the practice expense relative value units for certain drug administration services and other drug administration services will not be subject to administrative or judicial review under Section 1869 of the SSA or otherwise. The provision would be effective upon enactment.

The provisions concerning Medicare's treatment of other services currently in the non-physician work pool, payment for multiple chemotherapy agents furnished on a single day through the push technique, and the transitional adjustment will not be subject to administrative or judicial review under Sections 1869 and Section 1878 of the SSA or otherwise. The provision would be effective upon enactment.

Continuation of Payment Methodology for Radiopharmaceuticals (Section 303(h) of the Conference Agreement and Section 303(c) of the House Bill).

Present Law

Under certain circumstances, Medicare makes a separate payment for supplies furnished in connection with a procedure. Medicare will pay separately for pharmaceutical or radiopharmaceutical supplies when procedures such as diagnostic radiolologic procedures or other diagnostic tests requiring a pharmacological stressing agent.

Although Medicare uses the Healthcare Common Procedure Coding System (HCPCS) codes to identify and pay for physician administered drugs, the AWPs are established for national drug codes (NDC) codes that are maintained by the Food and Drug Administration (FDA). Until January 1, 2003, each Medicare carrier would convert NDC codes into HCPCS codes in order to develop AWP-based payments for physicians in its area. To address the variation in carrier-established drug pricing methods, CMS implemented a single drug pricer (SDP), a centrally administered fee schedule for covered outpatient drugs on January 1, 2003. The SDP excludes radiopharmaceuticals, outpatient hospital drugs, and drugs paid by the durable medical equipment regional carriers (DMERCs).

House Bill

These provisions would not affect the existing carrier invoice pricing method used to pay for radiopharmaceuticals. The provision would be effective upon enactment.

Senate Bill

No provision.

Conference Agreement

The conference agreement will not change the Part B payment methodology for radiopharmaceuticals including the use by carriers of the invoice pricing method.

Conforming Amendments (Section 303(i) of the Conference Agreement and Section 303(d) of the House Bill).

Present Law

No provision.

House Bill

The provisions in this section would not affect the existing coverage for outpatient drugs. The collection of data to calculate the manufacturer's average sales price and the manufacturer's wholesale acquisition cost would be included as part of the Medicaid drug rebate program for calendar quarters beginning on or after April 1, 2004. Information on sales that were made at a nominal price would also be submitted and be subject to audit by the HHS Inspector General. The provision would be effective upon enactment.

Senate Bill

No provision.

Conference Agreement

The conference agreement includes conforming amendments to the existing statutory language. A pharmacy-dispensing fee will not be paid when payment for a drug is made under the average sales price or competitive acquisition program. The provisions in this section will not affect the existing coverage for outpatient drugs. The list of services paid for under Part B will be amended to include drugs paid for under Sections 1847, 1847A, and 1847B. Information by NDC (including package size) on the manufacturer's average sales price and total number of units; the manufacturer's wholesale acquisition cost; sales that were made at a nominal price will be included as part of the Medicaid drug rebate program for calendar quarters beginning on or after January 1, 2004. This information will be subject to audit by the Inspector General. The Secretary will be able to survey wholesalers and manufacturers that directly distribute covered outpatient drugs to verify average sales price (including wholesale acquisition cost) under the Medicaid drug rebate program. The provisions with respect to the Congressional review of agency rulemaking will not apply with respect to regulations that implement adjustments to the physician fee schedule or the application of market based payment systems. The existing requirement that the Secretary study the effect on AWP of Medicare's policy to pay for covered outpatient drugs at 95% of AWP is repealed.

Extension

Payment for Inhalation Drugs and Certain Other Drugs (Section 305 of the Conference Agreement, Section 602(c) of the House Bill, and Section 432(b)(7) of the Senate Bill).

Present Law

Medicare will cover outpatient prescription drugs and biologicals if they are necessary for the effective use of covered durable medical equipment (DME), including those drugs that must be put directly into the equipment such respiratory drugs given through a nebulizer (inhalation drugs).

House Bill

GAO would be required to conduct a study to examine the adequacy of current reimbursements for inhalation therapy under the Medicare program and submit the results of the study in a report to Congress no later than May 1, 2004.

Senate Bill

The Secretary would be able to increase payments for covered DME associated with inhalation drugs and biologicals and make separate payments for such drugs and biologicals furnished through covered DME on or after January 1, 2004, if such payments are determined to be appropriate. The associated spending attributed to the increased and separate payments for the covered DME and inhalation drugs and biologicals in the year would not exceed the 10% of the difference between the savings in total spending for these drug and biologicals attributed to the prescription drug pricing changes enacted in this legislation. The provision would be effective upon enactment.

Conference Agreement

Inhalation drugs or biologicals furnished through covered durable medical equipment that is not described in subparagraph (A)(iv) will be paid at 85% of AWP in 2004. In 2005, it will be the amount provided under the average sales price methodology.

GAO is required to conduct a study to examine the adequacy of current reimbursements for inhalation therapy under the Medicare program and submit the results of the study in a report to Congress no later than 1 year from the enactment date of this legislation.

Demonstration Project for Use of Recovery Audit Contractors (Section 305 of the Conference Agreement and Section 304 of the House Bill).

Present Law

No provision.

House Bill

The Secretary would be required to conduct a demonstration project for up to 3 years on the use of recovery audit contractors under the Medicare Integrity Program. The recovery audit contractors would identify underpayments and overpayments in the Medicare program and would recoup overpayments made to providers. Payment would be made to these contractors on a contingent basis, a percentage of the amount recovered by the contractors would be able to be retained by the Secretary and available to the program management account of Centers for Medicare & Medicaid Services (CMS), and the Secretary would be required to examine the efficacy of using these contractors with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise. The demonstration project would be required to cover at least 2 states that are among the states with the highest per-capita utilization rates of Medicare services and have at least 3 recovery audit contractors. The Secretary would be able to waive Medicare statutory provisions to pay for the services of the recovery audit contractors. Recovery of an overpayment through this project would not prohibit the Secretary or the Attorney General from investigating and prosecuting appropriate allegations of fraud and abuse. Fiscal intermediaries, carriers, and Medicare Administrative Contractors would not be eligible to participate as a recovery audit contractor. The Secretary would be required to show preference to contracting with entities that have demonstrated more than 3 years direct management experience and a proficiency in recovery audits with private insurers or state Medicaid programs. Within 6 months of completion, the Secretary would be required to report to Congress on the project's savings to the Medicare program, including recommendations on the cost-effectiveness of extending or expanding the program. The provision would be effective upon enactment.

Senate Bill

No provision.

Conference Agreement

The conference agreement requires the Secretary to conduct a demonstration project for up to 3 years on the use of recovery audit contractors under the Medicare Integrity Program. The recovery audit contractors will identify underpayments and overpayments in the Medicare program and recoup overpayments made to providers. Payment may be made to these contractors on a contingent basis, a percentage of the amount recovered by the contractors is to be retained by the Secretary and available to the program management account of the Centers for Medicare & Medicaid Services (CMS), and the Secretary is required to examine the efficacy of using these contractors with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.

The demonstration project is required to cover at least 2 states that are among the states with the highest per-capita utilization rates of Medicare services and that have at least 3 recovery audit contractors. The Secretary is required to waive Medicare statutory provisions as necessary in order to pay for the services of the recovery audit contractors. The Secretary is required to show preference to contracting with entities that have demonstrated more than 3 years direct management experience and a proficiency in recovery audits with private insurers or state Medicaid programs. Fiscal intermediaries, carriers, and Medicare Administrative Contractors are not eligible to participate as a recovery audit contractor. Recovery of an overpayment through this project does not prohibit the Secretary or the Attorney General from investigating and prosecuting allegations of fraud or abuse arising from the overpayment. Within 6 months of completion, the Secretary is required to report to Congress on the project's savings to the Medicare program, including recommendations on the cost-effectiveness of extending or expanding the program. The provision is effective upon enactment.

Pilot Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities or Providers (Section 306 of the Conference Agreement and Section 620 of the Senate Bill).

Present Law

Nursing homes and home health agencies may request the Federal Bureau of Investigation (FBI) to search its all-state national data bank of arrest and convictions for the criminal histories of applicants who would provide direct patient care, as long as states establish mechanisms for processing these requests. Most states have enacted laws that require or allow nursing homes and home health agencies to conduct these criminal background checks for certain categories of potential employees. The Attorney General may charge nursing homes and home health agencies fees of no greater than $50 per request.

To conduct a criminal background check, nursing homes and home health agencies must provide a copy of an applicants fingerprints, a statement signed by the applicant authorizing the search, and other information to the appropriate state agency. Such information must be provided no later than 7 days after its acquisition by the nursing home or home health agency. Nursing facilities or home health care agencies that deny employment based on reasonable reliance on information from the Attorney General are exempt from liability for any action brought by the applicant. The information received from either the state or Attorney General may be used only for the purpose of determining the suitability of the applicant for employment by the agency in a position involved in direct patient care.

HHS maintains a national health care fraud and abuse data base, the Healthcare Integrity and Protection Data Bank (HIPDB), for the reporting of final adverse actions, including health care related civil judgments and criminal convictions of health care practitioners, providers and suppliers. This information is currently available for self-query by government agencies, health plans, health care providers, suppliers and practitioners. All states also maintain their own registries of persons who have completed nurse aide training and competency evaluation programs and other persons for whom the state determines meet the requirements to work as a nurse aide. Included in these registries are data describing state findings of resident neglect, abuse and/or the misappropriation of resident property.

State agencies that survey providers to ensure they meet Medicare and/or Medicaid requirements for participation are referred to as survey and certification agencies, or state survey agencies. Under current law, state survey agencies are required to investigate allegations of resident neglect, abuse and/or the misappropriation of resident property in nursing homes.

House Bill

No provision.

Senate Bill

Medicare and/or Medicaid certified nursing homes, home health agencies, hospices, long-term care hospitals, intermediate care facilities for the mentally retarded (ICF/MRs), and other entities providing long-term care services would be required to initiate background checks for certain workers. These workers would include those licensed, certified, nonlicensed, or contracted employee of a long term care facility or provider (other than a volunteer) that has access to a patient or resident, including nurse assistants, nurse aides, home health aides, individuals who provide home care, and personal care workers and attendants.

Providers would be required to: (1) give written notice to workers about background checks, (2) obtain a written statement disclosing any conviction for a relevant crime or finding of patient or resident abuse from the worker, (3) receive written permission from workers authorizing a criminal background check, (4) obtain fingerprints or thumb prints of workers, (5) conduct self-queries of the HIPDB, and (6) comply with other information requirements specified by the Secretary. States would then be required to check state arrest and conviction data banks, and if appropriate, request the FBI to check national criminal history records on behalf of providers that are required to conduct these background checks.

The long-term care providers would be prohibited from employing a worker who has any conviction for a relevant crime or a finding of patient or resident abuse. Those found to violate these requirements would be subject to criminal penalty fines and/or imprisonment. Providers that are found to violate these requirements would face civil monetary fines. Providers would be permitted to provisionally employ workers pending completion of the criminal background checks as long as they comply with supervisory requirements. Special consideration would be given to rural facilities and home health providers.

Providers would be reimbursed for their costs associated with the requirements of this provision by the Secretary of HHS. The Attorney General could charge fees to any state requesting a search and exchange of records. States could also charge providers fees. Yet, providers could not charge fees to workers.

The nurse aide registry would be expanded to include all employees of providers, including non-licensed workers, and renamed an employee registry. Survey and certification agencies would be required to investigate abuse and neglect allegations and misappropriation of resident property concerning any individual employed or used by any participating health and long-term care providers. $10.2 million would be authorized to be appropriated for FY 2004, with compliance with these provisions phases in for various groups of providers.

Grants would be available to public or private non-profit entities to develop information on best practices in patient abuse prevention training (including behavior training and interventions) for managers and staff of hospital and health care facilities, and for other purposes.

Long-term care providers could access the HIPDB data bank and HIPDB would be expanded to include findings of abuse, neglect, or misappropriation of resident property. A report would be due to Congress no later than 2 years after enactment on the number of requests for searches and exchanges of records, the disposition of requests, and the cost of responding to such requests.

Conference Agreement

The conference agreement requires the Secretary to establish pilot projects in no more than 10 states for the purpose of expanding background checks for workers to other Medicare and Medicaid long-term care providers. Long-term care facilities or providers include Medicare- and/or Medicaid-certified nursing homes, home health agencies, hospices, long-term care hospitals, intermediate care facilities for the mentally retarded (ICF/MRs), and other entities that provide long-term care services (except for those paid through a self-directed arrangement).

States that agree to participate in this pilot project will be responsible for monitoring provider compliance and must establish procedures for workers to appeal or dispute the findings of the background checks. The Secretary will establish criteria for selecting those states seeking to participate and pay those states for the costs of conducting the pilot program (reserving 2% of the payments for the program's evaluation).

Long-term care providers in participating states are required to: (1) give notice to new workers about background checks, and (2) obtain a written statement disclosing any conviction for a relevant crime or finding of patient or resident abuse from the worker, (3) receive written permission from workers authorizing a criminal background check, (4) obtain a rolled set of finger prints of workers, (5) obtain any other information specified by the state; and (6) initiate a check of available registries that document findings of resident or patient neglect, abuse, or misappropriation of property (if no information about a conviction of a relevant crime or finding of abuse are found). Providers must also obtain information on the workers from the state through a 10-fingerprint background check to be conducted using state criminal records and the Integrated Automated Fingerprint Identification system of the Federal Bureau of Investigation. Disqualifying information for employment includes information about a conviction for a relevant crime, a finding of patient or resident abuse, or a felony conviction related to health care fraud or a controlled substance. Under the agreement, at least one state should test if providers could contract with employment agencies, subject to conditions specified by the state, to conduct these background checks.

Pending completion of the national and state criminal history background checks, states may permit providers to provisionally employ workers as long as they comply with supervisory requirements established by the state. These requirements would take into account the cost or other burdens associated with small rural providers as well as the nature of care delivered by home health or hospice providers.

The information obtained from the check may only be used for the purpose of determining the suitability of the applicant for employment. Providers are also protected from liability for denying employment based on reasonable reliance on information from the background checks. For fiscal years 2005 and 2006, $25 million is appropriated from funds not otherwise appropriated.

GAO Study (Section 303(e) of the House Bill).

Present Law

No provision.

House Bill

GAO would be required to conduct a study to assess the impact of amendments made by this section on the delivery of services and their impact on access to drugs by beneficiaries. The report would be due no later than 2007.

Senate Bill

GAO would be required to conduct a study that examines the impact of the drug payment and adjustment provisions on the access of Medicare beneficiaries' to covered drugs and biologicals. The report, including appropriate recommendations, would be due to Congress no later than January 1, 2006. The Inspector General would be required to conduct one or more studies that examine the market prices for Medicare covered drugs and biologicals, which are widely available to physicians and suppliers. The report would examine those drugs and biologicals that represent the largest portion of Medicare spending on such items and include a comparison of market prices with Medicare payment amounts.

Conference Agreement

No provision.

Study on Codes for Non-Oncology Codes (Section 303(h) of the House Bill).

Present Law

No provision.

House Bill

The Secretary would be required to submit a study to Congress within one year of enactment that examines the appropriateness of establishing and implementing separate codes for non-oncology infusions that address the level of complexity and resource consumption. If deemed appropriate, the Secretary would be able to implement appropriate changes in the payment methodology. The provision would be effective upon enactment.

Senate Bill

No provision.

Conference Agreement

No provision.

Payment for Chemotherapy Drugs Purchased But Not Administered by Physicians (Section 432(b)(c) of the Senate Bill).

Present Law

Medicare does not pay for chemotherapy drugs that purchased by physicians, are not dispensed, and must be discarded.

House Bill

No provision.

Senate Bill

The Secretary would be able to compensate a physician for chemotherapy drugs that are purchased with a reasonable intent to administer to a Medicare beneficiary but which cannot be administered despite the physician's reasonable efforts, because the beneficiary is too sick or the beneficiary's condition changes and the physician must discard the drugs. The Secretary would be able to increase the Medicare payment amount for all covered chemotherapy drugs, but the total amount of the increase could not exceed one percent of the payment for chemotherapy drugs. The beneficiary's cost sharing amounts would not be affected. The provision would be effective upon enactment.

Conference Agreement

No provision.

Extension of Medicare Secondary Payer Rules for Individuals with End-Stage Renal Disease (Section 450F of the Senate Bill).

Present Law

Generally, Medicare is the primary payer, that is, it pays health claims first, with an individual's private or other public plan filling in some or all of the coverage gaps. In certain cases, the beneficiary's other coverage pays first, while Medicare is the secondary payer. This is known as the Medicare secondary payer (MSP program). The MSP provisions apply to group health plans for the working aged, large group health plans for the disabled, and, for 30 months, employer health plans for the end-stage renal disease (ESRD) population.

House Bill

No provision.

Senate Bill

This provision would extend the limited time period that employer health plans are primary payer for beneficiaries with end-stage renal disease from 30 months to 36 months. The provision would apply for items and services furnished beginning January 1, 2004.

Conference Agreement

No provision.

TITLE IV—RURAL PROVISIONS

Subtitle A—Provisions Relating to Part A Only

Equalizing Urban and Rural Standardized Payment Amounts under the Medicare Inpatient Hospital Prospective Payment System (Section 401 of the Conference Agreement, Section 402 of the House Bill, and Section 401 of the Senate Bill).

Present Law

Medicare pays for inpatient services in acute hospitals in large urban areas using a standardized amount that is 1.6% more than the standardized amount used to pay hospitals in other areas (both rural areas and smaller urban areas). The Consolidated Appropriations Act of 2003 (P.L. 108–7) provided for a temporary payment increase for rural and small urban hospitals; all Medicare discharges from April 1, 2003, to September 30, 2003, will be paid on the basis of the large urban area amount. This temporary increase was further extended to discharges through March 31, 2004 by P.L. 108–89, which permitted the Secretary to delay implementation of the payment increase until November 1, 2003, if necessary.

Under Medicare's prospective payment system for inpatient services, separate standardized amounts are used to establish payments for discharges from short-term general hospitals in Puerto Rico. The separate amounts are a blended calculation based on an equal proportion of the federal national amount and the local amount, which are computed using data from hospitals in Puerto Rico. Presently, two local amounts are calculated: one for hospitals in large urban areas and one for hospitals in other areas.

House Bill

Beginning for discharges in FY2004, the standardized amount for hospitals located in areas other than large urban areas would be equal to the amount used to pay hospitals located in large urban areas. Technical conforming amendments would also be adopted.

Senate Bill

Medicare would pay hospitals in rural and small urban areas in the fifty states using the standardized amount used to pay hospitals in large urban areas starting for discharges in FY2004. The Secretary would compute one standardized amount for hospitals in Puerto Rico equal to that for urban areas.

Conference Agreement

Medicare will pay hospitals in rural and small urban areas in the fifty states using the standardized amount that would be used to pay hospitals in large urban areas starting for discharges in FY2004. The Secretary will compute one local standardized amount for all hospitals in Puerto Rico equal to that for hospitals in large urban areas in Puerto Rico starting for discharges in FY2004. The existing single standardized amount will continue for hospitals that are not in Puerto Rico are not affected. Hospitals in Puerto Rico will receive the legislated payment increase starting for discharges on April 1, 2004.

Enhanced Disproportionate Share Hospital (DSH) Treatment for Rural Hospitals and Urban Hospitals with Fewer than 100 Beds (Section 402 of the Conference Agreement, Section 401 of the House Bill, and Section 404 of the Senate Bill).

Present Law

Medicare makes additional payments to certain acute hospitals that serve a large number of low-income Medicare and Medicaid patients as part of its inpatient prospective payment system (IPSS). As specified by BIPA, starting with discharges occurring on or after April 1, 2001, all hospitals are eligible to receive Medicare disproportionate share hospital (DSH) payments when their DSH patient percentage or threshold amount exceeds 15%. Different formulas are used to establish a hospital's DSH payment adjustment, depending upon the hospital's location, number of beds and status as a rural referral center (RRC) or sole community hospital (SCH). Although a SCH or RRC can qualify for a higher DSH adjustment, generally, the DSH adjustment that a small urban or rural hospital can receive is limited to 5.25%. Large (100 beds and more) urban hospitals and large rural hospitals (500 beds and more) are eligible for a higher adjustment that can be significantly greater; the amount of the DSH adjustment received by these larger hospitals will depend upon its DSH percentage. Certain urban hospitals (Pickle hospitals) receive DSH payments under an alternative formula that considers the proportion of a hospital's patient care revenues that are received from state and local indigent care funds.

House Bill

Starting for discharges after October 1, 2003, a hospital that is not a large urban hospital that qualifies for a DSH adjustment would receive its DSH payments using the current DSH adjustment formula for large urban hospitals, subject to a limit. The DSH adjustment for any of these hospitals, except for rural referral centers, would be capped at 10%. A Pickle hospital receiving a DSH adjustment under the alternative formula would not be affected.

Senate Bill

Starting for discharges after October 1, 2004, a hospital that qualifies for a DSH adjustment when its DSH patient percentage exceeds the 15% DSH threshold would receive the DSH payments using the current formula that establishes the DSH adjustment for a large urban hospital. A Pickle hospital receiving a DSH adjustment under the alternative formula would not be affected.

Conference Agreement

Starting for discharges after April 1, 2004, a hospital that is not a large urban hospital that qualifies for a DSH adjustment will receive its DSH payments using the current DSH adjustment formula for large urban hospitals, subject to a limit. The DSH adjustment for any of these hospitals, except for rural referral centers, will be capped at 12%. A Pickle hospital receiving a DSH adjustment under the alternative formula will not be affected by this provision.

Adjustment of the Medicare Inpatient Hospital Prospective Payment System Wage Index to Revise the Labor-Related Share of Such Index (Section 403 of the Conference Agreement, Section 416 of the House Bill, and Section 402 of the Senate Bill).

Present Law

Medicare's payments to acute hospitals are adjusted, either increased or decreased as appropriate, by the wage index of the area where the hospital is located or where it has been reassigned. Presently, approximately 71 percent of the standardized amount for each hospital discharge is adjusted by the area wage index. Decreasing this proportion or labor-related share would increase Medicare payments to hospitals in areas with wage indices below one and decrease Medicare payments to hospitals in areas with wage indices above one.

House Bill

For discharges occurring on or after October 1, 2003, the Secretary would be required to decrease the labor-related share to 62 percent of the standardized amount only if such change would result in higher total payments to the hospital. This provision would be applied without regard to certain budget-neutrality requirements.

Senate Bill

For cost reporting periods beginning on or after October 1, 2004, the Secretary would be required to decrease the labor-related share to 62 percent of the standardized amount only if such change would result in higher total payments to the hospital. This provision would be applied without regard to certain budget-neutrality requirements.

Conference Agreement

For discharges on or after October 1, 2004, the Secretary is required to decrease the labor-related share to 62 percent of the standardized amount when such change will result in higher total payments to the hospital. This provision is applied without regard to certain budget-neutrality requirements. For discharges on or after October 1, 2004, the Secretary is also required to decrease the labor-related share to 62 percent of the standardized amount for hospitals in Puerto Rico when such change results in higher total payments to the hospital.

More Frequent Update in Weights Used in Hospital Market Basket (Section 404 of the Conference Agreement and Section 404 of the House Bill).

Present Law

Medicare's standardized amounts, which serve as the basis of its payment per discharge from an acute hospital, are increased annually using an update factor that is determined in part by the projected increase in the hospital market basket. The market basket is a fixed-weight hospital input price index, which measures the average change in the price of goods and services that hospitals purchase in order to furnish inpatient care. The Centers for Medicare and Medicaid Services (CMS) revises the cost category weights, reevaluates the price proxies for such categories, and rebases (or changes the base period) for the market basket every 5 years. CMS implemented a revised and rebased market basket using 1997 cost data to set the FY2003 Medicare hospital payment rates.

House Bill

The Secretary would be required to revise the market basket weights to reflect the most currently available data and to establish a schedule for revising the cost category weights more often than once every 5 years. The Secretary would be required to submit a report to Congress by October 1, 2004 on the reasons for and the options considered in establishing such a schedule.

Senate Bill

No provision.

Conference Agreement

The Secretary is required to revise the market basket weights to reflect the most currently available data and to establish a schedule for revising the cost category weights more often than once every 5 years.

The Secretary is required to publish the reasons for and the options considered in establishing such a schedule in the final rule establishing FY2006 inpatient hospital payments.

Improvements to the Critical Access Hospital (CAH) Program (Section 405 of the Conference Agreement, Section 405 of the House Bill, and Section 405 of the Senate Bill).

Increase in Payment Amounts (Section 405(a) of the Conference Agreement and Section 405(a) of the House Bill).

Present Law

Generally, a critical access hospital (CAH) receives reasonable cost reimbursement for care rendered to Medicare beneficiaries. CAHs may elect either a cost-based hospital outpatient service reimbursement or an all-inclusive rate, which is equal to a reasonable cost reimbursement for facility services plus 115 percent of the fee schedule payment for professional services. Ambulance services that are owned and operated by CAHs are reimbursed on a reasonable cost basis if these ambulance services are 35 miles from another ambulance system.

House Bill

Inpatient, outpatient, and covered skilled nursing facility services provided by a CAH would be reimbursed at 102 percent of reasonable costs of services furnished to Medicare beneficiaries. This provision would apply to cost reporting periods beginning on or after October 1, 2003.

Senate Bill

No provision.

Conference Agreement

Inpatient, outpatient, and covered skilled nursing facility services provided by a CAH will be reimbursed at 101 percent of reasonable costs of services furnished to Medicare beneficiaries. This provision applies to cost reporting periods beginning on or after January 1, 2004.

Coverage of Costs For Certain Emergency Room On-Call Providers (Section 405(b) of the Conference Agreement, Section 405(b) of the House Bill, and Section 405(c) of the Senate Bill).

Present Law

BIPA required the Secretary to include the costs of compensation (and related costs) of on-call emergency room physicians who are not present on the premises of a CAH, are not otherwise furnishing services, and are not on-call at any other provider or facility when determining the allowable, reasonable cost of outpatient CAH services.

House Bill

Reimbursement of on-call emergency room providers would be expanded to include the costs associated with physician assistants, nurse practitioners, and clinical nurse specialists as well as emergency room physicians for covered Medicare services. This provision would apply to costs for services provided on or after January 1, 2004.

Senate Bill

The provision would expand reimbursement of on-call emergency room providers to include physician assistants, nurse practitioners, and clinical nurse specialists as well as emergency room physicians for covered Medicare services provided on or after January 1, 2005.

Conference Agreement

The provision expands reimbursement of on-call emergency room providers to include physician assistants, nurse practitioners, and clinical nurse specialists as well as emergency room physicians for the costs associated with covered Medicare services provided on or after January 1, 2005.

Authorization of Periodic Interim Payment (PIP) (Section 405(c) of the Conference Agreement, Section 405(d) of the House Bill, and Section 405(d) of the Senate Bill).

Present Law

Eligible hospitals, skilled nursing facilities, and hospices which meet certain requirements receive Medicare periodic interim payments (PIP) every 2 weeks; these payments are based on estimated annual costs without regard to the submission of individual claims. At the end of the year, a settlement is made to account for any difference between the estimated PIP payment and the actual amount owed. A CAH is not eligible for PIP payments.

House Bill

An eligible CAH would be able to receive payments made on a PIP basis for its inpatient services. The Secretary would be required to develop alternative methods based on the expenditures of the hospital for these PIP payments. This provision would apply to payments made on or after January 1, 2004.

Senate Bill

Starting with payments made on or after January 1, 2005, an eligible CAH would be able to receive payments made on a PIP basis for inpatient services. The provision would apply to payments for inpatient CAH services furnished on or after January 1, 2005.

Conference Agreement

An eligible CAH will be able to receive payments made on a PIP basis for its inpatient services. The Secretary is required to develop alternative methods for the timing of PIP payments to these CAHs. This provision applies to payments made on or after July 1, 2004.

Condition for Application of Special Professional Service Payment Adjustment (Section 405(d) of the Conference Agreement and Section 405(e) of the House Bill).

Present Law

As specified by BBRA, CAHs can elect to be paid for outpatient services using cost-based reimbursement for its facility fee and at 115 percent of the fee schedule for professional services otherwise included within its outpatient critical access hospital services for cost reporting periods starting on or after October 1, 2000.

House Bill

The Secretary would not be able to require that all physicians providing services in a CAH assign their billing rights to the entity in order for the CAH to be able to be paid on the basis of 115 percent of the fee schedule for the professional services provided by the physicians. However, a CAH would not receive payment based on 115 percent of the fee schedule for any individual physician who did not assign billing rights to the CAH. This provision would be effective as if it had been included as part of BBRA.

Senate Bill

No provision.

Conference Agreement

The Secretary cannot require that all physicians or practitioners providing services in a CAH assign their billing rights to the entity in order for the CAH to be able to be paid on the basis of 115 percent of the fee schedule for the professional services provided by the physicians. However, a CAH will not receive payment based on 115 percent of the fee schedule for any individual physician or practitioner who did not assign billing rights to the CAH. This provision applies to cost report periods starting on or after July 1, 2004 except for those CAHs that have already elected payment for physician services on this basis in the past; this provision will apply to those CAHs starting for cost reporting periods on or after July 1, 2003.

Revision in Bed Limitation for Hospitals (Section 405(e) of the Conference Agreement, Section 405(f) of the House Bill, and Section 405(a) of the Senate Bill).

Present Law

A CAH is a limited service facility that must provide 24-hour emergency services and operate a limited number of inpatient beds in which hospital stays can average no more than 96 hours. A CAH cannot operate more than 15 acute-care beds at one time, but can have an additional 10 swing beds that are set up for skilled nursing facility (SNF) level care. SNF beds in a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time of the facility's application for CAH designation are not counted toward these bed limits.

House Bill

The Secretary would be required to specify standards for determining whether a CAH has seasonal variations in patient admissions that would justify a 5-bed increase in the number of beds it can maintain (and still retain its classification as a CAH). CAHs that operate swing beds would be able to use up to 25 beds for acute care services as long as no more than 10 beds at any time are used for non-acute services. Those CAHs with swing beds that made this election would not be eligible for the 5-bed seasonal adjustment. A CAH with swing beds that elects to operate 15 of its 25 beds as acute care beds would be eligible for the 5-bed seasonal adjustment. These provisions would only apply to CAH designations made before, on, or after January 1, 2004.

Senate Bill

A CAH would be able to operate up to 25 swing beds or acute care beds, subject to the 96 hour average length of stay for acute care patients. The requirement that only 15 of the 25 beds be used for acute care at any time would be dropped. The provision would be effective for designations made on or after October 1, 2004.

Conference Agreement

A CAH will be able to operate up to 25 beds. The requirement that only 15 of the 25 beds be used for acute care at any time will be dropped. The provision will apply to CAH designations made before, on, or after January 1, 2004, but any election made pursuant to the regulations promulgated to implement this provision will only apply prospectively.

Provisions Relating to FLEX Grants (Section 405(f) of the Conference Agreement, Section 405(g) of the House Bill, and Section 405(f) of the Senate Bill).

Present Law

The Secretary is able to make grants for specified purposes to states or eligible small rural hospitals that apply for such awards. For example, the Medicare Hospital Flexibility Program awards grants to states for rural health care planning and implementation activities, rural network development and implementation, to establish or expand rural emergency medical services and for CAH designations.

The Secretary may also award grants to hospitals to assist eligible small rural hospitals in implementing data systems required under BBA 1997. Small rural hospitals are short term general hospitals with less than 50 beds that are located in rural areas.

Funding for the rural hospital flexibility grant program was $25 million from FY1999 through FY2001; $40 million in FY2002; and $25 million in 2003. The authorization to award the grants expired in FY2002.

House Bill

The authorization to award grants would be established from FY2004 through FY2008 from the Federal Hospital Insurance Trust Fund at amounts of up $25 million each year. The provision would be effective upon enactment.

Senate Bill

The provision would permit the Secretary to award grants under the Small Rural Hospital Improvement Program to hospitals that have submitted applications to assist eligible small rural hospitals in reducing medical errors, increasing patient safety, protecting patient privacy, and improving hospital quality. These grants would not exceed $50,000 and would be able to be used to purchase computer software and hardware, educate and train hospital staff, and obtain technical assistance. The provision would authorize appropriations of $40 million each year from FY2004 through FY2008 from the Federal Hospital Insurance Trust Fund for grants to states for specified purposes. States that are awarded grants would be required to consult with the hospital association and rural hospitals in the state on the most appropriate way to use such funds. The provision would also authorize $25 million each year from FY2004 through FY2008 for the Small Rural Hospital Improvement Program. This amount would be appropriated from amounts in the treasury not otherwise appropriated.

The provisions would be effective upon enactment. They would apply to grants awarded on or after the date of enactment and would apply to grants awarded prior to the date of enactment to the extent that the funds have not yet been obligated.

Conference Agreement

The authorization to award rural hospital flexibility grants is established at $35 million each year from FY2005 through FY2008. Starting with funds appropriated for FY2005 and in subsequent years, a state is required to consult with the hospital association and rural hospitals in the state on the most appropriate way to use such funds. A state may not spend more than 15% of the grant amount or the states federally negotiated indirect rate for administrative purposes. Beginning with FY2005 up to 5% of the total amount appropriated for grants will be available to the Health Resources and Services Administration for administering these grants.

Exclusion of Certain Beds from Bed Count and Removal of Barriers to Establishment of Distinct Part Units (Section 405(g) of the Conference Agreement and Section 405(g) of the Senate Bill).

Present Law

Beds in distinct part psychiatric or rehabilitation units operated by an entity seeking to become a CAH would not count toward the bed limit.

House Bill

No provision.

Senate Bill

The Secretary would not be able to count any beds in a distinct part psychiatric or rehabilitation unit operated by the entity seeking to become a CAH. The total number of beds in these distinct part units would not be able to exceed 25. A CAH would be able to establish a distinct part psychiatric or rehabilitation unit. The provision would apply to designations on or after October 1, 2003.

Conference Agreement

A CAH can establish a distinct part psychiatric or rehabilitation unit that meets the applicable requirements for such beds established for a short-term, general hospital, specifically, a subsection (d) hospital as defined in 1886(d)(1)(B). If the distinct part units do not meet these requirements during a cost reporting period, then no Medicare payment will be made to the CAH for services furnished in the unit during the period. Medicare payments will resume only after the CAH demonstrates that the requirements have been met. Medicare payments for services provided in the distinct part units will equal payments that are made on a prospective payment basis to distinct part units of short term general hospitals. The Secretary will not count any beds in the distinct part psychiatric or rehabilitation units toward the CAH bed limit. The total number of beds in these distinct part units cannot exceed 10. The provision will apply to cost reporting periods starting October 1, 2004.

Waiver Authority (Section 405(h) of the Conference Agreement).

Present Law

Currently to qualify as a CAH, the rural, for-profit, non profit or public hospital must be located more than 35 miles from another hospital or 15 miles in areas with mountainous terrain or those where only secondary roads are available. These mileage standards may be waived if the hospital has been designated by the state as a necessary provider of health care.

House Bill

No provision.

Senate Bill

No provision.

Conference Report

Currently to qualify as a CAH, the rural, for-profit, non profit or public hospital must be located more than 35 miles from another hospital or 15 miles in areas with mountainous terrain or those where only secondary roads are available. These mileage standards may be waived if the hospital has been designated by the state as a necessary provider of health care. This authority is eliminated 2 years after enactment.

Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals (Section 406 of the Conference Agreement and Section 403 of the Senate Bill).

Present Law

Medicare pays inpatient acute hospital services on a discharge basis without regard for the number of beneficiaries discharged from any given hospital. Under certain circumstances, however, sole community hospitals (SCHs) and Medicare dependent hospitals with more than a 5% decline in total discharges from one period to the next may apply for an adjustment to their payment rates to partially account for higher costs associated with a drop in patient volume due to circumstances beyond its control.

House Bill

No provision.

Senate Bill

The provision would require the Secretary to provide for a graduated adjustment to Medicare's inpatient payment rates to account for the higher unit costs associated with low-volume hospitals. Certain hospitals with fewer than 2,000 total discharges during the 3 most recent cost reporting periods would be eligible for up to a 25% increase in their Medicare payment amount starting for FY2005 cost reporting periods. Eligible hospitals would be located at least 15 miles from a similar hospital or those determined by the Secretary to be so located due to factors such as weather conditions, travel conditions, or travel time to the nearest alternative source of appropriate inpatient care. Certain budget-neutrality requirements would not apply to this provision.

Conference Agreement

The Secretary is required to provide for a graduated adjustment to Medicare's inpatient payment rates to account for the higher unit costs associated with low-volume hospitals starting for discharges occurring in FY2005. The Secretary shall determine the empirical relationship between the standardized cost per case, the number of discharges, and the additional incremental costs (if any) for low-volume hospitals; the percentage payment increase for these hospitals will be based on this relationship, but in no case will be greater than 25%. A low-volume hospital is a short-term general hospital (as defined by 1886(d)(B) of the Social Security Act or SSA) that is located more than 25 road miles from another such hospital and that has less than 800 discharges during the fiscal year. A discharge means an inpatient acute care discharge of an individual regardless of whether the individual is entitled to Part A benefits. Certain budget-neutrality requirements would not apply to this provision. The determination of the percentage payment increase is not subject to administrative or judicial review.

Treatment of Missing Cost Reporting Periods for Sole Community Hospitals (Section 407 of the Conference Agreement and Section 414 of the House Bill).

Present Law

Sole community hospitals (SCHs) are hospitals that, because of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, are the sole source of inpatient services reasonably available in a geographic area, or are located more than 35 road miles from another hospital. The primary advantage of an SCH classification is that these hospitals receive Medicare payments based on the current national PPS national standardized amount or on hospital-specific per discharge costs from either FY 1982, FY1987 or FY1996 updated to the current year, whatever amount will provide the highest Medicare reimbursement. The FY1996 base year option became effective for discharges on or after FY2001 on a phased in basis and will be fully implemented for SCH discharges on or after FY2004.

House Bill

A hospital would not be able to be denied treatment as a SCH or receive payment as a SCH because data are unavailable for any cost reporting period due to changes in ownership, changes in fiscal intermediaries, or other extraordinary circumstances, so long as data from at least one applicable base cost reporting period is available. The provision would apply to cost reporting periods beginning on or after January 1, 2004.

Senate Bill

No provision.

Conference Agreement

A hospital will not be able to be denied treatment as a SCH or receive payment as a

SCH because data are unavailable for any cost reporting period due to changes in ownership, changes in fiscal intermediaries, or other extraordinary circumstances, so long as data from at least one applicable base cost reporting period is available. The provision applies to cost reporting periods beginning on or after January 1, 2004.

Recognition of Attending Nurse Practitioners as Attending Physicians to Serve Hospice Patients (Section 408 of the Conference Agreement, Section 409 of the House Bill, and Section 407 of the Senate Bill).

Present Law

Medicare covers hospice services to care for the terminal illnesses of the beneficiary. In general, beneficiaries who elect the hospice benefit give up other Medicare services that seek to treat the terminal illness or that duplicate services provided by the hospice. Services are provided primarily in the patient's home by a Medicare approved hospice. Reasonable and necessary medical and support services for the management of the terminal illness are furnished under a written plan-of-care established and periodically reviewed by the patient's attending physician and the hospice. To be eligible for Medicare's hospice care, a beneficiary must be certified as terminally ill by an attending physician and the medical director or other physician at the hospice and elect hospice treatment. An attending physician who may be an employee of the hospice is identified by the patient as having the most significant role in the determination and delivery of the patient's medical care when the patient makes an election to receive hospice care.

House Bill

A beneficiary electing hospice care would be able to identify a nurse practitioner as an attending physician. This nurse practitioner would not be able to certify the beneficiary as terminally ill for the purpose of entering hospice care. The provision would be effective upon enactment.

Senate Bill

A terminally ill beneficiary under hospice care would be able to receive services provided by a physician assistant, nurse practitioner, or clinical nurse specialist who is not an employee of the hospice program and who the beneficiary identifies, when electing hospice care, as the health care provider having the most significant role in the determination of medical care provided to the beneficiary. A physician assistant, nurse practitioner, or clinical nurse specialist so identified by the beneficiary would be able to periodically review the beneficiary's written plan of care. The amendments would apply to hospice care furnished on or after October 1, 2004.

Conference Agreement

The conference agreement expands the definition of attending physician in hospice to include a nurse practitioner. A nurse practitioner is not permitted to certify a beneficiary as terminally ill for the purposes of receiving the hospice benefit. The provision would be effective upon enactment.

Rural Hospice Demonstration Project (Section 409 of the Conference Agreement and Section 418 of the House Bill).

Present Law

Medicare's hospice services are provided primarily in a patient's home to beneficiaries who are terminally ill and who elect such services. Medicare law prescribes that the aggregate number of days of inpatient care provided to Medicare beneficiaries who elect hospice care in any 12-month period cannot exceed 20% of the total number of days of hospice coverage provided to these persons.

House Bill

The Secretary would be required to establish a demonstration project of no more than 5 years in 3 hospice programs to deliver hospice care to Medicare beneficiaries in rural areas. Those Medicare beneficiaries who lack an appropriate caregiver and are unable to receive home-based hospice care would be able to receive hospice care in a facility of 20 or fewer beds that offers a full range of hospice services within its walls. The facility would not be required to offer services outside of the home and the limit on the aggregate number of inpatient days provided to Medicare beneficiaries who elect hospice care would be waived. The Secretary would be able to require the program to comply with additional quality assurance standards. Payments for the hospice care would be made at the rates that would be otherwise applicable to Medicare. Upon completion of the demonstration project, the Secretary would be required to submit a report to Congress, including recommendations, regarding the extension of the project to hospice programs serving rural areas.

Senate Bill

No provision.

Conference Agreement

The conference agreement requires the Secretary to establish a demonstration project in 3 hospice programs to deliver hospice care to Medicare beneficiaries in rural areas. A project is not permitted to last longer than 5 years. Those Medicare beneficiaries who lack an appropriate caregiver and are unable to receive home-based hospice care could receive hospice care in a facility of 20 or fewer beds that offers a full range of hospice services within its walls. The facility will not be required to offer services outside of the home. The limit on the aggregate number of inpatient days provided to Medicare beneficiaries who elect hospice care is waived under the demonstration. The Secretary may require the program to comply with additional quality assurance standards. Payments for the hospice care will be made at the rates that would be otherwise applicable to Medicare. Upon completion of the demonstration project, the Secretary is required to submit a report to Congress, including recommendations, regarding the extension of the project to hospice programs serving rural areas.

Establishment of Essential Rural Hospital Classification (Section 403 of the House Bill).

Present Law

Under current law, a critical access hospital (CAH) is a limited service facility that must provide 24-hour emergency services and operate a limited number of inpatient beds in which hospital stays can average no more than 96 hours. A CAH is exempt from Medicare's inpatient prospective payment system (IPPS) and receives reasonable cost reimbursement for care rendered to Medicare beneficiaries. Certain acute care general hospitals, particularly those facilities identified as isolated or essential hospitals primarily located in rural areas, receive special treatment under IPPS.

House Bill

The definition of CAH hospitals and services would be amended to add an essential rural hospital. An essential rural hospital would apply for such a classification, would have more than 25 licensed acute care beds, and would be located in a rural area as defined by IPPS. The Secretary would have to determine that the closure of this hospital would significantly diminish the ability of beneficiaries to obtain essential health care services based on the certain criteria. Specifically, the Secretary would determine that high proportion of Medicare beneficiaries residing in the service area of the hospital received basic inpatient care from the hospital; a hospital with more than 200 licensed beds would have to provide specialized surgical care to a high percentage of beneficiaries residing in the area who were hospitalized during the most recent year for which data are available. Regardless of the size of the hospital, almost all physicians in the area would have to have admitting privileges and provide their inpatient services primarily at the hospital. Also, the Secretary would have to determine the closure of the hospital would have a significant adverse impact on the availability of health care service in the absence of the hospital. In making such determination, the Secretary may also consider: (1) whether ambulatory care providers in the hospital's area are insufficient to handle the outpatient care of the hospital; (2) whether beneficiaries would have difficulty accessing care; and (3) whether the hospital has a significant commitment to provide graduate medical education in a rural area. The essential rural hospital would have to have a quality of care score above the median score for hospitals in the State. A hospital classified as an essential rural hospital would not be able to change such classification and would not be able to be treated as a sole community hospital, Medicare dependent hospital or rural referral center under IPPS. A hospital that is classified as an essential rural hospital for a cost reporting period beginning on or after October 1, 2004 would be reimbursed 102% of its reasonable costs for inpatient and outpatient services provided by acute hospitals Beneficiary cost-sharing amounts would not be affected and required billing for such services would not be waived. The provision would apply to cost reporting periods beginning on or after October 1, 2004.

Senate Bill

No provision.

Conference Agreement

No provision.

Modification of the Isolation Test for Cost-Based CAH Ambulance Services (Section 405(c) of the House Bill and Section 405(b) of the Senate Bill).

Present Law

Ambulance services provided by a CAH or provided by an entity that is owned or operated by a CAH is paid on a reasonable cost basis and not the ambulance fee schedule, if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of the CAH.

House Bill

The 35-mile requirement would not apply to the ambulance services that are furnished after the first cost reporting period beginning after the date of enactment by a provider or supplier of ambulance services who is determined by the Secretary to be a first responder to emergencies. This provision would apply to ambulance services furnished on or after the first cost reporting periods that begins after the date of enactment.

Senate Bill

The provision would drop the requirement that the CAH or the related entity be the only ambulance provider with a 35-mile drive in order to receive reasonable cost reimbursement for the ambulance services. The provision would apply to services furnished on or after January 1, 2005.

Conference Agreement

No provision.

Exclusion of New CAHs from PPS Hospital Wage Index Calculation (Section 405(e) of the Senate Bill).

Present Law

Certain qualified small hospitals are converting to CAHs. After conversion, these facilities are paid on a reasonable cost basis and are not paid under the hospital inpatient prospective payment system (IPPS). Medicare's IPPS payments to acute hospitals are adjusted by the wage index of the area where the hospital is located or has been reassigned. Although the hospital wage index is recalculated annually, the wage index for any given fiscal year is based on data submitted as part of a hospital's cost report from 4 years previously. As established by regulation, starting for FY2004 payments, wage data from hospitals that have converted to CAHs will be excluded in the IPPS wage index calculation.

House Bill

No provision.

Senate Bill

The Secretary would be required to exclude wage data from hospitals that have converted to CAHs from the IPPS wage index calculation starting for cost reporting periods on or after January 1, 2004. The provision would be effective upon enactment.

Conference Agreement

No provision.

Rural Community Hospital Demonstration Program (Section 410A of the Conference Report and Section 414 of the Senate Bill).

Present Law

No provision

House Bill

No provision.

Senate Bill

The Secretary would be required to establish a 5-year rural community hospital (RCH) demonstration program in 4 areas including Kansas and Nebraska that will pay for acute inpatient services, outpatient services, and certain home health services in qualifying hospitals either on the basis of its reasonable costs (without regard to the amount of customary charges) or using the respective prospective payment systems for those services. In this instance, reasonable cost reimbursement of capital costs would include a return on equity payment of 150% of the average rate of interest on obligations issued for purchase by the Federal Hospital Insurance (HI) Trust Fund.

Eligible rural hospitals would be those (1) located in counties that have not been assigned to metropolitan statistical areas or those urban hospitals that have been designated as rural; (2) with less than 51 acute inpatient beds (psychiatric and rehabilitation beds in distinct part units would not be counted); (3) offering 24-hour emergency care services; and (4) have a provider agreement in effect and is open to the public as of January 1, 2003. Critical access hospitals would be able to participate in the demonstration. Entities with replacement facilities, obtaining a new provider number because of an ownership change, or with a binding agreement for the construction, reconstruction, lease, rental or financing of building on January 1, 2003 would not be prohibited from participating. A qualified-RCH based home health agency would be a provider based agency that is located in a county in which no main or branch office of another home health agency is located or is at least 35 miles from any main or branch office of another home health agency.

Consolidated billing associated with skilled nursing facilities would be permitted. The cost of Medicare beneficiaries' bad debt would be reimbursed at 100%. Beneficiary copayments for hospital outpatient services would established as under the hospital outpatient prospective payment system. No cost sharing would apply to clinical diagnostic laboratory services. The cost sharing amounts associated with other services would be established according to the payment methodology selected by the provider for the services in question. Funding for the demonstration project would be transferred in appropriate proportions from the HI and the Federal Supplementary Insurance trust funds. The Secretary would be required to ensure that aggregate payments under this demonstration program do not exceed what would have been spent if the program had not been implemented. The Secretary would be permitted to waive administrative, peer review as well as fraud and abuse requirements in Title 11 and other Medicare requirements in Title 18 of the Social Security Act. The Secretary would be required to submit a report including recommendations to Congress no later than 6 months after completion of the demonstration. The Secretary would be required to implement the demonstration no later than January 1, 2005, but not before October 1, 2004.

Conference Agreement

The Secretary is required to establish a demonstration program in rural areas to test different payment methods for under 50 bed rural hospitals. The hospitals are paid their costs for inpatient and extended care (swing-bed) services for 5 years, subject to a cap. The payment methodology is similar to the Tefra payment system used for Children's hospitals. The hospitals cannot be eligible for the CAH program.

Critical Access Hospital Improvement Demonstration Program (Section 415 of the Senate Bill).

Present Law

No provision

House Bill

No provision.

Senate Bill

The Secretary would be required to establish a 5-year critical access hospital (CAH) demonstration program in 4 areas including Kansas and Nebraska to test various methods to improve the CAH program. Participating CAHs would be able to maintain distinct part psychiatric and rehabilitation units of up to 10 beds that would not be counted toward the CAH-bed limit. These psychiatric and rehabilitation services would be paid on a reasonable cost basis (without regard to the amount of customary charges). Home health agencies operated by participating CAHs would be able to opt out of the home health prospective payment system (PPS) and would be reimbursed on the basis of reasonable costs (without regard to the customary charge limit). Distinct part skilled nursing facilities (SNF) operated by a CAH would be exempt from SNF-PPS and would be reimbursed on the basis of reasonable costs (without regard to the customary charge limit). Consolidated billing associated with skilled nursing facilities would be permitted. In this instance reasonable cost reimbursement of capital costs associated with inpatient, outpatient, extended care, post-hospital extended care, home health, and ambulance services would include a return on equity payment of 150% of the average rate of interest on obligations issued for purchase by the Federal Hospital Insurance (HI) Trust Fund.

Eligible CAHs in the 4 demonstration areas would have to apply to participate in the demonstration project. Funding for the demonstration project would be transferred in appropriate proportions from the HI and the Federal Supplementary Insurance trust funds. The Secretary would be required to ensure that aggregate payments under this demonstration program do not exceed what would have been spent if the program had not been implemented. The Secretary would be permitted to waive administrative, peer review as well as fraud and abuse requirements in Title 11 and other Medicare requirements in Title 18 of the Social Security Act. The Secretary would be required to submit a report including recommendations to Congress no later than 6 months after completion of the demonstration. The Secretary would be required to implement the demonstration no later than January 1, 2005, but not before October 1, 2004.

Conference Agreement

No provision.

Increase in Payments for Certain Services Furnished by Small Rural Hospitals Under Medicare Prospective Payment System for Hospital Outpatient Department Services (Section 424 in the Senate Bill).

Present Law

Under the OPPS, which was implemented in August, 2000, Medicare pays for covered services using a fee schedule based on ambulatory payment classifications (APCs). Beneficiary copayments are established as a percentage of Medicare's fee schedule payment and differ by APC. Certain hospitals, including rural hospitals with no more than 100 beds, are protected from financial losses that result from implementation of the new outpatient PPS under hold harmless provisions.

House Bill

No provision.

Senate Bill

The provision would increase Medicare payments for covered outpatient clinic and emergency room visits that are provided by rural hospitals with up to 100 beds on or after January 1, 2005 and before January 1, 2008. Applicable Medicare outpatient fee schedule amounts would be increased up by 5%. The beneficiary copayment amounts for these services would not be affected. The resulting increase in Medicare payments would not be considered as PPS payments when calculating whether a rural hospital's PPS payments are less than its pre-BBA payment amounts under the temporary hold harmless provisions. Also, the budget-neutrality provisions for Medicare's outpatient PPS would not be applicable. Finally, these increased payments would not affect Medicare payments for covered outpatient services after January 1, 2007.

Conference Agreement

No provision.

Subtitle B—Provisions Relating to Part B Only

2-Year Extension of Hold Harmless Provisions for Small Rural Hospitals and Sole Community Hospitals Under Prospective Payment System for Hospital Outpatient Department Services (Section 411 of the Conference Agreement, Section 407 of the House Bill, and Section 423 of the Senate Bill).

Present Law

The prospective payment system (PPS) for services provided by outpatient departments (OPD) was implemented in August, 2000 for most acute care hospitals. Under the OPD PPS, Medicare pays for covered services using a fee schedule based on ambulatory payment classifications (APCs). Rural hospitals with no more than 100 beds are paid no less under this PPS system than they would have received under the prior reimbursement system for covered OPD services because of hold harmless provisions. The hold harmless provisions apply to services provided before January 1, 2004.

House Bill

The hold harmless provisions governing OPD reimbursement for small rural hospitals would be extended until January 1, 2006. The hold harmless provisions would be extended to sole community hospitals located in a rural area starting for services furnished on or after January 1, 2004 until January 1, 2006. The Secretary would be required to conduct a study to determine if the costs, by APC groups, incurred by rural providers exceed those costs incurred by urban providers. If appropriate, the Secretary would provide a payment adjustment to reflect the higher costs of rural providers by January 1, 2005.

Senate Bill

The hold harmless provisions governing OPD reimbursement for small rural hospitals would be extended until January 1, 2006. These hold harmless provisions would be extended to sole community hospitals located in rural areas for services provided in 2006.

Conference Agreement

The hold harmless provisions governing OPD reimbursement for small rural hospitals are extended until January 1, 2006. The hold harmless provisions are extended to sole community hospitals located in a rural area starting for services furnished on or after January 1, 2004 until January 1, 2006. The Secretary is required to conduct a study to determine if the costs, by APC groups, incurred by rural providers exceed those costs incurred by urban providers. If appropriate, the Secretary will provide for a payment adjustment to reflect the higher costs of rural providers by January 1, 2006.

Establishment of Floor on Work Geographic Adjustment (Section 412 of the Conference Agreement, Section 605 of the House Bill, and Section 421 of the Senate Bill).

Present Law

Medicare's payment for physicians' services under a fee schedule has three components: the relative value for the service, geographic adjustment factors and a conversion factor into a dollar amount. A service's relative value is made up of a physician work component, a practice expense component, and a malpractice expense component. Each of these is then adjusted by a separate geographic adjustment factor and combined together to calculate an indexed relative value for that service provided in a given location. This locality adjusted relative value unit is multiplied by the conversion factor to calculate Medicare's payment for a service provided by a physician in a given area.

The geographic adjustment factors are indices that reflect the relative cost difference in a given area in comparison to the national average. An area with costs above the national average would have an index greater than 1.00; alternatively, an area with costs below the national average would have an index less than 1.00. The physician work geographic adjustment factor is based on a sample of median hourly earnings in six professional specialty occupational categories. Unlike the other geographic adjustments, the work adjustment factor reflects only one-quarter of the cost differences in an area. The practice expense adjustment factor is based on employee wages, office rents, medical equipments and supplies, and other miscellaneous expenses. The malpractice adjustment factor reflects differences in malpractice insurance costs.

The Secretary is required to periodically review and adjust the relative values affecting physician payment to account for changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. Under the budget-neutrality requirement, changes in these factors cannot cause expenditures to differ by more than $20 million from what would have been spent if such adjustments had not been made.

House Bill

For services furnished after January 1, 2004 and before January 1, 2006, the Secretary would be required to increase the value of any work geographic index that is below 1.00 to 1.00 unless the Secretary determines, based on the subsequent GAO study, that there is no sound economic rationale for such change. The provision would be effective upon enactment.

Senate Bill

For services furnished after January 1, 2004, the Secretary would be required to increase the value of any work geographic index that is below .980 to .980. The values for work index would be raised to 1.0 for services furnished in 2005, 2006, and 2007. The practice expense and malpractice geographic indices in low value localities areas would be raised to 1.00 for services furnished in 2005 through 2008.

Conference Agreement

The Secretary is required to increase the value of any work geographic index that is below 1.0 to 1.0 for services furnished on or after January 1, 2004 and before January 1, 2007.

Medicare Incentive Payment Program Improvements for Physician Scarcity (Section 413 of the Conference Agreement, Section 417 of the House Bill, and Section 422 of the Senate Bill).

Present Law

Physicians providing services in a health professional shortage area (HPSA) are entitled to an incentive payment from the Medicare program. This incentive payment is a 10% increase over the amount which would otherwise be paid under the physician fee schedule. Physicians are responsible for indicating their eligibility for this bonus on their billing forms.

House Bill

This provision would establish a new five percent bonus payment program for physicians providing care to Medicare beneficiaries in physician scarcity areas. The Secretary would calculate two measures of scarcity. A primary care scarcity area would be determined based on the number of primary care physicians per Medicare beneficiary—the primary care ratio. A specialty care scarcity area would be based on the number of specialty care physicians per Medicare beneficiary—the specialty care ratio. The number of physicians would be based on physicians who actively practice medicine or osteopathy, and would exclude physicians whose practice is exclusively for the Federal Government, physicians who are retired, or physicians who only provide administrative services.

The Secretary would rank each county or area based on its primary care ratio. Primary care scarcity counties or areas would be those counties or areas with the lowest primary care ratios, such that 20 percent of Medicare beneficiaries reside in these counties, when each county or area is weighted by the number of Medicare beneficiaries in the county or area. Specialty care scarcity counties or areas would be identified in the same manner, using the specialty care ratio. There would be no administrative or judicial review of the identification of counties or areas, or of a specialty of any physician.

To the extent feasible, the Secretary would treat a rural census tract of a metropolitan statistical area, as determined under the most recent modification of the Goldsmith Modification, as an equivalent area for purposes of qualifying as a primary care scarcity area or specialty care scarcity area.

The Secretary would be required to publish a list of all areas which would qualify as primary care scarcity counties or specialty care scarcity counties as part of the proposed and final rules to implement the physician fee schedule.

The provision would also include improvement to the Medicare Incentive Payment Program, which provides a 10 percent bonus to physicians in shortage areas. The Secretary would be required to establish procedures under which the Secretary, and not the physician furnishing the service, would be responsible for determining when a bonus payment should be made. As part of the physician proposed and final rule for the physician fee schedule, the Secretary would be required to include a list of all areas which would qualify as a health professional shortage area for the upcoming year.

Senate Bill

The Secretary would be required to establish procedures to determine when the physician is eligible for a bonus payment. The Secretary would also be required to (1) establish an ongoing program to educate physicians about the incentive program; (2) establish an ongoing study of the incentive program to determine whether beneficiaries' access to physician's services within the HPSA has improved; and (3) submit annual reports including appropriate recommendations for necessary administrative or legislative action concerning improvements to the program. GAO would be required to conduct an ongoing study of the MIP program on beneficiary access to services and submit a report, including appropriate recommendations, no later than 1 year from the date of enactment.

Conference Agreement

Additional Incentive Payment for Certain Physician Scarcity Areas (Section 413(a) of the Conference Agreement).

The Conference Agreement establishes a new 5 percent incentive payment program designed to reward both primary care and specialist care physicians for furnishing services in the areas that have fewest physicians available to serve beneficiaries. The incentive payment will be made in counties accounting for 20 percent of Medicare beneficiaries, which is likely to represent more than 20 percent of counties. As with the current HPSA bonus program, the 5 percent bonus would be added to the amount that Medicare pays after deducting beneficiary cost sharing so that beneficiaries do not pay cost-sharing on the incentive payment.

The Secretary will calculate two measures of scarcity. A primary care scarcity area will be determined based on the number of primary care physicians per Medicare beneficiary—the primary care ratio. A specialty care scarcity area will be based on the number of specialty care physicians per Medicare beneficiary—the specialty care ratio. The number of physicians will be based on physicians who actively practice medicine or osteopathy, and will exclude physicians whose practice is exclusively for the Federal Government, physicians who are retired, or physicians who only provide administrative services.

The provision requires identification of the county in which the service is furnished in order to apply to the bonus. Currently, it is the understanding of the Conferees that the address where the service is furnished, including the 5-digit zip code, is contained on the Medicare claim form. Since some zip codes cross county boundaries, the provision allows the Secretary to assign zip codes to counties based on the dominant county of the zip code as determined by the US Postal Service or otherwise. However, nothing would preclude, nor require, the Secretary ultimately to use 9–digit zip codes to determine the county in which the service is furnished. The provision requires periodic review and revision of the counties eligible for the bonus, but not less often than once every three years. To the extent feasible, the Secretary will treat a rural census tract of a metropolitan statistical area, as determined under the most recent modification of the Goldsmith Modification, as an equivalent area for purposes of qualifying as a primary care scarcity area or specialty care scarcity area.

There will be no administrative or judicial review of the designation of the county or area as a scarcity area, the designation of an individual physician's specialty, the assignment of a physician to a county or the assignment of a postal zip code to the county or other area.

The Secretary will be required to publish a list of all areas which will qualify as primary care scarcity counties or specialty care scarcity counties as part of the proposed and final rules to implement the physician fee schedule.

The list of eligible counties will be published each year in the proposed and final rule implementing the physician fee schedule. The list of counties will be posted on the Internet website of the Centers for Medicare and Medicaid Services (CMS).

The new five percent bonus for physicians in either primary care scarcity counties or specialty care scarcity counties will increase financial incentives for physicians to provide care to Medicare beneficiaries in these areas with a shortage of physicians. This bonus payment will make it easier to recruit and retain physicians in these scarcity areas.

Improvement to Medicare Incentive Payment Program (Section 413(b) of the Conference Agreement).

The Conference Agreement requires the Secretary to pay the current law 10 percent Health Professional Shortage Area (HPSA) incentive payment for services furnished in full county primary care geographic area HPSAs automatically rather than having the physician identify that the services were furnished in such area. The implementation of the incentive payment will be the same as for the physician scarcity full county incentive payments, namely use of the 5 digit zip code with the dominant county of the zip code in cases where zip codes cross county boundaries. A physician will not need to report the HPSA modifier on the claim form for services furnished in full county HSPAs.

The Conference Agreement does not contain a requirement to automate payment of incentive payments for services furnished in partial county HPSAs. However, the provision does not preclude the Secretary from automating payment in partial county HPSAs if the Secretary determines that it is feasible to do so based on information on the Medicare claim form.

The Conference Agreement requires the Secretary to develop a user friendly web site through which physicians may obtain information on partial county HPSAs to facilitate reporting of the modifier to identify the applicability of the incentive payment in partial county HPSAs. The provision requires that before the beginning of a calendar year the Secretary will identify the HPSAs for which the incentive payments will be made for such calendar year. Since HRSA designates HPSAs, HRSA will transmit to CMS the list of applicable HPSAs with enough lead time for CMS to implement the incentive payments for the following calendar year.

Improvements to the Medicare Incentive Program will shift responsibility for identifying eligibility for the 10 percent bonus from physicians to the Secretary. A service furnished in a county that is both a full county HPSA and a scarcity county would receive both bonuses—a total incentive payment of 15 percent.

GAO Study of Geographic Differences in Payments for Physicians' Services (Section 413(c) of the Conference Agreement, Section 413 of the House Bill, and Section 444 of the Senate Bill).

Present Law

No provision.

House Bill

GAO would be required to study geographic differences in payment amounts in the physician fee schedule including: (1) an assessment of the validity of each component of the geographic adjustment factors; (2) an evaluation of the measures and the frequency with which they are revised; and (3) an evaluation of the methods used to establish the costs of professional liability insurance including the variation between physician specialties and among different states, the update to the geographic cost of practice index, and the relative weights for the malpractice component. The study, including recommendations concerning use of more current data and use of cost data rather than price proxies, would be due to Congress within 1 year of enactment.

Senate Bill

GAO would be required to study geographic differences in payment amounts in the physician fee schedule including: (1) an assessment of the validity of each component of the geographic adjustment factors; (2) an evaluation of the measures and the frequency with which they are revised; (3) an evaluation of the methods used to establish the costs of professional liability insurance including the variation between physician specialties and among different states, the update to the geographic cost of practice index, and the relative weighs for the malpractice component; (4) an evaluation of the economic basis for the floors on the geographic adjustments established previously in this legislation; (5) an evaluation of the effect of the geographic adjustments on physician retention, recruitment costs, physician mobility; (6) an evaluation of the appropriateness of extending such adjustment; (7) an evaluation of the adjustment of the work geographic practice cost index to reflect ¼ the area cost difference in physician work; (8) an evaluation of the effect of the geographic practice cost index on physician location and retention in higher cost areas; and (9) an evaluation of the 1/4 adjustment of such an index. The study would include recommendations concerning use of more current data and use of cost data rather than price proxies. The study would be due to Congress within 1 year of enactment.

Conference Agreement

GAO will study payment differences under the physician fee schedule for different geographic areas, including: (1) an assessment of the validity of the geographic adjustment factors for each component of the fee schedule; (2) an evaluation of the measures used for such adjustment, including the frequency of revisions; (3) an evaluation of the method used to determine professional liability insurance costs including the variation between physician specialties and among different states, the update to the geographic cost of practice index, and the relative weighs for the malpractice component; and (4) an evaluation of the effect of the physician work geographic adjustment as modified by this legislation on physician location and retention taking into account differences in recruitment costs and retention rates for physicians (including specialists) between large urban areas and other areas and the mobility of physicians over the last decade. The study, including recommendations concerning use of more current data and use of cost data rather than price proxies, is due to Congress within 1 year of the enactment date.

Payment for Rural and Urban Ambulance Services

Phase-In Providing Floor Using Blend of Fee Schedule and Regional Fee Schedule (Section 414(a) of the Conference Agreement and Section 622 of the House Bill).

Present Law

Traditionally, Medicare has paid suppliers of ambulance services on a reasonable charge basis and paid provider-based ambulances on a reasonable cost basis. BBA 1997 provided for the establishment of a national fee schedule which was to implemented in phases, in an efficient and fair manner. The required fee schedule became effective April 1, 2002 with full implementation by January, 2006. In the transition period, a gradually decreasing portion of the payment is to be based on the prior payment methodology (either reasonable costs or reasonable charges).

House Bill

Payments for ambulance services would be based on the ambulance specific amount blended with the national fee schedule amount or a combined rate of the national fee schedule and a regional fee schedule, whichever resulted in the larger payment. The blended rate during the phase-in period would incorporate a decreasing portion of the payment based on regional fee schedules calculated for each of nine census regions. Generally, the regional fee schedules would be based on the same methodology and data used to construct the national fee schedule. For services provided in 2004, the blended rate would be based on 20% of the national fee schedule and 80% of the regional fee schedule; in 2005 blended rate would be based on a 40% national and 60% regional split; in 2006, the blended rate would be based on a 60% national and 40% regional split; in 2007, 2008 and 2009, the blended rate would be based on a 80% national and 20% regional split; and in 2010 and subsequently, the ambulance fee schedule would be based on the national fee schedule.

Senate Bill

No provision.

Conference Agreement

Payments for ambulance services will be based on the ambulance specific amount blended with either the national fee schedule amount or a combined rate of the national fee schedule and a regional fee schedule, whichever resulted in the larger payment. The blended rate during the phase-in period will incorporate a decreasing portion of the payment based on regional fee schedules calculated for each of nine census regions. Generally, the regional fee schedules will be based on the same methodology and data used to construct the national fee schedule. For 2004, starting for services on July 1, 2004, the blended rate is based on 20% of the national fee schedule and 80% of the regional fee schedule; for 2005, the blended rate is based on a 40% national and 60% regional split; in 2006, the blended rate is based on a 60% national and 40% regional split; in 2007, 2008 and 2009, the blended rate is based on a 80% national and 20% regional split; and in 2010 and subsequently, the ambulance fee schedule is based on the national fee schedule.

Adjustment in Payment for Certain Long Trips (Section 414(b) of the Conference Agreement and Section 622 of the House Bill).

Present Law

The fee schedule payment amount equals the base rate for the level of service plus payment for mileage and specified adjustment factors. Additional mileage payments are made in rural areas. BIPA increased payment for rural ambulance mileage for distances greater than 17 miles and up to 50 miles for services provided before January 1, 2004. The amount of the increase was at least one-half of the payment per mile established in the fee schedule for the first 17 miles of transport.

House Bill

Medicare's payments for ground ambulance services would be increased by one quarter of the amount otherwise established for trips longer than 50 miles occurring on or after January 1, 2004 and before January 1 2009. The payment increase would apply regardless of where the transportation originated. GAO would be required to submit an initial report to Congress on the access and supply of ambulance services in regions and states where ambulance payments are reduced by December 31, 2005. GAO would be required to submit a final report to Congress no later than December 31, 2007. The provision would apply to ambulance services furnished on or after January 1, 2004.

Senate Bill

No provision.

Conference Agreement

Medicare's payments for ground ambulance services will be increased by one quarter of the payment per mile rate otherwise established for trips longer than 50 miles occurring on or after July 1, 2004 and before January 1, 2009. The payment increase applies regardless of where the transportation originates.

Improvement in Payments to Retain Emergency Capacity For Ambulance Services in Rural Areas (Section 414(c) of the Conference Agreement and Section 410 of the House Bill).

Present Law

Traditionally, Medicare has paid suppliers of ambulance services on a reasonable charge basis and paid provider-based ambulances on a reasonable cost basis. BBA 1997 provided for the establishment of a national fee schedule which was to be implemented in phases, in an efficient and fair manner. The required fee schedule became effective April 1, 2002 with full implementation by January, 2006. In the transition period, a gradually decreasing portion of the payment is to be based on the prior payment methodology (either reasonable costs or reasonable charges).

The fee schedule payment amount equals the base rate for the level of service plus payment for mileage and specified adjustment factors. Additional mileage payments are made in rural areas. BIPA increased payment for rural ambulance mileage for distances greater than 17 miles and up to 50 miles for services provided before January 1, 2004. The amount of the increase was at least one-half of the payment per mile established in the fee schedule for the first 17 miles of transport.

House Bill

Starting for services provided January 1, 2004 the Secretary would be required to provide a percentage increase in the base rate of the fee schedule for ground ambulance services that originate in a qualified rural area. The increase would be estimated using the average cost per trip for the base rate in the lowest quartile as compared to the average cost for the base rate in the highest quartile of all rural counties. A qualified rural county is a rural area (a county not assigned to a metropolitan statistical area) with a population density of Medicare beneficiaries in the lowest quartile of all rural counties.

Senate Bill

No provision.

Conference Agreement

The Secretary will provide a percentage increase in the base rate of the fee schedule for ground ambulance services furnished on or after July 1, 2004 and before January 1, 2010 that originate in a qualified rural area. The payment increase is estimated using the average cost per trip for the base rate (not taking into account mileage) in the lowest quartile as compared to the average cost for the base rate (not taking into account mileage) in the highest quartile of all rural counties. The Secretary will determine the population density for each rural area using 2000 Census data and rank each county accordingly. The qualified rural areas are those with the lowest population densities that collectively represent a total of 25% of the population in those areas. To the extent feasible, the Secretary is required to treat certain rural census tracts in metropolitan statistical areas as a rural area. There will be no administrative or judicial review under Sections 1869 and 1878 of the SSA or otherwise with respect to the identification of a qualified rural area. In order to promptly implement this provision, the Secretary may use data furnished by GAO.

Temporary Increase for Ground Ambulance Services (Section 414(d) of the Conference Agreement and Section 425 of Senate Bill).

Present Law

The ambulance fee schedule payment amount equals the base rate for the level of service plus payment for mileage and specified adjustment factors. Additional mileage payments are made in rural areas. BIPA increased payment for rural ambulance mileage for distances greater than 17 miles and up to 50 miles for services provided before January 1, 2004. The amount of the increase was at least one-half of the payment per mile established in the fee schedule for the first 17 miles of transport.

House Bill

No provision.

Senate Bill

The payments for ground ambulance services originating in a rural area or a rural census tract would be increased by 5% for services furnished on or after January 1, 2005 through December 31, 2007. The fee schedule for ambulances in other areas would be increased by 2%. These increased payments would not affect Medicare payments for covered ambulance services in subsequent periods. The conversion factor for ambulance services would not be adjusted downward because of the Secretary's evaluation of the prior year's conversion factor.

Conference Agreement

The payments for ground ambulance services originating in a rural area or a rural census tract will be increased by 2% (after application of the long trip and low density payment increases) for services furnished on or after July 1, 2004 through December 31, 2007. The fee schedule for ambulances in other areas (after application of the long trip adjustment) will increase by 1%. These increased payments will not affect Medicare payments for covered ambulance services after 2007.

Implementation, GAO Report on Costs and Access, and Technical Amendments (Section 414(e)–(g) of the Conference Agreement).

Present Law

No provision.

House Bill

No provision.

Senate Bill

No provision.

Conference Agreement

The Secretary is able to implement the amendments made by Section 414 and revisions to the conversion factor on an interim, final basis or by program instruction. GAO is required to submit an initial report to Congress on cost differences among different types of ambulance providers, and the impact of payment reductions in the ambulance fee schedule on access, supply, and quality of ambulance services in regions and states with such reductions. Other technical amendments will also be adopted.

Providing Appropriate Coverage of Rural Air Ambulance Services (Section 415 of the Conference Agreement and Section 426 in the Senate Bill).

Present Law

Medicare pays for ambulance services under a fee schedule. Seven categories of ground ambulance services, ranging from basic life support to specialty care transport, and two categories of air ambulance services are established. Payment for ambulance services can only be made if other methods of transportation are contraindicated by the patient's medical conditions, but only to the extent provided in regulations.

House Bill

No provision.

Senate Bill

The regulations governing ambulance services would be required to ensure that air ambulance services be reimbursed if: (1) the air ambulance service is medically necessary based on the health condition of the patient being transported at or immediately prior to the time of the transport service; and (2) the air ambulance service complies with the equipment and crew requirements established by the Secretary. An air ambulance service would be considered medically necessary when requested: (1) by a physician or hospital in accordance with their responsibilities under the Emergency Medical Treatment and Active Labor Act; (2) as a result of a protocol established by a state or regional emergency medical service agency; (3) by a physician, nurse practitioner, physician assistant, registered nurse, or emergency medical responder who reasonably determines or certifies that patient's condition is such that the time involved in land transport significantly increases the patient's medical risks; or (4) by a Federal or State agency to relocate patients following a natural disaster, an act of war, or a terrorist act. Air ambulance services would be defined as a fixed wing or rotary wing air ambulance services. The provision would apply to services furnished on or after January 1, 2005.

Conference Agreement

The regulations governing the use of ambulance services will provide that to the extent that any ambulance service (whether ground or air) may be covered, a rural air ambulance service will be at the air ambulance rate if: (1) the air ambulance service is reasonable and necessary based on the health condition of the patient being transported at or immediately prior to the time of the transport service; and (2) the air ambulance service complies with the equipment and crew requirements established by the Secretary. An air ambulance service is considered reasonable and necessary when requested: (1) by a physician or other qualified medical personnel who reasonably determines or certifies that an individual's condition is such that the time needed to transport the individual by land or the instability of land transportation poses a threat to the individual's survival or seriously endangers the individual's health or (2) such services is furnished pursuant to a protocol under which the use of an air ambulance is recommended that is established by a state or regional emergency medical services (EMS) agency and recognized or approved by the Secretary. The EMS agency cannot have an ownership interest in the entity furnishing such service. Also, there cannot be a financial or employment relationship or a common ownership arrangement between the person requesting the rural air ambulance service and the furnishing entity or a financial relationship between an immediate family member of such requester and such an entity. This prohibition does not apply to instances when a hospital and an entity furnishing the rural air ambulance services are under common ownership if remuneration (through employment or other relationship) is for provider based physician services furnished in a hospital which are reimbursed under Part A and is unrelated directly or indirectly to the provision of rural air ambulance services. A rural air ambulance service is defined as a fixed wing or rotary wing air ambulance service where the individual's point of pick up is in a rural area or rural census tract. The provision applies to services furnished on or after January 1, 2005.

Treatment of Certain Clinical Diagnostic Laboratory Tests Furnished To Hospital Outpatients in Certain Rural Areas (Section 416 of the Conference Agreement and Section 427 of the Senate Bill).

Present Law

Generally, hospitals that provide clinical diagnostic laboratory tests under Part B are reimbursed using a fee schedule. Sole community hospitals (SCHs) that provide some clinical diagnostic tests 24 hours a day qualify for a 2% increase in the amounts established in the outpatient laboratory fee schedule; no beneficiary cost-sharing amounts are imposed.

House Bill

No provision.

Senate Bill

SCHs that provide clinical diagnostic laboratory tests covered under Part B in 2005 and 2006 would be reimbursed their reasonable costs of furnishing the tests. No beneficiary cost sharing amounts would apply to these services.

Conference Agreement

Hospitals with under 50 beds in qualified rural areas (low density population rural areas established under Section 414(c) of this legislation) will receive 100% reasonable cost reimbursement for clinical diagnostic laboratory tests covered under Part B that are provided as outpatient hospital services. The Secretary will apply the rules that determine whether clinical diagnostic laboratory tests are furnished as an outpatient critical access hospital service to establish whether these clinical diagnostic laboratory tests are outpatient hospital services. The provision will apply to services furnished during a cost reporting period beginning during the 2-year period starting July 1, 2004.

Extension of the Telemedicine Demonstration Project (Section 417 of the Conference Agreement and Section 415 of the House Bill).

Present Law

BBA 1997 established a single 4-year demonstration project where an eligible health care provider telemedicine network would use high-capacity computer systems and medical infomatics to improve primary care and prevent health complications in Medicare beneficiaries with diabetes mellitus. The Informatics, Telemedicine, and Education Demonstration project uses modified home computers or home telemedicine units linked to clinical information systems to assist beneficiaries residing in medically under-served rural or medically underserved inner-city areas, interaction with a nurse case manager, video conferencing, and access to health information and medical data, in both Spanish and English. The demonstration will expire in February 2004.

House Bill

The demonstration project would be extended for 4 years and total funding would be increased from $30 million to $60 million. The provision would be effective upon enactment.

Senate Bill

No provision.

Conference Agreement

The demonstration project is extended for 4 years and total funding will be increased from $30 million to $60 million. The provision will be effective upon enactment.

Report on Demonstration Project Permitting Skilled Nursing Facilities to Be Originating Telehealth Sites (Section 418 of the Conference Agreement and Section 450H of the Senate Bill).

Present Law

Medicare will pay for use of certain telecommunications systems as a substitute for face-to-face encounters to provide consultations, office or other outpatient visits, individual psychotherapy and pharmacologic management services to eligible beneficiaries. With certain exceptions, Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in either a rural health professional shortage area or in a county that is not in a metropolitan statistical area. An originating site is the location of the beneficiary at the time the services being furnished by the telecommunications system occurs. Originating sites defined in statute include the office of a physician or practitioner, a hospital, a critical access hospital, a rural health clinic or a federally qualified health center.

House Bill

No provision.

Senate Bill

This provision would add types of providers to the list of originating sites that can bill Medicare for telehealth services. The additional providers are both those defined by the statute and those that would be defined by the Secretary. Providers defined in the statute are: a skilled nursing facility (1918(a)), a community mental health center (1861(ff)(2)(B)), and a facility operated by the Indian Health Service or by an Indian tribe, tribal organization, or an urban Indian organization (as defined in Senate Section 4 of the Indian Health Care Improvement Act). Providers that would be defined by the Secretary are: an assisted-living facility, a board-and-care home, a county or community health clinic, and a long-term care facility (as defined by the Secretary.) In addition, the Secretary would be required to encourage and facilitate the adoption of State provisions allowing for multi-state practitioner licensure across State boundaries. The provision would be effective upon enactment.

Conference Agreement

The Secretary will evaluate a demonstration project under which a skilled nursing facility is treated as an originating site for telehealth services. The Secretary will delegate the evaluation to the Administrator of the Health Resources and Services Administration who will consult with the Administrator for the Centers for Medicare & Medicaid Services. No later than January 1, 2005, the Secretary will submit a report to Congress on the evaluation including recommendations on mechanisms to ensure that permitting a skilled nursing facility to serve as an originating site for the use of telehealth services or any other services delivered via a telecommunications system does not substitute for in-person required visits furnished by physicians, physician assistants, nurse practitioners or clinical nurse specialists at specified intervals as required by the Secretary. If the Secretary concludes that it is advisable to permit a skilled nursing facility to be an originating site for telehealth services, and the Secretary can establish the mechanisms to ensure such permission does not serve as a substitute for in-person visits, the Secretary may deem a skilled nursing facility to be an originating site beginning on January 1, 2006.

Exclusion of Certain Rural Health Clinic and Federally Qualified Health Center Services from the Prospective Payment System for Skilled Nursing Facilities (Section 410 of the Conference Report and 408 of the House Bill and Section 429 of the Senate Bill).

Present Law

Under Medicare's prospective payment system (PPS), skilled nursing facilities (SNFs) are paid a predetermined amount to cover all services provided in a day, including the costs associated with room and board, nursing, therapy, and drugs; the daily payment will vary depending upon a patient's therapy, nursing and special care needs as established by one of 44 resource utilization groups (RUGs). Certain services and items provided an SNF resident, such as physicians' services, specified ambulance services, chemotherapy items and services, and certain outpatient services from a Medicare-participating hospital or critical access hospital, are excluded from the SNF–PPS and paid separately under Part B.

House Bill

Services provided by a rural health clinic (RHCs) and a federally qualified health center (FQHC) after January 1, 2004 would be excluded from SNF–PPS if such services would have been excluded if furnished by a physician or practitioner who was not affiliated with an RHC or FQHC. The provisions would apply to services furnished on or after January 1, 2004.

Senate Bill

Services provided by a rural health clinic (RHC) and a federally qualified health center (FQHC) after January 1, 2005 would be excluded from SNF–PPS if such services would have been excluded if furnished by a physician or practitioner who was not affiliated with an RHC or FQHC. Outpatient services that are beyond the general scope of SNF comprehensive care plans that are provided by an entity that is 100% owned as a joint venture by two Medicare-participating hospitals or critical access hospitals would be excluded from the SNF–PPS. The provision would apply to services furnished on or after January 1, 2005.

Conference Agreement

Services provided by a rural health clinic (RHC) and a federally qualified health center (FQHC) after January 1, 2004 would be excluded from SNF–PPS if such services would have been excluded if furnished by a physician or practitioner who was not affiliated with an RHC or FQHC. The provisions would apply to services furnished on or after January 1, 2004.

Improvement in Rural Health Clinic Reimbursement (Section 428 in the Senate Bill).

Present Law

BBA 1997 extended the per visit payment limits that had existed for independent rural health clinics to provider-based rural health clinics (RHC) except for those clinics based in small rural hospitals with fewer than 50 beds. For services rendered from January 1, 2003 through February 28, 2003, the RHC upper payment limit is $66.46, which reflects a 2.6% increase in 2002 payment limit as established by the 2002 Medicare Economic Index (MEI). For services rendered from March 1, 2003 through December 31, 2003, the Medicare RHC upper payment limit is $66.72, which reflects a 3.0% increase in the 2002 payment limit as established by the 2003 MEI. The 2002 MEI was used as an update for 3 months because the delayed implementation of the 2003 MEI.

House Bill

No provision.

Senate Bill

The RHC upper payment would be increased to $80.00 for calendar year 2005. The MEI applicable to primary care services would be used to increase the payment limit in subsequent years. The provision would be effective upon enactment.

Conference Agreement

No provision.

Frontier Extended Stay Clinic Demonstration Project (Section 434 of the Conference Report and Section 457/Duplicative Provision 460 of the Senate Bill).

Present Law

No provision.

House Bill

No provision.

Senate Bill

The Secretary would be required to conduct a demonstration project that would treat frontier extended stay clinics as a Medicare provider. A frontier extended stay clinic is one that is located in a community where the closest acute care hospital or critical access hospital is at least 75 miles away or is inaccessible by public road. Such clinics are designed to address the needs of seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or patients who need monitoring and observation for a limited period of time. The provision would be effective upon enactment.

Conference Agreement

The Secretary would be required to conduct a demonstration project that would treat frontier extended stay clinics as a Medicare provider. A frontier extended stay clinic is one that is located in a community where the closest acute care hospital or critical access hospital is at least 75 miles away or is inaccessible by public road and is designed to address the needs of seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or patients who need monitoring and observation for a limited period of time. The Secretary is required to develop life safety code standards for these clinics such as sprinkler system because the patients stay overnight. The provision would be effective upon enactment and is budget neutral.

Subtitle C—Provisions Relating to Parts A and B

1-Year Increase for Home Health Services Furnished in a Rural Area (Section 421 of the Conference Agreement, Section 411 of the House Bill, and Section 451 of the Senate Bill).

Present Law

The Medicare home health PPS which was implemented on October 1, 2000 provides a standardized payment for a 60–day episode of care furnished to a Medicare beneficiary. Medicare's payment is adjusted to reflect the type and intensity of care furnished and area wages as measured by the hospital wage index. BIPA increased PPS payments by 10% for home health services furnished in the home of beneficiaries living in rural areas during the 2–year period beginning April 1, 2001, through March 31, 2003, without regard to certain budget-neutrality provisions applying to home health PPS. The temporary additional payment is not included in the base for determination of payment updates.

House Bill

The provision would extend a 5% additional payment for home health care services furnished in a rural area during FY2004 and FY2005 without regard to certain budget-neutrality requirements. The provision would be effective upon enactment.

Senate Bill

The provision would provide a temporary payment increase of 5% for home health care services furnished in a rural area on or after October 1, 2004 and before October 1, 2006 without regard to certain budget-neutrality requirements. The temporary additional payment would not be considered when determining future home health payment amounts. The provision would be effective upon enactment.

Conference Agreement

The conference agreement provides a 1-year, 5% additional payment for home health care services furnished in a rural area without regard to certain budget-neutrality requirements. The temporary additional payment begins for episodes and visits ending on or after April 1, 2004 and before April 1, 2005 and is not to be used in calculating future home health payment amounts.

Redistribution of Unused Resident Positions (Section 422 of the Conference Agreement and Section 406 of the House Bill).

Present Law

Medicare has different resident limits for counting residents in its indirect medical education (IME) adjustment and for reimbursement for a teaching hospital's direct medical education (DGME) costs. Generally, a hospital's IME adjustment depends on a hospital's teaching intensity as measured by the ratio of the number of interns and residents per bed. Prior to BBA 1997, the number of residents that could be counted for IME purposes included only those in the hospital inpatient and outpatient departments. Effective October 1, 1997, under certain circumstances a hospital may now count residents in non-hospital sites for the purposes of IME. Medicare DGME payment to a teaching hospital is based on its updated cost per resident (subject to a locality adjustment and certain payment corridors), the weighted number of approved full-time-equivalent (FTE) residents, and Medicare's share of inpatient days in the hospital. Medicare counts residents in their initial residency period (the lesser of the minimum number of years required for board eligibility in the physician's specialty or 5 years) as 1.0 FTE. Residents whose training has extended beyond their initial residency period count as 0.5 FTE. Residents in certain specialties are allowed additional years in their initial residency period. Residents who are graduates from foreign medical schools do not count unless they pass certain exams.

Generally, the resident counts for both IME and DGME payments are based on the number of residents in approved allopathic and osteopathic teaching programs that were reported by the hospital for the cost reporting period ending in calendar year 1996. The DGME resident limit is based on the unweighted resident counts. It may differ from the IME limit because in 1996 residents training in non-hospital sites were eligible for DGME payments but not for IME payments. Hospitals that established new training programs before August 5, 1997 are partially exempt from the cap. Other exceptions apply to certain hospitals including those with new programs established after that date. Hospitals in rural areas (and nonrural hospitals operating training programs in rural areas) can be paid for 130% of the number of residents allowed by their cap. Under certain conditions, an affiliated group of hospitals under a specific arrangement may combine their resident limits into an aggregate limit. Subject to these resident limits, a teaching hospital's IME and DGME payments are based on a 3-year rolling average of resident counts, that is, the resident count will be based on the average of the resident count in the current year and the 2 preceding years. The rolling average calculation includes podiatry and dental residents.

House Bill

A teaching hospitals total number of Medicare-reimbursed resident positions would be reduced for cost reporting periods starting January 1, 2004 if its resident reference level is less than its applicable resident limit. If so, the reduction would equal 75% of the difference between the hospitals limit and its resident reference level. The resident reference level would be the highest number of allopathic and osteopathic resident positions (before the application of any weighting factors) for the hospital during the reference period. A hospitals reference period would be the 3 most recent consecutive cost reporting periods for which a hospitals cost reports have been settled (or in the absence of such settled cost reports, submitted reports) on or before September 30, 2002. The Secretary would be able to adjust a hospitals resident reference level, upon the timely request for such an adjustment, for the cost reporting period that includes July 1, 2003.

The Secretary would be authorized to increase the applicable resident limits for hospitals by an aggregate number that does not exceed the overall reduction in such limits. No increase would be permitted for any portion of cost reporting period that occurs before July 1, 2004 or before the date of a hospital's application for such an increase. No increase would be permitted unless the hospital applied for such an increase by December 31, 2005. The Secretary would consider the need for an increase in the physician specialty and the location involved. The Secretary would first distribute the increased resident count to programs in hospitals located in rural areas and hospitals that are not in large urban areas on a first-come-first-served basis. The hospital would have to demonstrate that the resident positions would be filled; not more than 25 positions would be given to any hospital. These hospitals would be reimbursed for DGME for the increase in resident positions at the locality adjusted national average per resident amount. Changes in a hospitals resident count established under this section would affect a hospitals IME adjustment. These provisions would not apply to reductions in residency programs that occurred as part of the voluntary reduction program or would affect the ability of certain hospitals to establish a new medical residency training programs. The Secretary would be required to submit a report to Congress no later than July 1, 2005 on whether to extend the application deadline for increases in resident limits. The provision would be effective upon enactment.

Senate Bill

No provision.

Conference Agreement

A teaching hospital's total number of Medicare-reimbursed resident positions will be reduced for cost reporting periods starting July 1, 2005 if its reference resident level is less than its applicable resident limit. Rural hospitals with less than 250 acute care inpatient beds would be exempt from such reductions. For other such hospitals, the reduction will equal 75% of the difference between the hospital's limit and its reference resident level. The resident reference level is the highest number of allopathic and osteopathic resident positions (before the application of any weighting factors) for the hospital during the reference period. This reference level is either (1) the resident level of the most recent cost reporting period of the hospital for which a cost report has been settled (or submitted, subject to audit) on or before September 30, 2002 or (2) the resident level for the cost reporting period that includes July 1, 2003, if requested on a timely basis by the hospital subject to audit. Upon this timely request at the discretion of the Secretary, a hospital's reference level will be adjusted to include the number of medical residents for the cost reporting period that includes July 1, 2003. Upon timely request of the hospital, the Secretary will adjust the reference resident level to include the number of medical residents that were approved in an application to the appropriate accrediting organization before January 1, 2002 if the program was not in operation by the cost reporting period in question (either September 30, 2002 or July 1, 2003 depending upon the hospital's circumstances and the Secretary's approval). The reduction will apply to hospitals that are members of the same affiliated group as of July 1, 2003.

The Secretary is authorized to increase the applicable resident limits for hospitals for portions of cost reporting periods occurring on or after July 1, 2005 by an aggregate number that does not exceed the overall reduction in such limits. The Secretary will take into account the demonstrated likelihood of the hospital filling the positions within the first 3 cost reporting periods beginning on or after July 1, 2005 when determining which hospitals would receive an increase in their resident levels. The Secretary will establish a priority order to distribute the increased resident count first to programs in hospitals located in rural areas, then to hospitals that are not in large urban areas and finally to other hospitals in a state where there is no other training program for a particular specialty. The Secretary shall consider giving special consideration to hospitals that train a large share of graduates from historically large medical colleges. Increases to limits with the same priority category will be determined by the Secretary. Not more than 25 additional FTEs will be given to any hospital. These hospitals will be reimbursed for DGME for the increase in resident positions at the locality adjusted national average per resident amount. Changes in a hospital's resident count established under this section will affect a hospital's IME adjustment; the IME adjustment will be calculated as if "c" is equal to 0.66 for these additional positions starting for discharges after July 1, 2005. These provisions will not apply to reductions in residency programs that occurred as part of the voluntary reduction program or will not affect the ability of certain hospitals to establish new medical residency training programs. The Secretary is required to submit a report to Congress no later than July 1, 2005 on whether to extend the application deadline for increases in resident limits. Requirement with respect to Federal information policy established by Chapter 35 of Title 44, United States Code will not apply to applications under this section.

Subtitle D—Other Provisions

Providing Safe Harbor for Certain Collaborative Efforts that Benefit Medically Underserved Populations (Section 431 of the Conference Agreement and Section 412 of the House Bill).

Present Law

People who knowingly and willfully offer or pay a kickback, a bribe, or rebate directly or indirectly to induce referrals or the provision of services under a Federal program may be subject to financial penalties and imprisonment. Certain exceptions or safe harbors that are not considered violations of the anti-kickback statute have been established.

House Bill

Remuneration in the form of a contract, lease, grant, loan or other agreement between a public or non-profit private health center and an individual or entity providing goods or services to the health center would not be a violation of the anti-kickback statute if such an agreement would contribute to the ability of the health center to maintain or increase the availability or quality of services provided to a medically underserved population. The Secretary would be required to establish standards, on an expedited basis, related to this safe harbor that would consider whether the arrangement (1) resulted in savings of Federal grant funds or increased revenues to the health center; (2) expanded or limited a patient's freedom of choice; and (3) protected a health care professional's independence regarding the provision of medically appropriate treatment. The Secretary would also be able to include other standards that are consistent with Congressional intent in enacting this exception. The Secretary would be required to publish an interim final rule in the Federal Register no later than 180 days from enactment that would establish these standards. The rule would be effective immediately, subject to change after a public comment period of not more than 60 days. The provision would be effective upon enactment.

Senate Bill

No provision.

Conference Agreement

Remuneration in the form of a contract, lease, grant, loan or other agreement between a public or non-profit private health center and an individual or entity providing goods or services to the health center would not be a violation of the anti-kickback statute if such an agreement would contribute to the ability of the health center to maintain or increase the availability or quality of services provided to a medically underserved population. The Secretary would be required to establish standards, on an expedited basis, related to this safe harbor that would consider whether the arrangement (1) results in savings of Federal grant funds or increased revenues to the health center; (2) expands or limits a patient's freedom of choice; and (3) protects a health care professional's independence regarding the provision of medically appropriate treatment. The Secretary would also be able to include other standards that are consistent with Congressional intent in enacting this exception. The Secretary would be required to publish a final regulation establishing these standards no later than 1 year from the date of enactment.

Office of Rural Health Policy Improvement (Section 432 of the Conference Agreement and Section 637 of the Senate Bill).

Present Law

Within the Department of Health and Human Services, the Office of Rural Health Policy advises the Secretary on the effects of current policies and proposed statutory, regulatory, administrative, and budgetary changes in Medicare and Medicaid program on the financial viability of small rural hospitals, the ability of rural areas to attract and retain physicians and other health professionals, and access to and the quality of health care in rural areas. In addition to advising the Secretary, the Office has other responsibilities including coordinating the activities within HHS that relate to rural health care.

House Bill

No provision.

Senate Bill

The list of explicit responsibilities of the Office is expanded to include administering grants, cooperative agreements, and contracts to provide technical assistance and other activities as necessary to support activities related to improving health care in rural areas. The provision would be effective upon enactment.

Conference Agreement

The functions of the Office of Rural Health Policy will be expanded; it will be authorized to administer grants, cooperative agreements, and contracts to provide technical assistance and other necessary activities to support activities related to improving rural health care. The provision is effective on enactment.

MedPAC Study on Rural Payment Adjustments (Section 433 of the Conference Agreement).

Present Law

No provision.

House Bill

NO PROVISION

Conference Agreement

MedPAC will study the effect on specified rural provisions in this legislation (specifically, Sections 401 through 405, 411, 416, and 504) including total payments, growth in costs, capital spending and other payment factors. An interim report on changes to the critical access hospital program (in Section 405) is due to Congress no later than 18 months from the date of enactment. MedPAC's final report on all topics is due to Congress no later than 3 years from the date of enactment.

TITLE V—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

Revision of Acute Hospital Payment Updates (Section 501(a) and 501(b) of the Conference Agreement and Section 501 of the House Bill).

Present Law

Each year, Medicare's operating payments to hospitals are increased or updated by a factor that is determined in part by the projected annual change in the hospital market basket (MB). Congress establishes the update for Medicare's inpatient prospective payment system (IPSS) for operating costs, often several years in advance. Currently, acute hospitals will receive the MB as an update for FY2004 and subsequently. CMS has asked hospital to report on 10 JCAHO/CMS measures, developed by the National Quality Foundation. For example, whether a patient with an acute myocardial infarction receives aspirin at arrival. As of October 9, 2003, 420 hospitals (out of the over 5,000 acute care hospitals that bill Medicare) had provided CMS with one of more measures.

House Bill

Acute hospitals would receive an operating update of the MB minus 0.4 percentage points for FY2004 through FY2006. The operating update would be the MB increase in FY2007 and subsequently. The provision would be effective upon enactment.

Senate Bill

No provision.

Conference Agreement

An acute hospital will receive an operating update of the MB in FY2004. An acute hospital will receive an operating update of the MB from FY2005 through FY2007 if it submits data on the 10 quality indicators established by the Secretary as of November 1, 2003. The Secretary will specify the form, manner, and time of the data submission except that any data collection and editing must be done before the start of the fiscal year. For FY2005, the Secretary will provide for a 30-day grace period for the submission of the required data. A hospital that does not submit data to the Secretary will receive an update of the MB minus 0.4 percentage points for the fiscal year in question. The Secretary will not take into account this reduction when computing the applicable percentage increase in subsequent years.

The Secretary is directed to compile and clarify the procedures and policies for billing for blood and blood costs in the hospital inpatient and outpatient settings as well as the operation of the collection of the blood deductible.

Inpatient rehabilitation facilities (IRF) provide Medicare patients with rehabilitation services. They are distinguished from acute care settings by a number of criteria including that 75 percent of their cases must be in ten categories—stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur, brain injury, and polyarthritis, including rheumatoid arthritis, neurological disorders, and burns. This criterion is commonly referred to as the "75 percent rule."

On September 2, 2003, CMS issued proposed changes in classifying IRFs. The Conferees are concerned that the rule, as written, would have severe consequences for access to inpatient rehabilitation hospital services. The Conferees concur with the Medicare Payment Advisory Commission (MedPAC) finding that further analysis should be conducted to identify which conditions are clinically appropriate for inclusion in the calculation of the 75 percent rule used to determine eligibility for reimbursement under the inpatient rehabilitation facility prospective payment system. The Conferees direct the GAO to issue a report, in consultation with experts in the field of physical medicine and rehabilitation to look at whether the current list of conditions represents a clinically appropriate standard for defining IRF services and, if not, which additional conditions should be added to the list. During the study period, the Committee urges the Secretary to delay implementation of the rule and not accept new IRF applications until the report is finished.

GAO Study and Report on Appropriateness of Payments Under the Prospective Payment System for Inpatient Hospital Services (Section 501(c) of the Conference Agreement and Section 413 of the Senate Bill).

Present Law

No provision.

House Bill

No provision.

Senate Bill

GAO would be required to use the most current data available to conduct a study to determine: (1) the appropriate level and distribution of Medicare payments in relation to costs to short-term general hospitals under the inpatient prospective payment system (IPPS) and (2) the need for geographic adjustments to reflect legitimate differences in hospital costs across geographic areas, kinds of hospitals, and types of cases. The study, including recommendations for necessary legislative and administrative action, would be due to Congress within 18 months of enactment.

Conference Agreement

GAO is required to use the most current data available to conduct a study to determine: (1) the appropriate level and distribution of Medicare payments in relation to costs for short-term general hospitals under the inpatient prospective payment system (IPPS) and (2) the need for geographic adjustments to reflect legitimate differences in hospital costs across geographic areas, kinds of hospitals, and types of cases. The study, including recommendations for necessary legislative and administrative action, is due to Congress within 24 months of enactment.

Revision of the Indirect Medical Education (IME) Adjustment Percentage (Section 502 of the Conference Agreement and Section 418 of the Senate Bill).

Present Law

A hospital's IME payment to a hospital is based on a percentage add-on to the PPS rate that is established by a curvilinear formula that currently provides a payment increase of approximately 5.5% for each 10% increase in the hospital's intern and resident-to-bed (IRB) ratio. The following formula is multiplied by a hospital's base payment rate for each Medicare discharge to determine the IME payment: $1.35 \times [(1+\mathrm{IRB})^{0.405} - 1]$. The multiplier of 1.35 increases the level of the IME adjustment to the existing target level of 5.5%. Congress has periodically changed the multiplier (or "c") to decrease or increase IME payments to teaching hospitals.

House Bill

No provision.

Senate Bill

The IME multiplier in 2004 and in 2005 would be 1.36; on or after 2005, the multiplier would be 1.355. This would increase payments to teaching hospitals by $300 million over 10 years. The provision would apply to discharges on or after October 1, 2003.

Conference Agreement

From April 1, 2004 until September 30, 2004, the IME multiplier is equal to 1.47; during FY2005, the IME multiplier is 1.42; during FY2006, the IME multiplier is 1.37; during FY2007, the IME multiplier is 1.32; and, starting October 1, 2007, the IME multiplier is equal to 1.35.

Recognition of New Medical Technologies Under Inpatient Hospital Prospective Payment System (Section 503 of the Conference Agreement and Section 502 of the House Bill).

Current Law

BIPA established that Medicare's inpatient hospital payment system should include a mechanism to recognize the costs of new medical services and technologies for discharges beginning on or after October 1, 2001. The additional hospital payments can be made by the means of a new technology groups, an add-on payment, a payment adjustment, or other mechanism, but cannot be a separate fee schedule and must be budget-neutral. A medical service or technology will be considered to be new if it meets criteria established by the Secretary after notice and the opportunity for public comment. The Centers for Medicare and Medicaid (CMS) published the final regulation implementing these provisions on September 7, 2001. This regulation changed the meeting schedule for decisions on the creation and implementation of new billing codes. (ICD–9–CM codes). The regulation also established that technology that provided a substantial improvement to existing treatments would qualify for additional payments. The add-on payment for eligible new technology would occur when the standard diagnosis related group (DRG) payment was inadequate; this threshold, which was established as one standard deviation above the mean standardized DRG. In these cases, the add-on payment for new technology would be the lesser of (a) 50% of the costs of the new technology or (b) 50% of the amount by which the costs exceeded the standard DRG payment; however if the new technology payments are estimated to exceed the budgeted target amount of 1% of the total operating inpatient payments, the add-on payments are reduced prospectively.

House Bill

The Secretary would be required to add new diagnosis and procedure codes in April 1 of each year but would not be required to affect Medicare's payment or DRG classification until the fiscal year that begins after that date. The Secretary would not be able to deny a service or technology treatment as a new technology because the service (or technology) has been in use prior to the 2–to–3 year period before it was issued a billing code and a sample of specific discharges where the service has been used can be identified. When establishing whether DRG payments are inadequate, the Secretary would be required to apply a threshold that is the lesser of 75% of the standardized amount (increased to reflect the difference between costs and charges) or 75% of one standard deviation for DRG involved. The Secretary would be required to provide additional clarification in regulation on the criteria used to determine whether a new service represents an advance in technology that substantially improves the existing diagnosis or treatment. The Secretary would be required to deem that a technology provide a substantial improvement on an existing treatment if the technology in question is a drug or biological that is designated under section 506 of the Federal Food, Drug, and Cosmetic Act, approved under section 314.510 or 601.41 of Title 21, Code of Federal Regulations, designated for priority review when the marketing application was filed, is a medical device for which an exemption has been granted under section 520(m) of such Act, or for which priority or expedited review has been provided under section 515(d)(5). For other technologies that may be substantial improvements, the Secretary would be required to: (1) maintain and update a public list of pending applications for specific services and technologies to be evaluated for eligibility for additional payment; (2) accept comments recommendations and data from the public regarding whether a service or technology represents a substantial improvement; and (3) provide for a meeting at which organizations representing physicians, beneficiaries, manufacturers or other interested parties may present comments, recommendations, and data to the clinical staff of CMS regarding whether a service or technology represents a substantial improvement. These actions would occur prior to the publication of the proposed regulation. Before establishing an add-on payment as the appropriate reimbursement mechanism, the Secretary would be directed to identify one or more DRGs and assign the technology to that DRG, taking into account similar clinical or anatomical characteristics and the relative cost of the technology. The Secretary would assign an eligible technology into a DRG where the average cost of care most closely approximates the cost of the new technology. In such a case, no add-on payment would be made; the application of the budget-neutrality requirement with respect to annual DRG reclassifications and recalculation of associated DRG weights would not be affected. The Secretary would be required to increase the percentage associated with add-on payments from 50% to the marginal rate or percentage that Medicare reimburses inpatient outlier cases. The provisions would not affect the Secretary's authority to determine whether services are medically necessary and appropriate. Funding for this new technology would no longer be budget neutral.

The Secretary would be required to implement these provisions to new technology determinations beginning in FY2005. The Secretary would be required to automatically reconsider an application as a new technology that was denied for FY2004 as an application under these new provisions. If such an application is granted, the maximum time period otherwise permitted for such classification as a new technology would be extended by 12 months.

Senate Bill

No provision.

Conference Agreement

The Secretary is required to add new diagnosis and procedure codes in April 1 of each year but is not be required to affect Medicare's payment or DRG classification until the fiscal year that begins after that date. When establishing whether DRG payments are inadequate, the Secretary would be required to apply a threshold that is the lesser of 75% of the standardized amount (increased to reflect the difference between costs and charges) or 75% of one standard deviation for the DRG involved. The Secretary should collect at least 2 years of data before incorporating the technology into a permanent group. The Secretary is be required to: (1) maintain and update a public list of pending applications for specific services and technologies to be evaluated for eligibility for additional payment; (2) accept comments recommendations and data from the public regarding whether a service or technology represents a substantial improvement; and (3) provide for a meeting at which organizations representing physicians, beneficiaries, manufacturers or other interested parties may present comments, recommendations, and data to the clinical staff of CMS regarding whether a service or technology represents a substantial improvement. These actions will occur prior to the publication of the proposed regulation. Before establishing an add-on payment as the appropriate reimbursement mechanism, the Secretary is directed to identify one or more DRGs and assign the technology to that DRG, taking into account similar clinical or anatomical characteristics and the relative cost of the technology. The Secretary will assign an eligible technology into a DRG where the average cost of care most closely approximates the cost of the new technology. In such a case, no add-on payment would be made; the application of the budget-neutrality requirement with respect to annual DRG reclassifications and recalculation of associated DRG weights will not be affected. The Secretary should consider increasing the percent of payment associated with the add-on payments up to the marginal rate used for the inpatient outlier. Funding for new technology will no longer be budget neutral.

The Secretary is required to implement these provisions to new technology determinations beginning in FY2005. The Secretary is required to automatically reconsider an application as a new technology that was denied for FY2005 as an application under these new provisions. If such an application is granted, the maximum time period otherwise permitted for such classification as a new technology is extended by 12 months.

Increase in Federal Rate for Hospitals in Puerto Rico (Section 504 of the Conference Agreement, Section 503 of the House Bill, and Section 409 of the Senate Bill).

Present Law

Under Medicare's prospective payment system for inpatient services, a separate standardized amount is used to establish payments for discharges from short-term general hospitals in Puerto Rico. BBA 97 provides for an adjustment of the Puerto Rico rate from a blended amount based on 25% of the federal national amount and 75% of the local amount to a blended amount based on a 50/50 split between national and local amounts.

House Bill

Hospitals in Puerto Rico would receive Medicare payments based on a 50/50 split between federal and local amounts before October 1, 2003. From FY2004 through FY2007, an increasing amount of the payment rate would be based on federal national rates as follows: during FY2004, payment would be 59% national and 41% local; this would change to 67% national and 33% local during FY2005 and 75% national and 25% local during FY2006 and subsequently.

Senate Bill

Hospitals in Puerto Rico would receive Medicare payments based on a 50/50 split between national and local amounts until September 30, 2003. These hospitals would receive Medicare payments based on 100% of the federal rate for discharges on or after October 1, 2004 and before October 1, 2009. The rate for hospitals Puerto Rico would revert to a 50/50 split after October 1, 2009.

Conference Agreement

Hospitals in Puerto Rico will receive Medicare payments based on a 50/50 split between federal and local amounts before April 1, 2004. Starting April 1, 2004 through September 30, 2004, payment will be based on 62.5% national amount and 37.5% local amount; this will change to 75% national and 25% local after October 1, 2004 and in subsequent years.

Wage Index Adjustment Reclassification Reform (Section 505 of the Conference Agreement and Section 504 of the House Bill).

Present Law

Unlike other providers, acute hospitals may apply to the Medicare Geographic Classification Review Board (MGCRB) for a change in classification from a rural area to an urban area, or reassignment from one urban area to another urban area. The MGCRB was created to determine whether a hospital should be redesignated to an area with which it has close proximity for purposes of using the other area's wage index. If reclassification is granted, the new wage index will be used to calculating Medicare's payment for inpatient and outpatient services.

Generally, hospitals must demonstrate a close proximity to the areas where they seek to be reclassified. This proximity can be established if one of two conditions is met: (1) an urban hospital must be no more than 15 miles and a rural hospital must be no more than 35 miles from the area where it wants to be reclassified; or (2) at least 50% of the hospital's employees reside in the area. A rural referral center (RRC) or a sole community hospital (SCH) or a hospital that is both a RRC and a SCH does not have to meet the proximity test. After establishing appropriate proximity, a hospital may qualify for the payment rate of another area if it proves that its incurred costs are comparable to those of hospitals in that area under established criteria. To use an area's wage index, a rural hospital must demonstrate that its average hourly wage is equal to at least 82% of the average hourly wage of hospitals in the area to which it seeks redesignation; an urban hospital must demonstrate that its average hourly wage is at least 84% of such an area. Also an urban hospital cannot be reclassified unless average hourly wage is at least 108% of the average hourly wage of the area in which it is located; this standard is 106% for rural hospitals seeking reclassification to an area.

For redesignations starting in FY2003, the average hourly wage comparisons used to determine whether a hospital can use another area's wage index are based on 3 years worth of lagged data submitted by hospitals as part of their cost report. For instance, FY2003 wage index reclassifications were based on weighted 3-year averages of average hourly wages using data from FY1997, FY1998, and FY1999 cost reports. Wage index reclassifications are effective for 3 years unless the hospital notifies the MCGRB and withdraws or terminates its reclassification.

House Bill

The Secretary would be required to establish an application process and payment adjustment to recognize the commuting patterns of hospital employees. A hospital that qualified for such a payment adjustment would have average hourly wages that exceed the average wages of the area in which it is located and have at least 10% of its employees living in 1 or more areas that have higher wage index values. This qualifying hospital would have its wage index value increased by the percentage of its total employees who live in any area with a higher wage index value. The process would be based on the MGCRB reclassification process and schedule with respect to data submitted. Such an adjustment would be effective for 3 years unless a hospital withdraws or elects to terminate its payment. A hospital that receives a commuting wage adjustment would not be eligible for reclassification into another area by the MCGRB. These commuting wage adjustments would not affect the computation of the wage index of the area in which the hospital is located or any other area. It would also be exempt from certain budget neutrality requirements. The provisions would apply to discharges on or after October 1, 2004.

Senate Bill

No provision.

Conference Agreement

The Secretary is required to establish a process and payment adjustment to recognize the out-migration of hospital employees who reside in a county and work in different area with a higher wage index. A hospital that receives such a payment adjustment will be located in a qualifying county that meets criteria established by the Secretary. This criteria will include (1) a threshold percentage of the weighted average of the area wage index or indices for the higher wage index areas; (2) a threshold of not less than 10 percent for minimum out-migration to a higher wage index area or areas and (3) a requirement that the average hourly wage of the hospitals in the qualifying county equals or exceeds the average hourly wage of all the hospitals in the area where the county is located. A qualifying hospital will have its wage index value increased by the percentage of the hospital employees residing in the qualifying county who are employed in any area with a higher wage value. The adjustment will equal the sum of the products of the difference between the wage index value of any higher wage area and the qualifying county multiplied by the number of hospital employee who reside in the qualifying county but are employed in any higher wage index area. The application process for this adjustment is based on the MGCRB reclassification process and schedule with respect to data submitted. Such an adjustment is effective for 3 years unless a hospital withdraws or elects to terminate its payment.

The Secretary may require acute hospitals and other hospitals as well as critical access hospitals to submit data regarding the location of their employee's residence or the Secretary may use data from other sources. A hospital that receives a commuting wage adjustment is not eligible for reclassification into another area by the MCGRB. The commuting wage adjustment does not affect the computation of the wage index of the area in which the hospital is located or any other area. It is also exempt from certain budget neutrality requirements. The thresholds and other qualifying criteria for the commuting wage adjustment is not subject to judicial review. The provisions apply to discharges on or after October 1, 2004. In initially implementing this adjustment, the Secretary may modify the deadlines otherwise applicable to data submission and actions on applications for geographic reclassification.

Limitation on Charges for Inpatient Hospital Contract Health Services Provided to Indians by Medicare Participating Hospitals (Section 506 of the Conference Agreement and Section 412 of the Senate Bill).

Present Law

The Indian Health Service (IHS) provides health care both directly, through tribes and tribal consortia, and through urban Indian organizations. The Indian Health Care Improvement Act (P.L. 94-437) authorized IHS to collect directly from Medicare, Medicaid, and other third party insurers for health services covered by those programs. In addition to care provided directly from IHS and tribal providers, contract health services are purchased by IHS and the tribes from more than 2,000 private providers, if the local facility is unable to provide the needed care. These health services are provided principally for members of tribes who live in contract health service delivery areas. Contract support funding across all IHS programs has been insufficient to cover all IHS and tribal costs. When the costs are not reimbursed through appropriations, the tribes and IHS use program funds to make up the difference.

House Bill

No provision.

Senate Bill

The amendment would prohibit hospitals that participate in Medicare and that provide Medicare covered inpatient hospital services under the contract health services program funded by the Indian Health Services from charging more than the Medicare established rates for these services. This provision would apply to contract health services programs operated by the Indian Health Service, an Indian tribe or tribal organization or an urban Indian organization. The provision would apply to Medicare participation agreements in effect or entered into by a date specified by the Secretary. In no case would this provision be applicable later than 6 months from the date of enactment.

Conference Agreement

Hospitals that participate in Medicare and that provide Medicare covered inpatient hospital services under the contract health services program funded by the Indian Health Services and operated by the Indian Health Service, an Indian tribe, an Indian tribal organization, or an urban Indian organization will be paid in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodologies, and rates of payments. This will include the requirement to accept these rates as payment in full. This provision will apply to Medicare participation agreements in effect or entered into by a date specified by the Secretary. In no case will this date be later than 1 year after the date of enactment.

Clarifications to Certain Exceptions to Medicare Limits on Physician Referrals (Section 507 of the Conference Agreement, Section 505 of the House Bill and Section 453 of the Senate Bill).

Present Law

Physicians are generally prohibited from referring Medicare patients to facilities in which they (or their immediate family member) have financial interests. Physicians, however, are not prohibited from referring patients to whole hospitals (and several other entities) in which they have ownership or investment interests.

House Bill

The Medicare Payment Advisory Commission (MedPAC) would be required to conduct a study of specialty hospitals compared with other similar general acute hospitals including the number and extent of patients referred by physicians with an investment interest in the facility, the quality of care furnished, the impact of the specialty hospital on the acute general hospital, and the differences in the scope of services, Medicaid utilization and the amount of uncompensated care that is furnished. The report, including recommendations, would be due to Congress no later than 1 year from enactment.

Senate Bill

The exception for physician investment and self-referral would not extend to specialty hospitals. In this instance, a specialty hospital would be one that is primarily or exclusively engaged in the care and treatment of patients with cardiac or orthopedic conditions, those receiving a surgical procedure, or other specialized categories of patients or cases deemed appropriate. A specialty hospital would not include any hospital that is determined by the Secretary to be in operation, under development as of such date, with the same number of beds and physician investors as of June 12, 2002. The Secretary would consider the following factors in determining whether a hospital is under development: whether the architectural plans have been completed; funding has been received; zoning requirements have been met; necessary approvals from appropriate State agencies have been received and other appropriate evidence.

The rural provider exception would be modified. These rural providers would not include specialty hospitals and the Secretary would determine, with respect to the entity, that such services would not be available in such area but for the ownership or investment interest.

Conference Agreement

For a period of 18 months from the date of enactment, the "whole hospital" exception would be amended to exclude those circumstances in which a physician's ownership interest is in a subsection d hospital devoted primarily or exclusively to cardiac, orthopedic surgical, or other specialties designated by the Secretary. Specialty hospitals in operation or under development as of November 18, 2003 would be exempt from the provision. Within a period of 15 months from the date of enactment MedPAC, in consultation with the General Accounting Office (GAO), and HHS would study the effects of the whole-hospital exception for physician-ownership in specialty hospitals.

In order to qualify for exception from this provision, a specialty hospital must have been in operation or under development (as defined in this bill) as of November 18, 2003. Additionally, in order to maintain the exception, a specialty hospital may not increase the number of physician investors as of November 18, 2003; change or expand the field of specialization it treats; expand beyond the main campus; or increase the total number of beds in its facilities by more than the greater of 5 beds or 50 percent of the number of beds in the hospital as of November 18, 2003. The Secretary shall determine what constitutes the number of beds in a hospital that is considered under development as of November 18, 2003. The Secretary may evaluate all relevant development plans and documents in order to make this determination.

Long-term acute care hospitals, rehabilitation hospitals, psychiatric hospitals, cancer hospitals, and children's hospitals are not considered to be specialty hospitals for purposes of this section. When studying the effects of the whole-hospital exception, MedPAC, in consultation with GAO shall undertake a study in accordance with the legislation.

Effective Date

Beginning on the date of enactment, this provision would establish an 18–month moratorium on physician self-referrals to specialty hospitals. Hospitals in existence or under development as of November 18, 2003 would be exempt from the moratorium. A study would be completed within 15 months of date of enactment.

MedPAC Study and Report Regarding Medicare Disproportionate Share Hospital

Adjustments (Section 404A of the Senate Bill).

Present Law

No provision.

House Bill

No provision.

Senate Bill

The Medicare Payment Advisory Commission (MedPAC) would be required to conduct a study to determine (1) whether disproportionate share hospital (DSH) payments should be made in the same manner as Medicare's graduate medical education payments; (2) the extent that hospitals receiving Medicaid DSH payments also receive Medicare DSH payments; and (3) whether to add uncompensated care costs to the Medicare DSH formula. The report, including recommendations, would be due to Congress within 1 year from enactment. The provision would be effective upon enactment.

Conference Agreement

No provision.

Treatment of Grandfathered Long-Term Care Hospitals (Section 416/Duplicate Provision 420B of the Senate Bill).

Present Law

A hospital-in-a-hospital is a long-term hospital that is physically located in an acute care hospital and provides inpatient services that are paid at a higher rate than would apply if the long term hospital were treated by Medicare as an acute care hospital. The Centers for Medicare and Medicaid Services (CMS) has established certain requirements for a hospital-in-a-hospital to be excluded from the inpatient prospective payment system and be paid as a long-term hospital. For instance, a hospital-within-a-hospital has to be able to independently perform certain basic hospital functions. CMS exempted existing hospitals-with-a-hospital (those that were in existence on or before September 30, 1995) when these requirements were established. On May 19, 2003, CMS proposed to revise the conditions of the hospitals' exemption; a hospital-within-a hospital would only be exempt from the existing requirements if it continues to operate within the same terms and conditions that were in effect as of September 30, 1995.

House Bill

No provision.

Senate Bill

The Secretary would not be able to impose any special conditions on the operation, size, and number of beds or location of an existing long-term hospital in order to continue participating in Medicare or Medicaid or to continue being classified as a long-term hospital. The Secretary would not be able to adopt a proposed regulation that would implement such conditions or any revision to such regulation that have a comparable effect. The provisions would apply to cost reporting periods ending on or after December 31, 2002.

Conference Agreement

No provision.

Treatment of Certain Entities For Purposes of Payments Under the Medicare Program (Section 417 of the Senate Bill).

Present Law

Acute care hospitals may apply to the Medicare Geographic Classification Review Board (MGCRB) for a change in classification from a rural area to an urban area, or reassignment from one urban area to another urban area. The MGCRB was created to determine whether a hospital should be redesignated to an area with which it has close proximity for purposes of using the other area's standardized amount or wage index, or both. (If, as proposed, the standardized amount for all hospitals will equal the amount used to pay hospitals in large urban areas, a hospital's need to reclassify to use of another area's standardized amount will virtually disappear.) If reclassification is granted, the new wage index will be used to calculating Medicare's payment for inpatient and outpatient services. Hospital reclassifications are established on a budget-neutral basis so aggregate inpatient prospective payment system expenditures will not increase as a result.

Generally, hospitals must demonstrate a close proximity to the areas where they seek to be reclassified. After establishing appropriate proximity, a hospital may qualify for the payment rate of another area if it proves that its incurred costs are comparable to those of hospitals in that area. Aside from reclassifications through the MGCRB, hospitals have also been reclassified by law.

House Bill

No provision.

Senate Bill

Starting on or after October 1, 2003, Iredell County and Rowan County, North Carolina would be deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area for the purpose of Medicare's inpatient and outpatient acute hospital reimbursement. The Secretary would be required to adjust the wage index values of all hospitals in North Carolina to assure that aggregate payments for hospital inpatient operating costs are not greater than they would have been without such a change.

Starting on or after October 1, 2003, Iredell County and Rowan County, North Carolina would be deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, and South Carolina Metropolitan Statistical Area for the purpose of Medicare's skilled nursing facility (SNF) and home health reimbursement. This change will be made in a way to ensure that aggregate payments for SNF and home health services in North Carolina are not greater than they would have been without such a change.

Conference Agreement

No provision.

Calculation of Wage Indices for Hospitals (Conference Report Section 508 and Section 419 of the Senate Bill).

Present Law

Acute hospitals may apply to the Medicare Geographic Classification Review Board (MGCRB) for a change in classification from a rural area to an urban area, or reassignment from one urban area to another urban area but no later than February 15, 2004. If reclassification is granted, the new wage index will be used to calculating Medicare's payment for inpatient and outpatient services. Generally, hospitals must demonstrate a close proximity to the areas where they seek to be reclassified. After establishing appropriate proximity, a hospital may qualify for the payment rate of another area if it proves that its incurred costs are comparable to those of hospitals in that area. The reclassification standards which are established by regulation are different for urban than for rural hospitals. It is easier for a rural hospital to reclassify to a different area. Aside from reclassifications through the MGCRB, hospitals have also been reclassified by law.

House Bill

No provision.

Senate Bill

The Secretary would be able to waive established reclassification criteria in calculating the wage index in a state when making payments for hospital discharges in FY2004. The provision would be effective upon enactment.

Conference Agreement

The Secretary shall establish by instruction not later than January 1, 2004 or otherwise a one-time process under which a hospital may appeal the wage index classification otherwise applicable to the hospital and select another area within the State (or at the discretion of the Secretary to a contiguous state. A qualifying hospital is not eligible for a wage index classification on the basis of distance and/or commuting. It also must meet such other criteria, such as quality, as the Secretary may specify by instruction or otherwise. The reclassification will be effective for three years beginning with April 1, 2004. Hospitals can waive reclassification under this provision during the three year period. The Secretary shall limit the additional expenditures to $900 million.

Subtitle B—Other Provisions

Payment for Covered Skilled Nursing Facility Services (Section 511 of the Conference

Agreement and Section 511 of the House Bill).

Present Law

Medicare uses a system of daily rates to pay for care in a skilled nursing facility (SNF). There are 44 daily rates categories, known as resource utilization groups (RUGs) and each group reflects a different case mix and intensity of services, such as skilled nursing care and/or various therapy and other services.

House Bill

The per diem RUG payment for a SNF resident with acquired immune deficiency syndrome (AIDS) would be increased by 128%. This payment increase would not apply on after such date when the Secretary certifies that the SNF case mix adjustment adequately compensates for the facility's increased costs associated with caring for a resident with AIDS. The provision would be effective for services on or after October 1, 2003.

Senate Bill

No provision.

Conference Agreement

The conference agreement increases the per diem RUG payment for a SNF resident with acquired immune deficiency syndrome (AIDS) by 128% (the BBRA temporary RUG add-on does not apply in this case). This payment increase would not apply on after such date when the Secretary certifies that the SNF case mix adjustment adequately compensates for the facility's increased costs associated with caring for a resident with AIDS. The provision is effective for services on or after October 1, 2004.

Coverage of Hospice Consultation Services (Section 512 of the Conference Agreement and Section 512 of the House Bill).

Present Law

Current law authorized coverage of hospice services, in lieu of certain other Medicare benefits, for terminally ill beneficiaries who elect such coverage.

House Bill

Coverage of certain physician's services for certain terminally ill individuals would be authorized. Persons entitled to these services would be individuals who have not elected the hospice benefit and have not previously received these physician's services. Covered services would be those furnished by a physician who is the medical director or employee of a hospice program. Services would include evaluating the individual's need for pain and symptom management, counseling the individual with respect to end-of-life issues and care options, and advising the individual regarding advanced care planning. Payment for such services would equal the amount established for similar services under the physician fee schedule, excluding the practice expense component. The provision would apply to consultation services provided by a hospice program on or after January 1, 2004.

Senate Bill

No provision.'

Conference Agreement

The conference agreement provides coverage of certain physician's services for certain terminally ill individuals. Beneficiaries entitled to these services are those who have not elected the hospice benefit and have not previously received these physician's services. Covered services are those furnished by a physician who is the medical director or employee of a hospice program. The covered services are: evaluating the beneficiary's need for pain and symptom management, including the individual's need for hospice care; counseling the beneficiary with respect to end-of-life issues and care options, and advising the beneficiary regarding advanced care planning. Payment for such services equals the amount established for similar services under the physician fee schedule, excluding the practice expense component. The provision would apply to consultation services provided by a hospice program on or after January 1, 2005.

Increase for Hospitals with Disproportionate Indigent Care Revenues (Section 420A of the Senate Bill).

Present Law

Certain hospitals receive additional Medicare payments because they serve a disproportionate share of poor Medicare and Medicaid patients measured by a formula that incorporates the proportion of the hospital's Medicare inpatient days provided to poor Medicare beneficiaries (those who receive Supplemental Security Income or SSI) added to the proportion of total hospital days provided to Medicaid recipients. A few urban hospitals receive disproportionate share hospital (DSH) payments under the Pickle Amendment (named after former Representative Pickle from Texas) which establishes an alternative formula that considers the proportion of a hospital's patient care revenues that are received from state and local indigent care funds. If a hospital receives at least 30% of its patient care revenue from these indigent care funds, it qualifies as a "Pickle" hospital and will get a 35% increase in its Medicare operating payments. The Pickle hospitals receive a capital DSH adjustment of 14.16%. The capital adjustment is calculated with the presumption that other urban hospitals would have had a DSH patient share percentage of 65.4% in order to receive a 35% operating DSH adjustment. If so, 65.4% DSH adjustment entered into the capital formula (a complicated calculation involving "e is the natural antilog of 1") would equal 14.16%.

House Bill

No provision.

Senate Bill

Hospitals that qualify for the DSH adjustment under the Pickle amendment would receive a DSH operating and capital adjustment of 40% for discharges on or after October 1, 2003. The provision would be effective upon enactment.

Conference Agreement

No provision.

Equitable Treatment for Children's Hospitals (Section 450J of the Senate Bill).

Present Law

Outpatient hospital prospective payment contains a permanent "hold harmless" for cancer hospitals and children's hospitals. Under this hold harmless, payments to these hospitals cannot fall below what these hospitals would have received under the payment system in place before PPS.

House Bill

No provision.

Senate Bill

The provision would modify the hold harmless that certain children's hospitals receive. To receive the hold harmless a children's hospital would be required to be located in a state with an inpatient PPS waiver (Maryland is the only state that continues its waiver under 1814(b)(3)) and to have an outpatient PPS payment that is less than either what the hospital would have received under the previous payment system or the hospital's reasonable operating and capital costs. A children's hospital meeting these criteria would receive payment reflecting the greater difference between the outpatient PPS amount and the greater of either the previous payment system amount or the reasonable costs. The provision would be effective for services furnished on or after October 1, 2003.

Conference Agreement

No provision.

TITLE VI—PROVISIONS RELATING TO PART B

Subtitle A—Provisions Relating to Physicians' Services

Revision of Updates for Physicians' Services (Section 601 of the Conference Agreement, Section 601 of the House Bill, and Sections 464/Duplicative Provisions 622 and 629 of the Senate Bill).

Present Law

Medicare pays for services of physicians and certain non-physician practitioners on the basis of a fee schedule. The fee schedule, in place since 1992, is intended to relate payments for a given service to the actual resources used in providing that service. The fee schedule assigns relative values to services. These relative values reflect physician work (i.e., the time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative values are adjusted for geographic variations in costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor.

The law provides a specific formula for calculating the annual update to the conversion factor. The intent of the formula is to place a restraint on overall increases in spending for physicians' services. Several factors enter into the calculation of the formula. These include: (1) the sustainable growth rate (SGR), which is essentially a target for Medicare spending growth for physicians' services; (2) the Medicare economic index (MEI), which measures inflation in the inputs needed to produce physicians' services; and (3) an adjustment that modifies the update, which would otherwise be allowed by the MEI, to bring spending in line with the SGR target. The SGR target is not a limit on expenditures. Rather, the fee schedule update reflects the success or failure in meeting the target. If expenditures exceed the target, the update for a future year is reduced.

The annual percentage update to the conversion factor equals the MEI, subject to an adjustment (known as the update adjustment factor) to match target spending for physicians services under the SGR system. (During a transition period, 2001–2005, an additional adjustment is made to achieve budget neutrality.) The update adjustment sets the conversion factor at a level so that projected spending for the year will meet allowed spending by the end of the year. Allowed spending for the year is calculated using the SGR. However, in no case can the update adjustment factor be less than minus 7% or more than plus 3%.

The update adjustment factor is the sum of: (1) the prior year adjustment component, and (2) the cumulative adjustment component. The prior year adjustment component is determined by: (1) computing the difference between allowed expenditures for physicians' services for the prior year and the amount of actual expenditures for that year; (2) dividing this amount by the actual expenditures for that year; and (3) multiplying that amount by 0.75. The cumulative adjustment component is determined by: (1) computing the difference between allowed expenditures for physicians' services from April 1, 1996 through the end of the prior year and the amount of actual expenditures during such period; (2) dividing that difference by actual expenditures for the prior year as increased by the SGR for the year for which the update adjustment factor is to be determined; and (3) multiplying that amount by 0.33. Use of both the prior year adjustment component and the cumulative adjustment component allows any deviation between cumulative actual expenditures and cumulative allowed expenditures to be corrected over several years rather than a single year.

The law also specifies a formula for calculating the SGR. It is based on changes in four factors: (1) estimated changes in fees; (2) estimated change in the average number of Part B enrollees (excluding Medicare+Choice beneficiaries); (3) estimated projected growth in real gross domestic product (GDP) growth per capita; and (4) estimated change in expenditures due to changes in law or regulations. This system is designed to adjust for how well actual expenditures meet SGR target expenditures.

Provisions in the Consolidated Appropriations Resolution of 2003 (P.L. 108-7) permitted redeterminations of SGR for prior years. As a result, the conversion factor for 2003 was increased 1.6% over the 2002 level. Other aspects of the formula for the annual payment rate were not addressed. CMS reports an update factor of −4.5% for 2004.

House Bill

The update to the conversion factor for 2004 and 2005 would be not less than 1.5% and would be exempt from the budget neutrality adjustment. This modification would not be treated as a change in law and regulation in SGR determination.

The formula for calculating the sustainable growth rate would be modified. The GDP factor would be based on the annual average change over the preceding 10 years (a 10-year rolling average). This calculation would replace the current GDP factor which measures the 1-year change from the preceding year. The 10-year rolling average calculation of the GDP would apply to computations of the SGR starting in 2003.

Senate Bill

The provision expresses a sense of the Senate that Medicare beneficiary access to quality care may be compromised if Congress does not prevent cuts in 2004 and following years that stem from the sustainable growth rate (SGR) formula.

The provision provides a sense of the Senate that the reductions in Medicare's physician fee schedule are untenable if not destabilizing, primarily caused by the sustainable growth rate calculation, and that CMS should use its discretion to make certain exclusions and adjustments to the calculation.

Conference Agreement

The update to the conversion factor for 2004 and 2005 will not be not less than 1.5% and will be exempt from the budget neutrality adjustment, instead of −4.5% in 2004 and a smaller reduction in 2005. This modification would not be treated as a change in law and regulation in SGR determination.

The formula for calculating the sustainable growth rate will be modified. The GDP factor will be based on the annual average change over the preceding 10 years (a 10-year rolling average). This calculation will replace the current GDP factor which measures the 1-year change from the preceding year. The 10-year rolling average calculation of the GDP will apply to computations of the SGR starting in 2003.

Treatment of Physicians' Services furnished in Alaska (Section 602 of the Conference Agreement and Section 450K of the Senate Bill).

Current Law

Physicians who provide services to Medicare beneficiaries are paid based on a physician fee schedule, which has three components: the relative value for the service, a geographic adjustment factor and a conversion factor. The geographic adjustment factor is the sum of three geographic practice cost indices (GPCIs), namely a work GPCI, a practice expense GPCI, and a malpractice GPCI. An area with costs above the national average would have a GPCI greater than 1.00; an area with costs below the national average would have a GPCI less than 1.00.

House Bill

No provision.

Senate Bill

For calendar year 2004, physicians providing Medicare services in Alaska would be paid 90 percent of the Veterans Affairs (VA) fee schedule for physician services that was used for fiscal year 2001. For calendar year 2005, this payment amount would be increased by the update amount for the Medicare physician fee schedule for 2005. If no VA fee schedule amount existed for a physician service, the payment amount would be the sum of the Medicare payment amount plus 90% of the percentage difference between the Medicare fee schedule and the VA fee schedule (on a claims-weighted basis). The provision would be effective for services furnished on or after January 1, 2004 and before January 1, 2006.

Conference Agreement

In calendar years 2004 and 2005, for physician services provided in Alaska, the Secretary is required to increase geographic practice cost indices to a level of 1.67 for each of the work, practice expense and malpractice cost indices.

Inclusion of Podiatrists, Dentists, and Optometrists under Private Contracting Authority (Section 603 of the Conference Agreement and Section 604 of the House Bill).

Present Law

Private contracting allows a physician and Medicare beneficiary not to submit a claim for a service which would otherwise be covered and paid for by Medicare. Under private contracting, physicians can bill patients at their discretion without being subject to upper payment limits specified by Medicare. If a physician decides to enter into a private contract with a Medicare beneficiary, that physician must agree to forego any reimbursement by Medicare for all Medicare beneficiaries for 2 years. The patient is not subject to the 2-year limit and is able to receive services from other physicians who do not have such private contracts and have Medicare pay for the services. Both physicians and practitioners may enter private contracts. In this instance, a physician is limited to a doctor of medicine and osteopathy; chiropractors, podiatrists, dentists, and optometrists are not included. Practitioners are physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists, and clinical social workers.

House Bill

Doctors of dental surgery or of dental medicine and doctors of podiatric medicine would be able to enter into private contracts with Medicare beneficiaries. The provision would be effective upon enactment.

Senate Bill

No provision.

Conference Agreement

Doctors of dental surgery or of dental medicine, doctors of podiatric medicine, and doctors of optometry will be able to enter into private contracts with Medicare beneficiaries. The provision will be effective upon enactment.

GAO Study on Access to Physicians' Services (Section 604 of the Conference Agreement and Sections 602(a) and 602(b) of the House Bill).

GAO Study on Beneficiary Access to Physicians' Services

Present Law

Periodic analyses by the Physician Payment Review Commission, and subsequently MedPAC, as well as CMS showed that access to physicians' services generally remained good for most beneficiaries through 1999. Detailed data are not available for a subsequent period; however, several surveys have showed a decline in the percentage of physicians accepting new Medicare patients.

House Bill

GAO would be required to conduct a study on access of Medicare beneficiaries to physician's services under Medicare. The study would include an assessment of beneficiaries' use of services through an analysis of claims data. It would also examine changes in use of physicians' services over time. Further, it would examine the extent to which physicians are not accepting new Medicare beneficiaries as patients. GAO would be required to submit a report to Congress on this study within 18 months of enactment. The report would determine whether data from claims submitted by physicians indicate potential access problems for beneficiaries in certain geographic areas. The report would determine whether access by beneficiaries to physicians' services has improved, remained constant, or deteriorated over time.

The Secretary would be required to request the Institute of Medicine to conduct a study on the adequacy of the supply of physicians (including specialists) in the country and the factors that affect supply. The Secretary would be required to submit the results of the study in a report to Congress no later than 2 years of the date of enactment.

Senate Bill

No provision.

Conference Agreement

GAO is required to conduct a study on access of Medicare beneficiaries to physicians' services under Medicare. The study will include an assessment of beneficiaries' use of physician services through an analysis of claims data. It will also examine changes in use of physicians' services over time. Further, it will examine the extent to which physicians are not accepting new Medicare beneficiaries as patients. GAO is required to submit a report to Congress on this study within 18 months of enactment. The report will determine whether data from claims submitted by physicians indicate potential access problems for beneficiaries in certain geographic areas. The report will also determine whether access by beneficiaries to physicians' services has improved, remained constant, or deteriorated over time.

Collaborative Demonstration-based Review of Physician Practice Expense Geographic Adjustment Data (Section 605 of the Conference Report and Section 421 of the Senate Bill).

Present Law

No provision.

House Bill

No provision.

Senate Bill

For services furnished after January 1, 2004, the Secretary would be required to increase the value of any work geographic index that is below .980 to .980. The values for work index would be raised to 1.0 for services furnished in 2005, 2006, and 2007. The practice expense and malpractice geographic indices in low value localities areas would be raised to 1.00 for services furnished in 2005 through 2008.

Conference Agreement

The Secretary is required to review and consider alternative data sources than those currently used to establish the geographic index for the practice expense component under Medicare's physician fee schedule no later than January 1, 2005. The Secretary will collaborate with state and other appropriate organizations representing physicians, and other appropriate persons. The Secretary will select 2 physician payment localities for this evaluation; one of the localities will be a rural area and one will be a statewide locality that includes both urban and rural areas. The Secretary will submit a report to Congress including recommendations on alternative data sources, including their accuracy and validity, the feasibility of using the alternative data, and the estimated impact of using these data for the practice expense adjustment. The report is due no later than January 1, 2006.

MedPAC Report on Payment for Physicians' Services (Section 606 of the Conference Agreement and Section 603 of the House Bill).

Present Law

Medicare pays for physicians' services on the basis of a fee schedule. The fee schedule assigns relative values to services. These relative values reflect physician work, practice expenses and malpractice expenses. Resource-based practice expense relative values were phased-in beginning in 1999. Beginning in 2002, the values were totally resource-based.

Certain services have a professional component and a technical component. The technical component does not include a relative value for physician work. A global value includes both the professional and technical components. The physician must bill for the global value if the physician furnishes both the professional component and the technical component.

House Bill

MedPAC would be required to report to Congress on the effects of refinements to the practice expense component of payments for physicians' services after full implementation of the resource-based payment in 2002. The report is to examine the following by specialty: (1) the effect of refinements on payments for physicians services; (2) interaction of the practice expense component with other components of and adjustments to payment for physicians' services; (3) appropriateness of the amount of compensation by reason of such refinements; (4) effect of such refinements on access to care by Medicare beneficiaries to physicians' services; and (5) effect of such refinements on physician participation under the Medicare program. The report would be due within 1 year of enactment. MedPAC would also be required to study the extent to which increases in the volume of physician services improves beneficiaries' health and well-being. MedPAC would be required to analyze the trends in components included in the sustainable growth rate calculation; the growth in volume of physician services provided to Medicare beneficiaries in comparison to other populations; the extent to which coverage determinations and new technology has affected growth in volume; the effect of demographic changes on volume; the effect of shifts in sites of services; and the extent to which the impact of law and regulations is taken into account.

Senate Bill

No provision.

Conference Agreement

MedPAC is required to report to Congress on the effects of refinements to the practice expense component of payments for physicians' services after full implementation of the resource-based payment in 2002. The report will examine the following by specialty: (1) the effect of refinements on payments for physicians' services; (2) the interaction of the practice expense component with other components of and adjustments to payment for physicians' services; (3) the appropriateness of the amount of compensation by reason of such refinements; (4) the effect of such refinements on access to care by Medicare beneficiaries to physicians' services; and (5) the effect of such refinements on physician participation under the Medicare program. The report is due within 1 year of enactment. MedPAC is also required to study the extent to which increases in the volume of physician services improves beneficiaries' health and well-being. MedPAC is required to analyze the trends in components included in the sustainable growth rate calculation; the growth in volume of physician service provided to Medicare beneficiaries in comparison to other populations; the extent to which coverage determinations and new technology has affected growth in volume; the effect of demographic changes on volume; the effect of shifts in sites of services; and the extent to which the impact of law and regulations is taken into account. The report is due within 1 year of enactment.

GAO Report Section (Section 605(b) of the House Bill).

Present Law

No provision.

House Bill

As part of the previously mandated study of geographic differences in physician payments, GAO would be required to evaluate (1) whether a sound economic basis for raising the geographic work adjustment exists; (2) the effect of such adjustment of physician location and retention including differences in recruitment cost and physician mobility; and the appropriateness of establishing a floor of 1.00 on the work geographic adjustment. GAO would be required to submit the report to Congress and the Secretary by September 1, 2004.

Senate Bill

No provision.

Conference Agreement

No provision.

GAO Study and Report on the Propagation of Concierge Care (Section 447 of the Senate Bill).

Present Law

No provision.

House Bill

No provision.

Senate Bill

GAO would be required to conduct a study on concierge care provided to Medicare beneficiaries and its affect on their access to Medicare covered services and submit a report to Congress, including recommendations, no later than 12 months from enactment. In this instance, concierge care would be an arrangement where a physician or practitioner charges an individual seeking care a membership fee or other fee or requires the purchase of an item or service as a prerequisite for providing the care. The provision would be effective upon enactment.

Conference Agreement

No provision.

Subtitle B—Preventive Services

Coverage of An Initial Preventive Physical Examination (Section 611 of the Conference Agreement and Section 611 of the House Bill).

Present Law

Medicare covers a number of preventive services. However, it does not cover routine physical examinations.

House Bill

Medicare coverage of an initial preventive physical examination would be authorized. The physical examination would be defined as physicians' services consisting of a physical examination with the goal of health promotion and disease detection. It would include items and services (excluding clinical laboratory tests) consistent with the recommendations of the United States Preventive Services Task Force as determined by the Secretary. A covered initial preventive physical examination would be one performed no later than 6 months after the individual's initial coverage date under Part B. Initial preventive physical exams would be included in the definition of physicians' services for purposes of the physician fee schedule. The Part B deductible and coinsurance would be waived for initial preventive physical exams. The provision would apply to services furnished on or after January 1, 2004 for those individuals whose coverage begins on or after such date.

Senate Bill

No provision.

Conference Agreement

Medicare coverage of an initial preventive physical examination is authorized, subject to deductible and beneficiary cost sharing. The physical examination is defined as physicians' services consisting of a physical examination (including measurement of height, weight, and blood pressure, and an electrocardiogram) with the goal of health promotion and disease detection. The examination includes education, counseling, and referral with respect to specific screening services and other preventive services, but does not include clinical laboratory tests. The screening and preventive services are certain vaccines, screening mammography, screening pap smear and screening pelvic exam, prostate cancer screening tests, colorectal cancer screening tests, diabetes outpatient self management, bone mass measurement, screening for glaucoma, medical nutrition therapy, cardiovascular screening blood tests and diabetes screening tests. A covered initial preventive physical examination is performed no later than 6 months after the individual's initial coverage date under Part B. Initial preventive physical exams are included in the definition of physicians services for purposes of the physician fee schedule. The provision applies to services furnished on or after January 1, 2005, but only for those individuals whose coverage begins on or after such date.

The Conference encourages the United States Preventive Services Task Force to examine aortic aneurysm screening using ultrasound. Aortic aneurysms are a leading cause of death in the United States, and many in the medical community believe that most, if not all, of the approximately 15,000 known deaths each year would be prevented with appropriate screening.

Coverage of Cardiovascular Screening Blood Tests (Section 612 of the Conference Agreement, Section 612 of the House Bill, and Section 450D of the Senate Bill).

Present Law

Medicare covers a number of preventive services. However, it does not cover cardiovascular screening tests.

House Bill

Medicare coverage of cholesterol and blood lipid screening would be authorized. The screening would be defined as diagnostic testing of cholesterol and other lipid levels of the blood for the purpose of early detection of abnormal cholesterol and other lipid levels. The Secretary would be required to establish standards regarding the frequency and type of these screening tests, but not more often than once every 2 years. The provision would apply to services furnished on or after January 1, 2005.

Senate Bill

Medicare coverage of cardiovascular screening tests would be authorized. The screening would be defined as diagnostic testing for the early detection of cardiovascular disease including tests for cholesterol levels, lipid levels of the blood, and other appropriate tests for cardiovascular disease. The Secretary would be required to consult with appropriate organizations and to establish standards regarding the frequency and type of these screening tests, but not more often than once every 2 years. The provision would apply to services furnished on or after January 1, 2005.

Conference Agreement

Medicare coverage of cardiovascular screening blood tests is authorized. The screening is defined as a blood test for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) including tests for cholesterol levels and other lipid or triglyceride levels as well as such other indications associated with the presence of (or an elevated risk for) cardiovascular disease as the Secretary may approve for all individuals or for some individuals determined to be at risk for such disease. These indications may include indications measured by noninvasive testing. The Secretary cannot approve an indication for any individual unless a blood test for such is recommended by the United States Preventive Services Task Force. The Secretary is required to consult with appropriate organizations and to establish standards regarding the frequency and type of these screening tests, but the frequency may not be more often than once every 2 years. The provision applies to services furnished on or after January 1, 2005.

Coverage of Diabetes Screening Tests (Section 613 of the Conference Agreement and Section 630 of the House Bill).

Present Law

On July 1, 1998, Medicare began covering diabetes self-management training services. These educational and training services are provided on an outpatient basis by physicians or other certified providers who have experience in diabetes self-management training services. Blood testing strips and home blood glucose monitors are used by diabetics to measure blood glucose levels to determine if these levels are being maintained adequately. Medicare covers blood testing strips and blood glucose monitors for all individuals with diabetes regardless of whether they are insulin-dependent. The Secretary is also required to consult with appropriate organizations to establish outcome measures to assess improvements in the health status of individuals with diabetes. Based on this information, the Secretary will make recommendations to Congress on changes to Medicare's coverage of services for these beneficiaries. Medicare does not presently cover laboratory diagnostic tests and other services that are used to screen for diabetes.

House Bill

Diabetes screening tests and services would be included as a covered medical service. In this instance, diabetes screening tests would include fasting plasma glucose tests and other appropriate tests provided to an individual at risk for diabetes. Individuals at risk for diabetes would have any or a combination of the following conditions: (1) have a family history of diabetes; (2) are overweight with a body mass index greater than or equal to 25 kg/m^2; (3) are habitually physically inactive; (4) are a member of a high-risk ethnic or racial group; (5) have previously been identified with an elevated impaired fasting glucose; (6) have hypertension; (7) have dyslipidemia; (8) have a history of gestational diabetes mellitus or have delivered a baby weighing more than 9 pounds; or (9) have polycystic ovary syndrome. The Secretary would be required to establish standards, in consultation with appropriate organizations regarding the frequency of screening tests except the tests would not be covered more often that twice in the 12-month period following the date of the individual's most recent diabetes screening test. The provision would apply to tests furnished on or after 90 days from enactment.

Senate Bill

No provision.

Conference Agreement

Diabetes screening tests furnished to an individual at risk for diabetes for the purpose of early detection of diabetes are included as a covered medical service. In this instance, diabetes screening tests include fasting plasma glucose tests as well as other tests and modifications to those tests deemed appropriate by the Secretary after consultation with appropriate organizations. Individuals at risk for diabetes have any or a combination of the following conditions: (1) hypertension; (2) dyslipidemia; (3) obesity, with a body mass index greater than or equal to 30 kg/m^2; (4) previous identification of an elevated impaired fasting glucose; (5) previous identification of impaired glucose tolerance or (6) a risk factor of at least 2 of the following characteristics: overweight with a body mass index of greater than 25, but less than 30, kg/m^2; a family history of diabetes; a history of gestational diabetes mellitus or delivery of a baby weighing more than 9 pounds; or age of 65 years or more. The Secretary is required to establish standards, in consultation with appropriate organizations regarding the frequency of screening tests except the tests will not be covered more often that twice in the 12-month period following the date of the individual's most recent diabetes screening test. The provision applies to tests furnished starting January 1, 2005.

Improved Payment for Certain Mammography Services (Section 614 of the Conference Agreement, Section 614 of the House Bill, and Section 445 of the Senate Bill).

Present Law

Screening mammography coverage includes the radiological procedure as well as the physician's interpretation of the results of the procedure. The usual Part B deductible is waived for tests. Payment is made under the physician fee schedule.

Certain services paid under fee schedules or other payment systems including ambulance services, services for patients with end-stage renal disease paid under the ESRD composite rate, professional services of physicians and non-physician practitioners paid under the physician fee schedule, and laboratory services paid under the clinical diagnostic laboratory fee schedule are excluded from Medicare's outpatient prospective payment system (OPPS).

House Bill

Unilateral and bilateral diagnostic mammography as well as screening mammography services would be excluded from OPPS. The Secretary would be required to provide an appropriate adjustment to the physician fee schedule for the technical component of the diagnostic mammography based on the most recent cost data available. This adjustment would be applied to services provided on or after January 1, 2004.

Senate Bill

Unilateral and bilateral diagnostic mammography as well as screening mammography services would be excluded from OPPS. The Secretary would be required to provide an appropriate adjustment to the physician fee schedule for the technical component of the diagnostic mammography based on the most recent cost data available. This adjustment would be applied to services provided on or after January 1, 2005.

Conference Agreement

Screening mammography and diagnostic mammography will be excluded from OPPS. This provision will apply to screening mammography services furnished on or after the date of enactment and will apply to diagnostic mammography services furnished on or after January 1, 2005.

Waiver of Deductible for Colorectal Cancer Screening Tests (Section 613 of the House Bill).

Present Law

Covered colorectal screening tests for prevention purposes include (1) an annual fecal-occult blood test for individuals age 50 and older; (2) flexible sigmoidoscopy every 4 years for individuals age 50 and older; (3) colonoscopy for high-risk individuals every 2 years and for other individuals every 10 years; and (4) screening barium enemas every 4 years for individuals age 50 and older who are not at high risk of developing colorectal cancer or every 2 years for high risk individuals. Payment is made according to the applicable payment system for the provider performing the test.

Unless otherwise specified, Part B services are subject to beneficiary cost sharing amounts, including an annual deductible and coinsurance amount. Colorectal screening tests are subject to the deductible and coinsurance.

House Bill

The Part B deductibles would be waived for colorectal cancer screening tests. The provision would apply to items and services furnished on or after January 1, 2004.

Senate Bill

No provision.

Conference Agreement

No provision.

Subtitle C—Other Provisions

Hospital Outpatient Department (HOPD) Payment Reform (Section 621 of the Conference Report, Section 621(a) of the House Bill, and Section 436 of the Senate Bill).

Payment for Drugs (Section 621(a) of the Conference Agreement, Sections 621(a) and 621(d) of the House Bill, and Section 436 of the Senate Bill).

Present Law

Under hospital outpatient department (HOPD) prospective payment system (OPPS), the unit of payment is the individual service or procedure as assigned to one of about 570 ambulatory payment classifications (APCs) groups. Services are classified into APCs based on their Healthcare Common Procedure Coding System (HCPCS), a standardized coding system used to identify products, supplies, and services for claims processing and payment purposes. To the extent possible, integral services and items including drugs are bundled or packaged within each APC. For instance, an APC for a surgical procedure will include operating and recovery room services, anesthesia and surgical supplies. Medicare's payment for HOPD services is calculated by multiplying the relative weight associated with an APC by a geographically adjusted conversion factor. The conversion factor is updated on a calendar year schedule and the annual updates are based on the hospital market basket (MB). Currently, the CY2004 HOPD update will equal the projected change in the MB.

Medicare pays for covered outpatient drugs in one of three ways: (1) as a transitional pass-through payment; (2) as a separate APC payment; or (3) as packaged APC payment with other services.

Transitional pass-through payments are supplemental payments to cover the incremental cost associated with new medical devices, drugs and biologicals that are inputs to an existing service. The additional payment for a given item is established for 2 or 3 years and then the costs are incorporated into the APC relative weights. BBRA specified that pass-through payments would be made for current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act; current cancer therapy drugs, biologicals, and brachytherapy; current radiophamaceutical drugs and biological products; and new drugs and biological agents.

Generally, CMS has established that a pass-through payment for an eligible drug is based on the difference between 95% of its average wholesale price and the portion of the otherwise applicable APC payment rate attributable to the existing drug, subject to a budget neutrality provision. The pass-through amount for new drugs with a substitute drug recognized in a separate drug APC payment is the difference between 95% of new drug's AWP and the payment rate for the comparable dose of the associated drugs APC.

CMS imputes the hospital costs for these drugs to establish the beneficiary copayment amounts as well as to project the amount of pass-through spending in order to calculate the uniform reduction to payments under the budget neutrality constraint. This imputed value is calculated by multiplying the average wholesale price (AWP) for the drug by the applicable cost-to-charge ratio which varies by the class of drug. For CY2003, the average ratio of cost to AWP for sole-source drugs manufactured by one entity is 0.71, for multiple source drugs is 0.68, and for multiple source drugs with generic competitors is 0.43. There is enormous variation within a category from close to zero to above 100% of AWP.

Current drugs and biologicals that have been in transitional pass-through status on or prior to January 1, 2000 were removed from that payment status effective January 1, 2003. CMS established separate APC payments for certain of these drugs, including orphan drugs, blood and blood products, and selected higher cost drugs in CY2003. CMS established a threshold of $150 per claim line for a drug to qualify for a separate APC payment as a higher-cost drug. Other drugs that had qualified for a transitional pass-through payment were packaged in to procedural APCs. For example, in some instances, brachytherapy seeds (radioactive isotopes used in cancer treatments) were packaged into payments for brachytherapy procedures. Essentially, the payment rates for these drug-related APCs are based on a relative weight calculated in the same way as procedural APCs are calculated. However, the cost to charge ratios are from only one department.

House Bill

Under Section 621(a), starting for services furnished on or after January 1, 2004, certain covered OPD drugs would be paid no more than 95% of AWP or be less than the transition percentage of the AWP from CY2004 through CY2006. In subsequent years, payment would be equal to average price for the drug in the area and year established by the competitive acquisition program under 1847A. The covered OPD drugs affected by this provision are radiopharmceuticals and outpatient drugs that were paid on a pass-through basis on or before December 31, 2002. These would not include drugs for which pass-through payments are first made on or after January 1, 2003 or those drugs for which a temporary HCPCS code has not been assigned. Drugs for which a temporary HCPCS code has not been assigned would be reimbursed at 95% of the AWP.

The transition percentage to AWP for sole-source drugs manufactured by one entity is 83% in CY2004, 77% in CY2005, and 71% in CY2006. The transition percentage to AWP for innovator multiple source drugs is 81.5% in CY2004, 75% in CY2005, and 68% in CY2006. The transition percentage to AWP for multiple source drugs with generic drug competitors is 46% in CY2004 through CY2006. Generally, a multiple source drug is a covered drug for which there are 2 or more therapeutically equivalent drug products. An innovator multiple source drug is a multiple source drug that was originally marketed under an original new drug application approved by the Food and Drug Administration (FDA). A sole source drug is not a multiple source drug. The additional expenditures resulting from these provisions would not be subject to the budget neutrality requirement.

Starting in CY2004, the Secretary would be required to lower the threshold for establishing a separate APC group for higher costs drugs from $150 to $50 per administration. These separate drug APC groups would not be eligible for outlier payments. Starting in CY2004, Medicare's transitional pass-through payments for drugs and biologicals covered under a competitive acquisition contract would reflect the amount paid under that contract, not 95% of AWP.

Under Section 621(d), the Secretary would be required to study the hospital acquisition costs related to covered outpatient drugs that cost $50 per administration and more that are reimbursed under the HOPD–PPS. The study would encompass a representative sample of urban and rural hospitals. The report including recommendations on the usefulness of the cost data and frequency of subsequent data collection efforts would be due to Congress no later than January 1, 2006. The report would also discuss whether the data is appropriate for making adjustments to payments made under the competitive acquisition contract established by section 1847A and whether separate estimates can be made for overhead costs including handling and administering drugs. The provision would be effective upon enactment.

Senate Bill

A new payment mechanism for certain drugs and biologicals provided in hospital outpatient departments (OPD) would be established from January 1, 2005 and before January 1, 2007. The drugs and biologicals would be those for which hospitals received transitional pass-through payments prior to January 1, 2005 and those that would have been paid in such a manner but for the application of this provision or those that are assigned to drug specific APCs on or after the date of enactment. Payments made under this provision would be exempt from the budget neutrality requirement in FY2005 and FY2006.

In 2005, these drugs or biologicals furnished as part of a current OPD service would be paid as follows: a single source or orphan product would be paid at 94% of the AWP existing on May 1, 2003; a multiple source drug would be paid at 91% of the AWP existing on May 1, 2003; and a multiple source drug with generic equivalents would be paid at 71% of AWP on May 1, 2003. Drugs and biologicals that were furnished as part of other OPD services would be paid using the same applicable percentage of the AWP that would have been determined on May 1, 2003 if payment could have been made on that date. For 2006, these payment amounts would be increased by the percentage increase in the consumer price index for all urban consumers for the 12–month period ending in June of the previous year.

The Secretary would be required to contract with an eligible organization (a private nonprofit organization) to conduct a study to determine the hospital acquisition, pharmacy services, and handling costs for each of the drugs paid in this fashion. The study would be required to be accurate with 3% of the true mean hospital acquisition and handling costs for each drug and biological at the 95% confidence level; begin not later than January 1, 2005; and be updated annually. Each year, beginning January 1, 2006, the Secretary would be required to submit a report to Congress, including recommendations, on the drug costs. These drug costs would be used in determining the payment amounts for each drug and biological provided as part of a covered OPD service furnished on or after January 1, 2007.

Conference Agreement

Starting for services furnished on or after January 1, 2004, specified covered OPD drugs would be paid based on a percentage of the reference average wholesale price for the drug. The percentage of the reference price for sole-source drugs manufactured by one entity can be no less than 88% and no greater than 95% in CY2004 and no less than 83% and no greater than 95% in CY2005. The percentage of the reference price for innovator multiple source drugs can be no greater than 68% in CY2004 and CY2005. The percentage of the reference price for noninnovator multiple source drugs can be no greater than 46% in CY2004 and CY2006. The reference average wholesale price is the average wholesale price for the drug as of May 1, 2003.

A sole source drug is biological product approved under a biologics license application under section 351 of the Public Health Services Act or a single source drug produced or distributed under an original new drug application approved by the Food and Drug Administration (FDA) which includes a drug product marketed by appropriate cross-licensed producers or distributors as established in Section 1927(k)(7)(A)(iv) of the Social Security Act (the Act); an innovator multiple source drug is a multiple source drug that was originally marketed under an original new drug application approved by FDA as established in Section 1927(k)(7)(A)(ii) of the Act; and, a noninnovator multiple source drug is a multiple source drug that is not an innovator multiple source drug as established in 1927(k)(7)(A)(iii) of the Act. A biological includes any product that the Centers for Medicare and Medicaid services has determined to be a biological under section 1861(t)(1) of the Act.

It is the intent of the Conference that products eligible for the transitional payment under the hospital outpatient department section include all products paid by Medicare on a pass-through list as a drug or biologic prior to December 31, 2002, or as a radiopharmaceutical product as a pass-through product are in a separate ambulatory payment classification (APC). This section clarifies that radiopharmaceuticals are drugs under the hospital outpatient department section and that the term "specified covered outpatient drug" includes radiopharmaceuticals.

In subsequent years, payment will be equal to the average acquisition cost for the drug for that year (which may vary by hospital group taking into account hospital volume or other hospital characteristics) or if hospital acquisition cost data are not available, the average price for the drug in the year other than radiopharmacuticals established under Sections 1842(o), 1847A or 1847B as calculated and adjusted by the Secretary. The covered OPD drugs affected by this provision are outpatient drugs that were paid on a pass-through basis on or before December 31, 2002. These would not include drugs for which pass-through payments are first made on or after January 1, 2003; those drugs for which a temporary HCPCS code has not been assigned; or, during 2004 and 2005, orphan drugs. Drugs for which a temporary HCPCS code has not been assigned will be reimbursed at 95% of the AWP. Orphan drugs during this 2 year time period will be paid at an amount specified by the Secretary.

GAO is required to conduct an acquisition cost survey for each specified covered drug in 2004 and 2005. The surveys (those done by GAO and then subsequently by the Secretary) will be based on a large sample of hospitals that is sufficient to generate a statistically significant estimate of the average hospital acquisition cost for each specified covered outpatient drug. No later than April 1, 2005, GAO will furnish this survey data to the Secretary to use in setting payment rates for 2006. GAO will evaluate the 2006 payment rates and submit a report to Congress on their appropriateness no later than 30 days after the date the Secretary promulgates the proposed rule setting forth these rates.

Upon completion of their surveys, GAO will submit recommendations regarding the survey methodology and survey frequency to the Secretary for subsequent surveys. The Secretary will conduct periodic surveys to determine the hospital acquisition costs for each specified covered outpatient drug to set subsequent payment rates. GAO will report to Congress on the justification for the size of the sample used in order to assure the validity of the estimates; the extent of variation in hospital acquisition costs among hospitals based on the volume of covered OPD services or other relevant characteristics.

MedPAC will submit a report to the Secretary on the payment adjustment to ambulatory payment classifications for specified covered outpatient drugs that takes into account overhead and related expenses (such as pharmacy services and handling costs). The report will include (1) a description and analysis of the available data; (2) a recommendation as to whether the payment adjustment should be made; and (3) if such an adjustment should be made, a recommendation regarding the appropriate methodology. The Secretary is authorized to adjust the weights for ambulatory payment classification based on such a recommendation.

The additional expenditures that result from the previous changes will not be taken into account in establishing the conversion, weighting and other adjustment factors for 2004 and 2005, but will be taken into account in subsequent years.

For drugs and biologicals furnished in 2004 and 2005, the Secretary is required to lower the threshold for establishing a separate APC group for higher costs drugs from $150 to $50 per administration. These separate drug APC groups are not be eligible for outlier payments. Starting in CY2004, Medicare's transitional pass-through payments for drugs and biologicals covered under a competitive acquisition contract will equal the average price for the drug or biological for all competitive acquisition areas calculated and adjusted by the Secretary for that year.

Special Payment for Brachytherapy (Section 421(b) of the Conference Report, Section 621(b) of the House Bill and Section 450A of the Senate Bill).

Present Law

Current drugs and biologicals that have been in transitional pass-through status on or prior to January 1, 2000 were removed from that payment status effective January 1, 2003. The Center for Medicare and Medicaid Services (CMS) established separate APC payments for certain of these drugs, including orphan drugs, blood and blood products, and selected higher cost drugs in CY2003. CMS established a threshold of $150 per claim line for a drug to qualify for a separate APC payment as a higher-cost drug. Essentially, the payment rates for these drug-related APCs are based on a relative weight calculated in the same way as procedural APCs are calculated. Other drugs that had qualified for a transitional pass-through payment were packaged in to procedural APCs. For example, in some instances, brachytherapy seeds (radioactive isotopes used in cancer treatments) were packaged into payments for brachytherapy procedures.

Essentially, the payment rates for these drug-related APCs are based on a relative weight calculated in the same way as procedural APCs are calculated.

House Bill

From January 1, 2004 through December 31, 2006, Medicare's payments for brachytherapy devices would equal the hospital's charges adjusted to cost. The Secretary would be required to create separate APCs to pay for these devices that reflect to the number, isotope, and radioactive intensity of such devices. This would include separate groups for palladium-103 and iodine-125 devices. GAO would be required to study the appropriateness of payments for brachytherapy devices and submit a report including recommendations to Congress no later than January 1, 2005. The provision would be effective upon enactment.

Senate Bill

The Secretary would be required to conduct a 3-year demonstration project that would exclude brachytherapy devices from the OPPS and paid on the basis of the hospital's charges for each device, adjusted to cost. The Secretary would be required to create separate, additional groups of covered HOPD services for brachytherapy devices to reflect the number, isotope, and radioactive intensity of such devices. The Secretary would be required to assure that aggregate payments under this project would not exceed what otherwise would have been spent. The project would begin 90 days after the date of enactment. The Secretary would be required to submit a report on the evaluation of patient outcomes and cost effectiveness of the project to Congress no later than January 1, 2007.

Conference Agreement

The provision would require the Secretary to make payment for each brachytherapy device furnished under the hospital outpatient prospective payment system equal to the hospital's charges for the brachytherapy device adjusted to cost for all brachytherapy devices furnished on or after January 1, 2004 and before January 1, 2007. Charges for such devices will not be included in determining any outlier payment.

The provision also would require the Secretary to create and use ambulatory payment classification (APC) groups that classify brachytherapy devices separately from all the other services and items paid for under the hospital outpatient prospective payment system. The Secretary must reflect the number, the radioactive isotope and the radioactive intensity of the brachytherapy devices furnished to each patient, including the use of separate APCs for brachytherapy devices made from palladium-103 and iodine-125.

Limitation of Application of Functional Equivalence Test (Section 622 of the Conference Agreement, Section 621(c) of the House Bill, and Section 437 of the Senate Bill).

Present Law

In the November, 1 2002 Federal Register, CMS established a new concept of functional equivalence for drugs to an existing treatment. The transitional pass-through rate for a drug was reduced to zero starting for services in 2003.

House Bill

The Secretary would be prohibited from applying a functional equivalence standard or any similar standard in order to deem a particular drug or biological to be similar or functionally equivalent to another drug unless the Commissioner of the Food and Drug Administration establishes such a standard and certifies that the two products are functionally equivalent. The Secretary would be able to implement this standard after applicable rulemaking requirements.

This provision would apply to the application of a functional equivalent on or after the date of enactment. The provision prohibits the application of this standard to a drug or biological prior to June 13, 2003.

Senate Bill

The Secretary would be prohibited from publishing regulations that apply a functional equivalence standard to a drug or biological for transitional pass-through payments under OPPS. This prohibition would apply to the application of the functional equivalence standard on or after the date of enactment, unless such application was made prior to enactment and the Secretary applies such standard to the drug only for the purposes of transitional pass-through payments. This provision would not affect the Secretary authority to deem a particular drug to be identical to another drug if the 2 products are pharmaceutically equivalent and bioequivalent, as determined by the Commissioner of the Food and Drug Administration.

Conference Agreement

The Secretary is prohibited from publishing regulations, program memorandum local medical review policies or any other guidance (including the HOPD-PPS payment rate rules) that apply a functional equivalence or similar standard to a drug or biological for transitional pass-through payments under OPPS. This prohibition applies to the application of the functional equivalence standard on or after the date of enactment, unless such application was made prior to enactment and the Secretary applies such standard to the drug only for the purposes of transitional pass-through payments. This provision does not affect the Secretary's authority to deem a particular drug to be identical to another drug if the 2 products are pharmaceutically equivalent and bioequivalent, as determined by the Commissioner of the Food and Drug Administration.

Payment for Renal Dialysis Services (Section 623 of the Conference Agreement, Section 623 of the House Bill, Section 432(b)(5) of the Senate Bill).

Present Law

Dialysis facilities providing care to beneficiaries with end-stage renal disease (ESRD) receive a fixed prospectively determined payment amount (the composite rate) for each dialysis treatment, regardless of whether services are provided at the facility or in the patient's home. The composite rate includes the dialysis costs but excludes separately billable drugs and biologicals and laboratory services. Providers receive 95% of the AWP for separately billable injectable medications other than erythropoietin (EPO) administered during treatments at the facility. Medicare pays separately for EPO which is used to treat anemia for persons with chronic renal failure who are on dialysis. Congress has set Medicare's payment for (EPO) at $10 per 1,000 units whether it is administered intravenously or subcutaneously in dialysis facilities or in patients' homes.

BBRA increased the composite rates by 1.2% for dialysis services furnished in both 2000 and 2001. BIPA subsequently increased the 2001 update to 2.4%. The composite rate has not been increased since then.

Prior to BIPA, an increase in the composite rate would trigger an opportunity for facilities to request an exception to the composite rate in order to receive higher payments. BIPA prohibited the Secretary from granting new exceptions to the composite rate (after applications received after July 1, 2001).

In 2003, Secretary announced a demonstration project establishing a disease-management program that will allow organizations experienced with treating end-stage renal disease (ESRD) patients to develop financing and delivery approaches to better meet the needs of beneficiaries with ESRD. CMS is soliciting a variety of types of organizations to coordinate care to patients with ESRD, encourage the provision of disease-management services for these patients, collect clinical performance data and provide incentives for more effective care.

House Bill

The provision would increase the ESRD composite payment rate by 1.6% for 2004.

The prohibition on exceptions contained in BIPA section 422(a)(2) would not apply to pediatric ESRD facilities as of October 1, 2002. Pediatric facilities would be defined as a renal facility with 50% of its patients under 18 years old. The provision would be effective upon enactment.

The provision would require the Secretary to establish an advisory board for the ESRD disease management demonstration. The advisory board would be comprised of representatives of patient organizations, clinicians, the Medicare Payment Advisory Commission (MedPAC), the National Kidney Foundation, the National Institute of Diabetes and Digestive and Kidney Diseases of the National Institutes of Health, ESRD networks, Medicare contractors to monitor quality of care, providers of services and renal dialysis facilities furnishing ESRD services, economists, and researchers. The provision would be effective upon enactment.

Senate Bill

The composite rate for dialysis services furnished during 2004 would be increased by an amount to ensure that the sum of the total amount of the composite rate payments plus the payments that are billed separately for drugs and biologicals (but not EPO) would equal the composite rate payments plus payments made for separately billed drugs and biologicals (not including EPO) as if the drug pricing provisions of this legislation were not enacted. During 2005, the ESRD composite rate would be increased by 0.05% and further increased by 1.6%. During 2006, the ESRD composite rate of the previous year would be increased by 0.05% and then further increased by 1.6%. During 2007 and subsequently, the composite ESRD rate of the previous year would be increased by 0.05%. In any year after 2004, the Secretary would be required to provide for additional increases in the composite rate to account for any payment reductions for separately administered drugs and biologicals (but not EPO) in the same manner as in 2004. These payment amounts, methods or adjustments would not be subject to administrative or judicial review under the statutory appeals processes as established by Senate section 1869 of the SSA, by the Provider Reimbursement Review Board established by Senate section 1878 of the SSA, or otherwise. The provision would be effective upon enactment.

Conference Agreement

The conference agreement increases the composite rate for renal dialysis by 1.6% for 2005.

The prohibition on exceptions contained in BIPA section 422(a)(2) does not apply to pediatric ESRD facilities as of October 1, 2002. Pediatric ESRD facilities are defined as renal facilities with 50% of their patients under 18 years old. The provision is effective upon enactment.

The Inspector General of HHS is required to conduct 2 studies regarding drugs and biologicals (including erythropoietin) furnished to ESRD patients and billed separately to Medicare by ESRD facilities. The first study will address existing drugs and biologicals—those for which a billing code exists prior to January 1, 2004—and is required to be submitted to the Secretary by April 1, 2004. The second study is of new drugs and biologicals—those for which a billing code does not exist prior to January 1, 2004—and is due to the Secretary by April 1, 2006. Each study is required to determine the difference, or spread, between the Medicare payment amount to ESRD facilities for drugs and biologicals, and the facilities' acquisition costs for the drugs and biologicals which are separately billed by the facilities. The studies are also to estimate the rates of growth of expenditures for these drugs and biologicals.

The conference agreement requires the Secretary to establish a basic case-mix adjusted prospective payment system for dialysis services. The basic case-mix adjusted system is required to begin for services furnished on January 1, 2005. The system is required to adjust for a limited number of patient characteristics (the case-mix).

The basic case-mix adjusted system is composed of two components: (1) those services which currently comprise the composite rate (including the 1.6% increase in 2005), and (2) the spread on separately billed drugs and biologicals (including erythropoietin and as determined by the Inspector General reports).

Drugs and biologicals (including erythropoietin) currently billed separately, will continue to be billed separately under the basic case-mix adjusted system at acquisition costs. They cannot be bundled into the new system.

In addition, the Secretary is also required to adjust the basic case-mix adjusted system payment rates by a geographic index. If the geographic index is different from the one used with the composite rate, then the Secretary is required to phase-in the application over a multi-year period.

Overall, spending for ESRD services included under the basic case-mix adjusted system is required to result in the same aggregate amount of expenditures as would occur if the current system continued in 2005

The system would be updated in 2006 for growth in drug spending for the portion of the basic case-mix adjusted payment amount that is represented by what is current spread on separately billed drugs and biologicals. However, the provision does not provide for an update to the composite rate portion of the base rate in 2006 and forward. The increase for drug growth for the spread component would be adjusted downward by its proportionate share (of the spread and composite rate components) and the resulting increase applied to the sum. An adjustment would be made in 2007 for the spread calculated for new drugs and biologicals (those for which a billing code does not exist prior to January 1, 2004) using the 2006 Inspector General study.

Payments for separately billed drugs and biologicals will be 95% of the AWP for 2004 and acquisition costs in 2005, and, beginning in 2006 the Secretary has the authority to apply a payment methodology he determines appropriate which may include the average sales price payment methodology (under the new section 1847A found in section 303(c) of the conference agreement) or acquisition costs.

No administrative or judicial review is permitted of the case-mix system, the relative weights, payment amounts, the geographic adjustment factor, or the update of the basic case-mix adjusted system portion related to drug spending growth applied to spread, or in the determination of the difference between Medicare payment amounts and acquisition costs for separately billed drugs and biologicals.

By October 1, 2005, the Secretary is required to report to Congress on the elements and features for the design and implementation of a fully case-mix adjusted, bundled prospective payment system for services furnished by ESRD facilities, including to the extent feasible, drugs, clinical laboratory tests, and other items that are separately billed by ESRD facilities. The report is required to include a description of the methodology to be used for the establishment of payment rates including the bundle of items and services, case-mix, wage index, rural area payment adjustments, other adjustments, and update framework.

The Secretary is required to establish a 3-year demonstration project of the fully case-mix adjusted payment system for ESRD services, beginning January 1, 2006. The fully case-mix adjusted system is to include a case-mix system for patient characteristics identified in the report and to bundle separately billed drugs and biologicals and related clinical laboratory tests into the payment rates. The Secretary is required to ensure that sufficient numbers of providers of dialysis services and ESRD facilities participate in the demonstration, but not to exceed 500. The Secretary is required to ensure that urban, rural, not-for-profit, for-profit, independent, and specialty providers and facilities are included in the demonstration. During the demonstration, the Secretary is required to increase payment rates that would otherwise apply by 1.6% for dialysis services furnished by demonstration participants. In carrying out the demonstration, the Secretary is required to establish an advisory board comprised of representatives of: patient organizations; individuals with expertise in ESRD services, such as clinicians, economists, and researchers; the Medicare Payment Advisory Commission, the National Institutes of Health, network organizations; Medicare contractors to monitor quality of care; and providers of services and renal dialysis facilities. The advisory panel is required to terminate December 31, 2008. Appropriations are authorized from the Medicare trust funds in the amount of $5 million in FY 2006 to conduct this demonstration.

1-Year Moratorium on Therapy Caps; Provisions Relating to Report (Section 624 of the Conference Agreement and Section 624 of the House Bill).

Present Law

Medicare provides that therapy patients must be under the care of a physician; a plan of treatment must be developed by the physician or therapist; and the plan must be periodically reviewed by the physician.

BBA 97 established annual payment limits per beneficiary for all outpatient therapy services provided by non-hospital providers. The limits applied to services provided by independent therapists as well as to those provided by comprehensive outpatient rehabilitation facilities (CORFs) and other rehabilitation agencies. There are 2 beneficiary limits. The first is a $1,500 per beneficiary annual cap for all outpatient physical therapy services and speech language pathology services. The second is a $1,500 per beneficiary annual cap for all outpatient occupational therapy services. Beginning in 2002, the amount would increase by the Medicare Economic Index (MEI), rounded to the nearest multiple of $10. The limits did not apply to outpatient services provided by hospitals. BBRA 99 suspended application of the therapy limits in 2000 and 2001. BIPA extended the suspension through 2002. The therapy caps became effective in September 2003.

BBA 97 required the Secretary to report to Congress by January 1, 2001, on recommendations on a revised coverage policy of outpatient physical therapy and occupational therapy services based on a classification of individuals by diagnostic category and prior use of services, in both inpatient and outpatient settings, in place of uniform dollar limitations. BIPA required the Secretary to conduct a study on the implications of eliminating the "in the room" supervision requirement for Medicare payment for physical therapy assistants who are supervised by physical therapists and the implications of this requirement on the physical therapy cap. A report on the study was due within 18 months of enactment.

House Bill

Application of the therapy caps would be suspended in 2004. The Secretary would be required to submit the reports required by BBA 97 and BIPA by December 31, 2002. The Secretary would be required to request the Institute of Medicine to identify conditions or diseases that should justify conducting an assessment of the need to waive the therapy caps. The Secretary would be required to submit to Congress a preliminary report on the conditions and diseases identified by July 1, 2004. A final report, including recommendations, would be due by October 1, 2004.

Senate Bill

No provision.

Conference Agreement

Application of the therapy caps is suspended as of the date of enactment through calendar year 2005. The implementation of this provision shall not be deemed to have any retroactive impact upon beneficiaries who exceeded their caps prior to the date of enactment. The Secretary is required to submit the reports required by BBA 97 and BIPA by March 31, 2004 relating to the alternatives to a single annual dollar cap on outpatient therapy and the utilization patterns for outpatient therapy. The GAO is required to identify conditions or diseases that may justify waiving the application of the therapy caps and report to Congress by October 1, 2004. The report is required to include a recommendation of criteria, with respect to the conditions and diseases, under which a waiver of the therapy caps would apply.

Waiver of Part B Late Enrollment Penalty for Certain Military Retirees; Special Enrollment Period (Section 625 of the Conference Agreement, Section 627 of the House Bill, and Section 439 of the Senate Bill).

Present Law

A late enrollment penalty is required to be imposed on beneficiaries who do not enroll in Medicare part B upon becoming eligible for Medicare.

House Bill

Congress enacted TRICARE for Life, which re-established TRICARE health care coverage as a wraparound to Medicare for military retirees, age 65 and older. To take advantage of the TRICARE for Life program, military retirees must be enrolled in Medicare Part B. There is a late enrollment penalty for military retirees who do not enroll in Medicare Part B upon becoming eligible for Medicare. This provision would waive the late enrollment penalty for military retirees, 65 and older, who enroll(ed) in the TRICARE for Life program from 2001–2004.

The Secretary would also be required to provide a special Part B enrollment period for these military retirees beginning as soon as possible after enactment and ending December 31, 2004. The provision would apply to premiums for months beginning January 2004. The Secretary would be required to rebate premium penalties paid for months on or after January 2004 for which a penalty does not apply as a result of this provision, but for which a penalty was collected.

Senate Bill

Beginning January 2005, the provision would waive the late enrollment penalty for certain military retirees who enrolled in Part B during 2002, 2003, 2004 or 2005. A special enrollment period, beginning 1 year after enactment and ending December 31, 2005 would be provided.

Conference Agreement

Congress enacted TRICARE for Life, which re-established TRICARE health care coverage as a wraparound to Medicare for military retirees, age 65 and older. To take advantage of the TRICARE for Life program, military retirees must be enrolled in Medicare Part B. The provision waives the late enrollment penalty for military retirees who did not enroll in Medicare Part B upon becoming eligible for Medicare. The waiver applies to the late enrollment penalty for military retirees, 65 and over, who enroll(ed) in the TRICARE for Life program from 2001 to 2004.

The Secretary is required to provide a special Part B enrollment period for these military retirees beginning as soon as possible after enactment and ending December 31, 2004. The provision applies to premiums for months beginning January 2004. The Secretary is required to rebate premium penalties paid for months on or after January 2004 for which a penalty does not apply as a result of this provision, but for which a penalty was collected.

Payments for Services Furnished in Ambulatory Surgical Centers (Section 626 of the Conference Agreement and Section 625 of the House Bill).

Present Law

Medicare uses a fee schedule to pay for the facility services related to a surgery provided in an ambulatory surgery center (ASC). The associated physician services (surgery and anesthesia) are reimbursed under the physician fee schedule. CMS maintains the list of approved ASC procedures which is required to be updated every 2 years. The Secretary is required to update ASC rates based on a survey of the actual audited costs incurred by a representative sample of ASCs every 5 years beginning no later than January 1, 1995. Between revisions, the rates are to be updated annually on a calendar year schedule using the CPI-U. From FY1998 through FY2002, the update was established as the CPI-U minus 2.0 percentage points, but not less than zero.

In June 1998, CMS issued a proposed notice which would have implemented a prospective payment system (PPS) for ASCs. The Balanced Budget Refinement Act of 1999 required that full implementation of the proposed ASC rates be phased in over a 3-year period. The Benefits Improvement and Protection Act of 2000 (BIPA) delayed implementation of the PPS before January 1, 2002. BIPA also required that CMS use 1999 or later cost survey data in the PPS. A final rule implementing the new payment system for ASCs has not yet been issued.

House Bill

The reduction in the update would be extended. ASCs would get an increase calculated as the CPI-U minus 2.0 percentage points (but not less than zero) in each of the fiscal years from 2004 through 2008.

Senate Bill

No provision.

Conference Agreement

In FY2004, starting April 1, 2004, the ASC update will be the CPI-U (estimated as of March 31, 2003 minus 3.0 percentage points. In FY2005, the last quarter of calendar year 2005, and each of the calendar years 2006 through 2009 the update will be 0%. Upon implementation of the new ASC payment system, the Secretary will no longer be required to update ASC rates based on a survey of the actual audited costs incurred by a representative sample of ASCs every 5 years. Subject to GAO's recommendations (discussed subsequently), the Secretary will implement a revised payment system for surgical services furnished in an ASC. This payment system will be designed to be budget neutral in the year it is implemented; the amount of aggregate expenditures for such services under the new system will be the same as would have occurred under the old system. The new system will be implemented so that it is first effective on or after January 1, 2006 and not later than January 1, 2008. There will be no administrative or judicial review of the ASC classification system, relative weights, payment amounts and any geographic adjustment factor. GAO will conduct a comparative study of the relative costs of procedures furnished in ASCs to those furnished in hospital outpatient departments under OPPS. The study will examine the accuracy of the ambulatory payment categories with respect to the procedures furnished in the ASCs. GAO will submit recommendations and consider ASC data with respect to (1) the appropriateness of using groups and relative weights established for the outpatient hospital PPS as the basis of the new ASC payment system; (2) if such weights are appropriate, whether the ASC payments should be based on a uniform percentage of such weights, whether the percentages should vary, or whether the weights should be revised for certain procedures or types of services; and (3) the appropriateness of a geographic adjustment in the ASC payment system and if appropriate, the labor and nonlabor shares of such payment.

Payment for Certain Shoes and Inserts under the Fee Schedule for Orthotics and Prosthetics (Section 627 of the Conference Agreement, and Section 626 of the House Bill).

Present Law

Subject to specified limits and under certain circumstances, Medicare will pay for extra-depth shoes with inserts or custom molded shoes with inserts for an individual with severe diabetic foot disease. Coverage is limited to one of the following within a calendar year: (1) one pair of custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or (2) one pair of extra-depth shoes (not including inserts provided with such shoes) and three pairs of inserts. An individual may substitute modifications of custom-molded or extra-depth shoes instead of obtaining one pair of inserts, other than the initial pair of inserts. Footwear must be fitted and furnished by a podiatrist or other qualified individual such as a pedorthist, orthotist, or prosthetist. The certifying physician may not furnish the therapeutic shoe unless the physician is the only qualified individual in the area.

Payment is made on a reasonable charge basis, subject to upper limits established by the Secretary. These limits are based on 1988 amounts that were set forth in Section 1833(o) of the Act and then adjusted by the same percentage increases allowed for DME fees except that if the updated limit is not a multiple of $1, it is rounded to the nearest multiple of $1. The Secretary or a carrier may establish lower payment limits than established by statute if shoes and inserts of an appropriate quality are readily available at lower amounts.

Although updates in payment for diabetic shoes are related to that used to increase the DME fee schedule, the shoes are not subject to DME coverage rules or the DME fee schedule. In addition, diabetic shoes are neither considered DME nor orthotics, but a separate category of coverage under Medicare Part B.

House Bill

Payment for diabetic shoes would be limited by the amount that would be paid if they were considered to be a prosthetic or orthotic device. The Secretary would be able to establish lower payment limits than these amounts if shoes and inserts of an appropriate quality are readily available at lower amounts. The Secretary would be required to establish a payment amount for an individual substituting modifications to the covered shoe that would assure that there is no net increase in Medicare expenditures. The provision would apply to items furnished on or after January 1, 2004.

Senate Bill

No provision.

Conference Agreement

Payment for diabetic shoes is limited under the conference agreement by the amount that would be paid if they were considered to be a prosthetic or orthotic device. The Secretary may establish lower payment limits than these amount if shoes and inserts of an appropriate quality are readily available at lower amounts. The Secretary is required to establish a payment amount for an individual substituting modifications to the covered shoe that would assure that there is no net increase in Medicare expenditures. The provision applies to items furnished on or after January 1, 2005.

Payment for Clinical Diagnostic Laboratory Tests (Section 628 of the Conference Agreement, Section 431 of Senate Bill).

Present Law

Medicare payment for clinical diagnostic laboratory test is made using a fee schedule. The fee schedule is updated on a calendar year basis using the CPI-U. BBA 97 froze the fee schedule from 1998 through 2002. The update for 2003 was equal to the full CPI-U increase. No beneficiary cost-sharing is imposed.

House Bill

No provision.

Senate Bill

Medicare would pay all clinical laboratories 80% of the applicable fee schedule amount. Hospital-based and physician office and independent laboratories would be able to charge beneficiaries a 20% coinsurance amount. The Medicare Part B deductible would apply to clinical diagnostic laboratory tests furnished across all settings; except for those tests provided by sole community hospitals (see Senate Section 427). The provision would apply to tests furnished on or after January 1, 2004.

Conference Agreement

The conference agreement does not provide for any updates to the clinical diagnostic laboratory test fee schedule for 2004 through 2008.

Indexing Part B Deductible to Inflation (Section 629 of the Conference Agreement, Section 628 of the House Bill, Section 433 of the Senate Bill).

Present Law

Under Part B, Medicare generally pays 80 percent of the approved amount for covered services after the beneficiary pays an annual deductible of $100. The Part B deductible has been set at $100 since 1991.

House Bill

Starting for January 1, 2004, the Medicare Part B deductible would be increased by the same percentage as the Part B premium increase. Specifically, the annual percentage increase in the monthly actuarial value of benefits payable from the Federal Supplementary Medical Insurance Trust Fund would be used as the update. The amount would be rounded to the nearest dollar. The provision would be effective upon enactment.

Senate Bill

The Medicare Part B deductible would be set at $100 through 2005 and then increased to $125 in 2006. Effective January 1 of subsequent years, the deductible would be increased annually by the percentage change in the CPI-U for the previous year ending in June. The amount would be rounded to the nearest dollar. The provision would be effective upon enactment.

Conference Agreement

The Medicare Part B deductible will remain $100 through 2004. The deductible will be $110 for 2005, and in subsequent years the deductible will be increased by the same percentage as the Part B premium increase. Specifically, the annual percentage increase in the monthly actuarial value of benefits payable from the Federal Supplementary Medical Insurance Trust Fund will be used as the update. The deductible amount will be rounded to the nearest dollar. The provision is effective upon enactment.

In 1966, Medicare's $50 Part B deductible equaled about 45 percent of Part B charges. Today's $100 deductible equals about three percent of such charges. Indexing the Part B deductible to grow at the same rate as total Part B spending per beneficiary would maintain the deductible at 3 percent of such charges over time.

An unchanged Part B deductible is a benefit increase over time, as costs of medical care rise. Beneficiaries pay about 25 percent of this benefit increase, through increased Part B premiums; taxpayers finance the remaining 75 percent. The Part B deductible has increased only three times since the beginning of Medicare, when it was $50. The deductible has since been increased to $60 in 1973, $75 in 1982, and $100 in 1991. About one-half of beneficiaries are insulated from Part B deductibles through Medigap, Medicaid, or employer-sponsored supplemental insurance that covers the Part B deductible. The Part B deductible has increased only three times since Medicare began in 1965, when it was $50. It was raised to $60 in 1973, $75 in 1982, and $100 in 1991.

5-year Authorization of Reimbursement for All Medicare Part B Services Furnished by Certain Indian Hospitals and Clinics (Section 630 of the Conference Agreement and Section 450C of the Senate Bill).

Present Law

Medicare covers specified Part B services provided by a hospital or ambulatory care clinic (whether provider-based or freestanding) that is operated by the Indian Health Service, by an Indian tribe, or by a tribal organization. These services include physicians' services, health practitioners (physician assistant, nurse practitioner, or clinical nurse specialist; certified registered nurse anesthetist; certified nurse-midwife; clinical social worker; clinical psychologist; and a registered dietitian or nutrition professional) and outpatient physical therapy services provided by a physical or occupational therapists.

House Bill

No provision.

Senate Bill

The provision would expand covered Medicare Part B items and services provided in hospitals or ambulatory care clinics (whether provider-based or freestanding) that are operated by the Indian Health Service or by an Indian tribe or tribal organization. All covered Part B items and services would be paid when provided in a hospital or ambulatory care clinic operated by the Indian Health Service or by an Indian tribe or tribal organization. The provision would apply to items and services furnished on or after October 1, 2004.

Conference Agreement

The conference agreement provides a 5-year expansion of the items and services covered under Medicare Part B when furnished in Indian hospitals and ambulatory care clinics. The conference agreement applies to items and services furnished on or after January 1, 2005.

Conforming Changes Regarding Federally Qualified Health Centers (Section 420 of the Senate Bill).

Present Law

Medicare pays federally qualified health centers (FQHCs) for their services on a reasonable cost basis.

House Bill

No provision.

Senate Bill

Medicare would exclude the costs incurred by a FQHC for providing services and receiving payments through a contract with an eligible entity operating a Medicare prescription drug plan. The provision would be effective upon enactment.

Conference Agreement

No provision.

Reimbursement for Total Body Orthotic Management for Certain Nursing Home Patients (Section 450B of the Senate Bill).

Present Law

Orthotics are rigid devices, often called braces, which are applied to the outside of the body as a means of support for a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. They are categorized into one of three groups of devices: custom fitted, which require alterations to a prefabricated product; custom fabricated, which are made for a specific patient from his/her individual measurements; and molded to patient model, which are created from a cast of the patient's body part. Examples of orthotics include spinal body jackets, hip abductors, and knee braces. Add-ons, such as straps and linings, are billed separately. Suppliers of orthotics include certified orthotists, medical equipment companies, and physicians' offices.

Orthotics (e.g., leg, arm, back, and neck braces) are covered Part B benefits when furnished in an institutional setting, such as in a hospital or skilled nurses facility, while durable medical equipment (DME) is not covered in those settings. Medicare considers a brace as an orthotic device when it can be used independently of DME. On the other hand, if a brace must be used in conjunction with, or is an accessory of, a DME item, then the brace is considered an item of DME. Orthotic devices include braces that are part of a bracing system even if the system depends on attachment to an external structure or frame.

At one point, the Centers for Medicare and Medicaid (CMS) in HCFA Ruling, No. 96-1, declared that bracing systems should be characterized as DME rather than orthotics. That ruling was deemed invalid because it made a substantive change in Medicare coverage rules and was not properly promulgated. Although the braces in a bracing system are attached to an external frame, they perform the functions of braces and the external frame is assistive in nature rather than determinative of the system's classification. Since the patients who need bracing systems typically are cared for in the nursing home environment, the classification of the bracing systems is crucial because orthotics are covered when furnished to nursing home patient, while DME is not. However, under the Benefits Improvement and Protection Act of 2000 (BIPA) (PubLNo 106-554), no payment may be made for prosthetics and certain custom-fabricated orthotics unless they are furnished by a qualified practitioner and fabricated by a qualified practitioner or a qualified supplier at an approved facility. Affected custom-fabricated orthotics are items requiring education, training, and experience to custom-fabricate and that are on a list to be published by the Secretary.

House Bill

No provision.

Senate Bill

The Secretary would be required to issue product codes that qualified practitioners and suppliers may used to receive Medicare reimbursement for qualified total body orthotic management devices no later than 60 days from enactment. These medically prescribed devices would consist of custom fitted individual braces with adjustable points at the hip, knee, ankle, elbow and wrists when the braces are attached to a frame that is integral to the device and the frame serves no purpose without the braces. The device would be designed to improve function, retard the progression of musculoskeletal deformity or restrict, eliminate, or assist in the functioning of the upper or lower extremities for a beneficiary who is in the full time care of a skilled nursing facility who requires such care for medical reasons. The provision would be effective upon enactment.

Conference Agreement

No provision.

Medicare Coverage of Self Injected Biologicals (Section 450E of the Senate Bill).

Although Medicare does not currently provide an outpatient prescription drug benefit, coverage of certain outpatient drugs and biologicals is specifically authorized by statute. For example, under Medicare Part B, outpatient prescription drugs and biologicals are covered if they are usually not self-administered and are provided incident to a physician's services. Generally, Medicare will cover an outpatient drug as usually self-administered if it is delivered by intramuscular injection, but not if it is injected subcutaneously.

House Bill

No provision.

Senate Bill

From January 1, 2004 and before January 1, 2006, Medicare would cover self-injected biologicals that are approved by the Food and Drug Administration and that are prescribed as complete replacements for drugs or biologicals that are currently covered in physicians' offices or as hospital services provided to outpatients that are usually self-administered and provided incident to a physician's services. Medicare would cover self-injected drugs that are used to treat multiple sclerosis. The provision would apply to drugs and biologicals furnished on or after January 1, 2004 and before January 1, 2006.

Conference Agreement

No provision.

Requiring the Internal Revenue Service to Deposit Installment Agreement and Other Fees in the Treasury as Miscellaneous Receipts (Section 450G of the Senate Bill).

Present Law

The Secretary of the Treasury was granted the authority by Senate Section 3 of the Administrative Provisions of the Internal Revenue Service of Public Law 103-286, the Treasury, Postal Service and General Government Appropriations Act of 1995 to establish new fees (if the fee is authorized by another law) or raise fees for services provided by the Internal Revenue Service to supplement appropriations made available to the Internal Revenue Service. The fees must be based on the costs of providing the specific services (to the persons paying the fees), and the Secretary must report quarterly to the Congress on the collection of such fees and how they are spent.

House Bill

No provision.

Senate Bill

The Secretary of the Treasury must deposit any fees collected under the authority provided by Senate Section 3 of the Administrative Provisions of the Internal Revenue Service of Public Law 103-286, the Treasury, Postal Service and General Government Appropriations Act of 1995 into the Treasury as miscellaneous receipts. The fees collected are only available to the Internal Revenue Service if authority is provided in advance in an appropriations Act. The provision would be effective upon enactment.

Conference Agreement

No provision.

Medicare Coverage of Kidney Disease Education Services (Section 456 of the Senate Bill).

Present Law

No provision.

House Bill

No provision.

Senate Bill

Kidney disease education services would be covered under Medicare. The services covered would be those: furnished to an individual with kidney disease who will require dialysis or a kidney transplant; furnished upon the referral of the physician managing the individual's kidney condition; and designed to provide comprehensive information regarding the management of comorbidities, the prevention of uremic complications, and each option for renal replacement therapy (including peritoneal diaylsis, hemodialysis and transplantation) and to ensure that the individual has the opportunity to actively participate in the choice of therapy. Kidney disease education services would be paid using the physician fee schedule on an assignment-related basis (thus prohibiting balance billing) outside the ESRD composite rate.

The Secretary would be required to ensure (and to monitor implementation to ensure) that each beneficiary who is entitled to kidney disease education services under Medicare receives such services in a timely manner that ensures that the beneficiary receives the maximum benefit of the services.

The Secretary would be required to report to Congress annually on the number of Medicare beneficiaries who are entitled to these education services and who received these services. In addition, the report would include any recommendations for legislative and administrative action as the Secretary determines appropriate. The first report would be due April 1, 2004. The provision would apply to services furnished on or after January 1, 2004.

Conference Agreement

No provision.

Subtitle D—Additional Demonstrations, Studies and Other Provisions

Demonstration Project for Coverage of Certain Prescription Drugs and Biologics (Section 641 of the Conference Agreement and Section 631 of the House Bill).

Present Law

No provision.

House Bill

The Secretary would be required to conduct a 2-year demonstration project in 3 states covering more than 10,000 patients under Part B of the Medicare program that would pay for drugs and biologicals that are prescribed as replacements for existing covered drugs that are furnished incident to a physician's professional service which are not usually self-administered including oral anticancer chemotherapeutic agents. The project would not extend beyond December 31, 2005 and would not cost more than $100 million. The Secretary would be required to submit an evaluation to Congress concerning patient access and outcomes as well as the project's cost effectiveness. The Secretary would also be required to examine any cost savings attributed to reduced physicians' services and hospital outpatient department services for the administration of the biological. The demonstration project would begin 90 days from enactment and would end no later than December 31, 2005.

Senate Bill

No provision.

Conference Agreement

The conference agreement requires the Secretary to conduct a 2-year demonstration project in 6 states covering more than 50,000 patients under Medicare Part B that pays for drugs and biologics that are prescribed as replacements for existing covered drugs that are furnished incident to a physician's professional service which are not usually self-administered, including oral anticancer chemotherapeutic agents. The project is required to provide for cost-sharing applicable with respect to the drugs or biologics in the same manner as the cost-sharing applicable under part D for standard prescription drug coverage. The project is not permitted to cost more than $500 million. No less than 40 percent of the funding shall be for oral cancer. The Secretary is required to submit an evaluation to Congress concerning patient access and outcomes as well as the project's cost effectiveness. The Secretary is also required to examine any cost savings attributed to reduced physicians' services and hospital outpatient department services for the administration of the biological. The demonstration project is required to begin 90 days following enactment and end no later than December 31, 2005.

The managers intend that this provision of the demonstration will provide immediate Part B coverage for all immunomodulating drugs and biologicals used when treating multiple sclerosis. Coverage will be extended without regard to whether there is medical or other supervision with respect to the administration of such drug or biological, and include the biological administered via intramuscular injection currently covered under Section 1861(s)(2)(A) or (B) of the Social Security Act.

Extension of Coverage of Intravenous Immune Globulin (IVIG) for the Treatment of Primary Immune Deficiency Diseases in the Home (Section 642 of the Conference Agreement and Section 629 of the House Bill).

Present Law

Intravenous immune globulin (IVIG) is a blood product prepared from the pooled plasma of donors. It has been used to treat a variety of autoimmune diseases, including mucocutaneous blistering diseases. It has fewer side effects than steroids or immunosuppressive agents. Effective October 1, 2002, IVIG is covered for the treatment of certain conditions including pemphigus vulgaris, pemphigus foliaceus, and epidermolysis bullosa acquisita for the following specific patient subpopulations: (1) patients who have failed conventional therapy; (2) patients in whom conventional therapy is otherwise contraindicated; and (3) patients with rapidly progressive disease in whom a clinical response could not be affected quickly enough using conventional agents. IVIG for the treatment of autoimmune mucocutaneous blistering diseases must be used only for short term therapy and not as a maintenance therapy. Contractors have discretion to define what constitutes a failure of conventional therapy and what constitutes short-term therapy.

House Bill

Intravenous immune globulin for the treatment of primary immune deficiency diseases in the home would be included as a covered medical service. Intravenous immune globulin would be defined as an approved pooled plasma derivative for the treatment in the patient's home of a patient with a diagnosed primary immune deficiency disease, if a physician determines administration of the derivative in the patient's home is medically appropriate. This would not include items or services related to the administration of the derivative. Intravenous immune globulin would be paid at 80 percent of the lesser of actual charge or the payment amount. This provision would apply to items furnished on or after January 1, 2004.

Senate Bill

No provision.

Conference Agreement

The conference agreement includes intravenous immune globulin for the treatment in the home of primary immune deficiency diseases as a covered medical service under Medicare. Intravenous immune globulin is defined as an approved pooled plasma derivative for the treatment, in the patient's home, of a patient with a diagnosed primary immune deficiency disease, if a physician determines administration of the derivative in the patient's home is medically appropriate. Items or services related to the administration of the derivative are not included in the definition. Intravenous immune globulin is to be paid at 80 percent of the lesser of actual charge or the payment amount. This provision applies to items furnished on or after January 1, 2004.

MedPAC Study of Coverage of Surgical First Assisting Services of Certified Registered Nurse First Assistants (Section 643 of the Conference Agreement and Section 450I of the Senate Bill).

Present Law

Surgical first assisting services are not separately covered services of Medicare and certified registered nurse first assistants are not able to bill the Medicare program directly for their services. Their services are paid by surgeons who are paid under the Medicare physician fee schedule.

House Bill

No provision.

Senate Bill

The Secretary would be required to conduct a 3-year demonstration in 5 states that would pay for "surgical first assisting services" to Medicare beneficiaries furnished by a certified registered nurse first assistant. These services would consist of assisting a physician with surgery and related preoperative, intraoperative, and postoperative care furnished by a certified registered nurse first assistant. Payment would be 80% of the lesser of: the actual charge for the services or 85% of the physician fee schedule amount. Aggregate payments for the demonstration would be required not to exceed the amount that would have been paid if this demonstration project had not been implemented. The Secretary would be required to report to Congress on the evaluation of patient outcomes and on the cost-effectiveness of the demonstration by January 1, 2007. The demonstration is required to begin 90 days after enactment.

Conference Agreement

The conference agreement requires that MedPAC study the feasibility and advisability of Medicare Part B payment for surgical first assisting services furnished to Medicare beneficiaries by a certified registered nurse first assistant. MedPAC is required to submit the report by January 1, 2005 and to include recommendations for legislation or administrative action.

MedPAC Study of Payment for Cardio-Thoracic Surgeons (Section 644 of the Conference Agreement).

Present Law

Cardio-thoracic surgeons are paid under the Medicare physician fee schedule for their services.

House Bill

No provision.

Senate Bill

No provision.

Conference Agreement

The conference agreement requires the MedPAC to study the practice expense relative values in the Medicare physician fee schedule for the specialty of thoracic surgery to determine whether such values adequately take into account the attendant costs of nurse assistants at surgery. The study is required to be submitted to Congress by January 1, 2005 and to include recommendations for legislative or administrative action.

Study on Coverage of Outpatient Vision Services Furnished by Vision Rehabilitation Professionals Under Part B (Section 645 of

the Conference Agreement and Section 446 of the Senate Bill).

Present Law

Medicare does not cover routine eye care or related services and will not pay for eyeglasses; most contact lenses; eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses; and most procedures performed to determine the refractive state of the eyes.

Medicare pays for prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) when furnished incident to physicians' services or on a physician's order. The law specifically provides coverage for one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens.

The Rehabilitation Act of 1973 as amended prohibits discrimination in programs conducted by federal agencies, in programs receiving federal financial assistance, in federal employment and employment practices of federal contractors. The act provides much of the basis for the Americans with Disabilities Act including its standards for determining employment discrimination.

House Bill

No provision.

Senate Bill

Medicare Part B would cover vision rehabilitation services furnished to a beneficiary who is diagnosed with certain vision impairments. These vision impairments would be vision loss that constitutes a significant limitation of visual capability that cannot be corrected by conventional means and that is manifested by one or more of the following conditions: (1) best corrected visual acuity of less than 20/60 or significant central field defect; (2) significant peripheral field defect including homonymous or heteronymous bilateral visual field defect or generalized contraction or constriction of field; (3) reduced peak contrast sensitivity; and (4) other appropriate diagnoses or indications. Covered services would be established by a plan of care developed by a qualified physician or qualified occupational therapist whose plan of care is periodically reviewed by a qualified physician. These services would be provided in an appropriate setting by a qualified physician, qualified occupational therapist, or vision rehabilitation professional under the general supervision of a qualified physician using a plan of care established and reviewed by the qualified physician. A qualified physician would be an ophthalmologist or a doctor of optometry. A vision rehabilitation professional would include an orientation and mobility specialist, a rehabilitation teacher, or a low vision therapist who is appropriately licensed and certified under prevailing state laws with appropriate education and training.

Medicare would pay for the services under the physician fee schedule. These services would not be paid under the hospital outpatient department prospective payment system. Payment would be made to the qualified physician or the facility (such as a rehabilitation agency, a clinic, or other facility) through which services are furnished under the plan care if there is a contractual arrangement between the vision rehabilitation specialist and the facility where the facility submits the bill for the services. Medicare's coverage of vision rehabilitation services would not be taken into account for any purpose under the Rehabilitation Act of 1973.

The Secretary would be required to publish a interim final rule in the Federal Register no later than 180 days from the date of enactment; the regulation, although effective immediately, would be subject to at least a 60–day public comment period. The Secretary would be required to consult with qualified professional and consumer groups including the National Vision Rehabilitation Cooperative, the Association for Education and Rehabilitation of the Blind and Visually Impaired, the Academy for Certification of Vision Rehabilitation and Education Professionals, the American Academy of Ophthalmology, the American Occupational Therapy Association, and the American Optometric Association.

Conference Agreement

The conference agreement requires the Secretary to study the feasibility and advisability of: (1) providing for payment for vision rehabilitation services furnished by vision rehabilitation professionals, and (2) implementing a demonstration project for vision care PPO networks to furnish and pay for conventional eyeglasses subsequent to each cataract surgery with the insertion of intra ocular lens. The Secretary is urged to examine any licensure or certification difficulties faced by vision rehabilitation professionals. The report is due to Congress by January 1, 2005 and is to include recommendations for legislation or administrative action. In reviewing reimbursement for vision rehabilitation professionals, the report shall examine payments through qualified physicians to vision rehabilitation professionals for either directly supervised services or services delivered under generalized supervision.

Medicare Health Care Quality Demonstration Programs (Section 646 of the Conference Agreement and Section 441 of the Senate Bill).

Present Law

No provision.

House Bill

No provision.

Senate Bill

The Secretary would be required to establish a 5-year demonstration program that examines the health delivery factors which encourage the delivery of improved patient care quality including: (1) incentives to improve the safety of care provided to beneficiaries; (2) appropriate use of best practice guidelines; (3) reduction of scientific uncertainty through examination of service variation and outcomes measurement; (4) encouragement of shared decision making between providers and patients; (5) the provision of incentives to improve safety, quality, and efficiency; (6) appropriate use of culturally and ethnically sensitive care; and (7) related financial effects associated with these changes. The participants would include appropriate health care groups including physician groups, integrated health care delivery systems, or regional coalitions. These health care groups may implement alternative payment systems that encourage the delivery of high quality care and streamline documentation and reporting requirements. They may also offer benefit packages distinct from those that are currently available under Medicare Parts A and B and under the Part C Medicare Advantage plan. To qualify for this demonstration, health care groups must meet Secretary-established quality standards; implement quality improvement mechanisms that integrate community-based support, primary care, and referral care; encourage patient participation in decisions; among other requirements.

The Secretary may waive Medicare and Peer Review and Administrative Simplification (Title XI) requirements as necessary and may direct agencies within Health and Human Services (HHS) to evaluate, analyze, support, and assist in the demonstration project. The demonstration program would be subject to budget-neutrality requirements. The Secretary would not be permitted to implement the program before October 1, 2004.

Conference Agreement

The conference agreement requires the Secretary to establish a 5-year demonstration program that examines the health delivery factors which encourage the delivery of improved patient care quality including: (1) incentives to improve the safety of care provided to beneficiaries; (2) appropriate use of best practice guidelines; (3) reduction of scientific uncertainty through examination of service variation and outcomes measurement; (4) encouragement of shared decision making between providers and patients; (5) the provision of incentives to improve safety, quality, and efficiency; (6) appropriate use of culturally and ethnically sensitive care; and (7) related financial effects associated with these changes. Health care groups that may participate are physician groups, integrated health care delivery systems, and regional coalitions. These health care groups may implement alternative payment systems that encourage the delivery of high quality care and streamline documentation and reporting requirements. They may also offer benefit packages distinct from those that are currently available under Medicare Parts A and B and under the Part C Medicare Advantage plan.

To qualify for this demonstration, health care groups must meet Secretary-established quality standards; implement quality improvement mechanisms that integrate community-based support, primary care, and referral care; encourage patient participation in decisions; among other requirements. The Secretary may waive Medicare and Peer Review and Administrative Simplification (Title XI) requirements as necessary and may direct agencies within Health and Human Services (HHS) to evaluate, analyze, support, and assist in the demonstration project. The demonstration program is subject to budget-neutrality requirements.

GAO Study on Coverage of Marriage and Family Therapist Services and Mental Health Counselor Services Under Part B of the Medicare Program (Section 647 of the Conference Agreement and Section 448 of the Senate Bill).

Present Law

Medicare's Part B payment for outpatient mental health services is limited to 62.5% of covered expenses incurred in any calendar year in connection with the treatment of a mental, psychoneurotic, or personality disorder of an individual who is not an inpatient of a hospital at the time such expenses are incurred. The term "treatment" does not include brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of such disorders or partial hospitalization services that are not directly provided by the physician. This 62.5% payment limitation applies to outpatient mental health treatments furnished by physicians, comprehensive outpatient rehabilitation facilities (CORFs), physician assistants, clinical psychologists, and clinical social workers. Items and supplies furnished by physicians or other mental health practitioners in connection with treatment are also subject to the limitation. The limitation is applied only to therapeutic services (e.g., psychotherapy) and to follow-up diagnostic services performed to evaluate the progress of a course of treatment. Charges for initial diagnostic services (i.e., psychiatric testing and evaluation used to diagnose the patient's illness) are not subject to this limitation. The 62.5% limitation is subject to Part B deductible and coinsurance requirements.

Medicare covers outpatient hospital partial hospitalization services connected with the treatment of mental illness. Partial hospitalization services are covered only if the individual would otherwise require inpatient psychiatric care. The 62.5% payment limitation does not apply to partial hospitalization services, except for services that are directly provided by a physician. Under this benefit, Medicare covers: (A) individual and group therapy with physicians or psychologists (or other authorized mental health professionals); (B) occupational therapy; (C) services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients; (D) drugs and biologicals furnished for therapeutic purposes that cannot be self-administered; (E) individualized activity therapies that are not primarily recreational or diversionary; (F) family counseling (for treatment of the patient's condition); (G) patient training and education; and (H) diagnostic services. Partial hospitalization services are also covered in community mental health centers. Family counseling services with members of the household are covered only where the primary purpose of such counseling is the treatment of the patient's condition.

House Bill

No provision.

Senate Bill

Medicare would cover marriage and family therapist services and mental health counselor services for the diagnosis and treatment of mental illness. The therapists would be legally authorized to provide such services under State law and would provide services that would be otherwise covered if furnished by a physician or furnished incident to a physician's professional service. No facility or other provider would charge or be paid for these services. The amount of payment would be 80% of the lesser of the actual charge or 75% of the amount paid to a psychologist. These services would be subject to assignment. These services would be excluded from the skilled nursing facility prospective payment system. Rural health clinics, federally qualified health centers, hospice programs would be authorized to provide such services. Marriage and family therapists would be authorized to develop post hospital discharge plans for patients. The provisions would apply to services furnished on or after January 1, 2004.

Conference Agreement

The conference agreement requires the GAO to study the feasibility and advisability of providing Medicare Part B coverage of marriage and family therapist services and mental health counselors and of the appropriate settings and payment methodologies of such services. Recommendations for legislation or administrative actions are also required to be included in the study. The report is required to be submitted to Congress no later than January 1, 2005.

MedPAC Study on Direct Access to Physical Therapy Services (Section 648 of the Conference Agreement, Section 624 of the House bill and Section 449 of the Senate bill).

Present Law

No provision.

House Bill

GAO would be required to conduct a study on access to physical therapist services in States authorizing access to such services without a physician referral compared to States that require such a physician referral. The study would: (1) examine the use of and referral patterns for physical therapist services for patients age 50 and older in states that authorize such services without a physician referral and in states that require such a referral; (2) examine the use of and referral patterns for physical therapist services for patients who are Medicare beneficiaries; (3) examine the physical therapist services within the facilities of the Department of Defense; and (4) analyze the potential impact on beneficiaries and on Medicare expenditures of eliminating the need for a physician referral for physical therapist services under the Medicare program. GAO would be required to submit a report to Congress on the study within one year of enactment.

Senate Bill

The Secretary would be required to establish a 3-year demonstration project in at least 5 states to examine the costs and patient satisfaction associated with allowing Medicare fee-for-service beneficiaries direct access to outpatient physical therapy services and comprehensive outpatient rehabilitation facility (CORF) services. In this instance, the beneficiary would not be required to be under the care of or referred by a physician to receive physical therapy services. Also, a physician or qualified physical therapist would be permitted to certify, recertify, establish and periodically review the beneficiary's plan of care. To the extent possible, the demonstration project would be conducted on a statewide basis. The project would be required to be established not later than 1 year after the date of enactment. The Secretary would be allowed to terminate the operation of a project at a site if, based on actual data, Medicare expenditures are greater than they otherwise would be without implementation of the demonstration project. The Secretary would be able to waive Medicare requirements as necessary and appropriate. The Secretary would be required to conduct interim and final evaluations of the project which would be submitted to the Congressional committees of jurisdiction no later than the end of the second year of operation and no later than 180 days after the end of the project. This provision would be effective upon enactment.

Conference Agreement

The conference agreement requires MedPAC to study the feasibility and advisability of allowing Medicare beneficiaries in fee-for-service direct access to outpatient physical therapy services and those physical therapy services that are furnished as comprehensive rehabilitation facility services. For the purposes of the study, direct access is defined as access to physical therapy services without the requirement that beneficiaries be under the care of, or referred by, a physician. Further, the services provided are not required to be under the supervision of a physician. Finally, either a physician or a qualified physical therapist could satisfy any requirement for certification, recertification and establishment and review of a plan of care. This study, together with recommendations for legislation or administrative actions, must be submitted to Congress no later than January 1, 2005.

Demonstration Project for Consumer Directed Chronic Outpatient Services (Section 648 of the Conference Report and Section 736 of the House bill)

Present Law

No provision. Medicare coverage requires that a beneficiary need medically necessary care. In general, Medicare pays the provider that delivers skilled health care services.

House Bill

The Secretary would be required to establish no fewer than 3 demonstration projects that evaluate methods to improve the quality of care provided to Medicare beneficiaries with chronic conditions and that reduce expenditures that would otherwise be made on their behalf by Medicare. The methods would be required to include permitting beneficiaries to direct their own health care needs and services. In designing the demonstrations, the Secretary would be required to evaluate practices used by group health plans and practices under State Medicaid programs that permit patients to self-direct the provision of personal care services and to determine the appropriate scope of personal care services that would apply under the demonstration projects.

The Secretary would be required to establish the demonstrations within 2 years of enactment. Demonstrations would be required to be located in an urban area, a rural area, and an area that has a Medicare population with a diabetes rate that significantly exceeds the national average rate. The Secretary would be required to evaluate the clinical and cost effectiveness of the demonstrations. Reports to Congress would be required biannually beginning 2 years after the demonstrations begin.

Senate Bill

No provision.

Conference Agreement

The conference agreement requires the Secretary to establish no fewer than 3 demonstration projects that evaluate methods to improve the quality of care provided to Medicare beneficiaries with chronic conditions and that reduce expenditures that would otherwise be made on their behalf by Medicare. The methods are required to include permitting beneficiaries to direct their own health care needs and services. In designing the demonstrations, the Secretary is required to evaluate practices used by group health plans and practices under State Medicaid programs that permit patients to self-direct the provision of personal care services and to determine the appropriate scope of personal care services that apply under the demonstration projects.

The Secretary is required to establish the demonstrations within 2 years of enactment. Demonstrations are required to be located in an urban area, a rural area, and an area that has a Medicare population with a diabetes rate that significantly exceeds the national average rate. The Secretary is required to evaluate the clinical and cost effectiveness of the demonstrations. Reports to Congress are required biannually beginning 2 years after the demonstrations begin.

Medicare Care Management Performance Demonstration (Section 649 of the Conference Report and Section 736 of the House Bill).

Current Law

No provision.

House Bill

No provision.

Senate Bill

The Secretary would be required to establish a 3-year demonstration program to promote continuity of care, help stabilize medical conditions, prevent or minimize acute exacerbations of chronic conditions, and reduce adverse health outcomes before October 1, 2004. Six sites would be designated for the demonstration, 3 in urban areas and at least 1 in a rural area. One site would be required to be located in Arkansas. Any Medicare beneficiary enrolled in part B who has at least 4 complex medical conditions and is unable to manage their own care or has a functional limitation and resides in a demonstration area may participate in the program if the beneficiary identifies a principal care physician who agrees to manage the complex clinical care of the beneficiary under the demonstration.

Each principal care physician who agrees to manage the complex clinical care of a beneficiary eligible to participate would be required to agree to: (1) serve as the primary contact of the beneficiary in accessing items and services under Medicare; (2) maintain medical information related to care and services furnished by other health care providers including clinical reports, medication and treatments prescribed by other physicians, hospital and hospital outpatient services, skilled nursing home care, home health care, and medical equipment services; (3) monitor and advocate for the continuity of care of the beneficiary and the use of evidence-based guidelines; (4) promote self-care and family care giver involvement where appropriate; (5) have appropriate staffing arrangements to conduct patient self-management and other care coordination activities as specified by the Secretary; refer the beneficiary to community service organizations and coordinate the services of such organizations with the care provided by health care providers; and (7) meet such other complex care management requirements as the Secretary may specify.

The Secretary would pay each principal care physician a monthly complex care management fee developed by the Secretary. The fee would be the full payment for all the functions performed by the principal care physician including any functions performed by other qualified practitioners acting on behalf of the physician, appropriate staff under the supervision of the physician, and any other person under a contract with the physician, including any person who conducts patient self-management and caregiver education. Aggregate payments by Medicare could not exceed the amount that would otherwise have been paid if the demonstration program had not been implemented. The Secretary would be required to report to Congress on the demonstration program 6 months after its completion.

Conference Agreement

The Secretary would be required to establish a 3-year demonstration program to promote continuity of care, help stabilize medical conditions, prevent or minimize acute exacerbations of chronic conditions, and reduce adverse health outcomes. Four sites would be designated for the demonstration: with at least two in urban areas and one in a rural area. One of the demonstration sites would be in a state with a medical school with a geriatrics department that manages rural outreach sites and is capable of managing patients with multiple chronic conditions, one of which is dementia. Any Medicare beneficiary enrolled in part A and B who has one or more chronic medical conditions specified by the Secretary (one of which may be a cognitive impairment) and is unable to manage their own care or has a functional limitation and resides in a demonstration area may participate in the program if the beneficiary identifies a principal care physician who agrees to manage the complex clinical care of the beneficiary under the demonstration.

The conferees encourage CMS to work with Agency for Healthcare Research and Quality (AHRQ) to provide grants to assist physicians in carrying out the health information technology aspect of the demonstration. In particular, the grants should focus on issues involving clinical decision support tools, clinical reminders, and improved communication between patients, providers and payors. AHRQ is currently working to provide grant programs in this area.

Demonstration of Coverage of Chiropractic Services under Medicare (Section 440 of the Senate Bill).

Present Law

No specific provision with respect to a demonstration project. Medicare covers limited chiropractic services, specifically manual manipulation for correction of a dislocated or misaligned vertebra or subluxation.

House Bill

No provision.

Senate Bill

The Secretary would be required to establish a 3-year demonstration program at 6 sites to evaluate the feasibility and desirability of covering additional chiropractic services under Medicare. These projects may not be implemented before October 1, 2004. The chiropractic services included in the demonstration shall include, at a minimum, care for neuromusculoskeletal conditions typical among eligible beneficiaries as well as diagnostic and other services that a chiropractor is legally authorized to perform. An eligible beneficiary participating in the demonstration project, including those enrolled in Medicare +Choice or Medicare Advantage plans, would not be required to receive approval by physician or other practitioner in order to receive chiropractic services under the demonstration project.

The Secretary would be required to consult with chiropractors, organizations representing chiropractors, beneficiaries and organizations representing beneficiaries in establishing the demonstration projects. Participation by eligible beneficiaries would be on a voluntary basis. The 6 sites would be equally split between rural and urban areas; at least one of the sites would be in a health professional shortage area. The Secretary would be required to evaluate the demonstration projects to determine (1) whether the participating beneficiaries used fewer Medicare covered services than those who did not participate; (2) the cost of providing such chiropractic services under Medicare; (3) the quality of care and satisfaction of participating beneficiaries; and (4) other appropriate matters.

The Secretary would be required to submit a report, including recommendations, to Congress on the evaluation no later than 1 year after the demonstration projects conclude. The Secretary would waive Medicare requirements as necessary. The demonstration program would be subject to a budget-neutrality requirement. Appropriations from the Federal Supplementary Insurance Trust Fund are authorized as necessary to conduct this demonstration. The provision would be effective upon enactment.

Conference Agreement

The Secretary would be required to establish a 2-year demonstration program at 4 sites to evaluate the feasibility and desirability of covering additional chiropractic services under Medicare. These projects may not be implemented before October 1, 2004. The chiropractic services included in the demonstration shall include, at a minimum, care for neuromusculoskeletal conditions typical among eligible beneficiaries as well as diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction where treatment occurs. An eligible beneficiary participating in the demonstration project, including those enrolled in Medicare +Choice or Medicare Advantage plans, would not be required to receive approval by physician or other practitioner in order to receive chiropractic services under the demonstration project.

The Secretary would be required to consult with chiropractors, organizations representing chiropractors, beneficiaries and organizations representing beneficiaries in establishing the demonstration projects. Participation by eligible beneficiaries would be on a voluntary basis. The 4 sites would be equally split between rural and urban areas; at least one of the sites would be in a health professional shortage area. The Secretary would be required to evaluate the demonstration projects to determine (1) whether the participating beneficiaries used fewer Medicare covered services than those who did not participate; (2) the cost of providing such chiropractic services under Medicare; (3) the quality of care and satisfaction of participating beneficiaries; and (4) other appropriate matters.

The Secretary would be required to submit a report, including recommendations, to Congress on the evaluation no later than 1 year after the demonstration projects conclude. The Secretary would waive Medicare requirements as necessary. The demonstration program would be subject to a budget-neutrality requirement. Appropriations from the Federal Supplementary Insurance Trust Fund are authorized as necessary to conduct this demonstration.

Demonstration Project to Examine What Weight Loss Weight Management Services Can Cost-Effectively Reach the Same Result as the NIH Diabetes Primary Prevention Trial Study: A 50 Percent Reduction in the Risk for Type 2 Diabetes for Individuals Who Have Impaired Glucose Tolerance and Are Obese (Section 450I of the Senate Bill).

Present Law

No provision regarding the demonstration. Medicare covers medical nutrition therapy services for beneficiaries with diabetes or a renal disease who (1) have not received diabetes outpatient self-management training services within a time period to be determined by the Secretary, (2) are not receiving maintenance dialysis, and (3) meet other criteria to be established by the Secretary. Nutrition therapy services are nutritional diagnostic, therapy, and counseling services for the purpose of disease management. The services must be provided by a registered dietitian or nutritional professional pursuant to a referral by a physician. Payment is based on the lower of actual charges or 85% of the physician fee schedule on an assignment-related basis.

House Bill

No provision.

Senate Bill

The Secretary would be required to establish a demonstration project that would examine the cost effectiveness and health benefits of providing group weight loss management services for Medicare beneficiaries who are obese and have impaired glucose tolerance. Group weight loss management services are those furnished to beneficiaries who have been diagnosed and referred by a physician for assessment and treatment based on individual needs or a specific program or method that has demonstrated efficacy to produce and maintain weight loss through results published in peer-reviewed scientific journals. The program would be required to provide assessment of current body weight and recording of weight status at each meeting session; provision of a healthy eating plan; provision of an activity plan; provision of a behavior modification plan; and a weekly group support meeting.

Expenditures would be constrained by 2 limitations: the costs of group weight loss management services could not exceed the annual cost per recipient of the medical nutritional therapy benefit and the total amount of payments made under the demonstration could not exceed $2.5 million for each fiscal year of the project. Medical nutrition therapy services that would be furnished under the demonstration project would be covered under part B of Medicare and payment would be 80% of the lesser of the actual charge for the services or 85% of the applicable physician fee schedule amount. Group weight loss management professionals would be paid by Medicare on an assignment-related basis and balance billing would not be permitted.

The demonstration project would be conducted for 2 years at sites designated by the Secretary. The Secretary would be required to give preference to sites located in rural areas or areas that have a high concentration of Native Americans with type 2 diabetes. The Secretary would be required to submit interim reports on this demonstration project to the Committee on Ways and Means and the Committee on Finance. A final report to both Committees would be due 6 months after the date the demonstration project concludes. The provision would be effective upon enactment.

Conference Agreement

No provision.

TITLE VII—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

Update in Home Health Services (Section 701 of the Conference Agreement and Section 701 of the House Bill).

Present Law

Home health service payments are increased on a federal fiscal year basis that begins in October. The FY 2004 statutory update will be the full increase in the market basket index. The prospective payment system provides for outlier payment B payments for extraordinarily costly cases B with the total amount of outlier payment (the outlier pool) not exceeding 5 percent of estimated total home health prospective payments.

House Bill

This provision would increase home health agency payments by the home health market basket percentage increase minus 0.4 percentage points for 2004 through 2006. The update for subsequent years would be the full market basket percentage increase. The provision would also change the time frame for the update from the federal fiscal year to a calendar year basis. The home health prospective payment rates would not increase for the October 1 through December 31, 2003 period.

Senate Bill

No provision.

Conference Agreement

The conference agreement changes the time frame for the home health update from the federal fiscal year to a calendar year basis beginning with 2004. Home health agency payments are increased by the full market basket percentage for the last quarter of 2003 (October, November, and December) and for the first quarter of 2004 (January, February, and March). The update for the remainder of 2004 and for 2005 and 2006 is the home health market basket percentage increase minus 0.8 percentage points. The size of the outlier pool for home health prospective payment may not exceed 3 percent of the total payment projected under the payment system beginning January 1, 2004, total payments are not increased to account for the difference.

Demonstration Project to Clarify the Definition of Homebound (Section 702 of the Conference Agreement, Section 704 of the House Bill, and Section 450 of the Senate Bill).

Present Law

Home health services are covered only if the Medicare beneficiary is confined to the home, needs skilled nursing care on an intermittent basis or needs physical or occupational therapy or speech-language pathology services, has had a plan of care established that is periodically reviewed by a physician, and is under a physician's care. Any absence of a beneficiary from the home for purposes of receiving health care treatment, including regular absences for participating in therapeutic, psychosocial, or medical treatment in an adult daycare program does not disqualify an individual from being considered confined to the home (or homebound). Further, any other absence of a beneficiary from the home cannot disqualify an individual from being considered homebound if the absence is of infrequent or of relatively short duration.

Absence from the home to attend a religious service is considered an absence of infrequent or short duration.

House Bill

The Secretary would be required to conduct a 2-year demonstration project where beneficiaries with chronic conditions would be deemed to be homebound in order to receive home health services under Medicare. A beneficiary would have to have been certified by a physician to have a permanent and severe condition that will not improve; to permanently need assistance with at least 3 out of the 5 activities of daily living (eating, toileting, transferring, bathing, and dressing); to permanently require skilled nursing services (not including medication management); to need either an attendant during the day to monitor and treat the beneficiary's medical condition or daily skilled nursing; and to require technological assistance or the assistance of another person to leave the home.

The Secretary would be required to select 3 states in which to conduct the demonstration in the northeast, midwest and western regions of the United States. Up to 15,000 beneficiaries would be permitted to participate. Data would be required to be collected regarding the quality of care, patient outcomes, and additional costs, if any to Medicare. The demonstration would be required to begin within 6 months of enactment. Within 1 year of completing the demonstration, the Secretary would be required to report to Congress on whether the subject of the demonstration adversely affected the provision of home health services under Medicare or directly caused an unreasonable increase of expenditures under Medicare; specific data showing any increase in expenditures directly attributable to the demonstration project; and specific recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency, and purpose of their absences from the home to qualify for home health services without incurring additional unreasonable costs to Medicare. The provision would be effective upon enactment.

Senate Bill

The Secretary would be required to conduct a 2-year demonstration project where beneficiaries with chronic conditions would be deemed to be homebound in order to receive home health services under Medicare. A beneficiary would have to have been certified by a physician to have a permanent and severe condition that will not improve; to permanently need assistance with at least 3 out of the 5 activities of daily living (eating, toileting, transferring, bathing, and dressing); to permanently require skilled nursing services (not including medication management); to need either an attendant during the day to monitor and treat the beneficiary's medical condition or daily skilled nursing; and to require technological assistance or the assistance of another person to leave the home.

The Secretary would be required to select 3 states in which to conduct the demonstration in the northeast, midwest and western regions of the United States. Up to 15,000 beneficiaries would be permitted to participate. Data would be required to be collected regarding the quality of care, patient outcomes, and additional costs, if any to Medicare. The demonstration would be required to begin within 6 months of enactment. Within 1 year of completing the demonstration, the Secretary would be required to report to Congress on whether the subject of the demonstration adversely effected the provision of home health services under Medicare or directly caused an unreasonable increase of expenditures under Medicare; specific data showing any increase in expenditures directly attributable to the demonstration project; and specific recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency, and purpose of their absences from the home to qualify for home health services without incurring additional unreasonable costs to Medicare. The provision would be effective upon enactment.

Conference Agreement

The Secretary is required to conduct a 2-year demonstration project where beneficiaries enrolled in Medicare Part B with specified chronic conditions would be deemed to be homebound in order to receive home health services under Medicare. A beneficiary is eligible to be deemed to be homebound if the beneficiary: (1) has been certified by a physician to have a permanent and severe condition that is not expected to improve; (2) permanently needs assistance with at least 3 out of the 5 activities of daily living (eating, toileting, transferring, bathing, and dressing); (3) permanently requires skilled nursing services (not including medication management); (4) needs either an attendant during each day to monitor and treat the beneficiary's medical condition or to assist the beneficiary with activities of daily living; (5) requires technological assistance or the assistance of another person to leave the home; and (6) does not regularly work in a paid position full-time or part-time outside the home.

The Secretary is required to select 3 states in the northeast, midwest and western regions of the United States in which to conduct the demonstration. Up to 15,000 beneficiaries can participate. Data must be collected regarding the quality of care, patient outcomes, and additional costs, if any to Medicare. The demonstration is required to begin within 6 months of enactment. Within 1 year of completing the demonstration, the Secretary is required to report to Congress on: whether the subject of the demonstration adversely effected the provision of home health services under Medicare or has directly caused an unreasonable increase of expenditures under Medicare; specific data showing any increase in expenditures directly attributable to the demonstration project; and specific recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency, and purpose of their absences from the home to qualify for home health services without incurring additional unreasonable costs to Medicare. Payment for the costs of carrying out the demonstration project will be made from the Part B Trust Fund. The provision is effective upon enactment.

Demonstration Project for Medical Adult Day Care Services (Section 703 of the Conference Agreement, Section 732 of the House Bill, Section 454 of the Senate Bill).

Present Law

No provision

House Bill

Subject to earlier provisions, the Secretary would be required to establish a demonstration project under which a home health agency, directly or under arrangement with a medical adult day care facility, provide medical adult day care services as a substitute for a portion of home health services otherwise provided in a beneficiary's home. Such services would have to be provided as part of a plan for an episode of care for home health services established for a beneficiary. Payment for the episode would equal 95% of the amount that would otherwise apply. In no case would the agency or facility be able to charge the beneficiary separately for the medical adult day care services. The Secretary would reduce payments made under the home health prospective payment system to offset any amounts spent on the demonstration project. The 3-year demonstration project would be conducted in not more than 5 sites (which can include multiple facilities) in states that license or certify providers of medical adult day care services, as selected by the Secretary. Participation of up to 15,000 Medicare beneficiaries would be on a voluntary basis.

When selecting participants, the Secretary would give preference to home health agencies that are currently licensed to furnish medical adult day care services and have furnished such services to Medicare beneficiaries on a continuous basis for a prior 2-year period. A medical adult day care facility would (1) have been licensed or certified by a State to furnish medical adult day care services for a continuous 2-year period; (2) have been engaged in providing skilled nursing services or other therapeutic services directly or under arrangement with a home health agency; and (3) would meet quality standards and other requirements as established by the Secretary. The Secretary would be able to waive necessary Medicare requirements except that beneficiaries must be homebound in order to be eligible for home health services.

The Secretary would be required to evaluate the project's clinical and cost effectiveness and submit a report to Congress no later than 30 months after its commencement. The report would include: (1) an analysis of patient outcomes and comparative costs relative to beneficiaries who receive only home health services for the same health conditions and (2) recommendations concerning the extension, expansion, or termination of the project. The provision would be effective upon enactment.

Senate Bill

Subject to earlier provisions, the Secretary would be required to establish a demonstration project under which a home health agency, directly or under arrangement with a medical adult day care facility, provide medical adult day care services as a substitute for a portion of home health services otherwise provided in a beneficiary's home. Such services would have to be provided as part of a plan for an episode of care for home health services established for a beneficiary. Payment for the episode would equal 95% of the amount that would otherwise apply. In no case would the agency or facility be able to charge the beneficiary separately for the medical adult day care services. The Secretary would reduce payments made under the home health prospective payment system to offset any amounts spent on the demonstration project. The 3- year demonstration project would be conducted in not more than 5 sites in states that license or certify providers of medical adult day care services, as selected by the Secretary. Participation of up to 15,000 Medicare beneficiaries would be on a voluntary basis.

When selecting participants, the Secretary would give preference to home health agencies that are currently licensed to furnish medical adult day care services and have furnished such services to Medicare beneficiaries on a continuous basis for a prior 2-year period. A medical adult day care facility would (1) have been licensed or certified by a State to furnish medical adult day care services for a continuous 2-year period; (2) have been engaged in providing skilled nursing services or other therapeutic services directly or under arrangement with a home health agency; and (3) would meet quality standards and other requirements as established by the Secretary. The Secretary would be able to waive necessary Medicare requirements except that beneficiaries must be homebound in order to be eligible for home health services.

The Secretary would be required to evaluate the project's clinical and cost effectiveness and submit a report to Congress no later than 30 months after its commencement. The report would include: (1) an analysis of patient outcomes and comparative costs relative to beneficiaries who receive only home health services for the same health conditions and (2) recommendations concerning the extension, expansion, or termination of the project. The provision would be effective upon enactment.

Conference Agreement

Subject to earlier provisions in the conference agreement, the conference agreement requires the Secretary to establish a demonstration project under which a home health agency, directly or under arrangement with a medical adult day care facility, provides medical adult day care services as a substitute for a portion of home health services otherwise provided in a beneficiary's home. Such services would be provided as part of a plan for an episode of care for home health services established for a beneficiary. Payment for the episode will equal 95% of the amount that would otherwise apply subject to budget neutrality provisions. The agency or facility is prohibited from charging the beneficiary separately for the medical adult day care services. The Secretary is required to reduce payments made to medical adult day care facilities under the demonstration to offset excess spending. The 3-year demonstration project is to be conducted in not more than 5 sites in states that license or certify providers of medical adult day care services, as selected by the Secretary. Participation of up to 15,000 Medicare beneficiaries is on a voluntary basis.

When selecting participants, the Secretary is required to give preference to home health agencies that are currently licensed to furnish medical adult day care services and have furnished such services to Medicare beneficiaries on a continuous basis for a prior 2-year period. A medical adult day care facility is one that: (1) has been licensed or certified by a State to furnish medical adult day care services for a continuous 2-year period; (2) has been engaged in providing skilled nursing services or other therapeutic services directly or under arrangement with a home health agency; and (3) would meet quality standards and other requirements as established by the Secretary. The Secretary is able to waive necessary Medicare requirements except that beneficiaries must be homebound in order to be eligible for home health services.

The Secretary is required to evaluate the project's clinical and cost effectiveness and submit a report to Congress no later than 6 months after completion of the demonstration. The report is required to include: (1) an analysis of patient outcomes and comparative costs relative to beneficiaries who receive only home health services for the same health conditions, and (2) recommendations concerning the extension, expansion, or termination of the project. The provision is effective upon enactment.

Temporary Suspension of OASIS Requirement for Collection of Data on Non-Medicare and Non-Medicaid Patients (Section 704 of the Conference Agreement, Section 954 in the House Bill, Section 630 in the Senate Bill).

Present Law

Medicare is required to monitor the quality of home health care and services for all patients as part of the survey process with a standardized, reproducible assessment instrument. The purpose of the monitoring is to determine whether the agency is helping all patients achieve and maintain the highest functional capacity that is possible as is reflected in the care plan the home health agency has developed for the patient. Medicare has implemented this requirement using the Outcomes and Assessment Information Set (OASIS). The OASIS data are used for Medicare payment (under home health prospective payment) and for quality improvement purposes for all patients.

House Bill

The requirement that home health agencies must collect OASIS data on private pay (non-Medicare, non-Medicaid) patients would be suspended until after the Secretary (1) reported to Congress on the benefits of these data, the value of the data compared to the administrative burden of data collection in small agencies, and the use of the OASIS information by both large and small agencies and then (2) published final regulations regarding the collection and use of non-Medicare/non-Medicaid OASIS data. The provision would not prohibit home health agencies from collecting OASIS data on private pay patients for the agencies' own use.

Senate Bill

Same provision.

Conference Agreement

The conference agreement suspends the requirement that home health agencies must collect OASIS data on private pay (non-Medicare, non-Medicaid) until the Secretary (1) reports to Congress on the benefits of these data, the value of the data compared to the administrative burden of data collection in small agencies, and the use of the OASIS information by both large and small agencies, and then (2) publishes final regulations regarding the collection and use of OASIS. The provision does not prohibit home health agencies from collecting OASIS data on private pay patients for the agencies' own use.

MedPAC Study of Medicare Margins of Home Health Agencies (Section 705 of the Conference Agreement and Section 703 of the House Bill).

Present Law

No provision.

House Bill

The provision would require MedPAC to study payment margins of home health agencies paid under the Medicare home health prospective payment system. The study would examine whether systematic differences in payment margins were related to differences in case mix, as measured by home health resource groups (HHRGs). MedPAC would be required to submit a report to Congress on the study within 2 years of enactment.

Senate Bill

No provision.

Conference Agreement

The conference agreement requires MedPAC to study payment margins of home health agencies paid under the Medicare home health prospective payment system, using cost reports filed by agencies. The study is required to examine whether systematic differences in payment margins are related to differences in case mix, as measured by home health resource groups (HHRGs), among agencies. MedPAC is required to submit a report to Congress on the study within 2 years of enactment.

Coverage of Religious Nonmedical Health Care Institution Services Furnished In the Home. (Section 706 of the Conference Report).

Present Law

No provision

House Bill

No provision

Conference Report

A religious nonmedical health care institution can provide home health services to individuals that meet the criteria laid out in 1821.

Increase in Medicare Payment for Certain Home Health Services (Section 451/Duplicative Provisions 459 and 463 of the Senate Bill).

Present Law

Home health PPS provides payment for a 60-day episode of care furnished to a Medicare beneficiary. Medicare's payment is adjusted to reflect the type and intensity of care furnished and area wages as measured by the hospital wage index. BIPA increased PPS payments by 10% for home health services furnished in the home of beneficiaries living in rural areas during the 2-year period beginning April 1, 2001, through March 31, 2003, without regard to certain budget- neutrality provisions applying to home health PPS. The temporary additional payment was not included in the base for determination of payment updates.

Home health PPS is required to make payments for extraordinarily costly cases. The total amount of the outlier payment may not exceed 5% of the total payment estimated to be made for the fiscal year.

House Bill

No provision.

Senate Bill

A 10% additional payment for home health care services furnished in a rural area during FY 2005 and FY 2006 would be provided without regard to certain budget-neutrality requirements. The total amount of outlier payments would be reduced to no more than 3% of total payments in FY 2004 and 4% for FYs 2005 and 2006. The provision would be effective for services furnished on or after October 1, 2003.

Conference Agreement

No provision.

Limitation on Reduction in Area Wage Adjustment Factors under the Prospective Payment System for Home Health Services (Section 452 of the Senate Bill).

Present Law

Home health agencies are paid under Medicare using the prospective payment system. In calculating payment, the portion of the base payment amount that is attributable to wages and wage related costs is required to be adjusted for those costs. The Secretary is required to calculate an area wage adjustment factor that is actually used to adjust the base payment amount. The factors change annually as new wage data are reported and areas change in relative costliness.

House Bill

No provision.

Senate Bill

The provision would limit any reduction in the home health area wage adjustment factor for fiscal years 2005 and 2006. Any reduction could be no more than 3% less than the area wage adjustment factor applicable to home health services for the area in the previous year. The provision would be effective upon enactment.

Conference Agreement

No provision.

Subtitle B—Graduate Medical Education

Extension of Update Limitation on High Cost Programs (Section 711 of the Conference Agreement and Section 711 of the House Bill).

Present Law

Medicare pays hospitals for its share of direct graduate medical education (DGME) costs in approved programs using a count of the hospital's number of full-time equivalent residents and a hospital-specific historic cost per resident, updated for inflation. BBRA changed Medicare's methodology for calculating DGME payments to teaching hospitals to incorporate a national average amount based on FY1997 hospital specific per resident amounts. Starting in FY2001, hospitals received no less than 70% of a geographically adjusted national average amount. BIPA increased this floor to 85% of the locality adjusted, updated, and weighted national PRA starting for cost report periods beginning during FY2002. Hospitals with per resident amounts above 140% of the geographically adjusted national average amount had payments frozen at current levels for FY2001 and FY2002, and in FY2003–FY2005 would receive an update equal to the Consumer Price Index (CPI) increase minus 2 percentage points. Currently, hospitals with per resident amounts between 85% and 140% of the geographically adjusted national average would continue to receive payments based on their hospital-specific per resident amounts updated for inflation.

House Bill

The hospitals with per resident amounts above 140% of the geographically adjusted national average amount would not get an update from FY2004 through FY2013.

Senate Bill

No provision.

Conference Agreement

Hospitals with per resident amounts about 140% of the geographically adjusted national average amount would not get an update from FY2004 through FY20013.

Exception to the Initial Residency Period for Geriatric Residency or Fellowship Programs (Section 712 of the Conference Agreement and Section 410 of the Senate Bill).

Present Law

Medicare counts residents in their initial residency period (the lesser of the minimum number of years required for board eligibility in the physician's specialty or 5 years) as 1.0 FTE. Residents whose training has extended beyond their initial residency period count as 0.5 FTE. Residents in certain specialties are allowed additional years in their initial residency period.

Geriatrics is a subspecialty of family practice, internal medicine and psychiatry. A 1-year fellowship is required for certification in geriatrics, following an initial residency in one of those three areas. The certifying boards agreed to reduce the minimum fellowship requirement from 2 years to 1 year, beginning with the 1998 exam. Those physicians interested in an academic career in geriatrics are encouraged to pursue 2-year and 3-year fellowships.

House Bill

No provision.

Senate Bill

The Secretary would be required to promulgate interim final regulations after notice and comment that establish a 2-year exception to the initial residency program for certain geriatric training programs. The regulations would be effective for cost reporting periods on or after October 1, 2003. The provision would be effective upon enactment.

Conference Agreement

The conference agreement clarifies that Congress intended to provide an exception to the initial residency period for geriatric fellowship programs to accommodate programs that require 2 years of training to initially become board eligible in the geriatric specialty. The Secretary is required to promulgate interim final regulations after notice and comment consistent with this intent after notice and subject to public comment. The regulations will be effective for cost reporting periods on or after October 1, 2003. The conferees also clarify that under section 1886(h) (5)(F), the initial residency period for any residency for which the ACGME requires a preliminary or general clinical year of training is to be determined in the resident's second year of training.

The Conference Committee is pleased that the Secretary has published a proposed rule, on January 12 2001, to provide Medicare payment for clinical psychology internship training programs. The Committee notes that Congress has consistently urged the Secretary to initiate payment for the training of clinical psychologists since 1997 and still awaits a final rule.

The Committee is concerned that delay in the rules will mean that hospitals and institutions will continue to reduce or eliminate psychology training programs as has been occurring in recent years to the detriment of Medicare beneficiaries. The Committee directs implementation of the rule within six months of the date of enactment of the law to which this report is attached. The Committee notes that clinical psychologists provide valuable and unique services to Medicare beneficiaries during their training. Regarding their training, clinical psychologists are distinguishable from other health care professionals in that they are the only doctoral level mental health professionals fully participating in Medicare whose clinical training is not currently reimbursed. In addition, their clinical internship training is entirely controlled, administered, supervised, evaluated, and certified by the hospital or institution, separately accredited, and distinct from any university training they receive. Clinical psychologists are hospital-based in the final stages of their training function in a parallel status to medical interns and residents, not medical nursing or health professional students. Where a clinical psychologist has clearly finished his or her educational curriculum and is training solely in the hospital setting, it is the intention of Congress that the hospital be reimbursed if that training is hospital-based.

Authority to Include Costs of Training of Psychologists in Payments to Hospitals Under Medicare (Section 408 of the Senate).

Present Law

Medicare pays hospitals for its share of direct costs associated with approved hospital-based training programs for nurses and certain other allied health professionals including inhalation therapists, nurse anesthetists, occupational and physical therapists. Medicare will not pay for such costs associated with psychologists' training.

House Bill

No provision.

Senate Bill

Medicare would reimburse its share of the reasonable costs of approved education activities of psychologists under the allied health professional training provisions. The provision would apply for cost reporting periods beginning on or after October 1, 2004.

Conference Agreement

No provision.

Clarification of Congressional Intent Regarding the Counting of Residents in a Nonprovider Setting and a Technical Amendment Regarding the 3-year Rolling Ratio and the IME Ratio (Section 411 of the Senate Bill).

Present Law

Medicare has different resident limits for counting residents its indirect medical education (IME) adjustment and for reimbursement for a teaching hospital's direct medical education (DGME) costs. Generally, a hospital's IME adjustment depends on a hospital's teaching intensity as measured by the ratio of the number of interns and residents per bed (the IRB ratio). Prior to BBA 1997, the number of residents that could be counted for IME purposes included only those in the hospital inpatient and outpatient departments. Effective October 1, 1997, under certain circumstances, a hospital may now count residents in non-hospital sites for the purposes of IME. Medicare's DGME payment to teaching hospital is based on its updated cost per resident (subject to a locality adjustment and certain payment corridors), the weighted number of approved full-time-equivalent (FTE) residents, and Medicare's share of inpatient days in the hospital. Medicare counts residents in their initial residency period (the lesser of the minimum number of years required for board eligibility in the physician's specialty or 5 years) as 1.0 FTE. Residents whose training has extended beyond their initial residency period count as 0.5 FTE. Residents in certain specialties are allowed additional years in their initial residency period. Residents who are graduates from foreign medical schools do not count unless they pass certain exams.

Generally, the resident counts for both IME and DGME payments are based on the number of residents in approved allopathic and osteopathic teaching programs that were reported by the hospital for the cost reporting period ending in calendar year 1996. The DGME resident limit is based on the unweighted resident counts. It may differ from the IME limit because in 1996 residents training in non-hospital sites were eligible for DGME payments but not for IME payments. Hospitals that established new training programs before August 5, 1997 are partially exempt from the cap. Other exceptions apply to certain hospitals including those with new programs established after that date. Hospitals in rural areas (and non-rural hospitals operating training programs in rural areas) can be reimbursed for 130% of the number of residents allowed by their cap. Under certain conditions, an affiliated group of hospitals under a specific arrangement may combine their resident limits into an aggregate limit.

Subject to these resident limits, a teaching hospital's IME and DGME payments are based on a 3-year rolling average of resident counts, that is, the resident count will be based on the average of the resident count in the current year and the 2 preceding years. The rolling average calculation includes podiatry and dental residents. If a hospital is above its limit, the count for the purposes of the rolling average is the FTE cap. In addition to the resident limit, BBA 1997 also places a limit on the IRB ratio itself. A hospital's IRB ratio used to calculate its IME adjustment for the current payment year cannot exceed its IRB ratio from the immediately preceding cost reporting period.

CMS has published regulations that limit Medicare's graduate medical payments when existing residents are transferred from a non-hospital entity to a teaching hospital, particularly when the non-hospital entity has historically paid for the training costs without hospital funding. CMS seeks to limit reimbursement to those residents that rotate from a hospital setting to non-hospital sites in order to (1) encourage hospitals to broaden physician training in ways that will encompass different primary care settings; and (2) prevent cost shifting from existing support within the community to Medicare.

House Bill

No provision.

Senate Bill

The Secretary would be required to reimburse teaching hospitals for residents in non-hospital locations, when hospitals incur all, or substantially all, the costs of the training in that site starting from the effective date of a written agreement between the hospital and the entity owning or operating the non-hospital site. The effective date of the written agreement would be determined according to generally accepted accounting principles. The Secretary would not be able to take into account the fact that the hospital costs incurred are lower than actual Medicare reimbursement. Starting for FY2004, dental and podiatric residents would be removed from the 3-year rolling average calculation for IME and DGME reimbursements. The provision would be effective upon enactment.

Conference Agreement

For 12 months as of January 1, teaching hospitals can count residents in non-hospital locations regardless of the financial arrangement between the hospital and the teaching physician at the nonhospital clinic site participating in a family practice program. Provisions regarding the payment of IME and DME for training in non-hospital sites that were included in the Balanced Budget Act of 1997 Congress were intended to encourage placement of residents in rural and other underserved areas and in ambulatory sites that are more in alignment with the types of practice they would have upon practice. The purpose was two-fold: to increase access to care by increasing the numbers of residents training in those settings, and to increase the likelihood of physicians placing themselves in practice in rural and underserved areas.

For programs established after January 1, 2002, the Secretary shall clarify in future regulation its definition of reasonableness of payment for supervisory physicians.

The Secretary shall initiate a study on the training of residents in non-hospital settings, and the use of volunteer faculty in those settings. The study is due within six months of enactment. The study shall include the following:

Examination of the effect of the change in the BBA that allowed payment by Medicare for graduate medical education in non-hospital settings, to include whether access and numbers of physicians placing in rural and underserved areas has increased.

Examination of programs on a national level regarding evidence of possible misuse of federal money with respect to volunteering supervisory physicians.

A determination whether supervisory physicians are freely volunteering their time.

A description of what incentives are available in each state that are offered to physicians who volunteer their time as supervisory physicians (eg. CME credit hours, hospital privileges, etc.)

Subtitle C—Chronic Care Improvement

Voluntary Chronic Care Improvement Under Traditional Fee-For-Service (Section 721 of the Conference Agreement, Section 721 of the House Bill, and Section 442 of the Senate Bill).

Present Law

No provision.

A hearing was held by the Ways and Means Committee, Health Subcommittee on February 25, 2003 on the importance of providing chronic care management in fee-for-service Medicare. Statistics from the Robert Wood Johnson Foundation state 84% of Medicare beneficiaries have one or more chronic conditions and account for 95% of Medicare spending. With Americans living longer due to advances in medical procedures and increased availability to medications, Medicare costs will continue to escalate. Thus, chronic care programs should be implemented in both traditional fee-for-service and private plans to target these individuals, improve health outcomes and save money.

The Centers for Medicare & Medicaid Services (CMS) has run demonstration programs in the Medicare program targeting high cost seniors. Currently, CMS is managing more than a dozen disease management demonstration projects. The BBA allowed for the continuation of demonstration projects that were cost-effective, improved quality of care and patient/beneficiary satisfaction. These demonstration sites enrolled more than 7,600 Medicare beneficiaries. CMS has also started on disease management demonstrations authorized by BIPA of 2000, to provide disease management services to Medicare beneficiaries with congestive heart failure, diabetes, or coronary heart disease. CMS estimates that enrollment will include around 30,000 Medicare beneficiaries. BIPA also required a physician group demonstration to encourage coordination and reward physicians for improving beneficiary health outcomes. CMS has demonstrated significant progress in integrating chronic care management programs into fee-for-service Medicare and HMOs. The following provision would increase the number of chronic care management programs (also known as disease management programs) in fee-for-service Medicare, with the intention of expanding these programs nationwide if health outcomes improve and Medicare costs decrease.

Additionally, a 1999 survey showed 56% of employers offer disease management services to their employees, along with 67% of HMOs and 64% of POS plans. Private plans continue to offer disease management programs to reduce costs, improve health outcomes, and increase patient and provider satisfaction. Because many of these health plans offer chronic care management programs already, it is important to require Medicare Advantage to offer these programs, as well.

House Bill

The Secretary would be required to establish a process for providing chronic care improvement programs for Medicare beneficiaries in fee-for-service Medicare (Parts A and B) who have certain chronic conditions such as congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), stroke or other diseases identified by the Secretary for inclusion in the program. The Secretary would establish administrative regions (called CCMA regions) within the United States for the chronic care improvement programs. Within each region, the Secretary would select at least two contractors under a competitive bidding process on the basis of the ability of each bidder to achieve improved health outcomes of beneficiaries and improved financial outcomes of the Medicare program. A contractor could be a disease improvement organization, health insurer, provider organization, a group of physicians, or any other legal entity that the Secretary determines appropriate. Contractors would be required to meet certain clinical, quality improvement, financial, and other requirements specified by the Secretary. Subcontractors could be used by the contractors. The Secretary would be able to phase-in implementation of the program beginning one year after enactment.

Each program would be required to have a method for identifying targeted Medicare beneficiaries who would be offered participation in the program. The Secretary would be required to assist the program in identifying beneficiaries. Each beneficiary would be assigned to only one contractor that would be responsible for guiding beneficiaries in managing their health, including all co-morbidities. Initial contact with a Medicare beneficiary would be from the Secretary who would provide information about the program, a description of advantages in participating, notification that the contractor could contact the beneficiary directly concerning participation, the voluntary nature of program participation, and a means to decline participation or decline being contacted by the program. Each program would be required to develop an individualized, goal-oriented chronic care improvement plan with the beneficiary. The chronic care improvement plan would be required to contain: a single point of contact to coordinate care; self-improvement education for the individual and support education for health care providers, primary caregivers, and family members; coordination between prescription drug benefits, home health, and other health care services; collaboration with physicians and other providers to enhance communication of relevant clinical information; the use of monitoring technologies, where appropriate; and information about hospice care, pain and palliative care, and end-of-life care, as appropriate. In developing the chronic care improvement plan, programs would be required to use decision support tools such as evidence-based practice guidelines to track and monitor each beneficiary across care settings and evaluate outcomes using a clinical information database. The program would be required to meet any additional requirements that the Secretary finds appropriate. Programs that have been accredited by qualified organizations would be deemed to have met such requirements as specified by the Secretary.

Contractor payments for each chronic care improvement program would be required to result in Medicare program outlays that would otherwise have been incurred in the absence of the program for the three-year contract period. The Secretary would be required to assure that there would be no net aggregate increase in Medicare payments, in entering into a contract for the program over the 3-year period, including program outlays, administrative expenses (that would not have been paid under Medicare without this demonstration), and contractor fees. Contracts for chronic care improvement programs would be treated as a risk-sharing arrangement. In addition, payment to contractors would be subject to the contractor meeting clinical and financial performance standards established by the Secretary.

Program contractors would be required to report to the Secretary on the quality of care and efficacy of the program in terms of process measures (such as reductions in errors of treatment and rehospitalization rates), beneficiary and provider satisfaction, health outcomes, and financial outcomes. The Secretary would be required to submit to Congress annual reports on the program including information on progress made toward national coverage, common delivery models, and information on improvements in health outcomes as well as financial efficiencies resulting from the program. The Secretary would also be required to conduct a randomized clinical trial to assess the potential for cost reductions under Medicare by comparing costs of beneficiaries enrolled in chronic care improvement programs and beneficiaries who are eligible to participate but are not enrolled.

Appropriations of such sums as necessary to provide for contracts with chronic care improvement programs would be authorized from the Medicare Trust Funds, but in no case would the funding be permitted to exceed $100 million over 3 years.

The provision would be effective upon enactment and the Secretary would be required to begin implementing the chronic care improvement programs no later than 1 year after enactment.

Senate Bill

No provision.

Conference Agreement

The conference agreement requires the Secretary to establish and implement chronic care improvement programs. If the programs are established, they are required to improve clinical quality and beneficiary satisfaction and achieve spending targets for Medicare for beneficiaries with certain chronic health conditions.

The chronic care improvement (CCI) program is required to (1) have a process to screen each targeted beneficiary for conditions other than the specified chronic conditions, such as impaired cognitive ability and co-morbidities, in order to develop an individualized, goal-oriented care management plan; (2) provide each targeted beneficiary participating in the program with the care management plan; and (3) carry out the plan and other chronic care improvement activities. The care management plan is required to be developed with the beneficiary and, to the extent appropriate, include: (1) a designated point of contact responsible for communications with the beneficiary and for facilitating communications with other health care providers; (2) self-care education for the beneficiary (through approaches such as disease management or medical nutrition therapy) and education for primary caregivers and family members; (3) education for physicians and other providers and collaboration to enhance communication of relevant clinical information; (4) the use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment; and (5) the provision of information about hospice care, pain and palliative care, and end-of-life care. To the extent that a care management plan includes medical nutrition therapy, such services should be delivered by a registered dietician or nutrition professional as defined in Section 1861 of the Social Security Act (42 U.S.C. 1395x.)

The Secretary is required to develop a method for identifying targeted beneficiaries who may benefit from participation in a chronic care improvement program and to communicate with the targeted beneficiary regarding the opportunity to participate. Targeted beneficiaries who are eligible to participate cannot be enrolled in a plan under Medicare Part C and must have one or more of the threshold conditions including: congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), or other diseases or conditions specified by the Secretary. Beneficiary participation is voluntary.

In carrying out the care management plan, the chronic care improvement organization is required to: (1) guide the participant in managing the participant's health (including all co-morbidities, relevant health care services, and pharmaceutical needs) and in performing activities as specified under the elements of the care management plan of the participant; (2) use decision-support tools such as evidence-based practice guidelines or other criteria as determined by the Secretary; and (3) develop a clinical information database to track and monitor each participant across settings and to evaluate outcomes.

The establishment of the chronic care improvement program is conducted in 2 parts. In phase I, the developmental phase, the Secretary is required to enter into contracts with chronic care improvement organizations for the development, testing, and evaluation of chronic care improvement programs using randomized controlled trials. The first contract is required 12 months after enactment for a 3-year period. The Secretary is required to enter into contracts to ensure that chronic care improvement programs cover geographic areas in which at least 10 percent of Medicare beneficiaries reside. The Secretary is further required to ensure that each chronic care improvement program includes at least 10,000 targeted beneficiaries along with a sufficient number of Medicare beneficiaries to serve as a control group. The Secretary is required to contract for an independent evaluation of each chronic care improvement program. The evaluation is required to include quality improvement measures, such as adherence to evidence-based guidelines and rehospitalization rates; beneficiary and provider satisfaction; health outcomes; and financial outcomes, including any cost savings to Medicare.

If the Secretary finds that the chronic care improvement programs have improved the clinical quality of care, improved beneficiary satisfaction, and achieved specified spending targets, then the Secretary is required to expand the program to additional geographic areas not covered during phase I. Phase II may include national expansion of the program and is required to begin no later than 6 months after the completion of phase I (nor earlier than 2 years after phase I began). The Secretary is also required to evaluate phase II programs using the same criteria used in the phase I evaluation.

Chronic care improvement organizations are required to monitor and report to the Secretary on health care quality, cost, and outcomes, in a time and manner specified by the Secretary. The organizations are also required to comply with any additional requirements the Secretary may specify. The Secretary may deem chronic care improvement organizations which are accredited by qualified organizations to have met requirements that the Secretary may specify.

The Secretary is not permitted to contract with an organization to operate a chronic care improvement program unless the organization meets the requirements for a chronic care improvement program and such clinical, quality improvement, financial, and other requirements as the Secretary deems to be appropriate for the target beneficiaries to be served; and the organization demonstrates (to the satisfaction of the Secretary) that it is able to assume financial risk for performance under the contract. Each contract is required to specify performance standards for each of the specified evaluation factors including clinical quality and Medicare spending targets, against which the performance of the chronic care improvement organization under the contract is measured. Contractual adjustments are required if the contractor fails to meet specified performance standards. Further, the contract is required to provide for full recovery by the government of any amount by which the fees paid to the contractor exceed the estimated savings to Medicare that are attributable to the implementation of the contract. The Secretary is required to ensure that aggregate Medicare benefit expenditures for targeted beneficiaries participating in the chronic care improvement program do not exceed estimated Medicare expenditures for a comparable population in the absence of such a program.

Appropriations of such sums as necessary to provide for contracts with chronic care improvement programs would be authorized from the Medicare Trust Funds, but in no case would the funding be permitted to exceed $100 million over 3 years, beginning October 1, 2003.

The Secretary is required to submit an interim report to Congress on the scope of implementation of the program, the design of the programs, and the preliminary cost and quality findings based on the evaluation criteria no later than 2 years after implementation. No later than 3½ years after implementation, the Secretary is required to submit an update to the interim report to Congress. The Secretary is further required to submit to Congress 2 additional biennial reports on the chronic care improvement programs. The first is due no later than 2 years after the update report.

Medicare Advantage Quality Improvement Programs (Section 722 of the House Bill and Sections 202 and 442 of the Senate Bill)

Present Law

Under the Medicare+Choice program, organizations are required to have quality assurance programs that include measuring outcomes, monitoring and evaluating high volume and high risk services and the care of acute and chronic conditions, and evaluating the effectiveness of the efforts.

House Bill

Each Medicare Advantage plan offered would be required to have a chronic care improvement program for enrollees with multiple or sufficiently severe chronic conditions such as congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), stroke, prostate and colon cancer, hypertension, or other disease identified by the Secretary. The program would be required to have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions and to develop with an enrollee's consent an individualized, goal-oriented chronic care improvement plan.

The chronic care improvement plan would be required to include: a single point of contact to coordinate care; self-improvement education for the individual and support education for health care providers, primary caregivers, and family members; coordination between prescription drug benefits, home health, and other health care services; collaboration with physicians and other providers to enhance communication of relevant clinical information; the use of monitoring technologies, where appropriate; and information about hospice care, pain and palliative care, and end-of-life care, as appropriate. In developing the chronic care improvement plan, programs would be required to use decision support tools such as evidence-based practice guidelines track and monitor each beneficiary across care settings and evaluate outcomes using a clinical information database. The program would be required to meet any additional requirements that the Secretary finds appropriate. Programs that have been accredited by qualified organizations would be deemed to have met such requirements as specified by the Secretary.

Each Medicare Advantage organization would be required to report to the Secretary on the quality of care and efficacy of the chronic care improvement program in terms of process measures (such as reductions in errors of treatment and rehospitalization rates), beneficiary and provider satisfaction, health outcomes, and financial outcomes. The provision would apply for contract years beginning on or after one year after enactment.

Senate Bill

The quality assurance program for Medicare Advantage plans would be required to provide access to disease management and chronic care services and to provide access to preventive benefits and information for enrollees on the benefits in addition to current quality assurance requirements.

The Secretary would be required to establish a demonstration program that uses qualified care management organizations to provide health risk assessment and care management services to Medicare beneficiaries that are at high-risk (as defined by the Secretary but including beneficiaries with multiple sclerosis or other disabling chronic conditions, nursing home residents or beneficiaries at risk for nursing home placement, or beneficiaries that are also eligible for Medicaid). The Secretary would select 6 sites, giving preference to sites located in rural areas. The demonstration program would last 5 years but would not be implemented before October 1, 2004.

Any high-risk beneficiary residing in a designated area who is not a member of a Medicare+Choice plan may participate if the beneficiary identifies a care management organization that agrees to furnish care management services to the beneficiary under the demonstration program. The Secretary would be required to contract with care management organizations to provide care management services to beneficiaries eligible to participate in the demonstration. The Secretary may contract with more than one care management organization in a geographic area.

The Secretary would pay the care management organization a fee that is based on bids submitted by care management organizations. The fee would be required to place the care management organization partially at risk. Payment of the full fee would depend upon the care management organization meeting benchmarks for quality and cost. The Secretary may cancel a contract with a care management organization if the organization does not meet negotiated savings or quality outcome targets for the year. Aggregate payments by Medicare could not exceed the amount that would otherwise have been paid if the demonstration program had not been implemented. The Secretary would be required to report to Congress six months after the completion of the demonstration on the program. The provision would be effective upon enactment.

Conference Agreement

The conference agreement requires each Medicare Advantage organization to have an on-going quality improvement program for improving the quality of care provided to enrollees (except for private fee-for-service plans or MSA plans) effective for contract years beginning January 1, 2006. As part of the quality improvement program, each MA organization is required to have a chronic care improvement program. Each chronic care improvement program is required to have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions that meet criteria established by the organization for participation under the program.

Each MA organization is required to provide for the collection, analysis and reporting of data that permit measurement of health outcomes and other indicators of quality. The Secretary will establish through regulation appropriate reporting requirements for regional PPOs. The Secretary is permitted to change the types of data that are required of plans only after submitting to Congress a report on the reasons for the changes that was prepared in consultation with MA plans and private accrediting bodies. The Secretary is not permitted to collect data on quality, outcomes, and beneficiary satisfaction for the purposes of consumer choice and program administration if the data were not already being collected as of November 1, 2003. However, these provision regarding data are not to be construed as restricting the ability of the Secretary to carry out the comparative information dissemination provisions regarding plan quality and performance that are contained in section 1851(d)(4)(D).

The conference agreement also provides that MA organizations are deemed to meet the quality improvement program requirements as the Secretary determines to be appropriate if the MA organization is accredited (and periodically reaccredited) by a private accrediting organization under a process that the Secretary has determined ensures that the accrediting organization applies and enforces standards that meet or exceed the standards established by the Secretary.

Chronically Ill Medicare Beneficiary Research, Data, Demonstration Strategy (Section 723 of the Conference Agreement).

Present Law

No provision.

House Bill

No provision.

Senate Bill

No provision.

Conference Agreement

The conference agreement requires the Secretary to develop a plan to improve quality of care and to reduce the cost of care for chronically ill Medicare beneficiaries within 6 months after enactment. The plan is required to use existing data and identify data gaps, develop research initiatives, and propose intervention demonstration programs to provide better health care for chronically ill Medicare beneficiaries. The plan is required to: (1) integrate existing datasets including the Medicare Current Beneficiary Survey, the Minimum Data Set, the Outcome and Assessment Information Set, data from the Quality Improvement Organizations, and claims data; (2) identify any new data needs and a methodology to address new data needs; (3) plan for the collection of such data in a data warehouse; and (4) develop a research agenda using the data. In developing the plan, the Secretary is required to consult with experts in the fields of care for the chronically ill (including clinicians) and is required to enter into contracts with appropriate entities for the development of the plan. The Secretary is required to implement the plan no later than 2 years after enactment. Appropriations are authorized from amounts in the Treasury not otherwise appropriated, such sums as may be necessary in fiscal years 2004 and 2005 to carry out this provision.

Subtitle D—Other Provisions

Improvements in the National and Local Coverage Determination Process to Respond to Changes in Technology (Section 731 of the Conference Agreement, Section 733 of the House Bill, and Sections 458 and 554 of the Senate Bill).

Present Law

Coverage Determinations. Under administrative authorities, CMS announced in March 2003 the establishment of a technology council charged with improving Medicare coverage, coding and payment for emerging technologies. Council membership includes senior CMS staff.

Clinical Trials. No explicit statutory authorization regarding category A clinical trials. Under existing authorities, Medicare covers the routine costs of qualifying clinical trials which includes items or services typically provided absent a clinical trial and items or services needed for the diagnosis or treatment of complications. Medicare does not pay for certain aspects of the clinical trial including: the investigational item or service, items and services not used in the direct clinical management of the patient, and items and services customarily provided by the research sponsor free of charge for any enrollee in the trial.

Coding. The Secretary issues temporary national Health care Common Procedure Coding System (HCPCS) codes under Medicare Part B that are used until permanent codes are established.

House Bill

Coverage. The Secretary would be required to make available to the public the factors considered in making national coverage determinations of whether an item or service is reasonable and necessary. The Secretary would be required to develop guidance documents similar to those required by the Federal Food, Drug and Cosmetic Act (21 U.S.C. 371(h)). The provision would establish a time frame for decisions regarding national coverage determinations of 6 months after a request when a technology assessment is not required and 9 months when a technology assessment is required and in which a clinical trial is not requested.

Following the 6- or 9-month period, the Secretary would be required to make a draft of the proposed decision available in the HHS website or by other means; to provide a 30-day public comment period; to make a final decision on the request within 60 days following the conclusion of the public comment period; make the clinical evidence and data used in making the decision available to the public when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and in the case of a decision to grant the coverage determination, assign a temporary or permanent code and implement the coding change. In instances where a request for a national coverage determination is not reviewed by the Medicare Coverage Advisory Committee, the Secretary would be required to consult with appropriate outside clinical experts.

The Secretary would also be required to develop a plan to evaluate new local coverage determinations to decide which local decisions should be adopted nationally and to decide to what extent greater consistency can be achieved among local coverage decisions, to require the Medicare contractors within an area to consult on new local coverage policies, and to disseminate information on local coverage determination among Medicare contractors to reduce duplication of effort. The provision would be effective for determinations as of January 1, 2004.

Clinical Trials. Medicare would cover the routine costs of care for beneficiaries participating in clinical trials that are conducted in accordance with an investigational device exemption approved under section 530(g) of the Federal Food, Drug, and Cosmetic Act. The provision would be effective for clinical trials begun before, on, or after the date of enactment and to items and services furnished on or after enactment.

Coding. The Secretary would be required to implement revised procedures for the issuance of temporary national HCPCS codes by January 1, 2004. The provision would further require the Secretary to use data reflecting prices and costs of products in the United States in setting payment rates. The provision would be effective upon enactment.

Senate Bill

Coverage. The provision would establish a time frame for decisions regarding national coverage determinations of 6 months after a request when a technology assessment is not required and 9 months when a technology assessment is required and in which a clinical trial is not requested. Following the 6- or 9-month period, the Secretary would be required to make a draft of the proposed decision available in the HHS website or by other means; to provide a 30-day public comment period; to make a final decision on the request within 60 days following the conclusion of the public comment period; make the clinical evidence and data used in making the decision available to the public when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and in the case of a decision to grant the coverage determination, assign a temporary or permanent code and implement the coverage decision at the end of the 60-day period. The provision would apply to national coverage determinations as of January 1, 2004.

The Secretary would be required to establish a Council for Technology and Innovation composed of senior CMS staff and clinicians to coordinate coverage, coding, and payment processes under Title XVIII and the exchange of information on new technologies between CMS and other entities that make similar decisions. The provision would be effective upon enactment.

Clinical Trials. The routine costs of care for Medicare beneficiaries participating in clinical trials that are conducted in accordance with an investigational device exemption approved under Senate Section 530(g) of the Federal Food, Drug, and Cosmetic Act would be covered. This provision would not require the Secretary to modify the existing regulations and cover the cost of a medical device that is the subject of an investigational device exemption by the Food and Drug Administration. The Secretary would be required to ensure that total Medicare expenditures associated with this provision do not exceed: $32 million in 2005; $34 million in 2006; $36 million in 2007; $38 million in 2008; $40 million in 2009; $42 million in 2010; $44 million in 2011; $48 million in 2012; and $50 million in 2013. The Secretary would be required to take appropriate steps to stay within these funding limitations, including limiting the number of clinical trials covered and paying for only a portion of the associated routine costs. The provision would be effective for clinical trials begun before, on, or after the date of enactment and to items and services furnished on or after January 1, 2005.

Coding. No provision.

Conference Agreement

Coverage. The conference agreement requires the Secretary to make available to the public the factors considered in making national coverage determinations of whether an item or service is reasonable and necessary. The Secretary is required to develop guidance documents similar to those required by the Federal Food, Drug and Cosmetic Act (21 U.S.C. 371(h)). The provision establishes a timeframe for decisions regarding national coverage determinations of 6 months after a request when a technology assessment is not required and 9 months when a technology assessment is required and in which a clinical trial is not requested.

Following the 6- or 9-month period, the Secretary is required to make a draft of the proposed decision available in the HHS website or by other means; to provide a 30-day public comment period; to make a final decision on the request with 60 days following the conclusion of the public comment period; make the clinical evidence and data used in making the decision available to the public when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and in the case of a decision to grant the coverage determination, assign a temporary or permanent code and implement the coding change. In instances where a request for a national coverage determination is not reviewed by the Medicare Coverage Advisory Committee, the Secretary is required to consult with appropriate outside clinical experts.

The Secretary is also required to develop a plan to evaluate new local coverage determinations to decide which local decisions should be adopted nationally and to decide to what extent greater consistency can be achieved among local coverage decisions, to require the Medicare contractors within an area to consult on new local coverage policies, and to disseminate information on local coverage determination among Medicare contractors to reduce duplication of effort. The provision is effective for national determinations as of January 1, 2004 and for local coverage determinations made on or after July 1, 2004.

Clinical Trials. The conference agreement prohibits the Secretary from excluding from Medicare coverage the routine costs of care incurred by a Medicare beneficiary participating in a category A clinical trial, beginning with routine costs incurred on and after January 1, 2005. The conference agreement makes clear that this provision does not apply to, or affect, Medicare coverage or payment for a non-experimental/investigational (category B) device.

Coding. The conference agreement requires the Secretary to implement revised procedures for issuing temporary national HCPCS codes under Medicare Part B no later than July 1, 2004.

Extension of Treatment for Certain Physician Pathology Services Under Medicare (Section 732 of the Conference Agreement, Section 734 of the House Bill, and Section 435 of the Senate Bill).

Present Law

In general, independent laboratories cannot directly bill for the technical component of pathology services provided to Medicare beneficiaries who are inpatients or outpatients of acute care hospitals. BIPA permitted independent laboratories with existing arrangements with acute care hospitals to bill Medicare separately for the technical component of pathology services provided to the hospitals' inpatients and outpatients. The arrangement between the hospital and the independent laboratory had to be in effect as of July 22, 1999. The direct payments for these services apply to services furnished during a 2-year period starting on January 1, 2001 and ending December 31, 2002.

House Bill

Medicare would make direct payments for the technical component of pathology services furnished to beneficiaries who are inpatients or outpatients of acute care hospitals on or after January 1, 2004 until December 31, 2008. A change in hospital ownership would not affect these direct billing arrangements. The provision would be effective as if it had been included in BIPA.

Senate Bill

Direct payments for the technical component for these pathology services would be made for services furnished during 2005. The provision would be effective upon enactment.

Conference Agreement

Direct payments for the technical component for these pathology services will be made for services furnished during 2005 and 2006.

Payment for Pancreatic Islet Cell Investigational Transplants for Medicare Beneficiaries in Clinical Trials (Section 733 of the Conference Agreement, Section 735 of the House Bill, and Section 462 of the Senate Bill).

Present Law

No explicit statutory authorization. Under existing authorities, Medicare covers the routine costs of qualifying clinical trials which includes items or services typically provided absent a clinical trial and items or services needed for the diagnosis or treatment of complications. Medicare does not pay for certain aspects of the clinical trial including: the investigational item or service, items and services not used in the direct clinical management of the patient, and items and services customarily provided by the research sponsor free of charge for any enrollee in the trial.

House Bill

Medicare would be required to pay for the routine costs for items and services that beneficiaries receive as part of a clinical investigation of pancreatic islet cell transplants conducted by the National Institute of Health. The provision would be effective upon enactment.

Senate Bill

The Secretary would be required to establish a 5-year demonstration project to pay for pancreatic islet cell transplantation and related items and services for Medicare beneficiaries who have type 1 diabetes and end-stage renal disease. The Secretary would be required to establish an appropriate methodology to pay for the items and services furnished under the demonstration. A report to Congress would be required on the project 4 months after the demonstration ends. The provision would be effective upon enactment.

Conference Agreement

The conference agreement requires the Secretary, acting through the National Institute of Diabetes and Digestive and Kidney Disorders, to conduct a clinical investigation of pancreatic islet cell transplantation which includes Medicare beneficiaries. Beginning no earlier than October 1, 2004, the Secretary is required to pay for the routine costs as well as transplantation and appropriate related items and services for Medicare beneficiaries who are participating in such a trial.

In implementing the clinical investigation of pancreatic islet cell transplantations, CMS, in working with NIH, should ensure that a sufficient number of Medicare beneficiaries participate so that the results are applicable to the broader Medicare population with Type 1 diabetes and Medicare is able to make an informed decision regarding coverage of pancreatic islet transplantation.

Restoration of Trust Funds (Section 734 of the Conference Agreement and Section 623 of the Senate Bill).

Present Law

The Federal Hospital Insurance (HI) Trust Fund was established on July 30, 1965 as a separate account in the U.S. Treasury. All of the HI financial operations are handled through this fund. The trust fund's primary source of income consists of amounts appropriated to it, under permanent authority, on the basis of taxes paid by workers, their employers, and individuals with self-employment income. Up to 85% of an individual or a couples Old Age and Survivors, Disability Insurance (OASDI) benefits may be subject to federal income taxation if their income exceeds certain thresholds. The income tax revenue attributable to the first 50% of the OASDI benefits is allocated to the OAS and DI trust funds. The revenue associated with the amount between 50% and 85% is allocated to the HI trust funds. An incorrect amount of income from the taxation of OASDI benefits was transferred into the HI Trust Fund in April 2001, because of clerical error. An additional amount was transferred into the HI Trust Fund in December, 2001 to correct for the principal component of the error. Correction of the interest component associated with the clerical error requires legislation.

House Bill

No provision.

Senate Bill

After consultation with the Secretary of HHS, the Secretary of the Treasury would be required to transfer into the HI Trust fund an amount that would have been held by that fund if the clerical error had not occurred within 120 days of enactment.

Conference Agreement

The conference agreement requires the Secretary of the Treasury to transfer into the HI Trust Fund an amount that would have been held by that fund if the clerical error had not ocourred. Such money is appropriated to the HI Trust Fund. The appropriation is made and transfer is required within 120 days of enactment of this Act. In the case of a clerical error that occurs after April 15, 2001, the Secretary of the Treasury is required to notify the appropriate committees of Congress about the error and the actions to be taken, before such action is taken.

Modifications to Medicare Payment Advisory Commission (MedPAC) (Section 735 of the Conference Agreement and Section 731 of the House Bill).

Present Law

The Medicare Payment Advisory Commission is a 17-member body that reports and makes recommendations to Congress regarding Medicare payment policies. The Comptroller General is required to establish a public disclosure system for Commissioners to disclose financial and other potential conflicts of interest.

House Bill

MedPAC would be required to examine the budgetary consequences of a recommendation before making the recommendation and to review the factors affecting the efficient provision of expenditures for services in different health care sectors under Medicare fee-for-service. MedPAC would be required to submit 2 additional reports no later than June 1, 2004. The first report would study the need for current data, and the sources of current data available, to determine the solvency and financial circumstances of hospitals and other Medicare providers. MedPAC would be required to examine data on uncompensated care, as well as the share of uncompensated care accounted for by the expenses for treating illegal aliens. The second report would address investments and capital financing of hospitals participating under Medicare and access to capital financing for private and not-for-profit hospitals. The provision would also require that members of the Commission be treated as employees of Congress for purposes of financial disclosure requirements.

Senate Bill

No provision.

Conference Agreement

The conference agreement requires that MedPAC is to examine the budgetary consequences of a recommendation before making the recommendation and to review the factors affecting the efficient provision of expenditures for services in different health care sectors under Medicare fee-for-service. MedPAC is required to submit 2 additional reports no later than June 1, 2004. The first report is to study the need for current data and the sources of current data available, to determine the solvency and financial circumstances of hospitals and other Medicare providers. The second report is to address investments and capital financing of hospitals participating under Medicare and access to capital financing for private and not-for-profit hospitals.

The conference agreement requires that the Comptroller General appoint experts in the area of pharmaco-economics or prescription drug benefit programs to MedPAC. In addition, members of the Commission are required to be treated as employees of Congress for purposes of financial disclosure requirements and the Comptroller General is required to ensure compliance with this requirement.

Technical Amendments (Section 736 of the Conference Agreement).

Present Law

The Medicare, Medicaid, and SCHIP Benefit Improvement and Protection Act of 2000 (BIPA) contains certain grammatical omissions.

House Bill

No provision.

Senate Bill

No provision.

Conference Agreement

The conference agreement corrects the grammatical omissions.

Institute of Medicine Report (Section 723 of the House Bill).

Present Law

No provision.

House Bill

No provision.

Senate Bill

No provision.

Conference Agreement

No provision.

MedPAC Report (Section 724 of the House Report).

Present Law

No provision.

House Bill

MedPAC would be required to evaluate the chronic care improvement program. The evaluation would be required to include a description of the status of the implementation of the programs, the quality of health care services provided to individuals participating in the program, and the cost savings attributed to the implementation of the program. The report of the evaluation would be required to be submitted to Congress not later than two years after the implementation of the programs. The provision would be effective upon enactment.

Senate Bill

No provision.

Conference Agreement

No provision.

MedPAC Study on Medicare Payments and Efficiencies in the Health Care System (Section 455 of the Senate Bill).

Present Law

No provision.

House Bill

No provision.

Senate Bill

MedPAC would be required to make recommendations to Congress regarding ways to recognize and reward efficiencies and lower utilization of services created by the practice of medicine in historically efficient and low-cost areas. The recommendations would be required to be made within established Medicare payment methodologies for hospitals and physicians. The measures of efficiency would include: shorter than average hospital stays; fewer than average physician visits; fewer than average laboratory tests; greater than average utilization of hospice services; and the efficacy of disease management and preventive health services. The recommendations would be due 18 months after enactment.

Conference Agreement

No provision.

TITLE VIII—COST CONTAINMENT

Subtitle A: Cost Containment

Inclusion in Annual Report of Medicare Trustees of Information on Status of Medicare Trust Funds (Section 801 of the Conference Agreement, Section 131 of House Bill; Sections 131 and 132 of Senate Bill).

Current Law

The Medicare Board of Trustees was established under the Social Security Act to oversee the financial operations of the Medicare Hospital Insurance (HI) trust fund and the Medicare Supplementary Medical Insurance (SMI) trust fund. The Trustees are required to submit annual reports to the Congress.

The HI trust fund revenues come primarily from payroll taxes. Employers and employees each pay 1.45% of their earnings, while self-employed workers pay 2.9% of their net income. Other HI revenue sources include interest on the investments of the trust fund, federal income taxes on Social Security benefits, premiums from voluntary enrollees into Part A, railroad retirement account transfers and reimbursement for certain uninsured persons. Medicare Part A pays for beneficiaries medical expenses incurred in hospitals, skilled nursing facilities, hospices, and a portion of home health care services.

The SMI trust fund revenues are composed of beneficiary premiums to purchase Part B and general revenues. The Part B premium is set at an amount so that aggregate premiums are estimated to equal 25% of program costs and the monthly premium for 2003 is $58.70. General revenues comprise the remaining 75% of Part B program costs. Medicare Part B pays for the following: physician and other health care practitioner services; other medical and health services, including laboratory and diagnostic tests; outpatient hospital services and clinic services; and therapy and ambulance services; durable medical equipment, and home health services not covered under Part A.

House Bill

The provision would require the trustees to submit a combined report on the status of the two trust funds and the Prescription Drug Trust Fund. The report would include a statement of the total amounts obligated during the preceding fiscal year from the General Revenues of the Treasury for payment of benefits and the percentage such amount bore to all other general revenue obligations of the Treasury in that year. This information would be provided for each year beginning with the inception of Medicare. Ten-year and 75-year projections would also be required. The report would also provide a comparison to the rate of growth in the gross domestic product. Each report would be published by the Committees on Ways and Means and Energy and Commerce and be made available on the Internet.

Senate Bill

Section 131 would require the trustees to submit a combined report on the status of the two trust funds including the Prescription Drug Account. The report would include a statement of the total amounts obligated during the preceding fiscal year from the General Revenues of the Treasury and the percentage such amount bore to all other obligations of the Treasury in that year. This calculation would be made separately for Medicare benefits and for administrative and other expenses. This information would be provided for each year beginning with the inception of Medicare. Ten-year and 50-year projections would also be required. The report would also provide a comparison of the rates of growth for both benefits and administrative costs to the rates of growth in the gross domestic product, health insurance costs in the private sector, employment-based health insurance costs in the public and private sectors, and other areas as determined appropriate by the Board of Trustees.

The section would express the sense of the Congress that the committees of jurisdiction would hold hearings on these reports.

Section 132 would require the 2004 reports to include an analysis of the total amount of unfunded obligation of Medicare. The analysis would compare long-term obligations, including the combined obligations of the HI and SMI trust funds, to the dedicated funding sources for the program (not including transfers of general revenue)

Conference Agreement

Beginning with their report in 2005, the Trustees' annual report is required to include information on: (1) projections of growth of general revenue Medicare spending as a percentage of the total Medicare outlays for the fiscal year and each of the succeeding 6 fiscal years, 10, 50, and 75 years after the fiscal year, and previous fiscal years; (2) comparisons with the growth trends for the gross domestic product, private health costs, national health expenditures, and other appropriate measures; (3) expenditures and trends in expenditures under Part D; and (4) a financial analysis of the combined Medicare trust funds if general revenue funding for Medicare is limited to 45 percent of total Medicare outlays. The trust fund reports are also required to include a determination as to whether there is projected to be "excess general revenue Medicare funding" (as defined in the paragraph below) for any of the succeeding 6 fiscal years in its annual reports of Medicare's trust funds.

"Excess general revenue Medicare funding" is defined as general revenue Medicare funding expressed as a percentage of total Medicare outlays in excess of 45 percent. This measure is calculated by dividing total Medicare outlays minus dedicated Medicare financing sources by total Medicare outlays.

An affirmative determination of excess general revenue funding of Medicare for 2 consecutive annual reports will be treated as funding warning for Medicare in the second year for the purposes of requiring Presidential submission of legislation to Congress. Whenever any Trustees report includes a determination that within the 7-fiscal-year period there will be excess general revenue Medicare funding, Congress and the President are advised to address the matter under existing rules and procedures.

Dedicated Medicare financing sources include amounts appropriated to the HI trust fund for payroll taxes, transfers from the Railroad Retirement accounts, reimbursements for uninsured persons, and reimbursement for transitional insured coverage; taxation of certain OASDI benefits and tier II railroad retirement taxes, state transfers for Medicare coverage of eligible individuals who receive public assistance; premiums for Parts A, B, and D paid by non-Federal sources including amounts from voluntary enrollees (Part A), adjustments (Part B) and the MA monthly prescription drug beneficiary premiums paid under Part C that are attributable to basic prescription drug coverage (Part D); and gifts received by the Medicare trust funds. The premium amounts are determined without regard to any reduction in the Part B premiums attributable to the beneficiary rebate under the MA program and Part D premium amounts are deemed to include any penalties for late enrollment.

Medicare outlays means total outlays from the Medicare trust funds and include payments made to plans under part C that are attributable to any rebates under the Medicare Advantage program and Medicare administrative expenditures. These outlays are required to be offset by the amount of fraud and abuse collection when applied to or deposited into a Medicare trust fund.

The Medicare trust funds are defined as the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund which includes the Medicare Prescription Drug Account.

Presidential Submission of Legislation (Section 802 of the Conference Agreement).

House Bill

No provision.

Senate Bill

No provision.

Conference Agreement

In the event that a Medicare funding warning is made, the President is required to submit to Congress proposed legislation to respond to the warning. This must be completed within the 15-day period beginning on the date of the budget submission to Congress for the succeeding year it is made. If during the year in which the warning is made, legislation is enacted which eliminates excess general revenue Medicare funding for the 7-fiscal year period, then the President is not required to make a legislative proposal. The conference agreement expresses a sense of Congress that legislation submitted in this regard should be designed to eliminate excess general revenue Medicare funding for the 7-fiscal year period that begins in such year, as certified by the Board of Trustees not later than 30 days after the date of enactment.

Procedures in the House of Representatives (Section 803 of the Conference Agreement).

House Bill

No provision.

Senate Bill

No provision.

Conference Agreement

The conference agreement sets out the procedures for House consideration of the President's legislative proposal. Within 3 days of receiving the President's legislative proposal, the Majority Leader and Minority Leader of the House, or their designees, are required to introduce the proposal. Any legislation introduced is required to be referred to the appropriate committees which are required to report Medicare funding legislation no later than June 30. The chairman of the Committee on the Budget is required to certify whether or not Medicare funding legislation eliminates excess general revenue Medicare funding for any year within the 7-fiscal year period and whether the legislation would eliminate excess general revenue Medicare funding within the 7-fiscal year period.

If the House fails to vote on final passage of the legislation by July 30, fallback procedures are provided for under the conference agreement. After 30 calendar days (and concurrently 5 legislative days) after the introduction of the legislation, a move to discharge any committee to which the legislation has been referred is in order, under specified circumstances, and debate on the motion to discharge is limited to one hour.

The conference agreement provides for floor consideration in the House of the discharged legislation by the Committee of the Whole no later than 3 legislative days after discharge.

House Bill

No provision.

Senate Bill

No provision.

Conference Agreement

Section 804 provides for some limited special procedures in the Senate for consideration of legislation arising from the Medicare Trustees determination that there will be "excess general revenue Medicare funding" under section 801.

If the Medicare Trustees report, pursuant to section 801, includes a "medicare funding warning" and if the President submits the legislation described in section 802 in response to such warning, that legislation (along with any other qualifying legislation otherwise introduced in the Senate or received from the House) will be entitled to the special procedures set out in section 804.

Section 804(a) requires the Majority Leader and the Minority Leader (or their designees) to introduce the President's legislation. Such legislation must be entitled "A bill to respond to a medicare funding warning." This bill, regardless of the subject matter and notwithstanding any jurisdictional precedents of the Senate, shall be referred to the Committee on Finance. Any other legislation introduced by any member of the Senate, bearing this same title, shall also be referred to the Committee on Finance. Such referrals shall not be considered to create any jurisdictional precedents for the Senate.

Section 804(c) provides that this "medicare funding legislation" will be entitled to the special rules set out in subsections (d) and (e) only if: (1) it was passed by the House or (2) it is limited to matters within the jurisdiction of the Committee on Finance. This subsection ensures that a measure is subject to the special rules (whether it be the President's bill or one introduced by a member of the Senate) only if its contents are limited to matters solely within the jurisdiction of Finance. Thus the President or any member of the Senate may propose any type of legislation in the name of eradicating the "excess general revenue Medicare funding", but only those measures which conform with the jurisdictional constraints of the Committee on Finance, shall be entitled to the special procedures set out in this section.

Clearly however, the Senate can not dictate the content of the House-passed measure. Thus subsection (c) explicitly states that a bill coming over from the House would still be entitled to these special procedures. The conferees intend that these procedures apply to the House-passed bill regardless of any jurisdictional issues, but limit the application of the procedures to a Senate-originated matter that is within the jurisdiction of Finance. If a measure does not qualify for these special procedures, then it shall be considered under the regular order in the Senate.

Section 804(d) provides a unique mechanism in the Senate: a motion to discharge a specific piece of legislation. Subsection (d) states that if the Committee on Finance has not reported any "medicare funding legislation" by June 30 then it is in order for any Senator to move to discharge the committee from any one of the pieces of "medicare funding legislation" that has been referred to that committee. Only one motion may be made in any session of Congress and such motion may only refer to a single piece of legislation. This motion is not amendable and debate of the motion and any related appeals is limited to 2 hours. The 2 hours is to be equally divided and controlled between the maker of the motion and the Majority Leader (or their designees). If the Majority Leader supports the motion, then the time in opposition will be controlled by the Minority Leader (or the Minority Leader's designee).

Unlike other instances of limited debate, in this case, a point of order may be made at any time during the 2 hours—a Senator need not await the expiration or yielding back of time to do so. Any appeal made within the 2 hours, may be debated for whatever time remains if any Senator desires to debate the appeal. Any motion or appeal made after the 2 hours shall be decided without debate. It is not in order to move to proceed to the consideration of any other measure or matter while the motion to discharge (or the motion to reconsider the vote with respect to the motion to discharge) is pending. The only motions in order during the 2 hours (or at the conclusion of the 2 hours) of debate are as follows: to postpone to a day certain, to postpone indefinitely, to lay on the table, to take a recess, to adjourn to a day certain, to adjourn. These motions shall have the same precedence as described in Rule XXII of the Standing Rules of the Senate. Note that pursuant to subsection (d)(2), the motion to proceed to executive business (which is listed in Rule XXII) as well as the motion to proceed to any other legislative matter is explicitly precluded.

Pursuant to subsection (d)(4), this special motion to discharge is no longer available if the Chairman of the Committee on the Budget certifies that "medicare funding legislation" which eliminates the "excess general revenue medicare funding" described in section 801(c) has been enacted in that session.

Subsection (e) reiterates the fact that under existing Senate procedures once "medicare funding legislation" has been placed on the Calendar (having been either reported or discharged from the committee) it is in order for any member of the Senate to make a motion to proceed to the consideration of that measure. Such motion and all subsequent actions in the Senate shall be considered under the Standing Rules of the Senate and the precedents thereto or pursuant to any unanimous consent agreements reached, as the case may be. This section should not be interpreted as creating a "privileged" measure in the Senate. Consequently, it is the intent of the Conferees that there will be no further special procedures (such as a waiver or alteration of the procedures with respect to reports set out in Rule XVII or any other rule of the Standing Rules of the Senate) available to such measures as a result of this Act.

Subtitle B: Income-Related Reduction in Part B Premium Subsidy

Present Law

The Medicare Part B premium is currently set each year to cover 25 percent of Medicare's benefits under Part B. When Medicare was created in 1965, the Part B premium was set to cover 50 percent of the costs of the Part B benefits. The share of Part B spending covered by the premium declined between 1975 and 1983 to less than 25 percent of spending, because during that time premium increases were limited by the cost-of-living adjustment for Social Security benefits. During the late 1980s and early 1990s, Congress routinely voted to set the Part B premium at 25 percent of Part B costs, and that percentage was codified in the Balanced Budget Act of 1997 (BBA 97).

All seniors over age 65 who elect Part B during their initial enrollment period pay the same Part B premium, regardless of income.

House Bill

No provision.

Senate Amendment

No provision.

Conference Agreement

In order to begin to address the fiscal challenges facing the Medicare program, beginning in 2007, Medicare beneficiaries with incomes over $80,000 for an individual or $160,000 for a married couple will be asked to contribute more to the cost of their Medicare benefits through payment of a higher premium. Approximately 4 percent of Medicare beneficiaries have incomes above these levels. All beneficiaries will continue to receive some level of premium assistance, and all beneficiaries will continue to be eligible for the full range of Medicare benefits. This proposal will target taxpayer dollars at those who need it the most by reducing the government subsidy for those who have the resources to cover more of their own costs.

Beneficiaries with incomes under $80,000 for an individual and $160,000 for a married couple will continue to receive a government subsidy at 75 percent and pay premiums at the 25 percent rate. Those with incomes between $80,000 and $100,000 ($160,000 and $200,000 for a married couple) will receive a 65 percent subsidy and pay 35 percent as a premium. Those with incomes between $100,000 and $150,000 ($200,000 and $300,000 for a couple) will receive a 50 percent subsidy and pay a premium at 50 percent. Those with incomes between $150,000 and $200,000 ($300,000 and $400,000 for a married couple) will receive a 35 percent subsidy and pay a premium at a 65 percent rate. Those with incomes above $200,000 ($400,000 for a married couple) will receive a 20 percent subsidy and pay a premium at an 80 percent rate.

Beneficiaries who are affected will be notified of their premium levels at the start of the year. They may appeal their premium level based on major changes in life circumstances, such as divorce, marriage, or death of a spouse. Although this policy affects only a small number of beneficiaries, it will have a significant impact in controlling the growth of Medicare spending in the future.

To facilitate the income-related reduction in Part B premium subsidy, the conference agreement authorizes the disclosure of certain return information to employees and contractors of the Social Security Administration. Upon written request from the Commissioner of Social Security, the IRS may disclose certain items of return information with respect to a taxpayer whose premium may be subject to adjustment. With respect to such taxpayers, the IRS may disclose (1) taxpayer identity information; (2) filing status; (3) adjusted gross income; (4) the amounts excluded from such taxpayer's gross income under sections 135 and 911 of the Internal Revenue Code (relating to income from United States Savings bonds used to pay higher education tuition and fees, and foreign earned income); (5) tax-exempt interest received or accrued during the taxable year to the extent such information is available; (6) amounts excluded from such taxpayer's gross income by sections 931 and 933 of the Internal Revenue Code (relating to income from sources within Guam, American Samoa, the Northern Mariana Islands, or Puerto Rico); (7) for nonfilers only, such other information relating to the liability of the taxpayer as the Secretary may prescribe by regulation, as might indicate that the amount of the premium of the taxpayer may be subject to adjustment (including estimated tax payments and income information derived from Form W-2, Form 1099, or similar information returns); and (8) the taxable year with respect to which the preceding information relates. Return information disclosed under this authority may be used by employees and contractors of the Social Security Administration only for purposes of, and to the extent necessary in, establishing the appropriate amount of any Part B premium adjustment. Employees and contractors of the Social Security Administration are subject to the penalties for unauthorized disclosure and inspection, as well as the applicable safeguard requirements.

TITLE IX—REGULATORY REDUCTION AND CONTRACTING REFORM

Administrative Improvements within the Centers for Medicare & Medicaid Services (CMS) (Section 900 of the Conference Agreement, Sections 801 and 802 of the House Bill, Sections 301 and 302 of the Senate Bill).

Present Law

The authority for administering the Medicare program resides with the Secretary of Health and Human Services. The Secretary originally created the agency that administers the Medicare and Medicaid programs in 1977 under his administrative authority. Regulations regarding Medicare are required to be promulgated by the Secretary. The Medicare statute requires that the Administrator of the Centers for Medicare & Medicaid Services (CMS formerly known as the Health Care Financing Administration) be appointed by the President with the advice and consent of the Senate. Title 5 of the U.S. Code sets the Administrator's salary at level IV of the Executive Schedule. The Medicare statute requires that the HCFA administrator appoint a Chief Actuary who reports directly to such administrator and is paid at the highest rate of basic pay for the Senior Executive Service.

House Bill

The section would amend title XVIII to add new section 1809 which, under subsection (a), would establish a new Medicare Benefits Administration (MBA) within the Department of Health and Human Services.

Subsection (b) would provide for an Administrator and Deputy Administrator of the MBA. Both would be appointed by the President with the advice and consent of the Senate for 4-year terms. If a successor did not take office at the end of the term, the Administrator would continue in office until the successor enters the office. In that event, the confirmed successor's term would be the balance of the 4-year period. The Administrator would be paid at level III of the Executive Schedule and the Deputy Administrator at level IV of the Executive Schedule. The Administrator would be responsible for the exercise of all powers and the discharge of duties of the MBA and has authority and control over all personnel. The provision would permit the Administrator to prescribe such rules and regulations as the Administrator determined necessary or appropriate to carry out the functions of MBA, subject to the Administrative Procedure Act. The Administrator would be able to establish different organizational units within the MBA except for any unit, component, or provision specifically provided for by section 1809. The Administrator may assign duties, delegate, or authorize redelegations of authority to MBA officers and employees as needed. The Secretary of Health and Human Services shall ensure appropriate coordination between the Administrator of MBA and the Administrator of the Centers for Medicare & Medicaid Services (CMS) in administering the Medicare program. The provision also would establish a position of Chief Actuary within the MBA who would be appointed by the Administrator and paid at the highest rate of basic pay for the Senior Executive Service. The Chief Actuary would exercise such duties as are appropriate for the office of Chief Actuary and in accordance with professional standards of actuarial independence.

Subsection (c) would prescribe the duties of the Administrator and administrative provisions relating to the MBA. In administering parts C, D, and E of Medicare, the Administrator would be required to negotiate, enter into and enforce contracts with Medicare Advantage plans and enhanced fee-for-service plans and with prescription drug plan sponsors for Medicare prescription drug plans. The Administrator would be required to carry out any duty provided for under part C, D, or E of Medicare including implementing the prescription drug discount card endorsement program and demonstration programs (that are carried out in whole or in part under part C, D, or E). The provision specifically prohibits the Administrator from requiring a particular formulary or instituting a price structure for the reimbursement of covered drugs, from interfering in any way with negotiations between prescription drug plan sponsors and Medicare Advantage organizations and enhanced fee-for-service organizations and drug manufacturers, wholesalers, or other suppliers of covered drugs; and otherwise interfering with the competitive nature of providing prescription drug coverage through such entities and organizations. These negotiations would be carried out by private plans, eager to capture market share through lower premiums, and manufacturers, willing to negotiate discounts for volume assurance. Such private sector entities are far better suited to achieve maximum discounts and lower premiums for plan participants than a disinterested Administrator.

The Administrator would be required to submit a report to Congress and the President on the administration of parts C, D, and E during the previous year by not later than March 31 of each year.

The Administrator, with the approval of the Secretary, would be permitted to hire staff to administer the activities of MBA without regard to chapter 31 of title 5 of the U.S. Code, except for 12 sections. The Administrator would be required to employ staff with appropriate and necessary experience in negotiating contracts in the private sector. The staff of MBA would be paid without regard to chapter 51 (other than section 5101 requiring classification of positions according to certain principles) and chapter 53 (other than section 5301 relating to the principles of pay systems) of title 5 of the U.S. Code. The rate of compensation for staff of MBA would not be able to exceed level IV of the Executive Schedule. The Administrator would be limited in the number of full-time-equivalent (FTEs) employees for the MBA to the number of FTEs within CMS performing the functions being transferred at the time of enactment. The Secretary, the Administrator of MBA and the Administrator of CMS would be required to establish an appropriate transition of responsibility to redelegate the administration of Medicare part C from CMS to MBA. The provision would require the Secretary to ensure that the Administrator of CMS transfers such information and data as the Administrator of MBA requires to carry out the duties of MBA.

Subsection (d) would require the Secretary to establish an Office of Beneficiary Assistance within MBA to coordinate Medicare beneficiary outreach and education activities, and provide Medicare benefit and appeals information to Medicare beneficiaries under parts C, D, and E.

Subsection (e) would establish the Medicare Policy Advisory Board (the Board) within the MBA to advise, consult with, and make recommendations to the Administrator regarding the administration and payment policies of parts C, D, and E. The Board would be required to report to Congress and to the Administrator of MBA such reports as the Board determines appropriate and may contain recommendations that the Board considers appropriate regarding legislative or administrative changes to improve the administration of parts C, D, and E including: increasing competition under part C, D, or E for services furnished to beneficiaries; improving efforts to provide beneficiaries information and education about Medicare, parts C, D, and E, and Medicare enrollment; evaluating implementation of risk adjustment under parts C and E; and improving competition and access to plans under parts C, D, and E. The reports would be required to be published in the Federal Register. The reports would be submitted directly to Congress and no officer or agency of the government would be allowed to require the Board to submit a report for approval, comments, or review prior to submission to Congress. Not later than 90 days after a report is submitted to the Administrator, the Administrator would be required to submit to Congress and the President an analysis of the recommendations made by the Board. The analysis would be required to be published in the Federal Register.

The Board would be made up of 7 members serving three-year terms, with 3 members appointed by the President, 2 appointed by the Speaker of the House of Representatives, and 2 appointed by the President pro tempore of the Senate. Board members may be reappointed but may not serve for more than 8 years. The Board shall elect the Chair to serve for 3 years. The Board is required to meet at least three times a year and at the call of the Chair.

The Board would be required to have a director who, with the approval of the Board, may appoint staff without regard to chapter 31 of title 5 of the United States Code (which addresses authority for employment). In addition, the director and staff could be paid without regard to the provisions of chapter 51 and 53 of title 5 which are related to classification and pay rates and pay systems—although the rate of compensation is capped at level IV of the Executive Schedule. The Board could contract with and compensate government and private agencies or persons to carry out its duties without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

Subsection (f) would authorize an appropriation of such sums as are necessary from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (including the Prescription Drug Account) to carry out section 1808.

The provision would be effective upon enactment, however, the enrollment and eligibility functions and implementation of parts C and E would be effective January 1, 2006.

Senate Bill

The section would amend title XVIII to add new section 1808, which, under subsection (a), would establish a new Center for Medicare Choices (CMC) within the Department of Health and Human Services by no later than March 1, 2004, to administer parts C and D of Medicare.

Subsection (b) would provide for an Administrator of CMC who would be appointed by the President with the advice and consent of the Senate for 5-year terms. The Administrator would be able to appoint a Deputy Administrator. If a successor did not take office at the end of the term, the Administrator would continue in office until the successor enters the office. In that event, the confirmed successor's term would be the balance of the 5-year period. The Administrator would be paid at level III of the Executive Schedule and the Deputy Administrator at level IV of the Executive Schedule. The Administrator would be responsible for the exercise of all powers and the discharge of duties of CMC and has authority and control over all personnel. The provision would permit the Administrator to prescribe such rules and regulations as the Administrator determined necessary or appropriate to carry out the functions of CMC, subject to the Administrative Procedure Act. The Administrator would be able to establish different organizational units within the CMC except for any unit, component, or provision provided by section 1808. The Administrator may assign duties, delegate, or authorize redelegations of authority to CMC officers and employees as needed. The Secretary of Health and Human Services shall ensure appropriate coordination between the Administrator of CMC and the Administrator of the Centers for Medicare & Medicaid Services in administering the Medicare program.

Subsection (c) would prescribe the duties of the Administrator and administrative provisions relating to the CMC. In administering parts C and D of Medicare, the Administrator would be required to negotiate, enter into and enforce contracts with MedicareAdvantage plans and with eligible entities for Medicare prescription drug plans. The Administrator would be required to carry out any duty provided for under part C or D of Medicare including demonstration programs (that are carried out in whole or in part under parts C or D). The Administrator of the agency, to the extent possible, would not be able interfere in any way with negotiations between eligible entities, MedicareAdvantage organizations, hospitals, physicians, other entities or individuals furnishing items and services under this title (including contractors for such items and services), and drug manufacturers, wholesalers, or other suppliers of covered drugs. The Administrator would be required to submit a report to Congress and the President on the administration of the voluntary prescription drug delivery program not later than March 31 of each year.

The Administrator, with the approval of the Secretary, would be able to employ management staff as determined appropriate. The Administrator would be able to compensate such managers up to the highest rate of basic pay for the Senior Executive Service. Any such manager would be required to have demonstrated, by their education and experience (either in the public or private sectors) superior expertise in the review, negotiation, and administration of health care contracts, the design of health care benefit plans, actuarial sciences, compliance and health plan contracts, consumer education and decision-making.

Subsection (d) would require the Secretary to establish an Office of Beneficiary Assistance within CMC to make Medicare eligibility determinations, enroll beneficiaries into Medicare, provide Medicare benefit and appeals information, and carry out any other activities relating to Medicare beneficiaries under title XVIII. Within the Office of Beneficiary Assistance, a Beneficiary Ombudsman would be established who is appointed by the Secretary. The Ombudsman would be required to receive complaints, grievances, and requests for information submitted by a Medicare beneficiary regarding any aspect of the Medicare program; to provide assistance with the complaints, grievances and requests including assisting beneficiaries with appeals; and with problems arising from disenrolling from a MedicareAdvantage plan or a prescription drug plan. The Ombudsman would be required to submit annual reports to Congress, the Secretary, and the Medicare Competitive Policy Advisory Board describing the activities of the Ombudsman's office and including any recommendations for improvement in the administration of title XVIII. The Ombudsman would also be required to coordinate with state medical ombudsmen programs, and with state- and community-based consumer organizations to provide information about the Medicare program and to conduct education outreach regarding resolution or avoidance of disputes and problems under the Medicare program.

Subsection (e) would establish the Medicare Competitive Policy Advisory Board (the Board) within the CMC to advise, consult with, and make recommendations to the Administrator regarding the administration and payment policies of parts C and D. The Board would be required to report to Congress and to the Administrator of CMC such reports as the Board determines appropriate and may contain recommendations that the Board considers appropriate regarding legislative or administrative changes to improve the administration of parts C and D including: stability and solvency of the program, increasing competition, improving the quality of benefits, incorporating disease management, improving competition and access to plans in rural areas, and improving beneficiary information and education for the entire Medicare program. The reports would be required to be published in the Federal Register. The reports would be submitted directly to Congress and no officer or agency of the government would be allowed to require the Board to submit a report for approval, comments, or review prior to submission to Congress. Not later than 90 days after a report is submitted to the Administrator, the Administrator would be required to submit to Congress and the President an analysis of the recommendations made by the Board. The analysis would be required to be published in the Federal Register. The Administrator of CMC is required to provide information and assistance to the Board as is requested to carry out its functions.

The Board would be made up of 7 members serving three-year terms, with three members appointed by the President, two appointed by the Speaker of the House of Representatives, and two appointed by the President pro tempore of the Senate. Board members may be reappointed but may not serve for more than 8 years. The Board shall elect the Chair to serve for three years. The Board is required to meet at least three times a year and at the call of the Chair. The Board is required to have an executive director who, with the approval of the Board, may appoint staff as appropriate.

Subsection (f) would authorize an appropriation of such sums as are necessary from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (including the Prescription Drug Account) to carry out section 1808.

The provision would also require that the Secretary provide 1–800–Medicare as a means by which individuals seeking information about or assistance with Medicare can receive assistance. The Secretary would be required to route calls to the appropriate entity to provide the assistance or information. The 1–800–Medicare number would be included in the Medicare handbook in place of the listing of phone numbers of individual contractors.

The Administrator of CMC would be added as Co-Secretary of the Board of Trustees of the Medicare Trust Funds. In addition, the pay level for the Administrator of CMS would be increased from level IV of the Executive Schedule to level III.

The CMC would be required to be established by the Secretary no later than March 1, 2004.

Conference Agreement

The conference agreement creates a new section 1808 of the Social Security Act establishing a center within the Centers for Medicare & Medicaid Services to administer Parts C and D of Medicare, provide notice and information to beneficiaries (as required under section 1804 of the Social Security Act), and other such duties as specified by the Secretary. The person heading the Center is required to report to the Administrator of CMS. The Secretary is required to ensure that the Center is carrying out these duties by no later than January 1, 2008.

The conference agreement permits the Secretary to employ management staff as he determines to be appropriate. If such staff are employed, the staff must have demonstrated superior expertise in at least one of the following areas: (1) the review, negotiation, and administration of health care contracts; (2) the design of health care benefit plans; (3) actuarial sciences; (4) consumer education and decision making; (5) any other area specified by the Secretary that requires specialized management or other expertise. The Secretary is required to establish the rate of pay taking into account expertise, experience, and performance. The pay rate cannot exceed the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code (currently ES–6). Such flexibility ensures those with private sector, real world experience managing benefit plans are hired and utilized to ensure the success of the new Medicare plans. This expertise will help mitigate against potential failure in coaxing integrated plans that promote coordinated care and modern health delivery into the Medicare program.

The conference agreement requires that an actuary within the office of the Chief Actuary of CMS have duties exclusively related to Parts C and D of Medicare and related provisions. The pay grade for the Administrator of CMS is increased to Executive Level III beginning January 1, 2004. The conferees strongly encourage the hiring of a separate actuary within the office of the actuary to assist the functions of the center. Because the analysis of the fee-for-service actuary can effect payment rates in private plan reimbursement, the two should be kept independent and answer directly to the Secretary.

In addition, the conference agreement changes statutory references from the Health Care Financing Administration to the Centers for Medicare & Medicaid Services.

Construction; Definition of Supplier (Section 901 of the Conference Agreement, Section 901 of the House Bill).

Present Law

Section 1861 of the Social Security Act contains definitions of services, institutions, and so forth under Medicare. Supplier is not explicitly defined.

House Bill

Nothing in this title would be construed as compromising or affecting existing legal remedies for addressing fraud or abuse, whether it be criminal prosecution, civil enforcement or administrative remedies (including the False Claims Act) or to prevent or impede HHS from its efforts to eliminate waste, fraud, or abuse in Medicare. The provision also would clarify that consolidation of the Medicare administrative contractors does not consolidate the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The provision would also clarify that the term "supplier" means a physician or other practitioner, a facility or other entity (other than a provider of services) furnishing items or services under Medicare. The provision would be effective upon enactment.

Senate Bill

No provision.

Conference Agreement

The conference agreement provides that nothing in this title shall be construed as compromising or affecting existing legal remedies for addressing fraud or abuse, whether it be criminal prosecution, civil enforcement or administrative remedies (including the False Claims Act) or to prevent or impede HHS from its efforts to eliminate waste, fraud, or abuse in Medicare. The conference agreement also clarifies that consolidating the Medicare administrative contractors does not consolidate the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The agreement also clarifies that the term "supplier" means a physician or other practitioner, a facility or other entity (other than a provider of services) furnishing items or services under Medicare. The provision is effective upon enactment.

Issuance of Regulations (Section 902 of the Conference Agreement, Section 902 of the House Bill, Section 501 of the Senate Bill).

Present Law

The Secretary is required to prescribe regulations that are necessary to administer the Medicare program. The Secretary must publish proposed regulations in the Federal Register, with at least 30 days to solicit public comment before issuing the final regulation except in the following circumstances: (1) the statute permits the regulation to be issued in interim final form or provides for a shorter public comment period; (2) the statutory deadline for implementing a provision is less than 150 days after the date of enactment of the statute containing the provision; (3) under the good cause exception contained in the rule-making provision of title 5 of the United States Code, notice and public comment procedures are deemed impracticable, unnecessary or contrary to the public interest. The Secretary must publish a list of all manual instructions, interpretative rules, statements of policy, and guidelines, which are promulgated to carry out Medicare law in the Federal Register no less frequently than every 3 months.

There is no explicit statutory instruction on logical outgrowth. The courts have repeatedly held that new matter in final regulations must be a "logical outgrowth of the proposed rule" and is an inherent aspect of notice and comment rulemaking.

House Bill

The provision would require the Secretary, in consultation with the Director of the Office of Management and Budget, to establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed rule or an interim final regulation. The timeframe established would not be permitted to be longer than three years, except under extraordinary circumstances. If the Secretary were to vary the timeline he established, the provision would require him to publish a notice in the Federal Register with the new timeline and an explanation of the variation. In the case of interim final regulations, the provision would require that if the Secretary did not meet his established timeframe, then the interim final regulation would not be able to continue in effect unless the Secretary published a notice of continuation of the regulation that included an explanation of why the regular time line had not been complied with. This provision regarding timelines would be effective upon enactment.

The provision also would require that a measure in a final regulation that is not a logical outgrowth of the proposed regulation or interim final regulation would be treated as a proposed regulation. The measure would not be able to take effect until public comment occurred and the measure was published as a final regulation. This provision would apply to final regulations published on or after the date of enactment.

Senate Bill

The Secretary would be required to publish a final regulation within 12 months of the publication of an interim final regulation or the interim final regulation would no longer be effective. Subject to appropriate notice, the Secretary would be able to extend this deadline for up to 12 additional months. The Secretary would be required to publish a notice in the Federal Register 6 months after the date of enactment providing the status of each interim final regulation for which no final regulation has been published and providing the date by which the final regulation is planned to be published. This provision would be effective upon enactment.

Conference Agreement

The conference agreement requires the Secretary, in consultation with the Director of the Office of Management and Budget, to establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed rule or an interim final regulation. The timeframe established is not be permitted to be longer than 3 years, except under extraordinary circumstances. If the Secretary varies the timeline he established, he is required to publish a notice in the Federal Register with the new timeline and an explanation of the variation. In the case of interim final regulations, if the Secretary does not meet his established timeframe, then the interim final regulation cannot continue in effect unless the Secretary publishes a notice of continuation of the regulation that includes an explanation of why the regular timeline was not complied with. This agreement regarding timelines is effective upon enactment.

The conference agreement also requires that a measure in a final regulation that is not a logical outgrowth of the proposed regulation or interim final regulation is to be treated as a proposed regulation. The measure could not take effect until public comment occurred and the measure is published as a final regulation. This agreement applies to final regulations published on or after enactment.

Compliance with Changes in Regulation and Policies. (Section 903 of the Conference Agreement, Section 903 of the House Bill, Sections 502 and 533 of the Senate Bill).

Present Law

No explicit statutory instruction. As a result of case law, there is a strong presumption against retroactive rulemaking. In *Bowen* v. *Georgetown University Hospital*, the Supreme Court ruled that there must be explicit statutory authority to engage in retroactive rulemaking.

House Bill

The provision would bar retroactive application of any substantive changes in regulation, manual instructions, interpretative rules, statements of policy, or guidelines unless the Secretary determines retroactive application is needed to comply with the statute or is in the public interest, effective upon enactment. No substantive change would go into effect until 30 days after the change is issued or published unless it would be needed to comply with statutory changes or was in the public interest. Compliance actions would be able to be taken for items and services furnished only on or after the effective date of the change, effective upon enactment. If a provider or supplier follows written guidance provided by the Secretary or a Medicare contractor when furnishing items or services or submitting a claim and the guidance is inaccurate, the provider or supplier would not be subject to penalty or repayment of overpayment (unless the inaccurate information was due to a clerical or technical operational error).

Senate Bill

Same provisions.

Conference Agreement

The conference agreement bars retroactive application of any substantive changes in regulation, manual instructions, interpretative rules, statements of policy, or guidelines unless the Secretary determines retroactive application is needed to comply with the statute or is in the public interest. No substantive change could go into effect until 30 days after the change is issued or published unless it is needed to comply with statutory changes or in the public interest. Compliance actions could be taken for items and services furnished only on or after the effective date of the change, effective upon enactment. If a provider or supplier follows written guidance provided by the Secretary or a Medicare contractor when furnishing items or services or submitting a claim and the guidance is inaccurate, the provider or supplier is not subject to penalty or interest (unless the inaccurate information was due to a clerical or technical operational error).

The conference agreement also makes clear that a provider or supplier is not subject to any penalty or interest on a repayment plan (including under section 1893 of the Social Security Act, relating to the Medicare Integrity Program, or otherwise) relating to the provision of such items or services or a claim if the provider or supplier reasonably relied on the guidance. The conference agreement applies to a sanction imposed with respect to guidance provided on or after July 24, 2003.

Reports and Studies Relating to Regulatory Reform. (Section 904 of the Conference Agreement, Section 904 of the House Bill, Section 503 of the Senate Bill).

Present Law

No provision.

House Bill

The GAO would be required to study the feasibility and appropriateness of the Secretary providing legally binding advisory opinions on appropriate interpretation and application of Medicare regulations. The report would be due to Congress 1 year after enactment.

The Secretary would be required to report to Congress every 2 years on the administration of Medicare and areas of inconsistency or conflict among various provisions under law and regulation. The report would include recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts. The first report would be due to Congress 2 years after enactment.

Senate Bill

Requires the Secretary to report to Congress in 2 years, and every 3 years thereafter, on the administration of Medicare and areas of inconsistency or conflict among various provisions under law and regulation and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.

Conference Agreement

The conference agreement requires the GAO to study the feasibility and appropriateness of the Secretary providing legally binding advisory opinions on appropriate interpretation and application of Medicare regulations. The report is due to Congress 1 year after enactment.

The Secretary is required to report to Congress in 2 years and every 3 years thereafter on the administration of Medicare and areas of inconsistency or conflict among various provisions under law and regulation. The report is to include recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.

Increased Flexibility in Medicare Administration. (Section 911 of the Conference Agreement, Section 911 of the House Bill, Section 521 of the Senate Bill).

Present Law

The Secretary is authorized to enter into agreements with fiscal intermediaries nominated by different provider associations to make Medicare payments for health care services furnished by institutional providers. For Medicare Part B claims, the Secretary is authorized to enter into contracts only with health insurers (or carriers) to make Medicare payments to physicians, practitioners and other health care suppliers. Section 1834(a)(12) of the Act authorizes separate regional carriers for the payment of durable medical equipment (DME) claims. The Secretary is also authorized to contract for certain program safeguard activities under the Medicare Integrity Program (MIP).

Certain terms and conditions of the contracting agreements for fiscal intermediaries and carriers are specified in the Medicare statute. Medicare regulations coupled with long-standing agency practices have further limited the way that contracts for claims administration services can be established.

Certain functions and responsibilities of the fiscal intermediaries and carriers are specified in the statute as well. The Secretary may not require that carriers or intermediaries match data obtained in its other activities with Medicare data in order to identify beneficiaries who have other insurance coverage as part of the Medicare Secondary Payer (MSP) program. With the exception of prior authorization of DME claims, an entity may not perform activities (or receive related payments) under a claims processing contract to the extent that the activities are carried out pursuant to a MIP contract. Performance standards with respect to the timeliness of reviews, fair hearings, reconsiderations and exemption decisions are established as well.

A Medicare contract with an intermediary or carrier may require any of its employees certifying or making payments provide a surety bond to the United States in an amount established by the Secretary. Neither the contractor nor the contractor's employee who certifies the amount of Medicare payments is liable for erroneous payments in the absence of gross negligence or intent to defraud the United States. Neither the contractor nor the contractor's employee who disburses payments is liable for erroneous payments in the absence of gross negligence or intent to defraud the United States, if such payments are based upon a voucher signed by the certifying employee.

House Bill

This provision would add a new Section 1874A to the Social Security Act and would permit the Secretary to competitively contract with any eligible entity to serve as a Medicare contractor. The provision would eliminate the distinction between Part A contractors (fiscal intermediaries) and Part B contractors (carriers) and take the separate authorities for fiscal intermediaries and carriers and merge them into a single authority for the new contractor. These new contractors would be called Medicare Administrative Contractors (MACs) and would assume all the functions of the current fiscal intermediaries and carriers: determining the amount of Medicare payments required to be made to providers and suppliers, making the payments, providing education and outreach to beneficiaries, providers and suppliers, communicating with providers and suppliers, and additional functions as are necessary.

The Secretary would be permitted to renew the MAC contracts annually for up to 5 years. All contracts would be required to be re-competed at least every 5 years using competitive processes. Federal Acquisition Regulations (FAR) would apply to these contracts except to the extent any provisions are inconsistent with a specific Medicare requirement, including incentive contracts. The contracts would be required to contain performance requirements that would be developed by the Secretary who could consult with beneficiary, provider, and supplier organizations, would be consistent with written statements of work and would be used for evaluating contractor performance. MAC would be required to furnish the Secretary such timely information as he may require and to maintain and provide access to records the Secretary finds necessary. The Secretary could require a surety bond from the MAC or certain officers or employees as the Secretary finds appropriate. The Secretary would be prohibited from requiring that the MAC match data from other activities for Medicare secondary payer purposes.

The provision would limit liability of certifying and disbursing officers and the Medicare Administrative Contractors except in cases of reckless disregard or the intent to defraud the United States. This limitation on liability would not limit liability under the False Claims Act. The provision also establishes circumstances where contractors and their employees would be indemnified, both in the contract and as the Secretary determines appropriate.

The provision would make numerous conforming amendments as the authorities for the fiscal intermediaries and carriers are stricken. After enactment of the bill, but before October 1, 2005, the Secretary would be permitted to enter into new fiscal intermediary agreements without regard to any of the provider nomination provisions.

The Secretary would be required to submit a report to Congress and the GAO by no later than October 1, 2004, that describes the plan for implementing these provisions. The GAO is required to evaluate the Secretary's plan and, within six months of receiving the plan, report on the evaluation to Congress and make any recommendations the Comptroller General believes appropriate. The Secretary is also required to report to Congress by October 1, 2008 on the status of implementing the contracting reform provisions including the number of contracts that have been competitively bid, the distribution of functions among contracts and contractors, a timeline for complete transition to full competition, and a detailed description of how the Secretary has modified oversight and management of Medicare contractors to adapt to full competition.

Competitive bidding for the MACs would be required to begin for annual contract periods that begin on or after October 1, 2005.

Senate Bill

Same provision, containing three main differences: First, contracts would be required to be recompeted every 6 years. Second, a MAC with a contract to perform local coverage determinations would be required to designate at least 1 different individual to serve as a medical director for each state for which local coverage determinations are made; use the medical director in making the local coverage determinations; and appoint a contractor advisory committee for each state for which local coverage determinations are made to participate in an advisory capacity in the development of the local determinations. Finally, competitive bidding for the MACs would be required to begin for annual contract periods that begin on or after October 1, 2011.

Conference Agreement

The conference agreement adds a new Section 1874A to the Social Security Act into which the Medicare contractor authority is consolidated. The conference agreement permits the Secretary to competitively contract with any eligible entity to serve as a Medicare Administrative Contractor (MAC). The conference agreement eliminates the distinction between Part A contractors (fiscal intermediaries) and Part B contractors (carriers) and takes the separate authorities for fiscal intermediaries and carriers and merges them into a single authority for the new contractor. All the functions of the current fiscal intermediaries and carriers are assumed by the new MACs: determining the amount of Medicare payments required to be made to providers and suppliers, making the payments, providing education and outreach to beneficiaries, providers and suppliers, communicating with providers and suppliers, and additional functions as are necessary.

The Secretary is permitted to renew the MAC contracts annually for up to 5 years. All contracts must be re-competed at least every 5 years using competitive processes. Federal Acquisition Regulations (FAR) apply to MAC contracts except to the extent any provisions are inconsistent with a specific Medicare requirement, including incentive contracts. (The conference agreement does not extend FAR provision to other contractors under title XVIII.) The Secretary is required to develop contract performance requirements to carry out the functions described in the provision and to develop standards for measuring the extent to which a contractor has met the requirements. The Secretary is required to consult with beneficiary and provider organizations, and organizations and agencies performing other Medicare functions. The Secretary is required to make the performance requirements and measurement standards available to the public and must include provider and beneficiary satisfaction levels as one of the requirements.

MAC performance requirements are required to be included in the contract and consistent with written statements of work and used for evaluating contractor performance. MACs are required to furnish the Secretary such timely information as he may require and to maintain and provide access to records the Secretary finds necessary. The Secretary may require a surety bond from the MAC or certain officers or employees as the Secretary finds appropriate. The Secretary is prohibited from requiring that the MAC match data from other activities for Medicare secondary payer purposes.

The conference agreement limits the liability of certifying and disbursing officers and the Medicare Administrative Contractors except in cases of reckless disregard or the intent to defraud the United States. The standard does not limit liability for conduct that constitutes a violation of the False Claims Act. The conference agreement also establishes circumstances where contractors and their employees are indemnified, both in the contract and as the Secretary determines appropriate.

The conference agreement makes numerous conforming amendments as the statutory authorities for the fiscal intermediaries and carriers are stricken. After enactment of the bill, but before October 1, 2005, the Secretary is authorized to enter into new fiscal intermediary agreements without regard to any of the provider nomination provisions under section 1816 of the Social Security Act and may enter into new carrier contracts. The Secretary is required to take such steps as are necessary to provide for an appropriate transition from the fiscal intermediary agreements and carrier contracts to the MAC contracts. In addition, the Secretary is explicitly authorized to continue Medicare Integrity Program fiscal intermediary agreements and carrier contracts from the enactment of this provision through October 1, 2011.

The Secretary is required to submit a legislative proposal providing technical and conforming amendments to this provision to the appropriate committees of Congress within 6 weeks of enactment. The Secretary is required to submit a report to Congress and the GAO by no later than October 1, 2004, that describes the plan for implementing these provisions. The GAO is required to evaluate the Secretary's plan and, within 6 months of receiving the plan, report on the evaluation to Congress and make any recommendations the Comptroller General believes appropriate. The Secretary is also required to report to Congress by October 1, 2008, on the status of implementing the contracting reform provisions including the number of contracts that have been competitively bid, the distribution of functions among contracts and contractors, a timeline for complete transition to full competition, and a detailed description of how the Secretary has modified oversight and management of Medicare contractors to adapt to full competition.

Competitive bidding for the MACs would be required to begin October 1, 2005 and all contracts should have been bid under the new structure by September 30, 2011.

Requirements for Information Security for Medicare Administrative Contractors (Section 912 of the Conference Agreement, Section 912 of the House Bill).

Present Law

No provision.

House Bill

Medicare administrative contractors (as well as fiscal intermediaries and carriers until the MACs are established) would be required to implement a contractor-wide information security program to provide information security for the operation and assets of the contractor for Medicare functions. The information security program would be required to meet certain requirements for information security programs imposed on Federal agencies under title 44 of the United States Code. Medicare administrative contractors would be required to undergo an annual independent evaluation of their information security programs. Existing contractors would be required to undergo the first independent evaluation within one year after the date of enactment and new contractors would be required to have such a program in place before beginning the claim determination and payment activities. The results of the independent evaluations would be submitted to the Secretary and the HHS Inspector General. The Inspector General of HHS would be required to report to Congress annually on the results of the evaluations. The Secretary would be required to address the results of the evaluations in required management reports.

Senate Bill

No comparable provision.

Conference Agreement

The conference agreement requires Medicare administrative contractors (as well as fiscal intermediaries and carriers until the MACs are established) to implement a contractor-wide information security program to provide information security for the operation and assets of the contractor for Medicare functions. The information security program is required to meet certain requirements for information security programs imposed on Federal agencies under title 44 of the United States Code. Medicare administrative contractors are required to undergo an annual independent evaluation of their information security programs. Current fiscal intermediaries and carriers are required to undergo the first independent evaluation within one year after the date of enactment and new contractors would be required to have such a program in place before beginning the claim determination and payment activities. The MACs are required to submit the results of the independent evaluations to the Secretary and the HHS Inspector General. The Inspector General of HHS is required to report to Congress annually on the results of the evaluations. The Secretary is required to address the results of the evaluations in required management reports.

Provider Education and Technical Assistance. (Section 921 of the Conference Agreement, Section 921 of the House Bill, Sections 531 and 532 of the Senate Bill).

Present Law

(a) Coordination of Education Funding.

Present Law

Medicare's provider education activities are funded through the program management appropriation and through Education and Training component of the Medicare Integrity Program (MIP). Both claims processing contractors (fiscal intermediaries and carriers) and MIP contractors may undertake provider education activities.

House Bill

The provision would add Section 1889 to the Social Security Act, which would require the Secretary to coordinate educational activities through the Medicare contractors to maximize the effectiveness of education efforts for providers and suppliers and to report to Congress with a description and evaluation of the steps taken to coordinate provider education funding. The provision would be effective upon enactment. The Secretary would be required to report to Congress on the steps taken to coordinate the funding of provider education under the provision by October 1, 2004.

Senate Bill

The provision would require the Secretary to coordinate educational activities through the Medicare contractors to maximize the effectiveness of education efforts for providers and suppliers. The provision would be effective upon enactment.

Conference Agreement

The conference agreement adds section 1889 to the Social Security Act requiring the Secretary to coordinate educational activities through the Medicare contractors to maximize the effectiveness of education efforts for providers and suppliers and to report to Congress with a description and evaluation of the steps taken to coordinate provider education funding. The agreement is effective upon enactment. The Secretary is required to report to Congress on the steps taken to coordinate the funding of provider education under the provision by October 1, 2004.

(b) Incentives to Improve Contractor Performance.

Present Law

No specific statutory provision. Since FY1996, as part of the audit required by the Chief Financial Officers Act, an estimate of improper payments in Medicare fee-for-service has been established annually. As a recent initiative, CMS is implementing a comprehensive error rate-testing program to produce national, contractor specific, benefit category specific and provider specific paid claim error rates.

House Bill

The Secretary would be required to use specific claims payment error rates (or similar methodology) to provide incentives for contractors to implement effective education and outreach programs for providers and suppliers. The provision would require the Comptroller General to submit to Congress and the Secretary a study and to make recommendations on the adequacy of the Secretary's methodology by October 1, 2004. The Secretary would be required to report to Congress by October 1, 2004 regarding how he intends to use the methodology in assessing Medicare contractor performance.

Senate Bill

The provision would require the Secretary to use specific claims payment error rates (or similar methodology) to provide incentives for contractors to implement effective education and outreach programs for providers and suppliers by October 1, 2004. The Conferees agree that any such methodology shall include non-responses in the measurement of the error rate. The Comptroller General would be required to study the adequacy of the methodology and make recommendations to the Secretary. The Secretary would be required to report to Congress regarding how he intends to use the methodology in assessing Medicare contractor performance.

Conference Agreement

The conference agreement requires the Secretary to use specific claims payment error rates (or similar methodology) to provide incentives for contractors to implement effective education and outreach programs for providers and suppliers. The Comptroller General is required to submit to Congress and the Secretary a study the adequacy of the methodology and to make recommendations. The Secretary is required to report to Congress by October 1, 2004 regarding how he intends to use the methodology in assessing Medicare contractor performance.

(c) Provision of Access to and Prompt Responses from Medicare Administrative Contractors.

Present Law

No specific statutory provision. Statutory provisions generally instruct carriers to assist providers and others who furnish services in developing procedures relating to utilization practices and to serve as a channel of communication relating information on program administration. Fiscal intermediaries are generally instructed to (1) provide consultative services to institutions and other agencies to enable them to establish and maintain fiscal records necessary for program participation and payment and (2) serve as a center for any information as well as a channel for communication with providers.

House Bill

The Secretary would be required to develop a strategy for communicating with beneficiaries, providers and suppliers. Medicare contractors would be required to provide responses to written inquiries that are clear, concise and accurate within 45 business days of the receipt of the written inquiry. The Secretary would be required to ensure that Medicare contractors have a toll-free telephone number where beneficiaries, providers and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate Medicare information. Medicare contractors would be required to maintain a system for identifying the person supplying information to beneficiaries, providers, and suppliers and to monitor the accuracy, consistency, and timeliness of the information provided. The Secretary would be required to establish and make public standards to monitor the accuracy, consistency, and timeliness of written and telephone responses of Medicare contractors as well as to evaluate the contractors against these standards. The provision would be effective October 1, 2004.

Senate Bill

Identical provision.

Conference Agreement

The conference agreement requires the Secretary to develop a strategy for communicating with beneficiaries, providers and suppliers, beginning October 1, 2004. Medicare contractors are required to provide responses to written inquiries that are clear, concise and accurate within 45 business days of the receipt of the written inquiry. The Secretary is required to ensure that Medicare contractors have a toll-free telephone number where beneficiaries, providers and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate Medicare information. Medicare contractors would be required to maintain a system for identifying the person supplying information to beneficiaries, providers, and suppliers and to monitor the accuracy, consistency, and timeliness of the information provided. The Secretary is required to establish and make public standards to monitor the accuracy, consistency, and timeliness of written and telephone responses of Medicare contractors as well as to evaluate the contractors against these standards. The conference agreement authorizes to be appropriated such sums as are necessary to carry out this subsection.

(d) Improved Provider Education and Training.

Present Law

In FY 2003, approximately $122 million was budget by CMS for provider education and training.

House Bill

The provision would authorize $25 million to be appropriated from the Medicare Trust Funds for fiscal years 2005 and 2006, and such sums as necessary for succeeding fiscal years for Medicare contractors to increase education and training activities for providers and suppliers. Medicare contractors would be required to tailor education and training activities to meet the special needs of small providers or suppliers. The provision defines a small provider as an institution with fewer than 25 full-time equivalents (FTEs) and a small supplier as one with fewer than 10 FTEs.

Senate Bill

The provision would provide increased funding for the Medicare Integrity Program of $35 million beginning with FY2004 for increased provider and supplier education. Also would require Medicare contractors to take into consideration the special needs of small providers or suppliers when conducting education and training activities and permits provision of technical assistance beginning January 1, 2004.

Conference agreement

The conference agreement authorizes such sums as necessary to be appropriated for fiscal years beginning with FY 2005 to be used to increase education and training activities for providers and suppliers regarding billing, coding, and other appropriate items and may be used to improve the accuracy, consistency, and timeliness of contractor responses. Beginning October 1, 2004, Medicare contractors are required to tailor education and training activities to meet the special needs of small providers or suppliers. Technical assistance is permitted to be included in the education and training activities. The provision defines a small provider as an institution with fewer than 25 full-time equivalents (FTEs) and a small supplier as one with fewer than 10 FTEs.

(e) Requirement to Maintain Internet Sites.

Present Law

No statutory provision. CMS and the Medicare contractors currently maintain internet sites.

House Bill

The provision would require that the Secretary and the Medicare contractors maintain Internet sites to answer frequently asked questions and provide published materials of the contractors beginning October 1, 2004.

Senate Bill

No provision.

Conference agreement

Beginning October 1, 2004, the conference agreement requires the Secretary and the Medicare contractors to maintain Internet sites to answer frequently asked questions and provide published materials of the contractors.

(f) Additional Provider Education Provisions.

Present Law

No provision.

House Bill

The provision would bar Medicare contractors from using a record of attendance (or non-attendance) at educational activities to select or track providers or suppliers in conducting any type of audit or prepayment review. The provision would not require Medicare contractors to disclose information that would compromise law enforcement activities or reveal findings of law enforcement-related audits. This provision would be effective upon enactment.

Senate Bill

The provision would bar Medicare contractors from using a record of attendance (or non-attendance) at educational activities to select or track providers or suppliers in conducting any type of audit or prepayment review. The provision would not require Medicare contractors to disclose the screens used for identifying claims that will be subject to medical review or information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits. This provision would be effective upon enactment.

Conference agreement

The conference agreements bars Medicare contractors from using a record of attendance (or non-attendance) at educational activities to select or track providers or suppliers in conducting any type of audit or prepayment review. Nothing in section 1889 or 1893(g) shall be construed as providing for disclosure by a Medicare contractor of the screens used for identifying claims that will be subject to medical review or of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits. The agreement is effective upon enactment.

Small Provider Technical Assistance Demonstration Program. (Section 922 of the Conference Agreement, Section 922 of the House Bill).

Present Law

No provision.

House Bill

The Secretary would be required to establish a demonstration program to provide technical assistance to small providers and suppliers, when they have requested the assistance, to improve compliance with Medicare requirements. If errors are found, the Secretary would be barred from recovering any overpayments barring evidence of fraud and if the problem that is the subject of the compliance review has been satisfactorily corrected within 30 days and the problem remains corrected. Providers participating would be expected to pay 25 percent of the cost of the technical assistance. A GAO study would be required not later than 2 years after the demonstration program begins. Appropriations would be authorized for $1 million for FY 2005 and $6 million for FY 2006 to carry out the demonstration.

Senate Bill

No provision.

Conference Agreement

The conference agreement requires the Secretary to establish a demonstration program to provide technical assistance to small providers and suppliers, when they have requested the assistance, in order to improve compliance with Medicare requirements. Technical assistance includes direct and in-person examination of billing systems and internal controls to determine program compliance and to suggest more efficient or effective means of achieving compliance. Providers participating are expected to pay 25 percent of the cost of the technical assistance. Appropriations of such sums as may be necessary to carry out this demonstration program are authorized from amounts not otherwise appropriated in the Treasury. The GAO is required to evaluate the demonstration no later than 2 years after it begins and submit a report to the Congress and the Secretary. The GAO is required to include in the report recommendations regarding the continuation or extension of the demonstration.

Medicare Provider Ombudsman; Medicare Beneficiary Ombudsman. (Section 923 of the Conference Agreement, Section 923 of the House Bill, Sections 301 and 534 of the Senate Bill).

Present Law

No provision.

House Bill

A Medicare Provider Ombudsman would be required to be appointed by the Secretary and located within the Department of Health and Human Services. The Provider Ombudsman would be required to provide confidential assistance to providers and suppliers regarding complaints, grievances, requests for information, and resolution of unclear or conflicting guidance about Medicare. The Ombudsman would submit recommendations to the Secretary regarding improving the administration of Medicare, addressing recurring patterns of confusion under Medicare, and ways to provide for an appropriate and consistent response in cases of self-identified overpayments by providers and suppliers. Such sums, as necessary, would be authorized and be appropriated for FY 2004 and subsequent years.

A Medicare Beneficiary Ombudsman would be required to be appointed by the Secretary and located within HHS. The Secretary would be required to appoint both ombudsmen not later than one year from the date of enactment. The Beneficiary Ombudsman would be required to have expertise and experience in health care, education of, and assistance to Medicare beneficiaries. The Beneficiary Ombudsman would be required to receive complaints, grievances, and requests for information submitted by Medicare beneficiaries. The Beneficiary Ombudsman would also be required to assist beneficiaries in collecting relevant information to seek an appeal of a decision or determination made by the Secretary, a Medicare contractor, or a Medicare+Choice organization and assisting a beneficiary with any problems arising from disenrolling in a Medicare+Choice plan and with presenting income information for purposes relating to the prescription drug benefit. The Beneficiary Ombudsman would be required to work with state Health Insurance Counseling Programs, to the extent possible.

Such sums as are necessary are authorized to be appropriated for FY 2004 and each succeeding fiscal year to carry out the ombudsmen provisions.

This provision would also require the use of 1–800–MEDICARE for all individuals seeking information about, or assistance with Medicare. Rather than listing individual telephone numbers for Medicare contractors in the Medicare handbook, only 1–800–MEDICARE would be shown. The Comptroller General would be required to study the accuracy and consistency of information provided by the 1–800–MEDICARE line and to assess whether the information sufficiently answers the questions of beneficiaries. The report on the study would be required to be submitted to Congress not later than one year after enactment.

Senate Bill

Same provisions.

Conference Agreement

The conference agreement creates a new section 1810 establishing a Medicare Beneficiary Ombudsman. The Secretary is required to appoint an Ombudsman with expertise and experience in the fields of health care and education of (and assistance to) Medicare beneficiaries not later than 1 year after the date of enactment. The Ombudsman will receive complaints, grievances, and requests for information from Medicare beneficiaries, and provide assistance in these matters and matters relating to appeals decisions made by Medicare contractors, Medicare+Choice organizations or the Secretary, as well as assistance to beneficiaries with any problems disenrolling from a Medicare+Choice plan. In addition, the Ombudsman will assist beneficiaries in presenting information relating to the income-related premium adjustment. The Beneficiary Ombudsman is required to work with State Health Insurance Counseling Programs, to the extent possible. The Ombudsman is prohibited from advocating for any increases in payment or new coverage of services, but may identify issues and problems in payment or coverage policies.

Appropriations are authorized to be appropriated in such sums as are necessary for FY 2004 and each succeeding fiscal year to carry out the Beneficiary Ombudsman provision.

The conference agreement also requires making 1-800-MEDICARE available to all individuals seeking information about, or assistance with, Medicare. Rather than listing individual telephone numbers for Medicare contractors in the Medicare handbook, only 1-800-MEDICARE would be shown. The Comptroller General is required to study the accuracy and consistency of information provided on the 1-800-MEDICARE line and to assess whether the information sufficiently answers the questions of beneficiaries. The report on the study is due to Congress not later than one year after enactment.

It is the intent of the Conferees that Medicare beneficiaries have access to prescription drugs for the treatment of mental illness and neurological diseases resulting in severe epileptic episodes under the new provisions of Part D. To fulfill this purpose the Administrator of the Center for Medicare Choices shall take the appropriate steps before the first open enrollment period to ensure that Medicare beneficiaries have clinically appropriated access to pharmaceutical treatments for mental illness, including but not limited to schizophrenia, bipolar disorder, depression, anxiety disorder, dementia, and attention deficit disorder/attention deficit hyperactivity disorder and neurological illnesses resulting in epileptic episodes.

The conferees anticipate that disabled individuals will enroll in one of the many private sector prescription drug plans or MA-PD plans. Competition will necessitate plans offering the full complement of medicines, including atypical antipsychotics, to treat the severely mentally ill. If a plan chooses not to offer or restrict access to a particular medication to treat the mentally ill, the disabled will have the freedom to choose a plan that has appropriate access to the medicine needed. The Conferees believe this is critical as the severely mentally ill are a unique population with unique prescription drug needs as individual responses to mental health medications are different.

Beneficiary Outreach Demonstration Program. (Section 924 of the Conference Agreement, Section 924 of the House Bill, Section 535 of the Senate Bill).

Present Law

No provision.

House Bill

The Secretary would be required to conduct a 3-year demonstration program where Medicare specialists would provide assistance to beneficiaries in at least 6 local Social Security offices (2 would be located in rural areas) that have a high volume of visits by Medicare beneficiaries. The Secretary would be required to evaluate the results of the demonstration regarding the feasibility and cost-effectiveness of permanently outstationing Medicare specialists at local Social Security offices and report to Congress. The provision would be effective upon enactment.

Senate Bill

Same provision

Conference Agreement

The conference agreement requires the Secretary to conduct a 3-year demonstration program where Medicare specialists would provide assistance to beneficiaries in at least 6 local Social Security offices (2 would be located in rural areas) that have a high volume of visits by Medicare beneficiaries. The Secretary is required to evaluate the results of the demonstration regarding the feasibility and cost-effectiveness of permanently outstationing Medicare specialists at local Social Security offices and report to Congress. The agreement is effective upon enactment.

Inclusion of Additional Information in Notices to Beneficiaries About Skilled Nursing Facility Benefits. (Section 925 of the Conference Agreement, Section 925 of the House Bill, Section 551 of the Senate Bill).

Present Law

Although the statute requires that beneficiaries receive a statement listing the items and services for which payment has been made, there is no explicit statutory instruction that requires the notice to include information about the number of days of coverage remaining in either the hospital or skilled nursing facility (SNF) benefit or the spell of illness.

House Bill

The Secretary would be required to provide information about the number of days of coverage remaining under the SNF benefit and the spell of illness involved in the explanation of Medicare benefits. The provision would be effective for notices provided during calendar quarters beginning more than 6 months after the date of enactment.

Senate Bill

Same provision.

Conference Agreement

The conference agreement requires the Secretary to provide information about the number of days of coverage remaining under the SNF benefit and the spell of illness involved in the explanation of Medicare benefits. The agreement applies to notices provided during calendar quarters beginning more than 6 months after the date of enactment.

Information on Medicare-Certified Skilled Nursing Facilities in Hospital Discharge Plans. (Section 926 of the Conference Agreement, Section 926 of the House Bill, Section 552 of the Senate Bill).

Present Law

The hospital discharge planning process requires evaluation of a patient's likely need for post-hospital services including hospice and home care.

House Bill

The Secretary would be required to make information publicly available regarding whether SNFs are participating in the Medicare program. Hospital discharge planning would be required to evaluate a patient's need for SNF care.

The provision would apply to discharge plans made on or after the date specified by the Secretary, but not later than six months after the Secretary provides information regarding SNFs that participate in the Medicare program.

Senate Bill

Same provision.

Conference Agreement

The conference agreement requires the Secretary to make information publicly available regarding whether SNFs are participating in the Medicare program. Hospital discharge planning is required to evaluate a patient's need for SNF care.

The agreement applies to discharge plans made on or after the date specified by the Secretary, but not later than six months after the Secretary provides information regarding SNFs that participate in the Medicare program.

Transfer of Responsibility for Medicare Appeals. (Section 931 of the Conference Agreement, Section 931 of the House Bill, Sections 511 and 519 of the Senate Bill).

Present Law

Denials of claims for Medicare payment may be appealed by beneficiaries (or providers who are representing the beneficiary) or in certain circumstances, providers or suppliers directly. The third level of appeal is to an administrative law judge (ALJ). The ALJs that hear Medicare cases are employed by the Social Security Administration—a legacy from the inception of the Medicare program when Medicare was part of Social Security. BIPA section 522 requires that appeals of local coverage determinations be heard by ALJs of the Social Security Administration (SSA). As a result, if the ALJ function were moved from SSA to HHS, these local coverage determination appeals would still need to be heard by SSA ALJs.

House Bill

The Secretary and the Commissioner of the Social Security Administration (SSA) would be required to develop a plan to transfer the functions of the administrative law judges (ALJs) who are responsible for hearing Medicare cases from SSA to HHS. This plan would be due to Congress not later than October 1, 2004. A GAO evaluation of the plan would be due within 6 months of the plan's submission. ALJ functions would be transferred no earlier than July 1, 2005 and no later than October 1, 2005.

The Secretary would be required to place the ALJs in an administrative office that is organizationally and functionally separate from the Centers for Medicare & Medicaid Services and the ALJs would be required to report to, and be under the general supervision of the Secretary. No other official within the Department would be permitted to supervise the ALJs. The Secretary would be required to provide for appropriate geographic distribution of ALJs, would have the authority to hire ALJs and support staff, and would be required to enter into arrangements with the Commissioner, as appropriate, to share office space, support staff and other resources with appropriate reimbursement.

Authorizes to be appropriated such sums as are necessary for FY2005 and each subsequent fiscal year to increase the number of ALJs, improve education and training of ALJs and to increase the staff of the Departmental Appeals Board (the final level of appeal).

Senate Bill

The Secretary and Commissioner of Social Security would be required to develop and transmit to Congress and the Comptroller General a plan for transferring the functions of administrative law judges (ALJs) responsible for hearing cases under Medicare from the Social Security Administration to HHS no later than April 1, 2004. The plan would be required to include information on: workload; cost projections and financing; transition timetable; regulations; development of a case tracking system; feasibility of precedential authority; feasibility of electronic appeals filings and teleconference; steps needed to assure independence of ALJs, including assuring that they are in an office that is operationally and functionally separate from the Centers for Medicare & Medicaid Services and the Center for Medicare Choices; geographic distribution of ALJs;

steps for hiring ALJs; performance standards of ALJs; sharing resources with Social Security regarding ALJs; training; and recommendations for further Congressional action. The GAO would be required to evaluate the Secretary's and Commissioner's plan and report to Congress on the result of the evaluation within 6 months of the receiving the plan. The Secretary would be prohibited from implementing the plan developed until no earlier than 6 month after the GAO report.

The statutory language that requires SSA ALJs be used to hear appeals of local coverage determinations would be eliminated. The requirement that these appeals be heard by ALJs would be retained. The provision would be effective upon enactment.

Conference Agreement

The conference agreement requires the Secretary and the Commissioner of Social Security to develop a plan to transfer the administrative law judge function from SSA to HHS for Medicare appeals. Their plan is due to Congress and the Comptroller General not later than April 1, 2004. The plan is required to include information on: anticipated workload and staffing requirements; funding requirements; transition timetable; regulations; case tracking system; feasibility of developing a process to give Department Appeals Board decisions binding precedential authority; feasibility of filing appeals with ALJs electronically and conducting hearings using tele- or video-conferencing technologies; steps that should be taken to ensure the independence of ALJs; steps that should be taken to provide for an appropriate geographic distribution of ALJs throughout the United States; steps that should be taken to hire ALJs and support staff; appropriateness of establishing performance standards; steps that should be taken to carry out any needed shared resources with SSA; needed training; and any additional recommendations for further Congressional action.

A GAO evaluation of the plan is required within 6 months of the plan's submission. ALJ functions are required to be transferred no earlier than July 1, 2005 and no later than October 1, 2005.

The Secretary is required to place the ALJs in an administrative office that is organizationally and functionally separate from the Centers for Medicare & Medicaid Services and the ALJs would be required to report to, and be under the general supervision of the Secretary. No other official within the Department is permitted to supervise the ALJs. The Secretary is required to provide for appropriate geographic distribution of ALJs, would have the authority to hire ALJs and support staff, and is required to enter into arrangements with the Commissioner, as appropriate, to share office space, support staff and other resources with appropriate reimbursement.

In addition to any amounts otherwise appropriated, the agreement authorizes to be appropriated such sums as are necessary for FY 2005 and each subsequent fiscal year to increase the number of ALJs, improve education and training of ALJs, and to increase the staff of the Departmental Appeals Board (the final level of appeal).

The conference agreement strikes the statutory language that requires SSA ALJs be used to hear appeals of local coverage determinations. The requirement that these appeals be heard by ALJs is retained. This provision is effective upon enactment.

Process for Expedited Access to Review. (Section 932 of the Conference Agreement, Section 932 of the House Bill, Sections 512 and 513 of the Senate Bill).

Present Law

In general, administrative appeals must be exhausted prior to judicial review. The statute requires the automatic suspension of nurse aide training programs in skilled nursing facilities that have been subject to extended survey (that is, found to provide substandard care), have had serious sanctions imposed, or have waivers for required licensed nurse staffing.

House Bill

The Secretary would be required to establish a process where a provider, supplier, or a beneficiary may obtain expedited access to judicial review when a 3-member review panel (composed of ALJs, members of the Departmental Appeals Board, or qualified individuals from qualified independent contractors designated by the Secretary) determines, within 60 days of a complete written request, that it does not have the authority to decide the question of law or regulation and where material facts are not in dispute. The decision would not be subject to review by the Secretary. Interest would be assessed on any amount in controversy and would be awarded by the reviewing court in favor of the prevailing party. This expedited access to judicial review would also be permitted for cases where the Secretary does not enter into or renew provider agreements.

Expedited review would also be established for certain remedies imposed against SNFs. The remedies in the provision are termination of participation, denial of payments, and imposition of temporary management. The Secretary would be required to develop a process for reinstating approval of nurse aide training programs that have been terminated (before the end of the mandatory 2-year disapproval period) if the only reason for the termination was the assessment of a civil money penalty of $5,000 or more. The appropriation of such sums as needed for FY2005 and subsequent years would be authorized to reduce by 50% the average time for administrative determinations, to increase the number of ALJs and appellate staff at the DAB, and to educate these judges and their staffs on long-term care issues. This provision would be effective for appeals filed one or after October 1, 2004.

Senate Bill

The Secretary would be required to establish a process where a provider, supplier, or a beneficiary may obtain expedited access to judicial review when a review entity (up to 3 qualified reviewers drawn from the ALJs or Departmental Appeals Board) determines, within 60 days of a complete written request, that it does not have the authority to decide the question of law or regulation and where material facts are not in dispute. The decision would not be subject to review by the Secretary. Interest would be assessed on any amount in controversy and is awarded by the reviewing court in favor of the prevailing party. Expedited access to judicial review would be permitted for cases where the Secretary does not enter into or renew provider agreements. The provision would be effective for appeals filed on or after October 1, 2004.

The Secretary also would be required to develop and implement a process to expedite review for certain remedies imposed against skilled nursing facilities (SNFs): termination of participation, immediate denial of payments, immediate imposition of temporary management, and suspension of nurse aide training programs.

This provision would authorize the appropriation of such sums as needed for FY2004 and subsequent years to reduce by 50% the average time for administrative determinations, to increase the number of ALJs and appellate staff at the DAB, and to educate these judges and their staffs on long-term care issues.

The Comptroller General would be required to report to Congress on the access of Medicare beneficiaries and health care providers to judicial review of actions of the Secretary and HHS after February 29, 2000 (the date of the decision of *Shalala* v. *Illinois Council on Long Term Care, Inc.* (529 U.S. 1 (2000)). The report would be due not later than one year after enactment.

Conference Agreement

The conference agreement requires the Secretary to establish a process where a provider, supplier, or a beneficiary may obtain access to judicial review when a review entity (up to 3 qualified reviewers drawn from the ALJs or Departmental Appeals Board) determines, within 60 days of a complete written request, that it does not have the authority to decide the question of law or regulation and where material facts are not in dispute. The decision is subject to review by the Secretary. Interest is assessed on any amount in controversy and is awarded by the reviewing court in favor of the prevailing party. Expedited access to judicial review is permitted for cases where the Secretary does not enter into or renew provider agreements. The conference agreement is effective for appeals filed on or after October 1, 2004.

The agreement requires the Secretary to establish a process to expedite appeals of provider terminations and certain other remedies imposed on skilled nursing facilities, including denial of payment for new admissions and temporary management, if imposed on an immediate basis. Providers who are subject to the remedies of denial of payment or temporary management may only access the expedited process when these remedies are imposed on an immediate basis and where the facility has no opportunity to correct the deficiency. The agreement would also allow an expedited appeal where a finding of substandard quality of care has resulted in the disapproval of a skilled nursing facility's nurse aide training program. The agreement requires the Secretary to give priority to cases where termination has been imposed on a provider.

The agreement includes a provision allowing the Secretary to waive disapproval of a nurse aide training program, upon application by a nursing facility if the disapproval resulted from the imposition of a civil monetary penalty that was not related to quality of care provided to residents of the facility. Quality of care in such instances refers to direct, hands on care provided to residents of a facility. This agreement does not permit the Secretary to waive the CMP.

In addition to any amounts otherwise appropriated, the conference agreement authorizes the appropriation of such sums as needed for FY2004 and subsequent years in order to reduce by 50% the average time for administrative determinations, to increase the number of ALJs and appellate staff at the DAB, and to educate these judges and their staffs on long-term care issues.

Revisions to Medicare Appeals Process. (Section 933 of the Conference Agreement, Section 933 of the House Bill, Section 514 of the Senate Bill).

(a) Requiring Full and Early Presentation of Evidence

Present Law

No provision. New evidence can be presented at any stage of the appeals process.

House Bill

The provision would require providers and suppliers to present all evidence for an appeal at the reconsideration level that is conducted by a qualified independent contractor (QIC) unless good cause precluded the introduction of the evidence. The provision would be effective October 1, 2004.

Senate Bill

No provision.

Conference Agreement

The conference agreement requires providers and suppliers to present all evidence for an appeal at the reconsideration level that is conducted by a qualified independent contractor (QIC) unless good cause precluded the introduction of the evidence. The conference agreement provision is effective October 1, 2004.

(b) Use of Patients' Medical Records

Present Law

No provision.

House Bill

The provision would provide for the use of beneficiaries' medical records in appeals reconsiderations by qualified independent contractors (QICs). The provision would be effective upon enactment.

Senate Bill

Beneficiaries' medical records would be able to be used in appeals reconsiderations by qualified independent contractors. The provision would be effective upon enactment.

Conference Agreement

The conference agreement provides for the use of beneficiaries' medical records in appeals reconsiderations by QICs. The conference agreement is effective upon enactment.

(c) Notice Requirements for Medicare Appeals

Present Law

No statutory provision. Determinations and denials of appeals currently include the policy, regulatory, or statutory reason for the denial and information on how to appeal the denial. The Benefits Improvement and Protection Act (BIPA) of 2000, changed the appeals process and created a new independent review (the qualified independent contractors or QICs), which has not yet been implemented.

House Bill

The provision would require that when claims are denied the written notice of determination include the reasons for the determination, including whether a local medical review policy or a local coverage determination was used; the procedures for obtaining additional information concerning the determination including, when requested, the specific provision of the policy, manual, or regulation used in making the determination; and notification of the right to seek an appeal and instructions for appealing the determination.

In the case when a redetermination (the first level of appeal) is denied, the written notice would be required to include: the specific reasons for the redetermination; as appropriate, a summary of the clinical or scientific evidence used in making the redetermination; a description of the procedures for obtaining additional information concerning the redetermination. The notice would be required to be written in a manner calculated to be understood by a beneficiary. A beneficiary receiving such a notice would be permitted to request and receive information on the specific provision of the policy, manual, or regulation used in making the redetermination.

In the case when a reconsideration (the second level of appeal) is decided, the written notice would be required to be written in a manner calculated to be understood by the beneficiary and information regarding appeal rights and processes provided.

For appeals (to either the ALJ or Departmental Appeals Board (DAB)), the notice of the decision would be required to be in writing and written in a manner calculated to be understood by the beneficiary, to include the specific reasons for the determination, including to the extent appropriate a summary of the clinical or scientific evidence used in making the determination; the procedures for obtaining additional information regarding the decision; and notification of the right to appeal and how to initiate such an appeal. The provision also requires that the qualified independent contractor submit information that is needed for an appeal of a decision.

Senate Bill

The provision would require that when claims are denied, the written notice of the decision at every level of the appeal or with the initial determination would be required to be written in a manner to be understood by the beneficiary and include notification of the right to appeal the decision and instruction on how to initiate an appeal.

In addition, the determination would be required to include the reasons for the determination including, as appropriate, the provision of the policy, manual, or regulation that resulted in the denial if requested; and the procedures for obtaining additional information concerning the determination.

In the case when a redetermination (the first level of appeal) is denied, the written notice would be required to include: the reasons for the decision and, as appropriate, the provision of the policy, manual, or regulation that resulted in the denial if requested, and a summary of the clinical or scientific evidence used in making the redetermination; and a description of the procedures for obtaining additional information concerning the redetermination.

In the case when a reconsideration (the second level of appeal) is decided, the written notice would be required to include a detailed explanation of the decision as well as a discussion of the pertinent facts and applicable regulations applied in making the decision, to the extent appropriate; and in the case of a decision regarding whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury, an explanation of the medical or scientific rationale for the decision.

For appeals (to either the ALJ or Departmental Appeals Board (DAB)), the notice of the decision would be required to include the specific reasons for the determination including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination; and the procedures for obtaining additional information concerning the decision.

Conference Agreement

The conference agreement requires that when claims are denied in either the initial determination or in subsequent appeals, a written notice of the decision is required and to be written in a manner calculated to be understood by the beneficiary and to include notification of the right to appeal the decision and instruction on how to initiate an appeal.

In addition, the determination is required to include the reasons for the determination, including whether a local medical review policy or a local coverage determination was used; and the procedures for obtaining additional information concerning the determination including, when requested, the specific provision of the policy, manual, or regulation used in making the determination.

In the case when a redetermination (the first level of appeal) is denied, the written notice is required to include: the specific reasons for the redetermination; as appropriate, a summary of the clinical or scientific evidence used in making the redetermination; a description of the procedures for obtaining additional information concerning the redetermination. A beneficiary receiving such a notice is permitted to request and receive information on the specific provision of the policy, manual, or regulation used in making the redetermination.

In the case when a reconsideration (the second level of appeal) is decided, the written notice is required to be written in a manner calculated to be understood by the beneficiary and information regarding appeal rights and processes provided.

For appeals (to either the ALJ or Departmental Appeals Board (DAB)), the notice of the decision is required to be in writing and written in a manner calculated to be understood by the beneficiary, to include the specific reasons for the determination, including to the extent appropriate a summary of the clinical or scientific evidence used in making the determination; the procedures for obtaining additional information regarding the decision; and notification of the right to appeal and how to initiate such an appeal.

The conference agreement also requires that the qualified independent contractor submit information that is needed for an appeal of a decision. The conference agreement is effective upon enactment.

(d) Qualified Independent Contractors

Present Law

BIPA established a new and independent second level of appeal called the qualified independent contractors (QICs). BIPA called for at least 12 QICs. The QICs have not yet been implemented.

House Bill

The provision would clarify eligibility requirements for qualified independent contractors and their reviewer employees including medical and legal expertise, independence requirements, and the prohibition on compensation being linked to decisions rendered. The required number of qualified independent contractors would be reduced from not fewer than 12 to not fewer than 4. The provisions regarding the eligibility requirements of QICs and QIC reviews would be effective as if included in the enactment of BIPA.

Senate Bill

The provision would clarify eligibility requirements for qualified independent contractors and their reviewer employees including medical and legal expertise, independence requirements, and prohibitions on compensation being linked to decisions rendered. The required minimum number of qualified independent contractors would be reduced from 12 to 4.

In addition, the provision would delay the effective date of certain appeals provisions until December 1, 2004. Expedited determinations would be delayed until October 1, 2003. The provision would allow the transitional use of peer review organizations (now called quality improvement organizations by the Secretary) to conduct expedited determinations until the QICs are operating.

Conference Agreement

The conference agreement clarifies eligibility requirements for qualified independent contractors and their reviewer employees including medical and legal expertise, independence requirements, and the prohibition on compensation being linked to decisions rendered. The required number of qualified independent contractors is reduced from not fewer than 12 to not fewer than 4. The provisions regarding the eligibility requirements of QICs and QIC reviews are effective as if included in the enactment of BIPA.

Implementation of Certain BIPA Effective Dates

Present Law

The BIPA claims appeals provisions were effective October 1, 2002 but have not been implemented.

House Bill

No provision.

Senate Bill

The provision would delay the effective date of certain appeals provisions until December 1, 2004. Expedited determinations would be delayed until October 1, 2003. The provision would allow the transitional use of peer review organizations (now called quality improvement organizations by the Secretary) to conduct expedited determinations until the QICs are operating.

Conference Agreement

No provision.

Prepayment Review. (Section 934 of the Conference Agreement, Section 934 of the House Bill, Section 541 of the Senate Bill).

Present Law

No explicit statutory instruction. Under administrative authorities, CMS has instructed the contractors to use random prepayment reviews to develop contractor-wide and program-wide error rates. Non-random payment reviews are permitted in certain circumstances laid out in instructions to the contractors.

House Bill

Medicare contractors would be permitted to conduct random prepayment reviews only to develop a contractor-wide or program-wide error rate or such additional circumstances as the Secretary provides for in regulations that were developed in consultation with providers and suppliers. Random prepayment review would only be permitted in accordance with standard protocol developed by the Secretary. Nonrandom payment reviews would be permitted only when there was a likelihood of sustained or high level of payment error. The Secretary would be required to issue regulations regarding the termination and termination dates of non-random prepayment review. Variation in termination dates would be permitted depending upon the differences in the circumstances triggering prepayment review.

The Secretary would be required to issue the required regulations not later than one year after enactment. The provision regarding the use of standard protocols when conducting prepayment reviews would apply to random prepayment reviews conducted on or after the date specified by the Secretary (but not later than one year after enactment). The remaining provisions would be effective one year after enactment.

Senate Bill

The conduct of random prepayment review would be limited only to those done in accordance with a standard protocol developed by the Secretary. Non-random reviews would be prohibited unless a likelihood of sustained or high level of payment error (as defined by the Secretary) existed and the Secretary would be required to establish protocols for terminating the non-random reviews within one year of enactment. The Secretary would be required to publish implementing regulations and develop and publish protocols not later than one year after enactment. The provision would be effective for random reviews conducted on or after the date specified by the Secretary (but not later than one year after enactment).

Conference Agreement

The conference agreement permits Medicare contractors to conduct random prepayment reviews only to develop a contractor-wide or program-wide error rate or such additional circumstances as the Secretary provides for in regulations that are developed in consultation with providers and suppliers. Random prepayment reviews are only permitted in accordance with standard protocol developed by the Secretary. Nonrandom payment reviews are permitted only when there is a likelihood of sustained or high level of payment error. The Secretary is required to issue regulations regarding the termination and termination dates of non-random prepayment review. Variation in termination dates is permitted depending upon the differences in the circumstances triggering prepayment review.

The Secretary is required to issue the required regulations not later than 1 year after enactment. The provision regarding the use of standard protocols when conducting prepayment reviews applies to random prepayment reviews conducted on or after the date specified by the Secretary (but not later than 1 year after enactment). The remaining provisions are effective 1 year after enactment.

Recovery of Overpayments. (Section 935 of the Conference Agreement, Section 935 of the House Bill, Section 542 of the Senate Bill).

Present Law

No explicit statutory instruction. Under administrative authorities, CMS negotiates extended repayment plans with providers that need additional time to repay Medicare overpayments.

House Bill

In situations where repaying a Medicare overpayment within 30 days would be a hardship for a provider or supplier, the Secretary would be required to enter into an extended repayment plan of at least 6 months duration. The repayment plan would not be permitted to go beyond 3 years (or 5 years in the case of extreme hardship, as determined by the Secretary). Interest would be required to accrue on the balance through the repayment period. Hardship would be defined if, for providers that file cost reports, the aggregate amount of the overpayment exceeded 10 percent of the amount paid by Medicare to the provider for the time period covered by the most recently submitted cost report. In the case of a provider or supplier that is not required to file a cost report, hardship would be defined if the aggregate amount of the overpayment exceeded 10 percent of the amount paid under Medicare for the previous calendar year. The Secretary would be required to develop rules for the case of a provider or supplier that was not paid under Medicare during the previous year or for only a portion of the year. Any other repayment plans that a provider or supplier has with the Secretary, would not be taken into account by the Secretary in calculating hardship. If the Secretary has reason to suspect that the provider or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in Medicare or there is an indication of fraud or abuse, the Secretary would not be obligated to enter into an extended repayment plan with the provider or supplier. If a provider or supplier fails to make a payment according to the repayment plan, the Secretary would be permitted to immediately seek to offset or recover the total outstanding balance of the repayment plan, including interest.

The Secretary would be prohibited from recouping any overpayments until a reconsideration-level appeal (or a redetermination by the fiscal intermediary or carrier if the QICs are not yet in place) was decided, if a reconsideration was requested. Interest would be required to be paid to the provider if the appeal was successful (beginning from the time the overpayment is recouped) or that interest would be required to be paid to the Secretary if the appeal was unsuccessful (and if the overpayment was not paid to the Secretary).

Extrapolation would be limited to those circumstances where there is a sustained or high level of payment error, as defined by the Secretary in regulation, or documented educational intervention has failed to correct the payment error.

Medicare contractors would be permitted to request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing in the case of a provider or supplier with prior overpayments.

The Secretary would be able to use consent settlements to settle projected overpayments under certain conditions. Specifically the Secretary would be required to communicate with the provider or supplier that medical record review has indicated an overpayment exists, the nature of the problems identified, the steps needed to address the problems, and afford the provider or supplier 45 days to furnish additional information regarding the medical records for the claims reviewed. If, after reviewing the additional information an overpayment continues to exist, the Secretary would be required to provide notice and an explanation of the determination and then may offer the provider two mechanisms to resolve the overpayment: either an opportunity for a statistically valid random sample or a consent settlement (without waiving any appeal rights).

The Secretary would be required to establish a process to provide notice to certain providers and suppliers in cases where billing codes were over-utilized by members of that class in certain areas, in consultation with organizations that represent the affected provider or supplier class.

If post-payment audits were conducted, the Medicare contractor would be required to provide the provider or supplier with written notice of the intent to conduct the audit. The contractor would further be required to give the provider or supplier a full and understandable explanation of the findings of the audit and permit the development of an appropriate corrective action plan, inform the provider or supplier of appeal rights and consent settlement options, and give the provider or supplier the opportunity to provide additional information to the contractor, unless notice or findings would compromise any law enforcement activities.

The Secretary would be required to establish a standard methodology for Medicare contractors to use in selecting a sample of claims for review in cases of abnormal billing patterns.

In general the provisions would be effective upon enactment. The limitation on extrapolation would apply to samples initiated after the date that is 1 year after the date of enactment. The Secretary would be required to establish the process for notice of overutilization of billing codes not later than 1 year after enactment. The Secretary would be required to establish a standard methodology for selecting sample claims for abnormal billing patterns not later than 1 year after enactment.

Senate Bill

This provision would add a new subsection (h) to 1874A that would require establishment of at least a 1 year repayment plan—but not longer than three years—when a provider requests a repayment plan, unless the Secretary believes the provider may declare bankruptcy. If a provider or supplier fails to make a scheduled payment, the Secretary could immediately offset or recover the outstanding balance. The Secretary would be required to develop standards for the recovery of overpayments not later than one year after enactment.

The Secretary would be barred from recouping any overpayments until a reconsideration-level appeal was decided (if one were requested). The paragraph provides that interest would be required to be paid to the provider if the appeal was successful (beginning from the time the overpayment is recouped) or that interest would be required to be paid to the Secretary if the appeal was unsuccessful (and if the overpayment was not paid to the Secretary).

The provision would also require that if post-payment audits were conducted, the Medicare contractor would be required to provide the provider or supplier with written notice of the intent to conduct the audit. The contractor would further be required to give the provider or supplier a full and understandable explanation of the findings of the audit and permit the development of an appropriate corrective action plan, inform the provider or supplier of appeal rights and consent settlement options, and give the provider or supplier the opportunity to provide additional information to the contractor, unless notice or findings would compromise any law enforcement activities.

The Secretary would be required to establish a process to provide notice to certain providers and suppliers in cases where billing codes were over-utilized by members of that class in certain areas, in consultation with organizations that represent the affected provider or supplier class. The process would be required not later than one year after enactment.

Not later than one year after enactment, the Secretary would be required to establish a standard methodology for Medicare contractors to use in selecting a sample of claims for review in cases of abnormal billing patterns.

The Secretary would be authorized to use a consent settlement process to settle projected overpayments under certain specified conditions.

The provisions affecting post-payment audits and consent settlements would be effective to audits initiated and consent settlements entered into after the date of enactment. Other provisions would be effective for action taken 1 year after enactment.

Conference Agreement

In situations where repaying a Medicare overpayment within 30 days would be a hardship for a provider or supplier, the conference agreement requires the Secretary to enter into an extended repayment plan of at least 6 months duration. The repayment plan is not permitted to go beyond 3 years (or 5 years in the case of extreme hardship, as determined by the Secretary). Interest is required to accrue on the balance through the repayment period. Hardship is defined if, for providers that file cost reports, the aggregate amount of the overpayment exceeded 10 percent of the amount paid by Medicare to the provider for the time period covered by the most recently submitted cost report. In the case of a provider or supplier that is not required to file a cost report, hardship is defined if the aggregate amount of the overpayment exceeded 10 percent of the amount paid under Medicare for the previous calendar year. The Secretary is required to develop rules for the case of a provider or supplier that was not paid under Medicare during the previous year or for only a portion of the year. Any other repayment plans that a provider or supplier has with the Secretary, are not taken into account by the Secretary in calculating hardship. If the Secretary has reason to suspect that the provider or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in Medicare or there is an indication of fraud or abuse, the Secretary is not obligated to enter into an extended repayment plan with the provider or supplier. If a provider or supplier fails to make a payment according to the repayment plan, the Secretary may immediately seek to offset or recover the total outstanding balance of the repayment plan, including interest.

The Secretary is prohibited from recouping any overpayments until a reconsideration-level appeal (or a redetermination by the fiscal intermediary or carrier if the QICs are not yet in place) was decided, if a reconsideration was requested. Interest is required to be paid to the provider if the appeal is successful (beginning from the time the overpayment is recouped) or interest is required to be paid to the Secretary if the appeal is unsuccessful (and if the overpayment was not paid to the Secretary).

Extrapolation is limited to those circumstances where there is a sustained or high level of payment error, as defined by the Secretary in regulation, or document educational intervention has failed to correct the payment error.

Medicare contractors are permitted to request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing in the case of a provider or supplier with prior overpayments.

The Secretary is permitted to use consent settlements to settle projected overpayments under certain conditions. Specifically the Secretary is required to communicate with the provider or supplier that medical record review has indicated an overpayment exists, the nature of the problems identified, the steps needed to address the problems, and afford the provider or supplier 45 days to furnish additional information regarding the medical records for the claims reviewed. If, after reviewing the additional information an overpayment continues to exist, the Secretary is required to provide notice and an explanation of the determination and then may offer the provider two mechanisms to resolve the overpayment: either an opportunity for a statistically valid random sample or a consent settlement (without waiving any appeal rights).

The Secretary is required to establish a process to provide notice to certain providers and suppliers in cases where billing codes were over-utilized by members of that class in certain areas, in consultation with organizations that represent the affected provider or supplier class.

If post-payment audits are conducted, the Medicare contractor is required to provide the provider or supplier with written notice of the intent to conduct the audit. The contractor is further required to give the provider or supplier a full and understandable explanation of the findings of the audit and permit the development of an appropriate corrective action plan, inform the provider or supplier of appeal rights and consent settlement options, and give the provider or supplier the opportunity to provide additional information to the contractor, unless notice or findings would compromise any law enforcement activities.

The Secretary is required to establish a standard methodology for Medicare contractors to use in selecting a sample of claims for review in cases of abnormal billing patterns.

In general, the provisions are effective upon enactment. The limitation on extrapolation would apply to samples initiated after the date that is 1 year after the date of enactment. The Secretary is required to establish the process for notice of overutilization of billing codes not later than 1 year after enactment. The Secretary is required to establish a standard methodology for selecting sample claims for abnormal billing patterns not later than 1 year after enactment.

Provider Enrollment Process; Right of Appeal. (Section 936 of the Conference Agreement, Section 936 of the House Bill, Section 515 of the Senate Bill).

Present Law

No explicit statutory instruction. Under administrative authorities, CMS has established provider enrollment processes in instructions to the contractors.

House Bill

The Secretary would be required to establish in regulation a provider enrollment process with hearing rights in the case of a denial or non-renewal. The process would be required to include deadlines for actions on applications for enrollment and enrollment renewals. The Secretary would be required to monitor the performance of the Medicare contractors in meeting the deadlines he establishes. Before changing provider enrollment forms, the Secretary would be required to consult with providers and suppliers. The provision would also establish hearing rights in cases where the applications have been denied.

The enrollment process would be required to be established within 6 months of enactment. The consultation process on provider enrollment forms would be required for changes in the form beginning January 1, 2004. The provision of hearing rights would apply to denials that occur 1 year after enactment or an earlier date specified by the Secretary.

Senate Bill

Same provisions.

Conference Agreement

The conference agreement requires the Secretary to establish in regulation a provider enrollment process with hearing rights in the case of a denial or non-renewal. The process is required to include deadlines for actions on applications for enrollment and enrollment renewals. The Secretary is required to monitor the performance of the

Medicare contractors in meeting the deadlines he establishes. Before changing provider enrollment forms, the Secretary is required to consult with providers and suppliers. The conference agreement also establishes hearing rights in cases where the applications have been denied.

The enrollment process is required to be established within 6 months of enactment. The consultation process on provider enrollment forms is required for changes in the form beginning

January 1, 2004. The provision of hearing rights applies to denials that occur 1 year after enactment or an earlier date specified by the Secretary.

Process for Correction of Minor Errors and Omissions without Pursuing Appeals Process. (Section 937 of the Conference Agreement, Section 937 of the House Bill, Section 543 the Senate Bill).

Present Law

No explicit statutory instruction. Administratively, the Medicare contractors send a claim's denial when a claim has been submitted that lacks required information. Amendments to cost reports are not allowed once a cost report is settled.

House Bill

This provision would require the Secretary to establish a process so providers and suppliers could correct minor errors in claims that were submitted for payment. The provision would also require the Secretary to permit hospitals to correct wage data errors that affect geographic reclassification even if the cost report has been settled. For FY 2004 alone, resubmittal of the application for geographic reclassification would be permitted. The provision would be effective upon enactment.

Senate Bill

This provision would require the Secretary to establish a process so providers and suppliers could correct minor errors in claims that were submitted for payment. The provision would require that the process be developed not later than 1 year after enactment.

Conference Agreement

The conference agreement requires the Secretary to establish a process so providers and suppliers could correct minor errors in claims that were submitted for payment within 1 year after enactment.

Prior Determination Process for Certain Items and Services; Advance Beneficiary Notices. (Section 938 of the Conference Agreement, Section 938 of the House Bill, Section 535(b) of the Senate Bill).

Present Law

Medicare law prohibits payment for items and services that are not medically reasonable and necessary for the diagnosis or treatment of an illness or an injury. Under certain circumstances, however, Medicare will pay for noncovered services that have been provided if both the beneficiary and the provider of the services did not know and could not have reasonably been expected to know that Medicare payment would not be made for these services.

A provider may be held liable for providing uncovered services, if, for example, specific requirements are published by the Medicare contractor or the provider has received a denial or reduction of payment on the same or similar service. In cases where the provider believes that the service may not be covered as reasonable and necessary, an acceptable advance notice of Medicare's possible denial of payment must be given to the patient if the provider does not want to accept financial responsibility for the service. The notice must be given in writing, in advance of providing the service; include the patient's name, date and description of service as well as reasons why the service would not be covered; and must be signed and dated by the patient to indicate that the beneficiary will assume financial liability for the service if Medicare payment is denied or reduced.

House Bill

The Secretary would be required to establish a process through regulation where physicians and beneficiaries can establish whether Medicare covers certain categories of items and services before such services are provided. An eligible requestor would be a physician, but only in case of items and services for which the physician is paid directly and a Medicare beneficiary who receives an advance beneficiary notice from a physician would receive direct payment for that service. The provisions would establish (1) that such prior determinations would be binding on the Medicare contractor, absent fraud or misrepresentation of facts; (2) the right to redetermination in the case of a denial; (3) the applicability of existing deadlines with respect to those redeterminations; (4) that contractors' advance determinations (and redeterminations) are not subject to further administrative or judicial review; and (5) an individual retains all rights to usual administrative or judicial review after receiving the service or receiving a determination that a service would not be covered. These provisions would not affect a Medicare beneficiary's right not to seek an advance determination. The prior determination process would be established in time to address such requests that are filed by 18 months of enactment. The Secretary would be required to collect data on the advance determinations and to establish a beneficiary outreach and education program. GAO is required to report on the use of the advance beneficiary notice and prior determination process within 18 months of its implementation.

Senate Bill

The Secretary would be required to establish a demonstration project to test the administrative feasibility of providing a process for beneficiaries and providers to request and receive a determination as to whether the item or service is covered under Medicare by reasons of Medical necessity, before the item or service involved is furnished to the beneficiary.

Conference Agreement

The conference agreement requires the Secretary to establish a prior determination process through regulation where physicians and beneficiaries can determine whether Medicare covers certain physician services before such services are provided. An eligible requestor is a physician, but only in case of services for which the physician is paid directly, or a Medicare beneficiary, who receives an advance beneficiary notice from a physician who would receive direct payment for that service. The provision establishes (1) that such prior determinations would be binding on the Medicare contractor, absent fraud or misrepresentation of facts; (2) the right to redetermination in the case of a denial; (3) the applicability of existing deadlines with respect to those redeterminations; (4) that contractors' advance determinations (and redeterminations) are not subject to further administrative or judicial review; and (5) an individual retains all rights to usual administrative or judicial review after receiving the service or receiving a determination that a service would not be covered. These provisions do not affect a Medicare beneficiary's right not to seek an advance determination. The prior determination process is required to be established in time to address such requests that are filed by 18 months after enactment and it sunsets 5 years later. For purposes of calculating the physician fee schedule sustainable growth rate, this provision is not to be considered to be a change in law or regulation. The Secretary is required to collect data on the advance beneficiary notices and to establish a beneficiary outreach and education program. GAO is required to report on the use of the advance beneficiary notices within 18 months of the implementation of the prior determination process. The GAO is also required to report on the use of the prior determination process within 36 months of the implementation of the prior determination process.

Appeals by Providers When There is No Other Party Available. (Section 939 of the Conference Agreement, Section 516 of the Senate Bill).

Present Law

Section 1870 of the Social Security Act provides for the recovery of overpayments and the settlement of claims for benefits on behalf of a deceased beneficiary

House Bill

No provision.

Senate Bill

In the case where a beneficiary dies before assigning appeal rights, a provider or supplier would be permitted to appeal a payment denial by a Medicare contractor. The provision would be effective for items and services furnished on or after enactment.

Conference Agreement

In the case where a beneficiary dies before assigning appeal rights, the conference agreement permits a provider or supplier to appeal a payment denial by a Medicare contractor. The provision is effective for items and services furnished on or after enactment.

Revisions to Appeals Timeframes and Amounts. (Section 940 of the Conference Agreement, Section 518 of the Senate Bill).

Present Law

BIPA revised the timeframes for Medicare appeals. For the first level of appeal, the "redetermination" level, the timeframe for decisions was reduced from 90 days for a part A appeal and 45 days for a part B appeal to 30 days; for the second level, the "reconsideration" level, the timeframe was reduced from 120 days for a part B appeal to 30 days (this is a new level of appeal for part A appeals); for the third level, appeals before administrative law judges, the timeframe was reduced from no time limit to 90 days; and the fourth level, appeals before the Department Appeals Board, the timeframe was reduced from no time limit to 90 days. BIPA also provided that a beneficiary could "escalate" his or her appeal to the next level if the appeal was not decided in a timely fashion.

To appeal a claim, the beneficiary must have an "amount in controversy" of $100 or more. Judicial review is available only for amounts in controversy of $1,000 or more. Claims are permitted to be aggregated in order to reach the amount in controversy if certain conditions are met.

House Bill

No provision.

Senate Bill

This provision would add 30 days to the timeframe for deciding an appeal at each of the four levels of appeal. No provision regarding the indexing of amounts in controversy.

Conference Agreement

The conference agreement adds 30 days to the timeframe for deciding an appeal at the redetermination and reconsideration levels of appeal (that is, the first two levels of appeal). The conference agreement also indexes the amount in controversy for appeals to the CPI–U, rounded to the nearest multiple of $10 beginning in 2005.

Mediation Process for Local Coverage Determinations (Section 940A of the Conference Agreement, Section 517 of the Senate Bill).

Present Law

Only beneficiaries have standing to appeal local coverage decisions by Medicare contractors. Mediation is not currently used in Medicare to resolve disputes.

House Bill

No provision.

Senate Bill

The parties that have standing to appeal local coverage decisions would be expanded to include providers or suppliers adversely affected by the determination. The Secretary would be required to establish a process whereby a provider or supplier may request a local coverage determination under certain circumstances. A provider or supplier could seek a local coverage determination if the Secretary determined that: (A) there have been at least five reversals by an ALJ of redeterminations made by a Medicare contractor in at least two different cases; (B) that each reversal involved substantially similar material facts; (C) each reversal involved the same medical necessity issue; and (D) at least 50% of the total claims submitted by the provider within the past year involving the requisite facts and medical necessity issue have been denied and then reversed by an ALJ. Such sums as necessary to carry out the provisions above would be authorized to be appropriated. Also the provision would require the Secretary to study and report to Congress on the feasibility and advisability of requiring Medicare contractors to track the subject and status of claims denials that are appealed and final determinations.

The expansion in standing would be effective for any review or request of any local coverage determination filed on or after October 1, 2003 and for any local coverage determination made on or after October 1, 2003. The requirement to establish a process for a provider or supplier to request a local coverage determination would be effective for requests filed on or after the date of enactment. The report would be due to Congress not later than one year after the date of enactment.

Conference Agreement

The conference agreement requires the Secretary to establish a mediation process using a physician trained in mediation and employed by CMS. This process is to be used to mediate disputes between groups representing providers, physicians, and suppliers and the medical director for the Medicare contractor in any area that the relevant CMS regional administrator determines that there is a systematic pattern and a large volume of complaints from such groups regarding decisions of the medical director or there is a complaint from the co-chair of the advisory committee for that contractor. The Secretary is required to include in the contract with Medicare Administrative Contractors the performance duties expected of a medical director including professional relations. The provision is effective upon enactment.

Policy Development Regarding Evaluation and Management (E&M) Documentation Guidelines. (Section 941 of the Conference Agreement, Section 941 of the House Bill, Section 553 of the Senate Bill).

Present Law

No provision.

House Bill

The Secretary would not be permitted to implement any new documentation guidelines for, or clinical examples of, evaluation and management (E&M) physician services unless the Secretary: (1) developed the guidelines in collaboration with practicing physicians (both generalists and specialists) and provided for an assessment of the proposed guidelines by the physician community; (2) established a plan containing specific goals, including a schedule, for improving the use of the guidelines; (3) conducted pilot projects to test modifications to the guidelines; (4) finds the guidelines have met established objectives; and (5) established and implemented an education program on the use of the guidelines with appropriate outreach. The Secretary would make changes to existing E&M guidelines to reduce paperwork burdens on physicians. The provision establishes objectives for modifications of the E&M guidelines: (1) identification of clinically relevant documentation needed to code accurately and assess coding levels accurately; (2) decrease the level of non-clinically pertinent and burdensome documentation time and content in the medical record; (3) increase accuracy of reviewers; and (4) education of physicians and reviewers.

The pilot projects would be required to be conducted on a voluntary basis in consultation with practicing physicians (both generalists and specialists) and be of sufficient length to educate physicians and contractors on E&M guidelines. A range of different projects would be established and include at least one project: using a physician peer review method, using an alternative method based on face-to-face encounter time with the patient, in a rural area, outside a rural area, and where physicians bill under physician services in a teaching setting and non-teaching setting. The projects would examine the effect of modified E&M guidelines on different types of physician practices in terms of the cost of compliance. Data collected under these projects would not be the basis for overpayment demands or post-payment audits. This protection would apply to claims filed as part of the project, would last the duration of the project and would last for as long as the provider participated in the project. Each pilot conducted would examine the effect of the new E&M documentation guidelines on different types of physician practices (including those with fewer than 10 full-time equivalent employees) and the costs of physician compliance including education implementation, auditing, and monitoring. The Secretary would be required to submit periodic reports to Congress on these pilot projects.

The provision would require a study of an alternative system for documenting physician claims. Specifically the Secretary would be required to study developing a simpler system for documenting claims for evaluation and management services and to consider systems other than current coding and documentation requirements. The Secretary would be required to consult with practicing physicians in designing and carrying out the study. This study would be due to Congress no later than October 1, 2005. MedPAC would be required to analyze the results of the study and report to Congress. The Secretary would also be required to study the appropriateness of coding in cases of extended office visits in which no diagnosis is made and report to Congress no later than October 1, 2005. The Secretary would be required to include in the report recommendations on how to code appropriately for these visits in a manner that takes into account the amount of time the physician spent with the patient.

Senate Bill

The Secretary would be required to ensure, before making changes in documentation guidelines for, or clinical examples of, or codes to report E&M physician services, that the process used in developing the guidelines, examples, or codes was widely consultative among physicians, reflects a broad consensus among specialties, and would allow verification of reported and furnished services.

Conference Agreement

The conference agreement does not permit the Secretary to implement any new or modified documentation guidelines (including clinical examples) for evaluation and management (E&M) physician services unless the Secretary has: (1) developed the guidelines in collaboration with practicing physicians (both generalists and specialists) and provided for an assessment of the proposed guidelines by the physician community; (2) established a plan containing specific goals, including a schedule, for improving the use of the guidelines; (3) conducted pilot projects to test modifications to the guidelines; (4) found the guidelines have met established objectives; and (5) established and implemented an education program on the use of the guidelines with appropriate outreach. The conference agreement requires the Secretary to make changes to existing E&M guidelines to reduce paperwork burdens on physicians. The conference agreement establishes objectives for modifications of the E&M guidelines: (1) identification of clinically relevant documentation needed to code accurately and assess coding levels accurately; (2) decrease the level of non-clinically pertinent and burdensome documentation time and content in the medical record; (3) increase accuracy of reviewers; and (4) education of physicians and reviewers.

The pilot projects are required to be conducted on a voluntary basis in consultation with practicing physicians (both generalists and specialists) and are of sufficient length (but, in no case longer than 1 year) to educate physicians and contractors on E&M guidelines. A range of different projects would be established and include at least one project that: (1) uses a physician peer review method (that is not used by a Medicare contractor) that evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to codes used for billing purposes for these services; (2) uses an alternative method based on face-to-face encounter time with the patient; (3) is conducted for services furnished in a rural area and one for services furnished outside a rural area; and (4) is conducted in a setting where physicians bill under physician services in a teaching setting and one in a nonteaching setting. The projects would examine the effect of modified E&M guidelines on different types of physician practices in terms of the cost of compliance. Each pilot conducted is required to examine the effect of the new E&M documentation guidelines on different types of physician practices (including those with fewer than 10 full-time equivalent employees) and the costs of physician compliance including education implementation, auditing, and monitoring. The provision requires the Secretary to submit a report to Congress on these pilot projects within 6 months of completion of the pilots.

A study of an alternative system for documenting physician claims is also required. Specifically, the Secretary is required to study developing a simpler system for documenting claims for evaluation and management services and to consider systems other than current coding and documentation requirements. The Secretary is required to consult with practicing physicians in designing and carrying out the study. This study is due to Congress no later than October 1, 2005. MedPAC would be required to analyze the results of the study and report to Congress. The Secretary is also required to study the appropriateness of coding in cases of extended office visits in which no diagnosis is made and report to Congress no later than October 1, 2005. The Secretary is required to include in the report recommendations on how to code appropriately for these visits in a manner that takes into account the amount of time the physician spent with the patient.

Improvement in Oversight of Technology and Coverage. (Section 942 of the Conference Agreement, Section 942 of the House bill, Section 554 of the Senate Bill).

(a) Council for Technology and Innovation

Present Law

No provision.

House Bill

The Secretary would be required to establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (CMS). The council would be composed of senior CMS staff and clinicians with a chairperson designated by the Secretary who reports to the CMS administrator. The Chairperson would serve as the Executive Coordinator for Technology and Innovation would be the single point of contact for outside groups and entities regarding Medicare coverage, coding, and payment processes. The Council would coordinate Medicare's coverage, coding, and payment processes as well as information exchange with other entities with respect to new technologies and procedures, including drug therapies.

Senate Bill

The provision would require the Secretary to establish a Council for Technology and Innovation composed of senior CMS staff and clinicians to coordinate coverage, coding, and payment processes under Title XVIII and the exchange of information on new technologies between CMS and other entities that make similar decisions.

Conference Agreement

The conference agreement requires the Secretary establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (CMS). The council is to be composed of senior CMS staff and clinicians with a chairperson designated by the Secretary who reports to the CMS administrator. The Chairperson will serve as the Executive Coordinator for Technology and Innovation and will be the single point of contact for outside groups and entities regarding Medicare coverage, coding, and payment processes. The Council is required to coordinate Medicare's coverage, coding, and payment processes as well as information exchange with other entities with respect to new technologies and procedures, including drug therapies.

(b) Methods for Determining Payment Basis for New Lab Tests

Present Law

Outpatient clinical diagnostic laboratory tests are paid on the basis of area wide fee schedules. The law establishes a cap on the payment amounts, which is currently set at 74 percent of the median for all fee schedules for that test. The cap is set at 100 percent of the median for tests performed after January 1, 2001 that the Secretary determines are new tests for which no limitation amount has previously been established.

House Bill

The Secretary would be required to establish procedures (by regulation) for determining the basis for and amount of payments for new clinical diagnostic laboratory tests. New laboratory tests would be defined as those assigned a new, or substantially revised Health Care Procedure Coding System (HCPCS) code on or after January 1, 2005. The Secretary, as part of this procedure, would be required to (1) provide a list (on an Internet site or other appropriate venue) of tests for which payments are being established in that year; (2) publish a notice of a meeting in the Federal Register on the day the list becomes available; (3) hold the public meeting no earlier than 30 days after the notice to receive public comments and recommendations; (4) take into account the comments, recommendations and accompanying data in both proposed and final payment determinations. The Secretary would set forth the criteria for making these determinations; make public the available data considered in making such determinations; and could convene other public meetings as necessary. Effective for codes assigned on or after January 1, 2005.

Senate Bill

No provision.

Conference agreement

The conference agreement requires the Secretary to establish procedures (by regulation) for determining the basis for and amount of payments for new clinical diagnostic laboratory tests. New laboratory tests are defined as those assigned a new, or substantially revised Health Care Procedure Coding System (HCPCS) code on or after January 1, 2005. The Secretary, as part of this procedure, is required to (1) provide a list (on an Internet site or other appropriate venue) of tests for which payments are being established in that year; (2) publish a notice of a meeting in the Federal Register on the day the list becomes available; (3) hold the public meeting no earlier than 30 days after the notice to receive public comments and recommendations; (4) take into account the comments, recommendations and accompanying data in both proposed and final payment determinations. The Secretary sets forth the criteria for making these determinations, which include whether a test should be established through gap-filling or cross-walking to an existing code. In these cases, carriers and CMS cannot substitute an alternative service for a gap filled amount, the Secretary shall make public the available data considered in making such determinations; and convenes other public meetings as necessary. The provision is effective for codes assigned on or after January 1, 2005.

(c) GAO Study on Improvements in External Data Collection for Use in the Medicare Inpatient Payment System.

Present Law

No provision.

House Bill

The GAO would be required to study which external data can be collected in a shorter time frame by CMS to use in calculating payments for inpatient hospital services. The GAO could evaluate feasibility and appropriateness of using quarterly samples or special surveys and would include an analysis of whether other executive agencies are best suited to collect this information. The report would be due to Congress no later than October 1, 2004.

Senate Bill

No provision.

Conference Agreement

The conference agreement requires the GAO to study which external data can be collected in a shorter time frame by CMS to use in calculating payments for inpatient hospital services. The GAO may evaluate feasibility and appropriateness of using quarterly samples or special surveys and is required to include an analysis of whether other executive agencies are best suited to collect this information. The report is due to Congress no later than October 1, 2004.

(d) Process for Adoption of ICD Codes as Data Standard

Present Law

The Secretary is required to rely on the recommendations from the National Committee on Vital and Health Statistics (NCVHS) before adopting health information standards and codes. The current standard for procedure codes is the International Classification of Diseases, 9th Revision, clinical modification (ICD–9–CM is the basis of the Medicare inpatient hospital PPS payment system). The NCVHS made a recommendation on November 5th to the Secretary about adopting the latest revision, the ICD–10–PCS (Procedure Coding System) or ICD–10–CM as a coding standard.

House Bill

The Secretary would be permitted to adopt the ICD–10–PCS and the ICD–10–CM within 1-year of enactment without receiving a recommendation from the National Committee on Vital and Health Statistics (NCVHS).

Senate Bill

No provision.

Conference Agreement

No provision. Because the NCVHS made a recommendation to the Secretary, Conferees believed the House provision was no longer necessary.

Conferees urge the Secretary, however, to accept the recommendation of the NCVHS and issue a notice of proposed rule making to initiate the regulatory process for the concurrent adoption of ICD–10–CM and ICD–10–PCS. ICD–10 would replace the 23-year-old ICD–9–CM coding classification system, which has highly limited reporting capabilities for today's needs and growth capacity for future needs, making it an unacceptable coding classification system for both inpatient and outpatient diagnosis. ICD–10 would be able to keep pace with advances in modern medicine, thus ensuring accurate reimbursement rates for emerging technologies and patient access to the highest quality care.

Since 1997, NCVHS has closely examined this issue and received testimonies and letters from more than 80 public- and private-sector groups representing the full range of interests in the health care community. NCVHS and other parties have commissioned numerous studies, all of which NCVHS also has carefully considered. The Committee finds that the recommendation made by NCVHS is based on sound evidence and is, in the words of NCVHS, "in the best interests of the country as a whole." Conferees encourage the Secretary to implement the recommendation as quickly as possible.

Treatment of Hospitals for Certain Services Under Medicare Secondary Payor (MSP) Provisions. (Section 943 of the Conference Agreement, Section 943 of the House Bill).

Present Law

In certain instances when a beneficiary has other insurance coverage, Medicare becomes the secondary insurance. Medicare Secondary Payer is the Medicare program's coordination of benefits with other insurers. Section 1862(b)(6) of the Social Security Act requires an entity furnishing a Part B service to obtain information from the beneficiary on whether other insurance coverage is available.

House Bill

The Secretary would not require a hospital or a critical access hospital to ask questions or obtain information relating to the Medicare secondary payer provisions in the case of reference laboratory services if the same requirements are not imposed upon those provided by an independent laboratory. Reference laboratory services would be those clinical laboratory diagnostic tests and interpretations of same that are furnished without a face-to-face encounter between the beneficiary and the hospital where the hospital submits a claim for the services.

Senate Bill

No provision.

Conference Agreement

The conference agreement prohibits the Secretary from requiring a hospital or a critical access hospital to ask questions or obtain information relating to the Medicare secondary payer provisions in the case of reference laboratory services if the same requirements are not imposed upon those provided by an independent laboratory. Reference laboratory services are those clinical laboratory diagnostic tests and interpretations of same that are furnished without a face-to-face encounter between the beneficiary and the hospital where the hospital submits a claim for the services.

EMTALA Improvements. (Section 944 of the Conference Agreement, Section 944 of the House Bill).

Present Law

Medicare requires participating hospitals that operate an emergency room to provide necessary screening and stabilization services to any patient who comes to an emergency room requesting examination or treatment in order to determine whether an emergency medical situation exists.

Hospitals that are found to be in violation of Emergency Medical Treatment and Active Labor Act (EMTALA) requirements may face civil monetary penalties and termination of their provider agreement. Prior to imposing a civil monetary penalty, the Secretary is required to request a peer review organization (PRO—currently called quality improvement organizations or QIOs) to assess whether the involved beneficiary had an emergency condition, which had not been stabilized and provide a report on its findings. Except in the case where a delay would jeopardize the health or safety, the Secretary provides 60-day period for the requested PRO review.

House Bill

Emergency room services provided to screen and stabilize a Medicare beneficiary furnished after January 1, 2004, would be evaluated for Medicare's "reasonable and necessary" requirement on the basis of the information available to the treating physician or practitioner at the time the services were ordered; this would include the patient's presenting symptoms or complaint and not the patient's principal diagnosis. The Secretary would not be able to consider the frequency with which the item or service was provided to the patient before or after the time of admission or visit. The Secretary would be required to establish a procedure to notify hospitals and physicians when an EMTALA investigation is closed.

Except in the case where a delay would jeopardize the health and safety of individuals, the Secretary would be required to request a PRO review before making a compliance determination that would terminate a hospital's Medicare participation because of EMTALA violations and provide a period of 5 business days for such review. The PRO would be required to provide a copy of the report on its findings to the hospital or physician, consistent with existing confidentiality requirements. This provision would apply to terminations initiated on or after enactment

Senate Bill

No provision.

Conference Agreement

The conference agreement requires emergency room services provided to screen and stabilize a Medicare beneficiary furnished after January 1, 2004, to be evaluated for Medicare's "reasonable and necessary" requirement on the basis of the information available to the treating physician or practitioner at the time the services were ordered; this includes the patient's presenting symptoms or complaint and not the patient's principal diagnosis. The Secretary is prohibited from considering the frequency with which the item or service was provided to the patient before or after the time of admission or visit.

The Secretary is required to establish a procedure to notify hospitals and physicians when an EMTALA investigation is closed.

Except in the case where a delay would jeopardize the health and safety of individuals, the Secretary is required to request a PRO review before making a compliance determination that would terminate a hospital's Medicare participation because of EMTALA violations and provide a period of 5 business days for such review. The PRO is required to provide a copy of the report on its findings to the hospital or physician, consistent with existing confidentiality requirements. This provision applies to terminations initiated on or after enactment.

Emergency Medical Treatment and Active Labor Act (EMTALA) Technical Advisory Group. (Section 945 of the Conference Agreement, Section 945 of the House Bill).

Present Law

No provision.

House Bill

The Secretary would be required to establish a 19-member technical advisory group under specified requirements to review issues related to EMTALA. The advisory group would be comprised of: the CMS Administrator; the HHS Inspector General; 4 hospital representatives who have EMTALA experience, (2 of whom have not experienced EMTALA violations) 7 practicing physicians with specified experience; 2 patient representatives; 2 regional CMS staff involved in EMTALA investigations; 1 representative from a State survey organization and 1 from peer review organization. The Secretary would select qualified individuals who are nominated by organizations representing providers and patients.

The advisory group would review EMTALA regulations; provide advice and recommendations to the Secretary; solicit public comments from interested parties; and disseminate information on the application of the EMTALA regulations. The advisory group would be required to (1) elect a member to as chairperson; (2) schedule its first meeting at the direction of the Secretary and meet at least twice a year subsequently; and (3) terminate 30 months after the date of its first meeting. The Secretary would be required to establish the advisory group regardless of any limitation that may apply to the number of advisory committees that may be established within HHS.

Senate Bill

No provision.

Conference Agreement

The conference agreement requires the Secretary to establish a 19-member technical advisory group under specified requirements to review issues related to EMTALA. The advisory group would be comprised of: the CMS Administrator; the HHS Inspector General; 4 hospital representatives who have EMTALA experience (2 of whom have not experienced EMTALA violations); 7 practicing physicians with specified experience; 2 patient representatives; 2 regional CMS staff involved in EMTALA investigations; 1 representative from a State survey organization and 1 from peer review organization. The Secretary is required to select qualified individuals who are nominated by organizations representing providers and patients.

The advisory group will review EMTALA regulations; provide advice and recommendations to the Secretary; solicit public comments from interested parties; and disseminate information on the application of the EMTALA regulations. The advisory group is required to: (1) elect a member to as chairperson; (2) schedule its first meeting at the direction of the Secretary and meet at least twice a year subsequently; and (3) terminate 30 months after the date of its first meeting. The Secretary is required to establish the advisory group regardless of any limitation that may apply to the number of advisory committees that may be established within HHS.

Authorizing Use of Arrangements to Provide Core Hospice Services in Certain Circumstances. (Section 946 of the Conference Agreement, Section 946 of the House Bill, Section 406 of the Senate Bill).

Present Law

A hospice is a public agency or private organization that is primarily engaged in providing and making available certain care to a terminally ill Medicare beneficiary under a written plan.

House Bill

A hospice would be permitted to (1) enter into arrangements with another hospice program to provide care in extraordinary, exigent or other non-routine circumstances, such as unanticipated high patient loads, staffing shortages due to illness, or temporary travel by a patient outside the hospice's service area; and (2) bill and be paid for the hospice care provided under these arrangements. The provision would be effective for hospice care provided on or after the date of enactment.

Senate Bill

Same provision.

Conference Agreement

The conference agreement permits a hospice to: (1) enter into arrangements with another hospice program to provide care in extraordinary, exigent or other non-routine circumstances, such as unanticipated high patient loads, staffing shortages due to illness, or temporary travel by a patient outside the hospice's service area; and (2) bill and be paid for the hospice care provided under these arrangements. The provision is effective for hospice care provided on or after the date of enactment.

Application of OSHA Bloodborne Pathogens Standard to Certain Hospitals. (Section 947 of the Conference Agreement, Section 947 of the House Bill).

Present Law

Section 1866 establishes certain conditions of participation that providers must meet in order to participate in Medicare.

House Bill

Public hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 would be required to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations. A hospital that fails to comply with the requirement would be subject to a civil monetary penalty, but would not be terminated from participating in Medicare. The provision would apply to hospitals as of July 1, 2004.

Senate Bill

No provision.

Conference Agreement

The conference agreement requires that public hospitals, not otherwise subject to the Occupational Safety and Health Act of 1970, comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations. A hospital that fails to comply with the requirement will be subject to a civil monetary penalty, but cannot be terminated from participating in Medicare. The provision applies to hospitals as of July 1, 2004.

BIPA-Related Technical Amendments and Corrections. (Section 948 of the Conference Agreement, Section 948 of the House Bill).

Present Law

BIPA established an advisory process for national coverage determinations where panels of experts formed by advisory committees could forward their recommendations directly to the Secretary without prior approval of the advisory committee or the Executive Committee.

House Bill

The statutory reference in BIPA would be changed from the Social Security Act to the Public Health Service Act. Other BIPA references would be changed from "policy" to "determinations." The provision is effective as if included in the enactment of BIPA.

Senate Bill

No provision.

Conference Agreement

The conference agreement changes the statutory reference in BIPA from the Social Security Act ,to the Public Health Service Act. Other BIPA references would be changed from "policy" to "determinations." The provision is effective as if included in the enactment of BIPA.

Conforming Authority to Waive a Program Exclusion. (Section 949 of the Conference Agreement, Section 949 of the House Bill, Section 544 of the Senate Bill).

Present Law

The Secretary is required to exclude individuals and entities from participation in federal health programs that are (1) convicted of a criminal offense related to health care delivery under Medicare or under state health programs; (2) convicted of a criminal offense related to patient abuse or neglect under federal or state law; (3) convicted of a felony relating to fraud, theft, or financial misconduct relating to a health care program finance or operated by the federal, state or local government; or (4) convicted of a felony related to a controlled substance.

House Bill

The administrator of a federal health program would be permitted to waive certain 5-year exclusions if the exclusion of a sole community physician or source of specialized services in a community would impose a hardship. The mandatory exclusions that could be waived would be those related to convictions associated with program-related crimes; health care fraud and controlled substance. The provision would be effective upon enactment.

Senate Bill

Same provision.

Conference Agreement

The conference agreement permits the administrator of a federal health program to waive certain 5-year exclusions if the exclusion of a sole community physician or source of specialized services in a community will impose a hardship. The mandatory exclusions that can be waived are those related to convictions associated with program-related crimes; health care fraud and controlled substance. The provision is effective upon enactment.

Treatment of Certain Dental Claims. (Section 950 of the Conference Agreement, Section 950 of the House Bill, Section 555 of the Senate Bill).

Present Law

The Medicare benefit does not include most dental services. Some insurers may require a claim denial from Medicare before accepting the dental claim for payment review, even if the service is not covered by Medicare.

House Bill

A group health plan providing supplemental or secondary coverage to Medicare beneficiaries would not be able to require dentists to obtain a claim denial from Medicare for noncovered dental services before paying the claim. The provision would be effective 60 days after enactment.

Senate Bill

Same provision.

Conference Agreement

The conference agreement provides that a group health plan providing supplemental or secondary coverage to Medicare beneficiaries cannot require dentists to obtain a claim denial from Medicare for dental services that are not covered by Medicare before paying the claim. The provision is effective 60 days after enactment.

Furnishing Hospitals with Information to Compute DSH Formula. (Section 951 of the Conference Agreement, Section 951 of the House Bill).

Present Law

Disproportionate share hospital (DSH) payments under Medicare are calculated using a formula that includes the number of patient days for patients eligible for Medicaid.

House Bill

The provision would require the Secretary to provide information that hospitals need to calculate the number of Medicaid patient days used in the Medicare DSH payment formula, not later than 1 year after enactment.

Senate Bill

No provision.

Conference Agreement

The conference agreement requires the Secretary to arrange for the provision of information that hospitals need to calculate the Medicare DSH payment formula not later than 1 year after enactment.

Revisions to Reassignment Provisions (Section 952 of the Conference Agreement, Section 952 of the House Bill, Section 434 of the Senate Bill).

Present Law

In general, Medicare Part B payments may be made only to a Medicare beneficiary or to physician or other person who provided the service. Section 1842(b)(6) of the Social Security Act establishes the Medicare reassignment prohibitions and does not permit physicians to reassign their Medicare payments to entities with which they have a relationship on an independent contractor basis. In order for an independent contractor to reassign Medicare benefits, the services must be performed on the premises of the entity to which the benefits will be reassigned.

House Bill

Medicare payment for Part B services would be permitted to be made to an entity, as defined by the Secretary, that has a contractual arrangement with the physician or other person who provided the service for the entity to bill for the service and the contractual arrangement meets program integrity and other safeguards specified by the Secretary.

The provision would be effective for payments made on or after one year after the date of enactment.

Senate Bill

Same provision, but would include a conforming amendment.

Conference Agreement

This provision amends the Social Security Act to allow physicians and non-physician practitioners to reassign payment for Medicare-covered services, regardless of where the arrangement (including but not limited to a hospital, clinic, medical group, a physician practice management organization, or a staffing company) so long as there is a contractual arrangement between the physician and the entity under which the entity submits the bill for such service. As a result, the Secretary could enroll these entities in the Medicare program. The Secretary may also provide for other enrollment qualifications to assure program integrity, including joint and several liability.

This provision will streamline Medicare enrollment while also enhancing HHS' program integrity efforts. By permitting entities that retain independent contractors to enroll with the Medicare program and thereby directly bill the Medicare program, HHS will be able to monitor the claims submitted by the entities that retain independent contractors as well as those entities that employ physicians. The Committee supports appropriate program integrity efforts (e.g. joint and several liability) for any entities billing the Medicare program including entities with employees as well as independent contractors. Further, the Committee believes that physicians' and non-physician practitioners' should be entitled to unrestrictive access to billings submitted on their behalf by the entity with which they have contracted. The Committee intends that the Secretary will implement this provision via program instructions to the Medicare contractors. The changes made by this provision shall apply to Medicare payments made on or after date of enactment.

The provision is effective upon enactment.

Other Provisions. (Section 953 of the Conference Agreement, Section 953 of the House Bill).

Present Law

No provisions.

House Bill

GAO Report on Physician Compensation. No later than six months from enactment, GAO would be required to report to Congress on the appropriateness of the updates in the conversion factor including the appropriateness of the sustainable growth rate (SGR) formula for 2002 and subsequently. The report would examine the stability and the predictability of the updates and rate as well as the alternatives for use of the SGR in the updates. No later than 12 months from enactment, GAO would be required to report to Congress on all aspects of physician compensation for Medicare services. The report would review the alternatives for the physician fee schedule.

Annual Publication of List of National Coverage Determinations. The Secretary would be required to publish an annual list of nation coverage determinations made under Medicare in the previous year. Included would be information on how to get more information about the determinations. The list would be published to the public in an appropriate annual publication.

GAO Report on Flexibility in Applying Home Health Conditions of Participation to Patients Who Are Not Medicare Beneficiaries. The GAO would be required to report to Congress on the implications if the Medicare conditions of participation for home health agencies were applied flexibly with respect to groups or types of patients who are not Medicare beneficiaries. The report would include an analysis of the potential impact of this flexibility on clinical operations and the recipients of such services and an analysis of methods for monitoring the quality of care provided to these recipients. The report would be due no later than six months after enactment.

OIG Report on Notices Relating to Use of Hospital Lifetime Reserve Days. The Inspector General of HHS would be required to report to Congress on the extent to which hospitals provide notice to Medicare beneficiaries, in accordance with applicable requirements, before they use the 60 lifetime reserve days under the hospital benefit. The report would also include the appropriateness and feasibility of hospitals providing a notice to beneficiaries before they exhaust the lifetime reserve days. The report would be due no later than one year after enactment.

Senate Bill

No provision.

Conference Agreement

GAO Report on Physician Compensation. The conference agreement requires that, no later than six months from enactment, the GAO report to Congress on the appropriateness of the updates in the conversion factor including the appropriateness of the sustainable growth rate (SGR) formula for 2002 and subsequent years. The report will examine the stability and the predictability of the updates and rate as well as the alternatives for use of the SGR in the updates. No later than 12 months from enactment, GAO is required to report to Congress on all aspects of physician compensation for Medicare services. The report is required to review the alternatives for the physician fee schedule.

Annual Publication of List of National Coverage Determinations. The conference agreement requires the Secretary publish an annual list of national coverage determinations made under Medicare in the previous year. Information on how to get more information about the determinations is required to be included in the publication. The list and the information are required to be published in an appropriate annual publication that is publicly available.

GAO Report on Flexibility in Applying Home Health Conditions of Participation to Patients Who Are Not Medicare Beneficiaries. The conference agreement requires the GAO to report to Congress on the implications if the Medicare conditions of participation for home health agencies were applied flexibly with respect to groups or types of patients who are not Medicare beneficiaries. The report is required to include an analysis of the potential impact of this flexibility on clinical operations and the recipients of such services and an analysis of methods for monitoring the quality of care provided to these recipients. The report is due no later than six months after enactment.

OIG Report on Notices Relating to Use of Hospital Lifetime Reserve Days. The conference agreement requires the Inspector General of HHS to report to Congress on the extent to which hospitals provide notice to Medicare beneficiaries, in accordance with applicable requirements, before they use the 60 lifetime reserve days under the hospital benefit. The report is required to include the appropriateness and feasibility of hospitals providing a notice to beneficiaries before they exhaust the lifetime reserve days. The report is due no later than one year after enactment.

Streamlining and Simplification of Medicare Regulations (Section 504 of the Senate Bill).

Present Law

No provision.

House Bill

No provision.

Senate Bill

The Secretary would be required to analyze Medicare regulations for the purposes of determining how to streamline the regulations and reduce the number of words in the regulations by two-thirds by October 1, 2004. If the Secretary determines that the two-thirds reduction is infeasible, he would be required to inform Congress in writing by July 1, 2004 of the reasons and then establish a feasible reduction to be achieved by January 1, 2005. The provision would be effective upon enactment.

Conference Agreement

No provision.

Elimination of the Requirement for De Novo Review by the Departmental Appeals Board (Section 520 of the Senate Bill).

Present Law

BIPA section 521 requires that the Departmental Appeals Board (DAB), the fourth level of appeal, review appeals cases *de novo*. Prior to BIPA, the DAB reviewed appeals based on the record established during the previous three levels of appeal.

House Bill

No provision.

Senate Bill

The DAB would be required to review a decision and render a decision or remand the appeal to the ALJ within the 90-day period. The provision would be effective upon enactment.

Conference Agreement

No provision.

TITLE X—MEDICAID AND MISCELLANEOUS PROVISIONS

Subtitle A—Medicaid Provisions

Medicaid Disproportionate Share (DSH) Hospital Payments—Temporary Increase. (Section 1001(a) of the Conference Agreement, Section 1001 of the House Bill, and Section 601 of the Senate Bill)

Present Law

Hospitals that serve a large number of uninsured patients and Medicaid enrollees receive additional Medicaid disproportionate share hospital (DSH) payments. As established in the BBA 1997, the federal share of Medicaid DSH payments is capped at specified amounts for each state for FY1998 through FY2002. For most states, those specified amounts declined over the 5-year period. A state's allotment for FY2003 and for later years is equal to its allotment for the previous year increased by the percentage change in the consumer price index for urban consumers (CPI-U) for the previous year. In addition, each state's DSH payment for FY2003 and subsequent years is limited to no more than 12% of total spending for medical assistance in each state for that year.

BIPA provided states with a temporary reprieve from the declining allotments by establishing a special rule for the calculation of DSH allotments for 2 years, raising allotments for FY2001 and for FY2002. The provision also clarified that the FY2003 allotments were to be calculated as specified under BBA 1997, using the lower, pre-BIPA levels for FY2002 in those calculations.

DSH payments to each inpatient general hospital are limited to some percentage of the costs of providing inpatient and outpatient services to Medicaid and uninsured patients at that hospital, less payments received from or on behalf of Medicaid and uninsured patients. These costs are considered to be unreimbursed costs. DSH payments to private hospitals may be no greater than 100% of unreimbursed costs. Public hospitals, for the two state fiscal years beginning after September 2002, cannot receive DSH payments that exceed 175% of unreimbursed costs. Thereafter, those hospitals would be limited to DSH payments of no more than 100% of unreimbursed costs.

House Bill

The provision would establish a temporary increase in DSH allotments for FY2004 and for certain subsequent fiscal years. Allotments for FY2004 would be set at 120% of FY2003 allotments as under BIPA and would not be subject to the ceiling capping states' allotments at 12% of medical assistance payments. Allotments for subsequent years would be equal to the allotments for FY2004 unless the Secretary determines that the allotments as would have been calculated prior to the enactment of this bill would equal or exceed the FY2004 amounts. For such fiscal years, allotments would be equal to allotments for the prior fiscal year increased by the percentage change in the consumer price index for all urban consumers for the previous fiscal year. The provision would be effective upon enactment.

Senate Bill

The special DSH rule established by BIPA that raised DSH allotments, subject to the current law limit of 12% of spending for medical assistance, would be extended for FY2004 and FY2005. Allotments for FY2004 would be calculated to be equal to FY2004 allotments (as established by BBA 1997) increased by the product of 0.50; and the difference between: (a) FY2002 allotments (as established by BIPA 2000) increased by the percentage change in the CPI–U for each of fiscal years 2002 and 2003, and (b) FY2004 allotments (as established by BBA 1997). Allotments FY2005 would be calculated to be equal to FY2005 allotments (as established by BBA 1997) increased by the product of 0.50; and the difference between: (a) FY2002 allotments (as established by the BIPA 2000) increased by the percentage change in the CPI–U for each of fiscal years, 2002, 2003, and 2004, and (b) FY2005 allotments (as established by BBA 1997). For FY2006 and thereafter, DSH allotments would be calculated based on the previous years' amount (as established by BBA 1997 and subject to the current law limit of 12% of spending for medical assistance) increased by the percentage change in the CPI–U for the previous fiscal year. All allotments would remain subject to the current law limit of 12% of medical assistance spending.

A separate calculation of the DSH allotment for the District of Columbia for FY2004 would be specified. The DSH allotment for the District of Columbia for FY2004 would be raised, subject to the current law limit of 12% of spending for medical assistance, by multiplying $49 million by the percentage change in the CPI–U for each of FY2000, FY2001, FY2002, and FY2003. The provision would be effective upon enactment.

Conference Agreement

The conference agreement will establish a temporary increase in DSH allotments for FY2004 and for certain subsequent fiscal years. Allotments for FY2004 are to be set at 116% of FY2003 allotments as under BIPA and will not be subject to the ceiling capping states' allotments at 12% of medical assistance payments. Allotments for subsequent years will be equal to the allotments for FY2004 unless the Secretary determines that the allotments as would have been calculated prior to the enactment of this bill would equal or no longer exceed the FY2004 amounts. For such fiscal years, allotments will be equal to allotments for the prior fiscal year increased by the percentage change in the consumer price index for all urban consumers for the previous fiscal year. The provision is effective upon enactment.

Increase in the Floor for Treatment as an Extremely Low DSH States Under the Medicaid Program for Fiscal Years 2004 and 2005. (Section 1001(b) of the Conference Agreement, Section 602 of the Senate Bill)

Present Law

Extremely low DSH states are those states whose FY1999 federal and state DSH expenditures (as reported to CMS on August 31, 2000) are greater than zero but less than 1% of the state's total medical assistance expenditures during that fiscal year. DSH allotments for the extremely low DSH states for FY2001 would be equal to 1% of the state's total amount of expenditures under their plan for such assistance during that fiscal year. For subsequent fiscal years, the allotments for extremely low DSH states would be equal to their allotment for the previous year, increased by the percentage change in the CPI–U for the previous year, subject to a ceiling of 12% of that state's total medical assistance payments in that year.

House Bill

No provision.

Senate Bill

Allotments for certain extremely low DSH states for FY2004 and FY2005 would be increased. For states with DSH expenditures for FY2000 (as reported to CMS as of August 31, 2003) that are greater than zero but less than 3% of the state's total medical assistance expenditures during that fiscal year, the provision would raise the DSH allotments for FY2004 to 3% of the state's total amount of expenditures for such assistance during that fiscal year. States with DSH expenditures for FY2001 (as reported to CMS as of August 31, 2004) that are greater than zero but less than 3% of the state's total medical assistance expenditures during that fiscal year would have the DSH allotments for FY2005 equal to such state's DSH allotment for FY2004 increased by the percentage change in the CPI–U for FY2004.

A special DSH allotment adjustment for certain states would be specified for FY2004 and FY2005. For Tennessee, if its state-wide Section 1115 waiver is revoked or terminated during FY2004 and/or FY2005, the Secretary of HHS would permit the state to submit an amendment to its state plan that would describe the methodology to be used by the state to identify and make payments for disproportionate share hospitals (including children's hospitals, and institutions for mental diseases, or other mental health facilities—other than state-owned institutions or facilities), based on the proportion of patients served by such hospitals that are low-income patients with special needs. The state would be required to provide data for the computation of an appropriate DSH allotment that does not result in greater expenditures under this title than would have been made if such waiver had not been revoked or terminated. The provision would be effective upon enactment.

Conference Agreement

The conference agreement will raise the temporary floor for extremely low DSH states as defined under current law for fiscal years 2004 through 2008 by 16% above current amounts.

Increased Reporting Requirements to Ensure the Appropriateness of Payment Adjustments to Disproportionate Share Hospitals Under the Medicaid Program. (Section 1001(c) of the Conference Agreement, Section 603 of the Senate Bill)

Present Law

BBA 1997 required each state to submit to the Secretary an annual report describing the disproportionate share payments made to each disproportionate share hospital (DSH) and the methodology used by the state for prioritizing payments to such hospitals.

House Bill

No provision.

Senate Bill

As a condition of receiving federal Medicaid payments for FY2004 and each fiscal year thereafter, the provision would require each state to submit to the Secretary an annual report (for the previous fiscal year) identifying each disproportionate share hospital that received a payment, the amount such hospital received, as well as other information the Secretary determines necessary to ensure the appropriateness of the DSH payments for the previous fiscal year. The provision would be effective upon enactment.

Conference Agreement

As a condition of receiving federal Medicaid payments for FY2004 and each fiscal year thereafter, the conference agreement will require each state to submit to the Secretary an annual report (for the previous fiscal year) identifying each disproportionate share hospital that received a payment, the amount such hospital received, as well as other information the Secretary determines necessary to ensure the appropriateness of the DSH payments for the previous fiscal year. In addition, the conference agreement will require states to submit annually to the Secretary an independent certified audit verifying: the extent to which hospitals receiving DSH payments have reduced their uncompensated care costs to reflect DSH payments received; the states' compliance with the hospital-specific payment ceilings; the methodology used to calculate those ceilings; and the documentation maintained by the states regarding claimed costs, expenditures and payments under this section. The conference agreement will be effective upon enactment.

Clarification of Inclusion of Inpatient Drug Prices Charged to Certain Public Hospitals in the Best Price Exemptions for the Medicaid Drug Rebate Program. (Section 1002 of the Conference Agreement, Section 1002 of the House Bill, and Section 604 of the Senate Bill)

Present Law

Medicaid drug rebates are calculated based on the difference between the average manufacturer's price (AMP) and the manufacturer's "best price." In determining the "best price" for a drug sold by a manufacturer, certain discounted prices and fee schedules are disregarded. The special discounted prices for outpatient drugs negotiated by the Office of Pharmacy Affairs (of HHS) with drug manufacturers on behalf of certain clinics and safety net providers are one example of prices excluded from Medicaid's "best price" determination. Because of this exclusion from Medicaid's "best price" definition, the discounts available to safety net providers have no bearing on the calculation of drug rebates under the Medicaid program, allowing those providers to negotiate better rates with manufacturers, since Medicaid rebates will not change with the size of their negotiated discounts. Discounted prices for inpatient drugs for many safety net providers, however, are not disregarded in the Medicaid "best price" determination.

House Bill

The provision would modify the definition of "best price" for the purpose of calculating Medicaid drug rebates, to also disregard the discounted inpatient drug prices charged to certain public safety net hospitals. Those hospitals would also be subject to the same auditing and record keeping requirements as other providers with similar exemptions from Medicaid's "best price" determination. The provision would be effective upon enactment.

Senate Bill

The provision would modify the definition of "best price" for the purpose of calculating Medicaid drug rebates, to also exclude the discounted inpatient drug prices charged to certain public safety net hospitals. Those hospitals would also be subject to the same auditing and record keeping requirements as other providers with similar exemptions from Medicaid's "best price" determination. The provision would be effective October 1, 2003.

Conference Agreement

The conference agreement will modify the definition of "best price" for the purpose of calculating Medicaid drug rebates, to also exclude the discounted inpatient drug prices charged to certain public safety net hospitals. Those hospitals will also be subject to the same auditing and record keeping requirements as other providers with similar exemptions from Medicaid's "best price" determination. The provision will be effective upon enactment.

Assistance for States for Legal Immigrants

Present Law

"Qualified aliens" who entered the United States after the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, August 22, 1996) are not eligible to receive federally funded benefits under Medicaid or SCHIP for 5 years. Qualified aliens who entered the United States prior to the enactment of PRWORA are eligible for federally funded Medicaid coverage as a state option, as are qualified aliens arriving after August 22, 1996 who have been present in the United States for more than 5 years.

A person who executed an affidavit of support for an alien under Senate Section 213A of the Immigration and Nationality Act (INA) is liable to reimburse the federal or state government for the public benefits received by the sponsored alien until the alien naturalizes or has accumulated 40 quarters of work. Senate Section 213A was enacted as a part of PRWORA on August 22, 1996.

House Bill

No provision.

Senate Bill

The provision would lift the 5-year ban and would allow states the option to provide medical assistance to certain lawfully residing individuals under Medicaid (including under a waiver authorized by the Secretary) or SCHIP for any of fiscal years 2005 through 2007. Those eligible would include lawfully residing women during pregnancy and the 60-day period after delivery, and children otherwise eligible for Medicaid or SCHIP as defined by the state plan. States opting to provide coverage to such lawfully residing individuals under SCHIP must also provide coverage to such individuals under Medicaid. If services are provided under the Medicaid program, the alien's sponsor would not be liable to reimburse the federal or state government for the cost of such services. The provision would be effective upon enactment.

Conference Agreement

No provision.

GAO Study Regarding Impact of Assets Test for Low-income Beneficiaries. (Section 607 of the Senate Bill)

Present Law

No provision.

House Bill

No provision.

Senate Bill

The provision would require the General Accounting Office (GAO) to conduct a study to determine the extent to which drug utilization and access to covered drugs differs between: (1) individuals who qualify for the transitional assistance prescription drug card program or for the premiums and cost sharing subsidies available to certain low-income beneficiaries (including qualified Medicare beneficiaries, specified low-income Medicare beneficiaries or qualifying individual under Senate Section 1860(D)), and (2) individuals who do not qualify for the transitional assistance prescription drug card program or for the premiums and cost sharing subsidies available to certain low-income beneficiaries solely as a result of the application of an assets test to the income eligibility requirements of such individuals. The GAO would be required to submit to Congress the final report (including recommendations for legislation) no later than September 30, 2007. The provision would be effective upon enactment.

Conference Agreement

No provision.

Clarification Regarding Non-Regulation of Transfers

Present Law

No specific provision

House bill

No provision

Senate bill

No provision

Conference Agreement

The final conference agreement permits the Secretary, in limited instances, to allow a publicly-owned regional medical center to utilize the disproportionate share hospital allotment of another State. This provision will apply through December 31, 2005.

Urban Health Provider Adjustment. (Section 625 of the Senate Bill)

Present Law

There are two other types of ceilings on DSH payments, in addition to the state-wide allotments. The "hospital-specific" ceiling limits payments to hospitals to some percentage of the each hospital's costs of providing inpatient and outpatient services to Medicaid and uninsured patients, less payments received from or on behalf of Medicaid and uninsured patients ("unreimbursed costs"). DSH payments to public hospitals are limited to 100% of these unreimbursed costs except in fiscal years 2003 and 2004 when the percentage of unreimbursed costs that can be covered by DSH rises to 175%. The hospital-specific ceiling for private hospitals is 100% of unreimbursed costs and for certain public hospitals in the state of California is 175% permanently.

House Bill

No provision.

Senate Bill

DSH payments made to hospitals that are owned and operated by the state of Indiana and located in Marion County would be made without regard to the state's DSH allotment limitation so long as those payment amounts, fit FY2004 and each fiscal year thereafter do not exceed 175% of the "unreimbursed costs" of furnishing hospital services.

Conference Agreement

No provision.

100% FMAP for Medical Assistance Provided to a Native Hawaiian Through a Federally-Qualified Health Center or a Native Hawaiian Health Care System Under the Medicaid Program. (Section 632 of the Senate Bill)

Present Law

The Medicaid program is jointly financed by the states and the federal government. The federal government share is based on each state's federal medical assistance percentage (FMAP). The FMAP for a state is calculated using a formula reflecting the state per capita income relative to the average U.S. per capita income. The formula is designed to give a higher FMAP to states with a per capita income below the U.S. average. No state can have an FMAP of less than 50% or more than 83%. Certain services including family planning are paid at an alternative FMAP rate, as are administrative expenses. In addition, the law provides that services provided through an Indian Health Service facility operated by the Indian Health Service or an Indian tribe or tribal organization have an FMAP of 100%.

The Jobs and Growth Tax Relief Reconciliation Act of 2003 (JEGTRRA, P.L. 108-026) altered the statutory calculation of the FMAPs by providing a hold harmless for declines from the prior year for each state FMAP, and a temporary increase of 2.95 percentage points for the last 2 quarters of fiscal year 2003 and the first three quarters of fiscal year 2004. The calculated statutory FMAPs for Hawaii would be 58.77% for fiscal year 2003 and 58.90% for fiscal year 2004. The JEGTRRA changes result in an FMAP of 61.75% for the last 2 quarters of fiscal year 2003, and 61.85% for the first three quarters of fiscal year 2004. The FMAP for services provided to a Native Hawaiian is the same as for services provided to other Medicaid beneficiaries in Hawaii.

House Bill

No provision.

Senate Bill

For services provided to a Native Hawaiian by a federally qualified health center or a Native Hawaiian health care system, the FMAP would be 100%. Services qualifying for the 100% FMAP would include those provided by referral, and under contract or other arrangement between a health care provider and the federally qualified health center or Native Hawaiian health care system. The provision would be effective for medical assistance provided on or after the date of enactment.

Conference Agreement

No provision.

Extension of Moratorium. (Section 633 of the Senate Bill)

Present Law

Medicaid payment for services provided by an institution for mental disease (IMD) may be made only for beneficiaries who are under age 21 or over 65. IMD means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. For two facilities in Michigan—Kent Community Hospital Complex and Saginaw Community Hospital—previous legislation has imposed a moratorium on determination of the facilities as IMDs through December 31, 2002.

House Bill

No provision.

Senate Bill

The moratorium on the determination of Saginaw Community Hospital as an IMD would be permanently extended. The provision would be effective as if included in the Balanced Budget Act of 1997.

Conference Agreement

The moratorium on the determination of Saginaw Community Hospital as an IMD would be extended for 2 years. The provision would be effective as if included in the Balanced Budget Act of 1997.

Subtitle B—Miscellaneous Provisions

Employer Flexibility. (Section 1011 of the Conference Agreement, and Section 631 of the Senate Bill)

Present Law

No provision.

House Bill

No provision.

Senate Bill

The provision would amend the Age Discrimination in Employment Act of 1967 to allow an employee benefit plan that provides medical benefits to be offered to retirees who are not eligible for Medicare benefits or benefits provided under a State plan without offering medical benefits, or the same medical benefits, to Medicare-eligible retirees or retirees eligible for benefits under a State plan. Under the provision, an employee benefit plan that distinguishes between those retirees and other retirees would not violate the ADEA. The provision would be effective upon enactment.

Conference Agreement

No provision. However, the conferees reviewed the ADEA and its legislative history and believe the legislative history clearly articulates the intent of Congress that employers should not be prevented from providing voluntary benefits to retirees only until they become eligible to participate in the Medicare program.

Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens

Present Law

The Balanced Budget Act of 1997 (BBA97) provided $25 million in funding for state emergency health services furnished to undocumented aliens for each of FY1998 through 2001. Funds were distributed among the 12 states with the highest number of undocumented aliens. In a fiscal year, each state's portion of the total funds available was based on its share of total undocumented aliens in all of the eligible states. The share of undocumented aliens in each state were based on the estimates provided by the Statistics Division of the Immigration and Naturalization Service (INS).

House Bill

No provision.

Senate Bill

For each of fiscal years 2005 through 2008 the provision would appropriate for allotment among states $250 million in funds for emergency health services furnished to undocumented aliens. Each such fiscal year the Secretary would distribute $167 million of $250 million among all states. Each state would receive an amount equal to the product of the total amount available in each fiscal year, and the proportion of the state's share of undocumented aliens to the total count of undocumented aliens residing in all states as determined by the Statistics Division of the Immigration and Naturalization Service, as of January 2003, based on the decennial census.

For each of fiscal years 2005 through 2008, the Secretary would distribute $83 million of $250 million among the 6 states with the highest number of undocumented alien apprehensions for such fiscal year. Each such state would receive an amount that bears the same ratio to the total amount available for allotments to such states (in each fiscal year) as the ratio of the number of undocumented alien apprehensions in the state (in each fiscal year) to the total number of undocumented alien apprehensions for all such states (in each fiscal year) based on the four most recent quarterly apprehensions rates for undocumented aliens as reported by the Immigration and Naturalization Service.

From the state allotments described above, the Secretary would pay directly to local governments, hospitals, or other providers located in the state (including providers of services rendered through an Indian Health Service facility) for costs incurred in providing emergency health care services furnished to undocumented aliens during that fiscal year (even if the care is furnished to aliens who have been allowed to enter for the sole purpose of receiving emergency health care services). No later than September 1, 2004, the Secretary would be required to establish a process, that includes measures to protect against fraud and abuse, under which entities would apply for reimbursement from the state's allotments for claims associated with emergency health care services furnished to undocumented aliens. Advanced payments would be made quarterly based on the applicants projected expenditures. The Secretary would also be required to set up a process to allow for prior period adjustments resulting from underpayment or over payment to an entity in a prior quarter. Funds shall remain available until they are expended. The provision would be effective upon enactment.

Conference Agreement

For each of fiscal years 2005 through 2008 the Conference agreement appropriates for allotment among eligible providers in the 50 states and the District of Columbia $250 million in additional federal funding for emergency health services furnished to undocumented aliens. For each such fiscal year, the Secretary must distribute $167 million of $250 million among eligible providers in all states. Each state's share of this amount will be based on its proportion of total number of undocumented aliens in all states as determined by the Statistics Division of the Immigration and Naturalization Service, as of January 2003, based on the decennial census.

For each of fiscal years 2005 through 2008, the Secretary must distribute $83 million of $250 million among eligible providers in the six states with the highest number of undocumented alien apprehensions for such fiscal year. Each state's share of this amount is equal to the product of the total amount available for allotments to such states (in each fiscal year), and the proportion of the number of undocumented alien apprehensions in the state (in each fiscal year) to the total number of undocumented alien apprehensions for all such states (in the preceding fiscal year) based on apprehensions rates for undocumented aliens as reported by the Immigration and Naturalization Service in the four consecutive-quarter period ending before the beginning of the fiscal year for which such information is available.

From the $250 million in state allotments described above, the Secretary will pay directly to eligible providers located in the state (including hospitals, physicians, or providers of ambulance services, and Indian Health Service facilities) for unreimbursed costs incurred by providing emergency health care services during that fiscal year to: (1) Undocumented aliens; (2) aliens who have been paroled in the United States at a port of entry for the purpose of receiving eligible services; and (3) Mexican citizens permitted to enter the United States for not more than 72 hours under the authority of a specified identification card. In establishing a payment methodology, the Secretary may establish different methodologies for different types of eligible providers, may calculate payments to hospitals based on hospital-specific cost-to-charge ratios, and shall make quarterly payments to eligible providers. Hospitals may elect to receive payment for hospital and all physician services in which case they may pass on payments for physician services directly to physicians without charging hospital administrative fees. If the amount of funds allotted to a state is insufficient to ensure that each eligible provider receives the amount described above then the Secretary is required to reduce the amount of payment to eligible providers to ensure that each eligible provider is paid.

No later than September 1, 2004, the Secretary must establish a process that includes measures to protect against fraud and abuse to ensure that inappropriate, excessive or fraudulent payments are not made from allotments. Advance payments may be made quarterly based on the applicants projected expenditures. The Secretary is also required to set up a process to allow for prior period adjustments resulting from under payments or over-payments. Funds will remain available until they are expended. The provision will be effective upon enactment.

Commission on Systematic Interoperability. (Section 1013 of the Conference Agreement)

Pediatric Palliative Care Demonstration

Medicare is designed for aged and disabled individuals (typically people over 65 years of age). It was not designed with children in mind.

The conferees are aware of potential barriers in the current system for children with life-threatening illnesses. First, in order to qualify for hospice, a doctor must certify that a child has 6-months to live. Determining how long a child has to live is often difficult. Second, the current system does not allow a patient to receive curative and palliative care simultaneously. This means that children can either receive treatment for their disease or they can receive palliative care.

HHS should conduct a demonstration project in up to 6 geographically diverse sites to determine whether palliative care for children may be improved under circumstances where such barriers are reduced or eliminated. Such demonstration shall take place over at least a three year period.

The Secretary, in conducting such demonstration project, should take into account the recommendations of the Institute of Medicine in its report: "When Children Die: Improving Palliative and End-of-Life Care for Children and their Families."

In particular, the Secretary should consider including as part of the demonstration:

1. Waivers to Elect Hospice Care and Receive Curative Treatment.
2. Care coordination from diagnosis to end of life.
3. Features to ensure that parents have information about existing pediatric hospice and palliative care programs to make decisions about the care of their child.
4. Bereavement counseling for the family and reimbursement to provider.

The conferees believe that it is important that the Secretary have flexibility when conducting such demonstration to provide additional benefits so long as they are consistent with the recommendations contained in the IOM Report and they are provided in budget neutral manner. The conferees also believe that the Secretary should provide reports to Congress, as appropriate, that include an evaluation of the short- and long-term costs and benefits of palliative care under traditional Medicare and the demonstration projects, determine the quality and duration of palliative care under the demonstration project, and evaluate whether there is an offset of savings by providing pediatric palliative care, and the projected cost of implementing the demonstrations on a national basis.

Present Law

No provision.

House Bill

No provision.

Senate Provision

No provision.

Conference Agreement

The conference agreement instructs the Secretary to establish a Commission on Systemic Interoperability to develop a comprehensive strategy for the adoption and implementation of health care information technology standards. In developing its strategy, the Commission must consider the costs and benefits of the standards, the current demand on industry resources to implement these and other electronic standards (including the HIPAA administrative simplification standards), and the most cost-effective and efficient means for industry to implement the standards. The Commission must not interfere with any ongoing process of developing or adopting standards, nor shall it replicate activities related to such standards or to the HHS National Health Information Infrastructure initiative. Not later than October 31, 2005, the Commission must submit a report to the Secretary and the Congress describing its strategy.

The Commission shall be composed of 11 members. The President shall appoint three members, including a Chairperson; the Senate Majority Leader, the Senate Minority Leader, the Speaker, and the House Minority Leader shall each appoint two members. Commission membership must include nationally recognized experts in health finance and economics, health plans and integrated delivery systems, health care reimbursement, health care technology and information systems, and other related fields, as well as physicians, pharmacists, and other health care providers, who provide a mix of professionals, broad geographic representation, and a balance between urban and rural representation. Each member shall be appointed for the life of the Commission.

Commission members shall be paid for each day (including travel days) of service at a rate not exceeding the rate of basic pay for level IV of the Executive Schedule. Each member shall also receive travel expenses and a per diem. Federal employees who serve on the Commission may not receive any financial compensation.

A majority of Commission members shall constitute a quorum but a lesser number may hold hearings. The Commission Chairperson must appoint a Director, to be paid at a rate not exceeding the rate of basic pay for level IV of the Executive Schedule. With the Commission's approval, the Director may appoint additional staff, as well as temporary experts and consultants. Employees of federal agencies may also be detailed to the Commission to assist in carrying out its duties.

The Commission may, as appropriate, hold hearings, take testimony, and receive evidence. Any Commission member or agent may, if so authorized by the Commission, take any action which the Commission is authorized to take. The Commission may obtain official information from a federal agency and may accept, use and dispose of gifts, bequests, or devises of services or property, both real and personal. Gifts, bequests, or devices or money and proceeds from sales of other property received as gifts, bequests, or devices shall be deposited in the Treasury and available for disbursement upon order of the Commission. The Commission may use the U.S. mail under the same conditions as other federal agencies and may enter into contracts as may be necessary to conduct its work. Upon the Commission's request, the Administrator of General Services must provide administrative support services to the Commission on a reimbursable basis.

The Commission shall terminate 30 days after submitting its report to the Secretary and the Congress. The conference report authorizes to be appropriated such sums as may be necessary to carry out this Section.

Research on Outcomes of Health Care Items and Services. (Section 1014 of the Conference Agreement)

Present Law

The Agency for Healthcare Research and Quality (AHRQ) is an agency within the Department of Health and Human Services. AHRQ's mission is to support, conduct, and disseminate research that improves access to care and the outcomes, quality, cost, and utilization of health care services. The research agenda is designed to be responsive to the needs of its customers, including patients, clinicians, institutions, plans, purchasers, and federal, state and local governments. The research conducted by AHRQ is used to inform medical practice, educate consumer understanding of health care, and expand policymakers' ability to monitor and evaluate the impact of system changes on outcomes, quality, access, cost, and use of health care, and to devise policies to improve system performance.

House Bill

No provision.

Senate Bill

No provision.

Conference Agreement

The conference agreement authorizes and appropriates $50 million for fiscal year 2004 for the Secretary through the Agency for Healthcare Research and Quality to conduct research to address the scientific information needs and priorities identified by the Medicare, Medicaid, and State Children Health Insurance Programs. The information needs and priorities will relate to the clinical effectiveness and appropriateness of specified health services and treatments, and the health outcomes associated with such services and treatments. The needs and priorities also will address strategies for improving the efficiency and effectiveness of those health care programs. The Secretary is required to establish a process for developing research priorities. Not later than 6 months after the date of enactment, the Secretary must establish an initial list of priorities. The Secretary must complete the evaluation and synthesis of the scientific evidence related to that initial list within 18 months after development of such a list and disseminate the research findings to the public, prescription drug plans, and other plans. Not later than 18 months after the date of enactment, the Secretary is required to identify voluntary options that could be undertaken by public and private entities to improve information sharing regarding outcomes and quality of care, adopt innovative quality improvement strategies, develop management tools to improve oversight by state officials, support federal and state initiatives to improve the quality, safety, and efficiency of services, and provide a basis for estimating the fiscal and coverage impact of federal or state policy changes of the Medicare, Medicaid, and State Children's Health Insurance Programs. The Administrator for the Center for Medicare and Medicaid Services may not use data from the research conducted to withhold coverage of a prescription drug, to mandate a national standard, or require a specific approach to quality measurement and reporting.

Health Care that Works for All American-Citizens Health Care Working Group. (Section 1015 of the Conference Agreement, and Section 620 of the Senate Bill)

Present Law

No provision.

House Bill

No provision.

Senate Bill

The bill would authorize $3 million for each of the fiscal years 2005 and 2006 for the Secretary of HHS, acting through the Agency for Healthcare Research and Quality, to establish a group that would be called the "Citizens' Health Care Working Group." The 25 members of the group would come from health care stakeholders and would be appointed by Congressional leaders. Working Group member appointments could not be made from elected officials. Appointments would be for a 2-year period. Once all the members of the Working Group have been appointed, Congressional leaders would appoint a chairperson from among the members. The Working Group would be responsible for holding hearings and producing public reports regarding expanding coverage options, the cost of health care, innovative state and community strategies to expand coverage or reduce costs, and the role of evidence-based medicine and technology in improving quality and lowering costs. The first hearing would be required to be held within 90 days after the chairperson was appointed and additional hearings would be permitted. Within 90 days of completing hearings, the Working Group would be required to prepare a report that discusses numerous health care issues including health care and related services used by individuals throughout their lifetimes, the cost of health care services, sources of coverage and payment, and reasons for uninsurance and underinsurance.

In addition to hearings, the Working Group would be required to hold community meetings throughout the United States in sufficient number to reflect geographic differences, diverse populations, and a balance among urban and rural populations. The Working Group would be required to prepare an interim set of recommendations on health care coverage and ways to improve and strengthen the health care system based on the information and preferences expressed at the community meetings within 180 days after the conclusion of the community meetings. There would be a 90-day public comment period on the recommendations. Not later than 120 days after the end of the public comment period, the Working Group would be required to submit to Congress and the President a final set of recommendations. Not later than 45 days after receiving the final recommendations, the President would be required to submit a report to Congress with additional views and comments on the recommendations and recommendations for legislation and administrative actions. Each congressional committee of jurisdiction would be required to hold at least one hearing on the report and the final recommendations.

The Working Group would be staffed by an Executive Director appointed by the chairperson, up to 20 Federal Government employees on detail, and could procure temporary or intermittent services of individuals. The Working Group would be required to report to Congress annually a detailed description of the expenditures of the Working Group used to carry out its duties. The Working

Group would terminate when the report with the final recommendations is submitted to Congress, but not later than two years after the date on which Working Group members were appointed. The provision would be effective upon enactment.

Conference Agreement

The conference agreement authorizes $3 million for each of the fiscal years 2005 and 2006 for the Secretary of HHS, acting through the Agency for Healthcare Research and Quality, to establish a group called the "Citizens" Health Care Working Group." The working group will be composed of 15 members; one member will be the Secretary and the other 14 members will be appointed by the Comptroller General. Appointments will include certain consumers of heath services, and individuals with expertise in the health care industry. Appointment will not include elected officials. The duration of appointments will be for the life of the Working Group. Not later than 15 days after which all appointments have been made, the Comptroller General will designate a chairperson from the members. The Working Group will be responsible for holding hearings and producing public reports regarding expanding coverage options, the cost of health care, innovative state and community strategies to expand coverage or reduce costs, and the role of evidence-based medicine and technology in improving quality and lowering costs. The first hearing must be held within 90 days after designation of the chairperson, and additional hearings would be permitted as long as such hearings do not delay the Working Group's other activities. Within 90 days of completing hearings, the Working Group will prepare a report that discusses numerous health care issues including health care and related services used by individuals throughout their lifetimes, the cost of health care services, sources of coverage and payment, and reasons for uninsurance and underinsurance.

In addition to hearings, the Working Group will hold community meetings throughout the United States in sufficient number to reflect geographic differences, diverse populations, and a balance among urban and rural populations. The Working Group will prepare an interim set of recommendations on health care coverage, and ways to improve and strengthen the health care system based on the information and preferences expressed at the community meetings within 180 days after the conclusion of such meetings. There will be a 90-day public comment period on the recommendations.

Not later than 120 days after the end of the public comment period, the Working Group will submit to Congress and the President a final set of recommendations. Not later than 45 days after receiving the final recommendations, the President will submit a report to Congress with additional views and comments on the recommendations, and recommendations for legislative and administrative actions. Each congressional committee of jurisdiction will hold at least one hearing on the report and the final recommendations. .

The Working Group will be staffed by an Executive Director appointed by the chairperson, up to 20 Federal Government employees on detail, and could procure temporary or intermittent services of individuals. The Working Group will report annually to Congress a detailed description of the expenditures used by the Working Group to carry out its duties. The Working Group will terminate within 2 years after the date on which all members of the Working Group were appointed.

Establishment of Consumer Ombudsman Account. (Section 606 of the Senate Bill)

Present Law

The Omnibus Budget Reconciliation Act of 1990 established State Health Insurance Counseling Assistance grants to states to provide education and information to Medicare beneficiaries. Funding has been subject to annual appropriations.

House Bill

No provision.

Senate Bill

A Consumer Ombudsman Account would be established in the Medicare Trust Fund and $1 for every Medicare beneficiary would be appropriated to the account from the Trust Fund beginning with fiscal year 2005. The account would be used to make grants to State Health Insurance Counseling Programs. The provision would be effective upon enactment.

Conference Agreement

No provision.

Health Care Infrastructure Improvement. (Section 1016 of the Conference agreement and Section 608 of the Senate Bill)

Present Law

No provision.

House Bill

No provision.

Senate Bill

A loan program would be established to improve the cancer-related health care infrastructure in certain geographic areas of the United States. Examples of potentially eligible projects would include the construction, renovation, or other capital improvement of any hospital, medical research facility or other medical facility or the purchase of any equipment to be used in a hospital, research facility or other medical research facility. In order to receive assistance, the project applicant would be required to: (1) be engaged in research in the causes, prevention, and treatment of cancer; (2) be designated as a cancer center for the National Cancer Institute (NCI) or be designated by the state as the sole official comprehensive cancer effort for the state; and (3) be located in a state that on the date of enactment of this title has a population of less than 3 million individuals. $49 million in budget authority would be authorized for July 1, 2004 through FY2008 to carry out the loan program, $2 million of which may be used each year for administration of the program by the Secretary. Not later than 4 years after enactment, the Secretary would be required to submit to Congress a report summarizing the financial performance of the projects that have received assistance under this program, including recommendations on the future operation of the program. The provision would be effective upon enactment.

Conference Agreement

A loan program would be established to improve the cancer-related health care hospital infrastructure in the United States. Examples of potentially eligible projects would include the construction, renovation, or other capital improvement of any hospital. In order to receive assistance, the project applicant would be required to: (1) be engaged in research in the causes, prevention, and treatment of cancer; (2) be designated as a cancer center for the National Cancer Institute (NCI) or be designated by the state as the sole official comprehensive cancer effort for the state. $200 million in budget authority would be authorized for July 1, 2004 through FY2008 to carry out the loan program, $2 million of which may be used each year for administration of the program by the Secretary. Not later than 4 years after enactment, the Secretary would be required to submit to Congress a report summarizing the financial performance of the projects that have received assistance under this program, including recommendations on the future operation of the program. The provision would be effective upon enactment.

Capital Infrastructure Revolving Loan Program. (Section 609 of the Senate Bill)

Present Law

The Public Health Services Act establishes a fund in the Treasury from which the Secretary of HHS can make loans or loan guarantees in the amounts that have been specified in appropriations Acts from time to time. Under the Medicare Rural Hospital Flexibility Program established as part of Title XVIII, the Secretary may award grants to rural hospitals to cover the implementation costs associated with data systems needed to meet the BBA 97 requirements.

House Bill

No provision.

Senate Bill

The Secretary would be able to make loans to any rural entity to acquire land, renovate buildings, and purchase major moveable equipment or other appropriate projects. A rural entity would include rural health clinics, a medical facility with less than 50 beds in a county that is not part of a metropolitan statistical area or is in a rural census tract of such area, a hospital that is a rural referral center or a sole community hospital. An entity that has been geographically reclassified for the purposes of Medicare reimbursement would not be precluded from being considered a rural provider. Loan guarantees and interest subsidies of up to 3% of the net effective interest rate would be authorized. The total of the government's exposure with respect to this program would not exceed $50 million per year. The total of the principal amount of all loans directly made or guaranteed in any year may not exceed $250 million per year. In addition, rural providers could apply to receive $50,000 planning grants to help assess capital and infrastructure needs. The grants awarded in any year would not exceed $2.5 million. The program would expire after September 30, 2008. The provision would be effective upon enactment.

Conference Agreement

No provision.

Increase in Appropriation to the Health Care Fraud and Abuse Control Account. (Section 611 of the Senate Bill)

Present Law

The Health Insurance Portability and Accountability Act of 1996 (HIPAA, PL.104-91) established the Health Care Fraud and Abuse Control (HCFAC) Program which is administered by the HHS Office of Inspector General and the Department of Justice. Funds for the HCFAC program are appropriated from the Federal Hospital Insurance Trust Fund. HIPAA provided for annual increases of 15% in HCFAC funding through 2003, after which the appropriation for HCFAC and the amount earmarked for HHS-OIG remains the same. In FY2003 the available appropriation for HCFAC was $240,558,320 of which $150 million to $160 million was available to the HHS-OIG.

House Bill

No provision.

Senate Bill

Additional appropriations to HCFAC would be authorized. In FY2004, the increase would be $10 million over the FY2003 appropriation limit; in FY2005 the increase would be $15 million over the FY2003 limit; in FY2006 the increase would be $25 million above the FY2003 limit. Subsequent years appropriations would be at the 2003 limit. The HHS–OIG earmarked appropriations would increase as well: to $170 million in FY2004, $175 million in FY2005, $185 million in FY2006. In subsequent years, it would be not more than $150 million and not more than $160 million. The provision would be effective upon enactment.

Conference Agreement

No provision.

Increase in Civil Penalties Under the False Claims Act. (Section 612 of the Senate Bill)

Present Law

The False Claims Act imposes a liability on those who knowingly present or cause to be presented a false or fraudulent claim for payment by the government. In certain instances, the person may be liable for a civil penalty of not less than $5,000 and not more than $10,000, plus treble damages.

House Bill

No provision.

Senate Bill

For violations occurring on or after January 1, 2004, the minimum amount of the civil penalty would be increased from $5,000 to $7,500 and the maximum amount would increase from $10,000 to $15,000. The provision would be effective for violations occurring on or after January 1, 2004.

Conference Agreement

No provision.

Increase in Civil Monetary Penalties under the Social Security Act. (Section 613 of the Senate Bill)

Present Law

The Office of the Inspector General (OIG) has the authority to impose civil monetary penalties (CMPs) on any person (including an organization or other entity, but not a beneficiary) who knowingly presents, or causes to be presented, to a state or federal government employee or agent certain false or improper claims for medical or other items or services. CMPs may also be imposed for other fraudulent activities such as inflating charges for services, providing services when not a properly licensed physician, billing for medically unnecessary services, falsely certifying that an individual meets the requirements for home health services, and offering or soliciting remuneration to influence the provision of medical services. Depending upon the violation, Section 1128A of the SSA authorizes the imposition of CMPs up to $10,000 for each item or service involved, up to $15,000 for individuals who provide false or misleading information in certain instances, and up to $50,000 per act in other instances as well as treble damages.

House Bill

No provision.

Senate Bill

The amount of penalties would be increased for violations that occur on or after January 1, 2004. In instances where penalties are limited to $10,000 would be increased to $12,500; those penalties that are limited to $15,000 would be increased to $18,750; and those that are limited to $50,000 would be increased to $62,500. The provision would be effective for violations occurring on or after January 1, 2004.

Conference Agreement

No provision.

Extension of Customs User Fees. (Section 614 of the Senate Bill)

Present Law

The U.S. Customs Service, the federal government's oldest revenue collecting agency is responsible for regulating the movement of persons, carriers, merchandise, and commodities between the United States and other countries. Its authority to impose user fees for certain services lapsed on September 30, 2003, but was subsequently restored.

House Bill

No provision.

Senate Bill

The authority to impose user fees would be extended until September 30, 2013.

Conference Agreement

No provision.

Provision of Information on Advance Directives. (Section 616 of the Senate Bill)

Present Law

Information about advance directives is required to be given to patients in hospitals, skilled nursing facilities, and served by home health agencies. The Secretary is required to provide Medicare beneficiaries annual information about Medicare benefits, limitations on payment, and a description of the limited benefits for long-term care. This information is provided to Medicare beneficiaries in the Medicare & You handbook that is mailed annually to all beneficiaries.

House Bill

No provision.

Senate Bill

The Secretary would be required to provide information on advance directives in the Medicare & You handbook. The information would be required to be presented in a separate Senate section on advance directives and would include specific information about living wills and durable power of attorney for health care. The Secretary would further be required to note the inclusion of this information in the introductory letter that accompanies the handbook. The provision would be effective upon enactment.

Conference Agreement

No provision.

Sense of the Senate Regarding Implementation of the Prescription Drug and Medicare Improvement Act of 2003. (Section 617 of the Senate Bill)

Present Law

No provision.

House Bill

No provision.

Senate Bill

The provision expresses a sense of the Senate that the Committee on Finance should hold at least four hearings to monitor implementation of the Prescription Drug and Medicare Improvement Act of 2003. The first hearing should be held within 60 days after enactment of the Act, the remaining hearings should be held May 2004, October 2004, and May 2005. The provision would be effective upon enactment.

Conference Agreement

No provision.

Extension of Municipal Health Service Demonstration Projects. (Section 618 of the Senate Bill)

Present Law

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, the Municipal Health Service Demonstration projects will expire on December 31, 2004. The municipal health services demonstration program is a multi-site demonstration intended to improve access to primary care services in underserved urban areas and to reduce the cost of health care. BBA 1997 authorized the Secretary to extend the project through December 31, 2000, but only with respect to persons who had received at least one service for the period of January 1, 1996–August 7, 1997 (the enactment date of BBA 97). Sites who wanted the demonstration project extended were required to submit plans for the orderly transition of participants to a non-demonstration health care delivery system. Subsequent legislation extended the project through December 31, 2004.

House Bill

No provision.

Senate Bill

This provision would extend these demonstration projects to December 31, 2009, for individuals who reside in the city in which the project is operated. The provision would be effective upon enactment.

Conference Agreement

No provision.

Study on Making Prescription Pharmaceutical Information Accessible for Blind and Visually Impaired Individuals. (Section 619 of the Senate Bill)

Present Law

No provision.

House Bill

No provision.

Senate Bill

The Secretary would be required to study how to make prescription drug information, including drug labels and usage instructions, accessible to blind and visually impaired individuals. The study would be required to include a review of existing and emerging technologies. A report would be required within 18 months of enactment and would include recommendations for implementing usable formats and an estimate of the associated costs. The provision would be effective upon enactment.

Conference Agreement

No provision.

GAO Study of Pharmaceutical Price Controls and Patient Protections in the G–7 Countries. (Section 621/Duplicative Provision 634 of the Senate Bill)

Present Law

No provision.

House Bill

No provision.

Senate Bill

The GAO would be required to study price controls on pharmaceuticals in France, Germany, Italy, Japan, the United Kingdom, and Canada to review the impact they have on consumers, including American consumers, and on innovation in medicine. The provision would be effective upon enactment.

Conference Agreement

No provision.

Safety Net Organizations and Patient Advisory Commission. (Section 624/Duplicative Provision 635 of the Senate Bill)

Present Law

No provision.

House Bill

No provision.

Senate Bill

The provision would establish the Safety Net Organizations and Patient Advisory

Commission that would conduct an ongoing review of the health care safety net programs including Medicaid, the State Children's Health Insurance Program (SCHIP), Maternal and Child Health Services Block Grant Programs, Federally qualified health center (FQHC) programs, rural health clinic (RHC) programs, disproportionate share hospital (DSH) payment programs, and the Emergency Medical Treatment and Active Labor Act (EMTALA). The Commission would review a variety of issues and data related to the safety net programs.

The Commission would be required to submit annual reports to the appropriate committees of Congress on the health care needs of the uninsured and the financial and infrastructure stability of the Nation's core health care safety net. The first report would be due June, 2005. Additional reports could be made if requested by the chairpersons or ranking minority members of appropriate committees of Congress or if the Commission deems such additional reviews and reports appropriate.

The Commission would have 13 members appointed by the Comptroller General of the United States in consultation with the appropriate committees of Congress. Members would be drawn from health professionals, employers, third-party payers, researchers, recipients of care from core health care safety net and individuals who provide and manage the delivery of care by the core health care safety net. The term of the members would be 3 years, although the initial appointments would be on a staggered basis. The Comptroller General would be required to establish a system for public disclosure of financial and other potential conflicts of interest by members of the Commission. The Commission could hire an executive director and other personnel without regard to the provisions of Title V of the United States Code. The Comptroller General would be required to appoint the initial members of the Commission by June 1, 2004.

Conference Agreement

No provision.

Committee on Drug Compounding. (Section 626 of the Senate Bill)

Present Law

No provision.

House Bill

No provision.

Senate Bill

The Secretary would be required to establish a committee on drug compounding within the Food and Drug Administration to ensure that patients are receiving necessary, safe, and accurate dosages of compounded drugs. The members of the committee would be appointed by the Secretary and would include representatives from the National Association of Boards of Pharmacy; pharmacy groups; physician groups; consumer and patient advocate groups; the United States Pharmacopoeia; and other individuals determined appropriate by the Secretary. The Committee would be required to submit a report with recommendations of the Committee to improve and protect patient safety within 1 year of enactment. The Committee would terminate 1 year after enactment.

Conference Agreement

No provision.

Sense of the Senate Concerning the Structure of Medicare Reform and the Prescription Drug Benefit. (Section 627 of the Senate Bill)

Present Law

No provision.

House Bill

No provision.

Senate Bill

The provision provides a sense of the Senate that Medicare reform legislation should achieve certain principles.

Conference Agreement

No provision.

Sense of the Senate Regarding the Establishment of a Nationwide Permanent Lifestyle Modification Program for Medicare Beneficiaries. (Section 628 of the Senate Bill)

Present Law

No provision.

House Bill

No provision.

Senate Bill

The provision provides a sense of the Senate that coronary disease is expensive, the Medicare Lifestyle Modification Program has been operating in 12 states as a demonstration program, and such program of behavior modification should be conducted on a national basis for those beneficiaries who elect to participate. The provision would be effective upon enactment.

Conference Agreement

No provision.

TITLE XI—ACCESS TO AFFORDABLE PHARMACEUTICALS

Current Law

Section 804 of the Federal Food, Drug, and Cosmetic Act—Importation of Covered Products—was established under the medicine Equity and Drug Safety Act of 2000 (P.L. 106-387). This section of current law has not been implemented.

House Bill

Section 1121(a) of H.R. 1 would replace the existing Section 804 entirely. The House bill directs the Secretary to establish, upon certification of safety and cost savings, a program that would allow for the importation of drugs from Canada by pharmacists, wholesalers, and individuals. The House bill incorporates new safety measures such as: (1) the use of tamper-resistant and counterfeit-proof packaging; (2) a new requirement that drugs must contain a statement informing the consumer that the drug has left the country; (3) any drug may only be shipped back to the country by the first Canadian recipient; (4) new authority to the Secretary of HHS to limit importation to certain ports of entry; (5) the importer would be required to keep detailed records and to conduct drug testing; and (6) a manufacturer must provide the importer with approved labeling of the drug. This provision applies to prescription drugs as subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act other than a controlled substance, a biological product, an infused drug, an intravenously injected drug, a drug that is inhaled during surgery, or a parenteral drug that the Secretary determines poses a threat to the public health.

Senate Bill

Section 801(a) of S. 1 would replace the existing Section 804 entirely. The Senate bill directs the Secretary to establish, upon certification of safety and cost savings, a program that would allow for the importation of drugs from Canada by pharmacists, wholesalers, and individuals. The Senate bill incorporates new safety provisions as well as provides new authority to the Secretary of HHS to suspend the program if public safety is compromised. Specifically, between 12 and 18 months after the regulations are implemented, if the Secretary certifies to Congress that, based on substantial evidence, the benefits of the implementation of the importation program do not outweigh any detriment, drug imports under this section would cease 30 days after the certification is submitted. However, the certification may not be submitted unless, after a public hearing, the Secretary finds it is more likely than not that implementation will result in an increased risk to the public health. This provision applies to prescription drugs as subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act other than a controlled substance, a biological product, an infused drug, an intravenously injected drug, or a drug that is inhaled during surgery that the Secretary determines poses a threat to the public health.

Conference Agreement

The Conference agreement, virtually identical to Section 801(a) of S. 1, gives the Secretary, upon certification of safety and cost savings, authority to create a system for the importation of drugs from Canada by pharmacists, wholesalers, and individuals.

The agreement directs the Secretary of HHS, in consultation with appropriate government agencies, to conduct a comprehensive study that identifies current problems with the implementation of existing law as well as examines a range of issues associated with the importation of drugs. In conducting the study, the Secretary shall take into account the distinctions between—

Drugs that are biological products with licenses under section 351 of the Public Health Service Act; and

Drugs with approved applications under subsection (b) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act.

The details of the study shall include the following:

Identification of the limitations, including limitations in resources and, if applicable, in current law authorities that may inhibit the Secretary's ability to certify the safety of pharmaceutical products imported into the US.

Assessment of the pharmaceutical distribution chain and the need for, and feasibility of, modifications, in order to assure the safety of products that may be imported into the US.

Analysis of whether anti-counterfeiting technologies could improve the safety of products in the domestic market as well as those products that could be imported from foreign nations. This analysis shall identify the types of technologies, if available, and assess the limitations of these technologies to the distribution chain.

Estimate of costs borne by entities within the pharmaceutical distribution chain to utilize any new technologies identified in paragraph (3).

Assess the scope, volume, and safety of unapproved drugs, including controlled substances, entering the United States via mail shipment. This assessment should include the percentage of drugs commercially available in other countries that conform in all respects to FDA requirements, and the limitations of visual inspection, sampling, and other testing methods to determine its quality.

The extent to which foreign health agencies are willing and/or able to ensure the safety of drugs being exported from their country into the United States, including drugs that are transshipped through their countries.

Assessment of the potential short and long-term impacts on drug prices and prices for consumers and other system costs associated with importation of pharmaceuticals from Canada and other countries into the U.S.

Assessment of the impact on the research and development of drugs—and the associated impact on consumers and patients—if importation were permitted.

Estimation of agency resources, including additional field personnel, needed to adequately inspect the current amount of pharmaceutical products entering into the country. This estimate shall detail the number of field personnel needed in order to appropriately secure all ports of entry on a daily basis.

Identification of liability protections, if any, that should be in place, if importation is permitted, for entities within the pharmaceutical distribution chain.

Identify the ways in which importation could violate United States and international intellectual property rights and describe the additional legal protections and agency resources that would be needed to assure the effective enforcement of these rights.

The Conference agreement directs the Secretary to submit a report providing the findings of the study under this section to the appropriate committees of Congress no later than 12 months after the date of enactment of this Act.

Report on Trade in Pharmaceuticals

The Conference agreement directs the Secretary of Commerce, in consultation with the International Trade Commission, the Secretary of Health and Human Services and the United States Trade Representative, to conduct a study and report on drug pricing practices of countries that are members of the Organization for Economic Cooperation and Development and whether those practices utilize nontariff barriers with respect to trade in pharmaceuticals. The study shall include an analysis of the use of price controls, reference pricing, and other actions that affect the market access of United States pharmaceutical products.

The study shall include the following:

Identification of the countries that use price controls or other such practices with respect to pharmaceutical trade.

Assessment of the price controls and other such practices used by the countries identified.

Estimate of additional costs to U.S. consumers because of such price controls and other such practices, and the extent to which additional costs would be reduced for U.S. consumers if price controls and other such practices are reduced or eliminated.

Estimate of the impact such price controls, intellectual property laws, and other such measures have on fair pricing, innovation, generic competition, and research and development in the United States and each country identified.

Not later than 9 months after the date of enactment of this Act, the report shall be submitted to the Committees on Finance, the Judiciary, and Health, Education, Labor, and Pensions of the Senate, and the Committees on Ways and Means, the Judiciary, and Energy and Commerce of the House of Representatives.

In addition, the United States Trade Representative, the Secretary of Commerce, and the Secretary of Health and Human Services shall analyze whether bilateral or multilateral trade or other negotiations present an opportunity to address these price controls and other such practices and shall develop a strategy to address such issues in appropriate negotiations. In so doing, these agencies shall bear in mind the negotiating objective set forth in the Bipartisan Trade Promotion Authority Act of 2002 to achieve the elimination of government measures such as price controls and reference pricing which deny full market access for United States products. In so doing, the agencies shall provide periodic and timely briefings for the Committees of the House and Senate listed above, with an interim briefing no later than 90 days after enactment to address negotiations to establish a U.S.-Australia Free Trade Agreement and, as appropriate, other current negotiations.

Provisions Related to Hatch-Waxman Law

AMENDMENTS AND SUPPLEMENTS

In including this provision, Congress does not intend this provision to alter current U.S. Food and Drug Administration's ("FDA") practice regarding acceptance of supplements to approved new drug applications ("NDAs"), or amendments and supplements to pending and approved abbreviated new drug applications ("ANDAs"). Instead, Congress intends this provision to reflect the FDA's current practice regarding those changes and variations to both innovator and generic drugs that may be approved under amendments and supplements to previously filed NDAs and ANDAs, and expects the Agency to maintain its current policy in designating "listed drugs." The conferees intend that FDA continue to use its existing scientific discretion to determine whether different polymorphs present safety, effectiveness, or bioavailability differences and therefore should be considered the same or different active ingredients.

The single 30-month stay provisions are a centerpiece of this legislation, allowing lower-priced generic products to enter the market more quickly. As a result, this provision must not be construed as requiring an ANDA applicant to file a new application where, before its enactment, the applicant would have been allowed to file an amendment or supplement to an existing application. Such a construction would run directly contrary to Congress' intent.

DECLARATORY JUDGMENTS

The conferees expect that courts will find jurisdiction, where appropriate, to prevent an improper effort to delay infringement litigation between generic drug manufacturers and pioneer drug companies. The conferees expect courts to apply the "reasonable apprehension" test in a manner that provides generic drug manufacturers appropriate access to declaratory judgment relief to the extent required by Article III.

Through the modifications in this Act, the conferees do not intend for the courts to modify their application of the requirements under Article III that a declaratory judgment plaintiff must, to the extent required by the Constitution, demonstrate a "reasonable apprehension" of suit to establish jurisdiction. See, e.g., *Fina Oil and Chemical Co.* v. *Ewen, 123 F.3d 1466, 1471* (Fed. Cir. 1997). The conferees expect the courts to examine as part of their analysis the particular policies served by the Hatch-Waxman Act.

In determining whether a reasonable apprehension of suit exists where an ANDA has been filed with a paragraph IV certification and the patentee has not brought an infringement suit within the 45 days, the conferees expect courts to examine these specific factors as part of the totality of the circumstances. See, e.g., *Vanguard Research, Inc.* v. *Peat, Inc., 304 F.3d 1249, 1254* (Fed. Cir. 2002). In any given case, the conferees expect a court may or may not find a reasonable apprehension of suit where these two specific factors are present.

Counterclaims

Section 1101 of the Conference agreement prohibits the recovery of damages resulting from a successful counterclaim in a paragraph IV patent suit by an ANDA applicant seeking removal of a patent listed in the Orange Book. It is not the intent of Congress to prohibit the recovery by a counterclaimant in a paragraph IV suit of anti-trust or any other damages as a result of the improper listing of a patent in the Orange Book. The language found in this section simply means that in the absence of any other cause of action, a ruling in favor of the counterclaimant resulting in the removal of the patent does not entitle the counterclaimant to recover damages.

TITLE XII.—HEALTH SAVINGS INCENTIVES

Health Savings Accounts and Health Savings Security Accounts (sec. 1202 of the House bill and new sec. 223 of the Code)

Present Law

OVERVIEW

Present law contains a number of provisions dealing with the Federal tax treatment of health expenses and health insurance coverage.

EMPLOYER-PROVIDED HEALTH COVERAGE

In general, employer contributions to an accident or health plan are excludable from an employee's gross income (and wages for employment tax purposes).[1] This exclusion generally applies to coverage provided to employees (including former employees) and their spouses, dependents, and survivors. Benefits paid under employer-provided accident or health plans are also generally excludable from income to the extent they are reimbursements for medical care.[2] If certain requirements are satisfied, employer-provided accident or health coverage offered under a cafeteria plan is also excludable from an employee's gross income and wages.[3] Present law provides for two general employer-provided arrangements that can be used to pay for or reimburse medical expenses of employees on a tax-favored basis: flexible spending arrangements ("FSAs") and health reimbursement arrangements ("HRAs"). While these arrangements provide similar tax benefits (i.e., the amounts paid under the arrangements for medical care are excludable from gross income and wages for employment tax purposes), they are subject to different rules. A main distinguishing feature between the two arrangements is that while FSAs are generally part of a cafeteria plan and contributions to FSAs are made on a salary reduction basis, HRAs cannot be part of a cafeteria plan and contributions cannot be made on a salary-reduction basis.[4]

Amounts paid or accrued by an employer within a taxable year for a sickness, accident, hospitalization, medical expense, or similar health plan for its employees are generally deductible as ordinary and necessary business expenses.[5]

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[1] Secs. 106, 3121(a)(2), and 3306(b)(2). All "section," "sec.," and "Code" references are to the Internal Revenue Code of 1986, as amended.

[2] Sec. 105. In the case of a self-insured medical reimbursement arrangement, the exclusion applies to highly compensated employees only if certain nondiscrimination rules are satisfied. Sec. 105(h). Medical care is defined as under section 213(d) and generally includes amounts paid for qualified long-term care insurance and services.

[3] Secs. 125, 3121(a)(5)(G), and 3306(b)(5)(G). Long-term care insurance and services may not be provided through a cafeteria plan.

[4] Notice 2002-45, 2002-28 I.R.B. 93 (July 15, 2002); Rev. Rul. 2002-41, 2002-28 I.R.B. 75 (July 15, 2002).

SELF-EMPLOYED INDIVIDUALS

The exclusion for employer-provided health coverage does not apply to self-employed individuals. However, under present law, self-employed individuals (i.e., sole proprietors or partners in a partnership)[6] are entitled to deduct 100 percent of the amount paid for health insurance for themselves and their spouse and dependents.[7]

ITEMIZED DEDUCTION FOR MEDICAL EXPENSES

Under present law, individuals who itemize deductions may deduct amounts paid during the taxable year (to the extent not reimbursed by insurance or otherwise) for medical care of the taxpayer, the taxpayer's spouse, and dependents, to the extent that the total of such expenses exceeds 7.5 percent of the taxpayer's adjusted gross income.[8]

ARCHER MEDICAL SAVINGS ACCOUNTS

In general

In general, an Archer medical savings account ("MSA") is a tax-exempt trust or custodial account created exclusively for the benefit of the account holder that is subject to rules similar to those applicable to individual retirement arrangements.[9]

Within limits, contributions to an Archer MSA are deductible in determining adjusted gross income if made by an eligible individual and are excludable from gross income and wages for employment tax purposes if made by the employer of an eligible individual. Earnings on amounts in an Archer MSA are not includible in gross income in the year earned (i.e., inside buildup is not taxable). Distributions from an Archer MSA for qualified medical expenses are not includible in gross income. Distributions not used for qualified medical expenses are includible in gross income and subject to an additional 15-percent tax unless the distribution is made after death, disability, or the individual attains the age of Medicare eligibility (i.e., age 65).

Qualified medical expenses are generally defined as under section 213(d), except that qualified medical expenses do not include expenses for health insurance other than long-term care insurance, premiums for health coverage during any period of continuation coverage required by Federal law, and premiums for health care coverage while an individual is receiving unemployment compensation under Federal or State law. For purposes of determining the itemized deduction for medical expenses, distributions from an Archer MSA for qualified medical expenses are not treated as expenses paid for medical care under section 213.

ELIGIBLE INDIVIDUALS

Archer MSAs are available only to employees of a small employer who are covered under an employer-sponsored high deductible health plan and to self-employed individuals covered under a high deductible health plan.[10] An employer is a small employer if it employed, on average, no more than 50 employees on business days during either of the two preceding calendar years. An individual is not eligible for an Archer MSA if he or she is covered under any other health plan that is not a high deductible health plan (other than a plan providing certain limited types of coverage). Individuals entitled to benefits under Medicare are not eligible individuals. Eligible individuals do not include individuals who may be claimed as a dependent on another person's tax return.

TREATMENT OF CONTRIBUTIONS

Individual contributions to an Archer MSA are deductible (within limits) in determining adjusted gross income (i.e., "above-the-line"). In addition, employer contributions are excludable from gross income and wages for employment tax purposes (within the same limits), except that this exclusion does not apply to contributions made through a cafeteria plan. In the case of an employee, contributions can be made to an Archer MSA either by the individual or by the individual's employer, but not by both.

The maximum annual contribution that can be made to an Archer MSA for a year is 65 percent of the annual deductible under the high deductible health plan in the case of self-only coverage and 75 percent of the annual deductible in the case of family coverage.

If an employer provides a high deductible health plan coupled with Archer MSAs for employees and makes employer contributions to the Archer MSAs, the employer must make available a comparable contribution on behalf of all employees with comparable coverage during the same period. Contributions are considered comparable if they are either of the same amount or the same percentage of the deductible under the high deductible health plan. If employer contributions do not satisfy the comparability rule during a period, then the employer is subject to an excise tax equal to 35 percent of the aggregate amount contributed by the employer to Archer MSAs of the employer for that period.

DEFINITION OF HIGH DEDUCTIBLE HEALTH PLAN

A high deductible health plan is a health plan with an annual deductible of at least $1,700 and no more than $2,500 in the case of self-only coverage and at least $3,350 and no more than $5,050 in the case of family coverage. In addition, the maximum out-of-pocket expenses with respect to allowed costs must be no more than $3,350 in the case of self-only coverage and no more than $6,150 in the case of family coverage.[11] Out-of-pocket expenses include deductibles, co-payments, and other amounts (other than premiums) that the individual must pay for covered benefits under the plan. A plan does not fail to qualify as a high deductible health plan merely because it does not have a deductible for preventive care as required under State law. A plan does not qualify as a high deductible health plan if substantially all of the coverage under the plan is certain permitted insurance or is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

TREATMENT OF DEATH OF ACCOUNT HOLDER

Upon death, any balance remaining in the decedent's Archer MSA is includible in his or her gross estate. If the account holder's surviving spouse is the named beneficiary of the Archer MSA, then, after the death of the account holder, the Archer MSA becomes the Archer MSA of the surviving spouse and the amount of the Archer MSA balance may be deducted in computing the decedent's taxable estate, pursuant to the estate tax marital deduction.[12] If, upon the account holder's death, the Archer MSA passes to a named beneficiary other than the decedent's surviving spouse, the Archer MSA ceases to be an Archer MSA as of the date of the decedent's death, and the beneficiary is required to include the fair market value of the Archer MSA assets as of the date of death in gross income for the taxable year that includes the date of death. The amount includible in gross income is reduced by the amount in the Archer MSA used, within one year after death, to pay qualified medical expenses incurred prior to the death. If there is no named beneficiary for the decedent's Archer MSA, the Archer MSA ceases to be an Archer MSA as of the date of death, and the fair market value of the assets in the Archer MSA as of such date is includible in the decedent's gross income for the year of the death.

LIMIT ON NUMBER OF MSAS; TERMINATION OF MSA AVAILABILITY

The number of taxpayers benefiting annually from an Archer MSA contribution is limited to a threshold level (generally 750,000 taxpayers). The number of Archer MSAs established has not exceeded the threshold level.

After 2003, no new contributions can be made to Archer MSAs except by or on behalf of individuals who previously had Archer MSA contributions and employees who are employed by a participating employer.

House Bill

In general

The House bill creates health savings accounts ("HSAs") and health savings security accounts ("HSSAs"), which provide tax-favored treatment for current medical expenses as well as the ability to save on a tax-favored basis for future medical expenses. In general, HSAs and HSSAs are tax-exempt trusts or custodial accounts created exclusively to pay for the qualified medical expenses of the account holder and his or her spouse and dependents that are subject to rules similar to those applicable to individual retirement arrangements.[13] Unless otherwise provided, the following description applies to both HSAs and HSSAs (jointly referred to as "health accounts").

Within limits, contributions to health accounts are deductible if made by an eligible individual and are excludable from gross income and wages for employment tax purposes if made by the employer of an eligible individual. In the case of HSSAs only, family members may make nondeductible contributions on behalf of an eligible individual. Distributions from health accounts for qualified medical expenses are not includible in gross income. Distributions that are not for qualified medical expenses are includible in gross income and subject to an additional 15 percent tax. The additional 15 percent tax does not apply after death, disability, or the individual attains the age of Medicare eligibility (i.e., age 65).

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[5] Sec. 162.

[6] Self-employed individuals include more than two-percent shareholders of S. corporations who are treated as partners for purposes of fringe benefit rules pursuant to section 1372.

[7] Sec. 162(1).

[8] Sec. 213. The adjusted gross income percentage is 10 percent for purposes of the alternative minimum tax. Sec. 56(b)(1)(B).

[9] Sec. 220.

[10] Self-employed individuals include more than two-percent sharholders of S corporations who are treated as partners for purposes of fringe benefit rules pursuant to section 1372.

[11] The deductible and out-of-pocket expenses dollar amounts are for 2003. These amounts are indexed for inflation in 450 increments.

[12] Sec. 2056.

[13] As under Archer MSAs, the House bill provision provides that the present-law requirement applicable to insurance companies that certain policy acquisition expenses must be capitalized and amortized (sec. 848) does not apply in the case of any contract that is a health account.

Eligible individuals

HSAS

Eligible individuals for HSAs are individuals who are covered by a high deductible health plan and no other health plan that is not a high deductible health plan. Individuals entitled to benefits under Medicare are not eligible to make contributions to an HSA. Eligible individuals do not include individuals who may be claimed as a dependent on another person's tax return.

An individual with other coverage in addition to a high deductible health plan is still eligible for an HSA if such other coverage is certain permitted insurance or permitted coverage. Permitted insurance is: (1) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker's compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (e.g., auto insurance), or (d) such other similar liabilities as the Secretary may prescribe by regulations; (2) insurance for a specified disease or illness; and (3) insurance that provides a fixed payment for hospitalization. Permitted coverage is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

A high deductible health plan is a health plan that in the case of self-only coverage has an annual deductible between $1,000 and $2,500 and in the case of family coverage has an annual deductible between $2,000 and $5,050 (for 2003).[14] The maximum out-of-pocket expenses must be no more than $3,350 in the case of self-only coverage and no more than $6,150 in the case of family coverage. The annual deductible maximum and minimum and out-of-pocket expense amounts are indexed for inflation. A plan is not a high deductible health plan if substantially all of the coverage is for permitted coverage or coverage that may be provided by permitted insurance, as described above.

HSSAS

Individuals eligible for HSSAs are individuals who (1) are covered under a health plan meeting minimum deductible requirements and no other health plan that does not meet the minimum deductible requirements, or (2) are uninsured. Individuals entitled to benefits under Medicare are not eligible to make contributions to an HSSA. Eligible individuals do not include individuals who may be claimed as a dependent on another person's tax return.

An individual with other coverage in addition to a plan meeting the minimum deductible requirements is still eligible for an HSSA if such other coverage is for permitted coverage or coverage that may be provided by permitted insurance, as described above. In addition, an individual is treated as uninsured if his or her only coverage is permitted coverage or coverage that may be provided by permitted insurance.

A plan meets the minimum deductible requirements if the plan is a health plan with an annual deductible of at least $500 in the case of self-only coverage and at least $1,000 in the case of family coverage. These dollar amounts are indexed for inflation. There are no maximum deductible requirements and no limits on out-of-pocket expenses. A plan is not a minimum deductible plan if substantially all of the coverage is for permitted coverage or coverage that may be provided by permitted insurance, as described above.

TAX TREATMENT OF AND LIMITS ON CONTRIBUTIONS

Contributions to a health account made by an eligible individual are deductible (within limits) in determining adjusted gross income (i.e., "above-the-line"). In addition, employer contributions to a health account (including salary reduction contributions made through a cafeteria plan) are excludable from gross income and wages for employment tax purposes to the extent the contribution would be deductible if made by the employee (e.g., in the case of an HSSA, subject to the adjusted gross income limits).[15] Nondeductible contributions may be made to an HSSA by a family member of an eligible individual. In the case of an employee, contributions to a health account may be made by both the individual (and family members in the case of an HSSA) and the individual's employer. All contributions are aggregated for purposes of the maximum annual contribution limit.

The maximum aggregate annual contribution that can be made to an HSA is 100 percent of the annual deductible under the high deductible plan.[16]

The maximum aggregate annual contribution that can be made to an HSSA is (1) $2,000 for (a) persons with self-only coverage and (b) uninsured individuals with no dependents[17] who do not file a joint return, and (2) $4,000 for (a) individuals with family coverage and (b) uninsured individuals with dependents or who file a joint return. In the case of individuals age 55 and older, the $2,000 and $4,000 HSSA annual contribution limits are increased by $500 in 2004, $600 in 2005, $700 in 2006, $800 in 2007, $900 in 2008, and $1,000 in 2009 and thereafter.

The maximum allowable contribution to an HSSA is phased out for taxpayers with adjusted gross income[18] above certain levels. In the case of individuals with self-only coverage (other than individuals filing a joint return), the phase-out range is $75,000 to $85,000. For individuals with family coverage and individuals filing a joint return, the phase-out range is $150,000 to $170,000. The adjusted gross income limits apply to HSSA contributions from all sources (e.g., both individual and employer contributions).

The maximum annual contribution limits for the health accounts are coordinated so that contributions to one type of health account reduce the annual contribution limit for the other type of health account.[19]

An excise tax applies to contributions in excess of the maximum contribution amount for the health account. The excise tax is generally equal to six percent of the cumulative amount of excess contributions that are not distributed from the health account to the contributor.[20]

Amounts can be rolled over into a health account from an Archer MSA or a health FSA on a tax-free basis. Amounts can be rolled over into an HSA from another HSA or HSSA and into an HSSA from another HSSA on a tax-free basis. Rollovers from an HSA into an HSSA are not permitted. Amounts transferred from another health account or Archer MSA are not taken into account under the annual contribution limits.

If an employer makes contributions to employees' health accounts, the employer must make available comparable contributions on behalf of all employees with comparable coverage during the same period. Contributions are considered comparable if they are either of the same amount or the same percentage of the deductible under the plan. The comparability rule is applied separately to part-time employees (i.e., employees who are customarily employed for fewer than 30 hours per week). The comparability rule does not apply to amounts transferred from an employee's health account, health FSA, or Archer MSA or to contributions made through a cafeteria plan.

If employer contributions do not satisfy the comparability rule during a period, then the employer is subject to an excise tax equal to 35 percent of the aggregate amount contributed by the employer to health accounts of the employer for that period. The excise tax is designed as a proxy for the denial of the deduction for employer contributions. In the case of a failure to comply with the comparability rule which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed to the extent that the payment of the tax would be excessive relative to the failure involved. For purposes of the comparability rule, employers under common control are aggregated.

TAXATION OF DISTRIBUTIONS

Distributions from a health account for qualified medical expenses of the individual and his or her spouse or dependents generally are excludable from gross income. In general, amounts in a health account can be used for qualified medical expenses even if the individual is not currently eligible for contributions to the health account.[21]

Qualified medical expenses generally are defined as under section 213(d) and include expenses for diagnosis, cure, mitigation, treatment, or prevention of disease, including prescription drugs, transportation primarily for and essential to such care, and qualified long-term care expenses. Qualified medical expenses do not include expenses for insurance other than for (1) long-term care insurance, (2) premiums for health coverage during any period of continuation coverage required by Federal law, and (3) premiums for health care coverage while an individual is receiving unemployment compensation under Federal or State law. In the case of HSSAs, qualified medical expenses also include (1) health insurance meeting the minimum deductible requirements if no portion of the cost of the insurance is paid by the employer or former employer of the individual or the individual's spouse,[22] and (2) health insurance for individuals who are older than age 65 (including Medicare expenses). For purposes of determining the itemized deduction for medical expenses, distributions from a health account for qualified medical expenses are not treated as expenses paid for medical care under section 213.

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[14] Special rules apply for determining whether a health plan that is a preferred provider organization plan meets the requirements of a high deductible plan.

[15] Employer contributions to a health account are excludable from wages for employment tax purposes if, at the time of payment, it is reasonable to believe that the employee will be able to exclude such payment from income (e.g., a reasonable basisis to believe that the employee's income is within the applicabale adjusted gross income limits for an HSSA).

[16] The annual contribution limit for a health account is the sum of the limits determined separately for each month, based on the individual's status and health plan coverage as of the first day of the month.

[17] Written declarations releasing a claim to a dependency exemption under section 152(e)(2) are disregarded in determining whether an individual has dependents.

[18] Adjusted gross income is defined generally as under the rules relating to individual retirement arrangements ("IRAs"), and is computed after the deduction for contributions to IRAs and before the deductions provided by the provision.

[19] The contribution limits are also coordinated with contributions to Archer MSAs.

[20] Ordering rules apply to determine the nature of any distributed excess contributions (e.g., nondeductible family contributions in the case of an HSSA or employer contributions).

[21] However, in any year for which a contribution is made to an HSA, withdrawals from the HSA maintained by that individual generally are excludable from income only if the individual for whom the expenses were incurred was covered under a high deductible plan for the month in which the expenses were incurred. The rule does not apply for continuation coverage or coverage while the individual is receiving unemployment compensation even if for an individual who is not an eligible individual.

Distributions from a health account that are not for qualified medical expenses are includible in gross income (except to the extent that the distribution is attributable to a return of nondeductible family contributions in the case of an HSSA).[23] Distributions includible in gross income are also subject to an additional 15-percent tax unless made after death, disability, or the individual attains the age of Medicare eligibility (i.e., age 65).

TAX TREATMENT OF HSAS AND HSSAS AFTER DEATH

Upon death, any balance remaining in the decedent's health account is includible in his or her gross estate.

If the health account holder's surviving spouse is the named beneficiary of the health account, then, after the death of the health account holder, the health account becomes the health account of the surviving spouse and the amount of the health account balance may be deducted in computing the decedent's taxable estate, pursuant to the estate tax marital deduction.[24] The surviving spouse is not required to include any amount in gross income as a result of the death; the general rules applicable to the health account apply to the surviving spouse's health account (e.g., the surviving spouse is subject to income tax only on distributions from the health account for nonqualified expenses). The surviving spouse can exclude from gross income amounts withdrawn from the health account for expenses incurred by the decedent prior to death, to the extent they otherwise are qualified medical expenses.

If, upon death, the health account passes to a named beneficiary other than the decedent's surviving spouse, the health account ceases to be a health account as of the date of the decedent's death, and the beneficiary is required to include the fair market value of health account assets as of the date of death in gross income for the taxable year that includes the date of death. The amount includible in income is reduced by the amount in the health account used, within one year after death, to pay qualified medical expenses incurred by the decedent prior to the death. As is the case with other health account distributions, whether the expenses are qualified medical expenses is determined as of the time the expenses were incurred. In computing taxable income, the beneficiary may claim a deduction for that portion of the Federal estate tax on the decedent's estate that was attributable to the amount of the health account balance.[25]

If there is no named beneficiary of the decedent's health account, the health account ceases to be a health account as of the date of death, and the fair market value of the assets in the health account as of such date is includible in the decedent's gross income for the year of the death.

This rule applies in all cases in which there is no named beneficiary, even if the surviving spouse ultimately obtains the right to the health account assets (e.g., if the surviving spouse is the sole beneficiary of the decedent's estate).

REPORTING REQUIREMENTS

Employer contributions are required to be reported on the employee's Form W-2. Trustees of health accounts may be required to report to the Secretary of the Treasury amounts with respect to contributions, distributions, and other matters as determined appropriate by the Secretary. In addition, providers of health insurance are required to report information as may be prescribed by the Secretary.

Effective date.—The House bill provision is effective for taxable years beginning after December 31, 2003.

Senate Amendment

No provision.

Conference Agreement

The conference agreement does not include the House bill provision relating to HSSAs. The conference agreement includes the HSA provision from the House bill, with the following modifications.[26]

The conference agreement modifies the definition of a high deductible health plan applicable to HSAs by removing the limitation on the maximum amount of the deductible and increasing the limit on out-of-pocket expenses. Under the conference agreement, a high deductible health plan is a health plan that has a deductible that is at least $1,000 for self-only coverage or $2,000 for family coverage[27] and that has an out-of-pocket expense limit that is no more than $5,000 in the case of self-only coverage and $10,000 in the case of family coverage.[28] As under present law, out-of-pocket expenses include deductibles, co-payments, and other amounts (other than premiums) that the individual must pay for covered benefits under the plan.

Under the conference agreement, the maximum aggregate annual contribution[29] that can be made to an HSA is the lesser of (1) 100 percent of the annual deductible under the high deductible health plan, or (2) the maximum deductible permitted under an Archer MSA high deductible health plan under present law, as adjusted for inflation. For 2004, the amount of the maximum high deductible is estimated to be $2,600 in the case of self-only coverage and $5,150 in the case of family coverage.

Under the conference agreement, contributions made by or on behalf of an eligible individual are deductible by the individual. Thus, for example, contributions made by an eligible individual's family members are deductible by the eligible individual to the extent the contributions would be deductible if made by the individual.[30] As under the House bill, all contributions by or on behalf of an eligible individual are aggregated for purposes of the maximum annual contribution limit. Contributions to Archer MSAs reduce the annual contribution limit for HSAs.

The conference agreement increases the annual contribution limits for individuals who have attained age 55 by the end of the taxable year. In the case of policyholders and covered spouses who are age 55 or older, the HSA annual contribution limit is greater than the otherwise applicable limit by $500 in 2004, $600 in 2005, $700 in 2006, $800 in 2007, $900 in 2008, and $1,000 in 2009 and thereafter.[31] As under the House bill, contributions, including catch-up contributions, cannot be made once an individual is eligible for Medicare. Under the conference agreement, qualified medical expenses are expanded to include health insurance premiums for individuals eligible for Medicare, other than premiums for Medigap policies. Qualified health insurance premiums include, for example, Medicare Part A and Part B premiums, Medicare HMO premiums, and the employee share of premiums for employer- sponsored health insurance including employer-sponsored retiree health insurance.

Except as otherwise provide by the Secretary, preventative care is defined as under section 1871 of the Social Security Act. It is intended that the Secretary of the Treasury will amend the definition of preventative care if the definition used under the Social Security Act is inconsistent with the purposes of the provision. Under the conference agreement, the additional tax on nonqualified distributions is reduced to 10 percent (rather than 15 percent as in the House bill).

Under the conference agreement, amounts can be rolled over into an HSA from another HSA or from an Archer MSA. The conference agreement also clarifies information reporting requirements in the House bill.

Effective date.—The provision is effective for taxable years beginning after December 31, 2003.

Disposition of Unused Health Benefits in Flexible Spending Arrangements (sec. 1203 of the House bill and sec. 125 of the Code)

Present Law

A flexible spending arrangement ("FSA") is defined under the Code as a benefit program which provides employees with coverage under which specified incurred expenses may be reimbursed and the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage.[32] A health FSA is an FSA that provides for reimbursement of medical expenses.[33] Health FSAs are typically part of a cafeteria plan and may be funded through salary reduction.[34] Health FSAs are commonly used, for example, to reimburse employees for medical expenses not covered by insurance. There is no special exclusion for benefits provided under an FSA. Thus, health benefits provided under an FSA are excludable from income only if they qualify for exclusion under sections 105 or 106.

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[22] Amounts paid by the employer include salary reduction contributions.

[23] Ordering rules apply to determine the extent to which distributions are attributable to nondeductible contributions.

[24] Sec. 2056.

[25] The deduction is calculated in accordance with the present-law rules relating to income in respect of a decedent set forth in section 691(c).

[26] The rules for HSAs generally follow those of Archer MSAs unless otherwise provided.

[27] The $1,000 limit is indexed for inflation. The family coverage limit will always be twice the individual limit (as indexed for inflation).

[28] In the case of the plan using a network of providers, the plan does not fail to be a high deductible health plan (if it would otherwise meet the requirements of a high deductible health plan) solely because the out of-pocket expense limit for services provised outside of the network exceeds the $5,000 and $10,000 out-of-pocket expense limits. In addition, such plan's deductible for out-of-network services is not taken into account in determining the annual contribution limit (i.e., the deductible for services within the network is used for such purpose).

[29] The maximum annual contribution limit is calculated as the sum of limits determined for each month based on the individual's health plan coverage on the first day of the month.

[30] Under present law, contributions made on behalf of another individual are generally treated as gifts. The present-law gift tax rules apply to contributions made on behalf of another individual.

[31] As in determining the general annual contribution limit, the increase in the annual contribution limit for individuals who have attained age 55 is also determined on a monthly basis.

[32] Sec. 106(c).

[33] FSAs may also be used to provide certain other nontaxable benefits, such as dependent care.

[34] Long-term care insurance cannot be offered through a cafeteria plan. Sec. 125(f).

FSAs that are part of a cafeteria plan must comply with the rules applicable to cafeteria plans generally. One of these rules is that a cafeteria plan may not offer deferred compensation except through a qualified cash or deferred arrangement.[35] Under proposed Treasury regulations, a cafeteria plan is considered to permit the deferral of compensation if it includes a health FSA which reimburses participants for medical expenses incurred beyond the end of the plan year.[36] Thus, amounts in an employee's health account that are not used for medical expenses incurred before the end of a plan year must be forfeited. This rule is often referred to as the "use it or lose it" rule.

House Bill

The House bill allows up to $500 of unused health benefits in an employee's health FSA to be carried forward to the employee's health account for the next plan year of the health FSA or transferred to an HSA or HSSA maintained for the benefit of the employee.[37] Amounts transferred to an HSA or HSSA are treated as employer contributions for purposes of the HSA and HSSA rules. Under the House bill, if an individual is not eligible to contribute to an HSA or HSSA for the taxable year, the individual may transfer up to $500 of unused health benefits in the employee's health FSA to a tax-qualified retirement plan, a tax-sheltered annuity (section 403(b)), an individual retirement arrangement ("IRA"), or an eligible deferred compensation plan of a State or local government (section 457). An employee's unused health benefit is the excess of the maximum amount of reimbursement allowable to the employee over the actual amount of reimbursement made during the year. Amounts transferred are subject to the rules and limits on contributions that would otherwise apply to contributions to the transferee plan.

Effective date.—The House bill provision applies to taxable years beginning after December 31, 2003.

Senate Amendment

No provision.

Conference Agreement

The conference agreement does not include the House bill provision.

Exclusion from Gross Income of Certain Federal Subsidies for Prescription Drug Plans (new sec. 139A of the Code)

Present Law

Gross income includes all income from whatever source derived unless a specific exclusion applies.[38]

House Bill

No provision.

Senate Amendment

No provision.

Conference Agreement

The conference agreement provides that gross income does not include any special subsidy payment received under section 1860D–22 of the Social Security Act. The exclusion applies for purposes of both the regular tax and the alternative minimum tax (including the adjustment for adjusted current earnings).

The exclusion is not taken into account in determining whether a deduction is allowable with respect to costs taken into account in determining the subsidy payment. Accordingly, a taxpayer could claim a deduction for prescription drug expenses incurred even though the taxpayer also received an excludible subsidy related to the same expenses.

Effective date.—The provision is effective for taxable years ending after the date of enactment.

Exception to Information Reporting Requirements for Certain Health Arrangements (sec. 1204 of the House bill and sec. 6041 of the Code)

Present Law

Any person in a trade or business who, in the course of that trade or business, makes specified payments to another person totaling $600 or more in a year, must provide an information report to the IRS (as well as a copy to the recipient) on the payments.[39] Reporting is required to be done on Form 1099. In general, these information reports remind taxpayers of amounts of income that should be reflected on their tax returns and assist the IRS in verifying that taxpayers have correctly reported these amounts.

Treasury regulations specify that fees for professional services, including the services of physicians, must be reported.[40] Treasury regulations also provide a general exception from these information reporting requirements for payments made to corporations, except that this exception is inapplicable if the corporation is "engaged in providing medical and health care services."[41] Earlier this year, the IRS issued a revenue ruling describing whether employer-provided expense reimbursements made through debit or credit cards or other electronic media are excludible from gross income.[42] The ruling states that "payments made to medical service providers through the use of debit, credit, and stored value cards are reportable by the employer on Form 1099–MISC under section 6041."[43]

House Bill

The House bill provides an exception from the generally applicable information reporting provisions for payments for medical care made under either: (1) a flexible spending arrangement,[44] or (2) a health reimbursement arrangement that is treated as employer-provided coverage.

Effective date.—The House bill provision applies to payments made after December 31, 2002.

Senate Amendment

No provision.

Conference Agreement

The conference agreement follows the House bill.

TAX COMPLEXITY ANALYSIS

Section 4022(b) of the Internal Revenue Service Reform and Restructuring Act of 1998 (the "IRS Reform Act") requires the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Department of the Treasury) to provide a tax complexity analysis. The complexity analysis is required for all legislation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code (the "Code") and has widespread applicability to individuals or small businesses.

The staff of the Joint Committee on Taxation has determined that a complexity analysis is not required under section 4022(b) of the IRS Reform Act because the bill contains no provisions that amend the Code and that have "widespread applicability" to individuals or small businesses

BILLY TAUZIN,
WILLIAM THOMAS,
MICHAEL BILIRAKIS,
NANCY L. JOHNSON,
TOM DELAY,
Managers on the Part of the House.

CHUCK GRASSLEY,
ORRIN HATCH,
DON NICKLES,
BILL FRIST,
JON KYL,
MAX BAUCUS,
JOHN BREAUX,
Managers on the Part of the Senate.

CONFERENCE REPORT ON H.R. 1904, HEALTHY FORESTS RESTORATION ACT OF 2003

Mr. GOODLATTE (during debate on the Inslee motion to instruct conferees on H.R. 1) submitted the following conference report and statement on the bill (H.R. 1904) to improve the capacity of the Secretary of Agriculture and the Secretary of the Interior to plan and conduct hazardous fuels reduction projects on National Forest System lands and Bureau of Land Management lands aimed at protecting communities, watersheds, and certain other at-risk lands from catastrophic wildfire, to enhance efforts to protect watersheds and address threats to forest and rangeland health, including catastrophic wildfire, across the landscape, and for other purposes:

CONFERENCE REPORT (H. REPT. 108–386)

The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 1904), to improve the capacity of the Secretary of Agriculture and the Secretary of the Interior to plan and conduct hazardous fuels reduction projects on National Forest System lands and Bureau of Land Management lands aimed at protecting communities, watersheds, and certain other at-risk lands from catastrophic wildfire, to enhance efforts to protect watersheds and address threats to forest and rangeland health, including catastrophic wildfire, across the landscape, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment, insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Healthy Forests Restoration Act of 2003".

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[35] Sec. 401(k).

[36] Prop. Treas. Reg. sec. 1.125–2 Q&A–5(a).

[37] Section 2 of the bill provides the eligibility rules for contributions to an HSA or HSSA.

[38] Sec. 61.

[39] Sec. 6041.

[40] Treas. Reg. sec. 1.6041–1(d)(2).

[41] Treas. Reg. sec. 1.6041–3(p)(1). These regulations also provide an eception from these information reporting requirements if the payment is made to a hospital that is tax-exempt or that is owned and operated by a government entity.

[42] Rev. Rul. 2003–43, 2003–21 I.R.B. 935 (May 27, 2003).

[43] *Id.*

[44] This term is defined in sec. 106(c)(2).

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Purposes.
Sec. 3. Definitions.

TITLE I—HAZARDOUS FUEL REDUCTION ON FEDERAL LAND

Sec. 101. Definitions.
Sec. 102. Authorized hazardous fuel reduction projects.
Sec. 103. Prioritization.
Sec. 104. Environmental analysis.
Sec. 105. Special administrative review process.
Sec. 106. Judicial review in United States district courts.
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TITLE VI—MISCELLANEOUS

Sec. 601. Forest stands inventory and monitoring program to improve detection of and response to environmental threats.

SEC. 2. PURPOSES.

The purposes of this Act are—

(1) to reduce wildfire risk to communities, municipal water supplies, and other at-risk Federal land through a collaborative process of planning, prioritizing, and implementing hazardous fuel reduction projects;

(2) to authorize grant programs to improve the commercial value of forest biomass (that otherwise contributes to the risk of catastrophic fire or insect or disease infestation) for producing electric energy, useful heat, transportation fuel, and petroleum-based product substitutes, and for other commercial purposes;

(3) to enhance efforts to protect watersheds and address threats to forest and rangeland health, including catastrophic wildfire, across the landscape;

(4) to promote systematic gathering of information to address the impact of insect and disease infestations and other damaging agents on forest and rangeland health;

(5) to improve the capacity to detect insect and disease infestations at an early stage, particularly with respect to hardwood forests; and

(6) to protect, restore, and enhance forest ecosystem components—

(A) to promote the recovery of threatened and endangered species;

(B) to improve biological diversity; and

(C) to enhance productivity and carbon sequestration.

SEC. 3. DEFINITIONS.

In this Act:

(1) FEDERAL LAND.—The term "Federal land" means—

(A) land of the National Forest System (as defined in section 11(a) of the Forest and Rangeland Renewable Resources Planning Act of 1974 (16 U.S.C 1609(a))) administered by the Secretary of Agriculture, acting through the Chief of the Forest Service; and

(B) public lands (as defined in section 103 of the Federal Land Policy and Management Act of 1976 (43 U.S.C 1702)), the surface of which is administered by the Secretary of the Interior, acting through the Director of the Bureau of Land Management.

(2) INDIAN TRIBE.—The term "Indian tribe" has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

TITLE I—HAZARDOUS FUEL REDUCTION ON FEDERAL LAND

SEC. 101. DEFINITIONS.

In this title:

(1) AT-RISK COMMUNITY.—The term "at-risk community" means an area—

(A) that is comprised of—

(i) an interface community as defined in the notice entitled "Wildland Urban Interface Communities Within the Vicinity of Federal Lands That Are at High Risk From Wildfire" issued by the Secretary of Agriculture and the Secretary of the Interior in accordance with title IV of the Department of the Interior and Related Agencies Appropriations Act, 2001 (114 Stat. 1009) (66 Fed. Reg. 753, January 4, 2001); or

(ii) a group of homes and other structures with basic infrastructure and services (such as utilities and collectively maintained transportation routes) within or adjacent to Federal land;

(B) in which conditions are conducive to a large-scale wildland fire disturbance event; and

(C) for which a significant threat to human life or property exists as a result of a wildland fire disturbance event.

(2) AUTHORIZED HAZARDOUS FUEL REDUCTION PROJECT.—The term "authorized hazardous fuel reduction project" means the measures and methods described in the definition of "appropriate tools" contained in the glossary of the Implementation Plan, on Federal land described in section 102(a) and conducted under sections 103 and 104.

(3) COMMUNITY WILDFIRE PROTECTION PLAN.—The term "community wildfire protection plan" means a plan for an at-risk community that—

(A) is developed within the context of the collaborative agreements and the guidance established by the Wildland Fire Leadership Council and agreed to by the applicable local government, local fire department, and State agency responsible for forest management, in consultation with interested parties and the Federal land management agencies managing land in the vicinity of the at-risk community;

(B) identifies and prioritizes areas for hazardous fuel reduction treatments and recommends the types and methods of treatment on Federal and non-Federal land that will protect 1 or more at-risk communities and essential infrastructure; and

(C) recommends measures to reduce structural ignitability throughout the at-risk community.

(4) CONDITION CLASS 2.—The term "condition class 2", with respect to an area of Federal land, means the condition class description developed by the Forest Service Rocky Mountain Research Station in the general technical report entitled "Development of Coarse-Scale Spatial Data for Wildland Fire and Fuel Management" (RMRS–87), dated April 2000 (including any subsequent revision to the report), under which—

(A) fire regimes on the land have been moderately altered from historical ranges;

(B) there exists a moderate risk of losing key ecosystem components from fire;

(C) fire frequencies have increased or decreased from historical frequencies by 1 or more return intervals, resulting in moderate changes to—

(i) the size, frequency, intensity, or severity of fires; or

(ii) landscape patterns; and

(D) vegetation attributes have been moderately altered from the historical range of the attributes.

(5) CONDITION CLASS 3.—The term "condition class 3", with respect to an area of Federal land, means the condition class description developed by the Rocky Mountain Research Station in the general technical report referred to in paragraph (4) (including any subsequent revision to the report), under which—

(A) fire regimes on land have been significantly altered from historical ranges;

(B) there exists a high risk of losing key ecosystem components from fire;

(C) fire frequencies have departed from historical frequencies by multiple return intervals, resulting in dramatic changes to—

(i) the size, frequency, intensity, or severity of fires; or

(ii) landscape patterns; and

(D) vegetation attributes have been significantly altered from the historical range of the attributes.

(6) DAY.—The term "day" means—

(A) a calendar day; or

(B) if a deadline imposed by this title would expire on a nonbusiness day, the end of the next business day.

(7) DECISION DOCUMENT.—The term "decision document" means—

(A) a decision notice (as that term is used in the Forest Service Handbook);

(B) a decision record (as that term is used in the Bureau of Land Management Handbook); and

(C) a record of decision (as that term is used in applicable regulations of the Council on Environmental Quality).

(8) FIRE REGIME I.—The term "fire regime I" means an area—

(A) in which historically there have been low-severity fires with a frequency of 0 through 35 years; and

(B) that is located primarily in low elevation forests of pine, oak, or pinyon juniper.

(9) FIRE REGIME II.—The term "fire regime II" means an area—

(A) in which historically there are stand replacement severity fires with a frequency of 0 through 35 years; and

(B) that is located primarily in low- to mid-elevation rangeland, grassland, or shrubland.

(10) FIRE REGIME III.—The term "fire regime III" means an area—

(A) in which historically there are mixed severity fires with a frequency of 35 through 100 years; and

(B) that is located primarily in forests of mixed conifer, dry Douglas fir, or wet Ponderosa pine.

(11) IMPLEMENTATION PLAN.—The term "Implementation Plan" means the Implementation Plan for the Comprehensive Strategy for a Collaborative Approach for Reducing Wildland Fire Risks to Communities and the Environment, dated May 2002, developed pursuant to the conference report to accompany the Department of

the Interior and Related Agencies Appropriations Act, 2001 (House Report 106–64) (and subsequent revisions).

(12) MUNICIPAL WATER SUPPLY SYSTEM.—The term "municipal water supply system" means the reservoirs, canals, ditches, flumes, laterals, pipes, pipelines, and other surface facilities and systems constructed or installed for the collection, impoundment, storage, transportation, or distribution of drinking water.

(13) RESOURCE MANAGEMENT PLAN.—The term "resource management plan" means—

(A) a land and resource management plan prepared for 1 or more units of land of the National Forest System described in section 3(1)(A) under section 6 of the Forest and Rangeland Renewable Resources Planning Act of 1974 (16 U.S.C. 1604); or

(B) a land use plan prepared for 1 or more units of the public land described in section 3(1)(B) under section 202 of the Federal Land Policy and Management Act of 1976 (43 U.S.C. 1712).

(14) SECRETARY.—The term "Secretary" means—

(A) the Secretary of Agriculture, with respect to land of the National Forest System described in section 3(1)(A); and

(B) the Secretary of the Interior, with respect to public lands described in section 3(1)(B).

(15) THREATENED AND ENDANGERED SPECIES HABITAT.—The term "threatened and endangered species habitat" means Federal land identified in—

(A) a determination that a species is an endangered species or a threatened species under the Endangered Species Act of 1973 (16 U.S.C. 1531 et seq.);

(B) a designation of critical habitat of the species under that Act; or

(C) a recovery plan prepared for the species under that Act.

(16) WILDLAND-URBAN INTERFACE.—The term "wildland-urban interface" means—

(A) an area within or adjacent to an at-risk community that is identified in recommendations to the Secretary in a community wildfire protection plan; or

(B) in the case of any area for which a community wildfire protection plan is not in effect—

(i) an area extending 1/2-mile from the boundary of an at-risk community;

(ii) an area within 1½ miles of the boundary of an at-risk community, including any land that—

(I) has a sustained steep slope that creates the potential for wildfire behavior endangering the at-risk community;

(II) has a geographic feature that aids in creating an effective fire break, such as a road or ridge top; or

(III) is in condition class 3, as documented by the Secretary in the project-specific environmental analysis; and

(iii) an area that is adjacent to an evacuation route for an at-risk community that the Secretary determines, in cooperation with the at-risk community, requires hazardous fuel reduction to provide safer evacuation from the at-risk community.

SEC. 102. AUTHORIZED HAZARDOUS FUEL REDUCTION PROJECTS.

(a) AUTHORIZED PROJECTS.—As soon as practicable after the date of enactment of this Act, the Secretary shall implement authorized hazardous fuel reduction projects, consistent with the Implementation Plan, on—

(1) Federal land in wildland-urban interface areas;

(2) condition class 3 Federal land, in such proximity to a municipal water supply system or a stream feeding such a system within a municipal watershed that a significant risk exists that a fire disturbance event would have adverse effects on the water quality of the municipal water supply or the maintenance of the system, including a risk to water quality posed by erosion following such a fire disturbance event;

(3) condition class 2 Federal land located within fire regime I, fire regime II, or fire regime III, in such proximity to a municipal water supply system or a stream feeding such a system within a municipal watershed that a significant risk exists that a fire disturbance event would have adverse effects on the water quality of the municipal water supply or the maintenance of the system, including a risk to water quality posed by erosion following such a fire disturbance event;

(4) Federal land on which windthrow or blowdown, ice storm damage, the existence of an epidemic of disease or insects, or the presence of such an epidemic on immediately adjacent land and the imminent risk it will spread, poses a significant threat to an ecosystem component, or forest or rangeland resource, on the Federal land or adjacent non-Federal land; and

(5) Federal land not covered by paragraphs (1) through (4) that contains threatened and endangered species habitat, if—

(A) natural fire regimes on that land are identified as being important for, or wildfire is identified as a threat to, an endangered species, a threatened species, or habitat of an endangered species or threatened species in a species recovery plan prepared under section 4 of the Endangered Species Act of 1973 (16 U.S.C. 1533), or a notice published in the Federal Register determining a species to be an endangered species or a threatened species or designating critical habitat;

(B) the authorized hazardous fuel reduction project will provide enhanced protection from catastrophic wildfire for the endangered species, threatened species, or habitat of the endangered species or threatened species; and

(C) the Secretary complies with any applicable guidelines specified in any management or recovery plan described in subparagraph (A).

(b) RELATION TO AGENCY PLANS.—An authorized hazardous fuel reduction project shall be conducted consistent with the resource management plan and other relevant administrative policies or decisions applicable to the Federal land covered by the project.

(c) ACREAGE LIMITATION.—Not more than a total of 20,000,000 acres of Federal land may be treated under authorized hazardous fuel reduction projects.

(d) EXCLUSION OF CERTAIN FEDERAL LAND.—The Secretary may not conduct an authorized hazardous fuel reduction project that would occur on—

(1) a component of the National Wilderness Preservation System;

(2) Federal land on which the removal of vegetation is prohibited or restricted by Act of Congress or Presidential proclamation (including the applicable implementation plan); or

(3) a Wilderness Study Area.

(e) OLD GROWTH STANDS.—

(1) DEFINITIONS.—In this subsection and subsection (f):

(A) APPLICABLE PERIOD.—The term "applicable period" means—

(i) the 2-year period beginning on the date of enactment of this Act; or

(ii) in the case of a resource management plan that the Secretary is in the process of revising as of the date of enactment of this Act, the 3-year period beginning on the date of enactment of this Act.

(B) COVERED PROJECT.—The term "covered project" means an authorized hazardous fuel reduction project carried out on land described in paragraph (1), (2), (3), or (5) of subsection (a).

(C) MANAGEMENT DIRECTION.—The term "management direction" means definitions, designations, standards, guidelines, goals, or objectives established for an old growth stand under a resource management plan developed in accordance with applicable law, including section 6(g)(3)(B) of the Forest and Rangeland Renewable Resources Planning Act of 1974 (16 U.S.C. 1604(g)(3)(B)).

(D) OLD GROWTH STAND.—The term "old growth stand" has the meaning given the term under management direction used pursuant to paragraphs (3) and (4), based on the structure and composition characteristic of the forest type, and in accordance with applicable law, including section 6(g)(3)(B) of the Forest and Rangeland Renewable Resources Planning Act of 1974 (16 U.S.C. 1604(g)(3)(B)).

(2) PROJECT REQUIREMENTS.—In carrying out a covered project, the Secretary shall fully maintain, or contribute toward the restoration of, the structure and composition of old growth stands according to the pre-fire suppression old growth conditions characteristic of the forest type, taking into account the contribution of the stand to landscape fire adaptation and watershed health, and retaining the large trees contributing to old growth structure.

(3) NEWER MANAGEMENT DIRECTION.—

(A) IN GENERAL.—If the management direction for an old growth stand was established on or after December 15, 1993, the Secretary shall meet the requirements of paragraph (2) in carrying out a covered project by implementing the management direction.

(B) AMENDMENTS OR REVISIONS.—Any amendment or revision to management direction for which final administrative approval is granted after the date of enactment of this Act shall be consistent with paragraph (2) for the purpose of carrying out covered projects.

(4) OLDER MANAGEMENT DIRECTION.—

(A) IN GENERAL.—If the management direction for an old growth stand was established before December 15, 1993, the Secretary shall meet the requirements of paragraph (2) in carrying out a covered project during the applicable period by implementing the management direction.

(B) REVIEW REQUIRED.—Subject to subparagraph (C), during the applicable period for management direction referred to in subparagraph (A), the Secretary shall—

(i) review the management direction for affected covered projects, taking into account any relevant scientific information made available since the adoption of the management direction; and

(ii) amend the management direction for affected covered projects to be consistent with paragraph (2), if necessary to reflect relevant scientific information the Secretary did not consider in formulating the management direction.

(C) REVIEW NOT COMPLETED.—If the Secretary does not complete the review of the management direction in accordance with subparagraph (B) before the end of the applicable period, the Secretary shall not carry out any portion of affected covered projects in stands that are identified as old growth stands (based on substantial supporting evidence) by any person during scoping, within the period—

(i) beginning at the close of the applicable period for the management direction governing the affected covered projects; and

(ii) ending on the earlier of—

(I) the date the Secretary completes the action required by subparagraph (B) for the management direction applicable to the affected covered projects; or

(II) the date on which the acreage limitation specified in subsection (c) (as that limitation may be adjusted by a subsequent Act of Congress) is reached.

(5) LIMITATION TO COVERED PROJECTS.—Nothing in this subsection requires the Secretary to revise or otherwise amend a resource management plan to make the project requirements of

paragraph (2) apply to an activity other than a covered project.

(f) LARGE TREE RETENTION.—

(1) IN GENERAL.—Except in old growth stands where the management direction is consistent with subsection (e)(2), the Secretary shall carry out a covered project in a manner that—

(A) focuses largely on small diameter trees, thinning, strategic fuel breaks, and prescribed fire to modify fire behavior, as measured by the projected reduction of uncharacteristically severe wildfire effects for the forest type (such as adverse soil impacts, tree mortality or other impacts); and

(B) maximizes the retention of large trees, as appropriate for the forest type, to the extent that the trees promote fire-resilient stands.

(2) WILDFIRE RISK.—Nothing in this subsection prevents achievement of the purposes described in section 2(1).

(g) MONITORING AND ASSESSING FOREST AND RANGELAND HEALTH.—

(1) IN GENERAL.—For each Forest Service administrative region and each Bureau of Land Management State Office, the Secretary shall—

(A) monitor the results of a representative sample of the projects authorized under this title for each management unit; and

(B) not later than 5 years after the date of enactment of this Act, and each 5 years thereafter, issue a report that includes—

(i) an evaluation of the progress towards project goals; and

(ii) recommendations for modifications to the projects and management treatments.

(2) CONSISTENCY OF PROJECTS WITH RECOMMENDATIONS.—An authorized hazardous fuel reduction project approved following the issuance of a monitoring report shall, to the maximum extent practicable, be consistent with any applicable recommendations in the report.

(3) SIMILAR VEGETATION TYPES.—The results of a monitoring report shall be made available for use (if appropriate) in an authorized hazardous fuels reduction project conducted in a similar vegetation type on land under the jurisdiction of the Secretary.

(4) MONITORING AND ASSESSMENTS.—Monitoring and assessment shall include a description of the changes in condition class, using the Fire Regime Condition Class Guidebook or successor guidance, specifically comparing end results to—

(A) pretreatment conditions;

(B) historical fire regimes; and

(C) any applicable watershed or landscape goals or objectives in the resource management plan or other relevant direction.

(5) MULTIPARTY MONITORING.—

(A) IN GENERAL.—In an area where significant interest is expressed in multiparty monitoring, the Secretary shall establish a multiparty monitoring, evaluation, and accountability process in order to assess the positive or negative ecological and social effects of authorized hazardous fuel reduction projects and projects conducted pursuant to section 404.

(B) DIVERSE STAKEHOLDERS.—The Secretary shall include diverse stakeholders (including interested citizens and Indian tribes) in the process required under subparagraph (A).

(C) FUNDING.—Funds to carry out this paragraph may be derived from operations funds for projects described in subparagraph (A).

(6) COLLECTION OF MONITORING DATA.—The Secretary may collect monitoring data by entering into cooperative agreements or contracts with, or providing grants to, small or micro-businesses, cooperatives, nonprofit organizations, Youth Conservation Corps work crews, or related State, local, and other non-Federal conservation corps.

(7) TRACKING.—For each administrative unit, the Secretary shall track acres burned, by the degree of severity, by large wildfires (as defined by the Secretary).

(8) MONITORING AND MAINTENANCE OF TREATED AREAS.—The Secretary shall, to the maximum extent practicable, develop a process for monitoring the need for maintenance of treated areas, over time, in order to preserve the forest health benefits achieved.

SEC. 103. PRIORITIZATION.

(a) IN GENERAL.—In accordance with the Implementation Plan, the Secretary shall develop an annual program of work for Federal land that gives priority to authorized hazardous fuel reduction projects that provide for the protection of at-risk communities or watersheds or that implement community wildfire protection plans.

(b) COLLABORATION.—

(1) IN GENERAL.—The Secretary shall consider recommendations under subsection (a) that are made by at-risk communities that have developed community wildfire protection plans.

(2) EXEMPTION.—The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the planning process and recommendations concerning community wildfire protection plans.

(c) ADMINISTRATION.—

(1) IN GENERAL.—Federal agency involvement in developing a community wildfire protection plan, or a recommendation made in a community wildfire protection plan, shall not be considered a Federal agency action under the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.).

(2) COMPLIANCE.—In implementing authorized hazardous fuel reduction projects on Federal land, the Secretary shall, in accordance with section 104, comply with the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.).

(d) FUNDING ALLOCATION.—

(1) FEDERAL LAND.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall use not less than 50 percent of the funds allocated for authorized hazardous fuel reduction projects in the wildland-urban interface.

(B) APPLICABILITY AND ALLOCATION.—The funding allocation in subparagraph (A) shall apply at the national level. The Secretary may allocate the proportion of funds differently than is required under subparagraph (A) within individual management units as appropriate, in particular to conduct authorized hazardous fuel reduction projects on land described in section 102(a)(4).

(C) WILDLAND-URBAN INTERFACE.—In the case of an authorized hazardous fuel reduction project for which a decision notice is issued during the 1-year period beginning on the date of enactment of this Act, the Secretary shall use existing definitions of the term “wildland-urban interface” rather than the definition of that term provided under section 101.

(2) NON-FEDERAL LAND.—

(A) IN GENERAL.—In providing financial assistance under any provision of law for hazardous fuel reduction projects on non-Federal land, the Secretary shall consider recommendations made by at-risk communities that have developed community wildfire protection plans.

(B) PRIORITY.—In allocating funding under this paragraph, the Secretary should, to the maximum extent practicable, give priority to communities that have adopted a community wildfire protection plan or have taken proactive measures to encourage willing property owners to reduce fire risk on private property.

SEC. 104. ENVIRONMENTAL ANALYSIS.

(a) AUTHORIZED HAZARDOUS FUEL REDUCTION PROJECTS.—Except as otherwise provided in this title, the Secretary shall conduct authorized hazardous fuel reduction projects in accordance with—

(1) the National Environmental Policy Act of 1969 (42 U.S.C. 4331 et seq.); and

(2) other applicable laws.

(b) ENVIRONMENTAL ASSESSMENT OR ENVIRONMENTAL IMPACT STATEMENT.—The Secretary shall prepare an environmental assessment or an environmental impact statement pursuant to section 102(2) of the National Environmental Policy Act of 1969 (42 U.S.C. 4332(2)) for each authorized hazardous fuel reduction project.

(c) CONSIDERATION OF ALTERNATIVES.—

(1) IN GENERAL.—Except as provided in subsection (d), in the environmental assessment or environmental impact statement prepared under subsection (b), the Secretary shall study, develop, and describe—

(A) the proposed agency action;

(B) the alternative of no action; and

(C) an additional action alternative, if the additional alternative—

(i) is proposed during scoping or the collaborative process under subsection (f); and

(ii) meets the purpose and need of the project, in accordance with regulations promulgated by the Council on Environmental Quality.

(2) MULTIPLE ADDITIONAL ALTERNATIVES.—If more than 1 additional alternative is proposed under paragraph (1)(C), the Secretary shall—

(A) select which additional alternative to consider, which is a choice that is in the sole discretion of the Secretary; and

(B) provide a written record describing the reasons for the selection.

(d) ALTERNATIVE ANALYSIS PROCESS FOR PROJECTS IN WILDLAND-URBAN INTERFACE.—

(1) PROPOSED AGENCY ACTION AND 1 ACTION ALTERNATIVE.—For an authorized hazardous fuel reduction project that is proposed to be conducted in the wildland-urban interface, the Secretary is not required to study, develop, or describe more than the proposed agency action and 1 action alternative in the environmental assessment or environmental impact statement prepared pursuant to section 102(2) of the National Environmental Policy Act of 1969 (42 U.S.C. 4332(2)).

(2) PROPOSED AGENCY ACTION.—Notwithstanding paragraph (1), but subject to paragraph (3), if an authorized hazardous fuel reduction project proposed to be conducted in the wildland-urban interface is located no further than 1½ miles from the boundary of an at-risk community, the Secretary is not required to study, develop, or describe any alternative to the proposed agency action in the environmental assessment or environmental impact statement prepared pursuant to section 102(2) of the National Environmental Policy Act of 1969 (42 U.S.C. 4332(2)).

(3) PROPOSED AGENCY ACTION AND COMMUNITY WILDFIRE PROTECTION PLAN ALTERNATIVE.—In the case of an authorized hazardous fuel reduction project described in paragraph (2), if the at-risk community has adopted a community wildfire protection plan and the proposed agency action does not implement the recommendations in the plan regarding the general location and basic method of treatments, the Secretary shall evaluate the recommendations in the plan as an alternative to the proposed agency action in the environmental assessment or environmental impact statement prepared pursuant to section 102(2) of the National Environmental Policy Act of 1969 (42 U.S.C. 4332(2)).

(e) PUBLIC NOTICE AND MEETING.—

(1) PUBLIC NOTICE.—The Secretary shall provide notice of each authorized hazardous fuel reduction project in accordance with applicable regulations and administrative guidelines.

(2) PUBLIC MEETING.—During the preparation stage of each authorized hazardous fuel reduction project, the Secretary shall—

(A) conduct a public meeting at an appropriate location proximate to the administrative

unit of the Federal land on which the authorized hazardous fuel reduction project will be conducted; and

(B) provide advance notice of the location, date, and time of the meeting.

(f) PUBLIC COLLABORATION.—In order to encourage meaningful public participation during preparation of authorized hazardous fuel reduction projects, the Secretary shall facilitate collaboration among State and local governments and Indian tribes, and participation of interested persons, during the preparation of each authorized fuel reduction project in a manner consistent with the Implementation Plan.

(g) ENVIRONMENTAL ANALYSIS AND PUBLIC COMMENT.—In accordance with section 102(2) of the National Environmental Policy Act of 1969 (42 U.S.C. 4332(2)) and the applicable regulations and administrative guidelines, the Secretary shall provide an opportunity for public comment during the preparation of any environmental assessment or environmental impact statement for an authorized hazardous fuel reduction project.

(h) DECISION DOCUMENT.—The Secretary shall sign a decision document for authorized hazardous fuel reduction projects and provide notice of the final agency actions.

SEC. 105. SPECIAL ADMINISTRATIVE REVIEW PROCESS.

(a) INTERIM FINAL REGULATIONS.—

(1) IN GENERAL.—Not later than 30 days after the date of the enactment of this Act, the Secretary of Agriculture shall promulgate interim final regulations to establish a predecisional administrative review process for the period described in paragraph (2) that will serve as the sole means by which a person can seek administrative review regarding an authorized hazardous fuel reduction project on Forest Service land.

(2) PERIOD.—The predecisional administrative review process required under paragraph (1) shall occur during the period—

(A) beginning after the completion of the environmental assessment or environmental impact statement; and

(B) ending not later than the date of the issuance of the final decision approving the project.

(3) ELIGIBILITY.—To be eligible to participate in the administrative review process for an authorized hazardous fuel reduction project under paragraph (1), a person shall submit to the Secretary, during scoping or the public comment period for the draft environmental analysis for the project, specific written comments that relate to the proposed action.

(4) EFFECTIVE DATE.—The interim final regulations promulgated under paragraph (1) shall take effect on the date of promulgation of the regulations.

(b) FINAL REGULATIONS.—The Secretary shall promulgate final regulations to establish the process described in subsection (a)(1) after the interim final regulations have been published and reasonable time has been provided for public comment.

(c) ADMINISTRATIVE REVIEW.—

(1) IN GENERAL.—A person may bring a civil action challenging an authorized hazardous fuel reduction project in a Federal district court only if the person has challenged the authorized hazardous fuel reduction project by exhausting—

(A) the administrative review process established by the Secretary of Agriculture under this section; or

(B) the administrative hearings and appeals procedures established by the Department of the Interior.

(2) ISSUES.—An issue may be considered in the judicial review of an action under section 106 only if the issue was raised in an administrative review process described in paragraph (1).

(3) EXCEPTION.—

(A) IN GENERAL.—An exception to the requirement of exhausting the administrative review process before seeking judicial review shall be available if a Federal court finds that the futility or inadequacy exception applies to a specific plaintiff or claim.

(B) INFORMATION.—If an agency fails or is unable to make information timely available during the administrative review process, a court should evaluate whether the administrative review process was inadequate for claims or issues to which the information is material.

SEC. 106. JUDICIAL REVIEW IN UNITED STATES DISTRICT COURTS.

(a) VENUE.—Notwithstanding section 1391 of title 28, United States Code, or other applicable law, an authorized hazardous fuels reduction project conducted under this title shall be subject to judicial review only in the United States district court for a district in which the Federal land to be treated under the authorized hazardous fuels reduction project is located.

(b) EXPEDITIOUS COMPLETION OF JUDICIAL REVIEW.—In the judicial review of an action challenging an authorized hazardous fuel reduction project under subsection (a), Congress encourages a court of competent jurisdiction to expedite, to the maximum extent practicable, the proceedings in the action with the goal of rendering a final determination on jurisdiction, and (if jurisdiction exists) a final determination on the merits, as soon as practicable after the date on which a complaint or appeal is filed to initiate the action.

(c) INJUNCTIONS.—

(1) IN GENERAL.—Subject to paragraph (2), the length of any preliminary injunctive relief and stays pending appeal covering an authorized hazardous fuel reduction project carried out under this title shall not exceed 60 days.

(2) RENEWAL.—

(A) IN GENERAL.—A court of competent jurisdiction may issue 1 or more renewals of any preliminary injunction, or stay pending appeal, granted under paragraph (1).

(B) UPDATES.—In each renewal of an injunction in an action, the parties to the action shall present the court with updated information on the status of the authorized hazardous fuel reduction project.

(3) BALANCING OF SHORT- AND LONG-TERM EFFECTS.—As part of its weighing the equities while considering any request for an injunction that applies to an agency action under an authorized hazardous fuel reduction project, the court reviewing the project shall balance the impact to the ecosystem likely affected by the project of—

(A) the short- and long-term effects of undertaking the agency action; against

(B) the short- and long-term effects of not undertaking the agency action.

SEC. 107. EFFECT OF TITLE.

(a) OTHER AUTHORITY.—Nothing in this title affects, or otherwise biases, the use by the Secretary of other statutory or administrative authority (including categorical exclusions adopted to implement the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.)) to conduct a hazardous fuel reduction project on Federal land (including Federal land identified in section 102(d)) that is not conducted using the process authorized by section 104.

(b) NATIONAL FOREST SYSTEM.—For projects and activities of the National Forest System other than authorized hazardous fuel reduction projects, nothing in this title affects, or otherwise biases, the notice, comment, and appeal procedures for projects and activities of the National Forest System contained in part 215 of title 36, Code of Federal Regulations, or the consideration or disposition of any legal action brought with respect to the procedures.

SEC. 108. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated $760,000,000 for each fiscal year to carry out—

(1) activities authorized by this title; and

(2) other hazardous fuel reduction activities of the Secretary, including making grants to States, local governments, Indian tribes, and other eligible recipients for activities authorized by law.

TITLE II—BIOMASS

SEC. 201. IMPROVED BIOMASS USE RESEARCH PROGRAM.

(a) USES OF GRANTS, CONTRACTS, AND ASSISTANCE.—Section 307(d) of the Biomass Research and Development Act of 2000 (7 U.S.C. 7624 note; Public Law 106–224) is amended—

(1) in paragraph (3), by striking "or" at the end;

(2) in paragraph (4), by striking the period at the end and inserting "; or"; and

(3) by adding at the end the following:

"(5) research to integrate silviculture, harvesting, product development, processing information, and economic evaluation to provide the science, technology, and tools to forest managers and community developers for use in evaluating forest treatment and production alternatives, including—

"(A) to develop tools that would enable land managers, locally or in a several-State region, to estimate—

"(i) the cost to deliver varying quantities of wood to a particular location; and

"(ii) the amount that could be paid for stumpage if delivered wood was used for a specific mix of products;

"(B) to conduct research focused on developing appropriate thinning systems and equipment designs that are—

"(i) capable of being used on land without significant adverse effects on the land;

"(ii) capable of handling large and varied landscapes;

"(iii) adaptable to handling a wide variety of tree sizes;

"(iv) inexpensive; and

"(v) adaptable to various terrains; and

"(C) to develop, test, and employ in the training of forestry managers and community developers curricula materials and training programs on matters described in subparagraphs (A) and (B).".

(b) FUNDING.—Section 310(b) of the Biomass Research and Development Act of 2000 (7 U.S.C. 7624 note; Public Law 106–224) is amended by striking "$49,000,000" and inserting "$54,000,000".

SEC. 202. RURAL REVITALIZATION THROUGH FORESTRY.

Section 2371 of the Food, Agriculture, Conservation, and Trade Act of 1990 (7 U.S.C. 6601) is amended by adding at the end the following:

"(d) RURAL REVITALIZATION TECHNOLOGIES.—

"(1) IN GENERAL.—The Secretary of Agriculture, acting through the Chief of the Forest Service, in consultation with the State and Private Forestry Technology Marketing Unit at the Forest Products Laboratory, and in collaboration with eligible institutions, may carry out a program—

"(A) to accelerate adoption of technologies using biomass and small-diameter materials;

"(B) to create community-based enterprises through marketing activities and demonstration projects; and

"(C) to establish small-scale business enterprises to make use of biomass and small-diameter materials.

"(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection $5,000,000 for each of fiscal years 2004 through 2008.".

SEC. 203. BIOMASS COMMERCIAL UTILIZATION GRANT PROGRAM.

(a) IN GENERAL.—In addition to any other authority of the Secretary of Agriculture to make

grants to a person that owns or operates a facility that uses biomass as a raw material to produce electric energy, sensible heat, transportation fuel, or substitutes for petroleum-based products, the Secretary may make grants to a person that owns or operates a facility that uses biomass for wood-based products or other commercial purposes to offset the costs incurred to purchase biomass.

(b) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section $5,000,000 for each of fiscal years 2004 through 2008.

TITLE III—WATERSHED FORESTRY ASSISTANCE

SEC. 301. FINDINGS AND PURPOSES.

(a) Findings.—Congress finds that—

(1) there has been a dramatic shift in public attitudes and perceptions about forest management, particularly in the understanding and practice of sustainable forest management;

(2) it is commonly recognized that the proper stewardship of forest land is essential to sustaining and restoring the health of watersheds;

(3) forests can provide essential ecological services in filtering pollutants, buffering important rivers and estuaries, and minimizing flooding, which makes forest restoration worthy of special focus; and

(4) strengthened education, technical assistance, and financial assistance for nonindustrial private forest landowners and communities, relating to the protection of watershed health, is needed to realize the expectations of the general public.

(b) Purposes.—The purposes of this title are—

(1) to improve landowner and public understanding of the connection between forest management and watershed health;

(2) to encourage landowners to maintain tree cover on property and to use tree plantings and vegetative treatments as creative solutions to watershed problems associated with varying land uses;

(3) to enhance and complement forest management and buffer use for watersheds, with an emphasis on community watersheds;

(4) to establish new partnerships and collaborative watershed approaches to forest management, stewardship, and conservation;

(5) to provide technical and financial assistance to States to deliver a coordinated program that enhances State forestry best-management practices programs, and conserves and improves forested land and potentially forested land, through technical, financial, and educational assistance to qualifying individuals and entities; and

(6) to maximize the proper management and conservation of wetland forests and to assist in the restoration of those forests.

SEC. 302. WATERSHED FORESTRY ASSISTANCE PROGRAM.

The Cooperative Forestry Assistance Act of 1978 is amended by inserting after section 5 (16 U.S.C. 2103a) the following:

"SEC. 6. WATERSHED FORESTRY ASSISTANCE PROGRAM.

"(a) Definition of Nonindustrial Private Forest Land.—In this section, the term 'nonindustrial private forest land' means rural land, as determined by the Secretary, that—

"(1) has existing tree cover or that is suitable for growing trees; and

"(2) is owned by any nonindustrial private individual, group, association, corporation, or other private legal entity, that has definitive decisionmaking authority over the land.

"(b) General Authority and Purpose.—The Secretary, acting through the Chief of the Forest Service and (where appropriate) through the Cooperative State Research, Education, and Extension Service, may provide technical, financial, and related assistance to State foresters, equivalent State officials, or Cooperative Extension officials at land grant colleges and universities and 1890 institutions for the purpose of expanding State forest stewardship capacities and activities through State forestry best-management practices and other means at the State level to address watershed issues on non-Federal forested land and potentially forested land.

"(c) Technical Assistance To Protect Water Quality.—

"(1) In general.—The Secretary, in cooperation with State foresters or equivalent State officials, shall engage interested members of the public, including nonprofit organizations and local watershed councils, to develop a program of technical assistance to protect water quality described in paragraph (2).

"(2) Purpose of program.—The program under this subsection shall be designed—

"(A) to build and strengthen watershed partnerships that focus on forested landscapes at the State, regional, and local levels;

"(B) to provide State forestry best-management practices and water quality technical assistance directly to owners of nonindustrial private forest land;

"(C) to provide technical guidance to land managers and policymakers for water quality protection through forest management;

"(D) to complement State and local efforts to protect water quality and provide enhanced opportunities for consultation and cooperation among Federal and State agencies charged with responsibility for water and watershed management; and

"(E) to provide enhanced forest resource data and support for improved implementation and monitoring of State forestry best-management practices.

"(3) Implementation.—In the case of a participating State, the program of technical assistance shall be implemented by State foresters or equivalent State officials.

"(d) Watershed Forestry Cost-Share Program.—

"(1) In general.—The Secretary shall establish a watershed forestry cost-share program—

"(A) which shall be—

"(i) administered by the Forest Service; and

"(ii) implemented by State foresters or equivalent State officials in participating States; and

"(B) under which funds or other support provided to participating States shall be made available for State forestry best-management practices programs and watershed forestry projects.

"(2) Watershed forestry projects.—The State forester, an equivalent State official of a participating State, or a Cooperative Extension official at a land grant college or university or 1890 institution, in coordination with the State Forest Stewardship Coordinating Committee established under section 19(b) (or an equivalent committee) for that State, shall make awards to communities, nonprofit groups, and owners of nonindustrial private forest land under the program for watershed forestry projects described in paragraph (3).

"(3) Project elements and objectives.—A watershed forestry project shall accomplish critical forest stewardship, watershed protection, and restoration needs within a State by demonstrating the value of trees and forests to watershed health and condition through—

"(A) the use of trees as solutions to water quality problems in urban and rural areas;

"(B) community-based planning, involvement, and action through State, local, and nonprofit partnerships;

"(C) application of and dissemination of monitoring information on forestry best-management practices relating to watershed forestry;

"(D) watershed-scale forest management activities and conservation planning; and

"(E)(i) the restoration of wetland (as defined by the States) and stream-side forests; and

"(ii) the establishment of riparian vegetative buffers.

"(4) Cost-sharing.—

"(A) Federal share.—

"(i) Funds under this subsection.—Funds provided under this subsection for a watershed forestry project may not exceed 75 percent of the cost of the project.

"(ii) Other federal funds.—The percentage of the cost of a project described in clause (i) that is not covered by funds made available under this subsection may be paid using other Federal funding sources, except that the total Federal share of the costs of the project may not exceed 90 percent.

"(B) Form.—The non-Federal share of the costs of a project may be provided in the form of cash, services, or other in-kind contributions.

"(5) Prioritization.—The State Forest Stewardship Coordinating Committee for a State, or equivalent State committee, shall prioritize watersheds in that State to target watershed forestry projects funded under this subsection.

"(6) Watershed forester.—Financial and technical assistance shall be made available to the State Forester or equivalent State official to create a State watershed or best-management practice forester position to—

"(A) lead statewide programs; and

"(B) coordinate watershed-level projects.

"(e) Distribution.—

"(1) In general.—Of the funds made available for a fiscal year under subsection (g), the Secretary shall use—

"(A) at least 75 percent of the funds to carry out the cost-share program under subsection (d); and

"(B) the remainder of the funds to deliver technical assistance, education, and planning, at the local level, through the State Forester or equivalent State official.

"(2) Special considerations.—Distribution of funds by the Secretary among States under paragraph (1) shall be made only after giving appropriate consideration to—

"(A) the acres of agricultural land, nonindustrial private forest land, and highly erodible land in each State;

"(B) the miles of riparian buffer needed;

"(C) the miles of impaired stream segments and other impaired water bodies where forestry practices can be used to restore or protect water resources;

"(D) the number of owners of nonindustrial private forest land in each State; and

"(E) water quality cost savings that can be achieved through forest watershed management.

"(f) Willing Owners.—

"(1) In general.—Participation of an owner of nonindustrial private forest land in the watershed forestry assistance program under this section is voluntary.

"(2) Written consent.—The watershed forestry assistance program shall not be carried out on nonindustrial private forest land without the written consent of the owner of, or entity having definitive decisionmaking over, the nonindustrial private forest land.

"(g) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section $15,000,000 for each of fiscal years 2004 through 2008.".

SEC. 303. TRIBAL WATERSHED FORESTRY ASSISTANCE.

(a) In General.—The Secretary of Agriculture (referred to in this section as the "Secretary"), acting through the Chief of the Forest Service, shall provide technical, financial, and related assistance to Indian tribes for the purpose of expanding tribal stewardship capacities and activities through tribal forestry best-management practices and other means at the tribal level to address watershed issues on land under the jurisdiction of or administered by the Indian tribes.

(b) TECHNICAL ASSISTANCE TO PROTECT WATER QUALITY.—

(1) IN GENERAL.—The Secretary, in cooperation with Indian tribes, shall develop a program to provide technical assistance to protect water quality, as described in paragraph (2).

(2) PURPOSE OF PROGRAM.—The program under this subsection shall be designed—

(A) to build and strengthen watershed partnerships that focus on forested landscapes at the State, regional, tribal, and local levels;

(B) to provide tribal forestry best-management practices and water quality technical assistance directly to Indian tribes;

(C) to provide technical guidance to tribal land managers and policy makers for water quality protection through forest management;

(D) to complement tribal efforts to protect water quality and provide enhanced opportunities for consultation and cooperation among Federal agencies and tribal entities charged with responsibility for water and watershed management; and

(E) to provide enhanced forest resource data and support for improved implementation and monitoring of tribal forestry best-management practices.

(c) WATERSHED FORESTRY PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a watershed forestry program in cooperation with Indian tribes.

(2) PROGRAMS AND PROJECTS.—Funds or other support provided under the program shall be made available for tribal forestry best-management practices programs and watershed forestry projects.

(3) ANNUAL AWARDS.—The Secretary shall annually make awards to Indian tribes to carry out this subsection.

(4) PROJECT ELEMENTS AND OBJECTIVES.—A watershed forestry project shall accomplish critical forest stewardship, watershed protection, and restoration needs within land under the jurisdiction of or administered by an Indian tribe by demonstrating the value of trees and forests to watershed health and condition through—

(A) the use of trees as solutions to water quality problems;

(B) application of and dissemination of monitoring information on forestry best-management practices relating to watershed forestry;

(C) watershed-scale forest management activities and conservation planning;

(D) the restoration of wetland and stream-side forests and the establishment of riparian vegetative buffers; and

(E) tribal-based planning, involvement, and action through State, tribal, local, and nonprofit partnerships.

(5) PRIORITIZATION.—An Indian tribe that participates in the program under this subsection shall prioritize watersheds in land under the jurisdiction of or administered by the Indian tribe to target watershed forestry projects funded under this subsection.

(6) WATERSHED FORESTER.—The Secretary may provide to Indian tribes under this section financial and technical assistance to establish a position of tribal forester to lead tribal programs and coordinate small watershed-level projects.

(d) DISTRIBUTION.—The Secretary shall devote—

(1) at least 75 percent of the funds made available for a fiscal year under subsection (e) to the program under subsection (c); and

(2) the remainder of the funds to deliver technical assistance, education, and planning in the field to Indian tribes.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $2,500,000 for each of fiscal years 2004 through 2008.

TITLE IV—INSECT INFESTATIONS AND RELATED DISEASES

SEC. 401. FINDINGS AND PURPOSE.

(a) FINDINGS.—Congress finds that—

(1) high levels of tree mortality resulting from insect infestation (including the interaction between insects and diseases) may result in—

(A) increased fire risk;

(B) loss of old trees and old growth;

(C) loss of threatened and endangered species;

(D) loss of species diversity;

(E) degraded watershed conditions;

(F) increased potential for damage from other agents of disturbance, including exotic, invasive species; and

(G) decreased timber values;

(2)(A) forest-damaging insects destroy hundreds of thousands of acres of trees each year;

(B) in the West, more than 21,000,000 acres are at high risk of forest-damaging insect infestation, and in the South, more than 57,000,000 acres are at risk across all land ownerships; and

(C) severe drought conditions in many areas of the South and West will increase the risk of forest-damaging insect infestations;

(3) the hemlock woolly adelgid is—

(A) destroying streamside forests throughout the mid-Atlantic and Appalachian regions;

(B) threatening water quality and sensitive aquatic species; and

(C) posing a potential threat to valuable commercial timber land in northern New England;

(4)(A) the emerald ash borer is a nonnative, invasive pest that has quickly become a major threat to hardwood forests because an emerald ash borer infestation is almost always fatal to affected trees; and

(B) the emerald ash borer pest threatens to destroy more than 692,000,000 ash trees in forests in Michigan and Ohio alone, and between 5 and 10 percent of urban street trees in the Upper Midwest;

(5)(A) epidemic populations of Southern pine beetles are ravaging forests in Alabama, Arkansas, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia; and

(B) in 2001, Florida and Kentucky experienced 146 percent and 111 percent increases, respectively, in Southern pine beetle populations;

(6) those epidemic outbreaks of Southern pine beetles have forced private landowners to harvest dead and dying trees, in rural areas and increasingly urbanized settings;

(7) according to the Forest Service, recent outbreaks of the red oak borer in Arkansas and Missouri have been unprecedented, with more than 1,000,000 acres infested at population levels never seen before;

(8) much of the damage from the red oak borer has taken place in national forests, and the Federal response has been inadequate to protect forest ecosystems and other ecological and economic resources;

(9)(A) previous silvicultural assessments, while useful and informative, have been limited in scale and scope of application; and

(B) there have not been sufficient resources available to adequately test a full array of individual and combined applied silvicultural assessments;

(10) only through the full funding, development, and assessment of potential applied silvicultural assessments over specific time frames across an array of environmental and climatic conditions can the most innovative and cost effective management applications be determined that will help reduce the susceptibility of forest ecosystems to attack by forest pests;

(11)(A) often, there are significant interactions between insects and diseases;

(B) many diseases (such as white pine blister rust, beech bark disease, and many other diseases) can weaken trees and forest stands and predispose trees and forest stands to insect attack; and

(C) certain diseases are spread using insects as vectors (including Dutch elm disease and pine pitch canker); and

(12) funding and implementation of an initiative to combat forest pest infestations and associated diseases should not come at the expense of supporting other programs and initiatives of the Secretary.

(b) PURPOSES.—The purposes of this title are—

(1) to require the Secretary to develop an accelerated basic and applied assessment program to combat infestations by forest-damaging insects and associated diseases;

(2) to enlist the assistance of colleges and universities (including forestry schools, land grant colleges and universities, and 1890 Institutions), State agencies, and private landowners to carry out the program; and

(3) to carry out applied silvicultural assessments.

SEC. 402. DEFINITIONS.

In this title:

(1) APPLIED SILVICULTURAL ASSESSMENT.—

(A) IN GENERAL.—The term "applied silvicultural assessment" means any vegetative or other treatment carried out for information gathering and research purposes.

(B) INCLUSIONS.—The term "applied silvicultural assessment" includes timber harvesting, thinning, prescribed burning, pruning, and any combination of those activities.

(2) 1890 INSTITUTION.—

(A) IN GENERAL.—The term "1890 Institution" means a college or university that is eligible to receive funds under the Act of August 30, 1890 (7 U.S.C. 321 et seq.).

(B) INCLUSION.—The term "1890 Institution" includes Tuskegee University.

(3) FOREST-DAMAGING INSECT.—The term "forest-damaging insect" means—

(A) a Southern pine beetle;

(B) a mountain pine beetle;

(C) a spruce bark beetle;

(D) a gypsy moth;

(E) a hemlock woolly adelgid;

(F) an emerald ash borer;

(G) a red oak borer;

(H) a white oak borer; and

(I) such other insects as may be identified by the Secretary.

(4) SECRETARY.—The term "Secretary" means—

(A) the Secretary of Agriculture, acting through the Forest Service, with respect to National Forest System land; and

(B) the Secretary of the Interior, acting through appropriate offices of the United States Geological Survey, with respect to federally owned land administered by the Secretary of the Interior.

SEC. 403. ACCELERATED INFORMATION GATHERING REGARDING FOREST-DAMAGING INSECTS.

(a) INFORMATION GATHERING.—The Secretary, acting through the Forest Service and United States Geological Survey, as appropriate, shall establish an accelerated program—

(1) to plan, conduct, and promote comprehensive and systematic information gathering on forest-damaging insects and associated diseases, including an evaluation of—

(A) infestation prevention and suppression methods;

(B) effects of infestations and associated disease interactions on forest ecosystems;

(C) restoration of forest ecosystem efforts;

(D) utilization options regarding infested trees; and

(E) models to predict the occurrence, distribution, and impact of outbreaks of forest-damaging insects and associated diseases;

(2) to assist land managers in the development of treatments and strategies to improve forest health and reduce the susceptibility of forest ecosystems to severe infestations of forest-damaging insects and associated diseases on Federal land and State and private land; and

(3) to disseminate the results of the information gathering, treatments, and strategies.

(b) COOPERATION AND ASSISTANCE.—The Secretary shall—

(1) establish and carry out the program in cooperation with—

(A) scientists from colleges and universities (including forestry schools, land grant colleges and universities, and 1890 Institutions);

(B) Federal, State, and local agencies; and

(C) private and industrial landowners; and

(2) designate such colleges and universities to assist in carrying out the program.

SEC. 404. APPLIED SILVICULTURAL ASSESSMENTS.

(a) ASSESSMENT EFFORTS.—For information gathering and research purposes, the Secretary may conduct applied silvicultural assessments on Federal land that the Secretary determines is at risk of infestation by, or is infested with, forest-damaging insects.

(b) LIMITATIONS.—

(1) EXCLUSION OF CERTAIN AREAS.—Subsection (a) does not apply to—

(A) a component of the National Wilderness Preservation System;

(B) any Federal land on which, by Act of Congress or Presidential proclamation, the removal of vegetation is restricted or prohibited;

(C) a congressionally-designated wilderness study area; or

(D) an area in which activities under subsection (a) would be inconsistent with the applicable land and resource management plan.

(2) CERTAIN TREATMENT PROHIBITED.—Nothing in subsection (a) authorizes the application of insecticides in municipal watersheds or associated riparian areas.

(3) PEER REVIEW.—

(A) IN GENERAL.—Before being carried out, each applied silvicultural assessment under this title shall be peer reviewed by scientific experts selected by the Secretary, which shall include non-Federal experts.

(B) EXISTING PEER REVIEW PROCESSES.—The Secretary may use existing peer review processes to the extent the processes comply with subparagraph (A).

(c) PUBLIC NOTICE AND COMMENT.—

(1) PUBLIC NOTICE.—The Secretary shall provide notice of each applied silvicultural assessment proposed to be carried out under this section.

(2) PUBLIC COMMENT.—The Secretary shall provide an opportunity for public comment before carrying out an applied silviculture assessment under this section.

(d) CATEGORICAL EXCLUSION.—

(1) IN GENERAL.—Applied silvicultural assessment and research treatments carried out under this section on not more than 1,000 acres for an assessment or treatment may be categorically excluded from documentation in an environmental impact statement and environmental assessment under the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.).

(2) ADMINISTRATION.—Applied silvicultural assessments and research treatments categorically excluded under paragraph (1)—

(A) shall not be carried out in an area that is adjacent to another area that is categorically excluded under paragraph (1) that is being treated with similar methods; and

(B) shall be subject to the extraordinary circumstances procedures established by the Secretary pursuant to section 1508.4 of title 40, Code of Federal Regulations.

(3) MAXIMUM CATEGORICAL EXCLUSION.—The total number of acres categorically excluded under paragraph (1) shall not exceed 250,000 acres.

(4) NO ADDITIONAL FINDINGS REQUIRED.—In accordance with paragraph (1), the Secretary shall not be required to make any findings as to whether an applied silvicultural assessment project, either individually or cumulatively, has a significant effect on the environment.

SEC. 405. RELATION TO OTHER LAWS.

The authority provided to each Secretary under this title is supplemental to, and not in lieu of, any authority provided to the Secretaries under any other law.

SEC. 406. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as are necessary to carry out this title for each of fiscal years 2004 through 2008.

TITLE V—HEALTHY FORESTS RESERVE PROGRAM

SEC. 501. ESTABLISHMENT OF HEALTHY FORESTS RESERVE PROGRAM.

(a) ESTABLISHMENT.—The Secretary of Agriculture shall establish the healthy forests reserve program for the purpose of restoring and enhancing forest ecosystems—

(1) to promote the recovery of threatened and endangered species;

(2) to improve biodiversity; and

(3) to enhance carbon sequestration.

(b) COORDINATION.—The Secretary of Agriculture shall carry out the healthy forests reserve program in coordination with the Secretary of the Interior and the Secretary of Commerce.

SEC. 502. ELIGIBILITY AND ENROLLMENT OF LANDS IN PROGRAM.

(a) IN GENERAL.—The Secretary of Agriculture, in coordination with the Secretary of the Interior and the Secretary of Commerce, shall describe and define forest ecosystems that are eligible for enrollment in the healthy forests reserve program.

(b) ELIGIBILITY.—To be eligible for enrollment in the healthy forests reserve program, land shall be—

(1) private land the enrollment of which will restore, enhance, or otherwise measurably increase the likelihood of recovery of a species listed as endangered or threatened under section 4 of the Endangered Species Act of 1973 (16 U.S.C. 1533); and

(2) private land the enrollment of which will restore, enhance, or otherwise measurably improve the well-being of species that—

(A) are not listed as endangered or threatened under section 4 of the Endangered Species Act of 1973 (16 U.S.C. 1533); but

(B) are candidates for such listing, State-listed species, or special concern species.

(c) OTHER CONSIDERATIONS.—In enrolling land that satisfies the criteria under subsection (b), the Secretary of Agriculture shall give additional consideration to land the enrollment of which will—

(1) improve biological diversity; and

(2) increase carbon sequestration.

(d) ENROLLMENT BY WILLING OWNERS.—The Secretary of Agriculture shall enroll land in the healthy forests reserve program only with the consent of the owner of the land.

(e) MAXIMUM ENROLLMENT.—The total number of acres enrolled in the healthy forests reserve program shall not exceed 2,000,000 acres.

(f) METHODS OF ENROLLMENT.—

(1) IN GENERAL.—Land may be enrolled in the healthy forests reserve program in accordance with—

(A) a 10-year cost-share agreement;

(B) a 30-year easement; or

(C) an easement of not more than 99 years.

(2) PROPORTION.—The extent to which each enrollment method is used shall be based on the approximate proportion of owner interest expressed in that method in comparison to the other methods.

(g) ENROLLMENT PRIORITY.—

(1) SPECIES.—The Secretary of Agriculture shall give priority to the enrollment of land that provides the greatest conservation benefit to—

(A) primarily, species listed as endangered or threatened under section 4 of the Endangered Species Act of 1973 (16 U.S.C. 1533); and

(B) secondarily, species that—

(i) are not listed as endangered or threatened under section 4 of the Endangered Species Act of 1973 (16 U.S.C. 1533); but

(ii) are candidates for such listing, State-listed species, or special concern species.

(2) COST-EFFECTIVENESS.—The Secretary of Agriculture shall also consider the cost-effectiveness of each agreement or easement, and associated restoration plans, so as to maximize the environmental benefits per dollar expended.

SEC. 503. RESTORATION PLANS.

(a) IN GENERAL.—Land enrolled in the healthy forests reserve program shall be subject to a restoration plan, to be developed jointly by the landowner and the Secretary of Agriculture, in coordination with the Secretary of Interior.

(b) PRACTICES.—The restoration plan shall require such restoration practices as are necessary to restore and enhance habitat for—

(1) species listed as endangered or threatened under section 4 of the Endangered Species Act of 1973 (16 U.S.C. 1533); and

(2) animal or plant species before the species reach threatened or endangered status, such as candidate, State-listed species, and special concern species.

SEC. 504. FINANCIAL ASSISTANCE.

(a) EASEMENTS OF NOT MORE THAN 99 YEARS.—In the case of land enrolled in the healthy forests reserve program using an easement of not more than 99 years described in section 502(f)(1)(C), the Secretary of Agriculture shall pay the owner of the land an amount equal to not less than 75 percent, nor more than 100 percent, of (as determined by the Secretary)—

(1) the fair market value of the enrolled land during the period the land is subject to the easement, less the fair market value of the land encumbered by the easement; and

(2) the actual costs of the approved conservation practices or the average cost of approved practices carried out on the land during the period in which the land is subject to the easement.

(b) 30-YEAR EASEMENT.— In the case of land enrolled in the healthy forests reserve program using a 30-year easement, the Secretary of Agriculture shall pay the owner of the land an amount equal to not more than (as determined by the Secretary)—

(1) 75 percent of the fair market value of the land, less the fair market value of the land encumbered by the easement; and

(2) 75 percent of the actual costs of the approved conservation practices or 75 percent of the average cost of approved practices.

(c) 10-YEAR AGREEMENT.—In the case of land enrolled in the healthy forests reserve program using a 10-year cost-share agreement, the Secretary of Agriculture shall pay the owner of the land an amount equal to not more than (as determined by the Secretary)—

(1) 50 percent of the actual costs of the approved conservation practices; or

(2) 50 percent of the average cost of approved practices.

(d) ACCEPTANCE OF CONTRIBUTIONS.—The Secretary of Agriculture may accept and use contributions of non-Federal funds to make payments under this section.

SEC. 505. TECHNICAL ASSISTANCE.

(a) IN GENERAL.—The Secretary of Agriculture shall provide landowners with technical assistance to assist the owners in complying with the *terms of plans (as included in agreements or easements) under the healthy forests reserve program.*

(b) TECHNICAL SERVICE PROVIDERS.—The Secretary of Agriculture may request the services of, and enter into cooperative agreements with, individuals or entities certified as technical service providers under section 1242 of the Food Security Act of 1985 (16 U.S.C. 3842), to assist the Secretary in providing technical assistance necessary to develop and implement the healthy forests reserve program.

SEC. 506. PROTECTIONS AND MEASURES

(a) PROTECTIONS.—In the case of a landowner that enrolls land in the program and whose conservation activities result in a net conservation benefit for listed, candidate, or other species, the Secretary of Agriculture shall make available to the landowner safe harbor or similar assurances and protection under—

(1) section 7(b)(4) of the Endangered Species Act of 1973 (16 U.S.C. 1536(b)(4)); or

(2) section 10(a)(1) of that Act (16 U.S.C. 1539(a)(1)).

(b) MEASURES.—If protection under subsection (a) requires the taking of measures that are in addition to the measures covered by the applicable restoration plan agreed to under section 503, the cost of the additional measures, as well as the cost of any permit, shall be considered part of the restoration plan for purposes of financial assistance under section 504.

SEC. 507. INVOLVEMENT BY OTHER AGENCIES AND ORGANIZATIONS.

In carrying out this title, the Secretary of Agriculture may consult with—

(1) nonindustrial private forest landowners;

(2) other Federal agencies;

(3) State fish and wildlife agencies;

(4) State forestry agencies;

(5) State environmental quality agencies;

(6) other State conservation agencies; and

(7) nonprofit conservation organizations.

SEC. 508. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to carry out this title—

(1) $25,000,000 for fiscal year 2004; and

(2) such sums as are necessary for each of fiscal years 2005 through 2008.

TITLE VI—MISCELLANEOUS

SEC. 601. FOREST STANDS INVENTORY AND MONITORING PROGRAM TO IMPROVE DETECTION OF AND RESPONSE TO ENVIRONMENTAL THREATS.

(a) IN GENERAL.—The Secretary of Agriculture shall carry out a comprehensive program to inventory, monitor, characterize, assess, and identify forest stands (with emphasis on hardwood forest stands) and potential forest stands—

(1) in units of the National Forest System (other than those units created from the public domain); and

(2) on private forest land, with the consent of the owner of the land.

(b) ISSUES TO BE ADDRESSED.—In carrying out the program, the Secretary shall address issues including—

(1) early detection, identification, and assessment of environmental threats (including insect, disease, invasive species, fire, and weather-related risks and other episodic events);

(2) loss or degradation of forests;

(3) degradation of the quality forest stands caused by inadequate forest regeneration practices;

(4) quantification of carbon uptake rates; and

(5) management practices that focus on preventing further forest degradation.

(c) EARLY WARNING SYSTEM.—In carrying out the program, the Secretary shall develop a comprehensive early warning system for potential catastrophic environmental threats to forests to increase the likelihood that forest managers will be able to—

(1) isolate and treat a threat before the threat gets out of control; and

(2) prevent epidemics, such as the American chestnut blight in the first half of the twentieth century, that could be environmentally and economically devastating to forests.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $5,000,000 for each of fiscal years 2004 through 2008.

That the House recede from its disagreement to the amendment of the Senate to the title of the bill, and agree to the same.

And the Senate agree to the same.

From the Committee on Agriculture, for consideration of the House bill and the Senate amendments, and modifications committed to conference:

BOB GOODLATTE,
JOHN BOEHNER,
WILLIAM L. JENKINS,
GIL GUTKNECHT,
ROBIN HAYES,
CHARLIE STENHOLM,
COLLIN C. PETERSON,
CAL DOOLEY,

From the Committee on Resources, for consideration of the House bill and the Senate amendments, and modifications committed to conference:

RICHARD POMBO,
SCOTT MCINNIS,
GREG WALDEN,
RICK RENZI,

From the Committee on the Judiciary, for consideration of sections 106 and 107 of the House bill, and sections 105, 106, 1115, and 1116 of the Senate amendment and modifications committed to conference:

F. JAMES SENSENBRENNER, Jr.,
LAMAR SMITH,
Managers on the Part of the House.

THAD COCHRAN,
MITCH MCCONNELL,
MICHAEL CRAPO,
PETE V. DOMENICI,
TOM DASCHLE,
Manager on the Part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERNCE

The Managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 1904), An Act to improve the capacity of the Secretary of Agriculture and the Secretary of the Interior to conduct hazardous fuels reduction projects on National Forest System lands and Bureau of Land Management lands aimed at protecting communities, watersheds, and certain other at-risk lands from catastrophic wildfire, to enhance efforts to protect watersheds and address threats to forest and rangeland health, including catastrophic wildfire, across the landscape, and for other purposes, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The Senate amendments struck out all of the text of the House bill after the enacting clause and inserted a substitute text and a new title.

The House recedes from its disagreement to the amendment of the Senate with an amendment which is a substitute for the House bill and the Senate amendment. The House also recedes from its disagreement to the amendment of the Senate to the title of the bill. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

SHORT TITLE: TABLE OF CONTENTS

(1) Short Title

The House bill cites that this Act may be cited as "Healthy Forests Restoration Act of 2003" and lists the table of contents. (Section 1)

The Senate amendment has an identical short title and differences in the table of contents that reflect the Senate amendment. (Section 1)

The Conference substitute adopted the House provision with an amendment to conform the table of contents to the conference agreement. (Section 1)

(2) Purpose

The House bill lists the purposes of this Act, including: to reduce the risks of damage to communities, municipal water supplies and federal lands from catastrophic wildfire; to authorize grant programs to improve the commercial value of forest biomass; to enhance efforts to protect watersheds and address threats to forest and rangeland health; to promote systematic information gathering to address the impacts of insect infestation on forest and rangeland health; to improve the capacity to detect insect and disease infestations at an early stage; and to benefit threatened and endangered species, improve biological diversity and enhance carbon sequestration. (Section 2)

The Senate amendment contains similar purposes with only technical and clarifying changes. (Section 2)

The Conference substitute adopts the Senate provision with an amendment that reflects changes made necessary by deletions from the bill. (Section 2)

TITLE I—HAZARDOUS FUEL REDUCTION ON FEDERAL LAND

(1) Definitions

The House bill defines terms necessary for implementation of the bill, including: interface community and intermix community; authorized hazardous fuel reduction project; condition class 2; condition class 3; day; decision document; Federal land; implementation plan; municipal water supply system; Secretary concerned; threatened and endangered species habitat. (Section 101)

The Senate amendment defines the same terms as the House bill with only technical differences, and defines additional terms, including: at-risk community; community wildfire protection plan; fire regime i, ii, and iii; Indian tribe; resource management plan; and Wildland-urban interface. (Sections 3, 101)

The Conference substitute [adopts the Senate provisions, with an amendment to modify the definition of wildland-urban interface. (Sections 3, 101)]

(2) Authorized Hazardous Fuel Reduction Projects

The House bill allows for authorized hazardous fuels reduction projects on federal lands that (1) are located in an interface or intermix community; (2) are located in proximity to such communities; (3) are condition class 3 or 2 and located in proximity to a municipal water supply (or a perennial stream, including rivers and other permanent natural flowing water sources feeding a municipal water supply); (4) are condition class 3 or 2 and have been identified as an area where windthrow, blowdown, the existence or threat of disease or insect infestation poses a threat to forest or rangeland health, or (5) contain threatened and endangered species, if: the natural fire regimes are important for, or wildfire is a threat to threatened or endangered species or their habitat; the authorized hazardous fuel reduction project will enhance protection from catastrophic wildfire, and; the Secretary complies with applicable guidelines in any management or recovery plan. (Section 102(a))

The Senate amendment allows for authorized hazardous fuel reduction projects on federal lands that: (1) are in wildland-urban interface areas, (2) are condition class 3 and located in such proximity to a municipal water supply system or a stream feeding such a system within a municipal watershed that a significant risk exists that a fire disturbance event would have adverse effects on the water quality of the municipal water supply or the maintenance of the system, (3) are condition class 2 within fire regime I, fire regime II or fire regime III and otherwise the same as paragraph (2), (4) are identified as an area where windthrow, blowdown, ice storm damage, or the existence of insects or disease poses a significant threat to an ecosystem component, or forest or rangeland resource on federal land or adjacent non-federal land, or (5) contain threatened and endangered species habitat, if: the natural fire regimes are important for, or wildfire is a threat to threatened or endangered species or their habitat; the authorized hazardous fuel reduction project will enhance protection from catastrophic wildfire, and; the Secretary complies with applicable guidelines in any management or recovery plan. (Section 102(a))

The Conference substitute adopts the Senate provision with amendments modifying the definition of wildland-urban interface and that clarify the provision relating to insect and disease infestation. (Section 102(a))

(3) Agency Plans; Acreage Limitation; Exclusion of Certain Federal Land

The House bill requires projects to be planned and conducted in a manner consistent with land and resource management plans or an applicable land use plan; limits the acreage available for authorized hazardous fuels reduction projects to 20,000,000 acres; and prohibits authorized hazardous fuels reduction projects on the following federal lands: a component of the National Wilderness Preservation System, federal lands where the removal of vegetation is prohibited or restricted by a Congress or a presidential proclamation, or wilderness study areas. (Section 102(b), (c), and (d))

The Senate amendment contains similar provisions with only technical differences. (Section 102(b), (c), and (d)).

The Conference substitute adopts the Senate provisions. (Section 102(b), (c), and (d))

(4) Old Growth Stands and Large Tree Retention

The Senate amendment: (Section 102(e), (f))

Provides direction for projects that may occur within old growth stands;

Defines a covered project as all authorized hazardous fuel reduction projects except those in an area where windthrow, blowdown, ice storm damage, or the existence of insects or disease poses a significant threat to an ecosystem component (section 102(a)(4));

Identifies standards for old growth as the definitions, designations, standards, guidelines, goals, or objectives established for an old growth stand under a resource management plan, based on the structure and composition characteristic of the forest type, and in accordance with applicable law;

Requires the Secretary to fully maintain, or contribute toward the restoration of the structure and composition of structurally complex old growth stands according to the pre-fire suppression old growth conditions characteristic of the forest type, while considering the contribution of the stand to landscape fire adaptation and watershed health, and retaining the large trees contributing to old growth structure;

Provides that old growth standards that are 10 years old or less from the date of enactment of this Act shall be used by the Secretary in carrying out a covered project;

Requires that any amendment or revision to standards for which final administrative approval is granted after the date of enactment of this Act shall be consistent with the requirement described above;

Provides that old growth standards established before the 10-year period may be used for a 2-year period beginning on the date of enactment of this Act, or if in the process of revising a resource management plan, may be used for a 3-year period;

Provides that older standards shall be reviewed and revised, if necessary, to reflect relevant information not considered in formulating the resource management plan. If such review is not completed within the appropriate time period, no covered project shall occur in a stand that is identified as an old growth stand (based on substantial supporting evidence) by any person during scoping; and

Requires that covered projects outside of old growth stands focus largely on small diameter trees, thinning, strategic fuel breaks, and prescribed fire to modify fire behavior, as measured by the projected reduction of uncharacteristically severe wildfire effects; and, maximizes the retention of large trees, as appropriate for the forest type, to the extent that the large trees promote fire-resistant stands.

The House bill has no comparable provisions.

The Conference substitute adopts the Senate provisions with an amendment that makes technical and clarifying changes to the old growth provisions; and adds a clause to the large tree retention provision to clarify that such provision is not intended to prevent achieving the purpose in section 2(1). (Section 102(e), (f))

The Managers note that nothing in subsection 102(e) requires resource management plans to be amended.

(5) Prioritization for Communities

The House bill directs the Secretary to give priority to authorized hazardous fuel reduction projects that provide for the protection of communities and watersheds as provided for in the implementation plan. (Section 103)

The Senate amendment: (Section 103)

Directs the Secretary to develop an annual program of work that gives priority to authorized hazardous fuel reduction projects that provide for protection of at-risk communities or watersheds or that implement community wildfire protection plans;

Makes the Federal Advisory Committee Act and National Environmental Policy Act inapplicable to Federal involvement in the community wildfire protection plan planning and development process;

Directs that not less than 50 percent of the funds allocated for authorized hazardous fuel reduction projects shall be used in the wildland-urban interface. Such allocation shall apply at the national level. However, funds may be allocated differently within individual management units as appropriate, in particular to conduct authorized hazardous fuel reduction projects in areas with insects, disease, windthrow, blowdown or ice storm damage.

In providing financial assistance for authorized hazardous fuel reduction projects on non-federal land, the Secretary shall consider recommendations made by at-risk communities that have developed community wildfire protection plans.

The Conference substitute adopts the Senate provision with amendments directing the Secretary to: (1) use existing administrative authority to define wildland-urban interface for purposes of authorized hazardous fuel reduction projects for which a decision notice is issued within one year of date of enactment of this Act, and (2) give priority in allocating funding to communities that have adopted wildfire protection plans. (Section 103)

(6) Environmental Analysis

The House bill:

Requires the Secretary to prepare an environmental assessment (EA) or an environmental impact statement (EIS) for any authorized hazardous fuel reduction project; (104(a))

Gives the Secretary discretionary authority to limit the analysis ordinarily required under the National Environmental Policy Act ('NEPA') to the proposed agency action, meaning the agencies would not be required to analyze and describe a number of different alternatives to the preferred course; (104(b))

Requires the Secretary to provide notice of authorized hazardous fuel reduction projects and conduct a public meeting during the planning stage; (104(c))

Requires the Secretary to collaborate among governments and interested persons during the formulation of each authorized fuels reduction project; (104(d))

Requires the Secretary to allow public input in accordance with NEPA during the preparation of an EA or EIS or an authorized hazardous fuel reduction project; (104(e))

Requires the Secretary to sign a decision document for each authorized hazardous fuels reduction project and provide notice of that document; (104(f)) and

Requires the Secretary concerned to monitor the implementation of authorized hazardous fuels reduction projects. (104(g))

With respect to House bill sections 104 (a), (c), (d), (e), and (f), the Senate amendment contains essentially identical provisions, except for technical differences.

With respect to House bill section 104(b), the Senate amendment directs the Secretary to prepare an environmental assessment (EA) or an environmental impact statement (EIS) for any authorized hazardous fuel reduction project which describes the proposed action, a no action alternative, and an additional action alternative, if the additional alternative is proposed during scoping or the collaborative process and meets the purpose and need of the project. If more than 1 additional alternative is proposed, the Secretary shall select which additional alternative to consider and provide a written record describing the reasons for the selection. (Section 104(b))

With respect to House bill section 104(g), the Senate amendment:

Directs each Forest Service region and BLM State Office to monitor the results of authorized hazardous fuels reduction projects, and submit a report every 5 years that includes an evaluation of the progress towards project goals and recommendations for modifications to the projects and management treatments. It requires monitoring and assessment from a representative sample of authorized hazardous fuel reduction projects for each management unit as to the effects on changes in condition class, fire regime, watershed or landscape goals or objectives in the resource management plan, and requires the Secretary to track acres burned the degree of severity; and develop a process for monitoring the need for maintenance of treated areas, over time, in order to preserve the forest health benefits achieved; and (Section 102(g))

Instructs the Secretary to establish a collaborative monitoring, evaluation, and accountability process in order to assess the positive or negative ecological and social effects of a representative sampling of projects implemented pursuant to title I and section 404 of the Senate amendment, and include diverse stakeholders, including interested citizens and Indian tribes, in the monitoring and evaluation process. (Section 1108)

With respect to Section 104(b) of the House bill and the Senate amendment, the Conference substitute adopts the Senate provision with an amendment that provides for special expedited environmental analysis processes for hazardous fuels reduction projects within the wildland-urban interface and within 1½ miles of at risk communities (Section 104(d)).

For projects described in section 104(d)(1) of the Conference substitute, the Managers expect the Secretary to concisely analyze the likely environmental outcomes if the proposed treatment is not implemented.

The Managers note that, under subsection 104(c)(2), if more than one additional alternative is proposed during scoping that meets the purpose and need, the Secretary has the discretion to select which additional alternative to consider, and must provide a written record describing the reasons for the selection. The Managers note that the written record could be part of, or separate from, the environmental assessment or environmental impact statement.

The Managers expect, in carrying out authorized fuel reduction projects under the expedited processes provided by the Act, the Secretary not to neglect obligations under the provisions of section 6(g)(3)(B) of the Forest and Rangeland Renewable Resources Planning Act of 1976 (16 U.S.C. 1604(g)(3)(B)).

With respect to Section 104(g) of the House bill, the Conference substitute: (1) strikes the Senate amendment provision (Section 1108) regarding collaborative monitoring; and (2) adopts the Senate amendment provision (Section 102(g)) regarding monitoring with an amendment that allows the Secretary to utilize multiparty monitoring with diverse stakeholders in areas where interest in multiparty monitoring exists. (Section 102(g))

(7) Administrative Review

The House bill:

Directs the Secretary of Agriculture to establish an administrative review process for the Forest Service within 90 days after the enactment of this Act that will serve as the sole means by which a person can seek administrative redress regarding an authorized hazardous fuels reduction project; (Section 105(a))

Limits the administrative process to be developed to persons who have submitted specific and substantive written comments during the preparation stage of the project; and (Section 105(b))

Clarifies that the Appeals Reform Act relating to USFS administrative appeals does not apply to an authorized hazardous fuels reduction project. (Section 105(c))

The Senate amendment:

Directs the Secretary of Agriculture to establish, within 30 days after the date of the enactment of this Act, interim final regulations to establish a pre-decisional administrative review process that will serve as the sole means by which a person can seek administrative review regarding an authorized hazardous fuel reduction project on National Forest System land; (Section 105(a))

Requires the Secretary to establish final regulations after a time period for public comment; (Section 105(b))

Provides that a person may only bring a civil action challenging an authorized hazardous fuel reduction project in a Federal district court if the issue was raised during the administrative process and the person has exhausted the administrative review process established by the Secretary, with exceptions for futility or inadequacy claims; and (Section 105(c))

Clarifies that, with respect to projects and activities of the National Forest System other than authorized hazardous fuel reduction projects, nothing affects, or otherwise biases, the notice, comment, and appeal procedures for projects and activities of the National Forest System contained in part 215 of title 36, Code of Federal Regulations (including related legal actions). (Section 107(b))

The Conference substitute adopts the Senate provisions with an amendment that incorporates the substantive content of House bill section 105(b) and adds clarifying changes to section 105(c) of the Senate amendment. (Section 105)

The Managers do not expect the provisions in section 105(c)(3)(B) of the Conference substitute to be applicable to information which has not been brought to the attention of the Secretary.

(8) Judicial Review

The House bill:

Establishes a time limit for filing a challenge to an authorized hazardous fuels reduction project to 15 days within notice of the final agency action; (Section 106(a))

Limits the duration of any preliminary injunction granted on an authorized project to 45 days subject to renewal, and requires Secretarial notification to Congress upon an injunction renewal; (106(b))

Encourages a court in which an action or an appeal is filed to render a final determination within 100 days of when the complaint or appeal is filed; (106(c))

With respect to all agency actions on Federal lands, directs a court, in considering a request for injunctive relief, to balance the impact to the ecosystem of the short-term and long-term effects of undertaking the agency action against the short-term and long-term effects of not undertaking the agency action, and to give deference to any agency finding that the balance of harm and the public interest in avoiding the short-term effects of the agency action is outweighed by the public interest in avoiding long-term harm to the ecosystem. (Section 107)

The Senate amendment:

Requires lawsuits challenging an authorized hazardous fuel reduction project to be filed only in the United States district court for the district in which the federal land to be treated is located; (Section 106(a))

Encourages the court to expedite the proceedings with the goal of rendering a final determination as soon as practicable; (Section 106(b))

Limits the length of any preliminary injunctive relief and stays pending appeal not to exceed 60 days, subject to renewal with a requirement that parties to the action shall present updated information on the status of the project; (Section 106(c)(1), (2))

Directs the court reviewing the project, as part of its weighing the equities while considering any request for an injunction, to balance the impact to the ecosystem likely affected by the project of the short- and long-term effects of undertaking the agency action against the short- and long-term effects of not undertaking the agency action. (Section 106(c)(3))

The Conference substitute adopts the Senate provision. (Section 106)

(9) Effect of Title; Rules of Construction

The House bill clarifies that nothing in this title:

shall be construed to affect or limit the use of other authorities by the Secretary concerned to plan or conduct a hazardous fuels reduction project on federal lands; and (Section 108(a))

shall be construed to prejudice the consideration or disposition of any legal action concerning the Roadless Area Conservation Rule. (Section 108(b))

The Senate amendment provides that nothing in this title affects, or otherwise biases, the use by the Secretary of other statutory or administrative authority (including categorical exclusions adopted to implement the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.)) to conduct a hazardous fuel reduction project on Federal land (including Federal land identified in section 102(d)) that is not conducted using the process authorized by section 104. (Section 107(a))

The Conference substitute adopts the Senate provision. (Section 107)

(10) Authorization of Appropriations

The Senate amendment authorizes $760 million annually for activities under this title and other hazardous fuel reduction activities of the Secretary. (Section 108)

The House bill has no comparable provision.

The Conference substitute adopts the Senate provision. (Section 108)

TITLE II—BIOMASS

(1) Findings; Definitions

The House bill contains Congressional findings that that show high risk of wildfires across many acres due to the accumulation of heavy fuel loads from insect infestations and disease, and defines the terms: Biomass, Person, Preferred Community, and Secretary Concerned. (Sections 201, 202)

The Senate amendment has comparable provisions with minor differences. (Sections 201, 202)

(2) Grants to Improve the Commercial Value of Forest Biomass; Reporting requirement

The House bill establishes biomass commercial use and value-added grant programs to benefit anyone who owns or operates a facility to produce energy from biomass, as well as a monitoring program for participants, while complying with existing endangered species protections; authorizes appropriations of $25,000,000 for fiscal years 2004 to 2008; and requires that the Secretary concerned submit a report of the grant programs no later than October 1, 2010. (Sections 203, 204)

The Senate amendment has a comparable amendment with minor differences. (Sections 203, 204)

With respect to sections 201 and 202 of the House bill and sections 203 and 204 of the

Senate amendment, the Conference substitute adopts an amendment that authorizes the Secretary to provide biomass purchase grants to owners and operators of biomass facilities that use such materials for production of wood-based products or other commercial purposes. (Section 203)

(3) Improved Biomass Use Research Program

The Senate amendment amends the Biomass Research and Development Act of 2000 by adding a silviculture component to the program. (Section 205)

The House has no provision on this subject.

The Conference substitute adopts the Senate provision. (Section 201)

(4) Rural Revitalization Through Forestry

The Senate amendment establishes a program to facilitate small business use of biomass and authorizes appropriations of $5,000,000 for fiscal years 2004 to 2008 to carry out the program. The program is established by amending the Food, Agriculture, Conservation, and Trade Act of 1990. (Section 206)

The House bill has no provision on this subject.

The Conference substitute adopts the Senate provision. (Section 202)

TITLE III—WATERSHED FORESTRY ASSISTANCE

(1) Findings and Purpose

The House bill contains Congressional findings that the proper stewardship of forest lands is essential to sustaining and restoring the health of watersheds. The purpose of this title is to improve watershed health by forest management practices, such as maintaining tree cover, buffer strips. (Section 301)

The Senate contains a comparable provision with minor changes. (Section 301)

(2) Watershed Forestry Assistance Program

The House bill establishes a program to assist State foresters in expanding stewardship capacities to address watershed issues on non-Federal lands through technical assistance and a cost-share program by amending the Cooperative Forestry Assistance Act. An authorization for appropriations of $15,000,000 for each of the fiscal years 2004 through 2008 is also included. (Section 302)

The Senate contains a comparable provision with minor changes and also defines the term Nonindustrial Private Forest Land. (Section 302)

The Conference substitute adopts the Senate provision. (Section 302)

(3) Tribal Watershed Forestry Assistance

The Senate amendment directs the Secretary of Agriculture to provide assistance to Indian tribes for expanding forestry projects and to address watershed issues on tribal lands and provides the same basic authorities for Indian tribes as are provided in Section 302. (Section 303)

The House bill has no comparable provision.

The Conference substitute adopts the Senate provision. (Section 303)

TITLE IV—INSECT INFESTATIONS

(1) Definitions, Findings, and Purpose

The House bill defines the terms Applied Silvicultural Assessment, Federal Lands, Secretary Concerned, 1890 Institutions. The bill also contains Congressional findings that insect infestations have many adverse effects on forest health, and states that the purpose of this title is to require the Secretary concerned to develop an assessment program to combat insect infestations, to enlist the assistance of educational institutions, and to carry out applied silvicultural assessments. (Section 401)

The Senate bill contains comparable provisions and also defines the term Forest Damaging Insect. (Sections 401, 402)

The Conference substitute adopts the Senate provision. (Sections 401, 402)

(2) Accelerated Information Gathering Regarding Forest Damaging Insects

The House bill establishes a program for information gathering on bark beetles, including Southern pine beetles, hemlock woolly adelgids, emerald ash borers, red oak borers, and white oak borers, to assist land managers in the development of treatments to improve forest health, and disseminate results in cooperation with scientists from university and forestry schools. (Section 402)

The Senate amendment contains a comparable provision with minor changes and expands program to include all forest-damaging insects and associated diseases. (Section 403)

The Conference substitute adopts the Senate provision. (Section 403)

(3) Applied Silvicultural Assessments

The House bill enables the Secretary concerned to conduct applied silvicultural assessments on federal lands that the Secretary determines in its sole discretion are at risk for infestation with certain named pests. It limits such assessment areas to 1,000 acres per assessment; applies an overall acreage limitation to 250,000 acres; requires the Secretary to provide notice of each applied silvicultural assessment proposed to be carried out; requires the Secretary to provide an opportunity for public input; creates a categorical exclusion from further analysis under NEPA which the environment. (Section 403)

The Senate amendment contains a comparable provision with minor technical differences, and expands to all forest-damaging insects and associated diseases. The Senate bill precludes categorical exclusions using similar methods from being carried out adjacent to one another and subjects them to the extraordinary circumstances procedures. (Section 404)

The Conference substitute adopts the Senate provision. (Section 404)

(4) Relation to Other Laws; Authorization of Appropriations

The House bill provides that authorities of the Secretary under this title are in addition to other authorities of the Secretary under other laws, and authorizes such sums as may be necessary to be appropriated between fiscal year 2004 and 2008. (Sections 404, 405)

The Senate amendment contains comparable provisions with only technical differences. (Sections 405, 406)

The Conference substitute adopts the Senate provisions. (Sections 405, 406)

TITLE V—HEALTHY FORESTS RESERVE PROGRAM

(1) Establishment of Program

The House bill directs the Secretary of Agriculture to establish a program with the purpose of protecting, restoring, and enhancing forest ecosystems to promote the recovery of endangered species, improve biodiversity, and enhance carbon sequestration. (Section 501)

The Senate amendment has a comparable provision. (Section 501)

The Conference substitute adopts the Senate provision. (Sections 501)

(2) Eligibility and Enrollment of Lands in Program

The House bill specifies lands eligible for enrollment and lists eligibility and enrollment requirements for program participants, including enrollment priorities for land with threatened and endangered species. (Section 502 (a), (b), (c), (f))

The Senate amendment has comparable provisions with minor differences. (Section 502 (a), (b), (c), (d), (g))

The Conference substitute adopts the Senate provisions. (Section 502 (a), (b), (c), (d), (g))

(3) Maximum Enrollment; Methods of Enrollment

The House bill establishes a maximum enrollment of 1,000,000 acres, and authorizes acres to be enrolled through a permanent easement with buyback option, a 30-year easement, or a 10-year agreement for enrolled lands under this program. (Section 502 (d) and (e))

The Senate amendment establishes a maximum enrollment of 2,000,000 acres, and authorizes acres to be enrolled through agreements of not more than 99 years with no buyback option, 30-year agreements; or 10-year cost share agreements. (Section 502 (e) and (f))

The Conference substitute adopts the Senate provision with respect to maximum enrollment (502(e) and the House provision with an amendment with respect to methods of enrollment to allow for 10-year cost share agreements, and 30-year and up to 99-year easements. (Section 502(f))

(4) Conservation Plans

The House bill requires lands enrolled shall be subject to a conservation plan developed by USDA and the US Fish and Wildlife Service; requires a description of the permissible land-use activities; authorizes applicable State agencies and nonprofit conservation organizations to provide technical or financial assistance in development of the plans; and requires that the plan maximize the environmental benefits per dollar expended. (Section 503)

The Senate amendment has comparable provisions. (Sections 502(g)(2), 503, 507)

The Conference substitute adopts the Senate provision. (Sections 502(g)(2), 503, 507)

(5) Financial Assistance

The House bill specifies maximum amounts of financial assistance for each method of enrollment of acres into the Healthy Forest Reserve. (Section 504)

The Senate amendment contains similar language (Section 504).

The Conference substitute adopts the Senate provision with an amendment reflecting the changes made in the methods of enrollment. (Section 504)

(6) Technical Assistance

The House bill directs the Forest Service and U.S. Fish and Wildlife service to provide participants with technical assistance. (Section 505)

The Senate amendment has a comparable provision and also adds that the Secretary may enter into cooperative agreements with third parties certified as technical service providers. (Section 505)

The Conference substitute adopts the Senate provision. (Section 505)

(7) Safe Harbor

The House bill instructs the Secretary of Interior to provide safe harbor to landowners who enroll land in this program when enrollment results in a net conservation benefit for listed species. (Section 506)

The Senate amendment has a comparable provision and also provides that the cost of any additional measures taken besides those covered in the restoration plan will be considered part of the restoration plan for financial purposes. (Section 506)

The Conference substitute adopts the Senate provision. (Section 506)

(8) Authorization of Appropriations

The House bill authorizes to be appropriated $15,000,000 for each of the fiscal years 2004 through 2008. (Section 507)

The Senate amendment authorizes to be appropriated $25,000,000 for fiscal year 2004 and such sums necessary for each of the fiscal years 2005–2008. (Section 508)

The Conference substitute adopts the Senate provision. (Section 508)

TITLE VI—MISCELLANEOUS PROVISIONS

(1) Inventory and Monitoring Program

The House bill instructs the Secretary of Agriculture to carry out a program to monitor forest stands on National Forest System lands and private lands; lists issues to be addressed; establishes an early warning system; and authorizes $5,000,000 for each of the fiscal years 2004 through 2008 for such activities. (Section 601)

The Senate amendment has a comparable provision that also lists specific means and offices for carrying out the program, and authorizes such sums as are necessary to carry out this section without fiscal year limitation. (Section 1101)

The Conference substitute adopts the House provision. (Title VI)

The managers expect the Secretary to consult and collaborate with the National Aeronautics and Space Administration, Stennis Space Center in carrying out this title.

(2) Public Land Corps

The Senate amendment creates a public land corps to carry out rehabilitation projects enlisting the help of disadvantaged young people. The amendment authorizes to be appropriated $15,000,000 for each of the fiscal years 2004 through 2008. (Title VI)

The House bill contains no comparable provision.

The Conference substitute strikes the Senate provision.

(3) Rural Community Forestry Enterprise Program

The Senate amendment establishes a program to assist in the economic revitalization of rural forest research-dependent communities. The amendment authorizes to be appropriated $15,000,000 for each of the fiscal years 2004 through 2008. (Title VII)

The House bill contains no comparable provision.

The Conference substitute strikes the Senate provision.

(4) Firefighters Medical Monitoring Act

The Senate amendment provides that the National Institute for Occupational Safety and Health shall monitor the long-term medical health of those firefighters who fought fires in any area declared a disaster area by the Federal Government. The amendment authorizes to be appropriated such sums as may be necessary in each of the fiscal years 2004 through 2008 to carry out this title. (Title VIII)

The House bill contains no comparable provision.

The Conference substitute strikes the Senate provision.

(5) Disaster Air Quality Monitoring Act

The Senate amendment instructs the Environmental Protection Agency to provide each of its regional offices a mobile air pollution monitoring network to monitor the emissions of hazardous air pollutants in disaster areas and publish the findings. The amendment authorizes to be appropriated $8,000,000 to carry out this title. (Title IX)

The House bill contains no comparable provision.

The Conference substitute strikes the Senate provision.

(6) Highlands Region Conservation

The Senate amendment recognizes the importance of the water, forest, agricultural, wildlife, recreational and cultural resources of the Highlands, and the national significance of the Highlands region to the United States. The amendment authorizes the Secretary of Interior to work in partnership with the Secretary of Agriculture to provide financial assistance to the Highlands States to preserve and protect high priority conservation lands in the Highlands region, and continues the ongoing Forest Service programs in the Highlands region to assist the Highlands States, local units of government and private forest and farm landowners in the conservation of lands and natural resources in the Highlands region. (Title X)

The House bill contains no comparable provision.

The Conference substitute strikes the Senate provision.

(7) Emergency Treatment and Reduction of Nonnative Invasive Plants

The Senate amendment establishes a program for emergency treatment and reduction of nonnative invasive plants to provide to State and local governments and agencies, conservation districts, tribal governments, and willing private landowners grants for use in carrying out hazardous fuel reduction projects to address threats of catastrophic fires that have been determined by the Secretaries to pose a serious threat, including work to eradicate Salt Cedar and Russian Olive trees and other brush along the Bosque lands on the Rio Grande River in the State of New Mexico. (Section 1102)

The House bill contains no comparable provision.

The Conference substitute strikes the Senate provision.

(8) USDA National Agroforestry Center

The Senate amendment amends section 1243 of the Food, Agriculture, Conservation, and Trade Act of 1990 to establish a National Agroforestry Center. (Section 1103)

The House bill contains no comparable provision.

The Conference substitute strikes the Senate provision.

(9) Upland Hardwoods Research Center

The Senate amendment directs the Secretary to establish an upland hardwood research center. (Section 1104)

The House bill contains no comparable provision.

The Conference substitute strikes the Senate provision.

(10) Emergency Fuel Reduction Grants

The Senate amendment instructs the Secretary of Agriculture to establish an emergency fuel reduction grant program under which the Secretary shall provide grants to State and local agencies to carry out hazardous fuel reduction projects addressing threats of catastrophic fire that pose a serious threat to human life, as determined by the Forest Service. (Section 1105)

The House bill contains no comparable provision.

The Conference substitute strikes the Senate provision.

(11) Eastern Nevada Landscape Coalition

The Senate amendment authorizes the Secretary of Agriculture and the Secretary of the Interior to make grants to the Eastern Nevada Landscape Coalition for the study and restoration of rangeland and other lands in Nevada's Great Basin in order to help assure the reduction of hazardous fuels and for related purposes. (Section 1106)

The House bill contains no comparable provision.

The Conference substitute strikes the Senate provision.

(12) Sense of Congress Regarding Enhanced Community Fire Protection

The Senate amendment states that it is the sense of Congress to reaffirm the importance of enhanced community fire protection program, as described in section 10A of the Cooperative Forestry Assistance Act of 1978 (16 U.S.C. 2106c) (as added by section 8003(b) of the Farm Security and Rural Investment Act of 2002 (Public Law 107 09171; 116 Stat. 473)). (Section 1107)

The House bill contains no comparable provision.

The Conference substitute strikes the Senate provision.

(13) Best-Value Contracting

The Senate amendment allows the Secretaries to use best value contracting criteria in awarding contracts and agreements. Best-value contracting criteria includes the ability of the contractor to meet the ecological goals of the projects; the use of equipment that will minimize or eliminate impacts on soils; and benefits to local communities such as ensuring that the byproducts are processed locally. (Section 1109)

The House bill contains no comparable provision.

The Conference substitute strikes the Senate provision.

(14) Suburban and Community Forestry and Open Space Program; Forest Legacy Program

The Senate amendment establishes within the Forest Service a program to be known as the "Suburban and Community Forestry and Open Space Program" (Section 1110)

The House bill contains no comparable provision.

The Conference substitute strikes the Senate provision.

(15) Wildland Firefighter Safety

The Senate amendment directs the Secretaries to ensure that any Federal contract or agreement entered into with a private entity for wildland firefighting services requires the entity to provide firefighter training that is consistent with qualification standards management direction established by the National Wildfire Coordinating Group. (Section 1111)

The House bill contains no comparable provision.

The Conference substitute strikes the Senate provision.

(16) Green Mountain National Forest Boundary Adjustment

The Senate amendment states the boundaries of the Green Mountain National Forest are modified to include all parcels of land depicted on the forest maps entitled "Green Mountain Expansion Area Map I" and "Green Mountain Expansion Area Map II", each dated February 20, 2002, which shall be on file and available for public inspection in the Office of the Chief of the Forest Service, Washington, District of Columbia. (Section 1112)

The House bill contains no comparable provision.

The Conference substitute strikes the Senate provision.

(17) Puerto Rico Karst Conservation

The Senate amendment authorizes and supports conservation efforts to acquire, manage, and protect the tropical forest areas of the Karst Region, with particular emphasis on water quality and the protection of the aquifers that are vital to the health and wellbeing of the citizens of the Commonwealth; and promotes cooperation among the Commonwealth, Federal agencies, corporations, organizations, and individuals in those conservation efforts. (Section 1113)

The House bill contains no comparable provision.

The Conference substitute strikes the Senate provision.

(18) Effective Date of Section 10806 of Farm Security and Rural Investment Act

The Senate amendment states Section 10806(b)(1) of the Farm Security and Rural Investment Act of 2002 (21 U.S.C. 321d; 116 Stat. 526), is deemed to have first become effective 15 days after the date of the enactment of this Act. (Section 1114)

The House bill contains no comparable provision.

The Conference substitute strikes the Senate provision.

(19) Enforcement of Animal Fighting Prohibitions Under the Animal Welfare Act

The Senate amendment amends Section 26 of the Animal Welfare Act. (Section 1115)

The House bill contains no comparable provision.

The Conference substitute strikes the Senate provision.

(20) Changes in Fines for Violation of Public Land Regulations During a Fire Ban

The Senate amendment contains provisions to modify the penalties for violations of fire bans. (Section 1116)

The House bill contains no comparable provision.

The Conference substitute strikes the Senate provision.

From the Committee on Agriculture, for consideration of the House bill and the Senate amendments, and modifications committed to conference:

BOB GOODLATTE,
JOHN BOEHNER,
WILLIAM L. JENKINS,
GIL GUTKNECHT,
ROBIN HAYES,
CHARLIE STENHOLM,
COLLIN C. PETERSON,
CAL DOOLEY,

From the Committee on Resources, for consideration of the House bill and the Senate amendments, and modifications committed to conference:

RICHARD POMBO,
SCOTT MCINNIS,
GREG WALDEN,
RICK RENZI,

From the Committee on the Judiciary, for consideration of sections 106 and 107 of the House bill, and sections 105, 106, 1115, and 1116 of the Senate amendment and modifications committed to conference:

F. JAMES SENSENBRENNER, Jr.
LAMAR SMITH,
Managers on the Part of the House.

THAD COCHRAN,
MITCH MCCONNELL,
MICHAEL CRAPO,
PETE V. DOMENICI,
TOM DASCHLE,
Managers on the Part of the Senate.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. BISHOP of New York (at the request of Ms. PELOSI) for November 19th on account of illness.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. HASTINGS of Florida) to revise and extend their remarks and include extraneous material:)

Mr. DEFAZIO, for 5 minutes, today.

Mr. BROWN of Ohio, for 5 minutes, today.

Ms. NORTON, for 5 minutes, today.

Mr. EMANUEL, for 5 minutes, today.

Ms. WOOLSEY, for 5 minutes, today.

Mr. SCHIFF, for 5 minutes, today.

Mr. HINCHEY, for 5 minutes, today.

Mr. DAVIS of Illinois, for 5 minutes, today.

Mr. PALLONE, for 5 minutes, today.

Mr. HOYER, for 5 minutes, today.

Ms. JACKSON-LEE of Texas, for 5 minutes, today.

(The following Members (at the request of Mr. BURTON of Indiana) to revise and extend their remarks and include extraneous material:)

Mrs. JO ANN DAVIS of Virginia, for 5 minutes, today.

Mr. SHUSTER, for 5 minutes, today.

Mr. LINCOLN DIAZ-BALART of Florida, for 5 minutes, today.

Mr. GUTKNECHT, for 5 minutes, today and November 21.

Mr. SMITH of New Jersey, for 5 minutes, today.

Ms. ROS-LEHTINEN, for 5 minutes, today.

Mr. MARIO DIAZ-BALART of Florida, for 5 minutes, today.

Mr. ROHRABACHER, for 5 minutes, today.

ADJOURNMENT

Mr. THOMAS. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 1 o'clock and 18 minutes a.m.), the House adjourned until today, Friday, November 21, 2003, at 9 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

5512. A letter from the Director, Regulations Policy and Management Staff, Food and Drug Administration, Department of Health and Human Services, transmitting the Department's final rule — Medical Devices; Cardiovascular Devices; Reclassification of the Arrhythmia Detector and Alarm [Docket Nos. 1994N-0418 and 1996P-0276] received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5513. A letter from the Director, Regulations Policy and Management Staff, Food and Drug Administration, Department of Health and Human Services, transmitting the Department's final rule — Medical Devices; Immunology and Microbiology Devices; Classification of the West Nile Virus IgM Capture Elisa Assay [Docket No. 2003P-0450] received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5514. A letter from the Regulations Coordinator, Centers for Disease Control and Prevention, Department of Health and Human Services, transmitting the Department's final rule — Possession, Use, and Transfer of Select Agents and Toxins — received October 31, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5515. A letter from the Deputy Assistant Administrator, Office of Diversion Control, DEA, Department of Justice, transmitting the Department's final rule — Sale by Federal Departments or Agencies of Chemicals Which Could Be Used in the Illicit Manufacture of Controlled Substances [Docket No. DEA-176F] (RIN: 117-AA47) received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5516. A letter from the Attorney-Advisor, National Highway Traffic Safety Administration, Department of Transportation, transmitting the Department's final rule — Federal Motor Vehicle Safety Standards; Occupant Crash Protection [Docket No. NHTSA 03-16476, Notice 1] (RIN: 2127-A182) received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5517. A letter from the Sr. Legal Advisor to the Chief, Media Bureau, Federal Communication Commission, transmitting the Commission's final rule — Implementation of Section 304 of the Telecommunications Act of 1996 [CS Docket No. 97-80]; Commercial Availibility of Navigation Devices; Compatibility Between Cable Systems and Consumer Electronic Equipment [PP Docket No. 00-67] received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5518. A letter from the Special Assistant to the Bureau Chief, Media Bureau, Federal Communication Commission, transmitting the Commission's final rule — Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations. (Archer City, Texas) [MB DOcket No. 03-116] received October 28, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5519. A letter from the Senior Legal Advisor to the Chief, Media Bureau, Federal Communication Commission, transmitting the Commission's final rule — Amendment of Section 73.202(b) Table of Allotments, FM Broadcast Stations. (Ehrenberg, Arizona) [MB Docket No. 03-174 RM-10754] received October 31, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5520. A letter from the Senior Legal Advisor, International Bureau, Federal Communication Commission, transmitting the Commission's final rule — Flexibility for Delivery of Communication by Mobile Satellite Service Providers in the 2 GHz Band, the L-Band, and the 1.6/2.4 GHz Bands [IB Docket No. 01-185] received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5521. A letter from the Chief, Policy and Rules Division, Federal Communications Commission, transmitting the Commission's final rule — Amendment of Parts 2,25 of the Commission's Rules to Permit Operation of NGSO FSS Sysytems Co-Frequency with

GSO and Terrestrial Systems in Ku-Band [ET Docket No. 98-206] received October 28, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5522. A letter from the Attorney Advisor, Wireless Telecommunications Bureau, Federal Communications Commission, transmitting the Commission's final rule — Amendment of Parts 2 and 87 of the Commission's Rules to Accomodate Advanced Digital Communications in the 117.975-137 MHz Band and to Implement Flight Information Services in the 136-137 MHz Band [WT Docket No. 00-77 RM Nos. 9376, 9462] received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5523. A letter from the Legal Advisor, Media Bureau, Federal Communications Commission, transmitting the Commission's final rule — Implementation of LPTV Digital Data Services Pilot Project — received October 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5524. A letter from the Bureau Chief, CGB, Federal Communications Commission, transmitting the Commisison's final rule — Provision of Improved Telecommunications Relay Services and Speech-to-Speech Services for Individuals with Hearing and Speech Disbilities [CC Docket No. 98-67]; Petition for Clarification of WorldCom, Inc. — received October 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5525. A letter from the Senior Legal Advisor to the Chief, Media Bureau, Federal Communications Commission, transmitting the Commission's final rule — Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations. (Payson and Camp Verde, Arizona) [MB Docket No. 03-160 RM-10706] received October 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5526. A letter from the Senior Legal Advisor to the Chief, Media Bureau, Federal Communications Commission, transmitting the Commission's final rule — Amendment of Section 73.622(b), Table of Allotments, Digital Television Broadcast Stations. (Butte, Montana) [MB Docket No. 03-118 RM-10585] received October 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5527. A letter from the Senior Legal Advisor to the Chief, Media Bureau, Federal Communications Commission, transmitting the Commission's final rule — Amendment sof Section 73.622(b), Table of Allotments, Digital Television Broadcast Stations. (Fayetteville, Arkansas) [MM Docket No. 01-55 RM-10034] received October 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5528. A letter from the Senior Legal Advisor to the Chief, Media Bureau, Federal Communications Commission, transmitting the Commission's final rule — Amendment of Section 73.606(b), Table of Allotments, Television Broadcast Stations. (Bay City, Michigan) [MM Docket No. 01-84 RM-10067] received October 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5529. A letter from the Senior Legal Advisor to the Chief, Media Bureau, Federal Communications Commission, transmitting the Commission's final rule — Amendment of Section 73.202(b) FM Table of Allotments, FM Braodcast Stations. (Harrison, Michigan) [MB Docket No. 03-176 RM-10720] received October 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5530. A letter from the Senior Legal Advisor, International Bureau, Federal Communications Commission, transmitting the Commission's final rule — Amendment of Parts 2 and 25 of the Commission's Rules to Permit Operation of NGSO FSS Systems Co-Frequency with GSO and Terrestrial Systems in the Ku-Band Frequency Range [ET Docket No. 98-206] received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5531. A letter from the Senior Legal Advisor to the Chief, Media Bureau, Federal Communications Commission, transmitting the Commission's final rule — Amendment of the Commission's Rues for Implementation of its Cable Operations And Licensing System (COALS) to Allow for Electronic Filing of Licensing Applications, Forms, Registrations and Notifications in the Multichannel Video and Cable Television Service and the Cable Television Relay Service [CS Docket No. 00-78] received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5532. A letter from the Legal Advisor, Media Bureau, Federal Communications Commission, transmitting the Commission's final rule — Review of the Commission's Rules and Policies Affecting the Conversion to Digital Television [MM Docket No. 00-39] received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5533. A letter from the Assistant Chief, WCB, TAPD, Federal Communications Commission, transmitting the Commission's final rule — Federal-State Joint Board on Universal Service [CC Docket No. 96-45] received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5534. A letter from the Senior Legal Advisor, International Bureau, Federal Communications Commission, transmitting the Commission's final rule — Partial Band Licensing and Loading Standards for Earth Stations in the FSS That Share Spectrum With Terrestrial Services [IB Docket No. 00-203; RM-9649], Blanket Licensing for Small Aperture Terminals in the C-Band [SAT-PDR-19990910-00091], Routine Licensing of 3.7 Meter Transmit and Receive Stations at C-Band, and Deployment of Geostationary-Orbit FSS Earth Stations in the Shared Portion of the Ka-Band, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5535. A letter from the Senior Legal Advisor, International Bureau, Federal Communications Commission, transmitting the Commission's final rule — Amendment of the Commission's Rules to Establish Rules and Policies Pertaining to a Mobile Satellite Service in the 1610-1626.5/2483.5-2500 MHz Frequency Band [CC Docket No. 92-166] received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5536. A letter from the Senior Legal Advisor, International Bureau, Federal Communications Commission, transmitting the Commission's final rule — Review of the Spectrum Sharing Plan Amoung Non-Geostationary Satellite Orbit Mobile Satellite Service Systems in the 1.6/2.4 GHz Bands [IB Docket No. 02-364] received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5537. A letter from the Senior Legal Advisor, International Bureau, Federal Communications Commission, transmitting the Commission's final rule — The International Bureau Revises and Reissues the Commission's List of Foreign Telecommuncations Carriers that Are Presumed to Possess Market Power in Foreign Telecommunications Markets — received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5538. A letter from the Associate Bureau Chief, WTB, Federal Communications Commission, transmitting the Commission's final rule — Reallocation and Service Rules for the 698-746 MHz Spectrum Band (Television Channels 52-59) [GN Docket No. 01-74; FCC 02-185] received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5539. A letter from the Attorney Advisor, Federal Communications Commission, transmitting the Commission's final rule — Implementation of Sections 309(j) and 337 of the Communications Act of 1934 as Amended [WT Docket No. 99-87] received November 13, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5540. A letter from the Senior Legal Advisor, International Bureau, Federal Communications Commission, transmitting the Commission's final rule — Enforcement of Other Nations' Prohibitions Against the Uncompleted Call Signaling Configuration of International Call-back Service [IB Docket No. 02-18]; Petition for Rulemaking of the Telecommunications Resellers Association To Eliminate Comity-Based Enforcement of Other Nations' Prohibitions Against the Uncompleted Call Signaling Configurations of International Call-back Service [RM-9249] received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5541. A letter from the Senior Legal Advisor to the Chief, Media Bureau, Federal Communications Commissission, transmitting the Commission's final rule — Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations. (Glen Falls, Indian Lake, Malta and Queensbury, New York) [MB DOcket No. 03-105 RM-10671] received October 28, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5542. A letter from the Director, Office of Congressional Affairs, Nuclear Regulatory Commission, transmitting the Commission's final rule — Assesment of Access Authorization Fees (RIN: 3150-AH30) received November 5, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

5543. A letter from the transmitting the Commission's final rule — Amdt. of Part 2 of the Commission's Rules to Allocate Spectrum Below 3 GHz for Mobile and Fixed Services to Support the Introduction of New Advanced Wireless Services [ET Dkt No.00-258]; The Establishment of Policies and Service Rules for the Mobile-Satellite Service in the 2 GHz Band [IB Dkt. No.99-81]; Amdt. of the Table of Frequency Allocations to Designate the 2500-2520/2670-2690 MHz Frequency Bands for the Mobile-Satellite Service [RM-9911]; Petition for Rule Making of the Wireless Information Networks Forum Concerning the Unlicensed Personal Communications Service [RM-9498]; Petition for Rule Making of to the Committee on Energy and Commerce.

5544. A letter from the Director, International Cooperations, Department of Defense, transmitting a copy of Transmittal No. 20-03 which informs of an intent to sign Amendment Number One to the Project Arrangement between the United States and Canada concerning Distributed Mision Training Technologies, pursuant to 22 U.S.C. 2767(f); to the Committee on International Relations.

5545. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed license for the export of major defense equipment and defense articles to Australia (Transmittal No. DDTC 104-03), pursuant to 22 U.S.C. 2776(c); to the Committee on International Relations.

5546. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed license for the export of major defense equipment and defense articles to the Republic of Korea (Transmittal No. DDTC 118-03), pursuant to 22 U.S.C. 2776(c); to the Committee on International Relations.

5547. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed license for the export of major defense equipment and defense articles to Belgium (Transmittal No. DDTC 103-03), pursuant to 22 U.S.C. 2776(c); to the Committee on International Relations.

5548. A letter from the Assistant Legal Adviser for Treaty Affairs, Department of State, transmitting copies of international agreements, other than treaties, entered into by the United States, pursuant to 1 U.S.C. 112b(a); to the Committee on International Relations.

5549. A letter from the Regulations Coordinator, Department of Health and Human Services, transmitting the Department's "Major" final rule — Medicare Program; Part A Premium for 2004 for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement [CMS-8018-N] (RIN: 0938-AM33) received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5550. A letter from the Regulations Coordinator, Department of Health and Human Services, transmitting the Department's "Major" final rule — Medicare Program; Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for 2004 [CMS-8016-N] (RIN: 0938-AM31) received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5551. A letter from the Acting Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting the Service's final rule — Losses Claimed and Income to be Reported from Lease In/Lease Out Transactions — received October 28, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5552. A letter from the Acting Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting the Service's final rule — Examination of returns and claims for refund, credit, or abatement; determination of correct tax liability (Rev. Proc. 2003-75) received October 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5553. A letter from the Acting Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting the Service's final rule — Business Purpose (Rev. Rul. 2003-110) received October 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5554. A letter from the Acting Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting the Service's final rule — Reimbursements and other expense allowance arrangements (Rev. Rul. 2003-106) received October 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5555. A letter from the Acting Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting the Service's final rule — Amount of Credit (Rev. Rul. 2003-112) received October 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5556. A letter from the Acting Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting the Service's final rule — Ruling and determination letters (Rev. Proc. 2003-81) received October 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5557. A letter from the Acting Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting the Service's final rule — Last-in, first-out inventories (Rev. Rul. 2003-113) received October 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5558. A letter from the Acting Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting the Service's final rule — Examination of returns and claims for refund, credit, or abatement; determination of correct tax liability (Rev. Proc. 2003-80) received October 24, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5559. A letter from the Acting Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting the Service's final rule — 2004 Limitations Adjusted As Provided in Section 415(d), etc. [Notice 2003-73] received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5560. A letter from the Acting Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting the Service's final rule — Weighted Average Interest Rate Update [Notice 2003-74] received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5561. A letter from the Acting Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting the Service's final rule — Last-in, first-out inventories (Rev. Rul. 2003-121) received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5562. A letter from the Acting Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting the Service's final rule — Special Rules for Certain Transactions Where Stated Principal Amount Does Not Exceed $2,800,000 (Rev. Rul. 2003-119) received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5563. A letter from the Acting Chief, Publications and Regulations Branch, Internal Revenue Service, transmitting the Service's final rule — Gross income defined (Rev. Rul. 2003-115) received November 3, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5564. A letter from the Chief, Regulations Unit, Internal Revenue Service, transmitting the Service's final rule — Definition of Company's Share and Policyholders' Share (Rev. Rul. 2003-120) received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

5565. A letter from the Regulations Coordinator, Department of Health and Human Services, transmitting the Department's "Major" final rule — Medicare Program; Monthly Actuarial Rates and Monthly Supplementary Medical Insurance Premium Beginning January 1, 2004 [CMS-8017-N] (RIN: 0938-AM91) received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); jointly to the Committees on Ways and Means and Energy and Commerce.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Mr. POMBO: Committee on Resources. H.R. 2408. A bill to amend the Fish and Wildlife Act of 1956 to reauthorize volunteer programs and community partnerships for national wildlife refuges; with amendments (Rept. 108–385). Referred to the Committee of the Whole House on the State of the Union.

Mr. GOODLATTE: Committee of Conference. Conference report on H.R. 1904. A bill to improve the capacity of the Secretary of Agriculture and the Secretary of the Interior to plan and conduct hazardous fuels reduction projects on National Forest System lands and Bureau of Land Management lands aimed at protecting communities, watersheds, and certain other at-risk lands from catastrophic wildfire, to enhance efforts to protect watersheds and address threats to forest and rangeland health, including catastrophic wildfire, across the landscape, and for other purposes (Rept. 108–386). Ordered to be printed.

Mr. SESSIONS: Committee on Rules. House Resolution 456. Resolution providing for consideration of motions to suspend the rules (Rept. 108–387). Referred to the House Calendar.

Mr. HASTINGS of Washington: Committee on Rules. House Resolution 457. Resolution waiving points of order against the conference report to accompany the bill (H.R. 1904) to improve the capacity of the Secretary of Agriculture and the Secretary of the Interior to plan and conduct hazardous fuels reduction projects on National Forest System Lands and Bureau of Land Management lands aimed at protecting communities, watersheds, and certain other at-risk lands from catastrophic wildfire, to enhance efforts to protect watersheds and address threats to forest and rangeland health, including catastrophic wildfire, across the landscape, and for other purposes (Rept. 108–388). Referred to the House Calendar.

Mr. LINDER: Committee on Rules. House Resolution 458. Resolution waiving a requirement of clause 6(a) of rule XIII with respect to consideration of certain resolutions reported from the Committee on Rules (Rept. 108–389). Referred to the House Calendar.

Ms. PRYCE of Ohio: Committee on Rules. House Resolution 459. Resolution waiving a requirement of clause 6(a) of rule XIII wtih respect to consideration of certain resolutions reported from the Committee on Rules (Rept. 108–390). Referred to the House Calendar.

[Submitted November 21 (legislative day of November 20), 2003]

Mr. THOMAS: Committee of Conference. Conference report on H.R. 1. A bill to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, and for other purposes (Rept. 108–391). Ordered to be printed.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions were introduced and severally referred, as follows:

By Mr. SMITH of Michigan (for himself and Ms. BALDWIN):

H.R. 3540. A bill to extend for an additional year the period for which chapter 12 of title 11 of the United States Code is reenacted; to the Committee on the Judiciary.

By Mr. LANTOS:

H.R. 3541. A bill to provide authority to prevent human rights violations by controlling certain exports, and for other purposes; to the Committee on International Relations.

By Ms. BALDWIN (for herself, Mr. SMITH of Michigan, and Mr. HOLDEN):

H.R. 3542. A bill to extend for 6 months the period for which chapter 12 of title 11 of the United States Code is reenacted; to the Committee on the Judiciary.

By Mr. CAPUANO (for himself, Mr. MEEHAN, Mr. FRANK of Massachusetts, Mr. SESSIONS, Mr. WYNN, and Mr. LYNCH):

H.R. 3543. A bill to limit liability under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 for service station dealers with respect to the release or threatened release of recycled oil; to the Committee on Energy and Commerce, and in addition to the Committee on Transportation and Infrastructure, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. CASE:

H.R. 3544. A bill to direct the Secretary of the Interior to study the suitability and feasibility of designating certain lands along the southern coast of Maui, Hawaii, as a unit of the National Park System; to the Committee on Resources.

By Mr. FARR:

H.R. 3545. A bill to establish a program of research and other activities to provide for the recovery of the southern sea otter; to the Committee on Resources.

By Ms. DEGETTE (for herself, Ms. DELAURO, Mr. HINCHEY, Mr. STARK, and Mr. ENGLISH):

H.R. 3546. A bill to amend the Federal Meat Inspection Act and the Poultry Products Inspection Act to improve the safety of meat and poultry products by enhancing the ability of the Secretary of Agriculture to retrieve the history, use, and location of a meat or poultry product through a recordkeeping and audit system or registered identification, and for other purposes; to the Committee on Agriculture.

By Ms. DEGETTE (for herself, Ms. DELAURO, Mr. HINCHEY, Mr. STARK, and Mr. WAXMAN):

H.R. 3547. A bill to amend the Federal Meat Inspection Act, the Poultry Products Inspection Act, and the Federal Food, Drug, and Cosmetic Act to provide for improved public health and food safety through enhanced enforcement, and for other purposes; to the Committee on Agriculture, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. DICKS (for himself and Mr. INSLEE):

H.R. 3548. A bill to amend title 5, United States Code, to exclude civilian personnel at naval shipyards from the national security personnel system; to the Committee on Government Reform.

By Mr. HILL (for himself, Mr. SANDLIN, Mr. LAMPSON, Mr. MCINTYRE, Mr. ETHERIDGE, Mr. HOYER, Mr. TANNER, Mr. WU, and Ms. PELOSI):

H.R. 3549. A bill to amend titles XVIII and XIX of the Social Security Act to improve payments to providers of services and physicians furnishing services to Medicare and Medicaid beneficiaries, and for other purposes; to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. YOUNG of Alaska (for himself, Mr. OBERSTAR, Mr. PETRI, Mr. LIPINSKI, Mr. BOEHLERT, Mr. RAHALL, Mr. COBLE, Mr. DEFAZIO, Mr. DUNCAN, Mr. COSTELLO, Mr. GILCHREST, Ms. NORTON, Mr. MICA, Mr. NADLER, Mr. HOEKSTRA, Mr. MENENDEZ, Mr. QUINN, Ms. CORRINE BROWN of Florida, Mr. EHLERS, Mr. FILNER, Mr. BACHUS, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. LATOURETTE, Mr. TAYLOR of Mississippi, Mrs. KELLY, Ms. MILLENDER-MCDONALD, Mr. BAKER, Mr. CUMMINGS, Mr. NEY, Mr. BLUMENAUER, Mr. LOBIONDO, Mrs. TAUSCHER, Mr. MORAN of Kansas, Mr. PASCRELL, Mr. GARY G. MILLER of California, Mr. BOSWELL, Mr. BEREUTER, Mr. HOLDEN, Mr. ISAKSON, Mr. LAMPSON, Mr. HAYES, Mr. BAIRD, Mr. SIMMONS, Ms. BERKLEY, Mrs. CAPITO, Mr. HONDA, Mr. BROWN of South Carolina, Mr. LARSEN of Washington, Mr. JOHNSON of Illinois, Mr. CAPUANO, Mr. REHBERG, Mr. WEINER, Mr. PLATTS, Ms. CARSON of Indiana, Mr. GRAVES, Mr. HOEFFEL, Mr. KENNEDY of Minnesota, Mr. THOMPSON of California, Mr. SHUSTER, Mr. BISHOP of New York, Mr. BOOZMAN, Mr. MICHAUD, Mr. CHOCOLA, Mr. DAVIS of Tennessee, Mr. BEAUPREZ, Mr. BURGESS, Mr. BURNS, Mr. PEARCE, Mr. GERLACH, Mr. MARIO DIAZ-BALART of Florida, Mr. PORTER, Mr. MATHESON, and Mr. CARSON of Oklahoma):

H.R. 3550. A bill to authorize funds for Federal-aid highways, highway safety programs, and transit programs, and for other purposes; to the Committee on Transportation and Infrastructure.

By Mr. EHLERS:

H.R. 3551. A bill to authorize appropriations to the Department of Transportation for surface transportation research and development, and for other purposes; to the Committee on Science, and in addition to the Committee on Transportation and Infrastructure, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. KING of New York:

H.R. 3552. A bill to amend the Foreign Intelligence Surveillance Act of 1978 to cover individuals, other than United States persons, who engage in international terrorism without affiliation with an international terrorist group; to the Committee on the Judiciary, and in addition to the Committee on Intelligence (Permanent Select), for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. LAHOOD (for himself, Mr. HASTERT, Mr. RUSH, Mr. JACKSON of Illinois, Mr. LIPINSKI, Mr. GUTIERREZ, Mr. EMANUEL, Mr. HYDE, Mr. DAVIS of Illinois, Mr. CRANE, Ms. SCHAKOWSKY, Mr. KIRK, Mr. WELLER, Mr. COSTELLO, Mrs. BIGGERT, Mr. JOHNSON of Illinois, Mr. MANZULLO, Mr. EVANS, Mr. SHIMKUS, Mr. ISSA, Mr. UPTON, Mr. RAHALL, Mr. WAXMAN, and Ms. SLAUGHTER):

H.R. 3553. A bill to establish the Abraham Lincoln National Heritage Area, and for other purposes; to the Committee on Resources.

By Mr. MCDERMOTT (for himself, Mr. WU, Mr. DEFAZIO, Mr. INSLEE, Ms. KILPATRICK, and Mr. LARSEN of Washington):

H.R. 3554. A bill to amend the Temporary Extended Unemployment Compensation Act and the Federal-State Extended Unemployment Compensation Act to temporarily allow States to disregard the look-back requirement of these Acts for purposes of determining unemployment insurance eligibility; to the Committee on Ways and Means.

By Mr. MORAN of Virginia:

H.R. 3555. A bill to amend the Clean Air Act to prohibit stationary sources located in ozone nonattainment areas from purchasing nitrogen oxide emission credits under the Environmental Protection Agency's nitrogen oxide trading program without the consent of the State in which such source is located, and for other purposes; to the Committee on Energy and Commerce.

By Mr. NADLER (for himself, Mr. RANGEL, Mr. MCNULTY, Mr. HOUGHTON, Mrs. MCCARTHY of New York, Mr. CROWLEY, Mr. ENGEL, Mr. BOEHLERT, Mr. SERRANO, Mr. OWENS, Mr. WEINER, Mr. HINCHEY, Mrs. MALONEY, Ms. SLAUGHTER, and Mrs. LOWEY):

H.R. 3556. A bill to provide for income tax treatment relating to certain losses arising from, and grants made as a result of, the September 11, 2001, terrorist attacks on New York City; to the Committee on Ways and Means.

By Ms. PELOSI (for herself, Mr. COX, Mr. BAIRD, Mr. DOOLEY of California, Mr. LANTOS, Ms. LOFGREN, and Ms. WOOLSEY):

H.R. 3557. A bill to designate the United States courthouse located at 95 Seventh Street in San Francisco, California, as the "James R. Browning United States Courthouse"; to the Committee on Transportation and Infrastructure.

By Mr. PITTS (for himself and Mr. MARKEY):

H.R. 3558. A bill to amend the Communications Act of 1934 to protect the privacy rights of subscribers to wireless communications services; to the Committee on Energy and Commerce.

By Mr. PLATTS:

H.R. 3559. A bill to amend title 10, United States Code, to allow faculty members at Department of Defense service academies and schools of professional military education to secure copyrights for certain scholarly works that they produce as part of their official duties in order to submit such works for publication, and for other purposes; to the Committee on the Judiciary, and in addition to the Committees on Transportation and Infrastructure, and Armed Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Ms. SCHAKOWSKY (for herself, Mr. CONYERS, Ms. MCCOLLUM, Mr. TOWNS, Mr. ACEVEDO-VILÁ, Ms. LEE, Mrs. CHRISTENSEN, Mr. EMANUEL, Mr. LIPINSKI, Mr. PALLONE, Ms. MILLENDER-MCDONALD, Mrs. JONES of Ohio, and Mr. CUMMINGS):

H.R. 3560. A bill to amend the temporary assistance to needy families program under part A of title IV of the Social Security Act to provide grants for transitional jobs programs, and for other purposes; to the Committee on Ways and Means, and in addition to the Committee on Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. SHAW:

H.R. 3561. A bill to amend the Internal Revenue Code of 1986 to provide a shorter recovery period for the depreciation of certain improvements to retail space; to the Committee on Ways and Means.

By Mr. SHUSTER:

H.R. 3562. A bill to amend the Internal Revenue Code of 1986 to allow businesses a credit for security devices, assessments, and other security-related expenses; to the Committee on Ways and Means.

By Mr. STEARNS (for himself and Mr. Upton):

H.R. 3563. A bill to coordinate cargo theft crime data collection and to amend title 18, United States Code, to make improvements relating to cargo theft prevention, and for other purposes; to the Committee on the Judiciary, and in addition to the Committee on Transportation and Infrastructure, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. STRICKLAND:

H.R. 3564. A bill to remove United States fair trade laws from the World Trade Organization dispute settlement system process; to the Committee on Ways and Means.

By Mr. STUPAK:

H.R. 3565. A bill to provide that a grantee may not receive the full amount of a block grant under the Local Law Enforcement Block Grant program unless that grantee adopts a health standard establishing a legal presumption that heart, lung, and respiratory disease are occupational diseases for public safety officers and to provide that such diseases are presumed to be sustained in the performance of duty, and for other purposes; to the Committee on the Judiciary, and in addition to the Committee on Government Reform, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. WALDEN of Oregon:

H.R. 3566. A bill to amend the Cooperative Forestry Assistance Act of 1978 to establish a program using geospatial and information management technologies to inventory, monitor, characterize, assess, and identify forest stands and potential forest stands, and for other purposes; to the Committee on Agriculture, and in addition to the Committee on Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. WU:

H.R. 3567. A bill to require the General Accounting Office to conduct an investigation of the high price of college textbooks; to the Committee on Education and the Workforce.

By Mr. WELDON of Pennsylvania (for himself, Ms. Harman, Mr. Kirk, Mr. Berman, Mr. Souder, Mr. Cardoza, Mr. Wilson of South Carolina, Mr. Meek of Florida, Mr. Nunes, Mr. LaHood, Mr. Jones of North Carolina, Mr. Case, Mr. Deutsch, and Mr. Shaw):

H. Con. Res. 332. Concurrent resolution expressing the deep concern of Congress regarding the failure of the Islamic Republic of Iran to adhere to its obligations under a safeguards agreement with the International Atomic Energy Agency and the engagement by Iran in activities that appear to be designed to develop nuclear weapons; to the Committee on International Relations.

By Ms. MILLENDER-McDONALD (for herself and Mr. Tom Davis of Virginia):

H. Con. Res. 333. Concurrent resolution expressing support and appreciation for the longstanding alliance between the United States and the Republic of Korea, and for other purposes; to the Committee on International Relations.

By Mr. GEORGE MILLER of California (for himself, Ms. Woolsey, and Mr. Meeks of New York):

H. Con. Res. 334. Concurrent resolution expressing the sense of Congress that "Kids Love a Mystery Month" should be established; to the Committee on Government Reform.

By Mrs. TAUSCHER (for herself, Mr. George Miller of California, Mr. Taylor of Mississippi, Mr. Cooper, Ms. Pelosi, Mr. Skelton, Mr. Moran of Virginia, Mr. McGovern, Mr. Davis of Tennessee, Mr. Udall of New Mexico, Mr. Van Hollen, Ms. Lee, Mr. Ryan of Ohio, Ms. Watson, Mr. Evans, Mr. Kildee, Mr. Towns, Mr. Kennedy of Rhode Island, Mr. Meehan, Mr. Rangel, Mr. Inslee, Mr. Israel, Mr. Blumenauer, Mr. McDermott, Ms. Eshoo, Mr. Lantos, Ms. DeLauro, Ms. Norton, Mr. Larsen of Washington, Ms. Lofgren, Mrs. Maloney, Mr. Bell, Mr. Lynch, Mr. Grijalva, Mr. Case, Mr. Cardoza, Mr. Matheson, Ms. Woolsey, Ms. McCarthy of Missouri, Mr. Frost, Mr. Brown of Ohio, Mr. Farr, Mr. Honda, Mrs. Capps, Ms. McCollum, Mr. Delahunt, Ms. Solis, Ms. Jackson-Lee of Texas, and Mr. Serrano):

H. Con. Res. 335. Concurrent resolution recognizing the sacrifices made by members of the regular and reserve components of the Armed Forces, expressing concern about their safety and security, and urging the Secretary of Defense to take immediate steps to ensure that the reserve components are provided with the same equipment as the regular component; to the Committee on Armed Services.

By Mrs. JONES of Ohio (for herself, Ms. Pryce of Ohio, Mr. Dingell, Mr. Tiberi, Mr. Turner of Ohio, Mr. Oxley, Mr. Gillmor, Mr. Strickland, Ms. Kaptur, Mr. Kucinich, Mr. Brown of Ohio, Mr. LaTourette, Mr. Ryan of Ohio, Mr. Ney, Mr. Kildee, Mr. Upton, Mrs. Miller of Michigan, Mr. Portman, Mr. Levin, Ms. Kilpatrick, Mr. Conyers, Mr. McCotter, Mr. Hobson, and Mr. Ford):

H. Res. 460. A resolution congratulating The Ohio State University and the University of Michigan on the 100th football game between the two teams and recognizing their rivalry as the greatest sports rivalry in history; to the Committee on Education and the Workforce.

By Mr. WEXLER (for himself, Mr. Grijalva, Mr. Towns, Mr. Hastings of Florida, Ms. McCollum, Mr. Crowley, Mr. Deutsch, Mr. Serrano, Mr. Hinchey, Ms. Woolsey, Mr. McDermott, Mr. Waxman, Ms. Millender-McDonald, Mr. Markey, Mr. Clay, and Ms. Norton):

H. Res. 461. A resolution expressing the sense of the House of Representatives with respect to the American Association of Retired Persons and the Republican Medicare prescription drug bill; to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions as follows:

H.R. 58: Mr. Simpson, Mr. Shimkus, and Mr. Gutierrez.

H.R. 173: Mr. Jefferson.

H.R. 375: Mr. Cole and Mr. Brady of Pennsylvania.

H.R. 525: Mr. Ackerman, Mr. Allen, Mr. Baird, Mr. Brady of Pennsylvania, Mr. Brown of Ohio, Mrs. Capps, Mr. Capuano, Mr. Cardin, Mr. Cardoza, Mr. Carson of Oklahoma, Ms. Carson of Indiana, Mr. Clay, Mr. Davis of Illinois, Mr. Davis of Florida, Mrs. Davis of California, Mr. DeFazio, Ms. DeGette, Mr. Deutsch, Mr. Dooley of California, Mr. Doyle, Mr. Etheridge, Mr. Farr, Mr. Green of Texas, Mr. Hinchey, Mr. Holden, Mr. Holt, Mr. Inslee, Mr. Jefferson, Mr. Kanjorski, Mr. Kennedy of Rhode Island, Ms. Kilpatrick, Mr. Lantos, Mr. Lipinski, Mrs. Maloney, Mr. McDermott, Mr. Menendez, Mr. George Miller of California, Mr. Moore, Mr. Price of North Carolina, Mr. Reyes, Mr. Rodriguez, Mr. Ruppersberger, Mr. Rush, Mr. Sabo, Mr. Sanders, Mr. Snyder, Mr. Stupak, Mr. Van Hollen, Ms. Woolsey, Mr. Pascrell, Mr. Olver, Mr. Kucinich, and Ms. McCarthy of Missouri.

H.R. 527: Mr. Gallegly.

H.R. 528: Mr. Lantos.

H.R. 645: Mr. Stenholm, Mrs. Musgrave, and Mr. Boozman.

H.R. 648: Mrs. Musgrave.

H.R. 717: Mr. Langevin.

H.R. 770: Ms. Kaptur.

H.R. 852: Mrs. Jones of Ohio and Ms. Millender-McDonald.

H.R. 857: Mr. Rush, Mr. Rahall, Mr. Bishop of New York, Mr. Inslee, Mr. Hoeffel, Mr. English, Mr. Jackson of Illinois, Ms. Eddie Bernice Johnson of Texas, Mr. Meeks of New York, and Ms. Millender-McDonald.

H.R. 876: Mr. Burns, Mr. Brown of Ohio, Ms. Jackson-Lee of Texas, Mr. Bartlett of Maryland, Mr. Paul, Mr. Crenshaw, Mr. Boehner, Mr. Lucas of Kentucky, Mr. Lipinski, Mrs. Jones of Ohio, Mr. Lantos, Mrs. Musgrave, Mr. Hefley, Mr. Culberson, Mr. Davis of Alabama, Ms. Lee, Mr. McGovern, Mr. McNulty, and Mr. Skelton.

H.R. 936: Mr. Hastings of Florida.

H.R. 955: Mr. Owens.

H.R. 997: Mr. Saxton.

H.R. 1034: Ms. McCollum, Mr. Rangel, Mrs. Capps, Mr. Grijalva, and Ms. Norton.

H.R. 1043: Mr. McHugh.

H.R. 1045: Mr. Weiner.

H.R. 1052: Mr. Lewis of Georgia.

H.R. 1102: Mr. Leach and Mr. Ruppersberger.

H.R. 1117: Mr. Hostettler and Mr. Tancredo.

H.R. 1125: Mr. Souder.

H.R. 1155: Mr. Rush and Mr. Shaw.

H.R. 1157: Mr. Spratt.

H.R. 1285: Mr. Kanjorski, Mr. Lynch, Mr. Rahall, and Mr. Davis of Tennessee.

H.R. 1336: Mrs. Capps and Mr. Hastings of Washington.

H.R. 1389: Ms. Linda T. Sánchez of California.

H.R. 1430: Ms. Woolsey.

H.R. 1513: Mr. Porter and Mr. Garrett of New Jersey.

H.R. 1523: Ms. Carson of Indiana.

H.R. 1532: Mr. Larsen of Washington, Mr. Ruppersberger, Ms. Lofgren, Mr. Upton, Mr. Evans, Mr. Rush, and Mr. Neal of Massachusetts.

H.R. 1552: Mr. Andrews and Ms. McCarthy of Missouri.

H.R. 1582: Mr. Nethercutt.

H.R. 1659: Mr. Schiff.

H.R. 1684: Mr. Towns, Mrs. Capps, and Mr. Meehan.

H.R. 1746: Mr. Abercrombie, Mr. Udall of New Mexico, Mr. Jenkins, Mr. Jackson of Illinois, and Mr. Kirk.

H.R. 1749: Mr. Hobson.

H.R. 1767: Mr. Gingrey and Mr. Tom Davis of Virginia.

H.R. 1812: Ms. Carson of Indiana and Mr. Dooley of California.

H.R. 1873: Mrs. Jones of Ohio.

H.R. 1895: Mr. Hinchey and Mr. Payne.

H.R. 1910: Mr. Scott of Georgia.

H.R. 1914: Mr. Akin, Mr. Castle, Mr. Costello, Mr. Davis of Alabama, Mr. Deutsch, Mr. Dingell, Mr. Engel, Mr. Evans, Mr. Gordon, Mr. Honda, Ms. Kaptur, Ms. Kilpatrick, Mr. Kolbe, Mr. Kucinich, Mr. Lampson, Mr. Lantos, Mr. Lipinski, Ms. Lofgren, Ms. Majette, Mr. Nadler, Mr. Oliver, Mr. Ortiz, Ms. Linda T. Sánchez of California, Mr. Scott of Georgia, Mr. Shays, Ms. Slaughter, Mr. Turner of Texas, Mr. Wynn, Mr. DeFazio, Mr. Doggett, and Ms. Baldwin.

H.R. 1919: Mr. John.

H.R. 1958: Mr. Payne.

H.R. 1998: Mr. Terry.

H.R. 2093: Mr. Sessions.

H.R. 2131: Mr. Gutierrez, Mrs. Bono, Mr. Bonilla, Mr. Franks of Arizona, Mr. Weller, Mr. Nunes, and Mr. Toomey.

H.R. 2217: Mr. Payne, Mr. Deutsch, Mr. Lewis of Georgia, Mr. Rangel, and Mr. Lipinski.

H.R. 2239: Mr. Lewis of Georgia.

H.R. 2262: Mr. Evans.

H.R. 2295: Mr. Boucher.

H.R. 2347: Mr. Murphy.

H.R. 2404: Mr. Pitts and Mr. Hall.

H.R. 2604: Mr. Foley.

H.R. 2628: Mr. Crowley.

H.R. 2720: Mr. Manzullo and Mrs. Lowey.

H.R. 2809: Mr. Greenwood, Mr. Tancredo, and Mr. English.

H.R. 2810: Mr. Greenwood, Mr. Tancredo, and Mr. English.

H.R. 2837: Ms. Woolsey.

H.R. 2880: Ms. Loretta Sanchez of California.

H.R. 2911: Mr. Waxman, Mr. Meehan, Ms. Millender-McDonald, Mr. Green of Texas, Ms. Woolsey, Mrs. Jones of Ohio, Mrs. Christensen, and Ms. Solis.

H.R. 2938: Ms. Jackson-Lee of Texas and Mr. Souder.

H.R. 2968: Mr. Price of North Carolina.

H.R. 2986: Mr. Duncan, Mr. Pascrell, Mr. Cummings, Mr. Frank of Massachusetts, Mr. Lipinski, Mr. Costello, and Mr. Hefley.

H.R. 3035: Mr. Moore.

H.R. 3039: Mrs. Kelly.

H.R. 3049: Ms. Baldwin.

H.R. 3109: Mr. Bachus, Mr. Ballanger, Mr. Barrett of South Carolina, Mr. Boehlert, Mr. Bonner, Mrs. Bono, Mr. Bradley of New Hampshire, Mr. Coble, Mrs. Emerson, Mr. Goode, Mr. Gutknecht, Mr. Hostettler, Mr. Hunter, Mr. Kingston, Mr. Knollenberg, Mr. Kolbe, Mr. LaHood, Mr. Lucas of Oklahoma, Mrs. Myrick, Mrs. Northup, Mr. Quinn, Mr. Reynolds, Mr. Rohrabacher, Mr. Saxton, Mr. Schrock, Mr. Shuster, Mr. Smith of New Jersey, Mr. Smith of Texas, Mr. Souder, Mr. Sweeney, and Mr. Wolf.

H.R. 3120: Ms. Carson of Indiana.

H.R. 3142: Mr. Rehberg, Mr. Boswell, Mr. English, and Mr. George Miller of California.

H.R. 3190: Mr. Latham, Mr. Brady of Texas, Mr. Norwood, Mr. Akin, Mr. Herger, Mr. Turner of Texas, and Mr. Everett.

H.R. 3191: Mr. Rehberg, Mr. Hayworth, and Mr. Janklow.

H.R. 3194: Mr. Lewis of Georgia and Mr. Rangel.

H.R. 3204: Mr. Burr, Mrs. Jo Ann Davis of Virginia, Mr. Gilchrest, Mr. Gillmor, Mr. Hastings of Washington, Mr. Linder, Mr. Lucus of Oklahoma, Mr. Mica, Mr. Moran of Kansas, Mr. Portman, Mr. Saxton, and Mr. Shays.

H.R. 3215: Mr. Tiahrt and Mr. Sessions.

H.R. 3228: Mr. Brown of Ohio.

H.R. 3230: Mr. Paul.

H.R. 3244: Mr. Pomeroy.

H.R. 3261: Mr. Wexler, Mr. Turner of Ohio, Mr. Portman, and Mr. Delahunt.

H.R. 3263: Ms. Ros-Lehtinen, Mr. Green of Wisconsin, Mr. Engel, Mr. Hoeffel, and Mr. Berman.

H.R. 3275: Mr. Lewis of Georgia and Mr. Olver.

H.R. 3277: Mr. Pastor, Mr. Graves, Mr. McKeon, Mr. Gutknecht, Mr. Bass, Mr. Beauprez, Mr. Hinchey, Mr. Gutierrez, Mr. Berry, Mr. Visclosky, Mr. Lipinski, Ms. Schakowsky, Mr. Sanders, Mr. Kolbe, Mr. Filner, Mr. George Miller of California, Mr. Nadler, Mr. Sabo, Mr. Moran of Virginia, Mr. Moore, Mr. Dingell, Mr. Menendez, Mr. Michaud, Mr. DeFrazio, Mr. Davis of Alabama, Mr. Inslee, Ms. Baldwin, Mr. Berman, Mr. Scott of Virginia, Ms. Harman, Mr. Holden, Mr. Reyes, Mr. Israel, Mr. Jenkins, Mr. Ryan of Wisconsin, and Mr. Pence.

H.R. 3344: Mr. Strickland, Ms. Waters, Mr. Langevin, and Mr. Bell.

H.R. 3355: Mrs. McCarthy of New York and Mr. Van Hollen.

H.R. 3362: Ms. DeLauro, Ms. Norton, Mr. Israel, Mr. Owens, Mr. Frost, Mr. Green of Texas, and Mr. Gutierrez.

H.R. 3368: Mr. English and Mr. Weldon of Pennsylvania.

H.R. 3378: Mr. Faleomavaega.

H.R. 3386: Ms. McCollum.

H.R. 3408: Mr. Lantos, Ms. Norton, Mr. Frost, Ms. Millender-McDonald, Mr. Frank of Massachusetts, Mr. Hinchey, Mr. McNulty, Mr. Serrano, Mr. Emanuel, Mrs. Jones of Ohio, and Mr. Meeks of New York.

H.R. 3422: Mr. Rangel, Mr. Frank of Massachusetts, and Mr. Van Hollen.

H.R. 3429: Mr. Whitfield and Mr. Otter.

H.R. 3432: Mr. Michaud.

H.R. 3459: Mr. Abercrombie, Mr. McDermott, Mr. Meehan, Ms. Woolsey, and Ms. Schakowsky.

H.R. 3509: Mr. Spratt, Mr. Grijalva, and Mr. Baird.

H.R. 3519: Mr. Meehan, Mr. Rodriguez, Mrs. Napolitano, Mr. Baca, Ms. Roybal-Allard, Mr. Ortiz, Mr. Serrano, Mr. Pastor, Mr. Becerra, Mr. Gutierrez, Mr. Menendez, Ms. Velázquez, Mr. Reyes, Ms. Loretta Sanchez of California, Mr. Gonzalez, Mr. Acevedo-Vilá, Ms. Solis, Mr. Cardoza, and Ms. Linda T. Sánchez of California.

H.J. Res. 22: Mr. Neugebauer.

H.J. Res. 56: Mr. Everett, Mr. Neugebauer, Mr. Baker, Mr. Shadegg, Mr. Janklow, Mr. Burton of Indiana, and Mr. Deal of Georgia.

H. Con. Res. 111: Mr. Bell.

H. Con. Res. 281: Mr. Van Hollen.

H. Con. Res. 304: Mr. Udall of Colorado, Mr. Langevin, Mr. Burr, Mr. Lincoln Diaz-Balart of Florida, Mr. Weiner, Mr. Ramstad, Mr. Hunter, Mr. Walsh, Mr. Lynch, Mrs. Maloney, Mr. Bradley of New Hampshire, Mr. DeFazio, Mr. Holt, Mr. Owens, and Ms. Lofgren.

H. Con. Res. 324: Mr. Blumenauer.

H. Con. Res. 103: Mrs. Northup.

H. Res. 313: Mr. Ryan of Ohio.

H. Res. 354: Mr. Clyburn.

H. Res. 389: Mr. Snyder.

H. Res. 441: Mr. Murphy.

H. Res. 446: Mr. Akin, Mr. Bartlett of Maryland, and Mr. Pickering.

H. Res. 453: Mr. Frost, Mr. Meeks of New York, Ms. Schakowsky, Ms. Carson of Indiana, Mr. Bereuter, Mr. Fattah, Mr. Saxton, Ms. Jackson-Lee of Texas, Ms. DeLauro, Mr. Hoeffel, Mr. Pitts, Mr. Cramer, Mr. Grijalva, Mr. Sandlin, Mr. Davis of Florida, Mr. Foley, Ms. Corrine Brown of Florida, Mr. Kleczka, Mr. Manzullo, and Ms. Berkley.

EXTENSIONS OF REMARKS

INTRODUCING THE LABOR RECRUITER ACCOUNTABILITY ACT OF 2003

HON. GEORGE MILLER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. GEORGE MILLER of California. Mr. Speaker, I rise today to introduce the "Labor Recruiter Accountability Act of 2003."

As has been well documented in the press, the abuse of recruited workers has become a very serious problem in many areas of our nation. Labor contractors lure workers to the U.S. by promising them a better life with decent wages and good jobs in exchange for thousands of dollars in fees. Instead, tens of thousands of workers arrive in the U.S. only to find that they were cruelly deceived. If they are paid at all, they earn unlivable wages for menial jobs to which they never agreed, with no insurance or health care. And in addition to earning little, they are bound deeply in debt to the recruiter for bringing them to their new home.

This is not employment opportunity: it is indentured servitude. It is modern slavery. Hard as it may seem to believe, this form of indentured servitude is the disturbing reality for thousands of workers, and it should not be occurring in the United States in 2003.

Today, I am introducing the "Labor Recruiter Accountability Act of 2003" to fight this cruel practice by providing for tighter accountability for foreign labor contractors and employers.

The "Labor Recruiter Accountability Act of 2003" holds recruiters and employers responsible for the promises they make to prospective employees, and discourages employers from using disreputable recruiters. The bill requires employers and foreign labor contractors to inform workers of the terms and conditions of their employment at the time they are recruited. It makes employers jointly liable for violations committed by recruiters in their employ. It imposes fines on employers and recruiters who do not live up to their promises and authorizes the Secretary of Labor to take additional legal action to enforce those commitments. Employers and recruiters are prohibited from requiring or requesting recruitment fees from workers and are required to pay the costs, including subsistence costs, of transporting the worker.

The bill discourages disreputable labor contractors by requiring the Secretary of Labor to maintain a public list of labor contractors who have been involved in violations of the Act and by providing additional penalties if employers use a contractor listed by the Secretary as having been involved in previous violations of this Act and that contractor contributes to a violation for which the employer may be liable. The remedies provided under the "Labor Recruiter Accountability Act" are not exclusive, but are in addition to any other remedies workers may have under law or contract.

Is it too much to ask that people who live on American soil, making products for American consumption, be treated like American workers? Even the most basic respect for human rights demands that we act now to protect these workers.

I am pleased that over 30 of our colleagues have joined me as original cosponsors of this bill. I am hopeful that all of our colleagues, on both sides of the aisle, will add their support to this critical legislation to end this kind of despicable exploitation of workers in the United States once and for all. This legislation is also supported by the AFL–CIO, the National Council of La Raza, and the Farmworker Justice Fund. Mr. Speaker, I urge Members of the House to join me and co-sponsor the "Labor Recruiter Accountability Act of 2003."

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RECOGNIZING THE 5TH ANNIVERSARY OF THE INTERNATIONAL RELIGIOUS FREEDOM ACT OF 1998

HON. STENY H. HOYER

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. HOYER. Mr. Speaker, I am pleased to rise in support of H. Res. 423, recognizing the 5th anniversary of the International Religious Freedom Act of 1998, legislation that established the Office of International Religious Freedom within the Department of State.

This office is most often associated with its Annual Report on International Religious Freedom, which describes the status of religious freedom in each foreign country, government policies violating religious belief and practices, and U.S. policies to promote religious freedom around the world.

This document serves as an important tool for both Congress and the administration in making policy decisions regarding our relations with, and support for, countries around the world.

But in addition to the report, and frankly just as importantly, the Office develops strategies to promote religious freedom, both to attack the root causes of persecution and as a means of promoting other fundamental U.S. interests, such as protecting other core human rights, and encouraging the development of mature democracies.

The importance of this work cannot be overstated—the promotion of religious freedom is intimately connected to the promotion of other fundamental human and civil rights, as well as to the growth of democracy.

A government that acknowledges and protects freedom of religion and conscience is one that understands the inherent and inviolable dignity of the human person, and is more likely to protect, the other rights fundamental to human dignity, such as freedom from arbitrary arrest or seizure, or freedom from torture and murder.

But our interest in promoting religious freedom runs deeper than our support for democracy and stability—it is, simply put, our most important core value, the very reason the 13 colonies were established. American support for religious freedom abroad certainly predates passage of this legislation in 1998. I am particularly proud of the role I played during my tenure as the Chairman and Ranking Member of the Helsinki Commission to raise awareness of religious persecution in Eastern Europe and the former Soviet Republics, and the work of the Commission to promote the protection of religious minorities in the Eastern Bloc and elsewhere around the world.

Religious freedom is the first of the freedoms enumerated in the Bill of Rights—a reflection of the founders' belief that freedom of religion and conscience is the cornerstone of liberty.

As Thomas Jefferson wrote in 1803, "It behooves every man who values liberty of conscience for himself, to resist invasions of it in the case of others; or their case may, by change of circumstances, become his own."

I was an active supporter of the original legislation, I am proud of the work done by the office since its creation, and am pleased to help commemorate this important anniversary.

* * *

PAYING TRIBUTE TO CHERYL CHITTENDEN

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. MCINNIS. Mr. Speaker, it is my honor to rise and pay tribute to a remarkable woman from my district. Cheryl Chittenden has dedicated her life to ending domestic violence and assisting victims of domestic abuse. For her service, Cheryl was recently recognized as Advocate of the Year and it is my honor to rise and pay tribute to her contributions before this body of Congress today.

Cheryl has been battling the terrors of domestic violence for fifteen years. In 1985, she became the Director of the Latimer House Domestic Violence Shelter. During that time, Cheryl acted as chairperson of the Domestic Violence Task Force, and was one of the founders of the Sexual Assault Nurse Examiner program.

Currently, Cheryl is a Victim Advocate in Mesa, Colorado. Each day, she goes beyond the call of duty for the betterment of domestic violence victims. Cheryl takes each victim's case to heart and treats him or her as though they were family. The Mesa community is truly

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.
Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

a better place as the result of Cheryl's contributions.

Mr. Speaker, it is my honor to rise and pay tribute to Cheryl Chittenden before this body of Congress and this nation. Cheryl has dedicated her life to helping others while maintaining her devotion as a loving wife and caring mother. I am honored to join all of those Cheryl has helped in thanking her for her service.

CONFERENCE REPORT ON H.R. 6, ENERGY POLICY ACT OF 2003

SPEECH OF

HON. MARK UDALL

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mr. UDALL of Colorado. Mr. Speaker, I cannot support this legislation.

We all know that this country is overly dependent on a single energy source—fossil fuels—to the detriment of our environment, our national security, and our economy. To lessen this dependence and to protect our environment, we must pass a bill that helps us balance our energy portfolio and increase the contributions of alternative energy sources to our energy mix.

Unfortunately, this bill doesn't provide that balance. And for the most part it not only falls short of meeting the challenges of our time, in many ways it can be described as an energy policy for the nineteenth century.

Of course just as no bill is perfect, even this bill is not totally bad.

For example, I am pleased that legislation I've initiated is being considered as part of this bill.

The bill includes the Federal Laboratory Educational Partners Act of 2003, legislation I introduced with my colleague Rep. BEAUPREZ that would permit the National Renewable Energy Laboratory and other Department of Energy laboratories to use revenue from their inventions to support science education activities in their communities.

The bill includes the Distributed Power Hybrid Energy Act, a bill I introduced to direct the Secretary of Energy to develop and implement a strategy for research, development, and demonstration of distributed power hybrid energy systems. It makes sense to focus our R&D priorities on distributed power hybrid systems that can both help improve power reliability and affordability and bring more efficiency and cleaner energy resources into the mix.

The bill includes my High Performance Schools Act, which would enable our school districts to build school buildings that take advantage of advanced energy conservation technologies, daylighting, and renewable energy to help the environment and help our children learn. As included in the conference report, my bill would be expanded to help state and local governments improve not only energy efficiency in schools, but also in public buildings in general.

I am also pleased that this bill includes the Clean School Buses Act, a bill that Chairman BOEHLERT and I drafted that authorizes grants to help school districts replace aging diesel vehicles with clean, alternative fuel buses.

But despite these bright spots, most of the bill is bad policy—bad for the environment, bad for the taxpayers, and bad for the country.

Like its predecessor in the last Congress, this bill puts all its eggs in one basket, the wrong basket. For every step the bill takes to move us away from our carbon-based economy, it takes two in the opposite direction.

The bill fails to take any steps whatsoever to require that the nation reduce its dependence on oil or improve the fuel economy of our cars, trucks, and SUVs. In fact, the bill makes it more difficult to update fuel economy standards by adding new requirements for redundant studies to the National Highway Traffic Safety Administration's CAFE standards-setting process.

By contrast, just today we learned that China is preparing to impose minimum fuel economy standards on new cars for the first time—rules that will be significantly more stringent than those in this country. This is great news for the world—but what an embarrassing proof that we won't even do as much for our own national security and the environment.

That contrast speaks volumes about this bill's priorities, which are the priorities of this Administration.

This bill not only does nothing to decrease our dependence on oil—it also does almost nothing to control demand. But increasing production while ignoring demand is a recipe for disaster.

The Administration boasts that this bill is a balanced approach because it would promote the development of renewable energy and energy efficiency technologies. But aside from a few provisions on electrical appliances and heating systems, the bill does little to promote energy conservation. And although there are some tax incentives for renewable fuels, they pale in comparison to the lavish tax breaks the bills gives the oil and gas industry.

And for all we hear from the Administration about the hydrogen provisions, the bill doesn't go far enough. It's all well and good to authorize billions of dollars to deploy hydrogen fuel cell vehicles, but the bill includes no production or deployment requirements or even goals to ensure that a meaningful number of hydrogen vehicles will be delivered to consumers.

As co-chair of the Renewable Energy and Energy Efficiency Caucus in the House, I define a balanced bill as one that gives more than a passing nod to the development of alternative sources of energy. The Senate version of this bill included sensible provisions to require large utilities to get modest amounts of their power from renewable sources. Although 13 states have already passed their own versions of such a Renewable Portfolio Standard, and although the energy bill conferees just yesterday voted to include the RPS in the conference report, the Republicans stripped it out late last night. If this were really about jobs, as the Republicans claim, they would have retained the RPS provision—which experts say could create millions of new jobs in this country.

I won't even get into some of the other egregious provisions, such as the incentives in the bill for new nuclear and coal development, and the repeal of the Public Utility Holding Company Act, the main law to protect consumers from market manipulation, fraud, and abuse in the electricity sector.

Nor will I complain in detail about process—the fact that Democrats were shut out of conference proceedings, that we don't even know the cost of this 1100-page bill that we were able to review in its entirety only last night, that Republican conferees have essentially been buying votes over the last week to ensure the bill's passage.

An example of this vote-buying is the bill's language to allow polluted areas to have more time to reduce smog pollution but without having to implement stronger air pollution controls, placing a significant burden on states and communities down-wind of these urban areas.

There are other provisions related to public health that should never have been included in this bill. The bill eliminates protections for underground drinking water supplies from potential damages caused by hydraulic fracturing. The bill also provides a special liability waiver for MTBE producer who face lawsuits from states and localities for polluting their water supplies, thereby shifting cleanup costs to taxpayers.

Bad for the country, the bill is particularly bad for the West.

Many of its provisions will directly and immediately affect Colorado and other western States. We have important resources of oil and gas, as well as great potential for solar energy and wind energy. I support energy development in appropriate places and in ways that balances that development with other uses and such other vital resources as water and the people, fish, and wildlife that depend on it. Unfortunately, here again this bill does not reflect the needed balance.

Instead, it combines big subsidies for energy development with lessening of the procedural and substantive requirement that have been established to protect our lands, water, and environment.

Overall, the oil and gas title of the bill is intended to stimulate increased production from both the Outer Continental Shelf and onshore lands. It combines a series of royalty reductions, so companies will pay the public less for the oil, gas, and other energy resources developed on publicly-owned lands.

It also would completely exempt oil and gas construction activities—including roads, drill pads, pipeline corridors, refineries, and other facilities—from the stormwater drainage requirements of the Clean Water Act.

It also has provisions designed to speed up establishing rights-of-way and corridors for oil and gas pipelines and electric transmission lines. Under section 350, within 2 years the federal agencies are to designate new corridors for oil and gas pipelines and electricity transmission and facilities on Federal land in the eleven contiguous Western States of Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming. And it provides for a pilot project to speed up the processing of federal permits related to oil and gas development in several parts of the BLM lands. This includes the Glenwood Springs Resource Area in Colorado as well as areas in Montana, New Mexico, Utah, and Wyoming.

Nothing in the bill would increase the resources available to BLM or the other federal land managing agencies to carry out their other responsibilities in connection with management of the affected lands. As a result, this bill has the potential to essentially repeal multiple-use management and to make energy development the dominant use on the public lands.

Similarly, the bill includes a requirement for a study and report on opportunities to develop renewable energy on the public lands and National Forests as well as lands managed by the energy and defense departments—including units of the National Wilderness Preservation System and wilderness study areas, National Monuments, National Conservation Areas, and other environmentally-sensitive areas. At best, this is a prescription for controversy. At worst, it threatens to open the door for incompatible development on lands that should be left as they are.

These are big steps backward. So is the provision that would allow geothermal-energy leases to be in effect converted into claims under the Mining Law of 1872.

In conclusion, Mr. Speaker, we need a well-designed policy to meet the challenges of our time, not a policy that will diminish our energy security. With the Middle East—the world's main oil-producing region—in turmoil, we must question the predictability of future foreign oil supplies. Fully 30 percent of the world's oil supply comes from the volatile and politically unstable Persian Gulf region. Yet with only 3 percent of the world's known oil reserves, we are not in a position to solve our energy vulnerability by drilling at home.

This bill does nothing to tackle this fundamental problem. I only wish my colleagues in the House could understand that a vision of a clean energy future is not radical science fiction but is instead based on science and technology that exists today.

In much the same way that America set about unlocking the secrets of the atom with the "Manhattan Project" or placing a man on the moon with the Apollo program, we can surely put more public investment behind new energy sources that will free us from our dependence on oil.

This bill would continue our addiction to finite and politically unstable energy resources, while undermining public health, the environment, and ultimately our national security itself. It should be rejected.

SUPPORT OF THE CONFERENCE AGREEMENT ON THE DEFENSE AUTHORIZATION ACT (H.R. 1588)

SPEECH OF

HON. BETTY McCOLLUM

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 7, 2003

Ms. MCCOLLUM. Mr. Speaker, I rise today in support of the Conference Agreement on the Defense Authorization Act (H.R. 1588), and in support of our armed forces and the service men and women who defend our great country, and their families.

Unlike the Iraq War Supplemental, which I opposed, the FY04 Defense Authorization bill is not a "blank check" for the Administration. Rather, this bill was carefully drafted to address many of our military's most pressing needs. This legislation provides a substantial pay raise for service members, boosts military special pay and extends enlisted and reenlistment bonuses. Additionally, this legislation extends the military's TRICARE health coverage to National Guard and Reservists and their families if such service members have been called to active duty. We need to assure our military that as we continue to support their readiness capabilities, we remember the personal well being of the men and women in uniform as well as their families.

The FY04 Defense Authorization bill also addresses the disabled veterans tax, or "concurrent receipt", by ensuring a significant number of disabled veterans will no longer be subjected to this unjust tax. As a cosponsor of H.R. 303, the Retired Pay and Restoration Act, I would have preferred the Defense Authorization bill include full concurrent receipt for all disabled veterans. However, this compromise is an important step forward and will allow the House to continue working toward the full elimination of the disabled veterans tax.

While I am supporting passage of this authorization, there are several provisions of this legislation that I oppose. The first regards civil service protections for civilian employees at the Department of Defense (DOD). H.R. 1588 gives the DOD broad authority to strip almost 700,000 civilian employees of fundamental rights relating to due process, appeal and collective bargaining rights. This means the DOD will be able to fire employees with no notice and no opportunity to respond, prevent discrimination actions from being heard by the Equal Employment Opportunity Commission, strip employees of their right to join a union and repeal the laws preventing nepotism. Civil service employees at DOD have defended our nation bravely and made enormous sacrifices to support the military effort in Iraq. DOD should not be given unlimited authority to trample on their basic rights.

H.R. 1588 also unnecessarily weakens long-standing environmental protections at our military facilities by lowering the accountability standard DOD must follow when recovering imperiled species under the Endangered Species Act. The new standard fails to ensure the DOD's conservation plans are actually effective in assisting the recovery of imperiled species. H.R. 1588 also creates a far less protective definition of 'harassment' of marine life by military activities under the Marine Mammal Protection Act. This new definition allows DOD to avoid ensuring its activities are conducted in a manner to minimize harm to marine life such as whales, dolphins, and sea lions.

Although I fully appreciate the importance of military training and readiness, the DOD has not made the case that exemptions to important and long-standing environmental laws are necessary or that training is greatly impaired because of those laws. Furthermore, the President already has the authority to waive environmental laws if he deems it a matter of national security, and not once has a waiver requested by the President been turned down. Until our national security is at stake, no government agency—including the DOD—should be above laws that preserve our air and water and sustain America's wildlife.

This measure also authorizes $9.1 billion for the unproven and untested National Missile Defense system. This costly program fails to address the rising threat of a chemical or biological weapons attack by terrorists and will divert precious resources away from the very real human investments needed to keep our military, intelligence agencies and domestic security agencies strong. I have voted time again to remove funding for the National Missile Defense system, but the Republican Majority defeated each attempt. It is a mistake to fund this unproven program while our citizens at home are without the appropriate resources they need to respond to a terrorist attack on American soil.

I have met with National Guard members, Reservists and regular military personnel who have chosen to put their lives on the line to protect our freedoms. They have sacrificed a tremendous amount, even when their service means putting their family's financial solvency at risk. We owe them our support and our gratitude.

As I stated above, this is not a "blank check" for the President. Rather, this legislation will go a long way toward helping our troops in their time of need.

TRIBUTE TO COLONEL MICHAEL VACCA

HON. GARY G. MILLER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. MILLER of California. Mr. Speaker, I rise to pay tribute today to one of our Nation's finest young men who demonstrated exceptional courage and concern for our troops. Colonel Michael Vacca of the United States Marine Corps is to be commended for his actions, and I applaud him for his dedication to the American spirit.

On the morning of August 26, 2003, one of the many brave soldiers from my district, Private First Class Daniel Humphreys, was injured while riding in a two-vehicle convoy heading north to Baghdad. When an Improvised Explosive Device hit the rear vehicle of this mission, the vehicle's tires were blown out, the engine and steering systems were destroyed, and Private First Class Humphreys was severely wounded along with other Marines. Private First Class Humphreys and his fellow Marines were taken to hospitals in Germany and Iraq for treatment, and Colonel Michael Vacca showed a tremendous amount of support for his Corpsmen that extended beyond the call of duty.

Not only did Colonel Vacca make regular visits to the hospital, he also notified the wounded soldiers' loved ones and kept them informed of their progress. When a soldier was unable to send word home, Colonel Michael Vacca did so with hope, enthusiasm and pride.

The men and women of our armed forces have been away from their families and friends defending democracy and freedom. Colonel Michael Vacca has not only put his life on the line for his country, he has also brought the spirit of his fellow Marines back home to their families.

Mr. Speaker, Colonel Michael Vacca is a true American hero, and this Congress should celebrate his outstanding service and loyalty to the Marine Corps and the United States of America.

CLEAN WATER ACT ROLLBACKS

HON. HILDA L. SOLIS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Ms. SOLIS. Mr. Speaker, I rise today to bring attention to efforts by the Environmental Protection Agency (EPA) to rollback the Clean Water Act.

Several days ago, in the Los Angeles Times and other newspapers, an internal EPA memo was quoted saying that the EPA is preparing a rule that would eliminate Clean Water Act protections for, "Streams that flow for less than six months a year . . ." State and federal officials have estimated that up to 20 million acres of wetlands would be lost.

This preliminary rule would devastate the Southwest where many streams flow only seasonally or after rain or snowmelts. In Los Angeles County, our rivers are often only a trickle, since our community gets an average of 15 inches of rainfall a year. And we are not alone.

Interior Secretary Gale Norton notes that, "The American West is facing a serious crisis. In the long run, we will not have enough water to meet the fast-growing needs of city residents, farmers, ranchers, Native Americans, and wildlife. The demand is increasing; the supply is not." Unfortunately, the EPA must have not gotten that memo because if our limited water supply is jeopardized, no one's needs will be met.

I encourage the Bush Administration to throw this rule draft away and start fresh with guidelines that will protect our water supplies so that our families are not left out to dry.

CONDEMNING THE RISE OF HIGH-TECH ANTI-SEMITISM

HON. JON C. PORTER

OF NEVADA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. PORTER. Mr. Speaker, I rise today to bring to the attention of the House an issue that this House bravely stood against earlier this year, the rise of anti-Semitism. While we understand the danger of anti-Semitism, I rise today to remind the House of the possible consequences of anti-Semitism in the developing world.

Last month the House unanimously passed House Resolution 409, condemning the anti-Semitic remarks of the former Prime Minister of Malaysia, Doctor Mahathir Mohamad. This House joined international condemnation of the hate-speech and stereotypes contained in Doctor Mahathir's speech. It seemed inconceivable that a man of such education and leadership could sink to so low a level.

Little noticed amid the well-earned condemnation of Dr. Mahathir's comments was the rest of his speech. It surprised many to see that the remainder of the speech was a call for advanced technical research, social and political modernization, and the development of first-rate communications in the Islamic world. These things are the very things that our country has been urging as a means of integrating these countries into the international community. How can Dr. Mahathir share the means and yet call for such a different end?

Since the end of the Second World War, anti-Semitism has not been seen as a disease that modern countries are susceptible to. Many have forgotten how scientifically advanced Hitler's Germany was, and how increases in knowledge were used to increase the murdering power of hate. Despite our hopes to the contrary, science proved to be values free, and the minds that could improve the lot of all mankind were put to the work of killing as many defenseless people as possible.

For 50 years after the end of the war, we kept close watch on the spread of technology, and trained scientists on how not to become a tool for evil. Science has brought the world closer together than ever, and technology has allowed the flowering of commerce and the arts. Yet the lesson remains, that this is because we make it so, not because of any moral value in technology itself.

While our Nation prides itself on the great advances being made in developing countries, and the ease with which technophobia around the world is dispelled, we cannot rest comfortably. Every invention, every improvement, can be used for evil when held by men with hate-filled minds. The periodic table and computer code do not contain hidden lessons on rooting out anti-Semitism and murder. New ministries and parliaments can be elected as fairly, and corrupted as easily, as the Reichstag that brought Hitler to power.

This Nation, and every nation of goodwill, must not be satisfied with spreading democracy and development. Without a commitment to fighting anti-Semitism, bringing murderers to justice, refusing to collaborate with evil, and speaking out for the truth, true peace and freedom in the Islamic world, and the rest of this planet, cannot be obtained.

TRIBUTE TO DR. EDWARD ROZEK

HON. MARILYN N. MUSGRAVE

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mrs. MUSGRAVE. Mr. Speaker, I rise today to honor a great American, Dr. Edward Rozek, for his years of dedicated service to the cause of freedom and democracy as a soldier, scholar, author, and college professor.

Edward Rozek was 18 years old when Adolf Hitler conquered Poland. He decided to join the Allied forces in the west and escaped through Slovakia to Hungary, where he was captured by the Nazis and spent several months in a slave labor camp.

Upon escaping from the Nazi camp, Rozek made his way to England, where he joined the First Polish Armored Division. He became a tank officer in the Armored Division's Reconnaissance Regiment and fought from Normandy through Belgium. Achieving the rank of Major, Rozek was wounded four times and received four Purple Hearts, three Crosses of Valor, as well as numerous other decorations.

In 1948 Dr. Rozek arrived in the United States without family, money, or profession. He was admitted to Harvard after earning money to pay tuition by working on a dairy farm and then at a gasoline station. In 7 years, he earned a Bachelor of Arts, Magna cum Laude and Phi Beta Kappa, Master of Arts, and his Doctorate of Philosophy.

After leaving Harvard, Dr. Rozek became a Professor of Comparative Governments at the University of Colorado. He was Director of Slavic Studies for 25 years and Deputy Editor for one of the most prestigious publications on Eastern Europe in the world, Journal of Central European Affairs. His best-known book is Allied Wartime Diplomacy, for which he received the National Foundation Book Award. The students at the University of Colorado selected him as Professor of the Year and Distinguished Faculty Member.

During the 1980 Presidential campaign, Rozek was a member of Ronald Reagan's Advisory Council on Defense and Foreign Policy and is currently a member of the Reagan Associates. He is an honorary member of Solidarity, and received Knighthood in the Venerable Order of St. John from Queen Elizabeth.

Presently, Dr. Rozek holds the Endowed Garnsey-Rozek Professorship in Economic and Political Freedom at the University of Northern Colorado. He will retire at the end of this year. Dr. Rozek is married to Elizabeth and has two sons and four grandchildren.

On behalf of the countless number of students, citizens, and legislators he has touched, I want to thank Dr. Rozek for his years of dedicated service to liberty through classical liberal education. As the famous philosopher Sidney Hook said of Dr. Rozek in the dedication to his book, Academic Freedom and Academic Anarchy, Ed is truly an "embattled fighter for free men, free society, and a free university against fascism, communism, and totalitarian liberalism."

May God bless Dr. Edward Rozek and his epic legacy of service to free people everywhere.

EXPRESSING APPRECIATION TO THE ROMAN CATHOLIC CHURCH FOR ITS SUPPORT OF STRONG ANTI-DRUG POLICIES

HON. MARK E. SOUDER

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. SOUDER. Mr. Speaker, I rise to express my deep thanks and appreciation to Pope John Paul II and the Roman Catholic Church for their unwavering support of a strong and balanced anti-drug strategy. Last month, at a European Union conference held in Dublin, Ireland, the Holy See submitted a statement outlining the Catholic Church's approach to drug policy. As chairman of the Government Reform Committee's Subcommittee on Criminal Justice, Drug Policy and Human Resources, I have long supported a vigorous but multipronged approach to reducing the scourge of drug abuse, emphasizing tough law enforcement, effective prevention, and treatment that works. I am submitting the Holy See's statement for the RECORD, as I believe it provides an eloquent and timely defense of those policies.

As the Vatican's statement makes clear, the problem of drug abuse is deeply rooted in the spiritual crisis that has gripped much of modern society. We live in a culture that often finds itself incapable of educating our young people in the values that give them an alternative to drugs. "One of the most important factors leading to drug abuse," warns the statement, "is the lack of clear motivation, the absence of values, the conviction that life is not worth living." We must ensure that our children are raised with the knowledge both of their own self-worth and of their responsibility to work for a better world. That knowledge is the best bulwark against drug abuse and other self-destructive behavior, and prevention efforts in our schools and communities must be grounded in such an approach.

But we must also make sure that we don't send the wrong message to young people by suggesting that governments tolerate the use of drugs. I strongly agree with the Catholic Church in its rejection of drug legalization. Legalizing the use of even the so called "lighter" drugs will only lead to the greater use of stronger drugs. Nor can we afford to condone drug abuse in a misguided attempt at "harm reduction." As the Vatican's statement notes, "The State should not assist its more vulnerable citizens to alienate themselves from society and ruin their lives."

Mr. Speaker, the problem of drug abuse is one of the most difficult facing lawmakers and parents today. It is deeply rooted, and will require a great and continuing effort to keep it under control. But we must not give up—there is simply too much at stake. I thank the Catholic Church for its ongoing support of that effort.

INTERVENTION OF THE DELEGATION OF THE HOLY SEE AT THE MINISTERIAL CONFERENCE ON "NEW CHALLENGES FOR DRUG POLICY IN EUROPE"

(Dublin, October 16–17, 2003)

MR. CHAIRMAN: The Holy See is pleased to participate in this Ministerial Conference sponsored by the Pompidou Group, for it sees this as a fitting and encouraging opportunity to discuss and analyze the strategies in the fight against the threat represented by drug abuse, as the Conference theme aptly suggests.

The data provided by the European Observatory for Drugs and Drug Addiction in the 2002 Annual Report on the Evolution of the Drug Phenomenon in the European Union and Norway continue to raise alarms and indicate that the situation, instead of improving, is growing worse.

Great concern is caused both by the constant increase in the use of synthetic drugs and by the ever decreasing age at which drug abuse is observed.

Pope John Paul II, already in 1984, noted that "among the threats facing young people and all of society today, drug abuse is one of the greatest, since it is a danger that is as insidious as it is invisible, and one that is not yet properly recognized according to the extent of its seriousness".

If politics is at the service of the human person and society, it must not fail to go to the root of problems. This means grappling with the anxiety, that is, the existential crisis or apprehensions, that in a consumerist and materialistic society finds rich soil for shattering the inner equilibrium in subjects who are particularly weak, fragile and sensitive. There is no doubt that the phenomenon of drug abuse is connected with a crisis of civilization and with great dejection. One of the most important factors leading to drug abuse is the lack of clear motivation, the absence of values, the conviction that life is not worth living.

Among the political measures to be adopted in the fight against this phenomenon, my Delegation would point out in the first place those aimed at combating illicit trafficking in drugs, controlled by powerful criminal organizations. This takes place in the larger context of arms trade, terrorism and trafficking in human beings. Such criminal activity goes beyond national borders and therefore requires a concerted policy of international cooperation.

Faced with the many suggestions and decisions made in different national contexts for the purpose of resolving the problem, the Holy See does not agree with the proposal to legalize the circulation and distribution of drugs, not even so-called light drugs. We must not fail to take into account the risk of moving from the use of light drugs to the use of those with more destructive effects. The State should not assist its more vulnerable citizens to alienate themselves from society and ruin their lives.

Rather, the Holy See encourages above all the promotion of preventive information and education, and the possibility of the proper treatment and reintegration into society of those who unfortunately fall prey to drug addiction.

More resources should be destined to the application of preventive and educational measures in the family, in schools, in sports clubs and in society in general. There is a need for placing renewed emphasis on the human values of love and life, the only values capable of giving meaning to human existence.

As far as treatment and reintegration into society are concerned, my Delegation places great importance on the work of assistance and recovery communities. This is a matter of helping drug addicts, in the midst of their inner suffering and their state of anxiety, to rediscover dignity, to take control of their lives once more and to reintegrate themselves into their families and into society.

An integrated system of services offered by local agencies, institutions and educational groups (family, school, community) should increase the ability to bring effective aid to the lives of young people who, once they are freed from drug addiction, will be able to avoid a relapse. Only the desire to be reborn and the ability to heal will ensure that "recovered" young people can return to a normal life after having passed through the frightening tunnel of drug addiction.

An adequate policy in this regard must also address the ethical questions involved, seeking to place the problem in a wider anthropological, ethical, social, political and economic context. Means and resources need to be set-aside for this purpose.

Mr Chairman, allow me to conclude by reaffirming the willingness of the Holy See and the Catholic Church—with their extensive networks of institutions and structures devoted to the education, assistance and rehabilitation of drug addicts—to work with European institutions in seeking together paths and means for a policy in the fight against drug abuse and addiction that will not only resist the criminal and subversive phenomenon but will also take into consideration the moral issue of drug addiction and of a society that promotes a culture of solidarity for life.

Thank you, Mr. Chairman.

PAYING TRIBUTE TO GREAT SAND DUNES' OUTDOOR EDUCATION PROGRAM

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. McINNIS. Mr. Speaker, I would like to take a moment to honor the Great Sand Dunes National Park in Colorado for its award-winning Outdoor Education Program. Recently, the Colorado Alliance for Environmental Education awarded the Great Sand Dunes with the Governmental Environmental Education Award for Excellence for 2003. The Outdoor Education Program is an excellent source of information and entertainment for all who enjoy nature and have an interest in wildlife. I would like to join my colleagues here today in recognizing the tremendous service provided to the Colorado community by the Great Sand Dunes Outdoor Education Program.

The Great Sand Dunes have offered education programs for almost twenty years. Staff members and volunteers enthusiastically provide research and expertise for service-learning projects, field trips, outreach events and workshops that encourage environmental awareness in the community. The educational program works in conjunction with the U.S. Fish and Wildlife Service, the U.S. Forest Service and the Nature Conservancy, in order to provide students and instructors with the latest and most accurate information.

Mr. Speaker, the Great Sand Dunes Outdoor Education Program is an exciting and instructional educational tool for the Colorado community. This program has shown extraordinary dedication to teaching adults and children about the environment and conservation. It is my great honor today to recognize the devotion and commitment of those involved with the program. Congratulations on a well deserved award.

CONFERENCE REPORT ON H.R. 2754, ENERGY AND WATER DEVELOPMENT APPROPRIATION ACT, 2004

SPEECH OF

HON. MARK UDALL

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mr. UDALL of Colorado. Mr. Speaker, I rise in support of this bill. But I do have reservations about a number of provisions included in it.

As co-chair of the Renewable Energy and Energy Efficiency Caucus in the House, I have worked for years to increase—or at a minimum, hold steady—funding for DOE's renewable energy and energy efficiency research and development programs. So I am disappointed that for yet another year, the bill shortchanges these important clean energy programs.

Given our finite supply of fossil fuels and increasing global demand, investing in clean energy is more important than ever. DOE's renewable energy programs are vital to our Nation's interests, helping provide strategies and tools to address the environmental challenges we will face in the coming decades. By reducing air pollution and other environmental impacts from energy production and use, they also constitute the single largest and most effective federal pollution prevention program.

Investments in sustainable energy technologies meet multiple other public policy objectives. Far from decreasing, U.S. dependence on imported oil has increased to record levels over the past 25 years. These programs are helping to reduce our reliance on oil imports, thereby strengthening our national security, and also creating hundreds of new domestic businesses, supporting thousands of American jobs, and opening new international markets for American goods and services.

While these technologies have become increasingly cost-competitive, the pace of their penetration into the market will be determined largely by government support for future research and development as well as by assistance in catalyzing public-private partnerships, leading to full commercialization.

For our investment in these technologies to pay off, our efforts must be sustained over the long term. This bill does not do that. This bill is fully $75 million less than last year's bill in the area of research energy research. Much of this reduction is used to fund a new Office of Electricity Transmission and Distribution. Cuts to renewable energy accounts are also used to boost hydrogen programs fully $38 million above last year's levels. Although I'm certainly supportive of both the electricity and hydrogen programs, I believe they should be additive to take advantage of the synergies they present with the other important and established programs at DOE. Instead, the bill cuts biomass/biofuels by $14.4 million, solar energy by $9.4 million, and geothermal by $3.8 million.

I believe that the reductions in funding levels for the core renewable energy programs are ill-advised at a time when the need for a secure, domestic energy supply is so crucial. Clean energy technologies have a critically important role to play in promoting public health and enhancing the energy security of the nation by promoting fuel diversity, harnessing safe and abundant domestic resources, and expanding the use of small-scale, dispersed technologies.

Overall, the bill provides necessary funding for some important Army Corps of Engineers projects and for DOE's Office of Science and non-proliferation programs. It also includes critical funding for defense environmental management programs—in particular, funding for Rocky Flats, the former weapons production site in Colorado. Funding in this bill keeps Rocky Flats on track for finishing cleanup and closure by the end of 2006.

So on balance, Mr. Speaker, I believe this bill contains more good than bad. Although I am not satisfied with the levels of funding in this bill for DOE's clean energy programs, I will continue to work to increase funding for these programs in years to come.

RECOGNIZING THE SACRIFICE OF OUR VETERANS

HON. BETTY McCOLLUM

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Ms. MCCOLLUM. Mr. Speaker, earlier this month our Nation took the time to honor and recognize the tremendous sacrifice our veterans have given to protecting our freedom and safeguarding democracy for us all. During this special time, it is important we remember all our veterans and thank them for their service.

Today, however, I would like to specifically recognize our Korean War Veterans and their service to the United States.

The Korean War resonates deeply with many Minnesota families. Through the duration of the conflict, close to 95,000 Minnesotans served their country with honor and courage, with 749 paying the ultimate sacrifice. Countless others lost their lives training for service in Korea. One hundred seventy remain missing. They were our fathers, mothers, brothers and sisters. Their service was integral in ensuring that the long arm of communism would stretch no farther than the 39th parallel and their sacrifices enabled countless numbers of Americans and Koreans to raise their families and live their lives in freedom.

As we reflect on their service, it is important to remember that the armistice ending military action in Korea signaled an end to the fighting, but not the war. Today, 37,000 U.S. military personnel remain in South Korea to supplement the 650,000-strong South Korean armed forces. These men and women serve to protect America's economic and political interests in the region, while ensuring our national security by providing a counter-balance to North Korea. The dangers our U.S. soldiers in South Korea face are very real and the merits of their courage is tested everyday.

In Minnesota, the Korean War veterans remain very active. They visit hospitals, are active in their local VFW and American Legion and participate in parades. Many take time to visit schools in their area, talking to students about the Korean War and answering questions about military service. Recently, a large group ascended on Washington, D.C. to participate in Veterans Day events and to mark the 50th anniversary of the end of the Korean War. In D.C., they participated in the wreath-laying ceremony at Arlington Cemetery and took a tour of the U.S. Capitol, among other things. I am inspired by their continued patriotism and commitment to their families, the United States, and each other.

As a former Minnesota State Legislator, I had the distinct privilege to help enable the creation of a memorial to Minnesota's Korean War veterans, that stands today at the Minnesota State Capitol. Near this grand memorial is a time capsule, to be opened 100 years after its burial. In it lie a U.S. flag, pictures and other memorabilia commemorating our war veterans and the important news of our day. The capsule also holds a letter to future generations of Americans. The letter asks those who read it to never forget the events of the past, and expresses hope that when the capsule is opened, our nation and the world will be at peace. I, like all Americans, share the optimism that when this letter is next read, the hope of its authors has become reality.

I ask all Americans to never forget those of the "forgotten" war in Korea. At a minimum, Congress should grant the Korean War Veterans Association a Federal Charter, allowing the Association to expand its mission and further its charitable and benevolent causes. Specifically, it will afford the Korean War Veterans Association the same status as other major veterans organizations and would allow it to participate as part of select committees with other Congressional chartered veterans and military groups. While they seek no recognition for what they have done, it is important their story is told and the debt of their service is remembered.

Thank you to all our Korean War Veterans. Your commitment to our country is greatly appreciated.

TRIBUTE TO THE CITY OF LA HABRA HEIGHTS, CALIFORNIA

HON. GARY G. MILLER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. GARY G. MILLER of California. Mr. Speaker, I rise to pay tribute today to the City of La Habra Heights, California, as their community celebrates 25 years of cityhood this year.

Since incorporating on December 4, 1978, La Habra Heights has succeeded in maintaining a quality environment for its residents by providing excellent municipal services and keeping a strong community spirit alive. The citizens of La Habra Heights continually demonstrate their enthusiasm for their City by actively participating in local government and future city planning. It is indeed my honor to represent the residents of this beautiful city, who have contributed much of their time towards the betterment of their community.

Mr. Speaker, on this very special year for the City of La Habra Heights, please join me in commemorating their twenty-fifth anniversary.

THE PASSING OF REGINALD ARTHUR STONE

HON. HILDA L. SOLIS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Ms. SOLIS. Mr. Speaker, I rise to pay tribute to Mr. Reginald Arthur Stone who passed away on November 12th at the age of 67. Mr. Stone was a loving husband to his wife Judy, the father of two and the grandfather of five. In addition to being a community leader, Mr. Stone was known as a person who could create compromise out of chaos.

Reginald "Reg" Stone was the longtime chairman of the Main San Gabriel Basin Water Master Board of Directors, where he was a key figure in negotiations that led to a $250 million cleanup agreement with industrial companies that polluted the area's groundwater. Because of his gentle, yet determined efforts, thousands of homes will have cleaner water and the health of working families will be improved.

In addition to serving on the Main San Gabriel Basin Water Master Board of Directors, he worked for 43 years at Suburban Water Systems. Starting off as a meter reader, Mr. Stone rose to senior Vice President at the time of his death. More importantly than his title, however, is that he is remembered as a person who was liked and appreciated by all and was able to bring even the most adversarial people together with the belief that you should start to negotiate from common ground.

Reg Stone will be missed by all who knew him and our prayers are with his family during this time of mourning.

HONORING DON LAUGHLIN, FOUNDER OF LAUGHLIN, NEVADA

HON. JON C. PORTER

OF NEVADA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. PORTER. Mr. Speaker, I rise today to honor the founder and namesake of one of the fastest growing, most dynamic communities in my district, Don Laughlin. On Friday the community of Laughlin will join together to celebrate the unveiling of a statue of Don that will greet visitors to the many gaming, entertainment, and recreational opportunities in the city along the Colorado River he created just a few decades ago. Don is a visionary leader, and I urge the House to join with the thousands of residents, and millions of visitors to Laughlin who celebrate his permanent contribution to the landscape and culture of Nevada and our country.

TRIBUTE TO CONAGRA FOODS—LONGMONT FACILITY

HON. MARILYN N. MUSGRAVE

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mrs. MUSGRAVE. Mr. Speaker, I rise today to recognize the outstanding achievement of ConAgra Foods—Longmont Facility in Longmont, Colorado in the field of occupational safety and health. I also commend Ms. Stephanie Sparks, the Complex Safety & Health Manager for this facility, and her team for their continued excellence.

Recently, the Occupational Safety and Health Administration (OSHA) awarded this facility with the agency's approval as a Merit participant in the Voluntary Protection Program (VPP). This exceptional facility joins fewer than 850 worksites under Federal jurisdiction that have received this prestigious award.

To achieve important recognition, ConAgra has demonstrated an exemplary record of workplace safety and health, achieving injury and illness rates well below the industry average.

ConAgra continually exceeds industry performance records and sets extremely high standards for their competition. I am very proud to represent such a commendable Colorado facility. Congratulations to ConAgra for another job well done.

THE IMPACT OF LEFT-WING SPECIAL INTEREST GROUPS ON THE JUDICIAL NOMINATION PROCESS

HON. MARK E. SOUDER

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. SOUDER. Mr. Speaker, yesterday I introduced into the RECORD several memos written by Democratic Congressional staff illustrating how deeply politicized the process of appointing new judges to the Federal bench has become. Today I am introducing two more such memos—which were reported by the Wall Street Journal last week—which further reveal the damage that a handful of liberal special interest groups are inflicting on that process.

The memos show how much influence is being wielded by left-wing fringe groups like the so-called People for the American Way and the Alliance for Justice, and extreme pro-abortion groups like the National Abortion Rights Action League (NARAL). These groups apparently were called on to dig up dirt on President Bush's judicial nominees, and were allowed to dictate which nominees to oppose and when to schedule them. One nominee was only supported because another liberal special interest group, the trial lawyers' lobby, wanted to remove him from the trial bench to the appellate bench. Taken together, these memos show the unhealthy influence these groups are having on the federal judiciary—a judiciary that is supposed to serve all the American people, and not just a few special interests.

MEMORANDUM

JUNE 4, 2002.

To: Senator Kennedy.
Subject: Meeting with Groups on Judges—Wednesday, 11:50 a.m.

As you know, the meeting with the groups to discuss the strategy on judicial nominations is scheduled for tomorrow at 11:50. Both Senator Schumer and Senator Durbin will be able to attend. The six principals who will attend are: (1) Wade Henderson, (2) Ralph Neas, (3) Leslie Proll of the NAACP LDF, (4) Nancy Zirkin, (5) Nan Aron, and (6) Kate Michelman. It turns out that neither Marcia nor Judy can make it tomorrow—Marcia has a board meeting and Judy, a family emergency.

We expect that the agenda will include a discussion of: (1) delaying a hearing for Dennis Shedd, a nominee to the Fourth Circuit, who Sen. Leahy would like to schedule on June 27th; (2) which circuit court nominees should be scheduled prior to adjournment; and, (3) our next big fight.

SCHEDULE

At present, there is only one noncontroversial circuit court nominee (with a complete file and blue slips) who has not already been scheduled for a hearing. This nominee is John Rogers (6th Circuit), who Senator Leahy will likely schedule for a hearing on June 13th. In addition, there have been two recent nominees to the 2nd Circuit and to the Ninth Circuit, whose records are now being researched, and who may prove to be noncontroversial.

Senator Leahy would then like to schedule Dennis Shedd on June 27th, Judge Priscilla Owen after the July 4th recess, and Miguel Estrada in September.

The groups should be encouraged to propose some specific nominees who can be moved forward before adjournment. Clearly, there are few nominees who are noncontroversial, but the groups should be pushed on whether they would agree on a hearing for some controversial nominees such as Steele, Tymkovich, or Michael McConnell (for whom Leahy has already promised a hearing), on the theory that these nominees are less problematic than others.

SHEDD

Senator Leahy has told the groups that he would like to have a hearing on Dennis Shedd this month. Senator Hollings is supportive of Dennis Shedd's nomination and is, reportedly, pressuring Senator Leahy to move forward on a hearing. The groups have strong concerns about Shedd. He is quite bad on civil rights and federalism issues, and he has hundreds of unpublished opinions that have not yet been reviewed. The groups are opposed to having a hearing on him this month in part because they do not believe that they will be able to do an adequate review of his extensive record by June 27th, particularly given that they are gearing up to oppose Judge Owen.

We believe that you should hear the groups' concerns regarding Shedd, but that you should strongly encourage the groups to work with South Carolina groups and individuals to apply pressure on Senator Hollings. We know that some of the groups, including LCCR and the NAACP will meet with Sen. Hollings on Thursday regarding Shedd, but more pressure will likely need to be applied because Sen. Hollings is quite committed to moving Shedd this month.

Recommendation: Encourage groups to work with South Carolina groups to influence Sen. Hollings.

OUR NEXT BIG FIGHT

The current thinking from Senator Leahy is that Judge Owen will be our next big fight, after July 4th recess. We agree that she is the right choice—she has a bad record on labor, personal injury, and choice issues, and a broad range of national and local Texas groups are ready to oppose her. The groups seem to be in agreement with the decision to move Owen in July.

Recommendation: Move Owen in July.

MEMORANDUM

To: Senator Durbin.
From:
Date: June 5, 2002.
Re: Meeting with Civil Rights Leaders to Discuss Judicial Nominations Strategy Thursday, June 6, 5:30 p.m., Russell 317.

Senator Kennedy has invited you and Senator Schumer to attend a meeting with civil rights leaders to discuss their priorities as the Judiciary Committee considers judicial nominees in the coming months. This meeting was originally scheduled for late Wednesday morning.

This meeting is intended to follow-up your meetings in Senator Kennedy's office last fall. The guest list will be the same: Kate Michelman (NARAL), Nan Aron (Alliance for Justice), Wade Henderson (Leadership Conference on Civil Rights), Ralph Neas (People For the American Way), Nancy Zirkin (American Association of University Women), Marcia Greenberger (National Women's Law Center), and Judy Lichtman (National Partnership).

The meeting is likely to touch upon the following topics:

—Their floor strategy for opposing D. Brooks Smith, who was voted out of Committee 12–7.

—Their concerns with Dennis Shedd, a controversial 4th Circuit nominee from South Carolina—Under pressure from Senator HOLLINGS—who apparently is backing SHEDD because the trial lawyers want him off the district court bench—Chairman Leahy is planning to hold a hearing in late June. The groups would like more time to read through SHEDD's many unpublished opinions, which were only recently provided to the Committee, and to request court transcripts. Based on a preliminary review, this nominee poses a number of problems: he has narrowly interpreted Congress's power under the 14th Amendment (in one instance, he was unanimously reversed by the Supreme Court); he has a long track record of dismissing civil rights claims; he once revoked indigent status for a litigant who used her mother's computer and fax machine to file pleadings; and he has made insensitive comments about the Confederate flag.

—The Judiciary Committee's schedule for the summer and fall. In spite of the White House's intransigence, the Committee continues to schedule hearings at a rapid pace—every two weeks through the end of the session. Bruce Cohen has outlined the following schedule:

June: Rogers (6th Circuit-KY); Shedd (4th Circuit-SC)

July: Owen (5th Circuit-TX); Raagi (2d Circuit-NY)

Sept: Estrada (DC Circuit); possibly Bybee (9th Circuit-NV) (backed by Reid)

Oct: McConnell (10th Circuit-UT)

Leahy has effectively promised that OWEN, ESTRADA, and MCCONNELL would get hearings this year. Like SHEDD, these three will generate significant opposition and controversy. The groups feel that OWEN is vulnerable to defeat, but ESTRADA and MCCONNELL will be hard to vote down in Committee.

—The White House's unwillingness to compromise. On NPR this week, White House Counsel Alberto Gonzalez said:

> I'm not sure this [judges] is an area where there should be a great deal of compromise on principle. Regrettably, . . . we may have to be patient and wait to see what happens in the November election. And that may be viewed as a sort of crass political assessment but that is in fact true. One way to get this thing moving is to take back the Senate so that we can at least get our judges onto the full Senate floor.

At the moment, a number of Democrats—Edwards, Graham, Nelson (FL), Levin, Stabenow—are in stalled negotiations with the White House over judges.

HONORING SAMUEL FISHER FOR HIS HEROIC SERVICE IN WORLD WAR II

HON. JON C. PORTER

OF NEVADA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. PORTER. Mr. Speaker, I rise today to honor my constituent, Samuel Fisher, for his heroic service in World War II. As a rifleman with Company B, 49th Armored Infantry Battalion, Eighth Armored Division he helped participate in the final drive of the American and Allied armies that drove the Nazis from France and ended Hitler's rule over Germany. He, and the other brave soldiers of the 49th Armored Infantry, were instrumental in capturing the Ruhr Valley, the center of the German armament industry. By capturing the Ruhr, they deprived the Nazis of the weapons they had used for so long to bring oppression and death across Europe. I am proud to represent Samuel Fisher, and so many other American heroes from the Second World War, and urge this House to join me in thanking Samuel Fisher and all World War II veterans for saving our country, and the world, from fascism.

PAYING TRIBUTE TO NANCY RATZLAFF

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. MCINNIS. Mr. Speaker, it is with great pride that I rise today to pay tribute to a talented artist from Craig, Colorado. Nancy Ratzlaff uses her creative gift to inspire people to think outside the box. Her enthusiasm spirals through the community as she passes her knowledge of art to her students. I would like to join my colleagues here today in recognizing Nancy's tremendous service to the Craig community.

At sixty-one years old, Nancy Ratzlaff has been painting for more than 4 decades. She is both a commissioned artist and a teacher of her trade. Three years ago, Nancy suffered a heart attack that caused her to lose her leg and spend 5 months in the hospital. However, despite cumbersome crutches and an artificial leg, she continues to find time to teach painting at Craig's Colorado Northwest Community College. Nancy encourages her students to learn from each other and let art open them up to new challenges. She maintains that everyone has a creative drive inside because anyone who can dream can create.

Mr. Speaker, Nancy Ratzlaff is a dedicated individual who uses her talent to enrich the lives of members of her Craig community. Nancy has demonstrated a love for art that resonates in her compassionate and selfless service to her town. Nancy's enthusiasm and commitment certainly deserve the recognition of this body of Congress.

PERSONAL EXPLANATION

HON. JOHNNY ISAKSON

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. ISAKSON. Mr. Speaker, I was unavoidably detained yesterday and missed the votes. Had I been present I would have voted as follows: Rollcall number 620—"yes"; rollcall number 621—"yes"; rollcall number 622—"yes"; and rollcall number 623—"yes."

AMERICANS PUSH FOR RENEWED FIGHT AGAINST DRUNK DRIVING

HON. NITA M. LOWEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mrs. LOWEY. Mr. Speaker, Congress has made good progress over the past 20 years in combating drunk driving, culminating when we passed legislation creating a national .08 blood alcohol content level in 2000. I am pleased that New York recently passed .08, which will save 500–600 lives in the U.S. annually when it is adopted by all states. All but a handful of states have .08 laws on the books—a testament to the effectiveness of the sanction.

Despite this progress, a disturbing complacency about drunk driving seems to have settled upon the nation. In 2002, alcohol-related fatalities rose for the third year in a row, and now account for well over 40 percent of all traffic fatalities. Last year, drunk driving took nearly 18,000 lives. Public policy experts are now beginning to grasp the full economic costs of drunk driving. When one factors health care costs, lost work time, collision repairs, and insurance, the price tag exceeds $200 million annually.

Almost 6 years ago, a constituent, Burton Greene, was killed by a repeat offender with a .18 blood alcohol content. Mr. Greene's death inspired me to introduce legislation requiring tougher penalties for repeat offenders and high-BAC drivers.

About one-third of all drunk drivers are repeat offenders. Unfortunately, the lack of a national minimum standard for punishing repeat offenders and high-BAC drivers has created an easily exploitable, unwieldy patchwork of laws that varies from state to state. My legislation would require states to pass laws that employ a comprehensive approach to fighting drunk driving, including license restrictions, effective vehicle sanctions, treatment programs, ignition interlocks, fines, and imprisonment. This comprehensive system of penalties builds on the recommendations of numerous studies, as well as measures proven to be effective on the state and local level.

I am proud that Good Housekeeping magazine, which has always tackled the leading issues of the day, has become a partner in the effort to combat drunk driving. An article about Brigid Kelly, a young woman killed by an impaired driver with a suspended license, appeared in the July 2003 issue of the magazine. Brigid's senseless death, which has brought untold grief to her family and friends, is a wake up call to the nation and a powerful reminder of the stakes in the battle against drunk driving.

I was also touched by the response to the article. Over 6,000 readers took the time to write Good Housekeeping in support of national minimum standards for punishing repeat offenders. This outpouring leaves no doubt about where Americans stand on tougher penalties for chronic drunk drivers.

More than 40 people die daily from drunk driving. We should do all we can to prevent such tragedies. I encourage my colleagues to listen to the voices of Good Housekeeping's readers and support swift passage of the Burton Greene bill.

CONFERENCE REPORT ON H.R. 6, ENERGY POLICY ACT OF 2003

SPEECH OF

HON. TAMMY BALDWIN

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Ms. BALDWIN. Mr. Speaker, yesterday, this House considered H.R. 6, the Energy Policy Act of 2003. Our country has been waiting almost three years for a sound and comprehensive energy bill, and I am sad to say that they will still be waiting if H.R. 6 is signed into law.

It was my hope that rolling blackouts in California three years ago, the terrorist attacks on September 11 two years ago, and the massive blackouts in the northeast this past August would have provided Congress with the will and fortitude to pass a truly comprehensive energy bill. This bill should have presented a clear vision of what our energy policies should be well into the 21st century; provided us with the tools and resources to reduce our dependence on foreign oil and improve the security of our nation; and made investments in alternative and renewable fuels to provide better answers to our energy needs than simply encouraging more drilling and more pollution. It is crystal clear that H.R. 6 fails on all these counts.

The Republican leadership crafted this 1,700-page bill in secret and sold out to special interests. For months, Republican leaders presided over meetings in which they were supposed to be laying the foundation for the nation's long-term energy priorities. Instead, they chose to negotiate the bill alone, refusing even to tell their Democratic colleagues where or when important sessions were being held. I believe that cowering under the cloak of darkness and cutting backroom deals are not the ways a bill of this magnitude should be debated, discussed, and crafted.

The Energy Policy Act makes a number of changes to our nation's electricity system. The blackouts that wreaked havoc across parts of the Midwest and Northeast four months ago prompted legislators to include much-needed electricity reliability standards in the final bill. I believe this is a good first step in improving the transmission and distribution of the electricity that powers our homes and businesses. Despite this sound provision, H.R. 6 is wrong to repeal the Public Utility Holding Company Act (PUHCA). PUHCA was designed to oversee mergers and prevent power companies from investing in unrelated businesses. PUHCA has been the linchpin in protecting investors and consumers from market fraud and abuse by utilities. By repealing PUHCA and not replacing it with a better alternative, the risk of future Enron-type abuses increases exponentially and our constituents will be the victims.

I am pleased H.R. 6 does not include language that would allow drilling in the Arctic National Wildlife Refuge (ANWR) or allow for an inventory of oil reserves in our nation's Outer Continental Shelf—but, any benefits of this bill provides our environment stop there. The bill expedites the approval of permits for drilling and mining on federal lands. H.R. 6 also exempts oil and gas drilling activities from some of the major tenants of the Clean Water Act, such as exempting the industry from certain requirements when they inject diesel fuel and other harmful chemicals underground when drilling.

The most egregious provision of this bill grants the producers of MTBE, a gasoline additive that pollutes underground drinking water, a liability waiver. While the bill phases out the use of MTBE over the next decade, it makes taxpayers pick up the bill for cleaning up the mess. More incredulously, the bill provides the producers of MTBE $2 billion in subsidies to help them convert MTBE into other types of chemicals. I believe this is simply unacceptable. Polluters should be made to clean up and pay for their messes, not the American taxpayer.

Altogether, the energy proposal includes $23 billion in tax giveaways over 10 years and calls for tens of billions of dollars in additional spending. The Republican leadership rejected Senate provisions that would have partially paid for these costs, despite a deficit in the federal budget that could top $500 billion this year. Two-thirds of the tax breaks would go to the oil, natural gas and coal industries, helping to perpetuate the country's dependence on fossil fuels. Less than a quarter of the tax breaks would promote the use and development of renewable-energy sources, and less than a tenth would reward energy efficiency or conservation.

It makes no sense to lavish billions of dollars in subsidies to companies that consistently earn large profits every year. The bill does encourage the use of some alternative fuels such as ethanol—which I strongly support—and $2.5 billion to boost development of hydrogen-powered vehicles. However, the money allocated for renewable and alternative fuel development is a mere pittance of what is given to producers of traditional sources of energy.

This bill is equally bad for what it does not contain: the legislation does almost nothing to reduce the nation's dependence on foreign gas and oil and nothing to reduce global warming. For example, this bill does not increase the fuel efficiency standards for cars and trucks. The bill may even wind up lowering the current 27.5 miles per gallon average since it discourages tougher standards. It also scraps a Senate plan that would have required electric utilities to generate more of their power from renewable sources like wind and solar energy by 2015. Finally, outside of a few provisions on electrical appliances and heating systems, the bill does not significantly encourage energy conservation.

Instead of creating and carrying out a vision in this bill, lawmakers have put together a jigsaw puzzle with hundreds of unrelated pieces crammed together. A few initiatives are worthwhile, but most look more like a laundry list of special-interest subsidies. Together, they do not add up to a policy that I believe will come close to meeting our future energy needs. While it took three years to finish this energy bill, it is my fear that Congress will spend the next several decades fixing the problems this bill could eventually create.

IN REMEMBRANCE OF LILLIAN KESSLER

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. STARK. Mr. Speaker, I rise to pay tribute to my longtime friend Lillian Kessler. It is with sadness that I announce Lillian's recent passing. She resided in my 13th congressional district and I was pleased and proud to have her support and friendship for many years.

As a truly committed political and community activist, Lillian spent years volunteering in the community and working tirelessly to elect individuals to public office. She was proud to call herself a Democrat for more than 50 years. Lillian and her husband Mike were the first two people to encourage me to seek my present office in Congress.

Lillian was an active member in the Hayward Demos Democratic Club. Her fellow club members describe her as "a tower of strength for their club, the Democratic Party and progressives everywhere. She was a quintessential activist, organizing precinct walking, phone banks, fundraisers, all the necessary jobs to run and win grassroots campaigns."

I shall remember with fondness and admiration Lillian's passion, strength and perseverance to make a difference. She believed that just one progressive idea or action, no matter how small, could strengthen each and every community for the better.

Lillian will be sorely missed by me and all who knew her. My thoughts and condolences are with her husband Mike and her children, Civia and Stuart.

CONFERENCE REPORT ON H.R. 6, ENERGY POLICY ACT OF 2003

SPEECH OF

HON. CAROLYN B. MALONEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mrs. MALONEY. Mr. Speaker, I rise today in opposition to this conference report. H.R. 6 contains several harmful provisions including exempting the producers of MTBE from product liability claims and repealing the Public Utility Holding Company Act, which limits mergers between utilities companies. Additionally, the conference report does not prioritize the use of renewable resources by large utilities to generate power. H.R. 6 rolls back important safeguards in the Clean Water Act and the Safe Drinking Water Act which are critical in keeping the nation's waterways safe for people and wildlife. The country needs an energy policy that reduces pollution, protects consumers, and reduces the burden on the nation's electricity grid. This bill fails to meet those standards. I regret that we were not given the opportunity to vote on legislation that would reduce our dependence on foreign sources of oil.

PERSONAL EXPLANATION

HON. STEVE KING

OF IOWA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. KING of Iowa. Mr. Speaker, I was absent during rollcall votes 620, 621, 622 and 623. Had I been present, I would have voted "aye" on 620, 621, 622 and 623.

PAYING TRIBUTE TO MARILYN A. HALL—

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. McINNIS. Mr. Speaker, it is with great pride that I rise today to pay tribute to a remarkable woman from my district. Marilyn Hall of Cortez, Colorado is a dedicated public servant who has devoted many years to promoting safety and order in her community. Marilyn has a friendly soul and touches the heart of everyone she meets. I would like to join with my colleagues here today in recognizing Marilyn's tremendous service to the Cortez community.

Marilyn served the Cortez Police Department for 29 years. She began as a dispatcher and then moved to records before retiring. Marilyn was excellent at her job and was instrumental making the system of city and county record keeping significantly more efficient. In her retirement, Marilyn is an active community member who is a vigorous advocate for Mothers Against Drunk Drivers. In addition to volunteer work, Marilyn will spend her retirement with her many loving family members and friends.

Mr. Speaker, Marilyn Hall has shown incredible dedication in her service to the Cortez community. Marilyn's friendly assistance to others is a shining example of what it means to be a good citizen. It is my great honor today to recognize her excellent work ethic and selflessness before this body of Congress. Thanks Marilyn, you will be missed.

H.R. 2205: NATIONAL MUSEUM OF AFRICAN AMERICAN HISTORY AND CULTURE ACT

HON. GREGORY W. MEEKS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. MEEKS of New York. Mr. Speaker, I rise to express my unparalleled support for this bill. However, I do not feel that this bill is complete in its entirety. Provisions concerning a feasibility study for a future sister museum facility at the site of the African Burial Ground in New York City, which were present in the Lewis/Watts bipartisan piece of legislation in the last session, are not included in this current bill. The erection of the African Burial Ground International Memorial Museum and Research Center in lower Manhattan is a goal that I intend to work feverishly on with my New York colleagues and others. Such a facility would pay homage to those souls who were brought to this country to help build it, while under enslavement. Such a facility would join the Statue of Liberty, Ellis Island, the Museum of the American Indian, the World Trade Center site, and other great New York City landmarks as a national and international symbol that tells America's full story of freedom, the quest for freedom, and the openness of our society. Most important, the study of African culture through the results of DNA testing on the African Burial Grounds will help to further educate and enlighten our citizens to a culture that is central to the building of this proud nation.

As the Lewis/Watts bill reflected in a Finding, the Secretary of the Smithsonian declared in 1998 that the African Burial Ground site provided the "perfect" opportunity to dissect the institution of slavery in this country—urban, rural, northern, and southern—including the aspects of the international trade. The Burial Grounds in New York are home to the remains of 20,000 enslaved Africans. These men and women were first generation African Americans, who had to endure inhumane conditions aboard slave ships, before they were forced into labor.

I attended the ceremonies of October 3rd and 4th at the African Burial Ground commemorating the reinterment of some 430 sets of remains that had been under study at Howard University for the last decade. Thousands of people were also in attendance for this event, signaling a clear indication of the powerful feelings of respect that lies with our citizens for an African sanctum in lower Manhattan.

I feel that, ultimately, the new national museum should follow the model of the National Museum of the American Indian, with facilities at both Washington and New York City. The facility in New York, in combination with the magnificent facility to be created here in Washington, would have an overall national and international impact of breathtaking scope and scale. As evident during the ceremonies, an African Burial Ground museum facility would also play a significant role in the revitalization of lower Manhattan in this post-9/11 world, with the hopes that it will become a major national and international visitor's mecca that would join with other New York sites in bringing millions of people, and with them, an economic boom to the entire area.

I whole-heartedly believe that the African Burial Ground is a true national treasure. It is unique in this nation and all the world as an archaeological site, and a site of unparalleled significance, symbolism, and power. A site and museum facility of this magnitude of importance must be part of any national museum, and it must be part of New York's African Burial Grounds.

I would like to thank John Lewis for his long fight to make the dream of a National Museum of African American History and Culture a reality. I would also like to thank my distinguished colleagues from Kansas and Connecticut, Senators BROWNBACK and DODD, for leading these efforts in the Senate.

MOTION TO GO TO CONFERENCE, OBEY MOTION TO INSTRUCT

HON. ROBERT T. MATSUI

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. MATSUI. Mr. Speaker, yesterday's CONGRESSIONAL RECORD reflects my vote as "yea" on rollcall Vote 624, Representative OBEY's motion to instruct conferees on the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act of 2004. I would like to state for the RECORD that my vote should have been "nay."

I have long opposed the reimportation of prescription drugs because it creates a significant safety risk for consumers. A recent examination of several mail facilities by FDA and U.S. Customs reinforces these concerns. After six days in four cities, these examinations found drugs being reimported that have never been approved by the FDA, without labeling or instructions for safe use, and even some that the FDA has withdrawn from the U.S. market for safety reasons. In addition, expanding the importation of prescription drugs increases the likelihood that seniors will receive counterfeit drugs, a potentially very serious health hazard.

Finally, liberalizing the importation of prescription drugs does not address the underlying problem of high prescription drug costs. There are other legislative remedies that can decrease prescription drug costs without undermining consumer safety. For these reasons, I oppose the Obey motion to instruct conferees on the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 2004.

RECOGNIZING THE PUBLIC SERVICE OF DON MOCK

HON. MARK UDALL

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. UDALL of Colorado. Mr. Speaker, I rise today to honor Don Mock for his exemplary public service as a member of the Boulder City Council from 1996 through 2003. I would like to thank him on behalf of all Boulder's citizens for the depth and diversity of contributions he has made to ensure that our city remains a very special place to live.

Raised in Florida, Don received his BS and MS in Physics from the University of Florida, and his PhD in Atmospheric Sciences from the University of Washington. He has worked as a Research Assistant in the Department of Atmospheric Sciences at the University of Washington and as a Support Scientist for the Physical Oceanography Group of the NASA/Caltech Jet Propulsion Laboratory. In 1989, Don moved to Colorado to work as Systems Manager for the Cooperative Institute for Research in Environmental Sciences at the University of Colorado in Boulder. Since 1991 he has been a Systems Manager and later a Director of Computing and Network Services at the Climate Diagnostics Center of the National Oceanographic and Atmospheric Administration's Environmental Research Laboratories.

In 1996, Don was appointed to the Boulder City Council and elected a year later to another term. On the Council, he quickly earned the respect of his colleagues for his intelligence, sound judgment, and moderate approach to a wide range of issues. He provided thoughtful and skilled leadership in the areas of budget policy, taxes, transportation, affordable housing, school overcrowding and the environment. Don was actively engaged in resolving the status of the 9th and Canyon hotel site and was a strong proponent of the comprehensive rezoning project to address commercial growth issues.

He has served successfully in such diverse organizations as the Denver Regional Council of Governments, the Bureau of Conference Services and Cultural Affairs, the Boulder Community Celebrations, and the Dairy Center for the Arts. An important part of his focus on Council has been sensible growth management, sustainable use of resources, and a strong, stable economy.

Prior to his appointment to Council, Don was chair of the City's Parks and Recreation Advisory Board and served four years as a co-chair of the Whittier Neighborhood Association, as well as two years on the Steering Committee for the Pine Street/Whittier Traffic Mitigation Project. In 1995, he was especially effective in working with the Citizens for Parks and Recreation to successfully pass the Parks Ballot Issue which led to new acquisitions of park land in the city of Boulder. Over the years, Don has been unswerving in his commitment to policies that serve the environment, the education and health of people, and principles of integrity and fairness.

I ask my colleagues to join with me in expressing our gratitude to Councilman Mock for his years of public service and his contributions to the people of Boulder, Colorado. I wish him continued success in all his future endeavors.

PERSONAL EXPLANATION

HON. BETTY McCOLLUM

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Ms. McCOLLUM. Mr. Speaker, due to a scheduling conflict, I was unable to vote on rollcall votes 620 to 623. Had I been present, I would have voted the following:

On rollcall vote 620, S.J. Res. 22—Recognizing the Agricultural Research Service of the Department of Agriculture for 50 years of outstanding service, I would have voted "aye".

On rollcall vote 621, S.J. Res. 18—Commending the Inspectors General for their efforts to prevent and detect waste, fraud, abuse, and mismanagement, and to promote economy, efficiency, and effectiveness in the Federal Government during the past 25 years, I would have voted "aye".

On rollcall vote 622, H. Con. Res. 299—Honoring Mr. Sargent Shriver for his dedication and service to the United States of America, I would have voted "aye".

On rollcall vote 623, on hour of meeting, I would have voted "aye".

"FOR THOSE WHO HAVE FALLEN"—A NATIONAL TRIBUTE SONG

HON. MARK GREEN

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. GREEN of Wisconsin. Mr. Speaker, today before this house I would like to recognize "For Those Who Have Fallen," a national tribute song written by Tonia Barnes (Arpke) of Clyman, Wisconsin. At a time when our brave men and women in uniform are fighting to protect freedom and democracy in the Middle East, it is important for citizens across the country to support their efforts, and remember America's fallen heroes who have secured peace in battles past. This song is an eloquent tribute to all those who sacrificed for our nation, and it is with great honor that I submit the following lyrics for the RECORD.

Working in an office or on the beat
Looking from a window, from a city street
The heart of a stranger giving his all
Doing what he can when he got the call.

America hold your head up high
The Eagle is still the pride of the sky
She shed many tears today
And spread her wings as if to say.

For those who have fallen
I will never forget
The sacrifice you've given
When the face of God you met
For those who have fallen
I will never forget.

Searching through all the rubble
Knowing that lives are on the line
Hands that never get tired
Paws, though bloody, never whine.

A strong shoulder to lean on
An ear listening to the horrible tale
America will keep on living
And our pride will always prevail.

For those who have fallen
I will never forget
The sacrifice you've given
When the face of God you met
For those who have fallen
I will never forget.

For those who have fallen
I will never forget
The sacrifice you've given
When the face of God you met
For those who have fallen
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When the face of God you met
For those who have fallen
I will never forget.

For those who have fallen
I will never forget.

THE TRANSPORTATION EQUITY ACT: LEGACY FOR USERS

HON. JAMES L. OBERSTAR

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. OBERSTAR. Mr. Speaker, for most of the 20th Century, the primary focus of surface transportation policy was constructing a safe, efficient highway system, the Interstate and Defense Highway System, to connect our cities, farms, and defense bases. We invested more than $114 billion in constructing the 42,800–mile Interstate system and that investment has paid phenomenal returns in mobility, productivity, and economic growth. It is an unparalleled success: 1 percent of highway miles carry 24 percent of traffic. Today, the vision of that system is complete.

As the Interstate era came to a close, a new vision of transportation began to emerge—shifting from a focus on moving vehicles to providing transportation choices. The early framing of this vision was embodied in Congress' passage of the Intermodal Surface Transportation Efficiency Act (ISTEA) in 1991. The "highway bill" became more than that as we focused new efforts (and funding) on transit, congestion mitigation, intelligent transportation systems, and transportation alternatives such as pedestrian and bike paths. The landmark achievement of ISTEA was its vision for transportation policy: moving beyond where highways now lead us, to where it is people want to go and how we can give them choices to get there.

In 1998, Congress built upon ISTEA by ensuring that we would begin to make the necessary infrastructure investment to achieve this vision. With passage of the Transportation Equity Act for the 21st Century (TEA 21), we authorized $218 billion for our highway, transit, and highway and motor carrier safety programs—the highest surface transportation funding levels in U.S. history and 44 percent more than ISTEA. However, we knew too well that increased "authorization levels" meant nothing if they did not become a reality. We unlocked the Highway Trust Fund and codified a principle: the highway user fees collected from the traveling public will be invested in our surface transportation infrastructure each and every year. That is the landmark achievement of TEA 21 and, over its life, we invested $214 billion in our Nation's surface transportation infrastructure—$100 million more in that 6-year period than in the 40 years of building the Interstate.

On the first anniversary of TEA 21, I joined our Committee Leadership (then-Chairman SHUSTER, Chairman PETRI, and Subcommittee Ranking Member RAHALL), then-Senator

Chafee, Senator VOINOVICH, and Secretary of Transportation Rodney Slater and said: "Although the legacy of the surface transportation system of the 21st Century is far off, we have begun the journey of writing that legacy here and now. ISTEA and TEA 21 have set the framework for the beginning of the new century. Nevertheless, we must continue to develop innovative solutions if we are to overcome our Nation's many transportation problems."

The journey of writing that legacy continues here today. The "Transportation Equity Act: A Legacy for Users" bill builds upon the vision of ISTEA, maintains the guaranteed funding principle of TEA 21, and outlines its own landmark achievement: providing the investment levels necessary to maintain and begin to improve our Nation's highway and transit infrastructure. The bill provides a 72 percent increase in funding over TEA 21. We increase investment in highway and highway and motor carrier safety programs from $177 billion under TEA 21 to $306 billion under this bill. Similarly, for transit, we almost double the investment over 6 years: growing from $36.2 billion guaranteed under TEA 21 to $69.2 billion under the introduced bill.

Although these funding levels are significant increases over current levels, it is important to note that they are not our numbers, they are the Department of Transportation's own estimates of the Federal investment necessary to maintain and begin to improve our Nation's surface transportation system. These funding levels recognize what the Texas Transportation Institute has repeatedly told us: congestion is beginning to cripple our largest cities, the primary engines of our Nation's economic growth. In 75 large metropolitan areas alone, the cost of congestion is $69.5 billion—including 3.5 billion hours of delay and 5.7 billion gallons of excess fuel consumption. The average annual delay for every person in these cities has climbed to 26 hours. While these statistics are startling, the average American family does not need them recited—they are stuck in traffic on their way home from work, picking up the kids at daycare, or running the endless errands that seem a part of today's society, and they lose what precious little time they have together.

More importantly, our Nation's highways, bridges, and transit systems are not as safe as they need to be and the highway death toll is unacceptably high. Over the past 25 years, 1.2 million have died on our roads. Last year, 42,815 people died and 2.9 million more were injured on our highways. Highway fatalities remain the leading cause of death of our youth (people ages 4 to 33). In addition to the personal tragedy of each of these deaths and many of the injuries, the economic cost of these accidents is more than $230 billion per year.

Considering the congestion and highway safety impacts of insufficient investment in transportation alone, our economy is losing $300 billion per year because we are not investing the necessary resources to maintain and improve our Nation's transportation systems. We cannot afford to continue to shortchange our Nation's transportation systems. To effectively reduce congestion, to increase mobility, to truly improve highway safety, and to achieve continuing long-term increases in productivity and economic growth, we must invest in our Nation's transportation future. And we must do it now. That is why we join together today to introduce this bill to authorize $375 billion over 6 years.

The bill increases the minimum guarantee rate of return from 90.5 percent in FY2003 to 95 percent in FY2009. The bill also provides significant increases for the core highway programs. The National Highway System increases from $27.4 billion under TEA 21 to $39 billion under this bill. In addition, after a portion of the minimum guarantee funds are distributed to the core highway programs, NHS funding increases to $49.3 billion over the next 6 years. Similarly, the Bridge program grows from $19.3 billion under TEA 21 to $34.3 billion with the redistributed minimum guarantee funds. Finally, the CMAQ program almost doubles—growing from $7.9 billion to $13.9 over the next 6 years.

Moreover, the bill provides similar increases for transit. Guaranteed transit funding increases 92 percent to $69.2 billion. The core transit formula programs increase to $34 billion and the transit capital program (new starts, rail modernization, and bus capital invesment) increases to almost $30 billion over the 6 years of the bill.

Beyond building upon the success of ISTEA and TEA 21, as I said at the TEA 21 anniversary, we must continue to develop innovative solutions if we are to overcome our Nation's many transportation problems. Let me touch on a couple of new programs included in the bill that propose new and different way to address transportation issues.

As I have traveled the country over the last several years to review the condition of our Nation's infrastructure, I have noted that, despite the significant funding increases of TEA 21, current levels of surface transportation investment are insufficient to fund critical high-cost transportation infrastructure facilities that address critical economic and transportation needs. These projects, whether it is Alameda Corridor East or Chicago's CREATE, have national and regional benefits, including facilitating international trade, relieving congestion, and improving transportation safety by significantly improving freight and passenger movement in critical transportation bottlenecks. The bill creates a $17.6 billion Projects of National and Regional Significance program to enable the Secretary of Transportation to competitively select such projects of national significance (project cost of more than $500 million).

I also want to touch on a much smaller, but equally important, new program: Safe Routes to School. Several years ago, I began working with two communities, Marin County, California and Arlington, Massachusetts, to develop a program to enable and encourage children to walk or bike to school. These two pilot projects have been incredible successes. With this experience in hand, the bill creates a new $1.5 billion Safe Routes to School formula program to enable and encourage children to walk or bike to school; to make bicycling and walking to school a safer and more appealing transportation alternative, thereby encouraging a healthy and active lifestyle from an early age; and to improve safety and reduce traffic, wasted fuel, and air pollution in school neighborhoods.

Finally, the Committee's proposal will provide badly needed economic stimulus. The Federal Highway Administration reports that every $1 billion of federal funds invested in highway infrastructure creates 47,500 jobs and $6.2 billion in economic activity. When enacted, the Committee's introduced bill will create and sustain up to 3.6 million family-wage construction jobs, including 1.7 million new jobs.

Moreover, a recent study found that the Committee's bipartisan proposal to invest $375 billion in surface transportation over the next 6 years would add $290 billion more to the Nation's Gross Domestic Product than the administration's proposal to invest only $247 billion. The Committee's proposal would also lead to an additional $129 billion of household disposable income and. an additional $98 billion in consumer spending—millions of new, good-paying jobs, billions of dollars of new consumer spending: now that's the way to get the economy growing again.

I join with Chairman YOUNG, Subcommittee Chairman PETRI, and Subcommittee Ranking Member LIPINSKI, and the Members of the Committee on Transportation and Infrastructure, in introducing this bipartisan bill today. We will continue to work together on the journey of writing the legacy of our surface transportation future.

TRIBUTE TO PAUL SCANNELL

HON. ANNA G. ESHOO

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Ms. ESHOO. Mr. Speaker, I rise today to honor a distinguished Californian, Paul Scannell, as he retires from his service as Assistant County Manager of the County of San Mateo, California.

Paul Scannell has served as Assistant County Manager since 1982. During that time he has represented the County in complex and sensitive negotiations with other governmental agencies, companies, and persons doing business with the County. He's also worked in cooperation with County department managers to recommend County programs and activities, and managed the County team responsible for public financing issues. He has served on a wide variety of committees, as well as advising and staffing the Charter Review Committee. He has also acted as the County Manager in the Manager's absence.

Paul Scannell prepared for his career by earning a Bachelor's degree in Economics from the University of San Francisco and a Master's of Public Administration from Golden Gate University. He also pursued graduate studies in Economics at the University of California, Berkeley. He held positions of increasing importance with the City and County of San Francisco between 1964 and 1982, including serving as Deputy Director of the Clean Water Program, Assistant to the Chief Administrative Officer and as Senior Departmental Personnel Officer at San Francisco General Hospital.

I had the honor to work with Paul Scannell for ten years as a Member of the Board of Supervisors, and I saw and experienced firsthand his professionalism, his integrity and his extraordinary knowledge of County government.

Mr. Speaker, I ask my colleagues to join me in honoring Paul Scannell for his superb service to our community and our country and wish him every blessing in the years ahead. He has established the gold standard for public service and we are grateful to him for it.

PAYING TRIBUTE TO BOB GERLER

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. McINNIS. Mr. Speaker, it is with great pride that I rise today to pay tribute to an extraordinary public servant from Otero County, Colorado. Bob Gerler is a compassionate mental health advocate who has dedicated his life to improving the quality of care at Southeast Mental Health Services. I would like to join my colleagues here today in recognizing Bob's contributions to Otero County.

In recognition of his 24 years of service, Bob has been named the Colorado Behavioral Healthcare Council's 2003 Outstanding Board Member of the Year. Over time, Bob has been instrumental in implementing numerous programs for the betterment of patient's lives. His dedication, integrity and intelligence have truly made Bob a tremendous asset to the board.

In addition to his service to Southeast Mental Health Services, Bob has also served as a County Commissioner, a member of the South Sink Water Company Board of Directors, and chairman of Otero Junior College Council.

Mr. Speaker, Bob Gerler is a dedicated community leader who willingly devotes his time to improving the lives of those in need. Bob has been a reliable and innovative administrator over the course of his many years of public service and I am honored to pay tribute to him for his many contributions to the Colorado community. Congratulations on a well deserved award Bob.

TRIBUTE TO SPENSER HAVLICK

HON. MARK UDALL

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. UDALL of Colorado. Mr. Speaker, I rise today to pay tribute to Spenser Havlick, who this month is retiring from membership on the Boulder, CO, City Council. Elected to the council in 1982, Spense has had 21 years of distinguished public service.

Born in Oak Park, IL and raised in Green Bay, WI, he received his B.A. Degree from Beloit College, his M.A. from the University of Colorado in limnology and his Ph.D. in environmental planning and water resource management from the University of Michigan.

He became the Assistant Dean and Director of the College of Environmental Design at the University of Colorado in Boulder in 1975. His research and teaching focused on natural hazard mitigation, the citizen's role in the planning process, and the impact of urbanization on the environment. He has written on ecology and design and is preparing another book on transportation management and traffic calming.

He has taught at the University of Michigan and Murdoch University in Western Australia, consulted for the U.S. Environmental Protection Agency, the U.S. Army Corps of Engineers, the National Science Foundation and the U.S. Information Agency.

With this outstanding academic background, Spense has been a champion of the values that embody the spirit of Boulder. His commitment to defending these values made him a distinctive member of the council.

A passionate environmentalist, Spense had a two-decade struggle with transportation problems and worked diligently to promote public transportation, rail service between Denver and Boulder, bicycle paths, city open space and pedestrian walkways.

In his role as professor of environmental design at the University of Colorado, Spense encouraged his students to adopt Boulder's environmental values. He urged students to give up their cars, get more exercise and walk, or use alternative transportation.

A top vote getter in all his elections, Spense promoted a strategy to find more affordable housing, worked on growth management, led the effort for the largest purchase of open space in the history of Boulder and worked to streamline the city's budget in tough economic times.

Spense's civic commitment is demonstrated through his service on the City Council Environmental and Transportation Committees, as an Eco-cycle block leader, and as a Commissioner for the Boulder Urban Renewal Authority.

The City Council of Boulder, CO, has been fortunate to have had Spenser Havlick as a member for the past 21 years. On behalf of Boulder's residents, I wish him well as he continues to pursue his commitment to a better community and State.

PERSONAL EXPLANATION

HON. MIKE McINTYRE

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. McINTYRE. Mr. Speaker, on Thursday, November 6, 2003, I was unavoidably absent for rollcall vote 612, final passage of H.R. 1829, the Federal Prison Industries Competition in Contracting Act. Had I been present I would have voted "yes" on rollcall vote 612.

HONORING JEROME HOLTZMAN

HON. HENRY J. HYDE

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. HYDE. Mr. Speaker, I rise today to recognize Jerome Holtzman, who on November 20 will receive the prestigious Chicago Athletic Association Ring Lardner Award. Jerome Holtzman has forgotten more about baseball than most will ever know and he is well deserving of the award. Chicago Sun-Times sports columnist Ron Rapoport honored Mr. Holtzman in his column on November 11—a column I am pleased to share with my colleagues:

FOR HIS SCOOPS AND SAVES, HOLTZMAN AWARDED HONOR

> The major exhibit in Jerome Holtzman's baseball legacy always will be his invention of the save rule, but my favorite story about him is the time he scooped the judge.
>
> Charlie Finley was suing baseball commissioner Bowie Kuhn, and Holtzman, who had covered every day of the trial for the Sun-Times, got the word that Finley had lost. Holtzman rushed the story into the last edition of the paper, which so infuriated people at the Tribune, they rousted the judge out of bed after midnight to demand some information.
>
> "But I haven't even written the decision yet," the judge protested.
>
> Holtzman, who receives the Chicago Athletic Association's Ring Lardner Award on November 20, and I tried to figure out Monday how many baseball games he has covered in his life. The best we could come up with was about 200 a year for 28 years and maybe 100 a year for the decade after that. So how many is that—7,000 or 8,000? A lot, anyway.
>
> "We never had any days off," said Holtzman, who joined the old Chicago Times as a copy boy in 1943, before it merged with the Sun. "Maybe if I didn't go to the All-Star Game, I'd have a two- or three-day break, but otherwise it was every game from spring training to the World Series."
>
> Holtzman was more than just a sportswriter, though. He became our trade's historian, with his classic book "No Cheering in the Press Box" and his beautifully bound reprints of sports books, such as "Eight Men Out, The Boys of Summer and Babe."
>
> When Holtzman invented the save rule, he received a bonus of $100 or $200 from The Sporting News. The best closers soon became rich men because their performances came with numbers attached. Or as former Expos relief ace Jeff Reardon once said, "Jerome Holtzman is a friend of mine."
>
> Mine, too.
>
> The Lardner Awards dinner will be a star-studded affair, with David Halberstam presenting an award to Bob Costas, Ira Berkow giving Holtzman his plaque and Bill Jauss honoring former Chicago Daily News sports editor John Carmichael.

HIV/AIDS EPIDEMIC IN DALLAS-FORT WORTH AREA

HON. EDDIE BERNICE JOHNSON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I rise today to address the steady meteoric rise of the deadly epidemic of HIV/AIDS in the Dallas-Fort Worth area. The HIV/AIDS epidemic is proving to be one of the most devastating social conditions of our time.

In my home state of Texas, the numbers have been steadily rising since 1998 at a rate of about 7 percent per year. In fact, according to the Texas Department of Health, Dallas County reported the highest number of new HIV positive individuals in Texas, that's just ahead of Harris County (which includes Houston) which reported 1,212 new HIV cases.

So far in 2003, Dallas County has reported 609 new HIV cases and 355 new AIDS cases. Moreover, so much work needs to be done to inform the public about this disease's disproportionate impact on African Americans.

Dallas County Health and Human Services chief epidemiologist announced that there were 1,271 new HIV cases and 548 new AIDS cases reported in 2002. African Americans, comprise 20 percent of the Dallas County population, but 41 percent of the new HIV cases and 46 percent of the new AIDS cases in 2003.

As reported by the Centers for Disease Control and Prevention (CDC), although African Americans make up only about 12 percent on the U.S. population, cumulatively they have accounted for half of the new HIV infections reported in the United States in 2001.

African Americans have accounted for more than 320,000, or 38 percent, of the more than 833,000 estimated AIDS cases diagnosed since the beginning of the epidemic. In addition to experiencing historically higher rates of HIV infection, African Americans continue to face challenges in accessing health care, prevention services, and treatment. Race and ethnicity are not, themselves, risk factors for HIV infection. However, African Americans are more likely to face challenges associated with risk for HIV infection, including poverty, denial and discrimination, partners at risk, substance abuse, and sexually transmitted disease connection.

Globally more than 16 million people have died of AIDS and more than 16,000 people become newly infected each day.

It is imperative for us to take immediate steps to address these alarming statistics. As a former nurse and Chair of the Congressional Black Caucus, I supported funding increases for the Minority AIDS Initiative and the Housing Opportunities for Persons, which is the only federal housing program that provides comprehensive, community-based HIV-specific housing programs.

I have always supported the four main lines of action created by an International Partnership against AIDS: encouraging visible and sustained political support; helping to develop nationally negotiated joint plans of action; increasing financial resources; and strengthening national and regional technical capacity.

We must make an ongoing commitment toward working diligently to find a cure for this very fatal epidemic. We must strongly encourage more widespread support for those who are living with this horrifying disease.

CONFERENCE REPORT ON H.R. 6, ENERGY POLICY ACT OF 2003

SPEECH OF

HON. JOHN CONYERS, JR.

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mr. CONYERS. Mr. Speaker, for the first time in history Congress has voted to protect known polluters from legal liability. H.R. 6, the "Energy Policy Act of 2003", not only implements a restructured energy system that would harm consumers and provide unaffordable subsidies to energy companies, but Title XV of the bill, the Ethanol and Motor Fuels title, would particularly immunize the producers of a toxic contaminant from liability for its effects on those people who have been harmed by it. These provisions were unilaterally inserted into the conference report without the benefit of a single committee hearing or markup.

MTBE (methyl tertiary butyl ether) has been classified by the EPA as a possible human carcinogen and can render water undrinkable in concentrations as low as two parts per billion. Due to the synthetic chemical properties of MTBE, when it leaks into water, it moves and dissolves through water rapidly, resists natural degradation, and causes water to take on the taste and smell of turpentine. According to the General Accounting Office, MTBE, a chemical which has been shown to cause liver damage, kidney damage, and even cancer in humans, has now been detected in the groundwater and drinking water in every state in the nation.

The Ethanol and Motor Fuels title in H.R. 6 contains an outright and retroactive liability waiver for MTBE producers that knowingly polluted the tap water of millions of Americans. Specifically, the title would:

Protect responsible parties from liability—The title would give MTBE producers a special liability waiver from strict product liability suits. Because these strict product liability suits have been the only effective measure of holding MTBE producers accountable for polluting public water supplies, denying water districts and city and county governments the right to bring defective product lawsuits against the MTBE polluters would effectively end their accountability.

Shift cleanup costs to taxpayers—The MTBE provisions in the bill would shift the burden of paying for the cleanup of the polluted water to the water consumers. An estimated $29 billion in clean up costs will fall squarely on states, cities, and their citizens. MTBE manufacturers and gasoline companies will not have to pay for the contamination of the water supplies that they caused, nor will they have to pay to acquire new water sources for hundreds of thousands of customers.

Nullify pending litigation against MTBE producers, leaving hundreds of thousands of people without recourse—There are currently 130 communities and water suppliers across the nation that have litigation pending to reclaim damages for MTBE pollution of public drinking water sources. Because this bill is retroactive, taking effect for lawsuits pending on September 5, 2003, all of these lawsuits would be nullified.

The MTBE provisions contained in the Energy Policy Act of 2003 benefit the wrongdoers and have a number of harmful consequences for the victims of drinking water contamination. Any policy that has the effect of leaving hundreds of thousands of victims without any recourse against their wrongdoers is bad policy.

NATIONAL DIABETES MONTH

HON. DOUG OSE

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. OSE. Mr. Speaker, as a member of the Diabetes Caucus, I rise today in honor of National Diabetes Month. Diabetes is a growing concern in this country as each year increasing numbers of Americans are being diagnosed with the disease. The disease does not discriminate; children, adults and senior citizens alike are realizing the devastating impact of diabetes and its tragic effects have touched the lives of Americans across the country.

Diabetes itself is debilitating, but it can also lead to heart, kidney, nervous system or dental diseases, as well as blindness, high blood pressure, complications during pregnancy, strokes, and even death. Today, 17 million people live with diabetes and approximately 1 million new cases are diagnosed each year in people over the age of 20. It is the sixth leading cause of death in the United States, with 19 percent of Americans over the age of 25 losing their lives to diabetes each year. The statistic that 1 million children have been diagnosed with juvenile diabetes is particularly unnerving.

In my home state of California, every half-hour a life is lost due to causes directly or indirectly linked to diabetes. Currently, there are two million Californians who have been diagnosed with diabetes, putting California's average above the national rate. That number is expected to double by the year 2020.

Organizations such as the Juvenile Research Fund are vital to research efforts to find a cure for diabetes. In addition to conducting its own research, JDRF provides valuable outreach programs in schools and the community to educate the public on diabetes related issues.

This past June, the Sacramento chapter of JDRF sent two of my constituents, Juleah Cordi and Gianna Gallo, to the Children's Congress. At this conference, children afflicted with diabetes spoke with Members of Congress to raise awareness of this debilitating disease. As a congressional co-chair of this event, I would like to thank Juleah, Gianna and other Children's Congress participants for their help in bringing attention to this issue.

The cost of diabetes is rising, both in terms of the cost to treat the disease and the number of American lives lost resulting from complications relating to the disease. We must support the National Institute of Health's funding for diabetes research so that organizations like JDRF may continue to provide preventative education and help curb the spread of the disease. Education is a key component in preventative efforts, by encouraging individuals to make life-style changes that will reduce their risk of getting diabetes.

Mr. Speaker, we have made great strides over the years in diabetes research and outreach education. I applaud the many organizations that have contributed to this effort and I urge my colleagues to join me in honoring National Diabetes Month. Let's help give those Americans living with diabetes hope that one day soon, we will find a cure to diabetes.

PAYING TRIBUTE TO RICHARD WREN

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. McINNIS. Mr. Speaker, it is with great pride that I pay tribute today to Police Captain Richard Wren of La Junta, Colorado. Recently, Richard was honored by the La Junta City Council for two decades of honorable service. Richard has dedicated his life to serving and protecting the citizens of Colorado and it is my honor to call his many contributions to the attention of this body of Congress here today.

Richard was born in Denver, Colorado and moved to La Junta to attend Otero Junior College in 1980. Upon graduation, Richard attended the Law Enforcement Academy in Trinidad and in 1983 he became a patrolman for the La Junta Police Department. He rose quickly through the ranks to achieve his status as Captain.

Richard has achieved a great deal in his tenure with the La Junta Police Department. Richard is an expert in canine police work. During his career, he established the La Junta canine program and attended two national competitions for the United States Police Canine Association. In 2002, Richard furthered his law enforcement education by attending the National Federal Bureau of Investigation's Academy in Quantico, Virginia. In addition, Richard is an expert in firearms and patrol procedures, and he holds teaching certificates in both of those disciplines.

Mr. Speaker, it is my honor to rise and pay tribute to Captain Richard Wren before this body of Congress and this nation. Richard has managed to balance his tireless dedication to the citizens of La Junta, while gladly serving as a loving father and husband as well. The Citizens of La Junta Colorado are safer as the result of Richard's tireless dedication to their well-being and it is my honor to join them in thanking him for his service.

H.R. 1588, DEFENSE AUTHORIZATION CONFERENCE REPORT

HON. MARK UDALL

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. UDALL of Colorado. Mr. Speaker, when this House voted on H.R. 1588 in May, I voted against it. I didn't think the bill as it stood then was one I could endorse. The conference report that we are considering today is marginally better. Although I still have strong reservations, I will support the conference report.

We are 2 years into our war on terrorism and still engaged in military action in Iraq. There is no doubt that we must continue to focus on defending our homeland against terrorism, we must support our military personnel, and we must give our military the training, equipment, and weapons it needs to beat terrorism around the world.

That's why I'm in favor of provisions in the bill that support those men and women who have put their lives on the line in Afghanistan and Iraq. The bill provides an average 4.15 percent pay raise for service members, boosts military special pay and extends bonuses, and funds programs to improve living and working facilities on military installations.

I am pleased that the report includes provisions recognizing the importance of non-citizen soldiers and the many sacrifices and contributions they have made. The report eases the naturalization process for these soldiers and their families, reducing to one year the length of service requirement for naturalization during peacetime; allowing soldiers to apply and take oaths for citizenship overseas; and granting permanent resident status to the surviving family of U.S. citizen soldiers who are granted posthumous citizenship as a result of death incurred in combat.

I'm also pleased that this bill will allow approximately one-third of eligible disabled military retirees to receive both their retirement and disability benefits. I would have preferred that the bill extend this "concurrent receipt" to all disabled retirees, but this is a great improvement on the bill the House considered earlier this year—which included no such provisions. I am also pleased that the bill extends the military's TRICARE health coverage to National Guard and reservists and their families if servicemembers have been called to active duty. These are all necessary and important provisions that I support.

I do have a number of serious reservations about the bill.

I don't believe it addresses 21st century threats as well as it could. With the exception of the Crusader artillery system, the Administration and Congress have continued every major weapons system inherited from previous administrations. So although the bill brings overall defense spending to levels 13 percent higher than the average Cold War levels, it doesn't present a coherent vision of how to realign our defense priorities.

The bill still includes provisions that would exempt the Department of Defense from compliance with some requirements under the Endangered Species Act (ESA) and the Marine Mammal Protection Act (MMPA). There is broad-based support for existing environmental laws—as there should be—and these laws already allow case-by-case flexibility to protect national security. The Pentagon has never sought to take advantage of this flexibility, so it strains belief that these laws are undermining our national security. Indeed, the General Accounting Office has found that training readiness remains high at military installations notwithstanding our environmental laws. I am not persuaded that the changes to these acts proposed by the military are justified.

The bill still includes worrisome provisions to overhaul DOD's personnel system. Although they are improved from the bill the House considered earlier this year, these provisions would still strip DOD's civilian employees of worker rights relating to due process, appeals, and collective bargaining.

Most disturbingly, the bill still includes provisions on nuclear weapons development. This bill provides funding to study the feasibility of developing nuclear earth-penetrating weapons and authorizes previously prohibited research on low-yield nuclear weapons. Low-yield nuclear weapons have an explosive yield of five kilotons or less—"only" a third of the explosive yield of the bomb dropped on Hiroshima. Our obligations under the Treaty on the Non-Proliferation of Nuclear Weapons (NPT) require the United States to work towards nuclear disarmament, rather than further increase the size and diversity of our arsenal. By continuing the development of new U.S. nuclear weapons at the same time that we are trying to convince other nations to forego obtaining such weapons, we undermine our credibility in the fight to stop nuclear proliferation.

Mr. Speaker, I am very disappointed that this conference report rolls back civil service protections, environmental protections, and our work in the area of nuclear nonproliferation. But some of these provisions were improved in conference, and the addition of concurrent receipt provisions for our nation's veterans is critical. In view of these changes to the bill, added to my belief in the importance of supporting our men and women in uniform, I will support the conference report today.

TRIBUTE TO SAGINAW VALLEY STATE UNIVERSITY, SAGINAW, MICHIGAN

HON. DAVE CAMP

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. CAMP. Mr. Speaker, I rise today to pay tribute to the Saginaw Valley State University in celebration of its 40th Anniversary.

Founded in 1963, Saginaw Valley State University has quickly become one of the fastest-growing universities in Michigan. The university's humble beginnings as a community college in the late 1950s have encouraged the rapid growth and expansion of the university as demonstrated by their recent additions. From holding early classes in the basement of Delta College, to its current situation on a 782-acre campus, Saginaw Valley State University has become an unrivaled success story in mid-Michigan.

I am honored today to recognize Saginaw Valley State University for its many accomplishments, and to thank the many staff, faculty, students, and families who have endeavored to support Saginaw Valley State University.

VETERANS MEMORIAL AT THE KOOTENAI COUNTY ADMINISTRATION BUILDING

HON. C.L. "BUTCH" OTTER

OF IDAHO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. OTTER. Mr. Speaker, I rise today to bring to the attention of the House the creation of a Veterans Memorial at the Kootenai County Administration Building in Coeur d'Alene, Idaho. Former commissioner Ron Rankin has spearheaded the effort to pay tribute to Kootenai County's brave veterans with memorials honoring their sacrifice.

The first phase of the Veterans Memorial, dedicated on Veterans Day 1998, is a striking seven-by-five-foot, 8,000-pound black granite monument naming Kootenai County veterans killed in action from the Spanish American War through the Vietnam War. Their names are etched in large gold letters followed by their branch of service, and the war in which they served. "In God We Trust" is etched above all the names in three-inch gold letters. The monument is strategically placed at the main entrance of the new administration building to remind visitors of the heroes who gave their lives for our freedom.

On Memorial Day 1999, the county dedicated 13 unique murals for the outside of the new courthouse. The 39-by-42-inch granite plaques depict historically significant military events in the 20th century. They are reproductions of photographs and paintings that were laser-etched in color on polished granite slabs. The first two were completed at a cost of $2,000 each while the remaining 11 will have been added at a cost of $3,000 each. The scenes include: Pearl Harbor, the Bataan Death March, the Battle of Midway, the flag raising on Iwo Jima, Army rangers climbing a 100-foot Normandy cliff on "D" Day, troops assaulting the beach at Normandy, gun ships off the coast of Vietnam, and "Dust Off" helicopters retrieving the wounded in Vietnam. When the entire project is completed, there will be pamphlets in the foyer of the new administration building describing each scene in detail. The foyer already includes interesting information, photos and paintings of our heroic armed forces from battle scenes of 20th century wars.

A Purple Heart Honor Roll now is in place in the courthouse foyer, and a wall of gold-framed certificates of veterans who were awarded medals of valor will complete the project. The display was dedicated at a ceremony on November 10, 2003. The event's keynote speaker was Idaho Supreme Court Justice Daniel Eismann, who earned two Purple Hearts and three Air Medals during the Vietnam War. I would like to submit the speech Justice Eismann delivered at the dedication for the RECORD.

HALL OF HEROES DEDICATION—KOOTENAI COUNTY

(Hon. Daniel T. Eismann, Nov. 10, 2003)

I first want to commend the citizens of Kootenai County for this impressive memorial to those who have served in the United States military. As a veteran, I thank you. I also commend Ron Rankin, who was the driving force behind this growing monument.

The words "Keeping America Free" on the murals outside summarize the primary mission of the United States military. The freedom we enjoy today did not come cheaply. It was purchased during the Revolutionary War with the blood of American soldiers; for over two hundred years it has been guarded and defended both here and abroad by the blood of American soldiers; and it will be preserved in the future by the blood of American soldiers. In the words of Daniel Webster, "God grants liberty only to those who love it, and are always ready to guard it and defend it."

It is because of our God-given freedom that we are the most prosperous and powerful nation on earth. It is the desire for that freedom that causes many from other countries to flock to our borders. It is envy of that freedom, and the prosperity and power it produces, that causes others to hate and want to destroy us.

With oceans to our east and west and good neighbors to our north and south, we have for many years felt secure in our freedom. We may even have taken it for granted. No nation on earth could be powerful enough to invade us. The tragic events of September 11, 2001, however, shattered that security. Although the enemies of freedom cannot take ours by force, they showed that they will try to destroy it by fear. Those tragic events confirmed that to preserve our freedom here, we will sometimes have to root out evil and tyranny in other parts of the world. We cannot be truly free unless people around the world are free. The enemies of freedom will always desire to extinguish the beacons of liberty shining around the world, and ours shines the brightest. The tragic events of September 11th also rekindled a deep appreciation and respect for those who have donned the uniform of the United States military.

We are here today to honor some of those who have helped to preserve our freedom. We have come together to dedicate the Hall of Heroes, to honor those from Kootenai County who have been awarded a medal for heroism while serving in our nation's military. By honoring them, we are not in any way minimizing the sacrifice and contribution of all others who have served in uniform. Any of you who saw the movie "We Were Soldiers" may remember the helicopter pilot in the movie whose nickname was "Too Tall." The real "Too Tall" is a friend of mine named Ed Freeman who lives in Boise. The movie does not do justice to what Ed actually did during that battle.

On November 14, 1965, after LZ X-Ray had been closed to helicopters because of intense enemy fire, Ed flew fourteen missions into and out of that landing zone delivering ammunition, water, and medical supplies to the troops on the ground and evacuating 30 seriously wounded soldiers. For his actions, Ed was awarded the Congressional Medal of Honor, our nation's highest award for heroism. Ed's Medal of Honor was certainly well-deserved, but he could not have made the impact he did without the help of others. He could not have delivered the much-needed ammunition, water, and medical supplies to the men on the ground unless others had worked to have those items waiting at his base to be loaded on his helicopter. Few if any of the seriously wounded soldiers that he rescued would have survived had it not been for the medical personnel who were waiting to care for them.

The military is a team, with every person doing his or her part. Those of us who served in combat would not have lasted long without others who kept us supplied with needed materiel—weapons, munitions; equipment, fuel, medical supplies, and food—or who equipped and directed the planes, artillery, and ships that rained bombs, missiles, and shells on the enemy. Thus, by honoring those who have been awarded medals for heroism we are in no way forgetting or diminishing the contribution made by all who have faithfully served our nation as members of its armed forces.

Because we are honoring those whose names will be in the Hall of Heroes, it seems fitting to ask, "What is a hero?" The first time someone called me a hero, my reaction was, "I am no hero. I just did my duty." As I have thought about it, however, maybe that is part of what a hero is. It is someone who puts duty above self—someone who exhibits selfless dedication to a noble cause.

Another characteristic of a hero is courage. But, what is courage? British author C.K. Chesterton aptly described courage as follows:

"Courage is almost a contradiction in terms. It means a strong desire to live taking the form of a readiness to die. 'He that will lose his life, the same shall save it,' is not a piece of mysticism for saints and heroes. It might be printed in . . . a drill book. The paradox is the whole principle of courage. . . . A soldier surrounded by enemies, if he is to cut his way out, needs to combine a strong desire for living with a strange carelessness about dying. He must not merely cling to life, for then he will be a coward, and will not escape. He must not merely wait for death, for then he will be a suicide, and will not escape. He must seek his life in a spirit of furious indifference to it; he must desire life like water and yet drink death like wine.

In combat, you have no future. You have no past. You have only the present. To survive, you must consider yourself already dead, and then fight with all that is in you to stay alive, and to keep alive those who are fighting alongside you.

I first learned this truism not long after I started flying as a crew chief on a Huey gunship. As a crew chief, my job was to maintain the helicopter and to be a door gunner when we were flying. One afternoon, as we were returning from a mission, I moved from my normal position literally two seconds before a 51-caliber round tore through my helicopter. Had I not moved, it would have hit me right in the Adam's apple, and would have taken my head off. There was no reason for me to have moved, other than the intervention of God.

I pondered that event for a little while. Before then, being killed in combat had been an abstract possibility. I now realized that as long as I was flying in gunships, being killed was a distinct probability. Perhaps what was most disconcerting was that the bullet came without any warning. It was like a bolt out of the blue. We were not even in a place where we were expecting enemy fire. I realized that on any given day, I could be killed by one bullet coming without warning out of nowhere. I concluded that I could either worry about dying and get ulcers, or simply choose not to worry about it. I chose the latter course. From that day on, I simply considered myself already dead. Those who have accepted their death need not fear it.

Certainly, those who willingly risk their lives in combat while fighting for our country are heroes. The people we are honoring today, however, did more than merely risk their lives. The military does not award medals for valor simply for risking one's life. That is expected in combat. I was on a Huey gunship during most of my two years in Vietnam. Our job was to find the enemy and engage them. We did not have any high-tech equipment to help us locate the enemy. Our most sophisticated electronics were our two-way radios. To find the enemy, we simply tried to be an attractive target so that they would shoot at us. We would fly as low as we could, sometimes only a few feet above the ground, over or near places where the enemy may be hiding, trying to draw their fire. Once the enemy opened fire, we would know where they were and could take them on. Having the enemy shoot at us was simply part of our job; it was all in a day's work. That is the same for anyone who serves in combat.

Those we are honoring today did not merely risk their lives in combat. They went far above and beyond the call of duty, putting then lives at extraordinary risk. They may have done so to rescue wounded or trapped comrades, or to accomplish the mission. Firefights are decided, battles are won, and victory is gained because of soldiers like these—who put themselves at extraordinary risk to save others, to accomplish the mission, and to defeat the enemies of freedom.

One of God's blessings upon this nation has been that throughout her history, in times of great trials, ordinary people have come forward and done extraordinary deeds. Today, we are honoring some of those people. On behalf of my fellow Americans, I thank them and I salute them.

TRIBUTE TO A GOOD FRIEND AND LOYAL PUBLIC SERVANT, JAMES J. MANCINI

HON. JIM SAXTON

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. SAXTON. Mr. Speaker, it is with a heavy heart that I rise today to pay tribute to one of my greatest friends and one of Ocean County's finest, Ocean County Freeholder and Long Beach Township Mayor James J. Mancini.

Upon hearing of his passing, I was deeply saddened, given the tremendous impact he had on my life and those he served in Ocean County. To say that Jim will be missed is an understatement; he touched the lives of so many around him and spent every day of his life helping others.

A champion for seniors and veterans, Mayor Mancini's dedication to his community and his genuine interest in reaching out to others was unparalleled. As one of Ocean County's best advocates for seniors, his commitment to providing retirees with quality health care was unwavering. Every chance he had, Jim worked to make life better for every senior who lived in Ocean County.

Additionally, as a Veteran of World War II, Mayor Mancini made it his top priority to work on behalf of our local veterans. In fact, as a result of his efforts, services to tens of thousands of veterans were increased and improved.

Many of us from south Jersey remember the two "nor'easter" storms in the early 1990's that severely damaged the beaches of Long Beach Island. As a result of the threat to property and lives, Mayor Mancini made it his mission to guarantee these beaches would be rebuilt.

After ten years of work—including securing 3 million federal dollars, 8 years of study and design, and overcoming hurdles that prevented new beach replenishment projects from starting—just yesterday we found out that Jim's long-sought after funding to begin replenishing Long Beach Island's beaches came to fruition. This funding was included in the House-passed final version of the 2004 Energy and Water Appropriations Bill.

How ironic. After more than a decade, the project was approved by the House of Representatives on the same day as Mayor Mancini's passing. Without his persistence, it likely would not have happened.

Beginning from his election as Mayor of Long Beach Township in 1964 to his serving as a State Assemblyman in the 1970s to his becoming an Ocean County Freeholder in the 1980's, Mayor Mancini lived his life to serve and help others, and his legacy will live on for many years to come.

Throughout my life, I have met few people as compassionate and as selfless as Jim Mancini; it was an honor and privilege to be his friend. I extend my deepest sympathies to Madeline Mancini and the rest of their family, and know we will remember this caring friend, wonderful father and grandfather, admired leader, and dedicated public servant for the rest of our lives.

PAYING TRIBUTE TO DON SCHNEIDER

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. McINNIS. Mr. Speaker, it is with great pride that I pay tribute to Retired Lieutenant Colonel Don Schneider from Grand Junction, Colorado. Don has dedicated his life to the betterment of his family, country and community, and I am proud to call his contributions to the attention of this body of Congress here today.

Don moved to Colorado Springs, Colorado in 1959. Between 1959 and 1964, he accomplished a great deal. He attended the Air Force Academy, completed Airborne Jump School, Officer Training School, and earned a degree from the University of Denver, eventually working with Martin-Marietta on the Titan II missile program. In addition, Don met and married his wife Judy and had three wonderful children during this period.

After his training, Don was transferred to Tennessee, where he served as a navigator and instructor at Stewart Air Force Base. While stationed in Tennessee, Don acquired 2000 hours of flying time on deployments worldwide. Between 1970 and 1971, Don flew 180 combat missions in the Vietnam conflict. In a time of war, Don's patriotism and valor shone through, proving him a true hero. At war's end, Don's honorable service had earned him numerous decorations, including the Distinguished Flying Cross and the Meritorious Service Medal.

Following the war, Don was stationed in Myrtle Beach, where he was a pilot, safety officer, and instructor who trained a number of National Guard units, including the Colorado Air Squadron stationed at Colorado's Buckley Air Force Base. Don completed his service to the United States Air Force in 1985. After entering the private sector for some time, Don and his family moved to Grand Junction in 1998. In Grand Junction, Don has continued his service to his country. He currently serves as the President of the Western Colorado Chapter of Military Officers, and is an active member of the Order of the Dandelions, the Red River Valley Fighter Pilots Association and the Aircraft Owners and Pilots Association.

Mr. Speaker, I am proud to pay tribute to Don Schneider's courageous service before this body of Congress and this nation. His selfless desire to protect the freedom of all Americans is a reflection of his unwavering love for our country and his continued service to his community is further illustration of a lifetime of devotion to our nation. Thank you, Don, for your service.

CONFERENCE REPORT ON H.R. 6, ENERGY POLICY ACT OF 2003

SPEECH OF

HON. W.J. (BILLY) TAUZIN

OF LOUISIANA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mr. TAUZIN. I rise to elaborate on the colloquy I had with Mr. Norwood during consideration of the conference report for H.R. 6 regarding section 1242 (relating to participant funding). Section 1242 ("Voluntary transmission pricing plans") adds a new section 219 to the Federal Power Act. Under this section, any transmission provider ("TP"), regardless of whether the TP is a member of an RTO or ISO, is eligible to submit a transmission pricing plan to the FERC. In the case of a participant funding ("PF") plan, the Federal Energy Regulatory Commission ("FERC") must approve the plan if it meets the requirements of the section, regardless of whether a TP is in an RTO or ISO, because the native load customers of the TP should not be penalized by being compelled to pay for unneeded generator interconnection transmission upgrades.

The provision requires the FERC to approve a PF plan if the plan is just and reasonable and meets other requirements relating to cost responsibility and allocation. The rates referenced means rates as they affect the TP's shareholders and native load customers. The rate must not be so low as to be confiscatory of the TP-shareholder's property. At the same time, the rate must not unjustly shift costs to the TP's native load customers. The just and reasonable requirement here operates in the context of a clear policy choice by Congress in favor of PF where an application meets the other requirements of this section. The requirements of (b)(2)(B) constitute a limitation or channelling of the FERC's discretion within the bounds of the just and reasonable standard, which the courts have held does not require a specific formula, method, or single numeric result in any given case. In determining the zone of reasonableness, the FERC is required to comply with the policy of allowing PF as provided in (b)(2)(B).

PF ensures just and reasonable rates in three ways. First, the TP fully recovers (in charges assessed to all transmission customers) the costs of any monetary credits it must grant to the party requesting the upgrade. Second, PF protects consumers from bearing costs for facilities they do not need, by ensuring that the party causing the upgrade costs is assigned those costs. Third, rates are kept at reasonable levels by ensuring that generation and transmission are sited in an economically efficient manner.

Subsection (b)(2)(B) provides that the upgrade costs are "assigned in a fair manner."

The costs "assigned" or "paid" here means the costs initially allocated at the time of the upgrade. If a cost is assigned to the TP, the TP rolls that cost into its embedded cost rate base and recovers the entire cost in a transmission charge assessed to all its own transmission customers. If a cost is assigned to, or paid by, the requesting party, the requesting party makes a lump-sum payment at the outset, financed by whatever means the requester arranges. Subsequently, the requesting party pays the same embedded cost transmission charge assessed to and paid by any transmission customer—this charge is not considered a "payment" in this context.

Subsection (b)(2)(B)(i) means that if, at the time of the request, the native load customers had no need for the upgrade, they do not have to pay for it. The phrase "such transmission service related expansion or new generator interconnection" refers to the specific upgrade requested. Thus, if the TP would not have built the same upgrade at the same time to serve its own customers, such customers should not have to pay for it. The phrase "would not have required" means that, at the time the upgrade is requested, the native load customers would not have needed the upgrade to reliably meet their load. Projected or hypothetical future "needs" or other "benefits" in no way qualify as upgrades required by these customers for the purposes of this provision.

Going forward, the requester would be charged the same embedded cost transmission service charge as any other transmission customer—a charge that includes the cost of any monetary credit (as it is used) or any other item in the embedded cost ratebase. This point is made clear in subsection (b)(2)(B)(iii)(I), which provides that a monetary credit would be "against the transmission charges that the funding entity or its assignee is otherwise assessed [by the TP]."

Clause (ii) is a clarification of precisely what costs are assigned in the up-front allocation of the upgrade costs. Clause (ii)(I) references the requirement that the requesting party "pay for" the "assigned" cost of the upgrade as set forth in clause (i). This language means that the requesting party makes a lump sum payment at the time of the upgrade for the costs of constructing the upgrade and any costs associated with completing the upgrade. Clause (ii)(II) makes clear that the requester is not also assigned, as part of this initial, lump-sum payment, certain future costs, resulting from the upgrade, that are later included in the TP's embedded cost rate base. The initial cost of the "physical" upgrade is not directly or immediately included in the embedded cost because the upgrade itself is paid for (assigned to) up front by the requesting party. The term "embedded cost" is a term of art typically defined as funds already expended for investment in plant and operating expenses, as shown on the utility's books.

The physical upgrade does not immediately qualify as a cost of "plant" because the TP has not been assigned the cost in the initial upgrade—such cost is paid for in the initial cost assignment by the requester, not by the TP. The "cost of the requested upgrade" does, however, enter the TP's embedded cost basis in the form of any monetary credit given to the requester as compensation for the requester's initial payment. Because this credit is a credit against the transmission charge assessed to the requester, it is revenue foregone by the TP that must be recovered in the TP's rolled-in transmission rate. This cost is included in the TP's embedded cost charge to all transmission customers each billing period in the form of the cost of the monetary credit. Every transmission customer's rate (including the requester's) includes the cost of such credit. The difference for the requester is that he gets a credit against the same embedded cost transmission rate as charged to all transmission customers. Clause (ii)(II) means that, in the initial cost assignment, the requester does not also pay up front for the future rolled-in cost of the monetary credit. In the initial cost assignment, the requester pays only once for the transmission upgrade—and, under a PF plan using the monetary credit approach of (iii)(1), he gets full compensation for that lump sum payment in the form of the monetary credit over a 30 year period. In this lump-sum, up-front cost allocation, the requester does not have to pay for the upgrade twice by paying in advance for the monetary credit cost of the upgrade. For clarity, subclause (II) is expressed as a formula. The "difference" between the embedded cost including the upgrade and the embedded cost absent the upgrade equals the total cost of credits associated with the upgrade. Subclause (ii), in other words, means that the requester does not, in the up-front cost allocation, need to pay for both the cost of building the upgrade and the future cost of the credits needed to compensate it for that payment.

Subsequent to the initial cost allocation, the requester, like any other transmission customer, is assessed a standard transmission service charge for accessing the transmission system. It is against this service charge that any monetary credit under (iii)(I) is applied. Nothing in the provision prevents the TP from rolling the cost of the monetary credit into the embedded cost transmission charge for the use of the system—a charge that all transmission customers must pay as they take service. Clause (ii)(II) does not say or imply that the requester should not have to pay a transmission charge for the use of the system. Such a misreading would result in an unjust and unreasonable confiscation of utility-shareholder property, as well as an absurd departure from the FERC policy requiring all transmission customers to pay an access charge derived from the embedded cost of the system, including the cost of any credits given as the requester is assessed transmission charges. In other words, the provision is not intended to give the requester a double credit or double compensation (i.e., a discounted transmission rate on top of a credit or other compensation).

Conversely, the fact that the requester is assessed this charge (including the portion of the charge attributable to the cost of the monetary credit) in no way means that the requester is having to "pay twice" for the upgrade, because the transmission service charge is entirely separate from the cost allocation provided for in clause (ii). The requester pays for the upgrade in advance, and in exchange receives the credit or rights. By contrast, the requester is assessed a transmission charge in exchange for accessing the transmission system. Thus, this is not so-called "and" pricing.

Clause (iii) provides that the requester over time shall receive a form of compensation for its up-front, lump-sum payment. This compensation may be in the form of a monetary credit of equal value, or financial or physical transmission rights, or another form of compensation proposed by the TP. Under (iii)(I), the requirement that the crediting period be "not more than 30 years" means that, so long as the crediting period proposed in the plan is 30 years or less, the FERC has no discretion to require that the crediting period be different from the proposed period.

The term "full compensation" in clause (iii) generally means that the requester gets appropriate compensation in exchange for making the up-front payment for the upgrade. In the case of a monetary credit under (iii)(I), this compensation is specifically identified as being "equal" to the cost of the participant funded facilities (spread over 30 years). In the case of the "financial or physical rights" option under (iii)(II), the compensation need not be quantified in terms of an amount equal to the cost of the upgrade. For example, in the case of a market using locational marginal pricing ("LMP"), such amount need not (and cannot) be calculated in advance. Nevertheless, such property rights resulting from the expansion are of great benefit to the requester as a hedge against paying potential congestion charges in the future. Thus, they are appropriate compensation. Subclause (III) gives the TP the option of proposing a different form of compensation. It does not give FERC discretion to require a different form of compensation when the TP proposes a monetary credit under subclause (I) or appropriate rights under subclause (II).

To ensure that native load consumers are protected from paying for facilities they do not need, I urge my colleagues in the House and Senate to vote for the conference report.

HONORING OUR FALLEN HEROES STAFF SGT. LINCOLN HOLLINSAID, CAPT. RYAN BEAUPRE AND PVT. SHAWN PAHNKE

HON. JERRY WELLER

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. WELLER. Mr. Speaker, I rise today to commend the heroic actions of three service members from the 11th Congressional District of Illinois who gave the ultimate sacrifice of their life to the defense of our Nation. Army Staff Sgt. Lincoln Hollinsaid of Malden, Marine Capt. Ryan Beaupre of St. Anne and Army Pvt. Shawn Pahnke of Manhattan each served proudly and bravely.

Today, I am introducing legislation to honor their sacrifice by naming each of their hometown post offices in their name and I urge my colleagues to support these bills.

The Malden, Illinois post office would be named after Army Staff Sgt. Lincoln Hollinsaid, age 27. Staff Sgt. Hollinsaid was an engineer with the U.S. Army Third Infantry Division. He was killed April 7, 2003 while operating a crane to help clear a path allowing U.S. Army forces to penetrate the grounds of the Bagdad Airport and capture this key facility. Lincoln loved fishing, four-wheeling in his truck and was also a self taught guitar player.

The St. Anne, Illinois post office would be named after Marine Capt. Ryan Beaupre, age 30. Capt. Beaupre was a helicopter pilot with the U.S. First Marine Expeditionary Force. He was killed March 20, 2003 while piloting a CH–46 Sea Knight helicopter in Kuwait, nine miles from the border with Iraq. Ryan enjoyed competing in cross-country and track. He was also a volunteer at "Home-Sweet-Home" mission, a homeless shelter and transitional housing program.

The Manhattan, Illinois post office would be named after Army Pvt. Shawn Pahnke, age 25. Pvt. Pahnke was a main battle tank crewman with the U.S. Army First Armored Division's First Brigade. He was killed June 16, 2003 while patrolling Baghdad in a Humvee. Shawn enjoyed playing baseball. He was also a husband and a father of a new born son.

Naming the Malden, St. Anne and Manhattan post offices after these brave soldiers is a fitting tribute to remember each of their lives, their service and the sacrifices of their families and their communities.

When we lose a soldier, it is a terrible loss for their families and for our Nation. Hardships are also felt by every family of those who are abroad who not only miss their loved ones, but may be having a difficult time making ends meet. The members of the armed forces are giving greatly to defend and protect our Nation, and we owe them an enormous debt of gratitude.

America's soldiers serve our country with honor. I hope that you will join me in honoring these soldiers who gave so much to our country.

On a personal note, my heart and prayers go out to all those who have sacrificed for this ongoing war on terror, and I urge my colleagues to support these fitting bills.

PERSONAL EXPLANATION

HON. CHARLES A. GONZALEZ

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. GONZALEZ. Mr. Speaker, on rollcall Nos. 620, 621, 622, 623, had I been present, I would have voted "yea."

CONFERENCE REPORT ON H.R. 6, ENERGY POLICY ACT OF 2003

SPEECH OF

HON. BOB ETHERIDGE

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mr. ETHERIDGE. Mr. Speaker, I rise today to vote against the conference report to H.R. 6, the Energy Policy Act of 2003.

It is a sad day in America for today Congress has passed up an historic opportunity to craft an energy policy for the 21st century. The legislation we are voting on could have been an honest, bipartisan effort to halt America's growing dependence on fossil fuels for energy. It could have been focused on new technologies, energy efficiency, renewable energy, and the research and development that could produce the breakthroughs that would power the world of tomorrow. Instead, this bill is stuck in the past. Modeled after the energy plan developed by Vice President CHENEY's secret energy committee, H.R. 6 reflects the philosophy that there is no energy problem that cannot be solved with another oil well.

I have no objection with supporting some new or additional oil and gas exploration or production because, until we develop the energy alternatives of the future, we must continue to meet our oil and gas needs. However, it must be done responsibly. Sacrificing environmental protection for petroleum production is not responsible. Exposing our great natural treasures, especially the North Carolina coastline, to exploitation and possible degradation is not responsible. And placing the vast majority of economic incentives that H.R. 6 offers toward more fossil fuel production, instead of energy efficiency and research into new technologies, is not responsible.

H.R. 6 provides $23.5 billion in tax breaks over the next 10 years, the majority of that for oil and gas production. That's billions in tax breaks for energy companies paid for by our children and grandchildren. I could support some tax incentives for new sources of energy, but this Administration's economic record has already created a more than $400 billion budget deficit. I cannot support more debt for future generations to pay off. The Senate version of the energy bill offered ways to pay for these tax breaks, but the Republican leadership struck them. Why are the Republicans so opposed to fiscal responsibility?

Not all of the bill's provisions are bad. I am pleased with the provisions on ethanol. They will provide new markets for corn growers and help reduce harmful emissions. The ban on the fuel additive methyl tertiary butyl ether (MTBE) will also help ethanol users while keeping more MTBE from seeping into the Nation's water supply. But H.R. 6 provides liability protection for MTBE manufacturers. So when somebody gets sick because their products got into the water supply, these companies cannot be held accountable. That's just plain wrong.

Like the Vice President's energy plan, this bill was developed by Republican leaders behind closed doors without concern for the needs of consumers. Republicans are demanding that this House vote on a 1000+ page bill after having less than a day to review it. How many of our constituents would sign a 1000 page contract after having barely a day to read it? None. That's why organizations like the Carolina Utility Customers Association—composed of North Carolina companies like Bayer Corporation, GlaxoSmithKline, Lorillard Tobacco, and R.J. Reynolds Tobacco—oppose H.R. 6. To quote their letter, "While H.R. 6 contains positive aspects, the fact remains that many questions need to be asked and adequately answered before this bill is passed. It is simply unwise to hastily pass a bill without fully understanding its impact."

Unfortunately, the Republican congressional leadership wasted an opportunity to develop a prudent energy policy. I must oppose H.R. 6.

PAYING TRIBUTE TO JAMES FUNK

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. MCINNIS. Mr. Speaker, it is with a solemn heart that I take this opportunity to pay tribute to the life of James Funk who recently passed away at the age of 85. Jim was a pillar of the Hayden, Colorado community, and as his family mourns their loss, I think it is appropriate that we remember Jim's life and celebrate his contributions to our nation today.

Jim, a native Coloradan, grew up in various towns in the mountains of the West. He lived in Steamboat Springs, Hayden, and McCoy. Following high school, Jim answered his country's call to duty and served in the United States Army for four years. In 1947, Jim married Avis Hooker, his wife of 56 years.

Throughout his life, Jim was active in numerous community groups, including the Farm Bureau, the Upper Yampa River Water Conservancy Board, the Hayden School Board, and the Routt County Planning Commission. He was a member and former Commander of the Hayden American Legion Post and a member of the Hayden Congregational Church. In addition, Jim was instrumental in organizing the West Routt Fire Protection District. Despite his busy schedule, Jim managed to be a loving father, husband and friend.

Mr. Speaker, James Funk's dedication and selflessness certainly deserve the recognition of this body of Congress. It is my privilege to pay tribute to him for his contributions to the community of Hayden and our nation. I would like to extend my thoughts and deepest sympathies to Jim's family and friends during this difficult time of bereavement.

CONFERENCE REPORT ON H.R. 6, ENERGY POLICY ACT OF 2003

SPEECH OF

HON. DAVE CAMP

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mr. CAMP. Mr. Speaker, I rise in support of H.R. 6.

We have pushed for and promised a new national energy policy for a decade, and it is time we deliver on that promise; a promise that tells our families they won't be left out in the cold due to skyrocketing home-heating bills, a promise that tells the American worker that an unstable and unaffordable energy supply won't force employers to reduce benefits or eliminate jobs, and a promise that tells our children that they will be able to live and grow in a clean, healthy environment.

It is on that last point, encouraging the development of environmentally friendly energy, that I rise today. Transportation accounts for more than 75 percent of total oil consumption in the United States. Accelerating the use of fuel-efficient technologies and cleaner burning fuels by the auto industry will have a profound impact on safeguarding our health and our environment.

The high costs of new technologies, however, have stalled progress in the past. And, as California's experiment with electric engines quotas proved, top-down, government-driven reforms do not work. We cannot expect results if the expectations and demands of consumers are not met. This energy bill puts consumers in the driver's seat for developing technology, and will create a sustainable effort to improve fuel efficiency and reduce pollution.

By providing tax credits directly to consumers, this bill will help offset the thousands of dollars added to the ticket price of a hybrid or alternative fuel vehicle. Without these incentives, up to $3,400 for the purchase of a hybrid vehicle and up to $8,000 for a fuel cell vehicle, we will not change the status quo.

The energy bill compromise is not only fair and balanced; it is a major step forward for our country. By providing a more stable, affordable supply of energy, it will protect and create hundreds of thousands of jobs, save families money, and reduce pollution.

PERSONAL EXPLANATION

HON. MAC COLLINS

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. COLLINS. Mr. Speaker, I was not present for rollcall vote 634, the Captive Wildlife Safety Act (H.R. 1006); rollcall vote 635, Expressing the sense of Congress regarding the importance of motorsports (H. Con. Res. 320); rollcall vote 636, National Museum of African-American History and Culture Act (H.R. 3491); rollcall 637, Berkley Motion to Instruct Conferees; rollcall 638, Mutual Fund Integrity and Fee Transparency Act (H.R. 2420); rollcall 640, Honoring the victims of the Cambodian genocide (H. Con. Res. 83); rollcall 641, Honoring the Seeds of Peace (H. Con. Res. 288); rollcall 642, Commending Afghan Women (H. Res. 393); rollcall 643, Recognizing the Fifth Anniversary of the signing of the International Religious Freedom Act (H. Res. 423); and rollcall 644, Fairness to Contact Lens Consumer Act (H.R. 3140).

Had I been present, I would have voted "yea" for rollcall votes 634, 635, 636, 638, 640, 641, 642, 643, and 644. I would also vote "nay" for rollcall vote 637.

UNITED KINGDOM FREE TRADE AGREEMENT RESOLUTION

HON. MARK E. SOUDER

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. SOUDER. Mr. Speaker, I rise today to introduce a resolution expressing the sense of Congress that the President of the United States should enter into a free trade agreement (FTA) with the United Kingdom of Great Britain and Northern Ireland.

The United States and the United Kingdom share one of the closest and most unique cultural, economic, strategic relationships of any two countries in history. Our nations are based on the rule of law. We share a common history, language, and love of freedom and liberty. Our military alliance liberated Europe from Adolf Hitler and removed Saddam Hussein from power in Iraq. The entrepreneurial spirit of Americans and Britons is evident in the economic power our countries have exerted for over two hundred years.

I believe that it is no accident that two of the most freedom-loving countries on earth have also been the most economically successful countries. The independence and liberties Americans and Britons enjoy politically have transferred themselves to an economic freedom to invent, innovate, and trade.

Unfortunately, that freedom to trade is often hindered by barriers and tariffs. Some barriers give unfair advantage to goods through artificially lower prices. Other barriers try to protect domestic industries, sometimes delaying much needed innovation.

Countries that open their domestic markets, remove barriers to foreign direct investment, and promote free enterprise improve the lives of their citizens. The US and the UK should encourage open markets because limiting the availability of goods or increasing the final price paid by consumers can directly inhibit consumer freedom and reduce consumer welfare.

As the largest economy in the world, the United States should lead the movement for free trade because free trade boosts our economy. An International Trade Commission report estimates that the elimination of tariffs between the United States and the United Kingdom would result in an 11 percent to 16 percent increase in American exports to the United Kingdom.

The economic relationship between the US and UK is one of the largest trading relationships in the world. Direct foreign investment flowing between our countries totals nearly $400 billion—the largest such relationship in the world. British investment in the United States helps to sustain over 1 million American jobs.

In my home state of Indiana, there are 141 British companies doing business, including Rolls Royce and Smith Industries. These companies provide 36,000 Hoosiers with jobs. Furthermore, major Indiana companies such as Eli Lilly, Great Lakes Chemical, Biomet, and Lincoln National Corporation have substantial interests in Great Britain.

In the past few years the United States negotiated or is negotiating FTAs with a number of countries. Yet, the United Kingdom is not one of those countries. Given the depth of our relationship and that exports could increase 11 percent to 16 percent, it seems natural for Americans to push for this FTA. Increasing trade will help workers in Indiana and throughout the United States.

Furthermore, as the European Union continues to tighten its control over member states, the days when the United Kingdom is free to set its own trade policy and negotiate its own trade agreements may be numbered. A proposed EU constitution will potentially put more power in the hands of bureaucrats in Brussels rather than London.

Also, given the recent anti-American sentiment running through much of continental Europe, it is highly probable that those in control of the EU will use the organization to stymie US economic interests. The United States must take this opportunity to protect its trade with Great Britain and to help Great Britain protect its right to trade with whomever it wants, however it wants.

In an amendment offered by Senator MITCH MCCONNELL of Kentucky to its Fiscal Year 2004 budget resolution, the United States Senate expressed its support for an FTA with the United Kingdom (S. Con. Res. 23). It is time the House of Representatives expresses its support too.

PAYING TRIBUTE TO EDGAR STOPHER

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. MCINNIS. Mr. Speaker, it is with a solemn heart that I take this opportunity to pay tribute to the life of Edgar Stopher who passed away recently at the age of 93. Edgar was a pillar of our Colorado community, and as his family mourns their loss, I think it is appropriate that we remember his life and celebrate his contributions to our nation today.

Edgar was born in Loveland, Colorado in 1909. After his graduation from high school in 1929, Edgar continued his education at the University of Colorado, where he earned a bachelors degree in 1932. During World War II, Edgar answered his country's call to duty and served in the United States Air Force. By war's end Edgar had achieved the rank of Major and was awarded numerous decorations.

Following the War, Edgar moved to Estes Park, where he became the General Manager of the Stanley Hotel. In 1970, he joined the Sheraton Corporation as General Manager of the French Lick Springs Hotel in Indiana. Edgar's position with the Sheraton ultimately led to his relocation to Steamboat Springs, where he became the manager of the Sheraton Hotel there. He retired from that position in 1985.

Edgar was active in volunteer work in every Colorado community in which he lived. He was a member of the Chamber of Commerce, President of the Board of Education and also gave his time to the Masonic Lodge.

Mr. Speaker, Edgar Stopher's dedication and selflessness certainly deserve the recognition of this body of Congress. It is my privilege to pay tribute to him for his contributions to the State of Colorado and our nation. I would like to extend my thoughts and deepest sympathies to Edgar's family and friends during this difficult time.

TEXAS TROOPS IN IRAQ

HON. GENE GREEN

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. GREEN of Texas. Mr. Speaker, I rise today to pay tribute to the brave men and women of our Armed Forces and especially to honor those who have bravely fought and given their lives in Iraq.

Texans have a long history of serving in our military, and the same holds true today in Iraq.

There have been more men and women from Texas who have given their lives in Iraq, than from any other State other than California.

Since the U.S. launched its first airstrike in Iraq, 273 Americans have been killed in hostile action; 158 of those deaths coming after the President declared major combat to be over on March 1.

As of Friday, the Defense Department knew of 34 Texans who had been killed serving their country in Iraq.

Our hearts go out to the family members of these individuals who have made the ultimate sacrifice for their country:

Sgt. Edward Anguiano, 24, of Los Fresnos, was killed in action on March 23;

Chief Warrant Officer Andrew Arnold, 30, of Spring, was killed in action on March 22;

Spc. Richard Arriaga, 20, of Ganado, was killed in an action on September 18;

Sgt. Michael Barrera, 26, of Von Ormy, was killed in action on October 28;

Staff Sgt. Gary Collins, 32, of Hardin, was killed in action on November 8;

Capt. Eric Das, 30, of Amarillo, was killed in action on April 7;

Pvt. Ruben Estrella-Soto, 18, of El Paso, was killed in action on March 23;

Master Sgt. George Fernandez, 36, of El Paso, was killed in action on April 2;

Pvt. Robert Frantz, 19, of San Antonio, was killed in action on June 17;

Spc. Rodrigo Gonzalez-Garza, 26, of Texas, was killed in action on February 25;

Pfc. Analaura Esparza-Gutierrez, 21, of Houston, was killed in action on October 1;

Chief Warrant Officer Second Class Scott Jamar, 32, of Granbury, was killed in action on April 2;

Staff Sgt. Phillip Jordan, 42, of Brazoria, was killed in action on March 23;

Cpl. Brian Kennedy, 25, of Houston, was killed in action on March 21;

Spc. James Kiehl, 22, of Comfort, was killed in action on March 23;

Chief Warrant Officer Johnny Mata, 35, of Amarillo, was killed in action on March 23;

Cpl. Jesus Medellin, 21, of Fort Worth, was killed in action on April 7;

Sgt. Daniel Methvin, 22, of Belton, was killed in action on July 26;

Pfc. Anthony Miller, 19, of San Antonio, was killed in action on April 7;

Sgt. Keelan Moss, 23, of Houston, was killed in action on November 2;

Spc. Joseph Norquist, 26, of San Antonio, was killed in action on October 9;

Staff Sgt. Hector Perez, 40, of Corpus Christi, was killed in action on July 24;

Second Lt. Jonathan Rozier, 25, of Katy, was killed in action on July 19;

Cpl. Tomas Sotelo, Jr., 20, of Houston, was killed in action on June 27;

Spc. James Wright, 27, of Morgan, was killed in action on September 18;

Pfc. Stephen Wyatt, 19, of Kilgore, was killed in action on October 13;

Pfc. Chad Bales, 20, of Coahoma, died on April 3.

Spc. Zeferino Colunga, 20, of Bellville, died on August 6.

1st Sgt. Joe Garza, 43, of Robstown, died on April 28.

Spc. John Johnson, 24, of Houston, died on October 22.

Spc. Christian Schulz, 20, of Colleyville, died on July 11.

Spc. Joseph Suell, 24, of Lufkin, died on June 16.

Sgt. Melissa Valles, 26, of Eagle Pass, died on July 9.

Sgt. Henry Ybarra, 32, of Austin, died on September 11.

These men and women gave their lives defending their country and fighting to liberate a country that has never experienced freedom.

Our thoughts and prayers go out to the family and friends of these individuals.

They served their country bravely, and they will forever be remembered as heroes.

INTRODUCTION OF THE WILSON-TOWNS HEPATITIS C EPIDEMIC CONTROL AND PREVENTION ACT

HON. EDOLPHUS TOWNS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. TOWNS. Mr. Speaker, I rise today to urge my colleagues to join me in support of the Wilson-Towns Hepatitis C Epidemic Control and Prevention Act, which I have introduced today with Representative WILSON of New Mexico.

The virus which causes Hepatitis C was first identified in 1989. Currently, about 4 million people in the United States are believed to have the Hepatitis C virus. However, exact figures are not available because of the stealthy nature of this virus. Often called the “silent epidemic,” people infected with the Hepatitis C virus can be virtually symptom-free for decades before realizing that life-threatening damage has occurred. Unfortunately, to date, there is no vaccine to prevent this disease.

When this virus first appeared, it was believed that only intravenous drug users were at risk. However, today we know that this disease is no respecter of persons. People from all walks of life have become victims of this virus. Our young people are particularly at risk because tattoos and body piercings have become the fastest growing mode of transmission for Hepatitis C. Many young people are unwittingly putting themselves at risk for contracting this disease. We must provide them with information which will enable them to make informed decisions about this risk.

Mr. Speaker, this bipartisan effort, which is modeled after a bill introduced on the Senate side by Senators KAY BAILEY HUTCHISON of Texas and EDWARD KENNEDY of Massachusetts, will direct the Secretary of Health and Human Services to establish, promote and support a comprehensive prevention, research and medical management referral program for persons suffering from the Hepatitis C virus. If passed, this bill will represent the first federal effort to provide a strategic approach to combat this disease.

Mr. Speaker, this disease has affected almost 2 percent of the population of this country. We must take concrete action now before many more are needlessly subjected to this virus. Let us not miss this opportunity to avert this potential public health threat. I urge my colleagues to support this bill.

CONGRATULATIONS, DR. ANDREW BELSER

HON. BILL SHUSTER

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. SHUSTER. Mr. Speaker, I rise today to congratulate Dr. Andrew Belser of Juniata College on receiving the prestigious Pennsylvania Professor of the Year award and to thank him for the dedication and guidance with which he has provided his students.

Since 1981, the United States Professors of the Year program has rewarded outstanding professors for their invaluable work. It is the only national program to recognize college and university professors for their teaching skills, and thus, this award is a testament to Dr. Belser's commitment to his students and the dedication to teaching upon which he prides himself.

Since 1997, Dr. Belser has inspired and directed Juniata College students to study and perform to the best of their abilities. He teaches the importance of maintaining tremendous discipline, technique and skill while making theater, which is a valuable lesson that will influence and guide these students in every endeavor. An experience in the arts, such as the one that Dr. Belser provides, contributes greatly to one's personal growth as well as the growth of the community.

Dr. Belser commands a very influential and central role in the construction of the Regional Performing Arts Center, the new theater complex at Juniata College. He has used his expertise not only to teach and enliven his students, but to entertain and educate the surrounding community as well. Dr. Belser's dedication and loyalty to the arts is uncommon in the technologically focused world we live in today, but without such invigorating mentors people would lose the rich culture that influences every action and inspires every thought.

I congratulate Dr. Andrew Belser on this great honor and hope that he continues to spread his wisdom and passion for many years to come.

PERSONAL EXPLANATION

HON. LUIS V. GUTIERREZ

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. GUTIERREZ. Mr. Speaker, I was also unavoidably absent from this Chamber on June 3, 2003. I would like the RECORD to show that, had I been present, I would have voted “yea” on rollcall vote 232. On June 9, 2003, I was absent from this chamber and I would like the RECORD to show that, had I been present, I would have voted “yea” on rollcall votes 249, 250, and 251. I was also absent from this Chamber on June 11, 16 and 19, 2003, and would like the RECORD to show that, had I been present, I would have voted “nay” on rollcall vote 257 and “yea “ on rollcall votes 258, 259, 260, 261, 276, 277, 278, and 294.

On June 24, 2003, I was also absent from this Chamber and would like the RECORD to show that, had I been present, I would have voted "nay" on rollcall vote 305.

PERSONAL EXPLANATION

HON. SOLOMON P. ORTIZ

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. ORTIZ. Mr. Speaker, due to inclement weather and travel delays from my district, I was unable to vote during the following rollcall votes. Had I been present, I would have voted as indicated below.

Rollcall No. 624: "yes"; rollcall No. 625: "yes"; rollcall No. 626: "yes"; rollcall No. 627 "yes."

PAYING TRIBUTE TO SAM MAYNES

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. MCINNIS. Mr. Speaker, it is my honor to rise and pay tribute to my friend Sam Maynes. Sam has dedicated his life to advocating for the empowerment of those less fortunate. He is a tremendous attorney, husband, father, and friend. As Sams's 70th birthday approaches, I would like to call attention to his many contributions to the Colorado community.

Sam is the senior partner of the Durango law firm of Maynes, Bradford, Shipps and Sheftel. Formed in 1961, Sam's firm is general counsel for the Ute Indian Tribe, and special counsel for the Ute Mountain Tribe. Sam is also one of the foremost experts in water law in the United States. He is general counsel for the Southwestern Water Conservation District in Colorado and was instrumental in working to reach a compromise to make the Animas La Plata water project possible. As an attorney, Sam redefines the phrase 'zealous advocacy.' He is renowned for fighting ferociously for what he believes in. Sam is a man of conviction, and principle, when his morals dictate a position for one of his clients; he is willing to go to the ends of the earth to assure that justice prevails.

Sam's ferocious advocacy has earned him many accolades. He is the recipient of the United States Bureau of Reclamation Citizen Award, the Wayne N. Aspinall Water Leader of the Year Award, the Distinguished Achievement Award from the University of Colorado Law School, and the Citizen of the Year Award from the Durango Area Chamber Resort Association. In addition, Sam was named an Honorary Order of the Coif by the University of Colorado School of Law. Sam's many recognitions are a testament to his talent, conviction and integrity. The State of Colorado is truly a better place as the result of Sam's contributions.

The year since Sam's last birthday has been a trying one. Last winter, Sam lost his wonderful wife Jacqueline to multiple sclerosis. Jacqueline was Sam's "angel" and the mother of his four tremendous children. However, even after her death, Sam approaches each day with the knowledge that Jacqueline is there with him as he fights for those who need his help. Despite these tribulations, Sam still displays a playful zest for life each day. Those who visit Sam in his office are often treated to a piece of Sam's famous homemade apricot brandy pound cake while they are amused by Sam's charm, humor and contentment. Sam is truly a magnificent person.

Mr. Speaker, it is my privilege to come before Congress to pay tribute to a man who has dedicated his life to the "under dog." Sam's life is the embodiment of all that makes this country great and I consider it an honor to be his friend. Happy Birthday, Sam.

NATIONAL MUSEUM OF AFRICAN AMERICAN HISTORY AND CULTURE ACT

SPEECH OF

HON. JACK KINGSTON

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mr. KINGSTON. Mr. Speaker, I rise in support of this bill and encourage all of my colleagues to support this long overdue museum.

I would like to thank Chairman NEY, Mr. LARSON, Chairman LATOURETTE, Ms. HOLMES-NORTON for their diligence in improving this bill and bringing it before us today. It has been a pleasure working with each of you and your staffs.

I would especially like to thank my colleague from Georgia, Mr. LEWIS, for his tireless efforts over the years to ensure that a National Museum of African American History and Culture will be added soon to our Smithsonian Institution. This project would not be as close as we are today without him, and I am proud to be a part of it.

Mr. LEWIS, thank you for your steadfast commitment and leadership on this issue and for allowing me to work with you on it.

Mr. Speaker, the time has come for a dedicated, national museum to celebrate African American culture, experience, and history.

The history and culture of African Americans is our history and culture. When we learn that history—the good and the bad, the tragic and the inspiring—we learn about ourselves. By understanding our common past we can begin to envision a brighter future.

Bringing this museum into our national memory at the Smithsonian Institution is the right thing to do. And bringing this museum to a prominent and fitting home in our Nation's Capital is also the right thing to do.

There are many issues surrounding this museum which I believe have been fairly addressed by this bill. We have tried to closely follow the model recently adopted for the Native American Museum currently under construction. Issues regarding museum governance and cost sharing, for example, follow this model.

We ensure this is a true partnership with the private sector and the public at-large by capping Federal contributions at 50 percent.

We ensure the historical integrity of the project by fully integrating this museum into the Smithsonian system.

We ensure the project fits into our Nation's Capital by preserving the consultative role of the National Capital Planning Commission.

The one point that has been made many times throughout this process was that a specific site for this museum should be decided now. The Presidential Commission, authorized by the Congress, recommended five sites within the District of Columbia, four of which are included as options in this bill. Each of these sites has significant benefits as well as drawbacks. I strongly believe that is critical to the timely success of this project that a final, achievable and suitable site is agreed upon as soon as possible.

To that end, all the members who have worked so hard on this bill agreed to drop consideration of a site on the Capitol grounds which would have likely resulted in many years of further delay with no promise that the site could ever be made compatible with Capitol security and overall development plans.

This bill and this museum can serve a valuable purpose in furthering our national dialogue on race. I know that it is the intention of everyone associated with this bill to see this project move forward in a spirit reconciliation and not recrimination. I know we all believe this effort is about seeking the truth of our common history without malice. I am confident we all share the view that this museum must be a place to bring all Americans closer together and that it not be allowed to become a taxpayer subsidized headquarters for angry activists or the domain of politically correct historical revisionists. I hope that all of us here today, and those of us who will be here in the future, will remain committed to this museum in the spirit of truth, reconciliation, and respect with which we take this action here today.

Mr. Speaker, expanding our national treasure, the Smithsonian Institution, to include the National Museum of African American History and Culture is a tremendous opportunity to remember our past while looking forward our common future. I encourage all my colleagues to vote in favor of this bill.

URGING THE PRESIDENT TO PRESENT THE PRESIDENTIAL MEDAL OF FREEDOM TO HIS HOLINESS, POPE JOHN PAUL II

SPEECH OF

HON. BART STUPAK

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mr. STUPAK. Mr. Speaker, I rise to honor His Holiness Pope John Paul II as Roman Catholics throughout the world celebrate his Silver Jubilee anniversary this year.

The resolution before us, H. Con. Res. 313, recognizes the Pope for his enduring and historic contributions to human dignity and peace and urges President Bush to present him with the Presidential Medal of Freedom.

I can think of no more fitting a tribute to Pope John Paul II, our first ever non-Italian pope, in honoring his 25th year as Bishop of Rome and Supreme Pastor of the Catholic Church. His service began on October 22, 1978.

As the spiritual leader of more than one billion Catholic Christians worldwide, including 66 million in the United States alone, the resolution memorializes the gratitude of many. During his tenure he has visited more than 125 countries and traveled more than 750,000 miles making unprecedented contributions to the freedom of the world community.

The Holy Father's remarkable work has been globally reaching—from his diplomatic leadership toward the peaceful liberation of his Polish homeland and demise of the Soviet empire, to his promotion of human rights in rogue nations, to his efforts to heal historic divisions between the Catholic Church and other worldwide religions.

Mr. Speaker, whether you are Catholic or not, no one can deny the significant impact Pope John Paul II has made on world peace and freedom. His efforts have improved the lives of Christians and non-Christians alike.

I urge my colleagues to support this special resolution for the honored accomplishments of His Holiness Pope John Paul II—a positive inspiration to Catholics and all humankind.

ESTABLISHING NATIONAL AVIATION HERITAGE AREA

SPEECH OF

HON. DONNA M. CHRISTENSEN

OF THE VIRGIN ISLANDS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mrs. CHRISTENSEN. Mr. Speaker, I rise in support of H.R. 280, legislation to create the National Aviation Heritage Area and urge my colleagues to support its passage. H.R. 280 includes as one of its sections, my bill, H.R. 1594, to provide for a suitability and feasibility study of establishing a St. Croix National Heritage Area in the United States Virgin Islands.

The island of St. Croix has a long, distinguished, and varied history, including being the site where Christopher Columbus first stepped onto what is now American soil. There is significant interest in preserving and enhancing the natural, historical and cultural resources of the island on a cooperative basis and such a study would provide guidance on how we can best achieve those purposes.

National Heritage areas are places where natural, cultural, historical and recreational resources combine to form a nationally distinctive landscape arising from patterns of human activity shaped by geography.

While each island can make a good case for designation, the island of St. Croix with its two historic towns—Christiansted built in 1734 and Frederiksted built in 1752—is richly blessed with all of the attributes that would justify this designation.

The town's historic architecture matured over a 100-year period. The town of Christiansted is one of the finest examples of Danish architectural designs in this hemisphere. Its history can be traced back some 4,000 years to 2500 BC.

In 1493 Columbus arrived at what is now the Salt River National Historic Park and Ecological Preserve, making it the only site under the American flag where his men went ashore, as well as the first recorded hostile encounter between Europeans and Native Americans.

Frederiksted has the distinction of having been the first jurisdiction to have raised its flag in salute of the new republic of the United States of America, and indeed the first designed flag was done by a resident of that island.

Among the many strong ties of great national significance between St. Croix and the United States, perhaps the most significant one is that this island was the boyhood home of Alexander Hamilton, and where he began to develop the skills employed as the first Secretary of the Treasury of this country.

I want to thank Full Committee Chairman POMBO, Ranking Member RAHALL as well as Subcommittee Chairman RADANOVICH for their support is getting H.R. 1594 and H.R. 280 to the floor of the House today.

My colleagues, H.R. 1549 is a good bill, which could serve as a catalyst for reinvigorating the lagging tourism sector on St. Croix. I urge its adoption.

INCREASING THE WAIVER REQUIREMENT FOR CERTAIN LOCAL MATCHING REQUIREMENTS TO AMERICAN SAMOA, GUAM, THE VIRGIN ISLANDS, OR THE COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

SPEECH OF

HON. DONNA M. CHRISTENSEN

OF THE VIRGIN ISLANDS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mrs. CHRISTENSEN. Mr. Speaker, I rise in support of H.R. 1189, to increase the waiver requirement for certain local matching requirements for grants to American Samoa, Guam, the Virgin Islands or the Commonwealth of the Northern Mariana Islands. I want to commend my colleagues ENI FALEOMAVAEGA and MADELEINE BORDALLO for introducing the bill, which would increase the matching waiver requirement for the first time in twenty years.

Last year the Resources Committee unanimously passed a similar bill jointly sponsored by our former colleague from Guam Robert Underwood, ENI FALEOMAVAEGA and myself and I'm pleased that we are once again taking this action.

Mr. Speaker, as I indicated, it has been nearly twenty years since this law has been revisited. While territorial economies have improved each government, particularly my own, the government of the U.S. Virgin Islands continues to be challenged with rising unemployment, decreased government revenues, and attracting new capital for diversification. H.R. 1189 will help broaden U.S. territories' access to Federal grants by increasing the amount Federal agencies shall waive to $500,000.

The bill also seeks to end the inconsistent manner in which 48 U.S.C. section 1469(a) is applied by clarifying that the matching waiver applies to all federal agencies and departments making grants to the U.S. territories, not just the Department of Interior (DOI). The bill also requires DOI to provide a report to Congress on the effect of the updated waiver requirement.

It is my hope also Mr. Speaker, that Federal agencies will apply the waiver not just to grants awarded to the territorial governments, but also to non-profit organizations and other eligible non-governmental entities in the territories. Non-profit organizations in the territories fulfill a significant role in our communities. Groups such as Lutheran Social Services, the St. Croix Community Foundation and the V.I. Resource Center help meet the needs of the homeless, the disadvantaged, and those whose lives are buffeted by tough economic times. Their work is often supported by federal grants. Without such Federal assistance, the non-profit organizations in the territories would struggle to meet their missions and most would not be able to maintain the current level of assistance to our communities.

In conclusion, Mr. Speaker, I want to thank Chairman POMBO and Ranking Member RAHALL for their willingness to support and shepherd this bill through the legislative process. I also want to particularly thank our former colleague Bob Underwood, who for most of his tenure in the House, made increasing the matching waiver for the territories one of his highest priorities. I urge my colleagues to support passage of this bill.

A TRIBUTE TO A.C. LYLES

HON. NICK SMITH

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. SMITH of Michigan. Mr. Speaker, recently I had the privilege of visiting with a great American by the name of A.C. Lyles, who has befriended many celebrities over the years. Throughout the decades that he has worked at Paramount Pictures, A.C. Lyles has become loved by studio staff, by stars, and by Presidents. He has made countless contributions to the motion picture industry and become a legendary producer, writer and partners in numerous theatrical features and television shows.

A.C. Lyles was born May 17, 1918 in Jacksonville, Florida. Even as a young boy, he dreamed of Hollywood. Following his high school graduation, A.C. was hired by Paramount to work in the mail room. It was not long before he was promoted to a director of publicity at the tender age of 19, and eventually became a producer in 1954. Among the variety of successful features and television shows that he produced over the years, A.C. was perhaps best known for the western movies that became a Paramount trademark.

As the Hollywood liaison to Presidents, A.C. brought the culture of art to the White House. During the administration of his close friend, Ronald Reagan, and throughout the Bush Administration, he brought celebrities to entertain at presidential functions. He also served on the Presidential Board of Advisors on Private Sector Initiatives and regularly attended meetings at the White House and on Capitol Hill.

A.C. has been recognized countless times over the years for his work at Paramount. These awards include the famed Golden Spurs award, the George Washington Award of the Freedoms Foundation, and a star on the Hollywood Walk of Fame. On behalf of the United States Congress, and his good friends the Hon. DAVID DREIER and the Hon. MARY BONO, I am pleased to recognize his extraordinary career once again in admiration of his unyielding dedication and unparalleled achievement.

SENATE—*Friday, November 21, 2003*

The Senate met at 9:30 a.m. and was called to order by the PRESIDENT pro tempore [Mr. STEVENS].

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

Creator of all life, Who satisfies the longings of our souls, thank You for Your faithfulness, which is as enduring as the Heavens. Your peace radiates in our hearts on wings of faith, hope, and love.

Bless our Senators. Strengthen them for today's challenges. Energize them so that they are more than a match for these momentous times. May they soar on eagle's wings. May they run and not be weary. May they walk and not faint. When they are lost, provide them with direction. Show them duties left undone. Remind them of promises yet to keep, and reveal to them tasks unattended.

Enrich us all with Your loving presence. We pray this in Your hallowed Name. Amen.

PLEDGE OF ALLEGIANCE

The PRESIDENT pro tempore led the Pledge of Allegiance, as follows:

> I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. FRIST. Mr. President, this morning the Senate will resume consideration of the Energy conference report. There will be 60 minutes of debate prior to the vote on the motion to invoke cloture. Therefore, the first vote of today's session is expected to occur shortly after 10:30.

At this point, I ask unanimous consent that the live quorum that is required under rule XXII be waived.

The PRESIDENT pro tempore. Is there objection?

Without objection, it is so ordered.

Mr. FRIST. Mr. President, I urge my colleagues this morning to vote for cloture. I will say more just before the vote. But I do encourage Members to weigh very carefully the vote that will be taken in about an hour.

This bill is a balanced approach to ensuring this country's energy security through this national energy policy.

If cloture is invoked, we will work with Members to establish a time certain for the vote on passage of this conference report.

In addition, throughout the afternoon we will attempt to clear any additional conference reports that may arise from the House.

I will update everyone on the schedule later today as we watch the progress on the remaining legislative items.

MODIFICATION OF AMENDMENT NO. 2208

Mr. FRIST. Mr. President, I ask unanimous consent that notwithstanding passage of H.J. Res. 78, the previously agreed to amendment No. 2208 be modified with changes that are at the desk.

Mr. REID. Mr. President, we have no objection.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment (No. 2208), as modified, is as follows:

> On page 2, line 7, strike "23" and insert "24"
>
> On page 2, line 1, strike "23" and insert "24"

RECOGNITION OF THE ACTING MINORITY LEADER

The PRESIDENT pro tempore. The Senator from Nevada is recognized.

Mr. REID. Mr. President, while the majority leader is on the Senate floor, before we begin the final hour of debate on this important issue, I think the last 2 days have been some of the finest hours of the Senate this year. The debate has been constructive on both sides. I think it has been issue-oriented. I have been very impressed with the manner in which the debate has proceeded. The two managers of the bill are, of course, both experienced, and I am confident that the debate for the next hour will be just as constructive.

We have our time lined up. Everyone is here to make their speeches.

I look forward to a vigorous debate and a vote in about an hour.

RESERVATION OF LEADER TIME

The PRESIDENT pro tempore. Under the previous order, leadership time is reserved.

ENERGY POLICY ACT OF 2003—CONFERENCE REPORT

The PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of the conference report to accompany H.R. 6, which the clerk will report.

The legislative clerk read as follows:

> Conference report to accompany H.R. 6, an act to enhance energy conservation and research and development, to provide for security and diversity and the energy for the American people, and for other purposes.

The PRESIDENT pro tempore. Under the previous order, there will now be 60 minutes equally divided between the chairman and ranking member of the Energy Committee, and the final 10 minutes will be divided with the first 5 minutes under the control of Senator BINGAMAN and the final 5 minutes under the control of the Senator from New Mexico, Mr. DOMENICI.

Who yields time?

The Senator from Idaho.

Mr. CRAIG. Mr. President, we are in the final hour of debate on probably one of the most important policy issues to come before this Senate in a good number of years. The Senator from Nevada has talked about the quality of the debate and the detail of the debate. Certainly, that is true.

I yield to the chairman of the committee, Senator DOMENICI.

The PRESIDENT pro tempore. Will the Senator yield to the Senator from New Mexico?

Mr. CRAIG. I am happy to yield to the chairman of the Energy and Natural Resources Committee.

Mr. DOMENICI. Mr. President, I want to make sure that we understand the timing. I asked Senator CRAIG if he would come to the Senate floor so I could give him some time. I wonder if 5 minutes would be enough.

I yield 5 minutes to the Senator.

The PRESIDENT pro tempore. The Senator from Idaho is recognized for 5 minutes.

Mr. DOMENICI. I thank the Chair.

Mr. CRAIG. Mr. President, what we are attempting to do for the American people is allow them, their country, and the energy sector of our economy to get back into the business of producing energy. We may well be faced with some of the highest natural gas prices that any consumer will have paid in the United States this winter. If we have a cold winter, it will be time for those who are paying exorbitant energy bills to ask a fundamental question: Why? Why is the public policy of this country driving up our energy bills? Why is not there a public policy that begins to put this country back into the business of producing energy?

Our historic wealth, in large part, has been based on an abundance of high-quality, low-cost energy in all kinds of forms.

The Energy Policy Act of 2003 continues that most important economic legacy for this country—to assure that we continue our traditional energy sources but with new technologies and cleaner approaches; that we invest money in new technologies so that the next generation of Americans can have the same abundance of energy that I have had and that my father had before me.

It would be an absolute tragedy if in the fine ticking of all of the issues within this very large bill someone collectively decides to vote against it because, if they do, they ought to go home and try to explain why in February or March of this year their constituents are continuing to pay ever increasingly higher rates, or why there was a blackout in the Northeast this year, or why the brownouts in California a few years ago, and why gas prices at the pump are at an average historic high.

There are sound answers to all of those questions. But, more importantly, the Energy Policy Act of 2003 begins to address resolution of those questions, bringing those prices down overall and creating a greater abundance.

We have also stepped out in a variety of new areas, including new nuclear technologies, new fuels approaches, and new hydrogen technology which our President was very daring to talk about—a new surface transportation fuel future, hydrogen. We have set about the technology and the planning and the design for all of those types of new approaches.

I say to the Senator from Alaska, his State is one of the largest energy producers of all of our States.

This bill clearly gives companies the ability to come in and invest and bring literally trillions of cubic feet of gas to the lower 48 that will offer help in bringing down those high prices.

We created the incentives. We have allowed them to invest in the marketplace and to get a good return on their investment.

This is a truly comprehensive bill. There is no question that we have spent literally the last 5 years in attempting to design an Energy bill that will fill all of the needs of this country, and to restructure and refine the existing energy sector of our country especially in the electrical area.

This has a new electrical title much different from the one before. Compromises were made. I stood in the Senate a year ago and offered an amendment to take the electrical title out because of its controversy and its impact on the Pacific Northwest. Today we have changed that. Today we have said all areas of the country can grow and develop and we will work to build an interconnectivity between those regions of the country that will, hopefully, disallow the kind of problems we had in the Northeast this summer and certainly begin to address the inability of California to produce its energy needs.

All of those issues are bound up in this bill. Yet some of our colleagues have picked a very small piece of this bill, less than one-half of 1 percent of the total impact of this bill, and have said that is the problem, that is the destructive character of the bill. That is why some Members oppose it.

This is a very good piece of work. It brings our country back into energy production. I urge my colleagues to vote for cloture and allow the Senate to move toward final passage for this critical piece of public policy.

The PRESIDENT pro tempore. The Senator from New Mexico.

Mr. BINGAMAN. Mr. President, I yield 4 minutes to the Senator from Vermont.

The PRESIDENT pro tempore. The Senator from Vermont is recognized for 4 minutes.

Mr. JEFFORDS. Mr. President, America needs an energy policy, but not this one. This bill fails to provide a realistic, sustainable energy plan for America's future. Observers have called this Energy bill "three parts corporate welfare and one part cynical politics." They call it a complete waste of energy and say it fails to address the fuel and power needs of the average American. They are absolutely right.

The bill includes environmental rollbacks. It threatens public health. It weakens consumer protections against electricity market manipulation. It gives out billions of dollars in subsidies to fossil fuel and nuclear industries. The rollback of three of our most fundamental environmental laws—the Clean Air Act, the Drinking Water Act, and the Clean Water Act—is terrible environmental policy.

This bill allows more smog pollution. This bill exempts all oil and gas construction activities from the Clean Water Act. The Senate's renewable portfolio standard requiring utilities to generate 10 percent of their power from renewable sources by 2020 was struck from the bill.

What we needed was a bill to decrease our energy dependence on foreign oil, but this bill will not conserve a drop of oil. We need to protect our consumers, our public lands, and our public health. Instead, this bill weakens protections. We need to give a boost to the renewable energy sector, but instead the bill is a kickback to the fossil fuel industry.

We now need to do the right thing and oppose cloture. We need to spend more time developing the right energy policy for America.

I reserve the remainder of my time.

The PRESIDENT pro tempore. Who yields time?

Mr. DOMENICI. I yield 3 minutes to the Senator from Wyoming.

The PRESIDENT pro tempore. The Senator is recognized for 3 minutes.

Mr. THOMAS. Mr. President, I am excited about the opportunity we have today to finally, after a number of years, come forward with a broad, encompassing policy for energy.

We ought to give a little thought to where we will be in the future as individuals, as families, think about the energy we use, the energy we need, where it will come from. Our demands go up, yet we do not really have a policy.

Nothing is more important to the economy than having accessible energy and jobs. This bill creates a great number of jobs. It is a policy on conservation. It includes the types of equipment we use. It includes renewables, with a good many dollars spent for renewables. We talk of alternative fuels. We talk of hydrogen. We talk about domestic production.

It does not roll back the economy despite what is being said on the floor. It does conserve. We have conservation methods included. What is most important in terms of the environment is a good deal of research for coal development so we can have energy from our largest fossil fuel, coal, and do it in a way that is clean for the air. We will hear that it amounts to politics regarding MTBE, which is a very small aspect of this.

We need to have an energy policy for our country. We must have an energy policy. Now is our opportunity to have an energy policy. Certainly we ought to at least be able to vote to have an up-or-down vote on this issue.

The PRESIDENT pro tempore. Who yields time?

Mr. BINGAMAN. Mr. President, I suggest the absence of a quorum and the time be charged equally.

Ms. LANDRIEU. Reserving the right to object, I would like to speak on the bill.

The PRESIDENT pro tempore. Does the Senator withhold his suggestion of a quorum?

Mr. BINGAMAN. I withhold my request.

Ms. LANDRIEU. I will speak for the bill.

Mr. CRAIG. I yield 5 minutes to the Senator from Louisiana.

The PRESIDENT pro tempore. The Senator from Louisiana is recognized for 5 minutes.

Ms. LANDRIEU. Mr. President, as a member of the energy committee who has worked very hard with both the distinguished Senators from New Mexico, Mr. BINGAMAN and Mr. DOMENICI, as well as the former chair from Alaska, Senator MURKOWSKI, trying to fashion a bill that balances the great interests of every region of this country, I am proud to come to the Senate and urge my colleagues to vote for this Energy bill.

There are provisions that should be in this bill that are not. There are many aspects of this bill that I would have written differently myself. However, the fact is, as any member on the Energy and Natural Resources Committee can state, we have had hours and hours, maybe hundreds of hours, of hearings on how we create a more reliable electricity structure in this Nation, how we try to use our great natural resources in a better fashion to help create the energy this country needs to be more independent and more economically competitive.

I come from the State of Louisiana, which is a net exporter of energy. We do a lot of energy production in Louisiana, not just in oil and gas but cogeneration. We have municipal as well as private companies, public companies, municipal generators of electricity. We drill for a lot of oil and gas. We are not a mining State in that sense, like the West, but we mine our resources and we do a much better job than we did 10 years ago and a heck of a lot better job than 20 or 30 years ago. Why? Because the United States has some of the toughest, most stringent environmental laws in the world when we take our coal out of the ground or when we drill off our shore. The Shell Oil company told me last year if they put all the oil they spilled off the coast of Louisiana in a container, it would not fill up the bottom fourth of a barrel.

There are people in the Senate who think we cannot mine our resources in a way that protects our environment. Do we have a perfect system? No. Is it one of the best in the world? Absolutely. So this Senator and this Democrat is for using our natural resources in a way that helps meet the energy demands of this Nation.

This country consumes more energy per capita than any nation in the world. As far as I am concerned, we have an obligation to produce it. Some Members think we can consume, consume, consume and not produce anything. One of the most extraordinary aspects about this bill is streamlining of regulations, trying to untie people's lands so we can appropriately extract natural resources, clean our coal, have good technology off our shores, and use that money to invest in our environment.

People say the Senator from Louisiana is on the floor because Louisiana gets money out of this bill. The State gets some help. We deserve some help because for 50 years we have sent over $140 billion of this Nation's treasury off the shores of Louisiana. That is not pocket change.

We have saved the redwood forests, and we have funded the whole land and water conservation funding for the Nation. Now we have an opportunity to take a portion of that money and save the wetlands of America. It is not Louisiana's wetlands. This is the largest delta in the continental United States, and it is in crisis. It is washing away. The chairman from New Mexico came to see it. He does not need to read a book or anything about it; he has seen it.

So, yes, we have some resources, a tiny percentage of the money that comes out of the great natural resources of the Gulf of Mexico, not to give this Senator any special project, because I sure do not have any special sweet deal. The deal I have cut for my State, which the Senator knows, is to save these wetlands, where migratory birds for the whole Nation go, and fisheries off the coast of the Gulf of Mexico, from the east coast to the west coast.

So there are lots of good things in this bill. I know we have problems with MTBE. I know we have problems. I am very disappointed in the hydrogen section that would have helped us move to hydrogen cars. I am very disappointed. The ranking member fought very hard for renewable portfolio standards, and I am disappointed that his language was stripped out.

But I can tell you, the chairman from New Mexico has fought like a tiger to get a balanced bill. The fact is, we are not divided Democrat against Republican; we are divided regionally.

Mr. President, I ask unanimous consent for 1 more minute.

The PRESIDENT pro tempore. Is there objection?

Without objection, it is so ordered.

Ms. LANDRIEU. Mr. President, I know people have come down here and complained about standard market design. I realize the Senators from the Northeast are concerned about the language that has been put in this bill. But I will tell you, the reason the language has been put in the bill like this is that there are Southerners who are generating a lot of electricity. Why? Because we are drilling, and we are producing, and we are building plants in the South. And I will be darned if our ratepayers have to pick up the tab to ship that electricity to the Northeast. They need to be doing a better job of building plants and laying down pipelines.

I have more pipelines in Louisiana per capita than any State in the Union. If you took an x-ray of the country, you would be shocked. Like a little skeleton, you could see the pipelines under Louisiana. We cannot build any more. And do not believe we are taking the gas from those pipelines. We are sending it all over the country. We are happy to. But we cannot pay for all of it. We have to share the costs in an appropriate way.

So I say to my Democratic colleagues, when they say there is nothing in the bill for Democrats, may I please remind them there is no drilling—30 more seconds—there is no drilling in this bill in ANWR.

Mr. McCAIN. Regular order, Mr. President.

The PRESIDENT pro tempore. Does the Senator yield 30 seconds?

Mr. DOMENICI. Yes. I say to the Senator, we are not using your time.

Ms. LANDRIEU. I thank the Senator from New Mexico.

There is no drilling, in this bill, in ANWR, which I know the President fought very hard for and this Senator thought might be reasonable, but the majority wasn't there.

The PRESIDENT pro tempore. The Senator's time has expired.

Ms. LANDRIEU. Thank you. I urge Democrats and Republicans to support cloture on this bill.

The PRESIDENT pro tempore. The Senator's time has expired.

The Senator from New Mexico.

Mr. DOMENICI. Mr. President, I yield myself 30 seconds.

The PRESIDENT pro tempore. The Senator is recognized.

Mr. DOMENICI. Mr. President, I say to the distinguished Senator from Louisiana, I am very pleased I got to know you in the past year and a half. I do not think we would have had a chance to meet each other but for the energy crisis. I visited your State. And everything you have said today, and on the floor time after time, about what is going to happen in your State because of what is happening to the water line is true. We can kill this bill and kill that. You know how long you have been waiting for it.

Ms. LANDRIEU. Fifty years.

Mr. DOMENICI. And you are going to wait 60 more because there is nobody going to pass another bill like this with these kinds of things in it for a long time. Why do I know that? Because I have been through it. And every time we just about get there, somebody has some objection, and we have a big hole, it all falls in, and nothing gets done.

The PRESIDENT pro tempore. The Senator's time has expired.

Mr. DOMENICI. I say to the Senator, thank you for your effort. I appreciate it.

The PRESIDENT pro tempore. Who yields time?

The Senator from New Mexico.

Mr. BINGAMAN. Mr. President, I yield the Senator from Arizona 6 minutes.

The PRESIDENT pro tempore. The Senator from Arizona.

Mr. McCAIN. Mr. President, I had an opportunity earlier this week to speak about this bill, but I think so much is objectionable in this legislation that I am compelled to expend a little more energy on it.

I have listened to my colleagues' statements, and I have yet to hear any plausible, substantiated argument in support of ethanol. Even my colleagues from corn-producing States who have indicated they support this bill have not been able to identify one benefit ethanol provides the American taxpayers, who pay dearly for it—including the taxpayers in those corn-producing States.

Ethanol is a product that would not exist if Congress did not create an artificial market for it. No one would be willing to buy it. Yet thanks to agricultural subsidies and ethanol producer subsidies, it is now a very big business—tens of billions of dollars that have enriched a handful of corporate interests, primarily one big corporation, Archer Daniels Midland.

Ethanol does nothing to reduce fuel consumption, nothing to increase our energy independence, nothing to improve air quality. Let me repeat: Ethanol does nothing to reduce fuel consumption, nothing to increase our energy independence, nothing to improve air quality.

As far as reducing fuel consumption is concerned, it requires 70 percent more energy to produce a gallon of ethanol than it provides when combusted. There is actually a net energy loss from the use of ethanol. There is nothing about ethanol that will increase our energy independence. More energy is used in the production of ethanol, and it has reduced the amount of gasoline consumed in the United States by 1 percent.

Ethanol does not improve air quality. In fact, doubling the amount of ethanol, as required by this bill, will most certainly degrade air quality. A National Academy of Sciences report in 2000 found that oxygenates, meaning ethanol and MTBE, can lead to higher nitrous oxide emissions, which contribute to higher ozone levels in some areas.

That means in large cities, such as Phoenix, AZ, air quality degradation could be increased under this legislation. The residents of my State already suffer due to the impact of a lingering brown cloud. I dread the effects of this bill—doubling our national use of ethanol—on my town and communities across this Nation.

The American public has to pay a lot of money not only in taxes but at the pump for all these negative impacts on the national economy, the country's energy supply, the environment, and public health. The total cost of ethanol to the consumer is about $3 per gallon, and the highway trust fund is deprived of over $1 billion per year to the ethanol producers.

Plain and simple, the ethanol program is highway robbery perpetrated on the American public by Congress. I maintain you cannot claim to be a fiscal conservative and support the profligate spending and corporate welfare in this bill.

Mr. President, I will talk just for a minute about another problem I had with this bill, the way it was developed. A secretive, exclusive process has led to a 1,200-page monstrosity that is chock full of special interest giveaways and exemptions from environmental and other laws that, frankly, cannot withstand the light of scrutiny.

I mentioned one such provision earlier. It is a glaring example of corporate favors. Section 637 carves out a very special deal for a consortium of energy companies, predominantly foreign owned, called Louisiana Energy Services, which would allow it to construct a uranium enrichment plant in a small town in New Mexico at taxpayers' expense—to the tune of $500 million to $1 billion. This is not your ordinary pork project; it is in a class almost by itself.

Louisiana Energy Services has had some serious difficulties getting a license from the Nuclear Regulatory Commission, and for good reason. One major British partner of this group was fired by the Department of Energy from a $7 billion cleanup contract due to safety and financial failures. Even more disturbing, the major French partner, Urenco, has been associated with leaks of uranium enrichment technology to Iran, Iraq, North Korea, and Pakistan. One high-level U.S. nuclear security administrator stated:

> [T]o have this company operate in the U.S. after it was the source of sensitive technology reaching foreign powers does raise serious concerns.

There is significant reason to believe the NRC would not issue a license to this group of companies. And communities in other States did not want the LES facility in their backyard.

This bill gives LES a helping hand in New Mexico. The criteria for NRC licensing and the time period for review have been modified to make it easier and quicker for LES to get a license. Opportunities for challenges on environmental or other grounds would be severely restricted. And if you are wondering how sweet it could possibly get for this company, the uranium waste from the plant would be reclassified as low-level radioactive waste and the cost of disposal would be borne by the Department of Energy—the taxpayers of America.

Furthermore, there isn't any disposal method or site currently available. This provision, which was inserted in conference at the eleventh hour, is the epitome of corporate welfare. Allowing foreign companies with questionable reputations to circumvent long-standing environmental and nuclear regulations is simply wrong.

Let me quote from a few of the many editorials opposing this bill. I have never seen anything quite like this level of agreement in newspapers representing all regions of the country. In fact, I have yet to see a single editorial in favor of this, although I am sure there is one.

The Philadelphia Inquirer:

> . . . what most Americans were looking for was an energy bill that protected their interests. . . . Instead they got this unbalanced, shameful mess.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. BINGAMAN. I yield the Senator an additional 30 seconds.

Mr. McCAIN. From the Chicago Tribune:

> Neither the contents nor the process for cobbling it together suggest this is the type of energy legislation this country needs.

The Denver Post:

> . . . the most pernicious pork got added in conference committee. Congress should start over next year.

Mr. President, let's put this up against the backdrop of a $500 billion deficit we are facing this year, with 12 percent growth of the Government. Don't call yourself a fiscal conservative and vote for this bill.

The PRESIDING OFFICER (Mr. CHAFEE). Who yields time?

Mr. CRAIG. How much time remains on each side?

The PRESIDING OFFICER. Fourteen minutes to the Senator from Idaho, and 20½ minutes for the junior Senator from New Mexico.

Mr. CRAIG. Do you want to go to another speaker?

Mr. BINGAMAN. I yield 4 minutes to the Senator from Washington, Ms. CANTWELL.

Ms. CANTWELL. Mr. President, I know we have had a healthy debate on this issue and in a few minutes we will probably have one of the closest votes this body has seen in a while. But I want to make one point clear this morning. This vote is about whose side you are on: Whether you are on the side of ratepayers and consumers in making sure we have a national energy policy that works or whether you are going to give in to the special interests who are at this very moment trying to put last-minute deals on the table, ripening other bills with projects that will convince Members to switch over at the last minute instead of standing up for the public.

When the Vice President started this effort, he said, "We are going to have a national energy policy," quoting from his report that a lot of people took pride in, thinking that somehow this administration was going to play a leadership role in an energy policy for the 21st century.

In that report, the Vice President said:

> It envisions a comprehensive long-term strategy that uses leading edge technology to produce an integrated energy, environmental, and economic policy to achieve a 21st century quality of life, enhanced by renewable energy and a clean environment. We must modernize conservation, modernize our infrastructure, increase energy supply, including renewables, accelerate the protection and improvement of our environment, and increase greater energy security.

That is what the Vice President's goal and objectives were. Unfortunately, this bill cannot defy gravity. It is so weighted down with special interest pork subsidies and things that Americans are going to be shocked to see that this bill needs to fail.

We have all heard about the subsidies in the wrong place, $23 billion in incentives, mostly going to the fossil fuel industry. We have heard about the exemptions for Texas. Here it is that we are trying to come up with an electricity title that somehow makes everybody else more responsible and accountable with electricity, but we are going to exempt Texas.

Also, the overturning of various environmental laws—why is it that every other business in America, whether a high-tech firm or a farmer, has to comply with environmental laws, but somehow we are going to let new construction of oil, gas, and coal out of the mandates of the Clean Air Act, the Clean Water Act, the Safe Drinking Water Act, and some of our rules on public lands?

As I said yesterday, one of the biggest tragedies of this bill is the missed opportunity for jobs. We could have gotten language in this bill that would have provided for a natural gas pipeline out of Alaska that would have benefited many in this country as far as job creation is concerned. It would have benefited many of us in the Northwest in getting off our overreliance on hydro energy.

We missed an opportunity in planning for the hydrogen economy; 750,000 jobs could have been created in the next 10 years by having a vision. Not just one line in a State of the Union speech about a hydrogen car, but instead a plan with specifics and incentives so the United States could be a world leader in the hydrogen fuel economy. That is not what is in this bill.

I woke up this morning to read in the Seattle Post-Intelligencer online an article that was entitled "The Energy Bill, It Would Be A Hoot, If It Wasn't So Sad."

In that article it says:

> Vice President Dick Cheney, whose secretive energy task force crafted much of the energy bill in consultation with industry executives, is coming to our Washington next month for a GOP fundraiser.

I would advise the Vice President not to come and talk about his energy policy in the Northwest.

> Curiously, the Senate yesterday debated the energy bill and its subsidies in a virtual media blackout.

The PRESIDING OFFICER. The Senator has used 4 minutes.

Ms. CANTWELL. I ask for an additional 30 seconds.

Mr. BINGAMAN. We yield the Senator an additional 30 seconds.

Ms. CANTWELL. This bill hasn't gotten the attention it deserves. But one thing is clear: Members are going to be held accountable for whose side they are on. The energy policy of this administration has fleeced Northwest ratepayers from essential dollars and now this bill promulgates that policy further by giving in to special interests. This bill should fail.

The PRESIDING OFFICER. The minority leader.

Mr. DASCHLE. Mr. President, I will use my leader time so as not to take away from the time allotted to those who still wish to speak.

America needs a comprehensive national energy plan that increases our energy independence, that creates jobs, that lowers energy prices for consumers, and that is environmentally and fiscally responsible.

We have been trying in the Senate for 3 years to pass such a plan.

Regrettably, this is not that plan.

This plan will move America forward in some ways. But it falls far short of a comprehensive approach to America's energy needs. In fact, it does not even attempt to address some of our most pressing problems. And it is extremely generous to a variety of special interests.

I am greatly disappointed by the number of opportunities we are missing here.

This bill fails to significantly reduce America's growing dependence on foreign oil.

Today, our Nation imports 60 percent of our oil, much of it from some of the most volatile and dangerous areas on Earth. Over the next 10 years, the United States is expected to consumer roughly 1.5 trillion gallons of gasoline.

The Republicans in the House and Senate who wrote this conference report actually rejected measures that would have reduced our dependence on foreign oil.

They rejected efforts to mandate oil savings.

The authors of this conference report also rejected a common-sense plan to address America's projected natural gas shortage.

They killed tax incentives needed for construction of a pipeline to bring natural gas from Alaska to the lower 48 States.

The provision, which was contained in the Senate passed bill, was dropped in conference. And, when Senator BINGAMAN offered a motion in conference to restore it—in the one meeting of Conferees to discuss substantive issues—that motion was defeated on a straight party line vote, with the seven Republican Senate conferees voting against it.

The Alaska Natural Gas Pipeline would have been the largest construction project ever in this country. It would have brought down 35 trillion cubic feet of known natural gas reserves on the North Slope of Alaska. Right now, we are paying to pump that gas back into the ground because there is no way to get it to the American consumers who need it.

The pipeline would also have created 400,000 good jobs and used an estimated 5 million tons of U.S. steel. It would have reduced our dependence on foreign oil by bringing Alaska gas directly to the Midwest.

This conference report also fails to address the problems that led to the catastrophic energy crisis California experienced, and the blackout that left nearly one-third of the country without electricity this past summer.

In addition, this bill actually repeals existing consumer protections—and does nothing to prevent a repeat of the Enron schemes that cost consumers hundreds of millions of dollars. In fact, this bill could make such schemes more likely by tying the hands of regulators.

This bill fails to include a renewable portfolio standard that would diversify America's sources of electricity. The Senate-passed energy bill includes a requirement that 10 percent of America's electricity come from renewable sources, such as wind and solar. This would increase our energy security and create new jobs and opportunities in America's rural communities.

The people who wrote this bill ignored 53 Senators who said this provision should be in the final bill.

Last year, and again this year, the Senate passed energy bills that reflected the growing scientific and bipartisan consensus that the threat of global climate change is real and, unless we act, will have devastating consequences for our children and grandchildren.

This bill simply ignores that fact.

Many important provisions that the Senate passed with strong bipartisan support are nowhere to be found in this bill.

But there are many provisions that are in this conference report that were not even debated in either the House or the Senate. They were simply added in a back room.

One of the most egregious is the retroactive liability protections for MTBE manufacturers.

Forty-three states have problems with contaminated groundwater as a result of MTBE.

The National Conference of Mayors estimates clean-up costs at $29 billion. This bill dumps those costs on local taxpayers, by granting immunity from liability to the polluters.

In fact, this bill provides retroactive liability protection to MTBE producers dating back to September 5 of this year.

It is no coincidence that this is one day before the State of New Hampshire filed its lawsuit against companies responsible for the contamination of groundwater by MTBE.

The authors of this conference report know that provisions like this could not survive open debate. That is why they chose to write this bill in secret.

This process began in secrecy—with Vice President CHENEY's energy task force. And it ended in secrecy.

Democrats in Congress were shut out. The American people were shut out. That is not the way to debate a matter that is so critical to our Nation's security.

Even with these obstacles, we were able to make some important improvements over the bill we were originally given.

Against great odds, we succeeded in protecting the Arctic National Wildlife Refuge from oil drilling.

We increased efficiency standards for appliances and machinery, and increased investments in research and development of new energy-saving technologies.

This bill also makes an historic commitment to expanding the use of renewable energy sources by nearly tripling the use of ethanol.

This is important to the people of South Dakota and many other farm States. And it is important to our national energy security.

A year and a half ago, President Bush came to South Dakota. We visited an ethanol plant in Wentworth. The President said: "[ethanol is] important for the agricultural sector of our economy, it's an important part of making sure we become less reliant on foreign sources of energy."

I agree. I've been fighting for ethanol and other renewable fuels for over 20 years.

Nearly tripling America's use of ethanol will create 214,000 new jobs and produce $5.3 billion in new investments in America.

It will significantly reduce greenhouse gas emissions. And it will save $4 billion in imported oil each year.

Ethanol comes from American farmers and producers, passes through American refiners, and fuels American energy needs. No soldier will have to fight overseas to protect them. And no international cartel can turn off the spigot on us.

I understand and respect my colleagues who oppose this bill. There is much in this conference report that is objectionable.

Despite secrecy, the partisanship and the shortcomings in this bill, I will vote to invoke cloture—reluctantly—because America needs to improve its energy situation, and I think this proposal takes a few small steps forward.

However, the people who wrote this bill must understand that a vote for this bill is not a vote of support for their radical energy agenda that some of it includes.

We can—indeed must—revisit the shortcomings in this bill. We must reexamine the MTBE liability waiver, the effects of this legislation on environmental laws and consumer protections.

I intend to press these issues in the next session of this Congress and for as long as it takes to get it right.

So I will vote for this bill. But I tell my colleagues—especially those who were involved in its drafting—that this bill could have been much better, and the American people deserve better from us in the future.

I yield the floor.

The PRESIDING OFFICER. The Senator from Idaho is recognized.

Mr. CRAIG. Mr. President, I commend to my colleagues the 9th Report on Carcinogens 2000, as it relates to MTBE. This report is a product of the U.S. Department of Health and Human Services, Public Health Service, which says that it is not carcinogenic. It is a true ground water pollutant, but there is no indication of a carcinogenic effect.

Mr. DOMENICI. How much time remains on each side?

The PRESIDING OFFICER. There are 14 minutes for the Senator from New Mexico, and 15½ minutes for the other side.

Mr. BINGAMAN. Mr. President, I yield 4 minutes to the Senator from New York, Mr. SCHUMER.

Mr. SCHUMER. Mr. President, I rise in strong opposition to this legislation, and I have fervent hopes that we will not invoke cloture.

Mr. President, this bill is bad for what is in it and bad for what is not in it. I don't know which is worse. It is bad for what is in it because there are so many provisions that don't make much sense that are done to help one State or another but don't really add up to a national policy.

It is particularly bad for what is in it because the MTBE provision is one of the worst provisions that has come down the legislative pike in decades. To tell homeowners who have lost their homes that they cannot take a shower, cannot drink the water and, through no fault of their own, they are out of luck, that their life savings which they invested in their little homes is gone—even though the MTBE producers knew the stuff was bad and didn't inform anybody—is an outrage.

Some say the Government authorized MTBE. Then let the Government help the homeowners if you don't want to have the oil companies, the MTBE producers, be sued. But don't leave tens of thousands today, and hundreds of thousands within a few years, of homeowners high and dry. I am not a big fan of lawsuits all the time, as my colleagues know. But if there were ever a case where lawsuits were justified, it is in this case. To cut them off, and to cut them off retroactively, is dastardly.

In addition, there is no energy policy in this bill. We have had the triple storm: we have had 9/11; we have had Enron, we have had the blackout. And we do virtually nothing to deal with the aftermath of all three of those.

There is no conservation in the bill. There is no real dealing with the Enron excesses. When it comes to the blackout, we take a baby step that utilities okayed but not what we have to do. Great nations have failed when faced with a crisis and they refused to grapple with it. That is what is happening here.

This bill, whether it passes or fails, will be deeply regretted 5 years from now for what it does and what it does not do.

Mr. President, when pork is used to grease a policy along, well, that is not good. But when pork is used as a substitute for policy, that can be disastrous. I argue that in this case that is what has happened. I had wished that we had a real energy policy in this bill.

My colleagues are all people of good faith. Both Senators from New Mexico, the Senator from Iowa, and the Senator from Montana have all tried their best. Unfortunately, at a time when America demands a thoughtful and far-reaching energy policy, this proposal, instead, delivers little bags of goodies to some individuals, not others, and says that is a substitute for policy.

I hope the bill is defeated.

The PRESIDING OFFICER. The Senator's time has expired.

The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I yield myself 4 minutes out of the time allotted to Senator DOMENICI.

Unlike my colleague and supporter of ethanol, Senator DASCHLE—and he is a big supporter of ethanol—I am not reluctant to vote for cloture because if we don't get cloture on this bill, we will never have the opportunity to get renewable fuels and the environmental impact of those renewable fuels and what it does for American agriculture. This is the best thing for renewable fuels and ethanol that we have had before this Congress in 25 years.

This is an opportunity for people to decide: Are they for the farmers or are they against the farmers? This bill, for the most part, is very good for the green growing regions of the Midwest. The choice is easy. This bill contains those production incentives for ethanol, biodiesel, and other renewable energy sources—the best ever for Senators from other energy-producing regions, such as the gulf States, the Southwest, the Rocky Mountains, and the Appalachians. The bill moves the ball forward for energy production.

The Finance Committee has a history in the area of energy-related tax policy. Almost one decade ago, my committee put its imprint on a comprehensive energy-related tax policy. The bill the committee produced strikes a very good balance between conventional energy, alternative renewable energies, and conservation.

I thank Senator BAUCUS for working with me and every member of this committee on its priorities. I also thank the Democratic staff for its hard work in helping us put together a bipartisan bill that may now be destroyed because of a Democratic filibuster.

First and foremost, we have an expansion of production credit for wind energy. Back in 1992, I was the first to offer this proposal. Now we have an important expansion of this production credit to cover, in addition to wind, biomass, geothermal, and solar energy. As the President has wisely said, as a matter of national security, we need to reduce our dependence on foreign oil. That means all domestic energy sources—green or otherwise—are fair game.

Along those lines, we have a new tax credit for biodiesel fuel that is included in this bill. The conference report contains several provisions that enhance tax incentives for ethanol production because it is a clean-burning fuel that will continue to be a key element in our transportation fuel needs.

We also remove in this bill the prejudice against ethanol for highway trust fund purposes by providing a tax credit for ethanol production. When we complete our work on the highway bill next year, ethanol fuels will pay the full gas tax into the highway trust fund.

This bill also provides an effective small producer tax credit.

With this bill, ethanol will be treated as all other energy incentives. It will be derived from the general fund. Ultimately, all communities, rural and urban, will get more highway money if this bill passes. If you care about highway money for your local roads, you should vote for cloture.

There are a number of other good provisions in this bill that benefit agriculture, clean coal, and new technologies for gas production. The bill, in other words, is balanced with new energy conservation measures, as well as alternative renewable fuels.

We have an opportunity—almost the last opportunity—to do what it takes to get this bill passed. We are responding to national priorities. There is no going back to the House for another chance.

I ask all Senators to think long and hard about what this vote today represents. This is an historical moment. It is as if we are on the last steps of a trail to the top of a big mountain that we have climbed. We can either take the next few steps and enjoy the view or we can jump off the side of the mountain. There is no going back down the trail.

For Senators from my part of the world, the grain growing regions of the Midwest, the choice is easy. This bill contains production incentives for ethanol, biodiesel and other renewable energy sources. We are for farmers they are against farmers. For Senators from other energy-producing regions, like the Gulf States, the Southwest, the Rocky Mountains, and the Appalachians, this bill moves the ball forward on energy production.

The Finance Committee has a distinct history in the area of energy-related tax policy. Almost one decade ago, this committee put its imprint on comprehensive energy-related tax policy. Then, as now, the bill the committee produced strikes a balance between conventional energy sources, alternative energy, and conservation.

I would like to thank Senator BAUCUS for working with me and every member of this committee on their priorities. I would also like to thank the Finance Committee Democratic staff for the hard work they have put in to get us here.

First and foremost, we have an extension and expansion of the production credit for wind energy. Back in 1992, I was the first to offer this proposal to the Senate. Now, we have an important expansion of this production credit to cover biomass, geothermal wells and solar energy.

As the President has wisely said, as a matter of national security, we need to reduce our dependence on foreign oil. That means all domestic energy sources, green and otherwise, are fair game. Along those lines, we have a new tax credit for bio diesel fuels that will be included in this bill.

The conference report contains several provisions that enhance the tax incentives for ethanol production. Ethanol is a clean burning fuel that will continue to be a key element in our transportation fuels policy.

We remove the prejudice against ethanol for highway trust fund purposes by providing a tax credit for ethanol production. When we complete our work on the highway bill next year, ethanol fuels will pay the full gas tax into the highway trust fund. We are most of the way there. This bill also provides an effective small producer tax credit. With this bill, ethanol will be treated as all other energy incentives. It will be derived from the general fund.Ultimately, all communities, rural and urban, will get more highway money if this bill passes. If you care about highway money for your local roads, you should vote for cloture.

There are a number of other very good proposals in the conference report. They benefit agriculture, clean coal, and new technologies for gas production. The bill is balanced with new energy conservation measures as well.

So, to sum up, we have an opportunity to do what we should do. We are responding to a national priority, energy security, in a balanced and comprehensive way. Let there be no mistake about it, Mr. President. A vote against cloture is a vote to stop this bill. There is no going back to the House for another chance. There is no going back to conference with the House with the leverage the energy-producing States had on this bill. As the lead negotiator on the Senate side for the tax provisions, let me tell you it was not easy. The Ways and Means Committee likes oil—they don't like clean-burning ethanol. It was a difficult conference. We will not get this chance again.

So, for my friends on both sides of the aisle, especially those from the Midwest, this is the time to show your cards. You can show whether you are with farmers or with other interests.

As I said, at the start, we are on the last steps of the trail to the mountain top. There is no looking back now. A vote for cloture completes the journey.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. GRASSLEY. We either pass this bill or the good provisions in it for ethanol are lost forever.

The PRESIDING OFFICER. Who yields time?

Mr. BINGAMAN. Mr. President, I yield 5 minutes to the Senator from Illinois, Mr. DURBIN.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. I thank the ranking member for yielding. I spoke on 2 successive days on this bill, and I feel strongly about it. I spent 20 years in Congress supporting ethanol and I believe in it. I think it is important to help our farm economy, reduce pollution, and reduce our dependence on foreign oil. There is no doubt this bill would greatly expand ethanol across America. That is a good thing. It is something I support.

I cannot support this bill. I cannot support this bill because, frankly, it is fundamentally unfair and unjust and it is unbecoming of the Senate to offer this to America as an energy policy.

When it comes to energy, this bill is a full-scale retreat. This bill fails to include any provisions whatsoever to deal with fuel efficiency and fuel economy of the cars and trucks we drive. How can we in good conscience stand before the American people and say this is an Energy bill for our future and not address the No. 1 consumption of energy, oil imported from overseas—the cars and trucks that we drive? Why? Because the special interest groups that oppose fuel efficiency and fuel economy won the battle. They won the argument. The American people were the losers.

There is another aspect to this bill which troubles me. This bill is a full-scale retreat when it comes to environmental protection for America. Think about this for a moment. Every major environmental group in America opposes this Energy bill. What has brought them all together? The fact that in the course of negotiating this bill, those few people sat in that secret room, gave away the Clean Air Act, the Clean Water Act, access to America's public lands, and the natural heritage which we helped to leave to our children. That is what is at stake. To walk away from basic environmental protection in the name of promoting energy is a bad deal for America's future.

To think for a moment that we have reached a point in time where China—this new developing Nation, China—has more and better fuel efficiency standards than the United States of America should be a supreme embarrassment to everyone in this Chamber.

This bill is a gusher of giveaways. We are going to build a nuclear reactor. We are going to start building coal mines in some States. We are going to build all sorts of shopping centers. It goes on and on. I am no babe in the woods. I have served in Congress and on the Appropriations Committee long enough to tell you I have an appetite for pork like every Member of the Senate and the House, but I have to agree with the Senator from New York. If giveaways turn out to be a substitute for energy policy, then we have defrauded the American public. We need to have leadership on this issue, and we do not.

The single worst part of this bill, as far as I am concerned, the most shameless aspect of this bill is found in section 1502. It is the most egregious giveaway I have ever seen in my time on Capitol Hill because in a dark room, the people who wrote this conference report said to the major oil companies and some major chemical companies that they would protect them from liability for the very product which they sold, which has contaminated water supplies across America.

Think about that for a moment. They have said that for families and individuals whose health and homes have been damaged by MTBE as a contaminant, they are going to close the courthouse doors. They are going to lock the doors and say to those families: You are going to have to bear these losses and these medical bills on your own. That is shameless. To think it is included in here should be enough for every Senator to vote against this bill.

To add insult to this injury, there is a $2 billion Federal subsidy for the MTBE producers and industry, not just protecting them in court for their wrongdoing but giving them a lavish Federal subsidy.

What does it come down to? Who are the big winners in this bill? It is obvious: Big oil companies, big energy companies, high rollers on K Street, and the muscle men on Capitol Hill.

Who are the big losers in this bill? Families with kids who have asthma, who will find more air pollution, which will mean that their kids have to stay home from school; families with water supplies contaminated by MTBE, which make their homes uninhabitable and they have no recourse to go to court to hold these oil companies accountable.

Basically, the biggest loser in this bill is Americans who expected more from this Congress, who expected leadership and vision and instead have a very sorry work product which should be defeated.

The PRESIDING OFFICER. The Senator's time has expired. Who yields time?

Mr. BINGAMAN. Mr. President, how much time remains on the two sides?

The PRESIDING OFFICER. The junior Senator from New Mexico has 6½ minutes. The senior Senator from New Mexico has 9 minutes 45 seconds.

Mr. BINGAMAN. I suggest the absence of a quorum and ask that the time be equally divided.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BINGAMAN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BINGAMAN. Mr. President, we have come to the point of deciding whether to vote to send this bill to the President for his signature or to effectively set this conference report aside, regroup, and pursue another strategy.

Those of us who are about to vote against cloture do so not because we are against having an Energy bill but because we are against having this Energy bill. A view has been stated over the last few days that this particular conference report, even with its problematic provisions and its excess spending, is the only option available if we wish to deal with energy problems in this Congress.

It is argued that if we do not pass this bill today, then energy is dead as an issue for this Congress. In my view, that is not a logical conclusion to reach. We are not at the end of this Congress. We are reaching the midpoint in this Congress. There is nothing magical about having to pass energy legislation in odd-numbered years.

The Energy Policy Act of 1992, which was the last fairly comprehensive bill passed through this Congress, was put to final passage a few weeks before the Presidential election in that year.

There is a broad consensus in the Senate for enacting forward-looking energy legislation. We know this is true. Three and a half months ago, we passed an Energy bill by a margin of 84 to 14. That bill would have made 35 trillion cubic feet of Alaskan natural gas available to the country, which this conference report would not. That bill would have saved twice as much energy as this conference report is projected to save. That bill gave a real boost to renewable energy in the production of electricity. It took a modest first step toward dealing with the reality of global warming. It did not undercut the National Environmental Policy Act. It did not roll back the Clean Air Act. It did not exempt anyone from the Clean Water Act. It was $10 billion lighter on the tax side than this legislation before us. It was another $3 billion lighter on the direct spending portion of the bill. It did not unfairly shift all of the costs of building new electric transmission to consumers who do not get the full benefit of that transmission. It did not contain embarrassing tax giveaways such as a proposal to build a mall for a Hooters restaurant. It was a reasonably good bill.

I have served on the Committee on Energy and Natural Resources for 19 years. That is longer than any Member of my party in the Senate. I did not get on that committee to filibuster Energy bills. I went on the committee to pass good energy legislation.

The reason so many of us believe we should not proceed to pass this Energy bill is that many of the provisions that caused the earlier bill I referred to to pass with 84 votes 3½ months ago have been deleted in conference and an array of irrelevant and objectionable provisions have been added. It is almost as if a calculation had been made that as long as we stuck ethanol provisions into the bill and kept provisions out that would open the Arctic National Wildlife Refuge to drilling, then there would be 60 votes for passage of the bill and no one would look too much at the other details and no one would be concerned about the other effects of the legislation.

Well, we are about to test that proposition. I hope it turns out to be wrong. If it turns out to be a miscalculation and cloture cannot be invoked on this bill this morning, then our job on energy will not be done in this Congress. In fact, this may be an opportunity to get things back on a better and a more bipartisan track.

Both sides have made their share of mistakes in assembling massive Energy bills in this Congress and in the last Congress. Yesterday, Senator NICKLES criticized the process Democrats used in the last Congress to move an Energy bill directly to the floor, and many of those criticisms were valid. Throughout this Congress and at each stage, we Democrats have tried to make a constructive contribution to the bill, even in spite of the flawed process that has seemed excessively partisan and closed to us and to the public, but now we are faced with a choice of voting for or against the bill in its totality. Those who oppose cloture, both Democrats and Republicans, choose to do so because in its totality the conference report will not lead us to an energy future that is secure, clean, affordable, and fiscally responsible.

If this conference report is rejected, I for one will continue to push for the enactment of a good, comprehensive energy policy. It may be that having tried twice to do so with thousand-page bills and failed, Congress should look at smaller legislation.

I hope this conference report is rejected and, once the dust settles, we can find a way to move forward with forward-looking legislation.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

The Senator from New Mexico.

Mr. DOMENICI. How much time do I have remaining?

The PRESIDING OFFICER. Nine minutes.

Mr. DOMENICI. I yield 1 minute to Senator BURNS.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BURNS. Mr. President, I thank my good friend from New Mexico for yielding.

I want to say one thing, and that is that the general premise of this bill is in the right direction. The emphasis is on renewables and things we can do that are good for the environment and still produce energy. All this other chaff and dust that has been kicked up around it that gives opponents such a move in the right direction can be dealt with later, but the general premise of the bill is good because a balance is there in the areas in which most of us really believe.

Let us not take our eye off the ball. Let us move it on down the field under a premise of developing a policy and a way to not only deal with the environment but also produce energy.

I tell my colleagues, we can deal with those things that are objectionable at a later time, but we must move in this kind of a direction.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Has Senator Burn's minute expired?

The PRESIDING OFFICER. Yes.

Mr. DOMENICI. Mr. President, first of all, there are a lot of people to thank for getting us where we are. We are a long way from where we started. I want to thank them. In particular, on the Democratic side I thank the distinguished Senator from Louisiana—from the very beginning; thank you very much for all your help and all the others who put a lot of work into this.

I regret very much the statements that this bill was done in privacy and secrecy, in some way different in terms of a conference than most conferences around here. But I would like to tell the Senate, energy is a big hole in the Congress. Energy policy is a big hole, and we keep dropping problems in it but we never solve them.

Everyone talks about conservation and renewables, but we happen to be talking about those and production. As soon as you start talking about production, somebody produces and they are certainly not nonprofit corporations. So as soon as you say "produce and we'll give you an incentive," you are "giving money to big companies." You are giving it to companies who will do the job and wouldn't otherwise do it.

I want to repeat, for everybody, the history. Last year we could not write a bill in committee. Think of that. My good friend, Senator BINGAMAN, talks about how poorly we conducted ourselves. They couldn't write a bill in committee. So we wrote it on the Senate floor. Do you all remember that? We were down here, humiliated that we had to write an Energy bill on the Senate floor because we couldn't write it in committee.

Then what happened? We went to conference with the House. And, boy, if it was ever a storybook conference, it was wide open. And it took month after month, and guess what happened, Senator BURNS—zero. Nothing was done. So there is another one, the big hole sucked it up. But we did it right. We had a conference. We had it open.

This Senator decided that to do it that way would yield nothing. For the first time I decided that we should write the bill differently and we should circulate it differently. Most of this bill was put on the Internet. In fact, that is the first time in history that a conference report was on the Internet. Anybody who wanted to read this bill had weeks and weeks to read all but the last 15 percent. It was on the Internet. It was delivered to every single office. If you didn't read it, that is not my fault. Then for the last part we gave the opposition 48 hours' notice on the Internet to everybody.

Do you know, this bill was more discussed by the press, piece by piece, than any conference report in the history of America? You will never find a conference report that is reported piecemeal in the media of America.

So where was the clandestine bill? Everybody knew about it. The problem is, just as before, the Democrats didn't like it. Yet they offered amendments. For not knowing anything about it, the distinguished Democrat leader offered 21 amendments, or at least he had them ready. We discussed them. The fact they didn't win them, does that mean the bill is no good? What would you expect when you go to conference? I heard somebody say we should have passed the 15 or 20 percent mandates for renewables. Yes, we should have. We did in our committee. But what do you know about it, the House said no. Not only "no," but "absolutely no." So what do we do, throw the bill out? Of course not.

We have the most powerful renewable provisions in history.

I want to tell everybody the true facts. We have worked harder for the farmers of America than anybody in history. The farmers who are looking to see who is for the farmers, once and for all, you can look to the Republicans, not the Democrats; for the Democrats are leading a parade to kill the most important provision ever thought up for the farmers. The Republicans are here, trying to get it done. Senator GRASSLEY stood in a corner with his arms out, put on the armor and said, "It will be this way or we don't have a bill." We got it. And guess what. We are just about to throw it away.

If I were the farmers of America, I would ask: Who threw it away? And they are going to all know, the people who killed this bill threw it away. And guess what. Over the last 3 or 4 days, an array of people who build wind energy and solar energy in America walked up to our office. Incidentally, Senator GRASSLEY, before they opened their mouth about the bill, they thanked you because they said all significant wind energy will stop if this bill is not adopted. They didn't say "tone down; we will come down at half mast." They say it stops, because wind energy is predicated upon the credits in this bill, the most significant credits in history; solar energy, the most significant credits in history. Renewables will go faster and farther with this bill than they ever have.

But I don't believe you can leave here today having voted, especially if you vote to kill this bill, and walk out and tell people: Oh, don't worry, we will take care of the farmers next week. Next week is not going to come because I am aware of what it is. You will not get this ethanol bill through the House again. So it is gone and there are some people walking around liking that. Some people have a smile on their face. But I tell you there is no way to get this ethanol bill through the House. I can't imagine another format where Senator GRASSLEY can do what he did and we get this issue out of conference and here.

Then we have all the other things in this bill that we thought were interesting and good for America. They are all falling by the wayside because, for the first time, people have brought an issue called MTBE to the floor and talked about it. The United States House said we ought to hold harmless the product called MTBE—just the product, not people who spill it, not people who cheat with it, not people who, instead of putting it in cars pour it on somebody's lawn—we didn't protect those. We just said the product is OKed by the Environmental Protection Agency, approved by the U.S. Government, and whether I liked it or not, the House said let's hold them harmless for the product itself.

Frankly, I am just beginning to read some stories about the lawsuits on MTBE. In fact, if we had another day at it, I would give you some that would shock you as to what is going on in the United States with these MTBE lawsuits. I can tell you there is one in one State—we got a message on it. Somebody is walking around trying to drum up the lawsuits. It happens to be the chairperson of the bar association of the State. She went to one city that wrote us a letter and said: We told her we are not interested. As far as we know there is no problem in our city with MTBE. Go someplace else and look for your lawsuits. Precisely what I said yesterday—precisely.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. DOMENICI. In addition, if you like blackouts, then you vote to kill this bill because this bill provides a clear, absolute remedy for blackouts.

The PRESIDING OFFICER. The time of the Senator has expired.

Mr. DOMENICI. I thank the Chair. I think the majority leader is here. I yield at this time.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. FRIST. Mr. Leader, on leader time I just have very brief closing comments.

I thank the chairman and the ranking member. They have done a superb job.

Several issues have come up. I want to make it clear that this vote is the vote on the Energy bill and on the energy provisions. People have envisioned that there will be other votes, other opportunities; that if this bill has not passed, we can address some of these issues later in some other form.

First, some have made a procedural argument that if cloture is not invoked this morning, we can simply recommit the bill to conference and strip out a provision or two provisions and then bring it back to the Senate.

Everybody needs to understand that is not an option. The other body, the House, has already approved the conference report and therefore the conference committee has been dissolved. It has been dissolved. There is no motion to recommit available. So this is the vote. If you are for a comprehensive Energy bill, you need to vote for cloture. This is the vote.

Second, there has been some speculation, people have mentioned on the floor, if we do not pass this conference report we will pull out this provision or that provision and enact them separately. I wanted to dispel that idea as well. We are not going to pull apart pieces of this conference report and pass them separately. We are not going to do it. We are either going to pass this Energy bill now or the individual provisions that many Senators favor are not going to become law. It is as simple as that. I just use the example of ethanol because, as everybody knows, I joined the Democratic leader in offering the ethanol amendment on the Senate floor earlier this summer.

I have to say it very clearly that this Energy conference report is the vehicle for ethanol. We are not going to enact that as a stand-alone. We are not going to attach ethanol to another vehicle. To the Senators who favor this strong ethanol provision that we have in this conference report—this is the vote. You vote for cloture if you want to see it actually enacted into law. It is important for people to understand.

In closing, this is a good bill. It is a balanced bill. It will make America more secure. It will make America more energy independent, and, as we all have talked about, it will create jobs. We should pass it now. We should send it to the President. The first step right now with this vote is to invoke cloture.

I yield the floor.

CLOTURE MOTION

The PRESIDING OFFICER. By unanimous consent, pursuant to rule XXII, the Chair lays before the Senate the pending cloture motion, which the clerk will report.

The legislative clerk read as follows:

Cloture Motion

We the undersigned Senators, in accordance with the provisions of Rule XXII of the Standing Rules of the Senate, do hereby move to bring to a close debate to the conference report H.R. 6, the energy policy bill to enhance energy conservation and research and development, to provide for security and diversity in the energy supply for the American people, and for other purposes.

Bill Frist, Pete Domenici, John Cornyn, Mike Crapo, Larry Craig, Ben Nighthorse Campbell, Michael B. Enzi, Mike DeWine, Christopher Bond, Robert F. Bennett, Trent Lott, Pat Roberts, Jim Bunning, Mitch McConnell, Richard G. Lugar, Norm Coleman, Conrad Burns.

The PRESIDING OFFICER. By unanimous consent, the quorum call is waived.

The question is, Is it the sense of the Senate that debate on the conference report to accompany H.R. 6 shall be brought to a close?

The yeas and nays are required. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. REID. I announce that the Senator from North Carolina (Mr. EDWARDS), the Senator from South Carolina (Mr. HOLLINGS), and the Senator from Massachusetts (Mr. KERRY) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "nay."

The yeas and nays resulted—yeas 57, nays 40, as follows:

[Rollcall Vote No. 456 Leg.]

YEAS—57

Alexander
Allard
Allen
Baucus
Bennett
Bond
Breaux
Brownback
Bunning
Burns
Campbell
Chambliss
Cochran
Coleman
Conrad
Cornyn
Craig
Crapo
Daschle
Dayton
DeWine
Dole
Domenici
Dorgan
Ensign
Enzi
Fitzgerald
Graham (SC)
Grassley
Hagel
Harkin
Hatch
Hutchison
Inhofe
Johnson
Kyl
Landrieu
Lincoln
Lott
Lugar
McConnell
Miller
Murkowski
Nelson (NE)
Nickles
Pryor
Roberts
Santorum
Sessions
Shelby
Smith
Specter
Stevens
Talent
Thomas
Voinovich
Warner

NAYS—40

Akaka
Bayh
Biden
Bingaman
Boxer
Byrd
Cantwell
Carper
Chafee
Clinton
Collins
Corzine
Dodd
Durbin
Feingold
Feinstein
Frist
Graham (FL)
Gregg
Inouye
Jeffords
Kennedy
Kohl
Lautenberg
Leahy
Levin
Lieberman
McCain
Mikulski
Murray
Nelson (FL)
Reed
Reid
Rockefeller
Sarbanes
Schumer
Snowe
Stabenow
Sununu
Wyden

NOT VOTING—3

Edwards
Hollings
Kerry

The PRESIDING OFFICER (Mr. ENZI). On this vote, the yeas are 57, the nays are 40. Three-fifths of the Senators duly chosen and sworn not having voted in the affirmative, the motion is rejected.

Mr. FRIST. Mr. President, I enter a motion to reconsider the vote by which cloture was not invoked.

The PRESIDING OFFICER. The motion is entered.

Mr. FRIST. Mr. President, the vote, prior to switching my vote for procedural reasons, was 58 to 39; thus, two votes short for invoking cloture. As I said just prior to the vote, America needs a comprehensive national energy policy, and we need it now. Congress has been debating this energy issue for a long time, for nearly 3 years. It is now time for us to stop talking and to deliver to the American people.

I truly believe the bill before us, that the chairman and the other members on the Energy Committee have worked so hard to produce, is a fair bill. It is a balanced bill. It addresses everything from future blackouts to the whole discussion on development of a wide range of reliable energy resources. Now is the time for us to act.

I am very disappointed that we are, at this point, two votes short; that we are facing another filibuster on a very important policy for the American people. I do want to let colleagues know that this will not be the last vote that we have on this bill. We are going to keep voting until we pass it so we get it to the President's desk. We will have at least one more vote before we leave the early part of next week on stopping this filibuster. I don't know when that vote will be, but we will have at least one more vote. I hope we will respond at that time by giving the American people the energy security, the economic security, and the job security that they deserve.

INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 2004—CONFERENCE REPORT

Mr. FRIST. Mr. President, I now move to proceed to the consideration of

H.R. 2417, the Intelligence authorization conference report. Before the Chair puts the question, this conference report has been cleared on both sides, and I hope that we can finish action on it very quickly.

The PRESIDING OFFICER. The question is on agreeing to the motion to proceed.

The Senator from Nevada.

Mr. REID. Mr. President, in response to the leader's statement, we also believe in energy independence and the security of the Nation.

The PRESIDING OFFICER. It is not a debatable motion.

Mr. REID. Fine. I will withhold.

The PRESIDING OFFICER. The question is on agreeing to the motion to proceed.

The motion was agreed to.

The PRESIDING OFFICER. The report will be stated.

The legislative clerk read as follows:

> The Committee of Conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2417) to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes, having met, have agreed that the House recede from its disagreement to the amendment of the Senate, and agree to the same with an amendment and the Senate agree to the same, signed by a majority of the conferees on the part of both Houses.

The Senate proceeded to consider the conference report.

(The conference report is printed in the House proceedings of the RECORD of November 19, 2003.)

Mr. FRIST. Mr. President, I am happy to yield to the distinguished assistant Democratic leader for a question.

ENERGY POLICY ACT

Mr. REID. Mr. President, I say through the Chair to my colleagues, we also believe in energy independence. We also believe in the security of this Nation. This was a bipartisan vote that just took place. I think we would all be well advised, this late in the session, to recognize that we should take this bill back to the committee, conference, if necessary, but I suspect it would be better off going back to committee and coming up with a different piece of legislation. People over here want badly to have a bill. The 58 votes we have are firm votes. It would not be advisable to have a vote, say, on Monday or Sunday. Cloture is not going to be invoked.

But let's assume it were for purposes of this argument. Then we have the situation where there are hours following that debate, and I just think we should recognize where we are. The reality is, it is late in the session. We need to go to some other matters. With this vote, we did the Senate a favor, as everyone knows. There are points of order, rule XXVIII. This bill was going nowhere. We just did it quickly rather than prolong it. It doesn't help the Senate to prolong the inevitable. The inevitable is this bill is history. It is not going to go anyplace.

We really did the Senate a favor. Cloture was not invoked. There are points of order against this bill, as we all know. There would be bipartisan votes on those matters. I think we should go on to something else. This was a very good debate. I think we should look back at this as something that is good for the Senate in the sense that the tone was good, and look forward to the very important issues we have facing us, difficult issues. We have the omnibus bill. We have the important Medicare bill. I hope that we would not prolong things on this much longer because this bill, in its present form, is just not going anyplace.

The PRESIDING OFFICER. The majority leader.

Mr. FRIST. Again, to clarify for our colleagues, two votes short, as I implied in my statement. This policy is too important to the American people for us to desert. So we are going to come back. We are going to come back with another opportunity, after I talk to the Democratic leadership. And we will do that at the appropriate time.

For the information of our colleagues, we will be going to other issues—right now, the Intelligence authorization conference report. It is likely today we will be doing Healthy Forests shortly. We have a lot of business today. Medicare will be addressed shortly. The two Houses will be addressing that today.

It may well be that we will begin to address issues such as Medicare later today and continue debate on energy today and look at both issues over the course of tomorrow.

Again, in the intervening time, we will be addressing issues such as Intelligence, Healthy Forests, and other conference reports as they come to the floor.

The PRESIDING OFFICER. The Democratic leader is recognized.

Mr. DASCHLE. Mr. President, I, too, wish to have an opportunity to comment briefly on the vote we have just taken.

Mr. President, for Senators like me, who support enactment of a comprehensive energy bill, the Senate's failure this morning to break this filibuster was as unnecessary as it is unfortunate.

It is a classic example of insisting on provisions that were simply too much for the traffic to bear.

The Senate's lead negotiator, Senator DOMENICI, was, I believe, prepared to work in good faith with his House counterparts to craft a comprehensive energy bill that could attract broad bipartisan support in this body.

Regrettably, his best intentions were undercut by the cynical manipulations of the House Republican leadership during the conference proceedings, which cut Senator BINGAMAN out of the conference process and produced a product that was a far cry from the bipartisan energy bill that passed the Senate in July.

I am convinced that a true conference would have produced a much more balanced energy bill than that before us today.

Make no mistake, however, the overriding reason for the failure of this bill today was not what I consider to be its disturbing lack of balance between production and conservation or between promotion of fossil fuels and renewable energy sources. It was the House Republican leadership's insistence on inclusion of retroactive liability protections for MTBE shielding MTBE producers from legal exposure.

The provision was not contained in either the House or Senate-passed energy bills. In an effort to aid a major special interest, the House Republicans wrote the provision so that it would specifically invalidate the State of New Hampshire's lawsuit against the MTBE industry.

So it is no surprise that New Hampshire's two Republican Senators chose to filibuster this bill.

The drive to placate a narrow special interest not only came at the expense of the public, it trumped the Republican Party's own legislative strategy.

I personally—on numerous occasions—warned Chairman DOMENICI, Chairman TAUZIN, and others responsible for the closely held Republican energy bill conference deliberations that inclusion of this provision threatened enactment of this legislation.

This scenario has, unfortunately, come to pass, ironically because the inclusion of MTBE liability waiver was the straw that broke the camel's back for many Republicans.

While the drumbeat of recriminations about who bears responsibility for this setback had begun even before the vote, the question I am concerned about is what we can do to enact a comprehensive energy bill quickly.

My first preference would be to adopt something close to the bipartisan energy bill that passed the Senate by overwhelming bipartisan votes in the current and past Congresses under the leadership of both parties. But experience tells us that won't happen.

While I fully appreciate that the current bill without MTBE liability relief would still be objectionable to many Senators, there should be no doubt that if this provision was not included, the bill would pass the Senate today and be enacted into law.

Therefore, Mr. President, I call on the White House, and the House and Senate Republican leadership, to join with me to immediately strip out the offending safe harbor language now in the bill.

Further, as a demonstration of good will, I propose that safe harbor language be eliminated for ethanol as well as MTBE.

Once these changes are made, the comprehensive energy bill could be brought back to the Senate and the House, either as a new conference report or as part of the Omnibus Appropriations bill now being readied for final passage in both Chambers.

This simple action would have this energy bill, as imperfect as it is, ready for the President's signature yet this session.

I yield the floor.

Mr. INOUYE. Mr. President, after much deliberation, I have decided to oppose the conference report to H.R. 6, the Energy Policy Act.

The conference report before us today is a serious departure from the comprehensive and balanced approach to energy policy passed by the U.S. Senate earlier this year by an overwhelming bipartisan vote of 84 to 14. The Senate bill carefully weighed many competing interests and struck a fair and even-handed balance that would have strengthened our national security, safeguarded consumers, and protected the environment.

The conference report has tipped the studied balance of the Senate bill drastically in favor of short-term business interests. Regrettably, I am not surprised by the sweeping changes made to the Senate bill because the conference report was prepared by the Republican leadership behind closed doors, without the participation of their Democratic counterparts. Under these circumstances, one cannot be surprised that balance was lost, and a flawed conference report emerged.

Upon review of the bill, I was initially pleased to note its positive aspects. My completed review of the conference report, however, revealed that these few beneficial provisions were far outweighed by the many items injurious to the American people as a whole. The conference report erodes the careful web of environmental protections that safeguard the public health and our natural resources. It promotes a static energy industry by failing both to encourage the development of alternate fuel sources and energy efficient technologies, and does nothing to police the energy industry to prevent a recurrence of the Enron debacle. For example, the conference report does not include the broad, effective prohibitions against price gouging schemes used by Enron and other energy trading firms, included in the Senate version of the Energy bill.

As science has helped to illuminate the negative impacts of environmental pollutants on public health, Congress has responded by enacting a series of statutory protections designed to safeguard the American people by restricting the levels of pollutants that enter our environment. The conference report substantially undermines these protections.

For example, the report would exempt three major metropolitan areas from meeting the Clean Air Act's ozone-smog standard. While industry in these areas may enjoy a respite as a result of the conference report, people with asthma and other respiratory diseases will not. Moreover, it should be noted that this particular provision appeared for the first time in the conference report, and was never debated by the Senate or the House. Without such debate, my colleagues and I are unable to judge whether there are any mitigating factors that might justify a rollback of the Clean Air Act in these three cases.

Of direct concern to my home state of Hawaii is the treatment of methyl tertiary butyl ether, MTBE, and producers of this common gasoline additive. As a fuel additive, MTBE helps gasoline to burn more cleanly, but outside of our gas tanks, MTBE is a proven cancer causing agent that has contaminated groundwater supplies across the country. In Hawaii alone, there are approximately 500 known contamination sites, and in a state completely dependent on its isolated groundwater, this is an alarming statistic. Under this conference report, the State and its counties would have no legal recourse against the producers of MTBE for the expensive process of environmental cleanup, including the remediation and clean up of contaminated soil, water supplies and wells.

The conference report also exempts all construction activities at oil and gas drilling sites from coverage under the Clean Water Act. It goes further and completely removes hydraulic fracturing—an underground oil and gas recovery method from coverage under the Safe Drinking Water Act. Domestic oil and gas production contributes significantly to the short-term security of our national energy infrastructure, but I do not believe that our security interests outweigh our health interests. Nor do I believe that conventional fuel sources can ever provide a long-term solution to our energy security.

As a further blow to ongoing efforts to reduce our nation's dependence on conventional fuels, the Republican conferees dropped Senate-passed provisions that would have encouraged further research, development, and demonstrations of hydrogen fuel resources, for which Hawaii is rapidly developing a keen expertise. The measure also eliminated the broadly-supported goals for introduction of hydrogen fuel cell vehicles.

I support strong renewable portfolio standards, RPS, that provide incentives for producing renewable energy in this country. These measures—such as RPS for electricity, requirements for measures to reduce dependence on foreign oil, climate change policy, and technology—have been dropped from the conference report.

The conference report further dilutes efforts to reduce our dependence on fossil fuels by weakening Corporate Average Fuel Efficiency, CAFÉ standards. I believe that strong CAFÉ standards drive the development and implementation of fuel efficient technologies for use in cars and trucks, and history has proven the strength of this approach. With the volatility of international fossil fuel sources, and the decline of our worldwide stock of this resource, strong CAFÉ standards are more important than ever. By introducing a variety of new and difficult criteria for the administrative development of CAFÉ standards, it will prove difficult or impossible for any President to strengthen the current set of standards before being halted by industry lawsuits.

As a Senator from an island state, I am also concerned about provisions that seek to weaken the laws that protect our coastlines such as the Coastal Zone Management Act, CZMA. For example, the conference report shortens the time within which states can appeal state consistency review determinations made by the Secretary of Commerce, thus limiting the rights of states under the CZMA.

The conference report also jeopardizes federal conservation lands by allowing the Secretary of Energy to determine the siting of transmission lines through certain national forests and national monuments—even over the objections of the Federal agency charged with maintaining and preserving these natural treasures.

Mr. President, I must also express my serious concern with regard to the provisions of H.R. 6 as they relate to the development of energy resources on Indian lands and the impact of these provisions on the United States trust responsibility for Indian lands and resources. To allow this bill to be passed without amendment, would, in my view, alter the bedrock principles upon which relations between the United States and the Indian nations are founded.

The United States trust responsibility is perhaps the most fundamental principle of Federal Indian law. It was first enunciated in 1832 by United States Supreme Court Chief Justice Marshall. It is the polestar which has guided the course of dealings between the Indian tribes and the United States over the last two centuries.

The United States trust responsibility for Indian lands and resources is derived from treaties and agreements between the Indian nations and the United States, statutes, executive orders, court rulings, and regulations. The Congress has legislated on this basis. The Federal courts have ruled on that basis, and the Executive branch has premised policy on this basis and promulgated regulations based upon this fundamental principle of Federal-Indian law.

The Federal Government's trust responsibility for Indian lands and resources is based on the fact that the United States holds legal title to lands that are held in trust for Indian tribal governments. As the principal agent of the United States as trustee for Indian lands and resources, under current law, the Secretary of the Interior must authorize and approve any activities affecting Indian lands and trust assets.

However, recently the United States Supreme Court ruled in the United States v. Navajo Nation case that tribal governments may not hold the Secretary of the Interior accountable for mismanaging trust assets except if there is a specific authorization contained in a Federal statute. As a result of this ruling, tribal governments are looking to the Congress to protect longstanding principles of established trust law and to clarify with certainty the meaning of the trust responsibility after the Court's pronouncement in the Navajo Nation case.

The Indian provisions of H.R. 6 unfortunately fail to provide a means for tribal governments to call upon the United States, as trustee for Indian lands and resources, to assist them in remedying any damages incurred to tribal lands, nor do they establish express statutory standards for the administration of the U.S. trust responsibility.

The bill requires that any tribe attempting to avail itself of the powers to regulate and develop its own energy resources must waive its rights to seek any recourse against the Secretary of the Interior. This requirement signals a dramatic departure from existing law, and tribal governments across the country have expressed serious concern that this bill will erode the United States' trust responsibility, especially in the aftermath of the Supreme Court's ruling in the Navajo Nation case.

As tribal governments seek to further their rights to self-determination in new areas, such as the leases, agreements, and rights-of-way affecting tribal lands that are addressed in this bill, there must also be an evolution of the duties that the trustee for Indian lands and resources—the United States—undertakes on behalf of tribes desiring to develop energy resources.

My view is that there is a well-founded and long-established partnership between Indian tribal governments and their trustee—and that it is this relationship which assures that if there is any harm or damage done to tribal lands and resources caused by other parties, the tribes will have the full force of the United States government to assist them in securing redress for such harm.

With this end in mind, I respectfully suggested that those standards applicable under the Indian Self-Determination Act be incorporated into this bill, such as the annual trust asset evaluation that is authorized in that act to be conducted by the Secretary of the Interior as a condition of the Secretary's approval of a tribal government's right to enter into leases, business agreements, and rights-of-way without the Secretary's approval.

Unfortunately, this language was not adopted, and instead the bill provides that the Secretary will have the discretion to determine the manner in which trust resources will be managed, and what, if any, ongoing oversight there will be as tribal governments move into an arena that is associated with serious financial and environmental risks.

In addition, in the wake of the Supreme Court's ruling in the Navajo Nation case, the absence of expressly-stated statutory standards for the administration of the government's trust responsibilities as they relate to the development of energy resources on Indian lands is, I believe, a further derogation of the trust relationship that cannot be overstated.

In another section of the bill, state and tribal governments are effectively excluded from the process by which conditions for the operation of hydropower projects are established, and as a result, the protection of fish and wildlife resources is left up to those for whom the financial incentives to reduce costs at the expense of the survival of fish and wildlife resources are great.

There are many in Indian country who share these concerns, and would perhaps express them more strongly than I have been able to do. We do not have a record of which we can be proud when it comes to our dealings with the first citizens of this land, and I fear that this measure will not mark a new, more constructive direction in Federal-Indian relations.

Mr. President, two men involved in the process of bringing this conference report to the floor for a vote—Senator PETE DOMENICI and Senator TED STEVENS—are very dear to me and I have the honor of working with them on a daily basis. I hope they will understand that, as much as I would like to support them and their interests, I must oppose this conference report.

ETHANOL SUBSIDY

Mr. BAUCUS. Mr. President, for several years now I have worked with the highway community to hold the Highway Trust Fund harmless with respect to the ethanol subsidy. While it is good agriculture and energy policy to encourage alternative fuels, it should not be the Highway Trust Fund, and therefore the Nation's transportation system, that bears the burden of the ethanol subsidy.

A few years ago I introduced a bill that transferred revenue from the general fund to the Trust Fund so it could be the general fund that would bear the responsibility rather than the Trust Fund.

This Congress, Senator GRASSLEY and I introduced a bill, S. 1548, that replaced the ethanol exemption with a credit and that transferred the 2.5 cents, currently retained by the general fund to the Highway Trust Fund. Although other provisions in S. 1548 are now contained in the energy bill conference agreement, including the new ethanol credit, the provisions most important to me did not make it in.

I appreciate your commitment and that of Speaker HASTERT and Ways and Means Chairman THOMAS to ensure that the provisions in S. 1548, regarding the Highway Trust Fund will be enacted no later than February 29, 2004 which is the day that the TEA 21 extension expires.

In fact, Speaker HASTERT sent out a press release today that confirms his commitment to enacting these important provisions from S. 1548.

I thank Senator FRIST for working with me to ensure that the Highway Trust Fund will receive all the taxes due to it and that our Nation's transportation program will thrive.

Mr. FRIST. Mr. President, I extend my gratitude to Senator BAUCUS for working together with the Vice President, the Speaker of the House and myself to reach a compromise on the ethanol issue in the energy bill conference agreement. We understand this is a very important issue to him and to the country and his efforts on this matter have been crucial to developing a strong energy policy.

As per the agreement, I would like to reiterate our commitment regarding the portions of the ethanol issue which are not currently in the conference agreement. In the next highway bill, we will make certain that the 2.5 cents that currently goes into the General Fund, as well as the proceeds from repealing the 5.2 cents from the ethanol tax exemption, are credited to the Highway Trust Fund. Moreover, it would be my desire to hold the Highway Trust Fund harmless with respect to this late date of enactment.

Once again, I thank Mr. BAUCUS for working closely with us to resolve this very important issue. We look forward to enacting these provisions.

Mr. COCHRAN. Mr. President, there are several provisions in this conference report that amend the Commodity Exchange Act, which is administered by the Commodity Futures Trading Commission.

I appreciate the Energy Committee's consultation with the Agriculture Committee with respect to the amendments to the Commodity Exchange Act.

The most important change to the act is to the CFTC's antifraud authority in section 4b, which is found in section 33 of the conference report. Section 4b is the CFTC's main antifraud weapon. In November, 2000, the U.S. Court of Appeals for the Seventh Circuit ruled in *Commodity Trend Service, Inc.*, v. *CFTC*, 233 F.3d 981, 992 (7th Cir. 2000) that the CFTC could only use section 4b in intermediated transactions, thus prompting this clarification. We are amending section 4b to provide the CFTC with clear antifraud authority over non-intermediated futures transactions. Newly revised subsection 4b(a)(2) prohibits fraud in transactions with another person that are within the CFTC's jurisdiction. This new language will make it clear that the CFTC has the authority to bring antifraud actions in off-exchange principal-to-principal futures transactions, including retail foreign currency transactions and exempt commodity transactions in energy and metals. In addition, the new section 4b also clarifies that this fraud authority applies to transactions conducted on derivatives transaction execution facilities as well. The amendments to section 4b(a) of the CEA regarding transactions currently prohibited under subparagraph (iv) are not intended to affect in any way the CFTC's historic ability to prosecute cases of indirect bucketing of orders executed on designated contract markets. *See, e.g., Reddy* v. *CFTC*, 191 F.3d 109 (2nd Cir. 1999); *In re DeFrancesco, et al.*, CFTC Docket No. 02–09 (CFTC May 22, 2003) (Order Making Findings and Imposing Remedial Sanctions as to Respondent Brian Thornton).

The next important changes, or clarifications, come in section 9 of the Commodity Exchange Act that deals with CFTC's false reporting authority. These clarifications are also found in section 332 of the conference report.

In the last 12 months the CFTC has received approximately $100 million in settlements from energy trading firms accused of filing knowingly inaccurate reports. Despite these successes, the amendment to section 9(a)(2) has been included in the legislation in response to a recent U.S. Federal District Court decision in the criminal case of *U.S.* v. *Valencia*, No. H–03–024 (S.D. Tex.). In this case, the U.S. attorney brought a criminal case against an energy trader for filing false reports regarding fictitious natural gas transactions in an attempt to manipulate natural gas price indexes. The Court, recognizing that the U.S. attorney had to show intent for knowingly inaccurate reports, dismissed some of the false reporting counts because there arguably was no intent requirement for false or misleading reports. The CFTC consistently has maintained that an intent to file a false report is necessary for there to be a violation of section 9(a)(2). Accordingly, to address the concerns of the Court in Valencia, section 9(a)(2) will be revised by inserting the word knowingly in front of both false and misleading so it is clear that the CFTC and the U.S. attorneys must show intent.

The legislation also includes an amendment clarifying Congress' intent that section 9 provides a civil enforcement remedy to the CFTC, in addition to criminal prohibitions. This amendment merely clarifies and confirms the CFTC's longstanding use of section 9, as the CFTC has brought over 60 enforcement actions charging violations of its provisions, including but not limited to false reporting charges under subsection (a)(2).

These amendments will permit the CFTC and U.S. Attorneys to continue to bring false reporting cases in the energy arena for acts or omissions that occurred prior to enactment. The bill expressly provides that these amendments simply restate, without substantive change, existing burden of proof provisions and existing CFTC civil enforcement authority, and do not alter any existing burden of proof or grant any new statutory authority.

The last amendment I will mention is a set of savings clauses for the Natural Gas Act and the Federal Power Act. These savings clauses are intended to help clarify the dividing line between the jurisdiction of the CFTC and the Federal Energy Regulatory Commission. The two savings clauses, which are virtually identical, can be found in section 332 and section 1281 of the conference report.

The savings clauses have two purposes. The first purpose is to make it clear that nothing in the Natural Gas Act or the Federal Power Act affects the exclusive jurisdiction of the CFTC with respect to accounts, agreements and transactions involving commodity futures and options. The CFTC, not FERC, has exclusive jurisdiction over commodity futures and options. This exclusive jurisdiction extends to futures and options on natural gas, electricity and other energy commodities, regardless of whether the futures or options contract goes to delivery, is cash settled or offset in some other fashion.

The second purpose of the savings clauses is to clarify that FERC should follow the existing Commodity Exchange Act statutory scheme for requesting futures and options trading data from futures exchanges through the CFTC. Section 8 of the Act recognizes the highly sensitive nature of futures and options trading data and specifically restricts its public disclosure except in very limited circumstances. The regulatory scheme of the act ensures the confidentiality of futures and options trading data and is one of the reasons that investors have such confidence in the U.S. futures markets. FERC can and should be able to obtain futures and options trading data by directing its request to the CFTC not to a futures exchange such as the New York Mercantile Exchange. The CFTC has a long history of sharing futures and options trading data with other Federal and State regulators that agree to abide by the public disclosure restrictions found in section 8. The savings clauses assure that requests for futures and options trading data will be processed in the same way and be subject to the same protections.

I believe the clarifications to the Commodity Exchange Act included in the conference report will only strengthen what is already a strong and sensible regulatory program administered by the Commodity Futures Trading Commission, and I support passage of the conference report to accompany H.R. 6, the Energy Policy Act.

Mr. CAMPBELL. Mr. President, I rise today in strong support of the energy bill conference report and urge its quick passage. I am deeply troubled by the misinformation being cast about by opponents of this bill on the Senate floor and in the press. I would like to take just a moment and distinguish some of the fact from fiction.

First, opponents of the bill have been criticizing the energy bill's electricity provisions. They have made sensationalistic allegations about Enron and the August blackout, among others, and conclude that this bill does nothing to improve our Nation's electricity grid. If opponents of this bill were to take the time to read the bill they have been so fervently criticizing, they would have reached far different conclusions.

Opponents have been desperately trying to color a good piece of legislation with known bad guys. I don't know how many times I have heard Enron thrown around, but never have those folks mentioned that this bill includes significant market transparency, consumer protection, and improved enforcement provisions. The fact: this bill improves matters.

Second, critics have criticized this bill for shielding MTBE producers from product liability lawsuits. Many of those Senators represent States that have sued MTBE producers for contaminating groundwater. On one hand, I appreciate why they object to that provision. My State of Colorado too is searching for ways to meet funding shortfalls, and groundwater out West is always a premium. However, MTBE isn't in groundwater because someone put it there. MTBE is in groundwater because the underground storage tanks made to hold gasoline with MTBE leaked.

Another fact: Congress mandated MTBE's use, requiring the oxygenate be added to gasoline to meet Clean Air Act requirements.

My friends on the other side should focus on fairness, and not just the deep pockets their trial lawyer friends are after. Fairness is the special interest opponents of the bill are so adamant on vilifying.

Opponents of the energy bill conference report have made outlandish claims that this bill does nothing for renewable energy. Again, such statements beg the question; have they bothered to read the bill? The fact of the matter is that this bill includes significant financial incentives for wind, biomass, and solar energy, and has the full support of the Solar Energy Industries Association. Further, the bill requires that 7.5 percent of electricity purchased by the Federal Government come from renewable energy.

Opponents have criticized the Indian energy title of the bill as offensive to the environment. They claim that if Indians opt-in to the voluntary provisions, then those tribes can skirt NEPA. Without touching the prejudicial nature of that statement—the assumption that Indians would violate the environment—I seriously doubt that opponents know why NEPA might apply at all. Under current law, if a tribe wanted to build an energy production facility on their own land with their own money, NEPA would not apply. NEPA only applies on Federal land or when there is some Federal action. Although some critics may like to think otherwise, Indian land is treated as their own land. In the example above, there is no Federal action.

However, if the Nation's most disenfranchised and poverty stricken group seeks third-party funding to develop their own resources, then the Secretary of Interior must review the proposed project. This paternalistic Secretarial review, a historical construct in the law, is tantamount to Federal action triggering NEPA. Indians believe that their lands should be treated like other private land under the law.

Opponents of this bill are playing a cruel joke on Indians. On one hand, they argue that Indians should be free to exercise their right to self-determination. Yet, on the other hand they tell the poorest of the poor that they must do so without any third-party financing. It seems that opponents of this bill believe that, for Indians, self-determination may only be exercised through posing for tourist photos and making handcrafts.

The Indian Energy title in the bill under discussion provides Indians with a completely voluntary tool that could help them to develop their own resources. This title could be a significant empowerment vehicle providing much needed jobs and economic development.

Last, my friends on the other side have made several statements criticizing this bill's process. In part, I have to agree with them. Similar to the failed energy bill of the democratically controlled 107th Congress that never benefited from being drafted in the Energy and Natural Resources Committee, the current energy bill has reached the floor in an imperfect way.

However, the fact of the matter is that the energy bill of the 108th Congress is a far reaching piece of legislation that is good for the country, good for my State of Colorado, which still relies heavily on the agricultural industries, and good for workers. It is important to note that all manner of farm groups support this bill, including the American Farm Bureau, the American Corn Growers, the National Farmers Union, and the National Cattleman's Beef Association. Furthermore, this bill is supported by a host of labor organizations; the Brotherhood of Locomotive Engineers, the United Mine Workers, and the United Transportation Union, to name just a few.

Mr. President, the comprehensive energy bill before the Senate is a critical piece of legislation for the country. Its writers had the unenviable task to ask the questions that most in the Nation are never required to consider—where does our energy come from, and how can we meet future demand? This bill provides important answers and plans for the future. I urge its passage.

Mr. NELSON of Florida. Mr. President, I rise to oppose the energy bill. I wanted to support this bill, but the many environmentally questionable provisions and the large price tag prevent me from doing so.

This bill is not an energy policy bill. It is a special interest bill. We are at war in two countries, and we receive more than 50 percent of our oil from sources beyond our shores. But this bill does not provide a way for us to break free from the security threat that poses. It lacks clear vision for how this country moves away from our dependence on foreign oil and dirty fuel and towards new, cleaner sources of energy.

There are no oil saving provisions or climate change provisions. I do support the incentives for nuclear energy, wind energy, solar energy and other renewable energy sources. I also support the provisions for tax credits for the sale of hybrid and alternative fuel vehicles. The repeal of the Public Utility Holding Company Act and reform of the Public Utility Regulatory Act's mandatory purchase obligation are positive changes. But I can't get past the MTBE liability waiver, the coastal zone management changes, and the huge tax credits for the oil and gas industry. Half of the tax benefits—approximately $11.9 billion of the $22.9 billion—in tax provisions will go to the oil and gas industries, some $72 billion in authorized spending, a 50 percent increase over the price tag going into conference. And this price tag is not offset anywhere in this budget.

With regard to MTBE, my State of Florida has more MTBE spills than any other State in the country—more than 20,000—and those communities in Florida may be held responsible for the cleanup of those sites if the liability waiver in this bill passes. And the ratepayer in these communities, instead of the producers of MTBE, will have to pay the price for the cleanup.

In fact, a lawsuit filed by Escambia County Utilities Authority would be nullified by this bill. And at least 11 other water systems serving 629,000 people will be prevented from seeking redress from the refiners of MTBE who caused the contamination.

My staff talked to the Executive Director of the Escambia County Utilities Authority, Steve Sorrell, and he told my staff that if Escambia's suit cannot go forward the County will be on the hook for an expensive cleanup and the ratepayer will have to pay the price. So if this energy bill passes, the main cause of action in Escambia County FL's suit will be taken away and the ratepayers, the citizens of Escambia County, not the producers or oil refiners, who knew this substance was a health and environmental hazard when it was introduced, will pay the price.

Some have said that we shouldn't hold the producers responsible for the contamination, they just produced the MTBE. They didn't know it was a health risk or environmental hazard.

But the successful lawsuits have uncovered that the refiners did know it was a health and environmental risk and why not let the courts decide whether they are at fault instead of the U.S. Congress. In a document dated April 3, 1984 an MTBE producer employee said:

> We have ethical and environmental concerns that are not too well defined at this point; e.g., 1. possible leakage of [storage] tanks into underground water systems of a gasoline component that is soluble in water to a much greater extent [than other chemicals], 2. potential necessity of treating water bottoms as a "hazardous waste," [and] 3. delivery of a fuel to our customers that potentially provides poorer fuel economy . . .

Another memo by an energy company engineer in 1984 is even more egregious.

This memo says:

> Based on higher mobility and taste/odor characteristics of MTBE, Exxon's experiences with contaminations in Maryland and our knowledge of Shell's experience with MTBE contamination incidents is estimated to increase three times following the widespread introduction of MTBE into Exxon gasoline . . .

Later the memo notes:

> Any increase in potential groundwater contamination will also increase risk exposure to major incidents.

These memos were written more than 5 years before the Clean Air Act amendments passed that ushered in the widespread use of MTBE in gasoline. These documents were uncovered in lawsuits in California in which manufacturers and distributors of MTBE, the very entities immunized from product liability suits in this bill, were found guilty of irresponsibly manufacturing and distributing a product they knew would contaminate water. The jury found by "clear and convincing evidence" that these companies acted with "malice" by failing to warn customers of the almost certain environmental dangers of MTBE water contamination.

The coastal provisions of this bill are also troubling. Under section 321, of the Oil and Gas title, the Secretary of the Interior will be given broad new authority to grant leases, easements or right-of-ways on the Outer Continental Shelf in moratorium areas. Interestingly, this provision left the Senate prohibiting these oil and gas activities in the moratorium areas, but came back allowing those projects to go forward in moratorium areas—without input from the Department of Commerce as required under the Outer Continental Shelf Lands Act. Section 325 restricts the appeals process for coastal states appealing an oil or gas exploration or development plan to the Department of Commerce. The timeline put in place by this provision is even shorter than that requested by the Bush administration. Section 330 circumvents the Coastal Zone Management Act and deems the Federal Energy Regulatory Commission record the record for a Coastal Zone Management Act appeal—limiting a State's input into the process. For these reasons, I cannot support the bill.

Mr. ENZI. Mr. President, there is an old adage we have heard many times that says that the journey of a thousand miles begins with a single step. Today we are taking another one of those steps in a long journey that will hopefully lead to an increase in our energy independence, more reliable sources of energy, and more stable prices that are not so subject to fluctuations in the energy market.

The bill we have before us is something that will truly affect every American, no matter their age, where they work, where they live, or what activities they pursue in life. One of the many things that bonds us as Americans is our love of so many things that makes us consumers of energy. No matter who you are, you are a strong and vital part of that market.

If you drive a car, you won't get very far without a full tank of gas.

If you use a computer, you have to tie it to some source of electricity to get the power you need to access the Internet or the information stored on your hard drive.

If you live in a mobile home, or in a cabin in the woods and cook your food over an open fire, you are still an energy consumer who is using a resource to make your dinner.

Every lifestyle has its own energy needs and we have been incredibly blessed to have had access to an abundance of energy for many, many years.

In fact, we had such relatively easy access to energy we started to take it for granted. That led to calls for conservation and more wise use of our resources when energy costs first started to rise. That was the start of our journey to create an energy policy—one that has seen us through these past years. Unfortunately, it has taken quite a long time to agree on an update to our policy, one that takes into consideration the changes we have seen in our society and in the availability of energy both here and abroad.

Our dependence on foreign sources of energy continues to be a national concern, one that had me and many others calling for the creation of a national energy policy, which we have done since 1973 when OPEC and the Saudi Arabians first pulled the plug on our supply of crude oil.

The irony was the fact that we had an abundance of oil here in the United States at the time. In fact, we still have a huge supply of oil in the country today, but that oil has not been made available for exploration. Because we hadn't taken the steps to develop it, we allowed a foreign government to disrupt and control part of our daily lives. We became vulnerable to their manipulations and it took us months to recover. In some ways, we are continuing to recover from those days of the long gas lines, high prices and short supplies that we saw in the 1970s.

Things were bad enough back then when we didn't have an energy policy. Still, they could have been much worse. I shudder to think what might have happened if we'd had a situation like 9/11 occur at the heart of that crisis. If the terrorists had struck when we were economically crippled and energy supplies were low, what effect could they have had on our national security?

That kind of scenario is exactly the kind of thing that a national energy policy like the one we are taking up today is supposed to avoid.

It has taken us quite a while to get where we are, but we finally have something before us that will provide us with a plan, a blueprint for the future that will also address our needs in the present. It is time now for us to take it off the planning board and put it into action. After all, 30 years ought to be enough time to put the basics of a plan together, and that is how long we have had since the energy crisis of the 1970s to work out a plan like this. Now we have before us the beginning of what will be a long and continuing effort to stabilize our energy markets and protect our national security.

This bill isn't perfect, but it is a good start. It is more than a beginning, but it is not the final answer. It is a temporary remedy that will start producing results immediately while it lets us continue working on a more permanent solution. In other words, it is a chance to grab the brass ring and get another ride on the energy merry-go-round, while providing for the ride we are currently on.

I am pleased that this bill includes a number of important provisions that support and promote clean coal development. Coal is an important product of Wyoming, and one of the most important ways we can reduce our dependence on foreign energy is to find ways to diversify our energy supplies and better utilize our Nation's abundant coal supplies—especially clean burning coal like what we mine in Wyoming.

In addition to our coal supplies, in recent years our new energy development has focused on the increased use of natural gas. I support natural gas development and I hope that our gas industry continues to grow and flourish. IO am also keenly aware of the fact that there isn't enough natural gas or infrastructure available to supply all of the world's energy needs so we are going to have to continue relying on coal for some of our energy uses.

That does not mean we have to continue doing business as usual and continue to push our aging coal-fired power plants well beyond their originally designed lifetimes. We have the technology and the ability to design and build cleaner and more efficient power plants that utilize new clean coal technology, but we won't be able to do that if we cripple our economy and prohibit new development.

This won't surprise anyone, but none of us are going to be enthusiastic about everything in this bill. Again, it is not a perfect bill, but it is a good start on a policy. It does not have everything I want in it, but it does have more than enough to make it worth our support. There is a provision that would have greatly helped Wyoming get the more than $400 million that it is owed by the Federal Government through the Abandoned Mine Lands Trust Fund, but that provision was not included in this bill. We have received assurances from the Finance and Energy Committees that they would take up this matter early next year, and we are grateful for their commitments. However, I would have preferred that the provision had been included in this bill and we didn't have to take up any of the committee's time next year. Still, again, on balance, and taking the whole bill into consideration, it is a good bill and it deserves our support.

I know I am not the only one who feels that one provision or another could have been added or left out and it would have made for a better bill. Like me, almost every State can point at something that they wish could have been included but was not. It is a reason to be disappointed, but it's not a reason to ignore the task at hand, which is to continue the process and develop a national energy policy.

There are just too many positive things that the bill would do for the country in the long and short term. To begin with, the bill would create nearly 1 million jobs and implement mandatory electricity reliability standards that we believe may prevent future massive blackouts as was experienced in August by the Northeast.

It would encourage the Federal Government to increase energy efficiency in Federal installations.

It would increase assistance for lower income families by raising the base authorization of LIHEAP to $3.4 billion. The bill also includes incentives to increase solar, wind, geothermal and other biomass technologies.

It encourages modernizing and streamlining our Nation's hydropower laws.

It provides incentives for responsible oil and gas development and royalty relief for marginal wells. In other words, it helps keep wells that are slow, but long-term energy suppliers going so we don't always have to rely on short-term, get-rich-quick wells for all of our energy needs.

It provides incentives to encourage consumers to purchase more hybrid and alternative fuel vehicles and authorizes two new programs that would improve the efficiency and quality of our Nation's fleet of school buses.

There are a number of other provisions included in this bill that will contribute to our Nation's energy security and I hope my colleagues will take the time to look at what is in this bill for what it really is: A desperately needed and all-important first step toward a policy that will increase our energy independence, ensure we have a more reliable supply of energy available, and a more stable energy market for consumers to purchase from with prices that are not so subject to as much fluctuation and change.

Mr. BURNS. Mr. President, I would like to commend the chairman of the Energy Committee for his leadership on this challenging bill both on the Senate floor and through the conference. This is the first comprehensive energy legislation this country has seen in more than a decade, and it is a huge step forward for America. This energy bill is about looking forward to our future, and creating the energy and the jobs that will keep this country best in the world.

This is a large and complicated bill. It addresses everything from energy efficiency and conservation, to research and development for new technologies, and policies to encourage a wide variety of energy sources nationwide. People will always find something to criticize in a sweeping piece of legislation, but we need to focus on the huge accomplishments this bill will achieve.

We will advance cutting-edge technologies such as hydrogen fuel cells and improve clean technologies already in place like nuclear power, hydropower, wind, and solar energy. At the same time we will shore up our own domestic production of the resources we use most, including clean coal, oil, and natural gas. We will begin to use 5 billion gallons of ethanol and biodiesel annually as a result of this bill, and that is a very good thing for farmers and consumers across America. Real reforms in the electricity title will result in more reliable service and more investment in the backbone of our electricity infrastructure.

I would especially like to acknowledge Senator DOMENICI's wise counsel in regard to an amendment I had intended to propose to enhance the economic growth of western States. My amendment would have provided for the study and creation of National Interest Electric Transmission Corridors by the Secretary of Energy, based on national security and energy policy grounds. Pursuant to those designations, the permitting and siting of needed electric transmission lines would be provided for. While most of this additional capacity would probably be achieved by broadening existing rights-of-way, there would no doubt be some need for additional rights of way. Upon the advice of the chairman and his assurance that he would pursue these concepts, I declined to offer that amendment on the Senate floor.

I am very encouraged that the chairman has been successful in having the concept of National Interest Electric Transmission Corridors included in the bill, for any area experiencing electric energy transmission constraints or congestion. Transmission capacity in these western States is one of the significant issues regarding their future economic expansion. Furthermore, if we could unlock the tremendous coal, wind and other resources of these States through mine-mouth electric generation and provide for the transmission of that electricity to load centers it would take significant pressure off our increasing reliance on natural gas as a power source. This is one of the keys to a balanced energy portfolio and lessened reliance on foreign energy sources.

My home State of Montana can make a significant contribution to our Nation's energy independence, provided we can develop the needed transmission infrastructure to move electricity to market if we generate it from our coal and wind resources. This is very important for both the generating States and the end-user markets and is simply good national energy policy and good national security policy.

This energy bill isn't perfect, but it helps us transition into tomorrow's economy without sacrificing our quality of life today. It is a good balance, and a good compromise between the countless demands that have been made by those with opposing viewpoints. No one can win every battle, but without this energy legislation the entire country loses. I am disappointed there are Members in this body who would rather complain about this bill than enact it. We shouldn't let partisanship get in the way of progress, and this bill is progress. No one got all they wanted, but every State in the Union will benefit, and every American will be better off if we ensure this country's energy security by passing this legislation.

Mr. HATCH. Mr. President, I rise today to express my strong support for H.R. 6, the Energy Policy Act. It has been a long, long time since we could claim to have a national energy policy, and I am very proud to say that we are about to deliver an energy plan to the American people that is comprehensive and forward looking. It is a balanced bill that promotes greater energy independence and cleaner air.

It is no simple task to construct complex legislation of such a broad scope. A good deal of the credit for the fact that we have a conference report today goes to the heroic leadership of Chairman DOMENICI and Chairman GRASSLEY, and the respective Democratic ranking members Senator BINGAMAN and Senator BAUCUS. I congratulate our colleagues for their leadership.

And when it comes to leadership, we all know that it was President George W. Bush who first put us on the path to a national energy plan. One of the President's earliest acts was to establish the National Energy Policy Development Group, which produced the National Energy Policy Report, an early template for the legislation we have before us today.

We don't have to convince the American people that we need this energy bill. They already know. They are the ones who paid more than $2 per gallon to fill their cars this summer. They are the ones who sat in blackouts for days. And, they are the ones who have watched their natural gas bills go through the roof.

I am pleased to report to the American people that the Energy Policy Act addresses each of those problems—and more.

My State of Utah is an energy resource State. Utah has long helped to fuel our Nation's growth, whether it be by supplying the uranium that fueled our early nuclear industry, the oil and natural gas for our vehicles and homes, or the clean coal which powers our coal-fired electricity plants. Utah has also been a leader in producing renewable electricity with our large hydropower facilities and our significant geothermal plants. Thanks to environmental protections, labor laws, and health and safety regulations, our Nation is cleaner and stronger than ever before. And I am glad these protections are in place. However, the many layers of these rules and regulations do make energy production more expensive. In Utah, where we have many millions of acres of beautiful public lands, we have the extra difficulty of developing energy while trying to preserve significant portions of scenic areas. In my State we want all the protections our laws provide, but we recognize the need for assistance from the Federal Government to keep this activity going in this country. And in doing so, this legislation leaves almost no stone unturned.

The act will help us to leap forward in creating more efficient buildings and homes in this Nation, and it starts at home by addressing congressional and other Federal buildings. The act takes large strides forward in promoting the use of renewable energy in the United States. The bill also covers solar energy, wind energy, hydro power, and geothermal energy, the latter being particularly important in my State of Utah.

I am pleased that the Energy Policy Act includes important provisions to increase the reliability of our electricity system.

We have seen what happens when we lack a reliable affordable electricity supply; our modern society comes to a near standstill. Reliable electricity is one of the most important services we can provide our Nation. Most of the electricity produced in the United States comes from coal-fired power plants. The newer coal plants which are prevalent in the West are very clean and very efficient. This legislation promotes the most advanced technologies in this industry which will lead to further improvements in the reliability of our electricity system and in the quality of our air. The bill also provides programs to improve electricity service to our Native Americans.

Importantly, the Energy Policy Act addresses our need for a more reliable fossil fuel supply. This includes home heating oil, natural gas, and our other basic transportation fuels, petroleum and gasoline.

The transportation sector in the U.S. accounts for nearly two-thirds of all oil consumption, and we are almost entirely dependent on petroleum for our transportation needs. Is it any wonder, that 50 percent of our urban smog is caused by mobile sources? If we want to clean our air and address our Nation's energy dependency, we must focus on the transportation sector. And we must focus first on those technologies and alternative fuels that are already available and abundant domestically.

To that end, 14 cosponsors and I introduced S. 505, the Clean Efficient Automobiles Resulting from Advanced Car Technologies Act of 2003, or the CLEAR Act. The CLEAR Act is the most comprehensive and effective plan we have seen in this country to accelerate the transformation of the automotive marketplace toward the widespread use of fuel cell vehicles. And it would do so without any new Federal mandates. Rather, it would offer powerful market incentives to promote the advances in technology, in our infrastructure, and in the alternative fuels that are necessary if fuel cells are to ever reach the mass market. As a result our Nation benefits from cleaner air and greater energy independence.

I am very pleased to report that a large portion of the CLEAR Act was included in the Energy Policy Act. And for that I give my heartfelt thanks to Finance Committee Chairman GRASSLEY and Senator BAUCUS.

First, the bill offers CLEAR Act credits to consumers who purchase alternative fuel and advanced technology vehicles, such as hybrid-electric vehicles. These credits would lower the price gap between these cleaner and more efficient vehicles and conventionally-fueled vehicles of the same type. This is a direct attack on our Nation's huge appetite for petroleum as a transportation fuel, and I am confident that the CLEAR Act credits will accelerate our shift toward a more efficient and cleaner transportation future.

When I introduced the CLEAR Act, it contained a significant tax credit for the installation costs of retail and residential refueling stations. I was disappointed that this provision was weakened in conference and replaced with a provision that extends and expands an existing tax deduction for infrastructure. However, I am pleased that an infrastructure incentive did survive in the Energy Policy Act.

As originally introduced, the CLEAR Act also provided a very important tax credit of 50 cents per gasoline-gallon equivalent for the purchase of alternative fuel at retail. This would have brought the price of these cleaner fuels much closer in line with conventional automotive fuels and contributed significantly to the diversity of our fuel supply.

This was a very important component of the CLEAR Act that did not survive the conference process. It was important because of the combination of this incentive, the infrastructure incentive, and the alternative fuel vehicle credit working together was meant to have a larger effect on the market than could have been accomplished by providing these incentives alone at different times. For instance, the fuel credit would have combined with the vehicle credit for an added incentive to consumers to buy cleaner cars. The fuel credit also would have combined with the infrastructure credit for a very powerful incentive to install new fueling stations. The presence of more fueling stations also opens the way for the purchase of more clean vehicles, and so on. Because all three incentives are not in the final bill, we will not achieve the synergy that would otherwise have been possible, and the potential benefits of the CLEAR Act may not be fully realized.

In spite of this disappointment, I am very pleased that such a large portion of the CLEAR Act was included in the energy bill. I can see the day when alternative vehicle fuels, fuel cells, and other advanced car technologies will be common. And considering the environmental and security costs associated with our petroleum-based transportation system, that day cannot come too soon.

As I have outlined in my statement, the Energy Policy Act will go a long way to bringing our nation into the future. It will increase our energy security and clean our air. I urge my colleagues to support these goals and throw their support behind it.

Mr. CONRAD. Mr. President, I come to the floor today to support the energy bill conference report.

I have long believed we need a comprehensive national energy policy. The reality is that our economy depends on affordable energy. We often take it for granted, but just imagine how different our daily lives would be if we did not have plentiful, affordable oil, natural gas, and electricity. We depend on energy in almost everything we do in our lives, from turning on the light in the morning, to driving our cars to work, to cooking our dinner, to watching TV at the end of the day.

And energy is absolutely critical to the functioning of our economy. Our manufacturing sector uses vast amounts of energy to produce the whole range of products we take for granted in stores all across the country. Our services sector—and particularly our high tech sector—rely on electricity. Our agriculture economy uses enormous energy inputs for planting, harvesting and processing its bountiful production. And without energy, we could not transport these goods and services to consumers.

It is virtually impossible to understate the importance of energy to our daily lives and to our economy. Yet our energy policy is seriously lacking.

As the blackout in the northeast demonstrated last summer, our national electricity infrastructure is decades old and dangerously overloaded. Quite simply, we have under-invested in making sure that the national electricity grid can keep up with demand for electricity. Since 1992, demand for electricity has been growing at 2–3 percent per year while transmission capacity has been growing at only .7 percent per year. At the same time, deregulation of the electricity industry has led to a hodgepodge of control over transmission capacity, without clear rules and responsibility for maintaining the reliability of the system. We need new rules to improve the reliability of the grid and new incentives to increase transmission capacity if we're to avoid future meltdowns.

And, we remain overly dependent on foreign oil. Oil imports now account for nearly 60 percent of consumption, and the projection is for that percentage to continue increasing inexorably. That puts our economy at risk, because it is vulnerable to price spikes caused by OPEC or supply disruptions in foreign trouble spots. And it creates national security challenges. We currently rely on the vast oil reserves in the Middle East to meet our import demands, and that makes ensuring the free flow of oil from that unstable, undemocratic part of the world a vital national security interest. So we need an energy policy that will reduce our reliance on imported oil.

For these reasons, I have long believed we need to update our national energy policy. The bill we have before us begins to address these challenges. It will improve the reliability of our electric grid. It provides positive incentives for renewable energy. And it promotes conservation.

Let me be clear, though. This is not a perfect bill. It does not go nearly as far as I would like in addressing the issues I have outlined and other critical elements of a comprehensive national energy policy. It contains several provisions that I do not think should be in an energy bill. But on balance, it is a positive step for North Dakota and the national economy, and it will mean additional jobs in my State.

Let me first talk about the provisions I support that will help ensure our national energy security and benefit North Dakota.

First, the bill strongly promotes the use of ethanol and other bio-fuels. The bill will require 5 billion gallons of ethanol by 2012. And it will create a biodiesel tax credit of $1 per gallon for feedstocks such as canola and 50 cents a gallon for recycled feedstock such as restaurant grease. These are clean and renewable fuels, and these provisions are good for the environment, good for our energy independence, and good for North Dakota farmers.

Second, I am very pleased that the bill contains a provision I fought for to extend the production tax credit for wind for 3 years. North Dakota has the highest potential for wind energy of any State in the Nation. This provision will spur the production of wind energy facilities and equipment in North Dakota. That is good for electricity consumers, good for the environment, good for wind energy equipment manufacturing workers, and good for farmers and others who will benefit from having wind turbines on their land.

Third, the bill contains a 15 percent investment tax credit to support the development of clean coal technology that will benefit North Dakota's lignite coal industry. We have a thriving lignite coal industry in North Dakota, with seven lignite plants that use 30 million tons of lignite each year. And jobs in the lignite industry are among the highest paying jobs in my State.

Fourth, the bill contains incentives for adding pollution control equipment on older coal plants and incentives for building new, more environmentally friendly coal plants. This could be a big help in getting a new lignite plant in western North Dakota while maintaining our pristine environment, something I have been working on for years.

Fifth, the bill contains modest steps to promote energy conservation, including a tax credit of up to $2000 to encourage people to better insulate their homes, and provisions to encourage the purchase and use of more energy efficient appliances.

Sixth, there are provisions to encourage small producers of oil and gas. Many people do not think of North Dakota as an oil and State, but we have significant reserves that can be tapped to help reduce our dependence on foreign oil and address the shortage of domestic natural gas production. The bill includes a tax credit for marginal wells, provisions to speed up permitting on Federal lands, and a section to encourage a particularly important process for natural gas extraction.

Seventh, the bill includes a set of provisions to improve the reliability of the national electric transmission grid, reducing the chances of a massive failure like the one that affected the northeast last summer.

Eighth, the electricity title also ensures that small cooperatives will not be subject to burdensome FERC jurisdiction and contains native load protections for co-operatives, which are a major source of electricity in North Dakota. These provisions ensure that North Dakota rural electric co-ops can continue to provide low-cost power to their consumers.

Finally, the bill expands and extends assistance to low income families in meeting their home heating needs. The Low Income Home Energy Assistance Program, LIHEAP, has provided valuable assistance to thousands of North Dakota families in paying their winter heating bills.

Because of all these important provisions, a number of North Dakota groups support the bill. These include the North Dakota Farmers Union, the North Dakota Farm Bureau, the North Dakota Rural Electric Cooperative Association, the Lignite Energy Council, and the Greater North Dakota Association.

As I said earlier, however, this bill is far from perfect. There are a number of areas where it could and should have been much better.

For example, the conference report does not contain a Renewable Portfolio Standard. The bill that passed the Senate required that 10 percent of electricity be produced from renewable energy sources by 2020. This modest RPS would have helped to clean up our environment and spurred wind energy development. I supported this provision and wish it had been included in the conference report.

More generally, the conference report falls short on promoting the use of renewable fuels and emphasizing conservation. If we are ever to overcome our dependence on foreign oil imports, we will need to be more aggressive on these fronts. The conference report could and should have done more in this area.

I am also disappointed that the bill does not contain tradeable tax credits to encourage cooperatives and municipal utilities to further invest in renewable energy sources. Tradeable credits would have leveled the playing field for these electricity suppliers as we build wind farms and other renewable energy facilities. The conference report could and should have included this provision.

And I do not believe the conference report goes nearly far enough in creating new incentives for expanding transmission capacity to reduce the risk of blackouts. I had hoped the conference report would contain provisions to eliminate the transmission bottleneck that is preventing my state from expanding lignite and wind energy plants to export more electricity to regional markets. Here again, the conference report could and should have done more.

Finally, the bill contains a number of unnecessary provisions that I do not support. The liability waiver for the dangerous fuel additive known as MTBE—or methyl tertiary butyl ether—is troubling. Clean Air Act changes that will allow certain cities to postpone compliance with reductions in ozone damaging pollutants have nothing to do with promoting sound energy policy and should not be in the bill.

I believe we have more work to do to produce a truly comprehensive energy policy that addresses our energy, economic and national security challenges. In particular, I will continue to push for an expansion of transmission capacity to protect against the failure of our electricity grid and allow North Dakota to increase its exports of electricity. It is my hope that we will be able to work on these issues in a bipartisan manner.

Despite its shortcomings, on balance the bill before us takes positive steps to address our Nation's energy needs. It will encourage domestic energy production, promote renewable fuels, and modestly encourage conservation to help reduce our reliance on foreign oil. It will help to reduce the likelihood of major transmission breakdowns.

And it will provide significant benefits to my State of North Dakota. Energy is the second largest sector of the North Dakota economy, and it will benefit very directly from a number of provisions in the bill. And agriculture, the largest sector of the North Dakota economy, will also see important benefits from the various renewable fuel incentives.

For those reasons, I support the conference report.

Mrs. LINCOLN. Mr. President, I rise today to announce my support for the Energy Policy Act of 2003. I want to thank Chairmen GRASSLEY and DOMENICI and Senators BAUCUS and BINGAMAN for working with me to include renewable energy and energy efficiency provisions important to my home State of Arkansas. While some may say this bill is not perfect, it is a step toward reducing our dependence on foreign oil and increasing the use of renewable resources in this country.

Nine months ago, I stood before this body and spoke on the dangers of continued reliance on foreign sources of energy. Today, I am pleased to stand here in support of a bill that includes several provisions I believe will take our country's energy policy in the right direction. I know this bill is not perfect, and I am disappointed that some of my colleagues who have been leaders on this issue for many, many years were excluded from the drafting of this bill.

But I am pleased that those who did draft this bill made an effort to address energy concerns in every sector of this industry. In Arkansas, we have investor owned utilities and co-operatives. This bill will help both of these providers serve their customers in a more efficient and reliable manner. And while this bill may not go as far as some would like in the direction of renewable energy, there are many provisions in this package which will help the United States begin the long process of eliminating our dependence on foreign oil. I believe the renewable fuel standard, requiring our government to purchase at least 5 percent of its energy from renewable sources, represents a positive step toward this goal. I personally fought to include provisions that will encourage greater use of renewable resources, increased production of efficient appliances, and greater investment in delivering fuels to rural America.

In Arkansas, we recognize the importance of renewable fuels in helping the United States to become more energy-independent. That's why I am excited about the provisions in this bill that will encourage greater use of a valuable new alternative fuel, biodiesel. Biodiesel, which can be made from just about any agricultural oil, including oils from soybeans, cottonseed, or rice, is completely renewable, contains no petroleum, and can be easily blended with petroleum diesel. It can be added directly into the gas tank of a compression-ignition, diesel engine vehicle with no major modifications. Biodiesel is completely biodegradable and nontoxic, contains no sulfur, and it is the first and only alternative fuel to meet EPA's Tier I and II health effects testing standards. Biodiesel also stands ready to help us reach the EPA's new rule to reduce the sulfur content of highway diesel fuel by over 95 percent. These tax credits are necessary as biodiesel is not yet cost-competitive with petroleum diesel.

This legislation will provide tax incentives for the production of biodiesel from agricultural oils, recycled oils, and animal fats and will ensure that biodiesel becomes a central component of this Nation's automobile fuel market. This legislation is identical to language authored by myself and Senator GRASSLEY included in the last Congress's Energy Bill. It is intended to be a starting point for our debate and discussion as we draft an energy bill for consideration in this Congress.

This legislation will provide a partial exemption from the diesel excise tax for diesel blended with biodiesel. Specifically, the bill provides a one-cent reduction for every percent of biodiesel from virgin agricultural oils blended with diesel up to 20 percent.

The legislation will also provide a half-cent reduction for every percent of biodiesel from recycled agricultural oils or animal fats. With today's depressed market for farm commodities, biodiesel will serve as a ready new market for surplus farm products. Investment now in the biodiesel industry will level the playing field and create new opportunities in rural America. This bill also contains a provision I fought for that will provide a tax credit for production of fuels from animal and agricultural waste.

Thanks to new technological developments, we can now produce significant quantities of alternative fuels from agricultural and animal wastes in an environmentally-friendly manner. The production incentives included in this bill will assure implementation and commercialization of this new generation of technology. I am also pleased this bill includes language to encourage additional collection and productive use of methane gas generated by garbage decomposing in America's landfills. Landfill gas is a renewable fuel that can be used directly as an energy source for heating, as a clean burning vehicle fuel, and as a hydrogen source for fuel cells. Furthermore, it can power generators to produce electricity. There are compelling environmental reasons to encourage these projects.

Even the large landfills that are required under the Clean Air Act to collect their gas and control non-methane organic compounds often find it more cost-effective to simply flare or otherwise waste the gas rather than use the methane to produce electricity. Some smaller landfills are not required to collect the gas, and may continue to emit it for decades under the Clean Air Act. Thus, landfill gas projects will not only reduce local and regional air pollution while yielding a renewable source of energy, they will also reduce the country's yearly emissions of greenhouse gases by a very substantial amount at a relatively small cost. I also worked to include a provision that will encourage new waste-to-energy facilities to produce electricity directly from the combustion of our trash. Arkansas stands with other environmentally conscious States in understanding that waste-to-energy technology saves valuable land and significantly reduces the amount of greenhouse gases that would have been released into our atmosphere without its operation. The volume of waste generated in this country could be reduced by greater than 90 percent by utilizing waste-to-energy facilities, and EPA has confirmed that more than 33 million tons of greenhouse gases can be avoided annually by the combustion of municipal solid waste. Municipal solid waste is a sustainable source of clean, renewable energy and I am proud to see this measure enacted into law.

Another provision I am extremely proud of is one that will provide a tax credit for the production of super energy-efficient clothes washers and refrigerators if those appliances exceed new Federal energy efficiency standards. Conservation and efficiency are the most effective and immediate ways to limit our energy consumption and reduce pollution. I am confident this provision will spur manufacturers to develop super-efficient appliances that will be affordable for consumers.

Another provision of which I am particularly proud relates to the clean-up of Southwest Experimental Fast Oxide Reactor, a decommissioned nuclear reactor near the community of Strickler, Arkansas, in the northwest corner of my State. The site is contaminated with residual radiation, liquid sodium, lead, asbestos, mercury, PCBs, and other environmental contaminants and explosive chemicals. I have been fighting to rehabilitate this site since I came to the Senate, and now we know that persistence pays off.

SEFOR was built by the Southwest Atomic Energy Associates, a consortium of investor-owned electric utilities, and the U.S. Atomic Energy Commission for testing liquid metal fast breeder reactor fuel. SEFOR began operations in 1969 and was permanently shut down in 1972. After the reactor's useful life, the ownership of the site was transferred to the University of Arkansas. The Federal Government helped create these contaminants, and therefore should pay to help clean them up. This is great news for northwest Arkansas, because this site has threatened public health and the environment in one of our state's most beautiful areas for too long. I thank the conferees for retaining my provision related to cleaning up this site.

The final provision I would like to praise relates to improving our country's natural gas infrastructure. I am proud that this bill contains provisions to make it easier for natural gas companies to deliver clean-burning natural gas to this Nation's rural homes, by decreasing the depreciation time for natural gas pipelines.

America's demand for energy is expected to grow by 32 percent during the next 20 years and consumer demand for natural gas will grow at almost twice that rate, due to its economic, environmental, and operational benefits. That level of natural gas use is almost 60 percent greater than the highest recorded level. To satisfy this projected demand, we must substantially expand our existing gas infrastructure and this provision will do that. These are provisions in this bill that I am very proud of, but there are also provisions in this bill that I am not proud of. I am very disappointed by the way in which the issue of MTBE liability is handled in this bill. I am also disappointed by the lack of a renewable portfolio standard in this bill and I will continue to work to see that a RPS is enacted in coming years.

Our current global situation shows us just how important it is that we takes steps to reduce our dependence on foreign oil. I hope that this bill is taken for what it is: not a comprehensive solution, but a certain step in the right direction. Much more work needs to be done if we ever expect this country to lose its dependence on fossil fuel and foreign sources of energy and I urge my colleagues to continue to work hard until we achieve this goal.

Mr. BIDEN. Mr. President, for our national security, for our economic future, for the health of our environment, our country needs an effective, comprehensive national energy policy. We must free ourselves from dependence on foreign sources of energy. We must leave behind costly, inefficient energy practices and invest in cutting-edge technologies that will keep our economy the most productive in the world. And we must protect and heal the natural environment that we will leave to our children and grandchildren.

The legislation before us fails to meet those needs. When I, and 83 other Senators, voted for the Energy Policy Act on July 31, it was very a different piece of legislation. Unfortunately, the bill has been drastically changed since then. Without sufficient discussion and input from our side of the aisle, unacceptable parts were added to this legislation and crucial parts were taken away. We have been left with a bloated symbol of lost opportunity. I cannot support it.

This is not a trivial matter. This bill would set our energy policy for the next 10 years; we must get it right. Consider how things have changed since we last enacted an energy policy in 1992 and what new challenges we will face in the next 10 years.

Cracks in our energy policy, both in infrastructure and regulation, have become evident in the last few years. They have been most clearly shown during the Enron scandal and the August blackout in the Northeast and Midwest. These were clear signals of serious problems in the current system. Sixty million people were affected by the blackout, and it cost New York City alone $1 billion. This should have been a call to action, but it was not. This bill fails to address the weaknesses in our electrical grid that were exposed over the summer.

The Federal Energy Regulation Commission is prohibited in this bill, until 2007, from reforming the national power grid through mandating Regional Transmission Organizations, which would be necessary to ensure that further blackouts don't occur. This legislation also requires those who want to construct a Regional Transmission Organization to foot the full bill themselves, basically guaranteeing that it won't happen. I have received complaints from the Public Service Commission in Delaware on this very provision.

As our colleagues from the West Coast have reminded us so forcefully, Enron-style energy market manipulation was a major force in undermining the energy system in that part of the country. But this bill does not close the loopholes, with cute names like "Fatboy" and "Get Shorty," that allowed Enron to inflate their profits, and that directly caused some of the disruptive and costly power shortages.

The bill also rescinds the Public Utility Holding Company Act without providing an adequate replacement. PUHCA has for decades protected energy customers from energy corporations, like Enron, who might undertake predatory actions or make risky acquisitions or mergers. The repeal of this legislation leaves consumers holding the bag if a power company loses money on a non-energy investment. They could just put it on their customers' electric bills.

Not only does this bill not address the problems of the past, it doesn't plan at all for the future. Our reliance on oil and gas today is inescapable, but the need to move toward something better is undeniable. We will invest billions of taxpayer dollars in this bill for a resource that can't possibly sustain us. Our dependence on oil ties us to internal politics of unstable countries around the world. It condemns us to unsustainable levels of pollution. It should not be a very radical idea to suggest that we need to shift the type of energy that we use in this country. We consume almost 25 percent of the world's daily production of oil, though we hold only 3 percent of the world's oil reserves. This is a deficit that we will pay for with lack of control over our own economy and security. We are bound to the price fixing of Middle East suppliers and unrest in South America and the states of the former Soviet Union, and we will continue to be unless we invest in alternate sources of energy and curb the rate at which we consume.

Unfortunately, this bill takes no major steps toward these goals. In fact, the conference refused to include renewable portfolio standards, supported by 52 Senators, which would have required utilities to generate 10 percent of their electricity from renewable energy sources by 2020.

To deal with our dependence on fossil fuels, we must address both supply and demand. But this bill fails to provide us with a sensible energy conservation program. It doesn't address the need to improve fuel efficiency in our cars and trucks. In that regard, we can now count China among the countries with more foresight than this legislation provides on the issue of automobile efficiency. And this bill simply dropped a measure, accepted 99 to 1 by the Senate, that would have instructed the President to reduce our daily oil consumption by a little more than 5 percent by 2013.

Instead of a forward-looking policy on energy, this bill has been turned into a vehicle to undermine our Nation's environmental laws to the benefit of fossil fuel producers. The bill spends $1.8 billion in taxpayer dollars for the purchase of conventional coal-burning technologies, which reduces future demand for "clean-coal." At the same time, subsidies to promote the cleanest coal technologies have been cut by 20 percent.

It rolls back provisions of the Clean Air Act, by allowing communities to bypass compliance deadlines on ozone attainment standards if they can prove that some of the pollution drifts into their area from upwind locations. Unfortunately, almost all communities with poor air quality can meet this test. The result is a significant weakening of the Clean Air Act and a slap in the face to cities, like Wilmington, DE, who have met clean air standards despite dealing with upwind pollution.

This is not only an environmental problem. Currently, 130 million Americans are living in areas that don't comply with the air quality standards, and non-compliance has been linked to an increased occurrence of respiratory problems. A group of health organizations including Physicians for Social Responsibility and the American Lung

Association have estimated that this rollback would cause more than 385,000 asthma attacks and nearly 5,000 hospital admissions per year.

The Clean Water Act has likewise been weakened. Oil and gas drilling sites are exempted in this bill from run-off compliance, and hydraulic fracturing, an oil and gas recovery technique, has been completely removed from regulation under the Safe Drinking Water Act.

These are two major changes, but there are other assaults on the environment. For instance, royalties charged to oil and gas recovery units on public land were reduced; offshore oil drilling in the Outer Continental Shelf was authorized; and, a Senate-approved provision, authorizing research on global climate change, was eliminated. This bill prefers ignorance to understanding when it comes to the most important environmental issues that our planet faces today.

And, in perhaps the most transparent concession to special interests, this bill not only waives liability, retroactively to September 5, for those who have produced the toxic substance, MTBE, that is polluting our ground water supply, but it grants its manufacturers $2 billion in transition funds and doesn't ban the additive until 2014, a provision which can be easily waived by the President or any Governor. This leaves those affected communities with a $29 billion clean up tab.

But, that is not the only tab that this bill leaves with the American people. It leaves us to pay $25 billion, mostly in pork, almost half in backward-looking tax breaks to fossil fuel producers. That is simply too much to be spent on a bad idea. This is not a roadmap, a vision on the horizon, to guide us for the next decade.

This bill fails to give us the comprehensive energy policy our Nation needs in this new century. It does nothing to free us from our dangerous dependence on fossil fuels. It does not set a clear course toward cleaner, more efficient technologies. And it fails to protect our environment. In too many ways it has sacrificed the long-term interests that we all share for short-sighted special interests. We can, we must do better.

Mr. KOHL. Mr. President I regret having to vote against this energy package. The country needs a coherent energy policy to help us tackle the challenges that come with economic growth. Our constituents need to know that when they wake up in the morning, the lights will be on and the energy to power our days will be available.

Our economy needs plentiful, affordable, reliable energy as we struggle to climb out of a devastating period of slow growth and job loss. Unfortunately, this bill does more to meet the needs of special interests than the needs of a growing economy.

We need an energy bill that leads to lower prices, a clean environment, and consumer protection. The bill before us today is a missed opportunity to further any of those goals. It has come up short in its effort to lower natural gas prices for Wisconsin consumers. Natural gas prices have been a roller coaster for the people from my State, and we need a large long term supply to come on line. The North Slope of Alaska was the answer, but this bill has done little to make that supply a reality.

Another problem plaguing consumers in Wisconsin is spikes in gas prices brought on by our overdependence on boutique fuels. Most recently, in southeastern Wisconsin, a fire at a refinery resulted in consumers paying $2 a gallon for gasoline because we could not bring in gasoline from other regions without violating the Clean Air Act. The bill before us could have limited the different blends of gasoline in use around the country, so that if one area had a supply disruption, fuel could be imported from another region. I worked with members of the Wisconsin delegation to include language to solve this problem in the future, but that was not retained in the conference Committee negotiations. Wisconsinites will continue to be held hostage to local refineries during supply disruptions.

I supported provisions in the Senate energy bill that would have created a renewable fuels portfolio standard or RPS. The RPS was going to be an aggressive target that would have created a significant market for renewable energy technologies. While the bill does contain tax provisions to encourage the use of renewable energy, the RPS was a new and exciting effort to wean us of our addiction to fossil fuels. The RPS was dropped in conference, even though it had received several strong votes in the Senate. Many States are creating their own RPS, but a national requirement would have set the renewable energy industry on a path to mainstream success. Instead, we are left with small changes at the margins which will not significantly affect our energy production mix.

High electricity prices over the last few years have made it clear that consumers need better protection from unscrupulous companies. Again the Senate bill contained provisions that would protected consumers from the kind of price gouging schemes created by Enron. My colleagues worked hard to make sure the Federal Energy Regulatory Commission had the teeth and the oversight capability to protect consumers in a world without the Public Utility Holding Company Act. Again the conference turned their back on the Senate provision and embraced House language that defends industry at the expense of State and Federal regulators.

The Congress has squandered another opportunity to craft a far reaching and progressive energy policy for this country. Instead we have chosen to pander to special interests and create a particularly unsavory piece of legislative sausage. The bill before has been laden with three time the tax breaks the President requested, and more than $100 billion in spending. We can do better than this. We should do better than this, which is why I oppose the bill and support the filibuster. Congress owes it to the American people to come back next year and put together a bill that meets the needs of everyone, consumers and industry alike, instead of playing favorites and leaving the taxpayers with the bill.

Mrs. MURRAY. Mr. President, I want to take time to comment on the Energy bill before us today.

It is disappointing that such a massive bill could do so little to promote our energy independence, national security, economy, or environment. It does nothing to protect our rate-payers from the type of energy crisis we faced in the Pacific Northwest and California. Those who claim otherwise are simply masking the real mission of this bill which is a taxpayer giveaway to the big energy companies.

A 1,200-page bill has much to comment on, but I will not take time to detail every concern I have. I want to discuss the electricity title, the lack of a true energy policy, and threats to our environment.

First let me discuss the electricity title of the bill. For those of us from the Pacific Northwest this title was of the utmost concern.

For over 2 years the Pacific Northwest has been struggling against the Federal Energy Regulatory Commission's, FERC, effort to deregulate the transmission system through its promotion of regional transmission organizations, RTOs, and standard market design, SMD, rules.

Two simple points: First, FERC had proposed a solution in search of a problem that doesn't exist in the Pacific Northwest. Second, the one-size-fits-all approach being promoted by FERC would neither work nor be cost-effective in our unique hydropower based system.

With those concerns in mind I have been working with many of my colleagues in the Pacific Northwest and Southeast, who have similar regional concerns, to keep FERC from moving forward with these plans. I am pleased that the bipartisan group has been successful in delaying until 2007 FERC's ability to move forward with SMD.

While the bill delays SMD implementation, it does not permanently stop FERC from ultimately pursuing this power grab, and does nothing to stop RTO development.

In fact, the bill is an outright endorsement of the RTO plan, going so far as to provide incentives to utilities for joining such transmission organizations.

FERC has not demonstrated that such a system in the Pacific Northwest will be an economic benefit to the region and, to date, the majority of Washington State utilities remain opposed to the RTOs. Even with the SMD delay provision, this bill is a threat to the electricity system of the Northwest, and I cannot add my voice to this bill's support of RTOs.

Also of great concern in the electricity title is the bill's failure to deal with market manipulation. The Pacific Northwest and California are still feeling the direct effects of the 2000–2001 energy crisis that we now know was caused, in large measure, by energy companies manipulating prices.

Given the lessons we have learned over the past 3 years, one would have hoped that this Energy bill would aggressively attack these known methods of market manipulation. But that is not the case. This bill only bans one type of manipulation and ignores all the other methodologies we know were used.

By remaining virtually silent on market manipulation, this bill is giving a nod to energy companies to once again employ Fat Boy, Get Shorty, and other infamous price-gouging schemes.

This bill is an open invitation for companies to once again seek to fatten shareholders' wallets at the expense of ratepayers. This is more true now that the bill repeals the Public Utility Company Holding Act, PUHCA, without implementing any countervailing laws to protect against abuse in the industry.

In total, this bill promotes schemes that are counter to Washington's ratepayers and fails to protect them against the manipulative practices that have already raised their rates.

The bill also lacks a comprehensive energy policy.

During the past 3 years of debate on energy I have acknowledged we should recognize the current importance of oil, gas, and coal in our energy production today. But to ensure America's energy security for the future, it must strongly promote energy efficiency, conservation, clean, and renewable energy sources, and should diversify our energy sources.

But rather than aggressively promoting renewable energy and conservation, this bill maintains the status quo. This bill directs billions of taxpayer dollars to traditional energy producers who already have healthy market shares and hardly need Government support.

Of the roughly $23 billion in tax credits in this bill, only $4.9 billion, or 20 percent, would go towards renewable energy or conservation.

I support the production tax credits for wind, solar, geothermal, and biomass renewable energy in this bill, but unfortunately public power is left out of the equation.

Many Washington residents are served by publicly owned utilities and cooperatives and they should receive the same incentives to invest in renewable energy as this bill gives to the for-profit utilities.

Earlier drafts of the tax title included a tradable tax credit for public power investment in renewables. I know that Senate Finance committee members fought for this provision, but unfortunately the President and House objected to the provision.

With so much of Washington and the Pacific Northwest served by public power utilities, it will be much harder to get these type of investments made.

We hear constantly that we need to decrease our reliance on oil from the Middle East and yet this bill does nothing substantive to increase automobile efficiency standards. The United States is the most technologically advanced country in the world. There is no reason we cannot build and produce more fuel-efficient cars.

Without addressing fuel efficiency standards, it is hard to praise this bill for promoting energy efficiency or national security.

In the end, this bill does nothing more than preserve the status quo of energy production in the United States. We are not more secure, we are not more independent, and we have not truly diversified our production sources. All we have done is promote the traditional energy sources of oil, coal, and gas at the expense of our national security and environment.

This bill does serious harm to our environment and our health by effectively turning back the clock on decades-old environmental protections.

First, the bill includes a provision that would amend the Clean Air Act to allow more delays for adhering to the EPA's smog regulations. This provision is not just illogical, it is dangerous.

Second, the bill's provisions for our coastal regions present a threat to an area my State wants protected.

For Washingtonians, the coastal areas are some of the most pristine and cherished natural areas in the State. Under this bill, these areas, along with coastal areas in many other States, would be placed in serious jeopardy.

The bill would grant new authority to the Department of the Interior to authorize energy development projects on the Outer Continental Shelf, OCS, including the transport and storage of oil and gas. At the same time, it would undermine the rights of States to manage their coasts. Under the Coastal Zone Management Act, CZMA, States were given the right to have a say in Federal projects that impacted their coastal regions. This bill would severely compromise these rights.

Third, the bill has alarming environmental implications for drilling and construction projects. It would allow an expedited application process for drilling on Federal lands by requiring the Department of the Interior to automatically approve applications once they have met certain standards, regardless of any outstanding environmental concerns.

It also exempts companies from adhering to the Clean Water Act's runoff regulations for construction and drilling sites. Without adherence to these guidelines, the risk of ground water contamination increases dramatically.

Fourth, I am concerned about a measure to provide legal immunity to chemical companies that produce the gasoline additive MTBE. The toxic substance is known to have caused ground water contamination, and this bill shifts costs for cleanup to taxpayers.

Lastly, this bill contains huge amounts of subsidies for the oil and coal industries. Nearly half of this bill's incentives are given to the oil and coal industries, two of the most environmentally destructive fossil fuels that have contributed to global warming. This is not just irresponsible; it is wrong.

We must actively work to reduce our dependence on foreign oil, but subsidizing the industries and rolling back environmental protections is not a logical methodology.

In contrast, the bill provides less than one-quarter of its incentives to industries that produce renewable energy. The facts are clear. Renewables are simply not the top priority of this piece of legislation.

These are some of the many reasons I cannot support this piece of energy legislation. Not only does it put consumers at risk by repealing necessary protections, but it seriously puts at risk our own health and the health of our environment with the special interest giveaways to the oil, gas, and coal industries.

Finally, let me address the claims about job creation in this bill. For Washington State, a more aggressive promotion of renewable energy could have been a boost to local companies involved in this area of generation, but this bill did not provide that direction.

Proponents have argued that the bill encourages the construction of a natural gas pipeline from Alaska, which would create jobs in Washington State. Unfortunately the bill does not provide the guarantees needed for what could have been an important project. To construct the pipeline, its builders say they would need some protection against gas prices falling below a certain level. But, this bill provides no mechanism for risk mitigation, so according to its own builders, the pipeline will not be built.

The negative aspects of this bill are overwhelming. It fails to adequately address the real problems that we all face. It threatens the environmental progress we have made in the past and the progress we hope to make in the future. Without measures that substantively promote responsible energy use, increased conservation, energy independence, consumer protection, and environmental safeguards, this bill is simply unacceptable.

I cannot support legislation that puts us all in danger, and that is exactly what this bill does. The people of Washington State deserve better, and the people of America deserve better.

Mr. LEVIN. Mr. President, it is difficult to oppose a bill that has a number of provisions that I not only support, but worked to have included in the bill. However, the process and the product are deeply flawed and I cannot support it.

There are many objectionable provisions that were added to this bill that were not in either the House or Senate versions of this legislation; for instance the retroactive MTBE liability waiver, underground storage tank provisions that would require taxpayers, rather than polluters, to pay $2 billion to clean up leaking underground storage tanks containing gasoline and other toxic chemicals, even at sites where viable responsible parties are identifiable, and the numerable State-specific projects that will cost billions of dollars and were, again, not considered by the House or the Senate.

The Senate passed a comprehensive and balanced Energy bill in July. Then, after weeks of closed-door meetings with virtually no input from Democratic conferees, the Republicans put forward this "take it or leave it" Energy bill that is drastically different than the bill that the Senate passed. We have no opportunity to amend this bill, or choose among its good and bad provisions. It is all or nothing.

There are simply too many provisions on the negative side of the ledger. The massive power failure of August 2003, on top of the massive price manipulation perpetrated by Enron and others, provided additional proof, proof that shouldn't have been needed, that the United States' deregulated energy markets are not functioning well. This bill doesn't help that problem. It may make it worse.

The Conference report would repeal the Public Utility Holding Company Act of 1934, PUHCA, longstanding consumer and investor protection legislation governing energy industry structure and consolidation, 1 year after enactment of this bill. Unfortunately, the bill fails to provide adequate protections to prevent industry market manipulation and consumer abuses. Governor Granholm of Michigan has said that replacing PUHCA with "weaker anti-fraud and market manipulation rules" could weaken the States' ability to protect consumers. Further, while the enactment of this legislation's mandatory reliability provisions would be an improvement over the current voluntary system of standards, the bill fails to ensure that regional transmission organizations will have the authority to enforce those standards in order to prevent, or respond effectively to, another blackout. Uncertainty in the power industry threatens our economy and security and creates the loss of investor confidence in U.S. energy markets. If necessary, we should adopt a stand-alone bill that sets mandatory reliability standards, requires utilities to join regional transmission organizations and establishes consistent rules for the enforcement of standards nationwide than pass an Energy bill filled with so many harmful provisions.

In addition, two provisions in this conference report would significantly impede the ability of Federal and State agencies to investigate and prosecute fraud and price manipulation in energy markets. These provisions would make it easier to manipulate energy markets without detection.

Section 1281 of the electricity title states: "Any request for information to a designated contract market, registered derivatives transaction execution facility, board of trade, exchange, or market involving accounts, agreements, contracts, or transactions in commodities (including natural gas, electricity and other energy commodities) within the exclusive jurisdiction of the Commodity Futures Trading Commission shall be directed to the Commodity Futures Trading Commission." Section 332(c) of the oil and gas title contains similar language specifically applicable to investigations by the Federal Energy Regulatory Commission, FERC.

If adopted, this would curtail all State and Federal authority, other than CFTC, to investigate wrongdoing in CFTC-regulated markets. This would impede FERC, Department of Justice, and State investigations of fraud and manipulation in these markets. It would turn the CFTC into an impediment for all other Federal and State investigations into matters within CFTC-regulated markets, which would be an unprecedented intrusion into the enforcement of State and Federal consumer protection laws. Had this approach been in effect in recent years, FERC would not have been able to investigate manipulation of the energy markets, including the fraud and manipulation perpetrated by Enron through EnronOnline.

Section 1282 of the electricity title would impose a higher criminal standard, "knowingly and willfully," for filing false information and for improper round trip trading than exists under current law. The new round trip trading provision is inconsistent with current law and the Cantwell amendment, which prohibited market manipulation in electricity markets, and which recently passed the Senate.

For example, section 4c of the Commodity Exchange Act states it is "unlawful for any person to enter into . . . a transaction . . . involving the purchase or sale of any commodity for future delivery" if the transaction "is, of the character of, or is commonly known to the trade as a 'wash sale' or . . . is a fictitious sale." There is no requirement that the violation be "willful."

Manipulation is difficult to prove even under current law. By raising the burden of proof, this provision will make it nearly impossible to prove illegal round trip trading or wash sales. Rather than weakening the laws preventing fraud and manipulation in energy markets, the Congress should be strengthening these prohibitions.

There are other provisions that would affect FERC's ability to ensure markets are transparent and fair..

The "Enron loophole" was attached during the conference on an omnibus appropriation bill in 2000, and was a factor underlying the massive manipulation of the energy markets in 2000 and 2001. The provisions in this bill, attached under hurried circumstances would widen the loophole and increase the chances of more manipulation and dysfunctional markets. This is the wrong response to the current crisis of confidence and integrity in our energy markets.

I am also disappointed that the conference report on this bill directs the Department of Energy, DOE, to "as expeditiously as practicable, acquire petroleum in amounts sufficient to fill the Strategic Petroleum Reserve to the [1 billion] barrel capacity," but does not include any direction to DOE to fill the SPR in a manner that minimizes the cost to the taxpayer or maximizes the overall supply of oil in the United States. That second direction is critical—otherwise the filling of the SPR could lead to continuing high gas prices.

The Levin-Collins amendment, which was adopted unanimously by the Senate last month, directed DOE to develop procedures to fill the SPR in a manner that minimizes the cost to the taxpayer and maximizes the overall supply of oil in the United States. The Levin-Collins amendment expressed the sense of the Senate that the DOE's current procedures for filling the SPR are too costly for the taxpayers and have not improved our overall energy security.

DOE's internal documents state that filling the SPR without regard to the price and supply of oil in the global markets exacerbates price problems in those markets. By increasing demand for oil at a time when oil is in scarce supply, the SPR program pushes the price of oil up even further. Moreover, when near-term prices are higher than future prices, oil companies will meet the additional demand for crude oil by removing oil from their own inventories rather than purchasing high-priced oil on the spot market. Thus, under these price conditions, which have generally prevailed over the past year and a half, adding oil to the SPR will lead to a corresponding decrease in private sector inventories. Since market prices are so closely tied to inventory levels, filling the SPR under these market conditions both depletes private sector inventories and pushes up prices for America's consumers.

Furthermore, according to the Department of Energy's own analyses, taking costs into consideration—as the DOE did prior to early 2002—can save taxpayers several hundreds of millions of dollars over the span of a few years. Acquiring more oil when prices are low will increase revenues to the Treasury from the sale of high-priced royalty oil that is not needed to fill the SPR. Secondly, allowing oil companies to defer deliveries to the SPR when prices are high in return for the delivery of additional barrels of oil at a later date—as DOE did prior to early 2002—enables the DOE to increase the amount of oil in the SPR without any additional costs.

In summary, the unqualified direction in the bill to DOE to fill the Strategic Petroleum Reserve to 1 billion barrels is likely to increase the cost of crude oil and crude oil products, such as gasoline, home heating oil, and diesel and jet fuel, to American consumers and businesses, as well as to the taxpayer, with uncertain benefits to our national security.

Also, while I support the provision in this legislation that would increase the use of ethanol to 5 billion gallons by 2012 and 3.1 billion gallons by 2005, it needs to be reasonable in a way that ensures the continued viability of the Highway Trust Fund.

Twice the Senate passed legislation that included a Volumetric Ethanol Excise Tax Credit, VTEEC, that would address the shortfall in revenue to the Highway Trust Fund that was caused by the ethanol tax exemption. In addition to taxing ethanol, the VTEEC, as passed by the Senate, would maintain the credit for ethanol production by paying for it from the general treasury, create a biodiesel credit and ensure that all taxes charged on ethanol go to the highway trust fund.

Unfortunately, the arrangement worked out by House and Senate Republicans gives ethanol blenders the new option to receive a 5.2 cent tax credit after paying the federal gas tax or they could continue receiving the current ethanol exemption of 5.2 cents. Since most blenders likely would continue to choose to receive the exemption up front rather than wait for a tax credit, the highway trust fund would still lose billions of dollars per year. Efforts by Senator BAUCUS to address this problem were approved by the Senate conferees, but was refused by the House. While I support increased ethanol production, it is imperative that increased ethanol production does not diminish the Highway Trust Fund.

Additionally, I am troubled that this legislation exempts producers of MTBE from liability. MTBE, an oxygenate that can and should be replaced by ethanol, is a potentially harmful product and its producers should not be exempt from liability. In Michigan, it has been estimated that MTBE has contaminated ground water around over 700 leaking underground storage tank sites. Further, as many as 22 water supply wells have been deemed unusable due to MTBE contamination. Because of this MTBE liability waiver, the State of Michigan may have to pay over $200 million to clean up those sites. Governor Granholm has strongly protested that we need to hold manufacturers accountable for the damage that MTBE does to public health and the environment, not guard them from liability which then allows them to pass the cleanup costs on to the States.

As I stated earlier, this bill has a number of provisions that I support and that I worked to have included in it. These include tax credits for advanced technology vehicles and joint research and development between the Government and the private sector to promote the expanded use of advanced vehicle technologies. But in the end, the good provisions must be weighed against the large number of bad provisions, and there are too many objectionable provisions for me to support this bill.

The Senate has worked to create a national energy policy for years. In just a few weeks, without bipartisan negotiation, this piece of legislation was created. We should work to complete a long-term, comprehensive energy plan that provides consumers with affordable and reliable energy, increases domestic energy supplies in a responsible manner, invests in energy efficiency and renewable energy sources and protects the environment and public health.

Mr. LIEBERMAN. Mr. President, I rise in the strong opposition to the bill before us, the conference Energy Policy Act of 2003. The bill before us is a pork-laden, budget-busting, fossil-fuel promoting vestige of the past, developed largely in secret by a handful of GOP Members. This legislation is a mere shadow of what it was and could be.

This could have been a proud moment for this Congress and for the Nation. Rather than caving to special interests and wallowing in pork barrel politics, we could have risen to the challenge and met our obligation to help prevent such crises as the Enron energy scandal and the blackout of 2003 from reoccurring. We could have acted to promote our economic prosperity, strengthen our national security, and protect the health and welfare of all Americans through bold, balanced legislation. We could have finally tackled global warming—the greatest environmental challenge of our time. We could have considered a real jobs bill, based on opening new markets and spurring new technologies. We could have set American energy policy on a better, brigther course.

Instead, we are stuck with this—a sewer of an Energy bill. The bill that has emerged from the closed door, Republican-only conference, and which we consider today is a legislative disaster. Sadly, it bears little resemblance to the balanced, bipartisan legislation that passed the Senate last July. The Senate bill, which originally passed this body in the 107th Congress, strengthened our national security, safeguarded consumers, and protected the environment, and was developed in open, meaningful, bipartisan fashion.

Before I move to the substance of the conference bill, I must offer a few harsh words with the process of GOP majority employed to produce it. In all my time in the Senate, I have never witnesses a more unfair and unstatesmanlike spectacle. With the exception of the tax provisions of this bill, in which Senator GRASSLEY seized every possibility to involve his Democratic colleagues, this is a thoroughly partisan product.

Here is the way the conference went: One conference meeting at which Democratic conferences offered opening statements only: complete shut out of Democratic conferences from negotiations over the substance of the bill: a few staff-level meetings for show after policy decisions had already been made and reflected in GOP-only developed text; special-interest lobbyists exerting extraordinary influence over the bill; release of a more than 1,000-page document only 48 hours before the scheduled meeting to adopt it—40 percent or more of which was new text. It is inconceivable to me that legislation of this import was developed this way. Quite simply, this process afforded no real opportunity for Democrats to influence the final product and no opportunity for the American public—whom this body is charged to represent—to view and comment on the final product. I second the comments of many of my Democratic colleagues that we will never be subject to a conference like this again.

In dissecting the pork-laden bill that emerged from the smoke-filled back rooms of the conference committee, let me first highlight one provision of extraordinary importance to the State of Connecticut. Connecticut has worked for decades to ensure that the construction and operation of natural gas pipelines and electric cables across our national treasure, the Long Island Sound, fully comply with State and Federal environmental and energy laws. The bill before us contains a provision to permanently activate the Cross Sound Cable—a provision that did not appear in either the House or the Senate bill and as to which no one received advance notice. The Cross Sound Cable had been temporarily activated by Federal order in emergency response to the summer's massive blackout, but had been prevented from permanent activation by the State of Connecticut until it complies with State laws. So much for States rights and environmental and consumer protection. Shameful.

That is only the tip of the iceberg. Let me review the most egregious offenses buried in this bill.

First, subsidies and giveaways to industries and special interests. My good friend, Senator McCAIN, has labeled this bill the porkiest of the porkbarrel, budget-busting bills. CBO estimates that the bill will cost more than $30 billion in industry tax incentives and direct spending. Taxpayers for Common Sense has estimated that it will cost in excess of $90 billion. This stunning price tag includes millions of dollars in direct incentive payments to mature energy industries, including payments to undertake equipment upgrades they would have to do anyway. The bill authorizes $1.1 billion for a nuclear reactor in Idaho to demonstrate uneconomic hydrogen production technologies. It has loan guarantees to build coal plants in several States, provided as last-minute sweeteners to secure Senatorial support for the bill. The bill contains interesting new "green bonds" for five projects throughout the country, by which projects would get financial benefits for "green" construction of primarily shopping centers. One project, in Shreveport, LA includes a new Hooters restaurant. Is this groundbreaking energy legislation? How can we approve legislation gushing money this way given the mushrooming budget deficit? Our neediest citizens will surely pay the cost.

Second, inadequate consumer protections. The bill does not adequately protect consumers against utility mergers and electricity market manipulation. For example, broad, effective prohibitions against price gouging schemes used by Enron and other energy trading firms, which passed the Senate 57 to 40 earlier this month, are excluded from the bill. The legislation repeals the requirements of the Public Utility Holding Company Act, PUHCA, without putting adequate consumer protections in place.

Third, electric transmission line and natural gas pipeline and construction. The bill allows the Secretary of Energy to determine the siting of transmission lines through Federal lands, including national forests and national monuments, except those in the National Park System, over the objection of the responsible Federal agency. The bill overrides State energy and environmental legal authorities to give the Federal Government power to site and construct transmission lines and natural gas pipelines.

Fourth, MTBE liability protection. In a provision added in conference to benefit companies primarily based in Louisiana and Texas, the bill provides retroactive and prospective liability protection for producers of methyl tertiary-butyl ether, MTBE, cutting off the rights of injured Americans across the country and imposing a huge financial burden for cleanup on our States and local communities. Simply unbelievable.

Fifth, environmental protection rollbacks and giveaways. The icing on the cake for this bad bill is the significant environmental protections it strips away for the benefit of energy producers. The bill also contains new provisions to make our air much dirtier. The conference bill would exempt metropolitan areas from meeting the Clean Air Act's ozone-smog standard. This issue was never considered by the Senate or the House and was inserted into the conference report during "conference committee" meetings. A new report from Clean the Air reveals that the ill-conceived Energy bill would have severe public health consequences around the country, especially for children. Delays in implementing the Clean Air Act could lead to nearly 5000 hospitalizations due to respiratory illness and more than 380,000 asthma attacks and 570,000 missed school days each year. The bill exempts all construction activities at oil and gas drilling sites from coverage under the Clean Water Act and removes hydraulic fracturing, an underground oil and gas recovery method, from coverage under the Safe Drinking Water Act. The conference bill expedites energy exploration and development at the expense of current National Environmental Policy Act, NEPA, requirements. Environmental review is waived for all types of energy development projects and facilities on Indian land.

I want to be fair. The conference bill does contain provisions that make limited progress—baby steps only—toward achieving energy goals. And the bill recognizes the political reality that the Senate has spoken forcefully to the fact that it will not permit the Bush administration to drill in another of our Nation's treasures, the Arctic National Wildlife Refuge. You can search the bill to find requirements for renewable fuels, (increase in sales of renewable fuels, including ethanol, from 2 billion gallons to 5 billion gallons by 2012); Federal energy efficiency standards for energy use and appliances; increase in Federal Government purchase of renewable energy, 7.5 percent of electricity from sources such as wind, solar, geothermal, and biomass; funding for energy research and development, including related to hydrogen fuels; and limited tax incentives for alternative vehicles, renewable energy sources, and energy efficiency. That is why some of my colleagues claim this bill articulates an energy program for the 21st century. Hogwash. These weak provisions do not even register on the scale against the predominant special interest, fossilized provisions of the conference bill.

What is this bill missing? Frankly, the list is staggering. I have time to highlight five key areas:

First, renewable portfolio standards. Our Senate-passed bill required utilities to generate 10 percent of their electricity from renewable energy facilities by 2020. Such a provision would spur new technology development and work to wean the country off foreign oil dependence and the drilling-first-and-only mindset that has predominated American energy policy for generations. In addition, the majority touts this bill as a great jobs creation bill; according to studies of the Tellus Institute and Union for Concerned Scientists, the renewable industry would create new, sophisticated job opportunities for hundreds of thousands of Americans.

Second, climate change. Greenhouse gas emissions from the burning of fossil fuels threaten not only our environment, but also our economy and our public health. Should we continue unabated our current rate of polluting, we threaten to disrupt the delicate ecological balance on which our livelihoods and lives depend. This bill is so short-sighted that it contains no provisions of any kind to address climate change.

Third, fuel economy improvements. No credible Energy bill can lack means to improve fuel economy for automobiles and trucks. This is key to reducing our dependence on foreign oil because the transportation sector is the single largest user of petroleum.

Fourth, oil savings provision and specific hydrogen standards. Amendments agreed to by the Senate last summer contained provisions with specific deadlines—real teeth—to reduce our dependence on foreign oil and to move us to the hydrogen fuel program of the future. Neither appears in this bill.

Fifth, Alaska natural gas pipeline. I strongly support the construction of this pipeline, which will bring millions of gallons of natural gas to the lower 48 States and create almost half of the new jobs, 400,000, touted under this bill. The conference bill, however, fails to provide the necessary incentives to enable construction of the Alaska natural gas pipeline, which would prevent the U.S. from becoming more dependent on natural gas imports.

This abominable bill must not be made law. Any Senator serious about advancing America's energy and environmental policies and curtailing Government waste is compelled to vote against the Energy bill before us. We can and must do better. Americans deserve a real Energy bill, one that we can be proud of. This is not it. Let us reject this legislation and return to the drawing board, recommitting ourselves to producing a balanced, innovative, and responsible energy policy for the 21st century.

Ms. SNOWE. Mr. President, as I rise to speak to the issue of the conference report to H.R. 6, the Energy Policy Act of 2003, I want to first recognize the efforts of Energy Committee Chairman DOMENICI and Finance Committee Chairman GRASSLEY for the extraordinary time and effort they have devoted to developing a national energy policy for a 21st century America. Theirs was an arduous task in addressing not only political differences with the bill but also regional ones as well. So I thank them for their work.

This has certainly been a long road. Congress has been debating and voting on a number of energy issues over the past two Congresses, one when under Democratic control and one under Republican leadership. There have been a myriad of issues to consider as we have attempted to shape appropriate policy, and to help increase the public's awareness of the benefits to our health and national security in shifting from foreign fossil fuel imports toward renewable, efficient, and alternative energy sources and manufacturing technologies. Yes, it has been a long, hard road but this conference report simply does not put us on the right road to accomplish these goals for the good of the Nation. We have yet to find that new direction, but we must keep seeking it.

As Theodore Roosevelt once said, "Conservation is a great moral issue, for it involves the patriotic duty of ensuring the safety and continuance of the nation." The conferees had the opportunity to raise the bar for the Nation's future domestic energy systems through new energy policies, through the creation of tax incentives for available and developing technologies, and most of all for incentivizing the entrepreneurial spirit of the American people. But, this goal, in my opinion, has not been reached in the Energy conference report before us.

Since we started to develop new strategies for the Nation's energy policy for the 21st century, we have had to undergo a fundamental reassessment of our energy infrastructure in the aftermath of the horrific events of 9/11 and the ongoing turmoil in the Middle East. We realize now more than ever that we must reduce our vulnerabilities to terrorism with more secure, localized, and reliably distributed energy delivery systems rather than relying solely on our current centralized infrastructure of pipelines, refineries, powerplants, patchwork of electricity grids, and oil tankers berthed in our harbors. The United States simply cannot afford to continue to spend at least $57 billion a year buying oil from the Middle East and continue its upward trend of fossil fuel usage.

The entire world—particularly the developing and fast-growing nations of China, India, and Brazil—desperately needs access to clean, low-cost, energy-efficient and renewable resources. The key is to make the best alternate energy systems that are competitive with today's nonrenewable sources of energy so that they can be developed and used both at home and sold abroad.

Since 2000, I have been proud to have been a member of the Finance Committee where I worked to develop responsible tax incentives to increase the efficiencies of the electricity we produce, the vehicles we drive, the appliances we use, the homes in which we live, and, in turn, enhance the competitiveness of our domestic manufacturers. Our task is to incentivize, through the Tax Code, our U.S. manufacturers to develop and employ the most promising and cost-effective technologies to the U.S. and global marketplace with all due speed.

Unfortunately, the conference report increases oil and gas tax credits to $11.9 billion while conservation and energy efficiency incentives were decreased to $1.5 billion. An equitable balance has not been achieved nor is it a step forward.

We need to expand the mix of the country's energy sources with the realization that power from nuclear and fossil fuels will continue to be a large part of the energy basket in the next decades—but, at the same time, we must encourage safer, cleaner and decentralized sources as well. The conference report before us simply does not progress far enough in this direction, instead maintaining more of a "business as usual" approach to the Nation's energy future.

One of my greatest disappointments is the absence of provisions from the Feinstein-Snowe SUV loophole legislation that would have phased-in changes in CAFE standards requirements in four, attainable stages that would have brought the standards for SUVs in line with passenger cars within the next 8 years. Closing this loophole alone would save our nation approximately 1 million barrels of oil, or fully 10 percent of the oil our vehicles consume on a daily basis.

Right now, all our vehicles combined consume 40 percent of our oil, while coughing up 20 percent of U.S. carbon dioxide emissions—the major greenhouse gas linked to global climate change. To put this in perspective, the amount of carbon dioxide emissions just from U.S. vehicles alone is the equivalent of the fourth highest carbon dioxide emitting country in the world. Given these stunning numbers, I cannot fathom why we continue to allow SUVs to spew three times more pollution into the air than our passenger cars.

Like Senator FEINSTEIN and I, other nations have realized the value of these changes. Even China—a developing country—has great concerns about its increased reliance on foreign oil, so much so that Chinese officials say they have to save energy—and how are they prepared to accomplish this? By implementing more stringent CAFE standards for new vehicles—including those manufactured in the United States—in their country than we currently have in the United States or in this conference report. How ironic that China is more progressive than the United States in their attempts to save energy and decrease dependency in oil imports at the same time that the United States overall fuel economy has actually fallen to its lowest level since 1980.

According to a November 18 New York Times article, vehicles made by Western automakers that do not meet the standards the Chinese Government has drafted may have to be modified to get better gas mileage before the first phase of the new rules becomes effective in July of 2005. I ask unanimous consent to print the November 18 article in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

CHINA SET TO ACT ON FUEL ECONOMY; TOUGHER STANDARDS THAN IN U.S.

(By Keith Bradsher)

GUANGZHOU, CHINA, Nov. 17—The Chinese government is preparing to impose minimum fuel economy standards on new cars for the first time, and the rules will be significantly more stringent than those in the United States, according to Chinese experts involved in drafting them.

The new standards are intended both to save energy and to force automakers to introduce the latest hybrid engines and other technology in China, in hopes of easing the nation's swiftly rising dependence on oil imports from volatile countries in the Middle East.

They are the latest and most ambitious in a series of steps to regulate China's rapidly growing auto industry, after moves earlier this year to require that air bags be provided for both front-seat occupants in most new vehicles and that new family vehicles sold in major cities meet air pollution standards nearly as strict as those in Western Europe and the United States.

Some popular vehicles now built in China by Western automakers, including the Chevrolet Blazer, do not measure up to the standards the government has drafted, and may have to be modified to get better gas mileage before the first phase of the new rules becomes effective in July 2005.

The Chinese initiative comes at a time when Congress is close to completing work on a major energy bill that would make no significant changes in America's fuel economy rules for vehicles. The Chinese standards, in general, call for new cars, vans and sport utility vehicles to get as much as two miles a gallon of fuel more in 2005 than the average required in the United States, and about five miles more in 2008.

This country's economy is booming, and a growing upper class in big cities like this one is rapidly buying all the accouterments of a prosperous Western life, including cars. As China burns more fossil fuels, both in factories and in a rapidly growing fleet of motor vehicles, its contribution to global warming is also rising faster than any other country's.

But Zhang Jianwei, the vice president and top technical official of the Chinese agency that writes vehicle standards, said in a telephone interview on Monday that energy security was the paramount concern in drafting the new automotive fuel economy rules, and that global warming has received little attention.

"China has become an important importer of oil so it has to have regulations to save energy," said Mr. Zhang, who is also deputy secretary of the 39-member interagency committee that approved the rules at a meeting this month.

China was a net oil exporter until a decade ago, but its output has not kept up with soaring demand. It now depends on imports of oil for one-third of its needs, mainly from Saudi Arabia and Angola. Before the war, Iraq was also an important supplier. By comparison, the United States now imports about 55 percent of the oil it uses.

The International Energy Agency predicts that by 2030, the volume of China's oil imports will equal American imports now. Chinese strategists have expressed growing worry about depending on a lifeline of oil tankers stretching across the Indian Ocean, through the Strait of Malacca, a waterway plagued by piracy, and across the South China Sea, protected mainly by the United States Navy.

Various Chinese government agencies still have three months to review the legal language in the fuel economy rules, giving automakers some time to lobby against them; as yet, there has been no mention of the approval of the new rules in the government-controlled Chinese media.

But Mr. Zhang said that the rules in draft form were the product of a very strong consensus among government agencies and that "the technical content won't be changed."

Two executives at Volkswagen, the largest foreign automaker in China, said that representatives of their company and of domestic Chinese automakers attended what they described as the final interagency meeting to approve the rules. Under pressure from the government, these auto industry representatives agreed to the new rules despite misgivings, the executives said. "They had no choice but to agree," one of the Volkswagen executives added.

The executive said that Volkswagen's vehicles would meet the first phase of the standards in 2005, while declining to comment on compliance with the second, more rigorous phase, which is to take effect in July 2008.

The new standards are based on a vehicle's weight—lighter vehicles must go the farthest on a gallon—and on the type of transmission, with manual-shift cars required to go farther than those with less efficient automatic transmissions.

In a major departure from American practice, all new sport utility vehicles and minivans in China would be required to meet the same standards as automatic-shift cars of the same weight. In the United States, standards for sport utilities and minivans are much lower than for cars.

The Chinese rules do not cover pickups or commercial trucks. According to General Motors market research, there is little demand for pickup trucks in China except from businesses, because the affluent urban consumer who can afford a new vehicle regards pickup trucks as unsophisticated and too reminiscent of the horse-drawn carts still used in some rural areas.

Typically, heavy vehicles are much harder on fuel than light ones, but the new Chinese standards permit the heavy vehicles to get only slightly worse gas mileage. As a result, they provide an incentive for manufacturers to offer smaller, lighter vehicles, which will be easier to design.

The new standards would require all small cars sold in China to achieve slightly better gas mileage than the average new small car sold in the United States now gets, according to calculations by An Feng, a consultant who advised the government on the rules. But officials in Beijing would require much better minimum gas mileage for minivans and, especially, S.U.V.'s than the average vehicle of either type now gets in the United States.

American regulations call for each automaker to produce a fleet of passenger cars with an average fuel economy of 27.5 miles a gallon under a combination of city and highway driving with no traffic; window-sticker values for gas mileage, which include the effects of traffic, are about 15 percent lower. Light trucks, including vans, S.U.V.'s and pickups, are allowed an average of 20.7 miles a gallon without traffic.

But the Bush administration has raised the comparable American standard to 22.2 miles a gallon for the 2007 model year and is now completing a review of whether to raise limits further for 2008. The administration is also considering adopting different standards for different weight classes of light trucks.

Over all, average fuel economy in the United States has been eroding since the late 1980's as automakers shifted production from cars to light trucks. It fell in the 2002 model year to the lowest level since 1980. Automakers in Europe have accepted European Union demands to increase fuel economy under different rules that could prove at least as stringent as China's minimums.

The Chinese standards would require the greatest increases for full-size S.U.V.'s like the Ford Expedition, which would have to go as much as 29 percent farther on a gallon of fuel in 2008 than they do now in the United States, Mr. An calculated. Sport utility sales in China have more than doubled so far this year, but are still a much smaller part of the overall market than they are in the United States.

Because the American standards are fleet averages while the Chinese standards are minimums for each vehicle, the effect of the Chinese rules could be considerably more stringent. A manufacturer can sell vehicles in the United States that are far below average in fuel efficiency if it has others in its product line that offset it by being above average. But under the Chinese rules, the fuel-inefficient models—especially new ones introduced after the standards take effect—would be subject to fines no matter how well their siblings do, Mr. Zhang said, and the maker would not be allowed to expand production of the gas-guzzling models. In Garrison Keillor's phrase, China plans to require that every vehicle be above average.

Mr. An said that at the final meetings on the new rules, the only outspoken objections had come from a representative of the Beijing Automotive Industry Holding Company, which makes Jeeps in a joint venture with DaimlerChrysler.

According to people who have seen the new standards, many Jeep models sold in China do not now comply with them; neither do the Chevrolet Blazer sport utilities built by a General Motors joint venture in Shenyang. Some of Volkswagen's car models also fall slightly short, these people said. By contrast, Honda's cars, built at a sprawling factory complex here in Guangzhou, the commercial hub of southern China, would comply easily because they use advanced engine technology, these people said.

Trevor Hale, a DaimlerChrysler spokesman, declined to comment in detail. "DaimlerChrysler complies with local regulations where it does business," Mr. Hale said in an e-mail response to an inquiry. "It continues working to improve fuel economy in the vehicles it develops, builds and sells around the world."

Bernd Leissner, the president of Volkswagen Asia Pacific, said that his company's cars would comply because "it's just a question of how to adapt the engine—it's something that could be done quickly."

The fastest way to improve fuel efficiency is to switch from gasoline to diesel engines, as Volkswagen is starting to do in China. The latest diesel engines are much cleaner then those of a decade ago, but are still more polluting than gasoline engines of similar power.

A spokeswoman for General Motors, which is beginning to introduce Cadillac luxury cars in China, said she did not have enough information about the newly drafted rules to comment on them, but that her company's vehicles were comparable in fuel economy to those of rival manufacturers in the same market segments. Executives of G.M. were preparing for an event in Beijing on Tuesday and Wednesday when the company plans to showcase examples of its work on gasoline-saving fuel-cell and hybrid engines for cars.

In the United States, G.M. has argued that tighter fuel economy rules are unnecessary because technological improvements will someday improve efficiency anyway. G.M. and other automakers have also contended in the United States that higher gasoline taxes would represent a better policy than higher gas mileage standards, because it would give drivers an economic incentive to choose more efficient vehicles and to drive fewer miles.

China is still considering its policy on fuel taxes, but has not acted so far, because higher fuel taxes would impose higher costs on many sections of society, Mr. Zhang said.

Another company that could run into trouble over the Chinese mileage standards is Toyota, which on Nov. 6 began selling a locally produced version of its full-sized Land Cruiser sport utility vehicle in China. A spokesman said on Monday that Toyota had not yet heard about the new Chinese fuel economy regulations, which has been prepared with a level of secrecy typical of many Chinese regulatory actions.

Japan is also phasing in new fuel efficiency standards based on vehicle weight that allow heavier vehicles only slightly worse gas mileage than lighter ones. American automakers have complained that the Japanese rules discriminate against them because Japanese automakers tend to produce slightly lighter cars anyway.

China has more than 100 automakers, as Detroit did a century ago, but the bulk of its output comes from a small number of joint ventures with multinational companies. Total production has more than doubled in the last three years, to about 3.8 million cars and light trucks in 2002, nearly as many as Germany. The United States builds about 12 million a year, Japan about 10 million.

The cars that Chinese automakers produce on their own tend to very small and lightweight, but the engines are built on older technology, and may not have an easy time complying with the new fuel economy standards.

The government has been encouraging the industry to consolidate, and the new rules may hasten that process by forcing investment in engine designs that small companies may not be able to afford on their own.

Ms. SNOWE. Mr. President, just consider for a moment how much the world has changed technologically over the past 25 years. We have seen the advent of the home computer and the information age. Computers are now running our automobiles, and global positioning system devices are guiding drivers to their destinations. Are we to believe that technology couldn't have also helped those drivers burn less fuel in getting there? Are we going to say that, while even a developing country like China is transforming, America doesn't have the wherewithal to make SUVs that get better fuel economy?

We should keep in mind that China is expected to pass the United States in the next 10 years as the largest emitter of manmade carbon dioxide, the major greenhouse gas that the vast majority of international scientists believe is causing global climate change. And, it is interesting to note that there is not one mention of climate change in the entire conference report. Not one reference in a report of over 1,000 pages that is supposed to shape the Nation's energy policy for the 21st century.

Last year's Energy bill—which I remind my colleagues is the bill the Senate actually passed this year—had at least three different titles addressing climate change, including research on abrupt climate change. Also, the administration's National Energy Policy of May, 2001, stated, "Energy-related activities are the primary sources of U.S. man-made greenhouse gas emissions representing about 85 percent of the U.S. man-made total carbon-equivalent emissions in 1998."

Other grave concerns I have involve provisions in the report that will threaten coastal and marine environments and lead to further degradation of our oceans. As Chair of the Subcommittee on Oceans, Fisheries, and Coast Guard, I am troubled by the ramifications of these provisions, as I strongly believe that any changes to U.S. marine policy should only be developed with contributions and oversight of the subcommittee.

For example, under section 321 of title III, the bill grants sole authority for all energy-related projects in the Outer Continental Shelf to the Secretary of the Interior. Currently, protecting these ecosystems is the responsibility of the Department of Commerce. This section does not suggest that the Department of the Interior should even consult with Commerce.

Two other sections in this bill would limit the ability of the Secretary of Commerce and coastal States to guide, plan, and regulate activities that affect coastal and ocean resources and that occur in offshore areas— a right they currently have under the Coastal Zone Management Act.

Further, section 325 would shorten the timeframes for submitting information and appealing the permitting decisions for offshore activities that are inconsistent with States' coastal management plans—regardless of the quality or quantity of information received. Another section, section 330 would limit all appeals or reviews of offshore energy action to the Federal Energy Regulatory Commission record. I believe that the Secretary of Commerce should have the discretion to develop a record that is relevant to issues on appeal.

These provisions are inconsistent with the administration's proposed rule amending the appeals processes, and they conflict with the goals and purposes of the Coastal Zone Management Act reauthorization bill, S. 241, I introduced last January. Moreover, the U.S. Commission on Ocean Policy, established and appointed by President Bush pursuant to the Oceans Act of 2000, is poised to present its recommendations to Congress on offshore energy and other ocean-related issues.

All of these provisions have serious consequences for marine environmental health, and they should not be hastily adopted without the thoughtful input of the Commerce Committee, the administration, and the U.S. Commission on Ocean Policy.

Moving from our oceans to our air, there are other disturbing provisions in the conference report that have been raised by many of my colleagues. For instance, the report contains a provision delaying clean air protections for millions of Americans, leading to thousands of additional asthma attacks—and that is of particular concern to me as my State of Maine leads the Nation in per capita cases of asthma.

Also, I am disappointed that the conference report contains no renewable portfolio standard, or RPS, to raise the amount of renewable energy as a source of electricity nationwide by increasing the percentage of electricity produced from wind, solar, geothermal, incremental hydropower, and clean biomass that produces electricity from burning forest waste.

The conference report does not ban MTBE that is polluting our ground water for another decade rather than the 4 years in the Senate bill, while at the same time virtually dismissing pending lawsuits states already have filed against MTBE producers for cleanup. State officials in Maine do not approve of extending the ban on MTBE or the fact that the heavy financial burden of cleanup will shift to the communities and water users because MTBE producers receive a safe harbor from lawsuits in the report.

For hydropower, the conference report provisions give the last say for hydropower permits to industry and does not give equal weight to the agencies/stakeholders process that has worked so well in Maine for reaching consensus on hydropower decisions, especially for dam removals.

On electricity reliability, the report holds up FERC's ability to go forward with its standard market design for regional transmission organizations—or RTOs except on a voluntary basis, until 2007. A voluntary only program, however, does not spur the capital needed right now for increased electricity transmission in New England, for instance. I hope my colleagues are aware that the New England RTO kept the great majority of New England's electricity grid working and the lights on during the blackout of August of 2003. Actually, the only component of the electricity title that effectively addresses the basic causes of the 2003 blackout is the establishment of electric reliability organizations that would enforce reliability standards through improved communication standards and would be overseen by FERC.

Regarding consumer protections, the conference report repeals PUHCA, the Public Utility Holding Company Act, that currently protects consumers from higher electricity prices. However, the conference report contains little language that ensures that consumers are shielded from higher bills resulting from, for instance, large electricity and gas convergence mergers. Public Power, co-ops and municipalities, who represent 25 percent of the industry, are especially vulnerable to the lack of adequate consumer protections in the report.

Also, the conferees stripped the tradable tax credits for Public Power that I and others had included in the Senate Finance Committee amendment. These tradable tax credits would have allowed Public Power to invest in renewable energy and assist them in decreasing their CO2 emissions by moving away from burning as much coal as they currently do.

On fiscal policy, I do not believe the conference report shows fiscal restraint or uses taxpayer dollars wisely. The fiscal year 2004 budget resolution calls for approximately $15.5 billion to be spent on tax incentives, and the Senate Finance Committee stayed within this budget blueprint. The conference report contains $24 billion in tax incentives plus another $5.4 billion in spending and with no offsets.

One of my concerns is that important tax incentives that appeared in the Senate and House Energy bills over the past 2 years have not been included in the conference. Where they have been included, they are so pared back that I question whether the various industries will take advantage of the smaller energy efficiency tax incentives provided, particularly for the construction, lighting, and heating, ventilation and air-conditioning, or HVAC, for commercial buildings.

Gone are provisions for tax incentives to promote the use of more efficient air-conditioners, even though 70 percent of the energy demand in peak periods is for air-conditioners, and that was a significant factor in last August's major blackout in the Northeast. The lack of these provisions that could be instrumental in the short term for energy savings simply does not move the Nation's energy policy forward into this century.

The knowledge of alternative and renewable sources has been known for over a century as the simple principle of fuel cells —combining hydrogen and oxygen to produce electricity and pure water—and the photovoltaic principle behind the solar power of the sun, were both discussed in 1839—164 years ago. We should ask ourselves why, instead of our daily diet of approximately 19 million barrels of oil a day, we are not also choosing to bolster even more the development of these sources of renewable energy for our consumption and to grow our economy.

Imagine automobiles driven by fuel cells—our U.S. auto manufacturers and the Federal Government are beginning to invest in fuel cells. Imagine businesses and homes having their own free-standing and reliable fuel cells—one of the cleanest means of generating electricity—that Senator LIEBERMAN and I have promoted. Fuel cells can provide electricity instead of our current vast, centralized fossil fuel systems that make our air dirtier and less healthy, causing us to spend millions more on health care each year. We need to be more serious about promoting these technologies.

I do not believe that the Energy conference report before us sets the Nation on the right course for the future and well being of the Nation, and I will, regretfully, vote against the conference report with the hope that Congress can continue working toward a more meaningful, secure, and balanced energy-efficient future for the Nation.

Mr. DORGAN. Mr. President, I rise to support the Energy conference report. While I have some serious concerns about the way this bill was created, I believe our country will be better off with this bill than without it. On balance, it will advance our interests.

This bill takes important, major steps toward developing renewable and limitless sources of energy such as ethanol, wind, and biodiesel. It puts us on the road to the development of a new hydrogen fuel cell economy, which is essential if we are to lessen our dependence on foreign oil. And it contains important conservation measures by improving efficient standards on appliances and other devices we use in our daily lives. If we are serious about security our energy future, I believe we must implement these measures without delay.

Additionally, this bill enhances our ability to develop more traditional sources of energy, while protecting our environment. It contains strong provisions to promote clean coal technology so that we can more effectively use our coal resources without degrading our environment. The bill also funds a pipeline to access over 30 million cubic feet of natural gas in Alaska and bring it to the lower 48 States. And it provides additional incentives for the discovery and recovery of oil and natural gas.

There is much in this bill that is positive, and I intend to vote for it. Having said that, I know this bill is far from perfect. But in some important matters, it is a step in the right direction.

The bill omits a renewable portfolio standard, RPS, that would have required utilities to produce 10 percent of their electricity from renewable sources. That is a serious omission. A majority of the Senate conferees voted to add this amendment to the conference measure and it passed. Unfortunately, the House stripped this amendment out without even debating it. I want to make it clear that I have not given up on this issue. I want to inform those who blocked this provision—get ready. I am going to keep fighting until we get an RPS standards enacted into law.

Unfortunately, this bill also provides liability protection for the producers of the fuel additive, MTBE. This is a major mistake. Insulating the big oil companies, while making the mom and pop gas stations of America liable for the costs of cleaning up these contaminated sites is simply wrong and bad policy.

I also want to address concerns that the bill waives a number of other important environmental provisions. For years, the administration has complained that the process of siting and permitting new energy projects is cumbersome and in the name of efficiency needs to be modified. This measure does that. But let me caution the administration for a moment. While Congress has provided discretion to the appropriate agencies in an effort to streamline the process, these agencies will be held accountable if they violate the spirit and trust we have given them. I expect these agencies to make informed decisions based on public input, sound science, and common sense.

Additionally, as a member and former chairman of the Commerce Committee's Consumer Affairs Subcommittee, let me address the issue of consumer protection. This bill repeals the Public Utility Holding Company Act and does not, in my opinion, go far enough to protect consumers from price gouging. Congress will be watching very closely to ensure that the agencies responsible for preventing market consolidation and market manipulation are doing their job. I believe we must keep pushing to get better protections for consumers. The experience on the west coast in recent years is a painful reminder that corporate power, if left unchecked, can cause serious injury to our consumers.

These deficiencies in the Energy bill could have been avoided had the majority party included Democratic conferees in a meaningful dialogue. Instead, Democrats were frozen out of the Energy conference. It was a flawed and arrogant process that prevented the American people from getting the best of what both political parties had to offer in the development of a national energy policy.

However, does the lack of involvement lessen the need for us to take steps to reduce our dependence on foreign oil? Does it lessen our need to promote energy efficiency and energy conservation? Does it lessen our need to promote the use of renewable energy and renewable fuels and vehicles? I believe the answer to all of these questions is no.

I will vote for the conference report, because on balance, this bill is a net plus for America. But my vote is in no way an endorsement of the manner in which the majority conducted this conference. In the future, before conferees are appointed, we will insist on a commitment that both political parties be represented in the deliberations of the conference.

These concerns aside, we must remember that energy is vital to our economy and our way of life. We count on a reliable energy supply for our everyday needs—heat, light, electricity, and all of the things that keep our society productive. Our economy would be devastated if we lost access to that supply, and were left without alternatives.

If, God forbid, terrorists would shut off the supply of oil to our country tomorrow, our economy would be flat on its back. We now import 55 percent of the oil we use, much of it from troubled parts of the world. That holds our economy hostage to this growing dependence on imported oil, in particular to the Middle East.

We need a new energy future that contains strong provisions dealing with conservation, aggressive approaches to renewable and limitless sources of energy, and embraces a new hydrogen fuel cell future which can allow us to break our dependence on foreign oil.

If a meaningful energy policy is analogous to a novel, then this bill is just a first chapter. It is not as comprehensive, as wise, or as bold as the American people have a right to expect. Let me reiterate, this is not a be-all-end-all comprehensive Energy bill, no matter who tells you it is. I am prepared to continue to modify, amend, and reform this measure as many times and as long as it takes in order to ensure it does what it is supposed to do: create a fair and balanced national energy policy, one that works to advance our country's interest.

In closing, we are left with two choices: one, do nothing and pray we don't have further blackouts, further price spikes, or God forbid, a terrorist strike on our supply of foreign oil; or two, enact the proposed energy legislation and use it as the first brick in the foundation of crafting a comprehensive energy policy that will reduce our dependence on foreign oil and strengthen our energy diversity and security.

Given these two choices, I choose action over inaction and urge my colleagues to do the same.

The PRESIDING OFFICER. The Senator from Kansas is recognized.

Mr. ROBERTS. Mr. President, it is my understanding that the pending business before the Senate is the Intelligence conference report; is that correct?

The PRESIDING OFFICER. The Senator is correct.

Mr. ROBERTS. Mr. President, I rise today to urge Senate passage of the conference report for the Fiscal Year 2004 Intelligence Authorization Act.

On November 20 the conference report was approved by the House of Representatives. In order to quickly provide the Intelligence Community the authorities it requires in order to pay, house, and equip its personnel for our most sensitive and critical national security work, this legislation should be sent to the President without delay. The horrible terrorist attacks in Turkey underscore the urgency of our task.

This conference report is good legislation with important management and budget authorities. I will review just a few of them for you.

In the conference report, the Senate receded to a number of significant House provisions of interest. The most significant of these is a provision that will consolidate and organize existing intelligence-related functions in the Department of the Treasury by creating a new Office of Intelligence and Analysis. This administration-supported provision also creates a new Assistant Secretary position.

Senate managers also accepted a House provision intended to foster better information-sharing among Federal, State and local government officials. The bombings in Turkey illustrate that terrorists remain capable of striking at the heart of peaceful societies. We must be prepared to meet this continuing threat.

The conference report retains a Senate provision on Central Intelligence Agency Compensation Reform, with a House amendment to ensure that Congress will have an opportunity to assess the impact of such reform before it becomes permanent.

The conference report provides important new personal services contracting authority to the Director of the Federal Bureau of Investigations. This authority is intended to permit the Director to exercise greater hiring flexibility as was recommended post-9/11 in order to bring aboard certain categories of critically-needed skills more quickly.

Turning to the budget, when we began to review the President's fiscal year 2004 request I became very concerned at the recent growth in intelligence funding. I am still concerned.

There is clearly not enough money in future years to fully fund the intelligence programs in this year's budget request. That is the sad reality of this budget. The intelligence community is stretched thin, with far more requirements than available funds. Too many projects and activities have been started that cannot be accommodated in the top line. It does not matter what caused this problem. The problem exists. Unless the President directs a dramatic and sustained increase to the intelligence budget next year, we will have to make the hard choices ourselves.

A significant issue that must be addressed by the executive branch is the manner in which cost estimates for the procurement of major intelligence community systems are conducted. The magnitude and consistency in the cost growth on recent acquisitions indicates a systemic intelligence community bias to underestimate the cost of major systems.

This "perceived affordability" creates difficulties in the out years as the National Foreign Intelligence Program becomes burdened with content that is more costly than the budgeted funding. This underestimation of future costs has resulted in significant re-shuffling of NFIP funds to meet emerging shortfalls.

In an attempt to correct this problem, the conference report contains a provision which would mandate a fundamentally more sound approach to cost estimates for major systems. The business-as-usual approach must end.

There is another area I wish to mention in general terms concerning the analytical capabilities of the intelligence community. All recent after-action reports or studies of intelligence failures point to the inability of analysts to process ever-growing quantities of information. In an effort to correct this problem, the conferees agreed to move funds to programs at the Defense Intelligence Agency, the National Security Agency, and the CIA to improve the community's analytic capabilities.

My key objectives in formulating the conference report were to ensure our Nation's continuing effort to prosecute the war on terrorism and to ensure that the "longer view" about intelligence community requirements is taken into account. I believe that this conference report meets both objectives.

We met those objectives because we had bipartisan cooperation when and where it counted. I wish to thank the distinguished vice chairman, Senator ROCKEFELLER, as well as the distinguished House chairman, Representative GOSS, and his ranking member, Representative HARMAN, for their assistance in making the conference report possible. The staff of both intelligence Committees must also be commended for their diligent work on this important legislation.

There is no opposition on our side of the aisle. We have worked very hard with the House to come up with a good compromise. This bill is vitally needed on behalf of national security. A similar bill passed the Senate several weeks ago by unanimous consent.

I yield to my distinguished colleague, the vice chairman, Senator ROCKEFELLER.

The PRESIDING OFFICER. The Senator from West Virginia is recognized.

Mr. ROCKEFELLER. Mr. President, I agree with the chairman of the committee, the Senator from Kansas. There is no objection on this side. It has been cleared. There is no objection on our side. I presume the bill will be voted through.

Mr. President, I am pleased to join the distinguished chairman of the Select Committee on Intelligence in recommending passage of the conference report on H.R. 2417, the Intelligence Authorization Act for Fiscal Year 2004.

The bill authorizes appropriations for the Central Intelligence Agency, the Defense Intelligence Agency, the National Security Agency, and the intelligence components of the F.B.I. and other U.S. government agencies. It also contains a number of important provisions intended to lay the foundation for process and organizational changes in the intelligence community.

The classified nature of U.S. intelligence activities prevents us from disclosing publicly the details of our budgetary recommendations. As I described to the Senate when our bill was considered in July, 10 years ago I joined a majority of Senate colleagues in voting to express the sense of Congress that the aggregate amount requested, authorized, and spent for intelligence should be disclosed to the public in an appropriate manner. The House opposed the provision. I continue to believe that we should find a means, consistent with national security, of sharing with the American taxpayer information about the total amount, although not the details, of our intelligence spending. In holding the intelligence community accountable for performance, and the Congress and the President accountable for the resources they provide to the Intelligence Community, citizens should know the Nation's overall investment in intelligence.

The bill includes a number of provisions intended to promote innovations in information sharing, human intelligence, and counterintelligence, among other things. Many of these initiatives represent initial steps rather than solutions, but they are necessary to raise the level of awareness in Congress and the executive branch regarding a variety of urgent and complex challenges and to lay the foundation for reforms the committee will be considering next year.

Section 351 of the bill requires a report on the threat posed by espionage in an era when secrets are stored on powerful, classified U.S. computer networks rather than on paper. A single spy today can remove more information on a disk than spies of yesteryear could remove with a truck. We have already suffered losses, for example, in the Ames, Regan, and Hanssen cases, where sloppy computer security permitted traitors to exploit large quantities of highly classified information. Unfortunately, these cases provide a warning that appears to have gone largely unheeded. We still do not have a cohesive set of policies and procedures to protect our classified networks from cleared insiders who seek to betray their country. Our reliance on classified information systems for warfighting and intelligence is growing daily, yet hundreds of thousands of individuals have virtually unrestricted access to these critical networks.

All but a few Government personnel are honest and patriotic Americans, but the sad fact is that there has not been a day since WWII when we have not had spies within our Government. There have been over 80 espionage convictions in the last 25 years. They include personnel from the Army, Navy, Air Force, Marine Corps, NSA, CIA, FBI, State Department, the National Reconnaissance Office and the Office of the Secretary of Defense. It is a very real and continuing problem and there will undoubtedly be more espionage arrests in the months and years ahead. Espionage is an unfortunate fact of life, and we simply cannot afford to operate classified systems in which thousands of individuals enjoy the ability to download or upload classified information at will.

Other countries are seeking to exploit this situation to collect defense secrets, and no doubt contemplate blinding our Government and troops in time of war. We would never permit such broad access to weapons in an armory, yet these classified systems are of much greater strategic significance than M-16 rifles, tanks, or 500 pound gravity bombs. We simply must develop the policies and capabilities necessary to control input and output devices on these systems and monitor their use.

Section 352 of the bill calls for a review of our cumbersome, outmoded, and many would say ineffective personnel security system. It is a fact that almost every spy has held high-level security clearances. It is also a fact that few, if any of these individuals were identified through routine security clearance updates.

Most people who become spies join the government with no intention of betraying their country. Research by the Defense Department shows that most spies are people who develop grievances as their careers progress, at times having developed money and alcohol problems as well, and then turn to espionage as a way of feeding their egos and their bank accounts.

Yet, we give a young, single Navy recruit seeking an intelligence assignment the same scrutiny as a 30-year intelligence operative with financial troubles who routinely travels to countries of concern. Further, even when derogatory information surfaces, sometimes even very disturbing information which raises serious espionage issues, the government rarely revokes the clearances we rely on so heavily and which cost so much.

In the information age, we cannot wait 5 to10 years to identify employee problems that may be related to espionage. Too much damage can be done too quickly. We need fresh thinking and recommendations that will provide more effective security for the large sums of money the taxpayer is investing.

Section 354 of our bill calls for a review of classified information sharing policies within the Federal Government. This is an issue closely related to the foregoing provisions regarding inadequate security policies. ATM machines, for example, are a wonderfully convenient and effective means of providing access to banking resources—but they could not exist without magnetic cards, personal identification numbers, cameras and locks. Similarly, improved security is not a barrier to more flexible information sharing, it is a fundamental ingredient. The Joint Inquiry report on the 9/11 attacks highlighted information sharing as a critical shortcoming that prevented the interception of several hijackers. To help accelerate reform, the Joint Inquiry requested an administration report by this past June 30 on progress to reduce barriers among intelligence and law enforcement agencies engaged in counterterrorism. Unfortunately, no report has been submitted.

We have the technology for improved information sharing, and significant progress is being made. A Terrorist Threat Integration Center has been established, and new guidelines regarding sharing of grand jury information have been promulgated. These are very important steps forward. But to truly break down the barriers to information sharing, rather than relying on workarounds, we need revised policies on sharing classified information which recognize and exploit the opportunities provided by modern information technology. This is especially important as we look to bridging the gap between the Intelligence Community and organizations charged with Homeland Security.

Section 355 of the bill identifies a problem that would probably stun most taxpayers. Simply stated, notwithstanding the many billions of dollars invested in complex intelligence systems, ranging from satellites, to aircraft, to ships, and land-based collection platforms, there is no capability in the executive branch to independently and comprehensively model the performance of these systems. Consequently, new multi-billion-dollar systems are procured without the ability to rigorously evaluate potential trade-offs with other systems.

Questions such as these should be asked: Given projected satellite, aircraft and UAV constellations, what is the marginal value of adding space-based radar satellites? Are there alternative investments that can better satisfy intelligence requirements? Don't senior policymakers need the ability to systematically examine the interactions of these many systems to identify trade-offs that can be achieved?

Currently, most of the analysis of proposed collection systems is performed by the agencies seeking to justify their programs, or by senior policy officials who struggle to apply common sense and spread-sheet level analysis to systems that often have overlapping capabilities. There is no reason that a rigorous, independent and comprehensive capability cannot be developed to support the programmatic reviews of the DCI and the Defense Department. This is but one example, though an important one, of the ways in which we believe the intelligence community can improve its strategic planning and decisionmaking processes.

Section 356 of the bill raises an issue of profound strategic significance for the United States, namely the growing reliance of our country on hardware and software produced overseas. Although specific cases are classified, this is clearly a growing problem.

After 1973, when the risks inherent in America's reliance on foreign oil became clear, many positive steps were taken to ameliorate our national vulnerabilities. Those steps included establishment of a strategic petroleum reserve, establishment of the Central Command, and research into alternative fuels. Unlike our dependence on foreign oil, however, our rapidly growing dependence on foreign hardware and software creates numerous opportunities for espionage and information operations that are extremely difficult to detect. Ironically, the countries identified by the FBI as most actively engaged in economic espionage against the United States are leading producers of the hardware and software we all use on a daily basis.

The plain truth is that even the Defense Department does not know where most of the hardware and software it uses originates. Moreover, the Government does not have the right to examine source code unless voluntarily supplied. Further, at the present time, there are limited capabilities for analyzing source code that is made available. This situation requires serious attention by senior policymakers, including Congress, and the report required by section 356 should help to prompt a long overdue discussion of these issues.

In concluding my remarks, I would like to look beyond our current bill to the issues the Intelligence Committee must contend with next year. Other committees share responsibility for reviewing the funding and systems needed by the intelligence community, but our committee is uniquely positioned to evaluate the intelligence community's performance—both its successes and failures—and to identify the changes required to meet the challenges of the future.

In my view, money alone is not sufficient to enable the intelligence community to reach its full potential. The current structure of the intelligence community is fundamentally unchanged from its establishment in 1947. Serious change is long overdue. I strongly believe that new structures and authorities, coupled with able and aggressive leadership, are required to dramatically improve our intelligence community's efficiency and effectiveness.

In many respects, the organizational issues confronting the intelligence community are analogous to those confronting the Defense Department prior to the Goldwater-Nichols Act. The fundamental problem confronting the Department of Defense prior to Goldwater-Nichols was excessive military service control over military operations, policies and budgets. In response, Congress strengthened the weak integrating mechanisms in DoD, specifically the Chairman of the Joint Chiefs and the Commanders of the Combatant Commands. The difference in military performance before Goldwater-Nichols—e.g., Desert 1, Lebanon, and Grenada—and after—Panama, Haiti, and Iraq—is stark and clear. In fact, I am convinced that the Goldwater-Nichols Act did more to enhance U.S. national security than any weapons system ever procured by the Department of Defense.

Although the Goldwater-Nichols reorganization is not a precise template for restructuring the intelligence community, the problems are fundamentally similar: towering vertical structures—NSA, CIA, DIA, NRO, NIMA, the service intelligence components—and relatively weak integrating mechanisms—the DCI and his Community Management Staff. Any reorganization proposal needs to address this fundamental problem of inadequate integration and coordination. In that regard, I would suggest that the intelligence community's lack of responsiveness to the DCI's declaration of war on al-Qaida prior to 9/11 was in part a result of the DCI's weak community management authorities and inability to move the system. I am convinced that a strengthened DCI could more effectively manage the intelligence community, leading to performance improvements comparable to those achieved by the military in the wake of the Goldwater-Nichols Act.

A conservative, incremental approach would involve the creation of a permanent cadre to staff the DCI much as the Secretary of Defense has an OSD staff. This simple change, coupled with aggressive business process re-engineering and "year of execution budget authority" for the DCI over NFIP programs, would significantly strengthen the DCI's ability to manage the intelligence community and respond to new threats and opportunities.

A more aggressive and far-reaching plan would have to address the fundamental changes that have occurred since the current structure was established by the National Security Act of 1947. Specifically, it would recognize that the once useful distinction between home and abroad has become not only irrelevant, but dysfunctional. This is not to suggest any need to reduce the protections afforded U.S. persons under the Constitution, merely that globalization and the development of cyberspace, combined with the rise of apocalyptic terrorists groups empowered by lethal new technologies, require a different, more agile structure that is not impeded by outmoded geographic distinctions. In that regard, we should find ways to more effectively coordinate foreign and domestic intelligence.

Achievement of any substantial reorganization will require meticulous research by the congressional oversight committees, a substantial hearing record, and sustained interest by the administration. At the end of the day, incremental steps will be better than none, and a more aggressive reorganization require a consensus not only on the Intelligence Authorization Committees, but with the Armed Services Committees as well. As challenging as these issues are, we simply cannot fulfill our duty to the American people unless we confront these crucial issues when Congress returns next year.

In conclusion, the important steps we have taken with this measure, to include full funding of the administration's requests for intelligence activities, are the result of lengthy deliberations on matters as complex as they are vital. It is gratifying to see the work that has been done in both Chambers come together today in a bill we can send to the President. It is a useful first step, but only a first step, towards the development of an intelligence community better able to adapt to the rapidly evolving threats confronting our great nation.

Finally, I would like to thank the chairman and the Committee staff for their arduous work on this bill. I look forward to making great strides together next year.

I urge support for this measure.

OFFICE OF INTELLIGENCE AND ANALYSIS

Mr. SHELBY. Mr. President, I rise in my capacity as the chairman of the Committee on Banking, Housing and Urban Affairs regarding the Conference Report to accompany H.R. 2417, the Intelligence Authorization Act of 2004. Section 105 of the act will create a new Office of Intelligence and Analysis within the Department of the Treasury. The Office is to be headed by a newly authorized Assistant Secretary for Intelligence and Analysis appointed by the President and confirmed by the Senate. It will enhance the Department's access to intelligence community information and permit a reorganization and upgrading of the scope and capacities of Treasury's intelligence functions in light of the Nation's counterterrorist and economic sanctions programs. This section was drafted with bipartisan participation and close coordination with the Department of the Treasury.

The particular terms governing the new office are important to me as chairman of the Committee on Banking, Housing, and Urban Affairs over legislative and oversight matters relating, inter alia, to the Nation's economic sanctions laws and the Bank Secrecy Act, and, more generally, because of the importance of carefully delineating the limitations on any part of the U.S. intelligence community that lie within the structure of an executive department of the Government. I have a letter signed by the ranking member of the Banking Committee, Senator PAUL S. SARBANES, and myself addressed to Secretary of the Treasury John W. Snow, as well as Secretary Snow's response. This letter reflects the agreement of Treasury about the organization, structure and role of the new Office and Assistant Secretary position created and important related organizational matters concerning the Financial Crimes Enforcement Network and the Office of Foreign Assets Control.

I request unanimous consent that the two letters be included in the RECORD. They provide, I believe, a good statement of congressional intent with regard to the establishment of the new Office and the new Assistant Secretary position. At this time I would yield the floor to the ranking member of the committee on Banking, Housing and Urban Affairs, Senator SARBANES.

Mr. SARBANES. I thank the Senator. I simply want to note my agreement with the chairman and with his request to include the two letters in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. SENATE, COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS,
Washington, DC, November 20, 2003.

Hon. JOHN W. SNOWE,
Secretary of the Treasury, Department of the Treasury, Washington, DC.

DEAR SECRETARY SNOWE: A proposed amendment to section 105 of the Intelligence Authorization Act of 2004, H.R. 2417, would create a new Office of Intelligence and Analysis within the Department of the Treasury. The Office would be headed by a newly-authorized Assistant Secretary for Intelligence and Analysis appointed by the President and confirmed by the Senate. The Office would enhance the Department's access to Intelligence Community information and permit a reorganization and upgrading of the scope and capacities of Treasury's intelligence functions in light of the nation's counterterrorist and economic sanctions programs.

We are writing to you to confirm formally, before consideration of the amendment proceeds, your and our mutual understanding of the role of the proposed new Office and Assistant Secretary within the Department of the Treasury. Such confirmation is necessary because of the authority of the Senate Committee on Banking, Housing, and Urban Affairs over legislative and oversight matters relating, inter alia, to the Nation's economic sanctions laws and the Bank Secrecy Act, and, more generally, to the Nation's financial system. In that context, the Committee is necessarily concerned with the careful delineation of the functions, and limitations, of any part of the U.S. Intelligence Community that lies within the structure of the Department of the Treasury.

Based on discussions between members of our staffs and the Assistant Secretary of the Treasury (Legislative Affairs), we understand that:

1. The new Office is to be responsible for the receipt, collation, analysis, and dissemination of all foreign intelligence and foreign counterintelligence information relevant to the operations and responsibilities of the Treasury Department, and to have such other directly related duties and authorities as the Secretary of the Treasury may assign to it. The new Office will replace and absorb the duties and personnel of Treasury's present Office of Intelligence Support ("OIS") and will carry on OIS' work in the provision of information for use of the Department's senior policy makers.

2. The Assistant Secretary for Intelligence and Analysis will report to an Under Secretary of the Treasury (Enforcement) as required by the statute. The Assistant Secretary for Intelligence and Analysis will at no time supervise any organization other than the new Office or assume any other policy or supervisory duties not directly related to that Office.

3. The Secretary will seek prompt designation of a new appointee for the vacant position of Under Secretary, and ensure the chain of command will be organized and implemented as outlined above.

4. Our mutual understanding is that Treasury plans to have an official appointed to a vacant Assistant Secretary position. The official appointed to that position will supervise the Office of Foreign Assets Control ("OFAC") and the Financial Crimes Enforcement Network ("FinCEN") as well as other functions, but he or she will at no time supervise the Office of Intelligence and Analysis. This Assistant Secretary also will report to the Under Secretary referred to in paragraphs 2. and 3., above.

5. The general responsibilities of OFAC and FinCEN will not be changed in the course of creating the new Office and these new positions. However, it is anticipated that the new Office will coordinate and oversee all work involving intelligence analysts who work in OFAC and FinCEN (or in other parts of the Treasury) primarily with classified information, in the interest of creating the more robust analytic capability at Treasury that was the articulated reason for the authorization of this new Office. One of the primary tasks of the new Office will be to examine and analyze classified information, in conjunction with the relevant unclassified information already available to OFAC and FinCEN, so that the resultant product can be of use to OFAC and FinCEN as well as to other agencies, under applicable legal rules. Thus, the new Office will have access to all relevant information held by FinCEN and OFAC for national security and anti-terrorism purposes.

The expertise of the Department of the Treasury is necessary and integral to our Nation's security and to success in the war on terrorism. We expect within the next year to highlight your efforts in this area in one of the series of Terror Finance hearings to be held by the Committee, and we look forward to hearing at that time about the innovative approaches to counter-terrorism efforts that the proposed revitalization of Treasury's capacity for financial intelligence analysis can produce.

Sincerely,

RICHARD C. SHELBY,
Chairman, Committee on Banking, Housing and Urban Affairs.
PAUL S. SARBANES,
Ranking Member, Committee on Banking, Housing and Urban Affairs.

DEPARTMENT OF THE TREASURY,
Washington, DC, November 21, 2003.

Hon. RICHARD SHELBY,
Chairman, Committee on Banking, Housing and Urban Development, U.S. Senate, Washington, DC.

DEAR CHAIRMAN SHELBY: Thank you for your letter concerning creation, in section 105 of the Intelligence Authorization Act of 2004, of the proposed Office of Intelligence and Analysis, to be headed by a new Assistant Secretary for Intelligence and Analysis, within the Department of the Treasury. I have reviewed your letter and it correctly states the commitments made to you on behalf about the role of the proposed new Office and new Assistant Secretary within the Department of the Treasury.

I appreciate your input and look forward to working with you, Senator Sarbanes, and your House colleagues to make sure the Treasury Department meets the Congress' expectations. An identical letter has also been sent to Senator Sarbanes.

If there is anything that I can do to be of assistance to you, please do not hesitate to contact me.

Sincerely,

JOHN W. SNOW.

Mr. ROBERTS. Mr. President, I ask that the Chair put the question to the body.

The PRESIDING OFFICER. Is there further debate?

If not, the question is on agreeing to the conference report.

The conference report was agreed to.

MORNING BUSINESS

Mr. ROBERTS. Mr. President, I ask unanimous consent that there now be a period for morning business, with Senators permitted to speak therein for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

Who seeks recognition?

Mr. CHAMBLISS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. REED. I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

ENERGY POLICY ACT

Mr. REED. Mr. President, we have just concluded a cloture vote which will give us the opportunity to look more carefully at the Energy bill that is before the Senate. I believe such a careful and thorough review of the bill is entirely warranted. Indeed, it is not just my opinion but the opinion of countless numbers of Americans and also countless numbers of opinion leaders throughout the country.

These are a sample of some of the editorials that have appeared with respect to the Energy bill. The Washington Post calls the bill "depleted energy." The New York Times says "a shortage of energy". The Atlanta Journal-Constitution directs: "Put backroom energy bill out of the country's misery." The Houston Chronicle: "Fix the flaws—this proposed energy bill is half a loaf, half baked."

The American people deserve good national energy policy, created through an open and democratic process. Sadly, the legislation before the Senate is not such a policy nor has it been achieved through an open and transparent and collaborative process. The Energy bill was crafted behind closed doors by members of one political party who chose to involve industry but not elected Senators and Congress men and women. It looks as if the industry got the bill they wanted.

We have been told "take it or leave it." I hope we can leave this bill behind. I hope this cloture vote signifies such a development.

If we leave it behind, one of the salient aspects of the Energy bill presented to Members is that it does not leave any lobbyist behind. In fact, to borrow a statement from my colleague from Arizona, this bill, indeed, leaves no lobbyist behind.

There is an Archer Daniels Midland ethanol provision adding $8.5 billion to gas prices over each of the next 5 years while cutting $2 billion a year from the highway trust fund. It seems to me to be implausible, indeed irrational, that we would enhance an industry while at the same time depriving our local cities and towns and States of the money they need to maintain the roads and bridges of America.

According to the Denver Post, there is $180 million to pay for development projects in Shreveport, LA, including the city's first ever Hooters restaurant. I am not sure how that will help our energy policy.

Let's not forget the $2 billion that taxpayers bear to clean up the mess left by MTBE producers.

As the Wall Street Journal wrote:

> We'll say this for the energy bill that is about to come to a final vote in Congress: It's certainly comprehensive. It may not have all that much to do with energy anymore, but it does give something to every last elected Representative.

This bill utterly fails to establish an energy policy for the 21st century. It does nothing to address our country's dependence on foreign oil, an issue I will discuss at length in a few minutes.

In addition, it contains so many provisions that will hurt consumers and damage the environment that it is impossible to list them all. Here are just a few:

The bill doubles the use of ethanol in gasoline, which will drive up gasoline prices and deny valuable revenue to fix our roads.

The bill fails to make the reforms necessary to modernize our electricity grid and enhance reliability by providing a standard set of rules for our electricity markets. These rules would have provided greater efficiencies, greater reliability, and reasonably priced electricity that our homes and businesses need.

The bill increases air pollution by delaying rules to control mercury and ozone pollution, putting millions of Americans at risk for health problems.

The bill increases water pollution by exempting oil and gas exploration and production activities from the Clean Water Act storm water program.

The bill allows drilling on our coastlines by diminishing States' rights to review offshore oil development projects and other proposed Federal activities to determine if the projects are consistent with the State coastal management plans.

The bill threatens our national security by failing to reduce the Nation's dependence on foreign oil and providing billions of dollars in subsidies to build new nuclear powerplants. And the list goes on and on and on.

The American public deserves an economically sound Energy bill that will strengthen our economy and create good-paying jobs for Americans. But that is not this Energy bill before us.

This Energy bill is business as usual. It is a special interest grab bag cloaked in the rhetoric that it would create jobs and spur the economy. The cost of the entire bill is estimated to exceed $100 billion, more than $120,000 for each job that the authors claim the bill will create. With the tax breaks alone costing American taxpayers over $25 billion, this bill adds to the deficit and further reduces spending for vital programs, such as education, health care, and water infrastructure.

The American public also deserve an environmentally friendly Energy bill that will protect our air and water and reduce greenhouse gases. But that is not this Energy bill.

This Energy bill will endanger the public's health by allowing the energy industry to increase the pollution it emits into the air and water and limiting environmental review of energy projects.

One of the most egregious giveaways to corporations, at the expense of the environment and public health, is the product liability protection for MTBE. MTBE is known to cause serious damage to water quality nationwide. This immunity provision—which is retroactive to September 5, 2003, before virtually all the recent lawsuits involving MTBE—would shift $29 billion in cleanup costs from polluting corporations to taxpayers and water customers.

My State of Rhode Island and our residents are all too familiar with the dangers of MTBE. After MTBE leaked from an underground storage tank at a gas station and found its way into the water system of the Pascoag Utility District in Burrillville, RI, in the summer of 2001, more than 1,200 families were forced to use bottled water for drinking, cooking, and food preparation for several months. Subsequent tests showed MTBE at such high levels that the State department of health recommended residents reduce shower and bath times and ventilate bathrooms with exhaust or window fans. Fortunately, Pascoag's lawsuit against ExxonMobil to pay for the cleanup was filed before the September 5, 2003, cutoff date, but many similar suits filed on behalf of residents in New Hampshire and other States will be thrown out by this bill. That, to me, is a tragedy.

The American people deserve a meaningful Energy bill that will ensure our national security by ending our dependence on foreign oil, diversifying our energy resources, and increasing our Nation's energy efficiency. But that is not this Energy bill.

This Energy bill perpetuates the failed policies of the past 30 years, focusing almost exclusively on squeezing what little domestic energy production is available and offering generous incentives to the oil and gas industry while giving little attention to developing alternative sources of energy and reducing consumption. We have to face the facts: We cannot drill our way to energy independence.

Furthermore, the bill creates new security threats by reversing a longstanding ban on the reprocessing of spent fuel from commercial nuclear reactors. It promotes, through the Department of Energy's advanced fuel cycle initiative, joint nuclear research efforts with nonweapon states, undermining efforts to curtail new weapons systems. The proliferation of nuclear weapons is one of the most challenging and difficult and serious problems we face, and we are now involving ourselves with states that do not have nuclear weapons, but we are doing so in a way that we could inadvertently and unintentionally give them insights that are advantages. This is poor proliferation policy as well as, I believe, poor energy policy.

Our Nation needs a comprehensive Energy bill, but we must reorder our priorities if we want to achieve greater energy independence. Yesterday's solutions will not meet today's urgent need for energy security. Increased efficiency in our homes, our cars, and our industries, renewable energy resources, and new technologies will secure our energy independence.

We are on a collision course that threatens our economic and national security. Worldwide oil consumption is projected to grow by 60 percent over the next two decades. For developing countries, the growth is expected to be much higher, possibly as much as 115 percent. China and India will be major contributors to these increases in demand and will require imports to meet their needs.

Chinese economic expansion is rapidly changing the oil demand map throughout the world. The International Energy Agency estimates that Chinese demand for oil next year will rise to 5.7 million barrels per day. This would account for about a third of global demand growth. Growing global demand will raise prices for U.S. consumers as countries race for the world's remaining oil supply.

Two-thirds of the world's proven crude oil reserves are in the Middle East. While experts disagree about when global oil production is likely to peak, they agree that when it does, the vast majority of remaining untapped reserves will be left in the Middle East and imports to feed our growing global demand for oil will come from the Persian Gulf.

What is the result of this increasing global demand? Many countries, including our allies and trading partners, will compete with us for finite oil supplies as their and our economies rely more heavily on imports. This will inevitably stress the delicate balance that exists among national interests in the world and give the Middle East a disproportionate leverage in the international arena.

America's dependence on imported oil is a major constraint on our foreign policy. A substantial portion of our Nation's military budget is spent in the Middle East for the defense of oil. Our policy toward the Middle East will not change as long as our economy remains dependent on oil from the region. The United States has less than 5 percent of the world's population but consumes 26 percent of the world's oil. Oil imports contribute to our trade deficit and heighten our economy's vulnerability to oil price spikes. According to the Rocky Mountain Institute, 53 percent of the U.S. oil supply is imported and one-fourth is from the 11 countries of the OPEC cartel.

Net oil imports cost the United States $109 billion in the year 2000—29 percent of the then-record trade deficit. Retail oil products cost Americans more than one-quarter trillion dollars per year. As long as the U.S. economy is dependent on oil, we remain vulnerable to major oil disruptions anywhere in the world and to domestic price spikes. According to the Department of Energy, every million barrels of oil per day taken out of production increases world oil prices by $3 to $5 per barrel. The Organization of Economic Cooperation and Development estimates that an increase of $10 per barrel would cut U.S. economic growth by .2 percent and boost consumer prices by .4 percent. A .2 percent drop in growth would cost the economy $22 billion.

Our economy is extremely vulnerable to variability in oil prices, and we are doing nothing in this legislation to give ourselves a hedge against those variable oil prices.

To achieve energy security, we must wean our economy off its heavy reliance on oil. The immediate priority must be to head off growth in demand. Efficiency is the cheapest energy source. Let me say that again. Efficiency is the cheapest energy source—not drilling in Alaska or the gulf or any place else.

In 2000, America used 40 percent less energy and 49 percent less oil to produce each dollar of GDP than in 1975. Why? Because after the 1973 oil embargo, we were shocked into taking steps to improve our efficiency. We raised gas mileage standards. We provided support incentives for energy improvements and efficiencies throughout our society. This savings we have been able to develop since 1975 has been five times our domestic output of oil in that period.

So we essentially saved five times more oil than we produced in the period. We need to use energy in a way that saves money. It is much cheaper to conserve energy and increase efficiency than build a nuclear powerplant. It is much cheaper and much less deadly to conserve energy and increase efficiency than to send troops to protect oil interests in the Middle East, as we have done since the first Persian Gulf war. While our soldiers in Iraq are fighting for many reasons, we cannot divorce what is happening in the Middle East from our dependence on oil. This bill may create a few jobs, but will it save lives? Will it prevent future military conflicts undertaken to feed America's addiction to oil? I don't think so. I think a bill like this should do precisely that.

The Energy conference report that we are considering is too heavily weighted towards production with minimal emphasis on increasing energy efficiency. According to the American Council for an Energy-Efficient Economy, the conservation savings in the bill will amount to only about 3 months of U.S. energy consumption between now and the year 2020. That fact bears repeating. Over the next 17 years, this bill conserves only 3 months worth of energy or 1.5 percent of energy use. The bill could have and should have saved at least four times as much energy through conservation.

This bill could have taken meaningful steps to secure our energy future, but the drafters of the bill chose not to. The energy conference could have reduced our dependence on foreign oil by increasing CAFE standards, but they did not. In model year 2002, the average fuel economy for cars and light trucks was 20.4 miles per gallon, a 22-year low. Yet if performance and weight had stayed constant since 1981, the average fuel economy would have improved 33 percent, enough to displace the amount of oil we import from the Persian Gulf 2.5 times over. To displace Persian Gulf imports would only take a 3.35 mile-per-gallon increase in the 2000 light vehicle fleet. We are risking our soldiers in the Persian Gulf, but we are unwilling to raise mileage standards in the United States. If we don't do that, I fear we will be at risk again and again and again—our troops, our economy, and our society.

According to the Rocky Mountain Institute, since 1975, the U.S. has doubled the economic activity wrung from each barrel of oil. Overall energy savings, worth about $365 billion in 2000 alone, are effectively the Nation's biggest and fastest growing major energy source, equivalent to three times our total oil imports or 12 times our Persian Gulf imports. Let me say that again. We have the greatest resource available to us. It is not oil under the ground or under the sea. It is energy efficiency. Yet this bill refuses to tap that great resource.

During 1977 to 1985, gross domestic product rose 27 percent. Oil use fell 17 percent. Net oil imports fell 42 percent, and imports from the Persian Gulf fell 87 percent. When we were forced by the embargo in 1973 to take steps to improve efficiency, the results were palpable, dramatic, and beneficial. The key to the huge 1977–85 oil savings was better mileage for our automobiles. Unfortunately, light vehicle efficiency stagnated through the 1990s. And we refused to do the obvious and increase those standards.

Taking steps to reinvigorate the CAFE program is the best way to produce dramatic savings in oil consumption, those savings that we witnessed in the 1970s and 1980s. That is why I am an original cosponsor of S. 794, which would increase fuel economy standards for passenger vehicles to 40 miles per gallon by 2015 and for pickup trucks by 27.4 miles per gallon. This would save 1.8 million barrels of oil a day by 2015, and 3.1 million barrels a day by 2020. This is the Energy bill we need, not the one we are considering.

Indeed, this approach, a technological approach, is most suited to our greatest advantages. We are the Nation of technological innovation. We are the Nation that first ventured into space dramatically and went to the moon. I cannot believe that if we give them the simple mission of raising gas mileage standards, that our automobile industry cannot do so and do so promptly without losing jobs, without losing market share.

While we fail to take action to increase fuel economy standards and provide $100,000 tax loopholes for SUVs, China, already a growing economic power, recognizes the need to reduce its oil demands from the Middle East. In contrast to this bill, China is preparing fuel efficiency rules that will be significantly more stringent than those in the United States. The Chinese standards call for new cars, vans, and sport utility vehicles to get as much as 2 miles a gallon of fuel more in 2005 than the average required in the United States and about 5 miles more in 2008.

Let me guarantee you, our automobile manufacturers will be trying desperately to sell in that market, and we will be producing cars that go into that market. Yet they will turn to us and say: It is impossible to do that here in the United States.

The Chinese are more sensitive to the global imbalance in supply and demand for petroleum products than we are. They are taking action—and we can't—

because they recognize the economic implications and the national security implications.

The Energy bill before us could have reduced our dependence on foreign oil and strengthened national security by including a renewable portfolio standard for America's electricity industry. A strong renewable portfolio standard would diversify our fuel supply, clean our air, and better protect our consumers from electricity price shocks.

According to the Energy Information Agency, gradually requiring utilities to produce 20 percent of electricity from renewable resources such as solar and wind is both affordable and feasible. In addition, it would create jobs by spurring $80 billion in new capital investment. Again, this is the Energy bill we need, not the one we are considering.

For over 30 years, through four different Presidencies, Americans have been promised that our Government would end the national security threat caused by our dependence on foreign oil. But energy security means more than drilling in new places for oil and natural gas. It starts with using less energy far more efficiently. It means obtaining energy from sources that are less vulnerable to terrorism or world politics. Unfortunately, it appears that the American people will continue to wait for a meaningful energy policy that promotes national security and reduces our dependency on foreign oil.

We faced an important vote today. I believe we made the right vote. We have given ourselves more time to improve this bill, to develop legislation that will meet our economic, our environmental, and our national security needs, to serve the American people in a way which will make them more secure and more prosperous. I hope we use this intervening time not simply to return to this legislation but to vigorously reform legislation so that we can present the American people a bill that will serve their needs and not the needs of special interests.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DASCHLE. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. THOMAS). Without objection, it is so ordered.

HONORING TWO SOUTH DAKOTA SOLDIERS KILLED OVER THE WEEKEND IN IRAQ

Mr. DASCHLE. Mr. President, yesterday was a national day of mourning in Italy. Tens of thousands of people lined a procession route and gathered at a basilica in Rome to pay their final respects to 19 Italian soldiers killed last week in a truck bombing in Nasiriyah, Iraq. The soldiers' deaths mark Italy's worst military loss since World War II.

The American people share Italy's sorrow over their enormous loss.

There is also a profound sense of sorrow this week in South Dakota, Mr. President. Two of the 17 American soldiers killed last Saturday, when those 2 Army Black Hawk helicopters collided in the sky over the northern Iraqi city of Mosul, were from our State.

South Dakota lost as many soldiers in that instant as we had lost in the entire Iraq war so far.

We mourn our lost sons: Army CWO Scott Saboe; and Army PFC Sheldon Hawk Eagle.

We also mourn the 15 soldiers lost with them, and all the 424 U.S. servicemembers who have given their lives, so far, in this war, as well as the sons and daughters of our allies who have been lost in this war.

CWO Scott Saboe was 33 years old, a career soldier with 14 years of military service.

He leaves behind his wife, Franceska, and their 6-year-old son, Dustin, who live in Alabama.

His father, Arlo Saboe, with whom I just spoke, is a decorated Vietnam war veteran who lost his wife and brother in the last 2 years. His sister, Ann Remington, is stationed at Walter Reed Army Medical Center near Washington.

Willow Lake, where Scott Saboe grew up, is a small town. Only about 300 people live there. On Sunday, more than half of them stopped by Arlo Saboe's house to pay their condolences.

Before Iraq, Scott Saboe had flown helicopters over the demilitarized zone in Korea. As his father told a reporter for the Sioux Falls Argus Leader, "He was willing to go anywhere."

He reportedly was scheduled to return to the United States in 2 weeks for training.

Today, at Willow Lake High School, where he played center on the football team, the flag has been lowered to half-staff.

Bill Stobbs, a former teacher and football coach who now is the school's principal, told the Argus Leader:

> He died doing what he loved, and he was a dedicated soldier. That's all there is to it.

Darin Michalski, a childhood friend, said:

> Most of us can go through our whole lives and don't really accomplish anything, and some of us only live to be 33, and we're heroes.

PFC Sheldon Hawk Eagle was just 21.

He lived in Eagle Butte, on the Cheyenne River Sioux reservation, and was an enrolled member of the Cheyenne River Sioux tribe—one of about 90 members of the tribe deployed to Iraq.

He was a descendant of the legendary Lakota warrior leader, Crazy Horse. His Lakota name was Wanbi Ohitika, "Brave Eagle".

Like Scott Saboe, Sheldon Hawk Eagle grew up in a family that viewed military service as a citizen's duty. His grandfather, father and uncle all served.

Friends and family members describe him as a hard-working, quiet young man. One of his former teachers remembers his "nice smile."

His parents died when he was a young boy. He was raised by his aunt and uncle, Harvey and Fern Hawk Eagle.

His only surviving sibling, his sister, Frankie Allyn Hawk Eagle, lives in Grand Forks, ND. He enlisted in Grand Forks, in June 2002, to be close to her.

He was deployed to Iraq in March and reportedly had hoped to be home this coming February.

Emmanuel Red Bear, a spiritual leader who teaches Lakota language and culture at Eagle Butte High School, remembered Hawk Eagle to a reporter as an aggressive, but fair, football player who was a model of sportsmanship on and off the field.

Said Red Bear of Hawk Eagle:

> He was a role model, in his quiet way. The younger kids looked up to him. . . . He really was a modern-day warrior.

Tribal Chairman Harold Frazier said simply:

> He's our hero. He defended our country and protected our freedom.

News of Scott Saboe's and Sheldon Hawk Eagle's deaths reached their hometowns on Sunday. Many people first heard the news first at church services.

It had been some time since South Dakota had lost anyone in Iraq.

On May 9, CWO Hans Gukeisen, of Lead, was killed when the Black Hawk helicopter he was copiloting got caught in a power line and went down in the Tigris River.

On June 18, PFC Michael Deuel of Nemo, was killed while on guard duty at a propane distribution center in Baghdad.

The crash of the two Black Hawks last Saturday was the deadliest single incident since the United States invaded Iraq. The military is investigating whether enemy ground fire may have caused the crash.

All 17 of the victims were from the Army's 101st Airborne Division—the famed "Screaming Eagles"—the same unit that parachuted into Normandy on D-Day.

Like people in every state, South Dakotans sometimes focus on our superficial differences: East River versus West River, Native American versus the sons and daughters of pioneers and immigrants. Today, we are one State, united in sadness over the deaths of our soldiers, and pride over the noble lives they lived.

I yield the floor. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

OBESITY

Mr. FRIST. Mr. President, I rise for a few moments to speak to a once silent, now highly visible epidemic that plagues every neighborhood in this country. It is an epidemic that plagues our schools. It is an epidemic that plagues our school grounds. It is an epidemic that plagues youth in our playgrounds and it plagues older people in the workplace. It is a plague that in many ways is a new problem—a problem that is only really 15, 20, maybe 30 years old—but it is a problem and a plague that is growing. It is one that specifically hurts children, and, indeed, once it attacks our children, it can destroy in many ways their future quality of life and their future life in terms of longevity. This epidemic, this plague, is childhood obesity.

Just this summer, the Food and Drug Administration announced it will require food labels to list trans fatty acids. Most people do not know what trans fatty acids are; people do not know exactly what they do. But they do things which make in many ways food taste better. They make foods last longer. They give flavor to foods. They increase shelf life. The problem is that these trans fats contribute to heart disease. Heart disease is the No. 1 killer in the United States of America today.

For 20 years, before coming to the Senate, I spent my life in medicine and ended up gravitating to this field of heart disease. It wasn't as big of a problem in the late 1970s or early 1980s, but it was there. What bothers me most is that it is skyrocketing today, and it is increasing faster among adolescents—children—than it is among anyone else.

It is interesting. If my colleagues are listening to me, the likelihood is one out of every two of you is going to die of heart disease—not just my colleagues but on average around the country. That is how common heart disease is in terms of mortality.

Various food companies really deserve praise for their plans to reduce the level of trans fats in their most popular products. These are important advances in public health, and I applaud our food manufacturers for stepping up and taking this leadership position.

Ultimately, however, the responsibility for this growing, skyrocketing epidemic rests with all of us—individual consumers, American consumers—you and me—and all of us because ultimately we make that decision for ourselves in terms of our shopping, in terms of how we conduct our lifestyle, how much exercise we get, and what we eat.

But the point is that we have an epidemic. It is hurting specifically children. Children are really condemned to a lower quality of life because of this epidemic. But the good news is that there is something we can do about it; we can reverse these trends.

Sixty percent of Americans today are overweight. More than one out of two are overweight. By itself, obesity might be considered just another choice we have in life, that we just choose, that is what we do, and, if it hurts us, that is just the way it goes. It is more than just another choice. It really does come down to what we do, which may not be a choice in part because there may be even a genetic component to it. We don't know for sure. But researchers in England believe they have discovered a gene which they are calling an obesity gene that some way predisposes some to overeat. It is a choice in terms of lifestyle: People choose to take the metro or the subway rather than walk. We know our children in schools today are exercising a lot less. We know that our kids today are spending a lot more time in front of the television or at the computer and are less likely to be exercising.

Whether by choice or by some combination of genes and environment, we know obesity is now a major public health threat in the United States of America. Obesity contributes directly to heart disease but also to diabetes. Diabetes is reaching epidemic proportions in our children today. It directly contributes to other illnesses, including cancer and stroke.

There are 300,000 deaths a year that can be directly attributed to fat. The epidemic is spreading in faster and faster proportions with our children. The percentage of kids age 6 to 19 who are overweight has quadrupled since the early 1960s. It is not a static problem; it is getting worse.

Pick any city in the country. Look at New York City's public school children, nearly half are overweight; one in four is obese. The problem is particularly acute among African-American and Hispanic children, especially Hispanic boys. More Hispanic boys than Hispanic girls are obese. In my own State of Tennessee, the statistics are even worse.

Nationwide, type 2 diabetes, the kind of diabetes that is associated with obesity, is skyrocketing. At the Centers for Disease Control and Prevention, estimates are that one in three Americans born in the year 2000 will develop diabetes in their lifetime. One in three Americans born today will develop diabetes in their lifetime. This is attributed to obesity. It is attributed to being overweight. Among African-American and Hispanic children that number is not just one in three Americans, but it is one in two Americans in those populations that will develop diabetes in their lifetime.

People say diabetes is bad and that should be reversed. But it is even worse than saying it is just diabetes because diabetes itself is the leading cause of kidney failure, which is renal failure. Diabetes is the leading cause of heart disease. Diabetes is a leading cause of blindness as well as amputations. It all starts as a child, who, in this growing epidemic, is led to be obese.

As adults, we know how hard it is to battle the fat or the battle of the bulge. We all struggle with that in our environment of fast food and transportation. It is very easy to find excuses not to exercise four times a week for 30 minutes. But imagine struggling with obesity when you are just 10 years of age, where this is reaching those epidemic proportions. Teachers say they see the physical toll on their students every day. Kids are out of breath walking up the school stairs. Kids are not able to participate fully in sports. Kids are not able to participate when they do field trips and go outside, activities we associate with playing and vigorous childhood activity. Kick-ball, jumping rope, and climbing trees for many children today, unlike in the past, have become grueling exercises that, indeed, they try to avoid. They say they will not participate because they are embarrassed to participate.

Mr. President, 25 percent of our Nation's children say they do not participate in any vigorous activity today. That is one out of four children. Obesity is not only robbing them of those everyday pastimes, it is also robbing them of their childhood years. Obesity is associated with the early onset of puberty among girls.

According to a study from the University of North Carolina, 48 percent of African-American girls begin puberty by age 8; over a quarter by age 7.

Yes, we are in the midst of a national health crisis. It is harming our children in ways that we can observe, but the crisis also occurs in ways we cannot observe. It threatens their future. It also condemns their future in many ways to the lower threshold of having other adult diseases if they start as a child being obese. They carry that with them for the rest of their life.

It affects what we call their morbidity, the relationship to other disease patterns. It affects their longevity in terms of length of life.

There is a lot we can do. We cannot just talk about it. The Surgeon General, Dr. Richard Carmona—for whom I have tremendous respect—is so alarmed, this month he urged the American Academy of Pediatrics to step up the fight against childhood obesity. In the Washington Post yesterday, Rob Stein wrote an article "Obesity on FDA's Plate" and he pointed out the Food and Drug Administration has launched an initiative to determine how and in what way it can play a role in helping to fight obesity, which, as the article points out, has reached epidemic proportions in this country.

In that article from yesterday, FDA Commissioner Mark McClellan—again, a physician for whom I have great respect and with whom I have worked in many capacities before; he is doing a great job at the FDA—said:

> The issue of obesity challenges us in every aspect of our efforts to protect and advance the public health, and that is why it needs to be front and center of our public health agenda.

The good news to all this is that there is action in government that obesity is both treatable and preventable, which means there are things we can do to reverse the epidemic. We can reverse the trends. We must reverse the trends. It is now time to put our minds to it in this body.

I am gratified by the action of the HELP Committee which unanimously approved recently the IMPACT Act, the Improved Nutrition and Physical Activity Act. I urge my colleagues to look at this piece of legislation. I urge my colleagues to support this legislation. I hope we can bring it to the Senate floor in the near future.

Very briefly, this act takes a multifaceted approach. It emphasizes youth education to jump-start healthy habits. We know if they begin in their early years, they are carried through life. It funds demonstration projects to find innovative ways to improve health, eating, and exercise and includes vigorous evaluations so we can learn what works best in reversing this epidemic. It does not attempt in any way to control what individual Americans eat or drink. It does not outlaw so-called bad foods. It does not try to replicate the $1 billion diet industry that we know exists. It does not try to replicate the fitness industry, which is actually doing a wonderful job around the country.

It does have a modest pricetag reflecting on the appropriate role of the Federal Government to set this platform to combat this epidemic.

There is no single solution to the growing epidemic of obesity. I believe we must increase awareness of it first and then implement programs we know will have an impact; look at the medical consequences. That is why I come to the Senate floor to share the medical consequences that are totally avoidable if we act, if we educate, and if we adopt practices that we know will work.

We do know the consequences of obesity today. We can and should keep our kids safe by keeping them fit. I look forward to working with my colleagues on this very important issue. It is a new problem, a growing problem, a problem we are obliged to reverse.

Mr. REID. Mr. President, I wish I listened to the speech before I had lunch.

On a serious note, Senator DURBIN is here and he will start talking about the Medicare bill that will soon be taken up in the Senate. I think the leader would agree that people should come now and start talking about this most important piece of legislation.

Senator DURBIN is in the Chamber to talk about it. I think we should invite all Senators because the time later could be a little more constrictive.

I also say, on a serious note, about the speech the distinguished majority leader just gave, one of the reasons the leader has such high respect on both sides of the aisle is we know of his background. It is not often we have someone of his medical talents come to this body. In fact, no one has ever had the same background. He uses it in such a dignified way, in his charitable work when we are on break, doing things for the less fortunate in Africa and other places. And here, it is always good for us to know that when we do deal with health issues, he is here.

So I speak for the entire Senate when I say this presentation he just delivered on obesity is something we should all pay attention to because I know this is not a speech that someone prepared for him; this is something he spoke to with his knowledge as one the finest physicians in America.

The PRESIDING OFFICER. The majority leader.

Mr. FRIST. Mr. President, I appreciate the comments, through the Chair, from the assistant Democratic leader. One of the great things about these issues is we do have the opportunity here to work together on both sides of the aisle on issues which affect people broadly. I very much appreciate his comments in that regard.

I do also add the point, and reinforce the statement the Senator made, that over the course of the afternoon we would like to shortly—and, hopefully, a little bit after 2 or after the appropriate comments are made on Medicare—go to Healthy Forests. We are waiting on some final agreements, but hopefully we can address that today.

But what I really want to say is, this is exactly the way to handle it. I encourage people right now to come and make their statements and make their points and have the debate on Medicare. The bill is out. The bill has been filed. People have access to that bill. I think everybody should take that opportunity, this afternoon, through tomorrow, and through the weekend, to come to the floor to begin talking about that very important issue.

We want to make the very best use of time today, tomorrow, and Sunday, in all likelihood, and Monday, on that issue as well as others. It may be confusing to people. We will be going back and forth because we have a lot of business to do. So we will be on Medicare, and then we will take up Healthy Forests, and then I encourage people to come back and begin Medicare.

I yield the floor.

The PRESIDING OFFICER (Mr. COLEMAN). The Senator from Illinois.

Mr. DURBIN. Thank you, Mr. President.

I join my friend and colleague from Nevada, Senator REID, in saying to Senator FRIST, thank you for your leadership. We disagree on issues from time to time, but we agree on some, too. You have been an exceptionally good leader on the Republican side. I have said this to you privately, and I want to make it a matter of public record: I think you have been eminently fair to the minority in this Senate. And that is, I am sure, not an easy task. There are certainly forces at work in your party, as there are in our party, calling for a different outcome.

But I applaud you for your fairness in allowing the minority on this side of the aisle an opportunity to debate, offer amendments, to express our points of view, and bring an issue to a vote. I do not think a member of any legislature—national or State—could ask for anything more. I think you have worked long and hard to make that a hallmark of your leadership.

As a member of the minority, let me say to the Republican leader, thank you for your service to this institution. You have been a great asset to our Nation and to this body.

MEDICARE AND PRESCRIPTION DRUGS FOR SENIORS

Mr. DURBIN. Mr. President, let me, if I may, address another issue which is about to come before us. If you follow boxing and have watched any big championship fights, you may know that it comes at the end of the evening. During the course of the day and afternoon and the early evening hours, there are preliminary fights, and they are interesting, but they are young boxers who are untested. But the excitement builds and the attention of the audience builds for the prize fight, the heavyweight championship fight, always the last thing on the card.

Much the same occurs in Washington, DC. We have a lot of preliminary fights that lead up to the championship. You are here witnessing on the floor of the Senate today, and in the closing days of this session, the heavyweight fights.

We just finished one. That was the Energy bill. This was a controversial issue of some 1,400 pages that had been debated for years. It came to the Senate floor and just a short time ago was basically stopped. A filibuster prevailed by a bipartisan rollcall with, I believe, six Republican Senators and a number of Democratic Senators. The Energy bill was stopped. It was a heavyweight fight because those supporting the bill include the biggest energy interests in America, the big oil companies.

Certainly the President and the Vice President and the Republican Party, which controls the House and the Senate, were, by and large, anxious to pass this bill, and we had a confrontation on the floor and my position prevailed on that. It came as somewhat of a shock to people who follow this Senate. It is not very often that the favored side in one of these debates loses. And just a short time ago they did, by two votes. They needed 60 votes to stop the debate and move the issue to a vote, and the motion to stop that debate did not prevail; it only received 58 votes.

Well, the windows are open now, and there is anxious negotiation and a lot of effort underway to try to find two more votes. And I would imagine, in the closing days of the session, we may see this issue surface again. I could express myself in saying I hope it does not, but it makes no difference what I hope. I am in the minority here, and the majority will decide whether they have the votes to bring it to closure.

That is one of the heavyweight fights. But there are two more coming, two more that will affect virtually every family in America.

One is an omnibus appropriations bill, with five major appropriations bills lumped into one, that is now in conference, a conference on which I serve; and debate is underway. The debate is behind closed doors, and I, frankly, do not know what is happening there. But before we can leave, we need to pass that bill. It could include a myriad of issues, issues as far-flung as stem cell research in medicine, issues as diverse as education, transportation. All of these issues could come before us in that large bill. That is another heavyweight fight.

But the one I come to address today is one that has received a lot of attention across America for a long time, and it is likely to receive even more attention in the closing days of the session, both in the House and in the Senate.

The issue is the issue of prescription drugs, particularly for seniors. I do not know of a single Member of the Senate who has not expressed support for finding some way to help seniors pay for prescription drugs.

We all know what has happened here. We have more and more and better and better prescription drugs available across America, and a lot of people have learned—in my family and yours, too—that if you take the appropriate medication, with the advice of a good physician, your life can be healthier and you can be stronger and more independent.

So people try to find the right drugs to keep them healthy and to move along with the happiness of life, trying to avoid going in for hospitalization or surgery. Prescription drugs are an important part of that.

But, sadly, prescription drugs for seniors in America are not covered by Medicare. So unless you are in a hospital receiving those drugs, you have to pay for them. For a lot of seniors, it is too expensive. There are people living on fixed incomes under Social Security or relatively small pensions. They have a few assets left on Earth, maybe a home they saved up for all their lives and a car, and they are trying to figure out how to pay several hundred dollars per month for prescription drugs they need, and they can't afford it. So, many do not take the drugs, some take half of what they need, and many find themselves in a terrible, perilous personal position.

We have come forward and said: We should change Medicare. If Medicare covers your illness when you go into a hospital, why wouldn't Medicare cover the drug that would keep you from going into the hospital? That makes eminent sense not just from a human point of view but from an economic point of view. It is money well spent to keep people healthy and to pay for prescription drugs.

So we had this debate, and it went on for years, and we talked about how to do it, and we did not get much done. But we did finally pass a bill out of the Senate, a bill which I supported. It was not the greatest bill. In fact, there were some aspects of it I thought were pretty bad.

Then it went into a conference between the House and the Senate, and they started working out differences. Then something unusual occurred. Someone in the House of Representatives decided that this debate was not about prescription drug benefits for seniors; no; they said this debate is really about the future of Medicare, the whole program.

It isn't about adding a benefit for seniors to pay for prescription drugs but how we are going to change Medicare in the future. Republican leaders in the House said the best way to change Medicare is to change it as a government insurance program and instead let private insurance companies, HMOs, offer Medicare coverage in the future.

My experience as a Senator from Illinois and as a Congressman is that HMOs can break your heart. They cost a lot of money. They deny care, they limit your choice in terms of doctors and hospitals, and, frankly, when the going gets rough and they are not making enough money, they cut and run. Is that what we want to hold out as the future of Medicare? I don't think so. But a lot of people do.

The Republican majority in the House certainly believes that, and that is what they have pushed now in this so-called prescription drug bill. It is no longer a bill about just paying for the prescriptions. It is now a bill about changing the face and future of Medicare. That, to me, makes a substantial difference in our mission and what we need to do.

The bill, as it is currently written, is not a bill which I can support. I guess the biggest disappointment I have is the fact that we started off with such a valid goal and such a lofty purpose. We were going to help our mothers and fathers and grandmothers and grandfathers pay for their prescription drugs. Now we have gone far afield. There are many who want to change Medicare.

Let me ask you: If you stepped back in the course of legislation and wanted to determine whether or not it was good for consumers and families in America, isn't it fair to say that one of the first questions you would ask is: Where does the money go? Who ends up profiting from this bill, and who ends up losing as a result?

Clearly, you want to turn first to the pharmaceutical industry, the people who sell drugs in America. I will readily concede this is one of the most important industries in America. We lead the world in breakthrough drugs and pharmaceuticals. I want to make certain that these drug companies in my State and others are profitable; that with their profits they can fund research to find new drugs. I want to make certain that those drugs are available to Americans. That is something on which everybody agrees. But sadly, what we find in this bill is that the pharmaceutical industry is cheering the loudest for the bill to pay for prescription drugs. That leads us to ask some serious and important questions.

First, let me show you how profitable drug companies are in America today. Take a look at the profitability of Fortune 500 drug companies versus the profitability for all Fortune 500 companies in the year 2002. The red bars indicate the profitability of the drug companies, the drug industry median, and the yellow bar is all other Fortune 500 companies. You can see profits as a percent of revenue in the first illustration, 17-percent profit for the drug industry; 3.1 percent for the rest of the Fortune 500 companies. You can see profits as a percent of assets, 14 percent. Then when it comes to profits as a percent of equity, 27.6 percent for the pharmaceutical companies; 10.2 percent for the rest of the Fortune 500. So it is very clear that we are talking about a profitable industry.

Here is another illustration of the same point. This is an indication from Fortune magazine of the most profitable industries in America, with 2002 profits as a percentage of revenues. No. 1 on the list is pharmaceutical companies. Pharmaceutical companies are extremely profitable in America today. We understand that. We ought to keep it in mind as we discuss how we are going to pay for prescription drugs for seniors.

Then I would like to show you what some of the people who are the CEOs of managed care companies earn. Here we have a chart that shows the chairman of Aetna, John Rowe, his compensation, exclusive of stock options, $8.9 million; Anthem, Larry Glasscock, president and CEO, $6.8 million; CIGNA, Edward Hanway, chairman and CEO, $5.9 million—this is exclusive of stock options which are usually considerably more—Coventry, Allen Wise, president and CEO, $21.6 million annual compensation; Health Net, senior vice president, $6 million; Humana, president and CEO, $1.6 million—that is pretty small in comparison—then Oxford, Norman Payson, former chairman and CEO, made $76 million; PacifiCare—you may have seen the ads that show the whale flopping in the water—Mr. Howard Phanstiel is not a flop when it comes to his salary, $3 million; Sierra Health, Dr. Marlon, chairman and CEO, $4.7 million; UnitedHealth, Channing Wheeler, chairman and CEO, $9.5 million; WellPoint, Leonard Schaeffer, chairman and CEO, $21.7 million.

The total compensation for these 11 executives at these managed care companies is $166.3 million. Their average compensation, $15 million.

We are struggling to figure out how people who make $200 or $300 or maybe $500 a month can survive. And we are dealing with two industries that are extremely profitable. The obvious question we should ask is: What is fair? What is fair compensation to the pharmaceutical companies and managed care companies, but what is fair to the seniors in America? Therein lies the problem.

This morning's Washington Post, on page A4 in the first section, I think, is written an article that every Senator should read, and those who follow this debate on prescription drugs.

It is entitled "Drugmakers Protect Their Turf." It says: "Medicare Bill Represents Success for Pharmaceutical Lobby." Let me read a little bit from this article:

> No industry in negotiations over the $400 billion Medicare prescription drug bill headed to the House floor today outpaced the pharmaceutical lobby in securing a favorable program design and defeating proposals most likely to cut into its profits, according to analysts in and out of the industry.
>
> If the legislation passes as Republican leaders predict, it will generate millions of new customers who currently lack drug coverage. At the same time, drug manufacturing lobbyists overcame efforts to legalize the importation of lower-cost medicines from Canada and Europe and instead inserted language that explicitly prohibits the federal government from negotiating prices on behalf of Medicare recipients.

The pharmaceutical lobby has become the biggest player in Washington, DC. When I got here, it was the tobacco lobby. I know it because I fought them—beat them a couple times, too—over the course of my career. They had more money than friends, and they went out to buy a few friends, and they did.

Listen to what the pharmaceutical companies have done:

> After objecting for years to proposals to add prescription drug coverage to Medicare, the pharmaceutical lobby recently shifted position and poured enormous resources into shaping this legislation. Since the 2000 election cycle, the pharmaceutical industry has contributed $60 million in political donations and spent $37.7 million in lobbying in the first 6 months of this year.

Thirty-seven million dollars on Capitol Hill? You will meet these fine men and women in their beautiful suits and well-shined shoes in the lobbies right outside this Chamber. The article goes on to say:

> The lobbying continued in earnest this week with a television and print advertising campaign urging passage of this bill. In one series of witty commercials sponsored by the industry-backed Alliance to Improve Medicare, elderly citizens look into the camera and demand: "When ya gonna get it done?"

I think I may have a copy of that ad somewhere around here. You have seen it. The fellow is pointing to Congress saying, "When ya gonna get it done." That is paid for by the pharmaceutical companies. So if we are talking about helping seniors pay for prescription drugs and the pharmaceutical companies can't wait to see this legislation passed, what does that tell you? It tells you they are not going to have to cut their prices. It tells you they are going to make more money. It tells you that ultimately we are not producing a bill which helps consumers and families and senior Americans. We are creating a profit opportunity for pharmaceutical companies that already lead the Nation in profitability.

The pharmaceutical lobby is so strong in this town that they have been able to deceive the American people into believing that this prescription drug package is somehow going to cause some sacrifice on the part of pharmaceutical companies. It will not.

They are the big winners in this, just as the big oil companies and energy companies would have been the big winners in the last bill. This is the heavyweight fight, the match you can expect to see in the closing hours of this session.

Let me tell you, in closing, what the Washington Post says this morning:

> Perhaps the most striking political victory for the pharmaceutical industry was the decision to reject provisions that would have allowed Americans to legally import drugs from Canada and Europe, where medications retail for as much as 75 percent less than in the United States. Polls show that an overwhelming majority of Americans support that change, and the House approved a measure 243–136. But the Bush administration and the pharmaceutical lobby said the move was dangerous and would cut into future research and development. The provision was dropped from the bill's final version.

So why would people want to import drugs? I think we know the answer. They are cheaper. The same drug made in the United States by an American company, based on research paid for by the Federal Government many times—that same drug for sale in Canada is a fraction of the price. Why? Why is it cheaper in Canada or in Europe, if it comes from the same American drug company? Because we are not importing drugs from Canada or Europe; we are importing leadership.

The Canadian Government, and governments around the world, have decided to stand up to the pharmaceutical companies and tell them there is a limit to how much money they can charge for their drugs. Our Government is unwilling to do that. This bill will not do that. Instead, what seniors have been forced to do—and families, I might add—is to pay high pharmaceutical drug bills, and some are going to Canada trying to keep up with the costs. This bill closes that border for the reimportation of drugs from Canada—meaning that America's senior citizens will continue paying the highest drug prices in the world.

This is all in the name of a prescription drug benefit for those seniors. So it is natural that pharmaceutical companies are spending millions of dollars trying to urge Congress to pass this bill as quickly as possible. The ads that they run—some are directly from their own front organizations, but others come through organizations such as AARP. I know about AARP because once you reach age 50 in America, they start filling your mailbox with solicitations for membership. I have been rejecting those for many years. I don't plan on being a retired person soon. However, the voters will have the last word on that decision.

Here is their full-page ad calling for Congress to pass the proposed prescription drug Medicare bill. Honestly, I think if you looked under the lid, you would find that AARP money to pay for this ad comes through the pharmaceutical companies that cannot wait to see this bill passed. It means more money for them. They want to cut off the sources of drugs coming in from Canada and Europe so they can really charge seniors the highest prices in America.

Let me give you an illustration of what competition can mean when it comes to drug prices. If you said to people: Do you want price controls from the Federal Government, they would say: No, no, no, that is too much Government.

But if you say: Would you want your Government to bargain for the best prices for people who need prescription drugs, most people would say: Why, sure. And why wouldn't they? You could say to them: Do you realize we do that now?

The Veterans Administration does that today; it bargains with drug companies so veterans get cheaper drugs, and the Veterans Administration pays less. The Indian Health Service does it, and some community health centers do it. States also do it through the Medicaid programs. They bargain with them successfully. A lot of people are not covered in those groups—veterans health care, Indian Health Service, or Medicaid. They are left totally unprotected, with no bargaining power.

Look at this chart. These are some fairly common drugs. Xalatan is an eyedrop. If you buy this at the Federal supply schedule price, it is $41 for the prescription. If you go to the drugstore to buy it, it is $101. So we manage, through the Federal Government, to bargain with the drug companies and bring prices down for some people.

Celebrex, for arthritis, is $108 on the Federal Supply Schedule. That is what we pay because we bargain down the price. If your grandmother goes into the drugstore to have that filled, she will pay $173—$65 more.

Lipitor, a very valuable and important drug, is $215, based on what we have negotiated and bargained. If you pay the full price at the drugstore, which many American seniors do, it is $446.

Plavix, for stroke, is $257. It is $593 at the drugstore.

The point I am making is this: This bill is designed so that the Federal Government is prohibited from bargaining and negotiating for lower prices for seniors across America. That is why the pharmaceutical companies are so wild to pass it. That is why they want to see this enacted as soon as possible. It closes down competition. You can no longer go over the border to buy drugs in Canada or Europe, and you cannot find the Federal Government standing up for you and bargaining for seniors to bring down costs.

That is why the pharmaceutical companies are salivating. They cannot wait. They want to see this thing passed because, frankly, it means less competition. So who pays the highest prices for prescription drugs in America today? The people who can afford it the least—senior citizens on fixed incomes.

Even with the prescription drug benefit in this bill, there is no cost containment, no effort to keep the prices under control. So no matter how much money you put into this prescription drug benefit, it is going to go bankrupt because prescription drugs go up in cost 10 to 15 percent a year, and they will continue to. That inflation is going to destroy this program, and it is going to destroy seniors, because this Congress and this President refuse to confront the pharmaceutical companies.

In Canada, their government stands up for their people and says to American drug companies: We are not going to let you gouge or take advantage of our people when it comes to prescription drugs. Our Government refuses to do that. As a result, we find ourselves in this predicament. AARP and others are pleading for a prescription drug benefit that, frankly, has no cost containment built into it.

I came to the floor during this debate and urged colleagues to give to the Medicare Program the ability to bargain, which is what we give to the Veterans Administration and other Federal agencies, to let Medicare go to the drug companies and bargain for the best price for Medicare recipients across America. I was summarily defeated. The pharmaceutical lobby prevailed. I think that answered the basic question as to whether this bill truly will lead to lower drug prices across America. It will not. It will help some seniors pay for drugs, but the cost of drug prices will continue to skyrocket, and the competition from Canada and Europe will disappear. It specifically prohibits the Federal Government from negotiating on behalf of Medicare recipients.

This bill rewards pharmaceutical companies and HMOs—insurance companies. The pharmaceutical companies are going to gain, the Medicare purchasing pool is divided to prevent large group purchasing discounts, and the House language on reimportation was rejected.

There is another element. One of the ways to cut the cost of drugs is to encourage the use of generics. Once a drug has been discovered, it is the exclusive right of the drug company to sell it under a patent. During that period of time, nobody else can make that drug and sell it. When the patent expires, everybody can make the same drug and they do it under a generic name.

You may remember Claritin, with all the ads on television that showed the happy faces skipping through the field of wildflowers saying, "I don't sneeze anymore." It went off patent and it is now available over the counter. So they came in with Clarinex—I think that is the name.

So once you see the generic drugs come in, the prices go down for consumers, and they get the benefit of what was a pretty expensive drug for a long time.

We tried in the Senate to make sure there were more generic drugs for sale because it is a good way to keep everybody healthy at a lower cost. It turns out that the pharmaceutical companies didn't care for that at all. They want people to pay for the more expensive drugs under patent. So they ended up weakening the language we had, which would have allowed generics to come to the market more quickly so seniors could take advantage of it. Also, this would weaken the ability of States to negotiate with drug manufacturers.

Some States are way ahead of the Federal Government. Oregon is one, and my State of Illinois has a plan. The ability of each State to bargain for the people living in that State is also restricted by this bill because all drugs are paid for through Medicare—something else the pharmaceutical companies wanted. They don't want to have to bargain with anybody. They want to charge top dollar. They don't want any voice from consumers or Government to reduce their profitability, which is already at record-breaking levels. They have been successful. They cannot wait for this bill to pass because they are already profitable, and this bill will enhance their profits even more.

Under this bill, seniors will receive a benefit that will cover less than 20 percent of the projected drug costs for seniors over the next 10 years.

A break-even point of $810 is what you have to put in, in payments and copayments, before you get anything back, which means about 40 percent of seniors will either lose money or gain very little under this prescription drug plan.

There is also a hole in this plan. It is complicated, but I will try to explain it, and it has been changing, even this week.

The coverage on this plan, once you make your monthly premium cost and once you pay your copayment—and then understand that you have to pay 25 percent of the cost of the drug itself—the coverage goes up to a certain point and then it stops. If you are still paying for drugs at that point, you have to go to your pocket to pay out. Then when you reach the higher level, it kicks back in again. So there is a period where you are, frankly, not covered.

If you have expensive pharmaceutical costs, you buy into the program, you make your copayment, and you are paying a percentage for each prescription you take, at a certain level the Federal help stops. Then if you keep paying out of pocket without Federal assistance, it kicks in again for catastrophic coverage. Let me try to describe where it is today.

The reports in the news have been, frankly, misleading. They have been reporting the catastrophic cap in the Medicare prescription drug bill is $3,600. It is not true. It is $5,100. So the gap between $2,250 and $5,100 is $2,850, the total out-of-pocket expenses for which seniors will be responsible is $3,600.

We have a situation where at $2,250 worth of costs, the seniors are on their own. It turns out, according to the Congressional Budget Office, 30 percent of seniors spend between $2,000 and $5,000 per year on prescriptions. That is 12.6 million people. It basically means even though prescription drug coverage and this complicated scheme I just described has been offered, there is an exposure where seniors will have to pay out of pocket, which will be a surprise to many of them, particularly when they are facing astronomical costs.

I had some examples made to give you some idea of what seniors might face in my State and others. One involves Mrs. Jones who has arthritis and takes Celebrex, which costs about $86 a month. Her husband has high blood pressure and takes Norvasc, which costs $152 per month. Under this plan, Mrs. Jones would pay at least $865. If her premium is more than $35 a month, she would pay more. There is no set premium in this bill. Mr. Jones will pay at least $1,064, for a combined cost of $1,929. This benefit will only cover a third of the drug costs of Mr. and Mrs. Jones.

There are other elements we ought to look at here. If you want to get the most help from this bill, you have to be in the lowest income categories. That is fair. I think that is the right thing to do. The people struggling to get by should get the first helping hand from our Government. They decide they are going to look at certain income levels as to whether or not you benefit from this prescription drug. Then they have an asset test which, as I understand it, is $6,000. That means if you have assets of $6,000 or more, you don't get the most help.

Some of these seniors, I know, have the old family car that may still be worth $6,000, and they would be disqualified when, frankly, they have almost no income and very few other assets on Earth.

The asset test is extremely low. Six million poor seniors will be made worse off by this bill. They previously paid nothing for drugs. They will now have to pay copays that increase annually.

Three million fewer low-income senior citizens will receive enhanced benefits than under the original Senate bill because of the strict assets test. Let me give an example.

If a senior has an income of $12,000 a year but owns a $6,100 savings bond, burial plot, insurance policy, or car worth $6,000 or more, they will not have access to low-income assistance. They will have to pay the full premium, deductible and donut, or the period where the Federal program does not apply.

That means if they have high drug costs, they could pay more than $5,000 a year for their medications simply because they own a burial plot and an insurance policy. That is what the bill says. That, frankly, is something about which we ought to be concerned.

We have to understand that when it comes to this prescription drug situation, most seniors are going to be stunned by it. I might add something else that is interesting. The decision was made by the Administration and the Republican leaders in Congress that this prescription drug plan would not go into effect until after the next election, a very interesting political move.

If this is really supposed to help seniors across America, wouldn't you think this President and this Congress would want to put it in place and activate it before the election?

The reason they won't is because it is extraordinarily complicated, it is unfair to many seniors, and it includes provisions that, frankly, seniors won't be happy with at all. So they want to put it off until after the next election, and that is what they have done.

One of the other concerns I have is the role of AARP in this whole conversation. AARP is an interesting organization. Most of us over the age of 50 receive a lot of solicitations. A lot of seniors 50 and older across America have joined. If you look at AARP, it is more than a feel-good operation to try to help seniors pay for trips overseas and maybe give them a few discounts.

It turns out it is a major earner of insurance money. Here is a chart which shows the insurance royalties at AARP over the last several years—insurance royalties which, frankly, indicate $111 million in 1999 up to $123 million in 2002. The same thing goes for the investments they have made. We can see that AARP makes a lot of money from the insurance business.

One of the companies they sell insurance with is UnitedHealth Group. It turns out, coincidentally, that UnitedHealth Group could be one of the biggest beneficiaries of the bill that is going to come before us. So AARP comes to this debate not with clean hands.

AARP is fronting for an insurance company that has the potential for dramatic profitability from this bill. So when AARP announces they are for this bill, they ought to be very honest with the seniors about what that means.

AARP receives millions of dollars from the sale of health insurance policies. AARP's insurance-related revenues made up a quarter of their operating revenues last year and one-third of their operating revenue in 2001.

They receive royalties from AARP insurance policies marketed to their members by UnitedHealth Group, MetLife, and others.

More than 3 million AARP members have health-related insurance policies from UnitedHealth Group. Last year, UnitedHealth Group earned $3.7 billion in premium revenues from their offerings to AARP members.

The royalties AARP earned as a result of lending their name to insurance products, as I mentioned, went up to $123 million in 2002. They received so-called access fees from insurance companies of over $10 million. They received something called a quality control fee of almost $1 million from insurers.

AARP also earns investment income on premiums received for members until the premiums are forwarded to UnitedHealth Group and MetLife. In 2002, AARP earned $26.7 million in such investment income.

There is a total of $161.7 million in revenue from insurance just in 2002.

According to Advertising Age magazine, AARP and UnitedHealth Group hired a direct marketing agency in May to conduct a marketing campaign for their insurance product that could cost $100 million.

UnitedHealth Group stands to gain significant portions of the new Medicare Advantage market that would be created by this bill, given that it is currently participating in a Medicare PPO demonstration project in eight States.

AARP can make a lucrative business even more lucrative by continuing its partnership with UnitedHealth Group. Let's take a look at AARP's advertising.

Last year, AARP earned $76 million on advertising. Their magazine, formerly called Modern Maturity, and now called AARP, The Magazine, has the largest circulation of any magazine in the United States, going to 21.5 million households.

The latest issue has three full-page ads for brand-name drugs, and another for a Pfizer glaucoma kit. It contains four ads for AARP's various kinds of insurance.

Combine that with the four ads for insurance in the November AARP Bulletin, and that is a lot of insurance advertising. The September/October AARP magazine and the October bulletin have a combined 14 ads for insurance.

There is a direct linkage between AARP and the insurance industry and another industry that stands to profit from this so-called Medicare prescription drug bill. It is interesting, too, that when the members of AARP were recently asked in a nationwide poll what they thought of this prescription drug bill that is pending before Congress, the results were amazing. A poll that was released 2 days ago showed that 66 percent of AARP members were somewhat or very unfavorable to the level of prescription drug coverage which I have just described in this bill. Eighty percent of AARP members do not believe this bill does enough to encourage employers to maintain current retiree coverage. Sixty-eight percent of AARP's membership were somewhat or very unfavorable to the following statement: This provision is designed to increase the number of seniors receiving their Medicare coverage through private health plans like HMOs and PPOs by significantly increasing Government subsidies for these plans.

So I would just ask this: If AARP is spending all of this money on behalf of their membership to promote a proposal which two-thirds or more of the members of AARP at this point oppose, what is driving this? I think it goes back to the earlier explanation. AARP is not acting as an advocate for seniors. AARP is acting like an insurance company. AARP has forgotten their mission. They have decided they have a new responsibility: They have to generate money from insurance companies.

Frankly, it is a sad situation because for many years AARP was respected across America for being a nonpartisan voice for seniors. Sadly, at this point in time they are not. As a result, there are very few who are standing up to speak for seniors and what they need.

When I take a look at this bill and what it does, it worries me that what started off as a prescription drug bill to help seniors has become so complicated that it is almost impossible to explain. It has gaps in coverage that will leave seniors without any help when they need it the most and instead is trying to dramatically privatize Medicare as we know it.

There are forces in Congress, primarily on the Republican side of the aisle, who want to privatize both Medicare and Social Security. That has been their goal. As a party, they never supported Medicare. Only a handful of Republicans voted for its creation. Over the years, they have made it clear where they stand. There was a time when former Speaker Gingrich and his assistant Richard Armey, who was a Congressman from Texas, said their goal was for Medicare to "wither on the vine." That does not sound like a group that really is supportive of the program. Instead, it sounds like a group that will look for every opportunity to make sure that Medicare is not as good as it should be.

So ultimately what they are proposing is this: They are going to move Medicare from the program we know today, a Government-run program with low overhead and low administrative costs that serves all Americans universally, to a new model which will bring in HMO insurance companies to cover senior citizens.

Naturally, they are afraid the free market will not work. So they put in generous subsidies to these HMOs so that they will lure away seniors out of Medicare. Here is how this will work: An insurance company wants to insure the healthiest people it can find. Insurance companies do not go out and look for sick people. Insurance companies try, if they can, to exclude from coverage anybody who is going to be expensive. Understandable. If they reduce their risk and exposure, they increase their profitability. So these HMO companies, which are being designed to lure away seniors from Medicare, are going to not only achieve this by looking for the healthiest seniors, they get an added boost from our Republican friends, our free market advocates who argue that they need a subsidy on top of the—billions of dollars in subsidies to these HMOs.

What is wrong with this picture? If one believes in the free market, why in the world would they subsidize an HMO company: so they could take the healthy people out of Medicare? That is exactly what they want to do. What will happen to Medicare then? There will be fewer people in Medicare because these Government-subsidized HMOs will be creaming off and cherry-picking the healthiest people and those left in Medicare are going to be poorer and sicker.

The net result of that is obvious. At the end of any given year, there is going to be a more expensive per-claimant Medicare cost. There will be sicker people left in Medicare.

Those who are opposed to Medicare and behind this idea believe that will drive down the popularity of Medicare. They will be able to stand on the Senate floor and the House floor and say: See, we showed you; Medicare just is not going to work; look how expensive it is for every senior under Medicare.

So they will have achieved their dream and goal by reducing the coverage of Medicare and convincing Congress not to stand behind it.

That is the goal of those who took what was a prescription drug bill, as complicated as it is, and turned it into a bill to privatize Medicare. That is what we have coming before us in the next few hours, in the next few days.

I think, frankly, that when one looks at the HMOs across America, they find that they are doing pretty well. They are pretty profitable, just like these pharmaceutical companies. The average compensation of a chief executive of the 11 largest insurance companies currently serving Medicare was more than $15 million—average compensation, $15 million. The former chairman of Oxford Health Plan—and I mentioned it earlier—was paid $76 million in 2002. According to Weiss Ratings, an insurance rating agency, profits for 519 health insurance companies they evaluated jumped 77 percent from 2001 to 2002.

UnitedHealth Group reported a 35 percent increase. That is the group that is joined at the hip with AARP, and both of them are widely applauding this new idea to move seniors out of Medicare into these HMOs, to privatize Medicare and raise the premiums seniors would have to pay under Medicare. So when we look at this alliance, we can understand why we have now come to the heavyweight division of the prize fights at the close of the congressional session. That is exactly what we are facing.

We have a situation where two of the largest lobbies in this town, two of the biggest special interest groups, two of the best financed industries in America, pharmaceutical companies and HMO insurance companies, are anxious to see us pass a bill which means more profitability for them. Sadly, it will be at the expense of the same people we were really trying to help in the first place.

When it is all said and done, the seniors will not get a helping hand. Drug costs are going to go up. The program they are proposing is so complicated, it is impossible to explain, so it is understandable, and ultimately Medicare as we know it, a program which has served America well for over 40 years, is going to be phased out and privatized and HMOs will take over.

Some people believe—and I believe they think it passionately—that the free market is the answer to everything. I would say to them, take a look at what the free market is doing to health insurance in America today. The free market is at work. The free market is in the process of doing what we expect it to do, increasing profitability. Ask anybody in America about health insurance costs or ask any group why they are going on strike in America. Nine times out of 10 they will say it is because of health insurance coverage: The company we worked for will not pay for the coverage; there is less coverage, and, frankly, we had to go on strike.

It is the No. 1 reason for work stoppages and strikes across America. It is the biggest problem in my State when it comes to business complaints. Health insurance companies are using the free market exactly as they are supposed to. They are reducing their exposure and risk, and they are increasing the cost to the people who need help. As a result, we are finding fewer Americans with worse coverage, and those who have it have worse coverage every single year.

The Republicans believe that that is what we should do to Medicare: We ought to let the same HMO companies that are fleecing businesses and families across America get their grimy hands on Medicare recipients. Let them, with a Government subsidy, lure away the healthiest Medicare recipients and leave the sickest behind. Now, that is good for the companies. It is not good for Medicare, it is not good for seniors, and I believe it is not good for America.

We are in a situation where we have an important decision to make. Some people have said to me: How can you possibly go back to your State and explain that you voted against a prescription drug benefit for seniors? Well, I think those people do not understand the seniors I represent and most seniors across America. These are people wise with years. These are people who have heard a lot of political promises. These are folks who are skeptical when politicians say: I am going to give you the Sun and the Moon. They ask hard questions.

When the seniors across America ask hard questions about this prescription drug benefit, they are going to be sorely disappointed. Two-thirds of seniors already say what they have heard is not enough. They do not want any part of it. That tells me that they are tuned in and following this debate. They want something that is basic, universal, and fair, something that does not come to them at the cost of things they value such as Medicare and Social Security.

Unfortunately, this program, which has been designed behind closed doors and is now being unveiled one corner at a time, is not going to meet the needs of seniors across America.

In the next few days, I am sure you will hear from my colleagues who are going to come and will explain in detail why this is a bad idea. I think we started off with the right goal, to help seniors pay for prescription drugs. Today, with this bill, we will have failed in meeting that goal. That is why I oppose it.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BYRD. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BYRD. Mr. President, I am under the impression that there will be a session of the Senate either tomorrow or on Monday or on Tuesday or on any number of those days. I am also under the impression that the Senate is rapidly, hopefully, approaching a sine die date for adjournment.

Being confronted with those expectations, I want to make a speech about Thanksgiving. I don't want it to appear in today's RECORD, necessarily, but I would ask for it to appear in the RECORD of the last day's session prior to Thanksgiving, whatever day that is.

I make such a unanimous consent request, that my speech not appear in today's RECORD but that it appear in the RECORD of the last day of the session prior to Thanksgiving.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The remarks of Mr. BYRD are printed in a future edition of the RECORD.)

Mr. BYRD. Mr. President, I yield the floor. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. COCHRAN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. BURNS). Without objection, it is so ordered.

HEALTHY FORESTS RESTORATION ACT OF 2003—CONFERENCE REPORT

Mr. COCHRAN. Mr. President, I ask unanimous consent that the Senate now proceed to the consideration of the conference report to H.R. 1904, the Healthy Forests Restoration Act.

The PRESIDING OFFICER. Without objection, the report will be stated.

The legislative clerk read as follows:

> The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 1904) to improve the capacity of the Secretary of Agriculture and the Secretary of the Interior to plan and conduct hazardous fuels reduction projects on National Forest System lands and Bureau of Land Management lands aimed at protecting communities, watersheds, and certain other at-risk lands from catastrophic wildfire, to enhance efforts to protect watersheds and address threats to forest and rangeland health, including catastrophic wildfire, across the landscape, and for other purposes, having met, have agreed that the House recede from its disagreement to the amendment of the Senate to the text of the bill and agree to the same with an amendment, and the Senate agree to the same; that the House recede from its disagreement to the amendment of the Senate to the title of the bill and agree to the same, signed by a majority of the conferees on the part of both Houses.

There being no objection, the Senate proceeded to consider the conference report.

(The conference report is printed in the House proceedings of November 20, 2003.)

Mr. COCHRAN. Mr. President, I am pleased to present to the Senate the conference report on the Healthy Forests Restoration Act.

Senators may remember that this bill was passed by the Senate on October 30 by a vote of 80 to 14. It embodied a bipartisan agreement to improve forest health on both public and private lands. It provides Federal land managers the tools to implement scientifically supported management practices on Federal forests, in consultation with local communities. It also establishes new conservation programs to improve water quality and regenerate declining forests on private lands. The legislation will reduce the amount of time and expense required to conduct hazardous fuel projects.

The conference report retains provisions adopted by the Senate that will protect old growth forests. It improves the processes for administrative and judicial review of hazardous fuel projects. But it will continue to require rigorous but expedited environmental analysis of such projects.

The conference report specifically encourages collaboration between Federal agencies and local communities to treat hazardous fuels that threaten communities and their sensitive watersheds. It provides for expedited environmental analysis of hazardous fuel reduction projects adjacent to communities that are at risk to catastrophic wildfire. It requires spending at least 50 percent of Federal hazardous fuels reduction funds to protect communities.

It requires courts considering legal actions to stop a hazardous fuel reduction project to balance the environmental effects of undertaking the project against those of not carrying it out. And in carrying out hazardous fuel reduction projects in areas that may contain old growth forests, it requires Federal agencies to protect or restore these forests.

In other areas, it requires agencies to maintain older trees consistent with the objective of restoring fire resilient stands. It authorizes $720 million annually for hazardous fuels reduction activities. It provides grants for removal of hazardous fuels and other biomass to encourage their utilization for energy and other products. It provides for assistance to private land owners to protect and restore healthy watershed conditions.

It authorizes research projects designed to evaluate ways to treat forests to reduce their susceptibility to insects, diseases and fire. It also authorizes agreements and easements with private landowners to protect and enhance habitats for endangered and threatened species. And it encourages more effective monitoring and early warning programs for insect and disease outbreaks.

This conference report would not be possible without the active involvement of Senators on both sides of the aisle who worked hard together to develop this bill. I especially appreciate the able assistance of the distinguished Senator from Idaho, Mr. CRAPO, who chairs the Forestry Subcommittee of the Senate Agriculture Committee; the Energy Committee chairman, the distinguished Senator from New Mexico, Mr. DOMENICI, and his Forestry Subcommittee chair from Idaho, Mr. CRAIG, were also very helpful in guiding this legislation along its path passage.

The Agriculture Committee also had assistance of Senator LINCOLN of Arkansas and active involvement on her part in developing the bill, and we also had the benefit of suggestions and assistance from Senators WYDEN and FEINSTEIN who came to me early and asked to be a part of the effort to develop this bill. They were involved along with many others whose contributions were necessary to make the approval of this bill possible.

The Agriculture Committee also benefited from the assignment of an employee of the Forest Service, Doug MacCleery, who assisted our staff in the development of this legislation. We appreciate his assistance. And our committee staff did a superb job under the able direction of the Agriculture Committee staff director, Hunt Shipman.

Let's not forget, it was President Bush, the President of the United States, who recommended in the first place that Congress act on a healthy forest initiative. It was at his suggestion and his urgings that we pushed and pushed until we finally achieved success, with the adoption today by the other body of the conference report, on this bill. I must also mention the able assistance of his Secretary of Agriculture, Ann Veneman, who provided valuable insight and assistance all along the way.

I urge the Senate approve this conference report.

The PRESIDING OFFICER. The Senator from Idaho.

Mr. CRAPO. Mr. President, this is truly a historic day. As the Presiding Officer knows, we have worked literally for a decade or more to try to find a path forward in the area of finding a solution to the problems we face in our national forests.

In recent years, we have seen an average of 4 million acres a year burn. We have seen devastating wildfires this year that have destroyed not only tremendous amounts of property and environment in our forests, but have also taken lives. We have seen insect infestations that have jeopardized the future of one of the most incredible environmental resources we have in America, our forests.

All of it has occurred while we have been battling in the courts, trying to find a path forward simply to allow our forest managers the ability to implement their forest management decisions, to deal with insect infestation, to deal with the threat of catastrophic wildfire, and to help preserve the great legacy we have in America, in our forests.

I stand today to thank those in our Senate conference who have worked with us to build and strengthen the bipartisan solution that has brought us to this point.

Sitting here beside me is the Senator from Mississippi, THAD COCHRAN, chairman of the Agriculture Committee. Without Senator COCHRAN's able leadership, without his patience and his wisdom in guiding us through this process, we would not be here today. I want to personally thank him. I thank him, as well, on behalf of a grateful Nation for the skill and the patience he has given us to help bring this bill forward.

Also, I thank Senator LARRY CRAIG, my colleague from Idaho, who has worked on this issue tirelessly for the better part of the last decade to try to help bring America to an understanding of the need for reform, and for helping us work through a bipartisan solution in the Senate. Senator CRAIG deserves great praise and commendation for his untiring work to help give us the possibility of being here today—just a short time away from successfully passing in both the House and the Senate this Healthy Forests legislation.

Also, Senator DOMENICI, chairman of the Energy Committee, has worked tirelessly on this issue and he deserves to be thanked for his tremendous efforts. Not many people follow it this closely, but there is forestry jurisdiction in both the Energy Committee and the Agriculture Committee. Senator COCHRAN chairs the Agriculture Committee, and Senator DOMENICI the Energy Committee. By coincidence, both of the Idaho Senators chair the respective subcommittees on forestry. Senator CRAIG chairs the subcommittee on forestry in the Energy Committee, and I chair the forestry subcommittee on the Agriculture Committee. Together, on the Republican side, we have developed a strong team to work in the Senate.

I also thank Senator BLANCHE LINCOLN, from Arkansas, for stepping forward as the ranking member on the forestry subcommittee and working with me to develop the senate bill that set the mark for improving this legislation and moving it through the Senate. We then expanded that bipartisan base and worked with Senators FEINSTEIN from California, WYDEN from Oregon, and others, including additional Republicans and Democrats, all of whom came together to bring a bipartisan solution to the Chamber.

It was not easy. There were many who wanted to use this issue to further their political efforts, to either cause further strife and conflict on the issue surrounding our forests or to simply promote some agenda that was not consistent with our efforts to move forward on a bipartisan basis to protect and preserve our forests.

We fought many battles over the last 2 or 3 months, and they were the resulting, concluding battles in a crescendo that has been developing over the last decade. When we were done, we needed to work with the House of Representatives. There was concern at that point. There was actually another filibuster to stop us from even going into conference with the House because there was concern that the bill would be changed too much in ways that would not allow us to find a common consensus-based path forward.

Yet we have gone on together, again, in that bipartisan fashion that we developed in the Senate to work in a bicameral fashion and bipartisan fashion with the House to come together with this legislation that is now before us.

As many of us said as we developed this legislation, it is not necessarily what any of us would have written had we had complete control over the issue. But it is the result of what can happen if we work across party lines, across the lines of the rotunda between the House and Senate, and across regional lines in our Nation, to try to make sure that we get past the politics, the partisanship, past the personal attacks, and focus on the principles that will allow us to move forward and develop positive legislation such as that.

I am confident this legislation will pass the Senate today. I am confident that when it goes to the President's desk, he will sign it. The United States will have taken a very big step forward in terms of preserving one of the great environmental legacies we have—our forests; we will have taken a step to protect and preserve our rural areas in America; we will have done much to protect our great firefighters, many of whom gave their lives this year, and in previous years, in trying to protect our forests and our communities; we will have put statutory protection in place for old-growth forests in our Nation; we will have worked to develop small-diameter timber and other uses of those parts of our forests that need thinning; we will have taken steps to make sure that rural communities such as Elk City, ID—literally at the end of the road—do not face the potential devastation a wildfire could cause not only to their economy but to their safety and the community at large; we will have protected the wildland urban interface, where so many of the people who now live in urban areas find their homes and lives and property threatened by the danger of uncontrolled wildfire.

All of these things will be brought together because we were successful today and, over the past few years, in bringing together the kind of politics that America wants, the kind of politics that is good and beneficial, that helps us to cross the divisions and eliminate those conflicts that so often bring us to a stalemate or a stall on the floor of the Senate or on the floor of the House.

Mr. President, again, I thank all Senators and all of the House Members who have done so much to look past their own individual concerns and to work together for the collective good of the whole as we built this strong bipartisan solution to a critical issue facing our Nation.

With that, I yield the floor.

Mr. DASCHLE. Mr. President, I am pleased to support the conference report on the Healthy Forest initiative.

The question of how we effectively and efficiently deal with the threat of wildfire is a complex one, and I have been committed to finding a solution that will provide the Forest Service with additional tools, can win approval in the Senate, and can become law. This bipartisan compromise meets that test.

As I toured the Black Hills National Forest this August, it was clear that the Forest Service needs additional tools to address the increasing fire risk to South Dakota communities. There are currently over 460,000 acres of the Black Hills National Forest that are in moderate to high fire risk. And, it is increasing. The Forest Service estimates that over 550,000 acres will fall into this category in the next 10 years if we do nothing to address it.

It is clear that we must find a way to allow Forest Service personnel to spend less time in the office planning, and more time in the forest actually clearing high fuel loads.

This legislation takes major steps to do just that. The legislation provides communities more flexibility in defining what should be considered priority areas as well as incentives to work near communities. It clarifies how much detail is needed for environmental analysis of fuel reduction projects. The conference report adopts the Senate-passed streamlined appeals process, expediting decisions for fuel-reduction projects while ensuring that the public has an opportunity to be heard early in the developmental stages forest restoration projects. And, it includes Senate-passed language encouraging speedy disposition of any projects that are challenged in court without giving undue deference to any party.

While the legislation is not exactly how I would have written it, I think it is the best shot we have to get something meaningful enacted into law this year. I am please the House has passed this legislation and encourage my colleagues to pass it, and hope the President will quickly sign it into law.

Mr. BAUCUS. Mr. President, I rise to urge my colleagues to support the Healthy Forests Restoration Act of 2003. This bill is extremely important to the west and to my constituents as we look for ways to reduce the risk of large and dangerous wildfires that threaten our homes and communities. You just have to look at the devastating fire season Montana went through this past summer to understand why we feel so strongly about this issue.

I have said that a healthy forests bill must first allow Federal agencies and communities to address dangerous fuel loadings on a local level, quickly and efficiently. Second, it must support small, independent mills and put local people to work in the forests and the mills. Third, it must promote and protect citizen involvement and be fair to the principals underlying the federal judicial system. And finally, it must protect special and sensitive places.

We have achieved that with this legislation.

My one disappointment is that the conference committee stripped out the Rural Community Forestry Enterprise Program. I worked together with Senators CRAPO and LEAHY to include this program in the Senate bill, first in the Agriculture Committee and then as part of the Senate-passed bill.

The Rural Community Forestry Enterprise Program would bring much needed support for building and maintaining a thriving forest industry in rural communities.

Just as this industry is important to maintaining the economic vitality of these small and often remote communities, it is vital to meeting the objectives of this legislation. We cannot afford to lose more mills and highly skilled forest industry workers in Montana. We cannot accomplish needed hazardous fuel reduction work without them.

I would like to share with you concerns I heard today about the removal of the Community Enterprise Program from a friend, Jim Hurst, the owner and operator of a small family-owned mill called Owens and Hurst, in Eureka, Montana.

He said:

> Small mill owners like myself and Ron Buentemeier, the General Manager of F.H. Stoltze Land and Lumber Company in Columbia Falls, told you we needed this type of help to make the Small Business Set-Aside program more responsive to the needs of small, independent and mostly family-owned mills across Montana. You responded with the Community Enterprise program.
>
> This is an important program and should be put back into the Healthy Forests Bill. Independents have been under long-time family ownership and because of that my family and the other families who own mills know that we each have one heck of a responsibility to our communities. This Community Enterprise program would help the independents who have been impacted the hardest by reduced federal timber supply. They have shown their mettle and have been courageous. We need to keep fighting for small mill owners, operators and the rural communities who depend on these small mills for their livelihood.

While I will continue to work with my colleagues on both sides of the aisle to ensure a thriving forest industry in our rural communities, it is imperative to pass this legislation now. I believe we do have a serious problem with the buildup of hazardous forest fuels and that we need to do a better job of addressing it now.

The legislation has the elements necessary to allow local citizens and leaders to make wise decisions that address this problem efficiently and effectively and I urge my colleagues to support it. I would like to thank several Senators for their hard work on this bill, including Senators WYDEN, FEINSTEIN, CRAPO, LINCOLN and COCHRAN. Without their dedicated efforts and leadership that I was very pleased to support, we would not be the close to passing this bill today.

Ms. MURKOWSKI. Mr. President: I rise today in strong support of the conference report for the Healthy Forest Restoration Act of 2003.

I especially thank my colleagues—Senator COCHRAN, Senator DOMENICI, Senator CRAPO, Senator CRAIG, Senator LINCOLN, Senator WYDEN, and Senator FEINSTEIN for the leadership they demonstrated in addressing this national crisis that affects all Americans, particularly those who live in the urban-wildland interface.

The conference report is a major step forward toward preventing the severe wildland forest and rangeland fires that have become an annual event. What is more important is that the human tragedy associated with wildfires the heartbreak of losing one's home and possessions, the economic losses, and the dangers that wildfires pose to our devoted wildland firefighters will be reduced through the sound forest management practices provided for in this legislation.

The 2002 and 2003 fire seasons have been some of the worst on record nationally. Forest fires continue to create extensive problems for many Americans, predominantly for those living and working in the West. In 2002, Alaska alone experienced fires that burned more than one million acres.

These catastrophic wildfires caused great damage to our forested lands; many were already vulnerable as a result of unaddressed insect and disease damage.

Deteriorating forest and rangeland health now affects more than 190 million acres of public land, an area twice the size of California.

In my home State of Alaska, the damage caused by the spruce bark beetle, especially on the Kenai Peninsula has been devastating. Over 5 million acres of trees in south central and interior Alaska have been lost to insects over the last 10 years.

I am particularly enthusiastic that this legislation authorizes and expedites fuel reduction treatment on Federal land on which the existence of disease or insect infestation has occurred, such as those on the Kenai Peninsula. Federal land managers will now be able to manage these dead and dying tree stands.

The key to long-term forest management on the Kenai Peninsula is to manage the forested landscape for a variety of species compositions, structures and age classes; not simply unmanaged stands. The legislation before us will do just that, and will prevent a reoccurrence of the type of spruce bark beetle mortality we have experienced in Alaska.

I firmly believe that this conference report is a comprehensive plan focused on giving Federal land managers and their partners the tools they need to respond to a national forest health crisis. The legislation directs the timely implementation of scientifically supported management activities to protect the health and vibrancy of Federal forest ecosystems as well as the communities and private lands that surround them.

Under this legislation, the Secretaries of the Interior and Agriculture will conduct authorized hazardous fuel reduction projects in accordance with the National Environmental Policy Act with a critical, streamlined process.

Additionally, for those authorized fuel reduction projects proposed to be conducted in the wildland-urban interface, the Secretaries will be able to expedite such projects without the need to analyze and describe more than the proposed agency action and one alternative action. In other words, we can now get the work on the ground done quickly.

Still, the Secretaries must continue to provide for public comment during the preparation of any environmental assessment or EIS for these authorized hazardous fuel reduction projects. The public process is not undermined in this legislation.

I also support the proposed new administrative review process associated with these authorized fuel reduction projects. Too often we have become mired in administrative appeal gridlock in this country at the expense of communities at risk to wildland fire. We saw such devastation recently in the State of California.

This legislation will establish a fair and balanced predecisional review process. Specific, written comments must be submitted during the scoping or public comment period.

Additionally, civil actions may be brought in Federal district court only if the person has exhausted his/her administrative review process. The legislation will foreclose venue-shopping.

It encourages the courts to weigh the environmental consequences of management inaction when the potential devastation from fires could occur. This provision is important public policy and demonstrates to the American people that the risk of catastrophic wildfire must be known, understood and respected in our judicial system and acted upon quickly.

I am also excited about title 2 of the legislation which will encourage the production of energy from biomass. Developing energy from biomass could provide a tremendous boost to the local economy on the Kenai Peninsula while reducing the dangerous wildland fire risks that exists there. That is a win-win solution. The biomass provision is innovative, environmentally sound and a good approach in achieving healthy forests.

The bipartisan legislation before us is good for the nation and good for Alaska. I will enthusiastically support its passage today.

Mrs. BOXER. Mr. President, southern California has recently experienced the devastating impacts of wildfire first-hand. More than 750,000 acres burned, and 24 people died. We have seen how important it is to take the appropriate steps to protect our vulnerable communities from the threat of wildfire, and that is why I am supporting this bill.

The bill before us invests in preventing wildfires, rather than just trying to fight them after the fact. Each year, $760 million is authorized for wildfire prevention projects, such as tree and brush removal, thinning, and prescribed burning. In total, the bill would allow treatment of 20 million acres. Priority is given to projects that protect communities and watersheds, and at least 50 percent of the funds must be used near at-risk communities. The other 50 percent will be spent on projects near municipal water supply systems and on lands infested with disease or insects. This is a good start at preventing fires.

I do, however, have to mention my deep disappointment with the House Republican conferees for removing my amendment to help firefighters who battle the biggest fires. I am almost speechless that the House Republicans would turn their backs on our brave firefighters.

My amendment, which passed the Senate 94 to 3, would have required long-term health monitoring of firefighters who fought fires in a Federal disaster area. These firefighters are exposed to several toxins known to be harmful to long-term health, including fine particulates, carbon monoxide, sulfur, formaldehyde, mercury, heavy metals, and benzene. This amendment was important to the firefighters in my State and was supported by the International Association of Firefighters.

I pledge to the firefighters, this is not over. I will be back to continue fighting on behalf of all firefighters who are put at risk in Federal disasters.

I am also disappointed that the conferees dropped another amendment of mine, which was included in the Senate-passed bill. My amendment required the EPA to provide each of its regional offices a mobile air pollution monitoring network, so that in the event of a catastrophe, toxic emissions could be monitored and the public could know the health risks.

Despite the fact that the conferees dropped my two amendments, I believe this bill will help protect communities from the threat of wildfires, which is why I am supporting it.

Mrs. FEINSTEIN. Mr. President, today's vote to pass the Healthy Forests legislation is a major bipartisan victory. This is not just because it is the first major forest bill in 27 years.

Much more significantly, we have nourished the middle ground in the forest debate that is so often lost in the partisan rhetoric.

We actually can create good rural jobs, protect our communities, and restore our forest environment at the same time.

Let me repeat this: we can create rural jobs, protect our communities, and take action to restore the health of our forests at the same time.

Ever since I cosponsored the Herger-Feinstein Quincy Library Group Act 5 years ago, I have been working to bring together the rural, forest-dependent communities—rather than unnecessarily dividing them.

This bill goes a long way to that end throughout the West and the Nation.

There are many people who deserve credit for this bill, but there are a few Senators in particular to whom I want to give special thanks. Senators PETE DOMENICI and LARRY CRAIG were the best bipartisan allies I could ever ask for in terms of how they approached this issue.

Even though they are in the majority, Senators DOMENICI and CRAIG realized that a forestry bill needed a bipartisan coalition. They worked in good faith with me and Senator WYDEN from start to finish, and I am deeply grateful for it.

I also want to thank Senator COCHRAN, the chairman of the conference on this bill, for his leadership throughout the process. Senator COCHRAN ably and skillfully represented the Senate position in the negotiations. I particularly want to emphasize that his staff conducted the conference in a fine and fair manner throughout, and it's a credit to his leadership.

There are many others Senators who played critical roles in this process, including Senators CRAPO, KYL, LINCOLN, MCCAIN, BAUCUS, and BINGAMAN.

I finally want to thank Senator WYDEN, the ranking member on the Forestry Subcommittee of the Energy Committee. He is as good a ranking member and as good a leader on forestry as the Democrats could ever have.

I also want to say that I second his views on the meaning of the different parts of the bill in his statement today. As the two principal Democratic negotiators of this bill, he and I are in complete accord as to the meaning of its contents.

This legislation H.R 1904, approved by a House-Senate conference committee today is very similar to a bill passed by the Senate last month, with priority given toward removing dead and dying trees and dangerously thick underbrush in areas nearest communities as well as targeting areas where insects have devastated forests. This is especially important in California, where hundreds of thousands of trees have been killed by the bark beetle, creating tinderbox conditions.

While the recent wildfires in Southern California have been contained, these deadly fires consumed a total of 738,158 acres, killed 23 people, and destroyed approximately 3,626 residences and 1,184 other structures. Clearly, we must do everything we can to avert such a catastrophe in the future. The National Forest Service estimates that 57 million acres of Federal land are at the highest risk of catastrophic fire, including 8.5 million in California, so it is critical that we protect our forests and nearby communities.

More than 57 million acres of Federal land at the highest risk of catastrophic fire, including 8.5 million in California. In the past 5 years alone, wildfires have raged through over 27 million acres, including nearly 3 million acres in California. It is critical that Congress acts to protect our forests and nearby communities.

The House-Senate agreement both speeds up the process for reducing hazardous fuels and provides the first legal protection for old growth in our nation's history.

Let me describe what the legislation would do.

Critically, it would establish an expedited process so the Forest Service and the Department of the Interior can get to work on brush-clearing projects to minimize the risk of catastrophic wildfire.

Up to 20 million acres of lands near communities, municipal watersheds and other high-risk areas can be treated. This includes lands that have suffered from serious wind damage or insect epidemics, such as the bark beetle.

We made an important change to the bill's language in section 102(a)(4) in the conference report. In the Senate-passed bill, the insect and disease exception was related to infestations, whereas in the conference bill, the exception has been clarified to apply only where there is a presence of an epidemic of insects or disease. By its own terms, an insect or disease-related event of "epidemic" proportions is different from "endemic" insects and disease, which are present in a naturally functioning forest ecosystem.

Under the final bill, only epidemics are given special treatment. This is an important distinction.

A total of $760 million annually for hazardous fuel reduction is authorized by the legislation, a $340 million increase over current funding.

At least 50 percent of the funds would be used for fuels reduction near communities.

The legislation also requires that large, fire-resilient, old-growth trees be protected from logging immediately.

It mandates that forest plans that are more than 10 years old and most in need of updating must be updated with old growth protection consistent with the national standard within 2 to 3 years.

Without this provision in the amendment, we would likely have to wait a decade or more to see improved old-growth protection. And even then there would be no guarantee that this protection—against the threat of both logging and catastrophic fire—would be very strong.

In California, the amendment to the Sierra Nevada Framework that is currently in progress will have to comply with the new national standard for old-growth protection.

Let me explain how the agreement improves and shortens the administrative review process and makes it more collaborative and less confrontational. It is critical that the Forest Service can spend the scarce dollars in the federal budget in doing vital work on the ground, rather than being mired in endless paperwork.

The legislation fully preserves multiple opportunities for meaningful public involvement. People can attend a public meeting on every project, and they can submit comments during both the preparation of the environmental impact statement and during the administrative review process. I guarantee you the public will have a meaningful say in these projects.

The legislation changes the environmental review process so the Forest Service still considers the effects of the proposed project in detail, but can focus its analysis on the project proposal, one reasonable alternative that meets the project's goals and the alternative of not doing the project, instead of the 5-9 alternatives now often required.

In the highest priority areas within 1½ miles of communities, the Forest Service need only study the proposed action and not alternatives. There is no relaxation from current law, however, in how closely the Forest Service must study the environmental effects of the project it is proposing to undertake.

The legislation replaces the current Forest Service administrative appeals with an administrative review process that will occur after the Forest Service finishes its environmental review of a project, but before it reaches its decision. This new approach is similar to a process adopted by the Clinton administration in 2000 for review of forest plans and amendments to those plans. The process will be speedier and less confrontational than the current administrative appeal process.

Next I want to turn to judicial review. I want to emphasize that cases will be heard more quickly under the legislation and abuses of the process will be checked, but nothing alters citizens' opportunity for fair and thorough court review.

Parties can sue in Federal court only on issues raised in the administrative review process. This is a commonsense provision that allows agencies the opportunity to correct their own mistakes before everything gets litigated.

Lawsuits must be filed in the same jurisdiction as the proposed project.

Courts are encouraged to resolve the case as soon as possible.

Preliminary injunctions are limited to 60 days, although they can be extended if appropriate. This provision sends a signal to courts not to delay important brush-clearing projects indefinitely unless there really is a good reason to do so.

The court must weigh the environmental benefit of doing a given project against its environmental risks as it reviews the case.

In closing, I want to say that my colleagues and I have been trying to come to an agreement on a forest bill for several years. We finally broke through the deadlock.

I am deeply pleased that we are enacting this legislation to give the residents of southern California and elsewhere a better chance against the fires that will come next time.

SECTION 105(C)(3)(B)

Mrs. FEINSTEIN. I have a question for the Senator from Oregon as to the meaning of one specific provision of the conference report on the Healthy Forests Restoration Act of 2003. This provision is section 105(c)(3)(B), which sets forth an exception to the general requirement that parties must participate in the administrative review process before raising claims in Federal court. I don't understand the conference report and statement of the managers as doing anything to change the parties' preexisting obligations as to environmental review except as explicitly provided in the statute. Do you agree, as the ranking member on the Subcommittee on Public Lands and Forests of the Senate Committee on Energy and Natural Resources?

Mr. WYDEN. I have the same understanding of this matter as the Senator from California.

Mr. LEAHY. Mr. President, I will oppose the conference report on H.R. 1904, the so-called Healthy Forests Act. While I have several substantive concerns about this legislation, let me first speak about the process by which this legislation has come before the Senate.

As my colleagues know, there has been a significant and growing concern about the way the other side is operating conference committees. In fact this conference was delayed several weeks because the minority has continually been excluded from conferences.

However, in good faith, I, along with interested Members and their staffs, worked out an agreement on the first six titles of the bill. Coincidentally, there were only six titles in the House version of the bill. An agreement was reached on those first six titles, and while I still had serious concerns about the substance of the agreement, I did not object to the process moving forward. I did so because I was given commitments that we would work out an agreement between the House and Senate on the remaining three titles that were passed by the Senate.

But what happened next is absolutely astounding. One half hour before the conference committee was scheduled to meet, I was informed that the conference would only consider the first six titles of the bill, and that the remaining titles that were passed by the Senate were "off the table."

Yet another backroom deal was cut by the other side to exclude the minority from any real conference proceedings.

These were highly important provisions that were passed by the Senate. Of particular importance to me was the Rural Community Forestry Enterprise

Program, which I authored with Senators CRAPO and BAUCUS. In my State of Vermont we have a good deal of small-diameter trees for which we need help finding markets. This program would build on the existing expertise of the Forest Service by providing technical assistance, cooperative marketing and new product development to small timber-dependent communities. Whether it is producing furniture, pallets, or other creative new markets, this program would help small forest-dependent communities expand economically.

Back room deals summarily excluded this, and several other important initiatives in the Senate-passed bill, from consideration in the conference committee. That is why I declined to sign this conference report.

I will not vote for this conference report because this bill before us remains a well-camouflaged attempt to limit the right of the American people to know and to question what their Government is doing on the public's lands.

The bill before us is really a solution looking for a problem. So let's take a closer look at the "solution" on the table.

First, the bill would make it much more difficult for the public to have any oversight or say in what happens on public lands, undermining decades of progress in public inclusion. In this new and vague pre-decisional protest process, this bill expects the public to have intimate knowledge of aspects of the project early on, including aspects that the Forest Service might not have disclosed in its initial proposal.

The bill gives the Forest Service a real incentive to hide the ball or to withhold certain information about a project that might make it objectionable, such as endangered species habitat data, watershed analysis, or road-building information. If concerns are not raised about this possibly undisclosed information in the vaguely outlined "predecisional" process, the Forest Service can argue to the courts that no claims can be brought on these issues in the future when the agency, either through intent or negligence, withholds important information from the public.

Essentially, this provision penalizes citizens and rewards agency staff when the agency does not do its job in terms of basic investigation and information sharing regarding a project. This bill makes other significant changes to judicial review. It will force judges to reconsider preliminary injunctions every 60 days, whether or not circumstances warrant it.

In many ways, this provision could backfire on my colleagues' goal of expediting judicial review. It will force judges to engage in otherwise unnecessary proceedings, slowing their consideration of the very cases that proponents of H.R. 1904 want to fast track. Moreover, taking the courts' time to engage in this process will also divert scarce judicial resources away from other pending cases. It is also likely to encourage more lawsuits. Requiring that injunctions be renewed every 60 days, whether needed or not, gives lawyers another bite at the apple, something they often find hard to resist.

Instead of telling the courts when and how to conduct their business, we should instead be working to find a workable and effective approach to reducing wildfire risks.

This bill does not achieve that, but, with these provisions that minimize the public's input, it instead poses a real risk to the checks and balances that the American people and their independent judiciary now have on Government decisions affecting the public lands owned by the American people.

Sadly, this bill plays a bait-and-switch trick on communities threatened by wildfires. It is not fair to roll back environmental laws, public oversight, or judicial review under the guise of reacting toe devastating wildfires. It will do nothing to help or to prevent the kid of devastation that southern California recently faced. It is a special interest grab-bag shrouded behind a smokescreen.

We should be offering real help and real answers, instead of allowing fear to be used as a pretext for taking the public's voice out of decisions affecting the public's lands and for ceding more power to special interests.

Mr. COCHRAN. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. COCHRAN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. COCHRAN. I understand we can proceed to adopt the conference report on a voice vote since there is no objection to that. First, I am happy to yield to the assistant majority leader.

Mr. McCONNELL. Mr. President, I will not object. I simply came to the floor to congratulate the distinguished Senator from Mississippi and the Senator from Idaho for an extraordinary job on a very difficult subject on which they have worked for years. I commend them both so much for this very important piece of legislation.

The PRESIDING OFFICER. If there is no further debate, the question is on agreeing to the conference report.

The conference report was agreed to.

Mr. COCHRAN. Mr. President, I move to reconsider the vote.

Mr. CRAPO. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. COCHRAN. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

MEDICARE PRESCRIPTION BENEFITS

Mr. BAUCUS. Mr. President, I would like to speak a few minutes about the upcoming Medicare conference report that will be before this body—I don't know when—maybe Sunday, Monday, Tuesday. Before I do so, I would like to thank and compliment many people who helped bring this legislation to this point. For many years, many of us in Congress have urged the passage of prescription drug benefits legislation for seniors. We have been close to passage many times in the last several years.

I remember last year, for example, about this time when Congress was close to adjournment. I called a meeting together in my office for one last chance—Senator KENNEDY, Senator SNOWE, myself, Senator HATCH, and other Senators who were vitally concerned about passing prescription drug legislation. We worked mightily. We worked very hard. At the very end, the talks collapsed. It didn't work, largely for political, partisan reasons, I might add, and we were not able to get a bill passed.

Here we are again. We are at the brink. We are on the verge. We are very close to getting prescription drug legislation passed. This time I very much hope that all of us—as Senators and House Members—put partisan differences aside and suspend judgment. That is, we should look at the legislation, look at the facts, and not listen to the rhetoric from various groups, to see what really makes sense.

There are a number of people I wish to thank at this time—the chairman of the committee, Senator CHUCK GRASSLEY, who has worked very hard; Senator BREAUX, also a member of the committee; Senator OLYMPIA SNOWE, a member of the committee.

In addition, Congressman BILL THOMAS, chairman of the Ways and Means Committee, has worked extremely diligently. The Speaker of the House, the majority leader of the House, TOM DELAY; the majority leader of the Senate, BILL FRIST—there are many people who have worked very hard. I thank them very much for their efforts and for their work.

One person I also wish to thank is Senator TED KENNEDY. Senator KENNEDY worked very hard to help us pass prescription drug legislation in the

Senate not too many weeks ago. He worked very hard. He worked with me. He worked with the minority leader. He worked with the majority leader. He worked with various Members of the Senate who were critical to passage of the bill.

I thank Senator KENNEDY for his yeoman's work to help pass prescription drug benefits legislation in the Senate. He also worked very hard to help get a conference report put together. He spent a good deal of time with the conferees, with myself, with the Senator from South Dakota, Mr. DASCHLE, the Senator from Tennessee, Mr. FRIST, and many other people trying to help get prescription drug legislation passed. I regret at this point that he and I have a different view of this bill. He believes there are certain flaws in this bill. I think this is a good bill and should be passed. Nevertheless, Senators should know that Senator TED KENNEDY has done a great job in helping move this legislation to the point it is today. Without his efforts, this bill would be flawed in many areas. He helped make this, in my judgment, quite a good bill.

Why should we pass prescription drug benefits legislation? I suppose the main reason is that times have changed so dramatically. In 1965, when Medicare was enacted—and it was enacted by a large vote margin—prescription drugs were not necessary. Most senior citizens were more concerned with doctors, office calls, and hospital visits for their medical concerns, rather than prescription drugs.

Look what has happened in the last 38 years since the Medicare Act passed. Prescription drugs and generic drugs are so vitally important today. They replace procedures. They help prevent the onset of disease. Often times, the medications people take tend to prevent, forestall, and delay all kinds of maladies. They are really important, much more important today and getting more important every day.

In addition, prescription drugs are becoming more expensive—much more expensive—and it is putting seniors in a bind. Many low-income seniors are in a real bind.

I worked at a pharmacy during one of my work days at home. I have worked at many different jobs in Montana. I show up at 8 o'clock in the morning with a sack lunch. I have worked in sawmills, I have waited tables. One day I was working in a pharmacy in Montana. I saw senior citizens walk up to the pharmacist in a quiet voice and ask how perhaps they could change their medication or what prescription should they cut back on because they couldn't afford to pay for them all.

Seniors couldn't afford to pay it. It was stunning, and it was sad. It was a revelation to me. You hear about it, but when you see it, it has a real effect. It happens. Many low-income seniors are having a very difficult time trying to make ends meet. Sometimes it is a tradeoff between buying prescription drugs, buying food, and paying the rent. It happens way too frequently, and it is just not right for our country, the United States of America, to let this happen.

This legislation does a good job in remedying this situation. First of all, it is $400 billion of prescription drug benefits for seniors spread out over 10 years—$400 billion. That is a lot of money, but we have a lot of seniors who have great needs.

Under this legislation, seniors will find they will not have to pay all the cost of the drug but, rather, 25 percent, and the rest will be picked up by Medicare, the Federal Government, through the mechanism that is designed in this bill. They will only pay a quarter. But if you are a low-income senior, you are in a much better position under this legislation.

One-third of United States seniors are classified as low-income. A full one-third are low-income. Under this bill, low-income citizens will find that 90 percent of their benefits are covered—90 percent. That means low-income people can get the prescription drugs they need and will not have to walk up to that pharmacist and, in a hushed, quiet tone, ask what tradeoff, what drugs that person should cut back on because he or she cannot afford them.

If you are a low-income senior—and one-third of Americans are low-income. In my State, that is about 46,000 seniors who will be affected; there are about 46,000 seniors in the State of Montana who are low-income, out of about 140,000 seniors statewide. The general rule for all seniors is 75 percent of your prescription drug costs; if you are low-income, 90 percent of your prescription drugs will be paid for.

This is good legislation. We are here at a time when people in our country are asking us, Should we help our seniors or should we not?

Let me mention a couple additional reasons why I support this bill.

First of all, it helps rural America. Mr. President, there is an extra $25 billion in this bill for rural health care. The $400 billion I mentioned earlier all goes to benefits for seniors, either directly or indirectly. But $25 billion extra goes for providers and $25 billion is for rural America.

Why is that so important? It is so important because of the cost and the strain of the practice of medicine in rural America. We run the risk of not having good, adequate health care in rural parts of our country. We have all talked to many doctors and nurses who practice in rural parts of our country. They talk about the hours. They want to serve their patients. Believe me, they want to serve their patients, but after a while there comes a time when they are just worn out.

In rural parts of America, there are often pathologists—or pulmonologists or other specialists—who have to be on call all the time or on call every second or third day. Why? Because there are fewer of them in rural America than in urban America. The costs, believe it or not, are also very high in rural America—in many cases higher than in cities. There are the transportation costs, the cost of distances, the travel costs, for patients, doctors, and suppliers.

Our State of Montana is a low-income State, unfortunately. Our per capita income in Montana is low, but we are in the middle of all the States when it comes to cost of living. We are about the bottom when it comes to family income, but we are in the middle when it comes to costs. It is because we are a rural State, and this is true for rural parts of all States.

This bill finally helps address the unlevel playing field that has existed between urban and rural America. Now rural America, finally after many years, gets its fair share.

When I first came to the Senate years ago, I realized just how hard it was for rural America to get a square deal, particularly in health care. It was stunning. Every year since I have been here, I have been working to try to get rural America a square deal compared with urban America. I was part of an organization—and I still am—called the Rural Medicare Caucus. In fact, I chaired it for a few years. Every year I am here, I have—as I know my good friend from Montana, the Presiding Officer has—worked to help to make sure that rural parts of the country are getting a fair deal. This is not rhetoric. This is real. After all of these years, finally rural America gets a fair deal.

I also support this legislation and strongly advocate for its passage because it makes sure that senior citizens, wherever they live in our country, get a universal Medicare prescription drug benefit. Now, this certainly is true in the first years after this legislation is effective, but it is also true in the future. It is also true when preferred provider organization plans are designed to come into effect. It is also true in the year 2010 when in six regions of the country, there may be demonstration projects selected to test a new system called premium support.

In all respects, all seniors in all parts of the country, in all years, will have access to the same prescription drug benefit as any other senior, in any other part of the country, in any other year. This bill does not undermine traditional Medicare fee-for-service. The drug benefit is universal and nationwide in all respects. The bill does not undermine traditional Medicare—that is, Part A and B—during the years in which it is in effect. In a few moments I will return to this and will explain in greater detail.

This bill also very much helps address an issue that is on the minds of a lot of Senators—retiree coverage. When the bill was debated in the Senate, the prediction was that companies, States, municipalities, and nonprofit organizations might drop their retiree coverage because the bill, when passed, would provide government drug benefits to seniors. The thinking was why should companies not just go ahead and drop their retiree coverage.

Well, when the Senate took up this legislation, the CBO, which is the organization we rely upon for estimates, said that the drop rate might be about 37 percent. Since then, they have revised their numbers and they have come up with other figures. In short, if one compares apples with apples, the conference report that will soon be before this body results in a retiree droppage rate that is about 50 percent less than the bill that passed this body by a vote of 76 to 21. Maybe it is 45 percent. Stop and think about that for a moment.

For Senators who voted for the Senate bill, they can be comforted and relieved that retiree droppage rate is estimated by CBO to be about half of what it was in the Senate bill.

Let's focus a little bit on the retiree provisions. Essentially, companies receive about $88 billion under this bill for their retiree benefits. The net effect is that it will discourage companies from dropping—not encourage droppage. We all are very concerned that companies across America are beginning to cut back, and have cut back, on the number of retirees who have health care benefits or on the nature of the benefits. It is happening in America. It is happening in America as the world becomes even more competitive with global competition and as companies strive to cut down on their costs to increase their profit margins. One of the ways they can do so is cut back on employee and retiree benefits. This is happening. We know it is happening.

This legislation tends to discourage companies from cutting back. It tends to help companies keep coverage. It discourages dropping retiree coverage—it does not accelerate it. Again, it is because of the additional dollars that are going to companies. The companies still get the tax deduction for their health benefit plans. That is unchanged. In addition, under this legislation, the payments to the companies for retiree coverage are tax free. One could even say perhaps there is a little double-dipping because the assistance is tax free. This is a tremendous additional financial benefit to companies, to nonprofits, to cities, and other plans to encourage them to keep their coverage. It is a bonus. It is an incentive. This is another reason passage of this legislation is important—because it helps companies keep their retiree health plans. As a result, employers will tend less to drop retiree coverage. They will probably tend to maintain and increase it.

There is also a myth about this bill that is there is a coverage gap on prescription drug coverage that will leave seniors out in the cold. Well, the truth about this so-called donut hole gap is the majority of seniors will never reach the spending level where they would not have coverage. Even more important, seniors who are low-income get full coverage in the benefit gap.

Of course, we wish we had more money to give a complete benefit to everyone without any donut hole, but we do not have an infinite number of dollars. We only have $400 billion. It sounds like a lot, and it is a lot, but if we are going to give a universal drug benefit to seniors that is honest, that makes sense, that does something, not over the top but that makes sense for all seniors, it would cost a lot more than $400 billion. We have limited ourselves to $400 billion, and at $400 billion there are going to be some people who will not get quite the same benefit as other people, but they will all get the benefit.

I might add that if we looked at each State, the number of seniors who have coverage for prescription drugs varies. In some States it is very high. In some States it is low. Compare that with the passage of this bill, every State gets about 96.6 percent. That is virtually 100-percent coverage. That is a big improvement.

Let's take the State of Delaware, for example. I know the Senators from Delaware know their State a lot better than I. Today, about 27 percent of seniors in Delaware have no drug coverage. Only 3.4 percent will be without coverage once this bill is enacted. Let me restate this positively; 27 percent of seniors in Delaware today do not have drug coverage. When this bill passes, virtually every Delawarean will have drug coverage.

The same is true of the State of California. Now about 21 percent of California's seniors and disabled live without prescription drug benefits. This bill will reduce this number to 5 percent. Again, most seniors, in California and in every other State, would benefit as a consequence of this legislation.

I would like to address some concerns others have raised regarding this bill. The concerns are that this legislation undermines traditional fee-for-service Medicare—that this is the beginning of undermining Medicare, the camel's nose under the tent. This is the charge.

What are the facts? The bottom line: Fee-for-service Medicare, traditional fee-for-service Medicare as we know it today, is held harmless under this bill. This is the bottom line. So if you are a senior in the United States of America you can decide that you want to keep traditional Medicare and that you do not want to join a private plan—any of the plans that may or may not exist in the future. That is, it is voluntary. A senior can either join or not join. It depends on what he or she wants to do. It is an honest choice because fee-for-service traditional Medicare remain what it is today. It is held harmless. That is, the deductible doesn't change, the copay doesn't change, the benefits don't change. What exists today is what exists under this legislation. I hope Senators listen to that. I hope staffs of Senators listen to that. I hope the others who are listening, who are concerned about the bill, listen to that.

Let me explain this in greater detail. The bill finally provides a prescription drug benefit for senior citizens. We have had this opportunity many times in the past. We now have the chance to seize this opportunity. The bill also makes some changes in the general Medicare structure in terms of setting up some health care plans in the future, assuming the plans actually take shape, form, and come into existence. They don't exist today. I am referring to regional PPOs; that is, regional preferred provider organizations. They don't exist today. There are other managed care companies called HMOs in many cities. They exist in the cities primarily because they can cherry-pick counties. They can pick the counties in which they want to provide service, and if they do not want to pick one county because it is less profitable, they do not have to. If they want to serve another county because it is more profitable for them, they do. This is the way HMOs operate today. This is the system today.

This legislation says, beginning in the year 2006, our country will be divided up into various regions. Insurance companies will be allowed to offer Medicare services, including drugs, in any of the regions. The question remains, What about traditional fee-for-service? What happens to traditional fee-for-service in an area where a company sets up a plan? What if one wants to remain in traditional Medicare? The answer is, fee-for-service is held harmless. There is no change in fee-for-service.

If regional PPOs serve a region, it has to serve the entire region. It can't choose this part of this State and that part of that State. It has to serve the entire region—people in the cities; people in the rural parts of that region. Everybody has to get the same deal.

The senior living in one of these regions has a choice. The senior can stay in traditional fee-for-service Medicare or can join the plan. But fee-for-service Medicare is held harmless. There is no change to traditional Medicare.

Obviously, this does not undermine traditional Medicare as we know it. This bill builds up and strengthens Medicare. There are additional dollars here for hospitals, for doctors, for providers who will provide traditional

Medicare. So this bill does not in any way undermine traditional fee for service. In fact, Medicare is held harmless under this legislation.

Some people say: That's OK, Max, we understand that, but what we are really concerned about is the so-called premium support demonstration areas. Their argument is, in those areas, traditional fee-for-service is undermined. Private plans will pull away seniors, and it will be unfair to seniors who remain in Medicare. It is the beginning of the demise of traditional fee-for-service Medicare, they argue.

That is not true. It is nonsense. Look at the facts. Look at what is in the legislation.

Let me just remind Senators that this legislation is now available for Senators to look at. Thank goodness, because when they look at it, they are going to see what is and is not included. I just ask Senators to trust me long enough to suspend judgment on it so they can go look at the legislation and make up their own minds. That is what the Senators are supposed to do—make up their own minds. I am urging Senators to suspend judgment for a little while, listen to what I am saying, because I think when they do look at the legislation, they will see that what I am saying is true. But you do not have to take it on my account. Just please do not make up your minds until you read what is actually in the legislation. You will see, even in the supposed premium support demos, and there might be up to six cities in the country, that fee-for-service Medicare is held harmless. There is no change in fee-for-service in any respect, deductibles and on—except for one. That one possible change is the Part B premium.

However, this legislation ensures that seniors who happen to live in one of the six demonstration areas can keep the same fee-for-service Medicare. If it happens that your Part B premium goes up as a result of the demonstration—it may or may not go up—but if it does, the legislation says there can be no more than a 5 percent increase on your Part B premium. This is the only possible way a senior citizen could be adversely affected in these demonstration projects.

Another point regarding these demonstrations. I have heard various figures that the demos are going to affect 10 million fee-for-service beneficiaries. We have all heard the 10 million figure. It is what some Senators suggest.

It is not true; it is untrue.

How many seniors might possibly be affected? Let's get an unbiased, objective opinion.

We asked the CBO, the Congressional Budget Office: Mr. CBO, what is the answer? How many seniors may potentially be in an area where they would be faced with a choice, stay in fee-for-service Medicare or join one of these premium support organizations? How many could be adversely affected? The answer is not 10 million. CBO says: We think it is between 670,000 and 1 million. 10 million is the figure of scare rhetoric. The actual facts are 670,000 to 1 million.

There are many other instances where there is a lot of rhetoric floating around. But if you look at the facts, if you read the legislation that is now available, you will find it is really good legislation and all these worries and exaggerated claims about the bill are just not true.

I have a couple of additional points regarding premium support. It is a time-limited demonstration. It exists only for 6 years, starting in 2010. It would take an act of Congress to change it, an act to expand it. It cannot be extended or expanded by the Secretary or anybody else.

Fact No. 2, the demonstration will only affect limited areas of the country—up to six areas of the country only.

Fact No. 3, low-income beneficiaries are totally protected in any of these areas where premium support might occur.

Facts No. 4 and No. 5. There is no requirement for beneficiaries to enroll in the private plans. None. There is no inducement to enroll in any of these plans unless the plan happens to be a lot better than traditional fee-for-service Medicare which this bill strengthens.

How does this bill undermine traditional fee-for-service Medicare? How?

The fact is, it doesn't.

I will close by saying this is a good bill. It provides prescription drug benefits for seniors. Seniors need and deserve this help. It provides $400 billion of help. We are not going to have this opportunity again. It is true that this bill is not perfect. But I think on the whole it is a very good. This bill is much closer to the Senate bill than it is to the House bill. It is about one-quarter away from the Senate bill. It is about three-quarters away from the House bill. Seventy-six Senators voted for the Senate bill. I think that the 76 Senators who voted for the Senate bill will find that in many respects, this bill is better than the Senate bill they supported. Additionally, when my colleagues look at the facts of this bill, they are going to find that this is pretty good legislation. It is something we should pass.

I hope people will look at the actual language and look at the facts and will support this bill.

The PRESIDING OFFICER (Mr. Cornyn). The Senator from Idaho.

Mr. CRAIG. Mr. President, I will be brief. My colleague from Oregon and I wish to mention only briefly the health bill which was passed.

MORNING BUSINESS

Mr. CRAIG. Mr. President, the leadership asked that I ask unanimous consent that there now be a period of morning business, with Senators permitted to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

THE HEALTHY FORESTS BILL

Mr. CRAIG. Mr. President, my colleague from Oregon is on the Senate floor. We thought for a few moments we would talk about something that just passed the Senate which we think is landmark forestry legislation. It has come in several forms over the last year and a half. But we here in the Senate call it Healthy Forests. The President calls it Healthy Forests.

The House and Senate have worked together over the last year to try to resolve an issue that the American public has seen in the form of devastating wildfires across our public land and forests for the last several years. Of course, we watched the tragedy of San Bernadino in southern California and the greater Los Angeles area just in the last month and a half that was truly devastating not only to 3,700 homes and human life but hundreds of thousands of acres of wildlife habitat and watershed.

Clearly, as chairman of the Forestry Subcommittee of the Energy and Natural Resources Committee, Senator WYDEN and I have been working for the last several years to resolve this issue. My colleague from Oregon is the ranking member of that Forestry Subcommittee. We have known that the team effort in a bipartisan way to resolve this issue would produce a resolution. The answer is that it has.

The Senate and the House just passed a conference report that has our fingerprints all over it. Frankly, we are mighty proud of it. It moves us in the right direction of active management of these dead and dying, bug-infested, and drought-impacted forested areas that are creating phenomenal fuel loads that the American public has seen played out in wildfires across our western public land and forests for the last good number of years. It is a clear step in the right direction. It is a cautious step. We certainly do not take away the right of appeal, but we limit it.

We don't want an effort on the part of the Forest Service to do what we asked them to do to be tied up in the courts endlessly in many instances as it has been over the last several years. We also want them to be selective. We targeted most of our efforts in what we call the wildland- urban interface which will impact most of those forested areas where there is a substantial human presence in the form of homes and, obviously, communities.

At the same time, we also recognize that the problem exists elsewhere across our forested landscape. We allow that treatment of those areas with caution.

We have designated old growth definitions for protection. We have also limited it in the next decade to 20 million acres. For those critics who would suggest that this is a "ticket to log," that is purely political rhetoric to solve a political constituency problem that they have because they can't justify anymore the phenomenal loss of wildlife and watershed and habitat that we have seen over the last 4 or 5 years.

It is a cautious approach. It is certainly going to be limited in character. Why? Because we want to prove to the American people that there is a way to manage our forests in a right and reasonable fashion; that it does not do what we did historically 40 years ago—logged by clear-cut or logged with substantial problems of erosion and watershed degradation and all of that.

This is a new day. We want to treat our forests differently. But we also understand that if we don't do something, our forestry experts have told us that we could see devastating wildfires for decades to come that will destroy the watershed, the wildlife habitat, and release huge amounts of carbon into the atmosphere; and, oh, yes, by the way, destroy a very valuable resource in the form of timber that might in some areas be allowed for logging or for reasonable approaches of commercial value of the thinning and cleaning.

All of that said, we have worked hard to produce a bill. My colleague from Oregon is on the Senate floor. I will yield to him for any comments he would want to make. We have other colleagues here who I think are going to address the issue of prescription drugs and Medicare reform.

But today is an important day in the Senate in the area of forestry and forest and public land management. I am proud of the work we have done.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. WYDEN. Mr. President, before he leaves the floor, I want to commend Senator CRAIG. He and I have been working with Senator FEINSTEIN in particular on this legislation in the Energy and Natural Resources Committee. We have really been a triumvirate with respect to this issue.

I am so pleased to have a chance to be on the Senate floor today to speak on this conference report. This is the first forest management bill to pass both Houses in the U.S. Congress in 27 years. The fact is, the forestry legislation that is now on its way to the President of the United States will protect our communities. It will offer the first legal protection for old-growth trees, and it will create jobs.

As the distinguished Senator from Idaho, Mr. CRAIG, just noted, this legislation came together because at every stage of the process Senators said we want to get beyond the old rhetoric. We want to get beyond the polarization that has dominated this issue in the past, and we want to, in particular, take meaningful action to protect our communities.

That is what this legislation has been all about. The fires in the West, as the Senator from Idaho has known through his field hearings and other such sectors, have literally be infernos. We just felt it was critical to take steps to ensure that the rural West wouldn't be sacrificed.

I am proud today to rise in support of the conference report on H.R. 1904. This conference report is based upon the Senate-based wildfire bill compromise brokered by Senators FEINSTEIN, CRAIG, COCHRAN, DOMENICI and myself passed by the Senate on October 30. With the good faith efforts of Representatives POMBO, GOODLATTE, and my friend and colleague from Oregon, Representative WALDEN, this conference report has made only minor changes to the Senate approved version. This legislation will get us back on track restoring forests, protecting the environment, and putting people back to work in rural communities.

This conference report is the first forest management bill to pass both houses of the United States Congress in 27 years. The last time Congress was able to send a forest management bill to the President of the United States, the President was Gerald Ford and it was the Nation's bicentennial. The bill was the National Forest Management Act of 1976.

The world has changed a lot in the last 27 years. Forest management and forest-related economies have changed dramatically. Americans have grown more interested in protecting the environment while using natural resources to support rural communities like those in my home state of Oregon. The conference report we passed today reflects some of those changes: it contains the first ever statutory recognition and meaningful protection of old growth forests and large trees, while streamlining a National Environmental Policy Act process that has seemed to favor paperwork over forest health.

This conference report will streamline restorative forestry in forests at risk of unnaturally catastrophic fires resulting from 100 years of fire suppression. It provides the authorities and guidelines for the Forest Service and Bureau of Land Management to treat unhealthy forests while preserving public input and protecting old growth it's a truly balanced approach to forest health.

There were times when I was not sure this day would come. After the Senate passed our version of H.R. 1904 on October 30, 2003, there was doubt and disagreement on how to proceed with the House of Representatives. As a solution to the gridlock threatening the final passage of wildfire legislation, Senator FEINSTEIN and I proposed informal meetings. The staffs of the two Houses reached the agreement on Title I, the forest health title, through these informal meetings that allowed for a formal conference on all the rest of the Titles. That conference was held Thursday, November 20. I lost a couple of provisions for Oregon that I cared deeply about. But, I am overall pleased that the forest health provisions worked out so diligently by both Houses were preserved intact.

The Senate said there were four features that were particularly important to us to maintain in the legislation.

First, we said we have to have the funding to do the job right. We are not going to get this work done without funding to get this work done on the ground. I am very pleased with the conference report in that it keeps that funding intact. I am very pleased that the conference report will authorize $760 million annually for the projects, a $340 million increase over current funding. It also ensures that we spend the money in the right place. That is in the area known as the wildland/urban interface. The Senate took one approach, the House had other ideas. With some very minor tweaking, this, too, was preserved in terms of the work done by the Senate.

On the old-growth part of the legislation, I am especially pleased because all Americans value these unique treasures, our very large old-growth trees. Professor Jerry Franklin of the University of Washington is considered the leading authority on this subject. He says our provisions with respect to old growth are a major step forward. I am particularly pleased and honored to have Dr. Franklin's comments on this. He is the authority, as Chairman CRAIG knows, on this subject. For those who have followed the environmental aspects of the forestry legislation, let the word go out that Professor Jerry Franklin from the University of Washington, one of the most distinguished scholars in this field—not just now but at any time—believes this is a significant step forward in terms of environmental protection.

We were able to protect the public involvement aspect of forestry policy. Citizens all across this country—whether in Senator DODD's part of the world in Connecticut or any other part of the country—feel passionately about their natural resources and want to be involved in the debate over this process. As Senator CRAIG has noted, we have streamlined the process but we have preserved every single opportunity for the public to comment. Every opportunity that exists today, for the public to comment on forestry legislation, has been preserved in this bipartisan compromise.

Finally, the Senate conferees did very well at defending the Senate compromise. The Senate kept the number one issue the environmental community was concerned about off the table and preserved the Senate compromise position on judicial process. In negotiating this bill, I did not accept the notion that any special deference beyond the deference that is ordinarily due should be given to any agency determinations under the Act, except where explicitly provided in the statute's text. In fact, the conference report expressly rejected the House bill's language giving special deference to agency determinations.

This section, section 106 of Title I, limits venue for these hazardous fuels reduction cases exclusively to the district court for the district in which the federal land to be treated is located. It also encourages expedited review of jurisdictional and substantive issues leading to resolution of cases as soon as practicable. In addition, this section limits the duration of any injunctions and stays pending appeal to 60 days and provides an opportunity to renew an injunction and stay pending appeal. It also requires the parties to the action to present updated information regarding the status of the authorized hazardous fuel reduction project in connection with such injunction and stay renewals. This last provision is intended to provide an incentive and opportunity for the parties to the complaint to work together to resolve their differences or explain to the judge why that is not possible over time.

This section also directs the courts to balance the impact to the ecosystem likely affected by the project of the short- and long-term effects of undertaking the agency action, against the short- and long-term effects of not undertaking the agency action. There can be environmental risks associated with both management action and inaction. America is acutely aware that the past few fire seasons have been among the worst in modern history in terms of effects on natural resources, people and private property. Air pollution problems are rising and wildland fires have forced thousands to evacuate. In 2002 in one state alone, Colorado, 77,000 residents were evacuated for periods of a few days to several weeks. Seventeen thousand people in Oregon's Illinois Valley were on half-hour evacuation notice the same year. In 2002, millions of dollars of property damage included the destruction of over 2300 homes and other buildings. It is becoming increasingly evident that while one cannot uncut a tree, similarly one cannot unburn a forest. In hazardous fuel reduction projects it is important to focus on the removal of the right vegetation to modify fire behavior—primarily surface and ladder fuels.

At the same time, there can also be adverse environmental consequences of hazardous fuel reduction projects, including but not limited to loss of wildlife habitat, increased sedimentation in streams, soil compaction, and fragmenting of unroaded areas. As documented by the General Accounting Office, poorly designed vegetation treatments in the past have contributed to increased fire risk by removing the large and fire resistant trees, while leaving highly flammable smaller trees behind.

This Act is intended to foster prompt and sound decision making rather than perfectly executed procedures and documentation. Environmental analyses should concentrate on issues that are essential to the proposed projects rather than on amassing needless detail. Section 106 is intended to reinforce Congress's desire that the totality of circumstances be assessed by the courts to assure that public interest in the environmental health of our forests will be served.

Let me be more specific about a few of the other provisions of this legislation. The Senate also prevailed in keeping the Senate funding requirements and levels, preserving the Senate NEPA language on at-risk lands outside the wildland urban interface; preserving the Senate old growth and large tree protections, and preserving the Senate administrative appeals process.

The legislation changes the environmental review process so the Forest Service still considers the effects of the proposed project in detail, but can focus its analysis on the project proposal, one reasonable alternative that meets the project's goals and the alternative of not doing the project, instead of the 5–9 alternatives now often required. In the highest priority areas within one mile and a half of communities, the Forest Service need only study the proposed action and no alternatives. There is no relaxation from current law in any areas, however, in how closely the Forest Service must study the environmental effects of the project it is proposing to undertake.

The changes that were made to the Senate compromise on H.R. 1904 include more relief and respect for rural forested communities. This conference report allows a single action alternative to be analyzed under the National Environmental Policy Act inside the wildland urban interface defined as 1.5 miles from the community boundary. Within the area identified for protection as the wildland urban interface under a community fire plan, the agency is not required to analyze the "no action" alternative under NEPA, but is required to analyze two action alternatives. This conference report also limits the treatment of diseased forests to those with epidemics, whereas the Senate compromise allowed the treatment of forests with only an infestation of bugs.

This conference report preserves all current opportunities for public input and appeal, while streamlining the appeals process and eliminating some of its worst abuses. Not one current opportunity for public comment would be lost under the compromise. The compromise will require the Forest Service to rewrite their appeals process using the pre-decisional appeals and comment process that has been used by the Bureau of Land Management since 1984. It works by encouraging the public to engage in a collaborative process with the agency to improve projects before final decisions have been rendered upon them by the agency. This model places a premium on constructive public input and collaboration, and less emphasis on the litigation and confrontation of the post-decisional appeals process currently used by the Forest Service. The compromise is designed to move from the current model of confrontation, litigation and delay to one which places a premium on constructive, good faith public input. Whereas in the past, parties could "sandbag" the appeals process by not raising salient points in hopes of later derailing the entire proposed action in the courts, parties would not be allowed to litigate on issues they had failed to raise in the comment or appeal period unless those issues or critical information concerning them arose after the close of the appeals process—as a result of the revised agency decision.

This conference report provides the first-ever statutory recognition and meaningful protection of old growth forests. Never before has Congress recognized by statute the importance of maintaining old growth stands. Under the compromise, the Forest Service must protect these trees by preventing the agency from logging the most fire-resilient trees under the guise of fuels reduction under these new authorities.

The issue of old growth continues to be the subject of considerable scientific inquiry and debate. What is not subject to debate is the special character and ecological value of old growth. Clearly, it is the intent of Congress that in interpreting the provisions of section 102(e), federal agencies affirmatively recognize the special importance of old growth forests while maintaining the deference they are due unless their determinations are arbitrary, capricious or an abuse of discretion.

This legislation is designed to address past mismanagement of federal forests, and to protect old-growth so that we don't repeat the mistakes of the past. The majority of old-growth stands are healthy, and don't require management. In some old-growth stands in the drier parts of the west, where natural fire regimes have been disrupted by a century of fire suppression, silviculture with a minimum of disturbance can be appropriate that will restore natural forest structure and fire regimes.

Where old growth stands are healthy, as they are throughout much of the forest on the west side of the Cascade Ridge in Oregon, the compromise requires that they be "fully maintained." Section 102(e) of the conference addresses the treatment by the Forest Service and Bureau of Land Management of old growth stands that may occur on authorized hazardous fuels treatment projects. Since recently issued resource management plans of the two agencies are supposed to provide guidance on the treatment of old growth Section 102(e) directs the agencies to rely on the old growth definitions contained in resource management plans that were established in the ten-year period prior to the enactment of the legislation.

Older plans must be reviewed, and if necessary, revised and updated, to take into account relevant information that was not considered in developing the existing definitions or other direction relating to old growth. Any revision or update must meet the requirements of subsection 102(e)(2), which requires the Secretary, in carrying out authorized hazardous fuels treatment projects, to fully maintain, or contribute toward the restoration of, the structure and composition of structurally complex old growth stands according to the pre-fire suppression old growth conditions characteristic of the forest type, taking into account the contribution of the stand to landscape fire adaptation and watershed health, and retaining the large trees contributing to old growth structure. Nothing in the bill is intended to prohibit or restrict establishing other standards for old growth stands where purposes other than hazardous fuel management are being pursued under other authorities.

The intent of section 102(e)(4) is to avoid disrupting resource management plan revisions that are already underway. Comprehensive revision of older resource management plans may be preferable to separate amendments or updates for old growth standards, and the bill allows additional time for operating under older plans where revisions are in progress.

In negotiating this bill, I did not agree to the imposition of any more restrictive standards than the "substantial supporting evidence" explicitly set forth in the statute for members of the public's identification of old growth stands during scoping in subsection 102(e)(4)(C).

The compromise makes it less likely that old growth will be harvested under current law by mandating the retention of large trees and focusing the hazardous fuels reduction projects authorized by this bill on thinning small diameter trees.

In moving this legislation, it was my intent to see that the right work get done in the right way in the right place using the right tools. In other words, to see that the risk of catastrophic fire is reduced through legitimate hazardous fuel reduction activities.

These activities are referenced in Section 101(2) of the bill and are spelled out in detail in the Implementation Plan for the Comprehensive Strategy for a Collaborative Approach for Reducing Wildland Fire Risk to Communities and the Environment, dated May 2002. That document lists the following tools as being appropriate for hazardous fuel reduction: prescribed fire, wildland fire use, and various mechanical methods such as crushing, tractor and hand piling, thinning, and pruning.

In other words, this bill does not authorize a new wave of large tree commercial timber sales. It must be noted that the bill emphasizes the avoidance of the cutting of large trees in Section 102(f), where it specifically states that protects must focus largely on small diameter trees, thinning, strategic fuelbreaks and prescribed fire to modify fire behavior and that projects maximize the retention of large trees.

Section 104(f) requires the agencies to focus on small diameter trees, thinning, fuel breaks and prescribed fire to modify unnaturally severe fire effects, and to maximize the retention of large trees. Large trees are important ecological components of most forest systems. In particular, they are often more fire and insect resistant than smaller diameter trees, and therefore, with rare exceptions do not contribute to hazardous fuels overloads. They are also considered to be critical ecological legacies because they are essential to the desired future structure and composition of forests. However, large trees are now often underrepresented components of many forest types. In those forest types, forest health will not be restored without a diversity of age classes and types, including large trees.

Section 102(f) deals with federal agency treatment of large trees in authorized hazardous fuels treatment projects outside of the areas identified under section 102(e) and requires the Forest Service and Bureau of Land management to maximize the retention of large trees, as appropriate for the forest type, to the extent that the trees promote fire-resilient stands. From an ecological standpoint, and in regards to modifying future fire behavior, large trees are the very last ones that should be removed, if at all.

This is an appropriate limitation in that the last trees that need to be removed from an ecological sense, as well as to modify fire behavior, are the large trees. The clear intent of this legislation is to focus primarily on surface fuels such as brush and dead and down woody material and ladder fuels consisting of small diameter trees and saplings.

This direction is very important to me and I intend on remaining vigilant and responsive to concerns where projects veer from this important direction.

This conference report restores balance to healthy forests legislation by authorizing $760 million annually for these projects. This is a $340 million authorized increase over the currently appropriated level of $420 million for hazardous fuel reduction projects. The conference report maintains the requirement that at least 50 percent of funds spent on restorative projects to be spent to safeguard communities which face the greatest risks from fire.

This conference report also includes improved monitoring language that will help Congress track the successes and failures of this legislation. Section 104(g) requires the Secretaries to monitor and assess the results of authorized projects and to report on the progress of projects towards forest health objectives. This evaluation and reporting will help guide the agencies in future hazardous fuels reduction treatments in existing project areas and in other project areas with similar vegetation types.

The Senate intends that treatments authorized under this Act be directed to restoration of fire-adapted ecosystems as well as hazard reduction. The threat of uncharacteristically severe fires and insect and disease outbreaks decreases when the structure and composition of fire-adapted ecosystems are restored to historic conditions. Thus, section 104(g)(4) directs agencies to evaluate, among other things, whether authorized projects result in conditions that are closer to the relevant historical structure, composition and fire regime.

The Senate recognizes that fire ecologists have learned that fire is a landscape process and that treatments are most effective when conducted in accordance with landscape- or watershed-scale analyses. Section 104(g)(4) requires the agencies to evaluate project results in light of any existing landscape—or watershed—scale direction in resource management plans or other applicable guidance or requirements. Managers should also evaluate and use available relevant scientific studies or findings.

Section 104(g) also requires the Secretaries, in areas where significant interest is expressed, to establish a multiparty monitoring and evaluation process in order to assess the environmental and social effects of authorized hazardous fuel reduction projects and projects implemented pursuant to section 404 of this Act. Many forest-dependent communities support multiparty monitoring, which simply means that communities and individuals may participate with the Federal agencies in monitoring the projects. The Managers recognize the importance of multiparty monitoring as a way to rebuild trust between rural communities and the agencies.

In conclusion, we have a lot of work to do. We will have others raise questions about the ramifications of this legislation as it relates to the National Environmental Policy Act and other concerns. We want to get this done and implemented properly. As Chairman CRAIG and I have seen in the subcommittee on forestry, we know, for example, it will be tough to get all the funds that are going to be necessary to do these projects on the ground. Our bipartisan coalition is committed to doing that. Then we can turn our coalition to looking at other areas where we can find common ground and move forward in the natural resources area.

A lot of people never thought we would get to this day. Look at the editorials that have been written, some of the interest groups with respect to this legislation, and some of the attacks made on Members. I recall some of those to which Senator FEINSTEIN was subjected. She showed the courage to make it clear she would hang in there and work to get this legislation enacted.

We had a lot of Members of the Senate on both side of the aisle say they would put the public interests first, they would concentrate on protecting communities. That is what has brought us to this day.

I want to thank the following Senate staff for all their hard work on this important legislation: Lance Kotschwar and West Higginbothom of the Senate Agriculture Committee staff, Frank Gladics and Kira Finkler of the Senate Energy and Natural Resources staff, Calli Daly of Senator CRAIG's staff, John Watts of Senator FEINSTEIN's staff and Sarah Bittleman and Josh Kardon of my own staff. Josh Penry and Doug Crandall, staff from the House Resources Committee, did yeomen's work to get this bill to conference. These folks, and many others, put in countless and numerous evenings and weekends into this bill and they deserve our appreciation for their hard work and dedication.

This legislation will now go to the President's desk for his signature. I look forward to that happening. Just this week it snowed in Oregon—the fire season has passed for another year but it will come again next year as sure as the spring follows the winter. With this bill in place as law I am hopeful that we will be a bit better prepared.

I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. Mr. President, are we in morning business?

The PRESIDING OFFICER. That is correct.

MEDICARE

Mr. DODD. Mr. President, I will take a few minutes and comment on the upcoming debate on Medicare. Let me begin by expressing my appreciation and my respect for those who have worked on this issue for a great deal of time. I have nothing but the highest admiration for my colleagues, Senator BAUCUS, Senator GRASSLEY, Senator BREAUX, Senator KENNEDY, and others who have spent a great deal of time over the last number of months trying to put together a proposal to provide Americans with a comprehensive prescription drug benefit while not undermining the core program of Medicare which has served millions of Americans so well for the past 38 years. Whatever other views I may have on this proposal, it does not diminish my respect for the efforts they have made to put this bill together. I begin on that note.

Let me state the obvious. I don't know of many other programs that have enjoyed as widespread and as deep and profound a degree of support in our Nation's history as the Medicare Program. I cannot think of another program which has done as much for as many people as Medicare has over the past 38 years. When you look back at the statistics of the poor in America prior to 1965, without exception, the poorest group of Americans were older Americans, our senior citizens. That was, of course, because they had left the labor force and to what extent they had any coverage at all, it was usually lost upon their retirement. As happens when people age, health problems often emerge, people become sicker and require more help. America could only watch as parents and grandparents got sicker and poorer and faced great difficulty making ends meet.

Through a very extensive and elaborate and lengthy debate, our predecessor Congress, both in this body and in the House of Representatives, under the leadership of Lyndon Baines Johnson, in 1964, giants in this body, crafted the Medicare Program. In fact, President Johnson went to Missouri, to the home of Harry Truman, who had been such a great advocate of universal health care, to sign that historic piece of legislation into law. There have been a lot of other things we have done over the years, such as Title I of elementary and secondary education, that might come close—certainly Social Security—I suspect if we had to pick two programs this Government has fashioned in the 20th century that have meant as much to such a critical part of our society, one would certainly have to identify Social Security and Medicare.

It is with that background that I rise this afternoon to express my deep concern and worry over what we may be doing in the next few hours in a rather hasty manner. That does not mean to suggest that the conferees and others who have worked a long time on this have acted in haste; although I disagree with their product, I respect the amount of time and effort they have put into this. The Presiding Officer and this Senator are the only two Members present at this moment, and our ability to go through this and to understand what is about to happen in the coming days is rather limited.

Sometime tomorrow, Sunday, or Monday, but certainly no later than that, we will be asked to vote up or down on a conference report that does something all Members have wanted to do for years—provide a prescription drug benefit for older Americans under the Medicare program. Knowing, as we all do, that had we been writing the Medicare bill in the year 2003 for the very first time, or several years ago, we would never have considered a Medicare proposal without the inclusion of a prescription drug benefit. But those who wrote the bill in 1964 were not confronted with the terribly high cost of prescribed medicines. At that time, there simply were not that many pharmaceutical products out there, so prescription drugs were not as major a factor as they are today. The idea of providing basic healthcare services was what originally drove Congress to enact the Medicare Program.

Obviously, the world has changed. So the need for a prescription drug benefit today, given the tremendous costs our elderly face every single day across this country, where they literally, without any exception at all, are forced to make choices about whether or not to take the drugs they have been prescribed, to have a meal, or to pare back on their prescriptions so as to spread them out over a longer period of time so they will not have to go back in and pay for the drugs which they cannot afford, in which case they are not getting the full benefit of the prescriptions because they are self-medicating themselves, and in many cases can do far more harm than not taking a drug at all, as any good doctor can tell you—that is the reality today fro millions of our senior citizens.

It is my belief that if we were solely dealing with the prescription drug benefit piece of this package, it would pass 98 to 2, maybe 100 to 0. There is no doubt in my mind that would be the case. If that were the only issue before the Senate, that would clearly be the outcome. Although I would quickly tell you there are parts of this prescription drug benefit that could be drawn far more wisely and far more fairly in many ways, I could not argue over the fact that a $400 billion appropriation over the next 10 years offered a good start.

But also just as quickly I would say to my colleagues, if we were dealing with the portion of this package dealing with the structural reform of Medicare, and they were standing alone just as I suggested a moment ago if the prescription drug benefit package were standing alone, the parts of this package instituting structural changes to

Medicare would not get 10 votes. I don't know of many people who would support a Medicare package that had the sections this bill does that would so dramatically alter Medicare. The only reason it is getting any consideration at all is that we have lured people into this on the prescription drug benefit aspects of this conference agreement.

So if you set that aside for a minute and begin to look at the structural side of this, and understand how many years it originally took to put together the Medicare program, what a difference it has made in people's lives—when you consider the tremendous salvation this has been to people—and then recognize the direction in which we are about to go if this conference agreement is adopted—and I suspect it may be—then it will not take long, in my view, when you will find what we saw only a few years ago, with the Congress coming back in to reverse itself in 2006 or shortly thereafter when the provisions of this bill go into place.

The more you look at the structural side of this particular proposal, then the more people are going to be concerned about what they are doing. So I applaud those who have worked on the prescription drug side of this bill. But I have great concerns about what this conference report would do to the foundation of Medicare.

In June of this year, when S. 1 was before this Senate, I based my support for that measure on the belief that it offered a strong, though not complete, first step towards ensuring prescription drug coverage for America's seniors and strengthening the overall structure of the Medicare Program.

This conference report, I say with deep regret, can now be accurately characterized, in my view, as a misguided step down the wrong path. The agreement before us today will lead us down the path towards greater privatization of Medicare, towards a greater burden on our States trying to meet the needs of their own low-income senior citizens, and towards an overall weakening of the Medicare Program.

A very simple way to describe this, as we look at the great success the Medicare program has enjoyed over the past 38 years, is to remember that this is a universal program. This program says to everybody who reaches a certain age, regardless of how healthy you are, or how wealthy you are, or how poor you are, or how sick you are, you can qualify and be a part of this Medicare Program. We are about to do something now that is going to say to those who are wealthier and healthier, you can move off into private plans, in which case the only ones who will be left within traditional Medicare are those who are less wealthy and those who are most sick.

Now, you do not have to have a Ph.D. in mathematics to understand what the outcome will be if this conference report is adopted. If Medicare becomes a program of poor, sicker people because wealthier, healthier people have left, as I believe they will under this bill, then you have just forced either a reduction of benefits or increased costs for those under traditional Medicare—those who can least afford it.

There is no other outcome you can draw from that which we are about to do. That is the eventual outcome. It fundamentally changes and alters the basic concept that was part of the plan passed in 1965—its universality.

The underlying concept of wealthy, healthy people joining with poorer, sicker people—being together—has been the cornerstone of this tremendously successful program. When you begin to pick off those who are wealthier and healthier, for all the obvious reasons, into private plans, the sicker and poorer people will be left with either Medicare benefits getting cut or premium costs going up. That is the sadly predictable outcome of this legislation, Mr. President.

Medicare is first and foremost a program to protect our Nation's seniors from the often insurmountable costs associated with securing quality health care services. Prior to its inception in 1965, as I mentioned, many seniors—the overwhelming majority, in fact—faced abject poverty as a result of skyrocketing health care costs. The creation of the Medicare Program provided a critical safety net for those seniors and allowed them to retain both their access to quality health care, as well as their financial security.

Earlier this year, and prior to the Senate's consideration of the underlying legislation, I had the opportunity to convene a series of forums in my home State of Connecticut on health care issues in an attempt to frame the scope of this debate for them. At those forums, I heard from my constituents on many matters regarding health care. I heard from seniors who literally could not afford to fill prescriptions—and I know my colleagues have heard the same stories—called for by their doctors. I heard from elderly Medicare beneficiaries forced to choose between purchasing groceries or filling their prescriptions. I heard from seniors who were forced to skip dosages of their medicines in an attempt to stretch their limited supplies of these needed medicines. I heard from Medicare beneficiaries requiring more than 10 prescribed medicines a day unable to afford even half of those prescriptions.

Clearly, what I heard from hundreds of my own constituents is their grave concern over the present lack of a prescription drug benefit under the Medicare Program.

When Medicare was first enacted, few could have envisioned the tremendous costs associated with prescription medicines. However, it is the great need for prescription drug coverage under Medicare that was firmly behind my initial support for S. 1. Sadly, however, the conference report before us simply does not go anywhere near far enough to provide sufficient coverage for prescription medicines for the great majority of Medicare beneficiaries. That said, we cannot turn our backs on what this bill would do for Medicare beneficiaries with severely limited incomes. This bill says, if you make under $13,470, representing 150 percent of the federal poverty level, then you will get real help under this bill. But if you make anything more than $13,470, which is what two-thirds of our seniors citizens do, then you are going to be offered little in the way of help under ths bill. That is why it is my belief the prescription drug benefit aspect of this bill should be greatly strengthened.

But I believe for most seniors that it is terribly unrealistic to suggest that someone making more than $13,470 can somehow manage to afford the cost of their prescription medicines, particularly if they have costs that would push their spending into the bill's gap in coverage, or donut hole, as it is often described. But, nonetheless, that is the direction we are going with this conference agreement.

The emerging bill contains a gap, as I mentioned, of more than $2,800, twice the size, by the way, contained in the Senate-passed legislation. Under this conference agreement, Medicare beneficiaries with costs within this so-called donut hole will be forced to pay for the full cost of their prescribed medicines as well as the monthly premium of an estimated $35—and I stress the word "estimated"; I will get to that in a minute—and receive absolutely no financial assistance whatsoever.

Only 4 percent of seniors in the country make over $80,000 a year. Two-thirds of seniors make somewhere above $13,470. The idea that somehow people are going to have enough money, as a senior, trying to pay a home mortgage or pay whatever obligations they have, not to mention food and other things, and also be able to pick up as much as $2,800 a year for prescription drugs, is, I think, terribly unrealistic.

This bill would require Medicare to move dangerously toward privatization, which is what I want to get back to, because it is the side of this bill calling for structural change to the Medicare program that causes me the greatest concern and greatest worry, and undermines this incredibly fine program. I can't tell you how disappointed I am in the AARP for endorsing this conference agreement. I truly wish that AARP's affiliates across the country had been heard on this issue before their national leadership decided that they would support this bill and disregard the 38 years of history when it comes to Medicare and the millions of people who have greatly benefitted from its coverage.

As one who has witnessed firsthand the tumult and confusion created by Medicare+Choice organizations entering and then quickly withdrawing from communities in my home State of Connecticut, I can say assuredly to my colleagues here today that this would establish a dangerous precedent that may very well lead to the devolution of the Medicare Program as we know it.

Also of great concern to me is the effect this legislation will have on employers that have already provided their retirees with prescription drug coverage. In my State of Connecticut, more than 225,000 Medicare beneficiaries, fully one-third of my State's senior citizens, receive coverage for their prescribed medicines from their former employers. Under this bill, about 40,000 of those elderly will lose this coverage as a result of employers dropping their prescription drug plans.

I don't know the numbers in every other State, but if 40,000 of my 225,000 beneficiaries presently with prescription drug plans from their former employers are going to be dropped from their prescription drug programs, how many in other States are going to be? Where do the States of other Senators fall in this category?

I additionally have another 74,000 people in my State—and I represent a small State with a little more than 3.5 million people—who qualify for both Medicare and Medicaid. These beneficiaries—and there are 6.4 million of them across the country that are eligible for both Medicare and Medicaid—will face increased prescription drug costs under the underlying bill. There will be a significant cost increase for those people who fall within both Medicare and Medicaid if this conference report is adopted. So even before we start talking about what will happen in the year 2010 and down the road under this bill, Mr. President, we are going to witness significant numbers of people lose their present coverage or be forced to withstand both higher costs and diminished benefits.

Also very troubling to this Senator in the underlying conference agreement is its unqualified support for private for-profit insurers at the expense of traditional fee-for-service programs. Particularly disturbing are the provisions securing $12 billion to be solely reserved for these private insurers in order to entice them to enter the Medicare market. Twelve billion dollars is going to the private companies, just so they can compete against the traditional Medicare program. They are calling this competition. Back in the Roman Empire, they had a competition like that. You would go to the forum and on one side were the lions. Under this bill is a similar situation, private insurers will get $12 billion to compete, but Medicare will not get anything. Under this bill, we are going to cap Medicare spending and then say: Go out and compete against enriched private plans.

I was born at night, Mr. President, but not last night. I know and most other people know, without a great deal more knowledge about this, that if you provide $12 billion, as this bill does, to private companies to go out and compete against a company that doesn't get that kind of help, do you know who is going to win that competition? I wonder. I wonder what the outcome will be there. Yet that is what this bill does. Twelve billion dollars reserved for private insurers in order to entice them to enter the Medicare market. The inclusion of this provision truly represents a solution in need of a problem, Mr. President. Traditional Medicare already serves 89 percent of all Medicare beneficiaries and the addition of $12 billion to entice private plan participation is wholly unwarranted and unnecessary.

In fact, this bill will also prohibit the Medicare program from going out and forming a consortium to drive down the cost of prescription drugs. Under this bill, you are violating the law if you go out and do that. While we are going to provide $12 billion instead to others to allow them to compete with Medicare, we will not allow Medicare itself to go out and lobby or negotiate to lower the costs of prescription medicines. The traditional Medicare Program is a proven success and would be better served if this valuable funding of $12 billion were directed toward further strengthening its foundation.

Lastly, the conference agreement before us today establishes the dangerous precedent of instituting so-called cost containment measures that could directly lead to severe cuts in what Medicare covers and just as severe increases in the costs Medicare beneficiaries will be forced to bear. Very specifically, the conference report calls on the Congress and the administration to address Medicare's costs when general revenue spending on Medicare reaches 45 percent of the program's total cost.

Can anyone cite for me any other Federal agency where that kind of provision has been imposed? There is not one—not one. Yet this bill goes out and places this kind of a restraint on Medicare, and on no other part of our Government do we do it, only on Medicare. It is my belief that the adoption of this purely arbitrary cap, which you will find nowhere else, will lead to almost certain erosion of critical programs, scope of coverage, and affordability.

Today, nearly 40 years after Medicare's inception, we find ourselves at a crossroads. I can truly say that I am somewhat stunned that we are about to make a decision on a program that has worked so well for so long within a matter of hours here, without any of us fully understanding—at least most don't seem to understand—the implications of what we are about to do. How could you take a program that has worked so well for so many people and, in the waning days of a session, with just a few hours remaining, get up and ask the Congress to do what we are about to do here? I don't understand how we could allow this to happen. We are on the cusp of fundamentally altering a program that has worked so well for this nation's elderly and most frail citizens.

Again, Mr. President, we find ourselves at a crossroads. The opportunity is before us to move Medicare toward the future without threatening its proven availability to provide for the health and well-being of our Nation's senior citizens. Sadly, however, this conference agreement before us represents an opportunity lost, an opportunity not only to add comprehensive coverage for prescribed medicines under the Medicare Program, which would have been a great success story, but also an opportunity to strengthen the Medicare Program for future generations.

So it is with great sadness that I find myself, only months after originally supporting the underlying legislation when it was first considered by the Senate earlier this year, now having to oppose this conference agreement in its current form. Under the guise of providing needed prescription drug coverage under the Medicare Program, this conference agreement falls far short of addressing this need for the great majority of our Nation's nearly 41 million Medicare beneficiaries.

Forty-one million Americans take note. Over the weekend, in the next 72 hours, a program that has served you for 40 years, serving more than 40 million people presently, is going to be fundamentally altered unless this body, and only this body, stands up and says: Stop. Go back. Let's rethink this before we go out and make the kind of changes that are being proposed in this legislation.

While there have been numerous articles and commentaries written about this plan over the last number of days, people trying to attract attention, numerous editorial comments that I have found tremendously compelling, I come back to the basic point that this is dangerous policy. I put my colleagues on notice; I tell you this will happen.

In the Senate passed bill, which, again, I supported, in order to receive prescription drug coverage, there had to be two drug-only providers available. However, this conference agreement calls for only one of these plans and an HMO. This is a fundamental change. Let me describe what this can mean in the clearest terms I have seen written about this.

Under the conference report, we have now learned that the Medicare guaranteed fallback is only triggered if a senior does not have a choice of two private plans, one of which can be an HMO. Again, that was not in the Senate bill and it is in the conference report before us.

In order to receive prescription drug coverage under this bill you have two choices: One, you can choose traditional Medicare and receive no prescription drug coverage. Two, you can choose to keep traditional Medicare and purchase a drug-only plan. The problem is that there is no limit on the monthly premiums these drug-only plans can charge. When you hear about the $35 cost of premiums for these plans, you must remember that this is only an estimate. If there is only one provider of the drug-only plan in your area—and that is all there has to be under this bill the monthly premium could be $100 or more. Nothing in this bill caps what the premium should be on a monthly basis for the drug coverage. That is what the offer is under this bill.

In other words, it will be permissible for only one insurer to offer the new Medicare drug benefit and charge whatever premium they desire, as long as there is also an HMO option in the area. This type of arrangement strategically avoids the protection of a traditional Medicare fallback benefit from being made available to seniors. As a result, seniors in these regions, many of which will be rural areas, will be financially forced into HMOs just to obtain an affordable drug benefit. In the meantime, they will lose their choice of doctors.

Does this sound familiar? Earlier this year, President Bush and his administration made clear that he wanted to reform Medicare by providing a prescription drug benefit, but only to those seniors who were willing to go into a private insurance plan and HMOs. This compromise has been designed to help achieve that goal.

So that it is further understood, it is important to note that the Senate required that there be at least two private stand-alone options for Medicare beneficiaries. This would have ensured that there would at least be competition for premiums for the new standalone drug benefit. Some have argued that the competition between the drug-only plan and an HMO or PPO will force down the premium of the drug-only plan. The fact is, drug-only plans cannot compete on an even playing field with PPOs or HMOs. This is because HMOs and PPOs are provided additional subsidies under this bill and, by definition, offer a wide variety of services that give these plans a competitive advantage over the standalone drug plans. Any losses on the drug side can be offset by gains on the medical side, in a sense.

This is yet another example of how all financial incentives are designed to advantage the private HMOs and PPOs over traditional Medicare. People need to understand the fundamental changes in this bill that will greatly alter the very structure of the Medicare program.

I have taken a lot of time this afternoon, Mr. President, and I apologize to my colleagues. But I feel very strongly about this critically important issue. Last week in this body we had a filibuster that went on for 4 days because people were upset over the nomination of 4 judges. I contend that perhaps there ought to be a filibuster on this legislation as nearly 41 million Medicare beneficiaries are going to be adversely affected if this legislation is adopted by this body.

Here we are toady, Mr. President, down to the waning few hours of the session, and we are about to consider fundamentally altering and setting back Medicare for years to come. When the roll is called on this, I will vote no. I will seek other options between now and then to see if there is a way to delay consideration of this until we have more time to examine more fully the implications of this bill. Under the guise of providing needed prescription drug coverage under Medicare, the conference agreement before us today offers far too little coverage for the great majority of Medicare beneficiaries, while at the same time institutes structural reforms to the underlying Medicare program that will significantly weaken its ability to provide for the health and well being of our nation's senior citizens. It should be soundly rejected. I thank my colleagues and I yield the floor.

The PRESIDING OFFICER (Mrs. DOLE). The Senator from Iowa is recognized.

Mr. GRASSLEY. Madam President, I didn't interrupt the Senator from Connecticut, so I hope my colleagues will let me give my remarks in rebuttal unhindered by any other obstacles.

It is about time that we pass a prescription drug bill for Medicare. It is about time that we strengthen and improve Medicare, as we have been telling the voters for three elections.

In the 2000 election, it was an issue. It was an issue on the floor of the Senate last summer. It didn't pass last summer because the other party in this body wanted an issue for the election coming up last fall. The leader of the other party took it away from his own chairman of the committee, so there could not be a bipartisan bill put together.

In the Senate, nothing gets done that is not done in a bipartisan way. Maybe a lot of people don't like that about the Senate, but it has been that way for 214 years, and our country has functioned well. This is the only body in our political system where minority interests are protected. We are going to have broad, bipartisan support for this bill, and we are going to pass it because when Republicans won the last election, we won it because there were a lot of things buried in this body by the leadership of the other party because they wanted issues for that election and because they thought they would increase their strength in this body and get more of what they wanted this year than last year.

But they miscalculated. The people of this country put the Republicans in charge of this body. But they didn't put the Republicans in charge of this body to do things just in a partisan way because we in the majority party know that nothing gets done here that doesn't have some bipartisanship with it.

As chairman of the committee of jurisdiction over Medicare, taxes; international trade, and a lot of other social programs, I have the privilege of having a good working relationship with the former chairman of this committee, now the ranking Democrat, Senator BAUCUS. We started out on Medicare prescription drugs, like we did on some other issues this year, to put together a bipartisan approach so that we could deliver on the promises of the last several elections—not just the last election, but the last several elections. Both political parties have been saying that we are going to strengthen and improve Medicare, and one of those strengthenings and improvements is going to be a universal and comprehensive and voluntary prescription drug program.

We are about to deliver on it, and people on the other side don't like it because they had an opportunity and they lost that opportunity because they wanted to do something in a partisan way. Previous speakers on the other side have raised this point about the AARP backing this plan. They are saying they are caving in to political pressure.

It seems as though, as far as the other side is concerned, the only time the AARP is political, in the eyes of the Democratic Party, is when AARP agrees with the Republican Party.

Senator BAUCUS and I have been working together, and we will bring to the Senate, after the House passes it tonight, a bipartisan, bicameral compromise out of conference, which will deliver on the promises of the last three elections. We are even going to deliver on the promise of the Democratic Party, where they were going to provide prescription drugs for seniors. The only thing I can think is that they regret it. They had an opportunity a year ago, when they were in the majority and when our President wanted to work with them, to do it, and they didn't take advantage of it.

I want to speak about this product that we have before us. It was just yesterday, after 4 months of conferencing, that the conferees agreed to a bipartisan breakthrough on a conference report that will make comprehensive prescription drug coverage a reality for our 40 million Medicare beneficiaries, both seniors and disabled. After 4 months of hard work, the conferees approved a sweeping package of new prescription drug benefits and other program improvements that makes good on our commitment to our seniors.

I am urging all my colleagues to support it. Since 1965, seniors have had health insurance without prescription drugs. By reaching agreement yesterday, the conferees came one step closer to changing that. The Senate can make history by improving this compromise report.

This important breakthrough came because of the tireless work of our committee members, both Democrats and Republicans, over the last 5 years. Senators FRIST and BREAUX led the way on prescription drugs before any of us were listening. Senators SNOWE, HATCH, and JEFFORDS, along with Senator BREAUX and this Senator, carried the torch as members of the Finance Committee, but also because we wanted to do things in a bipartisan way. We even called that a "tripartisan way" because Senator JEFFORDS lists himself not as a Republican or Democrat but as an Independent. That is an effort we have exceeded in the bill, but it was an effort that somewhat blazed the trail to where we are today, and I am glad to have been a part of it.

Finally, this breakthrough came because of the President's unyielding commitment to getting something done for seniors once and for all. Last December 10, I had an opportunity to meet with the President, as he knew I was going to be the new chairman of the Senate Finance Committee after the Republicans had won control of the Senate. We, in fact, had that meeting, anticipating all this time we had to work to get ready, a long time before Congress even convened. At that meeting, the President said two things that I remember. I did not take notes, but I remember very well that he was willing to commit political capital to this effort and that he was willing to put money in his budget for that effort.

The President delivered on both of those statements because his budget put $400 billion in over 10 years for this bill. That is exactly what we in the Senate wanted. We approved that last March. By June, the Senate Finance Committee had reported out a strong bipartisan bill by a vote of 15 to 6, building upon the agreement with the President and the agreement of the Senate for $400 billion for the budget.

The Senate, as you know, passed S. 1 on strong bipartisan grounds in June. The other body passed a similar bill, H.R. 1, that same night. I believe the committee report is measurably better than either S. 1 or the House bill, H.R. 1. It contains improvements, refinements, and changes that are better for seniors and better for the doctors and the hospitals that serve them.

We have come a very long way in getting to this point, and I am proud of where we have ended up. I will do everything I can to ensure successful passage of this conference report over the next few days.

Of course, the conference report can't and won't be all things to all people. Like any compromise, no one is left perfectly happy. That probably means that the conference committee came out just about at the right place. I urge all my colleagues to go beyond the perfect and to focus on the good that the conference agreement accomplishes.

The greatest good at the heart of this conference report is a comprehensive prescription drug benefit that will give immediate assistance starting next year and continuing as a permanent part of Medicare to every senior. Not only is it comprehensive, it is universal, and if nobody wants to participate in it, they don't have to. It is voluntary as well.

The conference report provides affordable comprehensive prescription drug coverage on a voluntary basis to every senior in America. The coverage is stable, it is predictable, and it is secure. Most importantly, the value of the coverage does not vary based on where you live and whether you have decided to join a private health plan. For Iowans and others in rural America who have been left behind by most Medicare private health plans, this is an important accomplishment that I insisted on way back as early as January of this year. I haven't budged on that commitment and that protection is in this conference agreement.

Overall, the conference agreement relies on the best of the private sector to deliver drug coverage, supported by the best of the public sector to secure consumer protection and important patient rights. This combination of public and private resources is what stabilizes the benefit and helps keep costs down.

Keeping costs down is essential not just for seniors but for the program as a whole. Throughout this bill, we have targeted our resources very carefully, giving additional help to the poorest of our seniors. Consistent with the policy of targeted policymaking, we have worked hard to keep existing sources of prescription drug coverage, such as employer-sponsored benefits, and to do it in a viable way.

This conference agreement goes great distances to keep employers in the game providing drug coverage, as they do now, to their retirees under those plans that were promised to people after retiring from their employment.

We all worried very much when we passed this bill in June that, as CBO scored our Senate bill, it might cause 37 percent of the corporations to drop their employees on the Government plan. The House bill had a 32-percent drop rate, according to the Congressional Budget Office. As a result of the conference activity and what we have done to shore up existing retiree plans, that percentage is now much less than 20 percent due to the substantial investment made by conferees to ensure that employers can continue offering the good coverage they have for a long period of time.

The conference report includes additional subsidies. It also includes regulatory flexibility that will do much more to help, rather than threaten, employer-sponsored coverage for those who currently receive it.

Still, we all must acknowledge that decisions about scaling back coverage or dropping it altogether are bound to be made regardless of whether we pass this conference report. But I am confident that the balanced policies before us are a very good deal for employers and their retirees.

I want to make it very clear to people listening who might be worrying about corporation retirees losing their health coverage because of something we are doing here, we are doing our darndest to supplement these plans and to give regulatory flexibility so these plans are not dropped. But Congress cannot pass a law that says corporation X, Y, or Z, some day, if they decide they want to dump them, might be dumped. That could be happening in some corporation in America today. This law is not even on the books. That happened in my State earlier this year and last year and the year before, not because Congress was talking but just because that was the policy of that corporation. It is something they felt they couldn't afford any longer, and they did it.

That could happen even after we pass this legislation, but where would we be if we didn't pass this legislation? The 35 percent of the seniors today who have no coverage whatsoever, and probably never have had it in retirement, will still not have drug coverage. Also, the corporations that dump their plans might not have anything either. By passing this legislation, even considering all the resources—about 20 percent of this legislation contains resources for these corporations to keep their plans—if they would drop them, at least these people have something on which to fall back.

I would think that is a better situation than the uncertainty of, Is my corporation going to dump me or are they not going to dump me?

If they are dumped, then they have zilch, unless they want to buy an expensive Medigap policy or something like that. So we are trying to have a safety net for all seniors, and we are trying to do it in a way that is very helpful. So I want to make that very clear. We cannot force corporations—never could and never will be able to—to say they have to provide health care coverage and prescription drug coverage for their retirees. But we do have a plan that is very good for people who do not have prescription drugs or people who might have prescription drugs today but tomorrow might not have it. This is a safety net and a darn good safety net.

Beyond just prescription drugs, the conference report is a milestone accomplishment for improving traditional Medicare, especially in rural America. The conference report includes the best rural improvement in the Medicare equity package that Congress has ever passed. The rural health care safety net is coming apart in rural areas. It is difficult to recruit doctors to rural areas because of low reimbursement. The conference report begins to mend that safety net.

As many in this Chamber know, hospitals, home health agencies, and ambulance companies in rural America lose money on every Medicare patient they see. Rural physicians are penalized by bureaucratic formulas that reduce payments below those of their urban counterparts for the same service. The conference report takes historic steps toward correcting geographic disparities that penalize rural health care providers. Providers in rural States such as Iowa practice some of the lowest cost, highest quality medicine in America. This is widely understood by researchers, academics, and citizens of those States, but not by Medicare.

Medicare instead rewards providers in high-cost, inefficient States with bigger payments that have the perverse effect of incentivizing overutilization of services and poor quality. This is very noted in my State.

The Des Moines Register has been very clear in informing the people of my State that Iowa is 50th in reimbursement in Medicare on a per beneficiary basis over a year, 50th of the 50 States, but yet under indices we are fifth or sixth in quality of care.

Over at the other end, there is Louisiana, No. 1 in reimbursement, about $7,000 per beneficiary per year compared to about $3,400 for Iowa, the lowest of the 50 States. More money to be spent on Medicare for seniors' medical care does not guarantee quality of care because Louisiana is listed 50th in quality of care. So we want to make sure that where one is getting high-quality delivery of health care, there is reimbursement that takes that into consideration. So the conference report begins to reverse that trend.

It also includes long overdue pilot programs that will test the concept of paying for performance and making bonus payments for high-quality health care. This benefits taxpayers and, most of all, patients.

Beyond prescription drugs and beyond rural health care, the conference report goes at great length to give better benefits and more choices—the right to choose is very basic in this bill—available to our seniors. It specifically authorizes preferred provider organizations—we call them PPOs—to participate in Medicare, something the current law does not fully allow. The idea is that these kinds of lightly managed care plans more closely resemble the kinds of plans that we in the Federal Government have and close to 50 percent of working Americans have. Baby boomers then, when they go into retirement, will be able to compare fee-for-service 1965 model Medicare with these new PPOs. I think they are going to find new PPOs closer to what they had in the workplace than traditional Medicare, but they have the right to choose. We think they ought to have that right, too, because traditional Medicare has not kept up with changes in the practice of medicine like the private health plans employees have in the workplace.

PPOs have the advantage of offering the same benefits of traditional Medicare, including prescription drugs, but they do that on an integrated, coordinated basis. So this creates new opportunities for chronic disease management and access to innovative new therapies. Unlike Medicare+Choice, we set up a regional system where plans will bid in a way that does not allow them to choose the most profitable cities and towns. They cannot do cherry-picking. Systems like this work well for Federal employees such as the postmaster in my hometown of New Hartford, IA. He has a choice of several plans. We want to give that same choice to his parents, who today have only Medicare and nothing else.

Are PPOs right for everyone? It is the right to choose that is important about this bill. Let the seniors decide. Our bill sets up a playing field for PPOs to compete for beneficiaries. We believe PPOs can be competitive and offer a stronger, more enhanced benefit than traditional Medicare. But let me be clear, no senior has to choose PPOs. My policy has been to let seniors keep what they have, if they like it, with no change. All seniors, regardless of whether they choose a PPO, can still get prescription drugs. They do not have to choose that, but they can choose that as an add-on to traditional Medicare if they want.

So I hope I have protected all of my colleagues, and maybe my colleagues do not need any protection, insisting on the voluntariness of this and the right to choose. I think it is pretty essential for people who are older, who do not want change in their life, not to have to make a change in their life.

I fear maybe, as the Senator from Iowa, that somebody is going to come up to me someday and say: GRASSLEY, just leave my Medicare alone.

They do not follow Congress closely, but they read here and there and they get nervous: What Senator is taking away their Medicare? I can say to Mary Smith in Columbus Junction, IA: You do not have to worry about anything. If you are satisfied with the Medicare you have, you can keep it. If you want to join a prescription drug program to add to it, you can do that, but you do not have to worry about Medicare. If you like it the way it has been all your life, we are leaving it alone.

I think that sounds like protection for Senator GRASSLEY, but I am concerned about the cynicism my seniors have about Government, maybe because they do not study it as much as we do or understand it as much as we do. I want to reduce that cynicism, but I want them to have confidence in their Medicare as well. I think this right to choose gives them that confidence.

The conference report also includes other important policies that I believe make a much stronger, better bill. First, we make wealthier people pay a slightly higher premium. Why should someone who makes $80,000 a year or more pay exactly the same price for coverage as someone who makes $30,000 a year? The conference report makes wealthy seniors pay slightly more, and this is a very important and rational step toward stabilizing Medicare's growth.

The conference report also injects new and transparent accountancy rules into Medicare, making the trustees show in a comprehensive way what all of Medicare's assets and liabilities truly are. There are also expedited procedures for committee consideration of legislation that addresses any future Medicare funding crisis without changing the Senate rules.

Finally, and in my view most importantly, the conference agreement authorizes health savings accounts. I have been a long-time supporter of medical savings accounts. Now they are going to be called health savings accounts. Such tax-favored accounts encourage responsible utilization of health care services. They offer low-cost insurance to farmers and other self-employed people. For too long, medical savings accounts have languished under regulatory inflexibility. The provisions in the conference report go to great length to make medical savings accounts a stronger, more accessible option for more Americans, and I think that is very appropriate because it adds to the right to choose.

We are in a unique moment in our history as far as health insurance legislation is concerned. We have a limited opportunity to deliver on our promises to get this done once and for all.

Let me remind everyone, there is $400 billion sitting in front of America's seniors. If we let partisan disagreement prevent us from snatching it up for them, shame on us because, what do you think the chances are next March of this Senate adopting a budget with $400 billion set aside for Medicare? I think the chances of that happening are not very good.

Let's not allow the perfect to be the enemy of the good. I urge my colleagues to continue in the bipartisan tradition of the Finance Committee and deliver a balanced bipartisan product that does right by our seniors.

I yield the floor. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Ms. COLLINS. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mrs. DOLE). Without objection, it is so ordered.

VISION 100—CENTURY OF AVIATION REAUTHORIZATION ACT—CONFERENCE REPORT

Ms. COLLINS. Madam President, I ask unanimous consent that the Senate now proceed to the conference report to accompany H.R. 2115, the FAA authorization bill.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report.

The legislative clerk read as follows:

The Committee of Conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2115), to amend title 49, United States Code, to reauthorize programs for the Federal Aviation Administration, and for other purposes, having met, have agreed that the House recede from its disagreement to the amendment of the Senate, and agree to the same with an amendment, signed by a majority of the conferees on the part of both Houses.

The PRESIDING OFFICER. The Senate will proceed to the consideration of the conference report.

(The conference report is printed in the House proceedings of the RECORD of July 25, 2003.)

Ms. COLLINS. Madam President, I ask that the conference report be agreed to, the motion to reconsider be laid upon the table, and any statements relating to the conference report be printed in the RECORD.

Mr. REID. Reserving the right to object, I would like to extend the appreciation of the entire Senate, especially on this side, to those who worked to allow us to be at this point: Senators LAUTENBERG, DORGAN, and ROCKEFELLER, and the ranking member of the committee, Senator HOLLINGS, and the cooperation of Senator LOTT, and others. This is a very important piece of legislation for the State of Nevada but also for the entire country. I underscore the very good work of the individuals I mentioned.

This is not perfect, but it goes a long way to protecting working men and women who make it possible for everyone to fly safely in America today.

Madam President, I ask unanimous consent that copies of a letter from Marion C. Blakey, the Administrator of the Federal Aviation Administration, be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

DEPT. OF TRANSPORTATION,
FEDERAL AVIATION ADMINISTRATION,
Washington, DC., November 21, 2003.

Hon. ERNEST HOLLINGS,
Russell Senate Office Building,
Washington, DC.

DEAR SENATOR HOLLINGS: I have received your November 13, 2003 letter regarding the issue of contracting out functions performed by Federal Aviation Administration (FAA) employees. Your letter requested clarification on the status of "contracting out" of FAA functions related to flight services and the certification or maintenance of air traffic control equipment used in the national airspace system. I understand that you are not advocating that the FAA in-source any functions currently performed by contractors or cease work and analysis already underway. As you know, several months ago the FAA initiated a competitive sourcing process with respect to the FAA's Automated Flight Service Stations (AFSS). Under the FAA's current schedule, the final source selection decision with respect to the AFSS competition will occur early in fiscal year 2005.

During this fiscal year we have no plans to initiate additional competitive sourcing studies, nor will we displace FAA employees by entering into binding contracts to convert to private entities any existing FAA position directly related to our air traffic control system.

I look forward to working with the Committee on the important challenges facing the Federal Aviation Administration. The Conference Report contains many provisions which will provide us with important tools to enhance aviation safety, security, and capacity. Thank you for your efforts on this important piece of legislation.

Sincerely,
MARION C. BLAKEY,
Administrator.

DEPT. OF TRANSPORTATION,
FEDERAL AVIATION ADMINISTRATION,
Washington, DC, November 21, 2003.

Hon. JOHN MCCAIN,
Chairman, Committee on Commerce, Science and Transportation, Russell Senate Office Building, Washington, DC.

DEAR MR. CHAIRMAN: I have received your November 13, 2003 letter regarding the issue of contracting out functions performed by Federal Aviation Administration (FAA) employees. Your letter requested clarification on the status of "contracting out" of FAA functions related to flight services and the certification or maintenance of air traffic control equipment used in the national airspace system. I understand that you are not advocating that the FAA in-source any functions currently performed by contractors or cease work and analysis already underway. As you know, several months ago the FAA initiated a competitive sourcing process with respect to the FAA's Automated Flight Service Stations (AFSS). Under the FAA's current schedule, the final source selection decision with respect to the AFSS competition will occur early in fiscal year 2005.

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I look forward to working with the Committee on the important challenges facing the Federal Aviation Administration. The Conference Report contains many provisions which will provide us with important tools to enhance aviation safety, security, and capacity. Thank you for our efforts on this important piece of legislation.

Sincerely,
MARION C. BLAKEY,
Administrator.

Mr. MCCAIN. Mr. President, I am pleased that the Senate is about to vote on the Conference Report to H.R. 2115, the FAA reauthorization bill. This legislation is critical to our Nation's air transportation system, providing necessary funding for aviation safety and security for fiscal years 2004 to 2007.

Civil aviation generates more than $900 billion in GDP every year, and we all know that it has faced very difficult economic times. Since September 11, 2001, Congress has passed a number of bipartisan aviation bills to aid the industry and, more importantly, to assure that the air traveling public could continue to rely on this vital transportation mode. Among the many bills enacted, we established the Transportation Security Administration (TSA) to oversee aviation security; we provided grants and loans to help the airline industry through their difficult economic times; and we extended terrorism insurance to the aviation industry. Without these important measures, the aviation industry would be in far worse condition.

The Conference Report pending before us is as important to the health of our aviation system as any of the other bills I just mentioned. This multi-year FAA authorization legislation is needed by airports, so that airport construction projects don't come to a halt and cause layoffs in the construction sector. It is needed by aviation manufacturers and by the airline industry. Above all, it is needed by our air travelers, who rely on a safe and security air transportation system.

The Conference Report on H.R. 2115 authorizes over $60 billion in aviation spending over the next four years to improve our Nation's aviation system. It includes: $14.2 billion for security, safety and capacity projects for the Airport Improvement Program (AIP)—over 50 percent of this funding is likely to be spent on safety projects. In fiscal year 2004 alone, this funding will create approximately 162,000 direct and indirect jobs. However, the AIP funding ONLY becomes available if this Conference Report is signed into law—the passage of the transportation appropriations bill is NOT sufficient to make the funds available; $13.3 billion to modernize the air traffic control system; $31 billion to operate the FAA's air traffic control system and to support the FAA's safety programs; $1.6 billion for aviation research and development; $2 billion for airport security projects, and, $500 million for the Essential Air Service program. The majority of this funding will come from the Aviation Trust Fund, which is supported by taxes paid by the users of the system.

Although this Conference Report provides a great boost for the modernization of the aviation system and for increasing capacity and efficiency, there are also numerous provisions in the Conference Report that will improve aviation safety and security.

In support of improving safety, the Conference Report strengthens FAA enforcement against the users of fraudulent aircraft parts; increases penalties that the FAA may impose for safety violations—fines have not been adjusted since 1947, and as such, are sometimes simply treated as the cost of doing business by the entity being fined; and requires the FAA to update and improve its airline safety oversight program.

In support of improved aviation security, the Conference Report includes $500 million per year to finance security capital improvements at airports—including the installation of explosive detection systems. After September 11, almost $500 million per year in AIP funds were diverted to security projects from safety and capacity projects. Although this may have been justifiable immediately after September 11, in the long run, a continuation of such diversion could be detrimental to the aviation system; extends the Secretary of Transportation's authority to provide War Risk insurance to airlines against terrorism; expands the armed pilot program to include cargo pilots; requires the TSA to improve the security at foreign repair stations that conduct work on U.S. aircraft; authorizes compensation to general aviation entities for losses resulting from security mandates; and provides for certification and better security training for flight attendants.

In order to improve air transportation service, especially to smaller and rural communities, the Conference Report contains a number of provisions. The report reauthorizes the Essential Air Service (EAS) at current funding levels; establishes a number of EAS pilot programs to give communities flexibility in how they receive EAS service; makes permanent the Small Community Air Development program; establishes a National Commission on Small Community Air Service to make recommendations on how to improve air service to such communities; and includes a Sense of Congress that airlines should provide the lowest possible fare for all active duty members of the Armed Forces.

Further, for large airports in Western States and smaller airports in the East, it frees up more takeoff and landing slots at Reagan National Airport.

The Conference Report addresses numerous environmental issues. It streamlines environmental review of projects to increase airport capacity and improve aviation safety and security; authorizes grants to airports to permit them to purchase or retrofit low emission vehicles at airports; and authorizes projects that improve air quality and give airports emission credits for undertaking such projects.

I want to recognize all the hard work that Senator LOTT, as Chairman of the Aviation Subcommittee, has put into the bill this year. Last winter, many in the aviation community predicted that Congress would not enact an aviation reauthorization bill this year. Senator LOTT would not even consider such a scenario and kept us on a schedule where the Conference Report was actually completed before the August recess. This was only possible, as always, due to the work and cooperation on this bill from the ranking Democratic members of the Commerce Committee and its Aviation Subcommittee, Senators HOLLINGS and ROCKEFELLER.

I also wish to thank Senator DORGAN for his work in brokering the compromise that allowed us to move forward with this Conference Report today. And I want to thank the administration, especially Secretary Mineta and FAA Administrator Blakey, in working long and hard with us to get a final compromise on the issue of privatization.

I urge my colleagues to support final passage of the Conference Report and send it to the President.

Mr. HOLLINGS. Mr. President, I rise today to express my support for passage of H.R. 2115, Vision 100—Century of Aviation Reauthorization Act. I am pleased that we have finally reached agreement on this important legislation and can now move forward on enacting this bill into law. This comprehensive reauthorization bill will provide $60 billion in funding for FAA operations, including some $14.2 billion for airport grants that will create an estimated 600,000 jobs and support for key aviation projects in communities across the country.

Achieving consensus on the conference report has not been easy, and while I think all of us should be encouraged by the results of these efforts, we should take this opportunity to fully consider and appreciate the critical role that compromise has played in achieving this positive result. Colleagues on both sides of the aisle have expressed their concerns about the process by which the FAA Conference Report was deliberated and produced. FAA reauthorization bills have always been moved out of Congress with little controversy, but after passing a bill on the Senate floor with unanimous support and cooperating on developing the bulk on the FAA Reauthorization bill, Democrats were cut out of the process. This was an unacceptable development that violated the spirit of this body, and ultimately it led to the creation of flawed legislation.

For three months after it was filed, there was a lack of will in Congress to pass the FAA Conference Report in the form that the Republican leadership demanded. As a result, FAA projects went unauthorized after the fiscal year ended, and in an effort to end the stalemate they had created the House Leadership was forced to recommit the legislation on October 28, 2003. At this time, they stripped out the most troubling provision in the bill—language that allowed for the immediate privatization of 69 of FAA's air traffic control (ATC) towers and the entire ATC system in 2007. However, the Senate remained unsatisfied with the bill's lack of protection for the Nation's ATC system after it was recommitted, and we voted against cloture 45-43 on November 17, 2003.

Prior to the vote, I worked with Senators MCCAIN, ROCKEFELLER, and LOTT to seek commitment from the Bush administration to impose a 1-year moratorium on the contracting out or privatization of any ATC functions so that the Senate Commerce Committee can properly conduct its oversight responsibilities of this matter. The Committee plans to hold hearings on this subject next year, and we will also request detailed analyses from the Government Accounting Office and the Department of Transportation Inspector General (DOT IG) in an effort to determine how to best enhance safety, the steps that should be taken to keep pace with future growth, and the best way for the Federal Government to get there.

Today, we have received the proper commitment from the Bush administration to proceed in this manner. Under the arrangement, the FAA has agreed not to proceed with the privatization or outsourcing of any FAA air traffic separation and control functions in fiscal year 2004. The written agreement includes a prohibition on contracting out the maintenance and certification of the systems and equipment in the air traffic control system in the National Airspace System. In addition, the Administration has committed to maintaining the existing Federal relationship with the Nation's Flight Service Stations, with the understanding that they will be allowed to continue on-going evaluations of how best to revamp the entire program. The DOT IG's office has estimated that consolidation of the FSSs, combined with a new computer system, could provide a better arrangement and save $500 million over 7 years.

With this understanding in place, I am pleased that we can now move forward with broad support for a multi-year reauthorization of FAA programs. Indeed, H.R. 2115 has many good provisions in it that will go a long way towards improving and enhancing our aviation system as we move into the 21st Century. I would like to add that conservative estimates by the FAA show that the formula funding in this legislation will provide more than $112 million and at least 5,325 jobs in my home State of South Carolina over the next 4 years. I look forward to passing the bill.

Finally, I want to thank Chairman McCAIN, Senator LOTT, the Aviation Subcommittee Chairman, and Ranking Member ROCKFELLER for all of their hard work over the last several days and for the long months that they put in prior to that. We came together with a common purpose—to pass this Conference Report—and with bipartisan cooperation have developed comprehensive legislation that provides the American people the proper level of safety, security and financial support.

Mr. ROCKEFELLER. Mr. President, I am pleased to finally be able to support the adoption of the Federal Aviation Administration conference report.

The process that allowed us to get to this point has been unlike any other that I have ever experienced in my 19 years in the Senate, but we have secured a commitment from the administration that they will not move forward with contracting out any air traffic control functions, which has prevented the Senate from passing this report. I am pleased that my colleagues have confirmed this commitment.

Over the last year, I have worked closely with Senators McCAIN, HOLLINGS, and LOTT on developing this important legislation. I thank them for all of their efforts on getting this bill done. It has not gone as easy as any of us would have liked, but the debate on privatization is important as it is fundamentally a debate on safety and security. Senator LAUTENBERG should be commended for his unrelenting commitment to making sure the United States has the safest and most secure air traffic control system in the world.

We have secured an agreement on this issue that all parties can accept, but it does not mean that this debate is over. I know my colleagues have committed to holding hearings on this issue, and we will be closely monitoring the administration's actions in this area.

The reauthorization of the FAA is a vitally important piece of legislation. It would be the first genuine economic stimulus bill that the Senate has passed this year.

No question exists that since the tragedy of September 11, aviation in this country has been permanently changed. Over the last 2 years, we have seen a decrease in the demand for air travel, hundreds of thousands of aerospace and aviation employees have lost their jobs and the economic pain has rippled through the economy. We cannot have a sustained economic recovery in this country until we have a healthy and vibrant aviation industry.

This bill provides the foundation for the resurgence of an essential sector of our economy.

I cannot emphasize the importance of a vibrant and strong aviation industry. It is fundamental to our nation's long-term economic growth. It is also vital to the economic future of countless small and local communities that are linked to the rest of the nation and world through aviation.

Just as the aviation industry is a catalyst of growth for the national economy, airports are a catalyst of growth for their local communities. In my State of West Virginia, aviation represents $3.4 billion of the state's gross domestic product and directly and indirectly employs over 51,000 people.

Aviation also links our Nation's small and rural citizens and communities to the national and world marketplace. My home State of West Virginia has been able to attract firms from Asia and Europe because of reliable access to their West Virginia investments.

Without access to an integrated air transportation network, small communities can not attract the investment necessary to grow or allow home grown businesses to expands. A modern and adequately funded aviation network is fundamental to making sure that all Americans can participate in the global economy. This bill makes sure the United States will continue to have the best aviation system in the world.

This legislation builds upon our commitment to improving the aviation infrastructure of the nation that started with the landmark Aviation Investment and Reform Act for the 21st Century. I believe that this legislation meets the challenges facing the FAA and the aviation industry in the years ahead.

This $60 billion bill focuses on improving our Nation's aviation safety and air service development, and aeronautical research. While my distinguished colleagues have provided an excellent overview of the bill, I would like to highlight some areas for the bill that I believe are particularly important.

No higher goal exists than the safety and security of the Nation's airports and airspace. Over the past 24 months, we have worked every day to improve security in our airports and on our airplanes. However, until this bill, we had fallen short on providing funding to make sure our Nation's airports have the resources available to make the required improvements.

Airports estimate that they have $3 billion in unmet security infrastructure needs. Airports have been forced to tap their expansion and development funds to pay for security. It makes no sense to raid funds for safety improvements for security improvements. The security of our Nation is a Federal responsibility and the Federal Government must pay for it.

One of the most important provisions in this bill is the establishment of a $500 million fund to assist airports with capital security costs. This new fund is intended to stop the diversion of airport development funds meant for safety and capacity enhancements. We will be able to pay for new security requirements while simultaneously improving safety and expanding capacity.

Even in these difficult budgetary times, we were able to modestly increase the Airport Improvement Program funding, which will provide the economy a real stimulus through direct and indirect job creation. Airport development is economic development as airports are economic development for their local communities. It is estimated that U.S. Airports are responsible for nearly $507 billion each year in total economic activity nationwide. Investment in airport infrastructure is a real economic stimulus that creates both immediate jobs and long-term economic development.

In order to facilitate airport development, I am pleased that this bill includes much of the text of the legislation that Senator HUTCHINSON and I worked on last Congress to streamline and expedite the airport development process. This country needs to expand its airport infrastructure. Without a substantial increase in this area, aviation delays would increase resulting in billions of dollars of costs to the economy.

Finally, we have authorized a significant increase in aeronautical and aviation research in order to preserve America's leadership in these industries.

Today, we also meet the challenge of making sure our small and rural communities have access to the nation's air transportation network. I continue to be very concerned that air carriers are abandoning small and rural markets. We cannot let these communities go without adequate and affordable air service—their future depends upon it.

I am enormously pleased that the bill extends and expands the Small Community Air Service Development Program, which I fought for in AIR 21. In West Virginia, Charleston used funding from this program to attract new service to Houston, which has been a hugh success. Parkersburg was recently awarded a grant and already working on implementing its initiatives to improve air service to new hubs. This program has proven an innovative and flexible tool for communities to address air service needs.

Many of our most isolated and vulnerable communities whose only service is through the Essential Air Service

Program have indicated that they would like to develop innovative and flexible programs similar to those communities who received Small Community Air Service Development grants to improve the quality of their air service.

It is for this reason that I, along with Senator LOTT, developed the Small Community and Rural Air Service Revitalization Act of 2003. The FAA conference report incorporates the basic provisions of this legislation. The FAA Bill reauthorizes the Essential Air Service, EAS, program and creates a series of new innovative pilot programs for EAS communities to participate in to stimulate passenger demand for air service in their communities.

By providing communities the ability to design their own air service proposals, a community has the ability to develop a plan that meets its locally determined needs, improves air service choices, and gives the community a greater stake in the EAS program.

Small and rural communities are the first to bear the brunt of bad economic times and the last to see the benefits of good times. The general economic downturn and the dire straits of the aviation industry have placed exceptional burdens on air service to our most isolated communities. The Federal Government must provide additional resources and tools for small communities to help themselves attract adequate air service. The Federal Government must make sure that our most vulnerable towns and cities are linked to the rest of nation. This legislation authorizes the tools and resources necessary to attract air service, related economic development, and most importantly expand their connections to the national and global economy.

This bill meets the challenges facing our aviation system—increasing security, expanding airport safety and capacity, and making sure our smallest communities have access to the network. We can all be proud of this bill.

Again, I thank Senator MCCAIN, Senator LOTT, and Senator HOLLINGS for all their hard work to improve aviation in this country.

Mr. ROCKEFELLER. I have a question for the subcommittee chairman about section 808 of the conference report concerning international air cargo shipped through Alaska.

Mr. LOTT. I am happy to answer the Senator's question. This provision was adopted in the Senate after being offered by the Senator from Alaska.

Mr. ROCKEFELLER. I thank the Chairman. Is it the Chairman's understanding that section 808 only addresses international cargo and does not address the carriage of cargo which first originates in Alaska?

Mr. LOTT. That is correct. Section 808 will allow carriers to interline cargo in Alaska so long as the cargo has an ultimate origin and/or destination outside of the United States. It does not allow foreign carriers to carry or transfer cargo with an ultimate origin and destination both in the United States.

Mr. STEVENS. I thank my colleagues for explaining that this important provision allows carriers to interline cargo in Alaska, with an ultimate origin and/or destination outside of the United States, but does not allow foreign carriers to carry or transfer cargo with an ultimate origin and destination both in the United States.

Mr. BURNS. Mr. President, I come to the floor today in support of the conference report accompanying H.R. 2115, which reauthorizes the Federal Aviation Administration (FAA).

Vision 100—Century of Aviation Reauthorization Act would provide just under $60 billion over the next 4 years for FAA activities. These are much needed funding improvements because we find ourselves in one of the greatest transition periods as a country, and as proponents of the aviation industry, in the history of our nation. With the slow recovery of the industry and the economy since the attacks of 9/11 it is important we pass this legislation immediately.

As a member of the conference, my colleagues and I addressed several important issues and challenges. One of the most important achievements is the progress made in funding the Airport Improvement Program, which is funded at $3.4 billion in 2004 and increases $100 million each year ending at $3.7 billion in 2007. This is a necessary increase, as we need to constantly improve our Nations' airport infrastructure especially in rural and underserved areas.

Mr. President, as you know, several provisions in or absent from the bill have bogged down its passage. As a member of the conference, even I do not support all provisions in this bill, but I understand the importance of the bill as a whole and the potential pitfalls our infrastructure will take if not enacted.

I do not intend to discuss the entire report, but there are several critical provisions I would like to briefly address which greatly affect my State of Montana and my constituents.

The first provision is intended to make additional slots available to improve access to the Nation's Capital for cities located beyond the 1,250 mile service perimeter at Ronald Reagan Washington National Airport, DCA. I am particularly concerned that small and midsized communities in the west, especially in Montana and neighboring states, continue to have far fewer service options to reach DCA than communities located in any other area of the country. This is due to the fact that the most important hub airport serving the northern tier and intermountain region, Salt Lake City, is located outside the DCA perimeter.

Network benefits are critical to improving this situation, and it is very important that the Department of Transportation consider and award these limited opportunities to western hubs that connect the largest number of cities to the national transportation network. Salt Lake City is a prime example. That airport serves as a primary transportation hub for the intermountain west. I was very disappointed that Salt Lake City received only a single flight from the prior AIR-21 allocation, while other hubs servicing the southwest region received two, or even three daily flights. Increased service at Salt Lake City should be a priority, because of the many critically underserved communities in the northern tier and intermountain west that will receive significant network benefits from additional flights at that hub.

The second issue is the Essential Air Service Program, EAS. As you know, the EAS program provides subsidies to carriers for providing service between small communities and hub airports and is, no pun intended, essential to my state. This report authorizes approximately $500 million for EAS, and I am extremely supportive of that level.

Unfortunately, the conference report also contains a provision, which directs the DOT to establish a pilot program for up to 10 EAS communities located within 100 miles of a large hub, and those communities will be required to pay 10 percent match of the EAS subsidy. While this provision does not affect my Montana EAS communities, I am still extremely unsupportive of this provision. If any Montana communities were asked to pay this match, there is no way they could come up with the funds. I want this body to know I will fight expansion of this pilot program in future authorizations. While we need to work on possible alternatives to EAS, we cannot ask small communities across the Nation to fork out funds they do not have for a service they deserve and need.

Finally, this report contains language based on two amendments I offered on the Senate floor during debate earlier this year. The first asks for a report from the Secretary of Transportation on any actions that should be taken with respect to recommendations made by the National Commission to Ensure Consumer Information and Choice in the Airline Industry. The second amendment authorizes compensation to General aviation businesses for losses incurred after the attacks of 9/11. General aviation is an extremely important piece of this country's aviation backbone and we need to keep their perspective in mind whenever any aviation legislation is addressed whether it deals with security or overall aviation policy.

In summation, we have crafted a fair and necessary piece of legislation that needs immediate passage. I ask my colleagues to support final passage of this critical piece of legislation that will aide all aviation sectors across this Nation.

Mr. JEFFORDS. Mr. President, I have serious concerns about several provisions found in the FAA reauthorization conference report. Before the Senate passed S. 824, the FAA reauthorization bill, we expressly prohibited additional privatization of air traffic controllers. We also eliminated a proposed cost-sharing requirement for local communities that participate in the essential air service program. This requirement would have placed an insurmountable burden on many remote communities struggling to maintain commercial air service. While I understand that Administrator Blakey today has promised our Senate colleagues to forestall privatization until the next fiscal year, I am concerned that the window is nevertheless open for eventual privatization and would not support such a result.

I remain concerned about the provisions in this bill affecting the National Environmental Policy Act, NEPA. As I discussed in my statement of November 17, 2003, the legal obligations of Federal agencies to evaluate aviation projects under Federal environmental laws have not been repealed by the language in this bill, nor should they be. If better coordination is the intent of this legislation, there is ample authority contained in the existing NEPA statute and regulations for coordination among Federal agencies in performing required environmental reviews of these projects. The confusing statutory directions contained in this bill are both unnecessary and counterproductive if the desired result is efficient project completion.

I am disappointed that this conference report contains these provisions, and I will work to ensure that the FAA scrutinizes the potential consequences of privatization of air traffic controllers if that issue arises next year. In addition, as the ranking member of the Environment and Public Works Committee, I will continue to conduct oversight pertaining to the implementation of environmental laws for these and other Federal projects.

Mr. THOMAS. Mr. President, as the Senate considers the final conference report to the FAA reauthorization bill, I would like to take a moment to thank Chairman McCAIN and subcommittee Chairman TRENT LOTT, for their assistance regarding a provision that is very important to my home State.

For years, I have been working with the FAA and the Jackson Hole Airport to reduce the noise that is produced by older private jets. As some of my colleagues know, the Jackson Hole Airport is the only commercial airport that is located in a national park. Since 1983, the Jackson Hole Airport has operated under a "land use agreement" with the Secretary of the Interior. This agreement requires the airport to implement technological advances to reduce aircraft noise.

However, the FAA has prevented the airport from instituting a Stage 2 restriction on older "noisy" private jets even though the Air Noise Capacity Act of 1990 includes a provision that allows folks to enforce pre-existing noise control measures. Currently, only a small portion, 2.6 percent, of the airport's operations are conducted by older noisy jet aircraft. However, these old noisy jets have a disproportionately high noise impact on Grand Teton National Park and the National Elk Refuge. Because the FAA has failed to recognize the grandfathered status of the Jackson airport, I offered an amendment to the Senate version of the FAA reauthorization bill.

On June 12 the Senate unanimously agreed to my amendment. I am thankful for Senator McCAIN's and House Chairman DON YOUNG's understanding regarding the need to protect Grand Teton National Park and the National Elk Refuge from the high levels of noise that older private jets produce. The provision is supported by the Jackson Airport Board, Grand Teton National Park, the Town of Jackson, Teton County, and U.S. Department of the Interior.

Mr. President, the Jackson Hole Airport is a commercial service airport located on Federal land within Grand Teton National Park. It operates under a long-term lease agreement with the Department of the Interior. That agreement contains noise control measures, including cumulative and single event noise limits, and requirements for an airport-adopted noise control plan.

Section 825 of the conference report authorizes a commercial service airport that does not own the airport land and is a party to a long-term lease with a Federal agency, such as the Department of the Interior, to restrict or prohibit Stage 2 aircraft weighing less than 75,000 pounds, to help meet the noise control plan contained in its lease.

It is my understanding that the conferees did not intend to limit application of section 825 to only those noise control measures that are expressly referred to as "plans," but intended the term to refer to the range of noise control requirements and standards imposed by these Federal lease agreements.

Mr. McCAIN. The Senator from Wyoming is correct. The conferees intended "plan" to refer to the range of requirements and standards contained in a Federal lease, which together constitute its plan to limit airport-generated noise. Section 523 of the Senate bill, introduced by the Senator from Wyoming, would have given similar authority to the Jackson Hole Airport Board. The conference substitute will permit the Jackson Hole Airport, and others if subject to similar Federal lease requirements, to adopt these measures.

Mrs. MURRAY. Mr. President, I rise in strong support of the Vision 100–Century of Aviation Reauthorization Act. This bill authorizes critical aviation infrastructure and operations spending for the fiscal years 2004 through 2007. The bill also makes important legislative adjustments for our aviation security program at the Transportation Security Administration.

I represent a State with tens of thousands of aviation workers. I appreciate fully the essential contribution that our Nation's aviation industry makes to our national economic prosperity. As the former chairman and now ranking member of the Transportation Appropriations Subcommittee, I spend a considerable amount of my time seeing to it that the needs of our national aviation enterprise are adequately funded.

As my colleagues are aware, consideration of this FAA authorization bill has been delayed for an extraordinary period of time over the issues surrounding the Bush administration's stated desire to privatize certain aspects of our Nation's air traffic control system.

At one time, this legislation included language that specifically authorized the FAA Administrator to privatize the controller workforce at scores of air traffic control towers, including the air traffic control tower at Boeing Field in Seattle. Senators who are not familiar with the geography of the greater Seattle area may not be aware that Boeing Field sits right between Seattle-Tacoma International Airport and downtown Seattle. It is extraordinarily close to our port, our central business district, our major sporting venues—Safeco Field and the Seahawks Stadium. It is also a major installation for the Boeing Company and a busy general aviation airport.

In the wake of the events of September 11, 2001, I cannot support a proposal to contract out the air traffic control function to the lowest bidder in the heart of this critically important corridor.

Immediately after September 11, this Congress passed legislation to take the air passenger screening function out of the hands of private bidders and place it in the hands of a federalized screening force. For the life of me, I do not understand why the Bush administration wants to take the exact opposite approach when it comes to the highly skilled personnel that actually control the movement of our aircraft.

The administration has also cited an interest in privatizing other aspects of our Nation's national air traffic control enterprise, including the employees at our Nation's flight service stations and the technicians that maintain our Nation's air traffic control equipment.

These privatization ideas have not been adequately explained or adequately justified to the Congress or to the public. It has not been determined that such contracting out activities would actually improve upon the exemplary safety record that we currently enjoy with our air traffic control system. I, along with many of my colleagues, have deep-seated doubts about the safety ramifications, the security ramifications and whether there will be any real financial benefit to the taxpayer as a result of such a privatization scheme. It was for these reasons that I and 42 of my Senate colleagues, both Democrats and Republicans, were required to vote against bringing debate on this bill to a close on November 17, and why I joined 55 of my colleagues in support of a measure to explicitly exclude privatization of our air traffic control towers during the initial debate on the Senate bill. At that time, we did not have what I considered to be adequate assurances from the FAA that they would not be launching into these privatization schemes in the very near future.

I am pleased that we have now overcome this hurdle and the administration has given us assurances that they will not engage in any competition studies or outsourcing activities for air traffic controllers or for maintenance and technician personnel during fiscal year 2004. This will give the Congress some time to review the administration's plans in detail, which I intend to do during next year's appropriations' hearings process. Also, with the written assurance now in hand that no outsourcing activities related to our air traffic control system will take place in 2004, we can, if need be, work on putting sufficient safeguards in the 2005 Transportation Appropriations Act if we feel that the administration is heading in the wrong direction when it comes to protecting safety and security.

It is for these reasons that I am relieved by the administration's new letter on this topic which I understand has already been put into the RECORD. I am glad that we have overcome this hurdle.

This bill will provide investments in critical infrastructure and operations at our Nation's airports. Furthermore, it will allocate needed funding to continue our efforts to improve the security of aviation system.

For these reasons, I support this important conference report today.

The PRESIDING OFFICER. Without objection, the request of the Senator from Maine is so ordered.

The conference report was agreed to.

Ms. COLLINS. Madam President, I see the Senator from North Dakota. If the Senator has a very brief comment to make, I yield to him.

Mr. DORGAN. Madam President, I appreciate the courtesy of the Senator from Maine. Let me say with respect to the unanimous consent she just offered to pass the FAA conference report, I would like to say that Senator LAUTENBERG has led the fight in this Chamber to try to prevent the privatization during this coming fiscal year of those who work for the FAA. That fight required us to go through one cloture vote and the majority did not invoke cloture. As a result, the FAA conference report was not passed.

Since that time, I and Senators LAUTENBERG, HOLLINGS, LOTT, ROCKEFELLER and others have engaged in discussions with the administration. I want to point out that the letter just printed in the RECORD by unanimous consent is from Marion Blakey. She says:

> During this fiscal year we have no plans to initiate additional competitive sourcing studies, nor will we displace FAA employees by entering into binding contracts to convert to private entities any existing FAA position directly related to our air traffic control system.

I point out that the reason we were able to move this conference report tonight was because the administration has agreed they will not, during this fiscal year, privatize those positions in the FAA. That is a very important position, one that my colleague, Senator LAUTENBERG, from New Jersey, fought very hard for. We have achieved that commitment from the administration.

For that reason, we were able to move that FAA reauthorization. Let me say how pleased I am because it is so important to virtually every region of this country. The investment in the Airport Improvement Program and the other things that provide strength to the FAA system is very important to our country.

Let me thank my colleague from Maine. I wanted to explain the circumstances that have led to this point and especially say I have been pleased to work with Senator LOTT, in many contacts over recent days, to try to accomplish this and again say that my colleague from New Jersey, Senator LAUTENBERG, deserves a pat on the back for forcing this result.

I yield the floor.

The PRESIDING OFFICER. The Senator from Maine.

NATIONAL WOMEN'S HISTORY MUSEUM ACT OF 2003

Ms. COLLINS. Madam President, I ask unanimous consent the Senate now proceed to consideration of Calendar No. 404, S. 1741, a bill to provide a site for the National Women's History Museum in the District of Columbia.

The PRESIDING OFFICER. The clerk will report the bill by title.

The assistant legislative clerk read as follows:

> A bill (S. 1741) to provide a site for the National Women's History Museum in the District of Columbia.

There being no objection, the Senate proceeded to consider the bill.

Ms. COLLINS. Madam President, I ask unanimous consent the bill be read the third time and passed, the motion to reconsider be laid upon the table, and any statements related to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (S. 1741) was read the third time and passed, as follows:

S. 1741

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "National Women's History Museum Act of 2003".

SEC. 2. FINDINGS.

Congress finds that—

(1) the National Women's History Museum, Inc., is a nonprofit, nonpartisan, educational institution incorporated in the District of Columbia;

(2) the National Women's History Museum was established—

(A) to research and present the historic contributions that women have made to all aspects of human endeavor; and

(B) to explore and present in a fair and balanced way the contributions that women have made to the Nation in their various roles in family and society;

(3) the National Women's History Museum will collect and disseminate information concerning women, including through the establishment of a national reference center for the collection and preservation of documents, publications, and research relating to women;

(4) the National Women's History Museum will foster educational programs relating to the history and contribution to society by women, including promotion of imaginative educational approaches to enhance understanding and appreciation of historic contributions by women;

(5) the National Women's History Museum will publicly display temporary and permanent exhibits that illustrate, interpret, and demonstrate the contributions of women;

(6) the National Women's History Museum requires a museum site near the National Mall to accomplish the objectives and fulfill the ongoing educational mission of the museum;

(7) the 3-story glass enclosed structure known as the "Pavilion Annex" is a retail shopping mall built next to the Old Post Office in 1992 by private developers using no Federal funds on public land in the Federal Triangle south of Pennsylvania Avenue, N.W.;

(8) the Pavilion Annex came into the possession of the General Services Administration following bankruptcy and default by the private developer of the Old Post Office Pavilion;

(9) the Pavilion Annex has been vacant for 10 years and is in a state of disrepair;

(10) the Pavilion Annex is located near an area that has been identified as an ideal location for museums and memorials in the

Memorials and Museums Master Plan developed by the National Capital Planning Commission;

(11) the National Women's History Museum will provide a vibrant, cultural activity in a building currently controlled by the General Services Administration but unused by any Federal agency or activity;

(12) the General Accounting Office has determined that vacant or underutilized properties present significant potential risks to Federal agencies, including—

(A) lost dollars because of the difficulty of maintaining the properties; and

(B) lost opportunities because the properties could be put to more cost-beneficial uses, exchanged for other needed property, or sold to generate revenue for the Government;

(13) the National Women's History Museum will use Government property for which there is no Government use as of the date of enactment of this Act, in order to—

(A) promote utilization, economy, and efficiency of Government-owned assets; and

(B) create an income producing activity;

(14) the National Women's History Museum will attract an estimated 1,500,000 visitors annually to the District of Columbia; and

(15) the National Women's History Museum will promote economic activity in the District of Columbia by—

(A) creating jobs;

(B) increasing visitor spending on hotels, meals, and transportation; and

(C) generating tax revenue for the District of Columbia.

SEC. 3. DEFINITIONS.

In this Act:

(1) Administrator.—The term "Administrator" means the Administrator of General Services.

(2) Museum sponsor.—The term "Museum Sponsor" means the National Women's History Museum, Inc., a nonprofit organization incorporated in the District of Columbia.

(3) Pavilion annex.—The term "Pavilion Annex" means the building (and immediate surroundings, including any land unoccupied as of the date of enactment of this Act) in Washington, District of Columbia that is—

(A) known as the "Pavilion Annex";

(B) adjacent to the Old Post Office Building;

(C) located on Pennsylvania Avenue, N.W., to the east of 11th Street N.W.; and

(D) located on land bounded on 3 sides by the Internal Revenue Service buildings.

SEC. 4. OCCUPANCY AGREEMENT.

(a) In General.—Notwithstanding any other provision of law, the Administrator shall enter into an occupancy agreement to make the Pavilion Annex available to the Museum Sponsor for use as a National Women's History Museum in accordance with this section.

(b) Appraisal.—

(1) In general.—Not later than 90 days after the date of enactment of this Act, a fair market value for the purpose of determining rent shall be determined by not more than 3 appraisers, operating under a common set of instructions, of whom—

(A) 1 shall be retained by the Administrator;

(B) 1 shall be retained by the Museum Sponsor; and

(C) 1 shall be selected by the first 2 appraisers only if—

(i) the first 2 appraisals are irreconcilable; and

(ii) the difference in value between the first 2 appraisals is greater than 10 percent.

(2) Difference of not more than 10 percent.—If the 2 appraisals differ by not more than 10 percent, the fair market value shall be the average of the 2 appraisals.

(3) Irreconcilable appraisals.—If a third appraiser is selected—

(A) the fee of the third appraiser shall be paid in equal shares by the Administrator and the Museum Sponsor; and

(B) the fair market value determined by the third appraiser shall bind both parties.

(c) Term of Occupancy Agreement.—

(1) In general.—The term of the occupancy agreement shall be at least 99 years, or any lesser term agreed to by the Museum Sponsor.

(2) First payment.—The first payment shall be due on the date that is 5 years after the date of execution of the occupancy agreement.

(d) Private Funds.—The terms and conditions of the occupancy agreement shall facilitate raising of private funds for the modification, development, maintenance, security, information, janitorial, and other services that are necessary to assure the preservation and operation of the museum.

(e) Shared Facilities.—The occupancy agreement may include reasonable terms and conditions pertaining to shared facilities to permit continued operations and enable development of adjacent buildings.

(f) Renovation and Modification.—

(1) In general.—The renovation and modification of the Pavilion Annex—

(A) shall be carried out by the Museum Sponsor, in consultation with the Administrator; and

(B) shall—

(i) be commenced as soon as practicable but not later than 5 years after the date of execution of the occupancy agreement;

(ii) sever the walkway to the Old Post Office Building; and

(iii) enhance and improve the Pavilion Annex consistent with the needs of the National Women's History Museum and the adjacent structures.

(2) Expense credit.—Any expenses incurred by the Museum Sponsor under this subsection shall be credited against the payment under subsection (c)(2).

(g) Report.—If the Administrator is unable to fully execute an occupancy agreement within 120 days of the date of enactment of this Act, not later than 150 days after the date of enactment of this Act, the Administrator shall submit to the Committee on Governmental Affairs in the Senate and the Committee on Government Reform in the House of Representatives a report summarizing the issues that remain unresolved.

SEC. 5. EFFECT ON OTHER LAW.

Nothing in this Act limits the authority of the National Capital Planning Commission.

Ms. COLLINS. Madam President, I now ask unanimous consent to engage in a colloquy with the Senator from Alaska, and I yield to the Senator from Alaska for that purpose.

The PRESIDING OFFICER. Without objection, it is so ordered.

Ms. MURKOWSKI. Madam President, I appreciate the opportunity to speak today and engage in this colloquy with the Senator from Maine. I thank the Presiding Officer for the opportunity to speak about opening a National Women's History Museum near the National Mall.

Currently, the National Women's History Museum is without a home. It is accessible online, but Americans need a physical location for the National Women's History Museum so a history from every State can be collected, viewed, and analyzed.

Recognizing the Senator from Maine and this Senator from Alaska have a connection, both of us coming from Northern States, both of us coming from States with populations that are relatively small, both States have a history that demonstrates a history of pioneering women. Alaska and Maine have historically afforded opportunities that might not be available to women in other States.

Throughout Alaska's and Maine's history, women have had perhaps more opportunities because our populations are isolated, and you are forced to be a little more self-reliant.

Women of Alaska and Maine, as their male counterparts, are ingrained with the ability to make do with what we have. I ask the Senator from Maine if she would agree with some of my statements?

Ms. COLLINS. Madam President, I certainly do agree with the distinguished Senator from Alaska. Both of us have had the opportunity to serve in public office. Both of us come from States that are small in population but large in the impact that women have had on our Nation's history. We are from States with rich histories of accomplishments by women of all backgrounds and cultures.

For example, the legendary Senator Margaret Chase Smith was the first woman in history to serve in both the U.S. House and the Senate.

Pauline Elizabeth Hopkins, who has been called the dean of African-American Women Writers, and who has been considered one of the most prolific black female writers in the beginning of the 1900s, was born in Portland, ME.

Mary Gabriel, of the Passamaquoddy Tribe, was a famous Native-American basket weaver, largely credited with reviving the art in the State of Maine.

Brenda Commander is the first woman to be elected as chief of Maine's Maliseet Indian Tribe.

Is the Senator from Alaska aware of similar accomplishments by Alaskan women?

Ms. MURKOWSKI. We have a history, as I have said, of pioneering women, women who perhaps have done the unexpected, who have reached out into areas that we would not anticipate, at a time we would not anticipate, women such as Kate Carmack, who is especially important in Alaska's history. Kate was an Athabascan woman who married an American trader. She is actually credited with discovering the first gold in Bonanza Creek, which started the Alaska gold rush in 1896.

As the story is told, when Kate first discovered the gold, it was frozen in the mud. Kate and her husband did not have the grub stake, if you will. They did not have the cash necessary to do the digout that winter. So they literally were sitting on the largest gold discovery in history. Kate's resourcefulness as a skin sower and her skill as an outdoorsman earned enough cash for the family to pull together that grub stake to hit "pay dirt" when the ground thawed the next spring.

When we think of women like Kate Carmack in Alaska, who braved some pretty tough, some pretty difficult conditions, I ask the Senator from Maine if she has any similar stories from her State?

Ms. COLLINS. I certainly do. That is a wonderful story of a truly courageous woman.

We have many women such as that throughout Maine's history. Josephine Peary was one such woman. She was married to the great explorer, Robert E. Peary, who was the first to reach the North Pole, not that far from Alaska. They lived together on Eagle Island in Casco Bay, ME. Josephine began exploring when she accompanied her husband to Greenland on a journey sponsored by the Academy of Natural Sciences that would last for a year and a half. That travel, in 1892, made Josephine the first woman in history to be a member of an Arctic exploration team.

I understand that women in Alaska also have been pioneers in expanding opportunities for women to work outside of the home. I wonder if the Senator from Alaska might expand on that.

Ms. MURKOWSKI. We have a lot of firsts that, again, when we look at Alaska's history and recognize we did not become a State until 1959, it is a very recent history, but yet women's involvement in some very important firsts have gone back so many years prior to statehood it really gets your attention.

Historically, Alaskan women were employed in jobs that women in other areas of the country could only dream about. In 1915, Anchorage employed its first female principal in the Anchorage School District, our largest community now, 3 years before World War I and 5 years before women's suffrage was ratified.

A year later, 1916, and still 4 years before national women's suffrage passed, Lena Morrow Lewis is believed to be the first woman to campaign for Alaska's territorial seat in the U.S. Congress. She did not win, but she was certainly followed by other pioneering women in the workforce.

Marvel Crosson was the first female licensed pilot in Alaska in 1927. Mildred Herman became the first woman admitted to the Alaska Bar Association in 1934. And Barbara Washburn was the first woman to climb Mount McKinley, the tallest mountain in North America.

This is all long before Alaska became a State. Other opportunities for women, as we flip through the history books, become very apparent. A woman by the name of Nell Scott became the first woman to serve in the Alaska State legislature in 1937. This was a year before the National Fair Labor Standards Act of 1938 was passed, which established a minimum wage.

Blanche McSmith was the first Black woman to serve in the Alaska State legislature. Sadie Neakok was the first Native Alaskan woman to serve as a magistrate in Alaska in 1960, during the same time period when the struggle for civil rights was raging in the South. Blanche and Sadie began serving in Alaska in very prominent roles 4 years before the Civil Rights Act was passed.

Could the Senator from Maine describe for me some of the pioneering women in her State.

Ms. COLLINS. I would love to share that information with the Senator from Alaska. It is just fascinating to hear the many firsts that women from her State have established.

The Senator from Alaska obviously has a great deal of pride in the history of women in her State.

In Maine, too, we have women who have played influential roles throughout history, but especially in the field of literature.

I am sure all of my colleagues know well the story of Harriet Beecher. She wrote "Uncle Tom's Cabin" in 1850 while pregnant with her seventh child. She began writing the book while residing in Brunswick, ME. Her deep religious faith and dedication to bringing to light the problems with slavery encouraged "Hattie" to write with such passion that she quickly finished and continued to write an average of a book a year to support her family.

Another famous Mainer, Martha Ballard, also made important contributions. She lived in Hallowell, ME, and was a midwife and a healer. She faithfully maintained a diary from 1785 to 1812, and her meticulous records have provided us with a rare glimpse into the daily life in Maine in the late 1700s and the early 1800s. Her contributions and life were only recently highlighted when Laurel Ulrich documented her work in a Pulitzer Prize winning book "The Midwife's Tale."

America's first female novelist, Sally Sayward Barrell, also known as Madam Wood, was born in York, ME, in the southern tip of our State. She wrote five gothic novels, first under the signature of "A Lady of Massachusetts," and then, later, under the signature of "A Lady of Maine" when Maine was granted statehood in 1820.

Another pioneering woman was Dorothea Dix. She was born in Hampden, ME, in 1802, and is considered a groundbreaking reformer in the area of treatment for individuals suffering from mental illness. She traveled the Nation advocating for a more compassionate, holistic approach to the treatment of those suffering from mental illness. She was truly ahead of her time. She also successfully lobbied Congress to establish the first and only national Federal mental health facility which would become a world premiere mental health and research center.

I ask my colleague to further expand on how Alaska has supported women and their accomplishments.

Ms. MURKOWSKI. Well, as the Senator has noted, her home State of Maine and Alaska both have a very rich history of groundbreaking women, women who have been pioneers, women who have reached out. I think our States have demonstrated the very supportive nature of moving women forward in their prosperity.

In Alaska, as a for instance, since we are talking about "for instances and firsts," the very first bill ever passed by the Territory of Alaska was the Shoup women's suffrage bill in 1913.

That was our first bill as it related to women's rights. Seven years before women's suffrage was ratified in the rest of the country and 46 years before Alaska became a State, our territorial legislature's first bill was related to women's rights.

I ask the Senator from Maine, in terms of your role model throughout your political career, who would you cite as that role model, that individual?

Ms. COLLINS. I would reply to my friend and colleague from Alaska that my role model and inspiration was the great Senator Margaret Chase Smith. She served as Senator from Maine the entire time I was growing up. She served in the Senate from 1949 to 1972. I realize how fortunate I was to have as a role model this courageous, smart, and brave woman who did so much and set so many firsts for America. I have often thought that the path for my colleague OLYMPIA SNOWE and myself to the Senate was paved by the remarkable Senator Margaret Chase Smith.

I remember well my very first meeting with Senator Smith. I was a senior in high school. I was in Washington for a special program, and she spent nearly 2 hours talking with me. She talked about national defense, her service on the Armed Services Committee and, most of all, about her decision to speak out against the excesses of Joseph McCarthy. That was an extraordinarily brave thing to do, but it was typical of Senator Smith, who had a courageous and independent spirit.

She was the first to do so many things. She was the first Republican Senator elected to the Senate. I would note that when I was elected to the Senate, Maine became the first State to send two Republican women to the Senate to serve at the same time. She was the first woman to serve in both the House and the Senate. She was the first woman to be backed by a major political party in a Presidential election. Long after it became commonplace for women to serve in the highest ranks of our Government, Senator Smith will always be acknowledged and remembered and honored in Maine for her dignity and her courage.

Although I didn't realize it at the time, when I look back at her meeting with me, I realize that that was the first step in a journey that led me to run for her seat 25 years later. I am so proud to hold the seat once held by the legendary Senator Margaret Chase Smith.

Women such as those the Senator from Alaska has spoken of and whom I have talked about today are the reason we are so proud to sponsor a bill that, at no cost to the taxpayers, directs that the Old Post Office Annex be made available to house the National Women's History Museum. We need a place for our country to honor the contributions of women, particularly for young girls who are coming to Washington to be able to go to this museum and learn about some of the remarkable women who have changed American history, about whom the Senator from Alaska and I have talked today. Women's history needs a place in our capital and in our collective American history.

I ask my colleague from Alaska if she would agree with that sentiment. She has been such a leader in getting this bill through.

Ms. MURKOWSKI. I couldn't agree more with the Senator from Maine. Just in the discussion we have had this evening about some of the women from my State and their pioneering enterprises and hearing the stories about the women of Maine, I would love to be able to go somewhere and spend the time to do more research, to find out more about these pioneering women, not only in Alaska and Maine but all of the States in between. By having the women's history museum here in Washington, DC, we will be able to do that.

Women have played such a crucial role in the development of my State, as you have heard, and certainly in the development of yours. By encouraging women's history of all of our respective States, we can see and celebrate this common history from as far apart as Maine to the east and Alaska in the west.

Those frontier women, women of independent spirit, demonstrated self-reliance, themes that embody all American women and the American spirit. I, too, am most proud to be a cosponsor of this bill and thank the Senator from Maine for her leadership in moving this forward so that we do have a place to house these great collections.

Ms. COLLINS. Madam President, I thank the Senator from Alaska for participating in this discussion tonight. She certainly continues that proud tradition in Alaska of women who have made a real difference. I am honored to serve with her. She does an extraordinary job. I also think we would be remiss in not recognizing the contributions of our Presiding Officer today, the Senator from North Carolina, Mrs. DOLE, who also has established so many firsts in American history. I know that she, too, will be prominently featured in this museum once it comes about.

I think we can take great pride in being here tonight and knowing we have passed this legislation unanimously.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. LAUTENBERG. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Ms. MURKOWSKI.) Without objection, it is so ordered.

AIR TRAFFIC CONTROL

Mr. LAUTENBERG. Madam President, tonight we got some good news. I want to just say a few words about the FAA bill because we have resolved the issue on air traffic control. The good news is that tonight we scored a victory, a victory for safety and a victory for homeland security.

As many of my colleagues know, I held up the FAA traffic control bill in order to get some assurance that the safety and security of the flying public would not be jeopardized by the privatization of the air traffic control system. I am pleased to announce that we have now received an assurance from the administration regarding fiscal year 2004. Until the end of this fiscal year, the administration has agreed not to privatize any components of our air traffic control system. The controllers are protected, the technicians are protected, the flight service station controllers—all of those units that make up the air traffic control system—are protected. We have a letter stating the administration's assurance.

Some of my colleagues have asked why I was doing this: Why do you feel so strongly about it? I put it in personal terms. I told them: Because I don't want my grandchildren or your grandchildren or the grandchildren of our constituents put in danger by a risky privatization scheme. That is what was at stake here.

I extend my thanks to many of my colleagues for their support in this fight, specifically our Commerce Committee ranking member, Senator HOLLINGS, and the subcommittee ranking member, Senator ROCKEFELLER, Senator DORGAN, and the leader and assistant leader of our caucus, Senators DASCHLE and REID. They always stayed strong and said "safety first."

Senator LOTT has been an honest broker throughout this process. He kept the discussions alive.

It was a tough fight. But at the heart of this fight was the reality that it was a bipartisan decision. In June of this year, 11 Republicans voted to prevent privatization, to stand up for safety. I know we often get pressured to vote with our caucus or vote with our party's President, but sometimes you just have to stand up for your constituents' safety, and that is what my Republican friends did here.

Within days of returning to the Senate earlier this year, I learned that the administration intended, through this A–76 process, to privatize air traffic control. In my previous 18 years, I had an active interest in aviation and the air traffic control system. But the moment I learned of the administration's actions, I knew I would spend much of this year fighting to prevent that action from taking place. We won a Senate vote to prevent privatization. We fought off the terrible first conference report. We fought the pending conference report until we received the assurances that we got tonight.

But the fight is not over, and I will continue to push for a permanent prohibition. In the words of California's current Governor, I'll be back. We are going to fight this again, and we will keep fighting it until it goes away for good.

I am reminded, 700 million people fly in our skies every year, roughly 2 million a day. Our system is going to be pushed to the limits of capacity in these next couple of weeks in what will be the busiest travel day of the year. I hope travelers will rest assured knowing that control of the skies will be in the hands of professionals, the Government employees who make up the air traffic control system.

This is the greatest air traffic control system in the world, most safe, most efficient. There are 15,000 Federal air traffic controllers and thousands of professional systems specialists and flight service station controllers. These are the men and women who keep our skies safe and secure.

But there are some obvious lessons we need to heed, those of September 11, when the air traffic control system worked flawlessly to bring home safely some 5,000 airplanes in just a couple of hours. These are the lessons from other countries that have tried this. They were left with just what could be expected: Less safety, more delays, and more cost in the end.

There are lessons from the space program.

I look forward to examining these issues during the policy debate to which our chairman is committed. I hope there can be an adequate discussion for the American people so they can learn how, after next year, the

White House proposes to put their safety and security at risk—if they do, all for the benefit of the profit motive.

I would like to mention one other item in this bill that is of particular importance to the State of New Jersey. Our great State has a proud history of aviation with a number of public use airports. Certainly the occupant of the chair understands since aviation in Alaska is the lifeblood of that beautiful State. Our great State has a proud history with a number of public use airports, and now some of these airports are disappearing, giving way to urban sprawl and development. To help stem this problem, a key provision in this bill establishes a pilot program which offers additional tools to States to enable them to preserve these public use airports. I am hopeful this program will be used to keep these important facilities for general aviation, corporate, and agricultural uses, and the medevac and firefighting uses which depend on sufficient airport facilities to continue to operate.

I commend the chairman of the Commerce Committee, Chairman MCCAIN, for working with me on this provision.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. ENSIGN). Without objection, it is so ordered.

OFFICE OF COMPLIANCE MEETING CANCELLATION

Mr. STEVENS. Mr. President, I ask unanimous consent that the attached statement from the Office of Compliance be printed in the RECORD today pursuant to section 303(b) of the Congressional Accountability Act of 1995 (2 U.S.C. 1383(b)).

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. CONGRESS,
OFFICE OF COMPLIANCE.
Washington, DC, November 20, 2003.

Hon. TED STEVENS,
Speaker of the House, House of Representatives, Washington, DC.

DEAR MR. PRESIDENT: A Notice of Proposed Rulemaking (NPR) for amendments to the Procedural Rules of the Office of Compliance was published in the Congressional Record dated September 4, 2003. Subsequent to the publication of this notice, this office announced a hearing for public comment on the proposed amendments in the Congressional Record on October 15, 2003.

The Board of Directors of the Office of Compliance cancels the hearing regarding the proposed amendments to the Procedural Rules of the Office of Compliance which had been scheduled for December 2, 2003, at 10 a.m. in room SD–342 of the Dirksen Senate Office Building.

We request that this notice of cancellation be published in the Congressional Record. Any inquiries regarding this notice should be addressed to the Office of Compliance at our address below, or by telephone at 202–724–9250, TTY 202–426–1665.

Sincerely,
SUSAN S. ROBFOGEL,
Chair.

TRIBUTE TO CPL RODNEY "JIMMY" ESTES II

Mr. MCCONNELL. Mr. President, I rise today to pay tribute to a brave young man who just returned from a tour of duty in Iraq. Rodney "Jimmy" Estes II is from my hometown of Louisville, KY. A few months ago, Jimmy was dressed in fatigues fighting the war on terror in the Iraqi desert. But today, you can find him wearing red and white and playing football for the University of Louisville Cardinals—my favorite team.

Jimmy Estes, a 1998 graduate of St. Xavier High School, turned down a football scholarship to Georgetown College to follow in his grandfather's footsteps—to serve in the U.S. Marine Corps. The day after graduation, he left Kentucky for boot camp at Parris Island. And on January 7, 2003, Jimmy was called to active duty.

As a member of the Alpha Company, 8th Tank Battalion, Jimmy was on the front lines in An Nasiriyah, Iraq. During his time in the country, he experienced some of the war's most intense fighting. In his tank, he worked as the loader and operated the 240-millimeter gun on top of the vehicle. Jimmy and his comrades are unsung heroes in one of our troops' finest hours. They were the lead tank in the rescue mission of PVT Jessica Lynch.

To pass the hours in Iraq, Jimmy played football with his fellow soldiers, reminding him of his lifelong dream—to play football for the University of Louisville Cardinals. Following his tour of duty, which ended this past May, Jimmy returned home and enrolled at U of L. Determined to play football, Jimmy spent his summer preparing to try out for one of four walk-on positions. And just like on the battlefield, Jimmy succeeded. Not only is he a wide receiver on his university's football team, he also continues to serve his Nation as a Marine reservist.

Jimmy's bravery, humility, and determination should be commended. On behalf of this grateful Nation, I ask my colleagues to join me in thanking Corporal Estes for his dedicated service. As a proud U of L alum and most importantly, a football fan, I wish Jimmy and his teammates a winning season. Go Cards!

I ask unanimous consent that the article, "For Jimmy Estes, that was war; this is football" from my hometown paper, The Courier-Journal, be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Louisville Courier-Journal, Oct. 10, 2003]

FOR JIMMY ESTES, THAT WAS WAR; THIS IS FOOTBALL

(By Pat Forde)

The war wasn't so bad until bedtime.

Jimmy Estes spent the dusty desert days in the company of his M1A1 Abrams tank crew or with the other members of Alpha Company, 8th Tank Battalion. On the dull days the Marines opened care packages or talked about family, sports and what they'd give for cold water and hot showers. On the deadly days they went out and killed Iraqis because it was their job, and when the battles around An Nasiriyah were done, the soldiers rehashed them in detached terms.

But at the end of the day, when Cpl. Rodney J. Estes II would lie down and stare up at the inky Arabian night, he was alone with the whole thing. It was just him and the horror: the dead women and children, the dogs tugging at corpses, the Iraqis he personally shot in combat, the bullets they shot at him that pinged off the tank's armor.

It was just him and the heroism: Estes and his mates rode the lead tank on the famous Jessica Lynch rescue mission, laying down fire and securing the perimeter before Army Rangers and Navy SEALs went into Saddam Hussein General Hospital to retrieve America's most famous POW.

He took all of it to bed with him.

"Those were some lonely nights," Estes said.

It was during those lonely nights that he made a vow: "If I get out of here and make it home alive, I'm going to do it."

Go to college. And play football. For his hometown team, the University of Louisville.

Today Jimmy Estes is alive and well and a 23-year-old walk-on wide receiver for the Cardinals.

He saw enough death in the desert to learn that dreams can come with an expiration date—probably not one of your choosing. A young man who had drifted along without plan or purpose since graduating from St. Xavier High School in 1998 had an epiphany in Iraq.

"Absolutely, it changed me," said Estes, who hadn't played organized football in six years. "I kind of piddled around at jobs here and there, not anything I'd call a career. If I hadn't gotten deployed, to be honest, I don't know where I'd be right now.

"I don't take things for granted like I used to. I realize how lucky I am. I realize life can end."

Now his life is just restarting. He is a justice administration major in the classroom, with designs on becoming a football coach. On the field he is a humble freshman who hasn't even dressed out for a game.

Yet there is no bigger hero in the U of L football program.

Said offensive lineman Will Rabatin, Estes' friend since grade school: "I'm proud to know him."

No more proud than Estes is to have this long-shot college football experience. Think of all the coddled athletes out there, complaining that a full ride isn't enough. Then listen to Estes, who's been through more than those guys can ever imagine and now cherishes the chance to pay his way through college and play on the scout team.

"He's just a great kid to have around," said offensive coordinator and wide receivers coach Paul Petrino. "Every day when we start out doing ball drills, he has a lot of enthusiasm, a lot of fire. You can tell he loves being here."

"I look forward to going out there every day," Estes said. "I really appreciate the opportunity. It's just so great to be a part of it."

In the weeks before the invasion of Iraq, the Marines played touch football in Kuwait all the time. Tankers against tank maintenance. In combat boots. In the desert.

Talk about your sandlot games.

For Estes, this was a continuation of his life long love of sports. When he played flag football in grade school, all the kids on the sidelines were squirting each other with water bottles, oblivious to the game. Jimmy was running the sidelines, keeping pace with the action and imploring his coaches to put him in.

When he was 6 he persuaded his father, Rodney, a retired Louisville police officer, to get him out of school early for the first two days of the NCAA basketball tournament. Jimmy sat in front of the television from noon until midnight each day, transfixed.

At age 7 he was reading Sports Illustrated cover to cover.

Later on he played at St. Martha for Rabatin's father, once catching the winning touchdown pass in the Toy Bowl. Then it was on to St. X, where he played little his final year after a disagreement with the coaches.

"He just didn't have a positive experience," his father said. "Part of that was his fault."

Estes' only football option was a partial scholarship to Georgetown College. He turned it down to follow in his grandfather's footsteps—into the Marine Corps and into a tank.

"That broke my heart when he didn't take that scholarship to Georgetown," Rodney Estes said. "You know how you envision going down there on Saturdays to watch your son and walk around campus?"

Instead, a day after graduation from St. X, Estes was off to Parris Island for boot camp as a Marine reservist. Higher education—and football—flickered out of sight.

In 1999 he had talked to UofL assistant Greg Nord and then-coach John L. Smith about walking on, but he never followed through. He worked a job here and a job there and performed his duties with the reserves. Life was standing still.

"He kind of had his head up his—in other words," said Lance Cpl. Nick Rassano, a 2000 Trinity graduate who was in the same tank in the Middle East with Estes.

Then last Jan. 7, the phone rang at Ruby Tuesday, where Estes was bartending. The order was expected but still jarring: Report for active duty.

He told his family the news at dinner that night. Two days later he was gone—but not without some prescient final words from his father.

"Remember," Rodney Estes told his oldest son, "the way you handle yourself out there probably says a lot about how you'll handle the rest of your life."

First stop was Camp Lejeune, N.C. Then he was on a ship 30 days to Kuwait, for a month of preparation, some touch football and the last decent meals for a long time.

Finally, after a month in Kuwait, Estes and the rest of the American military force invaded Iraq.

"I was a policeman 25 years, and I'm not the kind of guy who gets overly worried," Rodney Estes said. "But I tell you, that night he left I thought, 'This could be the last night I ever see him.' When your own kid goes off, that puts you through some changes.

"I'd wake up in the middle of the night and watch CNN. I watched so much TV I was about to drive myself crazy."

Over in Iraq, the A-8 Marines were pushing hard toward An Nasiriyah and what ultimately would be some of the most intense fighting of the war. The first day of combat was the worst, as Estes watched a rocket-propelled grenade blow up an American vehicle and kill several soldiers.

He said they arrived in the area to find the streets flooded with sewage that stalled half of Alpha Company's 14 tanks—including his, christened the "Think Tank" because of the crew's propensity for making maintenance errors.

When the tanks bogged down, the Iraqis lit up. They were firing on foot, from orange-and-white taxis and from SUVs.

Estes was the loader in his tank but also was charged with manning the 240-millimeter gun on top of the vehicle. With the upper half of his body in view, he exchanged fire with the enemy.

Welcome to the terror and exhilaration of warfare, Cpl. Estes.

"It was a heck of an adrenaline rush," he said. "I was scared, excited, all those things. I think of it like going into a big game, only times 100. Obviously, the stakes are much higher.

"You get a sick feeling in the pit of your stomach. I didn't freeze or tense up, but I definitely had butterflies."

Asked if he personally shot anyone, Estes looked down briefly and answered yes. There was no bravado in his voice.

"The first time you see somebody get hit with a round is a crazy feeling," he said. "It's a sick feeling. But when you sign up to be a Marine, that's something you obviously know can be part of the job.

"I can't sit here and describe the feelings you get. I can tell you what I saw, but in no way does it simulate what it was like."

There is no simulation. Just late-night assimilation—alone, lying on your back and staring at the sky in a strange and dangerous land.

One day the Think Tank crewmen got the call to be part of a hush-hush mission. They were to be the lead among three tanks escorting a group of Special Ops forces into town. It had the potential to be dangerous. Estes' tank commander had him clear out space inside the tank, in case they needed it to transport bodies.

They originally were told that the target was a Saddam look-alike. They had no idea that they were going to play a part in the most dramatic—and later controversial—event in the war.

In the early hours of April 1, their tank led a group of other vehicles carrying Special Operation Unit Task Force 20 into Nasiriyah, storming into position around the hospital. Night-vision goggles on, Estes laid down suppression fire with the 240-mm gun for a few minutes and set up a perimeter before the Rangers and SEALs went in.

Lynch was rushed out and loaded onto a helicopter, though most involved in the rescue still didn't know the particulars of what happened. Estes' tank remained in position for hours afterward.

At one point he was told to hand some Special Ops soldiers a tank shovel. They used it to dig up a shallow grave outside the hospital, locating the bodies of several Americans from Lynch's 507th Maintenance Company.

It wasn't until days later that the Think Tank crew was able to piece together the story and realize that their mission was the rescue dominating news coverage at home.

"We didn't realize how big a deal it was until we saw it on the cover of Newsweek," Rassano said.

To Estes the mission was important for one other reason: He never again discharged his weapon. A series of moves to other cities resulted in nothing more noteworthy than a couple of utterly uneventful weeks guarding a bridge.

With the action centralizing on Baghdad, there wasn't much to do other than reading the Sports Illustrateds and eating the beef jerky sent from home. Finally, Alpha Company pulled out and returned to Kuwait on May 5.

The war was over for Cpl. Estes. It was time to act on his vow.

During the interminable 38-day voyage back to America, Estes e-mailed his father and told him his plans: He was going to enroll at U of L and walk on to the football team. Rodney Estes was thrilled.

Jimmy returned to Kentucky on July 2, and he and the rest of his battalion were feted at Fort Knox. He obviously was thrilled to see his family—his father, mother, stepmother, stepsister and two half-siblings.

Especially his 11-year-old half-sister, Jennifer Estes. He thought of her often when he saw children her age caught in the calamity of war.

"He's crazy about her," Jimmy's dad said. "He's not exactly a sensitive kid by any stretch of the imagination, but I think some of the things he saw over there affected him."

To help put the war behind, Estes plunged into his future plans. After about a week of acclimation, he began working out six days a week toward his goal of becoming a Cardinal.

A depressing and debilitating diet of MREs—the scarcely edible Meals Ready to Eat—had killed his appetite. By the end of the war Estes could eat barely half an MRE a day, and he lost a significant amount of weight and muscle mass.

But that could be overcome with work, and he was driven. His first couple of calls to U of L graduate assistant Sam Adams, in charge of the walk-on program, went unreturned. Finally, Adams called back.

He said that Estes couldn't walk on until classes started, but in the meantime the coaches wanted to look at some videotape of him. He had nothing significant to show since his days on the St. X junior varsity. Nevertheless, Adams told him to report for a one-day group tryout.

Estes arrived in excellent physical condition, performed well in the fitness tests and was one of four walk-ons chosen for the team. After U of L upset Kentucky to open the season Aug. 31, he reported for his first practice as a Louisville Cardinal.

"It was awesome that first day, just putting on the equipment again," he said. "I was looking around saying, 'I'm playing with a Division I football program. Four months ago I was shooting at Iraqis running around with AK-47s.'"

Today life is easy. The 18-hour days don't pile up for weeks on end. The food is edible. There are no tank repairs, no missions, no imminent danger.

The load so many student-athletes find so difficult is like vacation to Jimmy Estes.

"All you've got to do is go to class and play football," Rassano said. "That's got to be the easiest thing he's done all year. After going through there, everything's easier.

"The whole experience kind of straightened him out. I'm real proud of Jimmy."

A good many Cardinals have no idea what Estes was going through while they were in spring practice. But a few have seen the USMC tattoo on the 5-foot-11, 200-pound receiver's left shoulder and inquired, and a few others have heard a story or two about the walk-on soldier.

He doesn't hide his history, but he doesn't broadcast it, either. He's not looking for hero status in the locker room.

"The coaches can't give me any special treatment, and I don't want it," he said. "I'd always heard stories of people coming back (from a war) and thinking the world owed them something, or they were messed up mentally. I didn't want that. I just wanted to make that experience a positive."

U of L will play Army tomorrow. Estes has been where none of the celebrated West Pointers has gone yet: into combat for his country.

He is a Cardinal worthy of a salute from the Cadets.

Yet he wasn't even supposed to be at the stadium. Instead, he was scheduled for real military work: a reunion with Alpha Company at Fort Knox for their first weekend of reservist training since the war.

But at practice yesterday head coach Bobby Petrino informed Estes that he will be dressing out and joining the squad if he can get a furlough from Marine drills.

Estes plans to wear two uniforms tomorrow; he'll be in Papa John's Cardinal Stadium in the afternoon after meeting up with his mates in the morning. He's looking forward to seeing the men with whom he shared a life-altering experience—and telling them about his college football career.

"I don't think a whole lot of them really believed me," he said with a smile.

But it's true. A desert dream that materialized on lonely nights under an inky Arabian sky has come true.

MILITARY SNIPER WEAPON REGULATION ACT

Mr. LEVIN. Mr. President, in the November 3, 2003 edition of Air Safety Week a connection was drawn between airline safety and gun safety. And, while some people may think there is no connection between airline safety and gun safety, the connection is serious. Attention has been paid to potential vulnerabilities of commercial aircraft to terrorists armed with shoulder-fired missiles. A more pedestrian but an equally deadly potential threat looms from terrorists armed with .50 caliber sniper rifles.

The .50 caliber sniper rifle is among the most powerful weapons legally available. These weapons are not only powerful, but they're accurate. According to the House Government Reform staff report, the most common .50 caliber weapon can accurately hit targets a mile away and can inflict damage to targets more than four miles away. The thumb-size bullets, which come in armor-piercing and incendiary variants, can easily punch through aircraft fuselages, fuel tanks, and engines.

These weapons pose a serious threat to planes both in the air and on the ground. According to a recent Violence Policy Center report, aircraft landing are particularly vulnerable, as illustrated by the testimony of Ronnie G. Barrett, President of Barrett Firearms Manufacturing. As an expert witness during a 1999 criminal trial, Barrett was asked about the relative difficulty of hitting a stationary target and a moving target, such as a motorcycle or an airplane. He was asked about shooting at an airplane "coming in to land . . . descending over 120 miles an hour." He testified: "If it is coming directly at you, it is almost as easy. Just like bird hunting. But yes, it is more difficult if it is horizontally, or moving from left to right . . . " In other words, according to Barrett, shooting at a moving object coming directly at one is "almost as easy" as a stationary target, an answer that is consistent with detailed instructions given in a variety of U.S. Army manuals about engaging aircraft with small arms.

Despite these facts, long-range .50 caliber weapons are less regulated than handguns. Buyers must simply be 18 years old and submit to a Federal background check. In addition, there is no Federal minimum age requirement for possessing a .50 caliber weapon and no regulation on second-hand sales.

I believe the easy availability and the increased popularity of the .50 caliber sniper rifle poses a danger to airline safety, as well as homeland security. That's why last year I cosponsored Senator FEINSTEIN's Military Sniper Weapon Regulation Act. This bill would change the way .50 caliber guns are regulated by placing them under the requirements of the National Firearms Act. This would subject these weapons to the same registration and background check requirements as other weapons of war, such as machine guns. This is a necessary step to protecting the safety of airline travelers.

The .50 caliber sniper rifle is among the most powerful and least regulated firearms legally available. Tighter regulation is needed. I urge my colleagues to support Senator FEINSTEIN's bill.

LOCAL LAW ENFORCEMENT ACT OF 2003

Mr. SMITH. Mr. President, I rise today to speak about the need for hate crimes legislation. On May 1, 2003, Senator KENNEDY and I introduced the Local Law Enforcement Enhancement Act, a bill that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society.

In San Antonio, TX, on October 26, 2003, Allen Everton, age 74, was beaten to within inches of his life. His assailant believed that Everton was gay, and while hitting the elderly man with a baseball bat, called him a "freaking faggot." Mr. Everton died 11 days later of natural causes, but I can only imagine how scarred he must have felt after being the victim of a senseless attack.

I believe that Government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

HONORING OUR ARMED FORCES

Mr. GRASSLEY. Mr. President, I rise today in honor of a fellow Iowan and a true American hero PVT Kurt R. Frosheiser. Private Frosheiser was killed while serving our country in Operation Iraqi Freedom on November 8, 2003, when his humvee was struck by an improvised explosive device in Baghdad. Private Frosheiser was only 22 years old at the time of his death.

I ask my colleagues in the Senate, my fellow Iowans, and all Americans to join me today in paying tribute to Private Frosheiser for his bravery and for his dedication to the cause of freedom. Private Frosheiser had a deep desire to serve his country, and we are all indebted to him for his service and for his sacrifice.

In an interview with the Des Moines Register, Private Frosheiser's mother, Jeanie Hudson, said the following about her son: "He loved this land and its principles. He loved Iowa. It's an honor to give my son to preserve our way of life."

Throughout our history, we have found extraordinary men and women who are willing to give their lives to defend our country and families willing sacrifice those who they love most to the cause of freedom. It is with great sadness, but also great pride, that I honor one such patriot today on the floor of the Senate, PVT Kurt Frosheiser.

Today we honor a fallen patriot, but we must also remember to pay tribute to the loved ones whose grief we share. My deepest sympathy goes out to the members of Private Frosheiser's family, to his friends, and to all those who have been touched by his untimely passing. May his mother, Jeanie, his father, Chris, his step-father, Daniel, his sister, Erin, and his twin brother, Joel, be comforted with the knowledge that they are in the thoughts and prayers of many Americans, and that they have the eternal gratitude of an entire nation.

Kurt Frosheiser did not die in vain. He died defending the country he loved. May he always be remembered as a true American hero.

SGT ROSS A. PENNANEN

Mr. INHOFE. Mr. President, I rise to pay homage to Sergeant Ross Pennanen, who, in the words of his father, "gave the ultimate sacrifice for his country—his life." Sergeant Pennanen, or "Penn", as his friends called him, was a dedicated defender of

America who learned the value of serving his country from his father's example in the United States Air Force. For his service and his sacrifice, I am proud to honor him on the Senate floor today.

Sergeant Pennanen was assigned to C Battery, 2nd Battalion, 5th Field Artillery Regiment, III Corps Artillery at Fort Sill, OK. A native Oklahoman whose mother and father live in Ada and Midwest City, respectively, Sergeant Pennanen grew up in McLoud and joined the Army 2 years ago at the age of 34 in hopes of improving himself and emulating his father. He was himself a good father who spent a lot of time with his 7-year-old son, Gage.

Sergeant Pennanen died tragically on November 2 when a CH-47 Chinook helicopter in which he was riding crashed in Fallujah, Iraq. He was a good soldier: he received the Army Commendation Medal two days before his death. Despite questions about his age, Sergeant Pennanen proved a "gung-ho" example for his fellow soldiers. According to his stepmother, "He didn't keep up with them. He set the pace out in front of them."

On behalf of the U.S. Senate, I ask that we pay tribute to Sergeant Pennanen and the men and women like him, who know the true meaning of service and sacrifice. These men and women have tasted freedom, and wish to ensure that freedom for those who have never experienced it. I honor the memory of our sons and daughters who have died for this noble cause.

We could not have asked for a better soldier or diplomat of humanity than Sergeant Ross Pennanen. I am proud of him, and proud of the commitment he showed to winning the freedom of those he did not know. My prayers are with his family for the loss of such a special man.

PVT JASON M. WARD

Mr. INHOFE. Mr. President, I rise today to honor the memory of a courageous young Oklahoman who died while defending his Nation. Private Jason M. Ward grew up in the great State of Oklahoma, and was a 1997 graduate of Broken Arrow High School.

Private Ward joined the military in April 2002, although he had been seriously considering military service for years. He married his high school sweetheart after graduating, and when Jason and Jordan welcomed their first son shortly thereafter, the duties of fatherhood took priority. After having another son 4 years later, Jason and Jordan began discussing Jason's longtime military aspirations and decided that it would be a good time for him to pursue a lifelong career in the military.

Private Ward was a member of the 1st Armored Division, stationed at Fort Riley, KS. His unit was sent to the Middle East in March to protect the freedom of this fellow Americans, and he was highly involved in the outstanding and courageous work of that unit. Unfortunately, Private Ward fell ill, and was scheduled to return to the U.S. for treatment when he unexpectedly passed away. His sudden death has left his young family with questions that none of us can answer, but we can tell them with confidence that Private Ward was serving his Nation with honor until this tragedy took his life.

Private Ward was only 25 years old when he died. I hope his friends and family know that he died a true hero, worthy of the respect and gratitude of every American because of his contribution to defending his country. His loved ones will miss him dearly, and our thoughts and prayers are with them today. And though we are all grieved by the loss of this man, we will never cease to be proud of him—Oklahoma's son and America's hero—Private Jason M. Ward.

SPEC DUSTIN K. MCGAUGH

Mr. INHOFE. Mr. President, I stand today to honor the memory of a brave young American who gave his life defending the Nation. He felt a call to serve his country, to be part of something bigger than himself, and ultimately, paid the highest price.

SPEC Dustin K. McGaugh, of Tulsa, OK was a firing specialist assigned to the Army's 17th Field Artillery Brigade stationed in Fort Sill, OK. His mother, Marina Yancy lives in Tulsa, OK, where he graduated from Nathan Hale High School in 2001.

On September 30 in Balad, Iraq, he died tragically from a non-hostile gunshot wound. He gave his life for the freedom of millions of Americans, and also for the peace and prosperity of the Iraqi people crippled by a totalitarian regime.

Specialist McGaugh had a heart for the less fortunate. According to his fellow soldiers, he would leave the safety of his Jeep and give candy to the Iraqi children. Imagine an American soldier who truly cared for the least among us, and performed simple acts of kindness to his fellow humans. Imagine an American soldier who represented America with a noble heart, and reminded us all of the freedoms we take for granted. Specialist McGaugh was that soldier.

His compassion is a microcosm of the American spirit, the spirit that drives us to fight oppression around the world. The Iraqi people are an oppressed people, and Specialist McGaugh showed us how our inherent humanity can overcome even the broadest of differences. He refused to sit idly and watch the tyranny in Iraq take place any longer. It is for the sake of these broken, defeated people that Specialist McGaugh risked his life on a daily basis. It is for these people that he gave his life in the end. He was a true American hero.

His twin sister Windy said that her "kid brother" became her hero. Specialist McGaugh should not only be his sister's hero, but the Nation's hero as well. He set a high example of what it means to be an American and what it means to be human. It is for men like Specialist McGaugh that I am proud to be a part of this great country. He was a special soldier, but more importantly, a special man.

* * *

BUDGET SCOREKEEPING REPORT

Mr. NICKLES. Mr. President, I hereby submit to the Senate the budget scorekeeping report prepared by the Congressional Budget Office under section 308(b) and in aid of section 311 of the Congressional Budget Act of 1974, as amended. This report meets the requirements for Senate scorekeeping of section 5 of S. Con. Res. 32, the First Concurrent Resolution on the Budget for 1986.

This report shows the effects of congressional action on the 2004 budget through November 19, 2003. The estimates of budget authority, outlays, and revenues are consistent with the technical and economic assumptions of the 2004 Concurrent Resolution on the Budget, H. Con. Res. 95, as adjusted.

The estimates show that current level spending is below the budget resolution by $7.0 billion in budget authority and by $11.1 billion in outlays in 2004. Current level for revenues is $57 million below the budget resolution in 2004.

Since my last report, dated November 11, 2003, the Congress has cleared for the President's signature the following acts that changed budget authority, outlays, or revenues for 2004: the National Defense Authorization Act for 2004, H.R. 1588; the Military Construction Appropriations Act, 2004, H.R. 2559; the Energy and Water Development Appropriations Act, 2004, H.R. 2754; and, the District of Columbia Military Retirement Equity Act of 2003, H.R. 3054.

I ask unanimous consent that the budget scorekeeping report be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, November 20, 2003.

Hon. DON NICKLES,
Chairman, Committee on the Budget,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The enclosed tables show the effects of Congressional action on the 2004 budget and are current through November 19, 2003. This report is submitted under section 308(b) and in aid of section 311 of the Congressional Budget Act, as amended.

The estimates of budget authority, outlays, and revenues are consistent with the technical and economic assumptions of H. Con. Res. 95, the Concurrent Resolution on the Budget for Fiscal Year 2004, as adjusted.

Since my last letter dated November 10, 2003, the Congress has cleared for the President's signature the following acts that changed budget authority, outlays, or revenues for 2004: The National Defense Authorization Act for Fiscal Year 2004 (H.R. 1588); the Military Construction Appropriations Act, 2004 (H.R. 2559); the Energy and Water Development Appropriations Act, 2004 (H.R. 2754); and the District of Columbia Military Retirement Equity Act of 2003 (H.R. 3054).

The effects of these actions are detailed on Table 2.

Sincerely,

DOUGLAS HOLTZ-EAKIN
Director.

TABLE 1.—SENATE CURRENT-LEVEL REPORT FOR SPENDING AND REVENUES FOR FISCAL YEAR 2004, AS OF NOVEMBER 19, 2003

[In billions of dollars]

	Budget resolution	Current level [1]	Current level over/ under (−) resolution
On-Budget:			
Budget Authority	1,873.5	1,866.4	−7.0
Outlays	1,897.0	1,885.9	−11.1
Revenues	1,331.0	1,330.9	−0.1
Off-Budget:			
Social Security Outlays	380.4	380.4	0
Social Security Revenues	557.8	557.8	0

[1] Current level is the estimated effect on revenue and spending of all legislation that the Congress has enacted or sent to the President for his approval. In addition, full-year funding estimates under current law are included for entitlement and mandatory programs requiring annual appropriations even if the appropriations have not been made.

Source: Congressional Budget Office.

TABLE 2.—SUPPORTING DETAIL FOR THE SENATE CURRENT-LEVEL REPORT FOR ON-BUDGET SPENDING AND REVENUES FOR FISCAL YEAR 2004, AS OF NOVEMBER 19, 2003

[In millions of dollars]

	Budget authority	Outlays	Revenues
Enacted in previous sessions:			
Revenues	n.a.	n.a.	1,466,370
Permanents and other spending legislation [1]	1,081,649	1,054,550	n.a.
Appropriation legislation	0	345,754	n.a.
Offsetting receipts	−366,436	−366,436	n.a.
Total, enacted in previous sessions	715,213	1,033,868	1,466,370
Enacted this session:			
Authoriziang Legislation:			
American 5-Cent Coin Design Continuity Act of 2003 (P.L. 108–15)	−1	−1	0
Postal Civil Service Retirement System Funding Reform Act of 2003 (P.L. 108–18)	2,746	2,746	0
Clean Diamond Trade Act (P.L. 108–19)	0	0	*
Prosecutorial Remedies and Other Tools to End Exploitation of Children Today Act (P.L. 108–21)	0	0	*
Unemployment Compensation Amendments of 2003 (P.L. 108–26)	4,730	4,730	145
Jobs and Growth Tax Relief Reconciliation Act of 2003 (P.L. 108–27)	13,312	13,312	−135,370
Veterans' Memorial Preservation and Recognition Act of 2003 (P.L. 108–29)	0	0	*
Welfare Reform Extension Act of 2003 (P.L. 108–40)	99	108	0
Burmese Freedom and Democracy Act (P.L. 108–61)	0	0	−10
Smithsonian Facilities Authorization Act (P.L. 108–72)	1	1	0
Family Farmer Bankruptcy Relief Act of 2003 (P.L. 108–73)	0	0	*
An act to amend Title XXI of the Social Security Act (P.L. 108–74)	1,325	100	0
Chile Free Trade Agreement Implementation Act (P.L. 108–77)	0	0	−5
Singapore Free Trade Agreement Implementation Act (P.L. 108–78)	0	0	−55
First Continuing Resolution, 2004 (P.L. 108–84)	−2,222	1	−2
Surface Transportation Extension Act of 2003 (P.L. 108–88)	6,405	0	0
An act to extend the Temporary Assistance for Needy Families block grant program (P.L. 108–89)	15	−36	33
An act to amend chapter 84 of title 5 of the United States Code (P.L. 108–92)	1	1	0
An act to amend the Immigration and Nationality Act (P.L. 108–99)	0	0	2
The Check Clearing Act for the 21st Century (P.L. 108–100)	0	0	*
An act to amend Title 44 of the United States Code (P.L. 108–102)	0	0	*
Second Continuing Resolution, 2004 (P.L. 108–104)	1	0	*
Partial-Birth Abortion Act of 2003 (P.L. 108–105)	0	0	*
Third Continuing Resolution, 2004 (P.L. 108–107)	0	0	−1
Military Family Tax Relief Act of 2003 (P.L. 108–121)	−599	−599	−169
An act to amend Title XXI of the Social Security Act (P.L. 108–127)	0	9	0
Total, authorizing legislation	25,813	20,372	−135,432
Appropriations Acts:			
Emergency Wartime Supplemental Appropriations Act, 2003 (P.L. 108–11)	215	27,349	0
Legislative Branch Appropriations (P.L. 108–83)	3,539	3,066	0
Defense Appropriations (P.L. 108–87)	368,694	251,486	0
Homeland Security Appropriations (P.L. 108–90)	30,216	18,192	0
Emergency Supplemental Appropriations Act for Defense and Reconstruction of Iraq and Afghanistan (P.L. 108–106)	3,555	1,133	0
Interior Appropriations (P.L. 108–108)	19,673	13,202	0
Total, appropriation acts	425,892	314,428	0
Passed Pending Signature:			
National Defense Authorization Act for Fiscal Year 2004 (H.R. 1588)	4,418	960	4
Military Construction Appropriations (H.R. 2559)	9,316	2,567	0
Energy and Water Appropriations (H.R. 2754)	27,328	18,143	0
District of Columbia Military Retirement Equity Act of 2003 (H.R. 3054)	1	1	1
An act to reauthorize certain school lunch and child nutrition programs (H.R. 3232)	7	7	0
Total, passed pending signature	41,070	21,678	5
Continuing Resolution Authority: Continuing Resolution, 2004 (P.L. 108–107)	300,025	157,423	0
Entitlements and mandatories: Difference between enacted levels and budget resolution estimates for appropriated entitlements and other mandatory programs	358,395	338,102	n.a.
Total Current Level [1] [2]	1,866,408	1,885,871	1,330,943
Total Budget Resolution	1,873,459	1,896,973	1,331,000
Current Level Over Budget Resolution	n.a.	n.a.	n.a.
Current Level Under Budget Resolution	7,051	11,102	57

[1] Per section 502 of H. Con. Res. 95, the concurrent Resolution on the Budget for Fiscal Year 2004, provisions designated as emergency requirements are exempt from enforcement of the budget resolution. As a result, the current level excludes the following items: outlays of $262 million from funds provided in the Emergency Supplemental Appropriations for Disaster Relief Act of 2003 (P.L. 108–69); outlays of $456 million from funds provided in the Legislative Branch Appropriations Act, 2004 (P.L. 108–83); budget authority of $400 million and outlays of $67 million provided in the Interior Appropriations Act, 2004 (P.L. 108–108); and budget authority of $83,992 million and outlays of $35,970 million provided in the Emergency Supplemental Appropriations Act for Defense and for the Reconstruction of Iraq and Afghanistan, 2004 (P.L. 108–106).

[2] Excludes administrative expenses of the Social Security Administration, which are off-budget.

Source: Congressional Budget Office.

Notes: n.a. = not applicable; P.L. = Public Law; * = less than $500,000.

TERRORIST APPREHENSION ACT

Mr. LEVIN. Mr. President, earlier this week, an article in the Washington Post highlighted concerns about limits on the Federal Bureau of Investigation's ability to pursue terrorists who try to buy guns. After September 11, 2001, the FBI launched an initiative to notify Federal law enforcement officials and other national security officials when suspects on the FBI's terrorist watch list attempt to purchase a firearm. However, according to the Washington Post article, an interpretation of current law by the Attorney General has precluded Federal agents from obtaining any details about gun purchase transactions unless the purchaser is identified by the National Instant Criminal Background Check System as a prohibited buyer.

The Post article cited situations in which law enforcement officials have not been able to pursue known terrorists armed with a firearm. According to the Washington Post, as many as 21 suspects on the FBI's terrorist watch list have attempted to buy guns since the spring of 2003. According to Justice Department officials cited in the Post article, the rules established by the Attorney General prevent Federal officials from sharing information with investigators about legal gun buyers, even if these gun buyers are suspected terrorists.

Law enforcement officials told the Post that the FBI frequently does not know the whereabouts of suspected terrorists on its watch lists. In such cases, learning where a suspected terrorist bought a firearm and what address they provided could be extremely helpful to counterterrorism investigators.

To assist the FBI in monitoring and apprehending suspected terrorists, Senator LAUTENBERG introduced the Terrorist Apprehension Act. This bill would require NICS to alert the FBI, Department of Homeland Security, and local law enforcement officials anytime an individual on a terrorist watch list attempts to buy a firearm.

I believe this is common sense homeland security legislation, and I hope the Congress will enact it quicky.

S. 1896, THE TAX RELIEF EXTENSION ACT, AND H.R. 1664, THE ARMED FORCES TAX FAIRNESS ACT

Mr. WYDEN. Mr. President, consistent with my policy of publishing in the RECORD a statement whenever I place a hold on legislation, I am announcing my intention to object to any unanimous consent request on S. 1896, the Tax Relief Extension Act, and to H.R. 1664, the Armed Forces Tax Fairness Act. I am doing so because these bills are the only relevant amendable legislation expected to be taken up in the Senate before the end of the current session and, therefore, they provide the only opportunity to extend unemployment benefits before they expire at the end of the year.

Oregon currently has the highest unemployment rate in the Nation with an unemployment rate of 8 percent. Extension of unemployment benefits is critical for many Oregonians who are in jeopardy of running out of benefits if they are not extended before the end of the year. In order to ensure unemployed workers in Oregon and many other states will not be left without benefits, I am objecting to unanimous consent on S. 1896 or H.R. 1664, unless extension of unemployment benefits and reform of a lookback rule that affects Oregon and other high unemployment states is included as part of the legislation.

REPEALING THE MEDICARE PHYSICIAN FEE CUT

Mr. GRAHAM of South Carolina. Mr. President, I express my support for repealing the Medicare physician fee cut. The issue of reimbursements for physicians who treat Medicare patients has been an ongoing battle. Currently, these reimbursements are inadequate and inefficiently paid through a bureaucratic system. Some physicians have been even been forced to refuse Medicare recipients due to these inappropriate reimbursement levels. With so many Medicare recipients who need medical services in South Carolina, the situation with low reimbursements poses a challenge to both physicians and patients.

I have supported updating and increasing the reimbursements physicians receive under the Medicare program. The schedule of fee cuts for these reimbursements has been temporarily suspended due to the actions of Congress. I supported legislation to repeal physician fee cuts for both fiscal year 2002 and 2003. However, in October 2003, the Centers for Medicare and Medicaid Services, CMS, reported that the physician fee cut for 2004 would be 4.5 percent. This necessitates a further repeal to ensure this fee cut does not move forward.

While annual repeals of the physician fee cuts are vital, I also support a substantive change to the reimbursement calculations so physicians are not held in limbo each year regarding their fee updates. I am hopeful that Congress will address this issue in a comprehensive manner.

Since I support legislative action to make sure this cut is repealed and to ensure future repeals are dealt with effectively, I am exceedingly concerned that the most current repeal in the Medicare physician fee cut is contained within the mammoth Medicare prescription drug bill. This blocks me voting solely on the merit of the repeal.

I have many reasons a to why I plan to oppose the Medicare prescription drug bill conference report. None of my reasons are concerns with the Medicare physician fee cut repeal. Rather, my opposition stems from the lack of real cost containment of the program, exclusion of true Medicare reform, the weakening of the premium support issue, the treatment of "dual eligibles" coverage, and other issues related to oncology drugs, durable medical equipment, DME, and local pharmacies.

It frustrates me that this latest repeal is in a bill with literally dozens of other Medicare provisions in a $400 billion dollar bill. While I cannot support the Medicare prescription drug bill, I will continue to support the repeal of next year's Medicare physician fee cut and addressing the ongoing issue of fee cuts in a comprehensive manner. I am hopeful that our leadership will give us a vehicle for a straight up or down vote on this issue.

A TRIBUTE TO RALPH BUNCHE

Mr. SARBANES. Mr. President, it is difficult to know exactly how to pay tribute to Ralph J. Bunche for his extraordinary contributions to scholarship, diplomacy, civil rights, social justice and international cooperation and development. The Senate has approved H. Con. Res 71, "Recognizing the importance of Ralph Bunche as one of the great leaders of the United States . . . The year-long centennial commemoration of his birth, which is now well underway, involves many more professional societies, educational institutions and public-policy organizations than it is possible to list; among them are the American Political Science Association, the Association of Black American Ambassadors, the American Library Association, the Council on Foreign Relations, Facing History and Ourselves, national foundation, the NAACP, the National Urban League, the New York Public Library, numerous United Nations Associations and dozens of colleges and universities in this country and abroad. At UCLA, Ralph Bunche's alma mater, the African American Studies center has been renamed in his honor. I am especially pleased to note that the American Academy of Diplomacy has chosen to honor Ralph Bunche by sponsoring the two-year Philip Merrill Fellowship for the two-year M.A. program at the Paul H. Nitze School of Advanced International Studies of Johns Hopkins University.

Among his many accomplishments, Ralph Bunche received the first doctoral degree in government and international relations ever awarded by Harvard University, thereby earning the title "Dr. Bunche." But Benjamin Rivlin, who is Co-Chair of the Ralph Bunche Centenary Committee, has told us that he was specifically instructed to "cut out this doctor business" when as a young soldier he was assigned to work for Ralph Bunche in the OSS sixty years ago.

The vast array of tributes now being paid to Ralph Bunche reflects just how extraordinary a person he was. Born in Detroit and orphaned at eleven, he went to live with his grandmother, Lucy Johnson, in what is today the Watts neighborhood of Los Angeles.

By all accounts, Lucy Johnson was as extraordinary as her illustrious grandson. Writing in the Reader's Digest many years after her death, Dr. Bunche called her "My Most Unforgettable Character . . . Caucasian 'on the outside' and 'all black fervor inside.'" One of his teachers said of her, "I have never forgotten the emanation of power from that tiny figure." Ms. Johnson's remark to the principal of Jefferson High School, where Dr. Johnson was valedictorian of his class and a varsity athlete, is especially memorable. In a disastrously misguided effort at flattery, the principal is reported to have said, "We never thought of Ralph as a Negro," to which Ms. Johnson replied: "Why haven't you thought of him as a Negro? He is a Negro and he is proud of it. So am I."

From his grandmother Ralph Bunche learned the fundamental lessons of self-respect and respect for others. He also took from her a passion for education. It was she who insisted that he go to UCLA, where he majored in international relations and was valedictorian of the Class of 1927. Upon his graduation from UCLA, Bunche received a fellowship for graduate study in political science at Harvard. Shortly after enrolling he received what was to be his grandmother's last letter. Writing just a week before her death, she asked, "Will you finish at Harvard this year?"

Ralph Bunche did indeed receive his Master's degree at the end of that year, but he did much more. In the small African American community at Harvard at that time he made lifelong friendships with, among others, the future Judge William Hastie and the future cabinet member Robert Weaver. He completed his Ph.D. in 1934, receiving the government department's annual award for the best dissertation. And while working toward his degree he also taught at Howard University—America's "black Athens" —where he helped organize the political science department at a time when, according to Kenneth Clark, the distinguished psychologist who was a student at the time, "the seeds of a legal and constitutional attack on racial segregation were being sown in the intellectual soil of Howard University."

Although bent on an academic career, Ralph Bunche postponed research in South Africa to work closely with Gunnar Myrdal on Myrdal's historic and highly influential study of race in this country, "An American Dilemma." With the outbreak of World War II he was brought into the newly-established OSS for his expertise on Africa, and in 1944 he moved on to the State Department. The following year he served as an advisor to the American delegation at the San Francisco Conference, where the Charter establishing the United Nations was signed, and in 1946 he joined the U.N. Secretariat, where he remained until shortly before his death. As Brian Urquhart, who first went to work for Ralph Bunche in the U.N. Secretariat in 1954, later observed, "Public service had called him, and he responded with all of his ability and strength."

Ralph Bunche went on to become the U.N. Undersecretary-General, but he is probably best remembered as the recipient of the 1950 Nobel Peace Prize, which he was awarded for negotiating the armistice that ended military hostilities between the new State of Israel and its enemies. He was not only the first African American to receive the prize, he was also the first person of color; as an American, he joined the distinguished community of U.S. laureates that included Presidents Theodore Roosevelt and Woodrow Wilson, Jane Adams and Nicholas Murray Butler.

In his own view, however, the Nobel Prize was not at all his most significant accomplishment, and his initial reaction upon being informed of the award was to decline it: "Peacemaking at the U.N. was not done for prizes," he explained. He agreed to accept only when the argument was put to him that it would be good for the United Nations. Rather, Ralph Bunche gave a quarter-century of dedicated service to the United Nations, working day in and day out to build and secure harmonious relations among free and prosperous nations.

Ralph Bunche touched the life of everyone who knew him. He is remembered as "brilliant," with "an uncanny ability to produce stupendous amounts of work over long sustained periods of application;" as someone who "play(ed) to win, but always played fair;" as "a man of extraordinary kindness and compassion (who) never turned his back on those in trouble;" as a person. Kenneth Clark has paid him an eloquent and enduring tribute as "above all the model of a human being who by his total personality demonstrated that disciplined human intelligence and courage were most effective instruments in the struggle for social justice."

CBO SUMMARY OF S. 1522

Ms. COLLINS. I ask unanimous consent that the following CBO summary of the cost estimate regarding S. 1522 be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

S. 1522—GAO Human Capital Reform Act of 2003

Summary: S. 1522 would authorize the General Accounting Office (GAO) to modify its personnel and workforce practices to allow greater flexibility in determining pay increases, pay retention rules, and other compensation matters. The bill also would permanently extend GAO's authority to offer separation (buyout) payments and early retirement to employees who voluntarily leave GAO. Finally, S. 1522 would rename GAO as the Government Accountability Office.

CBO estimates that enacting S. 1522 would increase direct spending for retirement annuities and related health benefits by about $1 million in fiscal year 2004, by $19 million over the 2004–2008 period, and by $40 million over the 2004–2013 period. Several provisions of S. 1522 could affect GAO employee compensation costs, but the net budgetary effect of such provisions would depend on how GAO exercises its new authorities and on whether future agency appropriations are adjusted to reflect any savings or costs. Finally, we expect that any additional discretionary costs associated with changing the agency's name would not be significant.

S. 1522 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandate Reform Act (UMRA) and would not affect the budgets of state, local, or tribal governments.

Estimated costs to the Federal Government: The estimated impact of S. 1522 on direct spending is shown in the following table. The costs of this legislation fall within budget function 800 (general government).

	By fiscal year, in millions of dollars—									
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
CHANGES IN DIRECT SPENDING										
Estimated budget authority	1	3	5	5	5	5	4	4	4	4
Estimated outlays	1	3	5	5	5	5	4	4	4	4

Basis of estimate

Direct spending

S. 1522 would give GAO permanent authority to offer retirement to employees who voluntarily leave the agency early. GAO's existing buyout authority, which will expire on December 31, 2003, allows the agency to offer certain employees a lump sum payment of up to $25,000 to voluntarily leave the agency. In addition, certain qualified employees who leave (whether they collect a separation payment or not) are entitled to receive immediate retirement annuities earlier than they would have otherwise. CBO estimates that extending this authority would increase direct spending by $1 million in 2004, by $19 million over the 2004–2008 period, and by $40 million over the 2004–2013 period.

Based on information provided by GAO about use of its early retirement authority over the past several years, CBO estimates that each year about 35 agency employees would begin receiving retirement benefits three years earlier than they would have under current law. Inducing some employees to retire early results in higher-than-expected benefits from the Civil Service Retirement and Disability Fund (CSRDF). CBO estimates that the additional retirement benefits would increase direct spending by $1 million in 2004, by $16 million over the 2004–2008 period, and by $32 million over the 2004–2013 period.

Extending GAO's buyout and early retirement authority also would increase direct spending for federal retiree health benefits. Many employees who retire early would continue to be eligible for coverage under the

Federal Employees' Health Benefits (FEHB) program. The government's share of the premium for retirees is classified as mandatory spending. Because many of those accepting the buyouts under the bill would have retired later under current law, mandatory spending on FEHB premiums would increase. CBO estimates these additional benefits would increase direct spending by less than $500,000 in 2004, by $3 million over the 2004–2008 period, and by $8 million over the 2004–2013 period.

Spending subject to appropriation

The authorities provided by S. 1522 would allow GAO to create a performance-based employee compensation system to govern basic pay adjustments, pay retention for employees affected by reductions in force, relocation reimbursements, and annual leave accruals beginning in fiscal year 2006. (Under existing law, GAO is required to follow personnel management policies determined by the Office of Personnel Management.) Implementing the new authorities that would be provided by S. 1522 could affect GAO's total costs of providing employee compensation, but CBO cannot predict any cost or saving associated with these new authorities, or the net effect of all such changes on the Federal budget. Ultimately, the net budgetary effect of the proposed authorities would depend on the features of the compensation system adopted by GAO and on how the agency applies that new system to individual employees. Moreover, any resulting savings or costs would only be realized if the agency's annual appropriations are adjusted accordingly.

Providing GAO with the option of providing voluntary separation payments could also increase GAO's costs, but CBO estimates that any new costs would average less than $500,000 annually over the 2004–2013 period. Section 2 of the bill would allow GAO to offer certain employees payments of up to $25,000 to voluntarily leave the agency. The bill also requires that GAO make a deposit amounting to 45 percent of each buyout recipient's basic salary toward the CSRDF. Unlike an increase in retirement benefits, these two payments would be from the agency's discretionary budget and are thus subject to appropriation. Since GAO's current buyout authority was first authorized in October 2000, no one at the agency has received a buyout payment. As such, CBO expects that relatively few employees would receive a buyout payment over the next 10 years and that the cost of any buyout payments and required deposits toward the CSRDF would be negligible in any given year.

Intergovernmental and private-sector impact: S. 1522 contains no intergovernmental or private-sector mandates as defined in UMRA and would not affect the budgets of State, local, or tribal governments.

Estimate prepared by: Federal Costs: Ellen Hays, Geoffrey Gerhardt, and Deborah Reis. Impact on State, Local, and Tribal Governments: Sarah Puro. Impact on the Private Sector: Paige Piper/Bach.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

GROUP OF EIGHT

Mr. LIEBERMAN. Mr. President, I rise today to discuss a matter of great importance related to Russia's continued participation in the Group of Eight, or G–8. Senator McCAIN and I submitted today a resolution calling on the President of the United States and the Secretary of State to work with our partners in the G–8 to condition Russia's continued involvement on its meetings the basic norms and standards of a democratic government.

The G–8 is a gathering of the world's wealthiest industrial democracies. It is important that we do not lose sight of this world. It is well and good that all of the G–8 members are wealthy industrialized nations, but the real thing that binds us, the real thing that makes it a club worth joining is the fact that all of the participants are democracies. It is for this reason that China is not a member.

When President Clinton discussed Russia's joining the G–8 back in 1997 when Russia participated in the summit in Denver, he attributed Russia's participation to "President Yeltsin's leadership and to the commitment of the Russian people to democracy and reform."

But the actions of President Yeltsin's successor, President Putin, over the past 3 years raise serious concerns about Russia's continued commitment to democracy. This drift away from democratic practices cannot and should not be ignored. The list of offending actions is long and disturbing. Since 2000, President Putin has seized control of national television networks and otherwise limited the freedom of expression to the point that the group "Reporters without Borders" ranks Russia 121st out of 139 countries in its worldwide press freedom index. The recent arrest of Mikhail Khodorkovsky set off alarm bells because of its blatant political motives, despite claims otherwise. President Putim's government has attempted to control the activities of nongovernmental organizations, religious organizations, and other pluralistic elements of Russian society in an attempt to mute criticism of the government. Russian troops in Chechnya have been allowed to suppress the rights of Russian citizens with impunity, including in the conduct of recent elections that fell far short of minimal international standards of freedom and fairness. And the list could go on.

Continued membership in the G–8 is very important to Russia and to President Putin personally. We should use this leverage to get Russia back on the democratic track. Allowing Russia to continue its involvement in the G–8 and to host the 2006 G–8 Summit while continuing to undermine democracy makes mockery of the very principles that bind the G–8 countries together. We need to take steps not to ensure that Russia lives up to the commitments it made when it joined this club of industrialized democracies. To do otherwise would be to shirk our responsibilities as a leader of the democratic world. I urge my fellow Senators to support this resolution.

NATIONAL RETIREMENT PLANNING WEEK

Mr. AKAKA. Mr. President, I rise today to illuminate the merits of National Retirement Planning Week, which is currently underway. National Retirement Planning Week is organized by a coalition of financial industry and advocacy organizations to raise the awareness of the importance of retirement planning. I applaud the coalition for its efforts to increase public awareness of this critical topic.

The need to adequately prepare for retirement has significantly increased due to the growth in life expectancy and reduction in employer-provided retirement health benefits. In addition, increasing debt burdens confronting many families will make a comfortable retirement more difficult to achieve.

Americans are living longer. According to the U.S. National Center for Health Statistics, in 1950, an individual 65 years of age was expected to live an additional 13.9 years. This grew to 17.9 years by 2000. These additional years, many or most in retirement, will require Americans to have saved and invested additional financial resources to help meet their living expenses in retirement. Furthermore, the fastest growing segment of the population is made up of those 85 years and older, according to the Bureau of Labor Statistics.

While Americans have been living longer, employers have been reducing the health benefits provided to retirees. According to the Kaiser Family Foundation and Health Research and Education Trust, 38 percent of all large firms offer retirement benefits in 2003. This is a significant reduction from the 66 percent that offered retiree coverage in 1988. As employers continue to stop providing coverage and as health care costs continue to increase, proper planning is imperative for individuals to pay for healthcare expenses that may not be covered by Medicare.

In addition, another important component of preparing for retirement is to effectively manage and pay down debt. According to the Federal Reserve, consumer borrowing through auto loans, credit cards, and other debt increased by $15.1 billion in September, which brings the total consumer debt to $1.97 trillion. Substantial consumer debt will likely result in individuals having to work additional years beyond their preferred retirement age in order to pay off their credit cards and other consumer debts.

Obtaining home equity loans and refinancing mortgages to take cash out of homes may make it harder for working Americans to retire at the age and with quality of life they desire. Thirty-two percent of all mortgage refinancings in the third quarter of this year involved cash-outs of additional money beyond the existing loan balance, according to Freddie Mac. Although this is significantly lower than the record 93 percent in 1989, the additional debt brought on by these refinancings can significantly extend the time and cost of paying off a mortgage.

There is a greater need for larger nest eggs and better debt management. Unfortunately, defined benefit pension plans have become much less common and are not available for most working Americans to help meet these increasing costs. According to the Congressional Research Service, 72 percent of pension plan assets were held by defined benefit plans in 1975. Unfortunately, by 1998, this percentage fell to 48 percent. Changes in the contributions to pension plans and benefit payments between 1975 and 1998 also reflect the significant shift towards defined contribution retirement plans. Defined contribution plans require that employees be much more involved in their preparation for retirement. Employees must be aware of their alternatives in participating in their employer's plan. The matching contributions made by employers can provide employees with an immediate return on their investment. Employees must fully understand the importance of planning for retirement and the significance of participating in tax-advantaged employer plans and investment options that can be used, such as Individual Retirement Accounts, IRAs, to ensure that they will have sufficient resources for retirement. In addition, defined contribution plans require employees to manage their investments and make important asset allocation decisions. If employees do not have a sufficient level of financial literacy they will not be able to adequately manage their retirement portfolio.

Despite the need to ensure that employees have adequate resources for retirement, fewer employers are sponsoring plans and fewer employees are participating in employer-sponsored plans. According to a Congressional Research Service analysis of the Census Bureau's Current Population survey, the number of 25-to 64-year old, full-time employees in the private sector whose employer sponsored a retirement plan fell from 45.1 million in 2001 to 42.8 million in 2002. The survey also indicated that, among this population, participation in an employer sponsored retirement plan fell from 55.8 percent in 2001 to 53.5 percent in 2002. More employers must sponsor retirement plans and more employees need to participate in them. Working Americans will be in a better position to retire on their terms by starting to prepare for retirement early and utilizing investment vehicles that have preferential tax treatment such as 401(k) plans and Individual Retirement Accounts. A long-term time horizon allows investors to reap greater benefit from the compounding of their returns.

An important component of retirement security is financial and economic literacy, which should be at higher levels in our country. We must do more throughout the lives of individuals to ensure that they are financially and economically literate and can make informed financial decisions and participate effectively in the modern economy. Without a sufficient understanding of economics and personal finance, individuals will not be able to appropriately manage their finances, evaluate their credit opportunities, and successfully invest for their long-term financial goals.

Starting with our youth, it is necessary to fund the Excellence in Economic Education, EEE, Act, which provides resources for teacher training, evaluations, research, and other activities in K–12 education. There is no better time to instill in individuals the knowledge and skills that they need to make good decisions throughout their lives than during their years in elementary and secondary education.

I have also introduced S. 1800, the College LIFE, or Literacy in Finance and Economics Act, to address needs in this area for the college population. We must give students access to the tools that they need to make sound economic and financial decisions once they are on campus. Without an understanding of finance and economics, college students are not able to effectively evaluate credit alternatives, manage their debt, and prepare for long-term financial goals, such as saving for a home or retirement. I am working with my colleagues on both sides of the aisle to come up with a package based on S. 1800 that can be included in the Higher Education Act.

I also appreciate the work done by my colleague from New Jersey, Senator CORZINE, in developing and introducing S. 386, the Education for Retirement Security Act of 2003. The legislation authorizes grants for financial education programs targeted towards mid-life and older Americans to increase financial and retirement knowledge and reduce their vulnerability to financial abuse and fraud. I am a cosponsor of this legislation which will help Americans prepare for retirement.

I look forward to continuing to work with my colleagues to improve economic and financial literacy. I also want to express my appreciation for the significant efforts made by Senators SARBANES, ENZI, CORZINE, ALLEN, STABENOW, and FITZGERALD to improve economic and financial literacy. Our efforts need to continue so that individuals will be able to make informed decisions and be able to pursue their long-term financial goals, particularly into their golden years of retirement.

NATIONAL ADOPTION MONTH

Mr. JOHNSON. Mr. President. As we approach this holiday season of Thanksgiving, I want to draw attention to National Adoption Month as we celebrate it this month.

I am joining my colleagues on the Congressional Coalition for Adoption this month to increase awareness and knowledge of the obstacles that children in foster care face while waiting to be adopted and to encourage more families to consider adopting.

Currently, there are 580,000 children in the foster care system in America, 126,000 of whom are waiting to be adopted. Yet, only 20 to 25 percent of foster children waiting for adoption will ever find an adoptive family before aging out of government care. The foster care system has been extremely important in rescuing abused and neglected children. However, the foster care system was designed to be a temporary situation, but it is increasingly becoming a permanent guardian for many children. This is particularly true for children who are not adopted in their early years or who find themselves in foster care at an older age. Of the 126,000 children waiting to be adopted approximately half are 9 years of age or older.

Every year an average of 100 children in South Dakota, and 25,000 children nationally, age out of the foster care system at the age of 18, often with very little if any support system in pace. These children often face the challenges of homelessness, college noncompletion, unemployment, and a lack of health care. Transitional living and mentoring program can alleviate some of these concerns but programs face the strains of staff shortages and underfunding. I must commend the South Dakota Coalition for Children for working to secure Medicaid coverage for children that age out of the foster care system until they reach the age of 22. This eliminates one serious concern many former foster care youths face with they are no longer in Government care, but it does not replace the support of a loving family.

On November 22, 2003, courts across the country joined State agencies, children in foster care and hopeful parents to finalize adoptions and demonstrate the large number of children waiting for safe, stable, permanent homes.

As we approach the Thanksgiving holiday and gather with our families, we should not forget those children still waiting for a loving, permanent family to be thankful for.

ADDITIONAL STATEMENTS

HONORING ARVILLA "BILLIE" CAMPBELL ON HER 100TH BIRTHDAY

• Mr. CRAPO. Mr. President, I honor Arvilla "Billie" Campbell of Meridian, ID, who is approaching her 100th birthday on January 21, 2004. Arvilla's impressive longevity is matched by her positive contributions to home and country. I am sure that her six children, 19 grandchildren, and 48 great-grandchildren join me in paying tribute to this great women.

Arvilla was born and raised in Preston, ID, where she attended high school at the Preston Academy. In 1923, she married Elgin Campbell, and the couple had six children together. Her children report that Arvilla set a great foundation for each of their lives through the principles she taught. Arvilla recognized the important of a strong work ethic, telling her children that you only get what you work for. Arvilla herself was a hard worker, doing all she could during the Great Depression to ensure that her family had what they needed. She was known to comment that though the family may have been broke, they were never poor. Arvilla taught her children to have pride in their appearance and made sure they had impeccable decorum and proper speech at all times. Arvilla was also active in the Church of Jesus Christ of Latter Day Saints, and she taught many children over the occurs of many years of service.

Arvilla also taught love of country, a fact reflected in the lives of her children. Remarkably, all six of her children have served or are affiliated with the Armed Forces. She encouraged them to serve in the military because she believes freedom is a privilege that deserves effort and sacrifice. All four of Arvilla's sons have served in combat. E. Stewart Campbell served in the Navy, starting in World War II through the Vietnam War, attaining the rank of lieutenant colonel. Garth K. Campbell served in the Pacific Theatre of World War II as a petty officer in the Navy. Bruce E. Campbell served in the Korean War as a corporal in the Army. Doug Campbell served in both the Korean and Vietnam wars as an Army platoon sergeant. Helen Campbell Harden, one of the Arvilla's daughters, is married to John Harden, an Army warrant officer in the Army. Ruth Campbell Rivers, another daughter, is also closely connected to the military: her husband Gerald is a lance corporal in the Marine Corps. America has benefited from the efforts of each of these individuals, and Arvilla is to be commended for her children's unselfish service to the United States.

I wish Arvilla a Happy Birthday. She has been a great teacher, example, and citizen of Idaho. I wish her health and happiness on this exciting day, and join with family and friends in honoring her contribution to Idaho.•

GENE BOYT

• Mr. INHOFE. Mr. President, I stand today to pay tribute to a great American and a great Oklahoman. Gene Boyt was a member of our Nation's "Greatest Generation" and served his country during World War II in the United States Army. He died at the age of eighty-six in Chickasha, OK.

After being assigned to the Philippines as a lieutenant in the Engineering Corps, he was taken captive by the Japanese on April 9, 1942. As a prisoner, he was forced to march 90 miles in 6 days in what has become known as the Bataan Death March. The prisoners marched without food or water, and many were executed or died along the way from exhaustion and dehydration. After surviving the grueling journey, Lieutenant Boyt spent 3½ years in Japanese prisons.

Gene Boyt knew what persecution meant. He knew what it meant to stand up for the cause of freedom, for the honor and integrity of the United States. Gene Boyt knew what it meant to defend this country from enemies determined to destroy it. He knew what it meant to suffer for what he believed.

I stand today proud to be an American because men like Gene Boyt lived and died protecting that right. He was awarded the Purple Heart, the Bronze Star, three Presidential Citations, the Philippines's Presidential Citation Medal, and the Oklahoma Medal of Valor. He deserves to be honored once again today on the Senate floor.

Today I stand in tribute to one of Oklahoma's favorite sons, a great American hero and devoted family man. Gene Boyt sacrificed everything for his country, and I am sure that his family is proud of this great man, and the legacy he left behind. The thoughts and prayers of a grateful Nation are with them during this difficult time.•

(At the request of Mr. DASCHLE, the following statement was ordered to be printed in the RECORD.)

HONORING MILITARY RESERVISTS AND THEIR SMALL BUSINESS EMPLOYERS DURING NATIONAL EMPLOYER SUPPORT OF THE GUARD AND RESERVE WEEK

• Mr. KERRY. Mr. President, as this is National Employer Support of the Guard and Reserve Week, it seems an appropriate time to speak on the honorable Americans serving in our National Guard and Reserve.

To fight our wars and to meet our military responsibilities, the United States supplements its regular, standing military with a capable band of citizen soldiers, reservists who serve nobly and continue to make the ultimate sacrifice for this country. At present, there are about 165,000 national guardsmen and reservists on active duty—more than half of the 300,000 called to active duty since September 11. They serve admirably around the world, performing critical wartime functions in Iraq, Afghanistan, and elsewhere. This country does not go into battle without members of the National Guard and Reserve, and we should be grateful for their service.

Instead of gratitude, members of the Guard and Reserve find the Bush administration's military agenda leaving them behind. In addition, earlier this year, the Republican majority in the U.S. House of Representatives sought to cut reservist pay by 40 percent for normal peacetime training requirements. The Republican majority in the U.S. Senate blocked efforts to extend health care benefits to Guard and Reserve members. Just this month, the Republican majority in Congress voted against legislation by Senator DURBIN that would have provided supplemental income for Federal employees who are called up to active duty. These efforts are wrong and demonstrate the misplaced priorities of the Republican Party.

To make matters worse, the Bush administration recently announced that it would require thousands of National Guard and Army Reserve troops to extend their tours of duty up for an additional six months. This extension will cause significant economic difficulties for the reservists, their families, their employers, and our national economy.

Beyond the hardship of leaving their families, their homes and their regular employment, more than one-third of military reservists and National Guard members face a pay cut when they're called for active duty. Many of these reservists have families who depend upon that paycheck and can least afford a substantial reduction in pay.

The United States Chamber of Commerce estimates that 70 percent of military reservists called to active duty work in small- or medium-size companies. The continued activation of military reservists to serve in Iraq and the broader war on terrorism has imposed a tremendous burden on many of our country's small businesses. Too many of these businesses, when their employees are asked to leave their jobs and serve the Nation, are unable to continue operating successfully—resulting in severe financial difficulty and even bankruptcy. Large businesses have the resources to provide supplemental income to reservist employees called up for active duty and to replace them with a temporary employee. However, many small businesses are unable to provide this assistance or temporarily cover the reservist's duties.

The Federal Government has an obligation to help small businesses weather the loss of an employee to a call-up and a duty to protect small business employees and their families from suffering a pay cut to serve our Nation. It is imperative that we help families of reservists maintain their standard of living while their loved one protects our country abroad.

That is why I have proposed creating a Small Business Military Reservist Tax Credit, which does two things.

First, it provides an immediate Federal income tax credit to any small business to help with the cost of temporarily replacing a reservist employee that has been called up to active duty. Second, it provides a tax credit to small businesses that pay any difference in salary for an employee who is called up. This tax credit is worth up to $12,000 to any small business and up to $20,000 for small manufacturers.

It is common knowledge that small businesses continue to be our most effective tool at creating new jobs and spurring economic growth nationwide. Small businesses employ over 50 percent of the Nation's work force. Across the country, small businesses are currently creating 75 percent of new jobs. Furthermore, many of these small businesses provide quality goods and services that are a vital link in the supply chain for national defense. Many of these small companies need immediate help to keep their business going while their employees encounter tremendous personal sacrifice in service of our country.

This assistance will immediately help struggling entrepreneurs keep their small businesses running during the loss of an employee to temporary military service. It will also help the families of military reservists cope with the financial burden of their absence. In this way we ensure that we preserve our great tradition of citizen soldiers at such a critical time in the Nation's history.

In his speech designating this week National Employer Support of the Guard and Reserve Week, President Bush recognized several large businesses for their support of the Guard and Reserve. I, too, commend these big corporations for their support of our reservists and guardsmen, but the President has again showed that he doesn't understand the plight of our military reservists and their smaller employers. The fact is big businesses, like those the President recently honored, aren't going out of business if one of their reservist employees is called up. Small businesses may.

My legislation provides a real solution—helping small businesses maintain productivity and helping make up the difference for reservists who face pay cuts when they're deployed—not just a pat on the back that this week provides. I urge the President and all of my colleagues to support my proposal.•

HONORING NOR-LEA GENERAL HOSPITAL

• Mr. DOMENICI. Mr. President, today I recognize the outstanding achievement of a hospital in my home State of New Mexico. Nor-Lea General Hospital, which is located in Lovington, New Mexico, was recently honored as one of the Nation's "Top 100" Hospitals by Solucient Corporation, a healthcare information company, in their 10th National Benchmarks for Success study. Nor-Lea was recognized because they have demonstrated superior clinical, operational, and financial performance in overall service.

I am proud to recognize Nor-Lea Hospital for its strong commitment to help the community. Too often we hear about hospitals that are struggling; hospitals asserting they can not save money and improve patient services and thus are not able to meet the needs of their communities.

Nor-Lea represents the exception. They represent the value of management, not only to save money, but also to improve efficiency. Nor-Lea is demonstrating what kind of performance is possible when this is done and they are setting new targets for performance improvement across the industry.

Nor-Lea General Hospital is a 25-bed Medicare-certified facility. Medicare, Medicaid, private insurance and private pay are accepted for services rendered. Nor-Lea General Hospital offers comprehensive outpatient services, which include a state-of-the-art laboratory facility with national lab affiliations, radiology services, MRI, bone densitometry, fluoroscopy, x-ray, ultrasound, and respiratory services. The hospital also has a newly enlarged emergency room which is open 24 hours a day, 7 days a week. Each month about 385 individuals utilize this emergency room.

Nor-Lea was recognized as a top performing "Small Community Hospital" because of their higher survival rate and because they spend less money, release patients from the hospital faster, and have fewer employees. In short, Nor-Lea treats more of the sickest patients, while maintaining high customer service and preserving profits in a difficult marketplace.

Congratulations, Nor-Lea General Hospital. I hope that your success will be a catalyst for continuous hospital performance improvement.•

HONORING LINDA BARKER

• Mr. JOHNSON. Mr. President, today I wish to publicly commend Linda Barker, a resident of Sioux Falls, SD, on her selection as the recipient of the Sioux Falls Development Foundation's annual Spirit of Sioux Falls Award.

The Spirit of Sioux Falls Award is given annually in memory of the eight people who were killed when then South Dakota Gov. George Mickelson's plane crashed in 1993. This year, the recipient was Linda Barker, a member of the community who has shown leadership and commitment to the economic development in Sioux Falls. Dan Scott, President of the Sioux Falls Development Foundation, said that Linda, who is currently a member of the Board of Directors for the Development Foundation, was chosen because she "has been an incredibly valuable member of the Board of Directors. Not just because she has attended the meetings, but because she has been in our office on a weekly basis offering any kind of help the staff needed."

During her service with the South Dakota Development Foundation, she was instrumental in a number of ways. In addition to her work with the Forward Sioux Falls program, her leadership helped the Development Foundation acquire enough land to serve as development parks for the next fifteen years. According to Mr. Scott, they are now well prepared to handle the needs in the development park arena for the future. She was also instrumental in serving as chairman of the membership committee—essentially revitalizing and reenergizing their membership effort, raising the number from 350 to 400 members.

Linda's involvement in the Sioux Falls area comes from her love of the community. In her thirteen years as part owner of Business Aviation Services in Sioux Falls, she was instrumental in helping the company more than quadruple its business, increasing sales from $4 million to $18 million annually. The company has also added 100 employees and it now owns or manages 48 aircraft, compared with six in 1990, when Linda joined the ownership team. Dale Froehlich, president and chief executive officer of Business Aviation, said Linda's success is "because of her unwillingness to give up, even in the dreariest of situations." It is this type of hard work and dedication that led Linda to her success and her subsequent recognition with the Spirit of Sioux Falls Award.

This prestigious award is a reflection of her extraordinary leadership, skill and commitment to South Dakota. I am pleased that her success is being publicly recognized, and I am confident that her achievements will serve as an exemplary model for talented South Dakotans throughout our state. People of all ages need to think more about how we, as individual citizens, can work together at the local level to ensure the health and vitality of our towns and neighborhoods. Citizens such as Linda Barker are examples to all of us. She is an extraordinary individual who richly deserves this distinguished recognition. I strongly commend her hard work and dedication, and I am very pleased that her efforts are being publicly honored and celebrated.

It is with great honor that I share her impressive accomplishments with my colleagues.•

IN REMEMBRANCE OF THE REVEREND DR. AVERY ALDRIDGE

• Mr. LEVIN. Madam President, I want to call my colleagues' attention to the loss of one of the most influential civic and religious leaders in Flint, MI, Dr.

Avery Aldridge, who passed away at the age of 78 on November 1, 2003. He is greatly mourned by his wife and family, his church community, and people in my home State of Michigan who knew and loved him as a man of great faith, devoted to his family, and a voice for justice and equality in the African American community.

Dr. Aldridge was born in Widener, AR on February 9, 1925, the fourth of nine children. He completed his secondary education in Memphis, TN, and from there was inducted in the Army in 1943. He served as a Sergeant during World War II, defending the cause of freedom for his country until his honorable discharge in 1946. He then settled in Flint, MI where he married Mildred Light and had two children, Karen and Derrick. Dr. Aldridge and his wife were dedicated members of Antioch Baptist Church where he served as General Superintendent of the Sunday School and was later ordained into the ministry.

In December, 1956, Dr. Aldridge founded Foss Avenue Missionary Baptist Church with his wife, Mildred, and two others. The church has grown through the years to a congregation of two thousand families, with 50 auxiliaries and committees, an elementary and secondary school, a credit union, an activity center and a free clothing center. Dr. Aldridge also led Foss Avenue to initiate a small business center to train youth for employment, provide food baskets to those in need, organize a prison ministry and annually provide Thanksgiving Day dinner to all incarcerated in the Genessee County Jail. Dr. Aldridge's vision and leadership also supported four missionaries to Africa, and led to the founding of Concerned Pastors for Social Action (CPSA), the CPSA Courier, a weekly community and religious publication, and Faith Access to Community Economic Development (FACED), a community development organization.

Dr. Aldridge was a lifelong learner and furthered his education at Moody Bible Institute in Chicago and the University of Michigan-Flint. He believed strongly in the value of education and supported black colleges across the country, as well as scholarships for local youth. Because of his work, he was awarded several honorary degrees through the years.

Dr. Avery was committed to serving the needs of people and improving the quality of community life. He rose to prominence in Flint during the civil rights movement of the 1960s, and was a calming influence in the city during tensions in the wake of the Detroit riots in 1967. He became known as "The Rights Activist," serving on local, State, and national commissions, including the Flint Human Relations Commission, the Flint Housing Commission, the Michigan AIDS Policy Commission, and the National Holiday for Martin Luther King, Jr. Commission.

I know my colleagues join me in paying tribute to the life and ministry of Reverend Dr. Avery Aldridge who will be missed by the many people whose lives he touched. I hope his family takes comfort in knowing that his legacy will stand as an inspiration for generations to come.•

PRINCIPAL OF THE YEAR FINALIST

• Mr. CORZINE. Mr. President, it is my distinct honor and pleasure to recognize Richard Roberto of John F. Kennedy High School in Paterson, NJ as one of six finalists for the National High School Principal of the Year.

The impact that Mr. Roberto has made on the students and faculty at John F. Kennedy High School cannot be overstated. His leadership has produced remarkable results for students—indeed, test scores are higher at John F. Kennedy, in part, I am sure, because he created an extended year program for juniors and established freshman houses to personalize the learning environment. He also administered the expansion of eight career academies. These academies provide small learning communities in which students can explore diverse interests. As you can see, students have thrived under Mr. Roberto because of his efforts to develop opportunities for their success.

Not only has his work affected students, but his staff development program, which includes a focus on core curriculum content, has fostered collaboration among all the teachers at John F. Kennedy High School. Through newsletters, needs assessments, teachers surveys, and collaborative groups Mr. Roberto has instituted whole school reform that concentrates on the needs of all members of his faculty.

I congratulate Mr. Roberto on his success in building a school environment that facilitates communication and creates a learning environment enabling student success. His dedication, innovation, and leadership are qualities that every principal in our Nation should have. It is with great admiration that I acknowledge Mr. Roberto as a 2003 Principal of the Year finalist.•

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mr. Thomas, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Office laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGES FROM THE HOUSE

At 10:57 a.m., a message from the House of Representatives, delivered by Ms. Niland, one its reading clerks, announced that the House has passed the following bills, without amendment:

S. 189. An act to authorize appropriations for nanoscience, nanoengineering, and nanotechnology research, and for other purposes; and

S. 1895. An act to temporarily extend the programs under the Small Business Act and the Small Business Investment Act of 1958 through March 15, 2004, and for other purposes.

The message also announced that the House has passed the following bill, with an amendment:

S. 686. An act to provide assistance for poison prevention and to stabilize the funding of regional poison control centers.

The message further announced that the House passed the following bills in which it requests the concurrence of the Senate:

H.R. 253. An act to amend the National Flood Insurance Act of 1968 to reduce losses to properties for which repetitive flood insurance claim payments have been made; and

H.R. 3521. An act to amend the Internal Revenue Code of 1986 to extend certain expiring provisions, and for other purposes.

The message also announced that the House agree to the amendments of the Senate to the bill (H.R. 1828) to halt Syrian support for terrorism, end its occupation of Lebanon, and stop its development of weapons of mass destruction, and by so doing hold Syria accountable for the serious international security problems it has caused in the Middle East, and for other purposes.

The message further announced that the House agree to the amendments of the Senate to the resolution (H. Con. Res. 209) commending the signing of the United States-Adriatic Charter, a charter of partnership among the United States, Albania, Croatia, and Macedonia.

ENROLLED BILLS SIGNED

The message also announced that the Speaker has signed the following enrolled bills:

S. 117. An act to authorize the Secretary of Agriculture to sell or exchange certain land in the State of Florida, and for other purposes;

S. 286. An act to revise and extend the Birth Defects Prevention Act of 1998;

S. 650. An act to amend the Federal Food, Drug, and Cosmetic Act to authorize the Food and Drug Administration to require certain research into drugs used in pediatric patients;

S. 1685. An act to extend and expand the basic pilot program for employment eligibility verification, and for other purposes.

S. 1720. An act to provide for Federal court proceedings in Plano, Texas;

S. 1824. An act to amend the Foreign Assistance Act of 1961 to reauthorize the Overseas Private Investment Corporation, and for other purposes; and

H.R. 3182. An act to reauthorize the adoption incentive payments program under part E of title IV of the Social Security Act, and for other purposes.

The enrolled bills were signed subsequently by the President pro tempore (Mr. STEVENS).

At 12:12 p.m., a message from the House of Representatives, delivered by Mr. Hays, one of its reading clerks, announced that the House has passed the following bill in which it requests the concurrence of the Senate:

H.R. 135. An act to establish the "Twenty-First Century Water Commission" to study and develop recommendations for a comprehensive water strategy to address future water needs.

At 3:17 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House agree to the report of the committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 1904) to improve the capacity of the Secretary of Agriculture and the Secretary of the Interior plan and conduct hazardous fuels reduction projects on National Forest System lands and Bureau of Land Management lands aimed at protecting communities, watersheds, and certain other at-risk lands from catastrophic wildfire, to enhance efforts to protect watersheds and address threats to forest and rangeland health, including catastrophic wildfire, across the landscape, and for other purposes.

At 5:20 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bills, without amendment:

S. 1152. An act to reauthorize the United States Fire Administration, and for other purposes.

S. 1156. An act to amend title 38, United States Code, to improve and enhance provision of health care for veterans, to authorize major construction projects and other facilities matters for the Department of Veterans Affairs, to enhance and improve authorities relating to the administration of personnel of the Department of Veterans Affairs, and for other purposes.

At 9:43 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following joint resolution, in which it requests the concurrence of the Senate:

H.J. Res: 79. Joint resolution making further continuing appropriations for the fiscal year 2004, and for other purposes.

MEASURES PLACED ON THE CALENDAR

The following bill was read the second time, and placed on the calendar:

H.R. 1274. An act to direct the Administrator of General Services to convey to Fresno County, California, the existing Federal courthouse in that county.

ENROLLED BILLS PRESENTED

The Secretary of the Senate reported that on today, November 21, 2003, she had presented to the President of the United States the following enrolled bills:

S. 117. An act to authorize the Secretary of Agriculture to sell or exchange certain land in the State of Florida, and for other purposes;

S. 286. An act to revise and extend the Birth Defects Prevention Act of 1998;

S. 650. An act to amend the Federal Food, Drug, and Cosmetic Act to authorize the Food and Drug Administration to require certain research into drugs used in pediatric patients;

S. 1685. An act to extend and expand the basic pilot program for employment eligibility verification, and for other purposes.

S. 1720. An act to provide for Federal court proceedings in Plano, Texas;

S. 1824. An act to amend the Foreign Assistance Act of 1961 to reauthorize the Overseas Private Investment Corporation, and for other purposes; and

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. BENNETT, from the Committee on Joint Economic Committee:

Special Report entitled "The 2003 Joint Economic Report" (Rept. No. 108–206).

By Ms. COLLINS, from the Committee on Governmental Affairs, with amendments:

S. 1522. A bill to provide new human capital flexibility with respect to the GAO, and for other purposes.

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of committees were submitted:

By Mr. WARNER for the Committee on Armed Services.

Air Force nomination of Maj. Gen. William Welser III.

Air Force nominations beginning Colonel Paul F. Capasso and ending Colonel Robert M. Worley II, which nominations were received by the Senate and appeared in the Congressional Record on January 9, 2003.

Air Force nomination of Col. Stephen L. Lanning.

Air Force nomination of Brigadier General Robin E. Scott.

Army nomination of Maj. Gen. Larry J. Dodgen.

Army nomination of Maj. Gen. John M. Curran.

Army nomination of Brig. Gen. Keith M. Huber.

Army nomination of Brig. Gen. Dennis E. Hardy.

Army nominations beginning Brig. Gen. James R. Sholar and ending Col. Henry J. Ostermann, which nominations were received by the Senate and appeared in the Congressional Record on August 1, 2003.

Navy nomination of Rear Adm. Walter B. Massenburg.

Navy nominations beginning Rear Adm. (1h) Robert E. Cowley III and ending Rear Adm. (1h) Steven W. Maas, which nominations were received by the Senate and appeared in the Congressional Record on March 19, 2003.

Navy nomination of Capt. Brian G. Brannman.

Navy nomination of Capt. Raymond K. Alexander.

Navy nominations beginning Rear Adm. (1h) Donald K. Bullard and ending Rear Adm. (1h) John J. Waickwicz, which nominations were received by the Senate and appeared in the Congressional Record on October 16, 2003.

Mr. WARNER. Mr. President, for the Committee on Armed Services I report favorably the following nomination lists which were printed in the RECORDS on the dates indicated, and ask unanimous consent, to save the expense of reprinting on the Executive Calendar that these nominations lie at the Secretary's desk for the information of Senators.

The PRESIDING OFFICER. Without objection, it is so ordered.

Air Force nomination of Gary H. Sharp.

Air Force nomination of Jeffrey N. Leknes.

Air Force nomination of Samuel B. Echaure.

Air Force nominations beginning Thomas E. Jahn and ending Rodney D. Lewis, which nominations were received by the Senate and appeared in the Congressional Record on October 23, 2003.

Air Force nominations beginning Samuel C. Fields and ending Kevin C. Zeeck, which nominations were received by the Senate and appeared in the Congressional Record on October 23, 2003.

Air Force nomination of Robert G. Cates III.

Air Force nomination of Mary J. Quinn.

WITHDRAWALS

Executive message transmitted by the President to the Senate on November 21, 2003, withdrawing from further Senate consideration the following nominations:

April H. Foley, of New York, to be a Member of the Board of Directors of the Export-Import Bank of the United States for a term expiring January 20, 2007, which was sent to the Senate on April 10, 2003.

April H. Foley, of New York, to be a Member of the Board of Directors of the Export-Import Bank of the United States for a term expiring January 20, 2007, which was sent to the Senate on May 14, 2003.

DISCHARGED NOMINATIONS

The Senate Committee on Health, Education, Labor, and Pensions was discharged from further consideration of the following nominations and the nominations were:

James McBride, of New York, to be a Member of the National Council on the Arts for a term expiring September 3, 2008.

David Eisner, of Maryland, to be Chief Executive Officer of the Corporation for National and Community Service.

Read Van de Water, of North Carolina, to be a Member of the National Mediation Board for a term expiring July 1, 2006.

Raymond Simon, of Arkansas, to be Assistant Secretary for Elementary and Secondary Education, Department of Education.

Jose Antonio Aponte, of Colorado, to be a Member of the National Commission on Libraries and Information Science for a term expiring July 19, 2007.

Sandra Frances Ashworth, of Idaho, to be a Member of the National Commission on Libraries and Information Science for a term expiring July 19, 2004.

Edward Louis Bertorelli, of Massachusetts, to be a Member of the National Commission on Libraries and Information Science for a term expiring July 19, 2005.

Carol L. Diehl, of Wisconsin, to be a Member of the National Commission on Libraries and Information Science for a term expiring July 19, 2005.

Allison Druin, of Maryland, to be a Member of the National Commission on Libraries and Information Science for a term expiring July 19, 2006.

Beth Fitzsimmons, of Michigan, to be a Member of the National Commission on Libraries and Information Science for a term expiring July 19, 2006.

Patricia M. Hines, of South Carolina, to be a Member of the National Commission on Libraries and Information Science for a term expiring July 19, 2005.

Colleen Ellen Huebner, of Washington, to be a Member of the National Commission on Libraries and Information Science for a term expiring July 19, 2007.

Stephen M. Kennedy, of New Hampshire, to be a Member of the National Commission on Libraries and Information Science for a term expiring July 19, 2007.

Bridget L. Lamont, of Illinois, to be a Member of the National Commission on Libraries and Information Science for a term expiring July 19, 2008.

Mary H. Perdue, of Maryland, to be a Member of the National Commission on Libraries and Information Science for a term expiring July 19, 2008.

Herman Lavon Totten, of Texas, to be a Member of the National Commission on Libraries and Information Science for a term expiring July 19, 2008.

Public Health Service nomination beginning with Vincent A. Berkley and ending with James Syms.

Drew R. McCoy, of Massachusetts, to be a Member of the Board of Trustees of the James Madison Memorial Fellowship Foundation for a term of six years.

Carol Kinsley, of Massachusetts, to be a Member of the Board of Directors of the Corporation for National and Community Service for a term expiring October 6, 2006.

Susan K. Sclafani, of the District of Columbia, to be Assistant Secretary for Vocational and Adult Education, Department of Education.

Laurie Susan Fulton, of Virginia, to be a Member of the Board of Directors of the United States Institute of Peace for a term expiring January 19, 2007.

Steven J. Law, of the District of Columbia, to be Deputy Secretary of Labor.

J. Robinson West, of the District of Columbia, to be a Member of the Board of Directors of the United States Institute of Peace for a term expiring January 19, 2007.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. JEFFORDS (for himself, Ms. SNOWE, and Mr. HATCH):

S. 1912. A bill to amend the Internal Revenue Code of 1986 to expand pension coverage and savings opportunities and to provide other pension reforms; to the Committee on Finance.

By Mr. MCCAIN (for himself and Mr. FEINGOLD):

S. 1913. A bill to amend the Internal Revenue Code of 1986 to reform the system of public financing for Presidential elections, and for other purposes; to the Committee on Finance.

By Ms. STABENOW (for herself and Mr. LEVIN):

S. 1914. A bill to prohibit the closure or realignment of inpatient services at the Aleda E. Lutz Department of Veterans Affairs Medical Center in Saginaw, Michigan, as proposed under the Capital Asset Realignment for Enhanced Services initiative; to the Committee on Veterans' Affairs.

By Mr. LIEBERMAN:

S. 1915. A bill to ensure that the Government fully accounts for both its explicit liabilities and implicit commitments and adopts fiscal and economic policies that enable it to finance and manage these liabilities and commitments, to honor commitments to the Baby Boom and subsequent generations with regard to social insurance programs, and to provide for the national defense, homeland security, and other critical governmental responsibilities; to the Committee on the Budget and the Committee on Governmental Affairs, jointly, pursuant to the order of August 4, 1977, with instructions that if one Committee reports, the other Committee have thirty days to report or be discharged.

By Ms. LANDRIEU:

S. 1916. A bill to amend title 10, United States Code, to increase the minimum Survivor Benefit Plan basic annuity for surviving spouses age 62 and older, to provide for a one-year open season under that plan, and for other purposes; to the Committee on Armed Services.

By Mrs. HUTCHISON:

S. 1917. A bill to amend the Internal Revenue Code of 1986 to permit the issuance of tax-exempt bonds for certain air and water pollution control facilities, and to provide that the volume cap for private activity bonds shall not apply to bonds for facilities for the furnishing of water, sewage facilities, and air or water pollution control facilities; to the Committee on Finance.

By Mr. SANTORUM (for himself and Mrs. FEINSTEIN):

S. 1918. A bill to amend the Internal Revenue Code of 1986 to provide that qualified homeowner downpayment assistance is a charitable purpose; to the Committee on Finance.

By Mr. ALLEN:

S. 1919. A bill to designate a portion of the United States courthouse located at 2100 Jamieson Avenue, in Alexandria, Virginia, as the "Justin W. Williams United States Attorney's Building"; to the Committee on Environment and Public Works.

By Mr. GRASSLEY (for himself and Mr. LEAHY):

S. 1920. A bill to extend for 6 months the period for which chapter 12 of title 11 of the United States Code is reenacted; to the Committee on the Judiciary.

By Mr. GRASSLEY (for himself and Mr. SESSIONS):

S. 1921. A bill to amend chapter 3 of title 28, United States Code, to provide for 11 circuit judges on the United States Court of Appeals for the District of Columbia Circuit; to the Committee on the Judiciary.

By Mr. SMITH (for himself and Mr. BREAUX):

S. 1922. A bill to amend the Internal Revenue Code of 1986 to comply with the World Trade Organization rulings on the FSC/ETI benefit in a manner that preserves manufacturing jobs and production activities in the United States, and for other purposes; to the Committee on Finance.

By Mr. LEAHY:

S. 1923. A bill to reauthorize and amend the National Film Preservation Act of 1996; to the Committee on the Judiciary.

By Mr. JEFFORDS:

S. 1924. A bill to provide for the coverage of milk production under the H-2A nonimmigrant worker program; to the Committee on the Judiciary.

By Mr. KENNEDY (for himself, Mr. SCHUMER, Mr. DODD, Mr. HARKIN, Ms. MIKULSKI, Mrs. MURRAY, Mr. EDWARDS, Mrs. CLINTON, Mr. INOUYE, Mr. LEAHY, Mr. LEVIN, Mr. KERRY, Mr. BIDEN, Mr. ROCKEFELLER, Mr. LIEBERMAN, Mr. AKAKA, Mrs. BOXER, Mr. FEINGOLD, Mr. DURBIN, Mr. BAYH, Mr. CORZINE, Mr. DAYTON, and Mr. LAUTENBERG):

S. 1925. A bill to amend the National Labor Relations Act to establish an efficient system to enable employees to form, join, or assist labor organizations, to provide for mandatory injunctions for unfair labor practices during organizing efforts, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Ms. STABENOW (for herself, Mr. GRAHAM of Florida, Mrs. CLINTON, Mrs. MURRAY, Mr. LEAHY, Mr. DASCHLE, Mr. PRYOR, Mr. LEVIN, Mr. SCHUMER, and Ms. CANTWELL):

S. 1926. A bill to amend title XVIII of the Social Security Act to restore the medicare program and for other purposes; to the Committee on Finance.

By Mrs. CLINTON:

S. 1927. A bill to establish an award program to encourage the development of effective bomb-scanning technology; to the Committee on Commerce, Science, and Transportation.

By Mr. SARBANES (for himself, Mr. SCHUMER, Ms. STABENOW, Mr. CORZINE, Mr. DURBIN, Mr. KERRY, Ms. MIKULSKI, Mrs. CLINTON, Mr. LEVIN, Mr. LEAHY, Mr. AKAKA, Mr. KENNEDY, Mr. LAUTENBERG, Mr. DAYTON, and Mr. DODD):

S. 1928. A bill to amend the Truth in Lending Act to protect consumers against predatory practices in connection with high cost mortgage transactions, to strengthen the civil remedies available to consumers under existing law, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. GREGG (for himself and Mr. KENNEDY):

S. 1929. A bill to amend the Employee Retirement Income Security Act of 1974 and the Public Health Service Act to extend the mental health benefits parity provisions for an additional year; considered and passed.

By Mr. BROWNBACK (for himself, Mr. ENSIGN, Mr. ENZI, Mr. HAGEL, Mr. INHOFE, Mr. NICKLES, Mr. SANTORUM, and Mr. SESSIONS):

S. 1930. A bill to provide that the approved application under the Federal Food, Drug, and Cosmetic Act for the drug commonly known as RU-486 is deemed to have been withdrawn, to provide for the review by the Comptroller General of the United States of the process by which the Food and Drug Administration approved such drug, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. COLEMAN (for himself, Mr. CORZINE, Mr. VOINOVICH, and Mr. LAUTENBERG):

S. Res. 271. A resolution urging the President of the United States diplomatic corps to dissuade member states of the United Nations from supporting resolutions that unfairly castigate Israel and to promote within the United Nations General Assembly more balanced and constructive approaches to resolving conflict in the Middle East; to the Committee on Foreign Relations.

By Ms. SNOWE (for herself, Mrs. MURRAY, Mr. WARNER, Mr. BREAUX, Mr. CRAPO, Mr. CONRAD, Mr. DASCHLE, Mr. EDWARDS, Mr. KENNEDY, Mr. JOHNSON, and Mr. GRASSLEY):

S. Res. 272. A resolution designating the week beginning November 16, 2003, as American Education Week; considered and agreed to.

By Mr. DASCHLE (for Mr. KERRY):

S. Con. Res. 84. A concurrent resolution recognizing the sacrifices made by members of the regular and reserve components of the Armed Forces, expressing concern about their safety and security, and urging the Secretary of Defense to take immediate steps to ensure that the reserve components are provided with the same equipment as regular components; to the Committee on Armed Services.

By Mr. McCAIN (for himself and Mr. LIEBERMAN):

S. Con. Res. 85. A concurrent resolution expressing the sense of Congress that the continued participation of the Russian Federation in the Group of 8 nations should be conditioned on the Russian Government voluntarily accepting and adhering to the norms and standards of democracy; to the Committee on Foreign Relations.

ADDITIONAL COSPONSORS

S. 665

At the request of Mr. GRASSLEY, the name of the Senator from Alaska (Ms. MURKOWSKI) was added as a cosponsor of S. 665, a bill to amend the Internal Revenue Code of 1986 to provide tax relief for farmers and fisherman, and for other purposes.

S. 1136

At the request of Mr. SPECTER, the name of the Senator from Georgia (Mr. MILLER) was added as a cosponsor of S. 1136, a bill to restate, clarify, and revise the Soldiers' and Sailors' Civil Relief Act of 1940.

S. 1245

At the request of Ms. COLLINS, the name of the Senator from Rhode Island (Mr. REED) was added as a cosponsor of S. 1245, a bill to provide for homeland security grant coordination and simplification, and for other purposes.

S. 1431

At the request of Mr. LAUTENBERG, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 1431, a bill to reauthorize the assault weapons ban, and for other purposes.

S. 1549

At the request of Mr. JOHNSON, his name was added as a cosponsor of S. 1549, a bill to amend the Richard B. Russell National School Lunch Act to phase out reduced price lunches and breakfasts by phasing in an increase in the income eligibility guidelines for free lunches and breakfasts.

S. 1586

At the request of Mr. DAYTON, his name was withdrawn as a cosponsor of S. 1586, a bill to authorize appropriate action if the negotiations with the People's Republic of China regarding China's undervalued currency and currency manipulations are not successful.

S. 1700

At the request of Mr. LEAHY, the name of the Senator from New Mexico (Mr. BINGAMAN) was added as a cosponsor of S. 1700, a bill to eliminate the substantial backlog of DNA samples collected from crime scenes and convicted offenders, to improve and expand the DNA testing capacity of Federal, State, and local crime laboratories, to increase research and development of new DNA testing technologies, to develop new training programs regarding the collection and use of DNA evidence, to provide post-conviction testing of DNA evidence to exonerate the innocent, to improve the performance of counsel in State capital cases, and for other purposes.

S. 1755

At the request of Mr. LEAHY, the name of the Senator from Washington (Ms. CANTWELL) was added as a cosponsor of S. 1755, a bill to amend the Richard B. Russell National School Lunch Act to provide grants to support farm-to-cafeteria projects.

S. 1792

At the request of Mr. DOMENICI, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 1792, a bill to amend the Internal Revenue Code of 1986 to provide the same capital gains treatment for art and collectibles as for other investment property and to provide that a deduction equal to fair market value shall be allowed for charitable contributions of literary, musical, artistic, or scholarly compositions created by the donor.

S. 1825

At the request of Mr. DEWINE, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 1825, a bill to amend title 18, United States Code, to provide penalties for the sale and use of unauthorized mobile infrared transmitters.

S. 1853

At the request of Mr. KENNEDY, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 1853, a bill to provide extended unemployment benefits to displaced workers.

S. 1858

At the request of Mr. COCHRAN, the names of the Senator from Kansas (Mr. ROBERTS), the Senator from Georgia (Mr. MILLER) and the Senator from Michigan (Ms. STABENOW) were added as cosponsors of S. 1858, a bill to authorize the Secretary of Agriculture to conduct a loan repayment program to encourage the provision of veterinary services in shortage and emergency situations.

S. 1879

At the request of Ms. MIKULSKI, the name of the Senator from New Hampshire (Mr. GREGG) was added as a cosponsor of S. 1879, a bill to amend the Public Health Service Act to revise and extend provisions relating to mammography quality standards.

S. 1907

At the request of Mr. DASCHLE, the name of the Senator from North Dakota (Mr. DORGAN) was added as a cosponsor of S. 1907, a bill to promote rural safety and improve rural law enforcement.

S. CON. RES. 77

At the request of Mr. SESSIONS, the names of the Senator from Utah (Mr. HATCH), the Senator from Iowa (Mr. GRASSLEY), the Senator from Kentucky (Mr. BUNNING), the Senator from Oklahoma (Mr. INHOFE) and the Senator from Georgia (Mr. CHAMBLISS) were added as cosponsors of S. Con. Res. 77, a concurrent resolution expressing the sense of Congress supporting vigorous enforcement of the Federal obscenity laws.

S. CON. RES. 81

At the request of Mrs. FEINSTEIN, the name of the Senator from Ohio (Mr. VOINOVICH) was added as a cosponsor of S. Con. Res. 81, a concurrent resolution expressing the deep concern of Congress regarding the failure of the Islamic Republic of Iran to adhere to its obligations under a safeguards agreement with the International Atomic Energy Agency and the engagement by Iran in activities that appear to be designed to develop nuclear weapons.

S. CON. RES. 83

At the request of Mr. BIDEN, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. Con. Res. 83, a concurrent resolution promoting the establishment of a democracy caucus within the United Nations.

S. RES. 120

At the request of Mr. JEFFORDS, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. Res. 120, a resolution commemorating the 25th anniversary of Vietnam Veterans of America.

S. RES. 253

At the request of Mr. CAMPBELL, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. Res. 253, a resolution to recognize the evolution and importance of motorsports.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. JEFFORDS (for himself, Ms. SNOWE, and Mr. HATCH):

S. 1912. A bill to amend the Internal Revenue Code of 1986 to expand pension coverage and savings opportunities and to provide other pension reforms; to the Committee on Finance.

Mr. JEFFORDS. Mr. President, today, together with Senators HATCH and SNOWE, I am introducing, the Retirement Account Portability and Improvement Act of 2003. This legislation improves the portability of retirement savings by eliminating unnecessary complexities and barriers in the retirement savings system, and helps preserve retirement savings by giving American workers tools that will help them consolidate their retirement savings into one easily managed account.

In brief, this bill will make a number of improvements in the retirement savings system to help families preserve retirement assets. It will, for example, enhance the portability of retirement savings by expanding rollover options in traditional IRAs, Roth IRAs, and SIMPLE Plans. The bill also clarifies that when employees are permitted to make after-tax contributions to retirement plans, those after-tax amounts may be rolled over into other retirement plans eligible to receive such rollovers. This clarification will make it easier for workers to move all elements of their 401(k) of 403(b) savings when they change jobs and move between private sector and the tax-exempt sector.

In addition, the bill builds on defined contribution plan reforms enacted in 2001 by requiring a shortened vesting schedule for employer non-elective contributions, such as profit-sharing contributions, to defined contribution plans. As a result, employer contributions will become employee property more quickly, helping workers to build more meaningful retirement benefits. This new vesting schedule corresponds to rules for 401(k) matching contributions enacted in 2001.

Another provision in the bill would end an unfair tax penalty faced by nonspouse beneficiaries. Today, when an employee dies, the benefits in that employee's retirement account are paid out to a non-spouse beneficiary in one payment. The beneficiary must pay tax on the entire amount, and is often forced into a higher tax bracket as a result of the payment. A provision in this bill would allow non-spouse beneficiaries—siblings, children, domestic partners, parents—to roll over the money from the plan to an IRA. This will prevent an immediate tax bite to grieving beneficiaries and allow them to withdraw the money from their IRA over five years or over their own life expectancy.

The bill also helps preserve retirement savings by allowing plans to designate default IRAs or annuity contracts to which employee rollovers may be directed. Employers should be more willing to establish default IRA and annuity rollover options as a result, making it easier for employees to keep savings in the retirement system when they change jobs.

For workers who leave a job without claiming their retirement benefits, the bill improves on the automatic rollover provisions enacted in 2001, by allowing certain small distributions from retirement plans to be sent to the Pension Benefit Guaranty Corporation (PBGC), ensuring that participants are ultimately reunited with their earned benefits. The bill also expands the scope of the PBGC's successful Missing Participants program that matches workers with lost pension benefits.

Employees of state and local governments, including teachers, will benefit from a number of this bill's technical corrections that will facilitate the purchase of service credits in public pension programs, allowing state and local employees to more easily attain a full pension in the jurisdiction where they conclude their career. The bill also contains provisions that would clarify eligibility rights of certain state and local employees who participate in a Section 457 deferred compensation plan.

Congress must take every opportunity to encourage American workers not only to save for retirement, but also to preserve those hard-earned retirement savings. These portability improvements offer one set of tools for making it easier to navigate the retirement savings system and reach retirement with an adequate nest egg. There are many pressing and complex retirement issues that demand attention, but I am hopeful that this legislation, narrowly focused on portability, can be considered quickly and on its own merits.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1912

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; AMENDMENT OF 1986 CODE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Retirement Acount Portability Act of 2003".

(b) AMENDMENT OF 1986 CODE.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

(c) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; amendment of 1986 Code; table of contents.

TITLE I—BUILDING AND PRESERVING RETIREMENT ASSETS AND ENHANCING PORTABILITY

Sec. 101. Allow rollovers by nonspouse beneficiaries of certain retirement plan distributions.
Sec. 102. Facilitation under fiduciary rules of certain rollovers and annuity distributions.
Sec. 103. Faster vesting of employer nonelective contributions.
Sec. 104. Allow rollover of after-tax amounts in annuity contracts.

TITLE II—EXPANDING RETIREMENT PLAN COVERAGE TO EMPLOYEES OF SMALL BUSINESSES

Sec. 201. Elimination of higher penalty on certain Simple distributions.
Sec. 202. Simple plan portability.

TITLE III—EXPANDING RETIREMENT SAVINGS FOR TAX-EXEMPT ORGANIZATION AND GOVERNMENT EMPLOYEES

Sec. 301. Clarifications regarding purchase of permissive service credit.
Sec. 302. Eligibility for participation in retirement plans.

TITLE IV—SIMPLIFICATION AND EQUITY

Sec. 401. Allow direct rollovers from retirement plans to Roth IRAs.
Sec. 402. Transfers to the PBGC.

TITLE I—BUILDING AND PRESERVING RETIREMENT ASSETS AND ENHANCING PORTABILITY

SEC. 101. ALLOW ROLLOVERS BY NONSPOUSE BENEFICIARIES OF CERTAIN RETIREMENT PLAN DISTRIBUTIONS.

(a) IN GENERAL.—

(1) QUALIFIED PLANS.—Section 402(c) (relating to rollovers from exempt trusts) is amended by adding at the end the following new paragraph:

"(11) DISTRIBUTIONS TO INHERITED INDIVIDUAL RETIREMENT PLAN OF NONSPOUSE BENEFICIARY.—

"(A) IN GENERAL.—If, with respect to any portion of a distribution from an eligible retirement plan of a deceased employee, a direct trustee-to-trustee transfer is made to an individual retirement plan described in clause (i) or (ii) of paragraph (8)(B) established for the purposes of receiving the distribution on behalf of an individual who is a designated beneficiary (as defined by section 401(a)(9)(E)) of the employee and who is not the surviving spouse of the employee—

"(i) the transfer shall be treated as an eligible rollover distribution for purposes of this subsection,

"(ii) the individual retirement plan shall be treated as an inherited individual retirement account or individual retirement annuity (within the meaning of section 408(d)(3)(C)) for purposes of this title, and

"(iii) section 401(a)(9)(B) (other than clause (iv) thereof) shall apply to such plan.

"(B) CERTAIN TRUSTS TREATED AS BENEFICIARIES.—For purposes of this paragraph, to the extent provided in rules prescribed by the Secretary, a trust maintained for the benefit of one or more designated beneficiaries shall be treated in the same manner as a trust designated beneficiary.".

(2) Section 403(a) plans.—Subparagraph (B) of section 403(a)(4) (relating to rollover amounts) is amended by inserting "and (11)" after "(7)".

(3) Section 403(b) plans.—Subparagraph (B) of section 403(b)(8) (relating to rollover amounts) is amended by striking "and (9)" and inserting ", (9), and (11)".

(4) Section 457 plans.—Subparagraph (B) of section 457(e)(16) (relating to rollover amounts) is amended by striking "and (9)" and inserting ", (9), and (11)".

(b) Effective Date.—The amendments made by this section shall apply to distributions after December 31, 2003.

SEC. 102. FACILITATION UNDER FIDUCIARY RULES OF CERTAIN ROLLOVERS AND ANNUITY DISTRIBUTIONS.

(a) In General.—Section 404(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1104(c)) is amended by adding at the end the following new paragraph:

"(4)(A) In the case of a pension plan which makes a transfer under section 401(a)(31)(A) of the Internal Revenue Code of 1986 to an individual retirement plan (as defined in section 7701(a)(37) of such Code) in connection with a participant or beneficiary or makes a distribution to a participant or beneficiary of an annuity contract described in subparagraph (B), the participant or beneficiary shall, for purposes of paragraph (1), be treated as exercising control over the transfer or distribution if—

"(i) the participant or beneficiary elected such transfer or distribution, and

"(ii) in connection with such election, the participant or beneficiary was given an opportunity to elect any other individual retirement plan (in the case of a transfer) or any other annuity contract described in subparagraph (B) (in the case of a distribution).

"(B) An annuity contract is described in this subparagraph if it provides, either on an immediate or deferred basis, a series of substantially equal periodic payments (not less frequently than annually) for the life of the participant or beneficiary or the joint lives of the participant or beneficiary and such individual's designated beneficiary. Annuity payments shall not fail to be treated as part of a series of substantially equal periodic payments because the amount of the periodic payments may vary in accordance with investment experience, reallocations among investment options, actuarial gains or losses, cost of living indices, or similar fluctuating criteria. The availability of a commutation benefit, a minimum period of payments certain, or a minimum amount to be paid in any event shall not affect the treatment of an annuity contract as an annuity contract described in this subparagraph.

"(C) Under regulations prescribed by the Secretary, this paragraph shall apply without regard to whether the particular individual retirement plan receiving the transfer or the particular annuity contract being distributed is specifically identified by the pension plan as available to the participant or beneficiary.

"(D) Notwithstanding the preceding provisions of this paragraph, paragraph (1)(B) shall not apply with respect to liability under section 406 in connection with the specific identification of any individual retirement plan or annuity contract as being available to the participant or beneficiary.".

(b) Effective Date and Related Rules.—

(1) Effective date.—The amendment made by this section shall take effect on the date of the enactment of this Act.

(2) Issuance of final regulations.—Final regulations under section 404(c)(4) of the Employee Retirement Income Security Act of 1974 (added by this section) shall be issued no later than 1 year after the date of the enactment of this Act.

SEC. 103. FASTER VESTING OF EMPLOYER NONELECTIVE CONTRIBUTIONS.

(a) Amendments to the Internal Revenue Code of 1986.—

(1) In general.—Paragraph (2) of section 411(a) (relating to employer contributions) is amended to read as follows:

"(2) Employer contributions.—

"(A) Defined benefit plans.—

"(i) In general.—In the case of a defined benefit plan, a plan satisfies the requirements of this paragraph if it satisfies the requirements of clause (ii) or (iii).

"(ii) 5-year vesting.—A plan satisfies the requirements of this clause if an employee who has completed at least 5 years of service has a nonforfeitable right to 100 percent of the employee's accrued benefit derived from employer contributions.

"(iii) 3 to 7 year vesting.—A plan satisfies the requirements of this clause if an employee has a nonforfeitable right to a percentage of the employee's accrued benefit derived from employer contributions determined under the following table:

"Years of service:	The nonforfeitable percentage is:
3	20
4	40
5	60
6	80
7 or more	100.

"(B) Defined contribution plans.—

"(i) In general.—In the case of a defined contribution plan, a plan satisfies the requirements of this paragraph if it satisfies the requirements of clause (ii) or (iii).

"(ii) 3-year vesting.—A plan satisfies the requirements of this clause if an employee who has completed at least 3 years of service has a nonforfeitable right to 100 percent of the employee's accrued benefit derived from employer contributions.

"(iii) 2 to 6 year vesting.—A plan satisfies the requirements of this clause if an employee has a nonforfeitable right to a percentage of the employee's accrued benefit derived from employer contributions determined under the following table:

"Years of service:	The nonforfeitable percentage is:
2	20
3	40
4	60
5	80
6	100.".

(2) Conforming amendment.—Section 411(a) (relating to general rule for minimum vesting standards) is amended by striking paragraph (12).

(b) Amendments to the Employee Retirement Income Security Act of 1974.—

(1) In general.—Paragraph (2) of section 203(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1053(a)(2)) is amended to read as follows:

"(2)(A)(i) In the case of a defined benefit plan, a plan satisfies the requirements of this paragraph if it satisfies the requirements of clause (ii) or (iii).

"(ii) A plan satisfies the requirements of this clause if an employee who has completed at least 5 years of service has a nonforfeitable right to 100 percent of the employee's accrued benefit derived from employer contributions.

"(iii) A plan satisfies the requirements of this clause if an employee has a nonforfeitable right to a percentage of the employee's accrued benefit derived from employer contributions determined under the following table:

"Years of service:	The nonforfeitable percentage is:
3	20
4	40
5	60
6	80
7 or more	100.

"(B)(i) In the case of an individual account plan, a plan satisfies the requirements of this paragraph if it satisfies the requirements of clause (ii) or (iii).

"(ii) A plan satisfies the requirements of this clause if an employee who has completed at least 3 years of service has a nonforfeitable right to 100 percent of the employee's accrued benefit derived from employer contributions.

"(iii) A plan satisfies the requirements of this clause if an employee has a nonforfeitable right to a percentage of the employee's accrued benefit derived from employer contributions determined under the following table:

"Years of service:	The nonforfeitable percentage is:
2	20
3	40
4	60
5	80
6	100.".

(2) Conforming amendment.—Section 203(a) of such Act is amended by striking paragraph (4).

(c) Effective Dates.—

(1) In general.—Except as provided in paragraph (2), the amendments made by this section shall apply to contributions for plan years beginning after December 31, 2003.

(2) Collective bargaining agreements.—In the case of a plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to contributions on behalf of employees covered by any such agreement for plan years beginning before the earlier of—

(A) the later of—

(i) the date on which the last of such collective bargaining agreements terminates (determined without regard to any extension thereof on or after such date of the enactment); or

(ii) January 1, 2004; or

(B) January 1, 2006.

(3) Service required.—With respect to any plan, the amendments made by this section shall not apply to any employee before the date that such employee has 1 hour of service under such plan in any plan year to which the amendments made by this section apply.

SEC. 104. ALLOW ROLLOVER OF AFTER-TAX AMOUNTS IN ANNUITY CONTRACTS.

(a) In General.—Subparagraph (A) of section 402(c)(2) (maximum amount which may be rolled over) is amended by striking "and which" and inserting "or to an annuity contract described in section 403(b) and such plan or contract".

(b) Effective Date.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 2003.

TITLE II—EXPANDING RETIREMENT PLAN COVERAGE TO EMPLOYEES OF SMALL BUSINESSES

SEC. 201. ELIMINATION OF HIGHER PENALTY ON CERTAIN SIMPLE DISTRIBUTIONS.

(a) In General.—Subsection (t) of section 72 (relating to 10-percent additional tax on early distributions from qualified retirement plans) is amended by striking paragraph (6) and redesignating paragraphs (7), (8), and (9) as paragraphs (6), (7), and (8), respectively.

(b) CONFORMING AMENDMENTS.—

(1) Section 72(t)(2)(E) is amended by striking "paragraph (7)" and inserting "paragraph (6)".

(2) Section 72(t)(2)(F) is amended by striking "paragraph (8)" and inserting "paragraph (7)".

(3) Section 408(d)(3)(G) is amended by striking "applies" and inserting "applied on the day before the date of the enactment of the Retirement Account Portability Act of 2003)".

(4) Section 457(a)(2) is amended by striking "section 72(t)(9)" and inserting "section 72(t)(8)".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to years beginning after December 31, 2003.

SEC. 202. SIMPLE PLAN PORTABILITY.

(a) REPEAL OF LIMITATION.—Paragraph (3) of section 408(d) (relating to rollover contributions), as amended by this Act, is amended by striking subparagraph (G) and redesignating subparagraph (H) as subparagraph (G).

(b) Section 402(c)(8)(B) is amended by adding at the end the following new sentence: "Individual retirement accounts and individual retirement annuities described in clauses (i) and (ii) shall be treated as eligible retirement plans without regard to whether they are part of a simplified employee pension (within the meaning of section 408(k)) or a simplified retirement account (within the meaning of section 408(p)).".

(c) EFFECTIVE DATE.—The amendment made by this section shall apply to years beginning after December 31, 2003.

TITLE III—EXPANDING RETIREMENT SAVINGS FOR TAX-EXEMPT ORGANIZATION AND GOVERNMENT EMPLOYEES

SEC. 301. CLARIFICATIONS REGARDING PURCHASE OF PERMISSIVE SERVICE CREDIT.

(a) IN GENERAL.—Subparagraph (A) of section 457(e)(17) (relating to trustee-to-trustee transfers to purchase permissive service credit), and subparagraph (A) of section 403(b)(13) (relating to trustee-to-trustee transfers to purchase permissive service credit), are both amended by striking "section 415(n)(3)(A)" and inserting "section 415(n)(3) (without regard to subparagraphs (B) and (C) thereof)".

(b) DISTRIBUTION REQUIREMENTS.—Section 457(e)(17) and section 403(b)(13) are both amended by adding at the end the following sentence: "Amounts transferred under this paragraph shall be distributed solely in accordance with section 401(a) as applicable to such defined benefit plan.".

(c) SERVICE CREDIT.—Clause (ii) of section 415(n)(3)(A) is amended to read as follows:

"(ii) which relates to benefits with respect to which such -participant is not otherwise entitled, and".

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the.amendments made by section 647 of the Economic Growth and Tax Relief Reconciliation Act of 2001.

SEC. 302. ELIGIBILITY FOR PARTICIPATION IN RETIREMENT PLANS.

An individual shall not be precluded from participating in an eligible deferred compensation plan by reason of having received a distribution under section 457(e)(9) of the Internal Revenue Code of 1986, as in effect prior to the enactment of the Small Business Job Protection Act of 1996.

TITLE IV—SIMPLIFICATION AND EQUITY

SEC. 401. ALLOW DIRECT ROLLOVERS FROM RETIREMENT PLANS TO ROTH IRAS.

(a) IN GENERAL.—Subsection (e) of section 408A (defining qualified rollover contribution) is amended to read as follows:

"(e) QUALIFIED ROLLOVER CONTRIBUTION.—For purposes of this section, the term 'qualified rollover contribution' means a rollover contribution—

"(1) to a Roth IRA from another such account,

"(2) from an eligible retirement plan, but only if—

"(A) in the case of an individual retirement plan, such rollover contribution meets the requirements of section 408(d)(3), and

"(B) in the case of any eligible retirement plan (as defined in section 402(c)(8)(B) other than clauses (i) and (ii) thereof), such rollover contribution meets the requirements of section 402(c), 403(b)(8), or 457(e)(16), as applicable.

For purposes of section 408(d)(3)(B), there shall be disregarded any qualified rollover contribution from an individual retirement plan (other than a Roth IRA) to a Roth IRA.".

(b) CONFORMING AMENDMENTS.—

(1) Section 408A(c)(3)(B) is amended—

(A) in the text by striking "individual retirement plan" and inserting "an eligible retirement plan (as defined by section 402(c)(8)(B))", and

(B) in the heading by striking "IRA" and inserting "ELIGIBLE RETIREMENT PLAN".

(2) Section 408A(d)(3) is amended—

(A) in subparagraph (A) by striking "section 408(d)(3)" inserting "sections 402(c), 403(b)(8), 408(d)(3), and 457(e)(16)",

(B) in subparagraph (B) by striking "individual retirement plan" and inserting "eligible retirement plan (as defined by section 402(c)(8)(B))",

(C) in subparagraph (D) by striking "or 6047" after "408(i)",

(D) in subparagraph (D) by striking "or both" and inserting "persons subject to section 6047(d)(1), or all of the foregoing persons", and

(E) in the heading by striking "IRA" and inserting "ELIGIBLE RETIREMENT PLAN".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions after December 31, 2003.

SEC. 402. TRANSFERS TO THE PBGC.

(a) MANDATORY DISTRIBUTIONS TO PBGC.—Clause (i) of section 401(a)(31)(B) (relating to general rule for certain mandatory distributions) is amended by inserting "to the Pension Benefit Guaranty Corporation in accordance with section 4050(e) of the Employee Retirement Income Security Act of 1974 or" after "such transfer".

(b) TAX TREATMENT OF DISTRIBUTIONS.—Subparagraph (B) of section 401(a)(31) is amended by adding at the end the following new clause:

"(iii) INCOME TAX TREATMENT OF TRANSFERS TO PBGC.—For purposes of determining the income tax treatment relating to transfers to the Pension Benefit Guaranty Corporation under clause (i)—

"(I) the transfer of amounts to the Pension Benefit Guaranty Corporation pursuant to clause (i) shall be treated as a transfer to an individual retirement plan under such clause, and

"(II) the distribution of such amounts from the Pension Benefit Guaranty Corporation shall be treated as a distribution from an individual retirement plan.".

(c) MISSING PARTICIPANTS AND BENEFICIARIES.—

(1) IN GENERAL.—Section 4050 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1350) is amended by redesignating subsection (c) as subsection (f) and by inserting after subsection (b) the following new subsections:

"(c) MULTIEMPLOYER PLANS.—The corporation shall prescribe rules similar to the rules in subsection (a) for multiemployer plans covered by this title that terminate under section 4041A.

"(d) PLANS NOT OTHERWISE SUBJECT TO TITLE.—

"(1) TRANSFER TO CORPORATION.—The plan administrator of a plan described in paragraph (4) may elect to transfer the benefits of a missing participant or beneficiary to the corporation upon termination of the plan.

"(2) INFORMATION TO THE CORPORATION.—To the extent provided in regulations, the plan administrator of a plan described in paragraph (4) shall, upon termination of the plan, provide the corporation information with respect to benefits of a missing participant or beneficiary if the plan transfers such benefits—

"(A) to the corporation, or

"(B) to an entity other than the corporation or a plan described in paragraph (4)(B)(ii).

"(3) PAYMENT BY THE CORPORATION.—If benefits of a missing participant or beneficiary were transferred to the corporation under paragraph (1), the corporation shall, upon location of the participant or beneficiary, pay to the participant or beneficiary the amount transferred (or the appropriate survivor benefit) either—

"(A) in a single sum (plus interest), or

"(B) in such other form as is specified in regulations of the corporation.

"(4) PLANS DESCRIBED.—A plan is described in this paragraph if—

"(A) the plan is a pension plan (within the meaning of section 3(2))—

"(i) to which the provisions of this section do not apply (without regard to this subsection), and

"(ii) which is not a plan described in paragraphs (2) through (11) of section 4021(b), and

"(B) at the time the assets are to be distributed upon termination, the plan—

"(i) has one or more missing participants or beneficiaries, and

"(ii) has not provided for the transfer of assets to pay the benefits of all missing participants and beneficiaries to another pension plan (within the meaning of section 3(2)).

"(5) CERTAIN PROVISIONS NOT TO APPLY.—Subsections (a)(1) and (a)(3) shall not apply to a plan described in paragraph (4).

"(e) INVOLUNTARY CASHOUTS.—

"(1) PAYMENT BY THE CORPORATION.—If benefits under a plan described in paragraph (2) were transferred to the corporation under section 401(a)(31)(B) of the Internal Revenue Code of 1986, the corporation shall, upon application filed by the participant or beneficiary with the corporation in such form and manner as may be prescribed in regulations of the corporation, pay to the participant or beneficiary the amount transferred (or the appropriate survivor benefit) either—

"(A) in a single sum (plus interest), or

"(B) in such other form as is specified in regulations of the corporation.

"(2) INFORMATION TO THE CORPORATION.—To the extent provided in regulations, the plan administrator of a plan described in paragraph (3) shall, upon transferred to the corporation under section 401(a)(31)(B) of such Code, provide the corporation information with respect to benefits of the participant or beneficiary so transferred.

"(3) PLANS DESCRIBED.—A plan is described in this paragraph if the plan is a pension plan (within the meaning of section 3(2))—

"(A) which provides for mandatory distributions under section 401(a)(31)(B) of the Internal Revenue Code of 1986, and

"(B) which is not a plan described in paragraphs (2) through (11) of section 4021(b).

"(4) CERTAIN PROVISIONS NOT TO APPLY.—Subsections (a)(1) and (a)(3) shall not apply to a plan described in paragraph (2).".

(2) CONFORMING AMENDMENTS.—Section 206(f) of such Act (29 U.S.C. 1056(f)) is amended—

(A) by striking "title IV" and inserting "section 4050"; and

(B) by striking "the plan shall provide that,".

(d) EFFECTIVE DATE.—

(1) INTERNAL REVENUE CODE OF 1986 PROVISIONS.—The amendments made by subsections (a) and (b) shall take effect as if included in the amendments made by section 657 of the Economic Growth and Tax Relief Reconciliation Act of 2001.

(2) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 PROVISIONS.—The amendments made by subsection (c) shall apply to distributions made after final regulations implementing subsections (c), (d), and (e) of section 4050 of the Employee Retirement Income Security Act of 1974 (as added by subsection (c)), respectively, are prescribed.

(3) REGULATIONS.—The Pension Benefit Guaranty Corporation shall issue regulations necessary to carry out the amendments made by subsection (c) not later than December 31, 2004.

By Mr. McCAIN (for himself and Mr. FEINGOLD):

S. 1913. A bill to amend the Internal Revenue Code of 1986 to reform the system of public financing for Presidential elections, and for other purposes; to the Committee on Finance.

Mr. McCAIN. Mr. President, along with Senator RUSS FEINGOLD, I am proud today to introduce the Presidential Funding Act of 2003. This legislation will improve and reform the presidential public financing system. With major presidential candidates opting out of public financing for their 2004 primary campaigns, reform of the system of financing presidential nominations is needed more than ever.

The presidential public financing system has been in place for three decades and has achieved broad public acceptance. From 1976 to 2000, every major party presidential nominee has accepted public financing for the general election and, nearly all of the nominees have also accepted it for their primary elections. A total of 46 Democrats and 29 Republicans have accepted public financing for the presidential primaries during this period.

Since its creation, the presidential financing system has worked non-ideologically, with victories for three Republicans and two Democrats. It has also provided for competitive elections. In the five races that have been run under the system involving an incumbent president, challengers have won in three of those elections. This system of voluntary spending limits in exchange for public funding has been a nonpartisan success.

Last year's enactment of a ban on soft money addressed what had become a basic problem for the effectiveness and credibility of the presidential system. For the system to continue serving the nation effectively, its remaining problems now must be solved. This legislation will repair and revitalize the presidential campaign finance system in the following ways.

First, our legislation increases the overall spending limit for the presidential primaries and provide more public matching funds for presidential primary candidates.

The overall spending limit in the primaries for publicly financed candidates has failed to keep pace with reality. This was demonstrated when in 2000, public financing and spending limits for the primaries were rejected and a record $100 million in private contributions was spent to gain the Republican party's nomination—more than twice the amount that the publicly financed candidates were allowed to spend. During the 2004 presidential primary period, it is expected that Republicans will raise and spend as much as $200 million.

Our legislation increases the individual contribution limit from $1,000 to $2,000. Therefore, it will be easier over time for other candidates to reject public financing and raise private money in excess of the overall primary spending limit, thereby worsening the competitive disadvantage of publicly-financed candidates.

In addition, the "front-loading" of presidential primaries has created a much shorter nominating period—now likely to end by early March—and a longer actual general election period than existed when the presidential financing system was created in 1974. As a result, a potential "gap" exists in funds available for a publicly financed nominee to spend between gaining the party nomination in March and the party's summer nominating convention, when the nominee receives public funds for the general election. This creates a further competitive disadvantage.

To address these problems, our legislation increases the overall spending limit for the presidential primaries to $75 million from the $45 million limit in effect for the 2004 presidential election. This would equal the $75 million spending limit in effect for the general election, which applies to a much shorter period than the primaries.

The amount of public matching funds for individual contributions in the primaries is also increased from the current one-to-one match to a four-to-one match for up to $250 of each individual contribution. This would greatly increase the value of smaller contributions in the presidential nominating process, as was intended by the presidential financing system. It would decrease the reliance on larger contributions, provide more public funds to meet the higher spending limit, and improve the ability of publicly financed candidates to run competitive elections.

When the $1000 individual contribution limit was doubled last year, increasing the potential role of private contributions in the presidential financing system, no similar adjustment was made to increase the role of public matching funds. A new four-to-one multiple match for up to $250 of each individual contribution would accomplish that goal.

In addition, the threshold for qualifying for matching public funds in the primary has not changed since the system was established. Our legislation increases the qualifying threshold should be increased by more than doubling the threshold to require candidates to raise $15,000 in each of 20 states in amounts of no more than $250 per individual donor. Although the existing threshold has worked well during the history of the current system, a higher qualifying amount is appropriate for the future, especially since candidates would now be eligible to receive greater amounts of matching funds.

Second, our legislation requires a candidate to opt in or out of the public financing system for the entire presidential election, including both the primary and general election.

The purpose of the presidential public financing system is to allow candidates to run competitive races for the presidency without becoming dependent on or obligated to campaign donors. That purpose is undermined when a candidate opts out of the system to raise and spend large amounts of private money for a primary or general election race. Such candidates should not be able to reject public financing and then get the system's benefits when it suits their tactical advantage. A candidate should have to opt in or out of the system for the whole election.

Third, our legislation repeals the state-by-state primary spending limits and allows publicly financed primary candidates to receive their public matching funds before January 1st of the presidential election year.

The State-by-State primary spending limits have not worked. The limits have proven to be ineffective and have served to unjustifiably micromanage presidential campaigns.

Under current law, primary candidates can begin to raise private contributions eligible to be matched beginning on January 1 of the year before a presidential election year. They are not eligible, however, to receive any of the matching public funds until January 1 of the presidential election year. With the current "front-loaded" primary system, and with the nomination likely to be decided in the early months of a presidential election year, primary candidates need to be able to spend more funds at an earlier period than before. As a result, under our legislation, presidential primary candidates will be eligible to start receiving matching public funds on July 1 of the year before a presidential election year.

Fourth, our legislation provides additional public funds in the presidential general election for a publicly financed candidate facing a privately financed candidate who has substantially outspent the combined primary and general election spending limits.

As more wealthy individuals decide to spend their personal wealth to run for public office, the potential grows for an individual to spend an enormous amount of personal wealth to seek the presidency. There already have been candidates for the U.S. Senate and in mayoral races, for example, who have spent as much in personal wealth on their races as each major party presidential nominee received in public funds in 2000 to run their general election campaign.

In addition, with the increased individual contribution limit, a presidential candidate could decide to forgo public funding and raise and spend private contributions far in excess of the spending limits for publicly financed candidates.

To address this potential problem, our legislation makes a publicly financed major party nominee eligible to receive an additional $75 million for the general election race, when a privately financed general election candidate has spent more than 50 percent above the total primary and general election spending limit for the publicly financed candidate.

In other words, once a presidential general election candidate has spent more than a total of $225 million to seek the presidency, a publicly financed major party nominee, subject to a spending limit of $75 million for the primaries and $75 million for the general election, would receive an additional $75 million for the general election race.

Fifth, our legislation increases the funds available to finance the presidential public financing system.

Currently, the public financing system is funded by a voluntary $3 check-off available to taxpayers on their tax forms on an annual basis. This mechanism will not raise sufficient resources in the long term to finance the costs of a revised presidential system.

The $3 tax check-off is increased to $6 and indexed for inflation to help ensure there are sufficient funds available for future presidential elections. In addition, the Federal Election Commission (FEC) is authorized to conduct a public education campaign to explain to citizens why the check-off exists and how it works, including the fact that it does not increase the tax liability of taxpayers.

The current presidential public financing law creates a priority system that allocates available public funds from the check-off to the nomination conventions, the presidential general election and the presidential primaries in that order. This order of priority does not make sense.

Our legislation revises the order of priority for use of public funds to make funding of the general election candidates the first priority, funding of the primary election candidates the second priority, and funding of the nomination conventions the third priority.

Furthermore, a U.S. Department of the Treasury ruling prohibits taking into account the tax check-off revenues that will be received in April of the presidential election year in determining at the start of each presidential election year the total amount of funds available to be given to eligible candidates from the fund. This has had the effect of artificially lowering the amount of funds available and creating temporary shortfalls for primary candidates during the opening months of the presidential election year at the time when they need the funds the most.

Our legislation revises the law to require the U.S. Department of the Treasury (as it used to do) to estimate at the end of the year prior to a presidential election year the amount of check-off funds that will be received in the presidential election year and to take these funds into account in determining the total amount of funds available under the presidential system.

Finally, our legislation implements the soft money ban to ensure that the parties and federal officeholders and candidates do not raise or spend soft money in connection with the presidential nominating conventions.

Despite the passage of the new campaign finance law and its ban on soft money, federal officeholders and national party officials have continued to raise soft money to finance the national nomination conventions on the fictional premise that such funds are not in connection with a "federal election" but rather are for municipal or civic purposes.

The reality is that a presidential nominating convention is defined as a "federal election" election under the campaign finance law. Furthermore, federal officeholders and candidates and national party officials who raise soft money for the conventions are subject to precisely the same kind of problems of corruption and the appearance of corruption that the new law prevents by banning soft money.

To reaffirm that the soft money ban applies to the presidential nominating conventions, our legislation explicitly prohibits the national parties and federal officeholders and candidates from raising and spending soft money to pay for the presidential nominating conventions, including for a host committee, civic committee or municipality.

The highly expensive, front-loaded, nationalized, primary system requires that we more than ever fix the presidential public funding system. We must continue to promote competition in order to give voters choices. Our legislation not only saves the existing system but improves it as well. It not only shores up the financial foundations of the system but it would also bring more donors into the system, making financial participation more democratic. It would give our citizens a stake in their government. It is our hope that with the enactment of this legislation, candidates will no longer take small donors for granted and finally hear their voices. In return, all of our citizens will feel reconnected to the presidential financing process that at times, has left them behind.

Mr. FEINGOLD. Mr. President, it is pleasure to join my friend and colleague Senator McCAIN in introducing a bill to repair and strengthen the presidential public financing system. The Presidential Funding Act of 2003 will ensure that this system that has served our country so well for over a generation will continue to fulfill its promise in the 21st century.

The presidential public financing system was put into place in the wake of the Watergate scandals as part of the Federal Election Campaign Act of 1974. It was held to be constitutional by the Supreme Court in Buckley v. Valeo. Every major party nominee for President since 1976 has participated in the system for the general election. The system, of course, is voluntary, as the Supreme Court required. In the last election, then-Governor George W. Bush opted out of the system for the presidential primaries, but elected to take the taxpayer funded grant in the general election. He appears ready to make the same choice in this election, and so far two of the Democratic presidential candidates have decided not to seek federal matching funds in the primaries. Before 2000, almost all serious candidates for President had participated in the system.

It is unfortunate that the matching funds system for the primaries is becoming less viable. The system reduces the fundraising pressures on candidates and levels the playing field between candidates. It allows candidates to run viable campaigns without becoming overly dependent on private donors. The system has worked well in the past, and its advantages for candidates and for the country make it worth repairing so that it can work in the future. If we don't repair it, the pressures on candidates to opt out because their opponents are opting out will increase until the system collapse from disuse.

At the outset, I want to emphasize that this bill is not designed to have any impact on the ongoing presidential race. It will take effect only after the 2004 elections. Therefore, there is no partisan purpose here. Once again, Senator McCAIN and I are working together to try to improve the campaign finance system, regardless of any partisan impact that these reforms might have. Second, we do not expect Congress to take action on this bill during an election year. Instead, our hope is that by introducing a bill now we can begin a conversation with our colleagues and with the public that will allow us to take quick action beginning in 2005 so that a new system can be in place for the 2008 election.

The bill makes changes to both the primary and general election system to address the weaknesses and problems that have been identified by both participants in the system and experts on the presidential election financing process. First and most important, it eliminates the state-by-state spending limits in the current law and substantially increases the overall spending limit from the current limit of approximately $45 million to $75 million. This should make the system more viable for serious candidates facing opponents who are capable of raising significant sums outside the system. The bill also makes available significantly more public money for participating candidates by increasing the match of small contributions from 1:1 to 4:1. Thus, significantly more public money will be available to those candidates who choose to participate in the system.

One very important provision of this bill ties the primary and general election systems together and requires candidates to make a single decision on whether to participate. Candidates who opt out of the primary system and decide to rely solely on private money cannot return to the system for the general election. And candidates must commit to participate in the system in the general election if they want to receive federal matching funds in the primaries. The bill also increases the spending limits for participating candidates in the primaries who face a non-participating opponent if that opponent raises more than 33 percent more than the spending limit. This provides some protection against being far outspent by a non-participating opponent.

The bill also sets the general election spending limit at $75 million, indexed for inflation, which is about what it is projected to be in 2008. And if a general election candidate does not participate in the system and spends more than 33 percent more than the combined primary and general election spending limits, a participating candidate will receive a grant equal to twice the general election spending limit.

This bill also addresses what some have called the "gap" between the primary and general election seasons. Presumptive presidential nominees have emerged earlier in the election year over the life of the public financing system. This had led to some nominees being essentially out of money between the time that they nail down the nomination and the convention where they are formally nominated and become eligible for the general election grant. For a few cycles, soft money raised by the parties filled in that gap, but the Bipartisan Campaign Reform Act of 2002 thankfully has now closed that loophole. This bill doubles the amount of hard money that parties can spend in coordination with their candidates, allowing them to fill the gap once the party has a presumptive nominee.

Fixing the presidential public financing system will obviously cost money, but our best calculations at the present time indicate that the changes to the system in this bill can be paid for by doubling the income tax check-off on an individual return from $3 to just $6. The total cost of the changes to the system is projected to be around $175 million over the four-year election cycle. Of course, these projections may change as we get more data from the 2004 elections. But even a somewhat larger cost would be a very small investment to make to protect the health of our democracy and integrity of our presidential elections. The American people do not want to see a return to the pre-Watergate days of unlimited spending on presidential elections and candidates entirely beholden to private donors. We must act now to preserve the crown jewel of the Watergate reforms and assure the fairness of our elections and the confidence of our citizens in the process.

By Ms. STABENOW (for herself and Mr. LEVIN):

S. 1914. A bill to prohibit the closure or realignment of inpatient services at the Aleda E. Lutz Department of Veterans Affairs Medical Center in Saginaw, Michigan, as proposed under the Capital Asset Realignment for Enhanced Services initiatives; to the Committee on Veterans' Affairs.

Ms. STABENOW. Mr. President, I rise today to introduce legislation that would prevent the closure of the Saginaw Veterans Administration Medical Center in Saginaw, MI.

As of August 2003, there were almost one million veterans in lower Michigan and Northwestern Ohio. These one million veterans are served by four V.A. Medical Centers—Saginaw, Detroit, Ann Arbor and Battle Creek—and 12 Community Based Outpatient Clinics (CBOCs), all located in lower Michigan or Toledo, OH.

Regrettably, the Department of Veterans Affairs' Capitol Asset Realignment for Enhanced Services (CARES) Commission is recommending closing all acute care beds at the Aleda E. Lutz Department of Veterans Affairs Medical Center in Saginaw, MI. The geographic range for the acute services in Saginaw is vast. The facility essentially covers half of Michigan's Lower Peninsula. Therefore, closing these inpatient beds in Saginaw would have a devastating impact on veterans who live in Central and Northern Michigan.

If the Saginaw facility were to close, a veteran who lived in Mackinaw City would have to drive 281 miles to the Detroit facility or 272 miles to the Ann Arbor facility for medical care. Under ideal conditions these trips would take six hours instead of the current two hour trip that it would take to reach the existing Saginaw facility. Asking a veteran to go from Mackinaw City to Detroit is like asking a veteran to go from southeast Michigan to Buffalo, New York to get acute care.

How can we ask veterans, many of whom are sick and frail, to travel six hours to get necessary inpatient services? Going through a major illness is tough enough for our veterans. The closing of this hospital would add insult to injury.

This bill seeks to stop this closure and ensure that the thousands of veterans who live in central and northern Michigan have access to the medical services they deserve. I urge my colleagues to support this bill.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1914

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. PROHIBITION ON CLOSURE OR REALIGNMENT OF INPATIENT SERVICES AT ALEDA E. LUTZ DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER IN SAGINAW, MICHIGAN.

The Secretary of Veterans Affairs shall not carry out the closure or realignment of inpatient services at the Aleda E. Lutz Department of Veterans Affairs Medical Center in Saginaw, Michigan, as proposed under the Capital Asset Realignment for Enhanced Services (CARES) initiative.

By Mrs. HUTCHISON:

S. 1917. A bill to amend the Internal Revenue Code of 1986 to permit the issuance of tax-exempt bonds for certain air and water pollution control facilities, and to provide that the volume cap for private activity bonds shall not apply to bonds for facilities for the furnishing of water, sewage facilities, and air or water pollution control facilities; to the Committee on Finance.

Mrs. HUTCHISON. Mr. President, I am proud to offer the Clean Air and

Water Investment and Infrastructure Act.

Texas, like many States, faces increasingly difficult challenges in improving air and water quality.

The Clean Air Act requires the Environmental Protection Agency to set air quality standards and establishes deadlines for State and local governments to achieve those levels. Today, more than 90 communities across the country are out of compliance with the Clean Air Act. These so-called "non-attainment" areas are threated with regulatory sanctions, such as loss of federal highway funding, if they do not meet mandated ozone levels by 2007.

Texas has four non-attainment areas: Beaumont-Port Arthur, Dallas-Fort Worth, El Paso and Houston. The Houston area alone needs an estimated $4.1 billion annually in order to meet Federal air quality standards.

These communities will not achieve compliance without assistance. Too many industrial plants need to install expensive equipment. If these environmental investments do not become more affordable, communities will either suffer sanctions or force industrial facilities to close and move offshore, causing substantial economic hardship.

Texas and many areas of the country, especially in the Southwest and West, also face critical water and wastewater problems. Investments in sources of clean water must be made or we will face shortages in the coming decades. However, necessary water infrastructure improvements are extremely expensive. According to the Texas State water plan, the cost of water supply acquisition projects, water and wastewater treatment, and other infrastructure projects in Texas through 2050 will be more than $100 billion.

Currently, air and water pollution control facilities cannot be financed by tax-exempt bonds. Even if they could, they would be limited by a cap which sets the total amount of tax-exempt private activity bonds issued by a state. Given the demands of other projects, such as housing, relatively few of the air and water pollution projects would have an opportunity to access this financing option.

In order to help us meet the challenges, I am introducing the Clear Air and Water Investment and Infrastructure Act. My bill will allow federal tax-exempt bonds to be used by private firms for air and water pollution control projects. Given the importance of these critical projects, these bonds also would be issued outside the constraints of the private-activity bond caps. The Texas Water Development Board estimates this could save 30 percent in financing costs for water projects.

For example, this bill would allow tax-exempt debt to be used to finance private systems along the Gulf Coast that desalinate seawater and brackish groundwater, and to install air pollution facilities on electric utility plants. States and communities would have an important new tool for addressing air and water pollution control needs.

Pollution control is a problem for all of us. It is to everyone's benefit to develop ways to promote public and private partnerships which can finance projects to improve air and water quality. I hope my colleagues will support this effort.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1917

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Clean Air and Water Investment and Infrastructure Act".

SEC. 2. TAX-EXEMPT BONDS FOR AIR AND WATER POLLUTION CONTROL FACILITIES.

(a) IN GENERAL.—Subsection (a) of section 142 of the Internal Revenue Code of 1986 (defining exempt facility bond) is amended by striking "or" at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting ", or", and by adding at the end the following new paragraph:

"(14) air or water pollution control facilities.".

(b) AIR OR WATER POLLUTION CONTROL FACILITIES.—Section 142 of the Internal Revenue Code of 1986 (relating to exempt facility bond) is amended by adding at the end the following new subsection:

"(l) POLLUTION CONTROL FACILITIES ACQUIRED BY REGIONAL POLLUTION CONTROL AUTHORITIES.—

"(1) IN GENERAL.—For purposes of paragraph (14) of subsection (a), a bond shall be treated as described in such paragraph if it is part of an issue substantially all of the proceeds of which are used by a qualified regional pollution control authority to acquire existing air or water pollution control facilities which the authority itself will operate in order to maintain or improve the control of pollutants.

"(2) RESTRICTIONS.—Paragraph (1) shall apply only if—

"(A) the amount paid, directly or indirectly, for a facility does not exceed the fair market value of the facility,

"(B) the fees or charges imposed, directly or indirectly, on the seller for any use of the facility after the sale of such facility are not less than the amounts that would be charged if the facility were financed with obligations the interest on which is not exempt from tax, and

"(C) no person other than the qualified regional pollution control authority is considered after the sale as the owner of the facility for the purposes of Federal income taxes.

"(3) QUALIFIED REGIONAL POLLUTION CONTROL AUTHORITY.—For purposes of this subsection, the term 'qualified regional pollution control authority' means an authority which—

"(A) is a political subdivision created by State law to control air or water pollution,

"(B) has within its jurisdictional boundaries all or part of at least 2 counties (or equivalent political subdivisions), and

"(C) operates air or water pollution control facilities.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to bonds issued after the date of the enactment of this Act.

SEC. 3. EXEMPTION FROM VOLUME CAP FOR FACILITIES FURNISHING WATER, SEWAGE FACILITIES, AND AIR OR WATER POLLUTION CONTROL FACILITIES.

(a) IN GENERAL.—Paragraph (3) of section 146(g) of the Internal Revenue Code of 1986 (relating to exception for certain bonds) is amended—

(1) by inserting "(4), (5)," after "(2),",

(2) by striking "or (13)" and inserting "(13), or (14)",

(3) by inserting "facilities for the furnishing of water, sewage facilities," after "wharves,",

(4) by striking "and" before "qualified", and

(5) by inserting ", and air or water pollution control facilities" after "educational facilities".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to bonds issued after the date of the enactment of this Act.

By Mr. SANTORUM (for himself and Mrs. FEINSTEIN):

S. 1918. A bill to amend the Internal Revenue Code of 1986 to provide that qualified homeowner downpayment assistance is a charitable purpose; to the Committee on Finance.

Mr. SANTORUM. Mr. President, I am please to introduce today, along with my colleague from California, Senator FEINSTEIN, legislation that will further one of the most important public policy goals we have as a Nation—the goal of homeownership. Homeownership is a significant part of the American dream. It has been called the backbone of our economy. It is widely considered the primary means by which American families create middle-class wealth and build financial security.

Homeownership is all those things and more. It is the cornerstone of healthy communities across our Nation. It is good for families, good for our schools, good for our neighborhoods. Equity in homes is the leading source for collateral for small business start-up borrowing, and home equity loans are the leading provider of funds for a college education. Some experts even say home owners are more likely to vote.

Despite the many benefits, there are still too many Americans for whom the American dream of homeownership is unreachable. There are too many American families who pay rent month after month, never accumulating equity, never experiencing the joy of raising their children in a home they own, and look forward to passing along to future generations. That is especially true among Americans from minority populations. Though nationwide nearly 70 percent of Americans own their own home, homeownership rates among African-Americans and Hispanics is less than 50 percent.

There are any number of obstacles to homeownership, but there is one problem that is widely considered the single biggest obstacle: the lack of funds for a down payment. Again, this is disproportionately true among minority families, which frequently have less accumulated wealth that can be used for a down payment.

President Bush has proposed creating the American Dream Down Payment Fund, which would provide down payment assistance to 40,000 families every year. I support that effort, and I applaud President Bush for proposing this bold new initiative. The President has set a goal of increasing the number of minority homeowners by at least 5.5 million by the end of this decade, which the Department of Housing and Urban Development estimates would create $256 billion in economic activity. I believe that is an important goal for us as a Nation.

I also believe that as we work to find ways for the Federal Government to increase homeownership, we need to encourage the private sector to do the same. There are a number of non-profit organizations in our country doing just that by providing a gift of down payment assistance to potential homeowners. These gifts of down payment assistance go to families and individuals who have the income to afford a mortgage, but who would otherwise be prevented from buying a home because they lack funds for a down payment. Last year non-profit organizations provided gifts of down payment assistance to over 85,000 home buyers—and the number will likely be much higher this year. One organization alone has helped over 160,000 individuals and families become homeowners, by providing a gift of funds for a down payment. And all without collecting a single dime of government funding.

That is why I am so pleased to be introducing this legislation today. I want to be sure the private sector can continue playing such a vital role in increasing homeownership by providing down payment assistance. Although many charities holding tax exemptions under section 501(c)(3) of the Internal Revenue Code provide down payment assistance, IRS regulations do not clearly address down payment assistance programs.

Our legislation will clarify that, under certain circumstances, the provision of down payment assistance to American families for use in purchasing low or moderate price homes constitutes charitable activity. Rather than developing our own standard for eligible home purchases, we have relied on the National Housing Act rule for FHA-insured loans. Our provision applies to purchases of a principal residence if the amount of the mortgage is less than the maximum mortgage amount eligible for FHA insurance in the geographic area in which the home is located. That will ensure that a charitable down payment assistance program is not used to support the purchase of rental properties or expensive homes.

Our legislation also includes one other provision designed to protect the Treasury. Home sellers often contribute to charitable down payment assistance providers in connection with the sale of a home. Those contributions are used to replenish the pool to make available gift assistance for other home buyers. Although the contributions are being made to a charity, they are not charitable in nature; they are expenses of selling a home. The legislation clarifies that a party to a home sale transaction may not claim a charitable contribution deduction for a contribution to a down payment assistance provider made in connection with the sale.

Although IRS regulations do not clearly address down payment assistance programs, our legislation merely codifies current practice. As a result, I do not anticipate that the legislation will result in a significant change in tax revenues.

Non-profit providers of down payment assistance help tens of thousands of Americans every year become homeowners. These organizations are changing lives, changing families, changing our communities—and they are doing it all without a single dime of taxpayer funds. I am pleased my colleague from California, Senator FEINSTEIN, has joined me in introducing this legislation. I ask all of my colleagues to join us in this important effort.

Mrs. FEINSTEIN. Mr. President, I am pleased to join with the distinguished Senator from Pennsylvania, Senator SANTORUM, to introduce legislation that will promote the American dream of homeownership.

Our legislation will specify that providing homeownership down payment assistance to American families constitutes a charitable activity under the regulations of the Internal Revenue Service.

As the cornerstone of middle-class wealth in our nation, we should be doing everything possible to promote broad investment in owner-occupied housing. Today, we have that chance.

It should not be a surprise that homeownership among low to moderate income families is lower than for those with higher incomes. The single biggest obstacle to achieving this dream is the lack of a downpayment.

Across America there are organizations that assist low to moderate income families with that first important step toward homeownership. In California, one of these groups, the Nehemiah Corporation, helps literally thousands of families each year by providing down payments.

While the Federal Government provides tax incentives for increased homeownership, we should make it easier for the private sector to provide their own brand of incentives. Importantly, this legislation will do several things to ensure that the private sector continues to have the tools it needs to provide this important assistance.

One, our legislation will specify that homeownership down payment assistance to American families constitutes a charitable activity.

Currently, Internal Revenue Service regulations do not clearly address the special circumstances of those organizations that provide downpayment assistance to families.

Two, our bill is structured to ensure that a charitable down payment assistance program is not used to support the purchase of rental properties or expensive homes.

Three, our legislation is designed so that the taxpayers do not pick-up the tab. Since, home sellers often contribute to charitable down payment assistance providers in connection with the sale of a home, those contributions are not charitable in nature; they are an expense related to selling a home.

This legislation clarifies that a party to a home sale transaction may not claim a charitable contribution deduction for a contribution to a down payment assistance organization made in connection with the sale.

And, although Internal Revenue Service regulations do not specifically address down payment assistance programs, our legislation merely codifies current practice.

This legislation will ensure the continued growth of this essential segment of the financial services market at no cost to the taxpayers.

And, as my friend from Pennsylvania has said, equity in homes is the leading source for collateral for small business start-up borrowing.

At a time when the economy still fails to produce jobs, the expansion of small business and the employment they provide is essential to the health of our economy.

It is a win-win situation in the truest sense of the term and I urge my colleagues to support it.

By Mr. SMITH (for himself and Mr. BREAUX):

S. 1922. A bill to amend the Internal Revenue Code of 1986 to comply with the World Trade Organization rulings on the FSC/ETI benefit in a manner that preserves manufacturing jobs and production activities in the United States, and for other purposes; to the Committee on Finance.

Mr. SMITH. Mr. President, I rise today to introduce The American Manufacturing Jobs Bill of 2003—which will provide a tax rate cut for all manufacturers who employ American workers. I am pleased to be joined in this effort by Senator JOHN BREAUX. On October 1, 2003, the Senate Finance Committee approved on a bipartisan basis S. 1673, the centerpiece of which resolves the FSC/ETI issue by replacing the export tax benefit with a reduction in the tax burden on domestic manufacturing companies.

I applaud S. 1673, a balanced piece of legislation crafted by Chairman CHARLES GRASSLEY, R–IA, and ranking member Senator MAX BAUCUS, D–MT. I am, however, concerned that the domestic manufacturing benefit in S. 1673 is not applied equally to all U.S. manufacturers. This bill includes a provision—a "haircut"—that provides less of a benefit to companies that also manufacture abroad.

For example, a company that has 55 percent of its manufacturing in the United States and 45 percent abroad will calculate its benefit under the bill and then reduce that benefit by a fraction—the numerator of which is the gross receipts from domestic manufacturing over the same derived from worldwide manufacturing.

This company thus suffers twice. First, the domestic manufacturing benefit in S. 1673 is less valuable than the benefit currently provided under FSC/ETI. Second, this company's manufacturing benefit is further reduced by the "haircut" merely because it also has overseas manufacturing operations in order to be closer to their markets.

The "haircut" is a discriminatory measure that hurts both foreign-owned and U.S.-owned companies alike. It is structured so that the more a company manufactures abroad, the less of a manufacturing rate cut it gets. The "haircut" makes the United States a less competitive location for current and future investment because multinational companies will believe they are being "cheated" and discriminated against.

At a time when American manufacturing jobs are leaving our country in record numbers, Congress should support all companies that employ Americans. U.S. companies with global operations employ more than 23 million Americans—9 million of which are in manufacturing jobs—this is tantamount to three out of every five manufacturing jobs in this country. Foreign-owned companies with U.S. operations employ more than 2 million manufacturing workers in the United States. It is these many of millions of manufacturing workers who will suffer if the "haircut" remains and companies are therefore discouraged to invest in the United States.

Moreover, the "haircut" is inconsistent with historic tax and trade policies to encourage U.S. companies to open up facilities outside the United States. In fact, there is an entire department—the Department of Commerce—set up to assist U.S. companies going global and then to promote and facilitate those same companies' efforts once they have established themselves in-country. I am also concerned that the "haircut" invites mirror legislation in other countries and may invite another WTO challenge to this legislation.

I believe we have a duty to encourage the retention and creation of manufacturing jobs in the United States. We must not treat U.S. jobs created by multinational companies as "less worthy" than U.S. jobs created by strictly domestic manufacturers. Congress should be in the business of rewarding all well-paid, manufacturing jobs that are created in the United States, not just those created by domestic manufacturers. I believe that by eliminating the "haircut" and providing a tax rate cut for all manufacturers who employ American workers, we can help to revitalize the U.S. manufacturing sector. I ask unanimous consent that the full text of this important legislation be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1922

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; AMENDMENT OF 1986 CODE.

(a) SHORT TITLE.—This Act may be cited as the "American Manufacturing Jobs Act of 2003".

(b) AMENDMENT OF 1986 CODE.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

SEC. 2. REPEAL OF EXCLUSION FOR EXTRATERRITORIAL INCOME.

(a) IN GENERAL.—Section 114 is hereby repealed.

(b) CONFORMING AMENDMENTS.—

(1)(A) Subpart E of part III of subchapter N of chapter 1 (relating to qualifying foreign trade income) is hereby repealed.

(B) The table of subparts for such part III is amended by striking the item relating to subpart E.

(2) The table of sections for part III of subchapter B of chapter 1 is amended by striking the item relating to section 114.

(3) The second sentence of section 56(g)(4)(B)(i) is amended by striking "or under section 114".

(4) Section 275(a) is amended—

(A) by inserting "or" at the end of paragraph (4)(A), by striking "or" at the end of paragraph (4)(B) and inserting a period, and by striking subparagraph (C), and

(B) by striking the last sentence.

(5) Paragraph (3) of section 864(e) is amended—

(A) by striking:

"(3) TAX-EXEMPT ASSETS NOT TAKEN INTO ACCOUNT.—

"(A) IN GENERAL.—For purposes of"; and inserting:

"(3) TAX-EXEMPT ASSETS NOT TAKEN INTO ACCOUNT.—For purposes of", and

(B) by striking subparagraph (B).

(6) Section 903 is amended by striking "114, 164(a)," and inserting "164(a)".

(7) Section 999(c)(1) is amended by striking "941(a)(5),".

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to transactions occurring after the date of the enactment of this Act.

(2) BINDING CONTRACTS.—The amendments made by this section shall not apply to any transaction in the ordinary course of a trade or business which occurs pursuant to a binding contract—

(A) which is between the taxpayer and a person who is not a related person (as defined in section 943(b)(3) of such Code, as in effect on the day before the date of the enactment of this Act), and

(B) which is in effect on September 17, 2003, and at all times thereafter.

(d) REVOCATION OF SECTION 943(e) ELECTIONS.—

(1) IN GENERAL.—In the case of a corporation that elected to be treated as a domestic corporation under section 943(e) of the Internal Revenue Code of 1986 (as in effect on the day before the date of the enactment of this Act)—

(A) the corporation may, during the 1-year period beginning on the date of the enactment of this Act, revoke such election, effective as of such date of enactment, and

(B) if the corporation does revoke such election—

(i) such corporation shall be treated as a domestic corporation transferring (as of such date of enactment) all of its property to a foreign corporation in connection with an exchange described in section 354 of such Code, and

(ii) no gain or loss shall be recognized on such transfer.

(2) EXCEPTION.—Subparagraph (B)(ii) of paragraph (1) shall not apply to gain on any asset held by the revoking corporation if—

(A) the basis of such asset is determined in whole or in part by reference to the basis of such asset in the hands of the person from whom the revoking corporation acquired such asset,

(B) the asset was acquired by transfer (not as a result of the election under section 943(e) of such Code) occurring on or after the 1st day on which its election under section 943(e) of such Code was effective, and

(C) a principal purpose of the acquisition was the reduction or avoidance of tax (other than a reduction in tax under section 114 of such Code, as in effect on the day before the date of the enactment of this Act).

(e) GENERAL TRANSITION.—

(1) IN GENERAL.—In the case of a taxable year ending after the date of the enactment of this Act and beginning before January 1, 2007, for purposes of chapter 1 of such Code, a current FSC/ETI beneficiary shall be allowed a deduction equal to the transition amount determined under this subsection with respect to such beneficiary for such year.

(2) CURRENT FSC/ETI BENEFICIARY.—The term "current FSC/ETI beneficiary" means any corporation which entered into one or more transactions during its taxable year beginning in calendar year 2002 with respect to which FSC/ETI benefits were allowable.

(3) TRANSITION AMOUNT.—For purposes of this subsection—

(A) IN GENERAL.—The transition amount applicable to any current FSC/ETI beneficiary for any taxable year is the phaseout percentage of the base period amount.

(B) PHASEOUT PERCENTAGE.—

(i) IN GENERAL.—In the case of a taxpayer using the calendar year as its taxable year, the phaseout percentage shall be determined under the following table:

Years:	The phaseout percentage is:
2004	80
2005	80
2006	60.

(ii) Special rule for 2003.—The phaseout percentage for 2003 shall be the amount that bears the same ratio to 100 percent as the number of days after the date of the enactment of this Act bears to 365.

(iii) Special rule for fiscal year taxpayers.—In the case of a taxpayer not using the calendar year as its taxable year, the phaseout percentage is the weighted average of the phaseout percentages determined under the preceding provisions of this paragraph with respect to calendar years any portion of which is included in the taxpayer's taxable year. The weighted average shall be determined on the basis of the respective portions of the taxable year in each calendar year.

"(C) Short taxable year.—The Secretary shall prescribe guidance for the computation of the transition amount in the case of a short taxable year.

(4) Base period amount.—For purposes of this subsection, the base period amount is the FSC/ETI benefit for the taxpayer's taxable year beginning in calendar year 2002.

(5) FSC/ETI benefit.—For purposes of this subsection, the term "FSC/ETI benefit" means—

(A) amounts excludable from gross income under section 114 of such Code, and

(B) the exempt foreign trade income of related foreign sales corporations from property acquired from the taxpayer (determined without regard to section 923(a)(5) of such Code (relating to special rule for military property), as in effect on the day before the date of the enactment of the FSC Repeal and Extraterritorial Income Exclusion Act of 2000).

In determining the FSC/ETI benefit there shall be excluded any amount attributable to a transaction with respect to which the taxpayer is the lessor unless the leased property was manufactured or produced in whole or in significant part by the taxpayer.

(6) Special rule for agricultural and horticultural cooperatives.—Determinations under this subsection with respect to an organization described in section 943(g)(1) of such Code, as in effect on the day before the date of the enactment of this Act, shall be made at the cooperative level and the purposes of this subsection shall be carried out in a manner similar to section 199(h)(2) of such Code, as added by this Act. Such determinations shall be in accordance with such requirements and procedures as the Secretary may prescribe.

(7) Certain rules to apply.—Rules similar to the rules of section 41(f) of such Code shall apply for purposes of this subsection.

(8) Coordination with binding contract rule.—The deduction determined under paragraph (1) for any taxable year shall be reduced by the phaseout percentage of any FSC/ETI benefit realized for the taxable year by reason of subsection (c)(2) or section 5(c)(1)(B) of the FSC Repeal and Extraterritorial Income Exclusion Act of 2000, except that for purposes of this paragraph the phaseout percentage for 2003 shall be treated as being equal to 100 percent.

(9) Special rule for taxable year which includes date of enactment.—In the case of a taxable year which includes the date of the enactment of this Act, the deduction allowed under this subsection to any current FSC/ETI beneficiary shall in no event exceed—

(A) 100 percent of such beneficiary's base period amount for calendar year 2003, reduced by

(B) the FSC/ETI benefit of such beneficiary with respect to transactions occurring during the portion of the taxable year ending on the date of the enactment of this Act.

SEC. 3. DEDUCTION RELATING TO INCOME ATTRIBUTABLE TO UNITED STATES PRODUCTION ACTIVITIES.

(a) In General.—Part VI of subchapter B of chapter 1 (relating to itemized deductions for individuals and corporations) is amended by adding at the end the following new section:

"SEC. 199. INCOME ATTRIBUTABLE TO DOMESTIC PRODUCTION ACTIVITIES.

"(a) Allowance of Deduction.—

"(1) In general.—There shall be allowed as a deduction an amount equal to 9 percent of the qualified production activities income of the taxpayer for the taxable year.

"(2) Phasein.—In the case of taxable years beginning in 2003, 2004, 2005, 2006, 2007, or 2008, paragraph (1) shall be applied by substituting for the percentage contained therein the transition percentage determined under the following table:

"Taxable years beginning in:	The transition percentage is:
2003 or 2004	1
2005	2
2006	3
2007 or 2008	6.

"(b) Deduction Limited to Wages Paid.—

"(1) In general.—The amount of the deduction allowable under subsection (a) for any taxable year shall not exceed 50 percent of the W-2 wages of the employer for the taxable year.

"(2) W-2 wages.—For purposes of paragraph (1), the term 'W-2 wages' means the sum of the aggregate amounts the taxpayer is required to include on statements under paragraphs (3) and (8) of section 6051(a) with respect to employment of employees of the taxpayer during the taxpayer's taxable year.

"(3) Special rules.—

"(A) Pass-thru entities.—In the case of an S corporation, partnership, estate or trust, or other pass-thru entity, the limitation under this subsection shall apply at the entity level.

"(B) Acquisitions and dispositions.—The Secretary shall provide for the application of this subsection in cases where the taxpayer acquires, or disposes of, the major portion of a trade or business or the major portion of a separate unit of a trade or business during the taxable year.

"(c) Qualified Production Activities Income.—For purposes of this section, the term 'qualified production activities income' means an amount equal to the portion of the modified taxable income of the taxpayer which is attributable to domestic production activities.

"(d) Determination of Income Attributable to Domestic Production Activities.—For purposes of this section—

"(1) In general.—The portion of the modified taxable income which is attributable to domestic production activities is so much of the modified taxable income for the taxable year as does not exceed—

"(A) the taxpayer's domestic production gross receipts for such taxable year, reduced by

"(B) the sum of—

"(i) the costs of goods sold that are allocable to such receipts,

"(ii) other deductions, expenses, or losses directly allocable to such receipts, and

"(iii) a proper share of other deductions, expenses, and losses that are not directly allocable to such receipts or another class of income.

"(2) Allocation method.—The Secretary shall prescribe rules for the proper allocation of items of income, deduction, expense, and loss for purposes of determining income attributable to domestic production activities.

"(3) Special rules for determining costs.—

"(A) In general.—For purposes of determining costs under clause (i) of paragraph (1)(B), any item or service brought into the United States shall be treated as acquired by purchase, and its cost shall be treated as not less than its fair market value immediately after it entered the United States. A similar rule shall apply in determining the adjusted basis of leased or rented property where the lease or rental gives rise to domestic production gross receipts.

"(B) Exports for further manufacture.—In the case of any property described in subparagraph (A) that had been exported by the taxpayer for further manufacture, the increase in cost or adjusted basis under subparagraph (A) shall not exceed the difference between the value of the property when exported and the value of the property when brought back into the United States after the further manufacture.

"(4) Modified taxable income.—The term 'modified taxable income' means taxable income computed without regard to the deduction allowable under this section.

"(e) Domestic Production Gross Receipts.—For purposes of this section—

"(1) In general.—The term 'domestic production gross receipts' means the gross receipts of the taxpayer which are derived from—

"(A) any sale, exchange, or other disposition of, or

"(B) any lease, rental, or license of,

qualifying production property which was manufactured, produced, grown, or extracted in whole or in significant part by the taxpayer within the United States.

"(2) Special rules for certain property.—In the case of any qualifying production property described in subsection (f)(1)(C)—

"(A) such property shall be treated for purposes of paragraph (1) as produced in significant part by the taxpayer within the United States if more than 50 percent of the aggregate development and production costs are incurred by the taxpayer within the United States, and

"(B) if a taxpayer acquires such property before such property begins to generate substantial gross receipts, any development or production costs incurred before the acquisition shall be treated as incurred by the taxpayer for purposes of subparagraph (A) and paragraph (1).

"(f) Qualifying Production Property.—For purposes of this section—

"(1) In general.—Except as otherwise provided in this paragraph, the term 'qualifying production property' means—

"(A) any tangible personal property,

"(B) any computer software, and

"(C) any property described in section 168(f) (3) or (4), including any underlying copyright or trademark.

"(2) Exclusions from qualifying production property.—The term 'qualifying production property' shall not include—

"(A) consumable property that is sold, leased, or licensed by the taxpayer as an integral part of the provision of services,

"(B) oil or gas,

"(C) electricity,

"(D) water supplied by pipeline to the consumer,

"(E) utility services, or

"(F) any film, tape, recording, book, magazine, newspaper, or similar property the market for which is primarily topical or otherwise essentially transitory in nature.

"(g) Definitions and Special Rules.—

"(1) Application of section to pass-thru entities.—In the case of an S corporation, partnership, estate or trust, or other pass-thru entity—

"(A) subject to the provisions of paragraph (2) and subsection (b)(3)(A), this section shall be applied at the shareholder, partner, or similar level, and

"(B) the Secretary shall prescribe rules for the application of this section, including rules relating to—

"(i) restrictions on the allocation of the deduction to taxpayers at the partner or similar level, and

"(ii) additional reporting requirements.

"(2) Exclusion for patrons of agricultural and horticultural cooperatives.—

"(A) In general.—If any amount described in paragraph (1) or (3) of section 1385(a)—

"(i) is received by a person from an organization to which part I of subchapter T applies which is engaged in the marketing of agricultural or horticultural products, and

"(ii) is allocable to the portion of the qualified production activities income of the organization which is deductible under subsection (a) and designated as such by the organization in a written notice mailed to its patrons during the payment period described in section 1382(d),

then such person shall be allowed an exclusion from gross income with respect to such amount. The taxable income of the organization shall not be reduced under section 1382 by the portion of any such amount with respect to which an exclusion is allowable to a person by reason of this paragraph.

"(B) Special rules.—For purposes of applying subparagraph (A), in determining the qualified production activities income of the organization under this section—

"(i) there shall not be taken into account in computing the organization's modified taxable income any deduction allowable under subsection (b) or (c) of section 1382 (relating to patronage dividends, per-unit retain allocations, and nonpatronage distributions), and

"(ii) the organization shall be treated as having manufactured, produced, grown, or extracted in whole or significant part any qualifying production property marketed by the organization which its patrons have so manufactured, produced, grown, or extracted.

"(3) Special rule for affiliated groups.—

"(A) In general.—All members of an expanded affiliated group shall be treated as a single corporation for purposes of this section.

"(B) Expanded affiliated group.—The term 'expanded affiliated group' means an affiliated group as defined in section 1504(a), determined— .

"(i) by substituting '50 percent' for '80 percent' each place it appears, and

"(ii) without regard to paragraphs (2) and (4) of section 1504(b).

"(4) Coordination with minimum tax.—The deduction under this section shall be allowed for purposes of the tax imposed by section 55; except that for purposes of section 55, alternative minimum taxable income shall be taken into account in determining the deduction under this section.

"(5) Ordering rule.—The amount of any other deduction allowable under this chapter shall be determined as if this section had not been enacted.

"(6) Trade or business requirement.—This section shall be applied by only taking into account items which are attributable to the actual conduct of a trade or business.

"(7) Possessions, etc.—

"(A) In general.—For purposes of subsections (d) and (e), the term 'United States' includes the Commonwealth of Puerto Rico, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and the Virgin Islands of the United States.

"(B) Special rules for applying wage limitation.—For purposes of applying the limitation under subsection (b) for any taxable year—

"(i) the determination of W–2 wages of a taxpayer shall be made without regard to any exclusion under section 3401(a)(8) for remuneration paid for services performed in a jurisdiction described in subparagraph (A), and

"(ii) in determining the amount of any credit allowable under section 30A or 936 for the taxable year, there shall not be taken into account any wages which are taken into account in applying such limitation.

"(8) Coordination with transition rules.—For purposes of this section—

"(A) domestic production gross receipts shall not include gross receipts from any transaction if the binding contract transition relief of section 2(c)(2) of the American Manufacturing Jobs Act of 2003 applies to such transaction, and

"(B) any deduction allowed under section 2(e) of such Act shall be disregarded in determining the portion of the taxable income which is attributable to domestic production gross receipts.".

(b) Minimum Tax.—Section 56(g)(4)(C) (relating to disallowance of items not deductible in computing earnings and profits) is amended by adding at the end the following new clause:

"(v) Deduction for domestic production.—Clause (i) shall not apply to any amount allowable as a deduction under section 199.".

(c) Clerical Amendment.—The table of sections for part VI of subchapter B of chapter 1 is amended by adding at the end the following new item:

"Sec. 199. Income attributable to domestic production activities.".

(d) Effective Date.—

(1) In general.—The amendments made by this section shall apply to taxable years ending after the date of the enactment of this Act.

(2) Application of section 15.—Section 15 of the Internal Revenue Code of 1986 shall apply to the amendments made by this section as if they were changes in a rate of tax.

By Mr. LEAHY:

S. 1923. A bill to reauthorize and amend the National Film Preservation Act of 1996; to the Committee on the Judiciary.

Mr. LEAHY. Mr. President, I call attention today to a part of American heritage that is literally disintegrating faster than can be saved. Motion pictures are an important part of our American experience and provide an extraordinary record of our history, our dreams, and our aspirations. The National Film Preservation Board and the National Film Preservation Foundation were created by Congress under the auspices of the Library of Congress, to help save America's film heritage. Today, I am introducing the "National Film Preservation Act of 2003," which will reauthorize and extend the "National Film Preservation Act of 1996."

We first acted in 1988 in order to recognize both the educational, cultural, and historical importance of our film heritage, and its inherently fragile nature. The "National Film Preservation Act of 2003" will allow the Library of Congress to continue its important work in preserving America's fading treasures, as well as providing grants that will help libraries, museums, and archives preserve films, and make those works available for study and research. These continued efforts are more critical today than ever before. Fewer than 20 percent of the features of the 1920s exist in complete form and less than 10 percent of the features of the 1910s have survived into the new millennium.

The films saved by the National Film Preservation Board are precisely those types of films that would be unlikely to survive without public support. At-risk documentaries, silent-era films, avant-garde works, ethnic films, newsreels, and home movies are in many ways more illuminating on the question of who we are as a society than the Hollywood sound features kept and preserved by major studios. What is more, in many cases only one copy of these "orphaned" works exists. As the Librarian of Congress, Dr. James H. Billington, has noted, "Our film heritage is America's living past." I encourage my colleagues to support the "Film Preservation Act of 2003" so that America's past can survive in order to enlighten and entertain future generations.

I ask unanimous consent that the text of this bill be printed in the Record.

There being no objection, the bill was ordered to be printed in the Record, as follows:

S. 1923

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

TITLE I—REAUTHORIZATION OF THE NATIONAL FILM PRESERVATION BOARD

SEC. 101. SHORT TITLE.

This title may be cited as the "National Film Preservation Act of 2003".

SEC. 102. REAUTHORIZATION AND AMENDMENT.

(a) Duties of the Librarian of Congress.—Section 103 of the National Film Preservation Act of 1996 (2 U.S.C. 179m) is amended:

(1) in subsection (b)—

(A) by striking "film copy" each place that term appears and inserting "film or other approved copy";

(B) by striking "film copies" each place that term appears and inserting "film or other approved copies"; and

(C) in the third sentence, by striking "copyrighted" and inserting "copyrighted, mass distributed, broadcast, or published" ; and

(2) by adding at the end the following:

"(c) COORDINATION OF PROGRAM WITH OTHER COLLECTION, PRESERVATION, AND ACCESSIBILITY ACTIVITIES.—In carrying out the comprehensive national film preservation program for motion pictures established under the National Film Preservation Act of 1992, the Librarian, in consultation with the Board established pursuant to section 104, shall—

"(1) carry out activities to make films included in the National Film registry more broadly accessible for research and educational purposes, and to generate public awareness and support of the Registry and the comprehensive national film preservation program;

"(2) review the comprehensive national film preservation plan, and amend it to the extent necessary to ensure that it addresses technological advances in the preservation and storage of, and access to film collections in multiple formats; and

"(3) wherever possible, undertake expanded initiatives to ensure the preservation of the moving image heritage of the United States, including film, videotape, television, and born digital moving image formats, by supporting the work of the National Audio-Visual Conservation Center of the Library of Congress, and other appropriate nonprofit archival and preservation organizations.".

(b) NATIONAL FILM PRESERVATION BOARD.—Section 104 of the National Film Preservation Act of 1996 (2 U.S.C. 179n) is amended—

(1) in subsection (a)(1) by striking "20" and inserting "22";

(2) in subsection (a) (2) by striking "three" and inserting "5";

(3) in subsection (d) by striking "11" and inserting "12"; and

(4) by striking subsection (e) and inserting the following:

"(e) REIMBURSEMENT OF EXPENSES.—Members of the Board shall serve without pay, but may receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.".

(c) RESPONSIBILITIES AND POWERS OF BOARD.—Section 105(c) of the National Film Preservation Act of 1996 (2 U.S.C. 179o) is amended by adding at the end the following:

"(3) REVIEW AND APPROVAL OF SPECIAL FOUNDATION PROJECTS.—The Board shall review special projects submitted for its approval by the National Film Preservation Foundation under section 151711 of title 36, United States Code.".

(d) NATIONAL FILM REGISTRY.—Section 106 of the National Film Preservation Act of 1996 (2 U.S.C. 179q) is amended by adding at the end the following:

"(e) NATIONAL AUDIO-VISUAL CONSERVATION CENTER.—The Librarian shall utilize the National Audio-Visual Conservation Center of the Library of Congress at Culpeper, Virginia, to ensure that preserved films included in the National Film Registry are stored in a proper manner, and disseminated to researchers, scholars, and the public as may be appropriate in accordance with—

"(1) title 17 of the United States Code; and

"(2) the terms of any agreements between the Librarian and persons who hold copyrights to such audiovisual works.".

(e) USE OF SEAL.—Section 107 (a) of the National Film Preservation Act of 1996 (2 U.S.C. 179q) is amended—

(1) in paragraph (1), by inserting "in any format" after "or any copy"; and

(2) in paragraph (2), by striking "or film copy" and inserting "in any format".

(f) EFFECTIVE DATE.—Section 113 of the National Film Preservation Act of 1996 (2 U.S.C. 179w) is amended by striking "7" and inserting "17".

TITLE II—REAUTHORIZATION OF THE NATIONAL FILM PRESERVATION FOUNDATION

SEC. 201. SHORT TITLE.

This title may be cited as the "National Film Preservation Foundation Reauthorization Act of 2003".

SEC. 202. REAUTHORIZATION AND AMENDMENT.

(a) BOARD OF DIRECTORS.—Section 151703 of title 36, United States Code, is amended—

(1) in subsection (b)(2)(A), by striking "nine" and inserting "12"; and

(2) in subsection (b)(4), by striking the second sentence and inserting "There shall be no limit to the number of terms to which any individual may be appointed.".

(b) POWERS.—Section 151705 of title 36, United States Code, is amended in subsection (b) by striking "District of Columbia" and inserting "the jurisdiction in which the principal office of the corporation is located".

(c) PRINCIPAL OFFICE.—Section 151706 of title 36, United States Code, is amended by inserting ", or another place as determined by the board of directors" after "District of Columbia".

(d) AUTHORIZATION OF APPROPRIATIONS.—Section 151711 of title 36, United States Code, is amended by striking subsections (a) and (b) and inserting the following:

"(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Library of Congress amounts necessary to carry out this chapter, not to exceed $500,000 for each of the fiscal years 2004 and 2005, and not to exceed $1,000,000 for each of the fiscal years 2006 through 2013. These amounts are to be made available to the corporation to match any private contributions (whether in currency, services, or property) made to the corporation by private persons and State and local governments.

"(b) LIMITATION RELATED TO ADMINISTRATIVE EXPENSES.—Amounts authorized under this section may not be used by the corporation for management and general or fundraising expenses as reported to the Internal Revenue Service as part of an annual information return required under the Internal Revenue Code of 1986.".

(e) COOPERATIVE FILM PRESERVATION.—

(1) IN GENERAL.—Chapter 1517 of title 36, United States Code, is amended—

(A) by redesignating sections 151711 and 151712 as sections 151712 and 151713, respectively; and

(B) by adding at the end the following:

"§ 151711. Cooperative film preservation

"(a) COOPERATIVE FILM PRESERVATION.—

"(1) IN GENERAL.—The corporation shall design and support cooperative national film preservation and access initiatives. Such initiatives shall be approved by the corporation, the Librarian of Congress, and the National Film Preservation Board of the Library of Congress under section 105(c)(3) of the National Film Preservation Act of 1996.

"(2) SCOPE.—Cooperative initiatives authorized under paragraph (1) may include—

"(A) the repatriation and preservation of American films that may be found in archives outside of the United States;

"(B) the exhibition and dissemination via broadcast or other means of "orphan" films;

"(C) the production of educational materials in various formats to encourage film preservation, preservation initiatives undertaken by 3 or more archives jointly; and

"(D) other activities undertaken in light of significant unfunded film preservation and access needs.

"(b) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—There are authorized to be appropriated to the Library of Congress amounts not to exceed $1,000,000 for each of the fiscal years 2006 through 2013, to carry out the purposes of this section.

"(2) MATCHING.—The amounts made available under paragraph (1) are to be made available to the corporation to match any private contributions (whether in currency, services, or property) made to the corporation by private persons and State and local governments.

"(3) LIMITATION RELATED TO ADMINISTRATIVE EXPENSES.—Amounts authorized under this section may not be used by the corporation for management and general or fundraising expenses as reported to the Internal Revenue Service as part of an annual information return required under the Internal Revenue Code of 1986.".

(2) TECHNICAL AND CONFORMING AMENDMENT.—The table of sections for chapter 1517 of title 36, United States Code, is amended by striking the matter relating to section 151711 and 151712 and inserting the following:

"151711. Cooperative film preservation.
"151712. Authorization of appropriations.
"151713. Annual report.".

By Mr. JEFFORDS:

S. 1924. A bill to provide for the coverage of milk production under the H–2A nonimmigrant worker program; to the Committee on the Judiciary.

Mr. JEFFORDS. Mr. President, today I rise to introduce the Dairy Farm Workers Fairness Act.

Family dairy farms are critically important to our agricultural economy and to the rural way of life in many parts of the country. These farms support the rural economy by supporting the local tax base and many local businesses. The working landscape created by our farms, especially a patchwork of small farms, is also the best antidote for the urban sprawl that is overtaking so much of the country. And, of course, the availability of fresh, locally produced milk is an amenity that we have come to take for granted. To support our rural economies, the working landscape and our local food supply systems we need to help small family dairy farms survive and thrive.

The most difficult challenge to the family dairy farm, after the volatility in milk price, is finding and hiring workers. In my home State of Vermont, dairy farms are not only an important part of our economy; they are an institution that has come to define our landscape. Vermont's beauty lies in the green fields, the red barns and the cows grazing on the hillside. When a farm family sells their land, which in many cases may have been worked by them and their ancestors for 5 or more generations, the decision is often driven by the non-stop, 7 day a week, 365 days a year work schedule. As fewer rural residents choose to work in agriculture, these farmers have been forced to take on more themselves. The whole family can end up working without vacations, sick leave or having weekends off. Although dairy farming might not seem seasonal, the burden becomes particularly heavy during the growing season when planting, haying, harvesting and storage of feed must all occur.

Dairy farmers are being forced to explore other options to find a predictable source of qualified labor. While other agricultural businesses in the country benefit from the temporary workers qualified under the H2A Work Visa Program, dairy farms do not. The job of milking cows on dairy farms has been judged under the current H2A program to not meet the definition of temporary or seasonal and is thus excluded. The largest labor need on dairy farms during the growing season, remains the need for assistance with milking. The cows must be milked two or three times a day by hired help so the farmer is able to take on the more complex and specialized work of operating large machinery to plant and harvest. While the work of milking is not seasonal or temporary, the need for additional labor to accomplish the work is seasonal and temporary. I believe the exclusion of dairy farming under the H2A program is an unintended problem in definitions, and our legislation is designed to fix that glitch. We must do this out of fairness, so that dairy farms can benefit from the same access to labor that other farms have, and more importantly to help our farms survive.

Recently, I heard from a farmer who owns and operates, along with his wife, a small dairy farm in central Vermont. The couple is nearing retirement age and have no children of their own. They had attempted to find a farm hand that could live on the farm and help with milking and some of the heavier chores. After placing ads in the paper and working with the state of Vermont's Department of Employment and Training, it became clear that their best option was to hire a family friend who had a strong desire to learn farming. Since the young man was from Honduras they began the visa process only to have their request for certification by the U.S. Department of Labor denied because their need was considered neither temporary nor seasonal. This farm plays such an important role in their rural Vermont community that I heard from several other constituents who asked for my assistance on this family's behalf. The couple continues to work their land but in doing so they are straining their health and pushing themselves harder than they should. They continue to operate their farm because they do not want to sell it since it is land that has been farmed for generations.

The legislation I am introducing today would allow this family farm, and so many others like it, to avail themselves of a labor source that exists for virtually every other farm in this country. By creating a period based on the summer growing season, dairy farms will be able to bring on extra help during the busiest part of the year, providing much needed relief for our farm families. I urge my colleagues to join me in supporting dairy farms across the United States by cosponsoring this important legislation. I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1924

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Dairy Farm Workers Fairness Act".

SEC. 2. COVERAGE OF MILK PRODUCTION UNDER H-2A NONIMMIGRANT WORKER PROGRAM.

(a) IN GENERAL.—For purposes of the administration of the H-2A worker program in a year, work performed in the production of milk for commercial use not earlier than April 15 or later than October 15 of that year shall qualify as agriculture labor or services of a seasonal nature.

(b) DEFINITIONS.—In this section:

(1) H-2A NONIMMIGRANT WORKER PROGRAM.—The term "H-2A nonimmigrant worker program" means the program for the admission to the United States of H-2A nonimmigrant workers.

(2) H-2A NONIMMIGRANT WORKERS.—The term "H-2A worker" means a nonimmigrant alien described in section 101(a)(15)(H)(ii)(a) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(H)(ii)(a)).

By Ms. STABENOW (for herself, Mr. GRAHAM of Florida, Mrs. CLINTON, Mrs. MURRAY, Mr. LEAHY, Mr. DASCHLE, Mr. PRYOR, Mr. LEVIN, Mr. SCHUMER, and Ms. CANTWELL):

S. 1926. A bill to amend title XVIII of the Social Security Act to restore the medicare program and for other purposes; to the Committee on Finance.

Ms. STABENOW. Mr. President, I rise today to introduce legislation that would allow us to help our providers and patients now.

If we immediately pass this bill, we can make our providers whole and then go back to the drawing board to get a better Medicare prescription drug benefit bill.

The bill includes all of the provider givebacks in the Conference Report accompanying H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003.

It includes all adjustments, word for word, for the rural provisions, physician updates, graduate medical education, GME, and home health services.

It does not add new language.

It does not include any provider cuts or premium increases in H.R.1.

Congress should pass these provisions on their own to help hospitals, physicians, and patients and not hold them hostage to a prescription drug bill that privatizes Medicare and provides a mediocre benefit to most seniors.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the Record, as follows:

S. 1926

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BIPA AND SECRETARY; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Support Our Health Care Providers Act of 2003".

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in division A of this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) BIPA; SECRETARY.—In this Act:

(1) BIPA.—The term "BIPA" means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106-554.

(2) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(d) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—RURAL PROVISIONS

Subtitle A—Provisions Relating to Part A Only

Sec. 101. Equalizing urban and rural standardized payment amounts under the medicare inpatient hospital prospective payment system.
Sec. 102. Enhanced disproportionate share hospital (DSH) treatment for rural hospitals and urban hospitals with fewer than 100 beds.
Sec. 103. Adjustment to the medicare inpatient hospital prospective payment system wage index to revise the labor-related share of such index.
Sec. 104. More frequent update in weights used in hospital market basket.
Sec. 105. Improvements to critical access hospital program.
Sec. 106. Medicare inpatient hospital payment adjustment for low-volume hospitals.
Sec. 107. Treatment of missing cost reporting periods for sole community hospitals.
Sec. 108. Recognition of attending nurse practitioners as attending physicians to serve hospice patients.
Sec. 109. Rural hospice demonstration project.
Sec. 110. Exclusion of certain rural health clinic and federally qualified health center services from the prospective payment system for skilled nursing facilities.
Sec. 110A. Rural community hospital demonstration program.

Subtitle B—Provisions Relating to Part B Only

Sec. 111. 2-year extension of hold harmless provisions for small rural hospitals and sole community hospitals under the prospective payment system for hospital outpatient department services.
Sec. 112. Establishment of floor on work geographic adjustment.
Sec. 113. Medicare incentive payment program improvements for physician scarcity.
Sec. 114. Payment for rural and urban ambulance services.
Sec. 115. Providing appropriate coverage of rural air ambulance services.
Sec. 116. Treatment of certain clinical diagnostic laboratory tests furnished to hospital outpatients in certain rural areas.
Sec. 117. Extension of telemedicine demonstration project.
Sec. 118. Report on demonstration project permitting skilled nursing facilities to be originating telehealth sites; authority to implement.

Subtitle C—Provisions Relating to Parts A and B

Sec. 121. 1-year increase for home health services furnished in a rural area.
Sec. 122. Redistribution of unused resident positions.

Subtitle D—Other Provisions

Sec. 131. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.
Sec. 132. Office of rural health policy improvements.
Sec. 133. MedPac study on rural hospital payment adjustments.
Sec. 134. Frontier extended stay clinic demonstration project.

TITLE II—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

Sec. 201. Revision of acute care hospital payment updates.
Sec. 202. Revision of the indirect medical education (IME) adjustment percentage.
Sec. 203. Recognition of new medical technologies under inpatient hospital prospective payment system.
Sec. 204. Increase in Federal rate for hospitals in Puerto Rico.
Sec. 205. Wage index adjustment reclassification reform.
Sec. 206. Limitation on charges for inpatient hospital contract health services provided to Indians by medicare participating hospitals.
Sec. 207. Clarifications to certain exceptions to medicare limits on physician referrals.
Sec. 208. 1-time appeals process for hospital wage index classification.

Subtitle B—Other Provisions

Sec. 211. Payment for covered skilled nursing facility services.
Sec. 212. Coverage of hospice consultation services.
Sec. 213. Study on portable diagnostic ultrasound services for beneficiaries in skilled nursing facilities.

TITLE III—PROVISIONS RELATING TO PART B

Subtitle A—Provisions Relating to Physicians' Services

Sec. 301. Revision of updates for physicians' services.
Sec. 302. Treatment of physicians' services furnished in Alaska.
Sec. 303. Inclusion of podiatrists, dentists, and optometrists under private contracting authority.
Sec. 304. GAO study on access to physicians' services.
Sec. 305. Collaborative demonstration-based review of physician practice expense geographic adjustment data.
Sec. 306. MedPac report on payment for physicians' services.

Subtitle B—Preventive Services

Sec. 311. Coverage of an initial preventive physical examination.
Sec. 312. Coverage of cardiovascular screening blood tests.
Sec. 313. Coverage of diabetes screening tests.
Sec. 314. Improved payment for certain mammography services.

Subtitle C—Other Provisions

Sec. 321. Hospital outpatient department (HOPD) payment reform.
Sec. 322. Limitation of application of functional equivalence standard.
Sec. 323. Payment for renal dialysis services.
Sec. 324. 2-year moratorium on therapy caps; provisions relating to reports.
Sec. 325. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.
Sec. 326. Payment for services furnished in ambulatory surgical centers.
Sec. 327. Payment for certain shoes and inserts under the fee schedule for orthotics and prosthetics.
Sec. 328. 5-year authorization of reimbursement for all medicare part B services furnished by certain Indian hospitals and clinics.

Subtitle D—Additional Demonstrations, Studies, and Other Provisions

Sec. 341. Demonstration project for coverage of certain prescription drugs and biologicals.
Sec. 342. Extension of coverage of intravenous immune globulin (IVIG) for the treatment of primary immune deficiency diseases in the home.
Sec. 343. MedPac study of coverage of surgical first assisting services of certified registered nurse first assistants.
Sec. 344. MedPac study of payment for cardio-thoracic surgeons.
Sec. 345. Studies relating to vision impairments.
Sec. 346. Medicare health care quality demonstration programs.
Sec. 347. MedPac study on direct access to physical therapy services.
Sec. 348. Demonstration project for consumer-directed chronic outpatient services.
Sec. 349. Medicare care management performance demonstration.
Sec. 350. GAO study and report on the propagation of concierge care.
Sec. 351. Demonstration of coverage of chiropractic services under medicare.

TITLE IV—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

Sec. 401. Demonstration project to clarify the definition of homebound.
Sec. 402. Demonstration project for medical adult day-care services.
Sec. 403. Temporary suspension of oasis requirement for collection of data on non-medicare and non-medicaid patients.
Sec. 404. MedPac study on medicare margins of home health agencies.
Sec. 405. Coverage of religious nonmedical health care institution services furnished in the home.

Subtitle B—Graduate Medical Education

Sec. 411. Exception to initial residency period for geriatric residency or fellowship programs.
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TITLE V—ADMINISTRATIVE IMPROVEMENTS, REGULATORY REDUCTION, AND CONTRACTING REFORM

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Sec. 511. Increased flexibility in medicare administration.
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Subtitle C—Education and Outreach

Sec. 521. Provider education and technical assistance.
Sec. 522. Small provider technical assistance demonstration program.
Sec. 523. Medicare beneficiary ombudsman.
Sec. 524. Beneficiary outreach demonstration program.
Sec. 525. Inclusion of additional information in notices to beneficiaries about skilled nursing facility benefits.

Sec. 526. Information on medicare-certified skilled nursing facilities in hospital discharge plans.

Subtitle D—Appeals and Recovery

Sec. 531. Transfer of responsibility for medicare appeals.
Sec. 532. Process for expedited access to review.
Sec. 533. Revisions to medicare appeals process.
Sec. 534. Prepayment review.
Sec. 535. Recovery of overpayments.
Sec. 536. Provider enrollment process; right of appeal.
Sec. 537. Process for correction of minor errors and omissions without pursuing appeals process.
Sec. 538. Prior determination process for certain items and services; advance beneficiary notices.
Sec. 539. Appeals by providers when there is no other party available.
Sec. 540. Revisions to appeals timeframes and amounts.
Sec. 540A. Mediation process for local coverage determinations.

Subtitle E—Miscellaneous Provisions

Sec. 541. Policy development regarding evaluation and management (E & M) documentation guidelines.
Sec. 542. Improvement in oversight of technology and coverage.
Sec. 543. Treatment of hospitals for certain services under medicare secondary payor (MSP) provisions.
Sec. 544. EMTALA improvements.
Sec. 545. Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group.
Sec. 546. Authorizing use of arrangements to provide core hospice services in certain circumstances.
Sec. 547. Application of osha bloodborne pathogens standard to certain hospitals.
Sec. 548. Bipa-related technical amendments and corrections.
Sec. 549. Conforming authority to waive a program exclusion.
Sec. 550. Treatment of certain dental claims.
Sec. 551. Furnishing hospitals with information to compute DSH formula.
Sec. 552. Revisions to reassignment provisions.
Sec. 553. Other provisions.

TITLE VI—MEDICAID AND MISCELLANEOUS PROVISIONS

Subtitle A—Medicaid Provisions

Sec. 601. Medicaid disproportionate share hospital (DSH) payments.
Sec. 602. Clarification of inclusion of inpatient drug prices charged to certain public hospitals in the best price exemptions for the medicaid drug rebate program.
Sec. 603. Extension of moratorium.

Subtitle B—Miscellaneous Provisions

Sec. 611. Federal reimbursement of emergency health services furnished to undocumented aliens.
Sec. 612. Commission on Systemic Interoperability.
Sec. 613. Research on outcomes of health care items and services.
Sec. 614. Health care that works for all Americans: Citizens Health Care Working Group.
Sec. 615. Funding start-up administrative costs for medicare reform.
Sec. 616. Health care infrastructure improvement program.

TITLE I—RURAL PROVISIONS

Subtitle A—Provisions Relating to Part A Only

SEC. 101. EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

(a) In General.—Section 1886(d)(3)(A)(iv) (42 U.S.C. 1395ww(d)(3)(A)(iv)) is amended—

(1) by striking "(iv) For discharges" and inserting "(iv)(I) Subject to subclause (II), for discharges"; and

(2) by adding at the end the following new subclause:

"(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.".

(b) Conforming Amendments.—

(1) Computing DRG-specific rates.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking "IN DIFFERENT AREAS";

(B) in the matter preceding clause (i), by striking ", each of";

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting "for fiscal years before fiscal year 2004," before "for hospitals"; and

(ii) in subclause (II), by striking "and" after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting "for fiscal years before fiscal year 2004," before "for hospitals"; and

(ii) in subclause (II), by striking the period at the end and inserting "; and"; and

(E) by adding at the end the following new clause:

"(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

"(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

"(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.".

(2) Technical conforming sunset.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by inserting ", for fiscal years before fiscal year 1997," before "a regional adjusted DRG prospective payment rate"; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting ", for fiscal years before fiscal year 1997," before "a regional DRG prospective payment rate for each region,".

(3) Additional technical amendment.—Section 1886(d)(3)(A)(iii) (42 U.S.C. 1395ww(d)(3)(A)(iii)) is amended by striking "in an other urban area" and inserting "in an urban area".

(c) Equalizing Urban and Rural Standardized Payment Amounts Under the Medicare Inpatient Hospital Prospective Payment System for Hospitals in Puerto Rico.—

(1) In general.—Section 1886(d)(9)(A) (42 U.S.C. 1395ww(d)(9)(A)), as amended by section 204, is amended—

(A) in clause (i), by striking "and" after the comma at the end; and

(B) by striking clause (ii) and inserting the following new clause:

"(ii) the applicable Federal percentage (specified in subparagraph (E)) of—

"(I) for discharges beginning in a fiscal year beginning on or after October 1, 1997, and before October 1, 2003, the discharge-weighted average of—

"(aa) the national adjusted DRG prospective payment rate (determined under paragraph (3)(D)) for hospitals located in a large urban area,

"(bb) such rate for hospitals located in other urban areas, and

"(cc) such rate for hospitals located in a rural area,

for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels; and

"(II) for discharges in a fiscal year beginning on or after October 1, 2003, the national DRG prospective payment rate determined under paragraph (3)(D)(iii) for hospitals located in any area for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels.

(2) Application of Puerto Rico standardized amount based on large urban areas.—The authority of the Secretary referred to in paragraph (1) shall apply with respect to the amendments made by subsection (c) (2) of this section in the same manner as that authority applies with respect to the extension of provisions equalizing urban and rural standardized inpatient hospital payments under subsection (a) of such section 402, except that any reference in subsection (b)(2)(A) of such section 402 is deemed to be a reference to April 1, 2004.

SEC. 102 ENHANCED DISPROPORTIONATE SHARE HOSPITAL (DSH) TREATMENT FOR RURAL HOSPITALS AND URBAN HOSPITALS WITH FEWER THAN 100 BEDS.

(a) Doubling the Cap.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended by adding at the end the following new clause:

"(xiv)(I) In the case of discharges occurring on or after April 1, 2004, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subclause (I)) or under clause (viii), (x), (xi), (xii), or (xiii), the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

"(II) Under subclause (I,) the disproportionate share adjustment percentage shall not exceed 12 percent for a hospital that is not classified as a rural referral center under subparagraph (C).".

(b) Conforming Amendments.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended—

(1) in paragraph (5)(F)—

(A) in each of subclauses (II), (III), (IV), (V), and (VI) of clause (iv), by inserting "subject to clause (xiv) and" before "for discharges occurring";

(B) in clause (viii), by striking "The Formula" and inserting "Subject to clause (xiv), the formula"; and

As used in this section, the term 'subsection (d) Puerto Rico hospital' means a hospital that is located in Puerto Rico and that would be a subsection (d) hospital (as defined in paragraph (1)(B)) if it were located in one of the 50 States.".

(2) Application of Puerto Rico standardized amount based on large urban areas.—

Section 1886(d)(9)(C) (42 U.S.C. 1395ww(d)(9)(C)) is amended—

(A) in clause (i)—

(i) by striking "(i) The Secretary" and inserting "(i)(I) For discharges in a fiscal year after fiscal year 1988 and before fiscal year 2004, the Secretary"; and

(ii) by adding at the end the following new subclause:

"(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute an average standardized amount for hospitals located in any area of Puerto Rico that is equal to the average standardized amount computed under subclause (I) for fiscal year 2003 for hospitals in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B) for the fiscal year involved.";

(B) in clause (ii), by inserting "(or for fiscal year 2004 and thereafter, the average standardized amount)" after "each of the average standardized amounts"; and

(C) in clause (iii)(I), by striking "for hospitals located in an urban or rural area, respectively".

(d) Implementation.—

(1) In general.—The amendments made by subsections (a), (b), and (c)(1) of this section shall have no effect on the authority of the Secretary, under subsection (b)(2) of section 402 of Public Law 108–89, to delay implementation of the extension of provisions equalizing urban and rural standardized inpatient hospital payments under subsection (a) of such section 402.

(2) Application of puerto rico standardized amount based on large urban areas.—The authority of the Secretary referred to in paragraph (1) shall apply with respect to the amendments made by subsection (c)(2) of this section in the same manner as that authority applies with respect to the extension of provisions equalizing urban and rural standardized inpatient hospital payments under subsection (a) of such section 402, except that any reference in subsection (b)(2)(A) of such section 402 is deemed to be a reference to April 1, 2004.

SEC. 102. ENHANCED DISPROPORTIONATE SHARE HOSPITAL (DSH) TREATMENT FOR RURAL HOSPITALS AND URBAN HOSPITALS WITH FEWER THAN 100 BEDS.

(a) Doubling the Cap.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended by adding at the end the following new clause:

"(xiv)(I) In the case of discharges occurring on or after April 1, 2004, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subclause (I)) or under clause (viii), (x), (xi), (xii), or (xiii), the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

"(II) Under subclause (I), the disproportionate share adjustment percentage shall not exceed 12 percent for a hospital that is not classified as a rural referral center under subparagraph (C).".

(b) Conforming Amendments.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended—

(1) in paragraph (5)(F)—

(A) in each of subclauses (II), (III), (IV), (V), and (VI) of clause (iv), by inserting "subject to clause (xiv) and" before "for discharges occurring";

(B) in clause (viii), by striking "The formula" and inserting "Subject to clause (xiv), the formula"; and

(C) in each of clauses (x), (xi), (xii), and (xiii), by striking "For purposes" and inserting "Subject to clause (xiv), for purposes"; and

(2) in paragraph (2)(C)(iv)—

(A) by striking "or" before "the enactment of section 303"; and

(B) by inserting before the period at the end the following: ", or the enactment of section 402(a)(1) of the Medicare Provider Restoration Act of 2003".

SEC. 103. ADJUSTMENT TO THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM WAGE INDEX TO REVISE THE LABOR-RELATED SHARE OF SUCH INDEX.

(a) Adjustment.—

(1) In general.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(A) by striking "WAGE LEVELS.—The Secretary" and inserting "WAGE LEVELS.—

"(i) In general.—Except as provided in clause (ii), the Secretary"; and

(B) by adding at the end the following new clause:

"(ii) Alternative proportion to be adjusted beginning in fiscal year 2005.—For discharges occurring on or after October 1, 2004, the Secretary shall substitute '62 percent' for the proportion described in the first sentence of clause (i), unless the application of this clause would result in lower payments to a hospital than would otherwise be made.".

(2) Waiving budget neutrality.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as amended by subsection (a), is amended by adding at the end of clause (i) the following new sentence: "The Secretary shall apply the previous sentence for any period as if the amendments made by section 103(a)(1) of the Medicare Provider Restoration Act of 2003 had not been enacted.".

(b) Application to Puerto Rico Hospitals.—Section 1886(d)(9)(C)(iv) (42 U.S.C. 1395ww(d)(9)(C)(iv)) is amended—

(1) by inserting "(I)" after "(iv)";

(2) by striking "paragraph (3)(E)" and inserting "paragraph (3)(E)(i)"; and

(3) by adding at the end the following new subclause:

"(II) For discharges occurring on or after October 1, 2004, the Secretary shall substitute '62 percent' for the proportion described in the first sentence of clause (i), unless the application of this subclause would result in lower payments to a hospital than would otherwise be made.".

SEC. 104. MORE FREQUENT UPDATE IN WEIGHTS USED IN HOSPITAL MARKET BASKET.

(a) More Frequent Updates in Weights.—After revising the weights used in the hospital market basket under section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most current data available, the Secretary shall establish a frequency for revising such weights, including the labor share, in such market basket to reflect the most current data available more frequently than once every 5 years.

(b) Incorporation of Explanation in Rulemaking.—The Secretary shall include in the publication of the final rule for payment for inpatient hospital services under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) for fiscal year 2006, an explanation of the reasons for, and options considered, in determining frequency established under subsection (a).

SEC. 105. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

(a) Increase in Payment Amounts.—

(1) In general.—Sections 1814(l), 1834(g)(1), and 1883(a)(3) (42 U.S.C. 1395f(l), 1395m(g)(1), and 1395tt(a)(3)) are each amended by inserting "equal to 101 percent of" before "the reasonable costs".

(2) Effective date.—The amendments made by paragraph (1) shall apply to payments for services furnished during cost reporting periods beginning on or after January 1, 2004.

(b) Coverage of Costs for Certain Emergency Room On-Call Providers.—

(1) In general.—Section 1834(g)(5) (42 U.S.C. 1395m(g)(5)) is amended—

(A) in the heading—

(i) by inserting "CERTAIN" before "EMERGENCY"; and

(ii) by striking "PHYSICIANS" and inserting "PROVIDERS";

(B) by striking "emergency room physicians who are on-call (as defined by the Secretary)" and inserting "physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services"; and

(C) by striking "physicians' services" and inserting "services covered under this title".

(2) Effective date.—The amendments made by paragraph (1) shall apply with respect to costs incurred for services furnished on or after January 1, 2005.

(c) Authorization of Periodic Interim Payment (PIP).—

(1) In general.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(A) in the matter before subparagraph (A), by inserting ", in the cases described in subparagraphs (A) through (D)" after "1986";

(B) by striking "and" at the end of subparagraph (C);

(C) by adding "and" at the end of subparagraph (D); and

(D) by inserting after subparagraph (D) the following new subparagraph:

"(E) inpatient critical access hospital services;".

(2) Development of alternative timing methods of periodic interim payments.—With respect to periodic interim payments to critical access hospitals for inpatient critical access hospital services under section 1815(e)(2)(E) of the Social Security Act, as added by paragraph (1), the Secretary shall develop alternative methods for the timing of such payments.

(3) Authorization of pip.—The amendments made by paragraph (1) shall apply to payments made on or after July 1, 2004.

(d) Condition for Application of Special Professional Service Payment Adjustment.—

(1) In general.—Section 1834(g)(2) (42 U.S.C. 1395m(g)(2)) is amended by adding after and below subparagraph (B) the following:

"The Secretary may not require, as a condition for applying subparagraph (B) with respect to a critical access hospital, that each physician or other practitioner providing professional services in the hospital must assign billing rights with respect to such services, except that such subparagraph shall not apply to those physicians and practitioners who have not assigned such billing rights.".

(2) Effective date.—

(A) In general.—Except as provided in subparagraph (B), the amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after July 1, 2004.

(B) Rule of application.—In the case of a critical access hospital that made an election under section 1834(g)(2) of the Social Security Act (42 U.S.C. 1395m(g)(2)) before November 1, 2003, the amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after July 1, 2001.

(e) REVISION OF BED LIMITATION FOR HOSPITALS.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i–4(c)(2)(B)(iii)) is amended by striking "15 (or, in the case of a facility under an agreement described in subsection (f), 25)" and inserting "25".

(2) CONFORMING AMENDMENT.—Section 1820(f) (42 U.S.C. 1395i–4(f)) is amended by striking "and the number of beds used at any time for acute care inpatient services does not exceed 15 beds".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to designations made before, on, or after January 1, 2004, but any election made pursuant to regulations promulgated to carry out such amendments shall only apply prospectively.

(f) PROVISIONS RELATING TO FLEX GRANTS.—

(1) ADDITIONAL 4-YEAR PERIOD OF FUNDING.—Section 1820(j) (42 U.S.C. 1395i–4(j)) is amended by inserting before the period at the end the following: ", and for making grants to all States under paragraphs (1) and (2) of subsection (g), $35,000,000 in each of fiscal years 2005 through 2008".

(2) ADDITIONAL REQUIREMENTS AND ADMINISTRATION.—Section 1820(g) (42 U.S.C. 1395i–4(g)) is amended by adding at the end the following new paragraphs:

"(4) ADDITIONAL REQUIREMENTS WITH RESPECT TO FLEX GRANTS.—With respect to grants awarded under paragraph (1) or (2) from funds appropriated for fiscal year 2005 and subsequent fiscal years—

"(A) CONSULTATION WITH THE STATE HOSPITAL ASSOCIATION AND RURAL HOSPITALS ON THE MOST APPROPRIATE WAYS TO USE GRANTS.—A State shall consult with the hospital association of such State and rural hospitals located in such State on the most appropriate ways to use the funds under such grant.

"(B) LIMITATION ON USE OF GRANT FUNDS FOR ADMINISTRATIVE EXPENSES.—A State may not expend more than the lesser of—

"(i) 15 percent of the amount of the grant for administrative expenses; or

"(ii) the State's federally negotiated indirect rate for administering the grant.

"(5) USE OF FUNDS FOR FEDERAL ADMINISTRATIVE EXPENSES.—Of the total amount appropriated for grants under paragraphs (1) and (2) for a fiscal year (beginning with fiscal year 2005), up to 5 percent of such amount shall be available to the Health Resources and Services Administration for purposes of administering such grants.".

(g) AUTHORITY TO ESTABLISH PSYCHIATRIC AND REHABILITATION DISTINCT PART UNITS.—

(1) IN GENERAL.—Section 1820(c)(2) (42 U.S.C. 1395i–4(c)(2)) is amended by adding at the end the following:

"(E) AUTHORITY TO ESTABLISH PSYCHIATRIC AND REHABILITATION DISTINCT PART UNITS.—

"(i) IN GENERAL.—Subject to the succeeding provisions of this subparagraph, a critical access hospital may establish—

"(I) a psychiatric unit of the hospital that is a distinct part of the hospital; and

"(II) a rehabilitation unit of the hospital that is a distinct part of the hospital,

if the distinct part meets the requirements (including conditions of participation) that would otherwise apply to the distinct part if the distinct part were established by a subsection (d) hospital in accordance with the matter following clause (v) of section 1886(d)(1)(B), including any regulations adopted by the Secretary under such section.

"(ii) LIMITATION ON NUMBER OF BEDS.—The total number of beds that may be established under clause (i) for a distinct part unit may not exceed 10.

"(iii) EXCLUSION OF BEDS FROM BED COUNT.—In determining the number of beds of a critical access hospital for purposes of applying the bed limitations referred to in subparagraph (B)(iii) and subsection (f), the Secretary shall not take into account any bed established under clause (i).

"(iv) EFFECT OF FAILURE TO MEET REQUIREMENTS.—If a psychiatric or rehabilitation unit established under clause (i) does not meet the requirements described in such clause with respect to a cost reporting period, no payment may be made under this title to the hospital for services furnished in such unit during such period. Payment to the hospital for services furnished in the unit may resume only after the hospital has demonstrated to the Secretary that the unit meets such requirements.".

(2) PAYMENT ON A PROSPECTIVE PAYMENT BASIS.—Section 1814(l) (42 U.S.C. 1395f(l)) is amended—

(A) by striking "(l) The amount" and inserting "(l)(1) Except as provided in paragraph (2), the amount"; and

(B) by adding at the end the following new paragraph:

"(2) In the case of a distinct part psychiatric or rehabilitation unit of a critical access hospital described in section 1820(c)(2)(E), the amount of payment for inpatient critical access hospital services of such unit shall be equal to the amount of the payment that would otherwise be made if such services were inpatient hospital services of a distinct part psychiatric or rehabilitation unit, respectively, described in the matter following clause (v) of section 1886(d)(1)(B).".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to cost reporting periods beginning on or after October 1, 2004.

(h) WAIVER AUTHORITY.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(i)(II) (42 U.S.C. 1395i–4(c)(2)(B)(i)(II)) is amended by inserting "before January 1, 2006," after "is certified".

(2) GRANDFATHERING WAIVER AUTHORITY FOR CERTAIN FACILITIES.—Section 1820(h) (42 U.S.C. 1395i–4(h)) is amended—

(A) in the heading preceding paragraph (1), by striking "OF CERTAIN FACILITIES" and inserting "PROVISIONS"; and

(B) by adding at the end the following new paragraph:

"(3) STATE AUTHORITY TO WAIVE 35-MILE RULE.—In the case of a facility that was designated as a critical access hospital before January 1, 2006, and was certified by the State as being a necessary provider of health care services to residents in the area under subsection (c)(2)(B)(i)(II), as in effect before such date, the authority under such subsection with respect to any redesignation of such facility shall continue to apply notwithstanding the amendment made by section 105(h)(1) of the Medicare Provider Restoration Act of 2003.".

SEC. 106. MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

(a) IN GENERAL.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following new paragraph:

"(12) PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.—

"(A) IN GENERAL.—In addition to any payments calculated under this section for a subsection (d) hospital, for discharges occurring during a fiscal year (beginning with fiscal year 2005), the Secretary shall provide for an additional payment amount to each low-volume hospital (as defined in subparagraph (C)(i)) for discharges occurring during that fiscal year that is equal to the applicable percentage increase (determined under subparagraph (B) for the hospital involved) in the amount paid to such hospital under this section for such discharges (determined without regard to this paragraph).

"(B) APPLICABLE PERCENTAGE INCREASE.—The Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) as follows:

"(i) The Secretary shall determine the empirical relationship for subsection (d) hospitals between the standardized cost-per-case for such hospitals and the total number of discharges of such hospitals and the amount of the additional incremental costs (if any) that are associated with such number of discharges.

"(ii) The applicable percentage increase shall be determined based upon such relationship in a manner that reflects, based upon the number of such discharges for a subsection (d) hospital, such additional incremental costs.

"(iii) In no case shall the applicable percentage increase exceed 25 percent.

"(C) DEFINITIONS.—

"(i) LOW-VOLUME HOSPITAL.—For purposes of this paragraph, the term 'low-volume hospital' means, for a fiscal year, a subsection (d) hospital (as defined in paragraph (1)(B)) that the Secretary determines is located more than 25 road miles from another subsection (d) hospital and has less than 800 discharges during the fiscal year.

"(ii) DISCHARGE.—For purposes of subparagraph (B) and clause (i), the term 'discharge' means an inpatient acute care discharge of an individual regardless of whether the individual is entitled to benefits under part A.".

(b) JUDICIAL REVIEW.—Section 1886(d)(7)(A) (42 U.S.C. 1395ww(d)(7)(A)) is amended by inserting after "to subsection (e)(1)" the following: "or the determination of the applicable percentage increase under paragraph (12)(A)(ii)".

SEC. 107. TREATMENT OF MISSING COST REPORTING PERIODS FOR SOLE COMMUNITY HOSPITALS.

(a) IN GENERAL.—Section 1886(b)(3)(I) (42 U.S.C. 1395ww(b)(3)(I)) is amended by adding at the end the following new clause:

"(iii) In no case shall a hospital be denied treatment as a sole community hospital or payment (on the basis of a target rate as such as a hospital) because data are unavailable for any cost reporting period due to changes in ownership, changes in fiscal intermediaries, or other extraordinary circumstances, so long as data for at least one applicable base cost reporting period is available.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to cost reporting periods beginning on or after January 1, 2004.

SEC. 108. RECOGNITION OF ATTENDING NURSE PRACTITIONERS AS ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS.

(a) IN GENERAL.—Section 1861(dd)(3)(B) (42 U.S.C. 1395x(dd)(3)(B)) is amended by inserting "or nurse practitioner (as defined in subsection (aa)(5))" after "the physician (as defined in subsection (r)(1))".

(b) CLARIFICATION OF HOSPICE ROLE OF NURSE PRACTITIONERS.—Section 1814(a)(7)(A)(i)(I) (42 U.S.C. 1395f(a)(7)(A) (i)(I)) is amended by inserting "(which for purposes of this subparagraph does not include a nurse practitioner)" after "attending physician (as defined in section 1861(dd)(3)(B))".

SEC. 109. RURAL HOSPICE DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary shall conduct a demonstration project for the delivery of hospice care to medicare beneficiaries in rural areas. Under the project medicare beneficiaries who are unable to receive hospice care in the facility for lack of an appropriate caregiver are provided such care in a facility of 20 or fewer beds which offers, within its walls, the full range of services provided by hospice programs under section 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)).

(b) SCOPE OF PROJECT.—The Secretary shall conduct the project under this section with respect to no more than 3 hospice programs over a period of not longer than 5 years each.

(c) COMPLIANCE WITH CONDITIONS.—Under the demonstration project—

(1) the hospice program shall comply with otherwise applicable requirements, except that it shall not be required to offer services outside of the home or to meet the requirements of section 1861(dd)(2)(A)(iii) of the Social Security Act; and

(2) payments for hospice care shall be made at the rates otherwise applicable to such care under title XVIII of such Act.

The Secretary may require the program to comply with such additional quality assurance standards for its provision of services in its facility as the Secretary deems appropriate.

(d) REPORT.—Upon completion of the project, the Secretary shall submit a report to Congress on the project and shall include in the report recommendations regarding extension of such project to hospice programs serving rural areas.

SEC. 110. EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES FROM THE PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITIES.

(a) IN GENERAL.—Section 1888(e)(2)(A) (42 U.S.C. 1395yy(e)(2)(A)) is amended—

(1) in clause (i)(II), by striking "clauses (ii) and (iii)" and inserting "clauses (ii), (iii), and (iv)"; and

(2) by adding at the end the following new clause:

"(iv) EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—Services described in this clause are—

"(I) rural health clinic services (as defined in paragraph (1) of section 1861(aa)); and

"(II) Federally qualified health center services (as defined in paragraph (3) of such section);

that would be described in clause (ii) if such services were furnished by an individual not affiliated with a rural health clinic or a Federally qualified health center.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished on or after January 1, 2005.

SEC. 110A. RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT OF RURAL COMMUNITY HOSPITAL (RCH) DEMONSTRATION PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program to test the feasibility and advisability of the establishment of rural community hospitals (as defined in subsection (f)(1)) to furnish covered inpatient hospital services (as defined in subsection (f)(2)) to medicare beneficiaries.

(2) DEMONSTRATION AREAS.—The program shall be conducted in rural areas selected by the Secretary in States with low population densities, as determined by the Secretary.

(3) APPLICATION.—Each rural community hospital that is located in a demonstration area selected under paragraph (2) that desires to participate in the demonstration program under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(4) SELECTION OF HOSPITALS.—The Secretary shall select from among rural community hospitals submitting applications under paragraph (3) not more than 15 of such hospitals to participate in the demonstration program under this section.

(5) DURATION.—The Secretary shall conduct the demonstration program under this section for a 5-year period.

(6) IMPLEMENTATION.—The Secretary shall implement the demonstration program not later than January 1, 2005, but may not implement the program before October 1, 2004.

(b) PAYMENT.—

(1) IN GENERAL.—The amount of payment under the demonstration program for covered inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is—

(A) for discharges occurring in the first cost reporting period beginning on or after the implementation of the demonstration program, the reasonable costs of providing such services; and

(B) for discharges occurring in a subsequent cost reporting period under the demonstration program, the lesser of—

(i) the reasonable costs of providing such services in the cost reporting period involved; or

(ii) the target amount (as defined in paragraph (2), applicable to the cost reporting period involved.

(2) TARGET AMOUNT.—For purposes of paragraph (1)(B)(ii), the term "target amount" means, with respect to a rural community hospital for a particular 12-month cost reporting period—

(A) in the case of the second such reporting period for which this subsection is in effect, the reasonable costs of providing such covered inpatient hospital services as determined under paragraph (1)(A), and

(B) in the case of a later reporting period, the target amount for the preceding 12-month cost reporting period,

increased by the applicable percentage increase (under clause (i) of section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B))) in the market basket percentage increase (as defined in clause (iii) of such section) for that particular cost reporting period.

(c) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(d) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(e) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(f) DEFINITIONS.—In this section:

(1) RURAL COMMUNITY HOSPITAL DEFINED.—

(A) IN GENERAL.—The term "rural community hospital" means a hospital (as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e))) that—

(i) is located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) or treated as being so located pursuant to section 1886(d)(8)(E) of such Act (42 U.S.C. 1395ww(d)(8)(E));

(ii) subject to paragraph (2), has fewer than 51 acute care inpatient beds, as reported in its most recent cost report;

(iii) makes available 24-hour emergency care services; and

(iv) is not eligible for designation, or has not been designated, as a critical access hospital under section 1820.

(B) TREATMENT OF PSYCHIATRIC AND REHABILITATION UNITS.—For purposes of paragraph (1)(B), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital shall not be counted.

(2) COVERED INPATIENT HOSPITAL SERVICES.—The term "covered inpatient hospital services" means inpatient hospital services, and includes extended care services furnished under an agreement under section 1883 of the Social Security Act (42 U.S.C. 1395tt).

Subtitle B—Provisions Relating to Part B Only

SEC. 111. 2-YEAR EXTENSION OF HOLD HARMLESS PROVISIONS FOR SMALL RURAL HOSPITALS AND SOLE COMMUNITY HOSPITALS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) HOLD HARMLESS PROVISIONS.—

(1) IN GENERAL.—Section 1833(t)(7)(D)(i) (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(A) in the heading, by striking "SMALL" and inserting "CERTAIN";

(B) by inserting "or a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) located in a rural area" after "100 beds"; and

(C) by striking "2004" and inserting "2006".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1)(B) shall apply with respect to cost reporting periods beginning on and after January 1, 2004.

(b) STUDY; AUTHORIZATION OF ADJUSTMENT.—Section 1833(t) (42 U.S.C. 1395l(t)) is amended—

(1) by redesignating paragraph (13) as paragraph (16); and

(2) by inserting after paragraph (12) the following new paragraph:

"(13) AUTHORIZATION OF ADJUSTMENT FOR RURAL HOSPITALS.—

"(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals located in rural areas by ambulatory payment classification groups (APCs) exceed those costs incurred by hospitals located in urban areas.

"(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals located in rural areas exceed those costs incurred by hospitals located in urban areas, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs by January 1, 2006.".

SEC. 112. ESTABLISHMENT OF FLOOR ON WORK GEOGRAPHIC ADJUSTMENT.

Section 1848(e)(1) (42 U.S.C. 1395w–4(e)(1)) is amended—

(1) in subparagraph (A), by striking "subparagraphs (B) and (C)" and inserting "subparagraphs (B), (C), and (E)"; and

(2) by adding at the end the following new subparagraph:

"(E) FLOOR AT 1.0 ON WORK GEOGRAPHIC INDEX.—After calculating the work geographic index in subparagraph (A)(iii), for purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2007, the Secretary shall increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00.".

SEC. 113. MEDICARE INCENTIVE PAYMENT PROGRAM IMPROVEMENTS FOR PHYSICIAN SCARCITY.

(a) ADDITIONAL INCENTIVE PAYMENT FOR CERTAIN PHYSICIAN SCARCITY AREAS.—Section 1833 (42 U.S.C. 13951) is amended by adding at the end the following new subsection:

"(u) INCENTIVE PAYMENTS FOR PHYSICIAN SCARCITY AREAS.—

"(1) IN GENERAL.—In the case of physicians' services furnished on or after January 1, 2005, and before January 1, 2008—

"(A) by a primary care physician in a primary care scarcity county (identified under paragraph (4)); or

"(B) by a physician who is not a primary care physician in a specialist care scarcity county (as so identified),

in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid an amount equal to 5 percent of the payment amount for the service under this part.

"(2) DETERMINATION OF RATIOS OF PHYSICIANS TO MEDICARE BENEFICIARIES IN AREA.—Based upon available data, the Secretary shall establish for each county or equivalent area in the United States, the following:

"(A) NUMBER OF PHYSICIANS PRACTICING IN THE AREA.—The number of physicians who furnish physicians' services in the active practice of medicine or osteopathy in that county or area, other than physicians whose practice is exclusively for the Federal Government, physicians who are retired, or physicians who only provide administrative services. Of such number, the number of such physicians who are—

"(i) primary care physicians; or

"(ii) physicians who are not primary care physicians.

"(B) NUMBER OF MEDICARE BENEFICIARIES RESIDING IN THE AREA.—The number of individuals who are residing in the county and are entitled to benefits under part A or enrolled under this part, or both (in this subsection referred to as 'individuals').

"(C) DETERMINATION OF RATIOS.—

"(i) PRIMARY CARE RATIO.—The ratio (in this paragraph referred to as the 'primary care ratio') of the number of primary care physicians (determined under subparagraph (A)(i)), to the number of individuals determined under subparagraph (B).

"(ii) SPECIALIST CARE RATIO.—The ratio (in this paragraph referred to as the 'specialist care ratio') of the number of other physicians (determined under subparagraph (A)(ii)), to the number of individuals determined under subparagraph (B).

"(3) RANKING OF COUNTIES.—The Secretary shall rank each such county or area based separately on its primary care ratio and its specialist care ratio.

"(4) IDENTIFICATION OF COUNTIES.—

"(A) IN GENERAL.—The Secretary shall identify—

"(i) those counties and areas (in this paragraph referred to as 'primary care scarcity counties') with the lowest primary care ratios that represent, if each such county or area were weighted by the number of individuals determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the individuals determined under such paragraph; and

"(ii) those counties and areas (in this subsection referred to as 'specialist care scarcity counties') with the lowest specialist care ratios that represent, if each such county or area were weighted by the number of individuals determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the individuals determined under such paragraph.

"(B) PERIODIC REVISIONS.—The Secretary shall periodically revise the counties or areas identified in subparagraph (A) (but not less often than once every three years) unless the Secretary determines that there is no new data available on the number of physicians practicing in the county or area or the number of individuals residing in the county or area, as identified in paragraph (2).

"(C) IDENTIFICATION OF COUNTIES WHERE SERVICE IS FURNISHED.—For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code is in a scarcity county identified in subparagraph (A) or revised in subparagraph (B).

"(D) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting—

"(i) the identification of a county or area;

"(ii) the assignment of a specialty of any physician under this paragraph;

"(iii) the assignment of a physician to a county under paragraph (2); or

"(iv) the assignment of a postal ZIP Code to a county or other area under this subsection.

"(5) RURAL CENSUS TRACTS.—To the extent feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)), as an equivalent area for purposes of qualifying as a primary care scarcity county or specialist care scarcity county under this subsection.

"(6) PHYSICIAN DEFINED.—For purposes of this paragraph, the term 'physician' means a physician described in section 1861(r)(1) and the term 'primary care physician' means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

"(7) PUBLICATION OF LIST OF COUNTIES; POSTING ON WEBSITE.—With respect to a year for which a county or area is identified or revised under paragraph (4), the Secretary shall identify such counties or areas as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the applicable year. The Secretary shall post the list of counties identified or revised under paragraph (4) on the Internet website of the Centers for Medicare & Medicaid Services.".

(b) IMPROVEMENT TO MEDICARE INCENTIVE PAYMENT PROGRAM.—

(1) IN GENERAL.—Section 1833(m) (42 U.S.C. 13951(m)) is amended—

(A) by inserting "(1)" after "(m)";

(B) in paragraph (1), as designated by subparagraph (A)—

(i) by inserting "in a year" after "In the case of physicians' services furnished"; and

(ii) by inserting "as identified by the Secretary prior to the beginning of such year" after "as a health professional shortage area"; and

(C) by adding at the end the following new paragraphs:

"(2) For each health professional shortage area identified in paragraph (1) that consists of an entire county, the Secretary shall provide for the additional payment under paragraph (1) without any requirement on the physician to identify the health professional shortage area involved. The Secretary may implement the previous sentence using the method specified in subsection (u)(4)(C).

"(3) The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the health professional shortage areas identified in paragraph (1) that consist of a partial county to facilitate the additional payment under paragraph (1) in such areas.

"(4) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, respecting—

"(A) the identification of a county or area;

"(B) the assignment of a specialty of any physician under this paragraph;

"(C) the assignment of a physician to a county under this subsection; or

"(D) the assignment of a postal zip code to a county or other area under this subsection.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to physicians' services furnished on or after January 1, 2005.

(c) GAO STUDY OF GEOGRAPHIC DIFFERENCES IN PAYMENTS FOR PHYSICIANS' SERVICES.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study of differences in payment amounts under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians' services in different geographic areas. Such study shall include—

(A) an assessment of the validity of the geographic adjustment factors used for each component of the fee schedule;

(B) an evaluation of the measures used for such adjustment, including the frequency of revisions;

(C) an evaluation of the methods used to determine professional liability insurance costs used in computing the malpractice component, including a review of increases in professional liability insurance premiums and variation in such increases by State and physician specialty and methods used to update the geographic cost of practice index and relative weights for the malpractice component; and

(D) an evaluation of the effect of the adjustment to the physician work geographic index under section 1848(e)(1)(E) of the Social Security Act, as added by section 112, on physician location and retention in areas affected by such adjustment, taking into account—

(i) differences in recruitment costs and retention rates for physicians, including specialists, between large urban areas and other areas; and

(ii) the mobility of physicians, including specialists, over the last decade.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under

paragraph (1). The report shall include recommendations regarding the use of more current data in computing geographic cost of practice indices as well as the use of data directly representative of physicians' costs (rather than proxy measures of such costs).

SEC. 114. PAYMENT FOR RURAL AND URBAN AMBULANCE SERVICES.

(a) Phase-In Providing Floor Using Blend of Fee Schedule and Regional Fee Schedules.—Section 1834(l) (42 U.S.C. 1395m(l)) is amended—

(1) in paragraph (2)(E), by inserting "consistent with paragraph (11)" after "in an efficient and fair manner"; and

(2) by redesignating paragraph (8), as added by section 221(a) of BIPA (114 Stat. 2763A-486), as paragraph (9); and

(3) by adding at the end the following new paragraph:

"(10) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In carrying out the phase-in under paragraph (2)(E) for each level of ground service furnished in a year, the portion of the payment amount that is based on the fee schedule shall be the greater of the amount determined under such fee schedule (without regard to this paragraph) or the following blended rate of the fee schedule under paragraph (1) and of a regional fee schedule for the region involved:

"(A) For 2004 (for services furnished on or after July 1, 2004), the blended rate shall be based 20 percent on the fee schedule under paragraph (1) and 80 percent on the regional fee schedule.

"(B) For 2005, the blended rate shall be based 40 percent on the fee schedule under paragraph (1) and 60 percent on the regional fee schedule.

"(C) For 2006, the blended rate shall be based 60 percent on the fee schedule under paragraph (1) and 40 percent on the regional fee schedule.

"(D) For 2007, 2008, and 2009, the blended rate shall be based 80 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule.

"(E) For 2010 and each succeeding year, the blended rate shall be based 100 percent on the fee schedule under paragraph (1).

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the nine census divisions (referred to in section 1886(d)(2)) using the methodology (used in establishing the fee schedule under paragraph (1)) to calculate a regional conversion factor and a regional mileage payment rate and using the same payment adjustments and the same relative value units as used in the fee schedule under such paragraph.".

(b) Adjustment in Payment for Certain Long Trips.—Section 1834(l), as amended by subsection (a), is amended by adding at the end the following new paragraph:

"(11) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—In the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2009, regardless of where the transportation originates, the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by ¼ of the payment per mile otherwise applicable to miles in excess of 50 miles in such trip.".

(c) Improvement in Payments To Retain Emergency Capacity for Ambulance Services in Rural Areas.—

(1) In general.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by subsections (a) and (b), is amended by adding at the end the following new paragraph:

"(12) ASSISTANCE FOR RURAL PROVIDERS FURNISHING SERVICES IN LOW POPULATION DENSITY AREAS.—

"(A) IN GENERAL.—In the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2010, for which the transportation originates in a qualified rural area (identified under subparagraph (B)(iii)), the Secretary shall provide for a percent increase in the base rate of the fee schedule for a trip established under this subsection. In establishing such percent increase, the Secretary shall estimate the average cost per trip for such services (not taking into account mileage) in the lowest quartile as compared to the average cost per trip for such services (not taking into account mileage) in the highest quartile of all rural county populations.

"(B) IDENTIFICATION OF QUALIFIED RURAL AREAS.—

"(i) DETERMINATION OF POPULATION DENSITY IN AREA.—Based upon data from the United States decennial census for the year 2000, the Secretary shall determine, for each rural area, the population density for that area.

"(ii) RANKING OF AREAS.—The Secretary shall rank each such area based on such population density.

"(iii) IDENTIFICATION OF QUALIFIED RURAL AREAS.—The Secretary shall identify those areas (in subparagraph (A) referred to as 'qualified rural areas') with the lowest population densities that represent, if each such area were weighted by the population of such area (as used in computing such population densities), an aggregate total of 25 percent of the total of the population of all such areas.

"(iv) RURAL AREA.—For purposes of this paragraph, the term 'rural area' has the meaning given such term in section 1886(d)(2)(D). If feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725) as a rural area for purposes of this paragraph.

"(v) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of an area under this subparagraph.".

(2) Use of data.—In order to promptly implement section 1834(l)(12) of the Social Security Act, as added by paragraph (1), the Secretary may use data furnished by the Comptroller General of the United States.

(d) Temporary Increase for Ground Ambulance Services.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by subsections (a), (b), and (c), is amended by adding at the end the following new paragraph:

"(13) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—

"(A) IN GENERAL.—After computing the rates with respect to ground ambulance services under the other applicable provisions of this subsection, in the case of such services furnished on or after July 1, 2004, and before January 1, 2007, for which the transportation originates in—

"(i) a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section shall provide that the rate for the service otherwise established, after the application of any increase under paragraphs (11) and (12), shall be increased by 2 percent; and

"(ii) an area not described in clause (i), the fee schedule established under this subsection shall provide that the rate for the service otherwise established, after the application of any increase under paragraph (11), shall be increased by 1 percent.

"(B) APPLICATION OF INCREASED PAYMENTS AFTER 2006.—The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished after the period specified in such subparagraph.".

(e) Implementation.—The Secretary may implement the amendments made by this section, and revise the conversion factor applicable under section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)) for purposes of implementing such amendments, on an interim final basis, or by program instruction.

(f) GAO Report on Costs and Access.—Not later than December 31, 2005, the Comptroller General of the United States shall submit to Congress an initial report on how costs differ among the types of ambulance providers and on access, supply, and quality of ambulance services in those regions and States that have a reduction in payment under the medicare ambulance fee schedule (under section 1834(l) of the Social Security Act, as amended by this Act). Not later than December 31, 2007, the Comptroller General shall submit to Congress a final report on such access and supply.

(g) Technical Amendments.—(1) Section 221(c) of BIPA (114 Stat. 2763A-487) is amended by striking "subsection (b)(2)" and inserting "subsection (b)(3)".

(2) Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by moving subparagraph (U) 4 ems to the left.

SEC. 115. PROVIDING APPROPRIATE COVERAGE OF RURAL AIR AMBULANCE SERVICES.

(a) Coverage.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by subsections (a), (b), (c), and (d) of section 114, is amended by adding at the end the following new paragraph:

"(14) PROVIDING APPROPRIATE COVERAGE OF RURAL AIR AMBULANCE SERVICES.—

"(A) IN GENERAL.—The regulations described in section 1861(s)(7) shall provide, to the extent that any ambulance services (whether ground or air) may be covered under such section, that a rural air ambulance service (as defined in subparagraph (C)) is reimbursed under this subsection at the air ambulance rate if the air ambulance service—

"(i) is reasonable and necessary based on the health condition of the individual being transported at or immediately prior to the time of the transport; and

"(ii) complies with equipment and crew requirements established by the Secretary.

"(B) SATISFACTION OF REQUIREMENT OF MEDICALLY NECESSARY.—The requirement of subparagraph (A)(i) is deemed to be met for a rural air ambulance service if—

"(i) subject to subparagraph (D), such service is requested by a physician or other qualified medical personnel (as specified by the Secretary) who reasonably determines or certifies that the individual's condition is such that the time needed to transport the individual by land or the instability of transportation by land poses a threat to the individual's survival or seriously endangers the individual's health; or

"(ii) such service is furnished pursuant to a protocol that is established by a State or regional emergency medical service (EMS) agency and recognized or approved by the Secretary under which the use of an air ambulance is recommended, if such agency does not have an ownership interest in the entity furnishing such service.

"(C) RURAL AIR AMBULANCE SERVICE DEFINED.—For purposes of this paragraph, the term 'rural air ambulance service' means fixed wing and rotary wing air ambulance service in which the point of pick up of the individual occurs in a rural area (as defined in section 1886(d)(2)(D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

"(D) LIMITATION.—

"(i) IN GENERAL.—Subparagraph (B)(i) shall not apply if there is a financial or employment relationship between the person requesting the rural air ambulance service and the entity furnishing the ambulance service, or an entity under common ownership with the entity furnishing the air ambulance service, or a financial relationship between an immediate family member of such requester and such an entity.

"(ii) EXCEPTION.—Where a hospital and the entity furnishing rural air ambulance services are under common ownership, clause (i) shall not apply to remuneration (through employment or other relationship) by the hospital of the requester or immediate family member if the remuneration is for provider-based physician services furnished in a hospital (as described in section 1887) which are reimbursed under part A and the amount of the remuneration is unrelated directly or indirectly to the provision of rural air ambulance services.".

(b) CONFORMING AMENDMENT.—Section 1861(s)(7) (42 U.S.C. 1395x(s)(7)) is amended by inserting ", subject to section 1834(l)(14)," after "but".

(c) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 2005.

SEC. 116. TREATMENT OF CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL OUTPATIENTS IN CERTAIN RURAL AREAS.

(a) IN GENERAL.—Notwithstanding subsections (a), (b), and (h) of section 1833 of the Social Security Act (42 U.S.C. 1395l) and section 1834(d)(1) of such Act (42 U.S.C. 1395m(d)(1)), in the case of a clinical diagnostic laboratory test covered under part B of title XVIII of such Act that is furnished during a cost reporting period described in subsection (b) by a hospital with fewer than 50 beds that is located in a qualified rural area (identified under paragraph (12)(B)(iii) of section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)), as added by section 114(c)) as part of outpatient services of the hospital, the amount of payment for such test shall be 100 percent of the reasonable costs of the hospital in furnishing such test.

(b) APPLICATION.—A cost reporting period described in this subsection is a cost reporting period beginning during the 2-year period beginning on July 1, 2004.

(c) PROVISION AS PART OF OUTPATIENT HOSPITAL SERVICES.—For purposes of subsection (a), in determining whether clinical diagnostic laboratory services are furnished as part of outpatient services of a hospital, the Secretary shall apply the same rules that are used to determine whether clinical diagnostic laboratory services are furnished as an outpatient critical access hospital service under section 1834(g)(4) of the Social Security Act (42 U.S.C. 1395m(g)(4)).

SEC. 117. EXTENSION OF TELEMEDICINE DEMONSTRATION PROJECT.

Section 4207 of the Balanced Budget Act of 1997 (Public Law 105–33) is amended—

(1) in subsection (a)(4), by striking "4-year" and inserting "8-year"; and

(2) in subsection (d)(3), by striking "$30,000,000" and inserting "$60,000,000".

SEC. 118. REPORT ON DEMONSTRATION PROJECT PERMITTING SKILLED NURSING FACILITIES TO BE ORIGINATING TELEHEALTH SITES; AUTHORITY TO IMPLEMENT.

(a) EVALUATION.—The Secretary, acting through the Administrator of the Health Resources and Services Administration in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall evaluate demonstration projects conducted by the Secretary under which skilled nursing facilities (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)) are treated as originating sites for telehealth services.

(b) REPORT.—Not later than January 1, 2005, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a). Such report shall include recommendations on mechanisms to ensure that permitting a skilled nursing facility to serve as an originating site for the use of telehealth services or any other service delivered via a telecommunications system does not serve as a substitute for in-person visits furnished by a physician, or for in-person visits furnished by a physician assistant, nurse practitioner or clinical nurse specialist, as is otherwise required by the Secretary.

(c) AUTHORITY TO EXPAND ORIGINATING TELEHEALTH SITES TO INCLUDE SKILLED NURSING FACILITIES.—Insofar as the Secretary concludes in the report required under subsection (b) that is advisable to permit a skilled nursing facility to be an originating site for telehealth services under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)), and that the Secretary can establish the mechanisms to ensure such permission does not serve as a substitute for in-person visits furnished by a physician, or for in-person visits furnished by a physician assistant, nurse practitioner or clinical nurse specialist, the Secretary may deem a skilled nursing facility to be an originating site under paragraph (4)(C)(ii) of such section beginning on January 1, 2006.

Subtitle C—Provisions Relating to Parts A and B

SEC. 121. 1-YEAR INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) IN GENERAL.—With respect to episodes and visits ending on or after April 1, 2004, and before April 1, 2005, in the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))), the Secretary shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 5 percent.

(b) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a).

(c) NO EFFECT ON SUBSEQUENT PERIODS.—The payment increase provided under subsection (a) for a period under such subsection—

(1) shall not apply to episodes and visits ending after such period; and

(2) shall not be taken into account in calculating the payment amounts applicable for episodes and visits occurring after such period.

SEC. 122. REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.

(a) IN GENERAL.—Section 1886(h) (42 U.S.C. 1395ww(h)(4)) is amended—

(1) in paragraph (4)(F)(i), by inserting "subject to paragraph (7)," after "October 1, 1997,";

(2) in paragraph (4)(H)(i), by inserting "and subject to paragraph (7)," after "subparagraphs (F) and (G)"; and

(3) by adding at the end the following new paragraph:

"(7) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

"(A) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

"(i) PROGRAMS SUBJECT TO REDUCTION.—

"(I) IN GENERAL.—Except as provided in subclause (II), if a hospital's reference resident level (specified in clause (ii)) is less than the otherwise applicable resident limit (as defined in subparagraph (C)(ii)), effective for portions of cost reporting periods occurring on or after July 1, 2005, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such otherwise applicable resident limit and such reference resident level.

"(II) EXCEPTION FOR SMALL RURAL HOSPITALS.—This subparagraph shall not apply to a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds.

"(ii) REFERENCE RESIDENT LEVEL.—

"(I) IN GENERAL.—Except as otherwise provided in subclauses (II) and (III), the reference resident level specified in this clause for a hospital is the resident level for the most recent cost reporting period of the hospital ending on or before September 30, 2002, for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

"(II) USE OF MOST RECENT ACCOUNTING PERIOD TO RECOGNIZE EXPANSION OF EXISTING PROGRAMS.—If a hospital submits a timely request to increase its resident level due to an expansion of an existing residency training program that is not reflected on the most recent settled cost report, after audit and subject to the discretion of the Secretary, the reference resident level for such hospital is the resident level for the cost reporting period that includes July 1, 2003, as determined by the Secretary.

"(III) EXPANSIONS UNDER NEWLY APPROVED PROGRAMS.—Upon the timely request of a hospital, the Secretary shall adjust the reference resident level specified under subclause (I) or (II) to include the number of medical residents that were approved in an application for a medical residency training program that was approved by an appropriate accrediting organization (as determined by the Secretary) before January 1, 2002, but which was not in operation during the cost reporting period used under subclause (I) or (II), as the case may be, as determined by the Secretary.

"(iii) AFFILIATION.—The provisions of clause (i) shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) as of July 1, 2003.

"(B) REDISTRIBUTION.—

"(i) IN GENERAL.—The Secretary is authorized to increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2005. The aggregate number of increases in the otherwise applicable resident limits under this subparagraph may not exceed the

Secretary's estimate of the aggregate reduction in such limits attributable to subparagraph (A).

"(ii) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under clause (i), the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions within the first 3 cost reporting periods beginning on or after July 1, 2005, made available under this subparagraph, as determined by the Secretary.

"(iii) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under clause (i), the Secretary shall distribute the increase to programs of hospitals located in the following priority order:

"(I) First, to hospitals located in rural areas (as defined in subsection (d)(2)(D)(ii)).

"(II) Second, to hospitals located in urban areas that are not large urban areas (as defined for purposes of subsection (d)).

"(III) Third, to other hospitals in a State if the residency training program involved is in a specialty for which there are not other residency training programs in the State.

Increases of residency limits within the same priority category under this clause shall be determined by the Secretary.

"(iv) LIMITATION.—In no case shall more than 25 full-time equivalent additional residency positions be made available under this subparagraph with respect to any hospital.

"(v) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this subparagraph, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under paragraph (4)(E) for that hospital.

"(vi) CONSTRUCTION.—Nothing in this subparagraph shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6), under a demonstration project approved as of October 31, 2003, under the authority of section 402 of Public Law 90–248, or as affecting the ability of a hospital to establish new medical residency training programs under paragraph (4)(H).

"(C) RESIDENT LEVEL AND LIMIT DEFINED.—In this paragraph:

"(i) RESIDENT LEVEL.—The term 'resident level' means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under paragraph (4)), in the fields of allopathic and osteopathic medicine for the hospital.

"(ii) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph.

"(D) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, with respect to determinations made under this paragraph.".

(b) CONFORMING PROVISIONS.—(1) Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended—

(A) in the second sentence of clause (ii), by striking "For discharges" and inserting "Subject to clause (ix), for discharges"; and

(B) in clause (v), by adding at the end the following: "The provisions of subsection (h)(7) shall apply with respect to the first sentence of this clause in the same manner as it applies with respect to subsection (h)(4)(F)(i)."; and

(C) by adding at the end the following new clause:

"(ix) For discharges occurring on or after July 1, 2005, insofar as an additional payment amount under this subparagraph is attributable to resident positions redistributed to a hospital under subsection (h)(7)(B), in computing the indirect teaching adjustment factor under clause (ii) the adjustment shall be computed in a manner as if 'c' were equal to 0.66 with respect to such resident positions.".

(2) Chapter 35 of title 44, United States Code, shall not apply with respect to applications under section 1886(h)(7) of the Social Security Act, as added by subsection (a)(3).

(c) REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2005, the Secretary shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident limits under section 1886(h)(4)(I)(ii)(II) of the Social Security Act (as added by subsection (a)).

Subtitle D—Other Provisions

SEC. 131. PROVIDING SAFE HARBOR FOR CERTAIN COLLABORATIVE EFFORTS THAT BENEFIT MEDICALLY UNDERSERVED POPULATIONS.

(a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C. 1320a–7(b)(3)), as amended by section 101(e)(2), is amended—

(1) in subparagraph (F), by striking "and" after the semicolon at the end;

(2) in subparagraph (G), by striking the period at the end and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(H) any remuneration between a health center entity described under clause (i) or (ii) of section 1905(l)(2)(B) and any individual or entity providing goods, items, services, donations, loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity.".

(b) RULEMAKING FOR EXCEPTION FOR HEALTH CENTER ENTITY ARRANGEMENTS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary shall establish, on an expedited basis, standards relating to the exception described in section 1128B(b)(3)(H) of the Social Security Act, as added by subsection (a), for health center entity arrangements to the antikickback penalties.

(B) FACTORS TO CONSIDER.—The Secretary shall consider the following factors, among others, in establishing standards relating to the exception for health center entity arrangements under subparagraph (A):

(i) Whether the arrangement between the health center entity and the other party results in savings of Federal grant funds or increased revenues to the health center entity.

(ii) Whether the arrangement between the health center entity and the other party restricts or limits an individual's freedom of choice.

(iii) Whether the arrangement between the health center entity and the other party protects a health care professional's independent medical judgment regarding medically appropriate treatment.

The Secretary may also include other standards and criteria that are consistent with the intent of Congress in enacting the exception established under this section.

(2) DEADLINE.—Not later than 1 year after the date of the enactment of this Act the Secretary shall publish final regulations establishing the standards described in paragraph (1).

SEC. 132. OFFICE OF RURAL HEALTH POLICY IMPROVEMENTS.

Section 711(b) (42 U.S.C. 912(b)) is amended—

(1) in paragraph (3), by striking "and" after the comma at the end;

(2) in paragraph (4), by striking the period at the end and inserting ", and"; and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) administer grants, cooperative agreements, and contracts to provide technical assistance and other activities as necessary to support activities related to improving health care in rural areas.".

SEC. 133. MEDPAC STUDY ON RURAL HOSPITAL PAYMENT ADJUSTMENTS.

(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study of the impact of sections 401 through 406, 411, 416, and 505. The Commission shall analyze the effect on total payments, growth in costs, capital spending, and such other payment effects under those sections.

(b) REPORTS.—

(1) INTERIM REPORT.—Not later than 18 months after the date of the enactment of this Act, the Commission shall submit to Congress an interim report on the matters studied under subsection (a) with respect only to changes to the critical access hospital provisions under section 105.

(2) FINAL REPORT.—Not later than 3 years after the date of the enactment of this Act, the Commission shall submit to Congress a final report on all matters studied under subsection (a).

SEC. 134. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas are treated as providers of items and services under the medicare program.

(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—

(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

(B) patients who need monitoring and observation for a limited period of time.

(c) SPECIFICATION OF CODES.—The Secretary shall determine the appropriate life-safety codes for such clinics that treat patients for needs referred to in subsection (b)(2).

(d) FUNDING.—

(1) In general.—Subject to paragraph (2), there are authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, such sums as are necessary to conduct the demonstration project under this section.

(2) Budget Neutral Implementation.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under the medicare program do not exceed the amount which the Secretary would have paid under the medicare program if the demonstration project under this section was not implemented.

(e) 3-Year Period.—The Secretary shall conduct the demonstration under this section for a 3-year period.

(f) Report.—Not later than the date that is 1 year after the date on which the demonstration project concludes, the Secretary shall submit to Congress a report on the demonstration project, together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

(g) Definitions.—In this section, the terms "hospital" and "critical access hospital" have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

TITLE II—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

SEC. 201. REVISION OF ACUTE CARE HOSPITAL PAYMENT UPDATES.

(a) In General.—Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(1) by striking "and" at the end of subclause (XVIII);

(2) by striking subclause (XIX); and

(3) by inserting after subclause (XVIII) the following new subclauses:

"(XIX) for each of fiscal years 2004 through 2007, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and

"(XX) for fiscal year 2008 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.".

(b) Submission of Hospital Quality Data.—Section 1886(b)(3)(B) (42 U.S.C. 1395ww(b)(3)(B)) is amended by adding at the end the following new clause:

"(vii)(I) For purposes of clause (i)(XIX) for each of fiscal years 2005 through 2007, in a case of a subsection (d) hospital that does not submit data to the Secretary in accordance with subclause (II) with respect to such a fiscal year, the applicable percentage increase under such clause for such fiscal year shall be reduced by 0.4 percentage points. Such reduction shall apply only with respect to the fiscal year involved, and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i)(XIX) for a subsequent fiscal year.

"(II) Each subsection (d) hospital shall submit to the Secretary quality data (for a set of 10 indicators established by the Secretary as of November 1, 2003) that relate to the quality of care furnished by the hospital in inpatient settings in a form and manner, and at a time, specified by the Secretary for purposes of this clause, but with respect to fiscal year 2005, the Secretary shall provide for a 30-day grace period for the submission of data by a hospital.".

(c) GAO Study and Report on Appropriateness of Payments Under the Prospective Payment System for Inpatient Hospital Services.—

(1) Study.—The Comptroller General of the United States, using the most current data available, shall conduct a study to determine—

(A) the appropriate level and distribution of payments in relation to costs under the prospective payment system under section 1886 of the Social Security Act (42 U.S.C. 1395ww) for inpatient hospital services furnished by subsection (d) hospitals (as defined in subsection (d)(1)(B) of such section); and

(B) whether there is a need to adjust such payments under such system to reflect legitimate differences in costs across different geographic areas, kinds of hospitals, and types of cases.

(2) Report.—Not later than 24 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislative and administrative action as the Comptroller General determines appropriate.

SEC. 202. REVISION OF THE INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT PERCENTAGE.

(a) In General.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) in subclause (VI), by striking "and" after the semicolon at the end;

(2) in subclause (VII)—

(A) by inserting "and before April 1, 2004," after "on or after October 1, 2002,"; and

(B) by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new subclauses:

"(VIII) on or after April 1, 2004, and before October 1, 2004, 'c' is equal to 1.47;

"(IX) during fiscal year 2005, 'c' is equal to 1.42;

"(X) during fiscal year 2006, 'c' is equal to 1.37;

"(XI) during fiscal year 2007, 'c' is equal to 1.32; and

"(XII) on or after October 1, 2007, 'c' is equal to 1.35.".

(b) Conforming Amendment Relating to Determination of Standardized Amount.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

(1) by striking "1999 or" and inserting "1999,"; and

(2) by inserting ", or the Medicare Provider Restoration Act of 2003" after "2000".

(c) Effective Date.—The amendments made by this section shall apply to discharges occurring on or after April 1, 2004.

SEC. 203. RECOGNITION OF NEW MEDICAL TECHNOLOGIES UNDER INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

(a) Improving Timeliness of Data Collection.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is amended by adding at the end the following new clause:

"(vii) Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.".

(b) Eligibility Standard for Technology Outliers.—

(1) Adjustment of threshold.—Section 1886(d)(5)(K)(ii)(I) (42 U.S.C. 1395ww(d)(5)(K)(ii)(I)) is amended by inserting "(applying a threshold specified by the Secretary that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation for the diagnosis-related group involved)" after "is inadequate".

(2) Process for public input.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as amended by subsection (a), is amended—

(A) in clause (i), by adding at the end the following: "Such mechanism shall be modified to meet the requirements of clause (viii)."; and

(B) by adding at the end the following new clause:

"(viii) The mechanism established pursuant to clause (i) shall be adjusted to provide, before publication of a proposed rule, for public input regarding whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of individuals entitled to benefits under part A as follows:

"(I) The Secretary shall make public and periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

"(II) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

"(III) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, such individuals, manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking regarding whether service or technology represents a substantial improvement.".

(c) Preference for Use of DRG Adjustment.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as amended by subsections (a) and (b), is amended by adding at the end the following new clause:

"(ix) Before establishing any add-on payment under this subparagraph with respect to a new technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology. Within such groups the Secretary shall assign an eligible new technology into a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. No add-on payment under this subparagraph shall be made with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii).".

(d) Establishment of New Funding for Hospital Inpatient Technology.—

(1) In general.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by striking "subject to paragraph (4)(C)(iii),".

(2) Not budget neutral.—There shall be no reduction or other adjustment in payments under section 1886 of the Social Security Act because an additional payment is provided under subsection (d)(5)(K)(ii)(III) of such section.

(e) Effective Date.—

(1) In general.—The Secretary shall implement the amendments made by this section so that they apply to classification for fiscal years beginning with fiscal year 2005.

(2) Reconsiderations of applications for fiscal year 2004 that are denied.—In the case of an application for a classification of a medical service or technology as a new medical service or technology under section 1886(d)(5)(K) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(K)) that was filed for fiscal year 2004 and that is denied—

(A) the Secretary shall automatically reconsider the application as an application for fiscal year 2005 under the amendments made by this section; and

(B) the maximum time period otherwise permitted for such classification of the service or technology shall be extended by 12 months.

SEC. 204. INCREASE IN FEDERAL RATE FOR HOSPITALS IN PUERTO RICO.

Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking "for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)" and inserting "the applicable Puerto Rico percentage (specified in subparagraph (E))"; and

(B) in clause (ii), by striking "for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent)" and inserting "the applicable Federal percentage (specified in subparagraph (E))"; and

(2) by adding at the end the following new subparagraph:

"(E) For purposes of subparagraph (A), for discharges occurring—

"(i) on or after October 1, 1987, and before October 1, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

"(ii) on or after October 1, 1997, and before April 1, 2004, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

"(iii) on or after April 1, 2004, and before October 1, 2004, the applicable Puerto Rico percentage is 37.5 percent and the applicable Federal percentage is 62.5 percent; and

"(iv) on or after October 1, 2004, the applicable Puerto Rico percentage is 25 percent and the applicable Federal percentage is 75 percent.".

SEC. 205. WAGE INDEX ADJUSTMENT RECLASSIFICATION REFORM.

(a) In General.—Section 1886(d) (42 U.S.C. 1395ww(d)), as amended by section 106, is amended by adding at the end the following new paragraph:

"(13)(A) In order to recognize commuting patterns among geographic areas, the Secretary shall establish a process through application or otherwise for an increase of the wage index applied under paragraph (3)(E) for subsection (d) hospitals located in a qualifying county described in subparagraph (B) in the amount computed under subparagraph (D) based on out-migration of hospital employees who reside in that county to any higher wage index area.

"(B) The Secretary shall establish criteria for a qualifying county under this subparagraph based on the out-migration referred to in subparagraph (A) and differences in the area wage indices. Under such criteria the Secretary shall, utilizing such data as the Secretary determines to be appropriate, establish—

"(i) a threshold percentage, established by the Secretary, of the weighted average of the area wage index or indices for the higher wage index areas involved;

"(ii) a threshold (of not less than 10 percent) for minimum out-migration to a higher wage index area or areas; and

"(iii) a requirement that the average hourly wage of the hospitals in the qualifying county equals or exceeds the average hourly wage of all the hospitals in the area in which the qualifying county is located.

"(C) For purposes of this paragraph, the term 'higher wage index area' means, with respect to a county, an area with a wage index that exceeds that of the county.

"(D) The increase in the wage index under subparagraph (A) for a qualifying county shall be equal to the percentage of the hospital employees residing in the qualifying county who are employed in any higher wage index area multiplied by the sum of the products, for each higher wage index area of—

"(i) the difference between—

"(I) the wage index for such higher wage index area, and

"(II) the wage index of the qualifying county; and

"(ii) the number of hospital employees residing in the qualifying county who are employed in such higher wage index area divided by the total number of hospital employees residing in the qualifying county who are employed in any higher wage index area.

"(E) The process under this paragraph may be based upon the process used by the Medicare Geographic Classification Review Board under paragraph (10). As the Secretary determines to be appropriate to carry out such process, the Secretary may require hospitals (including subsection (d) hospitals and other hospitals) and critical access hospitals, as required under section 1866(a)(1)(T), to submit data regarding the location of residence, or the Secretary may use data from other sources.

"(F) A wage index increase under this paragraph shall be effective for a period of 3 fiscal years, except that the Secretary shall establish procedures under which a subsection (d) hospital may elect to waive the application of such wage index increase.

"(G) A hospital in a county that has a wage index increase under this paragraph for a period and that has not waived the application of such an increase under subparagraph (F) is not eligible for reclassification under paragraph (8) or (10) during that period.

"(H) Any increase in a wage index under this paragraph for a county shall not be taken into account for purposes of—

"(i) computing the wage index for portions of the wage index area (not including the county) in which the county is located; or

"(ii) applying any budget neutrality adjustment with respect to such index under paragraph (8)(D).

"(I) The thresholds described in subparagraph (B), data on hospital employees used under this paragraph, and any determination of the Secretary under the process described in subparagraph (E) shall be final and shall not be subject to judicial review.".

(b) Conforming Amendments.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (R), by striking "and" at the end;

(2) in subparagraph (S), by striking the period at the end and inserting ", and"; and

(3) by inserting after subparagraph (S) the following new subparagraph:

"(T) in the case of hospitals and critical access hospitals, to furnish to the Secretary such data as the Secretary determines appropriate pursuant to subparagraph (E) of section 1886(d)(12) to carry out such section.".

(c) Effective Date.—The amendments made by this section shall first apply to the wage index for discharges occurring on or after October 1, 2004. In initially implementing such amendments, the Secretary may modify the deadlines otherwise applicable under clauses (ii) and (iii)(I) of section 1886(d)(10)(C) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(C)), for submission of, and actions on, applications relating to changes in hospital geographic reclassification.

SEC. 206. LIMITATION ON CHARGES FOR INPATIENT HOSPITAL CONTRACT HEALTH SERVICES PROVIDED TO INDIANS BY MEDICARE PARTICIPATING HOSPITALS.

(a) In General.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)), as amended by section 205(b), is amended—

(1) in subparagraph (S), by striking "and" at the end;

(2) in subparagraph (T), by striking the period and inserting ", and"; and

(3) by inserting after subparagraph (T) the following new subparagraph:

"(U) in the case of hospitals which furnish inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care both—

"(i) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian tribe, or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and

"(ii) under any program funded by the Indian Health Service and operated by an urban Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in such section 4),

in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services.".

(b) Effective Date.—The amendments made by this section shall apply as of a date specified by the Secretary of Health and Human Services (but in no case later than 1 year after the date of enactment of this Act) to medicare participation agreements in effect (or entered into) on or after such date.

(c) Promulgation of Regulations.—The Secretary shall promulgate regulations to carry out the amendments made by subsection (a).

SEC. 207. CLARIFICATIONS TO CERTAIN EXCEPTIONS TO MEDICARE LIMITS ON PHYSICIAN REFERRALS.

(a) Limits on Physician Referrals.—

(1) Ownership and investment interests in whole hospitals.—

(A) In general.—Section 1877(d)(3) (42 U.S.C. 1395nn(d)(3)) is amended—

(i) by striking ", and" at the end of subparagraph (A) and inserting a semicolon; and

(ii) by redesignating subparagraph (B) as subparagraph (C) and inserting after subparagraph (A) the following new subparagraph:

"(B) effective for the 18-month period beginning on the date of the enactment of the Medicare Provider Restoration Act of 2003, the hospital is not a specialty hospital (as defined in subsection (h)(7)); and".

(B) Definition.—Section 1877(h) (42 U.S.C. 1395nn(h)) is amended by adding at the end the following:

"(7) Specialty hospital.—

"(A) In general.—For purposes of this section, except as provided in subparagraph (B), the term 'specialty hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B)) that is primarily or exclusively engaged in the care and treatment of one of the following categories:

"(i) Patients with a cardiac condition.

"(ii) Patients with an orthopedic condition.

"(iii) Patients receiving a surgical procedure.

"(iv) Any other specialized category of services that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section.

"(B) EXCEPTION.—For purposes of this section, the term 'specialty hospital' does not include any hospital—

"(i) determined by the Secretary—

"(I) to be in operation before November 18, 2003; or

"(II) under development as of such date;

"(ii) for which the number of physician investors at any time on or after such date is no greater than the number of such investors as of such date;

"(iii) for which the type of categories described in subparagraph (A) at any time on or after such date is no different than the type of such categories as of such date;

"(iv) for which any increase in the number of beds occurs only in the facilities on the main campus of the hospital and does not exceed 50 percent of the number of beds in the hospital as of November 18, 2003, or 5 beds, whichever is greater; and

"(v) that meets such other requirements as the Secretary may specify.".

(2) OWNERSHIP AND INVESTMENT INTERESTS IN A RURAL PROVIDER.—Section 1877(d)(2) (42 U.S.C. 1395nn(d)(2)) is amended to read as follows:

"(2) RURAL PROVIDERS.—In the case of designated health services furnished in a rural area (as defined in section 1886(d)(2)(D)) by an entity, if—

"(A) substantially all of the designated health services furnished by the entity are furnished to individuals residing in such a rural area; and

"(B) effective for the 18-month period beginning on the date of the enactment of the Medicare Provider Restoration Act of 2003, the entity is not a specialty hospital (as defined in subsection (h)(7)).".

(b) APPLICATION OF EXCEPTION FOR HOSPITALS UNDER DEVELOPMENT.—For purposes of section 1877(h)(7)(B)(i)(II) of the Social Security Act, as added by subsection (a)(1)(B), in determining whether a hospital is under development as of November 18, 2003, the Secretary shall consider—

(1) whether architectural plans have been completed, funding has been received, zoning requirements have been met, and necessary approvals from appropriate State agencies have been received; and

(2) any other evidence the Secretary determines would indicate whether a hospital is under development as of such date.

(c) STUDIES.—

(1) MEDPAC STUDY.—The Medicare Payment Advisory Commission, in consultation with the Comptroller General of the United States, shall conduct a study to determine—

(A) any differences in the costs of health care services furnished to patients by physician-owned specialty hospitals and the costs of such services furnished by local full-service community hospitals within specific diagnosis-related groups;

(B) the extent to which specialty hospitals, relative to local full-service community hospitals, treat patients in certain diagnosis-related groups within a category, such as cardiology, and an analysis of the selection;

(C) the financial impact of physician-owned specialty hospitals on local full-service community hospitals;

(D) how the current diagnosis-related group system should be updated to better reflect the cost of delivering care in a hospital setting; and

(E) the proportions of payments received, by type of payer, between the specialty hospitals and local full-service community hospitals.

(2) HHS STUDY.—The Secretary shall conduct a study of a representative sample of specialty hospitals—

(A) to determine the percentage of patients admitted to physician-owned specialty hospitals who are referred by physicians with an ownership interest;

(B) to determine the referral patterns of physician owners, including the percentage of patients they referred to physician-owned specialty hospitals and the percentage of patients they referred to local full-service community hospitals for the same condition;

(C) to compare the quality of care furnished in physician-owned specialty hospitals and in local full-service community hospitals for similar conditions and patient satisfaction with such care; and

(D) to assess the differences in uncompensated care, as defined by the Secretary, between the specialty hospital and local full-service community hospitals, and the relative value of any tax exemption available to such hospitals.

(3) REPORTS.—Not later than 15 months after the date of the enactment of this Act, the Commission and the Secretary, respectively, shall each submit to Congress a report on the studies conducted under paragraphs (1) and (2), respectively, and shall include any recommendations for legislation or administrative changes.

SEC. 208. 1-TIME APPEALS PROCESS FOR HOSPITAL WAGE INDEX CLASSIFICATION.

(a) ESTABLISHMENT OF PROCESS.—

(1) IN GENERAL.—The Secretary shall establish not later than January 1, 2004, by instruction or otherwise a process under which a hospital may appeal the wage index classification otherwise applicable to the hospital and select another area within the State (or, at the discretion of the Secretary, within a contiguous State) to which to be reclassified.

(2) PROCESS REQUIREMENTS.—The process established under paragraph (1) shall be consistent with the following:

(A) Such an appeal may be filed as soon as possible after the date of the enactment of this Act but shall be filed by not later than February 15, 2004.

(B) Such an appeal shall be heard by the Medicare Geographic Reclassification Review Board.

(C) There shall be no further administrative or judicial review of a decision of such Board.

(3) RECLASSIFICATION UPON SUCCESSFUL APPEAL.—If the Medicare Geographic Reclassification Review Board determines that the hospital is a qualifying hospital (as defined in subsection (c)), the hospital shall be reclassified to the area selected under paragraph (1). Such reclassification shall apply with respect to discharges occurring during the 3-year period beginning with April 1, 2004.

(4) INAPPLICABILITY OF CERTAIN PROVISIONS.—Except as the Secretary may provide, the provisions of paragraphs (8) and (10) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) shall not apply to an appeal under this section.

(b) APPLICATION OF RECLASSIFICATION.—In the case of an appeal decided in favor of a qualifying hospital under subsection (a), the wage index reclassification shall not affect the wage index computation for any area or for any other hospital and shall not be effected in a budget neutral manner. The provisions of this section shall not affect payment for discharges occurring after the end of the 3-year-period referred to in subsection (a).

(c) QUALIFYING HOSPITAL DEFINED.—For purposes of this section, the term "qualifying hospital" means a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) that—

(1) does not qualify for a change in wage index classification under paragraph (8) or (10) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) on the basis of requirements relating to distance or commuting; and

(2) meets such other criteria, such as quality, as the Secretary may specify by instruction or otherwise.

The Secretary may modify the wage comparison guidelines promulgated under section 1886(d)(10)(D) of such Act (42 U.S.C. 1395ww(d)(10)(D)) in carrying out this section.

(d) WAGE INDEX CLASSIFICATION.—For purposes of this section, the term "wage index classification" means the geographic area in which it is classified for purposes of determining for a fiscal year the factor used to adjust the DRG prospective payment rate under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) for area differences in hospital wage levels that applies to such hospital under paragraph (3)(E) of such section.

(e) LIMITATION ON EXPENDITURES.—The aggregate amount of additional expenditures resulting from the application of this section shall not exceed $900,000,000.

(f) TRANSITIONAL EXTENSION.—Any reclassification of a county or other area made by Act of Congress for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) that expired on September 30, 2003, shall be deemed to be in effect during the period beginning on January 1, 2004, and ending on September 30, 2004.

Subtitle B—Other Provisions

SEC. 211. PAYMENT FOR COVERED SKILLED NURSING FACILITY SERVICES.

(a) ADJUSTMENT TO RUGS FOR AIDS RESIDENTS.—Paragraph (12) of section 1888(e) (42 U.S.C. 1395yy(e)) is amended to read as follows:

"(12) ADJUSTMENT FOR RESIDENTS WITH AIDS.—

"(A) IN GENERAL.—Subject to subparagraph (B), in the case of a resident of a skilled nursing facility who is afflicted with acquired immune deficiency syndrome (AIDS), the per diem amount of payment otherwise applicable (determined without regard to any increase under section 101 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, or under section 314(a) of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000), shall be increased by 128 percent to reflect increased costs associated with such residents.

"(B) SUNSET.—Subparagraph (A) shall not apply on and after such date as the Secretary certifies that there is an appropriate adjustment in the case mix under paragraph (4)(G)(i) to compensate for the increased costs associated with residents described in such subparagraph.".

(b) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after October 1, 2004.

SEC. 212. COVERAGE OF HOSPICE CONSULTATION SERVICES.

(a) COVERAGE OF HOSPICE CONSULTATION SERVICES.—Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

(1) by striking "and" at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting "; and"; and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) for individuals who are terminally ill, have not made an election under subsection (d)(1), and have not previously received services under this paragraph, services that are furnished by a physician (as defined in section 1861(r)(1)) who is either the medical director or an employee of a hospice program and that—

"(A) consist of—

"(i) an evaluation of the individual's need for pain and symptom management, including the individual's need for hospice care; and

"(ii) counseling the individual with respect to hospice care and other care options; and

"(B) may include advising the individual regarding advanced care planning.".

(b) PAYMENT.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

"(4) The amount paid to a hospice program with respect to the services under section 1812(a)(5) for which payment may be made under this part shall be equal to an amount established for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity and requiring medical decisionmaking of low complexity under the fee schedule established under section 1848(b), other than the portion of such amount attributable to the practice expense component.".

(c) CONFORMING AMENDMENT.—Section 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is amended by inserting before the comma at the end the following: "and services described in section 1812(a)(5)".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided by a hospice program on or after January 1, 2005.

SEC. 213. STUDY ON PORTABLE DIAGNOSTIC ULTRASOUND SERVICES FOR BENEFICIARIES IN SKILLED NURSING FACILITIES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of portable diagnostic ultrasound services furnished to medicare beneficiaries in skilled nursing facilities. Such study shall consider the following:

(1) TYPES OF EQUIPMENT; TRAINING.—The types of portable diagnostic ultrasound services furnished to such beneficiaries, the types of portable ultrasound equipment used to furnish such services, and the technical skills, or training, or both, required for technicians to furnish such services.

(2) CLINICAL APPROPRIATENESS.—The clinical appropriateness of transporting portable diagnostic ultrasound diagnostic and technicians to patients in skilled nursing facilities as opposed to transporting such patients to a hospital or other facility that furnishes diagnostic ultrasound services.

(3) FINANCIAL IMPACT.—The financial impact if Medicare were make a separate payment for portable ultrasound diagnostic services, including the impact of separate payments—

(A) for transportation and technician services for residents during a resident in a part A stay, that would otherwise be paid for under the prospective payment system for covered skilled nursing facility services (under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)); and

(B) for such services for residents in a skilled nursing facility after a part A stay.

(4) CREDENTIALING REQUIREMENTS.—Whether the Secretary should establish credentialing or other requirements for technicians that furnish diagnostic ultrasound services to medicare beneficiaries.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a), and shall include any recommendations for legislation or administrative change as the Comptroller General determines appropriate.

TITLE III—PROVISIONS RELATING TO PART B

Subtitle A—Provisions Relating to Physicians' Services

SEC. 301. REVISION OF UPDATES FOR PHYSICIANS' SERVICES.

(a) UPDATE FOR 2004 AND 2005.—

(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraph:

"(5) UPDATE FOR 2004 AND 2005.—The update to the single conversion factor established in paragraph (1)(C) for each of 2004 and 2005 shall be not less than 1.5 percent.".

(2) CONFORMING AMENDMENT.—Paragraph (4)(B) of such section is amended, in the matter before clause (i), by inserting "and paragraph (5)" after "subparagraph (D)".

(3) NOT TREATED AS CHANGE IN LAW AND REGULATION IN SUSTAINABLE GROWTH RATE DETERMINATION.—The amendments made by this subsection shall not be treated as a change in law for purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)).

(b) USE OF 10-YEAR ROLLING AVERAGE IN COMPUTING GROSS DOMESTIC PRODUCT.—

(1) IN GENERAL.—Section 1848(f)(2)(C) (42 U.S.C. 1395w–4(f)(2)(C)) is amended—

(A) by striking "projected" and inserting "annual average"; and

(B) by striking "from the previous applicable period to the applicable period involved" and inserting "during the 10-year period ending with the applicable period involved".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to computations of the sustainable growth rate for years beginning with 2003.

SEC. 302. TREATMENT OF PHYSICIANS' SERVICES FURNISHED IN ALASKA.

Section 1848(e)(1) (42 U.S.C. 1395w–4(e)(1)), as amended by section 121, is amended—

(1) in subparagraph (A), by striking "subparagraphs (B), (C), (E), and (F)" and inserting "subparagraphs (B), (C), (E), (F) and (G)"; and

(2) by adding at the end the following new subparagraph:

"(G) FLOOR FOR PRACTICE EXPENSE, MALPRACTICE, AND WORK GEOGRAPHIC INDICES FOR SERVICES FURNISHED IN ALASKA.—For purposes of payment for services furnished in Alaska on or after January 1, 2004, and before January 1, 2006, after calculating the practice expense, malpractice, and work geographic indices in clauses (i), (ii), and (iii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.67 if such index would otherwise be less than 1.67.".

SEC. 303. INCLUSION OF PODIATRISTS, DENTISTS, AND OPTOMETRISTS UNDER PRIVATE CONTRACTING AUTHORITY.

Section 1802(b)(5)(B) (42 U.S.C. 1395a(b)(5)(B)) is amended by striking "section 1861(r)(1)" and inserting "paragraphs (1), (2), (3), and (4) of section 1861(r)".

SEC. 304. GAO STUDY ON ACCESS TO PHYSICIANS' SERVICES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on access of medicare beneficiaries to physicians' services under the medicare program. The study shall include—

(1) an assessment of the use by beneficiaries of such services through an analysis of claims submitted by physicians for such services under part B of the medicare program;

(2) an examination of changes in the use by beneficiaries of physicians' services over time; and

(3) an examination of the extent to which physicians are not accepting new medicare beneficiaries as patients.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall include a determination whether—

(1) data from claims submitted by physicians under part B of the medicare program indicate potential access problems for medicare beneficiaries in certain geographic areas; and

(2) access by medicare beneficiaries to physicians' services may have improved, remained constant, or deteriorated over time.

SEC. 305. COLLABORATIVE DEMONSTRATION-BASED REVIEW OF PHYSICIAN PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT DATA.

(a) IN GENERAL.—Not later than January 1, 2005, the Secretary shall, in collaboration with State and other appropriate organizations representing physicians, and other appropriate persons, review and consider alternative data sources than those currently used in establishing the geographic index for the practice expense component under the medicare physician fee schedule under section 1848(e)(1)(A)(i) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(A)(i)).

(b) SITES.—The Secretary shall select two physician payment localities in which to carry out subsection (a). One locality shall include rural areas and at least one locality shall be a statewide locality that includes both urban and rural areas.

(c) REPORT AND RECOMMENDATIONS.—

(1) REPORT.—Not later than January 1, 2006, the Secretary shall submit to Congress a report on the review and consideration conducted under subsection (a). Such report shall include information on the alternative developed data sources considered by the Secretary under subsection (a), including the accuracy and validity of the data as measures of the elements of the geographic index for practice expenses under the medicare physician fee schedule as well as the feasibility of using such alternative data nationwide in lieu of current proxy data used in such index, and the estimated impacts of using such alternative data.

(2) RECOMMENDATIONS.—The report submitted under paragraph (1) shall contain recommendations on which data sources reviewed and considered under subsection (a) are appropriate for use in calculating the geographic index for practice expenses under the medicare physician fee schedule.

SEC. 306. MEDPAC REPORT ON PAYMENT FOR PHYSICIANS' SERVICES.

(a) PRACTICE EXPENSE COMPONENT.—Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the effect of refinements to the practice expense component of payments for physicians' services, after the transition to a full resource-based payment system in 2002, under section 1848 of the Social Security Act (42 U.S.C. 1395w–4). Such report shall examine the following matters by physician specialty:

(1) The effect of such refinements on payment for physicians' services.

(2) The interaction of the practice expense component with other components of and adjustments to payment for physicians' services under such section.

(3) The appropriateness of the amount of compensation by reason of such refinements.

(4) The effect of such refinements on access to care by medicare beneficiaries to physicians' services.

(5) The effect of such refinements on physician participation under the medicare program.

(b) VOLUME OF PHYSICIANS' SERVICES.—Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the extent to which increases in the volume of physicians' services under part B of the medicare program are a result of care that improves the health and well-being of medicare beneficiaries. The study shall include the following:

(1) An analysis of recent and historic growth in the components that the Secretary includes under the sustainable growth rate (under section 1848(f) of the Social Security Act (42 U.S.C. 1395w–4(f))).

(2) An examination of the relative growth of volume in physicians' services between medicare beneficiaries and other populations.

(3) An analysis of the degree to which new technology, including coverage determinations of the Centers for Medicare & Medicaid Services, has affected the volume of physicians' services.

(4) An examination of the impact on volume of demographic changes.

(5) An examination of shifts in the site of service or services that influence the number and intensity of services furnished in physicians' offices and the extent to which changes in reimbursement rates to other providers have effected these changes.

(6) An evaluation of the extent to which the Centers for Medicare & Medicaid Services takes into account the impact of law and regulations on the sustainable growth rate.

Subtitle B—Preventive Services

SEC. 311. COVERAGE OF AN INITIAL PREVENTIVE PHYSICAL EXAMINATION.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking “and” at the end;

(2) in subparagraph (V)(iii), by inserting “and” at the end; and

(3) by adding at the end the following new subparagraph:

“(W) an initial preventive physical examination (as defined in subsection (ww));”.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

“Initial Preventive Physical Examination

“(ww)(1) The term ‘initial preventive physical examination’ means physicians' services consisting of a physical examination (including measurement of height, weight, and blood pressure, and an electrocardiogram) with the goal of health promotion and disease detection and includes education, counseling, and referral with respect to screening and other preventive services described in paragraph (2), but does not include clinical laboratory tests.

“(2) The screening and other preventive services described in this paragraph include the following:

“(A) Pneumococcal, influenza, and hepatitis B vaccine and administration under subsection (s)(10).

“(B) Screening mammography as defined in subsection (jj).

“(C) Screening pap smear and screening pelvic exam as defined in subsection (nn).

“(D) Prostate cancer screening tests as defined in subsection (oo).

“(E) Colorectal cancer screening tests as defined in subsection (pp).

“(F) Diabetes outpatient self-management training services as defined in subsection (qq)(1).

“(G) Bone mass measurement as defined in subsection (rr).

“(H) Screening for glaucoma as defined in subsection (uu).

“(I) Medical nutrition therapy services as defined in subsection (vv).

“(J) Cardiovascular screening blood tests as defined in subsection (xx)(1).

“(K) Diabetes screening tests as defined in subsection (yy).”.

(c) PAYMENT AS PHYSICIANS' SERVICES.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) is amended by inserting “(2)(W),” after “(2)(S),”.

(d) OTHER CONFORMING AMENDMENTS.—(1) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 303(i)(3)(B), is amended—

(A) in paragraph (1)—

(i) by striking “and” at the end of subparagraph (I);

(ii) by striking the semicolon at the end of subparagraph (J) and inserting “, and”; and

(iii) by adding at the end the following new subparagraph:

“(K) in the case of an initial preventive physical examination, which is performed not later than 6 months after the date the individual's first coverage period begins under part B;”; a

(B) in paragraph (7), by striking “or (H)” and inserting “(H), or (K)”.

(2) Clauses (i) and (ii) of section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) are each amended by inserting “and services described in subsection (ww)(1)” after “services which would be physicians' services”.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2005, but only for individuals whose coverage period under part B begins on or after such date.

SEC. 312. COVERAGE OF CARDIOVASCULAR SCREENING BLOOD TESTS.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by section 311(a), is amended—

(1) in subparagraph (V)(iii), by striking “and” at the end;

(2) in subparagraph (W), by inserting “and” at the end; and

(3) by adding at the end the following new subparagraph:

“(X) cardiovascular screening blood tests (as defined in subsection (xx)(1));”.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

“Cardiovascular Screening Blood Test

“(xx)(1) The term ‘cardiovascular screening blood test’ means a blood test for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) that tests for the following:

“(A) Cholesterol levels and other lipid or triglyceride levels.

“(B) Such other indications associated with the presence of, or an elevated risk for, cardiovascular disease as the Secretary may approve for all individuals (or for some individuals determined by the Secretary to be at risk for cardiovascular disease), including indications measured by noninvasive testing.

The Secretary may not approve an indication under subparagraph (B) for any individual unless a blood test for such is recommended by the United States Preventive Services Task Force.

“(2) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency for each type of cardiovascular screening blood tests, except that such frequency may not be more often than once every 2 years.”.

(c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by section 311(d), is amended—

(1) by striking “and” at the end of subparagraph (K);

(2) by striking the semicolon at the end of subparagraph (L) and inserting “, and”; and

(3) by adding at the end the following new subparagraph:

“(M) in the case of cardiovascular screening blood tests (as defined in section 1861(xx)(1)), which are performed more frequently than is covered under section 1861(xx)(2);”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2005.

SEC. 313. COVERAGE OF DIABETES SCREENING TESTS.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by section 312(a), is amended—

(1) in subparagraph (W), by striking “and” at the end;

(2) in subparagraph (X), by adding “and” at the end; and

(3) by adding at the end the following new subparagraph:

“(Y) diabetes screening tests (as defined in subsection (yy));”.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x), as amended by section 312(b), is amended by adding at the end the following new subsection:

“Diabetes Screening Tests

“(yy)(1) The term ‘diabetes screening tests’ means testing furnished to an individual at risk for diabetes (as defined in paragraph (2)) for the purpose of early detection of diabetes, including—

“(A) a fasting plasma glucose test; and

“(B) such other tests, and modifications to tests, as the Secretary determines appropriate, in consultation with appropriate organizations.

“(2) For purposes of paragraph (1), the term ‘individual at risk for diabetes’ means an individual who has any of the following risk factors for diabetes:

“(A) Hypertension.

“(B) Dyslipidemia.

“(C) Obesity, defined as a body mass index greater than or equal to 30 kg/m^2.

“(D) Previous identification of an elevated impaired fasting glucose.

“(E) Previous identification of impaired glucose tolerance.

“(F) A risk factor consisting of at least 2 of the following characteristics:

“(i) Overweight, defined as a body mass index greater than 25, but less than 30, kg/m^2.

“(ii) A family history of diabetes.

“(iii) A history of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.

“(iv) 65 years of age or older.

“(3) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency of diabetes screening tests, except that such frequency may not be more often than twice within the 12-month period following the date of the most recent diabetes screening test of that individual.”.

(c) Frequency.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by section 312(c), is amended—

(1) by striking “and” at the end of subparagraph (L);

(2) by striking the semicolon at the end of subparagraph (M) and inserting “, and”; and

(3) by adding at the end the following new subparagraph:

“(N) in the case of a diabetes screening test (as defined in section 1861(yy)(1)), which is performed more frequently than is covered under section 1861(yy)(3);”.

(d) Effective Date.—The amendments made by this section shall apply to tests furnished on or after January 1, 2005.

SEC. 314. IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) Exclusion From OPD Fee Schedule.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by inserting before the period at the end the following: “and does not include screening mammography (as defined in section 1861(jj)) and diagnostic mammography”.

(b) Conforming Amendment.—Section 1833(a)(2)(E)(i) (42 U.S.C. 1395l(a)(2)(E)(i)) is amended by inserting “and, for services furnished on or after January 1, 2005, diagnostic mammography” after “screening mammography”.

(c) Effective Date.—The amendments made by this section shall apply—

(1) in the case of screening mammography, to services furnished on or after the date of the enactment of this Act; and

(2) in the case of diagnostic mammography, to services furnished on or after January 1, 2005.

Subtitle C—Other Provisions

SEC. 321. HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT REFORM.

(a) Payment for Drugs.—

(1) Special rules for certain drugs and biologicals.—Section 1833(t) (42 U.S.C. 1395l(t)), as amended by section 111(b), is amended by inserting after paragraph (13) the following new paragraphs:

“(14) Drug APC payment rates.—

“(A) In general.—The amount of payment under this subsection for a specified covered outpatient drug (defined in subparagraph (B)) that is furnished as part of a covered OPD service (or group of services)—

“(i) in 2004, in the case of—

“(I) a sole source drug shall in no case be less than 88 percent, or exceed 95 percent, of the reference average wholesale price for the drug;

“(II) an innovator multiple source drug shall in no case exceed 68 percent of the reference average wholesale price for the drug; or

“(III) a noninnovator multiple source drug shall in no case exceed 46 percent of the reference average wholesale price for the drug;

“(ii) in 2005, in the case of—

“(I) a sole source drug shall in no case be less than 83 percent, or exceed 95 percent, of the reference average wholesale price for the drug;

“(II) an innovator multiple source drug shall in no case exceed 68 percent of the reference average wholesale price for the drug; or

“(III) a noninnovator multiple source drug shall in no case exceed 46 percent of the reference average wholesale price for the drug; or

“(iii) in a subsequent year, shall be equal, subject to subparagraph (E)—

“(I) to the average acquisition cost for the drug for that year (which, at the option of the Secretary, may vary by hospital group (as defined by the Secretary based on volume of covered OPD services or other relevant characteristics)), as determined by the Secretary taking into account the hospital acquisition cost survey data under subparagraph (D); or

“(II) if hospital acquisition cost data are not available, the average price for the drug in the year established under section 1842(o), section 1847A, or section 1847B, as the case may be, as calculated and adjusted by the Secretary as necessary for purposes of this paragraph.

“(B) Specified covered outpatient drug defined.—

“(i) In general.—In this paragraph, the term ‘specified covered outpatient drug’ means, subject to clause (ii), a covered outpatient drug (as defined in section 1927(k)(2)) for which a separate ambulatory payment classification group (APC) has been established and that is—

“(I) a radiopharmaceutical; or

“(II) a drug or biological for which payment was made under paragraph (6) (relating to pass-through payments) on or before December 31, 2002.

“(ii) Exception.—Such term does not include—

“(I) a drug or biological for which payment is first made on or after January 1, 2003, under paragraph (6);

“(II) a drug or biological for which a temporary HCPCS code has not been assigned; or

“(III) during 2004 and 2005, an orphan drug (as designated by the Secretary).

“(C) Payment for designated orphan drugs during 2004 and 2005.—The amount of payment under this subsection for an orphan drug designated by the Secretary under subparagraph (B)(ii)(III) that is furnished as part of a covered OPD service (or group of services) during 2004 and 2005 shall equal such amount as the Secretary may specify.

“(D) Acquisition cost survey for hospital outpatient drugs.—

“(i) Annual GAO surveys in 2004 and 2005.—

“(I) In general.—The Comptroller General of the United States shall conduct a survey in each of 2004 and 2005 to determine the hospital acquisition cost for each specified covered outpatient drug. Not later than April 1, 2005, the Comptroller General shall furnish data from such surveys to the Secretary for use in setting the payment rates under subparagraph (A) for 2006.

“(II) Recommendations.—Upon the completion of such surveys, the Comptroller General shall recommend to the Secretary the frequency and methodology of subsequent surveys to be conducted by the Secretary under clause (ii).

“(ii) Subsequent secretarial surveys.—The Secretary, taking into account such recommendations, shall conduct periodic subsequent surveys to determine the hospital acquisition cost for each specified covered outpatient drug for use in setting the payment rates under subparagraph (A).

“(iii) Survey requirements.—The surveys conducted under clauses (i) and (ii) shall have a large sample of hospitals that is sufficient to generate a statistically significant estimate of the average hospital acquisition cost for each specified covered outpatient drug. With respect to the surveys conducted under clause (i), the Comptroller General shall report to Congress on the justification for the size of the sample used in order to assure the validity of such estimates.

“(iv) Differentiation in cost.—In conducting surveys under clause (i), the Comptroller General shall determine and report to Congress if there is (and the extent of any) variation in hospital acquisition costs for drugs among hospitals based on the volume of covered OPD services performed by such hospitals or other relevant characteristics of such hospitals (as defined by the Comptroller General).

“(v) Comment on proposed rates.—Not later than 30 days after the date the Secretary promulgated proposed rules setting forth the payment rates under subparagraph (A) for 2006, the Comptroller General shall evaluate such proposed rates and submit to Congress a report regarding the appropriateness of such rates based on the surveys the Comptroller General has conducted under clause (i).

“(E) Adjustment in payment rates for overhead costs.—

“(i) MedPAC report on drug APC design.—The Medicare Payment Advisory Commission shall submit to the Secretary, not later than July 1, 2005, a report on adjustment of payment for ambulatory payment classifications for specified covered outpatient drugs to take into account overhead and related expenses, such as pharmacy services and handling costs. Such report shall include—

“(I) a description and analysis of the data available with regard to such expenses;

“(II) a recommendation as to whether such a payment adjustment should be made; and

“(III) if such adjustment should be made, a recommendation regarding the methodology for making such an adjustment.

“(ii) Adjustment authorized.—The Secretary may adjust the weights for ambulatory payment classifications for specified covered outpatient drugs to take into account the recommendations contained in the report submitted under clause (i).

“(F) Classes of drugs.—For purposes of this paragraph:

“(i) Sole source drugs.—The term ‘sole source drug’ means—

“(I) a biological product (as defined under section 1861(t)(1)); or

“(II) a single source drug (as defined in section 1927(k)(7)(A)(iv)).

“(ii) Innovator multiple source drugs.—The term ‘innovator multiple source drug’ has the meaning given such term in section 1927(k)(7)(A)(ii).

“(iii) Noninnovator multiple source drugs.—The term ‘noninnovator multiple source drug’ has the meaning given such term in section 1927(k)(7)(A)(iii).

“(G) Reference average wholesale price.—The term ‘reference average wholesale price’ means, with respect to a specified covered outpatient drug, the average wholesale price for the drug as determined under section 1842(o) as of May 1, 2003.

“(H) Inapplicability of expenditures in determining conversion, weighting, and other adjustment factors.—Additional expenditures resulting from this paragraph shall not be taken into account in establishing the conversion, weighting, and other adjustment factors for 2004 and 2005 under paragraph (9), but shall be taken into account for subsequent years.

“(15) Payment for new drugs and biologicals until HCPCS code assigned.—With respect to payment under this part for an outpatient drug or biological that is covered under this part and is furnished as part of covered OPD services for which a HCPCS code has not been assigned, the amount provided for payment for such drug or biological under this part shall be equal to 95 percent of the average wholesale price for the drug or biological.''.

(2) REDUCTION IN THRESHOLD FOR SEPARATE APCS FOR DRUGS.—Section 1833(t)(16), as redesignated section 111(b), is amended by adding at the end the following new subparagraph:

''(B) THRESHOLD FOR ESTABLISHMENT OF SEPARATE APCS FOR DRUGS.—The Secretary shall reduce the threshold for the establishment of separate ambulatory payment classification groups (APCs) with respect to drugs or biologicals to $50 per administration for drugs and biologicals furnished in 2005 and 2006.''.

(3) EXCLUSION OF SEPARATE DRUG APCS FROM OUTLIER PAYMENTS.—Section 1833(t)(5) is amended by adding at the end the following new subparagraph:

''(E) EXCLUSION OF SEPARATE DRUG AND BIOLOGICAL APCS FROM OUTLIER PAYMENTS.—No additional payment shall be made under subparagraph (A) in the case of ambulatory payment classification groups established separately for drugs or biologicals.''.

(4) PAYMENT FOR PASS THROUGH DRUGS.—Section 1833(t)(6)(D)(i) (42 U.S.C. 1395l(t)(6)(D)(i)) is amended by inserting after ''under section 1842(o)'' the following: ''(or if the drug or biological is covered under a competitive acquisition contract under section 1847B, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary for purposes of this paragraph)''.

(5) CONFORMING AMENDMENT TO BUDGET NEUTRALITY REQUIREMENT.—Section 1833(t)(9)(B) (42 U.S.C. 1395l(t)(9)(B)) is amended by adding at the end the following: ''In determining adjustments under the preceding sentence for 2004 and 2005, the Secretary shall not take into account under this subparagraph or paragraph (2)(E) any expenditures that would not have been made but for the application of paragraph (14).''.

(6) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items and services furnished on or after January 1, 2004.

(b) SPECIAL PAYMENT FOR BRACHYTHERAPY.—

(1) IN GENERAL.—Section 1833(t)(16), as redesignated by section 111(b) and as amended by subsection (a)(2), is amended by adding at the end the following new subparagraph:

''(C) PAYMENT FOR DEVICES OF BRACHYTHERAPY AT CHARGES ADJUSTED TO COST.—Notwithstanding the preceding provisions of this subsection, for a device of brachytherapy consisting of a seed or seeds (or radioactive source) furnished on or after January 1, 2004, and before January 1, 2007, the payment basis for the device under this subsection shall be equal to the hospital's charges for each device furnished, adjusted to cost. Charges for such devices shall not be included in determining any outlier payment under this subsection.''.

(2) SPECIFICATION OF GROUPS FOR BRACHYTHERAPY DEVICES.—Section 1833(t)(2) (42 U.S.C. 1395l(t)(2)) is amended—

(A) in subparagraph (F), by striking ''and'' at the end;

(B) in subparagraph (G), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(H) with respect to devices of brachytherapy consisting of a seed or seeds (or radioactive source), the Secretary shall create additional groups of covered OPD services that classify such devices separately from the other services (or group of services) paid for under this subsection in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate groups for palladium-103 and iodine-125 devices.''.

(3) GAO REPORT.—The Comptroller General of the United States shall conduct a study to determine appropriate payment amounts under section 1833(t)(16)(C) of the Social Security Act, as added by paragraph (1), for devices of brachytherapy. Not later than January 1, 2005, the Comptroller General shall submit to Congress and the Secretary a report on the study conducted under this paragraph, and shall include specific recommendations for appropriate payments for such devices.

SEC. 322. LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.

Section 1833(t)(6) (42 U.S.C. 1395l(t)(6)) is amended by adding at the end the following new subparagraph:

''(F) LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.—

''(i) IN GENERAL.—The Secretary may not publish regulations that apply a functional equivalence standard to a drug or biological under this paragraph.

''(ii) APPLICATION.—Clause (i) shall apply to the application of a functional equivalence standard to a drug or biological on or after the date of enactment of the Medicare Provider Restoration Act of 2003 unless—

''(I) such application was being made to such drug or biological prior to such date of enactment; and

''(II) the Secretary applies such standard to such drug or biological only for the purpose of determining eligibility of such drug or biological for additional payments under this paragraph and not for the purpose of any other payments under this title.

''(iii) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall be construed to effect the Secretary's authority to deem a particular drug to be identical to another drug if the 2 products are pharmaceutically equivalent and bioequivalent, as determined by the Commissioner of Food and Drugs.''.

SEC. 323. PAYMENT FOR RENAL DIALYSIS SERVICES.

(a) INCREASE IN RENAL DIALYSIS COMPOSITE RATE FOR SERVICES FURNISHED.—The last sentence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended—

(1) by striking ''and'' before ''for such services'' the second place it appears;

(2) by inserting ''and before January 1, 2005,'' after ''January 1, 2001,''; and

(3) by inserting before the period at the end the following: '', and for such services furnished on or after January 1, 2005, by 1.6 percent above such composite rate payment amounts for such services furnished on December 31, 2004''.

(b) RESTORING COMPOSITE RATE EXCEPTIONS FOR PEDIATRIC FACILITIES.—

(1) IN GENERAL.—Section 422(a)(2) of BIPA is amended—

(A) in subparagraph (A), by striking ''and (C)'' and inserting '', (C), and (D)'';

(B) in subparagraph (B), by striking ''In the case'' and inserting ''Subject to subparagraph (D), in the case''; and

(C) by adding at the end the following new subparagraph:

''(D) INAPPLICABILITY TO PEDIATRIC FACILITIES.—Subparagraphs (A) and (B) shall not apply, as of October 1, 2002, to pediatric facilities that do not have an exception rate described in subparagraph (C) in effect on such date. For purposes of this subparagraph, the term 'pediatric facility' means a renal facility at least 50 percent of whose patients are individuals under 18 years of age.''.

(2) CONFORMING AMENDMENT.—The fourth sentence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by striking ''The Secretary'' and inserting ''Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Secretary''.

(c) INSPECTOR GENERAL STUDIES ON ESRD DRUGS.—

(1) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct two studies with respect to drugs and biologicals (including erythropoietin) furnished to end-stage renal disease patients under the medicare program which are separately billed by end stage renal disease facilities.

(2) STUDIES ON ESRD DRUGS.—

(A) EXISTING DRUGS.—The first study under paragraph (1) shall be conducted with respect to such drugs and biologicals for which a billing code exists prior to January 1, 2004.

(B) NEW DRUGS.—The second study under paragraph (1) shall be conducted with respect to such drugs and biologicals for which a billing code does not exist prior to January 1, 2004.

(3) MATTERS STUDIED.—Under each study conducted under paragraph (1), the Inspector General shall—

(A) determine the difference between the amount of payment made to end stage renal disease facilities under title XVIII of the Social Security Act for such drugs and biologicals and the acquisition costs of such facilities for such drugs and biologicals and which are separately billed by end stage renal disease facilities, and

(B) estimate the rates of growth of expenditures for such drugs and biologicals billed by such facilities.

(4) REPORTS.—

(A) EXISTING ESRD DRUGS.—Not later than April 1, 2004, the Inspector General shall report to the Secretary on the study described in paragraph (2)(A).

(B) NEW ESRD DRUGS.—Not later than April 1, 2006, the Inspector General shall report to the Secretary on the study described in paragraph (2)(B).

(d) BASIC CASE-MIX ADJUSTED COMPOSITE RATE FOR RENAL DIALYSIS FACILITY SERVICES.—(1) Section 1881(b) (42 U.S.C. 1395rr(b)) is amended by adding at the end the following new paragraphs:

''(12)(A) In lieu of payment under paragraph (7) beginning with services furnished on January 1, 2005, the Secretary shall establish a basic case-mix adjusted prospective payment system for dialysis services furnished by providers of services and renal dialysis facilities in a year to individuals in a facility and to such individuals at home. The case-mix under such system shall be for a limited number of patient characteristics.

''(B) The system described in subparagraph (A) shall include—

''(i) the services comprising the composite rate established under paragraph (7); and

''(ii) the difference between payment amounts under this title for separately billed drugs and biologicals (including erythropoietin) and acquisition costs of such drugs and biologicals, as determined by the Inspector General reports to the Secretary as required by section 323(c) of the Medicare Provider Restoration Act of 2003—

''(I) beginning with 2005, for such drugs and biologicals for which a billing code exists prior to January 1, 2004; and

"(II) beginning with 2007, for such drugs and biologicals for which a billing code does not exist prior to January 1, 2004,

adjusted to 2005, or 2007, respectively, as determined to be appropriate by the Secretary.

"(C)(i) In applying subparagraph (B)(ii) for 2005, such payment amounts under this title shall be determined using the methodology specified in paragraph (13)(A)(i).

"(ii) For 2006, the Secretary shall provide for an adjustment to the payments under clause (i) to reflect the difference between the payment amounts using the methodology under paragraph (13)(A)(i) and the payment amount determined using the methodology applied by the Secretary under paragraph (13)(A)(iii) of such paragraph, as estimated by the Secretary.

"(D) The Secretary shall adjust the payment rates under such system by a geographic index as the Secretary determines to be appropriate. If the Secretary applies a geographic index under this paragraph that differs from the index applied under paragraph (7) the Secretary shall phase-in the application of the index under this paragraph over a multiyear period.

"(E)(i) Such system shall be designed to result in the same aggregate amount of expenditures for such services, as estimated by the Secretary, as would have been made for 2005 if this paragraph did not apply.

"(ii) The adjustment made under subparagraph (B)(ii)(II) shall be done in a manner to result in the same aggregate amount of expenditures after such adjustment as would otherwise have been made for such services for 2006 or 2007, respectively, as estimated by the Secretary, if this paragraph did not apply.

"(F) Beginning with 2006, the Secretary shall annually increase the basic case-mix adjusted payment amounts established under this paragraph, by an amount determined by—

"(i) applying the estimated growth in expenditures for drugs and biologicals (including erythropoietin) that are separately billable to the component of the basic case-mix adjusted system described in subparagraph (B)(ii); and

"(ii) converting the amount determined in clause (i) to an increase applicable to the basic case-mix adjusted payment amounts established under subparagraph (B).

Nothing in this paragraph shall be construed as providing for an update to the composite rate component of the basic case-mix adjusted system under subparagraph (B).

"(G) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of the case-mix system, relative weights, payment amounts, the geographic adjustment factor, or the update for the system established under this paragraph, or the determination of the difference between medicare payment amounts and acquisition costs for separately billed drugs and biologicals (including erythropoietin) under this paragraph and paragraph (13).

"(13)(A) The payment amounts under this title for separately billed drugs and biologicals furnished in a year, beginning with 2004, are as follows:

"(i) For such drugs and biologicals (other than erythropoietin) furnished in 2004, the amount determined under section 1842(o)(1)(A)(v) for the drug or biological.

"(ii) For such drugs and biologicals (including erythropoietin) furnished in 2005, the acquisition cost of the drug or biological, as determined by the Inspector General reports to the Secretary as required by section 323(c) of the Medicare Provider Restoration Act of 2003. Insofar as the Inspector General has not determined the acquisition cost with respect to a drug or biological, the Secretary shall determine the payment amount for such drug or biological.

"(iii) For such drugs and biologicals (including erythropoietin) furnished in 2006 and subsequent years, such acquisition cost or the amount determined under section 1847A for the drug or biological, as the Secretary may specify.

"(B)(i) Drugs and biologicals (including erythropoietin) which were separately billed under this subsection on the day before the date of the enactment of the Medicare Provider Restoration Act of 2003 shall continue to be separately billed on and after such date.

"(ii) Nothing in this paragraph, section 1842(o), section 1847A, or section 1847B shall be construed as requiring or authorizing the bundling of payment for drugs and biologicals into the basic case-mix adjusted payment system under this paragraph.".

(2) Paragraph (7) of such section is amended in the first sentence by striking "The Secretary" and inserting "Subject to paragraph (12), the Secretary".

(3) Paragraph (11)(B) of such section is amended by inserting "subject to paragraphs (12) and (13)" before "payment for such item".

(e) DEMONSTRATION OF BUNDLED CASE-MIX ADJUSTED PAYMENT SYSTEM FOR ESRD SERVICES.—

(1) IN GENERAL.—The Secretary shall establish a demonstration project of the use of a fully case-mix adjusted payment system for end stage renal disease services under section 1881 of the Social Security Act (42 U.S.C. 1395rr) for patient characteristics identified in the report under subsection (f) that bundles into such payment rates amounts for—

(A) drugs and biologicals (including erythropoietin) furnished to end-stage renal disease patients under the medicare program which are separately billed by end stage renal disease facilities (as of the date of the enactment of this Act); and

(B) clinical laboratory tests related to such drugs and biologicals.

(2) FACILITIES INCLUDED IN THE DEMONSTRATION.—In conducting the demonstration under this subsection, the Secretary shall ensure the participation of a sufficient number of providers of dialysis services and renal dialysis facilities, but in no case to exceed 500. In selecting such providers and facilities, the Secretary shall ensure that the following types of providers are included in the demonstration:

(A) Urban providers and facilities.

(B) Rural providers and facilities.

(C) Not-for-profit providers and facilities.

(D) For-profit providers and facilities.

(E) Independent providers and facilities.

(F) Specialty providers and facilities, including pediatric providers and facilities and small providers and facilities.

(3) TEMPORARY ADD-ON PAYMENT FOR DIALYSIS SERVICES FURNISHED UNDER THE DEMONSTRATION.—

(A) IN GENERAL.—During the period of the demonstration project, the Secretary shall increase payment rates that would otherwise apply under section 1881(b) of such Act (42 U.S.C. 1395rr(b)) by 1.6 percent for dialysis services furnished in facilities in the demonstration site.

(B) RULES OF CONSTRUCTION.—Nothing in this subsection shall be construed as—

(i) as an annual update under section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b));

(ii) as increasing the baseline for payments under such section; or

(iii) requiring the budget neutral implementation of the demonstration project under this subsection.

(4) 3-YEAR PERIOD.—The Secretary shall conduct the demonstration under this subsection for the 3-year period beginning on January 1, 2006.

(5) USE OF ADVISORY BOARD.—

(A) IN GENERAL.—In carrying out the demonstration under this subsection, the Secretary shall establish an advisory board comprised of representatives described in subparagraph (B) to provide advice and recommendations with respect to the establishment and operation of such demonstration.

(B) REPRESENTATIVES.—Representatives referred to in subparagraph (A) include representatives of the following:

(i) Patient organizations.

(ii) Individuals with expertise in end-stage renal dialysis services, such as clinicians, economists, and researchers.

(iii) The Medicare Payment Advisory Commission, established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6).

(iv) The National Institutes of Health.

(v) Network organizations under section 1881(c) of the Social Security Act (42 U.S.C. 1395rr(c)).

(vi) Medicare contractors to monitor quality of care.

(vii) Providers of services and renal dialysis facilities furnishing end-stage renal disease services.

(C) TERMINATION OF ADVISORY PANEL.—The advisory panel shall terminate on December 31, 2008.

(6) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, $5,000,000 in fiscal year 2006 to conduct the demonstration under this subsection.

(f) REPORT ON A BUNDLED PROSPECTIVE PAYMENT SYSTEM FOR END STAGE RENAL DISEASE SERVICES.—

(1) REPORT.—

(A) IN GENERAL.—Not later than October 1, 2005, the Secretary shall submit to Congress a report detailing the elements and features for the design and implementation of a bundled prospective payment system for services furnished by end stage renal disease facilities including, to the maximum extent feasible, bundling of drugs, clinical laboratory tests, and other items that are separately billed by such facilities. The report shall include a description of the methodology to be used for the establishment of payment rates, including components of the new system described in paragraph (2).

(B) RECOMMENDATIONS.—The Secretary shall include in such report recommendations on elements, features, and methodology for a bundled prospective payment system or other issues related to such system as the Secretary determines to be appropriate.

(2) ELEMENTS AND FEATURES OF A BUNDLED PROSPECTIVE PAYMENT SYSTEM.—The report required under paragraph (1) shall include the following elements and features of a bundled prospective payment system:

(A) BUNDLE OF ITEMS AND SERVICES.—A description of the bundle of items and services to be included under the prospective payment system.

(B) CASE MIX.—A description of the case-mix adjustment to account for the relative resource use of different types of patients.

(C) WAGE INDEX.—A description of an adjustment to account for geographic differences in wages.

(D) Rural areas.—The appropriateness of establishing a specific payment adjustment to account for additional costs incurred by rural facilities.

(E) Other adjustments.—Such other adjustments as may be necessary to reflect the variation in costs incurred by facilities in caring for patients with end stage renal disease.

(F) Update framework.—A methodology for appropriate updates under the prospective payment system.

(G) Additional recommendations.—Such other matters as the Secretary determines to be appropriate.

SEC. 324. 2-YEAR MORATORIUM ON THERAPY CAPS; PROVISIONS RELATING TO REPORTS.

(a) Additional Moratorium on Therapy Caps.—

(1) 2004 and 2005.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended by striking "and 2002" and inserting "2002, 2004, and 2005".

(2) Remainder of 2003.—For the period beginning on the date of the enactment of this Act and ending of December 31, 2003, the Secretary shall not apply the provisions of paragraphs (1), (2), and (3) of section 1833(g) to expenses incurred with respect to services described in such paragraphs during such period. Nothing in the preceding sentence shall be construed as affecting the application of such paragraphs by the Secretary before the date of the enactment of this Act.

(b) Prompt Submission of Overdue Reports on Payment and Utilization of Outpatient Therapy Services.—Not later than March 31, 2004, the Secretary shall submit to Congress the reports required under section 4541(d)(2) of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 457) (relating to alternatives to a single annual dollar cap on outpatient therapy) and under section 221(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Appendix F, 113 Stat. 1501A–352), as enacted into law by section 1000(a)(6) of Public Law 106–113 (relating to utilization patterns for outpatient therapy).

(c) GAO Report Identifying Conditions and Diseases Justifying Waiver of Therapy Cap.—

(1) Study.—The Comptroller General of the United States shall identify conditions or diseases that may justify waiving the application of the therapy caps under section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) with respect to such conditions or diseases.

(2) Report to congress.—Not later than October 1, 2004, the Comptroller General shall submit to Congress a report on the conditions and diseases identified under paragraph (1), and shall include a recommendation of criteria, with respect to such conditions and disease, under which a waiver of the therapy caps would apply.

SEC. 325. WAIVER OF PART B LATE ENROLLMENT PENALTY FOR CERTAIN MILITARY RETIREES; SPECIAL ENROLLMENT PERIOD.

(a) Waiver of Penalty.—

(1) In general.—Section 1839(b) (42 U.S.C. 1395r(b)) is amended by adding at the end the following new sentence: "No increase in the premium shall be effected for a month in the case of an individual who enrolls under this part during 2001, 2002, 2003, or 2004 and who demonstrates to the Secretary before December 31, 2004, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.".

(2) Effective date.—The amendment made by paragraph (1) shall apply to premiums for months beginning with January 2004. The Secretary shall establish a method for providing rebates of premium penalties paid for months on or after January 2004 for which a penalty does not apply under such amendment but for which a penalty was previously collected.

(b) Medicare Part B Special Enrollment Period.—

(1) In general.—In the case of any individual who, as of the date of the enactment of this Act, is eligible to enroll but is not enrolled under part B of title XVIII of the Social Security Act and is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code), the Secretary of Health and Human Services shall provide for a special enrollment period during which the individual may enroll under such part. Such period shall begin as soon as possible after the date of the enactment of this Act and shall end on December 31, 2004.

(2) Coverage period.—In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under part B of title XVIII of the Social Security Act shall begin on the first day of the month following the month in which the individual enrolls.

SEC. 326. PAYMENT FOR SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.

(a) Reductions in Payment Updates.—Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is amended to read as follows:

"(C)(i) Notwithstanding the second sentence of each of subparagraphs (A) and (B), except as otherwise specified in clauses (ii), (iii), and (iv), if the Secretary has not updated amounts established under such subparagraphs or under subparagraph (D), with respect to facility services furnished during a fiscal year (beginning with fiscal year 1986 or a calendar year (beginning with 2006)), such amounts shall be increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

"(ii) In each of the fiscal years 1998 through 2002, the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points.

"(iii) In fiscal year 2004, beginning with April 1, 2004, the increase under this subparagraph shall be the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with March 31, 2003, minus 3.0 percentage points.

"(iv) In fiscal year 2005, the last quarter of calendar year 2005, and each of calendar years 2006 through 2009, the increase under this subparagraph shall be 0 percent.".

(b) Repeal of Survey Requirement and Implementation of New System.—Section 1833(i)(2) (42 U.S.C. 1395l(i)(2)) is amended—

(1) in subparagraph (A)—

(A) in the matter preceding clause (i), by striking "The" and inserting "For services furnished prior to the implementation of the system described in subparagraph (D), the"; and

(B) in clause (i), by striking "taken not later than January 1, 1995, and every 5 years thereafter,"; and

(2) by adding at the end the following new subparagraph:

"(D)(i) Taking into account the recommendations in the report under section 326(d) of Medicare Provider Restoration Act of 2003, the Secretary shall implement a revised payment system for payment of surgical services furnished in ambulatory surgical centers.

"(ii) In the year the system described in clause (i) is implemented, such system shall be designed to result in the same aggregate amount of expenditures for such services as would be made if this subparagraph did not apply, as estimated by the Secretary.

"(iii) The Secretary shall implement the system described in clause (i) for periods in a manner so that it is first effective beginning on or after January 1, 2006, and not later than January 1, 2008.

"(iv) There shall be no administrative or judicial review under section 1869, 1878, or otherwise, of the classification system, the relative weights, payment amounts, and the geographic adjustment factor, if any, under this subparagraph.".

(c) Conforming Amendment.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended by adding the following new subparagraph:

"(G) with respect to facility services furnished in connection with a surgical procedure specified pursuant to subsection (i)(1)(A) and furnished to an individual in an ambulatory surgical center described in such subsection, for services furnished beginning with the implementation date of a revised payment system for such services in such facilities specified in subsection (i)(2)(D), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by the Secretary under such revised payment system,".

(d) GAO Study of Ambulatory Surgical Center Payments.—

(1) Study.—

(A) In general.—The Comptroller General of the United States shall conduct a study that compares the relative costs of procedures furnished in ambulatory surgical centers to the relative costs of procedures furnished in hospital outpatient departments under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)). The study shall also examine how accurately ambulatory payment categories reflect procedures furnished in ambulatory surgical centers.

(B) Consideration of ASC data.—In conducting the study under paragraph (1), the Comptroller General shall consider data submitted by ambulatory surgical centers regarding the matters described in clauses (i) through (iii) of paragraph (2)(B).

(2) Report and recommendations.—

(A) Report.—Not later than January 1, 2005, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

(B) Recommendations.—The report submitted under subparagraph (A) shall include recommendations on the following matters:

(i) The appropriateness of using the groups of covered services and relative weights established under the outpatient prospective payment system as the basis of payment for ambulatory surgical centers.

(ii) If the relative weights under such hospital outpatient prospective payment system are appropriate for such purpose—

(I) whether the payment rates for ambulatory surgical centers should be based on a uniform percentage of the payment rates or weights under such outpatient system; or

(II) whether the payment rates for ambulatory surgical centers should vary, or the weights should be revised, based on specific procedures or types of services (such as ophthalmology and pain management services).

(iii) Whether a geographic adjustment should be used for payment of services furnished in ambulatory surgical centers, and if so, the labor and nonlabor shares of such payment.

SEC. 327. PAYMENT FOR CERTAIN SHOES AND INSERTS UNDER THE FEE SCHEDULE FOR ORTHOTICS AND PROSTHETICS.

(a) IN GENERAL.—Section 1833(o) (42 U.S.C. 1395l(o)) is amended—

(1) in paragraph (1)(B), by striking "no more than the limits established under paragraph (2)" and inserting "no more than the amount of payment applicable under paragraph (2)"; and

(2) in paragraph (2), to read as follows:

"(2)(A) Except as provided by the Secretary under subparagraphs (B) and (C), the amount of payment under this paragraph for custom molded shoes, extra-depth shoes, and inserts shall be the amount determined for such items by the Secretary under section 1834(h).

"(B) The Secretary may establish payment amounts for shoes and inserts that are lower than the amount established under section 1834(h) if the Secretary finds that shoes and inserts of an appropriate quality are readily available at or below the amount established under such section.

"(C) In accordance with procedures established by the Secretary, an individual entitled to benefits with respect to shoes described in section 1861(s)(12) may substitute modification of such shoes instead of obtaining one (or more, as specified by the Secretary) pair of inserts (other than the original pair of inserts with respect to such shoes). In such case, the Secretary shall substitute, for the payment amount established under section 1834(h), a payment amount that the Secretary estimates will assure that there is no net increase in expenditures under this subsection as a result of this subparagraph.".

(b) CONFORMING AMENDMENTS.—(1) Section 1834(h)(4)(C) (42 U.S.C. 1395m(h)(4)(C)) is amended by inserting "(and includes shoes described in section 1861(s)(12))" after "in section 1861(s)(9)".

(2) Section 1842(s)(2) (42 U.S.C. 1395u(s)(2)) is amended by striking subparagraph (C).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items furnished on or after January 1, 2005.

SEC. 329. 5-YEAR AUTHORIZATION OF REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

Section 1880(e)(1)(A) (42 U.S.C. 1395qq(e)(1)(A)) is amended by inserting "(and for items and services furnished during the 5-year period beginning on January 1, 2005, all items and services for which payment may be made under part B)" after "for services described in paragraph (2)".

Subtitle D—Additional Demonstrations, Studies, and Other Provisions

SEC. 341. DEMONSTRATION PROJECT FOR COVERAGE OF CERTAIN PRESCRIPTION DRUGS AND BIOLOGICALS.

(a) DEMONSTRATION PROJECT.—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which payment is made for drugs or biologicals that are prescribed as replacements for drugs and biologicals described in section 1861(s)(2)(A) or 1861(s)(2)(Q) of such Act (42 U.S.C. 1395x(s)(2)(A), 1395x(s)(2)(Q)), or both, for which payment is made under such part. Such project shall provide for cost-sharing applicable with respect to such drugs or biologicals.

(b) DEMONSTRATION PROJECT SITES.—The project established under this section shall be conducted in sites selected by the Secretary.

(c) DURATION.—The Secretary shall conduct the demonstration project for the 2-year period beginning on the date that is 90 days after the date of the enactment of this Act, but in no case may the project extend beyond December 31, 2005.

(d) LIMITATION.—Under the demonstration project over the duration of the project, the Secretary may not provide—

(1) coverage for more than 50,000 patients; and

(2) more than $500,000,000 in funding.

(e) REPORT.—Not later than July 1, 2006, the Secretary shall submit to Congress a report on the project. The report shall include an evaluation of patient access to care and patient outcomes under the project, as well as an analysis of the cost effectiveness of the project, including an evaluation of the costs savings (if any) to the medicare program attributable to reduced physicians' services and hospital outpatient departments services for administration of the biological.

SEC. 342. EXTENSION OF COVERAGE OF INTRAVENOUS IMMUNE GLOBULIN (IVIG) FOR THE TREATMENT OF PRIMARY IMMUNE DEFICIENCY DISEASES IN THE HOME.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by sections 611(a) and 612(a) is amended—

(1) in subsection (s)(2)—

(A) by striking "and" at the end of subparagraph (X);

(B) by adding "and" at the end of subparagraph (Y); and

(C) by adding at the end the following new subparagraph:

"(Z) intravenous immune globulin for the treatment of primary immune deficiency diseases in the home (as defined in subsection (zz));"; and

(2) by adding at the end the following new subsection:

"Intravenous Immune Globulin

"(zz) The term 'intravenous immune globulin' means an approved pooled plasma derivative for the treatment in the patient's home of a patient with a diagnosed primary immune deficiency disease, but not including items or services related to the administration of the derivative, if a physician determines administration of the derivative in the patient's home is medically appropriate.".

(b) PAYMENT AS A DRUG OR BIOLOGICAL.—Section 1833(a)(1)(S) (42 U.S.C. 1395l(a)(1)(S)) is amended by inserting "(including intravenous immune globulin (as defined in section 1861(zz)))" after "with respect to drugs and biologicals".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items furnished administered on or after January 1, 2004.

SEC. 343. MEDPAC STUDY OF COVERAGE OF SURGICAL FIRST ASSISTING SERVICES OF CERTIFIED REGISTERED NURSE FIRST ASSISTANTS.

(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the "Commission") shall conduct a study on the feasibility and advisability of providing for payment under part B of title XVIII of the Social Security Act for surgical first assisting services furnished by a certified registered nurse first assistant to medicare beneficiaries.

(b) REPORT.—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate.

(c) DEFINITIONS.—In this section:

(1) SURGICAL FIRST ASSISTING SERVICES.—The term "surgical first assisting services" means services consisting of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care (as determined by the Secretary) furnished by a certified registered nurse first assistant (as defined in paragraph (2)) which the certified registered nurse first assistant is legally authorized to perform by the State in which the services are performed.

(2) CERTIFIED REGISTERED NURSE FIRST ASSISTANT.—The term "certified registered nurse first assistant" means an individual who—

(A) is a registered nurse and is licensed to practice nursing in the State in which the surgical first assisting services are performed;

(B) has completed a minimum of 2,000 hours of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care; and

(C) is certified as a registered nurse first assistant by an organization recognized by the Secretary.

SEC. 344. MEDPAC STUDY OF PAYMENT FOR CARDIO-THORACIC SURGEONS.

(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the "Commission") shall conduct a study on the practice expense relative values established by the Secretary of Health and Human Services under the medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians in the specialties of thoracic and cardiac surgery to determine whether such values adequately take into account the attendant costs that such physicians incur in providing clinical staff for patient care in hospitals.

(b) REPORT.—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate.

SEC. 345. STUDIES RELATING TO VISION IMPAIRMENTS.

(a) COVERAGE OF OUTPATIENT VISION SERVICES FURNISHED BY VISION REHABILITATION PROFESSIONALS UNDER PART B.—

(1) STUDY.—The Secretary shall conduct a study to determine the feasibility and advisability of providing for payment for vision rehabilitation services furnished by vision rehabilitation professionals.

(2) REPORT.—Not later than January 1, 2005, the Secretary shall submit to Congress a report on the study conducted under paragraph (1) together with recommendations for such legislation or administrative action as the Secretary determines to be appropriate.

(3) VISION REHABILITATION PROFESSIONAL DEFINED.—In this subsection, the term "vision rehabilitation professional" means an orientation and mobility specialist, a rehabilitation teacher, or a low vision therapist.

(b) REPORT ON APPROPRIATENESS OF A DEMONSTRATION PROJECT TO TEST FEASIBILITY OF USING PPO NETWORKS TO REDUCE COSTS OF ACQUIRING EYEGLASSES FOR MEDICARE BENEFICIARIES AFTER CATARACT SURGERY.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the feasibility of establishing a two-year demonstration project under which the Secretary enters into arrangements with vision care preferred provider organization networks to furnish and pay for conventional eyeglasses subsequent to each cataract surgery with insertion of an intraocular lens on behalf of Medicare beneficiaries. In such report, the Secretary shall include an estimate of potential cost savings to the Medicare program through the use of such networks, taking into consideration quality of service and beneficiary access to services offered by vision care preferred provider organization networks.

SEC. 346. MEDICARE HEALTH CARE QUALITY DEMONSTRATION PROGRAMS.

Title XVIII (42 U.S.C. 1395 et seq.) is amended by inserting after section 1866B the following new section:

"SEC. 1866C. HEALTH CARE QUALITY DEMONSTRATION PROGRAM.

"SEC. (a) DEFINITIONS.—In this section:

"(1) BENEFICIARY.—The term 'beneficiary' means an individual who is entitled to benefits under part A and enrolled under part B, including any individual who is enrolled in a Medicare Advantage plan under part C.

"(2) HEALTH CARE GROUP.—

"(A) IN GENERAL.—The term 'health care group' means—

"(i) a group of physicians that is organized at least in part for the purpose of providing physician's services under this title;

"(ii) an integrated health care delivery system that delivers care through coordinated hospitals, clinics, home health agencies, ambulatory surgery centers, skilled nursing facilities, rehabilitation facilities and clinics, and employed, independent, or contracted physicians; or

"(iii) an organization representing regional coalitions of groups or systems described in clause (i) or (ii).

"(B) INCLUSION.—As the Secretary determines appropriate, a health care group may include a hospital or any other individual or entity furnishing items or services for which payment may be made under this title that is affiliated with the health care group under an arrangement structured so that such hospital, individual, or entity participates in a demonstration project under this section.

"(3) PHYSICIAN.—Except as otherwise provided for by the Secretary, the term 'physician' means any individual who furnishes services that may be paid for as physicians' services under this title.

"(b) DEMONSTRATION PROJECTS.—The Secretary shall establish a 5-year demonstration program under which the Secretary shall approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including—

"(1) the provision of incentives to improve the safety of care provided to beneficiaries;

"(2) the appropriate use of best practice guidelines by providers and services by beneficiaries;

"(3) reduced scientific uncertainty in the delivery of care through the examination of variations in the utilization and allocation of services, and outcomes measurement and research;

"(4) encourage shared decision making between providers and patients;

"(5) the provision of incentives for improving the quality and safety of care and achieving the efficient allocation of resources;

"(6) the appropriate use of culturally and ethnically sensitive health care delivery; and

"(7) the financial effects on the health care marketplace of altering the incentives for care delivery and changing the allocation of resources.

"(c) ADMINISTRATION BY CONTRACT.—

"(1) IN GENERAL.—Except as otherwise provided in this section, the Secretary may administer the demonstration program established under this section in a manner that is similar to the manner in which the demonstration program established under section 1866A is administered in accordance with section 1866B.

"(2) ALTERNATIVE PAYMENT SYSTEMS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include proposals for the use of alternative payment systems for items and services provided to beneficiaries by the group that are designed to—

"(A) encourage the delivery of high quality care while accomplishing the objectives described in subsection (b); and

"(B) streamline documentation and reporting requirements otherwise required under this title.

"(3) BENEFITS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include modifications to the package of benefits available under the original medicare fee-for-service program under parts A and B or the package of benefits available through a Medicare Advantage plan under part C. The criteria employed under the demonstration program under this section to evaluate outcomes and determine best practice guidelines and incentives shall not be used as a basis for the denial of medicare benefits under the demonstration program to patients against their wishes (or if the patient is incompetent, against the wishes of the patient's surrogate) on the basis of the patient's age or expected length of life or of the patient's present or predicted disability, degree of medical dependency, or quality of life.

"(d) ELIGIBILITY CRITERIA.—To be eligible to receive assistance under this section, an entity shall—

"(1) be a health care group;

"(2) meet quality standards established by the Secretary, including—

"(A) the implementation of continuous quality improvement mechanisms that are aimed at integrating community-based support services, primary care, and referral care;

"(B) the implementation of activities to increase the delivery of effective care to beneficiaries;

"(C) encouraging patient participation in preference-based decisions;

"(D) the implementation of activities to encourage the coordination and integration of medical service delivery; and

"(E) the implementation of activities to measure and document the financial impact on the health care marketplace of altering the incentives of health care delivery and changing the allocation of resources; and

"(3) meet such other requirements as the Secretary may establish.

"(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII as may be necessary to carry out the purposes of the demonstration program established under this section.

"(f) BUDGET NEUTRALITY.—With respect to the 5-year period of the demonstration program under subsection (b), the aggregate expenditures under this title for such period shall not exceed the aggregate expenditures that would have been expended under this title if the program established under this section had not been implemented.

"(g) NOTICE REQUIREMENTS.—In the case of an individual that receives health care items or services under a demonstration program carried out under this section, the Secretary shall ensure that such individual is notified of any waivers of coverage or payment rules that are applicable to such individual under this title as a result of the participation of the individual in such program.

"(h) PARTICIPATION AND SUPPORT BY FEDERAL AGENCIES.—In carrying out the demonstration program under this section, the Secretary may direct—

"(1) the Director of the National Institutes of Health to expand the efforts of the Institutes to evaluate current medical technologies and improve the foundation for evidence-based practice;

"(2) the Administrator of the Agency for Healthcare Research and Quality to, where possible and appropriate, use the program under this section as a laboratory for the study of quality improvement strategies and to evaluate, monitor, and disseminate information relevant to such program; and

"(3) the Administrator of the Centers for Medicare & Medicaid Services and the Administrator of the Center for Medicare Choices to support linkages of relevant medicare data to registry information from participating health care groups for the beneficiary populations served by the participating groups, for analysis supporting the purposes of the demonstration program, consistent with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996.".

SEC. 347. MEDPAC STUDY ON DIRECT ACCESS TO PHYSICAL THERAPY SERVICES.

(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the "Commission") shall conduct a study on the feasibility and advisability of allowing medicare fee-for-service beneficiaries direct access to outpatient physical therapy services and physical therapy services furnished as comprehensive rehabilitation facility services.

(b) REPORT.—Not later than January 1, 2005, the Commission shall submit to Congress a report on the study conducted under subsection (a) together with recommendations for such legislation or administrative action as the Commission determines to be appropriate.

(c) DIRECT ACCESS DEFINED.—The term "direct access" means, with respect to outpatient physical therapy services and physical therapy services furnished as comprehensive outpatient rehabilitation facility services, coverage of and payment for such services in accordance with the provisions of title XVIII of the Social Security Act, except that sections 1835(a)(2), 1861(p), and 1861(cc) of such Act (42 U.S.C. 1395n(a)(2), 1395x(p), and 1395x(cc), respectively) shall be applied—

(1) without regard to any requirement that—

(A) an individual be under the care of (or referred by) a physician; or

(B) services be provided under the supervision of a physician; and

(2) by allowing a physician or a qualified physical therapist to satisfy any requirement for—

(A) certification and recertification; and

(B) establishment and periodic review of a plan of care.

SEC. 348. DEMONSTRATION PROJECT FOR CONSUMER-DIRECTED CHRONIC OUTPATIENT SERVICES.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, the Secretary

shall establish demonstration projects (in this section referred to as "demonstration projects") under which the Secretary shall evaluate methods that improve the quality of care provided to individuals with chronic conditions and that reduce expenditures that would otherwise be made under the medicare program on behalf of such individuals for such chronic conditions, such methods to include permitting those beneficiaries to direct their own health care needs and services.

(2) INDIVIDUALS WITH CHRONIC CONDITIONS DEFINED.—In this section, the term "individuals with chronic conditions" means an individual entitled to benefits under part A of title XVIII of the Social Security Act, and enrolled under part B of such title, but who is not enrolled under part C of such title who is diagnosed as having one or more chronic conditions (as defined by the Secretary), such as diabetes.

(b) DESIGN OF PROJECTS.—

(1) EVALUATION BEFORE IMPLEMENTATION OF PROJECT.—

(A) IN GENERAL.—In establishing the demonstration projects under this section, the Secretary shall evaluate best practices employed by group health plans and practices under State plans for medical assistance under the medicaid program under title XIX of the Social Security Act, as well as best practices in the private sector or other areas, of methods that permit patients to self-direct the provision of personal care services. The Secretary shall evaluate such practices for a 1-year period and, based on such evaluation, shall design the demonstration project.

(B) REQUIREMENT FOR ESTIMATE OF BUDGET NEUTRAL COSTS.—As part of the evaluation under subparagraph (A), the Secretary shall evaluate the costs of furnishing care under the projects. The Secretary may not implement the demonstration projects under this section unless the Secretary determines that the costs of providing care to individuals with chronic conditions under the project will not exceed the costs, in the aggregate, of furnishing care to such individuals under title XVIII of the Social Security Act, that would otherwise be paid without regard to the demonstration projects for the period of the project.

(2) SCOPE OF SERVICES.—The Secretary shall determine the appropriate scope of personal care services that would apply under the demonstration projects.

(c) VOLUNTARY PARTICIPATION.—Participation of providers of services and suppliers, and of individuals with chronic conditions, in the demonstration projects shall be voluntary.

(d) DEMONSTRATION PROJECTS SITES.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall conduct a demonstration project in at least one area that the Secretary determines has a population of individuals entitled to benefits under part A of title XVIII of the Social Security Act, and enrolled under part B of such title, with a rate of incidence of diabetes that significantly exceeds the national average rate of all areas.

(e) EVALUATION AND REPORT.—

(1) EVALUATIONS.—The Secretary shall conduct evaluations of the clinical and cost effectiveness of the demonstration projects.

(2) REPORTS.—Not later than 2 years after the commencement of the demonstration projects, and biannually thereafter, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

(A) An analysis of the patient outcomes and costs of furnishing care to the individuals with chronic conditions participating in the projects as compared to such outcomes and costs to other individuals for the same health conditions.

(B) Evaluation of patient satisfaction under the demonstration projects.

(C) Such recommendations regarding the extension, expansion, or termination of the projects as the Secretary determines appropriate.

(f) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(g) AUTHORIZATION OF APPROPRIATIONS.—(1) Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

(2) There are authorized to be appropriated from such Trust Fund such sums as may be necessary for the Secretary to enter into contracts with appropriate organizations for the deign, implementation, and evaluation of the demonstration project.

(3) In no case may expenditures under this section exceed the aggregate expenditures that would otherwise have been made for the provision of personal care services.

SEC. 349. MEDICARE CARE MANAGEMENT PERFORMANCE DEMONSTRATION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a pay-for-performance demonstration program with physicians to meet the needs of eligible beneficiaries through the adoption and use of health information technology and evidence-based outcomes measures for—

(A) promoting continuity of care;

(B) helping stabilize medical conditions;

(C) preventing or minimizing acute exacerbations of chronic conditions; and

(D) reducing adverse health outcomes, such as adverse drug interactions related to polypharmacy.

(2) SITES.—The Secretary shall designate no more than 4 sites at which to conduct the demonstration program under this section, of which—

(A) 2 shall be in an urban area;

(B) 1 shall be in a rural area; and

(C) 1 shall be in a State with a medical school with a Department of Geriatrics that manages rural outreach sites and is capable of managing patients with multiple chronic conditions, one of which is dementia.

(3) DURATION.—The Secretary shall conduct the demonstration program under this section for a 3-year period.

(4) CONSULTATION.—In carrying out the demonstration program under this section, the Secretary shall consult with private sector and non-profit groups that are undertaking similar efforts to improve quality and reduce avoidable hospitalizations for chronically ill patients.

(b) PARTICIPATION.—

(1) IN GENERAL.—A physician who provides care for a minimum number of eligible beneficiaries (as specified by the Secretary) may participate in the demonstration program under this section if such physician agrees, to phase-in over the course of the 3-year demonstration period and with the assistance provided under subsection (d)(2)—

(A) the use of health information technology to manage the clinical care of eligible beneficiaries consistent with paragraph (3); and

(B) the electronic reporting of clinical quality and outcomes measures in accordance with requirements established by the Secretary under the demonstration program.

(2) SPECIAL RULE.—In the case of the sites referred to in subparagraphs (B) and (C) of subsection (a)(2), a physician who provides care for a minimum number of beneficiaries with two or more chronic conditions, including dementia (as specified by the Secretary), may participate in the program under this section if such physician agrees to the requirements in subparagraphs (A) and (B) of paragraph (1).

(3) PRACTICE STANDARDS.—Each physician participating in the demonstration program under this section must demonstrate the ability—

(A) to assess each eligible beneficiary for conditions other than chronic conditions, such as impaired cognitive ability and comorbidities, for the purposes of developing care management requirements;

(B) to serve as the primary contact of eligible beneficiaries in accessing items and services for which payment may be made under the medicare program;

(C) to establish and maintain health care information system for such beneficiaries;

(D) to promote continuity of care across providers and settings;

(E) to use evidence-based guidelines and meet such clinical quality and outcome measures as the Secretary shall require;

(F) to promote self-care through the provision of patient education and support for patients or, where appropriate, family caregivers;

(G) when appropriate, to refer such beneficiaries to community service organizations; and

(H) to meet such other complex care management requirements as the Secretary may specify.

The guidelines and measures required under subparagraph (E) shall be designed to take into account beneficiaries with multiple chronic conditions.

(c) PAYMENT METHODOLOGY.—Under the demonstration program under this section the Secretary shall pay a per beneficiary amount to each participating physician who meets or exceeds specific performance standards established by the Secretary with respect to the clinical quality and outcome measures reported under subsection (b)(1)(B). Such amount may vary based on different levels of performance or improvement.

(d) ADMINISTRATION.—

(1) USE OF QUALITY IMPROVEMENT ORGANIZATIONS.—The Secretary shall contract with quality improvement organizations or such other entities as the Secretary deems appropriate to enroll physicians and evaluate their performance under the demonstration program under this section.

(2) TECHNICAL ASSISTANCE.—The Secretary shall require in such contracts that the contractor be responsible for technical assistance and education as needed to physicians enrolled in the demonstration program under this section for the purpose of aiding their adoption of health information technology, meeting practice standards, and implementing required clinical and outcomes measures.

(e) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds

as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary estimates would have been paid if the demonstration program under this section was not implemented.

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(g) REPORT.—Not later than 12 months after the date of completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(h) DEFINITIONS.—In this section:

(1) ELIGIBLE BENEFICIARY.—The term "eligible beneficiary" means any individual who—

(A) is entitled to benefits under part A and enrolled for benefits under part B of title XVIII of the Social Security Act and is not enrolled in a plan under part C of such title; and

(B) has one or more chronic medical conditions specified by the Secretary (one of which may be cognitive impairment).

(2) HEALTH INFORMATION TECHNOLOGY.—The term "health information technology" means email communication, clinical alerts and reminders, and other information technology that meets such functionality, interoperability, and other standards as prescribed by the Secretary.

SEC. 350. GAO STUDY AND REPORT ON THE PROPAGATION OF CONCIERGE CARE.

(a) STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on concierge care (as defined in paragraph (2)) to determine the extent to which such care—

(A) is used by medicare beneficiaries (as defined in section 1802(b)(5)(A) of the Social Security Act (42 U.S.C. 1395a(b)(5)(A))); and

(B) has impacted upon the access of medicare beneficiaries (as so defined) to items and services for which reimbursement is provided under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) CONCIERGE CARE.—In this section, the term "concierge care" means an arrangement under which, as a prerequisite for the provision of a health care item or service to an individual, a physician, practitioner (as described in section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C))), or other individual—

(A) charges a membership fee or another incidental fee to an individual desiring to receive the health care item or service from such physician, practitioner, or other individual; or

(B) requires the individual desiring to receive the health care item or service from such physician, practitioner, or other individual to purchase an item or service.

(b) REPORT.—Not later than the date that is 12 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a)(1) together with such recommendations for legislative or administrative action as the Comptroller General determines to be appropriate.

SEC. 351. DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.

(a) DEFINITIONS.—In this section:

(1) CHIROPRACTIC SERVICES.—The term "chiropractic services" has the meaning given that term by the Secretary for purposes of the demonstration projects, but shall include, at a minimum—

(A) care for neuromusculoskeletal conditions typical among eligible beneficiaries; and

(B) diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided.

(2) DEMONSTRATION PROJECT.—The term "demonstration project" means a demonstration project established by the Secretary under subsection (b)(1).

(3) ELIGIBLE BENEFICIARY.—The term "eligible beneficiary" means an individual who is enrolled under part B of the medicare program.

(4) MEDICARE PROGRAM.—The term "medicare program" means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.—

(1) ESTABLISHMENT.—The Secretary shall establish demonstration projects in accordance with the provisions of this section for the purpose of evaluating the feasibility and advisability of covering chiropractic services under the medicare program (in addition to the coverage provided for services consisting of treatment by means of manual manipulation of the spine to correct a subluxation described in section 1861(r)(5) of the Social Security Act (42 U.S.C. 1395x(r)(5))).

(2) NO PHYSICIAN APPROVAL REQUIRED.—In establishing the demonstration projects, the Secretary shall ensure that an eligible beneficiary who participates in a demonstration project, including an eligible beneficiary who is enrolled for coverage under a Medicare+Choice plan (or, on and after January 1, 2006, under a Medicare Advantage plan), is not required to receive approval from a physician or other health care provider in order to receive a chiropractic service under a demonstration project.

(3) CONSULTATION.—In establishing the demonstration projects, the Secretary shall consult with chiropractors, organizations representing chiropractors, eligible beneficiaries, and organizations representing eligible beneficiaries.

(4) PARTICIPATION.—Any eligible beneficiary may participate in the demonstration projects on a voluntary basis.

(c) CONDUCT OF DEMONSTRATION PROJECTS.—

(1) DEMONSTRATION SITES.—

(A) SELECTION OF DEMONSTRATION SITES.—The Secretary shall conduct demonstration projects at 4 demonstration sites.

(B) GEOGRAPHIC DIVERSITY.—Of the sites described in subparagraph (A)—

(i) 2 shall be in rural areas; and

(ii) 2 shall be in urban areas.

(C) SITES LOCATED IN HPSAS.—At least 1 site described in clause (i) of subparagraph (B) and at least 1 site described in clause (ii) of such subparagraph shall be located in an area that is designated under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) as a health professional shortage area.

(2) IMPLEMENTATION; DURATION.—

(A) IMPLEMENTATION.—The Secretary shall not implement the demonstration projects before October 1, 2004.

(B) DURATION.—The Secretary shall complete the demonstration projects by the date that is 2 years after the date on which the first demonstration project is implemented.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration projects—

(A) to determine whether eligible beneficiaries who use chiropractic services use a lesser overall amount of items and services for which payment is made under the medicare program than eligible beneficiaries who do not use such services;

(B) to determine the cost of providing payment for chiropractic services under the medicare program;

(C) to determine the satisfaction of eligible beneficiaries participating in the demonstration projects and the quality of care received by such beneficiaries; and

(D) to evaluate such other matters as the Secretary determines is appropriate.

(2) REPORT.—Not later than the date that is 1 year after the date on which the demonstration projects conclude, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) together with such recommendations for legislation or administrative action as the Secretary determines is appropriate.

(e) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of the medicare program to the extent and for the period the Secretary finds necessary to conduct the demonstration projects.

(f) FUNDING.—

(1) DEMONSTRATION PROJECTS.—

(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (2), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration projects under this section.

(B) LIMITATION.—In conducting the demonstration projects under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under the medicare program do not exceed the amount which the Secretary would have paid under the medicare program if the demonstration projects under this section were not implemented.

(2) EVALUATION AND REPORT.—There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (d).

TITLE IV—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

SEC. 401. DEMONSTRATION PROJECT TO CLARIFY THE DEFINITION OF HOMEBOUND.

(a) DEMONSTRATION PROJECT.—Not later than 180 days after the date of the enactment of this Act, the Secretary shall conduct a 2-year demonstration project under part B of title XVIII of the Social Security Act under which medicare beneficiaries with chronic conditions described in subsection (b) are deemed to be homebound for purposes of receiving home health services under the medicare program.

(b) MEDICARE BENEFICIARY DESCRIBED.—For purposes of subsection (a), a medicare beneficiary is eligible to be deemed to be homebound, without regard to the purpose, frequency, or duration of absences from the home, if—

(1) the beneficiary has been certified by one physician as an individual who has a permanent and severe, disabling condition that is not expected to improve;

(2) the beneficiary is dependent upon assistance from another individual with at least 3 out of the 5 activities of daily living for the rest of the beneficiary's life;

(3) the beneficiary requires skilled nursing services for the rest of the beneficiary's life and the skilled nursing is more than medication management;

(4) an attendant is required to visit the beneficiary on a daily basis to monitor and treat the beneficiary's medical condition or to assist the beneficiary with activities of daily living;

(5) the beneficiary requires technological assistance or the assistance of another person to leave the home; and

(6) the beneficiary does not regularly work in a paid position full-time or part-time outside the home.

(c) Demonstration Project Sites.—The demonstration project established under this section shall be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

(d) Limitation on Number of Participants.—The aggregate number of such beneficiaries that may participate in the project may not exceed 15,000.

(e) Data.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to medicare beneficiaries that relates to quality of care, patient outcomes, and additional costs, if any, to the medicare program.

(f) Report to Congress.—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project using the data collected under subsection (e). The report shall include the following:

(1) An examination of whether the provision of home health services to medicare beneficiaries under the project has had any of the following effects:

(A) Has adversely affected the provision of home health services under the medicare program.

(B) Has directly caused an increase of expenditures under the medicare program for the provision of such services that is directly attributable to such clarification.

(2) The specific data evidencing the amount of any increase in expenditures that is directly attributable to the demonstration project (expressed both in absolute dollar terms and as a percentage) above expenditures that would otherwise have been incurred for home health services under the medicare program.

(3) Specific recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency, and purpose of their absences from the home to qualify for home health services without incurring additional costs to the medicare program.

(g) Waiver Authority.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(h) Construction.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act for acts prohibited under such titles, including penalties for false certifications for purposes of receipt of items or services under the medicare program.

(i) Authorization of Appropriations.—Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

(j) Definitions.—In this section:

(1) Medicare beneficiary.—The term "medicare beneficiary" means an individual who is enrolled under part B of title XVIII of the Social Security Act.

(2) Home health services.—The term "home health services" has the meaning given such term in section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)).

(3) Activities of daily living defined.—The term "activities of daily living" means eating, toileting, transferring, bathing, and dressing.

SEC. 402. DEMONSTRATION PROJECT FOR MEDICAL ADULT DAY-CARE SERVICES.

(a) Establishment.—Subject to the succeeding provisions of this section, the Secretary shall establish a demonstration project (in this section referred to as the "demonstration project") under which the Secretary shall, as part of a plan of an episode of care for home health services established for a medicare beneficiary, permit a home health agency, directly or under arrangements with a medical adult day-care facility, to provide medical adult day-care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home.

(b) Payment.—

(1) In general.—Subject to paragraph (2), the amount of payment for an episode of care for home health services, a portion of which consists of substitute medical adult day-care services, under the demonstration project shall be made at a rate equal to 95 percent of the amount that would otherwise apply for such home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff). In no case may a home health agency, or a medical adult day-care facility under arrangements with a home health agency, separately charge a beneficiary for medical adult day-care services furnished under the plan of care.

(2) Adjustment in case of overutilization of substitute adult day-care services to ensure budget neutrality.—The Secretary shall monitor the expenditures under the demonstration project and under title XVIII of the Social Security Act for home health services. If the Secretary estimates that the total expenditures under the demonstration project and under such title XVIII for home health services for a period determined by the Secretary exceed expenditures that would have been made under such title XVIII for home health services for such period if the demonstration project had not been conducted, the Secretary shall adjust the rate of payment to medical adult day-care facilities under paragraph (1) in order to eliminate such excess.

(c) Demonstration Project Sites.—The demonstration project established under this section shall be conducted in not more than 5 sites in States selected by the Secretary that license or certify providers of services that furnish medical adult day-care services.

(d) Duration.—The Secretary shall conduct the demonstration project for a period of 3 years.

(e) Voluntary Participation.—Participation of medicare beneficiaries in the demonstration project shall be voluntary. The total number of such beneficiaries that may participate in the project at any given time may not exceed 15,000.

(f) Preference in Selecting Agencies.—In selecting home health agencies to participate under the demonstration project, the Secretary shall give preference to those agencies that are currently licensed or certified through common ownership and control to furnish medical adult day-care services.

(g) Waiver Authority.—The Secretary may waive such requirements of title XVIII of the Social Security Act as may be necessary for the purposes of carrying out the demonstration project, other than waiving the requirement that an individual be homebound in order to be eligible for benefits for home health services.

(h) Evaluation and Report.—The Secretary shall conduct an evaluation of the clinical and cost-effectiveness of the demonstration project. Not later than 6 months after the completion of the project, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

(1) An analysis of the patient outcomes and costs of furnishing care to the medicare beneficiaries participating in the project as compared to such outcomes and costs to beneficiaries receiving only home health services for the same health conditions.

(2) Such recommendations regarding the extension, expansion, or termination of the project as the Secretary determines appropriate.

(i) Definitions.—In this section:

(1) Home health agency.—The term "home health agency" has the meaning given such term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(2) Medical adult day-care facility.—The term "medical adult day-care facility" means a facility that—

(A) has been licensed or certified by a State to furnish medical adult day-care services in the State for a continuous 2-year period;

(B) is engaged in providing skilled nursing services and other therapeutic services directly or under arrangement with a home health agency;

(C) is licensed and certified by the State in which it operates or meets such standards established by the Secretary to assure quality of care and such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the facility; and

(D) provides medical adult day-care services.

(3) Medical adult day-care services.—The term "medical adult day-care services" means—

(A) home health service items and services described in paragraphs (1) through (7) of section 1861(m) furnished in a medical adult day-care facility;

(B) a program of supervised activities furnished in a group setting in the facility that—

(i) meet such criteria as the Secretary determines appropriate; and

(ii) is designed to promote physical and mental health of the individuals; and

(C) such other services as the Secretary may specify.

(4) Medicare beneficiary.—The term "medicare beneficiary" means an individual entitled to benefits under part A of this title, enrolled under part B of this title, or both.

SEC. 403. TEMPORARY SUSPENSION OF OASIS REQUIREMENT FOR COLLECTION OF DATA ON NON-MEDICARE AND NON-MEDICAID PATIENTS.

(a) IN GENERAL.—During the period described in subsection (b), the Secretary may not require, under section 4602(e) of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 467) or otherwise under OASIS, a home health agency to gather or submit information that relates to an individual who is not eligible for benefits under either title XVIII or title XIX of the Social Security Act (such information in this section referred to as ‘‘non-medicare/medicaid OASIS information’’).

(b) PERIOD OF SUSPENSION.—The period described in this subsection—

(1) begins on the date of the enactment of this Act; and

(2) ends on the last day of the second month beginning after the date as of which the Secretary has published final regulations regarding the collection and use by the Centers for Medicare & Medicaid Services of non-medicare/medicaid OASIS information following the submission of the report required under subsection (c).

(c) REPORT.—

(1) STUDY.—The Secretary shall conduct a study on how non-medicare/medicaid OASIS information is and can be used by large home health agencies. Such study shall examine—

(A) whether there are unique benefits from the analysis of such information that cannot be derived from other information available to, or collected by, such agencies; and

(B) the value of collecting such information by small home health agencies compared to the administrative burden related to such collection.

In conducting the study the Secretary shall obtain recommendations from quality assessment experts in the use of such information and the necessity of small, as well as large, home health agencies collecting such information.

(2) REPORT.—The Secretary shall submit to Congress a report on the study conducted under paragraph (1) by not later than 18 months after the date of the enactment of this Act.

(d) CONSTRUCTION.—Nothing in this section shall be construed as preventing home health agencies from collecting non-medicare/medicaid OASIS information for their own use.

SEC. 404. MEDPAC STUDY ON MEDICARE MARGINS OF HOME HEALTH AGENCIES.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study of payment margins of home health agencies under the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff). Such study shall examine whether systematic differences in payment margins are related to differences in case mix (as measured by home health resource groups (HHRGs)) among such agencies. The study shall use the partial or full-year cost reports filed by home health agencies.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study under subsection (a).

SEC. 405. COVERAGE OF RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTION SERVICES FURNISHED IN THE HOME.

(a) IN GENERAL.—Section 1821(a) (42 U.S.C. 1395i–5(a)) is amended—

(1) in the matter preceding paragraph (1), by inserting ‘‘and for home health services furnished an individual by a religious nonmedical health care institution’’ after ‘‘religious nonmedical health care institution’’; and

(2) in paragraph (2)—

(A) by striking ‘‘or extended care services’’ and inserting ‘‘, extended care services, or home health services’’; and

(B) by inserting ‘‘, or receiving services from a home health agency,’’ after ‘‘skilled nursing facility’’.

(b) DEFINITION.—Section 1861 (42 U.S.C. 1395x), as amended by section 342, is amended by adding at the end the following new section:

‘‘Extended Care in Religious Nonmedical Health Care Institutions

‘‘(aaa)(1) The term ‘home health agency’ also includes a religious nonmedical health care institution (as defined in subsection (ss)(1)), but only with respect to items and services ordinarily furnished by such an institution to individuals in their homes, and that are comparable to items and services furnished to individuals by a home health agency that is not religious nonmedical health care institution.

‘‘(2)(A) Subject to subparagraphs (B), payment may be made with respect to services provided by such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations consistent with section 1821.

‘‘(B) Notwithstanding any other provision of this title, payment may not be made under subparagraph (A)—

‘‘(i) in a year insofar as such payments exceed $700,000; and

‘‘(ii) after December 31, 2006.’’.

Subtitle B—Graduate Medical Education

SEC. 411. EXCEPTION TO INITIAL RESIDENCY PERIOD FOR GERIATRIC RESIDENCY OR FELLOWSHIP PROGRAMS.

(a) CLARIFICATION OF CONGRESSIONAL INTENT.—Congress intended section 1886(h)(5)(F)(ii) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(F)(ii)), as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272), to provide an exception to the initial residency period for geriatric residency or fellowship programs such that, where a particular approved geriatric training program requires a resident to complete 2 years of training to initially become board eligible in the geriatric specialty, the 2 years spent in the geriatric training program are treated as part of the resident's initial residency period, but are not counted against any limitation on the initial residency period.

(b) INTERIM FINAL REGULATORY AUTHORITY AND EFFECTIVE DATE.—The Secretary shall promulgate interim final regulations consistent with the congressional intent expressed in this section after notice and pending opportunity for public comment to be effective for cost reporting periods beginning on or after October 1, 2003.

SEC. 412. TREATMENT OF VOLUNTEER SUPERVISION.

(a) MORATORIUM ON CHANGES IN TREATMENT.—During the 1-year period beginning on January 1, 2004, for purposes of applying subsections (d)(5)(B) and (h) of section 1886 of the Social Security Act (42 U.S.C. 1395ww), the Secretary shall allow all hospitals to count residents in osteopathic and allopathic family practice programs in existence as of January 1, 2002, who are training at non-hospital sites, without regard to the financial arrangement between the hospital and the teaching physician practicing in the non-hospital site to which the resident has been assigned.

(b) STUDY AND REPORT.—

(1) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study of the appropriateness of alternative payment methodologies under such sections for the costs of training residents in non-hospital settings.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Inspector General shall submit to Congress a report on the study conducted under paragraph (1), together with such recommendations as the Inspector General determines appropriate.

Subtitle C—Chronic Care Improvement

SEC. 421. VOLUNTARY CHRONIC CARE IMPROVEMENT UNDER TRADITIONAL FEE-FOR-SERVICE.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1806 the following new section:

‘‘CHRONIC CARE IMPROVEMENT

‘‘SEC. 1807. (a) IMPLEMENTATION OF CHRONIC CARE IMPROVEMENT PROGRAMS.—

‘‘(1) IN GENERAL.—The Secretary shall provide for the phased-in development, testing, evaluation, and implementation of chronic care improvement programs in accordance with this section. Each such program shall be designed to improve clinical quality and beneficiary satisfaction and achieve spending targets with respect to expenditures under this title for targeted beneficiaries with one or more threshold conditions.

‘‘(2) DEFINITIONS.—For purposes of this section:

‘‘(A) CHRONIC CARE IMPROVEMENT PROGRAM.—The term ‘chronic care improvement program’ means a program described in paragraph (1) that is offered under an agreement under subsection (b) or (c).

‘‘(B) CHRONIC CARE IMPROVEMENT ORGANIZATION.—The term ‘chronic care improvement organization’ means an entity that has entered into an agreement under subsection (b) or (c) to provide, directly or through contracts with subcontractors, a chronic care improvement program under this section. Such an entity may be a disease management organization, health insurer, integrated delivery system, physician group practice, a consortium of such entities, or any other legal entity that the Secretary determines appropriate to carry out a chronic care improvement program under this section.

‘‘(C) CARE MANAGEMENT PLAN.—The term ‘care management plan’ means a plan established under subsection (d) for a participant in a chronic care improvement program.

‘‘(D) THRESHOLD CONDITION.—The term ‘threshold condition’ means a chronic condition, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), or other diseases or conditions, as selected by the Secretary as appropriate for the establishment of a chronic care improvement program

‘‘(E) TARGETED BENEFICIARY.—The term ‘targeted beneficiary' means, with respect to a chronic care improvement program, an individual who—

‘‘(i) is entitled to benefits under part A and enrolled under part B, but not enrolled in a plan under part C;

‘‘(ii) has one or more threshold conditions covered under such program; and

‘‘(iii) has been identified under subsection (d)(1) as a potential participant in such program.

‘‘(3) CONSTRUCTION.—Nothing in this section shall be construed as—

“(A) expanding the amount, duration, or scope of benefits under this title;

“(B) providing an entitlement to participate in a chronic care improvement program under this section;

“(C) providing for any hearing or appeal rights under section 1869, 1878, or otherwise, with respect to a chronic care improvement program under this section; or

“(D) providing benefits under a chronic care improvement program for which a claim may be submitted to the Secretary by any provider of services or supplier (as defined in section 1861(d)).

“(b) Developmental Phase (Phase I).—

“(1) In general.—In carrying out this section, the Secretary shall enter into agreements consistent with subsection (f) with chronic care improvement organizations for the development, testing, and evaluation of chronic care improvement programs using randomized controlled trials. The first such agreement shall be entered into not later than 12 months after the date of the enactment of this section.

“(2) Agreement period.—The period of an agreement under this subsection shall be for 3 years.

“(3) Minimum participation.—

“(A) In general.—The Secretary shall enter into agreements under this subsection in a manner so that chronic care improvement programs offered under this section are offered in geographic areas that, in the aggregate, consist of areas in which at least 10 percent of the aggregate number of medicare beneficiaries reside.

“(B) Medicare beneficiary defined.—In this paragraph, the term ‘medicare beneficiary’ means an individual who is entitled to benefits under part A, enrolled under part B, or both, and who resides in the United States.

“(4) Site selection.—In selecting geographic areas in which agreements are entered into under this subsection, the Secretary shall ensure that each chronic care improvement program is conducted in a geographic area in which at least 10,000 targeted beneficiaries reside among other individuals entitled to benefits under part A, enrolled under part B, or both to serve as a control population.

“(5) Independent evaluations of phase I programs.—The Secretary shall contract for an independent evaluation of the programs conducted under this subsection. Such evaluation shall be done by a contractor with knowledge of chronic care management programs and demonstrated experience in the evaluation of such programs. Each evaluation shall include an assessment of the following factors of the programs:

“(A) Quality improvement measures, such as adherence to evidence-based guidelines and rehospitalization rates.

“(B) Beneficiary and provider satisfaction.

“(C) Health outcomes.

“(D) Financial outcomes, including any cost savings to the program under this title.

“(c) Expanded Implementation Phase (Phase II).—

“(1) In general.—With respect to chronic care improvement programs conducted under subsection (b), if the Secretary finds that the results of the independent evaluation conducted under subsection (b)(6) indicate that the conditions specified in paragraph (2) have been met by a program (or components of such program), the Secretary shall enter into agreements consistent with subsection (f) to expand the implementation of the program (or components) to additional geographic areas not covered under the program as conducted under subsection (b), which may include the implementation of the program on a national basis. Such expansion shall begin not earlier than 2 years after the program is implemented under subsection (b) and not later than 6 months after the date of completion of such program.

“(2) Conditions for expansion of programs.—The conditions specified in this paragraph are, with respect to a chronic care improvement program conducted under subsection (b) for a threshold condition, that the program is expected to—

“(A) improve the clinical quality of care;

“(B) improve beneficiary satisfaction; and

“(C) achieve targets for savings to the program under this title specified by the Secretary in the agreement within a range determined to be appropriate by the Secretary, subject to the application of budget neutrality with respect to the program and not taking into account any payments by the organization under the agreement under the program for risk under subsection (f)(3)(B).

“(3) Independent evaluations of phase II programs.—The Secretary shall carry out evaluations of programs expanded under this subsection as the Secretary determines appropriate. Such evaluations shall be carried out in the similar manner as is provided under subsection (b)(5).

“(d) Identification and Enrollment of Prospective Program Participants.—

“(1) Identification of prospective program participants.—The Secretary shall establish a method for identifying targeted beneficiaries who may benefit from participation in a chronic care improvement program.

“(2) Initial contact by secretary.—The Secretary shall communicate with each targeted beneficiary concerning participation in a chronic care improvement program. Such communication may be made by the Secretary and shall include information on the following:

“(A) A description of the advantages to the beneficiary in participating in a program.

“(B) Notification that the organization offering a program may contact the beneficiary directly concerning such participation.

“(C) Notification that participation in a program is voluntary.

“(D) A description of the method for the beneficiary to participate or for declining to participate and the method for obtaining additional information concerning such participation.

“(3) Voluntary participation.—A targeted beneficiary may participate in a chronic care improvement program on a voluntary basis and may terminate participation at any time.

“(e) Chronic Care Improvement Programs.—

“(1) In general.—Each chronic care improvement program shall—

“(A) have a process to screen each targeted beneficiary for conditions other than threshold conditions, such as impaired cognitive ability and co-morbidities, for the purposes of developing an individualized, goal-oriented care management plan under paragraph (2);

“(B) provide each targeted beneficiary participating in the program with such plan; and

“(C) carry out such plan and other chronic care improvement activities in accordance with paragraph (3).

“(2) Elements of care management plans.—A care management plan for a targeted beneficiary shall be developed with the beneficiary and shall, to the extent appropriate, include the following:

“(A) A designated point of contact responsible for communications with the beneficiary and for facilitating communications with other health care providers under the plan.

“(B) Self-care education for the beneficiary (through approaches such as disease management or medical nutrition therapy) and education for primary caregivers and family members.

“(C) Education for physicians and other providers and collaboration to enhance communication of relevant clinical information.

“(D) The use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment.

“(E) The provision of information about hospice care, pain and palliative care, and end-of-life care.

“(3) Conduct of programs.—In carrying out paragraph (1)(C) with respect to a participant, the chronic care improvement organization shall—

“(A) guide the participant in managing the participant's health (including all co-morbidities, relevant health care services, and pharmaceutical needs) and in performing activities as specified under the elements of the care management plan of the participant;

“(B) use decision-support tools such as evidence-based practice guidelines or other criteria as determined by the Secretary; and

“(C) develop a clinical information database to track and monitor each participant across settings and to evaluate outcomes.

“(4) Additional responsibilities.—

“(A) Outcomes report.—Each chronic care improvement organization offering a chronic care improvement program shall monitor and report to the Secretary, in a manner specified by the Secretary, on health care quality, cost, and outcomes.

“(B) Additional requirements.—Each such organization and program shall comply with such additional requirements as the Secretary may specify.

“(5) Accreditation.—The Secretary may provide that chronic care improvement programs and chronic care improvement organizations that are accredited by qualified organizations (as defined by the Secretary) may be deemed to meet such requirements under this section as the Secretary may specify.

“(f) Terms of Agreements.—

“(1) Terms and conditions.—

“(A) In general.—An agreement under this section with a chronic care improvement organization shall contain such terms and conditions as the Secretary may specify consistent with this section.

“(B) Clinical, quality improvement, and financial requirements.—The Secretary may not enter into an agreement with such an organization under this section for the operation of a chronic care improvement program unless—

“(i) the program and organization meet the requirements of subsection (e) and such clinical, quality improvement, financial, and other requirements as the Secretary deems to be appropriate for the targeted beneficiaries to be served; and

“(ii) the organization demonstrates to the satisfaction of the Secretary that the organization is able to assume financial risk for performance under the agreement (as applied under paragraph (3)(B)) with respect to payments made to the organization under such agreement through available reserves, reinsurance, withholds, or such other means as the Secretary determines appropriate.

"(2) MANNER OF PAYMENT.—Subject to paragraph (3)(B), the payment under an agreement under—

"(A) subsection (b) shall be computed on a per-member per-month basis; or

"(B) subsection (c) may be on a per-member per-month basis or such other basis as the Secretary and organization may agree.

"(3) APPLICATION OF PERFORMANCE STANDARDS.—

"(A) SPECIFICATION OF PERFORMANCE STANDARDS.—Each agreement under this section with a chronic care improvement organization shall specify performance standards for each of the factors specified in subsection (c)(2), including clinical quality and spending targets under this title, against which the performance of the chronic care improvement organization under the agreement is measured.

"(B) ADJUSTMENT OF PAYMENT BASED ON PERFORMANCE.—

"(i) IN GENERAL.—Each such agreement shall provide for adjustments in payment rates to an organization under the agreement insofar as the Secretary determines that the organization failed to meet the performance standards specified in the agreement under subparagraph (A).

"(ii) FINANCIAL RISK FOR PERFORMANCE.—In the case of an agreement under subsection (b) or (c), the agreement shall provide for a full recovery for any amount by which the fees paid to the organization under the agreement exceed the estimated savings to the programs under this title attributable to implementation of such agreement.

"(4) BUDGET NEUTRAL PAYMENT CONDITION.—Under this section, the Secretary shall ensure that the aggregate sum of medicare program benefit expenditures for beneficiaries participating in chronic care improvement programs and funds paid to chronic care improvement organizations under this section, shall not exceed the medicare program benefit expenditures that the Secretary estimates would have been made for such targeted beneficiaries in the absence of such programs.

"(g) FUNDING.—(1) Subject to paragraph (2), there are appropriated to the Secretary, in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, such sums as may be necessary to provide for agreements with chronic care improvement programs under this section.

"(2) In no case shall the funding under this section exceed $100,000,000 in aggregate increased expenditures under this title (after taking into account any savings attributable to the operation of this section) over the 3-fiscal-year period beginning on October 1, 2003.".

(b) REPORTS.—The Secretary shall submit to Congress reports on the operation of section 1807 of the Social Security Act, as added by subsection (a), as follows:

(1) Not later than 2 years after the date of the implementation of such section, the Secretary shall submit to Congress an interim report on the scope of implementation of the programs under subsection (b) of such section, the design of the programs, and preliminary cost and quality findings with respect to those programs based on the following measures of the programs:

(A) Quality improvement measures, such as adherence to evidence-based guidelines and rehospitalization rates.

(B) Beneficiary and provider satisfaction.

(C) Health outcomes.

(D) Financial outcomes.

(2) Not later than 3 years and 6 months after the date of the implementation of such section the Secretary shall submit to Congress an update to the report required under paragraph (1) on the results of such programs.

(3) The Secretary shall submit to Congress 2 additional biennial reports on the chronic care improvement programs conducted under such section. The first such report shall be submitted not later than 2 years after the report is submitted under paragraph (2). Each such report shall include information on—

(A) the scope of implementation (in terms of both regions and chronic conditions) of the chronic care improvement programs;

(B) the design of the programs; and

(C) the improvements in health outcomes and financial efficiencies that result from such implementation.

SEC. 422. MEDICARE ADVANTAGE QUALITY IMPROVEMENT PROGRAMS.

(a) IN GENERAL.—Section 1852(e) (42 U.S.C. 1395w–22(e)) is amended—

(1) in the heading, by striking "ASSURANCE" and inserting "IMPROVEMENT";

(2) by amending paragraphs (1) through (3) to read as follows:

"(1) IN GENERAL.—Each MA organization shall have an ongoing quality improvement program for the purpose of improving the quality of care provided to enrollees in each MA plan offered by such organization (other than an MA private fee-for-service plan or an MSA plan).

"(2) CHRONIC CARE IMPROVEMENT PROGRAMS.—As part of the quality improvement program under paragraph (1), each MA organization shall have a chronic care improvement program. Each chronic care improvement program shall have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions that meet criteria established by the organization for participation under the program.

"(3) DATA.—

"(A) COLLECTION, ANALYSIS, AND REPORTING.—

"(i) IN GENERAL.—Except as provided in clauses (ii) and (iii) with respect to plans described in such clauses and subject to subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality.

"(ii) APPLICATION TO MA REGIONAL PLANS.—The Secretary shall establish as appropriate by regulation requirements for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality for MA organizations with respect to MA regional plans. Such requirements may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans.

"(iii) APPLICATION TO PREFERRED PROVIDER ORGANIZATIONS.—Clause (i) shall apply to MA organizations with respect to MA local plans that are preferred provider organization plans only insofar as services are furnished by providers or services, physicians, and other health care practitioners and suppliers that have contracts with such organization to furnish services under such plans.

"(iv) DEFINITION OF PREFERRED PROVIDER ORGANIZATION PLAN.—In this subparagraph, the term 'preferred provider organization plan' means an MA plan that—

"(I) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

"(II) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

"(III) is offered by an organization that is not licensed or organized under State law as a health maintenance organization.

"(B) LIMITATIONS.—

"(i) TYPES OF DATA.—The Secretary shall not collect under subparagraph (A) data on quality, outcomes, and beneficiary satisfaction to facilitate consumer choice and program administration other than the types of data that were collected by the Secretary as of November 1, 2003.

"(ii) CHANGES IN TYPES OF DATA.—Subject to subclause (iii), the Secretary may only change the types of data that are required to be submitted under subparagraph (A) after submitting to Congress a report on the reasons for such changes that was prepared in consultation with MA organizations and private accrediting bodies.

"(iii) CONSTRUCTION.—Nothing in the subsection shall be construed as restricting the ability of the Secretary to carry out the duties under section 1851(d)(4)(D).";

(3) in paragraph (4)(B), by amending clause (i) to read as follows:

"(i) Paragraphs (1) through (3) of this subsection (relating to quality improvement programs)."; and

(4) by striking paragraph (5).

(b) CONFORMING AMENDMENT.—Section 1852(c)(1)(I) (42 U.S.C. 1395w–22(c)(1)(I)) is amended to read as follows:

"(I) QUALITY IMPROVEMENT PROGRAM.—A description of the organization's quality improvement program under subsection (e).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on and after January 1, 2006.

SEC. 423. CHRONICALLY ILL MEDICARE BENEFICIARY RESEARCH, DATA, DEMONSTRATION STRATEGY.

(a) DEVELOPMENT OF PLAN.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall develop a plan to improve quality of care and reduce the cost of care for chronically ill medicare beneficiaries.

(b) PLAN REQUIREMENTS.—The plan will utilize existing data and identify data gaps, develop research initiatives, and propose intervention demonstration programs to provide better health care for chronically ill medicare beneficiaries. The plan shall—

(1) integrate existing data sets including, the Medicare Current Beneficiary Survey (MCBS), Minimum Data Set (MDS), Outcome and Assessment Information Set (OASIS), data from Quality Improvement Organizations (QIO), and claims data;

(2) identify any new data needs and a methodology to address new data needs;

(3) plan for the collection of such data in a data warehouse; and

(4) develop a research agenda using such data.

(c) CONSULTATION.—In developing the plan under this section, the Secretary shall consult with experts in the fields of care for the chronically ill (including clinicians).

(d) IMPLEMENTATION.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall implement the plan developed under this section. The Secretary may contract with appropriate entities to implement such plan.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as may be necessary in fiscal years 2004 and 2005 to carry out this section.

Subtitle D—Other Provisions

SEC. 431. IMPROVEMENTS IN NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS TO RESPOND TO CHANGES IN TECHNOLOGY.

(a) NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS.—

(1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y), as amended by sections 948 and 950, is amended—

(A) in the third sentence of subsection (a), by inserting "consistent with subsection (l)" after "the Secretary shall ensure"; and

(B) by adding at the end the following new subsection:

"(l) NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS.—

"(1) FACTORS AND EVIDENCE USED IN MAKING NATIONAL COVERAGE DETERMINATIONS.—The Secretary shall make available to the public the factors considered in making national coverage determinations of whether an item or service is reasonable and necessary. The Secretary shall develop guidance documents to carry out this paragraph in a manner similar to the development of guidance documents under section 701(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 371(h)).

"(2) TIMEFRAME FOR DECISIONS ON REQUESTS FOR NATIONAL COVERAGE DETERMINATIONS.—In the case of a request for a national coverage determination that—

"(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

"(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 9 months after the date of the request.

"(3) PROCESS FOR PUBLIC COMMENT IN NATIONAL COVERAGE DETERMINATIONS.—

"(A) PERIOD FOR PROPOSED DECISION.—Not later than the end of the 6-month period (or 9-month period for requests described in paragraph (2)(B)) that begins on the date a request for a national coverage determination is made, the Secretary shall make a draft of proposed decision on the request available to the public through the Internet website of the Centers for Medicare & Medicaid Services or other appropriate means.

"(B) 30-DAY PERIOD FOR PUBLIC COMMENT.—Beginning on the date the Secretary makes a draft of the proposed decision available under subparagraph (A), the Secretary shall provide a 30-day period for public comment on such draft.

"(C) 60-DAY PERIOD FOR FINAL DECISION.—Not later than 60 days after the conclusion of the 30-day period referred to under subparagraph (B), the Secretary shall—

"(i) make a final decision on the request;

"(ii) include in such final decision summaries of the public comments received and responses to such comments;

"(iii) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and

"(iv) in the case of a final decision under clause (i) to grant the request for the national coverage determination, the Secretary shall assign a temporary or permanent code (whether existing or unclassified) and implement the coding change.

"(4) CONSULTATION WITH OUTSIDE EXPERTS IN CERTAIN NATIONAL COVERAGE DETERMINATIONS.—With respect to a request for a national coverage determination for which there is not a review by the Medicare Coverage Advisory Committee, the Secretary shall consult with appropriate outside clinical experts.

"(5) LOCAL COVERAGE DETERMINATION PROCESS.—

"(A) PLAN TO PROMOTE CONSISTENCY OF COVERAGE DETERMINATIONS.—The Secretary shall develop a plan to evaluate new local coverage determinations to determine which determinations should be adopted nationally and to what extent greater consistency can be achieved among local coverage determinations.

"(B) CONSULTATION.—The Secretary shall require the fiscal intermediaries or carriers providing services within the same area to consult on all new local coverage determinations within the area.

"(C) DISSEMINATION OF INFORMATION.—The Secretary should serve as a center to disseminate information on local coverage determinations among fiscal intermediaries and carriers to reduce duplication of effort.

"(6) NATIONAL AND LOCAL COVERAGE DETERMINATION DEFINED.—For purposes of this subsection—

"(A) NATIONAL COVERAGE DETERMINATION.—The term 'national coverage determination' means a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under this title.

"(B) LOCAL COVERAGE DETERMINATION.—The term 'local coverage determination' has the meaning given that in section 1869(f)(2)(B).".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to national coverage determinations as of January 1, 2004, and section 1862(l)(5) of the Social Security Act, as added by such paragraph, shall apply to local coverage determinations made on or after July 1, 2004.

(b) MEDICARE COVERAGE OF ROUTINE COSTS ASSOCIATED WITH CERTAIN CLINICAL TRIALS OF CATEGORY A DEVICES.—

(1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y), as amended by subsection (a), is amended by adding at the end the following new subsection:

"(m) COVERAGE OF ROUTINE COSTS ASSOCIATED WITH CERTAIN CLINICAL TRIALS OF CATEGORY A DEVICES.—

"(1) IN GENERAL.—In the case of an individual entitled to benefits under part A, or enrolled under part B, or both who participates in a category A clinical trial, the Secretary shall not exclude under subsection (a)(1) payment for coverage of routine costs of care (as defined by the Secretary) furnished to such individual in the trial.

"(2) CATEGORY A CLINICAL TRIAL.—For purposes of paragraph (1), a 'category A clinical trial' means a trial of a medical device if—

"(A) the trial is of an experimental/investigational (category A) medical device (as defined in regulations under section 405.201(b) of title 42, Code of Federal Regulations (as in effect as of September 1, 2003));

"(B) the trial meets criteria established by the Secretary to ensure that the trial conforms to appropriate scientific and ethical standards; and

"(C) in the case of a trial initiated before January 1, 2010, the device involved in the trial has been determined by the Secretary to be intended for use in the diagnosis, monitoring, or treatment of an immediately life-threatening disease or condition.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to routine costs incurred on and after January 1, 2005, and, as of such date, section 411.15(o) of title 42, Code of Federal Regulations, is superseded to the extent inconsistent with section 1862(m) of the Social Security Act, as added by such paragraph.

(3) RULE OF CONSTRUCTION.—Nothing in the amendment made by paragraph (1) shall be construed as applying to, or affecting, coverage or payment for a nonexperimental/investigational (category B) device.

(c) ISSUANCE OF TEMPORARY NATIONAL CODES.—Not later than July 1, 2004, the Secretary shall implement revised procedures for the issuance of temporary national HCPCS codes under part B of title XVIII of the Social Security Act.

SEC. 432. EXTENSION OF TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

Section 542(c) of BIPA (114 Stat. 2763A-551) is amended by inserting ", and for services furnished during 2005 and 2006" before the period at the end.

SEC. 433. PAYMENT FOR PANCREATIC ISLET CELL INVESTIGATIONAL TRANSPLANTS FOR MEDICARE BENEFICIARIES IN CLINICAL TRIALS.

(a) CLINICAL TRIAL.—

(1) IN GENERAL.—The Secretary, acting through the National Institute of Diabetes and Digestive and Kidney Disorders, shall conduct a clinical investigation of pancreatic islet cell transplantation which includes medicare beneficiaries.

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as may be necessary to conduct the clinical investigation under paragraph (1).

(b) MEDICARE PAYMENT.—Not earlier than October 1, 2004, the Secretary shall pay for the routine costs as well as transplantation and appropriate related items and services (as described in subsection (c)) in the case of medicare beneficiaries who are participating in a clinical trial described in subsection (a) as if such transplantation were covered under title XVIII of such Act and as would be paid under part A or part B of such title for such beneficiary.

(c) SCOPE OF PAYMENT.—For purposes of subsection (b):

(1) The term "routine costs" means reasonable and necessary routine patient care costs (as defined in the Centers for Medicare & Medicaid Services Coverage Issues Manual, section 30–1), including immunosuppressive drugs and other followup care.

(2) The term "transplantation and appropriate related items and services" means items and services related to the acquisition and delivery of the pancreatic islet cell transplantation, notwithstanding any national noncoverage determination contained in the Centers for Medicare & Medicaid Services Coverage Issues Manual.

(3) The term "medicare beneficiary" means an individual who is entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both.

(d) CONSTRUCTION.—The provisions of this section shall not be construed—

(1) to permit payment for partial pancreatic tissue or islet cell transplantation under title XVIII of the Social Security Act other than payment as described in subsection (b); or

(2) as authorizing or requiring coverage or payment conveying—

(A) benefits under part A of such title to a beneficiary not entitled to such part A; or

(B) benefits under part B of such title to a beneficiary not enrolled in such part B.

SEC. 434. RESTORATION OF MEDICARE TRUST FUNDS.

(a) Definitions.—In this section:

(1) Clerical error.—The term "clerical error" means a failure that occurs on or after April 15, 2001, to have transferred the correct amount from the general fund of the Treasury to a Trust Fund.

(2) Trust fund.—The term "Trust Fund" means the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t).

(b) Correction of Trust Fund Holdings.—

(1) In general.—The Secretary of the Treasury shall take the actions described in paragraph (2) with respect to the Trust Fund with the goal being that, after such actions are taken, the holdings of the Trust Fund will replicate, to the extent practicable in the judgment of the Secretary of the Treasury, in consultation with the Secretary, the holdings that would have been held by the Trust Fund if the clerical error involved had not occurred.

(2) Obligations issued and redeemed.—The Secretary of the Treasury shall—

(A) issue to the Trust Fund obligations under chapter 31 of title 31, United States Code, that bear issue dates, interest rates, and maturity dates that are the same as those for the obligations that—

(i) would have been issued to the Trust Fund if the clerical error involved had not occurred; or

(ii) were issued to the Trust Fund and were redeemed by reason of the clerical error involved; and

(B) redeem from the Trust Fund obligations that would have been redeemed from the Trust Fund if the clerical error involved had not occurred.

(c) Appropriation.—There is appropriated to the Trust Fund, out of any money in the Treasury not otherwise appropriated, an amount determined by the Secretary of the Treasury, in consultation with the Secretary, to be equal to the interest income lost by the Trust Fund through the date on which the appropriation is being made as a result of the clerical error involved.

(d) Congressional Notice.—In the case of a clerical error that occurs after April 15, 2001, the Secretary of the Treasury, before taking action to correct the error under this section, shall notify the appropriate committees of Congress concerning such error and the actions to be taken under this section in response to such error.

(e) Deadline.—With respect to the clerical error that occurred on April 15, 2001, not later than 120 days after the date of the enactment of this Act—

(1) the Secretary of the Treasury shall take the actions under subsection (b)(1); and

(2) the appropriation under subsection (c) shall be made.

SEC. 435. MODIFICATIONS TO MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) Examination of Budget Consequences.—Section 1805(b) (42 U.S.C. 1395b–6(b)) is amended by adding at the end the following new paragraph:

"(8) Examination of budget consequences.—Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.".

(b) Consideration of Efficient Provision of Services.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b–6(b)(2)(B)(i)) is amended by inserting "the efficient provision of" after "expenditures for".

(c) Application of Disclosure Requirements.—

(1) In general.—Section 1805(c)(2)(D) (42 U.S.C. 1395b–6(c)(2)(D)) is amended by adding at the end the following: "Members of the Commission shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).".

(2) Effective date.—The amendment made by paragraph (1) shall take effect on January 1, 2004.

(d) Additional Reports.—

(1) Data needs and sources.—The Medicare Payment Advisory Commission shall conduct a study, and submit a report to Congress by not later than June 1, 2004, on the need for current data, and sources of current data available, to determine the solvency and financial circumstances of hospitals and other medicare providers of services.

(2) Use of tax-related returns.—Using return information provided under Form 990 of the Internal Revenue Service, the Commission shall submit to Congress, by not later than June 1, 2004, a report on the following:

(A) Investments, endowments, and fundraising of hospitals participating under the medicare program and related foundations.

(B) Access to capital financing for private and for not-for-profit hospitals.

(e) Representation of Experts in Prescription Drugs.—

(1) In general.—Section 1805(c)(2)(B) (42 U.S.C. 1395b–6(c)(2)(B)) is amended by inserting "experts in the area of pharmaco-economics or prescription drug benefit programs," after "other health professionals,".

(2) Appointment.—The Comptroller General of the United States shall ensure that the membership of the Commission complies with the amendment made by paragraph (1) with respect to appointments made on or after the date of the enactment of this Act.

SEC. 436. TECHNICAL AMENDMENTS.

(a) Part A.—(1) Section 1814(a) (42 U.S.C. 1395f(a)) is amended—

(A) by striking the seventh sentence, as added by section 322(a)(1) of BIPA (114 Stat. 2763A–501); and

(B) in paragraph (7)(A)—

(i) in clause (i), by inserting before the comma at the end the following: "based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness"; and

(ii) in clause (ii), by inserting before the semicolon at the end the following: "based on such clinical judgment".

(2) Section 1814(b) (42 U.S.C. 1395f(b)), in the matter preceding paragraph (1), is amended by inserting a comma after "1813".

(3) Section 1815(e)(1)(B) (42 U.S.C. 1395g(e)(1)(B)), in the matter preceding clause (i), is amended by striking "of hospital" and inserting "of a hospital".

(4) Section 1816(c)(2)(B)(ii) (42 U.S.C. 1395h(c)(2)(B)(ii)) is amended—

(A) by striking "and" at the end of subclause (III); and

(B) by striking the period at the end of subclause (IV) and inserting ", and".

(5) Section 1817(k)(3)(A) (42 U.S.C. 1395i(k)(3)(A)) is amended—

(A) in clause (i)(I), by striking the comma at the end and inserting a semicolon; and

(B) in clause (ii), by striking "the Medicare and medicaid programs" and inserting "the programs under this title and title XIX".

(6) Section 1817(k)(6)(B) (42 U.S.C. 1395i(k)(6)(B)) is amended by striking "Medicare program under title XVIII" and inserting "program under this title".

(7) Section 1818 (42 U.S.C. 1395i–2) is amended—

(A) in subsection (d)(6)(A) is amended by inserting "of such Code" after "3111(b)"; and

(B) in subsection (g)(2)(B) is amended by striking "subsection (b)." and inserting "subsection (b)".

(8) Section 1819 (42 U.S.C. 1395i–3) is amended—

(A) in subsection (b)(4)(C)(i), by striking "at least at least" and inserting "at least";

(B) in subsection (d)(1)(A), by striking "physical mental" and inserting "physical, mental"; and

(C) in subsection (f)(2)(B)(iii), by moving the last sentence 2 ems to the left.

(9) Section 1886(b)(3)(I)(i)(I) (42 U.S.C. 1395ww(b)(3)(I)(i)(I)) is amended by striking "the the" and inserting "the".

(10) The heading of subsection (mm) of section 1861 (42 U.S.C. 1395x) is amended to read as follows:

"Critical Access Hospital; Critical Access Hospital Services".

(11) Paragraphs (1) and (2) of section 1861(tt) (42 U.S.C. 1395x(tt)) are each amended by striking "rural primary care" and inserting "critical access".

(12) Section 1865(b)(3)(B) (42 U.S.C. 1395bb(b)(3)(B)) is amended by striking "section 1819 and 1861(j)" and inserting "sections 1819 and 1861(j)".

(13) Section 1866(b)(2) (42 U.S.C. 1395cc(b)(2)) is amended by moving subparagraph (D) 2 ems to the left.

(14) Section 1867 (42 U.S.C. 1395dd) is amended—

(A) in the matter following clause (ii) of subsection (d)(1)(B), by striking "is is" and inserting "is";

(B) in subsection (e)(1)(B), by striking "a pregnant women" and inserting "a pregnant woman"; and

(C) in subsection (e)(2), by striking "means hospital" and inserting "means a hospital".

(15) Section 1886(g)(3)(B) (42 U.S.C. 1395ww(g)(3)(B)) is amended by striking "(as defined in subsection (d)(5)(D)(iii)" and inserting "(as defined in subsection (d)(5)(D)(iii))".

(b) Part B.—(1) Section 1833(h)(5)(D) (42 U.S.C. 1395l(h)(5)(D)) is amended by striking "clinic,," and inserting "clinic,".

(2) Section 1833(t)(3)(C)(ii) (42 U.S.C. 1395l(t)(3)(C)(ii)) is amended by striking "clause (iii)" and inserting "clause (iv)".

(3) Section 1861(v)(1)(S)(ii)(III) (42 U.S.C. 1395x(v)(1)(S)(ii)(III)) is amended by striking "(as defined in section 1886(d)(5)(D)(iii)" and inserting "(as defined in section 1886(d)(5)(D)(iii))".

(4) Section 1834(b)(4)(D)(iv) (42 U.S.C. 1395m(b)(4)(D)(iv)) is amended by striking "clauses (vi)" and inserting "clause (vi)".

(5) Section 1834(m)(4)(C)(ii)(III) (42 U.S.C. 1395m(m)(4)(C)(ii)(III)) is amended by striking "1861(aa)(s)" and inserting "1861(aa)(2)".

(6) Section 1838(a)(1) (42 U.S.C. 1395q(a)(1)) is amended by inserting a comma after "1966".

(7) The second sentence of section 1839(a)(4) (42 U.S.C. 1395r(a)(4)) is amended by striking "which will" and inserting "will".

(8) Section 1842(c)(2)(B)(ii) (42 U.S.C. 1395u(c)(2)(B)(ii)) is amended—

(A) by striking "and" at the end of subclause (III); and

(B) by striking the period at the end of subclause (IV) and inserting ", and".

(9) Section 1842(i)(2) (42 U.S.C. 1395u(i)(2)) is amended by striking "services, a physician" and inserting "services, to a physician".

(10) Section 1848(i)(3)(A) (42 U.S.C. 1395w–4(i)(3)(A)) is amended by striking "a comparable services" and inserting "comparable services".

(11) Section 1861(s)(2)(K)(i) (42 U.S.C. 1395x(s)(2)(K)(i)) is amended by striking "; and but" and inserting ", but".

(12) Section 1861(aa)(1)(B) (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking ",," and inserting a comma.

(13) Section 128(b)(2) of BIPA (114 Stat. 2763A–480) is amended by striking "Not later that" and inserting "Not later than" each place it appears.

(c) Parts A and B.—(1) Section 1812(a)(3) (42 U.S.C. 1395d(a)(3)) is amended—

(A) by striking "for individuals not" and inserting "in the case of individuals not"; and

(B) by striking "for individuals so" and inserting "in the case of individuals so".

(2)(A) Section 1814(a) (42 U.S.C. 1395f(a)) is amended in the sixth sentence by striking "leave home," and inserting "leave home and".

(B) Section 1835(a) (42 U.S.C. 1395n(a)) is amended in the seventh sentence by striking "leave home," and inserting "leave home and".

(3) Section 1891(d)(1) (42 U.S.C. 1395bbb(d)(1)) is amended by striking "subsection (c)(2)(C)(I)" and inserting "subsection (c)(2)(C)(i)(I)".

(4) Section 1861(v) (42 U.S.C. 1395x(v)) is amended by moving paragraph (8) (including clauses (i) through (v) of such paragraph) 2 ems to the left.

(5) Section 1866B(b)(7)(D) (42 U.S.C. 1395cc–2(b)(7)(D)) is amended by striking "(c)(2)(A)(ii)" and inserting "(c)(2)(B)".

(6) Section 1886(h)(3)(D)(ii)(III) (42 U.S.C. 1395ww(h)(3)(D)(ii)(III)) is amended by striking "and" after the comma at the end.

(7) Section 1893(a) (42 U.S.C. 1395ddd(a)) is amended by striking "Medicare program" and inserting "medicare program".

(8) Section 1896(b)(4) (42 U.S.C. 1395ggg(b)(4)) is amended by striking "701(f)" and inserting "712(f)".

(d) Part C.—(1) Section 1853 (42 U.S.C. 1395w–23), as amended by section 307 of BIPA (114 Stat. 2763A–558), is amended—

(A) in subsection (a)(3)(C)(ii), by striking "clause (iii)" and inserting "clause (iv)";

(B) in subsection (a)(3)(C), by redesignating the clause (iii) added by such section 307 as clause (iv); and

(C) in subsection (c)(5), by striking "(a)(3)(C)(iii)" and inserting "(a)(3)(C)(iv)".

(2) Section 1876 (42 U.S.C. 1395mm) is amended—

(A) in subsection (c)(2)(B), by striking "signifcant" and inserting "significant"; and

(B) in subsection (j)(2), by striking "this setion" and inserting "this section".

(e) Medigap.—Section 1882 (42 U.S.C. 1395ss) is amended—

(1) in subsection (d)(3)(A)(i)(II), by striking "plan a medicare supplemental policy" and inserting "plan, a medicare supplemental policy";

(2) in subsection (d)(3)(B)(iii)(II), by striking "to the best of the issuer or seller's knowledge" and inserting "to the best of the issuer's or seller's knowledge";

(3) in subsection (g)(2)(A), by striking "medicare supplement policies" and inserting "medicare supplemental policies";

(4) in subsection (p)(2)(B), by striking ", and" and inserting "; and"; and

(5) in subsection (s)(3)(A)(iii), by striking "pre-existing" and inserting "preexisting".

TITLE V—ADMINISTRATIVE IMPROVEMENTS, REGULATORY REDUCTION, AND CONTRACTING REFORM

SEC. 500. ADMINISTRATIVE IMPROVEMENTS WITHIN THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS).

(a) Coordinated Administration of Medicare Prescription Drug and Medicare Advantage Programs.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 421, is amended by inserting after 1807 the following new section:

"PROVISIONS RELATING TO ADMINISTRATION

"Sec. 1808. (a) Coordinated Administration of Medicare Prescription Drug and Medicare Advantage Programs.—

"(1) In general.—There is within the Centers for Medicare & Medicaid Services a center to carry out the duties described in paragraph (3).

"(2) Director.—Such center shall be headed by a director who shall report directly to the Administrator of the Centers for Medicare & Medicaid Services.

"(3) Duties.—The duties described in this paragraph are the following:

"(A) The administration of parts C and D.

"(B) The provision of notice and information under section 1804.

"(C) Such other duties as the Secretary may specify.

"(4) Deadline.—The Secretary shall ensure that the center is carrying out the duties described in paragraph (3) by not later than January 1, 2008.".

(b) Management Staff for the Centers for Medicare & Medicaid Services.—Such section is further amended by adding at the end the following new subsection:

"(b) Employment of Management Staff.—

"(1) In general.—The Secretary may employ, within the Centers for Medicare & Medicaid Services, such individuals as management staff as the Secretary determines to be appropriate. With respect to the administration of parts C and D, such individuals shall include individuals with private sector expertise in negotiations with health benefits plans.

"(2) Eligibility.—To be eligible for employment under paragraph (1) an individual shall be required to have demonstrated, by their education and experience (either in the public or private sector), superior expertise in at least one of the following areas:

"(A) The review, negotiation, and administration of health care contracts.

"(B) The design of health care benefit plans.

"(C) Actuarial sciences.

"(D) Compliance with health plan contracts.

"(E) Consumer education and decision making.

"(F) Any other area specified by the Secretary that requires specialized management or other expertise.

"(3) Rates of payment.—

"(A) Performance-related pay.—Subject to subparagraph (B), the Secretary shall establish the rate of pay for an individual employed under paragraph (1). Such rate shall take into account expertise, experience, and performance.

"(B) Limitation.—In no case may the rate of compensation determined under subparagraph (A) exceed the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.".

(c) Requirement for Dedicated Actuary for Private Health Plans.—Section 1117(b) (42 U.S.C. 1317(b)) is amended by adding at the end the following new paragraph:

"(3) In the office of the Chief Actuary there shall be an actuary whose duties relate exclusively to the programs under parts C and D of title XVIII and related provisions of such title.".

(d) Increase in Grade to Executive Level III for the Administrator of the Centers for Medicare & Medicaid Services.—

(1) In general.—Section 5314 of title 5, United States Code, is amended by adding at the end the following:

"Administrator of the Centers for Medicare & Medicaid Services.".

(2) Conforming amendment.—Section 5315 of such title is amended by striking "Administrator of the Health Care Financing Administration.".

(3) Effective date.—The amendments made by this subsection take effect on January 1, 2004.

(e) Conforming Amendments Relating to Health Care Financing Administration.—

(1) Amendments to the social security act.—The Social Security Act is amended—

(A) in section 1117 (42 U.S.C. 1317)—

(i) in the heading to read as follows:

"APPOINTMENT OF THE ADMINISTRATOR AND CHIEF ACTUARY OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES";

(ii) in subsection (a), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services"; and

(iii) in subsection (b)(1)—

(I) by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services"; and

(II) by striking "Administration" and inserting "Centers";

(B) in section 1140(a) (42 U.S.C. 1320b–10(a))—

(i) in paragraph (1), by striking "Health Care Financing Administration" both places it appears in the matter following subparagraph (B) and inserting "Centers for Medicare & Medicaid Services";

(ii) in paragraph (1)(A)—

(I) by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services"; and

(II) by striking "HCFA" and inserting "CMS"; and

(iii) in paragraph (1)(B), by striking "Health Care Financing Administration" both places it appears and inserting "Centers for Medicare & Medicaid Services";

(C) in section 1142(b)(3) (42 U.S.C. 1320b–12(b)(3)), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services";

(D) in section 1817(b) (42 U.S.C. 1395i(b))—

(i) by striking "Health Care Financing Administration", both in the fifth sentence of the matter preceding paragraph (1) and in the second sentence of the matter following paragraph (4), and inserting "Centers for Medicare & Medicaid Services"; and

(ii) by striking "Chief Actuarial Officer" in the second sentence of the matter following paragraph (4) and inserting "Chief Actuary";

(E) in section 1841(b) (42 U.S.C. 1395t(b))—

(i) by striking "Health Care Financing Administration", both in the fifth sentence of the matter preceding paragraph (1) and in the second sentence of the matter following paragraph (4), and inserting "Centers for Medicare & Medicaid Services"; and

(ii) by striking "Chief Actuarial Officer" in the second sentence of the matter following paragraph (4) and inserting "Chief Actuary";

(F) in section 1852(a)(5) (42 U.S.C. 1395w–22(a)(5)), by striking "Health Care Financing Administration" in the matter following subparagraph (B) and inserting "Centers for Medicare & Medicaid Services";

(G) in section 1853 (42 U.S.C. 1395w–23)—

(i) in subsection (b)(4), by striking "Health Care Financing Administration" in the first sentence and inserting "Centers for Medicare & Medicaid Services"; and

(ii) in subsection (c)(7), by striking "Health Care Financing Administration" in the last sentence and inserting "Centers for Medicare & Medicaid Services";

(H) in section 1854(a)(5)(A) (42 U.S.C. 1395w–24(a)(5)(A)), by striking "Health Care Financing Administration"and inserting "Centers for Medicare & Medicaid Services";

(I) in section 1857(d)(4)(A)(ii) (42 U.S.C. 1395w–27(d)(4)(A)(ii)), by striking "Health Care Financing Administration" and inserting "Secretary";

(J) in section 1862(b)(5)(A)(ii) (42 U.S.C. 1395y(b)(5)(A)(ii)), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services";

(K) in section 1927(e)(4) (42 U.S.C. 1396r–8(e)(4)), by striking "HCFA" and inserting "The Secretary";

(L) in section 1927(f)(2) (42 U.S.C. 1396r–8(f)(2)), by striking "HCFA" and inserting "The Secretary"; and

(M) in section 2104(g)(3) (42 U.S.C. 1397dd(g)(3)) by inserting "or CMS Form 64 or CMS Form 21, as the case may be," after "HCFA Form 64 or HCFA Form 21"

(2) AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.—The Public Health Service Act is amended—

(A) in section 501(d)(18) (42 U.S.C. 290aa(d)(18)), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services";

(B) in section 507(b)(6) (42 U.S.C. 290bb(b)(6)), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services";

(C) in section 916 (42 U.S.C. 299b–5)—

(i) in subsection (b)(2), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services"; and

(ii) in subsection (c)(2), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services";

(D) in section 921(c)(3)(A) (42 U.S.C. 299c(c)(3)(A)), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services";

(E) in section 1318(a)(2) (42 U.S.C. 300e–17(a)(2)), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services";

(F) in section 2102(a)(7) (42 U.S.C. 300aa–2(a)(7)), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services"; and

(G) in section 2675(a) (42 U.S.C. 300ff–75(a)), by striking "Health Care Financing Administration" in the first sentence and inserting "Centers for Medicare & Medicaid Services".

(3) AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.—Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended—

(A) in subparagraph (B), by striking "Health Care Financing Administration" in the matter preceding clause (i) and inserting "Centers for Medicare & Medicaid Services"; and

(B) in subparagraph (C)—

(i) by striking "HEALTH CARE FINANCING ADMINISTRATION" in the heading and inserting "CENTERS FOR MEDICARE & MEDICAID SERVICES"; and

(ii) by striking "Health Care Financing Administration" in the matter preceding clause (i) and inserting "Centers for Medicare & Medicaid Services".

(4) AMENDMENTS TO TITLE 10, UNITED STATES CODE.—Title 10, United States Code, is amended—

(A) in section 1086(d)(4), by striking "administrator of the Health Care Financing Administration" in the last sentence and inserting "Administrator of the Centers for Medicare & Medicaid Services"; and

(B) in section 1095(k)(2), by striking "Health Care Financing Administration" in the second sentence and inserting "Centers for Medicare & Medicaid Services".

(5) AMENDMENTS TO THE ALZHEIMER'S DISEASE AND RELATED DEMENTIAS SERVICES RESEARCH ACT OF 1992.—The Alzheimer's Disease and Related Dementias Research Act of 1992 (42 U.S.C. 11271 et seq.) is amended—

(A) in the heading of subpart 3 of part D to read as follows:

"Subpart 3—Responsibilities of the Centers for Medicare & Medicaid Services";

(B) in section 937 (42 U.S.C. 11271)—

(i) in subsection (a), by striking "National Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services";

(ii) in subsection (b)(1), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services";

(iii) in subsection (b)(2), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services"; and

(iv) in subsection (c), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services"; and

(C) in section 938 (42 U.S.C. 11272), by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services".

(6) MISCELLANEOUS AMENDMENTS.—

(A) REHABILITATION ACT OF 1973.—Section 202(b)(8) of the Rehabilitation Act of 1973 (29 U.S.C. 762(b)(8)) is amended by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services".

(B) INDIAN HEALTH CARE IMPROVEMENT ACT.—Section 405(d)(1) of the Indian Health Care Improvement Act (25 U.S.C. 1645(d)(1)) is amended by striking "Health Care Financing Administration" in the matter preceding subparagraph (A) and inserting "Centers for Medicare & Medicaid Services".

(C) INDIVIDUALS WITH DISABILITIES EDUCATION ACT.—Section 644(b)(5) of the Individuals with Disabilities Education Act (20 U.S.C. 1444(b)(5)) is amended by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services".

(D) THE HOME HEALTH CARE AND ALZHEIMER'S DISEASE AMENDMENTS OF 1990.—Section 302(a)(9) of the Home Health Care and Alzheimer's Disease Amendments of 1990 (42 U.S.C. 242q–1(a)(9)) is amended by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services".

(E) THE CHILDREN'S HEALTH ACT OF 2000.—Section 2503(a) of the Children's Health Act of 2000 (42 U.S.C. 247b–3a(a)) is amended by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services".

(F) THE NATIONAL INSTITUTES OF HEALTH REVITALIZATION ACT OF 1993.—Section 1909 of the National Institutes of Health Revitalization Act of 1993 (42 U.S.C. 299a note) is amended by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services".

(G) THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990.—Section 4359(d) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1395b–3(d)) is amended by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services".

(H) THE MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000.—Section 104(d)(4) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (42 U.S.C. 1395m note) is amended by striking "Health Care Financing Administration" and inserting "Health Care".

(7) ADDITIONAL AMENDMENT.—Section 403 of the Act entitled, "An Act to authorize certain appropriations for the territories of the United States, to amend certain Acts relating thereto, and for other purposes", enacted October 15, 1977 (48 U.S.C. 1574–1; 48 U.S.C. 1421q–1), is amended by striking "Health Care Financing Administration" and inserting "Centers for Medicare & Medicaid Services".

Subtitle A—Regulatory Reform

SEC. 501. CONSTRUCTION; DEFINITION OF SUPPLIER.

(a) CONSTRUCTION.—Nothing in this title shall be construed—

(1) to compromise or affect existing legal remedies for addressing fraud or abuse, whether it be criminal prosecution, civil enforcement, or administrative remedies, including under sections 3729 through 3733 of title 31, United States Code (commonly known as the "False Claims Act"); or

(2) to prevent or impede the Department of Health and Human Services in any way from its ongoing efforts to eliminate waste, fraud, and abuse in the medicare program.

Furthermore, the consolidation of medicare administrative contracting set forth in this division does not constitute consolidation of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund or reflect any position on that issue.

(b) DEFINITION OF SUPPLIER.—Section 1861 (42 U.S.C. 1395x) is amended by inserting after subsection (c) the following new subsection:

"Supplier

"(d) The term 'supplier' means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.".

SEC. 502. ISSUANCE OF REGULATIONS.

(a) REGULAR TIMELINE FOR PUBLICATION OF FINAL RULES.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraph:

"(3)(A) The Secretary, in consultation with the Director of the Office of Management and Budget, shall establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation or an interim final regulation.

"(B) Such timeline may vary among different regulations based on differences in the complexity of the regulation, the number and scope of comments received, and other relevant factors, but shall not be longer than 3 years except under exceptional circumstances. If the Secretary intends to vary such timeline with respect to the publication of a final regulation, the Secretary shall cause to have published in the Federal Register notice of the different timeline by not later than the timeline previously established with respect to such regulation. Such notice shall include a brief explanation of the justification for such variation.

"(C) In the case of interim final regulations, upon the expiration of the regular timeline established under this paragraph for the publication of a final regulation after opportunity for public comment, the interim final regulation shall not continue in effect unless the Secretary publishes (at the end of the regular timeline and, if applicable, at the end of each succeeding 1-year period) a notice of continuation of the regulation that includes an explanation of why the regular timeline (and any subsequent 1-year extension) was not complied with. If such a notice is published, the regular timeline (or such timeline as previously extended under this paragraph) for publication of the final regulation shall be treated as having been extended for 1 additional year.

"(D) The Secretary shall annually submit to Congress a report that describes the instances in which the Secretary failed to publish a final regulation within the applicable regular timeline under this paragraph and that provides an explanation for such failures.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act. The Secretary shall provide for an appropriate transition to take into account the backlog of previously published interim final regulations.

(b) LIMITATIONS ON NEW MATTER IN FINAL REGULATIONS.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

"(4) If the Secretary publishes a final regulation that includes a provision that is not a logical outgrowth of a previously published notice of proposed rulemaking or interim final rule, such provision shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to final regulations published on or after the date of the enactment of this Act.

SEC. 503. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh), as amended by section 502(a), is amended by adding at the end the following new subsection:

"(e)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

"(i) such retroactive application is necessary to comply with statutory requirements; or

"(ii) failure to apply the change retroactively would be contrary to the public interest.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of the enactment of this Act.

(b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE CHANGES AFTER NOTICE.—

(1) IN GENERAL.—Section 1871(e)(1), as added by subsection (a), is amended by adding at the end the following:

"(B)(i) Except as provided in clause (ii), a substantive change referred to in subparagraph (A) shall not become effective before the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

"(ii) The Secretary may provide for such a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.

"(C) No action shall be taken against a provider of services or supplier with respect to noncompliance with such a substantive change for items and services furnished before the effective date of such a change.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to compliance actions undertaken on or after the date of the enactment of this Act.

(c) RELIANCE ON GUIDANCE.—

(1) IN GENERAL.—Section 1871(e), as added by subsection (a), is further amended by adding at the end the following new paragraph:

"(2)(A) If—

"(i) a provider of services or supplier follows the written guidance (which may be transmitted electronically) provided by the Secretary or by a medicare contractor (as defined in section 1889(g)) acting within the scope of the contractor's contract authority, with respect to the furnishing of items or services and submission of a claim for benefits for such items or services with respect to such provider or supplier;

"(ii) the Secretary determines that the provider of services or supplier has accurately presented the circumstances relating to such items, services, and claim to the contractor in writing; and

"(iii) the guidance was in error;

the provider of services or supplier shall not be subject to any penalty or interest under this title or the provisions of title XI insofar as they relate to this title (including interest under a repayment plan under section 1893 or otherwise) relating to the provision of such items or service or such claim if the provider of services or supplier reasonably relied on such guidance.

"(B) Subparagraph (A) shall not be construed as preventing the recoupment or repayment (without any additional penalty) relating to an overpayment insofar as the overpayment was solely the result of a clerical or technical operational error.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act and shall only apply to a penalty or interest imposed with respect to guidance provided on or after July 24, 2003.

SEC. 504. REPORTS AND STUDIES RELATING TO REGULATORY REFORM.

(a) GAO STUDY ON ADVISORY OPINION AUTHORITY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine the feasibility and appropriateness of establishing in the Secretary authority to provide legally binding advisory opinions on appropriate interpretation and application of regulations to carry out the medicare program under title XVIII of the Social Security Act. Such study shall examine the appropriate timeframe for issuing such advisory opinions, as well as the need for additional staff and funding to provide such opinions.

(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than 1 year after the date of the enactment of this Act.

(b) REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by section 503(a)(1), is amended by adding at the end the following new subsection:

"(f)(1) Not later than 2 years after the date of the enactment of this subsection, and every 3 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

"(2) In preparing a report under paragraph (1), the Secretary shall collect—

"(A) information from individuals entitled to benefits under part A or enrolled under part B, or both, providers of services, and suppliers and from the Medicare Beneficiary Ombudsman with respect to such areas of inconsistency and conflict; and

"(B) information from medicare contractors that tracks the nature of written and telephone inquiries.

"(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.".

Subtitle B—Contracting Reform

SEC. 511. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

"CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

"SEC. 1874A. (a) AUTHORITY.—

"(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

"(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

"(A) the entity has demonstrated capability to carry out such function;

"(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

"(C) the entity has sufficient assets to financially support the performance of such function; and

"(D) the entity meets such other requirements as the Secretary may impose.

"(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

"(A) IN GENERAL.—The term 'medicare administrative contractor' means an agency, organization, or other person with a contract under this section.

"(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services or supplier (or class of such providers of services or suppliers), the 'appropriate' medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services or supplier or class of provider of services or supplier.

"(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions (including the function of developing local coverage determinations, as defined in section 1869(f)(2)(B)), provider services functions, and functions relating to services furnished to individuals entitled to benefits under part A or enrolled under part B, or both, as follows:

"(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, suppliers and individuals.

"(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

"(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Providing education and outreach to individuals entitled to benefits under part A or enrolled under part B, or both, and providing assistance to those individuals with specific issues, concerns, or problems.

"(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services or suppliers.

"(E) COMMUNICATION WITH PROVIDERS.—Communicating to providers of services and suppliers any information or instructions furnished to the medicare administrative contractor by the Secretary, and facilitating communication between such providers and suppliers and the Secretary.

"(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions relating to provider education, training, and technical assistance.

"(G) ADDITIONAL FUNCTIONS.—Performing such other functions, including (subject to paragraph (5)) functions under the Medicare Integrity Program under section 1893, as are necessary to carry out the purposes of this title.

"(5) RELATIONSHIP TO MIP CONTRACTS.—

"(A) NONDUPLICATION OF DUTIES.—In entering into contracts under this section, the Secretary shall assure that functions of medicare administrative contractors in carrying out activities under parts A and B do not duplicate activities carried out under a contract entered into under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

"(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

"(6) APPLICATION OF FEDERAL ACQUISITION REGULATION.—Except to the extent inconsistent with a specific requirement of this section, the Federal Acquisition Regulation applies to contracts under this section.

"(b) CONTRACTING REQUIREMENTS.—

"(1) USE OF COMPETITIVE PROCEDURES.—

"(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section, taking into account performance quality as well as price and other factors.

"(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every 5 years.

"(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors consistent with the provisions of this paragraph. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide public notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred, a description of the providers of services and suppliers affected by such transfer, and contact information for the contractors involved).

"(D) INCENTIVES FOR QUALITY.—The Secretary shall provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

"(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, quality of services provided, and other matters as the Secretary finds pertinent.

"(3) PERFORMANCE REQUIREMENTS.—

"(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—

"(i) IN GENERAL.—The Secretary shall develop contract performance requirements to carry out the specific requirements applicable under this title to a function described in subsection (a)(4) and shall develop standards for measuring the extent to which a contractor has met such requirements.

"(ii) CONSULTATION.—In developing such performance requirements and standards for measurement, the Secretary shall consult with providers of services, organizations representative of beneficiaries under this title, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements.

"(iii) PUBLICATION OF STANDARDS.—The Secretary shall make such performance requirements and measurement standards available to the public.

"(B) CONSIDERATIONS.—The Secretary shall include, as one of the standards developed under subparagraph (A), provider and beneficiary satisfaction levels.

"(C) INCLUSION IN CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

"(i) shall reflect the performance requirements published under subparagraph (A), but may include additional performance requirements;

"(ii) shall be used for evaluating contractor performance under the contract; and

"(iii) shall be consistent with the written statement of work provided under the contract.

"(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

"(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

"(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

"(5) SURETY BOND.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

"(c) TERMS AND CONDITIONS.—

"(1) IN GENERAL.—A contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

"(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

"(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

"(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

"(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General of the United States) of a certifying officer designated as provided in paragraph (1) of this subsection.

"(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—

"(A) IN GENERAL.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless, in connection with such payment, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

"(B) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code.

"(4) INDEMNIFICATION BY SECRETARY.—

"(A) IN GENERAL.—Subject to subparagraphs (B) and (D), in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from or relating directly to the claims administration process under this title, the Secretary may, to the extent the Secretary determines to be appropriate and as specified in the contract with the contractor, indemnify the contractor and such persons.

"(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the judicial proceeding or by the Secretary to be criminal in nature, fraudulent, or grossly negligent. If indemnification is provided by the Secretary with respect to a contractor before a determination that such costs arose directly from such conduct, the contractor shall reimburse the Secretary for costs of indemnification.

"(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

"(D) WRITTEN APPROVAL FOR SETTLEMENTS OR COMPROMISES.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate such settlement or compromise. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement or compromise of a proceeding described in such subparagraph are conditioned upon prior written approval by the Secretary of the final settlement or compromise.

"(E) CONSTRUCTION.—Nothing in this paragraph shall be construed—

"(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

"(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulation.".

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act, as inserted by paragraph (1), the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act.

(b) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows:

"PROVISIONS RELATING TO THE
ADMINISTRATION OF PART A".

(2) Subsection (a) is amended to read as follows:

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.".

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking "agreement under this section" and inserting "contract under section 1874A that provides for making payments under this part".

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking "An agreement with an agency or organization under this section" and inserting "A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part"; and

(B) by striking "such agency or organization" and inserting "such medicare administrative contractor" each place it appears.

(7) Subsection (l) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

"PROVISIONS RELATING TO THE
ADMINISTRATION OF PART B".

(2) Subsection (a) is amended to read as follows:

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.".

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking "carriers" and inserting "medicare administrative contractors"; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking "Each such contract shall provide that the carrier" and inserting "The Secretary";

(ii) by striking "will" the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting "shall";

(iii) in subparagraph (B), in the matter before clause (i), by striking "to the policyholders and subscribers of the carrier" and inserting "to the policyholders and subscribers of the medicare administrative contractor";

(iv) by striking subparagraphs (C), (D), and (E);

(v) in subparagraph (H)—

(I) by striking "if it makes determinations or payments with respect to physicians' services," in the matter preceding clause (i); and

(II) by striking "carrier" and inserting "medicare administrative contractor" in clause (i);

(vi) by striking subparagraph (I);

(vii) in subparagraph (L), by striking the semicolon and inserting a period;

(viii) in the first sentence, after subparagraph (L), by striking "and shall contain" and all that follows through the period; and

(ix) in the seventh sentence, by inserting "medicare administrative contractor," after "carrier,";

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking "carrier" and inserting "medicare administrative contractor"; and

(F) in paragraph (7), by striking "the carrier" and inserting "the Secretary" each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)(A), by striking "contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B)," and inserting "contract under section 1874A that provides for making payments under this part";

(C) in paragraph (3)(A), by striking "subsection (a)(1)(B)" and inserting "section 1874A(a)(3)(B)";

(D) in paragraph (4), in the matter preceding subparagraph (A), by striking "carrier" and inserting "medicare administrative contractor"; and

(E) by striking paragraphs (5) and (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking "carrier or carriers" and inserting "medicare administrative contractor or contractors".

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking "Each carrier having an agreement with the Secretary under subsection (a)" and inserting "The Secretary"; and

(ii) by striking "Each such carrier" and inserting "The Secretary";

(B) in paragraph (3)(A)—

(i) by striking "a carrier having an agreement with the Secretary under subsection (a)" and inserting "medicare administrative contractor having a contract under section 1874A that provides for making payments under this part"; and

(ii) by striking "such carrier" and inserting "such contractor";

(C) in paragraph (3)(B)—

(i) by striking "a carrier" and inserting "a medicare administrative contractor" each place it appears; and

(ii) by striking "the carrier" and inserting "the contractor" each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking "carriers" and inserting "medicare administrative contractors" each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking "carrier" and inserting "medicare administrative contractor"; and

(B) in paragraph (2), by striking "carrier" and inserting "medicare administrative contractor".

(9) Subsection (p)(3)(A) is amended by striking "carrier" and inserting "medicare administrative contractor".

(10) Subsection (q)(1)(A) is amended by striking "carrier".

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2005, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this Act, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2011.

(2) GENERAL TRANSITION RULES.—

(A) AUTHORITY TO CONTINUE TO ENTER INTO NEW AGREEMENTS AND CONTRACTS AND WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—Prior to October 1, 2005, the Secretary may, consistent with subparagraph (B), continue to enter into agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u). The Secretary may enter into new agreements under section 1816 prior to October 1, 2005, without regard to any of the provider nomination provisions of such section.

(B) APPROPRIATE TRANSITION.—The Secretary shall take such steps as are necessary to provide for an appropriate transition from agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) AUTHORIZING CONTINUATION OF MIP FUNCTIONS UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER TRANSITION CONTRACTS.—Notwithstanding the amendments made by this section, the provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply during the period that begins on the date of the enactment of this Act and ends on October 1, 2011, and any reference in such provisions to an agreement or contract shall be deemed to include a contract under section 1874A of such Act, as inserted by subsection (a)(1), that continues the activities referred to in such provisions.

(e) REFERENCES.—On and after the effective date provided under subsection (d)(1), any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to a medicare administrative contractor (as provided under section 1874A of the Social Security Act).

(f) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(g) REPORTS ON IMPLEMENTATION.—

(1) PLAN FOR IMPLEMENTATION.—By not later than October 1, 2004, the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes the plan for implementation of the amendments made by this section. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contracts and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

SEC. 512. REQUIREMENTS FOR INFORMATION SECURITY FOR MEDICARE ADMINISTRATIVE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 511(a)(1), is amended by adding at the end the following new subsection:

"(e) REQUIREMENTS FOR INFORMATION SECURITY.—

"(1) DEVELOPMENT OF INFORMATION SECURITY PROGRAM.—A medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall implement a contractor-wide information security program to provide information security for the operation and assets of the contractor with respect to such functions under this title. An information security program under this paragraph shall meet the requirements for information security programs imposed on Federal agencies under paragraphs (1) through (8) of section 3544(b) of title 44, United States Code (other than the requirements under paragraphs (2)(D)(i), (5)(A), and (5)(B) of such section).

"(2) INDEPENDENT AUDITS.—

"(A) PERFORMANCE OF ANNUAL EVALUATIONS.—Each year a medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall undergo an evaluation of the information security of the contractor with respect to such functions under this title. The evaluation shall—

"(i) be performed by an entity that meets such requirements for independence as the Inspector General of the Department of Health and Human Services may establish; and

"(ii) test the effectiveness of information security control techniques of an appropriate subset of the contractor's information systems (as defined in section 3502(8) of title 44, United States Code) relating to such functions under this title and an assessment of compliance with the requirements of this subsection and related information security policies, procedures, standards and guidelines, including policies and procedures as may be prescribed by the Director of the Office of Management and Budget and applicable information security standards promulgated under section 11331 of title 40, United States Code.

"(B) DEADLINE FOR INITIAL EVALUATION.—

"(i) NEW CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that has not previously performed the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) as a fiscal intermediary or carrier under section 1816 or 1842, the first independent evaluation conducted pursuant to subparagraph (A) shall be completed prior to commencing such functions.

"(ii) OTHER CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that is not described in clause (i), the first independent evaluation conducted pursuant to subparagraph (A) shall be completed within 1 year after the date the contractor commences functions referred to in clause (i) under this section.

"(C) REPORTS ON EVALUATIONS.—

"(i) TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The results of independent evaluations under subparagraph (A) shall be submitted promptly to the Inspector General of the Department of Health and Human Services and to the Secretary.

"(ii) TO CONGRESS.—The Inspector General of the Department of Health and Human Services shall submit to Congress annual reports on the results of such evaluations, including assessments of the scope and sufficiency of such evaluations.

"(iii) AGENCY REPORTING.—The Secretary shall address the results of such evaluations in reports required under section 3544(c) of title 44, United States Code.".

(b) APPLICATION OF REQUIREMENTS TO FISCAL INTERMEDIARIES AND CARRIERS.—

(1) IN GENERAL.—The provisions of section 1874A(e)(2) of the Social Security Act (other than subparagraph (B)), as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(2) DEADLINE FOR INITIAL EVALUATION.—In the case of such a fiscal intermediary or carrier with an agreement or contract under such respective section in effect as of the date of the enactment of this Act, the first evaluation under section 1874A(e)(2)(A) of the Social Security Act (as added by subsection (a)), pursuant to paragraph (1), shall be completed (and a report on the evaluation submitted to the Secretary) by not later than 1 year after such date.

Subtitle C—Education and Outreach

SEC. 521. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1888 the following new section:

"PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

"SEC. 1889. (a) COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (g), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services and suppliers.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(3) REPORT.—Not later than October 1, 2004, the Secretary shall submit to Congress a report that includes a description and evaluation of the steps taken to coordinate the funding of provider education under section 1889(a) of the Social Security Act, as added by paragraph (1).

(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—

(1) IN GENERAL.—Section 1874A, as added by section 511(a)(1) and as amended by section 512(a), is amended by adding at the end the following new subsection:

"(f) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—The Secretary shall use specific claims payment error rates or similar methodology of medicare administrative contractors in the processing or reviewing of medicare claims in order to give such contractors an incentive to implement effective education and outreach programs for providers of services and suppliers.".

(2) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(f) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(3) GAO REPORT ON ADEQUACY OF METHODOLOGY.—Not later than October 1, 2004, the Comptroller General of the United States shall submit to Congress and to the Secretary a report on the adequacy of the methodology under section 1874A(f) of the Social Security Act, as added by paragraph (1), and shall include in the report such recommendations as the Comptroller General determines appropriate with respect to the methodology.

(4) REPORT ON USE OF METHODOLOGY IN ASSESSING CONTRACTOR PERFORMANCE.—Not later than October 1, 2004, the Secretary shall submit to Congress a report that describes how the Secretary intends to use such methodology in assessing medicare contractor performance in implementing effective education and outreach programs, including whether to use such methodology as a basis for performance bonuses. The report shall include an analysis of the sources of identified errors and potential changes in systems of contractors and rules of the Secretary that could reduce claims error rates.

(c) PROVISION OF ACCESS TO AND PROMPT RESPONSES FROM MEDICARE ADMINISTRATIVE CONTRACTORS.—

(1) IN GENERAL.—Section 1874A, as added by section 511(a)(1) and as amended by section 512(a) and subsection (b), is further amended by adding at the end the following new subsection:

"(g) COMMUNICATIONS WITH BENEFICIARIES, PROVIDERS OF SERVICES AND SUPPLIERS.—

"(1) COMMUNICATION STRATEGY.—The Secretary shall develop a strategy for communications with individuals entitled to benefits under part A or enrolled under part B, or both, and with providers of services and suppliers under this title.

"(2) RESPONSE TO WRITTEN INQUIRIES.—Each medicare administrative contractor shall, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries of providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

"(3) RESPONSE TO TOLL-FREE LINES.—The Secretary shall ensure that each medicare administrative contractor shall provide, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, a toll-free telephone number at which such individuals, providers of services, and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

"(4) MONITORING OF CONTRACTOR RESPONSES.—

"(A) IN GENERAL.—Each medicare administrative contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

"(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

"(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

"(B) DEVELOPMENT OF STANDARDS.—

"(i) IN GENERAL.—The Secretary shall establish and make public standards to monitor the accuracy, consistency, and timeliness of the information provided in response to written and telephone inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

"(ii) EVALUATION.—In conducting evaluations of individual medicare administrative contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

"(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.

"(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this subsection.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect October 1, 2004.

(3) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(g) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(d) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) IN GENERAL.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsections:

"(b) ENHANCED EDUCATION AND TRAINING.—

"(1) ADDITIONAL RESOURCES.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) such sums as may be necessary for fiscal years beginning with fiscal year 2005.

"(2) USE.—The funds made available under paragraph (1) shall be used to increase the conduct by medicare contractors of education and training of providers of services and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses.

"(c) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

"(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall tailor such activities to meet the special needs of small providers of services or suppliers (as defined in paragraph (2)). Such education and training activities for small providers of services and suppliers may include the provision of technical assistance (such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance).

"(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term 'small provider of services or supplier' means—

"(A) a provider of services with fewer than 25 full-time-equivalent employees; or

"(B) a supplier with fewer than 10 full-time-equivalent employees.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(e) REQUIREMENT TO MAINTAIN INTERNET WEBSITES.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsection (d), is further amended by adding at the end the following new subsection:

"(d) INTERNET WEBSITES; FAQS.—The Secretary, and each medicare contractor insofar as it provides services (including claims processing) for providers of services or suppliers, shall maintain an Internet website which—

"(1) provides answers in an easily accessible format to frequently asked questions, and

"(2) includes other published materials of the contractor,

that relate to providers of services and suppliers under the programs under this title (and title XI insofar as it relates to such programs).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(f) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsections (d) and (e), is further amended by adding at the end the following new subsections:

"(e) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services or suppliers for the purpose of conducting any type of audit or prepayment review.

"(f) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor—

"(1) of the screens used for identifying claims that will be subject to medical review; or

"(2) of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

“(g) DEFINITIONS.—For purposes of this section, the term ‘medicare contractor’ includes the following:

“(1) A medicare administrative contractor with a contract under section 1874A, including a fiscal intermediary with a contract under section 1816 and a carrier with a contract under section 1842.

“(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services or supplier an entity that has no authority under this title or title IX with respect to such activities and such provider of services or supplier.”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

SEC. 522. SMALL PROVIDER TECHNICAL ASSISTANCE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the “demonstration program”) under which technical assistance described in paragraph (2) is made available, upon request and on a voluntary basis, to small providers of services or suppliers in order to improve compliance with the applicable requirements of the programs under medicare program under title XVIII of the Social Security Act (including provisions of title XI of such Act insofar as they relate to such title and are not administered by the Office of the Inspector General of the Department of Health and Human Services).

(2) FORMS OF TECHNICAL ASSISTANCE.—The technical assistance described in this paragraph is—

(A) evaluation and recommendations regarding billing and related systems; and

(B) information and assistance regarding policies and procedures under the medicare program, including coding and reimbursement.

(3) SMALL PROVIDERS OF SERVICES OR SUPPLIERS.—In this section, the term “small providers of services or suppliers” means—

(A) a provider of services with fewer than 25 full-time-equivalent employees; or

(B) a supplier with fewer than 10 full-time-equivalent employees.

(b) QUALIFICATION OF CONTRACTORS.—In conducting the demonstration program, the Secretary shall enter into contracts with qualified organizations (such as peer review organizations or entities described in section 1889(g)(2) of the Social Security Act, as inserted by section 521(f)(1)) with appropriate expertise with billing systems of the full range of providers of services and suppliers to provide the technical assistance. In awarding such contracts, the Secretary shall consider any prior investigations of the entity's work by the Inspector General of Department of Health and Human Services or the Comptroller General of the United States.

(c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The technical assistance provided under the demonstration program shall include a direct and in-person examination of billing systems and internal controls of small providers of services or suppliers to determine program compliance and to suggest more efficient or effective means of achieving such compliance.

(d) GAO EVALUATION.—Not later than 2 years after the date the demonstration program is first implemented, the Comptroller General, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct an evaluation of the demonstration program. The evaluation shall include a determination of whether claims error rates are reduced for small providers of services or suppliers who participated in the program and the extent of improper payments made as a result of the demonstration program. The Comptroller General shall submit a report to the Secretary and the Congress on such evaluation and shall include in such report recommendations regarding the continuation or extension of the demonstration program.

(e) FINANCIAL PARTICIPATION BY PROVIDERS.—The provision of technical assistance to a small provider of services or supplier under the demonstration program is conditioned upon the small provider of services or supplier paying an amount estimated (and disclosed in advance of a provider's or supplier's participation in the program) to be equal to 25 percent of the cost of the technical assistance.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, from amounts not otherwise appropriated in the Treasury, such sums as may be necessary to carry out this section.

SEC. 523. MEDICARE BENEFICIARY OMBUDSMAN.

(a) IN GENERAL.—Section 1808, as added and amended by section 500, is amended by adding at the end the following new subsection:

“(c) MEDICARE BENEFICIARY OMBUDSMAN.—

“(1) IN GENERAL.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals entitled to benefits under this title.

“(2) DUTIES.—The Medicare Beneficiary Ombudsman shall—

“(A) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under part A or enrolled under part B, or both, with respect to any aspect of the medicare program;

“(B) provide assistance with respect to complaints, grievances, and requests referred to in subparagraph (A), including—

“(i) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, MA organization, or the Secretary;

“(ii) assistance to such individuals with any problems arising from disenrollment from an MA plan under part C; and

“(iii) assistance to such individuals in presenting information under section 1839(i)(4)(C) (relating to income-related premium adjustment; and

“(C) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

“(3) WORKING WITH HEALTH INSURANCE COUNSELING PROGRAMS.—To the extent possible, the Ombudsman shall work with health insurance counseling programs (receiving funding under section 4360 of Omnibus Budget Reconciliation Act of 1990) to facilitate the provision of information to individuals entitled to benefits under part A or enrolled under part B, or both regarding MA plans and changes to those plans. Nothing in this paragraph shall preclude further collaboration between the Ombudsman and such programs.”.

(b) DEADLINE FOR APPOINTMENT.—By not later than 1 year after the date of the enactment of this Act, the Secretary shall appoint the Medicare Beneficiary Ombudsman under section 1808(c) of the Social Security Act, as added by subsection (a).

(c) FUNDING.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund, established under section 1817 of the Social Security Act (42 U.S.C. 1395i), and the Federal Supplementary Medical Insurance Trust Fund, established under section 1841 of such Act (42 U.S.C. 1395t)) to carry out section 1808(c) of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (a), such sums as are necessary for fiscal year 2004 and each succeeding fiscal year.

(d) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-MEDICARE).—

(1) PHONE TRIAGE SYSTEM; LISTING IN MEDICARE HANDBOOK INSTEAD OF OTHER TOLL-FREE NUMBERS.—Section 1804(b) (42 U.S.C. 1395b-2(b)) is amended by adding at the end the following: “The Secretary shall provide, through the toll-free telephone number 1-800-MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.”.

(2) MONITORING ACCURACY.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study to monitor the accuracy and consistency of information provided to individuals entitled to benefits under part A or enrolled under part B, or both, through the toll-free telephone number 1-800-MEDICARE, including an assessment of whether the information provided is sufficient to answer questions of such individuals. In conducting the study, the Comptroller General shall examine the education and training of the individuals providing information through such number.

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subparagraph (A).

SEC. 524. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the “demonstration program”) under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to individuals entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both, regarding the medicare program at the location of existing local offices of the Social Security Administration.

(b) LOCATIONS.—

(1) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to paragraph (2), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by individuals referred to in subsection (a).

(2) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas,

the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(c) Duration.—The demonstration program shall be conducted over a 3-year period.

(d) Evaluation and Report.—

(1) Evaluation.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(A) utilization of, and satisfaction of those individuals referred to in subsection (a) with, the assistance provided under the program; and

(B) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local offices of the Social Security Administration.

(2) Report.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing medicare specialists at local offices of the Social Security Administration.

SEC. 525. INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY BENEFITS.

(a) In General.—The Secretary shall provide that in medicare beneficiary notices provided (under section 1806(a) of the Social Security Act, 42 U.S.C. 1395b–7(a)) with respect to the provision of post-hospital extended care services under part A of title XVIII of the Social Security Act, there shall be included information on the number of days of coverage of such services remaining under such part for the medicare beneficiary and spell of illness involved.

(b) Effective Date.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

SEC. 526. INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS.

(a) Availability of Data.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.

(b) Inclusion of Information in Certain Hospital Discharge Plans.—

(1) In general.—Section 1861(ee)(2)(D) (42 U.S.C. 1395x(ee)(2)(D)) is amended—

(A) by striking "hospice services" and inserting "hospice care and post-hospital extended care services"; and

(B) by inserting before the period at the end the following: "and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides".

(2) Effective date.—The amendments made by paragraph (1) shall apply to discharge plans made on or after such date as the Secretary shall specify, but not later than 6 months after the date the Secretary provides for availability of information under subsection (a).

Subtitle D—Appeals and Recovery

SEC. 531. TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) Transition Plan.—

(1) In general.—Not later than April 1, 2004, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) Contents.—The plan shall include information on the following:

(A) Workload.—The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes.

(B) Cost projections and financing.—Funding levels required for fiscal year 2005 and subsequent fiscal years to carry out the functions transferred under the plan.

(C) Transition timetable.—A timetable for the transition.

(D) Regulations.—The establishment of specific regulations to govern the appeals process.

(E) Case tracking.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the medicare program.

(F) Feasibility of precedential authority.—The feasibility of developing a process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services addressing broad legal issues binding, precedential authority.

(G) Access to administrative law judges.—The feasibility of—

(i) filing appeals with administrative law judges electronically; and

(ii) conducting hearings using tele- or video-conference technologies.

(H) Independence of administrative law judges.—The steps that should be taken to ensure the independence of administrative law judges consistent with the requirements of subsection (b)(2).

(I) Geographic distribution.—The steps that should be taken to provide for an appropriate geographic distribution of administrative law judges throughout the United States to carry out subsection (b)(3).

(J) Hiring.—The steps that should be taken to hire administrative law judges (and support staff) to carry out subsection (b)(4).

(K) Performance standards.—The appropriateness of establishing performance standards for administrative law judges with respect to timelines for decisions in cases under title XVIII of the Social Security Act taking into account requirements under subsection (b)(2) for the independence of such judges and consistent with the applicable provisions of title 5, United States Code relating to impartiality.

(L) Shared resources.—The steps that should be taken to carry out subsection (b)(6) (relating to the arrangements with the Commissioner of Social Security to share office space, support staff, and other resources, with appropriate reimbursement).

(M) Training.—The training that should be provided to administrative law judges with respect to laws and regulations under title XVIII of the Social Security Act.

(3) Additional information.—The plan may also include recommendations for further congressional action, including modifications to the requirements and deadlines established under section 1869 of the Social Security Act (42 U.S.C. 1395ff) (as amended by this Act).

(4) GAO evaluation.—The Comptroller General of the United States shall evaluate the plan and, not later than the date that is 6 months after the date on which the plan is received by the Comptroller General, shall submit to Congress a report on such evaluation.

(b) Transfer of Adjudication Authority.—

(1) In general.—Not earlier than July 1, 2005, and not later than October 1, 2005, the Commissioner of Social Security and the Secretary shall implement the transition plan under subsection (a) and transfer the administrative law judge functions described in such subsection from the Social Security Administration to the Secretary.

(2) Assuring independence of judges.—The Secretary shall assure the independence of administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Centers for Medicare & Medicaid Services and its contractors. In order to assure such independence, the Secretary shall place such judges in an administrative office that is organizationally and functionally separate from such Centers. Such judges shall report to, and be under the general supervision of, the Secretary, but shall not report to, or be subject to supervision by, another officer of the Department of Health and Human Services.

(3) Geographic distribution.—The Secretary shall provide for an appropriate geographic distribution of administrative law judges performing the administrative law judge functions transferred under paragraph (1) throughout the United States to ensure timely access to such judges.

(4) Hiring authority.—Subject to the amounts provided in advance in appropriations Acts, the Secretary shall have authority to hire administrative law judges to hear such cases, taking into consideration those judges with expertise in handling medicare appeals and in a manner consistent with paragraph (3), and to hire support staff for such judges.

(5) Financing.—Amounts payable under law to the Commissioner for administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund shall become payable to the Secretary for the functions so transferred.

(6) Shared resources.—The Secretary shall enter into such arrangements with the Commissioner as may be appropriate with respect to transferred functions of administrative law judges to share office space, support staff, and other resources, with appropriate reimbursement from the Trust Funds described in paragraph (5).

(c) Increased Financial Support.—In addition to any amounts otherwise appropriated, to ensure timely action on appeals before administrative law judges and the Departmental Appeals Board consistent with section 1869 of the Social Security Act (42 U.S.C. 1395ff) (as amended by this Act), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund, established under section 1817 of the Social Security Act (42 U.S.C. 1395i), and the Federal Supplementary Medical Insurance Trust Fund, established under section 1841 of such Act (42 U.S.C. 1395t)) to the Secretary such sums as are necessary for fiscal year 2005 and each subsequent fiscal year to—

(1) increase the number of administrative law judges (and their staffs) under subsection (b)(4);

(2) improve education and training opportunities for administrative law judges (and their staffs); and

(3) increase the staff of the Departmental Appeals Board.

(d) CONFORMING AMENDMENT.—Section 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)) is amended by striking "of the Social Security Administration".

SEC. 532. PROCESS FOR EXPEDITED ACCESS TO REVIEW.

(a) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

(1) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)) is amended—

(A) in paragraph (1)(A), by inserting ", subject to paragraph (2)," before "to judicial review of the Secretary's final decision"; and

(B) by adding at the end the following new paragraph:

"(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

"(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or an individual entitled to benefits under part A or enrolled under part B, or both, who has filed an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)(i)) may obtain access to judicial review when a review entity (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation for a specific matter in dispute in a case of an appeal.

"(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute, and if such request is accompanied by the documents and materials as the appropriate review entity shall require for purposes of making such determination, such review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the request and such accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

"(C) ACCESS TO JUDICIAL REVIEW.—

"(i) IN GENERAL.—If the appropriate review entity—

"(I) determines that there are no material issues of fact in dispute and that the only issues to be adjudicated are ones of law or regulation that the Departmental Appeals Board does not have authority to decide; or

"(II) fails to make such determination within the period provided under subparagraph (B),

then the appellant may bring a civil action as described in this subparagraph.

"(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

"(I) clause (i)(I), within 60 days of the date of the determination described in such clause; or

"(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

"(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the District Court for the District of Columbia.

"(iv) INTEREST ON ANY AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier is granted judicial review pursuant to this paragraph, the amount in controversy (if any) shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services or suppliers under this title.

"(D) REVIEW ENTITY DEFINED.—For purposes of this subsection, the term 'review entity' means an entity of up to three reviewers who are administrative law judges or members of the Departmental Appeals Board selected for purposes of making determinations under this paragraph.".

(2) CONFORMING AMENDMENT.—Section 1869(b)(1)(F)(ii) (42 U.S.C. 1395ff(b)(1)(F)(ii)) is amended to read as follows:

"(ii) REFERENCE TO EXPEDITED ACCESS TO JUDICIAL REVIEW.—For the provision relating to expedited access to judicial review, see paragraph (2).".

(b) APPLICATION TO PROVIDER AGREEMENT DETERMINATIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting "(A)" after "(h)(1)"; and

(2) by adding at the end the following new subparagraph:

"(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.".

(c) EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.—

(1) TERMINATION AND CERTAIN OTHER IMMEDIATE REMEDIES.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)), as amended by subsection (b), is amended by adding at the end the following new subparagraph:

"(C)(i) The Secretary shall develop and implement a process to expedite proceedings under this subsection in which—

"(I) the remedy of termination of participation has been imposed;

"(II) a remedy described in clause (i) or (iii) of section 1819(h)(2)(B) has been imposed, but only if such remedy has been imposed on an immediate basis; or

"(III) a determination has been made as to a finding of substandard quality of care that results in the loss of approval of a skilled nursing facility's nurse aide training program.

"(ii) Under such process under clause (i), priority shall be provided in cases of termination described in clause (i)(I).

"(iii) Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.".

(2) WAIVER OF DISAPPROVAL OF NURSE-AIDE TRAINING PROGRAMS.—Sections 1819(f)(2) and section 1919(f)(2) (42 U.S.C. 1395i-3(f)(2) and 1396r(f)(2)) are each amended—

(A) in subparagraph (B)(iii), by striking "subparagraph (C)" and inserting "subparagraphs (C) and (D)"; and

(B) by adding at the end the following new subparagraph:

"(D) WAIVER OF DISAPPROVAL OF NURSE-AIDE TRAINING PROGRAMS.—Upon application of a nursing facility, the Secretary may waive the application of subparagraph (B)(iii)(I)(c) if the imposition of the civil monetary penalty was not related to the quality of care provided to residents of the facility. Nothing in this subparagraph shall be construed as eliminating any requirement upon a facility to pay a civil monetary penalty described in the preceding sentence.".

(3) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund, established under section 1817 of the Social Security Act (42 U.S.C. 1395i), and the Federal Supplementary Medical Insurance Trust Fund, established under section 1841 of such Act (42 U.S.C. 1395t)) to the Secretary such additional sums for fiscal year 2004 and each subsequent fiscal year as may be necessary. The purposes for which such amounts are available include increasing the number of administrative law judges (and their staffs) and the appellate level staff at the Departmental Appeals Board of the Department of Health and Human Services and educating such judges and staffs on long-term care issues.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to appeals filed on or after October 1, 2004.

SEC. 533. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE.—

(1) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by section 532(a), is further amended by adding at the end the following new paragraph:

"(3) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE BY PROVIDERS.—A provider of services or supplier may not introduce evidence in any appeal under this section that was not presented at the reconsideration conducted by the qualified independent contractor under subsection (c), unless there is good cause which precluded the introduction of such evidence at or before that reconsideration.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(b) USE OF PATIENTS' MEDICAL RECORDS.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)) is amended by inserting "(including the medical records of the individual involved)" after "clinical experience".

(c) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1869(a) (42 U.S.C.

1395ff(a)) is amended by adding at the end the following new paragraphs:

"(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS.—With respect to an initial determination insofar as it results in a denial of a claim for benefits—

"(A) the written notice on the determination shall include—

"(i) the reasons for the determination, including whether a local medical review policy or a local coverage determination was used;

"(ii) the procedures for obtaining additional information concerning the determination, including the information described in subparagraph (B); and

"(iii) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination under this section;

"(B) such written notice shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both; and

"(C) the individual provided such written notice may obtain, upon request, information on the specific provision of the policy, manual, or regulation used in making the redetermination.

"(5) REQUIREMENTS OF NOTICE OF REDETERMINATIONS.—With respect to a redetermination insofar as it results in a denial of a claim for benefits—

"(A) the written notice on the redetermination shall include—

"(i) the specific reasons for the redetermination;

"(ii) as appropriate, a summary of the clinical or scientific evidence used in making the redetermination;

"(iii) a description of the procedures for obtaining additional information concerning the redetermination; and

"(iv) notification of the right to appeal the redetermination and instructions on how to initiate such an appeal under this section;

"(B) such written notice shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both; and

"(C) the individual provided such written notice may obtain, upon request, information on the specific provision of the policy, manual, or regulation used in making the redetermination.".

(2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)) is amended—

(A) by inserting "be written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include (to the extent appropriate)" after "in writing,"; and

(B) by inserting "and a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section" after "such decision,".

(3) APPEALS.—Section 1869(d) (42 U.S.C. 1395ff(d)) is amended—

(A) in the heading, by inserting "; NOTICE" after "SECRETARY"; and

(B) by adding at the end the following new paragraph:

"(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include—

"(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

"(B) the procedures for obtaining additional information concerning the decision; and

"(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.".

(4) SUBMISSION OF RECORD FOR APPEAL.—Section 1869(c)(3)(J)(i) (42 U.S.C. 1395ff(c)(3)(J)(i)) is amended by striking "prepare" and inserting "submit" and by striking "with respect to" and all that follows through "and relevant policies".

(d) QUALIFIED INDEPENDENT CONTRACTORS.—

(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(3) (42 U.S.C. 1395ff(c)(3)) is amended—

(A) in subparagraph (A), by striking "sufficient training and expertise in medical science and legal matters" and inserting "sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing"; and

(B) by adding at the end the following new subparagraph:

"(K) INDEPENDENCE REQUIREMENTS.—

"(i) IN GENERAL.—Subject to clause (ii), a qualified independent contractor shall not conduct any activities in a case unless the entity—

"(I) is not a related party (as defined in subsection (g)(5));

"(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

"(III) does not otherwise have a conflict of interest with such a party.

"(ii) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

"(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.".

(2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—Section 1869 (42 U.S.C. 1395ff) is amended—

(A) by amending subsection (c)(3)(D) to read as follows:

"(D) QUALIFICATIONS FOR REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals)."; and

(B) by adding at the end the following new subsection:

"(g) QUALIFICATIONS OF REVIEWERS.—

"(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall assure that—

"(A) each individual conducting a review shall meet the qualifications of paragraph (2);

"(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

"(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a 'reviewing professional'), a reviewing professional meets the qualifications described in paragraph (4) and, where a claim is regarding the furnishing of treatment by a physician (allopathic or osteopathic) or the provision of items or services by a physician (allopathic or osteopathic), a reviewing professional shall be a physician (allopathic or osteopathic).

"(2) INDEPENDENCE.—

"(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

"(i) not be a related party (as defined in paragraph (5));

"(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

"(iii) not otherwise have a conflict of interest with such a party.

"(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

"(i) prohibit an individual, solely on the basis of a participation agreement with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

"(I) the individual is not involved in the provision of items or services in the case under review;

"(II) the fact of such an agreement is disclosed to the Secretary and the individual entitled to benefits under part A or enrolled under part B, or both, or such individual's authorized representative, and neither party objects; and

"(III) the individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

"(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of having such staff privileges if the existence of such privileges is disclosed to the Secretary and such individual (or authorized representative), and neither party objects; or

"(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

For purposes of this paragraph, the term 'participation agreement' means an agreement relating to the provision of health care services by the individual and does not include the provision of services as a reviewer under this subsection.

"(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

"(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be—

"(A) a physician (allopathic or osteopathic) who is appropriately credentialed or licensed in one or more States to deliver health care services and has medical expertise in the field of practice that is appropriate for the items or services at issue; or

"(B) a health care professional who is legally authorized in one or more States (in accordance with State law or the State regulatory mechanism provided by State law) to furnish the health care items or services at issue and has medical expertise in the field of practice that is appropriate for such items or services.

"(5) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a case under this title involving a specific individual entitled to benefits under part A or enrolled under part B, or both, any of the following:

"(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

"(B) The individual (or authorized representative).

"(C) The health care professional that provides the items or services involved in the case.

"(D) The institution at which the items or services (or treatment) involved in the case are provided.

"(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

"(F) Any other party determined under any regulations to have a substantial interest in the case involved.".

(3) REDUCING MINIMUM NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by striking "not fewer than 12 qualified independent contractors under this subsection" and inserting "with a sufficient number of qualified independent contractors (but not fewer than 4 such contractors) to conduct reconsiderations consistent with the timeframes applicable under this subsection".

(4) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA (114 Stat. 2763A–534).

(5) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by paragraph (2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).

SEC. 534. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 511(a)(1) and as amended by sections 912(b), 921(b)(1), and 921(c)(1), is further amended by adding at the end the following new subsection:

"(h) CONDUCT OF PREPAYMENT REVIEW.—

"(1) CONDUCT OF RANDOM PREPAYMENT REVIEW.—

"(A) IN GENERAL.—A medicare administrative contractor may conduct random prepayment review only to develop a contractor-wide or program-wide claims payment error rates or under such additional circumstances as may be provided under regulations, developed in consultation with providers of services and suppliers.

"(B) USE OF STANDARD PROTOCOLS WHEN CONDUCTING PREPAYMENT REVIEWS.—When a medicare administrative contractor conducts a random prepayment review, the contractor may conduct such review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

"(C) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review.

"(D) RANDOM PREPAYMENT REVIEW.—For purposes of this subsection, the term 'random prepayment review' means a demand for the production of records or documentation absent cause with respect to a claim.

"(2) LIMITATIONS ON NON-RANDOM PREPAYMENT REVIEW.—

"(A) LIMITATIONS ON INITIATION OF NON-RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate non-random prepayment review of a provider of services or supplier based on the initial identification by that provider of services or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error under section 1893(f)(3)(A).

"(B) TERMINATION OF NON-RANDOM PREPAYMENT REVIEW.—The Secretary shall issue regulations relating to the termination, including termination dates, of non-random prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect 1 year after the date of the enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(h) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of the enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(h)(1)(B) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary shall specify.

(c) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(h) of the Social Security Act, as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

SEC. 535. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1893 (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

"(f) RECOVERY OF OVERPAYMENTS.—

"(1) USE OF REPAYMENT PLANS.—

"(A) IN GENERAL.—If the repayment, within 30 days by a provider of services or supplier, of an overpayment under this title would constitute a hardship (as described in subparagraph (B)), subject to subparagraph (C), upon request of the provider of services or supplier the Secretary shall enter into a plan with the provider of services or supplier for the repayment (through offset or otherwise) of such overpayment over a period of at least 6 months but not longer than 3 years (or not longer than 5 years in the case of extreme hardship, as determined by the Secretary). Interest shall accrue on the balance through the period of repayment. Such plan shall meet terms and conditions determined to be appropriate by the Secretary.

"(B) HARDSHIP.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the repayment of an overpayment (or overpayments) within 30 days is deemed to constitute a hardship if—

"(I) in the case of a provider of services that files cost reports, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services for the cost reporting period covered by the most recently submitted cost report; or

"(II) in the case of another provider of services or supplier, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services or supplier for the previous calendar year.

"(ii) RULE OF APPLICATION.—The Secretary shall establish rules for the application of this subparagraph in the case of a provider of services or supplier that was not paid under this title during the previous year or was paid under this title only during a portion of that year.

"(iii) TREATMENT OF PREVIOUS OVERPAYMENTS.—If a provider of services or supplier has entered into a repayment plan under subparagraph (A) with respect to a specific overpayment amount, such payment amount under the repayment plan shall not be taken into account under clause (i) with respect to subsequent overpayment amounts.

"(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

"(i) the Secretary has reason to suspect that the provider of services or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

"(ii) there is an indication of fraud or abuse committed against the program.

"(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

"(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

"(2) LIMITATION ON RECOUPMENT.—

"(A) IN GENERAL.—In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination under section 1869(b)(1), the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1869(b)(1) (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

"(B) COLLECTION WITH INTEREST.—Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

"(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in section 1889(g).

"(3) LIMITATION ON USE OF EXTRAPOLATION.—A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless the Secretary determines that—

"(A) there is a sustained or high level of payment error; or

"(B) documented educational intervention has failed to correct the payment error.

There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations by the Secretary of sustained or high levels of payment errors under this paragraph.

"(4) Provision of supporting documentation.—In the case of a provider of services or supplier with respect to which amounts were previously overpaid, a medicare contractor may request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

"(5) Consent settlement reforms.—

"(A) In general.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

"(B) Opportunity to submit additional information before consent settlement offer.—Before offering a provider of services or supplier a consent settlement, the Secretary shall—

"(i) communicate to the provider of services or supplier—

"(I) that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment;

"(II) the nature of the problems identified in such evaluation; and

"(III) the steps that the provider of services or supplier should take to address the problems; and

"(ii) provide for a 45-day period during which the provider of services or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

"(C) Consent settlement offer.—The Secretary shall review any additional information furnished by the provider of services or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

"(i) shall provide notice of such determination to the provider of services or supplier, including an explanation of the reason for such determination; and

"(ii) in order to resolve the overpayment, may offer the provider of services or supplier—

"(I) the opportunity for a statistically valid random sample; or

"(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

"(D) Consent settlement defined.—For purposes of this paragraph, the term 'consent settlement' means an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved.

"(6) Notice of over-utilization of codes.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services and suppliers, a process under which the Secretary provides for notice to classes of providers of services and suppliers served by the contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

"(7) Payment audits.—

"(A) Written notice for post-payment audits.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services or supplier under this title, the contractor shall provide the provider of services or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

"(B) Explanation of findings for all audits.—Subject to subparagraph (C), if a medicare contractor audits a provider of services or supplier under this title, the contractor shall—

"(i) give the provider of services or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services or supplier and permits the development of an appropriate corrective action plan;

"(ii) inform the provider of services or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary);

"(iii) give the provider of services or supplier an opportunity to provide additional information to the contractor; and

"(iv) take into account information provided, on a timely basis, by the provider of services or supplier under clause (iii).

"(C) Exception.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

"(8) Standard methodology for probe sampling.—The Secretary shall establish a standard methodology for medicare contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.".

(b) Effective Dates and Deadlines.—

(1) Use of repayment plans.—Section 1893(f)(1) of the Social Security Act, as added by subsection (a), shall apply to requests for repayment plans made after the date of the enactment of this Act.

(2) Limitation on recoupment.—Section 1893(f)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date of the enactment of this Act.

(3) Use of extrapolation.—Section 1893(f)(3) of the Social Security Act, as added by subsection (a), shall apply to statistically valid random samples initiated after the date that is 1 year after the date of the enactment of this Act.

(4) Provision of supporting documentation.—Section 1893(f)(4) of the Social Security Act, as added by subsection (a), shall take effect on the date of the enactment of this Act.

(5) Consent settlement.—Section 1893(f)(5) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

(6) Notice of overutilization.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish the process for notice of overutilization of billing codes under section 1893A(f)(6) of the Social Security Act, as added by subsection (a).

(7) Payment audits.—Section 1893A(f)(7) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of the enactment of this Act.

(8) Standard for abnormal billing patterns.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1893(f)(8) of the Social Security Act, as added by subsection (a).

SEC. 536. PROVIDER ENROLLMENT PROCESS; RIGHT OF APPEAL.

(a) In General.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) by adding at the end of the heading the following: "; enrollment processes"; and

(2) by adding at the end the following new subsection:

"(j) Enrollment Process for Providers of Services and Suppliers.—

"(1) Enrollment process.—

"(A) In general.—The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this title.

"(B) Deadlines.—The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance of medicare administrative contractors in meeting the deadlines established under this subparagraph.

"(C) Consultation before changing provider enrollment forms.—The Secretary shall consult with providers of services and suppliers before making changes in the provider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this title.

"(2) Hearing rights in cases of denial or non-renewal.—A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.".

(b) Effective Dates.—

(1) Enrollment process.—The Secretary shall provide for the establishment of the enrollment process under section 1866(j)(1) of the Social Security Act, as added by subsection (a)(2), within 6 months after the date of the enactment of this Act.

(2) Consultation.—Section 1866(j)(1)(C) of the Social Security Act, as added by subsection (a)(2), shall apply with respect to changes in provider enrollment forms made on or after January 1, 2004.

(3) Hearing rights.—Section 1866(j)(2) of the Social Security Act, as added by subsection (a)(2), shall apply to denials occurring on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary specifies.

SEC. 537. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS WITHOUT PURSUING APPEALS PROCESS.

(a) Claims.—The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(g) of the Social Security Act, as inserted by section 301(a)(1)) and representatives of providers of services and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

(b) Deadline.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first develop the process under subsection (a).

SEC. 538. PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES; ADVANCE BENEFICIARY NOTICES.

(a) In General.—Section 1869 (42 U.S.C. 1395ff(b)), as amended by section 533(d)(2)(B), is further amended by adding at the end the following new subsection:

“(h) Prior Determination Process for Certain Items and Services.—

“(1) Establishment of process.—

“(A) In general.—With respect to a medicare administrative contractor that has a contract under section 1874A that provides for making payments under this title with respect to physicians' services (as defined in section 1848(j)(3)), the Secretary shall establish a prior determination process that meets the requirements of this subsection and that shall be applied by such contractor in the case of eligible requesters.

“(B) Eligible requester.—For purposes of this subsection, each of the following shall be an eligible requester:

“(i) A participating physician, but only with respect to physicians' services to be furnished to an individual who is entitled to benefits under this title and who has consented to the physician making the request under this subsection for those physicians' services.

“(ii) An individual entitled to benefits under this title, but only with respect to a physicians' service for which the individual receives, from a physician, an advance beneficiary notice under section 1879(a).

“(2) Secretarial flexibility.—The Secretary shall establish by regulation reasonable limits on the physicians' services for which a prior determination of coverage may be requested under this subsection. In establishing such limits, the Secretary may consider the dollar amount involved with respect to the physicians' service, administrative costs and burdens, and other relevant factors.

“(3) Request for prior determination.—

“(A) In general.—Subject to paragraph (2), under the process established under this subsection an eligible requester may submit to the contractor a request for a determination, before the furnishing of a physicians' service, as to whether the physicians' service is covered under this title consistent with the applicable requirements of section 1862(a)(1)(A) (relating to medical necessity).

“(B) Accompanying documentation.—The Secretary may require that the request be accompanied by a description of the physicians' service, supporting documentation relating to the medical necessity for the physicians' service, and any other appropriate documentation. In the case of a request submitted by an eligible requester who is described in paragraph (1)(B)(ii), the Secretary may require that the request also be accompanied by a copy of the advance beneficiary notice involved.

“(4) Response to request.—

“(A) In general.—Under such process, the contractor shall provide the eligible requester with written notice of a determination as to whether—

“(i) the physicians' service is so covered;

“(ii) the physicians' service is not so covered; or

“(iii) the contractor lacks sufficient information to make a coverage determination with respect to the physicians' service.

“(B) Contents of notice for certain determinations.—

“(i) Noncoverage.—If the contractor makes the determination described in subparagraph (A)(ii), the contractor shall include in the notice a brief explanation of the basis for the determination, including on what national or local coverage or noncoverage determination (if any) the determination is based, and a description of any applicable rights under subsection (a).

“(ii) Insufficient information.—If the contractor makes the determination described in subparagraph (A)(iii), the contractor shall include in the notice a description of the additional information required to make the coverage determination.

“(C) Deadline to respond.—Such notice shall be provided within the same time period as the time period applicable to the contractor providing notice of initial determinations on a claim for benefits under subsection (a)(2)(A).

“(D) Informing beneficiary in case of physician request.—In the case of a request by a participating physician under paragraph (1)(B)(i), the process shall provide that the individual to whom the physicians' service is proposed to be furnished shall be informed of any determination described in subparagraph (A)(ii) (relating to a determination of noncoverage) and the right (referred to in paragraph (6)(B)) to obtain the physicians' service and have a claim submitted for the physicians' service.

“(5) Binding nature of positive determination.—If the contractor makes the determination described in paragraph (4)(A)(i), such determination shall be binding on the contractor in the absence of fraud or evidence of misrepresentation of facts presented to the contractor.

“(6) Limitation on further review.—

“(A) In general.—Contractor determinations described in paragraph (4)(A)(ii) or (4)(A)(iii) (relating to pre-service claims) are not subject to further administrative appeal or judicial review under this section or otherwise.

“(B) Decision not to seek prior determination or negative determination does not impact right to obtain services, seek reimbursement, or appeal rights.—Nothing in this subsection shall be construed as affecting the right of an individual who—

“(i) decides not to seek a prior determination under this subsection with respect to physicians' services; or

“(ii) seeks such a determination and has received a determination described in paragraph (4)(A)(ii),

from receiving (and submitting a claim for) such physicians' services and from obtaining administrative or judicial review respecting such claim under the other applicable provisions of this section. Failure to seek a prior determination under this subsection with respect to physicians' service shall not be taken into account in such administrative or judicial review.

“(C) No prior determination after receipt of services.—Once an individual is provided physicians' services, there shall be no prior determination under this subsection with respect to such physicians' services.”.

(b) Effective Date; Sunset; Transition.—

(1) Effective date.—The Secretary shall establish the prior determination process under the amendment made by subsection (a) in such a manner as to provide for the acceptance of requests for determinations under such process filed not later than 18 months after the date of the enactment of this Act.

(2) Sunset.—Such prior determination process shall not apply to requests filed after the end of the 5-year period beginning on the first date on which requests for determinations under such process are accepted.

(3) Transition.—During the period in which the amendment made by subsection (a) has become effective but contracts are not provided under section 1874A of the Social Security Act with medicare administrative contractors, any reference in section 1869(g) of such Act (as added by such amendment) to such a contractor is deemed a reference to a fiscal intermediary or carrier with an agreement under section 1816, or contract under section 1842, respectively, of such Act.

(4) Limitation on application to SGR.—For purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)), the amendment made by subsection (a) shall not be considered to be a change in law or regulation.

(c) Provisions Relating to Advance Beneficiary Notices; Report on Prior Determination Process.—

(1) Data collection.—The Secretary shall establish a process for the collection of information on the instances in which an advance beneficiary notice (as defined in paragraph (5)) has been provided and on instances in which a beneficiary indicates on such a notice that the beneficiary does not intend to seek to have the item or service that is the subject of the notice furnished.

(2) Outreach and education.—The Secretary shall establish a program of outreach and education for beneficiaries and providers of services and other persons on the appropriate use of advance beneficiary notices and coverage policies under the medicare program.

(3) GAO report on use of advance beneficiary notices.—Not later than 18 months after the date on which section 1869(h) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of advance beneficiary notices under title XVIII of such Act. Such report shall include information concerning the providers of services and other persons that have provided such notices and the response of beneficiaries to such notices.

(4) GAO report on use of prior determination process.—Not later than 36 months after the date on which section 1869(h) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of the prior determination process under such section. Such report shall include—

(A) information concerning—

(i) the number and types of procedures for which a prior determination has been sought;

(ii) determinations made under the process;

(iii) the percentage of beneficiaries prevailing;

(iv) in those cases in which the beneficiaries do not prevail, the reasons why such beneficiaries did not prevail; and

(v) changes in receipt of services resulting from the application of such process;

(B) an evaluation of whether the process was useful for physicians (and other suppliers) and beneficiaries, whether it was timely, and whether the amount of information required was burdensome to physicians and beneficiaries; and

(C) recommendations for improvements or continuation of such process.

(5) Advance beneficiary notice defined.—In this subsection, the term “advance beneficiary notice” means a written notice provided under section 1879(a) of the Social Security Act (42 U.S.C. 1395pp(a)) to an individual entitled to benefits under part A or enrolled under part B of title XVIII of such Act before items or services are furnished under such part in cases where a provider of services or other person that would furnish the item or service believes that payment

will not be made for some or all of such items or services under such title.

SEC. 539. APPEALS BY PROVIDERS WHEN THERE IS NO OTHER PARTY AVAILABLE.

(a) In General.—Section 1870 (42 U.S.C. 1395gg) is amended by adding at the end the following new subsection:

"(h) Notwithstanding subsection (f) or any other provision of law, the Secretary shall permit a provider of services or supplier to appeal any determination of the Secretary under this title relating to services rendered under this title to an individual who subsequently dies if there is no other party available to appeal such determination.".

(b) Effective Date.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 540. REVISIONS TO APPEALS TIMEFRAMES AND AMOUNTS.

(a) Timeframes.—Section 1869 (42 U.S.C. 1395ff) is amended—

(1) in subsection (a)(3)(C)(ii), by striking "30-day period" each place it appears and inserting "60-day period"; and

(2) in subsection (c)(3)(C)(i), by striking "30-day period" and inserting "60-day period".

(b) Amounts.—

(1) In general.—Section 1869(b)(1)(E) (42 U.S.C. 1395ff(b)(1)(E)) is amended by adding at the end the following new clause:

"(iii) Adjustment of dollar amounts.—For requests for hearings or judicial review made in a year after 2004, the dollar amounts specified in clause (i) shall be equal to such dollar amounts increased by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount determined under the previous sentence that is not a multiple of $10 shall be rounded to the nearest multiple of $10.".

(2) Conforming amendments.—(A) Section 1852(g)(5) (42 U.S.C. 1395w-22(g)(5)) is amended by adding at the end the following: "The provisions of section 1869(b)(1)(E)(iii) shall apply with respect to dollar amounts specified in the first 2 sentences of this paragraph in the same manner as they apply to the dollar amounts specified in section 1869(b)(1)(E)(i).".

(B) Section 1876(b)(5)(B) (42 U.S.C. 1395mm(b)(5)(B)) is amended by adding at the end the following: "The provisions of section 1869(b)(1)(E)(iii) shall apply with respect to dollar amounts specified in the first 2 sentences of this subparagraph in the same manner as they apply to the dollar amounts specified in section 1869(b)(1)(E)(i).".

SEC. 540A. MEDIATION PROCESS FOR LOCAL COVERAGE DETERMINATIONS.

(a) In General.—Section 1869 (42 U.S.C. 1395ff), as amended by section 538(a), is amended by adding at the end the following new subsection:

"(i) Mediation Process for Local Coverage Determinations.—

"(1) Establishment of process.—The Secretary shall establish a mediation process under this subsection through the use of a physician trained in mediation and employed by the Centers for Medicare & Medicaid Services.

"(2) Responsibility of mediator.—Under the process established in paragraph (1), such a mediator shall mediate in disputes between groups representing providers of services, suppliers (as defined in section 1861(d)), and the medical director for a medicare administrative contractor whenever the regional administrator (as defined by the Secretary) involved determines that there was a systematic pattern and a large volume of complaints from such groups regarding decisions of such director or there is a complaint from the co-chair of the advisory committee for that contractor to such regional administrator regarding such dispute.".

(b) Inclusion in MAC contracts.—Section 1874A(b)(3)(A)(i), as added by section 511(a)(1), is amended by adding at the end the following: "Such requirements shall include specific performance duties expected of a medical director of a medicare administrative contractor, including requirements relating to professional relations and the availability of such director to conduct medical determination activities within the jurisdiction of such a contractor.".

Subtitle E—Miscellaneous Provisions

SEC. 541. POLICY DEVELOPMENT REGARDING EVALUATION AND MANAGEMENT (E & M) DOCUMENTATION GUIDELINES.

(a) In General.—The Secretary may not implement any new or modified documentation guidelines (which for purposes of this section includes clinical examples) for evaluation and management physician services under the title XVIII of the Social Security Act on or after the date of the enactment of this Act unless the Secretary—

(1) has developed the guidelines in collaboration with practicing physicians (including both generalists and specialists) and provided for an assessment of the proposed guidelines by the physician community;

(2) has established a plan that contains specific goals, including a schedule, for improving the use of such guidelines;

(3) has conducted appropriate and representative pilot projects under subsection (b) to test such guidelines;

(4) finds, based on reports submitted under subsection (b)(5) with respect to pilot projects conducted for such or related guidelines, that the objectives described in subsection (c) will be met in the implementation of such guidelines; and

(5) has established, and is implementing, a program to educate physicians on the use of such guidelines and that includes appropriate outreach.

The Secretary shall make changes to the manner in which existing evaluation and management documentation guidelines are implemented to reduce paperwork burdens on physicians.

(b) Pilot Projects to Test Modified or New Evaluation and Management Documentation Guidelines.—

(1) In general.—With respect to proposed new or modified documentation guidelines referred to in subsection (a), the Secretary shall conduct under this subsection appropriate and representative pilot projects to test the proposed guidelines.

(2) Length and consultation.—Each pilot project under this subsection shall—

(A) be voluntary;

(B) be of sufficient length as determined by the Secretary (but in no case to exceed 1 year) to allow for preparatory physician and medicare contractor education, analysis, and use and assessment of potential evaluation and management guidelines; and

(C) be conducted, in development and throughout the planning and operational stages of the project, in consultation with practicing physicians (including both generalists and specialists).

(3) Range of pilot projects.—Of the pilot projects conducted under this subsection with respect to proposed new or modified documentation guidelines—

(A) at least one shall focus on a peer review method by physicians (not employed by a medicare contractor) which evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to codes used for billing purposes for such services;

(B) at least one shall focus on an alternative method to detailed guidelines based on physician documentation of face to face encounter time with a patient;

(C) at least one shall be conducted for services furnished in a rural area and at least one for services furnished outside such an area; and

(D) at least one shall be conducted in a setting where physicians bill under physicians' services in teaching settings and at least one shall be conducted in a setting other than a teaching setting.

(4) Study of impact.—Each pilot project shall examine the effect of the proposed guidelines on—

(A) different types of physician practices, including those with fewer than 10 full-time-equivalent employees (including physicians); and

(B) the costs of physician compliance, including education, implementation, auditing, and monitoring.

(5) Report on pilot projects.—Not later than 6 months after the date of completion of pilot projects carried out under this subsection with respect to a proposed guideline described in paragraph (1), the Secretary shall submit to Congress a report on the pilot projects. Each such report shall include a finding by the Secretary of whether the objectives described in subsection (c) will be met in the implementation of such proposed guideline.

(c) Objectives for Evaluation and Management Guidelines.—The objectives for modified evaluation and management documentation guidelines developed by the Secretary shall be to—

(1) identify clinically relevant documentation needed to code accurately and assess coding levels accurately;

(2) decrease the level of non-clinically pertinent and burdensome documentation time and content in the physician's medical record;

(3) increase accuracy by reviewers; and

(4) educate both physicians and reviewers.

(d) Study of Simpler, Alternative Systems of Documentation for Physician Claims.—

(1) Study.—The Secretary shall carry out a study of the matters described in paragraph (2).

(2) Matters described.—The matters referred to in paragraph (1) are—

(A) the development of a simpler, alternative system of requirements for documentation accompanying claims for evaluation and management physician services for which payment is made under title XVIII of the Social Security Act; and

(B) consideration of systems other than current coding and documentation requirements for payment for such physician services.

(3) Consultation with practicing physicians.—In designing and carrying out the study under paragraph (1), the Secretary shall consult with practicing physicians, including physicians who are part of group practices and including both generalists and specialists.

(4) Application of HIPAA uniform coding requirements.—In developing an alternative system under paragraph (2), the Secretary

shall consider requirements of administrative simplification under part C of title XI of the Social Security Act.

(5) Report to congress.—(A) Not later than October 1, 2005, the Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

(B) The Medicare Payment Advisory Commission shall conduct an analysis of the results of the study included in the report under subparagraph (A) and shall submit a report on such analysis to Congress.

(e) Study on Appropriate Coding of Certain Extended Office Visits.—The Secretary shall conduct a study of the appropriateness of coding in cases of extended office visits in which there is no diagnosis made. Not later than October 1, 2005, the Secretary shall submit a report to Congress on such study and shall include recommendations on how to code appropriately for such visits in a manner that takes into account the amount of time the physician spent with the patient.

(f) Definitions.—In this section—

(1) the term "rural area" has the meaning given that term in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)); and

(2) the term "teaching settings" are those settings described in section 415.150 of title 42, Code of Federal Regulations.

SEC. 542. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY AND COVERAGE.

(a) Council for Technology and Innovation.—Section 1868 (42 U.S.C. 1395ee), as amended by section 521(a), is amended by adding at the end the following new subsection:

"(c) Council for Technology and Innovation.—

"(1) Establishment.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as 'CMS').

"(2) Composition.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

"(3) Duties.—The Council shall coordinate the activities of coverage, coding, and payment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

"(4) Executive coordinator for technology and innovation.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title.".

(b) Methods for Determining Payment Basis for New Lab Tests.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following:

"(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2005 (in this paragraph referred to as 'new tests').

"(B) Determinations under subparagraph (A) shall be made only after the Secretary—

"(i) makes available to the public (through an Internet website and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

"(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

"(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

"(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet website and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

"(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet website and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

"(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

"(i) set forth the criteria for making determinations under subparagraph (A); and

"(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

"(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

"(E) For purposes of this paragraph:

"(i) The term 'HCPCS' refers to the Health Care Procedure Coding System.

"(ii) A code shall be considered to be 'substantially revised' if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).".

(c) GAO Study on Improvements in External Data Collection for Use in the Medicare Inpatient Payment System.—

(1) Study.—The Comptroller General of the United States shall conduct a study that analyzes which external data can be collected in a shorter timeframe by the Centers for Medicare & Medicaid Services for use in computing payments for inpatient hospital services. The study may include an evaluation of the feasibility and appropriateness of using quarterly samples or special surveys or any other methods. The study shall include an analysis of whether other executive agencies, such as the Bureau of Labor Statistics in the Department of Commerce, are best suited to collect this information.

(2) Report.—By not later than October 1, 2004, the Comptroller General shall submit a report to Congress on the study under paragraph (1).

SEC. 543. TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) In General.—The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to medicare secondary payor provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

(b) Reference Laboratory Services Described.—Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.

SEC. 544. EMTALA IMPROVEMENTS.

(a) Payment for EMTALA-Mandated Screening and Stabilization Services.—

(1) In general.—Section 1862 (42 U.S.C. 1395y) is amended by inserting after subsection (c) the following new subsection:

"(d) For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1867 to an individual who is entitled to benefits under this title, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.".

(2) Effective date.—The amendment made by paragraph (1) shall apply to items and services furnished on or after January 1, 2004.

(b) Notification of Providers When EMTALA Investigation Closed.—Section 1867(d) (42 U.S.C. 42 U.S.C. 1395dd(d)) is amended by adding at the end the following new paragraph:

"(4) Notice upon closing an investigation.—The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.".

(c) Prior Review by Peer Review Organizations in EMTALA Cases Involving Termination of Participation.—

(1) In general.—Section 1867(d)(3) (42 U.S.C. 1395dd(d)(3)) is amended—

(A) in the first sentence, by inserting "or in terminating a hospital's participation under this title" after "in imposing sanctions under paragraph (1)"; and

(B) by adding at the end the following new sentences: "Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this title for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.".

(2) Effective date.—The amendments made by paragraph (1) shall apply to terminations of participation initiated on or after the date of the enactment of this Act.

SEC. 545. EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP.

(a) Establishment.—The Secretary shall establish a Technical Advisory Group (in this section referred to as the "Advisory Group") to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA) and its implementation. In this section, the term "EMTALA" refers to the provisions of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

(b) Membership.—The Advisory Group shall be composed of 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and of which—

(1) 4 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of EMTALA and at least 2 of which have not been cited for EMTALA violations;

(2) 7 shall be practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;

(3) 2 shall represent patients;

(4) 2 shall be staff involved in EMTALA investigations from different regional offices of the Centers for Medicare & Medicaid Services; and

(5) 1 shall be from a State survey office involved in EMTALA investigations and 1 shall be from a peer review organization, both of whom shall be from areas other than the regions represented under paragraph (4).

In selecting members described in paragraphs (1) through (3), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients.

(c) General Responsibilities.—The Advisory Group—

(1) shall review EMTALA regulations;

(2) may provide advice and recommendations to the Secretary with respect to those regulations and their application to hospitals and physicians;

(3) shall solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and

(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public.

(d) Administrative Matters.—

(1) Chairperson.—The members of the Advisory Group shall elect a member to serve as chairperson of the Advisory Group for the life of the Advisory Group.

(2) Meetings.—The Advisory Group shall first meet at the direction of the Secretary. The Advisory Group shall then meet twice per year and at such other times as the Advisory Group may provide.

(e) Termination.—The Advisory Group shall terminate 30 months after the date of its first meeting.

(f) Waiver of Administrative Limitation.—The Secretary shall establish the Advisory Group notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

SEC. 546. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) In General.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following:

"(D) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.

"(E) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services of a registered professional nurse and are provided non-routinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive.".

(b) Conforming Payment Provision.—Section 1814(i) (42 U.S.C. 1395f(i)), as amended by section 212(b), is amended by adding at the end the following new paragraph:

"(5) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.".

(c) Effective Date.—The amendments made by this section shall apply to hospice care provided on or after the date of the enactment of this Act.

SEC. 547. APPLICATION OF OSHA BLOODBORNE PATHOGENS STANDARD TO CERTAIN HOSPITALS.

(a) In General.—Section 1866 (42 U.S.C. 1395cc), as amended by section 206, is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (T), by striking "and" at the end;

(B) in subparagraph (U), by striking the period at the end and inserting ", and"; and

(C) by inserting after subparagraph (U) the following new subparagraph:

"(V) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 (or a State occupational safety and health plan that is approved under 18(b) of such Act), to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated)."; and

(2) by adding at the end of subsection (b) the following new paragraph:

"(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(V) (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

"(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(U) by a hospital that is subject to the provisions of such Act.

"(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.".

(b) Effective Date.—The amendments made by this subsection (a) shall apply to hospitals as of July 1, 2004.

SEC. 548. BIPA-RELATED TECHNICAL AMENDMENTS AND CORRECTIONS.

(a) Technical Amendments Relating to Advisory Committee Under BIPA Section 522.—(1) Subsection (i) of section 1114 (42 U.S.C. 1314)—

(A) is transferred to section 1862 and added at the end of such section; and

(B) is redesignated as subsection (j).

(2) Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the last sentence of subsection (a), by striking "established under section 1114(f)"; and

(B) in subsection (j), as so transferred and redesignated—

(i) by striking "under subsection (f)"; and

(ii) by striking "section 1862(a)(1)" and inserting "subsection (a)(1)".

(b) Terminology Corrections.—(1) Section 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)) is amended—

(A) in subclause (III), by striking "policy" and inserting "determination"; and

(B) in subclause (IV), by striking "medical review policies" and inserting "coverage determinations".

(2) Section 1852(a)(2)(C) (42 U.S.C. 1395w–22(a)(2)(C)) is amended by striking "policy" and "POLICY" and inserting "determination" each place it appears and "DETERMINATION", respectively.

(c) Reference Corrections.—Section 1869(f)(4) (42 U.S.C. 1395ff(f)(4)) is amended—

(1) in subparagraph (A)(iv), by striking "subclause (I), (II), or (III)" and inserting "clause (i), (ii), or (iii)";

(2) in subparagraph (B), by striking "clause (i)(IV)" and "clause (i)(III)" and inserting "subparagraph (A)(iv)" and "subparagraph (A)(iii)", respectively; and

(3) in subparagraph (C), by striking "clause (i)", "subclause (IV)" and "subparagraph (A)" and inserting "subparagraph (A)", "clause (iv)" and "paragraph (1)(A)", respectively each place it appears.

(d) Other Corrections.—Effective as if included in the enactment of section 221(c) of BIPA, section 1154(e) (42 U.S.C. 1320c–3(e)) is amended by striking paragraph (5).

(e) Effective Date.—Except as otherwise provided, the amendments made by this section shall be effective as if included in the enactment of BIPA.

SEC. 549. CONFORMING AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a–7(c)(3)(B)) is amended to read as follows: "Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of the administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both, the Secretary may, after consulting with the Inspector General of the Department of Health and Human Services, waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.".

SEC. 550. TREATMENT OF CERTAIN DENTAL CLAIMS.

(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by adding at the end, after the subsection transferred and redesignated by section 548(a), the following new subsection:

"(k)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

"(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of the enactment of this Act.

SEC. 551. FURNISHING HOSPITALS WITH INFORMATION TO COMPUTE DSH FORMULA.

Beginning not later than 1 year after the date of the enactment of this Act, the Secretary shall arrange to furnish to subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage under such section for that hospital for the current cost reporting year. Such data shall also be furnished to other hospitals which would qualify for additional payments under part A of title XVIII of the Social Security Act on the basis of such data.

SEC. 552. REVISIONS TO REASSIGNMENT PROVISIONS.

(a) IN GENERAL.—Section 1842(b)(6)(A) (42 U.S.C. 1395u(b)(6)(A)) is amended by striking "or (ii) (where the service was provided in a hospital, critical access hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service," and inserting "or (ii) where the service was provided under a contractual arrangement between such physician or other person and an entity, to the entity if, under the contractual arrangement, the entity submits the bill for the service and the contractual arrangement meets such program integrity and other safeguards as the Secretary may determine to be appropriate,".

(b) CONFORMING AMENDMENT.—The second sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by striking "except to an employer or facility as described in clause (A)" and inserting "except to an employer or entity as described in subparagraph (A)".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made on or after the date of the enactment of this Act.

SEC. 553. OTHER PROVISIONS.

(a) GAO REPORTS ON THE PHYSICIAN COMPENSATION.—

(1) SUSTAINABLE GROWTH RATE AND UPDATES.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the appropriateness of the updates in the conversion factor under subsection (d)(3) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), including the appropriateness of the sustainable growth rate formula under subsection (f) of such section for 2002 and succeeding years. Such report shall examine the stability and predictability of such updates and rate and alternatives for the use of such rate in the updates.

(2) PHYSICIAN COMPENSATION GENERALLY.—Not later than 12 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on all aspects of physician compensation for services furnished under title XVIII of the Social Security Act, and how those aspects interact and the effect on appropriate compensation for physician services. Such report shall review alternatives for the physician fee schedule under section 1848 of such title (42 U.S.C. 1395w–4).

(b) ANNUAL PUBLICATION OF LIST OF NATIONAL COVERAGE DETERMINATIONS.—The Secretary shall provide, in an appropriate annual publication available to the public, a list of national coverage determinations made under title XVIII of the Social Security Act in the previous year and information on how to get more information with respect to such determinations.

(c) GAO REPORT ON FLEXIBILITY IN APPLYING HOME HEALTH CONDITIONS OF PARTICIPATION TO PATIENTS WHO ARE NOT MEDICARE BENEFICIARIES.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the implications if there were flexibility in the application of the medicare conditions of participation for home health agencies with respect to groups or types of patients who are not medicare beneficiaries. The report shall include an analysis of the potential impact of such flexible application on clinical operations and the recipients of such services and an analysis of methods for monitoring the quality of care provided to such recipients.

(d) OIG REPORT ON NOTICES RELATING TO USE OF HOSPITAL LIFETIME RESERVE DAYS.—Not later than 1 year after the date of the enactment of this Act, the Inspector General of the Department of Health and Human Services shall submit a report to Congress on—

(1) the extent to which hospitals provide notice to medicare beneficiaries in accordance with applicable requirements before they use the 60 lifetime reserve days described in section 1812(a)(1) of the Social Security Act (42 U.S.C. 1395d(a)(1)); and

(2) the appropriateness and feasibility of hospitals providing a notice to such beneficiaries before they completely exhaust such lifetime reserve days.

TITLE VI—MEDICAID AND MISCELLANEOUS PROVISIONS

Subtitle A—Medicaid Provisions

SEC. 601. MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

(a) TEMPORARY INCREASE.—Section 1923(f)(3) (42 U.S.C. 1396r–4(f)(3)) is amended—

(1) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)"; and

(2) by adding at the end the following new subparagraphs:

"(C) SPECIAL, TEMPORARY INCREASE IN ALLOTMENTS ON A ONE-TIME, NON-CUMULATIVE BASIS.—The DSH allotment for any State (other than a State with a DSH allotment determined under paragraph (5))—

"(i) for fiscal year 2004 is equal to 116 percent of the DSH allotment for the State for fiscal year 2003 under this paragraph, notwithstanding subparagraph (B); and

"(ii) for each succeeding fiscal year is equal to the DSH allotment for the State for fiscal year 2004 or, in the case of fiscal years beginning with the fiscal year specified in subparagraph (D) for that State, the DSH allotment for the State for the previous fiscal year increased by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

"(D) FISCAL YEAR SPECIFIED.—For purposes of subparagraph (C)(ii), the fiscal year specified in this subparagraph for a State is the first fiscal year for which the Secretary estimates that the DSH allotment for that State will equal (or no longer exceed) the DSH allotment for that State under the law as in effect before the date of the enactment of this subparagraph.".

(b) INCREASE IN FLOOR FOR TREATMENT AS A LOW DSH STATE.—Section 1923(f)(5) (42 U.S.C. 1396r–4(f)(5)) is amended to read as follows:

"(5) SPECIAL RULE FOR LOW DSH STATES.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2000, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2003, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for the State with respect to—

"(A) fiscal year 2004 shall be the DSH allotment for the State for fiscal year 2003 increased by 16 percent;

"(B) each succeeding fiscal year before fiscal year 2009 shall be the DSH allotment for the State for the previous fiscal year increased by 16 percent; and

"(C) fiscal year 2009 and any subsequent fiscal year, shall be the DSH allotment for the State for the previous year subject to an increase for inflation as provided in paragraph (3)(A).".

(c) ALLOTMENT ADJUSTMENT.—Section 1923(f) (42 U.S.C. 1396r–4(f)) is amended—

(1) in paragraph (3)(A), by striking "The DSH" and inserting "Except as provided in paragraph (6), the DSH";

(2) by redesignating paragraph (6) as paragraph (7); and

(3) by inserting after paragraph (5) the following:

"(6) ALLOTMENT ADJUSTMENT.—Only with respect to fiscal year 2004 or 2005, if a statewide waiver under section 1115 is revoked or terminated before the end of either such fiscal year and there is no DSH allotment for the State, the Secretary shall—

"(A) permit the State whose waiver was revoked or terminated to submit an amendment to its State plan that would describe the methodology to be used by the State (after the effective date of such revocation or termination) to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities (other than State-owned institutions or facilities), on the basis of the proportion of patients served by such hospitals that are low-income patients with special needs; and

"(B) provide for purposes of this subsection for computation of an appropriate DSH allotment for the State for fiscal year 2004 or 2005 (or both) that would not exceed the amount allowed under paragraph (3)(B)(ii) and that does not result in greater expenditures under this title than would have been made if such waiver had not been revoked or terminated.

In determining the amount of an appropriate DSH allotment under subparagraph (B) for a State, the Secretary shall take into account the level of DSH expenditures for the State for the fiscal year preceding the fiscal year in which the waiver commenced.".

(d) INCREASED REPORTING AND OTHER REQUIREMENTS TO ENSURE THE APPROPRIATE USE OF MEDICAID DSH PAYMENT ADJUSTMENTS.—Section 1923 (42 U.S.C. 1396r–4) is amended by adding at the end the following new subsection:

"(j) ANNUAL REPORTS AND OTHER REQUIREMENTS REGARDING PAYMENT ADJUSTMENTS.—With respect to fiscal year 2004 and each fiscal year thereafter, the Secretary shall require a State, as a condition of receiving a payment under section 1903(a)(1) with respect to a payment adjustment made under this section, to do the following:

"(1) REPORT.—The State shall submit an annual report that includes the following:

"(A) An identification of each disproportionate share hospital that received a payment adjustment under this section for the preceding fiscal year and the amount of the payment adjustment made to such hospital for the preceding fiscal year.

"(B) Such other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made under this section for the preceding fiscal year.

"(2) INDEPENDENT CERTIFIED AUDIT.—The State shall annually submit to the Secretary an independent certified audit that verifies each of the following:

"(A) The extent to which hospitals in the State have reduced their uncompensated care costs to reflect the total amount of claimed expenditures made under this section.

"(B) Payments under this section to hospitals that comply with the requirements of subsection (g).

"(C) Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals described in paragraph (1)(A) of such subsection are included in the calculation of the hospital-specific limits under such subsection.

"(D) The State included all payments under this title, including supplemental payments, in the calculation of such hospital-specific limits.

"(E) The State has separately documented and retained a record of all of its costs under this title, claimed expenditures under this title, uninsured costs in determining payment adjustments under this section, and any payments made on behalf of the uninsured from payment adjustments under this section.".

(e) CLARIFICATION REGARDING NON-REGULATION OF TRANSFERS.—

(1) IN GENERAL.—Nothing in section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) shall be construed by the Secretary as prohibiting a State's use of funds as the non-Federal share of expenditures under title XIX of such Act where such funds are transferred from or certified by a publicly-owned regional medical center located in another State and described in paragraph (2), so long as the Secretary determines that such use of funds is proper and in the interest of the program under title XIX.

(2) CENTER DESCRIBED.—A center described in this paragraph is a publicly-owned regional medical center that—

(A) provides level 1 trauma and burn care services;

(B) provides level 3 neonatal care services;

(C) is obligated to serve all patients, regardless of State of origin;

(D) is located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 States, including the States described in paragraph (1);

(E) serves as a tertiary care provider for patients residing within a 125 mile radius; and

(F) meets the criteria for a disproportionate share hospital under section 1923 of such Act in at least one State other than the one in which the center is located.

(3) EFFECTIVE PERIOD.—This subsection shall apply through December 31, 2005.

SEC. 602. CLARIFICATION OF INCLUSION OF INPATIENT DRUG PRICES CHARGED TO CERTAIN PUBLIC HOSPITALS IN THE BEST PRICE EXEMPTIONS FOR THE MEDICAID DRUG REBATE PROGRAM.

(a) IN GENERAL.—Section 1927(c)(1)(C)(i)(I) (42 U.S.C. 1396r–8(c)(1)(C)(i)(I)) is amended by inserting before the semicolon the following: "(including inpatient prices charged to hospitals described in section 340B(a)(4)(L) of the Public Health Service Act)".

(b) ANTI-DIVERSION PROTECTION.—Section 1927(c)(1)(C) (42 U.S.C. 1396r–8(c)(1)(C)) is amended by adding at the end the following:

"(iii) APPLICATION OF AUDITING AND RECORDKEEPING REQUIREMENTS.—With respect to a covered entity described in section 340B(a)(4)(L) of the Public Health Service Act, any drug purchased for inpatient use shall be subject to the auditing and recordkeeping requirements described in section 340B(a)(5)(C) of the Public Health Service Act.".

SEC. 603. EXTENSION OF MORATORIUM.

(a) IN GENERAL.—Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993 and section 4758 of the Balanced Budget Act of 1997, is amended—

(1) by striking "until December 31, 2002", and

(2) by striking "Kent Community Hospital Complex in Michigan or."

(b) EFFECTIVE DATES.—

(1) PERMANENT EXTENSION.—The amendment made by subsection (a)(1) shall take effect as if included in the amendment made by section 4758 of the Balanced Budget Act of 1997.

(2) MODIFICATION.—The amendment made by subsection (a)(2) shall take effect on the date of enactment of this Act.

Subtitle B—Miscellaneous Provisions

SEC. 611. FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.

(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—

(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary $250,000,000 for each of fiscal years 2005 through 2008 for the purpose of making allotments under this section for payments to eligible providers in States described in paragraph (1) or (2) of subsection (b).

(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

(b) STATE ALLOTMENTS.—

(1) BASED ON PERCENTAGE OF UNDOCUMENTED ALIENS.—

(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $167,000,000 of such amount to make allotments for such fiscal year in accordance with subparagraph (B).

(B) FORMULA.—The amount of the allotment for payments to eligible providers in each State for a fiscal year shall be equal to the product of—

(i) the total amount available for allotments under this paragraph for the fiscal year; and

(ii) the percentage of undocumented aliens residing in the State as compared to the total number of such aliens residing in all States, as determined by the Statistics Division of the Immigration and Naturalization Service, as of January 2003, based on the 2000 decennial census.

(2) BASED ON NUMBER OF UNDOCUMENTED ALIEN APPREHENSION STATES.—

(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $83,000,000 of such amount to make allotments, in addition to amounts allotted under paragraph (1), for such fiscal year for each of the 6 States with the highest number of undocumented alien apprehensions for such fiscal year.

(B) DETERMINATION OF ALLOTMENTS.—The amount of the allotment for each State described in subparagraph (A) for a fiscal year shall be equal to the product of—

(i) the total amount available for allotments under this paragraph for the fiscal year; and

(ii) the percentage of undocumented alien apprehensions in the State in that fiscal year as compared to the total of such apprehensions for all such States for the preceding fiscal year.

(C) DATA.—For purposes of this paragraph, the highest number of undocumented alien apprehensions for a fiscal year shall be based on the apprehension rates for the 4-consecutive-quarter period ending before the beginning of the fiscal year for which information is available for undocumented aliens in such States, as reported by the Department of Homeland Security.

(c) USE OF FUNDS.—

(1) AUTHORITY TO MAKE PAYMENTS.—From the allotments made for a State under subsection (b) for a fiscal year, the Secretary shall pay the amount (subject to the total amount available from such allotments) determined under paragraph (2) directly to eligible providers located in the State for the provision of eligible services to aliens described in paragraph (5) to the extent that the eligible provider was not otherwise reimbursed (through insurance or otherwise) for such services during that fiscal year.

(2) DETERMINATION OF PAYMENT AMOUNTS.—

(A) IN GENERAL.—Subject to subparagraph (B), the payment amount determined under this paragraph shall be an amount determined by the Secretary that is equal to the lesser of—

(i) the amount that the provider demonstrates was incurred for the provision of such services; or

(ii) amounts determined under a methodology established by the Secretary for purposes of this subsection.

(B) PRO-RATA REDUCTION.—If the amount of funds allotted to a State under subsection (b) for a fiscal year is insufficient to ensure that each eligible provider in that State receives the amount of payment calculated under subparagraph (A), the Secretary shall reduce that amount of payment with respect to each eligible provider to ensure that the entire amount allotted to the State for that fiscal year is paid to such eligible providers.

(3) METHODOLOGY.—In establishing a methodology under paragraph (2)(A)(ii), the Secretary—

(A) may establish different methodologies for types of eligible providers;

(B) may base payments for hospital services on estimated hospital charges, adjusted to estimated cost, through the application of hospital-specific cost-to-charge ratios;

(C) shall provide for the election by a hospital to receive either payments to the hospital for—

(i) hospital and physician services; or

(ii) hospital services and for a portion of the on-call payments made by the hospital to physicians; and

(D) shall make quarterly payments under this section to eligible providers.

If a hospital makes the election under subparagraph (C)(i), the hospital shall pass on payments for services of a physician to the physician and may not charge any administrative or other fee with respect to such payments.

(4) LIMITATION ON USE OF FUNDS.—Payments made to eligible providers in a State from allotments made under subsection (b) for a fiscal year may only be used for costs incurred in providing eligible services to aliens described in paragraph (5).

(5) ALIENS DESCRIBED.—For purposes of paragraphs (1) and (2), aliens described in this paragraph are any of the following:

(A) Undocumented aliens.

(B) Aliens who have been paroled into the United States at a United States port of entry for the purpose of receiving eligible services.

(B) Mexican citizens permitted to enter the United States for not more than 72 hours under the authority of a biometric machine readable border crossing identification card (also referred to as a "laser visa") issued in accordance with the requirements of regulations prescribed under section 101(a)(6) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(6)).

(d) APPLICATIONS; ADVANCE PAYMENTS.—

(1) DEADLINE FOR ESTABLISHMENT OF APPLICATION PROCESS.—

(A) IN GENERAL.—Not later than September 1, 2004, the Secretary shall establish a process under which eligible providers located in a State may request payments under subsection (c).

(B) INCLUSION OF MEASURES TO COMBAT FRAUD AND ABUSE.—The Secretary shall include in the process established under subparagraph (A) measures to ensure that inappropriate, excessive, or fraudulent payments are not made from the allotments determined under subsection (b), including certification by the eligible provider of the veracity of the payment request.

(2) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The process established under paragraph (1) may provide for making payments under this section for each quarter of a fiscal year on the basis of advance estimates of expenditures submitted by applicants for such payments and such other investigation as the Secretary may find necessary, and for making reductions or increases in the payments as necessary to adjust for any overpayment or underpayment for prior quarters of such fiscal year.

(e) DEFINITIONS.—In this section:

(1) ELIGIBLE PROVIDER.—The term "eligible provider" means a hospital, physician, or provider of ambulance services (including an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization).

(2) ELIGIBLE SERVICES.—The term "eligible services" means health care services required by the application of section 1867 of the Social Security Act (42 U.S.C. 1395dd), and related hospital inpatient and outpatient services and ambulance services (as defined by the Secretary).

(3) HOSPITAL.—The term "hospital" has the meaning given such term in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)), except that such term shall include a critical access hospital (as defined in section 1861(mm)(1) of such Act (42 U.S.C. 1395x(mm)(1)).

(4) PHYSICIAN.—The term "physician" has the meaning given that term in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

(5) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms "Indian tribe" and "tribal organization" have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(6) STATE.—The term "State" means the 50 States and the District of Columbia.

SEC. 612. COMMISSION ON SYSTEMIC INTEROPERABILITY.

(a) ESTABLISHMENT.—The Secretary shall establish a commission to be known as the "Commission on Systemic Interoperability" (in this section referred to as the "Commission").

(b) DUTIES.—

(1) IN GENERAL.—The Commission shall develop a comprehensive strategy for the adoption and implementation of health care information technology standards, that includes a timeline and prioritization for such adoption and implementation.

(2) CONSIDERATIONS.—In developing the comprehensive health care information technology strategy under paragraph (1), the Commission shall consider—

(A) the costs and benefits of the standards, both financial impact and quality improvement;

(B) the current demand on industry resources to implement this Act and other electronic standards, including HIPAA standards; and

(C) the most cost-effective and efficient means for industry to implement the standards.

(3) NONINTERFERENCE.—In carrying out this section, the Commission shall not interfere with any standards development of adoption processes underway in the private or public sector and shall not replicate activities related to such standards or the national health information infrastructure underway within the Department of Health and Human Services.

(4) REPORT.—Not later than October 31, 2005, the Commission shall submit to the Secretary and to Congress a report describing the strategy developed under paragraph (1), including an analysis of the matters considered under paragraph (2).

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 11 members appointed as follows:

(A) The President shall appoint 3 members, one of whom the President shall designate as Chairperson.

(B) The Majority Leader of the Senate shall appoint 2 members.

(C) The Minority Leader of the Senate shall appoint 2 members.

(D) The Speaker of the House of Representatives shall appoint 2 members.

(E) The Minority Leader of the House of Representatives shall appoint 2 members.

(2) QUALIFICATIONS.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, health plans and integrated delivery systems, reimbursement of health facilities, practicing physicians, practicing pharmacists, and other providers of health services, health care technology and information systems, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

(d) TERMS.—Each member shall be appointed for the life of the Commission.

(e) COMPENSATION.—

(1) RATES OF PAY.—Members shall each be paid at a rate not to exceed the daily equivalent of the rate of basic pay for level IV of the Executive Schedule for each day (including travel time) during which they are engaged in the actual performance of duties vested in the Commission.

(2) PROHIBITION OF COMPENSATION OF FEDERAL EMPLOYEES.—Members of the Commission who are full-time officers or employees of the United States or Members of Congress may not receive additional pay, allowances, or benefits by reason of their service on the Commission.

(3) TRAVEL EXPENSES.—Each member shall receive travel expenses, including per diem in lieu of subsistence, in accordance with applicable provisions under subchapter I of chapter 57 of title 5, United States Code.

(f) QUORUM.—A majority of the members of the Commission shall constitute a quorum but a lesser number may hold hearings.

(g) DIRECTOR AND STAFF OF COMMISSION; EXPERTS AND CONSULTANTS.—

(1) DIRECTOR.—The Commission shall have a Director who shall be appointed by the Chairperson. The Director shall be paid at a rate not to exceed the rate of basic pay for level IV of the Executive Schedule.

(2) STAFF.—With the approval of the Commission, the Director may appoint and fix the pay of such additional personnel as the Director considers appropriate.

(3) APPLICABILITY OF CERTAIN CIVIL SERVICE LAWS.—The Director and staff of the Commission may be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of that title relating to classification and General Schedule pay rates, except that an individual so appointed may not receive pay in excess of level IV of the Executive Schedule.

(4) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the Director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(5) STAFF OF FEDERAL AGENCIES.—Upon request of the Chairperson, the head of any Federal department or agency may detail, on a reimbursable basis, any of the personnel of that department or agency to the Commission to assist it in carrying out its duties under this Act.

(h) POWERS OF COMMISSION.—

(1) HEARINGS AND SESSIONS.—The Commission may, for the purpose of carrying out this Act, hold hearings, sit and act at times and places, take testimony, and receive evidence as the Commission considers appropriate.

(2) POWERS OF MEMBERS AND AGENTS.—Any member or agent of the Commission may, if authorized by the Commission, take any action which the Commission is authorized to take by this section.

(3) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this Act. Upon request of the Chairperson of the Commission, the head of that department or agency shall furnish that information to the Commission.

(4) GIFTS, BEQUESTS, AND DEVISES.—The Commission may accept, use, and dispose of gifts, bequests, or devises of services or property, both real and personal, for the purpose of aiding or facilitating the work of the Commission. Gifts, bequests, or devises of money and proceeds from sales of other property received as gifts, bequests, or devises shall be deposited in the Treasury and shall be available for disbursement upon order of the Commission. For purposes of Federal income, estate, and gift taxes, property accepted under this subsection shall be considered as a gift, bequest, or devise to the United States.

(5) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the United States.

(6) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission, on a reimbursable basis, the administrative support services necessary for the Commission to carry out its responsibilities under this Act.

(7) CONTRACT AUTHORITY.—The Commission may enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5)).

(i) TERMINATION.—The Commission shall terminate on 30 days after submitting its report pursuant to subsection (b)(3).

(j) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 613. RESEARCH ON OUTCOMES OF HEALTH CARE ITEMS AND SERVICES.

(a) RESEARCH, DEMONSTRATIONS, AND EVALUATIONS.—

(1) IMPROVEMENT OF EFFECTIVENESS AND EFFICIENCY.—

(A) IN GENERAL.—To improve the quality, effectiveness, and efficiency of health care delivered pursuant to the programs established under titles XVIII, XIX, and XXI of the Social Security Act, the Secretary acting through the Director of the Agency for Healthcare Research and Quality (in this section referred to as the "Director"), shall conduct and support research to meet the priorities and requests for scientific evidence and information identified by such programs with respect to—

(i) the outcomes, comparative clinical effectiveness, and appropriateness of health care items and services (including prescription drugs); and

(ii) strategies for improving the efficiency and effectiveness of such programs, including the ways in which such items and services are organized, managed, and delivered under such programs.

(B) SPECIFICATION.—To respond to priorities and information requests in subparagraph (A), the Secretary may conduct or support, by grant, contract, or interagency agreement, research, demonstrations, evaluations, technology assessments, or other activities, including the provision of technical assistance, scientific expertise, or methodological assistance.

(2) PRIORITIES.—

(A) IN GENERAL.—The Secretary shall establish a process to develop priorities that will guide the research, demonstrations, and evaluation activities undertaken pursuant to this section.

(B) INITIAL LIST.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall establish an initial list of priorities for research related to health care items and services (including prescription drugs).

(C) PROCESS.—In carrying out subparagraph (A), the Secretary—

(i) shall ensure that there is broad and ongoing consultation with relevant stakeholders in identifying the highest priorities for research, demonstrations, and evaluations to support and improve the programs established under titles XVIII, XIX, and XXI of the Social Security Act;

(ii) may include health care items and services which impose a high cost on such programs, as well as those which may be underutilized or overutilized and which may significantly improve the prevention, treatment, or cure of diseases and conditions (including chronic conditions) which impose high direct or indirect costs on patients or society; and

(iii) shall ensure that the research and activities undertaken pursuant to this section are responsive to the specified priorities and are conducted in a timely manner.

(3) EVALUATION AND SYNTHESIS OF SCIENTIFIC EVIDENCE.—

(A) IN GENERAL.—The Secretary shall—

(i) evaluate and synthesize available scientific evidence related to health care items and services (including prescription drugs) identified as priorities in accordance with paragraph (2) with respect to the comparative clinical effectiveness, outcomes, appropriateness, and provision of such items and services (including prescription drugs);

(ii) identify issues for which existing scientific evidence is insufficient with respect to such health care items and services (including prescription drugs);

(iii) disseminate to prescription drug plans and MA-PD plans under part D of title XVIII of the Social Security Act, other health plans, and the public the findings made under clauses (i) and (ii); and

(iv) work in voluntary collaboration with public and private sector entities to facilitate the development of new scientific knowledge regarding health care items and services (including prescription drugs).

(B) INITIAL RESEARCH.—The Secretary shall complete the evaluation and synthesis of the initial research required by the priority list developed under paragraph (2)(B) not later than 18 months after the development of such list.

(C) DISSEMINATION.—

(i) IN GENERAL.—To enhance patient safety and the quality of health care, the Secretary shall make available and disseminate in appropriate formats to prescription drugs plans under part D, and MA-PD plans under part C, of title XVIII of the Social Security Act, other health plans, and the public the evaluations and syntheses prepared pursuant to subparagraph (A) and the findings of research conducted pursuant to paragraph (1). In carrying out this clause the Secretary, in order to facilitate the availability of such evaluations and syntheses or findings at every decision point in the health care system, shall—

(I) present such evaluations and syntheses or findings in a form that is easily understood by the individuals receiving health care items and services (including prescription drugs) under such plans and periodically assess that the requirements of this subclause have been met; and

(II) provide such evaluations and syntheses or findings and other relevant information through easily accessible and searchable electronic mechanisms, and in hard copy formats as appropriate.

(ii) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as—

(I) affecting the authority of the Secretary or the Commissioner of Food and Drugs under the Federal Food, Drug, and Cosmetic Act or the Public Health Service Act; or

(II) conferring any authority referred to in subclause (I) to the Director.

(D) ACCOUNTABILITY.—In carrying out this paragraph, the Secretary shall implement activities in a manner that—

(i) makes publicly available all scientific evidence relied upon and the methodologies employed, provided such evidence and method are not protected from public disclosure by section 1905 of title 18, United States Code, or other applicable law so that the results of the research, analyses, or syntheses can be evaluated or replicated; and

(ii) ensures that any information needs and unresolved issues identified in subparagraph (A)(ii) are taken into account in priority-setting for future research conducted by the Secretary.

(4) CONFIDENTIALITY.—

(A) IN GENERAL.—In making use of administrative, clinical, and program data and information developed or collected with respect to the programs established under titles XVIII, XIX, and XXI of the Social Security Act, for purposes of carrying out the requirements of this section or the activities authorized under title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), such data and information shall be protected in accordance with the confidentiality requirements of title IX of the Public Health Service Act.

(B) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require or permit the disclosure of data provided to the Secretary that is otherwise protected from disclosure under the Federal Food, Drug, and Cosmetic Act, section 1905 of title 18, United States Code, or other applicable law.

(5) EVALUATIONS.—The Secretary shall conduct and support evaluations of the activities carried out under this section to determine the extent to which such activities have had an effect on outcomes and utilization of health care items and services.

(6) IMPROVING INFORMATION AVAILABLE TO HEALTH CARE PROVIDERS, PATIENTS, AND POLICYMAKERS.—Not later than 18 months after the date of enactment of this Act, the Secretary shall identify options that could be undertaken in voluntary collaboration with private and public entities (as appropriate) for the—

(A) provision of more timely information through the programs established under titles XVIII, XIX, and XXI of the Social Security Act, regarding the outcomes and quality of patient care, including clinical and patient-reported outcomes, especially with respect to interventions and conditions for which clinical trials would not be feasible or raise ethical concerns that are difficult to address;

(B) acceleration of the adoption of innovation and quality improvement under such programs; and

(C) development of management tools for the programs established under titles XIX and XXI of the Social Security Act, and with respect to the programs established under such titles, assess the feasibility of using administrative or claims data, to—

(i) improve oversight by State officials;

(ii) support Federal and State initiatives to improve the quality, safety, and efficiency of services provided under such programs; and

(iii) provide a basis for estimating the fiscal and coverage impact of Federal or State program and policy changes.

(b) RECOMMENDATIONS.—

(1) DISCLAIMER.—In carrying out this section, the Director shall—

(A) not mandate national standards of clinical practice or quality health care standards; and

(B) include in any recommendations resulting from projects funded and published by the Director, a corresponding reference to the prohibition described in subparagraph (A).

(2) REQUIREMENT FOR IMPLEMENTATION.—Research, evaluation, and communication activities performed pursuant to this section shall reflect the principle that clinicians and patients should have the best available evidence upon which to make choices in health care items and services, in providers, and in health care delivery systems, recognizing that patient subpopulations and patient and physician preferences may vary.

(3) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to provide the Director with authority to mandate a national standard or require a specific approach to quality measurement and reporting.

(c) RESEARCH WITH RESPECT TO DISSEMINATION.—The Secretary, acting through the Director, may conduct or support research with respect to improving methods of disseminating information in accordance with subsection (a)(3)(C).

(d) LIMITATION ON CMS.—The Administrator of the Centers for Medicare & Medicaid Services may not use data obtained in accordance with this section to withhold coverage of a prescription drug.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2004, and such sums as may be necessary for each fiscal year thereafter.

SEC. 614. HEALTH CARE THAT WORKS FOR ALL AMERICANS: CITIZENS HEALTH CARE WORKING GROUP.

(a) FINDINGS.—Congress finds the following:

(1) In order to improve the health care system, the American public must engage in an informed national public debate to make choices about the services they want covered, what health care coverage they want, and how they are willing to pay for coverage.

(2) More than a trillion dollars annually is spent on the health care system, yet—

(A) 41,000,000 Americans are uninsured;

(B) insured individuals do not always have access to essential, effective services to improve and maintain their health; and

(C) employers, who cover over 170,000,000 Americans, find providing coverage increasingly difficult because of rising costs and double digit premium increases.

(3) Despite increases in medical care spending that are greater than the rate of inflation, population growth, and Gross Domestic Product growth, there has not been a commensurate improvement in our health status as a nation.

(4) Health care costs for even just 1 member of a family can be catastrophic, resulting in medical bills potentially harming the economic stability of the entire family.

(5) Common life occurrences can jeopardize the ability of a family to retain private coverage or jeopardize access to public coverage.

(6) Innovations in health care access, coverage, and quality of care, including the use of technology, have often come from States, local communities, and private sector organizations, but more creative policies could tap this potential.

(7) Despite our Nation's wealth, the health care system does not provide coverage to all Americans who want it.

(b) PURPOSES.—The purposes of this section are—

(1) to provide for a nationwide public debate about improving the health care system to provide every American with the ability to obtain quality, affordable health care coverage; and

(2) to provide for a vote by Congress on the recommendations that result from the debate.

(c) ESTABLISHMENT.—The Secretary, acting through the Agency for Healthcare Research and Quality, shall establish an entity to be known as the Citizens' Health Care Working Group (referred to in this section as the "Working Group").

(d) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Working Group shall be composed of 15 members. One member shall be the Secretary. The Comptroller General of the United States shall appoint 14 members.

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of the Working Group shall include—

(i) consumers of health services that represent those individuals who have not had insurance within 2 years of appointment, that have had chronic illnesses, including mental illness, are disabled, and those who receive insurance coverage through medicare and medicaid; and

(ii) individuals with expertise in financing and paying for benefits and access to care, business and labor perspectives, and providers of health care.

The membership shall reflect a broad geographic representation and a balance between urban and rural representatives.

(B) PROHIBITED APPOINTMENTS.—Members of the Working Group shall not include Members of Congress or other elected government officials (Federal, State, or local). Individuals appointed to the Working Group shall not be paid employees or representatives of associations or advocacy organizations involved in the health care system.

(e) PERIOD OF APPOINTMENT.—Members of the Working Group shall be appointed for a life of the Working Group. Any vacancies shall not affect the power and duties of the Working Group but shall be filled in the same manner as the original appointment.

(f) DESIGNATION OF THE CHAIRPERSON.—Not later than 15 days after the date on which all members of the Working Group have been appointed under subsection (d)(1), the Comptroller General shall designate the chairperson of the Working Group.

(g) SUBCOMMITTEES.—The Working Group may establish subcommittees if doing so increases the efficiency of the Working Group in completing its tasks.

(h) DUTIES.—

(1) HEARINGS.—Not later than 90 days after the date of the designation of the chairperson under subsection (f), the Working Group shall hold hearings to examine—

(A) the capacity of the public and private health care systems to expand coverage options;

(B) the cost of health care and the effectiveness of care provided at all stages of disease;

(C) innovative State strategies used to expand health care coverage and lower health care costs;

(D) local community solutions to accessing health care coverage;

(E) efforts to enroll individuals currently eligible for public or private health care coverage;

(F) the role of evidence-based medical practices that can be documented as restoring, maintaining, or improving a patient's health, and the use of technology in supporting providers in improving quality of care and lowering costs; and

(G) strategies to assist purchasers of health care, including consumers, to become more aware of the impact of costs, and to lower the costs of health care.

(2) ADDITIONAL HEARINGS.—The Working Group may hold additional hearings on subjects other than those listed in paragraph (1) so long as such hearings are determined to be necessary by the Working Group in carrying out the purposes of this section. Such additional hearings do not have to be completed within the time period specified in paragraph (1) but shall not delay the other activities of the Working Group under this section.

(3) THE HEALTH REPORT TO THE AMERICAN PEOPLE.—Not later than 90 days after the hearings described in paragraphs (1) and (2) are completed, the Working Group shall prepare and make available to health care consumers through the Internet and other appropriate public channels, a report to be entitled, "The Health Report to the American People". Such report shall be understandable to the general public and include—

(A) a summary of—

(i) health care and related services that may be used by individuals throughout their life span;

(ii) the cost of health care services and their medical effectiveness in providing better quality of care for different age groups;

(iii) the source of coverage and payment, including reimbursement, for health care services;

(iv) the reasons people are uninsured or underinsured and the cost to taxpayers, purchasers of health services, and communities when Americans are uninsured or underinsured;

(v) the impact on health care outcomes and costs when individuals are treated in all stages of disease;

(vi) health care cost containment strategies; and

(vii) information on health care needs that need to be addressed;

(B) examples of community strategies to provide health care coverage or access;

(C) information on geographic-specific issues relating to health care;

(D) information concerning the cost of care in different settings, including institutional-based care and home and community-based care;

(E) a summary of ways to finance health care coverage; and

(F) the role of technology in providing future health care including ways to support the information needs of patients and providers.

(4) COMMUNITY MEETINGS.—

(A) IN GENERAL.—Not later than 1 year after the date on which all the members of the Working Group have been appointed under subsection (d)(1) and appropriations are first made available to carry out this section, the Working Group shall initiate health care community meetings throughout the United States (in this paragraph referred to as "community meetings"). Such community meetings may be geographically or regionally based and shall be completed within 180 days after the initiation of the first meeting.

(B) Number of meetings.—The Working Group shall hold a sufficient number of community meetings in order to receive information that reflects—

(i) the geographic differences throughout the United States;

(ii) diverse populations; and

(iii) a balance among urban and rural populations.

(C) Meeting requirements.—

(i) Facilitator.—A State health officer may be the facilitator at the community meetings.

(ii) Attendance.—At least 1 member of the Working Group shall attend and serve as chair of each community meeting. Other members may participate through interactive technology.

(iii) Topics.—The community meetings shall, at a minimum, address the following questions:

(I) What health care benefits and services should be provided?

(II) How does the American public want health care delivered?

(III) How should health care coverage be financed?

(IV) What trade-offs are the American public willing to make in either benefits or financing to ensure access to affordable, high quality health care coverage and services?

(iv) Interactive technology.—The Working Group may encourage public participation in community meetings through interactive technology and other means as determined appropriate by the Working Group.

(D) Interim requirements.—Not later than 180 days after the date of completion of the community meetings, the Working Group shall prepare and make available to the public through the Internet and other appropriate public channels, an interim set of recommendations on health care coverage and ways to improve and strengthen the health care system based on the information and preferences expressed at the community meetings. There shall be a 90-day public comment period on such recommendations.

(i) Recommendations.—Not later than 120 days after the expiration of the public comment period described in subsection (h)(4)(D), the Working Group shall submit to Congress and the President a final set of recommendations.

(j) Administration.—

(1) Executive director.—There shall be an Executive Director of the Working Group who shall be appointed by the chairperson of the Working Group in consultation with the members of the Working Group.

(2) Compensation.—While serving on the business of the Working Group (including travel time), a member of the Working Group shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the chairperson of the Working Group. For purposes of pay and employment benefits, rights, and privileges, all personnel of the Working Group shall be treated as if they were employees of the Senate.

(3) Information from federal agencies.—The Working Group may secure directly from any Federal department or agency such information as the Working Group considers necessary to carry out this section. Upon request of the Working Group, the head of such department or agency shall furnish such information.

(4) Postal services.—The Working Group may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(k) Detail.—Not more than 10 Federal Government employees employed by the Department of Labor and 10 Federal Government employees employed by the Department of Health and Human Services may be detailed to the Working Group under this section without further reimbursement. Any detail of an employee shall be without interruption or loss of civil service status or privilege.

(l) Temporary and Intermittent Services.—The chairperson of the Working Group may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(m) Annual Report.—Not later than 1 year after the date of enactment of this Act, and annually thereafter during the existence of the Working Group, the Working Group shall report to Congress and make public a detailed description of the expenditures of the Working Group used to carry out its duties under this section.

(n) Sunset of Working Group.—The Working Group shall terminate on the date that is 2 years after the date on which all the members of the Working Group have been appointed under subsection (d)(1) and appropriations are first made available to carry out this section.

(o) Administration Review and Comments.—Not later than 45 days after receiving the final recommendations of the Working Group under subsection (i), the President shall submit a report to Congress which shall contain—

(1) additional views and comments on such recommendations; and

(2) recommendations for such legislation and administrative actions as the President considers appropriate.

(p) Required Congressional Action.—Not later than 45 days after receiving the report submitted by the President under subsection (o), each committee of jurisdiction of Congress, the Committee on Finance of the Senate, the Committee on Health, Education, Labor, and Pensions of the Senate, the Committee on Ways and Means of the House of Representatives, the Committee on Energy and Commerce of the House of Representatives, Committee on Education and the Workforce of the House of Representatives, shall hold at least 1 hearing on such report and on the final recommendations of the Working Group submitted under subsection (i).

(q) Authorization of Appropriations.—

(1) In general.—There are authorized to be appropriated to carry out this section, other than subsection (h)(3), $3,000,000 for each of fiscal years 2005 and 2006.

(2) Health report to the american people.—There are authorized to be appropriated for the preparation and dissemination of the Health Report to the American People described in subsection (h)(3), such sums as may be necessary for the fiscal year in which the report is required to be submitted.

SEC. 615. FUNDING START-UP ADMINISTRATIVE COSTS FOR MEDICARE REFORM.

(a) In General.—There are appropriated to carry out this Act (including the amendments made by this Act), to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund—

(1) not to exceed $1,000,000,000 for the Centers for Medicare & Medicaid Services; and

(2) not to exceed $500,000,000 for the Social Security Administration.

(b) Availability.—Amounts provided under subsection (a) shall remain available until September 30, 2005.

(c) Application.—From amounts provided under subsection (a)(2), the Social Security Administration may reimburse the Internal Revenue Service for expenses in carrying out this Act (and the amendments made by this Act).

(d) Transfer.—The President may transfer amounts provided under subsection (a) between the Centers for Medicare & Medicaid Services and the Social Security Administration. Notice of such transfers shall be transmitted within 15 days to the authorizing committees of the House of Representatives and of the Senate.

SEC. 616. HEALTH CARE INFRASTRUCTURE IMPROVEMENT PROGRAM.

Title XVIII is amended by adding at the end the following new section:

"HEALTH CARE INFRASTRUCTURE IMPROVEMENT PROGRAM

"Sec. 1897. (a) Establishment.—The Secretary shall establish a loan program that provides loans to qualifying hospitals for payment of the capital costs of projects described in subsection (d).

"(b) Application.—No loan may be provided under this section to a qualifying hospital except pursuant to an application that is submitted and approved in a time, manner, and form specified by the Secretary. A loan under this section shall be on such terms and conditions and meet such requirements as the Secretary determines appropriate.

"(c) Selection Criteria.—

"(1) In general.—The Secretary shall establish criteria for selecting among qualifying hospitals that apply for a loan under this section. Such criteria shall consider the extent to which the project for which loan is sought is nationally or regionally significant, in terms of expanding or improving the health care infrastructure of the United States or the region or in terms of the medical benefit that the project will have.

"(2) Qualifying hospital defined.—For purposes of this section, the term 'qualifying hospital' means a hospital that—

"(A) is engaged in research in the causes, prevention, and treatment of cancer; and

"(B) is designated as a cancer center for the National Cancer Institute or is designated by the State as the official cancer institute of the State.

"(d) Projects.—A project described in this subsection is a project of a qualifying hospital that is designed to improve the health care infrastructure of the hospital, including construction, renovation, or other capital improvements.

"(e) State and Local Permits.—The provision of a loan under this section with respect to a project shall not—

"(1) relieve any recipient of the loan of any obligation to obtain any required State or local permit or approval with respect to the project;

"(2) limit the right of any unit of State or local government to approve or regulate any rate of return on private equity invested in the project; or

"(3) otherwise supersede any State or local law (including any regulation) applicable to the construction or operation of the project.

"(f) Forgiveness of Indebtedness.—The Secretary may forgive a loan provided to a qualifying hospital under this section under terms and conditions that are analogous to the loan forgiveness provision for student loans under part D of title IV of the Higher Education Act of 1965 (20 U.S.C. 1087a et seq.), except that the Secretary shall condition such forgiveness on the establishment by the hospital of—

"(A) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of a State or region, including residents of rural areas;

"(B) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to multiple Indian tribes; and

"(C)(i) unique research resources (such as population databases); or

"(ii) an affiliation with an entity that has unique research resources.

"(g) Funding.—

"(1) In general.—There are appropriated, out of amounts in the Treasury not otherwise appropriated, to carry out this section, $200,000,000, to remain available during the period beginning on July 1, 2004, and ending on September 30, 2008.

"(2) Administrative costs.—From funds made available under paragraph (1), the Secretary may use, for the administration of this section, not more than $2,000,000 for each of fiscal years 2004 through 2008.

"(3) Availability.—Amounts appropriated under this section shall be available for obligation on July 1, 2004.

"(h) Report to Congress.—Not later than 4 years after the date of the enactment of this section, the Secretary shall submit to Congress a report on the projects for which loans are provided under this section and a recommendation as to whether the Congress should authorize the Secretary to continue loans under this section beyond fiscal year 2008.".

By Mrs. CLINTON:

S. 1927. A bill to establish an award program to encourage the development of effective bomb-scanning technology; to the Committee on Commerce, Science, and Transportation.

Mrs. CLINTON. Mr. President, ever since the events of September 11, 2001 awakened this Nation to the very real dangers of the world we live in, we have been struggling to defend ourselves against terrorism. Our aviation system remains a primary target for terrorists, and we must be every vigilant in the fight to keep that system safe. The economic viability, not to mention safety and security, of our country is at stake in that fight.

Nowhere is this more obvious than in New York. Not only did we bear the brunt of the worst terrorist attack in our Nation's history, but we also depend on our airports to fuel our state economy. John F. Kennedy Airport in Queens is the Nation's premier international gateway and contributes approximately $30 billion to the regional economy while employing 35,000 people. LaGuardia Airport, also in Queens, handles over 20 million passengers a year despite having only two 7000-foot runways on 680 acres. Our airports in Albany, Syracuse, Rochester, and Buffalo have seen strong growth in recent years with the arrival of low-cost carriers.

Unfortunately, our economic and physical security remains at risk because we still have not developed a way to effectively scan each piece of passenger luggage for explosives. We have recognized that in the current world environment, we must scan each bag, but technology has not kept up with our needs. The current technology used in most airports in this country is known to have a false-positive rate of approximately 20 percent. This means that machines incorrectly identify 20 percent of all bags going through them as containing explosives, thus slowing down the process considerably as well as costing time and money. Even more dangerous is the false-negative rate of these machines. This number, the percentage of bags going undetected through these machines with bombs inside of them during test runs, should be close to zero. The actual false-negative rate is not publicized for obvious reasons, but it is known to be well above zero.

I am proposing a bill today that seeks to create a major incentive for firms to invent a bomb-scanning technology that actually works. It will award $20 million to any firm that can successfully produce a machine that has a false-positive rate less than 10 percent, a false negative rate less than 2 percent, and is feasible for deployment en masse at our Nation's airports. Although we are currently spending money on researching this technology, that funding is clearly not getting us there fast enough. This new award will help to spur the private sector to develop new technology that will make a major difference in the safety of our aviation system.

By Mr. SARBANES (for himself, Mr. Schumer, Ms. Stabenow, Mr. Corzine, Mr. Durbin, Mr. Kerry, Ms. Mikulski, Mrs. Clinton, Mr. Levin, Mr. Leahy, Mr. Akaka, Mr. Kennedy, Mr. Lautenberg, Mr. Dayton, and Mr. Dodd):

S. 1928. A bill to amend the Truth in Lending Act to protect consumers against predatory practices in connection with high cost mortgage transactions, to strengthen the civil remedies available to consumers under existing law, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

Mr. SARBANES. Mr. President, in July of 2001, and continuing through January of the following year, the Committee on Banking, Housing, and Urban Affairs held a series of hearings to shine a bright light on the deceptive and destructive practices of predatory mortgage lenders. At those hearings, the Committee heard from housing experts, community groups, legal advocates, industry representatives and victims of predatory lending in an effort to determine how best to address this terrible problem. Today, I am introducing legislation, the "Predatory Lending Consumer Protection Act of 2003," along with a number of my colleagues, that would begin to address the problems that came to light in those hearings.

Homeownership is the American Dream. Indeed, the Committee has already passed legislation this year that would authorize a new $200 million downpayment assistance program to ensure that more people can achieve this goal.

We have taken this step because homeownership is the best opportunity for most Americans to put down roots and start creating equity for themselves and their families. Homeownership has been the path to building wealth for generations of Americans, wealth that can be tapped to send children to college, pay for a secure retirement, or simply work as a reserve against unexpected emergencies. It has been the key to ensuring stable communities, good schools, and safe streets. Common sense tells us, and the evidence confirms, that homeowners are more engaged citizens and more active in their communities.

Little wonder, then, that so many Americans, young and old, aspire to achieve this dream.

Unhappily, predatory lenders cynically play on these hopes and dreams to cheat people out of their wealth. These lenders target lower income, elderly, and, often, uneducated homeowners for their abusive practices. Study after study has shown that predatory lenders also target minorities, driving a wedge between these families and the hope of a productive life in the economic and financial mainstream of America.

We owe it to these hardworking families to provide protections against these unscrupulous players.

Let me share with you one of the stories we heard at our hearings. Mary Ann Podelco, a widowed waitress from West Virginia, used $19,000 from her husband's life insurance to pay off the balance on her mortgage, thus owning her home free and clear. Before her husband's death, she had never had a checking account or a credit card. She then took out a $11,921 loan for repairs. At the time, her monthly income from Social Security was $458, and her loan payments were more than half this amount. Ms. Podelco, who has a sixth grade education, testified that after her first refinancing, "I began getting calls from people trying to refinance my mortgage all hours of the day and night." Within 2 years, having been advised to refinance seven times—each time seeing high points and fees being financed into her new loan—she owed $64,000, and lost her home to foreclosure.

Ms. Podelco's story is all too typical. Unfortunately, most of the sharp practices used by unscrupulous lenders and brokers, while unethical and clearly abusive, are not illegal. This bill is designed to address that problem by tightening the interest rate and fee triggers that define high cost loans; the bill improves protections for borrowers receiving such loans by prohibiting the financing of exorbitant fees, "packing" in of unnecessary and costly products, such as single premium credit insurance, and limiting prepayment penalties. Finally, it protects these consumers' rights to seek redress by prohibiting mandatory arbitration, as the Federal Trade Commission (FTC) proposed unanimously in 2000.We often hear about the importance of improved enforcement as a way to combat this problem. As the FTC pointed out, mandatory arbitration prevents homeowners from exercising any of their rights to enforce existing law.

We cannot extol the virtues of homeownership, as we so often do, without seeking at the same time to preserve this benefit for so many elderly, minority, and unsophisticated Americans who are the targets of unscrupulous lenders and brokers. This legislation will help achieve this important goal. This bill has been endorsed by the Leadership Conference on Civil Rights, the U.S. Conference of Mayors, the National Council of La Raza, the National Consumer Law Center, ACORN, National Consumer Reinvestment Coalition, Consumer Federation of America, the NAACP, the Self-Help Credit Union, the National Association of Local Housing Finance Agencies, the National Community Development Association, the National Association of Consumer Advocates, and the National League of Cities, among others.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1928

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Predatory Lending Consumer Protection Act of 2003".

SEC. 2. TRUTH IN LENDING ACT DEFINITIONS.

(a) HIGH COST MORTGAGES.—

(1) IN GENERAL.—The portion of section 103(aa) of the Truth in Lending Act (15 U.S.C. 1602(aa)) that precedes paragraph (2) is amended to read as follows:

"(aa) MORTGAGE REFERRED TO IN THIS SUBSECTION.—

"(1) DEFINITION.—

"(A) IN GENERAL.—A mortgage referred to in this subsection means a consumer credit transaction—

"(i) that is secured by the principal dwelling of the consumer, other than a reverse mortgage transaction; and

"(ii) the terms of which provide that—

"(I) the transaction is secured by a first mortgage on the principal dwelling of the consumer, and the annual percentage rate on the credit, at the consummation of the transaction, will exceed by more than 6 percentage points the yield on Treasury securities having comparable periods of maturity on the 15th day of the month immediately preceding the month in which the application for the extension of credit is received by the creditor;

"(II) the transaction is secured by a junior or subordinate mortgage on the principal dwelling of the consumer, and the annual percentage rate on the credit, at the consummation of the transaction, will exceed by more than 8 percentage points the yield on Treasury securities having comparable periods of maturity on the 15th day of the month immediately preceding the month in which the application for the extension of credit is received by the creditor; or

"(III) the total points and fees payable on the transaction will exceed the greater of 5 percent of the total loan amount, or $1,000, excluding not more than 2 bona fide discount points.

"(B) INTRODUCTORY RATES NOT TAKEN INTO ACCOUNT.—For purposes of subparagraph (A)(ii), the annual percentage rate of interest shall be determined—

"(i) in the case of a fixed-rate loan in which the annual percentage rate will not vary during the term of the loan, as the rate in effect on the date of consummation of the transaction;

"(ii) in the case of a loan in which the rate of interest varies according to an index, or is less than the rate of interest which will apply after the end of an initial or introductory period, by adding the index rate in effect on the date of consummation of the transaction to the maximum margin permitted at any time during the loan agreement; and

"(iii) in the case of any other loan in which the rate may vary at any time during the term of the loan for any reason, by including in the finance charge component of the annual percentage rate—

"(I) the interest charged on the loan at the maximum rate that may be charged during the term of the loan; and

"(II) any other applicable charges that would otherwise be included in accordance with section 106.".

(2) TECHNICAL AND CONFORMING AMENDMENT.—Section 103(aa)(2) of the Truth in Lending Act (15 U.S.C. 1602(aa)(2)) is amended—

(A) by striking subparagraph (B); and

(B) by redesignating subparagraph (C) as subparagraph (B).

(b) POINTS AND FEES.—Section 103(aa)(4) of the Truth in Lending Act (15 U.S.C. 1602(aa)(4)) is amended—

(1) by striking subparagraph (B) and inserting the following:

"(B) all compensation paid directly or indirectly by a consumer or a creditor to a mortgage broker;";

(2) by redesignating subparagraph (D) as subparagraph (G); and

(3) by striking subparagraph (C) and inserting the following:

"(C) each of the charges listed in section 106(e) (except an escrow for future payment of taxes and insurance);

"(D) the cost of all premiums financed by the lender, directly or indirectly, for any credit life, credit disability, credit unemployment or credit property insurance, or any other life or health insurance, or any payments financed by the lender, directly or indirectly, for any debt cancellation or suspension agreement or contract, except that, for purposes of this subparagraph, insurance premiums or debt cancellation or suspension fees calculated and paid on a monthly basis shall not be considered financed by the lender;

"(E) the maximum prepayment penalties that may be charged or collected under the terms of the loan documents;

"(F) all prepayment fees or penalties that are charged to the borrower if the loan refinances a previous loan made by the same creditor or an affiliate of that creditor; and".

(c) HIGH COST MORTGAGE LENDER.—Section 103(f) of the Truth in Lending Act (15 U.S.C. 1602(f)) is amended by striking the last sentence and inserting "Any person who originates 2 or more mortgages referred to in subsection (aa) in any 12-month period, any person who originates 1 or more such mortgages through a mortgage broker or acted as a mortgage broker between originators and consumers on more than 5 mortgages referred to in subsection (aa) within the preceding 12-month period, and any creditor-affiliated party shall be considered to be a creditor for purposes of this title.".

(d) BONA FIDE DISCOUNT POINTS AND BENCHMARK RATE DEFINED.—Section 103 of the Truth in Lending Act (15 U.S.C. 1602) is amended by adding at the end the following:

"(cc) OTHER INTEREST RATE RELATED TERMS.—

"(1) BENCHMARK RATE.—The term 'benchmark rate' means an interest rate that the borrower may reduce by paying bona fide discount points, not to exceed the weekly average yield of United States Treasury securities having a maturity of 5 years, on the 15th day of the month immediately preceding the month in which the loan is made, plus 5 percentage points.

"(2) BONA FIDE DISCOUNT POINTS.—The term 'bona fide discount points' means loan discount points which are—

"(A) knowingly paid by the borrower;

"(B) paid for the express purpose of lowering the benchmark rate;

"(C) in fact reducing the interest rate or time-price differential applicable to the loan from an interest rate which does not exceed the benchmark rate; and

"(D) recouped within the first 4 years of the scheduled loan payments.

"(3) RECOUPMENT.—For purposes of paragraph (2)(D), loan discount points shall be considered to be recouped within the first 4 years of the scheduled loan payments if the reduction in the interest rate that is achieved by the payment of the loan discount points reduces the interest charged on the scheduled payments, such that the dollar amount of savings in payments made by the borrower over the first 4 years is equal to or exceeds the dollar amount of loan discount points paid by the borrower.".

SEC. 3. AMENDMENTS TO EXISTING REQUIREMENTS FOR HIGH COST CONSUMER MORTGAGES.

(a) ADDITIONAL DISCLOSURES.—Section 129(a)(1) of the Truth in Lending Act (15 U.S.C. 1639(a)(1)) is amended by adding at the end the following:

"(C) 'The interest rate on this loan is much higher than most people pay. This means the chance that you will lose your home is much higher if you do not make all payments under the loan.'.

"(D) 'You may be able to get a loan with a much lower interest rate. Before you sign any papers, you have the right to go see a housing or consumer credit counseling agency, as well as to consult other lenders to find ways to get a cheaper loan.'.

"(E) 'If you are taking out this loan to repay other loans, look to see how many months it will take to pay for this loan and what the total amount is that you will have to pay before this loan is repaid. Even though the total amount you will have to pay each month for this loan may be less than the total amount you are paying each month for those other loans, you may have to pay on this loan for many more months than those other loans which will cost you more money in the end.'".

(b) Prepayment Penalty Provisions.—Section 129(c) of the Truth in Lending Act (15 U.S.C. 1639(c)) is amended to read as follows:

"(c) Prepayment Penalty Provisions.—

"(1) No prepayment penalties after end of 24-month period.—A mortgage referred to in section 103(aa) may not contain terms under which a consumer must pay any prepayment penalty for any payment made after the end of the 24-month period beginning on the date the mortgage is consummated.

"(2) No prepayment penalties if more than 3 percent of points and fees were financed.—Subject to subsection (l)(1), a mortgage referred to in section 103(aa) may not contain terms under which a consumer must pay any prepayment penalty for any payment made at or before the end of the 24-month period referred to in paragraph (1) if the creditor financed points or fees in connection with the consumer credit transaction in an amount equal to or greater than 3 percent of the total amount of credit extended in the transaction.

"(3) Limited prepayment penalty for early repayment under certain circumstances.—Subject to paragraph (2), the terms of a mortgage referred to in section 103(aa) may contain terms under which a consumer must pay a prepayment penalty for any payment made at or before the end of the 24-month period referred to in paragraph (1) to the extent that the sum of the total amount of points or fees financed by the creditor, if any, in connection with the consumer credit transaction and the total amount payable as a prepayment penalty does not exceed the amount which is equal to 3 percent of the total amount of credit extended in the transaction.

"(4) Construction.—For purposes of this subsection, any method of computing a refund of unearned scheduled interest is a prepayment penalty if it is less favorable to the consumer than the actuarial method (as that term is defined in section 933(d) of the Housing and Community Development Act of 1992).

"(5) Prepayment penalty defined.—The term 'prepayment penalty' means any monetary penalty imposed on a consumer for paying all or part of the principal with respect to a consumer credit transaction before the date on which the principal is due.".

(c) All Balloon Payments Prohibited.—Section 129(e) of the Truth in Lending Act (15 U.S.C. 1639(e)) is amended by striking "having a term of less than 5 years".

(d) Assessment of Ability To Repay.—Section 129(h) of the Truth in Lending Act (15 U.S.C. 1639(h)) is amended—

(1) by striking "Consumer.—A creditor" and inserting "Consumer.—

"(1) Prohibition on patterns and practices.—A creditor"; and

(2) by adding at the end the following:

"(2) Case-by-case assessments of consumer ability to pay required.—

"(A) In general.—In addition to the prohibition in paragraph (1) on engaging in certain patterns and practices, a creditor may not extend any credit in connection with any mortgage referred to in section 103(aa) unless the creditor has determined, at the time such credit is extended, that 1 or more of the resident obligors, when considered individually and collectively, will be able to make the scheduled payments under the terms of the transaction based on a consideration of the current and expected income, current obligations, employment status, and other financial resources of any such obligor, without taking into account any equity of any such obligor in the dwelling which is the security for the credit.

"(B) Regulations.—The Board shall prescribe, by regulation, the appropriate format for determining the ability of a consumer to make payments and the criteria to be considered in making that determination.

"(C) Resident obligor.—For purposes of this paragraph, the term 'resident obligor' means an obligor for whom the dwelling securing the extension of credit is, or upon the consummation of the transaction will be, the principal residence.

"(3) Verification.—The requirements of paragraphs (1) and (2) shall not be deemed to have been met unless any information relied upon by the creditor for purposes of any such paragraph has been verified by the creditor independently of information provided by any resident obligor.".

(e) Requirements Relating to Home Improvement Contracts.—Section 129(i) of the Truth in Lending Act (15 U.S.C. 1639(i)) is amended—

(1) by striking "Improvement Contracts.—A creditor" and inserting "Improvement Contracts.—

"(1) In general.—A creditor"; and

(2) by adding at the end the following:

"(2) Affirmative claims and defenses.—Notwithstanding any other provision of law, any assignee or holder, in any capacity, of a mortgage referred to in section 103(aa) which was made, arranged, or assigned by a person financing home improvements to the dwelling of a consumer shall be subject to all affirmative claims and defenses which the consumer may have against the seller, home improvement contractor, broker, or creditor with respect to such mortgage or home improvements.".

(f) Clarification of Rescission Rights.—Section 129(j) of the Truth in Lending Act (15 U.S.C. 1639(j)) is amended to read as follows:

"(j) Consequence of Failure To Comply.—

"(1) In general.—The consummation of a consumer credit transaction resulting in a mortgage referred to in section 103(aa) shall be treated as a failure to deliver the material disclosures required under this title for the purpose of section 125, if—

"(A) the mortgage contains a provision prohibited by this section or does not contain a provision required by this section; or

"(B) a creditor or other person fails to comply with the provisions of this section, whether by an act or omission, with regard to such mortgage at any time.

"(2) Rule of application.—In any application of section 125 to a mortgage described in section 103(aa) under circumstances described in paragraph (1), paragraphs (2) and (4) of section 125(e) shall not apply or be taken into account.".

SEC. 4. ADDITIONAL REQUIREMENTS FOR HIGH COST CONSUMER MORTGAGES.

(a) Single Premium Credit Insurance.—Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended—

(1) by redesignating subsections (k) and (l) as subsections (s) and (t), respectively; and

(2) by inserting after subsection (j), the following:

"(k) Single Premium Credit Insurance.—

"(1) In general.—The terms of a mortgage referred to in section 103(aa) may not require, and no creditor or other person may require or allow in connection with any such mortgage, whether paid directly by the consumer or financed by the consumer through such mortgage—

"(A) the advance collection of a premium, on a single premium basis, for any credit life, credit disability, credit unemployment, or credit property insurance, and any analogous product; or

"(B) the advance collection of a fee for any debt cancellation or suspension agreement or contract.

"(2) Rule of construction.—Paragraph (1) shall not be construed as affecting the right of a creditor to collect premium payments on insurance or debt cancellation or suspension fees referred to in paragraph (1) that are calculated and paid on a regular monthly basis, if the insurance transaction is conducted separately from the mortgage transaction, the insurance may be canceled by the consumer at any time, and the insurance policy is automatically canceled upon repayment or other termination of the mortgage referred to in paragraph (1).".

(b) Restriction on Financing Points and Fees.—Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by inserting after subsection (k) (as added by subsection (a) of this section) the following:

"(l) Restriction on Financing Points and Fees.—

"(1) Limit on amount of points and fees that may be financed.—Subject to paragraphs (2) and (3) of subsection (c), no creditor may, in connection with the formation or consummation of a mortgage referred to in section 103(aa), finance, directly or indirectly, any portion of the points, fees, or other charges payable to the creditor or any third party in an amount in excess of the greater of 3 percent of the total loan amount or $600.

"(2) Prohibition on financing certain points, fees, or charges.—No creditor may, in connection with the formation or consummation of a mortgage referred to in section 103(aa), finance, directly or indirectly, any of the following fees or other charges payable to the creditor or any third party:

"(A) Any prepayment fee or penalty required to be paid by the consumer in connection with a loan or other extension of credit which is being refinanced by such mortgage if the creditor, with respect to such mortgage, or any affiliate of the creditor, is the creditor with respect to the loan or other extension of credit being refinanced.

"(B) Any points, fees, or other charges required to be paid by the consumer in connection with such mortgage if—

"(i) the mortgage is being entered into in order to refinance an existing mortgage of the consumer that is referred to in section 103(aa); and

"(ii) if the creditor, with respect to such new mortgage, or any affiliate of the creditor, is the creditor with respect to the existing mortgage which is being refinanced.".

(c) Creditor Call Provision.—Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by inserting after subsection (l) (as added by subsection (b) of this section) the following:

"(m) CREDITOR CALL PROVISION.—

"(1) IN GENERAL.—A mortgage referred to in section 103(aa) may not include terms under which the indebtedness may be accelerated by the creditor, in the sole discretion of the creditor.

"(2) EXCEPTION.—Paragraph (1) shall not apply when repayment of the loan has been accelerated as a result of a bona fide default.".

(d) PROHIBITION ON ACTIONS ENCOURAGING DEFAULT.—Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by inserting after subsection (m) (as added by subsection (c) of this section) the following:

"(n) PROHIBITION ON ACTIONS ENCOURAGING DEFAULT.—No creditor may make any statement, take any action, or fail to take any action before or in connection with the formation or consummation of any mortgage referred to in section 103(aa) to refinance all or any portion of an existing loan or other extension of credit, if the statement, action, or failure to act has the effect of encouraging or recommending the consumer to default on the existing loan or other extension of credit at any time before, or in connection with, the closing or any scheduled closing on such mortgage.".

(e) MODIFICATION OR DEFERRAL FEES.—Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by inserting after subsection (n) (as added by subsection (d) of this section) the following:

"(o) MODIFICATION OR DEFERRAL FEES.—

"(1) IN GENERAL.—Except as provided in paragraph (2), a creditor may not charge any consumer with respect to a mortgage referred to in section 103(aa) any fee or other charge—

"(A) to modify, renew, extend, or amend such mortgage, or any provision of the terms of the mortgage; or

"(B) to defer any payment otherwise due under the terms of the mortgage.

"(2) EXCEPTION FOR MODIFICATIONS FOR THE BENEFIT OF THE CONSUMER.—Paragraph (1) shall not apply with respect to any fee imposed in connection with any action described in subparagraph (A) or (B) if—

"(A) the action provides a material benefit to the consumer; and

"(B) the amount of the fee or charge does not exceed—

"(i) an amount equal to 0.5 percent of the total loan amount; or

"(ii) in any case in which the total loan amount of the mortgage does not exceed $60,000, an amount in excess of $300.".

(f) CONSUMER COUNSELING REQUIREMENTS.—Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by inserting after subsection (o) (as added by subsection (e) of this section) the following:

"(p) CONSUMER COUNSELING REQUIREMENT.—

"(1) IN GENERAL.—A creditor may not extend any credit in the form of a mortgage referred to in section 103(aa) to any consumer, unless the creditor has provided to the consumer, at such time before the consummation of the mortgage and in such manner as the Board shall provide by regulation—

"(A) all warnings and disclosures regarding the risks of the mortgage to the consumer;

"(B) a separate written statement recommending that the consumer take advantage of available home ownership or credit counseling services before agreeing to the terms of any mortgage referred to in section 103(aa); and

"(C) a written statement containing the names, addresses, and telephone numbers of counseling agencies or programs reasonably available to the consumer that have been certified or approved by the Secretary of Housing and Urban Development, a State housing finance authority (as defined in section 1301 of the Financial Institutions Reform, Recovery, and Enforcement Act of 1989), or the agency referred to in subsection (a) or (c) of section 108 with jurisdiction over the creditor as qualified to provide counseling on—

"(i) the advisability of a high cost loan transaction; and

"(ii) the appropriateness of a high cost loan for the consumer.

"(2) COMPLETE AND UPDATED LISTS REQUIRED.—Any failure to provide as complete or updated a list under paragraph (1)(C) as is reasonably possible shall constitute a violation of this section.".

(g) ARBITRATION.—Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by inserting after subsection (p) (as added by subsection (f) of this section) the following:

"(q) ARBITRATION.—

"(1) IN GENERAL.—A mortgage referred to in section 103(aa) may not include terms which require arbitration or any other nonjudicial procedure as the method for resolving any controversy or settling any claims arising out of the transaction.

"(2) POST-CONTROVERSY AGREEMENTS.—Subject to paragraph (3), paragraph (1) shall not be construed as limiting the right of the consumer and the creditor to agree to arbitration or any other nonjudicial procedure as the method for resolving any controversy at any time after a dispute or claim under the transaction arises.

"(3) NO WAIVER OF STATUTORY CAUSE OF ACTION.—No provision of any mortgage referred to in section 103(aa) or any agreement between the consumer and the creditor shall be applied or interpreted so as to bar a consumer from bringing an action in an appropriate district court of the United States, or any other court of competent jurisdiction, pursuant to section 130 or any other provision of law, for damages or other relief in connection with any alleged violation of this section, any other provision of this title, or any other Federal law.".

(h) PROHIBITION ON EVASIONS.—Section 129 of the Truth in Lending Act (15 U.S.C. 1639) is amended by inserting after subsection (q) (as added by subsection (g) of this section) the following:

"(r) PROHIBITIONS ON EVASIONS, STRUCTURING OF TRANSACTIONS, AND RECIPROCAL ARRANGEMENTS.—

"(1) IN GENERAL.—A creditor may not take any action—

"(A) for the purpose or with the intent to circumvent or evade any requirement of this title, including entering into a reciprocal arrangement with any other creditor or affiliate of another creditor or dividing a transaction into separate parts, for the purpose of evading or circumventing any such requirement; or

"(B) with regard to any other loan or extension of credit for the purpose or with the intent to evade the requirements of this title, including structuring or restructuring a consumer credit transaction as another form of loan, such as a business loan.

"(2) OTHER ACTIONS.—In addition to the actions prohibited under paragraph (1), a creditor may not take any action which the Board determines, by regulation, constitutes a bad faith effort to evade or circumvent any requirement of this section with regard to a consumer credit transaction.

"(3) REGULATIONS.—The Board shall prescribe such regulations as the Board determines to be appropriate to prevent circumvention or evasion of the requirements of this section or to facilitate compliance with the requirements of this section.".

SEC. 5. AMENDMENTS RELATING TO RIGHT OF RESCISSION.

(a) TIMING OF WAIVER BY CONSUMER.—Section 125(a) of the Truth in Lending Act (15 U.S.C. 1635(a)) is amended—

(1) by striking "(a) Except as otherwise provided" and inserting "(a) RIGHT ESTABLISHED.—

"(1) IN GENERAL.—Except as otherwise provided"; and

(2) by adding at the end the following:

"(2) TIMING OF ELECTION OF WAIVER BY CONSUMER.—No election by a consumer to waive the right established under paragraph (1) to rescind a transaction shall be effective if—

"(A) the waiver was required by the creditor as a condition for the transaction;

"(B) the creditor advised or encouraged the consumer to waive such right of the consumer; or

"(C) the creditor had any discussion with the consumer about a waiver of such right during the period beginning when the consumer provides written acknowledgement of the receipt of the disclosures and the delivery of forms and information required to be provided to the consumer under paragraph (1) and ending at such time as the Board determines, by regulation, to be appropriate.".

(b) NONCOMPLIANCE WITH REQUIREMENTS AS RECOUPMENT IN FORECLOSURE PROCEEDING.—Section 130(e) of the Truth in Lending Act (15 U.S.C. 1640(e)) is amended by inserting after the second sentence the following: "This subsection also does not bar a person from asserting a rescission under section 125, in an action to collect the debt as a defense to a judicial or nonjudicial foreclosure after the expiration of the time periods for affirmative actions set forth in this section and section 125.".

SEC. 6. AMENDMENTS TO CIVIL LIABILITY PROVISIONS.

(a) INCREASE IN AMOUNT OF CIVIL MONEY PENALTIES FOR CERTAIN VIOLATIONS.—Section 130(a) of the Truth in Lending Act (15 U.S.C. 1640(a)) is amended—

(1) in paragraph (2)(A)(iii), by striking "$2,000" and inserting "$10,000"; and

(2) in paragraph (2)(B), by striking "lesser of $500,000 or 1 percentum of the net worth of the creditor" and inserting "the greater of—

"(i) the amount determined by multiplying the maximum amount of liability under subparagraph (A) for such failure to comply in an individual action by the number of members in the certified class; or

"(ii) the amount equal to 2 percent of the net worth of the creditor.".

(b) STATUTE OF LIMITATIONS EXTENDED FOR SECTION 129 VIOLATIONS.—Section 130(e) of the Truth in Lending Act (15 U.S.C. 1640(e)) (as amended by section 5(b) of this Act) is amended—

(1) in the first sentence, by striking "Any action" and inserting "Except as provided in the subsequent sentence, any action"; and

(2) by inserting after the first sentence the following: "Any action under this section with respect to any violation of section 129 may be brought in any United States district court, or in any other court of competent jurisdiction, before the end of the 3-year period beginning on the date of the occurrence of the violation.".

SEC. 7. AMENDMENT TO FAIR CREDIT REPORTING ACT.

Section 623 of the Fair Credit Reporting Act (15 U.S.C. 1681s–2) is amended by adding at the end the following:

"(e) DUTY OF CREDITORS WITH RESPECT TO HIGH COST MORTGAGES.—

"(1) IN GENERAL.—Each creditor who enters into a consumer credit transaction which is a mortgage referred to in section 103(aa), and each successor to such creditor with respect to such transaction, shall report the complete payment history, favorable and unfavorable, of the obligor with respect to such transaction to a consumer reporting agency that compiles and maintains files on consumers on a nationwide basis at least quarterly, or more frequently as required by regulation or in guidelines established by participants in the secondary mortgage market, while such transaction is in effect.

"(2) DEFINITIONS.—For purposes of paragraph (1), the term 'credit' and 'creditor' have the same meanings as in section 103 of the Truth in Lending Act (15 U.S.C. 1602).".

SEC. 8. REGULATIONS.

The Board of Governors of the Federal Reserve System shall publish regulations implementing this Act and the amendments made by this Act in final form before the end of the 6-month period beginning on the date of enactment of this Act.

By Mr. BROWNBACK (for himself, Mr. ENSIGN, Mr. ENZI, Mr. HAGEL, Mr. INHOFE, Mr. NICKLES, Mr. SANTORUM, and Mr. SESSIONS):

S. 1930. A bill to provide that the approved application under the Federal Food, Drug and Cosmetic Act for the drug commonly known as RU–486 is deemed to have been withdrawn, to provide for the review by the Comptroller General of the United States of the process by which the Food and Drug Administration approved such drug, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. BROWNBACK. Mr. President, I rise today to introduce a very important piece of legislation, the RU–486 Suspension and Review Act of 2003. The abortion drug RU–486 increases in infamy as its lethal nature continues to reveal itself. As my colleagues may remember, in September, RU–486 claimed two more lives, one of whom was an 18-year-old woman. Holly Patterson, a resident of the San Francisco suburb of Livermore, died from an infection caused by fragments of her baby left in her uterus after she was administered RU–486 at a Planned Parenthood facility. This tragedy underscores the dangerous nature of this drug.

The available data from the U.S. trials of RU–486 raises serious questions in my mind as to whether or not this drug truly is "safe" for the women who use it. Women who participated in the U.S. trials of this drug were carefully screened, and only those who were in the most physically ideal condition were accepted. Even so, among these physically ideal participants, troubling results emerged. Two-percent of the women participating hemorrhaged; one-percent had to be hospitalized; several others required surgery to stop the bleeding—some of whom needed blood transfusions; and one woman in Iowa, after losing between one-half to two-thirds of her total blood volume, would have died if she had not undergone emergency surgery. If these side-effects occurred in the most physically ideal candidates,. what about those who are not in the physically ideal category? Is this drug "safe" for women? I believe medical results suggest it is not.

The bill I am introducing today will require the suspension of the Food and Drug Administration's approval of RU–486. Following this suspension, the General Accounting Office is directed to review the process the FDA used to approve RU–486 and to determine whether the FDA followed its own guidelines. If it is determined that the FDA violated its guidelines, RU–486 will be suspended indefinitely. Monty and Helen Patterson, the parents of Holly Patterson, have expressed their firm support for this legislation and have requested that it be known as "Holly's Law" in honor of their daughter whose life was prematurely ended. I ask that their open letter on this subject be printed in the RECORD.

The Food and Drug Administration should not have authorized this dangerous drug. RU–486 is perilous both to the baby and to the woman who uses it. I urgently call on my colleagues in this Chamber to support "Holly's Law" to prevent more unnecessary deaths.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

LIVERMORE, CA,
November 20, 2003.

DEAR SIR OR MADAM: The Alameda County Coroner's report has validated what we already believed to be true. Holly has died from an RU–486 chemical induced abortion. There are no quick fixes for a pregnancy or magical pills that will make it go away. Our family, friends and community are all deeply saddened and forever marred by Holly's tragic and preventable death.

Holly lived as an adult by law for only 19 days, yet she became pregnant when she was just 17 years old. We now know that she learned about her pregnancy in the second week of August and was so distraught over her unplanned pregnancy that she sought help for depression from her family doctor on September 10, 2003—the very day that she began the drug induced abortion process.

Holly was a strong, healthy, intelligent and ambitious teenager who fell victim of a process that wholly failed her, beginning with the 24-year-old man who had unprotected sex with her, impregnated her, and then proceeded to facilitate the secrecy that surrounded her pregnancy and abortion. Under this conspiracy of silence, Holly suffered and depended on the safety of the FDA approved pill administered by Planned Parenthood and emergency room treatment by Valley Care Medical Center where she received pain killers for severe cramping and was sent home. On Saturday and Sunday, Holly cried and complained of severe cramping and constipation, and even allowed us to comfort her but could not tell us what she was really going through. On September 17, 2003, she succumbed to septic shock and died while many members of our family waited anxiously, yet expectantly in the Critical Care Unit for her to recover until we were forced behind the curtain when it was clear that she was dying.

And in those last moments of her life feeling utter disbelief and desperation we formed a circle just beyond the curtain and prayed aloud, cried and screamed, "We love you, Holly" hoping beyond hope that those words would ring out and save her life. And the other members of our family who drove and flew from all over the country to be by her side did not make it in time to say, "I love you" just one last time. Holly was not alone, unloved, unprotected or unsupported; she had a large family who willingly supported her throughout her short life and tragic death.

In the weeks since we buried Holly's body we are now able to recall and share the memories of our daughter's brilliant blue eyes, engaging smile, laughter, unwavering determination and sheer gentle beauty that invoked our natural instinct to protect and love her, but we will never be able to forget those last moments of her life when she was too weak to talk and could barely squeeze our hands in acknowledgement of our words of encouragement. "We love you, Holly", "Just hang in there, the whole family is coming," "You fight this Holly, you can do it."

Because Holly has died this way, we have educated ourselves about the grave dangers of this drug, become conscious of the current lack of parental notification/consent laws in California and now recognize the critical need for accurate, impartial sources of information and resources for parents, teenagers and young women who want to learn about the real dangers and risks of unplanned pregnancy and abortion and the dire need for a national movement to encourage prevention and open dialogue in the home about unplanned pregnancy and abortion.

We will actively support "Holly's Law" in Congress by Reps. DeMint, Bartlett and Senator Brownback to suspend and review the abortion drug RU–486, the Tell-A-Parent (TAP) bill, which requires parental notification laws in California and a campaign to encourage prevention and open dialogue about unplanned pregnancy and abortion in the home.

As parents, we cannot allow our beautiful Holly's horrible death to be in vain. RU–486 has caused serious injury and has been implicated in the deaths of other young women. Now it has killed our daughter. We have learned that the initial trials were rushed and the drug was lumped in and approved with drugs designed for life threatening illnesses such as cancer and AIDS. Pregnancy is a natural process that a woman's body is designed to support and has never been classified as a life threatening illness. We need help to develop a website and provide a place for teenagers and women to report their stories and testimonials of their experience on the serious and adverse affects using RU–486.

The FDA has failed to carry out its mission of ensuring RU–486 is a safe and effective abortion drug regimen. According to the FDA, it is "responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation." Holly has already paid the ultimate price. The RU–486 abortion drug should not be either a Pro Life or Pro Choice issue. The most primary concern here must be the health and welfare of our children and young women. Hopefully, all parents can learn from Holly's horrible death and our loss.

According to Danco Laboratories, the abortion drug's distributor, the RU–486 regimen fails to work 7–8 percent of the time. Over a year ago the FDA received 400 reports of adverse reactions to the drug including several deaths.

Holly is yet another victim who was subject to an unacceptable risk to a drug that has a significant failure rate. And we demand that FDA Commissioner Mark McClellan and Health and Human services Secretary, Tommy Thompson take RU–486 off the market immediately pending an extensive investigation by the Comptroller General of the United States before more parents suffer and women die.

We respectfully request the name of the bill that is to be presented to the House of Representatives, an Act as the "[RU–486 Approval and Review Act of 2003]" to be known as "Holly's Law." With actively support a bill that halts the use of the drug that took Holly's young life.

We demand an investigation by the FDA and the California State Health Department as to why abortion clinics like Planned Parenthood are not following FDA approved regulations to administer the drug. We question the purity of the drugs they administer, especially when they are made in foreign countries, such as China.

In addition to the dangers of this drug and its administration, we believe that health care providers such as Valley Medical Center don't appear to be fully prepared to evaluate and treat patients with RU–486 complications in emergency situations. Holly was in the hospital twice and died within 20 minutes before her follow up appointment with Planned Parenthood.

FDA Commissioner Mark McClellan and Health and Human Services Secretary, Tommy Thompson should now have enough evidence to pull this drug from the market. How many more teenagers and young women will have to pay the price with their health or with their life, before the FDA decides to act?

Currently in California, teenage girls under the age of 18 can't get their ears pierced or go on a school trip, but they can have a medical or surgical abortion without parental knowledge or consent. This prevents parents from being able to talk to their children about a pregnancy that would allow them to keep a baby or to be able to follow the abortion process.

The first line of defense for a child is a parent. Kids wouldn't be walking into clinics under a veil of secrey if parents were notified first hand where they could talk to their children about abortion risks. We have now learned that Holly first sought a pregnancy test in the months leading up to her pregnancy while she was still 17 years old. We know now that a parental notification law would have brought Holly's activity to our attention and her needless death could have been prevented if we had been aware and intervened.

We actively support the Tell-A-Parent (TAP) ballot initative sponsored by Life on The Ballot www.LifeontheBallot.org. With enough petitions, this initiative will be on the 2004 ballot and requires parental notification 48 hours prior to an abortion in California. As parents, we are concerned about the health and welfare of all daughters; we are "Pro Holly" and look to our California Senators Barbara Boxer and Dianne Feinstein to support this initiative for the safety and protection of all young women in California.

Finally, we have suffered greatly with the realization that it's not enough to avoid the issue or talk to our children about why we don't want them to be involved in an unplanned pregnancy or abortion, but as parents, we must also talk about the tragic realities of unwanted pregnancy and abortion and reassure both, our daughters and sons that while we don't want this to happen, we will support them. We must focus on prevention and they must be told that they are not alone in this or any other unfortunate circumstances, regardless of the outcome.

We feel strongly that this country needs a national campaign to promote open and frank discussions in the home about unplanned pregnancy and the options that are available to our daughters who find themselves in this unfortunate predicament. We are eager to support such a campaign designed to bring about awareness, encourage parental involvement, and provide accurate information to minors, women, and parents about abstinence, birth control, unplanned pregnancy, abortion, parenting, and adoption options.

While parents would prefer that their daughters abstain from sex and many do, we must deal with the reality that many don't. In addition to unplanned pregnancy, girls can contract HIV and other STIs. As parents we need to prevent unplanned pregnancy instead of relying upon abortion clinics and agencies to educate our children and provide them with inaccurate information. No parent wants to see his or her teenage or college age daughter in the unfortunate situation that Holly was faced with.

We have lost our daughter, Holly, but we can still help to prevent this terrible tragedy from happening in other families. Holly's drive and determination to accomplish her goals gives us strength to pursue these critical issues in her name. Holly's memory and light will live on in our hearts, family, friends and our work. We will actively support the bill to suspend and review "Holly's Law" in Congress by Reps. DeMint and Bartlett and Senator Brownback to suspend and review the abortion drug RU–486, the Tell-A-Parent (TAP) bill, which requires parental notification laws in California and a campaign to encourage prevention and open dialogue about unplanned pregnancy and abortion in the home. Please contact us with any questions or requests for support of these very important issues.

Sincerely,

MONTY AND HELEN PATTERSON.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 271—URGING THE PRESIDENT AND THE UNITED STATES DIPLOMATIC CORPS TO DISSUADE MEMBER STATES OF THE UNITED NATIONS FROM SUPPORTING RESOLUTIONS THAT UNFAIRLY CASTIGATE ISRAEL AND TO PROMOTE WITHIN THE UNITED NATIONS GENERAL ASSEMBLY MORE BALANCED AND CONSTRUCTIVE APPROACHES TO RESOLVING CONFLICT IN THE MIDDLE EAST

Mr. COLEMAN (for himself, Mr. CORZINE, Mr. VOINOVICH, and Mr. LAUTENBERG) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 271

Whereas the United Nations General Assembly and United Nations Security Council have over a period of many years engaged in a pattern of introducing and enacting measures and resolutions unfairly castigating and condemning the state of Israel;

Whereas despite the myriad of challenges facing the world community, the United Nations General Assembly has devoted a disproportionate amount of time and resources to castigating Israel;

Whereas during the fifty-seventh session of the United Nations General Assembly, the General Assembly adopted a total of 69 resolutions by roll call vote, 22 of which related to Israel;

Whereas many member states of the United Nations General Assembly continue to engage in a discriminatory campaign against Israel, including enacting on October 21, 2003 a resolution that condemns Israeli security measures without proportional condemnation of terrorist attacks launched against Israel;

Whereas the discriminatory voting patterns in the United Nations have historically been driven by voting blocs and ideological divides originating from Cold War rivalries that are obsolete in the post-Cold War period; and

Whereas in the post-Cold War geopolitical environment, the United States has a special responsibility to promote fair and equitable treatment of all nations in the context of international institutions, including the United Nations: Now, therefore, be it

Resolved, That the Senate urges the President and all members of the United States diplomatic corps—

(1) to dissuade member states of the United Nations from voting in support of General Assembly resolutions that unfairly castigate Israel; and

(2) to promote within the United Nations General Assembly more balanced and constructive approaches to resolving conflict in the Middle East.

Mr. COLEMAN. Mr. President, today I am proud to submit, along with my good friend and colleague Senator CORZINE, a bipartisan resolution dealing with the unfair treatment of Israel at the United Nations.

For too long, Israel has been singled out for castigation by the United Nations General Assembly. Israeli defensive actions are condemned, while terrorism against Israeli civilians goes largely unnoticed. There are whole bodies designed to do nothing but produce anti-Israel materials. There is a Division of Palestinian Rights which sits at the same level in the U.N. organization as a single division for the Americas and Europe, a single division for Asia and the Pacific, and two Africa divisions. Of all the resolutions adopted by rollcall vote at the last session of the UN General Assembly, one-third singled out Israel.

Let me be clear on this point: I do think it is appropriate to help the Palestinian people, and I do share President Bush's vision of two states living side by side in peace.

But for the United Nations to spend so much of its time on this one crisis, with an unbalanced approach, ultimately undermines its ability to contribute constructively to the peace process. To accord the Palestinian people—however serious their problems are the same level of attention as entire continents is inappropriate in a world where there are so many other oppressed groups and nations. Why is there no Division of Tibetan Rights? Why no Division of Chechen Rights?

If you look at the General Assembly voting records, there are too many one-sided resolutions dealing with Israel that pass with only a handful of negative votes—cast by the U.S., Israel, Micronesia, the Marshall Islands, Nauru and Palau. Last Friday, I was pleased to note Australia joined us as well.

The good news is that we are starting to see some progress. A joint U.S.-European-Israeli effort to consolidate seven resolutions on UNRWA into one resolution recently was a good start. The resolution was passed out of the committee by a vote of 109 to 0, albeit with 54 abstentions. True, several superfluous resolutions on UNRWA were also approved by the committee. But this year, it was five resolutions instead of seven.

When the U.S., Europe, and Israel can work together on a resolution dealing with Palestinian refugees—and one that is passed without any negative votes—we get a glimpse of the U.N.'s potential for bringing parties together.

I would be remiss if I did not commend the work of U.S. diplomats, and applaud their increased attention to this issue. This resolution gives them a tool to use with their diplomatic counterparts—a strong statement from the U.S. Senate that we are paying attention to these votes, and that we support a more balanced approach toward the Middle East at the United Nations.

It should be a goal we can all agree upon. By reducing the number of anti-Israel resolutions passed by the General Assembly, the United Nations can live up to the promise of its charter: "to practice tolerance and live together in peace with one another as good neighbors."

Mr. CORZINE. Mr. President, today, along with Senators COLEMAN, LAUTENBERG and VOINOVICH, I am submitting a resolution to address a serious and persistent problem: the unfair and inequitable treatment of Israel in the United Nations. The resolution urges the President and all members of the United States diplomatic corps to dissuade member states of the United Nations from voting in support of General Assembly resolutions that unfairly castigate Israel, and to promote within the United Nations General Assembly more balanced and constructive approaches to resolving conflict in the Middle East.

On October 21, 2003, the United Nations General Assembly ratified a resolution condemning Israeli security measures. The resolution did not call on the Palestinian Authority to dismantle terrorist organizations, nor did it name those organizations. Yet it passed by a vote of 144-4, with 12 abstentions. Other than the United States, only Micronesia, the Marshall Islands, and Israel itself voted against the resolution.

This resolution was only the latest in a long line of General Assembly resolutions castigating Israel with little regard to the security threats that Israel faces. For decades, the Assembly has devoted a disproportionate amount of time and resources to resolutions related to Israel—conducting, for example, 22 rollcall votes on UN General Assembly resolutions that related to Israel out of the 69 for all of the 57th Session of the Assembly. Besides distracting the United Nations from the countless other critical issues the world faces, these resolutions undermine efforts to achieve peace in the Middle East by casting blame almost entirely on one party. They are also unfair in that they subject Israel to discriminatory treatment not accorded to any other member state of the UN.

It is long past time for the General Assembly to stop ratifying these biased, unproductive resolutions. Voting patterns that discriminate against Israel appeared during the Cold War, when conflict in the Middle East was fueled by the rivalry between the West and the Soviet bloc. The Cold War has ended. So, too, should the polarization it engendered. We have also seen new alliances and relationships emerge in the global war on terrorism, and have witnessed the world come together in condemning terrorist violence. I refer to UN Security Council Resolution 1373, passed on September 28, 2001, which reaffirmed that any act of international terrorism constitutes a threat to international peace and security and called on states to work together to prevent and suppress terrorist acts.

Resolution 1373 reminded us of what the United Nations was meant to be—a forum for the world to come together to identify common threats and find common ways to address them. It offered the hope of a world united in its resolve to fight terrorism, with the United States leading that fight—in Afghanistan and in other parts of the world where international terrorists operate.

It is therefore with great disappointment that we witness business as usual at the General Assembly. The spirit of unity that prevailed for a time after September 11 has not led to a common approach to the conflict in the Middle East, and the United States has thus far been unable to enlist its friends and allies in its effort to ensure that Israel is treated fairly.

Since the inception of the United Nations, the United States has played a unique and critical role in ensuring that the U.N. lives up to the promise of its Charter—to maintain peace and security. As the sole remaining superpower, we have an opportunity to shape a global consensus on terrorism and security, one that requires new, more productive approaches to the conflict in the Middle East. This requires that we recognize the harm that comes from repeated, biased condemnations of a valuable ally in the United Nations General Assembly. It also requires sustained efforts, in the United Nations and within our bilateral and multilateral relationships, to change the voting patterns of friends, allies, and other member states.

We must bring our own values and our own vision of peace and security to the United Nations. Voting against resolutions that unfairly castigate Israel is not enough, particularly when we find ourselves in a tiny minority. We must seek to ally the world with us on this critical matter. The resolution we are introducing today thus urges the President and all members of the United States diplomatic corps to dissuade member states of the United Nations from voting in support of General Assembly resolutions that unfairly castigate Israel, and to promote within the Nations General assembly more balanced and constructive approaches to resolving conflict in the Middle East.

The United Nations can be—must be—a forum for defending our values. Through committed leadership, we can begin to change how other countries approach the General Assembly and how they vote on issues related to the Middle East. By doing so, we will be taking an important step toward peace.

SENATE RESOLUTION 272—DESIGNATING THE WEEK BEGINNING NOVEMBER 16, 2003, AS AMERICAN EDUCATION WEEK

Ms. SNOWE (for herself, Mrs. MURRAY, Mr. WARNER, Mr. BREAUX, Mr. CRAPO, Mr. CONRAD, Mr. DASCHLE, Mr. EDWARDS, Mr. KENNEDY, Mr. JOHNSON, and Mr. GRASSLEY) submitted the following resolution; which was considered and agreed to:

S. RES. 272

Whereas schools are the backbone of democracy in the United States, providing young people with the tools necessary to maintain the precious values of freedom, civility, and equality;

Whereas, by equipping students with both practical skills and broader intellectual abilities, schools give young people in the United States hope for, and access to, a bright and productive future;

Whereas education employees, whether they provide educational, administrative, technical, or custodial services, work tirelessly to serve the children and communities of the United States with care and professionalism;

Whereas schools are the keystones of communities in the United States, bringing together adults and children, educators and volunteers, business leaders, and elected officials in a common enterprise; and

Whereas public school educators first observed American Education Week in 1921 and are now celebrating the 82nd annual observance of American Education Week: Now, therefore, be it

Resolved, That the Senate—

(1) designates the week beginning November 16, 2003, as American Education Week; and

(2) recognizes the importance of public education and the accomplishments of the many education professionals who contribute to the achievement of students across the United States.

SENATE CONCURRENT RESOLUTION 84—RECOGNIZING THE SACRIFICES MADE BY MEMBERS OF THE REGULAR AND RESERVE COMPONENTS OF THE ARMED FORCES, EXPRESSING CONCERN ABOUT THEIR SAFETY AND SECURITY, AND URGING THE SECRETARY OF DEFENSE TO TAKE IMMEDIATE STEPS TO ENSURE THAT THE RESERVE COMPONENTS ARE PROVIDED WITH THE SAME EQUIPMENT AS REGULAR COMPONENTS

Mr. DASCHLE (for Mr. KERRY) submitted the following concurrent resolution; which was referred to the Committee on Armed Services:

S. CON. RES. 84

Whereas, on September 11, 2001, the National Guard and Reserve responded to the horrific terrorist attacks on the United States with professionalism and courage, rescued the injured, saved lives in New York City, provided protection to the Pentagon, and flew combat air patrols over Washington, D.C., and other major cities;

Whereas, on September 14, 2001, in Executive Order 13223, President Bush proclaimed a national emergency, and exercised his authority under section 12302 of title 10, United States Code, to allow him to call up as many as 1,000,000 National Guard and Reserve members to active duty for up to two years;

Whereas more than 300,000 National Guard and Reserve members have been called to active duty under this Executive Order, serving on the front lines by fighting terrorists in Africa and Asia and keeping the peace in Afghanistan, the Balkans, and Iraq;

Whereas the National Guard and Reserve are taking on unprecedented challenges;

Whereas 64 percent of National Guard and Reserve members have been called up for active duty during at least one of the seven major mobilizations since 1990;

Whereas 7,800 National Guard and Reserve members have been mobilized more than once to serve in the Global War on Terrorism, and members serve between 60 and 120 days per year;

Whereas 42,000 of the approximately 160,000 United States troops currently in Iraq are members of the National Guard and Reserve;

Whereas the National Guard and Reserve are being deployed to Iraq without critical protective equipment, such as body armor, carbines, laser sights, night vision goggles, desert boots, Camel Back water carriers, aviation holsters, aviation protective masks, radios, and desert camouflage uniforms;

Whereas many National Guard and Reserve units are using older and outdated equipment;

Whereas, due to equipment shortages throughout the National Guard and Reserve, units are being stripped of equipment in favor of units being deployed, leaving other units without equipment with which to train;

Whereas at least one National Guard and Reserve unit asked hospitals in the United States to donate medical supplies to cover its shortages; and

Whereas a poll taken in Iraq by *Stars & Stripes* reveals that 48 percent of National Guard and Reserve troops consider their morale "low" or "very low", compared with only 15 percent reporting "high" or "very high" morale: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring), That Congress—

(1) recognizes the sacrifices made by the members in the regular and reserve components of the Armed Forces;

(2) expresses concern about their safety and security; and

(3) urges the Secretary of Defense to take immediate steps to ensure that the National Guard and Reserves are provided with the same equipment as the regular components.

(At the request of Mr. DASCHLE, the following statement was ordered to be printed in the RECORD.)

• Mr. KERRY. Mr. President, the relationship between the active and reserve components in the United States military is known as the "total-force" concept. Active duty units cannot fight wars without the support and participation of units from the National Guard and Reserve. It is this aspect of the all volunteer military that distinguishes the American armed forces from the praetorian armies of old and links the broader public, intimately, to the costs and sacrifices of war.

The men and women of the American military continue to preform magnificently. They are executing difficult missions in distant lands around the globe. There are more than 130,000 troops in Iraq, 30,000 in Kuwait, 37,000 in Korea, and 10,000 in Afghanistan. At this moment, more than 164,000 national guardsmen and reservists are on active duty, and the Pentagon has recently announced two more rounds of activation, increasing that number by another 58,000 troops. With more than 60 percent of the Army's active combat strength deployed or preparing to deploy, the men and women of the National Guard and Reserves are essential to our efforts in the war on terrorism and the stabilization of Iraq and Afghanistan.

These deployed "weekend warriors" are much more than part-time soldiers; they are full-time war-fighters serving alongside active duty units, performing the same missions, facing the same dangers, paying the same bloody price.

Despite this fact, the equipment of the National Guard and Reserves has been substandard when compared to the equipment available to members of the active units for far too long. This peace-time nuisance is a mortal danger in war. It is inexcusable that any U.S. units, whether active or reserve, would deploy to a combat zone without the latest equipment and technology.

But we have heard concerns about National Guard and Reserve units lacking the latest gear or technology: helicopters lacking basic defense systems; Humvees without the additional armor needed to protect their occupants; and inadequate supplies of personal body armor. It is a dereliction of duty to send anyone into harm's way without basic protective gear.

The Concurrent Resolution submit today, expresses our concern for the welfare and security of all the men and women of the United states military, whether they serve in the active duty military, the National Guard, or the reserves. If this is to truly be a "total-force," then we must also commit ourselves to equipping it as such. The courageous, young men and women of our armed forces deserve no less.•

SENATE CONCURRENT RESOLUTION 85—EXPRESSING THE SENSE OF CONGRESS THAT THE CONTINUED PARTICIPATION OF THE RUSSIAN FEDERATION IN THE GROUP OF 8 NATIONS SHOULD BE CONDITIONED ON THE RUSSIAN GOVERNMENT VOLUNTARILY ACCEPTING AND ADHERING TO THE NORMS AND STANDARDS OF DEMOCRACY

Mr. McCAIN (for himself and Mr. LIEBERMAN) submitted the following concurrent resolution; which was referred to the Committee on Foreign Relations:

S. CON. RES. 85

Whereas the countries that comprise the Group of 7 nations are pluralistic societies with democratic political institutions and practices, committed to the observance of universally recognized standards of human rights, respect for individual liberties, and democratic principles;

Whereas in 1991 and subsequent years, the leaders of the Group of 7 nations, heads of the governments of the major free market economies of the world who meet annually in a summit meeting, invited then-Russian President Boris Yeltsin to a post-summit dialogue;

Whereas in 1998, the leaders of the Group of 7 nations formally invited President Boris Yeltsin of Russia to participate in an annual gathering that subsequently was known as the Group of 8 nations, although the Group of 7 nations have continued to hold informal summit meetings and ministerial meetings that do not include the Russian Federation;

Whereas the invitation to President Yeltsin to participate in the annual summits was in recognition of his commitment to democratization and economic liberalization, despite the fact that the Russian economy remained weak and the commitment of the Russian Government to democratic principles was uncertain;

Whereas under the leadership of President Vladimir Putin, the Russian Government has attempted to control the activities of independent media enterprises, nongovernmental organizations, religious organizations, and other pluralistic elements of Russian society in an attempt to mute criticism of the government;

Whereas the suppression by the Russian Government of independent media enterprises has resulted in widespread government control and influence over the media in Russia, stifling freedom of expression and individual liberties that are essential to any functioning democracy;

Whereas the arrest and prosecution of prominent Russian business leaders who had supported the political opposition to President Putin are examples of selective application of the rule of law for political purposes;

Whereas the courts of Great Britain, Spain, and Greece have consistently ruled against extradition warrants issued by the Russian Government after finding that the cases presented by the Prosecutor General of the Russian Federation have been inherently political in nature;

Whereas Russian military forces continue to commit brutal atrocities against the civilian population in Chechnya;

Whereas the rise to influence within the Russian Government of unelected security officials from the KGB of the former Soviet Union is increasingly undermining the commitment of the Russian Government to democratic principles, accountability, and transparency;

Whereas a wide range of observers at think tanks and nongovernmental organizations have expressed deep concern that the Russian Federation is moving away from the political and legal underpinnings of a market economy; and

Whereas the continued participation of the Russian Federation in the Group of 8 nations, including the opportunity for the Russian Government to host the Group of 8 nations in 2006 as planned, is a privilege that is premised on the Russian Government voluntarily accepting and adhering to the norms and standards of democracy: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring), That it is the sense of Congress that—

(1) the selective prosecution of political opponents and the suppression of free media by the Russian Federation, and the continued commission of widespread atrocities in the conduct of the brutal war in Chechnya, do not reflect the minimum standards of democratic governance and rule of law that characterize every other member state in the Group of 8 nations;

(2) the continued participation of the Russian Federation in the Group of 8 nations, including the opportunity for the Russian Government to host the Group of 8 nations summit in 2006 as planned, should be conditioned on the Russian Government accepting and adhering to the norms and standards of free, democratic societies as generally practiced by every other member nation of the Group of 8 nations, including—

(A) the rule of law, including protection from selective prosecution and protection from arbitrary state-directed violence;

(B) a court system free of political influence and manipulation;

(C) a free and independent media;

(D) a political system open to participation by all citizens and which protects freedom of expression and association; and

(E) the protection of universally recognized human rights; and

(3) the President of the United States and the Secretary of State should work with the other members of the Group of 7 nations to take all necessary steps to suspend the participation of the Russian Federation in the Group of 8 nations until the President, after consultation with the other members of the Group of 7 nations, determines and reports to Congress that the Russian Government is committed to respecting and upholding the democratic principles described in paragraph (2).

AMENDMENTS SUBMITTED & PROPOSED

SA 2209. Mr. FRIST (for Mr. DODD) proposed an amendment to the bill S. 1680, to reauthorize the Defense Production Act of 1950, and for other purposes.

SA 2210. Mr. FRIST (for Mr. INHOFE (for himself, Mr. JEFFORDS, Mr. VOINOVICH, and Mrs. CLINTON)) proposed an amendment to the bill S. 1279, to amend the Robert T. Stafford Disaster Relief and Emergency Assistance Act to authorize the President to carry out a program for the protection of the health and safety of residents, workers, volunteers, and others in a disaster area.

SA 2211. Mr. FRIST (for Mr. MCCAIN (for himself and Mr. HOLLINGS)) proposed an amendment to the bill S. 579, to reauthorize the National Transportation Safety Board, and for other purposes.

TEXT OF AMENDMENTS

SA 2209. Mr. FRIST (for Mr. DODD) proposed an amendment to the bill S. 1680, to reauthorize the Defense Production Act of 1950, and for other purposes; as follows:

On page 6, strike line 1 and all that follows through page 7, line 2, and insert the following:

SEC. 7. REPORT ON IMPACT OF OFFSETS ON DOMESTIC CONTRACTORS AND LOWER TIER SUBCONTRACTORS.

(a) EXAMINATION OF IMPACT REQUIRED.—

(1) IN GENERAL.—As part of the annual report required under section 309(a) of the Defense Production Act of 1950 (50 U.S.C. App. 2099(a)), the Secretary of Commerce (in this section referred to as the "Secretary") shall—

(A) detail the number of foreign contracts involving domestic contractors that use offsets, industrial participation agreements, or similar arrangements during the preceding 5-year period;

(B) calculate the aggregate, median, and mean values of the contracts and the offsets, industrial participation agreements, and similar arrangements during the preceding 5-year period; and

(C) describe the impact of international or foreign sales of United States defense products and related offsets, industrial participation agreements, and similar arrangements on domestic prime contractors and, to the extent practicable, the first 3 tiers of domestic contractors and subcontractors during the preceding 5-year period in terms of domestic employment, including any job losses, on an annual basis.

(2) USE OF INTERNAL DOCUMENTS.—To the extent that the Department of Commerce is already in possession of relevant data, the Department shall use internal documents or existing departmental records to carry out paragraph (1).

(3) INFORMATION FROM NON-FEDERAL ENTITIES.—

(A) EXISTING INFORMATION.—In carrying out paragraph (1), the Secretary shall only require a non-Federal entity to provide information that is available through the existing data collection and reporting systems of that non-Federal entity.

(B) FORMAT.—The Secretary may require a non-Federal entity to provide information to the Secretary in the same form that is already provided to a foreign government in fulfilling an offset arrangement, industrial participation agreement, or similar arrangement.

(b) REPORT.—

(1) IN GENERAL.—Before the end of the 8-month period beginning on the date of enactment of this Act, the Secretary shall submit to Congress a report containing the findings and conclusions of the Secretary with regard to the examination made pursuant to subsection (a).

(2) COPIES OF REPORT.—The Secretary shall also transmit copies of the report prepared under paragraph (1) to the United States Trade Representative and the interagency team established pursuant to section 123(c) of the Defense Production Act Amendments of 1992 (50 U.S.C. App. 2099 note).

(c) RESPONSIBILITIES REGARDING CONSULTATION WITH FOREIGN NATIONS.—Section 123(c) of the Defense Production Act Amendments of 1992 (50 U.S.C. App. 2099 note) is amended to read as follows:

"(c) NEGOTIATIONS.—

"(1) INTERAGENCY TEAM.—

"(A) IN GENERAL.—It is the policy of Congress that the President shall designate a chairman of an interagency team comprised of the Secretary of Commerce, Secretary of Defense, United States Trade Representative, Secretary of Labor, and Secretary of State to consult with foreign nations on limiting the adverse effects of offsets in defense procurement without damaging the economy or the defense industrial base of the United States or United States defense production or defense preparedness.

"(B) MEETINGS.—The President shall direct the interagency team to meet on a quarterly basis.

"(C) REPORTS.—The President shall direct the interagency team to submit to Congress an annual report, to be included as part of the report required under section 309(a) of the Defense Production Act of 1950 (50 U.S.C. App. 2099(a)), that describes the results of the consultations of the interagency team under subparagraph (A) and the meetings of the interagency team under subparagraph (B).

"(2) RECOMMENDATIONS FOR MODIFICATIONS.—The interagency team shall submit to the President any recommendations for modifications of any existing or proposed memorandum of understanding between officials acting on behalf of the United States and 1 or more foreign countries (or any instrumentality of a foreign country) relating to—

"(A) research, development, or production of defense equipment; or

"(B) the reciprocal procurement of defense items.".

SA 2210. Mr. FRIST (for Mr. INHOFE (for himself, Mr. JEFFORDS, Mr. VOINOVICH, and Mrs. CLINTON)) proposed an amendment to the bill S. 1279, to amend the Robert T. Stafford Disaster Relief and Emergency Assistance Act to authorize the President to carry out a program for the protection of the health and safety of residents, workers, volunteers, and others in a disaster area; as follows:

On page 19, line 16, insert ", including a local health department," after "institution".

On page 21, between lines 18 and 19, insert the following:

"(7) PRIVACY.—The President shall carry out each program under paragraph (1) in accordance with regulations relating to privacy promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note; Public Law 104–191).

At the end, add the following:

SEC. 4. PREDISASTER HAZARD MITIGATION.

Section 203(m) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5133(m)) is amended by striking "December 31, 2003" and inserting "September 30, 2006".

SA 2211. Mr. FRIST (for Mr. MCCAIN (for himself and Mr. HOLLINGS)) proposed an amendments to the bill S. 579, to reauthorize the National Transportation Safety Board, and for other purposes; as follows:

On page 2, line 15, strike "$3,000,000." and insert "$4,000,000.".

On page 3, line 6, strike "paragraph" and insert "subsection".

On page 3, line 16, strike the closing quotation marks and the second period.

On page 3, line 17, strike "(c)" and insert " '(d)".

On page 3, line 21, insert closing quotation marks and a period after the period.

On page 5, strike lines 7 through 21, and insert the following:

SEC. 4. RELIEF FROM CONTRACTING REQUIREMENTS FOR INVESTIGATIONS SERVICES.

(a) IN GENERAL.—From the date of enactment of this Act through September 30, 2006, the National Transportation Safety Board may enter into agreements or contracts under the authority of section 1113 (b)(1)(B) of title 49, United States Code for investigations conducted under section 1131 of that title without regard to any other provision of law requiring competition if necessary to expedite the investigation.

(b) REPORT ON USAGE.—On February 1, 2006, the National Transportation Safety Board shall transmit a report to the House of Representatives Committee on Transportation and Infrastructure, the House of Representatives Committee on Government Reform, the Senate Committee on Commerce, Science, and Transportation, and the Senate Committee on Government Affairs that—

(1) describes each contract for $25,000 or more executed by the Board to which the authority provided by subsection (a) was applied; and

(2) sets forth the rationale for dispensing with competition requirements with respect to such contract.

On page 5, after line 21, add the following:

SEC. 5. ACCIDENT AND SAFETY DATA CLASSIFICATION AND PUBLICATION.

Section 1119 of title 49, United States Code, is amended by adding at the end the following:

"(c) APPEALS.—

"(1) NOTIFICATION OF RIGHTS.—In any case in which an employee of the Board determines that an occurrence associated with the operation of an aircraft constitutes an accident, the employee shall notify the owner or operator of that aircraft of the right to appeal that determination to the Board.

"(2) PROCEDURE.—The Board shall establish and publish the procedures for appeals under this subsection.

"(3) LIMITATION ON APPLICABILITY.—This subsection shall not apply in the case of an accident that results in a loss of life.".

SEC. 6. SECRETARY OF TRANSPORTATION'S RESPONSES TO SAFETY RECOMMENDATIONS.

Section 1135(d) of title 49, United States Code, is amended to read as follows:

"(d) REPORTING REQUIREMENTS.—

"(1) ANNUAL SECRETARIAL REGULATORY STATUS REPORTS.—On February 1 of each year, the Secretary shall submit a report to Congress and the Board containing the regulatory status of each recommendation made by the Board to the Secretary (or to an Administration within the Department of Transportation) that is on the Board's 'most wanted list'. The Secretary shall continue to report on the regulatory status of each such recommendation in the report due on February 1 of subsequent years until final regulatory action is taken on that recommendation or the Secretary (or an Administration within the Department) determines and states in such a report that no action should be taken.

"(2) FAILURE TO REPORT.—If on March 1 of each year the Board has not received the Secretary's report required by this subsection, the Board shall notify the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate of the Secretary's failure to submit the required report.

"(3) TERMINATION.—This subsection shall cease to be in effect after the report required to be filed on February 1, 2008, is filed.".

SEC. 7. TECHNICAL AMENDMENTS.

Section 1131(a)(2) of title 49, United States Code, is amended by moving subparagraphs (B) and (C) 4 ems to the left.

SEC. 8. DOT INSPECTOR GENERAL INVESTIGATIVE AUTHORITY.

(a) IN GENERAL.—Section 228 of the Motor Carrier Safety Improvement Act of 1999 (113 Stat. 1773) is transferred to, and added at the end of, subchapter III of chapter 3 of title 49, United States Code, as section 354 of that title.

(b) CONFORMING AMENDMENTS.—

(1) The caption of the section is amended to read as follows:

"§ 354. Investigative authority of Inspector General".

(2) The chapter analysis for chapter 3 of title 49, United States Code, is amended by adding at the end the following:

"354. Investigative authority of Inspector General".

SEC. 9. REPORTS ON CERTAIN OPEN SAFETY RECOMMENDATIONS.

(a) INITIAL REPORT.—Within 1 year after the date of enactment of this Act, the Secretary of Transportation shall submit a report to Congress and the National Transportation Safety Board containing the regulatory status of each open safety recommendation made by the Board to the Secretary concerning—

(1) 15-passenger van safety;

(2) railroad grade crossing safety; and

(3) medical certifications for a commercial driver's license.

(b) BIENNIAL UPDATES.—The Secretary shall continue to report on the regulatory status of each such recommendation (and any subsequent recommendation made by the Board to the Secretary concerning a matter described in paragraph (1), (2), or (3) of subsection (a)) at 2-year intervals until—

(1) final regulatory action has been taken on the recommendation;

(2) the Secretary determines, and states in the report, that no action should be taken on that recommendation; or

(3) the report, if any, required to be submitted in 2008 is submitted.

(c) FAILURE TO REPORT.—If the Board has not received a report required to be submitted under subsection (a) or (b) within 30 days after the date on which that report is required to be submitted, the Board shall notify the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. CRAIG. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate on Friday, November 21 at 9:30 a.m.

The purpose of the oversight hearings is to receive testimony on the implementation of the Energy Employees Occupational Illness Compensation Program.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FINANCE

Mr. CRAIG. Mr. President, I ask unanimous consent that the Committee on Finance be authorized to meet in open Executive Session during the session on Friday, November 21, 2003; to consider nomination of Arnold I. Havens, to be General Counsel for the Department of the Treasury.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. CRAIG. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Friday, November 21, 2003 at 9 a.m. to hold a hearing on Nominations.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. CRAIG. Mr. President, I ask unanimous consent that the Committee on Governmental Affairs be authorized to meet on Friday, November 21, 2003 at a time and location to be determined to hold a business meeting to consider the nominations of James M. Loy to be Deputy Secretary of Homeland Security, Department of Homeland Security; and Scott J. Bloch to be Special Counsel, Office of Special Counsel.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

Mr. CRAIG. Mr. President, I ask unanimous consent that the Committee on Health, Education, Labor, and Pensions be authorized to meet for a hearing on The Nomination of Steven J. Law, of the District of Columbia, to be Deputy Secretary of Labor during the session of the Senate on Friday, November 21, 2003 at 10 a.m. in SD–430.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON VETERANS' AFFAIRS

Mr. CRAIG. Mr. President, I ask unanimous consent that the Committee on Veterans' Affairs be authorized to meet during the session of the Senate on November 21, 2003, for a markup on the nominations of Gordon H. Mansfield to be Deputy Secretary of Veterans Affairs, Cynthia R. Church to be Assistant Secretary of Veterans Affairs for Public and Intergovernmental Affairs, Robert N. McFarland to be Assistant Secretary of Veterans Affairs for Information and Technology, Lawrence B. Hagel to be Judge, U.S. Court of Appeals for Veterans Claims, and Alan G. Lance, Sr. to be Judge, U.S. Court of Appeals for Veterans Claims.

The meeting will take place in the Senate Reception Room in the Capitol after the first rollcall vote of the day.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRIVILEGE OF THE FLOOR

Mr. GRAHAM. Mr. President, I ask unanimous consent that Mr. Chad Littleton, a Congressional Fellow in my office, be granted the privilege of the floor for the remainder of the Senate's consideration of this bill.

The PRESIDING OFFICER. Without objection, it is so ordered.

Ms. LANDRIEU. Mr. President, I ask unanimous consent that Neil Naraine be granted the privileges of the floor for the duration of the debate.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. I ask unanimous consent that Christine Evans, of the Finance Committee staff, be afforded the privilege of the floor for the remainder of today's session.

The PRESIDING OFFICER. Without objection, it is so ordered.

FEDERAL RECOGNITION TO CONFEDERATED TRIBES OF GRAND RONDE COMMUNITY OF OREGON MEMORIALIZED

Mr. FRIST. Mr. President, I ask unanimous consent that the Indian Affairs Committee be discharged from further consideration of S. Res. 246 and the Senate proceed to its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 246) expressing the sense of the Senate that November 22, 1983, the date of the restoration by the Federal Government of Federal recognition to the Confederated Tribes of the Grand Ronde Community of Oregon, should be memorialized.

There being no objection, the Senate proceeded to consider the resolution.

Mr. FRIST. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 246) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 246

Whereas the Grand Ronde Restoration Act (25 U.S.C. 713 et seq.), which was signed by the President on November 22, 1983, restored Federal recognition to the Confederated Tribes of the Grand Ronde Community of Oregon;

Whereas the Confederated Tribes of the Grand Ronde Community of Oregon historically inhabited land that extended from the summit of the Cascade Range, west along the shores of the Columbia River to the summit of the Coast Range, and south to the California border;

Whereas in addition to restoring Federal recognition, that Act and other Federal Indian statutes have provided the means for the Confederated Tribes to achieve the goals of cultural restoration, economic self-sufficiency, and the attainment of a standard of living equivalent to that enjoyed by other citizens of the United States;

Whereas by enacting the Grand Ronde Restoration Act (25 U.S.C. 713 et seq.), the Federal Government—

(1) declared that the Confederated Tribes of the Grand Ronde Community of Oregon were eligible for all Federal services and benefits provided to federally recognized tribes;

(2) established a tribal reservation; and

(3) granted the Confederated Tribes of the Grand Ronde Community of Oregon self-government for the betterment of tribal members, including the ability to set tribal rolls;

Whereas the Confederated Tribes of the Grand Ronde Community of Oregon have embraced Federal recognition and self-sufficiency statutes and are actively working to better the lives of tribal members; and

Whereas economic self-sufficiency, which was the goal of restoring Federal recognition for the Confederated Tribes of the Grand Ronde Community of Oregon, is being realized through many projects: Now, therefore, be it

Resolved, That it is the sense of the Senate that November 22, 1983, should be memorialized as the date on which the Federal Government restored Federal recognition to the Confederated Tribes of the Grand Ronde Community of Oregon.

DEFENSE PRODUCTION REAUTHORIZATION ACT OF 2003

Mr. FRIST. I ask unanimous consent that the Chair now lay before the Senate the House message to accompany S. 1680, the Defense Production Reauthorization Act.

The PRESIDING OFFICER laid before the Senate the following message from the House, as follows:

Resolved, That the bill from the Senate (S. 1680) entitled "An Act to reauthorize the Defense Production Act of 1950, and for other purposes", do pass with the following amendment:

Strike out all after the enacting clause and insert:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Defense Production Act Reauthorization of 2003".

SEC. 2. REAUTHORIZATION OF DEFENSE PRODUCTION ACT OF 1950.

(a) IN GENERAL.—The 1st sentence of section 717(a) of the Defense Production Act of 1950 (50 U.S.C. App. 2166(a)) is amended—

(1) by striking "sections 708" and inserting "sections 707, 708,"; and

(2) by striking "September 30, 2003" and inserting "September 30, 2008".

(b) AUTHORIZATION OF APPROPRIATIONS.—Section 711(b) of the Defense Production Act of 1950 (50 U.S.C. App. 2161(b)) is amended by striking "through 2003" and inserting "through 2008".

SEC. 3. RESOURCE SHORTFALL FOR RADIATION-HARDENED ELECTRONICS.

(a) IN GENERAL.—Notwithstanding the limitation contained in section 303(a)(6)(C) of the Defense Production Act of 1950 (50 U.S.C. App. 2093(a)(6)(C)), the President may take actions under section 303 of the Defense Production Act of 1950 to correct the industrial resource shortfall for radiation-hardened electronics, to the extent that such Presidential actions do not cause the aggregate outstanding amount of all such actions to exceed $200,000,000.

(b) REPORT BY THE SECRETARY.—Before the end of the 6-month period beginning on the date of the enactment of this Act, the Secretary of Defense shall submit a report to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives describing—

(1) the current state of the domestic industrial base for radiation-hardened electronics;

(2) the projected requirements of the Department of Defense for radiation-hardened electronics;

(3) the intentions of the Department of Defense for the industrial base for radiation-hardened electronics; and

(4) the plans of the Department of Defense for use of providers of radiation-hardened electronics beyond the providers with which the Department had entered into contractual arrangements under the authority of the Defense Production Act of 1950, as of the date of the enactment of this Act.

SEC. 4. CLARIFICATION OF PRESIDENTIAL AUTHORITY.

Subsection (a) of section 705 of the Defense Production Act of 1950 (50 U.S.C. App. 2155(a)) is amended by inserting after the end of the 1st sentence the following new sentence: "The authority of the President under this section includes the authority to obtain information in order to perform industry studies assessing the capabilities of the United States industrial base to support the national defense.".

SEC. 5. CRITICAL INFRASTRUCTURE PROTECTION AND RESTORATION.

Section 702 of the Defense Production Act of 1950 (50 U.S.C. App. 2152) is amended—

(1) by redesignating paragraphs (3) through (17) as paragraphs (4) through (18), respectively;

(2) by inserting after paragraph (2) the following new paragraph:

"(3) CRITICAL INFRASTRUCTURE.—The term 'critical infrastructure' means any systems and assets, whether physical or cyber-based, so vital to the United States that the degradation or destruction of such systems and assets would have a debilitating impact on national security, including, but not limited to, national economic security and national public health or safety."; and

(3) in paragraph (14) (as so redesignated by paragraph (1) of this section), by inserting "and critical infrastructure protection and restoration" before the period at the end of the last sentence.

SEC. 6. REPORT ON CONTRACTING WITH MINORITY- AND WOMEN-OWNED BUSINESSES.

(a) REPORT REQUIRED.—Before the end of the 1-year period beginning on the date of the enactment of this Act, the Secretary of Defense shall submit a report to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives on the extent to which contracts entered into during the fiscal year ending before the end of such 1-year period under the Defense Production Act of 1950 have been contracts with minority- and women-owned businesses.

(b) CONTENTS OF REPORT.—The report submitted under subsection (a) shall include the following:

(1) The types of goods and services obtained under contracts with minority- and women-owned businesses under the Defense Production Act of 1950 in the fiscal year covered in the report.

(2) The dollar amounts of such contracts.

(3) The ethnicity of the majority owners of such minority- and women-owned businesses.

(4) A description of the types of barriers in the contracting process, such as requirements for security clearances, that limit contracting opportunities for minority- and women-owned businesses, together with such recommendations for legislative or administrative action as the Secretary of Defense may determine to be appropriate for increasing opportunities for contracting with minority- and women-owned businesses and removing barriers to such increased participation.

(c) DEFINITIONS.—For purposes of this section, the terms "women-owned business" and "minority-owned business" have the meanings given such terms in section 21A(r) of the Federal Home Loan Bank Act, and the term "minority" has the meaning given such term in section 1204(c)(3) of the Financial Institutions Reform, Recovery, and Enforcement Act of 1989.

SEC. 7. REPORT ON IMPACT OF OFFSETS ON DOMESTIC CONTRACTORS AND HIGHER-TIER SUBCONTRACTORS.

(a) ASSESSMENT OF IMPACT REQUIRED.—In addition to the information required to be included in the annual report under section 309 of the Defense Production Act of 1950, the Secretary of Commerce shall assess the net impact, in the defense trade, of foreign sales and related foreign contracts that have been awarded through offsets, industrial participation agreements, or similar arrangements on domestic prime contractors and at least the first 3 tiers of domestic subcontractors during the 5-year period beginning on January 1, 1998.

(b) REPORT.—Before the end of the 1-year period beginning on the date of the enactment of this Act, the Secretary of Commerce shall submit a report to the Congress containing findings and the conclusions of the Secretary with regard to the assessment made pursuant to subsection (a).

(c) COPIES OF REPORT.—Copies of the report prepared pursuant to subsection (b) shall also be transmitted to the United States Trade Representative and the interagency team established pursuant to section 123(c) of the Defense Production Act Amendments of 1992.

Mr. FRIST. I ask unanimous consent that the Senate concur with the House amendment with an amendment, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 2209) was agreed to, as follows:

(Purpose: To modify the reporting requirements of the Secretary of Commerce and for other purposes)

On page 6, strike line 1 and all that follows through page 7, line 2, and insert the following:

SEC. 7. REPORT ON IMPACT OF OFFSETS ON DOMESTIC CONTRACTORS AND LOWER TIER SUBCONTRACTORS.

(a) EXAMINATION OF IMPACT REQUIRED.—

(1) IN GENERAL.—As part of the annual report required under section 309(a) of the Defense Production Act of 1950 (50 U.S.C. App. 2099(a)), the Secretary of Commerce (in this section referred to as the "Secretary") shall—

(A) detail the number of foreign contracts involving domestic contractors that use offsets, industrial participation agreements, or similar arrangements during the preceding 5-year period;

(B) calculate the aggregate, median, and mean values of the contracts and the offsets, industrial participation agreements, and similar arrangements during the preceding 5-year period; and

(C) describe the impact of international or foreign sales of United States defense products and related offsets, industrial participation agreements, and similar arrangements on domestic prime contractors and, to the extent practicable, the first 3 tiers of domestic contractors and subcontractors during the preceding 5-year period in terms of domestic employment, including any job losses, on an annual basis.

(2) USE OF INTERNAL DOCUMENTS.—To the extent that the Department of Commerce is already in possession of relevant data, the Department shall use internal documents or existing departmental records to carry out paragraph (1).

(3) INFORMATION FROM NON-FEDERAL ENTITIES.—

(A) EXISTING INFORMATION.—In carrying out paragraph (1), the Secretary shall only require a non-Federal entity to provide information that is available through the existing data collection and reporting systems of that non-Federal entity.

(B) FORMAT.—The Secretary may require a non-Federal entity to provide information to the Secretary in the same form that is already provided to a foreign government in fulfilling an offset arrangement, industrial participation agreement, or similar arrangement.

(b) REPORT.—

(1) IN GENERAL.—Before the end of the 8-month period beginning on the date of enactment of this Act, the Secretary shall submit to Congress a report containing the findings and conclusions of the Secretary with regard to the examination made pursuant to subsection (a).

(2) COPIES OF REPORT.—The Secretary shall also transmit copies of the report prepared under paragraph (1) to the United States Trade Representative and the interagency team established pursuant to section 123(c) of the Defense Production Act Amendments of 1992 (50 U.S.C. App. 2099 note).

(c) RESPONSIBILITIES REGARDING CONSULTATION WITH FOREIGN NATIONS.—Section 123(c) of the Defense Production Act Amendments of 1992 (50 U.S.C. App. 2099 note) is amended to read as follows:

"(c) NEGOTIATIONS.—

"(1) INTERAGENCY TEAM.—

"(A) IN GENERAL.—It is the policy of Congress that the President shall designate a chairman of an interagency team comprised of the Secretary of Commerce, Secretary of Defense, United States Trade Representative, Secretary of Labor, and Secretary of State to consult with foreign nations on limiting the adverse effects of offsets in defense procurement without damaging the economy or the defense industrial base of the United States or United States defense production or defense preparedness.

"(B) MEETINGS.—The President shall direct the interagency team to meet on a quarterly basis.

"(C) REPORTS.—The President shall direct the interagency team to submit to Congress an annual report, to be included as part of the report required under section 309(a) of the Defense Production Act of 1950 (50 U.S.C. App. 2099(a)), that describes the results of the consultations of the interagency team under subparagraph (A) and the meetings of the interagency team under subparagraph (B).

"(2) RECOMMENDATIONS FOR MODIFICATIONS.—The interagency team shall submit to the President any recommendations for modifications of any existing or proposed memorandum of understanding between officials acting on behalf of the United States and 1 or more foreign countries (or any instrumentality of a foreign country) relating to—

"(A) research, development, or production of defense equipment; or

"(B) the reciprocal procurement of defense items.".

MENTAL HEALTH PARITY REAUTHORIZATION ACT OF 2003

Mr. FRIST. I ask unanimous consent that the Senate proceed to the immediate consideration of S. 1929, which was introduced earlier today.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

A bill (S. 1929) to amend the Employee Retirement Income Security Act of 1974 and the Public Health Service Act to extend the mental health benefits parity provisions, and for other purposes.

There being no objection, the Senate proceeded to consider the bill.

Mr. FRIST. I ask unanimous consent that the bill be read a third time and passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (S. 1929) was read the third time and passed, as follows:

S. 1929

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Mental Health Parity Reauthorization Act of 2003".

SEC. 2. EXTENSION OF MENTAL HEALTH PROVISIONS.

(a) ERISA.—Section 712(f) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a(f)) is amended by striking "December 31, 2003" and inserting "December 31, 2004".

(b) PHSA.—Section 2705(f) of the Public Health Service Act (42 U.S.C. 300gg-5(f)) is amended by striking "December 31, 2003" and inserting "December 31, 2004".

VETERANS' COMPENSATION COST-OF-LIVING ADJUSTMENT ACT OF 2003

Mr. FRIST. I ask unanimous consent that the Veterans Affairs Committee be discharged from further consideration of H.R. 1683 and the Senate proceed to its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (H.R. 1683) to increase, effective as of December 1, 2003, the rates of disability compensation for veterans with service-connected disabilities and the rates of dependency and indemnity compensation for survivors of certain service-connected disabled veterans, and for other purposes.

There being no objection, the Senate proceeded to consider the bill.

Mr. FRIST. I ask unanimous consent that the bill be read a third time and passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (H.R. 1683) was read the third time and passed.

SERVICEMEMBERS CIVIL RELIEF ACT

Mr. FRIST. I ask unanimous consent the Senate now proceed to the immediate consideration of Calendar No. 393, S. 1136.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 1136) to restate, clarify, and revise the Soldiers' and Sailors' Civil Relief Act of 1940.

There being no objection, the Senate proceeded to consider the bill which had been reported from the Committee on Veterans' Affairs, with an amendment to strike all after the enacting clause and insert in lieu thereof the following:

[Strike the part shown in black brackets and insert the part shown in italic.]

S. 1136

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

[SECTION 1. RESTATEMENT OF ACT.

[The Soldiers' and Sailors' Civil Relief Act of 1940 (50 U.S.C. App. 501 et seq.) is amended to read as follows:

[“SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

[“(a) SHORT TITLE.—This Act may be cited as the ‘Servicemembers Civil Relief Act’.

[“(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

[“Sec. 1. Short title; table of contents.
[“Sec. 2. Purposes.

[“TITLE I—GENERAL PROVISIONS

[“Sec. 101. Definitions.
[“Sec. 102. Jurisdiction and applicability of Act.
[“Sec. 103. Protection of persons secondarily liable.
[“Sec. 104. Extension of protections to citizens serving with allied forces.
[“Sec. 105. Notification of benefits.
[“Sec. 106. Extension of rights and protections to Reserves ordered to report for military service and to persons ordered to report for induction.
[“Sec. 107. Waiver of rights pursuant to written agreement.
[“Sec. 108. Exercise of rights under Act not to affect certain future financial transactions.
[“Sec. 109. Legal representatives.

[“TITLE II—GENERAL RELIEF

[“Sec. 201. Protection of servicemembers against default judgments.
[“Sec. 202. Stay of proceedings when servicemember defendant has notice.
[“Sec. 203. Fines and penalties under contracts.
[“Sec. 204. Stay or vacation of execution of judgments, attachments, and garnishments.
[“Sec. 205. Duration and term of stays; codefendants not in service.
[“Sec. 206. Statute of limitations.
[“Sec. 207. Maximum rate of interest on debts incurred before military service.

[“TITLE III—RENT, INSTALLMENT CONTRACTS, MORTGAGES, LIENS, ASSIGNMENT, LEASES.

[“Sec. 301. Evictions and distress.
[“Sec. 302. Protection under installment contracts for purchase or lease.
[“Sec. 303. Mortgages and trust deeds.
[“Sec. 304. Settlement of stayed cases relating to personal property.
[“Sec. 305. Termination of leases by lessees.
[“Sec. 306. Protection of life insurance policy.
[“Sec. 307. Enforcement of storage liens.
[“Sec. 308. Extension of protections to dependents.

[“TITLE IV—INSURANCE

[“Sec. 401. Definitions.
[“Sec. 402. Insurance rights and protections.
[“Sec. 403. Application for insurance protection.
[“Sec. 404. Policies entitled to protection and lapse of policies.
[“Sec. 405. Policy restrictions.
[“Sec. 406. Deduction of unpaid premiums.
[“Sec. 407. Premiums and interest guaranteed by United States.
[“Sec. 408. Regulations.
[“Sec. 409. Review of findings of fact and conclusions of law.

[“TITLE V—TAXES AND PUBLIC LANDS

[“Sec. 501. Taxes respecting personal property, money, credits, and real property.
[“Sec. 502. Rights in public lands.
[“Sec. 503. Desert-land entries.
[“Sec. 504. Mining claims.
[“Sec. 505. Mineral permits and leases.
[“Sec. 506. Perfection or defense of rights.
[“Sec. 507. Distribution of information concerning benefits of title.
[“Sec. 508. Land rights of servicemembers.
[“Sec. 509. Regulations.
[“Sec. 510. Income taxes.
[“Sec. 511. Residence for tax purposes.

[“TITLE VI—ADMINISTRATIVE REMEDIES

[“Sec. 601. Inappropriate use of Act.
[“Sec. 602. Certificates of service; persons reported missing.
[“Sec. 603. Interlocutory orders.

[“TITLE VII—FURTHER RELIEF

[“Sec. 701. Anticipatory relief.
[“Sec. 702. Power of attorney.
[“Sec. 703. Professional liability protection.
[“Sec. 704. Health insurance reinstatement.
[“Sec. 705. Guarantee of residency for military personnel.
[“Sec. 706. Business or trade obligations.
[“Sec. 707. Return to classes at no extra cost.

[“SEC. 2. PURPOSES.

[“The purposes of this Act are—

[“(1) to provide for, strengthen, and expedite the national defense through protection extended by this Act to servicemembers of the United States to enable such persons to devote their entire energy to the defense needs of the Nation; and

[“(2) to provide for the temporary suspension of judicial and administrative proceedings and transactions that may adversely affect the civil rights of servicemembers during their military service.

[“TITLE I—GENERAL PROVISIONS

[“SEC. 101. DEFINITIONS.

[“For the purposes of this Act:

[“(1) SERVICEMEMBER.—The term ‘servicemember’ means a member of the uniformed services, as that term is defined in section 101(a)(5) of title 10, United States Code.

[“(2) MILITARY SERVICE.—

[“(A) With respect to a member of the Army, Navy, Air Force, Marine Corps, or Coast Guard, the term ‘military service’ means active duty, as that term is defined in section 101(d)(1) of title 10, United States Code.

[“(B) Active service of commissioned officers of the Public Health Service or National Oceanic and Atmospheric Administration shall be deemed to be ‘military service’ for the purposes of this Act.

[“(C) Service of a member of the National Guard under a call to active service authorized by the President or the Secretary of Defense for a period of more than 30 consecutive days under section 502(f) of title 32, United States Code, for purposes of responding to a national emergency declared by the President and supported by Federal funds shall be deemed to be ‘military service’ for the purposes of this Act.

[“(3) PERIOD OF MILITARY SERVICE.—The term ‘period of military service’ means the period beginning on the date on which a servicemember enters military service and ending on the date on which the servicemember is released from military service or dies while in military service.

[“(4) DEPENDENT.—The term ‘dependent’, with respect to a servicemember, means—

[“(A) the servicemember's spouse;

[“(B) the servicemember's child (as defined in section 101(4) of title 38, United States Code); or

[“(C) an individual for whom the servicemember provided more than one-half of the individual's support for 180 days immediately preceding an application for relief under this Act.

[“(5) COURT.—The term ‘court’ means a court or an administrative agency of the United States or of any State (including any political subdivision of a State), whether or not a court or administrative agency of record.

[“(6) STATE.—The term ‘State’ includes—

[“(A) a commonwealth, territory, or possession of the United States; and

[“(B) the District of Columbia.

[“(7) SECRETARY CONCERNED.—The term ‘Secretary concerned’—

[“(A) with respect to a member of the armed forces, has the meaning given that term in section 101(a)(9) of title 10, United States Code;

[“(B) with respect to a commissioned officer of the Public Health Service, means the Secretary of Health and Human Services; and

[“(C) with respect to a commissioned officer of the National Oceanic and Atmospheric Administration, means the Secretary of Commerce.

[“(8) MOTOR VEHICLE.—The term ‘motor vehicle’ has the meaning given that term in section 30102(a)(6) of title 49, United States Code.

[“SEC. 102. JURISDICTION AND APPLICABILITY OF ACT.

[“(a) JURISDICTION.—This Act applies to—

[“(1) the United States;

[“(2) each of the States, including the political subdivisions thereof; and

[“(3) all territory subject to the jurisdiction of the United States.

[“(b) APPLICABILITY TO PROCEEDINGS.—This Act applies to any judicial or administrative proceeding commenced in any court or agency in any jurisdiction subject to this Act. This Act does not apply to criminal proceedings.

[“(c) COURT IN WHICH APPLICATION MAY BE MADE.—When under this Act any application is required to be made to a court in which no proceeding has already been commenced with respect to the matter, such application may be made to any court which would otherwise have jurisdiction over the matter.

[“SEC. 103. PROTECTION OF PERSONS SECONDARILY LIABLE.

[“(a) EXTENSION OF PROTECTION WHEN ACTIONS STAYED, POSTPONED, OR SUSPENDED.—Whenever pursuant to this Act a court stays, postpones, or suspends (1) the enforcement of an obligation or liability, (2) the prosecution of a suit or proceeding, (3) the entry or enforcement of an order, writ, judgment, or decree, or (4) the performance of any other act, the court may likewise grant such a stay, postponement, or suspension to a surety, guarantor, endorser, accommodation maker, comaker, or other person who is or may be primarily or secondarily subject to the obligation or liability the performance or enforcement of which is stayed, postponed, or suspended.

[“(b) VACATION OR SET-ASIDE OF JUDGMENTS.—When a judgment or decree is vacated or set aside, in whole or in part, pursuant to this Act, the court may also set aside or vacate, as the case may be, the judgment or decree as to a surety, guarantor, endorser, accommodation maker, comaker, or other person who is or may be primarily or secondarily liable on the contract or liability for the enforcement of the judgment or decree.

[“(c) BAIL BOND NOT TO BE ENFORCED DURING PERIOD OF MILITARY SERVICE.—A court may not enforce a bail bond during the period of military service of the principal on the bond when military service prevents the surety from obtaining the attendance of the principal. The court may discharge the surety and exonerate the bail, in accordance with principles of equity and justice, during or after the period of military service of the principal.

[“(d) WAIVER OF RIGHTS.—

[“(1) WAIVERS NOT PRECLUDED.—This Act does not prevent a waiver in writing by a surety, guarantor, endorser, accommodation maker, comaker, or other person (whether primarily or secondarily liable on an obligation or liability) of the protections provided under subsections (a) and (b). Any such waiver is effective only if it is executed as an instrument separate from the obligation or liability with respect to which it applies.

[“(2) WAIVER INVALIDATED UPON ENTRANCE TO MILITARY SERVICE.—If a waiver under paragraph (1) is executed by an individual who after the execution of the waiver enters military service, or by a dependent of an individual who after the execution of the waiver enters military service, the waiver is not valid after the beginning of the period of such military service unless the waiver was executed by such individual or dependent during the period specified in section 106.

[“SEC. 104. EXTENSION OF PROTECTIONS TO CITIZENS SERVING WITH ALLIED FORCES.

[“A citizen of the United States who is serving with the forces of a nation with which the United States is allied in the prosecution of a war or military action is entitled to the relief and protections provided under this Act if that service with the allied force is similar to military service as defined in this Act. The relief and protections provided to such citizen shall terminate on the date of discharge or release from such service.

[“SEC. 105. NOTIFICATION OF BENEFITS.

[“The Secretary concerned shall ensure that notice of the benefits accorded by this Act is provided to persons in military service and to persons entering military service.

[“SEC. 106. EXTENSION OF RIGHTS AND PROTECTIONS TO RESERVES ORDERED TO REPORT FOR MILITARY SERVICE AND TO PERSONS ORDERED TO REPORT FOR INDUCTION.

[“(a) RESERVES ORDERED TO REPORT FOR MILITARY SERVICE.—A member of a reserve component who is ordered to report for military service is entitled to the rights and protections of this title and titles II and III during the period beginning on the date of the member's receipt of the order and ending on the date on which the member reports for military service (or, if the order is revoked before the member so reports, or the date on which the order is revoked).

[“(b) PERSONS ORDERED TO REPORT FOR INDUCTION.—A person who has been ordered to report for induction under the Military Selective Service Act (50 U.S.C. App. 451 et seq.) is entitled to the rights and protections provided a servicemember under this title and titles II and III during the period beginning on the date of receipt of the order for induction and ending on the date on which the person reports for induction, on the date on which the order is revoked).

[“SEC. 107. WAIVER OF RIGHTS PURSUANT TO WRITTEN AGREEMENT.

[“(a) IN GENERAL.—A servicemember may waive any of the rights and protections provided by this Act. In the case of a waiver that permits an action described in subsection (b), the waiver is effective only if made pursuant to a written agreement of the parties that is executed during or after the servicemember's period of military service. The written agreement shall specify the legal instrument to which the waiver applies and, if the servicemember is not a party to that instrument, the servicemember concerned.

[“(b) ACTIONS REQUIRING WAIVERS IN WRITING.—The requirement in subsection (a) for a written waiver applies to the following:

[“(1) The modification, termination, or cancellation of—

[“(A) a contract, lease, or bailment; or

[“(B) an obligation secured by a mortgage, trust, deed, lien, or other security in the nature of a mortgage.

[“(2) The repossession, retention, foreclosure, sale, forfeiture, or taking possession of property that—

[“(A) is security for any obligation; or

[“(B) was purchased or received under a contract, lease, or bailment.

[“(c) COVERAGE OF PERIODS AFTER ORDERS RECEIVED.—For the purposes of this section—

[“(1) a person to whom section 106 applies shall be considered to be a servicemember; and

[“(2) the period with respect to such a person specified in subsection (a) or (b), as the case may be, of section 106 shall be considered to be a period of military service.

[“SEC. 108. EXERCISE OF RIGHTS UNDER ACT NOT TO AFFECT CERTAIN FUTURE FINANCIAL TRANSACTIONS.

[“Application by a servicemember for, or receipt by a servicemember of, a stay, postponement, or suspension pursuant to this Act in the payment of a tax, fine, penalty, insurance premium, or other civil obligation or liability of that servicemember shall not itself (without regard to other considerations) provide the basis for any of the following:

[“(1) A determination by a lender or other person that the servicemember is unable to pay the civil obligation or liability in accordance with its terms.

[“(2) With respect to a credit transaction between a creditor and the servicemember—

[“(A) a denial or revocation of credit by the creditor;

[“(B) a change by the creditor in the terms of an existing credit arrangement; or

[“(C) a refusal by the creditor to grant credit to the servicemember in substantially the amount or on substantially the terms requested.

[“(3) An adverse report relating to the creditworthiness of the servicemember by or to a person engaged in the practice of assembling or evaluating consumer credit information.

[“(4) A refusal by an insurer to insure the servicemember.

[“(5) An annotation in a servicemember's record by a creditor or a person engaged in the practice of assembling or evaluating consumer credit information, identifying the servicemember as a member of the National Guard or a reserve component.

[“(6) A change in the terms offered or conditions required for the issuance of insurance.

[“SEC. 109. LEGAL REPRESENTATIVES.

[“(a) REPRESENTATIVE.—A legal representative of a servicemember for purposes of this Act is either of the following:

[“(1) An attorney acting on the behalf of a servicemember.

[“(2) An individual possessing a power of attorney.

[“(b) APPLICATION.—Whenever the term ‘servicemember’ is used in this Act, such term shall be treated as including a reference to a legal representative of the servicemember.

[“TITLE II—GENERAL RELIEF

[“SEC. 201. PROTECTION OF SERVICEMEMBERS AGAINST DEFAULT JUDGMENTS.

[“(a) APPLICABILITY OF SECTION.—This section applies to any civil action or proceeding in which the defendant does not make an appearance.

[“(b) AFFIDAVIT REQUIREMENT.—

[“(1) PLAINTIFF TO FILE AFFIDAVIT.—In any action or proceeding covered by this section, the court, before entering judgment for the plaintiff, shall require the plaintiff to file with the court an affidavit—

[“(A) stating whether or not the defendant is in military service and showing necessary facts to support the affidavit; or

[“(B) if the plaintiff is unable to determine whether or not the defendant is in military service, stating that the plaintiff is unable to determine whether or not the defendant is in military service.

[“(2) Appointment of attorney to represent defendant in military service.—If in an action covered by this section it appears that the defendant is in military service, the court may not enter a judgment until after the court appoints an attorney to represent the defendant. If an attorney appointed under this section to represent a servicemember cannot locate the servicemember, actions by the attorney in the case shall not waive any defense of the servicemember or otherwise bind the servicemember.

[“(3) Defendant's military status not ascertained by affidavit.—If based upon the affidavits filed in such an action, the court is unable to determine whether the defendant is in military service, the court, before entering judgment, may require the plaintiff to file a bond in an amount approved by the court. If the defendant is later found to be in military service, the bond shall be available to indemnify the defendant against any loss or damage the defendant may suffer by reason of any judgment for the plaintiff against the defendant, should the judgment be set aside in whole or in part. The bond shall remain in effect until expiration of the time for appeal and setting aside of a judgment under applicable Federal or State law or regulation or under any applicable ordinance of a political subdivision of a State. The court may issue such orders or enter such judgments as the court determines necessary to protect the rights of the defendant under this Act.

[“(4) Satisfaction of requirement for affidavit.—The requirement for an affidavit under paragraph (1) may be satisfied by a statement, declaration, verification, or certificate, in writing, subscribed and certified or declared to be true under penalty of perjury.

[“(c) Penalty for Making or Using False Affidavit.—A person who makes or uses an affidavit permitted under subsection (b) (or a statement, declaration, verification, or certificate as authorized under subsection (b)(4)) knowing it to be false, shall be fined as provided in title 18, United States Code, imprisoned for not more than one year, or both.

[“(d) Stay of Proceedings.—In an action covered by this section in which the defendant is in military service, the court shall grant a stay of proceedings for a minimum period of 90 days under this subsection upon application of counsel, or on the court's own motion, if the court determines that—

[“(1) there may be a defense to the action and a defense cannot be presented without the presence of the defendant; or

[“(2) after due diligence, counsel has been unable to contact the defendant or otherwise determine if a meritorious defense exists.

[“(e) Inapplicability of Section 202 Procedures.—A stay of proceedings under subsection (d) shall not be controlled by procedures or requirements under section 202.

[“(f) Section 202 Protection.—If a servicemember who is a defendant in an action covered by this section receives actual notice of the action, the servicemember may request a stay of proceeding under section 202.

[“(g) Vacation or Setting Aside of Default Judgments.—

[“(1) Authority for court to vacate or set aside judgment.—If a default judgment is entered in an action covered by this section against a servicemember during the servicemember's period of military service (or within 60 days after termination of or release from such military service), the court entering the judgment shall, upon application by or on behalf of the servicemember, reopen the judgment for the purpose of allowing the servicemember to defend the action if it appears that—

[“(A) the servicemember was materially affected by reason of that military service in making a defense to the action; and

[“(B) the servicemember has a meritorious or legal defense to the action or some part of it.

[“(2) Time for filing application.—An application under this subsection must be filed not later than 90 days after the date of the termination of or release from military service.

[“(h) Protection of Bona Fide Purchaser.—If a court vacates, sets aside, or reverses a default judgment against a servicemember and the vacating, setting aside, or reversing is because of a provision of this Act, that action shall not impair a right or title acquired by a bona fide purchaser for value under the default judgment.

[“SEC. 202. STAY OF PROCEEDINGS WHEN SERVICEMEMBER DEFENDANT HAS NOTICE.

[“(a) Applicability of Section.—This section applies to any civil action or proceeding in which the defendant at the time of filing an application under this section—

[“(1) is in military service or is within 90 days after termination of or release from military service; and

[“(2) has received notice of the action or proceeding.

[“(b) Automatic Stay.—

[“(1) Authority for stay.—At any stage before final judgment in a civil action or proceeding in which a servicemember described in subsection (a) is a party, the court may on its own motion and shall, upon application by the servicemember, stay the action for a period of not less than 90 days, if the conditions in paragraph (2) are met.

[“(2) Conditions for stay.—An application for a stay under paragraph (1) shall include the following:

[“(A) A letter or other communication setting forth facts stating the manner in which current military duty requirements materially affect the servicemember's ability to appear and stating a date when the servicemember will be available to appear.

[“(B) A letter or other communication from the servicemember's commanding officer stating that the servicemember's current military duty prevents appearance and that military leave is not authorized for the servicemember at the time of the letter.

[“(c) Application Not a Waiver of Defenses.—An application for a stay by a servicemember or a servicemember's representative under this section does not constitute an appearance for jurisdictional purposes and does not constitute a waiver of any substantive or procedural defense (including a defense relating to lack of personal jurisdiction).

[“(d) Additional Stay.—

[“(1) Application.—A servicemember who is granted a stay of a civil action or proceeding under subsection (b) may apply for an additional stay based on continuing material affect of military duty on the servicemember's ability to appear. Such an application may be made by the servicemember at the time of the initial application under subsection (b) or when it appears that the servicemember is unavailable to prosecute or defend the action. The same information required under subsection (b)(2) shall be included in an application under this subsection.

[“(2) Appointment of counsel when additional stay refused.—If the court refuses to grant an additional stay of proceedings under paragraph (1), the court shall appoint counsel to represent the servicemember in the action or proceeding.

[“(e) Coordination With Section 201.—A servicemember who applies for a stay under this section and is unsuccessful may not seek the protections afforded by section 201.

[“(f) Inapplicability to Section 301.—The protections of this section do not apply to section 301.

[“SEC. 203. FINES AND PENALTIES UNDER CONTRACTS.

[“(a) Prohibition of Penalties.—When an action for compliance with the terms of a contract is stayed pursuant to this Act, a penalty shall not accrue for failure to comply with the terms of the contract during the period of the stay.

[“(b) Reduction or Waiver of Fines or Penalties.—If a servicemember fails to perform an obligation arising under a contract and a penalty is incurred arising from that nonperformance, a court may reduce or waive the fine or penalty if—

[“(1) the servicemember was in military service at the time the fine or penalty was incurred; and

[“(2) the ability of the servicemember to perform the obligation was materially affected by such military service.

[“SEC. 204. STAY OR VACATION OF EXECUTION OF JUDGMENTS, ATTACHMENTS, AND GARNISHMENTS.

[“(a) Court Action Upon Material Affect Determination.—If a servicemember, in the opinion of the court, is materially affected by reason of military service in complying with a court judgment or order, the court may on its own motion and shall on application by the servicemember—

[“(1) stay the execution of such judgment or order entered against the servicemember; and

[“(2) vacate or stay an attachment or garnishment of property, money, or debts in the possession of the servicemember or a third party, whether before or after such judgment.

[“(b) Applicability.—This section applies to an action or proceeding commenced in a court against a servicemember before or during the period of the servicemember's military service or within 60 days after such service terminates.

[“SEC. 205. DURATION AND TERM OF STAYS; CODEFENDANTS NOT IN SERVICE.

[“(a) Period of Stay.—A stay of an action, proceeding, attachment, or execution made pursuant to the provisions of this Act by a court may be ordered for the period of military service and 90 days thereafter, or for any part of that period. The court may set the terms and amounts for such installment payments as is considered reasonable by the court.

[“(b) Codefendants.—If the servicemember is a codefendant with others who are not in military service and who are not entitled to the relief and protections provided under this Act, the plaintiff may proceed against those other defendants with the approval of the court.

[“(c) Inapplicability of Section.—This section does not apply to sections 202 and 701.

[“SEC. 206. STATUTE OF LIMITATIONS.

[“(a) Tolling of Statutes of Limitation During Military Service.—The period of a servicemember's military service may not be included in computing any period limited by law, regulation, or order for the bringing of any action or proceeding in a court, or in any board, bureau, commission, department, or other agency of a State (or political subdivision of a State) or the United States by or against the servicemember or the servicemember's heirs, executors, administrators, or assigns.

[“(b) Redemption of Real Property.—A period of military service may not be included in computing any period provided by law for the redemption of real property sold or forfeited to enforce an obligation, tax, or assessment.

[“(c) Inapplicability to Internal Revenue Laws.—This section does not apply to any period of limitation prescribed by or under the internal revenue laws of the United States.

[“SEC. 207. MAXIMUM RATE OF INTEREST ON DEBTS INCURRED BEFORE MILITARY SERVICE.

[“(a) Interest Rate Limitation.—

[“(1) 6-percent limit.—An obligation or liability bearing interest at a rate in excess of 6 percent per year that is incurred by a servicemember, or the servicemember and the servicemember's spouse jointly, before the servicemember enters military service shall not bear interest at a rate in excess of 6 percent per year during the period of military service.

[“(2) Applicability to student loans.—Notwithstanding section 428(d) of the Higher Education Act of 1965 (20 U.S.C. 1078(d)), paragraph (1) applies with respect to an obligation or liability of a servicemember, or the servicemember and the servicemember's spouse jointly, entered into under the Higher Education Act of 1965 (20 U.S.C. 1001 et seq.)

[“(3) Forgiveness of interest in excess of 6 percent.—Interest at a rate in excess of 6 percent per year that would otherwise be incurred but for the prohibition in paragraph (1) is forgiven.

[“(4) Prevention of acceleration of principal.—The amount of any periodic payment due from a servicemember under the terms of the instrument that created an obligation or liability covered by this section shall be reduced by the amount of the interest forgiven under paragraph (3) that is allocable to the period for which such payment is made.

[“(b) Implementation of Limitation.—

[“(1) Written notice to creditor.—In order for an obligation or liability of a servicemember to be subject to the interest rate limitation in subsection (a), the servicemember shall provide to the creditor written notice and a copy of the military orders calling the servicemember to military service and any orders further extending military service, not later than 180 days after the date of the servicemember's termination or release from military service.

[“(2) Limitation effective as of date of order to active duty.—Upon receipt of written notice and a copy of orders calling a servicemember to military service, the creditor shall treat the debt in accordance with subsection (a), effective as of the date on which the servicemember is called to military service.

[“(c) Creditor Protection.—A court may grant a creditor relief from the limitations of this section if, in the opinion of the court, the ability of the servicemember to pay interest upon the obligation or liability at a rate in excess of 6 percent per year is not materially affected by reason of the servicemember's military service.

[“(d) Interest Defined.—As used in this section, the term 'interest' means simple interest plus service charges, renewal charges, fees, or any other charges (except bona fide insurance) with respect to an obligation or liability.

[“TITLE III—RENT, INSTALLMENT CONTRACTS, MORTGAGES, LIENS, ASSIGNMENT, LEASES

[“SEC. 301. EVICTIONS AND DISTRESS.

[“(a) Court-Ordered Eviction.—Except by court order, a landlord (or another person with paramount title) may not—

[“(1) evict a servicemember, or the dependents of a servicemember, during a period of military service of the servicemember, from premises—

[“(A) that are occupied or intended to be occupied primarily as a residence; and

[“(B) for which the monthly rent does not exceed the greater of—

[“(i) $1,950; or

[“(ii) the monthly basic allowance for housing to which the servicemember is entitled under section 403 of title 37, United States Code; or

[“(2) subject such premises to a distress during the period of military service.

[“(b) Stay of Execution.—

[“(1) Court authority.—Upon an application for eviction or distress with respect to premises covered by this section, the court may on its own motion and shall, if a request is made by or on behalf of a servicemember whose ability to pay the agreed rent is materially affected by military service—

[“(A) stay the proceedings for a period of 90 days, unless in the opinion of the court, justice and equity require a longer or shorter period of time; or

[“(B) adjust the obligation under the lease to preserve the interests of all parties.

[“(2) Relief to landlord.—If a stay is granted under paragraph (1), the court may grant to the landlord (or other person with paramount title) such relief as equity may require.

[“(c) Penalties.—

[“(1) Misdemeanor.—Except as provided in subsection (a), a person who knowingly takes part in an eviction or distress described in subsection (a), or who knowingly attempts to do so, shall be fined as provided in title 18, United States Code, imprisoned for not more than one year, or both.

[“(2) Preservation of other remedies and rights.—The remedies and rights provided under this section are in addition to and do not preclude any remedy for wrongful conversion (or wrongful eviction) otherwise available under the law to the person claiming relief under this section, including any award for consequential and punitive damages.

[“(d) Rent Allotment From Pay of Servicemember.—To the extent required by a court order related to property which is the subject of a court action under this section, the Secretary concerned shall make an allotment from the pay of a servicemember to satisfy the terms of such order, except that any such allotment shall be subject to regulations prescribed by the Secretary concerned establishing the maximum amount of pay of servicemembers that may be allotted under this subsection.

[“(e) Limitation of Applicability.—Section 202 is not applicable to this section.

[“SEC. 302. PROTECTION UNDER INSTALLMENT CONTRACTS FOR PURCHASE OR LEASE.

[“(a) Protection Upon Breach of Contract.—

[“(1) Protection after entering military service.—After a servicemember enters military service, a contract by the servicemember for—

[“(A) the purchase of real or personal property (including a motor vehicle); or

[“(B) the lease or bailment of such property,

may not be rescinded or terminated for a breach of terms of the contract occurring before or during that person's military service, nor may the property be repossessed for such breach without a court order.

[“(2) Applicability.—This section applies only to a contract for which a deposit or installment has been paid by the servicemember before the servicemember enters military service.

[“(b) Penalties.—

[“(1) Misdemeanor.—A person who knowingly resumes possession of property in violation of subsection (a), or in violation of section 108, or who knowingly attempts to do so, shall be fined as provided in title 18, United States Code, imprisoned for not more than one year, or both.

[“(2) Preservation of other remedies and rights.—The remedies and rights provided under this section are in addition to and do not preclude any remedy for wrongful conversion otherwise available under law to the person claiming relief under this section, including any award for consequential and punitive damages.

[“(c) Authority of Court.—In a hearing based on this section, the court—

[“(1) may order repayment to the servicemember of all or part of the prior installments or deposits as a condition of terminating the contract and resuming possession of the property;

[“(2) may, on its own motion, and shall on application by a servicemember when the servicemember's ability to comply with the contract is materially affected by military service, stay the proceedings for a period of time as, in the opinion of the court, justice and equity require; or

[“(3) may make other disposition as is equitable to preserve the interests of all parties.

[“SEC. 303. MORTGAGES AND TRUST DEEDS.

[“(a) Mortgage as Security.—This section applies only to an obligation on real or personal property owned by a servicemember that—

[“(1) originated before the period of the servicemember's military service and for which the servicemember is still obligated; and

[“(2) is secured by a mortgage, trust deed, or other security in the nature of a mortgage.

[“(b) Stay of Proceedings and Adjustment of Obligation.—In an action filed during, or within 90 days after, a servicemember's period of military service to enforce an obligation described in subsection (a), the court may after a hearing and on its own motion and shall upon application by a servicemember when the servicemember's ability to comply with the obligation is materially affected by military service—

[“(1) stay the proceedings for a period of time as justice and equity require, or

[“(2) adjust the obligation to preserve the interests of all parties.

[“(c) Sale or Foreclosure.—A sale, foreclosure, or seizure of property for a breach of an obligation described in subsection (a) shall not be valid if made during, or within 90 days after, the period of the servicemember's military service except—

[“(1) upon a court order granted before such sale, foreclosure, or seizure with a return made and approved by the court; or

[“(2) if made pursuant to an agreement as provided in section 108.

[''(d) Penalties.—

[''(1) Misdemeanor.—A person who knowingly makes or causes to be made a sale, foreclosure, or seizure of property that is prohibited by subsection (c), or who knowingly attempts to do so, shall be fined as provided in title 18, United States Code, imprisoned for not more than one year, or both.

[''(2) Preservation of other remedies.—The remedies and rights provided under this section are in addition to and do not preclude any remedy for wrongful conversion otherwise available under law to the person claiming relief under this section, including consequential and punitive damages.

["SEC. 304. SETTLEMENT OF STAYED CASES RELATING TO PERSONAL PROPERTY.

[''(a) Appraisal of Property.—When a stay is granted pursuant to this Act in a proceeding to foreclose a mortgage on or to repossess personal property, or to rescind or terminate a contract for the purchase of personal property, the court may appoint three disinterested parties to appraise the property.

[''(b) Equity Payment.—Based on the appraisal, and if undue hardship to the servicemember's dependents will not result, the court may order that the amount of the servicemember's equity in the property be paid to the servicemember, or the servicemember's dependents, as a condition of foreclosing the mortgage, repossessing the property, or rescinding or terminating the contract.

["SEC. 305. TERMINATION OF LEASES BY LESSEES.

[''(a) Covered Leases of Real Property.—This section applies to the lease of premises occupied, or intended to be occupied, by a servicemember or a servicemember's dependents for a residential, professional, business, agricultural, or similar purpose if—

[''(1) the lease is executed by or on behalf of a person who thereafter and during the term of the lease enters military service; or

[''(2) the servicemember, while in military service, executes a lease and thereafter receives military orders for a permanent change of station or to deploy with a military unit for a period of not less than 90 days.

[''(b) Covered Leases of Vehicles.—This section applies to the lease of a motor vehicle used, or intended to be used, by a servicemember or a servicemember's dependents if the lease is executed by or on behalf of a person who thereafter and during the term of the lease enters military service.

[''(c) Notice to Lessor.—

[''(1) Delivery of notice.—A lease described in subsection (a) or (b) is terminated when written notice is delivered by the lessee to the lessor (or the lessor's grantee) or to the lessor's agent (or the agent's grantee).

[''(2) Time for notice.—The written notice may be delivered at any time after the lessee's entry into military service or, in the case of a lease described in subsection (a), the date of the military orders for a permanent change of station or to deploy for a period of not less than 90 days.

[''(3) Nature of notice.—Delivery may be accomplished—

[''(A) by hand delivery;

[''(B) by private business carrier; or

[''(C) by placing the written notice in an envelope with sufficient postage and addressed to the lessor (or the lessor's grantee) or to the lessor's agent (or the agent's grantee) and depositing the written notice in the United States mails.

[''(d) Effective Date of Termination.—

[''(1) Lease with monthly rent.—Termination of a lease providing for monthly payment of rent shall be effective 30 days after the first date on which the next rental payment is due and payable after the date on which the notice is delivered.

[''(2) Other lease.—All other leases terminate on the last day of the month following the month in which the notice is delivered.

[''(e) Arrearages.—Rents or lease amounts unpaid for the period preceding termination shall be paid on a prorated basis.

[''(f) Amounts Paid in Advance.—Rents or lease amounts paid in advance for a period succeeding termination shall be refunded to the lessee by the lessor (or the lessor's assignee or the assignee's agent).

[''(g) Relief to Lessor.—Upon application by the lessor to a court before the termination date provided in the written notice, relief granted by this section to a servicemember may be modified as justice and equity require.

[''(h) Penalties.—

[''(1) Misdemeanor.—Any person who knowingly seizes, holds, or detains the personal effects, security deposit, or other property of a servicemember or a servicemember's dependent who lawfully terminates a lease covered by this section, or who knowingly interferes with the removal of such property from premises covered by such lease, for the purpose of subjecting or attempting to subject any of such property to a claim for rent or lease payments accruing after the date of termination of such lease, or attempts to do so, shall be fined as provided in title 18, United States Code, imprisoned for not more than one year, or both.

[''(2) Preservation of other remedies.—The remedy and rights provided under this section are in addition to and do not preclude any remedy for wrongful conversion otherwise available under law to the person claiming relief under this section, including any award for consequential or punitive damages.

["SEC. 306. PROTECTION OF LIFE INSURANCE POLICY.

[''(a) Assignment of Policy Protected.—If a life insurance policy on the life of a servicemember is assigned before military service to secure the payment of an obligation, the assignee of the policy (except the insurer in connection with a policy loan) may not exercise, during a period of military service of the servicemember or within one year thereafter, any right or option obtained under the assignment without a court order.

[''(b) Exception.—The prohibition in subsection (a) shall not apply—

[''(1) if the assignee has the written consent of the insured made during the period described in subsection (a);

[''(2) when the premiums on the policy are due and unpaid; or

[''(3) upon the death of the insured.

[''(c) Order Refused Because of Material Affect.—A court which receives an application for an order required under subsection (a) may refuse to grant such order if the court determines the ability of the servicemember to comply with the terms of the obligation is materially affected by military service.

[''(d) Treatment of Guaranteed Premiums.—For purposes of this subsection, premiums guaranteed under the provisions of title IV shall not be considered due and unpaid.

[''(e) Penalties.—

[''(1) Misdemeanor.—A person who knowingly takes an action contrary to this section, or attempts to do so, shall be fined as provided in title 18, United States Code, imprisoned for not more than one year, or both.

[''(2) Preservation of other remedies.—The remedy and rights provided under this section are in addition to and do not preclude any remedy for wrongful conversion otherwise available under law to the person claiming relief under this section, including any consequential or punitive damages.

["SEC. 307. ENFORCEMENT OF STORAGE LIENS.

[''(a) Liens.—

[''(1) Limitation on foreclosure or enforcement.—A person holding a lien on the property or effects of a servicemember may not, during any period of military service of the servicemember and for 90 days thereafter, foreclose or enforce any lien on such property or effects without a court order granted before foreclosure or enforcement.

[''(2) Lien defined.—For the purposes of paragraph (1), the term 'lien' includes a lien for storage, repair, or cleaning of the property or effects of a servicemember or a lien on such property or effects for any other reason.

[''(b) Stay of Proceedings.—In a proceeding to foreclose or enforce a lien subject to this section, the court may on its own motion, and shall if requested by a servicemember whose ability to comply with the obligation resulting in the proceeding is materially affected by military service—

[''(1) stay the proceeding for a period of time as justice and equity require; or

[''(2) adjust the obligation to preserve the interests of all parties.

The provisions of this subsection do not affect the scope of section 303.

[''(c) Penalties.—

[''(1) Misdemeanor.—A person who knowingly takes an action contrary to this section, or attempts to do so, shall be fined as provided in title 18, United States Code, imprisoned for not more than one year, or both.

[''(2) Preservation of other remedies.—The remedy and rights provided under this section are in addition to and do not preclude any remedy for wrongful conversion otherwise available under law to the person claiming relief under this section, including any consequential or punitive damages.

["SEC. 308. EXTENSION OF PROTECTIONS TO DEPENDENTS.

[''Upon application to a court, a dependent of a servicemember is entitled to the protections of this title if the dependent's ability to comply with a lease, contract, bailment, or other obligation is materially affected by reason of the servicemember's military service.

["TITLE IV—INSURANCE

["SEC. 401. DEFINITIONS.

[''For the purposes of this title:

[''(1) Policy.—The term 'policy' means any contract for whole, endowment, universal, or term life insurance, including any benefit in the nature of such insurance arising out of membership in any fraternal or beneficial association which—

[''(A) provides that the insurer may not—

[''(i) decrease the amount of coverage or increase the amount of premiums if the insured is in military service; or

[''(ii) limit or restrict coverage for any activity required by military service; and

[''(B) is in force not less than 180 days before the date of the insured's entry into military service and at the time of application under this title.

[''(2) Premium.—The term 'premium' means the amount specified in an insurance policy to be paid to keep the policy in force.

[“(3) INSURED.—The term ‘insured’ means a servicemember whose life is insured under a policy.

[“(4) INSURER.—The term ‘insurer’ includes any firm, corporation, partnership, association, or business that is chartered or authorized to provide insurance and issue contracts or policies by the laws of a State or the United States.

[“SEC. 402. INSURANCE RIGHTS AND PROTECTIONS.

[“(a) RIGHTS AND PROTECTIONS.—The rights and protections under this title apply to the insured when the insured, the insured's designee, or the insured's beneficiary applies in writing for protection under this title, unless the Secretary of Veterans Affairs determines that the insured's policy is not entitled to protection under this title.

[“(b) NOTIFICATION AND APPLICATION.—The Secretary of Veterans Affairs shall notify the Secretary concerned of the procedures to be used to apply for the protections provided under this title. The applicant shall send the original application to the insurer and a copy to the Secretary of Veterans Affairs.

[“(c) LIMITATION ON AMOUNT.—The total amount of life insurance coverage protection provided by this title for a servicemember may not exceed $250,000, or an amount equal to the Servicemember's Group Life Insurance maximum limit, whichever is greater, regardless of the number of policies submitted.

[“SEC. 403. APPLICATION FOR INSURANCE PROTECTION.

[“(a) APPLICATION PROCEDURE.—An application for protection under this title shall—

[“(1) be in writing and signed by the insured, the insured's designee, or the insured's beneficiary, as the case may be;

[“(2) identify the policy and the insurer; and

[“(3) include an acknowledgement that the insured's rights under the policy are subject to and modified by the provisions of this title.

[“(b) ADDITIONAL REQUIREMENTS.—The Secretary of Veterans Affairs may require additional information from the applicant, the insured, and the insurer to determine if the policy is entitled to protection under this title.

[“(c) NOTICE TO THE SECRETARY BY THE INSURED.—Upon receipt of the application of the insured, the insurer shall furnish a report concerning the policy to the Secretary of Veterans Affairs as required by regulations prescribed by the Secretary.

[“(d) POLICY MODIFICATION.—Upon application for protection under this title, the insured and the insurer shall have constructively agreed to any policy modification necessary to give this title full force and effect.

[“SEC. 404. POLICIES ENTITLED TO PROTECTION AND LAPSE OF POLICIES.

[“(a) DETERMINATION.—The Secretary of Veterans Affairs shall determine whether a policy is entitled to protection under this title and shall notify the insured and the insurer of that determination.

[“(b) LAPSE PROTECTION.—A policy that the Secretary determines is entitled to protection under this title shall not lapse or otherwise terminate or be forfeited for the nonpayment of a premium, or interest or indebtedness on a premium, after the date of the application for protection.

[“(c) TIME APPLICATION.—The protection provided by this title applies during the insured's period of military service and for a period of two years thereafter.

[“SEC. 405. POLICY RESTRICTIONS.

[“(a) DIVIDENDS.—While a policy is protected under this title, a dividend or other monetary benefit under a policy may not be paid to an insured or used to purchase dividend additions without the approval of the Secretary of Veterans Affairs. If such approval is not obtained, the dividends or benefits shall be added to the value of the policy to be used as a credit when final settlement is made with the insurer.

[“(b) SPECIFIC RESTRICTIONS.—While a policy is protected under this title, cash value, loan value, withdrawal of dividend accumulation, unearned premiums, or other value of similar character may not be available to the insured without the approval of the Secretary. The right of the insured to change a beneficiary designation or select an optional settlement for a beneficiary shall not be affected by the provisions of this title.

[“SEC. 406. DEDUCTION OF UNPAID PREMIUMS.

[“(a) SETTLEMENT OF PROCEEDS.—If a policy matures as a result of a servicemember's death or otherwise during the period of protection of the policy under this title, the insurer in making settlement shall deduct from the insurance proceeds the amount of the unpaid premiums guaranteed under this title, together with interest due at the rate fixed in the policy for policy loans.

[“(b) INTEREST RATE.—If the interest rate is not specifically fixed in the policy, the rate shall be the same as for policy loans in other policies issued by the insurer at the time the insured's policy was issued.

[“(c) REPORTING REQUIREMENT.—The amount deducted under this section, if any, shall be reported by the insurer to the Secretary of Veterans Affairs.

[“SEC. 407. PREMIUMS AND INTEREST GUARANTEED BY UNITED STATES.

[“(a) GUARANTEE OF PREMIUMS AND INTEREST BY THE UNITED STATES.—

[“(1) GUARANTEE.—Payment of premiums, and interest on premiums at the rate specified in section 406, which become due on a policy under the protection of this title is guaranteed by the United States. If the amount guaranteed is not paid to the insurer before the period of insurance protection under this title expires, the amount due shall be treated by the insurer as a policy loan on the policy.

[“(2) POLICY TERMINATION.—If, at the expiration of insurance protection under this title, the cash surrender value of a policy is less than the amount due to pay premiums and interest on premiums on the policy, the policy shall terminate. Upon such termination, the United States shall pay the insurer the difference between the amount due and the cash surrender value.

[“(b) RECOVERY FROM INSURED OF AMOUNTS PAID BY THE UNITED STATES.—

[“(1) DEBT PAYABLE TO THE UNITED STATES.—The amount paid by the United States to an insurer under this title shall be a debt payable to the United States by the insured on whose policy payment was made.

[“(2) COLLECTION.—Such amount may be collected by the United States, either as an offset from any amount due the insured by the United States or as otherwise authorized by law.

[“(3) DEBT NOT DISCHARGEABLE IN BANKRUPTCY.—Such debt payable to the United States is not dischargeable in bankruptcy proceedings.

[“(c) CREDITING OF AMOUNTS RECOVERED.—Any amounts received by the United States as repayment of debts incurred by an insured under this title shall be credited to the appropriation for the payment of claims under this title.

[“SEC. 408. REGULATIONS.

[“The Secretary of Veterans Affairs shall prescribe regulations for the implementation of this title.

[“SEC. 409. REVIEW OF FINDINGS OF FACT AND CONCLUSIONS OF LAW.

[“The findings of fact and conclusions of law made by the Secretary of Veterans Affairs in administering this title may be reviewed by the Board of Veterans' Appeals and the United States Court of Appeals for Veterans Claims.

[“TITLE V—TAXES AND PUBLIC LANDS

[“SEC. 501. TAXES RESPECTING PERSONAL PROPERTY, MONEY, CREDITS, AND REAL PROPERTY.

[“(a) APPLICATION.—This section applies in any case in which a tax or assessment, whether general or special (other than a tax on personal income), falls due and remains unpaid before or during a period of military service with respect to a servicemember's—

[“(1) personal property; or

[“(2) real property occupied for dwelling, professional, business, or agricultural purposes by a servicemember or the servicemember's dependents or employees—

[“(A) before the servicemember's entry into military service; and

[“(B) during the time the tax or assessment remains unpaid.

[“(b) SALE OF PROPERTY.—

[“(1) LIMITATION ON SALE OF PROPERTY TO ENFORCE TAX ASSESSMENT.—Property described in subsection (a) may not be sold to enforce the collection of such tax or assessment except by court order and upon the determination by the court that military service does not materially affect the servicemember's ability to pay the unpaid tax or assessment.

[“(2) STAY OF COURT PROCEEDINGS.—A court may stay a proceeding to enforce the collection of such tax or assessment, or sale of such property, during a period of military service of the servicemember and for a period not more than 180 days after the termination of, or release of the servicemember from, military service.

[“(c) REDEMPTION.—When property described in subsection (a) is sold or forfeited to enforce the collection of a tax or assessment, a servicemember shall have the right to redeem or commence an action to redeem the servicemember's property during the period of military service or within 180 days after termination of or release from military service. This subsection may not be construed to shorten any period provided by the law of a State (including any political subdivision of a State) for redemption.

[“(d) INTEREST ON TAX OR ASSESSMENT.—Whenever a servicemember does not pay a tax or assessment on property described in subsection (a) when due, the amount of the tax or assessment due and unpaid shall bear interest until paid at the rate of 6 percent per year. An additional penalty or interest shall not be incurred by reason of nonpayment. A lien for such unpaid tax or assessment may include interest under this subsection.

[“(e) JOINT OWNERSHIP APPLICATION.—This section applies to all forms of property described in subsection (a) owned individually by a servicemember or jointly by a servicemember and a dependent or dependents.

[“SEC. 502. RIGHTS IN PUBLIC LANDS.

[“(a) RIGHTS NOT FORFEITED.—The rights of a servicemember to lands owned or controlled by the United States, and initiated or acquired by the servicemember under the laws of the United States (including the mining and mineral leasing laws) before military service, shall not be forfeited or prejudiced as a result of being absent from the land, or by failing to begin or complete any work or improvements to the land, during the period of military service.

[“(b) Temporary Suspension of Permits or Licenses.—If a permittee or licensee under the Act of June 28, 1934 (43 U.S.C. 315 et seq.), enters military service, the permittee or licensee may suspend the permit or license for the period of military service and for 180 days after termination of or release from military service.

[“(c) Regulations.—Regulations prescribed by the Secretary of the Interior shall provide for such suspension of permits and licenses and for the remission, reduction, or refund of grazing fees during the period of such suspension.

[“SEC. 503. DESERT-LAND ENTRIES.

[“(a) Desert-Land Rights Not Forfeited.—A desert-land entry made or held under the desert-land laws before the entrance of the entryman or the entryman's successor in interest into military service shall not be subject to contest or cancellation—

[“(1) for failure to expend any required amount per acre per year in improvements upon the claim;

[“(2) for failure to effect the reclamation of the claim during the period the entryman or the entryman's successor in interest is in the military service, or for 180 days after termination of or release from military service; or

[“(3) during any period of hospitalization or rehabilitation due to an injury or disability incurred in the line of duty.

The time within which the entryman or claimant is required to make such expenditures and effect reclamation of the land shall be exclusive of the time periods described in paragraphs (2) and (3).

[“(b) Service-Related Disability.—If an entryman or claimant is honorably discharged and is unable to accomplish reclamation of, and payment for, desert land due to a disability incurred in the line of duty, the entryman or claimant may make proof without further reclamation or payments, under regulations prescribed by the Secretary of the Interior, and receive a patent for the land entered or claimed.

[“(c) Filing Requirement.—In order to obtain the protection of this section, the entryman or claimant shall, within 180 days after entry into military service, cause to be filed in the land office of the district where the claim is situated a notice communicating the fact of military service and the desire to hold the claim under this section.

[“SEC. 504. MINING CLAIMS.

[“(a) Requirements Suspended.—The provisions of section 2324 of the Revised Statutes of the United States (30 U.S.C. 28) specified in subsection (b) shall not apply to a servicemember's claims or interests in claims, regularly located and recorded, during a period of military service and 180 days thereafter, or during any period of hospitalization or rehabilitation due to injuries or disabilities incurred in the line of duty.

[“(b) Requirements.—The provisions in section 2324 of the Revised Statutes that shall not apply under subsection (a) are those which require that on each mining claim located after May 10, 1872, and until a patent has been issued for such claim, not less than $100 worth of labor shall be performed or improvements made during each year.

[“(c) Period of Protection From Forfeiture.—A mining claim or an interest in a claim owned by a servicemember that has been regularly located and recorded shall not be subject to forfeiture for nonperformance of annual assessments during the period of military service and for 180 days thereafter, or for any period of hospitalization or rehabilitation described in subsection (a).

[“(d) Filing Requirement.—In order to obtain the protections of this section, the claimant of a mining location shall, before the end of the assessment year in which military service is begun or within 60 days after the end of such assessment year, cause to be filed in the office where the location notice or certificate is recorded a notice communicating the fact of military service and the desire to hold the mining claim under this section.

[“SEC. 505. MINERAL PERMITS AND LEASES.

[“(a) Suspension During Military Service.—A person holding a permit or lease on the public domain under the Federal mineral leasing laws who enters military service may suspend all operations under the permit or lease for the duration of military service and for 180 days thereafter. The term of the permit or lease shall not run during the period of suspension, nor shall any rental or royalties be charged against the permit or lease during the period of suspension.

[“(b) Notification.—In order to obtain the protection of this section, the permittee or lessee shall, within 180 days after entry into military service, notify the Secretary of the Interior by registered mail of the fact that military service has begun and of the desire to hold the claim under this section.

[“(c) Contract Modification.—This section shall not be construed to supersede the terms of any contract for operation of a permit or lease.

[“SEC. 506. PERFECTION OR DEFENSE OF RIGHTS.

[“(a) Right To Take Action Not Affected.—This title shall not affect the right of a servicemember to take action during a period of military service that is authorized by law or regulations of the Department of the Interior, for the perfection, defense, or further assertion of rights initiated or acquired before entering military service.

[“(b) Affidavits and Proofs.—

[“(1) In general.—A servicemember during a period of military service may make any affidavit or submit any proof required by law, practice, or regulation of the Department of the Interior in connection with the entry, perfection, defense, or further assertion of rights initiated or acquired before entering military service before an officer authorized to provide notary services under section 1044a of title 10, United States Code, or any superior commissioned officer.

[“(2) Legal status of affidavits.—Such affidavits shall be binding in law and subject to the same penalties as prescribed by section 1001 of title 18, United State Code.

[“SEC. 507. DISTRIBUTION OF INFORMATION CONCERNING BENEFITS OF TITLE.

[“(a) Distribution of Information by Secretary Concerned.—The Secretary concerned shall issue to servicemembers information explaining the provisions of this title.

[“(b) Application Forms.—The Secretary concerned shall provide application forms to servicemembers requesting relief under this title.

[“(c) Information From Secretary of the Interior.—The Secretary of the Interior shall furnish to the Secretary concerned information explaining the provisions of this title (other than sections 501, 510, and 511) and related application forms.

[“SEC. 508. LAND RIGHTS OF SERVICEMEMBERS.

[“(a) No Age Limitations.—Any servicemember under the age of 21 in military service shall be entitled to the same rights under the laws relating to lands owned or controlled by the United States, including mining and mineral leasing laws, as those servicemembers who are 21 years of age.

[“(b) Residency Requirement.—Any requirement related to the establishment of a residence within a limited time shall be suspended as to entry by a servicemember in military service until 180 days after termination of or release from military service.

[“(c) Entry Applications.—Applications for entry may be verified before a person authorized to administer oaths under section 1044a of title 10, United States Code, or under the laws of the State where the land is situated.

[“SEC. 509. REGULATIONS.

[“The Secretary of the Interior may issue regulations necessary to carry out this title (other than sections 501, 510, and 511).

[“SEC. 510. INCOME TAXES.

[“(a) Deferral of Tax.—Upon notice to the Internal Revenue Service or the tax authority of a State or a political subdivision of a State, the collection of income tax on the income of a servicemember falling due before or during military service shall be deferred for a period not more than 180 days after termination of or release from military service, if a servicemember's ability to pay such income tax is materially affected by military service.

[“(b) Accrual of Interest or Penalty.—No interest or penalty shall accrue for the period of deferment by reason of nonpayment on any amount of tax deferred under this section.

[“(c) Statute of Limitations.—The running of a statute of limitations against the collection of tax deferred under this section, by seizure or otherwise, shall be suspended for the period of military service of the servicemember and for an additional period of 270 days thereafter.

[“(d) Application Limitation.—This section shall not apply to the tax imposed on employees by section 3101 of the Internal Revenue Code of 1986.

[“SEC. 511. RESIDENCE FOR TAX PURPOSES.

[“(a) Residence or Domicile.—A servicemember shall neither lose nor acquire a residence or domicile for purposes of taxation with respect to the person, personal property, or income of the servicemember by reason of being absent or present in any tax jurisdiction of the United States solely in compliance with military orders.

[“(b) Military Service Compensation.—Compensation of a servicemember for military service shall not be deemed to be income for services performed or from sources within a tax jurisdiction of the United States if the servicemember is not a resident or domiciliary of the jurisdiction in which the servicemember is serving in compliance with military orders.

[“(c) Personal Property.—

[“(1) Relief from personal property taxes.—The personal property of a servicemember shall not be deemed to be located or present in, or to have a situs for taxation in, the tax jurisdiction in which the servicemember is serving in compliance with military orders.

[“(2) Exception for property within member's domicile or residence.—This subsection applies to personal property or its use within any tax jurisdiction other than the servicemember's domicile or residence.

[“(3) EXCEPTION FOR PROPERTY USED IN TRADE OR BUSINESS.—This section does not prevent taxation by a tax jurisdiction with respect to personal property used in or arising from a trade or business, if it has jurisdiction.

[“(4) RELATIONSHIP TO LAW OF STATE OF DOMICILE.—Eligibility for relief from personal property taxes under this subsection is not contingent on whether or not such taxes are paid to the State of domicile.

[“(d) Increase of Tax Liability.—A tax jurisdiction may not use the military compensation of a nonresident servicemember to increase the tax liability imposed on other income earned by the nonresident servicemember or spouse subject to tax by the jurisdiction.

[“(e) Federal Indian Reservations.—An Indian servicemember whose legal residence or domicile is a Federal Indian reservation shall be taxed by the laws applicable to Federal Indian reservations and not the State where the reservation is located.

[“(f) Definitions.—For purposes of this section:

[“(1) Personal property.—The term ‘personal property’ means intangible and tangible property (including motor vehicles).

[“(2) Taxation.—The term ‘taxation’ includes licenses, fees, or excises imposed with respect to motor vehicles and their use, if the license, fee, or excise is paid by the servicemember in the servicemember's State of domicile or residence.

[“(3) Tax jurisdiction.—The term ‘tax jurisdiction’ means a State or a political subdivision of a State.

[“TITLE VI—ADMINISTRATIVE REMEDIES

[“SEC. 601. INAPPROPRIATE USE OF ACT.

[“If a court determines, in any proceeding to enforce a civil right, that any interest, property, or contract has been transferred or acquired with the intent to delay the just enforcement of such right by taking advantage of this Act, the court shall enter such judgment or make such order as might lawfully be entered or made concerning such transfer or acquisition.

[“SEC. 602. CERTIFICATES OF SERVICE; PERSONS REPORTED MISSING.

[“(a) Prima Facie Evidence.—In any proceeding under this Act, a certificate signed by the Secretary concerned is prima facie evidence as to any of the following facts stated in the certificate:

[“(1) That a person named is, is not, has been, or has not been in military service.

[“(2) The time and the place the person entered military service.

[“(3) The person's residence at the time the person entered military service.

[“(4) The rank, branch, and unit of military service of the person upon entry.

[“(5) The inclusive dates of the person's military service.

[“(6) The monthly pay received by the person at the date of the certificate's issuance.

[“(7) The time and place of the person's termination of or release from military service, or the person's death during military service.

[“(b) Certificates.—The Secretary concerned shall furnish a certificate under subsection (a) upon receipt of an application for such a certificate. A certificate appearing to be signed by the Secretary concerned is prima facie evidence of its contents and of the signer's authority to issue it.

[“(c) Treatment of Servicemembers in Missing Status.—A servicemember who has been reported missing is presumed to continue in service until accounted for. A requirement under this Act that begins or ends with the death of a servicemember does not begin or end until the servicemember's death is reported to, or determined by, the Secretary concerned or by a court of competent jurisdiction.

[“SEC. 603. INTERLOCUTORY ORDERS.

[“An interlocutory order issued by a court under this Act may be revoked, modified, or extended by the court upon its own motion or otherwise, upon notification to affected parties as required by the court.

[“TITLE VII—FURTHER RELIEF

[“SEC. 701. ANTICIPATORY RELIEF.

[“(a) Application for Relief.—A servicemember may, during military service or within 180 days of termination of or release from military service, apply to a court for relief—

[“(1) from any obligation or liability incurred by the servicemember before the servicemember's military service; or

[“(2) from a tax or assessment falling due before or during the servicemember's military service.

[“(b) Tax Liability or Assessment.—In a case covered by subsection (a), the court may, if the ability of the servicemember to comply with the terms of such obligation or liability or pay such tax or assessment has been materially affected by reason of military service, after appropriate notice and hearing, grant the following relief:

[“(1) STAY OF ENFORCEMENT OF REAL ESTATE CONTRACTS.—

[“(A) In the case of an obligation payable in installments under a contract for the purchase of real estate, or secured by a mortgage or other instrument in the nature of a mortgage upon real estate, the court may grant a stay of the enforcement of the obligation—

[“(i) during the servicemember's period of military service; and

[“(ii) from the date of termination of or release from military service, or from the date of application if made after termination of or release from military service.

[“(B) Any stay under this paragraph shall be—

[“(i) for a period equal to the remaining life of the installment contract or other instrument, plus a period of time equal to the period of military service of the servicemember, or any part of such combined period; and

[“(ii) subject to payment of the balance of the principal and accumulated interest due and unpaid at the date of termination or release from the applicant's military service or from the date of application in equal installments during the combined period at the rate of interest on the unpaid balance prescribed in the contract or other instrument evidencing the obligation, and subject to other terms as may be equitable.

[“(2) STAY OF ENFORCEMENT OF OTHER CONTRACTS.—

[“(A) In the case of any other obligation, liability, tax, or assessment, the court may grant a stay of enforcement—

[“(i) during the servicemember's military service; and

[“(ii) from the date of termination of or release from military service, or from the date of application if made after termination or release from military service.

[“(B) Any stay under this paragraph shall be—

[“(i) for a period of time equal to the period of the servicemember's military service or any part of such period; and

[“(ii) subject to payment of the balance of principal and accumulated interest due and unpaid at the date of termination or release from military service, or the date of application, in equal periodic installments during this extended period at the rate of interest as may be prescribed for this obligation, liability, tax, or assessment, if paid when due, and subject to other terms as may be equitable.

[“(c) Affect of Stay on Fine or Penalty.—When a court grants a stay under this section, a fine or penalty shall not accrue on the obligation, liability, tax, or assessment for the period of compliance with the terms and conditions of the stay.

[“SEC. 702. POWER OF ATTORNEY.

[“(a) Automatic Extension.—A power of attorney of a servicemember shall be automatically extended for the period the servicemember is in a missing status (as defined in section 551(2) of title 37, United States Code) if the power of attorney—

[“(1) was duly executed by the servicemember—

[“(A) while in military service; or

[“(B) before entry into military service but after the servicemember—

[“(i) received a call or order to report for military service; or

[“(ii) was notified by an official of the Department of Defense that the person could receive a call or order to report for military service;

[“(2) designates the servicemember's spouse, parent, or other named relative as the servicemember's attorney in fact for certain, specified, or all purposes; and

[“(3) expires by its terms after the servicemember entered a missing status.

[“(b) Limitation on Power of Attorney Extension.—A power of attorney executed by a servicemember may not be extended under subsection (a) if the document by its terms clearly indicates that the power granted expires on the date specified even though the servicemember, after the date of execution of the document, enters a missing status.

[“SEC. 703. PROFESSIONAL LIABILITY PROTECTION.

[“(a) Applicability.—This section applies to a servicemember who—

[“(1) after July 31, 1990, is ordered to active duty (other than for training) pursuant to sections 688, 12301(a), 12301(g), 12302, 12304, 12306, or 12307 of title 10, United States Code, or who is ordered to active duty under section 12301(d) of such title during a period when members are on active duty pursuant to any of the preceding sections; and

[“(2) immediately before receiving the order to active duty—

[“(A) was engaged in the furnishing of health-care or legal services or other services determined by the Secretary of Defense to be professional services; and

[“(B) had in effect a professional liability insurance policy that does not continue to cover claims filed with respect to the servicemember during the period of the servicemember's active duty unless the premiums are paid for such coverage for such period.

[“(b) Suspension of Coverage.—

[“(1) Suspension.—Coverage of a servicemember referred to in subsection (a) by a professional liability insurance policy shall be suspended by the insurance carrier in accordance with this subsection upon receipt of a written request from the servicemember, or the servicemember's legal representative, by the insurance carrier.

[“(2) PREMIUMS FOR SUSPENDED CONTRACTS.—A professional liability insurance carrier—

[“(A) may not require that premiums be paid by or on behalf of a servicemember for any professional liability insurance coverage suspended pursuant to paragraph (1); and

[“(B) shall refund any amount paid for coverage for the period of such suspension or, upon the election of such servicemember, apply such amount for the payment of any premium becoming due upon the reinstatement of such coverage.

[“(3) Nonliability of carrier during suspension.—A professional liability insurance carrier shall not be liable with respect to any claim that is based on professional conduct (including any failure to take any action in a professional capacity) of a servicemember that occurs during a period of suspension of that servicemember's professional liability insurance under this subsection.

[“(4) Certain claims considered to arise before suspension.—For the purposes of paragraph (3), a claim based upon the failure of a professional to make adequate provision for a patient, client, or other person to receive professional services or other assistance during the period of the professional's active duty service shall be considered to be based on an action or failure to take action before the beginning of the period of the suspension of professional liability insurance under this subsection, except in a case in which professional services were provided after the date of the beginning of such period.

[“(c) Reinstatement of Coverage.—

[“(1) Reinstatement required.—Professional liability insurance coverage suspended in the case of any servicemember pursuant to subsection (b) shall be reinstated by the insurance carrier on the date on which that servicemember transmits to the insurance carrier a written request for reinstatement.

[“(2) Time and premium for reinstatement.—The request of a servicemember for reinstatement shall be effective only if the servicemember transmits the request to the insurance carrier within 30 days after the date on which the servicemember is released from active duty. The insurance carrier shall notify the servicemember of the due date for payment of the premium of such insurance. Such premium shall be paid by the servicemember within 30 days after receipt of that notice.

[“(3) Period of reinstated coverage.—The period for which professional liability insurance coverage shall be reinstated for a servicemember under this subsection may not be less than the balance of the period for which coverage would have continued under the insurance policy if the coverage had not been suspended.

[“(d) Increase in Premium.—

[“(1) Limitation on premium increases.—An insurance carrier may not increase the amount of the premium charged for professional liability insurance coverage of any servicemember for the minimum period of the reinstatement of such coverage required under subsection (c)(3) to an amount greater than the amount chargeable for such coverage for such period before the suspension.

[“(2) Exception.—Paragraph (1) does not prevent an increase in premium to the extent of any general increase in the premiums charged by that carrier for the same professional liability coverage for persons similarly covered by such insurance during the period of the suspension.

[“(e) Continuation of Coverage of Unaffected Persons.—This section does not—

[“(1) require a suspension of professional liability insurance protection for any person who is not a person referred to in subsection (a) and who is covered by the same professional liability insurance as a person referred to in such subsection; or

[“(2) relieve any person of the obligation to pay premiums for the coverage not required to be suspended.

[“(f) Stay of Civil or Administrative Actions.—

[“(1) Stay of actions.—A civil or administrative action for damages on the basis of the alleged professional negligence or other professional liability of a servicemember whose professional liability insurance coverage has been suspended under subsection (b) shall be stayed until the end of the period of the suspension if—

[“(A) the action was commenced during the period of the suspension;

[“(B) the action is based on an act or omission that occurred before the date on which the suspension became effective; and

[“(C) the suspended professional liability insurance would, except for the suspension, on its face cover the alleged professional negligence or other professional liability negligence or other professional liability of the servicemember.

[“(2) Date of commencement of action.—Whenever a civil or administrative action for damages is stayed under paragraph (1) in the case of any servicemember, the action shall have been deemed to have been filed on the date on which the professional liability insurance coverage of the servicemember is reinstated under subsection (c).

[“(g) Effect of Suspension Upon Limitations Period.—In the case of a civil or administrative action for which a stay could have been granted under subsection (f) by reason of the suspension of professional liability insurance coverage of the defendant under this section, the period of the suspension of the coverage shall be excluded from the computation of any statutory period of limitation on the commencement of such action.

[“(h) Death During Period of Suspension.—If a servicemember whose professional liability insurance coverage is suspended under subsection (b) dies during the period of the suspension—

[“(1) the requirement for the grant or continuance of a stay in any civil or administrative action against such servicemember under subsection (f)(1) shall terminate on the date of the death of such servicemember; and

[“(2) the carrier of the professional liability insurance so suspended shall be liable for any claim for damages for professional negligence or other professional liability of the deceased servicemember in the same manner and to the same extent as such carrier would be liable if the servicemember had died while covered by such insurance but before the claim was filed.

[“(i) Definitions.—For purposes of this section:

[“(1) The term ‘active duty’ has the meaning given that term in section 101(d)(1) of title 10, United States Code.

[“(2) The term ‘profession’ includes occupation.

[“(3) The term ‘professional’ includes occupational.

[“SEC. 704. HEALTH INSURANCE REINSTATEMENT.

[“(a) Reinstatement of Health Insurance.—A servicemember who, by reason of military service as defined in section 703(a)(1), is entitled to the rights and protections of this Act shall also be entitled upon termination or release from such service to reinstatement of any health insurance that—

[“(1) was in effect on the day before such service commenced; and

[“(2) was terminated effective on a date during the period of such service.

[“(b) No Exclusion or Waiting Period.—The reinstatement of health care insurance coverage for the health or physical condition of a servicemember described in subsection (a), or any other person who is covered by the insurance by reason of the coverage of the servicemember, shall not be subject to an exclusion or a waiting period, if—

[“(1) the condition arose before or during the period of such service;

[“(2) an exclusion or a waiting period would not have been imposed for the condition during the period of coverage; and

[“(3) if the condition relates to the servicemember, the condition has not been determined by the Secretary of Veterans Affairs to be a disability incurred or aggravated in the line of duty (within the meaning of section 105 of title 38, United States Code).

[“(c) Exceptions.—Subsection (a) does not apply to a servicemember entitled to participate in employer-offered insurance benefits pursuant to the provisions of chapter 43 of title 38, United States Code.

[“(d) Time for Applying for Reinstatement.—An application under this section must be filed not later than 120 days after the date of the termination of or release from military service.

[“SEC. 705. GUARANTEE OF RESIDENCY FOR MILITARY PERSONNEL.

[“For the purposes of voting for any Federal office (as defined in section 301 of the Federal Election Campaign Act of 1971 (2 U.S.C. 431)) or a State or local office, a person who is absent from a State in compliance with military or naval orders shall not, solely by reason of that absence—

[“(1) be deemed to have lost a residence or domicile in that State, without regard to whether or not the person intends to return to that State;

[“(2) be deemed to have acquired a residence or domicile in any other State; or

[“(3) be deemed to have become a resident in or a resident of any other State.

[“SEC. 706. BUSINESS OR TRADE OBLIGATIONS.

[“(a) Availability of Non-Business Assets To Satisfy Obligations.—If the trade or business (without regard to the form in which such trade or business is carried out) of a servicemember has an obligation or liability for which the servicemember is personally liable, the assets of the servicemember not held in connection with the trade or business may not be available for satisfaction of the obligation or liability during the servicemember's military service.

[“(b) Relief to Obligors.—Upon application to a court by the holder of an obligation or liability covered by this section, relief granted by this section to a servicemember may be modified as justice and equity require.

[“SEC. 707. RETURN TO CLASSES AT NO ADDITIONAL COST.

[“(a) In General.—Each institution of higher education that receives Federal assistance or participates in a program assisted under the Higher Education Act of 1965 (20 U.S.C. 1001 et seq.) shall permit each student who is enrolled in the institution and enters into military service—

[“(1) to return to the institution of higher education after completion of the period of military service; and

[“(2) complete, at no additional cost, each class the student was unable to complete as a result of the period of military service.

[“(b) Institution of Higher Education Defined.—In this section, the term ‘institution of higher education’ has the meaning given the term in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001).''.

[SEC. 2. CONFORMING AMENDMENTS.

[(a) MILITARY SELECTIVE SERVICE ACT.—Section 14 of the Military Selective Service Act (50 U.S.C. App. 464) is repealed.

[(b) TITLE 5, UNITED STATES CODE.—(1) Section 5520a(k)(2)(A) of title 5, United States Code, is amended by striking ''Soldiers' and Sailors' Civil Relief Act of 1940'' and inserting ''Servicemembers Civil Relief Act''; and

[(2) Section 5569(e) of title 5, United States Code, is amended—

[(A) in paragraph (1), by striking ''provided by the Soldiers' and Sailors' Civil Relief Act of 1940'' and all that follows through ''of such Act'' and inserting ''provided by the Servicemembers Civil Relief Act, including the benefits provided by section 702 of such Act but excluding the benefits provided by sections 104 and 106, title IV, and title V (other than sections 501 and 510) of such Act''; and

[(B) in paragraph (2), by striking ''person in the military service'' and inserting ''servicemember''.

[(c) TITLE 10, UNITED STATES CODE.—Section 1408(b)(1)(D) of title 10, United States Code, is amended by striking ''Soldiers' and Sailors' Civil Relief Act of 1940'' and inserting ''Servicemembers Civil Relief Act''.

[(d) INTERNAL REVENUE CODE.—Section 7654(d)(1) of the Internal Revenue Code of 1986 is amended by striking ''Soldiers' and Sailors' Civil Relief Act'' and inserting ''Servicemembers Civil Relief Act''.

[(e) PUBLIC LAW 91–621.—Section 3(a)(3) of Public Law 91–621 (33 U.S.C. 857–3(a)(3)) is amended by striking ''Soldiers' and Sailors' Civil Relief Act of 1940, as amended'' and inserting ''Servicemembers Civil Relief Act''.

[(f) PUBLIC HEALTH SERVICE ACT.—Section 212(e) of the Public Health Service Act (42 U.S.C. 213(e)) is amended by striking ''Soldiers' and Sailors' Civil Relief Act of 1940'' and inserting ''Servicemembers Civil Relief Act''.

[(g) ELEMENTARY AND SECONDARY EDUCATION ACT OF 1965.—Section 8001 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7701) is amended by striking ''section 514 of the Soldiers' and Sailors' Civil Relief Act of 1940 (50 U.S.C. App. 574)'' in the matter preceding paragraph (1) and inserting ''section 511 of the Servicemembers Civil Relief Act''.

[SEC. 3. EFFECTIVE DATE.

[The amendment made by section 1 shall apply to any case decided after the date of the enactment of this Act.]

SECTION 1. RESTATEMENT OF ACT.

The Soldiers' and Sailors' Civil Relief Act of 1940 (50 U.S.C. App. 501 et seq.) is amended to read as follows:

"SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

''(a) SHORT TITLE.—This Act may be cited as the 'Servicemembers Civil Relief Act'.

''(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

''Sec. 1. Short title; table of contents.
''Sec. 2. Purpose.

''TITLE I—GENERAL PROVISIONS

''Sec. 101. Definitions.
''Sec. 102. Jurisdiction and applicability of Act.
''Sec. 103. Protection of persons secondarily liable.
''Sec. 104. Extension of protections to citizens serving with allied forces.
''Sec. 105. Notification of benefits.
''Sec. 106. Extension of rights and protections to Reserves ordered to report for military service and to persons ordered to report for induction.
''Sec. 107. Waiver of rights pursuant to written agreement.
''Sec. 108. Exercise of rights under Act not to affect certain future financial transactions.
''Sec. 109. Legal representatives.

''TITLE II—GENERAL RELIEF

''Sec. 201. Protection of servicemembers against default judgments.
''Sec. 202. Stay of proceedings when servicemember has notice.
''Sec. 203. Fines and penalties under contracts.
''Sec. 204. Stay or vacation of execution of judgments, attachments, and garnishments.
''Sec. 205. Duration and term of stays; codefendants not in service.
''Sec. 206. Statute of limitations.
''Sec. 207. Maximum rate of interest on debts incurred before military service.

''TITLE III—RENT, INSTALLMENT CONTRACTS, MORTGAGES, LIENS, ASSIGNMENT, LEASES

''Sec. 301. Evictions and distress.
''Sec. 302. Protection under installment contracts for purchase or lease.
''Sec. 303. Mortgages and trust deeds.
''Sec. 304. Settlement of stayed cases relating to personal property.
''Sec. 305. Termination of residential or motor vehicle leases.
''Sec. 306. Protection of life insurance policy.
''Sec. 307. Enforcement of storage liens.
''Sec. 308. Extension of protections to dependents.

''TITLE IV—LIFE INSURANCE

''Sec. 401. Definitions.
''Sec. 402. Insurance rights and protections.
''Sec. 403. Application for insurance protection.
''Sec. 404. Policies entitled to protection and lapse of policies.
''Sec. 405. Policy restrictions.
''Sec. 406. Deduction of unpaid premiums.
''Sec. 407. Premiums and interest guaranteed by United States.
''Sec. 408. Regulations.
''Sec. 409. Review of findings of fact and conclusions of law.

''TITLE V—TAXES AND PUBLIC LANDS

''Sec. 501. Taxes respecting personal property, money, credits, and real property.
''Sec. 502. Rights in public lands.
''Sec. 503. Desert-land entries.
''Sec. 504. Mining claims.
''Sec. 505. Mineral permits and leases.
''Sec. 506. Perfection or defense of rights.
''Sec. 507. Distribution of information concerning benefits of title.
''Sec. 508. Land rights of servicemembers.
''Sec. 509. Regulations.
''Sec. 510. Income taxes.
''Sec. 511. Residence for tax purposes.

''TITLE VI—ADMINISTRATIVE REMEDIES

''Sec. 601. Inappropriate use of Act.
''Sec. 602. Certificates of service; persons reported missing.
''Sec. 603. Interlocutory orders.

''TITLE VII—FURTHER RELIEF

''Sec. 701. Anticipatory relief.
''Sec. 702. Power of attorney.
''Sec. 703. Professional liability protection.
''Sec. 704. Health insurance reinstatement.
''Sec. 705. Guarantee of residency for military personnel.
''Sec. 706. Business or trade obligations.

"SEC. 2. PURPOSE.

''The purposes of this Act are—

''(1) to provide for, strengthen, and expedite the national defense through protection extended by this Act to servicemembers of the United States to enable such persons to devote their entire energy to the defense needs of the Nation; and

''(2) to provide for the temporary suspension of judicial and administrative proceedings and transactions that may adversely affect the civil rights of servicemembers during their military service.

"TITLE I—GENERAL PROVISIONS

"SEC. 101. DEFINITIONS.

''For the purposes of this Act:

''(1) SERVICEMEMBER.—The term 'servicemember' means a member of the uniformed services, as that term is defined in section 101(a)(5) of title 10, United States Code.

''(2) MILITARY SERVICE.—The term 'military service' means—

''(A) in the case of a servicemember who is a member of the Army, Navy, Air Force, Marine Corps, or Coast Guard—

''(i) active duty, as defined in section 101(d)(1) of title 10, United States Code, and

''(ii) in the case of a member of the National Guard, includes service under a call to active service authorized by the President or the Secretary of Defense for a period of more than 30 consecutive days under section 502(f) of title 32, United States Code, for purposes of responding to a national emergency declared by the President and supported by Federal funds;

''(B) in the case of a servicemember who is a commissioned officer of the Public Health Service or the National Oceanic and Atmospheric Administration, active service; and

''(C) any period during which a servicemember is absent from duty on account of sickness, wounds, leave, or other lawful cause.

''(3) PERIOD OF MILITARY SERVICE.—The term 'period of military service' means the period beginning on the date on which a servicemember enters military service and ending on the date on which the servicemember is released from military service or dies while in military service.

''(4) DEPENDENT.—The term 'dependent', with respect to a servicemember, means—

''(A) the servicemember's spouse;

''(B) the servicemember's child (as defined in section 101(4) of title 38, United States Code); or

''(C) an individual for whom the servicemember provided more than one-half of the individual's support for 180 days immediately preceding an application for relief under this Act.

''(5) COURT.—The term 'court' means a court or an administrative agency of the United States or of any State (including any political subdivision of a State), whether or not a court or administrative agency of record.

''(6) STATE.—The term 'State' includes—

''(A) a commonwealth, territory, or possession of the United States; and

''(B) the District of Columbia.

''(7) SECRETARY CONCERNED.—The term 'Secretary concerned'—

''(A) with respect to a member of the armed forces, has the meaning given that term in section 101(a)(9) of title 10, United States Code;

''(B) with respect to a commissioned officer of the Public Health Service, means the Secretary of Health and Human Services; and

''(C) with respect to a commissioned officer of the National Oceanic and Atmospheric Administration, means the Secretary of Commerce.

''(8) MOTOR VEHICLE.—The term 'motor vehicle' has the meaning given that term in section 30102(a)(6) of title 49, United States Code.

"SEC. 102. JURISDICTION AND APPLICABILITY OF ACT.

''(a) JURISDICTION.—This Act applies to—

''(1) the United States;

''(2) each of the States, including the political subdivisions thereof; and

''(3) all territory subject to the jurisdiction of the United States.

''(b) APPLICABILITY TO PROCEEDINGS.—This Act applies to any judicial or administrative

proceeding commenced in any court or agency in any jurisdiction subject to this Act. This Act does not apply to criminal proceedings.

“(c) COURT IN WHICH APPLICATION MAY BE MADE.—When under this Act any application is required to be made to a court in which no proceeding has already been commenced with respect to the matter, such application may be made to any court which would otherwise have jurisdiction over the matter.

“SEC. 103. PROTECTION OF PERSONS SECONDARILY LIABLE.

“(a) EXTENSION OF PROTECTION WHEN ACTIONS STAYED, POSTPONED, OR SUSPENDED.—Whenever pursuant to this Act a court stays, postpones, or suspends (1) the enforcement of an obligation or liability, (2) the prosecution of a suit or proceeding, (3) the entry or enforcement of an order, writ, judgment, or decree, or (4) the performance of any other act, the court may likewise grant such a stay, postponement, or suspension to a surety, guarantor, endorser, accommodation maker, comaker, or other person who is or may be primarily or secondarily subject to the obligation or liability the performance or enforcement of which is stayed, postponed, or suspended.

“(b) VACATION OR SET-ASIDE OF JUDGMENTS.—When a judgment or decree is vacated or set aside, in whole or in part, pursuant to this Act, the court may also set aside or vacate, as the case may be, the judgment or decree as to a surety, guarantor, endorser, accommodation maker, comaker, or other person who is or may be primarily or secondarily liable on the contract or liability for the enforcement of the judgment or decree.

“(c) BAIL BOND NOT TO BE ENFORCED DURING PERIOD OF MILITARY SERVICE.—A court may not enforce a bail bond during the period of military service of the principal on the bond when military service prevents the surety from obtaining the attendance of the principal. The court may discharge the surety and exonerate the bail, in accordance with principles of equity and justice, during or after the period of military service of the principal.

“(d) WAIVER OF RIGHTS.—

“(1) WAIVERS NOT PRECLUDED.—This Act does not prevent a waiver in writing by a surety, guarantor, endorser, accommodation maker, comaker, or other person (whether primarily or secondarily liable on an obligation or liability) of the protections provided under subsections (a) and (b). Any such waiver is effective only if it is executed as an instrument separate from the obligation or liability with respect to which it applies.

“(2) WAIVER INVALIDATED UPON ENTRANCE TO MILITARY SERVICE.—If a waiver under paragraph (1) is executed by an individual who after the execution of the waiver enters military service, or by a dependent of an individual who after the execution of the waiver enters military service, the waiver is not valid after the beginning of the period of such military service unless the waiver was executed by such individual or dependent during the period specified in section 106.

“SEC. 104. EXTENSION OF PROTECTIONS TO CITIZENS SERVING WITH ALLIED FORCES.

“A citizen of the United States who is serving with the forces of a nation with which the United States is allied in the prosecution of a war or military action is entitled to the relief and protections provided under this Act if that service with the allied force is similar to military service as defined in this Act. The relief and protections provided to such citizen shall terminate on the date of discharge or release from such service.

“SEC. 105. NOTIFICATION OF BENEFITS.

“The Secretary concerned shall ensure that notice of the benefits accorded by this Act is provided in writing to persons in military service and to persons entering military service.

“SEC. 106. EXTENSION OF RIGHTS AND PROTECTIONS TO RESERVES ORDERED TO REPORT FOR MILITARY SERVICE AND TO PERSONS ORDERED TO REPORT FOR INDUCTION.

“(a) RESERVES ORDERED TO REPORT FOR MILITARY SERVICE.—A member of a reserve component who is ordered to report for military service is entitled to the rights and protections of this title and titles II and III during the period beginning on the date of the member's receipt of the order and ending on the date on which the member reports for military service (or, if the order is revoked before the member so reports, or the date on which the order is revoked).

“(b) PERSONS ORDERED TO REPORT FOR INDUCTION.—A person who has been ordered to report for induction under the Military Selective Service Act (50 U.S.C. App. 451 et seq.) is entitled to the rights and protections provided a servicemember under this title and titles II and III during the period beginning on the date of receipt of the order for induction and ending on the date on which the person reports for induction (or, if the order to report for induction is revoked before the date on which the person reports for induction, on the date on which the order is revoked).

“SEC. 107. WAIVER OF RIGHTS PURSUANT TO WRITTEN AGREEMENT.

“(a) IN GENERAL.—A servicemember may waive any of the rights and protections provided by this Act. In the case of a waiver that permits an action described in subsection (b), the waiver is effective only if made pursuant to a written agreement of the parties that is executed during or after the servicemember's period of military service. The written agreement shall specify the legal instrument to which the waiver applies and, if the servicemember is not a party to that instrument, the servicemember concerned.

“(b) ACTIONS REQUIRING WAIVERS IN WRITING.—The requirement in subsection (a) for a written waiver applies to the following:

“(1) The modification, termination, or cancellation of—

“(A) a contract, lease, or bailment; or

“(B) an obligation secured by a mortgage, trust, deed, lien, or other security in the nature of a mortgage.

“(2) The repossession, retention, foreclosure, sale, forfeiture, or taking possession of property that—

“(A) is security for any obligation; or

“(B) was purchased or received under a contract, lease, or bailment.

“(c) COVERAGE OF PERIODS AFTER ORDERS RECEIVED.—For the purposes of this section—

“(1) a person to whom section 106 applies shall be considered to be a servicemember; and

“(2) the period with respect to such a person specified in subsection (a) or (b), as the case may be, of section 106 shall be considered to be a period of military service.

“SEC. 108. EXERCISE OF RIGHTS UNDER ACT NOT TO AFFECT CERTAIN FUTURE FINANCIAL TRANSACTIONS.

“Application by a servicemember for, or receipt by a servicemember of, a stay, postponement, or suspension pursuant to this Act in the payment of a tax, fine, penalty, insurance premium, or other civil obligation or liability of that servicemember shall not itself (without regard to other considerations) provide the basis for any of the following:

“(1) A determination by a lender or other person that the servicemember is unable to pay the civil obligation or liability in accordance with its terms.

“(2) With respect to a credit transaction between a creditor and the servicemember—

“(A) a denial or revocation of credit by the creditor;

“(B) a change by the creditor in the terms of an existing credit arrangement; or

“(C) a refusal by the creditor to grant credit to the servicemember in substantially the amount or on substantially the terms requested.

“(3) An adverse report relating to the creditworthiness of the servicemember by or to a person engaged in the practice of assembling or evaluating consumer credit information.

“(4) A refusal by an insurer to insure the servicemember.

“(5) An annotation in a servicemember's record by a creditor or a person engaged in the practice of assembling or evaluating consumer credit information, identifying the servicemember as a member of the National Guard or a reserve component.

“(6) A change in the terms offered or conditions required for the issuance of insurance.

“SEC. 109. LEGAL REPRESENTATIVES.

“(a) REPRESENTATIVE.—A legal representative of a servicemember for purposes of this Act is either of the following:

“(1) An attorney acting on the behalf of a servicemember.

“(2) An individual possessing a power of attorney.

“(b) APPLICATION.—Whenever the term 'servicemember' is used in this Act, such term shall be treated as including a reference to a legal representative of the servicemember.

“TITLE II—GENERAL RELIEF

“SEC. 201. PROTECTION OF SERVICEMEMBERS AGAINST DEFAULT JUDGMENTS.

“(a) APPLICABILITY OF SECTION.—This section applies to any civil action or proceeding in which the defendant does not make an appearance.

“(b) AFFIDAVIT REQUIREMENT.—

“(1) PLAINTIFF TO FILE AFFIDAVIT.—In any action or proceeding covered by this section, the court, before entering judgment for the plaintiff, shall require the plaintiff to file with the court an affidavit—

“(A) stating whether or not the defendant is in military service and showing necessary facts to support the affidavit; or

“(B) if the plaintiff is unable to determine whether or not the defendant is in military service, stating that the plaintiff is unable to determine whether or not the defendant is in military service.

“(2) APPOINTMENT OF ATTORNEY TO REPRESENT DEFENDANT IN MILITARY SERVICE.—If in an action covered by this section it appears that the defendant is in military service, the court may not enter a judgment until after the court appoints an attorney to represent the defendant. If an attorney appointed under this section to represent a servicemember cannot locate the servicemember, actions by the attorney in the case shall not waive any defense of the servicemember or otherwise bind the servicemember.

“(3) DEFENDANT'S MILITARY STATUS NOT ASCERTAINED BY AFFIDAVIT.—If based upon the affidavits filed in such an action, the court is unable to determine whether the defendant is in military service, the court, before entering judgment, may require the plaintiff to file a bond in an amount approved by the court. If the defendant is later found to be in military service, the bond shall be available to indemnify the defendant against any loss or damage the defendant may suffer by reason of any judgment for the plaintiff against the defendant, should the judgment be set aside in whole or in part. The bond shall remain in effect until expiration of the time for appeal and setting aside of a judgment under applicable Federal or State law or regulation or under any applicable ordinance of a political subdivision of a State. The court may issue such orders or enter such judgments as the court determines necessary to protect the rights of the defendant under this Act.

"(4) SATISFACTION OF REQUIREMENT FOR AFFIDAVIT.—The requirement for an affidavit under paragraph (1) may be satisfied by a statement, declaration, verification, or certificate, in writing, subscribed and certified or declared to be true under penalty of perjury.

"(c) PENALTY FOR MAKING OR USING FALSE AFFIDAVIT.—A person who makes or uses an affidavit permitted under subsection (b) (or a statement, declaration, verification, or certificate as authorized under subsection (b)(4)) knowing it to be false, shall be fined as provided in title 18, United States Code, or imprisoned for not more than one year, or both.

"(d) STAY OF PROCEEDINGS.—In an action covered by this section in which the defendant is in military service, the court shall grant a stay of proceedings for a minimum period of 90 days under this subsection upon application of counsel, or on the court's own motion, if the court determines that—

"(1) there may be a defense to the action and a defense cannot be presented without the presence of the defendant; or

"(2) after due diligence, counsel has been unable to contact the defendant or otherwise determine if a meritorious defense exists.

"(e) INAPPLICABILITY OF SECTION 202 PROCEDURES.—A stay of proceedings under subsection (d) shall not be controlled by procedures or requirements under section 202.

"(f) SECTION 202 PROTECTION.—If a servicemember who is a defendant in an action covered by this section receives actual notice of the action, the servicemember may request a stay of proceeding under section 202.

"(g) VACATION OR SETTING ASIDE OF DEFAULT JUDGMENTS.—

"(1) AUTHORITY FOR COURT TO VACATE OR SET ASIDE JUDGMENT.—If a default judgment is entered in an action covered by this section against a servicemember during the servicemember's period of military service (or within 60 days after termination of or release from such military service), the court entering the judgment shall, upon application by or on behalf of the servicemember, reopen the judgment for the purpose of allowing the servicemember to defend the action if it appears that—

"(A) the servicemember was materially affected by reason of that military service in making a defense to the action; and

"(B) the servicemember has a meritorious or legal defense to the action or some part of it.

"(2) TIME FOR FILING APPLICATION.—An application under this subsection must be filed not later than 90 days after the date of the termination of or release from military service.

"(h) PROTECTION OF BONA FIDE PURCHASER.—If a court vacates, sets aside, or reverses a default judgment against a servicemember and the vacating, setting aside, or reversing is because of a provision of this Act, that action shall not impair a right or title acquired by a bona fide purchaser for value under the default judgment.

"SEC. 202. STAY OF PROCEEDINGS WHEN SERVICEMEMBER HAS NOTICE.

"(a) APPLICABILITY OF SECTION.—This section applies to any civil action or proceeding in which the defendant at the time of filing an application under this section—

"(1) is in military service or is within 90 days after termination of or release from military service; and

"(2) has received notice of the action or proceeding.

"(b) STAY OF PROCEEDINGS.—

"(1) AUTHORITY FOR STAY.—At any stage before final judgment in a civil action or proceeding in which a servicemember described in subsection (a) is a party, the court may on its own motion and shall, upon application by the servicemember, stay the action for a period of not less than 90 days, if the conditions in paragraph (2) are met.

"(2) CONDITIONS FOR STAY.—An application for a stay under paragraph (1) shall include the following:

"(A) A letter or other communication setting forth facts stating the manner in which current military duty requirements materially affect the servicemember's ability to appear and stating a date when the servicemember will be available to appear.

"(B) A letter or other communication from the servicemember's commanding officer stating that the servicemember's current military duty prevents appearance and that military leave is not authorized for the servicemember at the time of the letter.

"(c) APPLICATION NOT A WAIVER OF DEFENSES.—An application for a stay under this section does not constitute an appearance for jurisdictional purposes and does not constitute a waiver of any substantive or procedural defense (including a defense relating to lack of personal jurisdiction).

"(d) ADDITIONAL STAY.—

"(1) APPLICATION.—A servicemember who is granted a stay of a civil action or proceeding under subsection (b) may apply for an additional stay based on continuing material affect of military duty on the servicemember's ability to appear. Such an application may be made by the servicemember at the time of the initial application under subsection (b) or when it appears that the servicemember is unavailable to prosecute or defend the action. The same information required under subsection (b)(2) shall be included in an application under this subsection.

"(2) APPOINTMENT OF COUNSEL WHEN ADDITIONAL STAY REFUSED.—If the court refuses to grant an additional stay of proceedings under paragraph (1), the court shall appoint counsel to represent the servicemember in the action or proceeding.

"(e) COORDINATION WITH SECTION 201.—A servicemember who applies for a stay under this section and is unsuccessful may not seek the protections afforded by section 201.

"(f) INAPPLICABILITY TO SECTION 301.—The protections of this section do not apply to section 301.

"SEC. 203. FINES AND PENALTIES UNDER CONTRACTS.

"(a) PROHIBITION OF PENALTIES.—When an action for compliance with the terms of a contract is stayed pursuant to this Act, a penalty shall not accrue for failure to comply with the terms of the contract during the period of the stay.

"(b) REDUCTION OR WAIVER OF FINES OR PENALTIES.—If a servicemember fails to perform an obligation arising under a contract and a penalty is incurred arising from that nonperformance, a court may reduce or waive the fine or penalty if—

"(1) the servicemember was in military service at the time the fine or penalty was incurred; and

"(2) the ability of the servicemember to perform the obligation was materially affected by such military service.

"SEC. 204. STAY OR VACATION OF EXECUTION OF JUDGMENTS, ATTACHMENTS, AND GARNISHMENTS.

"(a) COURT ACTION UPON MATERIAL AFFECT DETERMINATION.—If a servicemember, in the opinion of the court, is materially affected by reason of military service in complying with a court judgment or order, the court may on its own motion and shall on application by the servicemember—

"(1) stay the execution of any judgment or order entered against the servicemember; and

"(2) vacate or stay an attachment or garnishment of property, money, or debts in the possession of the servicemember or a third party, whether before or after judgment.

"(b) APPLICABILITY.—This section applies to an action or proceeding commenced in a court against a servicemember before or during the period of the servicemember's military service or within 90 days after such service terminates.

"SEC. 205. DURATION AND TERM OF STAYS; CODEFENDANTS NOT IN SERVICE.

"(a) PERIOD OF STAY.—A stay of an action, proceeding, attachment, or execution made pursuant to the provisions of this Act by a court may be ordered for the period of military service and 90 days thereafter, or for any part of that period. The court may set the terms and amounts for such installment payments as is considered reasonable by the court.

"(b) CODEFENDANTS.—If the servicemember is a codefendant with others who are not in military service and who are not entitled to the relief and protections provided under this Act, the plaintiff may proceed against those other defendants with the approval of the court.

"(c) INAPPLICABILITY OF SECTION.—This section does not apply to sections 202 and 701.

"SEC. 206. STATUTE OF LIMITATIONS.

"(a) TOLLING OF STATUTES OF LIMITATION DURING MILITARY SERVICE.—The period of a servicemember's military service may not be included in computing any period limited by law, regulation, or order for the bringing of any action or proceeding in a court, or in any board, bureau, commission, department, or other agency of a State (or political subdivision of a State) or the United States by or against the servicemember or the servicemember's heirs, executors, administrators, or assigns.

"(b) REDEMPTION OF REAL PROPERTY.—A period of military service may not be included in computing any period provided by law for the redemption of real property sold or forfeited to enforce an obligation, tax, or assessment.

"(c) INAPPLICABILITY TO INTERNAL REVENUE LAWS.—This section does not apply to any period of limitation prescribed by or under the internal revenue laws of the United States.

"SEC. 207. MAXIMUM RATE OF INTEREST ON DEBTS INCURRED BEFORE MILITARY SERVICE.

"(a) INTEREST RATE LIMITATION.—

"(1) LIMITATION TO 6 PERCENT.—An obligation or liability bearing interest at a rate in excess of 6 percent per year that is incurred by a servicemember, or the servicemember and the servicemember's spouse jointly, before the servicemember enters military service shall not bear interest at a rate in excess of 6 percent per year during the period of military service.

"(2) FORGIVENESS OF INTEREST IN EXCESS OF 6 PERCENT.—Interest at a rate in excess of 6 percent per year that would otherwise be incurred but for the prohibition in paragraph (1) is forgiven.

"(3) PREVENTION OF ACCELERATION OF PRINCIPAL.—The amount of any periodic payment due from a servicemember under the terms of the instrument that created an obligation or liability covered by this section shall be reduced by the amount of the interest forgiven under paragraph (2) that is allocable to the period for which such payment is made.

"(b) IMPLEMENTATION OF LIMITATION.—

"(1) WRITTEN NOTICE TO CREDITOR.—In order for an obligation or liability of a servicemember to be subject to the interest rate limitation in subsection (a), the servicemember shall provide to the creditor written notice and a copy of the military orders calling the servicemember to military service and any orders further extending military service, not later than 180 days after the date of the servicemember's termination or release from military service.

"(2) LIMITATION EFFECTIVE AS OF DATE OF ORDER TO ACTIVE DUTY.—Upon receipt of written notice and a copy of orders calling a

servicemember to military service, the creditor shall treat the debt in accordance with subsection (a), effective as of the date on which the servicemember is called to military service.

“(c) Creditor Protection.—A court may grant a creditor relief from the limitations of this section if, in the opinion of the court, the ability of the servicemember to pay interest upon the obligation or liability at a rate in excess of 6 percent per year is not materially affected by reason of the servicemember's military service.

“(d) Interest.—As used in this section, the term ‘interest’ includes service charges, renewal charges, fees, or any other charges (except bona fide insurance) with respect to an obligation or liability.

“TITLE III—RENT, INSTALLMENT CONTRACTS, MORTGAGES, LIENS, ASSIGNMENT, LEASES

“SEC. 301. EVICTIONS AND DISTRESS.

“(a) Court-Ordered Eviction.—

“(1) In general.—Except by court order, a landlord (or another person with paramount title) may not—

“(A) evict a servicemember, or the dependents of a servicemember, during a period of military service of the servicemember, from premises—

“(i) that are occupied or intended to be occupied primarily as a residence; and

“(ii) for which the monthly rent does not exceed $2,400, as adjusted under paragraph (2) for years after 2003; or

“(B) subject such premises to a distress during the period of military service.

“(2) Housing price inflation adjustment.—(A) For calendar years beginning with 2004, the amount in effect under paragraph (1)(A)(ii) shall be increased by the housing price inflation adjustment for the calendar year involved.

“(B) For purposes of this paragraph—

“(i) The housing price inflation adjustment for any calendar year is the percentage change (if any) by which—

“(I) the CPI housing component for November of the preceding calendar year, exceeds

“(II) the CPI housing component for November of 1984.

“(ii) The term ‘CPI housing component’ means the index published by the Bureau of Labor Statistics of the Department of Labor known as the Consumer Price Index, All Urban Consumers, Rent of Primary Residence, U.S. City Average.

“(3) Publication of housing price inflation adjustment.—The Secretary of Defense shall cause to be published in the Federal Register each year the amount in effect under paragraph (1)(A)(ii) for that year following the housing price inflation adjustment for that year pursuant to paragraph (2). Such publication shall be made for a year not later than 60 days after such adjustment is made for that year.

“(b) Stay of Execution.—

“(1) Court authority.—Upon an application for eviction or distress with respect to premises covered by this section, the court may on its own motion and shall, if a request is made by or on behalf of a servicemember whose ability to pay the agreed rent is materially affected by military service—

“(A) stay the proceedings for a period of 90 days, unless in the opinion of the court, justice and equity require a longer or shorter period of time; or

“(B) adjust the obligation under the lease to preserve the interests of all parties.

“(2) Relief to landlord.—If a stay is granted under paragraph (1), the court may grant to the landlord (or other person with paramount title) such relief as equity may require.

“(c) Penalties.—

“(1) Misdemeanor.—Except as provided in subsection (a), a person who knowingly takes part in an eviction or distress described in subsection (a), or who knowingly attempts to do so, shall be fined as provided in title 18, United States Code, or imprisoned for not more than one year, or both.

“(2) Preservation of other remedies and rights.—The remedies and rights provided under this section are in addition to and do not preclude any remedy for wrongful conversion (or wrongful eviction) otherwise available under the law to the person claiming relief under this section, including any award for consequential and punitive damages.

“(d) Rent Allotment From Pay of Servicemember.—To the extent required by a court order related to property which is the subject of a court action under this section, the Secretary concerned shall make an allotment from the pay of a servicemember to satisfy the terms of such order, except that any such allotment shall be subject to regulations prescribed by the Secretary concerned establishing the maximum amount of pay of servicemembers that may be allotted under this subsection.

“(e) Limitation of Applicability.—Section 202 is not applicable to this section.

“SEC. 302. PROTECTION UNDER INSTALLMENT CONTRACTS FOR PURCHASE OR LEASE.

“(a) Protection Upon Breach of Contract.—

“(1) Protection after entering military service.—After a servicemember enters military service, a contract by the servicemember for—

“(A) the purchase of real or personal property (including a motor vehicle); or

“(B) the lease or bailment of such property, may not be rescinded or terminated for a breach of terms of the contract occurring before or during that person's military service, nor may the property be repossessed for such breach without a court order.

“(2) Applicability.—This section applies only to a contract for which a deposit or installment has been paid by the servicemember before the servicemember enters military service.

“(b) Penalties.—

“(1) Misdemeanor.—A person who knowingly resumes possession of property in violation of subsection (a), or in violation of section 107 of this Act, or who knowingly attempts to do so, shall be fined as provided in title 18, United States Code, or imprisoned for not more than one year, or both.

“(2) Preservation of other remedies and rights.—The remedies and rights provided under this section are in addition to and do not preclude any remedy for wrongful conversion otherwise available under law to the person claiming relief under this section, including any award for consequential and punitive damages.

“(c) Authority of Court.—In a hearing based on this section, the court—

“(1) may order repayment to the servicemember of all or part of the prior installments or deposits as a condition of terminating the contract and resuming possession of the property;

“(2) may, on its own motion, and shall on application by a servicemember when the servicemember's ability to comply with the contract is materially affected by military service, stay the proceedings for a period of time as, in the opinion of the court, justice and equity require; or

“(3) may make other disposition as is equitable to preserve the interests of all parties.

“SEC. 303. MORTGAGES AND TRUST DEEDS.

“(a) Mortgage as Security.—This section applies only to an obligation on real or personal property owned by a servicemember that—

“(1) originated before the period of the servicemember's military service and for which the servicemember is still obligated; and

“(2) is secured by a mortgage, trust deed, or other security in the nature of a mortgage.

“(b) Stay of Proceedings and Adjustment of Obligation.—In an action filed during, or within 90 days after, a servicemember's period of military service to enforce an obligation described in subsection (a), the court may after a hearing and on its own motion and shall upon application by a servicemember when the servicemember's ability to comply with the obligation is materially affected by military service—

“(1) stay the proceedings for a period of time as justice and equity require, or

“(2) adjust the obligation to preserve the interests of all parties.

“(c) Sale or Foreclosure.—A sale, foreclosure, or seizure of property for a breach of an obligation described in subsection (a) shall not be valid if made during, or within 90 days after, the period of the servicemember's military service except—

“(1) upon a court order granted before such sale, foreclosure, or seizure with a return made and approved by the court; or

“(2) if made pursuant to an agreement as provided in section 107.

“(d) Penalties.—

“(1) Misdemeanor.—A person who knowingly makes or causes to be made a sale, foreclosure, or seizure of property that is prohibited by subsection (c), or who knowingly attempts to do so, shall be fined as provided in title 18, United States Code, or imprisoned for not more than one year, or both.

“(2) Preservation of other remedies.—The remedies and rights provided under this section are in addition to and do not preclude any remedy for wrongful conversion otherwise available under law to the person claiming relief under this section, including consequential and punitive damages.

“SEC. 304. SETTLEMENT OF STAYED CASES RELATING TO PERSONAL PROPERTY.

“(a) Appraisal of Property.—When a stay is granted pursuant to this Act in a proceeding to foreclose a mortgage on or to repossess personal property, or to rescind or terminate a contract for the purchase of personal property, the court may appoint three disinterested parties to appraise the property.

“(b) Equity Payment.—Based on the appraisal, and if undue hardship to the servicemember's dependents will not result, the court may order that the amount of the servicemember's equity in the property be paid to the servicemember, or the servicemember's dependents, as a condition of foreclosing the mortgage, repossessing the property, or rescinding or terminating the contract.

“SEC. 305. TERMINATION OF RESIDENTIAL OR MOTOR VEHICLE LEASES.

“(a) Termination by Lessee.—The lessee on a lease described in subsection (b) may, at the lessee's option, terminate the lease at any time after—

“(1) the lessee's entry into military service; or

“(2) the date of the lessee's military orders described in paragraph (1)(B) or (2)(B) of subsection (b), as the case may be.

“(b) Covered Leases.—This section applies to the following leases:

“(1) Leases of premises.—A lease of premises occupied, or intended to be occupied, by a servicemember or a servicemember's dependents for a residential, professional, business, agricultural, or similar purpose if—

“(A) the lease is executed by or on behalf of a person who thereafter and during the term of the lease enters military service; or

“(B) the servicemember, while in military service, executes the lease and thereafter receives military orders for a permanent change of station or to deploy with a military unit for a period of not less than 90 days.

“(2) Leases of motor vehicles.—A lease of a motor vehicle used, or intended to be used, by a

servicemember or a servicemember's dependents for personal or business transportation if—

"(A) the lease is executed by or on behalf of a person who thereafter and during the term of the lease enters military service under a call or order specifying a period of not less than 180 days (or who enters military service under a call or order specifying a period of 180 days or less and who, without a break in service, receives orders extending the period of military service to a period of not less than 180 days); or

"(B) the servicemember, while in military service, executes the lease and thereafter receives military orders for a permanent change of station outside of the continental United States or to deploy with a military unit for a period of not less than 180 days.

"(c) MANNER OF TERMINATION.—

"(1) IN GENERAL.—Termination of a lease under subsection (a) is made—

"(A) by delivery by the lessee of written notice of such termination, and a copy of the servicemember's military orders, to the lessor (or the lessor's grantee), or to the lessor's agent (or the agent's grantee); and

"(B) in the case of a lease of a motor vehicle, by return of the motor vehicle by the lessee to the lessor (or the lessor's grantee), or to the lessor's agent (or the agent's grantee), not later than 15 days after the date of the delivery of written notice under subparagraph (A).

"(2) DELIVERY OF NOTICE.—Delivery of notice under paragraph (1)(A) may be accomplished—

"(A) by hand delivery;

"(B) by private business carrier; or

"(C) by placing the written notice in an envelope with sufficient postage and with return receipt requested, and addressed as designated by the lessor (or the lessor's grantee) or to the lessor's agent (or the agent's grantee), and depositing the written notice in the United States mails.

"(d) EFFECTIVE DATE OF LEASE TERMINATION.—

"(1) LEASE OF PREMISES.—In the case of a lease described in subsection (b)(1) that provides for monthly payment of rent, termination of the lease under subsection (a) is effective 30 days after the first date on which the next rental payment is due and payable after the date on which the notice under subsection (c) is delivered. In the case of any other lease described in subsection (b)(1), termination of the lease under subsection (a) is effective on the last day of the month following the month in which the notice is delivered.

"(2) LEASE OF MOTOR VEHICLES.—In the case of a lease described in subsection (b)(2), termination of the lease under subsection (a) is effective on the day on which the requirements of subsection (c) are met for such termination.

"(e) ARREARAGES AND OTHER OBLIGATIONS AND LIABILITIES.—Rents or lease amounts unpaid for the period preceding the effective date of the lease termination shall be paid on a prorated basis. In the case of the lease of a motor vehicle, the lessor may not impose an early termination charge, but any taxes, summonses, and title and registration fees and any other obligation and liability of the lessee in accordance with the terms of the lease, including reasonable charges to the lessee for excess wear, use and mileage, that are due and unpaid at the time of termination of the lease shall be paid by the lessee.

"(f) RENT PAID IN ADVANCE.—Rents or lease amounts paid in advance for a period after the effective date of the termination of the lease shall be refunded to the lessee by the lessor (or the lessor's assignee or the assignee's agent) within 30 days of the effective date of the termination of the lease.

"(g) RELIEF TO LESSOR.—Upon application by the lessor to a court before the termination date provided in the written notice, relief granted by this section to a servicemember may be modified as justice and equity require.

"(h) PENALTIES.—

"(1) MISDEMEANOR.—Any person who knowingly seizes, holds, or detains the personal effects, security deposit, or other property of a servicemember or a servicemember's dependent who lawfully terminates a lease covered by this section, or who knowingly interferes with the removal of such property from premises covered by such lease, for the purpose of subjecting or attempting to subject any of such property to a claim for rent accruing subsequent to the date of termination of such lease, or attempts to do so, shall be fined as provided in title 18, United States Code, or imprisoned for not more than one year, or both.

"(2) PRESERVATION OF OTHER REMEDIES.—The remedy and rights provided under this section are in addition to and do not preclude any remedy for wrongful conversion otherwise available under law to the person claiming relief under this section, including any award for consequential or punitive damages.

"SEC. 306. PROTECTION OF LIFE INSURANCE POLICY.

"(a) ASSIGNMENT OF POLICY PROTECTED.—If a life insurance policy on the life of a servicemember is assigned before military service to secure the payment of an obligation, the assignee of the policy (except the insurer in connection with a policy loan) may not exercise, during a period of military service of the servicemember or within one year thereafter, any right or option obtained under the assignment without a court order.

"(b) EXCEPTION.—The prohibition in subsection (a) shall not apply—

"(1) if the assignee has the written consent of the insured made during the period described in subsection (a);

"(2) when the premiums on the policy are due and unpaid; or

"(3) upon the death of the insured.

"(c) ORDER REFUSED BECAUSE OF MATERIAL AFFECT.—A court which receives an application for an order required under subsection (a) may refuse to grant such order if the court determines the ability of the servicemember to comply with the terms of the obligation is materially affected by military service.

"(d) TREATMENT OF GUARANTEED PREMIUMS.—For purposes of this subsection, premiums guaranteed under the provisions of title IV of this Act shall not be considered due and unpaid.

"(e) PENALTIES.—

"(1) MISDEMEANOR.—A person who knowingly takes an action contrary to this section, or attempts to do so, shall be fined as provided in title 18, United States Code, or imprisoned for not more than one year, or both.

"(2) PRESERVATION OF OTHER REMEDIES.—The remedy and rights provided under this section are in addition to and do not preclude any remedy for wrongful conversion otherwise available under law to the person claiming relief under this section, including any consequential or punitive damages.

"SEC. 307. ENFORCEMENT OF STORAGE LIENS.

"(a) LIENS.—

"(1) LIMITATION ON FORECLOSURE OR ENFORCEMENT.—A person holding a lien on the property or effects of a servicemember may not, during any period of military service of the servicemember and for 90 days thereafter, foreclose or enforce any lien on such property or effects without a court order granted before foreclosure or enforcement.

"(2) LIEN DEFINED.—For the purposes of paragraph (1), the term 'lien' includes a lien for storage, repair, or cleaning of the property or effects of a servicemember or a lien on such property or effects for any other reason.

"(b) STAY OF PROCEEDINGS.—In a proceeding to foreclose or enforce a lien subject to this section, the court may on its own motion, and shall if requested by a servicemember whose ability to comply with the obligation resulting in the proceeding is materially affected by military service—

"(1) stay the proceeding for a period of time as justice and equity require; or

"(2) adjust the obligation to preserve the interests of all parties.

The provisions of this subsection do not affect the scope of section 303.

"(c) PENALTIES.—

"(1) MISDEMEANOR.—A person who knowingly takes an action contrary to this section, or attempts to do so, shall be fined as provided in title 18, United States Code, or imprisoned for not more than one year, or both.

"(2) PRESERVATION OF OTHER REMEDIES.—The remedy and rights provided under this section are in addition to and do not preclude any remedy for wrongful conversion otherwise available under law to the person claiming relief under this section, including any consequential or punitive damages.

"SEC. 308. EXTENSION OF PROTECTIONS TO DEPENDENTS.

"Upon application to a court, a dependent of a servicemember is entitled to the protections of this title if the dependent's ability to comply with a lease, contract, bailment, or other obligation is materially affected by reason of the servicemember's military service.

"TITLE IV—LIFE INSURANCE

"SEC. 401. DEFINITIONS.

"For the purposes of this title:

"(1) POLICY.—The term 'policy' means any individual contract for whole, endowment, universal, or term life insurance (other than group term life insurance coverage), including any benefit in the nature of such insurance arising out of membership in any fraternal or beneficial association which—

"(A) provides that the insurer may not—

"(i) decrease the amount of coverage or require the payment of an additional amount as premiums if the insured engages in military service (except increases in premiums in individual term insurance based upon age); or

"(ii) limit or restrict coverage for any activity required by military service; and

"(B) is in force not less than 180 days before the date of the insured's entry into military service and at the time of application under this title.

"(2) PREMIUM.—The term 'premium' means the amount specified in an insurance policy to be paid to keep the policy in force.

"(3) INSURED.—The term 'insured' means a servicemember whose life is insured under a policy.

"(4) INSURER.—The term 'insurer' includes any firm, corporation, partnership, association, or business that is chartered or authorized to provide insurance and issue contracts or policies by the laws of a State or the United States.

"SEC. 402. INSURANCE RIGHTS AND PROTECTIONS.

"(a) RIGHTS AND PROTECTIONS.—The rights and protections under this title apply to the insured when—

"(1) the insured,

"(2) the insured's legal representative, or

"(3) the insured's beneficiary in the case of an insured who is outside a State,

applies in writing for protection under this title, unless the Secretary of Veterans Affairs determines that the insured's policy is not entitled to protection under this title.

"(b) NOTIFICATION AND APPLICATION.—The Secretary of Veterans Affairs shall notify the Secretary concerned of the procedures to be used *to apply for the protections provided under this title. The applicant shall send the original application to the insurer and a copy to the Secretary of Veterans Affairs.*

"(c) LIMITATION ON AMOUNT.—The total amount of life insurance coverage protection provided by this title for a servicemember may not exceed $250,000, or an amount equal to the Servicemember's Group Life Insurance maximum limit, whichever is greater, regardless of the number of policies submitted.

"SEC. 403. APPLICATION FOR INSURANCE PROTECTION.

"(a) APPLICATION PROCEDURE.—An application for protection under this title shall—

"(1) be in writing and signed by the insured, the insured's legal representative, or the insured's beneficiary, as the case may be;

"(2) identify the policy and the insurer; and

"(3) include an acknowledgement that the insured's rights under the policy are subject to and modified by the provisions of this title.

"(b) ADDITIONAL REQUIREMENTS.—The Secretary of Veterans Affairs may require additional information from the applicant, the insured and the insurer to determine if the policy is entitled to protection under this title.

"(c) NOTICE TO THE SECRETARY BY THE INSURER.—Upon receipt of the application of the insured, the insurer shall furnish a report concerning the policy to the Secretary of Veterans Affairs as required by regulations prescribed by the Secretary.

"(d) POLICY MODIFICATION.—Upon application for protection under this title, the insured and the insurer shall have constructively agreed to any policy modification necessary to give this title full force and effect.

"SEC. 404. POLICIES ENTITLED TO PROTECTION AND LAPSE OF POLICIES.

"(a) DETERMINATION.—The Secretary of Veterans Affairs shall determine whether a policy is entitled to protection under this title and shall notify the insured and the insurer of that determination.

"(b) LAPSE PROTECTION.—A policy that the Secretary determines is entitled to protection under this title shall not lapse or otherwise terminate or be forfeited for the nonpayment of a premium, or interest or indebtedness on a premium, after the date on which the application for protection is received by the Secretary.

"(c) TIME APPLICATION.—The protection provided by this title applies during the insured's period of military service and for a period of two years thereafter.

"SEC. 405. POLICY RESTRICTIONS.

"(a) DIVIDENDS.—While a policy is protected under this title, a dividend or other monetary benefit under a policy may not be paid to an insured or used to purchase dividend additions without the approval of the Secretary of Veterans Affairs. If such approval is not obtained, the dividends or benefits shall be added to the value of the policy to be used as a credit when final settlement is made with the insurer.

"(b) SPECIFIC RESTRICTIONS.—While a policy is protected under this title, cash value, loan value, withdrawal of dividend accumulation, unearned premiums, or other value of similar character may not be available to the insured without the approval of the Secretary. The right of the insured to change a beneficiary designation or select.an optional settlement for a beneficiary shall not be affected by the provisions of this title.

"SEC. 406. DEDUCTION OF UNPAID PREMIUMS.

"(a) SETTLEMENT OF PROCEEDS.—If a policy matures as a result of a servicemember's death or otherwise during the period of protection of the policy under this title, the insurer in making settlement shall deduct from the insurance proceeds the amount of the unpaid premiums guaranteed under this title, together with interest due at the rate fixed in the policy for policy loans.

"(b) INTEREST RATE.—If the interest rate is not specifically fixed in the policy, the rate shall be the same as for policy loans in other policies issued by the insurer at the time the insured's policy was issued.

"(c) REPORTING REQUIREMENT.—The amount deducted under this section, if any, shall be reported by the insurer to the Secretary of Veterans Affairs.

"SEC. 407. PREMIUMS AND INTEREST GUARANTEED BY UNITED STATES.

"(a) GUARANTEE OF PREMIUMS AND INTEREST BY THE UNITED STATES.—

"(1) GUARANTEE.—Payment of premiums, and interest on premiums at the rate specified in section 406, which become due on a policy under the protection of this title is guaranteed by the United States. If the amount guaranteed is not paid to the insurer before the period of insurance protection under this title expires, the amount due shall be treated by the insurer as a policy loan on the policy.

"(2) POLICY TERMINATION.—If, at the expiration of insurance protection under this title, the cash surrender value of a policy is less than the amount due to pay premiums and interest on premiums on the policy, the policy shall terminate. Upon such termination, the United States shall pay the insurer the difference between the amount due and the cash surrender value.

"(b) RECOVERY FROM INSURED OF AMOUNTS PAID BY THE UNITED STATES.—

"(1) DEBT PAYABLE TO THE UNITED STATES.—The amount paid by the United States to an insurer under this title shall be a debt payable to the United States by the insured on whose policy payment was made.

"(2) COLLECTION.—Such amount may be collected by the United States, either as an offset from any amount due the insured by the United States or as otherwise authorized by law.

"(3) DEBT NOT DISCHARGEABLE IN BANKRUPTCY.—Such debt payable to the United States is not dischargeable in bankruptcy proceedings.

"(c) CREDITING OF AMOUNTS RECOVERED.—Any amounts received by the United States as repayment of debts incurred by an insured under this title shall be credited to the appropriation for the payment of claims under this title.

"SEC. 408. REGULATIONS.

"The Secretary of Veterans Affairs shall prescribe regulations for the implementation of this title.

"SEC. 409. REVIEW OF FINDINGS OF FACT AND CONCLUSIONS OF LAW.

"The findings of fact and conclusions of law made by the Secretary of Veterans Affairs in administering this title are subject to review on appeal to the Board of Veterans' Appeals pursuant to chapter 71 of title 38, United States Code, and to judicial review only as provided in chapter 72 of such title.

"TITLE V—TAXES AND PUBLIC LANDS

"SEC. 501. TAXES RESPECTING PERSONAL PROPERTY, MONEY, CREDITS, AND REAL PROPERTY.

"(a) APPLICATION.—This section applies in any case in which a tax or assessment, whether general or special (other than a tax on personal income), falls due and remains unpaid before or during a period of military service with respect to a servicemember's—

"(1) personal property (including motor vehicles); or

"(2) real property occupied for dwelling, professional, business, or agricultural purposes by a servicemember or the servicemember's dependents or employees—

"(A) before the servicemember's entry into military service; and

"(B) during the time the tax or assessment remains unpaid.

"(b) SALE OF PROPERTY.—

"(1) LIMITATION ON SALE OF PROPERTY TO ENFORCE TAX ASSESSMENT.—Property described in subsection (a) may not be sold to enforce the collection of such tax or assessment except by court order and upon the determination by the court that military service does not materially affect the servicemember's ability to pay the unpaid tax or assessment.

"(2) STAY OF COURT PROCEEDINGS.—A court may stay a proceeding to enforce the collection of such tax or assessment, or sale of such property, during a period of military service of the servicemember and for a period not more than 180 days after the termination of, or release of the servicemember from, military service.

"(c) REDEMPTION.—When property described in subsection (a) is sold or forfeited to enforce the collection of a tax or assessment, a servicemember shall have the right to redeem or commence an action to redeem the servicemember's property during the period of military service or within 180 days after termination of or release from military service. This subsection may not be construed to shorten any period provided by the law of a State (including any political subdivision of a State) for redemption.

"(d) INTEREST ON TAX OR ASSESSMENT.—Whenever a servicemember does not pay a tax or assessment on property described in subsection (a) when due, the amount of the tax or assessment due and unpaid shall bear interest until paid at the rate of 6 percent per year. An additional penalty or interest shall not be incurred by reason of nonpayment. A lien for such unpaid tax or assessment may include interest under this subsection.

"(e) JOINT OWNERSHIP APPLICATION.—This section applies to all forms of property described in subsection (a) owned individually by a servicemember or jointly by a servicemember and a dependent or dependents.

"SEC. 502. RIGHTS IN PUBLIC LANDS.

"(a) RIGHTS NOT FORFEITED.—The rights of a servicemember to lands owned or controlled by the United States, and initiated or acquired by the servicemember under the laws of the United States (including the mining and mineral leasing laws) before military service, shall not be forfeited or prejudiced as a result of being absent from the land, or by failing to begin or complete any work or improvements to the land, during the period of military service.

"(b) TEMPORARY SUSPENSION OF PERMITS OR LICENSES.—If a permittee or licensee under the Act of June 28, 1934 (43 U.S.C. 315 et seq.), enters military service, the permittee or licensee may suspend the permit or license for the period of military service and for 180 days after termination of or release from military service.

"(c) REGULATIONS.—Regulations prescribed by the Secretary of the Interior shall provide for such suspension of permits and licenses and for the remission, reduction, or refund of grazing fees during the period of such suspension.

"SEC. 503. DESERT-LAND ENTRIES.

"(a) DESERT-LAND RIGHTS NOT FORFEITED.—A desert-land entry made or held under the desert-land laws before the entrance of the entryman or the entryman's successor in interest into military service shall not be subject to contest or cancellation—

"(1) for failure to expend any required amount per acre per year in improvements upon the claim;

"(2) for failure to effect the reclamation of the claim during the period the entryman or the entryman's successor in interest is in the military service, or for 180 days after termination of or release from military service; or

"(3) during any period of hospitalization or rehabilitation due to an injury or disability incurred in the line of duty.

The time within which the entryman or claimant is required to make such expenditures and effect reclamation of the land shall be exclusive of the time periods described in paragraphs (2) and (3).

"(b) Service-Related Disability.—If an entryman or claimant is honorably discharged and is unable to accomplish reclamation of, and payment for, desert land due to a disability incurred in the line of duty, the entryman or claimant may make proof without further reclamation or payments, under regulations prescribed by the Secretary of the Interior, and receive a patent for the land entered or claimed.

"(c) Filing Requirement.—In order to obtain the protection of this section, the entryman or claimant shall, within 180 days after entry into military service, cause to be filed in the land office of the district where the claim is situated a notice communicating the fact of military service and the desire to hold the claim under this section.

"SEC. 504. MINING CLAIMS.

"(a) Requirements Suspended.—The provisions of section 2324 of the Revised Statutes of the United States (30 U.S.C. 28) specified in subsection (b) shall not apply to a servicemember's claims or interests in claims, regularly located and recorded, during a period of military service and 180 days thereafter, or during any period of hospitalization or rehabilitation due to injuries or disabilities incurred in the line of duty.

"(b) Requirements.—The provisions in section 2324 of the Revised Statutes that shall not apply under subsection (a) are those which require that on each mining claim located after May 10, 1872, and until a patent has been issued for such claim, not less than $100 worth of labor shall be performed or improvements made during each year.

"(c) Period of Protection From Forfeiture.—A mining claim or an interest in a claim owned by a servicemember that has been regularly located and recorded shall not be subject to forfeiture for nonperformance of annual assessments during the period of military service and for 180 days thereafter, or for any period of hospitalization or rehabilitation described in subsection (a).

"(d) Filing Requirement.—In order to obtain the protections of this section, the claimant of a mining location shall, before the end of the assessment year in which military service is begun or within 60 days after the end of such assessment year, cause to be filed in the office where the location notice or certificate is recorded a notice communicating the fact of military service and the desire to hold the mining claim under this section.

"SEC. 505. MINERAL PERMITS AND LEASES.

"(a) Suspension During Military Service.—A person holding a permit or lease on the public domain under the Federal mineral leasing laws who enters military service may suspend all operations under the permit or lease for the duration of military service and for 180 days thereafter. The term of the permit or lease shall not run during the period of suspension, nor shall any rental or royalties be charged against the permit or lease during the period of suspension.

"(b) Notification.—In order to obtain the protection of this section, the permittee or lessee shall, within 180 days after entry into military service, notify the Secretary of the Interior by registered mail of the fact that military service has begun and of the desire to hold the claim under this section.

"(c) Contract Modification.—This section shall not be construed to supersede the terms of any contract for operation of a permit or lease.

"SEC. 506. PERFECTION OR DEFENSE OF RIGHTS.

"(a) Right To Take Action Not Affected.—This title shall not affect the right of a servicemember to take action during a period of military service that is authorized by law or regulations of the Department of the Interior, for the perfection, defense, or further assertion of rights initiated or acquired before entering military service.

"(b) Affidavits and Proofs.—

"(1) In general.—A servicemember during a period of military service may make any affidavit or submit any proof required by law, practice, or regulation of the Department of the Interior in connection with the entry, perfection, defense, or further assertion of rights initiated or acquired before entering military service before an officer authorized to provide notary services under section 1044a of title 10, United States Code, or any superior commissioned officer.

"(2) Legal status of affidavits.—Such affidavits shall be binding in law and subject to the same penalties as prescribed by section 1001 of title 18, United State Code.

"SEC. 507. DISTRIBUTION OF INFORMATION CONCERNING BENEFITS OF TITLE.

"(a) Distribution of Information by Secretary Concerned.—The Secretary concerned shall issue to servicemembers information explaining the provisions of this title.

"(b) Application Forms.—The Secretary concerned shall provide application forms to servicemembers requesting relief under this title.

"(c) Information From Secretary of the Interior.—The Secretary of the Interior shall furnish to the Secretary concerned information explaining the provisions of this title (other than sections 501, 510, and 511) and related application forms.

"SEC. 508. LAND RIGHTS OF SERVICEMEMBERS.

"(a) No Age Limitations.—Any servicemember under the age of 21 in military service shall be entitled to the same rights under the laws relating to lands owned or controlled by the United States, including mining and mineral leasing laws, as those servicemembers who are 21 years of age.

"(b) Residency Requirement.—Any requirement related to the establishment of a residence within a limited time shall be suspended as to entry by a servicemember in military service until 180 days after termination of or release from military service.

"(c) Entry Applications.—Applications for entry may be verified before a person authorized to administer oaths under section 1044a of title 10, United States Code, or under the laws of the State where the land is situated.

"SEC. 509. REGULATIONS.

"The Secretary of the Interior may issue regulations necessary to carry out this title (other than sections 501, 510, and 511).

"SEC. 510. INCOME TAXES.

"(a) Deferral of Tax.—Upon notice to the Internal Revenue Service or the tax authority of a State or a political subdivision of a State, the collection of income tax on the income of a servicemember falling due before or during military service shall be deferred for a period not more than 180 days after termination of or release from military service, if a servicemember's ability to pay such income tax is materially affected by military service.

"(b) Accrual of Interest or Penalty.—No interest or penalty shall accrue for the period of deferment by reason of nonpayment on any amount of tax deferred under this section.

"(c) Statute of Limitations.—The running of a statute of limitations against the collection of tax deferred under this section, by seizure or otherwise, shall be suspended for the period of military service of the servicemember and for an additional period of 270 days thereafter.

"(d) Application Limitation.—This section shall not apply to the tax imposed on employees by section 3101 of the Internal Revenue Code of 1986.

"SEC. 511. RESIDENCE FOR TAX PURPOSES.

"(a) Residence or Domicile.—A servicemember shall neither lose nor acquire a residence or domicile for purposes of taxation with respect to the person, personal property, or income of the servicemember by reason of being absent or present in any tax jurisdiction of the United States solely in compliance with military orders.

"(b) Military Service Compensation.—Compensation of a servicemember for military service shall not be deemed to be income for services performed or from sources within a tax jurisdiction of the United States if the servicemember is not a resident or domiciliary of the jurisdiction in which the servicemember is serving in compliance with military orders.

"(c) Personal Property.—

"(1) Relief from personal property taxes.—The personal property of a servicemember shall not be deemed to be located or present in, or to have a situs for taxation in, the tax jurisdiction in which the servicemember is serving in compliance with military orders.

"(2) Exception for property within member's domicile or residence.—This subsection applies to personal property or its use within any tax jurisdiction other than the servicemember's domicile or residence.

"(3) Exception for property used in trade or business.—This section does not prevent taxation by a tax jurisdiction with respect to personal property used in or arising from a trade or business, if it has jurisdiction.

"(4) Relationship to law of state of domicile.—Eligibility for relief from personal property taxes under this subsection is not contingent on whether or not such taxes are paid to the State of domicile.

"(d) Increase of Tax Liability.—A tax jurisdiction may not use the military compensation of a nonresident servicemember to increase the tax liability imposed on other income earned by the nonresident servicemember or spouse subject to tax by the jurisdiction.

"(e) Federal Indian Reservations.—An Indian servicemember whose legal residence or domicile is a Federal Indian reservation shall be taxed by the laws applicable to Federal Indian reservations and not the State where the reservation is located.

"(f) Definitions.—For purposes of this section:

"(1) Personal property.—The term 'personal property' means intangible and tangible property (including motor vehicles).

"(2) Taxation.—The term 'taxation' includes licenses, fees, or excises imposed with respect to motor vehicles and their use, if the license, fee, or excise is paid by the servicemember in the servicemember's State of domicile or residence.

"(3) Tax jurisdiction.—The term 'tax jurisdiction' means a State or a political subdivision of a State.

"TITLE VI—ADMINISTRATIVE REMEDIES

"SEC. 601. INAPPROPRIATE USE OF ACT.

"If a court determines, in any proceeding to enforce a civil right, that any interest, property, or contract has been transferred or acquired with the intent to delay the just enforcement of such right by taking advantage of this Act, the court shall enter such judgment or make such order as might lawfully be entered or made concerning such transfer or acquisition.

"SEC. 602. CERTIFICATES OF SERVICE; PERSONS REPORTED MISSING.

"(a) Prima Facie Evidence.—In any proceeding under this Act, a certificate signed by the Secretary concerned is prima facie evidence

as to any of the following facts stated in the certificate:

"(1) That a person named is, is not, has been, or has not been in military service.

"(2) The time and the place the person entered military service.

"(3) The person's residence at the time the person entered military service.

"(4) The rank, branch, and unit of military service of the person upon entry.

"(5) The inclusive dates of the person's military service.

"(6) The monthly pay received by the person at the date of the certificate's issuance.

"(7) The time and place of the person's termination of or release from military service, or the person's death during military service.

"(b) CERTIFICATES.—The Secretary concerned shall furnish a certificate under subsection (a) upon receipt of an application for such a certificate. A certificate appearing to be signed by the Secretary concerned is prima facie evidence of its contents and of the signer's authority to issue it.

"(c) TREATMENT OF SERVICEMEMBERS IN MISSING STATUS.—A servicemember who has been reported missing is presumed to continue in service until accounted for. A requirement under this Act that begins or ends with the death of a servicemember does not begin or end until the servicemember's death is reported to, or determined by, the Secretary concerned or by a court of competent jurisdiction.

"SEC. 603. INTERLOCUTORY ORDERS.

"An interlocutory order issued by a court under this Act may be revoked, modified, or extended by that court upon its own motion or otherwise, upon notification to affected parties as required by the court.

"TITLE VII—FURTHER RELIEF

"SEC. 701. ANTICIPATORY RELIEF.

"(a) APPLICATION FOR RELIEF.—A servicemember may, during military service or within 180 days of termination of or release from military service, apply to a court for relief—

"(1) from any obligation or liability incurred by the servicemember before the servicemember's military service; or

"(2) from a tax or assessment falling due before or during the servicemember's military service.

"(b) TAX LIABILITY OR ASSESSMENT.—In a case covered by subsection (a), the court may, if the ability of the servicemember to comply with the terms of such obligation or liability or pay such tax or assessment has been materially affected by reason of military service, after appropriate notice and hearing, grant the following relief:

"(1) STAY OF ENFORCEMENT OF REAL ESTATE CONTRACTS.—

"(A) In the case of an obligation payable in installments under a contract for the purchase of real estate, or secured by a mortgage or other instrument in the nature of a mortgage upon real estate, the court may grant a stay of the enforcement of the obligation—

"(i) during the servicemember's period of military service; and

"(ii) from the date of termination of or release from military service, or from the date of application if made after termination of or release from military service.

"(B) Any stay under this paragraph shall be—

"(i) for a period equal to the remaining life of the installment contract or other instrument, plus a period of time equal to the period of military service of the servicemember, or any part of such combined period; and

"(ii) subject to payment of the balance of the principal and accumulated interest due and unpaid at the date of termination or release from the applicant's military service or from the date of application in equal installments during the combined period at the rate of interest on the unpaid balance prescribed in the contract or other instrument evidencing the obligation, and subject to other terms as may be equitable.

"(2) STAY OF ENFORCEMENT OF OTHER CONTRACTS.—

"(A) In the case of any other obligation, liability, tax, or assessment, the court may grant a stay of enforcement—

"(i) during the servicemember's military service; and

"(ii) from the date of termination of or release from military service, or from the date of application if made after termination or release from military service.

"(B) Any stay under this paragraph shall be—

"(i) for a period of time equal to the period of the servicemember's military service or any part of such period; and

"(ii) subject to payment of the balance of principal and accumulated interest due and unpaid at the date of termination or release from military service, or the date of application, in equal periodic installments during this extended period at the rate of interest as may be prescribed for this obligation, liability, tax, or assessment, if paid when due, and subject to other terms as may be equitable.

"(c) AFFECT OF STAY ON FINE OR PENALTY.—When a court grants a stay under this section, a fine or penalty shall not accrue on the obligation, liability, tax, or assessment for the period of compliance with the terms and conditions of the stay.

"SEC. 702. POWER OF ATTORNEY.

"(a) AUTOMATIC EXTENSION.—A power of attorney of a servicemember shall be automatically extended for the period the servicemember is in a missing status (as defined in section 551(2) of title 37, United States Code) if the power of attorney—

"(1) was duly executed by the servicemember—

"(A) while in military service; or

"(B) before entry into military service but after the servicemember—

"(i) received a call or order to report for military service; or

"(ii) was notified by an official of the Department of Defense that the person could receive a call or order to report for military service;

"(2) designates the servicemember's spouse, parent, or other named relative as the servicemember's attorney in fact for certain, specified, or all purposes; and

"(3) expires by its terms after the servicemember entered a missing status.

"(b) LIMITATION ON POWER OF ATTORNEY EXTENSION.—A power of attorney executed by a servicemember may not be extended under subsection (a) if the document by its terms clearly indicates that the power granted expires on the date specified even though the servicemember, after the date of execution of the document, enters a missing status.

"SEC. 703. PROFESSIONAL LIABILITY PROTECTION.

"(a) APPLICABILITY.—This section applies to a servicemember who—

"(1) after July 31, 1990, is ordered to active duty (other than for training) pursuant to sections 688, 12301(a), 12301(g), 12302, 12304, 12306, or 12307 of title 10, United States Code, or who is ordered to active duty under section 12301(d) of such title during a period when members are on active duty pursuant to any of the preceding sections; and

"(2) immediately before receiving the order to active duty—

"(A) was engaged in the furnishing of health-care or legal services or other services determined by the Secretary of Defense to be professional services; and

"(B) had in effect a professional liability insurance policy that does not continue to cover claims filed with respect to the servicemember during the period of the servicemember's active duty unless the premiums are paid for such coverage for such period.

"(b) SUSPENSION OF COVERAGE.—

"(1) SUSPENSION.—Coverage of a servicemember referred to in subsection (a) by a professional liability insurance policy shall be suspended by the insurance carrier in accordance with this subsection upon receipt of a written request from the servicemember by the insurance carrier.

"(2) PREMIUMS FOR SUSPENDED CONTRACTS.—A professional liability insurance carrier—

"(A) may not require that premiums be paid by or on behalf of a servicemember for any professional liability insurance coverage suspended pursuant to paragraph (1); and

"(B) shall refund any amount paid for coverage for the period of such suspension or, upon the election of such servicemember, apply such amount for the payment of any premium becoming due upon the reinstatement of such coverage.

"(3) NONLIABILITY OF CARRIER DURING SUSPENSION.—A professional liability insurance carrier shall not be liable with respect to any claim that is based on professional conduct (including any failure to take any action in a professional capacity) of a servicemember that occurs during a period of suspension of that servicemember's professional liability insurance under this subsection.

"(4) CERTAIN CLAIMS CONSIDERED TO ARISE BEFORE SUSPENSION.—For the purposes of paragraph (3), a claim based upon the failure of a professional to make adequate provision for a patient, client, or other person to receive professional services or other assistance during the period of the professional's active duty service shall be considered to be based on an action or failure to take action before the beginning of the period of the suspension of professional liability insurance under this subsection, except in a case in which professional services were provided after the date of the beginning of such period.

"(c) REINSTATEMENT OF COVERAGE.—

"(1) REINSTATEMENT REQUIRED.—Professional liability insurance coverage suspended in the case of any servicemember pursuant to subsection (b) shall be reinstated by the insurance carrier on the date on which that servicemember transmits to the insurance carrier a written request for reinstatement.

"(2) TIME AND PREMIUM FOR REINSTATEMENT.—The request of a servicemember for reinstatement shall be effective only if the servicemember transmits the request to the insurance carrier within 30 days after the date on which the servicemember is released from active duty. The insurance carrier shall notify the servicemember of the due date for payment of the premium of such insurance. Such premium shall be paid by the servicemember within 30 days after receipt of that notice.

"(3) PERIOD OF REINSTATED COVERAGE.—The period for which professional liability insurance coverage shall be reinstated for a servicemember under this subsection may not be less than the balance of the period for which coverage would have continued under the insurance policy if the coverage had not been suspended.

"(d) INCREASE IN PREMIUM.—

"(1) LIMITATION ON PREMIUM INCREASES.—An insurance carrier may not increase the amount of the premium charged for professional liability insurance coverage of any servicemember for the minimum period of the reinstatement of such coverage required under subsection (c)(3) to an amount greater than the amount chargeable for such coverage for such period before the suspension.

"(2) EXCEPTION.—Paragraph (1) does not prevent an increase in premium to the extent of any general increase in the premiums charged by that carrier for the same professional liability coverage for persons similarly covered by such insurance during the period of the suspension.

"(e) CONTINUATION OF COVERAGE OF UNAFFECTED PERSONS.—This section does not—

"(1) require a suspension of professional liability insurance protection for any person who is not a person referred to in subsection (a) and who is covered by the same professional liability insurance as a person referred to in such subsection; or

"(2) relieve any person of the obligation to pay premiums for the coverage not required to be suspended.

"(f) STAY OF CIVIL OR ADMINISTRATIVE ACTIONS.—

"(1) STAY OF ACTIONS.—A civil or administrative action for damages on the basis of the alleged professional negligence or other professional liability of a servicemember whose professional liability insurance coverage has been suspended under subsection (b) shall be stayed until the end of the period of the suspension if—

"(A) the action was commenced during the period of the suspension;

"(B) the action is based on an act or omission that occurred before the date on which the suspension became effective; and

"(C) the suspended professional liability insurance would, except for the suspension, on its face cover the alleged professional negligence or other professional liability negligence or other professional liability of the servicemember.

"(2) DATE OF COMMENCEMENT OF ACTION.—Whenever a civil or administrative action for damages is stayed under paragraph (1) in the case of any servicemember, the action shall have been deemed to have been filed on the date on which the professional liability insurance coverage of the servicemember is reinstated under subsection (c).

"(g) EFFECT OF SUSPENSION UPON LIMITATIONS PERIOD.—In the case of a civil or administrative action for which a stay could have been granted under subsection (f) by reason of the suspension of professional liability insurance coverage of the defendant under this section, the period of the suspension of the coverage shall be excluded from the computation of any statutory period of limitation on the commencement of such action.

"(h) DEATH DURING PERIOD OF SUSPENSION.—If a servicemember whose professional liability insurance coverage is suspended under subsection (b) dies during the period of the suspension—

"(1) the requirement for the grant or continuance of a stay in any civil or administrative action against such servicemember under subsection (f)(1) shall terminate on the date of the death of such servicemember; and

"(2) the carrier of the professional liability insurance so suspended shall be liable for any claim for damages for professional negligence or other professional liability of the deceased servicemember in the same manner and to the same extent as such carrier would be liable if the servicemember had died while covered by such insurance but before the claim was filed.

"(i) DEFINITIONS.—For purposes of this section:

"(1) ACTIVE DUTY.—The term 'active duty' has the meaning given that term in section 101(d)(1) of title 10, United States Code.

"(2) PROFESSION.—The term 'profession' includes occupation.

"(3) PROFESSIONAL.—The term 'professional' includes occupational.

"SEC. 704. HEALTH INSURANCE REINSTATEMENT.

"(a) REINSTATEMENT OF HEALTH INSURANCE.—A servicemember who, by reason of military service as defined in section 703(a)(1), is entitled to the rights and protections of this Act shall also be entitled upon termination or release from such service to reinstatement of any health insurance that—

"(1) was in effect on the day before such service commenced; and

"(2) was terminated effective on a date during the period of such service.

"(b) NO EXCLUSION OR WAITING PERIOD.—The reinstatement of health care insurance coverage for the health or physical condition of a servicemember described in subsection (a), or any other person who is covered by the insurance by reason of the coverage of the servicemember, shall not be subject to an exclusion or a waiting period, if—

"(1) the condition arose before or during the period of such service;

"(2) an exclusion or a waiting period would not have been imposed for the condition during the period of coverage; and

"(3) if the condition relates to the servicemember, the condition has not been determined by the Secretary of Veterans Affairs to be a disability incurred or aggravated in the line of duty (within the meaning of section 105 of title 38, United States Code).

"(c) EXCEPTIONS.—Subsection (a) does not apply to a servicemember entitled to participate in employer-offered insurance benefits pursuant to the provisions of chapter 43 of title 38, United States Code.

"(d) TIME FOR APPLYING FOR REINSTATEMENT.—An application under this section must be filed not later than 120 days after the date of the termination of or release from military service.

"SEC. 705. GUARANTEE OF RESIDENCY FOR MILITARY PERSONNEL.

"For the purposes of voting for any Federal office (as defined in section 301 of the Federal Election Campaign Act of 1971 (2 U.S.C. 431)) or a State or local office, a person who is absent from a State in compliance with military or naval orders shall not, solely by reason of that absence—

"(1) be deemed to have lost a residence or domicile in that State, without regard to whether or not the person intends to return to that State;

"(2) be deemed to have acquired a residence or domicile in any other State; or

"(3) be deemed to have become a resident in or a resident of any other State.

"SEC. 706. BUSINESS OR TRADE OBLIGATIONS.

"(a) AVAILABILITY OF NON-BUSINESS ASSETS TO SATISFY OBLIGATIONS.—If the trade or business (without regard to the form in which such trade or business is carried out) of a servicemember has an obligation or liability for which the servicemember is personally liable, the assets of the servicemember not held in connection with the trade or business may not be available for satisfaction of the obligation or liability during the servicemember's military service.

"(b) RELIEF TO OBLIGORS.—Upon application to a court by the holder of an obligation or liability covered by this section, relief granted by this section to a servicemember may be modified as justice and equity require.".

SEC. 2. CONFORMING AMENDMENTS.

(a) MILITARY SELECTIVE SERVICE ACT.—Section 14 of the Military Selective Service Act (50 U.S.C. App. 464) is repealed.

(b) TITLE 5, UNITED STATES CODE.—

(1) Section 5520a(k)(2)(A) of title 5, United States Code, is amended by striking "Soldiers' and Sailors' Civil Relief Act of 1940" and inserting "Servicemembers Civil Relief Act"; and

(2) Section 5569(e) of title 5, United States Code, is amended—

(A) in paragraph (1), by striking "provided by the Soldiers' and Sailors' Civil Relief Act of 1940" and all that follows through "of such Act" and inserting "provided by the Servicemembers Civil Relief Act, including the benefits provided by section 702 of such Act but excluding the benefits provided by sections 104, 105, and 106, title IV, and title V (other than sections 501 and 510) of such Act"; and

(B) in paragraph (2)(A), by striking "person in the military service" and inserting "servicemember".

(c) TITLE 10, UNITED STATES CODE.—Section 1408(b)(1)(D) of title 10, United States Code, is amended by striking "Soldiers' and Sailors' Civil Relief Act of 1940" and inserting "Servicemembers Civil Relief Act".

(d) INTERNAL REVENUE CODE.—Section 7654(d)(1) of the Internal Revenue Code of 1986 is amended by striking "Soldiers' and Sailors' Civil Relief Act" and inserting "Servicemembers Civil Relief Act".

(e) PUBLIC HEALTH SERVICE ACT.—Section 212(e) of the Public Health Service Act (42 U.S.C. 213(e)) is amended by striking "Soldiers' and Sailors' Civil Relief Act of 1940" and inserting "Servicemembers Civil Relief Act".

(f) ELEMENTARY AND SECONDARY EDUCATION ACT OF 1965.—Section 8001 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7701) is amended by striking "section 514 of the Soldiers' and Sailors' Civil Relief Act of 1940 (50 U.S.C. App. 574)" in the matter preceding paragraph (1) and inserting "section 511 of the Servicemembers Civil Relief Act".

(g) NOAA COMMISSIONED OFFICER CORPS ACT OF 2002.—Section 262(a)(2) of National Oceanic and Atmospheric Administration Commissioned Officer Corps Act of 2002 (33 U.S.C. 3072(a)(2)) is amended to read as follows:

"(2) The Servicemembers Civil Relief Act.".

SEC. 3. EFFECTIVE DATE.

The amendment made by section 1 shall apply to any case that is not final before the date of the enactment of this Act.

Mr. GRAHAM of Florida. Mr. President, as ranking member of the Committee on Veterans' Affairs, I ask my colleagues to join me today in passing S. 1136, the Servicemembers' Civil Relief Act. This important bill would restate and update the Soldiers' and Sailors' Civil Relief Act of 1940, a law that protects servicemembers from worrying about civil lawsuits and pre-existing debts while they are in uniform defending the United States. The bill reasserts our commitment to protect and care for those servicemen and women who often make tremendous sacrifices to serve our nation.

Civil protections have been afforded to servicemembers in the United States since the War of 1812. The first modern version of the SSCRA was enacted after the U.S. entered World War I. In 1940, Congress reenacted many of the WWI provisions, but raised the protection on rent evictions by $30 to reflect the rise in the cost of living. Congress continued to update and supplement provisions over the years to adapt the protections to the changing needs and circumstances of servicemembers. In 2002, responding to the lengthy mobilization of National Guard members to safeguard the nation's airports after the attacks of September 11, Congress extended SSCRA protections to Guard members called up by the President to respond to national emergencies who remain under the authority of the State Governors.

This legislation would restate, clarify, and revise the Soldiers' and Sailors' Civil Relief Act of 1940, SSCRA, and its subsequent amendments. The SSCRA's main purpose has been to suspend some of the legal obligations incurred by military personnel prior to entry into the service or mobilization for active service in the Reserves or the National Guard. The core protections provided by the SSCRA are: stays of civil legal proceedings during a person's period of military service; an interest rate cap of 6 percent on debts incurred before active duty; protection from eviction and termination of pre-service residential leases; and legal residency protection. Also, servicemembers are able to terminate a lease on a home if given orders to move. Because of the SSCRA, servicemembers have not had to worry about being sued or being evicted from their homes while deployed. Instead, the legislation has allowed them to properly keep their focus on military duties.

The legislation before us, S. 1136, would update the SSCRA to better address the obligations servicemembers incur today. For example, due to the escalating costs of rental housing over the past few decades, this act will provide greater protection for servicemembers and their families from being evicted during times of military service. Currently, servicemembers are protected from eviction if they have a monthly rent of $1200 or less. This legislation will raise the bar to $2,400, to be adjusted annually based on the annual increase in the Consumer Price Index, thus avoiding the future need for frequent amendments to the law.

Continuing the effort to make the SSCRA applicable to today's servicemembers' lifestyles, this legislation would allow servicemembers to be released from a lease for an automobile if they are deployed for an extended period of time or moved overseas. It was necessary to add this protection because auto leasing has become such a popular alternative to purchasing in recent times, yet many leases prohibit the removal of cars from the United States.

This bill would also look after the needs of small business owners who serve, particularly those in the Reserves and National Guard. If passed, the bill would preserve the assets of small business owners during military service if the servicemember is personally liable for trade or business debts.

I thank the leadership of my colleagues who serve on the House Committee on Veterans' Affairs, the Chairman of the Senate Committee on Veterans' Affairs, Senator SPECTER, and Senators BEN NELSON and ZELL MILLER, who have all worked together to provide a comprehensive and necessary set of benefits which will relieve many of the personal burdens some of our servicemembers face when they are called into duty. The benefits will allow them to continue focusing their efforts on their heroic duties for our Nation.

I urge my colleagues to support this critical measure and restore the fundamental justice due our veterans.

Mr. FRIST. I ask unanimous consent the committee substitute amendment be agreed to; the bill, as amended, be read a third time, and the Veterans' Affairs Committee then be discharged from further consideration of H.R. 100, and the Senate proceed to its consideration. I further ask all after the enacting clause be stricken, the text of S. 1136, as amended, be inserted in lieu thereof, the bill as amended be read a third time and passed, the motions to reconsider be laid on the table en bloc, S. 1136 then be returned to the calendar, and any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The committee amendment in the nature of a substitute was agreed to.

The bill was ordered to be engrossed for a third reading and was read the third time.

The bill (H.R. 100), as amended, was read the third time and passed.

DEPARTMENT OF HOMELAND SECURITY FINANCIAL ACCOUNTABILITY ACT

Mr. FRIST. I ask unanimous consent the Senate now proceed to consideration of Calendar No. 405, S. 1567.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 1567) to amend title 31, United States Code, to improve financial accountability requirements applicable to the Department of Homeland Security and for other purposes.

There being no objection, the Senate proceeded to consider the bill which had been reported from the Committee on Governmental Affairs, with an amendment to strike all after the enacting clause and insert in lieu thereof the following:

[Strike the part shown in black brackets and insert the part shown in italic.]

S. 1567

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

[SECTION 1. SHORT TITLE.

[This Act may be cited as the "Department of Homeland Security Financial Accountability Act".

[SEC. 2. CHIEF FINANCIAL OFFICER OF THE DEPARTMENT OF HOMELAND SECURITY.

[(a) IN GENERAL.—Section 901(b)(1) of title 31, United States Code, is amended—

[(1) by redesignating subparagraphs (G) through (P) as subparagraphs (H) through (Q), respectively; and

[(2) by inserting after subparagraph (F) the following:

["(G) The Department of Homeland Security.".

[(b) APPOINTMENT OR DESIGNATION OF CFO.—The President shall appoint or designate a Chief Financial Officer of the Department of Homeland Security under the amendment made by subsection (a) by not later than 180 days after the date of the enactment of this Act.

[(c) CONTINUED SERVICE OF CURRENT OFFICIAL.—The individual serving as Chief Financial Officer of the Department of Homeland Security immediately before the enactment of this Act may continue to serve in that position until the date of the confirmation or designation, as applicable (under section 901(a)(1)(B) of title 31, United States Code), of a successor under the amendment made by subsection (a).

[(d) CONFORMING AMENDMENTS.—

[(1) HOMELAND SECURITY ACT OF 2002.—The Homeland Security Act of 2002 (Public Law 107–296) is amended—

[(A) in section 103 (6 U.S.C. 113)—

[(i) in subsection (d) by striking paragraph (4), and redesignating paragraph (5) as paragraph (4);

[(ii) by redesignating subsection (e) as subsection (f); and

[(iii) by inserting after subsection (d) the following:

["(e) CHIEF FINANCIAL OFFICER.—There shall be in the Department a Chief Financial Officer, as provided in chapter 9 of title 31, United States Code."; and

[(B) in section 702 (6 U.S.C. 342) by striking "shall report" and all that follows through the period and inserting "shall perform functions as specified in chapter 9 of title 31, United States Code.".

[(2) FEMA.—Section 901(b)(2) of title 31, United States Code, is amended by striking subparagraph (B), and by redesignating subparagraphs (D) through (H) as subparagraphs (C) through (G), respectively.

[SEC. 3. FUNCTIONS OF CHIEF FINANCIAL OFFICER OF THE DEPARTMENT OF HOMELAND SECURITY.

[Section 3516 of title 31, United States Code, is amended by adding at the end the following:

["(f) The Secretary of Homeland Security—

["(1) shall submit for fiscal year 2004, and for each subsequent fiscal year, a performance and accountability report under subsection (a) that incorporates the program performance report under section 1116 of this title for the Department of Homeland Security; and

["(2) shall include in each performance and accountability report an audit opinion of the Department's internal controls over its financial reporting.".]

SECTION 1. SHORT TITLE.

This Act may be cited as the "Department of Homeland Security Financial Accountability Act".

SEC. 2. CHIEF FINANCIAL OFFICER OF THE DEPARTMENT OF HOMELAND SECURITY.

(a) IN GENERAL.—Section 901(b)(1) of title 31, United States Code, is amended—

(1) by redesignating subparagraphs (G) through (P) as subparagraphs (H) through (Q), respectively; and

(2) by inserting after subparagraph (F) the following:

"(G) The Department of Homeland Security.".

(b) APPOINTMENT OR DESIGNATION OF CFO.—The President shall appoint or designate a Chief Financial Officer of the Department of Homeland Security under the amendment made by

subsection (a) by not later than 180 days after the date of the enactment of this Act.

(c) CONTINUED SERVICE OF CURRENT OFFICIAL.—The individual serving as Chief Financial Officer of the Department of Homeland Security immediately before the enactment of this Act may continue to serve in that position until the date of the confirmation or designation, as applicable (under section 901(a)(1)(B) of title 31, United States Code), of a successor under the amendment made by subsection (a).

(d) CONFORMING AMENDMENTS.—

(1) HOMELAND SECURITY ACT OF 2002.—The Homeland Security Act of 2002 (Public Law 107–296) is amended—

(A) in section 103 (6 U.S.C. 113)—

(i) in subsection (d) by striking paragraph (4), and redesignating paragraph (5) as paragraph (4);

(ii) by redesignating subsection (e) as subsection (f); and

(iii) by inserting after subsection (d) the following:

"(e) CHIEF FINANCIAL OFFICER.—There shall be in the Department a Chief Financial Officer, as provided in chapter 9 of title 31, United States Code."; and

(B) in section 702 (6 U.S.C. 342) by striking "shall report" and all that follows through the period and inserting "shall perform functions as specified in chapter 9 of title 31, United States Code.".

(2) FEMA.—Section 901(b)(2) of title 31, United States Code, is amended by striking subparagraph (B), and by redesignating subparagraphs (C) through (H) as subparagraphs (B) through (G), respectively.

SEC. 3. FUNCTIONS OF CHIEF FINANCIAL OFFICER OF THE DEPARTMENT OF HOMELAND SECURITY.

(a) PERFORMANCE AND ACCOUNTABILITY REPORTS.—Section 3516 of title 31, United States Code, is amended by adding at the end the following:

"(f) The Secretary of Homeland Security—

"(1) shall for each fiscal year submit a performance and accountability report under subsection (a) that incorporates the program performance report under section 1116 of this title for the Department of Homeland Security; and

"(2) shall include in each performance and accountability report an audit opinion of the Department's internal controls over its financial reporting.".

(b) IMPLEMENTATION OF AUDIT OPINION REQUIREMENT.—The Secretary of Homeland Security shall include audit opinions in performance and accountability reports under section 3516(f) of title 31, United States Code, as amended by subsection (a), only for fiscal years after fiscal year 2004.

(c) ASSERTION OF INTERNAL CONTROLS.—The Secretary of Homeland Security shall include in the performance and accountability report for fiscal year 2004 submitted by the Secretary under section 3516(f) of title 31, United States Code, an assertion of the internal controls that apply to financial reporting by the Department of Homeland Security.

SEC. 4. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to the Secretary of Homeland Security such sums as are necessary to carry out this Act.

Mr. FRIST. I ask unanimous consent the committee substitute be agreed to, the bill, as amended, be read a third time and passed, the motion to reconsider be laid on the table, and any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The committee amendment in the nature of a substitute was agreed to.

The bill (S. 1567), as amended, was read the third time and passed.

UNANIMOUS CONSENT AGREEMENT—S. 1248

Mr. FRIST. I ask unanimous consent that at a time to be determined by the majority leader in consultation with the minority leader, the Senate proceed to consideration of Calendar No. 362, S. 1248, the IDEA Act Reauthorization bill, and that it be considered under the following limitations: That the following amendments be the only first-degree amendments in order, other than the committee-reported substitute amendment, and that any second-degree amendments be relevant to the first-degree amendment to which they are offered: Gregg or his designee, IDEA attorney's fees; Gregg or his designee, IDEA funding; Gregg or his designee, IDEA paperwork reduction; Gregg or his designee, IDEA relevant; Harkin, IDEA funding; Murray, IDEA for the homeless; Clinton, coordinating data on developmental disabilities; Kennedy or his designee, IDEA relevant; Gregg-Kennedy, managers' amendment.

I further ask that upon disposition of all amendments, the committee substitute as amended be agreed to, the bill as amended be read a third time, and the HELP Committee be discharged from further consideration of H.R. 1350, the House companion bill, and the Senate then proceed to its immediate consideration; provided further that all after the enacting clause be stricken, and the text of S. 1248, as amended, be inserted in lieu thereafter, the bill, as amended, be read a third time and the Senate proceed to a vote on passage, without any intervening action or debate, and following the vote the motion to reconsider be laid upon the table. I further ask that after the vote on passage, S. 1248 be returned to the calendar.

The PRESIDING OFFICER. Without objection, it is so ordered.

CHIEF JUSTICE JOHN MARSHALL COMMEMORATIVE COIN ACT

Mr. FRIST. Mr. President, I ask unanimous consent that the Banking Committee be discharged from further consideration of S. 1531 and that the Senate proceed to its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 1531) to require the Secretary of the Treasury to mint coins in commemoration of Chief Justice John Marshall.

There being no objection, the Senate proceeded to consider the bill.

Mr. HATCH. Mr. President, I rise today in strong support of S. 1531, the Chief Justice John Marshall Commemorative Coin Act. I am the sponsor of this significant legislation and I believe its passage is indeed a tribute to the most important Chief Justice to serve on the Supreme Court of the United States since our nation's founding.

John Marshall served as the fourth Chief Justice of the Supreme Court for over 34 years. He is the longest serving Chief Justice in our Nation's history. Throughout his years on the Supreme Court, he authored over 500 opinions, many of which significantly impacted the operations and interpretations of the Constitution. He was a distinguished leader who made a lasting impression on the Supreme Court.

For example, probably Marshall's most famous opinion, Marbury v. Madison, instilled in the Supreme Court the authority to review the constitutionality of congressional acts and instituted the doctrine of judicial review. Without judicial review, the Supreme Court and the lower courts of our great nation would not have the ability to uphold and sustain the Constitution and stop any unauthorized intrusion into the sacred freedoms that great document protects.

The Marshall Court decided numerous landmark and historically significant cases that have forever fashioned the Nation's constitutional law and history—including McCullough v. Maryland, Cohens v. Virginia, Stuart v. Laird, Dartmouth College v. Woodward, and Gibbons v. Ogden, just to name a few. These cases are still cited today by our Federal courts and State courts as impressive precedents important to recognize that establish significant legal doctrines and relevant constitutional interpretations.

Chief Justice Marshall is not only the longest serving Chief Justice in the history of the United States, but he has authored more opinions for the Court than any other Chief Justice in the Supreme Court's history. That impressive record remains in place today.

It is noteworthy to recognize that Chief Justice Marshall also introduced and implemented the practice of allowing one justice to speak for the Court while having the remaining justices either sign on to that opinion or issue their own concurring or dissenting opinion. Prior to Chief Justice Marshall's tenure, Justices usually wrote their own opinions and a party in a case had to thoroughly study the particular nuances in each individual Justice's opinion in order to discover which side prevailed.

Chief Justice Marshall was also a Revolutionary War veteran, Envoy Extraordinary and Minister Plenipotentiary to France, Member of the United States House of Representatives, and Secretary of State under President John Adams.

I believe minting a coin is a fitting honor for the Great Chief Justice. This coin will commemorate the 250th anniversary of the birth of Chief Justice Marshall, which will take place in the year 2005.

This legislation will allow the Supreme Court Historical Society to receive the necessary revenue it needs for worthwhile endeavors. The Supreme Court Historical Society is an established national organization whose programs and endeavors benefit Americans in every State in the Union. The Supreme Court Historical Society operates a Summer Institute for Teachers, with brings teachers from across the nation to Washington to study the Supreme Court and the Constitution first hand. This particular program helps to improve public school education about the role and importance of the Court in our Government.

The Supreme Court Historical Society collects antiques and historical artifacts for the use of the Court Curator's educational displays at the Supreme Court Building. There are still many artifacts and antiques that would preserve the precious history of the Court that the Society lacks the funds to acquire.

The Supreme Court Historical Society also holds public lectures at the Supreme Court Building and around the country which usually feature current Justices on the Supreme Court and other important leaders in constitutional and legal scholarship.

The Chief Justice John Marshall Commemorative Coin Act will allow for 400,000 coins bearing the likeness of the Great Chief Justice, John Marshall, in 2005, with a surcharge of $10 per coin. The sale of these coins has the capability to produce nearly $4,000,000 in direct support of the Supreme Court Historical Society's programs and functions.

Furthermore, I put a provision in this bill to ensure that there is no net cost to the Federal Government in minting this coin. This provision is important, especially in a time when many are concerned about controlling deficit spending and making sure Congress does not unduly burden the American people with unnecessary debt.

Never in the history of this country has a coin been minted focusing on the history of the Supreme Court or on its profound influence on our constitutional form of government. Unless citizens have some form of legal training or a scholarly interest, the Supreme Court and our Federal courts are usually the least understood of the three branches of the government. Yet what it does has an impact, both direct and indirect, on the rights of every citizen.

The Chief Justice John Marshall Commemorative Coin Act has the support of every sitting Justice on the Supreme Court of the United States. It is likewise supported by the Citizens Commemorative Coin Advisory Committee and the former Solicitors General across party lines.

I encourage my colleagues to support this bill, as many have. I am confident this bill will benefit the entire country and as it will help preserve and protect the history of the Supreme Court of the United States.

Mr. LEAHY. Mr. President, I am pleased that the Senate has passed the John Marshall Commemorative Coin Act, S. 1531.

As an original cosponsor of the John Marshall Commemorative Coin Act, I have worked closely with Senator HATCH to do all that we possibly can to speedily pass it into law.

This bill authorizes the Treasury Department to mint and issue coins in honor of Chief Justice John Marshall in the year 2005. Funds raised by sale of the coin will support the Supreme Court Historical Society. Sales of the coin also cover all of the costs of minting and issuing these coins, so that the American taxpayer is not bearing any cost whatsoever of this commemoration.

That sales of a coin that bears the likeness of Chief Justice Marshall will be used to the support of the Supreme Court Historical Society is fitting. The society is a nonprofit organization whose purpose is to preserve and disseminate the history of the Supreme Court of the United States. Founded by Chief Justice Warren Burger, the society's mission is to provide information and historical research on our Nation's highest court. The society accomplishes this mission by conducting programs, publishing books, supporting historical research and collecting antiques and artifacts related to the Court's history. John Marshall is known as "the great Chief Justice" of the Supreme Court. Marshall served on the bench for 34 years and established many of the constitutional doctrines we revere today. He is best known and respected for the fundamental principles of checks and balance of our democratic government.

In our successful efforts to gender support for the bill, we gained over 75 cosponsors in the U.S. Senate. Given the noble cause, it was not a hard sell. Yet, the sheer numbers of bipartisan supporters are a fitting tribute to the Great Chief Justice John Marshall. We are happy to assist a worthwhile organization like the Supreme Court Historical Society.

I thank all the Senators who supported this bill—too numerous to name. I also thank the Supreme Court Historical Society for its dedication to this important cause.

Mr. FRIST. Mr. President, I ask unanimous consent that the bill be read a third time and passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (S. 1531) was read the third time and passed, as follows:

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Chief Justice John Marshall Commemorative Coin Act".

SEC. 2. FINDINGS.

Congress finds that—

(1) John Marshall served as the Chief Justice of the Supreme Court of the United States from 1801 to 1835, the longest tenure of any Chief Justice in the Nation's history;

(2) Under Marshall's leadership, the Supreme Court expounded the fundamental principles of constitutional interpretation, including judicial review, and affirmed national supremacy, both of which served to secure the newly founded United States against dissolution; and

(3) John Marshall's service to the nascent United States, not only as Chief Justice, but also as a soldier in the Revolutionary War, as a member of the Virginia Congress and the United States Congress, and as Secretary of State, makes him one of the most important figures in our Nation's history.

SEC. 3. COIN SPECIFICATIONS.

(a) DENOMINATION.—In commemoration of the 250th anniversary of the birth of Chief Justice John Marshall, the Secretary of the Treasury (in this Act referred to as the "Secretary") shall mint and issue not more than 400,000 $1 coins, each of which shall—

(1) weigh 26.73 grams;

(2) have a diameter of 1.500 inches; and

(3) contain 90 percent silver and 10 percent copper.

(b) LEGAL TENDER.—The coins minted under this Act shall be legal tender, as provided in section 5103 of title 31, United States Code.

(c) NUMISMATIC ITEMS.—For purposes of sections 5134 and 5136 of title 31, United States Code, all coins minted under this Act shall be considered to be numismatic items.

SEC. 4. DESIGN OF COINS.

(a) DESIGN REQUIREMENTS.—

(1) IN GENERAL.—The design of the coins minted under this Act shall be emblematic of Chief Justice John Marshall and his contributions to the United States.

(2) DESIGNATION AND INSCRIPTIONS.—On each coin minted under this Act, there shall be—

(A) a designation of the value of the coin;

(B) an inscription of the year "2005"; and

(C) inscriptions of the words "Liberty", "In God We Trust", "United States of America", and "E Pluribus Unum".

(b) SELECTION.—The design for the coins minted under this Act shall be—

(1) selected by the Secretary, after consultation with the Commission of Fine Arts, and the Supreme Court Historical Society; and

(2) reviewed by the Citizens Coinage Advisory Committee.

SEC. 5. ISSUANCE OF COINS.

(a) QUALITY OF COINS.—Coins minted under this Act shall be issued in uncirculated and proof qualities.

(b) MINT FACILITY.—Only one facility of the United States Mint may be used to strike any particular quality of the coins minted under this Act.

(c) COMMENCEMENT OF ISSUANCE.—The Secretary may issue coins minted under this Act beginning on January 1, 2005.

(d) TERMINATION OF MINTING AUTHORITY.—No coins may be minted under this Act after December 31, 2005.

SEC. 6. SALE OF COINS.

(a) SALE PRICE.—The coins minted under this Act shall be sold by the Secretary at a price equal to the sum of—

(1) the face value of the coins;

(2) the surcharge provided in section 7 with respect to such coins; and

(3) the cost of designing and issuing the coins (including labor, materials, dies, use of machinery, overhead expenses, marketing, and shipping).

(b) BULK SALES.—The Secretary shall make bulk sales of the coins minted under this Act at a reasonable discount.

(c) PREPAID ORDERS.—

(1) IN GENERAL.—The Secretary shall accept prepaid orders for the coins minted under this Act before the issuance of such coins.

(2) DISCOUNT.—Sale prices with respect to pre-paid orders under paragraph (1) shall be at a reasonable discount.

SEC. 7. SURCHARGES.

(a) IN GENERAL.—All sales of coins minted under this Act shall include a surcharge of $10 per coin.

(b) DISTRIBUTION.—Subject to section 5134(f) of title 31, United States Code, all surcharges received by the Secretary from the sale of coins issued under this Act shall be promptly paid by the Secretary to the Supreme Court Historical Society for the purposes of—

(1) historical research about the Supreme Court and the Constitution of the United States and related topics;

(2) supporting fellowship programs, internships, and docents at the Supreme Court; and

(3) collecting and preserving antiques, artifacts, and other historical items related to the Supreme Court and the Constitution of the United States and related topics.

(c) AUDITS.—The Supreme Court Historical Society shall be subject to the audit requirements of section 5134(f)(2) of title 31, United States Code, with regard to the amounts received by the Society under subsection (b).

SEC. 8. FINANCIAL ASSURANCES.

(a) NO NET COST TO THE GOVERNMENT.—The Secretary shall take such actions as may be necessary to ensure that the minting and issuance of the coins referred to in section 3(a) shall result in no net cost to the Federal Government.

(b) PAYMENT FOR THE COINS.—The Secretary may not sell a coin referred to in section 3(a) unless the Secretary has received—

(1) full payment for the coin;

(2) security satisfactory to the Secretary to indemnify the Federal Government for full payment; or

(3) a guarantee of full payment satisfactory to the Secretary from a depository institution, the deposits of which are insured by the Federal Deposit Insurance Corporation, the Federal Savings and Loan Insurance Corporation, or the National Credit Union Administration Board.

AWARDING A CONGRESSIONAL GOLD MEDAL TO DR. DOROTHY HEIGHT

Mr. FRIST. Mr. President, I ask unanimous consent that the Banking Committee be discharged from further consideration of H.R. 1821, and the Senate proceed to its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (H.R. 1821) to award a Congressional Gold Medal to Dr. Dorothy Height in recognition of her many contributions to the Nation.

There being no objection, the Senate proceeded to consider the bill.

Mr. FRIST. Mr. President, I ask unanimous consent that the bill be read a third time and passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (H.R. 1821) was read the third time and passed.

ENVIRONMENTAL POLICY AND CONFLICT RESOLUTION ADVANCEMENT ACT OF 2003

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of H.R. 421, which is at the desk.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (H.R. 421) to reauthorize the United States Institute for Environmental Conflict Resolution, and for other purposes.

There being no objection, the Senate proceeded to consider the bill.

Mr. FRIST. Mr. President, I ask unanimous consent that the bill be read the third time and passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (H.R. 421) was read the third time and passed.

SOUTHERN UTE AND COLORADO INTERGOVERNMENTAL AGREEMENT IMPLEMENTATION ACT OF 2003

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 401, S. 551.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 551) to provide for the implementation of air quality programs developed in accordance with an Intergovernmental Agreement between the Southern Ute Indian Tribe and the State of Colorado concerning Air Quality Control on the Southern Ute Indian Reservation, and for other purposes.

There being no objection, the Senate proceeded to consider the bill which had been reported from the Committee on Environment and Public Works with an amendment.

[Strike the part shown in black brackets and insert the part shown in italic.]

S. 551

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Southern Ute and Colorado Intergovernmental Agreement Implementation Act of 2003".

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—Congress, after review and in recognition of the purposes and uniqueness of the Intergovernmental Agreement between the Southern Ute Indian Tribe and the State of Colorado, finds that—

(1) the Intergovernmental Agreement is consistent with the special legal relationship between Federal Government and the Tribe; and

(2) air quality programs developed in accordance with the Intergovernmental Agreement and submitted by the Tribe for approval by the Administrator may be implemented in a manner that is consistent with the Clean Air Act (42 U.S.C. 7401 et seq.).

(b) PURPOSE.—The purpose of this Act is to provide for the implementation and enforcement of air quality control programs under the Clean Air Act (42 U.S.C. 7401 et seq.) and other air quality programs developed in accordance with the Intergovernmental Agreement that provide for—

(1) the regulation of air quality within the exterior boundaries of the Reservation; and

(2) the establishment of a Southern Ute Indian Tribe/State of Colorado Environmental Commission.

SEC. 3. DEFINITIONS.

In this Act:

(1) ADMINISTRATOR.—The term "Administrator" means the Administrator of the Environmental Protection Agency.

(2) COMMISSION.—The term "Commission" means the Southern Ute Indian Tribe/State of Colorado Environmental Commission established by the State and the Tribe in accordance with the Intergovernmental Agreement.

(3) INTERGOVERNMENTAL AGREEMENT.—The term "Intergovernmental Agreement" means the agreement entered into by the Tribe and the State on December 13, 1999.

(4) RESERVATION.—The term "Reservation" means the Southern Ute Indian Reservation.

(5) STATE.—The term "State" means the State of Colorado.

(6) TRIBE.—The term "Tribe" means the Southern Ute Indian Tribe.

SEC. 4. TRIBAL AUTHORITY.

(a) AIR PROGRAM APPLICATIONS.—

(1) IN GENERAL.—The Administrator is authorized to treat the Tribe as a State for the purpose of any air program applications submitted to the Administrator by the Tribe under section 301(d) of the Clean Air Act (42 U.S.C. 7601(d)) to carry out, in a manner consistent with the Clean Air Act (42 U.S.C. 7401 et seq.), the Intergovernmental Agreement.

(2) APPLICABILITY.—If the Administrator approves an air program application of the Tribe, the approved program shall be applicable to all air resources within the exterior boundaries of the Reservation.

(b) TERMINATION.—If the Tribe or the State terminates the Intergovernmental Agreement, the Administrator shall promptly take appropriate administrative action to withdraw treatment of the Tribe as a State for the purpose described in subsection (a)(1).

[SEC. 5. CIVIL ENFORCEMENT.

[If any person fails to comply with a final civil order of the Tribe or the Commission made in accordance with a program under the Clean Air Act (42 U.S.C. 7401 et seq.) or any other air quality program established under the Intergovernmental Agreement, the Tribe or the Commission, as appropriate, may bring a civil action for declaratory or injunctive relief, or for other orders in aid of enforcement, in the United States District Court for the District of Colorado.]

SEC. 5. CIVIL ENFORCEMENT.

(a) In General.—If any person fails to comply with a final civil order of the Tribe or the Commission made in accordance with the Clean Air Act (42 U.S.C. 7401 et seq.) or any other air quality program established under the Intergovernmental Agreement, the Tribe or the Commission, as appropriate, may bring a civil action for declaratory or injunctive relief, or for other orders in aid of enforcement, in the United States District Court for the District of Colorado.

(b) No Effect on Rights or Authority.—Nothing in this Act alters, amends, or modifies any right or authority of any person (as defined in section 302(e) of the Clean Air Act (42 U.S.C. 7601(e)) to bring a civil action under section 304 of the Clean Air Act (42 U.S.C. 7603).

SEC. 6. JUDICIAL REVIEW.

Any decision by the Commission that would be subject to appellate review if it were made by the Administrator—

(1) shall be subject to appellate review by the United States Court of Appeals for the Tenth Circuit; and

(2) may be reviewed by the Court of Appeals applying the same standard that would be applicable to a decision of the Administrator.

SEC. 7. DISCLAIMER.

Nothing in this Act—

(1) modifies any provision of—

(A) the Clean Air Act (42 U.S.C. 7401 et seq.);

(B) Public Law 98-290 (25 U.S.C. 668 note); or

(C) any lawful administrative rule promulgated in accordance with those statutes; or

(2) affects or influences in any manner any past or prospective judicial interpretation or application of those statutes by the United States, the Tribe, the State, or any Federal, tribal, or State court.

Mr. FRIST. Mr. President, I ask unanimous consent that the committee amendment be agreed to, the bill, as amended, be read a third time and passed, the motions to reconsider be laid upon the table en bloc, and that any statements relating to the bill be printed in the Record.

The PRESIDING OFFICER. Without objection, it is so ordered.

The committee amendment was agreed to.

The bill (S. 551), as amended, was read the third time and passed, as follows:

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Southern Ute and Colorado Intergovernmental Agreement Implementation Act of 2003".

SEC. 2. FINDINGS AND PURPOSE.

(a) Findings.—Congress, after review and in recognition of the purposes and uniqueness of the Intergovernmental Agreement between the Southern Ute Indian Tribe and the State of Colorado, finds that—

(1) the Intergovernmental Agreement is consistent with the special legal relationship between Federal Government and the Tribe; and

(2) air quality programs developed in accordance with the Intergovernmental Agreement and submitted by the Tribe for approval by the Administrator may be implemented in a manner that is consistent with the Clean Air Act (42 U.S.C. 7401 et seq.).

(b) Purpose.—The purpose of this Act is to provide for the implementation and enforcement of air quality control programs under the Clean Air Act (42 U.S.C. 7401 et seq.) and other air quality programs developed in accordance with the Intergovernmental Agreement that provide for—

(1) the regulation of air quality within the exterior boundaries of the Reservation; and

(2) the establishment of a Southern Ute Indian Tribe/State of Colorado Environmental Commission.

SEC. 3. DEFINITIONS.

In this Act:

(1) Administrator.—The term "Administrator" means the Administrator of the Environmental Protection Agency.

(2) Commission.—The term "Commission" means the Southern Ute Indian Tribe/State of Colorado Environmental Commission established by the State and the Tribe in accordance with the Intergovernmental Agreement.

(3) Intergovernmental agreement.—The term "Intergovernmental Agreement" means the agreement entered into by the Tribe and the State on December 13, 1999.

(4) Reservation.—The term "Reservation" means the Southern Ute Indian Reservation.

(5) State.—The term "State" means the State of Colorado.

(6) Tribe.—The term "Tribe" means the Southern Ute Indian Tribe.

SEC. 4. TRIBAL AUTHORITY.

(a) Air Program Applications.—

(1) In general.—The Administrator is authorized to treat the Tribe as a State for the purpose of any air program applications submitted to the Administrator by the Tribe under section 301(d) of the Clean Air Act (42 U.S.C. 7601(d)) to carry out, in a manner consistent with the Clean Air Act (42 U.S.C. 7401 et seq.), the Intergovernmental Agreement.

(2) Applicability.—If the Administrator approves an air program application of the Tribe, the approved program shall be applicable to all air resources within the exterior boundaries of the Reservation.

(b) Termination.—If the Tribe or the State terminates the Intergovernmental Agreement, the Administrator shall promptly take appropriate administrative action to withdraw treatment of the Tribe as a State for the purpose described in subsection (a)(1).

SEC. 5. CIVIL ENFORCEMENT.

(a) In General.—If any person fails to comply with a final civil order of the Tribe or the Commission made in accordance with the Clean Air Act (42 U.S.C. 7401 et seq.) or any other air quality program established under the Intergovernmental Agreement, the Tribe or the Commission, as appropriate, may bring a civil action for declaratory or injunctive relief, or for other orders in aid of enforcement, in the United States District Court for the District of Colorado.

(b) No Effect on Rights or Authority.—Nothing in this Act alters, amends, or modifies any right or authority of any person (as defined in section 302(e) of the Clean Air Act (42 U.S.C. 7601(e)) to bring a civil action under section 304 of the Clean Air Act (42 U.S.C. 7603).

SEC. 6. JUDICIAL REVIEW.

Any decision by the Commission that would be subject to appellate review if it were made by the Administrator—

(1) shall be subject to appellate review by the United States Court of Appeals for the Tenth Circuit; and

(2) may be reviewed by the Court of Appeals applying the same standard that would be applicable to a decision of the Administrator.

SEC. 7. DISCLAIMER.

Nothing in this Act—

(1) modifies any provision of—

(A) the Clean Air Act (42 U.S.C. 7401 et seq.);

(B) Public Law 98-290 (25 U.S.C. 668 note); or

(C) any lawful administrative rule promulgated in accordance with those statutes; or

(2) affects or influences in any manner any past or prospective judicial interpretation or application of those statutes by the United States, the Tribe, the State, or any Federal, tribal, or State court.

DISASTER AREA HEALTH AND ENVIRONMENTAL MONITORING ACT OF 2003

Mr. FRIST. I ask unanimous consent that the Senate now proceed to consideration of Calendar 360, S. 1279.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 1279) to amend the Robert T. Stafford Disaster Relief and Emergency Assistance Act to authorize the President to carry out a program for the protection of the health and safety of residents, workers, volunteers, and others in a disaster area.

There being no objection, the Senate proceeded to consider the bill which had been reported from the Committee on Environment and Public Works, with an amendment to strike all after the enacting clause and insert in lieu thereof the following:

[Strike the part shown in black brackets and insert the part shown in italic.]

S. 1279

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

[SECTION 1. SHORT TITLE.

[This Act may be cited as the "Disaster Area Health and Environmental Monitoring Act of 2003".

[SEC. 2. PROTECTION OF HEALTH AND SAFETY OF INDIVIDUALS IN A DISASTER AREA.

[Title IV of the Robert T. Stafford Disaster Relief and Emergency Assistance Act is amended by inserting after section 408 (42 U.S.C. 5174) the following:

["SEC. 409. PROTECTION OF HEALTH AND SAFETY OF INDIVIDUALS IN A DISASTER AREA.

["(a) Definitions.—In this section:

["(1) Individual.—The term 'individual' includes—

["(A) a worker or volunteer who responds to a disaster, including—

["(i) a police officer;

["(ii) a firefighter;

["(iii) an emergency medical technician;

["(iv) any participating member of an urban search and rescue team; and

["(v) any other relief or rescue worker or volunteer that the President determines to be appropriate;

["(B) a worker who responds to a disaster by assisting in the cleanup or restoration of critical infrastructure in and around a disaster area;

["(C) a person whose place of residence is in a disaster area;

[“(D) a person who is employed in or attends school, child care, or adult day care in a building located in a disaster area; and

[“(E) any other person that the President determines to be appropriate.

[“(2) PROGRAM.—The term ‘program’ means a program described in subsection (b) that is carried out for a disaster area.

[“(3) SUBSTANCE OF CONCERN.—The term ‘substance of concern’ means any chemical or substance associated with potential acute or chronic human health effects, the risk of exposure to which could potentially be increased as the result of a disaster.

[“(b) PROGRAM.—

[“(1) IN GENERAL.—If the President determines that 1 or more substances of concern are being, or have been, released in an area declared to be a disaster area under this Act, the President may carry out a program for the protection, assessment, monitoring, and study of the health and safety of individuals to ensure that—

[“(A) the individuals are adequately informed about and protected against potential health impacts of the substance of concern and potential mental health impacts in a timely manner;

[“(B) the individuals are monitored and studied over time, including through baseline and follow-up clinical health examinations, for—

[“(i) any short- and long-term health impacts of any substance of concern; and

[“(ii) any mental health impacts;

[“(C) the individuals receive health care referrals as needed and appropriate; and

[“(D) information from any such monitoring and studies is used to prevent or protect against similar health impacts from future disasters.

[“(2) ACTIVITIES.—A program under paragraph (1) may include such activities as—

[“(A) collecting and analyzing environmental exposure data;

[“(B) developing and disseminating information and educational materials;

[“(C) performing baseline and follow-up clinical health and mental health examinations and taking biological samples;

[“(D) establishing and maintaining an exposure registry;

[“(E) studying the long-term human health impacts of any exposures through epidemiological and other health studies; and

[“(F) providing assistance to individuals in determining eligibility for health coverage and identifying appropriate health services.

[“(3) TIMING.—To the maximum extent practicable, a program under paragraph (1) shall be established, and activities under the program shall be commenced (including baseline health examinations), in a timely manner that will ensure the highest level of public health protection and effective monitoring.

[“(4) PARTICIPATION IN REGISTRIES AND STUDIES.—

[“(A) IN GENERAL.—Participation in any registry or study that is part of a program under paragraph (1) shall be voluntary.

[“(B) PROTECTION OF PRIVACY.—The President shall take appropriate measures to protect the privacy of any participant in a registry or study described in subparagraph (A).

[“(5) COOPERATIVE AGREEMENTS.—The President may carry out a program under paragraph (1) through a cooperative agreement with a medical institution, or a consortium of medical institutions, that is—

[“(A) located near the disaster area, and near groups of individuals that worked or volunteered in response to the disaster in the disaster area, with respect to which the program is carried out; and

[“(B) experienced in the area of environmental or occupational health, toxicology, and safety, including experience in—

[“(i) developing clinical protocols and conducting clinical health examinations, including mental health assessments;

[“(ii) conducting long-term health monitoring and epidemiological studies;

[“(iii) conducting long-term mental health studies; and

[“(iv) establishing and maintaining medical surveillance programs and environmental exposure or disease registries.

[“(6) INVOLVEMENT.—

[“(A) IN GENERAL.—In establishing and maintaining a program under paragraph (1), the President shall ensure the involvement of interested and affected parties, as appropriate, including representatives of—

[“(i) Federal, State, and local government agencies;

[“(ii) labor organizations;

[“(iii) local residents, businesses, and schools (including parents and teachers);

[“(iv) health care providers; and

[“(v) other organizations and persons.

[“(B) COMMITTEES.—Involvement under subparagraph (A) may be provided through the establishment of an advisory or oversight committee or board.

[“(c) REPORTS.—Not later than 1 year after the establishment of a program under subsection (b)(1), and every 5 years thereafter, the President, or the medical institution or consortium of such institutions having entered into a cooperative agreement under subsection (b)(5), shall submit to the Secretary of Homeland Security, the Secretary of Health and Human Services, the Secretary of Labor, the Administrator of the Environmental Protection Agency, and appropriate committees of Congress a report on programs and studies carried out under the program.”.

[SEC. 3. BLUE RIBBON PANEL ON DISASTER AREA HEALTH PROTECTION AND MONITORING.

[(a) ESTABLISHMENT.—Not later than 60 days after the date of enactment of this section, the Secretary of Homeland Security, the Secretary of Health and Human Services, and the Administrator of the Environmental Protection Agency shall jointly establish a Blue Ribbon Panel on Disaster Area Health Protection and Monitoring (referred to in this section as the “Panel”).

[(b) MEMBERSHIP.—

[(1) IN GENERAL.—The Panel shall be composed of—

[(A) 15 voting members, to be appointed by the Secretary of Homeland Security, the Secretary of Health and Human Services, and the Administrator of the Environmental Protection Agency in accordance with paragraph (2); and

[(B) officers or employees of the Department of Health and Human Services, the Department of Homeland Security, the Environmental Protection Agency, and other Federal agencies, as appropriate, to be appointed by the Secretary of Health and Human Services, the Secretary of Homeland Security, and the Administrator of the Environmental Protection Agency as nonvoting, ex officio members of the Panel.

[(2) BACKGROUND AND EXPERTISE.—The voting members of the Panel shall be individuals who—

[(A) are not officers or employees of the Federal Government; and

[(B) have expertise in—

[(i) environmental health, safety, and medicine;

[(ii) occupational health, safety, and medicine;

[(iii) clinical medicine, including pediatrics;

[(iv) toxicology;

[(v) epidemiology;

[(vi) mental health;

[(vii) medical monitoring and surveillance;

[(viii) environmental monitoring and surveillance;

[(ix) environmental and industrial hygiene;

[(x) emergency planning and preparedness;

[(xi) public outreach and education;

[(xii) State and local health departments;

[(xiii) State and local environmental protection departments;

[(xiv) functions of workers that respond to disasters, including first responders; and

[(xv) public health and family services.

[(c) DUTIES.—

[(1) IN GENERAL.—The Panel shall provide advice and recommendations regarding protecting and monitoring the health and safety of individuals potentially exposed to any chemical or substance associated with potential acute or chronic human health effects as the result of a disaster, including advice and recommendations regarding—

[(A) the implementation of programs under section 409 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (as added by section 2); and

[(B) the establishment of protocols for the monitoring of and response to releases of substances of concern (as defined in section 409(a) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (as added by section 2)) in a disaster area for the purpose of protecting public health and safety, including—

[(i) those substances of concern for which samples should be collected in the event of a disaster, including a terrorist attack;

[(ii) chemical-specific methods of sample collection, including sampling methodologies and locations;

[(iii) chemical-specific methods of sample analysis;

[(iv) health-based threshold levels to be used and response actions to be taken in the event that thresholds are exceeded for individual chemicals or substances;

[(v) procedures for providing monitoring results to—

[(I) appropriate Federal, State, and local government agencies;

[(II) appropriate response personnel; and

[(III) the public;

[(vi) responsibilities of Federal, State and local agencies for—

[(I) collecting and analyzing samples;

[(II) reporting results; and

[(III) taking appropriate response actions; and

[(vii) capabilities and capacity within the Federal Government to conduct appropriate environmental monitoring and response in the event of a disaster, including a terrorist attack; and

[(C) other issues as specified by the Secretary of Homeland Security, the Secretary of Health and Human Services, and the Administrator of the Environmental Protection Agency.

[(2) REPORT.—Not later than 1 year after the date of establishment of the Panel, the Panel shall submit to the Secretary of Homeland Security, the Secretary of Health and Human Services, and the Administrator of the Environmental Protection Agency a report of the findings and recommendations of the Panel under this section, including recommendations for such legislative and administrative actions as the Panel considers to be appropriate.

[(d) POWERS.—

[(1) HEARINGS.—The Panel may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Panel considers necessary to carry out this section.

[(2) INFORMATION FROM FEDERAL AGENCIES.—

[(A) IN GENERAL.—The Panel may secure directly from any Federal department or agency such information as the Panel considers necessary to carry out this section.

[(B) FURNISHING OF INFORMATION.—On request of the Panel, the head of the department or agency shall furnish the information to the Panel.

[(3) POSTAL SERVICES.—The Panel may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

[(e) PERSONNEL.—

[(1) TRAVEL EXPENSES.—The members of the Panel shall not receive compensation for the performance of services for the Panel, but shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Panel.

[(2) VOLUNTARY AND UNCOMPENSATED SERVICES.—Notwithstanding section 1342 of title 31, United States Code, the Secretary may accept the voluntary and uncompensated services of members of the Panel.

[(3) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Panel without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

[(4) STAFF, INFORMATION, AND OTHER ASSISTANCE.—The Secretary of Homeland Security, the Secretary of Health and Human Services, and the Administrator of the Environmental Protection Agency shall provide to the Panel such staff, information, and other assistance as may be necessary to carry out the duties of the Panel.

[(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

[(g) TERMINATION OF AUTHORITY.—This section, the authority provided under this section, and the Panel shall terminate on the date that is 18 months after the date of enactment of this Act.]

SECTION 1. SHORT TITLE.

This Act may be cited as the "Disaster Area Health and Environmental Monitoring Act of 2003".

SEC. 2. PROTECTION OF HEALTH AND SAFETY OF INDIVIDUALS IN A DISASTER AREA.

Title IV of the Robert T. Stafford Disaster Relief and Emergency Assistance Act is amended by inserting after section 408 (42 U.S.C. 5174) the following:

"SEC. 409. PROTECTION OF HEALTH AND SAFETY OF INDIVIDUALS IN A DISASTER AREA.

"(a) DEFINITIONS.—In this section:

"(1) INDIVIDUAL.—The term 'individual' includes—

"(A) a worker or volunteer who responds to a disaster, including—

"(i) a police officer;

"(ii) a firefighter;

"(iii) an emergency medical technician;

"(iv) any participating member of an urban search and rescue team; and

"(v) any other relief or rescue worker or volunteer that the President determines to be appropriate;

"(B) a worker who responds to a disaster by assisting in the cleanup or restoration of critical infrastructure in and around a disaster area;

"(C) a person whose place of residence is in a disaster area;

"(D) a person who is employed in or attends school, child care, or adult day care in a building located in a disaster area; and

"(E) any other person that the President determines to be appropriate.

"(2) PROGRAM.—The term 'program' means a program described in subsection (b) that is carried out for a disaster area.

"(3) SUBSTANCE OF CONCERN.—The term 'substance of concern' means a chemical or other substance that is associated with potential acute or chronic human health effects, the risk of exposure to which could potentially be increased as the result of a disaster, as determined by the President.

"(b) PROGRAM.—

"(1) IN GENERAL.—If the President determines that 1 or more substances of concern are being, or have been, released in an area declared to be a disaster area under this Act, the President may carry out a program for the protection, assessment, monitoring, and study of the health and safety of individuals to ensure that—

"(A) the individuals are adequately informed about and protected against potential health impacts of any substance of concern and potential mental health impacts in a timely manner;

"(B) the individuals are monitored and studied over time, including through baseline and followup clinical health examinations, for—

"(i) any short- and long-term health impacts of any substance of concern; and

"(ii) any mental health impacts;

"(C) the individuals receive health care referrals as needed and appropriate; and

"(D) information from any such monitoring and studies is used to prevent or protect against similar health impacts from future disasters.

"(2) ACTIVITIES.—A program under paragraph (1) may include such activities as—

"(A) collecting and analyzing environmental exposure data;

"(B) developing and disseminating information and educational materials;

"(C) performing baseline and followup clinical health and mental health examinations and taking biological samples;

"(D) establishing and maintaining an exposure registry;

"(E) studying the short- and long-term human health impacts of any exposures through epidemiological and other health studies; and

"(F) providing assistance to individuals in determining eligibility for health coverage and identifying appropriate health services.

"(3) TIMING.—To the maximum extent practicable, activities under any program established under paragraph (1) (including baseline health examinations) shall be commenced in a timely manner that will ensure the highest level of public health protection and effective monitoring.

"(4) PARTICIPATION IN REGISTRIES AND STUDIES.—

"(A) IN GENERAL.—Participation in any registry or study that is part of a program under paragraph (1) shall be voluntary.

"(B) PROTECTION OF PRIVACY.—The President shall take appropriate measures to protect the privacy of any participant in a registry or study described in subparagraph (A).

"(5) COOPERATIVE AGREEMENTS.—

"(A) IN GENERAL.—The President may carry out a program under paragraph (1) through a cooperative agreement with a medical institution or a consortium of medical institutions.

"(B) SELECTION CRITERIA.—To the maximum extent practicable, the President shall select to carry out a program under paragraph (1) a medical institution or a consortium of medical institutions that—

"(i) is located near—

"(I) the disaster area with respect to which the program is carried out; and

"(II) any other area in which there reside groups of individuals that worked or volunteered in response to the disaster; and

"(ii) has appropriate experience in the areas of environmental or occupational health, toxicology, and safety, including experience in—

"(I) developing clinical protocols and conducting clinical health examinations, including mental health assessments;

"(II) conducting long-term health monitoring and epidemiological studies;

"(III) conducting long-term mental health studies; and

"(IV) establishing and maintaining medical surveillance programs and environmental exposure or disease registries.

"(6) INVOLVEMENT.—

"(A) IN GENERAL.—In establishing and maintaining a program under paragraph (1), the President shall involve interested and affected parties, as appropriate, including representatives of—

"(i) Federal, State, and local government agencies;

"(ii) groups of individuals that worked or volunteered in response to the disaster in the disaster area;

"(iii) local residents, businesses, and schools (including parents and teachers);

"(iv) health care providers; and

"(v) other organizations and persons.

"(B) COMMITTEES.—Involvement under subparagraph (A) may be provided through the establishment of an advisory or oversight committee or board.

"(c) REPORTS.—Not later than 1 year after the establishment of a program under subsection (b)(1), and every 5 years thereafter, the President, or the medical institution or consortium of such institutions having entered into a cooperative agreement under subsection (b)(5), shall submit to the Secretary of Homeland Security, the Secretary of Health and Human Services, the Secretary of Labor, the Administrator of the Environmental Protection Agency, and appropriate committees of Congress a report on programs and studies carried out under the program.".

SEC. 3. NATIONAL ACADEMY OF SCIENCES REPORT ON DISASTER AREA HEALTH AND ENVIRONMENTAL PROTECTION AND MONITORING.

(a) IN GENERAL.—The Secretary of Homeland Security, the Secretary of Health and Human Services, and the Administrator of the Environmental Protection Agency shall jointly enter into a contract with the National Academy of Sciences to conduct a study and prepare a report on disaster area health and environmental protection and monitoring.

(b) EXPERTISE.—The report under subsection (a) shall be prepared with the participation of individuals who have expertise in—

(1) environmental health, safety, and medicine;

(2) occupational health, safety, and medicine;

(3) clinical medicine, including pediatrics;

(4) toxicology;

(5) epidemiology;

(6) mental health;

(7) medical monitoring and surveillance;

(8) environmental monitoring and surveillance;

(9) environmental and industrial hygiene;

(10) emergency planning and preparedness;

(11) public outreach and education;

(12) State and local health departments;

(13) State and local environmental protection departments;

(14) functions of workers that respond to disasters, including first responders; and

(15) public health and family services.

(c) Contents.—The report under subsection (a) shall provide advice and recommendations regarding protecting and monitoring the health and safety of individuals potentially exposed to any chemical or other substance associated with potential acute or chronic human health effects as the result of a disaster, including advice and recommendations regarding—

(1) the establishment of protocols for the monitoring of and response to chemical or substance releases in a disaster area for the purpose of protecting public health and safety, including—

(A) chemicals or other substances for which samples should be collected in the event of a disaster, including a terrorist attack;

(B) chemical- or substance-specific methods of sample collection, including sampling methodologies and locations;

(C) chemical- or substance-specific methods of sample analysis;

(D) health-based threshold levels to be used and response actions to be taken in the event that thresholds are exceeded for individual chemicals or other substances;

(E) procedures for providing monitoring results to—

(i) appropriate Federal, State, and local government agencies;

(ii) appropriate response personnel; and

(iii) the public;

(F) responsibilities of Federal, State and local agencies for—

(i) collecting and analyzing samples;

(ii) reporting results; and

(iii) taking appropriate response actions; and

(G) capabilities and capacity within the Federal Government to conduct appropriate environmental monitoring and response in the event of a disaster, including a terrorist attack; and

(2) other issues as specified by the Secretary of Homeland Security, the Secretary of Health and Human Services, and the Administrator of the Environmental Protection Agency.

(d) Authorization of Appropriations.—There are authorized to be appropriated such sums as are necessary to carry out this section.

Mr. FRIST. I ask unanimous consent that the Inhofe amendment at the desk be agreed to; the committee substitute amendment, as amended, be agreed to; the bill, as amended, be read the third time and passed, the motion to reconsider be laid upon the table, and any statements be printed in the Record.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 2210) was agreed to, as follows:

(Purpose: To require that health and safety programs be carried out in accordance with certain privacy regulations)

On page 19, line 16, insert ", including a local health department," after "institution".

On page 21, between lines 18 and 19, insert the following:

"(7) Privacy.—The President shall carry out each program under paragraph (1) in accordance with regulations relating to privacy promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note; Public Law 104–191).

At the end, add the following:

SEC. 4. PREDISASTER HAZARD MITIGATION.

Section 203(m) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5133(m)) is amended by striking "December 31, 2003" and inserting "September 30, 2006".

The committee amendment in the nature of a substitute, as amended, was agreed to.

The bill (S. 1279), as amended, was read the third time and passed, as follows:

S. 1279

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Disaster Area Health and Environmental Monitoring Act of 2003".

SEC. 2. PROTECTION OF HEALTH AND SAFETY OF INDIVIDUALS IN A DISASTER AREA.

Title IV of the Robert T. Stafford Disaster Relief and Emergency Assistance Act is amended by inserting after section 408 (42 U.S.C. 5174) the following:

"SEC. 409. PROTECTION OF HEALTH AND SAFETY OF INDIVIDUALS IN A DISASTER AREA.

"(a) Definitions.—In this section:

"(1) Individual.—The term 'individual' includes—

"(A) a worker or volunteer who responds to a disaster, including—

"(i) a police officer;

"(ii) a firefighter;

"(iii) an emergency medical technician;

"(iv) any participating member of an urban search and rescue team; and

"(v) any other relief or rescue worker or volunteer that the President determines to be appropriate;

"(B) a worker who responds to a disaster by assisting in the cleanup or restoration of critical infrastructure in and around a disaster area;

"(C) a person whose place of residence is in a disaster area;

"(D) a person who is employed in or attends school, child care, or adult day care in a building located in a disaster area; and

"(E) any other person that the President determines to be appropriate.

"(2) Program.—The term 'program' means a program described in subsection (b) that is carried out for a disaster area.

"(3) Substance of concern.—The term 'substance of concern' means a chemical or other substance that is associated with potential acute or chronic human health effects, the risk of exposure to which could potentially be increased as the result of a disaster, as determined by the President.

"(b) Program.—

"(1) In general.—If the President determines that 1 or more substances of concern are being, or have been, released in an area declared to be a disaster area under this Act, the President may carry out a program for the protection, assessment, monitoring, and study of the health and safety of individuals to ensure that—

"(A) the individuals are adequately informed about and protected against potential health impacts of any substance of concern and potential mental health impacts in a timely manner;

"(B) the individuals are monitored and studied over time, including through baseline and followup clinical health examinations, for—

"(i) any short- and long-term health impacts of any substance of concern; and

"(ii) any mental health impacts;

"(C) the individuals receive health care referrals as needed and appropriate; and

"(D) information from any such monitoring and studies is used to prevent or protect against similar health impacts from future disasters.

"(2) Activities.—A program under paragraph (1) may include such activities as—

"(A) collecting and analyzing environmental exposure data;

"(B) developing and disseminating information and educational materials;

"(C) performing baseline and followup clinical health and mental health examinations and taking biological samples;

"(D) establishing and maintaining an exposure registry;

"(E) studying the short- and long-term human health impacts of any exposures through epidemiological and other health studies; and

"(F) providing assistance to individuals in determining eligibility for health coverage and identifying appropriate health services.

"(3) Timing.—To the maximum extent practicable, activities under any program established under paragraph (1) (including baseline health examinations) shall be commenced in a timely manner that will ensure the highest level of public health protection and effective monitoring.

"(4) Participation in registries and studies.—

"(A) In general.—Participation in any registry or study that is part of a program under paragraph (1) shall be voluntary.

"(B) Protection of privacy.—The President shall take appropriate measures to protect the privacy of any participant in a registry or study described in subparagraph (A).

"(5) Cooperative agreements.—

"(A) In general.—The President may carry out a program under paragraph (1) through a cooperative agreement with a medical institution, including a local health department, or a consortium of medical institutions.

"(B) Selection criteria.—To the maximum extent practicable, the President shall select to carry out a program under paragraph (1) a medical institution or a consortium of medical institutions that—

"(i) is located near—

"(I) the disaster area with respect to which the program is carried out; and

"(II) any other area in which there reside groups of individuals that worked or volunteered in response to the disaster; and

"(ii) has appropriate experience in the areas of environmental or occupational health, toxicology, and safety, including experience in—

"(I) developing clinical protocols and conducting clinical health examinations, including mental health assessments;

"(II) conducting long-term health monitoring and epidemiological studies;

"(III) conducting long-term mental health studies; and

"(IV) establishing and maintaining medical surveillance programs and environmental exposure or disease registries.

"(6) Involvement.—

"(A) In general.—In establishing and maintaining a program under paragraph (1), the President shall involve interested and affected parties, as appropriate, including representatives of—

"(i) Federal, State, and local government agencies;

"(ii) groups of individuals that worked or volunteered in response to the disaster in the disaster area;

"(iii) local residents, businesses, and schools (including parents and teachers);

"(iv) health care providers; and

"(v) other organizations and persons.

"(B) Committees.—Involvement under subparagraph (A) may be provided through the establishment of an advisory or oversight committee or board.

"(7) Privacy.—The President shall carry out each program under paragraph (1) in accordance with regulations relating to privacy promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note; Public Law 104–191).

"(c) Reports.—Not later than 1 year after the establishment of a program under subsection (b)(1), and every 5 years thereafter, the President, or the medical institution or consortium of such institutions having entered into a cooperative agreement under subsection (b)(5), shall submit to the Secretary of Homeland Security, the Secretary of Health and Human Services, the Secretary of Labor, the Administrator of the Environmental Protection Agency, and appropriate committees of Congress a report on programs and studies carried out under the program.".

SEC. 3. NATIONAL ACADEMY OF SCIENCES REPORT ON DISASTER AREA HEALTH AND ENVIRONMENTAL PROTECTION AND MONITORING.

(a) In General.—The Secretary of Homeland Security, the Secretary of Health and Human Services, and the Administrator of the Environmental Protection Agency shall jointly enter into a contract with the National Academy of Sciences to conduct a study and prepare a report on disaster area health and environmental protection and monitoring.

(b) Expertise.—The report under subsection (a) shall be prepared with the participation of individuals who have expertise in—

(1) environmental health, safety, and medicine;

(2) occupational health, safety, and medicine;

(3) clinical medicine, including pediatrics;

(4) toxicology;

(5) epidemiology;

(6) mental health;

(7) medical monitoring and surveillance;

(8) environmental monitoring and surveillance;

(9) environmental and industrial hygiene;

(10) emergency planning and preparedness;

(11) public outreach and education;

(12) State and local health departments;

(13) State and local environmental protection departments;

(14) functions of workers that respond to disasters, including first responders; and

(15) public health and family services.

(c) Contents.—The report under subsection (a) shall provide advice and recommendations regarding protecting and monitoring the health and safety of individuals potentially exposed to any chemical or other substance associated with potential acute or chronic human health effects as the result of a disaster, including advice and recommendations regarding—

(1) the establishment of protocols for the monitoring of and response to chemical or substance releases in a disaster area for the purpose of protecting public health and safety, including—

(A) chemicals or other substances for which samples should be collected in the event of a disaster, including a terrorist attack;

(B) chemical- or substance-specific methods of sample collection, including sampling methodologies and locations;

(C) chemical- or substance-specific methods of sample analysis;

(D) health-based threshold levels to be used and response actions to be taken in the event that thresholds are exceeded for individual chemicals or other substances;

(E) procedures for providing monitoring results to—

(i) appropriate Federal, State, and local government agencies;

(ii) appropriate response personnel; and

(iii) the public;

(F) responsibilities of Federal, State and local agencies for—

(i) collecting and analyzing samples;

(ii) reporting results; and

(iii) taking appropriate response actions; and

(G) capabilities and capacity within the Federal Government to conduct appropriate environmental monitoring and response in the event of a disaster, including a terrorist attack; and

(2) other issues as specified by the Secretary of Homeland Security, the Secretary of Health and Human Services, and the Administrator of the Environmental Protection Agency.

(d) Authorization of Appropriations.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 4. PREDISASTER HAZARD MITIGATION.

Section 203(m) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5133(m)) is amended by striking "December 31, 2003" and inserting "September 30, 2006".

NATIONAL TRANSPORTATION SAFETY BOARD REAUTHORIZATION ACT OF 2003

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate now proceed to the immediate consideration of Calendar No. 112, S. 579.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 579) to reauthorize the National Transportation Safety Board, and for other purposes.

There being no objection, the Senate proceeded to consider the bill.

Mr. McCAIN. Mr. President, I am pleased that the Senate is now considering S. 579, the National Transportation Safety Board Reauthorization Act of 2003. This bill was introduced by Senators Hollings, Lott, Hutchison, Rockefeller and myself, and it was unanimously approved by the Senate Committee on Commerce, Science, and Transportation on March 22, 2003.

Each year, the National Transportation Safety Board, NTSB, investigates more than 2,000 transportation accidents and events, including all fatal aviation accidents, and hundreds of railroad, highway, maritime, and pipeline transportation accidents. The NTSB also conducts safety studies, and evaluates the effectiveness of other government agencies' programs for preventing transportation accidents. Most importantly, the NTSB makes safety recommendations, based on its investigations, to federal, state and local government agencies and to the transportation industry regarding actions that should be taken to prevent accidents.

This legislation would authorize appropriations for the NTSB for fiscal years 2003 through 2006. It also would allow the NTSB to relinquish responsibility for providing assistance to families of victims of accidents to the FBI if it takes over the investigation, and give the NTSB expedited procurement procedures to aid in accident investigations.

The bill is being proposed along with an amendment that incorporates provisions from the House-passed version of its NTSB reauthorization bill, H.R. 1527. The amendment was developed in cooperation with the House Transportation and Infrastructure Committee. Among other things, it includes a provision that would require the Secretary of Transportation to submit annual status reports on the Department's progress in meeting the safety recommendations stemming from the NTSB's "most wanted list."

The NTSB's safety investigations and the resulting recommendations play a vital role in ensuring the safe and efficient operation of our nation's transportation system. It is my understanding that the NTSB supports this legislation.

I urge the Senate to pass this important legislation so the House of Representatives can consider it before they adjourn for the year.

Mr. FRIST. I ask unanimous consent that the McCain-Hollings amendment at the desk be agreed to; the bill, as amended, be read the third time and passed; the motion to reconsider be laid upon the table en bloc, and any statements be printed in the Record.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 2211) was agreed to, as follows:

(Purpose: To add provisions relating to accident and safety data classification and publication from H.R. 1527, as passed by the House of Representatives, and for other purposes)

On page 2, line 15, strike "$3,000,000." and insert "$4,000,000.".

On page 3, line 6, strike "paragraph" and insert "subsection".

On page 3, line 16, strike the closing quotation marks and the second period.

On page 3, line 17, strike "(c)" and insert " '(d)".

On page 3, line 21, insert closing quotation marks and a period after the period.

On page 5, strike lines 7 through 21, and insert the following:

SEC. 4. RELIEF FROM CONTRACTING REQUIREMENTS FOR INVESTIGATIONS SERVICES.

(a) In General.—From the date of enactment of this Act through September 30, 2006, the National Transportation Safety Board may enter into agreements or con tracts under the authority of section 1113(b)(1)(B) of title 49, United States Code for investigations conducted under section 1131 of that title without regard to any other provision of law requiring competition if necessary to expedite the investigation.

(b) Report on Usage.—On February 1, 2006, the National Transportation Safety Board shall transmit a report to the House of Representatives Committee on Transportation and Infrastructure, the House of Representatives Committee on Government Reform, the

Senate Committee on Commerce, Science, and Transportation, and the Senate Committee on Government Affairs that—

(1) describes each contract for $25,000 or more executed by the Board to which the authority provided by subsection (a) was applied; and

(2) sets forth the rationale for dispensing with competition requirements with respect to such contract.

On page 5, after line 21, add the following:

SEC. 5. ACCIDENT AND SAFETY DATA CLASSIFICATION AND PUBLICATION.

Section 1119 of title 49, United States Code, is amended by adding at the end the following:

"(c) Appeals.—

"(1) Notification of rights.—In any case in which an employee of the Board determines that an occurrence associated with the operation of an aircraft constitutes an accident, the employee shall notify the owner or operator of that aircraft of the right to appeal that determination to the Board.

"(2) Procedure.—The Board shall establish and publish the procedures for appeals under this subsection.

"(3) Limitation on Applicability.—This subsection shall not apply in the case of an accident that results in a loss of life.".

SEC. 6. SECRETARY OF TRANSPORTATION'S RESPONSES TO SAFETY RECOMMENDATIONS.

Section 1135(d) of title 49, United States Code, is vended to read as follows:

"(d) Reporting Requirements.—

"(1) Annual secretarial regulatory status reports.—On February 1 of each year, the Secretary shall submit a report to Congress and the Board containing the regulatory status of each recommendation made by the Board to the Secretary (or to an Administration within the Department of Transportation) that is on the Board's 'most wanted list'. The Secretary shall continue to report on the regulatory status of each such recommendation in the report due on February 1 of subsequent years until final regulatory action is taken on that recommendation or the Secretary (or an Administration within the Department) determines and states in such a report that no action should be taken.

"(2) Failure to report.—If on March 1 of each year the Board has not received the Secretary's report required by this subsection, the Board shall notify the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate of the Secretary's failure to submit the required report.

"(3) Termination.—This subsection shall cease to be in effect after the report required to be filed on February 1, 2008, is filed.".

SEC. 7. TECHNICAL AMENDMENTS.

Section 1131(a)(2) of title 49, United States Code, is amended by moving subparagraphs (B) and (C) 4 ems to the left.

SEC. 8. DOT INSPECTOR GENERAL INVESTIGATIVE AUTHORITY.

(a) In General.—Section 228 of the Motor Carrier Safety Improvement Act of 1999 (113 Stat. 1773) is transferred to, and added at the end of, subchapter III of chapter 3 of title 49, United States Code, as section 354 of that title.

(b) Conforming Amendments.—

(1) The caption of the section is amended to read as follows:

"§ 354. Investigative authority of Inspector General".

(2) The chapter analysis for chapter 3 of title 49, United States Code, is amended by adding at the end the following:

"354. Investigative authority of Inspector General".

SEC. 9. REPORTS ON CERTAIN OPEN SAFETY RECOMMENDATIONS.

(a) Initial Report.—Within 1 year after the date of enactment of this Act, the Secretary of Transportation shall submit a report to Congress and the National Transportation Safety Board containing the regulatory status of each open safety recommendation made by the Board to the Secretary concerning—

(1) 15-passenger van safety;

(2) railroad grade crossing safety; and

(3) medical certifications for a commercial driver's license.

(b) Biennial Updates.—The Secretary shall continue to report on the regulatory status of each such recommendation (and any subsequent recommendation made by the Board to the Secretary concerning a matter described in paragraph (1), (2), or (3) of subsection (a)) at 2-year intervals until—

(1) final regulatory action has been taken on the recommendation;

(2) the Secretary determines, and states in the report, that no action should be taken on that recommendation; or

(3) the report, if any, required to be submitted in 2008 is submitted.

(c) Failure to Report.—If the Board has not received a report required to be submitted under subsection (a) or (b) within 30 days after the date on which that report is required to be submitted, the Board shall notify the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate.

The bill (S. 579), as amended, was read the third time and passed, as follows:

S. 579

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "National Transportation Safety Board Reauthorization Act of 2003".

SEC. 2. AUTHORIZATION OF APPROPRIATIONS.

(a) Fiscal Years 2003–2006.—Section 1118(a) of title 49, United States Code, is amended—

(1) by striking "and"; and

(2) by striking "such sums to" and inserting the following: "$73,325,000 for fiscal year 2003, $78,757,000 for fiscal year 2004, $83,011,000 for fiscal year 2005, and $87,539,000 for fiscal year 2006. Such sums shall".

(b) Emergency Fund.—Section 1118(b) of such title is amended by striking the second sentence and inserting the following: "In addition, there are authorized to be appropriated such sums as may be necessary to increase the fund to, and maintain the fund at, a level not to exceed $4,000,000.".

(c) NTSB Academy.—Section 1118 of such title is amended by adding at the end the following:

"(c) Academy.—

"(1) Authorization.—There are authorized to be appropriated to the Board for necessary expenses of the National Transportation Safety Board Academy, not otherwise provided for, $3,347,000 for fiscal year 2003, $4,896,000 for fiscal year 2004, $4,995,000 for fiscal year 2005, and $5,200,000 for fiscal year 2006. Such sums shall remain available until expended.

"(2) Fees.—The Board may impose and collect such fees as it determines to be appropriate for services provided by or through the Academy.

"(3) Receipts credited as offsetting collections.—Notwithstanding section 3302 of title 31, any fee collected under this subsection—

"(A) shall be credited as offsetting collections to the account that finances the activities and services for which the fee is imposed;

"(B) shall be available for expenditure only to pay the costs of activities and services for which the fee is imposed; and

"(C) shall remain available until expended.

"(4) Refunds.—The Board may refund any fee paid by mistake or any amount paid in excess of that required.

"(d) Report on Academy Operations.—The National Transportation Safety Board shall transmit an annual report to the Congress on the activities and operations of the National Transportation Safety Board Academy.".

SEC. 3. ASSISTANCE TO FAMILIES OF PASSENGERS INVOLVED IN AIRCRAFT ACCIDENTS.

(a) Relinquishment of Investigative Priority.—Section 1136 of title 49, United States Code, is amended by adding at the end the following:

"(j) Relinquishment of Investigative Priority.—

"(1) General rule.—This section (other than subsection (g)) shall not apply to an aircraft accident if the Board has relinquished investigative priority under section 1131(a)(2)(B) and the Federal agency to which the Board relinquished investigative priority is willing and able to provide assistance to the victims and families of the passengers involved in the accident.

"(2) Board assistance.—If this section does not apply to an aircraft accident because the Board has relinquished investigative priority with respect to the accident, the Board shall assist, to the maximum extent possible, the agency to which the Board has relinquished investigative priority in assisting families with respect to the accident.".

(b) Revision of MOU.—Not later than 1 year after the date of enactment of this Act, the National Transportation Safety Board and the Federal Bureau of Investigation shall revise their 1977 agreement on the investigation of accidents to take into account the amendments made by this section and shall submit a copy of the revised agreement to the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate.

SEC. 4. RELIEF FROM CONTRACTING REQUIREMENTS FOR INVESTIGATIONS SERVICES.

(a) In General.—From the date of enactment of this Act through September 30, 2006, the National Transportation Safety Board may enter into agreements or contracts under the authority of section 1113(b)(1)(B) of title 49, United States Code for investigations conducted under section 1131 of that title without regard to any other provision of law requiring competition if necessary to expedite the investigation.

(b) Report on Usage.—On February 1, 2006, the National Transportation Safety Board shall transmit a report to the House of Representatives Committee on Transportation and Infrastructure, the House of Representatives Committee on Government Reform, the

Senate Committee on Commerce, Science, and Transportation, and the Senate Committee on Government Affairs that—

(1) describes each contract for $25,000 or more executed by the Board to which the authority provided by subsection (a) was applied; and

(2) sets forth the rationale for dispensing with competition requirements with respect to such contract.

SEC. 5. ACCIDENT AND SAFETY DATA CLASSIFICATION AND PUBLICATION.

Section 1119 of title 49, United States Code, is amended by adding at the end the following:

“(c) APPEALS.—

“(1) NOTIFICATION OF RIGHTS.—In any case in which an employee of the Board determines that an occurrence associated with the operation of an aircraft constitutes an accident, the employee shall notify the owner or operator of that aircraft of the right to appeal that determination to the Board.

“(2) PROCEDURE.—The Board shall establish and publish the procedures for appeals under this subsection.

“(3) LIMITATION ON APPLICABILITY.—This subsection shall not apply in the case of an accident that results in a loss of life.”.

SEC. 6. SECRETARY OF TRANSPORTATION'S RESPONSES TO SAFETY RECOMMENDATIONS.

Section 1135(d) of title 49, United States Code, is amended to read as follows:

“(d) REPORTING REQUIREMENTS.—

“(1) ANNUAL SECRETARIAL REGULATORY STATUS REPORTS.—On February 1 of each year, the Secretary shall submit a report to Congress and the Board containing the regulatory status of each recommendation made by the Board to the Secretary (or to an Administration within the Department of Transportation) that is on the Board's ‘most wanted list’. The Secretary shall continue to report on the regulatory status of each such recommendation in the report due on February 1 of subsequent years until final regulatory action is taken on that recommendation or the Secretary (or an Administration within the Department) determines and states in such a report that no action should be taken.

“(2) FAILURE TO REPORT.—If on March 1 of each year the Board has not received the Secretary's report required by this subsection, the Board shall notify the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate of the Secretary's failure to submit the required report.

“(3) TERMINATION.—This subsection shall cease to be in effect after the report required to be filed on February 1, 2008, is filed.”.

SEC. 7. TECHNICAL AMENDMENTS.

Section 1131(a)(2) of title 49, United States Code, is amended by moving subparagraphs (B) and (C) 4 ems to the left.

SEC. 8. DOT INSPECTOR GENERAL INVESTIGATIVE AUTHORITY.

(a) IN GENERAL.—Section 228 of the Motor Carrier Safety Improvement Act of 1999 (113 Stat. 1773) is transferred to, and added at the end of, subchapter III of chapter 3 of title 49, United States Code, as section 354 of that title.

(b) CONFORMING AMENDMENTS.—(1) The caption of the section is amended to read as follows:

“§ 354. Investigative authority of Inspector General”.

(2) The chapter analysis for chapter 3 of title 49, United States Code, is amended by adding at the end the following:

“354. Investigative authority of Inspector General”.

SEC. 9. REPORTS ON CERTAIN OPEN SAFETY RECOMMENDATIONS.

(a) INITIAL REPORT.—Within 1 year after the date of enactment of this Act, the Secretary of Transportation shall submit a report to Congress and the National Transportation Safety Board containing the regulatory status of each open safety recommendation made by the Board to the Secretary concerning—

(1) 15-passenger van safety;

(2) railroad grade crossing safety; and

(3) medical certifications for a commercial driver's license.

(b) BIENNIAL UPDATES.—The Secretary shall continue to report on the regulatory status of each such recommendation (and any subsequent recommendation made by the Board to the Secretary concerning a matter described in paragraph (1), (2), or (3) of subsection (a)) at 2-year intervals until—

(1) final regulatory action has been taken on the recommendation;

(2) the Secretary determines, and states in the report, that no action should be taken on that recommendation; or

(3) the report, if any, required to be submitted in 2008 is submitted.

(c) FAILURE TO REPORT.—If the Board has not received a report required to be submitted under subsection (a) or (b) within 30 days after the date on which that report is required to be submitted, the Board shall notify the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate.

AMERICAN JEWISH HISTORY MONTH

Mr. FRIST. I ask unanimous consent that the Judiciary Committee be discharged and the Senate proceed to the immediate consideration of H. Con. Res. 106, American Jewish History Month.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (H. Con. Res. 106) recognizing and honoring America's Jewish community on the occasion of its 350th anniversary, supporting the designation of an “American Jewish History Month,” and for other purposes.

There being no objection, the Senate proceeded to consider the resolution.

Mr FRIST. I ask unanimous consent that the concurrent resolution be agreed to, the preamble be agreed to, the motion to reconsider be laid upon the table, and any statements be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The concurrent resolution (H. Con. Res. 106) was agreed to.

The preamble was agreed to.

DESIGNATING AMERICAN EDUCATION WEEK

Mr. FRIST. I ask unanimous consent that the Senate now proceed to consideration of S. Res. 272, submitted by Senator SNOWE earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 272) designating the week beginning November 16, 2003, as American Education Week.

There being no objection, the Senate proceeded to consider the resolution.

Mr. FRIST. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motion to reconsider be laid upon the table en bloc, and any statements be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 272) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 272

Whereas schools are the backbone of democracy in the United States, providing young people with the tools necessary to maintain the precious values of freedom, civility, and equality;

Whereas, by equipping students with both practical skills and broader intellectual abilities, schools give young people in the United States hope for, and access to, a bright and productive future;

Whereas education employees, whether they provide educational, administrative, technical, or custodial services, work tirelessly to serve the children and communities of the United States with care and professionalism;

Whereas schools are the keystones of communities in the United States, bringing together adults and children, educators and volunteers, business leaders, and elected officials in a common enterprise; and

Whereas public school educators first observed American Education Week in 1921 and are now celebrating the 82nd annual observance of American Education Week: Now, therefore, be it

Resolved, That the Senate—

(1) designates the week beginning November 16, 2003, as American Education Week; and

(2) recognizes the importance of public education and the accomplishments of the many education professionals who contribute to the achievement of students across the United States.

AUTHORIZING SALARY ADJUSTMENTS FOR JUSTICES AND JUDGES OF THE UNITED STATES

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate now proceed to the consideration of Calendar No. 371, H.R. 3349.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (H.R. 3349) to authorize salary adjustments for Justices and judges of the United States for fiscal year 2004.

There being no objection, the Senate proceeded to consider the bill.

Mr. LEAHY. Mr. President, I am pleased that the Senate is taking up and passing legislation to authorize salary adjustments for Justices and judges of the United States for fiscal year 2004.

As a member of both the Senate Judiciary Committee and the Appropriations Subcommittee on Commerce, Justice, State and the Judiciary, I have worked hard to help preserve a fair and independent judiciary. I have repeatedly introduced and cosponsored legislation to give our Federal judges meaningful and significant pay raises. I have been disappointed that the Continuing Resolutions approved by Congress fail to give the Federal judiciary even a cost-of-living adjustment, COLA.

In 1975, Congress enacted the Executive Salary Cost-of-Living Adjustment Act, intended to give judges, Members of Congress, and other high ranking executive branch officials automatic COLAs as accorded other Federal employees unless rejected by Congress. In 1981, Congress enacted section 140 of Public Law 97–92, mandating specific congressional action to give COLAs to judges. During the 21 years of section 140's existence, Congress has always accorded to the Federal judiciary coequal respect by suspending section 140 whenever Congress has granted to itself and other Federal employees a COLA. With the end of the last Congress, however, the continuing resolutions providing funding failed to suspend section 140, thus ensuring that no COLA would be provided for Federal judges during the current fiscal year, unless other action is taken.

In April of this year, I introduced legislation to respond to the shortfall in real judicial compensation, to repeal the link of judicial pay to congressional pay, to improve survivorship benefits, and to instill greater public confidence in our courts. This legislation would have obviated the annual need to pass judicial cost of living adjustments. Unfortunately, the Fair and Independent Judiciary Act of 2003 was never put on the agenda in committee for consideration.

I hope we can all agree that the Judiciary deserves a cost of living adjustment. I look forward to Senate passage of this bill to give our federal judges a cost of living adjustment. I hope the President will promptly sign our legislation into law.

Mr. FRIST. Mr. President, I ask unanimous consent that the bill be read a third time and passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (H.R. 3349) was read the third time and passed.

MEASURE PLACED ON THE CALENDAR—H.R. 1274

Mr. FRIST. Mr. President, I understand that there is a bill at the desk that is due for a second reading.

The PRESIDING OFFICER. The clerk will read the bill for the second time.

The legislative clerk read as follows:

A bill (H.R. 1274) to direct the Administrator of General Services to convey to Fresno County, California, the existing Federal courthouse in that county.

Mr. FRIST. Mr. President, I would object to further proceedings on the measure at this time.

The PRESIDING OFFICER. The bill will be placed on the calendar.

NOMINATIONS DISCHARGED

Mr. FRIST. Mr. President, as in executive session, I ask unanimous consent that the HELP Committee be discharged from further consideration of a list of nominations that I send to the desk; further, that the nominations be placed on the calendar.

The PRESIDING OFFICER. Without objection, it is so ordered.

The list is as follows:

NATIONAL COMMISSION ON LIBRARIES AND INFORMATION SCIENCE

Jose Aponte
Sandra Ashworth
Edward Bertorelli
Carol Diehl
Allison Druin
Beth Fitzsimmons
Patricia Hines
Colleen Huebner
Stephen Kennedy
Bridget Lamont
Mary Perdue
Herman Totten

CORPORATION FOR NATIONAL AND COMMUNITY SERVICE

David Eisner
Carol Kinsley

DEPARTMENT OF EDUCATION

Raymond Simon

NATIONAL MEDIATION BOARD

Read Van de Water

JAMES MADISON FOUNDATION

Drew McCoy

NATIONAL COUNCIL ON THE ARTS

James McBride

DEPARTMENT OF LABOR

Steven J. Law

PUBLIC HEALTH SERVICE

174 nominees

U.S. INSTITUTE OF PEACE

Laurie S. Fulton
John West

DEPARTMENT OF EDUCATION

Susan Sclafani

Mr. FRIST. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

RECESS SUBJECT TO THE CALL OF THE CHAIR

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate stand in recess subject to the call of the Chair.

There being no objection, the Senate, at 9:39 p.m., recessed subject to the call of the Chair and reassembled at 10:26 p.m. when called to order by the Presiding Officer (Mr. ENSIGN).

MAKING FURTHER CONTINUING APPROPRIATIONS FOR FISCAL YEAR 2004

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate now proceed to the immediate consideration of H.J. Res. 79; that the resolution be read three times and passed; and that the motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Without objection, it is so ordered.

The joint resolution (H.J. Res. 79) was read the third time and passed.

UNANIMOUS CONSENT AGREEMENT—H.R. 1

Mr. FRIST. Mr. President, I ask unanimous consent that the contingent upon its availability, the Senate proceed to the consideration of the conference report to accompany H.R. 1, the Medicare Prescription Drug Modernization Act, at 10 a.m. tomorrow; provided that for duration of tomorrow's session, consideration of the conference report be for debate only, and the speakers be recognized in an alternating fashion.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDERS FOR SATURDAY, NOVEMBER 22, 2003

Mr. FRIST. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 10 a.m., Saturday, November 22. I further ask unanimous consent that following the prayer and pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day, and the Senate then begin consideration of the conference report to accompany H.R. 1, the Medicare Prescription Drug Modernization Act, as provided under the previous order.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. FRIST. Mr. President, tomorrow morning, the Senate will begin debate on the Medicare conference report. Senators who wish to make statements on this historic bill are encouraged to come to the floor during tomorrow's session. In addition, I inform my colleagues that there will be no rollcall votes during tomorrow's session. It is my hope that we will be able to schedule a vote on the conference report for Monday. I will continue to work with the Democratic leadership to reach an agreement for a final vote.

In addition, we will in all likelihood be in session on Sunday as well to continue the debate on Medicare. I will tomorrow make further announcements about Sunday.

ADJOURNMENT UNTIL 10 A.M. TOMORROW

Mr. FRIST. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 10:28 p.m., adjourned until Saturday, November 22, 2003, at 10 a.m.

NOMINATIONS

Executive nominations received by the Senate November 21, 2003:

DEPARTMENT OF DEFENSE

LAWRENCE T. DI RITA, OF MICHIGAN, TO BE AN ASSISTANT SECRETARY OF DEFENSE, VICE VICTORIA CLARKE.

JAYMIE ALAN DURNAN, OF NEW HAMPSHIRE, TO BE AN ASSISTANT SECRETARY OF THE ARMY, VICE MARIO P. FIORI.

EXPORT-IMPORT BANK OF THE UNITED STATES

JOSEPH MAX CLELAND, OF GEORGIA, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE EXPORT-IMPORT BANK OF THE UNITED STATES FOR A TERM EXPIRING JANUARY 20, 2007, VICE DORIAN VANESSA WEAVER, TERM EXPIRED.

APRIL H. FOLEY, OF NEW YORK, TO BE FIRST VICE PRESIDENT OF THE EXPORT-IMPORT BANK OF THE UNITED STATES FOR THE REMAINDER OF THE TERM EXPIRING JANUARY 20, 2005, VICE EDUARDO AGUIRRE, JR., RESIGNED.

DEPARTMENT OF STATE

ANN M. CORKERY, OF VIRGINIA, TO BE AN ALTERNATE REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE FIFTY-EIGHTH SESSION OF THE GENERAL ASSEMBLY OF THE UNITED NATIONS.

BENJAMIN A. GILMAN, OF NEW YORK, TO BE A REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE FIFTY-EIGHTH SESSION OF THE GENERAL ASSEMBLY OF THE UNITED NATIONS.

WALID MAALOUF, OF VIRGINIA, TO BE AN ALTERNATE REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE FIFTY-EIGHTH SESSION OF THE GENERAL ASSEMBLY OF THE UNITED NATIONS.

OVERSEAS PRIVATE INVESTMENT CORPORATION

SANFORD GOTTESMAN, OF TEXAS, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE OVERSEAS PRIVATE INVESTMENT CORPORATION FOR A TERM EXPIRING DECEMBER 17, 2005, VICE GARY A. BARRON, TERM EXPIRED.

DEANE M. RUEBLING, OF CALIFORNIA, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE OVERSEAS PRIVATE INVESTMENT CORPORATION FOR A TERM EXPIRING DECEMBER 17, 2005. (REAPPOINTMENT)

C. WILLIAM SWANK, OF OHIO, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE OVERSEAS PRIVATE INVESTMENT CORPORATION FOR A TERM EXPIRING DECEMBER 17, 2005. (REAPPOINTMENT)

UNITED STATES ADVISORY COMMISSION ON PUBLIC DIPLOMACY

JAMES M. STROCK, OF CALIFORNIA, TO BE A MEMBER OF THE UNITED STATES ADVISORY COMMISSION ON PUBLIC DIPLOMACY FOR A TERM EXPIRING JULY 1, 2006, VICE PENNY PERCY KORTH, TERM EXPIRED.

EXECUTIVE OFFICE OF THE PRESIDENT

ROBERT HURLEY MCKINNEY, OF INDIANA, TO BE A MEMBER OF THE ADVISORY BOARD FOR CUBA BROADCASTING FOR A TERM EXPIRING OCTOBER 27, 2004, VICE WILLIAM A. GEOGHEGAN, TERM EXPIRED.

THE JUDICIARY

FRANKLIN S. VAN ANTWERPEN, OF PENNSYLVANIA, TO BE UNITED STATES CIRCUIT JUDGE FOR THE THIRD CIRCUIT, VICE EDWARD R. BECKER, RETIRED.

IN THE ARMY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES ARMY MEDICAL CORPS UNDER TITLE 10, U.S.C., SECTIONS 624 AND 3064:

To be major

MICHAEL K. VAUGHAN, 8463

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTION 12203:

To be colonel

DALE A ADAMS, 1903
DENNIS J ADAMS, 3865
PAUL AHERN, 5344
RONALD L ALBRECHT, 8517
RICHARD K ALFORD, 8606
STEPHEN M ALLEN, 9734
DAVID W ALTIERI, 8639
STEVEN W ALTMAN, 7931
MARCIA C ANDERSON, 6629
THOMAS D ARNHOLD, 8397
ERNEST C AUDINO, 3886
DAVID S BALDWIN, 3948
JULIO R BANEZ, 0862
BRENT C BANKUS, 1525
CRAIG A BARGFREDE, 6779
VANESSA D BARRON, 8199
DAVID R BATES, 5305
JAMES B BAXTER, 1354
MICHAEL E BEASLEY, 3952
PAUL D BELCZAK, 1040
DOUGLAS L BELK, 8980
RICKY L BELTRAN, 9415
THOMAS E BENDERNAGEL, 5960
GIDEON J BENHORIN, 6239
LENOID T BEST, 6615
CYNTHIA J BINGHAM, 9779
MICHAEL D BISH, 5004
DOUGLAS H BIXLER, 5061
DAVID G BODDINGTON, 6003
LINDA C BODE, 5232
BRUCE J BOIVIN, 3216
RALPH J BORKOWSKI, 7222
MICHAEL J BORREL, 3671
DENISE L BOUDREAU, 0547
DAVID L BOWMAN, 2060
LARRY C BOYD, 0078
GLENN A BRAMHALL, 5998
LEON M BRIDGES, 4335
MARCUS A BRINKS, 9320
BEVERLY R BROCKMAN, 0637
DAVID W BROWN, 0612
GERALD E BRUNN, 4934
MARK S BUECHLER, 9704
PAUL A BURKE, 8152
CURTIS R BURNS, 5560
JEROME K BUTLER, 6491
JODY P BUTLER, 8424
ALAN J BUTSON, 4077
STEPHEN E BUYER, 7586
PHILIP D CALAHAN, 7197
KENNETH W CALHOUN, 9422
WILLIAM J CALLAHAN, 7887
DANIEL E CAMERON, 7671
MICHAEL E CAPLES, 9756
COURTNEY P CARR, 1074
CARL J CARTER, 8093
FRANK S CARUSO JR., 5226
ROBERT CATALANOTTI, 4208
SCOTT E CHAMBERS, 9415
STEVEN W CHANDLER, 5323
WILLIAM V CLEMENT, 4858
PAUL D COLEMAN, 1614
DAVID L G COLLINS, 6690
WILFREDO A COLONMARTINEZ, 4148
DONALD R CONOVER, 0379
FREDDIE W COOK, 1896
JAMES T CORRIGAN III, 6542
MARK E CORZINE, 7479
RONNIE R COX, 3907
RICHARD V CRIVELLO, 1982
SYLVIA R CROCKETT, 3134
KENT M CROSSLEY, 0523
GREGG A CUNNINGHAM, 6001
TIMOTHY W CURRAN, 5113
FLOYD T CURRY, 6389
RONALD J CZMOWSKI, 1605
KATHLEEN F DAGGETT, 4777
PATRICK M DARDIS, 2968
JAMES A DAVIS, 6172
WALTER F DAVIS, 9792
REBECCA A DAVISON, 7055
WILLIE DAY JR., 2569
TIMOTHY K DEADY, 6129
ROBERT F DELCAMPO, 3312
EUGENE A DEVER JR., 0509
PAUL DEVINCENZO, 0589
KERRY L DIMINYATZ, 8417
DOUGLAS J DINON, 0208
ALAN S DOHRMANN, 3072
MONTGOMERY P DOLIESLAGER, 7802
STEPHEN M DOYLE, 9050
ALBERT A DREWKE JR., 7640
FRANK L DUCAR, 8370
STEVEN W DUFF, 2431
ROBERT J DUFFY, 0735
THOMAS C DUFFY JR., 5741
WILLIAM F DUFFY, 2080
ROBERT T DURBIN JR., 6940
ANDREW A EDMUNDS, 2823
DALE R ERICKSON, 9029
CATHERINE J ERVITI, 3939
MARK A EXLEY, 0168
ALAN EZZELL, 2982
EDWARD L FAISON, 5626
LYNN D FISHER, 0901
PHILIP R FISHER, 9702
MARK R FOLLETT, 1850
ROBERT S FORBES, 8075
GEORGE M FRIES III, 3206
JOE C GEREN JR., 5636
JOHN A GESSNER, 1015
SHERYL E GORDON, 9703
VINCENT R GRACE, 1752
JEFFREY D GREB, 9428
JAMES S GREEN, 3810
JUAN L GRIEGO, 6202
JAMES C GRIESE, 6892
MANY B GRINDER, 2472
FRANK GUEVARA, 6954
JACK C GUY JR., 2094
TOBY A HALE, 0711
LAWRENCE E HANNAN, 6052
JON D HANSON, 2579
STEVEN G HARDING, 9634
EARNEST L HARRINGTON JR., 8684
RANDY A HART, 4925
LUCRETIA G HEARDTHOMPSON, 9632
BJARNE R HENDERSON, 2076
MARK S HENDRIX, 6201
STEPHEN B HENSEL, 5849
MICHAEL F J HERCHMER, 1625
MICHAEL F HERMAN, 1754
PETER C HINZ, 2932
LOTHAR C HOLBERT, 3202
RICHARD L ILER, 5702
BRUCE H IRWIN, 6231
DAVID F IRWIN, 3872
RUTH A IRWIN, 5365
NATALIE R JACARUSO, 6255
SCOTT J JACOBSON, 5131
GRANT C JAQUITH, 8159
THOMAS R JENKINS, 3685
LEODIS T JENNINGS, 0274
MICHAEL J JENSEN, 9064
CRAIG D JOHNSON, 4878
DARREL L JOHNSON, 7206
STEPHEN J JURINKO, 4007
WILLIAM K KEITH, 7939
BERNARD M KELLY, 4796
TIMOTHY C KELLY, 1243
CHRISTOPHER R KEMP, 1837
SHAWN P KEMPENICH, 7886
JON R KER, 6791
MARK E KERRY, 0543
JAMES C KESTERSON JR., 8748
MARK H KING, 3202
JEFFERY P KOHLITZ, 9028
ALEX R KORZENEWSKI, 8859
FRED W KUBUS, 3868
TERRY A LAMBERT, 1967
DAVID W LARSEN, 1971
FRANCIS S LAUDANO III, 8550
PETER M LAWSON, 9754
PAUL W LAYMON JR., 4619
WING D LEE, 3508
JAMES R LEECH, 5377
F NICHOLAS R LETSON, 8601
MARLIN F LEVENDOSKI, 6616
BETSY A LEWIS, 6158
ELTON LEWIS, 0886
JOHN E LEY, 5952
ERIC D LINDNER, 2338
RUSTY L LINGENFELTER, 3673
ERIC B LINTZ, 7555
PHILIP C LOOTENS, 6652
WALTER T LORD, 6732
KERRY J LOUDENSLAGER, 1135
JOHN C LOWRY, 6246
KENNETH J LULL, 6753
BENSON W LUM, 0723
JOHN O LUTHRINGER, 3415
JUDD H LYONS, 5827
MARK J MACCARLEY, 2185
RANDALL R MARCHI, 4272
JEFFREY P MARLETTE, 1930
BRUCE R MARTIN, 2929
EUGENE L MASCOLO, 6188
JAMES E MASON, 1483
SAMUEL W MASSEY, 3549
WILLIAM R MAY, 4506
GREGORY N MCCALLON, 8809
MARK A MCCARTER, 1273
PATRICK J MCCARVILLE, 3158
ROGER L MCCLELLAN, 1876
THOMAS D MCCLUNG, 4079
DANA L MCDANIEL, 0195
PATRICIA J MCDANIEL, 0629
DANIEL MCELHINNEY, 3293
LARRY G MCLENDON, 4405
CRUZ M MEDINA, 7127
TIMOTHY M MEYER, 1514
HARVEY A MICHLITSCH, 1325

CHARLES W MITCHELL, 9760
STEVEN H MOGAN, 6909
RICHARD W MOLLICA, 0630
JEFFREY W MONTGOMERY, 0794
KENNETH R MORRIS, 6104
MICHAEL J MOS, 6398
JAMES E MOSE, 1911
WILLIAM S MOSER, 5652
WESLEY R MOY, 2497
REID K MRSNY, 4101
NANETTE B MUELLER, 9922
WILLIAM J MULLER, 3130
JOHN B MUNOZATKINSON, 8986
EDWARD A MUTH, 0146
TODD M NEHLS, 8309
MICHAEL J NEILSON, 1621
DARELL L NEPIL, 4558
RONALD A NEUMEISTER, 7907
DANIEL P NIEVINSKI, 0605
BRETT E NILA, 1302
CALVIN H NOMIYAMA, 4427
ROBERT C OCONNOR, 9615
KENT R OELRICH, 3008
CHRISTOPHER OGARA, 9584
JOHN V OHNSTAD, 7872
ROBERT C OLEARY, 5267
BRUCE E OLIVEIRA, 3801
DAEYVID S OLOCHLAYNE, 5285
WESLEY N OSBURN, 8827
CHRISTOPHER T OSCAR, 9876
JEANNE F PALUMBO, 3012
CHARLES L PARINS, 3470
KEVIN M PETER, 7949
MICHAEL A PETRASH, 9569
GEORGE S PETTIGREW, 4918
WILLIAM D PHELPS, 2973
JOHN G PHILLIPPE, 4911
CHARLES W PHILLIPS, 1854
TIMOTHY S PHILLIPS, 8483
WILLIAM J PHILLIPS, 7141
JANET E PHIPPS, 7694
ANDRES H PLOOMPUU, 2818
DANIEL H PRINE, 2947
MATTHEW T QUINN, 1101
WALTER F RANT II, 1967
ELIZABETH M REHWALT, 4320
JOHN D RENAUD, 2734
MARTHA REYES, 1174
ROBERT B RICE, 5734
LINDA I RIEGEL, 4254
JAMES O RIMEL SR, 5246
ANTHONY M RISCICA, 5548
JULIAN R RIVERA, 2003
ROBERT F ROACH, 0920
KENNETH C ROBERTS, 3451
WILLIAM S ROBERTSON, 6701
DANIEL L ROBEY, 5333
DAVID A ROBINSON, 6506
JESSIE R ROBINSON, 7982
RUBEN J RODRIGUEZ, 8215
HARVE T ROMINE, 3625
ISADORE F ROMMES JR., 7546
ROBERT H RONGE, 4027
MARK H ROUSSEAU, 3255
ALICIA C RUCKER, 6925
JUAN A RUIZ, 8943
PAUL S RUSINKO, 5865
MARK A RUSSO, 0481
PETER J SAMMARCO, 3083
MANUEL F SANTIAGO, 2949
MICHAEL J SAWYER, 5073
RONALD L SCARBRO, 8179
MARK SCATOLINI, 2576
WILLIAM C SCHNECK JR., 4516
BARRY A SEARLE, 3176
ROBERT E SEMBOWER JR., 9847
DANIEL S SHEAHAN, 3237
RAYMOND F SHIELDS JR., 6773
BRUCE M SHREWSBERY II, 2547
LAURA L SIEVERT, 7360
MICHAEL J SINNOTT, 0766
JAMES A SMITH JR., 6837
MARK A SMITH, 5258
STEPHEN W SMITH, 6094
WILLIAM A SODERBERG, 7826
ROBERT A SPARING, 0177
ROBERT L SPARKS, 1672
DEBRA A SPEAR, 0096
STEVEN C SPITZE, 2336
DAVID E SPURLING, 8984
ANDREW O STEWART, 8327
WILLIAM H STEWART, 7738
EUGENE H SULLIVAN, 6203
TERENCE P SULLIVAN, 9711
I MARLENE SUMMERS, 7023
MICHAEL A SUTTON, 7945
ALICIA A TATENADEAU, 2333
DONALD M TAYLOR, 8580
HOWARD S THEVENET, 4654
MICHAEL N THOME, 8619
CHARLIE M THORNTON III, 8042
JAMES R TORGLER, 3728
VICTOR J TORRESRODRIGUEZ, 4155
BARBARA E TRENT, 0545
GORDON D TROUNSON, 7894
MICHAEL S TUOMEY, 8234
JOHN H H TURNER III, 8081
WALLACE N TURNER, 5992
WILLIAM J TYNDALL, 2929
FRANCIS J VAHLE JR., 3347
JOHN E VALENTINE, 2324
PETER A VONJESS, 8433
BRADLEY V WAKEFIELD, 6194
LAWRENCE P WALDHART, 6315
M STEVENSON WALLACE, 5298
WILLIAM C WAMPLER JR., 7649
CHRISTOPHER R WARD, 8395
WILLIAM J WARD, 0464
STEPHEN J WARRILOW, 5879
DAVID L WEEKS, 9106
BILLY J WEST, 7090
JEFFREY B WHEELER, 1387
DAVID S WHITE, 8929
TED C WHITE, 4722
ANTHONY A WICKHAM, 1603
DOUGLAS R WILKEN, 3280
RICHARD S WILLIAMS, 6432
TIMOTHY P WILLIAMS, 0501
HENRY W WILSON, 6927
ALLEN R WOLFF, 7969
MARTHA N WONG, 0199
DEHAVEN C WOODCOCK II, 5759
PAUL T WRIGHT, 8405
JAMES G YOUNG JR., 2949
TRACEY L ZANDER, 9075
NICHOLAS E ZOELLER, 6792

IN THE NAVY

THE FOLLOWING NAMED OFFICERS FOR TEMPORARY APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 5721:

To be lieutenant commander

ALBERT A. ALARCON, 0906
BARRY W. BARROWS, 8262
CHRISTOPHER G. BOHNER, 6308
MATTHEW R. BOLAND, 6993
BRENT J. BROWN, 7383
DARRELL S. CANADY, 3537
ADAN G. CRUZ, 6281
CHRISTOPHER D. DELINSKI, 6021
THOMAS J. DIXON, 7036
STEVEN G. DUTTER, 9572
DAVID A. DYWER, 4879
MICHAEL D. EBERLEIN, 0150
JOSEPH J. FAUTH, 0827
DAVID E. FOWLER, 6426
JOHN H. GRIMES, 6309
CRAIG A. HACKSTAFF, 2930
DENNIS N. JOHNSON, 7440
JEREMY P. JURKOIC, 2751
DONALD P. LIBBY, 1565
RONALD B. LOTT JR., 3606
EARL F. MCNEIL JR., 4226
STEPHEN E. MONGOLD, 1315
JERRY E. MORTUS, 5771
CHRISTOPHER T. NICHOLS, 1843
ROBERT W. PATERSON, 3902
GEOFFRY W. PATTERSON, 2017
JULIAN E. SALLAS, 6938
THOMAS H. SHUGART III, 9528
JEFFREY W. WINTERS, 3043

WITHDRAWALS

Executive message transmitted by the President to the Senate on November 21, 2003, withdrawing from further Senate consideration the following nominations:

APRIL H. FOLEY, OF NEW YORK, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE EXPORT-IMPORT BANK OF THE UNITED STATES FOR A TERM EXPIRING JANUARY 20, 2007, WHICH WAS SENT TO THE SENATE ON APRIL 10, 2003.

APRIL H. FOLEY, OF NEW YORK, TO BE A MEMBER OF THE BOARD OF DIRECTORS OF THE EXPORT-IMPORT BANK OF THE UNITED STATES FOR A TERM EXPIRING JANUARY 20, 2007, WHICH WAS SENT TO THE SENATE ON MAY 14, 2003.

HOUSE OF REPRESENTATIVES—*Friday, November 21, 2003*

The House met at 9 a.m.

The Chaplain, the Reverend Daniel P. Coughlin, offered the following prayer:

Lord our God, grant Your servants patience and perseverance.

Patience calms the soul within.

Perseverance reaches beyond oneself to accomplish the task at hand.

Humbled by our own frailty and sometimes overwhelmed by the expectations laid upon us, we need Your mighty assistance.

Unsure which comes first, perseverance or patience, touch each Member of this House personally that all may contribute to the ways of freedom and the work of justice.

May virtue flourish here that all may see that by helping others to persevere we find the strength and purpose to persevere ourselves; for we are Your servants, both now and forever.

Amen.

THE JOURNAL

The SPEAKER. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

PLEDGE OF ALLEGIANCE

The SPEAKER. Will the gentleman from Georgia (Mr. GINGREY) come forward and lead the House in the Pledge of Allegiance.

Mr. GINGREY led the Pledge of Allegiance as follows:

> I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

ANNOUNCEMENT BY THE SPEAKER

The SPEAKER. The Chair will entertain five 1-minute speeches on each side.

ST. URSULA BULLDOGS WIN OHIO STATE VOLLEYBALL CHAMPIONSHIP

(Mr. CHABOT asked and was given permission to address the House for 1 minute.)

Mr. CHABOT. Mr. Speaker, this morning I would like to recognize the achievement of an exceptional group of young women in my Cincinnati congressional district, the St. Ursula Bulldogs volleyball team.

St. Ursula battled Ursuline Academy, another outstanding Cincinnati school, for Ohio's State volleyball championship. St. Ursula emerged victorious, capping off an undefeated season. With 29 wins and zero losses. St. Ursula was also declared national champion.

The victory marked St. Ursula's eighth State volleyball title, making it the only Ohio school to accomplish this feat in history.

Mr. Speaker, these are two excellent schools academically as well as in sports. They have faced each other three straight years for the State title. They are shining examples of what can be accomplished with hard work, perseverance, and teamwork.

It gives me great pleasure, especially since my niece, Maria, is a student at St. Ursula, to acknowledge in the United States Congress the success and achievement of these exceptional young women and their coaches, St. Ursula's Julie Perry and Ursuline's Amie Meyer.

Congratulations.

MEDICARE CONFERENCE REPORT'S RURAL PACKAGE

(Mr. GINGREY asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. GINGREY. Mr. Speaker, I rise today in support of the rural package provided for in the House-Senate Medicare agreement. The package corrects existing inequities for rural and small town hospitals and providers by equalizing the disproportionate reimbursement payments they have been experiencing in the past.

Rural hospitals' base payment rate will be permanently extended by 1.6 percent to match the urban hospital payment rate and the amount of disproportionate share payments will be more than doubled to 12 percent of total Medicare inpatient payments.

The bill additionally pays cost plus 1 percent to the Critical Access Hospitals to ensure that they can improve access and services.

And that, Mr. Speaker, is exactly the purpose of the rural package: To provide immediate help to rural area and small city hospitals so that they can provide sustained access and quality service to their patients.

Our seniors deserve nothing less than that, and I urge my colleagues to vote in favor of our Nation's rural hospitals. Pass the Medicare conference report.

CONGRESS COULD DO BETTER FOR SENIORS

(Mr. DEFAZIO asked and was given permission to address the House for 1 minute.)

Mr. DEFAZIO. Mr. Speaker, today the House will take up an incredibly complicated $400 million bill which purports to provide seniors something they need: help in buying pharmaceuticals. We could do this more simply and more cost effectively. We could have the government negotiate lower drug prices on behalf of seniors as they do for the Veterans' Administration, a minimum of a 24-percent reduction for veterans' drugs and actually an average of about 50 percent.

There is a bigger group of Medicare people. We could do better. It would not cost anything.

We could also allow the free reimportation of FDA-approved, U.S.-certified, U.S.-manufactured drugs from Canada and other countries. Many seniors in my district are doing that now, saving an average of 50 percent. But, no. Instead, this bill is going to prohibit the reimportation. This bill is going to prohibit the government from negotiating lower prices for pharmaceuticals, all to protect the profits of the pharmaceutical industry at a time when many seniors cannot afford the drugs they need to maintain their health.

PRESIDENT BUSH'S SPEECH IN LONDON

(Mr. WILSON of South Carolina asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. WILSON of South Carolina. Mr. Speaker, this week President George W. Bush gave an inspiring speech at Whitehall in London, while visiting the Royal Family and Prime Minister Tony Blair. The President stated clearly that the United States is committed to winning the war on terrorism.

In one of the most important moments of the speech, President Bush explains why we cannot forget September the 11th and the innocent thousands that were killed that day. The President said, "The hope that danger has passed is comforting, it is understandable, and it is false. The attacks that followed on Bali, Jakarta, Casa Blanca, Bombay, Mombassa, Najaf, Jerusalem, Riyadh, Baghdad and Istanbul were not dreams. They're part of the global campaign by terrorist networks to intimidate and demoralize those who oppose them."

☐This symbol represents the time of day during the House proceedings, e.g., ☐1407 is 2:07 p.m.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

The President is absolutely correct and I encourage all Americans to remember the act of war brought upon our Nation just 2 years ago. I have confidence that our military will win the global war on terror and I commend the dozens of coalition countries that have joined us in this fight for freedom.

Mr. Speaker, in conclusion, may God bless our troops.

BUSINESS WILL NOT ALLOW GOVERNMENT TO OPERATE LIKE A BUSINESS

(Mr. GEORGE MILLER of California asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. GEORGE MILLER of California. Mr. Speaker, very often when we go out and hold town hall meetings, people stand up in the town hall and say: Congressman, why do you not run the government more like a business?

The answer is when we try to run the government like a business, business won't let us.

If one is a Wal-Mart, they negotiate their pharmaceutical prices. They negotiate the prices of goods sold in their store.

If one is a COSTCO, they negotiate pharmaceutical prices and people go to COSTCO to buy their pharmaceuticals.

But if the government wants to negotiate the prices as the largest purchaser of pharmaceuticals in the world, we will not be allowed to because the Republican bill prohibits the Secretary of Health and Human Services from negotiating a better price for America's seniors and American families.

We cannot run the Congress like a business when the businesses are all lobbying to keep a monopoly, to keep high prices, to keep people from going to Canada and getting FDA-approved drugs. That is what suppliers do. People go where there are lower prices. They can search the world over in the globalized economy for lower prices. But American seniors who need lifesaving drugs cannot search the world over for lower prices like the businesses can, because business will not let government run the government like a business.

JOBS AND GROWTH PACKAGE REAPING BENEFITS FOR WORKING FAMILIES

(Mr. SHUSTER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SHUSTER. Mr. Speaker, it has become apparent that the Jobs and Growth Tax Relief Package passed by Congress earlier this year has helped fuel the recent surge in the economy. The American economy grew at a rapid pace of 7.2 percent during the third quarter of this year, the best since 1984.

The seeds of economic growth are beginning to take hold. Our economy is rebounding. We have created strong economic policy built on a foundation of tax relief. The jobs and growth package that Congress passed has been responsible for putting taxpayers' hard earned dollars back in their own pockets.

This week we further our focus on jobs by passing an important comprehensive energy package and we will have an opportunity to strengthen our health care system by passing an important Medicare prescription drug bill later today. These building blocks will continue to provide substantial stimulus over the coming months.

Most importantly, we must remember that America's strength comes from its workers, its small business owners, and its families dedicated to a better way of life. As a Congress, we must continue to assist our working men and women by removing the obstacles so they can capture the American dream.

NEVER NEVER LAND OF CORPORATE WELFARE

(Mr. EMANUEL asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. EMANUEL. Mr. Speaker, my colleagues on the other side of the aisle always talk about being the protectors of the free market system and believes if the free market would operate without government hindrance, business would be fine and society would be fine.

This week this House passed an energy bill that gave $20 billion of taxpayer money to companies to do drilling for oil, do their basic services, when they should be doing that on their own without taxpayer subsidies.

Now, we are about to pass a prescription drug bill that pays HMOs $80 billion to provide health insurance. .

These are the bastions of capitalism? We used to have "end welfare as we know it." This is a new form of welfare. These are businesses who have come to rely on the government subsidies as the only way to operate their businesses. I think that today, rather than being the culture of the protectors of capitalism and the principles of capitalism, the Republican Party has become the bastions of the culture of welfare and we need to end welfare as it is being abused in our society.

Lately, the way I have seen our government turn into literally a culture of welfare for corporate and special interests, I am beginning to think that we have been caught captive in the Never Never Land. It is not Michael Jackson, it is us who have been caught here in this culture of welfare that has come to dominate and be used by businesses that have come to rely on the government, and the taxpayers more importantly, to afford their basic bottom line.

ADOPTION INFORMATION ACT

(Mrs. JO ANN DAVIS of Virginia asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Mrs. JO ANN DAVIS of Virginia. Mr. Speaker, this Saturday, November 22, numerous organizations will join together in celebration of National Adoption Day to recognize the many blessings afforded by adoption. In honor of this day, I would like to draw attention to a bill that I introduced this year that seeks to raise awareness of adoption, the Adoption Information Act, H.R. 1229.

Essentially, the Adoption Information Act would require all federally funded clinics to provide a detailed pamphlet of adoption referral information to all people seeking family planning services. All too often, women seeking pregnancy counseling do not receive all the information necessary to make an informed decision. Information on what adoption is and referral for adoption services are rarely discussed at all, and when they are that information is often inaccurate and incomplete.

H.R. 1229 aims to ensure that women are empowered with the accurate and complete information they need to make informed decisions.

Mr. Speaker, I urge my colleagues to support the Adoption Information Act.

FIRST DO NO HARM

(Mrs. CHRISTENSEN asked and was given permission to address the House for 1 minute.)

Mrs. CHRISTENSEN. Mr. Speaker, I want to respond to one of my physician colleagues who was on the floor last evening and speak to others who think that they and we ought to support the conference report on Medicare reform. One of the most important tenets of the oath we take as physicians is that we must do no harm. This is to guide us in our practice and our interactions with both our patients and society.

The Medicare bill that will be before us today will do much harm by threatening to take away retiree prescription drug coverage. By refusing to provide wraparound coverage for poor seniors and disabled on Medicare, it will exclude many poor, disabled, and elderly by means testing, and most of all it will begin to destroy this important program which so many depend on and need.

Mr. Speaker, if this bill were to pass tomorrow, it would not help one senior next year. We have time to do it right and fulfill the promise we made to provide a comprehensive plan. Physicians, do not allow our profession to be used to pass a bad bill or hurt our patients.

I urge physicians to call their representatives and tell them to vote "no." I urge my colleagues to vote "no."

Whether physician or Member of Congress, above all we must do no harm.

PROVIDING FOR CONSIDERATION OF MOTIONS TO SUSPEND THE RULES

Mr. SESSIONS. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 456 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 456

Resolved, That it shall be in order at any time on the legislative day of Friday, November 21, 2003, for the Speaker to entertain motions that the House suspend the rules. The Speaker or his designee shall consult with the Minority Leader or her designee on the designation of any matter for consideration pursuant to this resolution.

☐ 0915

The SPEAKER pro tempore (Mr. SIMPSON). The gentleman from Texas (Mr. SESSIONS) is recognized for 1 hour.

Mr. SESSIONS. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentleman from Massachusetts (Mr. MCGOVERN), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Mr. Speaker, this rule provides for suspensions that will be in order at any time on the legislative day of Friday, November 21, 2003. It also provides that the Speaker or his designee will consult with the minority leader or her designee on any suspension considered under the rule.

Mr. Speaker, as I noted yesterday, the Republican leadership of this House has set out on an aggressive legislative plan for this week on behalf of the American people. The goal of this plan is to pass a number of bills over the next few days which will dramatically improve the quality of life for all Americans.

This week we have already succeeded in passing an energy conference report that will bring our Nation's outdated energy policy into the 21st century through comprehensive legislation that promotes conservation, reduces America's growing dependence on foreign oil, and creates new jobs and cleaner skies.

Today we will consider legislation to make sure that America uses best practices technology and procedures to prevent tragic wildfires, like the ones that California just suffered through, from ravaging our Nation's forests. This important bipartisan legislation takes a healthy step forward in providing a better approach to addressing the problems that have to date prevented the proper management of forest health on private forest land.

This bill creates new programs to detect and suppress dangerous forest pests. It also creates two new programs which help family forest owners to manage their forests, protect watersheds, and help to protect wildlife on private lands. Both of these programs use a nonregulatory, incentive-based approach to promote conservation, rather than a top-down, one-size-fits-all regulatory approach.

For the balance of the week, we are slated to consider legislation to, among other things:

Number one, to authorize spending levels for the intelligence activities we need to win the war.

Number two, to reform Medicare to make sure that more of our seniors have the prescription drug coverage that they need while giving them much more and more choices for their health care coverage, and also to allow all Americans to begin planning for their health needs through savings accounts that can be purchased, can grow, and can be used on a tax free basis.

Number three, and to provide for a uniform national credit reporting system that ensures that consumers are protected from identity theft while giving them access to the fast and reliable credit that makes our economy the envy of the world.

I understand that Members on either side of the aisle may have different views about how to address each of these issues that I have talked about, but we will have an opportunity to hear a great deal of debate from both sides over the next few days on each one of these issues, and so many other things. However, a great deal of the legislation that the Republican House leadership has also scheduled on behalf of all Americans has broad support from both the majority and the minority, and in an attempt to make sure that this important work is finished by the end of this legislative week as well, we are here today to pass a rule to provide for the consideration of those bills.

Mr. Speaker, this balanced rule provides the minority with the ability to consult with the Speaker on any suspension that is offered, ensuring that their input and views are duly considered before any legislation considered under this rule is brought to the floor.

Mr. Speaker, I encourage my colleagues on both sides of the aisle to support this uncontroversial and balanced rule which passed yesterday by a voice vote.

Mr. Speaker, I reserve the balance of my time.

Mr. MCGOVERN. Mr. Speaker, I thank the gentleman from Texas for yielding me 30 minutes, and I yield myself such time as I may consume.

Mr. Speaker, we have no objection to this rule which would allow for this House to consider suspension bills today. We are not going to ask for a vote. There is no controversy over this and there is no reason to debate this. But I do want to just take a couple of minutes to alert my colleagues to something that I think is quite serious, and that is the fact that we probably some time today will consider the so-called Medicare prescription drug bill.

Mr. Speaker, this bill, if I understand correctly, was filed at about 1:20 a.m. this morning and under House rules, Mr. Speaker, all Members of this House, Democrats and Republicans, are supposed to have 3 days, 3 days to review any conference report so they can actually read what is in it so that they will know what, in fact, that they are voting on. It is obvious, as has been the case so many times over and over, that the Republican majority is choosing to ignore the rules of this House and it is particularly disturbing that they have chosen to do so once again with regard to a bill that I think is so very important.

This is a bill, in my opinion, that is going to end Medicare as we know it. It is going to privatize Medicare and is not going to provide our senior citizens with the prescription drug benefits that they expect. But yet we are rushing it to the floor with very little consideration and with almost no opportunity for Members to know what is in it.

Mr. Speaker, let me read today the lead paragraph in an editorial that appeared in today's Washington Post. "Before we say anything else about the Medicare bill that the House-Senate conference committee approved yesterday, it is important to point out that the process by which this bill was created hardly reflects well on our political culture. This is an extremely expensive, 1,100-page bill that will have a profound effect on the Nation's fiscal and physical health and although it was not finished until yesterday afternoon after several months of a largely secret conference, last night House leaders were planning to bring it up for a vote tomorrow. If they do, most Members will have no real idea of what they are voting for or against."

Now, my colleagues on the other side will say, gee, we are coming up to Thanksgiving and we all need to go home and we need to get everything done before Thanksgiving. Well, most Americans have a couple of days off at Thanksgiving and then they go back to work the following week. There is no reason why this House cannot go to work the following week and do the people's business and do it right.

One of the problems with not being able to read bills before they come to the floor is that oftentimes days later, weeks later, sometimes months later we find out that there are little goodies, special interest provisions that are hidden in these bills that are very expensive, that help one particular special interest, but do great harm to the American people.

Mr. Speaker, I do not want anyone to have an excuse that they do not know what is in this bill. And there are people on the other side of the aisle who also had requested early on that we have at least 3 days to review this important piece of legislation. I think it is unfortunate that we are moving today on a very important piece of legislation, a bill, as I said before, that in my mind undermines one of the most important and successful social programs in the history of this country, and is being rushed to the floor without giving Members or their staff the opportunity to read the bill or to go home and check with their constituents.

In case my colleagues forgot, constituents are the people who elect us. We are supposed to be serving constituents who have elected us to this high office, and I think we are doing a great disservice to those by allowing this Medicare bill to come to the floor without at least respecting the rules.

Mr. Speaker, let me finally say if my Republican colleagues want to continue to waive these rules and not report rules, why do they not just repeal all the rules? There is no sense to have rules of this House if they are not going to follow them.

Mr. Speaker, I reserve the balance of my time.

Mr. SESSIONS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the gentleman from Massachusetts (Mr. MCGOVERN) is exactly correct. We are going to this morning, in about 35 minutes, walk upstairs here in the Capitol. We are going to go to the Committee on Rules. Our young chairman, the gentleman from California (DAVID DREIER), will open up the meeting where we will be open for debate and I am sure controversy. But most of all, it will be part of the process that has been something that the Committee on Rules in this House has done for a long time, and that is follow through with the process to make sure that people at 10 o'clock Eastern time in Washington, D.C., and Members of Congress have a chance to walk upstairs and to talk about this bill and to present their ideas and to talk about what this conference report is all about.

Obviously, this conference report is debatable. It is nonamendable. It will be an up-or-down vote. This is part of a process that has taken place where Members of this great body, with our colleagues on the other side of the Capitol, the Senate, got together, worked through problems. But I think that if we were trying to wait until today, as my colleague from Massachusetts would suggest, to find out what people want back home, I think we have made a terrible mistake. I think Members on this side of the aisle have already gone home and listened to people. That is what this is about, to be a body that has heard people. And we have passed not only this legislation as a result also of consultation back home, but even last January when we handled the budget we talked about what we thought this bill would look like. And, of course, our colleagues on the other side of the aisle, said there is no way that we could do that. We just would never pull that off.

Well, Mr. Speaker, today it looks like we have. And I would like to describe a little of what we pulled off. We will hear the details at 10 o'clock upstairs, but those details essentially include competition in the area of health care. This competition that we are talking about, which will be debated up in the Committee on Rules, is about allowing families back home, including people who may not be in Medicare yet, to begin saving for their future. We are going to have something that is called health savings accounts that were previously known as MSAs. These health savings accounts are going to allow people to save on a pre-tax basis and then save this money on a tax-free basis and then spend it in health care on a tax-free basis.

Why is this important? This is important because over the lifetime of a person and their family they will be able to prepare with this money for what their needs are going to be for health care. Why is that important? That is important to our Nation because a consumer that has money in their pockets can make wiser decisions, rather than showing up in a system like Medicare where many times they cannot even find where their doctor accepts Medicare.

This will change health care for this country as we continue on a moving-forward basis. It empowers people. We think it is the right thing. We think that is what people are asking for back home.

Mr. Speaker, on the prescription drug angle, no question in my mind, the Washington Post is probably right. Oh, my gosh, this is an expensive bill. But you know what? We did it in a way that will help people who need the most help and I am proud of that.

So, Mr. Speaker, I know that my friends want to talk about all the things that are going on up in the Committee on Rules here in just a few minutes. I can assure them and the American public that what we are all about is about process and doing the right thing for people back home.

Mr. Speaker, I reserve the balance of my time.

□ 0930

Mr. MCGOVERN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I appreciate the gentleman from Texas' comments, but he missed the whole point of what I was trying to say. On substance, we will debate that later.

This bill is a lousy bill. It privatizes Medicare. It does not provide our seniors with a prescription drug benefit that they believe they are going to get, and that they expect and deserve. This is a lousy bill.

But what I was talking about was the process. We will talk about the substance later. This process stinks, and the bottom line is that you and the majority continually ignore the rules of this House or waive the rules of this House.

The rules are that when you file a conference report, you are supposed to have 3 days to review it. This was filed, this important historical legislation that you talk about, was filed at 1:20 a.m. in the morning. All right. I do not know whether you read the whole thing, but I am going to tell you, most Members on both sides did not.

Let me read you a letter that was sent to the gentleman from Illinois (Speaker HASTERT); to the gentleman from Texas (Mr. DELAY), the majority leader; and to the majority whip, the gentleman from Missouri (Mr. BLUNT).

Dear gentleman: We write to request that if the conferees on the Medicare Prescription Drug and Modernization Act of 2003 report to the House a conference report, that copies of the text of the conference report, the text of the explanatory statement and the text of the Congressional Budget Office cost estimate for the conference report be made available to all Members at least 3 calendar days after filing, excluding Saturdays, Sundays and legal holidays, unless the House is in session on those days, and prior to consideration of the conference report or to any measure reported from the Committee on Rules providing for the consideration of the conference report.

"The general public will evaluate not only what Congress does regarding Medicare and prescription drugs, but the way in which it does it. A bill proposing such substantive changes to its Medicare system and costing an estimated $400 billion over the next decade deserves the careful and thoughtful consideration of all Members."

It goes on and on. I will include this letter for the RECORD, Mr. Speaker.

OCTOBER 29, 2003.

Hon. J. DENNIS HASTERT,
Speaker, House of Representatives, Washington, DC.
Hon. ROY BLUNT,
Majority Whip, House of Representatives, Washington, DC.
Hon. TOM DELAY,
Majority Leader, House of Representatives, Washington, DC.

DEAR GENTLEMEN: We write to request that if the Conferees on the Medicare Prescription Drug and Modernization Act of 2003 report to the House a Conference Report, copies of the text of the Conference Report, the text of the explanatory statement, and the text of Congressional Budget Office cost estimate for the Conference report be made available to all Members at least three calendar days after filing (excluding Saturdays, Sundays, and legal holidays, unless the House is in session on those days) and prior to consideration of the Conference Report or to any measure reported from the Committee on Rules providing for the consideration of the Conference Report.

The general public will evaluate not only what Congress does regarding Medicare and prescription drugs, but the way in which it does it. A bill proposing such substantive changes to the Medicare system and costing an estimated $400 billion over the next decade deserves the careful and thoughtful consideration of all Members.

Allowing Members adequate time to properly evaluate the Conference Report will avoid a needless and difficult internal fight on the Rule, and allow Leadership to concentrate its efforts on final passage of the Conference Report. It will also lead to more public confidence in the legislative process and greater acceptance of that process' final product.

Therefore, while some of us are likely to support and others to oppose the Conference Report on H.R. 1, each of us strongly urges you to abide by regular order and provide at least three calendar days for Members to review the Conference Report and materials necessary to properly evaluate the Conference Report.

Sincerely,

Mr. John Kline, Mr. C. Michael Burgess, Mr. Randy Neugebauer, Mr. Johnny Isakson, Mr. Tom Tancredo, Mr. Dave Weldon, Mr. Virgil H. Goode, Jr., Mr. Donald Manzullo, Mr. Jim Ryun, Mr. Todd Akin, Mr. Gil Gutknecht, Mr. Ernest J. Istook, Jr., Mr. Jeff Flake, Mrs. Sue Myrick, Mr. Jeff Miller, Mr. Phil Crane, Mr. Trent Franks, Mr. Mike Pence, Mrs. Marilyn Musgrave, Mr. Pete Hoekstra, Mr. Joseph R. Pitts, Mr. Scott Garrett, Mr. Tom Feeney, Mr. Kevin Brady, Mr. Roscoe Bartlett, Mr. William "Mac" Thornberry, Mr. Tim Murphy, Mr. Steve King, Mr. Ron Paul, Mr. Johnson Boozman, Mr. John Culberson, Mr. J. Gresham Barrett, Mr. John Carter, Mr. John N. Hostettler, Mr. Devin Nunes, Mr. J. Randy Forbes, Mr. Mark E. Souder, Mr. Jim DeMint, Mr. Mark Kennedy, Mr. Charlie Norwood, Mr. Chris Chocola.

This was signed by 41 Republican Members of this House, and it is clear by the fact that we are moving in the fashion that we are today that not only do you not care that those of us on the Democrat side feel it is important, but you do not even care what your Republican Members think with regard to being able to read this bill.

So, Mr. Speaker, I would say to my colleague from Texas, what I am complaining about right now is the process, and on a bill this important, Members, staff and our constituents deserve to know what is in this bill. Quite frankly, the sound bites and the press releases from the leadership of this House, from the gentleman from California (Mr. THOMAS) and others, that does not cut it. We have been there, we have done that before.

What we need to do is read the fine print to find out what other special interest goodies are tucked in there for the pharmaceutical industry or the HMOs.

Mr. Speaker, I yield 4 minutes to the gentleman from California (Mr. GEORGE MILLER)

Mr. GEORGE MILLER of California. Mr. Speaker, I thank the gentleman for yielding me time. I think he makes a very important point.

We thought we had an agreement. In fact, we had the word of the Speaker of the House there would be a 3-day layover period for this legislation so Members and interested parties could read this legislation to discover exactly what is in it.

The Republicans make a great deal out of the fact that this bill will provide for competition. We know it will not provide for price competition on pharmaceuticals, because it specifically prohibits price competition. It does not let the Secretary of Health and Human Services negotiate lower prices, lower costs, for senior citizens in the Medicare program.

But, interestingly enough, Mr. Speaker, and maybe every Member of Congress will want to read the bill very closely, the gentleman on the other side says what we do here is we promote competition. We are going to put in place private health plans that are going to compete with Medicare, and people are going to get better services, more services, at a lower cost.

Now, that is an interesting notion of competition. I don't know where the free market is, but they decided now in this bill that they are going to have to give these plans almost a 30 percent increase, more than they pay for Medicare, to try to make these plans run. But this competition is such a good idea, and it is pushed by the Republicans. The victims are going to be the senior citizens, but the Republicans are saying this competition is a great idea.

Well, I want to tell my Republican friends in the House who have not read the bill, pick up the Wall Street Journal today. See what your Senators have done. This is a great bill for competition. It is so good, it is so good, that Senator GORDON SMITH of Oregon, Senator KYL of Arizona, Senator SPECTER, and there is one other Senator whose name I cannot pick out of the story here, have decided it is so good, they have excluded their areas in their States from the competition.

They say, "Oh, no, you are not going to do this in my area. You are not going to do this with my senior citizens." The Senators apparently are a little closer to the process here, and they have read the bill. They said, "You know, we had one of these demonstrations a number of years ago, and it blew up in our face, both in terms of cost and in terms of services to the senior citizens."

So, Senators, you know how they make their deals over there; we cannot do this over here because of the Committee on Rules, they got in there in the last minute and said, "Exclude my area in Pennsylvania, exclude my area in Arizona, exclude my area in Oregon. I am not having any of this competition for my senior citizens. Just those lucky-duckies over there in the House that have one of these competition plans lands on their congressional district. Then we will see how it goes."

That is why you want to read the bill. That is why you want to be able to have a 3-day layover period to protect the rights of every Member of this House and the constituents and the people that they represent in their congressional districts.

But the arrogance of this leadership, the arrogance of the Speaker, the arrogance of the Committee on Rules just constantly suggests that democracy means very little to them; the rights of each and every Member mean very little to them. They now have the power, the Republicans have the power, and, with that power, slowly has come arrogance. And they have decided that there is no reason for debate; there is no reason for us to be able to try to tell the American people what is in this bill before we vote on it so maybe they can participate.

They want to run the Congress like AARP runs their organization; one person at the top makes a decision, and 30 million people out there are put in jeopardy. That is not the democratic process. That is not the democratic process.

I cannot wait to see the Constitution you guys want to write in Iraq. If this is what you are doing to the People's House on the most important piece of social legislation in this country, you want to shut down debate, you do not want to give people time to read it.

If you cannot read the bill, my colleagues in the House, read the Wall Street Journal. Read the Wall Street Journal, because maybe you, too, can scramble up to the Committee on Rules in the next hour and get an exemption from competition like those wonderful, powerful Senators have done. Do not read the bill, read the Wall Street Journal.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SIMPSON). The Chair would remind all Members that they should refrain from improper references to Senators.

Mr. GEORGE MILLER of California. Mr. Speaker, I do not know how to identify them if I do not identify them by name.

The SPEAKER pro tempore. The Chair would remind all Members they should refrain from identifying individual Senators by name.

Mr. SESSIONS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, this competition angle is an important part of what this Medicare bill will be. You see, we Members of Congress that occasionally go home who are aware of the things that happen at home in the real marketplace, some of those things that are very exciting in the world of competition are happening in health care. They are happening all across this country.

Sometimes when you go home and you open up a newspaper, or you watch on TV and they talk about LASIK eye surgery. LASIK eye surgery used to be $1,200 an eye. Due to competition, due to machines, due to procedures now becoming available, they are $299 an eye. That means that as a result of competition, as a result of physicians, medical doctors, learning how to do these procedures, we have sent these teachers all across the country, and they have perfected this technique. That is an example of where competition does work. Over 1 year these surgeries have gone from over $1,200 to $299 an eye. We think competition will be a huge part of the success of this Medicare bill.

But let us go back to the process. The process is that this has been debated not only in the public and in newspapers and TV and on this House floor since January, or before, when many of our colleagues on the other side were saying, where is that prescription drug bill? Where is that prescription drug bill?

Mr. Speaker, we now have it on the floor of the House of Representatives. It will be in the Committee on Rules today and on this floor very quickly. It will be something that has, by popular demand, been asked for, and it comes as a result of these two bodies, the House and the Senate, working through very difficult negotiations.

It is a process that has been followed, it is a process that works, it is a process that I think has allowed people for a long time to know the answer as to what is in this bill, so much so that the Democrat leadership has already blasted the AARP a week ago for supporting the bill because they knew what was in the bill.

So I think it is a misnomer to think that we just do not know or do not understand. People who wish to know, people who wish to be a part of this bill could gain the information. I am proud of what we are doing today. The gentleman from California (Chairman DREIER) will open up the Committee on Rules in about 20 minutes, and the debate there will start.

But, let us not forget, this is not about amending a bill. This is a conference report. This is not like one Member in this body can change one word that is in this document, because that is not our process or procedure. It will be an up-or-down vote. It will be based upon what a Member thinks is the right thing to do. I trust their judgment.

Mr. Speaker, I reserve the balance of my time.

Mr. McGOVERN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the gentleman from Texas keeps on talking about the Committee on Rules and the action we are about to take, as if something important is going to happen.

What is going to happen in the Committee on Rules is we are going to waive all the rules. We are going to waive the rule that says Members have a right to read this bill. So I guess it is historic in the fact that once again we are going to trample on the rights of Members of both parties.

I should say to the gentleman from Texas, it is not just Democrats that are complaining about the need to read the bill. I just cited to him a letter that was signed by 41 of some of the most conservative Republicans in this House who said, we should read the bill. One of the reasons why, I suspect, is if you read the Washington Post today, there is a headline, "Drug Makers Protect Their Turf." I will insert this article in the RECORD.

[From the Washington Post, Nov. 21, 2003]

Drugmakers Protect Their Turf

MEDICARE BILL REPRESENTS SUCCESS FOR PHARMACEUTICAL LOBBY

(By Ceci Connolly)

No industry in negotiations over the $400 billion Medicare prescription drug bill headed to the House floor today outpaced the pharmaceutical lobby in securing a favorable program design and defeating proposals most likely to cut into its profits, according to analysts in and out of the industry.

If the legislation passes as Republican leaders predict, it will generate millions of new customers who currently lack drug coverage. At the same time, drug-manufacturing lobbyists overcame efforts to legalize the importation of lower-cost medicines from Canada and Europe and instead inserted language that explicitly prohibits the federal government from negotiating prices on behalf of Medicare recipients.

"It couldn't be clearer there is going to be a positive effect overall," said Dan Mendelson, president of Health Strategies Consultancy, which bills itself as a think tank and consulting firm. "The volume will definitely go up. There will be a lot of people who didn't have coverage before who will have it now and a lot of people getting an upgrade in terms of coverage."

Democrats and consumer advocates complain that the Republican-crafted compromise does little to contain soaring drug costs. They say that by handing the Medicare drug program's administration to private insurers, Congress missed a chance to exert pressure on pharmaceutical companies to reduce prices.

But Republicans and some industry analysts say that adopting a drug-purchasing mechanism similar to those in corporate health plans is the best way to extract discounts from drugmakers.

If Medicare negotiated on behalf of its 40 million beneficiaries, "I wouldn't be negotiating; I'd just be fixing the price," said Thomas Scully, the program's administrator. "Let's get seniors organized into big purchasing pools and get bulk discounts and see how they fare."

Representatives of the industry's main lobbying arm, the Pharmaceutical Research and Manufacturers of America (PhRMA), declined yesterday to discuss the legislation. But the clearest indication that the bill offers a brighter future for the industry came from Wall Street, where pharmaceutical stock prices have steadily risen over the past week as the legislation's prospects for passage improved. Analysts at Goldman Sachs & Co. project the new Medicare benefit could increase industry revenue by 9 percent, or about $13 billion a year.

After objecting for years to proposals to add prescription drug coverage to Medicare, the pharmaceutical lobby recently shifted positions and poured enormous resources into shaping the legislation. Since the 2000 election cycle, the industry has contributed $60 million in political donations and spent $37.7 million in lobbying in the first six months of this year.

The lobbying continued in earnest this week with a television and print advertising campaign urging passage of the bill. In one series of witty commercials sponsored by the industry-backed Alliance to Improve Medicare, elderly citizens look into the camera and demand: "When ya gonna get it done?"

One Republican with ties to the industry said drugmakers eluded the three things they feared most: legalized importation of lower-cost medicines, many of them patented or made in the United States; government price controls; and easier market access for generic drugs that cost considerably less than brand-name drugs. "In their view, by improving access for all seniors, we will ameliorate any pressure on the industry toward price controls or reimportation," the source said.

About 24 percent of Medicare beneficiaries—nearly 10 million senior citizens—do not have any prescription benefits. some of them buy medicine at the highest retail prices. Academic studies and anecdotal evidence suggest, however, they many go without prescription medicines and would become new customers for drugmakers if the bill becomes law. The remaining 30 million Medicare recipients but some supplemental drug coverage, according to the most recent government figures.

Even those with some drug coverage are expected to spend more with the new benefit, said Fredric E. Russell, whose investment management company owns several drug stocks. Whenever a new health benefit is offered, he said, patients and doctors jump at the chance to take advantage of it.

Under the bill, beginning in 2006, all Medicare beneficiaries would have the option of buying a drug plan for about $35 a month, plus a $275 annual deductible. Insurance companies and pharmacy benefit managers (PBMs) would administer the programs for the government.

The great unknown is what sort of prices those insurers will ultimately negotiate on behalf of their Medicare clients, said Kristine Bryan, senior health care analyst at Brown Brothers Harriman & Co. "Generally, when you have a large purchaser, you have the ability to demand better pricing," she said.

Republican congressional staffers also point out that because the bill waives a requirement that state Medicaid programs receive the "best price" available, the new private insurers could save Medicare $18 billion. It would, however, likely increase states' drug costs.

Many Democrats say private purchases have not been as successful at bargaining as have government programs such as the Veterans Administration and Medicaid, which secure some of the steepest drug discounts available.

"We've been going through PBMs for 10 years and nothing's happened except the price of drugs has gone up," said Democratic presidential candidate Howard Dean, a physician.

Perhaps the most striking political victory for the pharmaceutical industry was the decision to reject provisions that would have allowed Americans to legally import drugs from Canada and Europe, where medications retail for as much as 75 percent less than in the United States. Polls show that an overwhelming majority supports the change, and the House approved the provision, 243 to 186. But the Bush administration and pharmaceutical lobby said the move was dangerous and would cut into future research and development.

The provision was dropped from the bill's final version.

□ 0945

Mr. Speaker, it talks about all the special sweetheart deals that are in this bill for the pharmaceutical industry. I do not know whether the gentleman was aware of all these little deals that were cut. I suspected they were there, but now I want to find out who is getting what and how much. I want to connect all the dots here. That is why we want to read the bill.

So, again, what we are saying here is not anything radical, quite frankly. We are saying follow the House rules. We have rules of this House. If you do not want to follow the House rules, if you keep on ignoring them, then do away with the rules. Do not have any rules. But we do have rules to protect not only the rights of the minority, but your Members, so they know what you are voting on.

Mr. Speaker, I yield 4 minutes to the gentleman from Oregon (Mr. DEFAZIO).

Mr. DEFAZIO. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, 14,345 days. That is how long it has been since Medicare was enacted, the most important social program to lift seniors out of poverty in the history of the United States.

I worked with seniors, ran a senior citizen program, studied in the field of gerontology. Before Medicare, we had double the rate of poverty among seniors because they were driven there because of the cost of medical care.

Medicare has been a tremendous benefit to our seniors. It was opposed by the Republicans, it was opposed by the AMA, it was opposed by the nursing homes and all of them. Now, of course, they are the greatest supporters of the program because of the reimbursement and the business it provides.

But now we are about to make the most important changes in the 13,435-day history of Medicare, and we cannot have 1 day. We are not to be allowed 1 day to read a 791-page bill, which, to the best of my knowledge, and the gentleman can correct me on his own time if this is wrong, is not available in printed form. Some people like to read 791 pages on a computer screen. I do not. I think there are a lot of other Members of this Congress and the public who would like to actually have a printed copy in their hand to be able to flip back and forth easily and understand what this bill really does. But we are not going to have printed copies, or perhaps we will at some point when the debate begins. But even with speed reading, that is going to be tough.

So a 791-page, unbelievably complicated bill making extraordinary changes in a program which we have had for 39 years, and we cannot take 24 hours, or even, as the rules would provide, 72 hours to read it. What would be the harm in voting on Monday? Let it sit over the weekend. Let everybody have a chance to read it. I would be willing to stay over the weekend, work through the weekend, get through the other work and vote on this bill on Monday.

The gentleman talks about competition in the marketplace. This is a bizarre bazaar of a marketplace, because this is more like a souk, where there are all these back-room deals, and you do not know what is going on.

Competition? Well, it has subsidies for the private health insurance industry, HMOs, who still continue to enjoy an antitrust exemption, so there will be no requirement that they offer these plans; there will be no requirement that they guarantee seniors coverage beyond a 1-year basis; and there will be no requirement for them to take seniors who are not good risks or keep seniors after they make a claim. As many of my constituents know, as soon as you claim against an insurance company these days, they tell you are going to be terminated when your renewable comes up. That is what is going to happen to seniors in these private plans.

Then we have protectionism. The party of free trade, free trade over here, the Republicans are trading our jobs to China and all these other places, this bill is protectionist. It is not going to allow Americans to reimport FDA-approved, U.S.-manufactured drugs from Canada or any of the other developed industrial nations who bargain on behalf of their citizens and get huge price reductions. So Americans are going to have the door slammed on the one place they can get less expensive drugs. And none of the benefits under the bill, even at the cost of $400 billion, will reach the simple benefit that my constituents can get by importing FDA-approved, U.S.-manufactured drugs from Canada.

So we are going to spend $400 billion, create this unbelievable Rube Goldberg, and the benefit for every one of my constituents will be less than they can get today by buying from Canada, and we are going to slam that door with this bill. So they are not going to have that opportunity any more. They are going to be forced to buy drugs at higher prices, even with the so-called coverage under this bill. That is price fixing.

So we have a bill that has protectionism, price fixing, subsidies for the HMOs, the insurance industry is exempt from antitrust laws, and the gentleman says somehow this is the marketplace of competition.

What a bizarre view of a true, free and competitive marketplace. We could more simply allow these Medicare constituents to have a negotiated price for the reduction of their drugs, as we do for VA, but the industry is opposed to that because there would be too much market force, too much market clout on the part of the government in those negotiations, and allow the continued, safe reimportation of drugs from Canada.

And there is a big red herring here. The administration says FDA-approved, U.S.-manufactured drugs reimported from Canada are not safe, they cannot guarantee their safety, except we know that the drug custody chain in the United States of America is much more compromised than in Canada.

Canada first negotiates about a 50 percent reduction in prices, licenses the importers, licenses everybody, and tracks all the people who touch the drugs. In the U.S., the pharmaceutical companies dump huge amounts of drugs into an unregulated secondary market that is licensed by the States, into these phony closed-door pharmacies, and organized crime is involved in getting counterfeit drugs into the system here in the United States.

There is a huge breach of the integrity and safety of the system here in the United States, which there is no concern about because the industry is making money by having that system, but we are going to say, oh, those Canadian drugs, they are not safe. They are safer, in all probability. There have been no instances proven in Canada, unlike the United States, of organized crime getting counterfeit drugs into the system.

Mr. Speaker, we could do something simpler and cheaper if we defeat this bill.

Mr. SESSIONS. Mr. Speaker, I have the honor and privilege to yield 4 minutes to the gentleman from Florida (Mr. FOLEY), a young man who serves on the Committee on Ways and Means.

Mr. FOLEY. Mr. Speaker, I thank the gentleman for bringing the rule to the floor and for yielding me time.

Mr. Speaker, there is a commercial on these days that has a catch line, and it says, "What is in your wallet?" Well, I ask Members of Congress to ask themselves that very question, what is in your wallet?

I will tell you what is in mine. It is a card that I get as a Member of Congress. It says BlueCross BlueShield Federal Employee Program. It is a PPO. It has a prescription drug benefit attached to it, a $35 copayment. Certain attributes of this plan work for Members of this Congress.

In my congressional district I have the fifth largest Medicare-eligible population of 435 Members of this body, the fifth largest Medicare-eligible population. When I go home to my town hall meetings, they say, "I want what you have. I want choice. I want opportunity." Interestingly enough, they do not say, "I want it all, and I want it free." They want fairness, because they want the system to continue.

The harangues on this floor the last couple days are amazing. We have heard repeatedly, speaker after speaker, "We haven't seen this bill; we haven't read this bill." But we have spent hours of time talking about what is bad about what is in this bill, so either they have not seen the bill, or they are just guessing what must be in the final work product.

For 4 years I have been on this committee, and I have met over on the other side of the Chamber with the respected Senator BOB GRAHAM, Senator HARRY REID, at that time Senator CHUCK ROBB and a number of Members of the Senate as we tried to work out an opportunity to find a prescription drug plan that would suit the test of time and be financially equivalent, if you will.

In our bill there is a wellness provision which allows us to do diagnostic testing for cardiovascular disease, allows us to test for diabetes early, before the onset of these diseases. There is, in fact, a drug discount card that will be offered to those lower-income individuals who need assistance. That drug discount card will have, much like an ATM, $600 of purchasing power so they will have an opportunity to buy the vital drugs they need.

Many people on the other side of the aisle decided politically to sign the AARP pledge. If you read the pledge, it says all Medicare beneficiaries will have access to a stable prescription drug benefit on a voluntary basis. Not forced, not coerced, not mandatory. Affordable prices will be the rule, not the exception. We are trying to do that.

To those who suggest just reimport drugs from Canada, let me ask the basic question; read the articles in Florida in the newspapers where there have been numerous arrests because of counterfeit drugs coming from Canada.

Reasonable premiums, deductibles and copayments. Those are in the bill. Prescription coverage will leave no individual with extraordinary out-of-pocket costs. There is a catastrophic provision written into this legislation. Reduction in soaring drug costs will keep the program affordable. Extra help for low-income individuals. Help for rural communities that I represent with their hospitals, their ambulances, their doctors. We talk about a number of things in the bill that I think provide relief for every American. Increased fees, if you will, for physicians, increased index for the hospital what we call the market basket.

So if you look at the Medicare bill, yes, there may be problems for some. But AARP, which was, up until last week, described as the "gold standard" of senior lobbying organizations, has decided to take this first step with us.

Will this be a perfect vehicle? No. No legislation I have ever worked on in this process has ever been perfect. We have had to come back, work it, amend it, and deal with some of the consequences. And if we fail to make this critical step and pass this rule and pass this legislation, we will have surrendered our ability to bring seniors a necessary improvement to the Medicare health delivery system that they so vitally need.

So I urge my colleagues, support the rule and support the underlying legislation. Let us do for seniors what Claude Pepper and Franklin Delano Roosevelt tried to do to enhance their safety and security.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair would remind Members to refrain from improper references to Senators.

Mr. McGOVERN. Mr. Speaker, I yield 30 seconds to the gentleman from California (Mr. GEORGE MILLER).

Mr. GEORGE MILLER of California. Mr. Speaker, the President stood in the well and said he wanted the senior citizens to have a drug benefit like Members of Congress have with this card. Under our prescription drug benefit, the government pays 80 percent, we pay 20 percent. Under this bill, of the first $5,000, the seniors pay 80 percent and the plan pays 20 percent.

You guys have reversed the figures on the senior citizens. Out of the first $5,000, the seniors pay $4,200. Out of our first $5,000, the government pays 80 percent. Somewhere between the President's speech there and this bill, you lost 80 percent of the benefits for seniors.

Mr. SESSIONS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, there was a statement that was made that I think we just need to set the record straight on, and that is that this bill does not talk about reimportation from Canada, where Congress makes a decision on that issue. We allow the FDA to make that decision. It is not the Congress that makes that decision.

Mr. Speaker, I reserve the balance of my time.

Mr. McGOVERN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, let me just say to the gentleman from Texas, he knows very well what is going on here. The administration already decided they are not going to allow citizens to be able to get their drugs from Canada, even though they are cheaper. They already made their decision.

What we have in this bill basically is to protect the status quo, which means our senior citizens get gouged and gouged and gouged and gouged.

Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Florida (Mr. HASTINGS), my colleague on the Committee on Rules.

Mr. HASTINGS of Florida. Mr. Speaker, I thank my good friend from Massachusetts for yielding me time.

Mr. Speaker, it is very difficult to not get involved in the discussion that is ongoing. There is a great need for us to correct a few things, and I hope that I can without exuding the passion that I normally bring to debate.

I would borrow from an article in today's New York Times written by Paul Krugman where he says, "Let's step back a minute. This is a bill with huge implications for the future of Medicare. It is also, at best, highly controversial. One might therefore have expected an advocacy group for retired Americans to take its time in responding, to make sure that major groups of retirees won't actually be hurt, and to poll its members to be sure that they are well informed about what the bill contains and do not object to it. Instead, AARP executives have thrown their weight behind an effort to ram the bill through before Thanksgiving. And, no, it is not urgent to get the bill passed so retirees can get immediate relief. The plan won't kick in until 2006 in any case, so no harm will be done if the Nation takes some time to consider."

What we have asked for here is 3 days. That is a part of the Rules of this House of Representatives, and every Member of this body, particularly those of us on the Committee on Rules, know that to be true. Despite my Democratic colleagues' best efforts to make this an inclusive and comprehensive process, one that addresses the real concerns of all of America's seniors and disabled, we were shut out from negotiations. We were shut out in June, and we are shut out now.

What we have before us, plain and simple, is an evisceration of Medicare. This bill was filed at 1:30 a.m. this morning. There is an axiom that says, "He who makes the rules, rules." All of us in the minority know that the majority rules. We should, however, in this great country be exemplars of fairness, lest we be perceived as fools making rules. If we cannot be fair, who can? And it is that this process is wrong, and it is just that simple. It is not a question about Medicare or anything, if we did this on the next bill, the forest measure, if we did it on yesterday's bill. This is the first time in the whole of this year that we have brought a bill in the daylight, and my colleagues know that.

What we are doing here is critically important. I, for one, do not want to go back to my district that joins the district of my good friend the gentleman from Florida (Mr. FOLEY), where both of us have as high as 34 percent seniors, and tell them that I sure did read this information that is in this bill. Never mind about castigating anybody, the fact of the matter is most Members of this body, all of them on this side, have not read the present contents of the bill.

Yes, there were hearings; yes, there were opportunities for people to talk through the years. I came here along with many of you 11 years ago. We were talking about prescription drugs then. I read my clippings. I was saying, "I am going up there and try to get you prescription drugs." The Democrats were in the majority, we did not get it. The Republicans have been in the majority, and we have not gotten it. And what we are getting ready to get is have this country in turmoil because we are not protecting all of our seniors.

□ 1000

Mr. SESSIONS. Mr. Speaker, I yield myself such time as I may consume. The Committee on Rules begins testimony in 2 minutes. We came down to the floor this morning to make sure that we were going to have the ability to have a same-day rule. I am satisfied that we have broken into a lot of other things to talk about this morning.

Mr. Speaker, I reserve the balance of my time.

Mr. MCGOVERN. Mr. Speaker, I yield myself the balance of my time.

Let me just conclude by saying that on the substance of the bill that we are talking about, the Medicare prescription drug bill, there is a fundamental disagreement between me and some of my friends on the other side of the aisle because to me protecting Medicare is nonnegotiable. I think we are going down a very dangerous road here with this bill.

But what my frustration is at this particular moment is that we are going down that road when most Members of this House have no idea exactly what is in this bill. We get little bits and pieces and some of what we are finding out, quite frankly, I think most Americans do not like, little special interest deals for pharmaceutical companies, for HMOs, a not-so-generous prescription drug benefit for senior citizens, something that does not kick in for another 2 years. I think the American people and the Members of this Congress deserve having all of us go into this with our eyes wide open.

I read to you before, I say to my colleague from Texas, a letter signed by 41 of some of the most conservative Republicans in this House who asked your leadership, made one simple request of your leadership, and that is that they respect the rules of this House and give them and the entire House 3 days to review the contents of this bill. That is not too much to ask for. I think people on both sides of the aisle, even those who are going to support this bill, want to know exactly what is in it. They do not.

The fact of the matter is we are about to go up to the Committee on Rules, we are going to waive all the rules, disregard them once again as has become a habit in this place, and I think it is sad, especially on a bill this important. Our constituents deserve better.

Mr. Speaker, I would hope that maybe between the time the gentleman from Texas and I leave the House floor to go up to the Committee on Rules that there might be a change of mind and the leadership might actually respect the rules of this House, but I doubt it. Having said that, I think it is unfortunate. I think the losers are the American people.

Mr. Speaker, I yield back the balance of my time.

Mr. SESSIONS. Mr. Speaker, I yield myself the balance of my time. I thank the time that the Speaker has given us this morning to debate this rule. I believe it is a fair rule. I have not heard much debate about it.

Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered.

The resolution was agreed to.

A motion to reconsider was laid on the table.

WAIVING POINTS OF ORDER AGAINST CONFERENCE REPORT ON H.R. 1904, HEALTHY FORESTS RESTORATION ACT OF 2003

Mr. HASTINGS of Washington. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 457 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 457

Resolved, That upon adoption of this resolution it shall be in order to consider the conference report to accompany the bill (H.R. 1904) to improve the capacity of the Secretary of Agriculture and the Secretary of the Interior to plan and conduct hazardous fuels reduction projects on National Forest System lands and Bureau of Land Management lands aimed at protecting communities, watersheds, and certain other at-risk lands from catastrophic wildfire, to enhance efforts to protect watersheds and address threats to forest and rangeland health, including catastrophic wildfire, across the landscape, and for other purposes. All points of order against the conference report and against its consideration are waived. The conference report shall be considered as read.

The SPEAKER pro tempore. The gentleman from Washington (Mr. HASTINGS) is recognized for 1 hour.

Mr. HASTINGS of Washington. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to my good friend and namesake, the gentleman from Florida (Mr. HASTINGS), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Mr. Speaker, House Resolution 457 is a rule providing for the consideration of the conference report to accompany H.R. 1904, the Healthy Forests Restoration Act of 2003. The rule waives all points of order against the conference report and its consideration and provides that the conference report shall be considered as read.

Mr. Speaker, recent reports of catastrophic wildfires in the West have helped millions of Americans to understand what Members of western districts have known for years, that steps must be taken to improve our management of national forests in order to reduce the risk of runaway forest fires that threaten lives, property and even entire communities.

H.R. 1904, the Healthy Forests Restoration Act, contains several key measures that will enable Federal land managers to better manage potentially explosive stands of timber and underbrush. Passage of the bill would also enable local communities to play a more meaningful role in the management of lands that pose potential threats. H.R. 1904 would authorize the removal of dead, dying and diseased trees and underbrush from Federal lands. It would also strengthen the ability of land managers to pursue fire prevention strategies under an expedited system that would limit excessive court challenges to proposed changes in management plans for Federal lands.

The bill authorizes $760 million annually for fire prevention, suppression and management activities, a significant increase over current allocations.

Mr. Speaker, the conferees have done an excellent job of protecting the House position on this legislation, which passed the House by a large margin back in May 2003. The conferees should be commended for moving to complete the work on this important legislation before Congress adjourns and we in turn should pass it without further delay.

Accordingly, Mr. Speaker, I urge my colleagues to support both the rule and the underlying conference report.

Mr. Speaker, I reserve the balance of my time.

Mr. HASTINGS of Florida. Mr. Speaker, I thank my good friend and namesake, the gentleman from Washington (Mr. HASTINGS), for yielding me the time.

Mr. Speaker, I am pleased to yield 4 minutes to the gentleman from Oregon (Mr. DEFAZIO).

Mr. DEFAZIO. I thank the gentleman for yielding me this time.

Mr. Speaker, it was just a little over a year ago that the Biscuit fire was raging in southwest Oregon in an area shared by myself and the gentleman from Oregon (Mr. WALDEN). We held a hearing in the Committee on Resources during that fire about the issue of the fuel buildup in our forests. After I listened to a few of the witnesses, I really did not ask any questions, I gave a pretty impassioned speech about how I was tired of the fact that we all kind of went to our political corners on this issue when a real solution was warranted. Surprisingly after the hearing I was approached by a number of Members that people would be surprised could sit down in a room and work together on an issue like this, but notably the gentleman from Colorado (Mr. McINNIS) came forward and said to me, I really agreed with a lot of what you said and I would like to try and work something out, as did the gentleman from Arizona (Mr. SHADEGG), the gentleman from Oregon (Mr. WALDEN), and the gentleman from California (Mr. GEORGE MILLER). We sat down and began some very difficult negotiations.

Unfortunately, last year the clock ran out on us. We had an election year, so we did not get the bill done. But now here we are hopefully at the point of adopting the bill in the House and the Senate and seeing it signed into law. This is not exactly the bill I would have written. It is not exactly what we negotiated last year, but I believe it is a bill that can get the job done. Most importantly, it authorizes $760 million. I think we could even authorize and do more work than that on an annual basis given the unnatural buildup of fuels in the forests, but if we can get that money actually spent, it will provide for a lot of jobs. It will provide for tremendous protection for communities and resources.

The bill has language about how the work should be conducted. The idea is to leave the big old fire-resistant trees and return the forest to what we call a presettlement condition, before we began unnaturally repressing fire more than 100 years ago with the settlement of the West. What you need to do, and there was a dramatic example at the Davis fire in central Oregon this year, you could see where the lodgepole pines were growing up into the crowns of the big old fire-resistant Ponderosas and unfortunately a lot of those Ponderosas went because that is called a ladder fuel. It just ran up this crummy old lodgepole and right up into the beautiful old Ponderosa and we lost everything. We need to go in and remove those lodgepole pines and other unnatural fuel buildups. That will provide both for jobs, potentially for some merchantable material in certain areas, and eventually we will be able to manage our forests back or help return them to a state where low-intensity fires can burn through, fires that do not destroy whole stands, that do not turn the Earth into glass and sterilize it. That is the condition that prevails today in the West.

This bill is not without controversy. That is again part of the process. I think the protections are there. People still have a right to appeal but appeals will be expedited. People have to participate meaningfully in the process. I do not have a problem with that. I think people should participate meaningfully in the process and we should open it up to everybody who is concerned. People will still have a right to go to court if they feel that the law is being violated but we are going to have the money, we are going to have the tools and if this administration applies this properly, if they get and spend all the money that is promised under this bill, we will begin a very long process of restoring our forests to a more natural state in the western United States and in a state that will not lead to a multi-number of catastrophic fires on an annual basis, which is the state we are seeing today.

I want to thank my colleagues on that side. I neglected the Committee on Agriculture, where I do not serve, but I know that the Committee on Agriculture also played a key role in this legislation. I think we will be all the better for it.

Mr. HASTINGS of Washington. Mr. Speaker, I am pleased to yield 4 minutes to the distinguished gentleman from Virginia (Mr. GOODLATTE), chairman of the Committee on Agriculture.

Mr. GOODLATTE. Mr. Speaker, I thank the gentleman from Washington for yielding me this time and for bringing this rule to the floor and I thank the Committee on Rules for very expeditiously moving this process. I know that when I left the Committee on Rules last night it was close to 9:30 and they were still going on to other legislative business. So often the members of the Committee on Rules have to do that. Of course part of the reason for that is that we are so very near the end of this session of Congress. So it is critically important given what happened in California just a few weeks ago and what is going to happen again next year that we pass this legislation promptly so we can begin the process. It is going to take a long time.

The gentleman from Oregon is correct. There are not enough resources nor are there enough acres being addressed in this legislation, but nonetheless this is a very important first step and this is the first major piece of legislation related to forestry to be passed out of a House-Senate conference committee in more than 20 years. This is a very, very important development. We have a tremendous opportunity today, and when the Senate acts to send to the President a good bill that will give us the first step in this process.

It has been a fair process that has involved everybody in it. Over 2 weeks ago, we came to the floor to appoint conferees. The ranking Democrat on the House Committee on Agriculture who has worked with us every step of the way, and I might add that I believe 19 of the 24 House Democrats on the Committee on Agriculture voted for the original House-passed legislation, very strong bipartisan support in crafting this legislation. He made a motion to instruct conferees calling for the prompt action at an open conference to report back a bill a week ago. Unfortunately, the other body did not respond in that fashion and did not appoint their conferees until yesterday morning. Nonetheless, in the meantime there was a tremendous amount of bipartisan and bicameral discussions going on about how to move the House and the Senate closer together on these pieces of legislation and we achieved that. Then yesterday we did have in the short period of time after the Senate appointed conferees the opportunity for an open conference, Members were given the opportunity to offer amendments, there was clearly a tremendous amount of consensus on both sides of the Capitol and in both parties on the need to move forward with this and we had a very expeditious conference.

Nonetheless, I think we kept the commitment made by the House on the motion of the ranking member, the gentleman from Texas, to have an open conference and to move as expeditiously as the process allowed us to do.

This bill is going to allow us to take major steps to let the Forest Service do the job they are charged with doing, protecting our national forests. This will also allow us to make absolutely certain that we have a process that is open and fair to everybody who is concerned about our national forests from any perspective. We are accelerating the process so that when ideas about what needs to be done to protect our forests take place, they can take place promptly, but we are not excluding the public in any way from this process. They will have the opportunity from start to—a judicial review if that becomes necessary—finish to have input in the process, but it will be done in such a way that the system can no longer be rigged to stretch out these decisions for many years and have our forests destroyed in the meantime.

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That is vitally important.

I want to thank everybody who has been involved in this process. The gentleman from California (Chairman POMBO), the Committee on Resources, made important contributions. The gentleman from Colorado (Mr. McINNIS), the subcommittee chairman, was also vitally important. He introduced the legislation. And certainly the gentleman from Oregon (Mr. WALDEN) has been with us every step of the way as well. The same thing has been true on the other side of the aisle, whether they have agreed with all the measures or not. We thank them for their input.

Mr. Speaker, I urge my colleagues to support this rule and the underlying bill.

Mr. HASTINGS of Florida. Mr. Speaker, I yield 4 minutes to the distinguished gentleman from California (Mr. GEORGE MILLER), my good friend.

Mr. GEORGE MILLER of California. Mr. Speaker, I, too, want to join in this in thanking Members on both sides of the aisle for their participation and cooperation in this legislation. As the gentleman from Oregon (Mr. DEFAZIO) noted, we started some 2 years ago with the gentleman from Colorado (Mr. MCINNIS) and others talking about what would be possible. The gentleman from Oregon (Mr. WALDEN) and we came up with what we thought was possible, we did not make it, went back this year and continued that process.

And we passed a bill out of the House, a bill that I did not agree with in its entirety by any means, but then the Senate was also able to pass legislation. And as a result of those negotiations, which I wish had been a little bit more open, but the fact of the matter is as a result of those negotiations, we now have this, we will have this bill before us later today. And I want to thank the Committee on Rules for providing us this opportunity.

Mr. Speaker, let me just say this one point. I wish the firefighter protections that had been offered and accepted in the Senate, they were offered by Senator BOXER of California, would have been kept in the bill. I think it is important now as we see these larger, more catastrophic fires, as we see fires that move through residential areas, to understand that the firefighters there are put in jeopardy from many other things besides just the fires themselves, but also the chemicals and building materials and the rest of it that are caught up in these huge winds created by the fires.

But let me say as to the bill, I think this is a bill that is a vast improvement over what left the House. In this compromise, in this conference report we will target half of the appropriated money into those areas most likely to have the most catastrophic fires. The rest of the money can be used in forest treatment and other areas of the national forest. That is important.

It is also important that we involve the communities, and communities can come up with those plans that they think serve their area best. Hopefully, they will use community resources, small businesses, and others to develop those plans. People are also entitled to have some review of those plans.

But what this bill does not allow you to do is to drag the process out forever, forever and ever. You have got to come in, make your case, you made it or you have not made it. But those rights are protected, and you can appeal that to court.

Some people do not like the fact that the bill extends the urban interface area out to a mile and a half. The fact of the matter is when you see the size of some of these fires, the treatment in the urban interface area is nothing more than a firebreak. And a little tiny area is not going to stop some of these fires that we have seen over the last decade in the West.

Finally, with respect to the treatment in the larger forest, the goods for services contracts are still allowed, but as the gentleman from Oregon (Mr. DEFAZIO) pointed out, the important part of this bill, what Senator FEINSTEIN was able to do was get an authorized amount of money in here, because if we just do it on goods for services, we will either have to cut down all the trees to save them in order to get enough money to carry out the project, or we will not be able to treat those areas, as we saw in southern California, of negligible timber value but high risk to the communities.

And so we need to have an appropriation to follow this authorization so we can treat those areas of high intensity, of great potential of catastrophic fires, the potential to engulf communities. We have got to go there with some Federal dollars and some goods for services. And I think that is a balance that makes sense.

I spend several weeks a year backpacking in the high country and the forests and parks of this country. You do not have to walk very long in the forest to see the need for treatment. If you love the big old trees, as the gentleman from Oregon (Mr. DEFAZIO) again pointed out, you have got to understand that we have allowed a ladder to build up in these forests. And the big ponderosas, the big sugar pines are at risk because of the understory, the undergrowth that is there that will take the flames right into the crowns. And, obviously, once in the crowns, with any wind they move so fast that we cannot deal with them.

So, Mr. Speaker, I would like to say that I think that this is a product that the House should vote for. Members on both sides of the aisle should support this. It is very, very important to so many of our communities and very important to the stewardship of our natural resources.

Mr. HASTINGS of Washington. Mr. Speaker, I yield 4 minutes to the gentleman from Oregon (Mr. WALDEN), an individual that has had a great deal of impact on this legislation.

Mr. WALDEN of Oregon. Mr. Speaker, I want to thank my colleague from Washington, with whom I have worked closely on this and other legislation to improve the great Northwest and certainly improve and protect America's forests. I want to thank the chairman of the Committee on Agriculture, the gentleman from Virginia (Mr. GOODLATTE), and the gentleman from California (Mr. POMBO), the chairman of the Committee on Resources, and certainly my friend and colleague, the gentleman from Colorado (Mr. MCINNIS), for their yeoman's effort on this legislation; my friend, the gentleman from California (Mr. GEORGE MILLER), and the gentleman from Oregon (Mr. DEFAZIO) as well for their work; and certainly the President of the United States, who on not one, but two occasions has come out to the Northwest to drive home the point that we had to pass legislation that embodies the principles contained in H.R. 1904.

I think it is especially important. There are not many of us who do not recognize that if we do not remove the ladder fuels that my colleague from California talked about, the old growth policy that will be out there is one of let it burn, because that is what is happening today in America's forests. Because we have taken natural fire out of the equation and taken human management out of the equation, these forests have become completely overstocked. So it is like any other fire, it is about the fuel load. And the fuel load is such that when fire starts today, unlike 100 years ago, when it starts today, it burns catastrophically.

We witnessed it in the Biscuit Fire in southern Oregon a year ago. We witnessed it in the B&B fire this summer in my district. We witnessed it in California. We can see it all across America's great forests and rangelands that when there is too much fuel, the fire is nearly uncontrollable and certainly catastrophic.

Let us talk about the human consequences, because we saw it especially this year in California, but we have seen it before. Last year 23 firefighters lost their lives, and the American taxpayer spent $1.5 billion containing 2002's record fires.

This shows you a scene that, unfortunately, is one that has been seen far too often: a home that has been destroyed in a forested area. This next shot shows you what happens to fish habitat. This was in my district in eastern Oregon, a fire that took place in 1989. This is a stream that used to be part of the spring Chinook salmon habitat. You can see it is nothing but a mudflow here. There is no buffer. These are all dead trees. It looks like a moonscape or a Mars-scape. This was in the Wallowa Whitman National Forest. This is what you get when you cannot control forest fires.

This, on the other hand, is an example of how a fire that has been treated like we are talking about treating performs. This is an area where President Bush accompanied me and Senator SMITH and others, Senator WYDEN, up to the Squires Peak fire in 2002. And you can see where the land had been treated, there are good healthy trees left behind. There is a fire burning here, but it has fallen to the ground, because that is what happens when you treat in these areas. The fire drops to the ground, and our firefighters are able to control and contain it. The damage is not that significant. In fact, it can be very positive in terms of when a fire burns like this to regenerate.

But just on the other side of this hill where the same people who fought the fire have been doing the thinning work, it was completely obvious because they had not thinned there yet. Where they had not thinned, the fire had been in the canopy, it had been at the top. It had been catastrophic and extraordinarily destructive.

Finally, let me make this point. By streamlining this process we are going to be able to get in and do this kind of work sooner so we do not end up with that kind of devastation I showed you earlier. But we also, as a policy, as a Congress, need to take a look at what happens after a catastrophic fire. How can we get in and restore America's great conifer forests instead of letting them become brush? How do we get in and protect the habitat that remains after a fire and improve it so our fish runs can come back? That is a debate we will have to have in the future.

Today, though, I am delighted that we are at this point with a comprehensive bipartisan, bicameral plan that will move us an enormous generation forward to protect and preserve America's forests, create jobs in our rural communities, and make sure fire, when it burns, is not catastrophic.

Mr. HASTINGS of Florida. Mr. Speaker, I would like to thank the gentleman from Oregon (Mr. WALDEN) and the gentleman from Virginia (Mr. GOODLATTE) and the ranking members. I know that they have done a serious and yoeperson's job in bringing us this far, which, while I thank them, I still have reservations, and I know the gentleman from Oregon (Mr. WALDEN) and I have talked about them. But that does not mean that they did not work hard.

Mr. Speaker, I yield 3 minutes to the gentleman from Washington (Mr. INSLEE), my good friend.

Mr. INSLEE. Mr. Speaker, unfortunately, actually the way this final package was developed was a continuation of the sad deterioration of an effort to actually reach consensus in this body. And the reason I say that is the way this package was put together is some folks went into a closed room and excluded other Members of the House from consideration. In fact, the ranking Democrat on the Subcommittee on Forests and Forest Health of the Committee on Resources was excluded from consideration to try to reach a consensus product here, as was virtually anyone who questioned the original bill who left the House.

This is the system, if you can imagine, when they are sitting around a table in Iraq right now and they ask, how do you do democracy in America, I guess you would have to say, in the House we just have this secret group and exclude Members from the minority party who are ranking Members. And that is what happened here, and it is unfortunate because we may have been able to reach a consensus of unanimity here on the House floor.

Now, let me point out a couple significant concerns with this final product. Number one, it does not cut the mustard in saving our houses and our towns from fire. We just witnessed this enormous devastation in California as a result of these fires, hundreds and hundreds of houses that were burned. And we do not have enough money in the Federal Treasury to come close to treating all of the acres that need treatment. At most, under this bill, we will only treat about 2 percent of the acres that need treating a year in our forests. That means we have got to be smart and target our resources where it is going to do the most good, and where it is going to do the most good fastest is around our homes and our towns to prevent the devastation that happened in California.

It ought to be a clear, unanimous consensus in this House that we put the majority of our resources protecting our families and our homes and our towns. And this bill does not do it. Yes, it is better than the House version because it says 50 percent, but what are you going to tell people next time? Sure, you had 200 houses burned, we will save 100 of them this time. Well, 50 percent is not good enough saying we are just going to save half your town; 50 percent is not good enough when we say we are going to save half your subdivision.

We ought to put a clear majority of our resources in protecting these belts, these protective moats, if you will, around our houses, and we are not doing it. Why we are not doing it? Because the timber industry has driven a lot of this debate. Who is for this is the timber industry. And who is against it is the Sierra Club. And it is too bad we did not really reach a consensus when we could have on this bill.

Mr. HASTINGS of Washington. Mr. Speaker, I yield 3 minutes to the gentleman from Colorado (Mr. MCINNIS), who has worked extremely hard on this issue and has been working on this issue.

Mr. MCINNIS. Mr. Speaker, I thank the chairman for yielding me time. I also thank the Members and my colleagues on the Democratic side who worked with me on my bill. This is a bill I introduced. I have been working on it in great detail for a number of years.

Now, it is true that in the process I did not include 435 Members to come to our meetings to come to some kind of compromise. Now, there are reasons I did not include 435. First of all, that is not routine. Second of all, we could not get them all into one location. Third of all, not very many of them were interested. They are interested, most of them, in the final product, but they are not interested because they have their own priorities in putting this together.

And, finally, there is a very definite class of people that you cannot bring in to a room and expect a compromise. My good colleague, the gentleman from Washington (Mr. INSLEE), is not one of those people that I felt that I could bring into these negotiations and come out with anything positive.

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I have got to get people in there that are willing to come up with a solution, and I will give you two good examples, two very ardent spokesmen for the environment, the gentleman from California (Mr. GEORGE MILLER) and the gentleman from Oregon (Mr. DEFAZIO).

Those are about two of the toughest individuals on this House floor when it comes to speaking about environmental issues. While the gentleman from Washington (Mr. INSLEE), for example, is very tough on environmental issues, the fact is I can negotiate with the gentleman from California (Mr. GEORGE MILLER). I can negotiate with the gentleman from Oregon (Mr. DEFAZIO). And that is exactly why the gentleman from California (Mr. GEORGE MILLER) and the gentleman from Oregon (Mr. DEFAZIO) and the gentleman from Oregon (Mr. WALDEN) and myself and the gentleman from Virginia (Mr. GOODLATTE) and the gentleman from California (Mr. POMBO), that is exactly why that group of people came together to work out a compromise with the Senate to come up with a bill that is good for all of us.

So what we are seeing today is not opposition to the content of the bill by the gentleman from Washington (Mr. INSLEE). What we are seeing with all due respect to the gentleman from Washington (Mr. INSLEE) is sour grapes. Hey, I did not get to play in the game. I was not invited to the meeting.

As I said, there is a reason why the gentleman from Washington (Mr. INSLEE) was not invited to the meeting. I wanted a meeting with production. I needed to have a meeting that would come out with a product that could pass both the Senate and the House and accomplish something out there with our forests, and that is exactly what this bill does. That is exactly why we should pass this rule and that is exactly why I expect this bill in both the Senate and the House, the Senate and the House, to pass with bipartisan; that is, Republican and Democratic, support.

Mr. HASTINGS of Florida. Mr. Speaker, I yield myself such time as I may consume. I thank again my good friend from Washington (Mr. HASTINGS) for having yielded me time.

As the gentleman previously mentioned, this is a typical rule for a conference report and I will not oppose it. I will, however, oppose the underlying conference report, not because my good friend said it would not have been productive to have some of us in the conference. I do not serve on the committee so I do not know how I got thrown into that. I would not have been in the conference in the first place and perhaps he should not have been.

But, Mr. Speaker, President Theodore Roosevelt told Congress in 1907, "The conservation of our natural resources and the proper use constitute the fundamental problem which underlies almost every other problem of our national life."

Indeed, it does, Mr. Speaker.

In 2002 alone, wildfires burned more than 6½ million acres at a cost to taxpayers of more than $1 billion. Hundreds of families were evacuated and uncontrollable fires caused millions of dollars worth of damage. The images of the recent wildfires in southern California are fresh in our minds and pictures of homes burning to the ground and thoughts of livelihoods being destroyed will never be forgotten.

Yes, the underlying report takes significant steps to improve our ability to combat and mitigate wildfires. And, again, I congratulate the gentleman from Oregon (Mr. WALDEN), the gentleman from Virginia (Mr. GOODLATTE) and their ranking members and their committee for their work. But in my opinion it goes a bit too far. And for anyone who says that this or any other bill is not a perfect bill but we should support it anyway, I say absolutely not. If we know that a problem exists in the legislation, then let us fix it. Let us fix it before it becomes law.

The underlying conference report loosens current law regarding the logging and controlled burning of our Nation's forests. Moreover, it eviscerates environmental studies and the ability of organizations and private citizens to submit appeals on the cutting down of as many as 20 million acres. Under the report, appeals are subject to, in my view, unnecessary and unrealistic deadliness that insult the process and force Federal judges to adhere to judicial deadlines that make it impossible to fully consider the complexities of the appeal.

Mr. Speaker, at a time when more than half of the United States is experiencing some form of drought and dryness, it is critical for Congress to consider legislation that is proactive in defending and responding to the adverse effects of wildfires. And I spoke last night with the gentleman from Oregon (Mr. WALDEN) and the gentleman from Virginia (Mr. GOODLATTE) and my friends in the Committee on Rules about the fact that drought is an attendant feature that must deal with our concerns about forest fires.

It is equally critical for Congress to also consider legislation that helps communities mitigate the effects of the reoccurring events that often result in an excessive and prolonged fire season. In fact, my colleague on the other side of the aisle, the gentleman from Montana (Mr. REHBERG) and I have introduced a bill that does just that. H.R. 2871, the National Drought Preparedness Act, moves our country away from an ad hoc response-oriented approach and towards a more proactive mitigation-based approach.

Our bill provides States and local communities with the resources and tools to develop drought preparedness plans and think about the ramifications of drought before we find ourselves in one.

We are now faced with a vote clearly indicative of the concerns raised by President Roosevelt nearly one century ago. Whether we answer the challenge made by the late President or allow his legacy to fall victim to an influential timber lobby is a decision that Members will have to make later today.

I realize we do not oppose removing excess vegetation that increases the risk and facilitates the spread of wildfires. I certainly do not take issue with the report's efforts to address insect manifestations in forests. It is, in fact, crucial that Congress address these two issues.

What I do take issue with, however, is why the majority cannot just stop there. Instead, it uses the report to further its agenda under the blanket of healthy forests. Cutting down national forests and limiting public participation and administrative reviews does not get us any closer to stopping the spread of wildfires, and it certainly does not make our forests any healthier.

Teddy Roosevelt once noted, "Forests are the lungs of our land, purifying the air and giving fresh strength to our people." He continued, "A nation that destroys its soils destroys itself."

Mr. Speaker, we must not allow the late President Roosevelt's warning to be realized by the 108th Congress. I urge my colleagues to support the rule and oppose the underlying report.

Mr. Speaker, I yield back the balance of my time.

Mr. HASTINGS of Washington. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the bill that this rule allows to be taken up is a very significant piece of legislation, and I just want to make one point that I do not think has been made in the debate on this rule regarding this underlying legislation, and that is that this legislation is geared towards what we call multiple use areas within our national system, our national forests and our BLM lands. Multiple use by definition means it should be open for recreation, commercial activity, and so forth. But, unfortunately, with policies that have been enacted de facto in the past 10 or 15 years, in fact, we have closed up these multiple use areas.

This legislation addresses these problems that have built up for a time and as a result has built up to unhealthy forests and unhealthy BLM lands. So it is a significant first start, an extremely significant first start.

With that, Mr. Speaker, I urge my colleagues to support the rule and support the underlying legislation.

Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered.

The resolution was agreed to.

A motion to reconsider was laid on the table.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or the yeas and nays are ordered or on which a vote is objected to under clause 6 of rule XX.

Record votes on postponed questions will be taken later today.

HIGHLANDS CONSERVATION ACT

Mr. CALVERT. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1964) to establish the Highlands Stewardship Area in the States of Connecticut, New Jersey, New York, and Pennsylvania, and for other purposes, as amended.

The Clerk read as follows:

H.R. 1964

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Highlands Conservation Act".

SEC. 2. FINDINGS.

Congress finds the following—

(1) The Highlands region is a physiographic province that encompasses more than 2,000,000 acres extending from eastern Pennsylvania through the States of New Jersey and New York to northwestern Connecticut.

(2) The Highlands region is an environmentally unique area that—

(A) provides clean drinking water to over 15,000,000 people in metropolitan areas in the States of Connecticut, New Jersey, New York, and Pennsylvania;

(B) provides critical wildlife habitat, including habitat for 247 threatened and endangered species;

(C) maintains an important historic connection to early Native American culture, colonial settlement, the American Revolution, and the Civil War;

(D) contains recreational resources for 14 million visitors annually;

(E) provides other significant ecological, natural, tourism, recreational, educational, and economic benefits; and

(F) provides homeownership opportunities and access to affordable housing that is safe, clean, and healthy.

(3) An estimated 1 in 12 citizens of the United States live within a 2-hour drive of the Highlands region.

(4) More than 1,400,000 residents live in the Highlands region.

(5) The Highlands region forms a greenbelt adjacent to the Philadelphia-New York City-

Hartford urban corridor that offers the opportunity to preserve water, forest and agricultural resources, wildlife habitat, recreational areas, and historic sites, while encouraging sustainable economic growth and development in a fiscally and environmentally sound manner.

(6) Continued population growth and land use patterns in the Highlands region—

(A) reduce the availability and quality of water;

(B) reduce air quality;

(C) fragment the forests;

(D) destroy critical migration corridors and forest habitat; and

(E) result in the loss of recreational opportunities and scenic, historic, and cultural resources.

(7) The water, forest, wildlife, recreational, agricultural, and cultural resources of the Highlands region, in combination with the proximity of the Highlands region to the largest metropolitan areas in the United States, make the Highlands region nationally significant.

(8) The national significance of the Highlands region has been documented in—

(A) the New York-New Jersey Highlands Regional Study conducted by the Forest Service in 1990;

(B) the New York-New Jersey Highlands Regional Study: 2002 Update conducted by the Forest Service;

(C) the bi-State Skylands Greenway Task Force Report;

(D) the New Jersey State Development and Redevelopment Plan;

(E) the New York State Open Space Conservation Plan;

(F) the Connecticut Green Plan: Open Space Acquisition FY 2001–2006;

(G) the open space plans of the State of Pennsylvania; and

(H) other open space conservation plans for States in the Highlands region.

(9) The Highlands region includes or is adjacent to numerous parcels of land owned by the Federal Government or federally designated areas that protect, conserve, or restore resources of the Highlands region, including—

(A) the Wallkill River National Wildlife Refuge;

(B) the Shawanagunk Grasslands Wildlife Refuge;

(C) the Morristown National Historical Park;

(D) the Delaware and Lehigh Canal Corridors;

(E) the Hudson River Valley National Heritage Area;

(F) the Delaware River Basin;

(G) the Delaware Water Gap National Recreation Area;

(H) the Upper Delaware Scenic and Recreational River;

(I) the Appalachian National Scenic Trail;

(J) the United States Military Academy at West Point, New York;

(K) the Highlands National Millenium Trail;

(L) the Great Swamp National Wildlife Refuge;

(M) the proposed Crossroads of the Revolution National Heritage Area;

(N) the proposed Musconetcong National Scenic and Recreational River in New Jersey; and

(O) the Farmington River Wild and Scenic Area in Connecticut.

(10) It is in the interest of the United States to protect, conserve, and restore the resources of the Highlands region for the residents of, and visitors to, the Highlands region.

(11) The States of Connecticut, New Jersey, New York, and Pennsylvania, and units of local government in the Highlands region have the primary responsibility for protecting, conserving, preserving, restoring and promoting the resources of the Highlands region.

(12) Because of the longstanding Federal practice of assisting States in creating, protecting, conserving, and restoring areas of significant natural and cultural importance, and the national significance of the Highlands region, the Federal Government should, in partnership with the Highlands States and units of local government in the Highlands region, protect, restore, and preserve the water, forest, agricultural, wildlife, recreational and cultural resources of the Highlands region.

SEC. 3. PURPOSES.

The purposes of this Act are as follows:

(1) To recognize the importance of the water, forest, agricultural, wildlife, recreational and cultural resources of the Highlands, and the national significance of the Highlands region to the United States.

(2) To authorize the Secretary of the Interior to work in partnership with the Secretary of Agriculture to provide financial assistance to the Highlands States to preserve and protect high priority conservation lands in the Highlands region.

(3) To continue the ongoing Forest Service programs in the Highlands region to assist the Highlands States, local units of government and private forest and farm landowners in the conservation of lands and natural resources in the Highlands region.

SEC. 4. DEFINITIONS.

In this Act:

(1) HIGHLANDS REGION.—The term "Highlands region" means the physiographic province, defined by the Reading Prong and ecologically similar adjacent upland areas, that encompasses more than 2,000,000 acres extending from eastern Pennsylvania through the States of New Jersey and New York to northwestern Connecticut.

(2) HIGHLANDS STATE.—The term "Highlands State" means—

(A) the State of Connecticut;

(B) the State of New Jersey;

(C) the State of New York;

(D) the State of Pennsylvania; and

(E) any agency or department of any Highlands State.

(3) LAND CONSERVATION PARTNERSHIP PROJECT.—The term "land conservation partnership project" means a land conservation project located within the Highlands region identified as having high conservation value by the Forest Service in which a non-Federal entity acquires land or an interest in land from a willing seller for the purpose of permanently protecting, conserving, or preserving the land through a partnership with the Federal Government.

(4) NON-FEDERAL ENTITY.—The term "non-Federal entity" means any Highlands State, or any agency or department of any Highlands State with authority to own and manage land for conservation purposes, including the Palisades Interstate Park Commission.

(5) STUDY.—The term "study" means the New York-New Jersey Highlands Regional Study conducted by the Forest Service in 1990.

(6) UPDATE.—The term "update" means the New York-New Jersey Highlands Regional Study: 2002 Update conducted by the Forest Service.

SEC. 5. LAND CONSERVATION PARTNERSHIP PROJECTS IN THE HIGHLANDS REGION.

(a) SUBMISSION OF PROPOSED PROJECTS.—Annually, the Governors of the Highlands States, with input from pertinent units of local government and the public, may jointly identify land conservation partnership projects in the Highlands region that shall be proposed for Federal financial assistance and submit a list of those projects to the Secretary of the Interior.

(b) CONSIDERATION OF PROJECTS.—The Secretary of the Interior, in consultation with the Secretary of Agriculture, shall annually submit to Congress a list of those land conservation partnership projects submitted under subsection (a) that are eligible to receive financial assistance under this section.

(c) ELIGIBILITY CONDITIONS.—To be eligible for financial assistance under this section for a land conservation partnership project, a non-Federal entity shall enter into an agreement with the Secretary of the Interior that—

(1) identifies the non-Federal entity that shall own or hold and manage the land or interest in land;

(2) identifies the source of funds to provide the non-Federal share required under subsection (d);

(3) describes the management objectives for the land that will assure permanent protection and use of the land for the purpose for which the assistance will be provided;

(4) provides that, if the non-Federal entity converts, uses, or disposes of the land conservation partnership project for a purpose inconsistent with the purpose for which the assistance was provided, as determined by the Secretary of the Interior, the United States may seek specific performance of the conditions of financial assistance in accordance with paragraph (3) in Federal court and shall be entitled to reimbursement from the non-Federal entity in an amount that is, as determined at the time of conversion, use, or disposal, the greater of—

(A) the total amount of the financial assistance provided for the project by the Federal Government under this section; or

(B) the amount by which the financial assistance increased the value of the land or interest in land; and

(5) provides that land conservation partnership projects will be consistent with areas identified as having high conservation value in the following:

(A) Important Areas portion of the Forest Service study.

(B) Conservation Focal Areas portion of the Forest Service update.

(C) Conservation Priorities portion of the update.

(D) Lands identified as having higher or highest resource value in the Conservation Values Assessment portion of the update.

(d) NON-FEDERAL SHARE REQUIREMENT.—The Federal share of the cost of carrying out a land conservation partnership project under this section shall not exceed 50 percent of the total cost of the land conservation partnership project.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary of the Interior from the general funds of the Treasury or the Land and Water Conservation Fund to carry out this section $10,000,000 for each of the fiscal years 2005 through 2014. Amounts appropriated pursuant to this authorization of appropriations shall remain available until expended.

SEC. 6. FOREST SERVICE AND USDA PROGRAMS IN THE HIGHLANDS REGION.

(a) IN GENERAL.—In order to meet the land resource goals of, and the scientific and conservation challenges identified in, the study, update, and any future study that the Forest Service may undertake in the Highlands region, the Secretary of Agriculture, acting through the Chief of the Forest Service and in consultation with the Chief of the National Resources Conservation Service, shall continue to assist the Highlands States, local units of government, and private forest and farm landowners in the conservation of lands and natural resources in the Highlands region.

(b) DUTIES.—The Forest Service shall—

(1) in consultation with the Highlands States, undertake other studies and research as appropriate in the Highlands region consistent with the purposes of this Act;

(2) communicate the findings of the study and update and maintain a public dialogue regarding implementation of the study and update; and

(3) assist the Highland States, local units of government, individual landowners, and private organizations in identifying and using Forest Service and other technical and financial assistance programs of the Department of Agriculture.

(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Secretary of Agriculture to carry out this section $1,000,000 for each of the fiscal years 2005 through 2014.

SEC. 7. PRIVATE PROPERTY PROTECTION AND LACK OF REGULATORY EFFECT.

(a) ACCESS TO PRIVATE PROPERTY.—Nothing in this Act shall be construed to—

(1) require any private property owner to permit public access (including Federal, State, or local government access) to such private property; and

(2) modify any provision of Federal, State, or local law with regard to public access to or use of private lands.

(b) LIABILITY.—Nothing in this Act shall be construed to create any liability, or to have any effect on any liability under any other law, of any private property owner with respect to any persons injured on such private property.

(c) RECOGNITION OF AUTHORITY TO CONTROL LAND USE.—Nothing in this Act shall be construed to modify any authority of Federal, State, or local governments to regulate land use.

(d) PARTICIPATION OF PRIVATE PROPERTY OWNERS.—Nothing in this Act shall be construed to require the owner of any private property located in the Highlands region to participate in the land conservation, financial, or technical assistance or any other programs established under this Act.

(e) PURCHASE OF LANDS OR INTERESTS IN LANDS FROM WILLING SELLERS ONLY.—Funds appropriated to carry out this Act shall be used to purchase lands or interests in lands only from willing sellers.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from California (Mr. CALVERT) and the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN) each will control 20 minutes.

The Chair recognizes the gentleman from California (Mr. CALVERT).

GENERAL LEAVE

Mr. CALVERT. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 1964.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

Mr. CALVERT. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, H.R. 1964, introduced by my good friend, the gentleman from New Jersey (Mr. FRELINGHUYSEN) and amended by the Committee on Resources, would authorize the Secretary of the Interior and the Secretary of Agriculture to provide financial assistance to States to preserve and protect high priority conservation lands in the Highlands region. This geographic region encompasses over 2 million acres of land stretching from western Connecticut across the Lower Hudson River Valley and northern New Jersey into northeastern Pennsylvania.

Mr. Speaker, not only has the U.S. Forest Service documented the national significance of the Highlands area in two extensive studies in 1990 and 2002, but the President in his 2004 budget recognized the New York-New Jersey Highlands forest area as one of nine priority forests areas in the country that are threatened.

H.R. 1964, as amended, is supported by the administration and the majority and minority of the committee. I urge adoption of this bill.

Mr. Speaker, I reserve the balance of my time.

Mrs. CHRISTENSEN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, we fully support the goals of H.R. 1964. The purpose of this legislation is to facilitate conservation and preservation, ideals we fight for in this Congress on a regular basis.

However, we must point out that the scope of H.R. 1964 is truly stunning. This legislation will create a new Federal conservation program covering 2 million acres and 1.4 million people in 4 States. The precise boundaries of this new Federally created area are only generally defined in the bill, and there are no references to a map to allow property owners to know if their property is included or not.

Furthermore, the goals of this new conservation program are sweeping. The bill states that the Federal Government should work with States, units of local government and private property owners to "protect, restore and preserve the water, forest, agricultural, wildlife, recreational and cultural resources" contained in this new Federal area. It is difficult to imagine a broader conservation mandate.

Given the ongoing and severe underfunding of the land and water conservation funds, we continue to have concerns regarding the impact of this new $100 million effort may have on other worthy conservation programs funded with LWCF dollars. However, we will support H.R. 1964 at this time.

Mr. Speaker, I reserve the balance of my time.

Mr. CALVERT. Mr. Speaker, I yield 3 minutes to the gentleman from New Jersey (Mr. FRELINGHUYSEN).

Mr. FRELINGHUYSEN. Mr. Speaker, I thank the gentleman for yielding me time.

My thanks to the gentleman from California (Mr. CALVERT), and particular thanks to the chairman, the gentleman from California (Mr. POMBO), the chair of the House Committee on Resources, for all of his work and the work of his staff that have helped improve this bill and make it possible for us to discuss it and vote on it today. I also thank the ranking member for her assistance and recognize the gentleman from New York (Mr. ENGEL), who is going to speak later, as well as the gentlewoman New York (Mrs. KELLY) and the gentleman from Pennsylvania (Mr. GERLACH) and over 30 Members of Congress that are sponsoring this bill.

Mr. Speaker, the Highlands is one of the last open treasures in the most densely populated area of the United States. In New Jersey alone, my home State, it includes more than a million acres of forests, farms, streams, wetlands, lakes, reservoirs and historic sites. We need to preserve these assets.

The Highlands Conservation Act represents a major commitment to protect them. While remaining mindful of property rights, this bill complements ongoing State, private and local partnerships that are actively working to protect open space. Our bill does not ask the Federal Government to become the landowner or steward to these lands; rather, the people of New Jersey, New York, Connecticut and Pennsylvania would retain ownership and responsibility for caretaking of these lands. Indeed, the government will not be taking any land. Participants would all be willing sellers.

Mr. Speaker, the President recognized the national significance of the Highlands in his 2004 budget message in January and designated the Highlands as one of nine national priorities areas threatened by development.

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These lands, as the gentleman from California (Mr. CALVERT) has said, have been identified by the U.S. Forest Service in virtually all other Federal, State and local entities as critical lands in need of preservation.

This bill represents an opportunity for the Federal Government to work with the State government and local groups to preserve the Highlands. It is a unique opportunity, an historic opportunity, and it is a symbolic opportunity of the Federal Government to work with so many partners.

This legislation also represents a landmark commitment of the Federal Government to the Highlands. It is a genuine partnership. It is important to preserving open space. I am proud to support the bill and to have so many partners in that regard.

Mrs. CHRISTENSEN. Mr. Speaker, I yield 5 minutes to the gentleman from New York (Mr. ENGEL).

Mr. ENGEL. Mr. Speaker, I thank the gentlewoman for yielding time to me, and I rise in strong support of H.R. 1954, the Highland Stewardship Act. I am proud to be an original cosponsor of this bill. I pledged that I would do everything in my power to pass this bill, and I am delighted that this bill is on the floor today.

I want to start by thanking the Committee on Resources chairman, the gentleman from California (Mr.

POMBO), the gentleman from West Virginia (Mr. RAHALL), the ranking member, and the gentleman from California (Mr. RADANOVICH), the subcommittee chairman, and the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN), the subcommittee ranking member, for their assistance and support.

More importantly, I want to commend the sponsor of this legislation the gentleman from New Jersey (Mr. FRELINGHUYSEN). It is because of his vigorous and stalwart support of this bill and his active participation in moving it forward that we are here today. It has been a pleasure to work with him, and this is a very, very important bill not only for his district and my district, but for many, many districts and many, many States in the Northeast.

I represent Rockland County. We have a pristine area there which is very, very important, and we need to protect this area. We very often talk about suburban sprawl and development, which is unwanted and which would mar this pristine land. This bill gives us the opportunity to balance that. That is what is so important.

The Highlands in my district encompasses an area totally of 1.5 million acres from the lower Hudson River Valley in New York to the Delaware River in New Jersey. Within this area are some spectacular things to see and do, and, of course, many people, 1.4 million people, live within the Highlands area.

The Highlands adjoins a metropolitan area, the New York metropolitan area, with a population of more than 20 million people. More than 11 million people rely on the Highlands' drinking water resources, which serves at least half of New York City's water supply. More than 14 million people visit the Highlands each year for recreational opportunities. Over 240 species of birds, mammals, amphibians and reptiles depend on Highlands habitat, and more than 160 historical and cultural sites have been identified in the region.

Where once apple farms and bungalows dotted the landscape, we now have 300,000 people living in Rockland County, and as I mentioned before, it is very, very important to have that balance between development and preserving pristine areas such as this.

The Federal Government has an important role to play in protecting our area of national significance here in our own backyard. I have supported increased funding for Forest Service programs such as the Forest Legacy Program, the Forest Stewardship Program and the new Forest Land Enhancement Program that protect environmentally sensitive forestlands such as the Highlands.

Again, I want to say that it is vitally important that the Federal Government facilitate partnerships between all levels of government to protect the Highlands and prevent the region from suffering from further urban sprawl. My district is a combination of an urban district and a suburban district, and I am very, very sensitive to the needs of the suburbs, and this bill and the money put into this bill goes a long way in keeping that balance and keeping these lands pristine.

The Highlands Act will really move us far along in this effort because we do not want further urban sprawl. So I thank the chairs and ranking members and, again, most of all, my friend from New Jersey (Mr. FRELINGHUYSEN). This is truly bipartisan and truly a very, very good day for the American people.

Mr. CALVERT. Mr. Speaker, I yield what time he may consume to the gentleman from California (Mr. POMBO), the chairman of the Committee on Resources.

Mr. POMBO. Mr. Speaker, I thank the chairman for yielding me the time.

I come to the floor today to speak in support of this bill. This is the kind of legislation that in the past I have opposed and have had concerns about, but I have to give all due credit to my colleague the gentleman from New Jersey (Mr. FRELINGHUYSEN) and the gentleman from New Jersey (Mr. SAXTON) for the work that they put into this bill.

When they originally introduced this legislation, I had some concerns over it, and they came in and sat down with me, and we were able to work through all of the concerns that I had, and they were very good at coming in and sitting down and working through the property rights concerns that I had, what impact this would have on small property owners that were involved with this area, and gave me the assurances that as we worked our way through this process, that their private property rights would be protected. They were willing to accept language into the bill that protects those small property owners, and I think that that is extremely important.

I will tell my colleagues, on any legislation like this in the future that we choose to move through the Committee on Resources, we will use this bill as a template, as a way to get things done in a bipartisan way in trying to move forward with a Federal and a local partnership in protecting lands that are environmentally sensitive and that are important, but at the same time protecting the property rights of those individual owners, which is something that is extremely important to me.

So I just want to come down here and tell my colleagues I strongly support this legislation. I think that the work that the gentleman from New Jersey (Mr. SAXTON) and the gentleman from New Jersey (Mr. FRELINGHUYSEN) did on this is a very, very positive step for the future. I know that they are going to do great things with this. I know that this land is extremely important to them. So I look forward to working with them in future and making sure that these lands are protected, at the same time that small property owners are protected.

So I thank them for all of the great work that they did, and I urge my colleagues to support this legislation.

Mrs. CHRISTENSEN. Mr. Speaker, I yield 5 minutes to the gentleman from New Jersey (Mr. PASCRELL), my good friend and classmate.

Mr. PASCRELL. Mr. Speaker, I rise in very strong support of H.R. 1964, the Highlands Conservation Act.

I want to congratulate the chairmen and ranking members for getting this to the floor, but I want to pay particular attention, and I know he does not like this but I will do it anyway, to the gentleman from New Jersey (Mr. FRELINGHUYSEN). This has been a continuation, Mr. Speaker, of his work in the New Jersey State Legislature, not to balance anything, but to secure and preserve lands not only in New Jersey, but to set a model throughout the United States, and I think he has done that, and he has done it in a most professional way.

I am proud to work with my colleagues across the aisle for years to preserve and protect this magnificent sweep of the Appalachian ridges, stretching for 1.5 million acres across New Jersey and New York.

The Highlands are an essential source of drinking water, we have heard that already, clean air, and wildlife habitat, and recreational opportunities for nearly 25 million people located right in the backyard of our Nation's most densely populated region. The irony is staring us right in the face.

The Highlands region has been in grave danger throughout the last decade. The region lost 5,200 acres a year to intensive development of strip malls and office campuses. Development also threatens the water supply for millions of residents in New Jersey and endangers critical wildlife.

In land right next to my district, millions of residents enjoy the drinking water and the recreational resources of the Ramapo Mountains, the Wyanokie Highlands and the Pequannock Watershed. This bill will provide millions of dollars in land preservation assistance to protect this core of wilderness in our region.

The Highlands Conservation Act should be a model for future land preservation efforts. We have debated land preservation on this very floor, and yes, we need to have a sensible approach to it and respect, as the gentleman from California pointed out, property rights.

This legislation encourages a strong partnership between the Federal, State and local communities, and the gentleman from New Jersey, my colleague in the State legislature, this has been the center of his work on preservation, and it is fitting, it is fitting on this floor that we salute his efforts, particularly at a time when things can get downright contentious here.

The bipartisan efforts we have made to create innovative legislation that preserves critical land while respecting the rights of property owners should set a standard for this House. Advocates for this bill worked tirelessly with environmentalists and private industry to create a worthy compromise that does a service to the legislative process.

So preservation of the Highlands will benefit all Americans. Indeed, the Highlands is not just a New Jersey resource. As in any other parts in this country, it is a national treasure.

Mr. CALVERT. Mr. Speaker, I yield myself such time as I may consume.

Again, I want to point out that this bill eliminated the Office of Highlands Stewardship and the accompanied regulatory process. It reduced the authorization level from $25 million annually to $10 million annually over 10 years. It focused conservation efforts only on those resources most important. This bill clarified that the bill would not establish a wholly new programmatic category of land use, and, finally, it assured landowners in the Highlands region that private property rights will be protected by including safeguards for those landowners potentially at risk.

So, Mr. Speaker, this is a good piece of legislation. It has been developed over a long period of time.

Mr. Speaker, I reserve the balance of my time.

Mrs. CHRISTENSEN. Mr. Speaker, I yield myself such time as I may consume.

As stated, we did have some concerns about the expense of the bill and the funding for it, given the limitations of the land and water conservation fund, but we are supportive of the bill.

Mr. HOLT. Mr. Speaker, I rise today in support of the Highlands Conservation Act.

To anyone in this Congress who questions the value of efforts to preserve open space, I invite them to come to New Jersey. My constituents, like most people around the state, have seen the ills of sprawl and the consequences of poor planning and meager preservation efforts.

Despite the fact that many see rampant commercial and industrial development in New Jersey, however, there are still some wonderful tracts of land left in some areas of our state. One in particular is part of this tract we are trying to save through today's legislation, the Highlands Region. These are important not just for aesthetically pleasing vistas, but especially for the health of our environment, our water, our air, and mostly our people.

The Highlands is an incredible 2 million acre swath across four states—New Jersey, New York, Connecticut, and Pennsylvania. This tract is home to nearly one and a half million people and is still a quick drive away from New York City and other major metropolitan areas.

Even more importantly, the Highlands provides and protects the drinking water supplies for over 15 million people who live in the Philadelphia-New York-Hartford metropolitan area, which cuts right through my central New Jersey district.

That is why it is so important that the House today pass the Highlands Conservation Act. This bill authorizes federal Land and Water Conservation Fund money that will be matched at least one to one by local, state, and private funding. The governors of the four Highlands states will identify which lands are best eligible for conservation efforts, then apply to the federal government for funding. I know that the governor of New Jersey is ready and eager to get to work identifying these areas and preserving more green space in the state.

I also want to highlight provisions in the bill that provide technical assistance to communities and organizations involved in conservation efforts for the Highlands. So many people in the region have already done so much wonderful work to help preserve the area, and they will now get the added benefit of assistance and expertise from the federal government.

I want to recognize Mr. FRELINGHUYSEN for his leadership on this issue and his hard work to get the legislation on the floor. I also want to salute the work of former Representative Ben Gilman, who led the effort on this legislation during the last Congress.

I also want to thank Chairman POMBO, Ranking Member RAHALL, Subcommittee Chairman RADANOVICH, and Ranking Member CHRISTENSEN for helping see this legislation through the Resources committee. This bill means a lot to New Jersey, and I urge my colleagues to support it.

Mrs. CHRISTENSEN. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. SIMPSON). The question is on the motion offered by the gentleman from California (Mr. CALVERT) that the House suspend the rules and pass the bill, H.R. 1964, as amended.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

The title of the bill was amended so as to read: "A bill to assist the States of Connecticut, New Jersey, New York, and Pennsylvania in conserving priority lands and natural resources in the Highlands region, and for other purposes.".

A motion to reconsider was laid on the table.

TWENTY-FIRST CENTURY WATER COMMISSION ACT OF 2003

Mr. CALVERT. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 135) to establish the "Twenty-First Century Water Commission" to study and develop recommendations for a comprehensive water strategy to address future water needs, as amended.

The Clerk read as follows:

H.R. 135

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Twenty-First Century Water Commission Act of 2003".

SEC. 2. FINDINGS.

Congress finds that—

(1) the Nation's water resources will be under increasing stress and pressure in the coming decades;

(2) a thorough assessment of technological and economic advances that can be employed to increase water supplies or otherwise meet water needs in every region of the country is important and long overdue; and

(3) a comprehensive strategy to increase water availability and ensure safe, adequate, reliable, and sustainable water supplies is vital to the economic and environmental future of the Nation.

SEC. 3. ESTABLISHMENT.

There is established a commission to be known as the "Twenty-First Century Water Commission" (in this Act referred to as the "Commission").

SEC. 4. DUTIES.

The duties of the Commission shall be to—

(1) use existing water assessments and conduct such additional assessments as may be necessary to project future water supply and demand;

(2) study current water management programs of Federal, Interstate, State, and local agencies, and private sector entities directed at increasing water supplies and improving the availability, reliability, and quality of freshwater resources; and

(3) consult with representatives of such agencies and entities to develop recommendations consistent with laws, treaties, decrees, and interstate compacts for a comprehensive water strategy which—

(A) respects the primary role of States in adjudicating, administering, and regulating water rights and water uses;

(B) identifies incentives intended to ensure an adequate and dependable supply of water to meet the needs of the United States for the next 50 years;

(C) suggests strategies that avoid increased mandates on State and local governments;

(D) eliminates duplication and conflict among Federal governmental programs;

(E) considers all available technologies and other methods to optimize water supply reliability, availability, and quality, while safeguarding the environment;

(F) recommends means of capturing excess water and flood water for conservation and use in the event of a drought;

(G) suggests financing options for comprehensive water management projects and for appropriate public works projects;

(H) suggests strategies to conserve existing water supplies, including recommendations for repairing aging infrastructure; and

(I) includes other objectives related to the effective management of the water supply to ensure reliability, availability, and quality, which the Commission shall consider appropriate.

SEC. 5. MEMBERSHIP.

(a) NUMBER AND APPOINTMENT.—The Commission shall be composed of 9 members who shall be appointed not later than 90 days after the date of enactment of this Act. Member shall be appointed as follows:

(1) 5 members appointed by the President;

(2) 2 members appointed by the Speaker of the House of Representatives, in consultation with the Minority Leader of the House of Representatives; and

(3) 2 members appointed by the Majority Leader of the Senate, in consultation with the Minority Leader of the Senate.

(b) QUALIFICATIONS.—Members shall be appointed to the Commission from among individuals who—

(1) are of recognized standing and distinction in water policy issues; and

(2) while serving on the Commission, do not hold any other position as an officer or employee of the United States, except as a retired officer or retired civilian employee of the United States.

(c) OTHER CONSIDERATIONS.—In appointing members of the Commission, every effort shall be made to ensure that the members represent a broad cross section of regional and geographical perspectives in the United States.

(d) CHAIRPERSON.—The Chairperson of the Commission shall be designated by the President.

(e) TERMS.—Members of the Commission shall be appointed not later than 90 days after the date of enactment of this Act and shall serve for the life of the Commission.

(f) VACANCIES.—A vacancy on the Commission shall not affect its operation, and shall be filled in the same manner as the original appointment provided under subsection (a).

(g) COMPENSATION AND TRAVEL EXPENSES.—Members of the Commission shall serve without compensation, except members shall receive travel expenses, including per diem in lieu of subsistence, in accordance with applicable provisions under subchapter I of chapter 57, United States Code.

SEC. 6. MEETINGS AND QUORUM.

(a) MEETINGS.—The Commission shall hold its first meeting not later than 60 days after the date on which all members have been appointed under section 5, and shall hold additional meetings at the call of the Chairperson or a majority of its members.

(b) QUORUM.—A majority of the members of the Commission shall constitute a quorum for the transaction of business.

SEC. 7. DIRECTOR AND STAFF.

A Director shall be appointed by the Speaker of the House of Representatives and the Majority Leader of the Senate, in consultation with the Minority Leader and chairmen of the Resources and Transportation and Infrastructure Committees of the House of Representatives, and the Minority Leader and chairmen of the Energy and Natural Resources and Environment and Public Works Committees of the Senate. The Director and any staff reporting to the Director shall be paid a rate of pay not to exceed the maximum rate of basic pay for GS-15 of the General Schedule.

SEC. 8. POWERS AND PROCEEDINGS OF THE COMMISSION.

(a) HEARINGS.—The Commission shall hold no fewer than 10 hearings during the life of the Commission. Hearings may be held in conjunction with meetings of the Commission. The Commission may take such testimony and receive such evidence as the Commission considers appropriate to carry out this Act. At least 1 hearing shall be held in Washington, D.C., for the purpose of taking testimony of representatives of Federal agencies, national organizations, and Members of Congress. Other hearings shall be scheduled in distinct geographical regions of the United States and should seek to ensure testimony from individuals with a diversity of experiences, including those who work on water issues at all levels of government and in the private sector.

(b) INFORMATION AND SUPPORT FROM FEDERAL AGENCIES.—Upon request of the Commission, any Federal agency shall—

(1) provide to the Commission, within 30 days of its request, such information as the Commission considers necessary to carry out the provisions of this Act; and

(2) detail to temporary duty with the Commission on a reimbursable basis such personnel as the Commission considers necessary to carry out the provisions of this Act, in accordance with section 5(b)(5), Appendix, title 5, United States Code.

SEC. 9. REPORTS.

(a) INTERIM REPORTS.—Not later than 6 months after the date of the first meeting of the Commission, and every 6 months thereafter, the Commission shall transmit an interim report containing a detailed summary of its progress, including meetings and hearings conducted in the interim period, to—

(1) the President;

(2) the Committee on Resources and the Committee on Transportation and Infrastructure of the House of Representatives; and

(3) the Committee on Energy and Natural Resources and the Committee on the Environment and Public Works of the Senate.

(b) FINAL REPORT.—As soon as practicable, but not later than 3 years after the date of the first meeting of the Commission, the Commission shall transmit a final report containing a detailed statement of the findings and conclusions of the Commission, and recommendations for legislation and other policies to implement such findings and conclusions, to—

(1) the President;

(2) the Committee on Resources and the Committee on Transportation and Infrastructure of the House of Representatives; and

(3) the Committee on Energy and Natural Resources and the Committee on the Environment and Public Works of the Senate.

SEC. 10. TERMINATION.

The Commission shall terminate not later than 30 days after the date on which the Commission transmits a final report under section 7(b).

SEC. 11. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated $9,000,000 to carry out this Act.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from California (Mr. CALVERT) and the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN) each will control 20 minutes.

The Chair recognizes the gentleman from California (Mr. CALVERT).

GENERAL LEAVE

Mr. CALVERT. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

Mr. CALVERT. Mr. Speaker, I yield myself such time as I may consume.

H.R. 135, introduced by the gentleman from Georgia (Mr. LINDER), and cosponsored by a wide range of Members from both parties, creates a national commission to develop increased water supplies. The gentleman from Georgia (Mr. LINDER) and his colleagues have properly recognized that drought is a national problem, not just a Western issue.

This bill creates a process while adhering to States' rights to address this problem. I urge my colleagues to support this bill.

Mr. Speaker, I reserve the balance of my time.

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Mrs. CHRISTENSEN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of H.R. 135. This legislation would establish the 21st Century Water Policy Commission to study Federal, State, local, and private water management programs in an effort to develop recommendations for a comprehensive national water strategy.

Mr. Speaker, the objectives of H.R. 135 are worthwhile, and I appreciate the cooperation we have received from the sponsor of this bill. I urge my colleagues to support this legislation.

Mr. Speaker, I yield 10 minutes to the gentleman from Illinois (Mr. COSTELLO) and ask unanimous consent that he be allowed to control said time.

The SPEAKER pro tempore (Mr. SIMPSON). Is there objection to the request of the gentlewoman from the Virgin Islands?

There was no objection.

Mr. CALVERT. Madam Speaker, I yield 10 minutes to the gentleman from Tennessee (Mr. DUNCAN) and ask unanimous consent that he be allowed to control that time.

The SPEAKER pro tempore (Mrs. BIGGERT). Is there objection to the request of the gentleman from California?

There was no objection.

Mr. DUNCAN. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, first of all, I want to commend my colleague, the gentleman from Georgia (Mr. LINDER), and I rise in strong support of H.R. 135, the 21st Century Water Commission Act of 2003.

Madam Speaker, I yield 5 minutes to the gentleman from Georgia (Mr. LINDER).

Mr. LINDER. Madam Speaker, I thank the gentleman for yielding me time.

Madam Speaker, I rise in support of H.R. 135, the 21st Century Water Commission Act of 2003. H.R. 135 is designed to bring together our Nation's premier water experts to recommend strategies for meeting our water challenges in the next century.

I would like to first thank the gentleman from California (Chairman CALVERT) and his staff and the gentleman from Tennessee (Chairman DUNCAN) and his staff for being so helpful in bringing this bill to the floor and having hearings.

Ensuring fresh water for U.S. citizens will be a critical challenge facing the United States as we enter the 21st Century. Water related issues have been of interest to me for many years. In fact, I wrote an article in 1978 that predicted that one of the 12 major challenges for our country in the next century would be providing enough fresh water for our booming population.

Since that time, about 25 years ago, America still does not have an integrated or comprehensive water policy, even with hundreds of thousands of Federal, State, local and private sector employees working to solve water problems. If we wait another 10 or 20 years to get serious about meeting our demand for clean water, it will be too late.

According to the October 27, 2003, edition of U.S. News and World Report, "Our population has more than doubled since World War II, and at this rate, we could be on our way to 1 billion people living in the United States by the end of this century." The population growth will clearly put a strain on our already-burdened water supply.

As my colleagues are aware, many States across the Nation are currently facing a water crisis. Once thought to be a problem only in the arid West, severe droughts last summer caused water shortages up and down the east coast. States once accustomed to an unlimited access to water realized that they are not immune to the problems which the West has experienced for decades.

In addition, numerous news articles over the past few years have increased our attention to other water problems that we currently face. To name just a few, aquifers are being challenged by salt water intrusion, rivers and wells are drying up all over the country, crops are being threatened, and our aging water pipes leak billions of gallons of fresh water in our cities all over the country. For example, New York City loses 36 million gallons per day and Philadelphia loses 85 million per day just through leaks in infrastructure.

Let me be clear about one thing: my bill does not give the Federal Government more direct authority or control over water. This commission is designed to make recommendations about how we can coordinate water management efforts on all levels, so that localities, States, and the Federal Government can work together.

Some highlights of the bill are as follows:

The commission will look for ways to ensure fresh water for citizens for the next 50 years.

The commission will be composed of nine members, appointed by the President and key leaders in the House and Senate.

The commission will look for ways to eliminate duplication and conflict among Federal Government agencies.

The commission will consider all available technologies and other methods to optimize water supply reliability.

The commission will hold hearings in distinct geographical regions of the United States and in Washington, D.C., to seek a diversity of views, comments, and input.

Not later than 6 months after the date of the first meeting of the commission, and every 6 months thereafter, the commission will transmit a report to the Congress. A final report will be due within 3 years of the commission's inception.

In John Steinbeck's novel, "East of Eden," the narrator observes, "It never failed that during the dry years that people forgot about the rich years, and during the wet years they lost all memory of the dry years. It was always that way."

The United States cannot afford to reevaluate its water policies every time a crisis hits. Now is the time to get ahead of this issue, and I believe the 21st Century Water Commission can serve as the channel for doing so.

Mr. COSTELLO. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I rise today in support of H.R. 135, the 21st Century Water Commission Act of 2003. This bill is a step towards addressing the availability of clean and safe water resources to meet the Nation's needs.

Madam Speaker, clean, safe and available sources of water are essential to the physical and economic well-being of this country. Commercial fishing, agriculture, real estate, manufacturing, and recreation and tourism are just a few of the economic sectors that rely on clean water to operate and ensure productivity. Every day, the U.S. economy relies on the availability of clean water to grow, process, or deliver products and services.

However, at the same time, there is an emerging concern about the availability of adequate safe supplies of water to meet the growing list of often competing needs.

Throughout the first three-quarters of the 20th century, demand for water in the United States dramatically increased.

However, this Nation made progress in reducing the overall consumption of water resources in the past 20 years. Water withdrawals in the United States are now 10 percent below their peak. In addition, industrial water use dropped nearly 40 percent from its height as industrial water-use efficiency improved and as the mix of U.S. industries changed. At the same time, industrial productivity continues to rise, demonstrating that improvements in water-use efficiency are possible without negatively impacting economic growth.

In the past few years, considerable media attention has focused on the availability of adequate water supplies to meet current and future demands. In the last 2 years, regions of the country that have not traditionally experienced water resource concerns, including the Midwest and the Northeast, often found themselves with a greater demand for water resources than were available—and were forced, in some communities to ration water use.

While this debate has long existed in the more arid regions of the West, these experiences in the eastern half of the country have served as a wake-up call to the fact that water supply problems can occur in almost every region of the country. The question is now being asked, "What can be done to ensure adequate water to meet current and future needs?"

This legislation would create a Federal commission of experts on water policy to study this issue, and to recommend strategies and changes to current law that may be necessary to ensure the availability of adequate water resources for future generations.

Madam Speaker, it is important for this Nation to have a dialogue on what can be done to ensure that sufficient water resources are available to meet current and future needs. I do have some concerns with this legislation, and with the broader topic of planning for water resource needs. We need to fully discuss what the Federal role in water resource planning should be, and how Federal financial resources are to be expended to address this growing concern.

In addition, I believe that the scope of any national water resource planning study must include all affected parties, and must look to both structural and non-structural approaches to reduce consumption and ensure adequate, safe, and reliable sources of water for generations to come.

If this Congress truly wants to enter the debate on a national water resource policy, we must make sure that the record is complete, and that all alternatives are examined to determine the appropriate means to resolve this important question.

I hope that we can continue to work together on this legislation as it continues through the legislative process.

Mr. DUNCAN. Madam Speaker, I yield such time as he may consume to the gentleman from Pennsylvania (Mr. SHUSTER).

Mr. SHUSTER. Madam Speaker, I thank the gentleman for yielding me time.

Madam Speaker, this legislation deals with an issue which I have considered a priority for some time, our water resources and the ability of the Federal Government to provide our communities with effective solutions to their problems.

Our economy depends on our Nation's water resources. In fact, the United States economy base has grown both geographically and economically through its efficient and effective water system. We must realize that water is a precious resource, and we take steps to ensure its proper use.

This legislation establishes a 21st Century Water Commission to study and develop recommendations for a comprehensive water strategy to address future waters needs. This commission would assess our current and future water supply needs and consider all available technologies for increasing water supply efficiently while safeguarding the environment. Additionally, this commission will suggest financing options and strategies to preserve existing water supplies.

Most importantly, the commission will pursue strategies that avoid increasing mandates on State and local governments. We understand that unfunded mandates take away from local decisionmaking. When the first withdrawal from a municipality's finances must go for an unfunded mandate, that community then has less discretion in paying for vital services and programs expected by its citizens. It is critical to the health of our local communities not to burden them with these types of mandates.

I would like to thank the gentleman from Tennessee (Chairman DUNCAN) and the ranking member, the gentleman from Illinois (Mr. COSTELLO), and the entire Committee on Resources for all their hard work.

I support H.R. 135 wholeheartedly and ask that my colleagues do the same.

Mrs. CHRISTENSEN. Madam Speaker, I yield back the balance of my time.

Mr. DUNCAN. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I have the privilege of chairing the Subcommittee on Water Resources and Environment. We held a hearing on this legislation, and the then chairman, the gentleman from Alaska (Mr. YOUNG), and I and the ranking member, the gentleman from Minnesota (Mr. OBERSTAR), and the ranking member of my subcommittee, the gentleman from Illinois (Mr. COSTELLO), all approved bringing this legislation to the floor at this time.

As I said a few moments ago, I rise in strong support of H.R. 135, the 21st Century Water Commission Act of 2003. I want to commend the gentleman from Georgia (Mr. LINDER) for his foresight and his hard work in bringing this legislation to this point.

A couple of years ago, the New York Times had a series of articles in which they called water the oil of the 21st century. There is probably nothing that people take more for granted than a clean, safe, adequate water supply.

This bill begins the hard work of tackling one of the most important and difficult environmental and economic issues facing our Nation, and that is ensuring that we have an adequate water supply. We need water for our homes, farms, and factories. Water also supports navigation, generates power, and sustains our environment. Communities cannot grow or even exist without adequate water.

As we enter the 21st century, demands for water are growing and are outstripping supplies in many areas, both in the West and the East, leading to disputes over water supply and allocation. In response, many municipalities, businesses and land developers are trying to secure more water rights so they will have adequate water supplies now and in the future.

Last year's drought in the East made it clear that while water may be abundant in many areas, it is not limitless, and even our Nation's most water-rich regions can run dry. Even though the East has been wet this year, much of the West remains very, very dry. Policymakers no longer can ignore this issue. We need to start planning for the future.

H.R. 135, the 21st Century Water Commission Act of 2003, will help start that planning process by looking at our Nation's available water supply and the projected demand for water and making recommendations on how to meet that demand.

Because of the importance of water to our Nation's economy and well-being, I held a series of hearings this past spring on water scarcity problems, ways businesses and communities are responding, and how H.R. 135 can help States and communities address their water problems. The witnesses strongly supported greater planning for future water needs, involving all levels of government, and supported H.R. 135 as a means to help start that process.

H.R. 135 respects the primary role that States play in addressing water supply issues, but the Federal Government can provide expertise and technical assistance. Numerous parties strongly support this legislation, including the U.S. Conference of Mayors, Urban Water Council, the American Farm Bureau Federation, the National Water Resources Association, the National Association of Homebuilders, the Association of California Water Agencies, and many others.

I urge all of my colleagues to support this very important bill and once again commend our colleague, the gentleman from Georgia (Mr. LINDER), for leading this effort.

Madam Speaker, I yield back the balance of my time.

Mr. CALVERT. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, once again I want to commend the gentleman from Georgia (Mr. LINDER) for his leadership on this bill. As the chairman of the Subcommittee on Water and Power, I have witnessed firsthand throughout this country water problems that tend to grow, not shrink, as our country faces the problem of less water and water quality issues throughout our country.

Vision is an important thing that we do around here that sometimes we forget. The gentleman from Georgia (Mr. LINDER) certainly is showing vision to make sure that we have adequate water in the future.

The 21st Century Water Commission, I refer to it as the Linder Water Commission, will recommend a strategy that recognizes and respects the primary role of States and water rights laws while eliminating duplication and conflict among governmental agencies. This is an incredibly important strategy. We need dependable water supplies that are safe and secure for our future generations.

Again, I commend the gentleman from Georgia (Mr. LINDER) for his leadership.

Madam Speaker, I yield back the balance of my time.

Mr. COSTELLO. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I support this legislation strongly. I commend our colleague, the gentleman from Georgia (Mr. LINDER), who came before our committee for a hearing, and to urge the adoption of this legislation.

Mr. OBERSTAR. Madam Speaker, I rise today in support of H.R. 135, a bill to establish a commission to examine the issue of clean, safe, and reliable water supplies for this generation and for generations to come.

Madam Speaker, water may well be the most precious resource the earth provides to humankind. The existence of water set the stage for the evolution of life and is an essential ingredient of all life today.

Recognizing the importance of this vital resource, the United Nations designated 2003 as the "International Year of Freshwater." Throughout the year, the United Nations has been conducting a series of international meetings to raise awareness on the importance of available sources of clean and safe fresh water. According to the U.N., throughout the world roughly one person in six lives without regular access to safe drinking water, and over twice that number—or 2.4 billion—lack access to adequate sanitation. In addition, water-related diseases kill a child every eight seconds.

In the United States, we have avoided many of these concerns through careful planning and decades of investment in our water infrastructure. Nationally, a combination of Federal, State, and local funds have built 16,024 wastewater treatment facilities that provide service to 190 million people, or 73 percent of the total population.

In addition, 268 million people in the United States—or 92 percent of the total population—are currently served by public drinking water systems, which provide a safe and reliable source of drinking water for much of the Nation.

As I noted earlier, clean, safe, and reliable sources of water are critical to this Nation's health and livelihood. However, in the past few decades, a series of natural and potentially human induced events have demonstrated that our Nation remains vulnerable to shortages of water.

In my own State, shortages of snowfall and rain of over the past few years have had an adverse impact on local water supplies, agriculture, and recreation and tourism, and have resulted in a lowering of water levels in Great Lakes to historic levels. One thing that is certain is that no area of this country is immune to the threat of diminished water supplies, and we must be vigilant to prepare for such occurrences.

This bill is a part of the debate on the very important issue of water resource planning in this country. The gentleman from Georgia, Mr. LINDER, has taken an important step in encouraging this debate, calling for the creation of a Federal commission to examine issues related to national water resource planning, and to report its findings on potential ways to insure against large-scale water shortages in the future.

While I believe that the legislation introduced by our colleague is a good starting point, we must be sure to fully examine all of the relevant issues for ensuring adequate supplies of clean and safe water to meet current and future needs.

For example, water resource planning should work toward increasing the efficiency of water consumption as well as increasing the supply of water. Simply increasing the supply of water can be a more costly approach to meeting future water needs, and in any case, merely postpones any potential water resource crisis.

In addition, it is important to remember that issues of water supply are closely related to water quality. Contaminated sources of freshwater serve little use to this Nation's health or livelihood, and merely increase the overall cost of providing safe a reliable water resources to the population. In addition, human activities, whether through the pollution of waterbodies from point or non-point sources, the elimination of natural filtration abilities of wetlands, or through the destruction and elimination of aquifer recharge points, can have a significant impact on available supplies of usable water.

We cannot base our future water resource planning needs on the possibility of continually finding "new" sources of freshwater while, at the same time, continuing to destroy or contaminate existing sources. Such a practice is unsustainable and unconscionable.

I urge my colleagues to support the bill.

Mr. STENHOLM. Madam Speaker, I rise today in strong support of H.R. 135, the Twenty-First Century Water Commission Act.

One thing I've learned since being elected twenty-five years ago, is that Congress can't pass a bill and make it rain.

This morning I look at the United States Drought Monitor again and I was reminded of a disturbing trend that several states have experienced for many years. Twenty-five states are suffering from drought conditions, and with no definite starting or ending point, droughts are extremely hard to predict.

But, as a cotton farmer from West Texas, I am always optimistic that the rains will come eventually. In the meantime, we cannot afford to leave a single stone unturned in our efforts to ensure that our citizens have a safe and adequate water supply.

Will my district be able to meet our water needs fifty years from Now? We aren't able to answer that question today, and we sure can't wait until that time is upon us to find out.

This is why I joined my colleagues in cosponsoring the 21st Century Water Policy Commission Act. This legislation does what so many communities in my West Texas district are already trying to do. It establishes commission to consider all aspects of water management, water supply and demand, and it recommends comprehensive policy for meeting our nation's water needs in the 21st Century. For these reasons, I'm glad to support H.R. 135.

Mr. COSTELLO. Madam Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from California (Mr. CALVERT) that the House suspend the rules and pass the bill, H.R. 135, as amended.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

CONVEYANCE OF DECOMMISSIONED SHIP TO UTROK ATOLL

Mr. CALVERT. Madam Speaker, I move to suspend the rules and pass the bill (H.R. 2584) to provide for the conveyance to the Utrok Atoll local government of a decommissioned National Oceanic and Atmospheric Administration ship, as amended.

The Clerk read as follows:

H.R. 2584

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

TITLE I—UTROK ATOLL RADIOLOGICAL MONITORING SUPPORT

SEC. 101. UTROK ATOLL RADIOLOGICAL MONITORING SUPPORT.

(a) In support of radiological monitoring, rehabilitation, and resettlement of Utrok Atoll, whose residents were affected by United States nuclear testing, the Secretary of Commerce may convey to the Utrok Atoll local government without consideration, all right, title, and interest of the United States in and to a decommissioned National Oceanic and Atmospheric Administration ship in operable condition.

(b) The Government of the United States shall not be responsible or liable for any maintenance or operation of a vessel conveyed under this section after the date of the delivery of the vessel to Utrok.

TITLE II—RATIFICATION OF CERTAIN NOAA APPOINTMENTS, PROMOTIONS, AND ACTIONS

SEC. 201. RATIFICATION OF CERTAIN NOAA APPOINTMENTS, PROMOTIONS, AND ACTIONS.

All action in the line of duty by, and all Federal agency actions in relation to (including with respect to pay, benefits, and retirement) a de facto officer of the commissioned corps of the National Oceanic and Atmospheric Administration who was appointed or promoted to that office without Presidential action, and without the advice and consent of the Senate, during such time as the officer was not properly appointed in or promoted to that office, are hereby ratified and approved if otherwise in accord with the law, and the President alone may, without regard to any other law relating to appointments or promotions in such corps, appoint or promote such a de facto officer temporarily, without change in the grade currently occupied in a de facto capacity, as an officer in such corps for a period ending not later than 180 days from the date of enactment of this Act.

TITLE III—INTERNATIONAL FISHERIES REAUTHORIZATION

SEC. 301. SHORT TITLE.

This title may be cited as the "International Fisheries Reauthorization Act of 2003".

SEC. 302. EXTENSION OF PERIOD FOR REIMBURSEMENT UNDER FISHERMEN'S PROTECTIVE ACT OF 1967.

Section 7(e) of the Fishermen's Protective Act of 1967 (22 U.S.C. 1977(e)) is amended by striking "2003" and inserting "2008".

SEC. 303. REAUTHORIZATION OF YUKON RIVER SALMON ACT OF 2000.

Section 208 of the Yukon River Salmon Act of 2000 (16 U.S.C. 5727) is amended by striking "2000" and all that follows through "2003" and inserting "2004 through 2008".

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from California (Mr. CALVERT) and the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN) each will control 20 minutes.

The Chair recognizes the gentleman from California (Mr. CALVERT).

GENERAL LEAVE

Mr. CALVERT. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 2584, as amended.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

Mr. CALVERT. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, H.R. 2584 will transfer a decommissioned NOAA vessel to the Utrok Atoll local government in the Republic of the Marshall Islands. The Utrok Atoll is one of 29 low coral atolls in the Marshall Islands that is inhabited by 600 people.

This small atoll has been exposed to the horrible effects of radioactive pollution during our nuclear bomb testing period. These citizens require ongoing tests, monitoring and medical care; and it is currently difficult for them to obtain access to that care.

The fundamental goal of this legislation is to provide these citizens with a reliable, safe means of transportation to the city of Majuro. This city is the capital of the Marshall Islands and is more than 300 miles from the Utrok Atoll.

The NOAA vessel likely affected by this measure is the McArthur. The ship is 175 feet long, has a cruising speed of 10 knots, a cruising range of over 6,000 nautical miles and a draft of 12 feet. It was commissioned as a NOAA research vessel in 1966 and decommissioned on May 20, 2003.

Under the terms of H.R. 2584, all rights, title, and interest in the ship are transferred to the Utrok Atoll government. The vessel must be in operable condition prior to the actual transfer; but in the future, all maintenance, responsibility, and liabilities are conveyed to the Utrok Atoll government.

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Title II of the bill is a corrective measure for the Department of Commerce which may approve appointments and confirmations made for the

NOAA Corps in the Clinton and Bush administrations. This measure has been unanimously adopted by the other body.

Title III of the bill reauthorizes two important laws dealing with international fisheries, the Fisherman's Protective Act and the Yukon River Salmon Act. Identical language was incorporated in H.R. 2048 which unanimously passed the House of Representatives on October 20 of this year. This title is noncontroversial and simply extends these two acts for an additional 5 years at existing funding levels.

Madam Speaker, I compliment the gentleman from American Samoa (Mr. FALEOMAVAEGA) for sponsoring this bill, and urge my colleagues to support this important humanitarian effort.

Madam Speaker, I reserve the balance of my time.

Mrs. CHRISTENSEN. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, as stated by the previous speaker, H.R. 2584 is noncontroversial legislation that would convey a decommissioned research vessel formerly operated by the National Oceanic and Atmospheric Administration to the local government of Utrok Atoll located in the Republic of the Marshall Islands.

Congress should do whatever we can to help the residents of Utrok Atoll. It is imperative that they receive the critical medical testing and treatment necessary to address the increased rates of thyroid cancer and birth defects that have arisen as a result of the U.S. nuclear testing program we conducted in the Northern Marshall Islands between 1946 and 1958.

The conveyance of this former NOAA vessel will allow more convenient and less expensive transportation for these residents who have to make a 265-mile trip to the neighboring islands of Majuro where the medical facilities are located.

I commend the gentleman from American Samoa (Mr. FALEOMAVAEGA) for introducing this legislation to help the residents of this very remote atoll in the Pacific Ocean.

This legislation also contains a very important amendment to address a problem regarding serious lapses in procedure affecting past appointments and promotions for NOAA's Uniformed Corps of Officers.

It is important that the chain of command of the NOAA Corps not be disrupted. And while any future repeat of these procedural lapses may not be tolerated, this matter must be addressed expeditiously to prevent any operational or command dysfunction from arising.

I urge all Members to support this legislation.

Mr. FALEOMAVAEGA. Madam Speaker, I rise in support of H.R. 2584, a bill I introduced to assist our friends from Utrōk Atoll as they continue efforts to resettle and rehabilitate their islands as a result of the effects of the United States nuclear testing in the Marshal Islands. I would like to express my gratitude to Chairman RICHARD POMBO and Ranking Member NICK RAHALL of the Resources Committee for their continued support of Pacific Island issues. I would also like to thank my distinguished colleagues and co-sonsors—Congressmen ANIBAL ACEVEDO-VILÁ (PR), DAN BURTON (IN), JOHN DOOLITTLE (CA), ELTON GALLEGLY (CA), JEFF FLAKE (AZ) and Congresswoman MADELEINE BORDALLO (Guam).

The purpose of this proposed legislation is simply to authorize the Secretary of Commerce to convey a decommissioned, operable NOAA vessel to the Government of Utrōk. The vessel would be used to provide support for radiological monitoring, rehabilitation and resettlement of Utrōk, an atoll that is part of the Republic of the Marshall Islands.

As you know, many of the Marshall Islands atolls were devastated by the effects of the U.S. Nuclear Testing activities during the 1940's and 50's. Utrōk was one of four atolls acknowledged by the U.S. Government and suffering unsafe radiologicval exposure and its residents were forced to evacuate 72 hours after the miscalculated Bravo shot. Two months later, the people of Utrōk were assured it was safe to return home. We know now that this was a grave mistake because Utrōk residents have since suffered increased radiological illnesses and birth defects. Today, the people of Utrōk are seeking to rehabilitate their home island so that it is a safe place to live.

Last year a comprehensive scientific report recommended a potassium fertilizer treatment to accompany the ongoing resettlement process on Utrōk, a treatment which would suppress the remaining radioactive Cesium-137 in the soil and prevent its further uptake in the food supply. In addition, the U.S. Department of Energy concluded a MOU with Utrōk that committed the DOE to build a Whole body Counting (WBC) facility in order to monitor radioactivity levels in the people of Utrōk. This new facility is located about 265 miles away in Majuro and will be used to ensure that the potassium fertilizer regime is effective and the administration of the fertilizer treatment is done properly. However, Utrōk residents are responsible for their own transportation to Majuro. Transportation by plane is expensive and available only once per week, and is unreliable, as the Utrōk runway is in disrepair and the airline often declines to land. Travel by commercial ships, although less expensive, is infrequent and unfeasible.

One solution to help facilitate transportation between Utrōk and Majuro is to transfer a decommissioned NOAA vessel to the Utrōk Atoll Local Government. In addition to transport of Utrōk residents to the WBC facility, the vessel will be used for moving several tons of potassium fertilizer, transporting equipment and materials for radiological remediation, and transporting USDA food supplies. Because of the Cesium-137 contamination is locally grown food, at least 50% of the diet of Utrōk residents must be imported to limit the risk of radiological poisoning.

The Utrōk Atoll Local Government also fully supports this measure and adopted are solution (022–03) on July 4th 2003 stating that the NOAA vessel transfer would be "one of the crucial needs that will fully support our future goals to develop, rehabilitate and resettle the atoll after the aftermath of the 'Bravo' fallout". The Utrōk Government also expects the ship to be available for use by other atolls for their respective communities, who will help pay for the ongoing maintenance of the vessel.

Mr. Speaker, I am hopeful that this bill will remind the Congress of our ongoing responsibility to the people of RMI for the mistakes the United States made regarding its nuclear testing activities in the Asia Pacific region. Once again, I urge my colleagues to support this important legislation and I thank my colleagues for their support.

Mrs. CHRISTENSEN. Madam Speaker, I yield back the balance of my time.

Mr. CALVERT. Madam Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mrs. BIGGERT). The question is on the motion offered by the gentleman from California (Mr. CALVERT) that the House suspend the rules and pass the bill, H.R. 2584, as amended.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

The title of the bill was amended so as to read: "A bill to provide for the conveyance to the Utrok Atoll local government of a decommissioned National Oceanic and Atmospheric Administration ship, and for other purposes.".

A motion to reconsider was laid on the table.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Monahan, one of its clerks, announced that the Senate has passed without amendment bills and a concurrent resolution of the House of the following titles:

H.R. 3038. An act to make certain technical and conforming amendments to correct the Health Care Safety Net Amendments of 2002.

H.R. 3140. An act to provide for availability of contact lens prescriptions to patients, and for other purposes.

H.R. 3166. An act to designate the facility of the United States Postal Service located at 57 Old Tappan Road in Tappan, New York, as the "John G. Dow Post Office Building".

H.R. 3185. An act to designate the facility of the United States Postal Service located at 38 Spring Street in Nashua, New Hampshire, as the "Hugh Gregg Post Office Building".

H.R. 3491. An act to establish within the Smithsonian Institution the National Museum of African American History and Culture, and for other purposes.

H. Con. Res. 320. Concurrent resolution expressing the sense of the Congress regarding the importance of motorsports.

The message also announced that the Senate has passed with amendments in which the concurrence of the House is requested, a joint resolution of the House of the following title:

H.J. Res. 78. Making further continuing appropriations for the fiscal year 2004, and for other purposes.

The message also announced that the Senate has passed bills of the following titles in which the concurrence of the House is requested:

S. 1152. An act to reauthorize the United States Fire Administration, and for other purposes.

S. 1561. An act to preserve existing judgeships on the Superior Court of the District of Columbia.

PREDISASTER MITIGATION PROGRAM REAUTHORIZATION ACT OF 2003

Mr. LATOURETTE. Madam Speaker, I move to suspend the rules and pass the bill (H.R. 3181) to amend the Robert T. Stafford Disaster Relief and Emergency Assistance Act to reauthorize the predisaster mitigation program, and for other purposes.

The Clerk read as follows:

H.R. 3181

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Predisaster Mitigation Program Reauthorization Act of 2003".

SEC. 2. PREDISASTER HAZARD MITIGATION.

Section 203(m) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5133(m)) is amended by striking "December 31, 2003" and inserting "September 30, 2006".

SEC. 3. HAZARD MITIGATION.

(a) IN GENERAL.—The last sentence of section 404(a) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5170c(a)) is amended by striking "7.5" and inserting "15".

(b) APPLICABILITY.—The amendment made by subsection (a) shall apply with respect to a major disaster declared by the President after September 30, 2002.

SEC. 4. REPAIR ASSISTANCE TO INDIVIDUALS AND HOUSEHOLDS.

(a) IN GENERAL.—Section 408(c)(2) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5174(c)(2)) is amended—

(1) in subparagraph (B) by inserting "initial" before "assistance" the first place it appears;

(2) in subparagraph (C)—

(A) in the subparagraph heading by inserting "INITIAL" before "ASSISTANCE"; and

(B) by inserting "initial" before "assistance"; and

(3) by adding at the end the following:

"(D) ADDITIONAL ASSISTANCE.—Subject to the limitation contained in subsection (h), the President may provide additional repair assistance under this paragraph to an individual or household that is unable to complete the repairs described in subparagraph (A) using insurance proceeds, loans, or other financial assistance, including assistance from the Small Business Administration.".

(b) APPLICABILITY.—The amendments made by subsection (a) shall apply with respect to a major disaster declared by the President after the date of enactment of this Act.

SEC. 5. STUDY REGARDING COST REDUCTION.

Section 209 of the Disaster Mitigation Act of 2000 (42 U.S.C. 5121 note; 114 Stat. 1571) is amended by striking "3 years after the date of the enactment of this Act" and inserting "September 30, 2005".

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Ohio (Mr. LATOURETTE) and the gentleman from Oregon (Mr. BLUMENAUER) each will control 20 minutes.

The Chair recognizes the gentleman from Ohio (Mr. LATOURETTE).

Mr. LATOURETTE. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, H.R. 3181, the Predisaster Mitigation Program Reauthorization Act of 2003 reauthorizes the Predisaster Mitigation Program for an additional 3 years and allows the President to offer additional home repair assistance to disaster victims; restores the percentage of Hazard Mitigation Grant Program funds to previously authorized levels; and requires the completion of a Congressional Budget Office study on the cost-effectiveness of the program.

This program, which was originally authorized as a pilot program as a part of the Disaster Mitigation Act of 2000 was intended to study the effectiveness of mitigation grants in the absence of a disaster, as opposed to solely following a disaster, as is currently the practice.

In addition to reauthorizing the Predisaster Mitigation Program, the bill makes two changes to other programs within the Stafford Act. H.R. 3181 authorizes the President to give additional home repair assistance when the initial amount is insignificant, and it also restores the percentage of funding available under the HMGP. In the omnibus appropriation bill that concluded the last Congress, this percentage was modified, and there was compelling testimony before our subcommittee and also brought to the attention of the members of the full Committee on Transportation and Infrastructure by people in emergency management administrations across the country that the previous levels authorized by the Committee on Transportation and Infrastructure were absolutely essential to the work that they do.

The bill also requires the completion of a CBO study on the effectiveness of the PDM. This study is required by December 30, 2006, by which time it is expected that there will be more information on which to study the effectiveness of the PDM.

This legislation is the product of a comprehensive and inclusive legislative process. It is, I believe, a balanced approach to disaster mitigation and worthy of our support. I thank the ranking member of our subcommittee, the gentlewoman from the District of Columbia (Ms. NORTON), for her invaluable assistance in crafting this legislation, and also the chairman of the Committee on Transportation and Infrastructure, the gentleman from Alaska (Mr. YOUNG) and the distinguished ranking member, the gentleman from Minnesota (Mr. OBERSTAR). Madam Speaker, I urge immediate adoption of H.R. 3181.

Madam Speaker, I reserve the balance of my time.

Mr. BLUMENAUER. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I rise in support of H.R. 3181 the Predisaster Mitigation Reauthorization Act. As the gentleman from Ohio (Mr. LATOURETTE) pointed out, the purpose is to reauthorize predisaster mitigation which provides assistance on a competitive basis to States and localities to undertake hazard mitigation projects. It is absolutely incontrovertible that if we take steps early in the process, we will protect lives, we will protect property. There is an added benefit in keeping disaster costs down and insurance rates in check.

One way or another, we all pay for natural disaster events through Federal disaster relief and insurance premiums. Nationwide, annual homeowner insurance premiums have increased 42.2 percent since 1995. In the last 25 years, there have been almost 1,000 Presidential disasters declared, and the GAO has estimated that Federal disaster relief has increased fivefold in the course of the last decade. From 1998 to 2001, this is almost $40 billion.

Not only will this legislation help homeowners be whole again, but it will save taxpayers billions of dollars in disaster assistance in the long haul.

One of the concerns I and a number of Members had when we had the Federal Emergency Management Agency with its long history of helping our Nation deal with natural disasters moved into the Department of Homeland Security was the concern that the focus on the day-to-day disaster preparedness and emergency response, I would be lost in that large bureaucracy. I am hopeful that in the course of our heightened homeland security concerns, that we do not allow the focus of that agency to become blurred. Maintaining the Hazard Mitigation Grant Program is an essential part of maintaining that focus.

By funding mitigation projects after disasters at the time when communities are most closely focused on the benefits of mitigation and protecting families from future loss, we are able to invent resources and make a difference. Sadly, there are already stories in the newspapers in southern California after, the disastrous fires and the testimony to inadequate planning and enforcement even of local regulations, the people are talking about moving back into harm's way.

The Predisaster Mitigation Program Reauthorization Act we bring to the floor today provides the balance between the predisaster program and reaffirming our support for postmitigation.

The pilot project, as has been referenced would provide for the distribution of grants to carry out disaster mitigation programs, was created to promote appropriate mitigation efforts without having to wait for a disaster to trigger the availability of funds in the future.

Even though authorized to start in 1999, it only began this calendar year, and the competitive grants have yet to be received or awarded. Even though we want to evaluate the effectiveness of the program, and the CBO cannot yet compete its mandate due to the lack of substantive information, it is appropriate for us to reauthorize for 3 years to make sure we get the evidence.

We ought to be very clear that we want to have the facts and figures to support being able to do more in the future. I deeply appreciate the work of our chairman, the gentleman from Alaska (Mr. YOUNG), and the ranking member, the gentleman from Minnesota (Mr. OBERSTAR), and the work of the chairman of the subcommittee, the gentleman from Ohio (Mr. LATOURETTE), and the ranking member, the gentlewoman from the District of Columbia (Ms. NORTON). They provide continuing focus on this important area that too often fail to get the attention it deserves. If we do our job right, we will make a difference for people all across the country: taxpayers, homeowners, and the people who have the tough jobs working in the trenches.

Madam Speaker, I reserve the balance of my time.

Mr. LATOURETTE. Madam Speaker, I yield such time as he may consume to the gentleman from Georgia (Mr. BURNS), a very valuable new member of our subcommittee and full committee. A lot of Members join the Committee on Transportation and Infrastructure, but few have understood it as quickly as the gentleman from Georgia.

□ 1130

Mr. BURNS. Madam Speaker, I rise today to support passage of H.R. 3181, the Predisaster Mitigation Program Reauthorization Act of 2003. This comprehensive bill, developed on a bipartisan basis, extends the predisaster mitigation program for an additional 3 years, makes two important changes to the Stafford Act, and requires a Congressional Budget Office study of the program's effectiveness.

This program, which was originally included in the Disaster Mitigation Act of 2000, takes the next step in protecting our communities from the devastating effects of disasters. By encouraging communities to engage in cost-effective disaster mitigation projects before disasters strike, we can dramatically reduce the response and recovery cost of these disasters.

Unlike terrorism, natural disasters can and will strike every State and territory in the United States. From the ice storms that we suffer in my home State of Georgia to hurricanes that have even impacted Washington, D.C., every State and locality can prepare itself to reduce its risk from disasters. Whether it be seismic retrofits of buildings, safe rooms in schools, improved levees, or awareness programs, the actions that we take today will determine how we fare in a disaster. This program makes necessary funds available for such projects.

H.R. 3181 also makes two very important changes to the Stafford Act. These changes have been requested by professional organizations and have strong bipartisan support. H.R. 3181 restores to previously authorized levels the percentage of HMGP funds available following disasters and authorizes additional home repair assistance for individuals when the initial amount of $5,000 is insufficient. Each of these changes will make recovering from a disaster and preparing for disasters easier, thereby reducing future costs.

Finally, this bill requires a CBO study of the effectiveness of this program, a study which will guide future considerations for our efforts in the United States to ensure disaster relief.

I urge the adoption of H.R. 3181.

Mr. BLUMENAUER. Madam Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. LATOURETTE. Madam Speaker, I yield myself the balance of my time.

I want to thank my friend from Oregon for participating, also my friend from Georgia, again thank all the members of the subcommittee and those in the emergency management field across the country that helped participate and craft this legislation. The very able and capable staff of the committee has reminded me that yesterday we had on the floor a bill dealing with flood insurance which has a mitigation program; and although they have done mighty work, to date they have only secured 938 properties and removed them from further flood damage. This program that we are reauthorizing today has engaged in the purchase of 20,000 properties.

Again, the testimony before the subcommittee was stark and it was clear. It is easy to get a community to come together and spend money after a flood, after a hurricane, after a tornado. It is very difficult to get people to make that investment prior to, but the testimony is clear that if you make that investment in seismic upgrading of buildings or other features throughout parts of the country, you can literally save billions of dollars. It is a good program. I urge support.

Mr. OBERSTAR. Madam Speaker, I rise in support of H.R. 3181, the Predisaster Mitigation Reauthorization Act of 2003. This bill makes a limited number of necessary amendments to the Stafford Act. The Stafford Act governs the Federal Emergency Management Agency's (FEMA) responsibilities to help communities prepare for and respond to disasters. Many of the FEMA's functions were transferred to the Department of Homeland Security's Directorate of Emergency Prepareness and Response when that Department was created last year.

Over the last 25 years, this country has had nearly one thousand presidential disaster declarations in the United States and the Insular Territories. These disasters have cost our Nation billions of dollars and taken an untold number of lives.

The Stafford Act authorizes programs that not only provide funding for post-disaster recovery, but also provide funding for importance pre-disaster hazard mitigation projects.

In October 2000, Congress passed the Disaster Mitigation Act of 2000 (DMA), which reauthorized the Stafford Act and created several new programs. One of those new programs was a pre-disaster mitigation program that allowed FEMA to award grants to States on a competitive basis to implement pre-disaster mitigation plans. Although authorized to begin in fiscal year 1999, the program began in earnest only a few months ago. No competitive grant applications have yet been received by FEMA, and none of the competitive grants have been awarded. In light of this, H.R. 3181 extends the authorization of this program for another three years in order to give FEMA the time to implement the program and to give Congress the time to fairly evaluate it. In addition, the bill redirects the Congressional Budget Office (CBO) to conduct a study on the program's effectiveness.

Further, the bill reaffirms our support for the Hazard Mitigation Grant Program (HMGP) that seeks to substantially reduce the risk of future damage, hardship, or loss in any area affected by a major disaster. This program has a proven record of success. It is successful in large part because it funds hazard mitigation projects immediately after a disaster strikes, when the public and local governments are most focused on mitigation measures. In addition, it has the strong support of State and local governments.

Finally, this bill would allow the Undersecretary to provide additional home repair assistance for a homeowner upon the homeowner's showing of an inability to make the necessary repairs by other means. Not being able to properly repair a home after a disease can add further distress to an already devastating situation. While current law provides for a $5,000 cap on home repair assistance for individuals who have been impacted by a disaster, there is a significant percentage of homeowners who continue to struggle with unmet needs. This bill remedies that concern.

Madam Speaker, I'd also like to thank my colleagues on the Transportation and Infrastructure Committee, Chairman YOUNG, Subcommittee Chairman LATOURETTE, and Subcommittee Democratic Ranking Member NORTON, for their work on this important bill. I believe this bill provides a balanced approach to mitigation by providing for both pre- and post-disaster mitigation programs. I urge my colleagues to join me in supporting it.

Mr. COSTELLO. Madam Speaker, I raise today in support of H.R. 3181, the Predisaster Mitigation Act Reauthorization Act of 2002. I would like to commend my colleagues on the Transportation and Infrastructure Committee, Chairman YOUNG, Subcommittee Chairman LATOURETTE and Subcommittee Democratic Ranking Member NORTON, for all of their work on this important bill.

This bill makes a limited number of necessary amendments to the Stafford Act, which governs the Federal Emergency Management Agency's (FEMA) responsibilities to help communities prepare for and respond to disasters. The Stafford Act authorizes programs that provide funding for both post-disaster recovery, and for important pre-disaster hazard mitigation projects.

The pre-disaster mitigation program was authorized to begin in fiscal year 1999; however, the program began in earnest only a few months ago. The program allowed FEMA to award grants to states on a competitive basis to implement pre-disaster mitigation plans. Because of its late start, no competitive grant applications have yet been received by FEMA, and none of the competitive grants have been awarded. Among other things, this bill extends the authorization of this program for another three years to give FEMA the time necessary to implement the program and to give Congress the time necessary to fairly evaluate it.

Madam Speaker, I believe this is a good bill that provides a balanced approach to both pre- and post-disaster mitigation programs. I urge my colleagues to join me in supporting the bill.

Mr. LATOURETTE. Madam Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mrs. BIGGERT). The question is on the motion offered by the gentleman from Ohio (Mr. LATOURETTE) that the House suspend the rules and pass the bill, H.R. 3181.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. LATOURETTE. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 3181.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Ohio?

There was no objection.

UNITED STATES FIRE ADMINISTRATION REAUTHORIZATION ACT of 2003

Mr. BOEHLERT. Madam Speaker, I move to suspend the rules and pass the Senate bill (S. 1152) to reauthorize the United States Fire Administration, and for other purposes.

The Clerk read as follows:

S. 1152

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

TITLE I—UNITED STATES FIRE ADMINISTRATION REAUTHORIZATION

SEC. 101. SHORT TITLE.

This title may be cited as the "United States Fire Administration Reauthorization Act of 2003".

SEC. 102. RE-ESTABLISHMENT OF POSITION OF UNITED STATES FIRE ADMINISTRATOR.

Section 1513 of the Homeland Security Act of 2002 (6 U.S.C. 553) does not apply to the position or office of Administrator of the United States Fire Administration, who shall continue to be appointed and compensated as provided by section 5(b) of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2204(b)).

SEC. 103. AUTHORIZATION OF APPROPRIATIONS.

Section 17(g)(1) of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2216(g)) is amended by striking subparagraphs (A) through (K) and inserting the following:

"(A) $63,000,000 for fiscal year 2005, of which $2,266,000 shall be used to carry out section 8(f);

"(B) $64,850,000 for fiscal year 2006, of which $2,334,000 shall be used to carry out section 8(f);

"(C) $66,796,000 for fiscal year 2007, of which $2,404,000 shall be used to carry out section 8(f); and

"(D) $68,800,000 for fiscal year 2008, of which $2,476,000 shall be used to carry out section 8(f).".

TITLE II—FIREFIGHTING RESEARCH AND COORDINATION

SEC. 201. SHORT TITLE.

This title may be cited as the "Firefighting Research and Coordination Act".

SEC. 202. NEW FIREFIGHTING TECHNOLOGY.

Section 8 of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2207) is amended—

(1) by redesignating subsection (e) as subsection (g); and

(2) by inserting after subsection (d) the following:

"(e) ASSISTANCE TO OTHER FEDERAL AGENCIES.—At the request of other Federal agencies, including the Department of Agriculture and the Department of the Interior, the Administrator may provide assistance in fire prevention and control technologies, including methods of containing insect-infested forest fires and limiting dispersal of resultant fire particle smoke, and methods of measuring and tracking the dispersal of fine particle smoke resulting from fires of insect-infested fuel.

"(f) TECHNOLOGY EVALUATION AND STANDARDS DEVELOPMENT.—

"(1) IN GENERAL.—In addition to, or as part of, the program conducted under subsection (a), the Administrator, in consultation with the National Institute of Standards and Technology, the Inter-Agency Board for Equipment Standardization and Inter-Operability, the National Institute for Occupational Safety and Health, the Directorate of Science and Technology of the Department of Homeland Security, national voluntary consensus standards development organizations, interested Federal, State, and local agencies, and other interested parties, shall—

"(A) develop new, and utilize existing, measurement techniques and testing methodologies for evaluating new firefighting technologies, including—

"(i) personal protection equipment;

"(ii) devices for advance warning of extreme hazard;

"(iii) equipment for enhanced vision;

"(iv) devices to locate victims, firefighters, and other rescue personnel in above-ground and below-ground structures;

"(v) equipment and methods to provide information for incident command, including the monitoring and reporting of individual personnel welfare;

"(vi) equipment and methods for training, especially for virtual reality training; and

"(vii) robotics and other remote-controlled devices;

"(B) evaluate the compatibility of new equipment and technology with existing firefighting technology; and

"(C) support the development of new voluntary consensus standards through national voluntary consensus standards organizations for new firefighting technologies based on techniques and methodologies described in subparagraph (A).

"(2) STANDARDS FOR NEW EQUIPMENT.—

(A) The Administrator shall, by regulation, require that new equipment or systems purchased through the assistance program established by the first section 33 meet or exceed applicable voluntary consensus standards for such equipment or systems for which applicable voluntary consensus standards have been established. The Administrator may waive the requirement under this subparagraph with respect to specific standards.

"(B) If an applicant for a grant under the first section 33 proposes to purchase, with assistance provided under the grant, new equipment or systems that do not meet or exceed applicable voluntary consensus standards, the applicant shall include in the application an explanation of why such equipment or systems will serve the needs of the applicant better than equipment or systems that do meet or exceed such standards.

"(C) In making a determination whether or not to waive the requirement under subparagraph (A) with respect to a specific standard, the Administrator shall, to the greatest extent practicable—

"(i) consult with grant applicants and other members of the fire services regarding the impact on fire departments of the requirement to meet or exceed the specific standard;

"(ii) take into consideration the explanation provided by the applicant under subparagraph (B); and

"(iii) seek to minimize the impact of the requirement to meet or exceed the specific standard on the applicant, particularly if meeting the standard would impose additional costs.

"(D) Applicants that apply for a grant under the terms of subparagraph (B) may include a second grant request in the application to be considered by the Administrator in the event that the Administrator does not approve the primary grant request on the grounds of the equipment not meeting applicable voluntary consensus standards.".

SEC. 203. COORDINATION OF RESPONSE TO NATIONAL EMERGENCY.

(a) IN GENERAL.—Section 10 of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2209) is amended—

(1) by redesignating subsection (b) as subsection (c); and

(2) by inserting after subsection (a) the following:

"(b) MUTUAL AID SYSTEMS.—

"(1) IN GENERAL.—The Administrator shall provide technical assistance and training to State and local fire service officials to establish nationwide and State mutual aid systems for dealing with national emergencies that—

"(A) include threat assessment and equipment deployment strategies;

"(B) include means of collecting asset and resource information to provide accurate and timely data for regional deployment; and

"(C) are consistent with the Federal Response Plan.

"(2) MODEL MUTUAL AID PLANS.—The Administrator shall develop and make available to State and local fire service officials model mutual aid plans for both intrastate and interstate assistance.".

(b) REPORT ON STRATEGIC NEEDS.—Within 90 days after the date of enactment of this Act, the Administrator of the United States Fire Administration shall report to the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committee on Science on the need for a strategy concerning deployment of volunteers and emergency response personnel (as defined in section 6 of the Firefighters' Safety Study Act (15 U.S.C. 2223e)), including a national credentialing system, in the event of a national emergency.

(c) REPORT ON FEDERAL RESPONSE PLAN.—Within 180 days after the date of enactment of this Act, the Department of Homeland Security shall transmit a report to the Senate Committee on Commerce, Science, and Transportation, the Senate Committee on Governmental Affairs, and the House of Representatives Committee on Science describing plans for revisions to the Federal Response Plan and its integration into the National Response Plan, including how the revised plan will address response to terrorist attacks, particularly in urban areas, including fire detection and suppression and related emergency services.

SEC. 204. TRAINING.

(a) IN GENERAL.—Section 7(d)(1) of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2206(d)(1)) is amended—

(1) by striking "and" after the semicolon in subparagraph (E);

(2) by redesignating subparagraph (F) as subparagraph (N); and

(3) by inserting after subparagraph (E) the following:

"(F) strategies for building collapse rescue;

"(G) the use of technology in response to fires, including terrorist incidents and other national emergencies;

"(H) response, tactics, and strategies for dealing with terrorist-caused national catastrophes;

"(I) use of and familiarity with the Federal Response Plan;

"(J) leadership and strategic skills, including integrated management systems operations and integrated response;

"(K) applying new technology and developing strategies and tactics for fighting forest fires;

"(L) integrating the activities of terrorism response agencies into national terrorism incident response systems;

"(M) response tactics and strategies for fighting fires at United States ports, including fires on the water and aboard vessels; and".

(b) CONSULTATION ON FIRE ACADEMY CLASSES.—The Superintendent of the National Fire Academy may consult with other Federal, State, and local agency officials in developing curricula for classes offered by the Academy.

(c) COORDINATION WITH OTHER PROGRAMS TO AVOID DUPLICATION.—The Administrator of the United States Fire Administration shall coordinate training provided under section 7(d)(1) of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2206(d)(1)) with the Attorney General, the Secretary of Health and Human Services, and the heads of other Federal agencies—

(1) to ensure that such training does not duplicate existing courses available to fire service personnel; and

(2) to establish a mechanism for eliminating duplicative training programs.

(d) COURSES AND TRAINING ASSISTANCE.—Section 7(l) of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2206(l)) is amended by adding at the end the following: "The Superintendent shall offer, at the Academy and at other sites, courses and training assistance as necessary to accommodate all geographic regions and needs of career and volunteer firefighters.".

SEC. 205. FIREFIGHTER ASSISTANCE GRANTS PROGRAM.

(a) ADMINISTRATION.—The first section 33 of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2229) is amended—

(1) by striking subsection (b)(2) and inserting the following:

"(2) ADMINISTRATIVE ASSISTANCE.—The Director shall establish specific criteria for the selection of recipients of assistance under this section and shall provide grant-writing assistance to applicants."; and

(2) by striking "operate the office established under subsection (b)(2) and" in subsection (e)(2).

(b) MARITIME FIREFIGHTING.—Subsection (b)(3)(B) of the first section 33 of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2229(b)(3)(B)) is amended by inserting "maritime firefighting," after "arson prevention and detection,".

(c) FIREFIGHTING IN REMOTE AREAS.—The first section 33 of the Federal Fire Prevention and Control Act of 1974 (15 U.S.C. 2229) is amended—

(1) by inserting "equipment for fighting fires with foam in remote areas without access to water, and" after "including" in subsection (b)(3)(H); and

(2) by inserting "Of the amounts authorized in this paragraph, $3,000,000 shall be made available each year through fiscal year 2008 for foam firefighting equipment." at the end of subsection (e)(1).

SEC. 206. NATIONAL FALLEN FIREFIGHTERS FOUNDATION.

(a) MEMBERS.—Section 151303(b) of title 36, United States Code, is amended—

(1) by striking "9" in paragraph (2) and inserting "12";

(2) by striking "six" in subparagraph (D) of paragraph (2) and inserting "nine"; and

(3) by striking "3 members" in paragraph (3) and inserting "4 members".

(b) COMPENSATION.—Section 151304(b)(3) of title 36, United States Code, is amended by inserting "15 percent above" after "more than".

(c) PERIOD OF AUTHORIZED ASSISTANCE.—Section 151307 of title 36, United States Code, is amended in subsection (a)(1), by striking "During the 10-year period beginning on the date of the enactment of the Fire Administration Authorization Act of 2000, the" and inserting "The".

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New York (Mr. BOEHLERT) and the gentleman from Texas (Mr. RODRIGUEZ) each will control 20 minutes.

The Chair recognizes the gentleman from New York (Mr. BOEHLERT).

GENERAL LEAVE

Mr. BOEHLERT. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and to include extraneous material on S. 1152, the bill now under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New York?

There was no objection.

Mr. BOEHLERT. Madam Speaker, I yield myself such time as I may consume.

I rise in support of the U.S. Fire Administration Reauthorization Act, which began life in the House as H.R. 2692, introduced by the gentleman from Michigan (Mr. SMITH), subcommittee chairman. Most Americans have never heard of the U.S. Fire Administration, but it has enhanced the protection of all of our communities, our neighborhoods; and firefighters know the agency well.

The funds we are authorizing in this bill will continue to train our local firefighters both at the National Fire Academy in Emmitsburg and in State and local training centers. These funds will also help promote residential fire sprinklers, fire prevention activities, and other activities that save lives. The U.S. Fire Administration has also administered the FIRE program, which helps our local fire departments purchase desperately needed fire equipment. It is one of the most successful Federal assistance programs devised by this Congress or any previous Congress.

One of the great things about this program is that the politicians, and I have fondness for politicians, but the politicians are sort of taking a back seat. It is the people involved, the firefighters themselves in every day protecting our homes and our neighborhoods and communities that established the criteria for this massive grant program and do the actual evaluating. It is a program with unquestioned integrity. I say that because I have watched it in operation, and all of our congressional districts across the country are taking advantage of it, not for selfish reasons but to protect our people in their homes, in their neighborhoods, in their communities, where they live.

I will tell my colleagues a personal experience in my own congressional district. Utica, New York, had an arson rate three times the national average. It was a serious problem in New York. I sat down with the previous administrator of FEMA and said, let's work with this community because this is a serious problem and it has to be addressed and it is far beyond the ability of the individual community to come to grips with it in any meaningful way without some added guidance and inspiration and, quite frankly, some financial support from beyond our borders. FEMA did it. We did it. Collectively, Utica has enjoyed its best day in the last couple of years. The arson rate is down dramatically. People feel more comfortable and safer in their homes. It is all because of some work that came out of the U.S. Fire Administration.

I would say for a whole lot of the right reasons, I urge approval of this bill which will help our localities in very tangible ways, meaningful ways that touch the lives of individual families. We owe it to our firefighters both paid and volunteer. Incidentally, let me just stress, paid and volunteer. I have heard some people suggest on occasion that we have professional firefighters and we have volunteer firefighters. There is no such differential. We have paid and unpaid but those volunteers from coast to coast are some of the most dedicated, professional, able, committed people we will find anyplace. Thank God for the volunteer firefighters of America. That is not to indicate I do not appreciate what the paid firefighters do day in and day out or making a professional career of it, but those volunteers in communities all across this land do outstanding work, give of their time and their talent and their energy to protect us and our communities. I want to salute them, and I want to dedicate passage of this bill to them.

Madam Speaker, I reserve the balance of my time.

Mr. RODRIGUEZ. Madam Speaker, I yield myself such time as I may consume.

I rise in support of S. 1152, the United States Fire Administration Reauthorization Act. I want to thank all the Members who had a part, including the gentleman from New York (Mr. BOEHLERT). The gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON) is on her way. I know she has worked on this very diligently.

Madam Speaker, I reserve the balance of my time.

Mr. BOEHLERT. Madam Speaker, I yield myself such time as I may consume.

I want to add something here. There was some confusion about section 204(c) of this bill regarding coordination of firefighting training activities. I want to clarify that the reference to "other Federal agencies" in this section includes the Office of Domestic Preparedness and does not conflict with the counterterrorism training provisions in the Homeland Security Act of 2002.

I also would like to place in the RECORD at this juncture an exchange of letters between me as chairman of the Committee on Science and Chairman YOUNG of the Committee on Transportation and Infrastructure. I also serve on that committee, too, so in some respects I am writing to myself. This is an exchange of letters that further clarifies it.

HOUSE OF REPRESENTATIVES, COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE,
Washington, DC, November 21, 2003.

Hon. SHERWOOD, L. BOEHLERT,
Chairman, Committee on Science,
Washington, DC.

DEAR MR. CHAIRMAN: I am writing to you concerning the jurisdictional interest of the Transportation and Infrastructure Committee in matters contained in S. 1152, the United States Fire Administration Reauthorization Act of 2003.

Our Committee recognizes the importance of S. 1152 and the need for the legislation to move expeditiously. Therefore, while we have a valid claim to jurisdiction over certain provisions of the bill, I agree not to request a referral and allow the bill to be considered in the House under suspension of the rules. This, of course, is conditional on our mutual understanding my decision to forego a sequential referral waives, reduces or otherwise affects the jurisdiction of the Transportation and Infrastructure Committee, and that a copy of this letter and of your response acknowledging our jurisdictional interest will be included as part of the Congressional Record during consideration of this bill by the House.

Thank you for your cooperation in this matter.

Sincerely,

DON YOUNG,
Chairman.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON SCIENCE,
Washington, DC, November 21, 2003.

Hon. DON YOUNG,
Chairman Committee on Transportation and Infrastructure, Washington, DC.

DEAR MR. CHAIRMAN: Thank you for your letter concerning the jurisdictional interest of the Transportation and Infrastructure Committee over matters contained in S. 1152, the United States Fire Administration Reauthorization Act of 2003.

I appreciate your not requesting a referral of this bill and allowing it to be considered by the House under suspension of the rules. Specifically, I acknowledge that your Committee has a valid claim to jurisdiction over certain provisions of the bill as drafted. I agree that by forgoing a sequential referral you do not waive, reduce, or otherwise affect the jurisdiction of the Committee on Transportation and Infrastructure.

I also agree that a copy of this letter and of your letter will be included as part of the Congressional Record during consideration of this bill by the House.

Thank you for your cooperation in this matter.

Sincerely,

SHERWOOD L. BOEHLERT,
Chairman.

Madam Speaker, I reserve the balance of my time.

Mr. RODRIGUEZ. Madam Speaker, I yield myself such time as I may consume.

I want to take this opportunity to commend the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON) on this specific legislation. I know that she has been working on this diligently. We recognize that there are a great number of deaths as a result of fire. We need to continue to work in this area. We know we have had natural disasters also in this area. I want to take this opportunity to thank the Members that have played a role.

Madam Speaker, I yield the balance of my time to the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON) and ask unanimous consent that she be permitted to control that time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Ms. EDDIE BERNICE JOHNSON of Texas. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, let me apologize for being late. I was told to be here by 12, and I was in a briefing, so I came running.

Let me thank the chairman of the Subcommittee on Research of the Committee on Science, the staff and the other leadership of the committee for working on this bill. I rise in support of Senate bill 1152, the United States Fire Administration Reauthorization Act of 2003.

This legislation is closely related to H.R. 2692, which I joined Research Subcommittee Chairman SMITH in introducing and which was ordered reported by the Committee on Science on July 22. I would like to thank Chairman SMITH for working with me in a collegial way in the development of the fire authorization bill. The version of the authorization bill before the House preserves the key features of H.R. 2692.

The Federal Fire Prevention and Control Act of 1974, which created the U.S. Fire Administration, was intended to address a serious problem affecting the safety of all Americans. Much progress has been made as a result of this legislation to advance public education about fire safety, to improve the effectiveness of the fire services throughout the Nation, and to foster the wider use of home fire safety devices.

Nevertheless, the United States still has one of the highest fire death rates among advanced nations, and fire deaths exceed the loss of life from all natural disasters combined. Clearly, much work remains to be done in order to make needed improvements in the Nation's fire safety record. I believe that S. 1152 will ensure that the U.S. Fire Administration has the resources and policies in place to help achieve this goal.

□ 1145

One matter of concern is that the effectiveness of the U.S. fire administration could suffer due to its submersion in the new Department of Homeland Security, which understandably must concentrate its efforts on combating threats from terrorism. The legislation seeks to preserve the status and visibility of the fire administration and its vital programs to advance fire safety within the Department of Homeland Security.

To achieve this result, the bill reestablishes the position of fire administrator as a Presidentially appointed and Senate-confirmed post. This is appropriate given the role of the Fire Administrator as the lead advocate for fire services within the Federal Government.

Another important function of the U.S. Fire Administration is to support research and development and testing of new firefighting technologies. This bill reemphasizes this role and authorizes new funding to help carry it out, including support for the process for developing consensus standards for the performance of new fire protection and control technologies.

Consistent with supporting the development of appropriate voluntary consensus standards for new firefighting equipment, the bill requires that equipment provided under the fire grants program conform to such standards where they exist. Fire grants provide fire departments across the Nation with the equipment and training they need to meet their important responsibilities in protecting the public from fire hazards. The Fire Administrator is given flexibility in applying the standards requirement for these grants so that the fire departments may propose solutions that make the most sense for their particular circumstances. Provision for this flexibility in the bill is in accordance with the recommendations received during the Committee on Science hearing on the legislation. The bill makes an additional modification to the statute creating the Fire Grants Program by specifying that awards to support training may include training firefighting personnel and maritime firefighting. The need for such training was ably advocated by the gentleman from Oregon (Mr. WU), championed this provision.

Madam Speaker, this bill is a bipartisan piece of legislation that authorizes the activities of a small, but extremely valuable, Federal agency that contributes to the safety of all Americans. I am pleased to commend the measure to my colleagues and ask for their support in the passage of this bill in the House.

Madam Speaker, I reserve the balance of my time.

Mr. BOEHLERT. Madam Speaker, I yield 3 minutes to the distinguished gentleman from Michigan (Mr. SMITH), the chairman of the Research Subcommittee and a real friend of the firefighters.

Mr. SMITH of Michigan. Madam Speaker, I thank the chairman for being one of the original congressional leaders for first responders and firefighters. And to the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON), who is the vice chairman or ranking member of our Research Subcommittee, I thank her for her help.

We have come a long way in this Congress helping first responders, and I think it has struck all of us after 9/11, the tremendous contribution that first responders add to the security of this country. So we are now asking even more of our firefighters and medical personnel. I would like to also commend Administrator Paulison, who has done an excellent job in terms of increasing the productivity and the efficiency of the United States Fire Administration.

This legislation is consistent with the President's request of a 3 percent increase in funding for the U.S. Fire Administration, but still at the same time with the help of the gentleman from Maryland (Mr. HOYER) and the gentleman from New Jersey (Mr. PASCRELL) on that side, certainly the gentleman from Pennsylvania (Mr. WELDON) and the chairman of this committee and myself and many others on the Republican side of the aisle, we worked together to make sure that we try to give firefighters the kind of training and support that they need to more effectively and efficiently conduct their business.

I would also like to commend the gentleman from Michigan (Mr. CAMP) for initiating the standards requirement that allows different fire departments to know the quality of some of the equipment and the machinery and the items that they might buy in that fire department to make sure that they do not, for lack of a better expression, get ripped off with equipment that is not as good as it seems.

Let me conclude by saying this is the bill I introduced and we passed in the House. It is a good bill. This Congress and America have increased our understanding that first responders and firefighters are very important to this country. Eighty percent of our firefighters in the United States are volunteers, but the full-time firefighter represents 80 percent of the people. So we have got to continue to support both the full-time firefighters and the volunteers, and that is what this bill does.

Madam Speaker, the legislation before us today would reauthorize the United States Fire Administration, which is charged with helping to prevent and control fire-related losses through leadership, advocacy, education, and support. This bill has been endorsed by a number of leading fire organizations including the Congressional Fire Services Institute, International Association of Fire Fighters, National Fire Protection Association, and National Volunteer Fire Council.

S. 1152, which is companion legislation to a bill that the distinguished Ranking Member of the Research Subcommittee and I introduced earlier this year, adheres to the Administration's budget request and provides 3 percent increases each year from 2005–2008. It would also restore the position of U.S. Fire Administrator as a Presidentially-appointed, Senate-confirmed position, after it was inadvertently eliminated by the Homeland Security Act of 2002.

USFA coordinates federal fire service training, public education, research, and data collection and analysis activities. In addition, USFA has administered the fire grant program, which supports fire departments by providing them with the tools and resources necessary to protect the health and safety of the public and firefighting personnel. USFA Administrator David Paulison has done an excellent job since being appointed in 2001, and I'd like to take this opportunity to publicly recognize his outstanding service.

This legislation also directs USFA to develop standards for firefighting equipment and technology. The new standards will help to ensure that firefighters have access to the highest quality equipment available. Equipment purchased through the fire grant program must meet the new standards, although under unique circumstances, the Administrator is given flexibility to waive this requirement.

There was an effort to attach language similar to Representative BOB ETHERIDGE's bill H.R. 919, the Hometown Heroes Survivor Benefit Act, to the bill before us today. I am one of 281 cosponsors of H.R. 919, which would ensure that the family of a public safety officer who suffers a fatal heart attack or stroke in the line of duty receives survivor benefits. These families are often forced to wrangle with the Justice Department to obtain compensation. In the interest of passing the USFA reauthorization expeditiously the language was eventually dropped. However, I would like to express my commitment to continuing to work for passage of H.R. 919.

In closing, I am pleased that we were able to work closely with members of the minority as well as members of the fire services community in drafting this bipartisan legislation. I urge every Member to support S. 1152 so that we can insure the long-term viability of this important program.

Ms. EDDIE BERNICE JOHNSON of Texas. Madam Speaker, I yield 3 minutes to the gentleman from New Jersey (Mr. PASCRELL).

Mr. PASCRELL. Madam Speaker, I rise in strong support of the United States Fire Administration Reauthorization Act. And I want to commend the gentleman from New York (Mr. BOEHLERT) and the gentleman from Texas (Mr. HALL) not only for bringing this important legislation to the floor, but for their exemplary leadership they have displayed on behalf of the fire community over these many years.

Providing firefighters with the training and equipment they need to protect our communities is about as important a job as the Congress is charged with. This Congress and the previous Congress have risen to the occasion. And I am heartened by the advancement of this goal in recent years. So to the Chair and ranking members, they have done a spectacular job.

We started with the passage of the FIRE Act in 2000, to provide Federal grants directly to local fire departments to help address equipment and training and other firefighter-related needs. Since then communities have received close to 13,000 awards nationwide. There are 32,000 fire departments. Figure out the math. This has been an amazing achievement.

Two weeks ago we were able to pass the "Staffing for Adequate Fire and Emergency Response," the SAFER program. That authorizes $7.6 billion through 2010 to combat the dangerous crisis of inadequate staffing in our Nation's career fire departments and volunteer departments at a time when it is more crucial than ever. We have come a long way. We have come a long way, indeed.

America's fire death rate is still one of the highest per capita in the industrial world. Fire kills 3,700 people per year, injures 20,000, and approximately 100 firefighters die annually while doing their work.

The USFA's National Fire Academy offers educational opportunities for firefighters in fire prevention and life safety activities, and, of course, we want it also to deal with the terrorist threat that is at hand. As a member of the Select Committee on Homeland Security, I find nothing to be more important than the defense of our families and our streets.

Through research, testing, and evaluation, USFA works with the public and private entities to promote and improve fire and life safety. Additionally, the data collection of the National Fire Safety Data Center is absolutely critical to identify problem areas for which prevention and mitigation strategies are needed. Firefighters, whose bravery and valor protect our Nation every day, deserve all that we can give them, and a strong, flourishing Fire Administration will assist in this regard.

And again, in conclusion, Madam Speaker, I think this is a great day for the fire services throughout the United States and a great day for our firefighters. They have earned it, and we are glad to participate in getting this legislation through today.

Mr. CAMP. Madam Speaker, I rise today in support of S. 1152, the United States Fire Administration Reauthorization Act. This bill appropriately recognizes the value of the United States Fire Administration (USFA) for its national leadership in reducing the threat of fires and educating Americans about fire prevention methods. I want to thank Research Subcommittee Chairman NICK SMITH and Science Chairman BOEHLERT for their leadership on this issue and their support for the inclusion of a bill I introduced, H.R. 545, the Firefighting Research and Coordination Act. I appreciate Senator MCCAIN'S leadership on this bill and for his hard work getting it passed last night in the Senate.

The Firefighting Research and Coordination Act helps address current policy questions on how the federal government can most effectively provide firefighters with the training and equipment necessary to protect lives. The bill gives appropriate weight to top fire service needs: the development of voluntary consensus standards for firefighting equipment and technology; establishing nationwide and State mutual aid systems for dealing with national emergencies; and authorizing the National Fire Academy to train firefighters to respond to acts of terrorism and other national emergencies.

This legislation enjoys wide bipartisan support and the endorsement of many national fire groups including the Congressional Fire Services Institute, National Fire Protection Association, and the International Association of Firefighters and Fire Chiefs, among others. With the tools this bill provides, I am confident the USFA will continue to be recognized as the preeminent authority in fire education and fire prevention. I urge my colleagues to support this critical legislation.

Mr. HOYER. Madam Speaker, I am pleased to support S. 1152, bipartisan legislation to reauthorize the important work done by U.S. Fire Administration R. David Paulison and his dedicated staff in Emmittsburg, MD and Washington, DC.

The Federal Fire Prevention and Control Act of 1974 established the United States Fire Administration and its National Fire Academy to reduce life and economic losses due to fire and related emergencies, through leadership, advocacy, coordination and support.

Since that time, through data collection, public education, research ad training efforts, USFA has helped reduce fire deaths by at least half—making our communities and our citizens safer. For the past three years, the Fire Administrator has been tasked with administering the Assistance to Firefighters Grant program, created by Congress to adequately train and equip our career and volunteer firefighters across the country.

This $750 million program is vital to our firefighters, too many of whom risk their lives on a daily basis to protect our homes and our families without the modern equipment and advanced training they deserve. The Fire Grant program has succeeded at getting much-needed dollars to fire departments in fair, efficient manner, and USFA has been widely praised for its work in administering the program.

Authority for the Fire Grant program has now been moved to the Department of Homeland Security, and Members of the Fire Caucus, and all supporters of the fire community, will closely monitor the administration of the Grant program to guarantee that it continues to meet the needs of our fire departments.

Madam Speaker, this legislation also contains provisions important to the National Fallen Firefighters Foundations, which was established more than a decade ago through the leadership of Senator PAUL SARBANES to create an organization that would properly honor all of America's fallen fire heroes—and take care of the surviving families and loved ones as they cope with their grief and attempt to move on after their loss.

The Foundation carries out this mission with great compassion and dedication, and they have achieved a tremendous record of assisting the families of our fallen firefighters through the many programs, projects and activities they promote throughout the year. The provisions included in this legislation will allow the Foundation to continue, and to improve upon, the important work we have charged them to do.

Mr. Speaker, I am pleased to support this legislation, and urge my colleagues to do the same.

Ms. EDDIE BERNICE JOHNSON of Texas. Madam Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. BOEHLERT. Madam Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore (Mrs. BIGGERT). The question is on the motion offered by the gentleman from New York (Mr. BOEHLERT) that the House suspend the rules and pass the Senate bill, S. 1152.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the Senate bill was passed.

A motion to reconsider was laid on the table.

CONDEMNING TERRORIST ATTACKS IN ISTANBUL, TURKEY, ON NOVEMBER 15, 2003

Mr. SMITH of New Jersey. Madam Speaker, I move to suspend the rules and agree to the resolution (H. Res. 453) condemning the terrorist attacks in Istanbul, Turkey, on November 15, 2003, expressing condolences to the families of the individuals murdered and expressing sympathies to the individuals injured in the terrorist attacks, and standing in solidarity with Turkey in the fight against terrorism, as amended.

The Clerk read as follows:

Whereas in Istanbul, Turkey, on November 15, 2003, two explosions, set off minutes apart during Sabbath morning services, devastated Neve Shalom, the city's largest synagogue, and the Beth Israel Synagogue, about three miles away;

Whereas more than 20 people, both Muslims and Jews, were killed, and more than 300 people, both Muslims and Jews, were wounded, in the bombing attacks on the synagogues;

Whereas on November 20, 2003, two bombs exploded at the Consulate of the United Kingdom in Istanbul and at the HSBC Bank;

Whereas among the more than 25 killed and 450 wounded in the November 20 bombing attacks on the consulate general and commercial buildings were Muslims and Christians—Turks, British diplomats, and visitors to the Turkish Republic;

Whereas the United Kingdom is an ally of the United States and Turkey in the global war on terrorism;

Whereas the acts of murder committed on November 15 and 20, 2003, in Istanbul, Turkey, were cowardly and brutal manifestations of international terrorism;

Whereas the Government of Turkey immediately condemned the terrorist attacks in the strongest possible terms and has vowed to bring the perpetrators to just at all costs;

Whereas the United States, the United Kingdom, and Turkey equally abhor and denounce these hateful, repugnant, and loathsome acts of terrorism;

Whereas with anti-Semitic activities escalating the safety and security of Jewish people throughout the world is a matter of serious concern;

Whereas since Turkey cherishes its traditions of hospitality and religious tolerance and in particular its history of more than five hundred years of good Jewish-Muslim relations, the attacks on synagogues and consular premises came as a special shock to the Turkish people and to their friends throughout the world;

Whereas the United States and turkey are allied by shared values and a common interest in building a stable, peaceful, and prosperous world;

Whereas Turkey, a predominantly Muslim nation with a secular government, has close relations with Israel and is also the only predominantly Muslim member of the North Atlantic Treaty Organization; and

Whereas as the acts of murder committed on November 15 and 20, 2003 show again that terrorism respects neither boundaries nor borders:

Now, therefore, be it *Resolved*, That the House of Representatives

(1) condemns in the strongest possible terms the terrorist attacks in Istanbul, Turkey, on November 15 and 20, 2003;

(2) expresses its condolences to the families of the individuals murdered in the terrorist attacks, expresses its sympathies to the individuals injured in the attacks, and conveys its hope for the rapid and complete recovery of all such injured individuals;

(3) expresses its condolences to the people and government of the Turkish Republic and of the United Kingdom over the losses they have suffered; and

(4) expresses its solidarity with the United Kingdom, the Turkish republic, and all other countries which stand united against terrorism and which work together to bring to justice the perpetrators of these and other terrorist attacks.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New Jersey (Mr. SMITH) and the gentleman from California (Mr. LANTOS) each will control 20 minutes.

The Chair recognizes the gentleman from New Jersey (Mr. SMITH).

GENERAL LEAVE

Mr. SMITH of New Jersey. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and to include extraneous material on the resolution under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

Mr. SMITH of New Jersey. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, the resolution before us condemns the terrorist attacks in Istanbul last Saturday as well as yesterday morning. I want to thank the gentleman from Florida (Mr. HASTINGS), my friend, for proffering this resolution and for the prompt consideration that is being given to it by our leadership in scheduling it very quickly before the body today.

This resolution conveys our deepest and heartfelt sympathy to the victims and their families and states that the United States stands in solidarity with the Turkish people in the fight against terrorism. These attacks, Madam Speaker, bear all the hallmarks of al Qaeda, and that terrorist group has claimed responsibility for these cruel and cowardly acts.

This demonstrates, once again, that the target of global terrorists is not just the United States of America, but all those who reject their hateful vision of a clash of civilizations and governments by religious extremism.

I thought President Bush in the United Kingdom the other day said it so well when he said, "I want to express my deep sympathy for the loss of life in Turkey. The nature of the terrorist enemy is evident once again. We see their contempt, their utter contempt, for innocent life. They hate freedom," the President went on. "They hate free nations. Today, once again, we saw their ambitions of murder. The cruelty is part of their strategy. The terrorists hope to intimidate; they hope to demoralize. They particularly want to intimidate and demoralize free nations. They're not going to succeed."

Madam Speaker, despite some significant human rights issues, and no one has been more of a critic of Turkey than I have in the past, although they are making some progress, despite all of that, Turkey remains one of the few successful democracies in the Muslim world, with a tradition of religious tolerance. The Turkish Republic is an example of how a predominantly Muslim country can enjoy a secular, democratic government. Turkey has shown that the Islamic faith of its citizens and a secular democracy can flourish side by side.

By targeting synagogues and Turkish citizens of the Jewish faith on Saturday, the terrorists attacked the notion that Muslims can live in peace and harmony with other faiths. It was a profoundly anti-Semitic act. The terrorists know that the successful example of Turkey lays bear the emptiness of their own hateful vision. It is working in Turkey, and yet now they are trying to give a different impression to the world.

By targeting the British Consulate General and a leading British bank, these terrorists viciously illustrated that all of our allies and their targets must remain united with our allies in the fight against terrorism.

Madam Speaker, these contemptible acts killed almost 50 people, including the British Consul General in Istanbul, and injured more than 750 innocent people. Our deepest condolences go out to their families and to their nations.

Turkey has been a strong American ally, as we all know, the underbelly of NATO for more than 50 years. By agreeing to this resolution, we affirm our mutual commitment to that common defense.

I would remind my colleagues that after the September 11 of 2001 attacks, NATO invoked its collective defense clause, declaring that the al Qaeda attacks in the United States were attacks against the entire alliance.

□ 1200

I thought British Prime Minister Tony Blair summed it up very well when he said, "And when they say is this an attack directed against our alliance, indeed, it is directed against anybody who stands in the way of that fanaticism" he went on to say, "That is why our response has got to be to say to them as clearly as we possibly can, you are not going to defeat us because our will to defend what we believe is, in actuality, and in the end, stronger, better, more determined than your will to inflict damage on innocent people."

Madam Speaker, let me conclude by saying this: Turkey and the United Kingdom both played important roles to drive al Qaeda from its base in Afghanistan and to replace the Taliban government that harbored those terrorists. They were the first two countries to command the International Security Assistance Force, which has stabilized the Kabul region and supported the Karzai government. Turkey and the United Kingdom stood by the United States when our Nation was the target of global terrorism. By passing this timely resolution today in a bipartisan way, Democrats, Republicans, moderates, liberals and conservatives, we affirm our determination to stand by our longtime allies and to defeat the terrorists who bear the guilt for these highly reprehensible acts.

Madam Speaker, I reserve the balance of my time.

Mr. LANTOS. Madam Speaker, I yield myself such time as I may consume. I am strongly in support of this resolution.

First, let me pay tribute to my dear friend, the gentleman from Florida (Mr. HASTINGS), for initiating this important legislation and to recognize the contributions of my friends, the gentleman from Florida (Mr. WEXLER) and the gentleman from New Jersey (Mr. SMITH). I particularly want to thank the gentleman from Illinois (Chairman HYDE) for being so gracious late yesterday afternoon in expediting the handling of this legislation.

Madam Speaker, at least 50 people are dead and over 700 are injured in a sickening and appalling wave of suicide bombings in Istanbul over this past week. The attacks targeted Jewish places of worship and British governmental and business institutions; but the overwhelming majority of the victims are Muslim Turks, proof positive of the total cynicism and utter phoniness of these so-called Islamist assassins.

This is not just a war on the Jews, though it is also that. It is not just a war on the British or on our own country, although it is that. It is a war on the entire civilized and democratic world and its values. It is now clear that al Qaeda and its Turkish supporters have declared war on the democratic Republic of Turkey as part of that overall assault. Al Qaeda recognizes that the existence of Turkey, 99 percent Muslim, pro-Western, a secular democracy on the frontiers of the Western world, makes a mockery of al Qaeda's religious extremism. These terrorists want to roll back Western values by destabilizing and destroying Turkish democracy.

Madam Speaker, the Turkish Government has behaved admirably in this dark hour. It condemned the action and it vowed to catch the perpetrators, and I have no doubt that they shall. Now, the hard work of finding these terrorists, destroying their cells, and preventing future attacks begins.

The Turkish Government and the Turkish people should know that the American people will be steadfast in our support of them in this dark hour. All civilized nations must do likewise. The Turkish Interior Minister is correct to dismiss what he calls the crocodile tears of those who express condolences, but do nothing to fight terrorism.

Madam Speaker, we mourn the deaths, we pray for the wounded, and our hearts go out to the families of all of the victims. And to all the citizens of Istanbul and all of Turkey whose lives have been so brutally violated, let us honor them by joining with Turkey and with all who believe in freedom to fight the extremist criminals who want to end our way of life. They will fail and we shall prevail. I strongly support this resolution, and I urge all of my colleagues to do likewise.

Madam Speaker, I am delighted to yield 6 minutes to the distinguished gentleman from Florida (Mr. HASTINGS), my good friend and the author of this resolution.

Mr. HASTINGS of Florida. Madam Speaker, I want to begin by thanking my good friend of long-standing here in the House of Representatives and a vigorous fighter for human rights and the protector of the rights of people who are set upon as this despicable act has done. I would also like to thank the gentleman from New Jersey (Mr. SMITH), my friend, and have him to know that I, along with him, am deeply saddened because so many of our colleagues that we serve with in the Organization for Security and Cooperation in Europe were affected. I have contacted Bruce George, our President's office from the U.K., and Dr. Yaleintas, or Professor Yaleintas, and expressed our condolences to them.

Most importantly, I would like to thank the gentleman from Illinois (Chairman HYDE), as the gentleman from California (Mr. LANTOS) has already, for expediting this matter for us and giving us an opportunity to go to the majority leader and the minority leader; and I thank them for expediting this process. The majority leader's office has been extremely helpful in that regard.

It would be remiss of me if I did not take this opportunity to commend the gentleman from Florida (Mr. WEXLER), who is my good friend and my soulmate geographically in Florida, as well as in our friendship; the gentlewoman from Texas (Ms. GRANGER) and the gentleman from Kentucky (Mr. WHITFIELD) from the majority side, my good friends that I have gotten to know through our efforts, not only in this resolution, but others; and also the gentlewoman from Nevada (Ms. BERKLEY); and countless others who have had direct involvement.

I had the good fortune less than 2 months ago to travel to Turkey with Brent Scowcroft, and it was the most illuminating and enlightening experience. It was not my first visit to Turkey; I have been there now a total of seven times.

On November 15, 2003, two explosions set off minutes apart devastated Nev Shalom Synagogue, Istanbul's largest synagogue and symbolic center to the city's 25,000-member Jewish community, and the Beth Israel Synagogue about 3 miles away. In addition, yesterday, explosions hit the Turkish headquarters of the London-based HSBC Bank and the British Consulate General, killing at least 26 people, including Roger Short, someone that I knew and the British Consul-General, and wounding over 450.

In the span of 5 days, terror claimed over 50 lives and injured more than 800 people in Turkey.

The House of Representatives gathers here today united in expressing that we abhor and denounce these hateful, repugnant, and loathsome acts of terrorism. We gather here to, in unison, make sure that the world understands our outrage by this week's attacks.

The United States is determined to stand by Turkey in the fight against the scourge of terrorism. The acts of murder committed in Istanbul were a cowardly and brutal manifestation of the moral vacuum directing the disease of international terrorism. My and all of our heartfelt condolences go out to the victims and their families.

Madam Speaker, the United States and Turkey are natural allies based on our shared values and common interests in building a stable, peaceful, and prosperous world. Moreover, as a predominantly Muslim nation with a secular government, Turkey is an example, as the gentleman from New Jersey (Mr. SMITH) has pointed out, of a successful secular Muslim democracy. Turkey is a pivotal showcase of the Muslim world that fundamentalists hate. Turkey is an ally of the United States and a friend of Israel and is NATO's only predominantly Muslim member. It has supported the war against terrorism, commandeering and offering peacekeeping forces in Afghanistan and offering peacekeepers for Iraq.

Terrorism respects neither boundaries nor borders. Instead, it intends to harm every nation that respects democracy, freedom, equality, and the rule of law.

These acts further demonstrate that the war on terrorism is not a war between civilizations. The attacks in Turkey were perpetrated by Muslim terrorists against a predominantly Muslim nation. They suggest that this is not a religious war, but one that is based on politics, culture, and our way of life.

Madam Speaker, I conclude by once again denouncing these vial, anti-Semitic, and anti-Muslim attacks against men, women, and children and expressing my sympathies to the individuals and families of the victims. I urge my colleagues to support this resolution.

Mr. SMITH of New Jersey. Madam Speaker, I yield such time as he may consume to the gentleman from Kentucky (Mr. WHITFIELD), my good friend and colleague.

Mr. WHITFIELD. Madam Speaker, I think it is certainly appropriate that we at this time are speaking about the nation of Turkey. As the gentleman from Florida so eloquently stated, Turkey has been a loyal ally of the U.S., a member of NATO, a Muslim secular country that is a great model for a Muslim democracy. Turkey has played a vital role and I think can play a much more vital role in helping with peace in the Middle East. They have a great relationship with the country of Israel. They have a large Jewish population and, as I said earlier, it is a 99 percent Muslim country.

We all abhor violence of any kind, and these acts of terrorism that seem to become more frequent throughout the world are causing all of us great heartache: the families that are involved, the suffering that is involved, the senselessness of the acts.

So I stand here today simply to express my condolences to the families in Turkey, to the nation of Turkey, and remind the American people, once again, that Turkey is a valuable and important ally of the United States. We have common interests, and I am quite confident that our nations will continue to work for peace in the Middle East and, by acts of goodness and kindness, will eventually be able to overcome these random acts of violence, this planned terrorism around the world.

Mr. LANTOS. Madam Speaker, I am very pleased to yield 3 minutes to the gentlewoman from Nevada (Ms. BERKLEY), a distinguished member of the Committee on International Relations and a steadfast fighter against global terrorism.

Ms. BERKLEY. Madam Speaker, I would like to thank the gentleman from California (Mr. LANTOS) for giving me the opportunity to speak and share my thoughts with my colleagues, and the gentleman from New Jersey (Mr. SMITH) for being stellar on this issue.

I rise today, Madam Speaker, in strong support of House Resolution 453, condemning the terrorist attacks in Istanbul, Turkey, on November 15 of this year and expressing my sincerest condolences to the victims and their families.

□ 1215

This past Saturday, as they gathered together to observe the holy Sabbath, two explosions devastated the Jewish community in Istanbul, Turkey. The first occurred at the city's largest synagogue and symbolic center to the city's 25,000-member Jewish community and the second at Beth Israel synagogue about three miles away.

More than 20 people lost their lives and more than 300 were injured as terrorism, yet again, tore the fabric of civilized society and shattered innocent lives. Most of those killed in the blasts, ironically, were Muslim Turks who lived or worked near the synagogues who were passing by when the bombs exploded. This is not the first time that al-Qaeda has targeted the Jewish institutions. In 2002, they killed 12 people in an attack at a synagogue in Tunisia.

The Turkish Government immediately condemned the terrorist attacks in the strongest possible terms and I am pleased that the Turkish people have reacted in strong solidarity with the Nation's small and long-established Jewish community.

Madam Speaker, as a youngster growing up in Las Vegas, I belonged to the Jewish youth groups, and occasionally the Anti-Defamation League would bring in films of the liberation of the concentration camps in World War II. I cannot minimize the impact of those films and their impact on my life then and now. And I would sit there and watch the films and ask myself how could one human being do such a horrific thing to another, and how is it that more people throughout the world did not stand up and vilify this horrific act.

I am here in the United States of America because my grandparents walked across Europe in order to come to this country to escape the persecution that 6 million of my fellow Jews were unable to escape in World War II. For me to have the opportunity to be on the floor of the House of Representatives and not condemn this horrific act of terrorism would be a shame and an insult to not only the 20 people that lost their lives recently in Istanbul, but the millions of other people across the world, Jewish and not Jewish, who have lost their lives senselessly and needlessly to terrorists.

I call upon my colleagues to join us, and vote for this resolution taking a strong stance against bigotry and intolerance, racism and anti-Semitism, violence and terrorism. These are very difficult and challenging times that we are living through. But it is incumbent upon all Americans, we in the House of Representatives leading the way, to stand up and condemn this sort of activity before it becomes pervasive and matter of fact.

Mr. LANTOS. Madam Speaker, I yield 3 minutes to the gentleman from Florida (Mr. WEXLER), my good friend, a distinguished member of the Committee on International Relations.

Mr. WEXLER. Madam Speaker, I want to also thank my good friend and close associate, the gentleman from Florida (Mr. HASTINGS), and my colleagues on the Congressional Turkey Caucus for initiating this vitally important resolution condemning the horrific terrorist attacks in Turkey over the past week. I also want to thank the gentleman from Illinois (Chairman HYDE), the gentleman from California (Ranking Member LANTOS), the gentleman from New Jersey (Mr. SMITH), for especially expeditiously bringing this very important resolution to the Floor.

I rise to express my most profound and heartfelt condolences to the Turkish people and to the Turkish Government on the terrorist attacks in Istanbul and pledge the support of each Member of Congress as we listen to this debate in the full Congress to bring to justice those individuals responsible for these heinous acts. Americans know all too well the horrors of terror, and today we mourn with the Turkish and British people for this senseless loss of life.

Madam Speaker, the recent bombings in Turkey epitomize the fact that terrorism knows no boundaries and does not distinguish between religion, nation or culture. What these attacks demonstrate the common thread of terror facing the United States, Turkey, and our allies throughout the world. They also serve as a solemn reminder of our Nation's shared principles of democracy, freedom, tolerance, and the pursuit of peace.

For over 50 years Turkey has stood shoulder to shoulder with the United States as a valued strategic partner, Nato ally, and friend. It is in this same spirit of partnership that the United States and the American people stand today with the Turkish people, ready to assist in punishing those murderers who carried out these cowardly actions. Together we will continue our pursuit of justice so that we may ensure that all victims of terror, whether in Turkey, the United States or elsewhere throughout the world, will not have died in vain.

As the gentleman from Florida (Mr. HASTINGS) stated earlier, I too have had the privilege of visiting Turkey on many occasions. The Turkish people are a warm and caring people. They have great national pride, they are patriots. That will continue. And we, the American people, must continue to assist them in their pursuit of terrorism within their boundaries.

Mr. LANTOS. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, before yielding back our time, I would merely like to mention that a number of us coming back from Baghdad were in Ankara, Turkey's capital, just a couple of weeks ago. We had a lengthy and significant discussion with the distinguished Foreign Minister of Turkey. We reaffirmed, as did our Turkish counterparts, our firm commitment to fight terrorism globally. These tragic events in Istanbul since our visit to Ankara underscore the urgency and the importance of our stand. I call on all of our colleagues to support this very important resolution.

Mr. BEREUTER. Madam Speaker, this Member, as a cosponsor of the resolution and a committed friend of the Turkish people, rises in strong support of H. Res. 453. This Member would like to thank the distinguished gentleman from Florida (Mr. HASTINGS) for introducing this very timely resolution. Mr. HASTINGS has worked closely with Members and staff of the Committee on International Relations and its Europe Subcommittee—including the distinguished ranking members of the full committee and subcommittee, Mr. LANTOS and Mr. WEXLER—to craft the resolution that is before us this morning.

This Member would also like to thank the distinguished gentleman from New Jersey (Mr. SMITH) for his leadership on this issue and his very thoughtful remarks. Mr. SMITH is the leader of the U.S. delegation to the Parliamentary Assembly of the Organization for Security and Cooperation in Europe, and Mr. HASTINGS is an active member of that delegation, and this Member commends them for their work.

Madam Speaker, this Member serves as President of the NATO Parliamentary Assembly (NATO PA) and Chairman of the House Delegation. Though such assemblies, Members get to know their counterparts from other nations first-hand and to visit these nations to understand more about these lands and their people.

This Member already has written to Mr. Vahit Erdem, the chairman of the Turkish delegation, expressing our deepest sympathies to the Turkish parliament and the Turkish people, particularly the families of the victims.

One year ago, the NATO PA met in Istanbul, in a conference center overlooking the Bosporus straits, separating Europe from Asia. From our hotel rooms, we could look south to see the Taksim neighborhood that was devastated by the bombing of the British Consulate General yesterday. Indeed, several of us had the opportunity at night to stroll the busy, historic streets of that district.

As we discussed the key issues in the transAtlantic relationship, we also had an opportunity to experience the great city of Istanbul, one of the most historically important cities in the world. Istanbul literally lies between Europe and Asia, the only city in the world on two continents, and its history is that of a bridge between east and west.

The reprehensible terrorist attacks of last Saturday, directed against Turks of the Jewish faith, were an attempt to directly assault the religious tolerance that has been a hallmark of the Turkish Republic. Yesterday's attacks, against the British Consulate and a British bank, were an attack on the strong ties between Turkey and its allies in Europe and in North America and on the long and extraordinary transAtlantic relationship between the United Kingdom and the United States of America by further inflaming the British critics of the Iraq war and our transAtlantic relationship.

Sadly, they remind us that international terrorism remains a grave threat to all nations of the North Atlantic Alliance. Two years ago, when NATO invoked Article 5 of the North Atlantic Treaty, both Turkey and the United Kingdom showed that they were prepared to play a leading role in the war against terrorism, both alternatively taking the command of the International Security Assistance Force in Afghanistan. We remember their clear and strongly anti-terrorism, pro-American response to the al-Qaeda attacks on the United States, and in this resolution today, we pledge our support to Turkey in response to this latest terrorist atrocity.

NATO already has declared that the September 11, 2001, attacks by al Qaeda constituted an attack on the entire Alliance. Likewise, these attacks on an ally are an attack on all allies. Article 5 has already been invoked against al Qaeda. As a result NATO today is in Afghanistan, working to defeat that terrorist organization and their Taliban allies.

In the words of Lord Robertson, the NATO secretary general: "If we fail, we will find Afghanistan on all of our doorsteps. Worse still, NATO's credibility will be shattered, along with that of every NATO government. Who will stand with us in the war against terror if we take on a commitment such as this and then fail to deliver?"

The bombings in Istanbul are a vicious reminder of the stakes in the global war on terrorism and the need to ensure that Afghanistan never again becomes a haven for those who seek to murder our people and destroy our societies. We all must provide the resources needed to win this war and protect our citizens.

Madam Speaker, in closing, this Member urges his colleague to pass this resolution.

Mr. ORTIZ. Madam Speaker, I rise to offer my condolences to the Turkish people and the Turkish government for the horrific terrorist attacks in Istanbul on November 15 and 20.

As al Qaeda has proved again and again, they intend to fight this 21st Century's first global war against civilians and non-combatants. As we have proved again and again, we will fight this war wherever it flares up. And we will win, because we have the fortitude to do the right thing.

Turkey is one of our strongest allies in the fight on global terrorism—and has repeatedly stood by our side in NATO matters (as a NATO ally) and in the war on terror, in understated ways. I have a number of friends and people we know there, that I met on numerous House Armed Services Committee trips to visit NATO allies.

All South Texans condemn the cowardly and senseless killing of innocent people in Turkey, one of the finest examples of a democracy in practice, and one of the few Muslim nations to practice democracy.

We have shared principles of democracy, freedom, tolerance and the pursuit of peace—and today we stand with our Turkish friends. Those who opposed democracy will eventually learn that to kill democracy is to kill all those who love democracy. Al Qaeda doesn't have enough bombs to kill all those who love democratic principals around the world.

My family and I are praying for the families and victims injured and perished in this atrocity.

The United States Congress hereby offers our judgment that this attack was cowardly, and we stand with our Turkish friends in this hour of great loss.

Mr. POMEROY. Madam Speaker, I rise today in support of this resolution condemning the terrorist attacks in Istanbul, Turkey on November 15 and 20, 2003. I wish to express my most sincere and heartfelt condolences to the Turkish government and the relatives of those killed or injured. My thoughts are with Turkey and its people in this time of sorrow.

If there is one thing these cowardly acts have demonstrated, it is that terrorism knows no borders. These catastrophic attacks were not just an attack on Turkey, but an attack on humanity and civilization. As Americans who have experienced terrorism firsthand, we share in Turkey's grief.

I am convinced that the United States must stand shoulder to shoulder with Turkey as it defends its safety and protects its liberty by bringing to justice those responsible for these heinous acts. Together, we must stand ready to provide any assistance deemed necessary to ensure that justice is served—not solely to account for the lives taken and injuries inflicted against the Turkish people, but in defense of freedom around the world.

In the end, Madam Speaker, these tragedies will be remembered as a time of incredible loss and sadness. But it will also mark a time when America and Turkey came even closer together to respond to global terrorism. We are united today as never to ensure that terrorism is defeated, completely and finally.

Mr. BURTON of Indiana. Madam Speaker, today I come to the House floor in strong support of H. Res. 453, a House resolution condemning the terrorist attacks in Istanbul, Turkey and expressing condolences to the families of the individuals murdered.

On November 15 and 20, four horrific terrorist attacks rocked Istanbul. Two Jewish synagogues, the British Consulate and the London-based HSBC bank were the targets. Faceless, cowardly terrorists who thrive on inflicting fear and terror on the innocent carried out these attacks. These recent attacks epitomize the fact that terrorism knows no boundaries and does not distinguish between religion, nationality or culture.

Terrorism must be condemned in the strongest terms whenever and wherever it occurs. The Government of Turkey appropriately did so and has vowed to bring the perpetrators to justice. But, no one country can do this alone. In order for the perpetrators of terrorism to be brought to justice, all the countries of the world must stand united against terrorism that targets the civilized world.

For over fifty years, Turkey has stood shoulder-to-shoulder with the U.S. as one of our most valued strategic partners and it is only fitting that Congress express sympathy for those murdered and wounded, extend condolences to the bereaved families and affirm our unity with Turkey in the ongoing fight against terror. I am pleased that the House Leadership scheduled H. Res. 453 for floor action today.

Mr. ROTHMAN. Madam Speaker, I rise today to express my sorrow and rage over the Saturday bombings of the Neve Shalom and Beth Israel synagogues and the Thursday bombings of the British Consulate and HSBC Bank in Istanbul, Turkey. Tragically, 51 innocent victims of the War on Terror have died in Turkey this week and over 750 were wounded. These victims died or were wounded simply because they gathered to pray on a Saturday morning in honor of Shabbat, the Jewish day of reflection and rest, or were going about their normal daily lives in Istanbul.

Turkish officials have identified the bombers of the Neve Shalom and Beth Israel synagogues as Turkish militants, with possible connections to al Qaeda, who loaded bombs, each with about 500 pounds of ammonium sulfate, nitrate, and fuel oil, into trucks they pulled in front of the synagogues and detonated nearly simultaneously. Among those who died were 6 Jews and 17 Muslims—each buried near the remains of the 22 victims killed in a 1986 bombing at Neve Shalom. Initial reports indicate that truck bombs were also used in the terrorist attacks against the British Consulate and London based HSBC Holdings, which killed at least 27 and wounded over 450 people.

Madam Speaker, approximately 30,000 Jews live in Turkey—a 99.8% Muslim nation. For years Jews have lived peacefully and freely and have in fact thrived in a predominately Muslim nation. Much of this is due to Turkey's historically good treatment of its Jewish residents—dating back to the early influx of Jews during the Spanish Inquisition and later to Turkey's refusal to deport and exterminate its Jewish population during the Holocaust despite its longstanding relationship with Germany. Today, a benevolent relationship has grown between the Turkish and Israeli governments who share close ties and hold joint military exercises.

The attacks in Turkey this week aim to undermine the relationship between Turkey, the U.S., and Britain, and highlight the growing resurgence of al Qaeda and its worldwide network. The attacks in Turkey follow the suspected hand of al Qaeda in incidents in Saudi Arabia, Indonesia, and Morocco. The attacks on Thursday also highlight the fact that Turkey is a secular Muslim country that leans West through its business dealings, culture, and government affairs. The terrorists are determined to undermine the links between Turkey and the Western world.

Madam Speaker, as fighting has flared up in Iraq and al Qaeda has again regrouped and gained strength, and as President Bush returns from his trip to England while Israel and the Palestinian Authority tentatively reach out to each other in hopes of a cease fire and peace, now is not the time to turn our backs on the War on Terror. Now is the time to stand together with our friends and allies around the world as we all mourn those who died in Turkey this past week and those we have lost to terror attacks in the past, while jointly taking a stand to continue to fight for our survival in our war of self-defense against these madmen. We must work to ensure that all our allies help us root out terror at its source by sharing intelligence, auditing finances and doing whatever else is necessary in the hopes that like the Jews and Muslims have done for years in Turkey: we can all live together in peace.

Mr. LANTOS. Madam Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. SMITH of New Jersey. Madam Speaker, I have no further requests for time, and I yield back the balance of my time.

The SPEAKER pro tempore (Mrs. BIGGERT). The question is on the motion offered by the gentleman from New Jersey (Mr. SMITH) that the House suspend the rules and agree to the resolution, H. Res. 453, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. SMITH of New Jersey. Madam Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

VETERANS HEALTH CARE, CAPITAL ASSET, AND BUSINESS IMPROVEMENT ACT OF 2003

Mr. SMITH of New Jersey. Madam Speaker, I move to suspend the rules and pass the Senate bill (S. 1156) to amend title 38, United States Code, to improve and enhance provision of health care for veterans, to authorize major construction projects and other facilities matters for the Department of Veterans Affairs, to enhance and improve authorities relating to the administration of personnel of the Department of Veterans Affairs, and for other purposes.

The Clerk read as follows:

S. 1156

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Veterans Health Care, Capital Asset, and Business Improvement Act of 2003".

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. References to title 38, United States Code.

TITLE I—HEALTH CARE AUTHORITIES AND RELATED MATTERS

Sec. 101. Improved benefits for former prisoners of war.
Sec. 102. Provision of health care to veterans who participated in certain Department of Defense chemical and biological warfare testing.
Sec. 103. Eligibility for Department of Veterans Affairs health care for certain Filipino World War II veterans residing in the United States.
Sec. 104. Enhancement of rehabilitative services.
Sec. 105. Enhanced agreement authority for provision of nursing home care and adult day health care in contract facilities.
Sec. 106. Five-year extension of period for provision of noninstitutional extended-care services and required nursing home care.
Sec. 107. Expansion of Department of Veterans Affairs pilot program on assisted living for veterans.
Sec. 108. Improvement of program for provision of specialized mental health services to veterans.

TITLE II—CONSTRUCTION AND FACILITIES MATTERS

Subtitle A—Program Authorities

Sec. 201. Increase in threshold for major medical facility construction projects.
Sec. 202. Enhancements to enhanced-use lease authority.
Sec. 203. Simplification of annual report on long-range health planning.

Subtitle B—Project Authorizations

Sec. 211. Authorization of major medical facility projects.
Sec. 212. Authorization of major medical facility leases.
Sec. 213. Advance planning authorizations.
Sec. 214. Authorization of appropriations.

Subtitle C—Capital Asset Realignment for Enhanced Services Initiative

Sec. 221. Authorization of major construction projects in connection with Capital Asset Realignment Initiative.
Sec. 222. Advance notification of capital asset realignment actions.
Sec. 223. Sense of Congress and report on access to health care for veterans in rural areas.

Subtitle D—Plans for New Facilities

Sec. 231. Plans for facilities in specified areas.
Sec. 232. Study and report on feasibility of coordination of veterans health care services in South Carolina with new university medical center.

Subtitle E—Designation of Facilities

Sec. 241. Designation of Department of Veterans Affairs medical center, Prescott, Arizona, as the Bob Stump Department of Veterans Affairs Medical Center.
Sec. 242. Designation of Department of Veterans Affairs health care facility, Chicago, Illinois, as the Jesse Brown Department of Veterans Affairs Medical Center.
Sec. 243. Designation of Department of Veterans Affairs medical center, Houston, Texas, as the Michael E. DeBakey Department of Veterans Affairs Medical Center.
Sec. 244. Designation of Department of Veterans Affairs medical center, Salt Lake City, Utah, as the George E. Wahlen Department of Veterans Affairs Medical Center.
Sec. 245. Designation of Department of Veterans Affairs outpatient clinic, New London, Connecticut.
Sec. 246. Designation of Department of Veterans Affairs outpatient clinic, Horsham, Pennsylvania.

TITLE III—PERSONNEL MATTERS

Sec. 301. Modification of certain authorities on appointment and promotion of personnel in the Veterans Health Administration.
Sec. 302. Appointment of chiropractors in the Veterans Health Administration.
Sec. 303. Additional pay for Saturday tours of duty for additional health care workers in the Veterans Health Administration.
Sec. 304. Coverage of employees of Veterans' Canteen Service under additional employment laws.

TITLE IV—OTHER MATTERS

Sec. 401. Office of Research Oversight in Veterans Health Administration.
Sec. 402. Enhancement of authorities relating to nonprofit research corporations.
Sec. 403. Department of Defense participation in Revolving Supply Fund purchases.
Sec. 404. Five-year extension of housing assistance for homeless veterans.
Sec. 405. Report date changes.

SEC. 2. REFERENCES TO TITLE 38, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

TITLE I—HEALTH CARE AUTHORITIES AND RELATED MATTERS

SEC. 101. IMPROVED BENEFITS FOR FORMER PRISONERS OF WAR.

(a) OUTPATIENT DENTAL CARE FOR ALL FORMER PRISONERS OF WAR.—Section 1712(a)(1)(F) is amended by striking "and who was detained or interned for a period of not less than 90 days".

(b) EXEMPTION FROM PHARMACY COPAYMENT REQUIREMENT.—Section 1722A(a)(3) is amended—

(1) by striking "or" at the end of subparagraph (A);

(2) by redesignating subparagraph (B) as subparagraph (C); and

(3) by inserting after subparagraph (A) the following new subparagraph (B):

"(B) to a veteran who is a former prisoner of war; or".

SEC. 102. PROVISION OF HEALTH CARE TO VETERANS WHO PARTICIPATED IN CERTAIN DEPARTMENT OF DEFENSE CHEMICAL AND BIOLOGICAL WARFARE TESTING.

Section 1710(e) is amended—

(1) in paragraph (1), by adding at the end the following new subparagraph:

"(E) Subject to paragraphs (2) and (3), a veteran who participated in a test conducted by the Department of Defense Deseret Test Center as part of a program for chemical and biological warfare testing from 1962 through 1973 (including the program designated as

'Project Shipboard Hazard and Defense (SHAD)' and related land-based tests) is eligible for hospital care, medical services, and nursing home care under subsection (a)(2)(F) for any illness, notwithstanding that there is insufficient medical evidence to conclude that such illness is attributable to such testing.";

(2) in paragraph (2)(B)—

(i) by striking out "paragraph (1)(C) or (1)(D)" and inserting "subparagraph (C), (D), or (E) of paragraph (1)"; and

(ii) by striking "service described in that paragraph" and inserting "service or testing described in such subparagraph"; and

(3) in paragraph (3)—

(A) by striking "and" at the end of subparagraph (B);

(B) by striking the period at the end of subparagraph (C) and inserting "; and"; and

(C) by adding at the end the following new subparagraph:

"(D) in the case of care for a veteran described in paragraph (1)(E), after December 31, 2005.".

SEC. 103. ELIGIBILITY FOR DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE FOR CERTAIN FILIPINO WORLD WAR II VETERANS RESIDING IN THE UNITED STATES.

The text of section 1734 is amended to read as follows:

"(a) The Secretary shall furnish hospital and nursing home care and medical services to any individual described in subsection (b) in the same manner, and subject to the same terms and conditions, as apply to the furnishing of such care and services to individuals who are veterans as defined in section 101(2) of this title. Any disability of an individual described in subsection (b) that is a service-connected disability for purposes of this subchapter (as provided for under section 1735(2) of this title) shall be considered to be a service-connected disability for purposes of furnishing care and services under the preceding sentence.

"(b) Subsection (a) applies to any individual who is a Commonwealth Army veteran or new Philippine Scout and who—

"(1) is residing in the United States; and

"(2) is a citizen of the United States or an alien lawfully admitted to the United States for permanent residence.".

SEC. 104. ENHANCEMENT OF REHABILITATIVE SERVICES.

(a) Rehabilitative Services Through Medical Care Authority.—Section 1701(8) is amended by striking "(other than those types of vocational rehabilitation services provided under chapter 31 of this title)".

(b) Expansion of Authorized Rehabilitative Services.—(1) Section 1718 is amended—

(A) by redesignating subsections (d), (e), and (f) as subsections (e), (f), and (g), respectively; and

(B) by inserting after subsection (c) the following new subsection (d):

"(d) In providing to a veteran rehabilitative services under this chapter, the Secretary may furnish the veteran with the following:

"(1) Work skills training and development services.

"(2) Employment support services.

"(3) Job development and placement services.".

(2) Subsection (c) of such section is amended—

(A) in paragraph (1), by striking "subsection (b) of this section" and inserting "subsection (b) or (d)"; and

(B) in paragraph (2)—

(i) by striking "subsection (b) of this section" and inserting "subsection (b) or (d)"; and

(ii) by striking "paragraph (2) of such subsection" and inserting "subsection (b)(2)".

SEC. 105. ENHANCED AGREEMENT AUTHORITY FOR PROVISION OF NURSING HOME CARE AND ADULT DAY HEALTH CARE IN CONTRACT FACILITIES.

(a) Enhanced Authority.—Subsection (c) of section 1720 is amended—

(1) by designating the existing text as paragraph (2); and

(2) by inserting before paragraph (2), as so designated, the following new paragraph (1):

"(1)(A) In furnishing nursing home care, adult day health care, or other extended care services under this section, the Secretary may enter into agreements for furnishing such care or services with—

"(i) in the case of the medicare program, a provider of services that has entered into a provider agreement under section 1866(a) of the Social Security Act (42 U.S.C. 1395cc(a)); and

"(ii) in the case of the medicaid program, a provider participating under a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.).

"(B) In entering into an agreement under subparagraph (A) with a provider of services described in clause (i) of that subparagraph or a provider described in clause (ii) of that subparagraph, the Secretary may use the procedures available for entering into provider agreements under section 1866(a) of the Social Security Act.".

(b) Conforming Amendment.—Subsection (f)(1)(B) of such section is amended by inserting "or agreement" after "contract" each place it appears.

SEC. 106. FIVE-YEAR EXTENSION OF PERIOD FOR PROVISION OF NONINSTITUTIONAL EXTENDED-CARE SERVICES AND REQUIRED NURSING HOME CARE.

(a) Noninstitutional Extended Care Services.—Section 1701(10)(A) is amended by striking "the date of the enactment of the Veterans Millennium Health Care and Benefits Act and ending on December 31, 2003," and inserting "November 30, 1999, and ending on December 31, 2008,".

(b) Required Nursing Home Care.—Section 1710A(c) is amended by striking "December 31, 2003" and inserting "December 31, 2008".

SEC. 107. EXPANSION OF DEPARTMENT OF VETERANS AFFAIRS PILOT PROGRAM ON ASSISTED LIVING FOR VETERANS.

Section 103(b) of the Veterans Millennium Health Care and Benefits Act (Public Law 106–117; 113 Stat. 1552; 38 U.S.C. 1710B note) is amended—

(1) by striking "Location of Pilot Program.—" and inserting "Locations of Pilot Program.—(1)"; and

(2) by adding at the end the following new paragraph:

"(2)(A) In addition to the health care region of the Department selected for the pilot program under paragraph (1), the Secretary may also carry out the pilot program in not more than one additional designated health care region of the Department selected by the Secretary for purposes of this section.

"(B) Notwithstanding subsection (f), the authority of the Secretary to provide services under the pilot program in a health care region of the Department selected under subparagraph (A) shall cease on the date that is three years after the commencement of the provision of services under the pilot program in the health care region.".

SEC. 108. IMPROVEMENT OF PROGRAM FOR PROVISION OF SPECIALIZED MENTAL HEALTH SERVICES TO VETERANS.

(a) Increase in Funding.—Subsection (c) of section 116 of the Veterans Millennium Health Care and Benefits Act (Public Law 106–117; 113 Stat. 1559; 38 U.S.C. 1712A note) is amended—

(1) in paragraph (1), by striking "$15,000,000" and inserting "$25,000,000 in each of fiscal years 2004, 2005, and 2006";

(2) in paragraph (2), by striking "$15,000,000" and inserting "$25,000,000"; and

(3) in paragraph (3)—

(A) by inserting "(A)" after "(3)"; and

(B) by adding at the end the following new subparagraph:

"(B) For purposes of this paragraph, in fiscal years 2004, 2005, and 2006, the fiscal year used to determine the baseline amount shall be fiscal year 2003.".

(b) Allocation of Funds.—Subsection (d) of that section is amended—

(1) by striking "The Secretary" and inserting "(1) In each of fiscal years 2004, 2005, and 2006, the Secretary"; and

(2) by adding at the end the following new paragraphs:

"(2) In allocating funds to facilities in a fiscal year under paragraph (1), the Secretary shall ensure that—

"(A) not less than $10,000,000 is allocated by direct grants to programs that are identified by the Mental Health Strategic Health Care Group and the Committee on Care of Severely Chronically Mentally Ill Veterans;

"(B) not less than $5,000,000 is allocated for programs on post-traumatic stress disorder; and

"(C) not less than $5,000,000 is allocated for programs on substance use disorder.

"(3) The Secretary shall provide that the funds to be allocated under this section during each of fiscal years 2004, 2005, and 2006 are funds for a special purpose program for which funds are not allocated through the Veterans Equitable Resource Allocation system.".

TITLE II—CONSTRUCTION AND FACILITIES MATTERS

Subtitle A—Program Authorities

SEC. 201. INCREASE IN THRESHOLD FOR MAJOR MEDICAL FACILITY CONSTRUCTION PROJECTS.

Section 8104(a)(3)(A) is amended by striking "$4,000,000" and inserting "$7,000,000".

SEC. 202. ENHANCEMENTS TO ENHANCED-USE LEASE AUTHORITY.

(a) Notification of Property To Be Leased.—Section 8163 is amended—

(1) in the first sentence of subsection (a)—

(A) by striking "designate a property to be leased under an enhanced-use lease" and inserting "enter into an enhanced-use lease with respect to certain property"; and

(B) by striking "before making the designation" and inserting "before entering into the lease";

(2) in subsection (b), by striking "of the proposed designation" and inserting "to the congressional veterans' affairs committees and to the public of the proposed lease"; and

(3) in subsection (c)—

(A) in paragraph (1)—

(i) by striking "designate the property involved" and inserting "enter into an enhanced-use lease of the property involved"; and

(ii) by striking "to so designate the property" and inserting "to enter into such lease";

(B) in paragraph (2), by striking "90-day period" and inserting "45-day period";

(C) in paragraph (3)—

(i) by striking "general description" in subparagraph (D) and inserting "description of the provisions"; and

(ii) by adding at the end the following new subparagraph:

"(G) A summary of a cost-benefit analysis of the proposed lease."; and

(D) by striking paragraph (4).

(b) DISPOSITION OF LEASED PROPERTY.—Section 8164 is amended—

(1) in subsection (a)—

(A) by striking "by requesting the Administrator of General Services to dispose of the property pursuant to subsection (b)" in the first sentence; and

(B) by striking the third sentence;

(2) in subsection (b)—

(A) by striking "Secretary and the Administrator of General Services jointly determine" and inserting "Secretary determines"; and

(B) by striking "Secretary and the Administrator consider" and inserting "Secretary considers"; and

(3) in subsection (c), by striking "90 days" and inserting "45 days".

(c) USE OF PROCEEDS.—Section 8165 is amended—

(1) in subsection (a)(2), by striking "and remaining after any deduction from such funds under the laws referred to in subsection (c)";

(2) in subsection (b), by adding at the end the following new sentence: "The Secretary may use the proceeds from any enhanced-use lease to reimburse applicable appropriations of the Department for any expenses incurred in the development of additional enhanced-use leases."; and

(3) by striking subsection (c).

(d) CLERICAL AMENDMENTS.—(1) The heading of section 8163 is amended to read as follows:

"§ 8163. Hearing and notice requirements regarding proposed leases".

(2) The item relating to section 8163 in the table of sections at the beginning of chapter 81 is amended to read as follows:

"8163. Hearing and notice requirements regarding proposed leases.".

SEC. 203. SIMPLIFICATION OF ANNUAL REPORT ON LONG-RANGE HEALTH PLANNING.

Section 8107(b) is amended by striking paragraphs (3) and (4).

Subtitle B—Project Authorizations

SEC. 211. AUTHORIZATION OF MAJOR MEDICAL FACILITY PROJECTS.

The Secretary of Veterans Affairs may carry out the following major medical facility projects, with each project to be carried out in an amount not to exceed the amount specified for that project:

(1) Construction of a long-term care facility in Lebanon, Pennsylvania, $14,500,000.

(2) Construction of a long-term care facility in Beckley, West Virginia, $20,000,000.

(3) Construction of a new bed tower to consolidate two inpatient sites of care in the city of Chicago at the West Side Division of the Department of Veterans Affairs health care system in Chicago, Illinois, in an amount not to exceed $98,500,000.

(4) Seismic corrections to strengthen Medical Center Building 1 of the Department of Veterans Affairs health care system in San Diego, California, in an amount not to exceed $48,600,000.

(5) A project for (A) renovation of all inpatient care wards at the West Haven, Connecticut, facility of the Department of Veterans Affairs health system in Connecticut to improve the environment of care and enhance safety, privacy, and accessibility, and (B) establishment of a consolidated medical research facility at that facility, in an amount not to exceed $50,000,000.

(6) Construction of a Department of Veterans Affairs-Department of the Navy joint venture comprehensive outpatient medical care facility to be built on the grounds of the Pensacola Naval Air Station, Pensacola, Florida, in an amount not to exceed $45,000,000.

SEC. 212. AUTHORIZATION OF MAJOR MEDICAL FACILITY LEASES.

The Secretary of Veterans Affairs may enter into leases for medical facilities as follows:

(1) For an outpatient clinic in Charlotte, North Carolina, in an amount not to exceed $3,000,000.

(2) For an outpatient clinic extension, Boston, Massachusetts, in an amount not to exceed $2,879,000.

SEC. 213. ADVANCE PLANNING AUTHORIZATIONS.

The Secretary of Veterans Affairs may carry out advance planning for a major medical facility project at each of the following locations, with such planning to be carried out in an amount not to exceed the amount specified for that location:

(1) Denver, Colorado, in an amount not to exceed $30,000,000, of which $26,000,000 shall be provided by the Secretary of Veterans Affairs and $4,000,000 shall be provided by the Secretary of Defense.

(2) Pittsburgh, Pennsylvania, in an amount not to exceed $9,000,000.

(3) Las Vegas, Nevada, in an amount not to exceed $25,000,000.

(4) Columbus, Ohio, in an amount not to exceed $9,000,000.

(5) East Central, Florida, in an amount not to exceed $17,500,000.

SEC. 214. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated for the Secretary of Veterans Affairs for fiscal year 2004—

(1) for the Construction, Major Projects, account, a total of $363,100,000, of which—

(A) $276,600,000 is for the projects authorized in section 211; and

(B) $86,500,000 is for the advance planning authorized in section 213; and

(2) for the Medical Care account, $5,879,000 for the leases authorized in section 212.

(b) LIMITATION.—The projects authorized in section 211 may only be carried out using—

(1) funds appropriated for fiscal year 2004 pursuant to the authorization of appropriations in subsection (a);

(2) funds appropriated for Construction, Major Projects, for a fiscal year before fiscal year 2004 that remain available for obligation; and

(3) funds appropriated for Construction, Major Projects, for fiscal year 2004 for a category of activity not specific to a project.

Subtitle C—Capital Asset Realignment for Enhanced Services Initiative

SEC. 221. AUTHORIZATION OF MAJOR CONSTRUCTION PROJECTS IN CONNECTION WITH CAPITAL ASSET REALIGNMENT INITIATIVE.

(a) AUTHORITY TO CARRY OUT MAJOR CONSTRUCTION PROJECTS.—Subject to subsection (b), the Secretary of Veterans Affairs may carry out major construction projects as specified in the final report of the Capital Asset Realignment for Enhanced Services Commission and approved by the Secretary.

(b) LIMITATION.—The Secretary may not exercise the authority in subsection (a) until 45 days after the date of the submittal of the report required by subsection (c).

(c) REPORT ON PROPOSED MAJOR CONSTRUCTION PROJECTS.—(1) The Secretary shall submit to the Committees on Veterans' Affairs and the Committees on Appropriations of the Senate and House of Representatives not later than February 1, 2004, a report describing the major construction projects the Secretary proposes to carry out in connection with the Capital Asset Realignment for Enhanced Services initiative.

(2) The report shall list each proposed major construction project in order of priority, with such priority determined in the order as follows:

(A) The use of the facility to be constructed or altered as a replacement or enhancement facility necessitated by the loss, closure, or other divestment of major infrastructure or clinical space at a Department of Veterans Affairs medical facility currently in operation, as determined by the Secretary.

(B) The remedy of life and safety code deficiencies, including seismic, egress, and fire deficiencies at such facility.

(C) The use of such facility to provide health care services to a population that is determined under the Capital Asset Realignment for Enhanced Services initiative to be underserved or not currently served by such facility.

(D) The renovation or modernization of such facility, including the provision of barrier-free design, improvement of building systems and utilities, or enhancement of clinical support services.

(E) The need for such facility to further an enhanced-use lease or sharing agreement.

(F) Any other factor that the Secretary considers to be of importance in providing care to eligible veterans.

(3) In developing the list of projects and according a priority to each project, the Secretary should consider the importance of allocating available resources equitably among the geographic service areas of the Department and take into account recent shifts in populations of veterans among those geographic service areas.

(d) SUNSET.—The Secretary may not enter into a contract to carry out major construction projects under the authority in subsection (a) after September 30, 2006.

SEC. 222. ADVANCE NOTIFICATION OF CAPITAL ASSET REALIGNMENT ACTIONS.

(a) REQUIREMENT FOR ADVANCE NOTIFICATION.—If the Secretary of Veterans Affairs approves a recommendation resulting from the Capital Asset Realignment for Enhanced Services initiative, then before taking any action resulting from that recommendation that would result in—

(1) a medical facility closure;

(2) an administrative reorganization described in subsection (c) of section 510 of title 38, United States Code; or

(3) a medical facility consolidation,

the Secretary shall submit to Congress a written notification of the intent to take such action.

(b) LIMITATION.—Upon submitting a notification under subsection (a), the Secretary may not take any action described in the notification until the later of—

(1) the end of the 60-day period beginning on the date on which the notification is received by Congress; or

(2) the end of a period of 30 days of continuous session of Congress beginning on the date on which the notification is received by Congress or, if either House of Congress is not in session on such date, the first day after such date on which both Houses of Congress are in session.

(c) CONTINUOUS SESSION OF CONGRESS.—For the purposes of subsection (b)—

(1) the continuity of a session of Congress is broken only by an adjournment of Congress sine die; and

(2) any day on which either House is not in session because of an adjournment of more

than three days to a day certain is excluded in the computation of any period of time in which Congress is in continuous session.

(d) Medical Facility Consolidation.—For the purposes of subsection (a), the term "medical facility consolidation" means an action that closes one or more medical facilities for the purpose of relocating those activities to another medical facility or facilities within the same geographic service area.

SEC. 223. SENSE OF CONGRESS AND REPORT ON ACCESS TO HEALTH CARE FOR VETERANS IN RURAL AREAS.

(a) Sense of Congress.—Recognizing the difficulties that veterans residing in rural areas encounter in gaining access to health care in facilities of the Department of Veterans Affairs, it is the sense of Congress that the Secretary of Veterans Affairs should take steps to ensure that an appropriate mix of facilities and clinical staff is available for health care for veterans residing in rural areas.

(b) Report.—Not later than 120 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report describing the steps the Secretary is taking, and intends to take, to improve access to health care for veterans residing in rural areas.

Subtitle D—Plans for New Facilities

SEC. 231. PLANS FOR FACILITIES IN SPECIFIED AREAS.

(a) Southern New Jersey.—(1) The Secretary of Veterans Affairs shall develop a plan for meeting the future hospital care needs of veterans who reside in southern New Jersey.

(2) For purposes of paragraph (1), the term "southern New Jersey" means the following counties of the State of New Jersey: Ocean, Burlington, Camden, Gloucester, Salem, Cumberland, Atlantic, and Cape May.

(b) Far South Texas.—(1) The Secretary shall develop a plan for meeting the future hospital care needs of veterans who reside in far south Texas.

(2) For purposes of paragraph (1), the term "far south Texas" means the following counties of the State of Texas: Bee, Calhoun, Crockett, DeWitt, Dimmit, Goliad, Jackson, Victoria, Webb, Aransas, Duval, Jim Wells, Kleberg, Nueces, Refugio, San Patricio, Brooks, Cameron, Hidalgo, Jim Hogg, Kenedy, Starr, Willacy, and Zapata.

(c) North Central Washington.—(1) The Secretary shall develop a plan for meeting the future hospital care needs of veterans who reside in north central Washington.

(2) For purposes of paragraph (1), the term "north central Washington" means the following counties of the State of Washington: Chelan, Douglas, Ferry, Grant, Kittitas, and Okanogan.

(d) Pensacola Area.—(1) The Secretary shall develop a plan for meeting the future hospital care needs of veterans who reside in the Pensacola area.

(2) For purposes of paragraph (1), the term "Pensacola area" means—

(A) the counties of Escambia, Santa Rosa, Okaloosa, Walton, Holmes, Washington, Bay, Jackson, Calhoun, Liberty, Gulf, and Franklin of the State of Florida; and

(B) the counties of Covington, Geneva, Houston, and Escambia of the State of Alabama.

(e) Consideration of Use of Certain Existing Authorities.—In developing the plans under this section, the Secretary shall, at a minimum, consider options using the existing authorities of sections 8111 and 8153 of title 38, United States Code, to—

(1) establish a hospital staffed and managed by employees of the Department, either in private or public facilities, including Federal facilities; or

(2) enter into contracts with existing Federal facilities, private facilities, and private providers for that care.

(f) Report.—The Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on each plan under this section not later than April 15, 2004.

SEC. 232. STUDY AND REPORT ON FEASIBILITY OF COORDINATION OF VETERANS HEALTH CARE SERVICES IN SOUTH CAROLINA WITH NEW UNIVERSITY MEDICAL CENTER.

(a) Study Required.—The Secretary of Veterans Affairs shall conduct a study to examine the feasibility of coordination by the Department of Veterans Affairs of its needs for inpatient hospital, medical care, and long-term care services for veterans with the pending construction of a new university medical center at the Medical University of South Carolina, Charleston, South Carolina.

(b) Matters To Be Included in Study.—(1) As part of the study under subsection (a), the Secretary shall consider the following:

(A) Integration with the Medical University of South Carolina of some or all of the services referred to in subsection (a) through contribution to the construction of that university's new medical facility or by becoming a tenant provider in that new facility.

(B) Construction by the Department of Veterans Affairs of a new independent inpatient or outpatient facility alongside or nearby the university's new facility.

(2) In carrying out paragraph (1), the Secretary shall consider the degree to which the Department and the university medical center would be able to share expensive technologies and scarce specialty services that would affect any such plans of the Secretary or the university.

(3) In carrying out the study, the Secretary shall especially consider the applicability of the authorities under section 8153 of title 38, United States Code (relating to sharing of health care resources between the Department and community provider organizations), to govern future arrangements and relationships between the Department and the Medical University of South Carolina.

(c) Consultation With Secretary of Defense.—The Secretary of Veterans Affairs shall consult with the Secretary of Defense in carrying out the study under this section. Such consultation shall include consideration of establishing a Department of Veterans Affairs-Department of Defense joint health-care venture at the site referred to in subsection (a).

(d) Report.—Not later than April 15, 2004, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the results of the study. The report shall include the Secretary's recommendations with respect to coordination described in subsection (a), including recommendations with respect to each of the matters referred to in subsection (b).

Subtitle E—Designation of Facilities

SEC. 241. DESIGNATION OF DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER, PRESCOTT, ARIZONA, AS THE BOB STUMP DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER.

The Department of Veterans Affairs Medical Center located in Prescott, Arizona, shall after the date of the enactment of this Act be known and designated as the "Bob Stump Department of Veterans Affairs Medical Center". Any reference to such medical center in any law, regulation, map, document, or other paper of the United States shall be considered to be a reference to the Bob Stump Department of Veterans Affairs Medical Center.

SEC. 242. DESIGNATION OF DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE FACILITY, CHICAGO, ILLINOIS, AS THE JESSE BROWN DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER.

The Department of Veterans Affairs health care facility located at 820 South Damen Avenue in Chicago, Illinois, shall after the date of the enactment of this Act be known and designated as the "Jesse Brown Department of Veterans Affairs Medical Center". Any reference to such facility in any law, regulation, map, document, record, or other paper of the United States shall be considered to be a reference to the Jesse Brown Department of Veterans Affairs Medical Center.

SEC. 243. DESIGNATION OF DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER, HOUSTON, TEXAS, AS THE MICHAEL E. DEBAKEY DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER.

The Department of Veterans Affairs Medical Center in Houston, Texas, shall after the date of the enactment of this Act be known and designated as the "Michael E. DeBakey Department of Veterans Affairs Medical Center". Any reference to such facility in any law, regulation, map, document, record, or other paper of the United States shall be considered to be a reference to the Michael E. DeBakey Department of Veterans Affairs Medical Center.

SEC. 244. DESIGNATION OF DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER, SALT LAKE CITY, UTAH, AS THE GEORGE E. WAHLEN DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER.

The Department of Veterans Affairs Medical Center in Salt Lake City, Utah, shall after the date of the enactment of this Act be known and designated as the "George E. Wahlen Department of Veterans Affairs Medical Center". Any references to such facility in any law, regulation, map, document, record, or other paper of the United States shall be considered to be a reference to the George E. Wahlen Department of Veterans Affairs Medical Center.

SEC. 245. DESIGNATION OF DEPARTMENT OF VETERANS AFFAIRS OUTPATIENT CLINIC, NEW LONDON, CONNECTICUT.

The Department of Veterans Affairs outpatient clinic located in New London, Connecticut, shall after the date of the enactment of this Act be known and designated as the "John J. McGuirk Department of Veterans Affairs Outpatient Clinic". Any reference to such outpatient clinic in any law, regulation, map, document, record, or other paper of the United States shall be considered to be a reference to the John J. McGuirk Department of Veterans Affairs Outpatient Clinic.

SEC. 246. DESIGNATION OF DEPARTMENT OF VETERANS AFFAIRS OUTPATIENT CLINIC, HORSHAM, PENNSYLVANIA.

The Department of Veterans Affairs outpatient clinic located in Horsham, Pennsylvania, shall after the date of the enactment of this Act be known and designated as the "Victor J. Saracini Department of Veterans Affairs Outpatient Clinic". Any reference to such outpatient clinic in any law, regulation, map, document, record, or other paper of the United States shall be considered to be a reference to the Victor J. Saracini Department of Veterans Affairs Outpatient Clinic.

TITLE III—PERSONNEL MATTERS

SEC. 301. MODIFICATION OF AUTHORITIES ON APPOINTMENT AND PROMOTION OF PERSONNEL IN THE VETERANS HEALTH ADMINISTRATION.

(a) POSITIONS TREATABLE AS HYBRID STATUS POSITIONS.—(1) Section 7401 is amended—

(A) by striking paragraph (2) and inserting the following new paragraph (2):

"(2) Scientific and professional personnel, such as microbiologists, chemists, and biostatisticians."; and

(B) by striking paragraph (3) and inserting the following new paragraph (3):

"(3) Audiologists, speech pathologists, and audiologist-speech pathologists, biomedical engineers, certified or registered respiratory therapists, dietitians, licensed physical therapists, licensed practical or vocational nurses, medical instrument technicians, medical records administrators or specialists, medical records technicians, medical and dental technologists, nuclear medicine technologists, occupational therapists, occupational therapy assistants, kinesiotherapists, orthotist-prosthetists, pharmacists, pharmacy technicians, physical therapy assistants, prosthetic representatives, psychologists, diagnostic radiologic technicians, therapeutic radiologic technicians, and social workers.".

(2) Personnel appointed to the Veterans Health Administration before the date of the enactment of this Act who are in an occupational category of employees specified in paragraph (3) of section 7401 of title 38, United States Code, by reason of the amendment made by paragraph (1)(B) of this subsection shall, as of such date, be deemed to have been appointed to the Administration under such paragraph (3).

(b) APPOINTMENTS AND PROMOTIONS.—Section 7403 of such title is amended—

(1) in subsection (f)(3)—

(A) by inserting "reductions-in-force, the applicability of the principles of preference referred to in paragraph (2), rights of part-time employees," after "adverse actions,";

(B) by inserting ", whether appointed under this section or section 7405(a)(1)(B) of this title" after "such positions"; and

(C) by inserting a comma after "status)"; and

(2) by adding at the end the following new subsection:

"(h)(1) If the Secretary uses the authority provided in subsection (c) for the promotion and advancement of an occupational category of employees described in section 7401(3) of this title, as authorized by subsection (f)(1)(B), the Secretary shall do so through one or more systems prescribed by the Secretary. Each such system shall be planned, developed, and implemented in collaboration with, and with the participation of, exclusive employee representatives of such occupational category of employees.

"(2)(A) Before prescribing a system of promotion and advancement of an occupational category of employees under paragraph (1), the Secretary shall provide to exclusive employee representatives of such occupational category of employees a written description of the proposed system.

"(B) Not later than 30 days after receipt of the description of a proposed system under subparagraph (A), exclusive employee representatives may submit to the Secretary the recommendations, if any, of such exclusive employee representatives with respect to the proposed system.

"(C) The Secretary shall give full and fair consideration to any recommendations received under subparagraph (B) in deciding whether and how to proceed with a proposed system.

"(3) The Secretary shall implement immediately any part of a system of promotion and advancement under paragraph (1) that is proposed under paragraph (2) for which the Secretary receives no recommendations from exclusive employee representatives under paragraph (2).

"(4) If the Secretary receives recommendations under paragraph (2) from exclusive employee representatives on any part of a proposed system of promotion and advancement under that paragraph, the Secretary shall determine whether or not to accept the recommendations, either in whole or in part. If the Secretary determines not to accept all or part of the recommendations, the Secretary shall—

"(A) notify the congressional veterans' affairs committees of the recommendations and of the portion of the recommendations that the Secretary has determined not to accept;

"(B) meet and confer with such exclusive employee representatives, for a period not less than 30 days, for purposes of attempting to reach an agreement on whether and how to proceed with the portion of the recommendations that the Secretary has determined not to accept;

"(C) at the election of the Secretary, or of a majority of such exclusive employee representatives who are participating in negotiations on such matter, employ the services of the Federal Mediation and Conciliation Service during the period referred to in subparagraph (B) for purposes of reaching such agreement; and

"(D) if the Secretary determines that activities under subparagraph (B), (C), or both are unsuccessful at reaching such agreement and determines (in the sole and unreviewable discretion of the Secretary) that further meeting and conferral under subparagraph (B), mediation under subparagraph (C), or both are unlikely to reach such agreement—

"(i) notify the congressional veterans' affairs committees of such determinations, identify for such committees the portions of the recommendations that the Secretary has determined not to accept, and provide such committees an explanation and justification for determining to implement the part of the system subject to such portions of the recommendations without regard to such portions of the recommendations; and

"(ii) commencing not earlier than 30 days after notice under clause (i), implement the part of the system subject to the recommendations that the Secretary has determined not to accept without regard to those recommendations.

"(5) If the Secretary and exclusive employee representatives reach an agreement under paragraph (4) providing for the resolution of a disagreement on one or more portions of the recommendations that the Secretary had determined not to accept under that paragraph, the Secretary shall immediately implement such resolution.

"(6) In implementing a system of promotion and advancement under this subsection, the Secretary shall—

"(A) develop and implement mechanisms to permit exclusive employee representatives to participate in the periodic review and evaluation of the system, including peer review, and in any further planning or development required with respect to the system as a result of such review and evaluation; and

"(B) provide exclusive employee representatives appropriate access to information to ensure that the participation of such exclusive employee representative in activities under subparagraph (A) is productive.

"(7)(A) The Secretary may from time to time modify a system of promotion and advancement under this subsection.

"(B) In modifying a system, the Secretary shall take into account any recommendations made by the exclusive employee representatives concerned.

"(C) In modifying a system, the Secretary shall comply with paragraphs (2) through (5) and shall treat any proposal for the modification of a system as a proposal for a system for purposes of such paragraphs.

"(D) The Secretary shall promptly submit to the congressional veterans' affairs committees a report on any modification of a system. Each report shall include—

"(i) an explanation and justification of the modification; and

"(ii) a description of any recommendations of exclusive employee representatives with respect to the modification and a statement whether or not the modification was revised in light of such recommendations.

"(8) In the case of employees who are not within a unit with respect to which a labor organization is accorded exclusive recognition, the Secretary may develop procedures for input from representatives under this subsection from any appropriate organization that represents a substantial percentage of such employees or, if none, in such other manner as the Secretary considers appropriate, consistent with the purposes of this subsection.

"(9) In this subsection, the term 'congressional veterans' affairs committees' means the Committees on Veterans' Affairs of the Senate and the House of Representatives.".

(c) TEMPORARY, PART-TIME, AND WITHOUT COMPENSATION APPOINTMENTS.—Section 7405 of such title is amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking subparagraphs (B) and (C) and inserting the following new subparagraphs:

"(B) Positions listed in section 7401(3) of this title.

"(C) Librarians."; and

(B) in paragraph (2), by striking subparagraph (B) and inserting the following new subparagraph (B):

"(B) Positions listed in section 7401(3) of this title."; and

(2) in subsection (c)(1), by striking "section 7401(1)" and inserting "paragraphs (1) and (3) of section 7401".

(d) AUTHORITY FOR ADDITIONAL PAY FOR CERTAIN HEALTH CARE PROFESSIONALS.—Section 7454(b)(1) of such title is amended by striking "certified or registered" and all that follows through "occupational therapists," and inserting "individuals in positions listed in section 7401(3) of this title,".

SEC. 302. APPOINTMENT OF CHIROPRACTORS IN THE VETERANS HEALTH ADMINISTRATION.

(a) APPOINTMENTS.—Section 7401 is amended—

(1) in the matter preceding paragraph (1), by striking "medical" and inserting "health"; and

(2) in paragraph (1), by inserting "chiropractors," after "podiatrists,".

(b) QUALIFICATIONS OF APPOINTEES.—Section 7402(b) is amended—

(1) by redesignating paragraph (10) as paragraph (11); and

(2) by inserting after paragraph (9) the following new paragraph (10):

"(10) Chiropractor.—To be eligible to be appointed to a chiropractor position, a person must—

"(A) hold the degree of doctor of chiropractic, or its equivalent, from a college of chiropractic approved by the Secretary; and

"(B) be licensed to practice chiropractic in a State.".

(c) Period of Appointments and Promotions.—Section 7403(a)(2) is amended by adding at the end the following new subparagraph:

"(H) Chiropractors.".

(d) Grades and Pay Scales.—Section 7404(b)(1) is amended by striking the third center heading in the table and inserting the following:

"CLINICAL PODIATRIST, CHIROPRACTOR, AND OPTOMETRIST SCHEDULE".

(e) Malpractice and Negligence Protection.—Section 7316(a) is amended—

(1) in paragraph (1), by striking "medical" each place it appears and inserting "health"; and

(2) in paragraph (2)—

(A) by striking "medical" the first place it appears and inserting "health"; and

(B) by inserting "chiropractor," after "podiatrist,".

(f) Treatment as Scarce Medical Specialists for Contracting Purposes.—Section 7409(a) is amended by inserting "chiropractors," in the second sentence after "optometrists,".

(g) Collective Bargaining Exemption.—Section 7421(b) is amended by adding at the end the following new paragraph:

"(8) Chiropractors.".

(h) Effective Date.—The amendments made by this section shall take effect at the end of the 180-day period beginning on the date of the enactment of this Act.

SEC. 303. ADDITIONAL PAY FOR SATURDAY TOURS OF DUTY FOR ADDITIONAL HEALTH CARE WORKERS IN THE VETERANS HEALTH ADMINISTRATION.

(a) In General.—Section 7454(b) is amended by adding at the end the following new paragraph:

"(3) Employees appointed under section 7408 of this title shall be entitled to additional pay on the same basis as provided for nurses in section 7453(c) of this title.".

(b) Applicability.—The amendment made by subsection (a) shall take effect with respect to the first pay period beginning on or after January 1, 2004.

SEC. 304. COVERAGE OF EMPLOYEES OF VETERANS' CANTEEN SERVICE UNDER ADDITIONAL EMPLOYMENT LAWS.

(a) Coverage.—Paragraph (5) of section 7802 is amended by inserting before the semicolon a period and the following: "An employee appointed under this section may be considered for appointment to a Department position in the competitive service in the same manner that a Department employee in the competitive service is considered for transfer to such position. An employee of the Service who is appointed to a Department position in the competitive service under the authority of the preceding sentence may count toward the time-in-service requirement for a career appointment in such position any previous period of employment in the Service".

(b) Technical Amendments.—Such section is further amended—

(1) by striking the semicolon at the end of each of paragraphs (1) through (10) and inserting a period;

(2) by striking "The Secretary " and all that follows through "(1) establish," and inserting "(a) Locations for Canteens.—The Secretary shall establish,";

(3) by redesignating paragraphs (2) through (11) as subsections (b) through (k), respectively, and by realigning those subsections (as so redesignated) so as to be flush to the left margin;

(4) in subsection (b) (as so redesignated), by inserting "Warehouses and Storage Depots.—The Secretary shall" before "establish";

(5) in subsection (c) (as so redesignated), by inserting "Space, Buildings, and Structures.—The Secretary shall" before "furnish";

(6) in subsection (d) (as so redesignated), by inserting "Equipment, Services, and Utilities.—The Secretary shall" before "transfer";

(7) in subsection (e) (as so redesignated and as amended by subsection (a)), by inserting "Personnel.—The Secretary shall" before "employ";

(8) in subsection (f) (as so redesignated), by inserting "Contracts and Agreements.—The Secretary shall" before "make all";

(9) in subsection (g) (as so redesignated), by inserting "Prices.—The Secretary shall" before "fix the";

(10) in subsection (h) (as so redesignated), by inserting "Gifts and Donations.—The Secretary may" before "accept";

(11) in subsection (i) (as so redesignated), by inserting "Rules and Regulations.—The Secretary shall" before "make such";

(12) in subsection (j) (as so redesignated), by inserting "Delegation.—The Secretary may" before "delegate such"; and

(13) in subsection (k) (as so redesignated), by inserting "Authority To Cash Checks, Etc.—The Secretary may" before "authorize".

TITLE IV—OTHER MATTERS

SEC. 401. OFFICE OF RESEARCH OVERSIGHT IN VETERANS HEALTH ADMINISTRATION.

(a) Statutory Charter.—(1) Chapter 73 is amended by inserting after section 7306 the following new section:

"§ 7307. Office of Research Oversight

"(a) Requirement for Office.—(1) There is in the Veterans Health Administration an Office of Research Oversight (hereinafter in this section referred to as the 'Office'). The Office shall advise the Under Secretary for Health on matters of compliance and assurance in human subjects protections, research safety, and research impropriety and misconduct. The Office shall function independently of entities within the Veterans Health Administration with responsibility for the conduct of medical research programs.

"(2) The Office shall—

"(A) monitor, review, and investigate matters of medical research compliance and assurance in the Department with respect to human subjects protections; and

"(B) monitor, review, and investigate matters relating to the protection and safety of human subjects and Department employees participating in medical research in Department programs.

"(b) Director.—(1) The head of the Office shall be a Director, who shall report directly to the Under Secretary for Health (without delegation).

"(2) Any person appointed as Director shall be—

"(A) an established expert in the field of medical research, administration of medical research programs, or similar fields; and

"(B) qualified to carry out the duties of the Office based on demonstrated experience and expertise.

"(c) Functions.—(1) The Director shall report to the Under Secretary for Health on matters relating to protections of human subjects in medical research projects of the Department under any applicable Federal law and regulation, the safety of employees involved in Department medical research programs, and suspected misconduct and impropriety in such programs. In carrying out the preceding sentence, the Director shall consult with employees of the Veterans Health Administration who are responsible for the management and conduct of Department medical research programs.

"(2) The matters to be reported by the Director to the Under Secretary under paragraph (1) shall include allegations of research impropriety and misconduct by employees engaged in medical research programs of the Department.

"(3)(A) When the Director determines that such a recommendation is warranted, the Director may recommend to the Under Secretary that a Department research activity be terminated, suspended, or restricted, in whole or in part.

"(B) In a case in which the Director reasonably believes that activities of a medical research project of the Department place human subjects' lives or health at imminent risk, the Director shall direct that activities under that project be immediately suspended or, as appropriate and specified by the Director, be limited.

"(d) General Functions.—(1) The Director shall conduct periodic inspections and reviews, as the Director determines appropriate, of medical research programs of the Department. Such inspections and reviews shall include review of required documented assurances.

"(2) The Director shall observe external accreditation activities conducted for accreditation of medical research programs conducted in facilities of the Department.

"(3) The Director shall investigate allegations of research impropriety and misconduct in medical research projects of the Department.

"(4) The Director shall submit to the Under Secretary for Health, the Secretary, and the Committees on Veterans' Affairs of the Senate and House of Representatives a report on any suspected lapse, from whatever cause or causes, in protecting safety of human subjects and others, including employees, in medical research programs of the Department.

"(5) The Director shall carry out such other duties as the Under Secretary for Health may require.

"(e) Source of Funds.—Amounts for the activities of the Office, including its regional offices, shall be derived from amounts appropriated for the Veterans Health Administration for Medical Care.

"(f) Annual Report.—Not later than March 15 each year, the Director shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the activities of the Office during the preceding calendar year. Each such report shall include, with respect to that year, the following:

"(1) A summary of reviews of individual medical research programs of the Department completed by the Office.

"(2) Directives and other communications issued by the Office to field activities of the Department.

"(3) Results of any investigations undertaken by the Office during the reporting period consonant with the purposes of this section.

"(4) Other information that would be of interest to those committees in oversight of the Department medical research program.

"(g) Medical Research.—For purposes of this section, the term 'medical research' means medical research described in section 7303(a)(2) of this title.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 7306 the following new item:

"7307. Office of Research Oversight.".

(b) Conforming Amendment.—Section 7303 is amended by striking subsection (e).

SEC. 402. ENHANCEMENT OF AUTHORITIES RELATING TO NONPROFIT RESEARCH CORPORATIONS.

(a) Coverage of Personnel Under Tort Claims Laws.—(1) Subchapter IV of chapter 73 is amended by inserting after section 7364 the following new section:

"§ 7364A. Coverage of employees under certain Federal tort claims laws

"(a) An employee of a corporation established under this subchapter who is described by subsection (b) shall be considered an employee of the Government, or a medical care employee of the Veterans Health Administration, for purposes of the following provisions of law:

"(1) Section 1346(b) of title 28.

"(2) Chapter 171 of title 28.

"(3) Section 7316 of this title

"(b) An employee described in this subsection is an employee who—

"(1) has an appointment with the Department, whether with or without compensation;

"(2) is directly or indirectly involved or engaged in research or education and training that is approved in accordance with procedures established by the Under Secretary for Health for research or education and training; and

"(3) performs such duties under the supervision of Department personnel.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 7364 the following new item:

"7364A. Coverage of employees under certain Federal tort claims laws.".

(b) Clarification of Executive Director's Ethics Certification Duties.—Section 7366(c) is amended—

(1) by inserting "(1)" after "(c)";

(2) by striking "any year—" and all that follows through "shall be subject" and inserting "any year shall be subject";

(3) by striking "functions; and" and inserting "functions."; and

(4) by striking paragraph (2) and inserting the following:

"(2) Each corporation established under this subchapter shall each year submit to the Secretary a statement signed by the executive director of the corporation verifying that each director and employee has certified awareness of the laws and regulations referred to in paragraph (1) and of the consequences of violations of those laws and regulations in the same manner as Federal employees are required to so certify.".

(c) Five-Year Extension of Authority to Establish Research Corporations.—Section 7368 is amended by striking "December 31, 2003" and inserting "December 31, 2008".

SEC. 403. DEPARTMENT OF DEFENSE PARTICIPATION IN REVOLVING SUPPLY FUND PURCHASES.

(a) Enhancement of Department of Defense Participation.—Section 8121 is amended—

(1) by redesignating subsections (b) and (c) as subsections (d) and (e), respectively;

(2) by designating the last sentence of subsection (a) as subsection (c); and

(3) by inserting after paragraph (3) of subsection (a) the following new subsection (b):

"(b) The Secretary may authorize the Secretary of Defense to make purchases through the fund in the same manner as activities of the Department. When services, equipment, or supplies are furnished to the Secretary of Defense through the fund, the reimbursement required by paragraph (2) of subsection (a) shall be made from appropriations made to the Department of Defense, and when services or supplies are to be furnished to the Department of Defense, the fund may be credited, as provided in paragraph (3) of subsection (a), with advances from appropriations available to the Department of Defense.".

(b) Effective Date.—The amendments made by subsection (a) shall apply only with respect to funds appropriated for a fiscal year after fiscal year 2003.

SEC. 404. FIVE-YEAR EXTENSION OF HOUSING ASSISTANCE FOR HOMELESS VETERANS.

Section 2041(c) is amended by striking "December 31, 2003" and inserting "December 31, 2008".

SEC. 405. REPORT DATE CHANGES.

(a) Senior Managers Quarterly Report.—Section 516(e)(1)(A) is amended by striking "30 days" and inserting "45 days".

(b) Annual Report on Assistance to Homeless Veterans.—Section 2065(a) is amended by striking "April 15 of each year" and inserting "June 15 of each year".

(c) Annual Report of Committee on Care of Severely Chronically Mentally Ill Veterans.—Section 7321(d)(2) is amended by striking "February 1, 1998, and February 1 of each of the six following years" and inserting "June 1 of each year through 2008".

(d) Annual Report on Sharing of Health Care Resources.—Section 8153(g) is amended—

(1) by striking "not more than 60 days after the end of each fiscal year" and inserting "not later than February 1 of each year"; and

(2) by inserting "during the preceding fiscal year" after "under this section".

(e) Annual Report of Special Committee on PTSD.—Section 110(e)(2) of the Veterans' Health Care Act of 1984 (38 U.S.C. 1712A note) is amended by striking "February 1 of each of the three following years" and inserting "May 1 of each year through 2008".

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New Jersey (Mr. SMITH) and the gentleman from Texas (Mr. RODRIGUEZ) each will control 20 minutes.

The Chair recognizes the gentleman from New Jersey (Mr. SMITH).

Mr. SMITH of New Jersey. Madam Speaker, I yield such time as he may consume to the gentleman from Connecticut (Mr. SIMMONS), the chairman of our Subcommittee on Health, who is the prime author of this legislation.

Mr. SIMMONS. Madam Speaker, I thank the gentleman from New Jersey (Mr. SMITH) the distinguished chairman of the Committee on Veterans' Affairs, for all the hard work that he has done over the course of this year, and in previous years, in an effort to bring this legislation to final passage today. He is truly a friend of America's veterans.

Madam Speaker, the bill before us combines substantial portions of seven House and Senate bills dealing with veterans health care matters. As the Subcommittee on Health chairman, I am pleased that we are proposing to rebuild substantial portions of the Department of Veterans Affairs aging capital infrastructure, which is a fancy way of saying their hospital and health care facilities.

Most Members know that America cares for her veterans more than any other country in the world and has provided health care facilities for her veterans for over 100 years. That is the good news. Regrettably, the bad news is that many of these facilities, which provide excellent health care services to our veterans, show signs of aging. They need upgrading or replacement, and that is one of the purposes of the bill before us today.

This legislation is the result of compromise between the House and the Senate. It is the product of many minds. And I am grateful to my ranking member, the gentleman from Texas (Mr. RODRIGUEZ) for all of his help in bringing us to this point here today.

In summary, the bill would authorize six new medical building probables at a total cost of $276.6 million in Chicago, San Diego, West Haven, Lebanon, Beckley, and Pensacola. It also authorizes advance planning of $86.5 million for the Veterans Administration to design five new projects in Denver, Colorado, Columbus, Ohio, Pittsburgh, Pennsylvania, Las Vegas, Nevada, and East Central, Florida. I am confident these projects will be funded once they are fully designed with the authorization provided in this bill.

The Denver project, for example, is a joint venture involving the Veterans Administration and the Air Force to establish a new Fitzsimmons Hospital Center. We believe this project will move forward with $26 million from the VA added to $4 million from the Air Force. And I thank my colleagues, the gentleman from Colorado (Mr. BEAUPREZ) and the gentleman from Colorado (Mr. HEFLEY) for all of their hard work on this project.

Another very important planning project in our bill is for Columbus, Ohio. It would relocate and expand an existing VA clinic to available Federal property. And while this committee wanted to provide the full authorization this year, and, in fact, this body did so, that was opposed by the other body. In the spirit of compromise the committees agreed to provide $9 million for advance planning for the new clinic in Columbus. I thank the gentleman from Ohio (Mr. HOBSON) for his leadership and help with this matter. I personally look forward to going out to Ohio, hopefully, in the company of Secretary Principi, to review the project.

In Pittsburgh, Pennsylvania, the VA needs a new health facility to replace two aging hospitals, both of which are over 50 years old. The committee has agreed to provide planning funds of $9 million for this project as well.

In addition to these projects, the bill with also delegate to Secretary Principi the ability to prioritize construction projects coming out of VA's so-called "CARES" process, provided appropriations to support these projects would be available. And we are confident this approach is a responsible way to proceed. With this delegation of authority to the Secretary, however, we also impose some limits on the VA in this bill. If, for example, as a result of CARES, the Secretary is closing VA medical facilities, or significantly reducing health care staff or consolidating two or more hospitals, we request that VA report these plans to Congress and wait 60 days before proceeding.

In closing, Madam Speaker, I would like to mention two hospital or facility naming pieces of this legislation. First of all, I had the honor as a member of the Committee on Armed Services to serve under Chairman Bob Stump, who also was a distinguished chairman of the Committee on Veterans' Affairs. There is no truer friend to America's veterans than Bob Stump. And we lost him earlier this year, unfortunately, to a long illness. But we wanted to memorialize his service to American veterans in an appropriate and respectful way, which is why our bill names the Prescott, Arizona, VA Medical Center the Bob Stump Department of Veterans Affairs Medical Center.

As well, I want to honor a very distinguished veteran from my own district, John McGuirk, a native of Connecticut, who enlisted in the United States Navy during World War II, serving as a salvage diver. He hazarded death and injury every day of his service, serving in the South Pacific from Pearl Harbor to Manila in the Philippines, including service aboard the salvage ship U.S.S. Laysan Island.

John McGuirk was instrumental in establishing a community-based outreach clinic in New London, Connecticut, on the grounds of the U.S. Coast Guard Academy. And this legislation will memorialize him by naming this clinic after him.

Madam Speaker, I urge all Members to vote in support of final passage of this legislation, the Veterans Health Care Capital Asset and Business Improvement Act of 2003.

□ 1230

Mr. RODRIGUEZ. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I rise in support of S. 1156, as amended, the Veterans Health Care, Capital Assets and Business Improvement Act of 2003.

This legislation draws the best from provisions offered in this body and the Senate. I have worked closely on the bill with the chairman of the Subcommittee on Health, the gentleman from Connecticut (Mr. SIMMONS). I want to thank him for his graciousness and the hard work. I would also like to thank the gentleman from New Jersey (Mr. SMITH) and also the ranking member, the gentleman from Illinois (Mr. EVANS), for their assistance in finalizing this bill.

I am very pleased that the bill includes important provisions from H.R. 2433, as amended, a bill I introduced with the support of the gentleman from Connecticut (Mr. SIMMONS). I also appreciate the persistence of the gentleman from California (Mr. THOMPSON), who will be speaking, in ensuring that these tests were brought to light in the items that we would be bringing before in this piece of legislation.

This bill will take important steps to remedy the serious wrong done to some of our veterans during the Cold War era. The military conducted a series of about 50 tests over almost a decade to determine the effects of the number of biological and chemical exposures to military operations and whether such exposures could be adequately protected. Many of these veterans participated without their knowledge, and too often veterans who participated in these tests were not properly protected from exposure to the number of stimulants as well as, occasionally, live agents. These agents included sarin and VX nerve gas, as well as biological war agents including Q fever and rabbit fever.

The military has now completed a number of investigations into the operations of the Deseret Test Center and concluded that as many as 6,000 veterans may have been involved. Veteran participation is unacceptable, and we recognize this, and we are concerned; and we want to assure them that if they are suffering lasting health consequence that we will do something about this.

I am very pleased that this legislation does something about that. This bill provides high-priority eligibility for the next 2 years to allow them to seek and receive VA treatment for the health problems including those that may be related to the problems, especially to the exposure of these hazardous agents.

This authority will allow them, and it will not adequately compensate them for what they have gone through, but we are at least beginning to try to correct the situation that we find ourselves in. Allowing them to have their health care concerns addressed may begin to give them the peace of mind this Nation owes them.

I am also pleased the final bill includes many provisions on the bill H.R. 1720, as amended. Madam Speaker, this bill authorizes many worthy construction projects to which the VA has given high priority. Unfortunately, the VA major medical construction has suffered for years as Congress has waited for the results of the CARES program, which is Capital Assets Realignment for Enhanced Services. I hope now that VA is about to approve a final plan, Congress will see fit to provide the appropriations VA requires to invest in its outdated infrastructure that we know is lacking. So we are hoping that we can do more as the report comes out.

A provision in our bill is designed to assure Congress that we are also adequately informed of some less positive developments that may result from this process, facility closures, staff realignments, as well as consolidations that may affect many veterans.

I am also pleased that this bill would give us both the assurance of this notification and the time to respond to these developments. Regardless of its outcome, CARES gave us at least one thing of value and that is the information that it has provided us. Last fall, the VA came forward with data that confirmed the ongoing concerns. I, along with my good friend, the gentleman from Texas (Mr. ORTIZ), have talked about the veterans of south Texas. I know the gentleman from Texas (Mr. ORTIZ) will be speaking today. They suffered long, miserable journeys, up to 6 hours one way, to receive hospital care and some specialized services. And I do not think that anyone knew many of our veterans had the worst access to acute hospital care in the Nation like in south Texas.

I am pleased this bill will require the VA to report to us on the steps it intends to take to resolve this long-lasting problem in south Texas.

This bill will also provide new benefits to former prisoners of war. Under the current law, neither Jessica Lynch nor her comrades who suffered internment in Iraq would be eligible to receive outpatient dental care from the VA. Why? Because they were in captivity for fewer than 90 days. Veterans who have experienced the trauma associated with being prisoners of war deserve dental care regardless of the time of the captivity.

This bill will also do away with these veterans medication co-payments. Surely we can all agree that these veterans have paid enough. This bill will extend and enhance long-term care and mental health programs. The VA continues to study how it will provide care in the future. Congress must remain vigilant about the programs that are needed by some of the most vulnerable veterans in the system.

I am pleased we have continued to support two internal watchdogs to monitor and report to Congress on the methods of improving mental health programs within the VA for the seriously mentally ill and for victims of post-traumatic stress disorder.

With troops who have seen the consequences of combat still in the field, we need the VA permanent programs to be available to both men and women who have trouble readjusting to civilian life.

Madam Speaker, there are numerous additional provisions in the bill that will allow the VA to provide better care to our veterans. I would like to thank the committee leadership and the staff for their hard work on this bill.

Madam Speaker, I rise in support of S. 1156, as amended, the Veterans Health Care, Capital Asset And Business Improvement Act of 2003. The bill draws the best from provisions offered in this body and in the Senate. I have worked closely on this bill with the Chairman of the Health Subcommittee, Mr. SIMMONS. I would also like to thank Chairman SMITH and Ranking Member EVANS for their assistance in finalizing this bill.

I am most pleased that the bill includes important provisions from H.R. 2433, as amended, a bill I introduced with the support of my Chairman, Mr. SIMMONS. I also appreciate the persistence of the gentleman from California, MIKE THOMPSON in ensuring that these tests were brought to light. This bill will take important steps to remedy a serious wrong done to some veterans during the Cold War era. The military conducted a series of about 50 tests over almost a decade to determine the effect of a number of biological and chemical exposures on military operations and whether such exposures could be adequately detected. Too often veterans who participated, sometimes unwittingly, in these tests were not properly protected from exposures to a number of stimulants and, occasionally, live agents. These agents included Sarin and VX nerve gas as well as biological war agents including Q fever and rabbit fever.

The military has now completed a number of investigations into the operations of the Deseret Test Center and concluded that as many as 6000 veterans may have been involved. Veteran participants are understandably concerned and want assurances that they are not suffering lasting health consequences related to these tests. This bill provides high-priority health care eligibility to these veterans for the next two years to allow them to seek and receive VA treatment for any health problems, including those they believe may be related to exposures to these hazardous agents. This authority will never adequately compensate veterans for their participation in dangerous tests, but allowing them to have their health care concerns addressed may begin to give them the peace-of-mind the nation owes them.

I am also pleased that the final bill includes many of the provisions from H.R. 1720, as amended. Madam Speaker, this bill authorizes many worthy construction projects to which VA has given high priority. Unfortunately, VA's major medical construction has languished for years as Congress has waited for the results of the Capital Assets Realignment for Enhanced Services (CARES) study. I hope now that VA is about to approve a final plan, Congress will see fit to provide the appropriations VA requires to invest in its outdated infrastructure. If so, this will be a positive outcome of CARES. A provision of our bill is designed to ensure Congress that we are also adequately informed of some less positive developments that may result from this process—facility closures, staff reassignments and consolidations that may affect many veterans. I am pleased that this bill will give us both the assurance of this notification and the time to respond to these developments.

Regardless of its outcomes, CARES gave us at least one thing of value—information. Last fall, VA came forward with data that confirm ongoing concerns I, along with my good friend Solomon Ortiz, have had about the veterans of South Texas. We knew they often suffered long, miserable journeys—up to 6 hours one way—to receive hospital care and some specialized services, but I don't think anyone knew many of our veterans had the worst access to acute hospital care in the nation! I am pleased this bill will require VA to report to us on steps it intends to take to resolve this longstanding problem.

This bill will provide new benefits to former prisoners-of-war. Under current law, neither Jessica Lynch nor her comrades who suffered internment in Iraq would be eligible to receive outpatient dental care from the VA. Why? Because they were in captivity for fewer than 90 days. While this limitation on eligibility was based on a rationale, it now seems capricious. Veterans who have experienced the trauma associated with being a prisoner of war deserve dental care regardless of their time in captivity. This bill will also do away with these veterans' medication copayments. Surely we can all agree that these veterans have paid enough.

This bill will extend and enhance long-term care and mental health problems. As VA continues to study how it will provide health care in the future Congress must remain vigilant about these programs that consume many resources but are needed by some of the most vulnerable veterans in the system. I am pleased we will also require two internal watchdogs that have made solid recommendations for improving mental health programs to continue to report to Congress on the VA's services for the seriously mentally ill and for veterans with Post-Traumatic Stress Disorder. With troops who have seen the consequences of combat still in the field we will need VA's pre-eminent programs to be available to the men and women who have trouble readjusting to civilian life.

Madam Speaker, there are a number of additional provisions in this bill that will allow VA to provide better care to our veterans. I thank the Committee leadership and the staff for their hard work on the bill and want to commend it to all of my colleagues.

Madam Speaker, I reserve the balance of my time.

Mr. SMITH of New Jersey. Madam Speaker, I yield 3 minutes to the gentleman from Indiana (Mr. BUYER), the distinguished chairman of our Subcommittee on Oversight and Investigations.

Mr. BUYER. Madam Speaker, this is excellent bipartisan legislation, not only between the Members of this body but also between the House and the Senate. This is a good compromise, not only with regard to major facility construction, whether it is to improve, renovate, replace, update and establish new health care facilities around the country. That is an excellent portion of this bill.

I would like to bring to my colleagues' attention that included in this compromise package is some legislation I authored to ensure the ethical treatment and safety of veterans who participate in VA medical research. We spend a lot of money on VA medical research, and there have been some incidents over the years whereby veterans have been harmed. And just the title of what it is called, Human Subject Protection, by calling humans subjects, it even sort of desensitizes the issue that there is a human being here at stake.

The VA medical research human subject protections section of this bill does the following:

We will establish an independent office to oversee research and compliance and assurance.

This bill will also provide that the new office counsels the Under Secretary for Health on all matters related to the protection of human research subjects, research misconduct and impropriety, and also the ethical conduct of research, and research safety.

That office shall investigate allegations of research, misconduct and impropriety; suspend or restrict research to ensure the safety and ethical treatment of human subjects; and assure compliance in the conduct of research.

The director of the office shall conduct periodic inspections at research facilities, observe external accreditation site visits, investigate allegations of research misconduct and improprieties.

This bill also requires the immediate notification of the Under Secretary for Health when endangerment of human research subjects is evident or suspected and requires that Congress be notified when research misconduct or impropriety has been discovered.

This bill provides that funding for the new office would be independent from the Office of Research and Development.

Finally, the bill mandates that the Comptroller General of the United States conduct a study of the effectiveness of this new office and submit a report to Congress by January 1, 2006.

I want to thank all Members of the House Committee on Veterans' Affairs and the Senate for including this language in section IV of the bill. In particular, I want to thank the gentleman from New Jersey (Mr. SMITH) and the ranking member, the gentleman from Illinois (Mr. EVANS), and the ranking member of the Subcommittee on Oversight and Investigations, the gentlewoman from Oregon (Ms. HOOLEY), for co-sponsoring the legislation. Also, in particular, the gentleman from Connecticut (Mr. SIMMONS) and the ranking member, the gentleman from Texas (Mr. RODRIGUEZ), for this bill at the subcommittee level, for bringing this to the attention of all of our colleagues. This is good legislation and good work, and I thank everyone for their efforts.

Mr. RODRIGUEZ. Madam Speaker, I yield 2 minutes to the gentleman from Illinois (Mr. EVANS), the ranking Democrat.

Mr. EVANS. Madam Speaker, I rise to support the Veterans Health Care, Capital Asset and Business Improvement Act of 2003. I want to start out by thanking the gentleman from New Jersey (Mr. SMITH) again for his willingness to work closely with me and the Democratic members of the committee to develop this as a final package. Credit goes to the gentleman from Connecticut (Mr. SIMMONS) and the ranking member, the gentleman from Texas (Mr. RODRIGUEZ), for moving these measures to the floor today.

The bill anticipates the final approval of the CARES plan, identifying Congress's priorities requiring notification of major initiatives that come before the plan. I will continue to work behind the curtain and in front of the public to get this legislation passed.

The bill memorializes two great friends of mine: Bob Stump, who was an advocate for veterans throughout his career. We truly miss him not being on the committee anymore. He was a great American, and we salute his courage in standing up for what he believed in. Also, Jesse Brown, a veterans advocate as well, the former Secretary of Veterans Affairs for veterans. And we recognize these contributions of these two veterans with the passage of this bill.

This is a laudable effort for improving services for elderly and mentally-ill veterans. It strives to make VA the first choice. I am proud of the committee's work.

Madam Speaker, I rise to support the Veterans Health Care, Capital Asset and Business Improvement Act of 2003. I want to thank Chairman SMITH for his ongoing commitment to veterans and his willingness to work closely with us on the development of this final package.

There are many important provisions in this bill. I appreciate the good bipartisan work of Chairman SIMMONS and Ranking Member RODRIGUEZ in shepherding these measures from the Health Subcommittee to our consideration of a final conference package on the floor today.

This bill anticipates the final approval of the National Capital Asset Realignment for Enhanced Services (CARES) Plan. This Plan may set the framework for the first significant investment in the VA medical care system's infrastructure in several years. We are now way behind in making the needed investments—some estimate that the deficit is as high as $6 billion in delayed VA projects. VA's Phase I Study in VISN 12 has offered interested parties a view to the future under a CARES-like process. I had to look no further than upstate Illinois to see how the administration might handle the hundreds of new proposals it has on tap if most of the recommendations in the Draft CARES Plan are adopted.

The answers I received about the plan for VISN 12 were unsettling. This is particularly true since this Phase I study is the prototype for the larger National plan. VA planned to close one of the divisions of VA Chicago without sure funding for a modern new bed tower at the other division. This replacement facility was, in my view and many others, the linchpin to a successful integration. There are still no plans to develop the on-site multispecialty outpatient clinic veterans were promised.

This spring I introduced H.R. 2349 which authorized funds to construct the new bed tower at the West Side division of VA in Chicago. It also attempted to hold VA's feet to the fire to fund and build the new bed tower by prohibiting VA from disposing of the closed facility until it began construction on its replacement. Instead of the restrictions I put on VA in my bill, I have agreed to establish priorities for spending appropriations designated for CARES projects. This conference package gives the highest priority to facilities, such as West Side, that are needed to replace capacity at facilities that CARES will recommend closing, consolidating or converting in some fashion. It also gives high priorities to projects that remedy life safety and seismic deficiencies.

My bill contained additional projects that are worthy of our appropriators' consideration. It authorizes $48,600,000 for the correction of seismic deficiencies in San Diego, California, and $50,000,000 for medical care and research renovations in West Haven, Connecticut. My bill included lease authority for Las Vegas. We have since learned that VA's needs there may be evolving and settled on appropriating advance planning funds in the amount of $25,000,000 for a major medical facility project there.

The bill also adopts language inspired by a provision introduced by my friend from Kansas, DENNIS MOORE. His bill has tremendous and broad-based support in this body. The provision requires VA to notify Congress in writing of actions proposed under the CARES initiative that would result in medical facility closures, significant staff realignments or medical facility consolidations and prohibits VA from taking these actions before 45 days following the notification or 30 days of continuous session of Congress.

I plan to continue to look behind the CARES process to ensure that VA is making its decisions in the best interest of veterans—not the bottom line.

In addition to honoring my friend, the late Jesse Brown, the former Secretary "for" Veterans Affairs by naming the VA Medical Center (West Side Division) in Chicago for him, this final package will name the Prescott VA Medical Center for our Committee's former Chairman, and my personal friend, the late Bob Stump. We honor two true veterans' advocates with the passage of this bill, and I am pleased to be associated with it.

Madam Speaker, I am pleased that we are finally able to authorize VA to provide health care to certain Filipino World War II veterans of the Philippines Commonwealth Army and former Philippines "New Scouts" who permanently reside in the United States, in the same manner as provided to U.S. veterans. I commend my colleague, Mr. FILNER, for his persistence in seeing this to fruition.

Several years ago, my friend from California, MIKE THOMPSON, discovered that many veterans had participated in a series of dangerous tests to identify the military's ability to detect and protect itself from biological and chemical attacks. His doggedness led the military to admit responsibility for conducting these tests which involved spraying American troops with agents that were, in some cases, extremely potent. The ranking member of the Health Subcommittee, CIRO RODRIGUEZ, saw an opportunity to do some justice for these veterans by giving them access to VA health care for any condition for two years. This will allow these veterans to seek care for conditions they believe may be related to their exposures. I am pleased to support this provision.

This bill is laudable for improving services for elderly and mentally ill veterans. One provision allows VA authority to provide work skills training and development services, employment support services and job development and placement services as part of a more comprehensive rehabilitation package. This is likely to improve the therapeutic outcomes for seriously mentally ill veterans, homeless veterans and veterans with substance use disorders—those who can truly benefit from hands-on job coaching services. It extends authority for VA to provide properties foreclosed under its home loan program to nonprofit homeless service providers. VA has made extensive use of this authority and nonprofits have provided many nights of care to homeless veterans as a result.

The bill extend VA's authority to provide a range of non-institutional extended care services and a mandate to provide medically necessary, institutional nursing care services to severely service-connected disabled veterans through December 31, 2008. It allows VA to extend and add a site to its important pilot program on assisted living for veterans. It provides earmarked funding for specialized mental health services for veterans in each of the next three fiscal years. It also continues the reports of two important VA advisory groups who have made a series of solid recommendations to the Under Secretary for Health and the Congress about programs for seriously mentally ill veterans and veterans with post-traumatic stress disorder.

Finally, this bill strives to make VA an employer of choice. We have reached one of those rare compromises that seem to offer something to everyone by creating a new appointment and promotion authority for certain clinical personnel, such as clinical psychologists, social workers, audiologists, kinesiologists, and others in the Veterans Health Administration (VHA). This authority will allow these employees to enjoy some of the same protections other Federal workers have, but will also provide VA with greater hiring and promotion flexibility. Some health care workers, mostly nursing assistants, will enjoy Saturday premium pay under this bill. It will allow VA to appoint employees of the Veterans' Canteen Service taking into consideration their time in service in that capacity. We have offered VHA the authority to hire chiropractors to enhance the types of health care services it routinely offers veterans.

Madam Speaker, I am proud of the Committee's work on this bill and encourage all of my colleagues to approve it.

Mr. SMITH of New Jersey. Madam Speaker, I yield 2 minutes to the distinguished gentleman from Arizona (Mr. RENZI), a member of the committee, and a very active one at that.

Mr. RENZI. Madam Speaker, I want to begin by commending the chairman, the gentleman from New Jersey (Mr. SMITH), and the gentleman from Illinois (Mr. EVANS), the gentleman from Connecticut (Mr. SIMMONS), and the gentleman from Texas (Mr. RODRIGUEZ) for their hard work in crafting a comprehensive bill that gives great improvements to veterans health care programs.

It is imperative at this time especially that we honor the service of veterans and provide for the quality of life they have helped foster for their years of service to us and this Nation.

This bill ensures the VA health care system will continue to provide the highest quality health care services to our Nation's patriots.

I would like to take a minute to highlight a provision in this bill that honors the memory of a veteran that served in this body. Congressman Bob Stump dedicated his life to the service of this country, first in World War II as a Navy medic, then as an elected official in the State of Arizona, and also in the House of Representatives here in Washington.

Throughout his career, he devoted his efforts to taking care of men and women in uniform on and off the battlefield who committed themselves to defend this Nation and our Constitution. As the previous chairman of the House Committee on Veterans' Affairs, he worked for over 20 years in support of increased health care benefits for veterans and in strengthening the Montgomery GI Bill to allow veterans to have greater access to education and training.

This bill honors the legacy of Bob Stump and his steadfast commitment to veterans by renaming the Prescott Veterans Affairs Medical Center in Prescott, Arizona, the Bob Stump Veterans Affairs Medical Center.

I would like to thank members of his staff, Delores Dunn, Joanne Keeane, and Susan Hosinpellar, who continue to carry on the tradition of his service. It is they who brought forward this idea, along with the Arizona delegation who helped make it happen. It is a fitting tribute to one of our Nation's greatest heroes.

Mr. RODRIGUEZ. Madam Speaker, I yield 3 minutes to the gentleman from California (Mr. FILNER).

Mr. FILNER. Madam Speaker, I also rise in support of S. 1156 as it comes to the House.

As I said yesterday on the floor of the House and I will say again to the chairman of the Committee on Veterans' Affairs and the ranking member, the gentleman from New Jersey (Mr. SMITH) and the gentleman from Illinois (Mr. EVANS), if we take the benefits package that we passed yesterday and the health package that we will pass today, the sum together of these make this year one of the most productive years ever for benefits and health care for our Nation's veterans.

□ 1245

I want to congratulate our leadership on that.

Let me just speak quickly to two of the provisions in this bill. One of them provides access to the veterans medical facilities to all Filipino World War II veterans who legally reside in the United States. This is a benefit that comes from my bill, H.R. 664, and for which I have been fighting for many years, and I thank all the folks involved, the gentleman from Connecticut (Chairman SIMMONS), the gentleman from Texas (Ranking Member RODRIGUEZ), as well as Veterans' Affairs Secretary Principi for bringing this to the floor today.

The Filipino soldiers during World War II helped us win the war in the Pacific, and their brave, courageous stands in the epic battles of Bataan and Corregidor, their critical participation in guerrilla warfare that slowed up the Japanese advance, caused them to suffer greatly after the war when the Congress of 1946 deprived them of the very benefits in both health and benefits that they had been promised.

These veterans are now in their seventies and eighties. Their most urgent need is health care. So it is with great joy that I urge my colleagues to vote for this bill. It will restore dignity and honor to these brave veterans where over 50 years of injustice burns in their hearts. Their sons and daughters and they themselves, I know, are watching this floor today and are going to have great celebration when we pass this bill later on.

What we are saying here today is that these veterans are indeed United States veterans, and we are going to begin remedying the historical injustice that we inflicted upon them. We will make good on the promise of America for these brave veterans.

In addition, as has been mentioned, this bill contains major medical investments in many areas of this country, including San Diego, California. The average health care facility in the VA is more than 50 years old. So we have to update these buildings. The building in San Diego is in dire need of seismic correction, and it is one of 60 projects that the VA has identified that need these seismic corrections. So we cannot turn our heads away without acting any longer. We cannot continue to leave VA patients and employees in harm's way.

For all these reasons and more, I urge passage of Senate bill 1156.

Mr. SMITH of New Jersey. Mr. Speaker, because there have been so many requests for time on our side, as well as on the Democratic side, I ask unanimous consent that we extend this debate by 10 minutes equally divided between the minority and majority.

The SPEAKER pro tempore (Mr. BURGESS). Is there objection to the request of the gentleman from New Jersey?

There was no objection.

Mr. SMITH of New Jersey. Mr. Speaker, I yield 2 minutes to the gentleman from Colorado (Mr. HEFLEY), the distinguished chairman of the Committee on Standards of Official Conduct.

Mr. HEFLEY. Mr. Speaker, let me tell my colleagues this is a good bill. This recognizes needs that have gone unmet for in some cases seems like generations, and I am not going to go through and describe the bill in its totality because other speakers have done it better than I can, but let me just say an area that I am particularly interested in is the authorization for the Secretary of Veterans' Affairs to enter into a contract in the amount of $26 million for the advance planning and engineering for the VA medical facility project at the former Fitzsimons Army Medical Center site in Aurora, Colorado.

As the gentleman from Connecticut (Mr. SIMMONS) said, the University of Colorado Hospital is moving to this new medical campus, which is really going to be something to see when it is completed, and they have cooperated with the veterans hospital over the years, and now to bring the veterans hospital out there with the savings that goes with that, it is going to be a magnificent medical facility.

The VA Medical Center at Fitzsimons, with this co-location with the Colorado Health Sciences Center and University of Colorado Hospital will be a veteran-friendly, state-of-the-art medical campus providing veterans with highly specialized medical needs with easy access to the best diagnostic and treatment programs that America can provide for veterans anywhere in America.

The Denver Veterans Medical Center's relocation is a unique opportunity to provide solid and constructive solutions to the challenges of aging facilities issues and new facilities costs while providing enhanced quality of medical care for veterans.

I believe that co-locating the Denver Veterans Medical Center with the University of Colorado Hospital will achieve the goals of providing the most modern, comprehensive and cost-effective medical care that our Nation can provide our veterans.

Congress has a duty to provide the best medical care it can to our Nation's veterans, and we must always strive for the very best health care services it can by utilizing the most cost-effective measures available, and for this reason, I am very much in support of Senate bill 1156 and encourage my colleagues to vote for it.

I have said it before, and so I am being redundant, but I will say it again, no one cares more about the veterans of this Nation than the gentleman from New Jersey (Mr. SMITH) and the gentleman from Connecticut (Mr. SIMMONS), and they have just done a magnificent job of putting this bill together with the limitations we have. It is a wonderful bill.

Mr. RODRIGUEZ. Mr. Speaker, I yield 3½ minutes to the gentlewoman from Nevada (Ms. BERKLEY), a member of the committee.

Ms. BERKLEY. Mr. Speaker, I thank the gentleman from Texas for his leadership in this issue.

Mr. Speaker, I rise today in support of this legislation which contains so many worthwhile VA medical construction projects across the country, including a medical complex in southern Nevada. I would like to thank the gentleman from New Jersey (Mr. SMITH), the Committee on Veterans' Affairs chairman, and the gentleman from Illinois (Mr. EVANS), the ranking member, for working closely with me and other members on this important measure.

Southern Nevada's veterans population is one of the fastest growing in the United States. The VA predicts that the number of annual visits by veterans in the Las Vegas Valley to their primary health care clinic will rise from 200,000 to more than a half a million by 2010. That is a mere 7 years from now, and the number of hospital beds needed to serve the veterans in my community will increase by 50 percent.

The VA is already struggling to address and meet the current demands on the VA health care structure in the Las Vegas valley. Last year, 1,500 southern Nevada veterans were sent to neighboring States because we could not provide the needed services locally. This is a terrible burden on those veterans and their families. They should not have to travel hundreds of miles across the country for needed care.

In addition, due to the decrepit conditions and structural deficiencies, the VA evacuated the Addelier D. Guy VA Clinic in Las Vegas after only 5 years in operation, forcing veterans to rely on a string of temporary clinics scattered across the Las Vegas Valley. I cannot tell my colleagues what a travesty it is when I see 80-year-old veterans waiting for a shuttle in 110 degree temperature in the middle of Las Vegas summers, waiting for a shuttle to pick them up to take them from one location to another for their health care needs. It is a horrible sight to see and must be corrected as quickly as possible.

In short, southern Nevada is facing a veterans health care crisis. Recently, the Department of Veterans' Affairs released the CARES document which proposes $4.6 billion worth of VA construction projects across the country. The CARES initiative directs funding to construct new facilities in areas where veterans populations are growing such as the Las Vegas Valley. Because of the explosive growth in the number of veterans living in and around Las Vegas, the CARES initiative calls for the construction of a full-scale medical facility, including a full-service patient care hospital and outpatient clinic and a comprehensive long-term care nursing facility of which we have none of those.

To fully understand the current health and medical care needs of the 5 million veterans and veteran services that will be needed in the next 20 years, the CARES Commission evaluated the plan and heard testimony in 38 public hearings across the country, including Las Vegas, from veterans, Members of Congress, VA employees, local government officials and veteran service groups. I commend the work of the CARES Commission. This process was done with our veterans squarely in mind, focused not only on those areas that have multiple facilities but also on the fastest growing regions, like southern Nevada, which lack the facilities needed to keep pace with the sudden influx of veterans from other areas of the country. Any plan to address shortcomings in veterans' care must reflect the need to expand services in areas where our veterans live.

This bill that I speak of, and that we are here today to discuss, authorizes the Secretary of the VA to provide $25 million to carry out the advance planning of a full-scale VA medical complex in Las Vegas, Nevada, as outlined through the draft of the CARES plan. This authorization is the first step in addressing the health care crisis of the veterans in southern Nevada.

I urge my colleagues to support this legislation. I cannot tell my colleagues how important it is to the veterans across the country.

Mr. SMITH of New Jersey. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Colorado (Mr. BEAUPREZ), who along with the gentleman from Colorado (Mr. HEFLEY) worked very, very hard for the Fitzsimons Hospital, and I am very grateful for their help.

Mr. BEAUPREZ. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, I am proud to speak today in support of the Veterans Health Care Capital Asset and Business Improvement Act of 2003.

Like many systems in the VA, the Denver Medical Veterans Center in Colorado was constructed about 50 years ago primarily to provide low-volume inpatient care to our veteran population in Colorado. Today, we have an opportunity to provide health care in a much more efficient manner.

This legislation, as has already been mentioned, will allow for the relocation of the VA hospital to the new Fitzsimons campus. Such relocation would allow for a modern facility to deliver modern health care on a state-of-the-art medical campus. The VA would be able to continue the synergistic University of Colorado partnership which will provide numerous operational efficiencies, as well as access to an extensive staff of doctors, technicians and specialists. S. 1156 would authorize this critical relocation.

It is my belief that the savings in operational efficiencies at Fitzsimons in itself will pay for the construction of the new hospital. Construction of a new hospital at Fitzsimons also allows for the ability to build a much-needed spinal cord injury center.

This new hospital and the strengthened partnership holds potential for cutting edge enhancements in veteran health care through collaborative research with the university. The unparalleled quality of health care that will be afforded to our veterans with this unique partnership is not something that we should deny our veterans. In addition to the university and the VA, this legislation authorizes the DOD to join the Fitzsimons VA partnership to provide health care to the nearby Buckley Air Force Base. Many of us believe that the new Fitzsimons VA Hospital may become a new model for delivery of health care for our veteran population.

Regardless of where our veterans happen to live, they deserve the best care possible, and as the House votes today on this measure, I ask that we all keep in mind the long-term planning mission of the VA, which is to improve access to and the quality and cost-effectiveness of veteran health care.

I want to particularly thank and commend my colleagues, the gentleman from Colorado (Mr. HEFLEY), especially the gentleman from New Jersey (Mr. SMITH), the chairman; and the gentleman from Connecticut (Mr. SIMMONS), subcommittee chairman; the gentleman from Texas (Mr. RODRIGUEZ), the subcommittee ranking member, and the gentleman from Illinois (Mr. EVANS), the ranking member, for their passionate, unrelenting service on behalf of our veterans and for bringing this legislation to the floor. I commend them, and I also thank my colleagues in the other body for looking favorably on this critical project. I strongly support the passage of S. 1156.

Mr. Speaker, I am proud to speak today in support of S. 1156, the Veterans Health Care Capital Asset and Business Improvement Act of 2003. Many facilities in the VA healthcare system are run-down, decrepit buildings that are not conducive to providing quality healthcare to our veterans.

The Denver Veterans Medical Center in Colorado was constructed about 50 years ago primarily to provide low-volume inpatient care to our veteran population. In Colorado today, we have an opportunity to provide health care in a much more efficient manner.

The Denver Veterans Medical Center in its decaying state is faced with two main alternatives with regard to their facility. The first alternative is to invest in the renovation of this facility to make it capable of handling the medical needs of our current veteran population, and the changing needs of that population over the next 20 years. After such a renovation, not only would the VA still be left with a 50-year old buildings, but it would also be an orphaned medical center, as the University of Colorado Health Science Center—the VA partner for 50 years—is relocating to the redeveloping Fitzsimons Army Base.

The second alternative is to relocate the VA Hospital to the new Fitzsimons campus, as well. Such relocation would allow for a modern facility to deliver modern health care on a state of the art medical campus. The VA would be able to continue the synergistic University of Colorado partnership, which will provide numerous operational efficiencies as well as access to an extensive staff of doctors, technicians, and specialists. S. 1156 would authorize this critical relocation.

It is my belief that the savings in operational efficiencies at Fitzsimons in itself will pay for the construction of the new hospital. Construction of a new hospital at Fitzsimons also allows for the ability to build a much-needed Spinal Cord Injury center.

One final reason construction of a new VA hospital at Fitzsimons is a better option, lies in the hospital's potential for cutting-edge enhancements in veteran health care through collaborative research with the university. The unparallel quality of healthcare that will be afforded to veterans with this unique partnership is not something we can deny to our veterans. Additionally, this legislation authorizes the DOD to join in the Fitzsimons VA partnership to provide healthcare to the nearby Buckley Air Force Base. Many of us believe that the new Fitzsimons VA Hospital may become a new model for delivery of healthcare for our military veterans.

Regardless of where our veterans happen to live, they deserve the best care possible. As the House votes on this measure today, I ask that we all keep in mind the long-term planning mission of the VA: "to improve access to, and the quality and cost effectiveness of, veterans health care." I would like to thank my colleagues Mr. HEFLEY, Chairman SMITH and Chairman SIMMONS for their leadership on their efforts to bring this measure to the floor. I also thank my colleagues in the other body for looking favorably on this critical project. I strongly support S. 1156 and hope my colleagues will join me in passing this important legislation.

Mr. RODRIGUEZ. Mr. Speaker, I yield 3 minutes to the gentlewoman from California (Ms. MILLENDER-McDONALD).

Ms. MILLENDER-McDONALD. Mr. Speaker, I rise in strong support of the Department of Veterans Affairs Long-Term Care and Personnel Authorities Enhancement Act of 2003. I would like to thank the gentleman from New Jersey (Chairman SMITH) and the gentleman from Illinois (Ranking Member EVANS) for their commitment to veterans issues and their steadfast leadership and dedication to those men and women who have served us admirably in this country and throughout the world.

I want to also thank the gentleman from Connecticut (Mr. SIMMONS), subcommittee chair, and the gentleman from Texas (Mr. RODRIGUEZ), the ranking member, for their dedication and leadership. They are all steadfast in ensuring that veterans have their proper stay in terms of care.

Another person who has worked tirelessly for the committee and for Filipino veterans is my colleague and friend from California (Mr. FILNER). His commitment and resolve has been stellar on behalf of these veterans whom we both serve.

□ 1300

This bill, Mr. Speaker, is a long time coming. There are many, many good measures in this bill. I applaud the committee for doing good and timely work.

Mr. Speaker, addressing the current and future needs of our veterans must continue to be a national top priority. There is one important measure in this bill, though, that has been particularly close to me for the past several years. I want to applaud and thank members of the Committee on Veterans' Affairs for including the authorization to provide hospital and nursing home care and medical services to Filipino World War II veterans of the Philippines Commonwealth Army and former Philippines New Scouts in the same manner that is provided for other U.S. veterans and who reside permanently in the United States.

Currently, there are 11,000 World War II Filipino veterans who are citizens or legal residents of the United States. Many of these brave veterans are in their seventies and eighties and in desperate need of health benefits, and I am proud to represent many of them in my district. Passage of this language provides health benefits to these brave men, as well as benefiting our communities across the country.

I represent a district with approximately 35,000 Filipinos, the largest population of Filipino veterans in America. And for several years now, I have put my heart and soul into the welfare of many Filipino veterans who have asked me to help them in their struggle for recognition and equity in acquiring benefits.

I have witnessed firsthand how providing these long overdue health benefits will affect our families, our neighborhoods, our friends and, ultimately, our communities. I urge my colleagues to support this very important legislation on behalf of all of our veterans, and especially these Filipino veterans who have waited long enough.

Finally, I want to commend the committee on H.R. 2297, the Veterans Benefit Act of 2003, which passed the floor last night. This legislation addressed many issues that are also very important to the Filipino community. H.R. 2297 included language that extended eligibility for burial in the National Cemeteries to new Filipino scouts.

For this, Mr. Speaker, and for all other reasons and the great provisions of this bill, I want to thank the committee, and especially thank the Secretary of Veterans Affairs, Secretary Principi, for his leadership and guidance.

Mr. SMITH of New Jersey. Mr. Speaker, I yield 1 minute to my good friend, the gentleman from Nevada (Mr. GIBBONS).

Mr. GIBBONS. Mr. Speaker, in honor of our former friend and colleague, a World War II veteran, the veterans' great friend across this country, the late Bob Stump, I rise in strong support of this legislation, S. 1156, the Department of Veterans Affairs Long-Term Care and Personnel Authorities Enhancement Act of 2003. I want to add my voice in support of those who have already spoken in support of this legislation.

This bill goes a long way in providing our Nation's veterans with the medical care that they have earned and deserve. The long-term health care that this bill provides communities across the country, including southern Nevada, is desperately needed. Southern Nevada, as you have already heard, has one of the highest, fastest-growing veterans populations in the country; and their needs have far outstrip the current care capacity of the current VA facilities in the area.

Fulfilling the current and future health care needs of our veterans must remain a high priority. I applaud the commitment of our colleagues in the House, especially the Nevada delegation, in meeting the needs of Nevada's veterans. I also applaud the work of my colleagues in the other Chamber on this bill.

I urge my colleagues in the House to support S. 1156. The assistance it provides to Nevada's veterans and veterans across this country is long overdue.

Mr. RODRIGUEZ. Mr. Speaker, I yield 3 minutes to the gentleman from California (Mr. THOMPSON), who has been in the forefront of the issue of Project SHAD and Project 112.

Mr. THOMPSON of California. Mr. Speaker, I thank the ranking member for yielding me time.

Mr. Speaker, I rise today in support of this bill. It includes a number of provisions that are of critical importance to our veterans community. One such inclusion is based on the bill authored by the gentleman from Texas (Mr. RODRIGUEZ) that would provide health care free of charge to veterans who participated in what are known as Project 112 and Project SHAD. These projects were a series of over 100 tests that subjected our servicemen and our servicewomen to harmful chemical and biological agents and possibly to decontaminates now believed to be harmful. While we still have a long way to go in getting to the bottom of this issue, this bill provides important care to our veterans who, in many cases, unknowingly participated in these trials. I commend the gentleman from Texas (Mr. RODRIGUEZ) and the other members of the committee for working to provide for this critical health care provision.

My own experience with this came when a constituent of mine called and said that he had participated in Project SHAD. He and a number of his shipmates now have cancer, and he wanted help.

After 3 years of investigation, the Department of Defense revealed last year that these tests involved live agents, in some cases, VX nerve gas, sarin nerve gas, and E. coli. The Department of Defense describes VX as one of the most lethal substances ever synthesized, and sarin, as we all know, was used in that tragic terrorist attack, not only tragic, but deadly terrorist attack, on the Tokyo subway a few years ago. We put at least 5,000 of our servicemembers at risk by exposing them to these hazardous agents.

We have a duty to rectify this disgraceful conduct on the part of the Department of Defense. Project 112 and Project SHAD and similar cases of chemical and biological testing involving servicemembers are issues of trust and integrity. Our military personnel put their trust in our government to protect them, and our integrity has been compromised because, nearly 40 years later, we are still not protecting them.

I urge all Members of this House to vote for this bill and take one step towards renewing this trust in our veterans, whom we so respect and so depend upon.

Mr. SMITH of New Jersey. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Nebraska (Mr. OSBORNE).

Mr. OSBORNE. Mr. Speaker, I would like to especially thank the gentleman from New Jersey (Chairman SMITH), the gentleman from Connecticut (Chairman SIMMONS), and the gentleman from Texas (Mr. RODRIGUEZ) for their work on this bill. It is an excellent piece of legislation.

Mr. Speaker, the biggest veterans health care issue in my district, which is largely rural, is access. We have a great many veterans who are driving hundreds of miles and sometimes many hours to a clinic; and as a result, many of them, particularly the oldest and the sickest, simply cannot get there. They do not have access. Also, of course, they are facing waiting lists sometimes of several months.

Mr. Speaker, what I did was I submitted legislation to provide vouchers for health care to local hospitals. That legislation is not in this particular bill. However, this legislation expresses the sense of Congress that the Secretary of Veterans Affairs should take steps to ensure that an appropriate mix of facilities and clinical staff is available for health care for veterans residing in rural areas. I really applaud members for getting that in there, because I think that is badly needed.

In addition, the legislation also contains a requirement that 120 days after the date of enactment of this legislation, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the House a report describing the steps the Secretary is taking to improve access to health care for veterans residing in rural areas.

So I applaud Members for getting that in there and also requiring at least a 120-day report. We appreciate this. I would like to thank my colleagues for including these important provisions, and thank them for this bill. I urge support.

Mr. RODRIGUEZ. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. ORTIZ), whom we consider our dean, who is also responsible for some of this legislation.

Mr. ORTIZ. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, this bill requires a plan for in-patient services for veterans in south Texas by January 31, 2004, either through VA or through contracts with private hospitals.

Of course, I would like to thank my good friend, the gentleman from Ohio (Mr. HOBSON), for his help in finding more health services for our veterans; and also my good friend, the gentleman from New Jersey (Chairman SMITH); the gentleman from Illinois (Chairman SIMMONS), my good friend; the gentleman from Illinois (Mr. EVANS); and, of course, the gentleman from Texas (Mr. RODRIGUEZ), who intervened at a critical point to ensure south Texas was kept in this bill.

In my district I have four military installations. Through the years, we know what happens when a veteran gets ready to retire. What he does is he moves close to a military installation. Well, in this case the hospital that we had was shut down several years ago. But now under this bill and with this contract that they are talking about, opening up for in-patient care, it gives hope to the veterans who live in the area.

Mr. Speaker, we have veterans from the Second World War and the Korean War. Some of them are bed-ridden, and it takes 6 to 7 hours for them to go to the nearest VA hospital, which happens to be in San Antonio. I think that part of the healing process is the idea of being close to your family. But when you are removed from your family and have to travel and take that patient away from his family to a point that is 200 to 300 miles away, it does not work.

They deserve no less than this. The Lord knows that these VA patients and veterans have waited for a long, long time.

I am glad that this bill is also honoring my good friend that I got to know for a long time, Bob Stump from Arizona. I am glad that we are honoring his memory.

Please, I ask my friends to vote for this bill.

Mr. SMITH of New Jersey. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Florida (Mr. MILLER), and thank him for the great work he did on the Pensacola Outpatient Clinic, the $45 million that he was instrumental in putting in there.

Mr. MILLER of Florida. Mr. Speaker, I will not say many of the things that a lot of my colleagues have already said on the floor today, but I do want to say thank you to our chairman, the gentleman from New Jersey (Mr. SMITH), our subcommittee chairman, the gentleman from Illinois (Mr. SIMMONS), and certainly the ranking member. In fact, I thank all the members of the Committee on Veterans' Affairs on both sides of the aisle.

I want to say that the first district of Florida probably includes some of the most striking examples of access to care challenges that this country ever had. I have almost 100,000 veterans that live in the Panhandle. All of them are eligible to receive health care through the VA. Pensacola ranks in the top 10 in veteran populations in the Nation, and Fort Walton Beach tops that list.

Despite these numbers, our community-based outpatient clinic in Pensacola treats twice the number of Panhandle veterans than it was designed to do. Veterans in Fort Walton and farther east must travel to the other side of Eglin Air Force Base, which spans over 700 square miles in the middle of my district, in order to even reach the Pensacola clinic. For VA in-patient care, all of my patients must go to Biloxi, Mississippi, a trip upwards of 200 miles for some of my residents.

I would say in VA's budget submission for this fiscal year, the Pensacola facility was described as "obsolete."

This description does not even come close to painting an accurate picture of the crowded and totally inadequate facility. The time to move forward on providing a new facility is now, and this bill sets the pace.

I am proud that the Naval Hospital Pensacola has been ahead of the bell curve on the implementation of cosharing agreements, as has the 96th Medical Group at Eglin Air Force Base. Whereas both facilities have the potential to set the pace for the rest of the Nation in regards to issues of VA and DOD resource-sharing, the CARES Commission report acknowledges this in its "highest priority project request" for land to build a replacement Pensacola clinic at the Naval Hospital Pensacola, with the Navy to provide contract hospitalization for medicine and surgical care.

This bill, Mr. Speaker, underscores the solidarity amongst all stakeholders in this endeavor. I would say that nothing makes me prouder than to represent the veterans of northwest Florida, and I urge my colleagues to support S. 1156.

Mr. RODRIGUEZ. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, let me take this opportunity, first of all, to thank the gentleman from New Jersey (Chairman SMITH) and the gentleman from Illinois (Chairman SIMMONS) for their hard work on this particular bill.

I also want to take time to also recognize our leading Democrat, the gentleman from Illinois (Mr. EVANS), for his hard work on this specific bill. I also want to take this opportunity to thank all the Members who participated to make this happen, such as the gentleman from Texas (Mr. ORTIZ) and the gentleman from California (Mr. THOMPSON), as well as those on the Republican side.

Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

□ 1315

Mr. SMITH of New Jersey. Mr. Speaker, I yield 1 minute to the gentleman from Ohio (Mr. TIBERI), and thank the gentleman for his work on the Columbus, Ohio project which has advance planning funds to the tune of $9 million in this bill.

Mr. TIBERI. Mr. Speaker, I am very disappointed that this final bill does not fully authorize a new veterans health care facility in central Ohio, as was done in the House bill we approved earlier this year, thanks to the hard work by the gentleman from Ohio (Chairman HOBSON), my central Ohio colleague; but as importantly, the gentleman from New Jersey (Chairman SMITH) and the subcommittee chairman, the gentleman from Connecticut (Mr. SIMMONS), who worked extremely hard to get that commitment in the bill that we passed here, a facility badly in need of expansion. That $90 million represented a beginning-to-end commitment that this House made. This bill before us includes only $9 million for planning purposes. That cut was made by the other body, and is something that we in the House knew nothing about, were not consulted with, and we are stuck with the version before us today.

The money included in this bill for the new central Ohio veterans' facility is a start for an area long underserved by the veterans administration, but it is only a start. I want to assure the veterans community in central Ohio that I am committed to finishing the job and making a new expanded health care facility a reality in the years to come.

Mr. SMITH of New Jersey. Mr. Speaker, I yield 1 minute to the gentleman from Connecticut (Mr. SIMMONS).

Mr. SIMMONS. Mr. Speaker, I would like to briefly respond to the gentleman from Ohio (Mr. TIBERI) to say that it is a start, it is a good start, and we are going to be with the gentleman all the way. I look forward to coming to Ohio with Secretary Principi to visit the facility.

I would also like to thank the subcommittee staff director, John Bradley, and the minority staff director, Susan Edgerton for their hard work, and I would like to make a comment. Over 100 years ago, the U.S. Marine Corps was dispatched to China to relieve the diplomatic legations in that country that were under great pressure from the Boxer Rebellion, and when they came back, they adopted the term "gung-ho." To be gung-ho, to be enthusiastic, to be filled with vigor for something. But the term "gung-ho" comes from the Chinese. I see the gentleman from Illinois (Mr. EVANS) is smiling, he probably knows, which means work together.

Under the leadership of the chairman and the ranking member, we have worked together on this legislation, and we have accomplished something that we have not accomplished for 5 years, which is an authorization bill, hopefully, heading to the White House for the President's signature.

Mr. SMITH of New Jersey. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, first of all, I thank the gentleman from Illinois (Mr. EVANS). Again, we have collaborated on a bill working with the subcommittee chairman, the gentleman from Connecticut (Mr. SIMMONS), and the ranking member, the gentleman from Texas (Mr. RODRIGUEZ), and we have produced an extraordinarily good piece of legislation.

We worked with the other body, and I want to thank Senator ARLEN SPECTER, the chairman, and the ranking member, Senator GRAHAM. There was give and take, obviously. We began working on this very comprehensive product last spring. Again, this is a combination of a number of bills rolled and packaged into one bill. Project Shad was mentioned earlier by my colleague from California, and the gentleman from Texas (Mr. RODRIGUEZ) mentioned it as well. This bill is not everything we would like. The next time I find a bill on this floor that is will be the first time.

We did pass over to the other body the full money for the Columbus project, and we got back advance planning funding from the other body. While it is not everything we wanted, it certainly will ensure that that project goes forward. The $9 million is not chump change and will be sufficient to get the job done. I want to assure my colleagues we have done our due diligence. This is a very good piece of veterans legislation.

I want to thank our staff, Pat Ryan; John Bradley, who is the staff director for the subcommittee; Kingston Smith, our deputy chief counsel; Jeannie McNally; Mary McDermott; Peter Dickinson; Steve Kirkland; Bernie Dotson; Summer Larson; Kathleen Greve; Delores Dunn; Paige McManus; Devon Seibert; and Veronica Crowe. As my colleague mentioned, we have had great cooperation with our friends on the other side of the aisle.

Again, this is a quintessential bipartisan piece of legislation, something that this entire body can be proud of, and it will advance the ball significantly when it comes to veterans health care as well as the construction project.

Let me also remind my colleagues that we have passed over to the other body H.R. 11 and another bill that I sponsored and a bill that the gentleman from Kansas (Mr. MORAN) sponsored in the last Congress, and they never came back. They listed a number of projects that should have but did not get funded and were not authorized. Now, finally in this Congress, under the great leadership of the gentleman from Connecticut (Mr. SIMMONS), we have gotten that product back from the Senate, and it will go to President Bush for his signature. This is a great day for veterans. Again, I thank all of my colleagues for their cooperation and leadership.

Mr. Speaker, I include for the RECORD a joint explanatory statement.

EXPLANATORY STATEMENT ON S. 1156, AS AMENDED, VETERANS HEALTH CARE, CAPITAL ASSET, AND BUSINESS IMPROVEMENT ACT OF 2003

S. 1156, as amended, the Veterans Health Care, Capital Asset, and Business Improvement Act of 2003 ("Compromise Agreement") reflects a negotiated agreement reached by the Senate and House of Representatives Committees on Veterans' Affairs concerning provisions in a number of bills considered by the House and Senate during the 1st session of the 108th Congress. The measures considered in this compromise are: S. 1156, as amended, as reported by the Senate Committee on Veterans' Affairs on November 10, 2003; S. 1815 introduced on November 4, 2003 ("Senate Bill"); H.R. 2357, as amended, passed the House on July 21, 2003; H.R. 2433, as amended, passed the House on September 10, 2003; H.R. 1720, as amended, passed the House on October 29, 2003; H.R. 3260, as introduced in the House on October 8, 2003; and H.R. 3387, as introduced in the House on October 29, 2003 ("House Bill").

The House and Senate Committees on Veterans' Affairs have prepared the following explanation of the Compromise Agreement. Differences between the provisions contained in the Compromise Agreement and the related provisions of the Senate bill and the House bills are noted, except for clerical corrections, conforming changes made necessary by the Compromise Agreement, and minor drafting, technical, and clarifying changes.

TITLE I—HEALTH CARE AUTHORITIES AND RELATED MATTERS

IMPROVED BENEFITS FOR FORMER PRISONERS OF WAR

Current Law

Section 1712 of title 38, United States Code, authorizes outpatient dental services and related dental appliances to veterans who are former prisoners of war (POWs) if they were detained or interned for a period of at least 90 days.

Section 1722A of title 38, United States Code, requires veterans who are not service-connected with a disability rated at more than 50 percent or eligible for pensions under section 1521 of title 38, United States Code, to make copayments for medications.

Senate Bill

The Senate Bill contains no comparable provision.

House Bill

Section 3 of H.R. 3260 would authorize veterans who are former POWs to receive outpatient dental care, irrespective of the number of days held captive, and would exempt former POWs from the requirement to make copayments on outpatient prescription medications.

Compromise Agreement

Section 101 of the Compromise Agreement follows the House language.

PROVISION OF HEALTH CARE TO VETERANS WHO PARTICIPATED IN CERTAIN DEPARTMENT OF DEFENSE CHEMICAL AND BIOLOGICAL WARFARE TESTING

Current Law

There is no comparable provision in current law.

Senate Bill

The Senate Bill contains no comparable provision.

House Bill

Section 2 of H.R. 2433, as amended, would authorize the Department of Veterans Affairs ("VA" or "Department") to provide higher priority health care to veterans who participated in Project Shipboard Hazard and Defense (SHAD), Project 112 or related land-based tests conducted by the Department of Defense Deseret Test Center, from 1962 through 1973, without those veterans needing an adjudicated service-connected disability to establish their priority for care.

Compromise Agreement

Section 102 of the Compromise Agreement follows the House language.

ELIGIBILITY FOR DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE FOR CERTAIN FILIPINO WORLD WAR II VETERANS RESIDING IN THE UNITED STATES

Current Law

Section 1734 of title 38, United States Code, establishes that veterans of the Commonwealth Army and New Philippine Scouts residing legally in the United States are eligible for VA health care services for the treatment of service-connected disabilities and, in the case of Commonwealth Army veterans, for non-service-connected conditions if they are in receipt of disability compensation.

Senate Bill

Section 421 of S. 1156 contains a similar provision.

House Bill

Section 3 of H.R. 2357, as amended, would authorize VA health care for additional World War II Filipino veterans who reside legally in the United States. These veterans of the Commonwealth Army and new Philippine Scouts, would be subject to the same eligibility and means test requirements as U.S. veterans. The House bill would require the Secretary of Veterans Affairs ("Secretary") to certify each fiscal year that sufficient resources are available at the VA health care facilities where the majority of these veterans would seek care.

Compromise Agreement

Section 103 of the Compromise Agreement follows the House language, except the Compromise Agreement does not include the resource availability certification requirement.

ENHANCEMENT OF REHABILITATIVE SERVICES

Current Law

Chapter 31 of title 38, United States Code, authorizes VA to provide vocational rehabilitation services. VA is authorized under chapter 17 of title 38 to offer medical care and compensated work therapy to certain veterans.

Senate Bill

The Senate Bill contains no comparable provision.

House Bill

Section 3 of H.R. 3387 would authorize the Secretary to provide therapeutic employment support services (i.e., skills training and development services, employment support services, and job development and placement services) to patients in need of rehabilitation for mental health disorders, including serious mental illness and substance use disorders.

Section 3 of H.R. 3387 would also authorize VA to use funds in the Special Therapeutic and Rehabilitation Activities Fund (STRAF) authorized under section 1718(c) of title 38, United States Code, to furnish such therapeutic employment support services.

Compromise Agreement

Section 104 of the Compromise Agreement follows the House language.

ENHANCED AGREEMENT AUTHORITY FOR PROVISION OF NURSING HOME CARE AND ADULT DAY HEALTH CARE IN CONTRACT FACILITIES

Current Law

Section 1720 of title 38, United States Code, authorizes VA to contract for the provision of nursing home care and adult day health care for certain veterans and members of the Armed Forces.

Senate Bill

Section 102 of S. 1156 would expand VA's authority to enter into relationships based upon "provider agreements" with Centers for Medicare and Medicaid Services (CMS)-certified, small, community-based nursing homes and non-institutional extended care providers, by permitting VA to use provider agreements similar to those used by CMS.

House Bill

The House Bill contains no comparable provision.

Compromise Agreement

Section 105 of the Compromise Agreement generally follows the Senate language.

FIVE-YEAR EXTENSION OF PERIOD FOR PROVISION OF NONINSTITUTIONAL EXTENDED-CARE SERVICES AND REQUIRED NURSING HOME CARE

Current Law

Section 1701(10)(A) of title 38, United States Code, requires VA to provide noninstitutional extended care services to enrolled veterans. In addition, section 1710A(c) of title 38, United States Code, requires VA to provide nursing home care to high-priority veterans in need of care.

Senate Bill

Section 101 of S. 1156 would extend the authorities for noninstitutional extended care and required nursing home care through December 31, 2008.

House Bill

Section 2 of H.R. 3260 would extend the authorities for the noninstitutional extended care services and required nursing home care to December 31, 2008. The report required under section 101 of Public Law 106–117 would be extended until January 1, 2008.

Compromise Agreement

Section 106 of the Compromise Agreement follows the House language from subsection 2(a) and (b) of H.R. 3260.

EXPANSION OF DEPARTMENT OF VETERANS AFFAIRS PILOT PROGRAM ON ASSISTED LIVING FOR VETERANS

Current Law

Section 103(b) of Public Law 106–117 authorizes the establishment of a pilot program in one VA geographic health care region to provide assisted living services to veterans.

Senate Bill

Section 103 of S. 1156 would authorize the establishment of one additional assisted living pilot program for three years from the commencement of the provision of assisted living services under the program.

House Bill

The House Bill contains no comparable provision.

Compromise Agreement

Section 107 of the Compromise Agreement follows the Senate language.

IMPROVEMENT OF PROGRAM FOR PROVISION OF SPECIALIZED MENTAL HEALTH SERVICES TO VETERANS

Current Law

Section 116(c) of Public Law 106–117 provides funding in the amount of $15,000,000 for specialized mental health services in fiscal years 2004, 2005 and 2006.

Senate Bill

Section 104 of S. 1156 would increase the funding authorization for these specialized mental health services from $15,000,000 to $25,000,000, and would specify allocation of these funds outside the Veterans Equitable Resource Allocation system.

House Bill

The House Bill contains no comparable provision.

Compromise Agreement

Section 108 of the Compromise Agreement follows the Senate language.

TITLE II—CONSTRUCTION AND FACILITIES MATTERS

Subtitle A—Program Authorities

INCREASE IN THRESHOLD FOR MAJOR MEDICAL FACILITY CONSTRUCTION PROJECTS

Current Law

Section 8104(a)(3) of title 38, United States Code, defines a major medical facility project as a project for construction, alteration, or acquisition of a medical facility involving a total expenditure of more than $4,000,000.

Senate Bill

Section 201 of S. 1156 would raise the threshold for major medical facility projects from $4,000,000 to $9,000,000.

House Bill

Section 7 of H.R. 1720, as amended, would raise the threshold for major medical facility projects from $4,000,000 to $6,000,000.

Compromise Agreement

Section 201 of the Compromise Agreement would raise the threshold for major medical facility projects from $4,000,000 to $7,000,000.

ENHANCEMENTS TO ENHANCED-USE LEASE AUTHORITY

Current Law

Section 8162 of title 38, United States Code, authorizes the Secretary to enter into enhanced-use leases of Veterans Health Administration (VHA) real property under the jurisdiction of the Secretary.

Senate Bill

The Senate Bill contains no comparable provision.

House Bill

Section 4 of H.R. 3260 would extend the jurisdiction of this authority to the Veterans Benefits Administration (VBA) and National Cemetery Administration (NCA), for properties of these Administrations under the control of the Secretary. Further, the bill would streamline the process and notification requirements and allow proceeds from an enhanced-use lease to be credited to accounts for use by VHA, VBA or NCA as appropriate. The bill would allow individual VA facilities to be reimbursed for the expenses incurred by the development and execution of enhanced-use leases.

Compromise Agreement

Section 202 of the Compromise Agreement adopts the provisions of the House bill which streamline the approval process for enhanced use leases in VHA. The provisions concerning the expansion of this authority to properties of NCA and VBA have been omitted due to mandatory spending concerns.

SIMPLIFICATION OF ANNUAL REPORT ON LONG-RANGE HEALTH PLANNING

Current Law

Section 8107 of title 38, United States Code, requires VA to submit annually a report regarding the long-range health planning of the Department. Included in that report is a five-year strategic plan for the provision of health care services to veterans, a plan for the coordination of care among the geographic health care regions of the Department, a profile of each such region, any planned changes to the mission of any medical facility of the Department, and a listing of the 20 VA major medical facility projects with the highest priority.

Senate Bill

The Senate Bill contains no comparable provision.

House Bill

Section 7(d) of H.R. 3260 would change the report date on the Annual Report on Long-Range Health Planning to June 1 of each year.

Compromise Agreement

Section 203 of the Compromise Agreement rescinds section 8107(b)(3) and (4) of title 38, United States Code, to simplify the required report by removing the detailed prescription of its content.

Subtitle B—Project Authorizations

AUTHORIZATION OF MAJOR MEDICAL FACILITY PROJECTS

Current Law

Section 8104(2) of title 38, United States Code, requires Congressional authorization of any VA major medical facility construction project.

Senate Bill

Section 211 of S. 1156 would authorize the following major construction projects:

Location	Purpose	Cost
Lebanon, PA	New Long-Term Care Facility	$14,500,000
Beckley, WV	New Long-Term Care Facility	20,000,000

House Bill

Section 3 of H.R. 1720, as amended, would authorize the following major construction projects:

Location	Purpose	Cost
Chicago, IL	New Inpatient Bed Tower	$98,500,000
San Diego, CA	Seismic Corrections, Building 1.	48,600,000
West Haven, CT	Renovate Inpatient Wards & Consolidate Research Facilities.	50,000,000
Columbus, OH	New Medical Facility	90,000,000
Pensacola, FL	New VA-Navy Joint Venture Outpatient Clinic.	45,000,000

Compromise Agreement

Section 211 of the Compromise Agreement authorizes the major construction projects for Lebanon, Pennsylvania; Beckley, West Virginia; Chicago, Illinois; San Diego, California; West Haven, Connecticut; and Pensacola, Florida.

AUTHORIZATION OF MAJOR MEDICAL FACILITY LEASES

Current Law

Section 8104 of title 38, United States Code, requires Congressional authorization of any VA medical facility lease with an annual lease payment of more than $600,000.

Senate Bill

Section 212 of S. 1156 would authorize the following leases:

Location	Purpose	Cost
Denver, CO	Relocate Health Administration Center.	$4,080,000
Pensacola, FL	Relocate Outpatient Clinic	3,800,000
Boston, MA	Extend Outpatient Clinic	2,879,000
Charlotte, NC	Relocate Outpatient Clinic	2,626,000

House Bill

Section 3 of H.R. 1720, as amended, would authorize the following leases:

Location	Purpose	Cost
Charlotte, NC	Outpatient Clinic	$3,000,000
Clark County, NV	Multi-specialty Outpatient Clinic.	6,500,000
Aurora, CO	Regional Federal Medical Center.	30,000,000

Compromise Agreement

Section 212 of the Compromise Agreement authorizes the leases for Charlotte, North Carolina; and Boston, Massachusetts.

The Compromise Agreement contains the provision of Section 211 of H.R. 1720, as amended, to authorize a major construction project for Pensacola, Florida. It was determined that no lease authority for the Pensacola site was necessary. Further, the Compromise Agreement would not authorize a lease supporting relocation and expansion of the Health Administration Center (HAC) in Denver, Colorado. The Committees believe the Department has not justified the continuing expansion of activities at the HAC. The Committees are concerned that this administrative function, originally authorized to process reimbursement claims for the Civilian Health and Medical Program for the VA (CHAMPVA), has inflated its activities well beyond its original responsibilities. The Committees urge VA to reconsider whether the long-term obligation of leased space and the significant growth of staff at the HAC, as opposed to other methods of accomplishing these various tasks, are warranted.

The Compromise Agreement generally follows the Senate language on the Regional Federal Medical Center lease at the former Fitzsimons Army Medical Center in Aurora, Colorado, pending a decision by the Secretaries of Veterans Affairs and Defense on the nature of any joint venture undertaking at the site. However, advance planning is authorized for this project under section 213 of the Compromise Agreement.

ADVANCE PLANNING AUTHORIZATIONS

Current Law

Section 8104(2) of title 38, United States Code, requires Congressional authorization of all VA major medical facility construction project.

Senate Bill

The Senate Bill contains no comparable provision.

House Bill

Section 3 of H.R. 1720, as amended, would authorize major construction projects in Columbus, Ohio; Denver (Aurora), Colorado; and the lease of a Multi-specialty Outpatient Clinic in Clark County (Las Vegas), Nevada.

Compromise Agreement

Section 213 of the Compromise Agreement authorizes advance planning funds for fiscal year 2004 for purposes of developing new medical facilities at the following locations:

Location	Purpose	Cost
Columbus, OH	Advance Planning	$9,000,000
Las Vegas, NV	Advance Planning	25,000,000
Pittsburgh, PA	Advance Planning	9,000,000
Denver (Aurora), CO	Advance Planning	26,000,000
East Central Florida	Advance Planning	17,500,000

The Committees concluded these projects, while warranted, require further development. The Committees believe these projects should be considered high priorities from VA's ongoing review of future health care infrastructure needs, the Capital Asset Realignment for Enhanced Services (CARES) initiative.

Given VA's documented plan to pursue significant capital investments and improvements in health care infrastructure and the Committees' understanding that the Appropriations Committees of the House and Senate are hesitant to provide funds for new VA medical facility construction prior to the completion of the CARES process, the Compromise agreement authorizes $86,500,000 to allow for planning of projects at these sites.

AUTHORIZATION OF APPROPRIATIONS

Current Law

Section 8104(2) of title 38, United States Code, requires Congressional authorization of appropriations for VA major medical facility projects.

Senate Bill

Section 213 of S. 1156 would authorize $34,500,000 for fiscal year 2004 for projects authorized and $4,984,000 for the leases authorized by this bill.

House Bill

Section 3 of H.R. 1720, as amended, would authorize $332,100,000 to be appropriated in fiscal year 2004 for the projects authorized by this bill.

Compromise Agreement

Section 214 of the Compromise Agreement would authorize $276,600,000 for fiscal year 2004 for the major construction projects authorized in section 211 of the Compromise Agreement. In addition, section 214 of the Compromise Agreement authorizes the appropriation of $86,500,000 for advanced planning projects identified in section 213 of the Compromise Agreement.

Subtitle C—Capital Asset Realignment for Enhanced Services Initiative

AUTHORIZATION OF MAJOR CONSTRUCTION PROJECTS IN CONNECTION WITH CAPITAL ASSET REALIGNMENT INITIATIVE

Current Law

Section 8104(2) of title 38, United States Code, requires Congressional authorization of all VA major medical facility projects.

Senate Bill

Section 402 of S. 1156 would authorize the Secretary to carry out major construction projects outlined in the final report on the CARES initiative. This authority would be subject to a 60-day advance notification to Congress. The Secretary would be required to submit a list containing each major project in order of priority, based on the criteria specified in the bill. The bill also would add a provision authorizing multi-year contract authority for major construction projects.

House Bill

The House Bill contains no comparable provision.

Compromise Agreement

Section 221 of the Compromise Agreement follows the Senate language with modifications. The Compromise Agreement would require a 45-day advance notification to Congress prior to carrying out major medical facility construction projects selected by the Secretary. The Secretary would be required to submit a one-time report to Congress by February 1, 2004, that lists each proposed major construction project in order of priority. The Compromise Agreement establishes these priorities as follows: (a) to replace or enhance a facility necessitated by the loss, closure or other divestment of a VA medical facility currently in operation; (b) to remedy life-safety deficiencies, including seismic, egress, and fire deficiencies; (c) to provide health care services to an underserved population; (d) to renovate or modernize facilities, including providing barrier free design, improving building systems and utilities, or enhancing clinical support services; (e) to further an enhanced-use lease or sharing agreement; and (f) to give the Secretary discretion to select other projects of importance in providing care to veterans.

The authority to enter into any major medical facility construction contracts for projects selected under the authority of section 221 of the Compromise Agreement would expire on September 30, 2006.

ADVANCE NOTIFICATION OF CAPITAL ASSET REALIGNMENT ACTIONS

Current Law

There is no comparable provision in current law.

Senate Bill

Section 401 of S. 1156 would require the Secretary to provide Congress a 60-day advance notification of any actions proposed by the Department under the CARES initiative.

House Bill

The House Bill contains no comparable provision.

Compromise Agreement

Section 222 of the Compromise Agreement follows the Senate language with modifications. VA would be required to notify Congress in writing of actions under the CARES initiative that would result in medical facility closures, significant staff realignments or medical facility consolidations. The Compromise Agreement would prohibit such actions for 60 days (or 30 days of continuous session of Congress) after such notifications are made.

SENSE OF CONGRESS AND REPORT ON ACCESS TO HEALTH CARE FOR VETERANS IN RURAL AREAS.

Current Law

There is no comparable provision in current law.

Compromise Agreement

Section 223 of the Compromise Agreement would express the sense of Congress recognizing the difficulties in access to VA health care faced by veterans residing in rural areas and require VA to report to the Committees on Veterans' Affairs with a plan of action to improve access to health care for veterans residing in rural areas. A report of VA's plan to improve access to health care for these veterans would be due not later than 120 days after the date of enactment of this Act.

Subtitle D—Plans for New Facilities

PLANS FOR HOSPITAL CARE FACILITIES IN SPECIFIED AREAS

Current Law

There is no comparable provision in current law.

Senate Bill

The Senate Bill contains no comparable provision.

House Bill

Section 6 of H.R. 1720, as amended, would require the Secretary to develop plans for meeting the future hospital care needs of veterans who reside in a number of counties of southern New Jersey and far southern counties of Texas, with a report to the Committees by January 31, 2004.

Compromise Agreement

Section 231 of the Compromise Agreement follows the House language and would add a requirement for plans for the Florida Panhandle and North Central Washington. The due date of the report required would be adjusted in section 231 of the Compromise Agreement to April 15, 2004.

STUDY AND REPORT ON FEASIBILITY OF COORDINATION OF VETERANS HEALTH CARE SERVICES IN SOUTH CAROLINA WITH NEW UNIVERSITY MEDICAL CENTER

Current Law

There is no comparable provision in current law.

Senate Bill

The Senate Bill contains no comparable provision.

House Bill

Section 8 of H.R. 1720, as amended, would require the Secretary to conduct a feasibility study in coordination with the Medical University of South Carolina and in consultation with the Secretary of Defense, to consider establishing a joint health-care venture to deliver inpatient, outpatient and/or long-term care to veterans, military personnel, and other beneficiaries who reside in Charleston, South Carolina, with a report to the Committees by March 31, 2004.

Compromise Agreement

Section 232 of the Compromise Agreement follows the House language and adjusts the due date of the report to April 15, 2004.

Subtitle E—Designation of Facilities

DESIGNATION OF DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER, PRESCOTT, ARIZONA, AS THE BOB STUMP DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER

Current Law

Section 531 of title 38, United States Code, requires a Department facility, structure or real property to be named after the geographic area in which the facility, structure or real property is located, except as expressly provided by law.

Senate Bill

The Senate Bill contains no comparable provision.

House Bill

Section 8 of H.R. 3260 would name the VA Medical Center in Prescott, Arizona, the "Bob Stump Department of Veterans Affairs Medical Center."

Compromise Agreement

Section 241 of the Compromise Agreement follows the House language.

DESIGNATION OF DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE FACILITY, CHICAGO, ILLINOIS, AS THE JESSE BROWN DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER

Current Law

Section 531 of title 38, United States Code, requires a Department facility, structure or real property to be named after the geographic area in which the facility, structure or real property is located, except as expressly provided by law.

Senate Bill

Section 222 of S. 1156 contains a similar provision.

House Bill

Section 9 of H.R. 1720, as amended, would name the VA Chicago Health Care System, West Side Division, the "Jesse Brown Department of Veterans Affairs Medical Center."

Compromise Agreement

Section 242 of the Compromise Agreement contains this provision.

DESIGNATION OF DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER, HOUSTON, TEXAS, AS THE MICHAEL E. DEBAKEY DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER

Current Law

Section 531 of title 38, United States Code, requires a Department facility, structure or real property to be named after the geographic area in which the facility, structure or real property is located, except as expressly provided by law.

Senate Bill

Section 223 of S. 1156 would name the VA Medical Center located in Houston, Texas, the "Michael E. DeBakey Department of Veterans Affairs Medical Center."

House Bill

The House Bill contains no comparable provision.

Compromise Agreement

Section 243 of the Compromise Agreement follows the Senate language.

DESIGNATION OF THE DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER, SALT LAKE CITY, UTAH, AS THE GEORGE E. WAHLEN DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER

Current Law

Section 531 of title 38, United States Code, requires a Department facility, structure or real property to be named after the geographic area in which the facility, structure or real property is located, except as expressly provided by law.

Senate Bill

S. 1815 would name the VA Medical Center located in Salt Lake City, Utah, the "George E. Wahlen Department of Veterans Affairs Medical Center."

House Bill

The House Bill contains no comparable provision.

Compromise Agreement

Section 244 of the Compromise Agreement follows the Senate language.

DESIGNATION OF DEPARTMENT OF VETERANS AFFAIRS OUTPATIENT CLINIC, NEW LONDON, CONNECTICUT

Current Law

Section 531 of title 38, United States Code, requires a Department facility, structure or real property to be named after the geographic area in which the facility, structure or real property is located, except as expressly provided by law.

Senate Bill

The Senate Bill contains no comparable provision.

House Bill

Section 10 of H.R. 1720, as amended, would name the outpatient clinic located in New London, Connecticut, the "John J. McGuirk Department of Veterans Affairs Outpatient Clinic."

Compromise Agreement

Section 245 of the Compromise Agreement follows the House language.

DESIGNATION OF DEPARTMENT OF VETERANS AFFAIRS OUTPATIENT CLINIC, HORSHAM, PENNSYLVANIA

Current Law

Section 531 of title 38, United States Code, requires a Department facility, structure or real property to be named after the geographic area in which the facility, structure or real property is located, except as expressly provided by law.

Senate Bill

Section 221 of S. 1156 would name the VA Outpatient Clinic located in Horsham, Pennsylvania, the "Victor J. Saracini Department of Veterans Affairs Outpatient Clinic."

House Bill

The House Bill contains no comparable provision.

Compromise Agreement

Section 246 of the Compromise Agreement follows the Senate language.

TITLE III—PERSONNEL MATTERS

MODIFICATION OF CERTAIN AUTHORITIES ON APPOINTMENT AND PROMOTION OF PERSONNEL IN THE VETERANS HEALTH ADMINISTRATION

Current Law

Section 7401 of title 38, United States Code, authorizes VA to appoint medical care personnel, under title 5, United States Code, or title 38, United States Code, depending on the duties of such personnel.

Senate Bill

Section 301 of S. 1156 would modify title 38, United States Code, to authorize the appointment of psychologists, kinesiologists and social workers, under title 38 provisions as opposed to title 5, United States Code, provisions.

House Bill

The House Bill contains no comparable provision.

Compromise Agreement

Section 301 of the Compromise Agreement follows the Senate language with modifications. The Compromise Agreement reflects two important policy goals: first, VA will be permitted to hire clinical staff in a timely fashion through use of the direct appointment authority provided in title 38, United State Code; second, employee representatives will be afforded an opportunity to participate in a dialogue and process with VA management to determine the best system under which to promote the clinicians appointed under this section.

The Committees believe that VA management and the promotion policy for clinical staff can benefit from interactions with employee representatives. The Committees would allow the Secretary the discretion to develop a system for judging the merits of an individual's advancement in VA, provided that the Secretary reports to the Committees the actions taken under this authority.

APPOINTMENT OF CHIROPRACTORS IN THE VETERANS HEALTH ADMINISTRATION

Current Law

Public Law 107–135 requires VA to establish a Veterans Health Administration-wide program for chiropractic care.

Senate Bill

The Senate Bill contains no comparable provision.

House Bill

Section 2 of H.R. 2357, as amended, would authorize VA appointment of chiropractors under title 38, United States Code. The House bill would establish the qualifications of appointees, the period of appointments and promotions, set grades and pay scales, provide temporary and part-time appointments, authorize residencies and internships, extend malpractice and negligence protection coverage, define chiropractors as scarce medical specialists for contracting purposes, authorize reimbursement of continuing professional education expenses, and exempt chiropractors from collective bargaining, consistent with the provisions in chapter 74 of title 38, the United States Code. The bill would provide for an effective date of 180 days from enactment.

Compromise Agreement

Section 302 of the Compromise Agreement follows the House language with modifications that would redefine "medical care" occupations as "health care" occupations and eliminate provisions that would provide for residencies and internships and reimbursement of continuing professional education expenses.

ADDITIONAL PAY FOR SATURDAY TOURS OF DUTY FOR ADDITIONAL HEALTH CARE WORKERS IN THE VETERANS HEALTH ADMINISTRATION

Current Law

Title 38, United States Code, specifies in sections 7453 and 7454 that nurses, physician assistants, and expanded-function dental auxiliaries are entitled to additional pay for working regular tours of duty of Saturdays. Under this authority, respiratory therapists, physical therapists, practical or vocational nurses, pharmacists and occupational therapists are also entitled to additional pay for Saturday tours, if the Secretary determines it is necessary in order to hire and retain these health care professionals.

Senate Bill

The Senate Bill contains no comparable provision.

House Bill

Section 4 of H.R. 2433, as amended, would amend section 7454(b) of title 38, United States Code, to authorize premium pay for Saturday tours of duty for additional VHA health care workers.

Compromise Agreement

Section 303 of the Compromise Agreement follows the House language.

COVERAGE OF EMPLOYEES OF VETERANS' CANTEEN SERVICE UNDER ADDITIONAL EMPLOYMENT LAWS

Current Law

Section 7802 of title 38, United States Code, authorizes appointment of Veterans' Canteen Service (VCS) employees.

Senate Bill

Section 302 of S. 1156 contains a similar provision.

House Bill

Section 5 of H.R. 2433, as amended, would authorize hourly workers of VCS to be qualified for competitive title 5, United States Code, appointments in VA in recognition of time-in service obtained in the VCS.

Compromise Agreement

Section 304 of the Compromise Agreement contains this provision.

TITLE IV—OTHER MATTERS

OFFICE OF RESEARCH OVERSIGHT IN VETERANS HEALTH ADMINISTRATION

Current Law

There is no comparable provision in current law.

Senate Bill

The Senate Bill contains no comparable provision.

House Bill

Section 11 of H.R. 1720, as amended, would add a new section 7307 to title 38, United States Code, to establish an Office of Research Oversight within the Veterans Health Administration to monitor, review and investigate matters of medical research compliance and assurance in VA, including matters relating to the protection and safety of human subjects, research animals and VA employees participating in VA medical research programs. The bill would require an annual report to the Committees on Veterans' Affairs of the Senate and House of Representatives on the activities of the Office of Research Oversight during the preceding calendar year and require that the activities of the Office of Research Oversight be funded from amounts appropriated for VA medical care.

Further, under the bill, the General Accounting Office (GAO) would be required to submit a report to Congress not later than January 1, 2006, on the results of the establishment of the Office of Research Oversight and any recommendations for other legislative and administrative actions. Finally, the Secretary would be required to submit a report to Congress setting forth the Department's implementation of the requirement to establish an Office of Research Oversight, and related provisions, not later than 180 days after the date of enactment.

Compromise Agreement

Section 401 of the Compromise Agreement follows the House language with modifications that would not include references to animal welfare, research animals and laboratory animals. Section 7307(c)(2)(A) of title 38, United States Code, referencing peer review responsibilities would also not be included in the Compromise Agreement, along with the required reports from GAO and the Secretary.

ENHANCEMENT OF AUTHORITIES RELATING TO NONPROFIT RESEARCH CORPORATIONS

Current Law

Sections 7361 through 7366 of title 38, United States Code, establish the authority for VA's Nonprofit Research Corporations. Section 7368 of title 38, United States Code, provides that no such corporations may be established after December 31, 2003.

Senate Bill

The Senate Bill contains no comparable provision.

House Bill

Section 6 of H.R. 3260 would cover employees of Nonprofit Research Corporations under the Federal Tort Claims Act and would extend the authority to create new Nonprofit Research Corporations through December 31, 2008.

Compromise Agreement

Section 402 of the Compromise Agreement follows the House language.

DEPARTMENT OF DEFENSE PARTICIPATION IN REVOLVING SUPPLY FUND PURCHASES

Current Law

Section 8121 of title 38, United States Code, establishes authority for VA to use a revolving supply fund to operate and maintain its supply system.

Senate Bill

The Senate Bill contains no comparable provision.

House Bill

Section 5 of H.R. 3260 would extend authority to the Secretary of Defense to purchase medical equipment, services and supplies through VA's revolving supply fund beginning in fiscal year 2004. The Department of Defense (DOD) would be required to reimburse VA's revolving supply fund using DOD appropriations.

Compromise Agreement

Section 403 of the Compromise Agreement follows the House language.

FIVE-YEAR EXTENSION OF HOUSING ASSISTANCE FOR HOMELESS VETERANS

Current Law

Section 2041(c) of title 38, United States Code, authorizes the Secretary to enter into housing assistance agreements for homeless veterans until December 31, 2003.

Senate Bill

Section 411 of S. 1156 would extend the authority of the Secretary to enter into housing assistance agreements through December 31, 2006.

House Bill

Section 6 of H.R. 3387 would extend the authority of the Secretary to enter into housing assistance agreements until December 31, 2008.

Compromise Agreement

Section 404 of the Compromise Agreement follows the House language.

REPORT DATE CHANGES

Current Law

Title 38, United States Code, requires:

(a) in section 516(e)(1)(A), a quarterly report summarizing the employment discrimination complaints filed against senior managers; the report is due no later than 30 days after the end of each quarter;

(b) in section 2065(a), an annual report on assistance to homeless veterans; the report is due no later than April 15 each year;

(c) in section 7321(d)(2), an annual report of the Committee on Care of Severely Chronically Mentally Ill Veterans; the report is due no later than February 1 each year through 2004;

(d) in section 8107, an annual report on long-range health planning; due June 1 of each year;

(e) in section 8153(g), an annual report on sharing of health care resources; the report is due no later than 60 days after the end of each fiscal year;

(f) in section 1712A note and enacted in section 110(e)(2) of Public Law 106–117, an annual report of the Special Committee on PTSD; the report is due February 1 of each of the three following years.

Senate Bill

The Senate Bill contains no comparable provision.

House Bill

Section 7 of H.R. 3260, subsection (a) would extend the Senior Managers Quarterly Report from 30 days to 45 days following each quarter; subsection (b) would change the report due date from April 15 to June 15 of each year for the annual report on Assistance to Homeless Veterans; subsection (c) would change the report due date from February 1 to June 1 of each year for the annual report of the Committee on Care of Severely Chronically Mentally Ill Veterans through 2004; subsection (d) would change the report date on the Annual Reports on Long-Range Health Planning to June 1 of each year; subsection (e) would change the report due dates on the Annual Report on Sharing of Health Care Resources to February 1 of each year; and subsection (f) would change the report due date on the Annual Report of the Special Committee on PTSD to May 1 of each year through 2004.

Section 7(a) of H.R. 3387 would extend the annual reporting requirement for the Committee on Care of Severely Chronically Mentally Ill Veterans in Section 7321(d)(2) to February 1, 2009. Section 7(b) of H.R. 3387 would extend the annual report of the Special Committee on PTSD to February 1, 2009.

Compromise Agreement

Section 405 of the Compromise Agreement follows the House language on the provisions in subsections (a), (b), and (e) of the House bill and would extend the reports in subsections (c) and (f) of the House bill through 2008. Section 405 of the Compromise Agreement would simplify the reporting requirements in subsection (d) of the House bill without altering the report due date.

LEGISLATIVE PROVISIONS NOT ADOPTED

DEMOLITION OF OBSOLETE, DILAPATED, AND HAZARDOUS STRUCTURES ON DEPARTMENT OF VETERANS AFFAIRS PROPERTY

Current Law

There is no similar provision in current law.

Senate Bill

Section 202 of S. 1156 would add section 8171 to title 38, United States Code, to authorize the demolition of obsolete, dilapidated, and hazardous structures; would establish a specific fund in the Treasury designated as the Department of Veterans Affairs Facilities Demolition Fund; and would authorize an appropriation of $25,000,000 for fiscal year 2004 for this Demolition Fund.

House Bill

The House Bill contains no comparable provision.

SUPPLEMENTARY MATTERS

SAN JUAN, PUERTO RICO VA MEDICAL CENTER

In 1999, Congress provided $50,000,000 to the VA Medical Center in San Juan, Puerto Rico, to assist that facility in correcting numerous structural safety issues. Since then, VA has spent $4,000,000 of those funds on the design and planning of a bed tower that will alleviate the strain on the older bed tower currently in use. The remaining $46,000,000 will be used for the tower's construction, with a projected Spring 2004 groundbreaking. The Committees understand that the Secretary has pledged at least an additional $25,000,000 to enhance this project and minimize any reduction of total beds at this facility. Even with the completion of this construction, the Committees are advised that additional seismic and utility upgrades are needed at the San Juan VA. The Committees encourage the Secretary to honor this pledge and continue the practice of providing high quality services to the veterans of Puerto Rico.

Mr. ACEVEDO-VILÁ. Mr. Speaker, I rise today to urge my colleagues to vote in favor of S. 1156—Department of Veterans Affairs Long-Term Personnel Authorities Act of 2003. This bill represents a step in the right direction for many of our veteran communities.

In the interest of my constituents, this bill and the language contained within brings to the forefront the problems at the San Juan VA Medical Center and opens opportunities to provide immediate relief for the Veterans in Puerto Rico to receive the care they need and deserve.

Through the actions of these two committees, the Democrats and Republicans alike, they have sent a clear message of appreciation to the over 140,000 Puerto Rican veterans for their service in defense of our shared values. Puerto Ricans have served proudly in every armed conflict since the First World War. The language in this bill acknowledges the value of their service.

Currently, there are over 5,000 Puerto Rican men and women who are serving in the armed forces in Iraq, Afghanistan, Guantanamo and many other regions throughout the world. The language in this bill sends the right message to these young men and women that when they serve their Nation well, the United States Congress will serve them well.

I congratulate my colleagues on a job well done. Through long hours of deliberation and patient listening and understanding, both chambers of this Congress have come to what I believe is an impressive piece of bipartisan work. Now, it is my hope that the Secretary will move swiftly to reprogram the necessary funds to build a new bed tower at the San Juan VA Medical Center. Without the additional dollars mentioned in this bill, the San Juan VA Medical Center would have been forced to provide services with a bed loss of 120. This would have put additional burdens on a facility, which the C.A.R.E.S. Committee has deemed to be spatially deficient. The Committees understood this and worked to include language to encourage the Secretary to move forward.

The construction of the new bed tower will allow the San Juan VA Medical Center to provide safer and more modern services for the immediate future to the veterans and the service people returning from Iraq and Afghanistan.

I would like to personally thank Chairman SMITH, the Ranking Member, Mr. FILNER, Ms. CORRINE BROWN and the other members of the committee for working with me on these vital projects. The report language is more than a listing of projects—it is sending the right message to the 140,000 veterans in Puerto Rico; it sends the right message to the 5,000 Puerto Ricans who have been called to active service in Iraq, and it certainly sends the right message to the families of the 13 Puerto Ricans who have sacrificed their lives this year in service of the United States against the war on terror.

I look forward to continually working with my colleagues in both chambers to provide for the veterans in Puerto Rico. Again, I thank my colleagues for working so diligently on these first steps to improve healthcare for our veterans and urge my colleagues to vote "yes" to approve this bill.

Mr. MATHESON. Mr. Speaker, as a strong supporter of the military, I am pleased to support this legislation, which enhances veterans health care.

I am especially pleased that this bill also honors George E. Wahlen, Utah's only living Medal of Honor winner. George Wahlen is a dedicated American and Utah is proud to pay tribute to his service by renaming the Salt Lake Veterans Affairs Medical Center in his honor.

George Wahlen's twenty-year service to this nation as a soldier was not his only contribution. Even now, he continues to serve as an advocate for both active troops and veterans. I am proud to honor this patriot, just as I am proud of all Americans who serve their country.

Mr. SMITH of New Jersey. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. BURGESS). The question is on the motion offered by the gentleman from New Jersey (Mr. SMITH) that the House suspend the rules and pass the Senate bill, S. 1156.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. SMITH of New Jersey. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

A FURTHER MESSAGE FROM THE SENATE

A further message from the Senate by Mr. Monahan, one of its clerks, announced that the Senate agreed to the report of the committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2417) "An Act to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes."

SUPPORTING NATIONAL MARROW DONOR PROGRAM AND OTHER BONE MARROW DONOR PROGRAMS

Mr. WALDEN of Oregon. Mr. Speaker, I move to suspend the rules and agree to the concurrent resolution (H. Con. Res. 206) supporting the National Marrow Donor Program and other bone marrow donor programs and encouraging Americans to learn about the importance of bone marrow donation.

The Clerk read as follows:

H. CON. RES. 206

Whereas up to 30,000 people each year are diagnosed with leukemia or other blood diseases and approximately 20,000 will not find a marrow donor match within their family and must rely upon strangers;

Whereas diseases such as leukemia, aplastic anemia, and defective immune systems can lead to a rapid deterioration in an individual's health and ultimately the individual's death if potential marrow donors are not identified;

Whereas volunteers in donor programs provide a life-saving service to those that are afflicted with leukemia or other blood diseases;

Whereas since the founding of the National Marrow Donor Program in 1986, it has facilitated more than 15,000 unrelated transplants for patients with leukemia or other blood diseases;

Whereas the National Marrow Donor Program provides potential donors with information on how to become a bone marrow donor;

Whereas the National Marrow Donor Program has a worldwide reach and a large database of potential donors;

Whereas the National Marrow Donor Program currently facilitates more than 160 transplants each month; and

Whereas the National Marrow Donor Program makes a positive impact on the lives of thousands of Americans: Now, therefore, be it

Resolved by the House of Representatives (the Senate concurring), That the Congress—

(1) supports the goals and ideals of the National Marrow Donor Program and other bone marrow donor programs; and

(2) encourages all Americans to learn about the importance of bone marrow donation and to discuss such donation with their families and friends.

The SPEAKER pro tempore (Mr. SIMMONS). Pursuant to the rule, the gentleman from Oregon (Mr. WALDEN) and the gentleman from Ohio (Mr. BROWN) each will control 20 minutes.

The Chair recognizes the gentleman from Oregon (Mr. WALDEN).

GENERAL LEAVE

Mr. WALDEN of Oregon. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and to insert extraneous material on the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Oregon?

There was no objection.

Mr. WALDEN of Oregon. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I am pleased that the House is considering House Concurrent Resolution 206 introduced by the gentleman from Texas (Mr. BURGESS) to recognize the important work that the National Marrow Donor Program and other bone marrow donor programs do to save lives.

Bone marrow transplants are often one of the last options available to patients struggling to fight debilitating and often terminal illnesses. Unfortunately, finding a bone marrow match is very difficult. In fact, every year nearly two-thirds of patients in need of a bone marrow transplant will not find a marrow donor match within their family and, therefore, must rely on the help of strangers.

Each month the National Bone Marrow Registry coordinates more than 150 transplants. With a diverse registry of more than 4 million potential bone marrow and cord blood donors, the National Bone Marrow Registry offers hope to thousands of patients. Just last month, the House approved H.R. 3034, the National Bone Marrow Donor Registry Reauthorization Act, to reauthorize the national bone marrow registry for an additional 5-year period.

Since 1986, the National Bone Marrow Donor Program has facilitated more than 15,000 transplants for patients. I hope the Senate will join us soon in extending this program to guarantee that thousands more will benefit. This resolution will raise awareness about the bone marrow donor programs, and will encourage more Americans to donate, and I urge all of my colleagues to support this resolution today.

Mr. Speaker, I reserve the balance of my time.

Mr. BROWN of Ohio. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I commend the gentleman from Texas (Mr. BURGESS) for raising awareness regarding the importance of bone marrow donation. There are at least 20,000 Americans today who need a bone marrow transplant but cannot find a compatible donor within their own family.

National Marrow Awareness Month is a vehicle for encouraging more people to join the bone marrow registry, a noble goal, and it is right that Congress acknowledge the importance of this month.

But, Mr. Speaker, the timing is unfortunate. The Republican majority today is giving this body fewer than 24 hours to consider legislation which will have a dramatic impact on the financial security of 39 million retirees and disabled Americans, as well as their families. This bill takes $400 billion out of taxpayers' pockets and puts much of that money in the pockets of the drug industry and the insurance industry, the two industries that sat in back rooms with Republican leaders and wrote this bill. Every American has a stake in the outcome of this. Less than 24 hours to review, debate and vote on an 1,100-page bill that erects a brand new private insurance system for stand-alone drug coverage which replaces tried and true Medicare. The bill features such a meager drug benefit that seniors will still be unable to afford the medicines they need, a bill that creates a fast-track process to expedite reductions in Medicare benefits, a bill that makes different seniors pay different premiums for the exact same coverage, and a bill that launches a private insurance experiment, privatizing Medicare, forcing millions of seniors in this country to pay more or join an HMO. We received that bill yesterday, that 1,100-page Medicare bill, and are being forced to vote on that bill today.

With all due respect, I support this Burgess legislation and applaud the gentleman's efforts, but we need every minute we can get to try to get a handle on just how dramatically this Medicare privatization bill will turn our world upside down.

Mr. Speaker, we all know what is going to happen tonight. We have seen this same scenario play out month after month this year. In April, it started where in the middle of the night Congress passed contentious, important tax legislation by a handful of votes. Every single month during the summer, Congress voted on important, controversial legislation: Head Start, budget reconciliation, the tax cut, Medicare, last year the trade promotion bill authority, always between 12 midnight and four in the morning, always in the dead of night, always on Thursday night so the papers did not pick it up until Saturday, always when the media had gone to bed and the American public had turned off their television sets, and never appearing in the paper the next day, always held over to Saturday's paper because of that.

I hope, Mr. Speaker that does not happen with this Medicare bill tonight. I hope we can actually debate it during the late afternoon and early evening so people in this country can see what in fact is in it.

On this legislation we are considering today, I appreciate the efforts of the gentleman from Texas (Mr. BURGESS), but on a day when this body is asked to participate in such remarkably irresponsible decisionmaking on the most important health care vote of this session, no Member right now can devote to this Burgess resolution the attention it deserves.

Mr. Speaker, I reserve the balance of my time.

Mr. WALDEN of Oregon. Mr. Speaker, I yield such time as he may consume to the gentleman from Texas (Mr. BURGESS), the author of this measure.

Mr. BURGESS. Mr. Speaker, I thank the gentleman from Louisiana (Mr. TAUZIN) and the gentleman from Oregon (Mr. WALDEN) for bringing this resolution to the floor. I would like to thank the leadership for allowing this resolution to come to the floor late in the session; and I would disagree that the timing is unfortunate, I think the timing is perfect. I would also like to thank the staff of the Committee on Energy and Commerce for their hard work on this issue.

Bone marrow donation is critical to millions of cancer patients. Every year, nearly 30,000 people are diagnosed with leukemia or other treatable blood diseases. Oftentimes, the only course of treatment is donation of bone marrow from one person to another.

The House Concurrent Resolution 206 urges Americans to register with the National Marrow Donor Registry. Since the National Donor Registry was founded some 16 years ago, it has facilitated the more than 15,000 donations for patients with blood disorders. The registry now has 5 million volunteers. I am one of those volunteers, having joined the registry in 1999. The 15,000 volunteers that have been called on to donate marrow to sick and dying patients have saved thousands of lives, but they have impacted even thousands more by saving the lives of a mother, a father, a brother, a sister, a son or a daughter, keeping loving families whole and communities intact.

□ 1330

On June 7 of this year, I had the opportunity to celebrate the life of one of my constituents who had been diagnosed with non-Hodgkin's lymphoma, Mr. Cliff Ackerman. A donor to the national marrow donor registry program saved Mr. Ackerman's life. Mr. Ackerman was diagnosed with cancer in March of 1998 and did not have a stem cell match in his family. He was forced to find a match through the National Bone Marrow Registry. A match was found from a donor in Washington, D.C., Mr. Perry Apelbaum. Perry is a member of the House Judiciary Committee staff. Mr. Apelbaum joined the registry in 1990. As fate would have it when Mr. Ackerman got sick, Mr. Apelbaum turned out to be a perfect match. This example underscores how important the program is: a congressional staffer here in Washington, D.C. turned out to save the life of a man in my district in Lewisville, Texas.

The marrow donor program has helped thousands of families who will experience a second chance to enjoy life with a child, with a husband or wife, or with a brother or sister. I thank the countless number of heroes who have given the gift of life or who are waiting on the donor list to provide a lifesaving service to those who are afflicted with leukemia or other blood disorders.

The House has already reauthorized the marrow donor program this year in a bipartisan manner. It is now up to the other body to complete this work. We hope that they will. But in the meantime, we must continue to raise the profile of this important program, and this resolution does just that.

Mr. BROWN of Ohio. Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. WALDEN of Oregon. Mr. Speaker, I yield myself the balance of my time.

I urge my colleagues to support this resolution. I think it is critically important that we do that to move this program forward.

Mr. YOUNG of Florida. Mr. Speaker, I rise in strong support of H. Con. Res. 206, legislation expressing Congressional support for the National Marrow Donor Program during this National Marrow Awareness Month.

At the outset, let me thank my colleague from Texas, Mr. BURGESS, for sponsoring this legislation, and Chairman TAUZIN of the Energy and Commerce Committee, and the Chairman of the Subcommittee on Health, my colleague and neighbor from Florida Mr. BILIRAKIS, for helping expedite consideration of this legislation.

Mr. Speaker, the National Marrow Donor Program is a true modern medical miracle that saves lives here and throughout the world every single day of the year. Since its establishment more than 16 years ago, the registry has grown to more than 5,000,000 volunteers. These are true volunteers in every sense of the word. They have given of their time to take a simple blood test to be listed in the national registry. For the more than 17,000 volunteers who have been called upon to donate marrow, they have undergone a relatively simple surgical procedure to donate their bone marrow to save the life of a man, woman or child with leukemia or one of 60 otherwise fatal blood disorders.

Earlier this year in a sign of strong Congressional support, the House unanimously approved my legislation, H.R. 3034, the National Bone Marrow Donor Registry Reauthorization Act, to continue the work of registry's work for another five years. We look forward to its passage in the other body.

The National Marrow Donor Program is a precious national resource, and I want to pay tribute to the men and women there who work tirelessly to ensure that Americans in need of life-saving transplants receive the bone marrow, peripheral blood steam cells, or umbilical cord blood they need.

Recognizing the need for a single source of information, Congress endorsed by request in 1986 for a small appropriation to the United States Navy to establish the National Bone Marrow Donor Registry. Our goal was to improve the facilitation of bone marrow transplants by coordinating adult, volunteer marrow donors as well as a full range of supporting services to donors, patients and physicians. With the funded I have provided every year since through appropriations bills for the Navy and the Department of Health and Human Services, The National Marrow Donor Program has operated the Registry first under contract with the Navy and now under a competitively awarded contract with the Department of Health and Human Services. During that time, I have watched proudly as the Registry has developed into the international leader in marrow, blood stem cell, and umbilical cord blood transplantation.

Having had the great pleasure to meet with hundreds of donors and patients, I can tell you that donating bone marrow is a true life-changing experience. The experience of giving life to another human being is beyond mere words. Today, the National Marrow Donor Program remains the single source for physicians and patients searching for marrow to treat a variety of diseases. Through a network of 91 Donor Centers, 11 Cord Blood Banks, 150 Transplant Centers, and 19 International Cooperative Registries, it allows physicians to select for the best matched source of adult stem cells whether it be from volunteer marrow or blood donors or umbilical cord blood units. This large network has made marrow donation a world-changing experience. On any given day, bone marrow from our registry is being flown around the world at the same time bone marrow is being flown to a U.S. hospital through our formal relationship with the international registries.

A diverse Registry of volunteer bone marrow donors has been recruited. And now the Registry also lists more than 28,000 units of umbilical cord blood for potential transfer. Additionally, the National Marrow Donor Program has helped more than 250 patients receive cord blood transplants since the inclusion of umbilical cord blood units in the Registry began in 1999. Working with the National Marrow Donor Program and individually, the NMDP network of 11 cord blood banks have provided more than 881 cord blood units for transplantation since 1997. This network represents the single largest number of cord blood donations in the U.S.—232—in the past year.

The National Marrow Donor Program also recognizes the importance of maintaining an infrastructure that supports the Registry. To help physicians maximize the time they spend with their patients and minimize the time it takes to search the Registry, the Program has developed a real-time, electronic searching database that links more than 400 partnering organizations. The resulting transplants are made possible through the efforts of millions of volunteers and professionals, connected through an award-winning integrated information system that quickly records, analyzes, and electronically transmits millions of pieces of critical medical data every day to and from hundreds of medical organizations.

There is more to providing marrow and other sources of blood stem cells than simply helping physicians search the Registry. Patients also need assistance. Therefore, the Program provides support services for individual patients to help them through the transplant process. The Patient Advocacy program provides patients with services such as information about transplants, assistance in intervening with insurers to determine coverage, and financial assistance. These efforts include patients assistance funds, case management services, referring physician education, consultation on the best match sources, and accelerated searching to facilitate transplants with an urgent need. The Program also provides support to patients after the transplant occurs to ensure that they can return to a normal, healthy life. Without this support, many patients would not be able to obtain life-saving transplants.

Even with these wonderful successes, we all recognize that the number of donors is not sufficient to meet the needs of every American. Each year more than 30,000 children and adults are diagnosed with life-threatening blood diseases, such as leukemia and plastic anemia, as well as certain immune system and genetic disorders for which a marrow or blood stem cell transplant can be a cure. These transplants require matching certain tissue traits of the donor and patient. Because these traits are inherited, a patient's most likely match is someone of the same heritage. Thus, men and women of the National Marrow Donor Program work continuously to recruit more donors, especially minorities who historically have difficulty finding matches. Since 1995, the Program has more than tripled the number of minority donors.

Mr. Speaker, at a time when our nation seeks to bring the nations and the people of the world closer together, to live in peace, and better understand each other, we can look to the National Marrow Donor Program as one important way to achieve these goals. There is no greater cause than to save a life, and with the ongoing support of every member of this House we can adopt this Resolution today to support the many heroes who have contributed to the work and vision of this program.

From the early days when we sought a home for the program, and had a few doors slammed in our faces, there was Admiral Elmo Zumwalt, Jr. and Dr. Bob Graves. There was Captain Bob Hartzman of the United States Navy who connected us with the Navy Medical Command where we appropriated the first small amount of funding to give birth to the program. There were the early medical pioneers such as Dr. Robert Good, Dr. John Hansen, Dr. Donnell Thomas, and Dr. Jerry Barbosa, all of whom helped perfect the science of marrow transplantation and who assisted us in our legislative quest to establish a federal registry.

There were the members of Congress, past and present, who stood by me as I sought funding to start up the program, to recruit marrow donors, and to perfect the marrow transplant procedures. There were my colleagues on the Appropriations and Energy and Commerce Committees who helped expedite these funding requests and the consideration of several authorization bills.

There were the members of the board of the National Marrow Donor Program and the Marrow Foundation, who have volunteered their time to establish a finely tuned international registry that quickly and efficiently matches marrow donors and patients to give them the best chance of a successful transplant. There is the staff of the NMDP, based in Minneapolis, Minnesota but with operations throughout our nation, who manage the flow of information, marrow and cord blood around the world. And there is the staff and medical teams at the transplant and donor centers who use their medical expertise to complete the transplantation procedures.

Finally, there are the true heroes of the program, the patients and donors. Every patient that has sought a transplant has helped the doctors and researchers perfect the marrow or cord blood transplant procedure to improve the outcome for every future patient. And every donor who has signed up for the national registry has given the ultimate gift of life. They are the heroes without whom we would not have this tremendously successful national and international life-saving program.

Mr. Speaker, in closing, let me again thank the sponsors of this Resolution. Let me thank every member of this House for their partnership in helping us continue the work of the National Marrow Donor Program. With your support, we are giving hope to thousands of patients here and throughout the world today and into the future.

I call on my colleagues to continue their support for the National Marrow Donor Program and its important mission. Whether it is working with physicians and patients to find the best source for a transplant, helping a patient navigate the complexities of the health care system and insurance, or encouraging more Americans to become part of the life-saving Registry, the Program has proven itself a critical part of our Nation's health care infrastructure. Today, we proudly support the work of the National Marrow Donor Program during National Marrow Awareness Month and share in the celebration of the program's successes. However, our work is not finished. We must continue to help all Americans in need of umbilical cord blood, bone marrow, or peripheral blood stem cells to have access to the life saving services and the patient advocacy programs of the National Marrow Donor Program.

Ms. BORDALLO. Mr. Speaker, I wholeheartedly support House Concurrent Resolution 206 supporting the National Marrow Donor Program and other bone marrow donor programs and encouraging Americans to learn about the importance of bone marrow donation. I commend Mr. BURGESS for introducing this legislation.

The importance of National Marrow Donor Program (NMDP) and other bone marrow donor programs cannot be overstated. Each year thousands of people are diagnosed with leukemia or other blood diseases which may be cured through a blood stem cell transplant may be a cure. Some will find a matched donor, but many others will have to rely on the kindness of strangers. For those of African-American, Asian, Pacific Islander, Hispanic, Native American, Native Alaskan descent, this is especially challenging.

I commend NMDP and other on their education and outreach initiatives particularly those programs aimed at recruiting donors from minority populations. In 1993, the NMDP Registry included 37,601 donors of African-American, Asian, Pacific Islander, Hispanic, Native American, Native Alaskan heritage. As of August 2003, the number is now 1,145,000 donors. This an increase of approximately 3,000 percent. But there is still a critical need for donors from minority populations.

Her name was Justice Taitague, She was one of the 70 percent who could not find a matched donor from among her family members. Sadly, the donor registry at the time could not provide a match. Through the efforts of Dr. Thomas Shieh, the Guam Medical Society, and the National and Hawaiian Marrow Donor Programs, the first ever marrow drive on Guam was held on her behalf. This "Drive for Justice" registered thirty-four hundred volunteers in just three days. But it was too late for Justice, who passed away a few days after the drive.

Justice will never know the impact her life, her story has had on others. She has given us a gift—the gift of understanding of the importance of the National Marrow Donor Program and other bone marrow donor programs and she has given hope to others of Asian/Pacific Island descent searching for a donor.

Mr. Speaker, I fully support House Concurrent Resolution 206 supporting the National Marrow Donor Program and other bone marrow donor programs and encouraging Americans to learn about the importance of bone marrow donation. For me and the people of Guam, it's a matter of Justice.

Mr. WALDEN of Oregon. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. SIMMONS). The question is on the motion offered by the gentleman from Oregon (Mr. WALDEN) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 206.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. WALDEN of Oregon. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

CONFERENCE REPORT ON H.R. 1904, HEALTHY FORESTS RESTORATION ACT OF 2003

Mr. GOODLATTE. Mr. Speaker, pursuant to House Resolution 457, I call up the conference report on the bill (H.R. 1904) to improve the capacity of the Secretary of Agriculture and the Secretary of the Interior to plan and conduct hazardous fuels reduction projects on National Forest System lands and Bureau of Land Management lands aimed at protecting communities, watersheds, and certain other at-risk lands from catastrophic wildfire, to enhance efforts to protect watersheds and address threats to forest and rangeland health, including catastrophic wildfire, across the landscape, and for other purposes.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Pursuant to House Resolution 457, the conference report is considered as having been read.

(For conference report and statement, see proceedings of the House of November 20, 2003, at page 30421.)

The SPEAKER pro tempore. The gentleman from Virginia (Mr. GOODLATTE) and the gentleman from Texas (Mr. STENHOLM) each will control 30 minutes.

Mr. INSLEE. Mr. Speaker, I respectfully demand one-third of the time under clause 8 of rule XXII.

The SPEAKER pro tempore. Is the gentleman from Texas opposed to the conference report?

Mr. STENHOLM. No, Mr. Speaker, I am in favor of the conference report.

The SPEAKER pro tempore. Under clause 8(d) of rule XXII, the Chair will divide the hour of debate on the conference report as follows: the gentleman from Virginia (Mr. GOODLATTE), the gentleman from Texas (Mr. STENHOLM), and the gentleman from Washington (Mr. INSLEE) each will control 20 minutes.

The Chair recognizes the gentleman from Virginia (Mr. GOODLATTE).

Mr. GOODLATTE. Mr. Speaker, I ask unanimous consent that the gentleman from California (Mr. POMBO), chairman of the Committee on Resources, be recognized for 10 minutes for the purposes of controlling debate.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Virginia?

There was no objection.

Mr. GOODLATTE. Mr. Speaker, I yield myself such time as I may consume.

Today, we are finally able to bring the Healthy Forests Restoration Act, H.R. 1904, for a vote. In spite of a severely flawed process to arrive at this point, we have driven a hard bargain, and we have got a bill that the President will sign. I believe it will make a difference on the ground, but it is only a first step towards fixing what is wrong with the management of our public lands.

I worked with two other distinguished full committee chairmen, the gentleman from California (Mr. POMBO) of the Committee on Resources and the gentleman from Wisconsin (Mr. SENSENBRENNER) of the Committee on the Judiciary, to craft a bipartisan bill that passed earlier this year by an overwhelming, and bipartisan, majority. I also want to note the outstanding efforts of my counterpart in the other Chamber, Agriculture Committee Chairman COCHRAN, and our distinguished ranking member, the gentleman from Texas (Mr. STENHOLM), for their efforts.

This bill seeks to address the issues that have tied the hands of our forest managers: National Environmental Policy Act analysis that drags on for months, administrative appeals that spring up at the last minute, and court actions that stall projects for so long that areas proposed for treatment frequently are destroyed by fires long before the judicial process concludes. The conference process has produced a bill that does not do as much as I would like to address on these issues. I understand there are many in both Chambers who would like to have seen a stronger product. But this bill creates the first real relief from bureaucratic gridlock after over 8 years of legislative effort. It sends a clear signal that the Congress favors results over process and that protecting our communities, our watersheds, and our people is more important than producing mountains of paperwork.

There are over 190 million acres of forests and rangelands which remain at risk of catastrophic wildfires, insect and disease, a landmass larger than New England. Our bill takes the modest step of addressing the hazardous conditions on only 20 million acres of this total. This bill also takes an innovative approach to forest health on private lands, creating new nonregulatory, incentive-based approaches to promote conservation on private lands. In short, it takes a national approach to a national problem.

H.R. 1904 has enjoyed broad support from groups such as the Society of American Foresters, the National Volunteer Fire Council, the International Association of Fire Chiefs and others. Professional wildlife managers, sportsmen, and serious conservation groups all support this bill.

We as a Congress have more work to do to perfect our forest management laws. Forest fires are a symptom of a land management system that suffers from procedural, managerial, and practical gridlock. Our forest management laws, environmental laws, and procedural laws do not work well together. They create a process that only highly trained legal minds can comprehend; and while claiming to encourage citizen participation, they often achieve just the opposite. So we need to do more, but we should be proud of what we are doing today. We are taking a bipartisan step toward better management of our forests. We are saying that protecting our communities, our watersheds, and our people comes before protecting the dilatory tactics of those who oppose any type of sensible land management.

I applaud President Bush for helping to bring this about. We would not be on the verge of passing this bill without his leadership. I hope he continues to exert leadership in this field to ensure that the Federal land managers act aggressively to implement this program as quickly as possible. I will do my utmost to ensure that bureaucratic inaction does not delay implementation. I urge my colleagues to support this conference report.

Mr. Speaker, I reserve the balance of my time.

Mr. STENHOLM. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in strong support of the Healthy Forests Restoration Act conference report, and I am pleased to be here on the verge of completing legislation that will give us a chance to return America's cherished forests back to a healthy landscape. For the last century, public land managers have suppressed all forms of wildfire, including natural small-scale fires that restore forest ecosystems.

The unintended result of this policy is a decades-long buildup of forest fuel, woody biomass, and dense underbrush that is as close as the next lightning strike or escaped campfire from exploding into a massive fire. In some areas, tree density has increased from 50 trees per acre to as many as 500 trees per acre, according to the Forest Service and fire ecologists. These unnaturally dense forests are a small-scale ignition away from a large-scale wildfire. These natural small-scale fires burn at the ground level and at relatively low temperatures, allowing some trees to survive and, in the process, renewing the forest.

The suppression of these natural small-scale fires, however, has resulted in an accumulation of fuel that supports catastrophic wildfires of unnatural intensity that burn hotter, spread faster and cause long-term severe environmental damage, sometimes even sterilizing the soil. America's forest ecosystems are being decimated at an alarming rate by large-scale catastrophic wildfire and massive outbreaks of disease, insect infestation, and invasive species. Federal foresters estimate that an astounding 190 million acres of land managed by the Secretary of Agriculture and the Secretary of the Interior are at unnatural risk to catastrophic wildfire. Of that, over 70 million acres are at extreme risk to catastrophic wildfire in the immediate future.

During the second year of the National Fire Plan implementation, we witnessed the second largest fire season this Nation has seen in half a century. An early widespread drought, unparalleled since the Dust Bowl of the 1930s, affected 45 percent of the country. On June 21, 2002, the national level of readiness rose to the highest level possible, 5 weeks earlier than ever before, and remained at that level for a record-setting 62 days. In fact, wildland fires burned 7.2 million acres, or nearly double the 10-year average. Colorado, Arizona and Oregon recently recorded their largest timber fires of the century. And then we saw the devastation in Southern California.

Forest ecologists, professional land managers, and many environmental groups agree, the exploding incidence of catastrophic wildfire and disease and insect infestation pose a massive threat to the health, diversity, and sustainability of America's national forests. The Nature Conservancy, one of the world's largest and most acclaimed environmental groups, has been a leader in the environmental community in building public awareness about the environmental calamities that catastrophic wildfires cause.

Of the three factors that most influence wildland fire behavior, weather, topography and fuel, land managers can effectively affect only fuel. Unless we take a proactive approach to fuel reduction, the remaining components of the National Fire Plan, which include firefighting, rehabilitation, community assistance and research, will only continue to increase in cost. Local governments, volunteer firefighters, professional foresters, conservationists, and labor organizations agree, it is time to act to protect our forests.

Fortunately, the Healthy Forests Restoration Act addresses these concerns by giving Federal land managers the opportunity to restore our forests to a more natural balance while maintaining important environmental requirements. The conference report before us allows for authorized hazardous fuel reduction projects on Federal lands, helps communities in the wildland-urban interface prepare for wildfires, improves the NEPA analysis process, and augments public involvement and review. Additionally, the report includes titles allowing grants to use biomass, providing watershed forestry assistance, addressing insect infestation research, and establishing private forest reserves.

In closing, let me remind Members that this is not a new issue to come before the United States Congress. We have been talking about this issue for years. I remember the tremendous work done by former House Agriculture Committee chairman Bob Smith and his efforts to reach out and find a compromise, only to go down in flames because of the inability of extreme sides of this question to come together.

I am disappointed that certain Members of the House were excluded from the process that got us here today. That certainly has not been the case with the House Committee on Agriculture. I commend Chairman GOODLATTE for his bipartisanship and leadership on this important issue. We all have differing opinions about the various components of the legislation before us; but in passing this legislation, we will restore America's treasured landscapes by reducing the risks of catastrophic wildfires and insect and disease infestations.

Mr. Speaker, I reserve the balance of my time.

Mr. INSLEE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, it is abundantly clear to all of us of all political persuasions and parts of the country that we need a vigorous, well-funded, well-prioritized hazardous fuels reduction program in our national forests.

□ 1345

The Nation needs that because of a "perfect storm," if I may use that term, of enormous changes in our climate which have led to drought, particularly in the western United States, leaving the most explosive conditions due to the lack of moisture in over 100 years and because of our misguided and mutually ignorant policy over the last several decades, if not century, of suppressing all fire, thereby allowing certain additional density to increase. All of us know we need a well-prioritized, well-funded, well-defined hazardous fuels reduction program.

But I, regretfully, cannot support this bill because it fails in several fundamental ways. It fails to prioritize the taxpayers' dollars where they ought to be prioritized which is the protect of human health and property first. It fails to protect our most treasured crown jewels in our Forest Service of our roadless areas, which I have to tell the Members in the part of the world where I come from, we treasure the roadless areas on our weekends and afternoons. It is part of our culture and our families, and they are unprotected in this bill. Third, it fails to adequately solve the problem as to why we cannot get these programs completed, which is money, and I will come back to that. We today change the law, but not the appropriations that we need to get this job done.

Let me start with a failure to prioritize in this bill. If I may, this ought to be job one for the U.S. Congress when it comes to hazardous fuels reduction. Job one for the U.S. Congress ought to be protecting, with a protective buffer, the homes and towns and cabins and barns in our thousands of acres from voracious forest fire, and this bill does not follow a fundamental precept that when we have got job one and when we have got limited dollars, we prioritize. To govern is to choose, and this bill consciously chose not to give the majority of funds in this program to protect these areas with moats, if I may, to protect them from this horrendous fire. And we have seen what happens in California when that occurs. And it ought to be a totally unanimous agreement here that the majority of our funds in our program ought to be directed to the areas around our towns and cities rather than spent up in Timbuktu harvesting commercial lumber.

We have seen that they split the baby 50/50, but spliting the baby 50/50 is not always right nor is it fair, and I will tell my colleagues why. This conference report says 50 percent of this money will go to the Wildland-Urban Interface. It will not do to tell people in this community that we have saved half their houses, and we have sacrificed the other half to the demands of those who want to continue commercial logging in our roadless areas. We failed in our duty to prioritize our precious dollars where they belong, and we have offered a modest amendment to improve that in the conference committee which were rejected out of hand.

And let me tell the Members why this prioritization is so important. Of the dollars we have spent next year, if we double the amount that has been appropriated by the majority party, whom I respect, and I respect their positions on this bill, but if we even double the amount that was spent in the last 3 years, we will still only do 2 to 3, maybe 4 percent of the acreage of the millions of acres that need to be treated. We have to prioritize. This bill did not do it.

The second thing this bill did not do, it did not protect our roadless areas. We have 58 million acres of roadless areas which are the crown jewels of our national forest, which are pristine, and everyone loves the trees in our roadless areas. The problem is some of them love them vertically and some of them like them horizontally. This bill does not protect our roadless areas from the ones who want to do commercial logging so that they will be horizontal. It does not protect them one wit in those roadless areas, and that is most discomforting, and I will tell the Members why. We should have been able to fashion a unanimous way to protect those roadless areas. Let me just suggest one way to do it. I offered an amendment in the conference committee that would simply say that if we have to, if there is some terrible disease-ridden patch in the roadless area that we have to build a road to get to it, to do an emergency program that would be allowed under this bill, okay; but let us at least restore the road after the project is completed to its original topography. How can anyone object to that? How could anyone object to that precept? If we are building a road in a roadless area to do a hazardous fuels reduction program, when we are done with the program, why not put the road back in its natural topography. Who could object to it? I will tell the Members who does object to it. The timber industry who wants to use these roads to punch them into the heart of our most virginal forests and then make them available for commercial harvest, and we do not need to do that to accomplish our ends here, and it is regrettable we did not solve that problem.

The third thing that this bill does not do, it does not cut to the heart of the problem. This bill, its whole fundamental idea is if we just cut off those pesky environmentalists, by gum there will not be any more forest fires. I will give the Members bad news. We can outlaw environmentalists if we want to, and I see some nods. My friend over on this side of the aisle would like to do that. I take a different view. They are my constituents. They are people who like to go up and have clean water out of the roadless areas. They are people who like to go on a picnic in the roadless areas, and they know, as I do, that if all we try to do to fix this program is to cut off citizen participation, we will not solve the problem of getting these fuels reduction programs in line, and I will tell the Members why we will not. The reason we have we are not getting the job done and giving therapy to our forests is that we have not appropriated one tenth of the money that is necessary to get this job done. It is not appeals. Come on. The GAO, in their last study, after four rounds to make sure they got it right, said that 92 percent of all of these fuels reduction projects go lickity-split right through the process without any problems and only 3 percent of them were litigated. Ninety-seven percent of these projects go through without litigation. So why have we not cut the mustard? Why have we not done enough therapy on these forests? It is because we have not invested the money to do it. We have only invested enough money to do 2 to 3 percent, and that is not going to significantly improve in this bill. Doubling does not even cut it, even if we got the appropriation. So we are united, I think, unanimously on this floor in the belief that we need to have a strong fuels reduction program, but we cannot say that this bill will provide what the American people need to get this job done in a reasonable fashion.

The fourth, if I can, problem with this bill: It is clear that we have got to cut down a whole bunch of trees to solve this problem because they are dense, they have grown up because of our misguided fuels suppression program, and now we have got this cataclysmic fire situation. But the question is what do we cut and where? That is really the issue we need to resolve on the floor of this House. And here is a tree, a mature tree. I wish I could tell the age, marked for cutting in the fuels reduction program. There is no reason to cut that tree except for commercial purposes. We needed to develop a firm definition, so that the Forest Service can use it to determine what trees to cut, and it would have been easier if we provided them adequate money to do it, so they do not have an incentive to log bigger trees to generate money for this program. But we did not do it, because the appropriations process did not cut the mustard. So we have a problem that we have not given adequate definition of what to cut and where.

Mr. Speaker, I reserve the balance of my time.

Mr. POMBO. Mr. Speaker, I yield myself 2 minutes.

I am glad that the gentleman from Washington (Mr. INSLEE) claimed the time in opposition to this because I think it is important for everyone to see just how difficult this bill has been to finally arrive at this point of developing a bill and a conference report that is so widely supported in both this Chamber and the Chamber across the Capitol, that we have brought together such divergent interests, so many people who may have initially opposed this bill that are now on board because of the great compromise that was reached to bring this bill to the floor.

The history behind the Healthy Forests initiative, it has been, I think, 8 years now since the very first bill was introduced and the work began to finally get to this point, and we have gone through, I believe, close to 75 hearings in Committee on Resources alone on this legislation. There has been a countless number of people that have testified, and we have gone back and forth. And these past 3 years, we actually have to give a lot of credit to two of my colleagues in the House, the gentleman from Colorado (Mr. MCINNIS), subcommittee chairman, and the gentleman from Oregon (Mr. WALDEN) for the work that they did in pulling together with all of the different interests to bring something together, the gentleman from California (Mr. GEORGE MILLER), former ranking member on the committee, and the gentleman from Oregon (Mr. DEFAZIO) and others to put together a bill that was really a great balance between so many different interests. And I found with interest the gentleman from Washington's (Mr. INSLEE) talk about a particular tree and saying that we need to resolve on the floor of the House whether or not that should be cut down. I have got to tell him, we do not know. That is the job of the professional foresters. The focus of this bill is to go out into the forests and let the professionals, the scientists, the people who really do understand what is going on out there, have them decide where the best place to do thinning projects is, not on the floor of the House. That is ridiculous to think that we on the floor of the House should be doing that.

But this is a grand compromise. It is a great bill, and I urge my colleague to support it.

Mr. GOODLATTE. Mr. Speaker, I yield 2 minutes to the gentleman from Minnesota (Mr. GUTKNECHT), chairman of the Department Operations, Oversight, Nutrition, and Forestry Subcommittee of the House Committee on Agriculture.

Mr. GUTKNECHT. Mr. Speaker, I thank the chairman for yielding me this time.

And I want to especially thank all those who have been involved, the gentleman from Virginia (Chairman GOODLATTE), the gentleman from California (Chairman POMBO), and the gentleman from Texas (Mr. STENHOLM), ranking member, for all of their work on this legislation. And in addition, I think we should thank President Bush because of his leadership on this issue.

Nearly half of the 190 million acres managed by the Secretaries of Agriculture and Interior are at extreme risk to wildfire. Millions of acres across the South, the East, and in my home State of Minnesota are facing disease and insect epidemics. And yet Federal land managers will treat only about 2.5 million of those acres each year because of the extraordinarily lengthy procedural and documentation requirements.

Time and again, we have seen the destruction that forest mismanagement and drought can cause to our landscape and to our families. This year alone 4.3 million acre of our Nation's forests have burned and 29 firefighters have lost their lives. Recently, more than 750,000 acres have been burned in southern California, and 22 Californians died trying to escape those fires.

Many see the fires on TV and think this is only an issue for "out West." Unfortunately, poor forest health is a national problem. The lack of forest management of our national forests in States across our country, including my home State of Minnesota, has placed private forests and communities at risk of fires, insects, and disease. Almost 3 million acres of the National Forest System lands in Minnesota are at high risk. Standing by and doing nothing to protect this precious resource is tantamount to criminal neglect. Congress has an obligation to ensure that we do not neglect our national forest lands and ensure that they are available for generations to come. Too often, excessive regulation and what I call "paralysis by analysis" has made even the simplest management project an ordeal of years instead of weeks. H.R. 1904 is critical to begin to solve the problems of proper management of our forests.

I urge all Members to support this important legislation.

□ 1400

Mr. STENHOLM. Mr. Speaker, I yield 3 minutes to the gentleman from Oregon (Mr. DEFAZIO).

Mr. DEFAZIO. Mr. Speaker, I thank the gentleman from Texas for yielding me this time, and I thank all of the members of the Committee on Agriculture and the Committee on Resources who have put so much time and effort into this. Yes, it was a long process, but I believe that a good result is worth the work. I wish we had got it done a year ago; but, hey, we are now finally going to get something in place long ahead of next year's fire season.

This bill, if properly implemented, will begin to carefully undo 100 years of mismanagement of our national forests. It recognizes that this is going to be a long and expensive process. It recognizes that it cannot be done for nothing. This bill includes a $760 million-a-year authorization. I think we could even go higher. Mr. Speaker, $1 billion a year could be productively spent in the West, given the magnitude of the problem; but it is a significant increase over the commitments we are currently making.

It will bring jobs to hard-hit rural areas in the forests. It sets a priority that half the funds should be spent in proximity to high-risk communities in the West, and it also sets priorities for protection of other high-value resources in high-risk areas.

If properly implemented and fully funded, I believe that we can begin to step incrementally away from the catastrophic, or potentially catastrophic, conditions that exist throughout the West today.

It contains old-growth language that clearly reflects the intent of Congress that the objective is to return the forests to presettlement conditions, which means there will be large, fire-resistant trees more widely spaced, particularly in the inter-mountain areas; that we would leave native stands intact, but we would aggressively thin from below. We would remove ladder fuels, we would remove trees that are growing into the crowns of the larger trees.

I mentioned earlier the Davis fire in Oregon and the lodgepole that carried the fire into the crowns of the Ponderosa, that would have survived the fire otherwise, had we gotten in there and removed those lodgepoles, which have little commercial value. That is why this program will be expensive. In many areas, what needs to be removed has little or no commercial value. Where it has commercial value, we will use that to offset the costs and to amplify the program.

It does not unduly restrict the right of appeal. It does require that people participate meaningfully in the process if they are going to appeal, and that is the way it should be. I want people to be involved from the beginning in communities, meaningfully commenting on the plans and proposals of the Forest Service. It allows judicial review if the bill is misapplied by this or any future administration.

But it will move the process along, and we will begin to chip away at the backlog. But make no mistake, even if we get the $760 million a year, this is going to take a long time to return our forests to their natural state.

Mr. INSLEE. Mr. Speaker, I yield 3 minutes to the gentleman from New York (Mr. HINCHEY).

Mr. HINCHEY. Mr. Speaker, this is an example of not just an act that will destroy good policy, but it also destroys the language; and it is consistent with the kind of thing that has been happening here recently, particularly with regard to environmental policy.

What is the name of this bill? The Healthy Forest Restoration Act. It reminds me very much of the Clear Skies Initiative that the President was pushing and the majority in this House was solidly behind. What did we get from the Clear Skies Initiative? Increased greenhouse gases, increased acid rain, a big gift to the polluters so that they do not have to upgrade their equipment. The same kind of thing occurs here.

The rationale behind this legislation as it is stated is that we need this act in order to carry out thinning processes in places where fires are likely to occur. Now, one would have the idea, based upon that, that these thinning processes are being held up. That is what they want us to believe, these thinning processes are being held up by litigation and things of that nature.

Well, what does the General Accounting Office say? The General Accounting Office has a lot of credibility around here. The General Accounting Office tells us that the appeals and litigation are not slowing thinning projects at all. In fact, 92 percent of the thinning projects are being completed without delay.

Now, why, then, are we engaged in this?

Well, the real reason is, just like under the Clear Skies Initiative, we were not interested in cleaning up the skies, and here we are not interested in healthy forests. What we are interested in is a big giveaway to the people who want to go out and cut down the trees that are on public land. That is what this is all about.

Now, another interesting aspect of it to me is a lot of people in this House who are dead set against any activity by the Federal Government, they want the Federal Government out of everything. Now, however, under this piece of legislation it is, no problem, just give them this authority, trust the administration, trust the Federal Government. They will do everything right. Totally inconsistent, obviously.

So what else does this bad bill do? It fails to focus on projects in communities that are actually in need of protection. It undercuts NEPA by eliminating the requirement to consider a full range of reasonable alternatives. It fails to treat or provide assistance to State, tribal, and private lands. It throws up unprecedented roadblocks to citizens across the country and their access to the courts, and it is a direct threat to the independence of the judiciary in this country on this specific issue. It curtails the rights to appeal bad projects and authorizes a new appeals process with no sideboards to be created by the Secretary.

This is an example of a bad bill and specious arguments driving bad policy.

Mr. POMBO. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. LEWIS).

Mr. LEWIS of California. Mr. Speaker, I thank the gentleman for yielding me this time. While I am doing so, I want to express my deep appreciation to the leadership on both sides of the aisle who have gone about the compromises necessary to bring this bill to the floor in the first place.

It is important to know that we have been mismanaging our forests for all too long now; and if there is a need for a demonstration project relative to that, all one has to do is look at the recent devastating fires in Southern California.

My territory is directly impacted. We have lost thousands and thousands of homes. We have lost dozens of lives as a direct result of mismanagement of our forests. And as of this moment, the most pristine areas of Southern California are in jeopardy of total loss because of mismanagement by this body and by the Federal Government of their forestlands.

This bill is a good step in the right direction. It is going to cost some money, but not nearly the billions and billions of losses that we have already suffered in Southern California.

Mr. GOODLATTE. Mr. Speaker, I yield 1 minute to the gentleman from Montana (Mr. REHBERG).

Mr. REHBERG. Mr. Speaker, I would like to add my voice to the chorus of accolades thanking the various chairmen and subcommittee chairmen and Members who have worked so hard on this piece of legislation.

It is ironic in this country when something like September 11 occurs, or a tornado or a flood that creates massive destruction quickly, we roll up our sleeves and we get to work rebuilding. Yet the cancer that is caused by drought and insect infestation, disease and such that is occurring within our forests somehow is treated differently.

What have we seen over the years? In 1988 we burned a large area of Montana, the Yellowstone ecosystem. We assumed that something would be done, but it was not. It got stuck back in Washington, D.C., and what did they do? They talked and talked and talked. And over the years, while we talked about solutions, what have we done? We have talked our forests to death. And eventually we go to the corners, and then we sue our ways back out. It is stupid. It is ridiculous. That is not the way to present a better forest. This piece of legislation in fact will now manage the lawsuits.

Please support this compromise. It is a good one.

Mr. STENHOLM. Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. STUPAK).

Mr. STUPAK. Mr. Speaker, as cosponsor of H.R. 1904, the Healthy Forest Restoration Act of 2003, I rise in support of this legislation because of the relief it provides to combat the challenges facing our forest system today. From hazardous fuel reduction to insect and disease infestation research, this bill gives our forest managers and our private citizens the money and the technical assistance they need to help bring our forests back to health.

Mr. Speaker, H.R. 1904 will work to alleviate the fire hazards that currently plague our forests. As evident by the rampant spread of the wildfires that recently ravaged Southern California, our Nation's forest system is overwhelmed with excess brush and foliage which could fuel catastrophic wildfires.

This bill provides thinning programs for up to 20 million acres of at-risk lands near communities and their water supplies, at-risk lands that serve as habitat for threatened and endangered species, and at-risk land that is particularly susceptible to disease or insect infestation.

Mr. Speaker, H.R. 1904 also provides money and technical assistance to stop the growing problem of insect and disease infestation. In southeastern Michigan, for example, Forest Service managers are battling the emerald ash borer. This insect has decimated the population of ash trees located in a 6-county area. Luckily, officials have responded quickly, and we are in the process of containing this threat. H.R. 1904 will assist in our fight against invasive species like the emerald ash borer and others around our country by promoting new research and quick action to reduce the impacts on these forest pests.

I strongly urge my colleagues to pass this conference agreement on H.R. 1904. I want to thank the ranking member, the chair, and all of the staff for their hard work on this. It is time we reduce the threat of wildfires to our communities and our environment. Support H.R. 1904.

Mr. POMBO. Mr. Speaker, I yield 1 minute to the gentleman from Arizona (Mr. HAYWORTH).

Mr. HAYWORTH. Mr. Speaker, I thank the chairman of the committee, my friend from California, and I thank him for yielding me this time. I rise in strong support of this conference report, which at once is an important first step and, at the same time, is long overdue.

It has been interesting to listen to the conflicting philosophies on the floor. There is one point of view represented that true environmentalism means therapy for the forests.

Mr. Speaker, I think the questions are accurate to be asked. Is it therapeutic to have such destruction in the forests that the number of particulates in the air eclipses rush hour in many of our major metropolitan areas? Is it therapeutic in the forests to see watersheds destroyed? Is it therapeutic in the forests to see land burned so badly that, as the gentleman from Texas pointed out, the land is sterilized?

No, the sound environmental position is to have sound scientific principles embracing healthy forest management. And to the effort of protecting homes and property and people like the 20-plus who perished in California, this job is long overdue. We must pass this bill; and, quite frankly, we should do more, not only for rural America, but for suburbanites who perished in the recent fires in California.

Mr. STENHOLM. Mr. Speaker, I yield 2 minutes to the gentlewoman from Oregon (Ms. HOOLEY).

Ms. HOOLEY of Oregon. Mr. Speaker, I thank the gentleman for yielding me this time and for all the hard work he has put in on this particular piece of legislation. I also want to especially thank my two colleagues, the gentlemen from Oregon (Mr. WALDEN) and (Mr. DEFAZIO), for their enormous work on this piece of legislation.

Mr. Speaker, this is an issue that is very important to my home State and to my congressional district. Reduction of hazardous fuels. Oregon has been hit hard by wildfires in recent years, and I am very happy that we are finally taking steps in this House to make up for years of neglect of our Federal forests. Forests and timber are vitally important to the citizens of Oregon. The economic costs of forest fires in Oregon have been astronomical and the human costs have been even higher. It is essential we do something about it, and something sooner rather than later.

Prior to coming to Congress, I served as a county commissioner in Clackamas County, which owned thousands of acres of forest land. I was responsible for management of those forests. I know from experience that it is possible to manage and protect a forest and that in many cases, it is necessary to manage a forest in order to protect it.

This legislation before us will have a positive impact. Not only will it help save people's homes and people's lives, it will focus money on lands that need it most and provide environmental protections.

□ 1415

At the same time it allows local communities and citizens to remain involved in the process. What I am most pleased about, however, is that this legislation provides funding for fuel reduction. The $760 million authorized in this bill is a great start and will help protect our forest and our communities.

The House and the Senate have reached an important compromise that is balanced, and provides money to get the job done. Mr. Speaker, I urge my colleagues to join with me in supporting this legislation that fosters a healthy management and protection of our national forests.

Mr. INSLEE. Mr. Speaker, I yield 2 minutes to the gentleman from New Mexico (Mr. UDALL).

Mr. UDALL of New Mexico. Mr. Speaker, I compliment the gentleman from Washington (Mr. INSLEE) for his management of this bill. Let me just talk a little bit about the judicial review test here, because I think that we are embarking on new ground. When we put in a test that talks about short-term and long-term, really what we are ending up doing is saying that if you cut down the whole forest and it is okay in 100 years, then that is all right. I mean, that is the kind of test that we are putting into this piece of legislation. We do not know what that means. And so we are encroaching into the judicial arena, trying to tell the courts what to do. This is a new test. It is a new standard. It has never been used before.

And what is going to happen? We hear all the talk about lawsuits and litigation from this side of the aisle. Guess what, folks? This is going to be a lawyers employment bill. If there is anything that is going to come out of this, it is going to be more litigation, it is going to be more billable time, it is going to be more lawyers involved in this process. And I think what is going to happen further, if we allow this to happen, if we allow this to happen, we are going to see this appear across the board in other areas, workers' rights, OSHA, any place where Federal agency decision-making is going on, this is going to be imposed on the Federal courts. And I think that is why the committees that supervise in the Congress judicial review have such a hard time with this provision.

With that, I would just urge my colleagues to vote against this bill.

The recent firestorm in Southern California acted to once again remind us of the gravity of rampant wildfires in the west. However, this issue is of such great importance that I am extremely concerned about, and strongly object to, the manner that this legislation was brought before us today.

You may recall that the Committee Print of the Healthy Forests Restoration Act was released to the members of the Resources Committee during a recess period, on the Friday afternoon before it was scheduled to be marked up in Resources committee, a few days later.

Similarly, we are called upon today to vote on the Healthy Forests Conference Committee report. This report was just released yesterday. It is my understanding that the rules for the House call for a minimum of 3 days of review of a conference report before it is voted upon.

So, in what now seems to be standard operating procedure of the House, we have barely had twenty-four hours, if that, to read and digest its contents. One day is hardly sufficient to allow all Members to carefully and thoughtfully consider this vital legislation.

I would like to point out that H.R. 1904 was not the sole option available for our protection from wildfire devastation. Mr. UDALL of Colorado and I introduced H.R. 1042, the Forest Restoration and Fire Risk Reduction Act.

Had we had an opportunity to hold hearings on our bill, Mr. UDALL and I would have been able to formally raise some of the issues that I view are not adequately addressed in H.R. 1904 or the conference report, but that are critically important to wildlife prevention and protection.

Our bill would place greater emphasis on protection of the "wildland/urban interface" without imposing the unprecedented deadlines and standards for injunctive relief on the Federal judiciary, and without emasculating our environmental laws that are present in both H.R. 1904 and the Report.

While the results of the conference are better than the version passed by the House, the provisions that I view to be most controversial remain in the text. The agreement places a greater emphasis on thinning forests very close to communities, but, like the House bill, it significantly limits environmental reviews of forest thinning projects and insect infestation field research projects.

I reemphasize that I believe that we must conduct thinning projects to help reduce the likelihood of unusually severe fires. However, I do not support the contention that to facilitate such projects we need to expunge our environmental laws and procedures for public comment and participation.

The limits placed on fire-risk reduction projects from environmental review and administrative appeals, especially in the wildland urban interface, in effect constrain the provisions of the National Environmental Policy Act. Furthermore, denying the public the full and fair opportunity to have viable alternatives to agency action considered circumvents established policy of public participation.

Such participation is an important aspect of our democratic process for making decisions affecting public lands. Limiting public comment and ignoring the provisions of NEPA and other laws designed to protect our environment does not assist in developing sound forest management.

I believe, however, that the conference report is a better bill than the version passed by the House. The Report contains specific provisions to protect the wildland urban interface. Furthermore, the report authorizes tribal watershed management programs for Indian tribes, an issue that I have strongly advocated for since we began working on this legislation in the 107th Congress.

Nonetheless, I am afraid that this legislation is just another assault by the Bush Administration on our Nation's forests. Most of the attacks over the last year have been below the radar—in arcane rules, stealth riders and misnamed legislation. In this many-fronted assault, big timber is the winner.

Under the guise of buzz words such as forest health, catastrophic-wildfire prevention and streamlining, the Administration's initiatives transform forest policy in ways that are staggering in their scope as well as in their implications for democracy.

The changes revamp laws fundamental to sound forest management, including the National Forest Management Act, the Appeals Reform Act and NEPA. The cumulative effect of these changes is to undermine or eliminate open decisionmaking, agency accountability, resource protection and recourse in the courts.

It began in December 2002, when the Administration proposed a forest-planning regulation that renders public involvement virtually meaningless. The rule ignores scientific involvement, eliminates fish and wildlife protection, and fails to protect roadless areas.

It skews the planning process to favor logging, mining and off-road vehicle use. It renders plan standards more discretionary, further reducing agency accountability. Most shocking, the final rule, due out imminently, exempts forest plans from environmental analysis and eliminates the opportunity for the public to appeal the final plan.

The Forest Service assured critics that it would undertake in-depth environmental studies when specific logging projects were proposed. Not so.

In June 2003, the Administration abolished environmental review of logging done in the name of "hazardous fuels reduction" on up to 1,000 acres of land as well as post-fire rehabilitation projects on up to 4,200 acres.

One month later, the Administration carved out more loopholes for National Environmental Policy Act exemptions for commercial logging by setting acreage limits of 70 acres for timber sales and 250 acres for salvage sales. These projects have few, if any, meaningful constraints.

For example, the projects must be "consistent" with local forest plans. Yet, under the soon-to-be final planning regulations, forest plans can be amended simply by changing the plan on an interim basis with no public notice.

Under the banner of hazardous fuels reductions, large-scale, intensive commercial logging projects may take place virtually anywhere in our forests, regardless of forest type or tree size. In effect, the conference report allows logging and associated road building with limited environmental analysis, administrative appeals, judicial review and public involvement.

The Appeals Reform Act of 1992 gave citizens a statutory right of appeal after the Forest Service tried to eliminate appeals on timber sales. Although billed as part of the "Healthy Forests Initiative," changes to these regulations significantly curtail rights to appeal a broad range of timber sales and land management decisions—not just those pertaining to fire risk.

H.R. 1904 sets no time frames for appeal, no required stay of action provision during the appeal, and no guaranteed right to appeal. Instead, the Forest Service would have 30 days after enactment of this legislation to develop the new administrative appeals process.

This legislation also pushes citizens out of the picture. In addition to altering the intentions of the Appeals Reform Act, H.R. 1904 reduces environmental review on logging projects not already given a wholesale exemption and severely restricts opportunities for public involvement.

Furthermore, it encroaches upon the courts' ability to review the legality of logging projects almost anywhere on our publicly owned forests, including roadless areas and old growth.

If bug and disease-control are the purported reasons for logging, projects up to 1,000 acres will bypass all environmental review and appeals.

With millions of dollars authorized in the act for any hazardous fuels project on public lands, logging without laws can proceed throughout the backcountry.

The synergistic effects of these radical rollbacks are breathtaking. I predict that the assault will only foment more controversy and stimulate more distrust of the Forest Service for years to come.

I urge my colleagues to vote "no."

Mr. STENHOLM. Mr. Speaker, I yield 1 minute to the gentleman from Pennsylvania (Mr. PETERSON).

Mr. PETERSON of Pennsylvania. Mr. Speaker, I rise to urge everyone if you want forests to be healthy and be managed, to support this bill. I have heard stated here that we have mismanaged, that the Forest Service and other agencies cannot manage forests under the current law. It is impossible to manage.

In the Allegheny National Forest in Pennsylvania, the finest hardwood forest in America, we just had 10,000 to 20,000 acres of blow-down in July. It has been assessed at somewhere between $50 to $100 million in value lying on the ground. The Forest Service chief there just determined that it would be at least 3 years before he could have people there harvesting trees on the ground. Tell me that the system isn't broke, that it makes sense to have $100 million worth of American assets to lie there and rot because in 3 years they are of little value at all.

Folks, this system is broken. We do not want judges managing our forests. We want soil scientists, fish and wildlife biologists, and all the people that our Forest Service hires. They have every kind of scientist there is managing our forests. They should make those decisions.

Mr. POMBO. Mr. Speaker, I yield 1 minute to the gentleman from Arizona (Mr. RENZI), who brought a renewed vigor to this debate.

Mr. RENZI. Mr. Speaker, I want to thank the chairman for his leadership, and I especially want to thank the gentleman from Colorado (Mr. MCINNIS) for his fighting spirit and 3 years of perseverance that it took us to finally get to this point.

I also maybe want to offer a little bit of a different view for those limousine environmentalists from the inner city, who do not necessarily live in the forests as we do. Coming from Flagstaff, Arizona, the largest Ponderosa pine forest in the world, where we suffered the likes of the Rodeo-Chedeski fire, a fire of 500 thousand acres.

I want my colleagues to know there is a science that is being ignored here. We are taking half the money and putting it into wildland urban interface right on the boundaries of our communities. Yet the forest managers want to be able to attack fire in the outlands. What they understand is in the West we have canyons. While they may have concrete canyons in New York City, we have real canyons in Arizona. In those canyons, we have up-slope terrain. When up-slope terrain combines with wind and temperature, that fire burns so hot and so fast that wildland urban interface and limiting the money will not be able to give us fallback positions for our firemen. It is a compromise that we have proposed here. Vote in favor of the bill.

Mr. GOODLATTE. Mr. Speaker, I yield 1 minute to the gentleman from Georgia (Mr. BURNS).

Mr. BURNS. Mr. Speaker, I want to join my colleagues in support of H.R. 1904, the Healthy Forest Initiatives. I want to thank the gentleman from Virginia (Mr. GOODLATTE), the gentleman from California (Mr. POMBO), my distinguished colleague from Texas (Mr. STENHOLM). We think about the healthy forests, we think about our homes, the wildlife, the lives of the men and women who live near and certainly the forest, and we want to protect those.

In California, we saw the devastating fires of this year. I can think of no better way to ease the minds of those in the West than to pass the Healthy Forest Initiative.

In Georgia, we do not have the wildfires and the large forest fires that we see in the West, but we have pests, and we have disease. We have millions of acres that are at risk in Georgia due to the southern pine beetle and other insects. We have seen a 278 percent in increase in pine beetle infestation last year alone. This Healthy Forest Restoration Act provides the Federal land managers with great flexibility to deal with the fire dangers in the West, but it also provides them with the authority to do innovative things in detection and suppression of pests that really threaten eastern forests.

Mr. Speaker, the Healthy Forest Restoration Act is a national solution to a national problem. I urge Congress to vote yes.

Mr. STENHOLM. Mr. Speaker, I reserve the balance of my time.

Mr. POMBO. Mr. Speaker, I yield 2 minutes to the gentleman from Oregon (Mr. WALDEN), the coauthor of the legislation.

Mr. WALDEN of Oregon. Mr. Speaker, this legislation provides for major improvements in how we will manage our forests. First of all, it reduces unneeded government analysis. Second, it provides for actually more public involvement, especially in the beginning, through better notice and better participation requirements. It requires and reforms the appeals process so we can end the costly delays that do keep our professional foresters from doing the work they need to do to make our forests more healthy.

Finally, it does require the courts to more quickly move on appeals and, more importantly, consider the catastrophic affect on forest health of preventing these projects from going forward.

Now, we have heard today about the problem with the General Accounting Office, but let us talk about what the General Accounting Office actually found. This is what the GAO report found: 58 percent of eligible thinning projects in the United States were appealed in fiscal year 2001 and fiscal year 2002. Fifty-two percent of the eligible forest thinning projects proposed near communities in the wildland urban interface were appealed. Half the projects, half the projects right around communities were appealed. The GAO found an overwhelming number of Forest Service appeals were found to be without merit. Seventy-three percent of the appeals were rejected.

Ladies and gentlemen, we have to change the process. That is what we are doing today. We are going to fund the work that needs to be done. This year alone we are going to spend $420 million to go in and thin out our forests so we will not have catastrophic fires in the future. I would like to see this bill expanded beyond 11 percent of the forests that need this kind of treatment, but that is as far as we could get under this act. I want to see our communities protected.

This legislation relies on the underlying National Forest management plans to protect old growth forests. My colleague, the gentleman from Washington (Mr. INSLEE) talks about protecting old growth. We do that in this bill because the underlying plans protect the old growth. And the alternative of defeating this bill is to have old growth forests that are blackened, burned and destroyed, and I will not stand for that. Vote for the bill.

Mr. GOODLATTE. Mr. Speaker, I yield 1 minute to the gentlewoman from Colorado (Mrs. MUSGRAVE).

Mrs. MUSGRAVE. Mr. Speaker, I would like to offer my gratitude to the chairman of the Committee on Agriculture, the gentleman from Virginia (Mr. GOODLATTE), the ranking member, the gentleman from Texas (Mr. STENHOLM), the gentleman from California (Mr. POMBO), and especially to my colleague, the gentleman from Colorado (Mr. MCINNIS).

In the West we care very deeply about this legislation, particularly in Colorado. We have had the Buffalo Creek Fire, we have had the Hayman Fire in Colorado, we have had massive loss in acres of our beautiful forest land. We have had immeasurable damage to the environment, to our water quality.

The Denver Water Board spent over $20 million cleaning up after the last fire. Habitat has been destroyed. Our tourism industry has been harmed greatly. And, more importantly, we have lost the lives of our brave firefighters in Colorado.

We are in strong support, those of us that care about our national forests and our private forests, are in strong support of this conference committee report. And I commend all those who have worked so hard on this conference committee and this legislation.

The SPEAKER pro tempore (Mr. BASS). The Chair would like to announce that the gentleman from California (Mr. POMBO) has 3 minutes remaining, the gentleman from Virginia (Mr. GOODLATTE) has 1 minute remaining, the gentleman from Texas (Mr. STENHOLM) has 7 minutes remaining, the gentleman from Washington (Mr. INSLEE) has 5 minutes remaining.

Mr. STENHOLM. Mr. Speaker, I yield 2 minutes to the gentleman from California (Mr. DREIER).

Mr. DREIER. Mr. Speaker, I rise in strong support of this conference report. And I was told that I had to spend my entire 2 minutes praising the gentleman from Texas (Mr. STENHOLM), but I am going to instead talk about the benefits of this bill. And I want to compliment my colleague, the gentleman from California (Mr. POMBO), and the chairman of the conference, our good friend, the gentleman from Virginia (Mr. GOODLATTE), the chairman of the Committee on Agriculture, the gentleman from Oregon (Mr. WALDEN), and others who have been so involved in this measure.

I happen to represent the Los Angeles area in southern California. And the world knows that we have just suffered devastating fires in the southern California area. It impacted the districts of my colleague, the gentleman from California (Mr. LEWIS) who represents the area in the Inland Empire to the east of Los Angeles, further east of the area I represent, and several others of our colleagues in San Diego. I know that my colleague, the gentleman from California (Mr. HUNTER), as we all know, lost his home. And this impacted the district of the gentleman from California (Mr. CUNNINGHAM). And I can go through the litany of our colleagues. Many members of the California delegation had their districts impacted by this. We lost lives, we lost a tremendous, tremendous amount of property. I lost in excess of 50 homes in the area that I represent.

And I was very pleased when the gentleman from Virginia (Mr. GOODLATTE) was before the Committee on Rules yesterday and talked about the fact that within this measure we will be able to have resources to deal with things like the bark beetle which has played a role in creating a problem in southern California when these trees were not cleared. And that played a role in starting these fires.

We know that some resources were provided through the Department of Agriculture to deal with this, but it was not handled appropriately from the reports that we had from the head of the Office of Emergency Services there. It is important for us to do everything that we can to ensure that the loss of life and property is diminished. I am convinced that passage of this conference report will go a long way towards doing just that. And I thank all my friends who played such an important role in making this happen.

The SPEAKER pro tempore (Mr. BASS). The Chair will advise that the closing order will be the gentleman from California (Mr. POMBO) first, the gentleman from Texas (Mr. STENHOLM) second, the gentleman from Washington (Mr. INSLEE) third, and the gentleman from Virginia (Mr. GOODLATTE) fourth.

□ 1430

Mr. POMBO. Mr. Speaker, I have one additional speaker to close.

Mr. Speaker, I reserve the balance of my time.

Mr. STENHOLM. Mr. Speaker, I yield 1 minute to the gentleman from Michigan (Mr. SMITH).

Mr. SMITH of Michigan. Mr. Speaker, our Committee on Agriculture is a great committee in terms of Republicans and Democrats working together.

Our forests in this country are one of our strong resources that not only help us economically but also help the environment, and conserving the environment is important. Our forests certainly are an important part of Michigan, but they are also a very important part of our economic strength in the United States.

In the West, catastrophic wildfires recently have decimated those forests over the last several years. We have made a mistake over how we want to control forests. And sometimes in our overzealousness to protect from fires, we have increased the potential of additional damage. Two days ago, we passed an energy bill. In this bill there is also language to utilize the natural renewable resources of our woodlands of America to also contribute to energy.

Removing some of the bureaucratic red tape for performing fire prevention measures is not only environmentally friendly but also fiscally responsible, as fire prevention costs American taxpayers approximately one-fourth of what it costs to fight catastrophic forest fires. The Healthy Forests Restoration Act authorizes the Bureau of Land Management (BLM) to reduce the amount of underbrush and deadwood buildup in forests that serve as kindling and fuel for the hottest, most dangerous fires. It would regulate BLM's activities by putting limits on the tree removal and road construction that has provoked controversy at times in the past. This would give BLM the tools it needs to confront the increasing threat of destructive forest fires on federal lands that have had serious impacts both on people and wildlife.

The bill takes additional measures to improve our forests. These include provisions to encourage energy production from renewable energy sources, protection of watersheds in forest areas and the creation of a forest reserve program aimed at preserving and rehabilitating up to one million acres of degraded and rare forest lands.

Disease and insect infestations are not only detrimental to our woodlands, but also to our tree-lined streets and backyards. In southeast Michigan, we are combating an exotic beetle known as the Emerald Ash Borer. The bettles' larvae feed on the sapwood and eventually kill branches and entire trees. This invasive pest has resulted in the quarantine of all ash products in six counties and southeastern Michigan. There are 28 million ash trees in the six quarantined counties and an estimated 700 million ash trees in Michigan. We are not finding that the pest is spreading into Ohio. The magnitude of this problem is serious. Preliminary data from the Forest Service estimates that the potential national impact of the Emerald Ash Borer is a loss of ash trees up to 2 percent of total timber with a value loss of between $20–60 billion.

Following discussions with Secretary Veneman and gaining the support of the Michigan delegation, Michigan Department of Agriculture, and DNR we were able to get the approval of substantial millions of dollars in emergency assistance from USDA to combat the Emerald Ash Borer. This federal funding will supplement resources provided by state and local authorities and will be used for pest surveillance, quarantine of infected areas, and some tree removal. In order to more efficiently combat destructive pests like the Emerald Ash Borer, the Healthy Forest Restoration Act puts in place measures that will allow accelerated information gathering on such insect infestations. By removing bureaucratic red tape and being more proactive in maintaining forest health, the Healthy Forest Restoration Act is a step in the right direction towards efficiently managing our forests, preventing catastrophic fires, controlling damaging insect infestations, and protecting our environment.

Mr. STENHOLM. Mr. Speaker, I ask unanimous consent to give two of my remaining minutes to the gentleman from Virginia (Mr. GOODLATTE) for the purposes of closing.

The SPEAKER pro tempore (Mr. BASS). Is there objection to the request of the gentleman from Texas?

There was no objection.

The SPEAKER pro tempore. The gentleman from Virginia (Mr. GOODLATTE) has 2 extra minutes.

Mr. POMBO. Mr. Speaker, I yield the balance of our time to the gentleman from Colorado (Mr. MCINNIS), the subcommittee chairman and co-author of the legislation.

Mr. MCINNIS. Mr. Speaker, I appreciate the yeoman's work of the chairman and the guidance of making sure that we could get this bill through. I also wish to acknowledge deeply the gentleman from Virginia's (Mr. GOODLATTE) service and especially the service of the staff who have worked so hard in making sure that we could come together on this side of the aisle so that when we approached this side of the aisle we had a package that had common sense. We had a package that people like the gentleman from Texas (Mr. STENHOLM), the gentleman from California (Mr. GEORGE MILLER), and the gentleman from Oregon (Mr. DEFAZIO) could come to the table and work with us on. And a lot of that was guided, a lot of the going back and forth was guided by someone who I consider an artist and that is the gentleman from Oregon (Mr. WALDEN), somebody who can negotiate between both the Republicans and the Democrats.

It was about 99 years ago when Teddy Roosevelt used his State of the Union address to urge Congress to create a national forest system to ensure proper stewardship of these tremendous assets that we have in our huge public lands. And by the way, I live in a district that has 23 million acres of public lands. It is fitting now that 99 years later, 99 years later we have one of the most significant pieces of forest legislation that has come in since.

What this piece of legislation does is over the 99 years we have seen the leadership, the guidance, the expertise and the science taken away from the Green Hats, who I complimentarily refer to as our Forest Service people, the people who understand the forests, the people who dream of running the forest, the people who have been educated in the forests. We have seen through some very tactical maneuvers their power and their authority taken by the Sierra Club-types and moved to the courts and moved to the Congress.

What this bill does is this bill allows this authority to go back to those people on a commonsense approach, on a balanced approach which is demonstrated by the fact that this will pass with bipartisan support, to let it go back to the Green Hats, to let the Forest Service manage those forests.

The passage of this legislation today means that the Congress, all of us are responding to the America forests health crisis, the crisis that was demonstrated recently in the State of California, the crisis which we have seen in the State of Oregon, the crisis through bug infestation, not just fires, but bug infestation down in the South. Storm King Mountain, the mountain that I grew up on, the mountain that I took bodies off of, we finally are responding and we are coming back. I am pleased that we are coming back and giving that authority where Theodore Roosevelt thought that authority ought to exist, and that is with the United States Forest Service.

Once again I want to compliment my colleagues on the Democratic side that have worked with us. And I want to point out those who have not. It amazes me that one like the gentleman from New York City (Mr. HINCHEY) would stand up and make the kind of statements that he made and speak from a wooden podium. A little ironic.

This is a good bill. It is bipartisan, and it is going to make a big, big difference.

Mr. INSLEE. Mr. Speaker, I will be closing, so when the appropriate order comes, I will take my turn.

The SPEAKER pro tempore. The closing order will be the gentleman from Texas (Mr. STENHOLM), the gentleman from Washington (Mr. INSLEE), and, lastly, the gentleman from Virginia (Mr. GOODLATTE).

Mr. STENHOLM. Mr. Speaker, I yield myself such time as I may consume.

I will yield to the gentleman from Virginia (Mr. GOODLATTE) if he would like to engage in a colloquy on monitoring.

Mr. GOODLATTE. Mr. Speaker, will the gentleman yield?

Mr. STENHOLM. I yield to the gentleman from Virginia.

Mr. GOODLATTE. Mr. Speaker, I will clarify a point that the gentleman from Texas (Mr. STENHOLM) is interested in. Let me state that the projects authorized by title IV are primarily scientific efforts, and scientific methods should be the primary means of assessing them. While we encourage multiparty monitoring, it is not our intent to require it, particularly for projects conducted under title IV.

Mr. STENHOLM. Mr. Speaker, I will state I certainly agree with the chairman. I understand the benefit of multiparty monitoring. However, the chairman is correct in expressing that our intent with respect to projects conducted under title IV are to be scientifically conducted and multiparty monitoring is not a requirement of these projects.

Mr. Speaker, I would like to conclude by thanking all who have worked so diligently for so long to bring us to this point to where we truly have a compromise that will move our forest policy in a desirable direction.

I thank the staff, all who have worked on both sides on the aisle so diligently under somewhat trying conditions from time to time as we have had some of the internal strife that unfortunately finds its way into this House of Representatives. But that certainly has not been the case regarding the House Committee on Agriculture, and the bipartisan support there is something that I have enjoyed and working with the chairman and the gentleman from California (Mr. POMBO) and others as we have strived to put together what is basically a good bill.

When you read the bill, much of the complaints about what we have heard today are not in the bill. If you are going to have sound forests, if you are going to have a sound forest policy, sound science, common sense has got to replace the opinions of many who have a difference of opinion regarding what is good conservation, what is good management, and how we do, in fact, manage our forests so that we do have lumber for housing and other projects.

So all in all, this is a good sound compromise worthy of overwhelming support of this body. I thank all of those who have worked on it. It certainly has been something that I personally have worked on for many, many years. I am glad to see it is getting to this point. I urge a very strong vote in favor of the project.

Mr. INSLEE. Mr. Speaker, how much time do I have remaining?

The SPEAKER pro tempore. The gentleman from Washington (Mr. INSLEE) has 5 minutes remaining.

Mr. INSLEE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I commend all of the people who have worked on this bill. There are a lot of technical and difficult issues trying to fashion a hazardous fuels reduction program. And I am unable to support this and I hope my colleagues will join me and the Sierra Club and the League of Conservation Voters and other main-line commonsense groups who have committed their lives to protecting our national forests in defeating this bill and moving on to a better one, and I hope that my colleagues will join me.

Underlying that position is the basic belief that the medicine that we are providing here is both inadequate and misguided. It is misguided because it is based on a myth; and that myth rising to an urban legend is that these fires have consumed thousands of acres because people have questioned what some government officials have done, and that is an abject falsehood.

The GAO report shows that 92 percent of these projects go ahead unimpeded. In California, you know why the California projects did not get done? It was not environmental project appeals. In the last 3 years, there has not been one hazardous fuel reduction program that held up national forests in Southern California the last 3 years. The reason some of this work did not get done is Uncle Sam, us, did not appropriate enough money for California to do the job. The State of California asked for $430 million last April to solve this problem. And what did Uncle Sam do in the Bush administration? They did not give it to them. And the fires occurred.

This is a failure of appropriations, not a failure because certain citizens once in a blue moon have the temerity to stand up on their back legs and question decisions by the Forest Service to do disguised commercial logging which has on occasion happened, thankfully not very often. Maybe 2 percent of the time. We are not doing enough to really solve this problem.

What we have done is in one of the most serious reductions of citizens' ability to question their government is reduce the ability to have their oversight of our Federal officials.

Now, it is kind of a conservative position to be rightfully sometimes distrustful of our Federal officials. Now, I have got to say there have been occasions, thankfully few, where these projects have been disguised timber sales. And the reason is because we are not appropriating enough to the Forest Service to do their job. And when that has happened, less than three pearls of the time there has been a brief appeal of that decision, and most frequently these things get worked out. But until we increase tenfold our appropriations, we are not going to cut the mustard in this program.

Now, let me mention something else, too. We have not talked about what the real debate is about here. The debate is as much about roads as it is about forests, because the real issue here is where we are going to build roads. We have 440,000 miles of Forest Service roads in our forests, 440,000 miles. They are falling apart, and we ought to be putting our money in and fixing those roads before we punch new roads into roadless areas.

Let me put this into real-life perspective. Take a couple in northeast Washington who is not getting adequately protected by this bill. Their house is surrounded by pine trees in the national forest. We have not prioritized those pine forests around their home for treatment like we should have in this bill. We did not do it. Now, when that couple leaves their home to drive over to the Olympic Peninsula to the Jupiter Ridge Roadless Area, if they hike out to a nice little picnic spot, they will find two trees. They are about maybe 6, 7, 8 feet in diameter, cedars, right next to each other. We call them Jefferson and Washington.

In this bill, neither protects that couple in their home surrounded by the pine forest, nor the two trees they go to visit in the roadless area.

Their home is not protected from fire adequately, and those two trees are not protected from chainsaws adequately in this bill.

It is my hope that this bill will be defeated and we will come back and make some very modest but important improvements on it to solve both of those problems.

Mr. Speaker, I yield back the balance of my time.

Mr. GOODLATTE. Mr. Speaker, I yield myself such time as I may consume.

Let me start by thanking the gentleman from Texas (Mr. STENHOLM) for yielding me 2 additional minutes for this close, but more importantly for the very cooperative way in which the House Committee on Agriculture has produced this legislation. This is truly the example of why this bill will pass by an overwhelming margin here today.

It passed out of the House Committee on Agriculture originally on a voice vote; and when it came to the floor, I believe, 19 of the 24 Democrats on the committee, Members who represent rural areas, Members who represent areas that are forests, voted for this legislation, nearly 80 percent.

Had we had that kind of support elsewhere in the Congress, this legislation would have been adopted a long time ago. It has been 8 years that we have been working on it. And I would have to say to the gentleman from Washington State (Mr. INSLEE) that if we were not to pass this conference report, not to send it to the President, we would be working on this for many more years. We would see more years like this year where 6½ million acres of forest land in this country were burned to the ground.

□ 1445

That is what we are faced with. That is why we need to begin this first step of solving this problem by giving the Forest Service the tools that it needs.

It is absolutely incorrect that these forest fires are not related to the problems that the Forest Service is presented with. Certainly, money is a problem. Certainly, we are going to have to deal with that, but in addition, massive parts of the Western part of this country are tied up in legal cases, including the entire southern California area that is tied up over litigation related to the spotted owl. This is clearly, clearly needed to address the problems that we face across the country.

I want to thank also the gentleman from California (Mr. POMBO). He recognizes very clearly the nature of this problem, and the gentleman from Colorado (Mr. MCINNIS), I want to congratulate him on his leadership in bringing this bill to the floor as well. He is leaving the Congress at the end of this term, and this is his signature bill. This is his legacy in the Congress. So I commend him as well.

I also commend Members who have fought against this process like the gentleman from California (Mr. GEORGE MILLER) and the gentleman from Oregon (Mr. DEFAZIO). They have seen the light. They understand what it takes. They understand that it is time to get about the business of solving the problem, rather than another 8 years of fighting, and I would say to those few remaining who do not understand, get on board, get this done.

Yes, there is additional work that needs to be done. Yes, we will look forward to working with them in future Congresses, but now is the time to give the President the ability to sign a bill that will put our Forest Service to work, to get this problem underway. We will come back for additional legislation because this problem is going to persist, and this is only a beginning.

Support this conference report. It is a good one.

Ms. LORETTA SANCHEZ of California. Mr. Speaker, my home state of California has just been through a terrible series of wildfires. The fires burned more than 800,000 acres, destroyed over 3,300 homes, caused over $12 billion in property damage, and tragically took the lives of 22 people.

What could have been done to prevent it? What should we do now to prevent such occurrences in the future?

The answer, it seems to me, is active management and control of overgrown areas near development, usually referred to as the Woodland-Urban Interface. This will go a long way to preventing fires from destroying homes and worse, killing our citizens.

We have a bill in front of us today, H.R. 1904, The Health Forests Initiative, that its proponents tell us will help prevent the kind of devastation that we endured in California.

This conference report is certainly better than the initial House version of the bill. In the House bill, money used for clearing would have had to come from nearby logging activities. In the chaparral of Southern California, there is no logging, and that means no removal of forest fuels would have occurred to protect our homes and our families.

The House-Senate compromise that is before us today is a step in the right direction. Most importantly, it provides $760 million to fund clearing forest fuels to prevent catastrophic wildfires. Nevertheless, there remain some fundamental problems with the bill.

First of all, the Healthy Forests Initiative is only effective for federal lands. Roughly two-thirds of the lands that burned in California was not federal land, and therefore would be unaffected by the healthy forests initiative.

Second, only half of the $760 million is set aside for forest clearing within 1½ miles of structures—the Wildlife-Urban Interface. The other half will go toward thinning in other areas. Moreover, where in the initial bill the clearing was paid for by nearby profitable logging, now we are giving $365 million to commercial loggers for these thinning activities. So, instead of asking logging companies to contribute their fair share to forest management and fire mitigation, we are subsidizing them to do it.

I am disappointed with this bill. We had an opportunity to craft a bipartisan bill, one that would have addressed the pressing issue of protecting lives and property in the Wildlife-Urban Interface. Instead, the Healthy Forests Initiative puts commercial logging interests ahead of protecting our vulnerable communities. Once again, the Republican-controlled Congress has it priorities all wrong.

While this bill does not sufficiently address this important priority, I am supporting an effort that does. I am working to provide more funding for community and individual-initiated and driven initiatives to clear fire fuels in their areas. We should be empowering local communities to clear these areas—they have the greatest knowledge of the environments in which they live, and the greatest personal stake in the success of these efforts. I am hopeful that this initiative will generate broad bipartisan support.

In the meantime, I regret that I must oppose the Health Forests Initiatives, principally because it uses a great deal of resources, but it won't do very much to make our Southern Californian forests any healthier.

Mr. GEORGE MILLER of California. Mr. Speaker, today the House of Representatives accepted the conference report for H.R. 1904, the Healthy Forests Restoration Act. I was appointed as a conferee, as was Representative INSLEE of Washington and Representative CONYERS of Michigan. Unfortunately, instead of using the conference process to reconcile differences between the House and Senate versions of the legislation, certain members of the conference committee were included in bicameral meetings to craft a compromise acceptable to the group of negotiators. In short, the negotiating group picked people from the conference committee who would agree with them and did not invite others to participate. Official members of the conference committee were invited to a conference meeting to consider the product negotiated outside the conference process. The conference consideration did not provide for a real debate of amendments and the Chair moved to close the conference 30 minutes after it began. This does not contain the elements of a democracy but the elements of arrogance of power.

Mr. UDALL of Colorado. Mr. Speaker, I am going to vote for this conference report.

It has flaws. But if its provisions are properly implemented it can help reduce the risk of severe wildfire damage that now threatens lives and property in many communities in Colorado and other States—and for me that is the bottom line.

I am convinced we need to act to protect our communities and their water supplies. For that, a variety of things must be done, including working to reduce the built-up fuels that can increase the severity of the wildland fires that will periodically occur nearby.

That's why I have introduced legislation to expedite those thinning projects. It is also why last year I joined with my Colorado colleague, Representative McINNIS, and other Members to develop a bill that was approved by the Resources Committee.

I voted for that bill last year, and if H.R. 1904 as it came to the House floor earlier this year had been the same as that bill, I would have voted for it again. But it wasn't the same bill, which was why I voted against it.

Instead of building on last year's work in the Resources Committee, the Resources and Agriculture Committees this year brought forth a quite different measure—one that added a long list of new provisions while omitting some of the key parts of last year's bill. As a result, it has taken much longer than I though it should have for us to reach the point of being ready to vote on a measure that has a good chance of clearing both chambers and being sent to the President for signing into law.

Because H.R. 1904 as passed by the House rejected key compromises that we worked our last year, the bill encountered more resistance in the Senate than otherwise would have been the case, and it was that much harder to shape compromises on a number of difficult points.

However, in the end the Senate passed a bill that made important improvements on the House version—and this conference report, while far from perfect, is itself a definite improvement over the legislation that I voted against earlier this year.

Let me briefly outline some of the ways in which the conference report is enough of an improvement over the House bill that I can and will vote for it today:

FUNDING FOCUS

Like the Senate bill, the conference report requires that at least 50 percent of all thinning-project funds be spent in the interface areas. Last year's Resources Committee bill would have required 70 percent of the money to be spent in the interface, but H.R. 1904 as passed by the House did not include any such requirement. So, the conference report is an improvement over the House bill in this area.

WILDLAND/URBAN INTERFACE

I think the highest priority for fuel-reduction work needs to be on the forest lands where accumulated fuels present the most immediate risks to our communities—those within the wildland/urban interface, or the "red zone," as it is called in Colorado—and to municipal water supplies. These are the places where forest conditions present the greatest risks to people's lives, health, and property, and so they should be where our finite resources—time, money, and people—are concentrated.

To properly focus on these areas, we have to properly identify them. In that regard, I had no quarrel with the provisions of H.R. 1904 as passed by the House. By referring to lands within either an "interface" or "intermix" community, it provided an appropriate limitation on the discretion of the agencies without drawing an arbitrary mileage line that would not appropriately reflect the reality that a community's exposure to the risk of wildfire depends on terrain, forest conditions, and other factors that can vary greatly from one place to another and over time.

However, proper focus also requires assured priority status for funds to carry out projects to protect communities and their water supplies. The bill reported by the Resources Committee last year required that at least 70 percent of the funds provided a for fuel-reduction purposes would have to be used for such projects—but no similar provision is included in H.R. 1904. I offered an amendment to restore the provision, and its absence was a major reason I voted against the House bill.

The Senate bill had a basic limit of one-half mile from a community's boundary, with some exceptions—if a larger area was identified in a community protection plan developed through a collaborative process; or if land near a community was steep; or if there was a geographical feature that would provide a firebreak within three-quarters of a mile, in which case the interface would go to that feature. The "community protection plan" provision was particularly good, in my opinion, because it did not require an arbitrary cutoff, and because it allowed both Federal and non-Federal land to be included. The rest of the definition was problematical.

The conference report improves somewhat on the Senate bill. It (1) retains the "community protection plan" part of the definition; (2) keeps the basic one-half mile limit; but (3) allows the interface to go to 1½ mile, if the slopes are steep or if there is a firebreak-feature within that distance and the lands are very susceptible to fire. Like the Senate bill, it also defines the interface as including a route identified as necessary for escape from a threatened community.

I think it is well established that reducing the fuels closest to structures pays big dividends in terms of reduced fire risks. However, I do into favor defining the interface in terms of arbitrary lines on the map, because fires do not respect those lines and because our experience in Colorado has shown that some of the high-priority "red zone" areas are extensive. A prime example is the Hayman fire—it was among the largest in our State's history, but all of the lands involved were within the "red zone" as defined by our State Forester (a definition that is included in my bill, H.R. 1042).

Nonetheless, on balance, I think the conference report is acceptable on this point because of the emphasis that it puts on community-protection plans. This should encourage at-risk communities, like those along the Front Range, to develop protection plans and to encourage owners of non-Federal lands to join in working to reduce fire risks.

COMMUNITY-PROTECTION PLANS

I strongly support increased public involvement during the planning and other initial stages of fuel-reduction projects. That was the purpose of an amendment I offered during the markup of the House bill. The ideal is to make it less likely those projects will be delayed by controversies or lawsuits, by developing support at the front end for projects that are urgently needed, narrowly tailored and scientifically sound. I think the conference report's provisions related to community protection plans can foster such involvement and promote a collaborative approach that will do much more to reduce conflicts and delays than will the provisions related to NEPA analysis, administrative appeals, and judicial review.

NEPA ANALYSIS AND JUDICIAL REVIEW OF THINNING PROJECTS

On judicial review, the Senate bill is slightly better than the House bill, and the conference report follows the Senate bill.

On NEPA analysis, the conference report is a compromise between the House and Senate bills. Under the House bill, no alternatives to a proposed action would have to be analyzed; under the Senate bill at least the "no-action" alternative would have to be analyzed, and so would a third if proposed during scoping. The conference report would follow the House bill for projects within the interface, but follow the Senate bill for projects outside the interface.

As passed by the House, H.R. 1904 clearly reflected the premise that the land-managing agencies are laboring under procedural burdens that unnecessarily delay work on fuel-reduction projects—a premise that I think has not been proved beyond doubt.

The Chief of the Forest Service has testified that the agency has been slow to act to reduce the risks of catastrophic wildfire because of "analysis paralysis," meaning that the fear of appeals or litigation has made Forest Service personnel excessively cautious in the way they formulate and analyze fuel-reduction—and other—projects. The chief may be correct in that diagnosis—certainly he is in a better position that I am to evaluate the mental states of his subordinates. But it is important to remember that the Chief has also testified that he does not think revision of the environmental laws is required in order to treat this condition—and on that point I am in full agreement.

Nonetheless, I supported some restrictions on NEPA analysis last year, and because the conference report does not go as far in that direction as the House bill I am prepared to reluctantly accept this part of the conference report as well as its provisions related to administrative appeals and judicial review even though I would have preferred the provisions of last year's Resources Committee bill or this year's Senate bill dealing with those topics.

OLD GROWTH AND BIG TREES

The House bill had no specific protection for old-growth stands, and only weak language to require that thinning projects focus on removing small trees. The Senate bill had provisions intended to protect old-growth stands and slightly stronger language to put emphasis on thinning out smaller trees. The conference report falls far short of ideal in these areas—in this respect it is weaker than either the Udall-Hefley bill of 2001 or H.R. 1042. However, it is an improvement over the House-passed bill.

FUNDING

The House bill had no specific authorization for funding thinning projects; the Senate bill authorized $760 million per year, and the conference report follows the Senate bill.

This part of the conference report is a definite improvement over the House bill, because the main obstacle to getting needed work done has been lack of funds, and lack of focus on red zone areas, not the environmental laws or the appeals process.

Of course, an authorization alone will not assure appropriation of adequate amounts, and nothing in the conference report will protect the funding that is appropriated for thinning projects from being used to fight fires if Congress does not provide adequate funding for that essential purpose. However, the specific authorization may assist in both respects by demonstrating the importance that Congress attaches to thinning projects.

OMITTED PROVISIONS

The conference report drops a number of provisions that the Senate added to the original House bill. I think some of those provisions should have been retained, such as those dealing with health monitoring of firefighters, monitoring of air quality, increases in the fines for violations of regulations related to fires on Federal lands, and the enforcement of animal fighting provisions of the Animal Welfare Act. I also would have preferred the deletion of some parts of the original House bill that have been retained in the conference report. On balance, however, neither the omission of some good Senate provisions nor the retention of some defective House provisions is enough to make the conference report unacceptable to me.

In conclusion, Mr. Speaker, let me say that while I am voting for this conference report, I do not expect this to be the last time Congress addresses the matters it addresses. I am under no illusions about the flaws in this legislation, and will be working to improve it. I will also do all I can to make sure that it is implemented in a way that is consistent with sound, balanced management of the Federal lands.

Mr. BLUMENAUER. Mr. Speaker, the problem of forest fires in the West that are aggravated, in some cases caused, by human mismanagement has been a problem as long as I have been in Congress. I am pleased that with the work of Oregonians Representative PETER DEFAZIO, Senator RON WYDEN and Representative GREG WALDEN, the bill that's moving forward is better than the bill I voted against in the past.

I wish I could vote for H.R. 1904 in good conscience, but it still has three fundamental problems. First, the procedural fix far exceeds any procedural problem. This bill would undermine the National Environmental Protection Act, the judicial process, and the system of administrative appeals to fix a perceived problem of too many projects being tied up in environmental litigation. However, the Government Accounting Office estimates that only 1 percent of forest management projects have been tied up in litigation. This type of sweeping procedural change is unnecessary.

Second, the bill opens up our forests to much broader timber harvest. This should be debated on its own merits and not under the guise of forest health and fire prevention. If we want to substantially increase timber harvest on Federal lands we ought to be clear and deal with it directly.

Last, and most troubling of all for me, is that this bill does not adequately protect families whose lives and property are at risk because of forest fire hazard. This bill does not focus our resources on the interface between residential properties and forest land, in what we are coming to know as the "flame zone." Focused hazardous fuel reduction around communities could substantially reduce the risk of fire damage by providing a buffer to help slow and stop advancing fires.

This is a better bill than before but it is still a missed opportunity. To adequately protect families and businesses we need to take a few, simple, proactive steps. We need to strengthen building codes and insurance requirements for "firewise" construction and "defensible space" landscaping. According to Forest Service scientists, these precautions can increase a home's ability to survive a wildfire by more than 90 percent. We need to educate homeowners of the dangers before wildfires start so they can adequately prepare, and make informed choices on where to live. We need to implement smart land-use planning that guides development away from fire-prone areas. And, we need to provide affordable, livable housing options for families away from danger.

Mr. RAHALL. Mr. Speaker, I rise in opposition to the conference report. Others will come to the floor to discuss the threat of wild fire to the health and general welfare of segments of the American population.

Others will come to the floor to discuss other elements of this legislation, such as its provisions concerning insect infestation which threatens some of our forests and forest industries.

I am not unmindful of the need to address the issues raised by the bill, but in our view, we would do so in a more prudent and responsible manner.

There is one issue in the pending legislation, however, which transcends the debate over forest fires and forest health: the independence of our judiciary and the right of Americans to seek redress from the courts when they believe they are aggrieved by a governmental action.

Indeed, the judicial review provisions of this bill would set a dangerous precedent for anybody concerned with civil liberties, civil rights, workers' rights and any other issue that may come before our judiciary.

Simply put, this legislation curtails access to the courts by American citizens by limiting where challenges can be brought, by whom, and on what issues.

This legislation interferes with how judges run their courtrooms. It arbitrarily requires courts to lift injunctions and stays after 60 days unless affirmatively renewed by the court.

A dangerous precedent and very bad policy. Our Constitution clearly delineates three branches of government. This conference report tramples on that tenant of our Constitution.

Incredible. Simply incredible.

This bill tells the court that litigation involving thinning trees is more important than prosecuting suspected Al Qaeda terrorists.

To judge suits over forest thinning projects more important than all other civil cases, let alone criminal cases, is seriously misguided. To make this policy law is absurd.

I have been here long enough to remember when conservatives did not trust the federal government and did not endorse expanded and unchecked federal powers.

It is unfortunate, it really is, that the sponsors of this bill chose to inject this controversial attack on the independence of our judiciary in a measure of this nature.

These provisions are a poison pill, and do a disservice to our addressing issues such as forest insect infestation and forest fires in a prudent and responsible fashion.

Mr. TANCREDO. Mr. Speaker, I rise today in support of H.R. 1904, the Healthy Forest Restoration Act. I would like to thank leadership for allowing this long overdue bill to come to the floor today, and most importantly, I would like to thank Forest Subcommittee Chairman SCOTT MCINNIS, whose hard work and dedication this bill has brought us to this point today.

Mr. Speaker, there are many reasons to cut through the current procedural and bureaucratic thicket that has engulfed the U.S. Forest Service. It is time to eliminate the "analysis paralysis" of administrative appeals and litigation that has heretofore prevented the U.S. Forest Service from conducting badly needed thinning projects that are needed to protect communities and wildlife.

The fires of the last few years have ravaged the west. My district was no exception, where the 137,000 acre Hayman Fire tore through the Pike National Forest last year. That wildfire—the largest and most destructive in state history—burned homes, fouled streams and reservoirs, and may even have pushed an endangered butterfly into extinction. Fires like these have proven once and for all that no management on our public lands, is bad management.

Unfortunately, much of the destruction caused by these fires is attributable to the bureaucracy, appeals, and red tape that have hamstrung land managers for years. The

Hayman Fire, for example, occurred in part in an area slated for treatment. Unfortunately, the treatments took years to plan because of arcane procedural rules, and were then further held up by frivolous appeals filed by a host of environmental groups. Before the treatments could begin, the fires reduced the area to ashes. This bill will seek to streamline that process, and curtail frivolous litigation so that we can avoid the large scale environmental devastation caused by these catastrophic fires in the future. In addition, the bill will help reduce costs to the American taxpayer.

The cost to extinguish these abnormally massive fires to protect communities and their water supplies has cost more than $1 billion. With the passage of H.R. 1904, rather than continuing to treat the expensive symptoms of this dangerous buildup of dead and diseased trees in our forests—we will finally get at the root cause of the problem.

Mr. Speaker, I believe every dollar we spent on a thinning project that prevents a fire, is several dollars saved in suppression and first responder costs when the fire starts. Restoring our forests to a healthier state by clearing out dead fuel and bug-infested trees before they feed wildfires isn't just good environmental policy, it's good fiscal policy too.

Mr. HERGER. Mr. Speaker, I rise in strong support of H.R. 1904, the "Healthy Forests Restoration Act of 2003." For the Northern California Congressional District I represent, this bill is long overdue. My District comprises 5 national forests, and wildfires are an annual and growing threat. Each day, month and year that good forest management is stymied, communities are placed in greater danger.

Mr. Speaker, in my view, this bill doesn't go far enough to address our monumental and compounding forest health crisis. With 190 million acres of forests at risk, and only 2 million acres being treated annually, we have to do much, much more. But it takes an important first step forward in the face of tremendous resistance from the radical environmentalists. And I want to commend my colleagues—Chairman Pombo, Chairman Goodlatte, Chairman McInnis and Congressman Walden—for their staunch leadership and dedication in fashioning a collaborative bill that is able to win a majority of the House and Senate. President Bush also deserves a great deal of credit and thanks for his efforts in bringing our growing forest health crisis to the attention of the American public, and to the forefront of our environmental policy debate.

An extraordinarily cumbersome environmental review process, which can delay forest health projects for years, has elevated the review "process" over good management and professional judgment. The Forest Service Chief, Dale Bosworth, testified to Congress that his agenda spends 40% of its time on planning and process activities. Litigation and an appeals process that is ripe for abuse have been utilized by radical environmental groups to stop community-supported forest health projects. A General Accounting Office study indicated that 59% of all projects eligible for appeal are appealed, the vast majority from radical environmental groups. The percentage is even higher in California. Meantime, our forests are literally burning up. Lives are being lost. Catastrophic fires are causing billions in property damage and costing the taxpayer billions in suppression and rehabilitation costs. Public health and safety demands that something be done.

For too long radical environmental groups have hijacked our forests to advance their own so-called "environmental agenda." Their handiwork has contributed to an immense forest health crisis where lives and property are threatened, billions of taxpayer dollars are spent to suppress destructive fires—instead of on common sense forest health projects that could prevent them—and millions are wasted on endless environmental reviews and litigation. It's high time for the rest of us to take our forests back.

This bill will not solve this enormous and compounding crisis. But it takes an important step forward by streamlining environmental reviews and preventing abuses of the appeals process, which will allow urgently needed management to move forward in a small portion of our at-risk forests. It will give forest professionals the tools they desperately need, and provide positive momentum for continuing active management throughout all of our forests to restore them to a healthy condition, and address a very serious and growing threat to lives and property. I urge my colleagues to support it.

Mr. MATHESON. Mr. Speaker, I rise today in support of the Healthy Forests bill. This legislation will help restore Utah's forests that have been devastated by fire, drought, and insect infestations.

I am hopeful that this legislation will prevent a repeat of this year's severe wildfire season and stop fires from spreading so quickly and affecting our communities. This legislation focuses its resources on hazardous fuel reduction efforts close to home by prioritizing efforts to prevent fires within a mile and a half of at-risk communities. This bill also provides grants for states and local communities to perform the fuel reduction activities that will benefit them the most.

Not only will this legislation help prevent forest fires, but it will address the infestation of the bark beetle that has affected much of southern Utah. This bill requires the Forest Service to develop a plan to combat insect infestation and allows for the expedition of projects that would help eliminate this problem that has turned Cedar Mountain in the Dixie National Forest into a skeleton of what it once was.

The passage of this bill is critical to protecting the health of the forests in Utah and throughout the West. We've seen too much devastation and damage in recent years to allow the situation to go unchanged. I am committed to this legislation as an important first step toward remediating our forests.

The SPEAKER pro tempore (Mr. Bass). All time has expired.

Without objection, the previous question is ordered on the conference report.

There was no objection.

The SPEAKER pro tempore. The question is on the conference report.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. GOODLATTE. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, this 15-minute vote on the conference report will be followed by 5-minute votes on H. Res. 453, on which the yeas and nays were ordered, and S. 1156, on which the yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 286, nays 140, not voting 8, as follows:

[Roll No. 656]

YEAS—286

Aderholt
Akin
Alexander
Baca
Bachus
Baird
Baker
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Berkley
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Cardoza
Carson (OK)
Carter
Castle
Chabot
Chocola
Clyburn
Coble
Cole
Collins
Cox
Cramer
Crane
Crenshaw
Culberson
Cunningham
Davis (AL)
Davis (CA)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emerson
English
Etheridge
Everett
Feeney
Flake
Foley
Forbes
Ford
Fossella
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Hall
Harman
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Holden
Hooley (OR)
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
John
Johnson (CT)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kline
Knollenberg
Kolbe
LaHood
Lampson
Larsen (WA)
Larson (CT)
Latham
LaTourette
Lewis (CA)
Lewis (KY)
Linder
Lipinski
Lucas (KY)
Lucas (OK)
Manzullo
Marshall
Matheson
Matsui
McCarthy (NY)
McCotter
McCrery
McHugh
McInnis
McIntyre
McKeon
Mica
Michaud
Miller (FL)
Miller (MI)
Miller, Gary
Miller, George
Mollohan
Moran (KS)
Murphy
Murtha
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Ortiz
Osborne
Ose
Otter
Oxley
Pearce
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Pryce (OH)
Putnam
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reyes
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Royce
Ryan (WI)
Ryun (KS)
Sandlin
Schrock
Scott (GA)
Sensenbrenner

Sessions
Shadegg
Shaw
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Smith (MI)
Smith (TX)
Smith (WA)
Snyder
Souder
Spratt
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Turner (TX)
Udall (CO)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Wu
Young (AK)
Young (FL)

NAYS—140

Abercrombie
Ackerman
Allen
Andrews
Baldwin
Becerra
Bell
Berman
Bishop (NY)
Blumenauer
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Carson (IN)
Case
Clay
Conyers
Cooper
Costello
Crowley
Cummings
Davis (FL)
Davis (IL)
Delahunt
DeLauro
Deutsch
Dingell
Doggett
Emanuel
Engel
Eshoo
Evans
Farr
Fattah
Ferguson
Filner
Frank (MA)
Gonzalez
Grijalva
Gutierrez
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holt
Honda
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson (IL)
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kirk
Kleczka
Langevin
Lantos
Leach
Lee
Levin
Lewis (GA)
LoBiondo
Lofgren
Lowey
Lynch
Majette
Maloney
Markey
McCarthy (MO)
McCollum
McDermott
McGovern
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller (NC)
Moore
Moran (VA)
Nadler
Napolitano
Neal (MA)
Olver
Owens
Pallone
Pascrell
Pastor
Paul
Payne
Pelosi
Price (NC)
Rahall
Rangel
Rodriguez
Rothman
Roybal-Allard
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Saxton
Schakowsky
Schiff
Scott (VA)
Serrano
Shays
Sherman
Slaughter
Smith (NJ)
Solis
Stark
Tauscher
Tierney
Towns
Udall (NM)
Van Hollen
Velázquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey

NOT VOTING—8

Cubin
Fletcher
Gephardt
Green (TX)
Kucinich
Quinn
Ruppersberger
Wynn

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. BASS) (during the vote). Members are advised 2 minutes remain in this vote.

☐ 1509

Ms. JACKSON-LEE of Texas and Messrs. CROWLEY, EVANS, ABERCROMBIE, DEUTSCH, LANTOS, OWENS, DELAHUNT, COSTELLO and JEFFERSON changed their vote from "yea" to "nay."

Mr. STRICKLAND changed his vote from "nay" to "yea."

So the conference report was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the remainder of this series of votes will be conducted as 5-minute votes.

CONDEMNING TERRORIST ATTACKS IN ISTANBUL, TURKEY ON NOVEMBER 15, 2003

The SPEAKER pro tempore. The pending business is the question of suspending the rules and agreeing to the resolution, H. Res. 453, as amended.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. SMITH) that the House suspend the rules and agree to the resolution, H. Res. 453, as amended, on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 426, nays 0, not voting 8, as follows:

[Roll No. 657]

YEAS—426

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Filner
Flake
Foley
Forbes
Ford
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Paul
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Young (AK)
Young (FL)

NOT VOTING—8

Cubin
Fletcher
Gephardt
Green (TX)
Kucinich
Quinn
Ruppersberger
Wynn

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised 2 minutes remain in this vote.

☐ 1520

So (two-thirds having voted in favor thereof) the rules were suspended and the resolution, as amended, was agreed to.

The result of the vote was announced as above recorded.

The title of the resolution was amended so as to read: "A resolution condemning the terrorist attacks in Istanbul, Turkey, on November 15 and 20, 2003, expressing condolences to the families of the individuals murdered and expressing sympathies to the individuals injured in the terrorist attacks, and expressing solidarity with Turkey and the United Kingdom in the fight against terrorism.".

A motion to reconsider was laid on the table.

VETERANS HEALTH CARE, CAPITAL ASSET, AND BUSINESS IMPROVEMENT ACT OF 2003

The SPEAKER pro tempore (Mr. BASS). The pending business is the question of suspending the rules and passing the Senate bill, S. 1156.

The Clerk read the title of the Senate bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. SMITH) that the House suspend the rules and pass the Senate bill, S. 1156, on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 423, nays 2, not voting 9, as follows:

[Roll No. 658]

YEAS—423

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Filner
Flake
Foley
Forbes
Ford
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Paul
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Young (AK)
Young (FL)

NAYS—2

Johnson, Sam
Thomas

NOT VOTING—9

Berman
Cubin
Fletcher
Gephardt
Green (TX)
Kucinich
Quinn
Ruppersberger
Wynn

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised 2 minutes remain in this vote.

☐ 1529

So (two-thirds having voted in favor thereof) the rules were suspended and the Senate bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. GREEN of Texas. Mr. Speaker, I regret I was unavoidably detained and missed the three votes earlier today.

Had I been present, I would have voted in the following manner: rollcall 656, approving H.R. 1904, the Healthy Forests Restoration Act of 2003, I would have voted "nay."

On rollcall 657, approving H.R. 453, I would have voted "yea."

On rollcall 658, approving S. 1156, I would have voted "yea."

☐ 1530

REPORT ON RESOLUTION WAIVING POINTS OF ORDER AGAINST CONFERENCE REPORT ON H.R. 1, MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003

Ms. PRYCE of Ohio, from the Committee on Rules, submitted a privileged report (Rept. No. 108–394) on the resolution (H. Res. 463) waiving points of order against the conference report to accompany the bill (H.R. 1) to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes, which was referred to the House Calendar and ordered to be printed.

WAIVING REQUIREMENT OF CLAUSE 6(a) OF RULE XIII WITH RESPECT TO CONSIDERATION OF CERTAIN RESOLUTIONS

Ms. PRYCE of Ohio. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 459 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 459

Resolved, That the requirement of clause 6(a) of rule XIII for a two-thirds vote to consider a report from the Committee on Rules on the same day it is presented to the House is waived with respect to any resolution reported on the legislative day of November 21, 2003, providing for consideration or disposition of a conference report to accompany the bill (H.R. 1) to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes.

The SPEAKER pro tempore (Mr. BASS). The gentlewoman from Ohio (Ms. PRYCE) is recognized for 1 hour.

Ms. PRYCE of Ohio. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentlewoman from New York (Ms. SLAUGHTER), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Mr. Speaker, yesterday the Committee on Rules met and passed this resolution waiving clause 6(a) of rule XIII, requiring a two-thirds vote to consider a rule on the same day it is reported from the Committee on Rules against certain resolutions reported from the Committee on Rules. The resolution applies the waiver to a special rule reported on or before the legislative day of Friday, November 21, 2003, providing for consideration or disposition of the conference report to accompany the bill, H.R. 1, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Mr. Speaker, as my colleagues are aware, the conference committee has completed its work and the conference report has been filed. In the spirit of bipartisanship to accommodate the request of the minority, the Committee on Rules met this morning, as opposed to last night, to give members of the minority an opportunity to come to the Committee on Rules at a convenient time and so that the witnesses could come to the Committee on Rules at a convenient time to talk about this extraordinarily important conference report which delivers to America's seniors a voluntary, universal, and guaranteed prescription drug benefit.

This morning, the Committee on Rules received testimony for more than 4 hours on this conference report from many Members in anticipation of reporting a rule to bring this very important and historic legislation before the House. Adoption of this same-day rule and a subsequent rule will simply allow us to consider the historic prescription drug and Medicare modernization plan today, hopefully moving us one day closer to sending this measure to the President of the United States for his signature and sending a strong message to the American people that this Congress is committed to ensuring our seniors that they have access to affordable medications that will keep them healthy and active.

Mr. Speaker, I strongly urge my colleagues to support this rule and allow the House to complete its work on this landmark legislation. America's seniors have waited far too long. It is time for us to act.

Mr. Speaker, I reserve the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, I thank the gentlewoman from Ohio for yielding me the customary 30 minutes, and I yield myself such time as I may consume.

Mr. Speaker, the rules of this body require that before considering a conference report, a copy of the report and the joint explanatory statement must be available to Members for 3 business days. The Medicare drug conference report and accompanying explanatory statement were filed very early this morning, 1:17 a.m. But here we are, Mr. Speaker, debating a special rule waiving the House rule prohibiting the same-day consideration of the Medicare conference report that is more than 1,000 pages long. This defies common sense. This tramples on the rights of the Members of this body. How are we to make the best informed decisions for our constituents and the Nation about monumental legislation when we do not have the required opportunity to examine this report? What should be bipartisan conference committees are, in fact, clandestine meetings held behind closed doors. Democratic House Members were deliberately excluded from the conference committee. The only African Americans on the Committee on Ways and Means were banned from a place at the negotiating table speaking for our African American citizens. That included the ranking member of the Committee on Ways and Means, who was appointed to the conference by the Speaker of the House. Key policy bargains were made out of sight of Members and hidden from public inspection.

What is it that we and the American people are not supposed to see in the fine print? Does this plan hand billions of dollars to the wealthy drug companies and insurance industry? Does this plan hurt seniors more than it helps? Will seniors end up paying more and receiving less? What will the impact be on minority seniors? They were not represented at the table. Is this bill a Trojan horse of privatizing and dismantling Medicare? If this bill is the answer to seniors' cries for help combating the skyrocketing prices charged for medications, why are we not allowed to carefully review the hundreds of pages of this report? News reports and a quick glance at the bill indicate that nothing is done to freeze or control out-of-control drug prices.

Just this morning, Thomas Scully, administrator of the Centers for Medicare and Medicaid Services, told a senior Member of the other body that he misunderstood this plan and needs to read the bill. That is a wonderful suggestion, Mr. Speaker. Too bad that we will not have that chance as the Senate has. Medicare is much too precious to kill because we will never, ever in our lifetimes and probably anybody else's in my voice's range be able to institute another program like this in America.

I remind my colleagues of the Medicare Catastrophic Coverage Act which was passed without providing Members and seniors sufficient opportunity to read the pages and pages of fine print. The result was a momentous backlash. American seniors were outraged by the legislation, so outraged that Congress was forced to repeal the law the very next year.

Mr. Speaker, I reserve the balance of my time.

Ms. PRYCE of Ohio. Mr. Speaker, I yield such time as he may consume to the gentleman from California (Mr. DREIER), chairman of the Committee on Rules.

Mr. DREIER. Mr. Speaker, I rise in strong support of this rule, and obviously we at this moment have begun the debate on what is clearly one of the most important issues that we will face in our entire careers here. We all know that 38 years ago the Medicare program was established, and it has met the very important needs of many retirees, many of our seniors. But we are also well aware of the fact that there have been more than a few problems with the Medicare program, and for years and years and years people have talked about bringing about reform of Medicare. There has been a lot of talk; and in just a few hours, we are going to finally have an opportunity to vote "yes" on this conference report which will effectively address many of those concerns which have existed for many, many years.

We all know, Mr. Speaker, that this measure will include a number of other very important items. Back in 1987, I had the privilege of introducing in this House legislation calling for the establishment of what we then called MSA, medical savings accounts, the opportunity for people to put dollars aside, tax deductible, so that they could plan for their future health care needs purchasing either health insurance or direct health benefits. Health needs that they had could be addressed with those dollars. We have already proceeded with bipartisan support in putting into place pilot programs, and there has been a great deal of success. Why? Because it does help diminish the demand for Federal programs by allowing people to again privately plan and privately save with some incentive as they look toward those health care needs in the future.

We also, Mr. Speaker, with this plan are doing something that is unprecedented, and it is a need which Democrats and Republicans alike have said needs to be met. We know that in the last Presidential campaign, both Vice President Al Gore, who was a candidate, and now President George Bush, when he was a candidate, talked about the need to ensure that we for our seniors provide an opportunity for them to have access to affordable prescription drugs. One of the things that is often said, our majority leader points it out, I have said it for a long period of time, 38 years ago when the Medicare program was established, the only prescription drug available was that doctors would say, "Take two aspirin and call me in the morning." We know that if today we were putting into place a Medicare program, there would clearly be a prescription drug component included in that program. That is why, Mr. Speaker, I believe we are taking this very bold and important step to enhance the availability of prescription drugs for our retirees.

Mr. Speaker, having said that, we know that we included $400 billion in our budget, but there are many who have projected that this program could in fact spiral out of control, that it could become another massive new entitlement program which would get us into a great deal of fiscal trouble for the future. That is why I am very pleased at the direction of the Speaker, who, as we all know, has been intimately involved in working on health care issues for years.

He was very involved, of course, in the medical savings account issue earlier. He has headed task forces on this issue. He instructed me and my colleagues on the Committee on Rules to work on a cost-containment vehicle that would help us take steps to diminish the prospects of having this program spiral out of control so that there would be a degree of accountability here in this institution. That is why I say, Mr. Speaker, this legislation that we are going to be voting on later this evening includes this unprecedented cost-containment requirement that will ensure the fiscal integrity of Medicare for more than just a generation of Americans.

The legislation protects Medicare in two ways. First, it instructs the Medicare trustees to keep a constant vigil over the ebbs and flows of revenues in their different systems. We need that kind of monitoring mechanism to make sure that the programs are working and to make sure that the cost stays within our expectations. More important than that, Mr. Speaker, however, this legislation defends against the creation of another out-of-control entitlement program. As Members know, this is one of the most serious and debilitating and unintended consequences of the good intentions of so many of our programs here, that the costs run way, way beyond what are anticipated. There are already too many entitlement programs, we know, over which we have very little or, in fact, no fiscal control. We know them as mandatory programs. This legislation is different because it sets up an early warning system that alerts us to unexpected and unintended spending increases and gives us a mechanism for applying the brakes if spending is driven out of control by events and circumstances we could not have foreseen.

Under this legislation, the Medicare trustees are required to notify the Congress if 45 percent or more of Medicare outlays are predicted to be funded through general revenue.

□ 1545

Two such notifications in consecutive years require both Presidential and congressional action. Within 15 days of his annual budget submission, the President then has to propose legislation to resolve the funding difficulties. Continuing under expedited procedures, the House then has 3 legislative days to introduce the measure, and any such legislation introduced on the President's behalf, or any legislation introduced by a Member with the same purpose, must be certified by the chairman of the Committee on the Budget to ensure that it adequately address the problem.

At this point, Mr. Speaker, it would be easy for some in Congress to take the path of least resistance and let the difficult solutions die in the committee process. I want to underscore to the Members that this legislation does not allow that to happen. It does not allow us to just push it off to the committee process. By July 30 of any year after a Medicare Funding Warning is issued, it is in order, under this legislation's special provisions, to move to discharge any committee that is holding up any legitimate attempt to address the funding gap. The motion to discharge would be in order with the support of one-fifth, one-fifth, of the House Members; that is, 87 Members can stand up.

After the legislation has been discharged, the measure would have to be considered on the floor within 3 days and must result in a vote. Mr. Speaker, this mechanism ensures that we are not going to in any way abrogate our constitutional duty to watch over the Federal Treasury even in the case of what is considered to be entitlement spending.

I want to congratulate the gentlewoman from North Carolina (Mrs. MYRICK), my Committee on Rules colleague, for working very closely with us on this issue, and I believe that taking this step, putting this mechanism into place which has never been put in place before, to help us ensure that we do not see the spending spiral out of control will go a long way towards addressing the need of making sure that we have a prescription drug program for our seniors and at the same time making sure that we do it in a fiscally responsible way. We do have a very unique opportunity ahead of us, and again I want to congratulate the gentleman from Illinois (Speaker HASTERT) for the vision that he has shown on this, the fact that we have worked in a bipartisan way.

And I want to say that as we proceed with work on the same-day rule and the rule that will allow for consideration of the conference report, we want to ensure that every Member has an opportunity to be heard. We will have an hour on this rule, an hour on the second rule, and then the traditional hour on the conference report; and we have been working on an arrangement which will allow an opportunity to at least double the amount of time on the conference report.

So I believe we have a very good measure here. I think that it is deserving of strong bipartisan support since both Democrats and Republicans have consistently said that we do need to address this need of both reforming Medicare and at the same time making sure that seniors have access to affordable prescription drugs.

So I thank my friend for yielding me this time for me to provide this explanation for our colleagues, and we look forward to strong passage of this rule, the next rule, and the conference report itself.

Ms. SLAUGHTER. Mr. Speaker, I yield myself such time as I may consume.

I feel compelled to say that two-thirds of this bill could have been paid for by the money that the United States owes the Medicare Trust Fund today, $270 billion.

Mr. Speaker, I yield 3 minutes to the gentleman from New York (Mr. RANGEL), ranking member of Committee on Ways and Means, who stood at the door and knocked.

Mr. RANGEL. Mr. Speaker, let me congratulate the chairman of the Committee on Rules for the splendid job he has done in explaining, as he sees it, a 1,000-page bill to this House, and why we should shove this down the throats of the Members of the House of Representatives without being privy to what he is privy to.

I do not know how in the world anybody can get to this well and say we are talking about a bipartisan bill when they had the Sergeant of Arms blocking out Democrats from the House from getting anywhere near the preparation of this bill.

Some people claim that they know what is in it. The eloquence of the chairman of the Committee on Rules was overwhelming. Why will he not allow the rest of the House to take a look at this 1,000-page bill so that they can be just as eloquent as he.

Let me tell the Members one thing. There are people in this House today that believe that in that 1,000-page bill is a plan to eliminate completely the Medicare system as we know it.

I know that you know better.

There are people here that really believe this is a payoff to the pharmaceuticals, to the HMOs, and even some of the folks that run around saying they represent old folks.

I know you know better.

There are people who truly believe that employees and retirees are going to lose out in this bill.

Republicans know better, but they want to keep it a secret. It is a Republican thing. Democrats not invited.

All we are saying is you put this bill together yourselves. You think you know what is the best for the Nation. You believe that Democrats have no contribution to make, whether they belong to the Congressional Black Caucus, you do not have one; the Hispanic Caucus; you do not have one; the nonexistent Jewish caucus, you have got one. No matter what you have got, you really believe that we have to be excluded until you decide what is best for us.

You know something, you just may be right. All we are asking for is let us have a day to take a look at it. Let us see what makes you right. Let us see why all of these people are calling us every day say that you are wrong, and you are trying to kill the system. Tell us why would you not let into the conference the gentleman from Michigan (Mr. DINGELL), the son of the author of the Medicare bill, the dean of the House of Representatives? Why is it that you believe that he would have nothing to offer to this bill? All I am saying is that you know what is in the bill. Give the House of Representatives, not the Republicans, not the Democrats, but the people's House, give us a chance to see what we truly believe is going to be good for the American people and our seniors. If you do that, maybe you are right. If you are afraid, you will not give us any more time.

Ms. PRYCE of Ohio. Mr. Speaker, I yield myself such time as I may consume.

This bill has been online on the Committee on Ways and Means Web site and the Committee on Rules Web site since last night. This is no secret to anyone, least of all the American public, and anyone is free to look it up and read it at their leisure.

Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. LINDER), my friend and colleague of the Committee on Rules.

Mr. LINDER. Mr. Speaker, I would like to say something about the rule. It is a fair rule. It is a rule that was used often as long as I have been here toward the end of a session to get pieces of legislation to the floor. The rule gives an extra hour for those opposing this bill to argue about it, and we are going to hear lots of arguing and lots of whining. But in the event we get through this rule and the rule on Medicare reformation and get to the bill, I think the public is going to know an awful lot about what is in it. Frankly, the substance of this agreement was known last Sunday, several days ago. And the 3-day rule layover that we are avoiding this time is normal for the end of year.

I just want to make one comment about something that I heard twice in a 4-hour hearing today in the Committee on Rules, and we will hear it later on the floor. On two occasions, it was said that former Speaker Gingrich said in a speech to the Blue Cross organization, or Blue Shield, that he wanted Medicare to wither on the vine. That was made into a commercial by AFL–CIO and run across the country. And Brooks Jackson on July 15, 1996, did an expose on that. He showed the entire speech, and he showed that what they had done was cut up a piece. What Newt Gingrich was talking about was not Medicare or its beneficiaries, but the bureaucracy that runs it. He said that given the opportunity to make free choices, our seniors will voluntarily, voluntarily, opt out of the Health Care Financing Administration, and it will wither on the vine. When Brooks Jackson did that expose, he said what the unions were doing was dishonest.

I want to make this point before the debate starts because I want you to know that we know that you know you are dishonest.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey (Mr. PASCRELL).

Mr. PASCRELL. Mr. Speaker, I just heard the epitome of hypocrisy from the gentleman from California when he tried to interrupt the gentleman from New York (Mr. RANGEL) and he would not let the gentleman from New York (Mr. RANGEL) into the room and the likes of the leadership. If this is not hypocrisy, what is? The movie "Thelma and Louise," watch it. Louise turns to Thelma and says "You get what you settle for." And how right she was.

This prescription drug bill is the worst example of accepting what we are given. The administration is telling seniors that they should settle. They have convinced that the AARP that they are getting half a loaf, which is, of course, better than no bread at all. But, seniors, beware. They are not getting a slice even, they are not getting a half a loaf. These are the crumbs off the table. Our seniors will be settling for crumbs while the special interests are getting fat, and are they happy this week.

Today, the leaders on the other side are here to try to pass a bill that provides a weak prescription drug benefit, that fails to lower drug costs because the bill prohibits the government to try to help negotiate down the cost of the drugs. They specifically put that into the legislation. And it privatizes Medicare. It changes Medicare as we know it, pushing millions of seniors into HMOs. And this is fiscally irresponsible. Do the Members know what HMOs have done in New Jersey? They have shoved 79,000 people out of those HMOs since 1999. That is what awaits our seniors.

You cannot ignore that. Democrats have led the charge for years to add a prescription drug benefit, but we are not going to settle. We will compromise. We will discuss, but at least invite us to the table to compromise. This is America, not the Soviet Union.

Ms. PRYCE of Ohio. Mr. Speaker, I yield such time as he may consume to the gentleman from the great State of Texas (Mr. SESSIONS), my friend and colleague from the Committee on Rules.

Mr. SESSIONS. Mr. Speaker, I thank the gentlewoman from Ohio (Ms. PRYCE) for yielding me this time.

There is a lot of talk today about what is occurring with procedures and whether it is right or wrong, but I want to stand up today and talk about the bill. I want to talk about the bill and the things that it does for not only families like mine, but also for millions of other families across this great Nation.

What this bill does is it modernizes Medicare and so much more because it then gets into health care for families. It talks about the opportunity for families to be able to save money on a pretax and tax-free basis. Why is that important to my family? That is important to me because I have got a beautiful wife of 19 years, I have got a son who is 14 years old, who plays football and wrestles, and he sometimes gets hurt, and I have a 9-year-old Down's syndrome son who spends an extensive amount of time needing help with physicians and health care professionals. Not always do we get an answer back from the insurance company that they want to cover the needs of my family. Sometimes the needs of my family go well beyond those needs of what insurance pays for. But my family, like millions of other families, will now be helped because of the extreme generosity of the gentleman from California (Mr. THOMAS) and the gentleman from Louisiana (Mr. TAUZIN) who have written a bill that will allow families to save up to $5,000 a year. Even if it is just $2,000 a year, if that is what we have got left over, then we can put that money in there, and it means that this money can grow, tax free, and then be used, tax free, on health care. It means that my family and myself will now be able to supplement those things that may not be covered under our health care. It means that we will be able to be decision-makers to get the right things if we need something that goes beyond what insurance pays for.

I cannot tell the Members how important that is because there are millions of other families that are less fortunate than mine who many times go without the ability to have the services that are necessary for their children.

□ 1600

This is a way that people can help. They can help their children. They can help their families. They can make sure that they supplement those things that insurance provides, and that is good.

We have heard today that all this is about is about rich people or about rich organizations. Let me tell my colleagues, when you have someone who is sick or hurt in your family and you find out that insurance does not cover everything you need, and then you look at the tab that is out there, you will look and say, thank goodness for what Republicans have done.

I am proud of what this bill does. It modernizes health care today the way it ought to be, where we can participate, where we can do the right things. So I am proud of what the gentlewoman from Ohio (Ms. PRYCE) is standing up for today, to stand for this House to confirm this rule, to make sure that this Republican body can deliver to Americans and their families and senior citizens not only the health care that they need, but as a result of listening to what people need, we will deliver prescription drugs and those things that America has been asking for.

And then we will have a President who will sign this bill and do the right thing. And in the scheme of things, us doing the right things to help people today and to make sure families can be prepared for tomorrow is part of the oath and obligation that I took when I said I will support and defend this Constitution and make sure that the people I represent get the best from what we can come up with.

Mr. Speaker, I support this rule. I support this bill. I encourage every single Member to think about what this is about. It is not about politics. It is not about ourselves. It is about our families, our children, and our future.

Ms. SLAUGHTER. Mr. Speaker, I yield 3 minutes to the gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Speaker, I appreciate that the gentleman from Texas is proud of this legislation, but I want to tell him, I am ashamed of this legislation, and I am ashamed of what we are about to do; and I hope we do not do it.

Secondly, he said his constituents are going to be helped. They are not going to be helped; they are going to be hurt. When he says this is a good bill, it is not a good bill; it is a bad bill. My constituents are calling, the gentleman from New York (Mr. RANGEL) said his constituents are calling, and they are calling me because they are scared to death about what you are going to do, because they think that Medicare is going to die, to disappear and that they are not going to get any kind of decent prescription drug benefit.

Let me tell my colleagues why they are right. There is no question that you are not going to get any kind of drug benefit under this bill unless you go private. You have to join an HMO. If you do not join an HMO and lose your choice of doctor or your choice of hospital, then you are not going to get the drug benefit. They are scared, because they do not want to do that. They do not want to have to trade and lose their doctor in order to get some kind of drug benefit.

Secondly, they are upset because there is no benefit here. There is nothing here for them to benefit from. They are going to have to pay more out, shell more out of their pocket than they are going to get back in terms of a prescription drug benefit. If we look at what this bill does, first of all, we do not know what the premium is going to be. You might have a premium of $75, $85 month. You have to pay a deductible of $275 a month. After you pay out $2,200, for the next $3,000 or so, you get no benefit at all, no drug benefit. You have to pay 100 percent out-of-pocket while you continue to pay probably a very high premium.

So they figure, I am going to lose my choice of doctor. I may lose my choice of hospital. And at the same time, I am not getting any benefit because of this doughnut hole and what you are causing me to pay out.

Then they say, they are expecting there is going to be some kind of controls on the price of prescription drugs, but you have a clause in the bill that says that we cannot even negotiate price. So the costs of prescription drugs will continue to rise, as all of these other terrible things are happening.

Then they say, my constituents say to me, Congressman, is it true that this bill does not even take effect until 2006 with the drug benefit? The answer is yes. That is what the bill says. Read the bill: 2006 before the drug benefit kicks in. You know what my constituents say? That is a joke. What kind of a joke is this? You are going to have some election in 2004 and then you are all going to run for election and say what a great thing this is and this is not even going to kick in. They want a prescription drug benefit now. Why can it not start January 1 of 2004?

Lastly, the reason they are really scared is because of the privatization. I heard the gentleman from California (Mr. DREIER) say "privatize" three times. That is what this is all about: privatizing, not just the prescription drug benefit, but Medicare as a whole. Because even though we are only going to have these demonstration programs in certain parts of the country, the bottom line is they are going to impact the whole country and ultimately, by the year 2010, you are going to force people to take a voucher, try to go out in the private sector and buy their Medicare as a whole, and if they cannot find it or they do not like what they are offering for that voucher, that set amount of money, then they are not going to be able to stay in traditional Medicare, fee-for-service Medicare.

Privatize Medicare, privatize the drug benefit, it does not even start until 2006, and you lose your doctor. That is why they are scared to death.

Ms. PRYCE of Ohio. Mr. Speaker, I must take 1 minute to say that the gentleman has misspoken. Our most needy seniors, the seniors who need it most will be getting help with their prescription drugs, the best tool medicine has to offer, by next spring if we pass this bill. But if we delay, if we continue to defeat our efforts, the Republican efforts to bring prescription drugs to the American people, we will never provide them help. We have to start and we have to pass this bill today.

Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Georgia (Mr. GINGREY), someone who should know a lot about this.

Mr. GINGREY. Mr. Speaker, I thank the gentlewoman from Ohio for yielding me this time, and I promise to tone down the rhetoric just for a couple of minutes.

Mr. Speaker, I rise today in support of the rule for the Medicare agreement. Today, we face a Medicare reality, a reality that requires change, reform, and willing leadership.

Though not a perfect solution, the Medicare agreement is a big step in the right direction, a step in the right direction by providing our seniors with assistance to pay for the rising cost of prescription medications, medications that will help them live longer and help their lives; a step in the right direction by supplying appropriate reimbursement updates for hospitals, and updates to ensure that hospitals sustain the ability to provide needed goods and quality services for their patients; a step in the right direction by blocking the proposed cut in Medicare reimbursements to physicians and, instead, provide a positive update, reimbursements that will allow physicians to properly serve their patients and curb the trend of reduced access.

I urge my colleagues to take this step to help our seniors, our hospitals, and our physicians and adopt this rule so we can pass the Medicare conference report.

Ms. SLAUGHTER. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from Rhode Island (Mr. LANGEVIN).

Mr. LANGEVIN. Mr. Speaker, I thank the gentlewoman for yielding me this time.

I rise in strong opposition to the proposed rule to consider the Medicare Modernization and Prescription Drug Act of 2003. We are about to vote on legislation that will have an enormous impact on every single American. While we know very little about the details, since we were only given this bill late last night, what we do know is that it offers a completely inadequate drug benefit, does nothing to contain the rapidly increasing cost of prescription drugs, and takes steps toward privatizing Medicare. When our seniors find out about the truth of what this bill will do to their health plans, they will be outraged. This is shameful, because it does not have to be this way.

We are poised to make the most significant changes to Medicare in history, and we are proposing to vote on it while the ink is still drying, a 600-page bill that we have scarcely been able to read. This is no way to make good public policy.

Mr. Speaker, as President Woodrow Wilson once said, "Whenever any business affecting the public is conducted, wherever any plans affecting the public are laid, over that place a voice must speak with the divine prerogative of the people's will the words 'let there be light.'" Mr. Speaker, there is no light in our work here today, and the Members of this House and the people that we represent deserve better.

I urge all of my colleagues, regardless of their position on this bill, to vote against this rule.

Ms. PRYCE of Ohio. Mr. Speaker, I reserve the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, I am happy to yield 3 minutes to the gentleman from Oregon (Mr. DEFAZIO).

Mr. DEFAZIO. Mr. Speaker, I thank the gentlewoman for yielding me this time.

Would every Member who is on the floor and who has read all 691 pages of this bill since it was made available at 1:30 in the morning please raise your hand. I do not see any hands raised, but we are going to vote on it very soon. We are not doing a service to the American public by violating the rules of the House and not allowing this bill to be held over for 3 days, as required by the rules, so Members of Congress, and maybe even members of the public and the fourth estate, could read it, analyze it, and report it so we could better hear the opinion of the American people. But from what I know of it and the bits I have read, it is not much of a benefit, and it is not what seniors need.

Americans pay more for U.S. manufactured, FDA-approved drugs than anybody else in the world. Our neighbors in Canada pay half as much, on average, for drugs manufactured in the United States of America. Now, how could that be? Well, the government of Canada bargains lower prices on behalf of Canadians. Well, maybe that would be a solution to the problem here in the United States: let us lower the extortionate price of drugs. Let us put the 40 million people in Medicare into a buying group, that would not cost anything, and let us negotiate lower prices. No.

This bill, at the behest of the pharmaceutical industry, a generous contributor to the Republican Party and the President, prohibits the Government of the United States of America, unlike any other industrial nation or democracy on Earth, from negotiating lower drug prices for its citizens with these multinational conglomerate pharmaceutical companies. There is no pain for the pharmaceutical industry in this bill. In fact, their stock has gone up dramatically in the last week. The analysts have read it, and they said, what a sweet deal for the pharmaceutical industry. Too bad it will not give seniors what they need.

Well, there are $400 billion of taxpayer money, copayments, premiums, deductibles, the doughnut exclusion. There is a nice $20 billion subsidy to private HMO insurance companies who might or might not offer benefits. But seniors, on average, are going to get a benefit that is less than they could get by mail-ordering their drugs from Canada. Oh.

Well, the bill is going to take care of that problem too. Despite the fact that this House of Representatives is on record by a large margin allowing the free reimportation of U.S.-manufactured, FDA-approved drugs for Americans from other industrialized nations that regulate safely those drugs, this bill is going to begin to block that process. They say, oh, well, that is not in the bill. We give the authority to the Secretary of Health and Human Services to allow the importation if he sees fit. Yes, sure. Except he has already said that he does not see fit and he will never, ever do that; and the FDA commissioner has said oh, no, we are not going to ever do that. We cannot certify that those U.S.-manufactured, FDA-approved drugs that took a little vacation in Canada are safe.

This is simply legislation that is not going to provide the benefits that seniors need at an extraordinary cost to the ultimate detriment of the core Medicare program. Vote "no."

Ms. PRYCE of Ohio. Mr. Speaker, I continue to reserve my time.

Ms. SLAUGHTER. Mr. Speaker, the gentleman is absolutely correct. There is no great list of dead Canadians from taking bad medicines.

Mr. Speaker, I yield 2 minutes to the gentleman from Washington State (Mr. BAIRD).

Mr. BAIRD. Mr. Speaker, at the beginning of this debate, the distinguished chairman of the Committee on Rules pointed out that this is one of the most important bills we have faced possibly in our careers. Indeed, he is correct. Yet, we are given less than 24 hours to consider this. The most important bill in our careers, 24 hours to consider it.

It is part of a very troubling pattern, and I call my colleagues' attention to this: in the last 7 legislative days in this Congress, we have either authorized or appropriated more than $1.26 trillion of the people's money. The defense authorization bill we were given 3 hours to read before the vote. The Medicare bill, we may have a total of about 28 hours, clock hours, if we read around the clock to read this. The intelligence authorization bill, 8 hours. A total of $1.26 trillion, and we are going to have an omnibus appropriation bill shortly.

I would like to yield, if I may, to the gentlewoman from Ohio. I have asked one of the pages to take her a piece of text from this legislation, and I would like her to explain this to me. If we have had adequate time to study it, then we should know what is in it.

The text reads as follows, and I will invite the gentlewoman to explain what it means.

□ 1615

On page 13, actually of the interpretive paper from the Republican party, it reads, "Plans would be permitted to substitute cost-sharing requirements for costs up to the initial coverage limit that were actuarially consistent with an average expected 25 percent coinsurance for costs up to the initial coverage limit. They could also apply tiered copayment, provided such copayments were actuarially consistent with the average 25 percent cost-sharing requirement."

I yield to the gentlewoman from Ohio (Ms. PRYCE) to explain what that means.

Ms. PRYCE of Ohio. Mr. Speaker, I thank the gentleman from Washington (Mr. BAIRD) for yielding. This was just put in front of me. I would defer to the chairman of the Committee on Ways and Means or a member of the Committee on Ways and Means because this is their jurisdiction and certainly not the jurisdiction of the Committee on Rules.

Mr. BAIRD. Mr. Speaker, reclaiming my time. I believe the gentlewoman from Ohio (Ms. PRYCE) has pointed out we have had adequate time to study the legislation. I presume she is going to vote on it. This is a summary provided by her Republican party, yet she fails to be able to explain it.

I would invite anyone here present with us today from the majority party, or who plans to vote from the minority party, to please explain what it is we are voting on. I would invite the next person to offer that explanation.

Ms. PRYCE of Ohio. Mr. Speaker, I will continue to reserve my time. We do not have any more speakers at this point.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentlewoman from Texas (Ms. JACKSON-LEE).

Ms. JACKSON-LEE of Texas. Mr. Speaker, my good friend has really laid it out for us. We are not yet debating the bill. I thank the distinguished gentlewoman from New York (Ms. SLAUGHTER) from the Committee on Rules, both of them in fact, we are debating the process. I think it is important because this is historic.

I sat for 2½ hours in the Committee on Rules, and I want to thank the Committee on Rules for giving me the 2½ hours to sit, and then the opportunity to express my opposition and challenges to this legislation. I have been taught as a child that it is all about who shows up. Not about whether you can finish or whether or not you are the best, but who shows up. Who shows up in school, who stays in school.

Let me tell about this legislation and what I went to the Committee on Rules about. I asked them to reserve what we call points or order. Because I believe this bill is fatally flawed. It has killer bees in the midst. It has a lot of roses in it. And people are talking about hospitals and doctors. I am glad to see the American Nurses Association is against this bill. But roses have thorns and thorns make you bleed. And there is a lot of bleeding going on in this bill.

This bill is a subsidy for HMOs and a subsidy, if you will, for prescription drug companies. And as I said, it is all about who shows up. And HMOs do not show up.

Take any city and any county and any State and when an HMO finds out they cannot make a profit, they close up. Take Harris County, 4 years ago, six HMOs, they closed up shop on our seniors because they could not make a profit.

And what does this bill do? It hurts low-income seniors and those who are disabled. I cannot imagine how we would vote for a bill that unravels Medicare by its premium support, even if it is an example program. It gives premium support to defer you over to a private insurance program and leaves Medicare unraveling on the vine.

In addition, it does not take a law graduate to understand what anticompetitiveness means. We call that antitrust violations. And how can you give benefits to private insurance companies and pharmaceutical companies when you allow them to establish the cost of the drugs, and you do not allow the Federal Government to compete fairly by bringing down the cost of the drugs. Some people say it is dumber than dumb. This is a dumber than dumb plan. We should have the opportunity to take 3 days to review this. This is a dumb plan, a dumb procedure. And, Mr. Speaker, how can you leave Democrats off the conference committee and say this is a good plan.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentleman from Tennessee (Mr. COOPER).

Mr. COOPER. Mr. Speaker, this is a very sad day for this House. I bring a unique perspective, I think, to this legislation because I represent probably more hospitals than any other Member of this body. Because Nashville, Tennessee, is the headquarters town for most of the for-profit hospitals in America. We also have a leading academic medical center and many nonprofit hospitals with some 300 health care companies headquartered in our city. We are Health Care U.S.A.

I have also been a professor of health care policy at Vanderbilt Business School; the last 7 years studying these issues. And in my prior service in Congress, I was one of the leaders in trying to craft bipartisan health care policy, getting Democrats and Republicans to work together, to do the right thing for our Nation's seniors and for all of our citizens.

This bill, which we were finally allowed to see a few short hours ago, is a travesty. First of all, very few, if any, Members really know what is in it. There simply has not been enough time. And our seniors deserve better than a martial law rule. Why not at least the regular 3 days, so Americans can see what is in this bill? What is the other side afraid of? What are they afraid of?

Sunshine is the best policy. Sunshine is the best disinfectant for what may or may not be in this bill.

Now, I had a head start, I have been trying to follow proceedings closely over the last several months of the conference from which all Democrats have been excluded in the House. But I have tried to pick up bits and pieces here or there. I have tried to read everything available on this. And the best I can tell, the policies in this bill come up way short.

Now, our hospitals in Nashville are proud of the 3 to 5 percent of the bill that covers their activities, but the rest of the bill, the other 95 percent, has severe policy shortcomings that I am afraid the other side feels cannot stand the light of day, cannot stand full debate.

So our seniors deserve better, Mr. Speaker. Let us give them a better bill. Let us take the time to do it right.

Ms. PRYCE of Ohio. Mr. Speaker, I yield myself such time as I may consume.

And in light of the comments of the gentleman from Tennessee (Mr. COOPER), the last speaker, I would say that every major hospital association in this Nation is on board with this legislation. He should be supportive of it. Not only the hospital associations, but the American Association of Retired Persons, the AARP, who speaks for every senior in this country. They are on board. The AIDS Institute, the Alzheimer's Association, the Coalition for Medicare Choices, Hepatitis C Global Foundation, International Patient Advocacy Association, Kidney Cancer Association, National Alliance for the Mentally Ill, the National Council on the Aging, the Seniors Coalition, United Seniors International Association, We Are Family Foundation, Academy of Family Practice Residence Directors, Alliance for Quality Nursing Home Care, Alliance to Improve Medicare, American Academy of Dermatology Association, American Academy of Family Practitioners and Physicians, American Academy of Home Care Physicians, American Academy of Neurology, Ophthalmology, Osteopathy, Pharmaceutical Physicians.

Mr. Speaker, this list is pages and pages long. Every significant health care provider, every significant person in this country who is touched by health care and feels the pain of seniors and understands their health care needs is on board with this legislation. Anyone who cares about the future of health care for seniors should be on board as well.

Mr. Speaker, I reserve the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, I am interested in the list that the gentlewoman from Ohio (Ms. PRYCE) read off. I hope that they know what is in the bill, because we sure do not.

Mr. Speaker, I yield 3 minutes to the gentleman from Arkansas (Mr. ROSS).

Mr. ROSS. Mr. Speaker, I thank the gentlewoman from New York (Ms. SLAUGHTER).

And to the gentlewoman from Ohio (Ms. PRYCE), let me assure you that AARP no longer speaks for America's seniors. The National Committee to Preserve Social Security and Medicare is the Nation's second largest senior advocacy group. Unlike AARP, they are not in the pharmacy business, and they are not in the discount prescription card business. And Max Richmond, their executive director said what? He said, "You ever heard of Medicare fraud? This Republican prescription drug bill is Medicare fraud." And let me tell you why: It is obscene that the Republicans in Congress would lock the door and refuse to allow the Democratic conferees in the room while this bill was being finalized. If that is not enough, now they are trying to use a parliamentary procedure to immediately bring this bill up for a vote, a bill that is 681 pages. It was received in my office just a few hours ago. I have not read it all. It is 681 pages, and I just got it.

If there is any Republican here who has already read it, then they have been through some kind of speed reading course that I have not been through. But I have gotten through a few pages. Page 54 is a good place to start. Surely to goodness, no one here has read page 54, because if they have, they would not be asking for this bill to be brought up immediately. They would want time to read it, because page 54 says what? It says the Federal Government shall be prohibited from negotiating with the big drug manufacturers to bring down the high cost of medicine. And they call this a seniors bill? Give me a break.

And if that is not enough, my colleagues can turn to page 18 of the bill. Page 18 of the bill tells us what seniors are going to get, or, really, what seniors are not going to get. This is clearly a bill written by the big drug manufacturers and the big insurance companies, not to benefit our seniors, not to bring down the high cost of medicine, but to benefit the big drug manufacturers and the big insurance companies.

Make no mistake about it, seniors, it is important the Members here understand, understand what the seniors get in this bill. There is a $420 yearly premium, $35 a month. There is a $250 deductible, and then, from $250 to $2,250, Medicare pays 75 percent of the bill leaving the senior to pay 25 percent. That part sounds pretty good. But then from $2,250 all the way up to $5,100, guess what? The senior is back stuck paying the full price for the prescription drug while still being required, under this bill, to pay a $35-a-month premium.

This legislation boils down to this: Of the first $5,100 worth of medicine, seniors are going to still be stuck paying $4,020 while Members of Congress, who wrote and approved this bill, only pay $1,275.

Ms. PRYCE of Ohio. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the gentleman from Arkansas (Mr. ROSS) says that the AARP does not speak for seniors of America? The AARP represents 35 million seniors, dues-paying, card-carrying voting seniors. These seniors care what we do, and they are watching what we do, and we better do right by them.

Mr. Speaker, I reserve the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentleman from Mississippi (Mr. TAYLOR).

Mr. TAYLOR of Mississippi. Mr. Speaker, a little over a year ago, the President of the United States, Secretary of Defense Donald Rumsfeld, Under Secretary of Defense Paul Wolfowitz all told me, me, that not only did the Iraqis have weapons of mass destruction, but that they had their finger on the trigger and were getting ready to use them. Now, 7 months after we have occupied Iraq, the only thing harder to find than a Republican who will tell me where those weapons of mass destruction are is a Republican who will tell me how they are going to pay for this bill.

In the 29 months since the passage of their budget, their spending, their tax cuts, they have increased our Nation's debt by $1,229,407,000.

□ 1630

This bill alone will add another $400 billion to our staggering $6.8 trillion debt.

But if you have noticed, not one of my Republican colleagues will say how they are going to pay for it, because they do not want you to know that a few seniors will benefit from this, but all of us will end up paying interest on it. And we are already squandering $1 billion of your money a day on that interest.

This is nothing but an auction to the insurance companies and the pharmaceutical companies of this Nation, for campaign contributions to the Republican party. And I want one Republican to hold up one prescription and just tell me how much less it is going to be 1 year from today, 2 years from today, because that is what seniors really want. They do not want another bureaucracy. They do not want $400 billion worth of debt.

The people who are seniors now are the Greatest Generation, and the last thing the Greatest Generation wanted is the country they fought for in World War II and Korea to be bankrupted by some political prank now.

So I ask the gentlewoman from Ohio (Ms. PRYCE) how are you going to pay for it, and please name one drug that will be cheaper 1 year from today.

Ms. PRYCE of Ohio. Mr. Speaker, I yield myself such time as I may consume.

I would just like to remind the gentleman that last year's Democrat prescription drug bill cost $1 trillion, $1 trillion, almost three times what this bill costs.

Mr. Speaker, I reserve the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, whether you support this bill or not, the Members should be very concerned that we are about to cast a vote on a major, major piece of legislation that only a small handful of House Members have actually read because it was not finalized and filed until 1:30 this morning.

They should be very concerned that this marshal law rule waives the House rule that requires the conference report layover for 3 days before coming to the floor for a vote. Of course, it was not supposed to be this way.

Just a few weeks ago, 44 members of the Republican Study Committee demanded that the Republican leadership allow Members 3 days to read the conference report after it was filed and before forcing them to vote on it. It was a reasonable demand since that is what the rules of the House say.

The gentleman from Illinois (Mr. HASTERT) agreed to it as has been publicly reported. Here is how the November 3, 2003, edition of Roll Call reported it: "At a GOP conference meeting that was called exclusively to update Members on the Medicare talks, Hastert assured his troops that they would now get regular briefings on the Medicare bill and would have at leave 3 days to look over the conference report before having to vote on it, according to several Members who attended.

"'The Speaker wants to make sure that Members are comfortable making this historic change' to Medicare, said Hastert spokesman John Feehery."

The November 7, 2003, edition of Congress Daily quoted the gentleman from Georgia (Mr. NORWOOD) "referring to a promise made by House Speaker HASTERT."

The gentleman from Georgia (Mr. NORWOOD) said, "The thing I'm happiest about is we get 3 days with the language."

Now, we all know the Speaker of the House is an honorable man, but apparently the Republican leadership is willing to renege on his commitment and to ensure Members do not get 3 days with the language. Because while various summaries, press releases, and drafts may have been posted on Web sites of today, the final language of that conference report was not filed until early this morning. And 3 days from Friday morning is Monday morning, not Friday afternoon.

For that reason, Mr. Speaker, I urge Members to join me in opposing the important parliamentary vote known as the previous question. If it is defeated, I will amend the rule so that it no longer waives the House's rule requiring a 3-day layover for all conference reports.

Voting no will not defeat the Republican Medicare bill, but it is the only way to uphold the commitment of the Speaker of the House and to allow Members and the public to examine this 700-page $400 billion Medicare bill before voting on it.

I urge Members to vote "no" on the previous question.

Mr. Speaker, I yield back the balance of my time.

Ms. PRYCE of Ohio. Mr. Speaker, I yield myself such time as I may consume.

I remind my colleagues that this body is about to embark on a monumental endeavor. We are about to consider the most significant benefit America's seniors have ever seen since the creation of the Medicare program nearly 40 years ago. We are about to give seniors the best tool that medicine has to offer, prescription drugs. A tool that they have been denied, that our government has not supplied to them. We are about to give that to them, Mr. Speaker. That is not even to mention the most significant and deliberative reform that Medicare has ever seen.

I urge my colleagues to support American seniors, to support the future of the Medicare program, and to support this Congress in one of the most promising endeavors I have ever been a part of in my years in this esteemed body. Join me in taking a bold step closer to consideration of this extraordinary legislation. I ask the Democrats, stop defeating these attempts, stop delaying help to our seniors, and stop destroying their trust in their government.

Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The SPEAKER pro tempore (Mr. BASS). The question is on ordering the previous question.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Ms. SLAUGHTER. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

WAIVING REQUIREMENT OF CLAUSE 6(a) OF RULE XIII WITH RESPECT TO CONSIDERATION OF CERTAIN RESOLUTIONS

Mr. LINDER. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 458 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 458

Resolved, That the requirement of clause 6(a) of rule XIII for a two-thirds vote to consider a report from the Committee on Rules on the same day it is presented to the House is waived with respect to any resolution reported on the legislative day of November 21, 2003, providing for consideration or disposition of any of the following measures:

(1) A bill or joint resolution making further continuing appropriations for the fiscal year 2004, or any amendment thereto.

(2) A bill or joint resolution making general appropriations for the fiscal year ending September 30, 2004, any amendment thereto, or any conference report thereon.

The SPEAKER pro tempore. The gentleman from Georgia (Mr. LINDER) is recognized for 1 hour.

Mr. LINDER. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentleman from Texas (Mr. FROST), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Mr. Speaker, H. Res. 458 is a rule that waives clause 6(a) of rule XIII with respect to same-day consideration against certain resolutions reported from the Committee on Rules. Specifically, this rule waives the requirement for a two-thirds majority vote in the House to consider a rule on the same day it has been reported by the Committee on Rules.

This rule's waiver applies to any special rule reported on the legislative day of November 21, 2003, providing for the consideration or disposition of any of the following:

A, a bill or joint resolution making further continuing appropriations for fiscal year 2004 or any amendments thereto; or

B, a bill or joint resolution making general appropriations for the fiscal year ending September 30, 2004, any amendment thereto or any conference reported thereon.

I urge my colleagues in the House to join me in approving H. Res. 458. Its passage will help expedite the consideration of either another continuing resolution, if that becomes needed, or even conference reports on the last few remaining fiscal year 2004 appropriations bills, including the Foreign Operations bill, Transportation-Treasury bill, the Agriculture bill, the VA-HUD bill, the Commerce-Justice bill, the District of Columbia bill, and the Labor-HHS bill.

I believe that we are in the waning days of this year's legislative session with only a relatively small number of must-do legislative items still left to finish. Approving this same-day waiver rule will help provide for prompt consideration of these important funding bills.

Mr. Speaker, the Committee on Rules approved this rule last night, and I urge my colleagues to join me in supporting its passage.

Mr. Speaker, I reserve the balance of my time.

Mr. FROST. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, marshal law rules like this one are symptomatic of the failure of this Republican government. Republicans are doing such harm to America, from Medicare and the economy to foreign policy and homeland security, that keeping the public in the dark has become their chief priority.

So today, Republican leaders are yet again waiving the rules of the House. Later today they plan to do it in order to force through their plan to end Medicare as we know it, which is how the chief author of the Republican Medicare bill describes their goal.

But first, Republican leaders want to pass this marshal law rule so that they can rush through a spending bill before Members, the press, and the public have had the chance to find out what is really in it.

Mr. Speaker, they will not even tell us which spending bill they plan to hide from us today. All we know is that it will either spend tens of billions of dollars in taxpayer money, or that it will spend hundreds of billions of dollars in taxpayer money. Either way, it will become law before it has even been read by anyone except for a handful of Republicans at the White House and in the Congress. But since these are the same Republicans who have exploded the budget deficit to nearly $500 billion, raising the debt tax on all Americans, no one has much faith in them anymore.

Mr. Speaker, after nearly a decade of controlling the Congress, the Republican Party's fundamental goal is simply protecting its own power by hiding from the public the damage they are doing to America. Of course, if you look at the Republican record, you can understand why they are so desperate to keep it hidden. In the nearly 3 years since George Bush became President, Republicans have created a whole host of problems for the American people.

On national security, the Bush administration has plunged this Nation into its worst foreign policy crisis since the end of the cold war because they would not trust the American people with the truth about Iraq and because they could not work with our allies around the world. And while U.S. taxpayers are spending hundreds of billions of dollars on Iraq, our homeland defense needs here in the United States remain dangerously unmet.

On domestic policy, of course, Republicans are going for the right wing gold. Later today they will try to finalize Newt Gingrich's dream of forcing Medicare to wither on the vine, shattering Medicare's nearly 40-year-old promise to American citizens. That debate, Mr. Speaker, will be a case study in the public dishonesty that is fundamental to the Republican government.

Over and over again, Republicans will repeat their poll-tested sound bytes. They will save Medicare reform and hope that millions of seniors do not notice the Republicans are forcing them out of traditional Medicare and into HMOs and insurance companies. They will talk about choice and ignore the fact that millions of seniors will lose the ability to choose their own doctors. And they will decry skyrocketing prescription prices and hope no one notices that they are actually protecting drug company profits by making it illegal for Medicare to negotiate lower prices for senior citizens.

Mr. Speaker, Republicans will wax poetic about the generosity of their drug benefit, hiding the fact that premiums and benefits will actually be set by HMOs and insurance companies; and that even under the Republicans rosiest scenario, seniors with average drug bills will still have to pay about $2,500 per year out of their own pockets. Of course, Republicans will not say a thing about the $12 billion slush funds they are setting up for HMOs or insurance companies or the $139 billion in windfall profits they are giving to the big drug companies.

Mr. Speaker, no wonder the Republican Medicare bill does not take effect until after the election. Republican political strategists are desperately hoping that seniors do not discover this truth about this assault on Medicare before they go to the polls in 2004. But make no mistake, when seniors sit down at their kitchen tables to pay their bills, they are going to do the math, and they are going to see that Republicans have sold them a very expensive and very harmful bill of goods.

Mr. Speaker, the false promise of the Republican Medicare plan will remind a lot of Americans of the false promise of the Republican economic plan. In less than 3 years, the Republicans have taken a historic budget surplus and turned it into a monumental deficit. They have done it through reckless fiscal irresponsibility and through an obsession with spending billions of taxpayer dollars for a small elite of the wealthiest few, people like the Bush campaign fund-raising Pioneers.

As a result, instead of using the budget surplus to help address priorities like skyrocketing prescription prices and strengthening Social Security and Medicare, Republicans have created a fiscal crisis and raised the debt tax on all Americans.

Along the way, nearly 3 million jobs have been lost, giving George W. Bush the worst job performance of any President since The Great Depression. Millions of families no longer share in the prosperity of the nineties. Of course, you would never know the facts if you just listened to Republican rhetoric. But talking points cannot cancel out the truth. And the truth is, Mr. Speaker, that Americans continue to be unemployed at alarmingly high rates. More than 2 million workers have been unable to find a job in this economy for more than 6 months, and many of them will lose their unemployment insurance over the holidays if this Republican Congress does not act this year before we adjourn.

□ 1645

That is why, Mr. Speaker, I intend to oppose the important parliamentary vote known as the previous question. That is the only way to ensure Republicans do not leave town for their own holiday vacations without providing unemployed Americans with the help they so desperately need.

Mr. Speaker, Americans are smarter than Republican leaders give them credit for. They know the difference between rhetoric and reality. So I urge my Republican friends to look past their leader's rhetoric and join me in providing real help to Americans suffering through this economy.

Mr. Speaker, I reserve the balance of my time.

Mr. LINDER. Mr. Speaker, I reserve the balance of my time.

Mr. FROST. Mr. Speaker, I yield 4 minutes to the gentleman from Maryland (Mr. CARDIN).

Mr. CARDIN. Mr. Speaker, let me thank my friend from Texas for yielding me this time.

Mr. Speaker, this rule will allow us to consider an additional continuing resolution which will allow us to go home over the holidays, and at this time, there is no indication from the majority that they are prepared to bring up an extension of the unemployment insurance benefits for thousands of our fellow citizens who will be running out of unemployment insurance benefits during that period of time. So, Mr. Speaker, I would hope that we would not approve the previous question so that we could bring up this unemployment insurance extension.

Let me just remind my colleagues that 1 year ago we were in a similar position, and the majority did not bring up an extension of the unemployment insurance benefits, and at Christmastime, we had to tell hundreds of thousands of Americans that they ran the risk of losing the Federal benefits that they needed during this recession. We are faced with the situation again.

Two days after Christmas, the current Federal 13-week unextended benefit program is scheduled to expire. If we do not do anything about it, 80- to 90,000 people in this Nation, every week, will exhaust their State extended benefits and will not be entitled to any Federal extended benefits; 1.4 million Americans during that 6-month period, until June of next year, are anticipated would be without benefits.

The exhaustion rate, those who have exhausted their State unemployment benefits without finding employment has reached the highest level on record, the highest level on record, 43 percent. Two million workers have been unemployed for more than 6 months, nearly triple the amount compared to the beginning of 2001. We have 2.4 million fewer jobs today compared to 2½ years ago.

Mr. Speaker, the majority leader recently said, I see no reason to be extending unemployment compensation since every economic indicator is better off than in 1993 when the Democrats ended the Federal unemployment program. Mr. Speaker, nothing could be further from what the record shows, and I could go through a list of the economic indicators from the last downturn in our economy and this time, but this one I think really puts it all in proper perspective.

The current amount of jobs that were created before we terminated the Federal unemployment benefits in the 1990s was 2.9 million additional jobs. What we are looking at now is 2.4 million less jobs in this recession. The majority leader refers to some slight job growth that we had, and we hope that continues, because, currently, if someone's looking for a job, there are three people looking for every job that is available today. These are people who cannot find employment, but the loss of employment in our economy in the last couple of years is 2.4 million jobs. The jobs are not there. People want work. They cannot find work. That is why we have the Federal unemployment benefit program.

There is $20 billion in the fund today to fund this program. The money is there. The money is there for this purpose. We should extend it before we go home. So I hope we will use this opportunity because, quite frankly, Mr. Speaker, I do not see any other opportunities coming along. This may be our last chance by using this vehicle so that we can consider legislation that would extend the Federal unemployment benefits for some additional weeks, and by the way, we should also take care of those who have already exhausted all their benefits.

The economy just is not there yet. We all hope we will get there. We usually do this on a bipartisan basis. Let us get together and help our uninsured.

Mr. LINDER. Mr. Speaker, I reserve the balance of my time.

Mr. FROST. Mr. Speaker, I yield 3 minutes to the gentleman from Michigan (Mr. LEVIN).

Mr. LEVIN. Mr. Speaker, I join the gentleman from Maryland (Mr. CARDIN), and I want to say to the Republicans, do not think this is a procedural vote on the previous question. This is a vote of substance. This is a vote questioning whether my colleagues will agree to bring up an unemployment compensation extension program.

As the gentleman from Maryland (Mr. CARDIN) said, the majority leader stated, "I see no reason to be extending unemployment compensation since every economic indicator is better than in 1993 when the Democrats ended the Federal unemployment program." He could not be further from the truth.

If we do not act, 90,000 a week who are out of work, exhausting their benefits, will be out in the cold; 90,000 a week, 350,000 more or less a month, and they will join the 1.4 million long-term unemployed in this country, and the percentage of unemployed workers who have exhausted their benefits, contrary to what the gentleman from Texas (Mr. DELAY) has said, will reach an all-time high, almost 44 percent, and even with this modest increase in jobs the last couple of months, the U.S. economy still has 2.4 million fewer jobs today than 2½ years ago.

I want to refer to Michigan. The unemployment figures just came out: 7.6 is the unemployment rate, a 3-year high, an 11-year high, actually, and higher than when the temporary unemployment program was set up.

So this is not a test on procedure. This is a test whether my colleagues will stand with those who are unemployed, looking for work or turn a cold shoulder to them. There is nothing compassionate about this kind of action, conservatism or anything else.

So I urge all my colleagues, Democrats and Republicans, to vote no on the previous question and stand up for those millions of Americans, millions who are looking for work, who cannot find it, who want not charity but unemployment compensation that they worked for. Vote no on the previous question.

Mr. LINDER. Mr. Speaker, I yield myself such time as I may consume just to observe the lesson I just learned from the gentleman from Michigan. When President Clinton ran for President, he said we had the worst economy in 50 years, and just a few months later, he turned everything around. Things were so wonderful that he could stop unemployment compensation. I had not realized he had done it so quickly.

Mr. Speaker, I reserve the balance of my time.

Mr. FROST. Mr. Speaker, I yield 3 minutes to the gentleman from Washington (Mr. MCDERMOTT).

Mr. MCDERMOTT. Mr. Speaker, several times this week the House has used emergency procedures to pass partisan legislation.

Yesterday, the Congress found time to give tax credits to Wal-Mart, but the Republican majority refuses to consider what is truly an emergency to millions of families, the fact that they do not have jobs, and millions of these workers are about to run out of unemployment insurance.

Last year, the same thing happened. The Republican Congress left town about Christmastime without extending the temporary program that provides employment benefits, leaving hundreds of thousands of unemployed workers to worry over the holidays about whether they were going to get the unemployment benefits that they had been expecting.

We have heard it has been reported that the majority leader said, "I see no reason to be extending unemployment compensation since every economic indicator is better than in 1993 when the Democrats ended the Federal unemployment program." Mr. Speaker, the esteemed majority leader does not know what he is talking about.

Washington State's unemployment is still among the highest in the Nation. It has grown for two solid years as we felt the brunt of the Bush recession. If the Congress does not extend the Federal program that provides unemployment compensation and fix a technical flaw in the Federal-State extended benefits program, over 83,000 workers in my State will stop, at Christmastime, receiving unemployment benefits.

I know the economy created 100,000 jobs last month, but 150,000 jobs must be created each month to maintain the employment rate because our population continues to grow.

Two days after Christmas, the temporary Federal unemployment benefits program is scheduled to expire, denying benefits to nearly 90,000 workers every single week. The unemployment picture today simply is not much better than it was last year, Mr. Speaker.

According to the Department of Labor, there is still only one job opening for every three unemployed workers. In other words, of the 9 million unemployed American workers, 6 million of them have no chance of finding a job in the current economic climate.

I urge my colleagues to vote against the previous question so that Congress can consider an emergency that faces millions of families, the Nation's unemployment problem.

It is Thanksgiving for heaven's sakes, and we are not even going to provide them a turkey at Thanksgiving or at Christmastime. That is really Scrooge, and it is really hard-hearted.

I urge my colleagues to vote against the previous question.

STATE OF WASHINGTON,
EMPLOYMENT SECURITY DEPARTMENT,
Olympia, WA, November 13, 2003.

Hon. JIM MCDERMOTT,
House of Representatives, Longworth Building, Washington, DC.

DEAR CONGRESSMAN MCDERMOTT: This letter is in response to your request (dated November 7, 2003) for unemployment projections and data.

Washington State's Seasonally Adjusted Total Unemployment Rate (SATUR) remained at 7.5 percent for the month of September, and this percentage is 116 percent of the same rate two years ago, keeping the State of Washington in a period of Extended Benefits (EB). The next issuance of the SATUR numbers is scheduled for November 21, 2003. Our forecast for October still shows that the State of Washington will again be above the required 110 percent of the same period for either of the past two years, and will remain in EB status for that period as well. Statistics due out on December 19, 2003 are indicating that the 110 percent criteria will not be met, and we would thus be out of EB for weeks after January 10, 2004.

Tables 1 and 2, enclosed, provide SATUR forecasts through calendar year 2005. As shown, the State of Washington Forecast Council estimates that the State of Washington's SATUR will remain above 6.5 percent through 2005.

Table 3 provides a count of claimants exhausting all benefits, by entitlement, for the first six months of 2003. Unemployment statistics are very cyclical and we believe the exhaustion rates for the first six months of 2004 will be very similar to those of 2003. Claimants exhausting Regular UI benefits become eligible for the TEUC program and claimants exhausting TEUC become eligible for the EB program. If the TEUC program were not continued, we estimate that close to 54,000 claimants would be without benefits in the first six months of 2004. Additionally, if the EB program were to end in January of 2004 due to the "look-back" provision, an additional 28,508 claimants exhausting the TEUC program would be without benefits.

Table 4 provides a summary of total dollars paid out to claimants by month ad entitlement, for the first six months of 2003. Similar to exhaustion rates, we believe that payment totals will be very similar in 2004. We estimate that we would pay $282 million out under the TEUC program and close to $83 million under the EB program.

Also enclosed for your information is an additional fact sheet on current unemployment insurance data.

Please let me know if you have any additional questions, or if we can be of further assistance.

Sincerely,
ANNETTE M. COPELAND,
Assistant Commissioner.

Mr. LINDER. Mr. Speaker, I reserve the balance of my time.

Mr. FROST. Mr. Speaker, I yield 3 minutes to the gentleman from Oregon (Mr. DEFAZIO).

Mr. DEFAZIO. Mr. Speaker, Congress has one last opportunity to provide unemployment benefits for Americans who have lost their jobs and been unable to find new jobs.

It is quite astounding. We at this point have what is called a jobless recovery. In my State, tens of thousands of people are unable to find employment with their benefits exhausted or near exhaustion. Across America it is millions.

I know budgets are tight around here. I know that Congress can afford to borrow money to pay Iraqis for no-show jobs, but the President says we cannot afford to spend down the $20 billion balance in the Unemployment Trust Fund, taxes paid by employers and employees, for just such a situation. So we cannot afford that. We cannot afford to spend that. We can borrow money to send to Iraq, but we cannot spend down the trust fund for unemployed Americans.

□ 1700

Is he saying it is their fault they are unemployed? Is he saying he does not care they are unemployed? Is he saying he does not care they might lose their home; they cannot feed their kids; they cannot afford essentials; they cannot even buy gas for the car to go out and look for work; that they are having their phones shut off?

I am getting those kinds of calls. We have the highest unemployment rate in the United States in Oregon. It is chronic. And there are a lot of people who want to work and cannot find jobs. The least this Nation could do would be to help them with a modest extension of unemployment benefits.

Now, this is not the first time this has happened. Last year, Congress skipped out of town, the President did not raise any concern, and unemployment benefits expired for millions of

Americans. This year, we are confronted with the same situation. Two days after Christmas, Merry Christmas, 90,000 workers will lose their extended unemployment benefits and have no income, and yet they cannot find a job. And it will be 90,000 workers a week. In 6 months, 2.2 million Americans will have lost everything, probably their homes, maybe their families, because this kind of breaks up families.

This is, of course, a family-friendly Republican majority and White House, but they just do not seem to care about these people wanting and needing jobs. Their jobs are being exported and have disappeared in the jobless recovery, or whatever. They cannot find work. In my State, it will be 43,000 people by February who will lose benefits.

Now, there is $20 billion, that is 20,000 million dollars, in the Unemployment Trust Fund. We do not even have to borrow the money to give Americans a little bit of help to stay in their homes and keep their families together. We do not have to borrow it because they pay the taxes, their employers pay the taxes. All the President has to do is say, I think that is a good idea, and the Republican majority will jump to it. We could do it right here, now, on the floor, by voting "no" and bringing that bill up today.

Mr. LINDER. Mr. Speaker, I reserve the balance of my time.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentlewoman from Oregon (Ms. HOOLEY).

Ms. HOOLEY of Oregon. Mr. Speaker, I thank my colleague for yielding me this time, and I rise in opposition to this bill.

While Congress dithers in what is probably the waning days of the first session of the 108th Congress, it is inexcusable that we are considering adjournment without first passing an extension of unemployment benefits for the millions of American workers who are currently jobless. In my home State of Oregon, the unemployment rate is still 7.6 percent, nearly 2 percentage points higher than the U.S. average. Even that number, though, is misleading, since it only counts the workers who are still looking for work. It does not include those people who have been off work, who no longer receive unemployment benefits.

Mr. Speaker, to me it is inexcusable and unconscionable that the bill offered by our colleague, the gentleman from Maryland (Mr. CARDIN), is not being brought to the floor right now. Instead, the Republican leadership has chosen to force a vote on a 2-day CR because they are unable to fund the government by passing appropriation bills on time and in regular order.

Let me tell you just a little bit about these people who are looking for work, Mr. Speaker. These are people who are out of work through no fault of their own. They go out every single day and look for a job. One gentleman said to me that it is like playing musical chairs. He says, I go in, I think I have this wonderful resume, I meet all of the criteria, and I go in and there are 200 people that all have the same qualifications to meet that job. So he said it is a little bit like playing musical chairs with 200 people in the room and only one chair.

One woman told me she had to sell her home. She has been looking for work every day. She has sold her home and is living off the profits of her home. She does not know what she is going to do when those run out.

Another gentleman said, I have been trying to reeducate myself, so every day I am out looking for work. He said, I just feel like if I can just hold on for a little longer that job is going to be there.

Let us tide over the 90,000 Americans per week who will lose their unemployment benefits by the end of this year. Congress can and should pass an extension that will allow workers who are seeking employment to provide for their most basic needs as the holidays approach. Let us get on with this. Let us extend those unemployment benefits.

Mr. LINDER. Mr. Speaker, I reserve the balance of my time.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentleman from California (Mr. STARK).

Mr. STARK. Mr. Speaker, I insert for the RECORD at this point a letter addressed to the chairman of the Committee on Rules that outlines some of the bases for our request for more time to evaluate the bill.

COMMITTEE ON RULES,
HOUSE OF REPRESENTATIVES,
Washington, DC, Nov. 19, 2003.

Hon. DAVID DREIER,
Chairman, House Committee on Rules, The Capitol, Washington, DC.

DEAR MR. CHAIRMAN: For the second time this week we are forced to write to you to protest the fact that the Republican majority will bring to the House floor a conference report on a major legislative proposal of enormous impact on every single American and is more than likely to do so without giving the Members of the House the opportunity to know what is in the bill. We are referring, of course, to the conference agreement on Medicare which we understand will be filed at some point today, this evening, or perhaps sometime in the wee hours of the morning.

Given our experience with the modus operandi of the Republican House Leadership, we believe we can safely assume that once that conference agreement has been filed the Rules Committee will convene in short order to report a rule. We must protest in the strongest possible terms. To bring this legislation to the Rules Committee in the middle of the night or at seven o'clock in the morning is a gross distortion and perversion of the legislative process and any sense of fairness to the Members of this institution and to the American people. Further, bringing this legislation to the floor while the ink is still drying on the paper, would renege on the promise made by the Speaker of the House in response to a letter signed by 41 Members of the Republican Conference who requested that the text of the Conference Report, its joint explanatory statement, and the CBO cost estimate be made available for three days before its consideration.

That letter reads: "We write to request if the Conferees on the Medicare Prescription Drug and Modernization Act of 2003 report to the House a Conference Report, copies of the text of the Conference Report, the text of the explanatory statement, and the text of the Congressional Budget Office cost estimate for the Conference report be made available to all Members at least three calendar days after filing (excluding Saturdays, Sundays, and legal holidays, unless the House is in session on those days) and prior to consideration of the Conference Report or to any measure reported from the Committee on Rules providing for the consideration of the Conference Report.

"The general public will evaluate not only what Congress does regarding Medicare and prescription drugs, but the way in which it does it. A bill proposing such substantive changes to the Medicare system and costing an estimated $400 billion over the next decade deserves the careful and thoughtful consideration of all Members."

As has been publicly reported, at a meeting of the Republican Conference on October 30 Speaker Hastert assured these members that they would indeed have three days to review the bill as they had requested. From the November 3, 2003 edition of Roll Call: "So last Thursday, at a GOP Conference meeting that was called exclusively to update Members on the Medicare talks, Hastert assured his troops that they would now get regular briefings on the Medicare bill and would have at least three days to look over the conference report before having to vote on it, according to several Members who attended. . . 'The Speaker wants to make sure that Members are comfortable making this historic change' to Medicare, said Hastert spokesman John Feehery."

On November 7, Congress Daily reported on the Speaker's promise: ". . . time is required for those outside the room to look over what everyone agrees are the most sweeping changes being made to Medicare in a generation. 'The thing I'm happiest about is we get three days with the language,' said Rep. Charlie Norwood, R–GA, referring to a promise made by House Speaker Hastert." Clearly, this was a promise that Members of the Republican Conference felt would be kept.

On November 12, at a symposium on the modern day Speaker of the House, Speaker Hastert outlined his own set of principles that guide him in his work: "When you are Speaker, people expect you to keep your word, and they will not quickly forgive you if you cannot deliver. I've learned that keeping your word is the most important part of this job. You are better off not saying anything than making a promise that you cannot keep. And you have to keep both the big promises and the small promises."

We believe the Speaker to be a man of honor and a man who lives up to the high-minded principles he outlined in his speech. Yet, yesterday it was reported in Congress Daily that the Majority Leader—who had previously said that Members would have three full days to look over the agreement—said that the clock had started running on Sunday.

Mr. Chairman, on Sunday there was an announcement that an agreement had been reached and a summary of the agreement was posted on the Web; but as of today, no finalized text of the bill, the joint explanatory statement of managers, or the CBO cost estimate have been released to Members of the House.

If the Rules Committee convenes at some point today or early tomorrow morning to pave the way for the consideration of this conference report, the Republican Leadership will have shown that political expediency, rather than the wishes of its own Members and the promise of the Speaker of the House, is what drives its agenda. Perhaps your Leadership can mollify these Members who wrote to the Speaker making a reasonable and rational request. Perhaps Members of the Republican Conference will agree to vote for a rule without ever knowing what is really in this bill. But we would consider that to be a sad turn of events, Mr. Chairman, and we would urge you to object to this process if for no other reason than to protect the prerogatives of Members of Congress to have the opportunity to understand what they are voting for or against.

Mr. Chairman, once again House Democratic conferees were deliberately excluded from negotiations on major legislation. Chairman Thomas stated on more than one occasion when asked about the Medicare conference that there was no reason to include anyone who did not want to reach an agreement. We believe what he really meant to say was there was no reason to include anyone in the negotiations who would not agree with him or the other Republican conferees. This attitude seems to pervade the manner in which this institution is being run and the fact that an agreement of this magnitude few people have seen will be rushed to the floor for a vote only adds to this perception. May we remind you that perception often become reality?

We are perfectly aware that our protests will most likely fall on deaf ears. But, for the sake of this institution and the United States, we urge you to ensure that the Republican Leadership keeps the promise made by the Speaker of the House.

We look forward to a response at your earliest convenience.

Sincerely,

MARTIN FROST.
JIM MCGOVERN.
LOUISE M. SLAUGHTER.
ALCEE L. HASTINGS.

Mr. Speaker, I just wanted to point out on the Medicare bill, getting back to that, that by not having time to review it and perhaps correct some of the technicalities, whether one thinks this is a good benefit or not, I am sure that many of my colleagues on the right take the same view as I do about privacy, and particularly privacy of our personal financial records.

I am sure that most of them are unaware that private contractors will now be able to willy nilly get tax returns from anybody who may be required to pay a higher premium under the income-adjusted premiums. This means that for the first time in the history of the Internal Revenue Code, we are making available personal tax information to private enterprise operators at will, and I am not sure my colleagues want to do that.

I hope our friends on the right will think about it and think about what unscrupulous folks might do with private personal tax information, which has been one of the bedrock principles of privacy in this country. And I would like to think that the Republicans would not support that. But they do not know what is in this bill. The chairman does not know what is in the bill. And I would submit that the members of the Committee on Rules do not know what is in the bill.

To vote in that kind of ignorance is an affront to the principles, if you have any, which you might stand for.

Mr. LINDER. Mr. Speaker, I reserve the balance of my time.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. GREEN).

Mr. GREEN of Texas. Mr. Speaker, I thank the ranking member and the dean of our Texas delegation for yielding me this time.

Mr. Speaker, martial law rules, it is interesting to note, always come up in the later part of the session because we always want to get finished. We did a martial law on Medicare so we could pass a 600-page document without having to digest it. Now we have a continuing resolution martial law.

But I really want to talk about the prescription drug provision in Medicare, because that is what will come up later. Our Houston Chronicle wrote an interesting editorial today which talks about the "scribbled prescription" in the bill that we are going to consider as an "intended cure could be worse than Medicare disease." It talks about the provisions of this bill we are going to consider tonight is stingy because it does not begin until 2006; and that there is such a donut hole in the middle that people will lose, if they have $300 a month in prescription drugs, because they will fall into that donut hole. So it is stingy.

The critics point out that providing a drug component to Medicare encourages businesses to dump their retirees. I had a constituent call me the other day from a utility company who said he was worried his retiree benefits for prescription drugs would be cut. And I said unless you have a collective bargaining agreement, that could happen.

A concern I have, as they quote in the Chronicle editorial, is that the "AARP, the most powerful senior citizen organization, has endorsed" this proposal. Again, I am quoting the Houston Chronicle, "But, as the plan before Congress offers such limited help for seniors with high prescription costs, it's no wonder so many people believe AARP's decision was motivated more by its own political dealmaking than concern for its 35 million members' best interests." And that is a direct quote.

Mr. Speaker, when I first came to Congress, a prescription drug bill was the goal, to pass something; but this bill actually goes in the wrong direction. It prohibits Medicare from negotiating for lower prices. HMOs do it, the Veterans Administration does it, companies do it; and yet now we are prohibiting Medicare from doing it by law. That ought to outrage our seniors, including those 35 million AARP members.

Mr. LINDER. Mr. Speaker, I reserve the balance of my time.

Mr. FROST. Mr. Speaker, how much time remains?

The SPEAKER pro tempore (Mr. THORNBERRY). The gentleman from Texas (Mr. FROST) has 5 minutes remaining, and the gentleman from Georgia (Mr. LINDER) has 28 minutes remaining,

Mr. FROST. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, if the previous question is defeated, I will offer an amendment to the rule. My amendment will provide that immediately after the House passes this resolution, it will take up legislation to extend the Federal unemployment insurance that is set to expire for new enrollees just 2 days after Christmas.

This legislation would continue the extended unemployment insurance program through the first 6 months of next year. The bill would also increase to 26 weeks the amount of benefits provided under that program, up from 13 weeks. This would provide new help to the 1.4 million workers who have already exhausted their extended benefits and have yet to find work.

This measure is identical to the text of H.R. 3244, the Rangel-Cardin unemployment extension; and it also contains the text of H.R. 3554, sponsored by the gentleman from Washington (Mr. MCDERMOTT), which would fix a flaw in current law that penalizes people in States with exceptionally high long-term unemployment rates by preventing them from receiving the unemployment benefits they need.

Here is why it is needed, Mr. Speaker. Americans continue to be unemployed at alarmingly high rates. The percentage of Americans exhausting their unemployment benefits without finding a job has reached its highest level on record. More than 2 million workers have been unemployed for more than 6 months. These Americans need relief, and they need it immediately. If we do not fix this today, over 400,000 jobless Americans will not be eligible for unemployment compensation after the first of the year.

Mr. Speaker, it appears likely that Congress will adjourn sine die within the next few days. This will very likely be the only opportunity we have to help unemployed Americans this year. Let us not abandon them today.

Let me make very clear that a "no" vote on the previous question will not stop consideration of this resolution for consideration of the appropriations items, but a "no" vote will allow the House to vote on legislation to help provide some much-needed relief to our Nation's unemployed workers, some relief that might be nice during the upcoming holiday season.

Again, I urge a "no" vote on the previous question.

Mr. Speaker, I ask unanimous consent that the text of the amendment be printed in the Record immediately before the vote on the previous question.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. FROST. Mr. Speaker, I yield back the balance of my time.

Mr. LINDER. Mr. Speaker, I yield myself such time as I may consume, and I urge my colleagues to vote "yes" on the previous question and "yes" on the rule, so we can hopefully have an appropriation bill later this evening or this weekend we can vote on and finish things up.

The text of the amendment previously referred to by Mr. Frost, is as follows:

Previous Question for H. Res. 458—Rule on waiving 2/3rds for C/R and Appropriations Measures

At the end of the resolution add the following new section:

Sec. 2. "Immediately after disposition of this resolution, it shall be in order without intervention of any point of order to consider in the House the bill (H.R. 3568) to provide extended unemployment benefits to displaced workers, and to make other improvements in the unemployment insurance system. The bill shall be considered as read for amendment. The previous question shall be considered as ordered on the bills to final passage without intervening motion except: (1) one hour of debate equally divided and controlled by the Chairman and ranking Minority Member of the Committee on the Ways and Means; and (2) one motion to recommit with or without instructions.

Mr. LINDER. Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The SPEAKER pro tempore. The question is on ordering the previous question.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. FROST. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this motion will be postponed.

A FURTHER MESSAGE FROM THE SENATE

A further message from the Senate by Mr. Monahan, one of its clerks, announced that the Senate agrees to the report of the committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 1904) "An Act to improve the capacity of the Secretary of Agriculture and the Secretary of the Interior to plan and conduct hazardous fuels reduction projects on National Forest System lands and Bureau of Land Management lands aimed at protecting communities, watersheds, and certain other at-risk lands from catastrophic wildfire, to enhance efforts to protect watersheds and address threats to forest and rangeland health, including catastrophic wildfire, across the landscape, and for other purposes."

CONTROLLING THE ASSAULT OF NON-SOLICITED PORNOGRAPHY AND MARKETING ACT OF 2003

Mr. TAUZIN. Mr. Speaker, I move to suspend the rules and pass the Senate bill (S. 877) to regulate interstate commerce by imposing limitations and penalties on the transmission of unsolicited commercial electronic mail via the Internet, as amended.

The Clerk read as follows:

S. 877

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Controlling the Assault of Non-Solicited Pornography and Marketing Act of 2003", or the "CAN-SPAM Act of 2003".

SEC. 2. CONGRESSIONAL FINDINGS AND POLICY.

(a) Findings.—The Congress finds the following:

(1) Electronic mail has become an extremely important and popular means of communication, relied on by millions of Americans on a daily basis for personal and commercial purposes. Its low cost and global reach make it extremely convenient and efficient, and offer unique opportunities for the development and growth of frictionless commerce.

(2) The convenience and efficiency of electronic mail are threatened by the extremely rapid growth in the volume of unsolicited commercial electronic mail. Unsolicited commercial electronic mail is currently estimated to account for over half of all electronic mail traffic, up from an estimated 7 percent in 2001, and the volume continues to rise. Most of these messages are fraudulent or deceptive in one or more respects.

(3) The receipt of unsolicited commercial electronic mail may result in costs to recipients who cannot refuse to accept such mail and who incur costs for the storage of such mail, or for the time spent accessing, reviewing, and discarding such mail, or for both.

(4) The receipt of a large number of unwanted messages also decreases the convenience of electronic mail and creates a risk that wanted electronic mail messages, both commercial and noncommercial, will be lost, overlooked, or discarded amidst the larger volume of unwanted messages, thus reducing the reliability and usefulness of electronic mail to the recipient.

(5) Some commercial electronic mail contains material that many recipients may consider vulgar or pornographic in nature.

(6) The growth in unsolicited commercial electronic mail imposes significant monetary costs on providers of Internet access services, businesses, and educational and nonprofit institutions that carry and receive such mail, as there is a finite volume of mail that such providers, businesses, and institutions can handle without further investment in infrastructure.

(7) Many senders of unsolicited commercial electronic mail purposefully disguise the source of such mail.

(8) Many senders of unsolicited commercial electronic mail purposefully include misleading information in the message's subject lines in order to induce the recipients to view the messages.

(9) While some senders of commercial electronic mail messages provide simple and reliable ways for recipients to reject (or "opt-out" of) receipt of commercial electronic mail from such senders in the future, other senders provide no such "opt-out" mechanism, or refuse to honor the requests of recipients not to receive electronic mail from such senders in the future, or both.

(10) Many senders of bulk unsolicited commercial electronic mail use computer programs to gather large numbers of electronic mail addresses on an automated basis from Internet websites or online services where users must post their addresses in order to make full use of the website or service.

(11) Many States have enacted legislation intended to regulate or reduce unsolicited commercial electronic mail, but these statutes impose different standards and requirements. As a result, they do not appear to have been successful in addressing the problems associated with unsolicited commercial electronic mail, in part because, since an electronic mail address does not specify a geographic location, it can be extremely difficult for law-abiding businesses to know with which of these disparate statutes they are required to comply.

(12) The problems associated with the rapid growth and abuse of unsolicited commercial electronic mail cannot be solved by Federal legislation alone. The development and adoption of technological approaches and the pursuit of cooperative efforts with other countries will be necessary as well.

(b) Congressional Determination of Public Policy.—On the basis of the findings in subsection (a), the Congress determines that—

(1) there is a substantial government interest in regulation of commercial electronic mail on a nationwide basis;

(2) senders of commercial electronic mail should not mislead recipients as to the source or content of such mail; and

(3) recipients of commercial electronic mail have a right to decline to receive additional commercial electronic mail from the same source.

SEC. 3. DEFINITIONS.

In this Act:

(1) Affirmative consent.—The term "affirmative consent", when used with respect to a commercial electronic mail message, means that—

(A) the recipient expressly consented to receive the message, either in response to a clear and conspicuous request for such consent or at the recipient's own initiative; and

(B) if the message is from a party other than the party to which the recipient communicated such consent, the recipient was given clear and conspicuous notice at the time the consent was communicated that the recipient's electronic mail address could be transferred to such other party for the purpose of initiating commercial electronic mail messages.

(2) Commercial electronic mail message.—

(A) In general.—The term "commercial electronic mail message" means any electronic mail message the primary purpose of which is the commercial advertisement or promotion of a commercial product or service (including content on an Internet website operated for a commercial purpose).

(B) Transactional or relationship messages.—The term "commercial electronic mail message'' does not include a transactional or relationship message.

(C) REGULATIONS REGARDING PRIMARY PURPOSE.—Not later than 12 months after the date of the enactment of this Act, the Commission shall issue regulations pursuant to section 13 further defining the relevant criteria to facilitate the determination of the primary purpose of an electronic mail message.

(D) REFERENCE TO COMPANY OR WEBSITE.—The inclusion of a reference to a commercial entity or a link to the website of a commercial entity in an electronic mail message does not, by itself, cause such message to be treated as a commercial electronic mail message for purposes of this Act if the contents or circumstances of the message indicate a primary purpose other than commercial advertisement or promotion of a commercial product or service.

(3) COMMISSION.—The term ''Commission'' means the Federal Trade Commission.

(4) DOMAIN NAME.—The term ''domain name'' means any alphanumeric designation which is registered with or assigned by any domain name registrar, domain name registry, or other domain name registration authority as part of an electronic address on the Internet.

(5) ELECTRONIC MAIL ADDRESS.—The term ''electronic mail address'' means a destination, commonly expressed as a string of characters, consisting of a unique user name or mailbox (commonly referred to as the ''local part'') and a reference to an Internet domain (commonly referred to as the ''domain part''), whether or not displayed, to which an electronic mail message can be sent or delivered.

(6) ELECTRONIC MAIL MESSAGE.—The term ''electronic mail message'' means a message sent to a unique electronic mail address.

(7) FTC ACT.—The term ''FTC Act'' means the Federal Trade Commission Act (15 U.S.C. 41 et seq.).

(8) HEADER INFORMATION.—The term ''header information'' means the source, destination, and routing information attached to an electronic mail message, including the originating domain name and originating electronic mail address, and any other information that appears in the line identifying, or purporting to identify, a person initiating the message.

(9) INITIATE.—The term ''initiate'', when used with respect to a commercial electronic mail message, means to originate or transmit such message or to procure the origination or transmission of such message, but shall not include actions that constitute routine conveyance of such message. For purposes of this paragraph, more than 1 person may be considered to have initiated a message.

(10) INTERNET.—The term ''Internet'' has the meaning given that term in the Internet Tax Freedom Act (47 U.S.C. 151 nt).

(11) INTERNET ACCESS SERVICE.—The term ''Internet access service'' has the meaning given that term in section 231(e)(4) of the Communications Act of 1934 (47 U.S.C. 231(e)(4)).

(12) PROCURE.—The term ''procure'', when used with respect to the initiation of a commercial electronic mail message, means intentionally to pay or provide other consideration to, or induce, another person to initiate such a message on one's behalf.

(13) PROTECTED COMPUTER.—The term ''protected computer'' has the meaning given that term in section 1030(e)(2)(B) of title 18, United States Code.

(14) RECIPIENT.—The term ''recipient'', when used with respect to a commercial electronic mail message, means an authorized user of the electronic mail address to which the message was sent or delivered. If a recipient of a commercial electronic mail message has 1 or more electronic mail addresses in addition to the address to which the message was sent or delivered, the recipient shall be treated as a separate recipient with respect to each such address. If an electronic mail address is reassigned to a new user, the new user shall not be treated as a recipient of any commercial electronic mail message sent or delivered to that address before it was reassigned.

(15) ROUTINE CONVEYANCE.—The term ''routine conveyance'' means the transmission, routing, relaying, handling, or storing, through an automatic technical process, of an electronic mail message for which another person has identified the recipients or provided the recipient addresses.

(16) SENDER.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term ''sender'' means a person who initiates such a message and whose product, service, or Internet web site is advertised or promoted by the message.

(B) SEPARATE LINES OF BUSINESS OR DIVISIONS.—If an entity operates through separate lines of business or divisions and holds itself out to the recipient of the message, in complying with the requirement under section 5(a)(5)(B), as that particular line of business or division rather than as the entity of which such line of business or division is a part, then the line of business or the division shall be treated as the sender of such message for purposes of this Act.

(17) TRANSACTIONAL OR RELATIONSHIP MESSAGE.—

(A) IN GENERAL.—The term ''transactional or relationship message'' means an electronic mail message the primary purpose of which is—

(i) to facilitate, complete, or confirm a commercial transaction that the recipient has previously agreed to enter into with the sender;

(ii) to provide warranty information, product recall information, or safety or security information with respect to a commercial product or service used or purchased by the recipient;

(iii) to provide—

(I) notification concerning a change in the terms or features of;

(II) notification of a change in the recipient's standing or status with respect to; or

(III) at regular periodic intervals, account balance information or other type of account statement with respect to,

a subscription, membership, account, loan, or comparable ongoing commercial relationship involving the ongoing purchase or use by the recipient of products or services offered by the sender;

(iv) to provide information directly related to an employment relationship or related benefit plan in which the recipient is currently involved, participating, or enrolled; or

(v) to deliver goods or services, including product updates or upgrades, that the recipient is entitled to receive under the terms of a transaction that the recipient has previously agreed to enter into with the sender.

(B) MODIFICATION OF DEFINITION.—The Commission by regulation pursuant to section 13 may modify the definition in subparagraph (A) to expand or contract the categories of messages that are treated as transactional or relationship messages for purposes of this Act to the extent that such modification is necessary to accommodate changes in electronic mail technology or practices and accomplish the purposes of this Act.

SEC. 4. PROHIBITION AGAINST PREDATORY AND ABUSIVE COMMERCIAL E-MAIL.

(a) OFFENSE.—

(1) IN GENERAL.—Chapter 47 of title 18, United States Code, is amended by adding at the end the following new section:

''§ 1037. Fraud and related activity in connection with electronic mail

''(a) IN GENERAL.—Whoever, in or affecting interstate or foreign commerce, knowingly—

''(1) accesses a protected computer without authorization, and intentionally initiates the transmission of multiple commercial electronic mail messages from or through such computer,

''(2) uses a protected computer to relay or retransmit multiple commercial electronic mail messages, with the intent to deceive or mislead recipients, or any Internet access service, as to the origin of such messages,

''(3) materially falsifies header information in multiple commercial electronic mail messages and intentionally initiates the transmission of such messages,

''(4) registers, using information that materially falsifies the identity of the actual registrant, for 5 or more electronic mail accounts or online user accounts or 2 or more domain names, and intentionally initiates the transmission of multiple commercial electronic mail messages from any combination of such accounts or domain names, or

''(5) falsely represents oneself to be the registrant or the legitimate successor in interest to the registrant of 5 or more Internet protocol addresses, and intentionally initiates the transmission of multiple commercial electronic mail messages from such addresses,

or conspires to do so, shall be punished as provided in subsection (b).

''(b) PENALTIES.—The punishment for an offense under subsection (a) is—

''(1) a fine under this title, imprisonment for not more than 5 years, or both, if—

''(A) the offense is committed in furtherance of any felony under the laws of the United States or of any State; or

''(B) the defendant has previously been convicted under this section or section 1030, or under the law of any State for conduct involving the transmission of multiple commercial electronic mail messages or unauthorized access to a computer system;

''(2) a fine under this title, imprisonment for not more than 3 years, or both, if—

''(A) the offense is an offense under subsection (a)(1);

''(B) the offense is an offense under subsection (a)(4) and involved 20 or more falsified electronic mail or online user account registrations, or 10 or more falsified domain name registrations;

''(C) the volume of electronic mail messages transmitted in furtherance of the offense exceeded 2,500 during any 24-hour period, 25,000 during any 30-day period, or 250,000 during any 1-year period;

''(D) the offense caused loss to 1 or more persons aggregating $5,000 or more in value during any 1-year period;

''(E) as a result of the offense any individual committing the offense obtained anything of value aggregating $5,000 or more during any 1-year period; or

''(F) the offense was undertaken by the defendant in concert with 3 or more other persons with respect to whom the defendant occupied a position of organizer or leader; and

''(3) a fine under this title or imprisonment for not more than 1 year, or both, in any other case.

"(c) FORFEITURE.—

"(1) IN GENERAL.—The court, in imposing sentence on a person who is convicted of an offense under this section, shall order that the defendant forfeit to the United States—

"(A) any property, real or personal, constituting or traceable to gross proceeds obtained from such offense; and

"(B) any equipment, software, or other technology used or intended to be used to commit or to facilitate the commission of such offense.

"(2) PROCEDURES.—The procedures set forth in section 413 of the Controlled Substances Act (21 U.S.C. 853), other than subsection (d) of that section, and in Rule 32.2 of the Federal Rules of Criminal Procedure, shall apply to all stages of a criminal forfeiture proceeding under this section.

"(d) DEFINITIONS.—In this section:

"(1) LOSS.—The term 'loss' has the meaning given that term in section 1030(e) of this title.

"(2) MATERIALLY.—For purposes of paragraphs (3) and (4) of subsection (a), header information or registration information is materially misleading if it is altered or concealed in a manner that would impair the ability of a recipient of the message, an Internet access service processing the message on behalf of a recipient, a person alleging a violation of this section, or a law enforcement agency to identify, locate, or respond to a person who initiated the electronic mail message or to investigate the alleged violation.

"(3) MULTIPLE.—The term 'multiple' means more than 100 electronic mail messages during a 24-hour period, more than 1,000 electronic mail messages during a 30-day period, or more than 10,000 electronic mail messages during a 1-year period.

"(4) OTHER TERMS.—Any other term has the meaning given that term by section 3 of the CAN-SPAM Act of 2003.".

(2) CONFORMING AMENDMENT.—The chapter analysis for chapter 47 of title 18, United States Code, is amended by adding at the end the following:

"Sec.
"1037. Fraud and related activity in connection with electronic mail.".

(b) UNITED STATES SENTENCING COMMISSION.—

(1) DIRECTIVE.—Pursuant to its authority under section 994(p) of title 28, United States Code, and in accordance with this section, the United States Sentencing Commission shall review and, as appropriate, amend the sentencing guidelines and policy statements to provide appropriate penalties for violations of section 1037 of title 18, United States Code, as added by this section, and other offenses that may be facilitated by the sending of large quantities of unsolicited electronic mail.

(2) REQUIREMENTS.—In carrying out this subsection, the Sentencing Commission shall consider providing sentencing enhancements for—

(A) those convicted under section 1037 of title 18, United States Code, who—

(i) obtained electronic mail addresses through improper means, including—

(I) harvesting electronic mail addresses of the users of a website, proprietary service, or other online public forum operated by another person, without the authorization of such person; and

(II) randomly generating electronic mail addresses by computer; or

(ii) knew that the commercial electronic mail messages involved in the offense contained or advertised an Internet domain for which the registrant of the domain had provided false registration information; and

(B) those convicted of other offenses, including offenses involving fraud, identity theft, obscenity, child pornography, and the sexual exploitation of children, if such offenses involved the sending of large quantities of electronic mail.

(c) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) Spam has become the method of choice for those who distribute pornography, perpetrate fraudulent schemes, and introduce viruses, worms, and Trojan horses into personal and business computer systems; and

(2) the Department of Justice should use all existing law enforcement tools to investigate and prosecute those who send bulk commercial e-mail to facilitate the commission of Federal crimes, including the tools contained in chapters 47 and 63 of title 18, United States Code (relating to fraud and false statements); chapter 71 of title 18, United States Code (relating to obscenity); chapter 110 of title 18, United States Code (relating to the sexual exploitation of children); and chapter 95 of title 18, United States Code (relating to racketeering), as appropriate.

SEC. 5. OTHER PROTECTIONS FOR USERS OF COMMERCIAL ELECTRONIC MAIL.

(a) REQUIREMENTS FOR TRANSMISSION OF MESSAGES.—

(1) PROHIBITION OF FALSE OR MISLEADING TRANSMISSION INFORMATION.—It is unlawful for any person to initiate the transmission, to a protected computer, of a commercial electronic mail message, or a transactional or relationship message, that contains, or is accompanied by, header information that is materially false or materially misleading. For purposes of this paragraph—

(A) header information that is technically accurate but includes an originating electronic mail address, domain name, or Internet protocol address the access to which for purposes of initiating the message was obtained by means of false or fraudulent pretenses or representations shall be considered materially misleading;

(B) a "from" line (the line identifying or purporting to identify a person initiating the message) that accurately identifies any person who initiated the message shall not be considered materially false or materially misleading; and

(C) header information shall be considered materially misleading if it fails to identify accurately a protected computer used to initiate the message because the person initiating the message knowingly uses another protected computer to relay or retransmit the message for purposes of disguising its origin.

(2) PROHIBITION OF DECEPTIVE SUBJECT HEADINGS.—It is unlawful for any person to initiate the transmission to a protected computer of a commercial electronic mail message if such person has actual knowledge, or knowledge fairly implied on the basis of objective circumstances, that a subject heading of the message would be likely to mislead a recipient, acting reasonably under the circumstances, about a material fact regarding the contents or subject matter of the message (consistent with the criteria are used in enforcement of section 5 of the Federal Trade Commission Act (15 U.S.C. 45)).

(3) INCLUSION OF RETURN ADDRESS OR COMPARABLE MECHANISM IN COMMERCIAL ELECTRONIC MAIL.—

(A) IN GENERAL.—It is unlawful for any person to initiate the transmission to a protected computer of a commercial electronic mail message that does not contain a functioning return electronic mail address or other Internet-based mechanism, clearly and conspicuously displayed, that—

(i) a recipient may use to submit, in a manner specified in the message, a reply electronic mail message or other form of Internet-based communication requesting not to receive future commercial electronic mail messages from that sender at the electronic mail address where the message was received; and

(ii) remains capable of receiving such messages or communications for no less than 30 days after the transmission of the original message.

(B) MORE DETAILED OPTIONS POSSIBLE.—The person initiating a commercial electronic mail message may comply with subparagraph (A)(i) by providing the recipient a list or menu from which the recipient may choose the specific types of commercial electronic mail messages the recipient wants to receive or does not want to receive from the sender, if the list or menu includes an option under which the recipient may choose not to receive any commercial electronic mail messages from the sender.

(C) TEMPORARY INABILITY TO RECEIVE MESSAGES OR PROCESS REQUESTS.—A return electronic mail address or other mechanism does not fail to satisfy the requirements of subparagraph (A) if it is unexpectedly and temporarily unable to receive messages or process requests due to a technical problem beyond the control of the sender if the problem is corrected within a reasonable time period.

(4) PROHIBITION OF TRANSMISSION OF COMMERCIAL ELECTRONIC MAIL AFTER OBJECTION.—

(A) IN GENERAL.—If a recipient makes a request using a mechanism provided pursuant to paragraph (3) not to receive some or any commercial electronic mail messages from such sender, then it is unlawful—

(i) for the sender to initiate the transmission to the recipient, more than 10 business days after the receipt of such request, of a commercial electronic mail message that falls within the scope of the request;

(ii) for any person acting on behalf of the sender to initiate the transmission to the recipient, more than 10 business days after the receipt of such request, of a commercial electronic mail message with actual knowledge, or knowledge fairly implied on the basis of objective circumstances, that such message falls within the scope of the request;

(iii) for any person acting on behalf of the sender to assist in initiating the transmission to the recipient, through the provision or selection of addresses to which the message will be sent, of a commercial electronic mail message with actual knowledge, or knowledge fairly implied on the basis of objective circumstances, that such message would violate clause (i) or (ii); or

(iv) for the sender, or any other person who knows that the recipient has made such a request, to sell, lease, exchange, or otherwise transfer or release the electronic mail address of the recipient (including through any transaction or other transfer involving mailing lists bearing the electronic mail address of the recipient) for any purpose other than compliance with this Act or other provision of law, except where the recipient has given express consent.

(B) OPT BACK IN.—A prohibition in clause (i), (ii), or (iii) of subparagraph (A) does not apply if there is affirmative consent by the recipient subsequent to the request under subparagraph (A).

(5) INCLUSION OF IDENTIFIER, OPT-OUT, AND PHYSICAL ADDRESS IN COMMERCIAL ELECTRONIC MAIL.—

(A) It is unlawful for any person to initiate the transmission of any commercial electronic mail message to a protected computer unless the message provides—

(i) clear and conspicuous identification that the message is an advertisement or solicitation;

(ii) clear and conspicuous notice of the opportunity under paragraph (3) to decline to receive further commercial electronic mail messages from the sender; and

(iii) a valid physical postal address of the sender.

(B) Subparagraph (A)(i) does not apply to the transmission of a commercial electronic mail if the recipient has given prior affirmative consent to receipt of the message.

(6) Subsequent affirmative consent.—The prohibitions in subparagraphs (A), (B), and (C) do not apply to the initiation of transmission of commercial electronic mail to a recipient who, subsequent to a request using a mechanism provided pursuant to paragraph (3) not to receive commercial electronic mail messages from the sender, has granted affirmative consent to the sender to recieve such messages.

(7) Materially.—For purposes of paragraph (1)(A), header information shall be considered to be materially misleading if it is altered or concealed in a manner that would impair the ability of an Internet access service processing the message on behalf of a recipient, a person alleging a violation of this section, or a law enforcement agency to identify, locate, or respond to the person who initiated the electronic mail message or to investigate the alleged violation, or the ability of a recipient of the message to respond to a person who initiated the electronic message.

(b) Aggravated Violations Relating to Commercial Electronic Mail.—

(1) Address harvesting and dictionary attacks.—

(A) In general.—It is unlawful for any person to initiate the transmission, to a protected computer, of a commercial electronic mail message that is unlawful under subsection (a), or to assist in the origination of such message through the provision or selection of addresses to which the message will be transmitted, if such person had actual knowledge, or knowledge fairly implied on the basis of objective circumstances, that—

(i) the electronic mail address of the recipient was obtained using an automated means from an Internet website or proprietary online service operated by another person, and such website or online service included, at the time the address was obtained, a notice stating that the operator of such website or online service will not give, sell, or otherwise transfer addresses maintained by such website or online service to any other party for the purposes of initiating, or enabling others to initiate, electronic mail messages; or

(ii) the electronic mail address of the recipient was obtained using an automated means that generates possible electronic mail addresses by combining names, letters, or numbers into numerous permutations.

(B) Disclaimer.—Nothing in this paragraph creates an ownership or proprietary interest in such electronic mail addresses.

(2) Automated creation of multiple electronic mail accounts.—It is unlawful for any person to use scripts or other automated means to register for multiple electronic mail accounts or online user accounts from which to transmit to a protected computer, or enable another person to transmit to a protected computer, a commercial electronic mail message that is unlawful under subsection (a).

(3) Relay or retransmission through unauthorized access.—It is unlawful for any person knowingly to relay or retransmit a commercial electronic mail message that is unlawful under subsection (a) from a protected computer or computer network that such person has accessed without authorization.

(c) Supplementary Rulemaking Authority.—The Commission shall by rule, pursuant to section 13—

(1) modify the 10-business-day period under subsection (a)(4)(A) or subsection (a)(4)(B), or both, if the Commission determines that a different period would be more reasonable after taking into account—

(A) the purposes of subsection (a);

(B) the interests of recipients of commercial electronic mail; and

(C) the burdens imposed on senders of lawful commercial electronic mail; and

(2) specify additional activities or practices to which subsection (b) applies if the Commission determines that those activities or practices are contributing substantially to the proliferation of commercial electronic mail messages that are unlawful under subsection (a).

(d) Requirement To Place Warning Labels on Commercial Electronic Mail Containing Sexually Oriented Material.—

(1) In general.—No person may initiate in or affecting interstate commerce the transmission, to a protected computer, of any commercial electronic mail message that includes sexually oriented material and—

(A) fail to include in subject heading for the electronic mail message the marks or notices prescribed by the Commission under this subsection; or

(B) fail to provide that the matter in the message that is initially viewable to the recipient, when the message is opened by any recipient and absent any further actions by the recipient, includes only—

(i) to the extent required or authorized pursuant to paragraph (2), any such marks or notices;

(ii) the information required to be included in the message pursuant to subsection (a)(5); and

(iii) instructions on how to access, or a mechanism to access, the sexually oriented material.

(2) Prior affirmative consent.—Paragraph (1) does not apply to the transmission of an electronic mail message if the recipient has given prior affirmative consent to receipt of the message.

(3) Prescription of marks and notices.—Not later than 120 days after the date of the enactment of this Act, the Commission in consultation with the Attorney General shall prescribe clearly identifiable marks or notices to be included in or associated with commercial electronic mail that contains sexually oriented material, in order to inform the recipient of that fact and to facilitate filtering of such electronic mail. The Commission shall publish in the Federal Register and provide notice to the public of the marks or notices prescribed under this paragraph.

(4) Definition.—In this subsection, the term "sexually oriented material" means any material that depicts sexually explicit conduct (as that term is defined in section 2256 of title 18, United States Code), unless the depiction constitutes a small and insignificant part of the whole, the remainder of which is not primarily devoted to sexual matters.

(4) Penalty.—Whoever knowingly violates paragraph (1) shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both.

SEC. 6. BUSINESSES KNOWINGLY PROMOTED BY ELECTRONIC MAIL WITH FALSE OR MISLEADING TRANSMISSION INFORMATION.

(a) In General.—It is unlawful for a person to promote, or allow the promotion of, that person's trade or business, or goods, products, property, or services sold, offered for sale, leased or offered for lease, or otherwise made available through that trade or business, in a commercial electronic mail message the transmission of which is in violation of section 5(a)(1) if that person—

(1) knows, or should have known in ordinary course of that person's trade or business, that the goods, products, property, or services sold, offered for sale, leased or offered for lease, or otherwise made available through that trade or business were being promoted in such a message;

(2) received or expected to receive an economic benefit from such promotion; and

(3) took no reasonable action—

(A) to prevent the transmission; or

(B) to detect the transmission and report it to the Commission.

(b) Limited Enforcement Against Third Parties.—

(1) In general.—Except as provided in paragraph (2), a person (hereinafter referred to as the "third party") that provides goods, products, property, or services to another person that violates subsection (a) shall not be held liable for such violation.

(2) Exception.—Liability for a violation of subsection (a) shall be imputed to a third party that provides goods, products, property, or services to another person that violates subsection (a) if that third party—

(A) owns, or has a greater than 50 percent ownership or economic interest in, the trade or business of the person that violated subsection (a); or

(B)(i) has actual knowledge that goods, products, property, or services are promoted in a commercial electronic mail message the transmission of which is in violation of section 5(a)(1); and

(ii) receives, or expects to receive, an economic benefit from such promotion.

(c) Exclusive Enforcement by FTC.—Subsections (f) and (g) of section 7 do not apply to violations of this section.

(d) Savings Provision.—Subject to section 7(f)(7), nothing in this section may be construed to limit or prevent any action that may be taken under this Act with respect to any violation of any other section of this Act.

SEC. 7. ENFORCEMENT GENERALLY.

(a) Violation Is Unfair or Deceptive Act or Practice.—Except as provided in subsection (b), this Act shall be enforced by the Commission as if the violation of this Act were an unfair or deceptive act or practice proscribed under section 18(a)(1)(B) of the Federal Trade Commission Act (15 U.S.C. 57a(a)(1)(B)).

(b) Enforcement by Certain Other Agencies.—Compliance with this Act shall be enforced—

(1) under section 8 of the Federal Deposit Insurance Act (12 U.S.C. 1818), in the case of—

(A) national banks, and Federal branches and Federal agencies of foreign banks, by the Office of the Comptroller of the Currency;

(B) member banks of the Federal Reserve System (other than national banks), branches and agencies of foreign banks (other than Federal branches, Federal agencies, and insured State branches of foreign banks), commercial lending companies owned or controlled by foreign banks, organizations operating under section 25 or 25A of the Federal Reserve Act (12 U.S.C. 601 and 611), and bank holding companies, by the Board;

(C) banks insured by the Federal Deposit Insurance Corporation (other than members of the Federal Reserve System) insured State branches of foreign banks, by the Board of Directors of the Federal Deposit Insurance Corporation; and

(D) savings associations the deposits of which are insured by the Federal Deposit Insurance Corporation, by the Director of the Office of Thrift Supervision;

(2) under the Federal Credit Union Act (12 U.S.C. 1751 et seq.) by the Board of the National Credit Union Administration with respect to any Federally insured credit union;

(3) under the Securities Exchange Act of 1934 (15 U.S.C. 78a et seq.) by the Securities and Exchange Commission with respect to any broker or dealer;

(4) under the Investment Company Act of 1940 (15 U.S.C. 80a–1 et seq.) by the Securities and Exchange Commission with respect to investment companies;

(5) under the Investment Advisers Act of 1940 (15 U.S.C. 80b–1 et seq.) by the Securities and Exchange Commission with respect to investment advisers registered under that Act;

(6) under State insurance law in the case of any person engaged in providing insurance, by the applicable State insurance authority of the State in which the person is domiciled, subject to section 104 of the Gramm-Bliley-Leach Act (15 U.S.C. 6701), except that in any State in which the State insurance authority elects not to exercise this power, the enforcement authority pursuant to this Act shall be exercised by the Commission in accordance with subsection (a);

(7) under part A of subtitle VII of title 49, United States Code, by the Secretary of Transportation with respect to any air carrier or foreign air carrier subject to that part;

(8) under the Packers and Stockyards Act, 1921 (7 U.S.C. 181 et seq.) (except as provided in section 406 of that Act (7 U.S.C. 226, 227)), by the Secretary of Agriculture with respect to any activities subject to that Act;

(9) under the Farm Credit Act of 1971 (12 U.S.C. 2001 et seq.) by the Farm Credit Administration with respect to any Federal land bank, Federal land bank association, Federal intermediate credit bank, or production credit association; and

(10) under the Communications Act of 1934 (47 U.S.C. 151 et seq.) by the Federal Communications Commission with respect to any person subject to the provisions of that Act.

(c) Exercise of Certain Powers.—For the purpose of the exercise by any agency referred to in subsection (b) of its powers under any Act referred to in that subsection, a violation of this Act is deemed to be a violation of a Federal Trade Commission trade regulation rule. In addition to its powers under any provision of law specifically referred to in subsection (b), each of the agencies referred to in that subsection may exercise, for the purpose of enforcing compliance with any requirement imposed under this Act, any other authority conferred on it by law.

(d) Actions by the Commission.—The Commission shall prevent any person from violating this Act in the same manner, by the same means, and with the same jurisdiction, powers, and duties as though all applicable terms and provisions of the Federal Trade Commission Act (15 U.S.C. 41 et seq.) were incorporated into and made a part of this Act. Any entity that violates any provision of that subtitle is subject to the penalties and entitled to the privileges and immunities provided in the Federal Trade Commission Act in the same manner, by the same means, and with the same jurisdiction, power, and duties as though all applicable terms and provisions of the Federal Trade Commission Act were incorporated into and made a part of that subtitle.

(e) Availability of Cease-and-Desist Orders and Injunctive Relief Without Showing of Knowledge.—Notwithstanding any other provision of this Act, in any proceeding or action pursuant to subsection (b), (c), or (d) of this section to enforce compliance, through an order to cease and desist or an injunction, with section 5(a)(2), subparagraph (B) or (C) of section 5(a)(4), or section 5(b)(1)(A), neither the Commission nor the Federal Communications Commission shall be required to allege or prove the state of mind required by such section or subparagraph.

(f) Enforcement by States.—

(1) Civil action.—In any case in which the attorney general of a State, or an official or agency of a State, has reason to believe that an interest of the residents of that State has been or is threatened or adversely affected by any person who violates paragraph (1) or (2) of section 5(a), or who engages in a pattern or practice that violates paragraph (3), (4), or (5) of section 5(a) of this Act, the attorney general, official, or agency of the State, as parens patriae, may bring a civil action on behalf of the residents of the State in a district court of the United States of appropriate jurisdiction—

(A) to enjoin further violation of section 5 of this Act by the defendant; or

(B) to obtain damages on behalf of residents of the State, in an amount equal to the greater of—

(i) the actual monetary loss suffered by such residents; or

(ii) the amount determined under paragraph (2).

(2) Availability of injunctive relief without showing of knowledge.—Notwithstanding any other provision of this Act, in a civil action under paragraph (1)(A) of this subsection, the attorney general, official, or agency of the State shall not be not required to allege or prove the state of mind required by section 5(a)(2), subparagraph (B) or (C) of section 5(a)(4), or section 5(b)(1)(A).

(3) Statutory damages.—

(A) In general.—For purposes of paragraph (1)(B)(ii), the amount determined under this paragraph is the amount calculated by multiplying the number of violations (with each separately addressed unlawful message received by or addressed to such residents treated as a separate violation) by up to $250.

(B) Limitation.—For any violation of section 5 (other than section 5(a)(1)), the amount determined under subparagraph (A) may not exceed $2,000,000.

(C) Aggravated damages.—The court may increase a damage award to an amount equal to not more than three times the amount otherwise available under this paragraph if—

(i) the court determines that the defendant committed the violation willfully and knowingly; or

(ii) the defendant's unlawful activity included one or more of the aggravating violations set forth in section 5(b).

(D) Reduction of damages.—In assessing damages under subparagraph (A), the court may consider whether—

(i) the defendant has established and implemented, with due care, commercially reasonable practices and procedures to effectively prevent such violations; or

(ii) the violation occurred despite commercially reasonable efforts to maintain compliance with such practices and procedures.

(3) Attorney fees.—In the case of any successful action under paragraph (1), the State may be awarded the costs of the action and reasonable attorney fees as determined by the court.

(4) Rights of federal regulators.—The State shall serve prior written notice of any action under paragraph (1) upon the Federal Trade Commission or the appropriate Federal regulator determined under subsection (b) and provide the Commission or appropriate Federal regulator with a copy of its complaint, except in any case in which such prior notice is not feasible, in which case the State shall serve such notice immediately upon instituting such action. The Federal Trade Commission or appropriate Federal regulator shall have the right—

(A) to intervene in the action;

(B) upon so intervening, to be heard on all matters arising therein;

(C) to remove the action to the appropriate United States district court; and

(D) to file petitions for appeal.

(5) Construction.—For purposes of bringing any civil action under paragraph (1), nothing in this Act shall be construed to prevent an attorney general of a State from exercising the powers conferred on the attorney general by the laws of that State to—

(A) conduct investigations;

(B) administer oaths or affirmations; or

(C) compel the attendance of witnesses or the production of documentary and other evidence.

(6) Venue; service of process.—

(A) Venue.—Any action brought under paragraph (1) may be brought in the district court of the United States that meets applicable requirements relating to venue under section 1391 of title 28, United States Code.

(B) Service of process.—In an action brought under paragraph (1), process may be served in any district in which the defendant—

(i) is an inhabitant; or

(ii) maintains a physical place of business.

(7) Limitation on state action while federal action is pending.—If the Commission or other appropriate Federal agency under subsection (b) has instituted a civil action or an administrative action for violation of this Act, no State attorney general, or official or agency of a State, may bring an action under this subsection during the pendency of that action against any defendant named in the complaint of the Commission or the other agency for any violation of this Act alleged in the complaint.

(8) Requisite Scienter for Certain Civil Actions.—Except as provided in subsections (a)(2), (a)(4)(B), (a)(4)(C), (b)(1), and (d) of section 5, and paragraph (2) of this subsection, in a civil action brought by a State attorney general, or an official or agency of a State, to recover monetary damages for a violation of this Act, the court shall not grant the relief sought unless the attorney general, official, or agency establishes that the defendant acted with actual knowledge, or knowledge fairly implied on the basis of objective circumstances, of the act or omission that constitutes the violation.

(g) Action by Provider of Internet Access Service.—

(1) ACTION AUTHORIZED.—A provider of Internet access service adversely affected by a violation of section 5(a) or of section 5(b), or a pattern or practice that vioalted paragraph (2), (3), (4), or (5) of section 5(a), may bring a civil action in any district court of the United States with jurisdiction over the defendant—

(A) to enjoin further violation by the defendant; or

(B) to recover damages in an amount equal to the greater of—

(i) actual monetary loss incurred by the provider of Internet access service as a result of such violation; or

(ii) the amount determined under paragraph (3).

(2) SPECIAL DEFINITION OF "PROCURE".—In any action brought under paragraph (1), this Act shall be applied as if the definition of the term "procure" in section 3(12) contained, after "behalf" the words "with actual knowlege, or by consciously avoiding knowing, whether such person is engaging, or will engage, in a pattern or practice that violates this Act".

(3) STATUTORY DAMAGES.—

(A) IN GENERAL.—For purposes of paragraph (1)(B)(ii), the amount determined under this paragraph is the amount calculated by multiplying the number of violations (with each separately addressed unlawful message that is transmitted or attempted to be transmitted over the facilities of the provider of Internet access service, or that is transmitted or attempted to be transmitted to an electronic mail address obtained from the provider of Internet access service in violation of section 5(b)(1)(A)(i), treated as a separate violation) by—

(i) up to $100, in the case of a violation of section 5(a)(1); or

(ii) $25, in the case of any other violation of section 5.

(B) LIMITATION.—For any violation of section 5 (other than section 5(a)(1)), the amount determined under subparagraph (A) may not exceed $1,000,000.

(C) AGGRAVATED DAMAGES.—The court may increase a damage award to an amount equal to not more than three times the amount otherwise available under this paragraph if—

(i) the court determines that the defendant committed the violation willfully and knowingly; or

(ii) the defendant's unlawful activity included one or more of the aggravated violations set forth in section 5(b).

(D) REDUCTION OF DAMAGES.—In assessing damages under subparagraph (A), the court may consider whether—

(i) the defendant has established and implemented, with due care, commercially reasonable practices and procedures to effectively prevent such violations; or

(ii) the violation occurred despite commercially reasonable efforts to maintain compliance with such practices and procedures.

(4) ATTORNEY FEES.—In any action brought pursuant to paragraph (1), the court may, in its discretion, require an undertaking for the payment of the costs of such action, and assess reasonable costs, including reasonable attorneys' fees, against any party.

SEC. 8. EFFECT ON OTHER LAWS.

(a) FEDERAL LAW.—

(1) Nothing in this Act shall be construed to impair the enforcement of section 223 or 231 of the Communications Act of 1934 (47 U.S.C. 223 or 231, respectively), chapter 71 (relating to obscenity) or 110 (relating to sexual exploitation of children) of title 18, United States Code, or any other Federal criminal statute.

(2) Nothing in this Act shall be construed to affect in any way the Commission's authority to bring enforcement actions under FTC Act for materially false or deceptive representations or unfair practices in commercial electronic mail messages.

(b) STATE LAW.—

(1) IN GENERAL.—This Act supersedes any statute, regulation, or rule of a State or political subdivision of a State that expressly regulates the use of electronic mail to send commercial messages, except to the extent that any such statute, regulation, or rule prohibits falsity or deception in any portion of a commercial electronic mail message or information attached thereto.

(2) STATE LAW NOT SPECIFIC TO ELECTRONIC MAIL.—This Act shall not be construed to preempt the applicability of—

(A) State laws that are not specific to electronic mail, including State trespass, contract, or tort law; or

(B) other State laws to the extent that those laws relate to acts of fraud or computer crime.

(c) NO EFFECT ON POLICIES OF PROVIDERS OF INTERNET ACCESS SERVICE.—Nothing in this Act shall be construed to have any effect on the lawfulness or unlawfulness, under any other provision of law, of the adoption, implementation, or enforcement by a provider of Internet access service of a policy of declining to transmit, route, relay, handle, or store certain types of electronic mail messages.

SEC. 9. DO-NOT-E-MAIL REGISTRY.

(a) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Commission shall transmit to the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committee on Energy and Commerce a report that—

(1) sets forth a plan and timetable for establishing a nationwide marketing Do-Not-E-mail registry;

(2) includes an explanation of any practical, technical, security, privacy, enforceability, or other concerns that the Commission has regarding such a registry; and

(3) includes an explanation of how the registry would be applied with respect to children with e-mail accounts.

(b) AUTHORIZATION TO IMPLEMENT.—The Commission may establish and implement the plan, but not earlier than 9 months after the date of enactment of this Act.

SEC. 10. STUDY OF EFFECTS OF COMMERCIAL ELECTRONIC MAIL.

(a) IN GENERAL.—Not later than 24 months after the date of the enactment of this Act, the Commission, in consultation with the Department of Justice and other appropriate agencies, shall submit a report to the Congress that provides a detailed analysis of the effectiveness and enforcement of the provisions of this Act and the need (if any) for the Congress to modify such provisions.

(b) REQUIRED ANALYSIS.—The Commission shall include in the report required by subsection (a)—

(1) an analysis of the extent to which technological and marketplace developments, including changes in the nature of the devices through which consumers access their electronic mail messages, may affect the practicality and effectiveness of the provisions of this Act;

(2) analysis and recommendations concerning how to address commercial electronic mail that originates in or is transmitted through or to facilities or computers in other nations, including initiatives or policy positions that the Federal government could pursue through international negotiations, fora, organizations, or institutions; and

(3) analysis and recommendations concerning options for protecting consumers, including children, from the receipt and viewing of commercial electronic mail that is obscene or pornographic.

SEC. 11. IMPROVING ENFORCEMENT BY PROVIDING REWARDS FOR INFORMATION ABOUT VIOLATIONS; LABELING.

The Commission shall transmit to the Senate Committee on Commerce, Science, and Transportation and the House of Representatives Committee on Energy and Commerce—

(1) a report, within 9 months after the date of enactment of this Act, that sets forth a system for rewarding those who supply information about violations of this Act, including—

(A) procedures for the Commission to grant a reward of not less than 20 percent of the total civil penalty collected for a violation of this Act to the first person that—

(i) identifies the person in violation of this Act; and

(ii) supplies information that leads to the successful collection of a civil penalty by the Commission; and

(B) procedures to minimize the burden of submitting a complaint to the Commission concerning violations of this Act, including procedures to allow the electronic submission of complaints to the Commission; and

(2) a report, within 18 months after the date of enactment of this Act, that sets forth a plan for requiring commercial electronic mail to be identifiable from its subject line, by means of compliance with Internet Engineering Task Force Standards, the use of the characters "ADV" in the subject line, or other comparable identifier, or an explanation of any concerns the Commission has that cause the Commission to recommend against the plan.

SEC. 12. RESTRICTIONS ON OTHER TRANSMISSIONS.

Section 227(b)(1) of the Communications Act of 1934 (47 U.S.C. 227(b)(1)) is amended, in the matter preceding subparagraph (A), by inserting ", or any person outside the United States if the recipient is within the United States" after "United States".

SEC. 13. REGULATIONS.

(a) IN GENERAL.—The Commission may issue regulations to implement the provisions of this Act (not including the amendments made by sections 4 and 12). Any such regulations shall be issued in accordance with section 553 of title 5, United States Code.

(b) LIMITATION.—Subsection (a) may not be construed to authorize the Commission to establish a requirement pursuant to section 5(a)(5)(A) to include any specific words, characters, marks, or labels in a commercial electronic mail message, or to include the identification required by section 5(a)(5)(A) in any particular part of such a mail message (such as the subject line or body).

SEC. 14. APPLICATION TO WIRELESS.

(a) EFFECT ON OTHER LAW.—Nothing in this Act shall be interpreted to preclude or override the applicability of section 227 of the Communications Act of 1934 (47 U.S.C. 227) or the rules prescribed under section 3 of the Telemarketing and Consumer Fraud and Abuse Prevention Act (15 U.S.C. 6102). To the extent that a requirement of such Acts, or rules or regulations promulgated thereunder, is inconsistent with the requirement of this Act, the requirement of such other Acts, or rules or regulations promulgated thereunder, shall take precedence.

(b) FCC RULEMAKING.—The Federal Communications Commission, in consultation with the Federal Trade Commission, shall promulgate rules within 270 days to protect consumers from unwanted mobile service commercial messages. The rules shall, to the extent consistent with subsection (c)—

(1) provide subscribers to commercial mobile services the ability to avoid receiving mobile service commercial messages unless the subscriber has provided express prior authorization, except as provided in paragraph (3);

(2) allow recipients of mobile service commercial messages to indicate electronically a desire not to receive future mobile service commercial messages from the initiator;

(3) take into consideration, in determining whether to subject providers of commercial mobile wireless services to paragraph (1), the relationship that exists between providers of such services and their subscribers, but if the Commission determines that such providers should not be subject to paragraph (1), the rules shall require such providers, in addition to complying with the other provisions of this Act, to allow subscribers to indicate a desire not to receive future mobile service commercial messages at the time of subscribing to such service, and in any billing mechanism; and

(4) determine how initiators of mobile service commercial messages may comply with the provisions of this Act, considering the unique technical aspects, including the functional and character limitations, of devices that receive such messages.

(c) OTHER FACTORS CONSIDERED.—The Federal Communications Commission shall consider the ability of an initiator of an electronic mail message to reasonably determine that the electronic mail message is a mobile service commercial message.

(d) MOBILE SERVICE COMMERCIAL MESSAGE DEFINED.—In this section, the term "mobile service commercial message" means a commercial electronic mail message that contains text, graphics, or images for visual display that is transmitted directly to a wireless device that—

(1) is utilized by a subscriber of commercial mobile service (as such term is defined in section 332(d) of the Communications Act of 1934 (47 U.S.C. 332(d)) in connection with such service; and

(2) is capable of accessing and displaying such a message.

SEC. 15. SEPARABILITY.

If any provision of this Act or the application thereof to any person or circumstance is held invalid, the remainder of this Act and the application of such provision to other persons or circumstances shall not be affected.

SEC. 16. EFFECTIVE DATE.

The provisions of this Act, other than section 9, shall take effect on January 1, 2004.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Louisiana (Mr. TAUZIN) and the gentleman from Massachusetts (Mr. MARKEY) each will control 20 minutes.

The Chair recognizes the gentleman from Louisiana (Mr. TAUZIN).

GENERAL LEAVE

Mr. TAUZIN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and to insert extraneous material on S. 877.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Louisiana?

There was no objection.

Mr. TAUZIN. Mr. Speaker, I ask unanimous consent that the gentleman from Wisconsin (Mr. SENSENBRENNER) be given control of 10 minutes of my time.

The SPEAKER pro tempore. Without objection, the request of the gentleman from Louisiana is granted.

There was no objection.

Mr. TAUZIN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, for the second time in just a few months, Congress is on the verge of passing watershed consumer protection legislation. Less than 2 months ago, we enacted, in record time I might add, legislation that codified the ability of the Federal Trade Commission to implement the Do Not Call Registry on telemarketing phone calls. Today, we take an equivalent step in the Internet area. S. 877, with the substitute I have called up, will give millions of Americans the ability to block unwanted and unsolicited commercial e-mail, what we now derisively call spam.

The Internet has given us abilities beyond our wildest dreams; and as it continues to grow in popularity and functionality, the time will come when every American, from school kids to senior citizens, homemakers to CEOs, will rely on it for crucial aspects of their lives. I received, by the way, my first e-mail from my mom just this month. And she was thrilled, and I was thrilled to see her enter the Internet Age.

But one of the terrific aspects of the Internet, the ability to send and receive e-mail, has given us enormous headaches because of spam. It cripples computer networks and makes regular e-mail checking a seemingly endless hassle.

□ 1715

Even worse, a great deal of spam channels in pornography and other subjects not worthy of discussion on a family cable channel, and this spam frequently preys on defenseless, unsuspecting children.

Well, we are here to provide the necessary tools to end the nonsense and to bring some peace of mind back to parents around the country. The substitute before us will empower American consumers with a right to opt out of all unwanted, unsolicited commercial e-mail, or spam, and it will also provide the Federal Trade Commission with the authority to set up a Do-Not-Spam Registry based upon the Do-Not-Call Registry. The substitute grants strong protection for parents and consumers to say no to the receipt of pornographic spam, and makes it a crime subject to 5 years in prison to send fraudulent spam. And finally, it gives the FTC and State attorneys general the ability to vigorously enforce the new law.

I am pleased to report that the product before us now enjoys broad bipartisan support here in the House and also in the other body. The bill can and should go to President Bush before we adjourn the first session of the 108th Congress. Mr. Speaker, I urge my colleagues to vote for this much-needed, bipartisan bill.

Mr. Speaker, I reserve the balance of my time.

Mr. MARKEY. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. GREEN).

Mr. GREEN of Texas. Mr. Speaker, I would like to thank our ranking member on the Subcommittee on Telecommunications and the Internet for yielding me this time.

I rise in strong support of S. 877, the compromise which has been worked out on the antispam legislation.

First, I want to thank the gentlewoman from New Mexico (Mrs. WILSON) for the many years of work she has put in with me and other members of the Committee on Energy and Commerce.

I also thank the leadership of our committee, the ranking member, the gentleman from Michigan (Mr. DINGELL) and the gentleman from Louisiana (Chairman TAUZIN) for their strong commitment to this effort which the gentlewoman from New Mexico (Mrs. WILSON) and I began almost 5 years ago. She had a terrible personal experience with spam, and I heard from constituents some of the same stories, and my wife and I have received some of that same unsolicited spam on our own personal e-mail account.

This legislation will set the fair and clear standards for e-mail marketing that consumers and the Internet need desperately. The future of e-mail is at stake, and the time to act is now. Congress is delivering the enforcement tools we need.

Importantly, this compromise has clear definitions of commercial e-mail which the FTC can enforce and any individual consumer's request to not receive further commercial e-mail from a sender will have the force of the law. Spammers who lie and deceive with false header information and deceptive subject lines will be lawbreakers and will be prosecuted as such.

After we enact this legislation, spammers will no longer be able to harvest e-mail addresses from Web pages across the Internet without the threat of prosecution. There are so many good things in this bill that it is hard to go over all of them in 2 minutes.

We will come after spammers from all angles. State attorneys general are empowered, and Internet service providers are empowered to seek damages up to $250 per e-mail or $6 million total.

After the success of the FTC's Do-Not-Call list, the Do-Not-Spam registry implementation is feasible. I thank the gentleman from Louisiana (Mr. TAUZIN) and our ranking member, and I also thank the many cosponsors of our original bill, H.R. 2515, on the antispam effort.

Mr. SENSENBRENNER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of the House-modified version of Senate 877, and wish to thank my fellow chairman, the gentleman from Louisiana (Mr. TAUZIN), as well as the gentleman from Michigan (Mr. DINGELL) and the gentleman from Massachusetts (Mr. MARKEY) in working out this compromise which deals with a very vexatious question, and I think provides a win/win situation for everybody except the few bad actors that flood the electronic media with spam.

The Internet has revolutionized commerce and communications by permitting businesses to reach consumers in a digital, global marketplace and has allowed individuals to communicate through the speed and convenience of electronic mail. Unfortunately, the massive growth of unsolicited e-mail or "spam" now threatens to kill the utility of this popular media. Last year over 6 trillion e-mails were transmitted. Today, almost half of those e-mails are unsolicited or unwanted.

Commercial e-mail is good, and a necessary and valuable component of electronic commerce. It allows legitimate businesses to customize offers of products and services and transmit them immediately to customers.

However, the same features that make e-mail a valuable commercial tool also lead to its abuse by spammers. Once a portable to the global network is obtained, sending e-mail is instantaneous and virtually costless. There are no stamps in cyberspace, no per-message cost, not even a post office. The costs of delivery are borne more by the recipient and the transmission network than by the sender. The exponential growth of spam and the advancing sophistication of efforts to block it threaten to turn the information superhighway into a nightmare for every info-commuter and parent.

Like other means of communication, e-mail can be used to cheat, defraud, and deceive consumers and also has been used to distribute computer viruses that have caused millions of dollars in economic damages. Unscrupulous spammers have transformed electronic inboxes and the Internet into virtual minefields strewn with lewd and pornographic images and solicitations, imperiling a medium that can serve as a critical learning tool for children.

I am pleased to support this version of Senate 877, which is substantially similar to H.R. 2214 introduced by the gentleman from North Carolina (Mr. BURR), the gentleman from Louisiana (Mr. TAUZIN) and myself earlier this year. I believe it will provide a remedial enforcement mechanism that private, regulatory, and individual State action cannot.

The criminal provisions contained in this legislation are central to its purpose and to its effectiveness. In order to provide a credible deterrent to spammers, this legislation enhances criminal penalties for predatory spamming, and provides law enforcement personnel far more authority to prosecute spammers whose electronic presence can shift with a keystroke.

The bill provides significant criminal penalties for the most egregious spammers by making it a crime to intentionally falsify the identity of the sender or disguise the routing and source information of e-mails. Other spammer tactics made criminal under this bill include the hijacking protected computers to send spam from the addresses of unsuspecting Internet users.

The House modification of S. 877 also provides for much higher penalties and more effective civil and criminal enforcement against spammers who send unwanted sexually explicit materials. This bill even requires special labels for this most offensive category of e-mail. The gentlewoman from Pennsylvania (Ms. HART) deserves special recognition for her work to get this provision into law.

Overall, the bill provides consumers with more information and choices to stop receiving all forms of unwanted commercial e-mail while providing law enforcement officials and providers of Internet access with the tools to go after spammers.

While S. 877 accomplishes these vital goals, there are some activities that it deliberately does not reach. Specifically, the legislation concerns only commercial and sexually explicit e-mail and is not intended to intrude on the burgeoning use of e-mail to communicate for political, news, personal and charitable purposes.

Moreover, this legislation, while preempting State spam specific laws with a uniform national standard, also preserves a role for State law enforcement officials to help combat this growing electronic menace. The bill also allows for State laws that deal with fraud and computer crimes to remain in effect. However, there is specific language in the bill limiting this authority to law enforcement officials or agencies of the State, and it is not the intent of Congress to allow outsourcing of this truly State function to the plaintiff's bar.

The House-modified legislation also contains other necessary amendments to the bill passed by the other body and reflects a thoughtful, bipartisan and bicameral approach to address the growing scourge of spam while preserving and promoting the commercial vitality of the Internet. I urge my colleagues to support this legislation.

Mr. Speaker, I reserve the balance of my time.

Mr. MARKEY. Mr. Speaker, I yield myself 2½ minutes.

Mr. Speaker, this is a very important bill, and it would not have been possible without the good work of the gentleman from Louisiana (Mr. TAUZIN) and his staff, David Cavicke, along with the gentleman from Michigan (Mr. DINGELL) and his staff, David Schooler and Gregg Rothschild, working with the majority. I think we have come to an excellent result. It builds upon the work that the gentlewoman from New Mexico (Mrs. WILSON) and the gentleman from Texas (Mr. GREEN) have been making for years in this area. I think that the public is really going to be a beneficiary from this product this evening. I would be remiss, of course, not to single out the gentleman from Wisconsin (Mr. SENSENBRENNER) as well and his staff for their excellent work on this bill.

In addition to the other provisions mentioned by other Members, this legislation now contains a modified version of the wireless spam amendment that I had offered for inclusion. The legislation preserves important authority of the Federal Communications Commission and FTC where it serves consumer interests. It also requires the FCC to initiate a rule-making for wireless spam so that no loopholes are created, but in a way to ensure that wireless consumers have greater protection than that accorded in the underlying bill.

As we attempt to tackle the issue of spam that is sent to our desktop computers, we must also recognize that millions of wireless consumers in the United States run the risk of being inundated by wireless spam. Unsolicited wireless text messages have plagued wireless users in Europe, South Korea and Japan over the last few years as wireless companies in such countries have offered wireless messaging services.

In Japan alone, NTT DoCoMo estimates that its wireless network processes some 800 million wireless spam messages a day. That is a day. As cumbersome and annoying as spam to a desktop computer is, at least a consumer can turn off their computer and walk away. Wireless spam is even more intrusive because spam to wireless phones is the kind of spam that follows you wherever you go, and according to the U.S. wireless carriers, is already on the rise.

Mr. Speaker, I reserve the balance of my time.

Mr. TAUZIN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I thank the gentleman from Massachusetts for thanking the majority staff. I wish I could introduce Mr. Cavicke because he has done such a great job on this bill, but he is not a Member.

Mr. Speaker, I yield 2 minutes to the gentlewoman from New Mexico (Mrs. WILSON) to speak on the bill.

Mrs. WILSON of New Mexico. Mr. Speaker, 5 years ago spam was a nuisance, and now it is a nightmare. It is interrupting people's legitimate use of the Internet and their ability to communicate without having a lot of junk to go through every morning.

I think today is a great victory for consumers and for parents. Parents should not have to worry about the kinds of things coming into their kids' inboxes. For the first time, Americans who use the Internet and get e-mail will have the right to say take me off your list, I do not want this in my house. That is a tremendous right to be given to citizens in this Nation.

I am glad we have a strong bill with strong enforcement that requires labels for sexually explicit material, and allows users to opt out without having things that are required to be viewed in order to do so.

E-mail has been called the "killer ap" of the Internet, the killer application. And now today, we are saying that the people who use it are going to have the right to take it back and own it without an encumbrance by spammers.

Mr. Speaker, I want to thank the gentleman from Louisiana (Mr. TAUZIN), the gentleman from Wisconsin (Mr. SENSENBRENNER), the gentleman from Texas (Mr. GREEN) with whom I have been working on this issue for over 4 years, and the gentleman from Michigan (Mr. DINGELL) who has also been a wonderful leader in this effort, as well as the gentlewoman from Pennsylvania (Ms. HART) and the gentleman from North Carolina (Mr. BURR) for their efforts. We have put together a good bill, and it is a better bill because we have all worked on it together.

Mr. MARKEY. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. GREEN).

Mr. GREEN of Texas. Mr. Speaker, I would like to talk about some of the good things about this agreement that is in the bill S. 877.

Spammers who lie and deceive with false header information and deceptive subject lines will be lawbreakers and prosecuted. After we enact this legislation, spammers will no longer be able to harvest e-mail addresses from Web pages across the Internet without the threat of prosecution.

□ 1730

Our bill cracks down on automated "dictionary" spam attacks, the spam version of the auto-dialer that sends spam to every possible e-mail combination. Most importantly for our families, and something that the gentlewoman from New Mexico (Mrs. WILSON) experienced with her daughter, this bill requires warning labels on sexually explicit e-mail; and we will be able to refuse further e-mail without having to view the offensive content. It will go after spammers again from all angles, from the Federal Trade Commission, from the States attorneys general and also Internet service providers who, as the gentleman from Wisconsin (Mr. SENSENBRENNER) said, 50 percent of the networks oftentimes are unsolicited e-mail. They will be able to sue for damages of $250 per e-mail or a total of $6 million. It is there so our attorneys general have the ability and our ISPs will do it.

Finally, after the success of the Do-Not-Call list, the FTC is to plan a Do-Not-Spam registry within 6 months and will implement it if it is feasible.

Like my colleagues, our staff worked hard on it in both our committees, Judiciary and Energy and Commerce. I thank my personal staff, Drew Wallace, for working on this with all the folks involved.

Mr. SENSENBRENNER. Mr. Speaker, I yield 2 minutes to the gentleman from Virginia (Mr. GOODLATTE).

Mr. GOODLATTE. Mr. Speaker, I thank the gentleman from Wisconsin, chairman of the Committee on the Judiciary, and the gentleman from Louisiana, chairman of the Committee on Energy and Commerce, for their leadership in pulling these two committees together. We have been working on this for a long time. It is that kind of teamwork that has resulted in this legislation today as well as a great deal of cooperation on the other side of the aisle. We really appreciate what it takes to write good legislation.

Spam is not just a nuisance anymore. Over half of the e-mail sent today is spam. Unsolicited e-mail, such as advertisements, solicitations, or chain letters is the junk mail of the Information Age. At best these unwanted messages burden consumers by slowing down their e-mail connections. At worst these messages bombard American families with unsolicited, sexually explicit materials and fraudulent information. It is time to can spam.

The bill before us makes it a criminal offense to send a commercial e-mail that falsifies the sender's identity. In addition, the House amendments which have been incorporated into this bill strengthen the provisions that punish spammers for failing to place warning labels on sexually explicit materials.

This bill makes the necessary changes to the Senate's "can spam act" to establish clear, uniform guidelines for those who send commercial e-mail and to criminalize fraudulent conduct. The bill provides State attorneys general, ISPs, the FTC, and the Department of Justice with the appropriate tools to enforce the bill against bad actors.

Because no legislation can provide a cure-all for spam, this bill is technology-friendly. It protects the ability of ISPs and small businesses to develop innovative technological solutions to combat spam and to protect consumers, such as filtering and blocking technologies. This bill establishes clear guidelines for legitimate businesses and punishes fraudulent conduct, not going after the good guys. It accomplishes these objectives without overregulating and without taking the information out of the Information Age.

I urge my colleagues to support this important legislation.

Mr. MARKEY. Mr. Speaker, I yield 5 minutes to the gentleman from Michigan (Mr. DINGELL), the ranking Democrat on the Committee on Energy and Commerce.

Mr. DINGELL. Mr. Speaker, we can work well together around here. I am sure that a lot of people are surprised.

I want to pay a congratulations and compliment to my distinguished friend, the gentleman from Louisiana (Mr. TAUZIN), the chairman of the committee, and also to the distinguished gentleman from Wisconsin (Mr. SENSENBRENNER) for his labors. I want to thank my good friend, the gentleman from Massachusetts (Mr. MARKEY), for his leadership in this valiant effort and undertaking, and I want to pay particular tribute to both the distinguished gentleman from Texas (Mr. GREEN) and the wonderful gentlewoman from New Mexico (Mrs. WILSON) for their outstanding leadership, for the courage and for the dedication with which they stood hitched on this difficult issue and these difficult negotiations. Congratulations to all of the above. And also to Mr. Gregg Rothschild, Mr. David Cavicke, Mr. Bryce Dustman, and Peter Filon of the staff; also David Schooler and Shannon Vildostegui for their wonderful work as members of the staff because their efforts have helped make this possible.

This is a good bill and it is worthy of our support. There are things that we could have done that would have been a little better, but it is a piece of legislation which is going to solve a concern of the American people, something which is good and is in the public interest. And it is an important first step in restoring consumers' control over their inboxes and stopping some of the evil and rascality that we are seeing in the telecommunications industry. It requires marketers to let people know who they are and where they can be located. It prohibits false and misleading transmission information so that marketers cannot hide their identity. It prohibits marketers from deceiving consumers by using false headers or subject lines. Importantly, it affords the Federal Trade Commission and the States full enforcement authority over these consumer protection provisions.

I am particularly pleased that the bill permits law enforcement to go after those who disguise sexual messages and through such deception are able to send sexual material into our homes and into the hands of our children. This is a critical first step against those who profit by sending unwanted and offensive sexual commercial messages. It will stop much wrongdoing.

I am also pleased that the House has adopted the Senate provision creating a do-not-spam registry. I expect the FTC to take their charge seriously under this provision and to do all that is necessary to implement such a registry at the earliest possible time.

Finally, I am pleased that the House has added a new provision to grant even stronger protections from spam to users of wireless cell phones. The gentleman from Massachusetts deserves the thanks of all of us for that. In connection with this provision, I commend the hard work of our dear friend, the ranking Democrat on the Subcommittee on Telecommunications and the Internet.

Mr. Speaker, I want to be clear that I do not expect this bill to solve totally the growing problem of unwanted spam. It must be recognized that the people who engage in this practice are most diligent, most able, and have a huge financial incentive to do it. It is quite possible that we will have to visit the matter again. It is regrettable that it does not contain an important deterrence against spam, citizen suits; but we can address that at a future time. It also has the regrettable practice in it of preempting stronger State laws, something which I do not favor. It is, however, a distinct improvement over the Senate-passed bill, and the hard work that has brought us to agreement on the part of those who have worked on it is something which merits the thanks of the public for work in the public interest.

I plan to work to try and expand this in future times and to do the things that are necessary to assure that our people are not abused by these people.

Mr. TAUZIN. Mr. Speaker, I thank the distinguished gentleman from Michigan for his statement and his kind friendship.

Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Michigan (Mr. UPTON), chairman of the Subcommittee on Telecommunications and the Internet.

Mr. UPTON. Mr. Speaker, today on the heels of our recent efforts to ensure that the do-not-call list was implemented, we are taking yet another major step forward in our efforts to protect consumers from unwanted commercial solicitations. With passage of this bill tonight, we are one more step closer to giving American consumers a Federal law which will for the first time allow them to just say no to unwanted commercial e-mails, otherwise known as spam. And we back it up with strong enforcement by the FTC, State attorneys general, and Internet service providers as well.

As the father of two young kids, I am particularly pleased that this bill requires warning labels on commercial e-mails which contain sexually oriented material, and it protects our kids from being unwittingly exposed to such garbage that might pop up in the family's inbox. As chairman of the Subcommittee on Telecommunications and the Internet, I am particularly pleased to have worked with my colleagues on this, particularly the gentleman from Massachusetts (Mr. MARKEY); the gentleman from Michigan (Mr. DINGELL); certainly the gentleman from North Carolina (Mr. BURR); and my chairman, the gentleman from Louisiana (Mr. TAUZIN), on provisions which direct the Federal Communications Commission to implement added protections against spam for cell phones and other wireless devices. What a nightmare ready to happen. On our staff I want to particularly thank Will Nordwind, who spent countless hours as we negotiated this the last number of months.

Mr. Speaker, I want to relate a small family story. When my dad came back from World War II, my mom fixed his first dinner. It was Spam. Dad said, no way. Battle of the Bulge, we had enough of that. No more are we going to have that junk. My family thankfully was spared that for 50 years. Sadly, American consumers have not been spared from that awful stuff called spam because this is spam on the Internet.

I can remember when e-mails came first off, everyone loved to get an e-mail. I thought we were finally making some headway. But lo and behold, my wife was out of town, and I did not realize she was deleting it. Every morning she would get up at 5:30 or 6 in the morning. She has been gone all week. Today just from last night, I had 150 spams.

Pass this bill. End this stuff. I cannot call it what I really think. God bless America.

Mr. MARKEY. Mr. Speaker, I yield 1 additional minute to the gentleman from Texas (Mr. GREEN).

Mr. GREEN of Texas. Mr. Speaker, I know we are getting down to the last few minutes, but, like my colleague from Michigan, I ate a lot of Spam. I am holding up my gift of Spam from my cosponsor. Like him, the only way I could ever survive Spam was with A-1 steak sauce. I remember the story that my first time, somebody showing up at a town hall meeting and saying, I'm tired of spam and I said, thank goodness I haven't had to eat it in years. But I do remember it tasted pretty good in college when I needed it.

But now as my colleague from Michigan said, spam will not have a bad name for people who use the Internet. Again, I would like to thank the gentlewoman from New Mexico (Mrs. WILSON) for providing me a can of Spam. I am not going to cook it. I am going to put it on the wall so hopefully I will not have to.

Mr. SENSENBRENNER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, after hearing about that stuff that the gentleman from Texas was waving around, let me say that we Yankees knew that Spam was bad 50 years ago. It has taken a long time for you rebels to do that.

Mr. Speaker, I yield 1 minute to the gentlewoman from Pennsylvania (Ms. HART).

Ms. HART. Mr. Speaker, I also thank the gentleman from Wisconsin (Mr. SENSENBRENNER), the gentleman from Louisiana (Mr. TAUZIN), the gentleman from Michigan (Mr. DINGELL), and the general public, really, for helping us move this bill forward. I am pleased we were able to work out a deal on this legislation. It has taken some time, but the product is well worth it. The American public has been flooded with millions of pieces of unsolicited e-mail every day. This legislation will help us provide the teeth in the law to stop this. But it is the content of certain e-mails, particularly e-mails containing sexually explicit material which is especially problematic.

I compliment the gentlewoman from New Mexico (Mrs. WILSON) for working together with us on language that is similar to the Pennsylvania law that I sponsored to help label and help us rid our computers of these sexually explicit e-mails. I am pleased this was put into the bill. We want our children to use the Internet and e-mail, but many parents fear what the children may see. Parents are stuck in the middle. They want their kids to use the educational tool of the Internet, they want them to be very capable of utilizing it, and it will help them in their schoolwork on one hand, but on the other when my Senator was sitting behind one of his children, in fact, he said to me, I could not believe what came up on the screen.

It is important for us to make sure that we control it but we allow freedom of speech. I compliment my colleagues. I look forward to a spam-free e-mail.

Mr. MARKEY. Mr. Speaker, I yield myself 2 minutes.

The reality is that this whole movement began as people several years ago saw what the impact would be of unwanted spam on their home or work computers. As the gentleman from Michigan (Mr. UPTON) pointed out, he had in one day 150 unwanted spam messages on his home computer. What this legislation does is to help every American to deal with that problem. What I ask the Members to do as well is to deal with another issue that quite likely is going to rise to a level of being a problem that eclipses even computer spam and that would be cell phone spam.

Imagine if you reach a point where there are 150 unwanted rings on your phone, your cell phone, this zone of privacy which we all have as these marketers are calling into your cell phone all day long. What this legislation does is it ensures that the Federal Communications Commission and the Federal Trade Commission take the actions which give protections against this being the new battleground. It is already a full scale epidemic in Europe, in Japan, in South Korea.

□ 1745

It is heading our way. Probably by the time the FCC has a chance to put the regulations on the books, maybe a year from now, we will have already seen its growth so those protections against these cell phones just ringing all day long becomes the epidemic that really just drives people crazy. So the bill will require the FCC to consider certain provisions with an eye towards assessing the problems and perhaps the unique capabilities or limitations of wireless devices. We have to be sure that wireless consumers and carriers can functionally implement the new legal requirements. But the Federal spam legislation ought to reflect the particular characteristics of the wireless technology and use this bill as a way to ensure that we have promulgated rules requiring a consumer opt-in for wireless e-mail messages so that the consumer has affirmatively said that they want these messages to come into their life. Otherwise, this device that is so valuable now to 170 million Americans would just be the single greatest nuisance ever invested.

Mr Speaker. I rise in support of the compromise spam legislation that we bring to the House Floor today.

Mr. Speaker, this legislation reflects a series of agreements between advocates for the two alternative House spam bills—one offered by Chairman TAUZIN, and the other offered by Ms. WILSON and Mr. GREEN of which I am an original cosponsor, as well as a series of compromises with our Senate counterparts. While not a perfect bill, I believe it merits support.

In addition, Mr. Speaker, this legislation now contains a modified version of the wireless spam amendment that I had offered for inclusion. The legislation preserves important authority of the FCC and FTC where it serves consumer interests. It also requires the FCC to initiate a rulemaking for wireless spam so that no loopholes are created but in a way to ensure that wireless consumers have greater protection than that accorded in the underlying bill.

As we attempt to tackle the issue of spam that is sent to our desktop computers, we must also recognize the millions of wireless consumers in the United States run the risk of being inundated with wireless spam. Unsolicited wireless text messages have plagued wireless users in Europe, South Korea, and Japan over the last few years as wireless companies in such countries have offered wireless messaging services. In Japan alone, NTT DoCoMo estimates that its wireless network processes some 800 million wireless spam messages a day. As cumbersome and annoying as spam to a desktop computer is, at least a consumer can turn off their computer and walk away. Wireless spam is even more intrusive because spam to wireless phones is the kind of spam that follows you wherever you go and according to U.S. wireless carriers, is already on the rise.

To prevent wireless spam from overwhelming the American wireless marketplace as it has networks in other countries, this legislation tasks the FCC to promulgate rules in order to put strong consumer protections on the books. In addition, the bill requires the FCC to consider certain provisions with an eye toward assessing them given the perhaps unique capabilities or limitations of wireless devices. We must be sure that wireless consumers and carriers can functionally implement the legal requirements. Federal spam legislation ought to reflect the particular characteristics of wireless technology and use and this bill will allow the FCC to promulgate rules requiring a consumer "opt-in" for wireless email messages while examining the nature of a consumer's relationship with their wireless phone and service to take into account the unique service and technical characteristics that may warrant wireless-specific rules affecting consumer and carrier rights and obligations.

The wireless spam provision of the bill offers wireless consumers relief by requiring an "opt-in" for spam to wireless consumers. This reflects the fact that spam to a mobile phone is more intrusive to consumers and the fact that some wireless payment plans currently charge users for the amount of text messages they receive.

The provision would require "express prior authorization" from the consumer before an entity could send spam to their wireless device. My intent is that this "express prior authorization" be implemented in a way that a request for "express prior authorization" is conspicuous and easily understood by consumers and that each entity seeking to send mobile service commercial messages pursuant to Section 14(b)(1) obtain such consumer authorization. In addition, the wireless spam provision requests that the FCC consider the ability of an initiator of spam to reasonably determine whether an electronic mail message is a mobile service commercial message. Obviously, as wireless service evolves, more and more consumers will receive Internet emails via their commercial mobile service provider's network and directly to their wireless device. If a person ha an email address from their commercial mobile service provide and it can be readily identified as a wireless address, such as name@verizonwireless.net or name@wireless.net then the reasonable ability of a potential spammer to recognize that as such is relatively easy. Hopefully, commercial mobile service providers—and consumers—will see the benefit of having an email address that can be reasonably determined to be a wireless address, so that the prospect of massive amounts of spam to consumers over wireless networks can be thwarted and consumers can enjoy the benefits of entities needing their express prior authorization before sending them wireless spam.

Spam sent to desktop computer email address, and which is then forwarded over a wireless network to a wireless devices, i.e., delivered "indirectly" from the initiator to the wireless device, would be treated by the rest of this bill and not by the wireless specific provisions we subject to an FCC rulemaking.

This legislation also represents an improvement in other areas over the Senate-passed bill. For example, the compromise doubles the damage caps in the Senate bill. It also eliminates the knowledge standards for the Federal Communications Commission (FCC), the Federal Trade Commission (FTC) and state Attorney General injunctive relief. The bill provides for rulemaking authority to clarify and tighten the definition of what constitutes a "commercial email." Requires that identifiers and a postal address musts be on all commercial emails to desktop computers. Finally, the bill also shortens the time frame from which an "opt-out" request would become enforceable.

All of these represent important improvements over the Senate bill.

I want to commend Chairman TAUZIN, Ranking Member Mr. DINGELL for their excellent work in this area. I want to salute Representatives HEATHER WILSON and GENE GREEN for spearheading House spam efforts in this session as well as in the previous Congress as the lead sponsors of the House bill.

Mr. Speaker, I reserve the balance of my time.

Mr. SENSENBRENNER. Mr. Speaker, I have no further requests for time from Committee on the Judiciary, and I yield the balance of my time to the gentleman from North Carolina (Mr. BURR).

Mr. BURR. Mr. Speaker, I ask unanimous consent to control the time of the gentleman from Louisiana (Mr. TAUZIN) as well as the time of the gentleman from Wisconsin (Mr. SENSENBRENNER).

The SPEAKER pro tempore (Mr. THORNBERRY). Is there objection to the request of the gentleman from North Carolina (Mr. BURR)?

There was no objection.

The SPEAKER pro tempore. The gentleman from North Carolina (Mr. BURR) has 5 minutes remaining, and the gentleman from Massachusetts (Mr. MARKEY) has 6 minutes remaining.

Mr. BURR. Mr. Speaker, I yield myself 2 minutes. Mr. Speaker, we are here today to get rid of unwanted sexually explicit e-mail, but we are also here to protect those individuals who want to use e-mail as a commercial tool in a responsible way based upon the rules, and the challenge for us was to design something that allowed commerce to take place but that got at the heart of what all of us wanted to do, and that is to get the smut off of our screen, to make sure that the ones that were unsolicited and that we did not want to see again, that we had the opportunity to get rid of them. And I am going to tell the Members it was tough, I think we would all agree, trying to find the right language, the right word in some cases, to make sure that the right penalty was in place but it did not go too far. And I think it is safe to say today that there is no single piece of legislation that will ultimately solve the spam problem.

It is my hope that this bill is an excellent first start. I believe that it is appropriate to praise the gentleman from Louisiana (Chairman TAUZIN) and the gentleman from Michigan (Mr. DINGELL), ranking member, and Gregg Rothschild and David Cavicke and many other committee staff and personal staffs that worked tirelessly to try to come up with a solution to the problem that we had. The FTC's own estimates estimate that 20 percent of all spam contains advertising of pornography. That is not counting the spam that we received that has deceptive content and fraudulent content.

Mr. Speaker, we are here today because we think we found the right blueprint. We think those businesses that are reputable can continue, and they can live within the framework, and they can live by the rules, and, hopefully, this will help to chase those that intended not to live by the rules out of the system and off our screen.

I want to praise once again both committees, the Committee on the Judiciary and the Committee on Energy and Commerce, the staffs and the members, and urge support for this bill.

Mr. MARKEY. Mr. Speaker, I yield 1 minute to the gentleman from Michigan (Mr. DINGELL).

Mr. DINGELL. Mr. Speaker, I thank the distinguished gentleman from Massachusetts for yielding me this time.

And I just want the attention of the gentleman from North Carolina (Mr. BURR). I want to pay tribute to him for the very honorable and splendid way in which he has worked with us to bring this matter to conclusion. Without his labors and those of the gentleman from Louisiana (Mr. TAUZIN), chairman of the Committee on Energy and Commerce, we would not be here talking about this matter. And I thank both gentlemen, and I thank also Jonathan Cordone.

Mr. MARKEY. Mr. Speaker, I yield myself such time as I may consume.

And I yield myself that time in order to conclude the debate for the Democratic side, and I would like to point out how important this bill is.

Congress many times acts in areas where most Americans say "How does that affect me?" This legislation will now affect every computer in the United States in the way in which it affects the user of that computer, and it will affect every user of a cell phone in the way that that cell phone is used or, to be more explicit, the way in which marketers abuse those phones and computers. So this is a great day, and the gentlewoman from New Mexico (Mrs. WILSON) and the gentleman from Texas (Mr. GREEN) did a great job in bringing it to our attention, and the gentleman from Louisiana (Chairman TAUZIN) and the gentleman from Michigan (Mr. DINGELL), in putting together an environment in which we can negotiate this bill out in a bipartisan fashion.

The litany of saints is long, and I mentioned many of them earlier. I would like to add the gentleman from Michigan (Mr. CONYERS), the ranking member of the Committee on the Judiciary. He and his staff contributed significantly to this legislation. To the gentleman from North Carolina (Mr. BURR), I want to congratulate him and his excellent work on this legislation. The consumers will be the beneficiary. I want to mention the gentlewoman from Silicon Valley, California (Ms. ESHOO) for all of her wonderful work on this legislation. The gentleman from New Jersey (Mr. HOLT), who had a deep interest in the wireless aspects of this legislation, I think he deserves credit for what is happening here today. The gentleman from Louisiana (Chairman TAUZIN), David Cavicke did a great job, and I think I should mention Howard Waltzman as well on the chairman's staff for his excellent work; on the gentleman from Michigan's (Mr. UPTON) staff, Will Nordwind, who has been working on this for several months, as well with the chairman. And I would conclude by thanking my own staff, Colin Crowell, who throughout this year had a plan to include a wireless cell phone antispam provision in the legislation, and today we see the fruition of all of his excellent work, and I think that consumers will be the beneficiary for the generation ahead. So I conclude by complimenting the chairman.

Mr. Speaker, I yield back the balance of my time.

Mr. TAUZIN. Mr. Speaker, I yield myself such time as I may consume.

In concluding, let me, first of all, again signal the extraordinary cooperation that exists between the Committee on the Judiciary and the Committee on Energy and Commerce as we conclude this debate and also to echo thanks and congratulations the gentleman from Massachusetts (Mr. MARKEY) has extended to so many of our staff and the members who have worked on this.

This is a consumer protection piece of legislation. Very often when we come to these consumer protection-type pieces of legislation, we will see this extraordinary bipartisanism and this ability of committees that often have conflicting versions of bills work them out as we have today. This is a huge consumer protection piece of legislation.

And I want to say something that I hope all the Federal judges of America will pay attention to tonight very carefully. This legislation specifically authorizes the Federal Trade Commission to create a Do Not Spam Registry. No one should have any doubt about it. It is as clear, it is explicit. When this legislation passes the Congress and is signed into law, the FTC will explicitly have that authority, and a Do Not Spam Registry will be available in our future.

I want to particularly thank the gentlewoman from New Mexico (Mrs. WILSON), the gentleman from North Carolina (Mr. BURR), the gentleman from Texas (Mr. GREEN). Of all the members who have put in yeoman hours in time and effort, these three members of our committee have done an extraordinary job. And I particularly, again, want to single out the gentleman from Michigan (Mr. DINGELL) and the gentleman from Massachusetts (Mr. MARKEY) with, again, the bipartisan spirit in which we worked together when we can and do work together so well. This is a good example where America will benefit because we are legislating as Americans and not as party members as we often do on this floor. And I want to thank the gentleman, again, for that respect and that spirit of cooperation that he always extended to the chair and to the management of our committee affairs.

Again, Mr. Speaker, this is an important day for consumers in America. Very soon a Do Not Spam Registry will be available to them. They will be able to call and have their names put on that registry. People who refuse to pay attention to that registry and spam them regardless will be subject to severe penalties. People who fraudulently continue to spam without identifying who they are, when they are caught, will pay a big price. Attorney Generals and the FTC are given enforcement authority under this compromise, and I think we are affording Americans with a brand new tool to protect themselves against the entry of material they do not want in their homes whether it comes in through the computer, through the telephone, or via the mail. This is a great step forward, and I urge adoption of this bill.

Ms. ESHOO. Mr. Speaker, I support the conference report and thank the chairman and ranking member for their work in this effort. I'm particularly pleased that the serious shortcomings of the bill which I've raised at our committee have been addressed.

The problem of spam has become so prolific that by the end of this year half of all e-mails sent will be spam.

The numbers are staggering: 76 billion spam e-mails will be delivered in 2003; 50 percent of kids have received e-mails containing pornographic or sexually explicit information; and U.S. businesses will spend close to $10 billion to fight spam this year.

And marketers have brazenly claimed that the success of the "Do Not Call List" will drive them to spam even more, costing U.S. businesses and consumers even more.

I sponsored legislation to curb the epidemic of spam and crafted the original proposal to empower the FTC to replicate the enormous success of the "Do Not Call List" by creating a "Cannot Spam List." I'm very pleased that a version of this measure has been included in the conference report, which I hope the FTC will implement soon after enactment of this bill.

I'm also pleased that the conference report strengthens some of the weaknesses of the Senate bill, especially by giving greater authority to states to enforce these laws.

This legislation does not end the entire problem of spam. I'll continue to fight for measures to prevent unauthorized and unwanted e-mail from flooding our inboxes and our computer networks. But this is a good start and important and I urge my colleagues to support it.

Mr. HOLT. Mr. Speaker, I rise in support of the anti-spam legislation before us, S. 877.

I am glad to see that Congress has finally taken definitive action on this issue. During my first term in Congress, I worked with my colleagues GENE GREEN and HEATHER WILSON, who have shown great leadership here, on anti-spam legislation that passed the House in 2000.

Today we have before us legislation to help address the mounting problem of unsolicited e-mail advertising, or spam, which has become perhaps the biggest nuisance of the Information Age and a drain on our economy.

I am particularly pleased that this legislation includes a provision intended to combat a related problem that has gotten out of hand in some countries and is growing ever worse in the United States—spam sent to wireless phones through text messaging.

As many of my colleagues know, I introduced legislation intended to draw attention to this issue—the Wireless Telephone Spam Protection Act. This bill was intended to launch what could be called a preemptive attack against wireless spam before it spins out of control in the United States. Congress too often acts once the fire is already lit. This time, we can put the fire out before it gets out of control.

The Japanese are already fighting off a tsunami of cell phone spam. On one recent day, the 38 million customers of the largest Japanese wireless company, NTT DoCoMo, received 150 million pieces of spam. Even today, after passage of anti-spam laws in Japan, DoCoMo's subscribers still receive up to 30 million wireless spam messages each day. This has caused millions of Japanese wireless phone users to simply stop using their cell phone service.

So far, U.S. cell phone users have been largely sparred this torrent of annoying, unwanted messages. I presume this is because a lot of telemarketers don't believe there are enough text-capable cell phones in the country. Most new phones are text capably, however, and the number of text messages sent in this country has been rising rapidly, quadrupling from 250 million messages sent in December 2001 to 1 billion messages sent in December 2002. Seventeen percent of cellular customers, about 23 million people, currently use text messaging—including 45 percent of cell phone users in the lucrative 18-to-25-year-old category. Direct marketers are already beginning to salivate.

That is why I am glad to see that this legislation includes a provision instructing the Federal Trade Commission to promulgate an opt-in rule for wireless spam. I would like to thank Mr. MARKEY for his work on this issue, and I would like to salute all of those who put this legislation together. It is by no means cure-all, but it is certainly a good first step towards ending the onslaught of e-mail spam and the tsunami of wireless spam. I urge my colleagues to support this bill.

Mr. STUPAK. Mr. Speaker, for several Congresses now we have had hearings and markups in the Energy and Commerce Committee on the nuisance of spam, but no progress has been made. I am pleased that a bill has finally come forward that looks headed for passage into law.

Through all this time, the flood of unsolicited e-mails has only grown, ISPs have become more and more overwhelmed, and consumers more aggravated.

I know that this bill will come as a welcome relief to many who are fed up with opening their e-mail accounts only have to unwanted commercial e-mails clogging up their Internet mailboxes.

Consumers have to waste time deleting numerous spam emails, and even worse, if they do unsuspectingly open one of these e-mails, they are often faced with offensive pornography.

I commend the members of the Judiciary and Energy and Commerce Committees for their ongoing efforts to address this problem, and I am pleased to support this bill.

I do believe that the bill falls short in one area, in that it does not provide a private right of action for individual consumers to seek their own remedies. But this legislation does much to strengthen enforcement, provide protection from harmful pornographic e-mails, and to set up a Do Not Spam Registry, which I can only guess will be as popular as the Do Not Call Registry.

I hope that this bill will put control over Internet mailboxes back in the hands of consumers, so that they can choose to receive e-mails that they want, and to get rid of e-mails that they do not.

And to those businesses and individuals that violate these provisions and send out spam illegally, this bill will provide the Federal Trade Commission, state attorney generals, and Internet Service Providers with the tools to crack down on these violators.

As the House attempts to wrap up its work for the session, there have been several bills coming to the floor that I do not believe have merit. This bill, however, shows that when we want to, Congress can truly act for the public benefit.

Mr. STEARNS. Mr. Speaker, I am pleased to join Chairman TAUZIN, Chairman SENSENBRENNER, Messrs. DINGELL and BURR, and Mrs. WILSON in supporting a good consumer protection bill that I hope will help us, as consumers, fight the scourge that is spam.

No one disputes the great utility of e-mail, the fact that it has brought great efficiency and productivity gains, not only to our professional lives but also our personal lives. Nonetheless, our daily routine of scouring through and reviewing our e-mail also tells us that e-mail as a critical communications medium is under assault from unwanted e-mail—most peddling goods or services ranging from the real to the absurd. I do not have a problem with e-marketing per se, after all, our consumer based economy is highly dependent on marketing. However, e-mail communications make accountability more difficult. Therefore, unscrupulous people use it to advance fraudulent and deceptive acts and even good commercial actors are tempted to take advantage of this lack of accountability.

Effective and narrowly tailored legislation, like the one before us today, can help bring greater accountability to e-mail solicitations. That greater accountability is achieved by making sure that fraud and deception is prosecuted and subjected to severe penalties.

Legislation is only part of the solution, and in my view a smaller part. Rather, technology, consumer education, and industry cooperation, in my view, are the key tools in combating spam and injecting real and effective accountability. Finally, combating spam requires international cooperation. I think my bi-partisan bill, H.R. 3143, which strengthens the Federal Trade Commission's ability to address the growing problem of transnational fraud, will go a long way in fighting spam that is not home grown.

Mr. TAUZIN. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Louisiana (Mr. TAUZIN) that the House suspend the rules and pass the Senate bill, S. 877, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. TAUZIN. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

CONFERENCE REPORT ON H.R. 2622, FAIR AND ACCURATE CREDIT TRANSACTIONS ACT OF 2003

Mr. OXLEY (during consideration of H. Res. 458) submitted the following conference report and statement on the bill (H.R. 2622) to amend the Fair Credit Reporting Act, to prevent identity theft, improve resolution of consumer disputes, improve the accuracy of consumer records, make improvements in the use of, and consumer access to, credit information, and for other purposes:

CONFERENCE REPORT (H. REPT. 108–396)

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2622), to amend the Fair Credit Reporting Act, to prevent identity theft, improve resolution of consumer disputes, improve the accuracy of consumer records, make improvements in the use of, and consumer access to, credit information, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment, insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Fair and Accurate Credit Transactions Act of 2003".

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Definitions.
Sec. 3. Effective dates.

TITLE I—IDENTITY THEFT PREVENTION AND CREDIT HISTORY RESTORATION

Subtitle A—Identity Theft Prevention

Sec. 111. Amendment to definitions.
Sec. 112. Fraud alerts and active duty alerts.
Sec. 113. Truncation of credit card and debit card account numbers.
Sec. 114. Establishment of procedures for the identification of possible instances of identity theft.
Sec. 115. Authority to truncate social security numbers.

Subtitle B—Protection and Restoration of Identity Theft Victim Credit History

Sec. 151. Summary of rights of identity theft victims.
Sec. 152. Blocking of information resulting from identity theft.
Sec. 153. Coordination of identity theft complaint investigations.
Sec. 154. Prevention of repollution of consumer reports.
Sec. 155. Notice by debt collectors with respect to fraudulent information.
Sec. 156. Statute of limitations.
Sec. 157. Study on the use of technology to combat identity theft.

TITLE II—IMPROVEMENTS IN USE OF AND CONSUMER ACCESS TO CREDIT INFORMATION

Sec. 211. Free consumer reports.
Sec. 212. Disclosure of credit scores.
Sec. 213. Enhanced disclosure of the means available to opt out of prescreened lists.
Sec. 214. Affiliate sharing.
Sec. 215. Study of effects of credit scores and credit-based insurance scores on availability and affordability of financial products.
Sec. 216. Disposal of consumer report information and records.
Sec. 217. Requirement to disclose communications to a consumer reporting agency.

TITLE III—ENHANCING THE ACCURACY OF CONSUMER REPORT INFORMATION

Sec. 311. Risk-based pricing notice.
Sec. 312. Procedures to enhance the accuracy and integrity of information furnished to consumer reporting agencies.
Sec. 313. FTC and consumer reporting agency action concerning complaints.
Sec. 314. Improved disclosure of the results of reinvestigation.
Sec. 315. Reconciling addresses.
Sec. 316. Notice of dispute through reseller.
Sec. 317. Reasonable reinvestigation required.
Sec. 318. FTC study of issues relating to the Fair Credit Reporting Act.
Sec. 319. FTC study of the accuracy of consumer reports.

TITLE IV—LIMITING THE USE AND SHARING OF MEDICAL INFORMATION IN THE FINANCIAL SYSTEM

Sec. 411. Protection of medical information in the financial system.
Sec. 412. Confidentiality of medical contact information in consumer reports.

TITLE V—FINANCIAL LITERACY AND EDUCATION IMPROVEMENT

Sec. 511. Short title.
Sec. 512. Definitions.
Sec. 513. Establishment of Financial Literacy and Education Commission.
Sec. 514. Duties of the Commission.
Sec. 515. Powers of the Commission.
Sec. 516. Commission personnel matters.
Sec. 517. Studies by the Comptroller General.
Sec. 518. The national public service multimedia campaign to enhance the state of financial literacy.
Sec. 519. Authorization of appropriations.

TITLE VI—PROTECTING EMPLOYEE MISCONDUCT INVESTIGATIONS

Sec. 611. Certain employee investigation communications excluded from definition of consumer report.

TITLE VII—RELATION TO STATE LAWS

Sec. 711. Relation to State laws.

TITLE VIII—MISCELLANEOUS

Sec. 811. Clerical amendments.

SEC. 2. DEFINITIONS.

As used in this Act—

(1) the term "Board" means the Board of Governors of the Federal Reserve System;

(2) the term "Commission", other than as used in title V, means the Federal Trade Commission;

(3) the terms "consumer", "consumer report", "consumer reporting agency", "creditor", "Federal banking agencies", and "financial institution" have the same meanings as in section 603 of the Fair Credit Reporting Act, as amended by this Act; and

(4) the term "affiliates" means persons that are related by common ownership or affiliated by corporate control.

SEC. 3. EFFECTIVE DATES.

Except as otherwise specifically provided in this Act and the amendments made by this Act—

(1) before the end of the 2-month period beginning on the date of enactment of this Act, the Board and the Commission shall jointly prescribe regulations in final form establishing effective dates for each provision of this Act; and

(2) the regulations prescribed under paragraph (1) shall establish effective dates that are as early as possible, while allowing a reasonable time for the implementation of the provisions of this Act, but in no case shall any such effective date be later than 10 months after the date of issuance of such regulations in final form.

TITLE I—IDENTITY THEFT PREVENTION AND CREDIT HISTORY RESTORATION

Subtitle A—Identity Theft Prevention

SEC. 111. AMENDMENT TO DEFINITIONS.

Section 603 of the Fair Credit Reporting Act (15 U.S.C. 1681a) is amended by adding at the end the following:

"(q) DEFINITIONS RELATING TO FRAUD ALERTS.—

"(1) ACTIVE DUTY MILITARY CONSUMER.—The term 'active duty military consumer' means a consumer in military service who—

"(A) is on active duty (as defined in section 101(d)(1) of title 10, United States Code) or is a reservist performing duty under a call or order to active duty under a provision of law referred to in section 101(a)(13) of title 10, United States Code; and

"(B) is assigned to service away from the usual duty station of the consumer.

"(2) FRAUD ALERT; ACTIVE DUTY ALERT.—The terms 'fraud alert' and 'active duty alert' mean a statement in the file of a consumer that—

"(A) notifies all prospective users of a consumer report relating to the consumer that the consumer may be a victim of fraud, including identity theft, or is an active duty military consumer, as applicable; and

"(B) is presented in a manner that facilitates a clear and conspicuous view of the statement described in subparagraph (A) by any person requesting such consumer report.

"(3) IDENTITY THEFT.—The term 'identity theft' means a fraud committed using the identifying information of another person, subject to such further definition as the Commission may prescribe, by regulation.

"(4) IDENTITY THEFT REPORT.—The term 'identity theft report' has the meaning given that term by rule of the Commission, and means, at a minimum, a report—

"(A) that alleges an identity theft;

"(B) that is a copy of an official, valid report filed by a consumer with an appropriate Federal, State, or local law enforcement agency, including the United States Postal Inspection Service, or such other government agency deemed appropriate by the Commission; and

"(C) the filing of which subjects the person filing the report to criminal penalties relating to the filing of false information if, in fact, the information in the report is false.

"(5) NEW CREDIT PLAN.—The term 'new credit plan' means a new account under an open end credit plan (as defined in section 103(i) of the Truth in Lending Act) or a new credit transaction not under an open end credit plan.

"(r) CREDIT AND DEBIT RELATED TERMS—

"(1) CARD ISSUER.—The term 'card issuer' means—

"(A) a credit card issuer, in the case of a credit card; and

"(B) a debit card issuer, in the case of a debit card.

"(2) CREDIT CARD.—The term 'credit card' has the same meaning as in section 103 of the Truth in Lending Act.

"(3) DEBIT CARD.—The term 'debit card' means any card issued by a financial institution to a consumer for use in initiating an electronic fund transfer from the account of the consumer at such financial institution, for the purpose of transferring money between accounts or obtaining money, property, labor, or services.

"(4) ACCOUNT AND ELECTRONIC FUND TRANSFER.—The terms 'account' and 'electronic fund transfer' have the same meanings as in section 903 of the Electronic Fund Transfer Act.

"(5) CREDIT AND CREDITOR.—The terms 'credit' and 'creditor' have the same meanings as in section 702 of the Equal Credit Opportunity Act.

"(s) FEDERAL BANKING AGENCY.—The term 'Federal banking agency' has the same meaning as in section 3 of the Federal Deposit Insurance Act.

"(t) FINANCIAL INSTITUTION.—The term 'financial institution' means a State or National bank, a State or Federal savings and loan association, a mutual savings bank, a State or Federal credit union, or any other person that, directly or indirectly, holds a transaction account (as defined in section 19(b) of the Federal Reserve Act) belonging to a consumer.

"(u) RESELLER.—The term 'reseller' means a consumer reporting agency that—

"(1) assembles and merges information contained in the database of another consumer reporting agency or multiple consumer reporting agencies concerning any consumer for purposes of furnishing such information to any third party, to the extent of such activities; and

"(2) does not maintain a database of the assembled or merged information from which new consumer reports are produced.

"(v) COMMISSION.—The term 'Commission' means the Federal Trade Commission.

"(w) NATIONWIDE SPECIALTY CONSUMER REPORTING AGENCY.—The term 'nationwide specialty consumer reporting agency' means a consumer reporting agency that compiles and maintains files on consumers on a nationwide basis relating to—

"(1) medical records or payments;

"(2) residential or tenant history;

"(3) check writing history;

"(4) employment history; or

"(5) insurance claims.".

SEC. 112. FRAUD ALERTS AND ACTIVE DUTY ALERTS.

(a) FRAUD ALERTS.—The Fair Credit Reporting Act (15 U.S.C. 1681 et seq.) is amended by inserting after section 605 the following:

"§605A. Identity theft prevention; fraud alerts and active duty alerts

"(a) ONE-CALL FRAUD ALERTS.—

"(1) INITIAL ALERTS.—Upon the direct request of a consumer, or an individual acting on behalf of or as a personal representative of a consumer, who asserts in good faith a suspicion that the consumer has been or is about to become a victim of fraud or related crime, including identity theft, a consumer reporting agency described in section 603(p) that maintains a file on the consumer and has received appropriate proof of the identity of the requester shall—

"(A) include a fraud alert in the file of that consumer, and also provide that alert along with any credit score generated in using that file, for a period of not less than 90 days, beginning on the date of such request, unless the consumer or such representative requests that such fraud alert be removed before the end of such period, and the agency has received appropriate proof of the identity of the requester for such purpose; and

"(B) refer the information regarding the fraud alert under this paragraph to each of the other consumer reporting agencies described in section 603(p), in accordance with procedures developed under section 621(f).

"(2) ACCESS TO FREE REPORTS.—In any case in which a consumer reporting agency includes a fraud alert in the file of a consumer pursuant to this subsection, the consumer reporting agency shall—

"(A) disclose to the consumer that the consumer may request a free copy of the file of the consumer pursuant to section 612(d); and

"(B) provide to the consumer all disclosures required to be made under section 609, without charge to the consumer, not later than 3 business days after any request described in subparagraph (A).

"(b) EXTENDED ALERTS.—

"(1) IN GENERAL.—Upon the direct request of a consumer, or an individual acting on behalf of or as a personal representative of a consumer, who submits an identity theft report to a consumer reporting agency described in section 603(p) that maintains a file on the consumer, if the agency has received appropriate proof of the identity of the requester, the agency shall—

"(A) include a fraud alert in the file of that consumer, and also provide that alert along with any credit score generated in using that file, during the 7-year period beginning on the date of such request, unless the consumer or such representative requests that such fraud alert be removed before the end of such period and the agency has received appropriate proof of the identity of the requester for such purpose;

"(B) during the 5-year period beginning on the date of such request, exclude the consumer from any list of consumers prepared by the consumer reporting agency and provided to any third party to offer credit or insurance to the consumer as part of a transaction that was not initiated by the consumer, unless the consumer or such representative requests that such exclusion be rescinded before the end of such period; and

"(C) refer the information regarding the extended fraud alert under this paragraph to each of the other consumer reporting agencies described in section 603(p), in accordance with procedures developed under section 621(f).

"(2) ACCESS TO FREE REPORTS.—In any case in which a consumer reporting agency includes a fraud alert in the file of a consumer pursuant to this subsection, the consumer reporting agency shall—

"(A) disclose to the consumer that the consumer may request 2 free copies of the file of the consumer pursuant to section 612(d) during the 12-month period beginning on the date on which the fraud alert was included in the file; and

"(B) provide to the consumer all disclosures required to be made under section 609, without charge to the consumer, not later than 3 business days after any request described in subparagraph (A).

"(c) ACTIVE DUTY ALERTS.—Upon the direct request of an active duty military consumer, or an individual acting on behalf of or as a personal representative of an active duty military consumer, a consumer reporting agency described in section 603(p) that maintains a file on the active duty military consumer and has received appropriate proof of the identity of the requester shall—

"(1) include an active duty alert in the file of that active duty military consumer, and also provide that alert along with any credit score generated in using that file, during a period of not less than 12 months, or such longer period as the Commission shall determine, by regulation, beginning on the date of the request, unless the active duty military consumer or such representative requests that such fraud alert be removed before the end of such period, and the agency has received appropriate proof of the identity of the requester for such purpose;

"(2) during the 2-year period beginning on the date of such request, exclude the active duty military consumer from any list of consumers prepared by the consumer reporting agency and provided to any third party to offer credit or insurance to the consumer as part of a transaction that was not initiated by the consumer, unless the consumer requests that such exclusion be rescinded before the end of such period; and

"(3) refer the information regarding the active duty alert to each of the other consumer reporting agencies described in section 603(p), in accordance with procedures developed under section 621(f).

"(d) PROCEDURES.—Each consumer reporting agency described in section 603(p) shall establish policies and procedures to comply with this section, including procedures that inform consumers of the availability of initial, extended, and active duty alerts and procedures that allow consumers and active duty military consumers to request initial, extended, or active duty alerts (as applicable) in a simple and easy manner, including by telephone.

"(e) REFERRALS OF ALERTS.—Each consumer reporting agency described in section 603(p) that receives a referral of a fraud alert or active duty alert from another consumer reporting agency pursuant to this section shall, as though the agency received the request from the consumer directly, follow the procedures required under—

"(1) paragraphs (1)(A) and (2) of subsection (a), in the case of a referral under subsection (a)(1)(B);

"(2) paragraphs (1)(A), (1)(B), and (2) of subsection (b), in the case of a referral under subsection (b)(1)(C); and

"(3) paragraphs (1) and (2) of subsection (c), in the case of a referral under subsection (c)(3).

"(f) DUTY OF RESELLER TO RECONVEY ALERT.—A reseller shall include in its report any fraud alert or active duty alert placed in the file of a consumer pursuant to this section by another consumer reporting agency.

"(g) DUTY OF OTHER CONSUMER REPORTING AGENCIES TO PROVIDE CONTACT INFORMATION.—If a consumer contacts any consumer reporting agency that is not described in section 603(p) to communicate a suspicion that the consumer has been or is about to become a victim of fraud or related crime, including identity theft, the agency shall provide information to the consumer on how to contact the Commission and the consumer reporting agencies described in section 603(p) to obtain more detailed information and request alerts under this section.

"(h) LIMITATIONS ON USE OF INFORMATION FOR CREDIT EXTENSIONS..—

"(1) REQUIREMENTS FOR INITIAL AND ACTIVE DUTY ALERTS.—

"(A) NOTIFICATION.—Each initial fraud alert and active duty alert under this section shall include information that notifies all prospective users of a consumer report on the consumer to which the alert relates that the consumer does not authorize the establishment of any new credit plan or extension of credit, other than under an open-end credit plan (as defined in section 103(i)), in the name of the consumer, or issuance of an additional card on an existing credit account requested by a consumer, or any increase in credit limit on an existing credit account requested by a consumer, except in accordance with subparagraph (B).

"(B) LIMITATION ON USERS.—

"(i) IN GENERAL.—No prospective user of a consumer report that includes an initial fraud alert or an active duty alert in accordance with this section may establish a new credit plan or extension of credit, other than under an open-end credit plan (as defined in section 103(i)), in the name of the consumer, or issue an additional card on an existing credit account requested by a consumer, or grant any increase in credit limit on an existing credit account requested by a consumer, unless the user utilizes reasonable policies and procedures to form a reasonable belief that the user knows the identity of the person making the request.

"(ii) VERIFICATION.—If a consumer requesting the alert has specified a telephone number to be used for identity verification purposes, before authorizing any new credit plan or extension described in clause (i) in the name of such consumer, a user of such consumer report shall contact the consumer using that telephone number or take reasonable steps to verify the consumer's identity and confirm that the application for a new credit plan is not the result of identity theft.

"(2) REQUIREMENTS FOR EXTENDED ALERTS.—

"(A) NOTIFICATION.—Each extended alert under this section shall include information that provides all prospective users of a consumer report relating to a consumer with—

"(i) notification that the consumer does not authorize the establishment of any new credit plan or extension of credit described in clause (i), other than under an open-end credit plan (as defined in section 103(i)), in the name of the consumer, or issuance of an additional card on an existing credit account requested by a consumer, or any increase in credit limit on an existing credit account requested by a consumer, except in accordance with subparagraph (B); and

"(ii) a telephone number or other reasonable contact method designated by the consumer.

"(B) LIMITATION ON USERS.—No prospective user of a consumer report or of a credit score generated using the information in the file of a consumer that includes an extended fraud alert in accordance with this section may establish a new credit plan or extension of credit, other than under an open-end credit plan (as defined in section 103(i)), in the name of the consumer, or issue an additional card on an existing credit account requested by a consumer, or any increase in credit limit on an existing credit account requested by a consumer, unless the user

contacts the consumer in person or using the contact method described in subparagraph (A)(ii) to confirm that the application for a new credit plan or increase in credit limit, or request for an additional card is not the result of identity theft.".

(b) RULEMAKING.—The Commission shall prescribe regulations to define what constitutes appropriate proof of identity for purposes of sections 605A, 605B, and 609(a)(1) of the Fair Credit Reporting Act, as amended by this Act.

SEC. 113. TRUNCATION OF CREDIT CARD AND DEBIT CARD ACCOUNT NUMBERS.

Section 605 of the Fair Credit Reporting Act (15 U.S.C. 1681c) is amended by adding at the end the following:

"(g) TRUNCATION OF CREDIT CARD AND DEBIT CARD NUMBERS.—

"(1) IN GENERAL.—Except as otherwise provided in this subsection, no person that accepts credit cards or debit cards for the transaction of business shall print more than the last 5 digits of the card number or the expiration date upon any receipt provided to the cardholder at the point of the sale or transaction.

"(2) LIMITATION.—This subsection shall apply only to receipts that are electronically printed, and shall not apply to transactions in which the sole means of recording a credit card or debit card account number is by handwriting or by an imprint or copy of the card.

"(3) EFFECTIVE DATE.—This subsection shall become effective—

"(A) 3 years after the date of enactment of this subsection, with respect to any cash register or other machine or device that electronically prints receipts for credit card or debit card transactions that is in use before January 1, 2005; and

"(B) 1 year after the date of enactment of this subsection, with respect to any cash register or other machine or device that electronically prints receipts for credit card or debit card transactions that is first put into use on or after January 1, 2005.".

SEC. 114. ESTABLISHMENT OF PROCEDURES FOR THE IDENTIFICATION OF POSSIBLE INSTANCES OF IDENTITY THEFT.

Section 615 of the Fair Credit Reporting Act (15 U.S.C. 1681m) is amended—

(1) by striking "(e)" at the end; and

(2) by adding at the end the following:

"(e) RED FLAG GUIDELINES AND REGULATIONS REQUIRED.—

"(1) GUIDELINES.—The Federal banking agencies, the National Credit Union Administration, and the Commission shall jointly, with respect to the entities that are subject to their respective enforcement authority under section 621—

"(A) establish and maintain guidelines for use by each financial institution and each creditor regarding identity theft with respect to account holders at, or customers of, such entities, and update such guidelines as often as necessary;

"(B) prescribe regulations requiring each financial institution and each creditor to establish reasonable policies and procedures for implementing the guidelines established pursuant to subparagraph (A), to identify possible risks to account holders or customers or to the safety and soundness of the institution or customers; and

"(C) prescribe regulations applicable to card issuers to ensure that, if a card issuer receives notification of a change of address for an existing account, and within a short period of time (during at least the first 30 days after such notification is received) receives a request for an additional or replacement card for the same account, the card issuer may not issue the additional or replacement card, unless the card issuer, in accordance with reasonable policies and procedures—

"(i) notifies the cardholder of the request at the former address of the cardholder and provides to the cardholder a means of promptly reporting incorrect address changes;

"(ii) notifies the cardholder of the request by such other means of communication as the cardholder and the card issuer previously agreed to; or

"(iii) uses other means of assessing the validity of the change of address, in accordance with reasonable policies and procedures established by the card issuer in accordance with the regulations prescribed under subparagraph (B).

"(2) CRITERIA.—

"(A) IN GENERAL.—In developing the guidelines required by paragraph (1)(A), the agencies described in paragraph (1) shall identify patterns, practices, and specific forms of activity that indicate the possible existence of identity theft.

"(B) INACTIVE ACCOUNTS.—In developing the guidelines required by paragraph (1)(A), the agencies described in paragraph (1) shall consider including reasonable guidelines providing that when a transaction occurs with respect to a credit or deposit account that has been inactive for more than 2 years, the creditor or financial institution shall follow reasonable policies and procedures that provide for notice to be given to a consumer in a manner reasonably designed to reduce the likelihood of identity theft with respect to such account.

"(3) CONSISTENCY WITH VERIFICATION REQUIREMENTS.—Guidelines established pursuant to paragraph (1) shall not be inconsistent with the policies and procedures required under section 5318(l) of title 31, United States Code.".

SEC. 115. AUTHORITY TO TRUNCATE SOCIAL SECURITY NUMBERS.

Section 609(a)(1) of the Fair Credit Reporting Act (15 U.S.C. 1681g(a)(1)) is amended by striking "except that nothing" and inserting the following: "except that—

"(A) if the consumer to whom the file relates requests that the first 5 digits of the social security number (or similar identification number) of the consumer not be included in the disclosure and the consumer reporting agency has received appropriate proof of the identity of the requester, the consumer reporting agency shall so truncate such number in such disclosure; and

"(B) nothing".

Subtitle B—Protection and Restoration of Identity Theft Victim Credit History

SEC. 151. SUMMARY OF RIGHTS OF IDENTITY THEFT VICTIMS.

(a) IN GENERAL.—

(1) SUMMARY.—Section 609 of the Fair Credit Reporting Act (15 U.S.C. 1681g) is amended by adding at the end the following:

"(d) SUMMARY OF RIGHTS OF IDENTITY THEFT VICTIMS.—

"(1) IN GENERAL.—The Commission, in consultation with the Federal banking agencies and the National Credit Union Administration, shall prepare a model summary of the rights of consumers under this title with respect to the procedures for remedying the effects of fraud or identity theft involving credit, an electronic fund transfer, or an account or transaction at or with a financial institution or other creditor.

"(2) SUMMARY OF RIGHTS AND CONTACT INFORMATION.—Beginning 60 days after the date on which the model summary of rights is prescribed in final form by the Commission pursuant to paragraph (1), if any consumer contacts a consumer reporting agency and expresses a belief that the consumer is a victim of fraud or identity theft involving credit, an electronic fund transfer, or an account or transaction at or with a financial institution or other creditor, the consumer reporting agency shall, in addition to any other action that the agency may take, provide the consumer with a summary of rights that contains all of the information required by the Commission under paragraph (1), and information on how to contact the Commission to obtain more detailed information.

"(e) INFORMATION AVAILABLE TO VICTIMS.—

"(1) IN GENERAL.—For the purpose of documenting fraudulent transactions resulting from identity theft, not later than 30 days after the date of receipt of a request from a victim in accordance with paragraph (3), and subject to verification of the identity of the victim and the claim of identity theft in accordance with paragraph (2), a business entity that has provided credit to, provided for consideration products, goods, or services to, accepted payment from, or otherwise entered into a commercial transaction for consideration with, a person who has allegedly made unauthorized use of the means of identification of the victim, shall provide a copy of application and business transaction records in the control of the business entity, whether maintained by the business entity or by another person on behalf of the business entity, evidencing any transaction alleged to be a result of identity theft to—

"(A) the victim;

"(B) any Federal, State, or local government law enforcement agency or officer specified by the victim in such a request; or

"(C) any law enforcement agency investigating the identity theft and authorized by the victim to take receipt of records provided under this subsection.

"(2) VERIFICATION OF IDENTITY AND CLAIM.—Before a business entity provides any information under paragraph (1), unless the business entity, at its discretion, otherwise has a high degree of confidence that it knows the identity of the victim making a request under paragraph (1), the victim shall provide to the business entity—

"(A) as proof of positive identification of the victim, at the election of the business entity—

"(i) the presentation of a government-issued identification card;

"(ii) personally identifying information of the same type as was provided to the business entity by the unauthorized person; or

"(iii) personally identifying information that the business entity typically requests from new applicants or for new transactions, at the time of the victim's request for information, including any documentation described in clauses (i) and (ii); and

"(B) as proof of a claim of identity theft, at the election of the business entity—

"(i) a copy of a police report evidencing the claim of the victim of identity theft; and

"(ii) a properly completed—

"(I) copy of a standardized affidavit of identity theft developed and made available by the Commission; or

"(II) an affidavit of fact that is acceptable to the business entity for that purpose.

"(3) PROCEDURES.—The request of a victim under paragraph (1) shall—

"(A) be in writing;

"(B) be mailed to an address specified by the business entity, if any; and

"(C) if asked by the business entity, include relevant information about any transaction alleged to be a result of identity theft to facilitate compliance with this section including—

"(i) if known by the victim (or if readily obtainable by the victim), the date of the application or transaction; and

"(ii) if known by the victim (or if readily obtainable by the victim), any other identifying information such as an account or transaction number.

"(4) NO CHARGE TO VICTIM.—Information required to be provided under paragraph (1) shall be so provided without charge.

"(5) AUTHORITY TO DECLINE TO PROVIDE INFORMATION.—A business entity may decline to provide information under paragraph (1) if, in

the exercise of good faith, the business entity determines that—

"(A) this subsection does not require disclosure of the information;

"(B) after reviewing the information provided pursuant to paragraph (2), the business entity does not have a high degree of confidence in knowing the true identity of the individual requesting the information;

"(C) the request for the information is based on a misrepresentation of fact by the individual requesting the information relevant to the request for information; or

"(D) the information requested is Internet navigational data or similar information about a person's visit to a website or online service.

"(6) LIMITATION ON LIABILITY.—Except as provided in section 621, sections 616 and 617 do not apply to any violation of this subsection.

"(7) LIMITATION ON CIVIL LIABILITY.—No business entity may be held civilly liable under any provision of Federal, State, or other law for disclosure, made in good faith pursuant to this subsection.

"(8) NO NEW RECORDKEEPING OBLIGATION.—Nothing in this subsection creates an obligation on the part of a business entity to obtain, retain, or maintain information or records that are not otherwise required to be obtained, retained, or maintained in the ordinary course of its business or under other applicable law.

"(9) RULE OF CONSTRUCTION.—

"(A) IN GENERAL.—No provision of subtitle A of title V of Public Law 106–102, prohibiting the disclosure of financial information by a business entity to third parties shall be used to deny disclosure of information to the victim under this subsection.

"(B) LIMITATION.—Except as provided in subparagraph (A), nothing in this subsection permits a business entity to disclose information, including information to law enforcement under subparagraphs (B) and (C) of paragraph (1), that the business entity is otherwise prohibited from disclosing under any other applicable provision of Federal or State law.

"(10) AFFIRMATIVE DEFENSE.—In any civil action brought to enforce this subsection, it is an affirmative defense (which the defendant must establish by a preponderance of the evidence) for a business entity to file an affidavit or answer stating that—

"(A) the business entity has made a reasonably diligent search of its available business records; and

"(B) the records requested under this subsection do not exist or are not reasonably available.

"(11) DEFINITION OF VICTIM.—For purposes of this subsection, the term 'victim' means a consumer whose means of identification or financial information has been used or transferred (or has been alleged to have been used or transferred) without the authority of that consumer, with the intent to commit, or to aid or abet, an identity theft or a similar crime.

"(12) EFFECTIVE DATE.—This subsection shall become effective 180 days after the date of enactment of this subsection.

"(13) EFFECTIVENESS STUDY.—Not later than 18 months after the date of enactment of this subsection, the Comptroller General of the United States shall submit a report to Congress assessing the effectiveness of this provision.".

(2) RELATION TO STATE LAWS.—Section 625(b)(1) of the Fair Credit Reporting Act (15 U.S.C. 1681t(b)(1), as so redesignated) is amended by adding at the end the following new subparagraph:

"(G) section 609(e), relating to information available to victims under section 609(e);".

(b) PUBLIC CAMPAIGN TO PREVENT IDENTITY THEFT.—Not later than 2 years after the date of enactment of this Act, the Commission shall establish and implement a media and distribution campaign to teach the public how to prevent identity theft. Such campaign shall include existing Commission education materials, as well as radio, television, and print public service announcements, video cassettes, interactive digital video discs (DVD's) or compact audio discs (CD's), and Internet resources.

SEC. 152. BLOCKING OF INFORMATION RESULTING FROM IDENTITY THEFT.

(a) IN GENERAL.—The Fair Credit Reporting Act (15 U.S.C. 1681 et seq.) is amended by inserting after section 605A, as added by this Act, the following:

"§605B. Block of information resulting from identity theft

"(a) BLOCK.—Except as otherwise provided in this section, a consumer reporting agency shall block the reporting of any information in the file of a consumer that the consumer identifies as information that resulted from an alleged identity theft, not later than 4 business days after the date of receipt by such agency of—

"(1) appropriate proof of the identity of the consumer;

"(2) a copy of an identity theft report;

"(3) the identification of such information by the consumer; and

"(4) a statement by the consumer that the information is not information relating to any transaction by the consumer.

"(b) NOTIFICATION.—A consumer reporting agency shall promptly notify the furnisher of information identified by the consumer under subsection (a)—

"(1) that the information may be a result of identity theft;

"(2) that an identity theft report has been filed;

"(3) that a block has been requested under this section; and

"(4) of the effective dates of the block.

"(c) AUTHORITY TO DECLINE OR RESCIND.—

"(1) IN GENERAL.—A consumer reporting agency may decline to block, or may rescind any block, of information relating to a consumer under this section, if the consumer reporting agency reasonably determines that—

"(A) the information was blocked in error or a block was requested by the consumer in error;

"(B) the information was blocked, or a block was requested by the consumer, on the basis of a material misrepresentation of fact by the consumer relevant to the request to block; or

"(C) the consumer obtained possession of goods, services, or money as a result of the blocked transaction or transactions.

"(2) NOTIFICATION TO CONSUMER.—If a block of information is declined or rescinded under this subsection, the affected consumer shall be notified promptly, in the same manner as consumers are notified of the reinsertion of information under section 611(a)(5)(B).

"(3) SIGNIFICANCE OF BLOCK.—For purposes of this subsection, if a consumer reporting agency rescinds a block, the presence of information in the file of a consumer prior to the blocking of such information is not evidence of whether the consumer knew or should have known that the consumer obtained possession of any goods, services, or money as a result of the block.

"(d) EXCEPTION FOR RESELLERS.—

"(1) NO RESELLER FILE.—This section shall not apply to a consumer reporting agency, if the consumer reporting agency—

"(A) is a reseller;

"(B) is not, at the time of the request of the consumer under subsection (a), otherwise furnishing or reselling a consumer report concerning the information identified by the consumer; and

"(C) informs the consumer, by any means, that the consumer may report the identity theft to the Commission to obtain consumer information regarding identity theft.

"(2) RESELLER WITH FILE.—The sole obligation of the consumer reporting agency under this section, with regard to any request of a consumer under this section, shall be to block the consumer report maintained by the consumer reporting agency from any subsequent use, if—

"(A) the consumer, in accordance with the provisions of subsection (a), identifies, to a consumer reporting agency, information in the file of the consumer that resulted from identity theft; and

"(B) the consumer reporting agency is a reseller of the identified information.

"(3) NOTICE.—In carrying out its obligation under paragraph (2), the reseller shall promptly provide a notice to the consumer of the decision to block the file. Such notice shall contain the name, address, and telephone number of each consumer reporting agency from which the consumer information was obtained for resale.

"(e) EXCEPTION FOR VERIFICATION COMPANIES.—The provisions of this section do not apply to a check services company, acting as such, which issues authorizations for the purpose of approving or processing negotiable instruments, electronic fund transfers, or similar methods of payments, except that, beginning 4 business days after receipt of information described in paragraphs (1) through (3) of subsection (a), a check services company shall not report to a national consumer reporting agency described in section 603(p), any information identified in the subject identity theft report as resulting from identity theft.

"(f) ACCESS TO BLOCKED INFORMATION BY LAW ENFORCEMENT AGENCIES.—No provision of this section shall be construed as requiring a consumer reporting agency to prevent a Federal, State, or local law enforcement agency from accessing blocked information in a consumer file to which the agency could otherwise obtain access under this title.".

(b) CLERICAL AMENDMENT.—The table of sections for the Fair Credit Reporting Act (15 U.S.C. 1681 et seq.) is amended by inserting after the item relating to section 605 the following new items:

"605A. Identity theft prevention; fraud alerts and active duty alerts.
"605B. Block of information resulting from identity theft.".

SEC. 153. COORDINATION OF IDENTITY THEFT COMPLAINT INVESTIGATIONS.

Section 621 of the Fair Credit Reporting Act (15 U.S.C. 1681s) is amended by adding at the end the following:

"(f) COORDINATION OF CONSUMER COMPLAINT INVESTIGATIONS.—

"(1) IN GENERAL.—Each consumer reporting agency described in section 603(p) shall develop and maintain procedures for the referral to each other such agency of any consumer complaint received by the agency alleging identity theft, or requesting a fraud alert under section 605A or a block under section 605B.

"(2) MODEL FORM AND PROCEDURE FOR REPORTING IDENTITY THEFT.—The Commission, in consultation with the Federal banking agencies and the National Credit Union Administration, shall develop a model form and model procedures to be used by consumers who are victims of identity theft for contacting and informing creditors and consumer reporting agencies of the fraud.

"(3) ANNUAL SUMMARY REPORTS.—Each consumer reporting agency described in section 603(p) shall submit an annual summary report to the Commission on consumer complaints received by the agency on identity theft or fraud alerts.".

SEC. 154. PREVENTION OF REPOLLUTION OF CONSUMER REPORTS.

(a) PREVENTION OF REINSERTION OF ERRONEOUS INFORMATION.—Section 623(a) of the Fair

Credit Reporting Act (15 U.S.C. 1681s–2(a)) is amended by adding at the end the following:

"(6) DUTIES OF FURNISHERS UPON NOTICE OF IDENTITY THEFT-RELATED INFORMATION.—

"(A) REASONABLE PROCEDURES.—A person that furnishes information to any consumer reporting agency shall have in place reasonable procedures to respond to any notification that it receives from a consumer reporting agency under section 605B relating to information resulting from identity theft, to prevent that person from refurnishing such blocked information.

"(B) INFORMATION ALLEGED TO RESULT FROM IDENTITY THEFT.—If a consumer submits an identity theft report to a person who furnishes information to a consumer reporting agency at the address specified by that person for receiving such reports stating that information maintained by such person that purports to relate to the consumer resulted from identity theft, the person may not furnish such information that purports to relate to the consumer to any consumer reporting agency, unless the person subsequently knows or is informed by the consumer that the information is correct.".

(b) PROHIBITION ON SALE OR TRANSFER OF DEBT CAUSED BY IDENTITY THEFT.—Section 615 of the Fair Credit Reporting Act (15 U.S.C. 1681m), as amended by this Act, is amended by adding at the end the following:

"(f) PROHIBITION ON SALE OR TRANSFER OF DEBT CAUSED BY IDENTITY THEFT.—

"(1) IN GENERAL.—No person shall sell, transfer for consideration, or place for collection a debt that such person has been notified under section 605B has resulted from identity theft.

"(2) APPLICABILITY.—The prohibitions of this subsection shall apply to all persons collecting a debt described in paragraph (1) after the date of a notification under paragraph (1).

"(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to prohibit—

"(A) the repurchase of a debt in any case in which the assignee of the debt requires such repurchase because the debt has resulted from identity theft;

"(B) the securitization of a debt or the pledging of a portfolio of debt as collateral in connection with a borrowing; or

"(C) the transfer of debt as a result of a merger, acquisition, purchase and assumption transaction, or transfer of substantially all of the assets of an entity.".

SEC. 155. NOTICE BY DEBT COLLECTORS WITH RESPECT TO FRAUDULENT INFORMATION.

Section 615 of the Fair Credit Reporting Act (15 U.S.C. 1681m), as amended by this Act, is amended by adding at the end the following:

"(g) DEBT COLLECTOR COMMUNICATIONS CONCERNING IDENTITY THEFT.—If a person acting as a debt collector (as that term is defined in title VIII) on behalf of a third party that is a creditor or other user of a consumer report is notified that any information relating to a debt that the person is attempting to collect may be fraudulent or may be the result of identity theft, that person shall—

"(1) notify the third party that the information may be fraudulent or may be the result of identity theft; and

"(2) upon request of the consumer to whom the debt purportedly relates, provide to the consumer all information to which the consumer would otherwise be entitled if the consumer were not a victim of identity theft, but wished to dispute the debt under provisions of law applicable to that person.".

SEC. 156. STATUTE OF LIMITATIONS.

Section 618 of the Fair Credit Reporting Act (15 U.S.C. 1681p) is amended to read as follows:

"§618. Jurisdiction of courts; limitation of actions

"An action to enforce any liability created under this title may be brought in any appropriate United States district court, without regard to the amount in controversy, or in any other court of competent jurisdiction, not later than the earlier of—

"(1) 2 years after the date of discovery by the plaintiff of the violation that is the basis for such liability; or

"(2) 5 years after the date on which the violation that is the basis for such liability occurs.".

SEC. 157. STUDY ON THE USE OF TECHNOLOGY TO COMBAT IDENTITY THEFT.

(a) STUDY REQUIRED.—The Secretary of the Treasury shall conduct a study of the use of biometrics and other similar technologies to reduce the incidence and costs to society of identity theft by providing convincing evidence of who actually performed a given financial transaction.

(b) CONSULTATION.—The Secretary of the Treasury shall consult with Federal banking agencies, the Commission, and representatives of financial institutions, consumer reporting agencies, Federal, State, and local government agencies that issue official forms or means of identification, State prosecutors, law enforcement agencies, the biometric industry, and the general public in formulating and conducting the study required by subsection (a).

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of the Treasury for fiscal year 2004, such sums as may be necessary to carry out the provisions of this section.

(d) REPORT REQUIRED.—Before the end of the 180-day period beginning on the date of enactment of this Act, the Secretary shall submit a report to Congress containing the findings and conclusions of the study required under subsection (a), together with such recommendations for legislative or administrative actions as may be appropriate.

TITLE II—IMPROVEMENTS IN USE OF AND CONSUMER ACCESS TO CREDIT INFORMATION

SEC. 211. FREE CONSUMER REPORTS.

(a) IN GENERAL.—Section 612 of the Fair Credit Reporting Act (15 U.S.C. 1681j) is amended—

(1) by redesignating subsection (a) as subsection (f), and transferring it to the end of the section;

(2) by inserting before subsection (b) the following:

"(a) FREE ANNUAL DISCLOSURE.—

"(1) NATIONWIDE CONSUMER REPORTING AGENCIES.—

"(A) IN GENERAL.—All consumer reporting agencies described in subsections (p) and (w) of section 603 shall make all disclosures pursuant to section 609 once during any 12-month period upon request of the consumer and without charge to the consumer.

"(B) CENTRALIZED SOURCE.—Subparagraph (A) shall apply with respect to a consumer reporting agency described in section 603(p) only if the request from the consumer is made using the centralized source established for such purpose in accordance with section 211(c) of the Fair and Accurate Credit Transactions Act of 2003.

"(C) NATIONWIDE SPECIALTY CONSUMER REPORTING AGENCY.—

"(i) IN GENERAL.—The Commission shall prescribe regulations applicable to each consumer reporting agency described in section 603(w) to require the establishment of a streamlined process for consumers to request consumer reports under subparagraph (A), which shall include, at a minimum, the establishment by each such agency of a toll-free telephone number for such requests.

"(ii) CONSIDERATIONS.—In prescribing regulations under clause (i), the Commission shall consider—

"(I) the significant demands that may be placed on consumer reporting agencies in providing such consumer reports;

"(II) appropriate means to ensure that consumer reporting agencies can satisfactorily meet those demands, including the efficacy of a system of staggering the availability to consumers of such consumer reports; and

"(III) the ease by which consumers should be able to contact consumer reporting agencies with respect to access to such consumer reports.

"(iii) DATE OF ISSUANCE.—The Commission shall issue the regulations required by this subparagraph in final form not later than 6 months after the date of enactment of the Fair and Accurate Credit Transactions Act of 2003.

"(iv) CONSIDERATION OF ABILITY TO COMPLY.—The regulations of the Commission under this subparagraph shall establish an effective date by which each nationwide specialty consumer reporting agency (as defined in section 603(w)) shall be required to comply with subsection (a), which effective date—

"(I) shall be established after consideration of the ability of each nationwide specialty consumer reporting agency to comply with subsection (a); and

"(II) shall be not later than 6 months after the date on which such regulations are issued in final form (or such additional period not to exceed 3 months, as the Commission determines appropriate).

"(2) TIMING.—A consumer reporting agency shall provide a consumer report under paragraph (1) not later than 15 days after the date on which the request is received under paragraph (1).

"(3) REINVESTIGATIONS.—Notwithstanding the time periods specified in section 611(a)(1), a reinvestigation under that section by a consumer reporting agency upon a request of a consumer that is made after receiving a consumer report under this subsection shall be completed not later than 45 days after the date on which the request is received.

"(4) EXCEPTION FOR FIRST 12 MONTHS OF OPERATION.—This subsection shall not apply to a consumer reporting agency that has not been furnishing consumer reports to third parties on a continuing basis during the 12-month period preceding a request under paragraph (1), with respect to consumers residing nationwide.";

(3) by redesignating subsection (d) as subsection (e);

(4) by inserting before subsection (e), as redesignated, the following:

"(d) FREE DISCLOSURES IN CONNECTION WITH FRAUD ALERTS.—Upon the request of a consumer, a consumer reporting agency described in section 603(p) shall make all disclosures pursuant to section 609 without charge to the consumer, as provided in subsections (a)(2) and (b)(2) of section 605A, as applicable.";

(5) in subsection (e), as redesignated, by striking "subsection (a)" and inserting "subsection (f)"; and

(6) in subsection (f), as redesignated, by striking "Except as provided in subsections (b), (c), and (d), a" and inserting "In the case of a request from a consumer other than a request that is covered by any of subsections (a) through (d), a".

(b) CIRCUMVENTION PROHIBITED.—The Fair Credit Reporting Act (15 U.S.C. 1681 et seq.) is amended by adding after section 628, as added by section 216 of this Act, the following new section:

"§629. Corporate and technological circumvention prohibited

"The Commission shall prescribe regulations, to become effective not later than 90 days after the date of enactment of this section, to prevent a consumer reporting agency from circumventing or evading treatment as a consumer reporting agency described in section 603(p) for purposes of this title, including—

"(1) by means of a corporate reorganization or restructuring, including a merger, acquisition, dissolution, divestiture, or asset sale of a consumer reporting agency; or

"(2) by maintaining or merging public record and credit account information in a manner that is substantially equivalent to that described in paragraphs (1) and (2) of section 603(p), in the manner described in section 603(p).".

(c) SUMMARY OF RIGHTS TO OBTAIN AND DISPUTE INFORMATION IN CONSUMER REPORTS AND TO OBTAIN CREDIT SCORES.—Section 609(c) of the Fair Credit Reporting Act (15 U.S.C. 1681g) is amended to read as follows:

"(c) SUMMARY OF RIGHTS TO OBTAIN AND DISPUTE INFORMATION IN CONSUMER REPORTS AND TO OBTAIN CREDIT SCORES.—

"(1) COMMISSION SUMMARY OF RIGHTS REQUIRED.—

"(A) IN GENERAL.—The Commission shall prepare a model summary of the rights of consumers under this title.

"(B) CONTENT OF SUMMARY.—The summary of rights prepared under subparagraph (A) shall include a description of—

"(i) the right of a consumer to obtain a copy of a consumer report under subsection (a) from each consumer reporting agency;

"(ii) the frequency and circumstances under which a consumer is entitled to receive a consumer report without charge under section 612;

"(iii) the right of a consumer to dispute information in the file of the consumer under section 611;

"(iv) the right of a consumer to obtain a credit score from a consumer reporting agency, and a description of how to obtain a credit score;

"(v) the method by which a consumer can contact, and obtain a consumer report from, a consumer reporting agency without charge, as provided in the regulations of the Commission prescribed under section 211(c) of the Fair and Accurate Credit Transactions Act of 2003; and

"(vi) the method by which a consumer can contact, and obtain a consumer report from, a consumer reporting agency described in section 603(w), as provided in the regulations of the Commission prescribed under section 612(a)(1)(C).

"(C) AVAILABILITY OF SUMMARY OF RIGHTS.—The Commission shall—

"(i) actively publicize the availability of the summary of rights prepared under this paragraph;

"(ii) conspicuously post on its Internet website the availability of such summary of rights; and

"(iii) promptly make such summary of rights available to consumers, on request.

"(2) SUMMARY OF RIGHTS REQUIRED TO BE INCLUDED WITH AGENCY DISCLOSURES.—A consumer reporting agency shall provide to a consumer, with each written disclosure by the agency to the consumer under this section—

"(A) the summary of rights prepared by the Commission under paragraph (1);

"(B) in the case of a consumer reporting agency described in section 603(p), a toll-free telephone number established by the agency, at which personnel are accessible to consumers during normal business hours;

"(C) a list of all Federal agencies responsible for enforcing any provision of this title, and the address and any appropriate phone number of each such agency, in a form that will assist the consumer in selecting the appropriate agency;

"(D) a statement that the consumer may have additional rights under State law, and that the consumer may wish to contact a State or local consumer protection agency or a State attorney general (or the equivalent thereof) to learn of those rights; and

"(E) a statement that a consumer reporting agency is not required to remove accurate derogatory information from the file of a consumer, unless the information is outdated under section 605 or cannot be verified.".

(d) RULEMAKING REQUIRED.—

(1) IN GENERAL.—The Commission shall prescribe regulations applicable to consumer reporting agencies described in section 603(p) of the Fair Credit Reporting Act, to require the establishment of—

(A) a centralized source through which consumers may obtain a consumer report from each such consumer reporting agency, using a single request, and without charge to the consumer, as provided in section 612(a) of the Fair Credit Reporting Act (as amended by this section); and

(B) a standardized form for a consumer to make such a request for a consumer report by mail or through an Internet website.

(2) CONSIDERATIONS.—In prescribing regulations under paragraph (1), the Commission shall consider—

(A) the significant demands that may be placed on consumer reporting agencies in providing such consumer reports;

(B) appropriate means to ensure that consumer reporting agencies can satisfactorily meet those demands, including the efficacy of a system of staggering the availability to consumers of such consumer reports; and

(C) the ease by which consumers should be able to contact consumer reporting agencies with respect to access to such consumer reports.

(3) CENTRALIZED SOURCE.—The centralized source for a request for a consumer report from a consumer required by this subsection shall provide for—

(A) a toll-free telephone number for such purpose;

(B) use of an Internet website for such purpose; and

(C) a process for requests by mail for such purpose.

(4) TRANSITION.—The regulations of the Commission under paragraph (1) shall provide for an orderly transition by consumer reporting agencies described in section 603(p) of the Fair Credit Reporting Act to the centralized source for consumer report distribution required by section 612(a)(1)(B), as amended by this section, in a manner that—

(A) does not temporarily overwhelm such consumer reporting agencies with requests for disclosures of consumer reports beyond their capacity to deliver; and

(B) does not deny creditors, other users, and consumers access to consumer reports on a time-sensitive basis for specific purposes, such as home purchases or suspicions of identity theft, during the transition period.

(5) TIMING.—Regulations required by this subsection shall—

(A) be issued in final form not later than 6 months after the date of enactment of this Act; and

(B) become effective not later than 6 months after the date on which they are issued in final form.

(6) SCOPE OF REGULATIONS.—

(A) IN GENERAL.—The Commission shall, by rule, determine whether to require a consumer reporting agency that compiles and maintains files on consumers on substantially a nationwide basis, other than one described in section 603(p) of the Fair Credit Reporting Act, to make free consumer reports available upon consumer request, and if so, whether such consumer reporting agencies should make such free reports available through the centralized source described in paragraph (1)(A).

(B) CONSIDERATIONS.—Before making any determination under subparagraph (A), the Commission shall consider—

(i) the number of requests for consumer reports to, and the number of consumer reports generated by, the consumer reporting agency, in comparison with consumer reporting agencies described in subsections (p) and (w) of section 603 of the Fair Credit Reporting Act;

(ii) the overall scope of the operations of the consumer reporting agency;

(iii) the needs of consumers for access to consumer reports provided by consumer reporting agencies free of charge;

(iv) the costs of providing access to consumer reports by consumer reporting agencies free of charge; and

(v) the effects on the ongoing competitive viability of such consumer reporting agencies if such free access is required.

SEC. 212. DISCLOSURE OF CREDIT SCORES.

(a) STATEMENT ON AVAILABILITY OF CREDIT SCORES.—Section 609(a) of the Fair Credit Reporting Act (15 U.S.C. 1681g(a)) is amended by adding at the end the following new paragraph:

"(6) If the consumer requests the credit file and not the credit score, a statement that the consumer may request and obtain a credit score.".

(b) DISCLOSURE OF CREDIT SCORES.—Section 609 of the Fair Credit Reporting Act (15 U.S.C. 1681g), as amended by this Act, is amended by adding at the end the following:

"(f) DISCLOSURE OF CREDIT SCORES.—

"(1) IN GENERAL.—Upon the request of a consumer for a credit score, a consumer reporting agency shall supply to the consumer a statement indicating that the information and credit scoring model may be different than the credit score that may be used by the lender, and a notice which shall include—

"(A) the current credit score of the consumer or the most recent credit score of the consumer that was previously calculated by the credit reporting agency for a purpose related to the extension of credit;

"(B) the range of possible credit scores under the model used;

"(C) all of the key factors that adversely affected the credit score of the consumer in the model used, the total number of which shall not exceed 4, subject to paragraph (9);

"(D) the date on which the credit score was created; and

"(E) the name of the person or entity that provided the credit score or credit file upon which the credit score was created.

"(2) DEFINITIONS.—For purposes of this subsection, the following definitions shall apply:

"(A) CREDIT SCORE.—The term 'credit score'—

"(i) means a numerical value or a categorization derived from a statistical tool or modeling system used by a person who makes or arranges a loan to predict the likelihood of certain credit behaviors, including default (and the numerical value or the categorization derived from such analysis may also be referred to as a 'risk predictor' or 'risk score'); and

"(ii) does not include—

"(I) any mortgage score or rating of an automated underwriting system that considers one or more factors in addition to credit information, including the loan to value ratio, the amount of down payment, or the financial assets of a consumer; or

"(II) any other elements of the underwriting process or underwriting decision.

"(B) KEY FACTORS.—The term 'key factors' means all relevant elements or reasons adversely affecting the credit score for the particular individual, listed in the order of their importance based on their effect on the credit score.

"(3) TIMEFRAME AND MANNER OF DISCLOSURE.—The information required by this subsection shall be provided in the same timeframe and manner as the information described in subsection (a).

"(4) APPLICABILITY TO CERTAIN USES.—This subsection shall not be construed so as to compel a consumer reporting agency to develop or disclose a score if the agency does not—

"(A) distribute scores that are used in connection with residential real property loans; or

"(B) develop scores that assist credit providers in understanding the general credit behavior of a consumer and predicting the future credit behavior of the consumer.

"(5) APPLICABILITY TO CREDIT SCORES DEVELOPED BY ANOTHER PERSON.—

"(A) IN GENERAL.—This subsection shall not be construed to require a consumer reporting agency that distributes credit scores developed by another person or entity to provide a further explanation of them, or to process a dispute arising pursuant to section 611, except that the consumer reporting agency shall provide the consumer with the name and address and website for contacting the person or entity who developed the score or developed the methodology of the score.

"(B) EXCEPTION.—This paragraph shall not apply to a consumer reporting agency that develops or modifies scores that are developed by another person or entity.

"(6) MAINTENANCE OF CREDIT SCORES NOT REQUIRED.—This subsection shall not be construed to require a consumer reporting agency to maintain credit scores in its files.

"(7) COMPLIANCE IN CERTAIN CASES.—In complying with this subsection, a consumer reporting agency shall—

"(A) supply the consumer with a credit score that is derived from a credit scoring model that is widely distributed to users by that consumer reporting agency in connection with residential real property loans or with a credit score that assists the consumer in understanding the credit scoring assessment of the credit behavior of the consumer and predictions about the future credit behavior of the consumer; and

"(B) a statement indicating that the information and credit scoring model may be different than that used by the lender.

"(8) FAIR AND REASONABLE FEE.—A consumer reporting agency may charge a fair and reasonable fee, as determined by the Commission, for providing the information required under this subsection.

"(9) USE OF ENQUIRIES AS A KEY FACTOR.—If a key factor that adversely affects the credit score of a consumer consists of the number of enquiries made with respect to a consumer report, that factor shall be included in the disclosure pursuant to paragraph (1)(C) without regard to the numerical limitation in such paragraph.".

(c) DISCLOSURE OF CREDIT SCORES BY CERTAIN MORTGAGE LENDERS.—Section 609 of the Fair Credit Reporting Act (15 U.S.C. 1681g), as amended by this Act, is amended by adding at the end the following:

"(g) DISCLOSURE OF CREDIT SCORES BY CERTAIN MORTGAGE LENDERS.—

"(1) IN GENERAL.—Any person who makes or arranges loans and who uses a consumer credit score, as defined in subsection (f), in connection with an application initiated or sought by a consumer for a closed end loan or the establishment of an open end loan for a consumer purpose that is secured by 1 to 4 units of residential real property (hereafter in this subsection referred to as the 'lender') shall provide the following to the consumer as soon as reasonably practicable:

"(A) INFORMATION REQUIRED UNDER SUBSECTION (f).—

"(i) IN GENERAL.—A copy of the information identified in subsection (f) that was obtained from a consumer reporting agency or was developed and used by the user of the information.

"(ii) NOTICE UNDER SUBPARAGRAPH (D).—In addition to the information provided to it by a third party that provided the credit score or scores, a lender is only required to provide the notice contained in subparagraph (D).

"(B) DISCLOSURES IN CASE OF AUTOMATED UNDERWRITING SYSTEM.—

"(i) IN GENERAL.—If a person that is subject to this subsection uses an automated underwriting system to underwrite a loan, that person may satisfy the obligation to provide a credit score by disclosing a credit score and associated key factors supplied by a consumer reporting agency.

"(ii) NUMERICAL CREDIT SCORE.—However, if a numerical credit score is generated by an automated underwriting system used by an enterprise, and that score is disclosed to the person, the score shall be disclosed to the consumer consistent with subparagraph (C).

"(iii) ENTERPRISE DEFINED.—For purposes of this subparagraph, the term 'enterprise' has the same meaning as in paragraph (6) of section 1303 of the Federal Housing Enterprises Financial Safety and Soundness Act of 1992.

"(C) DISCLOSURES OF CREDIT SCORES NOT OBTAINED FROM A CONSUMER REPORTING AGENCY.—A person that is subject to the provisions of this subsection and that uses a credit score, other than a credit score provided by a consumer reporting agency, may satisfy the obligation to provide a credit score by disclosing a credit score and associated key factors supplied by a consumer reporting agency.

"(D) NOTICE TO HOME LOAN APPLICANTS.—A copy of the following notice, which shall include the name, address, and telephone number of each consumer reporting agency providing a credit score that was used:

"'NOTICE TO THE HOME LOAN APPLICANT

"'In connection with your application for a home loan, the lender must disclose to you the score that a consumer reporting agency distributed to users and the lender used in connection with your home loan, and the key factors affecting your credit scores.

"'The credit score is a computer generated summary calculated at the time of the request and based on information that a consumer reporting agency or lender has on file. The scores are based on data about your credit history and payment patterns. Credit scores are important because they are used to assist the lender in determining whether you will obtain a loan. They may also be used to determine what interest rate you may be offered on the mortgage. Credit scores can change over time, depending on your conduct, how your credit history and payment patterns change, and how credit scoring technologies change.

"'Because the score is based on information in your credit history, it is very important that you review the credit-related information that is being furnished to make sure it is accurate. Credit records may vary from one company to another.

"'If you have questions about your credit score or the credit information that is furnished to you, contact the consumer reporting agency at the address and telephone number provided with this notice, or contact the lender, if the lender developed or generated the credit score. The consumer reporting agency plays no part in the decision to take any action on the loan application and is unable to provide you with specific reasons for the decision on a loan application.

"'If you have questions concerning the terms of the loan, contact the lender.'.

"(E) ACTIONS NOT REQUIRED UNDER THIS SUBSECTION.—This subsection shall not require any person to—

"(i) explain the information provided pursuant to subsection (f);

"(ii) disclose any information other than a credit score or key factors, as defined in subsection (f);

"(iii) disclose any credit score or related information obtained by the user after a loan has closed;

"(iv) provide more than 1 disclosure per loan transaction; or

"(v) provide the disclosure required by this subsection when another person has made the disclosure to the consumer for that loan transaction.

"(F) NO OBLIGATION FOR CONTENT.—

"(i) IN GENERAL.—The obligation of any person pursuant to this subsection shall be limited solely to providing a copy of the information that was received from the consumer reporting agency.

"(ii) LIMIT ON LIABILITY.—No person has liability under this subsection for the content of that information or for the omission of any information within the report provided by the consumer reporting agency.

"(G) PERSON DEFINED AS EXCLUDING ENTERPRISE.—As used in this subsection, the term 'person' does not include an enterprise (as defined in paragraph (6) of section 1303 of the Federal Housing Enterprises Financial Safety and Soundness Act of 1992).

"(2) PROHIBITION ON DISCLOSURE CLAUSES NULL AND VOID.—

"(A) IN GENERAL.—Any provision in a contract that prohibits the disclosure of a credit score by a person who makes or arranges loans or a consumer reporting agency is void.

"(B) NO LIABILITY FOR DISCLOSURE UNDER THIS SUBSECTION.—A lender shall not have liability under any contractual provision for disclosure of a credit score pursuant to this subsection.".

(d) INCLUSION OF KEY FACTOR IN CREDIT SCORE INFORMATION IN CONSUMER REPORT.—Section 605(d) of the Fair Credit Reporting Act (15 U.S.C. 1681c(d)) is amended—

(1) by striking "DISCLOSED.—Any consumer reporting agency" and inserting "DISCLOSED.—

"(1) TITLE 11 INFORMATION.—Any consumer reporting agency"; and

(2) by adding at the end the following new paragraph:

"(2) KEY FACTOR IN CREDIT SCORE INFORMATION.—Any consumer reporting agency that furnishes a consumer report that contains any credit score or any other risk score or predictor on any consumer shall include in the report a clear and conspicuous statement that a key factor (as defined in section 609(f)(2)(B)) that adversely affected such score or predictor was the number of enquiries, if such a predictor was in fact a key factor that adversely affected such score. This paragraph shall not apply to a check services company, acting as such, which issues authorizations for the purpose of approving or processing negotiable instruments, electronic fund transfers, or similar methods of payments, but only to the extent that such company is engaged in such activities.".

(e) TECHNICAL AND CONFORMING AMENDMENTS.—Section 625(b) of the Fair Credit Reporting Act (15 U.S.C. 1681t(b)), as so designated by section 214 of this Act, is amended—

(1) by striking "or" at the end of paragraph (2); and

(2) by striking paragraph (3) and inserting the following:

"(3) with respect to the disclosures required to be made under subsection (c), (d), (e), or (g) of section 609, or subsection (f) of section 609 relating to the disclosure of credit scores for credit granting purposes, except that this paragraph—

"(A) shall not apply with respect to sections 1785.10, 1785.16, and 1785.20.2 of the California Civil Code (as in effect on the date of enactment of the Fair and Accurate Credit Transactions Act of 2003) and section 1785.15 through section 1785.15.2 of such Code (as in effect on such date);

"(B) shall not apply with respect to sections 5–3–106(2) and 212–14.3–104.3 of the Colorado Revised Statutes (as in effect on the date of enactment of the Fair and Accurate Credit Transactions Act of 2003); and

"(C) shall not be construed as limiting, annulling, affecting, or superseding any provision of the laws of any State regulating the use in an insurance activity, or regulating disclosures concerning such use, of a credit-based insurance score of a consumer by any person engaged in the business of insurance;

"(4) with respect to the frequency of any disclosure under section 612(a), except that this paragraph shall not apply—

"(A) with respect to section 12–14.3–105(1)(d) of the Colorado Revised Statutes (as in effect on the date of enactment of the Fair and Accurate Credit Transactions Act of 2003);

"(B) with respect to section 10–1–393(29)(C) of the Georgia Code (as in effect on the date of enactment of the Fair and Accurate Credit Transactions Act of 2003);

"(C) with respect to section 1316.2 of title 10 of the Maine Revised Statutes (as in effect on the date of enactment of the Fair and Accurate Credit Transactions Act of 2003);

"(D) with respect to sections 14–1209(a)(1) and 14–1209(b)(1)(i) of the Commercial Law Article of the Code of Maryland (as in effect on the date of enactment of the Fair and Accurate Credit Transactions Act of 2003);

"(E) with respect to section 59(d) and section 59(e) of chapter 93 of the General Laws of Massachusetts (as in effect on the date of enactment of the Fair and Accurate Credit Transactions Act of 2003);

"(F) with respect to section 56:11–37.10(a)(1) of the New Jersey Revised Statutes (as in effect on the date of enactment of the Fair and Accurate Credit Transactions Act of 2003); or

"(G) with respect to section 2480c(a)(1) of title 9 of the Vermont Statutes Annotated (as in effect on the date of enactment of the Fair and Accurate Credit Transactions Act of 2003); or".

SEC. 213. ENHANCED DISCLOSURE OF THE MEANS AVAILABLE TO OPT OUT OF PRESCREENED LISTS.

(a) Notice and Response Format for Users of Reports.—Section 615(d)(2) of the Fair Credit Reporting Act (15 U.S.C. 1681m(d)(2)) is amended to read as follows:

"(2) Disclosure of address and telephone number; format.—A statement under paragraph (1) shall—

"(A) include the address and toll-free telephone number of the appropriate notification system established under section 604(e); and

"(B) be presented in such format and in such type size and manner as to be simple and easy to understand, as established by the Commission, by rule, in consultation with the Federal banking agencies and the National Credit Union Administration.".

(b) Rulemaking Schedule.—Regulations required by section 615(d)(2) of the Fair Credit Reporting Act, as amended by this section, shall be issued in final form not later than 1 year after the date of enactment of this Act.

(c) Duration of Elections.—Section 604(e) of the Fair Credit Reporting Act (15 U.S.C. 1681b(e)) is amended in each of paragraphs (3)(A) and (4)(B)(i), by striking "2-year period" each place that term appears and inserting "5-year period".

(d) Public Awareness Campaign.—The Commission shall actively publicize and conspicuously post on its website any address and the toll-free telephone number established as part of a notification system for opting out of prescreening under section 604(e) of the Fair Credit Reporting Act (15 U.S.C. 1681b(e)), and otherwise take measures to increase public awareness regarding the availability of the right to opt out of prescreening.

(e) Analysis of Further Restrictions on Offers of Credit or Insurance.—

(1) In general.—The Board shall conduct a study of—

(A) the ability of consumers to avoid receiving written offers of credit or insurance in connection with transactions not initiated by the consumer; and

(B) the potential impact that any further restrictions on providing consumers with such written offers of credit or insurance would have on consumers.

(2) Report.—The Board shall submit a report summarizing the results of the study required under paragraph (1) to the Congress not later than 12 months after the date of enactment of this Act, together with such recommendations for legislative or administrative action as the Board may determine to be appropriate.

(3) Content of report.—The report described in paragraph (2) shall address the following issues:

(A) The current statutory or voluntary mechanisms that are available to a consumer to notify lenders and insurance providers that the consumer does not wish to receive written offers of credit or insurance.

(B) The extent to which consumers are currently utilizing existing statutory and voluntary mechanisms to avoid receiving offers of credit or insurance.

(C) The benefits provided to consumers as a result of receiving written offers of credit or insurance.

(D) Whether consumers incur significant costs or are otherwise adversely affected by the receipt of written offers of credit or insurance.

(E) Whether further restricting the ability of lenders and insurers to provide written offers of credit or insurance to consumers would affect—

(i) the cost consumers pay to obtain credit or insurance;

(ii) the availability of credit or insurance;

(iii) consumers' knowledge about new or alternative products and services;

(iv) the ability of lenders or insurers to compete with one another; and

(v) the ability to offer credit or insurance products to consumers who have been traditionally underserved.

SEC. 214. AFFILIATE SHARING.

(a) Limitation.—The Fair Credit Reporting Act (15 U.S.C. 1601 et seq.) is amended—

(1) by redesignating sections 624 (15 U.S.C. 1681t), 625 (15 U.S.C. 1681u), and 626 (15 U.S.C. 6181v) as sections 625, 626, and 627, respectively; and

(2) by inserting after section 623 the following:

"§ 624. Affiliate sharing

"(a) Special Rule for Solicitation for Purposes of Marketing.—

"(1) Notice.—Any person that receives from another person related to it by common ownership or affiliated by corporate control a communication of information that would be a consumer report, but for clauses (i), (ii), and (iii) of section 603(d)(2)(A), may not use the information to make a solicitation for marketing purposes to a consumer about its products or services, unless—

"(A) it is clearly and conspicuously disclosed to the consumer that the information may be communicated among such persons for purposes of making such solicitations to the consumer; and

"(B) the consumer is provided an opportunity and a simple method to prohibit the making of such solicitations to the consumer by such person.

"(2) Consumer choice.—

"(A) In general.—The notice required under paragraph (1) shall allow the consumer the opportunity to prohibit all solicitations referred to in such paragraph, and may allow the consumer to choose from different options when electing to prohibit the sending of such solicitations, including options regarding the types of entities and information covered, and which methods of delivering solicitations the consumer elects to prohibit.

"(B) Format.—Notwithstanding subparagraph (A), the notice required under paragraph (1) shall be clear, conspicuous, and concise, and any method provided under paragraph (1)(B) shall be simple. The regulations prescribed to implement this section shall provide specific guidance regarding how to comply with such standards.

"(3) Duration.—

"(A) In general.—The election of a consumer pursuant to paragraph (1)(B) to prohibit the making of solicitations shall be effective for at least 5 years, beginning on the date on which the person receives the election of the consumer, unless the consumer requests that such election be revoked.

"(B) Notice upon expiration of effective period.—At such time as the election of a consumer pursuant to paragraph (1)(B) is no longer effective, a person may not use information that the person receives in the manner described in paragraph (1) to make any solicitation for marketing purposes to the consumer, unless the consumer receives a notice and an opportunity, using a simple method, to extend the opt-out for another period of at least 5 years, pursuant to the procedures described in paragraph (1).

"(4) Scope.—This section shall not apply to a person—

"(A) using information to make a solicitation for marketing purposes to a consumer with whom the person has a pre-existing business relationship;

"(B) using information to facilitate communications to an individual for whose benefit the person provides employee benefit or other services pursuant to a contract with an employer related to and arising out of the current employment relationship or status of the individual as a participant or beneficiary of an employee benefit plan;

"(C) using information to perform services on behalf of another person related by common ownership or affiliated by corporate control, except that this subparagraph shall not be construed as permitting a person to send solicitations on behalf of another person, if such other person would not be permitted to send the solicitation on its own behalf as a result of the election of the consumer to prohibit solicitations under paragraph (1)(B);

"(D) using information in response to a communication initiated by the consumer;

"(E) using information in response to solicitations authorized or requested by the consumer; or

"(F) if compliance with this section by that person would prevent compliance by that person with any provision of State insurance laws pertaining to unfair discrimination in any State in which the person is lawfully doing business.

"(5) No retroactivity.—This subsection shall not prohibit the use of information to send a solicitation to a consumer if such information was received prior to the date on which persons are required to comply with regulations implementing this subsection.

"(b) Notice for Other Purposes Permissible.—A notice or other disclosure under this section may be coordinated and consolidated with any other notice required to be issued under any other provision of law by a person that is subject to this section, and a notice or other disclosure that is equivalent to the notice required by subsection (a), and that is provided by a person described in subsection (a) to a consumer together with disclosures required by any other provision of law, shall satisfy the requirements of subsection (a).

"(c) User Requirements.—Requirements with respect to the use by a person of information received from another person related to it

by common ownership or affiliated by corporate control, such as the requirements of this section, constitute requirements with respect to the exchange of information among persons affiliated by common ownership or common corporate control, within the meaning of section 625(b)(2).

"(d) DEFINITIONS.—For purposes of this section, the following definitions shall apply:

"(1) PRE-EXISTING BUSINESS RELATIONSHIP.—The term 'pre-existing business relationship' means a relationship between a person, or a person's licensed agent, and a consumer, based on—

"(A) a financial contract between a person and a consumer which is in force;

"(B) the purchase, rental, or lease by the consumer of that person's goods or services, or a financial transaction (including holding an active account or a policy in force or having another continuing relationship) between the consumer and that person during the 18-month period immediately preceding the date on which the consumer is sent a solicitation covered by this section;

"(C) an inquiry or application by the consumer regarding a product or service offered by that person, during the 3-month period immediately preceding the date on which the consumer is sent a solicitation covered by this section; or

"(D) any other pre-existing customer relationship defined in the regulations implementing this section.

"(2) SOLICITATION.—The term 'solicitation' means the marketing of a product or service initiated by a person to a particular consumer that is based on an exchange of information described in subsection (a), and is intended to encourage the consumer to purchase such product or service, but does not include communications that are directed at the general public or determined not to be a solicitation by the regulations prescribed under this section.".

(b) RULEMAKING REQUIRED.—

(1) IN GENERAL.—The Federal banking agencies, the National Credit Union Administration, and the Commission, with respect to the entities that are subject to their respective enforcement authority under section 621 of the Fair Credit Reporting Act and the Securities and Exchange Commission, and in coordination as described in paragraph (2), shall prescribe regulations to implement section 624 of the Fair Credit Reporting Act, as added by this section.

(2) COORDINATION.—Each agency required to prescribe regulations under paragraph (1) shall consult and coordinate with each other such agency so that, to the extent possible, the regulations prescribed by each such entity are consistent and comparable with the regulations prescribed by each other such agency.

(3) CONSIDERATIONS.—In promulgating regulations under this subsection, each agency referred to in paragraph (1) shall—

(A) ensure that affiliate sharing notification methods provide a simple means for consumers to make determinations and choices under section 624 of the Fair Credit Reporting Act, as added by this section;

(B) consider the affiliate sharing notification practices employed on the date of enactment of this Act by persons that will be subject to that section 624; and

(C) ensure that notices and disclosures may be coordinated and consolidated, as provided in subsection (b) of that section 624.

(4) TIMING.—Regulations required by this subsection shall—

(A) be issued in final form not later than 9 months after the date of enactment of this Act; and

(B) become effective not later than 6 months after the date on which they are issued in final form.

(c) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) DEFINITIONS.—Section 603(d)(2)(A) of the Fair Credit Reporting Act (15 U.S.C. 1681(d)(2)(A)) is amended by inserting "subject to section 624," after "(A)".

(2) RELATION TO STATE LAWS.—Section 625(b)(1) of the Fair Credit Reporting Act (15 U.S.C. 1681t(b)(1)), as so designated by subsection (a) of this section, is amended—

(A) by striking "or" after the semicolon at the end of subparagraph (E); and

(B) by adding at the end the following new subparagraph:

"(H) section 624, relating to the exchange and use of information to make a solicitation for marketing purposes; or".

(3) CROSS REFERENCE CORRECTION.—Section 627(d) of the Fair Credit Reporting Act (15 U.S.C. 1681v(d)), as so designated by subsection (a) of this section, is amended by striking "section 625" and inserting "section 626".

(4) TABLE OF SECTIONS.—The table of sections for title VI of the Consumer Credit Protection Act (15 U.S.C. 1601 et seq.) is amended by striking the items relating to sections 624 through 626 and inserting the following:

"624. Affiliate sharing.
"625. Relation to State laws.
"626. Disclosures to FBI for counterintelligence purposes.
"627. Disclosures to governmental agencies for counterintelligence purposes."

(e) STUDIES OF INFORMATION SHARING PRACTICES.—

(1) IN GENERAL.—The Federal banking agencies, the National Credit Union Administration, and the Commission shall jointly conduct regular studies of the consumer information sharing practices by financial institutions and other persons that are creditors or users of consumer reports with their affiliates.

(2) MATTERS FOR STUDY.—In conducting the studies required by paragraph (1), the agencies described in paragraph (1) shall—

(A) identify—

(i) the purposes for which financial institutions and other creditors and users of consumer reports share consumer information;

(ii) the types of information shared by such entities with their affiliates;

(iii) the number of choices provided to consumers with respect to the control of such sharing, and the degree to and manner in which consumers exercise such choices, if at all; and

(iv) whether such entities share or may share personally identifiable transaction or experience information with affiliates for purposes—

(I) that are related to employment or hiring, including whether the person that is the subject of such information is given notice of such sharing, and the specific uses of such shared information; or

(II) of general publication of such information; and

(B) specifically examine the information sharing practices that financial institutions and other creditors and users of consumer reports and their affiliates employ for the purpose of making underwriting decisions or credit evaluations of consumers.

(3) REPORTS.—

(A) INITIAL REPORT.—Not later than 3 years after the date of enactment of this Act, the Federal banking agencies, the National Credit Union Administration, and the Commission shall jointly submit a report to the Congress on the results of the initial study conducted in accordance with this subsection, together with any recommendations for legislative or regulatory action.

(B) FOLLOWUP REPORTS.—The Federal banking agencies, the National Credit Union Administration, and the Commission shall, not less frequently than once every 3 years following the date of submission of the initial report under subparagraph (A), jointly submit a report to the Congress that, together with any recommendations for legislative or regulatory action—

(i) documents any changes in the areas of study referred to in paragraph (2)(A) occurring since the date of submission of the previous report;

(ii) identifies any changes in the practices of financial institutions and other creditors and users of consumer reports in sharing consumer information with their affiliates for the purpose of making underwriting decisions or credit evaluations of consumers occurring since the date of submission of the previous report; and

(iii) examines the effects that changes described in clause (ii) have had, if any, on the degree to which such affiliate sharing practices reduce the need for financial institutions, creditors, and other users of consumer reports to rely on consumer reports for such decisions.

SEC. 215. STUDY OF EFFECTS OF CREDIT SCORES AND CREDIT-BASED INSURANCE SCORES ON AVAILABILITY AND AFFORDABILITY OF FINANCIAL PRODUCTS.

(a) STUDY REQUIRED.—The Commission and the Board, in consultation with the Office of Fair Housing and Equal Opportunity of the Department of Housing and Urban Development, shall conduct a study of—

(1) the effects of the use of credit scores and credit-based insurance scores on the availability and affordability of financial products and services, including credit cards, mortgages, auto loans, and property and casualty insurance;

(2) the statistical relationship, utilizing a multivariate analysis that controls for prohibited factors under the Equal Credit Opportunity Act and other known risk factors, between credit scores and credit-based insurance scores and the quantifiable risks and actual losses experienced by businesses;

(3) the extent to which, if any, the use of credit scoring models, credit scores, and credit-based insurance scores impact on the availability and affordability of credit and insurance to the extent information is currently available or is available through proxies, by geography, income, ethnicity, race, color, religion, national origin, age, sex, marital status, and creed, including the extent to which the consideration or lack of consideration of certain factors by credit scoring systems could result in negative or differential treatment of protected classes under the Equal Credit Opportunity Act, and the extent to which, if any, the use of underwriting systems relying on these models could achieve comparable results through the use of factors with less negative impact; and

(4) the extent to which credit scoring systems are used by businesses, the factors considered by such systems, and the effects of variables which are not considered by such systems.

(b) PUBLIC PARTICIPATION.—The Commission shall seek public input about the prescribed methodology and research design of the study described in subsection (a), including from relevant Federal regulators, State insurance regulators, community, civil rights, consumer, and housing groups.

(c) REPORT REQUIRED.—

(1) IN GENERAL.—Before the end of the 24-month period beginning on the date of enactment of this Act, the Commission shall submit a detailed report on the study conducted pursuant to subsection (a) to the Committee on Financial Services of the House of Representatives and the Committee on Banking, Housing, and Urban Affairs of the Senate.

(2) CONTENTS OF REPORT.—The report submitted under paragraph (1) shall include the findings and conclusions of the Commission, recommendations to address specific areas of

concerns addressed in the study, and recommendations for legislative or administrative action that the Commission may determine to be necessary to ensure that credit and credit-based insurance scores are used appropriately and fairly to avoid negative effects.

SEC. 216. DISPOSAL OF CONSUMER REPORT INFORMATION AND RECORDS.

(a) IN GENERAL.—The Fair Credit Reporting Act (15 U.S.C. 1681 et seq.), as amended by this Act, is amended by adding at the end the following:

"§628. Disposal of records

"(a) REGULATIONS.—

"(1) IN GENERAL.—Not later than 1 year after the date of enactment of this section, the Federal banking agencies, the National Credit Union Administration, and the Commission with respect to the entities that are subject to their respective enforcement authority under section 621, and the Securities and Exchange Commission, and in coordination as described in paragraph (2), shall issue final regulations requiring any person that maintains or otherwise possesses consumer information, or any compilation of consumer information, derived from consumer reports for a business purpose to properly dispose of any such information or compilation.

"(2) COORDINATION.—Each agency required to prescribe regulations under paragraph (1) shall—

"(A) consult and coordinate with each other such agency so that, to the extent possible, the regulations prescribed by each such agency are consistent and comparable with the regulations by each such other agency; and

"(B) ensure that such regulations are consistent with the requirements and regulations issued pursuant to Public Law 106–102 and other provisions of Federal law.

"(3) EXEMPTION AUTHORITY.—In issuing regulations under this section, the Federal banking agencies, the National Credit Union Administration, the Commission, and the Securities and Exchange Commission may exempt any person or class of persons from application of those regulations, as such agency deems appropriate to carry out the purpose of this section.

"(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed—

"(1) to require a person to maintain or destroy any record pertaining to a consumer that is not imposed under other law; or

"(2) to alter or affect any requirement imposed under any other provision of law to maintain or destroy such a record.".

(b) CLERICAL AMENDMENT.—The table of sections for title VI of the Consumer Credit Protection Act (15 U.S.C. 1601 et seq.) is amended by inserting after the item relating to section 627, as added by section 214 of this Act, the following:

"628. Disposal of records.
"629. Corporate and technological circumvention prohibited.".

SEC. 217. REQUIREMENT TO DISCLOSE COMMUNICATIONS TO A CONSUMER REPORTING AGENCY.

(a) IN GENERAL.—Section 623(a) of the Fair Credit Reporting Act (15 U.S.C. 1681s–2(a)) as amended by this Act, is amended by inserting after paragraph (6), the following new paragraph:

"(7) NEGATIVE INFORMATION.—

"(A) NOTICE TO CONSUMER REQUIRED.—

"(i) IN GENERAL.—If any financial institution that extends credit and regularly and in the ordinary course of business furnishes information to a consumer reporting agency described in section 603(p) furnishes negative information to such an agency regarding credit extended to a customer, the financial institution shall provide a notice of such furnishing of negative information, in writing, to the customer.

"(ii) NOTICE EFFECTIVE FOR SUBSEQUENT SUBMISSIONS.—After providing such notice, the financial institution may submit additional negative information to a consumer reporting agency described in section 603(p) with respect to the same transaction, extension of credit, account, or customer without providing additional notice to the customer.

"(B) TIME OF NOTICE.—

"(i) IN GENERAL.—The notice required under subparagraph (A) shall be provided to the customer prior to, or no later than 30 days after, furnishing the negative information to a consumer reporting agency described in section 603(p).

"(ii) COORDINATION WITH NEW ACCOUNT DISCLOSURES.—If the notice is provided to the customer prior to furnishing the negative information to a consumer reporting agency, the notice may not be included in the initial disclosures provided under section 127(a) of the Truth in Lending Act.

"(C) COORDINATION WITH OTHER DISCLOSURES.—The notice required under subparagraph (A)—

"(i) may be included on or with any notice of default, any billing statement, or any other materials provided to the customer; and

"(ii) must be clear and conspicuous.

"(D) MODEL DISCLOSURE.—

"(i) DUTY OF BOARD TO PREPARE.—The Board shall prescribe a brief model disclosure a financial institution may use to comply with subparagraph (A), which shall not exceed 30 words.

"(ii) USE OF MODEL NOT REQUIRED.—No provision of this paragraph shall be construed as requiring a financial institution to use any such model form prescribed by the Board.

"(iii) COMPLIANCE USING MODEL.—A financial institution shall be deemed to be in compliance with subparagraph (A) if the financial institution uses any such model form prescribed by the Board, or the financial institution uses any such model form and rearranges its format.

"(E) USE OF NOTICE WITHOUT SUBMITTING NEGATIVE INFORMATION.—No provision of this paragraph shall be construed as requiring a financial institution that has provided a customer with a notice described in subparagraph (A) to furnish negative information about the customer to a consumer reporting agency.

"(F) SAFE HARBOR.—A financial institution shall not be liable for failure to perform the duties required by this paragraph if, at the time of the failure, the financial institution maintained reasonable policies and procedures to comply with this paragraph or the financial institution reasonably believed that the institution is prohibited, by law, from contacting the consumer.

"(G) DEFINITIONS.—For purposes of this paragraph, the following definitions shall apply:

"(i) NEGATIVE INFORMATION.—The term 'negative information' means information concerning a customer's delinquencies, late payments, insolvency, or any form of default.

"(ii) CUSTOMER; FINANCIAL INSTITUTION.—The terms 'customer' and 'financial institution' have the same meanings as in section 509 Public Law 106–102.".

(b) MODEL DISCLOSURE FORM.—Before the end of the 6-month period beginning on the date of enactment of this Act, the Board shall adopt the model disclosure required under the amendment made by subsection (a) after notice duly given in the Federal Register and an opportunity for public comment in accordance with section 553 of title 5, United States Code.

TITLE III—ENHANCING THE ACCURACY OF CONSUMER REPORT INFORMATION

SEC. 311. RISK-BASED PRICING NOTICE.

(a) DUTIES OF USERS.—Section 615 of the Fair Credit Reporting Act (15 U.S.C. 1681m), as amended by this Act, is amended by adding at the end the following:

"(h) DUTIES OF USERS IN CERTAIN CREDIT TRANSACTIONS.—

"(1) IN GENERAL.—Subject to rules prescribed as provided in paragraph (6), if any person uses a consumer report in connection with an application for, or a grant, extension, or other provision of, credit on material terms that are materially less favorable than the most favorable terms available to a substantial proportion of consumers from or through that person, based in whole or in part on a consumer report, the person shall provide an oral, written, or electronic notice to the consumer in the form and manner required by regulations prescribed in accordance with this subsection.

"(2) TIMING.—The notice required under paragraph (1) may be provided at the time of an application for, or a grant, extension, or other provision of, credit or the time of communication of an approval of an application for, or grant, extension, or other provision of, credit, except as provided in the regulations prescribed under paragraph (6).

"(3) EXCEPTIONS.—No notice shall be required from a person under this subsection if—

"(A) the consumer applied for specific material terms and was granted those terms, unless those terms were initially specified by the person after the transaction was initiated by the consumer and after the person obtained a consumer report; or

"(B) the person has provided or will provide a notice to the consumer under subsection (a) in connection with the transaction.

"(4) OTHER NOTICE NOT SUFFICIENT.—A person that is required to provide a notice under subsection (a) cannot meet that requirement by providing a notice under this subsection.

"(5) CONTENT AND DELIVERY OF NOTICE.—A notice under this subsection shall, at a minimum—

"(A) include a statement informing the consumer that the terms offered to the consumer are set based on information from a consumer report;

"(B) identify the consumer reporting agency furnishing the report;

"(C) include a statement informing the consumer that the consumer may obtain a copy of a consumer report from that consumer reporting agency without charge; and

"(D) include the contact information specified by that consumer reporting agency for obtaining such consumer reports (including a toll-free telephone number established by the agency in the case of a consumer reporting agency described in section 603(p)).

"(6) RULEMAKING.—

"(A) RULES REQUIRED.—The Commission and the Board shall jointly prescribe rules.

"(B) CONTENT.—Rules required by subparagraph (A) shall address, but are not limited to—

"(i) the form, content, time, and manner of delivery of any notice under this subsection;

"(ii) clarification of the meaning of terms used in this subsection, including what credit terms are material, and when credit terms are materially less favorable;

"(iii) exceptions to the notice requirement under this subsection for classes of persons or transactions regarding which the agencies determine that notice would not significantly benefit consumers;

"(iv) a model notice that may be used to comply with this subsection; and

"(v) the timing of the notice required under paragraph (1), including the circumstances under which the notice must be provided after the terms offered to the consumer were set based on information from a consumer report.

"(7) COMPLIANCE.—A person shall not be liable for failure to perform the duties required by this section if, at the time of the failure, the person maintained reasonable policies and procedures to comply with this section.

"(8) ENFORCEMENT.—

"(A) NO CIVIL ACTIONS.—Sections 616 and 617 shall not apply to any failure by any person to comply with this section.

"(B) ADMINISTRATIVE ENFORCEMENT.—This section shall be enforced exclusively under section 621 by the Federal agencies and officials identified in that section.".

(b) RELATION TO STATE LAWS.—Section 625(b)(1) of the Fair Credit Reporting Act (15 U.S.C. 1681t(b)(1)), as so designated by section 214 of this Act, is amended by adding at the end the following:

"(I) section 615(h), relating to the duties of users of consumer reports to provide notice with respect to terms in certain credit transactions;".

SEC. 312. PROCEDURES TO ENHANCE THE ACCURACY AND INTEGRITY OF INFORMATION FURNISHED TO CONSUMER REPORTING AGENCIES.

(a) ACCURACY GUIDELINES AND REGULATIONS.—Section 623 of the Fair Credit Reporting Act (15 U.S.C. 15 U.S.C. 1681s–2) is amended by adding at the end the following:

"(e) ACCURACY GUIDELINES AND REGULATIONS REQUIRED.—

"(1) GUIDELINES.—The Federal banking agencies, the National Credit Union Administration, and the Commission shall, with respect to the entities that are subject to their respective enforcement authority under section 621, and in coordination as described in paragraph (2)—

"(A) establish and maintain guidelines for use by each person that furnishes information to a consumer reporting agency regarding the accuracy and integrity of the information relating to consumers that such entities furnish to consumer reporting agencies, and update such guidelines as often as necessary; and

"(B) prescribe regulations requiring each person that furnishes information to a consumer reporting agency to establish reasonable policies and procedures for implementing the guidelines established pursuant to subparagraph (A).

"(2) COORDINATION.—Each agency required to prescribe regulations under paragraph (1) shall consult and coordinate with each other such agency so that, to the extent possible, the regulations prescribed by each such entity are consistent and comparable with the regulations prescribed by each other such agency.

"(3) CRITERIA.—In developing the guidelines required by paragraph (1)(A), the agencies described in paragraph (1) shall—

"(A) identify patterns, practices, and specific forms of activity that can compromise the accuracy and integrity of information furnished to consumer reporting agencies;

"(B) review the methods (including technological means) used to furnish information relating to consumers to consumer reporting agencies;

"(C) determine whether persons that furnish information to consumer reporting agencies maintain and enforce policies to assure the accuracy and integrity of information furnished to consumer reporting agencies; and

"(D) examine the policies and processes that persons that furnish information to consumer reporting agencies employ to conduct reinvestigations and correct inaccurate information relating to consumers that has been furnished to consumer reporting agencies.".

(b) DUTY OF FURNISHERS TO PROVIDE ACCURATE INFORMATION.—Section 623(a)(1) of the Fair Credit Reporting Act (15 U.S.C. 1681s–2(a)(1)) is amended—

(1) in subparagraph (A), by striking "knows or consciously avoids knowing that the information is inaccurate" and inserting "knows or has reasonable cause to believe that the information is inaccurate"; and

(2) by adding at the end the following:

"(D) DEFINITION.—For purposes of subparagraph (A), the term 'reasonable cause to believe that the information is inaccurate' means having specific knowledge, other than solely allegations by the consumer, that would cause a reasonable person to have substantial doubts about the accuracy of the information.".

(c) ABILITY OF CONSUMER TO DISPUTE INFORMATION DIRECTLY WITH FURNISHER.—Section 623(a) of the Fair Credit Reporting Act (15 U.S.C. 1681s–2(a)), as amended by this Act, is amended by adding at the end the following:

"(8) ABILITY OF CONSUMER TO DISPUTE INFORMATION DIRECTLY WITH FURNISHER.—

"(A) IN GENERAL.—The Federal banking agencies, the National Credit Union Administration, and the Commission shall jointly prescribe regulations that shall identify the circumstances under which a furnisher shall be required to reinvestigate a dispute concerning the accuracy of information contained in a consumer report on the consumer, based on a direct request of a consumer.

"(B) CONSIDERATIONS.—In prescribing regulations under subparagraph (A), the agencies shall weigh—

"(i) the benefits to consumers with the costs on furnishers and the credit reporting system;

"(ii) the impact on the overall accuracy and integrity of consumer reports of any such requirements;

"(iii) whether direct contact by the consumer with the furnisher would likely result in the most expeditious resolution of any such dispute; and

"(iv) the potential impact on the credit reporting process if credit repair organizations, as defined in section 403(3), including entities that would be a credit repair organization, but for section 403(3)(B)(i), are able to circumvent the prohibition in subparagraph (G).

"(C) APPLICABILITY.—Subparagraphs (D) through (G) shall apply in any circumstance identified under the regulations promulgated under subparagraph (A).

"(D) SUBMITTING A NOTICE OF DISPUTE.—A consumer who seeks to dispute the accuracy of information shall provide a dispute notice directly to such person at the address specified by the person for such notices that—

"(i) identifies the specific information that is being disputed;

"(ii) explains the basis for the dispute; and

"(iii) includes all supporting documentation required by the furnisher to substantiate the basis of the dispute.

"(E) DUTY OF PERSON AFTER RECEIVING NOTICE OF DISPUTE.—After receiving a notice of dispute from a consumer pursuant to subparagraph (D), the person that provided the information in dispute to a consumer reporting agency shall—

"(i) conduct an investigation with respect to the disputed information;

"(ii) review all relevant information provided by the consumer with the notice;

"(iii) complete such person's investigation of the dispute and report the results of the investigation to the consumer before the expiration of the period under section 611(a)(1) within which a consumer reporting agency would be required to complete its action if the consumer had elected to dispute the information under that section; and

"(iv) if the investigation finds that the information reported was inaccurate, promptly notify each consumer reporting agency to which the person furnished the inaccurate information of that determination and provide to the agency any correction to that information that is necessary to make the information provided by the person accurate.

"(F) FRIVOLOUS OR IRRELEVANT DISPUTE.—

"(i) IN GENERAL.—This paragraph shall not apply if the person receiving a notice of a dispute from a consumer reasonably determines that the dispute is frivolous or irrelevant, including—

"(I) by reason of the failure of a consumer to provide sufficient information to investigate the disputed information; or

"(II) the submission by a consumer of a dispute that is substantially the same as a dispute previously submitted by or for the consumer, either directly to the person or through a consumer reporting agency under subsection (b), with respect to which the person has already performed the person's duties under this paragraph or subsection (b), as applicable.

"(ii) NOTICE OF DETERMINATION.—Upon making any determination under clause (i) that a dispute is frivolous or irrelevant, the person shall notify the consumer of such determination not later than 5 business days after making such determination, by mail or, if authorized by the consumer for that purpose, by any other means available to the person.

"(iii) CONTENTS OF NOTICE.—A notice under clause (ii) shall include—

"(I) the reasons for the determination under clause (i); and

"(II) identification of any information required to investigate the disputed information, which may consist of a standardized form describing the general nature of such information.

"(G) EXCLUSION OF CREDIT REPAIR ORGANIZATIONS.—This paragraph shall not apply if the notice of the dispute is submitted by, is prepared on behalf of the consumer by, or is submitted on a form supplied to the consumer by, a credit repair organization, as defined in section 403(3), or an entity that would be a credit repair organization, but for section 403(3)(B)(i).".

(d) FURNISHER LIABILITY EXCEPTION.—Section 623(a)(5) of the Fair Credit Reporting Act (15 U.S.C. 1681s–2(a)(5)) is amended—

(1) by striking "A person" and inserting the following:

"(A) IN GENERAL.—A person";

(2) by inserting "date of delinquency on the account, which shall be the" before "month";

(3) by inserting "on the account" before "that immediately preceded"; and

(4) by adding at the end the following:

"(B) RULE OF CONSTRUCTION.—For purposes of this paragraph only, and provided that the consumer does not dispute the information, a person that furnishes information on a delinquent account that is placed for collection, charged for profit or loss, or subjected to any similar action, complies with this paragraph, if—

"(i) the person reports the same date of delinquency as that provided by the creditor to which the account was owed at the time at which the commencement of the delinquency occurred, if the creditor previously reported that date of delinquency to a consumer reporting agency;

"(ii) the creditor did not previously report the date of delinquency to a consumer reporting agency, and the person establishes and follows reasonable procedures to obtain the date of delinquency from the creditor or another reliable source and reports that date to a consumer reporting agency as the date of delinquency; or

"(iii) the creditor did not previously report the date of delinquency to a consumer reporting agency and the date of delinquency cannot be reasonably obtained as provided in clause (ii), the person establishes and follows reasonable procedures to ensure the date reported as the date of delinquency precedes the date on which the account is placed for collection, charged to profit or loss, or subjected to any similar action, and reports such date to the credit reporting agency.".

(e) LIABILITY AND ENFORCEMENT.—

(1) CIVIL LIABILITY.—Section 623 of the Fair Credit Reporting Act (15 U.S.C. 1681s–2) is

amended by striking subsections (c) and (d) and inserting the following:

"(c) Limitation on Liability.—Except as provided in section 621(c)(1)(B), sections 616 and 617 do not apply to any violation of—

"(1) subsection (a) of this section, including any regulations issued thereunder;

"(2) subsection (e) of this section, except that nothing in this paragraph shall limit, expand, or otherwise affect liability under section 616 or 617, as applicable, for violations of subsection (b) of this section; or

"(3) subsection (e) of section 615.

"(d) Limitation on Enforcement.—The provisions of law described in paragraphs (1) through (3) of subsection (c) (other than with respect to the exception described in paragraph (2) of subsection (c)) shall be enforced exclusively as provided under section 621 by the Federal agencies and officials and the State officials identified in section 621.".

(2) State actions.—Section 621(c) of the Fair Credit Reporting Act (15 U.S.C. 1681s(c)) is amended—

(A) in paragraph (1)(B)(ii), by striking "of section 623(a)" and inserting "described in any of paragraphs (1) through (3) of section 623(c)"; and

(B) in paragraph (5)—

(i) in each of subparagraphs (A) and (B), by striking "of section 623(a)(1)" each place that term appears and inserting "described in any of paragraphs (1) through (3) of section 623(c)"; and

(ii) by amending the paragraph heading to read as follows:

"(5) Limitations on state actions for certain violations.—".

(f) Rule of Construction.—Nothing in this section, the amendments made by this section, or any other provision of this Act shall be construed to affect any liability under section 616 or 617 of the Fair Credit Reporting Act (15 U.S.C. 1681n, 1681o) that existed on the day before the date of enactment of this Act.

SEC. 313. FTC AND CONSUMER REPORTING AGENCY ACTION CONCERNING COMPLAINTS.

(a) In General.—Section 611 of the Fair Credit Reporting Act (15 U.S.C. 1681i) is amended by adding at the end the following:

"(e) Treatment of Complaints and Report to Congress.—

"(1) In general.—The Commission shall—

"(A) compile all complaints that it receives that a file of a consumer that is maintained by a consumer reporting agency described in section 603(p) contains incomplete or inaccurate information, with respect to which, the consumer appears to have disputed the completeness or accuracy with the consumer reporting agency or otherwise utilized the procedures provided by subsection (a); and

"(B) transmit each such complaint to each consumer reporting agency involved.

"(2) Exclusion.—Complaints received or obtained by the Commission pursuant to its investigative authority under the Federal Trade Commission Act shall not be subject to paragraph (1).

"(3) Agency responsibilities.—Each consumer reporting agency described in section 603(p) that receives a complaint transmitted by the Commission pursuant to paragraph (1) shall—

"(A) review each such complaint to determine whether all legal obligations imposed on the consumer reporting agency under this title (including any obligation imposed by an applicable court or administrative order) have been met with respect to the subject matter of the complaint;

"(B) provide reports on a regular basis to the Commission regarding the determinations of and actions taken by the consumer reporting agency, if any, in connection with its review of such complaints; and

"(C) maintain, for a reasonable time period, records regarding the disposition of each such complaint that is sufficient to demonstrate compliance with this subsection.

"(4) Rulemaking authority.—The Commission may prescribe regulations, as appropriate to implement this subsection.

"(5) Annual report.—The Commission shall submit to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives an annual report regarding information gathered by the Commission under this subsection.".

(b) Prompt Investigation of Disputed Consumer Information.—

(1) Study required.—The Board and the Commission shall jointly study the extent to which, and the manner in which, consumer reporting agencies and furnishers of consumer information to consumer reporting agencies are complying with the procedures, time lines, and requirements under the Fair Credit Reporting Act for the prompt investigation of the disputed accuracy of any consumer information, the completeness of the information provided to consumer reporting agencies, and the prompt correction or deletion, in accordance with such Act, of any inaccurate or incomplete information or information that cannot be verified.

(2) Report required.—Before the end of the 12-month period beginning on the date of enactment of this Act, the Board and the Commission shall jointly submit a progress report to the Congress on the results of the study required under paragraph (1).

(3) Considerations.—In preparing the report required under paragraph (2), the Board and the Commission shall consider information relating to complaints compiled by the Commission under section 611(e) of the Fair Credit Reporting Act, as added by this section.

(4) Recommendations.—The report required under paragraph (2) shall include such recommendations as the Board and the Commission jointly determine to be appropriate for legislative or administrative action, to ensure that—

(A) consumer disputes with consumer reporting agencies over the accuracy or completeness of information in a consumer's file are promptly and fully investigated and any incorrect, incomplete, or unverifiable information is corrected or deleted immediately thereafter;

(B) furnishers of information to consumer reporting agencies maintain full and prompt compliance with the duties and responsibilities established under section 623 of the Fair Credit Reporting Act; and

(C) consumer reporting agencies establish and maintain appropriate internal controls and management review procedures for maintaining full and continuous compliance with the procedures, time lines, and requirements under the Fair Credit Reporting Act for the prompt investigation of the disputed accuracy of any consumer information and the prompt correction or deletion, in accordance with such Act, of any inaccurate or incomplete information or information that cannot be verified.

SEC. 314. IMPROVED DISCLOSURE OF THE RESULTS OF REINVESTIGATION.

(a) In General.—Section 611(a)(5)(A) of the Fair Credit Reporting Act (15 U.S.C. 1681i(a)(5)(A)) is amended by striking "shall" and all that follows through the end of the subparagraph, and inserting the following: "shall—

"(i) promptly delete that item of information from the file of the consumer, or modify that item of information, as appropriate, based on the results of the reinvestigation; and

"(ii) promptly notify the furnisher of that information that the information has been modified or deleted from the file of the consumer.".

(b) Furnisher Requirements Relating to Inaccurate, Incomplete, or Unverifiable Information.—Section 623(b)(1) of the Fair Credit Reporting Act (15 U.S.C. 1681s–2(b)(1)) is amended—

(1) in subparagraph (C), by striking "and" at the end; and

(2) in subparagraph (D), by striking the period at the end and inserting the following: "; and

"(E) if an item of information disputed by a consumer is found to be inaccurate or incomplete or cannot be verified after any reinvestigation under paragraph (1), for purposes of reporting to a consumer reporting agency only, as appropriate, based on the results of the reinvestigation promptly—

"(i) modify that item of information;

"(ii) delete that item of information; or

"(iii) permanently block the reporting of that item of information.".

SEC. 315. RECONCILING ADDRESSES.

Section 605 of the Fair Credit Reporting Act (15 U.S.C. 1681c), as amended by this Act, is amended by adding at the end the following:

"(h) Notice of Discrepancy in Address.—

"(1) In general.—If a person has requested a consumer report relating to a consumer from a consumer reporting agency described in section 603(p), the request includes an address for the consumer that substantially differs from the addresses in the file of the consumer, and the agency provides a consumer report in response to the request, the consumer reporting agency shall notify the requester of the existence of the discrepancy.

"(2) Regulations.—

"(A) Regulations required.—The Federal banking agencies, the National Credit Union Administration, and the Commission shall jointly, with respect to the entities that are subject to their respective enforcement authority under section 621, prescribe regulations providing guidance regarding reasonable policies and procedures that a user of a consumer report should employ when such user has received a notice of discrepancy under paragraph (1).

"(B) Policies and procedures to be included.—The regulations prescribed under subparagraph (A) shall describe reasonable policies and procedures for use by a user of a consumer report—

"(i) to form a reasonable belief that the user knows the identity of the person to whom the consumer report pertains; and

"(ii) if the user establishes a continuing relationship with the consumer, and the user regularly and in the ordinary course of business furnishes information to the consumer reporting agency from which the notice of discrepancy pertaining to the consumer was obtained, to reconcile the address of the consumer with the consumer reporting agency by furnishing such address to such consumer reporting agency as part of information regularly furnished by the user for the period in which the relationship is established.".

SEC. 316. NOTICE OF DISPUTE THROUGH RESELLER.

(a) Requirement for Reinvestigation of Disputed Information Upon Notice From a Reseller.—Section 611(a) of the Fair Credit Reporting Act (15 U.S.C. 1681i(a)(1)(A)) is amended—

(1) in paragraph (1)(A)—

(A) by striking "If the completeness" and inserting "Subject to subsection (f), if the completeness";

(B) by inserting ", or indirectly through a reseller," after "notifies the agency directly"; and

(C) by inserting "or reseller" before the period at the end;

(2) in paragraph (2)(A)—

(A) by inserting "or a reseller" after "dispute from any consumer"; and

(B) by inserting "or reseller" before the period at the end; and

(3) in paragraph (2)(B), by inserting "or the reseller" after "from the consumer".

(b) REINVESTIGATION REQUIREMENT APPLICABLE TO RESELLERS.—Section 611 of the Fair Credit Reporting Act (15 U.S.C. 1681i), as amended by this Act, is amended by adding at the end the following:

"(f) REINVESTIGATION REQUIREMENT APPLICABLE TO RESELLERS.—

"(1) EXEMPTION FROM GENERAL REINVESTIGATION REQUIREMENT.—Except as provided in paragraph (2), a reseller shall be exempt from the requirements of this section.

"(2) ACTION REQUIRED UPON RECEIVING NOTICE OF A DISPUTE.—If a reseller receives a notice from a consumer of a dispute concerning the completeness or accuracy of any item of information contained in a consumer report on such consumer produced by the reseller, the reseller shall, within 5 business days of receiving the notice, and free of charge—

"(A) determine whether the item of information is incomplete or inaccurate as a result of an act or omission of the reseller; and

"(B) if—

"(i) the reseller determines that the item of information is incomplete or inaccurate as a result of an act or omission of the reseller, not later than 20 days after receiving the notice, correct the information in the consumer report or delete it; or

"(ii) if the reseller determines that the item of information is not incomplete or inaccurate as a result of an act or omission of the reseller, convey the notice of the dispute, together with all relevant information provided by the consumer, to each consumer reporting agency that provided the reseller with the information that is the subject of the dispute, using an address or a notification mechanism specified by the consumer reporting agency for such notices.

"(3) RESPONSIBILITY OF CONSUMER REPORTING AGENCY TO NOTIFY CONSUMER THROUGH RESELLER.—Upon the completion of a reinvestigation under this section of a dispute concerning the completeness or accuracy of any information in the file of a consumer by a consumer reporting agency that received notice of the dispute from a reseller under paragraph (2)—

"(A) the notice by the consumer reporting agency under paragraph (6), (7), or (8) of subsection (a) shall be provided to the reseller in lieu of the consumer; and

"(B) the reseller shall immediately reconvey such notice to the consumer, including any notice of a deletion by telephone in the manner required under paragraph (8)(A).

"(4) RESELLER REINVESTIGATIONS.—No provision of this subsection shall be construed as prohibiting a reseller from conducting a reinvestigation of a consumer dispute directly.".

(c) TECHNICAL AND CONFORMING AMENDMENT.—Section 611(a)(2)(B) of the Fair Credit Reporting Act (15 U.S.C. 1681i(a)(2)(B)) is amended in the subparagraph heading, by striking "FROM CONSUMER".

SEC. 317. REASONABLE REINVESTIGATION REQUIRED.

Section 611(a)(1)(A) of the Fair Credit Reporting Act (15 U.S.C. 1681i(a)(1)(A)) is amended by striking "shall reinvestigate free of charge" and inserting "shall, free of charge, conduct a reasonable reinvestigation to determine whether the disputed information is inaccurate".

SEC. 318. FTC STUDY OF ISSUES RELATING TO THE FAIR CREDIT REPORTING ACT.

(a) STUDY REQUIRED.—

(1) IN GENERAL.—The Commission shall conduct a study on ways to improve the operation of the Fair Credit Reporting Act.

(2) AREAS FOR STUDY.—In conducting the study under paragraph (1), the Commission shall review—

(A) the efficacy of increasing the number of points of identifying information that a credit reporting agency is required to match to ensure that a consumer is the correct individual to whom a consumer report relates before releasing a consumer report to a user, including—

(i) the extent to which requiring additional points of such identifying information to match would—

(I) enhance the accuracy of credit reports; and

(II) combat the provision of incorrect consumer reports to users;

(ii) the extent to which requiring an exact match of the first and last name, social security number, and address and ZIP Code of the consumer would enhance the likelihood of increasing credit report accuracy; and

(iii) the effects of allowing consumer reporting agencies to use partial matches of social security numbers and name recognition software on the accuracy of credit reports;

(B) requiring notification to consumers when negative information has been added to their credit reports, including—

(i) the potential impact of such notification on the ability of consumers to identify errors on their credit reports; and

(ii) the potential impact of such notification on the ability of consumers to remove fraudulent information from their credit reports;

(C) the effects of requiring that a consumer who has experienced an adverse action based on a credit report receives a copy of the same credit report that the creditor relied on in taking the adverse action, including—

(i) the extent to which providing such reports to consumers would increase the ability of consumers to identify errors in their credit reports; and

(ii) the extent to which providing such reports to consumers would increase the ability of consumers to remove fraudulent information from their credit reports;

(D) any common financial transactions that are not generally reported to the consumer reporting agencies, but would provide useful information in determining the credit worthiness of consumers; and

(E) any actions that might be taken within a voluntary reporting system to encourage the reporting of the types of transactions described in subparagraph (D).

(3) COSTS AND BENEFITS.—With respect to each area of study described in paragraph (2), the Commission shall consider the extent to which such requirements would benefit consumers, balanced against the cost of implementing such provisions.

(b) REPORT REQUIRED.—Not later than 1 year after the date of enactment of this Act, the chairman of the Commission shall submit a report to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives containing a detailed summary of the findings and conclusions of the study under this section, together with such recommendations for legislative or administrative actions as may be appropriate.

SEC. 319. FTC STUDY OF THE ACCURACY OF CONSUMER REPORTS.

(a) STUDY REQUIRED.—Until the final report is submitted under subsection (b)(2), the Commission shall conduct an ongoing study of the accuracy and completeness of information contained in consumer reports prepared or maintained by consumer reporting agencies and methods for improving the accuracy and completeness of such information.

(b) BIENNIAL REPORTS REQUIRED.—

(1) INTERIM REPORTS.—The Commission shall submit an interim report to the Congress on the study conducted under subsection (a) at the end of the 1-year period beginning on the date of enactment of this Act and biennially thereafter for 8 years.

(2) FINAL REPORT.—The Commission shall submit a final report to the Congress on the study conducted under subsection (a) at the end of the 2-year period beginning on the date on which the final interim report is submitted to the Congress under paragraph (1).

(3) CONTENTS.—Each report submitted under this subsection shall contain a detailed summary of the findings and conclusions of the Commission with respect to the study required under subsection (a) and such recommendations for legislative and administrative action as the Commission may determine to be appropriate.

TITLE IV—LIMITING THE USE AND SHARING OF MEDICAL INFORMATION IN THE FINANCIAL SYSTEM

SEC. 411. PROTECTION OF MEDICAL INFORMATION IN THE FINANCIAL SYSTEM.

(a) IN GENERAL.—Section 604(g) of the Fair Credit Reporting Act (15 U.S.C. 1681b(g)) is amended to read as follows:

"(g) PROTECTION OF MEDICAL INFORMATION.—

"(1) LIMITATION ON CONSUMER REPORTING AGENCIES.—A consumer reporting agency shall not furnish for employment purposes, or in connection with a credit or insurance transaction, a consumer report that contains medical information about a consumer, unless—

"(A) if furnished in connection with an insurance transaction, the consumer affirmatively consents to the furnishing of the report;

"(B) if furnished for employment purposes or in connection with a credit transaction—

"(i) the information to be furnished is relevant to process or effect the employment or credit transaction; and

"(ii) the consumer provides specific written consent for the furnishing of the report that describes in clear and conspicuous language the use for which the information will be furnished; or

"(C) the information to be furnished pertains solely to transactions, accounts, or balances relating to debts arising from the receipt of medical services, products, or devises, where such information, other than account status or amounts, is restricted or reported using codes that do not identify, or do not provide information sufficient to infer, the specific provider or the nature of such services, products, or devices, as provided in section 605(a)(6).

"(2) LIMITATION ON CREDITORS.—Except as permitted pursuant to paragraph (3)(C) or regulations prescribed under paragraph (5)(A), a creditor shall not obtain or use medical information pertaining to a consumer in connection with any determination of the consumer's eligibility, or continued eligibility, for credit.

"(3) ACTIONS AUTHORIZED BY FEDERAL LAW, INSURANCE ACTIVITIES AND REGULATORY DETERMINATIONS.—Section 603(d)(3) shall not be construed so as to treat information or any communication of information as a consumer report if the information or communication is disclosed—

"(A) in connection with the business of insurance or annuities, including the activities described in section 18B of the model Privacy of Consumer Financial and Health Information Regulation issued by the National Association of Insurance Commissioners (as in effect on January 1, 2003);

"(B) for any purpose permitted without authorization under the Standards for Individually Identifiable Health Information promulgated by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996, or referred to under section 1179 of such Act, or described in section 502(e) of Public Law 106–102; or

"(C) as otherwise determined to be necessary and appropriate, by regulation or order and *subject to paragraph (6), by the Commission, any Federal banking agency or the National Credit Union Administration (with respect to any financial institution subject to the jurisdiction of such agency or Administration under paragraph (1), (2), or (3) of section 621(b), or the applicable State insurance authority (with respect to any person engaged in providing insurance or annuities).*

"(4) LIMITATION ON REDISCLOSURE OF MEDICAL INFORMATION.—Any person that receives medical information pursuant to paragraph (1) or (3) shall not disclose such information to any other person, except as necessary to carry out the purpose for which the information was initially disclosed, or as otherwise permitted by statute, regulation, or order.

"(5) REGULATIONS AND EFFECTIVE DATE FOR PARAGRAPH (2).—

"(A) REGULATIONS REQUIRED.—Each Federal banking agency and the National Credit Union Administration shall, subject to paragraph (6) and after notice and opportunity for comment, prescribe regulations that permit transactions under paragraph (2) that are determined to be necessary and appropriate to protect legitimate operational, transactional, risk, consumer, and other needs (and which shall include permitting actions necessary for administrative verification purposes), consistent with the intent of paragraph (2) to restrict the use of medical information for inappropriate purposes.

"(B) FINAL REGULATIONS REQUIRED.—The Federal banking agencies and the National Credit Union Administration shall issue the regulations required under subparagraph (A) in final form before the end of the 6-month period beginning on the date of enactment of the Fair and Accurate Credit Transactions Act of 2003.

"(6) COORDINATION WITH OTHER LAWS.—No provision of this subsection shall be construed as altering, affecting, or superseding the applicability of any other provision of Federal law relating to medical confidentiality.".

(b) RESTRICTION ON SHARING OF MEDICAL INFORMATION.—Section 603(d) of the Fair Credit Reporting Act (15 U.S.C. 1681a(d)) is amended—

(1) in paragraph (2), by striking "The term" and inserting "Except as provided in paragraph (3), the term"; and

(2) by adding at the end the following new paragraph:

"(3) RESTRICTION ON SHARING OF MEDICAL INFORMATION.—Except for information or any communication of information disclosed as provided in section 604(g)(3), the exclusions in paragraph (2) shall not apply with respect to information disclosed to any person related by common ownership or affiliated by corporate control, if the information is—

"(A) medical information;

"(B) an individualized list or description based on the payment transactions of the consumer for medical products or services; or

"(C) an aggregate list of identified consumers based on payment transactions for medical products or services.

(c) DEFINITION.—Section 603(i) of the Fair Credit Reporting Act (15 U.S.C. 1681a(i)) is amended to read as follows:

"(i) MEDICAL INFORMATION.—The term 'medical information'—

"(1) means information or data, whether oral or recorded, in any form or medium, created by or derived from a health care provider or the consumer, that relates to—

"(A) the past, present, or future physical, mental, or behavioral health or condition of an individual;

"(B) the provision of health care to an individual; or

"(C) the payment for the provision of health care to an individual.

"(2) does not include the age or gender of a consumer, demographic information about the consumer, including a consumer's residence address or e-mail address, or any other information about a consumer that does not relate to the physical, mental, or behavioral health or condition of a consumer, including the existence or value of any insurance policy.".

(d) EFFECTIVE DATES.—This section shall take effect at the end of the 180-day period beginning on the date of enactment of this Act, except that paragraph (2) of section 604(g) of the Fair Credit Reporting Act (as amended by subsection (a) of this section) shall take effect on the later of—

(1) the end of the 90-day period beginning on the date on which the regulations required under paragraph (5)(B) of such section 604(g) are issued in final form; or

(2) the date specified in the regulations referred to in paragraph (1).

SEC. 412. CONFIDENTIALITY OF MEDICAL CONTACT INFORMATION IN CONSUMER REPORTS.

(a) DUTIES OF MEDICAL INFORMATION FURNISHERS.—Section 623(a) of the Fair Credit Reporting Act (15 U.S.C. 1681s–2(a)), as amended by this Act, is amended by adding at the end the following:

"(9) DUTY TO PROVIDE NOTICE OF STATUS AS MEDICAL INFORMATION FURNISHER.—A person whose primary business is providing medical services, products, or devices, or the person's agent or assignee, who furnishes information to a consumer reporting agency on a consumer shall be considered a medical information furnisher for purposes of this title, and shall notify the agency of such status.".

(b) RESTRICTION OF DISSEMINATION OF MEDICAL CONTACT INFORMATION.—Section 605(a) of the Fair Credit Reporting Act (15 U.S.C. 1681c(a)) is amended by adding at the end the following:

"'(6) The name, address, and telephone number of any medical information furnisher that has notified the agency of its status, unless—

"(A) such name, address, and telephone number are restricted or reported using codes that do not identify, or provide information sufficient to infer, the specific provider or the nature of such services, products, or devices to a person other than the consumer; or

"(B) the report is being provided to an insurance company for a purpose relating to engaging in the business of insurance other than property and casualty insurance.".

(c) NO EXCEPTIONS ALLOWED FOR DOLLAR AMOUNTS.—Section 605(b) of the Fair Credit Reporting Act (15 U.S.C. 1681c(b)) is amended by striking "The provisions of subsection (a)" and inserting "The provisions of paragraphs (1) through (5) of subsection (a)".

(d) COORDINATION WITH OTHER LAWS.—No provision of any amendment made by this section shall be construed as altering, affecting, or superseding the applicability of any other provision of Federal law relating to medical confidentiality.

(e) FTC REGULATION OF CODING OF TRADE NAMES.—Section 621 of the Fair Credit Reporting Act (15 U.S.C. 1681s), as amended by this Act, is amended by adding at the end the following:

"(g) FTC REGULATION OF CODING OF TRADE NAMES.—If the Commission determines that a person described in paragraph (9) of section 623(a) has not met the requirements of such paragraph, the Commission shall take action to ensure the person's compliance with such paragraph, which may include issuing model guidance or prescribing reasonable policies and procedures, as necessary to ensure that such person complies with such paragraph.".

(f) TECHNICAL AND CONFORMING AMENDMENTS.—Section 604(g) of the Fair Credit Reporting Act (15 U.S.C. 1681b(g)), as amended by section 411 of this Act, is amended—

(1) in paragraph (1), by inserting "(other than medical contact information treated in the manner required under section 605(a)(6))" after "a consumer report that contains medical information"; and

(2) in paragraph (2), by inserting "(other than medical information treated in the manner required under section 605(a)(6))" after "a creditor shall not obtain or use medical information".

(g) EFFECTIVE DATE.—The amendments made by this section shall take effect at the end of the 15-month period beginning on the date of enactment of this Act.

TITLE V—FINANCIAL LITERACY AND EDUCATION IMPROVEMENT

SEC. 511. SHORT TITLE.

This title may be cited as the "Financial Literacy and Education Improvement Act".

SEC. 512. DEFINITIONS.

As used in this title—

(1) the term "Chairperson" means the Chairperson of the Financial Literacy and Education Commission; and

(2) the term "Commission" means the Financial Literacy and Education Commission established under section 513.

SEC. 513. ESTABLISHMENT OF FINANCIAL LITERACY AND EDUCATION COMMISSION.

(a) IN GENERAL.—There is established a commission to be known as the "Financial Literacy and Education Commission".

(b) PURPOSE.—The Commission shall serve to improve the financial literacy and education of persons in the United States through development of a national strategy to promote financial literacy and education.

(c) MEMBERSHIP.—

(1) COMPOSITION.—The Commission shall be composed of—

(A) the Secretary of the Treasury;

(B) the respective head of each of the Federal banking agencies (as defined in section 3 of the Federal Deposit Insurance Act), the National Credit Union Administration, the Securities and Exchange Commission, each of the Departments of Education, Agriculture, Defense, Health and Human Services, Housing and Urban Development, Labor, and Veterans Affairs, the Federal Trade Commission, the General Services Administration, the Small Business Administration, the Social Security Administration, the Commodity Futures Trading Commission, and the Office of Personnel Management; and

(C) at the discretion of the President, not more than 5 individuals appointed by the President from among the administrative heads of any other Federal agencies, departments, or other Federal Government entities, whom the President determines to be engaged in a serious effort to improve financial literacy and education.

(2) ALTERNATES.—Each member of the Commission may designate an alternate if the member is unable to attend a meeting of the Commission. Such alternate shall be an individual who exercises significant decisionmaking authority.

(d) CHAIRPERSON.—The Secretary of the Treasury shall serve as the Chairperson.

(e) MEETINGS.—The Commission shall hold, at the call of the Chairperson, at least 1 meeting every 4 months. All such meetings shall be open to the public. The Commission may hold, at the call of the Chairperson, such other meetings as the Chairperson sees fit to carry out this title.

(f) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(g) INITIAL MEETING.—The Commission shall hold its first meeting not later than 60 days after the date of enactment of this Act.

SEC. 514. DUTIES OF THE COMMISSION.

(a) DUTIES.—

(1) IN GENERAL.—The Commission, through the authority of the members referred to in section 513(c), shall take such actions as it deems necessary to streamline, improve, or augment the financial literacy and education programs, grants, and materials of the Federal Government, including curricula for all Americans.

(2) AREAS OF EMPHASIS.—To improve financial literacy and education, the Commission shall emphasize, among other elements, basic personal income and household money management and planning skills, including how to—

(A) create household budgets, initiate savings plans, and make strategic investment decisions for education, retirement, home ownership, wealth building, or other savings goals;

(B) manage spending, credit, and debt, including credit card debt, effectively;

(C) increase awareness of the availability and significance of credit reports and credit scores in obtaining credit, the importance of their accuracy (and how to correct inaccuracies), their effect on credit terms, and the effect common financial decisions may have on credit scores;

(D) ascertain fair and favorable credit terms;

(E) avoid abusive, predatory, or deceptive credit offers and financial products;

(F) understand, evaluate, and compare financial products, services, and opportunities;

(G) understand resources that ought to be easily accessible and affordable, and that inform and educate investors as to their rights and avenues of recourse when an investor believes his or her rights have been violated by unprofessional conduct of market intermediaries;

(H) increase awareness of the particular financial needs and financial transactions (such as the sending of remittances) of consumers who are targeted in multilingual financial literacy and education programs and improve the development and distribution of multilingual financial literacy and education materials;

(I) promote bringing individuals who lack basic banking services into the financial mainstream by opening and maintaining an account with a financial institution; and

(J) improve financial literacy and education through all other related skills, including personal finance and related economic education, with the primary goal of programs not simply to improve knowledge, but rather to improve consumers' financial choices and outcomes.

(b) WEBSITE.—

(1) IN GENERAL.—The Commission shall establish and maintain a website, such as the domain name "FinancialLiteracy.gov", or a similar domain name.

(2) PURPOSES.—The website established under paragraph (1) shall—

(A) serve as a clearinghouse of information about Federal financial literacy and education programs;

(B) provide a coordinated entry point for accessing information about all Federal publications, grants, and materials promoting enhanced financial literacy and education;

(C) offer information on all Federal grants to promote financial literacy and education, and on how to target, apply for, and receive a grant that is most appropriate under the circumstances;

(D) as the Commission considers appropriate, feature website links to efforts that have no commercial content and that feature information about financial literacy and education programs, materials, or campaigns; and

(E) offer such other information as the Commission finds appropriate to share with the public in the fulfillment of its purpose.

(c) TOLL-FREE HOTLINE.—The Commission shall establish a toll-free telephone number that shall be made available to members of the public seeking information about issues pertaining to financial literacy and education.

(d) DEVELOPMENT AND DISSEMINATION OF MATERIALS.—The Commission shall—

(1) develop materials to promote financial literacy and education; and

(2) disseminate such materials to the general public.

(e) COORDINATION OF EFFORTS.—The Commission shall take such steps as are necessary to coordinate and promote financial literacy and education efforts at the State and local level, including promoting partnerships among Federal, State, and local governments, nonprofit organizations, and private enterprises.

(f) NATIONAL STRATEGY.—

(1) IN GENERAL.—The Commission shall—

(A) not later than 18 months after the date of enactment of this Act, develop a national strategy to promote basic financial literacy and education among all American consumers; and

(B) coordinate Federal efforts to implement the strategy developed under subparagraph (A).

(2) STRATEGY.—The strategy to promote basic financial literacy and education required to be developed under paragraph (1) shall provide for—

(A) participation by State and local governments and private, nonprofit, and public institutions in the creation and implementation of such strategy;

(B) the development of methods—

(i) to increase the general financial education level of current and future consumers of financial services and products; and

(ii) to enhance the general understanding of financial services and products;

(C) review of Federal activities designed to promote financial literacy and education, and development of a plan to improve coordination of such activities; and

(D) the identification of areas of overlap and duplication among Federal financial literacy and education activities and proposed means of eliminating any such overlap and duplication.

(3) NATIONAL STRATEGY REVIEW.—The Commission shall, not less than annually, review the national strategy developed under this subsection and make such changes and recommendations as it deems necessary.

(g) CONSULTATION.—The Commission shall actively consult with a variety of representatives from private and nonprofit organizations and State and local agencies, as determined appropriate by the Commission.

(h) REPORTS.—

(1) IN GENERAL.—Not later than 18 months after the date of the first meeting of the Commission, and annually thereafter, the Commission shall issue a report, the Strategy for Assuring Financial Empowerment ("SAFE Strategy"), to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives on the progress of the Commission in carrying out this title.

(2) CONTENTS.—The report required under paragraph (1) shall include—

(A) the national strategy for financial literacy and education, as described under subsection (f);

(B) information concerning the implementation of the duties of the Commission under subsections (a) through (g);

(C) an assessment of the success of the Commission in implementing the national strategy developed under subsection (f);

(D) an assessment of the availability, utilization, and impact of Federal financial literacy and education materials;

(E) information concerning the content and public use of—

(i) the website established under subsection (b); and

(ii) the toll-free telephone number established under subsection (c);

(F) a brief survey of the financial literacy and education materials developed under subsection (d), and data regarding the dissemination and impact of such materials, as measured by improved financial decisionmaking;

(G) a brief summary of any hearings conducted by the Commission, including a list of witnesses who testified at such hearings;

(H) information about the activities of the Commission planned for the next fiscal year;

(I) a summary of all Federal financial literacy and education activities targeted to communities that have historically lacked access to financial literacy materials and education, and have been underserved by the mainstream financial systems; and

(J) such other materials relating to the duties of the Commission as the Commission deems appropriate.

(3) INITIAL REPORT.—The initial report under paragraph (1) shall include information regarding all Federal programs, materials, and grants which seek to improve financial literacy, and assess the effectiveness of such programs.

(i) TESTIMONY.—The Commission shall annually provide testimony by the Chairperson to the Committee on Banking, Housing, and Urban Affairs of the Senate and the Committee on Financial Services of the House of Representatives.

SEC. 515. POWERS OF THE COMMISSION.

(a) HEARINGS.—

(1) IN GENERAL.—The Commission shall hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission deems appropriate to carry out this title.

(2) PARTICIPATION.—In hearings held under this subsection, the Commission shall consider inviting witnesses from, among other groups—

(A) other Federal Government officials;

(B) State and local government officials;

(C) consumer and community groups;

(D) nonprofit financial literacy and education groups (such as those involved in personal finance and economic education); and

(E) the financial services industry.

(b) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out this title. Upon request of the Chairperson, the head of such department or agency shall furnish such information to the Commission.

(c) PERIODIC STUDIES.—The Commission may conduct periodic studies regarding the state of financial literacy and education in the United States, as the Commission determines appropriate.

(d) MULTILINGUAL.—The Commission may take any action to develop and promote financial literacy and education materials in languages other than English, as the Commission deems appropriate, including for the website established under section 514(b), at the toll-free number established under section 514(c), and in the materials developed and disseminated under section 514(d).

SEC. 516. COMMISSION PERSONNEL MATTERS.

(a) COMPENSATION OF MEMBERS.—Each member of the Commission shall serve without compensation in addition to that received for their service as an officer or employee of the United States.

(b) TRAVEL EXPENSES.—The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(c) ASSISTANCE.—

(1) IN GENERAL.—The Director of the Office of Financial Education of the Department of the

Treasury shall provide assistance to the Commission, upon request of the Commission, without reimbursement.

(2) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

SEC. 517. STUDIES BY THE COMPTROLLER GENERAL.

(a) EFFECTIVENESS STUDY.—Not later than 3 years after the date of enactment of this Act, the Comptroller General of the United States shall submit a report to Congress assessing the effectiveness of the Commission in promoting financial literacy and education.

(b) STUDY AND REPORT ON THE NEED AND MEANS FOR IMPROVING FINANCIAL LITERACY AMONG CONSUMERS.—

(1) STUDY REQUIRED.—The Comptroller General of the United States shall conduct a study to assess the extent of consumers' knowledge and awareness of credit reports, credit scores, and the dispute resolution process, and on methods for improving financial literacy among consumers.

(2) FACTORS TO BE INCLUDED.—The study required under paragraph (1) shall include the following issues:

(A) The number of consumers who view their credit reports.

(B) Under what conditions and for what purposes do consumers primarily obtain a copy of their consumer report (such as for the purpose of ensuring the completeness and accuracy of the contents, to protect against fraud, in response to an adverse action based on the report, or in response to suspected identity theft) and approximately what percentage of the total number of consumers who obtain a copy of their consumer report do so for each such primary purpose.

(C) The extent of consumers' knowledge of the data collection process.

(D) The extent to which consumers know how to get a copy of a consumer report.

(E) The extent to which consumers know and understand the factors that positively or negatively impact credit scores.

(3) REPORT REQUIRED.—Before the end of the 12-month period beginning on the date of enactment of this Act, the Comptroller General shall submit a report to Congress on the findings and conclusions of the Comptroller General pursuant to the study conducted under this subsection, together with such recommendations for legislative or administrative action as the Comptroller General may determine to be appropriate, including recommendations on methods for improving financial literacy among consumers.

SEC. 518. THE NATIONAL PUBLIC SERVICE MULTIMEDIA CAMPAIGN TO ENHANCE THE STATE OF FINANCIAL LITERACY.

(a) IN GENERAL.—The Secretary of the Treasury (in this section referred to as the "Secretary"), after review of the recommendations of the Commission, as part of the national strategy, shall develop, implement, and conduct a pilot national public service multimedia campaign to enhance the state of financial literacy and education in the United States.

(b) PROGRAM REQUIREMENTS.—

(1) PUBLIC SERVICE CAMPAIGN.—The Secretary, after review of the recommendations of the Commission, shall select and work with a nonprofit organization or organizations that are especially well-qualified in the distribution of public service campaigns, and have secured private sector funds to produce the pilot national public service multimedia campaign.

(2) DEVELOPMENT OF MULTIMEDIA CAMPAIGN.—The Secretary, after review of the recommendations of the Commission, shall develop, in consultation with nonprofit, public, or private organizations, especially those that are well qualified by virtue of their experience in the field of financial literacy and education, to develop the financial literacy national public service multimedia campaign.

(3) FOCUS OF CAMPAIGN.—The pilot national public service multimedia campaign shall be consistent with the national strategy, and shall promote the toll-free telephone number and the website developed under this title.

(c) MULTILINGUAL.—The Secretary may develop the multimedia campaign in languages other than English, as the Secretary deems appropriate.

(d) PERFORMANCE MEASURES.—The Secretary shall develop measures to evaluate the effectiveness of the pilot national public service multimedia campaign, as measured by improved financial decision making among individuals.

(e) REPORT.—For each fiscal year for which there are appropriations pursuant to the authorization in subsection (e), the Secretary shall submit a report to the Committee on Banking, Housing, and Urban Affairs and the Committee on Appropriations of the Senate and the Committee on Financial Services and the Committee on Appropriations of the House of Representatives, describing the status and implementation of the provisions of this section and the state of financial literacy and education in the United States.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary, not to exceed $3,000,000 for fiscal years 2004, 2005, and 2006, for the development, production, and distribution of a pilot national public service multimedia campaign under this section.

SEC. 519. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to the Commission such sums as may be necessary to carry out this title, including administrative expenses of the Commission.

TITLE VI—PROTECTING EMPLOYEE MISCONDUCT INVESTIGATIONS

SEC. 611. CERTAIN EMPLOYEE INVESTIGATION COMMUNICATIONS EXCLUDED FROM DEFINITION OF CONSUMER REPORT.

(a) IN GENERAL.—Section 603 of the Fair Credit Reporting Act (15 U.S.C. 1681a), as amended by this Act is amended by adding at the end the following:

"(x) EXCLUSION OF CERTAIN COMMUNICATIONS FOR EMPLOYEE INVESTIGATIONS.—

"(1) COMMUNICATIONS DESCRIBED IN THIS SUBSECTION.—A communication is described in this subsection if—

"(A) but for subsection (d)(2)(D), the communication would be a consumer report;

"(B) the communication is made to an employer in connection with an investigation of—

"(i) suspected misconduct relating to employment; or

"(ii) compliance with Federal, State, or local laws and regulations, the rules of a self-regulatory organization, or any preexisting written policies of the employer;

"(C) the communication is not made for the purpose of investigating a consumer's credit worthiness, credit standing, or credit capacity; and

"(D) the communication is not provided to any person except—

"(i) to the employer or an agent of the employer;

"(ii) to any Federal or State officer, agency, or department, or any officer, agency, or department of a unit of general local government;

"(iii) to any self-regulatory organization with regulatory authority over the activities of the employer or employee;

"(iv) as otherwise required by law; or

"(v) pursuant to section 608.

"(2) SUBSEQUENT DISCLOSURE.—After taking any adverse action based in whole or in part on a communication described in paragraph (1), the employer shall disclose to the consumer a summary containing the nature and substance of the communication upon which the adverse action is based, except that the sources of information acquired solely for use in preparing what would be but for subsection (d)(2)(D) an investigative consumer report need not be disclosed.

"(3) SELF-REGULATORY ORGANIZATION DEFINED.—For purposes of this subsection, the term 'self-regulatory organization' includes any self-regulatory organization (as defined in section 3(a)(26) of the Securities Exchange Act of 1934), any entity established under title I of the Sarbanes-Oxley Act of 2002, any board of trade designated by the Commodity Futures Trading Commission, and any futures association registered with such Commission.".

(b) TECHNICAL AND CONFORMING AMENDMENT.—Section 603(d)(2)(D) of the Fair Credit Reporting Act (15 U.S.C. 1681a(d)(2)(D)) is amended by inserting "or (x)" after "subsection (o)".

TITLE VII—RELATION TO STATE LAWS

SEC. 711. RELATION TO STATE LAWS.

Section 625 of the Fair Credit Reporting Act (15 U.S.C. 1681t), as so designated by section 214 of this Act, is amended—

(1) in subsection (a), by inserting "or for the prevention or mitigation of identity theft," after "information on consumers,";

(2) in subsection (b), by adding at the end the following:

"(5) with respect to the conduct required by the specific provisions of—

"(A) section 605(g);

"(B) section 605A;

"(C) section 605B;

"(D) section 609(a)(1)(A);

"(E) section 612(a);

"(F) subsections (e), (f), and (g) of section 615;

"(G) section 621(f);

"(H) section 623(a)(6); or

"(I) section 628."; and

(3) in subsection (d)—

(A) by striking paragraph (2);

(B) by striking "(c)—" and all that follows through "do not affect" and inserting "(c) do not affect"; and

(C) by striking "1996; and" and inserting "1996.".

TITLE VIII—MISCELLANEOUS

SEC. 811. CLERICAL AMENDMENTS.

(a) SHORT TITLE.—Section 601 of the Fair Credit Reporting Act (15 U.S.C. 1601 note) is amended by striking "the Fair Credit Reporting Act." and inserting "the 'Fair Credit Reporting Act'.".

(b) SECTION 604.—Section 604(a) of the Fair Credit Reporting Act (15 U.S.C. 1681b(a)) is amended in paragraphs (1) through (5), other than subparagraphs (E) and (F) of paragraph (3), by moving each margin 2 ems to the right.

(c) SECTION 605.—

(1) Section 605(a)(1) of the Fair Credit Reporting Act (15 U.S.C. 1681c(a)(1)) is amended by striking "(1) cases" and inserting "(1) Cases".

(2)(A) Section 5(1) of Public Law 105–347 (112 Stat. 3211) is amended by striking "Judgments which" and inserting "judgments which".

(B) The amendment made by subparagraph (A) shall be deemed to have the same effective date as section 5(1) of Public Law 105–347 (112 Stat. 3211).

(d) SECTION 609.—Section 609(a) of the Fair Credit Reporting Act (15 U.S.C. 1681g(a)) is amended—

(1) in paragraph (2), by moving the margin 2 ems to the right; and

(2) in paragraph (3)(C), by moving the margins 2 ems to the left.

(e) SECTION 617.—Section 617(a)(1) of the Fair Credit Reporting Act (15 U.S.C. 1681o(a)(1)) is amended by adding "and" at the end.

(f) SECTION 621.—Section 621(b)(1)(B) of the Fair Credit Reporting Act (15 U.S.C. 1681s(b)(1)(B)) is amended by striking "25(a)" and inserting "25A".

(g) TITLE 31.—Section 5318 of title 31, United States Code, is amended by redesignating the second item designated as subsection (l) (relating to applicability of rules) as subsection (m).

(h) CONFORMING AMENDMENT.—Section 2411(c) of Public Law 104-208 (110 Stat. 3009-445) is repealed.

And the Senate agreed to the same.

For consideration of the House bill and the Senate amendment, and modifications committed to conference:

MICHAEL G. OXLEY,
DOUG BEREUTER,
SPENCER BACHUS,
MIKE CASTLE,
ED ROYCE,
ROBERT W. NEY,
SUE KELLY,
PAUL GILLMOR,
STEVEN C. LATOURETTE,
JUDY BIGGERT,
PETE SESSIONS,
BARNEY FRANK,
PAUL E. KANJORSKI,
MELVIN L. WATT,
LUIS V. GUTIERREZ,
DARLENE HOOLEY,
DENNIS MOORE,
Managers on the Part of the House.

RICHARD SHELBY,
ROBERT F. BENNETT,
WAYNE ALLARD,
MICHAEL B. ENZI,
PAUL SARBANES,
CHRISTOPHER J. DODD,
TIM JOHNSON,
Managers on the Part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the House to the bill (H.R. 2622) to amend the Fair Credit Reporting Act, to prevent identity theft, improve resolution of consumer disputes, improve the accuracy of consumer records, make improvements in the use of, and consumer access to, credit information, and for other purposes, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The Senate amendment to the text of the bill struck all of the House bill after the enacting clause and inserted a substitute text.

The House recedes from its disagreement to the amendment of the Senate with an amendment that is a substitute for the House bill and the Senate amendment. The Committee of Conference met on November 21, 2003 (the Senate Chairing) and resolved their differences. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clerical changes.

The Fair Credit Reporting Act was enacted in 1970, and substantially amended in 1996. The amendments made at that time were necessary to make the law relevant in an information age. Included in the 1996 amendment were a number of provisions that explicitly preempt state laws. These preemptions expire on January 1, 2004.

Since 1996, the national credit markets have undergone significant change. Most of these changes were the result of technological innovations. Technology has expanded the availability of credit, and permitted instant credit decisions. Mortgage financing that once took weeks now takes hours, and home ownership rates are at historic highs. Consumer credit can be obtained at the point of sale for major items like automobiles. Technology and the prudently-regulated free flow of consumer information under the FCRA has made much of this possible. We live in a mobile society in which 40 million Americans move annually. The FCRA permits consumers to transport their credit with them wherever they go. Both Committees of jurisdiction have developed detailed records regarding the benefits that our national credit reporting system has visited upon consumers of financial products.

Despite the myriad benefits of technology to the American consumer, there has been one drawback. Namely, the free flow information has enabled the explosive growth of a new crime—identity theft. Both Committees developed comprehensive hearing records regarding the growth of this crime, and the havoc it visits upon the lives of its victims. Law enforcement professionals are cognizant of the growth of this crime, and have worked with the affected industries to combat it. While criminal prosecutions and strict fraud detection protocols can curtail identity theft, and punish the wrongdoers, not enough had been done heretofore to aid the real victims of this crime—the consumer whose identity is assumed, and can spend months or years trying to rehabilitate their credit and re-order their affairs.

The House bill and the Senate amendment contain a number of identical provisions. In other instances, the provisions in the respective bills addressed the same issue in a slightly different manner. Both the House bill and the Senate amendment addressed the provisions of the FCRA that preempted state laws, and are due to expire on January 1, 2004. Both bills addressed identity theft, medical information privacy and promote greater consumer access to their credit reports.

The House bill, H.R. 2622, and the bill that served as the core of the Senate amendment (S. 1753) are each the result of an extensive deliberative and legislative process with a three-fold purpose: to assist the victims of identity theft; modernize the FCRA and; enhance the national credit reporting system. Readers should refer to the Committee Reports for the respective bills for further elaboration. The conference agreement contains provisions to accomplish these goals. It is the conferees' belief that this legislation will assist the victims of identity theft, and ensure the operational efficiency of our national credit system by creating a number of preemptive national standards.

For consideration of the House bill and the Senate amendment, and modifications committed to conference:

MICHAEL G. OXLEY,
DOUG BEREUTER,
SPENCER BACHUS,
MIKE CASTLE,
ED ROYCE,
ROBERT W. NEY,
SUE KELLY,
PAUL GILLMOR
STEVEN C. LATOURETTE,
JUDY BIGGERT,
PETE SESSIONS,
BARNEY FRANK,
PAUL E. KANJORSKI,
MELVIN L. WATT,
LUIS V. GUTIERREZ,
DARLENE HOOLEY,
DENNIS MOORE,
Managers on the Part of the House.

RICHARD SHELBY,
ROBERT F. BENNETT,
WAYNE ALLARD,
MICHAEL B. ENZI,
PAUL SARBANES,
CHRISTOPHER J. DODD,
TIM JOHNSON,
Managers on the Part of the Senate.

Mr. OXLEY. Mr. Speaker, I move to suspend the rules and agree to the conference report on the bill (H.R. 2622) to amend the Fair Credit Reporting Act, to prevent identity theft, improve resolution of consumer disputes, improve the accuracy of consumer records, make improvements in the use of, and consumer access to, credit information, and for other purposes.

The Clerk read the title of the bill.

(For conference report and statement, see prior proceedings of the House of today.)

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Ohio (Mr. OXLEY) and the gentleman from Massachusetts (Mr. FRANK) each will control 20 minutes.

The Chair recognizes the gentleman from Ohio (Mr. OXLEY).

GENERAL LEAVE

Mr. OXLEY. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on the conference report and insert extraneous material thereon.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Ohio?

There was no objection.

Mr. OXLEY. Mr. Speaker, I yield myself 6 minutes.

Mr. Speaker, I am proud to bring before the House today the conference report on H.R. 2622, the Fair and Accurate Credit Transactions Act of 2003. This is a bipartisan bill that will foster economic growth and development throughout this country. When 9/11 hit our country, Congress responded quickly with the passage of the USA PATRIOT Act and the Terrorism Risk Insurance Act. When corporate scandals threatened to undermine the integrity of the stock market, we responded with the passage of the Sarbanes-Oxley Act. And today, as the laws governing our national credit markets are set to expire, we must again respond swiftly and responsibly with the passage of this bipartisan solution to keep the American economy stable and growing and assure that the American consumer continues to enjoy the benefits of a robust national credit granting system.

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One of the hallmarks of the modern U.S. economy is quick and convenient access to consumer credit. Though it would seem unimaginable a generation ago, consumers can now qualify for a mortgage over the telephone, walk into a showroom and finance the purchase of a car in one sitting, and get department store credit within minutes. As the distinguished Federal Trade Commission chairman Tim Muris has stated, the "miracle of instant credit" created by our national credit reporting system has given American consumers a level of access to financial services and products that is unrivaled anywhere in the world. The protection and growth of these services, as provided for in this legislation, are critical to the success of our economy.

Since the Fair Credit Reporting Act's uniform national standards were established in 1996, we have achieved some of the lowest mortgage rates and credit rates on record, with more competition and more offerings for consumers than ever before. This has led to the record level of credit available today to all Americans, regardless of income level. Over the past 30 years, the availability of nonmortgage credit to households in the lowest income bracket has increased by nearly 70 percent, including a nearly threefold increase in the number of low-income households owning credit cards just in this last decade. The increase of available credit, coupled with the declining price of this credit, has also fueled the record homeownership levels we are experiencing today, again with the largest gains achieved by low- and moderate-income groups. These improvements in the credit and mortgage systems have saved consumers nearly $100 billion annually, according to some estimates.

In addition to preserving our vital national credit system, this legislation is an extremely comprehensive consumer protection bill. The protections are designed to meet head-on the growing crime of identity theft which has accompanied the expanding credit market in our country. The FTC released a study in early September which revealed the damaging extent of this crime in our country. Ten million Americans were victimized by identity thieves last year alone, costing consumers and businesses over $55 billion, not counting the 300 million hours spent by victims to try to repair damaged credit records. The financial costs are staggering, with over $10,000 stolen in the average fraud.

The Committee on Financial Services has worked tirelessly to explore and find solutions to this destructive crime. Over 100 witnesses have come before the committee since last April to discuss the renewal of the Fair Credit Reporting Act, and many of them focused their statements on the urgent need to increase safeguards designed to protect consumers and businesses alike from this crime. With the bipartisan support in the House, as well as valuable input and assistance from our friends in the Senate, we have a bill before us today that empowers both consumers and businesses as we attempt to eliminate this terrible crime. Congress needs to pass strong, uniform identity theft protection; and it needs to do it now.

This conference report preserves many key elements designed to fight identity theft from the bill that passed the House with close to 400 votes. These strong new identity theft provisions standards established by the bill will be national, ensuring uniform protection for consumers in all 50 States.

This legislation includes provisions that allow consumers to place fraud alerts, allowing consumers to block information from being given to a credit bureau, providing identity theft victims with a summary of their rights, giving consumers the right to see their credit scores, giving all consumers the right to a free copy of their credit report, restricting access to consumers' sensitive health information, simplifying the way consumers can limit unsolicited marketing offers, ensuring improved accuracy of credit reporting procedures, and providing consumers with one-call-for-all protection by requiring credit bureaus to share consumer calls on identity theft, including requested fraud alert blocking.

This legislation also provides valuable tools and resources to financial institutions to ensure accuracy and prevent identity theft. These provisions include requiring creditors to take certain precautions before extending credit to consumers who have placed fraud alerts in their files; prohibiting merchants from printing more than the last five digits of a payment card on an electronic receipt, and others.

Mr. Speaker, this is a rather lengthy and long statement, and I will submit this for the RECORD.

I want to thank my ranking member, the gentleman from Massachusetts, for taking on this challenging and important legislation. Also to the chairman of our Subcommittee on Financial Institutions, the gentleman from Alabama (Mr. BACHUS), who sat through hours of hearings, over 100 witnesses in eight separate hearings; to Chairman SHELBY who chaired the conference committee and also, of course, is the chairman of the Banking Committee in the Senate, as well as Ranking Member Sarbanes for working in good faith on this effort.

Mr. Speaker, this was indeed truly a bipartisan, bicameral effort. We worked very closely with the White House and the Treasury to put together this conference report. This is good public policy. It is good for the country's economy, maintaining this constant flow of credit that we have come to take for granted. This is positive legislation, and I urge all Members to give it their strong support.

This legislation also provides valuable tools and resources to financial institutions to ensure accuracy and prevent identity theft. These provisions include:

Requiring creditors to take certain precautions before extending credit to consumers who have placed "fraud alerts" in their files; prohibiting merchants from printing more than the last 5 digits of a payment card on an electronic receipt; requiring banks to develop policies and procedures to identify potential instances of identity theft; and requiring financial institutions to reconcile potentially fraudulent consumer address information.

It is our duty to protect our national credit system and the economic growth that this system promotes by continuing to provide Americans with the most affordable and accessible credit market in the world today. We must ensure that the U.S. remains the engine of growth for the global economy.

I want to thank my ranking member from Massachusetts, Mr. FRANK, for taking on this challenging and imperative legislative project and for engaging all the major stakeholders in crafting a bipartisan piece of well balanced, highly effective legislation. I would also like to thank my friends from the Senate Banking Committee, Chairman SHELBY and Ranking Member SARBANES, for working in good faith to resolve differences between the House and Senate products. And finally, a huge debt of gratitude is owed by Members of this body to the gentleman from Alabama, SPENCER BACHUS, who wrote the House version of this bill; presided over countless hearings in his capacity as Chairman of the Financial Institutions and Consumer Credit Subcommittee; and helped lead the House conferees to a successful outcome in our negotiations with the Senate. Without the gentleman from Alabama, we would not be standing on the House floor today about to pass this historic consumer protection legislation.

The final FCRA legislation states that no requirement or prohibition may be imposed under the laws of any State with respect to the conduct required under the nine specific provisions included in the new identity theft preemption provision of the law. Accordingly, States cannot act to impose any requirements or prohibitions with respect to the conduct addressed by any of these provisions or the conduct addressed by any of the federal regulations adopted under these nine provisions. All of the rules and requirements governing the conduct of any person in these areas are governed solely by federal law and any State that attempts to impose requirements or prohibitions in these areas would be preempted.

I should note that the legislation lists the provisions to be preempted. However, to the extent such provisions would enjoy preemption under another provision in the FCRA, the other provision would control.

One of the central elements of the approach taken by the bill that the House passed overwhelmingly last September was to make the new fraud prevention and mitigation provisions contained in the legislation the new uniform national standards on those subject matters. The bill was drafted in this way because identity theft is a national concern, not only because of its impact on our system of granting credit, but because it knows no boundaries. The consumer victim may be in one State, the financial institution victim in another State, and the perpetrator may be in a third State. The credit bureaus that receive and report information relating to a fraudulent account may be in yet a fourth State.

In drafting the House bill, we were careful to stipulate—and to clarify in a colloquy on the House floor among the gentleman from Massachusetts, Mr. FRANK, the gentleman from Alabama, Mr. BACHUS, and myself—that the uniform national standards for identity theft were limited to the subject matters that the bill's provisions actually address, such as fraud alerts, blocking bad credit information, and truncating credit card account numbers at the point of sale. Thus, for example, this national uniformity would not affect State criminal statutes, or State laws governing the public display of social security numbers.

The conference committee further refined this standard, by providing that the new uniform national standards on identity theft created by this legislation apply with respect to the conduct required by those specific provisions.

I strongly urge my colleagues to vote for this Conference Report.

Mr. Speaker, I reserve the balance of my time.

Mr. FRANK of Massachusetts. Mr. Speaker, I am glad to yield 2½ minutes to the gentlewoman from Oregon (Ms. HOOLEY), a member of this committee who really did extraordinarily good work here and who early on became our task force head on identity theft, and this bill is really path-breaking in what it does for identity theft.

Ms. HOOLEY of Oregon. Mr. Speaker, I thank my good friend, the gentleman from Massachusetts, for yielding me this time.

During floor debate of the Fair and Accurate Credit Transaction Act back in September, I told a story of a constituent who had her purse stolen and ended up spending hours trying to clean up her credit files as a result. It got so bad, in fact, that the police officer suggested it would be easier for her to change her name than to deal with the damage caused by the result of a theft. At that time, I continued on to say that something is wrong with the law when a law enforcement official suggests changing your identity in order to protect yourself from identity theft.

Well, I am ecstatic to report to everyone that after 4 years' struggle, the law is changing. Today the House and Senate conferees met and approved the Fair and Accurate Credit Transaction Act, a bill that will do many things to protect consumers and safeguard our Nation's credit system. Above all, however, this legislation will put in place landmark protections against identity theft, the fastest-growing crime in the United States.

This legislation has been a long time coming and is the result of a lot of hard work by a number of Members of Congress. I would especially like to thank the gentleman from Massachusetts (Mr. FRANK) and the gentleman from Ohio (Mr. OXLEY) for all of their incredible work; Senator SARBANES and Senator SHELBY for the leadership they have shown through a bipartisan conference process; and a special thanks to the gentleman from Alabama (Mr. BACHUS) and the gentleman from Ohio (Mr. LATOURETTE) for the long hours they put in on this piece of legislation. Because of these leaders' work and the incredible staff that worked with us, we have a conference report that takes the best provisions from the Senate and the best provisions from the House to pass this piece of legislation.

I will share a few of the consumer protections it provides, and I will insert the remainder of this list in the CONGRESSIONAL RECORD.

First of all, it provides consumers with a free credit report, gives consumers the right to see their credit scores, provides consumers with broad new medical privacy rights, gives the consumers the ability to opt out of information-sharing between affiliated companies for marketing purposes, and establishes a financial literacy commission. Those are just a few.

I am proud of how the committee worked together. I think we were the poster child of how this process should be run. I am proud of the substance of this conference report that is good for consumers and good for businesses. I urge all of my colleagues on both sides of the aisle to support our Nation's consumers by voting "yes" for the conference report.

The agreement reached by conferees today will:

General Provisions:

Provide consumers with a free credit report every year from each of the three national credit bureaus, from a single centralized source;

Give consumers the right to see their credit scores;

Provide consumers with broad new medical privacy rights;

Give consumers the ability to opt-out of information sharing between affiliated companies for marketing purposes;

Establish a financial literacy commission and a national financial literacy campaign;

Ensure that consumers are notified if merchants are going to report negative information to the credit bureaus about them; and

Extend the seven expiring provisions of the Fair Credit Reporting Act.

Identify Theft Provisions:

Allow consumers to place "fraud alerts" in their credit reports to prevent identify thieves from opening accounts in their names; including special provisions to protect active duty military personnel;

Require creditors to take certain precautions before extending credit to consumers who have placed "fraud alerts" in their files;

Allow consumers to block information from being given to a credit bureau and from being reported by a credit bureau if such information results from identify theft;

Provide identify theft victims with a summary of their rights;

Provide consumers with one-call-for-all protection by requiring credit bureaus to share consumer calls on identify theft, including requested fraud alert blocking.

Prohibiting merchants from printing more than the last 5 digits of a payment care on an electronic receipt;

Require banks to develop policies and procedures to identify potential instances of identify theft;

Require financial institutions to reconcile potentially fraudulent consumer address information; and

Require lenders to disclose their contact information on consumer reports.

Mr. OXLEY. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Alabama (Mr. BACHUS), the chairman of the Subcommittee on Financial Institutions and Consumer Credit, who has done such a wonderful job on this bill.

Mr. BACHUS. Mr. Speaker, I thank the chairman for yielding me this time.

I am going to limit my time to thanking Members, because this legislation I think more than anything is a testimony of what we as Members do when we all work in the best interests of the American public.

This bill contains sweeping new protections against identity fraud. It also will enable consumers, which make up 70 percent of our economy, to have available more credit and more choices. And as important as that is, it does a third thing. It has many different tools to ensure that our credit information is accurately reported and that our private information and confidential information such as medical records are not shared.

At this time, I would like to thank the cosponsors. This bill was introduced by me; the gentlewoman from Oregon (Ms. HOOLEY), whom we have heard from; the gentlewoman from Illinois (Mrs. BIGGERT); and the gentleman from Kansas (Mr. MOORE). The gentlewoman from Oregon (Ms. HOOLEY), the gentlewoman from Illinois (Mrs. BIGGERT), and the gentleman from Kansas (Mr. MOORE) all had significant input into this legislation. The gentleman from Ohio (Mr. LATOURETTE), a lot of the fraud provisions were drafted by him or the gentlewoman from Oregon (Ms. HOOLEY). The gentleman from Pennsylvania (Mr. KANJORSKI), the gentleman from Delaware (Mr. CASTLE), the gentlewoman from New York (Mrs. MALONEY), the gentleman from Arizona (Mr. SHADEGG), the gentleman from Tennessee (Mr. FORD), the gentleman from Ohio (Mr. TIBERI), the gentleman from Texas (Mr. HINOJOSA), the gentleman from Texas (Mr. HENSARLING), the gentleman from New York (Mr. CROWLEY), the gentleman from Texas (Mr. SESSIONS), the gentleman from Arizona (Mr. ROSS), the gentleman from Utah (Mr. MATHESON), the gentleman from Alabama (Mr. DAVIS), the gentleman from Louisiana (Mr. BAKER), the gentleman from New York (Mr. KING), the gentleman from Oklahoma (Mr. LUCAS), and the gentleman from Kentucky (Mr. LUCAS), the gentleman from Ohio (Mr. NEY), the gentlewoman from New York (Mrs. KELLY), the gentleman from North Carolina (Mr. JONES), the gentleman from New York (Mr. ISRAEL), the gentlewoman from Pennsylvania (Ms. HART), the gentleman from North Carolina (Mr. MILLER), the gentlewoman from West Virginia (Mrs. CAPITO), the gentlewoman from New York (Mrs. MCCARTHY), the gentleman from South Carolina (Mr. BARRETT), the gentleman from Florida (Mr. FEENEY), and the gentlewoman from Florida (Ms. HARRIS).

All of these Members participated in this process, and the bill, which was passed almost unanimously by the House, went over to the Senate; and I would like to credit the other body for working, I think, in a professional manner and improving what we thought was a wonderful bill. And then, in conference, I would finally like to salute the gentleman from Ohio (Chairman OXLEY), first, for giving me the opportunity of working on this legislation; and secondly, I would like to salute him and the gentleman from Massachusetts (Mr. FRANK), our conferees, Mr. SARBANES and Chairman SHELBY. All of the people I have named deserve particular praise for a wonderful piece of legislation.

Mr. Speaker, I rise in strong support of the conference report to H.R. 2622, the Fair and Accurate Credit Transactions Act ("FACT Act"). H.R. 2622 represents the culmination of my efforts, and those of my colleagues, to craft legislation to strengthen our economy and to provide consumers with meaningful identity theft protections. The FACT Act is the bi-partisan product of a thorough review of the Fair Credit Reporting Act ("FCRA"), identity theft, and related issues, Indeed, the legislation was approved overwhelmingly in the House by a vote of 392–30 and in the Senate by a vote of 95–2.

I want to express my deepest sense of gratitude to Chairman OXLEY who gave me the opportunity to introduce this landmark piece of legislation and then skillfully guided it through the legislative process. In my career as a legislator, it is only on a rare occasion when you get the chance to draft legislation in such a bipartisan and cooperative atmosphere. The Chairman deserves a lot of credit for establishing such a collegial process, and I think our legislative product is better because of his efforts.

As Chairman of the Subcommittee on Financial Institutions and Consumer Credit. I conducted 8 hearings on the FCRA and related issues over the past year, receiving testimony from nearly one hundred witnesses including consumer groups, businesses, law enforcement, and various government regulators. On June 26, 2003, I introduced H.R. 2622 with Representatives HOOLEY, BIGGERT, and MOORE. The FACT Act—a byproduct of our hearings and bipartisan cooperation—passed its version of FCRA legislation—S. 1753—by a vote of 95–2. This week, the conference report to H.R. 2622 was approved almost unanimously by the conferees from both the House and Senate. H.R. 2622 is supported by a broad coalition of interested parties, including large financial institutions, community banks, credit unions, retailers as well as the Administration.

H.R. 2622 will benefit consumers and our economy by ensuring the continuity of our national uniform credit system. Indeed, our economy depends on several national delivery systems—each represented by incredible amounts of investment and infrastructure. For example, the national interstate highway system and our telecommunications networks are all critical to our national economy. Today we can drive from state to state without worrying about whether a road will come to an abrupt end at the state line. Our consumer credit system is similar to these examples—we do not really think about it, we just expect that it will work. Although not perfect, our consumer credit system makes life better, easier, and cheaper for American consumers.

Just as our highway and telecommunications networks have improved and become more efficient over the years, so has our credit system. Creditors have always needed to evaluate the likelihood that a borrower would repay a loan. As a result of the framework established by the FCRA, creditors, no longer need to "eyeball" an applicant and review application materials for days or weeks. Rather, our national credit system has produced a virtually seamless system whereby consumers can apply for, and receive a decision on, credit within minutes. The national uniform system has also lowered costs and increased choice and convenience for American consumers. By far the most striking result of our national credit system is the dramatically increased availability of credit—or the "democratization" of credit. However, this system could be put in jeopardy if the state law uniform standards in the FCRA were permitted to expire on January 1, 2004. H.R. 2622 would ensure the continuity of our national credit system by making these standards permanent.

The conference report also directly addresses the problem of identity theft.

Sec. 151 of the conference report requires that the FTC and the federal banking regulators provide identify theft victims with a summary of their rights. It is important for the agencies to let consumers know that identity thieves target home computers because they contain a goldmine of personal financial information about individuals. In educating the public about how to avoid becoming a victim of identity theft, the FTC and the federal banking regulators should inform consumers about the risks associated with having an 'always on' Internet connection not secured by a firewall, not protecting against viruses or other malicious codes, using peer-to-peer file trading software that might expose diverse contents of their hard drives without their knowledge, or failing to use safe computing practices in general.

Identity theft occurs when a criminal obtains enough information about an individual to allow the criminal to "assume" that individual's identity for nefarious purposes. My Subcommittee heard from two identity theft victims. Their stories were truly nightmarish, and we need to work to prevent countless others from joining the ranks of identity theft victims. Not only does identity theft harm the direct victims, but it also has an impact on all consumers. Financial institutions lose millions of dollars each year as a result of identity theft. This increased cost on financial institutions is absorbed, at least in part, through increased costs of financial products and services to all consumers.

H.R. 2622 will also improve consumers' access and understanding of their credit information by allowing consumers to request a free credit report annually from each credit bureau. In addition, consumers will have the opportunity to obtain their credit scores from credit bureaus. Transparency in the credit granting and reporting process will increase consumers' financial literacy and improve their confidence in the financial services system in general.

I want to commend Chairman OXLEY for the tremendous leadership he has shown in steering this complex bill through the legislative process. I also want to thank the Ranking Member of the Committee, Mr. FRANK, for his support of this important piece of legislation. In addition, let me commend Ms. HOOLEY, Ms. BIGGERT, Mr. MOORE, Mr. LATOURETTE and the Members of the Financial Services Committee on each of their efforts. I also appreciate the efforts of Mr. SANDERS, the Ranking Member on my subcommittee, for his work on this issue. Lastly, I want to mention my appreciation for the input we received from the Administration, particularly from Treasury Secretary John Snow and Treasury Assistant Secretary for Financial Institutions Wayne Abernathy.

Let me also take this opportunity to thank the staff members on the House Financial Services Committee who worked on this legislation. Both Chairman OXLEY and Ranking Member FRANK are to be commended for assembling such a talented group of staff to work on H.R. 2622. On the majority side, I would like to thank Bob Foster, Hugh Halpern, Carter McDowell, Jim Clinger; Robert Gordon, Charles Symington, Karen Lynch—who no longer works for the committee but did a lot of work on this issue before leaving—and Dina Ellis, my designee on the Committee. I would also like to thank Warren Tryon of my staff for his work on this issue. On the minority staff, I would like to thank the following staff members: Jeanne Roslanowick, Jaime Lizarraga, Ken Swab, Erika Jeffers, Dean Sagar and Warren Gunnels.

In conclusion, I would like to note that I am proud of the work we have done in crafting H.R. 2622. This has been, by necessity, a long and thorough process. I believe H.R. 2622 presents a solid achievement in protecting the security of consumers' personal information, enhancing the transparency of the credit reporting process, and ensuring continued access to a wide variety of financial products at low cost.

Mr. Speaker, our economy today is important to all of us. That goes without saying. But what a lot of people do not realize is that two-thirds of our economy is consumer spending. That is the driver in our economy today. And consumer spending today is contingent upon maintaining a national uniform credit reporting system. I urge all of my colleagues to support our economy by voting for H.R. 2622.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. THORNBERRY). The Chair would remind all Members it is inappropriate to characterize the other body, even in positive terms.

Mr. FRANK of Massachusetts. Mr. Speaker, I yield 2½ minutes to the gentleman from Vermont (Mr. SANDERS), the ranking member of the subcommittee from which this bill came.

Mr. SANDERS. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, this bill has a number of important and positive provisions. The idea that consumers will receive free credit reports is important. The provision strengthening identity theft is also very important.

But basically, the positive provisions in this bill do not outweigh the negative. And, in my view, this bill should be defeated. It should be defeated because it preempts States throughout this country from going forward with stronger consumer protections. And to my mind, States, in fact, are the laboratories of democracy; and it is a bad idea, especially from our conservative friends, who year after year have told us how bad it was for the Federal Government to have all this power, to now give power to the Federal Government and tell the State of Vermont, the State of California, that if you have specific needs dealing with consumer issues, you may not go forward. That is wrong. And for that reason alone, this legislation should be defeated, sent back, and strengthened in terms of consumer needs.

I would point out that virtually every consumer organization in America, the Consumer Federation of America, U.S. Public Interest Research Group, et cetera, oppose the preemption aspects of this legislation.

Second of all, Mr. Speaker, one of the great rip-offs that is taking place in America now deals with credit cards which, at a time of very, very low interest rates, are charging people up to 25 or 29 percent interest. And one way they do it, Mr. Speaker, is they send out notices and they say, come in and sign up: zero interest rate. What they forget to tell the consumer is that for any reason whatsoever, through a bait-and-switch scam, they can raise interest rates. So 5 years before, you were late on a student loan, you were late on an automobile payment, suddenly, you are going to be paying 15, 20 percent interest, and you do not know it.

This legislation rejected any effort to protect consumers in that way, not only outlawing this bait-and-switch scam, but even preventing strong disclosure. This legislation should be defeated, sent back, and improved.

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Mr. OXLEY. Mr. Speaker, I yield 2 minutes to the gentlewoman from New York (Mrs. KELLY), the chairwoman of the Subcommittee on Oversight and Investigations.

Mrs. KELLY. Mr. Speaker, it happens I do not agree with the previous speaker. I rise in strong support of the conference report before us. I would like to commend the gentleman from Ohio (Chairman OXLEY) and the gentleman from Massachusetts (Ranking Member FRANK) and their counterparts in the Senate for moving this legislation with great thoroughness, deliberation, and really in a strong spirit of bipartisanship.

At the heart of the legislation is the permanent reauthorization of the Fair Credit Reporting Act. It has provided a national uniform credit reporting system that has effectively lowered the cost of credit. And it has increased the choice and convenience for millions of Americans across the country.

The FCRA has helped to address other vital security issues such as combating identity theft and blocking terrorist financing under the U.S.A. Patriot Act, both issues that I have held hearings on in my subcommittee.

Combating identity theft and drying up terrorist financing requires a collaborative effort of law enforcement and regulatory agencies, consumers, and financial institutions, all with access to appropriate information.

We have also made some other important improvements to the FCRA in order to protect the sanctity of privacy for the American people throughout the credit granting process. I believe that one of the most important pieces of that is medical information. The medical information of consumers should be kept private. It does not need to be shared or be distributed by creditors or listed on credit reports.

Individuals should know that their personal medical information belongs to them and it is not released for any other purposes, whether it is for the credit-granting process or employee background checks. And we have done that with our legislation by coding the information.

I would like to thank the gentleman from Arkansas (Mr. ROSS) and the gentleman from North Carolina (Mr. WATT) for working with me on this amendment that will protect medical information of individuals without disrupting the access to low-cost credit and the security of information.

By allowing consumers to benefit from reporting the financial aspects of their transactions to credit bureaus while maintaining the sanctity of their medical privacy, this legislation is a real win for all Americans.

Finally, I am pleased we were able to include a new title in the legislation, which creates a Commission on Financial Literacy and Education, or the SAFE Act. As a result of that strategy, we will have a clear vision of the future financial literacy that will be the benefit of all Americans.

Mr. Speaker, I strongly support this legislation.

Mr. Speaker, I rise in strong support of the Conference Report before us.

I would like to commend Chairman OXLEY and Ranking Member FRANK—and their counterparts in the Senate—for moving this legislation with great thoroughness and deliberation and in the spirit of bipartisanship.

The legislation, "The FACT Act", is the result of a dozen hearings, one hundred witnesses, and months of deliberations by my colleagues on both sides of the aisle, and both sides of the Capitol.

At the heart of the legislation is the permanent reauthorization of the Fair Credit Reporting Act, or FCRA. FCRA has provided a national uniform credit reporting system that has effectively lowered the cost of credit, and increased choice and convenience for millions of Americans across the country.

As a conferee on this report, I can tell you that we worked with many diverse interests before we reached a unified, solid product. And in this product, we have built on the framework of FCRA to ensure that the legislation continues to lower the cost of credit and help fuel our economy—while also creating new opportunities for populations who have never had access. That's why this legislation has overwhelmingly bipartisan support.

FCRA has also helped address other vital security issues, such as combating identity theft and blocking of terrorist financing under the USA PATRIOT Act—both issues which I have held numerous hearings on in my Oversight Subcommittee. Combating identity theft and drying up terrorist financing requires the collaborative effort of law enforcement and regulatory agencies, consumers and financial institutions—all with access to appropriate information.

I am extremely pleased that this conference report addresses these important issues, and improves our ability to combat identity theft and help law enforcement officials track down illicit money. The information-sharing under this legislation is essential to protecting the American people by detecting suspicious activity and weeding out wrongdoers.

The national uniform standards under FCRA have also facilitated a financial institution's ability to utilize additional authentications and identity verifications to protect consumer security. And the increased protections incorporated in this legislation are critically important in enabling victims to correct the damage to their credit histories created by identity thieves.

This legislation will further help law enforcement combat financial fraud and track down criminals and terrorists. And it adds new protections that are important to achieving these goals.

We have also made other important improvements tc FCRA in order to protect the sanctity of privacy for the American people throughout the credit-granting process.

I believe the medical information of consumers should be kept private, and it does not need to be shared or distributed by creditors or listed on credit reports. Individuals should know that their personal medical information belongs to them and is not released for other purposes, whether it is for the credit granting process or employee background checks. And we have done this in our legislation by coding this information.

I would like to thank Reps. ROSS and WATT for working with me on an amendment that will protect the medical information of individuals without disrupting access to low cost credit and the security of information.

By allowing consumers to benefit from reporting the financial aspects of their transactions to credit bureaus while maintaining the sanctity of their medical privacy, this legislation is a real win for all Americans.

Finally, I am pleased that we were able to include a new title in the legislation, which creates a Commission on Financial Literacy and Education to improve the financial literacy of millions of Americans of all ages.

At the crux of this language is the creation of the first ever national strategy for financial literacy—which will facilitate new public, private and nonprofit partnerships to help educate all Americans in financial literacy. The national strategy, and its subsequent report to Congress, will be known as "The Strategy for Assuring Financial Empowerment" or "SAFE strategy", based on legislation that I introduced—H.R. 3520, "The SAFE Act".

As as result, the "SAFE strategy" will provide a clear vision for the future of financial literacy. The vision will provide a systematic approach to identify effective ways to increase the general education level of current, and future, consumers of financial services and products. The Commission and the "SAFE strategy" will be goal-oriented and subject to reviews by Congress through annual testimony.

Mr. Speaker, I strongly support this legislation that is crucial to the economy and the security of the American people.

I thank you for addressing these important issues and urge my colleagues to support this conference report.

Mr. FRANK of Massachusetts. Mr. Speaker, I yield 1½ minutes to the gentleman from Pennsylvania (Mr. KANJORSKI), who is the second ranking member of the full committee and the ranking member of the Subcommittee on Capital Markets, Insurance and Government Sponsored Enterprises and who has a major input to this bill.

Mr. KANJORSKI. Mr. Speaker, just as an aside, if I may, I urge all my colleagues on this side of the aisle and on the other side of the aisle to support one of the most bipartisan pieces of legislation. I want to congratulate the chairman of the committee, the gentleman from Ohio (Mr. OXLEY), the ranking member of the committee, the gentleman from Massachusetts (Mr. FRANK), and the chairman of the subcommittee, the gentleman from Alabama (Mr. BACHUS), and the ranking member of the subcommittee on our side of the aisle for a job well done.

And the fact that we set a new course of activity here in the House as to how this function of legislation should be done from not only the subcommittee, the full committee, the House and Senate, and the conference committee, but now as they work back today, I urge all my colleagues to support the legislation.

Mr. Speaker, I would like to enter into a colloquy with the gentleman from Alabama (Mr. BACHUS) on the Federal FTC advertising campaign.

Section 213 of the bill directs the Federal Trade Commission to increase public awareness regarding the availability of consumer rights to opt out of receiving prescreened credit offer solicitations. Is that his understanding as well?

I yield to the gentleman from Alabama.

Mr. BACHUS. Mr. Speaker, it is, yes.

Mr. KANJORSKI. Mr. Speaker, does the gentleman share with me the understanding that the FTC's public awareness campaign is to be designed to increase public awareness, not only of the right to opt out of receiving prescreened solicitations, but also of the benefits and consequences of opting out?

Mr. BACHUS. Mr. Speaker, yes, I share that understanding. Not only should consumers know they can opt out of getting these offers, they should also know that opting out or not affects their chances of getting additional credit offers with competitive terms.

Mr. KANJORSKI. Mr. Speaker, and if the FTC's public awareness campaign increases their understanding of the opt-out, consumers will make more informed better decisions. Does the gentleman agree?

Mr. BACHUS. Mr. Speaker, yes, I agree.

Mr. KANJORSKI. Mr. Speaker, I thank the gentleman from Alabama (Mr. BACHUS).

Mr. Speaker, I rise in very strong support of the conference report for H.R. 2622, the Fair and Accurate Credit Transactions Act.

The bill before us is an excellent piece of legislation. It advances consumer protection. It combats identity theft. And it allows businesses to operate efficiently when offering credit.

Moreover, the bill before us is a model of how the legislative process should work on a bipartisan basis. We held numerous hearings on the legislation. We deliberated on these matters thoroughly. We worked with one another on a bipartisan basis. The results of our efforts produced a bill that originally passed the House overwhelmingly.

If we fail to extend the expiring provisions of the Fair Credit Reporting Act before the end of this year, conflicting state laws could place financial institutions in a difficult compliance position, and the current efficiencies in obtaining credit could significantly decrease. We would, moreover, create more difficulties for our already struggling economy.

The Fair Credit Reporting Act and its 1996 amendments, in my view, have created a nationwide consumer credit system that works increasingly well. This law has expanded access to credit, lowered the price of credit, and accelerated decisions to grant credit. One reason that the law works so well is the establishment of a uniform system of national standards for credit reporting. As my colleagues may recall, Mr. Speaker, I strongly supported creating these state preemptions in the early 1990s. I also believe that we should extend them now.

In addition to extending the expiring preemptions of state law, H.R. 2622 will make a number of important improvements to current law with respect to consumer protection. These provisions, among other things, will improve the accuracy of and correction process for credit reports, and establish strong privacy protections for consumers' sensitive medical information.

Furthermore, identity theft is a growing problem in our country. A recent report by the Federal Trade Commission found that 27.3 million Americans have been victims of identity theft in the last five years. I am therefore particularly pleased that H.R. 2622 includes several provisions designed to combat these crimes and aid consumers.

Before I close, Mr. Speaker, I want to again commend the Ranking Member of the Committee [Mr. FRANK] for his work leading to a very strong bill, as well as the gentlelady from Oregon [Ms. HOOLEY] for her important work on identity theft. As I have already noted, we also worked on a bipartisan basis and in a pragmatic way with the Chairman of the Committee [Mr. OXLEY] and the Chairman of the Subcommittee [Mr. BACHUS] to produce a very worthwhile legislative product in the House and in the conference with the Senate on which I served.

Mr. Speaker, H.R. 2622 contains many important consumer protection provisions in a framework of uniform national standards. It is a good bill. I encourage my colleagues to support its passage.

Mr. OXLEY. Mr. Speaker, I yield 2 minutes to the gentlewoman from Illinois (Mrs. BIGGERT).

Mrs. BIGGERT. Mr. Speaker, I would like to commend the hard work that the gentleman from Ohio (Chairman OXLEY) and the gentleman from Alabama (Mr. BACHUS), subcommittee chairman, the gentleman from Massachusetts (Ranking Member FRANK), and the committee staff have done on this extremely important piece of legislation.

Mr. Speaker, to its sponsors and its cosponsors, every bill is an important bill. But there are few bills that we will take up this session or this Congress that are as critically important to our economy as reauthorizing and making permanent the expiring protections contained in the Fair Credit Reporting Act.

The FCRA may not be a household word, but it nonetheless touches virtually every aspect of our lives and our economy.

Without this reauthorization, there can be no national credit system, without a national credit system there will be less credit, slower credit, inaccurate credit, inefficient credit, and in some cases, no credit at all. Less, slower, inefficient and no credit will lead inevitably to less spending, slower growth, lower incomes, and fewer jobs.

That would be noticed by the American consumer and it would be a disaster for the American economy. That is why FCRA is a must-pass bill for this session.

This conference report addresses the challenges and problems created by new technologies as well. Chief among these are the provisions addressing identity theft. I am particularly pleased that this conference report contains language addressing the challenges of financial literacy.

As a member of the Committee on Financial Services and the Committee on Education and the Workforce, I have come to recognize the positive impact that a marriage of financial literacy and basic economics can have on millions of future investors.

I especially want to thank Senators Enzi and Sarbanes for working with me to perfect this language included in this conference report. H.R. 2622 is a good bill that provides important new protections for consumers and stops identity theft before it happens. I urge my colleagues to support this legislation and yield back the balance of my time.

Mr. FRANK of Massachusetts. Mr. Speaker, I yield 1½ minutes to the gentleman from Illinois (Mr. EMANUEL), who was very active particularly with regard to the medical privacy provision of this bill.

Mr. EMANUEL. Mr. Speaker, I would like to commend the Members on both sides of the aisle who worked in a bipartisan way to draft a good, strong bill with new identity theft protections and consumer protection. A special thanks to the gentleman from Ohio (Chairman OXLEY), to the gentleman from Massachusetts (Mr. FRANK), and to my colleague, the gentleman from California (Mr. OSE) for cosponsoring the amendment ensuring that this conference report has landmark provisions preventing banks and insurance companies from accessing and using the most sensitive private information of a consumer, medical information.

This medical privacy bill gives consumers a safe harbor they deserve by blacking out the use of medical information and making it off limits to banks and insurance companies. They cannot access it, period. This agreement makes that the law.

These new protections should go a long way to addressing America's concerns that their medical, mental health, or DNA information could be shared or used against them by banks and credit bureaus, when they apply for a mortgage, rent an apartment, or join a club. No one applying for a home should have to worry about a bank using their past cancer treatments against them. When this becomes law, they will not have to. This is a win for consumers and for the financial services industry.

Mr. OXLEY. Mr. Speaker, I yield 3 minutes to the gentlewoman from Florida (Ms. HARRIS).

Ms. HARRIS. Mr. Speaker, I want to discuss some of the exciting opportunities in the FCRA, specifically the aspects that Florida has engaged in. And I would like to enter a colloquy with the gentleman from Alabama (Mr. BACHUS) to discuss those.

Mr. Speaker, I would yield to the gentleman from Alabama (Mr. BACHUS).

Mr. BACHUS. Mr. Speaker, if the gentlewoman would yield, I would be glad to engage in a colloquy. I think what the gentlewoman from Florida (Ms. HARRIS) was inquiring into was that the Florida Banking Association has created a system that permits banks to combat identity theft, check fraud, and other criminal activity. And as I understand it, this system it produces reports that banks use exclusively to fight fraud not for the purpose, either in whole or part, of determining an individual's eligibility for credit insurance and employment.

And she has asked me to confirm that information that is provided for the exclusive purpose of detecting, preventing, or deterring a financial crime identity theft, or the funding of a criminal activity does not constitute a consumer report under the Fair Credit Reporting Act, even as amended by this bill. And my response to that is that is correct. Such information was not a consumer report under the Fair Credit Reporting Act as it existed before this legislation, nor will it constitute a consumer report as amended by this bill.

Ms. HARRIS. Mr. Speaker, reclaiming my time, I think that many people were confused by that, so I really appreciate the clarification that this information is not a consumer report under the Fair Credit Act neither before it was passed nor after it has been amended. So I really appreciate that clarification.

In fact, I think one of the biggest problems has been that the fraud and identity theft has created billions of dollars of losses in the U.S. economy and continues to create serious problems for individuals. The technology allows criminals to perpetuate this fraud with increasing rapidity.

Financial institutions and law enforcement need to fight the increases in fraud and identity theft with technology. So the proposed amendment would free the antifraud networks from compliance with certain requirements of the Fair Credit Reporting Act. But the amendment preserves the consumer protection features in the Fair Credit Reporting Act because it requires a notice to consumers and an opportunity to respond.

What is exciting about the Florida bankers is they actually created something called Fraud Net in 2000 and it was implemented in 2002. This is really sort of a neighborhood watch for bankers, if you will. Because banks post alerts when they experience a fraudulent or criminal act. It does not deal with individual transactions, opening accounts, credit insurance, or employment. Today 14 States are employing the specific program, and they expect 10 additional users next year.

So I thank the gentleman from Alabama (Mr. BACHUS) for clarifying.

Mr. FRANK of Massachusetts. Mr. Speaker, I yield 2 minutes to the gentlewoman from Indiana (Ms. CARSON), one of our most active and energetic members of our committee.

Ms. CARSON of Indiana. Mr. Speaker, I would like to thank the gentleman from Massachusetts (Mr. FRANK) and the gentleman from Alabama (Mr. BACHUS) for the bipartisan spirit to move the bill to the floor.

Mr. Speaker, the Fair Credit Reporting Act has been crucial to extending credit services to underserved populations and in protecting consumers from egregious abuses of their financial and personal privacy. However, the violations and abuses continue to persist. I have assisted a number of constituents who have had credit problems because of inaccurate credit reporting. In many instances, people have no idea there is a problem until they try to secure a loan or credit.

What I found especially troubling is larger than expected numbers of inaccuracies credit reporting agencies have on consumers. So H.R. 2622 provides a number of new important consumer protections that will make credit reports less frustrating for our consumers. The bill would give every person in America the ability to consider request an annual free credit report.

I certainly hope every American takes advantage of this. The bill deals a tremendous blow to identity thieves whose crimes are rising rapidly. Consumers will be able to place fraud alerts on their credit report when erroneous information is present. I applaud the leadership on this bill, a very needed bill. I encourage the Members to support it.

Mr. OXLEY. Mr. Speaker, I yield 1 minute to the gentleman from Texas (Mr. SESSIONS), a distinguished member of the Committee on Rules, who has an important measure in this legislation.

Mr. SESSIONS. Mr. Speaker, I wish to thank the great chairman of the committee, the gentleman from Ohio (Mr. OXLEY), and also the gentleman from Massachusetts (Mr. FRANK) for working with me on an important aspect of this Fair Credit Reporting Act.

I learned, Mr. Speaker, from one of my constituents, Bill Asher back in Dallas, Texas, during a town hall meeting about how the Federal Trade Commission had applied privacy rules to workplace misconduct which meant that in a workplace misconduct circumstance, a person who violated another person or who broke the law would actually have to be given information about any investigation that might take place against that individual under privacy rules and regulations passed by and supported by the Federal Trade Commission.

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This Federal Trade Commission now will be reversed; their ruling will be reversed by this Fair Credit Reporting Act to make sure that misconduct in a workplace, privacy rules do not apply.

I want to thank the gentleman from Massachusetts (Mr. FRANK) for his work on this, to ensure this became law, and also our great chairman, the gentleman from Alabama (Mr. BACHUS), and our great chairman, the gentleman from Ohio (Mr. OXLEY).

Mr. FRANK of Massachusetts. Mr. Speaker, I yield 1½ minutes to the gentleman from New York (Mr. CROWLEY), another member of our committee who played a very active role in this.

Mr. CROWLEY. Mr. Speaker, I would like to call this the comity before the storm. It is interesting that we have such comity here in the House on the floor dealing with the FACT Act, the Fair Credit Reporting Act. This has been a bipartisan piece of legislation.

It is interesting that we will take up a bill later on this evening that will not be as bipartisan, and it certainly will be a more partisan bill. I want to thank the gentleman from Ohio (Mr. OXLEY) for his extension of his arm. I wish the other committee, the Committee on Ways and Means, would act in kind; and hopefully that will happen at some point.

I want to thank the ranking member, the gentleman from Massachusetts (Mr. FRANK), for his work on this bill; the gentleman from Alabama (Mr. BACHUS), the subcommittee chairman; the ranking member, the gentleman from Vermont (Mr. SANDERS). Although he has indicated he will not support the bill, he certainly acted in a very bipartisan manner in helping to craft the legislation.

This bill represents the best of the House where Democrats, Republicans, and Independents work together to craft a bill that addresses real problems. But besides good procedure, this bill is also good policy.

It will provide permanency to our Nation's credit grantors to ensure the easy and available flow of capital to our constituents. It toughens up the law with respect to identity theft and ensures that health information is walled off and cannot be used in any credit-making decisions, ensuring the integrity of one's health privacy.

This bill is good for American consumers, and I am pleased to support it. I only wish that later on this evening I could also support a Medicare bill that was bipartisan as well.

Mr. OXLEY. Mr. Speaker, I yield 1 minute to the gentleman from Ohio (Mr. GILLMOR), a valuable member of the committee.

Mr. GILLMOR. Mr. Speaker, I thank the gentleman for yielding me time.

I want to commend both the chairman and the subcommittee chairman, as well as the ranking members, for the great job they did on this bill.

I rise in strong support of the conference report. Passage of this legislation is essential to maintaining our current national credit reporting system. This legislation maintains the free flow of credit reporting information to lenders, financial services providers, while it also creates some strong new consumer protections.

It also includes a provision that I introduced, H.R. 2622, to improve the transparency of the credit scoring systems by mandating that if the number of credit inquiries on a consumers account negatively affect their score, it must be disclosed in their consumer report. This ensures a consumer and a prospective lender are fully informed; and this important new requirement will allow conscientious consumers to shop around for the best loans and rates.

I urge my colleagues to support the report.

Mr. FRANK of Massachusetts. Mr. Speaker, I yield 1½ minutes to the gentlewoman from New York (Mrs. MALONEY), who played an important role in this bill.

Mrs. MALONEY. Mr. Speaker, I thank the gentleman for yielding me time. I thank our ranking member and chair and my colleagues.

I rise in support of this legislation that permanently reauthorizes the Fair Credit and Reporting Act, which is extremely important to our economy and our national credit system. It also greatly enhances legal protections for identity theft victims, protects medical information, and provides groundbreaking new limits on the sharing of private consumer information among the affiliates of financial services companies.

My constituents need this legislation because New York City claims the sad distinction of having the largest number of identity theft cases of any city in the entire country. The FACT Act helps break the cycle of identity theft with new consumer protections including the right to a free annual credit report, a new consumer-initiated fraud alert system, new protections that will prevent the recycling or repollution of consumer information that is known to be the product of fraud, mandatory truncation of credit and debt card numbers to prevent theft.

In addition to identity theft, this bill contains groundbreaking limits on how financial services companies can share the sensitive consumer financial information among affiliates. These are important consumer protections given that some of today's largest financial companies have more than 1,000 affiliates. While the identity theft and privacy provisions will have the most direct impact on our constituents, the FACT Act also ensures the long-term viability of our national credit market by extending the FCRA beyond the end of the year.

Today I rise in support of legislation that permanently reauthorizes the Fair Credit Reporting Act (FCRA) which is very important to our economy and our national credit system. It also greatly enhances legal protections for identity theft victims, protects medical information, and provides groundbreaking new limits on the sharing of private consumer information among the affiliates of financial services companies.

My constituents need this legislation because New York City claims the sad distinction of having the largest number of identity theft cases of any city in the country.

In addition, this bill contains groundbreaking limits on how financial services companies can share their sensitive customer financial information among affiliates.

These are important consumer protections given that some of today's largest financial companies have more than 1,000 affiliates.

Finally, while the identity theft and privacy provisions will have the most direct impact on our constituents, the FACT Act also ensures the long-term viability of our national credit market by extending the FCRA beyond the end of this year.

Mr. OXLEY. Mr. Speaker, I yield 1 minute to the gentleman from Ohio (Mr. LATOURETTE), a former prosecutor, who has done such great work, particularly in the identity theft part of the legislation.

Mr. LATOURETTE. Mr. Speaker, I want to first begin by commending the gentleman from Ohio (Mr. OXLEY) and the ranking member, the gentleman from Massachusetts (Mr. FRANK), for their hard work together with the conferees. I think the gentlewoman from Illinois (Mrs. BIGGERT) said earlier that this is the most important piece of legislation to come out of this committee this year, and I agree.

I also want to pay special tribute to the gentlewoman from Oregon (Ms. HOOLEY). When we began working in the 106th Congress on identity theft, some people had not heard of it. Today, I think every Member has a horror story about identity theft. In my district it was Maureen Mitchell. She and her husband found out that they owned not one, but two, luxury SUVs in the period of a couple of hours in Chicago, Illinois, that they had not participated in or purchased.

I think the conferees have produced a good bill. They have not only produced a good bill; they have produced a bill that does not have a one-size-fits-all remedy, and it still gives the regulators flexibility to deal with the ever-evolving strategies that identify thieves come up with.

Lastly, I want to pay tribute to the gentleman from Alabama (Mr. BACHUS), the chairman of the subcommittee, because he sat through hours and hours of hearings to make sure that we got it right; and, lastly, the ranking member, the gentleman from Vermont (Mr. SANDERS), I think he had some excellent ideas on bait and switch. I hope we revisit that in the next Congress.

Mr. FRANK of Massachusetts. Mr. Speaker, I yield 1½ minutes to the gentleman from Texas (Mr. HINOJOSA), another active member of our committee.

Mr. HINOJOSA. Mr. Speaker, I rise in strong support of the conference report to accompany the Fair and Accurate Transactions Act of 2003. And I congratulate the gentleman from Ohio (Mr. OXLEY) and the ranking member, the gentleman from Massachusetts (Mr. FRANK), the subcommittee chairman, the gentleman from Alabama (Mr. BACHUS), and the ranking member, the gentleman from Vermont (Mr. SANDERS), and all the committee staff for the wonderful work they did in completing this conference report.

This conference report will strengthen the provisions of the Fair Credit Reporting Act. I am proud to have been an original co-sponsor of this legislation, to have supported it in committee, and to have voted in favor of it on the House floor.

Let me take this opportunity to thank the conferees for including in the financial literacy provision of the legislation language that will allow the financial literacy commission the bill creates to take any action to develop and promote financial literacy and educational materials in languages other than English. This will apply to the hot line, Web site, and educational materials the commission produces or recommends.

It is imperative that financial literacy materials be created and disseminated in languages other than English to recognize the diversity of our great Nation. I especially want to thank the ranking member, the gentleman from Massachusetts (Mr. FRANK), for his assistance with this language and Jaime Lizarraga of his staff.

Rest assured that the Congressional Hispanic Caucus and the Hispanic community appreciate your efforts and the language you inserted into the conference report.

Mr. Speaker, I rise in strong support of the conference report to accompany The Fair and Accurate Transactions Act of 2003. I congratulate Chairman OXLEY and Ranking Member FRANK, Subcommittee Chairman BACHUS and Ranking Member SANDERS and all the House and Senate conferees on completing this conference report.

This conference report will strengthen the provisions of the Fair Credit Reporting Act. I am proud to have been an original cosponsor of this legislation, to have supported it in Committee and to have voted in favor of it on the House floor.

I want to read at this time a portion of a letter Federal Reserve Board Chairman Alan Greenspan sent to me dated February 28, 2003. Chairman Greenspan was responding to a question I submitted to him in writing asking what would happen to the U.S. economy if the exceptions to the Fair Credit Reporting Act were allowed to expire after January 1, 2004. In his letter, Chairman Greenspan warned that: "Limits on the flow of information among financial market participants, or increased costs resulting form restrictions that differ based on geography, may lead to an increase in the price or a reduction in the availability of credit, as well as a reduction in the optimal sharing of risk and reward."

I am very pleased that this conference report heeded Chairman Greenspan's warning, and I believe that its passage will help our struggling economy to improve.

Let me take this opportunity to thank the conferees for including in the financial literacy provision of the legislation language that will allow the Financial Literacy Commission the bill creates to "take any action to develop and promote financial literacy and education materials in languages other than English." This will apply to the hotline, website, and educational materials the Commission produces or recommends. It is imperative that financial literacy materials be created and disseminated in languages other than English to recognize the diversity of our great nation.

I especially want to thank Ranking Member FRANK for his assistance with this language and Jaime Lizarraga of his staff. Rest assured that the Congressional Hispanic Caucus and the Hispanic community appreciate your efforts and the language you inserted into the conference report.

The SPEAKER pro tempore (Mr. THORNBERRY). The gentleman from Ohio (Mr. OXLEY) has 1 minute remaining. The gentleman from Massachusetts (Mr. FRANK) has 6 minutes remaining.

Mr. OXLEY. Mr. Speaker, does the gentleman have any further speakers?

Mr. FRANK of Massachusetts. Mr. Speaker, I have several.

Mr. OXLEY. Mr. Speaker, I reserve the balance of my time.

I have the right to close, is that correct, Mr. Speaker?

The SPEAKER pro tempore. The gentleman is correct.

Mr. FRANK of Massachusetts. Mr. Speaker, I yield 1¼ minutes to the gentleman from Massachusetts (Mr. MARKEY), who has been so active on the privacy issue.

Mr. MARKEY. Mr. Speaker, I thank my friend, and I congratulate him for all the good things that are in this bill, all the credit report and the negative statement issues that are dealt with.

But there is one concern which I have which is consumers are, by this bill, going to see the California privacy law preempted, as they are going to see as well other States who want to make stronger privacy protection for their constituents something that is part of the law.

My concern is that increasingly what we see with companies like TransUnion and Equifax is that they are sending the records off shore. For example, TransUnion, one of the three major credit reporting agencies' spokesman said last month, 100 percent of our mail regarding customer disputes is going to India at some point. We expect to sign that contract by the end of the year.

My hope is that as the years go by we will be able to return to this issue because the globalization of the information marketplace is going to make clear that Americans are going to want more protection as their information is going to be put in the hands of foreigners with no laws on the books or the ability to police them.

I rise to opposition to this legislation.

I understand that some good things have been done in this bill, such as the provisions granting consumers free access to copies of their credit report, notice of negative statements being added to their credit reports, or adverse credit decisions being made based on their credit report. I support these provisions, and I also support stronger protections against identify theft.

The problem is that consumers are being asked to pay a price for these provisions—their privacy. As I read this bill, we are permanently pre-empting any stronger state privacy laws, such as the California law, in favor of a federal standard that provides consumers with only a very narrow "opt-out" right to block affiliate sharing of the consumer's information for marketing purposes. I do not believe that an "Opt Out" is appropriate. Companies should have to obtain the affirmative consent of the consumer—an "Opt In" before they share information about their transactions or experiences with the consumer with other affiliates or with unaffiliated third parties.

Moreover, I am concerned that by limiting the ability of a consumer to exercise their Opt-Out solely to marketing, this bill allows affiliates to share information about the consumers for other purposes without any consumer right to say "No." I am also concerned that even after a consumer has "opted out," their decision to do so gets sunsetted after 5 years and they have to "opt out" again. If the consumer has said no, that should mean no illness and until the consumer says yes.

I also want to raise a concern about some statements I have seen in the press from the credit reporting agencies suggesting that if these companies are forced to provide consumers with free credit reports, they will accelerate their current efforts to transfer their databases and back office operations off-shore.

TransUnion and Equifax, two out of the three major credit reporting agencies already are in the process of offshoring the processing of detailed credit files on 220 million U.S. consumers.

Earlier this month, a TransUnion spokesman said that "A hundred percent of our mail regarding customer disputes is going to go to India at some point. We expect to sign that contract by the end of the year."

Equifax has had a vendor in Jamaica for four years, where Jamaican workers handle data entry at the beginning of the reinvestigation process for disputed credit reports.

Experian, the third of the three major credit reporting agencies, is considering whether to offshore some of its operations: "We definitely are evaluating every option on the table, and offshoring is one of them. I don't want to be quoted as saying we'll never do it."

Privacy experts are concerned about offshoring of the Social Security numbers, addresses and other personal information contained in credit reports:

"Consumers should be worried. The infrastructure to protect information just isn't there in a lot of these places." (Beth Givens, director, Privacy Rights Clearing House)

"The problem is not that they're in India, the problem is that American laws are not going to be enforced in India." (Chris Hoofnagle, Electronic Privacy Information Center)

"If you're an international crime ring, and you want Social Security numbers for identity theft, you're going to look at the weakest link, and that's quite possibly these overseas companies." (Beth Givens)

In October, a Pakistani woman threatened to post UCSF patient files on the Internet, unless she was paid for the medical transcription services she had performed. In the email she sent to UCSF, the woman wrote: "Your patient records are out in the open to be exposed, so you better track that person and make him pay my dues or otherwise I will expose all the voice files and patient records on the Internet."

That is the future that we are looking at with the credit reporting agencies. Consumers may be able to call up to get a free copy of their credit report, but the person on the other end of the line may be in Karachi or New Delhi, where U.S. privacy standards do not apply.

Indeed, this bill may provide Americans with the most expensive "free" credit report they'll ever get. They'll pay with their privacy.

That is why I think that we need to put the consumer back in control of their own information. We need an "opt-in" not a limited "opt-out", and we need to ensure that American's privacy does not get offshored at the same time that their jobs are getting offshored.

I urge the defeat of this legislation.

Mr. FRANK of Massachusetts. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, I want to begin by saying that if we on the Democratic side were in the majority, this would be a different bill. We are not, so we have the bill that we have here.

Given that, given that there are some differences, I must tell you that this is a better bill than I had hoped we would see. And I am very appreciative of my colleagues on the other side. They did not give in on any issues of principle that are important to them. We have on both sides of the aisle a strong commitment to making sure that the free-market system in this country can work.

These credit allocations have become a very important part of that free-mark system. And this bill, I believe, preserves that system, the credit allocation system for individuals as well as need be.

We also, though, have, as we often do with the free market, a situation where the market does well what it is supposed to do, but it does not do everything. There are areas where we need to step in and help the market. What is important is for us to do that in ways that do not impinge on the market function.

I believe that working together we have come closer in doing that in this bill than I had thought. I would like if there had been fewer preemptions in the field, for instance, of identity theft; but as a result of a meeting which we had this morning, I think we agreed to preserve the integrity of the identity theft provisions that we have in there, to make sure that they can function without interference and without distraction, but did not unduly preempt if the States want to be additive in other areas. So there is, in fact, room for States to do something as long as the scheme that has been set forward in this bill is not interfered with, detracted from, and in particular, companies are not subjected to conflicting or confusing multiple requirements.

We have done other things. People, as a result of this, will be able to get a lot more information. Until recently, credit and credit scoring have been kind of mystical things to a lot of people. Consumers, home buyers, automobile buyers, others have found their lives affected financially by factors of which they were only dimly aware. As a result of several provisions in this bill, the system will be allowed to work, but consumers will have a lot more information about it. And they will get that information in many cases early enough to act on it.

Frankly, one of the things that some of our friends in the business community were skeptical of I think will wind up helping them. A requirement that people be notified if something they have either done or failed to do will cause them to have a negative comment on the credit report, I think that will have an incentivizing effect. I think the first time someone is late unneccessarily with a payment for a mortgage and is notified that this will be on your credit report, you are likely to see much less lateness. We also took steps to improve the accuracy of the data.

The system on the whole works very well, but no system works perfectly. I think this credit system was a little bit flawed in that it did not adequately give people a chance to correct errors. We do a much better job of this. I would have liked there to have been a sunset on the preemptions.

I think this bill benefits from the fact that it was here today. Congress did this 7 years ago. There was a sunset. And as a result, we are here today doing what everybody agrees is improving the bill. I would have liked, and my colleague from Pennsylvania (Mr. KANJORSKI) offered an amendment to give us a chance to do that again. We lost on the floor, and that is the way the votes went. But I do hope and I believe that we may very well from experience learn that more has to be done or things have to be done differently.

□ 1845

When this bill was passed in 1996, identity theft was not a big issue. The fact that it was sunsetted gave us a chance to deal with identity theft I think in a very effective way. This will not be the last time that the crooked people in this world will think of a way to swindle the great majority of the honest ones.

So I just want to make it clear that while we will not have this automatically coming up, I hope we are all committed, and I believe we are, that as new problems come up we will be able to deal with them.

Given the fact that the majority is the majority, I believe that we did a good job, not a perfect one, in adding consumer protections and safety factors to this general system of allowing the credit allocation to individuals to work, and for that reason, I would urge Members to vote for the bill.

Mr. OXLEY. Mr. Speaker, I yield myself the remaining time.

First of all, I want to thank the staff. I always tend to forget to do that, and we have been through a lot on this bill. This is a complicated piece of legislation that got more complicated as we took on this whole issue of identity theft, and throughout this process, the staff on both sides of the aisle have been just superb, working late nights and early mornings to get us where we are today, and I want to personally thank them for their efforts. They know who they are, and I know who they are and we most appreciate it, and also to the Members, I think this is, Mr. Speaker, perhaps a textbook example of how the legislative process ought to work in terms of hearings, in terms of everybody having an opportunity to have their say, involving Members on both sides of the aisle, many of them newer Members, freshmen Members, to really get their feet wet on an important piece of legislation that we bring to the floor today and this conference report that will close it out.

This is truly a historic day, and I think in the real traditional way that we have started in the Committee on Financial Services of turning out good legislation in a bipartisan manner, and for that, I am very thankful to all concerned.

Mr. BEREUTER. Mr. Speaker, as a member of the Financial Services Committee and a conferee, this member rises today to express his strong support for the conference report of H.R. 2622, the Fair and Accurate Credit Transactions Act of 2003 (FACT Act). This important legislation permanently extends those provisions in the Fair Credit Reporting Act (FCRA) which relate to the preemption of State laws—a very necessary step in this instance. The current provisions in the FCRA are set to expire on December 31, 2003. Thus when this conference report is enacted into law, it will continue the nationwide credit system while providing important consumer protections.

This member would like to thank the distinguished gentleman from Alabama, Mr. BACHUS, the chairman of the House Financial Services Subcommittee on Financial Institutions and Consumer Credit on which this member serves, for introducing the legislation on which this conference report is largely based. Furthermore, this member would like to thank both the distinguished gentleman from Ohio, Mr. OXLEY, the chairman of the House Financial Services Committee, and the distinguished gentleman from Massachusetts, Mr. FRANK, the ranking member of this committee, for their outstanding effort in bringing this excellent conference report to the House floor. As was suggested at the conclusion of the conference, this may be an instance where most of the conferees from both the House and Senate believe the conference report is better than either original Chamber's product.

The FCRA is the Federal law which governs the furnishing of reports on the credit worthiness of consumers. This member supports this conference report which would permanently extend the FCRA for many reasons. However, he would like to focus on the following three reasons.

First, this conference report provides for a free credit report annually for consumers. Typically, credit reporting agencies charge consumers up to $9 for the disclosure of the information in their credit files. Under current law, a consumer may receive a free consumer report from a reporting agency only under certain circumstances, such as when a consumer receives a notice of an adverse action by a reporting agency. The FACT Act would provider a free credit report annually for consumers for any reason. This member believes that this provision will promote consumer awareness of a person's credit history as well as provide an opportunity for the consumer to correct any inaccurate information on one's credit report.

Second, this conference report provides important provisions to curb identity theft. To illustrate the need for these provisions, the Federal Trade Commission (FTC) released a survey at the beginning of September of this year which showed that a staggering 27.3 million Americans had been victims of identity theft in the last 5 years, including 9.9 million people in the last year alone. This conference report, among other things, allows consumers to place "fraud alerts" in their credit reports to prevent identity thieves from opening accounts in their names.

Lastly, this conference report continues the Federal preemption of State laws as it relates to the corporate affiliate sharing of financial information. During the consideration of the 1996 amendments to the FCRA, this member authored a provision, which was signed into law, that required a consumer opt-out when nontransactional information is shared among corporate affiliates. Examples of nontransaction information include data from a consumer credit report and information on an application such as a consumer's income or assets. This provision on consumer notice is very important as it was the first consumer "opt out" on the sharing of financial information that this member is aware of that was signed into Federal Law.

Mr. Speaker, in conclusion, for the reasons stated above and many others, this member encourages his colleagues to support the conference report of H.R. 2622.

Mr. CANTOR. Mr. Speaker, I rise today on behalf of the Fair and Accurate Credit Transactions Act, H.R. 2622. This sound piece of legislation will aid in the prevention of identity theft. Additionally, it will guarantee that consumers have access to affordable credit.

I do have one concern, and I would like to clarify congressional intent in regard to this legislation. It is vitally important for consumers that the information reported about them to credit bureaus is accurate. When errors occur, they must be corrected. The overwhelming majority of disputes are properly handled through existing procedures as defined in section 611 of the Fair Credit Reporting Act. Nevertheless, a very small percentage of unusual disputes are not completely resolved through the reinvestigation process. Section 312 of the conference report for the bill provides a means by which some of these cases could be submitted directly to the furnisher for possible resolution.

I recognize that there are potential risks in the adoption of this section. For example, I am very concerned that any mechanism designed to address these few cases is not burdensome. If it becomes burdensome, furnishers may become discouraged from reporting complete and accurate information in the first instance. Additionally, this could lead to misuse by credit repair clinics to overwhelm furnishers in an attempt to cause them to change accurate information.

The conference report for H.R. 2622 has charged the relevant agencies with issuing rules only after they have determined the benefits of a direct resolution process. Congress has provided the agencies with four criteria to review in connection with any rulemaking pertaining to the direct reinvestigation of consumer disputes with furnishers. This criteria must be satisfied before any rules are to be issued.

I believe it is a positive piece of legislation that will give consumers the tools to fight identity theft and continue to access affordable credit.

Mr. Speaker, I urge passage of this legislation.

The SPEAKER pro tempore (Mr. THORNBERRY). The question is on the motion offered by the gentleman from Ohio (Mr. OXLEY) that the House suspend the rules and agree to the conference report on the bill, H.R. 2622.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr. SANDERS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

FURTHER MESSAGE FROM THE SENATE

A further message from the Senate by Mr. Monahan, one of its clerks, announced that the Senate has passed a bill of the following title in which the concurrence of the House is requested:

S. 1741. An act to provide a site for the National Women's History Museum in the District of Columbia.

The message also announced that the Senate agrees to the report of the committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2115) "An Act to amend title 49, United States Code, to reauthorize programs for the Federal Aviation Administration, and for other purposes."

VITIATION OF MOTION TO INSTRUCT CONFEREES ON H.R. 1, MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003

The SPEAKER pro tempore. Under clause 8 of rule XX, the filing of the conference report on H.R. 1 has vitiated the motion to instruct conferees offered by the gentleman from Washington (Mr. INSLEE) which was debated yesterday and on which further proceedings were postponed.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, and the Chair's prior announcement, the Chair will now put each question on which further proceedings were postponed earlier today in the following order:

Previous question on H. Res. 459, by the yeas and nays;

H. Res. 459, if ordered;

Previous question on H. Res. 458, by the yeas and nays;

H. Res. 458, if ordered;

H. Con. Res. 206, by the yeas and nays.

The Chair will reduce to 5 minutes the time for any electronic vote after the first such vote in this series.

WAIVING REQUIREMENT OF CLAUSE 6(a) OF RULE XIII WITH RESPECT TO CONSIDERATION OF CERTAIN RESOLUTIONS

The SPEAKER pro tempore. The pending business is the vote on ordering the previous question on H. Res. 459, on which the yeas and nays are ordered.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on ordering the previous question.

The vote was taken by electronic device, and there were—yeas 225, nays 202, not voting 7, as follows:

[Roll No. 659]

YEAS—225

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Foley
Forbes
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McInnis
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NAYS—202

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Hall
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Smith (WA)
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—7

DeMint
Fletcher
Fossella
Gephardt
Marshall
Murtha
Ruppersberger

□ 1909

Mrs. MALONEY and Messrs. WYNN, MORAN of Virginia, SCOTT of Georgia, PALLONE, ALLEN, and COSTELLO changed their vote from "yea" to "nay."

So the previous question was ordered.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. THORNBERRY). The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Ms. SLAUGHTER. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 228, nays 200, not voting 6, as follows:

[Roll No. 660]

YEAS—228

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Cramer
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goodlatte
Gordon
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McInnis
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NAYS—200

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Crowley
Cummings
Davis (AL)
Davis (CA)

Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Green (TX)
Grijalva
Gutierrez
Hall
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Smith (WA)
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—6

DeMint
Fletcher
Gephardt
Goode
Marshall
Ruppersberger

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised that 2 minutes remain in this vote.

☐ 1919

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

WAIVING REQUIREMENT OF CLAUSE 6(a) OF RULE XIII WITH RESPECT TO CONSIDERATION OF CERTAIN RESOLUTIONS

The SPEAKER pro tempore (Mr. THORNBERRY). The pending business is the vote on ordering the previous question on H. Res. 458, on which the yeas and nays are ordered.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on ordering the previous question.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 225, nays 202, not voting 7, as follows:

[Roll No. 661]

YEAS—225

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McInnis
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NAYS—202

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Hall
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Smith (WA)
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—7

DeMint
Fletcher
Gephardt
Jefferson
Jones (NC)
Marshall
Ruppersberger

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised 2 minutes remain in this vote.

☐ 1927

So the previous question was ordered.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. FROST. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 224, noes 203, not voting 7, as follows:

[Roll No. 662]

YEAS—224

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Ferguson
Flake
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McInnis
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NAYS—203

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Hall
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Smith (WA)
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—7

DeMint
Feeney
Fletcher
Gephardt
Marshall
Ruppersberger
Tauzin

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SHIMKUS) (during the vote). Members are advised that 2 minutes remain in this vote.

□ 1935

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

SUPPORTING NATIONAL MARROW DONOR PROGRAM AND OTHER BONE MARROW DONOR PROGRAMS

The SPEAKER pro tempore. The pending business is the question of suspending the rules and agreeing to the concurrent resolution, H. Con. Res. 206.

The Clerk read the title of the concurrent resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Oregon (Mr. WALDEN) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 206, on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 423, nays 2, not voting 9, as follows:

[Roll No. 663]

YEAS—423

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Cubin
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Filner
Flake
Foley
Forbes
Ford
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Manzullo
Markey
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon

McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Paul
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Solis
Souder
Spratt
Stark
Stearns
Stenholm
Strickland
Stupak
Sullivan
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NAYS—2

Kennedy (RI)
Maloney

NOT VOTING—9

Conyers
DeMint
Fletcher
Gephardt
Lewis (CA)
Marshall
Ruppersberger
Sweeney
Walsh

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised that 2 minutes remain in this vote.

□ 1944

So (two-thirds having voted in favor thereof) the rules were suspended and the concurrent resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mrs. MALONEY. Mr. Speaker, on rollcall No. 663, I had intended to vote "yea" on H. Con. Res. 206, and request that the RECORD reflect my intentions.

Mr. KENNEDY of Rhode Island. Mr. Speaker, I wish to inform you that I inadvertently misvoted on rollcall No. 663 on H. Con. Res. 206. I support this legislation and it was my intention to vote in support of it. I did not realize until after the voting had closed that I had mistakenly voted otherwise.

NATIONAL FLOOD INSURANCE PROGRAM REAUTHORIZATION ACT OF 2004

Mr. OXLEY. Mr. Speaker, I ask unanimous consent that the Committee on Financial Services be discharged from further consideration of the Senate bill (S. 1768) to extend the national flood insurance program, and ask for its immediate consideration in the House.

The Clerk read the title of the Senate bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Ohio?

There was no objection.

The Clerk read the Senate bill, as follows:

S. 1768

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "National Flood Insurance Program Reauthorization Act of 2004".

SEC. 2. EXTENSION OF NATIONAL FLOOD INSURANCE PROGRAM.

(a) EXTENSION.—The National Flood Insurance Act of 1968 is amended—

(1) in section 1309(a)(2) (42 U.S.C. 4016(a)(2)), by striking "December 31, 2003" and inserting "December 31, 2004";

(2) in section 1319 (42 U.S.C. 4026), by striking "after" and all that follows through the period at the end and inserting "after December 31, 2004.";

(3) in section 1336(a) (42 U.S.C. 4056(a)), by striking "ending" and all that follows through "in" and inserting "ending December 31, 2004, in"; and

(4) in section 1376(c) (42 U.S.C. 4127), by striking "December 31, 2003" and inserting "December 31, 2004".

(b) EFFECTIVE DATE.—The amendments made by this section shall be considered to have taken effect on December 31, 2003.

AMENDMENT IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. OXLEY

Mr. OXLEY. Mr. Speaker, I offer an amendment in the nature of a substitute.

The Clerk read as follows:

Amendment in the nature of a substitute offered by Mr. OXLEY:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "National Flood Insurance Program Reauthorization Act of 2004".

SEC. 2. EXTENSION OF PROGRAM.

(a) EXTENSION.—The National Flood Insurance Act of 1968 is amended as follows:

(1) AUTHORITY FOR CONTRACTS.—In section 1319 (42 U.S.C. 4026), by striking "December 31, 2003" and inserting "March 31, 2004.".

(2) BORROWING AUTHORITY.—In the first sentence of section 1309(a) (42 U.S.C. 4016(a)), by striking "December 31, 2003" and inserting "the date specified in section 1319".

(3) EMERGENCY IMPLEMENTATION.—In section 1336(a) (42 U.S.C. 4056(a)), by striking "December 31, 2003" and inserting "on the date specified in section 1319".

(4) AUTHORIZATION OF APPROPRIATIONS FOR STUDIES.—In section 1376(c) (42 U.S.C. 4127(c)), by striking "December 31, 2003" and inserting "the date specified in section 1319".

(b) EFFECTIVE DATE.—The amendments made by this section shall be considered to have taken effect on December 31, 2003.

Mr. OXLEY (during the reading). Mr. Speaker, I ask unanimous consent that the amendment in the nature of a substitute be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Ohio?

There was no objection.

The amendment in the nature of a substitute was agreed to.

The Senate bill was ordered to be read a third time, was read the third time, and passed, and a motion to reconsider was laid on the table.

□ 1945

MAKING IN ORDER AT ANY TIME CONSIDERATION OF H.J. RES. 79, FURTHER CONTINUING APPROPRIATIONS, FISCAL YEAR 2004

Mr. YOUNG of Florida. Mr. Speaker, I ask unanimous consent that it shall be in order at any time without intervention of any point of order to consider House Joint Resolution 79 in the House; the joint resolution shall be considered as read for amendment; the previous question shall be as ordered on the joint resolution to final passage without intervening motion except: one, 20 minutes of debate on the joint resolution, equally divided and controlled by the chairman and ranking member of the Committee on Appropriations; and, two, one motion to recommit.

The SPEAKER pro tempore (Mr. SHIMKUS). Is there objection to the request of the gentleman from Florida?

There was no objection.

GENERAL LEAVE

Mr. YOUNG of Florida. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on H.J. Res. 79, and that I may include tabular and extraneous material.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Florida?

There was no objection.

FURTHER CONTINUING APPROPRIATIONS, FISCAL YEAR 2004

Mr. YOUNG of Florida. Mr. Speaker, pursuant to the order of the House just adopted, I call up the joint resolution (H.J. Res. 79) making further continuing appropriations for the fiscal year 2004, and for other purposes, and ask for its immediate consideration.

The Clerk read the title of the joint resolution.

The text of House Joint Resolution 79 is as follows:

H.J. RES. 79

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That Public Law 108–84 is amended by striking the date specified in section 107(c) and inserting "January 31, 2004."

SEC. 2. Section 8144(b) of the Department of Defense Appropriations Act, 2003 (Public Law 107–248), as amended by Public Law 108–84, is further amended by striking "November 21, 2003" and inserting "January 31, 2004".

The SPEAKER pro tempore. Pursuant to the order of the House today, the gentleman from Florida (Mr. YOUNG) and the gentleman from Wisconsin (Mr. OBEY) each will control 10 minutes.

The Chair recognizes the gentleman from Florida (Mr. YOUNG).

Mr. YOUNG of Florida. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, yesterday the House passed H.J. Res. 78, the fifth continuing resolution for fiscal year 2004, which extends the date of the current CR through Sunday, November 23. The Senate has chosen to amend this CR so that it would remain in effect until Monday, November 24.

We have, in turn, decided with the Senate leadership just to introduce a clean CR, H.J. Res. 79, that we are now considering. That would extend the date of the CR to January 31, 2004. I think I should be very clear of what this means. It is not our intention with this CR to allow it to run through January 31, but it will allow us great flexibility in scheduling the completion of our work on the final appropriations bills and at the same time ensure that there will not be any disruption in government operations. And I would like to point out, Mr. Speaker, that the Committee on Appropriations has done its job and did so quite a long time ago, but some of the issues that are keeping us from completing work on the actual bills have nothing to do with appropriations. But, nevertheless, they are there, and we do have to deal with them, and we are dealing with them as best we can.

We are proceeding with our work on the remaining appropriations bills. And as my colleagues know, there are two conference reports that have been ready for some time to file, the conference report on Transportation and Treasury and the conference report on Foreign Operations. However, as we proceed, we will finish the remaining bills as quickly as we can, and it will be leadership's decision on when the bills will be filed and when we will vote on it. We are proceeding with our work as diligently as we can.

Mr. Speaker, I believe this CR is noncontroversial, and I urge the House to move the legislation to the Senate since the current CR does expire today.

Mr. Speaker, I reserve the balance of my time.

Mr. OBEY. Mr. Speaker I yield myself 6 minutes.

Mr. Speaker, as this joint resolution demonstrates, we are in another year that simply refuses to end. Last year we did not see this Congress finish the work that was supposed to be done by October 1 until well into the winter of the next calendar year. At that time the majority party in the House blamed that inability to get the work done on the fact that there was a majority of the other party in the other body.

This year they do not have Tom Daschle to kick around anymore. This year the Republicans control it all. They control the White House. They control the House. They control the Senate. They control the schedule. They control what gets to the floor. They control how long the votes are held open. They control everything. And yet we are in a situation where tonight, long after the fiscal year is supposed to be over, we still have not seen the budgets passed for VA–HUD, for the State Department, for the Justice Department, for the Commerce Department. We have yet to see the foreign aid budget pass. We have yet to see the budget for the Labor, Health and Human Services, Education, social services agencies pass and the agriculture budget. I think we ought to ask why.

I do not believe that we are in this box because of any failure of the Committee on Appropriations leadership. I think we are in this box because the Republican House leadership is insisting on having every decision made in a top-down style. That means that the only real decisions that count except on minor matters are those made in the office of the Speaker or in the office of the majority leader.

No conferees are appointed unless they agree with the leadership's position on major issues. And yet even after rigging those conferences, even after stacking those conferences, when they still cannot win the votes that they need to win in those stacked conferences, they simply adjourn those conferences and then put legislation together in some off-corner office without any meaningful participation by anybody except perhaps some unelected members of the leadership's staff. So much for the legislative process in what used to be regarded as the greatest deliberative body in the world.

This process is about as respectful of rank and file Members as an AARP board meeting is respectful of the senior citizens they supposedly represent. On the same night that legislation is going to be considered that will bankrupt Medicare, we see the ultimate degradation of the legislative process at the same time as it is demonstrated in the appropriations process.

It is not often, Mr. Speaker, that one can do in senior citizens and the democratic process on the same night, but the House leadership should be congratulated because they have managed to find a way.

Mr. Speaker, I reserve the balance of my time.

Mr. YOUNG of Florida. Mr. Speaker, I yield myself 2 minutes.

I just would like to point out, and I have done this so many times that it does not hurt to be repeated. The House completed its work during the summer, ahead of the end of the fiscal year. And I appreciate the cooperation we had from both parties as we proceeded with our appropriations bills. I am not here to blame anybody, and I certainly would not blame anybody but circumstances.

The Committee on Appropriations, as the gentleman from Wisconsin (Mr. OBEY) pointed out, we had to do all of last year's work this year in January and February. Then we had three supplementals plus we did the 13 regular bills. This Committee on Appropriations has done its work. It has done its work well, and it has done its work on time, as the gentleman from Wisconsin (Mr. OBEY) has conceded. There are other problems.

One of the problems, and I do not know that anybody is going to like to hear this especially on my side of the aisle, one of the problems is this tremendous desire to solve legislative problems that the authorizing committees either cannot or will not solve. They are put onto appropriations bills, and they ask us to solve them because appropriations bills have to pass, Mr. Speaker. They are the only bills here really that have to pass. So we become a magnet for all of those issues that authorizers cannot solve, and we try to do the best we can. I think we are on the verge of having completed this job for this year.

I do not think it does any good to blame anybody. In fact, I would like to say that the chairman of the Appropriations Committee in the Senate is an outstanding leader, a strong, dynamic leader, who is very knowledgeable and understands the process totally. He understands the issues as well as anybody that I know. But he has a very difficult situation in the Senate, and he has done the best job that he could.

Anyway, Mr. Speaker, we are closing in on this. We are really prepared. We have been prepared for 3 weeks to file the Transportation and Treasury appropriations bill. We have been prepared for a week to file the conference report on the Foreign Operations appropriations bill. And they can be completed in a very short period of time.

The other remaining issue would be the omnibus bill that includes five appropriations bills that have not been completed in conference. And we are very close to having that completed. We are very close to being able to file that bill and vote on it. As a matter of fact, we had hoped that we would file it tonight. A lot of changes happened during the day. And every time we make a change, it takes a little extra time. So we probably will not file that bill tonight unless the House remains in session very late.

Anyway, I would agree that the process has not worked the best, but I would also say that I compliment the Members of House and especially the members of the Committee on Appropriations in the House and the staff that worked so diligently with us. We did our job. We have done our job, and we are attempting to pursue the completion of the whole process.

Mr. Speaker, I reserve the balance of my time.

Mr. OBEY. Mr. Speaker, I yield myself 4 minutes.

Mr. Speaker, as the gentleman from Florida has indicated, the Commerce-Justice bill could very easily have been brought back to this floor separately and passed separately. The Transportation bill could very easily have been brought back to the floor and passed separately. The Foreign Operations bill could very easily have been brought back to the bill floor and passed separately. The Agriculture the same and the VA–HUD bill the same.

The problem is, as the gentleman indicated, that there are many other issues that are being drug into the appropriations process. And we also see the situation complicated by the fact that the House Republican leadership, despite votes to the contrary on a number of issues, is insisting on seeing an outcome on a number of these issues which is at variance with the expressed wishes of the Members of the House. And I think therein lies the reason for the delay and delay and delay.

I think the problem that we have, Mr. Speaker, the gentleman from Florida, my good friend, indicated that the committee product is serving as a magnet for other authorizations. I think a better metaphor would be that it is looking more and more like a garbage truck. And the problem we have is that this bill has not been allowed to proceed because I think the House leadership is still trying to determine what bags of garbage have to be tossed down to the truck before the truck is driven through here in the dead of night.

□ 2000

So that is the choice that we face, Mr. Speaker. It is not a pretty sight, and the outcome is not going to be very good. But there is not much we in the minority can do to affect either the scheduling or to affect how much garbage is tossed on the truck before it is run through the Capitol. I just hope the smell is not too bad before it is over.

Mr. Speaker, I urge a "yes" vote on the resolution.

Mr. OBEY. Mr. Speaker, I yield back the balance of my time.

Mr. YOUNG of Florida. Mr. Speaker, I ask for a "yes" vote, and I yield back the balance of my time.

The SPEAKER pro tempore (Mr. SHIMKUS). All time for debate as expired.

The joint resolution is considered read for amendment.

Pursuant to the order of the House of today, the previous question is ordered.

The question is on engrossment and third reading of the joint resolution.

The joint resolution was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the joint resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. OBEY. Mr. Speaker, on that, I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF JOINT RESOLUTION APPOINTING DAY FOR CONVENING OF SECOND SESSION OF 108TH CONGRESS

Mr. DREIER, from the Committee on Rules, submitted a privileged report (Rept. No. 108–398) on the resolution (H. Res. 464) providing for consideration of a joint resolution appointing the day for the convening of the second session of the One Hundred Eighth Congress, which was referred to the House Calendar and ordered to be printed.

REPORT ON RESOLUTION WAIVING REQUIREMENT OF CLAUSE 6(a) OF RULE XIII WITH RESPECT TO CONSIDERATION OF CERTAIN RESOLUTIONS

Mr. DREIER, from the Committee on Rules, submitted a privileged report (Rept. No. 108–399) on the resolution (H. Res. 465) waiving a requirement of clause 6(a) of rule XIII with respect to consideration of certain resolutions reported from the Committee on Rules, which was referred to the House Calendar and ordered to be printed.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess subject to the call of the Chair.

Accordingly (at 8 o'clock and 4 minutes p.m.), the House stood in recess subject to the call of the Chair.

□ 2050

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. SHIMKUS) at 8 o'clock and 50 minutes p.m.

COMMUNICATION FROM HON. NANCY PELOSI, DEMOCRATIC LEADER

The SPEAKER pro tempore laid before the House the following communication from NANCY PELOSI, Democratic Leader:

U.S. HOUSE OF REPRESENTATIVES,
OFFICE OF THE DEMOCRATIC LEADER,
Washington, DC, November 13, 2003.

Hon. J. DENNIS HASTERT,
Speaker of the House, House of Representatives, Washington, DC.

DEAR MR. SPEAKER: Pursuant to section 7(b)(1) of the Prison Rape Elimination Act of 2003 (P.L. 108–79), I hereby appoint Ms. Brenda V. Smith of the District of Columbia and Ms. Jamie Fellner, Esq. of New York, to the National Prison Rape Reduction Commission.

Best regards,

NANCY PELOSI.

FURTHER CONTINUING APPROPRIATIONS, FISCAL YEAR 2004

The SPEAKER pro tempore. The pending business is the vote on passage of the joint resolution, H.J. Res. 79, on which the yeas and nays are ordered.

The Clerk read the title of the joint resolution.

The SPEAKER pro tempore. The question is on the passage of the joint resolution.

The vote was taken by electronic device, and there were—yeas 407, nays 16, not voting 11, as follows:

[Roll No. 664]

YEAS—407

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clyburn
Coble
Cole
Collins
Cooper
Cox
Cramer
Crane
Crenshaw
Crowley
Cubin
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeGette
Delahunt
DeLauro
DeLay
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks

Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Flake
Foley
Forbes
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Solis
Souder
Spratt
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)
Young (FL)

NAYS—16

Becerra
Capuano
Conyers
DeFazio
Dingell
Filner
Ford
Jackson-Lee (TX)
Kucinich
McDermott
Miller, George
Olver
Sherman
Stark
Tierney
Watt

NOT VOTING—11

Clay
Costello
DeMint
Fletcher
Gephardt
Lewis (KY)
Marshall
Paul
Radanovich
Ruppersberger
Tauzin

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SHIMKUS) (during the vote). Two minutes remain in this vote.

□ 2137

Mr. GEORGE MILLER of California changed his vote from "yea" to "nay."

So the joint resolution was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PARLIAMENTARY INQUIRY

Ms. JACKSON-LEE of Texas. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore (Mr. LAHOOD). The gentlewoman will state it.

Ms. JACKSON-LEE of Texas. Mr. Speaker, is it my understanding that the rule we are about to take up for the underlying bill, H.R. 1, is a rule that is pursuant to a conference and a conference report where Democratic conferees were not even allowed into the room and where the Committee on Rules did not address the elimination or the lack of acknowledgment of the participation of the Democratic conferees? Is this H.R. 1 that we are about to take up? And is there any way for the points of order to be in order so that we could address that question on the floor of the House?

The SPEAKER pro tempore. The chair is about to recognize a member from the Committee on Rules to call up the rule, which will be read to the House.

WAIVING POINTS OF ORDER AGAINST CONFERENCE REPORT ON H.R. 1, MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003

Ms. PRYCE of Ohio. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 463 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 463

Resolved, That upon adoption of this resolution it shall be in order to consider the conference report to accompany the bill (H.R. 1) to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes. All points of order against the conference report and against its consideration are waived. The conference report shall be considered as read.

The SPEAKER pro tempore. The gentlewoman from Ohio (Ms. PRYCE) is recognized for 1 hour.

Ms. PRYCE of Ohio. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to my colleague and friend, the gentlewoman from New York (Ms. SLAUGHTER), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Mr. Speaker, H. Res. 463 is a standard rule waiving all points of order against the conference report to accompany H.R. 1, the Prescription Drug and Medicare Modernization Act of 2003. The rule also waives all points of order against its consideration.

Mr. Speaker, I rise today in full support of the rule and of the underlying bill. I would like to thank Chairman THOMAS and Chairman TAUZIN for their outstanding coordination, their remarkable leadership, and the inspiring vision that they have provided on this critical legislation. The conferees have all worked extraordinarily hard to produce the most sweeping Medicare bill in generations.

Since 1965, Medicare has provided a guarantee of health care coverage for most all Americans. Stability, longevity, and integrity have been the hallmarks of this program, offering the promise of a secure retirement. But a lot has changed since 1965. Our investment in research and medicine has yielded us advanced medications, therapies, and technology that have paved the way for our seniors to live longer, healthier lives. Unfortunately, Medicare has not changed with these medical advancements. The most obvious shortcoming is the lack of prescription drug coverage, the best tool medicine has to offer.

Before us today is an opportunity to pass landmark legislation that addresses these shortcomings and finally propels the program of Medicare into the 21st century, most notably by covering these prescription drugs. If we do not act and pass this plan before us today, the future of our seniors will be in doubt, with their happy and healthy lives uncertain. And if we do not act today, the fate of Medicare will be certain: bankruptcy.

So today we will accomplish two long overdue goals. First, we will strengthen Medicare to save it for future seniors; and, second, we will enhance the program by providing much-needed prescription drug coverage, bringing this 1965 health care program into the 21st century. And to those who are telling us to slow down, I say seniors have waited too long. This House has passed a Medicare prescription drug plan three times since Republicans have controlled Congress, each time only to be scuttled. Today we will finally end the denial of benefits to our seniors and end the delay.

Folks in my district tell me that they cannot go another year without the help of Medicare prescription drug coverage. They want us to speed up the process. They tell me that when you are sick and you are elderly, Medicare is not just health care; it is peace of mind. Well, we listened and we acted, producing this historic package.

Our seniors are not the only ones who have spoken out in support of this plan. Let me tell you, some very knowledgeable folks on the front lines of health care delivery, people who understand the needs of our seniors and the problems with Medicare, have made their support for this bill very clear. Allow me to name just a few: the American Association of Retired Persons, the AARP, the largest senior group in the Nation representing 35 million seniors, card-carrying, dues-paying, voting seniors; the American Medical Association; the American Hospitals Association; employers Coalition on Medicare; the Alzheimer's Association; American Society of Radiology and Oncology; Rural Hospital Coalition; National Hospice and Palliative Care Organization; the College of Obstetrics and Gynecology; American Society of Anesthesiologists; American Physical Therapy Association; pathologists; nurse practitioners. The list goes on and on. It includes hundreds and hundreds of supporters. They back this plan because they know how important and long overdue it is, plain and simple.

There are many reasons to vote for this package, but I want to call attention to a few that are significant. First of all, this prescription drug plan is voluntary, universal, and guaranteed. Period. If you are over 65 and you qualify for Medicare, you qualify for this benefit. If you want it, you can have it. If you do not, you do not have to take it. With this benefit, 40 million seniors will begin receiving significant savings on their medications.

□ 2145

To begin with, we offer immediate savings with the prescription drug discount card that will offer up to 25 percent in savings early next year. This drug discount card is a tremendous first step while the larger benefit is implemented.

After the drug is fully phased in in 2006 it will work like this: After a $250 deductible, Medicare will pay 75 percent of seniors' drug cost up to $2,250 a year. Medicare will then provide catastrophic protection, giving seniors 95 percent coverage for out-of-pocket drug costs. That is beyond $3,600. On average this reduces seniors' cost of medication by 50 percent.

This package also switches the focus of health care from reactive disease treatment to proactive disease prevention. The old saying "an ounce of prevention is worth a pound of cure" could not be more appropriate in this instance. Gone are the days of waiting until the symptoms are so obvious and the disease is so advanced that the only options are expensive hospital stays and surgeries.

Twenty-first century medicine can prevent, preempt, and predict illnesses through advanced screenings and innovative tests. In many cases taking a pill is all that it takes to prevent a chronic disease from becoming a life-threatening illness. Medicare will cover the preventative medications that keep our seniors out of the hospitals and off of the operating tables. And with this revolutionary shift in focus, Medicare will cover the $20 prescription before the $6,000 surgery even becomes necessary. That is not only real savings for the American taxpayer, but it is a real life savings for our seniors.

This landmark bill improves health care for our seniors, especially those who need it most, through significantly increased assistance for so-called "disproportionate share hospitals." Such hospitals, as the term implies, care for a disproportionate share of low-income patients, and the last thing they need is funding cuts. Under this plan the hospitals will see a significant increase and allow them to care for these low-income families and seniors.

In addition to its strong commitment to our lower-income seniors in general, the plan is particularly good news for women. Since women make up a majority of Medicare beneficiaries and tend to suffer more from chronic illnesses, this landmark improvement in the Medicare system will radically change their lives for better. Half of the senior women who are under Medicare will receive complete drug coverage, an extraordinary step forward for these women who are suffering unnecessarily high drug cost burdens even as we speak. The disease management aspect of this bill will help prevent the progression of the chronic illnesses from which a majority of senior women suffer.

Clearly, this plan means a better life for women and for all of our seniors, but it also will lessen the burden upon the Medicare program by creating a health savings account. Health savings accounts allow forward-thinking and penny-wise workers to start saving for their future medical costs tax free. These accounts are allowed to grow without burdensome taxation, providing all Americans with the opportunity to save for their own future medical expenses. Who can argue with the promotion of these strong values, values like personal responsibility, savings, financial discipline? These things have been gone from our health care delivery system for decades now. It is time we bring them back. And who can argue against a voluntary program that relieves the financial burden of Medicare and the taxpayers who fund it?

Finally, this package includes a provision that I have championed for many years. Under the current system, anticancer drugs are only covered if they are injected or intravenously delivered. But today with the new advances in cancer therapy, many anticancer drugs can be taken orally, and, therefore, are not covered by Medicare. This plan begins to change that finally.

The plan will deliver the comforting pain-relieving and cancer-curing drugs that these patients so desperately need to deal with their illnesses. They need these medications now, and they are going to start to get them now.

Mr. Speaker, there is a value attached to this legislation that resonates not only among our seniors but to all Americans. The value is the freedom to choose the plan that works best for someone in their own situation. Each senior is different with different needs and different family situations. With this plan these differences can, for the first time, be honored. Seniors who are happy with traditional Medicare in their current coverage are free to stay where they are, but if they choose, seniors will have many options available to them and they will be able to pick the coverage that best meets their health care needs. If they are not content with the current coverage, they can choose from other plans to save on their medications and preventative care. This is a win-win solution, a commonsense approach. So today the vote is simple. It is either "yes" in favor of millions of seniors who plead for us to pass this bill, or it is another "no," another "no" in favor of politics, another "no" in favor of partisanship, another "no" with an eye toward the upcoming election. In short, another "no" against American senior citizens and against the future viability of the Medicare system upon which they rely. Members can choose to listen to the seniors who are asking them to put partisanship, politics and election strategy aside, or they can oppose this bill.

But to those of my colleagues who plan to vote "no," I would ask: How is this package not an improvement for our seniors who have no coverage and are struggling to pay for their medications? Why would they rather give our seniors nothing at all than give them this plan that will help them? How will they explain that to future generations, their children, their grandchildren why they did not support bringing Medicare up to speed with their generation and their needs?

I remember the opponents of the tremendously successful welfare reform of 1996. They predicted doomsday scenarios, millions of women and children out on the streets starving. The reality is that 7 years later, the welfare rolls have dropped from 14 million to 5 million. The reality is that welfare reform made the American Dream possible for millions of Americans who were previously trapped in generational cycles of poverty and helplessness.

These same naysayers are making the same claims about this Medicare plan today. I say to my friends, their shouts, their cries, their failed predictions were myths in 1996 and they are myths today. To those who plan to vote against strengthening America, I urge them to be bold, to exercise leadership and show courage by propelling America's health care system into the 21st Century. Vote for this bill. If the Members think this bill does good but does not go far enough to help our seniors, then I ask them to support it and let us work together to improve it in the future. Do not let the perfect become enemy of the very good. Our seniors deserve our support, all of our support.

I urge this Congress to pass the underlying bill, but first of all, let us pass this rule.

Mr. Speaker, I reserve the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I thank the gentlewoman from Ohio for yielding me the customary 30 minutes.

Mr. Speaker, I want to repeat something I said earlier today when I heard the long list of people who support this bill. We have to ask ourselves do they know what in the world is in it? Because we certainly do not.

Seniors, we do know, are drowning from the high cost of prescription drugs and the Republicans are telling them to swim towards an HMO. To paraphrase the old saying, "Congress giveth and Congress taketh away," but in this case it mostly takes away. Congress takes away any hope for meaningful prescription drug coverage. It takes away the existing employer-provided benefits and low-income protections from retirees, and it takes away Medicare as we know it. It lures seniors with the promise of generosity and then gives them a pittance. But when this bill does give, it is wonderfully generous.

The Medicare Prescription Drug and Modernization Act is a boon for the pharmaceutical industry and for the insurance companies but does absolutely nothing to control the skyrocketing prices of prescription drugs. In fact, the bill forbids the government from doing anything about it.

Drug prices have risen dramatically in the last 20 years, increasing 256 percent since 1980. For years seniors have called our Congress to do something about these crushing drug prices, but this plan does nothing to freeze or reduce the out-of-control prices of medications. What it does do, as I said, is prevent the government from using its market power to bring the prices down. The Veterans Administration has had great success in reducing drug prices by bargaining with the drug companies. Why would we purposely tie our own hands? Our health system is crumbling under the burden of the prescription drug costs. Tossing billions of dollars at insurance companies to get them to do what they do not want to do and 70 billion to corporations to get them to do what they should do and a boon to pharmaceutical companies by not allowing reimportation to please them is not going to buttress this health care system. That money would have been far better spent on the prescription drug program. But saddling the elderly with even greater drug costs and our children with even greater deficits is no way to solve a public health crisis.

A few years ago, I organized a busload of seniors to travel to Canada to purchase medicine at a fraction of the prices charged in the American market. We had dozens more people interested in the trip than we could accommodate, but the savings were anywhere from $100 to $650 on a 3-month supply of medication.

Would it not be wonderful if the seniors could save that much at their local drug store? Unfortunately, this bill will not let them go to Canada anymore. Despite having passed the House twice, money-saving drug reimportation would be banned. The out-of-pocket costs for prescription drugs would continue to consume more and more of the seniors' fixed income.

Almost 40 years ago, Mr. Speaker, Congress created the Medicare program and promised to help seniors with the burden of their health care costs. Private insurers did not want to offer the health insurance to older people any more than they do now. The premiums were raised to unaffordable levels, and seniors were dropped from health coverage altogether. Companies saw older people as a threat to the bottom line. So the Federal Government stepped in and filled the void in the marketplace.

And now we face a similar situation. If insurers thought they could make a dollar or two by offering prescription drug coverage to seniors, the plans would have already been in the marketplace. The bill creates a new benefits program unwisely relying on insurance products that do not exist. The Republicans are hoping that a $12 billion slush fund will entice the private insurers to develop prescription drug insurance. But the lucrative pharmaceutical industry with about a 30 percent profit yearly is the big winner in this game. A blank check is being written to the big drug companies, and in the first 8 years of this program, the companies stand to make a windfall of $139 billion over and above their current profits of 30 percent annually. The market recognizes this plan as a boon for drug companies because the stock prices of the major companies went up just over the news that this bill is nearing completion.

The proponents of privatizing Medicare also win. The scheme takes the first giant step to privatize Medicare. In six metropolitan areas, Medicare's guaranteed coverage would be replaced with what is essentially a voucher program to purchase private insurance with public money if they can find it. This "demonstration" could force up to 10 million seniors who want traditional fee-for-service Medicare to pay the higher premiums or turn to HMOs. Once Medicare is gone, there will never be another program ever like it in the United States paid for by payroll taxes. I am worried about the seniors that I represent, and it would be devastating for the seniors in western New York to lose those guaranteed benefits.

Mr. Speaker, the pharmaceutical companies, the HMOs, and the insurance industry had far more access to the negotiations than the Democrats did, as the Members have heard that story before, and I will not belabor it. But I do want to say something about the AARP. President William Novelli's endorsement of this plan is no surprise. The support is waved around as if it is the seal of approval of every American senior. But 210 national, State, and local organizations oppose the plan, and seniors from coast to coast are ripping up their AARP cards. Interestingly, Mr. Novelli is the founder of the firm Porter Novelli, the group behind the television ads that brought down the efforts to reform health care in the 1990's. Do any of the Members remember "Harry and Louise"? Is Mr. Novelli hostile to meaningful health care reform, or can he just be paid to do anything, because $20 million in this bill goes to AARP?

□ 2200

This is not the first time that Congress has messed with Medicare. Congress passed the Medicare Catastrophic Coverage Act of 1988 without even providing the Members sufficient opportunity to read its pages, much like tonight, and the fine print. The result was a momentous backlash. American seniors were outraged with the legislation, so outraged that Congress was forced to repeal the law the very next year.

Congress later created a Medicare+Choice program, which was also a failure. Within a few short years after its conception, private insurers dropped Medicare+Choice beneficiaries by the thousands, leaving them with no health benefits at all. My constituents are asking, does this face them again? I hope we remember our history and not repeat these mistakes and vote against this bill.

But the prescription drug proposal before us is a placebo, not a cure. It fails seniors, the out-of-control cost of prescription drugs will remain unchecked, and some will argue that this scheme is better than nothing. But believe me, a bad bill is worse than no bill. Medicare must be preserved. To dismantle this historic program is to break the sacred promise that Congress made to seniors.

Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from California (Ms. WOOLSEY).

Ms. WOOLSEY. Mr. Speaker, I rise against this sham Republican prescription drug bill that will harm, not help, elderly women.

Mr. Speaker, I rise today to express my profound disappointment at the Medicare Conference Report and this squandered opportunity to help seniors afford the increasing cost of prescription drugs.

I want to make one thing abundantly clear to everyone here today: This debate is not about prescription drugs. Instead, the majority has taken this opportunity to advance a plan that will undermine the future of Medicare.

Seniors may think this final bill will help them with some of their prescription drug costs. While it will save some seniors a small amount of money after they pay an unspecified premium, this bill will give them little more than a false sense of security.

Seniors will read the newspaper headlines and believe that we have passed a drug benefit that will alleviate all of their financial hardships. They'll mistakenly think that they no longer have to choose between paying for groceries and paying for their prescriptions.

But imagine their surprise when they read the fine print. Our seniors need immediate help. Many will be shocked to learn that this bill won't give them a prescription drug benefit until 2006. If this is such a great plan, why must seniors wait 3 more years to reap its supposed benefits?

They'll find that their out of pocket costs are still enormous. Imagine their outrage, as they dutifully write a check to pay their monthly premium, even though they aren't receiving any drug coverage, because they have fallen into the "donut hole" coverage gap.

Seniors who currently enjoy quality prescription drug coverage many think this doesn't impact them, but they too are in for a rude shock. As many as 2 million will watch their prescription drug benefit provided by their former employer vanish into thin air.

Others will find their previously generous benefit slashed to the bare bones level of Medicare, complete with high deductibles, premiums, and a "donut hole" coverage gap. That's because employers will be eligible for subsidies if they provide any type of coverage—even if it's less than what they promised their employees.

But this bill is about far more than prescription drugs. This is the biggest bait and switch operation I've seen in quite some time. The majority is saving one thing and doing quite another. They'll talk all they want about providing prescription drugs. But their actions will ruin the Medicare program that for decades has so effectively provided seniors with access to health care.

You won't hear them talking about their large subsidies to private health plans. They won't talk about the voucher scheme that will begin in 2010. They'll employ the euphemism "demonstration project", instead of speaking honestly to seniors about their real goal: privatization.

They won't talk about the catastrophic impact this legislation will have on the poorest of the poor. By imposing an assets test on poor seniors who need additional help, this legislation could force a widow living only on her social security benefit to choose between selling her wedding ring and qualifying for an additional subsidy. She could be disqualified from receiving the help she needs because she has purchased a burial plot next to her husband's. This is tragic—and you won't hear about it from the majority.

They also won't talk about the ways in which they are helping their friends in the pharmaceutical industry. By continuing a long standing restriction on the reimportation of prescription drugs, and by prohibiting Medicare from negotiating lower prescription drug prices, the majority is assuring that seniors will continue to pay astronomically high prices for the medicines they need.

Our seniors deserve an honest and complete explanation of what this bill will do to Medicare. Seniors deserve a prescription drug bill that is actually about prescription drugs. Our seniors need a comprehensive benefit, not a false sense of security. I urge my colleagues to join me in opposing this bait and switch proposal.

Ms. SLAUGHTER. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from New York (Ms. VELÁZQUEZ).

Ms. VELÁZQUEZ. Mr. Speaker, I rise against this sham Republican drug bill that will increase costs, reduce coverage, and dismantle Medicare as we know it.

Ms. SLAUGHTER. Mr. Speaker, I yield for a unanimous consent to the gentlewoman from Wisconsin (Ms. BALDWIN).

Ms. BALDWIN. Mr. Speaker, I rise in opposition to this conference report which will dismantle Medicare as we know it, harming millions of women who depend on that program.

Mr. Speaker, I urge my colleagues to vote against this sham of a bill. It does not provide the real, guaranteed, affordable drug benefit that our seniors desperately need. Worse yet, this bill sets the stage for dismantling the entire Medicare program.

I think that all of my colleagues would agree with me when I say that one of the issues we hear most about is the need for affordable prescription drugs. Whether I am at the grocery store, at the airport baggage claim, or in meetings all across my district in Wisconsin, the one thing that I hear over and over is that seniors cannot afford to pay for their prescription drugs.

The bill on the floor today does not contain the prescription drug benefit that seniors deserve. Instead of providing an affordable prescription drug benefit, this bill creates an incomplete and expensive benefit—a benefit with a hole, where seniors will be paying premiums and receiving no benefit.

Aside from the meager benefit, there is nothing in this bill that addresses the ever-rising cost of prescription drugs. Instead of including measures to ensure that prescription drugs are affordable, this bill actually prohibits the federal government from negotiating lower drug prices for Medicare beneficiaries. Instead of helping seniors obtain affordable prescription drugs, this bill provides partial coverage of drug spending until total costs reach $2,250 and then leaves seniors high and dry. There is a huge gap in coverage where seniors must pay 100 percent out of pocket and continue paying premiums, until they reach a high out-of-pocket cap. Millions of seniors will fall into this gaping hole. I believe seniors deserve affordable drug coverage, and this bill fails to achieve that goal.

Further, this bill takes us down the dangerous road of privatizing Medicare. It is my strong belief that privatization of Medicare is unwarranted. Our Nation's seniors and persons with disabilities have counted on Medicare since it was first enacted in 1965. It has provided health care insurance to the oldest, sickest, and frailest in our society and done so in a cost-efficient manner. Why then, would we seek to dismantle such a successful program? This bill relies on private insurers to provide a prescription drug benefit. Seniors would have to join HMOs and private insurance plans to get the benefit, meaning that premiums and benefits would vary across the country and seniors would not be able to choose their own doctor or pharmacy.

In addition, this bill includes a provision that authorizes a massive "demonstration" project that could affect up to 6 million seniors. Starting in the year 2010, this "demonstration" project forces Medicare to compete with private plans. This competition is wholly unfair and on an unlevel playing field. Seniors will be given a voucher to purchase health care insurance, either from Medicare or from private insurers. We know from past experience what will happen: the youngest and healthiest seniors will go to private insurers, leaving the sickest and frailest seniors in Medicare. This will automatically drive up Medicare's costs and will give Republican legislators ammunition for dismantling this program. Make no mistake about it; this massive "demonstration" project will be the beginning of the end of Medicare.

Today, we will vote on the most dramatic changes in the Medicare program since its inception. This bill does include unprecedented benefits—unfortunately the benefits will go predominantly to the politically-connected pharmaceutical and insurance industries, rather than to America's seniors who need relief. It saddens me that the legislation we vote on today will not provide seniors with what they need most: comprehensive prescription drug coverage and affordable prices. Seniors need a comprehensive prescription drug benefit that is affordable and dependable for all—with no gaps or gimmicks in coverage. The conference agreement before us fails on all these counts, and I urge my colleagues to vote against it.

Ms. SLAUGHTER. Mr. Speaker, I yield for a unanimous consent to the gentlewoman from Texas (Ms. JACKSON-LEE).

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise against this misdirected Medicare proposal that will increase out-of-pocket expenses for the poorest and sickest women.

Mr. Speaker, this is about as ugly as it gets. Just when I thought the Republican Leadership could not work any harder to undermine the Democratic process, to abuse their power, and to play politics with critical issues at the expense of the American people—they have just taken it to a higher, or should I say "lower" level. This bill is a sham and the rule is a sham.

When this process first began, and the President and the House and Senate Leaders proclaimed that they intended to produce a Prescription Drug Plan, my Democratic Colleagues and I tried to give them the benefit of the doubt. We tried to work in a bipartisan fashion. At one point, I wrote a letter to the Members of the House-Senate Conference Committee and encouraged them to include fair provisions for our physicians and hospitals, so that they would be able to afford to continue providing excellent care for our seniors. I am pleased to say that they did respond to that request, and have put in some funds for those deserving groups. But that is where the collaborations ended.

The Democrats on the Conference Committee, among them, had decades of experience in the field of health policy. No one could question their commitment to helping Seniors, but in a deeply cynical move by Republican Leadership, Democrats were barred from even entering conference meetings. That is against everything our Founding Fathers intended this "People's House" to be. We got our first glimpse of this bill just over 24 hours ago. Even in our haste to get it read, we have found numerous flaws and pitfalls in it. In 2006, if it is allowed to come into effect, I am sure our Seniors will find many more.

No one in this House has had a chance to really think through this monstrous conference report. We should all join together and raise a massive point of order against it, so that we will have the time to give it the consideration it deserves. The Rule does not let us make that happen.

The Rules Committee Chairman seems to be saying, "well money is tight, so let's just take what we can get, and be happy with this bill. Let's just shove it through." But the conference report that we are now finally getting a glimpse of is so bad, it would actually leave millions of Senior Citizens worse off than they were without it. And as Doctors say in the Hippocratic Oath, the most important rule in healthcare is Do No Harm.

Furthermore, there is no rush to pass this bill. The Republican authors conveniently made their plan kick in in 2006, well after the presidential elections of 2004. Obviously, they don't want Seniors to go to the poll furious when they realize how bad this plan is. The point is, we can wait till Spring and do this job right—and still make their 2006 timeline.

This rule and this bill really are the epitome of just how bad partisanship and political demagoguery can get. Let's defeat this rule. Let's take a step back, get some fellowship back over Thanksgiving, and start fresh later. We can do this right. Our Seniors deserve it.

Ms. SLAUGHTER. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from Michigan (Ms. KILPATRICK).

Ms. KILPATRICK. Mr. Speaker, I ask unanimous consent to revise and extend my remarks on this Medicare proposal that takes Medicare from patient care.

Mr. Speaker, I rise today to urge all my colleagues to vote against the Medicare Conference Report offered by the Republican leadership. Seniors want a prescription drug benefit that is affordable and guaranteed under the Medicare system.

Passage of this bill would weaken prescription drug benefits, fail to lower drug costs, and weaken the Medicare program.

Congress needs to pass a good Medicare bill that actually helps seniors and not just any bill that benefits pharmaceutical companies, HMOs, and special interest. Our colleagues on the other side of the aisle have a take it or leave it attitude. They want the American public to believe that if this conference report is not passed then all opportunities for a real prescription drug benefit under Medicare is lost. However, I submit to you that if a true bipartisan effort was made at the conference table, then much could be accomplished.

Mr. Speaker, there are dozens of reasons why this conference report should be defeated and never become law. Many of these reasons have already been mentioned but I want to take this time to highlight a few.

The three Democratic House conferees were shut out of the process and were not allowed in the conferee meeting. The treatment of these House Members is reasons enough for every member of this body to reject this conference report.

The legislation would not create a prescription drug benefit until in 2006. However, HMOs, insurance companies, and pharmaceutical companies receive billions of dollars upon enactment of the conference report.

The bill also explicitly prohibits the Secretary of Health and Human Services from negotiating lower drug prices on behalf of America's 40 million Medicare beneficiaries.

The bill does not allow Americans to import drugs from Canada and other countries where prices are lower. International comparisons of pharmaceutical prices have shown that elderly and uninsured consumers in the United States often pay more for prescription drugs than consumers in other countries. As a result, more and more elderly consumers are traveling outside the country to find cheaper, more affordable prescription drugs. My district borders Windsor, Ontario, Canada, where I have known many of my seniors travel to get their prescriptions filled.

The GOP plan includes provisions that will privatize Medicare and force senior citizens into HMOs and other private insurance plans.

Millions of senior and Americans with disabilities currently covered by Medicare would actually find themselves worse off if the conference report becomes law. Low-income seniors who get additional assistance form Medicaid will pay more for their prescriptions because they will lose their Medicaid benefit.

Currently, Medicare beneficiaries who receive medicine through Medicaid either pay no co-payments or are charged nominal amounts per month per prescription. Under the new plan, people will pay three-to-five dollars per month, per brand-name prescription and one or two dollars for generic drugs. Depending on their income. These co-payments will increase each year.

The GOP plan creates an unlimited program of Health Savings Accounts (HSAs). This tax break benefits the healthy and wealthy and could dramatically raise health insurance premiums for other Americans—particularly families with moderate incomes and those with high health expenses.

Seniors will lose their retiree health benefits. More than two million seniors in employer-based retiree plans are in jeopardy of being dropped from coverage because the bill creates incentives for employers to drop prescription drug coverage.

Mr. Speaker, the Medicare Conference Report before this body will have a detrimental effect on senior and disabled citizens in my home state of Michigan.

143,000 Medicare beneficiaries in Michigan will lose their retiree health benefits.

183,200 Medicaid beneficiaries in Michigan will pay more for the prescription drugs they need.

90,000 fewer seniors in Michigan will qualify for low-income protections than under the Senate bill because of the assets test and lower qualifying income levels.

44,980 Medicare beneficiaries in Michigan will pay more for Part B premiums because of income relating.

Providing affordable prescription drugs to our seniors and the uninsured should have been the goal. The Republican lead Congress squandered this opportunity to include a real prescription drug benefit within the Medicare plan.

Mr. Speaker, there are hundreds of national, state, and regional organizations that have come out against the Medicare conference report. I stand today with the seniors in my district and across the nation in opposition to this bill.

I ask my colleagues to stand with me and vote against this Medicare Conference Report that fails to provide an affordable and reliable Medicare prescription drug coverage, gives billions to HMOs, insurance companies, and pharmaceutical companies, prohibits drug reimportation, and privatizes Medicare.

Ms. SLAUGHTER. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from New York (Mrs. LOWEY).

Mrs. LOWEY. Mr. Speaker, I rise against this prescription drug bill, because it will prohibit Medicare from negotiating price with the pharmaceuticals to lower prices for our sickest and most elderly population.

Mr. Speaker, we are on the cusp of passing a Medicare prescription drug benefit that should have put seniors first, but, instead, will become the death knell for Medicare.

Some are saying this is a matter of now or never, that we must pass this legislation tonight. That's just not true—where there's a will, there's a way. So, I urge my colleagues to refrain from rushing to judgment, vote against this bill, and work together, Republicans and Democrats alike, through December to craft a plan that will stay true to Medicare's tried and trusted roots.

Mr. Speaker, the bill before us will allow insurance bureacrafts—not doctors—decide which drugs to prescribe and how much to charge seniors; and leaves major gaps in coverage that will affect almost half of Medicare recipients. I will end Medicare as we know it, and will have questionable impacts on some of the most well regarded state-sponsored drug coverage programs, including New York's.

But, my colleagues, the straw that breaks the camel's back is the lack of any attempt to bring down the skyrocketing costs of drugs. H.R. 1 will prohibit the federal government from using the muscle of the 40 million seniors in Medicare to negotiate lower drug prices. And it puts the brakes on the reimportation of pharmaceuticals from Canada and overseas—where drugs are sold for two, three, and four times less than in the U.S.

This one-two punch will not only hurt seniors. It will block hard-working Americans, including the 43.6 million uninsured, from obtaining cheaper drugs—leaving taxpayers to foot the bill for a plan that rewards private industry at the expense of consumers.

The drug companies, with profit margins over 18 percent, have spend hundreds of millions of dollars trying to influence American opinion on prescription drugs. Yet, they will be rewarded with 40 percent profit increases. The same HMOs that left seniors in the cold under Medicare+Choice will be given a $12 billion slush fund to entice their participation in this plan.

I have fought for years to give seniors an affordable, guaranteed, comprehensive, and voluntary prescription drug benefit under Medicare. I am deeply saddened and disappointed that the House leadership in forcing a vote on a bill, which many of us have not even been able to read in completion, that is not worthy of our seniors.

I urge my colleagues to vote "no" on the bill.

Ms. SLAUGHTER. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON).

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I rise against this so-called Medicare proposal devised by former Speaker Gingrich and the pharmaceutical industry that will increase out-of-pocket expenses for the poorest and sickest women.

Mr. Speaker, the sham Republican prescription drug bill will harm, not help, elderly women.

I oppose the Republican Medicare bill because it does not ensure that our seniors, especially our most venerably elderly women, get the long overdue Medicare prescription drug benefit that is available and affordable to all.

How will this Medicare Reform proposal hurt women? First you must realize that women account for the majority of people who are on both Medicare and Medicaid. To make matters worst, the proposal is harmful to the poorest and sickest women because their out of pocket cost would increase above what Medicaid currently allows.

I believe we must carefully draft legislation to protect the health and well-being of our citizens. It is shameful that many American seniors must regularly make the heartbreaking choice between paying for food and paying for prescription medicine. As a former nurse, I have spend much of my career working to ensure that our nation's health care system provides a wide range of affordable services.

But unfortunately, drug prices are going up over 3 times the rate of inflation giving the drug industry more profits than all others—the result: seniors can't afford the medicine they need.

Yet this proposal would actually prohibit Medicare from getting the best price for seniors. This bill states, and I quote, "[Medicare] may not . . . interfere in any way with negotiations between . . . Medicare Advantage organizations . . . and drug manufacturers . . ." In laymen's term that means Medicare must pay whatever the drug companies want to charge. This makes the new law a multi-billion dollar subsidy to the drug industry and a rip-off for America's senior citizens.

This is especially hurtful to women because nearly eight in ten women on Medicare use prescription drugs regularly. Because the bill doesn't allow for the government to negotiate price controls on drugs, our women will have to face higher drug cost, as well as the American Treasury.

Democrats have led the fight to add a drug benefit to Medicare. But what started as a fight to add a drug benefit has become a fight to save Medicare as we know it. Over and over again we have demonstrated our willingness to compromise and accept a less-than-perfect drug benefit when they approved a bipartisan Senate bill this summer. But instead of seeking bipartisanship, Republicans have insisted on including provisions that would turn Medicare into a voucher program and could cap government spending on Medicare. These provisions have nothing to do with providing beneficiaries affordable prescription drugs. They are intended to undermine Medicare.

Medicare was created because the private health care system would not provide affordable health insurance coverage for seniors. We shouldn't be turning back the clock to those times. But that's exactly what the Republican bill—as written—will do.

The American public should be outraged that the Republican leadership is playing politics with the health and well-being of millions of our citizens, and I hope the voters will remember this shameful abuse of power when they go the polls at election time.

Ms. SLAUGHTER. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from New York (Mrs. McCARTHY).

Mrs. McCARTHY of New York. Mr. Speaker, I rise against the Medicare bill that is going to be giving billions of dollars of giveaway money that should be going for prescription drugs and not to the insurance companies and not to the pharmaceutical companies.

Mr. Speaker, I rise, once again, in opposition to this flawed prescription drug bill. It is nothing more than a sheep in wolf's clothing.

I'm frustrated because this Medicare bill contains some provisions I feel are necessary. Indeed, hospitals and doctors may see higher reimbursement rates. It would provide a meager prescription drug benefit, and includes some protections for low-income seniors.

All of these provisions are a step in the right direction. Unfortunately, they are overshadowed by the bill's overall shortcomings.

I had hoped that the effort to add a prescription drug benefit to Medicare would be a discussion about freeing seniors from the skyrocketing costs of medicine.

But instead, it's become a struggle for the future of Medicare.

The bill starts us down the path to privatizing Medicare. It damages the safety net we've stitched for our vulnerable seniors. And worst of all, it does nothing to make drug companies keep the cost of their medicines down, which is what I thought this effort was all about in the first place.

Most of Long Island's seniors would be forced to go to private insurers for their drug coverage. In fact, this bill takes us down the same road Long Island has already traveled with Medicare+Choice HMOs. At first, we throw money at them, the private plans provide coverage, and everyone's happy. But over time, costs mount, federal reimbursements don't keep up, and the private insurers cut and run. This Medicare plan would throw billions more at HMOs and other private insurers with no guarantee that they'd continue to cover seniors. What happens when the HMO gravy train stops? Once again, our seniors will be left holding the bag. That goes against the very reason we created Medicare in the first place: to provide seniors with a safety net that the private insurance market could not and did not provide them with.

In addition, the bill would actually prohibit the government from negotiating lower drug prices. Veterans on Long Island benefit from lower drug prices because the Veterans Administration negotiates prices on their behalf. If it works for veterans, why deny it to our seniors?

Finally, many seniors would find themselves in the "doughnut hole," a gap in the very prescription drug coverage we are supposedly trying to provide them.

Simply put, the bill is not good enough, and I refuse to compromise the needs of our seniors in hopes of advancing a political agenda.

We must go back to the drawing board and create a real prescription drug benefit for seniors. We must do it without damaging their safety net or turning Medicare over to HMOs and insurance companies. Finally, we must do no harm, I learned years ago as a young nurse.

Mr. Speaker, this bill will do harm. I must vote against it.

Ms. SLAUGHTER. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from California (Ms. WATSON).

Ms. WATSON. Mr. Speaker, I rise against this sham Medicare proposal that the AARP supports. Bill Novelli is smiling because AARP gets millions of dollars, he gets $420,000 annual salary, and all grandma gets is a doughnut hole.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LAHOOD). As recorded in section 957 of the House Rules and Manual, although a unanimous-consent request to insert remarks in debate may comprise a simple, declarative statement of the Member's attitude toward the pending measure, it is improper for a Member to embellish such a request with other oratory; and it can become an imposition on the time of the Member who has yielded for that purpose. The Chair will entertain as many requests to insert as may be necessary to accommodate Members, but the Chair also must ask that Members cooperate by confining such requests to the proper form.

Ms. SLAUGHTER. We would be happy to cooperate. Mr. Speaker, is it correct that we can rise for the unanimous consent request to say that we oppose the bill?

The SPEAKER pro tempore. The gentlewoman is correct.

Ms. SLAUGHTER. Mr. Speaker, I am pleased to yield for a unanimous consent request to the gentlewoman from California (Ms. LINDA T. SÁNCHEZ).

Ms. LINDA T. SÁNCHEZ of California. Mr. Speaker, I ask unanimous consent to revise and extend my remarks about this sham Medicare proposal that I oppose.

Ms. SLAUGHTER. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from Ohio (Mrs. JONES).

Mrs. JONES of Ohio. Mr. Speaker, without embellishing my statement, I adamantly oppose the legislation that is before us on behalf of the millions of low-income workers who will not receive adequate funding under this bill.

Ms. SLAUGHTER. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from California (Ms. LOFGREN).

Ms. LOFGREN. Mr. Speaker, I ask unanimous consent to revise and extend my remarks in opposition to the bill because it increases costs for the poorest who are mainly women.

Mr. Speaker, the current Medicare Prescription Drug bill we are debating this evening, if passed, will force many low-income seniors to pay more for their Medicare coverage. Despite its $400 billion price tag, this legislation will leave some 6.4 million of the poorest and sickest Medicare beneficiaries who currently receive prescription drug coverage through Medicaid, worse off, as they will no longer be able to depend on assistance with their co-payments and will no longer depend on getting help paying for prescription drugs that are prescribed by their doctors but are not on the list of drugs and therefore not covered by the private insurers who will administer the new Medicare bill.

Mr. Speaker, this piece of legislation is not "paid for." I expect that it will worsen the nation's long-term fiscal problems substantially adding to the deficit. Is the proposal good enough to justify this?

After weeks of secret hearings, in which not one Democratic Member of the House of Representatives was allowed to participate, we were presented with a Medicare prescription drug plan that is more geared towards benefiting industry, the HMOs, and insurance companies than in serving the healthcare needs of our elderly and disabled.

In the forty years since Medicare was created, it has been hailed as an affordable, defined, guaranteed, and comprehensive healthcare plan for all senior citizens. I agree that Medicare should evolve. I also understand that prescription drug costs are rising at an alarming rate of 17 percent per year. But the current proposal facing Congress does too little to help control drug costs, requires seniors to spend too much out-of-pocket, and compromises many of the basic principles that have made Medicare so valued and effective. This proposal prohibits the federal government from using its vast buying power to negotiate significant discounts for the millions of seniors and disabled who have come to rely on Medicare.

Mr. Speaker, my constituents and seniors across this nation believe that an affordable, guaranteed prescription drug benefit is urgently needed. Sadly, the prescription drug benefit in this bill would not go into effect until 2006.

Mr. Speaker, my constituents and seniors across this nation asked this Congress for a strong prescription drug benefit through Medicare, it did not ask this Congress to begin the process of privatizing Medicare. They believe that reforming Medicare does not mean privatizing Medicare. Under this bill, millions of Medicare beneficiaries are forced to pay more just to stay with their own doctors. Premium support, a provision included in this bill will allow private insurance plans to lure healthy seniors out of Medicare, leaving older and disabled seniors behind to pay higher premiums for the same coverage they're receiving today. Mr. Speaker, my district lies within Santa Clara County in California. Santa Clara County is in one of 41 metropolitan areas that could be selected to participate in this demonstration that would lead to the privatization of Medicare. Under this plan, seniors must be prepared to deal with changing benefits, premiums and access to care from year to year.

Mr. Speaker, these new benefits are not guaranteed. This Republican-drafted Medicare reform bill creates a major gap in coverage that will leave millions of seniors and disabled persons without any drug coverage during parts of the year. Once a senior's drug costs reaches a moderate level of $2,250, all coverage would be cut off. It isn't until the out-of-pocket prescription drugs costs rise to a much higher level—roughly $3600—that coverage kicks back in. It will also erode retiree coverage for up to 2.7 million seniors who, after years of hard work earned a prescription drug benefit through their retirement plans. Those lucky enough to have such coverage must now worry about whether or not they will lose that hard-earned benefit under this proposal.

Mr. Speaker, this bill is not comprehensive. The bill eliminates Medicare's promise to retirees by arbitrarily limiting the ability of Congress to fund the program. As baby boomers retire and require more physician visits, hospital services, and pharmaceutical coverage, Republicans want to limit the amount of money that would be spent on Medicare. This means the services seniors expect and deserve will be cut, premiums will increase, or reimbursements to physicians and hospitals will be severely restricted.

Mr. Speaker, I remind my colleagues and those trying to follow all the possible implications of this bill that the coverage offered under this plan is not, repeat not, like that offered to members of Congress and other federal workers. No Federal employee or member of Congress has a drug benefit that has a deductible, or a $2,850 coverage gap or donut hole in the benefit. In fact, during the debate on the drug benefit, Republican members of Congress voted to ensure that Federal employees' benefits would not be lowered to the level in the new drug plan.

There are many parts of this bill that I applaud. I am happy that the bill includes increased payments to doctors and to hospitals that will allow them to continue to offer services to Medicare patients. I am very happy that the bill includes critically needed funding for safety-net hospitals that serve our needy so well. Indeed in California, this provision alone will restore several hundred million dollars in reimbursements over the next ten years. Mr. Speaker, these provisions are the kind of reforms to Medicare that would pass this house nearly unanimously if they were presented separate from this bad bill.

Mr. Speaker, these good provisions do not override the potential devastating effects of this bill. I cannot support a bill that I feel will destroy the fundamental promise of Medicare, a program that seniors and the disabled have known and trusted for nearly 40 years. With the future of Medicare at stake, I believe that Congress can—and must—do better. Rather than pass a bad bill, we should defeat this bad bill and stand firm as we fight for a prescription drug benefit that our seniors demand and deserve.

Ms. SLAUGHTER. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from Nevada (Ms. BERKLEY).

Ms. BERKLEY. Mr. Speaker, I ask unanimous consent to revise and extend my remarks about premium support provisions in this conference report that will undermine the Medicare system on which older women depend.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlewoman from California (Ms. LEE) for a unanimous consent request.

Ms. LEE. Mr. Speaker, I ask unanimous consent to revise and extend my remarks on this sham Republican prescription drug bill because it will harm, not help, elderly women. I did not come to Congress to dismantle and privatize Medicare.

Ms. SLAUGHTER. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from California (Ms. LORETTA SANCHEZ).

Ms. LORETTA SANCHEZ of California. Mr. Speaker, I ask unanimous consent to revise and extend my remarks about the premium support provisions in this conference report that I believe will undermine the Medicare system on which elderly women rely.

Mr. Speaker, I wish to express my concerns today over the Medicare bill and how it will leave millions of seniors without the adequate care they deserve.

Under this bill nearly 3 million seniors will loose their prescription drug coverage, while 6 million will likely see an increase in the price of their medications and nearly 10 million would see an increase their Medicare premiums if they refuse to join an HMO.

This bill is not a plan for our seniors, rather it is a plan that benefits drug companies and the insurance industry. This legislation would even prohibit Medicare from negotiating better prices for prescription drugs. It would spend $7 billion, desperately needed for covering all retired Americans, on creating individual health security accounts for only those who could afford them.

I urge my colleagues to vote against this legislation. We need to work for our seniors and provide them with a Medicare bill that helps them and not the big pharmaceutical and insurance companies.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlewoman from California (Mrs. DAVIS) for a unanimous consent request.

Mrs. DAVIS of California. Mr. Speaker, I ask unanimous consent to revise and extend my remarks expressing my opposition to this bill, which fails to provide women with the affordable and reliable Medicare prescription drug coverage that they desperately need.

Mr. Speaker, I rise to talk about older women and their need for a real prescription drug benefit. The legislation we have before us represents a hollow substitute for a bona fide Medicare prescription drug benefit.

Every week, I hear from seniors overwhelmed with the cost of prescription drugs. Many find themselves juggling their expenses—often putting off paying some bills—in order to buy their medication. These seniors, our parents and grandparents, who have worked their whole lives and contributed to making our nation great never imagined they would spend their retirement struggling to make ends meet. Congress must act and provide seniors with a prescription drug benefit.

Our seniors—especially older women who, literally, are the face of Medicare—are counting on Congress to provide a real solution to the rising cost of prescription drugs. However, this debate has moved beyond providing prescription drugs to seriously undermine Medicare.

The Medicare conference report before us disportionately harms older women in the following ways: Women account for the majority of people who are on both Medicare and Medicaid. However, this proposal prohibits Medicaid from continuing to provide the poorest and sickest women with drugs that certain Medicare drug plans may not cover.

Older and sicker beneficiaries, often women, have not joined HMOs and tend to rely on the traditional Medicare program. This conference report is harmful to older and sicker women because its "premium support" provisions would undermine the traditional Medicare program and cause costs in that program to rise.

Nearly eight in ten women on Medicare use prescription drugs regularly. This legislation is harmful to women because it prohibits the government from negotiating price controls on drugs, leading to higher drug costs for both seniors.

Where is the benefit for women who are living on a fixed income and cannot afford to pay out-of-pocket during the coverage gap?

Where is the benefit for the women who, because they were stay-at-home mothers and did not earn a pension, cannot afford the prescription drugs they desperately need?

For my constituents, this legislation is not good enough. I cannot support this legislation when I know we can do better. We are doing more than providing prescription drugs, we are legislating the future of Medicare.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN) for a unanimous consent request.

Mrs. CHRISTENSEN. Mr. Speaker, I ask unanimous consent to revise and extend my remarks in strong opposition to the rule and the conference report, which helps HMOs and hurts poor women, minorities, and the disabled.

Mr. Speaker, I rise in opposition to the rule and the Medicare conference report.

The process by which we come to this place has been ugly. The conference committee locked out the democratic leadership from the process, and is sending this bill down without the 3 days to review it that we were promised.

But we should not be surprised. The bill itself is a more important broken promise—this one to the Senior citizens and disabled persons who have relied on Medicare to be there for them, and who have waited long for a comprehensive prescription drug benefit. They would be the real losers if we pass this bill and that is why I am asking my colleagues to vote "no."

Let us not take away the Medicare wrap around provision for those who need it, let us not jeopardize the good prescription drug benefit so many of our seniors and disabled now have, let us not put any more money in the already rich HMO's, let us take the means test and the mean out of this bill, and above all let us not destroy Medicare.

Mr. Speaker, this bill stinks, and no amount of promises to fund rural hospitals or increase physician's reimbursement can make it smell any better. Besides, this is coming from the same Party leadership that has been cutting physician and hospital fees, and refusing to remedy them for years. If they are known for anything, it is for broken promises.

We have no reason to rush and accept this defective piece of legislation that takes away more than it gives, and puts the first nail in the coffin the Republicans have been building for a long time for Medicare.

Any prescription drug benefit won't take effect until more than two years from now, so if we really care about our seniors and disabled we should take the time to get it right.

And if all of the tears I see shedding on the other side of the aisle for our suffering doctors, the struggling hospitals are any more than of the crocodile variety, we should do the right thing before we go home and pass those provisions now.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlewoman from Georgia (Ms. MAJETTE) for a unanimous consent request.

Ms. MAJETTE. Mr. Speaker, I rise to oppose the Republican prescription drug bill because it is bad for women, especially poor, elderly women; and they deserve better than this.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlewoman from California (Ms. MILLENDER-MCDONALD) for a unanimous consent request.

Ms. MILLENDER-MCDONALD. Mr. Speaker, I ask unanimous consent to revise and extend my remarks about the premium support provisions in this conference report that will undermine the Medicare system on which elderly women in my district depend.

Mr. Speaker, today I rise in opposition to H.R. 1. This conference report represents the beginning stages of this Administration's withdrawal from its promise to seniors. This report being considered on the House floor today, sets the stage for a gradual pullout of the federal government providing benefits to seniors and shifting the responsibility to private insurers.

As our nation's population ages and the baby boomer generation places additional burden on our healthcare infrastructure, we can no longer provide a "one-size fits all" level of healthcare. I am a strong and passionate advocate of a Medicare program that would cover all of our nation's seniors and provide a comprehensive prescription drug benefit. This is not that benefit. Mr. Speaker, this is not a better solution than "no benefits"—it's worse. It gives our seniors false hope. It makes seniors think that this government is expanding Medicare services, while it takes a backdoor approach to privatization of the Medicare program.

Mr. Speaker, in my home state of California, hundred of thousands of Medicare beneficiaries will lose their retiree health benefits. Medicaid beneficiaries will pay more for the prescription drugs they need. Hundreds of thousands of Medicare beneficiaries will pay more for Part B premiums because of so-called income relating provisions.

Last night, Mr. Speaker, I spoke with my Congressional Seniors Council which represents leaders from senior associations in the 37th congressional district. This council has expressed its deepest concerns with H.R. 1. On behalf of the more than 51,000 seniors in the 37th Congressional district, this council fears Seniors, who should otherwise qualify for a drug benefit, may no longer qualify because of the asset provision in this report. Seniors, who have saved their hard-earned money for use during retirement, who relied on the promises of this Administration, become disqualified from receiving the prescription drug benefit. Very poor and very sick dual eligible beneficiaries will lose wrap around coverage for prescription drugs making out-of-pocket costs more than they can afford.

I urge my fellow colleagues for the sake of Medicare beneficiaries in their districts, to vote against H.R. 1. Our seniors deserve better.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlewoman from California (Mrs. CAPPS), who is also a nurse, for a unanimous consent request.

Mrs. CAPPS. Mr. Speaker, I rise in opposition to the harmful cuts in care amounting to $1 billion a year for all those who are being treated for cancer.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlewoman from Ohio (Ms. KAPTUR) for a unanimous consent request.

Ms. KAPTUR. Mr. Speaker, I rise to oppose this GOP drug company bonanza that is going to make affordable drug prices impossible for the majority of this Nation's seniors. What a shame.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlewoman from California (Ms. SOLIS) for a unanimous consent request.

Ms. SOLIS. Pido permiso para revisar y decir estas palabras.

Sr. Orador, estoy en contra del proyecto de ley Medicare que no ayudara a las mujeres que son el 70 por ciento de los mayores de edad.

(English translation of the above statement is as follows:)

Mr. Speaker, I rise in opposition to this Medicare bill which does nothing to help women, who make up more than 70 percent of the elderly poor.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlewoman from California (Ms. WATERS) for a unanimous consent request.

Ms. WATERS. Mr. Speaker, I rise in opposition to this sham Medicare proposal that will end Medicare as we know it and simply fatten the pockets of the pharmaceutical industry and the HMOs.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlewoman from Missouri (Ms. MCCARTHY) for a unanimous consent request.

Ms. MCCARTHY of Missouri. Mr. Speaker, I ask unanimous consent to revise and extend my remarks about the premium support provisions in this conference report that will undermine the Medicare system on which the elderly in my district and around this Nation depend.

Mr. Speaker, I rise today in opposition to H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003. I strongly support the inclusion of a prescription drug benefit as part of the Medicare program. Unfortunately, instead of providing a prescription benefit, this legislation includes dramatic changes in the entire Medicare program. As Washington Post columnist E.J. Dionne recently wrote, "They went in to design a prescription drug benefit for seniors and came out with an aardvark."

Mr. Speaker, in 1965, President Johnson and the Congress had the wisdom to create the Medicare program. The program accomplished its mission—it has ensured every single American's health coverage upon reaching 65 years of age. Since the bill's passage, Congress has made changes to the program to keep it current and to ensure that seniors received the highest quality care.

Now seniors are asking us to include a prescription drug benefit within the Medicare program. They want a benefit that offers comprehensive, affordable coverage to all seniors. I agree with them wholeheartedly. Instead of designing a prescription drug benefit, the majority created H.R. 1, which will end Medicare as we know it.

Mr. Speaker, this proposal is confusing and inadequate. For the first $2,000 of coverage, the consumer will pay over $1,100; for the first $5,000 of coverage, the consumer will pay approximately $4,000. If a consumer buys $5,000 of drugs a year, the consumer will pay 80 percent of that cost. Elderly women will be hardest hit.

Under this misguided plan, seniors will be forced to choose private prescription plans each year. A move between states, or even between towns, could force them to select another plan. In my district, seniors who chose to relocate from Kansas to Missouri could face the loss of their chosen prescription drug plan.

I am also concerned that this legislation will encourage companies that offer employer-provided drug coverage to drop or reduce their benefits. While the bill includes billions in subsidies for companies to maintain their benefits, more than 2.7 million retirees are likely to lose their employer provided coverage under this bill.

Seniors have been asking for a prescription drug benefit. They have not been asking for HMOs to take over Medicare. Yet that is what we are being asked to vote on today. This legislation includes "cost containment" provisions that will prompt significant cuts in the Medicare program if more than 45 percent of the costs of Medicare are borne from general tax revenues. Let's be clear—this cost cap would effectively end Medicare as a basic right for our seniors.

In a machiavellian effort to pass this misguided legislation, the authors have included billions in additional payments for doctors, hospitals, rural health facilities, and ambulance services among others. Sadly, these quality health care providers are forced to support this legislation even though many fear it will be bad for seniors and could unravel the Medicare program. Those funds should not be held hostage by this Medicare privatization scheme. I urge my colleagues to consider supporting stand alone legislation that would help our providers and save the Medicare program.

As E.J. Dionne wisely recommended, we should reject this flawed bill and "let's then have a national debate on the future of Medicare, out in the open, and not in some congressional back room." Mr. Speaker, I urge all of my colleagues to reject this measure and go back to the basics. Give seniors what they deserve—a comprehensive Medicare prescription drug benefit.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlewoman from Connecticut (Ms. DELAURO) for a unanimous consent request.

Ms. DELAURO. Mr. Speaker, I rise against a prescription drug bill that prohibits the government from using its market power to negotiate the best price for prescription drugs, the central issue of this debate and concern of the people of this country.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlewoman from California (Ms. ESHOO) for a unanimous consent request.

Ms. ESHOO. Mr. Speaker, I rise against this bill which, in my view, I used the yardstick to measure it by my mother; and in doing the calculations, my mother, at 89½ years old, will be hurt by this, as will women her age across the country. She and they deserve so much better.

It's with great disappointment that I rise today to express my opposition to this Medicare Prescription Drug legislation. As the daughter of a Medicare beneficiary, I know first hand how important prescription drug coverage is for America's seniors, and I held out great hope that this would be the year we finally succeeded in providing seniors with an affordable, stable benefit.

Unfortunately, now that we have the long-awaited legislation before us, it is clear that it doesn't embody any of these important principles.

This bill does nothing to lower drug costs for America's senior citizens. It provides an unstable insurance benefit, undercuts the viability of the employer-provided retirement health insurance, and fundamentally undermines the Medicare program that has served seniors so well for nearly 40 years.

Specifically, the bill: Brings privatization to the Medicare program in 2010. Although this is being described as a "demonstration project," this "demonstration" will affect as many as 7 million beneficiaries who will be forced to pay higher premiums and more money to keep the same benefits they have today if they don't join an HMO; has a $2800 gap in drug coverage that will leave millions of seniors without any help in paying for their drugs for part of the year, even though they will have to continue to pay their monthly premiums; Creates disincentives to employers to retain retiree drug coverage. An estimated 2 to 3 million seniors who have good drug coverage now through retiree health plans could lose it under the proposed plan.

In California, this means more than a quarter of a million seniors may lose their employer-sponsored health care. Real reform would encourage employers to expand retiree coverage, not take it away; Purposefully creates, for the first time, disparities between seniors across the country. Seniors living in different areas of the country will pay different premiums for the exact same benefits. In another first, this bill links how much a senior earns to how much they will pay in premiums.

If a senior makes more than $80,000 they will pay higher premiums than the rest of the Medicare population.

Does not address the rising cost of prescription drugs for individuals, nor does it harness overall Medicare spending in future years. In fact, the bill specifically prohibits the Secretary of Health and Human Services from negotiating with drug companies for lower prices.

Jeopardizes coverage for cancer patients by drastically cutting funding for chemotherapy drugs.

Finally, this bill dramatically changes Medicare by limiting the total amount of money that can be spent on the program—meaning services will be cut and premiums will increase.

I do want to take a moment to highlight the few bright spots in this bill.

The bill reverses a recent decision by the Centers for Medicare and Medicaid Services (CMS) that threatened seniors' access to innovative treatments. For years biotechnology products, which often represent the most advanced treatments for diseases, were critically under-reimbursed. This bill ensures that these life-saving treatments will be available for all seniors by raising payment levels to an appropriate level. This bill also provides more speedy coverage of new medical device technologies and more streamlined processes by new technologies in the Medicare program.

Second, the bill includes critical funding for relief from the devastating payment reductions to Medicaid disproportionate share hospitals. This is very important for California which has a severe budget shortfall. The funding in the Conference Report restores several hundred million dollars to safety-net providers in California over the next 10 years. With more than six million MediCal recipients and 6.3 million uninsured residents in California, Medicaid DSH funds are invaluable to the safety net hospitals that serve low-income populations.

Unfortunately, these issues aren't enough to overcome the faulty foundation that this bill rests on. It's with a heavy heart that I say "This Medicare Prescription Drug bill should be rejected." We have not honored the seniors who have done so much to make our country great, and I cannot justify a "yes" vote on a bad bill just for the opportunity to say we've succeeded in providing a drug benefit.

Mr. Speaker, I urge my colleagues to vote against the bill.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlewoman from Florida (Ms. CORRINE BROWN) for a unanimous consent request.

Ms. CORRINE BROWN of Florida. Mr. Speaker, I rise against this sham Medicare proposal on behalf of Claude and Mildred Pepper, my grandmother, and all of the other seniors who will be increased out-of-pocket expenses for this sham Medicare bill.

Ms. SLAUGHTER. Mr. Speaker, I am proud to yield to the gentlewoman from California (Ms. PELOSI), our leader, for a unanimous consent request.

Ms. PELOSI. Mr. Speaker, I rise in opposition to this hoax of a plan. How can a plan be for the benefit of seniors when the first $4,000 of $5,000 of benefits have to be paid for by a senior who makes $13,500 a year?

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlewoman from New York (Mrs. MALONEY) for a unanimous consent request.

Mrs. MALONEY of New York. Mr. Speaker, I rise in opposition to this ill-conceived bill which promises to be a magic potion for seniors, but is a poison pill for Medicare.

Ms. SLAUGHTER. Mr. Speaker, I am pleased to yield to the gentleman from Florida (Mr. HASTINGS), my colleague on the Committee on Rules.

Mr. HASTINGS of Florida. Mr. Speaker, after that array, you have to be a very strong man to oppose this bill, and I ask unanimous consent that my remarks be included in the RECORD.

Mr. Speaker it gives me no greater disappointment to rise today in opposition to the co-called Prescription Drug and Medicare Modernization Act Conference Report. I might call it something else but that wouldn't be appropriate.

Since 1965 Medicare has been a vital instrument in ensuring quality healthcare to America's elderly and disabled. Medicare's 40 million beneficiaries use thousands of different health care products and services furnished by over 1 million providers in hundreds of markets nationwide. However, today a great number of you seek to dismantle Medicare with a fool's gold of a bill tilted the Prescription Drug and Medicare Modernization Act.

Despite my Democratic colleagues' best efforts to make this an inclusive and comprehensive process; one that addresses the real concerns of America's seniors and disabled, we were shut out from negotiations. We were shut out in June and we are shut out now. Today we have before us what the Republicans think is a Medicare and Prescription Drug reform. This is not a reform. This is a gutting of Medicare. It eviscerates one of the most successful great society programs in order to line the pockets of pharmaceutical companies.

Mr. Speaker, I am disturbed to my core that any person in their right mind would find this bill fit to deliver to America's seniors. HR 1 is seriously flawed and inept for several reasons. First, the prescription drug benefits is only available through private insurance companies and HMOs.

Second, the bill does not ensure affordable prescription drugs. Because of the arbitrary budget cap pushed by the administration, HR 1 has high deductibles and does not guarantee an affordable premium.

In addition, this scam of a sham bill creates large coverage gaps—with many seniors being required to pay high premiums even when they don't receive benefits.

Lastly, the bill does not promise prescription drug benefits to all beneficiaries. By relying on private insurance companies to offer coverage, this approach does not guarantee the same benefits for seniors, like Larry Colado of Myakka City, Florida, who lives in a rural community. Larry Colado is a Vietnam Veteran turned farmer who cannot afford health coverage and now faces losing the little that he has because, unlike Darwin, this administration believes in the survival of the richest.

Approving this bill may not guarantee a destitute future for members of Congress, but it will guarantee a destitute future for those seniors who do not and have not served in this body.

Mr. Speaker, simply put, this bill should be wrapped around a toilet paper holder and stuck in one of the Capitol's bathroom stalls.

I adamantly oppose the so-called Prescription Drug and Medicare Modernization Act. It is a snake oil and it stinks.

Ms. PRYCE of Ohio. Mr. Speaker, I yield such time as he may consume to the gentleman from California, the chairman of the Committee on Rules (Mr. DREIER).

Mr. DREIER. Mr. Speaker, continuing this spirit of comity, I ask unanimous consent that the conference report on H.R. 1 be debatable for 2 hours, doubling the amount of time that is made in order for consideration for a conference report.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

Ms. PRYCE of Ohio. Mr. Speaker, I am very pleased to yield 2 minutes to the gentleman from Florida (Mr. LINCOLN DIAZ-BALART), my friend and colleague from our Committee on Rules.

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, I thank the gentlewoman from Ohio for yielding me this time.

This legislation is very important legislation. It will help seniors, all seniors throughout the land; but especially low-income seniors will benefit, will benefit the most from this law. America's neediest seniors, individuals with up to $12,900 a year of income, $17,000 per couple, will immediately receive a cash credit of $600 to purchase their medications. And, again, in the year 2006, seniors with incomes of up to $10,300, or $13,250 per couple, will pay only $1 for generic prescriptions and $3 for brand-name medicines. Mr. Speaker, 13,235 reside in the district that I am honored to represent. I would urge all of my colleagues here this evening to check.

The gentleman from Florida (Mr. SHAW) has the information and he was so kind to provide it to me, district-by-district, how many low-income seniors will get extraordinary relief by this legislation.

□ 2215

Those with incomes of up to $13,900 a year, $17,900 per couple will pay only $2 for generic medications and $5 for brand name medications.

Mr. Speaker, 20,715 reside in the district that I am honored to represent. Seniors with incomes up to $15,500 a year, $20,000 per year per couple, will pay only a minimum monthly premium and initial deductible of $50 and then only 15 percent of their prescription drug costs up to $3,600 after which they will pay only $2 for generic drugs, $5 for brand names.

Now, all other seniors receive extraordinary help by this legislation, Mr. Speaker, but low-income seniors more than anyone else.

So I urge everyone in this hall, I think we all have an obligation to check the facts with regard to what we are voting on this evening: Concrete important specific help for seniors throughout the country on an issue that, I think, is the most important domestic issue facing this country. And I am proud to have supported this legislation in the Committee on Rules and to urge all of my colleagues to make it law, send it to the President tonight.

Ms. SLAUGHTER. Mr. Speaker, I yield 3 minutes to the gentleman from Massachusetts (Mr. MCGOVERN).

Mr. MCGOVERN. Mr. Speaker, Medicare is one of the most important successful social programs in the history of this country. For nearly 40 years, Medicare has been a lifeline for our senior citizens. I certainly do not argue that Medicare is perfect. Thanks to extraordinary advances in medical science, it is clear that Medicare needs a real prescription drug benefit.

The program should be strengthened so that future generations have access to high quality, affordable health care, but I believe that Medicare is a sacred trust between the United States government and the seniors of this country. The Republican majority in this House clearly does not believe what I believe, because if they did, this bill would not be before us.

This is a bill that fails to give seniors the drug benefit they need and deserve and expect. This bill forces millions of seniors to pay more for their prescription drugs. This bill is a huge giveaway to the HMOs and the drug companies. This bill does nothing to control the exploding costs of medicine. And worst of all, this bill shoves Medicare down the path to privatization. It ends Medicare as we know it. This is a defining issue. You can put all the bells and whistles and spin on it that you want. You can add a little money here or a tweak there to buy off a few interest groups or to make the bill more appealing to certain geographic areas. You can try to claw your way to a majority vote, and you might succeed. But your success will not mask the fact that this bill is bad for senior citizens.

So much of what people think is good about the Federal Government the supporters of this bill are ripping apart.

And let me say just a word, actually two words, about the processing used here. It is lousy. No one has had the time to properly review this. There are rules of this House, and we should follow them, especially with regard to giving Members of both parties the chance to actually see what they are voting on. But the Committee on Rules, once again, decided that the rules of this House do not matter. Maybe we should rename it the "Break the Rules Committee."

I guarantee you that for weeks to come we will be discovering lots of goods for special interests tucked into the dark corners of this legislation. The leadership of this House is more concerned with doing this bill fast than doing it right. If we take our time and do this right, it would give every Member the chance to read the fine print. Unless, of course, that is exactly what scares the leadership most.

Now, I have heard the argument out there that, well, this bill is not perfect. It is not even very good, but we have to pass something. Mr. Speaker, not if that something is a windfall for HMOs and drug companies. Not if that something is the privatization and dismantling of Medicare. Not if that something is a sound bite rather than a meaningful drug benefit.

There is a fundamental disagreement here because, to me, protecting Medicare is non-negotiable. If I voted for this bill I could not look at the people who sent me here and claim that I was representing their interests.

I believe our seniors deserve a defined, guaranteed, affordable prescription drug benefit under Medicare and that is what I am for. This bill does not even come close.

Vote no on the rule. Vote no on the bill.

Ms. PRYCE of Ohio. Mr. Speaker, I yield 3 minutes to gentleman from California (Mr. DREIER), the very distinguished Chairman of the Rules Committee.

Mr. DREIER. Mr. Speaker, I rise in strong support of this rule and the underlying conference report. My friend from Massachusetts (Mr. MCGOVERN) is absolutely right, Medicare is a sacred trust. He is also right when he says that this conference report, when we pass it, will end Medicare as we know it. Medicare as we know it does not have provisions for prescription drug coverage. And guess what? If we pass this, we will, in fact, end Medicare as we know it by making prescription drugs available to seniors.

It will also end Medicare as we know it because right now under Medicare there is a provision that allows for $148,000 to be expended on heart transplant surgery, but at the same time it does not provide the $1,000 a year that would be necessary for people to prevent heart disease by giving them access to Lipitor. And so it is true, we are going to finally bring about the very important reforms necessary so that we can maintain that sacred trust to which my friend refers.

So I believe, Mr. Speaker, that we have an opportunity to go a long way towards addressing this concern that exists on both sides of the aisle. I know that my democratic colleagues, Mr. Speaker, want to make sure that we do provide access for senior citizens to affordable prescription drugs. And I believe that on both sides of the aisle, Mr. Speaker, there is a clear understanding that if we are going to do that, we have to bring about major reforms so that we maintain the solvency of Medicare for the future. I also believe that as we look at the changes that will come about in the area of potentially creating another new entitlement program, Republicans and Democrats, Democrats who raise concern regularly about deficit spending, should feel good about the unprecedented measures that we put in this bill that allow for our Members to insist on a vote if, in fact, Medicare outlays exceed 45 percent of general revenues.

So I believe we are going a long way towards addressing these concerns. And then that wonderful incentive that also is there for people to plan for retirement with health savings accounts. Planning for their health care needs of the future is exactly what this measure will do by taking those very successful HSAs that have been out there and expanding that program.

Mr. Speaker, this may not be, this may not be the perfect solution, but this is our opportunity to bring about these much needed reforms.

And I urge my colleagues to support this rule, and, in a bipartisan way, do as I know the other body will do, and that is vote in support of this conference report so that we can help our seniors.

Ms. SLAUGHTER. Mr. Speaker, I yield 3 minutes to the gentleman from Maryland (Mr. HOYER), the minority whip.

Mr. HOYER. Mr. Speaker, I rise in opposition to this rule. And I invite the 41 Members of this side of the aisle who wrote a letter just a few days ago, those 41 Members, all Republicans, said to the gentleman from Illinois (Speaker HASTERT) and the gentleman from Texas (Majority Leader DELAY) that this is one of the most important issues that this Congress, or any Congress, will consider, and give us at least, they said, 3 days to consider this bill.

This bill is over 1,100 pages in length. It will affect not only the 40 million Americans who are eligible for Medicare, but it will also affect their families, their children, their sons and daughters who are confident that this country will provide for health care security for seniors.

I invite those 41 Members, this is about the process, this has been a terrible process, a shameful process. Speaker HASTERT, an honorable man, appointed the gentleman from Michigan (Mr. DINGELL), the Dean of this House, serving here since 1955, one of the most knowledgeable people, not Democrats or Republican, most knowledgeable Americans with respect to health care and Medicare and Social Security. And then he appointed one of the most senior Members of this House, the gentleman from New York (Mr. RANGEL) to this conference, and the gentleman from Arkansas (Mr. BERRY), the only pharmacist that serves in this House.

Shamefully, shamefully, they were neither invited, nor allowed, to come to the table to discuss this bill. I invite the 41 signers of this letter, if they meant what they said in this letter, to vote no on this rule. To vote no on this rule so that we can, in fact, look at it closely. Just 2 more days this bill, 1,100 pages in length, which was put on the Web just last afternoon, just approximately 24 hours ago.

I say to the signatories on this letter, if you meant what you said, if you believe the processes of this House ought to be followed, if you believe this issue is important enough to know what you are doing, to read the bill, to digest its consequences, to understand the adverse consequences that it will have on the poor, on those who were left behind in Medicare when the HSAs take the healthiest and wealthiest out of the system and force premiums higher for those who can least afford it, read this bill, understand this bill. You have not done so.

Some of our most respected colleagues signed this letter, Republicans all. I ask every Democrat to vote against this rule, to give ourselves and our constituents further time to consider this bill. I ask the Republicans honor their letter, honor their rules. Vote no on this one.

Ms. PRYCE of Ohio. Mr. Speaker, I yield 3 minutes to the gentleman from Washington (Mr. HASTINGS), my friend from our Committee on Rules.

Mr. HASTINGS of Washington. Mr. Speaker, I thank the gentlewoman from Ohio (Ms. PRYCE) for yielding, and I congratulate her on the way she excellently laid out the main provisions of this bill in her opening remarks.

I support this bill, Mr. Speaker, and this bill includes several important improvements to Medicare in addition to making prescription drugs available and affordable for seniors. But I am particularly pleased that this bill contains the largest, most comprehensive rural health care package ever considered by Congress to ensure that seniors in rural America are able to get the care they need.

I often hear from seniors they are having a hard time finding a doctor will accept Medicare patients. Now, doctors and hospitals in rural areas provide the same quality care as in urban areas, all too often Medicare fails to pay rural health care providers enough to cover their costs. This often forces doctors to consider whether they can continue accepting Medicare patients and, therefore, causes hospitals to cut back on their services.

As a member of two rural health care caucuses, I have met repeatedly with committee leaders and Secretary Thompson to stress the importance of ensuring that rural areas receive the Medicare payments that they deserve.

Mr. Speaker, until the disparity between rural and urban reimbursement is fixed, seniors in small town America have fewer and fewer health care options. I commend the conferees for recognizing this need. I am pleased that the National Rural Health Care Association has endorsed this bill saying, quote, "This is a strong step forward this strengthening the health care system for nearly 60 million rural Americans," end quote.

By passing this bill, we will permanently end the disparity in Medicare payments between urban and rural hospitals. We will provide more money to rural hospitals for the care of uninsured patients, we will increase funds for critical access hospitals and home health care agencies and raise payments to doctors to encourage them to provide services in physician-short areas.

Simply put, Mr. Speaker, after years of effort H.R. 1 will finally give doctors, hospitals, home health nurses, and other care providers the resources they need to provide seniors who live in rural areas like my district in central Washington the medical care they deserve.

Accordingly, I urge my colleague to support both the rule and the underlying bill.

□ 2230

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey (Mr. MENENDEZ), the minority caucus chairman.

Mr. MENENDEZ. Mr. Speaker, the Republican plan that we consider here tonight is not a Medicare prescription drug plan, but rather a poison bill for our Nation's seniors and for Medicare itself. The more you know about this bill, the less you like it.

The Republican plan would encourage employers to drop retiree coverage for their employees. And this means that approximately 94,000 New Jerseyans in my State will be left with no coverage. I thought this debate is supposed to be about expanding coverage for our seniors, not taking it away.

Under their demonstration plan, 7 million beneficiaries would be forced to pay more for Medicare if they do not give up their doctor and join an HMO. The Republican plan would cut payments to oncologists nationwide and would result in New Jersey cancer care providers losing $552 million, this in a State that has the third highest instance of cancer in the United States, and in which cancer is the second leading cause of death.

Republicans would include a $14 billion bribe to get private insurance company plans to compete against Medicare. Why give away billions of taxpayers money to private insurance interests when that money could be used to enhance a true prescription drug benefit under Medicare? Obviously, Republicans are more concerned about their special interests than senior interests.

Republicans would make millions of seniors pay more for their drugs. Seniors would pay $4,020 out of the first $5,100 in prescription drug costs. And low-income seniors, like my 83-year-old mother who worked her entire life in the factory of New Jersey and who suffers from Alzheimer's, would pay higher premiums and would lose additional assistance under Medicaid. And only in Washington would Republicans prohibit the Federal Government from using the collective purchasing power of 40 million citizens to obtain lower prescription drug prices.

Let us stand up for our parents and our grandparents and our seniors. Vote against the rule. Vote against this poison pill that is this plan.

Ms. PRYCE of Ohio. Mr. Speaker, I yield 2½ minutes to the gentleman from the State of New York (Mr. REYNOLDS), my very good friend from the Committee on Rules.

Mr. REYNOLDS. Mr. Speaker, I thank the gentlewoman for yielding me time.

Mr. Speaker, I rise in strong support of this rule and the underlying legislation.

For the first time in the nearly 40-year history of the Medicare program, Congress tonight has the opportunity to provide more than 40 million seniors and disabled Americans a guaranteed prescription drug benefit.

In my home State of New York, this means nearly 3 million Medicare beneficiaries will have greater access to life-saving prescriptions. For many of these beneficiaries, this amounts to drug coverage that they would not otherwise have; and for countless others, it means vastly improved benefits.

In providing a prescription drug discount card, greater access to less-expensive generic drugs, enhanced ability to create individualized health savings accounts and strong protections for retirees with current coverage, this bill helps bring Medicare into the 21st century.

What the bill also accomplishes is improved access to care in a variety of other areas that will help Americans all across the country get the care they need and deserve. For example, by updating the critical hospital formulas for marketbasket and indirect medical education, New York State will be infused with over $1.2 billion over the next 10 years.

Of that, hospitals in my congressional district will receive close to $40 million. In cash-strapped regions of western New York that I represent, this payment relief is great news for patients of all ages and income levels.

New York will also be bolstered by many other funding streams that will bring critical Federal funds into the

State and help mitigate local fiscal burdens. And the Federal Government assuming costs of New York beneficiaries eligible for both Medicare and Medicaid, the State will save over $3 billion over 8 years on prescription drug coverage for its Medicaid population.

Because New York already provides a popular, generous prescription drug program, well over 300,000 seniors, the State will have access to $125 million over 2 years in transitional assistance to help the new Federal drug program coordinate with the existing State program.

These funds will ensure a seamless transition and coordination of benefits for many seniors who want to remain in the State program, yet still receive enhanced benefits through the Federal plan.

Mr. Speaker, this body is poised to make history. Today begins the final step in a journey that began not 3 days ago, not 3 years ago, but nearly a decade ago. Congress promised a prescription drug benefit. Congress promised to make Medicare stronger, and it took this majority to deliver on that promise.

I urge my colleagues to support the rule and the underlying legislation.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. BROWN).

Mr. BROWN of Ohio. Mr. Speaker, I thank the gentlewoman from New York (Ms. SLAUGHTER) for yielding me time.

We have been here before, Mr. Speaker. We will debate late into the night and consider one of the most important votes we have ever cast. At 2:54 a.m. on a Friday last March, the House cut veterans benefits by 3 votes.

At 2:39 a.m. on a Friday in April, House Republicans slashed education by five votes.

At 1:56 a.m. on a Friday in May, the House passed the Leave No Millionaire Behind Tax Cut Bill by a handful of votes.

At 2:33 a.m. on a Friday in June, the House GOP passed Medicare privatization by one vote.

At 12:57 a.m. on a Friday in July, the House eviscerated Head Start by one vote. And then after returning from summer recess, at 12:12 a.m. on a Friday in October, the House voted $87 billion for Iraq.

Always in the middle of the night. Always after the press had passed their deadlines. Always after the American people had turned off the news and gone to bed. And here we go again, Mr. Speaker.

Republican leadership delivered this bill to us last night at 1:46 a.m.

Mr. Speaker, I do not really blame my Republican colleagues because when Republican leaders sit down with the insurance industry and the drug industry behind closed doors and write a bill to privatize Medicare, of course they do not want the public to know.

When Republican leaders sit down with the drug industry to write a bill to deliver $139 billion in additional pharmaceutical profits to their biggest contributors, of course they do not want the public to know.

When Republican leaders sit down with the insurance industry to write a bill to set up a $20 billion slush fund for HMOs, some of their biggest contributors, of course they do not want the public to know.

This bill proposes the most radical changes to Medicare since its creation a generation ago. We should not do it under the cover of darkness. Americans deserve better.

Ms. PRYCE of Ohio. Mr. Speaker, I yield 1 minute to the gentleman from Indiana (Mr. BURTON).

Mr. BURTON of Indiana. Mr. Speaker, I admire our President and my leaders in the House, but I want to tell you why I oppose this bill.

The average senior is going to pay $4,000 in order to receive the first $1,500 in benefits. Now, we should take care of the 24 percent of seniors across this country that have no drug coverage; but this covers all of them, including the 76 percent that do have coverage.

Employers will, in my opinion, in spite of a $70 billion payoff, drop their seniors and put them on the government program, and they are going to get less coverage than they have right now, and it will cost a lot more.

This program is going to cost much more, in my opinion, than the $400 billion that we estimate. I think it will go as high as maybe a trillion dollars over the next 10 years. And, finally, there is no negotiation with the pharmaceutical companies on drug prices even though Americans are paying as much as five to 10 times more than they are paying in Germany and Canada and other places in the world; and that is just not right.

Ms. SLAUGHTER. Mr. Speaker, I yield 1 minute to the gentlewoman from Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. Mr. Speaker, a little history lesson. August 17, 1989, front page of the Chicago Tribune, outside the Copernicus Senior Center in Chicago. These are the constituents of Congressman Dan Rostenkowski who is in this car.

They are not happy with their Congressman, and they are not happy with the catastrophic health care bill.

When the Congressman escaped from his car, a reporter asked him if he sympathized with the seniors who were mad about this bill, and he said, "No, they do not understand." But, unfortunately, it was not the seniors who did not get it. It was the Congressman. Three months later that bill was repealed.

A big mistake was made. This Congress overwhelmingly passed the catastrophic. Everyone on Capitol Hill liked it including the AARP. They did not check with the seniors, and we are about to make the same mistake tonight. A thousand pages and more, 40 years of Medicare, but 40 hours to read this bill.

I tell you, if you vote for this, you better get your running shoes. The senior citizens will be after you.

Ms. PRYCE of Ohio. Mr. Speaker, I yield 2 minutes to the gentleman from the State of Florida (Mr. SHAW), from the Committee on Ways and Means, who worked so hard on this bill.

Mr. SHAW. Mr. Speaker, I thank the gentlewoman for yielding me time.

Medicare passed this Congress on July 27 of 1965 and was signed into law in Independence, Missouri, on July 30 of 1965. It is interesting, and I was watching C-SPAN today and watching the goings on within the Committee on Rules. And I heard several of the Democrat witnesses come in and say, your party did not support Medicare in the first place and you want it to wither on the vine.

After hearing this over and over, I thought, well, it is about time somebody goes into the archives and finds out the truth. The truth is the majority of the Republicans in this House of Representatives in 1965 did support Medicare. So the big lie now can go down and be deflated.

Also, I have heard many witnesses on the other side say what a bonanza this is for big drug companies. Nobody is mentioning the fact that we are shortening the time that generics can get on the market. You think the big drug companies like that? Of course not.

Also, the discount card where prices will be negotiated and seniors will get their drugs for less money. Nobody on that side is talking about that.

What this is actually is a cost-containment bill and probably the largest one that will ever be signed into law providing for the cost containment in drugs.

I sent out a survey as many of us do to some of our constituents and was just simply asking them did they want this drug bill. I received back the biggest number that I have ever received. They are still coming in and they are just now hitting and we already have 12,000 replies. And guess what? Only 100 said no. And most of them were misinformed by this bill thinking they might have lost the coverage that they had. This is a good bill. Let us do it for our seniors. Let us do it for the people at the lower economic levels who desperately need this.

Why would you deny this to them? Somebody can buy drugs for so little and be able to get a better quality of life. Life is meant to be enjoyed, not endured. Let us vote "yes" on the rule. Let us vote "yes" on the bill.

The SPEAKER pro tempore (Mr. LAHOOD). The gentlewoman from Ohio

(Ms. PRYCE) has 3 minutes remaining. The gentlewoman from New York (Ms. SLAUGHTER) has 9½ minutes remaining.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentleman from North Carolina (Mr. PRICE).

Mr. PRICE of North Carolina. Mr. Speaker, we began this effort years ago with a relatively simple concept: let us add a prescription drug benefit to Medicare, giving help to the countless older Americans who so desperately need it. But this bill has ended up doing the very thing seniors do not want us to do—to privatize their coverage.

Little do they know that the so-called prescription drug benefit will operate nothing like their other Medicare benefits. An enormous sticker shock awaits them. If a senior needs $5,000 worth of medication, he or she will have to pay $4,000 in order to get it. If drug costs are $3,500, he or she will pay $2,500.

This bill has a gaping so-called doughnut hole where any drug costs that fall between $2,250 and $5,100 are not covered at all. Do you think that is what our constituents have in mind when they think of prescription drug coverage?

But this spotty coverage is not the worst of it. An even more unpleasant surprise awaits. This bill forces Medicare beneficiaries to get drug coverage through private companies or an HMO.

Our Republican friends would apparently rather do anything than strengthen basic Medicare, so they have devised a convoluted scheme to throw enough money at private companies to induce them to offer drug-only policies, policies which these same companies say make no sense in terms of insurance principles.

☐ 2245

The Senate bill offered a fallback plan to provide Medicare coverage if these private plans did not materialize, but that fallback has been fatally weakened in the bill before us.

We have heard a lot about choice tonight, but the only real choice most seniors will have under this bill is whether they obtain their prescription drug coverage through a private drug plan or an HMO, and whether they would rather have medications they can afford or a doctor of their own choosing. Under this plan they cannot have both.

Mr. Speaker, this bill is a betrayal of our seniors. This is not an improvement, an expansion of Medicare. It is just the opposite. We should defeat this bill and go back to the drawing board immediately.

Ms. PRYCE of Ohio. Mr. Speaker, I yield for a unanimous consent request to the gentleman from Florida (Mr. SHAW), a member of the Committee on Ways and Means.

Mr. SHAW. Mr. Speaker, I submit to the RECORD a letter of endorsement from the Republican Governors Association and a letter from my own Governor, Governor Jeb Bush, endorsing this bill.

STATE OF FLORIDA,
OFFICE OF THE GOVERNOR,
Tallahassee, FL, November 21, 2003.
Hon. E. CLAY SHAW, Jr.,
Rayburn House Office Building,
Washington, DC.

DEAR CONGRESSMAN SHAW: Today, there is very good news for Florida's three million Medicare beneficiaries. The recent bipartisan conference agreement for Medicare will provide first-time access to prescription drug coverage. As the second largest home to seniors, this drug benefit—along with many other improvements and modernizations—will have the most significant impact for residents in our State since the enactment of Medicare in 1965.

Medicare will increase in value as our beneficiaries will have available to them a prescription drug benefit, and critical protections against high out-of-pocket drug costs. New preventive benefits will keep our residents healthier, and provide a higher quality of life. The new opportunities to be screened for many illnesses and conditions will result in far fewer serious health consequences.

Designed to provide enhanced coverage for the lowest income beneficiaries, over 650,000 of Florida's low-income Medicare beneficiaries—who are not eligible for Medicaid drug coverage—will receive $10 billion in critical prescription drug benefits from 2006 through 2015. The prescription drug discount card will provide our seniors and disabled Medicare beneficiaries with much-needed discounts, and a $600 per year subsidy in transitioning to the new drug benefit.

Another 490,000 low-income individuals dually eligible for Medicare and Medicaid will receive more than $6.7 billion annually in prescription drug benefits, with no gap in coverage. This new federal benefit will save the taxpayers of Florida over $3 billion—in just the first 10 years. These are state Medicaid costs that can be reinvested in other health care needs.

This reform package will strengthen the Medicare program, while providing beneficiaries a prescription drug benefit, more choices and improved care options. All Floridians will benefit from the option to accumulate tax-free health dollars through Health Savings Accounts to pay for medical expenses. Other reforms include a transition to electronic prescribing, creating incentives for our hospitals and doctors to reduce errors by using this new e-technology.

Seniors cannot afford to indulge the political appetites of Washington, where the issue of prescription drugs has turned into a search for the perfect. Our representatives must look to those who are being denied the opportunity for life-saving prescription drugs. Today's bill may not be ideal, but it is just right for those who have been waiting too long.

AARP has led the long fight for a Medicare drug benefit, and I commend their leadership in ensuring passage of this bill. I join with them in urging you to support this historic legislation. There has never been a greater opportunity to do more for the seniors in Florida.

Sincerely,

JEB BUSH,
Governor.

REPUBLICAN GOVERNORS
ASSOCIATION,
Washington, DC, November 21, 2003.
Hon. J. DENNIS HASTERT,
Speaker, House of Representatives, The Capitol, Washington, DC.
Hon. BILL FRIST,
Majority Leader, U.S. Senate, The Capitol, Washington, DC.
Hon. NANCY PELOSI,
Minority Leader, House of Representatives, The Capitol, Washington, DC.
Hon. TOM DASCHLE,
Minority Leader, U.S. Senate, Washington, DC.

DEAR SPEAKER HASTERT, REPRESENTATIVE PELOSI, SENATOR FRIST, AND SENATOR DASCHLE: As Governors, we urge the U.S. Congress to pass the bipartisan Medicare Conference Agreement. Passage of this legislation will provide more choices and better benefits to Americans. Under the bipartisan agreement, Medicare beneficiaries would be provided significant savings and access to broader coverage.

Medicare will provide first-time access to prescription drug coverage to many of our seniors. The agreement also assists states with the costs related to the dual eligible population. Assistance to low income persons as well as critical protection against high out-of-pocket drug costs are essential components of this legislation. Most importantly, the preventive benefits found in this measure will keep our constituents healthier.

Passage of this historic legislation will modernize the delivery of quality healthcare in America. Therefore, we commend you and the conferees for providing leadership in developing this legislation and offer our support of its passage.

Sincerely,

Bill Owens, Governor of Colorado, RGA Chairman.
Bob Taft, Governor of Ohio, RGA Vice Chairman.
Robert R. Riley, Governor of Alabama.
Robert Ehrlich, Jr., Governor of Maryland.
Jeb Bush, Governor of Florida.
Felix Camacho, Governor of Guam.
Mitt Romney, Governor of Massachusetts.
Haley Barbour, Governor-elect of Mississippi.
Mike Johanns, Governor of Nebraska.
John Hoeven, Governor of North Dakota.
Olene S. Walker, Governor of Utah.
Ernie Fletcher, Governor-elect of Kentucky.
Frank H. Murkowski, Governor of Alaska.
John G. Rowland, Governor of Connecticut.
Sonny Perdue, Governor of Georgia.
Dirk Kempthorne, Governor of Idaho.
Tim Pawlenty, Governor of Minnesota.
Kenny Guinn, Governor of Nevada.
James H. Douglas, Governor of Vermont.
Don Carcieri, Governor of Rhode Island.
Mike Rounds, Governor of South Dakota.
Rick Perry, Governor of Texas.

Ms. PRYCE of Ohio. Mr. Speaker, I reserve the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentlewoman from Connecticut (Ms. DELAURO).

Ms. DELAURO. Mr. Speaker, this is a defining moment for the senior citizens of this country. For years we have tried to provide a prescription drug benefit to help them with the rising cost of medicine, but this bill does nothing about the central issue, price. It prohibits the government from using its market power to negotiate the best price for drugs and does nothing to allow Americans to import drugs from countries like Canada where prices are lower. As a result, prices will continue to rise and over time wipe out any gains that seniors realize from the new benefit which does not even begin until 2006.

Rather, the bill is the first step toward eliminating the universal guaranteed benefit that defines Medicare. For the first time, it caps the amount of money that can be spent on the program, meaning services that are guaranteed today will not be guaranteed tomorrow. It creates a two-tiered health care system, one for the affluent, one for everyone else. For as many as 10 million seniors, premium support will force them to give up the doctors that they have been with for years, force them into HMOs that will cut services and cost more.

So today we consider more than a prescription drug benefit. We consider the future of our contract with the families in this country, a contract that says that after a lifetime of hard work, paying taxes, that we have a moral obligation to ensure our parents and our grandparents have a dignified retirement. By ending the guarantee of equal health care provided to every senior in this country for nearly four decades, we are breaking that contract.

I was not elected to preside over the dismantling of Medicare, the embodiment of our country's shared values, in exchange for a feeble prescription drug benefit that does nothing to bring down the prices of prescription drugs. We should send this bill back to the drawing board, do whatever it takes to deliver a real drug benefit that maintains Medicare's promise to senior citizens. We owe them nothing less.

Ms. SLAUGHTER. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from Arkansas (Mr. BERRY), actually a pharmacist.

Mr. BERRY. Mr. Speaker, this is the most shameful attempt to deceive the Greatest Generation. The question that continues to go through my mind is why would you want to do this to these good people. They survived the Depression, they fought World War II, and they built this great Nation into what it is today.

Being an Anglo-Saxon, male Protestant, I have not known the hurt of being excluded or denied my rights like my dear friend the gentleman from Georgia (Mr. LEWIS). After having served on this conference committee, I have an idea of what that must feel like. At every attempt to be a part of this conference, the House Democrats were ridiculed, humiliated, used every trick that they could imagine to try to make us feel like we just simply should not be a part of this act, and we are not. This is the Republicans' deal. Let them have credit for this sorry piece of work.

I can tell my colleagues, I do not also understand why they would want to continue to give billions of dollars to the drug companies and to pass an act that would make it possible for the drug companies of this country to have the exclusive right to continue to rob the senior citizens. The burden of this dishonorable act rests on those that have written it and those that will vote to pass it.

I suspect that our Founding Fathers must be very sad this evening, but let it be known henceforth and hereafter, the Republicans did this to our seniors, and the Democrats fought every last step of the way to try to keep it from happening.

Ms. SLAUGHTER. Mr. Speaker, may I inquire from my colleague, does she have anymore speakers?

Ms. PRYCE of Ohio. I have one remaining speaker.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentleman from Washington (Mr. BAIRD).

Mr. BAIRD. Mr. Speaker, I thank the gentlewoman for yielding me the time.

I cannot get up and say this bill is awful entirely. I think there are some very good parts, and I think some good efforts have been put into it, but I have two concerns.

First of all, side effects. I think the side effects of this bill may well be fatal to some, and more importantly, I believe that most Members on both sides of the aisle have not really read this bill and do not fully understand it.

Earlier tonight, I invited the gentlewoman from Ohio to explain a simple passage.

Ms. PRYCE of Ohio. Mr. Speaker, will the gentleman yield?

Mr. BAIRD. I yield to the gentlewoman from Ohio.

Ms. PRYCE of Ohio. Mr. Speaker, I appreciate that. Earlier today, and once again now, a statement was placed in front of me, a statement which was a long, drawn out document, and he was asking me to explain it, and it is very unfortunate that we were not provided with that in advance.

Mr. BAIRD. Reclaiming my time, the point I am making is I do not think the gentlewoman has actually read the bill sufficiently to explain it.

I spent 23 years of my life in health care. I hold a doctorate in clinical psychology. I have spent hours on this bill. My eyes are exhausted. I must say I do not know fully well enough what is in it.

My colleagues have said to us, and I agree, this is one of the most important bills that we will face in our career, and yet my colleagues have given us less than 24 hours to look at it.

The great philosopher Socrates said this when the politicians of Athens imprisoned him, he said to his the young people he taught, he said, These people have imprisoned me for pointing out to them how little they know. Instead of being angry at me for pointing that out, they should be angry at themselves for knowing so little.

His advantage was he admitted that he did not know. What I would ask the gentlewoman is a simple request that we almost never do here. Let us break with precedent. Let us say, you know what, this is important, we are moving too fast. I look around this room and I will say to my distinguished colleagues I bet you, you have not read the bill carefully, and you really, fully cannot explain it to your constituents, and if you have not and if this bill spends $400 billion of the taxpayers' money and is going to blow a hole in the lid of this deficit and is going to deprive people who desperately need pharmaceutical care, then why do we not just take a little bit of time and read it? Who knows, I might actually like it well enough to vote for it, but I cannot vote for something you have not given us enough time to read.

That is what the people of expect of us when they send us here. That is what a republic is all about it, but we do it a great disservice in this institution of late.

Ms. PRYCE of Ohio. Mr. Speaker, may I inquire as to the time remaining and how many speakers the gentlewoman from New York has?

The SPEAKER pro tempore (Mr. LAHOOD). The gentlewoman from Ohio (Ms. PRYCE) has 3 minutes remaining. The gentlewoman from New York (Ms. SLAUGHTER) has 1½ minutes remaining.

Ms. PRYCE of Ohio. I have one speaker.

Ms. SLAUGHTER. I have one more speaker.

Mr. Speaker, I yield 1 minute to the gentleman from Ohio (Mr. KUCINICH).

Mr. KUCINICH. Mr. Speaker, this legislation was written at the behest of insurance companies and pharmaceutical companies. This is the beginning of the end of universal health care for seniors.

Since Medicare was enacted in 1965, seniors went from a group least likely to have health insurance to most likely to have health insurance because of Medicare. Medicare has achieved goals that Congress has not been able to accomplish for the rest of our population by keeping millions out of poverty, increasing access to health care, improving quality of life and even extending life expectancy by 20 percent.

This conference report will eliminate universal health care for the only part of our population that has it. It will lead to benefit cuts by the creation of an artificial cap on Medicare spending. It will increase costs for millions of seniors. It will privatize Medicare in order to dismantle it.

We should be expanding Medicare so that all Americans can have quality health care under a single-payer system with fully-paid prescription drug benefits.

This legislation is a choice between health care in the public interest which we still have with Medicare or health care in the private interest. Choose wisely. Reject the rule, reject the legislation.

Ms. SLAUGHTER. Mr. Speaker, I reserve the balance of my time.

Ms. PRYCE of Ohio. Mr. Speaker, I am very pleased to yield 2 minutes to the gentlewoman from West Virginia (Mrs. CAPITO), my friend and colleague.

Mrs. CAPITO. Mr. Speaker, I would like to thank my distinguished colleague from Ohio for yielding me the time. I rise in support of the rule and the underlying bill.

We have all listened to and viewed the rhetoric surrounding the Medicare prescription drug legislation this week. We have all faced the questions regarding what is in the bill and what is not. There has been a multitude of fallacies about who is covered and who is not. Mr. Speaker, the truth of the matter is this Medicare prescription drug package will grant 40 million Medicare seniors a drug benefit they do not have.

I am especially proud of the low-income provisions in this bill. In my home State of West Virginia where our seniors are clamoring for this coverage, fully one-third of the Medicare beneficiaries will only pay up to $5 for prescriptions. This is real savings for those who need it most.

The truth is that seniors fortunate enough to have coverage through a previous employer will maintain that benefit. Corporations, small businesses, unions, State and local governments will receive serious help to allow them to continue to offer that benefit.

The truth is that in this legislation senior women will now have greater access to more affordable health care. Women live longer than men, with less income and suffer from more chronic illnesses. Disease management and access to a prescription drug benefit will allow women to enhance the quality of life in their senior years.

Mr. Speaker, I can handle this truth. West Virginia's seniors can handle this truth. America's seniors can handle this truth. It is time to get past the rhetoric and deliver on a promise we have all made to America's seniors.

Ms. SLAUGHTER. Mr. Speaker, I yield myself the remaining time.

I am going to ask for a no vote on the previous question so we can amend the rule and restore the right of all Members under the House rules to consider the report for 3 days before they vote on it. Voting no on the previous question will not block consideration of the report. It will simply give all the Members who were not in the secret, closed meetings a chance to read it and a chance to look before we leap.

Mr. Speaker, I ask unanimous consent that the text of the amendment be printed in the RECORD immediately prior to the vote on the previous question.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from New York?

There was no objection.

□ 2300

Ms. PRYCE of Ohio. Mr. Speaker, I yield myself such time as I may consume.

We have heard a lot of rhetoric tonight, as the gentlewoman from West Virginia (Mrs. CAPITO) mentioned. You would think we were talking about different bills. But the truth is the 35 million seniors that the AARP represents cannot be wrong. This bill is what America's seniors need. They know it and we know it. We have heard them.

And let me remind my colleagues that we have before us today a historic opportunity, an opportunity to make the most sweeping changes to the outdated Medicare program since it began in 1965. Bring our seniors the financial relief and the lifesaving medications that they so desperately need and deserve. Support this rule and the bipartisan legislation that it supports.

The text of the amendment referred to previously by Ms. SLAUGHTER is as follows:

Strike all after the resolving clause and insert in lieu thereof the following:

"That upon adoption of this resolution it shall be in order to consider the conference report to accompany the bill (H.R. 1) to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes. All points of order against the conference report and against its consideration (except those arising under clause 8(a)(1)(A) of rule XXII) are waived."

Ms. PRYCE of Ohio. Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The SPEAKER pro tempore (Mr. LAHOOD). The question is on ordering the previous question.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Ms. SLAUGHTER. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

Pursuant to clause 9 of rule XX, the Chair will reduce to 5 minutes the minimum time for electronic voting, if ordered, on the question of agreeing to the resolution.

The vote was taken by electronic device, and there were—yeas 228, nays 204, not voting 2, as follows:

[Roll No. 665]

YEAS—228

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McInnis
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NAYS—204

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Cummings
Davis (AL)

Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Green (TX)
Grijalva
Gutierrez
Hall
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Smith (WA)
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—2

Gephardt
Gordon

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LAHOOD) (during the vote). Members are advised 2 minutes remain in this vote.

□ 2319

So the previous question was ordered.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Ms. SLAUGHTER. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 225, noes 205, not voting 4, as follows:

[Roll No. 666]

AYES—225

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McInnis
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (PA)
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NOES—205

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Green (TX)
Grijalva
Gutierrez
Hall
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Smith (WA)
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tancredo
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—4

Cannon
Gephardt
Gordon
Petri

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised 2 minutes remain in this vote.

□ 2328

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

FURTHER MESSAGE FROM THE SENATE

A further message from the Senate by Mr. Monahan, one of its clerks, announced that the Senate has passed without amendment bills of the House of the following titles:

H.J. Res. 79. Making further continuing appropriations for the fiscal year 2004, and for other purposes.

The message also announced that the Senate agreed to the amendment of the House to the bill (S. 1680) entitled "An Act to reauthorize the Defense Production Act of 1950, and for other purposes," with an amendment.

CONFERENCE REPORT ON H.R. 2622, FAIR AND ACCURATE CREDIT TRANSACTIONS ACT OF 2003

The SPEAKER pro tempore. The pending business is the question of suspending the rules and agreeing to the conference report on the bill, H.R. 2622.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Ohio (Mr. OXLEY) that the House suspend the rules and agree to the conference report on the bill, H.R. 2622, on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 379, nays 49, answered "present" 1, not voting 5, as follows:

[Roll No. 667]

YEAS—379

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bell
Bereuter
Berkley
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
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Burr
Burton (IN)
Buyer
Calvert
Camp
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Carson (IN)
Carson (OK)
Carter
Case
Castle
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Chocola
Clay
Clyburn
Coble
Cole
Collins
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Cubin
Culberson
Cummings
Cunningham
Davis (AL)
Davis (FL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
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DeLauro
DeLay
DeMint
Deutsch
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Granger
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Hart
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Hoyer
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Isakson
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Istook
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Rangel
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Rogers (AL)
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Rohrabacher
Ros-Lehtinen
Ross
Rothman
Royce
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sandlin
Saxton
Schrock
Scott (GA)
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Sessions
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Shuster
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Smith (MI)
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Taylor (MS)
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Turner (OH)
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Udall (CO)
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Upton
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Visclosky
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Walden (OR)
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Flake
Grijalva
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Jackson (IL)
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NOT VOTING—5

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Foley
Gephardt
Gordon
Gutierrez

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LAHOOD) (during the vote). Members are advised that 2 minutes remain in this vote.

□ 2337

Mr. DAVIS of Illinois changed his vote from "yea" to "nay."

Mr. RUPPERSBERGER changed his vote from "yea" to "present."

So (two-thirds having voted in favor thereof) the rules were suspended and the conference report was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. GUTIERREZ. Mr. Speaker, I was present today in this Chamber on November 21, 2003. However, I was inadvertently not recorded on rollcall vote number 667. Had my vote been recorded, it would have been a "yea" vote.

FURTHER MESSAGE FROM THE SENATE

A message from the Senate by Mr. Monahan, one of its clerks, announced that the Senate has passed a bill of the following title in which the concurrence of the House is requested:

S. 579. An act to reauthorize the National Transportation Safety Board, and for other purposes.

CONFERENCE REPORT ON H.R. 1, MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003

Mr. THOMAS. Mr. Speaker, on behalf of seniors and taxpayers, pursuant to House Resolution 463, I call up the conference report on the bill (H.R. 1) to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). Pursuant to House Resolution 463, the conference report is considered as having been read.

(For conference report and statement, see proceedings of the House of November 20, 2003, Book II at page 11877.)

The SPEAKER pro tempore. Pursuant to the order of the House of today, the gentleman from California (Mr. THOMAS) and the gentleman from New York (Mr. RANGEL) each will control 1 hour.

The Chair recognizes the gentleman from California (Mr. THOMAS).

Mr. THOMAS. Mr. Speaker, I yield one-half of my time to the gentleman from Louisiana (Mr. TAUZIN), chairman of the Committee on Energy and Commerce.

The SPEAKER pro tempore. Without objection, the gentleman from Louisiana will control 30 minutes.

There was no objection.

Mr. THOMAS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I called up this bill for seniors and for taxpayers. This evening you are going to hear some very harsh rhetoric. But what I really want to do is remind everyone here that since Republicans became the majority in this House in 1995, there has been a very positive and remarkable change to Medicare. Probably most important has been the introduction of preventive and wellness. For many years, it was available to be added to Medicare, but it was not. It took the Republican majority to add the testing and the education for diabetes, for osteoporosis, for improved mammography, for colorectal cancer screening, for prostate screening; and even today in this bill we continue with cholesterol screening and physical exams.

Tonight, the Republican majority is going to add prescription drugs to Medicare. We earnestly seek our friends across the aisle help in doing this. The conference report before us is bipartisan. It is bipartisan because of the House and the Senate structure. Tonight our friends across the aisle have a chance to make it bipartisan in the House. Our friends say that we are trying to destroy Medicare; but if we are trying to destroy Medicare, why is the American Association of Retired People supporting this proposal? Why is the AARP in favor of this bill? You have heard some very harsh rhetoric from my friends across the aisle describing their abandonment by the AARP. My friends, the AARP has not abandoned you. You have abandoned seniors. AARP has chosen to be with seniors, and they have chosen to be with us.

Fact: current Medicare cannot sustain itself financially. Question: Why in the world would we then be adding a $400 billion expansion of benefits under Medicare? Answer: today's medicine demands that we do so. Yesterday's medicine was hospitals and doctors. Hospitals and doctors still play a role, but prescription drugs play a central role. We simply would not be doing justice to our seniors if we did not try to add prescription drugs to Medicare.

But I also called this bill up for taxpayers, because if we add prescription drugs to Medicare, we need to be able to tell our taxpayers that we are also changing the funding structure of Medicare as well.

□ 2345

It cannot sustain itself, and we are adding an enormous new benefit. It would be irresponsible of us to simply think all we need to do is add prescription drugs. What we need to do is add prescription drugs, modernize Medicare, and make sure that those people who pay taxes today in the hopes of having a program tomorrow will be able to have one.

This bill protects low-income seniors. No one wants to place a financial burden on those unable to pay. But, Mr. Speaker, it is overdue to ask those who are financially well off enough to share.

We are hearing things from our friends across the aisle about how horrendous the suggested financial burdens are. For example, in today's voluntary, optional Part B Medicare, the premium is 75 cents on the dollar paid for by the taxpayers, 25 cents on the dollar paid for by the beneficiaries. This legislation is so radical, so extreme, that what it does is it asks people who are making $100,000 a year in retirement to pay 50 cents on the dollar and have the taxpayers pay 50 cents on the dollar. Ironically, that was the financial split when Part B Medicare began. All we are asking is for those who have the wherewithal to help share the financial burden. And where? There is an opportunity to provide a modest copay, one of the most significant factors in inhibiting overutilization. We ask those who are going to have a prescription drug, $2 on a generic prescription, $5 on a brand name. It will have a significant impact on utilization. It will also show that we understand, we need to be sensitive to taxpayers. Today they foot the bill, but tomorrow they also want a program. This bill is really all about a fair deal. Modernize Medicare with prescription drugs but put Medicare back on a sound financial basis as well.

We are going to hear a lot about what we are going to do for up to 40 million seniors in this legislation. Please understand with the modest structural changes we are asking for, there are going to be 140 million taxpayers who are going to be pleased as well.

This program cannot sustain itself. Add a new benefit and modernize the program. Medicare is not a Democrat program; they do not own it. Medicare is not a Republican program; we do not own it. It is a program that is in need of modernization, prescription drugs and better financing. The American people's Medicare, the seniors who receive the benefits, and the taxpayers who foot the bill deserve H.R. 1.

Mr. Speaker, I reserve the balance of my time.

Mr. RANGEL. Mr. Speaker, I ask unanimous consent to turn one-half of the time allotted to the distinguished gentleman from Michigan (Mr. DINGELL), a member of the Committee on Energy and Commerce, the dean of the House of Representatives, the son of the author of the Medicare bill, who was denied admission into the conference.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). Is there objection to the request of the gentleman from New York?

There was no objection.

Mr. RANGEL. Mr. Speaker, I yield myself such time as I may consume.

This must be a very important piece of legislation, Mr. Speaker. It is 10 minutes to 12. When else would the majority bring out an important piece of legislation but in the middle of the night?

But more importantly than that, tomorrow for many of us is a date that many of us will never, never forget, at least those of us that were old enough to know of and to love the late John F. Kennedy. Most all of us will remember where we were or what we were doing on November 22. And I suggest to the Members that history will record what we do this evening and what we do tomorrow. The arrogance that has been displayed on this landmark piece of legislation defies description tonight, but history will record it. The audacity for people to talk about bipartisan here where for hundreds of years we inherited a House of Representatives that whether one was a Republican or Democrat, liberal or conservative, we could say in this House the people rule, and we have enjoyed saying that. Where do the Republicans get the audacity to say that when there is a conference, they would select the willing coalition, that they could look at a person and because they are a Democrat, appointed by the Speaker of this great House of Representatives, they exclude them? And let me tell the Members something else I am proud of, not just being a Member of this House, but sitting on this side of the aisle and taking a look at the faces and the backgrounds of the Members and where they come from, from the rural areas, from the inner cities, from America. We do not have senior citizens? We do not have a contribution to make? We can be excluded? And then to have the audacity to come to this floor, even if it is in the middle of the night, and call it bipartisan because you borrowed two Democrats from the other side. That is shameful.

No, our citizens really will recall what we do tonight, what you have done for AARP, what you have done for the pharmaceuticals, what you have done for the private sector whom you have subsidized. The bill is only 1,100 pages, but seniors know that they asked for some help for prescription drugs. No, they did not ask for competition. They did not ask for you to set up paper outfits. They did not ask for, at the end of the day, that you try to run them out of business. And I am suggesting to you, how would you know what you are going to hear on this side when just common decency prevented you from allowing you to follow the mandate that the Speaker set when he said that the House and the Senate, Republicans and Democrats, please go to conference, and you locked the door? One thing is clear. Seniors understand it better than a whole lot of Members do because it may in the middle of the night, but tomorrow they will be reading what we have done tonight.

Mr. Speaker, I yield the balance of my time to the gentleman from California (Mr. STARK), who has worked hard for decades on this legislation, and I ask unanimous consent that he be allowed to administer the remainder of the time that has been allotted to me.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New York?

There was no objection.

Mr. THOMAS. Mr. Speaker, I yield the remainder of my time to the gentlewoman from Connecticut (Mrs. JOHNSON), the chairperson of the Health Subcommittee of the Committee on Ways and Means, and I ask unanimous consent that she control the remainder of my time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 2½ minutes to the gentlewoman from Washington (Ms. DUNN).

Ms. DUNN. Mr. Speaker, it is time to keep our promise and provide a comprehensive and voluntary prescription drug benefit for all seniors. Seniors cannot afford the frighteningly increasing cost of drugs any longer. This bill will protect the poorest seniors by helping pay for their drug costs immediately. By using the same principles already used by private companies, this bill will lower drug costs for seniors by passing along to them larger discounts from manufacturers.

As a result, over 775,000 Medicare beneficiaries in my State of Washington will get access to the drugs they need at affordable prices. The poorest seniors in Washington State, over 206,000 people living on fixed incomes, will pay only nominal fees, and I am talking about $2 to $5 for prescriptions, that is all, while qualifying for full assistance on their premiums, their deductions, and their coverage.

We can only strengthen Medicare's future if we are able to ensure access to the services that seniors need today. In this bill, we increase payments to doctors and hospitals, especially in rural communities, so that doctors will have some reason to stay in practice and seniors will get access to health services that they need.

For Medicare HMOs this bill requires Medicare to account for military retirees in the formula resulting in higher reimbursements in counties with military facilities. To help every State, the Federal Government will assume the drug costs for people eligible for both Medicare and Medicaid. This is hugely important. It will help 82,000 beneficiaries who qualify for both programs in my State with their drug costs, but this bill will also save my State $500 million, half a billion dollars over the next 8 years on drug coverage for its Medicaid population. In all, Washington State will receive at least an additional $800 million to serve our seniors.

Strengthening Medicare also means improving the quality of life for every senior. For this reason, I am very happy that we are able to provide preventative services to all seniors like a first-time initial physical exam. For the first time, seniors will have access to innovative treatments to deal with rheumatoid arthritis and other diseases. Seniors also will profit from disease management care, which means there will be coordination to help those seniors who suffer from multiple serious illnesses.

Mr. Speaker, these treatments will allow seniors to receive treatments in their homes, take the burden off physicians or hospitals, and I will tell the Members for too long our parents and grandparents have paid too much for the drugs they need. The time has come to strengthen the Medicare program so that seniors can get the care that they need and they deserve.

Mr. STARK. Mr. Speaker, I yield myself 2 minutes.

I first start by reminding the distinguished gentlewoman from Washington that the Seattle Times said that one suspects that many conservatives do not really care how the chips fall as long as they are heavy enough to break the back of traditional Medicare. All this talk about choice and updating or modernizing Medicare with market competition is pure malarky. So it does appear that somebody from the State of Washington understands what is going on here tonight.

But we are faced with a problem, and the Republican Party from the very top of its leadership to the very bottom have been lying to us. They have been lying to us about the war. They have been revising history. They have been going back on their word to give us 3 days. They have proven that we cannot trust them.

Just recently, the past few minutes, the chairman of the Committee on Ways and Means indicated that they had attempted to put in preventative measures. He seems to have forgotten that in 1995 he voted against colon cancer testing. He voted against prostate cancer testing. He voted against annual mammography. He voted against diabetes management. He has voted more often to cut Medicare benefits than he can remember it appears.

So we are faced tonight with people who want to destroy Medicare. They will lie to us. They will lie to seniors for the pure purpose of their own messianic desires to destroy a system that will protect the fragile seniors in this country.

Mr. Speaker, I reserve the balance of my time.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 2 minutes to the gentleman from Pennsylvania (Mr. ENGLISH).

Mr. ENGLISH. Mr. Speaker, I rise tonight without any messianic pretensions to urge my colleagues to cast a vote for our seniors and support improved health care by voting for this bipartisan Medicare bill.

Mr. Speaker, today we have the best, and perhaps the last, opportunity to provide America's seniors with a voluntary and affordable prescription drug benefit as a part of Medicare. This is an unprecedented expansion of an entitlement program that will make life easier and health care better for many millions of Americans.

Mr. Speaker, I acknowledge this legislation is not perfect. There are things I wanted to see included that are not in the bill.

□ 0000

Yet, I am convinced that this is the best and most realistic compromise Medicare bill that Congress has so far developed. There are some here, I realize, who would make the perfect enemy of the good. But when you strip away all of the rhetoric and the partisanship, it really comes down to this: Do you support adding a prescription drug benefit to Medicare, or not?

In my district in western Pennsylvania, we have a diverse population of seniors. Some live on very low incomes and qualify for our State prescription drug benefit, PACE. Others are happy with their own private health plans, and some live in areas where there is only one hospital within a reasonable driving range.

This bill helps all of these seniors by offering a benefit that wraps around PACE, allows seniors to selectively participate in the Medicare plan, and includes a number of provisions to ensure that rural health facilities remain open and accessible.

Mr. Speaker, in 1965, our predecessors took the courageous and compassionate step of creating this important program. Now we have the best opportunity in years to build on their work by guaranteeing access to lifesaving drugs for our seniors. It is time for Congress to put people over politics and pass this Medicare bill.

I urge my colleagues to join AARP, America's doctors, America's hospitals, and major health care providers and vote "yes" on prescription drugs for our seniors.

Mr. STARK. Mr. Speaker, I am honored to yield 1½ minutes to the gentleman from Michigan (Mr. LEVIN), who understands that the United Steel Workers of America have said a vote for this measure is a vote to destroy the stability and long-term viability of the Medicare system.

Mr. LEVIN. Mr. Speaker, the key question: Why not add a prescription drug benefit to Medicare like for physicians and hospital bills? Because Republicans want to force seniors to get their drugs from private insurance companies and HMOs, with no set premium, and insurance companies would decide the benefits and could change them every year.

So again, why not simply add a drug benefit directly to Medicare? Because Republicans want to make sure the government has zero involvement in lowering drug prices for consumers. Indeed, their bill would prohibit Medicare from negotiating lower prices for drugs, and the only thing the government could do would be to keep people from buying cheaper drugs from Canada.

Again, why not simply add a drug benefit to Medicare? Because the real Republican goal is to use a drug benefit as a vehicle for fundamentally changing and undermining Medicare.

The President's Medicare administrator called Medicare a dumb system. Under this bill, there would be a global cap on the size of the Medicare program and a voucher to buy private health insurance instead of getting regular Medicare, with the deck loaded against Medicare, $14 billion to HMOs.

Republican reforms are Medicare's destruction. Vote "no" on this Republican bill.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself 1 minute and 15 seconds.

I would remind the gentleman from Michigan that 28 percent of his seniors will have no more costs than either $1 per generic or $2 per generic or $3 for prescription and $5, and 35 percent of Michigan seniors have incomes under 150 percent of poverty and will be totally protected under this bill.

Mr. Speaker, I think as we proceed in this discussion, we ought to remember that 38 States, 38 States provide Medicaid coverage for people whose income is 74 percent of the national poverty income. So 38 States are not even at 100 percent of poverty income. We cover people completely, everything, except $1 per generic or $2, depending on income, and $3 or $5 per prescription drug.

Do my colleagues understand that of the Medicare population, 57 percent are women? Mr. Speaker, 57 percent are women, and half of them, half of those women will pay no more than $2 per generic or $5 per prescription. They will have no other obligation, all the way up through catastrophic. Half the women on Medicare. This is a giant stride forward in women's health.

Mr. Speaker, I reserve the balance of my time.

Mr. STARK. Mr. Speaker, I am pleased to yield 1½ minutes to the gentleman from Maryland (Mr. CARDIN), who knows that all of the other members of the Older Women's League understand that this bill was supposed to modernize Medicare, not eviscerate it; and to deny basic health services for those who need it most, to increase the profits of the health care industry is criminal.

Mr. CARDIN. Mr. Speaker, I am very disappointed. I had hoped that I would have an opportunity to vote for a real prescription drug benefit within the Medicare system, or at least I would be able to vote on a bill that provides the foundation on which we could build a real benefit within Medicare. Instead, this conference report provides no guaranteed benefit whatsoever to our seniors for prescription drugs. It uses what is known as "actuarial equivalent" which depends solely upon private insurance companies.

We know what happened to Medicare+Choice with private insurance companies. The eight that were operating in my State of Maryland are all gone, leaving my seniors.

It has an ineffective mechanism to control prescription drug costs. It denies the government the tools that every other industrial nation in the world is using to bring down the cost of prescription medicines.

But worse than this, Mr. Speaker, it actually causes harm to our seniors. The Congressional Budget Office has estimated that 2.7 million retirees will lose their prescription drug benefits by the enactment of this bill. Mr. Speaker, this is not a voluntary bill for those 2.7 million Americans; they have no choice. It cost-shifts costs on to our seniors from basic Medicare because of premium support and triggers and caps. We overpay HMOs, using money that could be available to help our seniors. We make it more difficult for our seniors to get cancer treatment by the changes that we make on the reimbursement for cancer drugs.

So, Mr. Speaker, this bill does more harm than good. I support providing our seniors with a meaningful prescription drug benefit within the Medicare system that will strengthen Medicare. Therefore, I must oppose this conference report and urge my colleagues to do the same.

Mr. Speaker, I rise to express my disappointment with the conference report on HR 1. For the past several years, I have worked toward enactment of a prescription drug benefit for those who rely on the Medicare program for their health care needs.

A meaningful Medicare prescription drug benefit must be affordable, guaranteed, and available to all, it must contain an effective mechanism to lower the cost of medicines and it must be built on a sound structure that can be improved upon in future years.

I have carefully considered the legislation that is before us today, and it fails each of these tests. This Congress has missed an opportunity to enact far-reaching, bipartisan legislation that would provide the help that millions of seniors need and deserve.

Some have criticized the Medicare program as outdated, inefficient, a dinosaur. These members are ignoring Medicare's success in providing universal, comprehensive coverage. They are ignoring Medicare's low administrative costs—3%—relative to private insurers at 15 to 20 percent. They are ignoring Medicare's ability to cover a population that has been shunned by private insurers for decades.

Before Medicare was enacted, there was little private interest in covering elderly and disabled Americans. And there is still little private interest in doing so. That is why in my own state of Maryland, several hundred thousand seniors who once had the choice of eight Medicare HMOs, now have no HMO options available to them. As the options dwindled between 1998 and 2002, the remaining plans quadrupled their premiums, slashed their drug coverage and eliminated extra benefits. By 2003, the M+C HMO penetration rate in Maryland was zero percent. Nationwide, since 1997, more than 2.4 million seniors have been abandoned by private insurance plans, even though the plans were paid at 119 percent of fee-for-service Medicare costs.

This conference report changes the name "Medicare+Choice" to "MedicareAdvantage," and adds $20 billion in subsidies to private plans, boosting their payments to equal more than 125 percent of the amount paid for traditional Medicare. But it cannot create private interest in the senior market. We have tried that and failed.

To be successful, a drug benefit must be within basic Medicare and based on a sound structure that can be improved over time. Only a benefit that is based on a solid foundation will give seniors the stability they need and deserve. Rather, this bill relies solely on the willingness of private insurance companies to offer the benefit. In the Ways and Means Committee, I fought for a fallback within Medicare that would be available to every beneficiary in the country. It would have a set premium, deductible, and copays that would always be there regardless of where seniors live and what plans enter their region. If the private sector offered a superior, more efficient plan, seniors would choose the private plan. But if the private plan never materialized, or if it offered a premium that was unaffordable, Medicare would be there for them. In rejecting my amendment, and choosing a "fallback" that could come and go from year-to-year, the conferees bypassed the opportunity to continue Medicare's promise of universally available health care for all seniors.

Ask your constituents if they want a choice of more private plans. They do not. They want a choice of hospitals and doctors, and they want stability, reliability, and real help with paying their prescription drug costs.

This conference report lets them down. It offers seniors an inadequate benefit. The President and the Republican leadership say that this plan gives seniors the same benefits enjoyed by Members of Congress and federal employees. That is untrue for several reasons. First, the benefit packages are nearly mirror images of one another. In most FEHBP plans, federal employees receive 80% coverage for prescription drugs. A federal employee with annual drug costs of $5,000, would pay about $1,000 out-of-pocket. But under this legislation, seniors with annual drug costs of $5,000 would have to pay $4,020 out-of-pocket.

Second, the Medicare drug benefit has a wide coverage gap that will leave many of our seniors paying premiums for several months when they are receiving no benefits. There is no plan approved by OPM that would require federal employees to continue paying premiums when we are receiving no benefits. Seniors should not have to do that either.

Third, under this bill, seniors who want to remain in traditional Medicare would have to enroll in a stand-alone drug plan to get prescription drug benefits, but there is no such plan in the under-65 market. The conference report does not guarantee them what their premium will be; only that a private company will offer them an actuarially equivalent benefit that can change from year to year. It is a level of uncertainty that our senior should not have to face.

Our seniors now know the details of this bill. They are calculating their prescription drug costs at kitchen tables across the country tonight. They are calling Congress to say how disappointed they are at the inadequate benefits this bill provides, and they are urging us to vote no.

Rather than providing relief to our seniors, this bill shifts additional costs from government onto their backs. Although the drug benefit premium is estimated at $35, the conference report gives insurers license to charge much more. The Medicare Part B deductible will increase by ten percent in 2005 and then by program costs each year.

Some of my colleagues have tried for years to curtail Medicare spending by hundreds of billions of dollars, usually in the form of targeted provider cuts. But our hospitals, doctors, nursing homes and rehabilitation providers need fair reimbursement, and Congress has usually answered the call. In addition, these members have found difficult to argue the need for drastic cost containment given that Part A Medicare solvency is now the third longest in the history of the program. So the conferees have taken a surreptitious approach, adding a provision that was not in the House or Senate-passed bills. They created a new definition of insolvency that caps Medicare's use of general revenues at 45 percent of total Medicare costs and would force government to cut benefits or raise payroll taxes if this limit is exceeded. By triggering an increase in payroll taxes, which disproportionately affect lower-income Americans, this provision shifts the burden of Medicare away from those most able to support it to those who are least able, further jeopardizing Medicare's long-term stability.

Because we are limited to $400 billion in this bill, it would make sense to use every instrument possible to get the best price for prescription medicines. But the conference report contains an inadequate mechanism to lower the price of drugs, which have escalated steadily over the past few years, and show no signs of decreasing. This bill specifically prohibits the Secretary of HHS from using the federal government's purchasing power to negotiate lower drug prices, a tool that has been used effectively in nearly every other industrialized nation in the world. Instead, it relies on pharmaceutical benefit managers, which have had mixed results in past years.

I had hoped that this bill would improve health care for seniors. Unfortunately, the provisions affecting oncology drug reimbursement will do just the opposite for cancer patients and reduce their ability to get needed cancer care. The final bill still contains severe cuts to cancer care providers, nearly $1 billion annually. If this bill becomes law, many cancer centers will close, others will sharply reduce their staffs, and others will be forced to turn away patients.

The Ways and Means Committee and the Energy and Commerce Committee have examined this issue carefully. We recognize that the current payment system for cancer care needs to be fixed. Medicare over-reimburses for the drugs themselves, while it under-reimburses for the services that oncologists provide. I support appropriate reimbursement for cancer drugs, but we cannot make cuts of this magnitude without simultaneously paying oncologists fairly for the care they render. To do so will endanger the lives of cancer patients.

Finally I cannot support a conference report that harms currently covered retirees. I remain concerned about the impact of this bill on retirees with employer-sponsored drug coverage. Because of the inadequate reimbursements to retiree health plans, CBO estimates that 2.7 million retirees are expected to lose their benefits. The bill also encourages employers to drop the coverage they now provide by excluding private plan spending from counting toward the catastrophic limit. Because of provisions written into the bill, most seniors with retiree coverage and high drug costs will never reach the point at which Medicare resumes coverage. The authors of this bill say that the benefit they're devised is voluntary, but for those seniors who lose their private retiree health coverage, this plan won't be optional, it will be the only game in town.

Tonight's vote caps several years' efforts to provide Medicare beneficiaries with desperately needed prescription drug coverage. Unfortunately, the conferees have produced a bill that won't result in better health care for our seniors, a more efficient Medicare program, or fiscal responsibility. It will eventually do more harm than good to Medicare, and to those who depend on it for their health care needs. I support providing our senior a meaningful prescription drug benefit within the Medicare system that will strengthen Medicare. Therefore I must oppose this conference report and urge my colleagues to do the same.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself 15 seconds.

Mr. Speaker, if the gentleman will note and other Members will note, and the listening public will note, on pages 49 to 53 of the bill, which is all on the Internet, they will see that there is what we call a hard fall-back. That is, if private plans do not offer prescription drugs to our seniors, the government will. The seniors will be guaranteed a drug plan; that is in the statute.

Mr. Speaker, I yield 2 minutes to the gentleman from Arizona (Mr. HAYWORTH).

Mr. HAYWORTH. Mr. Speaker, I thank my good friend, the chairwoman of the Subcommittee on Health of our full committee, for yielding me this time.

It has been interesting to listen to the debate thus far this evening. In fact, it evokes memories of an earlier time when I first arrived in this Chamber and, much to my surprise, heard all of these horror stories about what might happen to senior Americans and how schoolchildren might be starved and all sorts of villainy and demonizations that had no basis in fact.

Mr. Speaker, good people can disagree, but it is important to take a look at what we are doing with this legislation. The first thing we are doing is actually strengthening Medicare and preparing it for the 21st century, for the influx of more seniors, demographically what we will see in the 21st century, in just a few short years. And what we are also doing is updating Medicare for the 21st century to reflect changes in medicine. Prescription drugs are the first line of defense for America's seniors. This legislation recognizes that reality and moves to cover it. But moreover, Mr. Speaker, we first reach out to those seniors most in need, and we provide for all seniors next year immediate discounts, with our discount drug cards. Very, very important.

Now, we have heard a lot of wailing and gnashing of teeth about the endorsement of this plan by the AARP. I think rather than tearing up cards or engaging in personal attacks on those who may serve very competently in that association, it might be good to actually listen to the words of our seniors who belong, the millions of seniors who depend on prescription drugs and believe in the AARP. And they readily admit, as all of us would admit, this legislation may not be perfect, but it is a good place to start. We all know, on both sides of the aisle, change comes incrementally. Let us adopt this legislation for America's seniors and for future seniors.

Mr. STARK. Mr. Speaker, I yield 1½ minutes to the gentleman from Wisconsin (Mr. KLECZKA), who agrees with the Arizona Daily Star from Tucson that by doing nothing to address the cost of medicines and by raising payments to private HMOs that want to compete with Medicare, the bill dooms the Medicare program to major problems down the road.

Mr. KLECZKA. Mr. Speaker, the gentleman from Arizona who just spoke advised us to listen to our seniors; and many of us, I say to my colleagues, are doing just that with our vote today. Here is a senior from my district who advises me to oppose this bill, and they just canceled their AARP membership this morning.

What is going on here? This bill started out as a drug bill for senior citizens and, all of a sudden, we find the bill before us has over $100 billion for special interests in this country, and the calls we are getting to support the bill are from those special interests. They are saying, here is 200,000 specialty physicians; support the bill. Here, a big fat letter. And not once do they mention Medicare drugs for seniors. They are worried about their own pocket. Letter after letter in my office and on my fax machine are from special interests who have lobbyists in town urging Members to vote for this bill because they are getting something out of it: more money. And none of them are saying, and also the senior provision is good.

That is what is going on here. The seniors who call us are against the bill. The special interests who, in a campaign period can give us $10,000 in campaign contributions, are encouraging us to vote for the bill. Who do you think is going to win at the end of the day, huh? The seniors do not got a PAC. They do not give us $5,000 a crack, $10,000 a crack. That is what is happening, I say to my colleagues. And let us not forget it.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself 15 seconds.

I do not consider the AARP a special interest group, or the Coalition to Ensure Patient Access a special interest group, or the Alzheimer's Association a special interest group, or the Kidney Cancer Association a special interest group.

Mr. KLECZKA. The Hospital Association, the American Medical Association, that is who I am talking about.

Mrs. JOHNSON of Connecticut. Mr. Speaker, it is my time.

Mr. KLECZKA. Let us not kid a kidder; we know who they are.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman will suspend. The gentlewoman from Connecticut has the time.

Mrs. JOHNSON of Connecticut. The Mental Health Association of Central Florida, the Larry King Cardiac Foundation, the Latino Coalition.

Mr. Speaker, I yield 1 minute to the gentleman from Georgia (Mr. GINGREY).

Mr. GINGREY. Mr. Speaker, I rise tonight in support of the House-Senate Medicare agreement. For those of us who had hoped that this bill would contain more reforms or greater cost constraints, I agree. We did not accomplish all that we had hoped. But as a physician, I realize the medical reality of the bill, a medical reality that the prescription drug benefit itself is fiscally responsible and a potential cost-saver for Medicare.

By providing a prescription drug benefit, providers will be able to take the necessary preventive action to potentially stave off or treat an illness in an earlier stage, making it easier to control the cost of treatment.

□ 0015

The medical reality is that prescription medication can help seniors live longer, healthier lives, while saving a tremendous amount of money on treatment by avoiding costlier options.

Although I hope the future will bring about more changes and modernization to Medicare, the Medicare agreement will be a great start. And I urge my colleagues to take this fiscally responsible step and pass the Medicare conference report.

Mr. STARK. Mr. Speaker, I yield for the purpose of making a unanimous request to the gentleman from Minnesota (Mr. OBERSTAR).

Mr. OBERSTAR. Mr. Speaker, I rise in opposition to the conference report.

Mr. STARK. Mr. Speaker, I yield 1½ minutes to the gentleman from Georgia (Mr. LEWIS).

Mr. LEWIS of Georgia. Mr. Speaker, I stand in strong opposition to H.R. 1. I believe in Medicare, I believe that Medicare is a sacred trust between the Federal Government and the American people. I believe with all my heart, with all my soul, and with all my being that Medicare must have a dependable, affordable, and strong prescription drug benefit. And that is why I cannot support this bill.

Mr. Speaker, 38 years ago the Republicans did not like Medicare and they do not like it now. Republican Speaker Newt Gingrich gleefully stated that he wanted to see Medicare wither on the vine. Mr. Speaker, my colleagues, Newt Gingrich is back, and his fingerprints are all over this bill.

If this bill is passed, it would be a dagger in the heart of Medicare as we know it. This bill is an attempt by the Republican party to privatize Medicare. I stand against privatizing Medicare, and I stand against this bill.

Medicare is a sacred trust. It is a covenant with our seniors. Let us not breach this trust. Let us not violate this covenant. We must do what is right.

I urge my colleagues to vote against this unreliable bill, vote for the seniors, vote for those that are in need. Vote against this bill.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I reserve the balance of my time.

Mr. STARK. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Massachusetts (Mr. NEAL), who agrees with the Boston Globe that this experiment needs to be stopped before the Republicans in Congress damage a program that has served the elderly well for 38 years.

Mr. NEAL of Massachusetts. Mr. Speaker, it is not always an easy task to agree with the Boston Globe.

Mr. Speaker, I thank the gentleman from California (Mr. STARK). Well, here we are again in the dark of night, whether it is doing Trade Promotion Authority or whether it is doing tax cuts, or whether it is doing the privatization of Medicare, we do it in the dark of night.

Only could the gentleman from California (Mr. THOMAS), the chairman of the Committee on Ways and Means, talk about the crisis that confronts Medicare after they led the charge to rip $2 trillion out of the Federal budget over the next 10 years. Tonight we are children of Roosevelt on this side and Johnson, and let us not forget it. When you hear them talk about their newfound affinity for Medicare, recall that it was Dole and Michael and Rumsfeld and Ford who voted against the establishment of Medicare.

And I want to say something to my colleagues on the democratic side tonight who are tempted by what is about to happen. You mark my words, we are going to be back here in a year, and the next step is Social Security. That is where they are headed. Medicare is an amendment to the Social Security Act. America is a more egalitarian society today because it was our party who stood against the forces of privilege. They are the ones that said no.

Turn down this privatization of Medicare.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 1 minute to my colleague, the gentleman from Pennsylvania (Mr. PETERSON).

Mr. PETERSON of Pennsylvania. Mr. Speaker, I want to congratulate those that have worked on this very complicated bill. I was pleased this morning to receive from the Governor of Pennsylvania, Governor Rendell, an endorsement of this plan. Why would a democrat governor from Pennsylvania support his plan? His people were here and reviewed it.

This allows states like Pennsylvania and 20 other states who have pharmacy plans to wrap around and make a really comprehensive pharmacy program for their state with a state effort and the Federal effort.

Now, those of you who come from rural America better think seriously about voting against this bill. Rural health care has been fighting for its life. This is a lifeline that will for once and forever help stabilize Medicare payments. In rural America what good does a pharmacy program do if you do not have a doctor in a hospital and a home health care agency for him or her to work in?

This program does more to help rural health care than has ever been done. The urban areas of this country have had Medicare Plus Plus while rural America has had Medicare Minus Minus. An unfair system. And this bill does more to equalize that. It also preserves cancer care that has been under threat. And it brings health savings accounts that will be an offering to our businesses more seriously considering about walking away from health care because they cannot afford the current plan.

COMMONWEALTH OF PENNSYLVANIA,
OFFICE OF THE GOVERNOR,
Harrisburg, PA, November 21, 2003.

Hon. JOHN PETERSON,
Cannon Building,
Washington, DC.

DEAR REPRESENTATIVE PETERSON: I am writing to thank you for your efforts to develop provisions in the Medicare Prescription Drug bill to allow PACE to continue to be the primary source of drug benefits for qualifying seniors in Pennsylvania. As of early 2004, we expect approximately 325,000 Pennsylvania seniors to be in the PACE program, and we owe it to all of them to ensure the program on which they rely continues to work for them.

As the Medicare drug benefit legislation had been in development, our goals have been to ensure seniors in the PACE program would be able to benefit from the new federal benefit without experiencing any changes in the way they obtain prescription drugs and without being forced through a bureaucratic process along the way. Federal legislation must allow for a seamless transition for PACE beneficiaries while at the same time allowing PACE to expand its prescription drug program and services to more of our seniors.

I am informed that the language in the Medicare drug benefit bill achieves our major goals relating to the PACE program. This is good news for our constituents and I appreciate very much all the hard work you and others in the Pennsylvania delegation did to make this happen.

Should the legislation ultimately be enacted, I look forward to working with you and Secretary Thompson to make sure the PACE-related provisions are implemented as we all believe they should be.

Thank you again for your efforts on behalf of Pennsylvania's seniors.

Sincerely,

EDWARD G. RENDELL,
Governor.

Mr. STARK. Mr. Speaker, I yield 15 seconds to the gentleman from Pennsylvania (Mr. DOYLE).

Mr. DOYLE. Mr. Speaker, I just spoke with the Governor's office earlier this evening. I was aware of this letter that was sent out to four Republicans. Governor Rendell does not endorse this program. He does not support this program. And I just want that to be reflected in the RECORD.

Mr. STARK. Mr. Speaker, I yield 1½ minutes to the gentleman from Texas (Mr. SANDLIN) who agrees with the Houston Chronicle, the Republicans are interested only in the illusion of providing a popular benefit, a Republican driven bill to, 'quote, improve Medicare is impossible.

Mr. SANDLIN. Mr. Speaker, we have heard a lot of pretty words from the Republicans tonight, but every one on both sides of the aisle knows that this bill is nothing but a sham, a charade, a shameless trick on America's seniors.

America's seniors need help right now and yet the bill advanced by the Republicans does not even take effect until 2006. No coverage in 2003, no coverage in 2004, no coverage in 2005, and who knows what will happen in 2006.

Our seniors cannot afford prescription drugs, and in the face of that challenge, the Republicans have presented a bill that requires seniors to pay out of their pockets over $4,000 of the first $5,000 spent on drugs. That is no benefit at all.

Now, have the Republicans done anything to reduce the cost of drugs? No. The HMOs and the pharmaceutical companies will not let them do it. And this bill that is supposed to make drugs more affordable, there is no control over the prices charged by the pharmaceutical companies. Their greed is what got us in this situation in the first place. Do you think that philanthropy has suddenly invaded the boardroom of the pharmaceutical companies. Is that what you think?

Amazingly, this bill prohibits, makes it illegal, against the law for the government to negotiate for lower prices with a pharmaceutical companies. They supply the product, they set the price, the seniors foot the bill, that is a sweet deal for them. And can the seniors save money by getting drugs from Canada or Mexico? Oh, no, the Republicans in this bill that was written by the pharmaceutical companies say no. And that is the way it is.

Finally, Mr. Speaker, the Republicans have the audacity to support a plan that lines the pockets of HMOs by taking $10 billion out of cancer treatment, leaving America's seniors both broke and dying. If this bill passes, it passes on the back of the America's seniors. The Republicans will have to answer. They can run in the middle of the night, but they cannot hide.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I reserve the balance of my time.

Mr. STARK. Mr. Speaker, I yield 1½ minutes to the gentlewoman from Ohio (Mrs. JONES), who is a woman who agrees with Al Hunt, who wrote in the Wall Street Journal that this is an open rip-off by HMOs. There is a reason most Americans and, virtually all who have endured serious medical issues, despise HMOs. They are, with few exceptions, vultures.

Mrs. JONES of Ohio. Mr. Speaker, I am proud to have had the opportunity to serve my first year on the Committee on Ways and Means. And I think it is important for America to know that, finally, we had an African American male on the Committee on Ways and Means who rose to ranking member, who rose to representation on the conference committee, and he was excluded from being part of the willing coalition.

I say to people across America, particularly the African Americans in this country, you were not at the table, your interests were not represented. Let me, in addition, say that since we have two Houses in this Congress, the House of Representatives and the Senate, that the House was not represented on the Democratic side in this report.

But let me address another issue. And I have got a written statement that I will submit for the RECORD. Everybody keeps saying about AARP and how renowned they should be. But they do not talk about that in the last 4 years AARP made $608 million in insurance-related expenses, 30 percent of its income. They do not talk about that AARP had a 10-year Medigap contract with some company and the business is now worth $3.7 billion. They do not talk about that AARP made $10.8 million last year by selling its member list to insurance companies. And they do not talk about the fact that AARP spends $7 million in support of this legislation. Talk about a conflict of interest. If there ever was one, it is right there. So I say to you, we are going to ruin neighborhood drug companies. We are not drug pharmacies. Do not vote for this bill. This bill is not in the interest of senior citizens.

Mr. Speaker, I rise in opposition and with great disapproval of the Medicare conference agreement. The republican leadership in the House of Representatives has excluded Democratic Members from the negotiations and has written a Medicare bill that bows to major drug companies and prevents Medicare from negotiating better prices. This agreement masquerades as an attempt to add a long-overdue prescription drug benefit, but this is really a Trojan horse designed to dismantle Medicare, as we know it.

This agreement is flawed in countless ways. Its concentration on privatization is misguided at best and devastating. This is a special interest giveaway to the insurance companies with provisions including a $12 billion slush fund to bribe HMO's and PPO's to participate, all at the expense of taxpayers and the elderly alike. The agreement leaves a substantial number of the 6.4 million low-income Medicare beneficiaries who are also eligible for Medicaid worse off by requiring them to pay higher copayments for prescription drugs than they pay today. This agreement also prevents Medicaid from filling in the gaps of this new, limited benefit. This bill squanders $6 billion needed for coverage on tax breaks for the wealthy which in fact creates an unprecedented tax loophole that would undermine existing employer coverage and adds to the ever-growing number of uninsured. These funds should be used to prevent employers from dropping coverage or to improve the drug benefit. Even worse, this bill would force some low-income seniors who have modest savings to impoverish themselves in order to take advantage of the extra help allegedly available in this bill. A disproportionate share of African American Medicare recipients are disabled. The cut-off points chosen in this conference agreement will pigenhole African Americans into what is referred to as the "donut" on paying for the drug benefit. This will unreasonably hurt African American Medicare recipients, many of whom have chronic ailments. We are forcing our seniors to choose among purchasing food, prescription drugs or paying for a roof over their heads.

In closing, please let me inform America that this bill does not address the needs of our citizens. This bill would manufacture a crisis when an arbitrary cap on general revenue funding is reached, which would trigger a fast-track process for consideration of legislation to radically cut Medicare, including benefit cuts, payment cuts for hospitals, nursing homes, home health providers and increased cost sharing. Without hesitation, Congress provided $87 billion to rebuild Iraq; is it too much to provide the appropriate funding needed to give our Nation's seniors what they deserve—an affordable and guaranteed medicare drug benefit?

Mr. Speaker, I represent 206,000 constituents in my district who are 65 and older and are below the federal poverty level. The same constituents I promised that I would vote for a Medicare prescription drug bill that would be affordable with reasonable premiums and deductibles that are designed to significantly reduce the price of prescription drugs; a meaningful medicare prescription drug bill that would be defined, provide guaranteed benefits, there would be absolutely no gaps; no separate privatized plan; and most important, I repeatedly told my constituents that I would support a Medicare prescription drug bill that would be available to all seniors and disabled Americans. The results of the Medicare conference agreement is not what I expected. Dear colleagues, I ask that you join me and vote against this measure.

[From USA Today, Nov. 21, 2003]

AARP Accused of Conflict of Interest

(By Jim Drinkard and William M. Welch)

Washington.—AARP, the nation's leading lobbying force for retirees, has a major conflict of interest in its backing for a new Medicare prescription drug plan, opponents charge.

The organization receives millions of dollars a year in royalties for insurance marketed under its name. It stands to reap a windfall from the plan, which would pump $400 billion into a new drug benefit and open Medicare to private insurance competition.

AARP's annual reports show it has received about $608 million in insurance-related income over the four most recent years for which data are available. That's 30% of its total income, roughly equal to what it collects in membership dues.

"It's almost unimaginable that they wouldn't stand to gain" if the new benefit is passed, says David Himmelstein of Harvard Medical School. He is a proponent of national health insurance.

Much of AARP's insurance business is in policies that pay costs not covered by Medicare—so-called Medigap insurance. UnitedHealth Group signed a 10-year contract with AARP in 1998 to provide health coverage to its 35 million members. The business was worth $3.7 billion last year to the insurance company.

"The same folks who are in the Medigap market would want to get into this, and the best route in is through the AARP membership list," Himmelstein says.

AARP also collects millions of dollars a year from insurance and drug companies that advertise in the magazine it mails to members. It also makes money—$10.8 million last year—by selling its members list to insurance companies.

From its earliest roots in the 1950s, AARP has been closely tied to the insurance business. It grew out of a retired teachers group that sought to provide health insurance to its members. "They have always had this commercial identity," says Jonathan Oberlander, a political scientist at the University of North Carolina who has studied the politics of Medicare.

The breadth of AARP's business activities—which include not only insurance but credit cards, travel packages and prescription drugs—has drawn unwanted attention before. In 1995, Sen. Alan Simpson, R-Wyo., convened hearings that alleged the group was abusing its non-profit status. AARP was forced to pay back taxes on its earnings from those commercial ventures. and the group has faced periodic questioning about whether its business interests at times overshadow the interests of its members.

Simpson, now retired from the Senate, remains one of the group's sharpest critics. "If there was a sublime definition of conflict of interest, it would be AARP from morning to night," he says.

AARP is tax exempt and officially non-partisan. "We made public policy decisions without regard to business considerations," says the group's policy director, John Rother. Spokesman Steve Hahn says some of its Medigap policies and mail-order pharmaceutical sales are likely to be hurt by passage of the Medicare bill because it will increase competition.

Democrats in Congress seemed stunned this week when AARP announced it would support the Republican-drafted Medicare compromise and pour $7 million into a TV ad campaign urging passage.

Senate Minority Leader Tom Daschle, D-S.D., and House Minority Leader Nancy Pelosi, D-Calif., say the legislation would sell out the interests of senior citizens. It "undermines Medicare and serves the agendas of big drug and insurance companies," they wrote in a letter to AARP head William Novelli. They asked Novelli to pledge not to profit from any program that might be created.

Rep. Pete Stark, D-Calif., called the legislation a "special-interest boondoggle" that will split AARP's leaders from its grass roots. On Thursday, a message board on the group's Web site was peppered with angry postings from members, including 839 new missives under the title, "AARP sellout."

For a decade, AARP has been a sleeping giant. The organization felt burned after its support for a catastrophic insurance benefit in 1988 backfired with seniors and had to be repealed. It had since been reluctant to take positions on hot political issues. Its membership is evenly divided among Democrats, Republicans and independents, making it hard to take sides in policy fights.

But when the group does decide to engage, its clout is unmatched. "They are the most important and well-organized association in Washington," says James Thurber, who teaches lobbying at American University in Washington.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 1 minute to my colleague, the gentlewoman from Florida (Ms. Ginny Brown-Waite), who has experience legislating in the area of health care reform.

Ms. GINNY BROWN-WAITE of Florida. Mr. Speaker, I am one of those Republicans who grew up very poor. My dad was a Democrat. And I remember asking him why he was a Democrat, and he said because the Democrats protect the poor.

What I am hearing here tonight says the Democrats do not care about the poor. They do not care about the little old lady whose income is about $11,000, who only has Social Security, who cannot get prescription drugs today. That is the wrong message to be sending if they hope to be the savior of the poor and the drowntrodden.

I also teach health care. One of the things that I teach in my class are statistics. And the statistics are that the African American community and the Hispanic community pass away at a much earlier age from heart attacks, from coronary artery problems, and you know what? These are the prescription drugs that will be available under this prescription drug plan. How can they go back home and say that they are protecting the poor and the down-trodden? These are the same, the poor and the down-trodden, these are the people that are going to benefit from this prescription drug plan. I fully support it. It is a good bill for everyone.

Mr. Speaker, I rise today in support of the Bipartisan Medicare Prescription Drug, Improvement, and Modernization Act because it finally provides the much needed prescription drug relief seniors have asking for, offers help to our rural hospitals and our nation's doctors, and begins the real modernization and reform of a Medicare program in dire need.

Throughout my public service, I have heard a persistent question from my seniors how are you going to help us with the cost of prescription drugs? With the passage of this bill, I feel that I can finally begin to answer that question.

For the first time in history, we are going to provide all 40 million seniors and disabled Americans with prescription drug coverage.

It gives me great comfort to know that in 2006, with this Prescription Drug Plan, drug costs for seniors could be cut almost in half. And as early as next year, senior will begin to save an estimated 25 percent on prescription drugs with their Medicare prescription drug card. In the first year we expect seniors to save an estimated $365.

As a member of the Speaker's Prescription Drug Task Force, this is something we fought for, and this is something we got.

In addition, we are giving Americans more control over their health care by creating Health Savings Accounts, where they can contribute up to $2,500 a year into these tax-free accounts and citizens 55 years or older are permitted to make "catch up" payments. These accounts can be used for future medical expenses and may prove to be an additional much needed asset to our aging population.

Mr. Speaker, I would also like to bring to the attention of my colleagues a very important component to this bill. As we are all aware, in 2004, the prescription drug discount card in Medicare will offer seniors up to 25 percent off their drug costs and provide low-income seniors, those with incomes of less than 135 percent of poverty into account, a $600 subsidy on top of the discount card. That's great savings, especially for wealthier seniors.

But what if you have an income of over 135 percent of poverty and you're disqualified from receiving the cash subsidy? Currently, hundreds of thousands of seniors in this country are provided discount cards from the prescription drug companies that offer significant savings on medications that a particular company produces. The income-restrictions on these cards are in some cases up to 300 percent of poverty. This means virtually all seniors in my district are eligible for this savings, which in many cases equals up to 80 percent off the retail cost of the drug. For example, Mr. Speaker, Eli Lilly makes Prozac; and if one of my 5th district seniors needs assistance with the cost of that drug, they can sign up to receive a card from Eli Lilly that entitles them to receive a 30-day supply of any Eli Lilly product for just $12. If, due to the new Medicare discount card, these important voluntary programs were discontinued, many of our Nation's seniors would end up paying higher prices. My constituent would end up paying over $75 for the same Prozac he or she is now receiving for only $12. Just as there was a fear this benefit would cause employers to drop coverage once it became available, I was concerned that the drug card would cause drug manufacturers to discontinue their cards.

Mr. Speaker, working with you, Majority Leader DELAY, Majority Whip BLUNT and many of my other colleagues in this House, I took the lead and fought to protect seniors who are benefiting from the current prescription drug cards.

Now, on page 64 of the report language addendum and addressing section 1860D–31 of Conference agreement; Section 105 of House bill; Section 111 of Senate Bill reads:

> Seniors currently benefit from prescription drug assistance programs offered by pharmaceutical companies. Conferees intend that these programs continue to be offered until the full implementation of the prescription drug benefit. Nothing in this conference report shall be interpreted as encouraging the discontinuation or diminution of these benefits.

Additionally, I have secured several letters from drug manufacturers in this country indicating their commitment to continuing to offer these worthwhile and necessary card programs, copies of which I'd like to insert into the RECORD.

Mr. Speaker, I simply want to bring this to the attention of my colleagues on both sides of the aisle and especially to the seniors in my district. Neither conference staff nor most of the members of this body were aware of this glitch in the proposal and I am very proud of the work we were able to do together.

In closing, Mr. Speaker, friends, colleagues, the citizens of the 5th Congressional District of Florida elected me to this seat because they believed my voice would be heard and that I would stand with them in making a prescription drug benefit in Medicare a reality. It simply has been too long that our Nation's seniors have had to choose between life-saving drugs and food and this is unacceptable.

No one in this chamber believes that this bill is perfect, including myself, but I believe this bill is a good beginning and it signifies progress in our efforts to provide all of our constituents with the best, safest, and most affordable health care the world has to offer. In the months and years ahead, it is my hope and my promise that I will continue to work with Democrats and Republicans, to continue to make progress in our ongoing battle to improve health care for all Americans, including additional protections for retirees currently receiving health care benefits and addressing the rising costs of prescription drugs.

But tonight we have a choice to make—to take a step forward or to accept the status quo. Instead of concentrating on the weaknesses of this proposal, we must each embrace its strengths and dedicate ourselves to the next step forward. Accordingly, I urge my colleagues to vote in favor of the Prescription Drug and Medicare Modernization Act.

Mr. STARK. Mr. Speaker, I am delighted to yield 2 minutes to the minority whip, the gentleman from Maryland (Mr. HOYER).

Mr. HOYER. Mr. Speaker, this Medicare conference report is, sadly, a missed opportunity. I was here in 1983. Ronald Reagan, Tip O'Neill, and Bob Michael joined together to save Social Security. They came together, President Reagan, Speaker O'Neill, and Minority Leader Michael and said, we need to have a bill that has bipartisan support and will get the job done.

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It did.

The Republicans rejected that model. Most Members of this body on both sides of the aisle recognize that it is long past time that we provide for our seniors and give them a prescription drug program; but it is not this bill that they expected, a feeble benefit that forces them to pay 80 percent of their costs.

I will tell the gentlewoman from Florida (Ms. GINNY BROWN-WAITE) her dad was right. He was a Democrat because this party has historically and now believes that we should have done better by our seniors. Even the conservative Heritage Foundation, which is against this bill because they want to see Medicare done away with, says this, "The politically engineered premiums and deductibles, coupled with the odd combination of 'donut holes' or gaps in drug coverage, are likely to be unpopular with seniors."

The Heritage Foundation said that. Not STENY HOYER, not Democrats. Even Dick Armey, the immediate past leader of our party wrote in the Wall Street Journal on Friday that this conference report is "bad news for seniors."

Your majority leader just past said that. Now, he wants to do away with Medicare. He does not believe we ought to have Medicare. He nevertheless says this is bad news for seniors. Because it is bad news for seniors, we ought to vote against this bad bill.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself 10 seconds. I remind the gentleman from Maryland (Mr. HOYER) that of his 713,000 seniors, 31 percent will get total drug coverage under this bill.

Mr. Speaker, I yield 2 minutes to the gentleman from Illinois (Mr. WELLER), a member of the Committee on Ways and Means.

Mr. WELLER. Mr. Speaker, this is historic legislation tonight. Again, we make another positive step forward in modernizing Medicare, a process we have been working on every year the nine years that I have served in the House of Representatives.

I am proud that a majority of House Republicans voted in favor of Medicare when it was created. I am proud a majority of this House, who is the majority, continues to work to modernize and improve Medicare for our seniors.

This legislation that came out of bipartisan work, it is endorsed by the AARP, a trusted organization that represents millions of American seniors. And in the case of Illinois, my home State, 1.7 million seniors benefit in the State of Illinois. They benefit because they will have for the first time ever prescription drug coverage that is voluntary, it is affordable, and it is universal, available for every senior citizen. It will be immediately available.

In fact, within 6 months of this legislation becoming law, seniors will have a prescription drug card immediately this coming year allowing them to see up to a 25 percent savings; and 2 years later, 2006, every senior again will have the opportunity to see up to a 75 percent savings on prescription drugs. They choose to enroll in a prescription drug plan available through this modernization of Medicare. In fact, at a cost of about $1 a day, they can see a 75 percent savings, up to a 75 percent savings. And if they are low income, they will pay little or no premium. This is a good plan. That is why it has bipartisan support.

I want to salute Senator BREAUX and Senator BAUCUS for working with Republicans to come up with a bipartisan plan.

I would also note that hospitals and community health centers do benefit because when you modernize Medicare, you also fix the reimbursements. In communities that I represent, almost all of our hospitals, I think every one of them, is a not-for-profit. They struggle, both the hospitals and community health centers. Some call them special interests, but they get big improvements back for Illinois, $400 million in additional reimbursements as a result of this legislation.

Mr. STARK. Mr. Speaker, the Republicans can lock out two of the leading Democratic legislators from their conference committee, but just to show you that we are bigger than all that, we will turn the other cheek. I yield 2 minutes to the gentleman from Indiana (Mr. BURTON).

Mr. BURTON of Indiana. Mr. Speaker, first of all, I want to make it clear, I am a Republican and I am very proud to be a Republican. However, there are problems with this bill that make it impossible for me to vote for it.

It has been said tonight that 35 million AARP members cannot be wrong, but I am telling you AARP does not speak for all seniors. And when the seniors find out what is in this bill, that most of them initially are going to pay about $4,000 of the first $5,000 they are going to spend on pharmaceuticals, they are going to be so angry it is going to be like 1988 all over again.

Now, I want to talk a little bit about the pharmaceutical industry. There is nothing in here that allows our government to negotiate the prices with the pharmaceutical industry. We pay the highest prices in the world for pharmaceuticals. We pay seven, eight, nine, 10 times as much for Tamoxifen, a woman who has breast cancer and has to have it, than they do in Canada; and yet there is no provision in this bill for negotiation.

You say we have a 25 percent discount card. Twenty-five percent of what? If the pharmaceutical industry has these high prices and you knock 25 percent off, they are still a hell of a lot higher than they are in Canada or Germany, and yet we cannot reimport. Why? It does not make sense.

Do we believe in free trade? We have NAFTA. You can import everything back and forth across the borders, but not pharmaceuticals because it is not safe. Yet when we talk to the Canadians, and I had four hearings on it, they could not find one case where there was a problem. This is not a safety issue. The problem is profit and price.

I want to tell you something. It has been said that for too long seniors have paid too much. They have been paying too much. But we are not doing anything in this bill to lower the price of pharmaceutical products.

Now, I want to say to my colleagues also there is $70 billion in this bill, a pay-off to Big Business to keep their employees and their former employees covered under this plan.

I want to tell you something. As a businessman, they are going to look down the road and they are going to say, hey, Congress changes from time to time and they are going to start dumping their employees on the Federal plan. And when they do, those retirees are going to be so angry at us, you are not going to believe it.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield for the purpose of making a unanimous consent request to the gentleman from Florida (Mr. YOUNG).

Mr. YOUNG of Florida. Mr. Speaker, as one who represents the largest groups of senior citizens, older Americans who are on Medicare and Social Security, I rise in support of this bill.

Mr. Speaker, I rise in support of H.R. 1, The Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This is the most important and comprehensive improvement to the Medicare program since it was established 38 years ago.

For the first time, Medicare will provide prescription drug coverage for 40 million older Americans. It will provide lifesaving help for the millions of seniors who today forgo taking prescription drugs because they have no coverage and cannot afford them. It will allow seniors to take their full dose of medicine as prescribed rather than cut them in half or skip days to make the supply last longer. And it will eliminate the heart wrenching decisions many seniors must make over whether to buy food or prescription medicine, because they cannot afford both.

One of the reasons Americans are healthier and living longer is that prescription medication is available to control many chronic diseases such as high blood pressure, cholesterol, and diabetes. Unfortunately, these medicines are oftentimes not available to those living on fixed incomes. This legislation changes that by creating a tiered benefit program that provides prescription drug coverage for everyone eligible for Medicare. Yet it still allows those who receive prescription drug coverage through their employers or other health benefit plans to elect to retain that coverage.

Because of the complexity of bringing the new Part D prescription benefits on line, those benefits will not take effect until 2006. In the interim, however, Medicare beneficiaries will be eligible beginning next April to receive a Medicare-approved drug discount card. Seniors will take this card to their local pharmacy to receive discounts of 10 to 25 percent off their prescription medicine. This will provide immediate savings to seniors while preparations are underway to launch the full Medicare prescription drug program in 2006.

Once implemented, seniors electing prescription drug coverage will pay a monthly premium of $35. Following a $250 deductible, they will receive federal coverage for 75 percent of the costs of their prescription drugs up to $2,250. For each prescription filled, there will be a $2 co-payment for generic drugs and a $5 co-payment for brand name drugs. If a senior incurs catastrophic drug costs, exceeding $3,600 in out-of-pocket costs, Medicare will cover 95 percent of drug costs over that amount.

For those on small fixed, limited incomes (below $12,123 for individuals and $16,362 for couples), they will pay no deductible and no premium and there will be no gap in coverage between the initial coverage limit of $2,200 and the catastrophic coverage threshold of $3,600. For those with incomes between those levels and 150 percent of the federal poverty level ($13,470 for individuals and $18,180 for couples), the premiums and deductibles will increase on a sliding scale.

In addition, it is estimated that this legislation will drive down the price of prescription medication by as much as 20 percent, to yield further savings for seniors. It also sets in place new federal laws that will allow drug manufacturers to bring to market quicker, more affordable generic drugs.

In addition to the new prescription drug coverage, this legislation will improve the quality of care for seniors in a variety of other ways. Most notably, it provides coverage for the first time for important new preventative benefits. Beginning in 2005, all newly enrolled Medicare beneficiaries will be covered for an initial physical examination. All beneficiaries will be covered for cardiovascular and screening blood tests and those at risk will be covered for a diabetes screen. These new benefits will allow for the screening of patients to catch many illnesses and conditions early, allowing them to be treated and managed in a way that improves their health and quality of life while at the same time lowering medical costs to individuals and the program by preventing later serious health consequences.

Finally, this legislation will ensure that Medicare payments for physician and hospital services keep pace with inflation so that we do not lose health care providers who are available to care for the growing population older Americans. It also seeks to stabilize the reimbursement rates and drug coverage for cancer patients, who have faced increasing problems with the reduction in Medicare payments for these services over the past few years.

Mr. Speaker, as the representative of one of the largest populations of Medicare recipients in this Congress, I know first hand the life-line that this program provides for seniors. My highest priority in the development of this legislation was to ensure that we do nothing to diminish or endanger the health care coverage it provides. We have done a good job in seeing that just the opposite is true. With its enactment, H.R. 1 will provide expanded benefits and will ensure that these benefits are more affordable and more available to all.

H.R. 1 also responds to the three major concerns I have heard from my constituents throughout the development of this legislation. First, it guarantees access to the traditional Medicare program, services, and benefits that they currently receive. It will, however, allow those who are interested to consider new Medicare-approved plans where drug coverage is integrated into broader medical coverage or lower cost managed care plans offering expanded benefits.

Second, H.R. 1 maintains the full Federal commitment and backing of the Medicare program. Some were concerned that the final legislation would in some way privatize the delivery of these health care benefits. That is not the case in this bill.

Third, H.R. 1 does not in any way encourage employers or private health care plans to drop current employees or beneficiaries from their health care or prescription drug plans. Instead, it provides a number of important incentives for employers and private health care plans to retain employees and beneficiaries in their health care plans and allows the new Medicare benefits to supplement the benefits they already receive privately.

Addressing these concerns is one of the many reasons the American Association of Retired Persons has endorsed H.R. 1. In a statement earlier this week, AARP said, "AARP believe that millions of older Americans and their families will be helped by this legislation . . . The bill represents an historic breakthrough and important milestone in the nation's commitment to strengthen and expand health security for its citizens at a time when it is sorely needed. The bill will provide prescription drug coverage at little cost to those who need it most: People with low incomes, including those who depend on Social Security for all or most of their income. It will provide substantial relief for those with very high drug costs, and will provide modest relief for millions more. It also provides a substantial increase in protections for retiree benefits and maintains fairness by upholding the health benefit protections of the Age Discrimination and Employment Act."

Mr. Speaker, the historic legislation before us today provides long overdue reforms to the Medicare program. It provides for the first time prescription drug coverage for older Americans. For those seniors currently unable to afford their medicines, it provides important new access to many preventive drugs. It also provides access for them to treat serious conditions before they worsen and require emergency room or hospital care.

This legislation also improves Medicare coverage for preventative health care including physicals and cardiovascular health and diabetes screening tests. This too will improve the quality of medical care our seniors receive and will forestall many serious and costly medical problems.

Finally, this legislation modernizes the Medicare program to provide 21st Century solutions to give seniors more health care choices. It also will bring market forces to bear to ensure that they receive better medical care at more affordable and competitive prices.

This is the culmination of a six year legislative effort that included the consideration of three separate prescription drug bills in the House. Our colleagues in the House and Senate have taken a hard look at the problems facing older Americans who receive their care through Medicare and have agreed upon a thoughtful and comprehensive approach. Certainly we will identify problems that will need correcting as the next step in implementing this complex program begins. For our seniors, however, this legislation fulfills a promise to give them access to prescription drug coverage for the first time through the Medicare program. It is a good response to a long overdue problem and I urge support for its final passage.

Mrs. JOHNSON of Connecticut. Mr. Speaker, how much time remains on each side?

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentlewoman from Connecticut (Mrs. JOHNSON) has 9½ minutes remaining. The gentleman from California (Mr. STARK) has 8 minutes remaining.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself 30 seconds.

I would like to note that the 25 percent discount means you pay 25 percent less. And once the subsidies go into effect, you pay 75 percent less, and half the Medicare recipients are women and half of those women will be covered totally. So this is a big, powerful prescription drug bill that will help half the women on Medicare by providing all of their drug coverage.

Mr. Speaker, I yield 2 minutes to the gentleman from Iowa (Mr. NUSSLE), chairman of the Committee on the Budget.

Mr. NUSSLE. Mr. Speaker, I thank the gentlewoman for yielding me time and for her leadership on this issue, as well as the chairman of the Committee on Ways and Means.

Mr. Speaker, America has got a big decision tonight and seniors have been waiting a long time. The previous gentleman said that seniors when they wake up tomorrow, if this passes, will find out they still have to pay a little bit of money. Some will not have to pay at all, but seniors will really be mad if they wake up tomorrow morning and find out that we failed yet again.

Four budgets in a row we have had the pleasure of putting into our budget plan a prescription drug benefit. This year is the first time we have been able to get it to this point, a conference report; and that is because the President of the United States has provided the leadership to get us to this point.

In Iowa we have been waiting for 20 years for fairness when it comes to reimbursement. We have been waiting for 20 years when it comes to the difficulty of recruiting physicians and other health care providers. We have been waiting 20 years to stop the cost shifting to the private side of health care that drives up the cost for small business people and farmers. We have been waiting for 20 years for seniors to have prevention and drug benefits and basic services.

Tonight we have the opportunity to solve so many of these problems. It is not perfect, as many people have said; but it is on the road toward making Medicare a fiscally responsible, sound and a very beneficial program for seniors. And it is fiscally responsible. I know there are Members who are suggesting that somehow this may not be perfectly fiscally responsible. Let me ask you the question, If we do nothing tonight, is Medicare going bankrupt? Wake up if you want to talk about fiscal responsibility. We are seeing a program go bankrupt before our very eyes. Doing nothing is not an option.

It is fiscally responsible to fix a program that we know is going bankrupt, to fix a program that would have a prescription drug benefit if it were created today, to fix a program that is not paying the bills in rural America and keeping doctors and health care professionals located there to provide quality health care.

Vote for this bill because it is fiscally responsible. We have been waiting long enough. Seniors deserve our answer tonight.

Mr. STARK. Mr. Speaker, I yield myself 15 seconds.

I remind the gentlewoman from Connecticut (Mrs. JOHNSON) that the seniors do not need to be misrepresented. I will not call it lying, but nowhere in that bill does it mention any percentage that they will save on the drug discount. You cannot find it in the bill because it is not in there. So do not tell the seniors something that is not true. It is not respectful.

Mr. Speaker, I yield 45 seconds to the gentleman from Illinois (Mr. EMANUEL).

Mr. EMANUEL. Mr. Speaker, I rise in opposition to this conference report.

The conferees have three opportunities in this bill to lower the price of prescription drugs. They could have opened the markets and allowed prescription drugs to compete and allowed competition and choices to bring prices down. They passed.

They could have allowed Tommy Thompson to lower prices and create a Medicare Sam's Club, a right enjoyed by private companies and businesses everywhere in this country. They took a pass.

They could have included meaningful provisions for generics to get to market to create competition. They took a pass.

This box of Zocor, a cholesterol drug, was purchased in Germany for $41. Here in the United States it cost $90. It went up 10 percent the last year. It is going up another 10 percent this year.

The only immediate benefit that comes out of this bill is the political benefit that its supporters are expecting in 2004. The elderly, on the other hand, will have to wait until 2006. Hopefully, they can survive 2 years while the politicians take their victory lap.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 2½ minutes to the gentleman from Ohio (Mr. PORTMAN), a member of the committee.

Mr. PORTMAN. Mr. Speaker, I thank the gentlewoman for yielding me time, and I thank her for her leadership as chair of the Subcommittee on Health, as well as the gentleman from California (Mr. THOMAS), in getting us to this point.

This is not the first time we have had a Medicare prescription drug bill on the floor, but I think we have the best one. I think it is a great program that has been misdescribed tonight by a number of the speakers, and I just wanted to clarify a few things.

First of all, it is voluntary. People have come to the floor and talked about this is a mandate and people will be forced to get off their existing plans and get on this plan and so on. It is voluntary. If seniors do not choose to take up the prescription drug plans, they do not have to. Those who have looked at it, the Department of Health and Human Services, Special Budget Office, nonpartisan analysts think most seniors will, 90-some percent.

Second, I have heard people talk about the fact that, gee, some people have employer plans already. Let me give some statistics. In 1993, 40-some percent of employers provided coverage for their retirees. In 2002 it was 27 percent. It is happening. It is bleeding. People are not providing retiree benefits as they used to.

What I love about this bill is it goes the other way. It puts $88 billion into helping people be able to stay with their employer plans.

EBRI, which is a nonpartisan group that is called the Employee Benefit Research Institute, has studied this this week. Their analysis is that 2 percent, 2 percent of seniors will migrate from their existing retiree plans because their employers no longer offer it, into this. If this does not get passed, it will be greater than 2 percent. So those who have said this will result in a problem, I think it is just the opposite.

We are beginning to stop what is happening anyway. I think that is a good part of the plan.

People have talked about how puny the benefit is. Well, I have to tell you, over 35 percent of the American seniors, one figure says 38 percent, let us say over 35 percent of Americans who are seniors, who are low income, meaning they are less than 150 percent of poverty, their income, are going to be able to get prescription drug coverage with no premium, no deductible, no share. All they will do is pay a nominal co-pay, $5, $3.

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That is over 35 percent of our seniors, represented by all of us. Some of us in this House have districts where that number will be as high as 60 percent. So a puny benefit, I do not know where that comes from.

For other seniors that additional, let us say, 65 percent of seniors more than half of their drug costs, some say as high as 70 percent, more than half of their drug costs for the average senior, that is no average senior, but average senior costs for drugs will be covered, more than half of the drug cost.

This is why the AARP supports this. This is why the AARP is standing up for their seniors. Some people on my side of the aisle think it is too generous. People on the other side of the aisle ought to look at this plan, at what it is, not the politics, but the substance. It is a good plan, and I hope people on both sides of the aisle tonight will support it.

Mr. STARK. Mr. Speaker, I yield myself such time as I may consume.

There they go again. I do not think they understand their own bill. Between 135 percent and 150 percent of poverty, there is a 15 percent copay, and regardless of what my colleague says, there are many, many poor seniors are going to pay more under this bill than they do now, but it is sad that the people who wrote the bill do not know what they are talking about.

Mr. Speaker, I yield 45 seconds to the gentleman from Arkansas (Mr. ROSS), the distinguished member of our caucus who is in the pharmaceutical business.

Mr. ROSS. Mr. Speaker, as the owner of a small town family pharmacy and a wife who is a pharmacist, I see seniors who cannot afford their medicine. So I came here to help our seniors with the high cost of prescription drugs. This bill does not do that.

This morning we must decide whether to decide with the big drug manufacturers or side with America's seniors. In 2001, the gentlewoman from Missouri (Mrs. EMERSON) and I sponsored a bipartisan bill that would truly modernize Medicare to include medicine for our seniors, and the Republican leadership refused to give us a hearing or a vote on that issue, and now 2 years later the Republicans offer us a bill that does what? That says the Federal Government shall be prohibited from negotiating with the big drug manufacturers to bring down the high cost of medicine and provide seniors $1,080 worth of help on a $5,100 drug bill.

Have my colleagues ever heard of Medicare fraud? This is Medicare fraud.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I would like to inquire as to the time remaining.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentlewoman from Connecticut (Mrs. JOHNSON) has 4½ minutes remaining. The gentleman from California (Mr. STARK) has 6 minutes remaining.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I reserve the balance of my time.

Mr. STARK. Mr. Speaker, I yield 45 seconds to the distinguished gentleman from New York (Mr. CROWLEY).

Mr. CROWLEY. Mr. Speaker, I thank the gentleman for the time.

Mr. Speaker, let me see if I got this straight. In 1965, with a Democratic President, a Democratic House and a Democratic Senate the Medicare program was founded. Am I to believe today with a Republican President, a Republican House and a Republican Senate that somehow you all are going to save a program you did not support in the first place? We have an expression in New York and all around this country, give me a break. You are not about saving Medicare or Social Security. You are about dismantling it, and in 40 years, when I look at my children and they ask me where were you when they tried to dismantle Medicare, I will look them in the eye and I will be able to tell them that I voted against the dismantling of this great program.

I will vote against this, and I will vote against any chance that you may bring up to this floor to dismantle Social Security as well.

Mr. Speaker, I rise to support Medicare and oppose the incredibly offensive bill before us tonight. Medicare was created nearly 40 years ago to protect the health of seniors. And today, sadly, Members of this Congress are seeking to destroy the very program that has been so helpful to so many. In its place, Republicans claim they are inserting a new, better, and expanded program. But the reality is that this is not a bill about providing drug coverage under Medicare.

This is a bill about giving billions of dollars to insurance companies and drug companies. This is a bill about killing the Medicare program that seniors have depended on for generations.

Seniors in my district want and deserve prescription drug coverage. This could not be more true, as far too many of them are struggling without it. But I have yet to hear from a senior in my district who is asking for a $17 billion slush fund to be created for private insurance companies. Not one senior has talked to me about making sure that big drug companies are able to protect their massive profits. Not one of them has asked me for a prescription drug benefit where they have to pay $4,000 out of their first $5,000 in prescription drug costs. Not one of them has asked for a bill that would force seniors out of Medicare and push them into HMOs. And yet that is exactly what Republicans are giving them with this bill.

This bill seeks to help drug companies and insurance companies at the expense of seniors and American taxpayers of all ages. This bill does essentially nothing to bring down drug prices. It does not appropriately provide for reimportation despite this body overwhelmingly voicing its support of reimportation. Moreover, it expressly prohibits the government from trying to negotiate lower drug prices like other government entities have been able to do with much success.

Incredibly, Republicans are electing to protect drug company profits over the cost to our government. I have to wonder whose side the Republicans are really on?

Tonight Republicans are asking us to vote for a bill they claim will help seniors with their drug costs. Only the catch is that, in the process, we have to destroy Medicare, give billions to insurance companies and drug companies, and push seniors into HMOs. This bill is a slap in the face of the ideals that Medicare has stood for. This bill is a slap in the face of seniors who have waited far too long for a real prescription drug benefit.

But don't take my word for it. Listen to what the lead author, Republican Congressman BILL THOMAS of California said about this bill—a bill he wrote—and I quote him, "To those who say that the bill would end Medicare as we know it, our Republican answer is: We certainly hope so." Protect Medicare—oppose this sham bill.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. HOUGHTON).

Mr. HOUGHTON. Mr. Speaker, in any situation where there is an argument at stake, there are two things that are important. First of all, it is to get the facts. Secondly, to face the fact, and I do not mean to oversimplify this, and a lot of people know much more of the details, but it seems to me two things come to the floor. One, Medicare needs an update, seniors need help with their drug costs, and I think this bill does both those things.

I have since learned that virtually any piece of legislation that comes before this body can be argued and attacked and counterattacked to death, but who are the customers? Who are we trying to help and are they being helped? Are the seniors being helped? Yes, probably not enough, but we do not know yet. Are the hospitals being helped? Yes, but they certainly could be helped more, but this is a never ending process. Are the doctors being helped who are opting out of the Medicare program? Yes. Are the ambulance drivers being helped? Yes, and it is about time.

Will the companies be helped who are thinking about whether to drop programs for their retirees? Absolutely. Will those purchasing drugs be helped? According to the arithmetic I read, there is absolutely no question about this.

I would rate this bill a B+, and the reason I do this is I do not think there is any bill that can come before this body that can get an A, not with the attack and counterattack process we use.

One of the great poets of this country, Ralph Waldo Emerson, used to say history is no more than a biography of a few stout individuals. It is the few stout individuals, Mr. Speaker, that we need tonight.

Mr. STARK. Mr. Speaker, I yield 45 seconds to the gentleman from Texas (Mr. REYES), who agrees with the Albany Times Union that what older Americans can least afford is for Congress to rush into a sweeping overhaul of a successful health care program without doing its research. This is not only an imperfect bill. It may also be a disastrous one.

Mr. LAMPSON. Mr. Speaker, the previous speaker said that we do not know, and we do not know what all is in this bill, but during this week I have heard from representatives of thousands of senior citizens in southeast Texas, like my 93-year-old mother, that they overwhelmingly oppose this proposal, and they give three reasons why.

They believe the privatization provisions will cause Medicare to wither. They are astounded that the bill prohibits our government from bargaining for better drug prices. They are concerned about the uncertainty of being put back into HMOs that dumped them recently.

Do our seniors a favor, slow this train down. Put some dignity back in the process and open it up. The benefits will not even go into effect for 2 years. What is it going to hurt to wait two more weeks and do what the seniors requested at that White House Conference on Aging in 1995 at the beginning of this debate. Save Medicare and let us live our lives in dignity and independence.

In 1995 I was sent as a delegate to the White House Conference on Aging. 4000 seniors gathered for this non-partisan meeting. They set goals at that meeting and asked our government to do 3 things: protect medicare; protect social security; and allow seniors to live their last years in dignity and independence.

We have been debating medicare and a medicare drug component for years now. I have promised to work to create a program that would help seniors achieve the goals I just listed.

During this week I have heard from the representatives of thousands of seniors in Southeast Texas, like my 93 year old mother, that they overwhelmingly oppose this proposal . . . and the reasons they give are 3:

They believe privatization provisions will cause medicare to wither and die;

They are astounded that the bill prohibits our government from bargaining for better drug prices;

They are concerned about the uncertainty of having to go back into HMO's that dumped them.

My colleagues, do our seniors a favor, slow this train down. Put some dignity back into this process and open it up. The benefits won't even go into effect for 2 years. Let's take a couple more weeks and do what the seniors of this country asked at the beginning of this debate 8 years ago . . . save medicare and let them live their last years with dignity and independence.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I ask what time remains on each side.

The SPEAKER pro tempore. The gentlewoman from Connecticut (Mrs. JOHNSON) has 2¾ minutes remaining. The gentleman from California (Mr. STARK) has 4 minutes and 15 seconds remaining.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I reserve the balance of my time.

Mr. STARK. Mr. Speaker, I yield 45 seconds to the distinguished gentlewoman from Oregon (Ms. HOOLEY).

Ms. HOOLEY of Oregon. Mr. Speaker, despite the hard work and good intentions of many Members of Congress on both sides of the aisle, we have lost the forest for the trees, and so I rise today in opposition to conference report on H.R. 1.

We have lost sight of what seniors struggle with most, drug costs and the cost of coverage, and believe me, seniors have noticed that we have lost sight of them.

In the beginning and in the end, for me this issue has always been about the high cost of drugs and the need to affordably expand coverage. Regrettably, this bill prohibits ways to lower costs of drugs for American seniors, and for many, the coverage provided in the bill comes at a high price they simply cannot pay.

I urge my colleagues to reject this bill. Please go back to the negotiating table and give seniors what they really need, affordable drugs and affordable drug coverage.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself 10 seconds.

The gentlewoman from Oregon should know that with this prescription drug insurance plan Medicare recipients in Oregon who are covered will go from 60 percent up to 96.6 percent. This bill brings a benefit to Oregon.

Mr. Speaker, I reserve the balance of my time.

Mr. STARK. Mr. Speaker, I yield 45 seconds to the gentleman from New York (Mr. HINCHEY), and pending that, I would like to remind the gentlewoman from Connecticut that 41,000 people in Connecticut are likely to lose employer-sponsored coverage under this bill.

Mr. HINCHEY. Mr. Speaker, very few people are surprised that as soon as the Republican Party has control of both Houses of the Congress and the White House they move to destroy Medicare, and that is what this bill essentially will do. It will drive Medicare into the ground.

The disguise that they seek to use in order to accomplish that is a prescription drug program, but just today the National Center on Policy Analysis told us that only $1 out of every $16 in this bill will be spent to provide drugs for senior citizens who would not otherwise get them. Most of the rest of the money goes to drug companies and to insurance companies.

But the thing that surprises me about this bill is the Republican party is engaging in price fixing. They fixed the price of drugs so that they cannot go down, they can only go up. They have made sure that we cannot import drugs from Canada or other places at a cheaper price, and they guarantee that every time the prices change it will go up. Price fixing, increasing the cost of drugs.

Mr. STARK. Mr. Speaker, may I inquire as to the amount of time remaining?

The SPEAKER pro tempore. The gentlewoman from Connecticut (Mrs. JOHNSON) and the gentleman from California (Mr. STARK) have 2½ minutes remaining.

Mr. STARK. Mr. Speaker, I yield 45 seconds of that precious time to the gentleman from Texas (Mr. REYES).

Mr. REYES. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, I have a long been a strong advocate for an affordable, comprehensive Medicare prescription drug benefit, but I am opposed to this bill. I am opposed because the bill before us tonight would harm, rather than help, more than 77,000 Medicare beneficiaries in my district by breaking this program's promise of guaranteed quality health care for our seniors.

In my district, where approximately one in five seniors live below the poverty line, Medicare and Social Security are their only safety net in retirement. To jeopardize this safety net would be unconscionable.

Mr. Speaker, I urge my colleagues to oppose this conference report so Congress can instead offer America's seniors the kind of Medicare prescription drug benefit that they need and more than anything that they deserve.

Mr. STARK. Mr. Speaker, I am delighted to yield 45 seconds to the gentleman from Arkansas (Mr. BERRY), one of the gentlemen who was a conferee but does not know.

Mr. BERRY. Mr. Speaker, I thank the gentleman from California, and I appreciate his leadership on this matter for many, many years.

In the document that founded this great Nation, it says all men are created equal. Under this bill, the drug companies are a lot more equal than the seniors I can tell my colleagues. Why would we for any reason prohibit the negotiation of lower prices by Medicare? Why would we do that?

Tonight, we make a choice. We either serve the drug companies or serve our seniors. I find this a very easy choice to make. I choose to serve our seniors. I will not be a part of the continued effort to allow the prescription drug manufacturers of this country to rob the senior citizens of America.

Mr. STARK. Mr. Speaker, I yield the balance of our time to the gentleman from New York (Mr. RANGEL), the distinguished ranking member of the Committee on Ways and Means.

Mr. RANGEL. Mr. Speaker, I thank the gentleman from California (Mr. STARK) for the fine work he has done over the years on this subject, and as we close one-half of this debate on this historic subject, I would just like to remind those who are recording this event that when you excluded the Democrats from participating in the conference, you excluded 20 Members who are members of the Hispanic Caucus, 39 Members that are members of the Black Caucus.

□ 0100

You excluded the Congressional Asian Pacific Caucus. And you had the arrogance to believe that you had to be Republican to be concerned about our senior citizens. But the three that were selected by the Speaker, the Republican Speaker, was the gentleman from Arkansas (Mr. BERRY), who knows the problems of our seniors out there. It was me, who served for decades on the Committee on Ways and Means and has worked hard to participate to make this a better bill and a better Congress. But it also was the gentleman from Michigan (Mr. DINGELL), former chairman of the Committee on Energy and Commerce and a person who fashioned a program for the aged who are poor. He too was excluded.

So it is a great honor for me to invite up to manage the other half of the time here the gentleman from Michigan (Mr. DINGELL). He is the dean of this Congress, and we should feel proud that we are able to serve with him. His father is the author of the Medicare bill, and we should feel ashamed that he was excluded from the conference.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself the balance of my time, and I rise in strong support of this legislation. And, indeed, I believe its founders would be proud that tonight we bring a voluntary, generous drug benefit to all seniors under Medicare.

This is a milestone. That is why AARP describes it as a historic breakthrough in the Nation's commitment to strengthen and expand health security for its citizens. Something that has not been talked about much here tonight is the new support for seniors with chronic illness. We forget that one-third of our seniors have five or more chronic illnesses and use 80 percent of the money under Medicare, and yet Medicare has no way of supporting them to prevent their chronic illness from progressing.

In this bill, we couple the drug benefit and the disease management program to help our seniors prevent their chronic illness from progressing and thereby keep them healthy and keep Medicare costs under control. This is particularly important for minorities, for they tend not to use the medical system early, and they tend not to be diagnosed early. In this bill, we provide an entry-level physical so we can see what early signs of chronic illness they have, and we can help them prevent their chronic illness from progressing.

This will be an extraordinary boon to the well-being of our senior citizens. This is a historic advancement in both bringing prescription drugs to Medicare and improving the quality of health care Medicare is able to deliver, and in assuring that Medicare will be able to deliver 21st-century, cutting-edge health care.

And this is a historic bill for the rural communities of our Nation. Without it, they will not be able to attract the next generation of physicians as the current generation retires. They will lose small hospitals. They will lose small home health agencies. In fact, without this, our inner-city hospitals will not be able to continue to provide clinics for the poor, clinics for those with mental health problems. This is an important payer package because it restores fairness to our payment system.

And lastly, it cuts prices dramatically. It cuts prices dramatically by bringing the bargaining power of the seniors to the table to reduce prices and piercing right through that price support system that keeps State prices high. I am proud to support this legislation, and I urge my colleagues to do likewise, for half of America's women will experience free health care under this bill.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). Pursuant to a previous order of the House, the gentleman from Louisiana (Mr. TAUZIN) will control 30 minutes and the gentleman from Michigan (Mr. DINGELL) will control 30 minutes.

The Chair recognizes the gentleman from Louisiana (Mr. TAUZIN).

Mr. TAUZIN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I hope you will all bear with me for a second as I tell a short story. I recently accompanied my son, Tom, who is 25 years old, to see the movie "Matrix," the third in the evolution of the "Matrix" movies, a rather complex series of movies. Young people follow them, I think, better than my generation; but I try to follow them with him.

When we came out of the movie, I said, Son, what did you take from this? What did this mean to you? And he thought a long while and in the car with me he said, what I take from this movie, Dad, is that freedom is meaningless without choice. And I thought about that and I thought, that is pretty profound for a 25-year-old. What he was saying, basically, from this movie, is that if someone else is making all the choices for you, if you are without choice, you are not really free. Freedom, by definition, is choice. It is your capacity to choose for yourself right or wrong what you do with your life.

And then it occurred to me how meaningful that little profound conversation we had was and how it relates to this issue tonight. Because we are talking about a generation of Americans who Tom Brokaw called the Greatest Generation of Americans, who fought for this entire world to be free, for we in this country to have freedom of choice in our lives. And every day that we live in freedom, we have that generation to thank for it. And the ironic thing about it, when it comes to their health care, is that so far we have not given them choice. We have basically said if you want health care as you get older, after you fought to give us freedom, we will give you one plan. We will give you the choice of government Medicare. And if it works for you, great; if it does not work well for you, sorry, that is your choice.

Every despot, every tyrant, every monarch and feudal lord in medieval time took the attitude that the peasants, the servants were not smart enough to make choices for themselves; that they had to make all the decisions for them. That is the nature of people who think government always knows best and always knows the right answer and people are not wise enough to make good choices for themselves. The essence of this debate tonight is whether we are freedom-loving enough in this body, whether we understand and appreciate the freedoms that they fought for and gave to us, that we can, in the context of health care, give our seniors some real choice about how and where they take their health care and their coverage.

Now, it is about adding a significant new benefit to Medicare. It is that. But it is also about creating other choices for seniors. And I brought a picture of my mother with me tonight. I thought about her this evening. It is a small picture, but I wish you could all see it. She is a beautiful lady. She is 85 years old. She chose to remain in Medicare when she had a choice of a private plan in our hometown. She probably is going to choose to remain in Medicare and take her prescription drug benefit from Medicare when this program is completed and we pass this bill and it is signed into law. But I want her to have a choice to choose between that plan and any other plan that might be available, the same way we in this government, the workers and the Members of Congress, have choices to choose different plans for our medical needs.

I want Mom to have the same choice. Her generation fought for me to have choices and to make choices, right or wrong. And sometimes it hurt her deeply when I made bad choices, but she always knew I had the right to make them. And people died to give me that right. I think we owe that generation choice. And that is one of the things we do tonight, we give them choice how they take this new benefit. And if they want to choose, like my mother, to stay with Medicare, we fought for the right to make sure it is still in the Medicare bill, and she will have that right.

The other thing we did was to make sure if she chooses to have Medicare, that, indeed, it is still going to be around for her for as long as, God willing, she lives. She is a three-time cancer patient. A marvelous woman. She won eight gold medals at the Senior Olympics again this year. She took top place in the shot put. You do not mess with Mamma Tauzin. She is quite a gal. And she will probably choose to take her prescription drugs out of Medicare in this program. But if she ever wants to take it out of one of the PPOs or the new programs we develop out of this bill, I want her to have that choice. She deserves it. She ought to get it.

And I think that is why AARP has endorsed our bill, because they know we have gotten a great generous coverage for the low-income American seniors who want to stay in Medicare or who want to choose something else. And we create new plans for seniors and nonseniors to begin saving in their own health accounts; tax free in, tax free out, to build their own long-term care the way they want to design it. And I guess some people do not like that. I guess they think government ought to design it all and say, You got one choice, Mamma Tauzin, and that is it.

But I think, I think the benevolent government of the United States of America, respecting the freedom that so many fought and died for to give us choice and freedom, this government now, that we serve as Members of Congress, with such great appreciation of the people who sent us here, we ought to say here in Washington that we return the gift of freedom; that we give seniors more choices, and we give them a brand-new drug coverage program so they do not have to take chances on the Internet or go anywhere else to get drugs they cannot afford, that they can afford them under an insurance coverage here in America, and they can get it under a program they choose to live under.

Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield myself 3 minutes.

Mr. DINGELL. Mr. Speaker, almost 40 years ago, this body enacted Medicare. It was a great triumph for the senior citizens. Perhaps the most beloved program, with the exception of Social Security, was Medicare. It is also one of the most financially responsible and successful programs in the history of this country. Tonight, the fight is not about whether or not we are going to give prescription drugs to our seniors; it is about saving Medicare from my Republican colleagues, who now, finally, have figured a way to destroy it.

I want my colleagues to look at the kind of competition that the Republican Party is forcing upon the senior citizens of the United States: 120 or 125 percent of the costs of competing with Medicare is going to be given by the Federal taxpayers and by Medicare to, guess who, the HMOs. The Republicans have been trying to destroy this part for years. They are very close tonight.

A flawed process has brought forth a bad bill, which is laid before the House of Representatives in the wee hours of the morning so that the people will not know what is going on. What is at stake here is the existence of the most successful program to provide health care for our senior citizens.

Let me just tell my colleagues, the competition is unfair, 120 percent and more they give. They put forward a sham discount card, which will probably be given mostly by the retailers, not by the prescription pharmaceutical manufacturers. The senior citizens will not get much out of that.

Now, Medicare is going to be rewarding now the Republicans' friends in the HMOs and the pharmaceutical houses, huge amounts of money to each. No competition whatsoever will take place with regard to prescription pharmaceutical costs. Why? Because the Republican Members absolutely forbid that.

No wonder they want to do this at 2 a.m. in the morning. No wonder they want to foreclose the public from knowing. No wonder they would not let the people on this side of the aisle, they would not allow the Democrats into the meeting. Because it was the only way they could bring forward this slippery and dishonest program which is directed at destroying Medicare as we know it. And take the word not of myself on this, but of Mr. Newt Gingrich, of Mr. Armey, and the chairman of the Committee on Ways and Means on the Republican side. They want to destroy Medicare as we know it. That is what is at stake.

We can anticipate that they will allow Medicare to slowly wither away. And the senior citizens who are dependent upon it will no longer have the assurance that a program that they know they can choose their doctor and their hospital will be available to them. They will have to belong to the HMOs or pay more for it, and all in exchange for a proposal which has a huge donut hole which denies senior citizens care after they pay $2,000.

□ 0115

It does not add it at that point, it takes it away. This is a sham. It is a bad bill. It is one which takes from the senior citizens. It is one which threatens Medicare. It is an unfair, dangerous piece of legislation conceived in the darkness of night and slipped through over the heads of the senior citizens.

Mr. TAUZIN. Mr. Speaker, I yield 3 minutes to the gentleman from Florida (Mr. BILIRAKIS), the chairman of the Subcommittee on Health of the Committee on Energy and Commerce.

Mr. BILIRAKIS. Mr. Speaker, I would say I wish I had $100 for every hour that I spent in the wee hours of the morning during the time that the gentleman's party was in charge of this House.

Mr. Speaker, we have before us today an opportunity to finally provide our constituents with a meaningful prescription drug benefit that our Nation can afford. To finally do it; to finally do it, not to merely talk about it and to demagogue it. For four decades the other party controlled, and they did nothing. It seems every time we, since gaining the majority, attempt to meet a need, the Democrats finally awaken with nay comments. They do nothing. We attempt to do something, and they call our efforts a charade. We have not taken a pass, as one gentleman from the other side of the aisle said earlier. I would suggest the gentleman's party, which controlled for 40 years, took the pass.

While the bill before us certainly is not perfect, and we have admitted that, it targets the $400 billion available under our budget resolution towards areas where it can do the most good. Our bill provides a great deal of assistance to our low-income seniors. In fact, seniors who earn under $13,470 as a single or $18,180 as a couple will only be responsible for nominal copayments and will not experience a coverage gap. This is very generous coverage for the population of seniors who need it the most.

The conference report will also ensure that seniors will have the peace of mind of knowing that they will only be responsible for a very small amount of cost sharing once their out-of-pocket drug costs exceed $3,600 annually. It is a critical provision, and one I strongly support. This bill helps the poorest and sickest, and who can argue against that.

The conference report makes many other improvements to the Medicare program; in fact, too many to list tonight. However, I want to point out that the bill contains two provisions that I have long advocated for: Improved reimbursements for our Nation's physicians, and Medicare coverage for a physical exam upon entering the program. I call that the Dr. William Hale, "Welcome to Medicare Program." Dr. Hale of Dunedin, Florida, gave me the idea some time ago. I am confident that this new benefit will ultimately save the program billions of dollars in the long term.

I would like to close by quickly dispelling a number of myths that we have heard on the House floor tonight, and over the past few months. The conference report does not privatize Medicare. It improves it, namely by adding a voluntary prescription drug benefit available to everyone, including those who do not wish to leave traditional fee-for-service Medicare. We are not pushing seniors into HMOs; I will not be a part of that. Or creating a voucher system. We are offering seniors voluntary choices other than traditional Medicare. And, finally, the conference report does not signal the end of Medicare. Instead, it marks the beginning of a new, better Medicare that will be available for generations to come.

Mr. Speaker, I would like to close by thanking all of the staff members who have worked to help make this bill possible.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. BROWN).

Mr. BROWN of Ohio. Mr. Speaker, I thank the gentleman from Michigan.

Earlier this year President Bush stood in this well and pronounced solemnly, "Medicare is the binding commitment of a caring society." Today just a few short months later, those words sound so empty.

Our Medicare offers the same reliable health coverage to retired and disabled Americans regardless of whether they are rural or urban, whether they are rich or poor, whether they are healthy or sick. Our Medicare is equitable, dependable, it is flexible, and cost efficient; but their bill takes $20 billion out of our constituents' pockets and showers those dollars on HMOs. It rigs the game so that the coverage seniors have today, the equitable, reliable, flexible coverage they have today, is sure to wither on the vine. That is the way they have set it up. As one of the authors of this bill, the gentleman from California (Mr. THOMAS) said, "To those who say this bill would end Medicare as we know it, our answer is we certainly hope so."

A binding commitment, Mr. President? Their bill leaves seniors with such high drug costs they still will not be able to afford their prescriptions. Their bill places retiree drug coverage of $12 million seniors at risk. Their bill forces seniors to either pay significantly more if they want to keep their doctor and their hospital, or join an HMO that may or may not cover needed drugs, that may or may not raise premiums beyond the $35 guesstimate, that may or may not skip town if projected profits are not met. A caring society, Mr. President?

This bill is a big win for drug companies who stand to earn $139 billion in additional profits. No surprise there, the drug companies helped write the bill because the drug companies have given $50–60 billion to President Bush and to the Republican majority. It is a big win for insurance companies who are the beneficiaries of a $20 billion slush fund, no surprise there because the insurance industries and the HMOs gave tens of millions of dollars to the President and Republican leadership.

This is a tragic loss for America's seniors. Medicare should be the binding commitment of a caring society.

Mr. TAUZIN. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey (Mr. FERGUSON), a valuable, distinguished member of the Committee on Energy and Commerce.

Mr. FERGUSON. Mr. Speaker, in addition to expanding Medicare to include prescription drug coverage for 40 million seniors, this important conference report also represents significant benefits for my home State of New Jersey. For years, my State has offered one of the Nation's most generous prescription drug benefits. It is called PAAD. Under this historic agreement to strengthen Medicare, New Jersey wins big time. In addition to ensuring a seamless integration of the new Medicare drug benefit and PAAD, this conference report also provides New Jersey with billions of dollars to strengthen PAAD and expand the number of seniors who benefit.

By using the drug discount card before the PAAD coverage begins, the State government will save $73 million. Because PAAD's enrollees will receive their drug benefit from Medicare, the State will save $2.8 billion. New Jersey will receive a 28 percent tax free subsidy to offset the drug costs it provides for retired State employees, saving the State $222 million. PAAD will no longer be forced to pay drug costs for seniors who qualify for both Medicare and Medicaid, saving the State $872 million.

How else does New Jersey benefit? In addition to $80 million for increasing the Medicaid reimbursement rate, an additional $756 million will be forwarded to New Jersey's hospitals. That is nearly $5 billion in Federal aid for New Jersey.

This bill has language to require coordination between Medicare and PAAD, no disruption for any senior currently enrolled in PAAD, and billions and billions for our State government to strengthen PAAD, offset low-income seniors' drug costs and expand the number of seniors who are served under PAAD.

My colleagues from New Jersey on the other side of the aisle can try to hide behind their partisanship, but they cannot ignore the fact that this conference report represents one of the biggest and most important victories New Jersey has ever, ever received in Congress.

Mr. Speaker, shame on them.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentleman from California (Mr. WAXMAN).

Mr. WAXMAN. Mr. Speaker, today we should be voting on legislation that makes a good prescription drug benefit a part of the Medicare program. We should give people real help without gaps in coverage requiring seniors and the disabled to pay thousands of dollars for drugs out of their own pockets.

Instead, what we have got is a bill that makes seniors buy private insurance to get drug coverage or go into HMOs where they might not be able to see their own doctor, a bill that lets insurance companies interested in their own profits decide what premium to charge and what drugs to put on their formulary, and a bill that will lead people holding the bag for most of their drug costs in far too many cases.

This is not what seniors and the disabled want. This bill uses the cover of providing drug coverage, inadequate as it is, to make very dangerous changes in Medicare. This bill is based on the point of view that Medicare was a mistake, that we should have left it to private insurers to provide health care for our seniors. Well, if we had done that, we would have a lot more seniors today who would be uninsured and struggling with their medical bills.

I do not want to turn the clock back on Medicare, I want to make it better. Much as I want prescription drug coverage for seniors, this inadequate drug benefit is not worth destroying Medicare. I do not want a Medicare where seniors and disabled people have to spend a lot more just to be able to stay in regular Medicare. I do not want a Medicare where seniors in Los Angeles have to pay premiums that are twice as high as premiums in some other area of the country, and depend on private insurance companies for what benefits they get.

So we might wonder, who benefits from this bill? Well, not the almost 3 million retirees who will end up losing the drug coverage they now have, not the 6 million of our poorest seniors who end up being worst off, and not the 40 million Medicare beneficiaries who cannot use their bargaining power to get lower prices from the drug companies, and not the people who have been able to get their drugs cheaper by going to Canada. It is the drug companies and the insurance companies who benefit from this bill. Let us improve Medicare, not ruin it.

Mr. TAUZIN. Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. GINGREY), one of the three Members of the House who is an OB-GYN physician, and who happens to know something about health care.

Mr. GINGREY. Mr. Speaker, I thank the gentleman from Louisiana (Mr. TAUZIN) for yielding me this time.

Mr. Speaker, 35 million senior Members of AARP, 330,000 physician members of the American Medical Association who are providing care to hundreds of millions of Americans and 40 million Medicare beneficiaries, the American Hospital Association, the Rural Hospital Association, the United States Chamber of Commerce; Mr. Speaker, with so many for a prescription drug and Medicare modernization for our beloved seniors, who could be against it, and why?

The answer to that first question is pretty obvious, obstructionist Democrats. And why? Because they are more interested in attempting to embarrass President Bush and the Republican leadership of this House than they are in doing the right thing, the compassionate thing.

To suggest that this bill is nothing but a windfall for the pharmaceutical industry is like suggesting that Medicare Part A is nothing but a windfall for the hospital. Who is going to provide the prescription drugs, the chocolate chip cookie company? Give me a break.

But I say to my colleagues on the other side, stop the alliteration, stop the bizarre logic, the Mediscare rhetoric. Vote with us, vote for our seniors and make this truly a bipartisan victory.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey (Mr. PALLONE).

□ 0130

Mr. PALLONE. Mr. Speaker, I have listened to the rhetoric of the Republicans this evening, and it is cynical. They are trying to fool the seniors. I listened to the gentleman from Louisiana say that seniors are going to have a choice. They are not going to have any choice. They are going to lose their choice of doctors because they are going to be forced into an HMO. I listened to the gentleman from Florida say that seniors are going to get a meaningful benefit. Again they are fooling the seniors. There is no meaningful benefit here. They are going to have to shell out more out of pocket than they are going to get back in terms of a drug benefit. I listened to the gentlewoman from Connecticut earlier saying that she is going to give the seniors a discount. What a joke that is. There is no cost containment in this bill. The bill says that the Secretary cannot in any way negotiate price reductions. There is no reimportation in this bill. There is no way you are even going to be able to get discount drugs from other countries. There is no discount. There is no savings. They are just trying to fool the seniors.

I heard another speaker say that Medicare is going broke. The only reason it is going broke is because you have taken money away from their trust fund through your tax policies. You are trying to fool the seniors again. And then you are saying that the seniors are going to be able to have traditional Medicare, they can stay in their traditional Medicare. Again you are trying to fool them because they are going to be forced out of traditional Medicare. You are going to limit them to a voucher, a certain amount of money. You have something in the bill that would cap the amount of money that comes from the Federal Government. They are not going to be able to stay in traditional Medicare. They are going to be forced out of it. Then finally you say, oh, they are going to get the drug benefit immediately. You talk about the drug card or whatever it is, the discount card. Again you are fooling the seniors. This bill does not even take effect, there is no drug benefit until the year 2006.

I want to tell you, the last thing of all was when I listened to my colleague tonight here from New Jersey (Mr. FERGUSON) say that New Jersey is going to benefit from this. There are 1.2 million Medicare beneficiaries in New Jersey; 91,000 of them will lose their employer-based prescription drug benefits; 186,000 of them in South Jersey would be subject to premium support and will lose their traditional Medicare. The list goes on. New Jersey is no different than any other State. You are not going to be able to fool the seniors. You should not try to. You ought to be ashamed of yourselves.

Mr. TAUZIN. Mr. Speaker, I yield myself 30 seconds to point out that the statement that this bill does not go into effect until 2006 is erroneous. The fact is that the drug discount card is effective immediately when this bill goes into effect early next year. The fact is that $600 per senior for drug costs is allocated immediately, next year. Not only that, but the $1,200 per couple that is allocated for drug costs for seniors is rolled over. If the senior does not use it the first year, they can use it the second year. It becomes a $2,400 benefit for seniors for that second year while the full program is enacted by the year 2006.

Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. UPTON), the distinguished chairman of the Subcommittee on Telecommunications and the Internet of the Committee on Energy and Commerce.

Mr. UPTON. Mr. Speaker, I would like to focus on one misconception about this plan that we are debating today and set the record straight. I have heard from a lot of retirees who have been led to believe that enacting the conference agreement will cause them to lose their employer-provided prescription drug and health care coverage. That is not true.

First, it is important to note that under current law, employers who provide solid retiree health care benefits receive no assistance at all from the Federal Government. And even in the absence of a Medicare prescription drug plan, many of these same employers under increasing pressure from rising prescription drug and other related health care costs are already cutting back or entirely dropping their coverage that they provide to their retirees today. Under this plan if we pass it today, the Federal Government will partner with employers who maintain or improve their current health care retiree health plans. They will receive a subsidy of up to 28 percent of their retiree drug costs between $250 and $5,000 and the subsidy will not be subject to taxation. So the reality is if we do not enact this plan, there will be no incentives for those employers to maintain or improve their current retiree coverage. Thousands of retirees will wind up with no help with their prescription drug costs, and we most likely will continue to see those retiree benefits continue to be slashed. With this plan, they will have an incentive to keep it.

I also remember back to the days when we passed a catastrophic health care plan, back in the early nineties. It was mandatory. Guess what? We repealed it because it was mandatory. This is voluntary. You can participate if you want; and if you do not want, you do not have to participate. I also remember a woman that came up to me at my son's little league game. Her mom had just had a stroke, $600 in additional costs that she was going to face every month. She said, Mr. UPTON, will this plan help my mom? Yes, it will help her a lot. It will in fact save her family thousands of dollars, provide her with some quality of life that her family expects and the plan will help.

I urge my colleagues to vote for this plan this morning.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. Mr. Speaker, we have all not only been taught but tried to abide by something, part of the Ten Commandments, honor thy father and thy mother. I think more than anything else this evening, that is really what we are talking about, honoring our fathers and our mothers, our grandfathers and our grandmothers, the seniors, the elders of our Nation that are part of our Nation's family. It is not just my mother and father, and it is not just yours. It is collectively those that have built the country and handed it over to a new generation.

I do not believe that the process in this House for this bill is anything for the Members of Congress to be proud of, because if you do not honor those that represent the mothers and fathers of this country, it is a singular disgrace. So I start with that process. And I do not believe my friends, whom I have worked with day in and day out on the other side, tonight in their heart of hearts can be proud of that. It is dark. It is bad. It is wrong. And it has set a very bad tone for this bill.

We love Medicare on this side. You cannot drive a wedge between us and Medicare. If this were prescription drugs only, it would sail through the House. But that is the loss leader on this. This is about rewriting the contract between our mothers and fathers and our Nation. We object. We do not think it should be parceled out. My grandparents never said God bless the insurance companies. They said God bless America. Vote against this bill. It is wrong and it is bad. It dishonors our mothers and fathers and our grandparents.

Mr. TAUZIN. Mr. Speaker, I am pleased to yield 2 minutes to the distinguished gentleman from Oregon (Mr. WALDEN), a member of our committee.

Mr. WALDEN of Oregon. Mr. Speaker, my parents are both gone now. They died before this Congress could act to provide prescription drug coverage for them under Medicare. So they both paid for it out of their pocket. Let us talk about what this bill would do for those who survive. The agreement would provide 514,456 Oregonian seniors with access to a Medicare prescription drug benefit for the first time in the history of this program. Beginning in 2006, there would be 129,000 Medicare individuals in Oregon who would have access to drug coverage they would not otherwise have, and it will improve it for many more. They will get a $600 card if you are in the lower-income level of $12,000 a year. Couples who make $16,000 a year who lack prescription drug coverage today would be given $600 in annual assistance to help them afford their medicines along with the discount card of 15 to 25 percent. That is a total of $92 million for Oregon seniors that would help 76,000 of them be able to pay for their drugs in 2004 and 2005.

There are 151,000 seniors in Oregon who have limited savings and low incomes who will qualify for even more generous coverage. They will pay no premium, no deductible for their prescription drug coverage, and they will just be responsible for a minimal copayment. They will get the coverage. If you are low income under this plan, they get the coverage. Perhaps that is part of why the Portland Oregonian has endorsed this program. More importantly, my State like many has faced some fairly difficult fiscal challenges. I was there when we implemented the Oregon health plan and helped put it into place. Today because of the fiscal challenges, they are having to cut people off of Medicaid in Oregon. This plan over 8 years will return $279 million by having Medicare pick up the cost of those senior low-income people.

This is a balanced plan that will help our seniors get the prescription drug coverage they need. We ought to enact it.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from New York (Mr. ENGEL).

Mr. ENGEL. Mr. Speaker, for many years I have sponsored and worked for a real prescription drug bill for seniors and this bill breaks my heart. This bill is not a bipartisan bill. It is a Republican fraud. The Republican leadership would like to privatize Medicare and replace it with private insurance vouchers and HMO health care. That is what this bill does. It is the beginning of the destruction of Medicare and the destruction and privatization of Social Security is next.

You mark my words. We should be giving seniors a clean prescription drug bill under the Medicare program, but we do not have money for that because the Republican tax cuts for the rich and the stealing from the Social Security trust fund make it impossible to have any money left to pay for a real prescription drug program. The hodgepodge of benefits will do nothing but confuse seniors. After spending $2,200 in drug bills, seniors will have to pay the next $1,400 out of pocket without any help whatsoever while they still pay their monthly premiums. What kind of assistance is that? Seniors want a real drug bill and they want it to begin now, not in 2006. They want help in bringing drug prices down. This bill does none of that.

When I first came to Congress 15 years ago, I asked my mother what was the best thing we could do to help senior citizens and she said, give us a prescription drug program. Tonight, my colleagues, my mother gave me some more good advice. She said, vote against this sham bill. And that is exactly what I am going to do. Shame on this Congress for betraying our seniors and ramming this bill through in the middle of the night.

Mr. Speaker, I rise today in strong opposition to the Medicare Prescription Drug and Modernization Act. When I came to Congress 15 years ago, one of my highest priorities was to strengthen Medicare, provide drug coverage for seniors, and ensure that my children and generations to come would always have access to quality health care in their golden years. What the Republican leadership has put before us today does none of these things and threatens the very fabric of the Medicare program. The Republicans chose to give the richest Americans billions and billions of dollars in tax cuts rather than truly provide our seniors with relief from the high cost of prescription drugs. If this legislation is enacted, Medicare, and the cornerstone of Lyndon Johnson's Great Society, will be decimated.

There is nothing I would like more than to vote for legislation that would provide a meaningful Medicare drug benefit for seniors. In fact, I authored legislation to do just that. My legislation would have provided seniors with coverage comparable to most private plans and those utilized by federal employees. But what we have in this Conference Report is a fraction of that coverage. Most seniors will see little relief from the high cost of prescription drugs. Seniors will pay at least $35 a month in premiums with a $250 deductible, but these are just benchmarks and seniors may wind-up paying much more. There is also a gap in coverage where seniors will pay the premium while receiving no benefit. The gap in coverage is between $2,200 and $3,650 of out-of-pocket drug costs. This could mean that for half the year a senior will be paying a premium and getting no assistance. Additionally, the drug benefit doesn't even begin until 2006. Seniors in my district tell me they need help now. They don't want to wait two more years for this benefit to begin. I certainly think that they have waited long enough for assistance in paying for medicines that save and improve their lives. Our seniors deserve better treatment than this.

In keeping with the poor design of this benefit, it is expected that millions of retirees currently receiving drug benefits from their employers will lose it. So the Republican bill offers seniors a paltry benefit while taking away the quality benefits they currently enjoy. Wait till our seniors get a load of this.

As bad as all this sounds, it only gets worse. Despite the large outcry by seniors and Democrats across the country, this Conference Report embodies not the first small step toward privatization, but a giant leap that breaks the promise we made to our seniors and have kept since 1965 when Medicare was created. What is being dubbed as a demo project to "test" premium support, what is at best a voucher program, will encompass about ⅙th of Medicare beneficiaries. We're talking about 7 million people being forced out of traditional Medicare and into HMO's. These, the unluckiest of all the Medicare population, will pay higher premiums and receive some type of benefits, but we don't know what they are because the HMO's will package them as they see fit. For the first time in history seniors in different areas will be paying different premiums and receiving different benefits.

What is most troubling is that this legislation is setting Medicare up to fail. This legislation includes a provision that automatically triggers cuts in the program if Medicare spending increases to an amount determined by the Republicans. The likely scenario regarding this is that sometime over the next several years Medicare spending will increase triggering the cuts. In order to get under the arbitrary cap traditional fee-for-service Medicare will be decimated. Republicans will then point to their privatization as Medicare's savior and they will have finally succeeded in their ultimate goal of ending Medicare and leaving seniors to fend for themselves in the private market where HMO's will be the order. Make no mistake, we agreed on the path to full privatization and an end to one of the most successful government programs in our history.

We have all heard that this group endorsed the bill and that group endorsed the bill, so why are Democrats opposing it. The only reason this legislation has any life in it is because the Republicans have doled out billions of dollars in payouts to insurance companies, drug companies, and other special interests. These groups are not endorsing the bill because it helps seniors, they are looking out for themselves. Well I am not going to sell out our seniors.

Mr. Speaker, the greatest generation is about to face the brunt of the greatest hoax since since I have been in Congress. Most seniors are not watching this debate. They will have on their local news that Medicare will soon be covering their prescription drugs and they will be ecstatic. "Finally" many will say. What a shame it is that we re playing a political game with the lives of seniors around the country. I urge all of my colleagues to vote this bill down so that the can enact a real benefit that strengthens Medicare and provides a comprehensive drug benefit that will make this wonderful program even better.

Mr. TAUZIN. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from Texas (Mr. BRADY).

Mr. BRADY of Texas. Mr. Speaker, I appreciate the leadership of our chairman on this important issue. For the last 4 decades, Medicare has helped millions of American seniors get needed health care, helping them live longer than any other generation before them. However, Medicare has become dangerously outdated. In America today, Medicare refuses to pay $80 a month for Lipitor to prevent heart disease, but will pay $20,000 in hospital costs after a life-threatening emergency has occurred. That does not make sense. Medicare needs to keep pace with these medical breakthroughs.

Medicare must also be preserved and strengthened for future generations. We worked hard and we must act now so that seniors, baby boomers, and our young people can count on Medicare decades from now. We have worked hard to make sure Medicare is more like the health care plans Congress enjoys, more choices, better plans, and lower expenses for Medicare down the road. There are thoughtful new reforms to keep Medicare costs from ballooning out of control, and there are exciting new savings accounts that give Americans of every age more freedom to determine their health care costs.

Our seniors deserve a modern prescription plan now and future generations deserve Medicare that they can count on. The bottom line is we can invest a dime now to help seniors afford their medicines, or we can pay a dollar later when they end up in the hospital or face emergency surgery that we could have prevented. Our seniors deserve a modern prescription plan today, and Republicans in Congress are going to deliver it.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Texas (Mr. GREEN).

Mr. GREEN of Texas. Mr. Speaker, I rise in opposition to this so-called Medicare prescription drug conference report. Much as I want to support legislation creating a prescription benefit for our Nation's seniors, I cannot support this bill. First, the bill does absolutely nothing to drive down the outrageous costs of prescription drugs. In fact, it expressly prohibits Medicare from negotiating for 40 million seniors lower prices, and yet it still allows the insurance companies to do it. But they prohibit the government from doing it. The benefit has a huge doughnut hole that forces seniors to pay all their costs from $2,250 to $5,100. I guess I am so frustrated with this bill the best I can do is read a poem about America's Greatest Generation.

Rest gently, America's Seniors
You saved democracy in WW II
You survived a depression, too.
You built this Nation
to a great world power
so it is right you rest
at this late hour.

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But while you slumber
There are voices raised
In our Capitol yonder
Of your high costs for your drugs of wonder.
This proposed legislation
Considered in the dark of night
Will not reduce your cost a "widow's mite."
Awake you will from your night's slumber
To repay and respond to those who plunder
Your hard-earned Medicare benefits.

Mr. Speaker, I rise in opposition to this so-called Medicare prescription drug conference report.

Much as I want to support legislation creating a prescription drug benefit for our Nation's seniors, I cannot support this bill.

The bill does absolutely nothing to drive down the outrageous costs of prescription drugs. In fact, the legislation expressly prohibits Medicare from using the negotiating power of 40 million seniors to demand reasonable prices for our Nation's seniors but allows insurance companies to negotiate.

The benefit has a huge "donut hole" that will force seniors to pay for all of their costs from $2,250 until their costs exceed $5,100.

So if you have drug costs that are $300–400 per month, you're only going to get a benefit for the first half of the year.

The rest of the year, you'll continue to pay premiums, but get absolutely nothing from them.

And finally, this plan would require Medicare to compete with private plans that would be paid more to treat healthier seniors.

There is no way Medicare could honestly be expected to compete with these overpaid plans, and I think the bill's crafters did that on purpose.

Mr. Speaker, this legislation leaves people worse off than they were before it. The CBO estimates that 2.7 million employees will lose their retiree benefits.

More than 6.4 million Medicaid beneficiaries will lose their wrap-around coverage.

And in the long run, seniors will be left shouldering a significantly higher portion of their health care costs. This is unacceptable, and I urge my colleagues to vote against this bill.

Mr. TAUZIN. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Ohio (Mr. STRICKLAND).

Mr. STRICKLAND. Mr. Speaker, I thank my friend for yielding this time.

I probably will not need a minute to say what I want to say. But this bill was written by and for the pharmaceutical companies. Do the Members want an example of why I say that? A few days ago the Blue Dogs met with our Secretary of Health and Human Services, Mr. Tommy Thompson, and two Democratic Senators were there, Senator BREAUX and Senator BAUCUS. And in that meeting, a question was asked: Why is there a prohibition against the Secretary from negotiating discounted costs for America's senior citizens? And Senator BAUCUS said it is in there because PhRMA insisted that it be in there. Shame, shame, shame on you.

Mr. TAUZIN. Mr. Speaker, I yield myself 30 seconds.

I want to point out that the language that the gentleman just referred to in the bill first appeared in the motion to instruct by none other than the gentleman from California (Mr. STARK), who offered a motion to recommit H.R. 4680 with instructions that included the very same language that the gentleman is complaining about that was referenced in the Blue Dog meeting.

Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentlewoman from Colorado (Ms. DEGETTE).

Ms. DEGETTE. Mr. Speaker, the Hypocratic oath requires that doctors first do no harm. There is no such oath for Members of Congress. But we would be wise to heed it when we consider the Medicare prescription drug benefit tonight, for this bill certainly will do harm to millions of Americans. I know this. My constituents know this, and seniors across the country know this. They are furious with the organizations and the Members of Congress that support this plan.

This is not an abstract debate. This has a huge impact on real people. It will do harm to people like Helen Lay, my constituent, a retiree in Colorado. Helen is worried because, as she sees it, this bill has something in it for everyone except the senior citizens. Helen and her husband, Frank, are fortunate enough to have good prescription drug coverage through their retirement plan. Right now, they spend about $800 a year on prescription drugs. Without insurance, they would be spending nearly $12,000.

This bill will do great harm to Helen and Frank and millions of other seniors because it will encourage employer retirement plans to end prescription drug coverage, forcing seniors into substandard plans that cost more, and no one knows what the coverage or the price will be.

Helen and Frank have other serious problems. They take 12 brand-name medications per month. But this bill specifically prohibits Medicare from negotiating drug prices, even though private companies like Wal-Mart and agencies like the Veterans Administration are able to negotiate cheaper drugs. That means even if this bill passes, Helen and Frank will still pay exorbitant prices.

I say to Helen that we are here to stand up for her today.

Congress first must do no harm. Send this plan back.

Mr. TAUZIN. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentlewoman from California (Mrs. CAPPS).

Mrs. CAPPS. Mr. Speaker, I rise in opposition to the Medicare conference report. Seniors deserve a good prescription drug benefit through Medicare. This bill cripples Medicare and truly is not a prescription drug benefit at all. It forces seniors into private insurance plans to get all of their health care and contains a time-released poison pill that will starve Medicare of needed resources by arbitrarily capping federal funds.

But on top of this, the conference report cuts cancer care by $1 billion a year, $10 billion over 10 years. So many rural cancer centers will close as a result, and others will lay off oncology nurses and critical support staff. These centers are essential to the delivery of cancer care today. How can we do this to cancer patients? It is hard enough to live with this dreaded diagnosis, let alone the horrendous side effects of the treatments. And now this.

I repeat. This bill cuts $1 billion out of cancer care. I am ashamed.

Mr. TAUZIN. Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. ROGERS) for the purposes of colloquy.

Mr. ROGERS of Michigan. Mr. Speaker, I thank the chairman for his leadership on this for the millions of seniors who today have no access, no access to prescription drugs that will have that when this bill is signed into law. I thank him for each and every one of them.

For the purposes of colloquy, it is certainly not the chairman's intent that the cuts to oncology practices across the country would go below such a level that would cause practices to close, thus jeopardize access to care for thousands of cancer patients, and should we see that CBO's projections were wrong and that oncologists were found not to be made whole for their drug reimbursement under the new Average Sales Price that we would swiftly reverse this payment methodology?

Mr. TAUZIN. Mr. Speaker, will the gentleman yield?

Mr. ROGERS of Michigan. I yield to the gentleman from Louisiana.

Mr. TAUZIN. Mr. Speaker, the gentleman is correct, but let me point out that CBO's estimates now indicate that this bill makes oncologists perfectly whole in this first year of the changeover. In fact, for the first 2 years, it is a neutral completely, and oncologists will be getting something like 2½ to 3 times the practice expense allowance that CMS now estimates they would get under their own data. This bill will actually give oncologists 100 million more dollars than they are currently getting under the old AWP formula this year, 2004, and $100 million less the second year. So it is a total neutral policy for that 2-year period.

Mr. ROGERS of Michigan. Reclaiming my time, Mr. Speaker, I thank the gentleman for clarifying.

In addition, it is not the chairman's intent that small rural cancer centers across the country would be detrimentally impacted under the new Average Sales Price reimbursement method for their drugs based on their inability to buy in volume like their suburban neighbors. And if we found that to be the case, we would swiftly review the specific impact such a payment methodology had on access to care in these rural areas.

Mr. TAUZIN. Mr. Speaker, will the gentleman yield?

Mr. ROGERS of Michigan. I yield to the gentleman from Louisiana.

Mr. TAUZIN. Mr. Speaker, the gentleman is of course correct. That is why we built an ASP, Average Sales Price, plus a percentage to give the smaller oncology units a chance to buy, in case the larger units buy at a lower price, they could at least get coverage on top of the Average Sales Price to reimburse them, but we would always review that to make sure cancer care is indeed preserved.

Mr. ROGERS of Michigan. Mr. Speaker, I thank the gentleman for his attention on this matter.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentlewoman from Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. Mr. Speaker, I thank the gentleman for yielding me this time.

Earlier the gentleman from Louisiana (Chairman TAUZIN) waxed poetic about the deep meaning of a movie, of all things, and about the centrality of choice in our democracy. And I agree about choice.

But I have to tell the Members in all the years that I have worked for and with seniors, never, not once, did a senior citizen come up to me and say "What I really want is a choice of insurance plans. I want more salesmen to call me, send me those brochures, include all those charts and graphs and fine print. I cannot wait to sit down each year and choose among HMOs." Never, not once.

Seniors want a choice all right. They want to choose their doctor. They want to choose the drug that their doctor prescribes for them. They want the choice of their pharmacy if they want to go to their neighborhood pharmacy. They want the kind of real choice they get under Medicare, the Medicare that they know and love. And that is the kind of choice they will lose under this bill and under a pile of brochures that they are going to be burdened with. But do the Members know what? That is okay. I want to tell the Members it is okay because the seniors know the difference between real choices and phony choices. And we can put all kinds of fancy pictures on it, but senior citizens will know, and I want to tell the Members that it is to their peril that they vote for this legislation and give seniors a phony choice.

Mr. TAUZIN. Mr. Speaker, I yield 1½ minutes to the gentleman from Arizona (Mr. RENZI).

Mr. RENZI. Mr. Speaker, I thank the chairman for yielding me this time.

There has been some talk about this not being about prescription drugs and more about the changes that we are looking at for Medicare.

In the 1950's and 1960's on the border of Nevada and Arizona at the test sites for the atom bomb, the schoolchildren in Arizona, in Kingman, Arizona, were given the day off to go up on the mountains and watch the A-bomb blasts. The skies would turn brilliant pink and orange. Years later, those adults are the ones that come down with the highest cluster rates of cancer in America. A lot of the folks in the Rust Belt send their cancer patients out to beautiful, warm Arizona, whereas one of the benefits of their suffering has been our ability to understand how to better treat cancer in these communities now rather than in the hospitals.

The nurses who provide that cancer care under the current Medicare are not allowed to bill and get their full amounts. That is because Medicare has not changed enough or at all since its inception.

Medicare must be updated. It must be modernized. To do so denies the ability to provide the proper billable hours for our nurses who provide cancer care and the better system of cancer care that we are seeing out in the West.

Modernize Medicare. Do not deny those nurses that kind of coverage.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Maine (Mr. ALLEN).

Mr. ALLEN. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, we have talked a lot about this bill. I want to say just a couple of words about my seniors up in Maine. Two points. First, they are desperate for lower prescription drug prices. Number two, they want to keep the Medicare program that they have because it is all they have. There are no HMOs in Maine to provide services to them.

And here is what they do. To get lower prescription drug prices, they call my office in Maine every day. They pile into buses to go to Canada. They try to get their prescription drugs from Canada over the Internet.

And so what do they get out of this bill? They get a provision that says the government will not be able to negotiate lower prices for them, will not be able to negotiate lower prices. They get an inadequate benefit that is not as helpful to most seniors in Maine as the Canadian drug prices. It is a big win for PhRMA and a big loss for people in Maine.

Our seniors have come to rely on the stability, predictability, and continuity of Medicare. The chairman of the committee did talk about choice, but as in Illinois, no one in Maine has ever asked me for a choice between insurance plans. They have got the choice that matters now, a choice of doctors and hospitals. This bill over time drives them out of fee-for-service Medicare into HMOs. It is funded by an outrageous overpayment to private plans and HMOs.

My parents for 1 year were in a Medicare+Choice plan. It was not golden. It was not modern, not efficient, not fair. Just a bureaucratic nightmare. Defeat this Medicare bill. It is bad for Maine's seniors.

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Mr. TAUZIN. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from New York (Mr. ISRAEL).

Mr. ISRAEL. Mr. Speaker, last June I was one of nine Democrats who voted to move Medicare modernization into a House-Senate conference. That bill was flawed, but I wanted to give it a chance for bipartisan compromise and improvement. It saddens me that this bill was not improved, Medicare was not modernized; it has been privatized in this bill. I said when I voted for H.R. 1 that if it looked like privatization, if it sounded like privatization, if it felt like privatization, if it smelled like privatization, that I would oppose final passage. This bill sounds, it feels, it smells, it looks, it is privatization; and I have to oppose final passage.

Now, some say, well, it is not really privatization; this is just an experiment in six different areas. Do not worry. Mr. Speaker, when you are the guinea pig, you tend to worry.

We could have done a much better job with this bill, Mr. Speaker. We could have come up with a bill that Republicans and moderate Democrats could embrace, a bill that protects seniors and does not subvert them. I gave this bill every chance that I could. Tonight this bill robs our seniors of any hope that they have had for true Medicare reform. Medicare should be the Federal Government's obligation to seniors who need the right bill, not a profit center for the special interests who wrote this bill.

Mr. TAUZIN. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from New Jersey (Mr. ANDREWS).

Mr. ANDREWS. Mr. Speaker, I thank the gentleman for yielding me this time.

Several Members of the majority have said that this is a historic morning. They are correct. History will record that this is the day that any pretense the majority had, the Republican Party had of fiscal responsibility, ended.

Mr. Speaker, for every $100 we are spending to run our government tonight, we are only taking in $80, and you are taking every nickel out of the Social Security trust fund and then some to make up the difference. So what is your strategy to deal with this deficit? It is to add a $400 billion entitlement that you cannot pay for. You are using Social Security funds that are supposed to fund future retirements for our kids to pay for a sham prescription drug benefit for our grandparents.

This borrowing will purchase a Trojan horse, a massive giveaway to the health insurance industry disguised as a prescription drug benefit for senior citizens.

I listened to your speeches when you came here 10 years ago and said we could not afford to expand entitlements, and many of us on our side stood with you and made sure that we did not do that.

To have a real prescription drug benefit, you should repeal your sacred tax cut and pay for what is really necessary for America's seniors. Shame on the Republican Party for turning its back and releasing a torrent of red ink that we will pay for, for generations to come, when this bill metastasizes in the future. Oppose this ill-considered bill.

Mr. TAUZIN. Mr. Speaker, I yield myself 30 seconds. That was an interesting speech, but I got a letter from the Congressional Budget Office indicating that they prepared a preliminary estimate of the impact of the Democratic amendment to H.R. 1, the Democratic plan; and the estimate of CBO of their plan is $1 trillion. So a speech complaining about the fact that we in this House passed a budget that included $400 billion for this important program for seniors is wrong, when the other side prepared an amendment for $1 trillion; that is a little outrageous.

Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 30 seconds to the distinguished gentleman from Arkansas (Mr. BERRY).

Mr. BERRY. Mr. Speaker, I rise at this time to just express my gratitude and the gratitude of my caucus to the two gentlemen who have worked tirelessly for years on this issue, the gentleman from Michigan (Mr. DINGELL) and the gentleman from New York (Mr. RANGEL). And I hope that this entire body, even though they have been treated shamefully and disgustingly by the Republican leadership and by this conference committee, I hope that everyone here this evening will join me in thanking them for the magnificent job that they have done for America and America's seniors.

Mr. TAUZIN. Mr. Speaker, I yield myself 30 seconds. While he is not here, I think the Members on our side ought to show their appreciation for the chairman of the Committee on Ways and Means, the chairman of the conference who did an amazing job in bringing this excellent bill to the floor for our consideration, the gentleman from California (Mr. THOMAS).

Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the gentleman from Massachusetts (Mr. MARKEY).

Mr. MARKEY. Mr. Speaker, 40 years ago today, President Kennedy's assassination released an energy in our country that led to the passage of the Civil Rights Act and Medicare. By contrast, the bill before us today was conceived in secret, crafted by special interests, and cloaked in a prescription drug benefit to disguise its real purpose: the destruction of the Medicare program as we have known it in the United States over the past 40 years.

This bill is a Thanksgiving turkey, and this turkey will not fly. It forces senior citizens into HMOs. It gives HMOs billion-dollar subsidies. It raises drug costs for the poorest Americans, and it drops millions of seniors from their retirement plans.

Some claim this bill will provide America's senior citizens with new prescription drug coverage, but it will force millions of our frail elders to pay more for prescription drugs than they do now. Some claim it will lower Medicare premiums, but it will require Medicare beneficiaries to forfeit the power to choose their own doctors or their own drugs. Some claim it will make the Medicare program more efficient, but it will stick taxpayers with the bill for billions of dollars in subsidies to HMOs and new tax shelters for the rich.

This bill is not the elixir for Medicare; it is, rather, a poison pill that leads to the destruction of the Medicare program as John F. Kennedy and Lyndon Johnson envisioned it.

Mr. TAUZIN. Mr. Speaker, I yield myself 3 minutes.

Mr. Speaker, it is the season of Thanksgiving, and this House is about to say thank you to a generation of Americans who we ought to say thank you to, and we are about to say it in the most important way we can. We are about to pass a $400 billion-insured drug account for these citizens who have no drug insurance today. We are about to pass a voluntary plan that gives them the right to join or not join, their choice, not mandated by government. It includes catastrophic coverage so they never have to lose everything they have worked for and saved for all of their lives. And we give to all Americans on this Thanksgiving holiday a chance to open up health savings accounts, tax-free in, tax-free out, tax-free interest earned to build their own long-term health care plans for the future.

This, indeed, is a time of Thanksgiving, and it is indeed a time for this generation to be true to our obligations of the previous generation. This bill does that. It gives the new generation choice in drug coverage for the first time.

It is amazing to me tonight, this debate. I have taken my parents to the hospital many times during my dad's life and my mom's. I do not ever once remember a doctor asking me as I checked in to the room there whether my mom was a Democrat or a Republican. This is not a partisan issue. I have gone and filled my mom's prescriptions every now and then for her. They never asked me at the pharmacy what party she belongs to. And when health deserts us in our senior years, when the ravages of time take us and we pass away, no mortuary worker stamps Democrat or Republican on our tombstones.

Health care is not a partisan issue, and it should not be a partisan issue. We have a chance today to do something that seniors desperately need, and we ought to join tonight together to do it.

There are a lot of people who helped write this bill. Let me tell you who they were. They were, of course, the members of the conference committee who worked together to put this bill together, but there were a lot of staffers; and I want to mention them today. They are the staff of the House and Senate legislative counsel. Special thanks to the House legislative counsel, Ed Grossman, who is a draftsman extraordinaire. Additional thanks go to Pierre Poisson and Peter Goodloe.

From the Senate side, Ruth Ernst and John Goetcheus and Jim Scott.

Other staff members of the Congressional Budget Office and analysts, these individuals deserve great compliments for their analysis, their integrity, and their hard work. I want to thank Doug Holtz-Eakin and Steve Lieberman, Tom Bradley, and the entire CBO staff who worked night times and days for us.

I want to thank Tom Scully and the whole staff at HHS and CMS who sat and worked with us day after day to craft this bill.

I specifically want to thank the staffs of our committees. From Ways and Means, John McManus, who did such a great job; Madeleine Smith and Deborah Williams, and Joel White. From the majority side of the Finance Committee, I would like to thank Linda Fishman, Mark Hayes, Leah Kegler, Colin Roskey, and Jennifer Bell. Recognition is deserved to Liz Fowler and Andrea Cohen, Pat Bousilman and Jonathan Blum.

Last, but not least, all of the Committee on Energy and Commerce staff who toiled so hard for us, let me thank them again, over and over again: Dan Brouilette, Patrick Morrisey, Chuck Clapton, Jeremy Allen, Patrick Ronan, Kathleen Weldon, and Jim Barnette. They did a marvelous job for this House, and we owe them a debt of thanks. Thank you all.

Mr. DINGELL. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Ms. ROYBAL-ALLARD).

Ms. ROYBAL-ALLARD. Mr. Speaker, I rise in strong opposition to this bill.

Mr. Speaker, I rise in strong opposition to this extremely flawed bill. A bill that takes care of drug and insurance companies at the expense of our Nation's seniors.

Instead of helping our seniors, Mr. Speaker, this bill will result in higher drug prices, increased Medicare premiums for seniors who refuse to be forced into HMOs, and the erosion of retiree coverage for over two million seniors.

These are just a few of the problems with this bill, Mr. Speaker. There are far too many to name in the limited time I have.

Our seniors deserve better. They have worked and sacrificed and contributed greatly to our country.

We must not turn our backs on them, Mr. Speaker, with the passage of this bill. Instead let us honor our seniors by defeating this bill and coming back with a prescription drug plan that is affordable, comprehensive and guaranteed. A plan, Mr. Speaker, that protects Medicare not destroys it.

Let tonight's victory be for our seniors, not the pharmaceutical and insurance companies.

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to the gentleman from South Carolina (Mr. SPRATT).

Mr. SPRATT. Mr. Speaker, I rise in strong opposition to this bill.

Mr. Speaker, when we began this quest several years ago, our object was to make Medicare better by filing a big gap in its coverage. This conference report covers that gap with a drug benefit that is barely adequate and badly in need of redesign. The bill then goes on not to make Medicare better, but to move Medicare toward privatization, heavily subsidizing managed care with funds that could better be used to improve the meager drug coverage this bill provides.

I will vote against this bill not to kill it but to send it back to an open conference, where all participate, in an effort to make the bill worthy of our senior citizens who badly need this coverage, and depend on Medicare.

Here are some of the problems and objections that I find with this bill:

H.R. 1 couples meager drug coverage with major changes that move medicare toward privatization. The terms of coverage seem reasonable at first until you realize that they are not guaranteed. The premium of $35, the deductible of $250, and the co-payment of 25 percent are illustrative of what insurance companies may offer, but not written in stone. In any event, coverage stops after $2,250, just when it is needed most, and catastrophic coverage does apply until one has spent $5,100. For this first $5,100 in coverage, the consumer pays $4,020. Put another way, the plan pays 20 percent the consumer pays 80 percent. Catastrophic coverage starts after $5,100 has been spent, and seems reasonable, until you realize that this threshold, like all the other terms of coverage, is indexed to the rising cost of prescription drugs, and is likely to double in ten years. This is meager coverage, and a poor trade-off for all the changes crammed into this package to move Medicare toward privatization.

H.R. 1 contains a drug benefit that is flawed and needs to be fixed before it becomes law. Rather than providing continuous coverage, the Medicare benefit has a $2,850 gap in coverage that will leave millions of seniors without drug coverage for a good part of the year, even though they continue to pay premiums.

The drug benefit has a deductible of $250, and a coverage gap that begins at $2,250 in drug spending and ends at $5,100. According to CBO, this coverage gap of $2,850 will double to $5,065 by 2013. The structure of the benefit means that there will be several months out of the year when seniors are paying premiums and are not receiving any additional drug coverage. This odd benefit design, with its coverage gap does not currently exist as an insurance product.

H.R. 1 needlessly complicates prescription drug coverage by making it available only through private insurance policies and not through medicare. Even through stand-alone drug policies don't exist, and health insurance companies, fearing adverse selection, have made clear that they do not wish to write it, this bill provides primarily for private insurance coverage. Out of disdain for Medicare, the bill does not choose the simple solution and make drug coverage a feature of Medicare. Instead, in one of many steps toward privatization, this bill calls for drug coverage to be written by private insurance companies, adding unnecessary cost, complexity, and uncertainty.

H.R. 1 requires that drug coverage be purchased from a private insurance company even when there is only one underwriter and no competition. In regions where only one insurance company offers a drug-alone policy, Medicare will not provide "fallback" coverage under this bill, so long as there is a Medicare PPO or HOM in the area. The beneficiary will have three unappealing choices: take the coverage at a non-competitive price, leave Medicare fee-for-service and join the HMO, or go without drug coverage.

H.R. 1 bars the Federal Government from using the purchasing power of 40 million seniors to drive down the price of drugs—H.R. 1 flat prohibits the Secretary of Health and Human Services from negotiating better prices for prescription drugs. The bill divides Medicare's 41 million beneficiaries into numerous regions and to one or more private plans within each region. This fragmentation runs contrary to trends at the state level, where states have used the purchasing power of big beneficiary pools to negotiate better prices. This prohibition also flies in the face of prevailing federal practice, which requires government officials to seek the best possible price when spending the taxpayers' money—especially when spending $400 billion.

H.R. 1 overpays HMOs to induce them to join medicare and draw seniors into private plans—H.R. 1 provides $16.5 billion to sweeten subsidies paid to managed care plans and induce them to enter markets they have not found profitable. After spending billions to subsidize managed care plans, this bill then forces traditional Medicare to compete with the plans. This competition, known benignly as "premium support," will destabilize Medicare as we have known it and lead to premium increases for seniors who want to stay with the government-run program.

According to the Medicare Payment Advisory Commission, Medicare already overpays managed care plans by 19.6 percent. They are paid 19.6 percent more than their members would cost if enrolled in traditional fee-for-service Medicare.

H.R. 1 increases HMO payments by another $4.5 billion and sets up a $12 billion fund to induce private plans to enter new markets. According to MedPAC, these changes will result in overpayments to managed care plans of 25 percent.

Medicare fee-for-service will then have to compete with private plans in six metropolitan areas starting in 2010. Obviously, the increased payments will allow private plans an advantage in the competition, one they will enhance by marketing their services to healthy seniors.

Managed care plans have a record of designing and marketing benefit packages that appeal to healthy beneficiaries. As private plans "cherry pick" healthier beneficiaries, traditional Medicare will be stuck with sicker, more expensive beneficiaries. If competing private plans run costs below traditional Medicare, the beneficiaries in fee-for-service Medicare will be assessed the difference through their Part B premiums. Traditional Medicare premiums will spiral upwards, forcing seniors who cannot afford the rising premiums to move into private plans that limit their access to doctors. The process will repeat itself year after year, beginning an insurance "death spiral" that will destroy traditional Medicare.

H.R. 1 will cause over six million low-income seniors to be worse off—The 6.4 million low-income and disabled individuals who now receive health coverage from both Medicare and Medicaid will be worse off under this bill.

Under current law, when a benefit or service is covered by both Medicare and Medicaid Medicare serves as the primary payer and Medicaid "wraps around" that coverage. Medicaid fills gaps in coverage that exist under the Medicare benefit. Medicaid also picks up most or all of the beneficiary co-payments that Medicare charges.

This bill largely eliminates Medicaid's supplemental—or "wrap around"—coverage under the new Medicare drug benefit. As a result, substantial numbers of poor elderly and disabled people would be forced to pay more for their prescriptions than they now do.

In addition, in cases where Medicaid covers a prescription drug but the private plan that administers the Medicare drug benefit in the local area does not provide that particular drug under Medicare, poor, elderly and disabled beneficiaries who now receive the drug through Medicaid could lose access to it.

Under current law, low-income beneficiaries have co-payments that run from zero to as high as $3; but these amounts do not increase from year to year. The conference report raises cost-sharing for those with the lowest incomes by requiring $1 and $3 co-payments for beneficiaries whose income is less than $8,980 a year and $2 and $5 co-payments for beneficiaries whose income is between $8,980 and $12,123 a year. In addition, the $1 and $3 co-payments grow at CPI (1.5 percent to 3 percent). The $2 and $5 co-payments will rise at the same level as prescription drug spending, which is projected to average 10 percent a year, far exceeding the annual 1.5–3 percent. Social Security COLAs.

According to the Center on Budget and Policy Priorities, this provision will result in higher drug costs for 4.8 million seniors.

H.R. 1 will cause nearly 3 million seniors to lose retiree coverage—According to CBO, some employers will stop providing retiree coverage due to the structure of the drug bill, and this will result in 2.7 million seniors losing retiree drug coverage, in many cases far better than this plan.

According to the Congressional Budget Office, 11.7 million seniors currently have retiree coverage through their former employers. However, 23% of these seniors, or 2.7 million individuals, will lose this coverage. This loss of coverage results from the structure of the drug benefit, which gives employers an incentive to drop retiree coverage.

The drug bill targets Federal assistance toward those seniors who lack supplemental private drug coverage, most noticeably through the requirement that payments made by supplemental coverage don't count toward the beneficiaries' out-of-pocket limit. In effect, the out-of-pocket provision reduces Federal subsidies for beneficiaries with supplemental insurance. As a result, it provides a clear financial disincentive for employers to supplement the benefit.

Second, some employers see the enactment of a drug benefit as an opportunity to reduce the costs and risks of providing drug coverage.

H.R. 1 spends nearly $7 billion on tax shelters for the healthy and wealthy—Rather than marshaling funds to improve drug coverage, H.R. 1 diverts $7 billion to Health Security Accounts, which have nothing to do with Medicare drug coverage, and create an unprecedented tax break, which could undermine our employer-sponsored insurance system.

Under H.R. 1, tax-advantaged savings accounts to pay out-of-pocket medical expenses would be made universally available. These could be used with high-deductible health policies, but not with the comprehensive health coverage traditionally offered by employers. Holders of these accounts could make tax-deductible deposits, watch the earnings compound tax-free, and pay no tax upon withdrawal if the funds are used for medical expenses.

This would establish an unprecedented and lucrative tax shelter. In the existing tax code, when funds deposited in a tax-favored account are deductible, withdrawals are taxed. On the other hands, withdrawals are not taxed when deposits are not deducted. There is no precedent in the tax code for providing both "front end" and "back end" tax breaks. The political pressure to do the same for other types of savings and retirement accounts could become irresistible. A proliferation of such tax-free accounts would only send Federal deficits higher.

These savings accounts would also undermine comprehensive health insurance. Healthy, affluent workers would have an incentive to opt out of comprehensive health insurance in favor of the Health Security Accounts. They would receive a large tax break, and would not be much affected by switching to a high-deductible health policy since they generally use fewer health services. If large numbers of such workers opt out of comprehensive plans, the pool of people left in comprehensive plans would be older and sicker, causing premiums for comprehensive insurance to rise significantly.

That, in turn, would drive still more healthy workers out of comprehensive insurance, making those that remain even more costly to insure, adding pressure on employers to stop offering comprehensive coverage. Older and sicker workers could wind up paying more for health coverage or losing it altogether and becoming uninsured.

This suggests what could be done to make this bill better if it were taken back to a fair and open conference committee. The $7 billion allocated to Health Security Accounts and the $17 billion allocated to subsidizing HMOs could be used instead to narrow the "doughnut hole," the zone where there is no coverage between $2,250 and $5,100. This is just one example of how this bill can be fixed and improved, and should be before it is passed.

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to the gentleman from Pennsylvania (Mr. FATTAH).

Mr. FATTAH. Mr. Speaker, I rise in opposition to this conference report.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Arkansas (Mr. ROSS).

Mr. ROSS. Mr. Speaker, I thank the gentleman from Michigan for yielding me this time.

Mr. Speaker, in 2001, the Republican Congresswoman, the gentlewoman from Missouri (Mrs. EMERSON), and I offered up a bipartisan plan that would truly modernize Medicare to include medicine for our seniors, that recovered 80 percent of the cost of prescription drugs for our seniors, while taking on the big drug manufacturers, and the Republicans told us that we could not afford it. They said we could not afford $750 billion over 10 years.

But what has happened since then? They passed a $350 billion tax cut for the wealthy, and now they are proposing a $400 billion major prescription drug plan. I was not real good in math in high school, but I think I can figure that one out. That totals $750 billion. Two years later, we are getting a plan that does not even kick in until 2006. Our plan would be in effect today.

□ 0215

Seniors get $1,080 worth of help on the first $5,100 worth of medicine they need every year, and the Republicans even had the nerve at the urging of the big drug manufacturers to put language in the bill that says the Federal Government shall be prohibited from negotiating with the big drug manufacturers to bring down the high cost of prescription drugs. This is a bad bill. This is a bill that does not even fit our seniors, only the big drug manufacturers.

Mr. TAUZIN. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, again let me read the language of the bill that the gentleman just referred to, that terrible piece of language. It says in effect that in administering the prescription drug benefit program established under this, the Secretary may not, number two, interfere in any way with negotiations between private entities and drug manufacturers or wholesalers; or, three, otherwise interfere with the competitive nature of providing prescriptive drug benefit through private entities. That language in the bill comes from a motion to recommit prepared and filed in this House in the 106th Congress by the gentleman from California (Mr. STARK) on his motion to recommit. It is language of the other side that they are complaining about.

Mr. DINGELL. Mr. Speaker, I yield 2½ minutes to the gentleman from Texas (Mr. TURNER) for purposes of explaining the motion to recommit, which will be offered at the conclusion of the debate. I hope my colleagues will listen closely to this.

Mr. TURNER of Texas. Mr. Speaker, for years the pleas of our hurting seniors fell on the deaf ears of our Republican majority until one day our Republican friends were struck with an ingenious idea, wrapping a plan to privatize Medicare into a deceptive package called prescription drugs for seniors.

It keeps the drug companies happy because they can still charge twice as much for medicine here as anywhere else in the world. It keeps insurance companies happy by paying them 25 percent more to cover seniors than taxpayers pay to cover seniors under traditional Medicare. It keeps doctors and hospitals happy by paying them billions while leading them like sheep into the perils of managed care.

And it costs taxpayers $400 billion for a meager prescription drug savings of 25 percent, a savings that could be achieved at no cost to taxpayers by giving seniors the right to buy drugs at the same price they can get them in Canada. All this slight of hand to force seniors into private insurance and some day to give them a voucher and tell them fend for yourself. No security, no certainty, no guaranty of coverage, you are on your own. And the promise of Medicare is no more.

My seniors in east Texas see right through this. In a poll conducted tonight, over 6,000 seniors in my district, 85 percent said they were opposed to the Republican plan. Dress it all up as fancy as you can, it is a bad deal for America's seniors and they know it.

Mr. Speaker, I will be offering a motion to recommit to give seniors a meaningful prescription drug plan. This motion matches the conference report dollar for dollar on provider payments. It allows the Secretary of HHS to negotiate lower drug prices. It eliminates premium support ensuring that seniors will not have to pay more to keep the Medicare coverage they know and trust. It rejects the poison pill language that guts reimportation, and it prevents millions of retirees from losing their benefits and protects low-income seniors by allowing Medicaid to provide wrap around coverage.

Mr. Speaker, let us give the greatest generation the certainty, the security, and the guarantee they deserve. Vote for this motion to recommit.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The Chair would advise Members that there are 2 minutes remaining on either side. The gentleman from Louisiana (Mr. TAUZIN) has the right to close.

Mr. TAUZIN. Mr. Speaker, I might inquire of the gentleman from Michigan (Mr. DINGELL) if he has further speakers. I am reserving for the Speaker of the House to close.

Mr. DINGELL. Mr. Speaker, at this time I would inform my distinguished friend in the House, the gentleman from Louisiana (Mr. TAUZIN) that we have only one speaker remaining who will close for this side.

Mr. TAUZIN. Mr. Speaker, then I would advise my friend to take advantage of that time at this time and the Speaker will close on the Republican side.

Mr. DINGELL. Mr. Speaker, is my good friend assuring me he has only one speaker remaining?

Mr. TAUZIN. Mr. Speaker, I can assure my friend that is true.

Mr. DINGELL. Mr. Speaker, then with a great deal of pride and pleasure I yield the remainder of my time to the distinguished minority leader, the gentlewoman from California (Ms. PELOSI).

Ms. PELOSI. Mr. Speaker, I first I want to invite my colleagues to join me in expressing our appreciation to our Democratic conferees who have been true champions of a defined affordable prescription drug benefit under Medicare, the dean of the House and ranking Democrat on the Committee on Energy and Commerce, the gentleman from Michigan (Mr. DINGELL), the distinguished ranking Democrat on the Committee on Ways and Means, the gentleman from New York (Mr. RANGEL), and a true champion for health care in this Congress and the country, the gentleman from Arkansas (Mr. BERRY), all for their leadership on this important issue.

Sadly, Mr. Speaker, the Republicans would not let these appointed conferees into the conference room. And this bill does not reflect the benefit of the thinking and experience of our very diverse caucus. That is a great loss to this debate and a great loss to our country.

Mr. Speaker, the Democratic Party has made ensuring the dignity and security of our seniors a cornerstone of our mission for generations. Nearly 40 years, ago a Democratic Congress and the Democratic President, Lyndon Johnson, honored that mission by making Medicare the law of the land. Ever since then, America's seniors have known where Americans stand. We created Medicare, we want to protect it and strengthen it.

Americas seniors have also known where Republicans stand. For 40 years, they have waged war on Medicare. When Congress passed Medicare in 1965, only 13 Republicans in Congress supported it. Only 13 in Congress supported it. When Newt Gingrich and the Republicans tried to gut Medicare in 1995, President Clinton stopped them. That same year, Newt Gingrich made his intentions about Medicare clear. He said, "Now, we did not get rid of it in round 1, because we do not think that is politically smart, but we believe it is going to wither on the vine." And tonight the Republicans want to deliver the final blow. On behalf of America's seniors and disabled, we must stop them.

Recognizing the desperate need of America's seniors citizens, Democrats proposed a guaranteed, defined, affordable prescription drug benefit under

Medicare. Instead of joining us in this historic opportunity, Republicans offered up a Trojan horse, a deceptive gift intended to win their 40-year war against Medicare.

Republicans said this is a first step toward a prescription drug benefit. This Republican plan is not a first step, it is a false step, it is a mistake. It puts profits for HMOs and big pharmaceutical companies over seniors, providing a $12 billion slush fund for HMOs and gives a $139 billion in windfall profits to the pharmaceutical companies over 8 years.

The Republican plan does not lower costs for prescription drugs. It prohibits the government from negotiating for lower prices. It privatizes Medicare and pushes seniors into HMOs. It makes seniors pay more to keep the Medicare they know and trust. It does all of this for a deceptive plan that makes most seniors pay $4,000 out of their first $5,000 in prescription drug costs. How do you explain that to mom? You are going to get a new benefit, this is the Republican plan. And of the first $5,000 of prescription drugs cost, you, senior citizen of America, are going to pay the first $4,000.

Nearly half of all Medicare beneficiaries, up to 20 million seniors and disabled Americans, will fall into a coverage gap, meaning they will pay premiums all year without receiving benefits all year. Under the plan most seniors will be worse off than before, and millions of retirees will lose their existing employer provided coverage.

Republican priorities are clear: They place the special from interest of the HMOs and the pharmaceutical companies before the public interest of America's seniors and disabled. This is not the beginning of a real prescription drug benefit under Medicare. On the contrary, this is the beginning of the end of Medicare as we know it. The more seniors across America learn about the details of this scheme, the less they like it, and the more they want us to keep fighting for real prescription drug benefit that really answers their needs.

Mr. Speaker, this is an hour of decision. Tonight there is own one way to improve this bill and that is to and to provide the benefit seniors need and deserve and that is to vote no. I urge my colleagues to vote against this Republican hoax. I urge them to send all of the conferees, Democrats and Republicans, to the conference room to produce a bipartisan bill that will be sustainable over time and meet the needs of our seniors and disabled. I urge them to stand with 40 million seniors and disabled Americans who look to us for help and hope at this defining moment.

Speaking on the day when he signed Medicare into law, President Johnson said that this Nation's commitment to its seniors was part of a noble tradition that calls upon us never to be indifferent toward despair, never to turn away from helplessness, never to ignore or spurn those who suffer untended in a land that is bursting with abundance. Tonight the hopes of 40 million seniors and disabled Americans rest upon us. They have waited too long, fought too hard, endured too many broken promises, only to be sacrificed on the alter of the special interest. We cannot, we must not, and we will not abandon them now.

Mr. TAUZIN. Mr. Speaker, in order to close this historic debate we yield the balance of our time to the distinguished Speaker of this, the whole House of Representatives, the gentleman from Illinois (Mr. HASTERT).

Mr. HASTERT. Mr. Speaker, I thank the gentleman from Louisiana (Mr. TAUZIN). I also want to thank those many, many staff members who spent uncounted hours, night and day, to help make this bill possible. I especially want to thank my own staff member, Darren Willcox, who sacrificed many late nights and early mornings and long weekends despite having a wife and a baby boy at home. I want to thank Brett Shogren of the majority leader's staff, and many, many other young men and women who committed their time, dedicated their time to try to do a good job in this people's House.

I want to thank those folks at the legislative counsel who spend untold hours of trying to craft the right language to make this legislation the right legislation for the American people, and those folks at the Congressional Budget Office who crunched numbers day after day after day to make things work.

In this time and space of legislative arena, there are times when things come together. There are times of great opportunity. And there is a time for change.

□ 0230

This, indeed, is one of those times for that opportunity. This, indeed, is one of those times for great change. A poet once said that "things fall apart, the center cannot hold. The best lack conviction while the worst are full of passion and intensity."

For the good of our senior citizens and for the good of our Nation, the center must hold. The best must be full of passion and intensity. And today, we must pass this historic legislation.

I want to thank all of those who have put aside their partisanship and worked together for the good of this Nation. I want to thank the conferees, especially the gentleman from Louisiana (Mr. TAUZIN), the gentleman from California (Mr. THOMAS), the gentleman from Texas (Mr. DELAY), the gentlewoman from Connecticut (Mrs. JOHNSON), the gentleman from Florida (Mr. BILIRAKIS) in the House, and Senator FRIST and Senator BAUCUS and Senator BREAUX of the Senate.

They have worked long and they have worked hard on this product through many late nights and long weekends, and they deserve our gratitude.

The third time is a charm when it comes to prescription drugs. This Congress under this leadership passed drug prescription legislation in the 106th Congress. The House passed a prescription drug bill only to see it die in the Senate. In the 107th Congress, we passed a prescription drug bill only to see it die in the Senate. And finally, we are poised to complete this long journey.

When Medicare was first conceived, the baby boomers were young adults and most seniors got their health care from a doctor's visit or a trip to the hospital. Thus, those who constructed the program were not overtly concerned about long-term cost projections or about prescription drugs.

Today, we face a different story. The baby boomers are now thinking about retirement, and they want their prescription drugs. Prescription drugs now make up more than a third of health care costs.

This conference report makes two fundamental changes to the Medicare system. It makes it more sustainable in the future, and it provides seniors with a prescription drug benefit. Why do we have to make Medicare more sustainable in the future? Because if we do not, my kids and all those other young adults out there will be forced to pay 30 percent of their salary in the next decade or two for the Medicare program. And I just do not think we can make that happen, and that will not sustain Medicare; and I do not think it is fair to them.

So in this bill we start the process of making Medicare more sustainable. We means test the part B premium and index the deductible to inflation. We introduce free-market principles and give consumers more power to choose their health care. We include cost-containment measures so that if Medicare costs grow too quickly, the Congress and the President will be forced to confront that fact.

Finally, we create health savings accounts which might be the most dramatic and exciting reform of our health care system in generations. These health savings accounts give consumers the ability to make health care choices. This will hold down skyrocketing health care costs and deliver better health care for our citizens and for our seniors.

As we make these necessary financial reforms in Medicare, we also modernize the program with a prescription drug benefit. And after this legislation goes into effect, low-income seniors will never be confronted with the choice of putting food on the table or paying for life-saving prescription drugs. Low-income seniors will finally have the benefit that will take care of their drug costs, and this will save the deposit money in the long run. For example, if a low-income senior has diabetes, the monthly cost of Glucophage, a drug that helps control that disease, is about $30 a month. But if diabetes is left untreated, a single hospitalization for renal kidney failure is about $6,700. The benefit is both penny-wise and pound-wise.

It will also help the typical senior by cutting down their drug costs by 40 percent. And those seniors with high drug costs will save even more, up to 60 percent or more. In other words, this prescription drug benefit is a good deal for all seniors.

This legislation has other important factors. It includes incentives to employers so that they will not drop their current plans. In fact, this bill will make it more likely that if you have coverage with your employer, that employer will continue to offer that benefit. It also includes vitally important help to rural America. And if you live in the cities or urban America, it is probably not a problem. But if you are trying to compete with your rural hospitals and keep doctors and hospitals going in rural areas, you know that is a problem.

This bill solves the problem. It takes care of rural hospitals. It provides rural health care. That is something that many of us have been fighting for for a long, long time. Let me be the first to admit that this conference report is not perfect. The far left does not like it. And some of our friends on the far right do not like it. But let me tell you who does like it.

The AARP has endorsed it. So has the American Hospital Association and the American Medical Association and almost every other major seniors organization and doctor and patient group.

I urge my colleagues to put politics aside. I urge you to consider this piece of legislation for the good of this Nation. I urge you to stop and think when is the last time that we have really been able to change the paradigm of health care in this country. When is the last time that we have really had the chance to offer our seniors in this country a future for good health care, for good pharmaceutical coverage and for a chance to live and enjoy a great future.

I ask for a positive vote.

Mr. FILNER. Mr. Speaker, I rise today to say shame on this body for passing this reprehensible Medicare bill that has been rammed through Congress today by the Republican leadership.

This legislation does nothing that its supporters claim it does. They claim that this bill will help seniors with their prescription drug costs and give them more choices in their healthcare. But actually, this bill does none of that. It does not provide a comprehensive, affordable or reliable prescription drug benefit. Further, it unravels the consistent, guaranteed healthcare coverage that seniors have come to expect under Medicare. This bill is so bad, that even some Republicans refused to support it. Opponents of this terrible legislation see through the smoke and mirrors that supporters are putting up and realize that this bill was not about helping seniors pay for their prescription drugs or giving them access to better care, but that this bill was actually about helping the bottom lines of private insurance companies, HMOs and the pharmaceutical companies.

There are many, many bad provisions in this legislation, and I would like to highlight some of the worst of them here.

One: Under this bill, Medicare as we know it is completely unraveled. First, Medicare Part B will be forced to compete with private managed care plans. This leaves the health of our seniors to the whims of private insurance companies and does not guarantee that all seniors will be receiving the same benefits across the country. That means seniors in my District in San Diego, CA, might have better coverage than seniors in New York. Or seniors in New York might have better coverage than those in San Diego—we just don't know—it's completely up to the private insurance companies and HMOs to decide how much coverage they want to provide. Not only is the amount of coverage going to vary, but so are the costs of the premiums. Again, that means seniors in San Diego might pay more than seniors in New York—or vice versa—depending on how much the private insurance companies and the HMOs decide they want to charge!

Secondly, this bill would institute a "means test." In layman's terms, that means that in 2007, the Medicare part B premium would be linked to income. This not only goes against the main tenet of Medicare—which grants coverage to everyone, regardless of income—but also, higher premiums create an incentive for healthier seniors to leave Medicare. This would leave only the sickest seniors in Medicare and drive up premiums even more.

Two: The so-called prescription drug "benefit" is absolutely inadequate and actually decreases coverage for some seniors and can cost them more than they're paying right now. Supporters of this bill claim that the prescription drug benefit will help seniors cover the costs of their medications. However, there are so many problems with this benefit that it's hard to decide where to begin. First of all, this benefit does not even kick in until 2006. When it finally does begin, seniors are expected to pay a high deductible. Then, there is a piece de resistance of this so-called benefit: there is a big hole in coverage. Rather than providing continuous coverage throughout the year, this bill has a $2,850 coverage gap in which seniors don't receive any coverage at all. Half of America's seniors fall into this hole. The icing on the cake is that despite the fact that they would not be receiving coverage for part of the year, they are still expected to continue to pay the premiums.

Additionally, more than 2 million retirees, who currently have drug coverage through their former employers, will lose that coverage. Because drug costs keep rising and this bill has no measures to keep drug costs low, it is very tempting for employers to simply drop their coverage and force seniors onto this inadequate drug coverage plan. Furthermore, rather than having Medicare kick in when a retiree reaches catastrophic coverage, this bill forces the employer-provided benefits to cover those costs—yet another reason for employers to pull their coverage.

Three: This bill explicitly prohibits the government from negotiating with drug companies for lower drug prices. One of the greatest strengths of a prescription drug plan under Medicare is that it could reduce drug prices for participants using the large number of participants in the Medicare program to bargain with pharmaceutical companies for better prices on their products. Yet this bill denies Medicare participants those lower costs, ensuring continued skyrocketing prescription drug prices.

It is for those reasons—and many many more—that I could not support this poison pill for Medicare and a placebo of a prescription drug benefit.

Mr. THORNBERRY. Mr. Speaker, like most bills brought before us, this bill is a mixture of provisional I support and provisions I oppose. Unlike most bills brought before us, it affects every American and will have significant, long-term consequences for our Nation.

I believe that providing access to quality health care is one of the most formidable challenges facing our Nation now and in the decades to come. The retirement of the baby boom generation, which begins in less than 8 years, will make that challenge enormously difficult.

When the House considered its version of this bill in June of this year, I said that our objective should be to "update and strengthen Medicare so that it does a better job of providing health care for seniors and at the same time put Medicare on a sound financial footing so that it can be sustained through the baby boom generation retirement." This conference report does begin to update Medicare by adding prescription drug coverage. It does little to put Medicare on a sound financial footing.

Making prescription drug coverage available to all seniors is very important. Not only will that benefit keep seniors from having to choose between buying medicines and other necessities of life, it will help them stay healthier. As they stay healthier longer, hospital and other medical expenses should be less.

This bill includes reforms of the system which are also important. Allowing all Americans to choose Health Savings Accounts gives everyone a new option to pay for health care and could help stem the tide of rising insurance rates and rising health care costs. Beginning to consider income in calculating Part B premiums is a significant change in the law. Other provisions related to provider reimbursements and reducing the discrimination against rural health care providers are worthy of support.

I am concerned that the total cost of this bill is vastly underestimated, as has happened before in Medicare. There are payments or tax credits for virtually every group interested in health care, yet of all of the groups affected by this bill, I worry that the interests of those paying the bills, especially future taxpayers, are given the least consideration.

So, we are left weighing the benefit of modernizing Medicare and some reforms versus the danger that this bill will hasten the day of Medicare' collapse. It is not an easy judgment to make.

It is clear that if we do nothing, millions of seniors will go without the prescriptions they need and that none of the reforms essential to Medicare's survival will occur. We must begin somewhere. Reluctantly, I have concluded that this most imperfect bill is at least a place to start.

If we are honest, we have to admit that this bill is something of a gamble. We are betting that the limited reforms begun here will flourish and work to strengthen Medicare for the 21st century. If we are wrong, the added benefits and payments may sink the entire program. Tonight, I choose to vote with my hopes rather than my fears, prayerfully mindful of both my parents and my children.

Mr. UDALL of Colorado. Mr. Speaker, I want to support a Medicare drug bill, but I can't support this bill. Instead of giving us a foundation to build on, I believe it will compromise the effectiveness of a very popular healthcare program for seniors in order to deliver an inadequate, unreliable and unfair drug benefit. Under this bill seniors will pay higher premiums, higher deductibles and higher prices for drugs. It will force seniors into HMOs, and millions of seniors will lose drug benefits that they get through their retirement plans. Instead of crafting a drug bill, the Republican leadership has used the opportunity to dismantle Medicare and turn it over to private insurance and drug companies.

I have long believed that Congress should act to help seniors with their prescription drug expenses. Congress should give seniors greater choice in coverage, but it should not force seniors into HMOs in order to get a drug benefit. Colorado could be chosen as part of the demonstration project under this bill, which would force seniors into HOMs in order to get the drug benefit. According to a recent analysis by the Department of Health and Human Services, most seniors would see increases in their premiums with some facing increases as high as 88 percent. Colorado seniors would pay some of the highest premiums in the country. For example, seniors in Adams County, CO would pay $100 a month while seniors in some parts of North Carolina will pay $58 a month. Why should Coloradans pay higher premiums than seniors in other parts of the country for the exact same benefit?

It's no wonder that seniors in my district are skeptical about this plan. Let's not forget, we tried private competition in Medicare when HMOs were allowed to participate in the program as a result of legislation that passed in 1997. Seniors were told that managed care was better able to deliver healthcare services to them. Managed care aggressively courted seniors to join Medicare+Choice plans and then dropped them because they couldn't make a profit. That left millions of seniors searching for doctors and coverage. Now, this bill includes billions of dollars in subsidies to managed care to provide coverage. If privatization is such a good idea, why do insurance companies need these large subsidies in order to participate in Medicare?

There are a few provisions in this bill that I support, such as the payment increases for hospitals and physicians and other providers. In fact, I have consistently voted to increase provider payments and I have cosponsored legislation to change the flawed formula upon which these payments are based. But those payments should have been brought up separately rather than as part of the Medicare bill.

It is grossly ironic that Medicare will pay for a senior's care following a stroke but will not pay for the anti-hypertension drugs that prevent them. The time is ripe to pass a Medicare prescription drug benefit, but not as proposed in this legislation. I had hoped that we would vote on a bill that created a fair, workable, financially sound prescription drug benefit. But I am not willing to set in motion forces that will lead to the destruction of a program that seniors and the disabled have trusted for nearly 40 years in exchange for a feeble prescription drug benefit. We should work to get it done right rather than get it done right now.

Mr. BUYER. Mr. Speaker, the measure before the House tonight, the conference agreement on the Medicare Prescription Drug and Modernization Act, H.R. 1, is not a perfect bill. But, it is also not the bill that I opposed several months ago when the House first considered the measure. As with any conference agreement, this bill is a product of compromise and negotiations. It is an improvement in the House-passed bill in some respects, a disappointment in others. Nonetheless, I think it is time to end the debate on a prescription drug plan in Medicare and move forward.

While this bill has some troubling flaws, it does take major steps forward in improving access to health care of our nation's seniors. It serves as a blueprint for enhancements to Medicare that will enable Congress to resolve the long-term solvency issues in Medicare's structure.

Reform cannot occur in a vacuum. We must be vigilant as we take these necessary steps to reform Medicare to provide greater choice and health care services to beneficiaries.

This measure will require close scrutiny by Congress to oversee the implementation of the drug plan to insure that it provides cost containment and prevention of drug overutilization. The provisions before us to enhance Medicare are likely to require annual maintenance by Congress.

If the provisions of this bill that expand Medicare Advantage plans, that improve Medical Savings Accounts in Medicare, and that create Health Savings Accounts, are successful in the marketplace, beneficiaries will have alternatives to government-run health care and greater choices to meet their health care needs.

I applaud the inclusion in this bill of provisions to address the needs of rural providers, especially rural hospitals. Under this bill rural hospitals will see an equalization on reimbursement on inpatient care as compared to their urban counterparts. This bill includes provisions which I have urged that give Critical Access Hospitals more flexibility in their bed limits. I also applaud the conferees for including a provision that will enable hospitals to seek a reconsideration of their classification. The bill also extends Medicare cost contracts until Medicare Advantage plans are available. These are good provisions that will directly address patient care in my district.

I am also pleased to see the inclusion of regulatory reforms that this House has passed twice.

Finally, the bill gives seniors help with their prescription drugs almost immediately by authorizing a discount drug card. In a serious level of effort, I worked with four of my colleagues in drafting legislation to add a drug card to the Medicare program. Under our approach seniors would have been able to choose from a variety of discount drug cards available at a very low annual fee. We also included funds for seniors, based on income, to help seniors pay for drugs; a catastrophic limit; and a mechanism for seniors to save and for others to help seniors pay for their drugs.

Frankly, I think this is a better approach and I would have preferred to see it made a permanent feature of this bill, rather than expiring at the end of 2 years. Nonetheless, the discount drug card provisions of H.R. 1 do incorporate many of the ideas that my colleagues and I advocated. It would be my hope that Congress will see the wisdom of extending the drug card program.

I am troubled by the present fallback provisions, by the extent of the subsidies permitted under the bill, and by the uncertainty as to whether Medicare will be adequately reimbursing physicians for providing care to patients needing injectable drugs. I am also concerned that this bill still does not effectively keep the costs in-line with the ability of the taxpayers to fund the benefits.

Nonetheless, the bill, on the whole, is more positive and I am fully aware that Congress will have to tackle difficult issues down the road, however, I will support H.R. 1, to add a prescription drug benefit to Medicare and create long-term solutions to solve access, choice, and solvency of Medicare when baby boomers become seniors.

Mr. BEREUTER. Mr. Speaker, this Member wishes to add his support for the Medicare conference report and would like to commend the distinguished Chairman of the House Ways and Means Committee (Mr. THOMAS); the distinguished Chairman of the House Energy and Commerce Committee (Mr. TAUZIN); and the other Medicare conferees for their leadership, expertise, and good efforts on this comprehensive Medicare reform package. This Member would especially like to thank the distinguished gentleman from California (Mr. THOMAS) and his staff for the time he spent briefing this Member on the rural health provisions as Medicare conference negotiations were taking place and for his work to bring greater equity to the rural health care delivery system.

This measure may well be one of the most complex and important bills that this Member has ever had to consider during his tenure in Congress. Although the conference report lacks immediate controls on the high cost of pharmaceuticals—the market-oriented and pro-competition cost-containment provisions provided for the existing Medicare program are critically important reforms. The conference report makes Health Savings Accounts available for the first time ever to all Americans, and includes the undoubtedly controversial, but necessary means-testing of Part B premiums on a sliding scale, beginning at

$80,000 (for singles). The rural health care reforms are also exceedingly important for millions of Americans. The conference report is certainly not perfect, for the prescription drug benefits may be both unaffordable and a huge disappointment to the intended beneficiaries. Yet, the Medicare reform and greater Medicare equity for citizens of rural and non-metropolitan areas make this conference report on H.R. 1 worthy of an "aye" vote. Congress will have ample time and opportunity to address concerns, enhance, revise, and improve upon this historic legislation.

Until this year, there has been nothing but gridlock and delay in terms of how to reform the Medicare program. The Medicare conferees worked long and diligently to develop the Medicare reform agreement before us today. We cannot afford to let this prospect of Medicare reforms slip away.

Mr. Speaker, the rising cost of prescription drugs has become an issue that simply must be addressed. Senior citizens in Nebraska and throughout the United States should not have to compromise their quality of life or their health because the cost of their prescriptions is more than their income allows. Without an end to the ever higher prescription drug cost—the product largely of huge international cost-shifting onto the backs of American consumers—the prescription drug benefits we are adding will cost more than the $400 billion allocated—it will quickly be too expensive for our Nation to bear, even with Federal taxpayer funds. Therefore, this Member is very concerned that the measure lacks immediate restraints on the high cost of pharmaceuticals.

This Member is extraordinarily disappointed, but not surprised, with the intentionally unimplementable reimportation language included in the conference report. Drug re-importation from Canada was not the best approach to meeting the problem of escalating drug costs and it could be only an interim approach, but it is the only tool now available. The provisions of the bill allow for the importation of drugs from Canada, but the measure contains language in which the Department of Health and Human Services can say it cannot responsibly or legally implement the provision, as it has done on two previous congressional efforts. This language is the "poison pill," and it is wholly unsatisfactory.

Mr. Speaker, it is additionally important that the conference agreement authorizes $50 million for fiscal year 2004 for the Agency for Healthcare Research and Quality (AHRQ) to conduct research on health care outcomes, comparative clinical effectiveness, and appropriateness of health care items and services—including prescription drugs. This Member has been a strong advocate for such research, as evidenced by his amendment to the Labor, Health and Human Services, and Education appropriations bill (H.R. 2660).

Americans deserve the best health care for their dollar. Clinicians, patients, and those financing health care services need credible, objective information on the benefits, risks, and costs of prescription drugs so that they can make informed decisions about the prescriptions they consume and prescribe. Consumers need information regarding the effectiveness, quality, and cost-effectiveness of new drugs, in comparison with existing alternatives, especially when new drugs can cost much more than those now on the market. This Member is pleased that the conference report language authorizes the AHRQ to conduct such research and that comparative clinical effectiveness is referenced but is concerned that cost-effectiveness is also not mentioned.

Mr. Speaker, in addition to adding a long overdue prescription drug benefit to the Medicare program, the conference report provides for robust reform of the rural health care delivery system. It is the best bill ever for the health care of citizens living in rural and non-metropolitan areas; it moves them to a more equitable position with respect to their urban counterparts.

This Member is extremely pleased that the Medicare conference report includes a substantial amount of funding specifically for rural areas and small communities. As the Interim Co-Chair of the House Rural Health Care Coalition, this Member has been working diligently to address rural health care issues and the needs of those individuals who practice, work, and live in rural areas. This conference report includes funding that is dedicated to assisting community hospitals, outpatient facilities, home health agencies, skilled nursing facilities, ambulance service providers, rural physicians, and other skilled health professionals. Such funding is crucial for cash-strapped rural facilities which are near a breaking point and in need of urgent aid.

This Member is especially pleased that the Medicare conference report includes language to address the significant differential in Medicare reimbursement levels to urban and rural skilled health care professionals. For the past 2 years, this Member has introduced the Rural Equity Payment Index Reform Act to assure that physician work is valued, irrespective of the geographic location of the physician. The Medicare conference report establishes a 1.0 floor on the Medicare physician work adjuster from 2004 to 2006, thereby raising all localities with a work adjuster below 1.0 to that level. This is a huge victory for this Member, my very able legislative assistant, Ms. Michelle Spence, for Nebraska, and for all Medicare localities with a physician work adjuster below 1.0.

Several other provisions are included in the Medicare conference report to assist rural areas physicians and other skilled health professionals. For example, the measure protects senior citizens' access to physicians by replacing a 4.5 percent across-the-board physician payment cut—scheduled to take effect on January 1, 2004—with 2 years of payment increases. Additionally, this Medicare agreement provides a five percent bonus payment for primary and speciality care physicians who practice in scarcity areas.

This Member is also pleased that the Medicare conference report addresses hospital payment disparities to ensure that facilities in rural areas and small cities can stay in business and continue serving patients who need care by permanently extending the standardized base payment. This policy will help maintain access to care in rural and less populated urban areas of the country by better aligning hospital payments to actual costs. The estimated impact of eliminating the base rate differential will result in $26.7 million over 10 years for Nebraska hospitals in the First Congressional District, according to the American Hospital Association.

Additionally, the Medicare conference report lowers the labor share of hospital wage index to 62 percent. This change will increase inpatient reimbursement for many rural hospitals and will more accurately reflect the labor costs of many rural facilities. According to the American Hospital Association, this provision would bring $3.3 million over 10 years to the First Congressional District of Nebraska.

Several other provisions are included in the Medicare conference report to address rural hospitals. For example, the agreement increases disproportionate share hospital payments for small rural and urban hospitals and increases critical access hospital payments to 101 percent of reasonable costs.

Mr. Speaker, in closing, this Member supports the Medicare conference report. It finally gives the American people some of the critical reforms that are essential if the system is to avoid fiscal disaster or unaffordable burdens on American employers and employees. And, on what is a gamble, at least until we reduce the huge international pharmaceutical cost-shifting onto Americans, it will provide senior citizens with access to prescription drugs when they need them most and it will greatly improve health care for Americans living in rural areas.

Mrs. MALONEY. Mr. Speaker, the seniors in my district have made their views on Medicare clear.

They believe that it should provide the same coverage for prescription drugs that it does for doctors' appointment and hospital stays. And they think that they should no longer pay the highest prescription drug prices in the world.

Unfortunately, however, the bill before us will provide inadequate benefits that would leave half our seniors paying more out of pocket for prescription drug coverage than they do now. And it contains a gap in coverage that will leave half of seniors without any drug coverage for part of the year.

Just as bad, this bill will impose a global ceiling on the size of Medicare. If the overall cost of the Medicare program exceeds a predetermined cap, Congress will immediately be forced to slash benefits or hike premiums for those currently on Medicare.

To add insult to injury, this bill will undermine initiatives to cut the cost of prescription drugs. It would bar by law any effort by the Secretary of Health and Human Services to try to negotiate with pharmaceutical companies to lower prescription drug prices.

This bill will undermine and ultimately destroy Medicare as we know it.

It's not a magic potion. It's a poison pill. .

I urge my colleagues to vote "no."

Mr. LANGEVIN. Mr. Speaker, I rise today gravely disappointed by, and opposed to, the Medicare Modernization and Prescription Drug Act of 2003. The 108th Congress has squandered our best opportunity yet to provide a meaningful prescription drug benefit for our nation's seniors. I am outraged that the republican leadership has taken advantage of the public's cry for medication coverage. They have used the demand to exploit the elderly, funnel money to drug and insurance companies and privatize Medicare. Sadly, this debate is no longer simply about a prescription drug benefit. This debate is about the survival of the health care system that has been serving and protecting our seniors since 1965.

In a striking divergence from the universal nature of Medicare, the conference report we are voting on today establishes a system wherein seniors rely on private, drug-only companies to administer their drug coverage. Each of these companies will develop their own rules about premiums, deductibles and what medicines are covered. The standard this bill sets for the companies only offers 75 percent coverage of the costs up to $2,250—and no coverage at all until the expenses then reach $5,100. During that significant gap in coverage, seniors will still be responsible for paying a $35 monthly premium. Even more infuriating, that premium will not count toward their out of pocket expenses, making it take even longer for them to reach the catastrophic level. The Republican conferees claim to offer help for the poor, and indeed, premium subsidies are available to individuals earning less than $6,000 a year or couples earning less than $9,000. But these vulnerable, low-income seniors must first meet a strict assets test, where cars, burial plots and even wedding rights will be counted as assets. Additionally, I remain deeply concerned that the legislation fails to include a meaningful fallback plan seniors can rely on if private companies fail to emerge in their area, an all too likely scenario that it is our duty to protect against.

The prescription drug component of this bill contains a particularly troubling provision that strictly forbids the Secretary of Health & Human Services from using the bulk purchasing power of Medicare beneficiaries to negotiate for lower drug prices for senior citizens—a tactic that has proven effective in the state programs, as well as 25 other industrialized nations. America's seniors have made it clear that they want the government to assist them in obtaining their prescription drugs at a fair price. It infuriates me that that we have over 40 million people with a common and basic, need, yet instead of taking advantage of that power to secure lower prices for the most rapidly increasing component of health care, the Federal Government, under the proposal put forward, would outlaw that practice. This tremendous missed opportunity makes it clear to me that this bill was written with the interests of drug companies, not America's seniors, in mind.

The problems with this conference report go far beyond the inadequacy of the drug benefit. This bill not only fails to meet the needs of seniors and jeopardizes the retiree coverage used by 12 million Americans, it also lays a strong foundation for the demise of the Medicare program as we know it. Beginning in 2010, this agreement will expose millions of seniors to new cost and benefit uncertainties in as many as six large metropolitan areas, possibly including my home state of Rhode Island and neighboring Massachusetts.

This vast demonstration project, which will involve up to 7 million seniors, will subject Medicare to competition with private companies, coercing seniors into HMOs and private plans. These private companies will be given huge financial incentives to offer health coverage for seniors, funneling critical resources away from Medicare and those who rely on it. If a senior wishes to stay in the Medicare program, he or she will be required to pay the difference between the cost of the private plan and the cost of Medicare—which will, no doubt, skyrocket as private plans court the healthier seniors out of Medicare, leaving Medicare the more costly task of providing for a sicker, poorer risk pool. This plan breaks the fundamental promise of Medicare. It replaces a guarantee of quality health care with increased premiums, provides a voucher for health insurance, and leaves seniors and people with disabilities to fend for themselves in a market where they may not be able to find a health care plan that meets their needs. Medicare was created in 1965 because the private industry was unable to provide adequate health coverage for this population. The virtue of the system is that it creates a large risk pool. Injecting private competition, and subsidizing that competition with billions of taxpayer dollars, will leave the healthiest seniors with the ever-changing and unstable options of private plans, and will resign those who are not as fortunate, our most vulnerable population, to an even more uncertain fate.

Seniors in Rhode Island, and no doubt the rest of the country, will see through this scheme. My constituents remember the devastating effect of the abrupt departure of Harvard Pilgrim, an HMO that covered over 150,000 Rhode Islanders. The scramble to find a health insurance plan that would allow patients to keep their doctors, and the struggle to understand new sets of benefits that followed Harvard Pilgrim's exit from our state would be replicated on a regular basis in the regions affected by the so-called demonstration project contained in this bill.

I must also touch upon the issue of provider relief. I am a strong supporter of doctors and hospitals that serve Medicare beneficiaries, and voted three times this year in favor of striking the premium support provision from this bill and using that money to update provider payments instead of subsidizing private companies. The conferees failed to take this approach, instead providing some temporary relief to providers for the upcoming year, but no long term fix to the systemic problem that plagues doctors and hospitals year after year. Providers are already overburdened by Medicare-related paperwork and receive lower-than-average reimbursement rates for their services. Should the premium support provisions in this conference report become law, providers will be forced to negotiate new terms for payment annually with every private plan that emerges to serve Medicare beneficiaries in a region. This bill signs away the rights and responsibilities Congress currently has to these providers, leaving decisions about provider payments up to the CEOs of insurance companies. The high turnover rate of providers in participating Medicare + Choice plans signals the instability this will cause, for providers and patients alike.

In this year's debate over Medicare, once again, Congress has lost sight of what the public has asked for, and what American seniors need. Our seniors are choosing between paying their rent of buying food and obtaining the medication they need to stay alive. They need relief from prescription drug costs. They do not need the additional challenges, burdens and costs of navigating through a system of HMOs, subjected to a different plan, a different doctor and higher premiums each year. Our Medicare providers need a fair payment system over the long term. All Americans need their government to take action against the soaring cost of prescription drugs. Given the opportunity to make a difference in each of these areas, the Republican leadership chose to put their resources and their trust in the hands of insurance companies and drug companies. This Is a matter of priorities and principles. I urge my colleagues to make American seniors our priority, vote no on the conference report and immediately begin to take meaningful steps to solve these problems.

Ms. HOOLEY of Oregon. Mr. Speaker, over the last 7 years, Oregon seniors have told me that their top concern is the high cost of prescription drugs coupled with the lack of coverage for these lifesaving medicines under the Medicare program.

Regrettably, the bill before us today does nothing to address the high cost of drugs, and it comes at too high a price for coverage. Many seniors would lose the expanded coverage they currently have through their retirement and many others couldn't afford the high premiums, deductibles and gaps in coverage.

Despite the hard work and good intentions of many members of Congress on both sides of the aisle, we have lost the forest for the trees.

And so I rise today in opposition to the conference report on H.R. 1.

In August, I sat in the House gallery with some guests as the reimportation bill came to the floor. We sat with a group of interns and junior staffers. Along the back wall was a line of representatives of the pharmaceutical industry. It was an interesting mix.

From that unique vantage point, we watched members on the floor who were not speaking to represent "sides of the aisle," but who joined together across the aisle to form the People's House. It was an interesting perspective on the situation.

You couldn't necessarily tell what anyone's party affiliation was by the impassioned way they spoke about an issue that cuts across party lines. The vast majority of us were adamant about fighting for the people we represent back home who are no longer willing to tolerate the fact that people in Mexico and Canada can get their drugs for less than Americans.

That bill passed overwhelmingly, and yet this conference report has failed to include drug reimportation. It has failed to address the elephant in the middle of the living room: the high cost of drugs.

Seniors can't afford drugs, and they can't afford high priced coverage, or loss of coverage they currently enjoy.

Unfortunately, when we were closest to getting agreement on making medicines more affordable for all of the Nation's seniors, the pharmaceutical companies, who make the lifesaving drugs that patients need, killed every attempt to allow Americans to benefit from the same low drug costs that other countries enjoy.

They also made sure that this legislation specifically prohibits the Medicare program from negotiating the prices of drugs, a power that even other government agencies, such as the Department of Veterans' Affairs, have. Why? Because seniors would finally have the leverage to lower drug costs for themselves in this country. They would make one heck of a purchasing pool.

And, when we were closest to getting agreement on improving coverage for everyone, the conferees failed to adequately protect retirees' health coverage. Unfortunately, somewhere along the way we forgot that this isn't just a pharmaceuticals bill, this is a seniors' bill.

We lost sight of what senior's struggle with most . . . drug costs and the cost of coverage. And believe me, seniors themselves have noticed that we've lost sight of them.

Take 79-year old Ruth Beale of Portland who was just diagnosed with Parkinson's disease who writes: "I still work 3 days a week as a companion to a 103 year-old. This gives me just enough cash to pay the $300/month for my prescriptions. Of course that doesn't include the pain medication for the Parkinson's, my doctor gives me free samples when she can, though sometimes she runs out.

My Social Security check is barely enough to cover rent, (and I live in a subsidized senior apartment), food and the $72 per month for my Medicare HMO premium. Under this plan, I wouldn't get any help for my drug costs. I really can't afford to pay any more than I do now. So I guess I'll just keep on working until I can't anymore—I'm going to give this Parkinson's a run for it's money though."

And God bless her.

Although Dorothy Patch of Salem has supplemental insurance, she still pays over $230.00 per month out of pocket for her prescription drugs. Dorothy is concerned about being pushed out of the coverage.

Dorothy figures that she would actually pay more for her coverage if this legislation passes. Why?

1. Only 75 percent of her drugs would be covered up to $2,250 per year.

2. From $2,250 to $5,100 Dorothy would fall into the "donut hole" and not receive any coverage at all, while she is still responsible for paying a $250.00 deductible and $35.00 monthly premiums.

3. Even though under her current plan, Dorothy is paying $230.00 per month, there is no donut hole in her coverage and she is covered no matter how high her drug costs become per year.

4. She is using a fee for service system and does not want to be forced into an HMO.

The truth of the matter is that people who currently have no coverage would gain a little at a very high price, a cost that many who have contacted me say they cannot afford. For many in the district I represent, this legislation is a step backwards. For others, it is a sore disappointment that we were unable to slay the giant and make reasonably priced medicines within their grasp.

At the beginning and in the end, for me, this issue has always been about the high cost of drugs and the need to affordably expand coverage. Regrettably, this bill prohibits ways to lower drug costs for American seniors and, for many, the coverage provided in the bill comes at a high price they simply cannot pay.

I urge my colleagues to reject this bill, go back to the negotiating table and give seniors what they really need: affordable drugs and affordable drug coverage.

Mr. MATSUI. Mr. Speaker, I rise to express my strong opposition to the Medicare conference report before us today. It short-changes seniors who have waited far too long for a comprehensive, affordable prescription drug benefit and it undermines the Medicare coverage they have counted on for almost four decades.

First, the drug benefit in this bill is woefully inadequate. Seniors will have to pay a $250 deductible before they receive any benefit, and there is a significant gap in coverage, or "donut hole", where seniors will continue to pay monthly premiums but receive no assistance towards the cost of their drugs. In fact, a senior with $5,100 in annual drug costs would pay $4,020 of that cost out of their own pocket.

The fact that seniors have to pay 80 percent of their first $5,100 in drug costs is appalling. But, it doesn't stop there. This bill does nothing to lower drug prices. To the contrary, it explicitly prohibits the government from using the collective purchasing power of more than 40 million seniors to negotiate lower drug prices. So, not only does this bill make seniors pay 80 percent of their first $5,100 in drug costs, it prevents the use of reasonable tools to bring those costs down.

Now, let me address for a moment the 12 million retirees who already have health insurance from their former employers. The Congressional Budget Office estimates that this bill will cause 2.7 million of them to lose their existing coverage. This happens because the bill excludes employer contributions from counting towards the prescription drug catastrophic cap. This will incentivize employers to reduce their coverage to the level in this bill or drop it altogether to avoid having to pay the cost of prescription drugs in the donut hole.

Finally, this bill undermines the fundamental commitment of Medicare to seniors. Beginning in 2010, Medicare will be forced to compete with private companies for the provision of all Medicare and prescription drug benefits. Often referred to as "premium support" or "privatization", this provision shifts Medicare from the guaranteed, defined-benefit program it currently is to a defined contribution plan. Under this legislation, privatization is aided by almost $20 billion in subsidies to insurance companies and HMO's, creating a competitive advantage that allows them to attract healthier seniors, leaving sicker or chronically ill seniors in Medicare. The result will be a Medicare program that is unaffordable for the seniors who need it the most.

Mr. Speaker, as we consider the merits of this legislation, it is critical to look at the history of health coverage for seniors in this country. Medicare was created in 1965 because seniors were unable to find health insurance in the private marketplace. The bill before the Congress today would return us to that very same scenario and I urge my colleagues to vote against it.

Mr. CASTLE. Mr. Speaker, I rise today in support of the Medicare Prescription Drug Conference Report, and thank all the Conferees for their dedication to providing relief for our seniors. This landmark legislation updates Medicare and finally brings the program into the 21st Century by modernizing the program and providing a prescription drug benefit. While not perfect, this bill presents us with an historic opportunity of providing 40 million Medicare beneficiaries with relief in the face of rising prescription drug costs. Every member of this body has identified health care reform as a top priority and now we have the opportunity to make progress. The reality is clear—every year we postpone this debate and fail to compromise on a Medicare and prescription drug bill, while the burden of drug costs on seniors continues to increase.

In 1965 when the Medicare program first began, the average senior's spending for prescription drugs was $65 a year. In 2002, overall spending had risen to $2,149—a 35-fold increase. The average retail prescription price increased more than three times the rate of inflation from 1998 to 2000. Over 60 percent of seniors spend more than 1,000 per year on prescription drugs and of those seniors, 17 percent spend more than $5,000. And with 80 percent of retirees using a prescription drug every day, the expense for many is out of reach. These statistics clearly show the transition of patients relying mostly on hospitals and physician for their health care needs to patients relying more on prescription drugs as measures for health treatment and prevention.

The bill aims to make prescription drugs more affordable and more accessible by creating a voluntary prescription drug benefit. For the first time, since the creation of the Medicare Program, seniors, no matter where they live, will be able to receive financial assistance to help pay for these drugs, which are becoming increasingly integral to disease prevention, management and treatment. Seniors can keep whatever drug coverage they have now, choose a private plan or stay in the traditional Medicare program.

Once the benefits is in place, Medicare will pay 75 percent of seniors' drug costs up to $2,250 per year, with a $250 deductible and a monthly premium of $35. With the CBO estimate indicating that the average senior will spend $1,891 on drugs in 2006, I think most seniors will find this to be a strong improvement. Importantly, this legislation provides the most generous benefit to the lowest income seniors. These seniors do not pay a premium, nor do they have a deductible and there will not be gaps in coverage for the drug benefit.

This bill also takes strong steps towards preparing Medicare for future challenges, such as being equipped to meet the needs of retiring baby boomers. We offer new preventatives measures including an initial physical and certain preventative benefits such as diabetes and cholestrol screening as well as chronic care disease management. These common sense reforms are long over due—who can believe that Medicare was not covering an initial physical for our seniors? Encouraging beneficiaries to participate in preventive and early detection programs can not only improve their immediate health, but has potential to save billions in future healthcare costs.

Another key component of this legislation are incentives for employers to retain and enhance retiree coverage. During the debate in both the House and Senate a significant amount of time focused on employer-based coverage. With increasing costs of health care as a whole, it is logical that employers are looking for a way to reduce their overhead. Most likely, retirees who tend to be more costly than younger, healthier workers, are targeted for cost cutting measures. These are concerns that provisions would be included in this legislation to allow employers to drop coverage based on age, but fortunately, due to the work of many, that did not happen.

One-third of all Medicare beneficiaries currently have prescription drug coverage through their former employers. Retirees want to keep that coverage and frankly, I believe they should be able to make that choice for themselves. This legislation provides a percentage subsidy to employers who maintain coverage for their retirees, which also saves Medicare money. Specifically the legislation will provide a federal subsidy to employers equal to 28 percent of drug spending by their retirees between $250 and $5,000. This applies not only to private companies, but also to state governments, and unions, like teachers unions, which often have very generous retiree packages. Of course, this is not a fail-safe solution. The higher costs associated with retiree health care coverage is an expensive matter for most corporations, unions and other providers. But, we hope that these incentives will help curtail the problem.

Importantly, this legislation also contains numerous provisions intended to speed the entry of generic drugs into the market by preventing multiple 30-month stays by brand drugs and incentives for generic manufacturers to challenge weak or inappropriately listed patents. Generic drugs often provide consumers with a low cost alternative and I hope that the medical community will continue to make efforts to inform patients about the availability of generic drug options.

We also address the reoccurring problem of physician fee cuts by increasing reimbursements by 1.5 percent instead of earlier proposals to cut them by 4.5 percent. I have spoken to a lot of doctors in Delaware who said these cuts were likely to put them out of business. With the rising cost of malpractice premiums compounded by cuts in reimbursements, some physicians may have already been forced to close their doors, which clearly impacts all of us. However, this is only a temporary fix. We must now move forward to fix this physician fee formula that was laid out in the Balanced Budget Act so doctors are not strung along year in and year out worrying about this potential cut. I hope to work with my colleagues to ensure this formula is fixed in the coming years.

This legislation is not perfect and no one here today will tell you that it is. One of the major issues missing from this bill is a good faith provision allowing the reimportation of prescription drugs. Despite the overwhelming support in the House for true reimportation, this bill simply encourages the status quo by requiring the Secretary of Health and Human Services to certify the safety of these drugs coming from Canada. Essentially this is the current law of the land, yet we do not see pharmacists and wholesalers importing drugs from Canada and passing those savings on to consumers. Seniors will be forced to continue the bus trips to Canada and mayors and governors will continue to negotiate agreements with Canada, until we truly address our prescription drug costs. This bill does include a study to research the major safety and trade issues regarding reimportation, and I hope it will be conducted in good faith and in a timely manner so we can return to this important discussion.

I also have serious concerns about premium support and forcing Medicare to directly compete with private insurance plans because I believe it can lead to higher costs for those seniors who choose to stay in Medicare. While I believe the demonstration language in this legislation is far less disconcerting than a full premium support provision, I will continue to monitor this closely. In the end, we cannot undermine the basic tenets of the Medicare program, which has a history of providing an equal benefit no matter where seniors live. Varying premiums within and among states is surely not the message we want to send our seniors. Hopefully this demonstration program will yield positive results that drive costs down—only time will tell. I will work to ensure that Medicare is viable and that seniors who choose to stay in Medicare are protected.

I commit myself and I hope others will join me, in continuing to address the rising cost of health care, prescription drugs and the rising ranks of the uninsured. According to the U.S. Census Bureau, an estimated 15.2 percent of the population or 43.6 million people were without health insurance coverage during the entire year of 2002, up from 14.6 percent in 2001. That is an increase of 2.4 million people. What's even more disconcerting is the percentage of people who are employed but lack health care coverage. That number dropped from 62.6 percent to 61.3 percent. However, these are clear and challenging issues that we must address in the upcoming session.

Despite these and other concerns I have, I am supporting this legislation because I believe it provides desperately needed relief to Americans suffering from their overwhelming health care costs. American seniors have waited long enough for this assistance and I encourage my colleagues to provide them with the immediate relief in this bill.

Mr. RODRIGUEZ. Mr. Speaker, I rise to express my strong opposition to the Medicare Prescription Drug Conference Report that we will be forced to vote on today. This bill has been crafted behind closed doors with the help of those corporate interests which will most benefit. Unfortunately, the bill they have created offers nothing more than empty promises to our Nation's seniors.

Medicare was built on the principle that all seniors should have access to health care, regardless of how much you make or where you live. And for over forty years, this program has successfully worked to provide access to health care, offering hope and security to America's seniors. As the nature of health care has changed over the years, however, we recognize there is a need to improve upon the program and address the prescription drug price crisis.

Seniors that I have met with back home have asked that I fight for a prescription drug benefit under the traditional Medicare plan and that is exactly what I have done. Over the years, I have worked to enact legislation that would establish a guaranteed and affordable prescription drug benefit for all Medicare beneficiaries.

The industry-backed bill that Congress will vote on today falls far short of a benefit that will truly fit seniors' needs. While the bill provides $112 billion to entice managed care companies to participate in the program, seniors will receive little assistance with their drug costs. For the first $2,000 of coverage, the consumer will pay over $1,100; for the first $5,100 of coverage, the consumer will pay approximately $4,000. Put another way, if a consumer buys approximately $5,100 of drugs a year, the consumer will pay nearly 80 percent of that cost.

Despite the $400 billion price tag, millions of retirees and low-income beneficiaries will find themselves in an even worse situation. Up to 6.4 million of the poorest and sickest Medicare beneficiaries, including close to 390,000 Texans, could have drug coverage reduced. The bill prohibits Medicaid, the nation's low-income health insurance program, from helping with co-payments or paying for prescription drugs not on the formularies of the private insurers administering the new Medicare benefit. And 2 to 3 million seniors could lose retiree prescription coverage, including at least 132,000 Texas retirees, due to a provision that lowers Medicare assistance to employer-sponsored retiree health plans.

Furthermore, by relying on private companies to deliver a benefit, we force seniors into the arms of the health insurance industry. We have learned all too well that private Medicare insurance plans do not work. In the early 1990s, Medicare HMOs were touted as the way to control escalating costs, but by the end of the decade, private plans abandoned thousands of seniors in rural regions. Over the past couple of years, Medicare+Choice beneficiaries in metro areas have faced dramatic increases in premiums and co-payments, and reduced benefits. Given that the Republican Medicare bill does not guarantee a defined premium and plans will have substantial flexibility to create their drug benefit, millions of beneficiaries will face the same situation in the years to come.

Lastly, this bill forces us down a path towards privatization. By employing measures like the voucher-type premium support system and the creation of an overall budget cap, we end Medicare as we know it. Congress established Medicare to rescue seniors from the failure of the private sector to offer insurance or health coverage. Now we are going back.

This 600-page measure will produce the biggest change to our safety net system in over forty years. The crafting of the legislation was done behind closed doors with the help of special interest groups. Incredibly, most Members of Congress have had less than twenty-four hours to pore through the pages and analyze how the bill will truly impact America's seniors.

I understand there are important provisions in this bill for certain hospitals and providers such as increased Medicare reimbursement rates for physicians and an increase in the Medicare DSH cap for rural hospitals. I have supported similar measures in the past either by cosponsoring legislation or voting in support of such legislation.

However, there are also provisions in this bill that will hurt patients tremendously. The Medicare bill still contains drastic cuts to our nation's cancer care system. Despite several efforts by the cancer community to reach a compromise, the bill will deprive America's cancer care system of $1 billion a year. A cut like this will be devastating to cancer care. If this happens, many cancer centers will close, others will have to admit fewer patients, and still others will lay off oncology nurses and other critical support staff.

Mr. Speaker, I urge my colleagues to vote against this bill. I do not agree with those who say something is better than nothing. I say a bad bill is worse than no bill at all. This proposal goes against the fundamental principles of a program created to serve all seniors. Let's not give America's seniors more bad medicine. Reject the Republican plan and adopt one that provides real coverage for all seniors.

Mrs. TAUSCHER. Mr. Speaker, "I strongly believe that seniors deserve and need a prescription drug benefit that's part of Medicare. I believe we should strengthen Medicare by adding drug coverage that will save seniors money and preserve the choices that matter. I will vote against this bill because it does not get us where we need to be.

"This legislation prohibits Medicare from negotiating lower drug prices; gives big drug and insurance companies $82 billion in subsidies just to compete with Medicare; and will privatize Medicare by pushing seniors into HMOs.

"I introduced a bill that would have provided immediate, real drug discounts to all seniors without turning over part of Medicare to HMOs. Unfortunately, it was not brought to a vote.

"There are many serious problems with the bill being debated today that people are trying to sweep under the rug. Up to a quarter of seniors on Medicare would pay more for prescriptions than they do now. Up to seven million seniors would pay higher Medicare premiums unless they join an HMO and give up their choice of doctor. Two to three million retirees would lose the drug coverage provided by their former employers. Millions of seniors would go without drug coverage for parts of every year, even though they would be charged premiums year-around. Seniors would be prohibited from purchasing American-made drugs from Canada at lower prices. After they have spent $1,169 on prescription drugs, seniors will have to pay their full drug costs until they reach $3,600 in drug expenditures.

"I am deeply suspicious that this bill, written almost entirely by Republicans, put the special interests of HMOs and pharmaceutical companies over seniors' interests. It will give $82 billion to private insurance companies so they can compete with Medicare, yet Medicare will be forbidden from negotiating lower drug prices with drug companies and competing in the same way. Even AARP has a financial stake in this bill. The company derives almost 60% of its annual revenue from selling insurance products. If they capture even 10% of the prescription drug market, their profits would be $1.5 billion.

"As a former investment banker, I know risk management. The magic of Medicare is that everyone has always been in the pool—the wealthy and healthy as well as sick and lower-income seniors. This bill will turn that on its head—driving the healthy and wealthy out of Medicare and creating large tidal pools in which sick and lower-income people are left without anything.

"It is a bad bill that will hurt millions of seniors and not really benefit anyone but the drug and insurance companies. I will vote against it, and I encourage all of my colleagues to stand up for seniors and do the same."

Mr. HOLT. Mr. Speaker, I rise in opposition to this legislation.

As my constituents in central New Jersey know, I have been working ever since I came to Congress to provide Medicare beneficiaries with coverage for the prescription drugs that improve their quality of life and often save or extend lives. Today we are considering a bill that purports to provide such coverage, but unfortunately fails on several counts.

I have pledged to the seniors in my district that I will not support any legislation that undermines Medicare, a program that has succeeded in providing adequate health care to tens of millions of seniors for nearly 40 years. That is why I cannot and will not support the proposal that is before us. We can do much better, and with something this important, we should not get it wrong.

First and foremost, this legislation would devastate the Medicare program. It forces several million seniors into private plans and lays the groundwork for privatizing the traditional fee-for-service program. In New Jersey alone, an estimated 186,000 seniors will be affected. We need to strengthen Medicare with a drug benefit, not use prescription drug coverage as a mechanism for dismantling the entire program. It is simply not good policy to spend $12 billion of taxpayers' money just to set up a for-profit competitor to Medicare.

Second, even after the government spends all this money, seniors will not even get a very good benefit. It is true that any level of assistance will be of some help to seniors, but the gap in coverage under this bill will leave most seniors still paying thousands of dollars out-of-pocket. In fact, seniors with high drug costs must pay over $4,000 to receive $5,100 worth of medications. For many seniors, after August or September or whenever their drug bills reach $2,250, they would get no benefit—even though they would continue to pay their monthly premiums.

Third, this bill clearly undermines the universal nature of the Medicare program. Everyone, no matter what his or her income level, pays Medicare payroll taxes, and everyone is entitled to an equal benefit. But under this legislation, many low-income seniors would be subject to an assets test to see if they qualify for low-income subsidies. I know seniors in my district will be up in arms when they hear they have to send in bank statements or declare the value of things they own, potentially even having to sell some to get the benefit.

This bill is also bad news for the 220,000 seniors who currently receive prescription drug coverage through New Jersey's highly successful Prescription Drug Assistance for the Aged and Disabled (PAAD) program. While the bill will allow the state to receive Medicare funds for its PAAD spending, it also means that seniors will not receive their prescription drugs in the same simple, reliable way they did under PAAD. Seniors may find themselves limited to a list of approved drugs and face other restrictions not imposed by PAAD.

The bill also fails our physicians and other health care providers. While it purports to solve the problem of insufficient reimbursements, it actually offers little more than a Band-Aid. Two years of a 1.5 percent increase will provide some small measure of relief, but Congress must still address the long-term problems inherent in the current physician payment system.

Health care providers should also be alarmed by the provision that triggers an automatic congressional procedure once general revenues make up an arbitrary proportion of Medicare spending. This means that a few years down the road, providers may find themselves facing drastically insufficient reimbursement levels, and seniors will find themselves with fewer benefits and fewer doctors willing to accept Medicare patients. One editorial writer noted that the spending trigger would sound an alarm if Medicare spending exceeds certain levels, but the bill itself does almost nothing to control spending.

This bill fails our seniors, and unfortunately, it will fail the test of history. We have a historic opportunity to craft a bill that genuinely helps seniors afford the medicine they need. Sadly, the Republican leadership has decided to write a bill that privatizes Medicare, moves seniors into managed care plans, leaves gaping holes in coverage, and puts current retirees' benefits in jeopardy. I will not support such a plan.

I urge the Congress to address this again in January. I firmly believe we can pass a bipartisan prescription drug benefit that is universal, voluntary, dependable, and affordable, if we make the choices that put seniors first.

Mr. SKELTON. Mr. Speaker, there is no truer indication of a nation's priorities than the investment it makes in the health of its citizens, particularly our senior citizens. Medicare was created nearly 40 years ago with a basic fundamental principle in mind: health care coverage should be guaranteed, affordable, and equitable to all seniors. Throughout the time I have been privileged to serve in Congress, I have worked to make sure Medicare remains strong for those currently benefitting from its coverage and for those who will rely upon its benefits in the years ahead. As a member of the Rural Health Care Coalition, I was pleased when the administration and congressional leadership announced earlier this year that providing a prescription drug program within the reliable Medicare system was a high priority for the 108th Congress. However, it has become clear throughout the year that efforts to provide a meaningful prescription drug benefit within Medicare were being undermined by a systematic attempt to destroy the Medicare program. I am disappointed that the bill before us today, H.R. 1, does just that, undermining the very foundation of Medicare while creating a confusing and inadequate prescription drug coverage program for rural Missouri's seniors.

As I visit with seniors throughout Missouri's Fourth Congressional District, it remains clear that they depend on Medicare for their health care. They understand Medicare and trust it cannot be taken from them. Medicare is part of a health care contract with the senior citizens who brought this Nation out of the Depression, fought in our wars, and paid into the Medicare trust fund so they would have health coverage when they need it most. Unfortunately, H.R. 1 seeks to destroy the Medicare system on which these Americans have depended for nearly 40 years. Under this bill, in just six short years, millions of senior citizens in America could be coerced out of Medicare and into private insurance plans that generally don't do business in rural America. While the drafters of this measure explain that these private plans are simply a demonstration project and seniors don't have to participate if they don't want to, once the door is open to privatizing this vital government program, I am afraid it will not be closed.

It is also troubling that if these so-called demonstration projects take root around the nation as H.R. 1 prescribes, seniors within Missouri could be paying very different prices for the exact same health care benefit. It would create a very confusing situation, where folks in Versailles could pay more than citizens of Blue Springs or Lamar for their health care needs. Show-Me State seniors trust Medicare because they know that everyone participating in this program will pay the same rate for their health care insurance no matter where they reside. H.R. 1 undermines this fundamental principle, which could create even more disparity in the health care coverage of rural Missourians.

In addition to undercutting Medicare, I am concerned that the prescription drug portion of H.R. 1 will negatively impact seniors living in rural Missouri. This measure would require Medicare beneficiaries who wish to receive the new prescription drug benefit to enroll in private drug plans which rarely operate in rural America. These plans would be run by large insurance companies that would likely charge different premiums for the same prescription drugs. As an added benefit to large insurance companies, H.R. 1 would provide them with a $12 billion taxpayer subsidy while creating a $2,800 gap in prescription drug coverage for seniors. According to an article published in The Wall Street Journal on November 18, 2003, "for the drug industry, the legislation is good news, at least in the short run." This is just plain wrong.

For rural Missourians, H.R. 1 would also impose an assets test on low-income seniors who earn below 150 percent of the federal poverty level. Seniors whose income falls within this financial threshold may be forced to either pay additional prescription drug costs if their assets—their car, their farm equipment, or their acreage, for example—total $10,000 per individual or $20,000 per couple, or sell their possessions to get cheaper pills. Many seniors in rural areas rely solely on their Social Security checks to get by each month and they should not be forced to sell their belongings or their property to qualify for a more comprehensive drug benefit.

While I am dismayed that the leadership of this Congress would work to dismantle Medicare through this legislation, I am pleased that conferees were able to address Medicare reimbursement rates for rural doctors and hospitals. Through the years, I have worked with my colleagues in the Congressional Rural Caucus to boost reimbursements to those who provide health care in rural America. In fact, time and time again on the House floor, I have voted to instruct the conferees writing the Medicare bill to abandon divisive ideas of privatization in order to provide more adequate reimbursement to rural providers. Unfortunately, these motions were defeated each time.

Mr. Speaker, senior citizens throughout Missouri understand and trust Medicare. They have worked all their lives, paid their taxes, and contributed to a system that takes care of their health care needs. Medicare is a contract with our seniors that should not be broken. That is why I will oppose H.R. 1 and urge all my colleagues to do the same.

In the days ahead, I look forward to working with my colleagues in a bipartisan manner to provide senior citizens with a real prescription drug benefit that strengthens Medicare.

Ms. CORRINE BROWN of Florida. Mr. Speaker, today the Republican party will finally do what it has been trying to do for 35 years, destroy Medicare.

Claude Pepper, my mentor on health care issues, the most well known advocate for seniors, a man who fought for years and years to strengthen Medicare and Social Security, would be rolling in his grave if he were here today.

This is a life and death issue for many of our senior citizens, and this hollow bill does nothing for them.

A snake is a snake, no matter what color it is. And AARP is getting into bed with a snake, the Republican party, in supporting this bill. To the AARP leadership, I have some sage advice that my Grandmother used to tell me: "Those who sleep with dogs, wake up with fleas".

Each provision in this bill is one more nail in the coffin of a program that has guaranteed health care for this Nation's seniors for 38 years. Under the Republican plan, HMO's that offer an alternative to Medicare will pick and choose their customers, and get paid more than Medicare to do it. And yes folks, these are the same Plus Choice providers that are fleeing your districts in droves, and leaving your seniors with absolutely no healthcare options.

Even more disturbing is the fact that this bill prohibits, yes, prohibits, Medicare from using its bargaining power to cut drug prices.

What happened in the 2000 election is a U.S.A. coup d'etat. This is what happens when you don't have fair elections. Folks, it matters who is in the White House. This is entirely a Republican initiative, and their goal is to destroy Social Security and Medicare entirely. Their goals is not to modernize it, but to have it wither on the vine.

Mr. STRICKLAND. Mr. Speaker, today, this Congress is missing a golden opportunity to pass a real prescription drug benefit for all seniors. During the Energy and Commerce Committee's consideration of the prescription drug bill this summer, my colleagues and I offered many amendments that would have improved this bill to ensure that all seniors, regardless of where they live, have access to an adequate, affordable, reliable prescription drug benefit. But my Republican colleagues defeated our amendments and pushed through a partisan bill that will do little to give meaningful help to the middle income seniors who most need a prescription drug benefit.

In other words, Congress is passing up an opportunity to ensure that the retired, 68-year-old steelworker who had a heart surgery last spring and lost his retiree health insurance this summer, and who, along with his wife, has an annual income of about $28,000 can afford the prescription drugs they need to stay healthy. This bill does not even ensure that a person under these circumstances can access affordable prescription drugs from Canada or elsewhere in the world. For shame that we are passing up such an opportunity to do the right thing by our seniors.

The AARP says that the prescription drug bill we are considering today is better than nothing, that it's one foot in the door. I disagree. The voucher demonstration program in the bill lays dangerous groundwork for a privatization scheme that I believe will undermine Medicare's ability to provide a guarantee of health security for all Americans when they turn 65. In addition, the drug benefit created by this bill will force many seniors to private insurance plans for their drug benefit. My colleagues who support this bill say that seniors want "choice" and that the private plans will give them the choice they want. Well, the seniors I talk to want choice, but not choice of a private plan. Instead, they want choice of their doctor, pharmacist, and hospital; they want the ability to choose their treatment plan when they are sick and the choice to access preventive services to keep them as healthy as possible. If seniors in my district have the choice of a private plan, the Medicare safety net as we know it today is no longer there. This is especially true since the bill we are considering tonight doesn't require these private plans to offer a standard premium, deductible, or copayment—in fact, where these private plans have been tried, monthly premiums have ranged as high as $85 a month, not the $35 promised by proponents of this bill. I cannot overstate this: the bill we are voting on does not mandate a $35 premium.

Additionally, this bill includes a $12 billion slush fund to bribe private HMOs to participate in Medicare. This $12 billion is in addition to about $8 billion in huge overpayments to private plans. I believe that the billions we are spending in this bill in payments to private plans are simply to support an ideology of privatization that seeks eventually to destroy Medicare. This ideology is needless when you consider that traditional Medicare has both a strong track record with seniors and the amazingly low administrative overhead cost of only 2 to 3 percent.

It is for all of these reasons that I cannot support this bill. However, it does include some good provisions that I wish I could vote for today. I wholeheartedly support the physician and hospital provisions, particularly for rural providers. For the last 2 years, doctors have faced significant scheduled cuts in their Medicare reimbursements, leading some to stop-taking new Medicare patients or drop out of the program altogether. Especially in the current environment of high malpractice rates, rising medical school costs and medical school debt, rising overhall health care costs, and a growing Medicare population, it is unacceptable for Congress to ask doctors to continue providing the same care for less money. And our rural hospitals are struggling to maintain their ability to serve as our health care safety net for the uninsured. Seniors depend on a strong network of physicians and hospitals to provide care; each time a physician decides he or she cannot afford to take new Medicare patients, seniors are forced to look elsewhere to find care. This is particularly troubling in rural areas, where there are fewer physicians and where it may be more difficult to travel to a doctor's office.

I realize how important these provider provisions are, and I would say to the doctors and hospital advocates who are asking me to vote yes tonight that it is unfair to hold their needed reimbursement increases hostage in a bill that includes so many controversial provisions. We can and should pass a provider reimbursement bill apart from this Medicare package. In fact, I hope that we can defeat this Medicare bill and immediately pass these provider increases in a stand alone bill before we leave this session.

In closing, I reiterate my support for adding a strong, adequate prescription drug benefit to Medicare. Seniors need such a benefit and Medicare is not a complete health insurance program without it. But the benefit before us tonight does more harm than good, particularly in the long term. I urge my colleagues to vote no.

Mr. SERRANO. Mr. Speaker, I rise in strong opposition to the conference report on H.R. 1, the Republicans' Medicare "reform" bill. On procedure and on substance, the legislation is deeply flawed and the best course now would be to start all over and work toward a bipartisan package that truly provides benefits to our elderly and disabled Medicare participants.

Others have eloquently expressed the reasons to oppose this legislation, so I will not take much time to repeat what has been said. But I will quickly mention the major flaws.

This enterprise was meant to help seniors and the disabled get the prescriptions they need at affordable prices, but that's certainly not where it is ending up. This bill both increases the burden on seniors and lays the groundwork for taking Medicare apart altogether.

Coverage is limited and complicated, and there is a huge "donut hole" in coverage that, when combined with premiums, deductibles and copayments, can leave seniors paying up to $4,000 of the first $5,000 of prescription expenses as well as paying premiums but receiving no benefits for part of the year. Worse, dual eligibles, the Medicare beneficiaries who are poor enough also to be eligible for Medicaid, will end up worse off under an all-Medicare regime.

Drug prices in this country are high and rising fast, keeping even seniors with drug coverage through their employers facing difficult choices between medicines and other necessities. But the bill before us explicitly prohibits the Federal government from negotiating lower prices for Medicare beneficiaries. It also ignores the will of most Members of Congress who support reimportation of prescription drugs from Canada and other select countries. What a windfall for the pharmaceutical companies!

Millions of retirees who now have coverage through their former employers may end up without it when the bill's incentives cause employers to drop retiree health benefits.

The premium support demonstrations present insurers with the opportunity to cherry-pick healthier, wealthier beneficiaries, leaving Medicare covering the high-cost sicker and poorer elderly and disabled, which would force fewer beneficiaries to pay higher premiums until Medicare became unaffordable and unsustainable.

There are many other reasons to oppose this conference report. Let me just note that it does not include the Senate provision to remove the 5-year bar on federal health benefits for legal immigrant children and pregnant women.

The Republicans have not been shy about announcing their intention to dismantle the Medicare program, and this bill is a major step down that path.

Mr. Speaker, this is a profoundly bad bill that should go back to the drawing board. As the National Committee to Preserve Social Security and Medicare wrote to Members yesterday ". . . a bad bill is worse than no bill at all".

Mr. Speaker, I urge my colleagues to vote "no."

Mr. MORAN of Virginia. Mr. Speaker, I rise in opposition to the Medicare prescription drug benefit conference report that the House is scheduled to consider today.

I want to make it clear that I strongly support a Medicare prescription drug benefit for our nation's seniors and am supportive of a universal, affordable, voluntary and guaranteed Medicare prescription benefit for all.

Unarguably, the enactment of the Medicare program in 1965 was one of the wisest things Congress has ever done. At that time, there were very few prescription drugs with wide applicability, and that is why Medicare did not cover prescription drugs.

In large part, because of Medicare and Social Security, we have raised the life expectancy of our citizens, lifted millions of Americans out of poverty, and vastly increased the quality of life for our nation's senior citizens.

Unfortunately, this conference report does not reflect the vision and ideals of Medicare set forth by President Johnson and Congress, and will, if passed and signed into law, harm the 57,000 seniors that reside in my congressional district and millions of other seniors in America.

It had been my hope that any expansion of the Medicare program to include a prescription drug benefit would be above partisan politics. We have all heard first-hand from seniors how the high prices of their prescription drugs negatively impact their already limited incomes.

This issue which cuts across political lines should be about what's in the collective interest of our nation's seniors.

Unfortunately, this debate on one of the most important domestic issues, which not only affects today's seniors, but future generations as well, did not rise above partisan politics or enhance our democratic process.

In a decade, 10,000 people a day will turn 65 years old and with the retirement of the Baby Boom generation, America's senior population will almost double.

This conference report provides a weak prescription drug benefit for all seniors—regardless of income, and will change the Medicare program as we currently know it, by overpaying private insurance companies to administer this drug benefit, while giving them great latitude in setting premiums, deductibles, and pharmacy choice with little oversight through a premium support system.

One of the reasons why I voted against the House version of the Medicare Prescription Drug and Modernization Act of 2003 (H.R. 1) was that Medicare beneficiaries would pay 20% of their drug costs up to $2,000 and 100% of drug costs from $2,000 to $3,500, while still subjecting them to monthly premiums that would result in a gap of prescription drug coverage for most beneficiaries.

The coverage gap that exists in this conference report is even worse. Seniors will pay 100% of costs between $2,250 and $5,100—a gap of $2,800 which will be increased to over $5,000 by the year 2013.

I also cannot support a conference report that does nothing to alleviate the high costs of drugs imposed on seniors. This conference report actually prohibits the Secretary of the Health and Human Services from negotiating lower drug prices with the bargaining clout of the 40 million Medicare beneficiaries as well as the importation of drugs from countries where drug prices are lower, except Canada and only if they are certified by the Food and Drug Administration.

While I am pleased that this Congress has finally addressed the issue of reimbursement rates for doctors, hospitals, and other important health providers, I am discouraged that this conference report is still a bad deal for our seniors, and the endorsement of this legislation by the AARP, comes into question. The AARP is not recognizing its membership's need and desire for a true Medicare prescription drug benefit without the heavy reliance on the private health insurance industry.

It is with great sadness that I will have to vote no on this conference report. My constituents want a legitimate Medicare prescription drug benefit, lower drug prices and better Medicare services.

This conference report undermines the Medicare system, and I am afraid, will do more harm in the long run than good in the short term for our seniors.

Mr. ETHERIDGE. Mr. Speaker, I rise in opposition to H.R. 1. As the Representative of North Carolina's 2nd District, I know firsthand how hard our older people have to struggle to pay for their prescription medicines. Since I began my service in the people's House in 1997, I have worked to create a prescription medicine benefit for our seniors. Seniors deserve a guaranteed Medicare prescription medicine benefit, not empty promises. I have consistently supported a prescription medicine benefit plan that features low, predictable premiums and allows seniors to obtain medicine from any doctor they choose. And I want seniors to be able to get their medicine from the local pharmacy, not some huge mail order company.

I oppose H.R. 1 because it does not deliver on its promises. This bill will force 73,000 Medicare beneficiaries in North Carolina to lose their retiree health benefits entirely and leave thousands more with significantly reduced benefits. According to the nonpartisan Congressional Research Service of the Library of Congress, this bill will force 222,800 Medicaid beneficiaries in North Carolina to pay more for the prescription medicines they need. Under this bill 99,500 fewer seniors in North Carolina will qualify for low-income protections than under the Senate bill because of the assets test and lower qualifying income levels. This provision will hit particularly hard the many farmers in North Carolina whose farm equipment and land are considered financial assets even if the farmers' income is below the poverty line. Also according to CRS, under this bill, 37,920 Medicare beneficiaries in North Carolina will pay more for Part B premiums because of income relating. And according to the CMS Actuary Tables, the premium variation under the bill's premium support program would range form $1,225 in some parts of North Carolina to $675 in other areas of the state. The bill contains a huge hole in coverage which will result in no benefit at all for seniors with prescription costs between $2,200 and $5,044.

I oppose H.R. 1 because this bill will have devastating economic consequences because the $400 billion price tag will be added directly to our massive national debt of $6.8 trillion. A few short years ago, we had achieved surpluses as far as the eye could see and were on pace to erase the national debt. But this Administration's tax policies have produced record budget deficits that will be compounded by the conference report on H.R. 1. Deficits matter for our current economy because in creased borrowing means the government has to spend more and more tax money on interest costs and will have less available for other important priorities. "For example, even before this bill passage, this year the federal government will pay $156 billion for interest on the national debt. That is three times what the federal government will spend on education. When I asked a White House representative where the money will come from to pay for this bill, I was told that it is "new money." This is not new money. These are borrowed funds that will be paid for by our grandchildren and their grandchildren.

Mr. Speaker, prior to holding elected office, I spent nearly twenty years as a small businessman. There can be no doubt that I strangely support the private sector. But there are some things the private sector does well and some things the private sector does not do well. Medicare was created because the private sector by itself does not do well at the important priority of providing a strong public health system for older Americans. This bill is a $400 billion ticket back to the days when senior citizens were forced to fend for themselves in the private health care marketplace. This bill sacrifices Medicare as we know it, and will cast senior citizens to the mercy of HMOs and force them to give up their own doctors and pharmacists.

Congress should reject this flawed bill and go back to the drawing board and get it right once and for all for our seniors. I urge my colleagues to vote "no" on the Republican Medicare Privatization bill.

Mr. EVANS. Mr. Speaker, this has been a disappointing week in Washington for seniors around the country. Not only are we voting on a bill that provides a meager prescription drug benefit through Medicare, but the once-regarded AARP has apparently put their profit margins before the health of the seniors by endorsing this Republican Prescription Drug bill.

There are so many disturbing provisions in this bill that I will only take the time to mention a couple.

This bill explicitly prohibits the Secretary of Health and Human Services from negotiating lower drug prices on behalf of America's 40 million Medicare beneficiaries. With my support, the Veterans' Administration adopted this practice some time ago, and the VA enjoys the ability to negotiate drug prices for numbers of veterans. This restriction on the Secretary of Health and Human Services clearly crimps efforts to keep prices down for seniors.

Another troubling provision is the "demonstration project" in this bill that coerces seniors out of the traditional Medicare program they know and enjoy to sign on with an HMO. Up to 7 million seniors may be forced to choose between staying in Medicare and purchasing a likely expensive drug-only plan from a private insurer or leaving their trusted doctors to join an HMO or other plan that would provide Medicare-like benefits including drug coverage. This is hardly a choice for our nation's greatest generation.

As our healthcare delivery system moves increasingly toward managed care, many people have expressed concerns about the care they receive from HMOs. Today it is frighteningly common for insurance companies, rather than doctors, to make the medical decisions that affect people's lives. As these concerns are aired, we are ready to throw our seniors into this lion's den. Until doctors are free to give the best medical advice based on a patient's need, not an insurance company's bottom line, our seniors are better served by traditional Medicare. While others have let HMO reform legislation die away, I still believe that we need to address these concerns, and they should be addressed before seniors are coerced into the system.

This debate has been fundamentally changed from one focused on providing seniors with a solid prescription drug benefit to defending the integrity of one of America's finest programs, Medicare. I have been part of the Democratic fight for years to add a meaning drug benefit for our nation's seniors, but I will not be a part of destroying a vital program that seniors have trusted for almost 40 years to settle for inadequate drug coverage. I strongly urge my colleagues to reject this bad bill.

Ms. SOLIS. Mr. Speaker, in 1965, Congress created Medicare and promised seniors that after a lifetime of working and paying into the system they would have access to health care coverage during their retirement years, regardless of where they live, their age or their income. Thirty-eight years later, instead of honoring our commitment to affordable, accessible health care for all seniors, Congress is set to create a prescription drug benefit program that will destroy Medicare as we know it and turn it over to the unreliable for-profit insurance industry.

A Medicare prescription drug bill should use the purchasing power of our nation's seniors to negotiate lower prescription drug costs, just as we do for veterans now, and it should provide assistance to low-income seniors who need extra help in their retirement years. Our hard working seniors and their families expect a high quality, affordable, universal and guaranteed prescription drug benefit within their trusted Medicare program.

Unfortunately, the Republican plan dismantles Medicare as we know it by turning it into a voucher system with private HMOs competing with the traditional Medicare system. Under this system, seniors who want to stay with the traditional Medicare system they trust would face premiums that could vary dramatically across the nation. Premiums for traditional Medicare in the Los Angeles area could be as much as $1,700 per year—119% more than seniors in other parts of California.

This bill is especially troubling for retirees who have health benefits through a former employer. I have received dozens of calls and letters from retirees concerned about the Medicare proposal's impact on the prescription drug coverage they have through a former employer. Well, under the Republican bill an estimated 244,860 Medicare beneficiaries in California will lose their retiree health benefits because the bill does not sufficiently stem the tide of employers reducing or dropping their retiree health coverage.

Nearly 6,000 seniors in my district are living below the poverty level, so I am especially troubled about what this bill will mean for low-income seniors struggling to pay for the medicines they need. The bill will increase drug costs for six million elderly and disabled Medicaid beneficiaries by imposing co-payments on their prescription drugs and prohibiting Medicaid from filling in the gaps of the new Medicare benefit. It is shameful that this bill would harm our most vulnerable seniors.

The supporters of this bill talk about the funding it provides for disproportionate share hospital (DSH) payments to hospitals that serve a high number of indigent patients and for improved Medicare payments to physicians. I have a strong record of supporting DSH funding, which is critical to protecting California's safety not hospitals. I have also long supported fixing the flaws in the Medicare physician payment system in order to help doctors who serve elderly patients, and recently voted to increase physician payments. It is important to note that the Democratic Medicare prescription drug proposal would have done substantially more to help doctors and hospitals than the bill before us today.

I would like to take a moment to comment on AARP's endorsement of the bill. AARP claims to represent the needs of seniors throughout the country, but I can tell you that the seniors I represent are upset that AARP has chosen to endorse this wrong-headed bill that doesn't even meet the criteria they set back in July. I encourage seniors to continue to contact their lawmakers and let them know their views on this Medicare bill.

Let's be clear—the endeavor to make prescription drugs more accessible for seniors began as a bipartisan effort to modernize Medicare for our new era. Now it has turned into a fight for the soul of Medicare. I am tremendously disappointed that my Republican colleagues have chosen to reward the private insurance companies and big pharmaceutical industry at the expense of seniors. However, I will continue my efforts to ensure that seniors have access to the medicines they need.

Mr. REYES. Mr. Speaker, it is with great regret that I rise in opposition to the conference report on the Medicare Prescription Drug and Modernization Act of 2003.

I regret that I must do so, because I have long been a strong advocate for providing America's senior citizens with an affordable, comprehensive prescription drug benefit under Medicare. Unfortunately, however, the bill before us today would harm rather than help the more than 77,500 Medicare beneficiaries in El Paso County, Texas, which I represent, and millions of others like them across the country.

For example, instead of a comprehensive, continuous prescription drug benefit, the bill offers a benefit that has a $2,800 gap in coverage that will leave about half of Medicare beneficiaries without any prescription drug coverage for part of the year, even though they will still be paying monthly premiums. While without coverage, many Medicare beneficiaries in my district will have to pay the entire cost of their prescription drugs out of their own pockets, which is the very circumstance we are supposed to be remedying.

Rather than doing more to help low-income seniors, this bill fails to ensure that they will receive the prescription drugs they need under the proposed new program. The bill would, for the first time, prohibit federal Medicaid funding from being used to pay for drugs not paid for by Medicare. In Texas alone, it is estimated that 389,400 Medicaid beneficiaries would pay more for their prescription medications under the bill. In my congressional district, where approximately one in five people over age 65 lives below the poverty line, this change could be devastating.

At the same time, the bill requires states to make large annual payments to the federal government, offsetting the savings states would have realized by having the federal government provide drug coverage for low-income seniors under Medicare. In short, for the first time ever states will have to fund a federal Medicare benefit, at a time when my state of Texas and many other states are facing budget troubles.

Insteaad of expanding re-importation of prescription drugs, with appropriate safety checks, the bill blocks re-importation. By doing so, it ensures that Americans will continue to subsidize low drug prices in other countries, while paying the highest drug prices in the world here at home.

Rather than empowering Medicare with the authority to use its purchasing power to negotiate better drug prices, as the Veterans Administration currently does, the bill specifically prohibits Medicare from doing so. As a result, the pharmaceutical companies benefit, but hard-working taxpayer will have to foot the bill for the higher costs.

Perhaps most troubling, the bill puts us on a path toward privatizing the entire Medicare system, breaking our government's solemn promise to America's senior citizens to provide guaranteed, quality healthcare under Medicare. Two generations of seniors have relied on Medicare and Social Security to ensure their quality of life in their retirement years. For many poor seniors in my district, these programs are their only safety net. To jeopardize that safety net would be unconscionable.

This bill, with all its shortcomings, will cost the American people nearly $400 billion over the next decade. It does include a few provisions that I strongly support and have voted in favor of repeatedly—most notably provisions providing increased Medicare reimbursement rates for healthcare providers and funding to reimburse local governments and emergency medical providers for providing care to undocumented immigrants. However, the bill would do such significant harm to Medicare recipients and the Medicare program that, on balance, I find that I cannot support the legislation.

Mr. Speaker, I urge my colleagues to oppose this conference report, so Congress can instead offer America's seniors that kind of Medicare prescription drug benefit they desperately need and truly deserve.

Mr. BACA. Mr. Speaker, I rise in opposition of the Republican Conference Report on H.R. 1.

I oppose this Republican plan because it is bad for seniors. It's bad for California. And it's simply bad for the American people.

There are 40 million seniors across this Nation that need a safe and reliable healthcare plan that protects them, whether they are sick or not.

This plan will not help seniors. This is a $400 billion plan that will privatize care and cost seniors more than they pay now.

This plan is similar to having car insurance that doesn't really protect you. You're fine as long as you don't get into an accident.

Seniors are only fine under this plan if they don't get sick. But because of privatization, when a senior gets sick, this plan offers no guarantee that their premium will stay the same or that their carrier will continue to cover them.

Under Medicare, seniors at least had a guarantee that they would be insured. They at least had a guarantee that if they got sick; someone would be looking out for them.

Under this plan, privatization could force as many as 7 million seniors into HMO's. Seven million. How is this fixing Medicare? Who is this guaranteeing that all seniors have coverage?

Our parents and grandparents deserve better. They do not need privatization. They need to know they are going to be insured.

They need to know that they are going to be protected despite the cost.

Under this plan, there is a $2,800 gap that will leave millions of seniors without drug coverage. This plan leaves seniors uninsured for part of the year despite the fact that they are paying premiums.

Much like car insurance, if you knew your car wasn't going to be insured for half of the year, you wouldn't drive it.

But we can't do that with our health. Seniors can't say I just won't get sick. It doesn't work that way.

In my district of San Bernardino, California, we have seniors who board buses to travel down to Tijuana to purchase life saving prescription drugs.

Will this plan help the seniors in my district get off that bus?

No. If we pass this bill, seniors will still have to travel to Mexico to get their prescriptions.

The practice of forcing seniors to go across the border must stop. We have no way of knowing what our seniors are actually purchasing. This isn't safe and it isn't fair.

This bill could actually raise the cost of prescription drugs for over 6 million low-income seniors, and one in six Hispanics. In my home state of California, almost 900,000 will have to pay more.

Those are the people in my district. Those are the people that are risking their lives, going across the border, to purchase their prescriptions. And this bill does nothing to help them.

The Republicans are ignoring what seniors need.

Under this plan, over 3 million low-income seniors are going to be forced to pass a test before they get help paying for prescription drugs.

If you are a senior and you simply own a home, a car, or even a burial plot you could be considered too wealthy to get help with prescription drugs, under this plan.

If you are a homeowner, you'd better catch the bus for Tijuana because that is the only way you will be able to afford your prescription drugs because the Republicans think that you are too wealthy.

Many seniors in my district have worked hard their entire lives trying to put food on the table for their families. Many of them have been fortunate enough to have some health coverage from their employers.

Under this plan, 3 million retirees could lose that coverage. That affects over 250,000 seniors alone in California.

This plan leaves the seniors in my district will no option but privatized healthcare.

Our abuelos, our grandparents, have worked too long and too hard to be ignored.

They need a prescription drug coverage that preserves traditional Medicare, helps low-income seniors afford prescription drugs and keeps retirees in employer sponsored health plans.

It's time to give seniors what they want, what they need, and what they deserve.

Mr. OSBORNE. Mr. Speaker, I rise in support of H.R. 1, the Medicare Prescription Drug, Improvement and Modernization Act.

Today, this House will consider landmark legislation to help our Nation's seniors afford their prescription medications. I am particularly pleased with the generous assistance this legislation provides for the low-income seniors in my district.

Those seniors with incomes below 135 percent of poverty (individuals with incomes under $12,123 and couples under $16,362) will be eligible for a prescription drug discount card that immediately applies $600 annually toward the purchase of their medicines and covers up to 90 percent of their prescription drug costs. Seniors with incomes between 135 and 150 percent of the federal poverty level ($12,123–$13,470 for individuals and $16,632–$18,180 for couples) could ultimately have 85% of their drug costs covered.

Beginning in 2006, seniors without coverage would have the option to join a Medicare plan that requires a $35 monthly premium and would cut seniors' yearly drug costs roughly in half. For example, a senior without any drug coverage and monthly drug costs of $200 would save more than $1,700 each year. Seniors with no drug coverage and monthly drug costs of $800 would save nearly $5,900 on drug costs each year. In addition, seniors would be protected against high out-of-pockets costs with Medicare covering as much as 95% of drug costs over $3,600 each year.

Mr. Speaker, this legislation also provides a historic opportunity to help strengthen the rural health care delivery system with billions of dollars in additional Medicare payments. For far too long, Medicare has short-changed rural health care providers in my district, which threatens seniors' access to care. This legislation eliminates many of the disparities that exist between rural and urban physicians, hospitals, and other health care providers.

Finally, this bill includes important cost-containment provisions. These accounting safeguards will alert future Congresses and Presidents if the expenditures of the entire Medicare program exceed 45 percent of total Medicare spending so they can address the problem.

This may not be a perfect bill, but it is a good bill, and I urge my colleagues to support the Medicare conference report.

Mr. KANJORSKI. Mr. Speaker, I rise today to speak about the conference report on H.R. 1, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. While I wholeheartedly support providing a prescription drug benefit to our Nation's seniors, I cannot support this bill in its current form because it does more harm than good.

Since the House of Representatives first began debating the creation of a prescription drug benefit for Medicare recipients, I have consistently maintained that this proposal must adhere to four key principles to garner my support. In my view, we must create a benefit that is affordable, easy to administer, nationally available, and comprehensive. I believe that the bill crafted by the conference committee falls short on all counts.

In addition, there are many other provisions folded into this bill that will substantially alter the Medicare system as we know it. These provisions would privatize the program, cause millions of seniors to lose their prescription drug coverage through their employers, and result in insufficient reimbursements for some Medicare providers. These ill-crafted proposals also influenced my decision to vote against this bill.

AFFORDABLE PRESCRIPTION DRUGS

In working to create a prescription drug benefit, we must ensure that the plan is affordable for Medicare participants. The benefit that is outlined in this legislation, however, will provide little relief for the senior citizens in my district. Because the plan requires sizable premiums, deductibles and copayments, seniors can still expect to pay between 50 and 80 percent of the cost of their prescriptions. This bill also creates a gap in coverage that will leave millions of seniors with drug costs between $2,250 and $3,600 without any benefit, even though they continue to pay premiums. While some may conclude that this is a good start to providing a prescription drug benefit, I disagree. We must do more to make prescription drugs affordable.

Seniors across the country, and especially in my district, cannot afford to pay thousands of dollars each year in prescription drug costs. Those seniors living on fixed incomes must already sacrifice on other necessities in order to afford their costly medications. These seniors need immediate relief and this legislation will not provide that help. In addition to the cost-sharing provisions of this bill, the benefit does not even go into effect for another two years. In the interim, seniors will receive a discount drug card that will provide only minimal relief.

This legislation also purports to protect low-income senior citizens. Individuals at the poverty level will not pay premiums under the program and will have copayments of only $1 to $3 for each prescription. In addition, for individuals slightly above the poverty level, assistance with premiums and the deductible will be available. These individuals, however, will be subject to an assets test. Individuals must have less than $6,000 in assets to receive the benefit while married couples must have less than $9,000 in assets. Therefore, any low-income senior who owns a home, a car, or any other large asset will not be eligible for this financial assistance. In my view, we should not force senior citizens to choose between selling their homes and getting their prescription drugs.

In addition, this legislation does nothing to address the high cost of prescription drugs. Under the current bill, there is no methodology for insurance companies to negotiate for lower drug prices. If the program were administered through Medicare, the Government could negotiate with the pharmaceutical companies for lower, more affordable prices because the program would cover a larger number of seniors.

Furthermore, with my support, the House recently passed legislation that would allow for the reimportation of prescription drugs from 24 foreign countries. These medications are often the same as those sold in the United States. They are, however, sold at a much lower price. Unfortunately, this legislation provides only for the reimportation of drugs from Canada and requires that the U.S. Food and Drug Administration certify that the reimportation of drugs is safe. While this may seem like progress, it is not. The Food and Drug Administration has already indicated its unwillingness to consider such a certification. Consequently, this legislative sleight of hand on drug reimportation will not increase the availability of affordable prescription drugs in the United States.

EASE IN ADMINISTRATION

A Medicare prescription drug plan must also be easy to administer. The proposal before us fails to meet this standard. This plan will create a complicated system of payments and programs. As a result, it will be difficult to administer.

In particular, senior citizens should not have to worry about whether the amount of money they spend on prescriptions during the year will leave them paying the whole amount of their drug costs at some point during the year as this bill does. Seniors who annually spend more than $2,250 for prescription drugs will find themselves without any coverage at all for a portion of the year. In order to remain in the program, however, these seniors will need to continue to pay the monthly premium, whether the program provides assistance or not.

Such a system will create confusion for seniors. This benefit should provide a sense of security for the elderly, who are used to receiving their benefits through the Medicare program. Instead, this complicated program will only serve to provide older Americans with more worries about their health care needs.

NATIONWIDE AVAILABILITY

An effective Medicare prescription drug plan must also be available nationwide. By making the benefit available through private insurance companies, there is no way to ensure that benefits will be equal across the country. in an area like Northeastern Pennsylvania, this scheme would have a devastating effect. By moving towards privatization, areas like mine would be disadvantaged because insurance companies would not be enticed to operate there. Northeastern Pennsylvania has a higher concentration of older residents than most areas in the country, and insurance companies will not want to operate in our area because they would not find it profitable, unless they charge exorbitant premiums. As a result, the government fallback provision would engage, but it would still result in these seniors paying more than those in other areas across the country.

We have tried such a scheme before. In 1997, we created the Medicare+Choice program. This failed experiment operated in Northeastern Pennsylvania for awhile. Initially, this program provided tens of thousands of seniors in our area with prescription drug benefits. Insurance companies, however, discovered that they could not make a profit because of the economics of the region. As a result, they abandoned the program, leaving thousands of senior citizens without affordable prescription drugs once again. By providing a prescription drug benefit through private insurance companies, we can expect this legislation to result in a similar outcome for Northeastern Pennsylvanians.

In addition, this faulty Medicare plan already anticipates that there will be a problem with providing prescriptions through private plans in areas like Northeastern Pennsylvania. Included in the bill is a provision to set aside $12 billion to pay insurance incentives to provide the prescription drug benefit. One must ask why, if we already anticipate the failure of the program, we are not considering alternatives, such as adding the benefit through Medicare.

COMPREHENSIVE BENEFITS

Finally, a prescription drug program must be comprehensive. Under a government program, seniors should have access to any drug prescribed by their doctor and the program should cover the costs of that drug. This bill, however, establishes a limited list of categories and classes of drugs, and only these drugs will be covered under the program. Hence, this exclusion will leave many seniors to cover more costly medications and experimental treatments out of their own pockets.

PRIVATIZATION OF MEDICARE

In addition to the prescription drug coverage, there are other changes made to "reform" Medicare by this legislation. If passed, for example, this legislation would put in place a radical system to privatize Medicare.

For example, rather than providing a prescription drug benefit through the current

Medicare system, it will, as I have previously noted, instead be offered through private insurance companies, which can profit from their participation in the prescription drug program. Once the system is in place it will be difficult to go back and make the necessary changes to make the prescription drug benefit affordable, easy to administer, available nationwide, and comprehensive. Earlier this year, I supported the Democratic version of this legislation that would have provided prescription drugs through Medicare and achieved these objectives. We should be considering that bill today.

This bill will also change the way the current Medicare program is run and move it towards a total privatization of the benefits Americans have worked their whole lives for and have come to depend on in their golden years. In 2010, this legislation would create a premium support demonstration program. This program would require seniors to enroll in a private plan and would provide a voucher for the cost of the insurance premiums. In addition, this bill would break the country into sections, providing different benefits in each. Therefore, the amount of money a person in Northeastern Pennsylvania pays could be substantially higher than the amount paid by a senior living in another part of the country.

In my view, this program will move the country on the slippery slope towards the total privatization of Medicare. Rather than providing health care benefits to senior citizens that are guaranteed, money would instead be provided to insurance companies to support seniors in a private program. We should not allow Medicare to wither on the vine. There is also no reason to believe that other benefits, such as Social Security, would not also eventually be privatized if we begin to privatize Medicare now.

PROVIDER ISSUES

This prescription drug bill also seeks to increase Medicare payment to physicians and hospitals. I must acknowledge that some of the provisions in this bill would provide relief to the doctors and hospitals in my area. In particular, the bill's provision altering the weight given to labor costs when determining the reimbursement rate for an area would provide millions of dollars to the hospitals in my district. In addition, physicians who are anticipating a 4.5 percent cut in their payment through Medicare would instead receive a 1.5 percent increase. Further, this bill provides additional funding for rural hospitals and for teaching hospitals.

For hospitals like the ones in my district, this legislation provides only minimal relief and these changes should not be used as a justification for voting for this bill. As one hospital administrator in my district said, "If you are dying of thirst in a desert, even a drop of water looks good." Rather than providing a band-aid fix to these hospitals experiencing genuine financial difficulties, we should have worked to equalize reimbursements across the country.

In addition, there are portions, of this bill that will have severe impacts on the providers in my district. For example, the legislation provides for a system to competitive bidding for durable medical equipment to begin in 2007. This change in the program will have a devastating effect on the numerous small- and medium-sized medical equipment providers in my district. The competitive bidding system will cause a race to the bottom, resulting in cost cutting measures like layoffs and the loss of services provided for users of durable medical equipment.

RETIREE COVERAGE REDUCED

Beyond privatizing Medicare, this legislation will result in millions of retirees losing their employer-sponsored drug coverage, dealing an irreversible blow to the employer-based system that is the backbone of our Nation's health care system. Employer-sponsored retiree health benefits are the single greatest source of drug coverage for retirees, providing benefits to one in three Medicare beneficiaries. They also generally offer the best coverage available—generous benefits and low-cost sharing.

The Congressional Budget Office, however, projects that 2.7 million seniors in employer-based retiree plans will lose the coverage they have today due to the discriminatory treatment of seniors with retiree coverage in this legislation. As a result, those individuals would be forced into the flawed prescription drug program outlined in this measure. Men and women who have worked their whole lives with knowledge that they will have health and prescription drug benefits in their retirement should not be forced into a program that could leave them with inadequate benefits.

CLOSING

In sum, I cannot support this legislation. It falls short of providing seniors with an affordable, widely available, easily administered, and comprehensive prescription drug benefit. It will privatize the program and it will result in millions of retirees losing coverage through their former employers. Ultimately, this legislation will hurt senior citizens more than it will help them. We should do better for Americans in their golden years by defeating this bill and drafting a new one.

Mr. PASTOR. Mr. Speaker, I strongly support efforts to give prescription drug coverage to the Medicare patients who do not currently have it. But, this bill does a poor job of meeting our prescription drug needs, and it drastically and negatively alters the overall structure of the Medicare program.

We have the ability to give Medicare patients prescription drug coverage. But our hands have been tied by the arbitrary budget limits Congress has set on funding such a program.

Congress and the President decided that, over the next 10 years, $400 billion was all we could spend on helping the elderly who need prescription drugs. So, in order to meet this number, a prescription drug bill has been written that will prove inadequate for meeting the basic needs of today's senior citizens while proving itself a champion at destroying health care for the senior citizens of the future.

Simply put, Mr. Speaker, this bill is no longer about prescription drug coverage. It is about ending traditional Medicare coverage.

I oppose this bill for several specific reasons.

First, the bill will do little to alleviate significant out-of-pocket costs for most senior citizens. A senior who spends $2,200 a year, less than $200 a month, on prescription drugs, will be required to pay almost $1,200 for this coverage and the drugs. A senior spending $3,500 a year on prescription drugs will be forced to pay almost $2,500 out of his pocket. That is 70 percent of the total drug costs. While this bill provides some help, I fear it will not be enough to keep the poorest of our elderly from making the difficult choices between buying medicine and groceries.

I am also opposing this bill because, in essence, it is designed to privatize Medicare. The "demonstration" projects to be established in six areas of the country, the so-called Premium Support Program, is nothing more than a first step toward complete privatization. The authors of this bill hope that more and more people will forego traditional Medicare for cheaper private HMOs with less overall choice and coverage. In fact, the private insurance companies would receive billions of dollars in subsidies for luring patients away from the traditional program. We all know that the private insurance companies will only accept the healthiest of patients, leaving the sickest patients in traditional Medicare. This, in turn, would result in higher costs for traditional Medicare because it would serve a sicker population.

Additionally, I am opposing this plan because it will mean that a good portion of the 75 percent of Medicare patients who already have prescription drug coverage, many through former employers, will be dropped from their current plan and forced into a more expensive plan with less coverage. In hopes of avoiding that event, this bill is paying a tremendous subsidy to keep these companies from dumping their beneficiaries.

So, this bill provides billions and billions of dollars to private companies to help them lure senior citizens away from traditional Medicare and to continue to provide prescription drug coverage to former employees.

There is some disconnect here. As Robert Robb, the noted Arizona Republic conservative columnist writes, "Congress is proposing to subsidize private drug plans that are currently being offered at no cost to taxpayers, in order to offer taxpayer-financed drug coverage to seniors that Congress hopes they won't take." He continues, "See what I mean about being sort of stupid."

Mr. Robb and I rarely agree on issues. But he has hit this nail right on the head.

A more logical solution might be to take these subsidies and use them to simply pay for prescription drugs for those who don't currently have coverage.

Mr. Speaker, I say, let's give prescription drug coverage to the senior citizens who need it. We could do that, in a fair and meaningful way. We only need the desire to do so. But, let's not hurt the seniors who have coverage, and all those in future generations, by passing this ill-advised legislation. We have the opportunity to do something good and important. Yet, the drafters of this bill have taken it as an opportunity to change the Medicare program so drastically that it can only prove devastating to this country's older population. Let's reject this bill and force ourselves to set aside partisan ideologies and help the current and future senior citizens of this great land.

Mr. BLUMENAUER. Mr. Speaker, our senior citizens need help with spiraling drug costs. It is outrageous that moderate income seniors pay the highest prescription drug prices in the world. The idea was to fix this problem, but somewhere along the line, the bill was hijacked by the Republican leadership for other purposes. I can't remember how many of my Republican colleagues have told me that they think this is a bad bill. From the Wall Street Journal to consumer advocates, thoughtful conservatives to people who classify themselves as very liberal, all find this bill deeply flawed.

Spending what's claimed to be $400 billion, but will actually entail far more cost to the Treasury, and the unprecedented pressure and advertising may pass this bill. The fascinating reversal of position by the leadership of the AARP gives a public relations boost, but that move has already been attacked by its own members.

The authors of this bill are putting something in for almost everybody: not just the drug companies, but doctors, hospitals, insurance companies, and so on, but ignoring the fundamental needs of senior citizens. As over a thousand pages come into focus, details leak out and are investigated by outside groups, the press, even Members of Congress, it is clear the bill still does not meet the needs of our seniors. After all the dust settles, our senior citizens will still pay out of their pockets the highest drug prices in the world.

There's something wrong when the only people who appear to be happy with the Medicare Prescription Drug bill are the drug companies. They were able to strip out provisions that would have allowed reimportation of cheaper drugs from Canada. It will be illegal for the government to negotiate lower prices for Medicare recipients. Future price increases will not be indexed to inflation, but to the rate of runaway drug costs, ensuring that spending will continue to spiral out of control.

For the drug companies, the holidays may come a little early this year. Sadly, deserving senior citizens who need help won't even get this inadequate drug plan until 2006. Told that even in 2006, they will have to pay $4,000 of their first $5,100 of drug costs, they'll feel that they didn't get a present. I will vote against the conference report.

Ms. JACKSON-LEE of Texas. Mr. Speaker, this is about as ugly as it gets. Just when I thought the Republican Leadership could not work any harder to undermine the Democratic process, to abuse their power, and to play politics with critical issues at the expense of the American people—they have just taken it to a higher, or should I say lower level. Call it what you will. The Alliance for Retired Americans calls the Republican drug bill a lemon. Others call it a rotten turkey. Whatever it is, it sure isn't medicine for the American seniors who need it.

When Medicare was founded in 1965, U.S. Government formed a covenant with the people, and said, "If you work hard and pay your share, we will make sure that you have access to health care when you retire." Modern medicine has made great strides over the past decades at managing health problems, not just through surgery and hospitalizations, but also with pharmaceutical drugs developed through great research at the National Institutes of Health, and in pharmaceutical companies here and around the world. These drugs can lead to dramatic improvements in quality of life, by helping Americans live longer, more comfortable, more productive lives.

As great visionaries Lyndon Johnson and the Members of Congress designed Medicare, however, they did not predict that prescription drugs would revolutionize medicine, and therefore they did not include drug coverage in Medicare. Medicine has changed, but the promise that the U.S. Government made to the American people has not. It is time for Medicare to change with the times. It is time to do the right thing and create a real prescription drug benefit for our Nation's seniors in Medicare.

I, with my Democratic colleagues, have been fighting day after day to make that happen. We have gone to the people of this Nation, and to our academics, and health care providers and developed bold plans to get people the medicine they need. We had developed great momentum and help might have been on the way. The problem is that ever since the times of Newt Gingrich, the Republican dream has been to privatize or destroy Medicare. That is why the Republican plan is a risky scheme only an HMO could love.

The Bush administration's Medicare Administrator has called traditional Medicare dumb and a disaster, highlighting Republicans' hatred for a program that Democrats have been fighting for since 1965. While Democrats have worked to modernize Medicare with prescription drugs, preventive care and other new benefits, Republicans are insisting on a riskier course even the conservative Wall Street Journal calls a business and social experiment.

When this process first began, and the President and the House and Senate leaders proclaimed that they intended to produce a prescription drug plan, my Democratic colleagues and I tried to give them the benefit of the doubt. We tried to work in a bipartisan fashion. At one point, I wrote a letter to the Members of the House-Senate Conference Committee and encouraged them to include fair provisions for our physicians and hospitals, so that they would be able to afford to continue providing excellent care for our seniors. I am pleased to say that they did respond to that request, and have put in some funds for those deserving groups. But that is where the collaborations ended. I wish that they could take the handful of good pieces in this bill and move them as separate legislation—the reimbursement pieces I asked for, the rural health provisions, the Hatch-Waxman Reforms—but they won't. These good things are being held hostage to leverage passage of a terrible bill.

Ultimately, the core mission of this bill is to provide prescription drugs to seniors and the disabled on Medicare. On that, this bill fails horribly. The Democrats on the Conference Committee, among them, had decades of experience in the field of health policy. No one could question their commitment to helping seniors, but in a deeply cynical move by Republican leadership, Democrats were barred from even entering conference meetings. That is against everything our Founding Fathers intended this "People's House" to be. We got our first glimpse of this bill just over 24 hours ago. Even in our haste to get it read, we have found numerous flaws and pitfalls in it. In 2006, if it is allowed to come into effect, I am sure our seniors will find many more.

Instead of merely blocking our ideas, as they have done for years, they hijacked this issue and in the name of a prescription drug bill, they are trying to shove a piece of legislation through Congress that will destroy Medicare as we know it. It privatizes Medicare, pushing seniors into HMOs and private insurance plans expecting them to do what is right for seniors. And we know from Medicare+Choice, that we cannot count on that. In one year alone, 46 percent of Medicare beneficiaries in Houston were chopped out of HMOs. Switching plans every year jeopardizes health and wastes time and money. The Republicans have invented new gimmicks like artificial caps on spending, and buzzwords, like "premium support" instead of what it really is a "voucher" system to replace Medicare in 2010.

It is a misdirected attempt, with a terrible benefit—with a giant doughnut hole in coverage. And as bad as the benefit package is—even it is not guaranteed. The entire system is just basically a guideline that Republicans hope and pray insurance companies will follow, and develop drug plans for seniors.

It seems like at this point, we might say, "well money is tight, so let's just take what we can get, and be happy with this bill." But the conference report that we are now finally getting a glimpse of is so bad, it would actually leave millions of senior citizens worse off than they were without it. And as doctors say in the Hippocratic Oath, the most important rule in healthcare is do no harm.

Furthermore, there is no rush to pass this bill. The Republican authors conveniently made their plan kick in in 2006, well after the Presidential elections of 2004. Obviously, they don't want seniors to go to the polls furious when they realize how bad this plan is. The point is, we can wait until spring and do this job right—and still make their 2006 timeline.

AARP used to agree with us on every point I am making, but in a bizarre twist, this week the group, that supposedly represents the interests of our Nation's seniors declared that they would support this lousy bill. I was mystified by this until I learned that, according to a study done by Public Citizen that AARP will make an extra $1.56 billion in profits if this bill goes through. AARP is in the insurance business, and has become too tied to that industry and the Republican leadership. They have breached the trust of the American seniors, and seniors are angry. It is a sad turn of events.

With the measly Republican benefit, the average senior will actually be paying more for their prescription drugs a year after the bill kicks in, than they are paying now. And as every senior knows, it has a giant donut hole in the benefit plan, where seniors have to pay every nickel for their medications—thousands of dollars—while they keep paying premiums. This is tragic for seniors on fixed incomes, and it will be an administrative nightmare for pharmacies. It is a gimmick to compensate for the fact that the Republican administration has squandered and mismanaged our economy to a point that now they say we have no money to fund critical programs.

It seems that at every turn, the people who need our help are getting the short end of the stick. Minorities, who already suffer from tremendous disparities in health and health care, are left behind. While this bill gives a giant gift to the drug and insurance industries and other special interests, it does little to reverse those life-threatening disparities. My Democratic colleagues and I, in both the House and Senate, all came together recently and put forth the Healthcare Equality and Accountability Act of 2003. Our bill is the kind of thoughtful and comprehensive approach that healthcare deserves. One provision I wrote will create a Center for Cultural and Linguistic Competence to help every American take advantage of the health revolution that is upon us. The Republican Medicare bill seems to have the opposite goal.

For example, this conference report does not contain the Legal Immigrant Children's Health Improvement Act (ICHIA), included in the Senate Medicare bill, which would have removed the 5-year bar on Federal health benefits for legal immigrant pregnant women and children. While these children and pregnant women may still get emergency medical care, States are unable to cover this population with basic medical services that may reduce the need for such emergency care. This unnecessarily increases the cost to taxpayers.

Hispanics are the largest minority group in the United States, and it's estimated that by 2025, Hispanics will account for 18 percent of the elderly population. Currently, one in six Hispanics seniors live under the poverty level. For these Americans, an increase in prescription drug payments or doctor's visits could mean disaster. Houston has a strong Hispanic population, and therefore my district will be hit especially hard by this bill.

And there is more bad news for Texas. 132,300 Medicare beneficiaries in Texas will lose their retiree health benefits. 389,400 Medicaid beneficiaries in Texas will pay more for the prescription drugs they need. 209,000 fewer seniors in Texas will qualify for low-income protections than under the Senate bill because of the assets test and lower qualifying income levels. 97,420 Medicare beneficiaries in Texas will pay more for Part B premiums because of income relating.

When we look at the health care system for our seniors in the United States today, we see two undisputable facts. One is that Medicare is an excellent program that seniors trust, and that delivers quality care at a fair price to those who pay in. The other is that drug costs are out of control and need to be brought down.

The Republican bill preserves the bad, the high cost of drugs—and it dismantles the good—Medicare.

Americans pay about twice as much for drugs as people do in other rich countries in the world—Canada, Germany, England, Japan. This is outrageous, since many of those drugs were developed here, by our workers, trained in our universities, funded by our National Institutes of Health. Our seniors deserve to get the same prices as they get across the border in Canada. The reason they don't is because the Canadian government negotiates with the drug companies, and says "Hey, there are 30 million of us in Canada buying your products, give us a fair price." Both the Republican bill forbids the Secretary of Health and Human Services from bargaining on behalf of the 40 million seniors on Medicare. That is outrageous, especially considering how well such negotiations have worked at the Veterans Administration. This bill is a gift to the pharmaceutical industry and HMOs and the insurance industry.

This bill really is the epitome of just how bad partisanship and political demagoguery can get. Trying to pass it before Thanksgiving is a cruel—and expensive—joke on our seniors on Medicare. I don't want to do that to Houston. Let's don't do that to America.

I will vote against this bill, and keep fighting to get this done right.

Mrs. CHRISTENSEN. Mr. Speaker, I have listened to the debate tonight, and I think everyone agrees that some seniors and disabled would benefit by this bill. But if truth be told, many would lose, which is not what we set out to do—we need and promised a bill that provides a prescription drug benefit for all Medicare beneficiaries, not just a few.

What is clear and why we should oppose this bill, is that if passed it would sound the death-knell for Medicare.

We must insist that the Republicans provide funding to shore up our rural hospitals. We must insist that the Republican leadership not only increase the physician payments this fiscal year, but fix the formula, so that the payments won't be cut again next year.

But what we must not do, is let this divide and conquer tactic make us pass a bill that would do more harm than good and physicians and hospitals should not allow themselves to be used to dismantle the very program they and the patients they are sworn to serve, depend on for the long run.

With a few crumbs to seniors and the disabled, and playing on the dire need of hospitals and doctors, this bill is nothing more than another corporate give-away.

We can afford to vote this bill down, start again, with an inclusive process—the benefit doesn't start for two years anyway. What we cannot afford to do and must not do is to kill Medicare; we must vote no on H.R. 1.

Mrs. KELLY. Mr. Speaker, I rise in support of this important legislation. The Medicare Prescription Drug and Modernization Act will provide prescription drugs to seniors, and provide additional money for doctors and hospitals, both of which are the front line in providing health care.

I am particularly pleased with provisions in the bill which seek to provide financial assistance to hospitals currently experiencing difficulties with inadequate wage index reimbursement rates. And I am encouraged by the potential this bill holds for assisting hospitals in the Hudson Valley which are adversely affected by their proximity to the New York City Metropolitan Statistical Area (MSA).

I would also like to direct my colleagues' attention to an aspect of this legislation which perhaps hasn't received a great deal of attention, and that's the provision that creates Health Savings Accounts.

For years we have been concerned about the many people in this country who have no health insurance. Many of the uninsured are small business owners or employees who simply cannot afford health insurance. With the Health Savings Accounts established in this bill, the small business owner can not only save tax free money for health care, but offer tax free health care money to their employees.

Think of it. Now, because of Health Savings Accounts, the owners of small businesses across the country can make contributions—tax free contributions—to their employees.

Money in these accounts can be used for insurance premiums or spent directly on medical care. This means many more people can buy coverage. For the first time, health care will be more accessible to the millions of small businesses in this country.

This is a powerful tool for empowering working Americans who deserve to control important decisions over their own medical care.

Mr. NUSSLE. Mr. Speaker, I rise today to support a long overdue, welcome victory for Iowa's seniors and health care providers.

Medicare's policies have penalized health care providers in Iowa and other rural areas since the 1960s. While Medicare's primary purpose is to provide health care for seniors, its policies affect both our health care system and our economy. The flawed policies have had an impact not only on seniors, but on all Iowans.

As many of my House colleagues know, I have worked long and hard to address the problems affecting health care providers in rural states such as Iowa. In fact, I wrote this year's budget to reserve significant resources for rural health care as part of a $400 billion Medicare Reserve Fund. Later, in the Ways and Means Committee, I successfully amended the Medicare legislation to ensure that sufficient rural health care funds were included in the bill that was reported from committee. And I continued fighting on the House floor to ensure that these funds—the most generous rural package ever considered by the House—remained in the Medicare legislation as it worked its way through the House.

Today, we are considering a conference report that carries this rural health care package to the end of the process. The benefits for Iowa will be multiplied for years to come. This conference report contains an unprecedented $25 billion rural package including benefits of over $400 million for Iowa alone. I am proud to have worked toward this day with the distinguished chairman of the House Ways and Means Committee and with the senior Senator from my home state of Iowa.

With these significant strides to improve Medicare's reimbursement policies on Iowa's behalf, we help our health care providers to pay the bills and to continue recruiting and retaining top-notch professionals. With a more secure health care system in place, we can further job creation and economic growth for our state.

In addition to taking several steps to strengthen the overall program, we are, of course, finally giving seniors what they have sought since Medicare's inception in 1965—a prescription drug benefit that is affordable, accessible and completely voluntary. All seniors will save on their current prescription drug costs.

Another important feature in the bill is the provision to establish Health Savings Accounts (HSAs). These accounts will allow pre-retirees to accumulate tax-free savings over their lifetime and these savings will remain with the individual once they reach Medicare eligibility. Even with reforms such as these, I want to remind my colleagues that Medicare will still face long-term demographic pressures and Congress will likely have to take additional steps to address the program's sustainability.

Finally, as Chairman of the Budget Committee, I am pleased that the Medicare conference report—with a total cost of around $395 billion—is generally consistent with the $400 billion Medicare Reserve Fund that was laid out in this year's budget resolution. In a year of intense demands for limited government resources, this Medicare Reserve Fund was the largest policy initiative in the budget resolution and was arguably its centerpiece. Because the budget resolution struck a responsible balance between seniors' needs on the one hand and affordability on the other, we were able to generally stay within our own guidelines. I commend the conferees for staying within the $400 billion threshold.

Mr. Speaker, I have been spreading the word and twisting arms for a long time on behalf of legislation that would meet Iowa's health care needs. I am gratified that our message has been received and our persistence has paid off.

Mr. CAMP. Mr. Speaker, I rise in support of H.R. 1.

In the last five days, I've heard a lot about what this bill doesn't do. Let me be frank: life is not about what we don't do; it's about what we accomplish.

And, if I had a friend in need who asked me for $100 and all I had was $20, I wouldn't give him nothing. But that's what some here are prepared to do—turn away a friend in need.

For years we have agreed that our seniors needed a prescription drug benefit in Medicare; but unfortunately we have yet to provide them with any relief.

This Medicare bill offers a prescription drug benefit through competing private health insurance plans—marking the first time private sector plans and consumer choice would be the principal vehicle for delivering Medicare benefits. It also includes common sense reforms like preventive care and health savings accounts.

This is the first step in the direction of true reform. It's a step in the right direction and it is time we take it.

Mr. ORTIZ. Mr. Speaker, Congress created Medicare in 1965 to make healthcare affordable and available for all senior citizens. My colleagues and I have fought to maintain this original intent.

Today, the leaders in Congress are pushing dangerous legislation—called Medicare reform—on South Texas seniors that fails to include an adequate prescription drug benefit while privatizing Medicare, killing the program at the end of the decade.

This prescription drug "coverage" is not what seniors expect or deserve. When seniors have more than $2,200 in drugs costs, they will hit a gap, where Medicare will no longer cover the costs of their prescriptions until they reach $5,000.

When this happens, these seniors will be forced to pay 100% out of their own pockets while still paying monthly premiums. Meanwhile, their HMOs will select their doctors and their pharmacies.

Over 185 organizations with an interest in seniors' issues are wholly opposed to this bill. While one of the largest senior organizations has lent support to this bill (The American Association of Retired Persons, AARP), it is the only one to do so . . . it is the only one that provides insurance to seniors at a profit of $635 million . . . and the only one poised to take advantage of billions of dollars in the bill to entice private insurers to cover seniors.

The bill effectively ends drug reimportation by allowing the Secretary of Health and Human Services (HHS) to decide what prescriptions could be reimported. The HHS Secretary has already said he would allow none.

If this is not the answer, what is? I stand on my record, voting 8 times for a complete Medicare Rx drug plan . . . voting 6 times and co-sponsoring 6 bills supporting higher reimbursements to doctors and hospitals . . . voting 6 times not to kill Medicare . . . and voting 8 times and co-sponsoring 3 bills to improve rural healthcare.

Nothing in this bill makes prescription drugs cheaper. Other Federal programs, such as the Veteran's Administration, get cheap drugs negotiating directly with the big drug companies. The plan will keep the government from negotiating for lower drug prices for Medicare beneficiaries.

This plan protects the profits of drug manufactures instead of providing real savings to seniors. Rising drug prices are unaddressed in this bill, a victory for the drug industry for preventing any attempts to lower drug prices.

Meanwhile, the value of some seniors' property will be used to determine their level of coverage—including jewelry, cars, and other property of value for which they worked their entire lives.

In South Texas, for the short term anyway, the bill (which would not take effect until 2006) would help only about 30% of low-income seniors. Effectively, that means this bill will not help over two-thirds of our most needly seniors.

When I think about the seniors that bill will affect, I think of the ladies who took care of me as I grew up of Robstown, Texas. Life for them revolves around family and children, paying the bills and finding health care in their senior years.

These are the people affected by the bill, which ends Medicare as we know it, privatizing the entire progrm by the end of the decade. It is thousands of South Texans like these who have raised voices in opposition to this bill. I stand with them.

Medicare has been a trust between the government and those who do the hard work in our society, our senior citizens. Too many seniors depend on Medicare for their healthcare needs, and I will not support a bill that destroys that trust.

Mr. LARSON of Connecticut. Mr. Speaker, I rise today in opposition to H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003. Some may claim that this legislation is the answer to the high prices seniors are paying for their prescription drugs. That is far from true. The reality is that this legislation is a Medicare privatization plan masquerading as a prescription drug relief bill. The big winners in this bill are not the seniors that desperately need relief, but pharmaceutical companies and big business.

Does this conference report strengthen the Medicare program that seniors know and trust? The answer is no. It includes a premium support demonstration project that is the first step towards forcing all seniors to choose private insurers to get the prescription drug benefit they need, or to pay more to stay in the traditional Medicare program. This bill having any effect at all is contingent upon the willingness of HMOs and insurance companies to participate, and the track record does not paint a positive outlook. We in Connecticut remember HMOs pulling out of Medicare Plus Choice plans because they simply could not make a profit.

Does this conference report allow the Government to negotiate the costs of prescription drugs and provide relief to seniors? The answer is no. The bill specifically prohibits the Secretary of Health and Human Services from leveraging the tremendous buying power of the Federal Government to negotiate lower drug prices for 40 million Medicare recipients, a system the VA currently uses.

Does this conference report allow reimportation of drugs from other industrialized nations so that seniors will be able to purchase less expensive drugs? The answer is no. It ignores the reimportation measure that this House passed this summer and places the decision in the hands of health officials who have vocally opposed reimportation.

Does this conference report help low-income seniors who need help the most? The answer is no. First, the proposal actually reduces coverage for the 6.4 million lowest-income and sickest beneficiaries who qualify for Medicaid today. It prohibits Medicaid from helping these beneficiaries with copayments or from paying for prescription drugs not on the formularies of the private insurers administering the new Medicare benefits. It also leaves behind 3.9 million seniors that would have qualified under the Senate bill. One reason for this is the imposition of an invasive assets test. This means that seniors with modest savings will not receive any assistance with the cost of their premiums, the deductible, copayments, or the cost of the medications while they are in the $2,850 coverage gap.

Does this conference report help cancer patients? The answer is no. It falls well short of the drug and practice reimbursements needed to provide millions of cancer patients with the care they need.

Will this conference report prevent employers from dropping health insurance for their retirees? The answer is no. Though incentives were added to encourage employers to maintain their retiree plans, the Congressional Budget Office estimates 2.7 million retirees will lose the existing coverage they rely upon and countless others may have their benefits reduced. Furthermore, it does nothing to protect retired teachers, firefighters, police officers, State and local government employees, and those who worked for nonprofit organizations.

Does this conference report help the hospitals and doctors struggling to meet the needs of their patients? The answer, surprisingly, is yes. It provides an increase in the Medicare Disproportionate Share Hospital cap for rural hospitals and urban hospitals with fewer than 100 beds. It increases payments for indirect medical education that would provide increased funding for the twenty Connecticut hospitals that have medical education programs. Also, it eliminates the 4.2% reduction in payments to physicians in 2004 and replaces it with a 1.5% increase for the next two years. These provisions are positive. But, this was intended to be a prescription drug relief bill and these positives are by far outweighed by the negatives of this legislation.

So, who are the winners in this conference report? The answer is pharmaceutical companies. They will receive the majority of the $400 billion that this legislation will cost. But, even better for them, they will not be forced to lower their prices. The Government will not be allowed to negotiate prices and seniors will not be allowed to purchase imported drugs from other industrialized nations. Apparently, the industry's army of lobbyists and $22 million in campaign contributions were effective.

Who are the losers? The answer is seniors, the ones this bill was meant to assist. They asked for prescription drug relief and we are trying to give them a Medicare privatization bill. That is why I urge my colleagues to join me in voting against this conference report.

Mr. UDALL of New Mexico. Mr. Speaker, I rise today with great disappointment in the conference agreement that has been brought to the floor. I sincerely hoped that the bill that passed the House in July would have been moderated with provisions included in the other chamber's bill.

Unfortunately, instead of considering legislation today that would have modernized the Medicare program to provide prescription drug cost relief and coverage for seniors throughout this great nation, we have this agreement that is geared toward dismantling one of the most successful government programs ever implemented. Instead of considering legislation to modernize the Medicare formulas to fix the inequities between rural and urban areas, we are considering an agreement that wraps these crucial fixes in with a prescription drug benefit that is designed to achieve the ideologically extreme goal of privatizing Medicare.

Mr. Speaker, I will certainly admit that the provider package included in this agreement is excellent. For years doctors, hospital administrators, and other health care providers have suffered under the unfair Medicare formulas that severely hampered their ability to provide care to Medicare beneficiaries. The labor share revision, the geographic physician payment adjustment, increasing home health services furnished in rural areas, critical access hospital improvements—these are all incredibly important provisions that I strongly support in order to help strengthen the health care system in rural areas. I also support fixing the inequitable disproportionate share formula, which is done to a degree in this agreement. Unfortunately, however, the conference agreement removes language that would have given New Mexico a larger increase of DSH payments to $45 million. The physician fee formula update is another provision that is incredibly important. Without this fix, physicians will have no other choice but to stop seeing Medicare beneficiaries, which will lead to the total breakdown of a system that is already badly strained to its limits.

I recognize the importance of these provisions. I understand the difficulties that those in the health care industry are facing. I understand the difficulties seniors are facing in trying to purchase and pay for their medications. That is why I have cosponsored legislation to fix the disproportionate share provisions, I have cosponsored legislation to fix the Medicare physician payment updates, I have written letters supporting these provisions and urging Chairman Thomas to include these rural fixes in the legislation, I have written a letter to conferees asking them to retain this provisions, and, when this bill passed in July, I voted in favor of the Democratic alternative that not only included stronger rural provisions than those included in the Majority's bill, but also contained a real prescription drug benefit—not a benefit engineered to bring about the demise of the Medicare program.

Mr. Speaker, lets be clear about what our goal was supposed to be. We were supposed to create a new prescription drug benefit in Medicare. That's what we were supposed to be doing with this important legislation.

Unfortunately, we are doing much more than that, and a lot of it is terrible. We were supposed to be reducing the costs of drugs for seniors. Yet this plan prohibits the federal government from using its clout to force down the price of medicine.

We were supposed to help seniors keep their current drug coverage if they are fortunate enough to have it. Yet this plan may force up to three million seniors out of their current employer-based plans.

We were supposed to be strengthening the Medicare program by adding a voluntary benefit for prescription drug coverage. Yet this plan, under the guise of a premium support demonstration, weakens the Medicare program by forcing beneficiaries to pay more for Medicare if they don't give up their doctor and join an HMO.

We were supposed to help low-income seniors who get additional assistance from Medicaid afford their prescriptions. Yet this plan not only forces 6 million low-income seniors to pay more for their medications, but also imposes an unfair assets test that disqualifies seniors if they have modest savings.

We were supposed to be providing a prescription drug benefit that would ease the cost and emotional burden seniors face in dealing with medication purchases. Yet this plan leaves millions of seniors without drug coverage for part of the year due to the $2800 gap in coverage.

Mr. Speaker, I am extremely disappointed with this agreement. I am disappointed because what should have been a straightforward approach took a wrong-turn along the way. I think this is a terrible way to spend $400 million dollars on a supposed prescription drug benefit, and I will be forced to vote against this measure. I urge my colleagues to reject this shameless assault on Medicare.

Mr. STUPAK. Mr. Speaker, I rise today in opposition to this Medicare bill with limited prescription drug coverage.

This plan is bad for America's seniors and especially bad for rural areas like Northern Michigan, which I represent.

Medicare should be a right—this Republican Medicare bill threatens to undercut this right and destroy a program that seniors have trusted for nearly 40 years.

For most seniors, the prescription drug plan does not begin until 2006 while the Democrats' plan would have begun next year.

The Republican plan has a gap in prescription coverage the size of the Upper Peninsula. This gap starts at $2,250 and goes on until you hit $5,100.

We should be giving our seniors a real prescription benefit not one that gives you part-time coverage.

Illnesses and diseases do not take time off—you're not sick part of the time—seniors need full prescription drug coverage now.

Those seniors who now have coverage may lose it—CBO estimates that up to 3 million could lose their existing prescription drug coverage.

I cannot support a bill that will undercut our seniors' right to Medicare.

While Congress provides universal health coverage for Iraq that includes full prescription drug coverage—seniors in America will receive part-time prescription drug coverage but pay 100 percent of the costs.

Vote "no" on this ill-conceived bill.

Mr. DAVIS of Illinois. Mr. Speaker, I have heard my colleagues describe the prescription drug plan as "not perfect" and a "step in the right direction." However, this legislation is neither. Our seniors will not gain better health coverage or a prescription drug benefit that is affordable. Instead the CBO estimates that approximately 2–3 million seniors, 107,000 alone in my state of Illinois, who currently have drug coverage from their employer, will lost that coverage. This bill lowers Medicare's assistance to the employers making it unaffordable to keep their retirees' coverage. The new cap on general revenue spending will cause reductions in provider reimbursement rates, higher out of pocket cost, or even raise the payroll tax—once again passing the buck along to future generations. Worst of all for our senior consumers, we do not even allow the Secretary of HHS to negotiate lower drug prices for them.

I am disappointed in this House for turning its backs on fulfilling our promise to seniors, but I am extremely disappointed that we are completely abandoning our Nation's most needy—our Nation's poor seniors. We are expecting our States to pay the Federal Government 90 percent of the cost of drugs for our low-income seniors. During a time when States are already faced with large debts and complicated decisions on what to cut next—how do we expect the States to afford 90 percent of the cost of drugs for our poor seniors? An estimated 6.4 million low-income and disabled people will have significantly worse coverage under this new plan. It is probably because this bill actually prohibits Medicaid from helping with copayments or paying for prescription drugs that are not approved by the private insurers. This means that certain, needed medications that are currently covered by Medicaid will no longer be available to seniors. This plan does not even provide assistance for our seniors that are between 150 percent and 160 percent of the federal poverty line that is an annual income of $15,300 to approximately $17,850.

Mr. Speaker, no one is saying that we should give our seniors something for free.

But we are saying lets give them something that is fair, reasonable, and makes sense.

Mrs. BONO. Mr. Speaker, I rise in strong support of the Medicare Prescription Drug and Modernization Act of 2003. This has been a very long and cumbersome process; however, I believe that the American citizens will be pleased with what we have accomplished. I would particularly like to laud the accomplishments of the conferees who put in tireless hours crafting this monumental legislation.

More often than any other concern, I hear from the constituents of the 45th District regarding health care. They are legitimately frightened that without reform, they will lose their existing benefits and the standards of care to which they have become accustomed. The time had come to pass substantive legislation that will allow seniors to spend less money on prescription drugs and spend less time navigating through the red tape and paperwork.

This landmark legislation is responsive to the needs of our seniors and will allow access to affordable prescription drugs and improve health care to millions of our most needy senior citizens. This is the most generous package Congress has considered for rural and suburban health care giving seniors will have better access to doctors, hospitals and crucial treatment options, regardless of where they live. Additionally, this bill addresses the needs of the low income.

I am particularly proud that the bill includes the critical funding for relief from the drastic payment reductions in the Medicaid disproportionate share hospital (DSH) program. The provision will go a long way toward protecting California's fragile health care safety. The funding in the conference report will restore several hundred million dollars to safety-net providers in California over the next 10 years.

Safety net hospitals across the state of California, two of which are located in the 45th District in Moreno Valley and Indio, have had to absorb drastic reductions in Medicaid DSH funding at a time when demand for their services has been increasing. The additional funding will help ensure that services to the most vulnerable populations are available.

This bill represents a breakthrough in the nation's commitment to strengthen and expand health security for its citizens at a time when it is most needed. I rest assured knowing that our nation's future generations will continue to receive the highest level of health care available.

Mrs. BIGGERT. Mr. Speaker, no single piece of legislation is as important to meeting the health care needs of Americans as is the bill we will vote on shortly, the conference report to H.R. 1, the Medicare Modernization and Prescription Drug Act. I rise to express my strong support for this legislation.

Today is truly a momentous day. Finally, Medicare will catch up with the realities of twenty-first century medicine. When the program was first created in 1965, the majority of medical treatment was done in a hospital. This is reflected in Medicare's current generous hospitalization benefit and paltry prescription benefit.

Well, times have changed, to say the least. Today, life-saving medications are helping seniors stay out of the hospital and live longer, happier and more productive lives. But, as we all know, prescription drugs are expensive, and seniors too often are forced to cut back on other necessities to afford the medicine they need. Passage and enactment into law of this conference report will help to ensure that this never happens again.

Here's how it works.

Six months from now, seniors will begin to see the benefits. In April of 2004, any senior who wishes to have one will be issued a voluntary drug discount card that will save them 10 to 25 percent on their prescriptions. For low-income seniors, $600 automatically will be added to their cards to help them afford the drugs they need. The discount card will work like a supermarket discount card, giving users a discount at the time of the purchase.

Another very important benefit kicks in beginning in 2005, when all newly enrolled Medicare beneficiaries will be covered for an initial physical examination. At last, patients and physicians will have an early baseline that can signal if problems exist or what areas might need to be monitored more closely in the future.

All beneficiaries also will be covered for cardiovascular screening blood test, and those at risk will be covered for a diabetes screen. These new benefits can be used to screen Medicare beneficiaries for many illnesses and conditions that, if caught early, can be treated, managed, and can result in less serious health consequences.

And perhaps most importantly, beginning in 2006, for the very first time in the history of Medicare, seniors will have a prescription drug benefit. If they choose to participate, seniors would pay about $35 a month. Once they have met the $250 a year deductible, 75 percent of their drug costs will be covered up to $2,250. When drug costs exceed $3,600 a year, 95 percent of costs will be picked up by Medicare.

No matter where in the country they live, seniors will be able to choose between at least two prescription drug plans.

If seniors are happy with the coverage they now have—and many in my district are—they do not have to switch into a new plan. This new benefit is absolutely, completely, 100 percent voluntary.

But there is much, much more to this bill than a prescription drug benefit option for seniors. In fact, this bill can affect the health and welfare of every American citizen, no matter how young or old. How is this so?

Well, first, this bill will expand access to health care for everyone.

As you know, physicians who see Medicare beneficiaries are reimbursed for the extra cost of treating these patients. These payments are already woefully inadequate and physicians have been forced to stop taking on Medicare beneficiaries because they simply cannot afford to keep seeing them. Under current law, these reimbursements will be cut by an additional 4.5 percent next year.

I am very, very pleased that the conference report addresses this issue by reversing the scheduled cut and increasing the payments by 1.5 percent. This means that more doctors will be able to treat more seniors, and more seniors will have a choice of which doctors they see.

Hospitals also will be better off under this bill. The conference report provides increases in payments to teaching hospitals and increases funding for hospitals that treat a large number of Medicare patients. It also reimburses hospitals for the costs of using the most advanced technology. In short, the conference report ensures that hospitals can continue to care for Medicare beneficiaries.

Finally, this legislation encourages Americans of all ages to save for their own healthcare needs. The Health Savings Accounts—HSAs—will let people save money and accumulate interest—tax-free—in order to take care of health care premiums and other medical expenses.

HSAs are completely portable, so when people change jobs, they can take their accounts with them. Individuals also can make "catch-up" contributions to their accounts once they turn 55, and still enjoy the tax benefits.

These accounts will help thousands of individuals who do not have access to health insurance—or who wish to augment their coverage—to better afford it.

Our seniors have worked hard throughout their lives. They should be enjoying their golden years, not worring about how to pay for their life-sustaining medicines. This legislation will go a long way in helping them get back to the business of enjoying life.

Drug discount cards, baseline physical examinations, prescription drug coverage, and disease screenings are just a few of the great new features that will help seniors stay healthy.

Health savings accounts and improved levels of physician and hospital reimbursements will go a long way to improving access to health care for Americans of all ages.

I am honored to support this legislation and I encourage my colleagues to do so as well.

Mr. CAPUANO. Mr. Speaker, I rise today to voice my strong opposition to H.R. 1, the Republican Prescription Drug Bill.

This bill represents the first step in a Republican plan to end Medicare as we know it. Under the guise of providing seniors with the prescription drug coverage they so desperately need, this Congress is attempting to destroy the program that seniors have depended on for over 35 years to provide them with the affordable, reliable health care they need and deserve.

Mr. Speaker, not only does this bill fall far short of what the senior citizens of this country expected of us, but it fails by the most basic of standards: it prohibits the federal government from negotiating for lower-cost drugs; it may lead to 3 million seniors losing the good prescription drug coverage they currently have through former employers; it subsides HMOs at 124 percent of what it pays to traditional fee-for-service Medicare; it creates new Health Savings Accounts, which benefit mostly the wealthy; and it sets up new "cost-containment" measures, designed to lay the groundwork for future cuts to beneficiaries and providers. But most alarmingly, this bill contains a massive demonstration program that it the first step toward the privatization of Medicare.

The "premium support" demonstration project in this bill could force 7 million seniors to be subject to a social experiment that has never been tested. Under the demonstration program, HMOs could "cherry-pick" healthy and wealthy seniors citizens, leaving the poor and sick in the traditional program, undermining the social insurance pool. Premiums for those in the traditional program would be driven up, and they could also vary by region and fluctuate from year to year. This is an unacceptable assault on the Medicare program that will only result in higher profits for the insurance industry.

There is no denying that some people may benefit from this bill. For example, it does provide some prescription drug coverage for those with the lowest incomes. Although instituting the first assets-test for low-income beneficiaries in Medicare's history, it will mean that many of these senior citizens now have access to prescription drugs.

Further, as the Member representing many of the teaching hospitals in the Boston area, I am well aware of the important provisions in this bill that will provide essential funding for the world-class hospitals, dedicated doctors, and other health care professionals who work so hard to provide quality care to all the citizens of my district.

However, the positive elements of this bill do not outweigh my concern for the damage this bill could do to a program that has become an integral part of our society. The steps toward privatization contained in this legislation are unacceptable. I am not willing to gamble with the health of our nation's seniors, placing their well being in the hands of the insurance industry. I do not believe this is a risk worth taking. Medicare has served us well for over 35 years. Its demise would mean an America where senior citizens are left to fend for themselves in the private insurance market without a safety net. While this bill may offer some appealing short-term benefits, the price could be the end of Medicare as we know ti. I cannot and will not be a part of it.

I urge Members to vote "no" on H.R. 1.

Mr. SHERMAN. Mr. Speaker, I rise to protest the process that brings H.R. 1, the Medicare reform and prescription drug legislation, before the House today. These procedures could only be described as undemocratic and unfair.

Republican Leaders were in the room for weeks as this bill was drafted, and were able to brief their members on its contents. Democratic Members could not begin to analyze the bill's provisions until yesterday.

We were given almost no time to review the conference report for this momentous legislation. We have waived the rules of the House to allow for this hasty, almost immediate consideration of a bill more than 1,000 pages long, so that not even the members of this body, to say nothing of the public, can fully grasp what is included.

There is no way that we, with a fairly full day of debate in this body, could have read the bill in the short time provided. And it is not enough that we merely read the bill. One must understand its implications. This alone demands that we vote "no" now, to give ourselves more time to fully deliberate and debate this legislation.

Mr. Speaker, again, I rise to express my strong opposition to the process by which we are today voting to overhaul one of the most important institutions in our country. American seniors deserve better, and we owe them more of our time; we owe them full deliberation, debate and our full consideration of this legislation.

Mr. ROTHMAN. Mr. Speaker, for seven years, I have been pushing and voting for a voluntary prescription drug benefit under Medicare. Such a plan would give seniors access to the quality, affordable, life-saving medicines they need. Unfortunately, the final Medicare bill—written in secret by the very same Republicans who eight years ago shut down the federal government as part of their strategy to force Medicare to wither on the vine—does exactly the opposite of what it is supposed to do. Instead of providing seniors with a voluntary, guaranteed drug benefit, the bill provides no drug coverage until 2006, and then forces millions of seniors to pay more for drugs if they don't give up their doctor and join an HMO—HMOs that can raise premiums at will and will throw out seniors who get too sick. The bill is nothing less than an outrageous giveaway of taxpayer funds to the health insurance industry.

A $12 billion slush fund in the bill will be doled out to insurance companies that offer privatized Medicare services and employers are given a $70 million windfall to maintain their retiree drug plans. These subsidies create a huge bias in favor of private plans. That's not competition, it's corporate welfare, and it's wrong.

The Congressional Budget Office projects that when the drug benefit begins in 2006, the average senior will spend $3,155 annually on prescription drugs. Under the Republican bill, because it so loaded up with giveaways to the private insurance industry, a senior with an income over $13,500 will pay $2,075 out of the first $3,155 in total drug costs—66 percent or two-thirds of the total—including the $35 monthly premium and the $250 annual deductible. And on top of these costs, 52,000 New Jersey seniors will face additional increases in their Part B premiums.

Also, instead of a voluntary benefit under Medicare, seniors will lose their doctors and be forced out of the system they know and trust. Worse still, 220,000 New Jersey seniors enrolled in PAAD and Senior Gold will have their health jeopardized and their choice of medicines limited by restrictive drug formularies imposed on the State by managed care plans. These seniors will face disruption in their coverage and will likely get less help than they currently receive. And it's a bad bill for doctors, whose reimbursement rates will be set not by the federal government, but by HMOs out to make a profit.

It is an especially bad deal for New Jersey seniors. As a result of the Republican bill, 94,000 New Jersey retirees will lose their drug coverage, 2–3 million nationwide. Over 150,000 Medicaid beneficiaries in New Jersey will pay more for drugs and 186,000 New Jersey seniors will be forced to leave traditional fee-for-service and accept vouchers to enroll in private plans starting in 2008.

The Republicans controlling the House of Representatives today dislike Medicare so much that they are literally willing to subsidize private health insurance companies to compete with Medicare, paying those companies $82 billion to create new private bureaucracies to handle prescription drugs for seniors and to even go so far as to build in a profit for them. We tried this experiment once already, giving private plans subsidies to offer Medicare services in the form of Medicare+Choice. But despite these subsidies, private Medicare+Choice plans felt they could not make enough of a profit, so they cut benefits and dropped hundreds of thousands of policyholders. Not only will this bill ultimately destroy Medicare and force seniors and their doctors into dealing with private HMOs, but the $82 billion could have been invested into the existing Medicare infrastructure, covering all seniors with a voluntary prescription drug program and reducing the premiums and co-pays for our nation's seniors.

Most galling the bill expressly prohibits the federal government from negotiating prices with the drug industry. The government already permits such negotiation in prices by the Department of Veterans Affairs and the Department of Defense—if this is good enough for veterans and those serving on active duty in the armed forces, why not for seniors? This is a $139 billion gift to drug companies in windfall profits. If Republicans were serious about reducing costs, their bill would not block the Secretary of Health and Human Services from using Medicare's enormous purchasing power to bring drug prices down.

AARP, which claims to speak for seniors, but is in fact a big insurance company with over $200 million in commissions on health and life insurance policies and prescription drug plans, has hastily endorsed the bill. Like hundreds of rank and file AARP members in my district who have called my office to disavow the national group's decision, I am outraged that AARP renounced the anti-privatization principles it claimed were central to its support. For this reason, I have resigned my AARP membership.

As many have said, this bill is a Trojan Horse: a radical dismantling of Medicare masquerading as a prescription drug bill. We must not forget that only a handful of Republicans voted for Medicare when Democrats created the program nearly 40 years ago. And at every turn since 1965, the Republican Party has worked to weaken a popular and successful health care system that allows seniors and their personal doctors to manage their own care.

We must not now adopt a privatization scheme that will harm seniors and risk Medicare's future. Instead, Congress ought to add a simple, straightforward and voluntary drug benefit to Medicare, save the $82 billion in subsidies to private insurance companies and private plans, and apply that money to lessen seniors Medicare drug premiums and co-pays. And then we should engage in a real bipartisan discussion about the future of Medicare—out in the open and not in a secret congressional backroom.

Mr. COSTELLO. Mr. Speaker, I rise in strong opposition to H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003 conference report. Since coming to Congress, I have consistently promised over 70,000 seniors in my district that I would not support legislation that would fundamentally change the nature of Medicare and provide a prescription drug benefit that relies solely on insurance companies. This legislation does just that and I cannot in good faith support it.

Medicare has been a success because it provides guaranteed coverage for all elderly and disabled Americans. This legislation would end Medicare as we know it and may particularly harm rural areas that depend on the traditional Medicare program. Beginning in 2010, up to 6.8 million people could be part of a demonstration program that forces the Medicare fee-for-service program for doctors and hospital visits to compete with private insurance plans. People who wanted to remain in traditional Medicare would find their premiums going up as other beneficiaries opted for private insurance coverage. Seniors and the disabled would essentially be forced out of the traditional fee-for-service program and into some form of managed care.

In addition, this approach does not guarantee the same benefits for all seniors. Seniors who live where hospitals and doctors negotiate lucrative contracts with managed care plans would have to pay more; seniors with higher incomes would have to pay more; seniors in rural areas would have fewer choices of doctors and pharmacies; and seniors with low incomes but with assets such as a savings account might get nothing at all. These provisions violate the central promise of Medicare: to provide a consistent, guaranteed benefit that allows everyone, no matter where they live, how much they have, or how sick they are, access to quality medical care.

Further, I support a voluntary prescription drug benefit paid for by Medicare. However, this ill-conceived plan before us today will result in as many as three million retirees losing their employer-sponsored drug coverage which is more comprehensive than this legislation. At present, employer-sponsored retiree health benefits are the greatest source of coverage for retirees, providing drug coverage for one in three Medicare beneficiaries. Yet, this conference agreement creates an incentive for employers to drop retiree coverage they currently provide, rather than encouraging them to maintain it. In addition, it fails to help retirees from state and local government, multi-employer groups, and non-profit organizations. The additional funding, under the premise of shoring up retiree coverage, is meaningless to those who retire from public service, such as teachers, firefighters, and police, or other organizations with no tax liability.

Finally, the conference agreement is flawed because it offers seniors an inadequate prescription drug benefit. I am committed to providing a comprehensive benefit that is affordable and dependable for all beneficiaries with no gaps or gimmicks in its coverage. However, this legislation provides a huge gap in coverage leaving half of seniors without prescription drug coverage for part of every year.

Further, the bill is sorely lacking in any provision that might restrict the skyrocketing costs of the drugs themselves. It does not include meaningful reimportation language, strong language ensuring access to generic drugs, or the ability to negotiate prices as is done currently by the Veterans Administration.

This legislation relies too heavily on the insurance industry to bring drug costs down and does not guarantee seniors access to the medicine prescribed by their doctor or that they can get prescriptions filled at their local pharmacy. Seniors deserve fair drug prices and a real, affordable prescription drug plan.

Mr. Speaker, for these reasons, I oppose the conference report. I ask my colleagues to join me and reject this bill and send it back to the committee with instructions to bring the bill back to the floor with a real prescription drug plan that guarantees seniors affordable and dependable coverage.

Ms. MCCOLLUM. Mr. Speaker, tonight, Republican leaders in Congress are poised to pass an overhaul of Medicare that provides a weak prescription drug benefit, fails to lower drug costs, and starts the process for the privatizing of Medicare—a program that seniors have depended upon and trusted for almost 40 years.

Seniors have been fighting for years for a Medicare prescription drug benefit that is affordable; available to all seniors and disabled Medicare beneficiaries by providing meaningful benefits within the Medicare program.

However, the legislation Republicans have produced does not make prescription drugs affordable, does not offer a guaranteed benefit under Medicare and does not sufficiently protect current retiree plans. Instead, this bill caters to the pharmaceutical industry, bribes the HMOs with $12 billion in subsidies, and allows the AARP to reap $1.56 billion in profits. This bill threatens the future of Medicare and the health of America's seniors.

Under this Republican Medicare bill: $88 billion in tax credits will be given to employers to retain coverage for their retirees, and; Despite this windfall, 2 to 3 million seniors will still lose benefits from their employer-based coverage; and millions of seniors will pay more in Medicare premiums if they refuse to join an HMO.

The prescription drug plan that Republicans have proposed is a sham. Seniors will pay more than 50 percent of their drug costs for coverage up to $2,250. Most troubling, the bill leaves a huge "coverage gap." Seniors will have zero prescription drug coverage for medication costs that run between $2,250 and $5,100—and those beneficiaries will still have to pay the monthly premium! Over half of all Medicare beneficiaries would fall into this "coverage gap." And this bill will scale back coverage for the poorest seniors. Up to 6.4 million low-income Medicare beneficiaries will get less drug coverage than they have now as a result of new low-income thresholds and stringent asset testing. Also, seniors will only be eligible for drug coverage through private insurance companies that will have wide latitude in setting premiums and deductibles. Private insurance companies will also be able to make decisions about which drugs are covered, as well as which pharmacies seniors can use.

Today, there are approximately 648,000 Medicare enrollees in Minnesota. According to the Minnesota Department of Health, about 46 percent have no prescription drug coverage. In Minnesota alone, this bill that may cause at least 39,480 Medicare beneficiaries to lose their coverage from their former employers and 89,800 Minnesotans will pay more for prescription drugs.

And the most outrageous part is that the Republican plan benefits the pharmaceutical industry by explicitly prohibiting the Secretary of Health and Human Services from negotiating lower drug prices on behalf of America's 40 million Medicare beneficiaries. It also blocks the re-importation of drugs from Canada at lower prices. Additionally, the plan will create health savings accounts, which are tax-free savings accounts for medical expenditures. This creates an unprecedented tax loophole that would undermine existing employer coverage and provide $6.7 billion in tax relief for the wealthy.

Earlier this year, I supported a bill that provides for a voluntary prescription drug benefit under Medicare. Medicare would pay 80 percent of drug costs after a $100 deductible and no senior will have to pay more than $2,000 in costs per year. This plan would cover all Medicare beneficiaries, regardless of previous health conditions, and guarantee people's choice of medication, pharmacy, doctor and hospital. The plan that I supported would also give the Secretary of Health and Human Services the authority to use the collective bargaining power of 40 million beneficiaries to secure lower costs for the most popularly prescribed medications to end price gouging by the big drug companies.

Minnesota seniors and persons with disabilities deserve better than the Republican bill that is before us tonight. I will only vote for a prescription drug benefit that is affordable and available to all seniors and disabled Medicare beneficiaries regardless of geographic location or health condition.

Mr. BISHOP of Georgia. Mr. Speaker, although the massive conference agreement over Medicare reform contains some of the provisions the country needs and that I support, the overall legislation is deeply flawed. Congress can do better. By voting against the agreement, I am calling on Congress to correct the flawed provisions that would deny many seniors any prescription drug benefit, increase health care costs for many lower income citizens, push many seniors into managed care, put employer-based prescription drug coverage at greater risk, and create an uncertain privatization process that could change the face of Medicare forever.

By voting down this proposal, we could fix the critical flaws and still have time to enact a sound Medicare reform bill that the country desperately needs before the end of the 2003 session. I am cosponsoring a bill introduced Friday (11/21) that would shore up rural providers and maintain the integrity of Medicare for rural communities, while putting aside the more rancorous issues until later. I urge its consideration.

Among the agreement's provisions that I strongly support are those that would provide realistic reimbursements to providers, including giving rural hospitals parity with urban hospitals. Many community hospitals have shut down, and many are struggling to survive. This puts the health of many of our rural citizens, and the vitality of many rural communities, at risk. Relief for at-risk hospitals is one of the positive things about the agreement, and it should be a part of any health care reform enacted by Congress.

But I cannot overlook the agreement's overwhelming downside.

Dr. Kenneth Thorpe, a noted health policy authority from Emory University, calculates that under this agreement 51,450 Georgians would lose employer retiree health benefits; 161,300 Georgians would pay more for prescriptions; 82,000 fewer Georgians would qualify for low-income benefits than under the Senate version; and 34,000 Georgians would pay more for Part B premiums for doctor and outpatient care.

There are other sections of this lengthy bill, released the same day debate began, that few outside the conference committee have had an opportunity to examine. But much of what we know is disturbing.

There are no measures in this bill to respond to the problem of skyrocketing of drug costs. Not only would the government be prevented from negotiating drug prices, the possibility of reimportation of less expensive medicine from Canada is effectively killed.

The actual prescription drug benefit is skimpy, with an enormous coverage gap and an asset test designed to limit access for thousands of truly needy Americans. Moreover, millions of retirees will see the superior coverage they now receive from their former employers weakened or eliminated. That's nearly 3 million individuals nationally and more than 50,000 in the state of Georgia alone.

One of the biggest concerns is the agreement's push to privatization. As drafted, it appears private insurers would tend to pull in the healthiest beneficiaries while those with medical problems would remain with Medicare, causing Medicare costs to sharply rise. This could create what some are calling a 'death spiral' of escalating costs in traditional Medicare. More and more seniors would be pushed into the less-expensive HMOs and PPOs simply because they could not afford the higher cost of Medicare.

From the enormous premium support "demonstration projects" to the weakened Federal fallback for areas without meaningful access to private prescription drug plans, this agreement reveals a poor understanding of the needs of rural providers and residents.

All of these flaws make this agreement unattractive in the short term. But if we look just a bit further down the line, the picture becomes even bleaker. In 2006, when the prescription drug benefit would actually begin, the benefit would be essentially worthless to the average citizen. And, when 45 percent of spending on Medicare comes from general revenues, extreme measures to curtail Medicare spending would be triggered. It's extremely cynical to include such a dramatic cost-containment mechanism while excluding responsible measures to control Medicare spending.

There is much that is wrong in this bill, and much less that is right.

Rarely will we consider any legislation that will have a greater impact on the well being of the American people.

Let's get it right!

Mr. OBERSTAR. Mr. Speaker, Medicare is the most successful health initiative in American history—improving the quality of life for America's senior citizens, extending their longevity, and relieving their anxiety about affording the health care they need.

For the past several years, Democrats in Congress have worked tirelessly for affordable, comprehensive, and guaranteed coverage for prescription drugs under Medicare. This week, the Republican majority in Congress is poised to pass legislation that will require seniors to pay significant out-of-pocket costs for prescription drugs, will eliminate employer-provided health care coverage for 2.7 million retirees nationwide, and will ultimately undermine the entire Medicare program. Simply put, the Republicans brokered a deal that prioritizes the pharmaceutical and the insurance industries over providing a comprehensive benefit to seniors and the disabled.

I. EFFECTS ON MEDICARE BENEFICIARIES

I am particularly concerned with the inclusion of "premium support," a misguided proposal that will undermine Medicare. Instead of providing a Medicare prescription drug benefit for seniors, congressional Republicans have embarked on a radical and untested social experiment that threatens the future of Medicare. The final Medicare bill clearly takes the first step toward privatizing Medicare by implementing a "premium support demonstration project" in six metropolitan areas.

The bill threatens traditional Medicare because it includes provisions designed to stack the deck in favor of the health insurance industry. The legislation allots $17 billion to HMOs to lure them into the market to provide senior citizens with taxpayer-financed health and drug benefits. As the Washington Post recently pointed out, if Medicare "privatization is such a good idea, why do the private insurance companies need such big subsidies to enter the Medicare market? . . . That's not capitalism or competition. That's corporate welfare." Rather than divert $17 billion from Medicare to prop up private sector competition, it would be far better to invest that money in Medicare's future.

Seniors will essentially receive a voucher for services to cover the lowest-cost private insurance plan, if such plans are offered, which is not at all certain. If this plan does not pay for the services they need, seniors will have to cover the difference—which could be a big figure—out of their own meager income. Masquerading as increased efficiency, this concept disproportionately benefits healthier seniors and leaves seniors with more costly health care needs paying an estimated 25 percent more for traditional Medicare. Seniors living in different regions will also pay different prices for the exact same benefit. I believe America's seniors deserve a guaranteed drug plan that is available for all Medicare beneficiaries—regardless of where they live.

II. IMPROVED MEDICARE REIMBURSEMENT FOR RURAL HEALTH CARE PROVIDERS

I have strongly supported efforts to eliminate disparities in Medicare reimbursement for rural areas, and I am very pleased that the conference report contains significant improvements for rural health care providers. Health care is essential in greater Minnesota. The hospitals in many small communities throughout northern Minnesota are the major employer in town, and the health care they offer is critical for economic development and tourism.

It is encouraging news that 31 hospitals in my congressional district would receive $39 million over 10 years under this bill in improvements in Medicare reimbursement, including fourteen Medicaid Disproportionate Share Hospitals (DSH) and 12 Critical Access Hospitals (CAHs). Other notable changes in the policies for CAHs—albeit not attached to a dollar amount—would improve the delivery of mental health services in rural northeastern Minnesota by permitting 10 beds to be used for psychiatric or rehabilitative services. Physicians would see a payment increase of 1.5 percent rather than a 4.5 percent decrease. Teaching hospitals would each receive $183,000 spread out over 10 years in additional payments for Indirect Medicare Education, which would greatly assist the training of medical students at the University of Minnesota, Duluth, as they prepare to serve rural Minnesota.

III. PRESCRIPTION DRUG BENEFIT

Seniors will be eligible for drug coverage only through private insurance companies that will have wide latitude in setting premiums and deductibles. Private insurance companies will also be able to make decisions about which drugs are covered, as well as which pharmacies seniors can use.

The plan is difficult to explain, but let me try: it begins with uncertain private health insurance premiums, estimated to be $35 per month, but not specified in statute; then, seniors must pay a $250 deductible before they receive any assistance, after which they will pay a 25 percent co-insurance for up to $2,250 in drug costs. However, there is a large coverage gap where no assistance is provided between $2,250 and $5,100 in drug spending, the "hole in the doughnut," where seniors will be paying premiums but receiving no assistance at all. Those seniors with $5,100 in drug costs annually will still pay $4,020 under this bill. This plan is as unfair as it is complicated and costly to older Americans living on fixed incomes.

IV. IMPORTATION/COST ISSUE

I firmly believe that in order to ensure the continued affordability of Medicare benefits for seniors, greater efforts must be made to address escalating health care costs, particularly the price of prescription drugs. Yet this bill does precious little to contain the cost of prescription drugs in the future. The legislation once again deceptively appears to permit drug importation from Canada, while including a poison pill that the Secretary of the Department of Health and Human Services must certify to the Congress that its implementation does not present a health risk. During the Clinton Administration, HHS Secretary Donna Shalala refused to make such a certification, as has the current Secretary, Tommy Thompson. When Americans are paying 30 to 300 percent more for prescription drugs than Canadians or people in other industrialized countries, there must be a concerted effort to fix the safety concerns in the legislation rather than jettison the entire effort with this poison pill.

Despite claims that this legislation introduces free market principles and competition, I am deeply troubled that the Republican Medicare plan prevents federal cost-saving efforts that would reduce prescription drug costs for seniors. At a time when many seniors must pinch their pennies to afford the basic necessities, this bill—incredibly—explicitly prohibits the Secretary of the Department of Health and Human Services from negotiating lower drug prices on behalf of America's seniors. Unlike the Department of Veterans Affairs, which does have such authority, the Secretary of HHS would not be allowed to leverage the market power of 40 million Medicare beneficiaries to reduce prices.

In my view, the big winners are the drug and insurance companies, at the expense of our nation's seniors. In addition to providing $17 billion to HMOs and prohibiting the Secretary of the Department of Health and Human Services from negotiating lower prices, the final Medicare bill will eventually undermine community pharmacies. Pharmacy benefit manages (PBMs), charged with administering the prescription drug benefit, will be able to contract out and establish an unequal playing field whereby mail order companies can sell larger quantities for lower co-pays than community pharmacies can. There is no transparency for PBMs—just a conflict of interest; PBMs are not held responsible to report rebates or kick-backs they might receive from the pharmaceutical industry for selling specific drugs—that provision was stripped from the conference report. I am continually dismayed that Republicans go to great lengths to serve special interests rather than the public good.

I have voted many times this year in support of a strong prescription drug program that would strengthen the Medicare program. However, I am not willing to cast a vote to undermine a program that seniors and the disabled have trusted for nearly 40 years, in exchange for an atrocious prescription drug benefit that directs formidable sums of money to special interests. Congress can do better; our seniors certainly deserve better.

Mr. DAVIS of Illinois. Mr. Speaker, it is said that the cruelest lies are often told in silence—in what you don't say. If that's the case, then the silence is deafening as the Medicare prescription drug legislation looms ever closer to final passage.

We promised the American people we would protect and strengthen traditional Medicare. This legislation does the opposite—it begins coercing millions of seniors out the common Medicare insurance pool into private HMOs.

It creates huge new tax shelters for the ultra wealthy with the ironic name of "Health Savings Accounts."

Meanwhile the very poorest seniors, those who also qualify for Medicare, will see their benefits slashed.

The bill places draconian new caps on future Medicare services and spiraling new tax burdens on middle income working families.

The bill inaugurates the process of means-testing and asset-testing seniors before providing them benefits—of checking their wallets before checking their health.

It would also add heavy new financial burdens to state budgets already strained to bursting by federal cutbacks.

All this in return for a pathetically inadequate prescription drug benefit and skyrocketing drug company prices and profits as far as the eye can see.

Fool me once, shame on you. Fool me twice, shame on me. Fooling our seniors shame on all of us.

Mr. Speaker, this Medicare prescription drug bill is not what it is advertised to be. It is a cruel hoax and a danger to the health and well-being of America's seniors.

As Representatives of the American people, we have a special moral responsibility to be honest with the people.

This legislation breaks that sacred trust. This bill deceives and dispossesses America's seniors.

I'm with Will Rogers: I'd rather be the man who bought the Brooklyn Bridge than the man who sold it.

Mr. VAN HOLLEN. Mr. Speaker, with regret, I rise in opposition to the Medicare conference report now before us. Rather than giving seniors the simple, comprehensive and affordable prescription drug benefit they deserve, this bill recklessly undermines the Medicare program, threatens many seniors' existing drug coverage and fails to bring down skyrocketing drug costs.

Let's be clear: This is not about whether we ought to add a prescription drug benefit to Medicare. Democrats—including myself—have been calling for a meaningful Medicare prescription drug benefit for years. Now that the Republican party has dropped its historic opposition to modernizing Medicare, there is broad consensus—at least rhetorically—on the importance of this goal.

Additionally, this is not about whether doctors should receive a positive payment update for services rendered under Medicare. I think everyone in this chamber understands we could pass a free-standing positive payment update for physicians today—and by a wide margin. Frankly, I would be first in line—because I don't think you can ask providers to participate in a program without adequate reimbursement. But if we were really interested in giving doctors a fair reimbursement rate, we would end this untenable ritual of dodging the next round of scheduled payment cuts with stop-gap, band-aid measures and finally get around to fixing the obviously flawed Medicare reimbursement formula once and for all. Unfortunately, that's not what we are doing here today.

Instead, after months of secretive negotiations and much highly publicized bickering, the majority is now presenting this House with a prescription drug bill that blatantly violates the first tenet of responsible medicine: Do No Harm.

If this conference report is enacted into law, as many as 7 million seniors will be forced to pay more for Medicare—unless they agree to give up their doctor and join an HMO, according to analysis done by the House Ways and Means and Energy and Commerce Committee minority staff. Additionally, over 2 million retirees who already have private prescription drug coverage stand to lose that coverage, according to the same report.

That is also the conclusion reached by the former Republican Majority Leader of the House Dick Armey, who called on Congress to reject this misguided bill in today's Wall Street Journal, saying in part: "(T)his bill is going to cost millions of seniors their current prescription drug coverage."

In my home state of Maryland, an estimated 60,000 Medicare beneficiaries could lose their existing private prescription drug benefits, according to analysis based on CBO data prepared by the Senate Health, Education, Labor and Pension Committee minority staff. Moreover, similar analysis from the Senate HELP Committee minority staff using CRS data projects that 75,000 Maryland Medicaid beneficiaries will pay more than they do now for the prescription drugs they need.

This legislation puts seniors with existing coverage—and the future of the entire Medicare program—at risk. And for what? A prescription drug benefit that—after all the premiums and deductibles and co-pays and coverage caps and out-of-pocket costs are accounted for—provides $1 of assistance for every $4 that seniors with significant drug costs will still have to pay themselves.

There are smarter, more efficient ways to spend $400 billion on a Medicare prescription drug plan. For starters, we should eliminate the $12 billion subsidy being offered the private insurance industry as an inducement to participate in the Medicare market. If PPOs and HMOs are really more efficient than traditional than traditional Medicare in delivering high quality care at a lower cost, they don't need a $12 billion taxpayer handout to do it. Additionally, we should scrap the Administration's ill-conceived and deceptively named "Health Security Accounts", which amount to little more than a $6 billion tax break for the wealthy. And finally, we should get serious about making drugs affordable for seniors and for all Americans—through such common sense steps as permitting re-importation from our industrialized trading partners and allowing the federal government to negotiate for lower drug prices on behalf of Medicare's 41 million beneficiaries—something the bill before us today actually forbids the government to do.

The ultimate value of allowing the Center for Medicare and Medicaid Services (CMS) to negotiate for lower prices will obviously turn on the outcome of those particular negotiations. But we know from the experience of the Veterans Administration—which does currently have the ability to negotiate for lower prices—that the savings can run upwards of 60 percent. In the absence of meaningful steps to curb the exorbitant cost of drugs, this bill does more for the pharmaceutical industry than it does for consumers.

I believe seniors deserve a real Medicare prescription drug benefit plan; one that is comprehensive, affordable and easy to understand; one that will strengthen Medicare rather weaken it; and one that will not reduce the benefits of seniors who already have prescription drug coverage.

Mr. Speaker, we should defeat this fatally flawed conference report, come together on a bipartisan basis and give seniors the meaningful prescription drug assistance they are asking for and need.

Mr. CUMMINGS. Mr. Speaker, I rise today to speak against the woefully inadequate Medicare prescription drug conference bill being considered today.

Mr. Speaker, this report is an insult to our seniors. Instead of a bill that helps our seniors, we have a bill that makes an untenable trade-off. A meaningless prescription drug benefit and the dismantling of the Medicare "healthcare" program for 40 million seniors and disabled Americans as we know it today. Quality healthcare coverage should come along with a prescription drug benefit, which

Democrats have been fighting for over the past six years, not at the expense of it. But that is what this bill does. So today, what we have to consider is a bill that will do more harm than good—one that represents a giant first step in privatizing and the emasculation of Medicare—a program that our seniors and disabled know and love.

Under this disastrous plan:

Gone are retiree benefits. Because it gives employers no incentive to maintain prescription drug coverage for their retirees two or three million retirees will lose their current private drug coverage. In my home state of Maryland this includes 59,640 retirees.

Gone are wrap-around services. Six million low-income beneficiaries will pay more for their prescription drugs. Those who are dually eligible to receive both Medicare and Medicaid—seniors who are so poor that they need what we call wrap-around services to have healthcare coverage—will pay more for their prescription drugs under this plan. To add insult to injury this bill does not allow states to use their federal Medicaid monies to supplement them. This includes 75,800 seniors in Maryland.

Gone is the traditional Medicare Program as we know it. They say fee-for-service stays intact. Well if you as a beneficiary want to be nickeled and dimed to death—and pay almost 80 percent out of pocket for Medicare and prescription drug coverage up to $5,044, then it stays intact. Let me explain, that means that after a senior or disabled person has paid almost $4,000 out-of-pocket in premiums, deductibles and contributions, then the traditional Medicare coverage kicks back in.

Soon to be gone is traditional Medicare. Traditional Medicare is most threatened by what has been termed premium support. Beginning in 2010, about 7 million beneficiaries will be forced into a premium support demonstration that will make them pay more for Medicare if they don't give up their doctors and join an HMO. This also means that there will be tremendous premium variation from region to region even in the same state when this plan is fully rolled-out. While it may be just 7 million seniors in 2010, now make no mistake the goal is to end Medicare as a social compact, where eventually, Medicare will indeed "wither on the vine" and private insurance and pharmaceutical companies will rule the day. Unfortunately, passage of this legislation will mean that many of our seniors will wither right along with the Medicare program—which will no longer be seen as a guaranteed benefit—a concept our nation embraces.

Here to stay are vouchers for Medicare beneficiaries—to take to an HMO which will give these folks what they want them to have—there will be little real choice. Seniors want stability—knowing who their doctors will be, who will be able to fill their prescriptions, which drugs will be covered, and in which hospital they can receive services. I have not ever been told by a single senior that they want to be able to choose between profit-driven private insurer providers which may or may not want to have them as clients.

Here to stay is assets testing. What's good about this bill is that those beneficiaries who are 15 percent below the poverty level are able to forego paying the monthly premiums of $35 and the yearly deductible of $275, and to escape the donut hole in coverage from $2,200 to $5,044. But again our compassionate conservative friends give with one hand and take with the other.

In order to qualify as low-income, seniors have to go through the degradation of proving that they are poor enough to receive it—meaning all of their assets, not just incomes are tested. The one saving grace of this bill is poisoned by the lack of compassion. This means that low income seniors will be kicked out of receiving the low-income benefits of the plan depending on their assets—simply because they have been able to squirrel away a few thousand dollars into a savings account. This affects 53,000 seniors in Maryland, many in my district.

I ask, who is going to invade their privacy and check their assets—isn't it sufficient that they're already living off of meager means 150 percent below the poverty level, should they too have to pay $4,000 to receive both Medicare and prescription drug coverage? What a trade-off. How despicable. I think my colleagues can agree that this is a very troubling proposition and a totally unfair result.

Here to stay is big money to the drug companies and HMOs. In fact, this bill overpays the private insurance plans by $1,920 per beneficiary at the expense of traditional Medicare by creating a $12 billion slush fund for these companies just to take on these beneficiaries. Mr. Speaker, our seniors do not need a handout, but a hand-up—use that $12 billion to give to our current providers and hospitals who already give outstanding care to our seniors, along with a meaningful prescription drug benefit.

Here to stay are HMOs that seniors will feel coerced into joining because they will not be able to pay for the traditional Medicare they enjoy today.

Additionally, with the establishment of the Voluntary Prescription Drug Benefit Program, beneficiaries again lose because of the lack of negotiated prices for the prescription drugs. Why not leverage the power of the 40 million Medicare beneficiaries? Why not mandate containment of drug costs in this bill? Why give seniors and the disabled a prescription discount card they cannot use until 2006 while the drug companies still get to determine the cost? Why enact health savings accounts that only the well-off can afford? Why include a poison-pill that kills any chance of reimportation of affordable medicines? Why include an artificial budget cap on general revenues funding for Medicare that triggers a fast-track legislation procedure that would allow immediate cuts in benefits, cut payments to nursing homes and home health care providers and increase cost-sharing? Why leave our seniors and disabled powerless?

I know the answers. It's because this bill is not a reform bill, but a rewards bill—and the pharmaceutical and the private insurance companies are the winners.

Mr. KIND. Mr. Speaker, I rise in reluctant opposition to the bill before us today. It was my hope that the conference committee would work in a bicameral, bipartisan manner and produce a bill focused on providing prescription drug coverage to seniors and improving Medicare. Instead, House Democrats were shut out of the discussion completely, and special interest groups were given more information than members of Congress. Even more troubling than the process, however, was the legislation that came out of this conference. This bill is a bad deal for American seniors and an even worse deal for our children and grandchildren. Estimated at $400 billion, this bill is not paid for and, without basic cost containment measures, like price negotiation or drug reimportation from Canada, will leave a legacy of debt for our children and grandchildren to inherit. The easiest thing to do in politics is pass a bill and don't pay for it.

Certainly, there are portions of this bill which I support—portions which generously and correctly bring aid and equity to hospitals, especially those in rural areas like western Wisconsin. For far too long, rural hospitals and critical access hospitals have been treated as second-best, and I have long been a champion of bringing equity to these hospitals which do such important work throughout our country. This bill will at last begin to equalize the base inpatient payment rate, increase the cap for Medicare disproportionate share hospitals, and bring the hospital update to full market basket. Providers also benefit a great deal from this bill, and I am pleased that instead of receiving a cut, Medicare providers would receive a 1.5% update for the next two years. Furthermore, the assistance to our providers is paid for with offsets in the budget, so it does not add to the historically large federal deficit. If these provisions were separate from the bill, I could support them in a heartbeat, and I am confident that such a bill would pass overwhelmingly in Congress. In fact, just today my colleagues and I have introduced a bill that is identical to the rural health care package included in the Medicare Conference Report. We could still pass such a bill if the Republican leadership wanted to, but they do not. Instead, they are holding the rural provisions hostage to all ill-advised and costly prescription drug program to be delivered to private insurance companies after we bribe them with billions to do it, even after they have told us they do not want to do this.

As important as it is to sustain our hospitals and our doctors, aspects of the bill which will hurt our seniors, our pharmacists, and our states make it impossible to support this bill. Too many seniors in my district in western Wisconsin have told me stories of skipping meals in order to afford prescription drugs or cutting their pills in half to make their expensive prescriptions last longer. I came to Washington to work towards a real solution to this problem, and I have championed the New Democratic Coalition's plan, which is simple, progressive, and affordable. I would be proud to stand on this floor today and support the Dooley prescription drug plan. I would have been able to compromise and support a bill that was close to the Senate's bipartisan bill. But I am unable to support a bill that will do relatively little to provide seniors with drug coverage, that bribes insurance companies, that threatens to destabilize existing coverage for retirees, that undermines Medicaid, and that has no reasonable measures to contain costs.

Sadly, for all the excitement over a prescription drug benefit, this bill would bring little relief to struggling seniors. The drug benefit does no start until 2006, leaving struggling seniors a few more years before they receive any help in paying for their prescription drugs. Once 2006 rolls around, many seniors will find a drug benefit far less generous than the one they expected. In fact, a senior who spends slightly over $5,000 per year on prescription drugs will have to spend over $4,000 of his or her own money, meaning the consumer still pays 80 percent of drug costs. This is hardly the relief from expensive prescription drugs that seniors have been promised and that they deserve.

Also of concern is the effect this bill will have on seniors who currently have drug coverage. Astoundingly, an estimated 58,170 Medicare beneficiaries in Wisconsin will lost their retiree health benefits because of this bill. And they are not the only seniors who will suffer. Wisconsin's Seniorcare program is a shining example of the great work that can be done to aid our nation's seniors when federal and state governments cooperate. The bill before us would punish Wisconsin's leadership on this issue; Wisconsin would most likely lose the matching funds it receives for Seniorcare and be forced to drastically scale back the program. Wisconsin's Seniorcare participants currently pay a nominal enrollment fee, low drug co-payments, and a modest deductible, with those seniors below 160 percent of the poverty level paying no deductible whatsoever.

The Wisconsin Medicaid program, as well as the 110,200 seniors who are dual eligibles, will see a significant risk in their drug costs as a result of this legislation. The bill purports to do good things for low-income seniors, but in my state, it will have exactly the opposite effect. For the 99 percent of seniors in my state who already have health insurance, the introduction of a new prescription drug plan means a confusing new benefit with higher costs to the state and beneficiaries and less coverage than many Wisconsin seniors already enjoy.

All of this speculation over a prescription drug plan assumes, of course, that drug-only plans will be around to offer this less than substantial coverage. Currently, there are no drug-only insurance plans, and representatives of the industry have maintained they do not want to start such plans. Because of this reluctance, the bill bribes private insurance companies, pouring billions into the industry in an attempt to entice the companies to create drug-only plans. Clearly, $400 billion is just a floor, costs will explode, and the insurance companies will return to Congress in the future to ask for more money or they will drop coverage of our seniors, just as many Medicare plus Choice plans are doing today.

The $400 billion price-tag is only the beginning of spiraling costs to the federal government; we have no idea what costs might be in the future for this benefit. Incredibly, even the original $400 billion is not paid for, and there are no attempts at cost control in this measure. The government, for both Medicaid and the Veterans Administration, negotiates drug prices. The 40 million Americans covered by Medicare constitute an immense and potentially powerful purchasing pool. Great savings could be realized by negotiation, yet this bill specifically prohibits the government from negotiating with drug companies. Another potential for savings is reimportation from Canada; once again, this cost-cutting measure is prohibited, as the Secretary of Health and Human Services would have to approve reimportation, and the agency has already indicated no such approval will be granted.

Finally, Mr. Speaker, I would like to speak of a group that has received little attention in a debate focused on seniors—our children and grandchildren. While I fully support providing seniors with a prescription drug benefit, I do not believe it is right to shift the costs of this benefit to future generations. We must devise a way to pay for these benefits now; we cannot and must not rely on future Congresses and future taxpayers to fix a problem of our creation. The party in power in Washington today wants tax cuts for the wealthy and pays no attention to fiscal responsibility. It is wrong to create a larger deficit than the one we already face. To protect seniors, to protect our children and grandchildren, I am opposing this bill, and I urge my colleagues to reject the flawed proposals contained in this bill. We can and must do better.

Mrs. DAVIS of California. Mr. Speaker, I support providing our seniors with prescription drug benefits under Medicare. It is one of the most important efforts we have undertaken this session, and, I believe, one of the most attainable. This is why I rise, with regret, to oppose this Medicare Conference Report. The legislation before us fails our seniors and places them at the mercy of private plans and insurance companies.

There are some good items in this legislation. For example, the increased funding for hospitals and hard-working physicians is greatly needed in our communities. Unfortunately, the overall bill does not accomplish what our seniors need.

When I reviewed this legislation, I needed to answer the following questions: "What are the benefits for our seniors?" and "What do the changes mean in the long run?"

In the very limited amount of time I had to review this legislation, I have concluded that, in reality, this Medicare bill will hurt seniors by making health care less reliable and more costly.

We needed a prescription drug bill. We received, instead, legislation that has been called a "Medicare monstrosity." It mandates huge changes to Medicare, but evades the underlying issue of providing seniors with a comprehensive prescription drug benefit.

This legislation ends Medicare's guarantees to seniors. It gives billions for managed care, for tax shelters, and for many other special interests unrelated to prescription drugs. It significantly worsens current levels of coverage for millions of Medicare beneficiaries with increased Part B premiums and threats of disappearing employer benefits.

Are all of these changes worth a weak drug benefit that will disappoint millions of seniors? No.

Mr. Speaker, our seniors deserve better!

At townhall meetings and in thousands of letters, phone calls and emails, seniors have told me that they want a prescription drug benefit that is affordable, comprehensive, and guaranteed, and they would like the coverage provided in the current Medicare system. The bill before us meets none of these standards.

Instead this bill will make our seniors anxious—anxious about substantial cost increases; anxious about having to switch doctors; and anxious about losing he security that Medicare has provided for almost 40 years.

The Conference Report before us is a missed opportunity. I hope Congress does the right thing by going back to the drawing board, and giving seniors a reliable and affordable prescription drug benefit. We can do better or our seniors—and we must!

Join me in defeating this bill and working to pass legislation that truly addresses our seniors' needs.

Mr. RAMSTAD. Mr. Speaker, I rise in strong support of the Medicare Prescription Drug, Improvement and Modernization Act.

This is truly a historic day. After years of hard work, Congress is finally on the verge of delivering on our commitment to America's seniors. The bill before us will honor our promise to create a meaningful and long overdue prescription drug benefit for Medicare beneficiaries.

This legislation means seniors will no longer have to choose between purchasing life-saving drugs or the basic necessities of food and housing.

In addition to this important new prescription drug benefit, the bill modernizes and improves Medicare to give seniors better choices and greater access to state-of-the-art health care.

I am grateful for the many important provisions in this package from the bill I sponsored, the Medicare Innovation Responsiveness Act (H.R. 941), which will increase seniors' access to lifesaving medical technology. These provisions provide long needed reforms that will bring the Medicare program into the 21st Century.

As founded and co-chair of the Medical Technology Caucus, I have witnessed firsthand the remarkable advances that lifesaving and life-enhancing medical technology has made to treat and cure debilitating conditions. The current Medicare system is antiquated because of its failure to incorporate modern day advances in technology.

Currently, seniors face unconscionable delays of up to 5 years before Medicare grants access to new technology. This delay can literally be a matter of life or death for many seniors.

The legislation before us incorporates many of the reforms I proposed that will vastly improve medicare's coverage, coding and payment process. These reforms will remove barriers to FDA-approved, lifesaving technology for millions of seniors. The result will not only improve lives, but in many cases save lives as well.

Thanks to this legislation, we are finally eliminating the barriers that discourage innovation and deny America's seniors the medical technologies they desperately need. Seniors have waited too long for access to the same treatment options that other Americans routinely enjoy.

I am also pleased the bill includes legislation I introduced with Mr. Cardin to break down regulatory barriers facing specialized Medicare+Choice plans that serve the frail elderly.

I also worked diligently to ensure that seniors suffering from serious mental illness will have the necessary access, under the new drug benefit, to the psychotropic medication they desperately need. I am pleased that this legislation addresses this critical need.

Mr. Speaker, this package of reforms will improve the lives of today's seniors and seniors for generations to come. I urge my colleagues to support this landmark legislation and deliver on our promise to preserve, protect and strengthen Medicare.

Mr. CANTOR. Mr. Speaker, tonight is a truly historic night. Tonight we will reform and modernize the Medicare system to reflect the needs of seniors. This legislation will save Medicare for our children while allowing seniors access to affordable prescription drugs starting next year.

One important feature of this legislation that allows seniors to have more control of their health care is the inclusion of new Health Savings Accounts (HSAs). These tax-preferred savings accounts work like IRAs and allow individuals, not the government, to make choices that best suit their needs. HSAs, will put individuals back in the driver's seat when it comes to their own health care.

The success of 529 college-savings plans and Roth IRAs proves that HSAs will work. I am glad that we were able to add this conservative and common sense proposal to the bill.

Tonight for the first time in Medicare's history, we will provide nearly 1-million Virginians with access to affordable prescription drug coverage. I am proud to deliver this much-needed and past-due assistance to my fellow Virginians.

Mr. Speaker, I support the Medicare legislation before us. It is a critical step in the right direction, and I encourage my colleagues on both sides of the aisle to support this bill.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). Without objection, the previous question is ordered on the conference report.

There was no objection.

MOTION TO RECOMMIT OFFERED BY MR. TURNER OF TEXAS

Mr. TURNER of Texas. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the conference report?

Mr. TURNER of Texas. Yes, I am, Mr. Speaker.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. TURNER of Texas moves to recommit the conference report on the bill H.R. 1 to the committee of conference with the following instructions to the managers on the part of the House:

(1) Strike the provisions of section 1860D–11(i) of the Social Security Act, as added by section 101(a) of the conference substitute and relating to noninterference of the Secretary of Health and Human Services with the negotiations between drug manufacturers and pharmacies and PDP sponsors.

(2) Substitute the provisions of title I of the Senate amendment to the bill for title I of the conference substitute recommended by the committee of conference, but provide for medicare as primary payor for prescription drug coverage for low-income individuals (as contemplated by the House bill), and permit State medicaid programs to provide wrap-around coverage (as contemplated by the Senate amendment).

(3) Substitute the provisions of title II of the Senate amendment to the bill for title II of the conference substitute recommended by the committee of conference with the following changes:

(A) Omit the provisions of section 231 of the Senate amendment (relating to establishment of alternative payment system for preferred provider organizations in highly competitive regions).

(B) Omit the provisions of subtitle E (relating to the establishment of a National Bipartisan Commission on Medicare Reform).

(4) Within the scope of conference and to the maximum extent possible, take up and reconsider title VIII of the conference substitute.

(5) Strike section 1123 of the conference substitute (relating to a study and report on trade and pharmaceuticals).

(6) Within the scope of conference and to the maximum extent possible, take up and reconsider the issue of importation of prescription drugs.

(7) Within the scope of conference and to the maximum extent possible, take up and reconsider the issue of special rules for employer-sponsored programs, including qualified retiree prescription drug plans.

Mr. TURNER of Texas (during the reading). Mr. Speaker, I ask unanimous consent that the motion to recommit be considered as read and printed in the RECORD.

POINT OF ORDER

Mr. THOMAS. Mr. Speaker, I make a point of order.

The SPEAKER pro tempore. The gentleman will state his point of order.

Mr. THOMAS. Mr. Speaker, do we have the motion to recommit in written form?

The SPEAKER pro tempore. The Clerk is reading the motion now.

Mr. THOMAS. Mr. Speaker, are we allowed to have the motion?

The SPEAKER pro tempore. The gentleman submitted his motion to the desk.

The Clerk will read.

The Clerk concluded the reading of the motion to recommit.

The SPEAKER pro tempore. The motion to recommit is not debatable.

Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

Mr. TURNER of Texas. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 211, noes 222, not voting 2, as follows:

[Roll No. 668]

AYES—211

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Burton (IN)
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Emerson
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gephardt
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Gutknecht
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Paul
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Smith (WA)
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Wamp
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOES—222

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint

Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Hall
Harris
Hart
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McInnis
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NOT VOTING—2

Ehlers
Gillmor

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. HASTINGS of Washington) (during the vote). Members are advised 2 minutes remain in this vote.

□ 0301

Mr. SHADEGG, Mrs. BONO and Mrs. JO ANN DAVIS of Virginia changed their vote from "aye" to "no."

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

Stated against:

Mr. EHLERS. Mr. Speaker, on rollcall No. 668 I was delayed on the way to the floor to vote, and the vote ended just as I walked in the door. Had I been present, I would have voted "no."

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The question is on the conference report.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. DINGELL. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to rule XX, this 15-minute vote on adoption of the conference report will be followed by a 5-minute vote on the motion to suspend the rules on S. 877.

The vote was taken by electronic device, and there were—yeas 220, nays 215, not voting 0, as follows:

[Roll No. 669]

YEAS—220

Aderholt
Alexander
Bachus
Baker
Ballenger
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boucher
Boyd
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carson (OK)
Carter
Castle
Chocola
Coble
Cole
Collins
Cox
Cramer
Crane
Crenshaw
Cubin
Cunningham
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
Diaz-Balart, L.
Diaz-Balart, M.
Dooley (CA)
Doolittle
Dreier
Duncan
Dunn
Ehlers
English
Everett
Ferguson
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Hall
Harris
Hart
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, Sam
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
Marshall
Matheson
McCotter
McCrery
McHugh
McInnis
McKeon
Mica
Miller (MI)
Miller, Gary
Murphy
Myrick
Nethercutt
Neugebauer
Ney
Northup
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Pearce
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Saxton
Schrock
Scott (GA)
Sensenbrenner
Sessions
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (NJ)
Smith (TX)
Souder
Stearns
Stenholm
Sullivan
Sweeney
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Wu
Young (AK)
Young (FL)

NAYS—215

Abercrombie
Ackerman
Akin
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Barrett (SC)
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Brady (PA)
Brown (OH)
Brown, Corrine
Burton (IN)
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Case
Chabot
Clay
Clyburn
Conyers
Cooper
Costello
Crowley
Culberson
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
DeMint
Deutsch
Dicks
Dingell
Doggett
Doyle
Edwards
Emanuel
Emerson
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Feeney
Filner
Flake
Ford
Frank (MA)
Frost
Garrett (NJ)
Gephardt
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Gutknecht
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hostettler
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson, E. B.
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (FL)
Miller (NC)
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murtha
Musgrave
Nadler
Napolitano
Neal (MA)
Norwood
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Paul
Payne
Pelosi
Pence
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (VA)
Serrano
Shadegg
Sherman
Skelton
Slaughter
Smith (MI)
Smith (WA)
Snyder
Solis
Spratt
Stark
Strickland
Stupak
Tancredo
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Toomey
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Wamp
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wynn

Mr. MILLER of Florida and Mr. CULBERSON changed their vote from "yea" to "nay."

Messrs. ISTOOK, FRANKS of Arizona, OTTER, MARSHALL, DOOLEY of California, and SCOTT of Georgia changed their vote from "nay" to "yea."

□ 0553

So the conference report was agreed to.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). Without objection, the motion to reconsider is laid on the table.

Mr. FRANK of Massachusetts. Mr. Speaker, I object.

The SPEAKER pro tempore. Objection is heard.

Mr. FRANK of Massachusetts. Mr. Speaker, I move reconsideration. I move reconsideration, thanks to your arm-twisting.

The SPEAKER pro tempore. The gentleman will suspend.

Did the gentleman vote on the prevailing side?

Mr. FRANK of Massachusetts. I was until the game started.

The SPEAKER pro tempore. The motion to reconsider may be entered only by someone who voted on the prevailing side.

PARLIAMENTARY INQUIRY

Mr. FRANK of Massachusetts. Mr. Speaker, parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state his inquiry.

Mr. FRANK of Massachusetts. After all the razzle-dazzle, exactly what was the prevailing side?

The SPEAKER pro tempore. The yeas have it. Without objection, the motion to reconsider is laid on the table.

Mr. HOYER. Mr. Speaker, reserving the right to object, and I am not going to object, I am not going to put people to the purpose of voting; but I will again say the democratic process is that we come to this floor. I will remind you that you said we had 17 minutes to vote. You made it very clear. You sent us a notice, and you said come with 15 minutes; we will give you 2 more minutes.

This vote has now been held open longer than any vote that I can remember. I have been here 23 years. Perhaps some of you have been here longer. The outrage that was discussed when Speaker Wright held the vote open for far less time than this was palpable on your side of the aisle. Democracy is about voting. But just as you cannot say on Tuesday of Election Day, we will keep the polls open for 15 more hours until we get the result we want, you ought not to be able to do it here, Mr. Speaker. We have prevailed on this vote. Arms have been twisted and votes changed. And I will continue to reserve.

The SPEAKER pro tempore. Is there objection to tabling the motion to reconsider?

Mr. FRANK of Massachusetts. Objection.

Mr. THOMAS. Mr. Speaker, I move to reconsider the vote just taken.

MOTION TO TABLE OFFERED BY MR. DELAY

Mr. DELAY. Mr. Speaker, I move to lay the motion on the table.

The SPEAKER pro tempore. The question is on the motion to table the motion to reconsider. That is not debatable.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. FRANK of Massachusetts. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 210, nays 193, not voting 32, as follows:

[Roll No. 670]

YEAS—210

Aderholt
Akin
Bachus
Baker
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Cole
Collins
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
English
Feeney
Ferguson
Flake
Foley
Forbes
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gilchrest
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Harris
Hart
Hastert
Hastings (WA)
Hayes
Hayworth
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McInnis
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Nunes
Nussle
Osborne
Ose
Otter
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (FL)

NAYS—193

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clyburn
Cooper
Costello
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Doyle
Edwards
Emanuel
Emerson
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Frost
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Hall
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Paul
Payne
Pelosi
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sánchez, Linda T.
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Snyder
Solis
Spratt
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—32

Ballenger
Boucher
Clay
Coble
Conyers
Cramer
Davis (TN)
DeMint
Dooley (CA)
Everett
Fletcher
Ford
Gephardt
Gibbons
Gillmor
Hefley
Jones (NC)
Lantos
LaTourette
Meehan
Moran (KS)
Neal (MA)
Norwood
Oxley
Sanchez, Loretta
Smith (TX)
Smith (WA)
Stark
Tiahrt
Walsh
Wamp
Young (AK)

□ 0613

Mr. FRANK of Massachusetts changed his vote from "nay" to "yea."

So the motion to table was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid upon the table.

CONTROLLING THE ASSAULT OF NON-SOLICITED PORNOGRAPHY AND MARKETING ACT OF 2003

Mr. TAUZIN. Mr. Speaker, I ask unanimous consent that the motion to suspend the rules and pass the Senate bill S. 877, as amended, which is the spam bill that we have bipartisan agreement on, be modified by the amendment that is at the desk, which has been cleared with the other side.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The Clerk will report the amendment.

The Clerk read as follows:

On page 17, line 8 strike "misleading" and insert "falsified."

On page 27, line 9 strike "misleading" and insert "falsified."

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Louisiana?

There was no objection.

The SPEAKER pro tempore. The pending business is the question of suspending the rules and passing the Senate bill, S. 877, as amended.

The Clerk read the title of the Senate bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Louisiana (Mr. TAUZIN) that the House suspend the rules and pass the Senate bill, S. 877, as amended, on which the yeas and nays are ordered.

Without objection, this will be a 5-minute vote.

There was no objection.

The vote was taken by electronic device, and there were—yeas 392, nays 5, not voting 37, as follows:

[Roll No. 671]

YEAS—392

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Costello
Cox
Crane
Crenshaw
Crowley
Cubin
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Farr
Fattah
Feeney
Ferguson
Filner
Flake
Foley
Forbes
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
LaHood
Lampson
Langevin
Larsen (WA)
Larson (CT)
Latham
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Nethercutt
Neugebauer
Ney
Nunes
Nussle
Oberstar
Olver
Ortiz
Osborne
Ose
Otter
Owens
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sánchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Snyder
Solis
Souder
Spratt
Stearns
Stenholm
Strickland
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Vitter
Walden (OR)
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (FL)
Stupak
Tiahrt
Upton
Walsh
Wamp
Young (AK)

NAYS—5

Honda
Jackson-Lee (TX)
Kucinich
Lofgren
Paul

NOT VOTING—37

Ballenger
Boucher
Capuano
Clay
Cramer
Davis (TN)
DeLay
DeMint
Dooley (CA)
Everett
Fletcher
Ford
Frost
Gephardt
Gibbons
Gilchrest
Gillmor
Hefley
Jones (NC)
Lantos
LaTourette
Meehan
Moran (KS)
Neal (MA)
Northup
Norwood
Obey
Oxley
Smith (TX)
Smith (WA)
Stark

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. HASTINGS of Washington) (during the vote). Members are advised that 2 minutes remain in this vote.

☐ 0623

So (two-thirds having voted in favor thereof) the rules were suspended and the Senate bill, as amended, was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. TAUZIN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 1.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Louisiana?

There was no objection.

ADJOURNMENT TO TUESDAY, NOVEMBER 25, 2003

Mr. DELAY. Mr. Speaker, I move that when the House adjourns this legislative day, it adjourn to meet at noon on Tuesday, November 25, 2003.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Texas (Mr. DELAY).

The motion was agreed to.

APPOINTING DAY FOR THE CONVENING OF THE SECOND SESSION OF THE 108TH CONGRESS

Mr. DELAY. Mr. Speaker, I offer a joint resolution (H.J. Res. 80), and ask unanimous consent for its immediate consideration.

The SPEAKER pro tempore. The Clerk will report the joint resolution.

The Clerk read as follows:

H.J. RES. 80

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. DAY FOR CONVENING OF SECOND REGULAR SESSION OF ONE HUNDRED EIGHTH CONGRESS.

The second regular session of the One Hundred Eighth Congress shall begin at noon on Tuesday, January 20, 2004.

SEC. 2. AUTHORITY FOR CALLING SPECIAL SESSION BEFORE CONVENING OF SECOND REGULAR SESSION.

If the Speaker of the House of Representatives (or the designee of the Speaker) and the Majority Leader of the Senate (or the designee of the Majority Leader), acting jointly after consultation with the Minority Leader of the House of Representatives and the Minority Leader of the Senate, determine it is in the public interest for Congress to assemble during the period between the end of the first regular session of the One Hundred Eighth Congress at noon on January 3, 2004, and the convening of the second regular session of the One Hundred Eighth Congress as provided in section 1—

(1) the Speaker and Majority Leader, or their respective designees, shall notify the Members of the House and Senate, respectively, of such determination and of the place and time for Congress to so assemble; and

(2) Congress shall assemble in accordance with that notification.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

The joint resolution was ordered to be engrossed and read a third time, was read a third time, and passed, and a motion to reconsider was laid on the table.

PROVIDING FOR ADJOURNMENT SINE DIE AFTER COMPLETION OF BUSINESS OF FIRST SESSION OF 108TH CONGRESS

Mr. DELAY. Mr. Speaker, I offer a privileged concurrent resolution (H. Con. Res. 339), and ask for its immediate consideration.

The SPEAKER pro tempore. The Clerk will report the concurrent resolution.

The Clerk read as follows:

HOUSE CONCURRENT RESOLUTION 339

Resolved by the House of Representatives (the Senate concurring), That when the House adjourns on any legislative day from Friday, November 21, 2003, through Friday, November 28, 2003, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand adjourned until 2 p.m. on Tuesday, December 2, 2003, or until the time of any reassembly pursuant to section 2 of this concurrent resolution, whichever occurs first; that when the House adjourns on any legislative day from Tuesday, December 2, 2003, through the remainder of the first session of the One Hundred Eighth Congress, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand adjourned sine die, or until the time of any reassembly pursuant to section 2 of this concurrent resolution, whichever occurs first; that when the Senate recesses or adjourns at the close of business on any day from Friday, November 21, 2003, through Friday, November 28, 2003, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand recessed or adjourned until noon on Tuesday, December 2, 2003, or at such other time on that day as may be specified by its Majority Leader or his designee in the motion to recess or adjourn, or until the time of any reassembly pursuant to section 2 of this concurrent resolution, whichever occurs first; and that when the Senate adjourns at the close of business on any day from Tuesday, December 2, 2003, through the remainder of the first session of the One Hundred Eighth Congress, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand adjourned sine die, or until the time of any reassembly pursuant to section 2 of this concurrent resolution, whichever occurs first.

SEC. 2. The Speaker of the House and the Majority Leader of the Senate, or their respective designees, acting jointly after consultation with the Minority Leader of the House and the Minority Leader of the Senate, shall notify the Members of the House and the Senate, respectively, to reassemble at such place and time as they may designate whenever, in their opinion, the public interest shall warrant it.

The concurrent resolution was agreed to.

A motion to reconsider is laid upon the table.

NATIONAL TRANSPORTATION SAFETY BOARD REAUTHORIZATION ACT OF 2003

Mr. DELAY. Mr. Speaker, I ask unanimous consent to take from the Speaker's table the Senate bill (S. 579) to reauthorize the National Transportation Safety Board, and for other purposes, and ask for its immediate consideration in the House.

The Clerk read the title of the Senate bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

The Clerk read the Senate bill, as follows:

S. 579

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "National Transportation Safety Board Reauthorization Act of 2003".

SEC. 2. AUTHORIZATION OF APPROPRIATIONS.

(a) FISCAL YEARS 2003–2006.—Section 1118(a) of title 49, United States Code, is amended—

(1) by striking "and"; and

(2) by striking "such sums to" and inserting the following: "$73,325,000 for fiscal year 2003, $78,757,000 for fiscal year 2004, $83,011,000 for fiscal year 2005, and $87,539,000 for fiscal year 2006. Such sums shall".

(b) EMERGENCY FUND.—Section 1118(b) of such title is amended by striking the second sentence and inserting the following: "In addition, there are authorized to be appropriated such sums as may be necessary to increase the fund to, and maintain the fund at, a level not to exceed $3,000,000.".

(c) NTSB ACADEMY.—Section 1118 of such title is amended by adding at the end the following:

"(c) ACADEMY.—

"(1) AUTHORIZATION.—There are authorized to be appropriated to the Board for necessary expenses of the National Transportation Safety Board Academy, not otherwise provided for, $3,347,000 for fiscal year 2003, $4,896,000 for fiscal year 2004, $4,995,000 for fiscal year 2005, and $5,200,000 for fiscal year 2006. Such sums shall remain available until expended.

"(2) FEES.—The Board may impose and collect such fees as it determines to be appropriate for services provided by or through the Academy.

"(3) RECEIPTS CREDITED AS OFFSETTING COLLECTIONS.—Notwithstanding section 3302 of title 31, any fee collected under this paragraph—

"(A) shall be credited as offsetting collections to the account that finances the activities and services for which the fee is imposed;

"(B) shall be available for expenditure only to pay the costs of activities and services for which the fee is imposed; and

"(C) shall remain available until expended.

"(4) REFUNDS.—The Board may refund any fee paid by mistake or any amount paid in excess of that required.".

(c) REPORT ON ACADEMY OPERATIONS.—The National Transportation Safety Board shall transmit an annual report to the Congress on the activities and operations of the National Transportation Safety Board Academy.

SEC. 3. ASSISTANCE TO FAMILIES OF PASSENGERS INVOLVED IN AIRCRAFT ACCIDENTS.

(a) RELINQUISHMENT OF INVESTIGATIVE PRIORITY.—Section 1136 of title 49, United States Code, is amended by adding at the end the following:

"(j) RELINQUISHMENT OF INVESTIGATIVE PRIORITY.—

"(1) GENERAL RULE.—This section (other than subsection (g)) shall not apply to an aircraft accident if the Board has relinquished investigative priority under section 1131(a)(2)(B) and the Federal agency to which the Board relinquished investigative priority is willing and able to provide assistance to the victims and families of the passengers involved in the accident.

"(2) BOARD ASSISTANCE.—If this section does not apply to an aircraft accident because the Board has relinquished investigative priority with respect to the accident, the Board shall assist, to the maximum extent possible, the agency to which the Board has relinquished investigative priority in assisting families with respect to the accident.".

(b) REVISION OF MOU.—Not later than 1 year after the date of enactment of this Act, the National Transportation Safety Board and the Federal Bureau of Investigation shall revise their 1977 agreement on the investigation of accidents to take into account the amendments made by this section and shall submit a copy of the revised agreement to the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate.

SEC. 4. RELIEF FROM CONTRACTING REQUIREMENTS FOR INVESTIGATIONS SERVICES.

Section 1113(b) of title 49, United States Code, is amended—

(1) by striking "Statutes;" in paragraph (1)(B) and inserting "Statutes, and, for investigations conducted under section 1131, enter into such agreements or contracts without regard to any other provision of law requiring competition if necessary to expedite the investigation;"; and

(2) by adding at the end the following:

"(3) The Board, as a component of its annual report under section 1117, shall include an enumeration of each contract for $25,000 or more executed under this section during the preceding calendar year.".

Mr. OBERSTAR. Mr. Speaker, I rise in strong support of S. 579, the National Transportation Safety Board (NTSB) Reauthorization Act of 2003. The bill is substantially the same as the NTSB reauthorization passed by the House on May 15, 2003, by voice vote. Passage of the Senate bill will enable the bill to go to the President.

In the last 5 years, NTSB has investigated 8,124 aviation accidents, 166 highway accidents, 24 marine accidents, 41 pipeline/hazardous materials accidents, and 82 railroad accidents. In addition, the NTSB has issued a total of 881 safety recommendations: 374

aviation; 188 highway; 24 intermodal; 112 marine; 51 pipeline; and 132 railroad.

To maintain its position as the world's preeminent investigative agency, it is imperative that the NTSB has the resources necessary to handle increasingly complex accident investigations. The NTSB has recently broken ground for its new training academy that will teach state of the art investigative techniques for transportation accidents. The NTSB now needs sufficient funding to sustain budget and personnel for both its Headquarters operations as well as the academy. Accordingly, S. 579 authorizes increased funding over the next 4 years: $73 million in fiscal year 2003; $79 million in fiscal year 2004; $83 million in fiscal year 2005, and $87.5 million in fiscal year 2006. The bill also authorizes approximately $5 million per year for the training academy. This funding is critical to ensure that the Agency has the necessary resources to hire additional technical experts as well as to provide better training for its current workforce.

In 2000, Congress authorized the transfer of investigative priority from the NTSB to the Federal Bureau of Investigation (FBI) in the event of an accident caused by an international criminal act. However, there was no mechanism for the transfer of family affairs responsibility. Since the events of September 11th, the NTSB now believes that once the FBI has been transferred investigative responsibility for an aircraft accident, the family affairs responsibilities should transfer as well. S. 579 provides for the transfer of the family affairs responsibility when investigative authority has been relinquished in aviation accidents.

S. 579 also addresses another matter of great import; that is, the DOT's notoriously slow response to NTSB's safety recommendations. The bill requires an annual report from DOT on the regulatory status of safety recommendations on NTSB's "most wanted list." The bill also requires DOT to report biennially on NTSB safety recommendations concerning 15-passenger van safety, railroad grade crossing safety, and medical certifications for a commercial drivers license. These reports will enable the Committee to keep tabs on the progress of these very important recommendations.

Having a well funded, well-trained NTSB workforce is of the utmost importance for the American traveling public. I urge my colleagues to support this critical piece of legislation, and I compliment Chairman YOUNG, Chairman MICA, and Ranking member DEFAZIO for their efforts.

The Senate bill was ordered to be read a third time, was read the third time, and passed, and a motion to reconsider was laid on the table.

HOMETOWN HEROES SURVIVORS BENEFITS ACT OF 2003

Mr. DELAY. Mr. Speaker, I ask unanimous consent to take from the Speaker's table the Senate bill (S. 459) to ensure that a public safety officer who suffers a fatal heart attack or stroke while on duty shall be presumed to have died in the line of duty for purposes of public safety officer survivor benefits, and ask for its immediate consideration in the House.

The Clerk read the title of the Senate bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

Mr. ETHERIDGE. Mr. Speaker, reserving the right to object, I will not object, but let me thank the leader and his staff. I want to take this opportunity to thank the gentleman from Wisconsin (Mr. SENSENBRENNER) and his staff; the ranking member, the gentleman from Michigan (Mr. CONYERS), and his staff; the subcommittee chair, the gentleman from North Carolina (Mr. COBLE), and his staff; the ranking member, the gentleman from Virginia (Mr. SCOTT), and his staff; and my staff for all their hard work; the gentleman from Pennsylvania (Mr. WELDON); and the gentleman from Maryland (Mr. HOYER) and others because this bill is an important piece of legislation.

It provides for our first responders and their families a bit of security. There is a gap in the law where currently if they die of a heart attack or stroke doing their duties, their families would not get benefits. This is a bipartisan piece of legislation. Over 283 Members of this body have signed it. Let me thank the leader. I appreciate his help and the help of others in getting this to the floor.

Mr. SENSENBRENNER. Mr. Speaker, current law provides $267,494 to the survivors of public safety officers such as police officers, firefighters and rescue squad officers who die "as the direct and proximate result of a personal injury sustained in the line of duty". S. 459, the "Hometown Heroes Survivor Benefits Act of 2003", as introduced would provide that if a public safety officer dies as the direct and proximate result of a heart attack or stroke suffered while on duty or within 24 hours after participating in a training exercise or responding to an emergency situation, that officer shall be presumed to have died as the direct and proximate result of a personal injury sustained in the line of duty for purposes of that officer's survivors receiving a $267,494 death benefit.

The intent of the legislation was to cover officers who suffered a heart attack or stroke as a result of nonroutine stressful or strenuous physical activity; however, testimony at the hearing indicated that the legislation as drafted was overboard. Witnesses testified that the legislation as drafted would undermine the purpose of the Public Safety Officer Benefits program, which was intended to provide a benefit to heroes who gave their lives in the line of duty for their communities. As drafted, it would cover officers who did not engage in any physical activity but merely happened to suffer a heart attack at work.

A substitute amendment was introduced to address these concerns. The substitute amendment would create a presumption that an officer who died as a direct and proximate result of a heart attack or stroke died as a direct and proximate result of a personal injury sustained in the line of duty if: (1) that officer participated in a training exercise that involved nonroutine stressful or strenuous physical activity or responded to a situation and such participation or response involved nonroutine stressful or strenuous physical law enforcement, hazardous material response, emergency medical services, prison security, fire suppression, rescue, disaster relief or other emergency response activity; (2) that officer suffered a heart attack or stroke while engaging or within 24 hours of engaging in that physical activity; and (3) such presumption cannot be overcome by competent medical evidence.

For the purposes of this Act, the phrase "nonroutine stressful or strenuous physical" activity will exclude actions of a clerical, administrative or non-manual nature. Included in the category of "actions of a clerical, administrative or non-manual nature" are such tasks including, but not limited to, the following: sitting at a desk; typing on a computer; talking on the telephone; reading or writing paperwork or other literature; watching a police or corrections facility's monitors of cells or grounds; teaching a class; cleaning or organizing an emergency response vehicle; signing in or out a prisoner; driving a vehicle on routine patrol; and directing traffic at or participating in a local parade.

Such deaths, while tragic, are not to be considered in the line of duty deaths. The families of officers who died of such causes would therefore not be eligible to receive public safety officers benefits.

For the purposes of this Act, the phrase "nonroutine stressful or strenuous physical" actions will include, but are not limited to, the following: involvement in a physical struggle with a suspected or convicted criminal; performing a search and rescue mission; performing or assisting with emergency medical treatment; performing or assisting with fire suppression; involvement in a situation that requires either a high speed response or pursuit on foot or in a vehicle; participation in hazardous material response; responding to a riot that broke out at a public event; and physically engaging in the arrest or apprehension of a suspected criminal.

The situation listed above the types of heart attack and stroke cases that are considered to be in the line of duty. The families of officers who died in such cases are eligible to receive Public Safety Officers Benefits.

Mr. ETHERIDGE. Mr. Speaker, I withdraw my reservation of objection.

□ 0630

The SPEAKER pro tempore (Mr. HASTINGS of Washington). Is there objection to the request of the gentleman from Texas?

There was no objection.

The Clerk read the Senate bill, as follows:

S. 459

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Hometown Heroes Survivors Benefits Act of 2003".

SEC. 2. FATAL HEART ATTACK OR STROKE ON DUTY PRESUMED TO BE DEATH IN LINE OF DUTY FOR PURPOSES OF PUBLIC SAFETY OFFICER SURVIVOR BENEFITS.

Section 1201 of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796) is amended by adding at the end the following:

"(k) For purposes of this section, if a public safety officer dies as the direct and proximate result of a heart attack or stroke suffered while on duty, or not later than 24 hours after participating in a training exercise or responding to an emergency situation, that officer shall be presumed to have died as the direct and proximate result of a personal injury sustained in the line of duty.".

SEC. 3. APPLICABILITY.

Section 1201(k) of the Omnibus Crime Control and Safe Streets Act of 1968, as added by section 2, shall apply to deaths occurring on or after January 1, 2003.

AMENDMENT IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. DELAY

Mr. DELAY. Mr. Speaker, I offer an amendment in the nature of a substitute.

The Clerk read as follows:

Amendment in the nature of a substitute offered by Mr. DELAY:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may cited as the "Hometown Heroes Survivors Benefits Act of 2003".

SEC. 2. FATAL HEART ATTACK OR STROKE ON DUTY PRESUMED TO BE DEATH IN LINE OF DUTY FOR PURPOSES OF PUBLIC SAFETY OFFICER SURVIVOR BENEFITS.

Section 1201 of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796) is amended by adding at the end the following:

"(k) For purposes of this section, if a public safety office dies as the direct and proximate result of a heart attack or stroke, that officer shall be presumed to have died as the direct and proximate result of a personal injury sustained in the line of duty, if—

"(1) that office, while on duty—

"(A) engaged in a situation, and such engagement involved nonroutine stressful or strenuous physical law enforcement, fire suppression, rescue, hazardous material response, emergency medical services, prison security, disaster relief, or other emergency response activity; or

"(B) participated in a training exercise, and such participation involved nonroutine stressful or strenuous physical activity;

"(2) that officer died as a result of a heart attack or stroke suffered—

"(A) while engaging or participating as described under paragraph (1);

"(B) while still on that duty after so engaging or participating; or

"(C) not later than 24 hours after so engaging or participating; and

"(3) such presumption is not overcome by competent medical evidence to the contrary.

"(l) For purposes of subsection (k), 'nonroutine stressful or strenuous physical' excludes actions of a clerical, administrative, or non-manual nature.".

Mr. DELAY (during the reading). Mr. Speaker, I ask unanimous consent that the amendment in the nature of a substitute be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

The amendment in the nature of a substitute was agreed to.

The Senate bill was ordered to be read a third time, was read the third time, and passed, and a motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. DELAY. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on the Senate bill just passed.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

SENATE BILLS REFERRED

A bill of the Senate of the following title was taken from the Speaker's table and, under the rule, referred as follows:

S. 1561. An act to preserve existing judgeships on the Superior Court of the District of Columbia; to the Committee on Government Reform.

ENROLLED BILLS SIGNED

Mr. Trandahl, Clerk of the House, reported and found truly enrolled bills of the House of the following titles, which were thereupon signed by the Speaker:

H.R. 3182. An act to reauthorize the adoption incentive payments program under part E of title IV of the Social Security Act, and for other purposes.

H.J. Res. 79. Joint resolution making further continuing appropriations for the fiscal year 2004, and for other purposes.

SENATE ENROLLED BILLS SIGNED

The SPEAKER announced his signature to enrolled bills of the Senate of the following titles:

S. 117. An act to authorize the Secretary of Agriculture to sell or exchange certain land in the State of Florida, and for other purposes.

S. 286. An act to revise and extend the Birth Defects Prevention Act of 1998.

S. 650. An act to amend the Federal Food, Drug, and Cosmetic Act to authorize the Food and Drug Administration to require certain research into drugs used in pediatric patients.

S. 1685. An act to extend and expand the basic pilot program for employment eligibility verification, and for other purposes.

S. 1720. An act to provide for Federal court proceedings in Plano, Texas.

S. 1824. An act to amend the Foreign Assistance Act of 1961 to reauthorize the Overseas Private Investment Corporation, and for other purposes.

ADJOURNMENT

Mr. DELAY. Mr. Speaker, in honor of Scott Palmer's birthday, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 6 o'clock and 32 minutes a.m., Saturday, November 22, 2003), under its previous order, the House adjourned until Tuesday, November 25, 2003, at noon.

EXPENDITURE REPORTS CONCERNING OFFICIAL FOREIGN TRAVEL

Reports concerning the foreign currencies and U.S. dollars utilized for speaker-authorized official travel during the third and fourth quarters of 2003, pursuant to Public Law 95–384 are as follows:

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, DELEGATION TO KUWAIT AND IRAQ, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN OCT. 6 AND OCT. 10, 2003

Name of Member or employee	Date		Country	Per diem [1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]	Foreign currency	U.S. dollar equivalent or U.S. currency [2]
Hon. Fred Upton	10/6	10/10	Kuwait-Iraq		1,167.00						
Hon. Jim Davis	10/6	10/10	Kuwait-Iraq		1,167.00						
Hon. Mike Castle	10/6	10/10	Kuwait-Iraq		1,167.00						
Hon. Wayne Gilchrest	10/6	10/10	Kuwait-Iraq		1,167.00						
Hon. Amo Houghton	10/6	10/10	Kuwait-Iraq		1,167.00						
Hon. Ron Kind	10/6	10/10	Kuwait-Iraq		1,167.00						
Hon. Gregory Muujs	10/6	10/10	Kuwait-Iraq		1,167.00						
Hon. Greg Walden	10/6	10/10	Kuwait-Iraq		1,167.00						
Bill Livingood	10/6	10/10	Kuwait-Iraq		1,167.00						
Joan Hillebrands	10/6	10/10	Kuwait-Iraq		1,167.00						
John "JJ" Pishadlo	10/6	10/10	Kuwait-Iraq		1,167.00						
Committee total	10/6	10/10	Kuwait-Iraq		1,167.00						1,167.00

[1] Per diem constitutes lodging and meals.

[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.

——— ———, Nov. 10, 2003

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON APPROPRIATIONS, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY AND SEPT. 30, 2003

Name of Member or employee	Date		Country	Per diem[1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency[2]	Foreign currency	U.S. dollar equivalent or U.S. currency[2]	Foreign currency	U.S. dollar equivalent or U.S. currency[2]	Foreign currency	U.S. dollar equivalent or U.S. currency[2]
Hon. Kay Granger	6/28	7/1	Croatia		1,104.00						1,104.00
	7/01	7/7	Italy		2,848.00						2,848.00
									1,226.41		1,226.41
Commercial airfare							5,709.57				5,709.57
Hon. Bud Cramer	6/28	7/1	Croatia		1,104.00						1,104.00
	7/1	7/7	Italy		2,848.00						2,848.00
									1,226.41		1,226.41
Commercial airfare							[3]2,864.57				[3]2,864.57
John T. Blazey II	6/28	7/1	Croatia		1,104.00						1,104.00
	7/1	7/7	Italy		2,848.00						2,848.00
									1,226.41		1,226.41
Commercial airfare							5,709.57				5,709.57
Therese McAuliffe	6/28	7/1	Croatia		1,104.00						1,104.00
	7/1	7/7	Italy		2,848.00						2,848.00
									1,226.41		1,226.41
Commercial airfare							4,489.36				4,489.36
Hon. C.W. Bill Young	7/26	8/1	Italy		1,016.00						1,016.00
Military & misc. commercial							1,110.40				1,110.40
									3,399.82		3,399.82
Hon. Dave Weldon	7/26	8/1	Italy		1,016.00						1,016.00
Military and misc. commercial							1,100.40				1,110.40
									3,399.82		3,399.82
Doug Gregory	7/26	8/1	Italy		1,016.00						1,016.00
Military & misc. commercial							1,110.40				1,110.40
									3,399.82		3,399.82
Jane Porter	7/26	8/1	Italy		1,016.00						1,016.00
Military & misc. commercial							1,110.40				1,110.40
									3,399.82		3,399.82
Hon. David Hobson	8/5	8/11	Russia		2,116.91		(4)				2,116.91
Hon. Mike Simpson	8/5	8/11	Russia		2,116.91		(4)				2,116.91
Hon. Marion Berry	8/5	8/11	Russia		2,116.91		(4)				2,116.91
Hon. Kay Granger	8/5	8/11	Russia		2,116.91		(4)				2,116.91
Hon. Robert Aderholt	8/5	8/11	Russia		2,116.91		(4)				2,116.91
Hon. Ed Pastor	8/5	8/11	Russia		2,116.91		(4)				2,116.91
Bob Schmidt	8/5	8/11	Russia		2,116.91		(4)				2,116.91
Kevin Cook	8/5	8/11	Russia		2,116.91		(4)				2,116.91
Dennis Kern	8/5	8/11	Russia		2,116.91		(4)				2,116.91
Scott Burnison	8/5	8/11	Russia		2,116.91		(4)				2,116.91
Hon. Jerry Lewis	7/26	7/29	Poland		1,215.00						1,215.00
	7/29	8/1	Portugal		468.00						468.00
	8/1	8/5	United Kingdom		1,840.00						1,840.00
							(4)		819.00		819.00
Hon. Alan B. Mollohan	7/26	7/29	Poland		1,215.00						1,215.00
	7/29	8/1	Portugal		468.00						468.00
	8/1	8/5	United Kingdom		1,840.00						1,840.00
							(4)		819.00		819.00
Hon. Rodney Frelinghuysen	7/26	7/29	Poland		1,215.00						1,215.00
	7/29	8/1	Portugal		468.00						468.00
	8/1	8/5	United Kingdom		1,840.00						1,840.00
							(4)		819.00		819.00
Hon. Lucille Roybal-Allard	7/26	7/29	Poland		1,215.00						1,215.00
	7/29	8/1	Portugal		468.00						468.00
	8/1	8/5	United Kingdom		1,840.00						1,840.00
							(4)		819.00		819.00
Hon. John Shank	7/26	7/29	Poland		1,215.00						1,215.00
	7/29	8/1	Portugal		468.00						468.00
	8/1	8/5	United Kingdom		1,840.00						1,840.00
							(4)		717.00		717.00
John T. Blazey II	7/26	7/29	Poland		1,215.00						1,215.00
	7/29	8/1	Portugal		468.00						468.00
	8/1	8/5	United Kingdom		1,840.00						1,840.00
							(4)		717.00		717.00
Scott Gudes	8/2	8/7	Israel (& W Bank/Gaza)		1,450.00						1,450.00
	8/7	8/10	Bosnia and Herzegovina		722.00						722.00
	8/10	8/12	Montenegro		402.00						402.00
	8/12	8/14	Austria		564.00						564.00
	8/14	8/16	Bulgaria		530.00						530.00
Commercial airfare							6,954.10				6,954.10
Hon. James P. Moran	7/26	7/28	Senegal		541.50						541.50
	7/28	7/29	Mali		202.00						202.00
	7/29	7/31	Tunisia		402.00						402.00
	7/31	8/2	Malta		493.00		(4)				493.00
Hon. Charles Taylor	8/2	8/5	United Kingdom		1,380.00						1,380.00
	8/5	8/8	France		2,123.00						2,123.00
	8/8	8/11	Belgium		782.00						782.00
	8/11	8/15	Russia								
Commercial airfare							3,630.07				3,630.07
Elizabeth Dawson	7/26	7/29	Poland		1,215.00						1,215.00
	7/29	8/1	Portugal		468.00						468.00
	8/1	8/5	United Kingdom		1,840.00						1,840.00
	8/5	8/8	France		2,514.00						2,514.00
	8/8	8/11	Belgium		1,173.00						1,173.00
							(4)		717.00		717.00
Commercial airfare							2,857.00				2,857.00
							312.00				312.00
Chester Lee Turner III	8/1	8/5	United Kingdom		1,840.00						1,840.00
	8/5	8/8	France		2,514.00						2,514.00
	8/8	8/11	Belgium		1,173.00						1,173.00
	8/11		USA								
Commercial airfare							5,995.29				5,995.29
Hon. John Murtha	8/17	8/18	Kuwait		339.00						339.00
	8/18	8/18	Iraq		154.00						154.00
	8/18	8/19	Turkey		231.00		(4)				231.00
David Morrison	8/17	8/18	Kuwait		339.00						339.00
	8/18	8/18	Iraq		154.00						154.00
	8/18	8/19	Turkey		231.00		(4)				231.00
Hon. Jim Kolbe	8/18	8/19	Israel				362.00				362.00
	8/19	8/21	Kuwait				778.00				778.00
	8/21	8/23	Pakistan				526.00				526.00
	8/23	8/24	Turkey				276.00				276.00
Commercial airfare							6,175.62				6,175.62
Mark Murray	8/18	8/20	United Arab Emirates		400.00						400.00

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON APPROPRIATIONS, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY AND SEPT. 30, 2003—Continued

Name of Member or employee	Date		Country	Per diem[1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency[2]	Foreign currency	U.S. dollar equivalent or U.S. currency[2]	Foreign currency	U.S. dollar equivalent or U.S. currency[2]	Foreign currency	U.S. dollar equivalent or U.S. currency[2]
	8/20	8/23	Afghanistan		800.00						800.00
	8/23	8/25	Israel		400.00						400.00
Commercial airfare							6,959.04				6,959.04
Christine R. Kojac	8/26	8/27	Poland		187.80						187.80
	8/27	8/28	Czech Republic		283.00						283.00
	8/28	8/30	Switzerland		654.02						654.02
									59.45		59.45
Commercial airfare							5,864.12				5,864.12
John T. Blazey II	8/24	8/27	Poland		558.00						558.00
	8/27	8/29	Czech Republic		566.00						566.68
Commercial airfare							6,110.68				6,110.68
Mike Ringler	8/5	8/6	Kosovo		202.70						202.70
	8/6	8/8	Germany		676.00						676.00
	8/8	8/9	Bulgaria		265.00						265.00
Commercial airfare							6,432.76				6,432.76
Rob Nabors	8/5	8/6	Kosovo		202.70						202.70
	8/6	8/8	Germany		676.00						676.00
	8/8	8/9	Bulgaria		265.00						265.00
Commercial airfare							6,432.76				6,432.76
Hon. Bud Cramer	8/21	8/23	Russia		714.00						714.00
	8/23	8/26	Czech Republic		849.00						849.00
	8/24	8/28	Malta		506.00		(4)				506.00
James W. Dyer	8/23	8/25	Israel		628.00						628.00
	8/26	8/27	Jordan		376.00						376.00
	8/27	8/29	Egypt		334.00						334.00
	8/29	8/31	England		828.00						828.00
Commercial airfare							7,473.01				7,473.01
Leslie F. Albright	8/23	8/25	Israel		628.00						628.00
	8/26	8/27	Jordan		376.00						376.00
	8/27	8/29	Egypt		334.00						334.00
	8/29	8/31	England		828.00						828.00
Commercial airfare							8,589.30				8,589.30
Rob Nabors	8/23	8/25	Israel		628.00						628.00
							63.45				63.45
Commercial airfare							6,129.80				6,129.80
Scott Lilly	8/23	8/25	Israel		942.00						942.00
	8/26	8/27	Jordan		376.00						376.00
	8/27	8/29	Syria		436.00						436.00
	8/29	8/30	Lebanon		420.00						420.00
Commercial airfare							6,427.85				6,427.85
David Morrison	8/23	8/25	Israel		942.00						942.00
	8/26	8/27	Jordan		376.00						376.00
	8/27	8/29	Syria		436.00						436.00
	8/29	8/30	Lebanon		420.00						420.00
Commercial airfare							7,128.65				7,128.65
Hon. Jim Kolbe	9/10	9/13	Mexico		177.00						177.00
Commercial airfare							1,025.12				1,025.12
Hon. Jim Kolbe	9/26	9/27	Costa Rica		255.00						255.00
	8/27	9/29	Guatemala		434.00		(4)				434.00
Alice Hogans	9/26	9/27	Costa Rica		255.00						255.00
	8/27	9/29	Guatemala		434.00		(4)				434.00
Carolyn Murphy	9/26	9/27	Costa Rica		255.00						255.00
	8/27	9/29	Guatemala		434.00		(4)				434.00
Charles Flickner	9/16	9/17	Azerbaijan		282.00						282.00
	9/17	9/22	Afghanistan		240.00						240.00
	9/22	9/23	United Arab Emirates		209.00						209.00
Commercial airfare							7,199.52				7,199.52
Hon. Jerry Lewis	9/26	9/28	Jordan		476.00						476.00
	9/28	9/29	Spain		259.00		(4)				259.00
Hon. Norm Dicks	9/26	9/28	Jordan		476.00						476.00
	9/28	9/29	Spain		259.00		(4)				259.00
Hon. James Walsh	9/26	9/28	Jordan		476.00						476.00
	9/28	9/29	Spain		259.00		(4)				259.00
Hon. Henry Bonilla	9/26	9/28	Jordan		476.00						476.00
	9/28	9/29	Spain		259.00		(4)				259.00
Hon. Rodney Frelinghuysen	9/26	9/28	Jordan		476.00						476.00
	9/28	9/29	Spain		259.00		(4)				259.00
Hon. George Nethercutt	9/26	9/28	Jordan		476.00						476.00
	9/28	9/29	Spain		259.00		(4)				259.00
Hon. Todd Tiahrt	9/26	9/28	Jordan		476.00						476.00
	9/28	9/29	Spain		259.00		(4)				259.00
Hon. Kay Granger	9/26	9/28	Jordan		476.00						476.00
	9/28	9/29	Spain		259.00		(4)				259.00
Hon. Mark Kirk	9/26	9/28	Jordan		476.00						476.00
	9/28	9/29	Spain		259.00		(4)				259.00
John Scofield	9/26	9/28	Jordan		476.00						476.00
	9/28	9/29	Spain		259.00		(4)				259.00
Doug Gregory	9/26	9/28	Jordan		476.00						476.00
	9/28	9/29	Spain		259.00		(4)				259.00
Valerie Baldwin	9/26	9/28	Jordan		395.70						395.70
	9/28	9/29	Spain		342.25		(4)				342.25
John Shank	9/26	9/28	Jordan		476.00						476.00
	9/28	9/29	Spain		259.00		(4)				259.00
Steve Nixon	9/26	9/28	Jordan		476.00						476.00
	9/28	9/29	Spain		259.00		(4)				259.00
Committee total						11,6,736.77		126,916.81		23,991.37	267,644.95

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[1] Per diem constitutes lodging and meals.

[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.

[3] Reflects credit for return of unused portion cf ticket.

[4] Military air transportation.

———— ————, Oct. 30, 2003.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON EDUCATION AND THE WORKFORCE, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND OCT. 31, 2003[4]

Name of Member or employee	Date		Country	Per diem[1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency[2]	Foreign currency	U.S. dollar equivalent or U.S. currency[2]	Foreign currency	U.S. dollar equivalent or U.S. currency[2]	Foreign currency	U.S. dollar equivalent or U.S. currency[2]
Hon. Michael Castle	10/6	10/12	Iraq	....	....	[3]	....	....	....	....	....
Hon. Ron Kind	10/6	10/12	Iraq	....	....	[3]	....	....	....	....	....
Committee total	....	....	....	....	....	....	....	....	....	....	....

[1] Per diem constitutes lodging and meals.

[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.

[3] Military air transportation.

[4] Expenditures for the above travel unavailable by the deadline of Oct. 31, 2003 to file report.

JOHN BOEHNER, Chairman, Nov. 4, 2003.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON ENERGY AND COMMERCE, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND OCT. 31, 2003

Name of Member or employee	Date		Country	Per diem[1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency[2]	Foreign currency	U.S. dollar equivalent or U.S. currency[2]	Foreign currency	U.S. dollar equivalent or U.S. currency[2]	Foreign currency	U.S. dollar equivalent or U.S. currency[2]
Hon. Cliff Stearns	9/10	9/13	Mexico	....	708.00	....	....	....	....	....	708.00
Jack Seum	9/10	9/13	Mexico	....	708.00	....	....	....	....	....	708.00
Ramsen Betfarhad	9/10	9/13	Mexico	....	708.00	....	....	....	....	....	708.00
Manisha Singh	9/10	9/15	Mexico	....	1,239.00	....	771.65	....	....	....	2,010.65
Hon. Rick Boucher	7/26	7/31	Brazil	....	1,675.00	....	....	....	....	....	1,675.00
	7/31	8/3	Chile	....	822.00	....	....	....	....	....	822.00
	8/3	8/5	Costa Rica	....	450.00	....	....	....	....	....	450.00
Hon. John Shimkus	9/26	9/28	Jordan/Iraq	....	576.00	....	....	....	....	....	576.00
	9/29	9/29	Spain	....	259.00	....	....	....	....	....	259.00
Hon. Darrell Issa	8/27	9/2	Egypt	....	868.00	....	6,718.00	....	....	....	7,586.00
Chris Knauer	8/18	8/22	Germany	....	1,021.00	....	1,028.54	....	....	....	2,049.54
Hon. Cliff Stearns	6/27	7/2	Italy	....	1,005.00	....	....	....	1,527.45	....	2,532.45
Hon. Ed Whitfield	8/4	8/11	Russia	....	2,116.91	....	....	....	....	....	2,116.91
Hon. Michael Bilirakis	7/24	7/30	Italy	....	1,016.00	....	1,110.40	....	3,399.82	....	5,526.22
Hon. Joe Barton	7/25	7/29	Poland	....	1,065.00	....	....	....	....	....	1,065.00
	7/29	8/1	Portugal	....	1,042.50	....	....	....	....	....	1,042.50
	8/1	8/5	United Kingdom	....	1,640.00	....	....	....	....	....	1,640.00
Committee total	....	....	....	....	16,919.41	....	9,628.59	....	4,927.27	....	31,475.27

[1] Per diem constitutes lodging and meals.

[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.

BILLY TAUZIN, Chairman, Oct. 31, 2003.

REPORT OF EXPENDITURES FOR OFFICIAL FOREIGN TRAVEL, COMMITTEE ON FINANCIAL SERVICES, HOUSE OF REPRESENTATIVES, EXPENDED BETWEEN JULY 1 AND AUG. 30, 2003

Name of member or employee	Date		Country	Per diem[1]		Transportation		Other purposes		Total	
	Arrival	Departure		Foreign currency	U.S. dollar equivalent or U.S. currency[2]	Foreign currency	U.S. dollar equivalent or U.S. currency[2]	Foreign currency	U.S. dollar equivalent or U.S. currency[2]	Foreign currency	U.S. dollar equivalent or U.S. currency[2]

HOUSE COMMITTEES

Please Note: If there were no expenditures during the calendar quarter noted above, please check the box at right to so indicate and return. ☒

[1] Per diem constitutes lodging and meals.

[2] If foreign currency is used, enter U.S. dollar equivalent; if U.S. currency is used, enter amount expended.

MICHAEL G. OXLEY, Chairman, Oct. 29, 2003.

NOTICE OF PROPOSED RULEMAKING

U.S. CONGRESS,
OFFICE OF COMPLIANCE,
Washington, DC, November 20, 2003.

Hon. J. DENNIS HASTERT,
Speaker of the House of Representatives, Washington, DC.

DEAR MR. SPEAKER: A Notice of Proposed Rulemaking (NPR) for amendments to the Procedural Rules of the Office of Compliance was published in the Congressional Record dated September 4, 2003. Subsequent to the publication of this notice, this office announced a hearing for public comment on the proposed amendments in the Congressional Record on October 15, 2003.

The Board of Directors of the Office of Compliance cancels the hearing regarding the proposed amendments to the Procedural Rules of the Office of Compliance which had been scheduled for December 2, 2003, at 10:00 a.m. in room SD–342 of the Dirksen Senate Office Building.

We request that this notice of cancellation be published in the Congressional Record. Any inquiries regarding this notice should be addressed to the Office of Compliance at our address below, or by telephone 202–724–9250, TTY 202–426–1665.

Sincerely,

SUSAN S. ROBFOGEL,
Chair.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

5566. A letter from the Acting Under Secretary, Department of Defense, transmitting the Secretary's certification that the survivability testing of the E/A-18G system otherwise required by section 2366 would be unreasonably expensive and impractical, pursuant to 10 U.S.C. 2366(c)(1); to the Committee on Armed Services.

5567. A letter from the Acting Under Secretary, Department of Defense, transmitting a status report on each research and development program that is approved as a spiral development program, pursuant to Public Law 107—314, section 803(e); to the Committee on Armed Services.

5568. A letter from the Principal Deputy, Department of Defense, transmitting the Annual Report for the Armed Force Retirement Home (AFRH) for Fiscal Year 2002, pursuant to 24 U.S.C. 411(h); to the Committee on Armed Services.

5569. A letter from the Administrator, Energy Information Administration, transmitting the Administration's Short-Term Energy Outlook for October 2003, together with the special article entitled "Winter Fuels Outlook: 2003-2004," pursuant to 15 U.S.C. 790f(a)(2); to the Committee on Energy and Commerce.

5570. A letter from the Deputy Director, Defense Security Cooperation Agency, transmitting notification concerning the Department of the Army's Proposed Letter(s) of

Offer and Acceptance (LOA) to Saudi Arabia for defense articles and services (Transmittal No. 04-03), pursuant to 22 U.S.C. 2776(b); to the Committee on International Relations.

5571. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed license for the export of major defense equipment and defense articles to Israel (Transmittal No. DDTC 119-03), pursuant to 22 U.S.C. 2776(c); to the Committee on International Relations.

5572. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed license for the export of major defense equipment and defense articles to the United Kingdom (Transmittal No. DDTC 092-03), pursuant to 22 U.S.C. 2776(c); to the Committee on International Relations.

5573. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting certification of a proposed license for the export of defense articles or defense services sold commercially under a contract to Israel (Transmittal No. DDTC 115-03), pursuant to 22 U.S.C. 2776(c); to the Committee on International Relations.

5574. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting a copy of Presidential Determination No. 2004-07 on Waiving Prohibition on United States Military Assistance to Parties to the Rome Statute Establishing the International Criminal Court, pursuant to Public Law 107—206; to the Committee on International Relations.

5575. A letter from the Administrator, Office of the Independent Counsel, transmitting the annual report on Audit and Investigative Activities, pursuant to 28 U.S.C. 595(a)(2); to the Committee on Government Reform.

5576. A letter from the Secretary, Department of the Treasury, transmitting the Department's Performance and Accountability Report for FY 2003, as required by the Reports Consolidation Act of 2000; to the Committee on Government Reform.

5577. A letter from the Director, Office of Management and Budget, transmitting a draft bill "To make technical corrections in the Act making appropriations for the Department of the Interior and related agencies for the fiscal year ending September 30, 2004, and for other purposes"; to the Committee on Resources.

5578. A letter from the Senior Staff Attorney, United States Court of Appeals for the First Circuit, transmitting an opinion of the United States Court of Appeals for the District of Columbia Circuit (No. 02-2362 — United States v. Miguel Rosa-Ortiz (October 28, 2003)); to the Committee on the Judiciary.

5579. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Regulated Navigation Area and Security Zones; Port of Miami, FL [CGD07-03-144] (RIN: 1625-AA00, 1625-AA11) received November 18, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5580. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Security Zone: Pacific Ocean, San Diego, California [COTP San Diego 03-033] (RIN: 1625-AA00) received November 18, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5581. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Drawbridge Operating Regulation; St. Croix River, Hudson, Wisconsin [CGD08-03-043] (RIN: 1625-AA09) received November 10, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5582. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Special Local Regulations; World Championship Super Boat Race, Deerfield Beach, FL [CGD07-03-099] (RIN: 1625-AA08) received November 10, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5583. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Regulated Navigation Area; Reporting Requirements for Barges Loaded with Certain Dangerous Cargoes, Inland Rivers, Eighth Coast Guard District; Correction [CGD08-03-029] (RIN: 1625-AA11) received November 10, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5584. A letter from the Chief, Regulations and Administrative Law, USCG, Department of Homeland Security, transmitting the Department's final rule — Notification of Arrival in U.S. Ports; Correction [USCG-2002-11865] (RIN: 1625-AA41) received November 10, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5585. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Modification of Class D Airspce; and Modification of Class E Airspace; Topeka, Philip Billard Municipal Airport, KS [Docket No. FAA-2003-16407; Airspace Docket No. 03-ACE-75] received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5586. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Modification of Class D Airspace; and Modification of Class E Airspace; St. Joseph, MO [Docket No. FAA-2003-16026; Airspace Docket No. 03-ACE-70] received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5587. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Establishment of Class E Airspace; Viroqua, WI [Docket No. FAA-2003-16058; Airspace Docket No. 03-AGL-06] received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5588. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Amendment of Class E Airspace, Dunkirk, NY [Airspace Docket No. 02-AEA-08] received November 14, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5589. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Amendment to Class E Airspace; Charlottesville, VA [Docket No. FAA-2003-15789; Airspace Docket No. 03-AEA-09] received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5590. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Revision of Jet Route [Docket No. FAA 2001-10527; Airspace Docket No. ASD 02-AGL-16] (RIN: 2120-AA66) received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5591. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Amendment of Class E5 Airspace; Augusta, GA [Airspace Docket No. 02-ASO-19] received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5592. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Amendment of Class E Airspace; Jacksonville, NC [Docket No. FAA-2003-15846; Airspace Docket No. 03-ASO-12] received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5593. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Standard Instrument Approach Procedures; Miscellaneous Amendments [Docket No. 30341; Amdt. No. 3033] received November 17, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5594. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Amendment of Class E Airspace; Maxton, NC [Docket No. FAA-2003-15847; Airspace Docket No. 03-ASO-13] received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5595. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Amendment of Class E Airspace; Raleigh, NC [Docket No. FAA-2003-15845; Airspace Docket No. 03-ASO-11] received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5596. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Modification of Class E Airspace; Corning, IA. [Docket No. FAA-2003-15727; Airspace Docket No. 03-ACE-69] received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5597. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Establishment of Class D Airspace; Ramona, CA [Docket No. FAA-2003-15887; Airspace Docket No. 03-AWP-11] received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5598. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directive; Bombardier Model CL-600-1A11 (CL-600), CL-600-2A12 (CL-601), and CL-600-2B16 (CL-601-3A, CL-601-3R, and CL-604) Series Airplanes [Docket No. 2002-NM-157-AD; Amendment 39-13360; AD 2003-22-12] (RIN: 2120-AA64) received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5599. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule —

Modification of Class E Airspace; Chariton, IA. [Docket No. FAA-2003-15725; Airspace Docket No. 03-ACE-67] received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5600. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Standard Instrument Approach Procedures; Miscellaneous Amendments [Docket No. 30393; Amdt. No. 3080] received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5601. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Cessna Model 750 Citation X Series Airplanes [Docket No. 99-NM-229-AD; Amendment 39-13347; AD 98-16-17 R1] (RIN: 2120-AA64) received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5602. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model MD-11 and -11F Airplanes [Docket No. 2004-NM-52-AD; Amendment 39-13345; AD 2003-21-10] (RIN: 2120-AA64) received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5603. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Rolls-Royce plc RB211-524 Series Turbofan Engines [Docket No. 2003-NE-33-AD; Amendment 39-13351; AD 2003-22-04] (RIN: 2120-AA64) received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5604. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonell Douglas Model DC-10-10, -10F, -15, -30, -30F (KC-10A and KDC-10), -40, and-40F Airplanes; and Model MD-10-10F and -30F Airplanes [Docket No. 2002-NM-164-AD; Amendment 39-13308; AD 2003-19-05] (RIN: 2120-AA64) received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5605. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives Aerostar Aircraft Corporation Models PA-60-601, PA-60-601P, PA-60-602P, and PA-60-700P Airplanes [Docket No. 2003-CE-44-AD; Amendment 39-13348; AD 2003-22-01] (RIN: 2120-AA64) received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5606. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Rolls-Royce plc RB211-524 Series Turbofan Engines [Docket No. 2003-NE-36-AD; Amendment 39-13346; AD 2003-21-11] (RIN: 2120-AA64) received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5607. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; The Cessna Aircraft Company Model 525 Airplanes [Docket No. 2003-CE-46-AD; Amendment 39-13342; AD 2003-21-07] (RIN: 2120-AA64) received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5608. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Empresa Brasileira de Aeronautica S.A. (EMBRAER) Model EMB-135 and -145 Series Airplanes [Docket No. 2002-NM-88-AD; Amendment 39-13189; AD 2003-12-04] (RIN: 2120-AA64) received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5609. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnel Douglas Model MB-11 and-11F Airplanes [Docket No. 2001-NM-52-AD; Amendment 39-13345; AD 2003-21-10] (RIN: 2120-AA64) received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5610. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Eurocopter France Model AS355E, F, F1, F2, and N Helicopters [Docket No. 2003-SW-10-AD; Amendment 39-13344; AD 2003-21-09] (RIN: 2120-AA64) received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5611. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Eurocopter France Model AS332C, AS332L, AS332L1, and AS332L2 Helicopters [Docket No. 2002-SW-58-AD; Amendment 39-13343; AD 2003-21-08] (RIN: 2120-AA64) received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5612. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Boeing Model 757-200 Series Airplanes [Docket No. 2001-NM-192-AD; Amendment 39-12967; AD 2002-24-02] (RIN: 2120-AA64) received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5613. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Boeing Model 747 Series Airplanes Powered by General Electric (GE) CF6-80C2 Series Engines [Docket No. 2001-NM-17-AD; Amendment 39-12968; AD 2002-24-03] (RIN: 2120-AA64) received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5614. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Modification of Class E Airspace; Seward, NE [Docket No. FAA-2003-15719; Airspace Docket No. 03-ACE-61] received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5615. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Rolls-Royce Deutschland Ltd. & Co KG, Model Tay 620-15 and 650-15 Turbofan Engines [Docket No. 2002-NE-37-AD; Amendment 39-12971; AD 2002-24-06] (RIN: 2120-AA64) received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5616. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; CFM International CFM56-5B and -7B Series Turbofan Engines [Docket No. 2001-NE-37-AD; Amendment 39-12857; AD 2002-16-18] (RIN: 2120-AA64) received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5617. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Boeing Model 727 Airplanes [Docket No. 2002-NM-271-AD; Amendment 39-12970; AD 2002-24-05] (RIN: 2120-AA64) received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5618. A letter from the Paralegal Specialist, FAA, Department of Transportation, transmitting the Department's final rule — Revision of Class E Airspace, Holyoke, CO [Airspace Docket No. 00-ANM-32] received November 20, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

5619. A letter from the United States Trade Representative, Executive Office of the President, transmitting a report on the intent to initiate negotiations for a free trade agreement between the United States and the Republic of Panama, pursuant to Section 2104 (a)1 of the Trade Act of 2002; to the Committee on Ways and Means.

5620. A letter from the United States Trade Representative, Executive Office of the President, transmitting a report on the intent to initiate negotiations for a free trade agreement between the United States and Colombia, Peru, Ecuador, and Bolivia, the four Andean Trade Preference Act beneficiary countries, pursuant to Section 2104 (a)1 of the Trade Act of 2002; to the Committee on Ways and Means.

5621. A letter from the Secretary, Department of Agriculture, transmitting a draft of proposed legislation, "To amend the Poultry Products Inspection Act, the Federal Meat Inspection Act, and the Egg Products Inspection Act to require establishments and official plants to pay the costs of Federal Inspection for additional shifts, and for other purposes"; jointly to the Committees on Agriculture and Government Reform.

5622. A letter from the Chair, Office of Compliance, transmitting a Notice for publication in the Congressional Record cancelling the hearing regarding the proposed amendments to the Procedural Rules of the Office of Compliance originally published in the Congressional Record on October 15, 2003; jointly to the Committees on House Administration and Education and the Workforce.

5623. A letter from the Secretary, Department of Veterans Affairs, transmitting a draft bill, "To amend Title 38, United States Code, to improve veterans' benefits programs, and for other purposes"; jointly to the Committees on Veterans' Affairs and Education and the Workforce.

5624. A letter from the Chairman and Vice Chairman, U.S.-China Commission, transmitting the record of the Commission's hearing on September 25, 2003, on "China's Industrial, Investment and Exchange Rate Policies: Impact on the U.S."; jointly to the Committees on Ways and Means and International Relations.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Mr. POMBO: Committee on Resources. H.R. 1629. A bill to clarify that the Upper Missouri River Breaks National Monument does not include within its boundaries any privately owned property, and for other purposes (Rept. 108–392). Referred to the Committee of the Whole House on the State of the Union.

Mr. THOMAS: Committee on Ways and Means. H.R. 2896. A bill to amend the Internal Revenue Code of 1986 to remove impediments in such Code and make our manufacturing, service, and high-technology businesses and workers more competitive and productive both at home and abroad; with an amendment (Rept. 108–393). Referred to the Committee of the Whole House on the State of the Union.

Ms. PRYCE of Ohio: Committee on Rules. House Resolution 463. Resolution waiving points of order against the conference report to accompany the bill (H.R. 1) to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes (Rept. 108–394). Referred to the House Calendar.

Mr. TOM DAVIS of Virginia: Committee on Government Reform. Efforts to Rightsize the U.S. Presence Abroad Lack Urgency and Momentum (Rept. 108–395). Referred to the Committee of the Whole House on the State of the Union.

Mr. OXLEY: Committee of Conference. Conference report on H.R. 2622. A bill to amend the Fair Credit Reporting Act, to prevent identity theft, improve resolution of consumer disputes, improve the accuracy of consumer records, make improvements in the use of, and consumer access to, credit information, and for other purposes (Rept. 108–396). Ordered to be printed.

Mr. POMBO: Committee on Resources. H.R. 2696. A bill to establish Institutes to demonstrate and promote the use of adaptive ecosystem management to reduce the risk of wildfires, and restore the health of fire-adapted forest and woodland ecosystems of the interior West; with an amendment (Rept. 108–397 Pt. 1).

Mr. LINCOLN DIAZ-BALART of Florida: Committee on Rules. House Resolution 464. Resolution providing for consideration of a joint resolution appointing the day for the convening of the second session of the One Hundred Eighth Congress. (Rept. 108–398). Referred to the House Calendar.

Mr. LINDER: Committee on Rules. House Resolution 465. Resolution waiving a requirement of clause 6(a) of rule XIII with respect to consideration of certain resolutions reported from the Committee on Rules. (Rept. 108–399). Referred to the House Calendar.

Mr. POMBO: Committee on Resources. H.R. 958. A bill to authorize certain hydrographic services programs, to name a cove in Alaska in honor of the late Able Bodied Seaman Eric Steiner Koss, and for other purposes; with an amendment (Rept. 108–400). Referred to the Committee of the Whole House on the State of the Union.

DISCHARGE OF COMMITTEE

Pursuant to clause 2 of rule XII the Committee on Agriculture discharged from further consideration. H.R. 2696 referred to the Committee of the Whole House on the State of the Union and ordered to be printed.

TIME LIMITATION OF REFERRED BILL

Pursuant to clause 2 of rule XII the following action was taken by the Speaker:

H.R. 2696. Referral to the Committee on Agriculture extended for a period ending not later than November 21, 2003.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions were introduced and severally referred, as follows:

By Mr. RANGEL (for himself, Mr. Cardin, and Mr. McDermott):

H.R. 3568. A bill to provide extended unemployment benefits to displaced workers, and to make other improvements in the unemployment insurance system; to the Committee on Ways and Means.

By Mr. CONYERS (for himself and Mr. Berman):

H.R. 3569. A bill to reauthorize and amend the National Film Preservation Act of 1996; to the Committee on the Judiciary, and in addition to the Committee on House Administration, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. KILDEE:

H.R. 3570. A bill to prohibit the closure or realignment of inpatient services at the Aleda E. Lutz Department of Veterans Affairs Medical Center in Saginaw, Michigan, as proposed under the Capital Asset Realignment for Enhanced Services initiative; to the Committee on Veterans' Affairs.

By Mr. LARSEN of Washington:

H.R. 3571. A bill to modify the boundary of the San Juan Island National Historical Park; to the Committee on Resources.

By Mr. McDERMOTT (for himself, Mr. Royce, Mr. Rangel, Mr. Jefferson, Mr. Neal of Massachusetts, Mr. Payne, and Mr. Houghton):

H.R. 3572. A bill to amend the African Growth and Opportunity Act to expand certain trade benefits to eligible sub-Saharan African countries, and for other purposes; to the Committee on Ways and Means, and in addition to the Committees on International Relations, Financial Services, and Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. LEACH (for himself, Mr. Faleomavaega, Mr. Smith of New Jersey, and Mr. Royce):

H.R. 3573. A bill to promote human rights, democracy, and development in North Korea, to promote overall security on the Korean Peninsula and establish a more peaceful world environment, and for other purposes; to the Committee on International Relations, and in addition to the Committee on the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. BAKER (for himself, Ms. Eshoo, Mr. Dreier, Mr. Kennedy of Minnesota, Mr. Honda, Mrs. Tauscher, Ms. Lofgren, and Mr. Cantor):

H.R. 3574. A bill to require the mandatory expensing of stock options granted to executive officers, and for other purposes; to the Committee on Financial Services.

By Ms. JACKSON-LEE of Texas (for herself, Mr. Lewis of Georgia, Mrs. Christensen, Mr. Clay, Mr. Grijalva, Mr. Cummings, Mr. Payne, Ms. Kilpatrick, Mr. Ballance, Mr. Owens, Mr. Rush, Mr. Davis of Illinois, Mr. Conyers, and Ms. Watson):

H.R. 3575. A bill to amend title 18, United States Code, to provide an alternate release date for certain nonviolent offenders, and for other purposes; to the Committee on the Judiciary.

By Mr. NUSSLE:

H.R. 3576. A bill to amend the Harmonized Tariff Schedule of the United States to provide a new subheading for certain log forwarders used as motor vehicles for the transport of goods for duty-free treatment consistent with other agricultural use log handling equipment; to the Committee on Ways and Means.

By Mr. EHLERS:

H.R. 3577. A bill to authorize appropriations to the Department of Transportation for surface transportation research and development, and for other purposes; to the Committee on Science.

By Mr. HONDA (for himself, Mrs. Tauscher, Mr. Case, Mr. Acevedo-Vilá, Ms. Lofgren, Mrs. Jones of Ohio, Mr. George Miller of California, Mr. Meeks of New York, Ms. Eddie Bernice Johnson of Texas, Mr. Lewis of Georgia, Mr. Blumenauer, and Mr. Abercrombie):

H.R. 3578. A bill to amend title 49, United States Code, to ensure the continuation of fixed guideway system projects, and for other purposes; to the Committee on Transportation and Infrastructure.

By Mr. ROYCE (for himself, Mr. Kanjorski, Mr. LaTourette, and Mrs. Maloney):

H.R. 3579. A bill to ease credit union regulatory burdens, advance credit union efforts to promote economic growth, and modernize credit union capital standards; to the Committee on Financial Services.

By Mr. ANDREWS:

H.R. 3580. A bill to amend the Internal Revenue Code of 1986 to provide for the income tax treatment of legal fees awarded or received in connection with nonphysical personal injury cases; to the Committee on Ways and Means.

By Mr. BAKER:

H.R. 3581. A bill to amend title 28 of the United States Code with respect to venue in certain preference proceedings under title 11 of the United States Code commenced by the trustee against small businesses; to the Committee on the Judiciary.

By Ms. BALDWIN (for herself, Mr. Scott of Virginia, Ms. Carson of Indiana, Mr. Van Hollen, Mr. Hoeffel, Mr. McGovern, Mr. Frost, Ms. Norton, Mr. McDermott, Mr. Serrano, Ms. Schakowsky, Mr. Payne, Ms. Lee, Mr. Meeks of New York, Mrs. Jones of Ohio, Ms. McCollum, Mrs. McCarthy of New York, Ms. Woolsey, Mr. Kucinich, Ms. Majette, Mr. Hinojosa, and Mr. Grijalva):

H.R. 3582. A bill to amend the Elementary and Secondary Education Act of 1965 to prohibit federally subsidized discrimination in supplemental educational services, and for other purposes; to the Committee on Education and the Workforce.

By Mr. BARTLETT of Maryland (for himself, Mr. Wynn, Mr. Gilchrest, Mr. Cardin, Mr. Hoyer, Mr. Van Hollen, Mrs. Jo Ann Davis of Virginia, Ms. Norton, Mr. Goode, Mr. Ruppersberger, and Mr. Cummings):

H.R. 3583. A bill to direct the Secretary of Homeland Security to establish an independent panel to assess the homeland security needs of the National Capital Region; to the Committee on Homeland Security (Select).

By Ms. BERKLEY:

H.R. 3584. A bill to amend title XVIII of the Social Security Act to increase the amount of payment for physicians' services under the Medicare Program and to provide regulatory relief and contracting flexibility under the Medicare Program; to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. BURGESS (for himself, Mr. Barton of Texas, and Mr. Sessions):

H.R. 3585. A bill to require the Secretary of Transportation to develop and implement an environmental review process for safety emergency highway projects; to the Committee on Transportation and Infrastructure, and in addition to the Committee on Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. CANTOR (for himself, Mr. Wilson of South Carolina, Mr. Rogers of Michigan, Mr. Sessions, Ms. Pryce of Ohio, Ms. Dunn, Mr. Wicker, Mr. Hoekstra, Mr. Ehlers, Mr. Camp, and Mr. Pomeroy):

H.R. 3586. A bill to amend the Internal Revenue Code of 1986 to protect the health benefits of retired miners and to restore stability and equity to the financing of the United Mine Workers of America Combined Benefit Fund by providing additional sources of revenue to the Fund, and for other purposes; to the Committee on Ways and Means.

By Mr. CASE (for himself and Ms. Bordallo):

H.R. 3587. A bill to amend the Immigration and Nationality Act to give priority in the issuance of immigrant visas to the sons and daughters of Filipino World War II veterans who are or were naturalized citizens of the United States, and for other purposes; to the Committee on the Judiciary.

By Mrs. CHRISTENSEN (for herself, Mr. Lewis of Georgia, Mr. Cummings, Ms. Jackson-Lee of Texas, Mr. Watt, Ms. Watson, Ms. Lee, Mr. Hastings of Florida, Mr. Thompson of Mississippi, Ms. Majette, Ms. Kilpatrick, Mr. Clyburn, Mr. Meek of Florida, Ms. Waters, Ms. Eddie Bernice Johnson of Texas, Mr. Wynn, Ms. Corrine Brown of Florida, Mr. Jefferson, Mr. Payne, Ms. Carson of Indiana, and Mr. Scott of Virginia):

H.R. 3588. A bill to direct the Secretary of Health and Human Services to establish health empowerment zone programs in communities that disproportionately experience disparities in health status and health care, and for other purposes; to the Committee on Energy and Commerce.

By Mrs. CHRISTENSEN:

H.R. 3589. A bill to create the Office of Chief Financial Officer of the Government of the Virgin Islands; to the Committee on Resources.

By Mr. CRAMER:

H.R. 3590. A bill to amend the Internal Revenue Code of 1986 to allow employers a credit against income tax to encourage them to have their employees provide volunteer services that aid science, mathematics, and engineering education in grades K-12; to the Committee on Ways and Means.

By Mrs. CUBIN (for herself, Mr. John, Mr. Pickering, Mr. Simpson, Mr. Rogers of Michigan, and Mr. McGovern):

H.R. 3591. A bill to amend the Public Health Service Act with respect to health professions programs regarding the practice of pharmacy; to the Committee on Energy and Commerce.

By Mr. DAVIS of Florida:

H.R. 3592. A bill to amend the Elementary and Secondary Education Act of 1965 to condition receipt of funds under part A of title V of such Act by a State on the State requiring successful completion of courses in American history and American government as a prerequisite to high school graduation, and for other purposes; to the Committee on Education and the Workforce.

By Mr. DAVIS of Illinois (for himself and Mr. Osborne):

H.R. 3593. A bill to amend the Higher Education Act of 1965 to provide funds for campus mental and behavioral health service centers; to the Committee on Education and the Workforce.

By Ms. DeGETTE:

H.R. 3594. A bill to amend the Public Health Service Act with respect to the protection of human subjects in research; to the Committee on Energy and Commerce.

By Ms. DeLAURO (for herself, Mrs. Jones of Ohio, Mr. Sanders, Mr. Delahunt, Ms. Roybal-Allard, and Ms. Lee):

H.R. 3595. A bill to amend the Child Care and Development Block Grant Act of 1990 to authorize financial assistance to permit infants to be cared for at home by parents; to the Committee on Education and the Workforce.

By Mr. DeMINT (for himself and Ms. Slaughter):

H.R. 3596. A bill to amend the Internal Revenue Code of 1986 to repeal the medicine and drugs limitation on the deduction for medical care; to the Committee on Ways and Means.

By Mr. DOOLITTLE:

H.R. 3597. A bill to authorize the Secretary of the Interior, through the Bureau of Reclamation, to conduct a feasibility study on the Alder Creek water storage and conservation project in El Dorado County, California, and for other purposes; to the Committee on Resources.

By Mr. EHLERS (for himself and Mr. Udall of Colorado):

H.R. 3598. A bill to establish an interagency committee to coordinate Federal manufacturing research and development efforts in manufacturing, strengthen existing programs to assist manufacturing innovation and education, and expand outreach programs for small and medium-sized manufacturers, and for other purposes; to the Committee on Science.

By Mr. EMANUEL (for himself, Mr. Foley, Mr. Stupak, Mr. Camp, and Mr. Lantos):

H.R. 3599. A bill to prevent corporate auditors from providing tax shelter services to their audit clients; to the Committee on Financial Services.

By Mr. ENGEL:

H.R. 3600. A bill to amend the Public Health Service Act to require health insurance issuers to credit toward an annual deductible in case of subsequent issuance of similar health insurance policy by the same issuer to the same person; to the Committee on Energy and Commerce.

By Mr. ENGLISH (for himself and Mr. Cardin):

H.R. 3601. A bill to amend the Internal Revenue Code of 1986 to protect the health benefits of steel industry retirees by expanding the availability of the refundable tax credit to the health insurance costs paid by former employers; to the Committee on Ways and Means.

By Mr. FOSSELLA (for himself and Mrs. Kelly):

H.R. 3602. A bill to establish a grant program to provide comprehensive eye examinations to children, and for other purposes; to the Committee on Energy and Commerce.

By Mr. GERLACH (for himself, Mr. McGovern, Ms. Berkley, Ms. Ros-Lehtinen, and Mr. Gallegly):

H.R. 3603. A bill to provide for the adjudication of claims of nationals of the United States against the Government of Iraq arising during the period beginning on May 16, 1987, and ending on May 1, 2003; to the Committee on International Relations.

By Mr. GOODLATTE (for himself, Mr. Stenholm, Mr. Lucas of Oklahoma, Mr. Gutknecht, Mr. Blunt, Mr. Gallegly, Mr. Osborne, Mr. Burns, Mr. Chocola, Mr. Neugebauer, Mr. Nethercutt, Mr. Smith of Michigan, Mr. Kingston, Mr. Bartlett of Maryland, Mr. Brown of South Carolina, Mr. Upton, Mr. Camp, Mr. Young of Alaska, Mr. Collins, Mr. Baker, Mrs. Jo Ann Davis of Virginia, Mr. Duncan, Mr. Forbes, Mr. Garrett of New Jersey, Mr. Herger, Mr. Hoekstra, Mr. Janklow, Mr. Jones of North Carolina, Mr. Keller, Mrs. Miller of Michigan, Mr. Oxley, Mr. Souder, Mr. Tiberi, and Mr. Wicker):

H.R. 3604. A bill to simplify the process for admitting temporary alien agricultural workers under section 101(a)(15)(H)(ii)(a) of the Immigration and Nationality Act, to increase access to such workers, and for other purposes; to the Committee on the Judiciary, and in addition to the Committee on Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. HAYWORTH:

H.R. 3605. A bill to amend the Internal Revenue Code of 1986 and the Employee Retirement Income Security Act of 1974 to clarify that federally recognized Indian tribal governments are to be regulated under the same government employer rules and procedures that apply to Federal, State, and other local government employers with regard to the establishment and maintenance of employee benefit plans; to the Committee on Ways and Means, and in addition to the Committee on Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. HEFLEY:

H.R. 3606. A bill to amend the Internal Revenue Code of 1986 to eliminate the marriage penalty in the contribution rules for Roth IRAs; to the Committee on Ways and Means.

By Ms. HOOLEY of Oregon (for herself, Mr. Frost, Mr. Wu, Mrs. McCarthy of New York, Mr. DeFazio, Mr.

Evans, Mr. Grijalva, Ms. Kaptur, Ms. Woolsey, and Ms. DeGette):

H.R. 3607. A bill to amend the Internal Revenue Code of 1986 to provide a refundable tax credit to small businesses for the costs of qualified health insurance; to the Committee on Ways and Means.

By Ms. HOOLEY of Oregon (for herself, Mr. Frost, Mr. Wu, Mrs. McCarthy of New York, Mr. DeFazio, Mr. Evans, Ms. Carson of Indiana, Mr. Paul, Ms. McCollum, and Ms. DeGette):

H.R. 3608. A bill to amend the Internal Revenue Code of 1986 to provide a credit to employers for hiring new employees; to the Committee on Ways and Means.

By Mr. HOSTETTLER (for himself, Mr. Pitts, Mr. Bartlett of Maryland, Mr. Doolittle, Mr. Tancredo, Mr. Smith of Texas, and Mr. Souder):

H.R. 3609. A bill to amend the Revised Statutes of the United States to eliminate the chilling effect on the constitutionally protected expression of religion by State and local officials that results from the threat that potential litigants may seek damages and attorney's fees; to the Committee on the Judiciary.

By Mr. HOUGHTON (for himself, Mrs. Johnson of Connecticut, Mr. Rangel, and Mr. Neal of Massachusetts):

H.R. 3610. A bill to amend the Internal Revenue Code of 1986 to replace the recapture bond provisions of the low income housing tax credit program; to the Committee on Ways and Means.

By Ms. EDDIE BERNICE JOHNSON of Texas:

H.R. 3611. A bill to amend title 23, United States Code, to allocate transportation funds to metropolitan areas and increase planning funds to relieve metropolitan congestion, and for other purposes; to the Committee on Transportation and Infrastructure.

By Ms. EDDIE BERNICE JOHNSON of Texas (for herself, Mr. Frost, Mr. Bell, and Mr. Owens):

H.R. 3612. A bill to amend title 38, United States Code, to improve the outreach activities of the Department of Veterans Affairs, and for other purposes; to the Committee on Veterans' Affairs.

By Mr. SAM JOHNSON of Texas (for himself, Mr. Boehner, and Mr. Houghton):

H.R. 3613. A bill to amend the Internal Revenue Code of 1986 to provide for the disclosure of return information for student financial assistance purposes; to the Committee on Ways and Means.

By Mr. KING of New York:

H.R. 3614. A bill to ensure that the national instant criminal background check system provides the Federal Bureau of Investigation with information on approved firearms transfers to persons named in the Violent Gang and Terrorist Organization File; to the Committee on the Judiciary.S0634

By Mr. LARSON of Connecticut:

H.R. 3615. A bill to authorize the Secretary of Defense to reimburse members of the Armed Forces for the cost of protective body armor purchased by or on behalf of the member; to the Committee on Armed Services.

By Mr. LARSON of Connecticut:

H.R. 3616. A bill to establish the Commission on Preemptive Foreign Policy and Military Planning; to the Committee on International Relations, and in addition to the Committee on Armed Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. MEEHAN (for himself and Mr. Shays):

H.R. 3617. A bill to amend the Internal Revenue Code of 1986 to reform the system of public financing for presidential elections, and for other purposes; to the Committee on House Administration, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. MENENDEZ (for himself, Mr. Payne, Mr. Hinojosa, Mr. Owens, Mr. Clyburn, and Mr. Fattah):

H.R. 3618. A bill to ensure that all college students and their families have the tools and resources to adequately save for, finance, and repay their postsecondary and post-baccalaureate expenses; to the Committee on Education and the Workforce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. GEORGE MILLER of California (for himself, Mr. Gephardt, Mr. Bishop of New York, Mr. Kildee, Mr. Kucinich, Mr. Owens, Mr. Grijalva, Mr. Davis of Illinois, Ms. Woolsey, Mr. Payne, Ms. McCollum, Mr. Tierney, Mrs. McCarthy of New York, Mr. Andrews, Mr. Ryan of Ohio, Mr. Van Hollen, Mr. Holt, Mr. Wu, Mr. Hinojosa, Mr. Kind, Ms. Pelosi, Mr. Hoyer, Mr. Matsui, Ms. Kilpatrick, Mr. Holden, Ms. Carson of Indiana, Ms. Schakowsky, Mr. Sabo, Mr. Michaud, Mr. Delahunt, Mr. Pallone, Mr. Abercrombie, Mr. Peterson of Minnesota, Ms. Solis, Ms. Slaughter, Mr. Baca, Mr. Doyle, Mrs. Maloney, Mr. Sherman, Mr. Serrano, Mr. Gutierrez, Mr. Hoeffel, Mr. McNulty, Ms. Linda T. Sánchez of California, Mr. Hinchey, Mr. Baird, Mr. Rush, Mr. King of New York, Mr. Lynch, Ms. Millender-McDonald, Mr. Lantos, Mr. Allen, Mr. Rodriguez, Ms. DeLauro, Mr. Nadler, Mr. Brown of Ohio, Mr. Udall of New Mexico, Mr. Wexler, Mr. Levin, Mr. Weiner, Mr. Conyers, Mr. Jackson of Illinois, Mr. McGovern, Mr. Stark, Mr. Evans, Mr. Sanders, Mr. Rahall, Mr. Deutsch, Ms. Lee, Ms. Corrine Brown of Florida, Mr. Cardoza, Mr. Meehan, Mr. Simmons, Mr. Hastings of Florida, Mr. Langevin, Mr. Waxman, Mrs. Christensen, Mr. Pascrell, Mrs. Jones of Ohio, Mr. Smith of New Jersey, Mr. Honda, and Mr. Pastor):

H.R. 3619. A bill to amend the National Labor Relations Act to establish an efficient system to enable employees to form, join, or assist labor organizations, to provide for mandatory injunctions for unfair labor practices during organizing efforts, and for other purposes; to the Committee on Education and the Workforce.

By Mr. NEAL of Massachusetts:

H.R. 3620. A bill to provide duty-free treatment for certain tuna; to the Committee on Ways and Means.

By Mr. NETHERCUTT:

H.R. 3621. A bill to extend the grace period for personal watercraft use in Lake Roosevelt National Recreation Area; to the Committee on Resources.

By Ms. NORTON (for herself, Mr. Hoyer, Mr. Wynn, Mr. Moran of Virginia, and Mr. Van Hollen):

H.R. 3622. A bill to amend the Federal Water Pollution Control Act and the Water Resources Development Act of 1992 to provide for the restoration, protection, and enhancement of the environmental integrity and social and economic benefits of the Anacostia Watershed in the State of Maryland and the District of Columbia; to the Committee on Transportation and Infrastructure.

By Mr. OBERSTAR:

H.R. 3623. A bill to amend the Employee Retirement Income Security Act of 1974 to increase the maximum levels of guaranteed single-employer plan benefits, and for other purposes; to the Committee on Education and the Workforce.

By Mr. OBERSTAR:

H.R. 3624. A bill to provide that, for purposes of making determinations for certain trade remedies and trade adjustment assistance, imported semi-finished steel slabs and taconite pellets produced in the United States shall be considered to be articles like or directly competitive with each other; to the Committee on Ways and Means.

By Mr. PORTMAN (for himself, Mr. Houghton, and Mr. Pomeroy):

H.R. 3625. A bill to amend the Internal Revenue Code of 1986 to consolidate the Inspectors General relating to the Department of the Treasury, and for other purposes; to the Committee on Ways and Means, and in addition to the Committee on Government Reform, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. RODRIGUEZ (for himself, Mr. Gonzalez, and Mr. Doggett):

H.R. 3626. A bill to amend the National Trails System Act to designate El Camino Real de los Tejas as a National Historic Trail; to the Committee on Resources.

By Mr. SAXTON:

H.R. 3627. A bill to establish in the Executive Office of the President the Office of Oceans and Coastal Policy; to the Committee on Resources, and in addition to the Committee on Science, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Ms. SCHAKOWSKY:

H.R. 3628. A bill to amend the Federal Food, Drug, and Cosmetic Act to facilitate the procurement of safe food by hospitals, nursing homes, schools, and child care facilities; to the Committee on Energy and Commerce.

By Ms. SCHAKOWSKY (for herself, Ms. Solis, Ms. Carson of Indiana, Mr. Nadler, Ms. Norton, Mrs. Jones of Ohio, Ms. DeLauro, and Mr. Hinchey):

H.R. 3629. A bill to amend the Federal Insecticide, Fungicide, and Rodenticide Act and the Solid Waste Disposal Act to establish prohibitions and requirements relating to arsenic-treated wood, and for other purposes; to the Committee on Energy and Commerce, and in addition to the Committee on Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. SHAYS (for himself, Mr. Inslee, Mr. Price of North Carolina, and Mr. Green of Wisconsin):

H.R. 3630. A bill to make available on the Internet, for purposes of access and retrieval by the public, certain information available through the Congressional Research Service web site; to the Committee on House Administration.

By Mr. SHERMAN:

H.R. 3631. A bill to prohibit the collection, by interactive video-related service providers, of personally identifiable information regarding the viewing choices of subscribers to such services; to the Committee on Energy and Commerce.

By Mr. SMITH of Texas (for himself, Mr. Keller, Mr. Wexler, Mr. Goodlatte, Mr. Gallegly, and Mr. Carter):

H.R. 3632. A bill to prevent and punish counterfeiting of copyrighted copies and phonorecords, and for other purposes; to the Committee on the Judiciary.

By Mr. SOUDER (for himself, Mr. Hastert, Mr. DeLay, Mr. Blunt, Mr. Cantor, Mr. Cox, Mr. Dreier, Mrs. Myrick, Mr. DeMint, Mr. King of New York, Ms. Dunn, Mr. Burton of Indiana, Mr. Crane, Mr. Wilson of South Carolina, Mrs. Jo Ann Davis of Virginia, Mr. Carter, Mr. Goode, Mr. Linder, Mr. Rohrabacher, Mr. Gallegly, Mr. Doolittle, Mr. Pombo, Mr. Hunter, Mr. Franks of Arizona, Mr. Akin, Mr. Feeney, Mr. Buyer, Mr. Tiahrt, Mr. Brady of Texas, Mr. Chocola, Mr. Culberson, Mr. Burgess, Mr. Cunningham, Mr. Pence, Mr. Jones of North Carolina, Mr. Weller, Mr. Gibbons, Mr. Lincoln Diaz-Balart of Florida, Mr. King of Iowa, Mr. Duncan, Mr. Pitts, Mr. Herger, Mr. Thornberry, Mr. Hostettler, Mr. Toomey, Mr. Garrett of New Jersey, Mr. Kingston, Mr. Norwood, Mr. Terry, Mr. Bishop of Utah, Mr. McKeon, Mr. Ose, Mr. Manzullo, Mr. Osborne, Mr. Boozman, Mr. Shadegg, Mr. Wamp, Mr. Rehberg, Mr. Radanovich, Mr. Pearce, Mr. Weldon of Florida, Mr. LaHood, Mr. Mario Diaz-Balart of Florida, Ms. Ginny Brown-Waite of Florida, Mr. Ballenger, Mr. Thomas, Mr. Hoekstra, Mr. Forbes, Mr. Tauzin, Mr. Paul, Mr. Issa, Mr. Ramstad, Mrs. Musgrave, Mr. Sessions, Mr. Otter, Mr. Crenshaw, Mr. Walden of Oregon, and Mr. Shimkus):

H.R. 3633. A bill to provide for dime coins to bear the likeness of President Ronald Reagan, the Freedom President, in honor of his work in restoring American greatness and bringing freedom to captive nations around the world; to the Committee on Financial Services.

By Mr. SOUDER (for himself, Mr. Cummings, Mr. Tom Davis of Virginia, Mr. Scott of Virginia, Mr. Ballenger, Mr. Terry, Mr. Acevedo-Vilá, Mr. Sessions, Mr. Portman, and Mr. Boozman):

H.R. 3634. A bill to amend the Controlled Substances Act to lift the patient limitation on prescribing drug addiction treatments by medical practitioners in group practices, and for other purposes; to the Committee on Energy and Commerce, and in addition to the Committee on the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. STARK (for himself, Mr. McDermott, Mr. Kennedy of Rhode Island, Mr. Frost, Mrs. Christensen, Mr. Jefferson, and Mr. McNulty):

H.R. 3635. A bill to amend the Social Security Act to provide for coverage under the Medicare Program of chronic kidney disease patients who are not end-stage renal disease patients; to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. STEARNS:

H.R. 3636. A bill to amend the Public Health Service Act to prohibit health discrimination against individuals and their family members on the basis of genetic information, and for other purposes; to the Committee on Energy and Commerce.

By Mrs. TAUSCHER (for herself, Mr. Skelton, Mr. Cooper, and Mr. George Miller of California):

H.R. 3637. A bill to amend title 10, United States Code, to provide a temporary increase in the minimum end strength level for active duty personnel for the Army, and for other purposes; to the Committee on Armed Services.

By Mr. THOMPSON of California:

H.R. 3638. A bill to adjust the boundary of Redwood National Park in the State of California, and for other purposes; to the Committee on Resources.

By Mr. TIAHRT:

H.R. 3639. A bill to extend the Temporary Extended Unemployment Compensation Act of 2002, and for other purposes; to the Committee on Ways and Means.

By Mr. TIERNEY (for himself, Mr. Meeks of New York, Mr. George Miller of California, Mr. Acevedo-Vilá, Mr. Olver, Ms. Millender-McDonald, Mr. Delahunt, Mr. McGovern, Mr. Owens, Mr. Frank of Massachusetts, and Ms. Woolsey):

H.R. 3640. A bill to require the Commissioner of Labor Statistics to develop a methodology for measuring the cost of living in each State, and to require the Comptroller General to determine how certain Federal benefits would be increased if the determination of those benefits were based on that methodology; to the Committee on Education and the Workforce, and in addition to the Committees on Ways and Means, Financial Services, and Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. TIERNEY (for himself, Mr. Grijalva, Mr. Hoeffel, Mr. Kind, Mr. Case, Mr. George Miller of California, Ms. Baldwin, Mr. McDermott, Ms. Woolsey, Mr. Blumenauer, Ms. Kaptur, Ms. Schakowsky, Mr. Hinchey, Mr. Farr, Mr. Nadler, Mr. Olver, Mr. Frank of Massachusetts, Mr. McGovern, Mr. Sanders, Mr. Conyers, Ms. DeLauro, Mr. Lantos, Mr. Delahunt, Ms. Eshoo, Mr. Waxman, Mr. Stark, Mr. Van Hollen, Ms. Lee, Mr. Jackson of Illinois, and Mr. McNulty):

H.R. 3641. A bill to reform the financing of Federal elections, and for other purposes; to the Committee on House Administration, and in addition to the Committees on Energy and Commerce, and Government Reform, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Ms. WATERS:

H.R. 3642. A bill to require the Secretary of State to prepare an annual report on progress made to eradicate poppy cultivation and prevent illicit drug trafficking in Afghanistan; to the Committee on International Relations.

By Mr. WEINER (for himself, Mr. Crowley, Mr. Israel, Mr. Nadler, Ms. Berkley, Mr. Foley, Mrs. McCarthy of New York, Mrs. Maloney, Mr. Hill, Mr. McNulty, Mr. Frank of Massachusetts, Mr. Waxman, Mr. Sandlin, Mr. Strickland, Mrs. Tauscher, Mr. Emanuel, Mr. Bishop of Georgia, Mr. Matsui, Mr. Cardoza, Mr. Rush, Mr. Deutsch, Mr. Markey, Mr. Garrett of New Jersey, Mr. Andrews, and Mr. Ferguson):

H.R. 3643. A bill to halt Saudi support for institutions that fund, train, incite, encourage, or in any other way aid and abet terrorism, and to secure full Saudi cooperation in the investigation of terrorist incidents; to the Committee on International Relations.

By Mr. WELDON of Pennsylvania (for himself and Mr. Andrews):

H.R. 3644. A bill to establish a technology, equipment, and information transfer program within the Department of Homeland Security; to the Committee on Science, and in addition to the Committees on the Judiciary, Energy and Commerce, Transportation and Infrastructure, and Homeland Security (Select), for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. YOUNG of Alaska:

H.R. 3645. A bill To amend the Magnuson-Stevens Fishery Conservation and Management Act to clarify the definition of "essential fish habitat", and for other purposes; to the Committee on Resources.

By Mr. YOUNG of Florida:

H.J. Res. 79. A joint resolution making further continuing appropriations for the fiscal year 2004, and for other purposes; to the Committee on Appropriations. considered and passed.

By Mr. DELAY:

H.J. Res. 80. A joint resolution appointing the day for the convening of the second session of the One Hundred Eighth Congress; considered and passed.

By Mr. OWENS:

H.J. Res. 81. A joint resolution proposing an amendment to the Constitution of the United States limiting the number of consecutive terms that a Senator or Representative may serve and providing for 4-year terms for Representatives; to the Committee on the Judiciary.

By Mr. LANTOS (for himself and Mr. Cox):

H. Con. Res. 336. Concurrent resolution expressing the sense of Congress that the continued participation of the Russian Federation in the Group of 8 nations should be conditioned on the Russian Government voluntarily accepting and adhering to the norms and standards of democracy; to the Committee on International Relations.

By Mrs. KELLY:

H. Con. Res. 337. Concurrent resolution expressing the sense of the Congress that raising awareness and working to prevent suicide in the United States are worthy goals, and supporting the goals and ideals of National Survivors of Suicide Day, observed annually on the Saturday before Thanksgiving; to the Committee on Energy and Commerce.

By Ms. CARSON of Indiana:

H. Con. Res. 338. Concurrent resolution commemorating the 15th anniversary of Rebuilding Together, commending Rebuilding

Together for its service, and encouraging Americans to volunteer with Rebuilding Together and similar community organizations; to the Committee on Financial Services.

By Mr. DELAY:

H. Con. Res. 339. A concurrent resolution providing for the sine die adjournment of the first session of the One Hundred Eighth Congress; considered and agreed to.

By Mr. ANDREWS:

H. Con. Res. 340. Concurrent resolution expressing the sense of Congress that the people of Taiwan should be able to conduct referenda votes free from intimidation or threat of force; to the Committee on International Relations.

By Ms. HOOLEY of Oregon (for herself, Mr. WALDEN of Oregon, Mr. BLUMENAUER, Mr. WU, and Mr. DEFAZIO):

H. Con. Res. 341. Concurrent resolution recognizing the 20th anniversary of the restoration of Federal recognition of the Confederated Tribes of the Grand Ronde Community of Oregon; to the Committee on Resources.

By Mrs. MALONEY (for herself, Mrs. BIGGERT, and Ms. HOOLEY of Oregon):

H. Con. Res. 342. Concurrent resolution commending Iraqi women for their participation in Iraqi government and civil society, encouraging the inclusion of Iraqi women in the political and economic life of Iraq, and advocating the protection of Iraqi women's human rights in the Iraqi Constitution; to the Committee on International Relations.

By Mr. MCGOVERN (for himself, Mr. SWEENEY, Mr. CAPUANO, Mr. MCDERMOTT, Ms. SLAUGHTER, Mr. SANDERS, Mr. GRIJALVA, Mr. KUCINICH, Mr. EVANS, Mr. ISRAEL, Ms. KAPTUR, Mr. ETHERIDGE, Mr. HINCHEY, Mr. BLUMENAUER, Mr. OBERSTAR, Mr. FORD, Mr. LANTOS, Mr. ABERCROMBIE, Mr. MOORE, Mr. REYES, Mrs. JONES of Ohio, Mr. MICHAUD, Mr. CONYERS, Mr. STRICKLAND, Mr. LIPINSKI, Mr. MCNULTY, Mr. LEWIS of Georgia, Mr. BERRY, Mr. BRADY of Pennsylvania, Mr. SKELTON, Mrs. MALONEY, Mr. BISHOP of New York, Mr. HOEFFEL, Mr. TOWNS, Mr. MEEKS of New York, Ms. BORDALLO, Ms. DELAURO, Mr. LEVIN, Mr. PAYNE, Mr. HASTINGS of Florida, Mr. OBEY, Ms. KILPATRICK, Mr. MARKEY, Mr. PASCRELL, Mr. KENNEDY of Rhode Island, Mr. ENGEL, Mr. KILDEE, Mr. VISCLOSKY, Mr. DICKS, Mr. STARK, Ms. LEE, Ms. LINDA T. SÁNCHEZ of California, and Ms. CARSON of Indiana):

H. Con. Res. 343. Concurrent resolution affirming the support of Congress for preserving President Franklin D. Roosevelt's profile on the dime because of his innumerable contributions to and lasting impact on the Nation; to the Committee on Financial Services.

By Mr. MEEKS of New York (for himself and Mr. CONYERS):

H. Con. Res. 344. Concurrent resolution expressing the sense of the Congress that American prisoners of war (POWs) during the 1991 Gulf War and their immediate family members should be adequately compensated, without delay, for their suffering and injury, as decided by the United States District Court for the District of Columbia; to the Committee on International Relations.

By Mr. ISSA (for himself, Mr. FILNER, Mr. LEWIS of California, Mr. BALLENGER, Mrs. BONO, Mr. EMANUEL, Mr. HOUGHTON, Mr. TERRY, Mr. SMITH of Michigan, Mr. MORAN of Virginia, Mr. PITTS, Mr. BARTLETT of Maryland, Mr. GILLMOR, Mr. CUNNINGHAM, Mr. YOUNG of Alaska, Mr. REYES, Mr. CONYERS, Mr. RAHALL, and Mr. BLUMENAUER):

H. Res. 462. A resolution supporting the vision of Israelis and Palestinians who are working together to conceive pragmatic, serious plans for achieving peace, and for other purposes; to the Committee on International Relations.

By Ms. SOLIS (for herself, Mr. REYES, Mr. RAMSTAD, Ms. SLAUGHTER, Mrs. CAPITO, and Mr. RODRIGUEZ):

H. Res. 466. A resolution conveying the sympathy of the House of Representatives to the families of the young women murdered in the State of Chihuahua, Mexico, and encouraging increased United States involvement in bringing an end to these crimes; to the Committee on International Relations.

By Mr. GONZALEZ (for himself, Mr. SMITH of Texas, Mr. RODRIGUEZ, Mr. LAMPSON, and Mr. BELL):

H. Res. 467. A resolution commending the astounding work of the Southwest Research Institute in discovering the cause of the Columbia space shuttle disaster; to the Committee on Science.

By Mr. GRAVES:

H. Res. 468. A resolution expressing disapproval of the consideration by Justices of the Supreme Court of the United States of foreign laws and public opinion in their decisions, urging the end of this practice immediately to avoid setting a dangerous precedent, and urging all Justices to base their opinions solely on the merits under the Constitution of the United States; to the Committee on the Judiciary.

By Mr. JONES of North Carolina:

H. Res. 469. A resolution to authorize and direct the Committee on Appropriations to create a new Subcommittee on Veterans' Affairs; to the Committee on Rules.

By Ms. ROS-LEHTINEN:

H. Res. 470. A resolution expressing gratitude to Israeli law enforcement officers for the counterterrorism training and consultation they have provided to law enforcement officers in the United States, acknowledging the common challenges that terrorism presents to law enforcement in the United States and Israel, and for other purposes; to the Committee on International Relations, and in addition to the Committee on the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. RUSH:

H. Res. 471. A resolution congratulating the people of Haiti on the bicentennial of their independence; to the Committee on International Relations.

By Ms. SLAUGHTER:

H. Res. 472. A resolution providing for the consideration of the bill H.R. 3495; to the Committee on Rules.

MEMORIALS

Under clause 3 of rule XII, memorials were presented and referred as follows:

227. The SPEAKER presented a memorial of the Legislature of the State of Florida, relative to House Memorial No. 209 memorializing the Congress of the United States to provide the funds necessary for the Defense Prisoner of War/Missing Personnel Office of the Department of Defense and other Department of Defense agencies that play critical roles in achieving the fullest possible accounting of POW/MIA's to continue their work unimpeded from budgetary constraints or reductions; to the Committee on Armed Services.

228. Also, a memorial of the Legislature of the State of Michigan, relative to Senate Concurrent Resolution No. 11 memorializing the Congress of the United States and the Environmental Protection Agency to repeal 40 C.F.R. 122.3(a); to the Committee on Transportation and Infrastructure.

229. Also, a memorial of the Legislature of the State of Michigan, relative to Senate Concurrent Resolution No. 13 memorializing the Congress of the United States fund the Great Lakes Legacy Act at its authorized level of $54 million in Fiscal Year 2004; to the Committee on Transportation and Infrastructure.

PRIVATE BILLS AND RESOLUTIONS

Under clause 3 of rule XII, private bills and resolutions of the following titles were introduced and severally referred, as follows:

By Ms. CARSON of Indiana:

H.R. 3646. A bill for the relief of Adela and Darryl Bailor; to the Committee on the Judiciary.

By Mr. DAVIS of Illinois:

H.R. 3647. A bill for the relief of Roger Paul Robert Kozik; to the Committee on the Judiciary.

By Mr. DAVIS of Illinois:

H.R. 3648. A bill for the relief of Alzoubi Muhammed; to the Committee on the Judiciary.

By Mr. DAVIS of Illinois:

H.R. 3649. A bill for the relief of Stoyan Simeonov Stoyanov; to the Committee on the Judiciary.

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions as follows:

H.R. 211: Mr. EVANS, Mrs. MALONEY, Ms. VELÁZQUEZ, Mr. SERRANO, Mr. CLAY, Mr. BALLANCE, Ms. CORRINE BROWN of Florida, Mr. SCOTT of Virginia, Mr. HASTINGS of Florida, Mr. RUSH, and Mr. NADLER.

H.R. 303: Mr. JACKSON of Illinois.

H.R. 433: Mr. GERLACH.

H.R. 434: Mr. FERGUSON and Mr. RYAN of Wisconsin.

H.R. 476: Mr. LOBIONDO.

H.R. 486: Mr. LEWIS of Kentucky.

H.R. 489: Mr. GARRETT of New Jersey.

H.R. 527: Mr. SCHIFF and Mr. VAN HOLLEN.

H.R. 548: Mr. DELAHUNT.

H.R. 571: Mr. HENSARLING.

H.R. 713: Ms. MCCOLLUM and Mr. BAIRD.

H.R. 728: Mr. HENSARLING, Mr. TIBERI, and Mr. BURGESS.

H.R. 742: Ms. LEE and Mr. DELAHUNT.

H.R. 745: Ms. LEE and Mrs. JONES of Ohio.

H.R. 785: Mr. SNYDER and Mr. JACKSON of Illinois.

H.R. 813: Mr. DELAHUNT.

H.R. 814: Mr. BISHOP of New York.

H.R. 819: Mr. DOGGETT.

H.R. 832: Mr. NEAL of Massachusetts.

H.R. 839: Mr. EDWARDS.

H.R. 857: Mr. EMANUEL, Mr. MATSUI, Mr. PAYNE, Ms. CORRINE BROWN of Florida, Ms. KILPATRICK, Mr. OBERSTAR, Ms. WATERS, Mr.

LEWIS of Kentucky, Mr. FERGUSON, Mr. BECERRA, Mr. MEEHAN, Ms. MCCOLLUM, and Mr. GREEN of Texas.

H.R. 876: Ms. CORRINE BROWN of Florida, Mr. KILDEE, Mr. SABO, Mr. THOMPSON of Mississippi, Mr. NADLER, and Mr. RYAN of Ohio.

H.R. 918: Mr. RYAN of Wisconsin, Mr. ROSS, Mr. COSTELLO, Mr. WALSH, Mr. ROGERS of Kentucky, Mr. SMITH of New Jersey, Mr. CAMP, Mrs. JONES of Ohio, Mr. BOSWELL, Mr. BARTON of Texas, and Mr. GILLMOR.

H.R. 926: Mr. GOODE.

H.R. 933: Mr. GUTIERREZ.

H.R. 962: Mr. FROST and Mr. THOMPSON of Mississippi.

H.R. 990: Mr. CANTOR.

H.R. 1029: Mr. TOWNS.

H.R. 1034: Mr. SERRANO, Mr. GONZALEZ, Mr. BERMAN, Mr. NADLER, Mr. MARKEY, and Ms. LINDA T. SÁNCHEZ of California..

H.R. 1061: Mr. HEFLEY.

H.R. 1068: Mr. WELLER and Mr. JACKSON of Illinois.

H.R. 1083: Mr. WALDEN of Oregon and Mr. BISHOP of Georgia.

H.R. 1117: Mrs. BONO.

H.R. 1125; Mr. MANZULLO.

H.R. 1154: Mr. EVERETT.

H.R. 1157: Ms. LORETTA SANCHEZ of California.

H.R. 1227: Mrs. BLACKBURN, Mr. KLINE, and Mr. GARRETT of New Jersey.

H.R. 1258: Mr. ABERCROMBIE.

H.R. 1267: Mr. MEEKS of New York and Mr. NEAL of Massachusetts.

H.R. 1279: Mr. JACKSON of Illinois.

H.R. 1310: Mr. PETERSON of Pennsylvania.

H.R. 1325: Mr. FROST.

H.R. 1336: Mr. JACKSON of Illinois, Mr. DEAL of Georgia, and Mr. JOHNSON of Illinois.

H.R. 1348: Mr. GONZALEZ.

H.R. 1372: Mr. NEUGEBAUER, Mrs. BLACKBURN, and Mr. CRANE.

H.R. 1385: Mr. PASCRELL.

H.R. 1406: Mr. CUNNINGHAM.

H.R. 1414: Mr. DELAHUNT.

H.R. 1472: Mr. LANGEVIN.

H.R. 1477: Mr. JACKSON of Illinois.

H.R. 1501: Mr. BLUMENAUER, Mrs. CAPPS, Mr. CARSON of Oklahoma, Mr. KILDEE, and Mr. MARKEY.

H.R. 1508: Mr. HONDA.

H.R. 1513: Mr. JOHNSON of Illinois.

H.R. 1532: Mr. BISHOP of New York, Mr. SWEENEY, Mr. MATSUI, Ms. MILLENDER-MCDONALD, Mr. MEEKS of New York, Mr. EMANUEL, Mr. NADLER, Ms. CORRINE BROWN of Florida, Ms. WATERS, Mr. OBERSTAR, Mrs. NAPOLITANO, and Mr. FERGUSON.

H.R. 1534: Mr. CROWLEY.

H.R. 1546: Mr. GARRETT of New Jersey.

H.R. 1563: Mr. VAN HOLLEN.

H.R. 1582: Mr. LEVIN.

H.R. 1592: Mr. LARSEN of Washington.

H.R. 1600: Mr. SCHIFF.

H.R. 1657: Mr. BISHOP of New York.

H.R. 1662: Mr. WILSON of South Carolina.

H.R. 1688: Mr. DINGELL and Mr. JACKSON of Illinois.

H.R. 1694: Mr. HOEFFEL.

H.R. 1708: Mrs. CAPPS.

H.R. 1719: Mr. ANDREWS.

H.R. 1736: Mr. LAHOOD.

H.R. 1742: Ms. GRANGER.

H.R. 1749: Mr. RYUN of Kansas, Mr. PRICE of North Carolina, Mr. ISRAEL, and Mr. DEAL of Georgia.

H.R. 1752: Mr. FATTAH.

H.R. 1782: Mr. FROST and Mr. GONZALEZ.

H.R. 1793: Mr. NEUGEBAUER and Mr. OSBORNE.

H.R. 1796: Ms. LORETTA SANCHEZ of California.

H.R. 1800: Mr. PASCRELL.

H.R. 1861: Ms. DELAURO and Mr. THOMPSON of Mississippi.

H.R. 1873: Mr. BASS.

H.R. 1886: Mr. BERMAN and Mr. FILNER.

H.R. 1890: Mr. BRADY of Texas.

H.R. 1895: Mr. VAN HOLLEN.

H.R. 1905: Mr. BISHOP of New York.

H.R. 1919: Mr. DELAHUNT.

H.R. 1924: Ms. MILLENDER-MCDONALD and Mr. GUTIERREZ.

H.R. 1939: Mr. LEWIS of Georgia.

H.R. 1997: Mr. SHUSTER and Mr. HALL.

H.R. 2032: Mr. OLVER.

H.R. 2034: Mr. BURGESS.

H.R. 2039: Mr. TAUZIN.

H.R. 2052: Mr. BALLANCE, Mr. BISHOP of Georgia, Mr. EDWARDS, Mr. DICKS, Mr. TAYLOR of North Carolina, Mr. CRAMER, Mr. DOYLE, Mr. CLYBURN, Mr. BOSWELL, and Mrs. LOWEY.

H.R. 2062: Mr. TIERNEY.

H.R. 2072: Ms. GRANGER.

H.R. 2139: Mr. EVERETT.

H.R. 2157: Mr. ABERCROMBIE and Mr. ISSA.

H.R. 2166: Mr. HYDE.

H.R. 2173: Mr. JOHN, Mr. STUPAK, Mr. ACEVEDO-VILÁ, MR. BRADY of Pennsylvania, and Mr. TURNER of Texas.

H.R. 2217: Mr. DELAHUNT, Mr. NEAL of Massachusetts, and Mr. VAN HOLLEN.

H.R. 2239: Mr. SCHIFF, Mr. MICHAUD, Ms. MCCOLLUM, Mr. UDALL of Colorado, Mr. TIERNEY, and Ms. SLAUGHTER.

H.R. 2366: Ms. WATSON, Mr. STUPAK, and Mr. BISHOP of New York.

H.R. 2435: Mr. GUTIERREZ.

H.R. 2437: Ms. CARSON of Indiana.

H.R. 2449: Mr. MILLER of Florida, Mr. PUTNAM, and Mr. LEACH.

H.R. 2504: Mr. CARDIN.

H.R. 2509: Mr. RODRIGUEZ and Mr. BRADY of Texas.

H.R. 2511: Mr. DELAHUNT.

H.R. 2527: Ms. SOLIS.

H.R. 2539: Mr. OWENS.

H.R. 2540: Ms. CORRINE BROWN of Florida, Ms. HART, and Mr. SIMPSON.

H.R. 2560: Mr. ISRAEL and Ms. LOFGREN.

H.R. 2585: Ms. CARSON of Indiana and Mr. LANGEVIN.

H.R. 2625: Mr. DINGELL.

H.R. 2626: Mr. NEAL of Massachusetts.

H.R. 2665: Mr. BISHOP of New York.

H.R. 2671: Mr. GOODLATTE.

H.R. 2699: Mr. RUSH.

H.R. 2719: Mr. CASE.

H.R. 2733: Mr. SESSIONS.

H.R. 2743: Mr. OTTER.

H.R. 2809: Mr. WEXLER.

H.R. 2810: Mr. WEXLER.

H.R. 2823: Mr. BILIRAKIS and Mr. DELAHUNT.

H.R. 2830: Mr. WALSH.

H.R. 2853: Mr. GUTIERREZ.

H.R. 2880: Mr. OWENS.

H.R. 2906: Mr. JENKINS.

H.R. 2910: Mr. SESSIONS.

H.R. 2913: Ms. MCCOLLUM.

H.R. 2916: Ms. LOFGREN and Ms. BERKLEY.

H.R. 2929: Mr. GORDON, Mr. DEUTSCH, Ms. MCCARTHY of Missouri, Mr. GILLMOR, and Mr. HALL.

H.R. 2933: Mr. ISAKSON.

H.R. 2948: Ms. LEE and Mr. GONZALEZ.

H.R. 2959: Mr. ACKERMAN.

H.R. 2961: Mr. WAMP.

H.R. 2968: Mr. DREIER.

H.R. 2980: Ms. ROYBAL-ALLARD, Ms. SLAUGHTER, and Mr. KUCINICH.

H.R. 2983: Mr. FROST, Mr. FILNER, Mr. RANGEL, and Mr. KILDEE.

H.R. 2986: Mr. LANGEVIN, Ms. CARSON of Indiana, and Mr. WALSH.

H.R. 2990: Mrs. JONES of Ohio.

H.R. 3051: Ms. CARSON of Indiana, Mr. ORTIZ, Mr. BISHOP of New York, and Ms. SLAUGHTER.

H.R. 3057: Mrs. CAPPS and Mr. SCHIFF.

H.R. 3063: Mr. LANTOS and Ms. SCHAKOWSKY.

H.R. 3064: Mr. JOHNSON of Illinois.

H.R. 3066: Mr. RYAN of Wisconsin, Mr. HOUGHTON, Mrs. Musgrave, and Mr. OSBORNE.

H.R. 3099: Ms. DELAURO, Mr. MEEKS of New York, Mr. ALLEN, Mr. OWENS, and Ms. LINDA T. SANCHEZ of California.

H.R. 3104: Ms. KILPATRICK, Mr. KIRK, Mr. BISHOP of New York, and Mr. ORTIZ.

H.R. 3112: Mr. PASTOR.

H.R. 3133: Mr. CARDOZA.

H.R. 3142: Mr. SMITH of New Jersey, Mr. LATOURETTE, Mr. MATSUI, Mr. BERRY, and Mr. GUTIERREZ.

H.R. 3148: Mr. LEWIS of Georgia, Mr. MCNULTY, and Mr. SOUDER.

H.R. 3178: Mr. KIND, Ms. MCCOLLUM, Mr. ALLEN, Mr. UDALL of New Mexico, Mr. MORAN of Virginia, Mr. EHLERS, Mr. SNYDER, Mr. VAN HOLLEN, and Mr. ANDREWS.

H.R. 3190: Mr. BARTON of Texas, Mr. OSBORNE, Mr. KELLER, and Mr. HOEKSTRA.

H.R. 3192: Mr. MICHAUD.

H.R. 3193: Mr. CALVERT, Mr. ENGLISH, Mr. NUNES, Mr. BURNS, Mr. STUPAK, and Mr. TANCREDO.

H.R. 3203: Mr. HINOJOSA and Mr. EMANUEL.

H.R. 3204: Mr. BEREUTER, Mr. TOM DAVIS OF Virginia, Mr. HOBSON, Mr. OSE, Ms. PRYCE of Ohio, Mr. REGULA, Mr. REYNOLDS, Mr. ROGERS of Kentucky, Mr. TAYLOR of North Carolina, Mr. TERRY, Mr. TIBERI, Mr. WALSH, Mr. WELDON of Pennsylvania, and Mr. WHITFIELD.

H.R. 3220: Mr. MEEKS of New York.

H.R. 3242: Mr. MICHAUD and Mr. HERGER.

H.R. 3244: Ms. MCCARTHY of Missouri, Ms. LINDA T. SÁNCHEZ of California, and Mr. BISHOP of New York.

H.R. 3251: Ms. LINDA T. SÁNCHEZ of California

H.R. 3259: Mr. PLATTS and Mrs. WILSON of New Mexico.

H.R. 3263: Ms. BERKLEY, Mrs. JO ANN DAVIS of Virginia, and Mr. FALEOMAVAEGA.

H.R. 3275: Mr. LANTOS.

H.R. 3277: Mr. ABERCROMBIE, Mr. ACKERMAN, Ms. BERKLEY, Mr. BALLANCE, Mr. BECERRA, Ms. CORRINE BROWN of Florida, Mr. CLAY, Mr. CLYBURN, Mr. EDWARDS, Ms. ESHOO, Mr. FARR, Mr. GONZALEZ, Mr. GRIJALVA, Mr. HASTINGS of Florida, Mr. HOEFFEL, Mr. HOLT, Mr. HONDA, Ms. LOFGREN, Mrs. LOWEY, Mr. MILLER of North Carolina, Ms. PELOSI, Ms. LORETTA SANCHEZ of California, Mr. THOMPSON of Mississippi, Mr. VAN HOLLEN, Mrs. MILLER of Michigan, Mr. ISAKSON, Mr. KINGSTON, Mr. MCHUGH, Mr. CAPUANO, Mr. BISHOP of Georgia, Mr. BOSWELL, Mr. BOUCHER, Mr. BOYD, Mr. CONYERS, Mr. CUMMINGS, Mr. DAVIS of Illinois, Mr. DELAHUNT, Mr. DEUTSCH, Mr. ETHERIDGE, Mr. KLECZKA, Mr. LANGEVIN, Mr. MARKEY, Mr. MEEK of Florida, Mr. TAYLOR of Mississippi, Mr. UDALL of Colorado, Ms. VELÁZQUEZ, Mr. MANZULLO, Mr. BISHOP of New York, Mr. DOGGETT, Mr. HINOJOSA, Ms. HOOLEY of Oregon, Mr. KENNEDY of Rhode Island, Mrs. MALONEY, Mr. PAYNE, Mr. RANGEL, Ms. LINDA T. SÁNCHEZ of California, Mr. SERRANO, Ms. SLAUGHTER, Mr. TURNER of Texas, Mr. WAXMAN, Ms. WOOLSEY, Mr. BLUMENAUER, Mr. HOYER, Mr. COOPER, Mr. EMANUEL, Mr. OBEY, Mr. STENHOLM, Mr. ROTHMAN, Mr. OWENS, and Mrs. TAUSCHER.

H.R. 3286: Mr. SNYDER.

H.R. 3299: Mr. CASE, and Mr. HOEFFEL.

H.R. 3304: Ms. LINDA T. SÁNCHEZ of California.

H.R. 3309: Mr. SERRANO, Mr. MARIO DIAZ-BALART of Florida, Mr. MCDERMOTT and Mr. FRANK of Massachusetts.

H.R. 3310: Mr. HINOJOSA.

H.R. 3325: Mr. MARKEY.

H.R. 3327: Mrs. CAPPS, Ms. WATERS, Mr. WAXMAN, Mr. FRANK of Massachusetts, and Mr. MARKEY.

H.R. 3329: Mr. PETERSON of Pennsylvania.

H.R. 3338: Mr. TIBERI, Mr. STUPAK, and Mr. WAXMAN.

H.R. 3340: Mr. WELLER, Mrs. BIGGERT, Mr. LAHOOD, Mr. GUTIERREZ, and Mr. MANZULLO.

H.R. 3341: Ms. WATSON.

H.R. 3344: Mrs. NAPOLITANO, Mr. STUPAK, and Ms. LINDA T. SÁNCHEZ of California.

H.R. 3350: Mr. LANGEVIN and Ms. BERKLEY.

H.R. 3352: Mr. NETHERCUTT.

H.R. 3355: Mr. RUSH, Mr. MCNULTY, Mr. ABERCROMBIE, and Ms. LINDA T. SÁNCHEZ of California.

H.R. 3361: Mr. MCGOVERN, Mr. BECERRA, Mr. PAYNE, Mr. GONZALEZ, and Mr. HINOJOSA.

H.R. 3362: Ms. BERKLEY.

H.R. 3363: Mrs. NAPOLITANO and Mr. MICHAUD.

H.R. 3378: Mr. PALLONE and Mr. ABERCROMBIE.

H.R. 3380: Mr. VAN HOLLEN.

H.R. 3398: Ms. HARMAN.

H.R. 3403: Mr. NETHERCUTT and Mr. SIMPSON.

H.R. 3410: Mr. SPRATT and Mr. ENGLISH.

H.R. 3424: Mr. KUCINICH.

H.R. 3425: Ms. BERKLEY and Mr. MCGOVERN.

H.R. 3437: Mr. SIMMONS and Mr. GREEN of Texas.

H.R. 3438: Mr. BAIRD, Mr. PRICE of North Carolina, Mr. TIERNEY, and Mr. VAN HOLLEN.

H.R. 3440: Mr. RANGEL, Mr. DELAHUNT, Mr. STUPAK, and Mr. NEAL of Massachusetts.

H.R. 3444: Mr. JACKSON of Illinois.

H.R. 3446: Mr. INSLEE, Mr. RAHALL, Mr. FRANK of Massachusetts, Mr. GRIJALVA, and Mr. FROST.

H.R. 3447: Mr. SERRANO, Mr. BECERRA, Ms. VELÁZQUEZ, Mr. BACA, Mr. CARDOZA, and Ms. LINDA T. SÁNCHEZ of California.

H.R. 3451: Mr. GUTIERREZ and Mr. CLAY.

H.R. 3453: Mr. ISAKSON, Mr. LEWIS of Kentucky, Mr. PETRI, and Mr. WICKER.

H.R. 3474: Mr. ALEXANDER, Mr. CRAMER, Mr. KENNEDY of Rhode Island, Mr. CUMMINGS, Mr. SCOTT of Georgia, Mr. THOMPSON of Mississippi, Mr. FROST, Ms. CARSON of Indiana, Mr. GEORGE MILLER of California, Mr. MATSUI, Ms. WOOLSEY, Mr. HOLDEN, Mr. JONES of North Carolina, Mrs. MCCARTHY of New York, Ms. HART, Mr. MCGOVERN, Mr. KINGSTON, Mr. TAYLOR of North Carolina, Mr. EVANS, Mr. ACEVEDO-VILÁ, Mr. PAUL, Mr. HINCHEY, Mr. FATTAH, Mr. CARDOZA, Mr. GRIJALVA, Mr. BISHOP of Georgia, Mrs. CHRISTENSEN, Mr. LANTOS, Mr. PALLONE, Mr. KING of Iowa, Mr. KILDEE, Mr. UDALL of Colorado, Mrs. JONES of Ohio, Mr. BOYD, Mr. RANGEL, Mr. DOOLEY of California, Mr. LIPINSKI, Mr. PETERSON of Minnesota, Mr. KLINE, Mr. ISRAEL, Mr. GUTIERREZ, Mr. STRICKLAND, Mr. BASS, Mr. BRADY of Pennsylvania, Ms. LEE, Mr. BROWN of Ohio, Ms. MILLENDER-MCDONALD, Mr. SANDERS, Ms. SOLIS, Mr. DELAHUNT, Ms. WATSON, Ms. CORRINE BROWN of Florida, Mr. RYAN of Ohio, Ms. DELAURO, Mr. DEFAZIO, Mr. LATOURETTE, Mr. LYNCH, Mr. BISHOP of New York, Ms. BERKLEY, Mr. RODRIGUEZ, and Mr. FILNER.

H.R. 3500: Mr. DAVIS of Tennessee, Mr. MILLER of North Carolina, Mr. BALLANCE, and Mr. BISHOP of Georgia.

H.R. 3509: Mr. WELDON of Florida.

H.R. 3519: Mrs. JONES of Ohio, Mr. MATSUI, Mr. STARK, and Mr. MCGOVERN.

H.R. 3522: Mr. GARRETT of New Jersey and Mr. BILIRAKIS.

H.R. 3527: Mr. BURR.

H.R. 3539: Mr. ABERCROMBIE and Mr. MCNULTY.

H.R. 3544: Mr. ABERCROMBIE.

H.R. 3549: Mr. SCHIFF, Mr. HASTINGS of Florida, Mr. BOYD, Mr. WEINER, Mr. DAVIS of Alabama, Ms. LEE, Mr. GORDON, Mr. STUPAK, Mr. THOMPSON of Mississippi, Ms. MCCOLLUM, Mr. PASCRELL, Mr. FILNER, Mr. SCOTT of Virginia, Mr. CARSON of Oklahoma, Mr. MILLER of North Carolina, Mr. BAIRD, Mrs. MALONEY, Mrs. MCCARTHY of New York, Mr. FATTAH, Mr. GONZALEZ, Mr. RANGEL, Mr. STENHOLM, Mr. EDWARDS, Mr. JOHN, Mr. RODRIQUEZ, Ms. CORRINE BROWN of Florida, Mr. KILDEE, Ms. HOOLEY of Oregon, Mr. OBEY, Mr. PRICE of North Carolina, Mr. SCOTT of Georgia, Ms. MAJETTE, Mr. CARDOZA, Mr. MOORE, Mrs. CHRISTENSEN, Mr. BLUMENAUER, Mr. POMEROY, Mr. CASE, Mr. TOWNS, Mrs. TAUSCHER, Mr. FALEOMAVAEGA, Mr. BALLANCE, Mr. FORD, Mr. SKELTON, Mr. OBERSTAR, Ms. SCHAKOWSKY, Mr. INSLEE, Mr. COOPER, Mr. DAVIS of Florida, Mr. MARSHALL, Mr. MATHESON, Mr. TURNER of Texas, Mr. BACA, Mrs. TIERNEY, Mr. OLVER, Mr. SPRATT, Mr. EMANUEL, Mr. HOEFFEL, Ms. MILLENDER-MCDONALD, Ms. CARSON of Indiana, Ms. MCCARTHY of Missouri, Mr. LUCAS of Kentucky, Mr. EVANS, Mr. BOSWELL, Mr. DAVIS of Tennessee, Ms. LINDA T. SÁNCHEZ of California, Mrs. CAPPS, Ms. LORETTA SANCHEZ of California, Ms. SLAUGHTER, Ms. WOOLSEY, Mr. BERRY, Mr. HINCHEY, Mr. CAPUANO, Mr. MICHAUD, Mr. ROSS, Mr. THOMPSON of California, Mr. ABERCROMBIE, Mr. RAHALL, Mr. DICKS, Mr. KANJORSKI, Mr. STARK, Mr. DEFAZIO, Mr. GRIJALVA, Mr. GEPHARDT, Mr. LARSEN of Washington, Mr. ALEXANDER, Mr. KIND, Ms. DELAURO, Mr. HINOJOSA, Mr. HOLT, Mr. FARR, Mr. BISHOP of Georgia, Ms. BERKLEY, Mr. REYES, Mr. ORTIZ, Mr. ISRAEL, Ms. BALDWIN, Mr. STRICKLAND, Mr. BISHOP of New York, Mr. HOLDEN, Mr. ALLEN, Mr. UDALL of New Mexico, Mr. SNYDER, Mr. CLAY, Mr. JEFFERSON, and Mr. LIPINSKI.

H.R. 3550: Mr. BERRY, Mrs. JONES of Ohio, Mr. LAHOOD, Mr. EVANS, and Mr. GUTIERREZ.

H.R. 3554: Mr. BLUMENAUER, Mr. BAIRD, Mr. HOUGHTON, and Mr. DICKS.

H.R. 3556: Mr. BISHOP of New York.

H.J. Res. 28: Mr. FORD, Ms. WATSON, Mr. MEEK of Florida, Mr. CLAY, Mr. HASTINGS of Florida, Mr. FILNER, and Mr. HINCHEY.

H.J. Res. 29: Mr. FORD, Mr. MEEK of Florida, Mr. HASTINGS of Florida, and Mr. FILNER.

H.J. Res. 30: Ms. WATSON, Mr. MEEK of Florida, Mr. CLAY, Mr. HASTINGS of Florida, Mr. FILNER, and Mr. HINCHEY.

H.J. Res. 31: Mr. MEEK of Florida, Mr. CLAY, and Mr. CUMMINGS.

H.J. Res. 32: Mr. MEEK of Florida, Mr. CLAY, and Mr. CUMMINGS.

H.J. Res. 33: Mr. MEEK of Florida, Mr. CLAY, and Mr. CUMMINGS.

H.J. Res. 34: Mr. MEEK of Florida, Mr. CLAY, and Mr. CUMMINGS.

H.J. Res. 35: Mr. MEEK of Florida, Mr. CLAY, and Mr. CUMMINGS.

H.J. Res. 42: Mr. EVERETT.

H.J. Res. 56: Mr. SMITH of Texas, Ms. GINNY BROWN-WAITE of Florida, Mr. CANNON, and Mr. HULSHOF.

H.J. Res. 62: Mr. BISHOP of New York and Mrs. MCCARTHY of New York.

H. Con. Res. 15: Mr. FOLEY, Mr. MCCOTTER, and Mr. VITTER.

H. Con. Res. 30: Mr. GEPHARDT.

H. Con. Res. 37: Mr. SOUDER, Mr. GREEN of Texas, and Mr. VAN HOLLEN.

H. Con. Res. 87: Ms. SOLIS.

H. Con. Res. 234: Mr. LANGEVIN.

H. Con. Res. 242: Mr. GOODE.

H. Con. Res. 275: Ms. BERKLEY.

H. Con. Res. 304: Mr. ROHRABACHER, Mr. BOSWELL, Mr. OLVER, Mr. BROWN of Ohio, Mr. ISRAEL, Mr. WELDON of Pennsylvania, Mr. SCHIFF, Mr. JOHNSON of Illinois, Mr. GARRETT of New Jersey, Mr. FRANK of Massachusetts, and Mr. LANTOS.

H. Con. Res. 311: Mr. WAXMAN and Mr. RANGEL.

H. Con. Res. 317: Mr. FROST.

H. Con. Res. 324: Mr. FOLEY.

H. Con. Res. 326: Mr. LINCOLN DIAZ-BALART of Florida, Mr. LANTOS, Mr. SMITH of New Jersey, and Mr. CROWLEY.

H. Con. Res. 327: Ms. LEE, Mr. MCDERMOTT, Ms. BALDWIN, Mr. TANCREDO, and Mr. BROWN of Ohio.

H. Con. Res. 331: Mr. FLAKE.

H. Con. Res. 332: Mr. COLE, Mr. ANDREWS, and Mr. RUPPERSBERGER.

H. Res. 60: Mr. TANNER.

H. Res. 157: Ms. MCCOLLUM, Mr. WAXMAN, and Mr. SOUDER.

H. Res. 268: Mr. JACKSON of Illinois.

H. Res. 302: Ms. JACKSON-LEE of Texas and Mr. KENNEDY of Rhode Island.

H. Res. 320: Ms. SOLIS.

H. Res. 371: Mr. KNOLLENBERG and Mr. TANCREDO.

H. Res. 382: Mr. TOWNS, Mr. BERRY, Mr. MCGOVERN, and Mr. GRIJALVA.

H. Res. 389: Ms. LOFGREN.

H. Res. 402: Mr. DELAHUNT.

H. Res. 419: Mr. VAN HOLLEN.

H. Res. 440: Mr. DOGGETT.

H. Res. 445: Mr. PALLONE, Mr. DAVIS of Alabama, Mr. OBERSTAR, and Mr. BROWN of Ohio.

H. Res. 446: Mr. KINGSTON and Mr. GARRETT of New Jersey.

H. Res. 453: Mr. STEARNS, Mr. FRANK of Massachusetts, Mr. GARRETT of New Jersey, Mr. SOUDER, Mr. KING of New York, Mr. MCGOVERN, and Mr. STRICKLAND.

H. Res. 455: Ms. DUNN, Mr. GILCHREST, Mr. OSBORNE, Mr. WILSON of South Carolina, Mr. TIAHRT, Mr. BOOZMAN, Mr. MCCOTTER, Ms. GRANGER, Mrs. KELLY, Mr. BALLENGER, Mr. SAM JOHNSON of Texas, Mr. SHADEGG, and Mrs. MILLER of Michigan.

H. Res. 460: Mr. BOEHNER, Mr. CAMP, Mr. REGULA, Mr. CHABOT, Mr. HOEKSTRA, and Mr. STUPAK.

H. Res. 461: Mrs. NAPOLITANO, Mr. SANDERS, Mrs. MALONEY, Mr. FILNER, Mr. ABERCROMBIE, and Mr. FROST.

PETITIONS, ETC.

Under clause 3 of rule XII,

45. The SPEAKER presented a petition of the Legislature of Rockland County, NY, relative to Resolution No. 500 of 2003 petitioning the United States Senate to pass the Kennedy-Dodd Head Start Bill (S. 1483) or, in the alternative, pass the Alexander Head Start Bill (S. 1474); which was referred to the Committee on Education and the Workforce.

DISCHARGE PETITIONS—ADDITIONS OR DELETIONS

The following Members added their names to the following discharge petitions:

Petition 2, by Mr. JIM MARSHALL on House Resolution 251: David Vitter.

AMENDMENTS

Under clause 8 of rule XVIII, proposed amendments were submitted as follows:

H.R. 3482

OFFERED BY MR. PETERSON OF MINNESOTA

AMENDMENT NO. 1: Page 4, after line 24, insert the following:

(d) LIMITATION.—The Secretary may not award a grant to a State under this section if the laws of the State treat residents and non-residents differently with respect to the period in which an individual may engage in hunting or taking of migratory birds which are water fowl.

Page 5, line 1, strike "(d)" and insert "(e)".

Page 5, line 4, strike "(e)" and insert "(f)".

EXTENSIONS OF REMARKS

SENATOR ROBERT C. BYRD'S 86TH BIRTHDAY

HON. NICK J. RAHALL, II

OF WEST VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. RAHALL. Mr. Speaker, recently U.S. Senator ROBERT C. BYRD, D–W.Va., received the prestigious "Freedom from Fear" Medal from the Franklin and Eleanor Roosevelt Institute in Hyde Park, N.Y.

Shakespeare warned us, "men close their doors against a setting sun." But, in the extraordinary moments of human endeavor, when light of liberty dares to fade, often only a single soul stands to embrace its care—a soul who has stood vigil through the night armed with reason, buoyed by history and strengthened by vision. This award and Senator BYRD's honor reflect his place in human history.

Today marks the 86th Birthday of West Virginia's finest. Senator ROBERT C. BYRD's personal life and his public service have consistently embraced the same principles: diligent work, constant improvement, unwavering commitment, unswerving honesty, and an overarching sense of history.

In his 86 years Senator BYRD has been a legislative craftsman, parliamentarian extraordinaire, skillful architect, master builder, visionary, dreamer, and doer. From teacher, scholar, mentor, leader, author, historian, and diplomat, Senator BYRD has borne many mantles throughout the years. But the one of which he is most proud, and perhaps cherishes the most, is that of being a West Virginian.

He has been a mentor to me, a pillar of strength for West Virginia, and a voice of reason for the Nation. After 86 years and five decades of service in Congress, his work is not yet done. The West Virginian of the Past Century is quickly forging a sterling legacy in the new one. And, as before, he is leading the way.

TRIBUTE TO BOB BOWERS

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. MCINNIS. Mr. Speaker, it is with a solemn heart that I take this opportunity to pay tribute to the life of Bob Bowers who passed away recently at the age of 74. Bob was a pillar of the Alamosa, Colorado community, and as his family mourns their loss, I think it is appropriate that we remember his life and celebrate his contributions to our nation today.

Bob was born in Springfield, Massachusetts in 1929. As a young man, Bob answered our nation's call to duty and joined the United States Air Force, where he served honorably before moving to Colorado. Bob served the state of Colorado for 25 years as a Health Inspector for the Colorado Department of Health. He married his wife Jo in 1948; they were married for 55 years.

Bob was very active in the Alamosa community. He was a volunteer for 4-H, the Boys and Girls Club, Share Colorado, the American Legion and the Alamosa Senior Citizens Center. Bob also served as a Boy Scout leader, where he passed along his outdoors skills, knowledge and morals to young people. Each year, Bob spent his winter holidays volunteering as Santa Clause for charitable organizations throughout the San Luis Valley. Bob was truly dedicated to bettering the lives of the citizens of Alamosa and many people there are better off as the result of his contributions.

Mr. Speaker, the dedication and selflessness that Bob Bowers has shown is certainly worthy of recognition before this body of Congress. It is my privilege to pay tribute to him for his contributions to the State of Colorado and our nation. I would like to extend my thoughts and deepest sympathies to Bob's family and friends during this difficult time.

TRIBUTE TO IRV KUPCINET—KNOWN TO MANY AS MR. CHICAGO

HON. DANNY K. DAVIS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. DAVIS of Illinois. Mr. Speaker, it was virtually impossible to live in Chicago and not be affected by Irv Kupcinet or Kup as he was fondly called. Kup knew everybody who had any public presence in Chicago and of course, knew powerful people and celebrities from around the world.

Kup was best known as a columnist for the Chicago Sun Times but was much more than a columnist, he was a communicator and used many mediums for that purpose. He had a television show, was a great emcee, was actively involved in civic, community, charitable and philanthropic activity. He was a fundraiser, a promoter, an icon, a legend.

Kup had the ability to make use of not only himself; but he was also able to rely upon others in very serious and strategic ways as he did with his assistant for 34 years, Ms. Stella Foster.

Kup was a creative genius who could take a mere occurrence and turn it into a great and glorious event. He was very open, comfortable and at ease with practically any and everybody. Kup grew up on the westside of Chicago, which is the heart of my Congressional District. He learned to walk with kings and queens; but never lost the common touch, yes, all men and women did matter with him but none too much. Over the years, Kup's column was distributed to more than 100 newspapers around the world. In 1982, he was elected to Chicago's journalism Hall of Fame. He broadcast Chicago Bears Football games with Jack Brickhouse for 24 years, he appeared in two movies and had a syndicated television program "The Tonight Show," which ran from 1959 to 1986 and at one point was on 70 stations.

Kup never forgot the community of his birth, north Lawndale in Chicago which had some transitions and fell upon hard times. Kup was a star athlete, played football on a team with former president Gerald Ford and was drafted by the Philadelphia Eagles. Kup was many things to many people, but most of all he was husband and companion to his beloved wife Essee, father to his children, grandfather, son to his parents, brother to his siblings and friend to many.

There was nothing quite like being mentioned in Kup's column, and if you were on the scope, you'd eventually get there.

Yes, Kup walked with Kings, Queens, Presidents, Stars and Captains of business and industry, but never lost the common touch.

TRIBUTE TO MRS. HELEN EVERSON

HON. TAMMY BALDWIN

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Ms. BALDWIN. Mr. Speaker, I rise today to extend my congratulations to Mrs. Helen Everson, who has been selected as Edgerton Rotary's Honored Citizen of the Year. Helen and her husband, Harland Everson, purchased the Edgerton Reporter, in 1951 and made the risky yet insightful decision to change from hot type to offset printing, the first paper in Wisconsin to do so. I rise today to pay tribute to a constituent whose life-long commitment to serving her community as an entrepreneur, philanthropist, and mother serves as a shining example to us all.

Helen was raised on a 5,000-acre sheep ranch in northwestern South Dakota and attended a two-room country school until her graduation. Helen's professional experience began at Keating Buick where she quickly gained greater responsibility and expertise and eventually became the Secretary-Treasurer of the car dealership.

Helen's life would change dramatically after she met and married Harland. The couple tackled the challenges of operating a growing and award-winning newspaper, in addition to raising a family. Harland and Helen's daughters, Carol and Diane, are both accomplished women in their own right. Carol is an associate professor at the Medical College of Wisconsin and Diane is the publisher of the

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

Edgerton Reporter and past president of the National Newspaper Association.

Diane describes her mother as a "heat seeking missile with boundless energy." She is still a tireless advocate for civic development and the Edgerton community. Under her leadership of Edgerton's annual Tobacco Heritage Days, the celebration grew in popularity and became profitable for the first time. For an impressive 52 years, the Everson family has been the steward of one of the state's only independent newspapers.

Mr. Speaker, I join the Edgerton Rotary and the Edgerton community in recognizing Helen Everson's achievements and congratulate her as she accepts the Honored Citizen of the Year award.

IN RECOGNITION OF LEROY CARLSON

HON. MARK UDALL

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. UDALL of Colorado. Mr. Speaker, I rise today to honor LeRoy Carlson for his three decades of exemplary work with the United States Fish and Wildlife Service. Leroy Carlson is one of Colorado's outstanding field biologists, preserving and protecting the Rocky Mountain region's wildlife.

Lee received his bachelor's degree from Colorado State University in Wildlife Biology and his master's degree in 1974 with an emphasis on the wildlife impacts from oil shale development. He began his career in Galveston, Texas as a field staff biologist for the U.S. Fish and Wildlife Service where he did permitting work for the Army Corps of Engineers on housing developments, levies and wetlands.

After 2 years in Texas, Lee moved to the Lakewood, Colorado offices of the U.S. Fish and Wildlife Service where he worked for the next 27 years until his retirement in 2003. His innovative approaches to a wide range of issues enabled him to provide oversight and protection to the region's threatened and endangered species and to guide many of the region's largest projects to successful completion.

Lee's ability to coordinate the protection of wildlife was most evident on large Federal projects, such as the Animas-LaPlata water project in Southwest Colorado. He earned the respect of all involved during his 3-year oversight of negotiations between the Bureau of Reclamation, the regional Native American tribes, local water users and regional environmental groups. From these contentious discussions, the San Juan Recovery Program was created, which provided significant mitigation for fish and wildlife resources and included an additional 7 years of research on listed fish.

His experience and problem solving attitude in managing complex water projects led to the successful re-issuance of agency water permits on projects throughout the Roosevelt and Arapahoe National Forests. Lee also provided skilled leadership on the Platte River Program for endangered species conservation, involving multiple States and Federal agencies. The Platte River Program included a unique approach to conserving listed wildlife species through the conversion of water use to financial contributions paid by project developers.

When the Colorado Department of Transportation (CDOT) needed a new way to address U.S. Fish and Wildlife endangered species requirements, Lee developed an innovative solution that included staffing within CDOT to help that agency evaluate the impacts on wildlife so that the needs of CDOT could be met in a timely manner. His plan became a model for future projects and allowed CDOT to determine project impacts for the next 20 years and develop mitigation plans. The Short Grass Prairie Project received two national awards for the creative approaches Lee used with State and Federal agencies. This became the Colorado model for the Prebles Project in the East Plum Creek area, protecting the Prebles Meadow Jumping Mouse, a rare species that was placed on the Endangered Species list in 1998.

Lee's service and achievements show how a skilled public servant can make important contributions to the quality of our natural environment, as well as our communities. I ask my colleagues to join me in thanking LeRoy Carlson for his far-reaching accomplishments and his commitment to the protection of our wildlife resources. I wish him good health and happiness in the future.

TRIBUTE TO TOMMY THOMPSON

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. McINNIS. Mr. Speaker, it is my honor to rise and pay tribute to a man who has done a great deal for the betterment of the State of Colorado. Tommy Thompson is a Sergeant At Arms in the Colorado State legislature. At the age of 80, Tommy is the oldest person working in Colorado's State Capitol. However, he is also one of the most energetic and one of the most beloved. I am proud to call Tommy's contributions to the attention of my colleagues and our nation here today.

Tommy was serving as Vice-Chairman of the Arapahoe County Republican party when he was appointed as Sergeant At Arms in 1997. Tommy loves his job and comes to work each day with a smile. That smile, and Tommy's friendly demeanor, remain with him throughout the day. Tommy has many friends throughout the Capitol and he gets along fantastically with members from both sides of the aisle. Nearly everyone who has worked in the Capitol has fond memories of times spent with Tommy.

Tommy's contributions to our nation reach far beyond the steps of Colorado's state Capitol. In World War II, Tommy answered our country's call to duty and served honorably aboard the USS *Mount Vernon* for over three years. Following the war, Tommy went to work for Ford Motor Company, and then opened a bicycle repair shop. He is still active in the Republican Forum, in addition to his work at the state Capitol. At the age of 80, Tommy Thompson has never slowed his pace, and he has no plans to do so now.

Mr. Speaker, it is my honor to rise and pay tribute to Tommy Thompson before this body of Congress and our nation. Tommy has dedicated many years to assuring that Colorado's government runs efficiently. Tommy has touched the lives of many Coloradans, and it is my honor to pay tribute to his contributions here today. Thanks for your service, Tommy.

TRIBUTE TO MR. JOHN DONOVAN, EXECUTIVE DIRECTOR CHICAGO COALITION FOR THE HOMELESS

HON. DANNY K. DAVIS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. DAVIS of Illinois. Mr. Speaker, the poet Robert Frost is quoted as writing, "Some people see things that are and ask why, I dream of things that have never been and ask, why not." Such was the life, such was the philosophy and such was the work of John Donovan, known to his friends as Juancho.

John was a former Catholic priest who found his niche in organizing, working with and working for people in our world known as being poor. He worked in Panama, in the Rogers Park and Uptown communities of Chicago before becoming executive director of the coalition to end homelessness. He also worked as a priest, administrator and teacher at Chicago's Visitation High School. He was educated with a bachelor and masters degrees from Saint Mary of the Lake University in Mundelein.

John was the recipient of many awards and honors and was featured in Studs "Terkel's Hope Dies Last." In an interview with Studs, John said: "Some people who are better off have the luxury of losing hope. But poor people never lose hope. They can't afford to. That's the only thing they can hold on to, and that's where hope springs eternal." Some people say, "How can you continue to work with the homeless and the poor?" That's where I get my energy because they never lose hope." "I'm not practicing as a priest, but my ministry, remember is organizing. My job is organizing hope. There are people in the community who still have hope. That's the last thing they lose. I'm organizing hope for change."

John Donovan, a man of hope, a force for change. May he rest in peace. I extend condolence to John's wife, their children, and other members of John's family.

CHAPTER 12 BANKRUPTCY EXTENSION BILL

HON. TAMMY BALDWIN

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Ms. BALDWIN. Mr. Speaker, today I am once again introducing legislation to extend authorization of Chapter 12 of the bankruptcy code. This legislation should not be necessary, but a permanent Chapter 12 authorization remains a hostage to more comprehensive bankruptcy law changes.

Chapter 12 provides an important backstop for our Nation's struggling family farmers by allowing them to reorganize their debts and keep their farms. It provides an important bankruptcy option to farm families to keep their livelihood and maintain their way of life.

This bill provides a textbook example that what we do here in Washington directly affects the lives of real people facing real financial challenges.

In Wisconsin recently, a Columbus farmer filed for Chapter 12 bankruptcy. He works night and day to make his farm a success. Unfortunately, like many farmers, the weather and the market conspired to disrupt his cash flow. Filing Chapter 12 gave his family time to negotiate with his creditors, while he switched production from corn and soybeans to vegetable production and local market sales. He sells his produce at farmers markets in Madison and Princeton. And he is paying his debts. Under Chapter 12, it was not only the Columbus farmer that benefited. His creditors are receiving their money, the people in my district can purchase his bounty, and he can continue to support his family.

Chapter 12 does not just provide a direct benefit to those using its protections. Many farmers who face possible bankruptcy never get to a court filing. The very existence of the option of a Chapter 12 filing promotes negotiations between farmers and creditors.

Chapter 12 bankruptcy protection expires at the end of 2003. Before we leave town for the year, Congress should renew this bankruptcy law. That is why I am introducing this bipartisan bill today. I am pleased to be joined by my colleagues NICK SMITH of Michigan and TIM HOLDEN of Pennsylvania.

Once again, we are forced to approve a temporary extension of this vital protection. Since I was first elected to Congress 5 years ago, we have passed 8 temporary extensions. Making this noncontroversial program permanent is beyond overdue. In both this Congress and last Congress, I introduced legislation to modify Chapter 12 to include more family farmers and make it a permanent part of our bankruptcy law.

There is great consensus that Chapter 12 bankruptcy protection works well. It is for that reason that we have included a permanent authorization in the comprehensive bankruptcy reform bill for the past three Congresses. In fact, it is considered so popular that it has been held hostage to the bigger bill. Every time we come to the floor to extend Chapter 12, we are told that a permanent extension cannot be passed separately from the big bill because taking out popular items will slow the bill's momentum. We were told we had to strip the permanent extension from last year's farm bill because it would slow down the bankruptcy bill. We were told in June when we extended Chapter 12 again that we had to wait. Our farmers have been waiting for more than 5 years. It is time to just get this done. Let's end the uncertainty these extensions cause by passing a permanent authorization.

In reluctant acknowledgment that passage of the permanent Chapter 12 legislation is unlikely this year, I am introducing this 6-month extension. In the absence of a permanent authorization, I would prefer even longer than 6 months. This legislation is a realistic time period that can ensure passage in the few days we have left in this session.

Since the current authorization will expire at the end of the year, farmers will need the relief provided by this extension. As our family farmers begin to decide whether they can afford to plant next year, we need to make sure they have the ability to stay in farming by using Chapter 12 to reorganize their debts. This bill will provide the security family farmers to make that difficult decision.

Mr. Speaker, I hope that you and the chairman of the Judiciary Committee move this bill before we adjourn for the year. Chapter 12 has expired before, leaving many farmers in great uncertainty. Let's not let that happen again.

BASIC PILOT PROGRAM EXTENSION AND EXPANSION ACT OF 2003

SPEECH OF

HON. MARK UDALL

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. UDALL of Colorado. Mr. Speaker, I rise today in support of S. 1685, the Basic Pilot Extension Act of 2003.

The Basic Pilot Verification program was created in 1997 to assist employers in verifying the eligibility of prospective employees to work in the United States Currently the program is only available to employers in six States. Recently I voted against a bill to expand and extend the program, H.R. 2359, because I thought an expansion of this program deserved more debate and allowance for amendments to fix some of the more problematic parts of the bill.

The Senate-passed measure that we are considering today, S. 1685, is an improvement on the House bill.

Unlike the House bill, this bill does not open up access to the databases of the Homeland Security Department and the Social Security Administration to other Federal agencies or to State and local government agencies. I had grave concerns about the infringement of civil liberties in the House bill, which would have permitted widespread sharing of employee information. I am also pleased that concerns already identified by the Department of Homeland Security about the Basic Pilot program are being addressed. I still have apprehensions that the data used in this program is not always up-to-date or accurate, specifically in regard to the visa status of employees. However, I am hopeful that the Homeland Security Department report required under this legislation will address these concerns so that they can be resolved by the time the program is expanded to all fifty states.

The Basic Pilot Verifications program provides an efficient and effective method for ensuring that employers are hiring eligible employees. I hope that through the extension and expansion provided for in this bill, this program will provide accurate information about prospective employees and continue to address the needs of American employers.

PAYING TRIBUTE TO BUD ROMBERG

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. McINNIS. Mr. Speaker, it is my honor to rise and pay tribute to a remarkable man from my district. Bud Romberg has dedicated many years of his life to the betterment of the community of Steamboat, Colorado and it is my honor to pay tribute to him before this body of Congress and our nation.

Bud is a retired schoolteacher who has held a seat on the Steamboat Springs School Board for 18 years. He also serves on the City Planning Commission and just completed a four-year term of service on the Steamboat City Council. As a Councilman, Bud's tenure was defined by his honesty and integrity. Bud had no use for political double-speak or bureaucracy and approached his position in a straightforward and direct manner.

During Bud's tenure, he played a direct role in assuring that Steamboat maintained its small town charm, and family atmosphere. He was also instrumental in helping to form strong working relationships between the City of Steamboat and government agencies throughout Colorado.

Mr. Speaker it is my privilege to pay tribute to Bud Romberg before this body of Congress and our nation. Bud is a man of great honor and integrity and the community of Steamboat Springs is a better place as the result of his dedicated service. Thank you for your service, Bud.

TRIBUTE TO SILAS PURNELL

HON. DANNY K. DAVIS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. DAVIS of Illinois. Mr. Speaker, I rise to pay tribute to one of the most remarkable and most successful men that this country has produced, Mr. Silas Purnell, who is credited with assisting more than 50,000 students to gain acceptance to colleges and universities. Silas Purnell was born on March 10, 1923, graduated from Wendell Phillips High School, received a degree from the Sheil Institute, attended Roosevelt and Northwestern Universities. Silas went to World War II, was a member of the famed Tuskegee Airmen, got married to his wife Marilyn in 1946, and they had five children, Rosalind, Silas, Rosalinda, Ronald, and Donna.

Mr. Purnell took a job and worked 13 years for the Coca Cola Bottling Company. It was during this period that he began helping students get into college. He eventually went to the Ada S. McKinley Community Services Agency and established their education division. As director of this program Mr. Purnell hit stride and became one of the most knowledgeable persons in the country relative to the availability of grants, scholarships, special programs and opportunities for individuals who wanted to attend college.

Si Purnell developed such a reputation that people from all over the country would consult with him about getting into school.

By the time Mr. Purnell became ill and retired in the year 2000, it was partially documented and estimated on good authority that Silas Purnell had helped more than 50,000 individuals gain acceptance and receive some form of financial aid for college.

Mr. Speaker, there has never to my knowledge been a person to do more singlehandedly to get individuals help with their educational pursuits.

If I can help somebody as I pass along, If I can cheer somebody with a word or song, If I can steer somebody right who may be traveling wrong, then my living will not have been in vain.

I commend Mr. Silas Purnell for his passionate and effective work, extend condolences to his family, and urge passage of this resolution.

STOP PEER-TO-PEER USE BY PAEDOPHILES

HON. JOSEPH R. PITTS

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. PITTS. Mr. Speaker, I submit the following for the RECORD:

[From the Guardian, Nov. 4, 2003]

SPECIAL INVESTIGATION—RACE TO SAVE NEW VICTIMS OF CHILD PORN

(By Audrey Gillan)

Paedophiles are swapping thousands of hardcore images of child sex abuse in a new form of computer child pornography that police believe is feeding a demand for more real-time victims of abuse.

The Guardian has established that the demand for child porn through the use of file-sharing technology—normally associated with swapping music and movies—has grown so rapidly that law enforcement agencies are now employed in a global race to track down the children who are being abused. Some of the children, police believe, are being abused on a daily basis to provide a constant supply of new computerised material.

Senior officers have revealed that the scale of peer-to-peer traffic in illegal images of children now dwarfs almost any other paedophile network they have encountered. The images are generally more extreme and at least 20% of the users are what police class as Category One, meaning that the suspect is "of significant risk to children".

But resources available to police to tackle peer-to-peer child porn are limited and though they are catching some offenders, it may take months or even years to track down the location of some victims. In such cases, officers monitoring the images can only watch as the children grow older and continue to be abused.

Many of those addicted to child porn have flocked to peer-to-peer file sharing software such as KaZaA, Morpheus and Grokster because they are free so, crucially, users do not have to leave any credit card details, leading them to believe that they cannot be traced. The explosion in file sharing, driven by the demand for music files, has also made the technology readily accessible, quick and easy to use.

It also has the attraction of not requiring the users to be part of a traditional organised paedophile ring using password-protected, covert means to distribute images; rather peer-to-peer technology allows them direct access into the hard drives of other paedophiles' computers with no third party authority monitoring content as is the case with chat rooms and news groups.

Scotland Yard officers have told the Guardian that they stumbled across this phenomenon by accident during another inquiry and say they have been stunned by its exponential growth. They believe the phenomenon is more alarming than previous internet-related cases, such as the high-profile Operation Ore.

The Met's child protection hi-tech crime unit has already built a list of 800 suspects involved in file swapping illegal images in the UK alone. While most are involved only in sharing or downloading the images, a significant proportion are active abusers producing the material themselves, often using their own children, their neighbour's children or—in rarer cases—by luring strangers. At least 30 peer-to-peer cases in the UK so far involved hands-on abuse in which the children in the images were real-time victims.

Police found one man who had wired webcams into his daughter's bedroom so that he could share video images of his abuse with other peer-to-peer file sharers.

Detective Superintendent Peter Spindler, who heads Scotland Yard's paedophile unit, said: "We are finding real-time live abusers. These people are able to get brand new images straight up on the net." His officers have found that when new images appear, the children involved are often related to or live nearby the person distributing the material.

But the sheer volume of new material, combined with the fact that it could have been produced anywhere in the world, has meant that police have often been unable to pinpoint the child's location.

Detectives rely on two methods of tracing location: electronic footprints left by the user while online and forensic analysis of the images to find clues pointing to the country of origin, such as telephone books in the background or the style of furnishings. In some cases, often where the child is being held prisoner and abused in a completely blank room, there are not enough leads for police to chase.

One case being investigated involves a prepubescent girl who is being held prisoner in a room and repeatedly abused. International law enforcement agencies know only that she is in the United States and the FBI is trying to pinpoint her exact location. New images of the child are shared through KaZaA and other services but police have been unable to find her.

Gemma Holland, victim identification project manager at the University of Cork's Combating Paedophile Information Networks in Europe (Copine) which has a database of more than 600,000 child porn images, said: "This is a global problem. The abuse could be in the next village or somewhere near you but the problem is the images are being shown globally. Identifying the kids in these images should be our prime concern and of the greatest importance."

The decentralised nature of the internet and peer-to-peer specifically make it difficult to define numbers of images in circulation or children involved but experts says it is growing daily. Washington's national centre for missing and exploited children, which acts as a clearing house for child porn tip-offs, said that reports of such images in shared files had increased by 400% this year.

David Wilson, professor of criminology at the University of Central England in Birmingham, said: "Peer-to-peer facilitates the most extreme, aggressive and reprehensible types of behaviour that the internet will allow."

The Guardian understands that the National Crime Squad is considering coordinating all of this work, rather than leaving it to small groups working within the country's various forces; so far the leading forces have been the Met, West Midlands and Greater Manchester.

Peer-to-peer has become more attractive for paedophiles in the wake of Operation Ore, the high-profile British police operation which was launched after US authorities handed over the names of 7,200 people suspected of subscribing to websites offering paedophilic images. While Ore has grabbed headlines, many senior officers and child abuse experts believe that targeting people at the lower end of the paedophile spectrum has been a distraction in terms of child protection.

Prof Wilson believes Ore showed how the criminal justice system concentrated on the wrong type of offender, the people who downloaded the material rather than produced them. It needed to refocus on activities such as peer-to-peer file sharing and the producers of child pornography.

He said: "Police operations have not been getting to the type of paedophile that we need to get to. It's in their interests to keep the debate moving towards the kind of people they should be spending time and resources on.

"The achilles heel of peer-to-peer is that it makes something that is secret and furtive into something that is public and when it is public that offers the police a window of opportunity to police it."

In a room on the fifth floor at Scotland Yard, officers in the hi-tech crime unit are trying to do exactly that, sitting at computers, monitoring activity on the peer-to-peer boards. They are part of a team working on Operation Pilsey which started as a smalltime inquiry in March 2001 by the Met's clubs and vice unit and burgeoned with the number of people posting images via file sharing. The detectives working here are now inundated.

They explain that they can use technology to detect the location of those who download the images and sometimes that of the abusers. If there is a child immediately in danger, officers will conduct a raid as soon as they have a location.

Paedophiles believe it is harder for them to be detected through peer-to-peer software but investigators are able to access their shared folders and quickly discover if they contain illegal images of child abuse. They are then able to establish the location of the owner of the shared folder.

VETERANS' DAY SPEECH BY MG ROBERT SHIRKEY

HON. IKE SKELTON

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. SKELTON. Mr. Speaker, Major General Robert Shirkey, USA, Retired, delivered the following address at a Veterans' Day Memorial Service at the Liberty Memorial in Kansas City, MO. This is an excellent address by a highly decorated veteran of World War II and the Korean War. His speech is set forth as follows:

MAJOR GENERAL SHIRKEY, USA, RET., VETERANS' DAY OBSERVANCE, LIBERTY MEMORIAL KANSAS CITY, MO—NOVEMBER 11, 2003

I am an American—Let me tell you why:

Years ago persons from Ireland, Norway, Poland, Germany, and other locations, hugged their families for the last time and left their ancestral homes. These people boarded old, crowded ships to sail to America, leaving behind everything and everyone they knew in search of only one thing: Freedom.

These people crossed the ocean with the determination to stand firm in their new home and fight for the freedom which had been denied them for centuries. America was born from a union of courage and passion for freedom. This is my heritage.

My ancestors, under a new flag, represented a country that came to be known as the United States of America.

One Irishman, O'Sharkey, went through the Revolutionary War. As indentured servants from Norway, my grandmother's family worked out the $36.00 passage to become Americans. A Polish girl in Poznan, Poland, saved the life of a Prussian soldier being chased by Germans by hiding him in a haystack during the Prussian Revolution of 1848. He returned after peace was declared, married her and together with his parents migrated to the United States. He also then served with the 27th Wisconsin Cavalry during the Civil War. Another part of my heritage who served with the South during that long war was General Wade Hampton. These men were the Privates, Captains, Majors, Colonels and Generals. When the Revolutionary and Civil Wars were over, they were once again free.

They had paid the price with their lives, bloodshed, hardship and poverty. One of my ancestors, a second cousin, still lies in France, having paid the supreme sacrifice on September 27, 1918, for such freedom.

I am an American—Let me tell you why:

My patriotism can neither be contained nor displayed within the span of four (4) designated days every year. When I look at my country's flag, I see not only the Revolutionary War and Civil War, but ancestors who fought against injustice. I also see my ancestors who were on opposite sides of the Battle of the Wilderness, Chickamauga, and others. They smelled the gunpowder and heard the roar of musketry. Some of these men would never see another beautiful sunset, yet in each of their eyes were these same dreams of freedom and independence and a willingness to fight to the death for what they believed in.

Lest we forget: For those who have fought for it, freedom has a taste the protected will never know. As General Pershing said at this Memorial dedication:

". . . there are many forces trying to destroy this freedom, so band together and dedicate yourselves to protecting that freedom you have so valiantly won on the battlefield."

Never forget that the Ancient Romans sought freedom from responsibility and, as a consequence, lost all freedom.

My flag has flown over ancestors and fellow soldiers in distant parts of the world who were slain giving all their tomorrows for our todays. My flag flew over my best friend's hastily dug grave at Legaspi, Luzon, following his untimely death April 15, 1945. He gave his life to save five wounded comrades by crawling up under machine gun fire. An attempt to save a sixth man was rewarded with death. For my symbolic flag he knew he was expected to die. Like many others, my life was spared by the controversial atomic bomb. I came home carrying my flag. My best friend came wrapped in my country's flag. My flag went to Viet Nam and returned with some of my dear friends wrapped in it. My flag is the same flag that belongs to victims of the Bataan Death March as well as survivors. The attitude of those men is epitomized in the gallows humor of war correspondent Frank Hewlett which still echos amongst the jungle foliage:

"We're the battling bastards of Bataan.
No mamma, no papa, no Uncle Sam.
No uncles, no aunts, no nephews.
No nieces, no pills, no planes, no artillery pieces.
And nobody gives a damn."

These are the men who have carried my flag. Later, in fighting on Luzon, I walked that hallowed ground on Bataan. I saw the refuse of war and the fox holes-many of which had been dug with bayonets. In the words of William Lindsay White, author of They Were Expendable, "Where do we get such men?"

Tribute on this day is paid to those fellow Americans who served in the Korean War, which ended fifty years ago. Over one hundred thousand men were wounded; fifty-six thousand two hundred forty six killed; nine thousand were captured; three thousand five hundred eight were repatriated; six thousand died as a result of criminal acts of the enemy. By the peace agreement in 1953, not one of the enemy was prosecuted. The odds of death of those of us in the front lines in Korea were one in nine. By contrast the odds were one in eighteen in World War II and in Viet Nam the odds were one in twenty-three, a striking example of the dangers in Korea.

I fought through the Pacific War with one of the more noted Infantry Units the 158th RCT "Bushmasters." We were comprised of twenty-two Indian tribes, Hispanics, Chinese, Japanese and men from thirty-eight different states. General MacArthur opined that "no greater combat team has ever deployed for battle." Little known is the fact that Indians were finally given the right to vote in 1946. Strangely enough, not one black soldier was in our Infantry units!

I am an American—Let me tell you why:

To those Korean Veterans present and those of you who may read or hear what I have to say today, I want you to know as one soldier to another, we fought not for glory, for there was none, not for loot, for there was none. No crusading zeal drove us on. Our homeland was not threatened. Our countrymen at home made no comparable sacrifice. We fought and endured, while not understanding the geopolitics of that distant war and at a time when thousands of our fellow countrymen said we were engaged in a senseless war. We kept on much as we did in World War II. The real answer as to why we—the living and the dead—did this lies deep in the tissue of the substance which keeps America from becoming unstuck. It has to do with our parents, teachers, 4-H Clubs, Scouts, neighborhood centers, and belonging to a team; an implicit, unreasoned belief in our country and a natural belief in ourselves. To those present, to those now living, I bow to your patriotism. Many like myself were asked to again serve our country. I left behind two sons, one six months old and one three years old. Forty-eight hours after leaving Kansas City, I was again in the Korean front-lines.

Let me say now, for all to hear and know, as a rifle company commander of one hundred fifty to two hundred men, I personally led one of the first integrated companies in Korea. The twenty to twenty-five black soldiers I led served with honor, distinction and bravery. We cry the same salty tears and bleed the same red blood. Equally important, in our hour of need on the battle field, we do not care who rescues us or carries our stretcher. I shall never forget Lovell Page who gave his life at the Inje River. His beautiful smile is etched in my memory and will be throughout eternity.

These are the men who have carried my flag.

That same flag gave comfort and hope to those who endured horrors including war camp. It is the same flag the men and women carry who came home crippled and maimed so that the social class into which I was born would not determine the limits of my potential.

It is the flag that is seared into my memory as it lay draped over my dearest friends coffins while the echos of Taps were carried Heavenward on a windy day. It is the same flag that will someday drape over my coffin. I trust that you are as proud of that flag as I am. Protect it well. Protect it as I have.

Forty-Five million of us have served our Nation since 1776. We have never, ever, let our nation down. We took the Hill!!

I quote the last stanza of the poem by Billy Rose, which reflects the dedication of every American in their commitment to serve their country.

"I am the unknown soldier and maybe I died in vain, but if I were alive and my country called, I'd do it all over again. While I fought with and along side of the elite American Army troops, lest we forget, I should like to pay tribute to the troops of the twenty-one nations that comprised the United Nations forces in Korea. The undaunted courage and bravery of the Turks, British and Ethiopians, to mention a few that I witnessed, shall forever be with me. Likewise, the bravery of Republic of Korea soldiers like Chung Mun Joe, who served in my company, will never be forgotten as they fought for the freedom we Americans almost take for granted. To those who have not served and to those who never will, I quote Prophet Micah, as is etched in stone on the North side of this Monument, that all God requires of us is that "we should do justly, love mercy and walk humbly with thy God."

You now see that:

I am an American—I have told you why.

In closing, I quote the Unknown Confederate Soldier's words:

"I asked God for strength that I might achieve; I was made weak that I might learn humbly to obey.
I asked for health that I might do great things; I was given infirmity that I might do better things.
I asked for riches that I might be happy; I was given poverty that I might be wise.
I asked for power that I might have the praise of men; I was given weakness that I might feel the need of God.

I asked for all things that I might enjoy life;
I was given life that I might enjoy all things.
I got nothing I asked for, but everything that I had hoped for, almost despite myself.
My unspoken prayers were answered. I am, among all men, richly blessed."

I am indeed an American.

PAYING TRIBUTE TO SOUTHEAST MENTAL HEALTH SERVICES

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. MCINNIS. Mr. Speaker, it is my honor to rise and pay tribute to a remarkable non-profit organization located in my district. Southeast Mental Health Services was recently awarded the Silver Achievement Award from the American Psychiatric Association for being among the top mental health programs in the nation. I am proud to call the attention of my colleagues and this nation to all that Southeast Mental Health Services has done for those suffering from mental illness.

Southeast Mental Health Services has developed a revolutionary approach to treating the mentally ill. Their program focuses on helping each individual patient to live the happiest and most fulfilling life possible. Southeast Mental Health Services has found great success with this program. The dedication and selflessness of the program's administrators and staff set a fine example to all mental health care professionals.

Mr. Speaker, it is my honor to call the attention of this body of Congress and our nation to the many contributions of Southeast Mental Health Services. The organization's programs have made a significant contribution to the quality of life of numerous Coloradans suffering from mental illness. It is with great pride that I rise before you to recognize Southeast Mental Health Services and the notable contributions they have made to the community.

RECOGNIZING THE LIFE AND ACCOMPLISHMENTS OF YEVGENY YEVTUSHENKO

HON. GINNY BROWN-WAITE

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Ms. GINNY BROWN-WAITE of Florida. Mr. Speaker, "A poet in Russia is more than a poet." Yevgeny Yevtushenko was speaking of poetry's unique role in Russia, but the words apply equally to Yevtushenko himself—the world's most famous living poet, and also prose writer, photographer, filmmaker, congressman, professor, world traveler. In the civic tradition of Russian poetry, the poet is the voice of the people, the ombudsman, the champion of truth and justice, and the catalyst for social change. Because poets express the strivings and needs of the people, they are revered in Russia as nowhere else. In the Soviet Union, the message had to be elliptic, and poetry was read closely, between the lines.

Yevgeny Yevtushenko, born in Zima Junction, Siberia in 1933, burst onto the scene when very young, his first poems published in 1949, when he was just sixteen. He and his peers, Akhmadulina, Voznesensky, Rozhdestvensky, drew enormous, agitated crowds to their readings, and their popularity could be compared only to that of rock stars. They shaped an entire generation, the generation of Gorbachev and Yeltsin, who began the changes that ultimately brought an end to the Soviet Union.

His famous poem "Babi Yar," against anti-Semitism, was written in 1961 and set to music by Shostakovich. In 1952, Yevtushenko wrote "the Heirs of Stalin," with a call to throw off the oppressive shadow of the tyrant. He began his nonpoetic political protest activity with a telegram to Brezhnev condemning the Soviet invasion of Czechoslovakia in August 1968. Thirty years later, his political activity was channeled into a formal democratic role—he was elected a congressman with an overwhelming 74.9 percent of the vote (in a field of nine candidates). There was a national write-in-vote to select the cochairmen to join Andrei Sakharov in leading the Memorial Society, dedicated to the memory of the victims of Stalinism. Yevtushenko was one of the three co-chairmen selected, further evidence of the faith in his integrity and appreciation of his outspokenness among his countrymen.

Yevgeny Yevtushenko traveled extensively, and he brought the world to the Soviet Union through his writing, but he also brought Russia to the world. In 1960, he was the first Russian poet to break through the Iron Curtain and to recite his poetry in the West, where he was befriended by Pablo Picasso, Max Ernst, Henry Moore, Federico Fellini, John Steinbeck, Graham Greene, Heinrich Böll, T.S. Eliot and Gabriel García Marquez. Over the years, Yevtushenko has toured 94 countries, all of the republics of the USSR, and all of the states of the U.S.A. He has recited his poetry in sports arenas from Russia to Santiago, Chile (where he appeared with Pablo Neruda), in the Opera di Roma, in London's Albert Hall, in the Library of Congress, Smithsonian Institution, and National Cathedral in Washington, D.C, and in Madison Square Garden, Carnegie Hall, the Cathedral of St. John the Divine, and Lincoln Center in New York. His works have been translated into 72 languages. Eighteen of his books have been translated into English. Most of his readers in France, Cambodia, Africa, Greenland, Australia, Germany, and China—among other places—have never been to Russia but they know and love Russian poetry.

Yevtushenko has been in the center of the action for fifty years. Yet his insatiable curiosity about the human experience and his monumental energy remain at their highest levels. He celebrated his seventieth birthday in Moscow this July, reading to enormous, adoring crowds, and then continued the extravaganza across the country, reaching out to his readers. His life is heartening proof that one man's voice, raised high and often, can alter the course of events.

Welcome all over the world, Yevgeny Yevtushenko and his wife, Masha, have chosen to divide their time between Russia and the United States, where they are bringing up their family. He is Distinguished Visiting Professor at The University of Tulsa, Oklahoma, and tenured at Queens College, in New York City. He has received numerous international prizes in literature and the arts. In addition to receiving four honorary degrees, he was elected an honorary member of the American Academy of Arts and Letters and a member of the European Academy of Arts and Sciences, was awarded The American Liberties Medallion of the American Jewish Committee, and in 1999 was appointed Poet-in-Residence of the Walt Whitman House Museum in Long Island, New York. Naturally, he is writing poetry and a new novel and is in the finishing stages of a major anthology of Russian poetry. We are fortunate to have Yevgeny and Masha Yevtushenko in our country and even more fortunate to have them here at the Russian Fireworks gala.

THE IMPACT OF LEFT-WING SPECIAL INTEREST GROUPS ON THE JUDICIAL NOMINATION PROCESS

HON. MARK E. SOUDER

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. SOUDER. Mr. Speaker, today I rise to introduce into the RECORD two more memos—written by Democratic congressional staff—that illustrate the extent to which liberal special interest groups are controlling the judicial nomination process. These groups have been allowed a virtual veto power over any nominee they dislike. For example, groups like the so-called People for the American Way have apparently been able to delay or block the approval of judges who do not share their antilaw enforcement views, while groups like the National Abortion Rights Action League (NARAL) have been given a similar veto power over anyone who doesn't agree that parents shouldn't even be notified that their child is considering an abortion. One nominee, according to the memos, had to be cleared with "the gay rights groups" before he would even be considered. These memos show just how far the process has deteriorated—and are a wake-up call to anyone who wants to see fairness and objectivity restored to our Federal judiciary.

MEMORANDUM

To: Senator Kennedy.

Subject: Judges—Schedule for the Year & Chairing A Hearing.

I. SCHEDULE FOR THE YEAR AND THE SHEDD AND COOK PROBLEMS

As you know, during your meeting with the groups, you and Schumer discussed approaching Leahy regarding the Shedd hearing. You proposed telling him that because of the number of unpublished opinions and the divisiveness of the nomination (angering the African American community prior to the election), you think we should refrain from having a hearing on Shedd in June. Based on the groups recommendation, you were also going to propose an end-of-June hearing on another nominee. The following has happened in the interim:

Lott approached Daschle with an unreasonable request for nominations hearings before the July 4th recess. Daschle told him "no" but approached Leahy to discuss a more aggressive hearing schedule. The proposed schedule is as follows:

June 13th Rogers—(6th Circuit)
June 27th Shedd—(4th Circuit)
July 18th Owen—(5th Circuit)
August 1st Cook—(6th Circuit)
September 5th Raggi—(2nd Circuit)
September 19th Estrada—(DC Circuit)
October 3rd McConnell—(10th Circuit)

The August 1st Cook hearing is a surprise to us, and it will be a huge problem for the judges coalition. For many, many months they have told us that Cook is highly problematic—particularly for labor. Cook is consistently bad on labor/workplace injury cases, right to jury trial issues, civil rights and rights of criminal defendants cases. Her frequent dissents (from the moderate majority) show a pattern at least as egregious as Pickering. We must press Leahy not to schedule Cook (Cook is strongly supported by DeWine, but how many times did Hatch disregard your request to move DC Circuit nominee Alan Snyder?).

Regarding Shedd, Wade Henderson spoke with Mark Childress, Daschle's Chief Counsel and Childress is going to speak with Hollings' staff director. But, because we feel Leahy will not cancel the Shedd hearing unless Hollings backs off (and because several of the outside groups believe the same), we don't think you should expend a great deal of effort trying to change Leahy's mind about the Shedd hearing.

Instead, you should speak with Schumer, and the two of you should bring Durbin up to speed (since he couldn't attend the meeting in your hideaway). The three of you should approach Leahy as soon as possible and tell Leahy that:

You are very concerned about Shedd because he has numerous unpublished opinions and because his nomination will infuriate the African-American community before the SC election, but you understand the Hollings problem. If Hollings can be moved, you propose postponing the Shedd hearing.

You understand he is contemplating a more aggressive hearing schedule that includes a hearing for Debbie Cook for the 6th Circuit; and you believe she should not get a hearing this year. For months, labor and other groups have told us that she is highly problematic, and we should send her nomination back to the White House. We won't suffer publically if we don't have a nomination hearing for her.

Ultimately, if Leahy insists on having an August hearing, it appears that the groups are willing to let Tymkovich go through (the core of the coalition made that decision last night, but they are checking with the gay rights groups).

Given this information, do you want to talk to Schumer—and Durbin—about having this conversation with Leahy and then speak with Leahy? We strongly recommend that you have these conversations, and we believe Leahy must be approached quickly.

Decision:

Yes, I will talk to Schumer and Durbin; the three of us will go to Leahy _____.

No, I will not speak with Schumer and Durbin or Leahy _____.

II. CHAIRING A HEARING

As you know, Senator Leahy asked that you chair the last nominations hearing, but given your schedule, you could not. His staff is now asking us to choose the hearing you would like to chair (see the schedule above).

I propose that you chair the Owen hearing on July 18th. As you know, Owen will probably be our next big fight. The grassroots organizations are organized in Texas, and the national groups are prepared, as well. In addition, Judiciary Democrats expect to fight her, hearing attendance should be good, and the issues are clear—Enron/pro-business and choice.

You should know, the Leahy staff (and the Schumer staff) propose that you chair the Estrada hearing and I disagree. Although other staffers see Estrada as a civil rights problem, because he has no record, there isn't civil rights ammunition. We don't believe Estrada is "your kind of fight." We think Durbin or Schumer might be better for the Estrada hearing (and, at least on the staff level, there's interest from the Schumer office).

Decision: I will chair a hearing on:

Shedd (6/27) _____.
Owen (7/18) _____.
Cook (8/1) _____ (we want this to go away).
Raggi (9/5) _____.
Estrada (9/19) _____.
McConnell (10/3) _____.

MEMORANDUM

To: Senator Durbin.
Date: October 15, 2001.
Re: Meeting with Civil Rights Leaders, Tuesday, October 16, 2001 at 5:30 p.m.

You are scheduled to meet with leaders of several civil rights organizations to discuss their serious concerns with the judicial nomination process. The leaders will include: Ralph Neas (People For the American Way), Kate Michelman (NARAL), Nan Aron (Alliance for Justice), Wade Henderson (Leadership Conference on Civil Rights), Leslie Proll (NAACP Legal Defense & Education Fund), Nancy Zirkin (American Association of University Women), Marcia Greenberger (National Women's Law Center), Judy Lichtman (National Partnership), and a representative from the AFL–CIO. The meeting will take place in 317 Russell, with Senators Kennedy and (possibly) Schumer also present.

The immediate catalyst for Tuesday's meeting was the announcement last Thursday that the Judiciary Committee would hold a hearing in one week on district court judge Charles W. Pickering, Sr., a highly controversial nominee for the Fifth Circuit. The interest groups have two objections: (1) in light of the terrorist attacks, it was their understanding that no controversial. judicial nominees would be moved this fall; and (2) they were given assurances that they would receive plenty of notice to prepare for any controversial nominee.

Judge Pickering, you will recall, has a checkered past: he wrote a law review student note recommending that the Mississippi legislature restore its miscegenation law; as a state legislator, he opposed the Equal Rights Amendment and voted to seal the records of the infamous sovereignty commission; and as a Republican activist; he promoted an anti-abortion plank to the national party platform. He has written some controversial opinions while serving on the district court, criticizing prisoner access to the courts and the "one person-one vote" principle. The interest groups believe that a high percentage of Pickering's opinions are unpublished, one reason why they object to the lack of time to prepare for his hearing.

Recognizing that Thursday's hearing is likely to go forward, the groups are asking that the Committee hold a second hearing on Pickering in a few weeks, when they will have had adequate time to research him fully. The decision to schedule Pickering's hearing was made by Senator Leahy himself, not his staff, so the groups are likely to ask you to intercede personally. They will also seek assurances that they will receive adequate warning of future controversial nominees.

TRIBUTE TO GRAHAM NIELSON

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. McINNIS. Mr. Speaker, it is my honor to rise and pay tribute to a remarkable man from my district. Recently, Graham Nielson was awarded the "McGuffey Award" by the Colorado Association of School Boards for his twelve years of dedicated service on the Dolores School Board. Graham recently announced his retirement from the Board, and I would like to take this opportunity to join my colleagues in thanking him for his service.

Graham moved to Dolores while he was in grade school. After high school, Graham married Dianne Carver. Later, Graham and Dianne moved to Santa Fe, where Graham became an EMT and Fireman. In 1985, Graham and his family returned to Dolores, where he eventually took his current position as a computer systems analyst for Nielson Skansa, Inc. Until recently, Graham also served the community as a member of the Dolores Fire Department, and still holds a position on the board of the Colorado Firefighter's Academy.

Graham and Dianne have had five wonderful children. When the children entered the Dolores school system, Graham decided to run for a position on the School Board. He has served as the director of the RE–4 School Board for 12 years. Graham has dedicated a great deal to assuring that the children of Dolores have a positive educational experience. The children of Dolores have certainly benefited as the result of Graham's tireless dedication to their interests.

Mr. Speaker, I am proud to call the contributions of Graham Nielson to the attention of this body of Congress and our nation. Graham has dedicated his life to the betterment of others and I am proud to pay tribute to him here today. Thank you Graham, and congratulations on a well-deserved award.

IN MEMORY OF LANCE CPL. DAVID OWENS, JR., USMC

HON. FRANK R. WOLF

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. WOLF. Mr. Speaker, I was honored recently to be asked to participate in a memorial service for my constituent, Lance Cpl. David Owens, Jr., USMC, who was killed in action in Baghdad on April 12 of this year. The presentation of a memorial plaque was held in Winchester, Virginia, on October 24 during halftime ceremonies on the football field at James Wood High School, Corporal Owens' alma mater.

I would like to share with my colleagues the remarks given that evening in memory of this brave young man who served his nation proudly and who died defending our freedoms.

REMARKS BY FREDERICK COUNTY SUPERINTENDENT OF SCHOOLS, DR. WILLIAM C. DEAN

Good evening. The war in Iraq claimed the life of a James Wood High School graduate of the class of 2000. On Saturday, April 12, 2003, 20-year-old Marine Lance Corporal David Owens was killed in action in Baghdad.

It is with great pleasure that I introduce you to the parents of Corporal Owens, Mr. and Mrs. David Owens.

In creating this memorial, it is our hope this service tonight will remind Mr. and Mrs. Owens of one of the many places where David made an impact at James Wood High School. And, I also extend an invitation to them to return here often.

James Wood High School is a place David enjoyed, and we enjoyed and valued David's presence here. He is missed by his classmates, his teachers and those who knew him.

Ladies and gentlemen, I am honored to present David and Debbie Owens.

Thank you for allowing us to honor your son this evening.

REMARKS BY JAMES WOOD HIGH SCHOOL PRINCIPAL, JOSEPH SALYER

David E. Owens, Jr. a graduate of JWHS, entered as a freshman in 1997. During the span of this high school career many would describe David as an individual with strong character, high integrity and a sincere love for his school.

David was not merely a student who focused his attention on attending classes. He also took an active part in the life and traditions of JWHS.

He was a dedicated athlete who participated in the school's football and wrestling programs. During his senior year, he excelled by placing 4th in the Commonwealth District wrestling tournament. This earned him a spot representing the school in the regional wrestling competition. He also was the recipient of the 2000 Winchester Wrestling Officials Association Sportsmanship Award.

In addition, David was committed to serving in his local Future Farmers of America (FFA) chapter. He participated in a wide range of forestry-related events, sponsored by the FFA, because of his love for natural resources.

It is because of David's sincere devotion, that we the staff, faculty and student body of the James Wood community will forever be indebted to his legacy as a James Wood student and to the life he gave for his country.

REMARKS BY CONGRESSMAN FRANK R. WOLF, 10TH DISTRICT, VIRGINIA

It is important to remember those who have made the ultimate sacrifice for their country.

Marine Lance Cpl. David Owens Jr., age 20, served his country with pride and honor. His loss has touched many in this community. It is fitting that this plaque have a permanent place at James Wood High School as a remembrance of David's sacrifice for his country.

I know this has been a difficult time for his parents. As the father of five children, my heart goes out to them. They, too, have made the ultimate sacrifice.

I ask that everyone here tonight remember all the service men and women who have lost their lives defending our freedom. We owe them and their families a huge debt of gratitude.

I also ask that everyone pray for the men and women in uniform who are in harm's way in Iraq, in Afghanistan and other parts of the world where we have a military presence. They need and deserve our support.

I want to read the words of the hymn "Eternal Father," also known as the "Navy Hymn," which is often sung at the funeral of service men and women, particularly sailors and Marines.

It was the favorite hymn of President Franklin Delano Roosevelt, a former secretary of the Navy, and was sung at his funeral in Hyde Park, New York, in 1945.

It also was played by the Navy band in 1963 as President John F. Kennedy's body was carried up the steps of the U.S. Capitol to lie in state.

Eternal Father, strong to save
Whose arm hath bound the restless wave,
Who bidd'st the mighty ocean deep
Its own appointed limits keep;
Oh, hear us when we cry to Thee.
For those in peril on the sea!

Eternal Father, grant, we pray,
To all Marines, both night and day,
The courage, honor, strength and skill
Their land to serve, they law fulfill;
Be thou the sheild forevermore
From every peril to the Corps.

May we all remember Lance Cpl. David Owens, Jr. and keep his family in our thoughts and prayers.

REMARKS BY FREDERICK COUNTY BOARD OF SUPERVISORS CHAIRMAN, RICHARD SHICKLE

Tonight we are here to honor Marine Lance Cpl. David Owens, Jr. He made the ultimate sacrifice. He gave all that he had for his Country. He gave his life for each and every one of us. But he is not the only one that gave something to this great country and to each and every one of us. David Edward Owens, Sr. and Deborah Owens, mother and father, gave us their son Marine Lance Cpl. David Owens, Jr.

As a father of four I cannot imagine the pride and the pain that these two people must feel each and every day. The questions "Why him?" and "Why us?" must haunt them every minute of every day.

Mr. and Mrs. Owens, all that we can say is "Thank you" from the bottom of our hearts. Please allow the citizens of Frederick County to become part of your family.

REMARKS BY FREDERICK COUNTY SCHOOL BOARD CHAIRMAN, STUART WOLK

Tonight I stand before you humbled. Humbled by a life short lived but more accomplished in those few years than I can imagine accomplishing in my lifetime.

A few short years ago, David Owens engaged in battle on the ground we are now standing on. He fought valiantly for his team then and upon leaving James Wood, continued to fight valiantly. Only this time, the stakes were bigger and his new team for which he was fighting was our country. He made the ultimate sacrifice for his team and we mourn his loss tonight, as we have since receiving the tragic news. There is no greater love for country, for humanity than to give one's life for the freedom we all cherish. Let us never take those freedoms for granted and let us always remember the supreme sacrifice made by our hero: Lance Cpl. David Owens, Jr.

I cannot begin to fathom the loss that Mr. and Mrs. Owens have experienced but I wish to thank them for their son and the manner in which he always conducted himself. As a member of the Frederick County School Board, as a citizen of Frederick County and of this great country, I feel fortunate to stand here in his memory and in his honor.

Thank you.

BASIC PILOT PROGRAM EXTENSION AND EXPANSION ACT OF 2003

SPEECH OF

HON. DOUG BEREUTER

OF NEBRASKA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. BEREUTER. Mr. Speaker, this Member rises in strong support of S. 1685, the Basic Pilot Extension Act of 2003. This Member, who is a cosponsor of the House measure, would like to thank the distinguished gentleman from Iowa (Mr. GRASSLEY) for introducing the measure.

Under S. 1685, the Basic Pilot Program, which is an employment verification program, would be extended through 2008 and, indeed, would expand access to the program for the entire U.S.

Mr. Speaker, the Immigration Reform and Control Act (IRCA) of 1986 correctly prohibited employers from knowingly hiring illegal aliens or people with non-immigrant visas. Unfortunately, at that time, Congress did not give employers the corresponding tools with which to comply with this Act.

For example, due to concerns regarding discrimination, employers are limited in the questions they may ask of potential employees to verify if those individuals are authorized to work in the U.S. If the employment verification documents that potential employees produce appear to be legitimate, then employers must accept the documents as legitimate without further inquiry of the potential employee.

During Immigration and Naturalization Service (INS) enforcement raids, certain employers were found to have hired large numbers of illegal aliens, either knowingly or unintentionally, and subsequently they were subject to penalties. As technology has progressed to allow for the cheap and quick production of legitimate-looking fraudulent documents, the inability of employers to distinguish between valid documents and fraudulent documents has significantly increased. It became clear that businesses dedicated to complying with the IRCA needed new tools to assist with the endeavor.

When the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) of 1996 was enacted, it authorized the creation of three employment verification tools, including the Basic Pilot Program. Initially, employers in California, Florida, Texas, Illinois, Florida, New York, and Iowa could voluntarily use the Basic Pilot Program to compare the information received from potential employees with Immigration and Naturalization Service (INS) databases to determine if potential employees could be employed legally in the U.S.

Mr. Speaker, throughout the 1990's, many legal immigrants and illegal aliens moved to Nebraska seeking jobs in the meatpacking industry. Subsequently, this Member began to receive contacts from businesses in his district concerned about their capacity to comply with the IRCA. Therefore, on November 30, 1999, this Member joined his House and Senate colleagues in the Nebraska Congressional Delegation in a letter to then-INS Commissioner Doris Meissner requesting the extension of the

Basic Pilot Program to Nebraska. This Member continues to firmly believe that providing Nebraska businesses with the tools to hire a legal workforce is an important component in maintaining a stable economy in the state and in meeting needs to effectively enforce immigration laws in this country's interior. On March 19, 1999, the U.S. Department of Justice granted Nebraska businesses access to the Basic Pilot Program. Currently, about eight Nebraska businesses actively utilize the program.

Mr. Speaker, for Congress to allow the Basic Pilot Program to lapse following the horrific and unspeakable terrorist attacks of September 11, 2001, would demonstrate true negligence. More than ever, the U.S. must fully enforce its immigration laws to protect its citizens from future attacks. In its capacity to identify document fraud and illegal aliens, the Basic Pilot Program can indeed play a role in the fight against terrorism.

In conclusion, this Member encourages his colleagues to vote for S. 1685.

TRIBUTE TO PAT ELSBERRY

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. MCINNIS. Mr. Speaker, it is with great pride that I rise today to pay tribute to a devoted patriot from Denver, Colorado. Pat Elsberry is a great citizen who works to inspire America's youth to become involved with the American legion. Her enthusiasm permeates through the community as she passes her knowledge of the military and veteran's issues to her fellow Coloradans. I would like to join my colleagues here today in recognizing her tremendous contributions to the Denver community.

Each day, Pat proudly flies an American flag above her home. In Pat's garage, she displays scores of pictures, flags, articles and other memorabilia from the Korean War. Each keepsake is illustrative of Pat's patriotism and deep love for our country. During the Korean conflict, Pat answered our country's call to duty and honorably served in the Army for four years.

Pat has held the position of Commander of American Legion Post 37 for the past three years. In that time, membership numbers have soared from 40 to more than 160. Under Pat's guidance, the American Legion visits various schools in the area to talk about previous wars and what it means to be a veteran and serve our nation in the armed forces.

Mr. Speaker, Pat Elsberry is a dedicated individual who enriches the lives of her fellow Americans by educating them on the history of our country. Pat has encouraged the support of our American servicemen and women through her compassionate speeches and leadership. Pat's enthusiasm and selfless service to those in the Denver community, and this nation, certainly deserve the recognition of this body of Congress.

INTRODUCTION OF H.R. 3550 "THE TRANSPORTATION EQUITY ACT: A LEGACY FOR USERS"

HON. DON YOUNG

OF ALASKA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. YOUNG of Alaska. Mr. Speaker, today, along with nearly every member of the Committee on Transportation and Infrastructure, I and Congressman Jim Oberstar are introducing a truly historic highway and transit funding bill that will benefit every State in the Nation.

The introduction of this bipartisan legislation would not have been possible without the support and cooperation of Congressman Oberstar. In addition, the Chairman Petri of the Subcommittee on Highways, Transit and Pipelines, along with the subcommittee ranking Democrat, Congressman Lipinski were instrumental in getting this legislation written for introduction.

The legislation provides $375 billion over the next six years. This proposed level of funding is based upon the needs of our country as outlined in the U.S. Department of Transportation Condition and Performance report.

With this bill, we will have the resources to maintian our existing transportation infrastructure and begin to improve it as well. We can address our national congestion crisis and safety problems.

Our transportation infrastructure is old and getting worse. Thirty two percent of our major roads are in poor or mediocre condition and 28% of our bridges are structurally deficient or functionally obsolete.

Congestion is affecting our quality of life and costing our nation $67 billion a year—more than $1,100 for the average commuter each year.

Commuters are sitting longer and longer in traffic jams and billions of gallons of fuel is wasted each year due to congestion.

Most importantly, this country is facing a transportation safety crisis. More than 42,000 people die each year on our roads and highways. Nearly one-third of all these fatal crashes are caused by substandard road conditions and roadside hazards. This is totally unacceptable for the most advanced nation in the world.

Over the next six years, we provide $298 billion for highway, road and bridge improvements . . . and $69 billion for transit programs.

This legislation proposes to increase the minimum guaranteed percentage for every State from 90.5 percent to 95 percent by 2009. We understand that more equity is needed for all 50 States.

The bill significantly increases funding for highway safety programs.

In addition, the bill authorizes $17.6 billion for "Projects of National and Regional Significance"—a major boost for these important projects.

It also authorizes $7.5 billion to address the problem of railroad-highway crossings and the elimination of road hazards.

Our legislation will also have another positive benefit by giving a major boost to our nation's economy. Nationally, this proposal creates more than 1.3 million new highway jobs over the next six years.

It is time to face the facts—our highways, bridges and transit systems are aging and not up to the standards which our citizens expect. We need to stimulate the economy and this important legislation will do just that. America's congestion and safety crisis will not go away—it must be addressed immediately.

Enactment of this landmark legislation is a legacy for all users of our transportation infrastructure, both today and for future generations and moves our aging transportation system into the 21st century.

IN SUPPORT OF THE LIFESPAN RESPITE CARE ACT OF 2003

HON. EDWARD J. MARKEY

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. MARKEY. Mr. Speaker, I rise in support of the Lifespan Respite Care Act of 2003 and in celebration of the Nation's family caregivers during National Family Caregivers Month and Alzheimer's Awareness month. This week before Thanksgiving, as we anticipate gathering with family, friends and loved ones, I am privileged to recognize and honor the millions of family caregivers who care for family members with disabling or chronic conditions such as those afflicted by Alzheimer's disease. There is no doubt in my mind that caregivers—those who devote themselves selflessly to caring for loved ones with disease such as Alzheimer's—are the true heroes. I know because my dear mother was a victim of Alzheimer's and my father was a hero caring for her to the day she died.

Today over 4.5 million Americans suffer from Alzheimer's disease. Almost half of all Americans over age 85 suffer from this devastating debilitation. With the graying of the baby boomer population a sharp increase in Alzheimer's disease is expected. Over 70 percent of people afflicted with Alzheimer's disease live at home, with 75 percent of home bound care provided by family and friends. There are over 25 million family caregivers in America and by 2020, the number of adults requiring assistance with daily living will increase to almost 40 million, placing a tremendous load on the family caregivers.

We cannot afford to lose any family caregivers to stress or illness. We as a nation cannot afford it because family caregivers provide $250 billion per year in unpaid care. Yet, the lack of support is taking its toll on caregivers. While a large proportion of caregivers report finding an inner strength, significant numbers report serious physical or mental health problems, including headaches, stomach disorders, back pain, sleepless nights and depression. Mortality risks for caregivers are 63 percent higher than for noncaregivers.

In addition to serious health consequences, many families suffer emotionally and economically. Families of children with disabilities face a significantly higher divorce rate than families of children without disabilities. Lack of respite care has even been found to interfere with the ability of parents of children with disabilities to accept job opportunities.

Without adequate family support, children with disabilities face a nearly 4 times higher risk of abuse and neglect than children without disabilities and the abuse rate of the elderly is unacceptably high.

Respite works. It allows families to remain together and avoid more costly out-of-home placements. Hospitalizations, institutionalization, nursing home and foster care placements have been shown to actually decline when respite or crisis care is the intervention.

This bill will help create a family caregiving respite policy in our country, not just a band-aid solution. Families are under greater stress today than ever before and the numbers who will assume caregiving roles is rising at an alarming rate. Respite works, respite saves money, respite save families. We cannot afford to ignore the family caregivers any longer. We must give them respite.

PAYING TRIBUTE TO MATT McCHESNEY

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. McINNIS. Mr. Speaker, it is with great pride that I rise today to pay tribute to a dedicated law enforcement officer from my district. Deputy Matt McChesney is a caring and capable law enforcement professional who is committed to improving the lives of families impacted by domestic violence. I am proud to join my colleagues here today in recognizing Matt's tremendous service to the Colorado community before this body of Congress and our nation.

Matt often sacrifices sleep, and the few days he has off, to come into the District Attorney's office the morning after a domestic abuse arrest. There, he works tirelessly to ensure that each victim is treated with dignity and respect. In addition, Matt works with the Victim's Assistance Program and the Operations Division to educate and train volunteers on how to assist victims. For Matt's dedication and commitment to others, he was recently named Law Enforcement Officer of the Year. The people in Matt's district are safer as the result of his service and protection.

Mr. Speaker, Matt McChesney is a dedicated individual who sacrifices his time to helping those who are victim to the terrors of domestic violence. His compassion and selfless service to our state definitely deserve the recognition of this body of Congress and this nation. Thanks for your service Matt, and congratulations on a well-deserved award.

PERSONAL EXPLANATION

HON. JOSEPH M. HOEFFEL

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. HOEFFEL. Mr. Speaker, I was absent for four votes on Wednesday, November 19, 2003. Had I been present, I would have cast my votes as follows:

Rollcall No. 641 (H. Con. Res. 288): "aye."
Rollcall No. 642 (H. Res. 393): "aye."
Rollcall No. 643 (H. Res. 423): "aye."
Rollcall No. 644 (H.R. 3140): "aye."

TRIBUTE TO VACAVILLE'S CRIME PREVENTION EFFORTS

HON. GEORGE MILLER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. GEORGE MILLER of California. Mr. Speaker, I would like to take this opportunity to call my colleagues' attention to a real success story in the City of Vacaville, California. As this article printed in the Fairfield Daily Republic explains, the Police Department in Vacaville is receiving a good deal of well-deserved recognition for the programs and services it provides. The Vacaville P.D.'s comprehensive and preventative approach to crime is a welcome one, and it is having an amazing effect. Despite statewide increases in crime this past year, major crime in Vacaville is significantly down. In a sense, by investing time and effort in the community, they are stopping crime even before it happens. This should be a lesson to all of us. I urge my colleagues to read the attached article, and I commend the City of Vacaville and its Police Department for all their hard work.

[From Fairfield Daily Republic, Nov. 27, 2003]

COMBATTING CRIME "HOLISTICALLY"—VACA POLICE USE NEW APPROACHES TO MAKE COMMUNITY SAFER

(By Nada Behziz)

VACAVILLE.—For decades, American doctors have prescribed pills for pain—white ones, blue ones, big ones, new ones.

And for centuries, practitioners of traditional Chinese medicine have eased aches, strains and spasms through herbal remedies and preventive care.

Now, those two philosophies are merging in Vacaville in a slightly different venue: public safety.

The Vacaville Police Department's transition from the "war on crime" model to more of a preventive slant is what police officials attribute to the city's decrease in crime.

"We're not at war with our community," said Vacaville police Chief Bob Harrison. "We're looking at crime more holistically. We want to provide comprehensive care to really get at the problem."

Vacaville is one of the only cities in California that not only provides preventive programs within elementary and grade schools but has a department within the police department that provides comprehensive, preventive resources to the community.

Sarah Jacobs was torn between loving her husband and saving her children. It wasn't until a rainy evening when her husband threw her and her two sons out of the house with bruises that she packed her bags and left.

"We had no where to go, but I knew we had to leave," Jacobs said. "I heard from friends that the police department could help, so that was the first place I went."

Jacob found a warm place to sleep, an arrest warrant for her husband who left bruises all over her body and parenting resources to help her children recover, all in the same place.

"The police department was able to take care of my every need," Jacobs said. "Now it's time to take care of myself emotionally."

Vacaville's Family Investigative Response and Services Team office based within the police department staffs investigators, counselors and volunteers that provide resources for at-risk families.

Officials say their FIRST program helps stop crime before it happens by nourishing families and showing them non-violent ways of solving disagreements.

Many Vacaville residents in need of services, including parenting classes and access to computers, don't know where to find them. The center provides a "one-stop-shopping place" for people to get the help they need.

Through FIRST, 28-year-old Jacobs was placed in transitional housing, a furnished home of her own where the agency could counsel and monitor her.

And she was introduced to a new family.

"Anything I could possibly say I need, they're on top of it. I've never had to call my counselor in the middle of the night, but I know she's there," she said. "I never had family that I was close to and could trust, now I found them."

Today Jacobs plans to return to school next year to earn a bachelor's degree in business administration. She has hopes of one day becoming a lawyer.

The department first focused on domestic violence issues six years ago, but it wasn't long before police officers noticed that residents who visited were not in need of police services as much as they were human services. The program expanded to incorporate elder abuse, sexual assault and child abuse situations more than four years ago when FIRST opened its doors.

"People ask us often if we believe this is our job as a police department," said Lt. Scott Paulin, who runs the FIRST division of Vacaville Police. "We have to look beyond putting handcuffs on people and fill the gaps to prevent the criminals in the first place."

The gap between criminal activity and the department's clearance rate is slowly closing. While crime increases at a steady rate in California, this year alone, part one crimes—which include homicides, rape, assault and theft—have already dropped 6 percent from last year in Vacaville. The department's clearance rate hit almost 30 percent, a goal that Harrison says the department will surpass this year.

With one of the lowest percentages of overall crime in California, Vacaville was chosen this year by the California attorney general as one of two state police agencies for its "Best Practice Program," which will be featured on the attorney general's Web site as examples of excellence for other cities. The decline in crime, Harrison says, is in part due to the officers visibility in the area and their personal investment since the vast majority live in the city.

"If it's in your back yard, you care if it's clean," Harrison said. "Many of our officers live in town and it's a place they use on a daily basis and want to take good care of."

But Officer Erwin Ramirez says the commute from the Bay Area is worth not worrying about a parolee coming after his wife and three children.

"When you have three kids and a wife, you want to keep them away from danger," said Ramirez, who says he makes at least five arrests each month. "It's a great city but I don't want to risk my family's danger by living here."

Ramirez came to Vacaville three years ago after beginning his career as a patrol officer with the Suisun City Police Department and says the stark difference between the community's reaction to police officers is what makes Vacaville special.

Driving around in his patrol car, Ramirez is approached by children on their scooters smiling and waving as he drives by.

"The department has done a great job at dispelling the stereotype that comes with the police," Ramirez said. "We go around the neighborhoods and talk with the people and hand out stickers to the kids. Hopefully they will remember that the next time we come by."

TRIBUTE TO DENNIS DEVOR

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. McINNIS. Mr. Speaker, it is with great pride that I rise today to pay tribute to a dedicated volunteer from Montrose, Colorado. Dennis Devor is a humble and caring individual who commits his free time to the betterment of his community. His enthusiasm for serving others resonates throughout Colorado. I would like to join my colleagues here today in recognizing Dennis, and his tremendous service to the Montrose community before this body of Congress.

Dennis was recently awarded the prestigious "9Who Care" Award given out by a Denver television station to honor unsung heroes in the community. Dennis' primary occupation is in the law, but he makes time before and after work to be involved in charitable organizations like the Montrose Education Foundation, Salvation Army, Montrose Rotary Club and the Chamber of Commerce. In addition to those organizations, Dennis is also an active member of United Methodist Church. Dennis always makes volunteer work an important priority in his life. His tireless dedication often results in early mornings and late nights spent working to better the lives of those in need.

Mr. Speaker, Dennis Devor is a hard-working individual who has enriched the lives of many members of the Montrose community. He demonstrates a passion for public service that sets a fine example for all Americans. Dennis serves with enthusiasm and commitment, and he certainly deserves the recognition of this body of Congress and this nation. Thanks for your hard work, Dennis, and congratulations on a well-deserved award.

CONDEMNING THE TERROR ATTACKS IN TURKEY

HON. NITA M. LOWEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mrs. LOWEY. Mr. Speaker, I rise to condemn the horrendous and cowardly attacks carried out in Istanbul, Turkey, on November 15, 2003. Twenty-five people were killed and over 300 were injured, as suicide bombers in trucks attacked two synagogues crowded with families attending bar mitzvahs. We should all mourn the unspeakable nature of this tragedy, and we must take decisive action against those responsible.

We are witnessing the resurgence of a pervasive and violent anti-Semitism, last seen on a widespread scale in the 1930s and 1940s in Europe. Some claim that this resurgence can be tied to the continued violence and political conflict between Israel and the Palestinian Authority, but I fear it goes beyond that.

The November 15 attacks struck at Turkey's heart—deliberately—because since the 15th century, it has been a place of peaceful coexistence between Jews and Muslims. By targeting Jews there, the radical Islamic fundamentalists want to send a message: forget history and forget tradition. If you are Jewish, we will target you in any place, at any time. Ironically, and tragically, most of those who lost their lives in this attack were Muslim.

This is hatred, plain and simple. It is anti-Semitic and inhuman. As it destabilizes the Middle East, Asia, and Europe, it threatens our own national security and the security of our closest allies. I know that this Congress and the entire country have the resolve to combat these destructive forces wherever they might reside. I ask my colleagues to join me in mourning with the families of those killed in Istanbul and to stand firm with me as our long and difficult struggle against terrorism continues.

TRIBUTE TO ILLINOIS STATE SENATOR STAN WEAVER

HON. TIMOTHY V. JOHNSON

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. JOHNSON of Illinois. I rise today to pay tribute to my friend and mentor, the late Illinois State Senator Stan Weaver. When Senator Weaver passed away last week, aspiring public servants lost a role model. Few people in public life received the respect that he had among his colleagues, friends and constituents. His successful service to the people of east central Illinois began in 1956 when, at the urging of many citizens of Urbana, Illinois, he ran for mayor. He went on to serve one term as a State Representative then 10 terms as a State Senator. Best known for his exemplary service to his constituents and his ceaseless promotion of the University of Illinois, it is estimated that Stan Weaver alone guided over one billion dollars in construction projects to the University over 30 years.

Consistently prevailing in his campaigns for office, he never spent exorbitant amounts of money and rarely gave grand speeches but, instead, with quiet authority and an intimate knowledge of the political process and the inner-workings of government, translated his personable style into an incredible ability to relate with people and get things done.

I am very honored to have had such a close personal relationship with Senator Weaver and I am deeply saddened by the loss of my friend whom I knew and admired for, literally, my entire life.

TRIBUTE TO MARY JEAN STONER

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. McINNIS. Mr. Speaker, it is my honor to rise and pay tribute to a very special woman from my district. Mary Jean Stoner from Grand Junction, Colorado is known to many as the Grand Valley's favorite candy lady. Mary is retiring this year after 20 years in business and it is my honor to call her contributions to the attention of this body of Congress and our nation here today.

Mary grew up in Sutherland, Iowa and it was there that she began educating herself in the art of candy making. After graduating from Iowa State University, Mary was able to apply a number of her Home Economics and Art classes to become an expert candy maker. Over time, she became a true master of her trade.

Mary and her candy have been bringing smiles to the faces of Grand Valley residents for many years. The candy that Mary makes is truly amazing. The people of the Grand Valley will be sad to see Mary go. However, they will be glad that she now has more time to visit and catch up with her friends and neighbors.

Mr. Speaker, it is my honor to rise and pay tribute to Mary Jean Stoner. Mary dedicated her professional career to making people happy and it is my honor to call her contributions to the attention of this body of Congress and our nation. Thank you Mary.

HONORING EXERCISE TIGER FOUNDATION

HON. KENNY C. HULSHOF

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. HULSHOF. Mr. Speaker, I rise today to honor a distinguished group of Americans. On November 14, 2003 the Exercise Tiger Foundation held its National Adopt a Serviceman Program in Jefferson City. It is essential that we take a moment to remember not only the sacrifice of veterans of Exercise Tiger, but also those men and women currently serving our Nation in the military. Allow me, Mr. Speaker, to take a moment to remind all of us of the story of Exercise Tiger during the Second World War.

Unfortunately, for many people, the words "Exercise Tiger" hold no special significance. Few know of the sacrifice made by so many in late August of 1944. At its outset, Exercise Tiger was one of several training exercises conducted to prepare American and British troops for the upcoming invasion of Normandy. Concentrated on a beach near Dover, England, these operations were meant to prepare the raw recruits for combat, not provide them their first taste of war.

In the calm, early morning hours of April 28, 1944, tragedy struck. As eight Navy landing ships, or LST's, and their lone escort approached their landing area, nine German U-

Boats patrolling the English Channel attacked. LST–507 was the first ship to be torpedoed; it quickly caught fire and survivors abandoned ship. Moments later, LST–531 was hit and sank within 6 minutes. The American ships quickly regrouped and returned fire, with LST–289 suffering significant casualties.

In a moment, the green American recruits became battle-tested veterans. Out of a 4,000 man force, nearly one-quarter were either missing or dead. While the heroism of the American troops under heavy enemy fire deserves high praise, the men who participated in Exercise Tiger had a job to do—practice landing operations resumed the very next day, April 29, 1944.

In most cases, the casualty information and details surrounding the mission would have been made public within days or even hours of the attack. With Exercise Tiger, however, this information was not released until after the D-Day invasion. This was necessary to keep the German military from learning about the impending invasion of mainland Europe.

As the world now knows, the allied invasion of Europe on D-Day was a success. Unfortunately, those who helped make D-Day possible have not been properly recognized for their sacrifice. This too, must change. We must take it upon ourselves to ensure that the virtues those who served in Exercise Tiger—courage, humility and steadfast devotion to completing the task at hand—remembered and documented for future generations.

As such, it is only appropriate that the Exercise Tiger Foundation has nominated eight members from various branches of the active and reserve forces as part of the National Adopt a Serviceman Program. This year's honorees are Staff Sergeant Patrick Reed, 1107th AVCAD, Missouri Army Reserve National Guard, Command Sergeant Gary L. Murphy, 139th Security Forces Squadron, U.S. Air National Guard, Master Sergeant Robert A. Jackson, 442nd Fighter Wing, U.S. Air Force Reserve, Staff Sergeant Billy Jack Roberts, 509th Bomb Wing, U.S. Air Force, Petty Officer 2nd Class Yancy Woodard, Staff Sergeant Matthew Beadle, U.S. Marine Corps, Sergeant Dennis Payne, 110th Engineers, Missouri Army Reserve National Guard, and Boatswain's Mate 2nd Class Kristian Sova, U.S. Coast Guard. Without a doubt, their exemplary service to our Nation honors the example of those who came before them.

These individuals certainly deserve our recognition and support as they continue to defend our freedom both here and abroad. We stand united behind them, and united behind the freedom our Nation guarantees. May God continue to bless this Nation as well as all of those men and women who have served in uniform.

THE INTRODUCTION OF THE SURFACE TRANSPORTATION RESEARCH AND DEVELOPMENT ACT OF 2003

HON. VERNON J. EHLERS

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. EHLERS. Mr. Speaker, today I rise to introduce an important piece of legislation, "The Surface Transportation Research and Development Act of 2003." Our Nation's transportation system faces tremendous challenges. We have more drivers who are driving more miles leading to severe congestion, particularly in many urban areas. An aging infrastructure is putting a strain on State and local transportation budgets, which are tied up in maintaining our existing system, with little, if any, money left for improving the system and planning for the future. And an aging population and changing development patterns that demand an innovative response to ensure the transportation system meets future needs. The public demands safer, less congested roads, and more transportation choices. Considering that we won't have the ability to simply build more roads to address these challenges, especially in urban areas, we must look at new ways to improve the overall system, to make it safer and more efficient, and to ensure that the system meets future needs.

Fundamental improvements to the entire transportation system depend on high quality surface transportation research. Research can provide the proper tools and information needed to drive solutions. The last time Congress fully examined our Nation's transportation policy was through the debate and passage of the Transportation Equity Act for the 21st Century (better known as TEA–21). While Congress increased funding for overall transportation programs by upwards of 40 percent, funding for transportation research remained relatively flat. I think that lack of investment in research has hurt our ability to meet new challenges. However, simply providing more money for research will not solve our problems. Increased funding must be accompanied by some reforms of the existing research programs.

As Chairman of the House Science Subcommittee on Environment, Technology and Standards, which shares jurisdiction over surface transportation research with the Transportation and Infrastructure Committee, I held a hearing earlier this year to hear from experts on the state of the Federal Government's current surface transportation research program. In addition, we heard from a wide array of interests on how to improve and reform the research program, and the levels at which research should be funded. Based on this input, I am proud to introduce the Surface Transportation Research and Development Act of 2003.

This legislation has three overarching goals: to increase stakeholder input to ensure that the folks who must implement and use the research agree that it is worthwhile and transferable into practice; to create the highest quality research through increased competition and peer-review of all projects; and to ensure greater accountability so that our research supports the goals of our surface transportation system.

More specifically, the bill:

Creates and funds an important research program run by the National Academy of Sciences to address short to medium-term research needs. Research will focus on reducing congestion, renewing existing roads and bridges while minimizing impact to the public, improving safety by reducing crashes, and developing tools for getting more out of our existing highway capacity and assessing future needs. All projects funded by this program will be competitively awarded and peer-reviewed;

Provides needed funds to implement a public-private cooperative environmental research program, with the goal of developing the knowledge, tools, and performance measures that will help us understand the linkage between the environment and the transportation system;

Calls on the U.S. Department of Transportation to take the lead in carrying out fundamental, long-term research to achieve breakthroughs in transportation research;

Increases funding for University Transportation Centers and ensures greater competition among universities which seek to become transportation research centers;

Reforms and increases the responsiveness of the Bureau of Transportation Statistics to the needs of the transportation community; and

Provides States with additional resources to better train and educate the transportation workforce.

This legislation will significantly, yet prudently, increase funding for transportation research starting at $500 million a year in fiscal year 2004 for Federal research programs and gradually rising to $850 million a year by 2009. These funding levels are based on an overall level of $375 billion for the comprehensive six-year surface transportation reauthorization advocated by the House Transportation and Infrastructure Committee, which I support. I believe my approach ensures that our transportation research is well planned, peer-reviewed, properly funded, and evaluated and will go a long way to help solve the many challenges facing our Nation's transportation system.

I look forward to working with my colleagues on the Science and Transportation and Infrastructure Committees, the U.S. Department of Transportation, State transportation departments, and all other interested stakeholders as this legislation and the overall reauthorization of TEA–21 progress.

TRIBUTE TO ROBIN GARVIN

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. McINNIS. Mr. Speaker, it is my honor to rise and pay tribute to a remarkable woman from my district. Robin Garvin has dedicated her life in service of the children of the Roaring Fork Valley. It is my honor to pay tribute to her contributions here today.

Robin recently announced her retirement from the Roaring Fork School District's RE–1 Board of Education. Robin was an outstanding member of the Board for eight years and spent the last half of her tenure serving as the Board's President.

Robin approached her position with the best interests of children in mind. Her term was defined by a tireless commitment to providing the students of the Roaring Fork Valley with the best possible education. The Roaring Fork Valley is undoubtedly a better place as the result of Robin's service.

Mr. Speaker, I am honored to bring Robin Garvin's contributions to the attention of this body of Congress and our nation. Robin has managed to devote herself to bettering the Roaring Fork Valley's system of education while happily acting as a devoted mother, wife and friend. I am proud to join the citizens of the Roaring Fork Valley in thanking Robin for her service.

THANK YOU TO SCARLET TREU

HON. GARY G. MILLER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. GARY G. MILLER of California. Mr. Speaker, it is with great pride and personal interest that I rise to commend Mrs. Scarlet Treu of Hacienda Heights, California.

Since my election to Congress in 1999, Scarlet has served as my Senior Advisory for Asian-American issues in my congressional district. Her knowledge and insight into this important constituency has served me well. Unfortunately, after five years of service, she has decided to retire from congressional politics. Not only has she been an excellent employee, but she has also become a close personal friend.

Scarlet's life history is one of inspiration and admiration. Born in Taipei, Taiwan her family was forced to flee from China due to the repressive Communist Regime, Scarlet was able to complete her education at the prestigious Ming Chuang College and earned a degree in business administration. Upon graduation, she went on to serve as the original and founding member of the marketing department for Chase Manhattan Bank's Taipei branch. Immigrating to the United States in 1976, she went to work as an immigration section supervisor and then as a civil litigation specialist for two respected law firms in southern California.

Scarlet met her loving husband, Rolf Treu, in 1977 and they set out to establish two law offices before he was appointed to a State judgeship in 1995. Rolf and Scarlet have two wonderful children, Jacqueline and Eric.

Aside from her many children-related activities, Scarlet has focused on the needs of her community as well. For many years she has been supportive of and actively engaged in the Hacienda Heights Improvement Association Board, LA County Supervisor Don Knabe's Art Award, the Colima-Hacienda Women's Club, the Hacienda Heights Chinese-American Parents Advisory Board, and various Republican Party political appointments. She also formed my Business Advisory Board which has provided me with a forum to work with community leaders on issues important to their industries.

In 2001, Scarlet co-chaired a successful $221 million bond campaign for Mt. San Antonio College that will benefit future generations of students.

Mr. Speaker, I want to thank Scarlet for her years of service, hard work and personal sacrifices on my behalf.

IN HONOR OF DONNA TERESA, THE 2003 ANNE RICHARDSON READING IS FUNDAMENTAL VOLUNTEER OF THE YEAR

HON. SAM FARR

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. FARR. Mr. Speaker, I rise today to commemorate Donna Teresa, a compassionate and devoted member of the children's literacy community. In recognition of her activism, Ms. Teresa has been selected by Reading is Fundamental, as the Western representative for the "2003 Anne Richardson Reading is Fundamental Volunteer of the Year." For over six years, Ms. Teresa has worked tirelessly to develop and improve literacy programs at Henry F. Kammann School. In this effort, she has truly embodied the spirit of volunteerism and empathy that is attributed to the distinguished few who receive this award.

In her position as the school librarian, Ms. Teresa has restored the wonder and excitement that reading can provide to our Nation's children. She understands the value of literacy and has implemented many new programs to encourage reading, including a summer program that gives each a child a free book. Ms. Teresa has expressed her concern that for many of her students, books are scarce at home and the break from school puts many students behind their peers. This type of understanding and consideration of a student's living situation has allowed Ms. Teresa to reach out to each child and cater to their interests and needs. She also manages a student book club with more than 60 students and personally acquaints herself with each new text before giving it to a child to ensure that it is appropriate for their reading level and interests. Ms. Teresa derives her inspiration from the hope that her push towards literacy will encourage students to continue their education and make better choices down the line. Her efforts have also been recognized in Monterey County, where she was recently awarded the "2003 Monterey County Lighthouse for Literacy."

Mr. Speaker, on behalf of the United States Congress, I would like to honor the accomplishments of Donna Teresa and express sincere gratitude for her commitment to our community's children. I wish Ms. Teresa much success in her endeavors and I am confident that the efforts of those who strive to improve literacy will be valued for many generations to come.

NO ATTAINMENT—NO TRADE BILL

HON. JAMES P. MORAN

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. MORAN of Virginia. Mr. Speaker, today I am introducing the "No Attainment—No Trade bill."

This legislation amends the Clean Air Act to prohibit power plants and other major point sources of nitrogen oxide (NO_x) pollution that are in an ozone nonattainment area from participating in EPA's emission trading program.

In 1990 Congress passed amendments to the Clean Air Act to deal with the issue of acid rain deposition.

Harmful acid rain was destroying our buildings, personal property and turning freshwater lakes into dead zones.

The new law established an innovative emission trading program to reduce the precursors of acid rain, harmful nitrogen oxides and sulphur dioxides emitted by coal-burning power plants and major industrial boilers.

Since its establishment, the trading program has worked extremely well, better than even proponents of the 1990 amendment to the Clean Air Act ever expected.

While nitrogen and sulphur dioxides have been reduced, and reduced by millions of tons, an unanticipated new wrinkle has emerged as states and localities work to reduce urban smog and bring ozone non-attainment areas into compliance with other requirements in the Clean Air Act.

States and localities are bumping into the emission trading program for nitrogen oxides.

Not only are nitrogen oxides the precursors of acid rain, they also mix with hydrocarbons and form ground-level ozone.

Giving power plants in an ozone non-attainment area the authority to buy a credit from elsewhere and avoid nitrogen oxide reductions may help EPA meet its national acid rain reduction goals, but it can frustrate State and local efforts to lower ozone and urban smog.

I speak from experience.

Just across the Potomac River in Alexandria we have one power plant operated by Mirant that continues to violate its permit.

In fact, this past summer during the ozone season it violated its clean air emission limits by more than 1,000 tons of nitrogen oxide, double the tonnage allowed under its permit.

It my understanding that Mirant is trying to get off the hook by purchasing credits of emission reductions from sources elsewhere, outside this region, to meet its emission reduction goal.

"Not so," says the Commonwealth of Virginia.

The State's position, however, may be on less than firm legal ground.

I hope the Commonwealth holds its ground and stands strong, and I have encouraged them to do so.

The legislation I am introducing gives them the clear legal authority they need and discourages power plants from challenging State ozone implementation plans in court.

I also hope this legislation will give other States the authority they need to block power plants in a non-attainment area from engaging in NO_x emission trading and avoiding their responsibility to reduce ozone and urban smog.

It is my understanding that Mirant, the same company operating the plant in Alexandria, has violated its NO_x permits at its three coal-fired plants in Maryland.

During this summer's ozone season, Chalk Point, Morgantown and Dickerson power plants collectively exceeded their summer NO_x permits by more than 3,500 tons.

Unlike Virginia, State officials in Maryland appear inclined to let them buy credits through the emission trading program.

That's an additional 4,600 tons of nitrogen oxide that entered our air this past summer beyond what Virginia and Maryland agreed Mirant should emit.

It makes no sense, to force this region, or the jurisdictions of any ozone nonattainment area, to rachet down nitrogen oxides from other sources, beyond what may be necessary, simply because a few large sources are able to buy their way out of compliance.

It isn't fair, and it is not in anyone's best interest to do so.

My legislation puts an end to it.

It deserves consideration.

ESTABLISHING NATIONAL AVIATION HERITAGE AREA

SPEECH OF

HON. NANCY L. JOHNSON

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mrs. JOHNSON of Connecticut. Mr. Speaker, I rise today in support of H.R. 280 the National Aviation Heritage Area Act which includes in Title VI the Upper Housatonic Valley National Heritage Area Act. The Upper Housatonic Valley, encompassing 29 towns in the hilly terrain of western Massachusetts and northwestern Connecticut, is a singular geographical and cultural region that has made significant national contributions through its literacy, artistic, musical, and architectural achievements, its iron, paper, and electrical equipment industries and its scenic beautification and environmental conservation efforts.

The Upper Housatonic Valley National Heritage Area would extend from Lanesboro, Massachusetts 60 miles north to Kent, Connecticut. This region of New England is home to many of the Nation's first industrial iron sites. The iron produced at these sites was used to make weapons for the Revolutionary War. Furthermore, the area includes homes of historical significance belonging to Edith Wharton and author Herman Melville as well as the Monument Mountain Reservation, where Melville and Nathaniel Hawthorne picnicked. The area also has great outdoor recreational resources and is the base for much of Connecticut's agri-tourism business.

From the 1730s to the 1920s, it was home to many of the Nation's earliest iron industries. The first blast furance was built in 1762 by Ethan Allen and supplied the iron for the cannons that helped George Washington's army to win the American Revolutionary War. While most of the furnaces, mine sites and charcoal pits have been lost to development and time, the few that remain are in need of refurbishment. The Beckley Furnace in Canaan, Connecticut was designated an official project by the Millennium Committee to Save America's Treasures.

The Valley's history as a cultural retreat from the Boston and New York areas provides both past and current riches for the country. Since the 1930s visitors from all over have come to hear the music at Tanglewood, Music Mountain and Norfolk, see the paintings at the Norman Rockwell Museum, watch serious theater at Stockbridge and musical treats at Sharon. Today's local authors draw on a long tradition going back to the 19th century, when Herman Melville, Nathaniel Hawthorne and Edith Wharton lived and wrote here. The Upper Housatonic Area, with its remoteness from but ties to large cities, occupy a special niche in our national culture.

The Housatonic Valley is also rich with environmental and recreational treasures. The Housatonic River, just below Falls Village, Connecticut, is one of the prized fly-fishing centers in the Northeast and is enjoyed by fisherman from not only Connecticut and Massachusetts but the entire eastern seaboard. Olympic rowers have trained in this river as children have learned to swim, boat and fish and value its ecosystem.

Through this broad, flexible and locally led initiative, the states of Connecticut and Massachusetts will be able to make real progress in protecting the river and its heritage. Rather than depending on the Federal bureaucracy, States will be able to facilitate locally led, and truly voluntary programs that will help protect the river for future generations. This legislation encompassing all heritage areas has broad bipartisan support, I would like to thank the Resources Committee for bringing this legislation forward and I encourage my colleagues to support this legislation.

PERSONAL EXPLANATION

HON. ALLEN BOYD

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. BOYD. Mr. Speaker, I was unavoidably detained and unable to cast my vote on rollcall votes 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633. Had I been present I would have voted "aye" on rollcall votes 620, 621, 622, 623, 624, 625, 626, 627, 631, 632, 633. In addition, I would have voted "nay" on rollcall votes 628, 629, and 630.

IN HONOR OF STIRLING D. SCRUGGS, DIRECTOR, INFORMATION, EXECUTIVE BOARD AND RESOURCE MOBILIZATION DIVISION—UNITED NATIONS POPULATION FUND

HON. CAROLYN B. MALONEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mrs. MALONEY. Mr. Speaker, at the end of this year, Stirling Scruggs will be retiring after 22 dedicated years with the United Nations Population Fund (UNFPA). Stirling is a living example of the ideals behind the creation of UNFPA and the United Nations itself. A former high school football star in Tennessee, Stirling had many opportunities open to him in life. But his overriding ambition was one that so many of us shared in our youth: to make a difference in the world. Stirling has remained true to his youthful ideals and has made a difference, a substantial difference measured in millions of women and babies that survived because of his dedication and efforts; measured in the essential bonds between mothers and their children who survived to know each other and in the love of husbands and fathers who, rather than seeing their wives and children die in childbirth, have had long and full lives with their loved ones.

In speaking with his colleagues, there are three words that are always repeated when they describe Stirling Scruggs—Passion, Integrity and Kindness.

Passion: Stirling Scruggs has worked in some of the poorest places in the world. He has seen first hand the deprivations and struggles that hundreds of millions—in fact, billions of people—bear every hour, every day, every week throughout the year. Stirling Scruggs brings to his work a passion that bespeaks his own compassion and his own commitment to the cause of basic health, women and voluntary family planning around the world.

Integrity: Stirling combines his passion with unshakable integrity. He is unwavering in his commitment to basic health and rights for all the world's people. He has stood up for these ideals in some of the most difficult circumstances, including in China, where he worked tirelessly—as UNFPA does—to convince the Chinese about the greater wisdom of a voluntary, rights-based approach to family planning. Stirling Scruggs is a monument to personal integrity and professional dedication.

Kindness: Finally, and perhaps most importantly, Stirling brings to his work a core kindness—not only in his outlook to the dispossessed in our world, but in his dealings with all people. Stirling always has a kind word and a warm smile for those he works with, on behalf of and for. He is a tender man, who has a compassionate outlook toward those less fortunate and a compassionate manner with everyone he relates to.

There are few better, kinder men than Stirling Scruggs. He has represented the United States so well in the United Nations system. All Americans can be proud of the service he has rendered and we all wish him well as he continues his efforts to make the world—and each of us—a little better.

TRIBUTE TO WESLEY HEDSTROM

HON. JAMES L. OBERSTAR

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. OBERSTAR. Mr. Speaker, I rise today to pay tribute to former Cook County Commissioner Wesley Hedstrom, who passed away on November 7, 2003.

Wes Hedstrom was born in 1924 in Grand Marais, Minnesota, the youngest of thirteen children. After graduating from Grand Marais High School in 1942, Wes joined the U.S. Army and served during World War II. Returning to Minnesota, Wes, along with five of his brothers, took over operation of their father's business, Hedstrom Lumber, and he was company president from 1986 to 2000. In 1984, Wes was elected to the Cook County Board of Commissioners, on which he served for the next 16 years.

Except for the few years he was in the Army, Wes lived his entire life in Grand

Marais, a small fishing town along Minnesota's north shore. Many people say that Wes was largely responsible for the enormous growth of his family's lumber business, turning it into one of the region's largest and most successful companies. For Wes, however, it was more than a business; it was a way of life. He had extensive knowledge of lumber and the woodlands. I learned more from Wes about forestry, forest management and sustainable yield forestry than from any other source.

Wes understood the need for balance between the lumber industry and protections for the environment. He applied that fair-minded attitude to all the projects he worked on in the community, both as a County Commissioner and as a civic volunteer. From the renovation of a local hospital, to the creation of a new airport, to the advocacy for education funding, Wes worked to nurture people, find a consensus, and do what was in the public's best interest. That was his signature and his trademark.

Some called him an activist. Others said he was a pioneer. All who crossed his path considered him a friend. I knew Wes since he worked on my first Congressional campaign in 1974, and over the years, I marveled at his friendliness, magnanimity and selflessness. To me, Wes was a teacher, counselor and partner in ventures for the Northland, and he was a good friend to me. He was one of those rare people who truly made a difference in his community. I know my colleagues join me in honoring Wes Hedstrom for his many years of dedicated service to his town, his State and his country.

COMMENDING DENTON HOUSING AUTHORITY

HON. MICHAEL C. BURGESS

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. BURGESS. Mr. Speaker I rise today to recognize the Denton Housing Authority to commend them for receiving three National Association of Housing and Redevelopment Officials (NAHRO) Merit Awards in Tampa, Florida this year.

The Denton Housing Authority has been active in the North Texas community for years, working hard to provide quality public and affordable housing. This year at the 2003 NAHRO awards ceremony, the Denton Housing Authority was recognized for their achievements in Program Innovation for Resident and Client Services. NAHRO President Kurt Creager said, "These agencies are accomplishing remarkable levels of service for their communities and their residents. They are setting up programs and establishing standards that can be duplicated by other housing authorities around the country."

The Denton Housing Authority was recognized for three of their programs. The ARTS program brings together the DHA, University of North Texas, Center for Public Service, and Greater Denton Arts Council to provide an arts program and promote social skills for disadvantaged youth in low-income neighborhoods. The New Direction of Community Oriented Policy Services (COPS) program partners with the Denton Police Department to encourage community outreach services to create and sustain safer neighborhoods. Also, the Phoenix After-School Program teams with the University of North Texas and DHA to encourage social and academic success for socially challenged youth 4–11 years old living in the Phoenix Development. These are the kind of great programs that will create a better society in the future by giving our youth a strong foundation and forming a safer environment for our neighborhoods.

Once again, I would like to express my sincere congratulations to the Denton Housing Authority for their innovation and hard work in providing community outreach services to the City of Denton and surrounding communities.

TRIBUTE TO DAVID A. WIRSING

HON. DONALD A. MANZULLO

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. MANZULLO. Mr. Speaker, I rise today in tribute to my colleague and friend in Illinois, David A. Wirsing, State Representative from the 70th district. Dave went home to be with the Lord suddenly on Sunday, November 16, 2003. He leaves a loving wife of over 40 years, Nancy, four grown children—Mark, Steven, Angela and Susan—and 11 grandchildren.

Dave Wirsing was a friend in the truest sense of the word. He was a man of deep personal faith, a loving and faithful husband to Nancy and a wonderful father to his four children. He spent the majority of his life in agriculture as a former pork producer and grain farmer. He and Nancy had the same phone number their entire lives, and their address always ended with "Sycamore, Illinois". Then, in 1992, he decided to enter public service and run for State Representative of the 70th district.

Mr. Speaker, I want to pay tribute to Dave today not only for his selfless public service to the people of Illinois, but to Dave as a friend. Before Dave ever ran for public office, he was simply a husband, father and grandfather. He raised his children with a sense of humor, a stern discipline, high moral standards, a deep and abiding faith in God and taught them leadership skills and simple common sense. Mostly, he raised his children and provided his wife, Nancy, with love. Few knew at this point how much he would impact the lives of so many people or that so many would seek his counsel. His children never dreamed that the man they simply called "Dad" would become the man many would call "great."

Dave Wirsing was a friend to many. His small and large acts of kindness are unfathomable to some. However, to Dave, it was just the way he was meant to live his life. He was a humble man, never quite understanding why people outside of his family would honor him for achievements that to him were just what he was supposed to do. He was a man who dedicated his life—indeed, his heart and soul, to serving others—his family, his neighbors, his friends, his constituents.

Dave led by example—he lived by the Golden Rule, and yet he never expected anything in return for his kindness and compassion. He loved being around people—be it the company of his wife and family or in the presence of colleagues, acquaintances and even strangers. He was able to laugh at himself—a trait seldom seen these days. He dedicated his life to serving others. He helped his children grow, learn and prosper; he helped his neighbors in times of need; he helped his friends to resolve problems; he helped his colleagues see both sides of an issue and then beyond that to a resolution; he helped his constituents obtain the assistance and guidance they had a right to; he helped many young people grow in life through his wisdom, his gentle and jovial encouragement, his love and respect for each person as an individual, and his high regard for bettering oneself.

Mr. Speaker, Dave Wirsing's accomplishments were many, but most importantly, not a day went by that he did not share himself with someone. Solutions and advice came to him from principle and philosophy. He was not out to make a name for himself, he just wanted to make things right in his part of the world. If he did not have the skill necessary to help someone, he sought it out. He lived by the philosophy that if you always tell the truth, you won't have to remember what you said. Dave Wirsing did not live his life to achieve great moments, but instead had a lifelong commitment to a set of values and ideals. As I reflect today on the whole of his life, that is his greatest accomplishment. He leaves behind a legacy of faith, kindness, compassion and love for his family, friends and constituents. He will be deeply missed.

HONORING THE 30TH ANNIVERSARY GALA OF THE KOREAN AMERICAN MEDICAL ASSOCIATION, INCORPORATED OF DISTRICT OF COLUMBIA, MARYLAND AND VIRGINIA

HON. TOM DAVIS

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. TOM DAVIS of Virginia. Mr. Speaker, I would like to take this opportunity to honor the 30th anniversary of The Korean American Medical Association of District of Columbia, Maryland and Virginia, Incorporated.

The Korean American Medical Association of District of Columbia, Maryland and Virginia, Incorporated (KMA) is one of the most respected Korean-American nonprofit organizations in America. The association was founded in 1974 by a small group of respected Korean physicians. The KMA was the first Korean Medical Association in the United States. Its hard work and dedication has led the association to grow from a handful of members to a membership of about 400 physicians from the District of Columbia, Maryland and Virginia.

Since its inception, the association's involvement in the Great Washington, D.C. Metropolitan community has been commendable. The KMA provides health care services, seminars and educational opportunities to the community. The dedication that the members of the KMA have to its community is exceptional.

The KMA provides a forum for its members to exchange ideas and continue education helping its members continue to provide excellent service to the community. The care and services these physicians provide to their neighbors and friends is a testament of their hard work. The KMA certainly has distinguished itself as an outstanding group.

Mr. Speaker, in closing, with all the contributions to the community made by The Korean American Medical Association of District of Columbia, Maryland and Virginia, Incorporation, we have a great reason to celebrate today. I want to commend the association 30 years of excellence and extend my warmest wishes for the years to come. I call upon my colleagues to join me in applauding the KMA on its 30th anniversary.

IN HONOR OF LOULA LOI-ALAFOYIANNIS

HON. CAROLYN B. MALONEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mrs. MALONEY. Mr. Speaker, I rise today to pay tribute to Loula Loi-Alafoyiannis, the Executive Global President and C.E.O. of the Euro-American Women's Council (EAWC). Loula has spent her professional life facilitating the needs of Greek and American entrepreneurial communities and advancing the cause of women's rights in the areas of business and education.

Loula has demonstrated that intelligence, integrity, energy, clear objectives and the love of a task well executed create credibility. Her love for Greece and her desire to promote greater understanding between Greece and America has made her a strong advocate and a wonderful ally.

Loula, like so many talented women of her generation, has had several careers. For two decades, Loula served as an elementary school teacher, helping to ensure that young people have a strong educational foundation. Her work with young people inspired her to create a Youth Leadership Award given annually by EAWC.

She then turned to the challenges offered by business, public relations and event-planning. Loula's entrepreneurial skills are widely recognized and, as a result, she has served as a delegate to White House Conferences on small businesses since 1990, and has advised numerous public officials and government leaders. Loula has also sponsored numerous White House luncheons for prominent and influential business women from across the United States and Greece.

In 1991, she founded and organized the "Best Buddies Foundation" in Greece, along with Anthony Kennedy Shriver, who serves as its Global President and C.E.O. As the Founder and the executive Global President of Euro-American Women's Council, Loula has established a spirit of cooperation among business women globally. The women of EAWC bridge nations and cultures, set trends, exercise influence, innovate positive change and make a difference around the world. Since 2001, Loula has been the Coalition Partner for Europe of the Women Impacting Public Policy (WIPP) organization. She is currently a board member to the Human Rights Advisory Council of New York.

Loula has received a number of prestigious awards for her outstanding contributions, including the Crown Award, which recognizes her as one of the most creative minds of the top leading entrepreneurial women of the world. She has also earned the distinguished award of "Honorary Citizen of Baku" as a result of her pioneering efforts to improve entrepreneurial training in the former Soviet Union.

Mr. Speaker, I am pleased to bring to the attention of my colleagues the outstanding work of Loula Loi-Alafoyiannis. Her unwavering dedication to improving relations between the Greek and American entrepreneurial communities and promoting opportunities for women is truly worthy of our recognition.

A TRIBUTE TO REVEREND DR. JOHN L. GILES

HON. EDOLPHUS TOWNS

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. TOWNS. Mr. Speaker, I rise in honor of the Reverend Dr. John L. Giles in recognition of his pastoral anniversary.

While Reverend Giles was born in the tiny town of Sanger, TX, located 38 miles southwest of Fort Worth, he considers himself a native of San Francisco. It was during high school that he joined St. Kevin's Catholic Church and learned the Catholic discipline. He was also a member of Bethel A.M.E. Church. Upon graduating from Balboa High School, he had saved enough money to attend college and support himself. Through his hardships, he learned independence, responsibility, the importance of healthy living, and helping others and his family.

Drafted in the Vietnam War, he spent 18 months in Friedberg, Germany where he earned the rank of sergeant in 15 months and he attended both Catholic and Protestant churches. He read the bible more and more and his favorite scriptures are Psalm 23, 27, and 121. In May 1997, Pastor Giles earned his doctorate in Holistic Ministry at the United Theological Seminary in Dayton, OH.

Upon returning to San Francisco, he joined the Solid Rock M.B. Church and was baptized. In August 1970, he was accepted at the American Baptist Seminary of the West in Berkley, CA. He also attended Morehouse School of Religion and served briefly at Ebenezer Baptist Church in Atlanta as a youth minister under the late Dr. Martin Luther King, Sr. Additionally, he has served at First Baptist in LaGrange; First African Baptist, Bainbridge and the Beulah in Quitman. He served as Chaplain at the VA Medical Center in Bay Pines, FL and as pastor of New Hope M.B. Church until 1994. Presently, he is the Pastor of True Faith Inspirational Baptist Church in Tampa, FL.

He is married to JoVanore Sims Giles, who serves as chairperson of the Deaconess Ministry and participates in the choir and other activities. They have two daughters, JoVanore Giles-Galbreath and Jenee Codallo-Nelson, and one son, Johnathan who is attending college at the School of the Holy Cross.

Mr. Speaker, Reverend Dr. John L. Giles has honorably served our Nation in the armed services and has provided spiritual guidance and leadership to several parishes across the country. As such, he is more than worthy of receiving our recognition today and I urge my colleagues to join me in honoring this truly remarkable person.

CONGRATULATING PAUL SIMON

HON. RAHM EMANUEL

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. EMANUEL. Mr. Speaker, I rise today to join in congratulating former Senator Paul Simon, who will be celebrating his 75th birthday on November 29. As one of Illinois' favorite sons, and a man who fought hard for the people of the United States in this building for twenty-two years, it is only appropriate that this body honor one of the most outstanding and respected leaders our country has ever known.

Born in Eugene, Oregon on November 29, 1928, Paul Simon moved to Troy, Illinois upon his graduation from college and worked as a newspaper editor and publisher, eventually building a chain of fourteen weekly papers. After serving in the United States Army from 1951–1953, Senator Simon first ran for elective office in 1955, winning a seat in the Illinois General Assembly. He served as a State Representative from 1955–1963 and as a State Senator from 1963–1968. From 1969–1973 he served our state as Lieutenant Governor. He was elected to the Ninety-fourth Congress, and served in the House from 1975 to 1985. In 1984 he won election to the Senate and served until 1997 when he chose not to run for reelection. Additionally, Senator Simon was a candidate for the Democratic nomination for President of the United States in 1988, winning the Illinois Primary.

As a Member of Congress, Senator Simon championed many progressive issues, many of them long before they became fashionable, including campaign finance reform and the creation of new programs to make college more affordable and accessible for our children.

Since retiring from elected office, Senator Simon has continued to advance a lifetime passion of his: education. The founder and Director of the Public Policy Institute at Southern Illinois University, Senator Simon still teaches classes in journalism, political science and history. The author of over a dozen books, his 1998 autobiography P.S. remains a must-read for those interested in Illinois politics in the post-war period. Additionally, Senator Simon was one of the founders of the magazine Illinois Issues, which remains the definitive journal of Illinois' political landscape.

But despite winning elections in five different decades, serving his state and country in many different capacities, and being a leading educator, Senator Simon's character, integrity and intelligence are what have made him the most enduringly popular political figure in our state. The advice and support of Senator Simon remains cherished by those of us who have attempted to advance his ideals.

Mr. Speaker, I thank you for the opportunity to congratulate a true hero of mine and the entire State of Illinois, Senator Paul Simon, on the occasion of his 75th birthday.

PERSONAL EXPLANATION

HON. ROBERT E. ANDREWS

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. ANDREWS. Mr. Speaker, on Wednesday, November 19, I did not vote on the following measures, because of family commitments, and would like to include in the RECORD how I would have voted, had I been present: On H.R. 1006, I would have voted "yea"; on H. Con. Res. 320, I would have voted "yea"; on H.R. 3491, I would have voted "yea"; on rollcall No. 637, to instruct conferees on H.R. 1, I would have voted "yea"; on H.R. 2420 I would have voted "yea"; on H. Res. 427, I would have voted "yea"; on H. Con. Res. 83, I would have voted "yea"; on H. Con. Res. 288, I would have voted "yea"; on H. Res. 393, I would have voted "yea"; on H. Res. 423, I would have voted "yea"; and on H.R. 3140, I would have voted "yea."

A TRIBUTE TO MRS. EVERLEE SMAW MILLS

HON. FRANK W. BALLANCE, JR.

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. BALLANCE. Mr. Speaker, I rise to honor Mrs. Everlee Smaw Mills, one of my most senior constituents on the occasion of her 90th birthday. Mrs. Mills has lived through and experienced every noteworthy event in our nation's history that has punctuated the 20th Century. At the tender age of 16, instead of engaging in some of the lighthearted, fun activities enjoyed by youth today, Mrs. Mills was experiencing an America devastated by the stock market crash of 1929 and the onslaught of the Great Depression. At a time when she should have been enjoying life and planning for what little prosperity a segregated nation could offer an under-education Black woman, Mrs. Mills as a youth was facing bread lines and food rations.

Mr. Speaker, Mrs. Mills is a remarkable woman, not just because of her long tenure but also because of her resolve to do well in all circumstances. For instance, she lived through the death of both parents at an early age, World War I, death of her spouse, World War II, the Korean War, Vietnam War, Gulf War, death of three of her children, and has seen our troops sent to Iraq to battle terrorists.

Mr. Speaker, Mrs. Mills gave birth to 11 children and fed and nurtured many others, including grandchildren and neighborhood youth who wandered home with her children. It is my understanding, Mr. Speaker, that she never turned anyone away who needed a helping hand. Mr. Speaker, this remarkable lady, worked in a domestic capacity until she retired at the age of 75, and over the years she and her husband, (decedent) William Mills never once accepted welfare. As a widow, since the late 1940s, Mrs. Mills taught and stressed the importance of self-sufficiency to her children. They were taught to "pay their own way" in society.

To Mrs. Mill's credit, Mr. Speaker, her children have grown under the shade of her guidance to enter a cadre of notable professions. For instance, her children are employed in the following capacities: US Air Force serviceman, an engineer who has been assigned to work on NASA projects, a representative with the Wall Street Currency Exchange Department, the first Black elected to the Board of Commissioners in Beaufort County, an accomplished welder for the most prestigious truck body builders in the country, Hackney & Sons, and one daughter and son who have become ministers.

Mr. Speaker, Mrs. Mills is a lifelong member of Beebe Memorial CME Church of Washington and was named the Woman of the Year in the 1980s and Woman of Distinction in 2001. She is revered in her church for the solid advice that she imparts to the youth and her peers, and has become a well-respected pioneer in building church programs.

Mr. Speaker, Mrs. Mills is a true marvel. She still lives independently and enjoys "Soap Operas". She reads the Bible religiously. Her family history is traced in Beaufort County as far back as slavery. Her love for the area runs deeper than we understand. It pleases Mrs. Mills greatly to be simply a loving mother, devoted church member and lifelong resident of Beaufort County, North Carolina. I ask my Colleagues to join me in paying tribute to Mrs. Everlee Smaw Mills, an exemplary citizen.

HONORING BERT S. TURNER

HON. DAVID VITTER

OF LOUISIANA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. VITTER. Mr. Speaker, I rise today to honor Bert S. Turner, a distinguished alumnus of Louisiana State University. He has been selected by the LSU Alumni Association Hall of Distinction to receive the Alumnus of The Year Award. Every year, this award is bestowed to an individual not only for his or her distinguished accomplishments, but also for commitment and generosity to the university and the LSU Alumni Association.

Mr. Turner began his engineering and military career at LSU in 1939, where he became President of the College of Engineering Student Council, the LSU Post of American Society of Military Engineers, and a member of Tau Beta Pi. Following military duty, he then went to the Harvard Graduate School of Business Administration and graduated in 1949. For eleven years, from 1946 to 1957, Mr. Turner was recognized for his personal and civic accomplishments. Most notably, he was given the Distinguished Service Award for Baton Rouge in 1954, which recognized him as a loyal member of the community. After working in various engineer and management positions, he eventually became President and Chairman of the Board of Nichols Construction Corporation, a position he held for twenty years.

He has also served on the boards of the Baton Rouge Chamber of Commerce, the Louisiana State Museum Board, the Louisiana Labor Management Commission, the Salvation Army, the State of Louisiana Board of Regents for Higher Education, and the YMCA. He was previously inducted into the LSU College of Engineering Hall of Distinction in 1993 and the LSU Alumni Association Hall of Distinction in 1996. Presently, he is the Chairman Emeritus of the Board for Turner Industries, Ltd.

I extend my best wishes to Mr. Turner, the most recent recipient of this prestigious award, and to LSU for its support.

RECOGNIZING THE WORK OF MR. PHILIP WORKMAN, EXECUTIVE DIRECTOR OF THE OHIO PSYCHIATRIC ASSOCIATION

HON. TED STRICKLAND

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. STRICKLAND. Mr. Speaker, I stand today on the floor of the United States House of Representatives to recognize Mr. Philip Workman's contributions to the field of mental health treatment.

For nearly twenty years, Phil Workman has served as the Executive Director of the Ohio Psychiatric Association (OPA), the OPA Education and Research Foundation, and the Ohio Psychiatrists' Political Action Committee. In these positions, he has made an outstanding contribution to advancing education and treatment and reducing stigma and discrimination of mental illness.

Under Mr. Workman's watch, the membership of OPA has doubled to over 1,000 members; this growth in membership is due, in part, to his ability and willingness to reach out to residents and psychiatrists who are just beginning their careers in order to develop young leadership in the organization.

Mr. Workman has been a leader in Ohio and across the country in the fight for mental health parity. He worked in concert with other Ohio groups to establish the 1984 Fair Benefits Coalition. The Fair Benefits Coalition led directly to the creation of the Coalition for Healthy Communities, a coalition of over 25 professional agencies and consumer organizations devoted to providing quality mental health and substance abuse services in Ohio. And, he worked in the American Psychiatric Association to establish several groups and task forces that have been critical to the vitality of the national organization.

Appropriately, Mr. Workman's outstanding leadership, commitment, and dedication was honored in 2002, when he was named a "Mental Health Champion" by the National Alliance of the Mentally Ill of Ohio.

Phil Workman's long service to the Ohio Psychiatric Association and his strong advocacy for those who suffer from mental illness has inspired and served as a model to his many friends and professional associates. It has been said that "some people strengthen society just by being the kind of people they are." Mr. Speaker, Philip Workman is such a person.

JAMES R. BROWNING UNITED STATES COURTHOUSE

HON. NANCY PELOSI

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Ms. PELOSI. Mr. Speaker, I am pleased to announce that today I am introducing legislation to designate the United States Courthouse located at 95 Seventh Street in San Francisco, California as the "James R. Browning United States Courthouse," to honor Judge Browning for his lifetime of outstanding public service.

James R. Browning was born in Great Falls, Montana, and received his law degree from the University of Montana. Prior to his appointment to the bench, he served in the Pacific Theater during World War II, worked in the Antitrust Division of the U.S. Department of Justice, practiced in a law firm, and served as Clerk of the U.S. Supreme Court.

In 1961, President John F. Kennedy appointed James Browning to the United States Court of Appeals for the Ninth Circuit. He dedicated the rest of his career to the Ninth Circuit, becoming the longest serving judge in the history of the circuit. Judge Browning became very active in the Judicial Conference of the United States, serving on a number of committees that worked to strengthen the federal judiciary.

Upon becoming Chief Judge of the Ninth Circuit in 1976, Judge Browning focused on improving the function of the circuit, which was struggling with a large backlog of cases and delays in appeal decisions. Due to his efforts and innovative practices, additional judges were added to the court of appeals, the time required to decide appeals was cut in half, and the backlog was eliminated. He also improved communication among the justices, emphasizing the importance of good colleague rapport. His innovations were studied and adopted by other circuit courts, and he has received several prestigious awards in recognition of his achievements.

Judge Browning's contributions to national jurisprudence are also outstanding. During his forty-two years on the Ninth Circuit, Judge Browning has participated in almost 1000 published appellate decisions and authored many other unsigned per curiam opinions. In a 2001 tribute, a colleague described him as "the consummate appellate judge . . . he treats each case that comes before him with careful attention and produces succinct, clearly reasoned opinions." Colleagues have also lauded him for his seminal contributions to national antitrust jurisprudence and his attentiveness to ensuring that citizens have access to the justice system.

Judge Browning stepped down as Chief Judge in 1988 but did not retire, remaining an active circuit judge and a member of myriad committees and judicial groups. He took senior status in September 2000. His activities have been significantly curtailed due to declining health. It is my hope that we can enact this bill in the 108th Congress, so that Judge Browning can witness this much-deserved tribute to his lifetime of public service.

Judge Browning's achievements would be fittingly acknowledged by naming the historic federal building at Seventh and Mission streets in his honor. As one of his supporters said, "A great and sturdy courthouse needs the name of a great and sturdy judge." I invite my colleagues to cosponsor the "James R. Browning United States Courthouse" bill.

SOUTH MAUI COASTAL PRESERVATION ACT OF 2003

HON. ED CASE

OF HAWAII

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. CASE. Mr. Speaker, I rise today to introduce a bill directing the Secretary of the Interior to undertake a study to determine the suitability and feasibility of designating and acquiring lands located along the southern coast of the island of Maui as a National Seashore, National Recreation Area, National Monument, National Preserve, or other unit of the National Park Service.

The study area covered by the proposed South Maui Coastal Preservation Act of 2003 includes lands from and including the 'Ahihi-Kinau Natural Area Reserve to Kanaloa Point, a distance of approximately six miles.

The area is rich in archaeological, cultural, historical, and natural resources. Important sites in the proposed park area contain remnants of dwellings, heiau (places of worship), fishing shrines, platforms, enclosures, shelters, walls, graves, and canoe hale (houses) that date back as early as 1100 A.D. This portion of the southern coast is also the home of unique native plants and animals, some of which are endangered.

The County of Maui passed Resolution 00–136 on October 6, 2000, expressing its support for having this area designated as a National Park. The Hawaii State House and Senate also passed bills in support of having the area managed by the National Park Service. Both these resolutions were in support of my predecessor, Congresswoman Patsy T. Mink's bill, H.R. 591, introduced in the 107th Congress, to study the feasibility of designating the more limited area from Keone'o'io to Kanaloa Point as a National Park.

An initial reconnaissance survey by the NPS indicated that the resources deserved protection but stated that the more limited area was not appropriate for a National Park because most of the land was owned by the state. However, I believe the expressions of support for NPS control of the area by the County and State offer a firm basis for moving forward. Therefore, I have included a provision in my bill to ensure that the proposed study includes consultation with the State of Hawaii to assess the feasibility of transferring some or all of the State lands in the study area to the federal government.

The State of Hawaii has been unable to effectively manage and protect these important resources due to lack of funds. Operators of four-wheel drive vehicles are unknowingly destroying valuable resources at this site due to lack of supervision, signage, and cultural interpretation materials. Further, this pristine coastline lies directly in the path of development and, absent action, too soon will be lost forever.

This is a site of national significance, which deserves the level of protection only the National Park Service can provide. I urge my colleagues to support this bill.

PERSONAL EXPLANATION

HON. FRANK W. BALLANCE, JR.

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. BALLANCE. Mr. Speaker, I was unavoidable detained on official business and was not present for rollcall votes Nos. 634 through 637. Had I been present, on rollcall vote No. 634, I would have voted "yes", on rollcall vote No. 635, I would have voted "yes", on rollcall vote No. 636, I would have voted "yes", and on rollcall vote No. 637, I would have voted "Yes."

RECOGNIZING GENE ARGO OF HAYS, PRESIDENT OF MIDWEST ENERGY

HON. JERRY MORAN

OF KANSAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. MORAN of Kansas. Mr. Speaker, I rise today in recognition of a Kansan, Mr. Gene Argo, for his commitment to excellence and his devotion to service. This year, Mr. Argo will retire as president of Midwest Energy, based in my hometown of Hays, Kansas.

A true man of the west, Gene Argo drew many of his life lessons from his youth in Texas, including a profound love of nature and a respect for his fellow man. An avid bareback rider, Gene has learned that, through hardship and in the face of failure, you must always get back on your horse.

For the past decade, Mr. Argo has tirelessly devoted himself to the Midwest Energy Corporation. As president and general manager, he has guided the success of the company since 1992. Through his efforts, Midwest Energy has grown to serve 40 counties in western Kansas. As president, Gene Argo is respected by his employees not only because of his work ethic but because he respects his employees in turn.

Mr. Argo's passion for progress has also made a profound difference in his community. In Hays, Gene Argo served on various civic and industry organizations, including the board of directors of the Hays Medical Center and the Hays Medical Center Foundation. The community of Hays has also benefited under Mr. Argo's leadership as chairman of the Ellis County Economic Development Coalition and the Ellis County United Way. The growth of Ellis County is a testament to his vision and direction.

Gene Argo has also invested a great deal in the future of the State of Kansas. He supports Kansas youth as a member of the Kansas 4–H Foundation and also serves on the board of the Kansas Wildscape Foundation. An ardent hunter and sportsman, Gene is dedicated to preserving Kansas' natural beauty. As a small token of Kansas' appreciation, Mr. Argo was selected as the Leadership Kansas Alumnus of the Year in 2002.

In light of his many efforts and achievements, his family comes first. Gene and his wife Linda raised three children and are proud grandparents of three grandchildren.

Respected for his motivation and leadership, his employees will miss his starched shirts and smiles upon his retirement. I join his friends and family in extending to him my best wishes in all of his future endeavors.

TRIBUTE TO MATTIE MARIE FRANKLIN MARSHALL

HON. EDDIE BERNICE JOHNSON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I pay tribute today to one of Texas' truly outstanding citizens, Mattie Marie Franklin Marshall. As we recognize her 70 years of service to our State's education and her multitude of contributions to our community, I would like to take a moment to reflect on the remarkable achievements of this great woman.

Mattie Marie Franklin Marshall has devoted her entire life to the great State of Texas. Her life has been spent serving her fellow man—teaching, counseling, leading, advising, guiding, and nurturing.

She was born in Washington, Texas. Her father passed away when she was only two, but her mother watched her work her way upward despite many difficult obstacles.

Mattie continued the legacy of her sisters Ellie O. Laster, Anna M. Taylor, and Susie L. Jingles by becoming an educator. She began her adult life by working hard and knew success meant accepting life's challenges. She remained an educator for 35 years until she retired from the school system in 1977.

Following her retirement, Mattie broadened her public service from the school system to the greater community.

She was actively involved in the Girl Scouts of America, Young Women's Christian Association, the Friendly Neighborhood Club, Philodendron Garden Club, the Chanelle Club, and a Life Member of the Erma D. Leroy Club.

One of the highlights of her life was the organization of Fifth Ward Baptist Church. She was a founding member of the committee that organized the church and served as its first recording secretary. She has served her church with dedication for the last 59 years. In honor of her tireless efforts on behalf of the Fifth Ward Baptist Church, its library was renamed the Mattie M.F. Marshall Library in June 2003.

Just as significant as all of Mattie's achievements is the spirit of community service she represents. Her willingness to help individual community members of our society as a whole is what makes her especially deserving of our recognition and praise.

The spirit of service she actively portrays is something we see far too little of in this society. And we all would do well to follow the shining example that Mattie Marshall has given us.

I know that Mattie will continue to play an important role in our community for years to come, and that America will continue to benefit from her dedication and service.

Mr. Speaker, I urge you and my colleagues in the U.S. House of Representatives to join me in saluting Mattie M.F. Marshall and in applauding this remarkable citizen for all she has done, and for all she has meant to those of us whose lives she has touched.

AMERICAN DIABETES MONTH

HON. JOE BACA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. BACA. Mr. Speaker, I rise in support of American Diabetes Month.

In order to combat this deadly disease, we must focus on prevention, education and diet. Diabetes is the fifth-deadliest disease in the nation.

In California, there are about 2 million people with this disease. In my home county of San Bernardino over 100,000 have been diagnosed.

While this disease affects people of all walks-of-life, Hispanics are particularly vulnerable. Hispanics are almost two times as likely to develop Diabetes as non-Hispanic Whites. Twenty-four percent of Mexican-Americans in the United States currently have diabetes. Almost two million Hispanics struggle with the disease.

I don't have diabetes but my parents, my brother and my brother-in-law did. My father died of diabetes along with my brother. They didn't take care of it. We had a large family and could not afford health care.

Growing up, we ate what we could afford and too much of our diet contained foods like tortillas and frijoles that cause health problems and can eventually lead to diabetes. There was no health education or awareness. They didn't know how to take care of their diabetes. When they were diagnosed with diabetes they ignored it and it cost them their lives.

Fortunately, this disease can often be prevented.

We must educate our children and communities about the dangers of this disease. That is why American Diabetes Month is so important. We need to teach children prevention. The lifestyles they adopt today will carry over into their adult years. We are placing children at risk when we allow them to come home day after day, play videogames, sit in front of the TV and snack on soda and chips. Children eat what their parents eat and can afford. Eating a diet of high sugary foods—like tortillas, rice, and chips—at every meal is teaching our children unhealthy habits.

To help educate our children and our communities I participated in an educational video with Edward James Olmos and Liz Torres. This video, which comes in English and Spanish, helps educate Hispanics and all Americans about the disease. Additionally, with the help of Congressman PUTNAM and CARDOZA, we recently introduced legislation that would allow schools across the country to serve fresh fruits and vegetables in school lunch programs. This will help children afford to eat healthy and stay healthy.

I have been active in leading the charge to restore food stamp benefits to hard working immigrants, so that their children may have access to the healthier foods that help prevent diabetes.

But it is not enough to just educate people. We also must make sure that preventative screening and medical services are affordable and available to all Americans.

One of the biggest problems in early prevention is financial. People do not have the resources to seek medical help so the problems escalate. In California, the cost of diabetes per person per year is approximately $13,243. If they have additional problems, like dialysis, syringes, medications, or other items, the cost goes up an additional $8,500. Now the cost is over $22,000.

The healthcare costs of a person with diabetes are about 2½ times higher than the average person's healthcare costs. How can an uninsured person in this country afford $22,000 when some don't even make that much in a year?

To help those that can't afford to take care of their diabetes, I have co-sponsored the Diabetes Prevention, Access and Care Act and the Access to Diabetes Screening Services Act. These bills will increase access to diabetes screening, treatment and prevention in minority communities and all communities that are affected by Diabetes.

In the spirit of American Diabetes Month, we must not only look to legislation to help those that suffer from diabetes but we must educate our communities. We must take a personal interest. We must become involved on a personal level.

American Diabetes Month is a great opportunity to educate all Americans on how to help prevent diabetes.

CONFERENCE REPORT ON H.R. 6, ENERGY POLICY ACT OF 2003

SPEECH OF

HON. JERRY F. COSTELLO

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mr. COSTELLO. Mr. Speaker, I rise today in support of H.R. 6, the Energy Policy Act of 2003 Conference Report. Completion of this energy bill is yet another step forward in our struggle for energy security and independence. A reliable and affordable energy supply is crucial to America's economic vitality, security, and quality of life.

While this final conference report is not perfect, we continue to make progress towards promoting energy conservation and efficiency; increasing the use of all domestic energy resources, including coal; improving energy infrastructure; and promoting the development of advanced energy technologies.

The combustion of fossil fuels is essential to our energy policy and must continue to be a part of a balanced energy plan for this country. Coal is absolutely critical to our nation's economic health and global competitiveness. Coal accounts for more than 50 percent of U.S. electricity generation, far ahead of nuclear power, natural gas, hydroelectric power, petroleum and other sources. There is no present alternative to coal to meet our energy needs. New and improved technologies hold the promise of far greater emissions reductions and increased efficiency.

Clean coal provisions are included in the final conference report that would assist in burning coal more efficiently and cleanly. These clean coal technology initiatives encourage development of new technologies for cleaner, higher efficiency coal combustion in new and established plants with the hope of achieving a healthier environment while maintaining jobs. America's substantial investment in clean coal technology creates 62,000 jobs and ensures Americans new electricity that is abundant, reliable, affordable and cleaner than ever before.

The bill includes a $1.8 billion authorization for the Secretary of Energy to carry out the Clean Coal Power Initiative, which will provide funding to those projects that can demonstrate advanced coal-based power generating technologies that achieve significant reductions in emissions. Further, the bill authorizes $1.422 billion for coal research and development. I fought hard for increases to coal within the fossil energy research and development budget and I was glad to see they were included in the final version.

Finally, the legislation includes a provision, which I authored, called the Clean Coal Centers of Excellence. Under this provision, the Secretary of Energy will award competitive, merit-based grants to universities that show the greatest potential for advancing new clean coal technologies. Southern Illinois University Carbondale (SIUC), which I represent, continues to be a leader in clean coal technology research, doing extensive work at its Coal Research Center. With funding and collaborative support from industry and government, SIUC has conducted long-term projects relating to surface mine reclamation, mine subsidence, coal desulfurization, coal characterization and combustion, coal residue management and utilization, coal market modeling, and environmental policy. Faculty, staff, and students in fields as diverse as engineering, science, business, education, law, and agriculture have contributed to the University's international reputation in coal research. It is well-positioned to be a potential recipient of the Clean Coal Centers of Excellence.

In addition to the clean coal provision, the bill contains provisions instrumental in helping increase conservation and lowing consumption. Included in this are ethanol provisions that are used as a replacement and additive for gasoline consumption. Under this legislation, ethanol use would increase, nearly tripling the current requirement. This is expected to increase the average price of corn paid to farmers 6.6 percent, or 16 cents per bushel and increase average net cash income to farmers by $3.3 billion over the next decade, or more than six percent.

This increased use of ethanol will save 1.3 billion barrels of oil by 2016, improve the trade deficit by $28.5 billion over 15 years, add $135 billion to the American economy by 2016 through increased agricultural demand and new capital spending, and generate $32 billion in income for American consumers over 15 years.

Mr. Speaker, this energy bill will shape energy policy for the next decade and beyond. I am glad coal and ethanol remain an integral part of our energy future and I urge my colleagues to support this legislation.

CONFERENCE REPORT ON H.R. 6, ENERGY POLICY ACT OF 2003

SPEECH OF

HON. DON YOUNG

OF ALASKA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mr. YOUNG of Alaska. Mr. Speaker, electron scrubbing is the only air control process that allows older power plants to meet the Clean Air Act Amendments of 1990 (CAAA) and the New Source Performance Standards (NSPS) while burning the least cost, highest energy fuel—high sulfur coal. The electron scrubbing process removes almost all the pollutants emitted from power plants burning high sulfur coal. In a single step, the electrons convert the pollutants into a high grade, agriculture byproduct.

The Department of Energy's (DOE) Chicago Operations Office (COO) has been briefed on the electron scrubbing project at Eagle Valley and has agreed to manage the program. However, DOE must first transfer $5 million in earmarked funds to the COO so the Director can immediately implement the program.

A letter of intent, dated April 16, 2002, from Greg Daeger, program manager for the electron scrubbing project at Eagle Valley, attests to the commitment and due diligence of Eagle Valley to implement the project pursuant to Congress' direction and intent.

Electron scrubbing uses high-energy accelerators for air pollution cleanup. DOE's COO has the technical management capability in accelerator-related programs and air pollution programs used in other DOE applications. This location is an ideal venue for the effective and successful oversight of the electron scrubbing program. The transfer of funds would allow COO to continue and expand its management of high technology air pollution programs in the area of high-energy electrons.

The energy bill directs DOE to "use $5,000,000 from amounts appropriated to initiate, through the Chicago Operations Office, a project to demonstrate the viability of high-energy electron scrubbing technology on a commercial-scale electrical generation using high sulfur coal." Because it has both the authority and capability to oversee this demonstration project, $5 million must immediately be transferred from DOE to COO.

RESOLUTIONS IN SUPPORT OF H.R. 2656

HON. LYNN C. WOOLSEY

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Ms. WOOLSEY. Mr. Speaker, today I am submitting for the RECORD resolutions in support of H.R. 2656 from cities in the California Bay Area. The resolutions are regarding the planned casino in my congressional district. The communities surrounding the proposed site are doing all they can to ensure that their voices are heard on this controversial issue and it is extremely important that all sides of the issue are given a platform to do so. I hope that H.R. 2656 is brought before the House for a vote in the near future.

RESOLUTION NO. 2003-220 N.C.S.

Whereas, the Petaluma City Council respects the rights of Native Americans to establish and have recognized tribal sovereignty, and to secure lands under their jurisdiction; and,

Whereas, under the existing federal legislative requirements, there is no provision for coordination of gaming proposals or associated major tribal enterprises with established and approved off-reservation local or regional planning law and General Plans in any timely and meaningful way; and,

Whereas, developments of great magnitude are being proposed which are dependent upon local and regional public infrastructure, including highways, streets, transit systems, water, wastewater and energy systems and resources, affordable housing, and emergency services, both built and yet to be built; and,

Whereas, without appropriate mitigation, the developments proposed are very likely to have substantial negative impacts and place substantial burdens on the public infrastructure with a substantial burden falling upon existing and future taxpayers, residents, visitors and businesses; and,

Whereas, with the rapid construction of tribal gaming facilities, local governments are experiencing serious, adverse impacts related to off-reservation economic, environmental, health and safety issues; and,

Whereas, the current conditions placed on Indian gaming to achieve and preserve the environmental, public safety, and public health objectives of both state and local government have been insufficient to prevent such adverse impacts; and,

Whereas, when California voters approved Proposition 1A (Indian Gaming) in March of 2004 as a means of supporting the laudable goal of Indian economic development and self-sufficiency, they were not aware that such approval would allow Nevada developers to seize prized off-reservation environmental resources for intense development without regard to locally approved general plans or any meaningful environmental review or protection; and,

Whereas, under the provisions of Proposition 1A and the Tribal-State Compact, local communities have not been granted effective input into the development of proposed tribal casinos that threaten their rights and the State appears to have no effective redress for significant environmental impacts these gambling casinos impose on local communities; and,

Whereas, on February 6, 2003, the California State Association of Counties has adopted a policy document that includes seven principles of critical concern to counties, including a principle that tribes and local governments enter into binding and enforceable local agreements for the mitigation of off-reservation impacts that arise from a local gaming project; and,

Whereas, approximately 360 acres of prime agricultural lands west of Rohnert Park are presently in imminent danger of being withdrawn from County land use control and placed into trust for the purposes of casino development—including an extensive gaming complex, with a 300 room hotel, spas, restaurants, a 2000 seat entertainment venue, parking and other support services, by Station Casinos, a Las Vegas-based developer and the Federated Indians of the Graton Rancheria (Graton Tribe); and,

Whereas, Station Casino and the Graton Tribe's gaming proposal will have substantial negative impacts upon the federal highway system (US Highway 101), upon which it is dependent for bringing its customers into and out of the region; on local and regional roads; to the Santa Rosa Plain groundwater aquifer, to water quality, along with unknown local and regional fiscal impacts; and,

Whereas, the proposed Graton Tribe casino site is proposed on property whose zoning is inconsistent with the Sonoma County General Plan (on prime agricultural land, in the community separators and outside Rohnert Park's Urban Growth Boundary), within the Laguna de Santa Rosa's flood plain and within critical wetland habitat for several federally endangered species; and,

Whereas, the proposed Graton Tribe casino proposal is not subject to a thorough CEQA-like process that identifies fiscal and environmental impacts then to be mitigated by the Graton Tribe, nor is administrative consideration by the Department of the Interior required to determine if the use of this land, sought for gaming, will have significant detrimental impacts on the neighboring communities which outweigh the benefits to the tribe; and,

Whereas, the Graton Tribe was restored in 2000 based, in part, on its promise not to engage its Indian casino gaming: Now, therefore, be it

Resolved, That the Petaluma City Council strongly supports the revisions in federal legislation [HR 2656/S1342] introduced by Representative Woolsey and Senator Feinstein. The Petaluma City Council also urges all members of the Senate and House of Representatives to support these important statutory changes and immediately move for their passage; and be it further

Resolved, That the Petaluma City Council supports the California State Association of Counties policy document regarding compact negotiations for Indian Gaming; and requests that the Graton Tribe follow the principles contained therein; and be it further

Resolved, That the Petaluma City Council, based on the information currently available, strongly opposes the creation of a gambling casino resort on any site that is inconsistent with the local land use planning and zoning policies; and be it further

Resolved, That the Petaluma City Council calls on the Board of Supervisors of the County of Sonoma, in all negotiations with the Tribe concerning creation of a gambling casino resort, to safeguard the vital and legitimate interests of all Sonoma County citizens by requiring that the following minimum standards be included in a binding, legally-enforceable Memorandum of Understanding with the Tribe:

1. The proposed casino/resort project must be subject, at a minimum, to the same level of environmental review as would be required by the pending Federal legislation; and

2. The proposed casino/resort project must be subject to the principles of the California State Association of Counties policy document regarding compact negotiations for Indian Gaming; and

3. Even though the pending federal legislation does not require environmental mitigation, in order to ensure that the citizens of Sonoma County do not bear the costs associated with the impacts of the casino/resort, the Tribe must agree to mitigate, and must in fact mitigate, all environmental impacts caused by its project; and

4. In order to prevent Sonoma County cities from having land within their jurisdiction exempted from local land use control by reason of future acquisition by the Graton Tribe, the Tribe must agree that it will take NO OTHER LAND anywhere in Sonoma County or in any adjacent county into tribal trust NOW OR IN THE FUTURE.

5. The proposed casino/resort project must be subject, at a minimum, to the same level of public safety review and enforcement as would a private developer.

HELP PARENTS GET REAL JOBS, REAL WAGES, AND REAL SUCCESS

HON. JANICE D. SCHAKOWSKY

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Ms. SCHAKOWSKY. Mr. Speaker, today I am introducing a bill, the Business Links Act of 2003, that would provide needed resources to parents facing serious barriers to employment. The bill would provide grants for transitional jobs programs in order to support State efforts to help TANF recipients find work. Transitional jobs can provide the right combination of support, work, and vocational training and have the potential to turn many job seekers into permanent wage earners.

I would like to thank my colleagues who have joined me as original cosponsors on this bill. I would also like to commend Senator JEFF BINGAMAN who has already introduced companion legislation, S. 786, in the Senate.

This legislation would replace the TANF bonus grants currently provided to States and instead provide $200 million for each of fiscal years 2005 through 2009 for grants to be awarded to nonprofit organizations, local workforce investment boards, States, localities, and Indian tribes. The grant funds could be used either to promote business links by improving employee wages and job skills in partnership with employers or to provide fully subsidized wage-paying jobs to individuals who have been unemployed because of limited skills or other barriers. The legislation also includes worker protection provisions that, among other things, prohibit transitional job participants from displacing or replacing existing workers or positions and provide participants the same worker protections that all other workers receive. Parents who are currently receiving or have recently received Temporary Assistance for Needy Families (TANF), parents who are at risk of needing TANF, individuals with disabilities, and unemployed, noncustodial parents who are having difficulty meeting their child support obligations would be eligible to participate in transitional jobs programs.

Transitional jobs programs would provide intensive case management and access to needed support services such as vocational skills training, basic education, job placement services, and child care to all participants. Transitional jobs programs, which are aimed at helping those who have limited English proficiency and other barriers to employment, can be particularly effective for the hardest to serve welfare recipients. Program participants must work 30 to 40 hours a week, unless they have a child under the age of six, and participation is time limited to between six and 24 months. The goal of transitional jobs programs is to prepare and help participants find unsubsidized, permanent jobs. Because of the individual attention given to each transitional job holder, various programs across the country have proven very successful in achieving that goal. From January 2000 to July 2001, a Chicago program known as Transitional Community Service Jobs placed over 75 percent of its participants in unsubsidized jobs, more than one-third of which paid over $8.00 an hour.

Many cities and communities across the country have implemented transitional jobs programs because they understand the importance of helping those facing serious barriers to employment, and they recognize the long-term benefits of investing in a future workforce that is well-trained and able to contribute to the economy. However, because the Welfare-to-Work funds that help support transitional jobs programs are nearly exhausted and because of tight State budgets, many of those successful programs are at risk. This bill would provide a more stable funding source to allow many of these programs to survive, enable the development of new programs, and require a rigorous evaluation of funded programs.

I am proud that this bill would help those who are having a difficult time supporting their children by providing them with resources and skills that will help them immediately, as well as sustain them in the future. I urge my colleagues to join me in cosponsoring the Business Links Act of 2003.

EXPRESSING SENSE OF HOUSE REGARDING COURAGEOUS LEADERSHIP OF UNIFIED BUDDHIST CHURCH OF VIETNAM

SPEECH OF

HON. SHEILA JACKSON-LEE

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Ms. JACKSON-LEE of Texas. Mr. Speaker, I am here today as a staunch supporter of freedom of religion. While we have made progress in our own country, there are other areas in the world which still persecute unjustly. Buddhism has a 2,000-year tradition in Vietnam and the Unified Buddhist Church of Vietnam (UBCV) is an heir to this tradition. In 1981, the Government of Vietnam declared the UBCV, one of the largest religious denominations in the country, illegal, confiscated its temples, and persecuted its clergy for refusing to join the state-sponsored Buddhist organizations.

The Government of Vietnam has often imprisoned UBCV clergy and subjected them to other forms of persecution; the Patriarch of the UBCV, the 85-year-old Most Venerable Thich Huyen Quang, has been detained and restrained for more than 2 decades in isolated areas of Vietnam. The Vietnamese Government has held the Most Venerable Thich Quang Do, the Executive President of the UBCV and his deputy, the Venerable Thich Tue Sy, in various forms of detention since 1977. In 1978, he was tortured to death in a reeducation camp.

Many other leading UBCV figures have been detained and harassed. Evading tight surveillance, others have fled to Cambodia to escape religious repression and harassment.

Vietnam has acceded to international treaties that prohibit the forced repatriation of UNHCR-recognized refugees and that protect the right to faith, belief, and practice.

Vietnam's constitution protects the right of religious belief, yet on October 8, 2003, Vietnamese authorities initiated a tense standoff following the meeting, where police stopped a vehicle carrying the UBCV's new leadership and subsequently detained the eleven passengers. According to reports by the United States State Department, the United States Commission on International Religious Freedom, and the European Union, the Socialist Republic of Vietnam systematically limits the right of religious organizations to choose their own clergy.

During the 107th Congress, I along with my colleagues in the House of Representatives, passed H.R. 2833, the Vietnam Human Rights Act, on September 6, 2001, which noted the persecutions faced by various members of the UBCV over the past 25 years. Because of systematic, egregious, and ongoing abuses of religious freedom, the United States Commission on International Religious Freedom recommended that the President of the United States designate Vietnam as a "country of particular concern" under the provisions of the International Religious Freedom Act of 1998.

Today, I am pleased to join the House of Representatives in congratulating the new leadership of the Unified Buddhist Church of Vietnam and urging the Government of Vietnam to respect the right of all independent religious organizations to meet, worship, operate, and practice their faith in accordance with Vietnam's own constitution and international covenants to which Vietnam is a signatory.

We are joined by our allies in being committed to promoting religious freedom in Vietnam, and, in furtherance of this goal, and urge the implementation of the recommendations of the United States Commission on International Religious Freedom.

We ask that the United States Embassy in Vietnam to closely monitor cases of abuse of religious belief and practice, routinely visit detained clergy members, especially those in need of medical care, and report to the Congress on specific measures taken to protect and promote religious freedom in Vietnam.

HONORING SEEDS OF PEACE FOR ITS PROMOTION OF UNDERSTANDING AMONG YOUTH FROM REGIONS OF CONFLICT

SPEECH OF

HON. SHEILA JACKSON-LEE

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Ms. JACKSON-LEE of Texas. Mr. Speaker, I am pleased to be here today to honor such a valuable program. Seeds of Peace was founded by John Wallach in 1993. It is a program designed to bring together young people from regions of conflict to study and learn about coexistence and conflict resolution.

The original focus of Seeds of Peace was to bring Israeli, Palestinian, Jordanian, and Egyptian youth together, the program has since expanded to involve youths from other regions of conflict, including Greece, Turkey, Cyprus, the Balkans, India, Pakistan, and Afghanistan.

Seeds of Peace provides young people with the opportunity to study, learn and interact at a summer camp in Otisfield, Maine, and also through regional programs at the Jerusalem Center for Coexistence. Seeds of Peace works to dispel fear, mistrust, and prejudice, which are root causes of violence and conflict, and to build a new generation of leaders who are committed to achieving peace.

Seeds of Peace has been successful at revealing the human face of those whom youth have been taught to hate, by engaging campers in both guided coexistence sessions and ordinary summer camp activities such as living together in cabins, sharing meals, canoeing, swimming, playing sports, and creative exploration through arts and computers.

The Arab-Israeli conflict is currently at a critical juncture, and sustained progress towards peace depends on the emergence of a new generation of leaders who will choose dialogue, friendship, and openness over violence and hatred.

In addition to Seeds of Peace, I am a cosponsor of Global Family Day, a House Resolution that seeks to raise awareness of children by having a one day holiday every year dedicated to family, community and sharing global traditions.

Similar to Global Family Day, Seeds of Peace provides year-round opportunities for former participants to build on the relationships they have forged at camp, so that the learning processes begun at camp can continue back in the participants' home countries, where they are most needed.

Programs such as these bring us closer to our foreign policy goals of raising our future leaders to think about global issues, and see the neighbors as other children like them, rather than enemies.

Both Global Family Day and Seeds of Peace are strongly supported by participating governments and many world leaders. It is especially important to reaffirm that youth must be involved in long-term, visionary solutions to conflicts perpetuated by cycles of violence. I am glad we have the opportunity to honor Seeds of Peace, for the work it has accomplished thus far, and for the impact it will have for generations.

COMMENDING AFGHAN WOMEN FOR THEIR PARTICIPATION IN AFGHAN GOVERNMENT AND CIVIL SOCIETY

SPEECH OF

HON. SHEILA JACKSON-LEE

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Ms. JACKSON-LEE of Texas. Mr. Speaker, I am pleased to be here today to support H. Res. 393, commending Afghan women for their participation in Afghan government and civil society, encouraging the inclusion of Afghan women in the political and economic life of Afghanistan, and advocating the protection of the human rights of all Afghan women in their Constitution.

As we are all aware, the women of Afghanistan suffered horrible tragedies under the Taliban regime. The Afghan people have since rejected the Taliban and are in the process of building a free and democratic republic and repairing the damage. These efforts have improved the daily lives of all Afghan citizens, particularly Afghan women, children, and refugees.

More Afghan girls are attending school than ever before in the history of Afghanistan. Millions more adult women are either returning to school to make up for being forbidden to attend school during the Taliban regime, or taking vocational training classes to prepare for the job market. Now, women in Afghanistan are able to work outside the home and hold positions in all levels of government and in private sector organizations, something unheard of during the Taliban regime.

In order for women to fully participate in Afghan society, they must have the right to vote, the right to run for office, equality of opportunity, and access to health care, education, and employment. This is why I am joined by my colleagues today to advocate that women's human rights should be guaranteed in the Afghanistan Constitution.

I have traveled to Afghanistan and seen the plight of these women. I have heard their stories of hardships and their wishes for a better life for them and their children. I support this resolution because I know how timely and vital it is for the future of Afghani women to have these rights. The United States is actively involved in encouraging the full inclusion and participation of Afghan women in the political and economic life of their country, and must continue to do so throughout the reconstruction process. We must continue to urge the participation of women in the continued efforts toward a lasting peace in Afghanistan.

RECOGNIZING THE 5TH ANNIVERSARY OF THE SIGNING OF THE INTERNATIONAL RELIGIOUS FREEDOM ACT OF 1998

SPEECH OF

HON. SHEILA JACKSON-LEE

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today in strong support of H. Res. 423

which properly recognizes the 5th anniversary of the signing of the International Religious Freedom Act of 1998. The International Religious Freedom Act is an essential demonstration of our commitment to observing religious freedom for all human beings throughout the world.

Mr. Speaker, this Nation was built by those who escaped persecution in their own homelands. Today we continue to see people throughout the world who still can not freely practice their faith. The International Religious Freedom Act created the Office of International Religious Freedom in the Department of State and the United States Commission on International Religious Freedom. This has resulted in a greater awareness of religious persecution both in the United States and abroad. It is vital in order to protect the principles of freedom that this nation was founded on, that we protect the ability of each person in the United States to freely observe their religious practices. This also means that we as a Nation must push other countries throughout the world to meet this same ideal standard on religious freedom.

Mr. Speaker, it is truly tragic that so many people throughout the world have been murdered, raped, tortured, and brutalized simply because of the faith they belong to. This type of religious hatred must be countered strongly by this body. We can not insist on having full religious freedom for our own citizens and then turn a blind eye to the plight of oppressed people throughout the world. The International Religious Freedom Act was a step in the positive direction of eliminating this global scourge. Religious freedom is a fundamental human right as affirmed by numerous international declarations and covenants, as well as by the United Nations General Assembly. I stand proud of this body's work to pass the International Religious Freedom Act five years ago and I remain hopeful that we will continue with further efforts to fight religious intolerance.

TORTURE VICTIMS RELIEF REAUTHORIZATION ACT OF 2003

SPEECH OF

HON. SHEILA JACKSON-LEE

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Ms. JACKSON-LEE of Texas. Mr. Speaker, the Torture Victims Relief Reauthorization Act of 2003, H.R. 1813, would authorize appropriations for domestic and foreign torture victims treatment centers and for the United Nations Voluntary Fund for Victims of Torture.

In many places around the world, the survivors of torture have to grapple with the lingering effects of their torture alone. In the United States, we have 20 torture treatment centers that provide treatment and care for torture survivors. These centers help the survivors to overcome debilitating psychological and physical problems such as post traumatic stress disorder, depression, anxiety, limbs rendered useless, chronic pain, and excessive guilt. Moreover, torture assaults the victim's core values as a human being, including his humanity and his sense of trust in himself and in the world around him. The treatment centers also assist the victim in restoring these values and in getting on with his life.

Although funding has been increasing, it still remains insufficient to meet the treatment needs of torture survivors. The Torture Victims Relief Reauthorization Act of 2003 would help address these funding issues by authorizing the appropriation of $37 million for the treatment and care of torture survivors both in the United States and overseas. This would include $20 million to fund United States treatment centers, $11 million to fund treatment centers overseas, and $6 million to fund the United Nations Voluntary Fund for Victims of Torture.

With the additional funding, it is estimated that the American centers would have the capacity and ability to serve an additional 2,800 torture survivors per year.

The overseas funding would serve dual purposes. In addition to providing resources needed for treatment, it also would provide resources that the centers need to combat torture in their respective countries, some of which continue to have serious problems with torture.

I urge you to vote for H.R. 1813, the Torture Victims Relief Reauthorization Act of 2003.

HONORING VICTIMS OF CAMBODIAN GENOCIDE THAT TOOK PLACE FROM APRIL 1975 TO JANUARY 1979

SPEECH OF

HON. SHEILA JACKSON-LEE

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today in strong support of H. Con. Res. 83 which honors the victims of the Cambodian Genocide. Truly, this recognition is overdue for a people who suffered for so long under the brutal dictatorship of Pol Pot. It is unfortunate that the plight of the Cambodian people has not been more recognized in the United States. I want to thank Rep. MILLENDER-MCDONALD for introducing this legislation which affects not only the large Cambodian population in her district, but so many Cambodian people throughout the world who were forced to leave their homeland due to the brutalization they faced.

Mr. Speaker, the fact that between April 1975 and January 1979, up to 3 million Cambodians were deliberately and systematically killed shows the depth of suffering that the Cambodian people had to endure. Not only were scores of people brutally killed but they had to suffer through a vicious system of forced labor. In 1975, Pol Pot led the Communist guerilla group, the Khmer Rouge, in a large-scale insurgency in Cambodia that resulted in the removal of Cambodians from their homes and into labor camps in an attempt to restructure Khmer society. The Khmer Rouge maintained control by mass public tortures and executions. Families were separated. Men, women and young children were sent into labor camps and forced to do strenuous farm work with very little food. Famine and disease were epidemic while health care was non-existent. Literally these Cambodians were put through hell in order to maintain Pol Pot's hold on the nation.

We as a body must try to ensure that events like the Cambodian Genocide never go unnoticed again. Too many lives were lost and many of those who were killed were simply disposed of by the regime, in their effort to ensure that the victims would be forgotten. This resolution demonstrates that the victims of the Cambodian Genocide will not be forgotten by this Congress or by anyone of conscious. Many of those who suffered during the Cambodian Genocide are now residing in the United States. They are a living testament to the fact that brutality can not crush the spirit of even the most oppressed people.

OVERSEAS PRIVATE INVESTMENT CORPORATION AMENDMENTS ACT OF 2003

SPEECH OF

HON. SHEILA JACKSON-LEE

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today as a supporter of S. 1824 which amends the Foreign Assistance Act of 1961 to reauthorize the Overseas Private Investment Corporation. It is important that we as a Nation continue these efforts to invest abroad. This resolution will continue a successful program of overseas investment that was begun more than four decades ago.

I am also encouraged by the provisions in this resolution that outreach to minority-owned and women-owned businesses. The Overseas Private Investment Corporation will collect data on the involvement of minority-owned and women-owned businesses. Indeed, this outreach is needed as minorities and women continue to lag behind their counterparts when it comes to establishing businesses. This economic disparity often results in social inequality that this body must continue to work against. We have made efforts to support these same businesses in the United States and we must make similar efforts abroad.

I want to thank Chairman HYDE and Ranking Member LANTOS for their work in reauthorizing this important endeavor. In the future, I hope we will continue to come together as a body to support increased overseas investment especially among the disenfranchised.

SENATE—*Saturday, November 22, 2003*

The Senate met at 10 a.m. and was called to order by the President pro tempore [Mr. STEVENS].

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us Pray.

O God our God, in our more honest moments we must admit that because a chaplain prays or because we bow our heads it does not necessarily mean that we seriously desire Your presence. Yet invited or not, You are here.

Lead us to such a knowledge of You that our actions will be supported by belief. If our eyes have been closed to Your blessings, open them. Make us ever aware of Your providential movement in our lives.

We pray today, for the Members of this body, its officers, and its servants. Help them to remember that You govern in the affairs of humanity and that the hearts of the world's leaders are in Your hands. Give them the wisdom to permit You to direct their paths. Send Your power among us and give us Your peace. We Pray in Your strong Name. Amen.

PLEDGE OF ALLEGIANCE

The PRESIDENT pro tempore led the Pledge of Allegiance as follows:

> I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. FRIST. This morning the Senate will begin debate on the Medicare conference report. Senators who wish to make statements on this historic bill are encouraged to come to the floor during today's session. If possible, we will need to be in session tomorrow, Sunday, to continue debating the Medicare bill. It is my hope that we will be able to schedule a vote on the conference report for Monday. I will continue to work with the Democratic leadership to reach an agreement for a final vote. I do not anticipate votes this weekend. However, Senators should prepare for votes early on Monday.

At this point, I announce that no votes should occur any time until afternoon Monday, and we will be in discussion with the Democratic leadership as to the appropriate time for votes over that day.

RECOGNITION OF THE MINORITY LEADER

The PRESIDENT pro tempore. The minority leader is recognized.

Mr. DASCHLE. Mr. President, it is my understanding that we already have an agreement where we will alternate in recognition of Senators on either side of the aisle as we debate the Medicare bill. We have several hours of requests already from our colleagues. I will not propound a unanimous consent request, but I might propose that we consider limiting at least comments today on the floor to 15 minutes to accommodate as many Senators as possible.

I know there are a lot of Senators who are going to be attempting to schedule their day around their opportunity to come to the floor. If we have that understanding, if there are four or five in line, it would seem to me it would work. As I say, I will talk to the majority leader about that. I do hope Senators on this side of the aisle will call the cloakroom or call Senator REID or myself to let us know their intentions with regard to speaking so that we can coordinate the effective use of time.

As the majority leader has already announced, we will be in tomorrow as well. So Senators will have an opportunity to speak throughout the weekend in addition, of course, to Monday. We will work with him to accommodate all Senators who wish to speak. We will work on a time certain for a vote at a later date.

I yield the floor.

The PRESIDENT pro tempore. The majority leader.

Mr. FRIST. Mr. President, as our colleagues are well aware, the Democratic leader and I have set aside all day today, and we can stay as late today as necessary. We initially said around 5, but this issue is so important, and there are so many people, as the distinguished leader implied, who do want to come to the floor, and it is the only opportunity for some to come, therefore, we are going to spend all day today on it, as much time tomorrow as necessary, and in all likelihood Monday morning.

I hesitate a little bit trying to limit people to 15 minutes because I do know some people have 30 minutes of comments, but I think that we should stress keeping the comments to as short a period as possible to make their points because we have a lot of people on both sides of the aisle who have called and said we are going to be there all day Saturday; we want to be able to participate.

With this many Senators, it does mean that people need to keep their remarks fairly short. I understand we will be alternating back and forth. We do want to keep the time equally divided so that both sides will have the opportunity over the course of the day to speak. Then if there are a number of people who have waited and are unable to talk today or tonight, if we need to go into later tonight, we can come in a little bit earlier tomorrow or stay longer tomorrow as well.

Again, I appreciate the cooperation of all of our colleagues because it is not customary for us to be in session on Saturday, and certainly not on Sunday, but in order to pay respect to people's schedules over the holidays and to address this very important issue, we have elected to spend all day today and possibly tomorrow.

The PRESIDENT pro tempore. The minority leader.

Mr. DASCHLE. I ask the majority leader if it is his intention to set aside a moment of silence this afternoon in commemoration of the 40th anniversary of the assassination of President Kennedy. It is my understanding that some thought had been given to that time, and I think it would be helpful, if that time has been set aside, if we could make that announcement in the interest of all Senators.

Mr. FRIST. Mr. President, I believe the time will be set aside at 12:30 today. If there is a change in that particular time, we can make that announcement very shortly.

Mr. President, I do have a statement on an unrelated issue, which I can do now or we can proceed.

RESERVATION OF LEADER TIME

The PRESIDING OFFICER. Under the previous order, the leadership time is reserved.

ASBESTOS LITIGATION CRISIS

Mr. FRIST. Mr. President, before entering into the debate on Medicare, I will comment on an issue that the Democratic leader and I have worked on very aggressively over the last several months, and it relates to the current asbestos litigation crisis. The current asbestos litigation system is broken, and it is clear that we in this Congress should fix it. We have an obligation, a real responsibility, to fix it.

I would like to lay out what our plans are to resolve this asbestos litigation crisis early next year. We have made very good progress toward enacting Chairman HATCH's FAIR Act, which is the Fairness in Asbestos Injury Resolution Act. I have made it a personal priority that the Senate participate aggressively in resolving this challenging issue.

Why do we call what is occurring today a crisis? First, the events that are occurring are overwhelming. The torrent of asbestos litigation has wreaked havoc on asbestos victims, on American jobs, and this havoc has extended into our economy.

Over 600,000 claims have been filed and those 600,000 claims have already cost about $54 billion in settlements, judgments, and litigation costs. Yet even after 600,000 claims and $54 billion, the current asbestos tort system has become nothing more than a litigation lottery at this point in time.

Why do I say that? First, a few victims receive adequate compensation but far more suffer long delays for what ends up being unpredictable rewards—also, if one looks at the data, inequitable awards. Some deserving victims do not receive anything at all. It is a system that there is only one real consistent winner, and that is the plaintiffs' trial lawyers.

I say that because of all of these settlements. They are taking as much as half of every dollar that is awarded to the victims.

If you look to the future, it is a problem that only gets worse. It is accelerating in the negative aspect. But if you look to the future, it gets even worse.

Future funds for asbestos victims are threatened because company after company after company is going bankrupt. About 70 companies have gone bankrupt, and about a third of those have gone bankrupt in the last 2½ to 3 years. The pace of bankruptcies of very large companies with thousands and thousands of employees is accelerating.

Again, this is an issue for us to address. That is why I want to set a schedule for that in a few minutes.

Companies such as Johns Mansville, bankrupt; Owens Corning, bankrupt; U.S. Gypsum, bankrupt; and, W.R. Grace, bankrupt: these are large reputable companies that have gone bankrupt because of this crisis with the associated job losses.

Now the hunt is on to get new targets and to go out and sue. People say this is easy money, and the easy way is to go out in terms of bringing a lawsuit and filing a lawsuit. Thus, the hunt is on for new targets to sue. What is unfair and inequitable is that many of these lawsuits have no connection at all to asbestos. If you really look at the connection between asbestos and the victims, it is just not there.

Victims aren't the only ones who suffer but also the workers of these companies that are going bankrupt suffer. Asbestos-related bankruptcies spell doom for these workers' jobs; thus, their families, and, of course, incomes and retirement savings. Already, these lawsuits have cost more than 60,000 Americans their jobs. For those who lose their jobs, the average personal loss in wages over a career is as much as $50,000, and that doesn't include the loss of retirement wages or the loss of health benefits. Workers at asbestos-related bankrupt firms with 401(k) plans lost about 25 percent of the value of their 401(k) accounts because of this.

The economic reality of this crisis is not lost on my colleagues in this body. They understand that under the status quo the national asbestos crisis could cause our economy more than the savings and loan crisis of the 1980s and 1990s, and more than the Enron debacle or the WorldCom debacle. Member after Member from both sides of the aisle has voiced their agreement with the assessment of the Supreme Court that the system is broken and the Congress should fix it.

There is only one question: what can we do? Can we create a system better than the status quo? The answer is yes.

The FAIR Act—the Fairness in Asbestos Injury Resolution Act—has already made significant headway, and we look forward to progress today. Under the leadership of Chairman HATCH, it was passed by the Senate Judiciary Committee last July, and there have been ongoing discussions and negotiations since then.

I commend Chairman HATCH and the ranking minority member, Senator LEAHY, for their hard work on the bill.

I also want to recognize Senator SPECTER for his hard work in conjunction with Judge Becker.

I also want to note that my Democratic colleagues, organized labor, and other stakeholders have been deeply involved throughout the process. Led by Senator HATCH, bipartisan breakthroughs have been made on issues that previously have proved impossible to address, including such issues as—and there are many of them—the linchpin issue of the medical criteria that had proven historically to be so difficult and controversial.

In addition, agreements among stakeholders following the committee markup have resulted in even more modifications. The resulting bill creates a system that, while not perfect, is far superior to the current tort system for resolving asbestos issues.

I became deeply involved in the post-Judiciary Committee negotiating process, working in concert with Senator DASCHLE, as well as Chairman HATCH and Senators LEAHY, SPECTER, DODD, and CARPER, and some others on both sides of the aisle. We have made good progress. I know during the debate over this legislation all of the relevant issues have been unearthed. They have been exposed to public debate, and all parties have had an opportunity to get involved to contribute their points of view.

What emerged under S. 1125 and the current negotiations is a streamlined national trust fund for paying asbestos claimants quickly, paying them fairly, and paying them efficiently. The new system provides more certainty and efficiency for claimants, and more certainty and predictability for businesses.

Passing this bill will create enormous economic benefits. I say that because the certainty that flows from the bill will stimulate capital investment. It will also preserve existing jobs and create new jobs as well.

I had hoped that we would bring this bill to the floor before the end of this session, but we were unable to achieve that goal. Chairman HATCH and Senator LEAHY worked hard to resolve many difficult issues at the committee level. Senator DASCHLE and I, along with our staff, have continued to work with stakeholders to put more issues behind us over the past several months.

While there are several issues that remain outstanding, the core principles of an effective bill are now clear.

What are they?

First, the bill must create a trust fund that is capable of awarding adequate compensation to victims while providing more financial certainty and finality to the business community. The new funding proposal that I put on the table would generate payments that would exceed by $10 billion the expected funds which victims would receive if the current flawed tort system is left intact.

Second, the legislation must establish a schedule of claims values that will ensure victims consistent and equitable awards. We cannot tolerate the current system where payments can depend on where a plaintiff lives or which is capable of awarding only pennies for every dollar promised.

I am also prepared to consider further modest increases in claims values as requested by the Democrats and as requested by organized labor, provided that any new increase is targeted to the most severe disease categories where the relationship to asbestos exposure is most certain.

We must make sure, however, that lung cancer claims not caused by asbestos are not allowed to overwhelm the fund.

Third, the fund must be a nonadversarial program that ensures prompt payment of awards to eligible claimants while minimizing transaction costs, including attorney's fees. Care must be taken to ensure that the fund is established on an expedited basis, and adequate moneys are available to pay exigent claims from the outset.

Fourth, we must preserve the bipartisan medical criteria included in S.

1125 as reported by the Judiciary Committee. Only by ensuring the use of real diagnoses of asbestos-related illnesses can the fund avoid the pitfalls that plague the current mass tort system.

Fifth, and finally, asbestos victims should not bear the risk of inadequate funding or incorrect predictions about future claims, as is the case under the current tort system.

The legislation should make clear that if the fund cannot guarantee that victims will receive all of their claims, a program review is triggered, and if not corrected the fund should end and claims should revert to the tort system. To work, however, such a reversion would have to be to Federal court and should contain certain additional protections to ensure the current litigation morass is not recreated.

Such an approach reduces, if not eliminates, the need to worry about which claims projections are correct.

Clearly, a more thorough discussion of these observations, recommendations, and outstanding issues is warranted.

I ask unanimous consent that a document entitled "Moving Forward in Asbestos Injury Resolution Act, S. 1125" be printed in the RECORD at the conclusion of my remarks.

The PRESIDENT pro tempore. Without objection, it is so ordered.

(See exhibit I.)

Mr. FRIST. Mr. President, this allows a more complete discussion of the principles and observations I have made thus far. I do hope people take a look at that document.

As for the future, if we intend to make good on our collective hope to pass legislation, at some point the ongoing discussions and negotiations must cease and a bill must be brought to the floor. Victims are still going uncompensated today, companies are still going bankrupt today, and the economy is still unnecessarily burdened. We must act.

The minority leader as well as Senator LEAHY and other Democratic Members have made clear to me their interest in working toward consensus legislation. It is clear we still need a little more time for discussion. Consequently, we will not force a vote on the FAIR Act this session. Instead, I will give stakeholders more time to negotiate a compromise. There will, however, be a limit to these discussions because we must act. Thus, I will commence floor action on an asbestos bill by the end of March 2004. Again, I will commence floor action on an asbestos bill by the end of March of 2004.

There is no perfect solution to the current asbestos litigation crisis, but it is clear that maintaining the status quo is unacceptable. We have a responsibility to act, and we will act in this body. We must not let this historic opportunity to enact fair and meaningful reform pass in order to pursue a perfect solution that is unachievable. The time has come for the Senate to fashion the right solution to one of the most pressing issues facing us, facing our economy and this Nation today.

EXHIBIT I

MOVING FORWARD ON THE FAIRNESS IN ASBESTOS INJURY RESOLUTION ACT, S. 1125—STATEMENT OF SENATOR FRIST

To bring an end to the current asbestos litigation crisis, Congress must pass legislation creating a national no-fault asbestos trust fund ("Fund") that ensures adequate compensation to victims, while providing financial certainty to the business community. This kind of program would provide more direct compensation, more quickly to victims than the current system can deliver. Moreover, it would provide that compensation without the bankruptcies or the lost workers' jobs, incomes, and retirement savings that asbestos personal injury litigation produces. It represents, therefore, a tremendous achievement in the creation of a solution to a problem whose future economic consequences are enormous—in the magnitude of more than $100 billion if the claims stay in the tort system.

This past July, under the leadership of Chairman Hatch, the Senate Judiciary Committee approved S. 1125, the Fairness in Asbestos Injury Resolution Act ("FAIR Act"), which establishes the framework for reaching a bipartisan solution. To reach a consensus, we must build upon that structure, making improvements where possible but not jeopardizing the two most fundamental elements of the legislation—adequate, timely, and equitable compensation for claimants and financial predictability for the business community.

I. ENSURING ADEQUATE COMPENSATION FOR VICTIMS

According to the two actuarial studies on the magnitude of the problem, one by Tillinghast-Towers Perrin and the other by Milliman USA, ultimate loss and expenses under asbestos personal injury litigation are projected to reach $200 to $265 billion. With $70 billion already spent, total estimated future costs thus range from $130 to $195 billion. Victims, however, can expect to receive barely half that amount in actual compensation.

According to RAND's analysis of asbestos compensation, transaction costs under the current system—plaintiffs' attorney fees, defense costs, and expenses—consume more than half of the money that goes into the asbestos litigation system. In other words, only about 40 cents on every dollar spent in the asbestos tort system actually reaches victims. Thus, while today's system has a future price tag of $130 to $195 billion, victim compensation is estimated at only $61 to $92 billion of that total.

If adopted, the Act will rein in those runaway transaction costs and provide quick, certain and fair payment for victims. In fact, my funding proposal, which has been agreed to by the defendant companies and insurers, will actually provide asbestos victims at least $10 billion more than they would receive if the current litigation crisis is left intact.

The primary source of funding under the Act is derived from mandatory contributions: the Act (as reported) required $104 billion in total mandatory contributions from defendants and insurers. In reaching that total, companies and insurers were to be assessed equally and according to specific statutory provisions. Meanwhile, confirmed bankruptcy trust contributions are estimated to provide an additional $4 billion, bringing total mandatory funding under the Act (as reported) to $108 billion.

That funding proposal represented a very fair amount to solve the problem, and provided victims more in direct compensation than they would receive under the current system. The Committee, however, went well beyond this benchmark during markup. S. 1125 (as reported) included significant additional funding provisions. An amendment offered by Senators KOHL and FEINSTEIN authorized the Administrator to compel companies and insurers to pay additional contingent contributions of up to $31 billion, and allowed the Administrator to request back end contributions that could have reached a combined total of $48 billion.

The net effect of these changes to the Act was dramatic. S. 1125 (as reported) could have required businesses and insurers to provide compensation at up to two times the most credible estimates of total future plaintiffs' recoveries under the tort system. As a result, insurers almost uniformly withdrew their support for the Act, calling it "dangerously unaffordable" and "potentially worse than the existing system."

In order to get the legislation back on track, I initiated a mediation process between insurers and defendant companies. We were able to reach agreement on such major issues as overall funding, allocation of funding obligations, and insurance policy erosion, and gain renewed insurer support for the Act. The agreed-upon revisions not only garnered the support of the business community and insurers for the Act, but would also ensure greater Fund liquidity.

Under my funding proposal, insurers would make nominal mandatory contributions of $46.025 billion on an accelerated payment schedule. Meanwhile, defendants would pay $57.500 billion in total mandatory contributions and, if necessary, defendants would provide $10 billion in additional contingency funding. Most importantly, with confirmed bankruptcy trust assets and interest earned, my proposal would provide at least $10 billion more than the current tort system. It will also preserve one of the great breakthroughs that made widespread business community support for the Act possible—the landmark agreement on a fair and reasonable formula for sharing the funding obligation among defendants. Chairman Hatch is to be commended for shepherding the larger business community to his unprecedented agreement.

In addition, my proposal would better address the Fund's liquidity needs than the Act (as reported). The greatest stress on the Fund is expected to be in the early years when it is required to pay pending as well as current claims. In order to address the resulting liquidity demands, the Act (as reported) allows the Administrator to borrow against the Fund in an amount equal to that of the following calendar year's anticipated contributions. My proposal would give the Administrator authority to obtain billions of dollars of additional funds, if needed, by expanding the Administrator's borrowing authority. All of the Fund's repayment obligations would be fully collateralized by the defendants' and insurers' mandatory contributions, ensuring that federal monies are not put at risk.

Although there are still some funding issues to be worked out, the progress we have made to date is the result of unprecedented cooperation between industry and insurers to find an acceptable solution to the asbestos litigation crisis. We are confident that we can bridge the few remaining differences in the time frame provided.

II. AWARD VALUES

A further step on the path to providing fair compensation for asbestos victims is the establishment of a schedule of claim values that will result in consistent awards. The history of awards under the current tort system is one plagued by uncertainty and unfairness to asbestos victims. Many plaintiffs receive little or nothing, or die before their cases can be heard in court. Of those who do receive awards, the amount of compensation typically depends more on where and when the claims are filed than on the nature of the plaintiffs's illness. In one 1999 Mississippi case involving 4,000 plaintiffs, allocation of a $160 million settlement was based on how far plaintiffs lived from the courthouse in Mississippi. The Mississippi residents each received $263,000. Similarly situated plaintiffs from Ohio, Pennsylvania, and Indiana received only $14,000 each. (See David Cosey, et al. v. E.D. Bullard, et al).

As introduced, S. 1125 contained claim values that were among the highest of any federal compensation program: For example, the award value for claimants compensated under disease level X (mesothelioma) exceeded by three times the maximum death benefits generally available under the National Childhood Vaccine Injury Act, one of the most generous of comparable existing federal programs. Claimant compensation under the FAIR Act's other most serious disease levels was also very generous compared with existing federal programs. Moreover, although the Act's claim values were based loosely on those awarded in existing bankruptcy trusts, it ultimately paid more in real dollars. The Manville Trust, for example, has a scheduled value of $350,000 for mesothelioma claimants, but is only able to pay 5 cents on the dollar, resulting in an award of $17,500. Under S. 1125 (as introduced) such a claimant would have received $750,000—about 43 times the amount actually paid by the Manville Trust. Nonetheless, many Democrats indicated that the values under the Act should be even more generous to claimants.

During Committee consideration of S. 1125, a bipartisan amendment offered by Senators Graham and Feinstein significantly increased the claim values. This amendment was approved by a 14–3 vote of the Judiciary Committee. The Committee also considered and rejected an amendment offered by Senators Leahy and Kennedy to provide even higher claim values. That amendment misallocated funds too heavily toward those with illnesses less clearly linked to asbestos exposure. In addition, the Committee adopted an amendment to index claim awaard values to inflation, further providing billions of dollars in additional payments. Moreover, all claimants meeting Level I requirements—potentially over a million exposed workers—would be eligible for medical monitoring reimbursement and would have their statute of limitations tolled so that, if they do get sick, they would have recourse to all the benefits of the Fund. Since the Committee's consideration, Democrats and organized labor have suggested that the medical monitoring should include the out-of-pocket cost of the physician's examination. I believe this is reasonable and should be in the final bill.

With the changes reported out of Committee, the scheduled values under the FAIR Act were even more generous than before. Continuing an example previously mentioned, S. 1125 (as reported) set the Level X (mesothelioma) claim value at an amount that was not three times, but four times higher than the death benefits generally available under the National Childhood Vaccine Injury Act—a difference of $750,000. Similarly, in the bill as reported, mesothelioma claimants would have received not 43 times, but 57 times the amount at which the Manville Trust actually compensates similarly situated victims.

Finally, as introduced, S. 1125 granted the Administrator broad authority with respect to the timing of award payments. Organized labor expressed concerns that payments would drag out over a long period of time, and argued that claimants should receive payments over three to four years. The Judiciary Committee addressed this concern by providing that payments should be disbursed over a period of three years, and in no event more than four years from the date of final adjudication of the claim. Organized labor has continued to express concern, however, that there is no standard to guide how much of their awards claimants should receive each year. Again, this concern should be more adequately addressed, if possible. To address organized labor's concerns, negotiators have accepted a presumption for payment of awards over three years in the following percentages: 40 percent in the first year, and 30 percent in each of the next two years. However, if necessary to protect the fund from short-term liquidity problems, the Administrator has the authority to make payments in equal 25 percent installments over four years.

Notwithstanding the Committee's action to substantially increase claim values, my Democratic colleagues and organized labor continue to believe further increases are warranted. Although I believe the values in S. 1125 are more than fair, even generous, in a no-fault system, and will bring more to claimants in the aggregate than the current system, I am prepared to consider further modest increases in claims awards in an effort to forge a bipartisan consensus, provided they are targeted to categories most uniquely caused by asbestos exposure (versus other possible causes). Consistent with the express philosophy of S. 1125, the greatest increases must be targeted to the most severe disease categories in which the causal relationship to asbestos exposure is most certain.

A remaining challenge, and a prerequisite to any additional increase in claim values, is to address the concern that the criteria for eligible claims under Level VII are sufficiently broad that they could potentially sweep in claimants whose lung cancer is not caused by asbestos but by alternative causes, such as smoking. The American Cancer Society estimates that in 2003 alone there will be over 170,000 new lung cancer cases from all possible causes—or 30,000 more than the Fund's highest projected total of eligible claims over 50 years and over 110,000 more than the highest projections made by Dr. Mark Peterson (who testified before the Senate Judiciary Committee during the debate over the FAIR Act) for the same period. Exacerbating that risk is claims experience demonstrating that well over 90 percent of Manville Trust lung cancer claimants are current or former smokers. There is a substantial risk that, in moving to a no-fault system and eliminating the need to establish asbestos as the cause of the disease, compensating a large number of smoking-caused lung cancer claims could jeopardize the solvency of the Fund. If the current exposure criteria do not adequately narrow eligibility to those lung cancer claims where asbestos exposure significantly increases the risk over smoking, the Fund could potentially collapse.

Accordingly, a provision should be added to the legislation to make sure that lung cancer claims not related to asbestos exposure are not allowed to overwhelm the Fund's ability to compensate claimants who have disease caused by asbestos. I will continue to work with my Republican and Democratic colleagues to craft a program review which would authorize the Administrator (in consultation with Congress) to protect the fund if the total number of Level VII claims substantially exceeds projections.

III. ADMINISTRATION AND STARTUP

In addition to ensuring the availability of adequate funds to pay fair and consistent awards to asbestos victims, another critical element of any solution is to create a system that ensures prompt and efficient payment of awards to eligible claimants, while minimizing transaction costs. Again, this is an area in which we have made great headway towards resolution, but there are still some aspects to be worked out.

A number of parties have expressed concerns with the system for filing, evaluating, and reviewing claims established by the FAIR Act. Under S. 1125 as reported from Committee, claims would be filed with, and reviewed by, special masters operating under the guidance of the U.S. Court of Federal Claims. If a claimant were not satisfied with his or her initial award determination, the claimant could appeal to a separate panel of three special asbestos masters. From there, a claimant could appeal an adverse decision to an en banc panel of three judges of the Court of Federal Claims, sitting as the United States Court of Asbestos Claims. Appeals from the Court of Asbestos Claims would be heard by the U.S. Court of Appeals for the Federal Circuit. A separate Administrator would manage the Fund and pay final claims awards. Because the system was court based, there was no provision authorizing the promulgating of substantive regulations, which could help guide special asbestos masters through the establishment of generally applicable policies for claims evaluations and eligibility determinations. Instead, these issues have necessarily been addressed on an ad hoc basis in the context of individual claims determinations.

This court-based system was heavily criticized by Democrats and by organized labor as too complex and adversarial from the perspective of claimants. Labor in particular has insisted instead on an administrative review process, which it believes could resolve more claims in less time using a no-fault, non-adversarial system. With an administrative process, substantive regulations could be utilized to establish generally applicable presumptions and to help guide those evaluating claims to ensure eligibility criteria are fairly and consistently applied. Such a process could also be more "user friendly" and would allow claimants themselves, if they so desired, to navigate the process for filing claims without the need to retain counsel. While all parties recognize that legal representation may be beneficial or even necessary at some level of claims review, organized labor has consistently expressed the desire for an administrative system that minimizes the need for attorneys in order to maximize the recovery of a award values by claimants.

I recognize the benefits of such a system. I believe we can find common ground on developing a non-adversarial system that can effectively and quickly deliver benefits to claimants. I urge the parties to continue working towards a consensus on this issue. Such a system should significantly reduce transaction costs. We should therefore include a provision limiting plaintiffs' attorney fees to ensure that actual awards to victims are maximized. If done correctly, a new administrative process can also address another problem with the bill as reported by the Committee, by ensuring that the program is operating and processing claims in the minimum amount of time following passage of the FAIR Act.

On a related note, S. 1125, as introduced, provided that the new federal trust fund would be the exclusive remedy for all asbestos claims under state and federal law, and that all other remedies were preempted and barred as of the date of enactment. Exclusivity and finality are key elements of the necessary reform. The current tort system has failed victims, and it has done so largely because filing claims on behalf of the unimpaired has become too profitable a business for too many lawyers. Any legislation we pass must end the massive misallocation of limited funds to unimpaired claimants and their lawyers at the expense of those who are ill from asbestos-related disease. We cannot continue to tolerate the expenditure of limited funds into this broken system, a system which spawns inventory-style settlement agreements entered into by attorneys on behalf of claimants who have not even been identified much less bound by the agreement. Nor can we leave insurers and businesses exposed to collusive default judgments or other efforts to evade the Act's exclusivity provisions. Similarly, the bill should plainly foreclose all asbestos-related litigation by claimants against insurers and businesses, including direct actions. In short, given the consensus that the tort system is terribly flawed, we cannot allow the current abuses to persist. Proposals that would have the effect of continuing the status quo—and draining resources that would otherwise be available under the Fund for the truly impaired—are unacceptable.

During the markup, Democrats, organized labor, and the trial bar expressed concerns that asbestos victims could be faced with a period of time during program startup when they would have no remedy for their injuries—all tort suits would be preempted but the Fund would not yet be processing claims. In response to this concern, the Committee adopted an amendment offered by Senator Feinstein, which provided that the preemption and bar on asbestos claims would not be effective until the Administrator determined that the Fund was "fully operational and processing claims." Until that time, all remedies would remain available under state law, and defendants' and insurers' contributions to the Fund would be offset by "the amount of any claims made payable" during the startup period.

The Feinstein amendment was intended to address the legitimate concern that asbestos victims could face a potentially lengthy period of time during which they would be without a remedy. Unfortunately, the amendment would leave the current tort system, with all of its inherent problems, intact for too long and would allow some parties to manipulate this interim period for their personal benefit. No one wants to see the expectations of asbestos claimants undermined by the kind of legal chicanery that created the current crisis. If not fixed, the amendment could cause the very problem the bill is attempting to fix—even more bankruptcies and the continued diversion of resources away from legitimate victims.

Moreover, in practice, the Amendment would effectively doom the prospects of the Fund. As was the experience in states that have recently adopted tort reform laws, such as medical malpractice limits, the pending demise of a segment of the tort system inevitably leads to a flood of claims before the courthouse door is effectively closed. Under the Feinstein amendment, awards to plaintiffs, but not defense costs, could be offset against future Fund contributions. As a result, settling claims would be cost free to defendants and insurers, while defending claims in the tort system would continue to be prohibitively expensive. The certain result of this provision would be a very strong incentive, perhaps even a duty for publicly traded companies, to immediately settle all pending claims at potentially elevated values in order to avoid the expense of defending even the most illegitimate claims. Because all these settlement costs would be offset against Fund contributions, the financial effect on funding would be disastrous. Therefore, it is clear that the amendment is not the right solution to a very real problem.

To ensure that victims are not left without a remedy for an unjust period of time, I believe we need an alternative to the Feinstein amendment that will address the concerns raised by (1) authorizing the creation of an administrative program on an expedited basis that will be capable of quickly processing the most serious claims, and (2) enhancing the funding provisions to ensure adequate funds are available from the outset to pay these exigent claims on an expedited basis. The bill as reported by the Committee goes a long way toward ensuring that the Fund receives the mandated contributions within a reasonable time frame. Since that time, there has been a number of innovative suggestions relating to the funding and administrative provisions that would work in concert to address the concerns raised, without the dire consequences of the Feinstein amendment. I am confident we can resolve this issue, so that claimants with the most serious injuries are not left without a remedy, and I intend to continue working in conjunction with my Democratic colleagues toward a solution.

IV. ELIGIBILITY AND MEDICAL CRITERIA

Once the necessary funding is assured, and an administrative process is in place to manage claims fairly and efficiently, the next essential element is to make sure that available resources are directed to the most deserving claimants. In contrast to the existing tort system, in which many if not most asbestos claimants are unimpaired, the FAIR Act will ensure that awards are directed principally to those who have suffered the most from exposure to asbestos. This is assured through the consensus eligibility criteria in the bill, which set forth the applicable exposure, latency, medical, and diagnostic requirements for receiving compensation from the Fund.

The basic premise of the FAIR Act is to ensure that true victims of asbestos disease receive fair and consistent awards. To be eligible for compensation from the Fund, claimants must satisfy the eligibility criteria for various disease categories. The FAIR Act also provides a mechanism for consideration of exceptional cases, where claimants can clearly establish the presence of an asbestos-related disease but may not satisfy the otherwise applicable medical criteria. Exceptional cases, as well as those related to "take home" exposures where asbestos was brought into the home by an occupationally exposed person and those related to the high levels of environmental exposures of residents and workers in Libby, Montana, are eligible for review by a Medical Advisory Committee, made up objective, experienced physicians, to determine whether the claimant is eligible for compensation. Because the medical conditions of Libby residents are currently being studied by various agencies, claims filed by Libby claimants are automatically designated as exceptional medical claims and referred to the Medical Advisory Committee.

The consensus criteria reflected in S. 1125 provide a solid foundation to ensure that eligibility decisions are based on sound medical practices and real diagnoses by the claimants' physicians. As a doctor, I cannot emphasize enough the importance of a diagnosis by the claimant's physician. The success of the program hinges on ensuring that the Fund compensates only those with conditions caused by asbestos exposure and not other causes. Only by ensuring the use of real diagnoses of asbestos-related illnesses can the Fund avoid the pitfalls that plague the current mass tort system.

The eligibility criteria reflected in S. 1125, as reported, are the result of an unprecedented agreement among the various stakeholders working to find a solution to the current asbestos litigation crisis. I commend Chairman Hatch and Ranking Member Leahy for an achievement few thought possible. I appreciate how complex and contentious an issue the medical criteria presented. The approval of these criteria by a unanimous vote in the Judiciary Committee markup created the opportunity we have for an historic achievement.

V. PROTECTING VICTIMS FROM RISK

From the very beginning, one of the key goals of S. 1125 has been to ensure that compensation is directed at those legitimately ill from asbestos exposure and is awarded on a timely basis. The bill accomplishes this fundamental change from the status quo by moving from a system that compensates claims of questionable validity to one based on sound medical evidence and real doctors' diagnoses.

Nonetheless, legitimate concerns remain about the accuracy of estimates of the number of future claimants that will be eligible for compensation under the Act. Obviously, prior attempts to forecast asbestos claimants have proven inaccurate, leaving the very people who most deserve compensation with no real recourse. For example, claims to the Manville Trust have exceeded initial projections, and the Trust has been forced to reduce claim values to the point where today the Trust pays claimants as little as five cents on the dollar. Congress cannot and will not recreate the Manville experience.

Various experts have developed estimates about future claims, and the Congressional Budget Office has offered its own predictions based upon its review of the available evidence. The truth, however, is that there is no guarantee that any of these estimates is accurate. The legislation creates new eligibility criteria and establishes a new system for processing claims, one designed to weed out unimpaired claimants and those who suffer from diseases not caused by exposure to asbestos. Since there is no comparable system operating today, what is happening with the existing private asbestos trusts can at best offer only some general indication of what may happen over the 50-year life of the proposed Fund. Obviously, this reality makes it even more important for Congress to make sure that if we establish a national asbestos trust fund, that we also make sure that asbestos victims have someplace to go to seek compensation if the Fund cannot handle all future claimants.

The FAIR Act, as reported by the Judiciary Committee, includes an amendment offered by Senator Biden that requires the Fund to terminate and claims to revert to the tort system if funding proves inadequate. Specifically, the Administrator would be required to certify annually that 95 percent or more of the eligible claimants that year had received 95 percent of their compensation under the FAIR Act. If not, and the situation could not be remedied within 90 days, the program would sunset immediately. Although this language clearly shifts the risk away from claimants, it unnecessarily jeopardizes the Fund from its very inception and fails to provide sufficient flexibility to address unexpected, and possibly fixable, fluctuations in claims.

I agree with the key principle that the risk of inadequate funding cannot fall on those truly ill from asbestos exposure. However, the business community cannot be subjected to an open-ended funding commitment to accommodate an unknown and unlimited number of claimants into the future. Similarly, American businesses cannot risk paying over $100 billion dollars into a Fund only to see it sunset in a few short years. Either of these outcomes would be worse than the current broken system. To succeed, the business community believes the solution must provide at least a limited window of "peace" to bring certainty to business and to allow the economy to recover from the burden that asbestos litigation has imposed on it.

Therefore, I propose an alternative that will balance these competing tensions while fully protecting sick victims. Under my proposal, if victims do not receive 100 percent of their claim values, the Fund would end and claims would revert to the tort system so that claimants will still have a guaranteed avenue to receive compensation. This approach significantly reduces the need to worry about which claims projections are correct. If the estimates of eligible claims over the next 50 years are too low and the funding is exhausted, then claims will automatically return to the tort system and claimants will be able to preserve their ability to receive compensation. To avoid many of the abuses that have created the current crisis, however, this reversion to the tort system must be to the federal courts and must contain certain additional protections to ensure that the current litigation crisis is not recreated. Obviously, while protecting asbestos victims from risk, my proposal does impose a price on the business community. It compromises to a degree the absolute certainty and finality that have been the hallmarks of a solution for those that must fund the program. They will be forced to bear the risk that the total program funding is not sufficient.

There is also a legitimate concern that the Fund could sunset, not because of inaccurate claims projections, but because the new and untested eligibility criteria in the FAIR Act end up compensating the wrong kinds of claims. These would include claims for injuries not caused by asbestos (for example, smoking-related lung cancers, idiopathic pulmonary fibrosis, rheumatoid arthritis, byssinosis, etc.) or because the Fund's medical, diagnostic, and exposure criteria do not sufficiently eliminate unimpaired claimants. Future victims of asbestos-related disease, as well as those funding the program, have a legitimate and strong interest in ensuring that the Fund is not exhausted because of those kinds of claims. To address that risk, I propose the Fund undertake a periodic review of the program to ensure it is compensating legitimate asbestos-related illnesses. This program review would regularly evaluate the claims submitted, the quality of the supporting evidence, and eligibility and award determinations to determine whether the Fund is compensating the wrong kinds of claimants and to provide the authority and opportunity for the Administrator to address the problem early if that occurs.

My proposal also would address another reality—under the current tort system, too much of the risk already falls on victims. Today, some victims go uncompensated because they cannot remember the product to which they were exposed. Others are without recourse because they were exposed in connection with military service and cannot sue the federal government. Other victims who should be compensated too often experience long delays before they receive payment, waiting for their litigation and all possible appeals to be exhausted, and then only seeing half of their award, the rest taken by the lawyers. This is especially true for claimants who are suing companies that have been forced into bankruptcy. There, the legal process can take half a decade and consume millions of dollars, leaving claimants able to recover only pennies on the dollar from the resulting bankruptcy trust. In short, victims bear much of the risk under the status quo, and they will continue to bear that risk until Congress acts. My proposal protects victims from those risks, and offers asbestos victims far more protection and certainty than they have today.

The PRESIDING OFFICER (Mr. CORNYN). The Senator from Nevada.

Mr. REID. Mr. President, I want to make sure, having heard the distinguished majority leader speak about asbestos, that we understand, as he has indicated, it is a very complicated, difficult issue. But there are concerns that I have, and I think I speak for lots of people in this country. I am very concerned about how it affects business, but I am also concerned how it affects individual people.

I called Mrs. Bruce Vento this week, a woman from Minnesota whose husband served in the House of Representatives, a wonderful man. He worked in an asbestos facility for a few months as a young man. He is 58 years old, he gets sick, he is dead within a year as a result of the disease that comes from being around asbestos, mesothelioma. The average life expectancy of a person who is diagnosed with this disease is a little over a year. They die quickly.

Then we have asbestosis, where people live longer but it has a detrimental effect on their health.

What we have to do is get rid of the spurious lawsuits, those that don't deal with those two conditions about which I just spoke.

So I hope, as we proceed through asbestos legislation, we worry about and are concerned about these very sick people. People in this Senate have worked extremely hard to come up with a solution. The distinguished Senator from Utah is in the Chamber, the chairman of the Judiciary Committee. He and the ranking member, Senator LEAHY, have worked days and weeks to try to come up with something. We always get close but never quite close enough.

So I hope as we proceed, as the distinguished majority leader indicated, toward legislation dealing with this, that we keep in mind the main reason we are doing it. The main reason we need to legislate, in my opinion, is to take care of the people who get afflicted with the diseases that are related to asbestos. In the process, I hope we can ban the importation of asbestos into our country. We continue to import thousands of tons of this stuff on a yearly basis, even as we speak.

So I appreciate the concern of the majority leader. I have concerns also. But if I were giving a speech in a prolonged fashion, I would speak about the people who get sick, as Bruce Vento did, and are now dead.

Mr. LEAHY. Mr. President, I thank the distinguished Senate Majority Leader for his remarks today on the need for the Senate to consider asbestos legislation next year. I wholeheartedly agree with him on the need for reform to establish a better system for providing fair and efficient compensation to victims of asbestos-related diseases. I remain committed to working with Senator FRIST, Senator DASCHLE, Senator HATCH, Senator DODD, Senator SPECTER, and others, to forge a bipartisan solution to this complex challenge.

Last fall, as Chairman of the Judiciary Committee, I held the Committee's first hearing to begin a bipartisan dialogue about the best means to compensate current asbestos victims and those yet to come. Chairman HATCH wisely held two additional hearings this year. Our knowledge of the harms wreaked by asbestos exposure has certainly grown since last fall, as have the harms themselves. Not only do the victims of asbestos exposure continue to suffer, and their numbers to grow, but the businesses involved, along with their employees and retirees, are suffering from the economic uncertainty surrounding this litigation. More than 60 companies have filed for bankruptcy because of their asbestos-related liabilities.

These bankruptcies create a lose-lose situation. Asbestos victims who deserve fair compensation do not receive it, and bankrupt companies can neither create new jobs nor invest in our economy.

A solution has never before been closer than it is today. Since the beginning of 2003, we have come to complete accord on the idea that the fairest, most efficient way to provide compensation for asbestos victims is through the creation of a national fund that will apply agreed-upon medical criteria in evaluating patients' injuries. We have been working tirelessly with representatives from organized labor, defendant companies, insurers, and other interested parties, to craft an effective trust fund system that will bring the certainty of fair payments to victims and financial certainty to industry. A myriad of issues have been resolved, from the definitions of the panoply of illnesses resulting from asbestos exposure to a ban on the use of asbestos in the United States. We are working, even today, on the details of other aspects of this scheme, down to the fine points of the administrative mechanism for processing claims.

We have made real progress in finding common ground. But we have yet to reach consensus, and without consensus we cannot end this crisis. Too much is at stake for us to walk away when we have come so far. An effective and efficient means to end the asbestos litigation crisis is within reach, and we must grasp it. Although the year is drawing to a close, our bipartisan commitment to this effort remains strong. I look forward to continuing to work with my colleagues and all stake holders to craft a consensus bill that we can move through the legislative process and into law next year.

MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003—CONFERENCE REPORT

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to the consideration of the conference report to accompany H.R. 1, which the clerk will report.

The assistant legislative clerk read as follows:

> The Committee of Conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 1), to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the medicare program and to strengthen and improve the medicare program, and for other purposes, having met, have agreed that the House recede from its disagreement to the amendment of the Senate, and agree to the same with an amendment and the Senate agree to the same, signed by a majority of the conferees on the part of both Houses.

The PRESIDING OFFICER. The Senate will proceed to the consideration of the conference report.

(The conference report is printed in the proceedings of the House in the RECORD of November 20, 2003, Book II.)

The PRESIDING OFFICER. The Senator from Arizona.

Mr. KYL. Mr. President, we are now on this historic piece of legislation. I want to begin a discussion of that shortly.

But since the majority leader discussed the subject of asbestos legislation, and the chairman of the Judiciary Committee, who has been largely responsible for moving that legislation as far as it has come to date, is here and wishes to make a couple of comments, I would like to yield a couple of minutes to the distinguished Senator from Utah and then regain the floor to discuss the Medicare bill.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Utah.

Mr. REID. I am sorry, what was the concern?

The PRESIDING OFFICER. The Senator from Arizona has yielded to the Senator from Utah for 2 minutes and then will reclaim his time. Without objection, it is so ordered.

The Senator from Utah.

ASBESTOS REFORM

Mr. HATCH. Mr. President, I thank my colleague. I appreciated the remarks of the distinguished majority leader on the asbestos reform legislation. I certainly appreciate the kind remarks of the minority whip with regard to this. I think both of them spoke eloquently.

I rise today in support of the comments of the distinguished majority leader with respect to the asbestos legislation. This is an absolutely vital issue, and we have the opportunity with S. 1125, the Fairness in Asbestos Injury Resolution Act, to correct what has been a gross injustice—both to asbestos victims and to our economy.

For more than 20 years now, compensation to legitimate victims of asbestos exposure has been delayed and diminished, while scores of companies with almost no connection to the problem have had to file for bankruptcy and hundreds of others live under the constant threat of insolvency from litigation. As a result tens of thousands of victims are not compensated and tens of thousands of workers have lost their jobs.

We've heard the statistics, but they bear repeating. The RAND Institute for Civil Justice tells us that, to date, approximately 70 companies have been forced into bankruptcy—at least three with operations in my home state of Utah.

The number of claims continues to rise as does the number of companies pulled into the web of this abusive litigation, often with little, if any, culpability. More than 600,000 people have filed claims, and more than 8,400 companies have been named as defendants in asbestos litigation.

This has become such a gravy train for some abusive trial lawyers that over 2,400 additional companies were named in the last year alone. RAND also notes that "about two-thirds of the claims are now filed by the unimpaired, while in the past they were filed only by the manifestly ill." Former Attorney General Griffin Bell, amongst many others, has denounced this type of "jackpot justice."

To address this problem, I introduced a bipartisan bill with my friends Senators BEN NELSON, MIKE DEWINE, ZELL MILLER, GEORGE VOINOVICH, GEORGE ALLEN, SAXBY CHAMBLISS and CHUCK HAGEL. This bill creates a fund to provide fair compensation to victims, while reducing wasteful transaction costs dramatically. Let me first just dispel a few myths about this bill and set the record straight on a couple of issues. First, some Democrats and unions are saying there isn't enough money in the bill but the fact is that this bill gets more money to claimants on average than the current system does.

Let me explain how. There have been several studies of future asbestos-related costs under the current system, and the one which shows the highest reasonable estimate of prospective costs—the Milliman study—would result in approximately $92 billion for victims, after attorney fees and expenses.

Under the FAIR Act, it is estimated that claimants will receive 90 percent or more of the total funds under the no-fault, non-adversarial system. This means the FAIR Act fund—which will have $114 billion under the agreement proposed by Senator FRIST—will allow claimants to take home more than $100 billion. This is more total money than they are projected to receive under the current tort system.

But it is not just more money in the pockets of victims, it is faster and more certain compensation as well. We anticipate that claimants will not have to endure years of discovery battles and endless litigation before they get paid. Currently, some victims are dependent on the solvency of businesses to decide if they get paid or not. Under the FAIR Act, these victims will no longer have to go without payment. It is time to end the current system of Jackpot Justice where only some win and many lose.

Some have also argued that there aren't adequate safeguards to ensure solvency of the fund. Baloney. This fund—which is funded at the highest reasonable claim-rate scenario—is equipped with many mechanisms to ensure that the pay-in and pay-out requirements are met. This includes borrowing authority against future contributions.

It also includes guarantee surcharge and orphan share reserve accounts which set aside money to grow and pay for unexpected shortfalls. Another safeguard is the provision to empower the Attorney General to enforce contribution obligations and ensure collection. And beyond these, there is $10 billion in contingent funding as one more additional safety net. On top of all these safeguards, if the fund still becomes insolvent, claims would revert back to the tort system—a provision, by the way, which Democrats insisted be part of the bill.

Given that this bill is a clear net monetary gain for legitimate victims, and provides payments faster and with more certainty, I am at a loss as to why anyone could object to this bill. The unions that continue to oppose the bill risk throwing away the last, best chance to compensate fairly those who are truly sick and provide some protection to those whose jobs and pensions are at risk because of the asbestos litigation crisis.

Quite frankly, the only entity that stands to lose under this bill is the plaintiffs' bar which has siphoned off more than $20 billion of the costs incurred on this issue as of the end of last year. If the FAIR Act is passed, they will not be able to use unimpaired claims to continue to squeeze a projected $41 billion more for themselves from remotely-connected companies by abusing a broken system.

Fair is fair—I am all in support of compensating plaintiffs' attorneys for the value of their work. But when it diverts valuable resources away from sick victims, something is wrong with the system.

No one can accuse us of being unwilling to compromise in order to finally be able to address this overwhelming crisis being caused by asbestos litigation. When you look at where our bill started—and it was a good start—and where it is now, our efforts at compromise are blatantly clear.

In May we circulated a bipartisan draft measure and my staff met with Democrat staff to listen to their concerns and we incorporated several requests—even before introduction. We then embarked on several weeks of markup which saw 23 Democratic-initiated amendments adopted into this legislation. Now I didn't agree with all of them, but it can hardly be said that there hasn't been strong participation by Democrats on this bill. This chart behind me lists just some of the changes we made at the behest of Democrats; let me highlight a few of them for you.

We increased overall funding. Our bill started with a mandated $94 billion in contributions, which by most reasonable estimates should have provided sufficient resources for compensating legitimate claimants. In committee we increased base funding to $108 billion dollars. That additional $14 billion is not pocket change. We also took steps to ensure the enforcement of contributions as an added protection to the solvency of the fund.

We increased the number of claimants that would receive compensation by modifying the qualifying medical criteria and by including a provision to accommodate the unique circumstances of the victims in Libby, MT.

Moreover, we increased the amount of money that will go to claimants. Even though our original claim values would have on average provided more money to legitimate claimants, we increased the values even more. And we removed most collateral source offsets to ensure that more of the award goes directly to the claimant.

These changes listed on the chart behind me do not even include other changes that we have offered since the bill was reported out of committee to even further accommodate their requests, such as an additional $6 billion increase in overall funding and significant increases in claims values in many categories. And we also offered a more flexible borrowing authority as another safeguard for solvency.

Now I understand that some want to make further changes, including streamlining the claims process even more, and I have said I'm willing to look at such proposals. But this and other complaints have been raised without the follow up of a concrete, alternative proposal. I hope that before this issue comes up in March as the Majority Leader indicated that we will resolve the outstanding issues.

We cannot delay any longer—we need to ensure that the truly sick get paid, while providing stability to our economy by stemming the rampant litigation that has resulted in a tidal wave of bankruptcies, endangering jobs and pensions. This crisis reaches far and wide—and it hurts everyone.

On Monday, this body will pass an historic bipartisan Medicare bill that will provide our seniors with drug benefits.

We can and should use this spirit of bipartisanship to come together on the asbestos issue.

I thank Senator FRIST for his leadership on Medicare and the constructive role he is playing on asbestos. Working together I am confident that Senators DASCHLE, SPECTER, LEAHY and DODD will all join together when we bring the asbestos bill to the floor in March.

Mr. KYL. Mr. President, I say again, this asbestos legislation, discussed by the leader, is very important for us to conclude early next year, and I make the point again, were it not for the work of the chairman of the Judiciary Committee, we would not be at the position where we hope to be close to finishing that legislation at some point.

Mr. CRAIG. Will the Senator yield to determine where we might be this morning?

There are several in the Chamber who wish to begin to speak on the Medicare prescription drug issue. Have we established any order for that purpose?

The PRESIDING OFFICER. There is no order other than to alternate speakers.

Mr. REID. Mr. President, if the distinguished Senator will yield for a response?

Mr. CRAIG. I will be happy to yield.

Mr. KYL. I will be happy to yield to the Senator from Nevada.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. What is in place is an agreement, gentlemen's in nature, that we would go back and forth. We are trying to work out an agreement where we would divide the time between proponents and opponents until 11 o'clock tonight. That has not been done yet, but there is something that has been typed up.

The reason going back and forth may not be fair is someone may speak for an hour and a half and someone else may speak for 10 or 15 minutes. So we have to come up with something better than that. That is what we are trying to do now.

Mr. KYL. Mr. President, might I suggest that during the time I am speaking, those who would like to speak in conjunction with the Senator from Nevada begin to work up a schedule. I would be happy to propound a unanimous consent request when that is concluded to reflect the agreement, at least for the next several hours, if that could be done.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. KYL. Mr. President, this is a historic day. Obviously, when one goes back to 1965 and thinks about the creation of Medicare, a lot has changed since then. We are here today to begin debating in the Senate a bill which passed early this morning in the House of Representatives, has long been advocated by President Bush, and which many people have worked on for a very long time, to try to modernize our Medicare system which, after 35 years, we recognize in this new 21st century needs to be changed to some extent.

For example, during that period of time, prescription drugs have become a major component—indeed, in many cases the first component—of treatment for ailments, disease, and afflictions of people.

Mr. President, 35 years ago prescription drugs were used to alleviate symptoms of pain and occasionally to treat conditions, but more intrusive methods were the order of the day at that time. The Medicare program for seniors reflects the conditions then by covering hospital stays and physician benefits, but not outpatient prescription drugs. The prescription drugs which have over the last 35 years become a key, if not the key, component of medical treatment have not been a part of Medicare because they were not as key in 1965. So we know we need to add prescription drug coverage for our seniors and for those who are disabled and who qualify for Medicare.

There are other changes we know, also, that would help to strengthen Medicare, to ensure that as we proceed to provide Medicare to the baby boom generation, we will be able to do so with the highest quality of care possible, at prices that both they and the American people can afford and, as I say, which really encompasses the new concepts of modern medicine in this treatment.

So the question was how we would develop a system to provide prescription drugs as a component of Medicare. There were several different options, but the option that has been finally settled upon is one which I can support, and as someone who actually advocated a somewhat different approach, I would like to speak to those primarily who, like me, were not particularly pleased with the initial direction in which this legislation proceeded, to talk about why, at the end of the day, it is the best we can do under these circumstances and I think under any foreseeable circumstances of the near future, and therefore why it is important to move forward with this legislation.

It is momentous, it is huge in terms of the amount of money we are talking about, a commitment over the next 10 years of $400 billion. That was the amount that Congress agreed to with the adoption of our budget and the crafting of this legislation. We resolved that this money would be set aside to provide this prescription drug benefit and make changes in Medicare to ensure the benefits of Medicare would be available to everyone in a quality way during the 21st century.

Let me discuss first of all some disappointments I have with the bill because these have been discussed by others and I want them to know I am very cognizant of the concerns that have been expressed.

I served on the conference committee that crafted this legislation and I spent literally hundreds of hours working with colleagues through these issues. Some of the battles we fought, I helped to prevail on, others we did not prevail on. But it is the nature of compromise between the two bodies and between the two parties, especially when the Senate is almost equally divided that no one is going to get everything they think is best.

Let me first of all talk about the approach that was taken here and why in some respects I think we made some wrong turns, but how we have tried to recognize that and to ameliorate the effects of those wrong turns as much as we could.

There was a sense in this country, because there are many people who could not afford all of the prescription drugs they need in their treatment, that the Medicare plan had to be modified to ensure they could have access to those drugs at a reasonable cost. That was an approach that many Members thought would best utilize the funding available, to provide the maximum amount of benefit to those who most needed it.

Somewhere along the way, a major decision was made which fundamentally altered that concept. It was a decision that was strongly favored by the AARP, for example, a group which I am very pleased to say is in support of this legislation and has taken a strong role in educating America about the benefits of this legislation. That decision was to make the benefit of prescription drugs universal; that is to say, to make it available to all Medicare-eligible people, not simply to try to help those who needed the help the most.

The first result of that was it significantly reduced the amount of money we could make available to those who need it the most because, obviously, if you provide a universal benefit, you are providing it to everyone who qualifies for Medicare basically equally to those who do not need the benefit, because they have more money, as well as those who do need the benefit. Once that decision was made, it reduced the amount of money we could allocate to help those who needed the help the most. I regret that. We could have structured a plan that would have more targeted the benefits where they were needed the most.

In addition, we created some other problems. One of the problems is, employers who provide prescription drug retiree benefits will have less incentive to do that in the future because the Government will do so if they do not. Many will argue, why should we spend our money, our corporate funds, to support the prescription drug retiree benefits that we have done in the past when, if we stop that coverage, the Government will pick it up? The result of that was we had to allocate over $70 billion of this money to be paid to these business plans, union plans, and even government plans, that provided retiree health care benefits with drug coverage. We had to provide that money to them to enable them to continue providing the coverage. Some call it a subsidy. It is a fair term, I suppose. But one might say we are paying them three fourths of what it would cost the Government, to provide this particular benefit.

So from the Government's point of view, we are saving money because if these company plans did not continue the coverage, the Government would have to pick up 100 percent of the cost. Nevertheless, it took a chunk of the money out of the program to pay for benefits that are already being paid for by somebody else, thus further reducing the amount of money we could allocate to those that need the care the most.

So those are just two examples of problems created by this initial decision.

The original idea of many Members was that we should provide more choices to seniors. Many Members came to that conclusion because Federal Government employees such as Members of Congress have a lot more choices in our drug coverage. We are entitled to enroll in something called the Federal Employees Health Benefits Program, or FEHBP, and we have a lot of health insurance options. These insurance options are integrated healthcare plans. They provide all of our care, from hospitals to doctors as well as prescription drugs.

A lot of Federal employees, 10 million strong, like those kind of plans. Many are PPOs, preferred provider organizations, where you go to any one of the doctors on a list who has signed up with that organization, or you can even go out-of-network, you can go to a different doctor, and that is still OK. This was the concept the President originally announced and it is a concept I strongly supported because it would maximize choices.

At the same time, we recognize that a lot of people would still want to maintain what they currently have, what we call traditional fee-for-service Medicare, and simply add a drug benefit on top of that. We did not want to take that choice away. So the concept was to have basically two choices: Stay in traditional Medicare with the new drug benefit, or sign up with one of these new insurance programs, a PPO or what we call today Medicare+Choice, which is predominantly HMOs. That choice has been created in this legislation. The choice is a good choice.

I regret, however, that I don't think we have given the health insurance option a good enough chance to attract very many beneficiaries. There are efforts in the bill to do that, but I think we put too many restrictions on the PPOs, in particular, to expect they will be very successful. For one thing, we strongly regulate how much they can be paid. As a matter of fact, their payment rates are directly tied to what we pay in regular fee-for-service Medicare. That is price control. Congress and the administration set the prices that can be paid under the traditional Medicare Program. We were trying to get away from that heavy price control with this new insurance option. Unfortunately, in an effort to make sure we could keep the costs ratcheted down and compare those costs to what we are paying for traditional Medicare, there is a direct relationship between what we pay in traditional Medicare and what will be paid on the private health insurance side. It is not really like regular private insurance. This is very highly regulated, controlled price, controlled private insurance as the alternative to fee-for-service Medicare.

I think it is less likely those PPOs are going to succeed as a result of that. Nevertheless, we at least, for the first time, have the concept of private health insurance as an option to traditional fee-for-service Medicare for all beneficiaries.

Senator NICKLES, in particular, and I worked strongly to increase the flexibility that the insurance option could provide so there could be literally dozens of products out there like the

FEHBP for Federal employees, and people could decide what was best for them. Again, unfortunately, that flexibility has been greatly limited in this legislation, primarily because of concerns by the Congressional Budget Office that if very much flexibility were provided, the cost of the program could exceed the $400 billion.

As a result, the options that are offered by these private plans will be very limited. For example, as you will hear others get into the details of the legislation, especially the drug benefit—and my colleague, the Senator from Iowa, the chairman of the Finance Committee, Mr. GRASSLEY, is in the Chamber. I know he will go into great detail about precisely how this works.

When that occurs, and you see how this benefit is going to be provided, one of the things you will see is that even though there is a very generous benefit—the Government will pay 75 percent of your drug costs up to $2,250, after a $250 deductible; so it will pay about $1,500 worth of drug benefits—at that point, then, the individual is going to be responsible for a little under $3,000 worth of drug benefits, before the catastrophic coverage of 95 percent Government-paid kicks in. Some people refer to this as a donut hole.

Obviously, with $400 billion allocated to the problem, we are not going to be able the pay all of everybody's drug costs. There is not enough money in the Federal budget for us to do that. As a result, you can only cover what that amount of money will cover.

Well, it is hoped that the private sector insurance option will provide different ways of ensuring against that donut hole, ensuring against that out-of-pocket expense that individuals will have to pay. But, unfortunately, that cannot be done under this legislation. The threshold can be raised, but the out-of-pocket amount still has to remain the same. As a result, there is a limitation on the insurance product that can be offered.

Again, Senator NICKLES and I had hoped there would be a lot more flexibility. I am hoping in the future we can loosen this up so these health insurance options can act like regular insurance options.

Another point: If you go to an insurance company today, a preferred provider organization, and you would like to get treatment from a different doctor who is not in their network, you can go to that different doctor. The plan will only pay an agreed-upon amount, and then you are billed for the difference between that and the physician's reasonable and customary fee. That is standard practice today.

That cannot be done under the way this legislation is written. That has to be fixed as well. Right now there is a price cap on that, and, therefore, it will discourage people from going out of the network, which will discourage people from signing up with PPOs in the first place.

These issues will have to be addressed later because we did not give sufficient flexibility to the insurance company alternative in this current bill. Again, I am speaking primarily to those who, like me, approach this with the idea that we could provide coverage similar to FEHBP coverage that the President originally articulated as the goal, and as someone who did not win all of the battles in this negotiation, but who still believes that at the end of the day, this is the best we are going to do, either now or any time in the future, that I can predict, given the politics, given the closeness of the Democrat-Republican split in the Senate and in the House of Representatives and the various other factors that influenced the decisions that we made.

Let me talk a little bit more about the drug benefit. Seniors today buy Medigap insurance, and that provides them a certain degree of drug coverage. It is regulated by the Government, but I think a lot of seniors believe they have pretty good drug coverage because of the Medigap insurance they have. The reality is, they are paying a lot of money for not that great of coverage. They pay almost as much money in premiums as the amount of coverage they receive. So it is not completely dollar for dollar, but it is not the kind of insurance that ordinarily we would think of.

As a result, the drug benefit that we provide here will be more substantial for the amount of money that is paid. But I do fear a lot of people will see the drug benefit we provide here as less than they are able to obtain today through their Medigap insurance, and it is going to be incumbent upon all of us to explain to people how this drug benefit will work. Again, it calls for us to try to loosen up the way the private insurance market can provide the drug coverage to meet seniors' objectives, not all of which are precisely the same.

Therefore, in order to convince them there are good alternatives to what they have today, since they are not going to be able to purchase the new drug benefit through the means of Medigap insurance anymore—that will be done through a different mechanism—it is going to be important for us, I think, to provide them the maximum type of flexibility and choices, something, again, that we are going to have to address in the future because it is too restricted in the bill as we have it written today.

There are other items—and I do not want to dwell on the negative—but just to cite two or three others to show areas in which we could have done better.

Today, we reimburse physicians and hospitals in a very irrational way. It is very tightly controlled. It is price controls. We never get it right. We tend to want to save costs, so we do not reimburse them enough, and then hospitals begin to shut down, doctors begin to get out of Medicare, and we realize we have made a horrible mistake. So then we ratchet the payments back up, and it is a very herky, jerky way of reimbursing the very people we rely upon to provide the critical health care that we want. As a result, we have tried to figure out ways to make this more rational.

Well, the best example is in the case of oncologists, doctors who provide us drugs to treat cancer. The oncologists are not reimbursed at anywhere near what it costs them to provide this service for us. As a result, what they have to do is to buy the drugs for the chemo part of chemotherapy, and they mark up the value of those drugs, sell them to the patient, and that is how they get reimbursed for what they do. Of course, people have said: Well, it is a huge markup. They are making a lot of money off these drugs. And it is true that there is a huge markup. It is not a rational way of reimbursing them.

So what we tried to do was to go back and fix the basic formula, called the practice expense formula, to figure out how much it really costs those doctors to stay in business to provide this all-critical care for cancer patients, and we begin to re-adjust that formula so it will pay them more, and, at the same time reducing the markup they get on the drugs so they would not have to be paid out of that pot of money, in effect.

Well, we got about halfway there, but we still have more work to do on that particular formula. So it is just an example of how the Medicare system served seniors well, but there are clearly things in it that need to be fixed if we are going to continue to provide high-quality care and to ensure that we have physicians and hospitals that can stay in business to take care of us.

Cardiothoracic surgeons are another group. The very best of these surgeons go into the operating room with their own team. This is life and death. They have teams that work together for years. They have had a lot of experience in doing what they do. But they do not get reimbursed for their team members, their nurses, and so on. What they have to do is pay for that out of their own pocket. You can obviously see, at a certain point, they are not going to be able to provide the high-quality care. What they have to do is basically go into the hospital and take whoever the hospital has at that time. They do not work together as a team, and they provide about half as many people as some of these surgeons need in order to provide the highest quality cardiac care.

Here is another area in which we could have provided at least a demonstration project or two to figure out how best to reimburse these cardiothoracic surgeons. We failed to do so in this legislation. We need to do that in the future. Cost containment was another matter. We wanted, given the fact this legislation could explode in cost, to have something in this bill that would ensure that the costs would be controlled.

There is a section in here that purports to do that, but it is largely illusory. It basically says, at a certain point in time we have to get together and make some recommendations. The President has to send some recommendations down to us. We do not have to act on them, of course. And it is really very hard to change the rules of the Senate to force us to act on something like this.

So I just want to let my conservative friends know that, no, there is not good cost containment in this legislation. But I would also ask them to think about one other thing; and that is, there is no free lunch. If you want high-quality health care, you are going to have to be willing to pay something for it.

I think sometimes conservatives look at one side of that ledger but not the other. We have to do everything we can to ensure that taxpayers can afford this expense. But we also do not want to be penny-wise and pound-foolish when it comes to providing quality health care for our seniors and for others who are on Medicare.

Indeed, for those who say we are going to control the costs in this legislation, I would say that the means of doing so that are in the bill are primarily price controls by the Government, which have been demonstrated not to work very well, and I think we can expect that the younger generation is going to bear the full brunt of this expense.

It is a $400 billion expense over 10 years. It is not taken out of any kind of payroll tax or other kind of payment by the beneficiary for that segment of what we are providing. It is going to be paid for out of the pockets of people who are working to earn a living and pay for their kids' education. We have to stop and evaluate whether, with a lot of seniors who are well enough off to afford drug coverage, it is fair to ask their kids, who are struggling at this point to make a living, to bear more of the burden.

There is well over $100 billion of this, probably about $150 billion, in premiums and copays and deductibles that will go toward the benefit we are providing here that is worth $400 billion. But let us not forget that the $400 billion money is being paid by taxpayers. So cost containment is important, and it will boil down to the discipline that we in the House and Senate and the President can exercise in keeping the right balance between cost containment and providing high-quality care.

I have stressed the negatives to try to establish a point. I didn't get my way negotiating this legislation despite hundreds of hours of work in the conference committee. Nobody got 100 percent of what they wanted. For those conservatives who are disappointed because of the kind of things I have been talking about here or the lack thereof that shows we really missed a historic opportunity to make the bill better, I would like now to address why I think, nevertheless, they should support the legislation.

It boils down to the fact that it is extraordinarily difficult with something this big and this complicated and important to so many people, with every Senator and every Representative having a very big stake in trying to get it right, to reach the kind of compromise that is going to make any particular group happy.

I note there was a scathing op-ed piece against one of the Democratic Members who was substantially involved in these negotiations, criticizing him for not representing his point of view well. I can't tell you how wrong the writer of that piece was. From my perspective, that distinguished Senator got far more than I did out of this. He won more of the battles than I did.

I think one should be a little bit careful about simply putting the ideology out there and saying, because one side didn't get everything it wanted, therefore it is a bad bill. The reality is that under the circumstances we face today, I think it would be impossible to put together a bill that would provide drug benefits for our seniors that would do it any better than what we have done here.

Why do I say that? Some people say, let's let this bill fail and we will come back and simply provide a drug benefit to those who need it the most. I think we have gone too far for that. Groups such as AARP are not going to support that. Their support is very important for a program such as this. I don't think a lot of Senators would support that. So even though that might have been how I would have liked to have started this process, I don't think that is going to pass.

Do we let 2 or 3 more years elapse without providing a drug benefit? I don't think that is an alternative. So I would challenge anybody who says this bill isn't perfect to demonstrate to me how they could cobble together a majority to provide an important drug benefit and still achieve all of the objectives they want to achieve and get it passed.

We do need to include prescription drugs in Medicare. They haven't been included, and we all know this is the preferred method for treatment by most physicians for many illnesses and diseases today. We also need to ensure that those who don't have coverage can get it. The options we provide in this bill at least get us part way down that road.

Importantly, we will be reducing the costs of prescription drugs both to third party payers, whether it be the Government or the employers, as well as the seniors for the part they have to pay. How is this done? There are a variety of mechanisms in the bill. One of them is the fact that the Government and the private plans will be buying in bulk. Everybody can understand that concept. You can buy for a lower cost if you buy in bulk. Another is that there are a lot of incentives to use fewer drugs, to use generic drugs, drugs that are based on a formulary that more specifically fits the particular patient's need, and not to have a lot of extra drugs sitting around in the drug cabinet. Almost all of us have extra drugs sitting around, which is probably not a very healthy thing. It is a costly thing as well.

There are a lot of incentives built in this legislation that should permit us to reduce the cost of drugs both for the third party payers as well as for the seniors themselves for the portion they are going to have to take care of.

Another important thing in this legislation is that we at least go a little way toward rationalizing the system of paying the doctors and the hospitals and other health care providers that have not been adequately reimbursed. There were large cuts in store for hospitals and doctors. Those cuts are no longer in place. In fact, there are very modest increases for physicians and hospitals: A 1.5 percent increase for the physicians, instead of the 4.5 percent cut that was going to take place starting January 1 if we did not act. At least there is modest support for those that we really count on when the chips are down to take care of us.

As I said, if we defeat this bill now, I don't see how we can come back and provide these things, how we can get consensus to do it anytime in the near future.

Another important item is the health savings accounts provision. Many of us have believed for a long time this could really provide a long-term way for people to build up the savings they can apply toward health care for insurance and out-of-pocket expenses so that they won't need to rely as much on Medicare when they get to be eligible for Medicare.

We know one of the reasons we have high-priced drugs is that Americans have to bear almost the full burden of the cost of production of drugs since other countries, such as our friends to the south and north, have price controls on how much they can reimburse the drug companies for their prescription drugs. This is unfair trade. It puts all of the burden, a cost shift, on the American consumer. This bill provides instruction to our Trade Representative to come up with a way to deal with those other countries to get them to share more of the burden of the expense of producing these important drugs for us.

We also include the affluence testing of the Medicare Part B premium for those at the very wealthy end of the spectrum; a senior who makes over $80,000 a year, for example. I think it is not too much to ask them to pay a little bit more in their Medicare premium for the coverage they receive.

We index the Part B deductible so we don't have to come back every 10 years and have Congress pass a law. This will basically keep up with the cost of inflation. We also include a change for so-called 340B hospitals. These 340B hospitals are public safety net hospitals, and we enable them to purchase their inpatient drugs cheaper than they can purchase them today. I introduced legislation earlier on this subject, and I am pleased we have that provision included here.

Then finally a provision that is important to those States such as the border States—Arizona, Texas, California, and others—that are required under Federal law to provide treatment to illegal immigrants because of the law called EMTALA, the Emergency Medical Treatment and Active Labor Act, that says no emergency room can turn away a patient whether that patient can pay or not.

Because emergency rooms now are faced with treating illegal immigrants under this requirement and because the Federal Government has not been able to enforce the law to prevent those people from coming into the country illegally in the first instance, we believed it was important for the Federal Government to at least help these hospitals defray some of the expenses they are incurring, which in some cases are so severe, it is forcing hospitals to consider closing down and certainly shutting down emergency room care.

That can't be. American citizens should not suffer because of a law that requires that we provide care to illegal immigrants. We can at least reimburse those hospitals for a portion of the cost they bear. This bill provides $250 million a year for 4 years to provide that kind of reimbursement.

There are a lot of positives in the bill. There is a lot more I know the chairman of the Finance Committee will discuss in more detail.

What I want to do is discuss it from the standpoint of somebody who has been critical, who has constantly said: We can do better. We are missing opportunities. We ought to do this in a way that is more flexible, that looks more like the FEHBP. I didn't win a lot of those battles, but we have an opportunity to at least implement a plan that we have a possibility of making better over time as people see the advantages of the concepts we have put in the legislation.

We have the knowledge that at least in the foreseeable future, because we are adequately reimbursing those people upon whom we rely for care, that we are going to have that care provided to us in a quality way and that our seniors will not suffer because we didn't consider it important enough to provide for them the very best.

Without this legislation, they will continue to pay more than they should for prescription drugs. They won't receive as much in the way of prescription drug coverage or care. And that will be a shame at a time when this country has the capability of providing that kind of care.

Notwithstanding all of the concerns I have noted, the challenges we need to face in the future, we should support the legislation.

I chair the Health Care Subcommittee of the Finance Committee in the Senate. I intend to have hearings next year into areas that may need improvement. I look forward to working with my colleagues to improve this historic legislation as we move forward. We owe our senior citizens no less.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. REID. Mr. President, we are alternating back and forth. It is obvious that it is not fair. The Senator from Arizona did not speak for an inordinate amount of time. If somebody comes and speaks for 5 minutes who is opposed to the legislation and someone speaks for 45 minutes in favor of it, that doesn't work out. I am somewhat at a loss as to why we have not worked out an arrangement that the time between now and 11 o'clock be equally divided between proponents and opponents, with no limit as to how much they could speak.

If someone who wanted to speak in favor of the legislation were here and there was nobody to speak in opposition, that person could go ahead and speak. For reasons I don't understand, the floor staff has not gotten that approved by the managers and leadership.

The Senator from West Virginia is here in the Chamber. He is going to speak against the legislation. With the agreement now in effect, it would be his time to speak. I know the manager is here. Is that OK with the Senator?

Mr. CRAIG. Will the Senator yield? I know the Senator is going to speak at 11 o'clock. I was told I could speak. The Senator from Illinois has been here for some time. I understand both of these Senators anticipate fairly lengthy statements. I do not. I anticipated no more than 10 minutes. Is it possible that I could slip in there somewhere?

Mr. REID. Mr. President, I think the Senator from West Virginia would be happy to yield for 10 minutes to the Senator; is that right? I don't know that to be the case. This shows how unfair this whole situation is.

Mr. CRAIG. Exactly right.

Mr. REID. I cannot imagine what is holding up the UC to allow the time to be divided equally.

I yield to the Senator from West Virginia. He has an obligation. That is why he is here at 11. The Senator from Illinois said he would be happy to yield, following the statement of Senator BYRD, to the Senator. He has that right anyway; he doesn't need consent to do that.

Mr. BYRD. Mr. President, in any event, the distinguished Senator from Illinois would be recognized at the same time—if I understand the request of the Senator from Nevada. If the Senator from Idaho goes first and then I go next, then the Senator from Illinois would go; or if I go first, and the Senator from Idaho goes next, then the Senator from Illinois would go. So the Senator from Illinois, through his gracious courtesy, which is so characteristic of him, either way, that would suit the Senator from Illinois.

That being the case, I have no problem with yielding to the Senator from Idaho next, if he can limit his statement to 10 minutes, which I understood he would.

Mr. CRAIG. I would do that under a unanimous consent, certainly.

Mr. REID. Just understand that following Senator BYRD is Senator DURBIN. There could be as much as an hour and a half. I want to make sure everybody understands that.

Mr. President, I ask unanimous consent that the Senator from Idaho be recognized for up to 10 minutes, and then the Senator from West Virginia, followed by the Senator from Illinois.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. BYRD. I will not speak longer than 20 minutes.

Mr. CRAIG. Will the Chair signal me when I have spoken for 9 minutes?

The PRESIDING OFFICER. The Chair will do so.

Mr. CRAIG. Mr. President, the Medicare conference report now before the Senate, brings to fruition President Bush's early and strong commitment to prescription drug relief, and it reflects nearly 6 years of difficult congressional debate.

The Senator from Iowa is here in the Chamber. He has played a key role in shaping the final package, in hours and hours of work with our majority leader and with leaders from the other side, to try to strike a critical balance.

This historic legislation, like the 38-year-old program it seeks to reform, is indeed expensive, complex, and unweildy but it is a compromise I can and will support, although not without some very strong reservations.

This bill is a solid step toward accomplishing two core goals: Providing prescription drug relief to seniors in need, and strengthening Medicare's future through greater market competition.

This legislation also includes dramatic improvements in consumer choice through health savings accounts, and perhaps the best package of rural health care improvements Congress has ever considered. I know its impact on the rural hospitals of Idaho will be significant.

Despite its deep and undeniable faults, this bill offers a rare opportunity unlikely to return for several more years, if ever—years in which millions of seniors will continue to suffer for lack of needed drugs and years in which the retirement of America's baby boomers will draw ever closer, and the modernization of Medicare will become ever more urgent. No, it is not perfect, but to hold out for perfection would risk a permanent sacrifice of much that is good and necessary in this legislation.

As chairman of the Senate Special Committee on Aging, I have chaired several hearings examining many of the hard questions in this debate—including the long-term demographic and financial pressures facing Medicare, and the importance of integrating competitive alternatives into Medicare's future. I am pleased to see some of these themes reflected in the legislation before us today.

Mr. President, my reasons for supporting this legislation are straightforward:

First, the legislation provides long overdue drug relief for our Nation's seniors. Nearly every health insurance plan in America today contains drug coverage. It is time Medicare did, too.

Beginning in 2006, seniors who decide to enroll in this completely voluntary new program and will pay a premium of about $35 and will receive a 75 percent subsidy for the first $2,250 in annual drug costs, after meeting an initial $250 deductible. And after a senior's annual drug costs reach $3,600, Medicare will cover 95 percent, providing essential relief for those seniors with catastrophic drug needs.

Overall, the average senior enrolled in this program will see annual drug costs reduced by 44 percent to 68 percent. In the nearer term, prescription drug discount cards will be available, offering seniors drug discounts of up to 10 to 25 percent.

Second, I am very pleased that the bill devotes the greatest share of its relief to seniors of modest and low income, those who need it the most.

For these seniors, the relief will be even greater than in the basic package. In Idaho, nearly 35 percent of our Medicare beneficiaries are likely to qualify. Seniors whose incomes fall below about $13,500 for an individual or $18,200 for a couple will receive deeply discounted premiums and deductibles, and those whose income is below about $12,100 for an individual or $16,200 for a couple will have no premium or deductible and will pay only a few-dollar copayment for each prescription.

The important thing to keep in mind is that the proportion of seniors today who have no private drug coverage at all is relatively small—about 25 percent—and it is on these seniors, as well as those whose current coverage is inadequate, that this bill is focused. In short, those in the greatest need get the greatest benefit and that is as it should be.

Third, the bill before us today seeks to bring Medicare into the 21st century, not just by providing prescription drug coverage, but also by offering seniors the choice to enroll in federally supervised but privately operated health care plans—that same kind of choice and coverage currently enjoyed by other Americans under 65.

Medicare today remains weighted down by rigid bureaucracy and complex regulations—regulations that are already beginning to drive doctors and other health care providers out of the program. Even more distressing, the heavily bureaucratic Medicare Program has utterly failed to keep up with the kinds of medical innovations and coverage options most of the rest of us take for granted.

By contrast, this bill's new competing regional preferred provider plans will give seniors one-stop shopping for comprehensive and integrated coverage, including prescription drugs, preventive care, care coordination, and protection against very high catastrophic medical bills—benefits which are largely unheard of in today's Medicare Program. Even more encouraging, six large-scale demonstrations, beginning in 2010, will test direct price competition between private plans and traditional Medicare. Although not as extensive as I would have wanted, these competition-based reforms are nevertheless the most substantial steps Medicare has ever taken toward bringing marketplace innovation into the program.

Importantly, all of these new choices will be completely voluntary. Seniors who want to keep their current coverage and stay in the traditional Medicare will be free to do just that. No senior will see any reduction in any Medicare benefits under this bill. No benefits will be taken away—none.

Fourth, this legislation contains landmark improvements in the ability of Americans to take charge of their own health care through expanding the use of health savings accounts.

To a greater degree than ever before, this bill will permit individuals to build significant tax-free health care savings for use in meeting a family's health care needs, including long-term care. As we try to encourage those who are becoming seniors to acquire long-term health care insurance, here is a way to finance it and finance it with tax-free dollars. Together with high deductible insurance for very high medical expenses, this approach puts control of health care where it belongs—in the hands of the individual citizens of our country.

This is something I have been fighting for since I first came to Congress, and I believe this bill's health savings account provisions are among its most important accomplishments.

Fifth, I am tremendously pleased, as should be every Idahoan, that this bill includes an unprecedented package of nearly $25 billion in improvements for rural health care. Senator GRASSLEY can be extremely proud of the work he has done to ensure the stabilizing of rural hospitals and rural health care. Most importantly, this legislation achieves a permanent evening out of rural and urban Medicare reimbursement rates. For far too long, doctors and hospitals in Idaho and other rural States have suffered under payment classifications and reimbursement levels that put them at a significant disadvantage—and that makes the already difficult task of providing rural health care even more daunting.

Sixth, the conferees have included, for the first time, a requirement that high income seniors (those making over $80,000 individually or $160,000 as a couple) pay slightly more in Medicare premiums than those who are less well off.

In the decades to come, I believe our children will thank us for recognizing that America's taxpayers simply cannot afford to continue subsidizing care for the wealthiest among us at the same level we provide for the less well off.

Finally, I believe it is important to recognize that the conferees have taken great care to include protections against something I know has concerned many seniors—namely, Will this bill cause me to lose the drug coverage I already have? The final bill includes very significant assistance to employer-sponsored plans to help assure their continued participation in retiree health care. Indeed, some are concerned that this assistance is, in fact, too substantial. But Congress's intent on this issue is clear: Seniors who are happy with the coverage they have today should be free to keep it.

The underlying framework of this bill is a sound one, and it follows the strong and guiding principles laid out by President Bush earlier this year—namely to strengthen traditional Medicare and keep it as an alternative for those seniors who want it—but also to provide a new foundation for the future, one built on choices, competition, and innovation.

This said, however, I remain gravely troubled by certain aspects of this bill.

First, it troubles me deeply that this legislation will add substantially to an entitlement program whose long-term future is already sobering in the extreme. Even without a new $395 billion drug benefit, Medicare is expected to spend nearly $3.9 trillion over the next 10 years—and by 2075, these costs will nearly triple.

Nothing can change the fact that desperately hard choices lie ahead, regardless of what we do this year. Nevertheless, what we sow today, future generations will reap.

Second, I am disappointed that the conferees chose not to adopt firm expenditure restraints if and when Medicare cost growth rises faster than currently projected. Nearly all honest observers predict that this bill will ultimately cost more than the $395 billion over 10 years that is now budgeted. Such a cost restraint measure would have gone a long way toward assuring future generations that we are serious about fiscal restraint and preserving a viable Medicare program for our children and grandchildren.

Third, I believe this bill should have moved Medicare more assertively toward a 21st century competitive approach, with an even greater role for private plans and the innovation they generate—an approach patterned, for example, after the highly successful program now available to Members of Congress and other federal employees. As it is, this bill makes a credible start in that direction, but much more remains to be done.

And finally, I am concerned by this legislation's very high level of complexity and prescriptiveness. Of course, Medicare legislation is never simple. However, this bill runs to many hundreds of pages and is very heavy with exceptions, rules, and carveouts—including literally dozens of provisions and billions of dollars relating to specifics of provider payment.

This bill's new competitive alternatives, if they succeed, are intended to take us away from this kind of micromanagement. Unfortunately, if the complexity of this bill is any guide, we may yet have a ways to go.

My concerns about this bill are very serious ones. However, on balance, I believe this legislation is a positive step forward for America's seniors, for the Medicare program, for Idaho, and for the country as a whole.

President Bush deserves tremendous credit for making Medicare and prescription drugs a top priority this year, as do Majority Leader FRIST, Senator GRASSLEY, and the other conferees for bringing us to where we are today.

Medicare urgently cries out for a better future, and America's seniors desperately need meaningful prescription drug relief. This legislation moves solidly toward reaching both of these goals, and I urge my colleagues to stand with the President and support its passage into law.

I close by thanking the Senator from West Virginia for his courtesy. I will adhere to our agreement. I yield the floor, and I thank my colleague.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. BYRD. Mr. President, our friend, the distinguished Senator from Idaho, who serves on the Appropriations Committee, is welcome. I thank him for his kind references to me.

I thank the Chair, Senator CORNYN of Texas, who has had the good fortune of presiding over the Senate on many occasions this year. I say, I have had the good fortune of speaking on almost every occasion that the Senator from Texas has presided over the Senate, and he presides so well. He presides with a degree of dignity and skill and aplomb that is so rare as a day in June.

I also thank my majority whip, the best whip the Senate has ever had. And I have been the whip. I was the whip for 6 years. But I say—I will repeat the words of a great poet—"You're a better man than I am Gunga Din."

HARRY REID is a better whip than I was, and it wasn't because I didn't do my best. I don't grow lax in any job. Any duty that is placed on me, I do my very best. But he is a jewel, HARRY REID.

Let me thank the Senator from Illinois also, the distinguished Senator, Mr. DURBIN. He is always so gracious, but he can afford to be gracious. He is so able, an inimitable debater. He can speak at the drop of a hat, and the hat won't hit the ground. That man, DURBIN, is a very fluent and ready speaker. I am so pleased that he is my friend and that he is a Senator on my side of the aisle. I thank him for his courtesies on this beautiful morning in November.

It is a beautiful morning. May I say to the young pages who are here so early in the morning:

Ah, great it is to believe the dream
As we stand in youth by the starry stream;
But a greater thing is to fight life through
And say at the end,
The dream is true!

Mr. President, I had hoped to be out here on the floor talking about a plan to give senior citizens a prescription drug benefit for Medicare.

I had hoped to be extolling the virtues of a bill that would give needed relief to the millions of our Nation's elderly citizens who have been serving their country and their communities for so long and who are entitled to needed relief. Instead, the Congress will be voting on a measure that would undermine Medicare—undermine Medicare, I say. Listen to me. Hear me now. The elderly citizens who are watching through those electronic lenses, and also the sons and daughters of the elderly citizens as well, will be affected. So instead of voting on a measure that would give relief to the elderly citizens of this country, we are going to vote on something else.

In speaking of the elderly citizens, I speak of the young people as well. Why do I say that? I say it because I can remember the days when there was no Social Security or Medicare Program in this country. I used to go by the old county poor farm in Raleigh County, and as I traveled by there many years ago I would see sitting on the porch up there at the old county poor farm, sitting just within sight of the road, those old people in their rocking chairs. They had no dreams to look forward to. When they grew old, as some of them did—and those coal miners especially grew old early in life—they had no place to go, no place to go but to the homes of their sons and daughters. They would stand with their hats in their hands waiting to be taken in by their children. What a life.

Then there came to the White House of this country a crippled man, a man who was paralyzed, a man who could not walk, as I can walk even at my young age of 86. There they stood waiting at the gates of their children hoping that they could be taken in. Then that man came to the White House and a Democratic Congress worked with him to give to the people of this country, the elderly citizens and their children, that promise. He fulfilled that promise of Social Security so that no longer would the old folks stand at the gates of their children with their hats in their hands. They could live out their lives with dignity and not be such a burden to their children.

Then I remember Medicare when it came. I was a Member of the Senate and voted for that program. That was when Lyndon Johnson, a great Democrat, was President of this land. Again, the Democratic Congress, working with that Democratic President, gave to the country this program of Medicare, the most successful program that the country has ever had, a program that today's Senators know and trust.

The Congress should be fashioning a real prescription drug benefit. That is what the American people have been told we are doing, but we are not doing that. Instead, the Congress debates a major restructuring and a step toward the privatization of Medicare.

I watched them tearing a building down,
A gang of men in a busy town.
With a ho-heave-ho and a lusty yell,
They swung a beam and a sidewall fell.
I asked the foreman, "Are these men skilled,
As the men you'd hire if you had to build?"
He gave me a laugh and said, "No, indeed!
Just common labor is all I need.
I can easily wreck in a day or two
What builders have taken a year to do."
And I thought to myself as I went my way,
Which of these two roles have I tried to play?
Am I builder who works with care,
Measuring my life by the rule and square?
Am I shaping my deeds by well-made plan,
Patiently doing the best I can?
Or am I a wrecker who walks the town,
Content with the labor of tearing down?

That is what we are doing here. That is what we are about to do. That is what we are getting ready to do. That is what the seniors and their children of this country are about to see happen. This building which was built by careful hands, by caring hands, is about to be torn down.

This is a debate that has largely been hidden from the public, a debate for which our Nation's seniors did not ask. They did not ask for this.

The conference report before us was hatched behind closed doors. We see so much of that time and again under this Bush administration—programs, plots, hatched behind closed doors. Most Members of Congress have been largely excluded from the backroom deals—largely excluded from the backroom deals—that produced this conference report.

Some have asserted this legislation is merely a Trojan horse designed to get rid of Medicare. I hope that is not true, but there is something awfully suspicious about this particular horse that is galloping through the Congress.

We need to slow down and consider the unintended consequences of this massive bill. We may be signing off on the assisted suicide of Medicare as we know it. This legislation takes the first step to undermine a health care system that has benefited millions of retirees, and it is all happening within legislation designed to enhance Medicare to provide a drug benefit. Proponents are selling it one way but may be doing something quite different. You know the old magic tricks? I can remember vaudeville. I can remember when the vaudeville shows came to those coal camps in the hills of southern West Virginia and the actor would say: Watch my right hand, watch my hand, watch my hand. Don't look at this one. Watch this hand. Don't look at what's going on over here.

There is my friend from Maryland—he knows; he remembers—Senator SARBANES, one of the great pillars of the Senate, one of the truly great Senators, a thinker in the tradition of the venerable Socrates: PAUL SARBANES.

So proponents are selling it one way but may be doing something quite different—a classic bait and switch. But seniors are not falling for the bait. Many letters coming to me clearly reveal a genuine fear that this Medicare bill will leave seniors worse off. West Virginians have not been clamoring for enrollment in HMOs. They don't want restrictions on their choice of doctors. They have not been pushing for a new Medicare system that could leave them bouncing in and out of private health plans. My constituents are rightly fearful at the thought of having to pay significantly higher premiums just to stay in their current Medicare plan.

Some analysts of this bill estimate that as many as 29,000 beneficiaries in West Virginia will lose their retiree health benefits as a direct result of this bill and that as many as 45,000 Medicaid beneficiaries in my State will pay more for the prescription drugs they need. I thought our goal was to help seniors, not hurt them, as this bill may do.

Senior citizens across America are fed up with fast rising drug costs that they cannot afford. They are traveling by the busload to Canada—yes, traveling by the busload to Canada and Mexico—just to obtain the medications prescribed by their doctors. And this bill does nothing, zilch, to help reduce the price of prescription drugs. In fact, this legislation explicitly prohibits the Federal Government from directly negotiating with pharmaceutical companies to use the bargaining power of 40 million senior citizens to lower the cost of prescription medicines. This is something the Veterans' Administration, the Department of Defense, the Medicaid Program do every day to save money on drugs. Why in the world are we prohibiting Medicare from saving money?

Unfortunately, this bill offers more of a figleaf than sufficient prescription drug coverage—a figleaf. Do Senators remember the first question that was ever asked in the history of the human race? It occurred during the evening, during the cool of the day when God came walking through the Garden of Eden looking for Adam and Eve. There they were in that paradise—how it might have been, how it might have been. God came through in the cool of the evening looking for Adam, and it was there and then that God asked that first question:

> Adam, where art thou? Adam, where art thou?

Adam was hiding. Adam and Eve were hiding. They were trying to hide from that all-seeing eye that pierced through every veil. Yes, they were hiding back in the bushes with a figleaf—a figleaf.

That question: Where art thou? These seniors, senior citizens all over this country, are going to be asking their Senators: Where were you? Where were you when the critical moment came?

I hear the siren call: "You better take it. It's all you are going to get."

This Senator will never bow to that siren call. And there are others who will not.

Rather than building on the traditional and successful Medicare Program, the measure in front of us would force Medicare beneficiaries to rely on a private, untried, untested, drug-only insurance market for their prescription drug coverage. Is that what our seniors want? Is that what the people of West Virginia want? No. No.

It would cover less than a quarter of the Medicare beneficiaries' estimated drug costs over the next 10 years. The complicated coverage formula has a large, gaping hole smack in the middle, providing zero coverage just when seniors might need that coverage most—a large hole, large enough for Attila the Hun to drive his thousands of horsemen through.

This legislation includes copayments, premiums, and deductibles that may be unaffordable for many low- and middle-income seniors. A closer look at the fine print of this legislation reveals that private insurers could choose to charge seniors double or even triple these amounts. Seniors may find that their premiums could fluctuate dramatically based upon where they live and how healthy they are. At the same time, the Federal Government will be handing over billions of taxpayer dollars to for-profit insurance companies, just to get them to participate in Medicare.

Let's face it, the kind of prescription drug benefit that we have repeatedly promised to our Nation's seniors and they now rightly expect would cost at least $800 billion during the next decade. Drug costs for senior citizens alone are expected to total almost $2 trillion during this same period. Yet the Bush administration and congressional leadership have only set aside $400 billion for a Medicare prescription drug benefit. Although, isn't it remarkable that we can afford to spend $1 billion a week—$1 billion a week—in Iraq?

I will have plenty more to say about that. I made 62 speeches on that gargantuan mistake. I will make some more, the Lord willing.

Missiles? Yes. Medicines? No. Missiles? Yes. Medicines? No.

Where are the priorities of this administration? Where are the priorities of the Congress?

It seems that this Congress is trying to pull the wool over the eyes of our Nation's seniors hoping to claim victory and keep seniors in the dark until they become painfully aware of the fine print in this legislation upon a visit to their local pharmacy—in 2006. That will be my next election year, 2006, the Lord willing.

In the Book of James, we are told always never to say, I will go here, I will go to this city or to that city, I will buy this, or I will buy that tomorrow, but always to say, the Lord willing, I will go to this city or I will go to that city and I will buy this or that. So, the Lord willing, 2006 is my next election day. Eighty-six is not too old. I am 86 years old. Abraham lived to be 175, Isaac lived to be 180, Jacob lived to be 147, Moses, 160; and so on.

Mr. GRASSLEY. He lived to be 120.

Mr. BYRD. Was I wrong on that?

Mr. GRASSLEY. Moses lived to be 120, not 160.

Mr. BYRD. All right, 120. The distinguished Senator from Iowa corrected me. But he won't correct me on this bill. He won't correct me on the tragedies of this bill. But I accept his correction. I will go look it up to make sure.

As lobbyists for the pharmaceutical and health industry swarm all corners of the Capitol, the Congress is on a mad dash to pass this bill before Thanksgiving, regardless of its contents or its flaws, so long as it can be called prescription drug coverage. Unfortunately, when it comes to their health care security, it appears our Nation's senior citizens will find that they have little for which to be thankful.

I have heard some Senators argue that something is better than nothing. Is that what we are being given? Something rather than nothing? Nothing?

They try to rationalize a bad bill by claiming that this may be our last chance and you had better take it; something is better than nothing. They argue that we should vote for this now and fix the bill's problems down the road. I have been down that road. I have seen that and heard that many times in my 51 years in Congress. This conference report is a pill that is too bitter to swallow.

I am one of perhaps only a handful of Senators in this body who voted to create Medicare. I can say to you, Mr. President, that it was not created overnight. It was not created in the hidden dungeons, in the hidden subterranean caverns under this Capitol. It was created in response to a private sector that would not offer affordable and reliable health insurance to the elderly and the disabled.

Few can argue that seniors are not better off today as a result of Medicare. We should not turn our backs on one of the most successful Government initiatives ever created. We should seek ways to strengthen Medicare, not dismantle it.

Senior citizens who need life-sustaining medicines want us to get it right. They trust us to get it right. We should reject this bill and work to pass a bill that does get it right. Thanksgiving is an arbitrary deadline. It means nothing when measured against the potential damage that could be done in haste—haste that could jeopardize the health care security of generations to come. We should do better for our senior citizens. We owe them that much.

In closing, I thank Senators who have worked hard on this bill, Senators who have toiled late into the nights and weekends. I thank Senator GRASSLEY. I thank Senator BAUCUS. I thank all Senators. I thank all Senators for listening.

By the way, as to Joseph, how long did he live? He lived to be 110 years old.

The PRESIDING OFFICER (Mr. BENNETT). The Senator from Nevada.

UNANIMOUS CONSENT AGREEMENT

Mr. REID. Mr. President, I am sure the Chair can protect the majority if there is a problem. We need to get this unanimous consent agreement, which has been approved by both sides.

I ask unanimous consent that the time until 11 o'clock tonight be equally divided between the opponents and proponents; provided that when time expires on either, it be in order for either side to consume additional debate time; further, that the debate time used beginning with Senator KYL's statement this morning be counted against the time allotment. I further ask unanimous consent that notwithstanding the order for an alternating fashion following the remarks of Senator DURBIN, it be in order for two Republicans to speak consecutively, one Senator for 20 minutes and the other Senator for 15 minutes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. REID. Mr. President, further, so Senators will have some understanding as to when they can speak, I ask unanimous consent that the Democrat order be Senators STABENOW and REED of Rhode Island following Senator DURBIN, and that the Republicans be Senators SNOWE, CORNYN, COLLINS, BENNETT, HATCH, BOND, NICKLES, and GREGG.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Illinois.

Mr. DURBIN. Mr. President, before saying a few words about this Medicare bill, I would like to say a few words about the senior Senator from West Virginia. This man is such an amazing person. At 86 years of age, what he brings to public service and what he brings to the Senate is incredible.

I was in the Chamber earlier this morning when Senator BYRD arrived. He said he would like to say a few words. I said, quite honestly, I am ready to follow you into battle any day. I deferred to him, which I was happy to do. He is a grand person and such an amazing Senator.

I have been fortunate to represent a congressional district in Illinois and the State of Illinois for over 20 years on Capitol Hill, and I have many favorite moments. But in the top tier of those favorite moments was the time in a conference committee downstairs from this Chamber involving Senator BYRD, and I would like to tell those who are following this debate about that experience because I still marvel at what he did that day.

He came to a conference committee on the Transportation appropriations bill facing a critic in the House who said that Senator ROBERT C. BYRD of West Virginia had put too much in this bill for the State of West Virginia. And your critic from the House was going to have his day with you at that conference committee.

As some people know who follow the Senate, the appropriations conference committees gather at a large, long table and the House Members sit across the table directly from the Senate Members. So your critic in the House came and took his seat with a sheaf of papers prepared to do battle with you over the Transportation appropriations bill. You arrived and just fortuitously happened to sit directly across from him at that table. He began his peroration about how terrible it was that West Virginia would have so much in this Senate bill and he was going to do something about it. He went on for all of 15 minutes. He got red in the face, his arms were waving, and finally he was spent. He had nothing more to say.

Then, as I recall, you turned to the chairman—which could have been Senator Hatfield of Oregon—and asked if you could be recognized.

The Senator began his remarks, and that is what I thought was the most remarkable moment, saying, in the history of the United States there is an exchange of speeches between two individuals which defined Federalism as we know it and the role of small States like West Virginia in the Senate and larger States. That exchange was between Daniel Webster and Robert Hayne.

Senator BYRD went on to say, Webster's reply to Mr. Hayne was delivered on January 20, 1830. And then Senator BYRD added, "and if my memory serves me, it was a Thursday." He proceeded to give an important history lesson to all who had gathered, Members of the House and the Senate, about why West Virginia had a fighting chance in the Senate but might not have that same chance in the House, as each State has two Senators, of course, in this Chamber, and represented proportionately in the House.

I was absolutely spellbound by his performance that day in that small room. When it was all over, of course, West Virginia fared well in that appropriations bill, as it always has since Senator BYRD has been here to make sure his State was not shortchanged. I was in the House at the time, and a few years later I came to the Senate and said to Senator BYRD: Of all the things you said in the speeches, when you said, "If my memory serves me, it was a Thursday," I still remember those words.

Senator BYRD said: Well, Mr. DURBIN, if I am not mistaken, it was a Thursday.

I said: I am not questioning you; I am sure it was a Thursday.

Later in the day, he called me over to his desk and pulled out a perpetual calendar, and said, yes, January 20, 1830, was a Thursday.

It says a lot about this Senator, not only his reverence for history and this institution, but the fact that he brings to many of these political battles an insight that many Members admire so much and respect. Whether you are on his side or not, you best sit back and listen closely when Senator BYRD takes the floor because he brings to each one of these debates the very best in public debate and the very best in public service.

This Senator was happy to step back and listen very carefully as the Senator from West Virginia made another compelling argument on a very important and historic piece of legislation.

Mr. SARBANES. Will the Senator yield?

Mr. DURBIN. I am happy to yield.

Mr. SARBANES. I listened to the able Senator from Illinois with great pleasure because I strongly share his feeling and views about Senator BYRD. I took the floor for a brief moment to underscore the extraordinary contribution that Senator BYRD has been making to the national debate in the recent period on issues of critical national importance. He has taken to the floor time and time again and spoken with a clear strong voice. He has sounded a clarion call to the country. I know from people I talk to that voice is reaching into many corners across the land and prompting Americans to think deeply about the issues that confront the Nation, and even more deeply and fundamental about how we go about conducting our business and making these decisions.

The vote last night in the House of Representatives was held over for 3 hours in order for the Republican leadership to twist arms in order to change the outcome, which was already up on the board, where they had lost by two votes. That rollcall vote was held open indefinitely. My able colleague from Maryland, Congressman HOYER, remarked afterwards, it would be as though you had election day, the time came for the polls to close, and you held the polls open for another 15 hours while you went out and somehow found the votes to assure you the result. It is an abuse of the democratic process.

The Senator from West Virginia has always spoken. He sounded a loud trumpet about our Nation. We are deeply in debt to him and appreciate that.

Mr. DURBIN. I thank the Senator from Maryland. I might just add something I have said in the Senate and I told Senator BYRD during the debate on Iraq. I went to my church in Chicago with my wife—this is highly unusual in my church—as we came back from communion, and we are kneeling, an elderly man came up to me and leaned over on his way back from communion and he said: Stick with BOB BYRD.

I came back to tell Senator BYRD that his message reached beyond this Chamber and beyond the State of West Virginia. It has been not only heard, but it has been applauded by the Nation of grateful people who are glad you are here in service to our country and continue to be. If you reach the age of Methuselah, Abraham, Isaac, or Moses, I hope I am still here to defer to you and listen carefully as you make these presentations.

Mr. BYRD. Mr. President, will the Senator yield?

Mr. DURBIN. I am happy to yield.

Mr. BYRD. Mr. President, I am deeply grateful to these two fine Senators for the kind words they have just spoken, Senator DURBIN and Senator SARBANES. I will go to my everlasting resting place with love and gratitude and affection and admiration and respect for these two Senators and how they have served the Nation and this institution and been loyal and true to the Constitution of the United States forever. I shall think of them and be in their debt. I thank the Senator.

Mr. DURBIN. I thank the Senator from West Virginia.

The Senator from West Virginia, when he came to the floor, gave us an important message. He asked us to look at this very carefully. This, my friends and fellow colleagues, is a proposed law. It is huge. But that is not uncommon. And that should not be a reason to vote against it. The reason to vote against it is what is contained in this law, this proposal, this bill.

When we started this debate about prescription drugs for seniors, overwhelmingly the President, the Republicans, Democrats, all agreed on one thing: We needed to find a way to provide affordable prescription drugs for senior citizens. Medicare, as good as it is, provides good care through hospitals and doctors but not enough help when it comes to paying for prescription drugs. We understood that needed to be done.

The solution was obvious from the start. The solution to this challenge was to put under the Medicare Program a voluntary, comprehensive, and universal plan to pay for prescription drugs, to use the same successful model that has guided us for 40 years in keeping seniors healthy through good doctors and good hospitals, and also provide prescription drugs. We knew if we did that, it would work as Medicare has worked. The proof of Medicare's success is the fact that seniors are living longer, they are healthier, they are independent, and they are strong.

But there was a criticism of using this so-called Government approach. The criticism came from political extremes that argue that the Government shouldn't be involved, and also from the pharmaceutical industry which understood full well, if Medicare could bargain for seniors across America, Medicare could bring down the prices of prescription drugs just as the Canadian Government has brought down the price of those same drugs for its citizens.

The pharmaceutical companies lived in dread that Medicare would be able to have cost control and competition and bring down the price of drugs.

So we started on this convoluted path to find an alternative. The first suggestion was, why not let private insurance companies provide this prescription care benefit? Let them compete. There is nothing wrong with that from this Senator's point of view. If private companies want to offer prescription drug benefits and compete with Medicare, so be it. Let's see what happens. Let's see if that competition will also help seniors.

But they said, wait a minute, we are not wanting these private companies to compete with Medicare. We want Medicare out of the business of competition completely. That was the starting point for the Republican approach to prescription drugs. Of course, the pharmaceutical companies applauded this because if they do not have to answer to Medicare with 40 million Americans under its protection but, rather, to smaller companies, they have more bargaining power. So we went through this long exercise in the Senate about this proposition that private insurance companies would somehow provide prescription drug benefits to seniors.

I offered an amendment on the floor, supported by most of my colleagues who are here today, that said: Give Medicare a chance to compete. We did not prevail. In fact, we did not get any votes from the other side of the aisle. The Republican approach to this from the start was to say they believed in Medicare, but then to turn their backs on Medicare when it came to prescription drug benefits.

Well, eventually we were faced with the prospect, in the Senate bill, of either accepting their approach, and moving toward prescription drugs for seniors, and passing it out of the Senate, or doing nothing. Most of us voted to move the bill forward and into the conference committee. But, sadly, that was not the end of the story.

When it came to the conference committee, there was a new political force at work, not just the people who wanted to keep Medicare out of the prescription drug business but a new group from the House of Representatives with a much more radical agenda. What they wanted to achieve was not just private insurance companies offering prescription drug benefits, they, in fact, wanted to privatize Medicare itself.

We started by wanting to add a benefit to Medicare, and now the House Republicans, and their cohorts in the Senate, have said: We want to change Medicare. We want to make certain that Medicare as you know it will not be there in the future.

One of the proponents of this point of view was former Speaker of the House Newt Gingrich, who this week came to the Republican House caucus and said: Vote for this bill; this is a good bill. That should be proof positive to anyone listening that this is a bad bill. Because it was that same Speaker Newt Gingrich, whom I served under in the House, who said, at one point, that we should allow Medicare to wither on the vine. There was no personal or political commitment by Speaker Gingrich to Medicare. And for him to endorse this huge bill is proof positive to me that within the four corners of this bill are threats to Medicare we need to take seriously.

This morning, as I came to the office, on Saturday, I had an e-mail from one of my staffers who fields the phone calls that come into my office. She wrote and said: Senator, something unusual is happening out there. When you first started debating prescription drugs under Medicare a few months ago, the phone calls were generally positive. Seniors were saying: Let's do it; we have waited too long. But she said: Something's happened. There is a sea change out there. The phone calls are overwhelmingly negative now.

Seniors have come to understand this bill not only does not give them good prescription drug coverage but it is a full-scale assault on Medicare itself, and they are calling every office, congressional and senatorial office alike, saying: Defeat this legislation.

Now, doesn't that tell us something? Doesn't it tell us something, that what we started off in believing—that seniors wanted prescription drugs—has now been rejected by them when they learned what is at stake? And there is a lot at stake.

This bill will raise Medicare premiums, something which lower income seniors will find very difficult to deal with. It will force seniors into HMOs. And you know what that means. That means insurance companies will pick their doctors and their hospitals for them and say that they will lose the right to choose their own doctors and hospitals.

Of course, that is the grand old Republican plan: that Medicare as we know it would change; that, instead, we would be dealing with HMO insurance companies. And I can tell you, I have yet to run into a senior citizen anywhere who endorses HMOs, nor many doctors who believe they are very good when it comes to quality health care. Yet that is the solution that is being offered here.

It is not bad enough that my friends on the Republican side of the aisle have said they want to move toward private insurance companies and privatizing Medicare. They do not even believe in the value of the free market in this experiment. Because they are not saying to HMOs: We want to open the door and give you your chance to compete. No. They are coming through with more than $10 billion in Federal taxpayers' subsidies to be given to these HMO insurance companies so that they capture more and more seniors out of Medicare.

Think of that. The Republican free market, entrepreneurial spirit that is being sustained by a $10 billion Federal slush fund for HMOs so they can take more and more seniors out of Medicare.

What is even worse, as they draw seniors out of Medicare, they will look for, as most insurance companies do, the healthiest of the seniors, leaving behind the poorest and the sickest seniors in Medicare, meaning that the costs of Medicare per person are going to go up, and Medicare will become more expensive, and perhaps less popular from a budget point of view.

That is the grand plan here: Starve Medicare; have it wither on the vine. Newt Gingrich's vision for Medicare is finally realized in this 1,200-page bill. Speaker Gingrich rides again. He has prevailed. His was the voice that prevailed when it came to the contents of this bill.

Sadly, too, this bill will eliminate drug coverage for millions of Americans. We have had a Congressional Budget Office review of what happens when this bill goes into effect.

Mr. President, 2.7 million retirees will lose the private insurance coverage they currently have. Understand who these people are. These are people who have worked for a lifetime for a company, with the understanding they would receive a retirement benefit which included prescription drug coverage. And when this goes into effect, this proposal that has been brought before us, the Congressional Budget Office and other sources tell us 2.7 million Americans will lose their prescription drug coverage. They may lose all of their health coverage during retirement.

Over 100,000 of these unlucky retirees are in my State of Illinois. For them, if for no other reason, I will be voting no on this. I will be voting no because, frankly, we are basically saying: We want to reward HMOs. We want to reward pharmaceutical companies at the expense of people who have worked a lifetime for security in their retirement and will lose it because of this bill.

How can we, in good conscience, stand here and say we are going to create a mechanism where companies will have the rationale and the opportunity to drop their retiree health care coverage? That is sad. Medicare was created because seniors across America did not have a helping hand when it came to doctors and hospitals. And now, in this effort to privatize Medicare and reward the big drug companies, we are going to provide less coverage for seniors across America.

Let me speak for a moment about the pharmaceutical aspect of this bill. We know if we have competition, we can bring prices down. We also know if the Government shows leadership, as they have in Canada, prices of drugs will come down. But the pharmaceutical companies have prevailed. The pharmaceutical companies have won the argument.

The most important question asked about any piece of legislation before the Congress is this: Who wants it? Who wants this bill?

First and foremost, the pharmaceutical companies want this bill because there is no effort to bring down the cost of drugs that American families and seniors have to pay—no effort whatsoever.

We had a provision included that called for generic drugs, one way to try to get good drugs that are lower priced in the hands of seniors, and it was weakened dramatically in the conference. We had an opportunity, through a provision proposed by the House of Representatives, for reimportation of drugs from Canada and Europe so seniors had a chance to get a break there if they could not afford the drugs here in the United States. That was dramatically weakened, too. And the Bush administration has vowed they will never let it happen, they will not allow reimportation to happen.

So if you do not have generics encouraged, and you do not have reimportation, and Medicare is not competing for cost, what it means is the pharmaceutical companies have their prayers answered, their dreams come true. They will continue to hike the cost of pharmaceuticals and drugs, and this Government and this bill will do nothing to stop it, and seniors across America will find this so-called prescription drug benefit of little or no value as time passes. Because if the cost of drugs goes up 10 or 15 percent a year, no matter what the Federal Government offers, in the end, there is little to show for it—less and less each and every year.

Mr. SARBANES. Will the Senator yield for a question?

Mr. DURBIN. I am happy to yield for a question from the Senator from Maryland.

Mr. SARBANES. Am I correct in my understanding that under this bill, the Government, through Medicare, could not, in fact, bring its weight to bear in order to lower the cost of prescription drugs through a buying program, where they are a heavyweight in the scale—that the bill actually precludes that from happening?

Mr. DURBIN. The Senator is correct because Medicare is not given the option of offering prescription drug coverage here, an option which most seniors would gladly endorse. And the reason is obvious: If Medicare can bargain on behalf of 40 million Medicare recipients, it has the bargaining power to bring down the cost of drugs for seniors. The pharmaceutical companies hate that concept, "like the devil hates holy water," to quote our old friend Senator Bumpers, who used to say that on the floor from time to time.

They don't want competition. They don't want cost control. They have won the day.

The Senator from Maryland has turned on his television at home in the last few days and weeks and maybe heard his name mentioned on television commercials that are being paid for by the pharmaceutical companies saying: Senator MIKULSKI, Senator SARBANES, vote for this bill. They are spending millions of dollars saying vote for this bill because this bill will mean millions and millions more in profit for those same pharmaceutical companies.

Mr. SARBANES. Will the Senator yield for a further question?

Mr. DURBIN. I am happy to yield.

Mr. SARBANES. In addition to precluding the Government from bringing its weight to bear in purchasing in order to lower the cost of drugs because they would be a very big purchaser and obviously they would have an impact, some have said: Well, let's at least allow for the reimportation of drugs from other countries, particularly Canada. Some of our people have been going to Canada in order to get their prescription drugs. They cross the border, and they can buy them at 40, 50, 60 percent less than they pay in this country. So there were provisions that passed to allow reimportation. Am I correct that, in effect, this bill eliminates that?

Mr. DURBIN. The Senator is correct. This bill gives the last word to the Bush administration and the head of the FDA who have said categorically they are opposed to reimportation. The reason they are opposed is that it would be more competition for pharmaceutical companies that want to charge higher prices in the United States. I have believed all along that we are not importing drugs from Canada, we are importing leadership from Canada. The Canadian Government has stood up for its citizens and said: We are not going to allow the drug companies to raise their prices every single year. This Government, this Congress, refuses to show the same leadership, and now is effectively blocking the reimportation of drugs that seniors need to survive.

Mr. SARBANES. Will the Senator yield for a further question?

Mr. DURBIN. I am happy to yield.

Mr. SARBANES. I also understand there was an effort to clear the path for generic drugs to become available. Of course, generic drugs sell at a lesser cost than brand name drugs. A lot of the pharmaceutical people are opposed to that.

It is also my understanding that this bill fails to carry through on the efforts to make it easy to bring generic drugs to market. Am I correct in that respect?

Mr. DURBIN. The Senator from Maryland is correct. It is another success story for the pharmaceutical industry because they bring the drugs to market, brand name drugs, under patent, and during a period of time they have a right to sell them exclusively in America. But when that patent runs out, then other companies can make that same drug and sell it, usually at a much lower cost. So the pharmaceutical companies that make the brand-name drugs found ways to delay the process so that the generic drugs could not replace the brand-name drugs, so they could continue to make millions and millions of dollars off the brand-name drugs even when their patents expired. We changed that in the Senate.

We put in language that said we are going to move toward generic drugs so consumers can have affordable drugs. And, frankly, in conference committee, the pharmaceutical companies won again, another reason they are running ads about this Senator and the Senator from Maryland saying vote for this bill right now, because they know it means more money to an industry that is already the most profitable industry in America.

Mr. SARBANES. Will the Senator yield for one final question?

Mr. DURBIN. I am happy to.

Mr. SARBANES. I hate to intrude on his time, but this is a very important point. With this legislation, the pharmaceutical companies have, in effect, slowed the ability of generic drugs to come to market, which would be one source of competition that would lower their prices. The reimportation provisions have been written in such a way that it is completely in the hands of the administration whether reimportation of drugs, say, from Canada is allowed. The administration has been very clear that they are opposed to doing that. The legislation also, in effect, knocks out the Government from being a direct purchaser and controlling the prices.

Every source that potentially could exercise some pressure or influence on the pharmaceutical companies to lower or restrain their prices is being blocked out by this legislation. So the end result is that it is an absolute bonanza for the drug companies. Would you say that is a reasonable perception of what this legislation does?

Mr. DURBIN. I would say the Senator from Maryland is correct. I would refer him to a Bloomberg News article yesterday with the headline "139 Million Dollar Lobby Blitz Thrown at Medicare Bill." And it leads by saying:

> Health care companies, led by drug makers Merck & Co. and Eli Lilly, spent a record $139.1 million in six months to lobby Congress on a Medicare bill that will help the elderly buy prescription medicines. The pharmaceutical companies were the biggest spenders in the health care industry putting money into this lobbying effort.

The Senator knows, as I do, that if you find pharmaceutical companies working feverishly night and day to pass this legislation, it isn't because they want to make less money. They want to make more money. So we have the GOP, which could now be the acronym for the Greedy Old Pharmaceutical companies; that is what is pushing this legislation. That is proof positive that the seniors will be the losers.

The seniors understand that, as do families across America. It isn't bad enough that it is just pharmaceutical companies that are going to make out so well. The same thing is true about HMO companies, the HMO insurance companies with the more than $10 billion Federal slush fund so they can compete with traditional Medicare, $10 billion, and a reimbursement level of 109 percent for these same companies for their expenses while they are competing.

Then to add the crowning touch is something called health savings accounts. I would say to the Senator from Maryland, you are going to recognize this song after I sing a few lyrics. A company called Golden Rule Insurance Company, originally out of Evansville, IL, now based out of Indianapolis, with a man named Mr. Rooney as its CEO, has been locked at the hip with the Republican leadership on Capitol Hill since Speaker Gingrich took over in the House. That is when they dreamed up this idea of medical savings accounts and said: Here is the wave of the future. We can replace health insurance as we know it with the Golden Rule model of medical savings accounts, resulting in our efforts in 1996 of a demonstration project to so see if this flawed concept would work. So few people were interested in signing up for it, it was a failure on its face.

Guess what. In this bill there is a $6 billion subsidy for health savings accounts. In other words, not only are we guaranteeing record profits for pharmaceutical companies, not only are we creating a $10 billion slush fund for HMOs to take seniors out of Medicare, we are putting $6 billion into this boondoggle health savings account. I was on the floor watching the Energy bill yesterday and thinking it was scandalous that we were putting $2 billion into the MTBE and oil industry—$2 billion. They did us better with this bill. The Republican conferees came back and said: Let's up the ante; let's make it $6 billion to subsidize this crazy concept of health savings accounts engendered by the Golden Rule company, one of the greatest benefactors of the Republican Party on Capitol Hill. If that isn't proof positive that this bill has gone astray, I don't know what is.

I say to seniors who continue to call congressional offices, keep the calls coming in. Let me suggest to them as well that if many of them happen to be members of AARP, here is that telephone number. Call your friends at AARP, ask Mr. Novelli, who has endorsed this boondoggle, why in the world has he turned his back on seniors? Why is he not fighting for more competitive drug prices? Why isn't he trying to stop the HMOs from privatizing Medicare? And why are we putting a $6 billion subsidy in here for friends of the Republican Party, the Golden Rule Insurance Company. I think seniors across America get the message.

There was just a poll taken this week of members of AARP, which I hope Mr. Novelli will have a chance to read.

The poll shows that once seniors have been told what is in this bill, 65 percent of the members of AARP said they should stop trying to pass this bill and work for a better plan, and only 18 percent of the members of AARP supported it. So by a margin of almost 4 to 1, the members of AARP are saying to their leadership: You have it wrong.

I think, frankly, it is a burden now on AARP to come back to its roots and decide whether it is going to stand up for seniors or for pharmaceutical companies and HMOs. I hope the seniors across America who are as upset about this as many of us are will call AARP and tell them to stop spending millions of dollars trying to pass this bill. Instead, they should try to save Medicare first, and they should say basically don't sell out the seniors of America.

AARP is now in lockstep with these pharmaceutical companies and HMOs. They have forgotten their mandate, which is to stand up as a voice for seniors across America. That is unforgivable. I think they are going to find a lot of their members tearing up their cards and walking away from this organization. It has become very political and insensitive to the seniors across America.

Mr. SARBANES. Will the Senator yield for a question?

Mr. DURBIN. Yes.

Mr. SARBANES. The Senator made reference to a better bill. The very able Senator from Illinois, in the course of debate in the Senate, offered a better bill, which I was very pleased to support. That bill would have been a very significant and substantial step forward. Among other things, it did not have this "donut" in coverage that is in this bill.

As I understand this bill, at a certain point—I think $22.50 in drug cost—and beyond that, up to $3,600, the burden falls back on individuals; is that correct?

Mr. DURBIN. The Senator is correct.

Mr. SARBANES. In the Senator's bill that didn't happen; is that correct?

Mr. DURBIN. That is correct. This is a moving target. The fact is that there is a gap in coverage for prescription drugs built into this proposal so that the sickest seniors with the highest prescription drug costs will find some coverage on the front end of the year for their illness and then find themselves paying out of pocket $2,850, if I am not mistaken, before they get more coverage from the prescription drug benefit. So this so-called donut hole is one that I think seniors who are really sick and those who need expensive drugs should be aware of.

The bill we offered said Medicare will come in and compete for lower drug costs and the savings we can gather for lower drug costs will close this donut hole.

Mr. SARBANES. Will the Senator further yield for a question?

Mr. DURBIN. Yes.

Mr. SARBANES. Would we not also have been able to not have a donut hole if these moneys the Senator made reference to that are going to the HMOs—the $10 billion, I think you said—

Mr. DURBIN. Yes, a $10 billion slush fund for HMOs.

Mr. SARBANES. Also $6 billion—

Mr. DURBIN. Yes, for health savings accounts, for their buddies at Golden Rule.

Mr. SARBANES. So that $16 billion could have been taken and put directly to improve the benefit for our seniors, could it not?

Mr. DURBIN. The Senator is correct. The Senator starts with the same premise I do—that seniors are most comfortable with Medicare. If this started off as an added benefit to Medicare, this bill would have been much smaller and more understandable and supported by seniors. But when they rejected that and said, we are going to go to private companies, they really opened up all sorts of problems. They guaranteed profitability, put in slush funds, and they complicated it to the point where most seniors will struggle to understand it. This didn't have to be the case.

When you are out to privatize Medicare and reward pharmaceutical companies and help HMOs, that is where you end up.

Mr. SARBANES. As I perceive it, all of these things that are being done—the HMOs, the medical accounts, the limitation on Medicare being able to act directly, and so forth—if this stack of papers on the desk represents the Medicare Program itself, they are circling around it to undermine and undercut it. This bill has taken on an added fundamental dimension.

So as we look at this bill, we have to look at not only its shortcomings in adding prescription drugs to the Medicare Program, but we have to perceive that built into the bill are a number of efforts being put into place that will undercut the Medicare Program itself. Is that a reasonable view of the potential of this legislation?

Mr. DURBIN. The Senator is correct. There are those who began this debate saying: We are going to change Medicare. Well, they had their way. Many came here saying: We want to help seniors pay for prescription drugs. If we had stuck to our original goal and focused on what seniors really want and what works, I think we would have achieved this result through Medicare a long time ago. It would have been at the expense of the profitability of pharmaceutical companies.

I say to my friend, who follows some of these corporate reports more than I do, this pharmaceutical industry is the most profitable in America. Look at this chart. Profits as a percentage of revenue in 2002: No. 1, pharmaceutical companies, with 17 percent return on revenues. Return on assets: No. 1, pharmaceutical companies, with 14.1 percent. Then they were nosed out when it came to return on shareholders' equity by household and personal products, but they are still No. 2, with 27.6 percent profit as a percent of equity.

This bill is giving them more profit at the expense of families and low-income seniors in America. That is why the pharmaceutical companies are spending millions of dollars for television, radio, and newspaper ads telling this Congress to "do our bidding." That is why they already spent $139 million lobbying Congress to pass this bill.

If the pharmaceutical companies wanted to help seniors, they could have done this long ago. They could have charged more reasonable prices, particularly to low-income seniors. But that isn't their goal. Their goal is more profitability. Sadly, they found allies with the Republican majority who are attempting to pass this bill and make certain they are more profitable.

Mr. SARBANES. If the Senator will yield on that point, in confirmation of the Senator's analysis, the markets, in the last few days, have been boosting the price of the stocks of the pharmaceutical companies. The perception in the capital markets of the smart money people is that this legislation is going to significantly benefit the pharmaceutical companies, and they are building up the stock prices, which only goes to confirm and corroborate the analysis the Senator from Illinois has made on this issue.

Mr. DURBIN. The Senator from Maryland is correct. I will make this one last reference as I see colleagues in the Chamber who want the floor.

Represented on this chart are the compensation packages for the HMOs. This is another group that is benefiting. The $12 billion slush fund will be going to HMO companies such as these on the chart. They will leave poor and sicker people behind. There will be a $12 billion slush fund and some more benefits given to HMO companies. Look at the compensation for the executives. It runs from the obscene at Oxford, where Norman Payson gets $76 million.

Mr. SARBANES. Is that per year?

Mr. DURBIN. Yes. Mr. Payson had a very good year. Alan Wise at Coventry gets $21.6 million. This man must be really gifted if he is worth that to run a managed care company, which is now going to be in the category of companies eligible for the $10 billion Federal subsidy.

Down here is United Health Group, where R. Channing Wheeler is getting

$9.5 million. I bet he was embarrassed going to the country club with his friends and only making $9.5 million.

Incidentally, United Health Group—do I remember that name from the AARP newsletter? Yes. It turns out they are in business together. It turns out that AARP, which is for this bill, is in business with United Health Group, a managed care company. Frankly, as I understand it, 60 percent of the revenues of AARP come through their insurance and advertising. Is it any wonder that AARP is pushing for this bill, when seniors are opposed to it?

I want to close because I see other colleagues in the Chamber. I say to seniors across America: If you have received your AARP solicitation and sent back your membership card, please call AARP at 1–800–424–3410. Tell them to stand up for seniors for a change, to reject this bad bill that won't result in lower prescription drug costs and will privatize Medicare.

Tell them you are opposed to a slush fund that is being created for HMOS. Tell them you think it is scandalous that we give $6 billion to Golden Rule for health savings accounts. And tell them it is time for your organization, AARP, to stand up for seniors and stand up for Medicare instead of caving in to the special interest groups and supporting this legislation.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The majority leader.

REMEMBERING PRESIDENT JOHN F. KENNEDY

Mr. FRIST. Mr. President, we discussed this morning that we will have a moment of silence at 12:30. I request we have a moment of silence.

The PRESIDING OFFICER. The Senate will observe a moment of silence.

(Moment of Silence.)

The PRESIDING OFFICER. The majority leader is recognized.

Mr. FRIST. Mr. President, this moment of silence gives us an opportunity to reflect in a way that expresses our deep respect and also an opportunity to contemplate how we can capture what happened in the past and those lessons of the past and project them to the future but also in terms of carrying out our responsibilities in the Senate.

The PRESIDING OFFICER. The Democratic leader.

Mr. DASCHLE. Mr. President, for those of us who are old enough to remember President Kennedy, November 22 is always tinged with a sense of sadness and loss. Today, on this 40th anniversary of President Kennedy's death, we are especially aware of that loss.

One floor above us, in a corridor leading to the House side of the Capitol, there is a wonderful exhibit by a longtime Senate photographer named Arthur Scott—"Scotty." He was an official Senate photographer from 1955 until his death in 1976.

One of my favorite of his photos up on the third floor shows a very young-looking Senator John Kennedy playing catcher in a baseball game with other Senators in 1958. Scoop Jackson is at bat and Mike Mansfield is umpiring. John Kennedy looks more like a staffer than a Senator.

About 12 feet down that same hall hangs another photograph. This one was taken on January 20, 1961. It shows a smiling, older-looking JFK walking into the Rotunda shortly before he was sworn in as President. Next to that is another photograph, also taken in the Rotunda. It shows a grim-faced Everett Dirksen with his arm around the shoulders of Hubert Humphrey as the two men walk past President Kennedy's casket in November 1963.

Only 5 years passed between that first photograph and the last. Only 1,000 days elapsed between John Kennedy's inauguration and his death. Not long at all. Yet, 40 years after that terrible day in Dallas, President Kennedy remains vivid in our memories and he continues to inspire even people who were not yet born when he died.

There are many reasons for this, I believe.

John Kennedy believed that politics can be a noble profession. Many of us in this Senate are here, in part, because we were inspired by his belief and his example. That is certainly true of me. That belief was also shared by his brother Robert, and it continues to be demonstrated today by his last surviving brother, our friend and colleague, the senior Senator from Massachusetts.

Another reason that President Kennedy remains such a force in our national life is that he inspired us to be our best possible selves.

He led by appealing to our better instincts, not our base fears. He showed us that we need not fear great challenges, as when he said America chose to go to the moon not because it was easy, but because it was difficult. He understood that there is almost nothing Americans cannot achieve when we are united and willing to sacrifice and work together toward a common goal.

John Kennedy was, indelibly, the grandson of immigrants. He was deeply grateful for the freedoms and opportunities that America affords. But he also understood that, with rights come responsibilities. As he said so often, "To those whom much is given, much is required."

President Kennedy understood that the most powerful weapon America possesses is the power to do good in this world. And he transformed that belief into the Peace Corps.

President Kennedy understood that we are all connected to each other, as he said to the Soviet Premier Nikita Khrushchev when the two leaders began negotiations on the first limited nuclear test ban treaty following the near-cataclysm of the Cuban missile crisis. "In the final analysis, we all share the same planet, we all breathe the same air, we all cherish our children's future."

Today, thousands of people are expected to visit President Kennedy's grave in Arlington National Cemetery. They will file past that eternal flame. But we don't need to go to Arlington to pay our respects to John Fitzgerald Kennedy. That eternal flame also shines in the hearts of every American and every person on Earth who recalls what President Kennedy taught us in his too-brief life and who tries to live those lessons today.

Finally, Mr. President, I want to say a word about my friend, Senator KENNEDY. I know this is a sad day for him.

In the drawer of every desk on this floor are the names of the Senators who occupied these desks before us. I suspect we have all had the experience of seeing those names and thinking what an awesome responsibility it is to follow in such footsteps. In the drawer of Senator KENNEDY's desks are the names of two of his brothers, John and Robert. I am grateful to my friend that he chose to follow in his brothers' footsteps, despite the pain that public service has brought him and his family. It is an honor to work with him. America is better for the Kennedy family's service and sacrifices.

I yield the floor.

MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003—CONFERENCE REPORT—Continued

Mr. REID. Mr. President, I ask unanimous consent that the next Democratic speaker following Senator REED of Rhode Island be Senator HARKIN.

The PRESIDING OFFICER. Without objection, it is so ordered.

Under the previous order, the Senator from Maine is recognized. Does the manager of the bill seek recognition?

Mr. GRASSLEY. Mr. President, I ask unanimous consent to speak for 4 minutes and that Senator SNOWE and Senator CORNYN not lose their right to speak.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. Mr. President, I want to speak a lot longer to respond to what the Senator from Illinois has said because there is so much that can be so successfully rebutted. I will speak to two or three very obvious statements that are wrong.

The first one is that the Senator from Illinois has never run into a senior who endorsed HMOs. Forty percent of the seniors in Miami are voluntarily in Medicare+Choice. That is an HMO. And 6 percent of the seniors in his own large city of Chicago are members of HMOs. They are there because they want to be there. They can get in or, if they leave the area in which they live to go someplace elsewhere and they don't have HMOs, they are going to have fee for service. These seniors are there because they want to be there.

That brings me to the point that a major portion of this legislation is the right of seniors to choose. Seniors who want prescription drugs can have them or they don't have to buy into it if they don't want to. If they want to keep fee-for-service Medicare just as it is, they can stay there. They do not have to go into any of the new programs that we provide in this bill. They have the right to choose.

I believe members of the other party don't believe that seniors ought to have the right to choose because their response to Government health programs for seniors or others is more Government, more Government, more Government.

Another obvious point that was made that ought to be rebutted is the question about the AARP becoming so political. Why does the AARP support this legislation? "Seniors are the losers." The AARP speaks for 40 million members. Why is it that this year when we are dealing with bipartisan legislation and the AARP backs it that they are political, but last year when they backed the Democrats in their efforts to have a partisan bill, the AARP, at that point, was not partisan?

I yield the floor.

The PRESIDING OFFICER. Under the previous order, the Senator from Maine is recognized.

Ms. SNOWE. I thank the Chair.

Mr. President, today we stand at the precipice of opportunity. Culminating a decade of work, we have before us legislation that will forever change the face of Medicare, providing every senior in America with a prescription drug benefit under the Medicare Program that will experience the largest expansion in its 38-year history.

We would not have arrived at this day without the exceptional commitment by Finance Committee Chairman GRASSLEY to advance this issue and to meld the considerable policy and political differences that have marked the development of this legislation. His efforts were nothing short of Herculean from the outset and guided us through a very challenging and contentious conference committee over the last 4 months.

He, as well as Ranking Member BAUCUS, have remained committed to the bipartisan principles that forged the Senate legislation which garnered the support of 16 members of the Senate Finance Committee, as well as in the overall passage of the legislation last June of 76 Members of the full Senate.

I also wish to recognize the outstanding leadership of the President who, in 2001, challenged Congress to enact a Medicare prescription drug benefit, propounded a set of principles, and has provided strong impetus during this home stretch for Congress to complete our work and to send to his desk legislation that he can sign this year.

I know firsthand from my conversations with the President that this is a cornerstone of his agenda, and absent his driving force, we would not be here today.

So, too, has the majority leader redoubled his longstanding and unflagging commitment to enacting into law a bipartisan bill, moving us ever closer to that goal. And thanks to the unique confluence of his skills, his unparalleled knowledge and grasp of the issues, and his single-mindedness of purpose, more than three-quarters of the Senate came to support S. 1 that we passed last June. And in bringing that to the eve of final passage of this conference report, he has typically been respectful of and responsive to wide-ranging concerns and recommendations that have been voiced by me and others. I thank him for his leadership and for shaping this process to its ultimate and I know successful conclusion of this report.

I also extend my appreciation to my colleagues, Senator HATCH, Senator BREAUX, and Senator JEFFORDS, with whom I have worked so closely on a prescription drug benefit over the last 3 years. They have been stalwarts in this fight and developed the template tripartisan bill of which so many of the principles have been incorporated in this conference report.

Certainly no one has more fiercely championed the cause than another colleague I have joined with in this battle in the past, Senator KENNEDY, who I recognize does not support this conference report but whose early involvement and passionate policy advocacy unquestionably built momentum for this issue in Congress.

Finally, I want to thank my good friend and colleague, Ron WYDEN, with whom I began my prescription drug coverage journey almost 6 years ago when we developed the first bipartisan prescription drug plan in Congress, which established the principles that we both believed were so crucial and essential to shaping this benefit. We reached across this political aisle because we recognized that only through a bipartisan plan could we ever see the light of day in enacting this kind of benefit as part of the Medicare Program.

We joined forces, as members of the Budget Committee, to carve out the 2001 budget, believe it or not, which was a $40 billion 5-year reserve fund. Well, how far we have come from the $370 billion tripartisan plan developed last year to the historic passage of S. 1 this last June of $400 billion.

But I can tell my colleagues from my own personal professional experience that Congress' journey along this road has never been easy, although it has been infinitely more arduous for America's seniors. The process has borne witness to a multiplicity of goals and philosophies across the spectrum.

Some have wanted to add a drug benefit to the existing Medicare Program that would leverage purchasing power for the more than 40 million Medicare beneficiaries, while others sought to use the issue as either a vehicle for the wholesale privatization of Medicare or full scale Government-administered benefits. Some have said we are providing too great an incentive for people to enroll in private plans, while others argue we are starving those very same plans. As some have argued, the benefits provided in a particular bill are inadequate while others submit that they are, in fact, too generous and should be limited to a low-income catastrophic plan.

Today, we essentially all agree we are well beyond one question: The question of need. Therefore, it is imperative that we acknowledge the reality that just as the journey thus far has been imperiled by the slings and arrows of those on all sides of this issue that we have heard this morning, it will not be easier with the passage of time, not when we are debating the creation of the largest domestic program in nominal terms ever, not when we are attempting the largest expansion in the history of the third largest Federal domestic spending program.

I think it is important to emphasize the extent to which this is a sizable expansion. So for those on the other side who are talking about the fact that we are not doing enough, this is a substantial beginning. When we consider all of the significant challenges that are looming on the horizon, such as strengthening Social Security and Medicare as 77 million baby boomers will begin to retire in the year 2013, all the while we are facing record-setting deficits.

We did have an optimal window for positive change just 2½ years ago when the Congressional Budget Office was projecting surpluses as far as the eye could see, about $5.6 trillion through 2011. Now we have next year's Federal deficit alone projected to be nearly $500 billion. We know the reasons: In the aftermath of September 11, the war in Iraq, a declining economy.

It begins to illustrate how quickly the tide can turn; that is, how quickly the opportunities can be lost. Just think, many of the same speakers today are standing on the Senate floor arguing from different perspectives and plans on adding a prescription drug benefit to the Medicare Program. At that time, just a year ago, the Senate was presented with a choice between a tripartisan plan that ensured coverage would be available to all seniors—comprehensive, maximum benefit possible for low-income seniors and was a permanent part of the Medicare Program.

The alternate that we were debating at the time was temporary. It would have sunset and would have statutorily restricted access to drugs because it would have been a Government-run system that would have cost close to approximately $1 trillion; although at the time, as my colleagues recall, we did not have any CBO scores, so we could not possibly know or ascertain the exact cost, but we knew that it would probably be $1 trillion and counting because it would have been a Government-run system. It would have restricted choices to seniors, and they would not have had access to the array of drugs that are available on the market today with that type of system. The benefit sunsetted after 7 years.

Those who are dissatisfied with what we have before us today should fondly recall the tripartisan bill and lament its unfortunate demise because at that time we had a plan that brought together disparate interests for a very favorable benefit. That was then and this is now.

We are here, and the conference report before us is the result of an attempt to balance the competing viewpoints not only among Members but the stunningly disparate views between the House-passed legislation and the Senate-passed legislation. The simple truth is, while I continue to prefer the Senate bill, as many of us do, it is this conference report upon which we will vote.

After careful review, I have concluded that while it is not everything it could be, it is not everything it should be, in the end, make no mistake about it, millions of seniors will benefit over the stagnation of the status quo benefit.

Margaret Thatcher once said, you may have to fight a battle more than once in order to win. Well, some of us have been fighting this battle now for nearly 6 years, and for some even longer. The bottom line is, we cannot hold hostage our seniors' futures to a political unwillingness to compromise. This bill provides us with our best available opportunity to secure for the first time a legislative foothold that honors the same basic principles that I and others have expounded upon since I first came to this issue more than 6 years ago; that in keeping with the basic tenets of Medicare, this prescription drug benefit will be universal. Everybody in the system will have access to this benefit. That is important because there were other divergent views that simply wanted a low-income and a catastrophic.

We preserved the universal principle of Medicare, and that is not to be underestimated for a variety of reasons. It is comprehensive. It is a wide-ranging benefit. It is affordable, particularly for those at the low-income scale. It is voluntary participation and not mandatory. Seniors can choose to participate if they want to. It is permanent. Unlike what we were considering a year ago on this floor, it does not sunset because the costs were so prohibitive that the benefit had to be sunsetted. We have a permanent benefit, and it provides equal benefits across the spectrum of plans. That is also very important. So everybody will have access to the same benefit, regardless of what plan they choose.

Like the Senate bill and the tripartisan proposal before that, it directs the most assistance toward those seniors with the lowest income and includes a reliable Government fallback mechanism of last resort to make sure that every senior, regardless of where they live in America, will have access to and the stability of the traditional Medicare Program. But they will also, regardless of where they live in America, have access to a prescription drug benefit so there will be that reliability, with a Government fallback program.

In its totality, looking at this conference report, it fulfills all of those principles. That is very important. It is something we cannot overlook. It cannot be minimized. It cannot be denigrating. Those principles have been captured in this legislation, irrespective of all the other disparate views that come in between. Those principles framework this conference report. Those were the principles that were in the Senate-passed legislation.

Now let's look at some of the individual components of the package before us. We should be mindful of how we arrived at this destination because we have to put this conference report in context, not only for why we are here today but what happened previously, what happened last year, what happened 4 years ago, what happened 6 years ago, because it illustrates the long journey we have taken down this road and what has happened in the House—what has happened in America, in terms of the rising cost of prescription drugs and the impact on seniors.

As this Senate passed a bill with overwhelming bipartisan support, those 76 votes I was referring to earlier, last June, the House passed legislation with the most razor-thin margin of just 1 vote—just 1 vote. We all witnessed what unfolded this morning in the early morning hours when the House with a 5-vote margin passed the conference report. Obviously, it reflects some very different views between both Chambers, among philosophies, among regions of the country. We cannot overlook that, in terms of what do we do now. What can we ever potentially do in the future that will be even better?

We see the results, obviously, in those differences. Some have referred to the benefit that is available in this conference report. I think it is important to talk about some of those issues.

We see the result, obviously, in the starkest terms reflecting different philosophies in the nature of the benefit that ultimately was designed by the conference committee to sort of split the differences, because that is what conference committees are all about. No, it can't be all one way or the other. You have to sort of go back and forth, to figure out what can you do to design an equilibrium of thought. It has to be carefully calibrated so that you do not compromise what you believe but it advances the legislative agenda on your ultimate goal, in this case designing a prescription drug benefit as part of the Medicare program. So let's look at the underlying benefit when it comes to the drug plan.

It includes aspects that are modeled after each bill. The deductible was set at the House lower level of $250. We had $275. And the conferees worked to improve this proposal by offering a benefit that had an actuarial value that was higher than the benefit from both bills. However, in providing these improvements, concessions had to be made. In doing so, the Senate's benefit cap that was referred to by other speakers—we had a $4,500 benefit cap, a spending threshold—that was lowered to $2,250. So while they got a better actuarial benefit for all beneficiaries, the spending cap was lowered to $2,250.

But in the same respect, the cost sharing provided under this cap was lowered from 50 percent to 25 percent that was in the legislation in the Senate bill.

So we had a cost sharing between Government and the beneficiary that was 50–50. But in the conference report, now the Government will provide the 75 percent and the beneficiary 25. So that is an improvement. We see it is not all perfect, but again this benefit represents the art of the compromise. You have to think again, is this better than the status quo? I think there is no question that it is because millions will stand to gain, No. 1, getting a benefit; No. 2, getting generous assistance on the low end of the income scale. But everybody stands to gain who participates in the Medicare Program, who wants to participate in accessing this prescription drug plan.

As I see it, this conference report will at least get the Federal foot in the door in providing a significant level of assistance to one out of four Americans who, right now, don't have any assistance. They don't have any assistance currently. If you look at the graphs, a quarter of Medicare beneficiaries have nothing. So are we saying this is not better than that status quo?

We also design a benefit for all seniors with a $35 monthly premium that will save 50 percent on their cost of prescription drugs. So, for example, a senior who spends $3,600 on prescription drugs will realize a saving of $1,714 annually.

Then as I mentioned earlier about the lowest income and the assistance they will receive under this conference report, which was in keeping with the principles of the Senate-passed legislation for which we received 76 votes, we find that the conferees utilized the model that was established in the Senate bill. Most critically, no senior who qualifies for one of the low-income categories will experience a gap in coverage—none. So for those under the 150 percent of poverty level, they will experience no gap in coverage.

It also means in Maine, for example, there will be 93,450 Medicare beneficiaries, more than 40 percent of the overall Medicare population, who will receive a generous benefit with no gap in coverage, not to mention that it will be at a high level of assistance—up to 150 percent, with minimal copays, in some instances—most instances, no deductible, no premiums, and, as we know, a sliding scale on the monthly premium of 135 to 150.

The PRESIDING OFFICER. The time of the Senator has expired.

Ms. SNOWE. I did not know there was a time restriction, Mr. President.

The PRESIDING OFFICER. There was a 20-minute time limitation. The Senator may ask for additional time. The Senator's time has expired.

Ms. SNOWE. I ask unanimous consent for an additional 10 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator is recognized for an additional 10 minutes.

Ms. SNOWE. While the Senate has extended this to a greater number of seniors, unlike the Senate bill, this proposal ensures all seniors, even the so-called dual eligibles, will be part of this conference report. That certainly benefits my beneficiaries in Maine but 6 million nationally.

Not only do seniors deserve a subsidy to help make prescription drugs more affordable, they should also have the benefit of choice when it comes to the coverage they purchase. Seniors should not be limited in their options for coverage, so that we ensure all seniors have a choice of at least two privately delivered drug plans.

Options are important. They will have choice among prescription drugs as well. That is critically important because the choices will be there, and they will also have the benefit of a fallback to ensure this coverage and those options are available nationwide.

Finally, I want to get to the one remaining point because of time limitations. We have heard so much about the privatization of Medicare, what this would do. This conference report unquestionably represents the end of the House bill's open-ended efforts to move Medicare towards a national privatized system through an untested, untried policy known as premium support that could have led to a patchwork quilt of uneven health care delivery that existed prior to the creation of the Medicare Program in 1965. This approach would have fostered wild fluctuations in the premiums for the traditional Medicare Program whereas, incredibly, Medicare now provides all seniors with the same benefit for the same premium. Under this proposal, premium variations would have occurred not just from State to State but within a State and even within congressional districts across the country.

There are many illustrations of that point. For example, from the Center for Medicare and Medicaid, they indicated that in Miami, FL, they would pay $2,100 a year for the traditional Medicare Program compared to $900 to seniors who would pay that in Osceola, FL, for the same benefit.

When you compare North Carolina to variations from State to State, it would have been extreme.

For example, they would have paid $750 for the traditional Medicare; whereas, in Florida they were paying $2,100 for that same benefit but their premium, obviously, would be much higher.

In response to a letter that 43 colleagues and I sent—I ask unanimous consent to have printed in the RECORD two letters, along with an editorial on this subject.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

U.S. Senate,
Washington, DC, October 23, 2003.

Chairman Charles E. Grassley and Ranking Member Max Baucus,
Senate Finance Committee,
Washington, DC.
Chairman W.J. (Billy) Tauzin and Ranking Member John D. Dingell,
House Energy and Commerce Committee, Washington, DC.
Chairman William M. Thomas and Ranking Member Charles B. Rangel,
House Ways and Means Committee, Washington, DC.

Dear Conferees: The Medicare conference has reached a critical junction in its effort to craft a conference agreement to develop a Medicare prescription drug and modernization bill: The time is fast approaching when final agreements must be made if a proposal is to be developed prior to the November 7 target-adjournment date. However, many key issues remain unresolved, which will determine whether this bill can garner strong bipartisan support and ultimately become law. As you progress into this critical stage, we urge you to remain committed to the bipartisan principles contained in the legislation developed and passed by the United States Senate.

First, the Senate bill takes strong steps to provide every senior and disabled American, no matter where they live, with choices in coverage. Notably, this is done in a manner that preserves the traditional Medicare program as a viable option. This balance was achieved by providing all seniors with access to the same level of drug coverage no matter the coverage option chosen. Further, the Senate bill assures this choice will be a fair one that will not disadvantage senior citizens who remain in traditional Medicare. Accordingly, we urge you to remain committed to principles that provide a level playing field between the private sector and Medicare and reject proposals that would unduly raise Medicare premiums or otherwise advantage private plans.

Second, the Senate bill assures affordable, comprehensive coverage to those with incomes below 160 percent of the federal poverty level or $15,472 for an individual in 2006. Generous and affordable coverage for this population is essential, given that most presently do not have access to a prescription drug benefit. The conference must assure that the generous assistance provided to low income beneficiaries is maintained and reject measures that would reduce the benefits presently accorded Medicaid recipients.

Third, we urge the conferees to include a mechanism that will ensure that all seniors have access to a prescription drug benefit, no matter where they live. The Senate bill assures that private plans interested in providing this benefit can do so and will be the preferred mechanism of delivery in every geographic locality; however, it is not possible to guarantee their participation. Therefore, it is necessary that the final proposal include a ballback mechanism, as was included in the Senate bill, that will ensure that beneficiaries will have access to the drug benefit in the event that private plans are not available in a region.

Finally, we caution the conferees against including provisions that will circumvent established congressional procedures or delegate responsibilities for establishing the benefit and cost-sharing requirements to the Secretary of Health and Human Services (HHS). The responsibility for developing and overseeing benefits included in the Medicare program rests with the Congress, and this bill should not violate that principle.

Enactment this year of a bill that adds a Medicare prescription drug benefit and improves the program is a top priority for each of us. America's seniors have waited too long for comprehensive drug coverage and the addition of market-based options. However, to achieve this goal, we must continue to work together to develop agreements that will receive bipartisan support in each chamber, In 1965, the original Medicare bill garnered this level of support and a change to the program of this magnitude should be no different.

We remain ready to help you address these and other issues that will impact the final proposal, and hope you will work with us to develop bipartisan proposals that we can support.

Sincerely,
Olympia J. Snowe,
Arlen Specter,
Mike DeWine,
Edward M. Kennedy,
Jeff Bingaman,
Blanche L. Lincoln,
James M. Jeffords.

Congress of the United States,
Washington, DC, November 13; 2003.

The Hon. Bill Frist,
Majority Leader, U.S. Senate,
Washington, DC.

Dear Leader Frist: It has come to our attention that leadership is considering the inclusion of a new version of the policy model known as premium support. As you know, this policy places the traditional Medicare program and private plans into direct competition and according to the Centers for Medicare and Medicaid Services (CMS) will lead to dramatic increases in the annual premium for the traditional Medicare program.

We are extremely concerned about the inclusion of this policy proposal in a Medicare bill. Thought some may consider this a demonstration project, we disagree. This appears to be a veiled attempt to institute this policy into law. According to CMS data this proposal could capture up to 10 million seniors, 25 percent of Medicare beneficiaries. Further, it will require them to bear the burden of cost increases associated with the demonstration project.

This policy also unfairly targets some seniors simply based on their geographic location and mandates their participation. The likely result will be significant increases in traditional Medicare premiums for seniors living in the affected areas and could destabilize the Medicare program for all seniors.

We understand that leadership and some conferees may be considering possible changes to this latest proposal. We urge you to remove this policy from the bill. We believe there are other possible options that will encourage private plan participation in the Medicare program that do not negatively impact the traditional Medicare program.

Thank you for your consideration of this vitally important issue.

Sincerely,

SIGNED BY 44 MEMBERS OF CONGRESS.

[From the Bangor Daily News, Nov. 21, 2003]

HOBSON'S MEDICARE

Never have so many dollars been put to so little use. The $400 billion Medicare bill before Congress establishes what all sides agree is necessary—a prescription drug benefit—but blasts away at much of Medicare's foundation. It is a deal that makes all previously rejected Medicare reform look wise and generous by comparison. It is also the best deal the current Congress is likely to get.

The difficult calculation is this: Is a badly flawed bill that contains a needed drug benefit worth passing when the alternative is to reject it without the chance to enact approved legislation? The $400 billion has been set aside for funding this legislation; should it fail, the money would disappear and given the extent of the deficit for the next decade or more, would not be available next year, even in the unlikely chance a bill could be passed in an election year or perhaps after that.

Much of the debate this week has focused on the plan's intent to establish privatization pilot projects—subsidized private insurers would offer Medicare in six metropolitan areas in competition with traditional Medicare—but other aspects of it are equally important and equally troubling. The means-testing provision in the bill, for instance, raises costs for middle-class seniors; reimbursements for medical residents, harm clinic work; those who remain in traditional Medicare for the pilot program will see increases in their costs; states that could negotiate for their Medicaid-Medicare clients lose much of their bargaining power while also losing their federal support for the program. The fear remains strong among health care advocates that the entire reform is an attempt to cap the federal contribution to Medicare and shift future costs to seniors. Several of these problems are being debated now—Sen. Olympia Snowe has been in the middle of negotiations all week; imagine the time and argument that would have been saved had she been put on the conference committee. Some of these issues may be resolved but several are likely to remain as the House and Senate vote.

Some members of Congress do not support the bill for these many reasons; some don't support it because of its cost and relatively small nod toward privatization. But for those who believe a drug benefit is important and will become more important in the coming years, the choice is to vote yes, and immediately set about chipping away at some of the worst aspects of the bill. This is a terrible way to build a health care safety net for the nation's seniors, but lamenting the process is not an excuse for allowing this opportunity to pass by without approving the drug benefit.

At 1,100 pages, the Medicare bill is too long and complex to describe it merely as a sop to industry (though pharmaceutical manufacturers should love it), an ideological document (though its medical-savings accounts are a GOP crowd-pleaser) or a broad expansion of entitlements (though the drug benefit is exactly that). It is fair to say the bill is a poor version of what should have been passed years ago and now that Congress is out of time and out of money, it is about as much as the public can expect.

Ms. SNOWE. Mr. President, in that letter, we expressed our strong opposition to this ideological venture. It is important to know that significant changes were made to transform the full-scale national premium support proposal into a limited bone fide demonstration project. That is important to know.

I have it here on the chart. I hope it is something I can get back to on Monday.

It is important to know how far we have come from where it was. The open-ended privatization of the Medicare Program, starting in 2010, would have been a wholesale privatization which didn't offer any seniors any protection, regardless if they were low income, from premium fluctuations. Because it would open it up to competition in the private sector, the conferees shifted it to a bone fide limited demonstration project. We moved from that open-ended privatization to the first proposal in the conference report which provided protection for low-income seniors for any type of open-ended privatization.

They also moved to a demonstration project so it wouldn't be national—it wouldn't be permanent for one region in four metropolitan statistical areas. We said that is not enough; that is too open ended. We finally were able to reduce it to six MSAs with limited criteria. That limited the number of people who would participate in those six metropolitan areas.

It is very important, because what we had before was nationwide and open ended, which would have been a frontal assault on the traditional Medicare Program as we know it with an untested and untried approach where we don't have a scintilla of evidence whether it would work. Through our efforts and through the responsiveness of the leader and Chairman GRASSLEY, we were able to move from a nationwide approach to six metropolitan areas which includes criteria that GPO says will limit this to 1 million—anywhere from 650,000 seniors to 1 million seniors—and it would be sunset by the year 2016. It would kick in in the year 2010. It will be phased in and will be sunset in 2016.

That is important.

What is also important is the fluctuation in premiums, which I was referring to earlier. That is critical because that won't occur. Originally, there was no protection, with huge, wide variances, depending on where you live in America, and subject to undermining and destabilizing of the Medicare Program. The Congress agreed originally to fluctuations which would vary from 10 percent per year compounded. We were able to weigh in. Finally, what we have here is a reduction in the level of allowing increases in premiums to 5 percent, removing the compounding mechanism that originally would have had a total cumulative impact of 30 percent over 6 years.

We have come a long way from where this proposal was in the House that would have undermined the traditional fee for service.

When I hear speakers on the other side of the political aisle talking about privatization, I think it is important to stick to the facts of what we now have.

This is a sea change from the original initial proposal that was in the House-passed legislation. Obviously, the Senate had nothing referring to this premium support program. What we have now is a limitation to one Federal demonstration project for a legitimate avenue to experimenting with new options for potentially improving upon the Medicare Program in the future. But we cannot do it unless we absolutely have assurances that it will work.

That is what demonstration projects and programs are all about. We learn from them. I didn't want to use seniors as an experiment on the road to learning. That is why this is very limited. Now it is no longer nationwide. It is down to six MSAs.

It includes selection criteria that the Congressional Budget Office says will limit the number of impacted seniors to 1 million. It also offers protection even in that demonstration project to seniors under 50 percent of poverty level or below.

That is very important to note.

We are essentially holding seniors harmless even in those demonstration projects. But, again, this is no longer what it was in the House-passed legislation.

I think it is important that we understand that.

This is a means to evaluate anything in the future that may be potentially an improvement to strengthen the future of the Medicare Program. But, obviously, we don't want to use open-ended programs at the expense of the traditional program that has worked so well.

Ironically, in all of this, that is why this was not viable to what was in the

House-passed bill—that the traditional Medicare Program worked. In fact, the Congressional Budget Office told us it would not achieve the savings that the proponents were suggesting. It would only save $1 billion potentially, and it could threaten the underlying traditional fee for service. Where would the seniors be? Where they were prior to 1965 where a lot of working Americans are—barely being able to have access to any type of health care, let alone health care with consistency, or where the costs were so prohibitive they were restricted to catastrophic coverage. Why do we want to assign that problem to our seniors until we know what could work in the future?

I can tell you that there is not one scintilla of evidence in the public sector or in the private sector that would tell you that any premium support plan would work at this point. That is why it should be confined to a limited demonstration project of no more than 1 million—it could be as low as 650,000—to learn what will work to potentially improve. It sunsets, we will learn from it, and decide what it can do for the future.

I urge my colleagues to take a very careful look at this legislation because this is a transformational moment in history, and there will be no going back.

I yield the floor.

The PRESIDING OFFICER (Mr. ALLARD). The Senator from Texas is recognized for 15 minutes.

Mr. CORNYN. Thank you, Mr. President.

Mr. President, I wanted to speak for a few minutes about this conference report which is before the Senate.

I did not support the Medicare bill voted out of the Senate. I voted against it hoping and praying all along that this bill would be improved as a result of the collaboration of the leadership in the House and the Senate in the conference. Indeed, I believe it has. That is not to say that I believe this is a perfect bill—far from it. But this bill does represent an improvement.

This bill provides coverage for those who need it most. In Texas, nearly 300,000 low-income Medicare beneficiaries who are not eligible for Medicaid and who did not have any prescription drug coverage will be covered under this new bill.

It will increase the percentage of Medicare beneficiaries in Texas with prescription drug coverage from roughly 60 percent to 95 percent.

I would like to express my congratulations to leadership, to Majority Leader FRIST, who I know has taken a personal interest in this cause as a medical doctor and as someone who has worked very hard to get us to where we are today; Chairman CHUCK GRASSLEY, who has the patience of Job and who I know has worked very closely with Senator BAUCUS, the ranking member of the Finance Committee, and Senator JOHN BREAUX of Louisiana on other side, as well as Senators NICKLES and KYL and others who specifically shared some of the concerns that I had with the Senate bill but which I believe have produced as a result of their collaboration a much improved bill, and one which I am now proud to support.

I do not view this bill as the finished product. I view this as a good start. But I think it would be a mistake to say because we view the glass is half empty as opposed to half full that we ought to vote against this Medicare conference report. I have no confidence the stars will align and the political climate will be such that we could ever get to this point any time in the near future. It is important we deliver on the promise that each Member in this Chamber made when we ran for this office and which the President made when he was elected, that we would strengthen and improve Medicare by providing prescription drug coverage for seniors who need it. The reason I am proud to support this bill today is because this represents delivery on that promise.

In the end, I don't think the American people care very much about demagoguing certain aspects of the bill. They do not care very much about partisan differences. They do not care that much, really, about some of the ideological differences, the competing ideas that now have been melded into this bill and which create, to some extent, a hodgepodge, but on balance, an improvement over the status quo. It is our responsibility to govern. Governing means delivering results and not just criticizing things that are easy enough to criticize.

Frankly, any bit of legislation that comes before this floor has defects that are easy to criticize. We are sent here to get the work of the American people done. This bill represents delivery on a promise we have made.

We spend about $1.4 trillion a year in this country on health care. We know as much money as is spent on health care that still we have large segments of the population that are underserved and who do not have access to good quality health care. Fortunately, since 1965, our seniors have been provided access to good quality health care through the Medicare Program. We also know unless you happen to be among even the most modest means in our society, you would not have coverage. For example, under Medicaid, only those who are of very modest means who fall beneath the poverty level are eligible for that free health care program. Children are provided coverage to health care under the S-CHIP program which has provided coverage for many children who come from families of modest means who would not otherwise have access.

We still have about 45 million people in the United States who do not have health insurance and who have limited access to health care coverage. That is something that we need to address. Fortunately, it is something that has been addressed, at least in part, in this bill.

For example, in my State of Texas, we have many people who are uninsured and, indeed, who are undocumented. In other words, they have come to this country without the benefit of the legal process. But under Federal law, the Federal Government says you must provide free medical care at your emergency rooms and hospitals all across the country.

Finally, rather than to foist that financial burden on the local governments and the local taxpayers and the State government and State taxpayers, this bill starts at least a downpayment to provide for that previously unfunded mandate. Indeed, it provides $250 million a year to be distributed among the States based on their percentage of population of undocumented immigrants. For example, the State of Texas will receive about $50 million a year over the next 4 years to help make good on that broken promise by the Federal Government.

Indeed, that unfunded mandate will at least be funded to that extent. It is not by any stretch of the imagination enough to make Texas whole, but it is a start, a movement in the right direction.

The other reason I am for this bill is because in 1965 the U.S. Government made a promise to our senior citizens that if you played by the rules, if you worked, if you paid your Medicare taxes, when you turn 65, Medicare would be there for you. While we know there have been enormous changes in the practice of medicine and the delivery of health care since 1965, Medicare has not changed. It is in response to the demands of that passage of time that we see this bill which does actually strengthen and improve Medicare today.

If there is one fundamental reason I am for this bill it is because I think it is the best this body and our counterparts across the Rotunda are able to come up with at this time. It would be unconscionable to leave our seniors without prescription drug coverage, especially after all Members in this Chamber and elsewhere have campaigned on that issue, year after year after year, and left perhaps too many people skeptical or maybe even cynical about whether we actually intended to follow through on our campaign promises. This bill represents the kind of results I think they deserve and the kind of results that make good those promises we have made.

As I say, I believe this is a good start. This is not a finished product. One of the best aspects of this bill is it changes the nature of Medicare to some extent by turning at least to some small degree from the command and control model that says the Federal Government knows best, which provides no choice, no alternatives, no opportunities for seniors to actually get better service or better health care by having some competition in the marketplace. Now, 38 years after Medicare was first passed in 1965, we see better coverage under this bill. We see more choice. We see coordination of medical therapies because, of course, many people are on multiple types of therapies, even drugs that may interact. This bill provides for a coordination of those medical therapies in a way that will enhance and protect the health of our seniors, not damage them.

This bill places an important emphasis on prevention. This is one of the areas on which we need to do a lot more work. Frankly, it is much more humane and much cheaper and, indeed, much more compassionate to prevent disease than to wait until it has occurred and then try to treat it, perhaps with some or no success. This bill does provide for screening for cardiovascular disease, for diabetes, for greater access to mammography so that breast cancer can be diagnosed earlier, and it will provide an opportunity for every senior, as they go into Medicare, to get a complete physical examination so that if there is some way we can prevent them from becoming ill or perhaps address that illness much more effectively and efficiently by getting to it earlier, we can improve the quality of life and also save the taxpayers money when it comes to treating full-blown illnesses as they run amok.

This bill is a vast improvement over the status quo because it has strong provisions for prevention of fraud, waste, and abuse. It is inevitable in a bill this big, some $400 billion over the next 10 years, that there is potential for fraud, waste, and abuse. I congratulate Chairman GRASSLEY and the conference committee for writing into this bill important protections that will allow for the detection, indeed, for the investigation and hopefully for the prosecution of fraud, waste, and abuse when it comes to the taxpayers' dollars.

I know the chairman of the Finance Committee shares a passion for protecting people in the rural parts of his State, and certainly across the United States. I share that passion with him.

I still remember when I was campaigning up in the panhandle of Texas, a place where there is low-population density, in a rural part of our State where the county judge, who is the chief administrator for the county government, came up to me. She was concerned about her mother. She said the doctor for her mother, who was 80 years old, had refused to continue to accept Medicare patients. And this individual's mother had no other way to pay for her health care other than Medicare. So literally she lost access to the only doctor she had ever had and that she had ever known, at least during that period of her life.

This bill addresses that concern, too, by providing greater access to health care in rural parts of our country, and it imposes reimbursement rates for doctors and hospitals. Frankly, I have always thought it was wrong for us to try to balance the budget on the backs of health care providers because, frequently, these people provide free health care out of the goodness of their heart, for which they have no hope of compensation. I think it is only just and it is only right that we provide for fair and adequate reimbursement for treatment of Medicare patients. Frankly, that is the only way we are going to continue to see ready access for our seniors to the health care they need.

There were two reasons I was very concerned about the bill as it left the Senate. One was because it lacked any means testing; in other words, the young man or young woman who earns minimum wage would be expected, out of their Medicare taxes, to pay for the prescription drugs of Bill Gates or Ross Perot from my State, someone who is more than capable of paying for their prescription drugs. I, frankly, thought it was unfair to foist that on the minimum-wage worker.

Then the other concern I had was that I wanted to make sure we were not providing incentives for employers who maintain health insurance coverage for their employees after they retire, to simply drop them and create a greater burden on taxpayers.

I think both of those issues have been addressed.

Finally, Mr. President, I think the provision of health savings accounts represents a tremendous victory for those of us who believe that individuals ought to have greater choice, greater opportunity to manage their health care costs, by taking pretax dollars to pay for medical costs that are not otherwise covered by insurance.

So for all those reasons, I congratulate again Chairman GRASSLEY and those who have worked so hard on this bill. I know it has not been easy. It is not perfect, but, again, I do not think we should let the best be the enemy of the good. So I will proudly support it and work with Chairman GRASSLEY and others to see that this gets to the President's desk for signature as soon as possible.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator's time has expired.

The Senator from Rhode Island.

Mr. REED. Mr. President, I ask unanimous consent, with the concurrence of Senator STABENOW, that I be allowed to go in her place and she go in my place in the order of speaking.

The PRESIDING OFFICER. Is there objection?

Mr. GRASSLEY. Mr. President, reserving the right to object, could I ask, is that in line with what we have agreed to?

Mr. REED. Absolutely. The original order was that Senator STABENOW speak as the next Democratic speaker.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Rhode Island is recognized.

Mr. REED. Mr. President, opinion has already been registered with respect to this Medicare proposal before us today. I think one of the more interesting comments was from the Des Moines Register editorial board, describing this legislation as "a big, sloppy kiss to the pharmaceutical and insurance industries." That is essentially what this bill is. It is a huge payoff to pharmaceutical companies and to the insurance industry. It is not really about giving seniors what they deserve and what we have all labored for many years to provide them with; and that is, comprehensive drug coverage.

There is another fallacy that is operating, too, in our debate today. That fallacy is that this bill is the best we can do, so let's just move on. I think it is a fallacy because I checked this morning the discussion of the vote early, early this morning in the House of Representatives. Apparently, the last few votes that were arm-twisted into supporting this bill from conservatives in the House was based upon the logic that if this bill failed, the next bill, which would come promptly after this bill, would be, from their perspective, worse; but from the perspective of seniors, much better because it would not represent "a big, sloppy kiss to the pharmaceutical and insurance industries." It would represent a commitment to provide prescription drugs—real prescription drugs—and maintaining the Medicare system. And that is what seniors want.

So I believe we can make this bill better simply by holding our ground, by debating it extensively, by not rushing to judgment, by not surrendering to artificial deadlines of the Thanksgiving holiday or even the Christmas holiday.

This is the largest proposed change in the Medicare Program since its inception in 1965, and to rush through this in a few hours, not because of the substance of the bill, but because of the timetable for airplanes and trains to get home for the holidays, is wrong. We should stay here and do our job, just as thousands and thousands of young Americans are staying across the globe and doing their job to protect us.

I think there is another issue here, too; and that is the notion that this is the end of the privatization argument. On the contrary, this is the beginning of privatization. That is the quid pro quo for the support, particularly support of conservatives, of this bill in the House and here in the Senate. I can envision and anticipate that with each new reconciliation bill that is forced upon us, with a procedure that does not allow unlimited debate in the Senate, we will see again and again the slow erosion of the traditional Medicare Program, under the guise of cost savings, under the guise of competition, under the guise of so many other claims and so many other excuses.

So we are at a position where we are looking at legislation that represents, again, a massive giveaway to pharmaceutical and insurance companies, that does not provide an adequate benefit for seniors, and that really does begin the privatization of the Medicare Program.

Since 1965, Medicare has provided dependable health care for our seniors. But we have all recognized in the last decade or more the rise of pharmaceuticals as a principal, and expensive, way to treat diseases. We have all recognized that Medicare must adjust to this change. We have urged and fought to get an adequate benefit for our seniors for drug coverage.

Now, in Rhode Island, with 14.5 percent of the population over 65, this is of central concern to me. And I have worked very hard, as so many others have, to try to get a good drug benefit program, but not at the expense—not at the expense—of Medicare.

Now what has happened is that the administration, their allies in Congress, the pharmaceutical industry, and the insurance industry have all gotten together and have attempted not just to provide a drug benefit that is adequate for seniors, but to provide a drug profit bonanza for the pharmaceutical companies and the insurance companies and to alter fundamentally the shape of traditional Medicare.

Now, in the wake of the Gingrich revolution in 1995, Newt Gingrich declared his intention of letting Medicare wither on the vine. His undisguised hostility to Medicare met a swift rebuff from Democrats but, more importantly, from the American people because they understand the critical need and the value of Medicare.

Today, this hostility to Medicare persists, but it has been camouflaged under the cloak of a prescription drug benefit. As a result, we are on the verge of a historic bait and switch. Under the guise of providing drug coverage, the Bush administration is beginning the unraveling of the Medicare Program. The bait is drugs; the effect is the slow unraveling of the Medicare Program.

This bill was cobbled together by the administration, by their allies in Congress, and by lobbyists for the drug and insurance industries to entice support based upon the notion of a drug benefit. But the goal, ultimately, and the plan, in effect, is to privatize Medicare.

There is a memorable scene in America cinema in the movie "Patton," of George C. Scott, who plays the illustrious general, watching the retreat of the German forces from the Battle of El Guettar.

He bellows at the top of his voice: Rommel, I read your book.

Of course, the obvious inference is people will declare their intentions years before and then carry them out. And that is exactly what is happening here. If you read the Gingrich book, if you read the conservative "book", this is about the privatization of Medicare. Now it might take a few years because tactically the lessons have been learned since 1995. You can't get up on the rooftops and announce: We are ending traditional Medicare. This is a program that allows, in my view, more choice than an HMO because traditional Medicare allows seniors to choose their doctor, to change their doctor. In fact, if you ask most seniors if they could, they would have that choice without any type of condition whatsoever.

That is what is happening here. The intention is clear. But the tactics have been adjusted since 1995, since they ran into popular opposition. Now it is a subtle change, a series of changes over time, reconciliation bill after reconciliation bill. That would be incredibly disastrous to the system and a disservice to our seniors.

The drug benefit is scheduled to begin in roughly 2006. Conveniently, it is after the 2004 election, and it also allows additional time to fiddle with the benefits before any of this becomes real in the lives of our seniors. One can anticipate that these benefits will be adjusted as our fiscal crisis becomes deeper and as we try desperately to constrain costs within not just this program but every other program. The benefits, as they exist today, are a monthly premium averaging about $35, a deductible of $250 or so before Medicare covers 75 percent of an individual's drug costs. But because of inadequate funding in this bill—the $400 billion was never enough—and because of the lavish contribution to HMOs in a $12 billion slush fund, the lavish contribution to health savings accounts of $6 billion, we already have defects within the drug protection for our seniors because if a senior's drug costs reach $2,200, Medicare will pay nothing until that senior has already paid out of pocket $3,600. There is a gap, the proverbial donut hole. Must this donut hole exist? One could argue it has to. But certainly, if we had extra resources, if we had the $18 billion that this bill lavishes upon HMOs and insurance companies, why don't we simply close the gap? Because we are not interested in providing the best benefit under available resources to seniors. There is another priority: Let's go ahead and begin the slow privatization of Medicare.

There are those who say: Well, something is better than nothing; we will take anything now.

Again, we can do better. We could do better in this Congress because the fear last night that motivated those last few holdout votes was that the Senate would do better, that we would bring another bill to the Senate and to the House, and that bill would not have such a big gap; that bill would not be such a big sloppy kiss to the pharmaceutical and insurance industries; it would be something seniors could use, something seniors could use much more effectively than what we are presenting them today.

They should recognize, too, that "something is better than nothing" doesn't apply because the price of that something is the withering away of Medicare. We know what this is about. We know that if unchecked, that is what you will insist upon and demand over each coming year.

Medicare works because it covers every senior. It spreads the risk. An essential, fundamental point of any insurance plan is spreading the risk. It works also because Medicare is willing to subsidize the cost of providing health care to seniors. The reason the private insurance industry did not cover seniors before 1965 is simple: It was too expensive. They couldn't make any money on it.

It took the Government to say: We will use public resources to subsidize the health care costs of these seniors, and we will try to do it in an efficient way by first cutting out the overhead of a private health insurer, cutting out the profits of a private health insurer, making this a nationally based program having the broadest possible coverage for all seniors. That is the essence of Medicare.

This bill is turning that on its head. This bill is fragmenting the pool of seniors who will be covered. It is tilting the playing field against traditional Medicare by providing incentives for insurance companies. It is giving money not directly to subsidize the health care of seniors but to subsidize the bottom line of insurance companies. That is the only reason they will play in the senior market, because they are being paid to do so, paid in the form of their profits, not essentially in the form of services to seniors.

I suggest that if the market for senior health care was there to be exploited by private companies, it would have been exploited in 1965, in 1955, in 1945, but it wasn't. And we all know because this body contains people who at least have reached middle age. We all can remember in every home there was an elderly relative—a grandmother, a grandfather, an aunt or uncle—who had to live with you because they could not afford the price of health care; they could not afford the price of a nursing home. That all changed, not because private health insurance companies stepped up to the plate. It is because Medicare and Medicaid stepped up to the plate. And we are about to change that fundamentally. There are those who will say this is just a modest demonstration program. No, this is the first step. The path has been charted. The direction was declared years before. You just have to read the book.

This bill fragments senior health care coverage. It does so along the lines of age and health. By giving incentives to HMOs, it will encourage them to enroll the youngest and healthiest seniors.

Here is how you make money as a health insurance company. First you get a large subsidy from the Federal Government. Then you carefully select your risks so that they don't incur costs. That increases your profits. That is what any of my colleagues would do if they were directing an HMO, that is what I would do, because their business is to provide profits to their shareholders. That is what is going to happen. It is not because suddenly they have thought of a much more efficient way to deliver services to seniors.

Frankly, the way they derive efficiencies is to ration health care. We all know it because we have all heard the complaints from seniors and from doctors: They won't pay me for what I am doing. It takes me 6 or 7 months to get a bill through, and they give me 10 percent of what I claim as my true cost.

That is what the doctors tell me. They don't want to work with private insurers. They like Medicare. They like the fact that it is predictable. It pays them on time or certainly in a predictable range of time. That is not what HMOs do. They are in it for the money. That is the essence of what they do.

We think we can change the morbidity and the mortality rates of seniors and the costs associated with senior health care? We can't.

So what do we do? We give the HMO's subsidies, and then they will use the subsidies and the leverage of this new law to seek out the healthiest risk, and they will maximize their profits.

That is clear because Wall Street certainly has already voted on this bill. Pharmaceutical stocks are soaring; health insurance HMOs are doing very well. That is what is happening.

What happens also is that we take these healthy seniors out of the pool of traditional Medicare. Then what happens to the cost of traditional Medicare? It goes up. We no longer have the 65-year-old or 68-year-old marathon runners and triathletes. We have 85- and 90-year-old frail elderly who need increased care. No insurance company is going to underwrite those people if they can avoid it, and they can avoid it very easily. So the cost of traditional Medicare will go up.

Then, of course, a year or two from now the people who say this is not about privatization, this is about choice, will come in and say: Look how expensive Medicare is. The private sector is doing so much better. And we will see, I think, the inevitable erosion of traditional Medicare. The irony is that we already know traditional Medicare delivers high quality at essentially a lower cost than an HMO.

A report by the trustees of Medicare this year estimated that reimbursements for HMO enrollees would exceed the average cost of traditional Medicare. That makes sense. Medicare is not advertising on every billboard in Rhode Island like the Plan 65 is. Medicare is not putting out glossy 25-page brochures describing its great programs, or advertising on the radio for profit. Medicare doesn't have to run a multimillion-dollar profit. Medicare is not paying a CEO of an HMO $26 million, or $9 million a year. It is obvious why they are running more costs.

So, again, we know this already. We have Medicare+Choice. Every year, they say "we need greater reimbursement." Why are we then trying to tilt resources to induce private companies to come and do something that seniors will say general traditional Medicare does just as well? It is not about efficiency or a new innovative way of paying for health care, it is about ideology and catering to special interests—that big sloppy kiss again to the pharmaceutical industry and the insurance industry.

The Bush administration proposal, this proposal, divides seniors along the lines of income. For the first time, we are using means testing to determine how much someone must pay to participate in Medicare. Now, one could argue that if this was a last-ditch effort to save traditional Medicare and you had to make sufficient financial calls, you could consider means testing. But this is not about saving Medicare, this is about privatizing Medicare. This is about not saving the system but essentially destroying the system. It creates this fragmentation along the lines of income. When you start seeing the costs accumulate—when seniors start seeing those costs accumulate, a very wealthy senior might say, I don't want to participate anymore, and they will begin walking away from the system. That is not a lot of people, but once you have a public program, and people say, I don't want to participate any longer, and you see the income lines start dividing people it will undercut the support and the strength of the system.

I listened intently to my colleague from Texas say it is so unfair to have the minimum wage workers pay as much as the very wealthy who pay in. I am someone who is pretty sympathetic to minimum-wage workers. Unlike many of my colleagues on the other side, I think we can increase the minimum wage, and I think we can do that right now. They have avoided a vote on that for months and months.

Let me tell you, you have to recognize that, through our tax system, those upper income Americans are paying much more into the Medicare system during the course of their lifetime. But that is beside the point. I think that is a footnote. The fundamental point is that this program has worked so well because it is a social insurance program, not a welfare program. It is a program which every senior comes to, regardless of their health, age—other than meeting the 65-year-old threshold—or their income. It is really a common ground. That has a value above and beyond simple accounting, or who is paying what and who is doing what. So this is another way the program is divided. Again, I believe this is the wrong approach.

Now, this whole proposal eliminates the stability, dependability, and reliability of the Medicare Program. It is unfortunate that this process was essentially hijacked behind closed doors. All of the conferees didn't even meet. Two of our colleagues on the Democratic side, Senators BAUCUS and BREAUX, were admitted to the conference, but there were others who were deliberately excluded, which is against, if not the rules, the spirit of the Senate. I think that is wrong. This is not a product of the free interchange between all interested parties, this is simply a backroom deal. If they weren't willing to deal, they could not get in the back room.

This legislation will affect all seniors. That is another reason we need more time on this floor to debate this bill, explain the bill, to have the opinions registered by seniors who are not dazzled at first by an attempt or a first glimpse of a drug benefit but by the underlying reality of the bill.

There is much to be criticized in the bill, but I believe there are three general areas. First, when I was considering a drug benefit for seniors being attached to Medicare, I believed it had to meet three tests: affordability, accessibility to all beneficiaries, and uniform coverage. This bill fails those tests miserably.

In terms of affordability, seniors will pay, over the next 10 years, $1.8 trillion for drugs—a staggering total. We began this debate with $400 billion over 10 years for Federal support—much too inadequate, I believe. We were stuck with that. But as I pointed out in previous remarks, we didn't use all the money in this bill to creatively and innovatively help seniors buy drugs. It went to help the insurance companies and pharmaceutical companies.

We are beginning with a benefit scheme where a senior will have, first, a $250 deductible, roughly $35 a month premium; and if they do that, and they pay the deductible and the premiums, 75 percent of their cost of drugs up to

$2,250 will be absorbed by the Federal Government.

But these deductibles and premiums will increase each year. Our seniors should know that. In fact, by 2013, CBO estimates that beneficiaries will be paying a $445 deductible and almost $60 a month premium, and a quarter of their drug costs will be deferred up to $4,000. So we are looking not at a fixed benefit for seniors over the next 10 years, we are looking at increased premiums and deductibles.

I mentioned the donut hole before. Even paying these fees, this doesn't provide for continuous coverage for our seniors for the drugs. They will spend up to $2,250, and then they will get nothing. I would like to be around in at least—perhaps if this bill passes—I hope it doesn't—a few months or years because it doesn't really begin until 2006—when our offices get flooded with calls saying: I just got a bill for my premium this month, but I was informed that I will get no help with drug costs, and I have to choose—not between eating or buying drugs, but I have to choose between paying my premium or buying my drugs. That will happen to seniors when they get in this donut hole, this gap. That will be their choice.

I hope we are preparing good answers by saying: Oh, that is just the way it works. Keep paying your premium because if you don't, you will never be able to qualify for help $2,000 or $3,000 down the road—after you have spent that much more on drugs. It is a baffling system of insurance.

It is interesting because I have heard so many people on the floor talk about and say: We are just going to give the seniors what we have in the Federal Employees Health Benefits Plan. I can tell you, we don't have a donut hole in the Federal Employees Health Benefits Plan. We don't reach a point at which our drug coverage stops, while we spend some more money. No, we have what most insurance plans have; we have continuous coverage. Our deductibles and premiums might be different, but we have continuous coverage. So this is nothing close to the Federal Employees Health Benefits Plan.

It might be an interesting experiment—maybe our plan should be changed. Maybe we should have this gap. Maybe we should experience the fact of paying premiums and not getting anything for them.

Again, this is one of the problems we have with the bill. When this bill passed the Senate, there was some good work—some. One of the areas where we had good work was in trying to cushion the blow for poor people who could benefit from this drug bill. Specifically, the Senate bill had a section also for people at 160 percent of poverty. That has been pulled back to 150 percent of poverty—the threshold for low-income assistance. It is estimated that because of that change, over a million beneficiaries with annual incomes between $13,000 and $14,000, approximately, will lose out on their income assistance. Now, an annual income of $14,000 might be a lot of money in some States, but in the Northeast it is very difficult to get by on that.

When you are paying $800 a month for an apartment—and, indeed, we are doing so poorly at providing affordable housing for our seniors that more and more seniors are on the private market—if you are paying $800 to $1,000 a month for an apartment, that is about $10,000, $12,000 a year. And you don't qualify for this benefit? This is protection for low income seniors?

Millions more will be further disqualified by the imposition of an asset test. I must say, I voted against the Senate version of this bill for many other reasons. But, there were some commendable elements in that proposal. One was the elimination of the asset test. The asset test is back. That means if your income is below 135 percent of poverty and you have assets over $6,000, you will be disqualified for low-income assistance.

Let me put it in the vernacular. Assets over $6,000: If you have a Ford Escort, it is probably worth maybe $6,000. Certainly, if you own a Crown Victoria, it is $6,000. So let's tell the seniors right now, if they can afford to have a car or a little bit of savings, they are disqualified from the income protections for low-income seniors because of this asset test. That I think is wrong.

There is another aspect to this bill that has been much discussed and debated, and that is what are we going to do with dual eligibles, those individuals who qualify for Medicaid but also, because of age or disability, are in the Medicare system. There is a lot of discussion about the success of this bill dealing with dual eligibles, making sure they are protected. Frankly, I think the protections are ephemeral.

First, the States are not actually relieved of their fiduciary responsibility for these dual eligibles. The Governors all want the Medicare system to go in and say: You are going to take care of these people; they are Medicare individuals now with a drug benefit. Effectively what we have done is something called a clawback, I believe, which requires the States to keep paying forever.

More than that, I am told, is that before, the Medicaid systems in the State could negotiate better drug prices, and now I believe they are subject to whatever the traffic will bear in terms of prices established by this bill. And there is no cost containment on the drug companies. There are cost containments on what we can spend for seniors, but not on what the drug companies can charge. That is another real major problem with this bill.

When I go up to Rhode Island and talk about cost containment, what seniors say to me is: Hallelujah, you are finally going to be able to constrain these accelerating prices from drug companies. You are finally going to be able to do what we all want you to do—use the market creatively, not price controls but market force to get these prices down. No, because this bill essentially prevents Medicare from negotiating for drug prices effectively against the drug industry. That is why, again, it is a "big sloppy kiss" to the insurance industry and to the drug industry because they have their way. There will be no market power. There will be no Medicare with approximately 41 million beneficiaries saying: Give us your best price, drug companies. It is fragmented by region, by private entities. It is fragmented deliberately so there is no market power.

For those people who preach on and on about the power of the market, that we have to get away from all this command-and-control economic policy, they walked away from using the market creatively to deal with the No. 1 issue that has driven this whole debate: the ever-increasing cost of prescription drugs.

It is not an accident because the people who wrote this plan and the biggest beneficiaries of this plan are those in the drug industry.

There is another aspect of this whole issue of the States and Medicaid. We have prohibited the States from using Medicaid money to help address these increased drug costs. We have essentially said: You can't use Medicaid money for that. Again, this is not only something that is unfortunate, but it puts tremendous strain on the States.

It has been estimated that my State, over the next 10 years or so, could be paying up to $500 million to the Federal Government in this clawback. I hope my Governor is aware of that. I am going to make him aware of that because the states had always expected that the federal government would pay these costs if a Medicare drug benefit was created.

There is another issue. Because of the ambiguity of some of the language, it is unclear what happens to individuals in the TriCare Program and individuals who are in the Veterans Administration program. What happens to their drug coverage? Are they displaced? That remains to be seen.

Also, in terms of the approach to Medicare, as I said several times over, it is just not adding a pharmaceutical benefit. That is what seniors want many of us to do; create a Part D in Medicare, a pharmaceutical benefits with rules, with fair costs, and with protections. The overall effect to the Medicare Program is we are raising Part B from $100 to $110 in 2005, and then indexing it to expenditures in future years. We know that is going to keep going up, and some of the fastest growing costs in the country are health care expenditures.

By contrast, the Social Security benefits are tied to increase in the Consumer Price Index. Here is what is going to happen to seniors: The Social Security check goes up, a very modest figure because of the CPI indexing, and the part B goes up like a rocket because it is tied exclusively to the health care expenditures. In a way, it could lead to the point where Part B is more and more expensive and less and less attractive to seniors.

Again, with the means test, with deductibles, all those things, we could find initially wealthy seniors leaving the system, and that erosion could spread.

There is another aspect to this, too, and that is access to home health services. Again, there was a proposal initially to put on a copay, a co-fee, for home health care. That was defeated. I see my colleague from Maine, Senator COLLINS, in the Chamber. She led the fight to see that was protected and did it admirably and graciously, as always.

What I am reading in this bill is that we are reducing reimbursement rates for home health care providers by an estimated $6.5 billion over the next 10 years. We already know the home health care industry took a significant cut in the Balanced Budget Act. In fact, many were pushed to the brink of bankruptcy, some beyond and failed and closed their doors.

Now they have to adjust to a $6.5 billion reimbursement reduction over the next 10 years. Once again, why didn't we take some of this money going to the pharmaceutical industry and the insurance industry and keep the home health care industry strong and vibrant? We all know it is a much more efficient way to treat seniors, more so than having them traipse to the emergency room, then having them go home without home health care, and then come back a week later.

Frankly, in my view, that is what made traditional Medicare a very attractive program. We have ransacked many of the aspects of traditional Medicare to fund this experiment, this demonstration in privatization.

Another general topic of concern is the accessibility issues. There is a complicated scheme now that says we are not going to let Medicare run a drug program unless, of course, there are no private vendors. When it left the Senate, the fallback would begin to operate—i.e., a Federal program—a Medicare Program for drug provisions would operate when two drug-only plans were not available in the market. That has been changed. Now, it is a drug-only or another private plan. So essentially we are doing all we can to keep Medicare from running this drug plan, not because of efficiency, not because of anything except special interest politics and an erroneous ideological commitment to use the private market anytime, even when the market and the market for senior health care is not, without major subsidies, conducive to private plans.

If it was, why did we have to create Medicare in 1965? Because no insurance company will voluntarily enroll sick, elderly people unless they are highly subsidized. We did it not because we had a profit motive but because the American people decided in 1965 that this society would be more decent, stronger, and the fabric of this country would be better if we devoted public resources to help seniors with their health care needs.

The other aspect of this, which time and again is repeated, is why do we need a $12 billion slush fund to do what we think private health insurance companies will do anyway? Because we do not believe they will do it anyway. We know they will not. We have to give them lots of money to participate. Why can we not use that money to strengthen traditional Medicare? Why can we not use that money to decrease the gap in coverage? Why can we not use that money to provide further reimbursement to home health care, which we know is an efficient, valuable program? This does not make sense to me on simple grounds of economic efficiency, but it does have a certain logic if one is rewarding their friends and appealing to ideological concerns.

There is another important aspect, too, and that is the fact that we have seniors, retirees, already with health care and drug benefits through their employers. Two point seven million of these retirees are in danger of losing those benefits.

There have been attempts in this legislation that comes before us to bring that gap down. In fact, it was estimated that there were about 4 million retirees who would lose their benefits under previous versions of this legislation. That has been reduced, but 2.7 million Americans—at least 9,000 Rhode Islanders—are likely to lose better private drug benefits that they have today because of this proposal.

I can guarantee my colleagues, we will hear from every one of those 2.7 million retirees—the at least 9,000 in Rhode Island—because that is not what they thought Congress was doing when it was debating a drug benefit.

As I mentioned before, not only does this approach fragment the healthy and young seniors from the older and sicker seniors based upon the cherry-picking of the insurance industry—which they will do—it also fragments them in terms of income because of the nature of this means testing. It might not happen right away, but anyone who is under any illusion that we are setting in concrete this proposal right now has not been here long enough.

I can imagine, my colleagues can imagine, with every reconciliation bill—and for those who are not devotees of the parliamentary musings every year when we come and have a special procedure where there is no filibuster, it is just 50 or 51 votes—we find all sorts of interesting provisions in that bill. We all stand up and say, oh, that is terrible, but I have to vote for it because it is the budget.

What we will find is this means testing will become broader because the principle has been established. What we will find is these demonstration programs for privatization will become larger.

Let me talk about this demonstration program. It allows for demonstration projects to be established in six metropolitan statistical areas where there is a 25-percent private plan participation. Presently, there are 41 MSAs around the country that meet this test, including most of my State of Rhode Island, as well as border communities in Massachusetts. It is estimated that almost 7 million seniors and disabled beneficiaries, one in six Medicare beneficiaries, could find themselves subject to this privatization experiment. That is a heck of a demonstration project, 7 million people.

As I mentioned before, what are we demonstrating? We have had Medicare+Choice for a while. We know the problems. We know that seniors will go into it. In fact, in my home State of Rhode Island we have about 30 percent who have gone into these managed care plans. They went in originally because of the offer of pharmaceuticals and drugs. Every year we get complaints when they change the plan, when they raise the copays, when they do all of these things. We know how it is going to work and we also know that we have to pay more and more each year to subsidize these private plans to participate. As a result, we are going to see tremendous erosion. Seven million seniors could be affected.

What does this mean in terms of their coverage as they look at the competing plans? According to the office of the actuaries at CMS, beneficiaries could pay up to 5 and 25 percent more to remain in traditional Medicare in areas where these demonstration projects are going on. However, the proposal at least caps that increase at 5 percent. Why would premiums go up? Let me go back to two basic points. We are subsidizing the private plan and then they are out carefully selecting to minimize their risks. They do not have to do it by offering inducements. They can put signs up at the health club, go to these 5K races and hand out brochures. They will not go into neighborhoods with high rates of disease. They will not go into senior centers in low-income areas where people have the kind of health issues associated with having earned a low income all of their lives. They will not do that. They will go to the country clubs, to the affluent suburbs, and sign everybody up. Then we will subsidize it.

So when one is a senior trying to make a choice between traditional Medicare and this new plan, well, if they have to pay even 5 percent more, that might make them choose the new plan—not because they have better quality, not because they maintain their doctor, not because of any substantive reason, but simply because it is a little cheaper, in the beginning. Then a year later, when they discover it is a little more expensive, and 2 years later as Medicare continues to decline, the options start evaporating.

So, again, this proposal is not only dangerous but unnecessary. We could have simply done what many Americans think we are doing, create a Medicare drug benefit.

So I believe we can do much better. We should do much better. We have the time to do much better. Anyone who is saying that we cannot spend 2 weeks or 2 months continuing to discuss this bill, I think is putting an undue premium on enjoying the holiday over the health care of seniors and the structure of our health care for seniors that has been in place for more than 35 years.

I hope that rather than beginning the path of privatization of Medicare, providing an inadequate benefit not only because we started out with insufficient funds, but then diverting those funds to take care of the insurance industry and the pharmaceutical industry, that we would go back to principles and try to create, under the $400 billion cap, a program that would work for seniors. I hope we can do that, and I hope we can continue this debate.

I yield the floor.

The PRESIDING OFFICER (Mr. BOND). The Senator from Maine.

Ms. COLLINS. Mr. President, the Senate will soon have an historic opportunity to pass landmark legislation to make affordable prescription drug coverage available to all of our Nation's seniors, as well as to people with disabilities who receive Medicare benefits. This legislation, which represents the largest expansion of Medicare in the program's 38-year history, is long overdue, and it deserves our support. Prescription drugs are as important to the health of our seniors today as a hospital bed was back in 1965 when the Medicare Program was first created.

I have long been a supporter of providing a prescription drug benefit as part of an effort to strengthen the Medicare Program, and I believe that were prescription drugs as important back in the 1960s as they are today the creators of the Medicare Program undoubtedly would have provided for that coverage. But back then the focus was on covering hospitalization.

While I continue to have reservations about some of the conference agreement's provisions, we simply cannot allow the perfect to become the enemy of the good. This historic opportunity may never come again, and we cannot afford to let it pass. We cannot allow yet another year to go by without taking action to help our seniors with the soaring cost of prescription drugs. Millions of older Americans and their families will be helped by this legislation. Millions more will be helped in the future. I, therefore, will cast my vote in favor of the conference report, and I want to take a moment to commend the majority leader, the chairman of the Senate Finance Committee, Senator GRASSLEY, Senator BAUCUS, Senator BREAUX and, indeed, all of the conferees who have worked so hard to craft a compromise and to bring this bill before us.

With recent advances in research, prescription drugs can literally be a lifeline for many patients. They reduce the need to treat serious illness through hospitalization and surgery. They allow our seniors to live longer, healthier, happier lives. Soaring prescription drug costs, however, have placed a tremendous financial burden on millions of our disabled citizens and senior citizens who must pay the full retail price for these essential drugs out of their pockets. Monthly drug bills of $300 or even $400 or even more dollars per month are not at all uncommon for older Mainers living on very limited incomes.

Lorraine White, of Winthrop, ME, wrote to tell me that she and her husband spend about $400 each month on vital prescription drugs. They live on limited income and they have had to draw down their savings to make ends meet. They wonder what they are going to do when their savings are depleted.

Time and again, seniors in Maine have come up to me to tell me they simply cannot afford the essential prescription drugs their physicians have prescribed. I remember an elderly woman coming up to me in a grocery store in Bangor and telling me she could only get 12 of the 36 pills for which her doctor had written a prescription. None of our seniors should be faced with those kinds of decisions. They should not be choosing between paying their bills and buying the pills that they need to stay healthy.

The legislation that is before us today will make affordable prescription drug coverage available to seniors such as the Whites, like so many seniors with whom I have talked in Maine, and it will protect them from these high out-of-pocket costs that are such a burden.

Under this legislation, the Whites' drug costs would be cut by more than half, and the savings would be even greater for this couple if they qualify for the low-income subsidies provided under this legislation.

The legislation before us today makes prescription drug coverage a permanent part of the Medicare Program, and it provides a benefit that will be available to all seniors and disabled individuals on Medicare, regardless of where they live.

It is also crafted in a way that, if a senior citizen is very happy with their health care insurance, the drug coverage that that senior already has, he or she does not have to take this additional benefit under the Medicare Program. It is a voluntary benefit.

Beginning in 2006, all seniors will be eligible to get both upfront and catastrophic protection for an average premium of $35 a month. Moreover, low-income seniors, those who are most burdened with the high cost of prescription drugs, will receive generous subsidies and get additional protections. The more than 12 million older and disabled Americans nationwide, including 75,000 Mainers, with incomes below 135 percent of poverty will not have to pay any premiums at all to secure comprehensive prescription drug coverage, and they will have only minimal cost sharing. An additional 18,500 low-income Mainers will qualify for reduced premiums, lower deductibles, and coinsurance rates, and no gaps in coverage.

The senior Senator from Maine spoke earlier today about this legislation, and I agree wholeheartedly with her contention that our Medicare beneficiaries will, indeed, be far better off once this legislation is signed into law. Clearly, we are providing meaningful and realistic help to our seniors, particularly those who are struggling the most—low-income seniors and those with very high drug costs.

The one drawback that I see in the way this benefit is structured, that I want to discuss right now, is that, unfortunately, it takes time for this new benefit to come on line. I fear many of our seniors believe this benefit is going to be available immediately and, unfortunately, that is not the case. But there is still help, immediate help, in this bill for our seniors. To provide some interim assistance, starting next year seniors will receive discount cards that will save them between 15 and 25 percent on each prescription drug purchase. Moreover, low-income beneficiaries will receive a $600 credit on that card, in both 2004 and 2005, that they can apply to the purchase of their drugs. This subsidy in conjunction with the discount card will give our most vulnerable seniors immediate assistance in purchasing drugs that they otherwise might not be able to afford.

In addition to the prescription drug benefit, there are other significant features in this bill that I strongly support. For example, the bill takes major steps to make Medicare payments more equitable. This is an issue I have been working on since my first year in the Senate. The bill tracks very closely legislation that Senator FEINGOLD and I introduced earlier this year.

Medicare's reimbursement systems have historically tended to favor large urban areas and failed to take into account the special needs of rural States. This simply is not fair. Ironically, in Maine the low payment rates are also the result of the State's long history of providing high-quality, cost-effective care.

In the early 1980s, Maine's lower than average costs were used to justify lower payment rates to doctors and hospitals. Since then, Medicare's payment policies have only served to widen the gap between low-cost and high-cost States. I am, therefore, particularly pleased that the chairman of the Finance Committee worked so hard to include in the conference report significant steps to strengthen the health care safety net by increasing Medicare payments to physicians and hospitals in rural States such as Maine.

According to the American Hospital Association, these provisions will increase Medicare payments to Maine's rural hospitals by more than $125 million in the next 10 years.

Moreover, they will increase payments to physicians in Maine by an estimated $7 million a year.

I can't tell you how important these rural provisions are to my State. Maine ranks near the bottom in the rate of Medicare reimbursement despite the cost of survival care in my State and despite the fact that the providers in Maine give very high quality care. This inequity has only worsened as additional payments under the Medicare system have gone to large urban hospitals.

I am very pleased that the rural health care package will help relieve some of the stress on our rural hospitals which are so important to rural States such as Maine. It will help ensure that there is more equity in the Medicare reimbursement system.

I also include a special thanks to the conferees for including a provision at my request that will ensure continued Medicare graduate medical education funding for Maine's family residency programs. These family practice residency programs are absolutely essential in training physicians who tend to stay in Maine and serve. They practice in underserved areas of the State.

I am also pleased that the legislation restores the rural add-on; that is, the enhanced reimbursement for Medicare home health payments that is vital to sustaining home health care in the rural areas of our country.

The Presiding Officer, the Senator from Missouri, and I have worked very hard over the years to sustain and revitalize home health care. We are well aware that many of our elderly citizens would prefer to receive the health care they need in the privacy and security of their own home. But Medicare reimbursement rates, particularly in rural areas, have been so lacking that that home health care has been in jeopardy. I wish the bill went further. I think we should have had a 10-percent rural add-on in order to compensate for the additional costs in terms of travel time, long distances between patients, and other factors that come into play when home health care is provided to seniors and disabled citizens in rural areas.

In fact, surveys have shown that the delivery of home health services in rural areas can be as much as 12 to 15 percent more costly. But certainly the extension of a 5-percent rural add-on is a major step in the right direction.

I am also very relieved that the conferees rejected an ill-advised proposal to have our seniors have a copay for the cost of home health care. I am convinced that had that been included in this package and signed into law, it would have discouraged many of our most vulnerable sick seniors from getting the home health care they need. The conferees made a wise decision, indeed, in dropping that provision which was included in the House version of this bill.

The conference report will also make prescription drugs more affordable for all consumers by closing loopholes in our patent laws that some of the large brand name pharmaceutical companies have exploited in order to delay consumers access to lower priced generic drugs. According to the Congressional Budget Office, these provisions will help to reduce our Nation's drug costs by some $60 billion over the next decade.

I am very pleased to have played a role in drafting this legislation with leaders on the bill—Senator SCHUMER, Senator MCCAIN, Senator EDWARDS, and Senator GREGG. All of us worked very hard to bring this about. This is a really significant provision. It is going to help reduce the cost of drugs in State Medicaid programs. It will help to control the cost of drugs in the Medicare Program as we are adding this benefit. It will help uninsured individuals because it will lower the cost of drugs for them. It will help employers who are providing prescription drug coverage as part of a health insurance plan. This is a very important provision and one I advocated very strongly to be included in this conference report.

In addition, the conference report includes the provision which I offered, and which the Presiding Officer cosponsored, to the Senate bill to establish a pilot program to help modernize the outdated "homebound" definition that has impeded access to needed home health services for many of our elderly and disabled Medicare beneficiaries.

I know that when we start talking about the definition of "homebound" in the Medicare Act it may sound esoteric, but in fact it is vitally important for so many disabled and elderly citizens who, because of the interpretation of the law by some of the fiscal intermediaries in the Medicare Program, have literally become prisoners in their own homes fearful of leaving in that they will jeopardize their ability to continue to receive essential home health care.

I particularly thank David Jayne, the courageous advocate who inspired this legislation, a truly heroic individual, and also Senator Bob Dole who has been such an outstanding advocate for disabled Americans for so many years. They worked very hard to ensure that this provision was retained in the final version of the bill.

Overlooked in much of the discussion of this Medicare bill are other very important provisions that will provide better coordinated care for seniors with chronic conditions such as diabetes. As the cochair, along with Senator BREAUX and the founder of the Senate Diabetes Caucus, I believe these provisions will greatly improve the quality of care for individuals suffering from diabetes. I am very pleased that these provisions have been included in this bill.

I have talked now at some length about the many provisions in this conference report that I strongly support. I do, however, have reservations about other provisions.

The House bill included provisions based on a premium support model that would have called for direct competition between private plans and traditional Medicare. I have serious concerns about the implications of this proposal, particularly that it could result in driving up premiums in the traditional Medicare Program. That would be particularly problematic in a rural State such as Maine where seniors are not likely to have a host of insurance companies competing for their business because of the small size of the market.

Moreover, the House bill could have resulted in sharply different premiums for seniors in different parts of the country and even within a single State. Those health provisions really troubled me because I did not think that a senior living in Fort Kent, ME, should be paying a different rate for the same coverage as a senior who is living in San Francisco, CA. I therefore joined a number of my colleagues in sending a letter to the majority leader expressing concern about the inclusion of this controversial policy in the Medicare bill.

The final bill, while it still causes me a lot of concerns in this area, is different from what was in the original House proposal. The original proposal was significantly downsized to a limited pilot project that would not begin until the year 2010 and that would provide significant protections for those seniors who are remaining in the traditional Medicare Program.

While I continue to have reservations about even the demonstration project, I urge my colleagues to look at the package as a whole. I agree with the AARP and the National Council on the Aging that its strengths clearly outweigh its weaknesses. When I hear some say that somehow this legislation spells the end of the traditional Medicare Program, I know that is not true. I know it is not true because I have carefully studied this bill. I also am convinced it is not true because the AARP, the Nation's largest seniors organization, would never endorse a bill that spelled the end of the Medicare Program. That is just not conceivable.

This conference report represents the last real hope of getting an affordable Medicare prescription drug benefit anytime in the foreseeable future. Our seniors have already waited too long for this benefit. We cannot delay; we cannot continue to push this issue off to the future. Since the cost of providing a meaningful drug benefit will only increase as time passes, it is imperative we act now. Our seniors have waited too long for this coverage. We cannot push this off another year, another month, another week. Let's act now. Let's not let the perfect be the enemy of the good.

This package is worth supporting despite its flaws. I urge my colleagues to join me in voting yes on the conference agreement.

I yield the floor.

The PRESIDING OFFICER (Mr. GRASSLEY). The Senator from Michigan.

Ms. STABENOW. Mr. President, I ask unanimous consent that Senator BARBARA BOXER be the next Democrat to speak after Senator HARKIN, who I believe is the last person at the moment we have unanimous consent for in terms of speaking order.

The PRESIDING OFFICER. Without objection, it is so ordered.

Ms. STABENOW. Mr. President, it is interesting to listen to the debate with colleagues today on both sides of the aisle concerning this legislation. To hear the discussion from the other side of the aisle, there would be no reason at all to oppose the bill; there would be no reason at all, last night, to have to hold the voting boards open for 3 hours to twist arms to be able to change votes, to be able to get the votes to actually pass the bill; there would be no reason that overwhelmingly Members on the Democratic side of the House and the Senate who crafted and led the creation of Medicare would be opposed to this bill.

On its surface, what is happening makes no sense if, in fact, this is a good bill for seniors. There is no way, if this were a good bill for seniors and for the disabled in this country, that I would be standing here opposing it. There is no way my colleagues in the House of Representatives—some of whom were there when Medicare was passed, some of whom have championed health care and senior citizen services for decades—would have stood on the House floor and voted no if it was good for seniors and for the disabled.

On its face, that makes no sense.

For those who have worked for years on this issue, Mr. President, I actually came into public service over 25 years ago; I often joke that I was 5 at the time—I came into public service over the issue of senior health care in Michigan. That is what brought me into public service. Since that time, I have worked very hard to continue to improve services, access to care, expand home health care, to be able to modernize health care as we have changed with new technology, new medicines, and new opportunities. I was very pleased that the first bill I introduced coming to the Senate was a bill to lower prescription drug prices by allowing our local pharmacist to do business across the border in Canada and other States to lower prices. So I care very deeply about this issue.

Nothing would please me more than to be able to stand here today and declare a victory for our seniors and a victory for all Members because we have finally done the right thing. Seniors have waited too long, there is no question. They have waited way too long.

Unfortunately, under this plan, they are still waiting. Not only will an awful lot of people continue to wait, some of them will find instead of a step forward—which we all would like this to be—a step forward that I supported with the Senate bill, even though it was not all that I wanted it to be, but it was a bipartisan bill. It was truly a step forward. I supported it as something we could build on. Instead of this being a step forward for seniors, for too many it is a step off the cliff.

Let's look at what we are talking about, just the facts. For someone who is putting out $5,100 worth of prescription drugs in a year—which, unfortunately, is not a high amount given what people are having to pay for prescription drugs—if they are paying $5,100 for prescription drugs, they would have to have out of pocket under this bill $4,020 of that $5,100. They would still pay $4,020 for that $5,100.

Some would say—and I respect that—Well, at least it is something. It may not be much, but at least it is something. The question is, What are you giving up to get that less than $1,100 in help when you have a $5,100 drug bill? The first thing, you may be giving up your coverage altogether to get that benefit. Estimates are that 2.7 million retirees will lose their coverage as a result of this bill. That is about one out of four people in Michigan.

Some would say: Well, 75 percent will not lose coverage. That is great, if you are one of the 75 percent. But what if you are one of the 25 percent of folks who worked all their life, probably along the way gave up some pay raises to get a good health care benefit, may have made a number of tradeoffs to make sure in your retirement you and your family had quality health care?

To get a very meager amount of money for prescription drug help, one out of four folks will lose their benefits. We do not have to do that under a bill we passed when there was a Democratic majority in this Senate. That bill was brought forward under Senator BOB GRAHAM's leadership and sponsorship. I was pleased to be a cosponsor. We had a bill where nobody lost their coverage. We do not have to write a bill where 25 percent of the retirees lose their private insurance coverage. It is all in how it is designed.

This is designed in a way to give incentives, unfortunately, for some employers to drop their coverage—not everyone, but if you are that fourth person when it is one out of four, that is 100 percent of you, 100 percent of your coverage and your family's coverage. So for those folks, this is not a good deal.

Well, let's look at some more. Who else isn't it a good deal for? Well, we are told that about 6.4 million people are low-income seniors who will have less access to the drugs they need, and possibly pay more. These are folks who are the poorest of the poor seniors. These are the folks who really are sitting down tonight at the kitchen table and deciding, do they eat or do they get their medicine?

This is not some platitude, some rhetoric. This is real for people where a dollar or two-dollar or five-dollar copay on a prescription makes the difference between eating, paying their electric bill, or having a roof over their head.

We understand from the Center on Budget and Policy Priorities that many of these 6.4 million low-income and disabled Medicare beneficiaries would pay more for their prescription drugs, possibly much more because they would be moved from Medicaid for low-income seniors—where many only have a one-dollar copay for their prescriptions—to a system where they would be paying more. In addition to that, there are certain drugs now that seniors need or the disabled need that they receive under Medicaid that may not be available under the private insurance plans.

So when they move this system to private plans, which is the intent as much as possible—where there is one or more private insurance plans, plus an HMO or PPO—when they move in that direction, they possibly limit the prescription drug choices of our seniors.

So under this bill, if you have folks who have a bill of $5,100, they still pay $4,020 of it. On top of that, they may be one of the folks who loses all of their benefits. And they may be one of the folks who actually ends up paying more and having less choice about the prescriptions they will receive.

On top of that, what do folks get? Well, they get the pleasure of knowing there is no new competition put in this bill to lower prices. There, in fact, is language which is stunning to me, absolutely stunning, that prohibits Medicare from bulk purchasing, group purchasing, and negotiating on behalf of all Medicare beneficiaries to lower prices.

So no wonder the pharmaceutical lobbyists are thrilled. I have spent a lot of time on this floor talking about how there are at least six drug company lobbyists for every one Member of the Senate. They earned their pay in this bill, that is for sure. I am sure they are high-fiving it all the way to the bank because what has been done in this bill is lock in a whole new group of customers, millions—39 million customers potentially—locked in at the highest possible prices. That is what we get.

So on top of continuing to get very little prescription drug benefit—and you could pay more; you could lose your coverage, but you might get some; you might get $1,000 out of about a $5,000 drug bill—but you are hooked into the highest prices because of the inability to negotiate as broadly as possible to lower prices, the inability to go to Canada.

For Michigan that is a pretty big deal. That is 5 minutes across the bridge and the tunnel, and you can drop the prices in half—or 60 percent or 70 percent. We have, for years, been saying: Let the local pharmacists be able to do business to bring back safe FDA-approved drugs, with a closed supply chain so all the safety is there, to bring them back to the local pharmacies just as the drug companies do every single day. We are not talking about mail order. We are not talking about the Internet. We are talking about licensed pharmacists bringing back lower priced drugs, many of which we have helped to pay to make, to the local drugstores to lower prices.

So we are not seeing that. We are not going to see that in this bill. The prohibition continues. We are not going to see a strong bill to close patent loopholes, to be able to allow more generic drugs on the market to increase competition. There is some language, but it has been weakened. We actually have in the bill a prohibition on Medicare using their clout to lower prices.

The VA uses its clout for our veterans, and we do not pay retail for our veterans for prescription drugs. We get a 30- to 40-percent discount because, on behalf of the veterans, we use our clout, through the VA and the Federal Government, to negotiate a group price.

Well, the drug companies do not want that. I understand that. Their sole mission is to make sure their profits and their prices stay as high as possible, that they stop any competition and keep the prices high. I understand that. That is not our job. That is not our job. The seniors in this country, the families, the workers, the businesses that would benefit by more competition to lower prices—the taxpayers expect us to be fighting for them. When I look at this bill, it is shocking the extent to which that is not the case.

So we have a situation where one out of four people could lose their coverage. In a State such as mine, where we have a lot of retirees who have good benefits, this is a big deal. We have very low-income seniors, the poorest of the poor, living on Social Security, with no pension, trying to make it. They could pay more. Many of them will pay more. And we have everybody locking in to these high prices so that more and more we will see the Medicare dollars—the precious dollars we have—going for those high prices rather than helping more people on Medicare.

Then, to add insult to injury, in 2010—which is not that far away, much as we would like to think it is; basically, 6 years away or so, 7 years—this plan opens up a Pandora's box. It allows the beginning to experiment with privatizing Medicare.

It says—even though when folks, who had a choice between picking a private plan and traditional Medicare, 89 percent of them said, I like my Medicare, I am going to stay right where I am, only 11 percent picked private plans—even though that is the case, this bill now moves to put more people in the 11 percent.

This bill even says: We are going to take precious money from Medicare and give it to HMOs and insurance companies and we are going to actually pay them so they can compete with traditional Medicare. We are going to pay them more. We are going to spend more over here to get people over here.

Now, that would not seem to make sense if you are trying to look at the fact, as many have lamented, that we have a financial crisis with Medicare. We have a concern about not enough dollars under Medicare. Why would we set up a system that would cost more rather than less? Why would we set up a system that people have said they do not want? That does not make any sense, either.

This, starting in 2010, begins the process. It is called a pilot, but it begins a process where—instead of being in this column, where you can pick your own doctor and you know what you are going to pay, and you know what the copay is, and you know what the premium is; it does not matter where you live, you can have access to Medicare; in Michigan you can be up in Iron Mountain or Marquette or Houghton or Escanaba or Sault Sainte Marie in the upper peninsula or in northern Michigan or Detroit or Three Rivers or Lansing or Grand Rapids; you know you have Medicare; you know you can go to the doctor of your choice, the hospital of your choice; and you have health care coverage—now what they are putting in place, starting in 2010, is a system where the folks who look at analyzing this have said, for those who go into this privatizing process, you would be given, essentially, a defined contribution instead of a defined benefit.

You would be given what some call a voucher, some call it a contribution, X amount of money that you could then purchase between a private plan, an HMO, or traditional Medicare. It would begin to diffuse and pull people out into different kinds of plans. Some people have asked: What is wrong with that?

Unfortunately, what happens is that if you are healthy, you are a younger senior, you are going to get a better rate going to a private insurance company or into an HMO. So you may go in that direction. And gradually what happens is that they all have different rates, different costs, cover different things, cover different doctors. In some, you have your own doctor; in some, you can't have your own doctor.

What happens with traditional Medicare? Those who are the sickest, the most elderly, the most disabled, who can't get a good rate outside of traditional Medicare, will stay. The experts tell us the cost of Medicare will go up; because there are sicker, older, more disabled people here, and we are going to see increases. It has been estimated there will be a 25-percent increase over time in those costs.

What happens in the long run in that system? Gradually Medicare will have more and more costs, fewer and fewer people, and we will have what Newt Gingrich said he was hoping would happen or he expected to happen; that is, Medicare will wither on the vine.

It will take a few years. We can say: We are not going to be around then. It doesn't matter to me.

But what we vote on in the next couple days will begin a process that will unravel what has been one of the greatest American success stories ever—Medicare. That is what we are seeing happen here. Someone like myself, who cares so deeply about Medicare, who cares so deeply about providing prescription drug coverage and lowering prices, has to say, no way, no way will I support this.

I understand that there is a major philosophical difference—I respect that—between those who never supported Medicare, who view it as a big government program. I know that. I know that when Medicare originally passed, there were only 12 Republicans who supported it. There is a big philosophical difference.

I say Medicare is a big success story, so is Social Security. Other colleagues say: Big government program, it needs to be privatized or eliminated. Let folks go to the private sector. Let them buy insurance.

Prior to Medicare, half the seniors couldn't find or afford health insurance. They couldn't find it or afford it. Ask folks today, ask a small business person who is trying to find or afford health care, ask somebody who is a single entrepreneur or in a small nonprofit or single business person in their own private consulting business how easy it is to find and afford health insurance. We need to be addressing those issues.

I find it ironic that when we need to be addressing that and creating bigger insurance pools so that we can actually lower prices and create more access to health care and work with the business community to do so, this bill does exactly the opposite. It unravels the only piece we have had that has worked because it takes 39 million people, puts them in one plan—the sick, the healthy, the older, the younger. Because it spreads the costs and the risks in such a large pool, they have been able to keep the administration down, keep the growth in the program down. It has worked.

On the face of it, we would say: Why in the world would we want to change that? Why in the world would we want to create a system where it costs 2 percent right now to administer Medicare; private HMOs, it costs 15 percent? And we would set up a way to begin to move to this?

If we have a financial crisis with Medicare, I would argue it is because of a self-inflicted set of decisions. The tax cuts passed 2½ years ago were paid for by Medicare and Social Security. We would have dollars to be able to take care of everything we want to do with Medicare right now, and Social Security, if it were not for a decision that was more important—to give to those who already have great opportunity and have done well with it. It was decided it was better to give to them and hope it would trickle down to everybody else rather than keeping our promises to Medicare and Social Security.

So now folks say: We have to change it because the resources are gone. Well, the resources are a problem because of decisions made by this Congress and this President.

Even with that, if you say, well, we can't sustain Medicare as we know it, why would you then say, I have an idea: because Medicare is in crisis and because there is going to be a problem down the road funding it, let's make it more expensive? That doesn't make any sense. It doesn't make any sense at all.

It only makes sense in two ways: One, if you just consider Medicare a big government program and you believe everything should be done in the private sector, then from your standpoint, paying 15 percent instead of 2 percent is OK. But I think there is a broader issue at stake. The underlying focus, unfortunately, is that the folks who want to move us away from Medicare are the folks who benefit by this system. And even more than the insurance companies and the HMOs, that are going to have to be paid more to entice them into this, the folks who are benefiting are in the pharmaceutical industry.

What this battle has always been about is making sure that if we are going to provide prescription drug coverage, we are not doing it under one plan where all 39 million seniors are in one plan and they can get together and have the clout to force a group discount.

That is what all this is about. All of it is about the pharmaceutical industry that fought for years to try to make sure we would not have a prescription drug benefit because we could then get a group discount.

But then a couple years ago they changed their strategy. They said: OK, well, if we are going to have a benefit—because it is clear that seniors need help and we are not going to be able to stop it because seniors need help, something is going to happen—let's change our strategy and make sure that this is a plan that is putting seniors in a lot of different pots, lot of different insurance and HMO pots, so they can group purchase a little bit but they won't have the clout of 39 million people, they will have the clout of just a few, a little bit here, a little bit here, a little bit here; and let's make sure we don't allow any new competition; and if we were really good, we would even write in the bill that Medicare can't negotiate on behalf of everyone for a group discount.

I am sure that was their big wish list. And, lo and behold, in this great big bill, most of which has nothing to do with prescription drug coverage, they got it. They got it.

Because they got it, someone like me, who wants more than anything to see seniors helped in paying for their medicine, has to stand up and say, no, no way, no way is this thing a good deal for the seniors of this country.

(Mr. BOND assumed the Chair.)

Ms. STABENOW. Mr. President, I want to speak briefly to one thing that I believe in the bill is a good deal. There are positive things. I don't think it is all a negative bill. I think there are positive things in it. I know there are people who have worked hard, including our occupant of the chair, who led efforts to work in a bipartisan way and tried hard to get the right thing done.

On balance, there is no way I can support this bill, but there are some good provisions in it. I believe there are provisions in this bill that, right now, we could pass overwhelmingly, on a bipartisan basis, if we were to pull them out, take away all the bad provisions, and start over on prescription drugs.

I would simply say that to have no bill is better than to have a bad bill. Let's go back to work and get it right for our seniors. Absolutely, they have waited too long. They have waited so long to get this, and they are saying, I waited so long and this is what I got? So let's go back to the drawing board. We can do it quickly if we want to and get it right—lower prices, real prescription drug coverage.

But there is one section I believe we have a tremendous sense of urgency on right now. I know that my distinguished colleague in the chair has been a leader in this effort, and that is our rural providers and what happened with our hospitals, home health agencies, and doctors, and the cuts they have had to take. I want to speak to the fact that I am frustrated that we have not, before now, been able to help our providers.

I was in the House of Representatives in 1997 when we passed the balanced budget agreement at that time, putting into place certain reductions for providers. Unfortunately, since that time, they have seen cuts of twice as much as was originally suggested would happen at that time. It is the health care delivery organizations that will lose reimbursement. Frankly, the citizens of Michigan, indeed the citizens of the country, lose care when our providers are not given the assistance—the dollars to cover the care they need to be able to deliver.

I have been working since that balanced budget agreement in 1997 to turn that around. In fact, the very first amendment I offered on the floor of the Senate to the budget bill was to stop the 15 percent cut in home health care that was scheduled to take place. We have known about this latest round of cuts since December of 2000. We knew it was coming. At that time, we enacted a Medicare relief package, but we knew there was going to be another 15 percent cut in home health or a $1,500 cap on physical therapy services.

Unfortunately, there were a number of cuts that were just postponed at that time. We have known for 3 years that these cuts were coming, and there is no question that the portion of the bill that deals with help for our rural and urban hospitals, help for our doctors, nursing homes, home health agencies, physical therapists, all of the other providers of Medicare services need to be addressed. We need to fix that. We need to stop the cuts that are stopping services from being provided.

If health care providers are not able to get reimbursed for their services at a reasonable rate, we know they are going to simply decide not to serve Medicare recipients. Too many of them have made that decision—not because they wanted to but because they felt they had to. We know patients cannot simply decide not to seek care. It is our responsibility to make sure that providers are available in every community, every rural community, urban, or suburban area.

In the past 5 years, the numbers of physicians accepting Medicare patients has declined by 10 percent. I know there is a sense of desperation now as we look at this package. I have physicians saying to me: We know in the long run that this is not a good deal for seniors, not even a good deal for us; but we are so desperate for something that we feel we have to say yes to this package and then come back and fix it.

Of course, I say to them, I don't know if we can fix it. If we cannot get it right now, I have no confidence that we can come back and get the votes to fix this later and stop the bad things that I talked about earlier.

But I know that there is a sense of desperation. I know the annual increases in Medicare payment rates from my State of Michigan are less than the rate of inflation. In 2000, more than half of Michigan hospitals lost money helping Medicare patients. One of the things that happens when Medicare is cut and not covering the costs, as well as Medicaid, is that those costs—what it takes to care for people—is shifted to people who have insurance. So the providers are private sector providers now, and they are saying now that they have a stake in making sure that hospitals and doctors and other providers are reimbursed at a fair rate, covering their costs, so that those costs don't shift over onto our large businesses, small businesses, and so on. So we all have a stake in making sure that Medicare is paying a fair rate. Certainly our small businesses, which have seen their insurance rates at least double in the last 5 years, have a stake in this.

In my State, our big three automakers and other manufacturers struggle with issues of health care. So I am deeply concerned that the provisions in the bill that deal with our providers be passed.

This next round of cuts in 2004 to Michigan providers would be about $69 million to our hospitals; $53 million to teaching hospitals; $70 million to nursing homes; $120 million to physicians; and for independent home health care agencies, $16 million. Altogether, it is about a $329 million cost.

My concern is that these desperately needed funds are being held hostage in this bill. If we were addressing this package independently, I believe we would have overwhelming bipartisan support, if not unanimous support, for these provisions. They are long overdue. Many of us have been saying now for 3 years that this needs to get fixed. Our hospitals desperately need help, as do doctors, home health agencies, nursing homes, et cetera. And we need to do this now. But I am concerned that it is put in the middle of a bill that is not in the long-term best interest of these same providers.

I spoke a minute ago about how the highest possible pharmaceutical prices are locked into this bill. Because the highest possible prices are locked into this Medicare bill, as soon as the increases to providers are done with in this legislation, and because of the increases in pharmaceutical prices every year—we are seeing 12, 13, 14, 18 percent increases every year—I believe our providers will be in great jeopardy of being cut significantly once again, because an explosion in prescription drug prices will not have any accountability. There will be nowhere to go but back to the doctor to cut, back to the hospital, back to the home health agency, back to the nursing home, the physical therapist, the cancer services. There will be no place else to go. So even though my good friends, who are desperate, feel they have to support this package, which they know is not good for them a few years down the road, I believe we can do better by pulling that language out and today making it clear that we are not going to hold those who provide health care to seniors and the disabled hostage in this legislation.

We are not going to hold them hostage to a broader bill where there is such disagreement and controversy. I believe it is up to us to pass this legislation today.

UNANIMOUS CONSENT REQUEST—S. 1926

Mr. President, I ask unanimous consent that the Finance Committee be discharged from further consideration of S. 1926, which is cosponsored not only by myself but Senators GRAHAM, CLINTON, MURRAY, LEAHY, DASCHLE, PRYOR, LEVIN, CANTWELL, and SCHUMER—this is a bill to restore Medicare cuts to providers—that the Senate proceed to its immediate consideration; that the bill be read a third time and passed; and that the motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Is there objection?

Mr. GRASSLEY. Mr. President, as chairman of the Senate Finance Committee that has jurisdiction over the legislation, and I want to take a good look at it, I object.

The PRESIDING OFFICER. Objection is heard.

Ms. STABENOW. Mr. President, if I may take another moment, that is very disappointing to me. I believe our providers need help now. We can do this in a bipartisan way. My legislation would allow that to happen immediately. I will continue to work to make sure that happens.

In conclusion, I say to all of my colleagues, we can do better for our seniors than what is in this bill. I would like very much if we would all vote no and go back to work and get it done right. I thank the Chair.

The PRESIDING OFFICER. The Senator from Utah is recognized.

Mr. BENNETT. Mr. President, as this debate goes forward, it is beginning to take on somewhat of a formulae pattern with one side saying, There are some good things in this bill, but it is so bad that we must do nothing, and the other saying, We have problems; there may be some bad things in this bill, but we have to move forward. Both sides agree the bill is not what individual Senators might prefer, but the way the argument comes down on one side or the other as to the balance.

I am reminded of the statement my father used to make when he served in this body. He said: We legislate at the highest level at which we can obtain a majority. With the Senate as equally divided as this one, with only a one-vote margin between the parties, obtaining a majority is very difficult. I pay tribute not only to the chairman of the Finance Committee, but to the ranking member of the Finance Committee who, in a bipartisan fashion, obtained a majority within that committee and brought a bill that has now obtained a majority in the House of Representatives, however close that was, and is on its way to obtaining a majority in the Senate.

As the debate has gone on, those who are saying, No, this bill is more bad than it is good, seem to have another mantra that I have heard over and over again. That mantra is this: This bill will destroy Medicare. Indeed, there are some who have gone so far as to say that it is the motive and purpose of the Republicans in this matter to destroy Medicare. I have had some say the Republicans have hated Medicare ever since it was established, and they want to kill it, and this bill is somehow a Trojan horse aimed at killing Medicare from the inside.

I reject the notion that the Republicans are trying to kill Medicare. I think that is ridiculous. I don't think there is any indication that is the case, never has been, but it is part of the political mantra that we hear over and over again.

More importantly, I want to address the question of the present health of Medicare absent this bill. We hear over and over again: Medicare is wonderful; we can't tinker with it in any way. The best thing we could do is just take a prescription drug program and put it into the present Medicare mix. Some of the provisions that are in this bill are innovative. Some of the provisions that are in this bill tinker with this wonderful program that everybody loves.

I would suggest to those who have that particular point of view that they should go out and spend some time dealing with Medicare as it presently is constituted, not in the theory of a committee hearing, but on the firing line with providers. Let me give you a few anecdotes out of the real world that have convinced me that while I believe the Federal Government should have the responsibility that it has adopted with respect to Medicare, I do not believe that the present Medicare system is so wonderful that it should not be tinkered with.

Example No. 1: As I have held town meetings around my State, people come to me and talk about their problems. I am sure every Senator has the same experience. Very often, the problems they talk about have to do with Medicare.

A woman came to me and said: I have finally figured out how to deal with Medicare.

It struck me as a little bit strange that she should be talking about Medicare because she didn't strike me as being old enough to worry about Medicare. Then she made it clear; she handles her mother's financial affairs.

So she said: On behalf of my 85-year-old mother, I handle all of her relationships with Medicare. She said: Again, I finally figured out how to handle it: I throw away everything unopened, and then once a month, I call the Salt Lake Clinic and say: How much do I owe you? She said: I am a professional. I am a college graduate. I am an educated woman. I am probably at the top of my powers in terms of my career. I cannot understand anything that comes from Medicare. I open these envelopes, and I try to read what it has to say. It is absolutely impenetrable, and I spent time trying to figure it out; I spent time trying to work it through and finally I adopted my present strategy. Once again, I throw away everything unopened. I don't even bother to look at it, and then at the end of every month, I call the Salt Lake Clinic—which is where her mother gets her health care provided—and I say: How much do I owe you? They give me a number, I write out a check, and life is simple.

She said: I may be overpaying, I may be underpaying, but who knows? Indeed, I don't think there is anybody on the planet who knows how much the bill really should be. She said: I decided that the peace of mind that comes from being able to handle this in this kind of fashion is worth whatever financial discrepancies there might be.

That does not sound to me like a program that is working so well that we can't do a little tinkering with it or a program that is going so smoothly that we can't try some innovation.

Our friends on the other side of the aisle are so horrified that this bill calls for some health savings accounts. I say to them: What are they afraid of? That they will work? Are they afraid the health savings accounts might demonstrate that there is a different way to deal with this, a way that is a little more straightforward, a way that does not involve the mountains of paperwork and the tremendous bureaucracy connected with it?

Example No. 2: I have a daughter of whom I am enormously proud who has a master's degree in speech therapy. After she graduated with that degree from George Washington University, she went to work in a nursing home. This daughter is a very enthusiastic young lady. Some might even suggest she is a little bit excitable. I would not, as her father, make that kind of a charge, but I have heard some who have suggested she gets excited.

She had been on the job, I imagine, a week, maybe a week and a half. She called me. The call came in as calls from my children usually do: Just as I am getting ready to go to bed.

I am so delighted to hear from my children that I do not resent the fact that they prevent me from getting the amount of sleep I would normally like. They can call any time. When she called and I answered, she said: Dad, you are a Senator. You have got to fix Medicare.

I said: OK. Calm down. Tell me what you are talking about.

Then she described the details of the difficulty she was having in her first job in this nursing home trying to provide therapy for seniors who were having serious problems with respect to Medicare. She made this fascinating statement to me. She said: Dad, do you know who the highest paid person in this facility is?

Well, I would have assumed it would be the administrator.

No.

Well, if it is not the administrator, then the most skilled doctor. I can see that a doctor might be paid more than an administrator.

She said: No. The highest paid person in this facility is the woman who is in charge of handling Medicare regulations.

I stopped to think about that for a minute. That means the skill required to understand all of the regulations relating to Medicare is in shorter supply and therefore can command a higher salary than the skill necessary to administer an entire facility or the skill necessary to provide medical services from a skilled physician.

She gave me an example. She said there was a senior in that facility who was having some problems swallowing. The doctor looked at it. The doctor said, I do not understand what the problems are, and called the speech therapist. My daughter, the speech therapist, came in and said: Yes, I understand the problems connected with this. It is fairly straightforward. It is fairly normal among seniors. Here is the way you deal with it. She needs this kind of therapy to deal with her swallowing problems. They are not just minor problems. They could affect her ability to eat and ultimately her ability to live because she needs the nourishment.

So my daughter said: This is what needs to be done.

Well, the relatives of the woman who had the swallowing difficulties said: Absolutely not, until we are sure Medicare will pay for it. We cannot have this kind of procedure and therapy prescribed unless we are sure it is covered by Medicare. If Medicare will pay for it, then grandma can have it, but if Medicare will not pay for it, we are not paying for it, no.

My daughter, in her innocence, first time on the job, said: Let me find out. So she made the inquiry, Will Medicare cover this particular treatment? Three days later, she gets an answer. It took that long to wade through all of the regulations, and all of the rest of it, by this person who was the highest paid person in the nursing home, to figure it out.

My daughter has had the tragic experience of having patients die on her, patients whom she believed she could have helped but was unable to help because of the delays built into dealing with all of the complexities connected with Medicare.

She said, again: Dad, you are a Senator. Fix it.

I said: Well, it takes a little more than one Senator to fix this.

Then she made a very interesting statement. She said: I cannot admit to any of my coworkers in this facility that my father is a Senator because they will be so outraged that my father is a Senator and is not doing anything about fixing Medicare.

So I suggest to those who say Medicare is so sacrosanct that we cannot try anything new, they ought to spend a little time dealing with patients and providers to discover that Medicare has become a bureaucracy of incredible impenetrability and needs to be addressed.

This bill addresses some of those problems. The most significant one, of course, is the fact that Medicare as it currently stands does not provide reimbursement for prescription drugs. Now that is a scandal. Every other health program in this country immediately recognized, as it came along, the shift in the way medicine is practiced in this country, but because Medicare is written by the Congress, it is not flexible enough to make that kind of shift.

We now have prescription drugs that prevent hospitalization, that prevent the necessity for operations and surgical procedures, but Medicare will not reimburse for that even though ultimately it would save tremendous amounts of money. The reason: Medicare is the best Blue Cross/Blue Shield fee-for-service indemnity plan of 1965 frozen in time.

It is almost like a bad movie, a Woody Allen movie where he sleeps for awhile and comes back 40 years later.

Medicare has not kept up with the changes in the way medicine is practiced. It has not kept up with all of the things that happen outside of Medicare, in the private world, that happened just because the administrators of the plan look at what is happening in the practice of medicine and say we need to change the plan to adapt to the way medicine is practiced.

Medicare cannot because it has to be changed by Congress, and every time Congress comes along and says we need to try to make some of these changes, we run smack into the political reality that there can be some political hay made by standing up to defend Medicare, by saying the other side is trying to destroy Medicare. The scare tactics of this kind of campaign are something with which we are all familiar.

One of my colleagues on this side described a conversation she had during the 2000 election with her aunt who was in her nineties. Her aunt said: I am not sure I can vote for George W. Bush.

The Senator said: Why not?

She said: Well, he is going to destroy my Social Security.

Wait a minute, said the Senator. Governor Bush has not talked in any sense about your Social Security. He is talking about the future. He is talking about the teenagers. He is talking about the 20-somethings who are just coming into Social Security.

Oh, no, said the woman in her nineties, he is going to destroy Social Security and Medicare. Because she had seen television ads that suggested that any attempt to try to improve, modernize, change, or help either Social Security and Medicare meant destroy, meant we are against it.

We are hearing those same kinds of arguments today. Any attempt on the part of the Finance Committee to improve, change, innovate, experiment, or move in any direction other than the 1965 model is somehow an attempt to destroy.

Well, it is not. I think we all understand that. But that makes for a great bumper sticker. It makes for a great television 30-second sound bite to attack anybody who wants to try anything new as being against the old and, therefore, trying to destroy the whole program.

I have problems with this bill, as does every other Member of this body one way or the other. There are lots of things in it that I do not like and lots of things in it that I think will make the problem I have just described worse, make Medicare even more impenetrable than it is now, but I intend to vote for it. I intend to vote for it with enthusiasm, and I ask my colleagues to do the same thing, because for the first time since 1965, it is at least willing to break down some of the walls that have been built around this program. For the first time since 1965, it is at least willing to try and see if we can get a little experience with a few things that can move us into the 21st century.

I am sure I will be attacked in my election this November as being one who voted to destroy Medicare by virtue of this vote, by those who will want to continue to raise the specter that any kind of innovation or change is an attack at the fundamental program.

But let us understand the most important thing we are faced with here. Let us understand if we do nothing, if we preserve this program as it currently exists, it will destroy itself. This is not a partisan statement, this is not some conclusion Republicans have come to and Democrats dispute. The demographics are irresistible. What is happening in our country as we become older and older, as the good health care that we are receiving makes us live longer and longer, that demonstrates a financial situation that is unsustainable.

If we do nothing with Medicare in the name of preserving Medicare, we watch Medicare self-destruct. That is inexorable. There is no way around it.

I would have suggestions that would go far beyond what this bill does in moving us away from the present paradigm of Medicare into a world of innovation, change, and experimentation, not because I want to destroy Medicare but because I want it to survive. If you leave it on its present course, it is not going to survive.

There are a few halting steps in the right direction in this bill. We need more of them. We cannot stop with this bill. The Congresses of the future will have to deal with this problem, and it will only get worse the longer we delay taking those steps.

So I say let's take those steps now. Let's start with this bill with the full understanding, and with eyes wide open, that the future is going to bring us back to this issue again and again. The demographics are inexorable. They are going to require changes in the next Congress and in the Congress after that and in the Congress after that. They are going to force us to get out of the mindset that we have had since the 1960s, and that has nothing to do with who is in the White House or who controls the Senate in a partisan fashion. Those demographics are there. They are bearing down on us. The quicker we can understand that and begin to think in new ways, begin to experiment with new methods, the sooner we will solve the problem, not only for our existing seniors but, perhaps more important, for the baby boomers who are becoming seniors. We have to think in a new fashion or they will run into a demographic brick wall that will see this program self-destruct regardless of what we do.

So, as I say, for that reason, with all the problems I see in the bill, I am going to vote for it, and I am going to hope that future Finance Committees and Ways and Means Committees will move us in the direction of innovation and experimentation so we can boldly begin to find solutions to the problems that we face.

The PRESIDING OFFICER. The assistant minority leader.

Mr. REID. Mr. President, it is my understanding, on the Democratic side, the speaking order has been set for the next few speakers. Is that true?

The PRESIDING OFFICER. The Senator is correct.

Mr. REID. Who would they be?

The PRESIDING OFFICER. Senators HARKIN and BOXER.

Mr. REID. Following Senator BOXER, I ask that Senator CLINTON be recognized.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. I believe that is all we have at this stage, Mr. President.

For tomorrow, whatever time we come in, I ask on our side the Democratic leader be recognized first, I be recognized second, that Senator GRAHAM of Florida be recognized third, and Senator KERRY of Massachusetts be recognized fourth—that is for Sunday.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. I reserve the right to object.

The PRESIDING OFFICER. Is there objection?

Mr. GRASSLEY. Was the request just in the order on the Democrat side?

Mr. REID. Unless there is some change by the leadership, I assume we will do the same thing tomorrow we are doing today.

The PRESIDING OFFICER. Without objection, the order will be that stated by the Democratic whip.

The PRESIDING OFFICER (Mr. WARNER). The Senator from Iowa.

Mr. HARKIN. Mr. President, I do have quite a lengthy statement. I had estimated it might take me upwards of about 45 minutes. I know others want to speak. I am going to try to collapse it as much as I can, but I had a number of things I wanted to say. Hopefully, I can get them said within a certain amount of time. I don't mean to drag it out, but I did have a number of things I wanted to point out about this bill.

We are debating an issue of utmost importance—the health and security of this Nation's elderly and disabled. To repeat what has been said, Medicare was created 40 years ago with the purpose of providing this Nation's aged and disabled with a safety net to protect them from debt and destitution. For years, seniors have counted on health security in their golden years thanks to Medicare. This program stands as a social contract between the American Government and the American people, a social contract between one generation and the next.

The contract is simply this: After a lifetime of work, when you turn 65 you are promised health insurance covering doctors visits, hospitals, and many other health costs. But there has been one exemption from this social contract—no coverage for prescription drugs.

It is not possible to overstate what Medicare means to a citizen of modest means who has worked hard for a lifetime, who doesn't want to be a burden on the rest of his or her family. It is really kind of hard to overstate what it means. Medicare has been a rock-solid, reliable, guaranteed lifeline for a great number of America's senior citizens.

I think back to my father's own experience, my own family's experience in the days before Medicare. In 1958—I just pick that year because I was a senior in high school at that time—my father at that time was 74 years old. He had worked most of his life in coal mines, in Iowa. A lot of people don't know it, but we had a lot of coal mines in Iowa. He had a number of accidents in those mines and elsewhere. He suffered from what was then called miner's lung. That is what they called it at that time, miner's lung. Today we call it black lung disease.

As I said, he had several chronic injuries as well and he was in pretty tough shape. Keep in mind, my father only had an eighth grade education, and all of his work life basically had been prior to Social Security coming into existence.

My father's total income in retirement was less than $1,500. Again, thank goodness during World War II, even though he had been old then, he had worked for a while and was covered under Social Security. Other than that, he had no assets, he had no money, no stocks, no bonds. He did own a small house in Cumming, IA. Oh, yes, he had a model A Ford that was 30 years old. That was the only car he ever owned.

Of course, in 1958 he had no Medicare because the program didn't exist. This meant that my father couldn't afford the luxury of seeing a doctor. But every year, like clockwork, my father would get sick in the middle of wintertime. He had this terrible chronic lung problem, black lung, miner's lung. My mother had passed away 8 years prior to 1958. He was on his own and basically taking care of us. As I said, I was a senior in high school at the time.

Every year he would catch a cold, he couldn't get over it, he would come down with pneumonia, and a neighbor of ours who had a car would rush him to the hospital in Des Moines.

He would arrive at the hospital in Des Moines. They would take care of my father. They would put him in an oxygen tent. They would give him his antibiotics and send him home in a week or two.

How could he afford to do that if we were so poor and had no income? My father was 74 years old. Did we have a rich uncle? No. So what happened? I will tell you how we afforded it. We thanked Sisters of Mercy at the Mercy Hospital in Des Moines who gave us charity care because our family didn't have any money. That is the only way that my father got health care.

We forget. Those of us who are young perhaps forget that 45 years ago that was the status of elderly health care in America. My father was not unique. Our family was not unique. In my little town of 150 people, it was all the same. All my father's brothers, his sisters, our family—of all who were that age, none of them had any health care. None of them had any money. If it wasn't for the charity of the Catholic Church and the Sisters of Mercy, my father would have had no health care whatsoever.

Had my father had any money or health insurance, he could have seen a doctor. He could have had annual checkups. He could have prevented long stays in the hospital. But in the absence of anything like Medicare, he ended up in a dire situation, in effect, in the emergency room. For many uninsured in this Nation, things are still that way. But fortunately, Medicare has offered a better alternative for our Nation's elderly and disabled.

I can remember as though it were yesterday. After I left high school, I went to Iowa State University. I had a Navy ROTC scholarship. I was in the Navy. I was flying planes. And I can remember coming home on leave once. It was Christmas of 1966. I came home, and my father, who was nearing his 81st birthday, still with his bad lung problems—I remember coming home and I remember when he proudly showed me his Medicare card. He said: Now I can go to see a doctor. I can go to the hospital, if I have to. But I can see a doctor. We don't have to take charity anymore.

I think of the impact that Medicare card had on my father, and the impact it had on my family and what it meant to my father to be able to get health care without accepting charity. What a tremendous difference. I often think about what my father's later life would have been like had he had Medicare. I think about how much healthier he could have been with good preventive care, and how much more he could have enjoyed his later years if he had had decent health care.

Today, seniors rely on Medicare. It means everything to them. If you do not have your health in your older years, you just do not have much of anything.

Unfortunately, back in 1966, we weren't nearly as sophisticated about medicine and health care as we are now. Surely, if we were creating the Medicare Program today we would include coverage of prescription drugs. We know that drug breakthroughs and innovations have made it possible to prevent illness, control illness, and keep people out of the hospital. For many in this society, modern prescription drugs have been a lifesaver and a life sustainer. Here we are today debating a proposal that was originally supposed to accomplish one simple goal: To fill in the gap that was left in Medicare—to right the wrong in Medicare by providing coverage of prescription drugs and simply to make medicine more affordable to seniors.

That is what we started out to do.

I deeply regret that in writing this bill Congress has strayed from that straightforward objective. This bill got hijacked, and it got hijacked by the corporate special interests, insurance and HMOs, and it got hijacked by the pharmaceutical industry.

We have forgotten who we are supposed to be helping—our Nation's seniors. Instead of a straightforward drug benefit, we now have a Medicare privatization proposal that threatens to undo the entire Medicare Program that seniors and the disabled rely on each and every day—seniors like my father who relied upon the stability and the affordability of Medicare in his later years, and seniors like him back in my home State of Iowa who simply want and need affordable medical care. That is all they want.

But what they are offered in this bill is something else entirely. This bill totally violates the spirit and substance of the original Medicare Program. I call it the "Big Medicare Gamble." It is a roulette wheel. If you know anything about odds in roulette—I don't. I just learned this: The odds are tremendous against you. Roulette—that is what they are playing with Medicare. This bill threatens to unravel Medicare as we know it. Seniors are being told to head to the back of the line because the special interest drug companies and HMOs are more important than they are.

Seniors are being told there isn't enough money for a full drug benefit. That is because we have already squandered our surpluses in tax cuts worth trillions of dollars for the wealthy.

I heard someone the other day say: Look, we can't do any more in Medicare than we are doing now because we are limited by the $400 billion that was put in the budget. So all of you people want all of this stuff, but we can't do that, you see. We can't do it. We simply don't have the money. The very same person saying that voted for the tax cuts in 2001 and in 2003.

I am saying: Well, fine. If you vote for the tax cut, fine. But then don't say we don't have enough money to have a good meaningful prescription drug benefit under Medicare. What you are saying is you had different priorities. Your priority was to give tax breaks to the wealthy. That is your priority, and the seniors and elderly who need prescription drugs, they can go to the back of the line someplace else.

We had the amount of money—I will continue to say this because it is true—that we gave up in the tax breaks. If you spread that out over 75 years, that money is three times more than what we need to make Social Security and Medicare whole for 75 years—three times. So don't tell me we don't have the money. People just have different priorities on how to spend the money.

Once again, the well heeled on Wall Street are more important to this administration and to the supporters of this bill than the elderly and the disabled on Main Street.

What we have before us today is a bill drafted behind closed doors in the dark of night that amounts to a bonanza for special interests. Don't take my word for it. Look at what others are saying. Here is the Los Angeles Times: "Deal Would Alter the Essence of Medicare."

> As Congress prepares to vote on the final $400 billion Medicare prescription drug bill, there is one thing on which most lawmakers agree. The legislation would over time change the essence of the 38-year-old health insurance program for the elderly and disabled.

We are doing that and we are told that we have 2 days to debate it—2 days, Saturday, today, and tomorrow—and we are going to vote on Monday. My prescription for this bill is to put it out in the countryside, send it out across America, let us get out of here, go back home for Christmas, go back to our constituents, get it out among the elderly, let us see what they say about it, and come back here as we are going to do on January 20 and take it up in February. Let's hear what the American public has to say about it before we pass it. It does not go into effect until 2006, so what is the rush? If it does not go into effect until 2006, why not take a couple, 3 months to put it out there and let people think about it? No, no, we have to debate this Saturday, Sunday, and vote on it Monday.

Here is my own Des Moines Register editorial:

> This legislation is a big, sloppy kiss to the pharmaceutical and insurance industries.

From the Albany Times Union:

> This is not only an imperfect bill. It may also be a disastrous one.

That is what others are saying about it.

Another one, from the New York Times, on the 19th:

> . . . gift to pharmaceutical companies and insurers and a threat to elderly Americans.

From the Los Angeles Times:

> Deal would alter Medicare's core.

Continuing:

> If a comprehensive bill on prescription drugs passes, the government program will become a massive subsidized insurance market.

That is what we are doing. It is not just the media. Here is what conservative organizations are saying. Here is the Cato Institute, a more libertarian institute, perhaps, than conservative. I am not certain if it is conservative or libertarian:

> The Medicare prescription drug bill to be voted on by Congress is a terrible mistake that will dearly cost our children and grandchildren. This is not a Medicare reform bill. This is barely a Medicare prescription drug bill. This is a bill for politicians and special interests. Sometimes the better part of valor is recognizing when you have made a mistake. Congress should recognize this bill as a mistake and go back to the drawing board.

That is Cato director of health and welfare studies Michael Tanner.

From the Heritage Foundation:

> The agreement contains an unworkable and potentially unpopular drug benefit with millions of Americans losing part of their existing coverage.

That is not just me, a Democrat, saying that. It is the Heritage Foundation. They go on to say:

> More than four million seniors with existing private coverage are bound to lose it or have it scaled back. Meanwhile, the politically engineered premiums and deductibles coupled with their odd combination of "doughnut holes" or gaps in coverage are likely to be unpopular with seniors.

That was November 17, 2003, Heritage Foundation.

From the American Conservative Union:

> The Medicare prescription drug benefit bills that have passed the House and Senate would drive up costs for millions of senior citizens.

They go on:

> Millions more would lose their current coverage under private medigap insurance and employer-provided plans. The House-Senate conference committee should reject the current bill and start over with a bill that includes real Medicare reform.

That was the American Conservative Union, August 21, 2003.

It probably seems odd for this progressive Democrat to be agreeing with conservatives, but sometimes they get it right, and they are right on this.

This bill would provide billions of dollars in subsidies—make that bribes; they say subsidies, it is bribes; call it to what it is, bribes—to private plans and HMOs. It would ensure billions of dollars in profits, a projected $139 billion in profits to pharmaceutical companies.

It speaks volumes that on Wall Street this week, drug and health industry stocks have surged up on the news of this big money, special interest bonanza. I often pointed out that during the deliberations on this so-called prescription drug bill, you never saw any pharmaceutical companies around here. I can tell you one thing. I have been here 29 years, and I have seen times in the past whenever we had bills dealing with drugs or pharmaceutical companies, if it is something that is going to cost the pharmaceutical companies one penny, they are here. They are in the halls. Their private jets are parked out at the airport. They are calling; they are phoning; they are in our offices. If there is any legislation that is going to take a nick out of the pharmaceutical companies, believe me, you see them up here.

I never saw a one, not one during this entire debate and development of this bill, which indicates to me they love it. Why wouldn't they, with a projected $139 billion in profits?

Now, I don't mind pharmaceutical companies making profits. They have a right to it. They provide good drugs. They do good research. But what I mind is that the $139 billion in profits they are getting are coming out of taxpayers' pockets—not to buy drugs, just as a subsidy, a blatant subsidy. It is not something they are making in the marketplace; it is a funnel from taxpayers to the taxing power of the Government and giving it right back out to the pharmaceutical companies.

One of the oldest statements in medicine goes back to Hippocrates: The first thing in medicine is "do no harm." That is the oath that each doctor takes in this country: First do no harm.

We have to look at this bill. It does tremendous harm. Most egregiously, this legislation seeks to privatize Medicare, despite the fact that 89 percent of seniors are in traditional Medicare, and that is what they have chosen.

I listened to the Senator from Michigan, Ms. STABENOW. She pointed out we offered seniors a choice in this country in 1997. It is called Medicare+Choice. They could stay with traditional Medicare or they could join an HMO. Guess what, 89 percent of the seniors in this country stuck with Medicare and 11 percent went with HMOs. It seems to me they have already stated what they want.

Despite the fact that traditional Medicare is less expensive to administer—this is something else that a lot of people do not understand—they say private industry can do it cheaper than Medicare. The fact is, since we have had Medicare for over 40 years, we have good data. We know. We can look at the figures. This is not something on which you have to guess. So we look at the figures, and what do we find? We find that the average administrative expense in Medicare is 2 to 3 percent. In other words, for every $1 that goes to a Medicare recipient, 2 to 3 pennies are used in administration. In private plans, it is 15 percent. For every $1 that goes through a private plan in health care, 15 cents is used in administration; only 2 to 3 pennies in Medicare.

Why is that? With traditional Medicare, we do not have to spend millions on corporate CEO salaries or give them the private jets in which they fly all over the country. How about all the big page ads they take out in USA Today, New York Times, and Newsweek magazine? Those cost a lot of money. Medicare does not do that. So we have very cheap administrative expenses.

Despite the fact that administrative costs are 2 to 3 percent in Medicare and 15 percent in the private sector, they want to privatize Medicare. Despite the fact that under Medicare+Choice, which I just mentioned—they came in a few years ago in the late 1990s. HMOs have a history of dumping seniors. They get signed up, they are not making enough money, they leave town, and they dump them. But, still, we want to privatize it. They want to privatize it despite the fact that Medicare expenditures are growing at a slower rate than private plans. This is fact. This is not something we are guessing at. We have the data, how much Medicare has grown expenditures percentage-wise compared to private plans. We have the data. No one on that side will ever dispute it because it is factual. Medicare expenditures are growing at about 9.6 percent a year; private plans, 11.1 percent. Their expenditures are growing faster than Medicare.

They want to privatize Medicare despite the fact that private plans are concerned first with what? Profits. I do not say that as a bad word. That is their business. They are in business to make money for themselves and their shareholders. So their first concern is profit.

Senior citizens and the sickest are not profitable. The elderly are not profitable. The sickest and the disabled are not profitable for insurance companies.

Despite the clear wishes of senior citizens in this country, they want to privatize Medicare. The conferees have chosen to ignore all of these facts. Instead, they have concocted a witch's brew—a witch's brew—of seemingly appealing schemes which are designed to let Medicare wither on the vine, and to set the stage, next year and beyond, for attacking Social Security. Make no mistake about it; that is what this is designed to do. And I will have more to say about that in a minute because of what Newt Gingrich stood for.

The ideological experiment that we have confronting us is the result of what I call private sector worship. It is sort of a faith-based notion among some of our colleagues and administration officials that the private sector will take care of everything. It is a blind faith that free markets solve every problem. But this private sector worship flies in the face of past experience.

The entire reason we have Medicare today is because there is no private sector market for health insurance for sick seniors—none, zero, zip, nada—no private sector market because there is no money to be made in insuring the sick, the elderly.

The free market works just fine when you are talking about automobiles and airplanes and TVs, and widgets, et cetera. But the free market is not stupid. It cares about profit, not people. So by its very nature the free market shuts out people with disabilities, people with mental illnesses, people in the last years of their lives—in short, people who are not profitable.

So I have news for my colleagues who believe the free market is the answer to everything. The free market did not break down barriers to people with disabilities in our country.

When the Americans with Disabilities Act was passed in 1990 and signed into law, it was not the free market that did that. It was Government. It was us, the elected officials here in the Congress, working with the President, who did that. It was our free Government that had to step in to ensure that opportunities and openness in our country was there for people with disabilities. In the survival-of-the-fittest free market, these folks are just simply left behind.

Another example: We have been fighting in this Congress for years now to pass a bill ensuring mental health parity. But people with mental illnesses are not a profitable group. So the free market, left to its own devices, will have nothing to do with mental health parity in insurance. That is why I hope, as soon as we get back in our session next year, we can get to work passing the Paul Wellstone mental health parity bill because when we leave it up to the free market, folks with mental illness simply get left behind.

Another prime example of those left behind is simply the elderly. The elderly are not a profitable group of people to include in an insurance risk pool. They are sick. They are older. They have chronic illnesses. They are expensive to treat. On this score, the proof is all around us.

It is impossible to imagine private insurers fighting and competing with one another for the privilege of covering the elderly. That is why this bill has to bribe these companies with billions of dollars in subsidies to participate in this wrong-headed scheme we have before us.

As I said in my opening comments today, I have seen this proof firsthand. Now, back in 1958, when my father, as I said, was then 74, getting sick every year, going to the hospital, relying upon the charity of the Sisters of Mercy, we had insurance companies. There were a lot of insurance companies in those days.

Why weren't those insurance companies rushing out to Cumming, IA, with a population of 150 people, knocking on our door and competing with one another to cover my father with health insurance? Because they would never make any money off my dad. He got sick all the time. And he did not have any money.

Where was the free market? Where was the free market to cover my father in his time of need when he was elderly? The only market that was there was the charity market. Somehow I get the uneasy feeling that those promoting this bill see that as, once again, sort of the last kind of stopgap to helping our elderly, relying on charity once again, relying upon your kids, relying upon your families.

So do not tell me the private sector will solve every problem. I have lived through its failures firsthand. And I know that many elderly in my State of Iowa and around the country are in the same situation. They do not want to be let to not-so-tender mercies and whims of HMOs.

Now, it may sound like I have a real case against insurance companies. I do not. In fact, in my State of Iowa I think we are proud that we are the second largest domiciliary of insurance companies in the Nation, next to Connecticut, I believe. We are proud of our insurance companies in Iowa. They employ a lot of people. They are good corporate citizens. And they provide a very valuable commodity: insurance.

What the heck, I have a lot of insurance. I have life insurance, health insurance, car insurance. I probably have more insurance than I know what to do with, but it is a good tool, and I can afford it.

Insurance has been good for us ever since the first insurance scheme started about, I think it was, 3,000 years ago, in China, when Chinese farmers were sending their barges down the Yangtze River, down to the ports, down to the cities. They found the storms would come up, and they would lose some of the barges, so a few of them got together and they decided to pool—to pool—their risks so that if one barge went down, that one person would not be totally wiped out. They found out by doing that, they could cover one another. Thus began the whole idea of insurance—risk pool, sharing the risk, spreading the risk around.

So, no, I have a great deal of respect for insurance. I think it provides a very valuable, meaningful commodity for all of us. But it is not adaptable here in health care for the elderly. It is just not adaptable.

Many of my colleagues prefer the free market over Government intervention. In many cases this is a wise preference. But in other instances it is a misplaced faith that the free market can do anything. There is a time and a place for the Government to step in where the private sector either fears to tread or fails to tread because it is not profitable. No question, this is the case when it comes to helping people with disabilities, people with mental illnesses, and seniors with serious health problems.

We hear the claim that private sector competition will drive down costs and save Medicare.

Come on, let's get real about this. The only competition in this bill will be the competition for healthy seniors. That is where the competition will come.

It says right here in the Washington Post: "Medicare Deal Likely To Spark More Health Care Competition." When you read that, you say that is good, that is what you want. Except when you read in here, it says:

> "This could be like the wild west out there," Hayes said. "If suddenly there are five or six or seven plans out there, the insurance companies will be pricing their product to make a profit, as they are obligated to do. If the consumer is kind of shooting in the dark because of the complexity of this—and the darkness is deepened by age or disability—you'll have a customer primed for exploitation. We're real concerned that people could get ripped off."

If you are sick and you are a senior, you are going to be shunned. If you are a senior and you are healthy, you are going to have people fighting for you. Why? Not on a free-market basis, but that is where the subsidies go. We are going to give them subsidies to do this.

We hear the claim that Medicare should compete with the private sector, but they don't want an even playing field. This bill will give billions of extra dollars to the private plans so they can compete and make profits. That is not competition, that is simply another excuse to shovel taxpayers' dollars to the special interests. In fact, this bill will pay private plans 9 percent more than traditional fee-for-service Medicare.

But that is not the end of it. On top of that, the conferees have come up with what they call a stabilization fund, which amounts to a $12 billion slush fund for private plans.

Once again, the writing is on the wall. Privatization costs everyone more money. So understand this: They say they will pay the private plans 9 percent more, but when you add the $12 billion in this stabilization fund, it is more like 26 percent more. In other words, taxpayers of this country are going to pay, out of our tax dollars, 26 percent more to the private plans so they can compete with Medicare. What a sweetheart deal that is; what a sweetheart deal. And then they say that is competition, that is fair competition. It is nothing more than a scheme to give money to special interests.

We hear the claim that seniors should have a choice. Many people have said seniors should have a choice as we Members of Congress have. I can tell you this: When they find out what is in this bill, they are going to be disappointed to find out their options are nothing like our options.

Yes, I believe the seniors of this country ought to have what we Members of the Senate and Congress have. But they aren't going to get it under this bill.

Many seniors could actually end up with reduced choice with this legislation. Under this plan, if there are two private health plans, say an HMO and a PDP—I know, aside from a few people probably around here, no one has ever heard of a PDP. And why not? Because they don't exist. They have just been conjured up out of this witch's brew. It is called a prescription drug plan. There is no such animal out there now. In a particular area, if a senior wants drug coverage, that senior will be forced to get their drug coverage through one of those private plans, not Medicare. That senior will not be allowed to get their drugs through traditional Medicare. So they can go to the PDP or the HMO.

Well, they don't want to go to an HMO. Eighty-nine percent of seniors have already said they don't want to join an HMO. They want their choice of doctor. They want fee-for-service. So they can join a PDP, but we don't know what they are like because no one has ever built one. But once the senior goes in this private plan, they could face restrictions on what doctors they can see. The plan can change the drugs that are available to them. You could be on one drug and they could say: Well, we aren't going to cover that drug; we are going to cover another drug.

Now, why would they switch from one drug to another? Well, maybe they are getting a kickback from the pharmaceutical manufacturer that is making the drug. Maybe they get a bigger kickback on one drug than they do another. So they tell you: We are not going to cover that drug. So seniors could be forced to change drugs in midstream.

This is not competition. This is another excuse to shovel money to the special interests. I don't call that choice. That is not choice at all.

There is a lot of rhetoric surrounding this bill that doesn't match reality. This administration has said many times that seniors deserve choice, that seniors deserve what Members of Congress have. I am all for that. But let's put our money where our mouths are.

Right now, as a Senator, I pay about 25 percent of my drug costs, period—a heck of a deal. But the prescription drug plan put before seniors today won't even come close to this. Instead, it is a confusing, convoluted maze that—mark my words—will leave our seniors feeling betrayed and bewildered once they find out about it.

I say to my colleagues, if you like our seniors' reaction to the catastrophic health insurance plan of 1987, you are going to love their reaction to this grossly inadequate prescription drug plan.

In 1987, I was here. We all voted for a catastrophic health plan for the elderly. The AARP supported it and said it was wonderful. Guess what. We came back a year later and had our heads handed to us by seniors in our States. I know I had mine handed to me. We came back a year later and undid it.

I can barely lift the bill that we have before us. It got delivered to us sometime this morning or last night. I didn't see it last night when I went home so it must have been sometime during the night or this morning this was handed to us. I am not going to kid anybody. I haven't read this. I have been here all day. I haven't read this. I am not about to. I will have my staff look it over, and we will try to get through it. But no one is going to read this prior to the vote on Monday.

How many seniors in the country will go through this before Monday and be able to tell us what they think about it? Yet we are given 2 days—today and tomorrow—and we vote on Monday. A bill such as this, that is this big, that could have disastrous effects, is a bill that ought to be out there, around the countryside. Let's go home for Christmas and Thanksgiving. Let's let it out there. Let's get people looking at it, talking about it. See what the effect is going to be in your State and mine, urban and rural, wealthy, poor. Come back in February and let's take it up and see how we feel about it then. To me, that is the way democracy works.

This President wants to bring democracy to Iraq. I sure hope they are not watching this. I sure hope they are not watching this exercise. They might think democracy may be something they may not want if they watch this.

Look at what our seniors are going to be faced with. Once a year, we in our plan, the Federal Employees Health Benefits Program, get an open season in which we can leave the plan we are in and pick another one. Here are all the books I get once a year to look through to decide which plan I want.

I get 30 days, or something like that, to look through them and decide which one. Here is MD Individual Practice Association; here is GEHA; here is NALC; here is the Mail Handlers Benefit Plan; here is BPP and PPP—never heard of that; here is Kaiser Foundation; here is APWU—on and on and on. You get my point.

So we are now going to say to the seniors that every year you get a change and you will get all these wonderful books, like we do, to read, and you go through them and decide which plan you now want to be in. Give me a break. Maybe a person out there is sick and just hanging on, and they are supposed to decide by looking at these books. I suppose maybe they will have to go out and hire somebody to look at them. They will have to give a subsidy to somebody else. Maybe we will give a subsidy to the trial lawyers to help them decide which one to choose. Every single year. Who knows what drugs will be covered or what doctors? It is convoluted, bewildering. Every year they can bounce them around; you can be in a different plan.

At the end of the year, the plan can say: I am not making enough money, so I am out of town. Nothing in this bill stops them. Nothing in the bill says: We don't care if you don't make any money, you have to stay. If you are not making money, you can get out of there, and the senior is dropped, period.

Let's talk about what Senators are going to pay with this. They are going to find out, to their dismay, what they are going to have to pay. Aside from being confused and bewildered, being able to be dropped every year, let's see what they have to pay. Seniors who have an annual income above $13,470 per year—that is right, $13,470 a year—that is not a lot of money. If they have an income above that, they pay a yearly deductible of $250 before their coverage kicks in. They will pay $35 a month in premiums. Can I tell you also that this $35 is not fixed in law; it is estimated. It could go up every year. It could be $40, $42, $45, or who knows? There is no guarantee it is going to be $35. So now you have about $420 a year. As I said, the number could change every year. When a private plan is not making enough profits, they can increase the premiums every year. So seniors end up paying more.

So after seniors put at least $670 upfront into the program, they can start receiving some benefits. You might say, well, $670 is not a lot of money. If you are making $14,000 a year, or $13,470 a year, that is a lot of money. That is asking a lot. Then, after they pony up the $670, they pay 25 percent of their drug costs up to $2,250. At $2,250, the senior hits the gap—what we call the donut hole—at which point they pay 100 percent of their drug costs until they hit the catastrophic amount, even though they are still paying monthly premiums into the program.

So during the course of the year, a senior could have coverage one day, and the next day they could go to the pharmacy and be charged the full sticker price for the prescription drugs. That is the donut hole. It is not fair. It is outrageous.

Look at what they are paying now: Part A premium, zero. Part A deductible, for hospitalization, $876 per benefit period; Part B premium for doctors, $66.60 a month. The deductible is $100 a year with doctor visits. The cost share for doctor visits is 20 percent. That is straightforward, simple, and easy to understand. There are not income limits, asset tests, or anything else. It is just very straightforward. Seniors who have annual drug costs of $500 actually pay more into the program than what they receive. They would pay $500 for drugs, but they would pay $751.25 into the program. Tell me how fair that is. A senior with $1,000 in drug costs would pay $876.25. At the higher end, a senior with $5,000 in drug costs would pay nearly $4,000 for his or her drugs. What a deal. And for that, they get to read all these books every year. They get all these, I say to my friend from California, every year. And they have to try to decide. They can get bounced every year from one plan to another. For that, they pay $5,000, or they pay 4,000. It should not come as a surprise.

It is estimated that seniors, over the next 10 years, will have $1.8 trillion for prescription drugs costs, but we are allocating $400 billion to pay for it. Where did that money go? Well, it went to tax cuts. Hopefully, the people who voted for the tax cuts now will not bemoan the fact that we don't have the money. They voted to blow the money on tax breaks for the wealthy.

Now, let's look at one other thing. To make things even messier, this program would create several tiers of class under Medicare. Right now, you have one class. Everybody knows what he or she has to pay. Under the new program, we are going to classify you and have a lot of different strata here. There are different low-income benefits for those under 135 percent of the poverty level—$12,123, single—and another set of benefits for those under 150 percent of poverty—$13,470.

On top of that, to receive the low-income benefits, a senior has to undergo an asset test. Again, hang on here, folks. We will see if we can understand this. We will have a little test afterward. For those at 135 percent of the poverty level and below, the asset test is $6,000 for a single person, $9,000 for a couple. For the group at 150 percent of poverty and below, the asset test is different. In this group, a person cannot have more than $10,000 in assets, or $20,000 for a couple. Follow me?

So what you are going to have is this. I predict this is exactly what is going to happen. You are going to have seniors at the senior citizen center, or at the local McDonald's having a cup of coffee; and old Bob is going to say: You know, this thing they passed is a pretty good deal. I am getting all my free drugs and stuff like that. His friend, Sue, is sitting there and she might say: What are you talking about? I just took a job at the local supermarket bagging groceries or stocking shelves; I am retired and have Social Security, but I need to make ends meet and pay for my drugs. Because I took that extra job to help make ends meet, to pay for heating bills, to meet my drug costs—I took this job that doesn't pay a heck of a lot—minimum wage—but because I got bumped up a little, I don't get the same benefits you get, Bob. And Margaret, who is sitting there, thought she was going to get the low-income benefits, but she filled out her forms and found out she had too much life insurance, over $10,000 in life insurance. She cannot afford her medicine, but her life insurance is considered an asset.

If you are going to go to McDonald's in the morning and you are sitting and having coffee, they are going to talk about this. But for the spread of $25 a year—maybe $50 a year—one person will get great benefits and the other person won't. You tell me if this is not a formula for an uprising among the elderly. It is not rich and poor. I am talking about people who make $13,470 a year, or they make a little less than that.

Or $12,123 versus $12,150. That is the kind of difference you are going to have, and that is going to decide what you get. Then they are going to say: You know, old John over there is getting those low-income benefits, but, by gosh, he is cheating because I know he owns something else. He owns a better car than what he said or he has a little something stashed away someplace. How do we get those low-income benefits? We know he has more than that.

It is going to arouse suspicion among the elderly: Why do you get a better benefit than I get? We are both in the same boat, and you make 50 bucks more a year than I do and you get all these benefits and I don't.

Hang on to your hats. It is going to happen.

How are they going to know where they fit in? You will have several people who make nearly the same amount of money each year and they receive drastically different benefits. This is a formula for confusion and confrontation among the elderly.

Right now, there is only one group. When you have Part A deductible, you all pay. When you have a Part B premium of $66.60, everybody pays it. When you have deductible of $100, everybody pays it. When you have a Part B cost share of 20 percent, everybody pays it.

When they sit around McDonald's having their coffee in the morning, Bob isn't suspecting that Joe is getting away with something or that Sue maybe has a little something extra, and Margaret who took that job at the supermarket to have a little extra money doesn't feel as if she is discriminated against because she has a little extra pocket change. They all pay the same.

Wait until this program heads south. You just wait. You just wait and see what happens.

I don't know, did the authors of this bill deliberately design a system that is going to fail, that does more harm than good? There were a thousand pages delivered to us on Thursday. The drug and health industries are spending millions to ram this bill through immediately, even though seniors across the Nation don't know what is in it.

What is the rush, I ask again? It doesn't go into effect until 2006. What is the rush? Why must we pass this bill before seniors have had a chance to examine the provisions and voice their views?

I saw this cartoon in a newspaper from Newark, NJ. This is the cartoon. Here is the pharmacy and the pharmacist. This, obviously, is a senior citizen who has come in. She has a prescription to fill out. The pharmacist represents Congress. He is saying to her: Have a seat. It'll be ready in 2½ years.

That is what we are saying: Have a seat; in 2½ years, this will be ready. Why do we have to rush it through right now? Why do we have to fill the prescription now if she doesn't get it for 2½ years? Maybe we ought to write the prescription later on, next year after we have had a chance to really look at it.

I think seniors in this country deserve more. They deserve to be put first in the process. They have been given short shrift in this process by the corporate special interests who have a very different view about the direction of Medicare. As I said earlier this week, the stocks of pharmaceutical companies and health insurance stocks have gone up.

Maybe a lot of seniors assume that AARP would stand up for their interests; that AARP would come in here and stick up for them. But AARP, the American Association for Retired Persons, has brazenly betrayed the wishes of its members on this issue. Seniors with whom I have spoken from all across Iowa do not like this bill.

AARP came to Iowa late this summer and had three big town meetings on this drug bill. Several hundred people showed up. I was told when AARP presented it, they presented the House version and the Senate version, as we passed them, in a straightforward manner without editorializing whether one was better or worse or good or bad.

After presenting this to several hundred Iowans in three different locations, at every meeting, they asked the 200 to 250 people who showed up, all senior citizens: How many of you would sign up for this plan? Do you know how many hands were raised? Zero. Not one hand went up. Not one hand. Now AARP is saying this is a great bill. I don't know with whom they talked. When they talked to the elderly in Iowa, they didn't get any takers.

My constituents want an affordable, reliable benefit under the traditional Medicare Program. Seniors across the country agree. A poll released this week found that almost two-thirds of seniors view this bill unfavorably. Most of them identify themselves as AARP members. Among those, only 18 percent said Congress should pass the bill; 65 percent said Congress should go back to work on this bill. They need to know the direction Medicare is taking and whose side AARP is on.

It says everything about this bill that Newt Gingrich is urging Republicans to vote in favor of it. For those of you who have forgotten who Newt Gingrich is, he was Speaker of the House and was the one who uttered the famous phrase: It was his desire to let Medicare "wither on the vine."

Mr. Gingrich is one of those ideologs who insists the private marketplace will solve all the problems. It would make his day to see Medicare dismantled through privatization, and that is exactly why he is pulling out the stops in lobbying for this bill—because under this bill, Medicare not only withers on the vine, it is cut away from the vine.

This bill is a realization of Newt Gingrich's fondest dream: to end Medicare as we know it. I might also say that Newt Gingrich made no bones about it. He wanted to privatize Social Security—privatize it, put it out on the stock market. That is next. But he sees this as the first step to that privatization.

The newspapers have been full of accounts of Mr. Gingrich's "pull out the stops" lobbying for this bill. He says:

> Every conservative Member of Congress should vote for this Medicare bill.

I submit, if Newt Gingrich is for this bill, that is a serious red flag. That ought to raise a lot of questions because, as I said, Mr. Gingrich has made no bones about it—I give him marks for honesty—he has said time and time again that Medicare ought to wither on the vine; we ought to privatize Social Security. Not only does it privatize Medicare, it is a bonanza for Mr. Gingrich's corporate friends, the big money corporate interests.

This bill is like Christmas in November for Mr. Gingrich's corporate friends. It allows people to sock away thousands of dollars a year in tax-free medical savings accounts. Of course, the people from where I come don't have money for tax-tree accounts. It will be used mostly by the wealthy, not low-income seniors. Newt Gingrich is ecstatic. This Medicare bill is yet another tax cut bill with the benefits flowing overwhelmingly to the wealthy.

Here is more of what Mr. Gingrich has to say about this Medicare bill:

> I think this is one of the great historic moments in moving the Nation in a conservative direction.

He said—get this—this is Newt Gingrich:

> If you are a fiscal conservative who cares about balancing the Federal budget, there may be no more important vote in your career than one in support of this bill.

I guess as a supply-side zealot, he believes that the tax-cut provisions in this bill will help us balance the budget. That is bizarre. That is just bizarre. They just want to privatize Medicare. That is all they want to do.

They want to privatize Social Security. Mr. Gingrich claims that the shift towards medical savings accounts would be "the largest change in health policy in 60 years."

He made this claim to a gathering of his right-wing anti-tax enthusiasts at the Americans for Tax Reform headquarters in Washington. Of course, the head of Americans for Tax Reform, Mr. Grover Norquist, is famous for saying, "My goal is to cut government in half, to get it down to the size where we can drag it in the bathroom and drown it in the bathtub."

That includes Medicare and Social Security. That is part of his government. That is what he wants to drown in the bathtub.

So it is no wonder that Mr. Gingrich and his right-wing friends love this bill. Not only does it undermine a Government program that they despise; even better, it serves up another fat tax cut for the rich. Only the wealthy and healthy will benefit from this bill.

Mr. Gingrich is outspoken in his belief that pharmaceutical companies are getting unfair treatment and they are punished by their success. Well, Mr. Gingrich, that is wrong. This bill does not ask one penny from the pharmaceutical companies. In fact, it protects drug companies from Government efforts to negotiate lower costs. I am the first to support drug research and development, but the Medicare burden should not be taken solely out of the pockets of seniors and taxpayers.

In closing, I would have to ask: Exactly why are Newt Gingrich and AARP in the same bed? That seems odd. What are they up to? AARP's slogan is "the power to make it better." They claim to represent American seniors. However, millions of seniors are furious that AARP has endorsed this lousy bill. As I said earlier, a Peter Hart poll found almost two-thirds of seniors viewed the bill unfavorably, and most of those were AARP members. Among AARP members, only 18 percent said we should pass this bill, while 65 percent said we had to go back to work on it.

Yesterday, AARP members from Maryland, New York, and Pennsylvania tore up their membership cards in front of their organization's Washington headquarters. AARP's Web site community message board is filled with outraged comments. Members are accusing William Novelli, CEO of AARP, of selling out to conservatives and Newt Gingrich.

Now, where, I wonder did they get that idea? In fact, the relationship between Newt Gingrich and the bigwigs at AARP goes way back. William Novelli, executive director of AARP, wrote the preface to Newt Gingrich's book, "Saving Lives, Saving Money." In that preface, Mr. Novelli states that: Newt's ideas are influencing how we at AARP are thinking about our national role in health promotion and disease prevention and in our advocating for systems change. That is Mr. Novelli's preface in Newt Gingrich's book.

Well, I have to ask: Which of Newt's ideas are "influencing how we at AARP are thinking"? Is it Newt's fond wish that Medicare "wither on the vine"?

No wonder members of AARP feel so betrayed. I too feel betrayed that AARP's leaders have chosen to endorse the right-wing principles of this Medicare bill and endorse Newt Gingrich's ideas of how to undermine and privatize our Nation's health care system.

AARP's endorsement is disturbing for another reason. They have a flagrant conflict of interest in this matter. Bear in mind AARP receives vast revenues from the sale of insurance to seniors. Royalties from such arrangements include deals with United Health Care Insurance Company, Metropolitan Life Insurance Company, and Advanced PSC Pharmacy Benefit Management, accounted for more than one-third of AARP's $636 million in revenues last year, according to AARP's 2002 annual report. There we have it. AARP is looking at the insurance end of it, of course.

American seniors deserve better from the AARP and from Congress. They deserve a bill that includes an affordable prescription drug plan, that strengthens Medicare, that does not penalize the sickest and the poorest in our Nation.

This bill reflects the priorities of this Republican administration and of Newt Gingrich who have been hostile to Medicare since its inception. This bill needs to be written by individuals and groups that believe in Medicare, not those who want to undermine it. Seniors know that this bill is a betrayal. They know who the winners and losers are with this bill.

Under premium support, HMOs, PPOs, and pharmaceutical companies, they win; seniors and the disabled lose. Under cost containment, the private companies win; the seniors and disabled lose. Under drug coverage, pharmaceutical companies win; seniors lose. Under health savings accounts, the wealthy HMOs win; seniors and disabled lose. Under the so-called stabilization fund, this slush fund, HMOs, PPOs, and pharmaceutical companies win; seniors and the disabled lose. Under so-called competition—boy, there is a misnomer if I have ever heard it—HMOs, PPOs, and pharmaceutical companies win; seniors and disabled lose.

The seniors know this. Again, it is a question of priorities. This administration rammed through this Congress $1.6 trillion in tax cuts. Now they say they cannot take care of the elderly who have worked their entire lives, contributed to their communities and served this country. Once again, the administration has made a clear choice. They have chosen the folks on Wall Street over the folks on Main Street.

It is a big deal. I got to thinking the other day. I talked about how my father, during the Depression—I was born November 19, 1939. I just had my birthday this week. In 1939, my father was out of work. He had a wife, five kids, and one on the way. I was the sixth one. He had no money. He had an eighth grade education. My mother was an immigrant who had no formal education. They lived in a small house in a small town in rural Iowa, and my father had no hope. He was already 54 years old, had worked in the coal mines most of his life, and the only thing they had was this tiny little house in this small town.

As I walk out of my door every day, I have on my wall a little framed orange piece of paper. It is dated July 19, 1939, 4 months to the day before I was born. On that orange piece of paper, it is printed and it says: You, Patrick F. Harkin—that is my father—are to report to work at once as a laborer on a project, $48.30 a month. It was signed by somebody, and then my father signed it—4 months to the day before I was born. It was his WPA form when my father went to work on a WPA project.

Now, I look at that because I remember once George Bush, when he was a candidate for President, said: Government cannot give hope to people. Every day when I walk out of my office and I look at that piece of paper, I say: Mr. Bush, you are wrong. If it had not been for Franklin Roosevelt and the New Deal, I do not know what would have happened to my family and my father. They gave him a job. They gave him hope.

Years later, when I was in high school, my father took me to some of those projects he built. One of them was at Lake Okoboji. It is still in use as a recreational facility in Iowa; a high school in Indianola is still being used today built by WPA. Why do I say that? Because I got to thinking about the new deal and I got to thinking, it was a Government program; Roosevelt's New Deal. Who was the benefactor? The unemployed. To my father, who had no hope, it gave him hope and it gave him a job.

Then we had Truman's Fair Deal, and who benefited from that? The uninsured and low-wage workers.

Today we have a new Government program that they are trying to push on us, Bush's Big Deal. Not the New Deal, not the Fair Deal, but the Big Deal. Who wins? The HMOs, big pharmaceutical companies and private health plans. I call it the Big Deal because the bigger you are, the better the deal. Compare that to Franklin Roosevelt's New Deal and Harry Truman's Fair Deal, that reached down and helped bring people up. No, today we have the Big Deal: the bigger you are the better the deal.

This is a radical departure for Medicare. It changes the nature of this program as an entitlement. The conferees set an arbitrary cap on how much Medicare money can be spent. Instead of a cap, we ought to just be spending the money more wisely. We ought to be spending less on HMO subsidies, less on subsidies to the pharmaceutical companies, and more on preventive health care, keeping our seniors more healthy, getting them better diets and better exercise—more preventive health care to keep them healthy.

This is an article called "Entitlement Change Is Inevitable, Key Administration Officials Say." They went on to say: "In the long run, Social Security cannot meet its commitments."

That seems to be the constant refrain we hear from this administration. Social Security cannot meet its commitments. Of course not; we just took the huge surplus that had been built up under the Clinton administration and we squandered it on tax breaks for the wealthy.

I say again, the amount of money going out in tax breaks to the wealthy in our country that was passed in 2001 and 2003, over the next 75 years, is three times more than what is necessary to "save Social Security and Medicare." Don't tell me that the money is not there and that Social Security can't meet its commitments. It can't meet its commitments now because we squandered all the money on tax breaks for the wealthy. Sure, Medicare is headed for a train wreck, but it is a train wreck planned and plotted by this administration.

You can be sure as soon as this bill is out of the road they are going to start on Social Security. Headline: "Bush Pushes For Expanded Private Role in Medicare." That is what it is all about.

> "The foundation of this . . . compromise—is a level playing field between Medicare and private plans," said Senator Edward Kennedy. "What conservative Republicans are now trying to do is rig the system in a way that would coerce senior citizens away from Medicare and into private plans."

Senator KENNEDY said it right.

To be fair it is not just Mr. Gingrich and Mr. Bush who are hostile to the Medicare Program. Many others share their views.

The junior Senator from Pennsylvania and third ranking Republican, Mr. SANTORUM, said—I believe this is a direct quote:

> I believe the standard benefit through the traditional Medicare program has to be phased out.

That is the third ranking Republican on that side of the aisle.

The junior Senator from Utah, Mr. BENNETT, has said:

> Medicare is a disaster. Medicare will have to be overhauled. Let's create a whole new system.

Tom Scully, head of the Centers for Medicare & Medicaid, the top Medicare official in the Bush administration, said this about Medicare; he called it "an unbelievable disaster" and a "dumb system."

Medicare is not a disaster or a dumb system in the eyes of millions of seniors who rely on it every single day. As I said, this is too big an issue to address in a day or 2 days.

We have to act now, we are told.

Nonsense. The provisions in this bill don't kick in until 2006. We received the bill on Thursday, this right here. We received it this morning on our desks. We didn't have time to look at it. We ought to withdraw the bill, get it out to the public, and bring it back for consideration in February. That will allow time for seniors back home to analyze it, discuss it, and share their views with Members of Congress. Then we can take an informed vote on this bill, taking into consideration the views of seniors in our respective States.

This is the Senate, supposedly the world's greatest deliberative body. We can take more time, as we did last week, in going all day and all night and all day and all night, talking about four judges who were held up—we can take more time to do that than we can to debate and discuss this profound change in Medicare in the United States. What does that say about the state of affairs in the Senate today? Oh, yes, we can deliberate over four judges—168 that got approved and 4 that didn't. We can talk about that for days or weeks on end. But, no, to discuss this profound change in Medicare we take Saturday and Sunday and vote on Monday.

The Senate has ceased being the world's most deliberative body. It is now the world's most rushed body: Rush it through, stampede it, and get it done. This is a complex, confusing, bureaucratic nightmare of a bill. It is a bad bill procedurally.

This bill contains untested experimental privatization plans that especially threaten seniors in rural areas. To top it off, it offers yet another big tax break for wealthy Americans.

There is supposedly a fix in this bill for the disparities. There is supposed to be fairness, in terms of addressing the disparity between the States, in reimbursement for Medicare on a per beneficiary basis.

I have taken the floor many times to talk about how Iowa is No. 50 in the Nation in the per beneficiary reimbursement for Medicare. So Iowa has been 50th out of 50 States.

This bill was supposed to have a fix in it to make it more fair. So they put, I think, $25 billion into this bill to make it more fair over the next 10 years. Right now, the per beneficiary reimbursement in Louisiana is $7,336. In Iowa it is $3,053. In Virginia it is $4,611.

I say to the occupant of the chair, the citizens of Virginia pay the same Medicare taxes as anybody else in this country. Yet the seniors in Virginia get back $4,611 per beneficiary, the seniors in New York get $6,924; the seniors in Texas get $6,539; the seniors in Maryland, right next-door, get $6,301, but in Virginia they only get $4,611 per beneficiary. In Iowa it is $3,053. Yet we pay the same Medicare taxes.

So we have been fighting for a long time to try to straighten this system out and make it a little bit more fair.

They put some money in the bill. But guess what they did—they made it worse because what they basically did is they kind of gave a percentage increase. You know how that works.

If you get $100 and I get $10 and we get a 10-percent increase, you get a lot more money than I get. Right now, Iowa, we are 50th. Louisiana is first in terms of how much money they get per beneficiary. Now we are 50th. The disparity in payments for seniors between Iowa and Louisiana is $4,685. In other words, a beneficiary in Iowa gets $4,685 less. We get less in reimbursement per beneficiary than it cost Louisiana. Under this bill, supposedly meant to fix this, Iowa is still last. We are number 50th. The disparity has gone from $4,685 per beneficiary to $5,017 per beneficiary. It is worse. This was supposed to be fairness?

There are some who will say that Iowa, in terms of the beneficiary and the amount of money they got, is 13th. That is all right. It may be 13th. But other States are more.

As you can see, it increases the disparity rather than lessening it. That is what we want to do—lessen the disparity in the States.

Lastly, the Washington Post this morning said it all. "2 Bills Would Benefit Top Bush Fundraisers."

> At least 24 Rangers and Pioneers could benefit from the Medicare bills as executives of companies or lobbyists working for them, including 8 clients affected by both bills.

Meaning the Energy bill. "Pioneer" is someone, I guess, who raises $100,000 for the President, and "Ranger" is someone who raises $200,000 for the President.

I ask unanimous consent that the article be printed in the Record.

There being no objection, the material was ordered to be printed in the Record, as follows:

2 Bills Would Benefit Top Bush Fundraisers

(By Thomas B. Edsall)

More than three dozen of President Bush's major fundraisers are affiliated with companies that stand to benefit from the passage of two central pieces of the administration's legislative agenda: the energy and Medicare bills.

The energy bill provides billions of dollars in benefits to companies run by at least 22 executives and their spouses who have qualified as either "Pioneers" or "Rangers," as well as to the clients of at least 15 lobbyists and their spouses who have achieved similar status as fundraisers. At least 24 Rangers and Pioneers could benefit from the Medicare bill as executives of companies or lobbyists working for them, including eight who have clients affected by both bills.

By its latest count, Bush's reelection campaign has designated more than 300 supporters as Pioneers or Rangers. The Pioneers were created by the Bush campaign in 2000 to reward supporters who brought in at least $100,000 in contributions. For his reelection campaign, Bush has set a goal of raising as much as $200 million, almost twice what he raised three years ago, and established the designation of Ranger for those who raise at lest $200,000.

With the size of donations limited as a result of the campaign finance law enacted last year, fundraisers who can collect $100,000 or more in contributions of $2,000 or less have become key players this election cycle. The law barred the political parties from collecting large—sometimes reaching $5 million to $10 million—"soft money" contributions from businesses, unions, trade associations and individuals. This has put a premium on those who can solicit dozens, and sometimes hundreds, of smaller contributions from employees, clients and associates.

The energy and Medicare bills were drafted with the cooperation of representatives from dozens of industries. Power and energy company officials; railroad CEOs' pharmaceutical, hospital association and insurance company executives; and the lobbyists who represent them are among those who have supported the bills and whose companies would benefit from their passage.

The Medicare bill was scheduled to be acted upon by the House late last night. If passed, it will go to the Senate. The first comprehensive revision of energy policy in more than a decade passed the House this week, but in the Senate, the measure ran into a roadblock yesterday when opponents stopped it from coming to a vote. Sponsors promised to make further efforts to get the 60 votes to break the filibuster.

The energy bill provides industry tax breaks worth $23.5 billion over 10 years aimed at increasing domestic oil and gas production, and $5.4 billion in subsidies and loan guarantees. The bill also grants legal protections to gas producers using the additive methyl tertiary-butyl ether (MTBE), whose manufacturers face a wave of lawsuits, and it repeals the Public Utility Holding Company Act (PUHCA), a mainstay of consumer protection that limits mergers of utilities.

The bill has been the focus of a bitter ideological and partisan fight for three years. A leading sponsor, Rep. W.J. "Billy" Tauzin (R–La.), chairman of the House Energy and Commerce Committee, praised the legislation, saying, "All Americans can look forward to cleaner and more affordable energy, reliable electricity and reduced dependence on foreign oil for generations to come."

Public Citizen, which has tracked the legislation and correlated patterns of contributions to members of Congress and to Bush, denounced the bill as "a national energy policy developed in secret by corporate executives and a few members of Congress who are showered in special interest money."

Perhaps the single biggest winner in the energy bill, according to lobbyists and critics, is the Southern Co. One of the Nation's largest electricity producers, it serves 120,000 square miles through subsidiaries Alabama Power, Georgia Power, Gulf Power, Mississippi Power and Savannah Electric, along with a natural gas and nuclear plant subsidiary.

The repeal of PUHCA, for example, would create new opportunities to buy or sell facilities; "participation" rules determining how utilities share the costs of new transmission lines that are particularly favorable to Southern; two changes in depreciation schedules for gas pipelines and electricity transmission lines with a 10-year revenue loss to the Treasury of $2.8 billion; and changes in the tax consequences of decommissioning nuclear plants, at a 10-year revenue loss of $1.5 billion, according to the Joint Committee on Taxation.

At least five Bush Pioneers serve as a Southern Co. executive or as its lobbyists: Southern Executive Vice President Dwight H. Evans; Roger Windham Wallace of the lobbying firm Public Strategies; Rob Leebern of the firm Troutman Sanders; Lanny Griffith of the firm Barbour Griffith and Rogers; and Ray Cole, of the firm Van Scoyoc Associates.

The railroad industry also has a vital interest in the energy bill. For years, it has been fighting for the elimination of a 4.3 cent-a-gallon tax on diesel fuel, and, at a cost to the Treasury of $1.7 billion over 10 years, the measure repeals the tax. Richard Davidson, chairman and CEO of Union Pacific, is a Ranger, and Matthew K. Rose, CEO of Burlington Northern, is a Pioneer.

Among the major lobbying firms in Washington, Akin Gump Strauss Hauer & Feld has been one of the most successful collecting fees for work on the energy and Medicare bills. In the first six months of this year, Akin Gump, which has two partners who are Prioneers—Bill Paxon and James C. Langdon Jr.—received $1.6 million in fees from medical and energy interests.

Mr. HARKIN. Mr. President, I apologize to my fellow Senators. I have taken a long time. I have taken over 1 hour and 15 minutes, I believe. But I believe we ought to take a lot longer than that. I think we ought to get this bill out of here, send it into the countryside, let people see it, and come back in February rather than taking Sunday, Monday, Tuesday. Let us, as I said, take a week or two to get into this bill, debate it, discuss it, and yes; and amend it if we need to, rather than being ramroded through as they are doing.

If the seniors reject it, then we can reject it and go back to the drawing board. We should not at the eleventh hour when people want to go home for Thanksgiving be stampeded to support a bad bill, a bill that will destroy Medicare as we know it.

I yield the floor.

The PRESIDING OFFICER. The distinguished Democratic leader.

Mr. REID. Mr. President, I know the distinguished Senator from Missouri is anxious to speak. He is going to visit his son who is coming home on leave from the Marine Corps.

I will be very quick. Following the Senator from California, Mrs. BOXER, our next speaker will be Senator LINCOLN. Tomorrow, the Democrats, other than those we have already lined up—the last Member we lined up I believe was Senator KERRY—would be Senators WYDEN, LEVIN, KENNEDY, MURRAY, DORGAN, CORZINE, and AKAKA.

The PRESIDING OFFICER. Is there objection?

Mr. GRASSLEY. Mr. President, reserving the right to object, I want to ask a question. In the process of reserving the right to object, I want to know how much time has been used on the respective sides.

Mr. REID. Mr. President, I have spoken to the Parliamentarian. The opponents of this legislation have approximately 2 hours left tonight before 11 o'clock.

The PRESIDING OFFICER. The proponents have 3 hours 57 minutes remaining, and the Senator from Nevada, the assistant Democratic leader, is correct in his estimate.

Mr. GRASSLEY. I have no objection.

Mr. REID. Mr. President, following Senator AKAKA, we would like to have Senators JOHNSON, DAYTON, BINGAMAN, and Bill Nelson.

The PRESIDING OFFICER. If there is no objection, the Chair is prepared to rule.

Without objection, it is so ordered.

The Senator from Missouri.

Mr. BOND. Mr. President, I ask unanimous consent that I may go out of order to speak for 5 minutes prior to Senator HATCH, and then Senator HATCH may be recognized.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. BOND. Mr. President, I am most grateful to my colleagues. I have been here on the floor for 3 scintillating hours, and I have other commitments that I have to make.

Early this morning the House passed historic bipartisan legislation to improve and strengthen the Medicare program and give all seniors access to prescription drug coverage. Seniors will finally receive the prescription drug coverage they need and the health care security they deserve.

This Medicare conference report is a compromise in the truest sense of the word. It is not perfect—some on the far left don't like it and some on the far right don't like it either. But I will tell you who does like it: The AARP—this agreement has been endorsed by the leading voice for older Americans—representing 35 million members nationwide and 743,000 members in my home State of Missouri. As well as the hospitals, doctors, other health care providers and employers.

Why do these groups support this bill? Because in AARP's own words, "This is about getting vital help to people that need it most."

Before I talk about some of the strengths on this bill I wanted to take this opportunity to address some of the criticism from my friends on the other side of the aisle. I have heard some Members say that this bill "keeps drug prices high."

That is untrue. Seniors will realize significant savings off their current drug bills under this bill. In 2004–2005, senior citizens will receive a Prescription Drug Discount Card that the Department of Health & Human Services—HHS—estimates will cut drug costs by up to 25 percent.

In 2006, the prescription drug benefit is added to Medicare that HHS estimates will help seniors currently without coverage save up to half off what they're paying today. For the typical senior who spends $1,285 a year on prescription drugs, more than $640 they get to keep in their pocket translates into significant savings.

Lastly, the bipartisan Medicare plan also ensures generic drugs, less expensive than brand-name pharmaceuticals, are moved to market much faster to help hold down costs.

I have heard some members say that this bill will "cause two to three million retirees to lose drug coverage." This bill contains $88 billion worth of employer incentives to help protect retirees' private coverage. This bill will actually strengthen the safety net for seniors by providing financial incentives for employers to continue offering prescription drug coverage for their retirees.

This marks the first time that Medicare will provide a federal subsidy of 28 percent of beneficiaries' drug costs between $250 to $5,000—up to $1,330 per beneficiary. This subsidy is excluded from taxation, providing another incentive for employers to offer coverage.

Lastly, qualified retiree plans have maximum flexibility on plan design, formularies and networks, and allows employers to wrap-around Medicare coverage options. That is why the AARP and major employer groups, such as the National Association of Manufacturers, Employers' Coalition on Medicare, Chamber of Commerce and Business Roundtable, endorse the bipartisan Medicare plan. Some Members have said this bill is "bad for seniors" and cited a recent Consumers Union report.

Truth is this Medicare bill provides help to the two groups that need it most—low income seniors, and seniors with high drug costs. Even Consumers Union acknowledges that low-income seniors "will be eligible for substantial subsidies for their prescription drugs." Consumers Union also acknowledges that seniors with catastrophic drug expenditures get "measurable relief" under the bill, which will cover 95 percent of a senior's drug costs over $3,600. In other words, the Medicare bill provides help to the two groups that need it most—low income seniors, and seniors with high drug costs.

And finally some have claimed that this Medicare bill will destroys Medicare as we know it and privatize the whole program. That is one of my personal favorites. Bottom line is the AARP would never endorse a bill that privatizes or in any way destroys the Medicare program period.

I will support this bill because it is the first major upgrade to Medicare in

38 years, providing help to the two groups that need it most—low income seniors, and seniors with high drug costs.

For nearly four decades, Medicare has provided peace of mind and health care security for millions of seniors. Yet, increasingly this cherished program is no longer meeting the security needs of our seniors. Medicine has advanced exponentially since 1965, but the Medicare Program has not kept pace. When Medicare was launched 38 years ago, modern medicine meant surgery and hospitalization—and that is what Medicare covers.

Today, doctors routinely treat their patients with prescription drugs, preventive care and groundbreaking medical devices—but Medicare has not kept pace with these changes.

For example, today Medicare covers only about half of the typical seniors' health care costs. Medicare lacks good preventive coverage, wellness care, and chronic disease management. It doesn't even cover the costs of an annual physical. It does not protect against large, catastrophic health costs should serious illness strike. And we all know that it does not cover outpatient prescription drugs.

Additionally, the program faces serious financial and demographic pressures in the coming years. Between now and 2030 the number of seniors will nearly double from 40 million to 77 million. The program's costs will more than double to nearly $450 billion annually, even before we add prescription drug coverage or improve other benefits. And the number of taxpayers paying into the system to finance health coverage for seniors will drop from 4 today to 2.4 by 2030. This underscores the need to act and the need to act responsibly. We need to improve the program for today's seniors but we also need to put in place a more stable structure that will provide health care security for generations to come.

My goal is and has always been to give seniors the best, most innovative care. This will require a strong, up-to-date Medicare system that relies on innovation and competition, not bureaucratic rules, price controls and regulation.

The bill before us takes a bold new step and is an important achievement in the effort to strengthen and improve Medicare and provide meaningful prescription drug benefits to seniors. This bill offers beneficiaries a meaningful and reliable drug benefit through the private sector, with reasonable and fair cost-sharing. Beneficiaries will have the ability to receive the drugs of their choice without government interference and with better coverage options.

Most importantly, it will provide prescription drug coverage at little costs to those who need it most—people with low incomes. It will provide substantial relief to those with very high drug costs and relief to millions more. In a country as prosperous as ours, we can no longer tolerate situations where seniors have to split their pills in half or cannot fill necessary prescriptions because they can't afford the vital drugs they need.

This bill ensures access to drug benefits for beneficiaries who live in rural areas. Reliable coverage will be available everywhere in Missouri—wherever there is Medicare coverage, there will be prescription drug coverage.

As we work to implement this new Medicare benefit, this bill will provide immediate prescription drug assistance for beneficiaries through a temporary drug discount card available to seniors 6 months after the bill is signed into law.

This discount card is expected to yield a savings of between 10 and 25 percent. Some of our most vulnerable seniors would receive an additional $600 subsidy annually to assist with the purchase of prescription drugs. This drug card would be available until the Medicare prescription drug benefit is fully implemented in 2006. Adding vital prescription drug coverage is not the only thing that we are doing to improve Medicare coverage for seniors.

Medical experts long ago learned that preventive care extends and improves quality of life. The bill before us today adds vital preventive care, wellness services, and chronic care management. This long overdue step will keep seniors healthy and will save money and most importantly save lives.

This bill also includes $25 billion in new assistance to ensure patient access to hospitals, doctors and other health care providers, especially in rural areas. The Medicare bill corrects existing rural inequities by infusing billions of dollars over the next decade into rural and small towns as well as small hospitals everywhere.

Admittedly I remain concerned about the magnitude of the reductions in payments for cancer care included in the bill. I hope to work with the Senate leadership as well as Chairman GRASSLEY and Senator BAUCUS moving forward to ensure that these cuts do not threaten access to cancer care for patients in Missouri and across the country.

We must bring Medicare into the 21st century: add a prescription drug benefit, expand coverage, improve services, and give seniors more control over the health care they receive.

This week we are poised to make historic changes with bipartisan support to improve the Medicare Program, to strengthen it for seniors and to preserve and protect it for future generations.

I want to say why I am in favor of this Medicare conference report. I think that Senator GRASSLEY and Senator BAUCUS, in a bipartisan coalition, came up with a great compromise. Nobody should be surprised that it makes enemies left and right. That is what a compromise or a moderate proposal does.

I will tell you one group that is for it. That is the AARP, with 35 million members nationwide. There are 743,000 seniors in my State who have been deeply involved in the preparations of this legislation. They say it is a good deal because it is about getting the vital help to people who need it most.

I was a little amused hearing some of the folks on the other side of the aisle condemning AARP. Generally, AARP may side with the Democrats, but in this instance we have worked with them and on a bipartisan basis. It isn't just Republicans. Now that they endorse a bipartisan compromise, rather than going with the Democrats, they condemn them.

Let me just talk about a few of the misconceptions I have heard in the last 3½ hours: Drug prices will be high. There will be a senior citizen discount card with a 15 to 25 percent reduction; $600 for low-income seniors the next couple of years. HHS estimates in 2006 the typical senior will save approximately half of what he is paying today. This plan also ensures the less expensive generic drugs will get the market faster, helping to hold down the cost.

Some have said this is bad for seniors. The truth is that the Consumers Union acknowledges it will help the two most needy groups—the low-income seniors and those seniors with high drug costs. These are the people who really need the help.

Finally, this is the favorite charge: Some have said this is going to destroy Medicare; that it is going to privatize it. That is really one of my personal favorites.

I think the Senator from Utah, Mr. BENNETT, did a wonderful job of pointing out some of the demagoguery we hear when people talk about destroying Medicare.

There are problems in Medicare with the way it is administered. Senator BENNETT outlined quite a few of those. We can tell you about a lot of problems. I have staff people who work all the time helping people sort through Medicare.

To say that the Republicans and the Bush administration want to destroy it is a big, fat, flat lie. No matter how many times you repeat it, it is not true.

The whole purpose of this is to assure that there is a reliable drug benefit and health care benefit for seniors now and in the future. We are asking the next generation to pick up the ball for a $400 billion, 10-year plan that is going to continue to grow, and we owe them the solid viable Medicare program that is still in operation when they reach Medicare-eligible age.

One of the problems that Senator COLLINS of Maine discussed which she and I have been fighting with the former Health Care Financing Administration, HCFA, is they were ordered to save some money in Medicare. They squeezed it down so tightly that instead of saving $16 billion a year, they cut the cost by $64 billion a year, and they threw one-third of the home health care agencies out of business in Missouri.

Seniors could not get the home health care they needed because of HCFA. Somebody said the costs are not going up. The problem with Medicare is fewer and fewer doctors and hospitals can afford to take it because the Federal bureaucracy has ground down the reimbursements.

Then someone said Newt Gingrich wanted to abolish Medicare or have it wither away. That is absolutely flat wrong. Members cannot use that form of demagoguery in this body and expect to get away with it. Former Speaker Gingrich said HCFA is a problem. Frankly, I can show case after case after case where HCFA and the bureaucracy were a problem. He wanted to change the system so that seniors got good health care and you did not have a bureaucracy ratcheting down and controlling prices so rural hospitals such as a hospital in my home State could not afford to take seniors and doctors had to say: We cannot take any more Medicare patients because we are getting reimbursed from Medicare less than it costs us and we cannot give balanced billing so we have to arbitrarily ration on health care to the elderly because of the way Medicare is implemented.

That is wrong. That is what this bill is going to improve. I hope my colleagues will look at the significant improvements this $400 billion, 10-year bill will bring to improving health care for seniors and giving the seniors now better health care and assuring that seniors in the future—the current generation will be paid for—have the health care when they need it.

I thank my colleagues. I yield the floor.

CLOTURE MOTION

The PRESIDING OFFICER. The majority leader is recognized.

Mr. FRIST. Mr. President, I send a cloture motion to the desk and ask unanimous consent that it be in order at this time.

The PRESIDING OFFICER. Without objection, it is so ordered. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion.

The legislative clerk read as follows:

CLOTURE MOTION

We the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, do hereby move to bring to a close debate on the conference report to accompany H.R. 1, the Medicare Prescription Drug and Modernization Act, an act to amend Title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare Program and to strengthen and improve the Medicare Program, and for other purposes.

Bill Frist, Charles Grassley, John Ensign, Ted Stevens, Susan Collins, Lisa Murkowski, Jon Kyl, John Cornyn, Orrin G. Hatch, Larry Craig, Craig Thomas, Robert F. Bennett, Olympia J. Snowe, Jim Bunning, Christopher Bond, John Warner.

Mr. FRIST. Mr. President, I ask unanimous consent that the live quorum under rule XXII be waived.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. FRIST. Mr. President, I regret that it has become necessary to file a cloture motion on this bipartisan legislation being considered on the floor of the Senate. However, it appears that at this juncture we have no option.

I do want to express my deep disappointment that the senior Senator from Massachusetts has stated he intends to filibuster this landmark legislation. I seriously hope he will reconsider these intentions. His decision is particularly disappointing because it is clear to those of us who have followed this debate for the last several months, indeed, over the course of the day, that there is a strong bipartisan majority in this body in favor of this Medicare prescription drug legislation.

I am equally disappointed because it really points to what is going to happen to 40 million seniors in America today.

They have waited 38 years for what we are about to accomplish, and that is access, affordable access to prescription drugs. Prescription drugs are not a part of Medicare today for those 40 million Americans, and they will be once this legislation is passed. They are just moments away from what they desperately need, desperately have asked us for, and what we have a responsibility to deliver.

Senator KENNEDY has said that he intends to block the vote or do everything within his power to block an up-or-down vote; that he will obstruct a bipartisan Senate majority, and that he will stand in the way of health care security for these millions of seniors and individuals with disabilities.

In my own State of Tennessee, there are nearly a quarter million seniors who have no prescription drug coverage. There are millions all across the United States for whom this legislation means the difference between life and death. They simply cannot afford to wait any longer.

This generation that will be served by this legislation has survived the Depression, has fought in World War II, has helped make the United States into the prosperous Nation that we have. Again and again, they have answered the call. Now is the time for us to fulfill our duty to that generation, many of whom, as we all know, are sick and poor. Now is the time for us to answer their call. That is what this legislation does.

Those who would support a filibuster of this bill would hold our parents and grandparents, 40 million seniors, hostage to Washington politics. Our seniors simply deserve better.

In 1965, when President Johnson signed that Medicare bill into law, he said:

> No longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this . . . country.

Let us not stay that hand of justice now. Let us not turn our back on America's seniors and individuals with disabilities.

Once again, I regret this cloture motion is necessary, but we do need to protect our seniors. As I have said, for many this is a life-or-death issue. They simply cannot wait for help. I hope that, working with the minority leader, we can move toward vitiating this cloture motion at the appropriate time and, working together, schedule an up-or-down vote on this vital measure.

I implore the senior Senator from Massachusetts to listen to his own words of November 5 this year when he said:

> Senior citizens want help and they want it now. They don't want a partisan deadlock.

I think he was right then. I believe he is wrong now.

Mr. REID. Mr. President, I apologize to the Senator from Utah. If the Senator will allow me to ask a couple questions, through the Chair, I appreciate the majority leader coming in an hour earlier tomorrow. We have 15 speakers lined up on our side for tomorrow. We are going to try to work out some kind of time arrangement. I say to the staff listening, what we would like to do on our side is limit the time to a half hour each. If anybody has any objection to that, they should call here as soon as they can. Otherwise, it is unfair to people who are at the bottom of the list.

I also say to the majority leader, we have gotten a number of calls today about this being the last item of business before we go home until January. I know the majority leader is working on that. I hope that is the case. Some of our folks are willing to give up time and do various things as a result of family obligations they have at home. If they have to come back again after Thanksgiving, I think their family obligations will become so paramount that they may not be as cooperative as we would like them to be.

Mr. FRIST. Mr. President, the Democratic leader and the leadership on both sides of the aisle have been in conversation throughout the day. Our intention is to continue to address Medicare aggressively and I have a feeling we will be here for a while tonight to give people an opportunity to speak.

Tomorrow, we are going to start earlier, and we will run as late as necessary to give people the opportunity to speak.

Regarding Monday, I want to warn people a little bit because people who want to speak, I encourage them to come tonight, tomorrow, or tomorrow night. Monday, I have a feeling everybody is going to come back in and say: I want to speak.

In order to complete Medicare on Monday and to address the appropriations bills we are working together on, we can address that on Monday and Tuesday—to finish business and be gone for good, which is what we are working toward, so we don't have to come back after Thanksgiving. That is the objective of both sides of the aisle. It means we have to continue doing what we have done all day today, tomorrow, and Monday. We need to stay focused, keep our remarks short enough so everybody can participate. With that, I intend not to have to come back after the Thanksgiving holiday.

Mr. REID. Mr. President, briefly, I appreciate very much the majority leader mentioning that. We have had people say they want to speak Monday. What I have said is that we can have 90 minutes per side on Monday. That is my understanding, having spoken to the two leaders. People will only have very short periods of time because the managers will need to make the paramount arguments on Monday. You are absolutely right. For people wanting to come back, the time is going to be very minimal. I appreciate that from the majority leader.

Mr. FRIST. I thank the Senator.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. GRASSLEY). The Senator from Utah.

Mr. HATCH. Mr. President, I have sat here for hours now and listened to some of the comments by our colleagues on the other side. They must not have paid any attention to what this bill is all about or any attention to what the conferees, who worked day and night, did to put this bill together in a bipartisan way. They must not have paid any attention to the words in the bill or paid any attention to their respective caucus meetings where we discussed the aspects of it.

When a Senator said this bill is being ramrodded through, I want to make it clear that we have been trying to improve Medicare for 40 years, especially in the last 10, 15 years. That is hardly ramrodding it through.

This is it. This is the last chance to have prescription drug benefits for our seniors. It is amazing to me how many on the other side just want to say no to anything: No to judges. No to prescription drug benefits unless they are way out of sight as far as expenses go. No to any possible private sector improvements that might possibly work. No to all the ideas that Democrats and Republicans have worked on, 7 o'clock in the morning meetings, 3 o'clock to midnight, in the afternoons, day after day after day, week after week. We were not doing that for our fun. We were not doing that for political reasons. We were not doing that to try to hurt one side or the other or to make political points on one side or the other.

We were doing it the best we could to try to come up with a bill that would improve Medicare and get prescription drugs to our seniors who need them, who do not have drug coverage right now, or who do not have access to drugs because they cannot afford to pay for them.

We take care of beneficiaries from 150 percent of poverty or less. If I had my way, the whole $400 billion would have gone to those at 200 percent or 250 percent or less and we would not have made any benefits for people such as Bill Gates and Warren Buffett, billionaires who can afford their own prescription drugs. But no, there is a desire by some on the other side to have what is called "universal" health care. That is, the Federal Government controls everything, pays for everything, and we have socialized medicine. Not many people who think it through want to go to that extent. That is why they are not getting their way so they will continue to moan and groan. One of the most offensive things of all is the people whom AARP basically have supported through all these year, the Democrats, and some of these Democrats condemning AARP for supporting this legislation.

I have seen Democrats stand on the floor and put the AARP's number up and tell people to call AARP and tell AARP they are wrong.

We are here to make decisions as to what should be done. The decisions cannot always be no, no, no.

I have to admit I was irritated with my party in times past because we seemed to say no to everything the Democrats wanted. I will state what is really behind this. Many of our colleagues who are against this on the other side just plain do not want President George Bush to get any credit for this Medicare reform bill. They cannot tolerate that this President has called for this, has fought for this, has provided a climate for this, has a bureaucracy working for this, has his staff working for this, has helped us every step of the way. Health and Human Services Secretary Thompson, as tough as it was to sit in those meetings, said virtually every one of these meetings was tough on him. There were a lot of tough discussions.

They are so afraid President Bush might get some credit for enacting a prescription drug law. President Bush will probably be the last one to take credit for it, although he deserves credit for it because he has been a leader who has helped to bring this about. And he would deserve the credit. But so would every Democrat who votes for this. Above all, Senators Baucus and Breaux, who sat through every one of those meetings. They deserve a lot of credit for not letting politics distort their worldview of what should be done and for standing up for this bill. It is one of the reasons the AARP is for this bill.

Another reason happens to be our two leaders: Speaker of the House DENNY HASTERT, and of course our majority leader in the Senate, Dr. FRIST, who has worked with these problems his whole professional lifetime. He has wanted to get this done as much as, if not more than, anyone else. And Senator GRASSLEY worked day and night on this with his staff. We could not have a better person.

Then we have cheap politics because they know former House Speaker Newt Gingrich has not always been the most followed person in this world even though he is one of the brightest people with one of the brightest political minds in America today. So what do they do? They distort what former House Speaker Newt Gingrich said—not only distort it, they do it downright offensively. I am frustrated by the continued references to the alleged comments by the former Speaker of the House about the "Medicare Program," and those who insist that the former Speaker wanted Medicare to wither on the vine. We have heard it all day long by these people who are against everything. They are sadly mistaken. They are misrepresenting his remarks.

What the former Speaker said was that the agency that controlled Medicare, HCFA, the Health Care Financing Administration, which has evolved into CMS, said that HCFA should wither on the vine because that bureaucracy was so filled with command-and-control bureaucrats who were more concerned about redtape than seniors' health.

That is a far cry from condemning Medicare, which is the way they would present it. I personally resent that kind of distortion of what the former Speaker of the House had to say. Gingrich believed these bureaucracies were strangling Medicare. If anything, he was standing up for Medicare. He was arguing against large bureaucracies and for seniors to have more individual control over their health care dollars.

So do not believe this gibberish coming from some on the other side. That is exactly what it is.

I have heard Democrats who were opposed to everything with regard to Medicare, unless it is an $800 billion to $1 trillion program, and even then would be opposed to some of the approaches here.

They argue that 25 percent of seniors will be worse off than they are today because of this bill. That is pure, unmitigated bunk, and they know it. It is not true.

First of all, we are adding $400 billion to the Medicare Program in new spending for drug benefits and Medicare improvements—$400 billion. That is not chickenfeed. So how can anybody say they are going to be worse off?

Secondly, we take care of those who are in lower income brackets and those who have high drug costs. That is what this bill ought to do, and it does, and they are better off.

Very important to me, to Senator GRASSLEY, to Senator BAUCUS, and virtually all of us who have rural States, is that we improve access to quality care in rural areas—something that just has not happened under the old Medicare system, under traditional Medicare. We improved it. This bill does a lot towards helping those in rural America who have been shortchanged for years.

I do not see how anybody standing up from a rural State, with lots of farmers, can have the gall to come on this floor and say they are going to be worse off with this bill when we put very strong language in with regard to rural health care. Yet we have had some Senators from the other side doing that.

Unlike the 1988 catastrophic bill, which I virtually argued against at the time—it was a mandatory bill—but unlike that bill, this is a bill where you have a choice of whether you go into this program or not. You do not have to do it. You can stay right where you are in traditional Medicare if that is what you want. I do not think most people are going to do that, but who knows? But they have a right to do so. It is not like the 1988 catastrophic bill which was mandatory. And when the people found out they had to pay for it, yes, they rebelled because they did not want us telling them they had to pay for the benefit. Today, we are not telling them they have to participate. In fact, the two bills are quite different.

The Government is going to pay 75 percent of the cost of drugs for Medicare beneficiaries over 150 percent of poverty. Now, tell me that is not better than the current system.

The Democrats do not seem to understand the fact that a lot of corporations are dropping health care coverage because they cannot afford it anymore or they do not want to pay for it anymore.

I will never forget, I had a conversation with the head of IBM a few years back. He said: We are paying $7,000 per employee for health care. If it goes up any more, we are just going to turn around and give them the $7,000 and say, go get your own health care. He said: We just can't afford to keep going in this direction.

Well, before this bill, it was estimated that the corporations were going to drop the health care of 37 percent of retirees. Now it is estimated that the drop out number will be below 20 percent, probably closer to 15 percent. We have made some strides in trying to solve that problem.

This bill contains Hatch-Waxman reforms. For those who do not understand this, let me explain it as the author of the Hatch-Waxman bill in 1984.

Hatch-Waxman created the modern generic drug industry that is in competition with the pioneering companies and has brought drug prices down $10 billion in consumer savings every year since 1984. It is called, even by my friends on the other side, one of the greatest pieces of consumer legislation in the last century, and rightly so, because it has saved billions and billions of dollars for consumers.

But there was a gaming of Hatch-Waxman by some companies, and we have corrected that in this bill, which is a pretty important thing. These reforms will prevent gaming of the system, and they will provide seniors with less expensive generic drugs more quickly.

I get so tired of the demagoguery against the pioneering companies; that is, the PhRMA companies; that is, the large pharmaceutical companies. The generic companies know that if the large pharmaceutical companies do not spend their $30 to $35 billion every year in research and development, there will not be any drugs for them to take off into generic form. If these large companies spend that kind of money, then they have to find a way of recouping that money. Because of our current FDA system, it takes up to 15 years of patent life.

If you develop a gizmo, you have 20 years of patent life, or what you call market exclusivity, to sell your gizmo. In the case of prescription drugs, you might only have 5 years to recoup the moneys you have put in. And just for people's understanding, it takes up to 6,000 scientific misses, in other words, experiments—up to 6,000 of them—to arrive at a marketable drug, at a cost of around $1 billion per drug.

You wonder why companies have to charge as much as they do to get their money back? If they do not get their money back, they cannot conduct more research and development on future pharmaceutical products which are really saving our seniors and causing them to be able to live longer lives today.

I will talk a little bit more about drug reimportation in a few minutes. But in all honesty, that is an overblown, demagogued position, too. Our pharmaceutical industry in this country is one of our great industries. It is one of the reasons we have a balance of trade surplus. The pharmaceutical industry and the entertainment industry are about the only two that provide balance of trade surpluses.

What I hear from the other side that we have to have price controls, which is what Canada has; it is important to remember that Canada no longer has a pharmaceutical industry. The reason is that you cannot afford to do what it takes to get these drugs developed when you have price controls. Now, these are things that just are demagogued here on the floor, and I am personally getting tired of it.

There is so much I would like to say that would refute the demagoguery I have heard from some on the other side. Let me just take a second on AARP because it is amazing to me. The AARP has basically sided with the Democratic Party on almost everything with regard to seniors, and with the more liberal Republicans. They have been involved in this intimately for years. And here we have Democrats trashing the organization that has been one of their mainstays of support because all of a sudden the AARP is thinking for itself and doing what is right for seniors, and not keeping seniors under the thumb of Government regulation. So AARP has to be trashed here on the floor of the Senate by some of our friends on the other side.

I find it ironic that my friends on the other side of the aisle are criticizing the AARP for supporting legislation that will provide Americans access to drug coverage through Medicare. It is the first time this is going to happen, and they are trashing AARP?

What a difference a year makes. Last year, AARP could do no wrong as far as the Democrats were concerned. This year, it seems the AARP can do nothing right. That is because the more liberal Democrats, who are opposed to this bill because it is not socialized medicine, are up in arms that the AARP has finally decided to do what really is a bipartisan approach.

AARP made a courageous decision by endorsing our drug plan, a bill that I predict will soon be signed into law. And maybe my friends are just upset because they are on the losing side on this issue for a change, and they just do not want President Bush to get any credit for it.

Well, I also want to stress that the so-called slush fund I have heard mentioned on the other side, that my friend from Iowa raised, is no slush fund at all. This is a stabilization fund that is important for rural States such as Utah and Iowa. It is crucial to our States. Utah did not benefit from Medicare+Choice because it just did not work in my state. Health plans told me that the payments were too low.

So this stabilization fund provides assistance to those States, such as Iowa and Utah, that may not have regional PPOs, preferred provider organizations, or local plans that provide coverage they would offer to these beneficiaries living in rural areas.

Of course, look at what happened to Medicare+Choice. In Utah, the Medicare+Choice plans left the State, leaving my beneficiaries with nothing because Medicare+Choice plans could not survive in rural Utah. This bill will help to solve that problem. The stability fund will be used to encourage plans to enter rural States such as Utah and Iowa and stay there once and for all. It is not a slush fund.

This is a fund designed to help give rural beneficiaries choice and coverage through the HMOs, PPOs, and standalone drug plans. It helps seniors in rural areas. I find it disconcerting that someone from Iowa would criticize that aspect of this program. That shows he has not read the bill, does not understand the bill, has not listened to Senator GRASSLEY, who has read the bill, does understand it, and helped to implement it, and who is probably rural America's strongest advocate in the Congress. This is no exception.

Let me tell you what this legislation does for my folks in Utah. I think you can extrapolate this into every State in the Union, but let me talk about my State because I want my folks in Utah to realize this is a good bill.

The bipartisan agreement provides all of my 219,973 beneficiaries in Utah with access to a Medicare prescription drug benefit for the first time in the history of the Medicare Program, beginning in January of 2006. Beginning in 2006, the bipartisan agreement will give 55,538 Medicare beneficiaries in Utah access to drug coverage they would not otherwise have and will improve coverage for many more.

Within 6 months after this bill is signed, Utah residents will be eligible for Medicare approved prescription drug discount cards which will provide them with savings of between 10 and 25 percent off the retail price of prescription drugs, of most drugs. That is something they do not have now but they will have.

Beneficiaries with incomes of less than $12,123 or $16,362 for couples who lack prescription drug coverage, including drug coverage under Medicaid, will get up to $600 in annual assistance to help them afford their medicines along with a discount card. That is a total of $53,619,525 in additional help for 44,638 Utah residents in the years 2004 and 2005.

Mr. President, beginning in 2006, all 219,973 Medicare beneficiaries living in Utah will be eligible to get prescription drug coverage through a Medicare approved plan in exchange for a monthly premium of approximately $35. Seniors who are now paying the full retail price for prescription drugs will be able to cut drug costs roughly in half. In many cases, they will save more than 50 percent of what they pay for prescription medicines, and those at less than 150 percent of poverty basically will have their drugs for free.

Mr. President, 63,560 beneficiaries in Utah, who have limited savings and low incomes, generally below $12,123 for individuals and $16,232 for couples, will qualify for even more generous coverage, as I have said. They will pay no premium for prescription drug coverage, and they will be responsible only for a nominal copayment, no more than $2 for each generic drug or $5 for brand name drugs. Now, 17,613 additional low-income beneficiaries in Utah, with limited savings and incomes below $13,470 for individuals and $18,180 for couples, will qualify for reduced premiums, lower deductible, and coinsurance, and no gaps in coverage.

Additionally, Medicare, instead of Medicaid, will now assume the prescription drug costs of 17,739 Utah beneficiaries who are eligible for both Medicare and Medicaid. This will save Utah $51 million over 8 years on prescription drug coverage for its Medicaid population.

This is a bill that will help every State. I cite Utah just to show that in a State the size of mine, which is smaller in population than many other States but fairly substantial, there are substantial benefits that will come from this bill.

I want to make it clear that this is the last train out of town. We have been trying to do this for years and years. I listened to at least four of my colleagues on the other side who, in my opinion, were demagoguing this issue all day long. Frankly, they are wrong in most of their assertions, and they act as if all we have to do is take this back to committee and work it through again. If people had sat through those meetings we held in the conference committee, they would realize we went through every word, every aspect of this legislation. We had a heck of a time putting together a total bipartisan package such as this as it was. If you look at it, it barely passed the House—but it did pass the House. I hope it will pass the Senate because our seniors will be better off with the choices this bill gives them than with current law.

Yes, I wish we could have done more to reform Medicare; I wish we could have done more to put more private sector capability in this bill. I think over the long run that would really pay off. I wish we could have done more in a wide variety of areas that would have cost a lot more money. But I have to say, under the circumstances, the conference committee members really worked hard, and I think we did a good job.

So I rise to express my strong support for the final conference agreement on H.R. 1, the Medicare Prescription Drug Improvement and Modernization Act. Over the years, countless Medicare beneficiaries in Utah have written to me to express their desperation over the fact that Congress has not added a prescription drug benefit to the Medicare Program. Time after time, session after session, in Congress after Congress, we have tried to answer their pleas. Fifteen years ago, we almost made it. The plan was so flawed that it had to be repealed. Last year, I thought we might make it with the tripartisan initiative. I was one of the five tripartisan Senators, as was Senator GRASSLEY who is sitting in the chair now, and Senators SNOWE, JEFFORDS, and BREAUX. The five of us have come up short each and every time we have tried—except this year. I think if we had not had Presidential support this year, we probably would have come up short again.

We cannot afford to fail America's seniors. We cannot afford to fail America's disabled. I am dismayed to hear many colleagues preparing for us to fail again. Not if this Senator can help it. To me, it is unconscionable to let this opportunity pass us by out of a concern that this is not a perfect bill. I spent years working on this issue. Unlike some on the other side, who have been complaining about the issue, I have worked on every health care program in the last 27 years, and a number of them have my name on them. I believe I know the issues as well as anybody in this body. I worked hard on the conference committee as well.

Let me tell you, in all the experience of 27 years, I can tell you something I know is categorically true: We cannot have a perfect bill.

The intersection of Medicare, Medicaid, and responsible public policy is about the most complex pathway Congress has ever negotiated. On the one hand, we want to provide as many seniors and disabled with as comprehensive and affordable coverage as possible. On the other hand, we want to minimize Government and its attendant bureaucracy and cost. The two are in inherent conflict. So we do the best we can—and we did.

Since Congress first enacted Medicare nearly 40 years ago, we have seen miraculous breakthroughs in medicines that have allowed for diseases, conditions, to be treated by innovative prescription drugs. As seniors and the disabled have gained access to many treatments, many are faced with the choice of splitting pills or missing meals in order to afford their vital prescription drugs.

This is simply unconscionable. Providing access to these vital treatments is the right thing to do for our seniors and the right thing to do for our children. It will make our society more healthy, and it will save countless medical expenses. Seniors will live longer, as they are doing now, because of these inroads we have made.

Is there anyone who doubts that greater access to preventive medicine will save our Medicare system in the long run perhaps by tens of billions of dollars?

My constituents have been waiting for close to 40 years for this day to come. The time is here; the time is now. We are about to pass historic legislation that will make the most significant changes to the Medicare Program since it was created in 1965.

I say to my colleagues, Monday will be a momentous day in the Senate, and I hope we will invoke cloture so we can proceed with this bill. If we invoke cloture, we will pass this bill and millions and millions—40 million—of our senior citizens in this country will benefit. The whole country will benefit. Medicare beneficiaries will finally be offered a prescription drug benefit plan.

Medicare will offer beneficiaries more choice in coverage, and Medicare's fiscal solvency will be preserved for our children and grandchildren.

This bill has countless extra benefits. We have made improvements in the way health care is delivered to rural America, as I mentioned. Beneficiaries, like so many in the State of Utah, will receive quality health care. Providers in these areas will be reimbursed appropriately and have incentives to give good care.

Overall, we cannot escape the conclusion that this is a good bill. Whenever I go back home to Utah, the Medicare Program is the one topic that comes up in almost every conversation I have with constituents. No matter where I go—Salt Lake City, St. George, Beaver, Ogden, Cedar City, you name it, from the north to south, from east to west, the question is still the same: When will drugs be covered by Medicare? I have looked forward to this day for a long time—the day when I will be able to answer: Now.

I would like to read a letter, one of many I have received, from a different kind of constituent. For the past several years, Medicare providers, especially those in rural Utah, have complained about their insufficient Medicare reimbursement in Utah. As a result, many have threatened to leave the State if Medicare payments are not increased. Let me give you a quote from Dr. Beth Hanlon, a Utah physician, who is complaining about unfair reimbursement rates. Here is what she had to say:

> My patient population is 30 to 40 percent Medicare. I cannot continue to see our senior patients if rates drop further. My overhead costs continue to increase; I cannot provide the same services I did a year ago because of lower reimbursements. I will have to refer patients to consultants and the emergency room for problems I could previously have managed in my office. This is so distressing, as our population ages and we see more doctors planning retirement.

Dr. Hanlon, we have good news for you. We took your concerns seriously, and this bill takes the necessary steps to increase your Medicare reimbursement rates.

Let me talk a little bit about the process and how we got to this historic place in the annals of the Senate. As I said, I was privileged to serve as a member of the House-Senate Medicare conference committee. I served on many conferences during my 27 years in the Senate, but this was probably the most complex and technical conference I have ever encountered, and it was a difficult conference to be on.

Every Senate and House conferee—especially conference Chairman BILL THOMAS, chairman of the Ways and Means Committee, and Cochairman BILLY TAUZIN of the Energy and Commerce Committee, and conference Vice Chairman CHUCK GRASSLEY, chairman of the Finance Committee—did a great job, a fine job of guiding members to this final agreement. It was no easy task, and it took several months and many long hours to complete our work.

Other conference members made significant contributions to this historic conference report, and I would like to take the opportunity to recognize all of these members for their diligence and commitment to the process.

They certainly include Senate majority leader, BILL FRIST; Senate minority leader, TOM DASCHLE; Senate Finance Committee ranking member, MAX BAUCUS; Senator DON NICKLES; Senator JAY ROCKEFELLER; Senator JON KYL; and Senator JOHN BREAUX; House majority leader, TOM DELAY; the Speaker of the House, DENNY HASTERT; Ways and Means Committee ranking member, CHARLIE RANGEL; Energy and Commerce Committee ranking member, JOHN DINGELL; Ways and Means Health Subcommittee chairwoman, NANCY JOHNSON; and Energy and Commerce Health Subcommittee chairman, MIKE BILIRAKIS.

These are all the people who were concerned about this bill. Most of them worked to try to work out the differences between the House and Senate bills. Some of them did not, and some of them are complaining to this day.

I also wish to take this opportunity to recognize the staff who worked literally around the clock on this conference agreement for several months. They are: Dr. Mark Carlson, who was my legislative fellow this year; Colin Rosky; Leah Kegler; Jennifer Bell; Ted Totman; Alicia Ziemiecki; Liz Fowler; Bill Dauster; Russ Sullivan; Judy Miller; Jon Blum; Pat Bousliman; Andy Cohen; Danial Stein; Diana Birkett; Joelle Oishi; Jenny Wolff; Allison Giles; Julie Hasler; Patrick Morrisey; Chuck Clapton; Patrick Rowan; Jeremy Allen; Dean Rosen; Liz Scanlon; Eric Ueland; Sarah Walter; Michelle Easton; Paige Jennings; Lauren Fuller; Stacey Hughes; Don Dempsey; Diane Major; Lisa Wolski; Jane Lowenstein; Kate Leone; Susan Christianson; Bridgett Taylor; Amy Hall; John Ford; Cybele Bjorklund; and Terry Shaw.

Mr. President, I would like, though, to recognize the hard work of our Senate Finance Committee staff, especially Linda Fishman, Mark Hayes, Liz Fowler, and Jon Blum; and the staff of the Ways and Means Committee, John McManus, Deb Williams, Madeleine Smith, and Joel White; and staff of the House Energy and Commerce Committee, especially Patrick Morrissey and Chuck Clapton.

I also wish to acknowledge the work of my own staff: Pattie DeLoatche, Trish Knight, Bruce Artim, and others who worked very hard in this area.

I wish to acknowledge the work of the Senate and House legislative counsel staff, Jim Scott, John Goetcheus, Ruth Ernst, Ed Grossman, Pierre Poisson, and Pete Goodloe.

They have been the unsung heroes in this process and have given up significant time with their family in order to draft this legislation.

Another organization that deserves special recognition is the Congressional Budget Office. The staff of Steve Lieberman worked tirelessly for us, and it was a continuous process.

Finally, the Department of Health and Human Services, especially the Centers for Medicare & Medicaid Services staff, led by Administrator Tom Scully and Rob Foreman, worked around the clock to provide us with detailed information on questions we had about the Medicare legislation.

I thank all of these fine people for a job well done.

I have been involved in this issue for more than a decade, as I mentioned—actually for most of my Senate career. I worked closely with my Finance Committee colleagues to get this bill through the Finance Committee and the Senate earlier this year. I was also one of the authors of the Senate tripartisan Medicare bill which was considered last Congress and shot down because of nothing more than politics, something that appears to be rearing its ugly head right now.

In addition, I was lead sponsor with our colleague, Senator BILL ROTH, of the legislation establishing the Bipartisan Medicare Commission, which was included in the Balanced Budget Act of 1997.

Both the Medicare tripartisan bill and the Bipartisan Medicare Commission, which was chaired by my friend and colleague, JOHN BREAUX, laid the groundwork for the agreement we are currently considering.

We have learned from those efforts, and that has only improved the legislative effort that is before us today. That is why this bill presents the best opportunity that we will ever have to provide our seniors with the drugs they need so desperately.

Of course, the bill is not perfect. No compromise ever is to any one person. But after all these years, considering all the policy differences and all the differing views on entitlement programs and how a drug benefits should be delivered, we now have a bill that can pass.

With all of those differences, we finally have a bill that represents the best possible compromise. There will most certainly never be another opportunity like we have when we vote this Monday.

There is a lot of misunderstanding about what is in this bill. There is a lot of misinformation. I have mentioned some of it in my earlier remarks, but I would like to take a few more moments to clear up some of this.

First, I would like to explain one of the most important components of this legislation to my colleagues at this time, which is the drug benefit. Many Utahns are under the mistaken impression that they will be forced to participate in this new drug program, and that is simply not true. So I want all of you out there who are listening and watching and those who will read comments in the papers to note these comments by some of my colleagues, such as "you don't have any choice," are wrong. You have a choice whether you want to be in this program or not. No one will be forced into the new drug plan. No one is going to be forced into an HMO. No one will be forced to leave traditional Medicare on which they have come to depend.

I simply cannot stress enough that this is a voluntary benefit. If Medicare beneficiaries do not want drug coverage, they do not have to participate. I hope that point is clear to everyone across the country listening to this debate, especially senior citizens.

Second, in one word, this bill provides choice. Seniors will be able to choose the drug benefit that best suits their needs rather than be forced into a one-size-fits-all Government handout.

(Mr. ALLARD assumed the Chair.)

Mr. HATCH. Everyone will be offered a Medicare-endorsed drug discount card in April 2004. This will cost no more than $30 per year.

These drug discount cards will immediately provide our seniors with drug savings ranging from 10 to 25 percent. Right off, that's a benefit you don't have now.

In addition, this is a fair bill and a fair provision.

We have targeted the lion's share of this benefit to those seniors who have the greatest need. Those under 135 percent of the federal poverty level will receive $600 per year to buy their prescription drugs and will not be required to pay enrollment fees. That's a total of $53.6 million in additional help for 45,000 Utah residents in 2004 and 2005.These low-income beneficiaries would only be required to pay coinsurance between 5 and 10 percent for each prescription drug. That is a tremendous change from today.

The prescription drug card program concludes when the larger benefit kicks in on January 1, 2006.

Beginning in 2006, 220,000 Medicare beneficiaries will be offered access to the new standard prescription drug program. Standard coverage includes a $35 monthly premium, a $250 annual deductible, beneficiary coinsurance of 25 percent up to $2,250, and protections against high drug cost once out-of-pocket spending reaches $3,600.

While individual drug plan sponsors may change some of the specifications, every beneficiary who participates will be guaranteed a drug benefit that is at least equal in value to the standard benefit.

Those wishing to remain in traditional Medicare will have access to a stand-alone prescription drug plan.

Beneficiaries who want private, integrated health coverage may receive their drug benefits through local or regional Medicare Advantage plans. No one—not one senior or person with a disability—would be forced to give up the coverage that they receive from traditional Medicare. And this bill will provide 56,000 Medicare beneficiaries in Utah with access to drug coverage that they would not otherwise have.

This bill also has additional coverage for 63,000 Utahns with low-incomes.

For the dual-eligibles 18,000 in Utah—who are below 100 percent of the Federal poverty level, there would be no monthly premium, annual deductible, or gap in coverage. These individuals will merely have copayments of $1 for generic drugs and $3 for brand name drugs. Once the catastrophic limit is reached, there would be no beneficiary coinsurance for these individuals.

But there's even more help for our low-income beneficiaries. Those below 135 percent of poverty, there will be no monthly premium, annual deductible or gap in coverage. These individuals would have copayments of $2 for generic drugs and $5 for brand name drugs. Once the catastrophic limit is reached, there will be no beneficiary coinsurance for these individuals.

For those below 150 percent of poverty, there will be a sliding scale for monthly premiums, a $50 annual deductible, and up to 15 percent beneficiary coinsurance on the out-of-pocket spending. Once the catastrophic spending limit is reached, there will be beneficiary copayments of $2 for generic drugs and $5 for brand name drugs.

Let me illustrate how this would work.

Evelyn, a widow from Sandy, Utah makes $35,000 annually. She has diabetes, high blood pressure and arthritis and her annual drug expenditures are close to $5000. Evelyn decides to join the Medicare prescription drug plan. It's her choice.

Under the bipartisan Medicare agreement, her out-of-pocket spending on drugs will be reduced from $4800 per year to approximately $2400 cutting her prescription drug expenditures significantly. Factoring in her monthly premiums, she will save almost $2000 per year.

I continue to hear arguments on the floor about seniors being in worse shape if this bill becomes law.

Would Evelyn think saving $2000 puts her in worse shape? Not on your life.

This conference agreement provides additional assistance to the poorest and the sickest beneficiaries—that has always been my goal—to provide assistance to those beneficiaries who need the most help.

Who can argue against that?

It gives beneficiaries something that they have wanted for 40 years—prescription drug coverage—and it is strictly voluntary.

H.R. 1 also improves the traditional Medicare program by enhancing preventive services offered to beneficiaries.

The conference agreement includes a Welcome to Medicare preventive physical examination, cardiovascular and diabetes screening, and improved payments for mammography.

The new benefits will be used to screen Medicare beneficiaries for many illnesses, and in most cases, if these illnesses are caught early they may be treated. Conditions like diabetes, heart disease and asthma will be treated far more effectively due to this one-time physical examination. Would patients think they are worse off because their conditions are detected earlier and treated more effectively? Not on your life.

This conference agreement also establishes Health Savings Accounts, better known as HSAs. HSAs are tax-advantaged savings accounts which may be used to pay for medical expenses, and they have worked in numerous other forms in the private sector. They are open to everyone with a high deductible health insurance plan; however, the annual deductible must be at least $1,000 for individual coverage and at least $2,000 for family coverage, and the out-of-pocket expense limit must be no more than $5,000 for individual coverage and $10,000 for family coverage.

Employee HSA contributions are not included in the individual's taxable income. In addition, contributions by an individual are tax deductible. Also, the accounts are allowed to grow tax free and there is no tax on withdrawals for qualified medical expenses. Boy, does that make sense. But that is sticking in the craw of a number of those who want Government to pay for everything and don't want people to have to save for their own health care. I mean, that is in my view.

HSAs are portable, like an individual retirement account (IRA), the HSA is owned by the individual, not the employer. If the individual changes jobs, the HSA travels with them. In addition, individuals over age 55 may make extra contributions to their accounts and still enjoy the same tax advantages. In 2004, an additional $500 can be added to the HSA. By 2009, an additional $1,000 can be added to the HSA.

The inclusion of these new accounts is a significant part of the agreement that made this conference report possible. Yet some on the other side, because it is giving people a choice to save on their own, tax free, and pay for their own health care tax free, don't want this. It is easy to see why, if what you want is socialized medicine. The inclusion of these new accounts is a significant part of the agreement that made this conference report possible. Allowing individuals to take charge of their own savings for future health care expenses is an important and necessary change in the direction of our health care policy, and is one I support strongly.

In my opinion, the conference agreement made great strides in perfecting the Senate-passed language sponsored by Senators GREGG, SCHUMER, and KENNEDY pertaining to the Drug Price Competition and Patent Term Restoration Act of 1984, better known as the Hatch-Waxman Act.

The intent of the 1994 law is to provide incentives to develop valuable new drug treatments through patent and exclusivity protection, and also to facilitate access to generic versions of the drug after the innovator's patent or exclusivity expires. The CBO estimated that the Hatch-Waxman Act saves consumers $8 billion to $10 billion each year. I was pleased to be the prime sponsor and to work out every word in that Act.

In recent years, however, access to generic drugs has sometimes been delayed by litigation. The Judiciary Committee, which I chair, highlighted these problems in a hearing held in May of 2001 and two hearings this year.

The HELP Committee reported legislation on these matters both last year and this year. The Senate adopted these amendments by wide margins both last year and this year.

Although I opposed the specific provisions in these bills, I recognize the sustained efforts of Senators MCCAIN, SCHUMER, KENNEDY, COLLINS, EDWARDS, and FRIST. I want to especially commend Senator GREGG for his leadership in bringing this year's vehicle more in line with the policies that I have long advocated.

I also want to commend the leadership of President Bush who took regulatory action earlier this year to close a significant loophole in the 1984 law, which will save all Americans an estimated $35 billion over 10 years. Secretary Thompson and the Commissioner of Food and Drugs, Dr. Mark McClennan, deserve a lot of credit for completing this important rulemaking in less than one year. The expert advice given by the Chief Counsel for Food and Drugs, Dan Troy, must also be acknowldged.

Medicare legislation that passed the House and Senate earlier this year included the codification of the new FDA rule modifying the 30-month-stay provisions of Hatch-Waxman. Enactment of these provisions as part of the bipartisan agreement will lower prescription drug costs for millions of Americans by improving access to generic drugs, which are safe and effective and can be much less costly alternatives to brand-name prescription drugs.

A key component of the bipartisan agreement codify the recent regulation that limits drug manufacturers to one and only one 30-month automatic stay in patent infringement litigation involving a generic drug application. This is the policy that I advocated in May 2002 testimony before the HELP Committee and on the Senate floor during the debate of 2002.

Although the McCain-Schumer bill in the 107th Congress, S. 812, contained a very different provision with respect to the 30-month stay, in time the wisdom of my position on the 30-month stay took hold.

Last July, the Federal Trade Commission issued a report that recommended the policy I advocated and became a central feature of the FDA rule and the legislation contained in the conference report.

I want to commend the sustained effort and considerable expertise of FTC Chairman Muris in this area.

As well, I would be remiss not to single out such dedicated and thoughtful public servants as Mike Wroblenski at FTC and Jarilyn DuPont, Amit Sachdev, and Liz Dickinson at FDA, and many others.

One of the key provisions of the Greater Access to Affordable Pharmaceutical Act amendments are those pertaining to declaratory judgments. It was this provision that was discussed at our two most recent Judiciary Committee hearings on this legislation in June and August of this year. The Department of Justice, ably represented by a fellow Utahn, Deputy Assistant Attorney General Sheldon Bradshaw, understandably took the position that the Senate declaratory judgment provision was unconstitutional.

I am pleased that the conferees fixed the constitutional defect in the Gregg-Schumer-Kennedy language that passed the Senate.

The problem with the language, adopted by the Senate by, as I recall, a 94–1 margin, is that it tried to legislate directly counter to the "case or controversy" requirement of Article III of the Constitution.

Before reaching the merits of a case, including declaratory judgment actions, a Federal judge must first determine that there exists an actual dispute between the parties. Courts are not permitted by our Constitution to hear hypothetical cases or cases in which there is only a possibility of future litigation.

As both of the hearings of the Judiciary Committee documented, the law is settled with respect to the standards that must be met before a declaratory judgment may be heard in patent litigation. A court may only take a declaratory judgment case if and only if it finds that a "reasonable apprehension" of being sued by the patentee is present at the time the action is brought.

This is only common sense because it would be imprudent to allow the courts to be flooded with speculative, time consuming and costly patent suits. As the erudite statements of Mr. Boyden Gray fully documented, the Senate-passed language essentially stood the Constitution on its head by defining the absence of a lawsuit as a statutory basis for satisfying the "case or controversy" requirement.

I certainly enjoyed reading the several intriguing missives written on this topic by my former Judiciary Committee General Counsel, Professor John Yoo.

But neither his statements nor his surprise visit and testimony at our committee hearing have convinced me of either the constitutionality or policy wisdom of the declaratory judgment provisions contained in S.1. If we only knew Professor Yoo was coming to testify, we would have given Mr. Gray equal time.

In any event, in the provision the Senate considers today, the settled case law of the "reasonable apprehension" test remains undisturbed and the Constitutional requirements are observed.

In adopting this language it is important to note that the presence of the two factors referred to in the statute, the filing of an ANDA application with a Paragraph IV patent challenge certification and the absence of a suit filed by the patent-holding innovator firm, do not alone satisfy the reasonable apprehension test.

Certainly courts should, and in fact, must under the new language consider these two important factors but that should neither be the start nor the end of the inquiry.

For example, the result in the case of Dr. Reddy v. Pfizer, commented upon by many, including my friend from New York, Senator SCHUMER, does not appear to be affected by the language in this bill. In that case, which involved a challenge to patents set to expire three and one-half years later, the court found that the reasonable apprehension test was not satisfied.

Refiling the suit more proximate to the patent expiration date may yield a different result. That will be a matter for the courts to decide applying the new statute and the existing standards of the "reasonable apprehension" test.

I also want to make explicit, the implicit—that nothing in this new language pertaining to pharmaceutical patent-related declaratory judgments creates a new cause of action separate from the existing authority under title 28.

On balance, I believe that the conferees arrived at a fair resolution on the declaratory judgment provision that is a marked improvement over the Senate language.

I want to commend my colleagues in the Senate for recognizing the serious flaws in the language of S.1. I want to commend my colleagues in the House for recognizing the importance of retaining a strong declaratory judgment provision so that generic drug firms will be able to determine the status of their patent challenge in an appropriate fashion.

I plan to monitor closely the history of litigation of these new rules pertaining to pharmaceutical patent litigation and hope that the FTC and other governmental agencies and outside groups will also provide us with their analysis of how well the new provisions work in practice.

We need to be vigilant in assessing whether we have the proper balance between the interests of patent holders and patent challengers. I will expect and request an FTC report, similar to the agency's extremely helpful 2002 study, at an appropriate time.

There are also additional important provisions in this bill that affect Hatch-Waxman, but I would like to reserve my comments for this coming Monday.

One other important issue that we have addressed in this legislation is the preservation of retiree health coverage. My office has been flooded with calls from seniors worried about losing their retiree benefits.

And we have seen published reports indicating that rising drug and health care costs are pushing more and more employers and unions to drop their retiree health coverage.

We took these concerns very seriously as we negotiated this conference agreement.

That is why we have dedicated nearly one-quarter of the spending in this bill to protect retiree health benefits.

For the first time, Medicare will provide funding and incentives so employers and union officials will continue retiree health coverage. Under this bill, no beneficiary will be forced to drop retiree health coverage and participate in the new prescription drug program.

However, if employers drop health coverage in the future, those losing coverage will be allowed to enroll in the Medicare drug program without being penalized.

In addition, this legislation contains a 28 percent non-taxable employer subsidy for each retiree's annual drug spending between $250 and $5000—as high as $1,330 per beneficiary. To qualify, employer coverage must be as generous as, or more generous than, the Medicare Part D drug benefit.

We have made a lot of progress on this provision—protecting retiree health benefits was one of the primary goals of the Medicare conference committee. Let me tell you how much progress we have made—when we considered S.1 in the Senate this summer, CBO told us that the employer drop-out rate was 37 percent. The last CBO estimate on the conference report's employer drop-out rate is below 20 percent. This is a remarkable achievement.

The conference agreement is good for rural America. We want to ensure that Medicare beneficiaries will have access to quality health care—no matter where they live—and especially that rural providers, who provide these important health services to beneficiaries, will be properly reimbursed for their services.

Si Hutt, the CEO of Ashley Valley Medical Center in Vernal, Utah wrote to me asking:

> Please vote for the Prescription Drug Bill that came out of the conference committee. It not only assists Medicare beneficiaries with escalating drug costs, but it has key provisions which are important to rural hospitals and physicians.
>
> The last data that I looked at actually showed a negative margin for our Medicare business. At the same time, over 50 percent of our patients are Medicare, Medicaid, or self-pay.
>
> As you know, Medicare payment is very complicated and has some inequities that are improved with this bill. The bill stops a reduction of physicians' reimbursements—which is crucial in today's horrible malpractice premium situation and rising costs.
>
> It also gives a full market basket increase to hospitals for the next couple of years if hospitals participate in the American Health Association's (AHA's) national quality effort. We were among the first to sign up for this initiative.
>
> Please vote yes for this bill. Thank you.

Hospitals across America will receive a full market-basket update as long as they submit appropriate quality data to CMS. Medicare payments to hospitals providing services to a disproportionate share of low-income and uninsured patients, typically rural and small urban hospitals, were increased from 5.25 percent to 12 percent. It was an increase that was overdue.

There also is an increase in Medicaid DSH payments.

In addition, the legislation redistributes unused hospital residency positions and rural hospitals will be given top priority for receiving these redistributed resident positions.

The conference report does several things to assist critical access hospitals: namely, it increases payments for these hospitals and eases several burdensome requirements that have been imposed upon them.

Rural physicians benefit greatly under this conference report. We included legislation I helped develop that relieves Medicare providers from burdensome regulations and requirements.

Physicians will no longer be subjected to a 4.5 percent reduction; instead they will be receiving a slight increase in Medicare reimbursement for the next two years. We also modify the geographic adjustment for physician Medicare payments, which is extremely important to my Utah physicians back home.

And we reward physicians who are willing to provide care to Medicare beneficiaries who live in scarcity areas—areas that have medical shortages.

Home health care, skilled nursing facilities and hospice facilities in rural areas also receive an increase in Medicare payment. In addition, there are no home health care co-payments for beneficiaries.

As one of the authors of the home health care bill many years ago, I am proud to be able to say we were able to get that done in this bill. Finally, ambulance services in rural areas will be rewarded through increased payments.

Another issue that is extremely important to me is the reimportation of prescription drugs. I mentioned I would talk about this for a few minutes. My Utah constituents are deeply concerned about the high price of pharmaceutical products. But allowing drugs to be reimported from other countries is not the solution. In fact, it makes the problem worse because the safety of these drugs cannot be guaranteed by the Department of Health and Human Services. The recent Government sting operation in one U.S. port discovered that 85 percent of the reimported drugs seized were found to be counterfeit, outdated, or improperly packaged, knock-off packages.

This is very disturbing to me and an example of why I simply cannot support the reimportation of prescription drugs. The possibility of mistake and deception is just plain too great. People could die. Already the FDA has documented many cases of what appeared to be FDA-approved imported drugs that were, in fact, contaminated or counterfeit, contained the wrong product or incorrect dose, were accompanied by inadequate distributions, or had outlived their expiration date. These drugs would be, at a minimum, ineffective and would actually be harmful, if not fatal.

Those safety concerns are real and those in Congress who advocate reimportation ignore them not at their own risk but at the risk of the lives of millions of Americans. If we truly care about our seniors and others who depend on prescription drugs, we should not expose them to what amounts to pharmaceutical Russian roulette.

I might add that I will come up with an amendment that will give tort liability for local and State governments that encourage reimportation.

In addition to these safety concerns, reimported drugs are a threat to the innovation that Americans and the rest of the world have come to expect from our pharmaceutical industry. I am author of the FDA Revitalization Act that now is providing for, after 10 years, finally building the White Oak FDA Central Laboratories with the finest equipment and facilities in the world. It will take us another 10 years to do it. It should have been done 10 years ago. That should move this drug price problem forward because it would, hopefully, give them the facilities to acquire even better people to work there, tough scientists, whom they have not been able to attract for years, who basically will move these drugs through in a more safe and expeditious fashion, thus saving costs to those who develop the drugs, and thus bring prices down.

Canada and other countries with lower drug prices generally import superior American products but they impose price controls to keep costs down. However, it can cost up to $1 billion, as I have said, to produce a new drug, test it, win FDA approval, educate doctors, and make the drug available to patients. No pharmaceutical company could go through this without a chance to recover some of its costs, which will not be possible if we impose in America, however indirectly, Canadian-style price controls. They do not have a pharmaceutical industry in Canada anymore because they basically have thrown their business right out of the country. I don't want to see that happen in our country where we have the greatest pharmaceutical companies in the world. We should be proud.

I do not believe sacrificing the safety supply of our drugs by reimportation is the right answer to the high cost of prescription drugs. The conference committee reimportation provision is similar to what we passed earlier this year. The Secretary of HHS is directed to establish a program that would allow for the reimportation of drugs from Canada by pharmacists, wholesalers, and individuals. However, the Secretary has the authority to suspend such a program if public safety is compromised.

The conference agreement directs the Secretary to conduct an extensive study that identifies the barriers for implementing a drug reimportation program and the potential problems associated with it. I believe it is imperative that such a study be conducted by implementing a program that can pose such a serious public health risk.

Before I close, I take this opportunity to refute some of the arguments I have heard from the other side of the aisle. In fact, I will repeat some of the things I have said before but, hopefully, make them more clear.

My colleagues have said that 25 percent of seniors will be worse off when this bill passes than they are today. That is simply not true. It is false. And it is wrong for them to make these statements. This conference agreement provides Medicare beneficiaries with the benefit they have been demanding for close to 40 years, prescription drug coverage and quality health coverage. This week, we are finally going to give them what they want. We spend almost $400 billion in new money to accomplish that goal.

I also heard some say that this is catastrophic all over again and we will be back a year later repealing this legislation just like we repealed the Medicare Catastrophic Coverage Act of 1988. There is one fundamental difference between the current Medicare conference agreement and the Medicare Catastrophic Coverage Act of 1988—although there are other differences as well. Our Medicare benefit is voluntary. The Medicare catastrophic coverage law was mandatory. That is a major difference. No one is forced to participate in this program. But I think virtually everyone will want to.

In addition, this legislation offers drug coverage to the 33 percent of Medicare beneficiaries who do not have coverage today. I have mentioned how that benefits folks in my State. The Hatch-Waxman reforms on generic system drugs get less expensive drugs to the market faster, providing everyone with less expensive drugs.

This bill makes significant health care improvements for Medicare beneficiaries in rural America and the health care workers who care for these beneficiaries.

Before I close, I make an observation about the endorsement of this legislation from the AARP. Regarding the American Association of Retired People, I have not always been in agreement throughout the years, but I have a new regard for that organization because it made a courageous decision by putting seniors first. I respect the AARP for taking such a positive stand on this legislation. I personally resent some of the irresponsible attacks that have been made against them. If we are going to attack AARP, make sure we are right in doing so and do not use phony arguments because you are losing in the Senate.

In conclusion, passage of this Medicare conference agreement is the right thing to do for our seniors, especially those who currently do not have prescription drug coverage because they cannot afford it. I am pleased I have had an opportunity to play an important role in making this dream a reality for 41 million Medicare beneficiaries across the country. I am pleased I was able to work with such fine members of the conference committee, every one of them. Every one of them worked well. Every one of them deserves credit. Every one of them played a specific role. There were hardrock conservatives who made this bill passable in the House. There were those who were more liberal who made this bill acceptable to many in the Senate, if not the vast majority. There were many in the middle who were trying to make sure we got this thing done right and did the very best we could to do achieve that goal.

Again, I have mentioned the people who basically deserve most of the credit for working on this bill. Everyone on those conference committees worked long, hard hours.

So I resent some of the comments that were made by those who did not participate or, if they would have participated, would have done nothing but complain throughout the process and would have stalled the process. They are complaining because they did not have their way and we will not go towards a socialized medicine approach. They want Government to handle all these problems. We think Government can do a good job if it has some competitive aspects with the private sector as well. The vast majority of this is government, but in a reformed way, with new programs that do a lot of good for every senior citizen who wants to participate in them. It will be a sea change advantage to all as we go forward.

I hope my colleagues will pass this bill. This is a historic opportunity for to us do what is in the best interests of our senior citizens in this country. It is the only opportunity that has been brought to both floors of Congress and the only opportunity for us to pass legislation. This bill is important. This bill should not be subject to petty partisan politics, a superabundance of which I have seen through this process, but particularly yesterday and today. I hope all of our colleagues will vote for this bill.

I yield the floor.

Mrs. BOXER addressed the Chair.

Mr. HATCH. Mr. President, could I do just a little bit of wrap-up?

Mrs. BOXER. Of course.

Mr. HATCH. I thank my colleague from California. I thank her for her graciousness throughout this process with regard to my speech.

RECOGNIZING THE IMPORTANCE OF RALPH BUNCHE AS ONE OF THE GREAT LEADERS OF THE UNITED STATES

Mr. HATCH. Mr. President, I ask unanimous consent that the Judiciary Committee be discharged from further consideration of S. Con. Res. 82 and that the Senate proceed to its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report the concurrent resolution by title.

The assistant legislative clerk read as follows:

A concurrent resolution (S. Con. Res. 82) recognizing the importance of Ralph Bunche as one of the great leaders of the United States, the first African-American Nobel

Peace Prize winner, an accomplished scholar, a distinguished diplomat, and a tireless campaigner of civil rights for people throughout the world.

There being no objection, the Senate proceeded to consider the concurrent resolution.

Mr. HATCH. Mr. President, I ask unanimous consent that the concurrent resolution be agreed to, the preamble be agreed to, and the motion to reconsider be laid upon the table, with no intervening action or debate, and that any statements relating to this concurrent resolution be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The concurrent resolution (S. Con. Res. 82) was agreed to.

The preamble was agreed to.

The concurrent resolution, with its preamble, reads as follows:

S. CON. RES. 82

Whereas Ralph Bunche's life of achievement made him one of the 20th century's foremost figures and a role model for youth;

Whereas Ralph Bunche graduated valedictorian, summa cum laude, and Phi Beta Kappa from the University of California at Los Angeles in 1927 with a degree in International Relations;

Whereas Ralph Bunche was the first African-American to receive a Ph.D. in Government and International Relations at Harvard University in 1934;

Whereas Ralph Bunche served as a professor and established and chaired the Political Science Department at Howard University from 1928 to 1941;

Whereas, in 1941, Ralph Bunche served as an analyst for the Office of Strategic Services;

Whereas Ralph Bunche joined the Department of State in 1944 as an advisor;

Whereas Ralph Bunche served as an advisor to the United States delegation to the 1945 San Francisco conference charged with establishing the United Nations and drafting the Charter of the organization;

Whereas Ralph Bunche was instrumental in drafting Chapters XI and XII of the United Nations Charter, dealing with non-self-governing territories and the International Trusteeship System, which helped African countries achieve their independence and assisted in their transition to self-governing, sovereign states;

Whereas, in 1946, Ralph Bunche was appointed Director of the Trusteeship Division of the United Nations;

Whereas, in 1948, Ralph Bunche was named acting Chief Mediator in Palestine for the United Nations, and, in 1949, successfully brokered an armistice agreement between Israel, Egypt, Jordan, Lebanon, and Syria;

Whereas Ralph Bunche was deeply committed to ending colonialism and restoring individual State sovereignty through peaceful means;

Whereas the National Association for the Advancement of Colored People awarded its highest honor, the Spingarn Medal, to Ralph Bunche in 1949;

Whereas for his many significant contributions and efforts toward achieving a peaceful resolution to seemingly intractable national and international disputes, Ralph Bunche was awarded the Nobel Peace Prize in 1950, the first African-American and the first person of color to be so honored;

Whereas Ralph Bunche was named United Nations Under-Secretary-General in 1955, in charge of directing peacekeeping missions in several countries;

Whereas, in 1963, Ralph Bunche received the United States' highest civilian award, the Medal of Freedom; and

Whereas Ralph Bunche's critical contributions to the attempt to resolve the Arab-Israeli conflict and towards the de-colonization of Africa, and his commitment to and long service in the United Nations and numerous other national and international humanitarian efforts, warrant his commemoration: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring), That Congress—

(1) recognizes and honors Ralph Bunche as a pivotal 20th century figure in the struggle for the realization and attainment of human rights on a global scale; and

(2) urges the President to take appropriate measures to encourage the celebration and remembrance of Ralph Bunche's many significant achievements.

RECOGNIZING ALTHEA GIBSON FOR HER GROUND BREAKING ACHIEVEMENTS

Mr. HATCH. Mr. President, I ask unanimous consent that the Judiciary Committee be discharged from further consideration of H. Con. Res. 69 and that the Senate proceed to its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report the concurrent resolution by title.

The assistant legislative clerk read as follows:

A concurrent resolution (H. Con. Res. 69) expressing the sense of Congress that Althea Gibson should be recognized for her ground breaking achievements in athletics and her commitment to ending racial discrimination and prejudice within the world of sports.

There being no objection, the Senate proceeded to consider the concurrent resolution.

Mr. HATCH. Mr. President, I ask unanimous consent that the concurrent resolution be agreed to, the preamble be agreed to, and the motion to reconsider be laid upon the table, with no intervening action or debate, and that any statements relating to this concurrent resolution be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The concurrent resolution (H. Con. Res. 69) was agreed to.

The preamble was agreed to.

RECOGNIZING THE IMPORTANCE OF RALPH BUNCHE AS ONE OF THE GREAT LEADERS OF THE UNITED STATES

Mr. HATCH. Mr. President, I ask unanimous consent that the Judiciary Committee be discharged from further consideration of H. Con. Res. 71 and that the Senate proceed to its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report the concurrent resolution by title.

The assistant legislative clerk read as follows:

A concurrent resolution (H. Con. Res. 71) recognizing the importance of Ralph Bunche as one of the great leaders of the United States, the first African-American Nobel Peace Prize winner, an accomplished scholar, a distinguished diplomat, and a tireless campaigner of civil rights for people throughout the world.

There being no objection, the Senate proceeded to consider the concurrent resolution.

Mr. HATCH. Mr. President, I ask unanimous consent that the concurrent resolution be agreed to, the preamble be agreed to, the motion to reconsider be laid upon the table, with no intervening action or debate, and that any statements relating to this concurrent resolution be printed in the RECORD.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The concurrent resolution (H. Con. Res. 71) was agreed to.

The preamble was agreed to.

EXPRESSING THE SENSE OF CONGRESS SUPPORTING VIGOROUS ENFORCEMENT OF THE FEDERAL OBSCENITY LAWS

Mr. HATCH. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 375, S. Con. Res. 77.

The PRESIDING OFFICER. The clerk will report the concurrent resolution by title.

The assistant legislative clerk read as follows:

A concurrent resolution (S. Con. Res. 77) expressing the sense of Congress supporting vigorous enforcement of the Federal obscenity laws.

There being no objection, the Senate proceeded to consider the concurrent resolution.

Mr. HATCH. Mr. President, I ask unanimous consent that the concurrent resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table en bloc, and that any statements relating to the concurrent resolution be printed in the RECORD.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The concurrent resolution (S. Con. Res. 77) was agreed to.

The preamble was agreed to.

The concurrent resolution, with its preamble, reads as follows:

S. CON. RES. 77

Whereas the Supreme Court in Miller v. California, 413 U.S. 15 (1973) held that obscene material is "unprotected by the first amendment" (413 U.S. at 23) and that obscenity laws can be enforced against "'hard core' pornography" (413 U.S. at 28);

Whereas the Miller Court stated that "to equate the free and robust exchange of ideas and political debate with commercial exploitation of obscene material demeans the grand conception of the first amendment and its high purposes in the historic struggle for freedom." (413 U.S. at 34);

Whereas the Supreme Court in Paris Adult Theatre I v. Slaton, 413 U.S. 49 (1973) recognized that there are legitimate governmental interests at stake in stemming the tide of obscene materials, which include—

(1) protecting "the quality of life and total community environment" (413 U.S. at 58);

(2) protecting "public safety" (413 U.S. at 58);

(3) maintaining "a decent society" (413 U.S. at 59-60);

(4) protecting "the social interest in order and morality" (413 U.S. at 61); and

(5) protecting "family life" (413 U.S. at 63);

Whereas Congress, in an effort to protect these same legitimate governmental interests, enacted legislation in 1988 to strengthen federal obscenity laws and in 1996 to clarify that use of an interactive computer service to transport obscene materials in or affecting interstate or foreign commerce is prohibited;

Whereas the 1986 Final Report of the Attorney General's Commission on Pornography found that "increasingly, the most prevalent forms of pornography" fit the description of "sexually violent material" (p. 323) and that "an enormous amount of the most sexually explicit material available" can be categorized as "degrading" to people, "most often women" (p. 331);

Whereas the Internet has become a conduit for hardcore pornography that now reaches directly into tens of millions of American homes, where even small children can be exposed to Internet obscenity and older children can easily find it;

Whereas a national opinion poll conducted in March 2002 by Wirthlin Worldwide marketing research company found that 81 percent of adult Americans say that "Federal laws against Internet obscenity should be vigorously enforced";

Whereas a May 2 report from the National Academies' National Research Council stated that "aggressive enforcement of existing antiobscenity laws can help reduce children's access to certain kinds of sexually explicit material on the Internet";

Whereas vigorous enforcement of obscenity laws can help reduce the amount of "virtual child pornography" now readily available to sexual predators; and

Whereas it continues to be the desire of the People of the United States of America and their representatives in Congress to recognize and protect the governmental interests recognized as legitimate by the United States Supreme Court in Paris Adult Theatre I v. Slaton, 413 U.S. 49 (1973): Now, therefore be it

Resolved by the Senate (the House of Representatives concurring), That it is the sense of Congress that the Federal obscenity laws should be vigorously enforced throughout the United States.

FAIR AND ACCURATE CREDIT TRANSACTIONS ACT, 2003—CONFERENCE REPORT

Mr. HATCH. Mr. President, I ask unanimous consent that the Senate now proceed to the consideration of the conference report to accompany H.R. 2622, the Fair and Accurate Credit Transactions Act of 2003.

The PRESIDING OFFICER (Mr. BURNS). The report will be stated.

The assistant legislative clerk read as follows:

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2622) to amend the Fair Credit Reporting Act, to prevent identity theft, improve resolution of consumer disputes, improve the accuracy of consumer records, make improvements in the use of, and consumer access to, credit information, and for other purposes, having met, have agreed that the House recede from its disagreement to the amendment of the Senate, and agree to the same with an amendment, and the Senate agree to the same, signed by a majority of the conferees on the part of both Houses.

The PRESIDING OFFICER. Without objection, the Senate will proceed to the consideration of the conference report.

(The conference report is printed in the House proceedings of the RECORD of November 21, 2003.)

Mr. HATCH. Mr. President, I ask unanimous consent that the conference report be agreed to, the motion to reconsider be laid upon the table, and any statements relating to the conference report be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The conference report was agreed to.

HOMETOWN HEROES SURVIVORS BENEFITS ACT OF 2003

Mr. LEAHY. Mr. President, I rise today to express my pleasure with the House passage of the "Hometown Heroes Survivors Benefits Act of 2003," S. 459, at daybreak today. This bill, as amended and passed by unanimous consent in the House, will improve the Department of Justice's Public Safety Officers Benefits program by allowing survivors of public safety officers who suffer fatal heart attacks or strokes while participating in nonroutine stressful or strenous physical activities to qualify for Federal survivor benefits.

I want to pay special thanks to Congressman BOB ETHERIDGE, the author of the House companion bill, and House Judiciary Committee Chairman SENSENBRENNER for their leadership and fortitude while negotiating this legislation. Without their perseverance and willingness to find bipartisan compromise language, passage of this bill in the House would not have happened.

I also commend Congressman COBLE, Congressman BOBBY SCOTT, the Fraternal Order of Police and the Congressional Fire Services Institute for working with us on bipartisan compromise language so that we could pass the Senate bill through the House. I look forward to working with Senate Judiciary Chairman HATCH, Senator LINDSEY GRAHAM, the lead Republican cosponsor of this bill, and Senate leadership to quickly pass the Senate bill, as amended by the House, and send it to the President's desk for enactment into law.

Public safety officers are our most brave and dedicated public servants. I applaud the efforts of all members of fire, law enforcement and EMS providers nationwide who are the first to respond to more than 1.6 million emergency calls annually—whether those calls involve a crime, fire, medical emergency, spill of hazardous materials, natural disaster, act of terrorism, or transportation accident—without reservation. Those men and woman act with an unwavering commitment to the safety and protection of their fellow citizens, and forever willing to selflessly sacrifice their own lives to provide safe and reliable emergency services to their communities.

Sadly, that kind of dedication can result in tragedy, which we all witnessed on September 11 as scores of firefighters, police officers and medics raced into the burning World Trade Center and Pentagon with no other goal than to save lives. Every year, hundreds of public safety officers nationwide lose their lives and thousands more are injured while performing duties that subject them to great physical risks. And while we know that PSOB benefits can never be a substitute for the loss of a loved one, the families of all our fallen heroes deserve to collect these funds.

The PSOB program was established in 1976 to authorize a one-time financial payment to the eligible survivors of Federal, State, and local public safety officers for all line of duty deaths. In 2001, Congress improved the PSOB regulations by streamlining the process for families of public safety officers killed or injured in connection with prevention, investigation, rescue or recovery efforts related to a terrorist attack. We also retroactively increased the total benefits available by $100,000 as part of the USA PATRIOT Act. Survivors of first responders killed in the line of duty now receive $267,494 in PSOB.

Unfortunately, the issue of covering heart attack and stroke victims under PSOB regulations was not addressed at the time.

Service-connected heart, lung, and hypertension conditions are silent killers of public safety officers nationwide. The numerous hidden health dangers dealt with by police officers, fire fighters and EMS personnel are widely recognized, but officers face these dangers in order to serve and protect their fellow citizens.

The intent of the legislation Senator GRAHAM and I introduced earlier this year was to cover officer who suffered a heart attack or stroke as a result of nonroutine stressful or strenuous physical activity. As drafted and passed by the Senate by unanimous consent on May 16, however, members of the House

Judiciary Committee felt the bill's language would cover officers who did not engage in any physical activity, but merely happened to suffer a heart attack while at work. Chairman SENSENBRENNER, Congressman ETHERIDGE, Congressman COBLE, Congressman SCOTT, FOP, CFSI and I worked out a substitute amendment to address those concerns.

The substitute amendment to S. 459 will create a presumption that an officer who died as a direct injury sustained in the line of duty if the following is established: That officer participated in a training exercise that involved nonroutine stressful or strenuous physical activity or responded to a situation and such participation or response involved nonroutine stressful or strenuous physical law enforcement, hazardous material response, emergency medical services, prison security, fire suppression, rescue, disaster relief or other emergency response activity; that officer suffered a heart attack or stroke while engaging or within 24 hours of engaging in that physical activity; and such presumption cannot be overcome by competent medical evidence.

For the purposes of this act, the phrase "nonroutine stressful or strenuous physical" will exclude actions of a clerical, administrative or non-manual nature. Included in the category of "actions of a clerical, administrative or non-manual nature" are such tasks including, but not limited to, the following: sitting at a desk; typing on a computer; talking on the telephone; reading or writing paperwork or other literature; watching a police or corrections facility's monitors of cells or grounds; teaching a class; cleaning or organizing an emergency response vehicle; signing in or out a prisoner; driving a vehicle on routine patrol; and directing traffic at or participating in a local parade.

Such deaths, while tragic, are not to be considered in the lien of duty deaths. The families of officers who died of such causes would therefore not be eligible to receive PSOB.

For the purposes of this Act, the phrase "nonroutine stressful or strenuous physical" actions will include, but are not limited to, the following: involvement in a physical struggle with a suspected or convicted criminal; performing a search and rescue mission; performing or assisting with emergency medical treatment; performing or assisting with fire suppression; involvement in a situation that requires either a high speed response or pursuit on foot or in a vehicle; participation in hazardous material response; responding to a riot that broke out at a public event; and physically engaging in the arrest or apprehension of a suspected criminal.

The situations listed above are the types of heart attack and stroke cases that are considered to be in the line of duty. The families of officers who died in such cases are eligible to receive PSOB.

Heart attacks and strokes are a reality of the high-pressure jobs of police officers, firefighers and medics. These are killers that first responders contend with in their jobs, just like speeding bullets and burning buildings. They put their lives on the line for us, and we owe their families our gratitude, our respect and our help. No amount of money can fill the void that is left by these losses, but ending this disparity can help these families keep food on the table and shelter over their heads.

I urge the Senate to take up and pass the Hometown Heroes Survivors Benefits Act, S. 459, as amended and passed this morning by the House, and show its support and appreciation for these extraordinarily brave and heroic public safety officers.

ADDITIONAL STATEMENTS

IN MEMORY OF JUDGE RAYMOND J. PETTINE

• Mr. REED. Mr. President, on Monday, November 17, 2003, Rhode Island, the judicial community and the entire Nation lost a great jurist, a great scholar and a great man. U.S. District Court Judge Raymond J. Pettine passed away leaving a legacy of protecting individual liberties and constitutional rights.

Judge Pettine was born July 6, 1912 on America Street in Federal Hill, one of the original Italian neighborhoods in Providence; a fitting place to be born for someone who would champion the Constitution that distinguishes this country, America, from so many others. His father was a wigmaker in Italy who immigrated to these shores to find a better life for his family and to make a better America through his labors and his sacrifice. Judge Pettine was sustained and inspired by the example of these good people, his mother and father. The hard work, the great patriotism, the unwavering decency and integrity, the deep respect for both family and faith, the gracious manners of a true gentleman were learned in that home on America Street.

Early in his life, Judge Pettine became fascinated with the law. As a child of eight, he scrawled a note to the Dean of Harvard Law School and asked him, "What do you have to do to become a lawyer?" The Dean wrote in reply "study hard, be a good boy, always have a dream." His dream led him to Providence College and Boston University Law School. Soon after graduation, he enlisted in the U.S. Army and served on active duty from 1941 until 1946 rising to the rank of major. He later would be promoted to colonel in the Judge Advocate General Corps as a reservist.

After his discharge from active duty and a brief stint in private practice, Judge Pettine began a 13-year career as a prosecutor in the Rhode Island Attorney General's office. Like every task he undertook, he brought great passion and determination to this endeavor. He understood that our adversarial system of justice requires that both the prosecution and the defense must bring the full weight of the facts and the law before the jury so that they may have the benefit of principled and forceful advocacy to make their decision. He was a tough and uncompromising prosecutor determined to enforce the law.

His reputation and his record as a prosecutor earned him appointment as the Federal Attorney for the District of Rhode Island is 1961. His service as Federal Attorney won him the praise of Attorney General Robert F. Kennedy as one of the nation's top three federal prosecutors. And, this prosecutorial experience would help make him a superb judge upon his appointment to the bench in 1966 by President Johnson. Judge Pettine recognized that the role of a judge was different than that of a prosecutor or defense counsel. He was charged with something greater than simply enforcing the law or arguing for a client. He was charged with seeking justice, that delicate balance that rests on fairness and a keen understanding of the nature of people as well as the tenets of the law. He was also charged in a special way with defending the Constitution and the Bill of Rights. He recognized that our democracy, in his words, "prizes itself in having a Bill of Rights designed to protect us against despotic abuse of authority by the government."

There was no more courageous, forceful or principled defender of the Constitution than Raymond Pettine. In 30 years on the Federal bench, and as chief judge from 1971 to 1982, Judge Pettine staunchly guarded the individual rights enshrined in the Constitution. He said the Constitution should be interpreted in ways that "give meaning to the heart and soul of what it's all about: a kinder, more understanding Constitution that recognizes the disenfranchised, the poor and underprivileged."

In his rulings, he repeatedly upheld the Bill of Rights' freedom of speech, of religion and of privacy.

Pettine stood by the Constitution and showed courage in the face of controversy when he, a practicing Catholic, ruled that municipalities could not erect Christmas Nativity scenes on public land. As he said, "I firmly believe this with great conviction: that there has to be a separation between church and State—that one of the saving graces of this country is the fact that we are tolerant of all religions, and even of those who have no religion. And, if we start breaking that down, we are going to be in an awful lot of trouble."

His wise defense of the Constitution and its protections for individual conscience brought him vicious criticism and personal scorn. But, no amount of criticism or scorn could deter him from his obligation to extend the protections of the Constitution to the poor as well as the powerful, to the maligned as well as the popular.

Judge Pettine embraced his judicial duties with remarkable dedication. He became a scholar of the law and, in order to insulate himself from even the appearance of partiality, he led a life focused on his family and the lonely rigors of his judicial responsibilities. Nevertheless, he cut a dashing figure in Rhode Island. He was a man of great culture and erudition who exuded style and panache.

Judge Raymond J. Pettine has left a remarkable legacy. His wisdom, his integrity and his selfless devotion to the Constitution made him a judge of extraordinary achievement. His love of family and his compassionate regard for all he met made him a man of singular worth. I admire him greatly. He has given us the example and the confidence to carry on. And, his presence will continue to be felt whenever we stand up in defense of the Constitution and in defense of those who are "disenfranchised, the poor and underprivileged."

My deepest condolences go out to his family and friends, especially his daughter, Lee Gillespie, his granddaughter, Lauren Gillespie and his son-in-law, Thomas Gillespie.●

MESSAGE FROM THE HOUSE

At 10:01 a.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House agrees to the report of the committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 1) to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes.

The message also announced that the House agrees to the report of the committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2622) to amend the Fair Credit Reporting Act, to prevent identity theft, improve resolution of consumer disputes, improve the accuracy of consumer records, make improvements in the use of, and consumer access to, credit information, and for other purposes.

The message further announced that the House agrees to the following bills, each with an amendment in which it requests the concurrence of the Senate:

S. 459. An act to ensure that a public safety officer who suffers a fatal heart attack or stroke while on duty shall be presumed to have died in the line of duty for purposes of public safety officer survivor benefits;

S. 877. An act to regulate interstate commerce by imposing limitations and penalties on the transmission of unsolicited commercial electronic mail via the Internet; and

S. 1768. An act to extend the national flood insurance program.

The message also announced that the House has passed the following bill, without amendment:

S. 579. An act to reauthorize the National Transportation Safety Board, and for other purposes.

The message further announced that the House has passed the following bills and joint resolution, in which it requests the concurrence of the Senate.

H.R. 1964. An act to assist the States of Connecticut, New Jersey, New York, and Pennsylvania in conserving priority lands and natural resources in the Highlands region, and for other purposes;

H.R. 2584. An act to provide for the conveyance to the Utrok Atoll local government of a decommissioned National Oceanic and Atmospheric Administration ship, and for other purposes;

H.R. 3181. An act to amend the Robert T. Stafford Disaster Relief and Emergency Assistance Act to reauthorize the predisaster mitigation program, and for other purposes; and

H.J. Res. 80. Joint resolution appointing the day for the convening of the second session of the One Hundred Eighth Congress.

The message also announced that the House has agreed to the following concurrent resolutions, in which it requests the concurrence of the Senate:

H. Con. Res. 206. Concurrent resolution supporting the National Marrow Donor Program and other bone marrow donor programs and encouraging Americans to learn about the importance of bone marrow donation; and

H. Con. Res. 339. Concurrent resolution providing for the sine die adjournment of the first session of the One Hundred Eight Congress.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Ms. COLLINS, from the Committee on Governmental Affairs, without amendment:

S. 1683. A bill to provide for a report on the parity of pay and benefits among Federal law enforcement officers and to establish an exchange program between Federal law enforcement employees and State and local law enforcement employees (Rept. No. 108-207).

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. BUNNING (for himself, Mr. MILLER, Mr. INHOFE, Mr. NELSON of Nebraska, Mr. CRAIG, Mr. LUGAR, Mr. SANTORUM, Mr. COLEMAN, Mr. SMITH, Mr. HATCH, and Mr. CARPER):

S. 1931. A bill to repeal the sunset of the Economic Growth and Tax Relief Reconciliation Act of 2001 with respect to the expansion of the adoption credit and adoption assistance programs; to the Committee on Finance.

By Mr. CORNYN (for himself, Mrs. FEINSTEIN, Mr. HATCH, Mr. SMITH, Mr. ALEXANDER, and Mr. GRAHAM of South Carolina):

S. 1932. A bill to provide criminal penalties for unauthorized recording of motion pictures in a motion picture exhibition facility, to provide criminal and civil penalties for unauthorized distribution of commercial prerelease copyrighted works, and for other purposes; to the Committee on the Judiciary.

By Mr. HATCH (for himself, Mrs. FEINSTEIN, and Mr. CORNYN):

S. 1933. A bill to promote effective enforcement of copyrights, and for other purposes; to the Committee on the Judiciary .

ADDITIONAL COSPONSORS

S. 1549

At the request of Mrs. DOLE, the names of the Senator from Maine (Ms. COLLINS) and the Senator from Wisconsin (Mr. KOHL) were added as cosponsors of S. 1549, a bill to amend the Richard B. Russell National School Lunch Act to phase out reduced price lunches and breakfasts by phasing in an increase in the income eligibility guidelines for free lunches and breakfasts.

S. 1926

At the request of Ms. STABENOW, the name of the Senator from Nevada (Mr. REID) was added as a cosponsor of S. 1926, a bill to amend title XVIII of the Social Security Act to restore the medicare program and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. BUNNING (for himself, Mr. MILLER, Mr. INHOFE, Mr. NELSON of Nebraska, Mr. CRAIG, Mr. LUGAR, Mr. SANTORUM, Mr. COLEMAN, Mr. SMITH, Mr. HATCH, and Mr. CARPER):

S. 1931. A bill to repeal the sunset of the Economic Growth and Tax Relief Reconciliation Act of 2001 with respect to the expansion of the adoption credit and adoption assistance programs; to the Committee on Finance.

Mr. BUNNING. Mr. President, I rise today in celebration of National Adoption Day by introducing legislation to repeal the sunset on two current-law tax provisions that make adoption more affordable for American families.

In 2001, this Congress passed and President Bush signed into law the Economic Growth and Tax Relief Reconciliation Act. This act contains many much needed tax relief provisions for the American people. However, because of procedural rules in the

Senate, this law sunsets and expires after December 31, 2010.

The legislation I introduce today makes permanent two tax provisions contained in that law, the adoption tax credit and the exclusion for employer-provided adoption assistance benefits. If we do not pass this bill and therefore allow these provisions to sunset, then this tax credit will be cut overnight from a maximum of $10,000 to $5,000. Families who adopt special needs children will no longer receive a flat $10,000 credit, and instead, they will be limited to a maximum of $6,000. As well, families claiming the credit may be pushed into the Alternative Minimum Tax.

Today, National Adoption Day, we celebrate the adoption of over 3,000 children from foster care. There are over 542,000 kids in foster care. Of these, more than 125,000 children are waiting to be adopted permanently. We here in Congress need to continue to help these children to find loving homes. We need to make it easier for families to adopt, not throw up barriers. If the adoption tax credit is cut to the prior law level of $5,000, many families will not be able to afford adoptions. And therefore less children will be welcomed into what they want the most, a permanent family.

Last year, the House of Representative passed this permanent extension of the adoption tax credit by a vote of 391 yeas to 1 nay. We in this Chamber failed to act. I am hopeful that my colleagues in the Senate recognize the importance of moving on this legislation to permanently extend this tax credit. The children and parents deserve to see this adoption tax credit set into law for good. This is not a partisan issue, but something all Americans can agree on. We owe it to them all.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1931

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. REPEAL OF APPLICABILITY OF SUNSET OF THE ECONOMIC GROWTH AND TAX RELIEF RECONCILIATION ACT OF 2001 WITH RESPECT TO ADOPTION CREDIT AND ADOPTION ASSISTANCE PROGRAMS.

Section 901 of the Economic Growth and Tax Relief Reconciliation Act of 2001 is amended by adding at the end the following new subsection:

"(c) EXCEPTION.—Subsection (a) shall not apply to the amendments made by section 202 (relating to expansion of adoption credit and adoption assistance programs).".

Mr. INHOFE. Mr. President, I rise today to join my colleagues in introducing this bill to repeal the provisions of the Economic Growth and Tax Relief Act of 2001 that sunset the adoption tax credit and adoption assistance programs.

Under the current legislation, families with adopted children are given a tax credit of up to $10,000 to cover their adoption expenses and families who adopt children with special needs are credited the full $10,000. Providing this type of assistance is important in easing the costs of the adoption process and helping families cover expenses incurred by adopting children with special needs.

Currently, there are around 550,000 children in foster care. Of this number, 126,000 are up for adoption. In order to facilitate and expedite the adoption process, I have worked as a member of the Congressional Coalition on Adoption to encourage and support families who are willing to provide a loving, stable, and permanent home for these children. The Coalition has been active in promoting adoption around the country through a number of programs, including the National Adoption Day, a day set aside to draw attention to expediting and finalizing adoptions. In fact, Oklahoma held 20 adoptions this week in celebration of the day.

I strongly believe that it is critical to repeal the sunset provision of the Economic Growth and Tax Relief Act and continue to support those families who are making it possible for children to grow up in a loving and caring environment. As the grandfather of an adopted granddaughter, I can say through personal experience that providing a home where a child can be nurtured and given opportunities to become a contributing member of society is one of the greatest and most rewarding gifts we can ever give.

By Mr. HATCH (for himself, Mrs. FEINSTEIN, and Mr. CORNYN):

S. 1933. A bill to promote effective enforcement of copyrights, an for other purposes; to the Committee on the Judiciary.

Mr. HATCH. Mr. President, I rise to introduce the Enhancing Federal Obscenity Reporting and Copyright Enforcement Act of 2003, the EnFORCE Act. This bill makes three sets of narrow, but important, changes that will build greater flexibility and accountability into our system of intellectual property laws.

First the EnFORCE Act will expand an existing antitrust exemption to conform the law to market realities. Today, an antitrust exemption in the Copyright Act gives record companies and music publishers the flexibility they need to negotiate mechanical royalty rates in the rapidly evolving market for legal music downloading. These parties now need the same flexibility to ensure that they can negotiate royalties associated with innovative forms of physical phonorecords, like enhanced compact disks and DVD audio disks.

The music industry has sometimes been criticized for being too slow to adopt its business models to new technologies. The industry is now responding to such concerns by developing new products and new distribution channels. The EnFORCE Act will ensure that Federal law allows the music industry to provide consumers with these innovative products and services.

Second, the EnFORCE Act will also resolve two narrow issues relating to statutory damages in copyright infringement litigation. Some accused infringers have tried to avoid liability for statutory damages by challenging the accuracy of the information in copyright registrations; this bill clarifies that courts should resolve such challenges by applying the existing judicial doctrine of fraud-on-the-Copyright-Office. In other cases, disputes have arisen about how many "works" have been infringed for purposes of computing statutory damages. These disputes are important for the music industry, which has received inconsistent adjudications about whether an album consisting of ten songs counts as one or ten works for statutory-damages computation. The bill gives courts discretion to conform the law of statutory damages to changing market realities.

Third, and finally, the EnFORCE Act will also enhance both the enforcement and oversight of federal intellectual property law. The bill authorizes appropriations to ensure that all Department of Justice units that investigate intellectual property crimes have the support of at least one agent specifically trained in the investigation of such crimes. The bill also requires the Department of Justice to report to Congress detailed information about the scope of its efforts to investigate and prosecute crimes involving the sexual exploitation of minors or intellectual property.

For the above reasons, I urge my colleagues to support the Enhancing Federal Obscenity Reporting and Copyright Enforcement Act of 2003. I look forward to working with my colleagues in the Senate and the affected public to ensure that this bill achieves its important objectives.

PRIVILEGES OF THE FLOOR

Mr. HATCH. I ask unanimous consent that Grace Becker, a detailee from the Sentencing Commission, be granted the privilege of the floor for the duration of the 108th Congress.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that Grant Menke and Brett Swearingen be granted floor privileges throughout the debate on the conference report on H.R. 1.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. HARKIN. Mr. President, I ask unanimous consent that Jenelle

Krishramoorthy be granted the privilege of the floor for the remainder of the debate today, and the remainder of the debate on this Medicare conference report.

The PRESIDING OFFICER. Without objection, it is so ordered.

MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003—CONFERENCE REPORT—Continued

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. Mr. President, this debate so far has been very illuminating, in a way fascinating, to see how different Members of the Senate view the bill that is before us. I hope that America's seniors are watching this debate. I hope they are listening. I hope they will make up their own minds.

There are many groups out there who are going to give their opinions, and I respect them all. But I think if you just go to the debate and you listen to all sides of it, seniors will come up with their own conclusions. As a matter of fact, I also hope people in their fifties and forties are watching this debate because many of the changes that will be made, if this bill becomes law, are going to impact people in their fifties, people in their forties.

Let's face it, Medicare is a program that impacts all families because the children of senior citizens oftentimes bear the burden, if there are health problems. Of course, they care deeply about their families.

We know that Medicare is a nationwide health plan for aged and certain disabled Americans, and it was created 40 years ago for seniors to offer them access to good quality health care. There was a huge debate at that time about whether this was the right thing to do. But people looked around and saw that our seniors were in trouble. They were spending their money on health care, didn't have anything left, oftentimes had to move in with their families. Their families had to pick up their health care bills, and it was very difficult.

This program has fulfilled its promise. Is it perfect in every way? Of course not. What program is? What corporation is? What person is? But Medicare has saved many lives and has made the golden years golden for a lot of our seniors. That is why they feel so strongly about it.

I have been listening to some of the call-in shows. I have heard seniors identify themselves as Republicans, Democrats, and Independents. They are worried about the changes that are about to hit the system, and so am I.

The one thing I think everyone agrees on is that there ought to be a prescription drug benefit. At least I think most of us believe that from both sides of the aisle. We know this cost is heavy on our seniors. We know drug prices are skyrocketing because, unfortunately and very sadly, we don't allow drug reimportation from places like Canada and Mexico, although I have to tell you that in my State, people are going to Mexico.

I received a letter from a constituent of mine from San Marcos, CA, earlier this year. She told me that her annual cost for prescription drugs this year will top $10,000. Think about that, $10,000. How do our seniors deal with this when they are retired?

A retired physician from Marina del Rey told me that a pill he takes for his heart disease went up 600 percent, from $15 a month to $85. For seniors who have to take an assortment of medicines to manage their chronic diseases, the costs really start to add up.

Very sad to say, in this bill there is virtually no cost containment. Even though the House version said reimportation from Canada was a good idea, this has not happened. We will continue to pay the highest drug prices in the world. It is very sad, indeed. The provisions on generic drugs were watered down a bit. We have some in there but not what they should be.

For all the reasons that I talked about—the fact that I feel deep compassion for my constituents who have to pay these huge sums for medicines—I voted for the Senate bill. The Senate bill left here. I thought it made some sense. So let's look at what the Senate bill did for our seniors.

It had about six things that it did that I thought were really important.

First, there was a modest benefit for seniors that were hardest hit by the costly prescription drugs. That benefit was a lot better than the benefit that is currently before us. I will go into the differences. The benefit that is before us is so weak, it barely has a pulse. It is barely worth filling out the forms. It is barely worth your time. You could probably do better if you become friendly with your pharmacy down the road. They will probably give you a better deal.

The benefit before us, unlike the benefit we voted on, is this: If you have $5,100 worth of drug costs, you will pay $4,020 for those drugs. In the meanwhile, you will have to figure out what are your deductibles, what are your copays, filling out the forms, being nervous, getting notified that you no longer have the drug benefit because there is a benefit shutdown, which I will get into later. So think about it. You have a $5,000 drug bill, and you are paying $4,000. And you are going through probably bureaucratic hell to get that thousand dollars off.

So the benefit, when we got the bill, we voted it out. I voted for it. I wanted it. It was a modest benefit but a decent benefit. It was much better than this one. We will get into that later.

Secondly, all seniors were guaranteed a Medicare prescription drug benefit if they didn't have two private plans in their area. So you had a good fallback. If you didn't have two private drug plans competing for your business, could you say: Forget this. I can go to Medicare.

Third, Medicare could have bargained for lower prescription drug costs. Now, why is this important? Just look at the Veterans' Administration. They can get way lower costs for the drug benefits for their veterans because they represent millions of veterans. Therefore, they have bargaining power. It is not like if I walked into a pharmacy myself and said: Hi, I am a veteran, can you lower my drug prices. And the pharmacist looks at me and says: Well, no. But if I bring millions of people into the store, the pharmacist is going to say: You know, now I can talk to you about some bargain prices.

That is what we have done with the VA. In the original bill that came out of the Senate, Medicare could have bargained. We will talk about the current bill in a minute.

Then, No. 4, there were steps to privatize Medicare, but they were minor steps. They were balanced by a $6 billion sum that was added to Medicare. So while they gave the private plans $6 billion in the Senate bill to "encourage" them to stay in the Medicare business, I didn't agree with that. When I think about competition, I don't think about paying people to compete. I didn't think that is what capitalism is. I was a stockbroker. That is news to me. To me competition is what it says. You come in, you see you have a chance to make a profit, and you compete.

Well, we were giving them $6 billion. I wasn't happy about it, but I felt that, all in all, because we balanced it and gave $6 billion to Medicare to add prevention and some other very important benefits, it was worth it.

So just sum that up. I want to be clear here. I supported the Medicare prescription drug bill that was before the Senate because it was a decent benefit for seniors. It gave them about a third off their drugs. So it gave you a third off of your drugs. I thought that was a good benefit. You paid two-thirds and you got a third off. Again, I thought it should have been better. It was modest. I wasn't thrilled with it. I tried to have amendments to close the benefit shutdown, to bring the benefit up to 50 percent, but I did not succeed in that effort.

All seniors were guaranteed a Medicare drug benefit, that fallback, if they didn't have two private drug plans competing. Frankly, I wanted a Medicare fallback for everybody. I remember the debate. But they convinced me to compromise. I wasn't thrilled, but I voted for it. Medicare could have bargained for lower prices for drugs. I assumed that would be part of what we would do. We didn't prohibit it. The steps to privatize Medicare, to incentivize HMOs to stay in the Medicare business, were balanced by $6 billion added to Medicare for some important new benefits.

The last thing is, for the lowest income seniors, they got prescription drugs at no cost. That was a wonderful thing in the Senate bill. The poorest of the poor people who worked all their lives and found themselves in a horrible situation today would have gotten drugs at no cost. For all those reasons, I was very pleased in the end that I was able to move that bill forward.

I want to show you something I hope you can appreciate, as I hold this bill up for a minute. The bill itself that has now come back to us is very heavy. Here it is. This is the bill that is before us today. This bill I am holding is 678 pages. How much of this is the prescription drug benefit? It is 181 pages. What does that tell you? It tells you that most of this bill has nothing to do with prescription drugs. Think about it. We sent a prescription drug bill into the conference committee to come back to us, and here it is. This yellow tab shows me where it is. This is the prescription drug benefit. It is 181 pages. The balance of this bill is way more, 5 times more.

Think about it. If the folks who brought you this bill were sincere about giving you a prescription drug benefit, why did they then use that as an excuse to begin changing Medicare—changing Medicare in ways that are perplexing, that are going to be difficult to understand, and the rest?

Now, I am not, generally speaking, someone who is paranoid about things. But I have to tell you, I am when I hear Newt Gingrich, praising all 600 pages of this bill, who said in 1995:

> Now, we don't get rid of it [Medicare] in round one because we don't think that that's politically smart, and we don't think that's the right way to go through a transition. But we believe Medicare is going to wither on the vine, because we think people are voluntarily going to leave it.

Voluntarily. If you mess up Medicare and you make it confusing and start doing the things that they do in this bill, Newt Gingrich will be proven right. Why do you think he went over to the caucus on the other side, in the House, and talked to the Republicans who didn't like the bill? Because they thought it was too good to seniors.

He said: No, it is not. Trust me. Would I lead you astray?

That is Newt Gingrich. The senior citizens in this country, in my view, are the smartest of the folks when it comes to Medicare. They know it. They get it. They understand Social Security and they understand Medicare. They understand when Newt Gingrich said that Medicare should "wither on the vine," and that this isn't something they want to see happen.

Well, folks, please listen. "We don't have to get rid of it in round one," Newt said, "because we don't think it's politically smart." So what did they do? They take a prescription drug benefit that is popular—by the way, it is voluntary, but I will talk about that because it is not voluntary if you are on Medicaid, and it is not voluntary when you find out that your pension plan has dropped your prescription drug coverage because then you will have nothing. You will be forced into it. It is not voluntary for those folks.

But I can tell you that this is just what Newt Gingrich planned. You cannot do it all at once. Not in round 1. We have to go through a "transition." Remember that word because it shows up in this bill—"transition." So here is prescription drugs, and here is the withering on the vine.

A lot of the people who fought Medicare in the beginning are embracing this bill. Do you think they had a change of heart? Do you think those of us who built our careers on protecting seniors have somehow gone wacko on you by saying that this bill does more harm than good? Think about the Senators who are standing up here and extolling the virtues of this bill. One of them was here before and he said that people on the other side are saying we are trying to destroy Medicare. How ridiculous, he said. That's crazy. We would never do that. Then he launched into a harsh criticism of Medicare and how it needs to change.

Another, I thought, belied his point of view when he stood up and said—it is on the record from this afternoon—we need to get away from the "command and control" of Medicare.

Well, I have news for the Senator from Texas, who said that. In Medicare, do you know who is in command and control? The senior citizens. That senior citizen can go anywhere—to the doctor of choice. That is the beauty of the Medicare system. They are in command and control.

What this bill does is start the unraveling of that command and control and gives it to a whole new system that is so confusing that I would assure you, when you begin to hear the words and the acronyms associated with this new system, if you went up to any Senator and asked him or her a question about it, not one of them would pass the test of understanding every acronym—not even close. So the Senate bill benefited seniors. What we have before us is quite different.

To me, the saddest thing about this bill is that it turned a modest, but decent, benefit for seniors into an enormous benefit for the largest pharmaceutical companies and HMOs in America. Here is what we have now in the bill. This is what we have now. The bill benefits drug companies and HMOs.

First of all, the bill sets up a slush fund of $14 billion for HMOs. I have to say something here. The deficit that we are facing in our country today is nothing short of an abomination. From the minute this President took over until today, we have seen deficits as far as the eye can see and balanced budgets turn into $500 billion-a-year deficits every year. But the folks in the conference committee found $14 billion to give to those profitable corporations in America. Why do you think that is the case?

There is an article today in the Washington Post that tries to explain it. This is the headline on the front page:

> 2 Bills Would Benefit Top Bush Fundraisers. Executives' Companies Could Get Billions.

This is the selling of America. I want to quote from this article.

> More than three dozen of President Bush's major fundraisers are affiliated with companies that stand to benefit from the passage of two central pieces of the administration's legislative agenda: the energy and Medicare bills.

We stopped the Energy bill. I don't know how long we will be able to hold that, but the Energy bill is a clear-cut case. We talked about that the other day, and now there is the Medicare bill.

Continuing the quote:

> The energy bill provides billions of dollars in benefits to companies run by at least 22 executives and their spouses who have qualified as either "Pioneers" or "Rangers"—

That is what they call the big fat cats, Pioneers or Rangers——

> as well as to the clients of at least 15 lobbyists and their spouses who have achieved similar status as fundraisers. At least 24 Rangers and Pioneers could benefit from the Medicare bill—

Twenty-four Rangers and Pioneers, and those are the people who give the most money——

> could benefit from the Medicare bill as executives of companies or lobbyists working for them, including eight who have clients affected by both bills.

Talk about hitting the lottery. They benefit from the Energy bill and this bill. We know where the money is going. It is going out of the Federal Treasury to the fat cats. Face it. Unfortunately for the folks around here, we know now. We have it.

How about this?

> Hank McKinnell—

He may be a lovely man; this is not a personal attack on him——

> chairman and CEO of Pfizer, has pledged to raise at least $200,000 for Bush's reelection, although he is not yet listed as a Pioneer or Ranger. Pioneer Munr Kazmir, who runs a direct-mail drug company called Direct Meds Inc., estimates that he has about 100,000 customers on Medicare who will have more money to buy drugs from his company. "We know the patients, we know how important this bill is," he said.

Follow the money. Dress it up any way you want. Talk about how great this bill is. Follow the money. I hope seniors are watching this tonight. They will make up their own minds. They are calling my office. My phones are overwhelmed. What are they running on this? About 1,000 calls to 200 calls against this bill. For every 100 yeses, there are 1,000 nos. Seniors are smart.

They trust the AARP. Now they are finding out that the head of the AARP wrote the foreword to Newt Gingrich's book. Now they are finding out that the AARP gets 60 percent of their funds from selling insurance. Now they are finding out that the head of the AARP represented big drug companies. Follow the money.

There is a $14 billion slush fund for HMOs at a time when we don't have money to fully fund education. We can't fully fund education, but we can find $14 billion for a slush fund for HMOs. They don't call it a slush fund. They call it a few other names—a stabilization fund. They call it a stabilization fund.

Over 7 years, HMOs get $14 billion. This includes $10 billion in direct subsidies to HMOs handed out at the discretion of the head of the agency overseeing Medicare. How would you like to be that guy? At his whim, this bureaucrat can write checks to HMOs to bribe them to participate in Medicare.

In addition, there are nearly $4 billion of payments to the HMOs that already participate in Medicare just to bribe them to stay in Medicare. What kind of capitalism are we living in this country when we have to pay the private sector extra money when they went in the business in the first place? Things have changed. When I was a stockbroker, it wasn't that way. We didn't give corporations the kind of welfare we are giving them today. This is corporate welfare. Follow the money to the Presidential campaigns and you will get a very interesting story.

This $14 billion slush fund is particularly egregious when you consider that Medicare already pays HMOs more than the per-patient cost of traditional Medicare. Let me repeat that.

HMOs are getting paid more than the traditional Medicare. Do my colleagues know why? The overhead in Medicare is very small. Do we know exactly—is it 2 or 3 percent? Anyway, we do not pay CEOs millions and millions of dollars. They are taking that money right off the top and lining their pockets. Oh, but why not? They are nice people, give them $14 billion.

It is not that they are so great, these HMOs. People get the runaround. They do not get the care they need. People want their traditional Medicare.

Remember what I said. The bill I voted for in the Senate gave $6 billion to HMOs. I was not happy with that at all, but at least it gave $6 billion to traditional Medicare to help us do more prevention. Guess what happened. It is gone. The conference committee took it away. But they have added it on to the $6 billion already there. They added $6 billion that was going to go to Medicare. They put it in the HMOs, and they added $2 billion just in case it was not enough money for their friends.

Secondly, this bill benefits drug companies and HMOs. There is a gag rule on Medicare price negotiation. I talked a little bit about that before. Medicare has all of these clients. Think about the clout Medicare could have when they call a drug company and say that their drug X, Y, Z is a drug for arthritis and our patients like it; we are going to buy a lot of it for our patients; please give us a deal.

Oh, no, the conferees said, Medicare has a gag rule. Watch out. They may do it to the veterans next. The VA can bargain, but Medicare cannot bargain. The drug companies and the HMOs can bargain explicitly. They can bargain, and they can pocket some of the profits that they bargain, but not Medicare. Medicare cannot bargain. There is a gag rule on Medicare.

They will stand up on the other side and say: We are not trying to destroy Medicare; we think it is a great program. Just remember Newt Gingrich: Let it wither on the vine.

Seniors are expected to spend $1.6 trillion in prescription drugs over the next decade. By the way, there are a lot of pharmaceutical companies and a lot of wonderful research companies in my State. I have a great relationship with them. I support them getting an R&D tax credit; in other words, a tax credit for every penny they put into research and development. Why? Because I think that is important. I support their patents—reasonably support their patent rights. I support research through the NIH very strongly, and a lot of that benefits the drug companies as well. So I work very closely with my biotech companies, with my pharmaceutical companies, but, by God, I do not believe in giving them welfare.

Fourteen billion dollars? Is that because we have so much money? Is our deficit not big enough? It is only up to $500 billion in 2½ years or 3 years. Gee, we could do better. Why do we not make it $600 billion? Do I hear $700 billion?

I do not know what has happened, but it is not good. It took us 8 years to balance that budget. The other side said: We want a constitutional amendment to balance the budget. And our side said: Let's just balance it. Why do we need to amend the Constitution? Let's balance it. And President Clinton did that with us over 8 years.

Now it is gone. Now we have $14 billion to add to the deficit, and we are not going to let Medicare negotiate for us because, for whatever reason, they are tying Medicare's hand. I think it is because they want Medicare to wither on the vine. That is what Newt Gingrich said. That is the only thing I can come up with.

We know the cost of drugs could be lowered if Medicare negotiated those drug prices. One might say, well, maybe, Senator BOXER; that would be highly unusual for Medicare to negotiate with the drug companies. I would say, not at all. Medicare negotiates payments to hospitals. They have done that for years. When the bill left the Senate, there was no prohibition, but now there is. Why? Because they do not want the Medicare drug plan to be able to offer lower prices. They have given the right to negotiate to the private sector. They are going to push seniors into those plans.

Just remember where I started from. Just remember, "wither on the vine," and "follow the money." These are some simple concepts. At the end of my statement, just put a little ribbon and tie the bow and everyone will get the picture as to why we are going down a very dangerous path.

In this bill, we are going to be giving to HMOs payments above their stated cost to deliver service. Has anyone ever heard of anything like that in their entire life? A firm bids on a contract. They say: We can supply you with X number of widgets for a thousand dollars. On the dot, you get it. You deliver the thousand widgets, I give you $1,000.

Here, HMOs are saying: We can deliver health care for patients at a cost of X dollars per patient. In this conference committee, they said: Well, we are going to give them more money than they say they need. It is called a lot of different names, such as premium support. It is payment above and beyond what they said it would cost. So put together the slush fund and the payments above their cost of service and you are scratching your head, saying, maybe I ought to get into this business.

I say to people all over the country, small businesspeople who work hard in their business, be it retail or wholesale, you do not have a deal like this. You open up your doors, you go into business, and suddenly Uncle Sam is knocking on the door: Hey, I got a check for you HMOs, $14 billion over 7 years just to stay in the business; and, by the way, we love you so much, we are going to give you dollars above and beyond what you say it costs. And, by the way, no one will catch on. We are going to call these names different things. We are not going to call it a slush fund.

So the bill left the Senate. It was a good benefit, a decent benefit, but a modest benefit. It was not perfect, but at least it was a bill on prescription drugs. It came back a benefit for drug companies and HMOs. Somebody said to me there was a hostile takeover in the conference committee of the Medicare bill, that the Senate passed, by the HMOs and the prescription drug companies.

If we look at Wall Street, follow the money. Look at the prices of these stocks. They are going out of sight because people know this is a deal of a lifetime, that is for sure.

The last point I want to make is that this bill hurts our seniors. I am going to be specific. First, it hurts all our seniors, and in the end I am going to show you how it hurts my seniors in California, the largest State in the Union.

These are facts. We have gotten them from the staff that worked on this conference bill. Six million seniors will pay more for prescriptions than they do now. Let me tell you who these people are. Six million low-income and disabled beneficiaries currently receive prescription drug benefits from the Medicaid Program, which is a matching Federal-State program administered by the State. These programs are more generous in coverage than the proposed bill that is before us because they serve our very sickest Americans.

For example, a Medicare/Medicaid-eligible person in California can, but does not have to, pay a $1 per prescription copayment. The copayment is voluntary. A dollar may sound like zero, nothing, to people. But if you are an inch away from owning nothing, every dollar counts.

Under the conference bill the same person will now be required to make a copayment, maybe, up to $5. Some will pay premiums of $50 and be subject to a strict asset test. Studies have shown that even small copayments for prescription drugs can make essential medicines unaffordable for low-income seniors, resulting in an 88-percent increase in hospitalizations and deaths, and a 78-percent increase in emergency room visits.

So they say to my State, now you can't help these poorest of the poor. Sorry. They gave that a name, too, which we will get into later. They give it a nice name, but the bottom line is the people, the poorest of the poor, the States that help them can no longer help them once they get into this program.

The copayments to these poorest of the poor are indexed for inflation. So they can and they will go up. Remember, most of these people don't make any money. When you get hit with inflation and you are on a fixed income, that bites. That takes food off the table. So we know there will be an increase in hospitalizations. That was in the background information, that 88-percent increase in hospitalizations and deaths because people will not take their medicine.

States are prohibited from covering the out-of-pocket costs of these dual eligibles, and the bill prohibits States from establishing more expansive drug lists for the mentally ill, disabled, and other groups.

That is important. They may be taking a drug that isn't covered on this formulary.

I want to talk about people with AIDS. We have a high number in our State. People are suffering. Many of them are dual eligibles. They are eligible for Medicare disability and Medicaid. For them this bill is catastrophic. My phones are ringing off the hook with calls from them, their parents, their families. It is likely that they may not have access to or be able to afford all the drugs they need. So this is why this bill is opposed by the AIDS Medicare Project, San Francisco; AIDS Project, Los Angeles; Project Inform, San Francisco; San Francisco AIDS Foundation. But let's face it, it is not just AIDS patients who are going to be harmed. Anyone with a life-threatening illness runs the risk of not having coverage for the drugs they need. If they are denied coverage for these drugs under Medicare, they can appeal the decision, but this doesn't mean they can afford them.

So when it comes to my State, I will show you later the numbers of people who will be worse off. It goes in the hundreds of thousands—the hundreds of thousands.

Now there is a very cruel asset test. When I voted for the bill in the Senate that the Senator from Iowa worked so hard on with the Senator from Montana, that was a good bill. That bill would have allowed low-income seniors to receive assistance without forcing them to sell a car because it was worth over $4,500 or a ring that maybe was their most precious possession from their loved one or a family heirloom.

The conference bill imposes a Draconian asset test of $6,000 per person, $10,000 per couple, for the poorest of the poor. As a result, 3 million low-income seniors nationwide, and 300,000 in California, will be deprived of assistance that would not only help them with their prescription drugs but help them pay the premium so they could receive the coverage in the first place.

In other words, the bill that is before us has some generosity towards the poorest of the poor, but they have added an asset test into it so if you have a family heirloom or you own a car worth more than $4,500 or you have a diamond ring and a gold wedding band that your husband may have given you when you were married, you have to sell it. You have to get rid of it. Otherwise you don't get the benefit of this prescription drug benefit.

I don't get that. I am sad the conferees didn't go with the bill that most of us voted for in the Senate.

Now you come to seniors who are forced into demonstration projects that penalize them for staying in Medicare. That happens in 2010. You say we are just in 2003. We are almost in 2004—that is 6 years away, big deal. One thing I have learned, as long as I have lived, is that time goes fast. Six years will be here. If you are in one of those demonstration projects, what is going to happen is plain and simple: Your premiums are going to go up if you stay in Medicare—bottom line. Even though people say you are not forced into these other plans, the costs may force you into these other plans.

One in six Medicare beneficiaries will be forced to participate in this experiment. In California, 12 of its metropolitan statistical areas will qualify for these demonstration projects. Let's say two of the largest are chosen; one is in L.A. and the other is in San Francisco. So what we will have is my seniors in those areas will have to make a very tough choice. Do they stay in Medicare and pay more money or do they go into an HMO and lose the choice of their doctors?

We have already had some experimentation. We know the healthy people will choose the HMOs because they are cheaper. After all, they are healthy so they are not worried about getting messed up by an HMO. If they are not sick, you know, it is not a problem.

But the sicker seniors would be left in Medicare, and we know that we will see costs spiral out of control because there will be a sick pool of seniors, rather than spreading the risk, which is what insurance is all about.

Now we have a situation where premiums for middle and upper class people are going to go up. My colleagues say they are only going to go up if you earn $80,000 a year. I understand that is quite a bit. That is not that many people. But this is the problem. This number of $80,000 a year is not indexed for inflation. So it looks like it is a lot now, but in the future it will not look like it is that big.

For example, if this provision, the one that my colleague from Iowa supports, was in place in 1980, the equivalent level of income would be $33,000, and the person at that level would have to pay much more for their Medicare. So the fact is, they have done an interesting thing: They have not indexed this, so in the end you will have people of very moderate incomes paying huge premiums to Medicare.

Now what is going to happen? It will wither on the vine because people will say: I don't want anything to do with this. It is too costly. I don't need it. I will just go out and buy a catastrophic policy elsewhere.

I will tell you, if you take that fact, along with the fact that this bill sets up health savings accounts for the wealthiest people, you are going to have middle-income people and wealthy people walk away from Medicare, and you will lose the class you have when you have a larger pool. That is just a fact of life. That is why we have had a successful program—because insurance needs a very big pool.

I am going to put up a chart that I hope all of you who might be crazy enough to be watching this will remember. I know this isn't exactly prime-time television. But I want to show you a chart of "Fear and Confusion." This is a BARBARA BOXER homemade chart. This is the chaos and confusion that our seniors are going to be facing.

If any of you are watching this tonight, I am telling you to take note. I am telling you to call the AARP. Senator DURBIN gave you the number. I do not know it. I want you to take notes and ask them to explain each of these concepts they have endorsed in this bill. Then I want you to call everyone who votes for this bill, if this bill passes, and call your Senators and ask them to explain what all of this means. I am not going to tell you what it means tonight because we would be here all night. These are the terms that have been thrown around in this bill. You are going to have to understand this if you are going to understand what Congress is about to do to you. You will have to understand this.

Confusion and fear—some of them you know; HMO, you know that one. There is fear there, but it has nothing to do with the fact you don't know what Health Maintenance Organization stands for.

Risk corridors: I want you to learn what risk corridors mean; copayments, plan retention funding, MA-prescription drug plans, or MA-PD plans; donut hole. No, it is not what you buy in the store that is so good. I am on a diet. I haven't had one of them in a while. But a donut hole is something you had better understand because it is going to cost you when you get to it.

Here is another one: MA-Regions; catastrophic, premium support, assets test. I explained that one to you. That is one where you have to sell your wedding band, if you are poor, in order to qualify for getting your drugs free.

Average weighted premium; MSP, Medicare Secondary Payment; coordination requirements; initial coverage limit; CMS, you had better know that because the man who is the head of it is the one who is going to control the slush fund for HMOs.

Here is one which is kind of my favorite because I actually understand it: Claw back. That is a new word for you. That expresses what happens if you are a State and you have helped your poorest people pay for their Medicaid. You no longer can help them, but you can't keep the money. You have to send it to Uncle Sam. That is a claw back.

Transitional assistance, MSA. That stands for Metropolitan Statistical Area. If you are in one of those, you are forced into a demonstration project even if you do not want to be.

Benefit shutdown: This is one I know very well. After you buy a certain amount of drugs—around $2,000—you get a letter in the mail from your company that is giving you this drug benefit, and they say: Sorry, sir, your benefits shut down until you go past $5,100. Benefit shutdown is not a good thing.

Risk adjustment premiums—you all know what that means; Part D, income relating, SA-wraparound; national bonus payment. But don't get excited. It doesn't go to you. Comparative Cost Adjustment Program; Stabilization Fund—that sounds as if it is a good thing. If you are an HMO, that is the money you get to keep you in business.

I tell you, if something happens to me and I am not back here after my next election, which could happen to anybody, I am going to consider helping one of these big HMOs. I understand half of this. I may help them.

Medicare advantage competition, wraparound—we did that—MA-regional plans; MA-prescription drugs; annual out-of-pocket threshold. Watch out for that one. Annual out-of-pocket threshold is what you have paid for your drugs out-of-pocket before you can get the benefit. However, if your drug isn't on the formulary, it doesn't count. So don't count on it too soon.

Return disclosure: This has to do with your tax return. You are going to have your tax return sent to the IRS from the Health and Human Services Department if you are an upper income senior. They want to know what you earn. Before, Medicare never asked that because it is an insurance program. Now, do you know in this bill that the people who do not like taxes are making sure the IRS receives from the Health and Human Services Department information about your tax return?

Deductible: Again, very tricky. You have to understand that.

PDP sponsors, Prescription Drug Plan sponsors; monthly benchmarks. I am not sure about that one myself. But monthly benchmarks, we have to be careful about those.

Fallback: The fallback is in the prescription drug plan. In the Senate bill that I voted for, if you didn't have two plans come in to compete, you could always fall back to Medicare. Now it is basically one plan.

I told you about fallback. I went over all of it. MSP; average weighted premium—I think I pretty well went over this; coverage gap; plan retention funding.

The way I have done this chart, it looks kind of chaotic. It is to make a point. I don't even have half of the terms that are in this bill. I am going to work on this so that after the cloture vote when we have a little more debate, I will be able to get a better list.

But there is no secret why seniors are calling up our offices. They are smart. They are the smartest folks around. They have lived a long time. They are smart. They know what Newt Gingrich said: Let it wither on the vine. And then he endorses this. They weren't born yesterday.

The one thing I was interested in with C-SPAN is the people who were calling were Republicans and Democrats, and they all sounded alike. One out of 10 said they liked the deal. So this bill hurts seniors. We know that for sure.

Confusion and fear, large benefit shutdown, which is daunting and penalizes innocent seniors.

I told you before. You get to a certain point, and your benefits stop. A couple of thousand dollars, and then it starts up again at $5,000. Name for me one other drug program that does that. I checked it out. There are hundreds of them. Maybe there was one other that had a small benefit. I have never seen it. We don't have that in our plan. We just go in the pharmacy and give them our Senator's health card. We get a good deal. They never shut us down. Why should we shut you down? It is a bad thing. It is not right. If I was a local pharmacist, I would say to my seniors, I can do better than this plan. Come into my store, buy your drugs here, and I will give you a discount card.

Seniors will have to worry about filling out this form, filling out that form, is this drug on the formulary, and so on—fear and confusion. The bill hurts seniors.

Now we will look at what it does to my State's seniors. This is the direct impact on my State's seniors: 867,000 sick low-income seniors will have worse Medicaid prescription drug coverage. Boom. This starts in 2006 when 867,000 sick low-income seniors will have worse Medicaid prescription drug coverage than now.

Mr. President, 250,000 retirees will lose their more generous prescription drug coverage even after we give payments to the employers. I supported that. That was a good move. But even with that, they are dropping coverage once they know their retirees have another option. Wait until those people get the clue that is happening.

Years ago we passed a catastrophic medical bill and I remember seniors were attacking Congress people. Wait until they hear they get dropped—retirees who worked all their life, who like their plan and they get dropped. They do not have a choice. If they want prescription drugs they have to come with this plan. Wait until they have to deal with benefit shutdowns.

Mr. President, 296,000 fewer low-income seniors will qualify for low-income protections than under the Senate bill because of the assets test that I talked about and lower-qualifying income levels. The poorest of the poor—when compared to what we did in the Senate, the bill I voted for—are worse off. These numbers are huge because I represent a big State. And 230,000 Medicare beneficiaries will pay higher Part B premiums because they are upper middle income and wealthy. That will happen to them.

Also, because they are in the MSA or metropolitan statistical area, that demonstration project, 1.4 million could be forced into them as we projected because we have the big metropolitan areas, or be penalized for staying in traditional Medicare because the people who are healthy will go into those private plans and the people who are sick will stay in Medicare and the costs will go up.

We have fear and confusion. I don't know how many of these figures are double-counted, so I cannot just add them up. Some of these figures may fit into more than one category, but I can state with certainty a couple of million of my 4 million people on Medicare are going to be worse off with this bill, much worse off. That is a very bad thing to do.

I don't know where the votes are. I think they have the votes to pass this. But if seniors across this country got a couple of days—there are about 48 hours to pick up your phone, call your Senator and say: Senator, maybe you are right. But this thing is confusing. I am fearful. Give me a little more time.

The bill was just printed and we saw it for the first time the day before yesterday. This bill is bigger than I am, and we got it the day before yesterday.

I have shared some of the new bureaucratic "wordspeak" in the bill and I have just had a couple of days to look it over. At the least, we should say to our colleagues, put this thing off. We are going to come back in January. This Congress goes 2 years. That is the beauty of it. If it was next year, the legislation would die. But we have 1 more year of this session. What is the rush? Tell your Senator, maybe Senator BOXER is wrong when she says this will hurt me. I am not sure, but she has raised some issues.

Change, if it is positive change, is something we all want. But change could be negative, could be disruptive, could cause us to be confused or fearful. What is the problem in taking a little while longer? To be honest, I would love to have the Christmas holiday recess to read every line of this bill. I started to do that. That is how I came up with all of these words, by reading the bill and trying to understand all of this. I did not even scratch the surface.

This Senate voted down an Energy bill which I felt, frankly, was in many ways a giveaway for a lot of special interests. And the good that was in it—and there were good things in it—was outweighed by the special interest provisions. We should be here for the public interests, for the people we represent.

I remember one of my colleagues saying to me, when someone asked a question about oncology, because there has been some concern about how the oncologists are being treated—someone in the room said, just look, there is a company being traded, a health care company that deals with oncology, and the stock is shooting up. It must be that oncologists are being treated fairly.

I used to be a stockbroker. It is not of any interest to me to do things that make the stock of a company go up. Do you know what I want to go up? The stock of the American people, the lives of the American people, the quality of life of the American people, the quality of life of grandmas and grandpas and their families.

This is truly not a partisan issue. It is an issue of how do we give a prescription drug benefit to our senior citizens and keep Medicare strong and not make this bill a giveaway to the largest HMO and pharmaceutical companies and insurance companies in the country. They are doing very well. This debate has been a good debate so far. We have serious disagreement. I am sure I will be back in the Senate after we have a cloture vote, one way or the other, just to add more terminology to my fear and confusion chart.

I know my colleagues on the other side of the aisle are waiting with bated breath to see my next version of this fear and confusion chart because I know they understand every single one of these terms. It is interesting to look at these terms and to realize how far reaching and how bureaucratic this new bill is.

I will say one last thing and then I will leave the floor, much to the delight of the Senator from Iowa and the Senator from Montana. I say to any senior citizen, any human being who is within the reach of my voice, and there may be a few at this late hour, if you feel we need more time to see whether Senator BOXER is right or Senator GRASSLEY is right or Senator BAUCUS is right or Senator KENNEDY is right or Senator DURBIN is right or Senator HATCH is right, if you think you need more time to take a look at this bill, to get this bill analyzed, this bill that weighs a lot, this bill that is over 600 pages, call your Senator, e-mail your Senators and tell them to take some more time, to put this thing over until after the first of the year and we can come back here and have the whole year to work on this bill, which is really rewriting the Medicare Program.

Thank you very much, Mr. President. I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I think the place for me to start is where the Senator from California left off; that is, the impression that is left that this bill is going to confuse the seniors of America, and almost that the purpose of it might be to confuse seniors.

But let me make very clear to all the seniors who are listening, and everybody else who is listening, one of the keystones of this legislation is to say to the seniors of America: If you do not want to do anything, if you do not want anything to do with this, you do not have to have it. This is strictly voluntary.

For any senior in Iowa or California who comes to their respective Members of Congress and says: Congressman so and so, or Senator so and so, just leave my Medicare alone; I am satisfied, each of us can say to them: If you do not want to worry about all this that we are talking about—prescription drugs or anything new about Medicare—you do not have to because you can keep traditional Medicare as you have known it for the last 35 years. Just keep it as is, if you are satisfied with it.

But for those who might not be satisfied, we give them several options. They have a right to choose. They have a right to keep traditional Medicare with a prescription drug program that they can choose to go into, or they also have the right to choose a new Medicare—preferred provider organizations—that is very close to what baby boomers now have in the workplace. They can choose that with an integrated drug benefit plan.

So we are not trying to confuse anybody. We are trying to give seniors the right to choose. We are trying to give seniors who are totally satisfied with what they have right now an opportunity to just stay where they are right now. It is the right of seniors to choose.

I think I better be very clear because so much of the opposition to this bill today has come from the other side of the aisle, mostly Democratic Members of the Senate.

We are here today with a piece of legislation because over the years 2001 and 2002—after Senator JEFFORDS switched from being a Republican to being an independent and casting his lot with the Democrats, so they were a majority during the remainder of 2001 and all of 2002—there was an effort early on to develop a bipartisan approach to a drug benefit during the last Congress.

When that was developing, there was a fear that there might be a bipartisan bill reported out of the Senate Finance Committee, a year ago, and the then-majority leader, now the minority leader, Senator DASCHLE, decided that this was an issue that ought to be brought to the Senate floor, not worked out in committee.

Remember, you develop bipartisanship in the Senate in the committee. You do not do it very often here on the floor of the Senate. You build coalitions.

Remember, nothing gets done in the Senate that is not bipartisan—unlike the House of Representatives, where partisan things can be done—because, remember, the Senate of the United States is that only institution in our political system where minority rights are protected.

So a year ago, the then-majority party decided that this ought to be debated on the floor. But they also knew that it would be impossible to get the bipartisan majority that it takes to get things done. They gambled that they needed an issue for the last election rather than a product. They gambled on an issue that we would not do anything last year, and the way they maneuvered this, nothing was done because nothing in a partisan way, even by majority Democrats, can be produced out of this body that is not somewhat bipartisan.

Then there was an election, and they found out that issue did not work for them; that Republicans were put in a majority. This gave, in this new majority, in this new Congress, Senator BAUCUS and I, the top Democrat and the top Republican on the committee, an opportunity to do our magic and put together a bipartisan bill. That bill came to the Senate floor and was passed 76 to 21. It went to conference, and came out of conference in a bipartisan way. And we are here because the majority Republicans and some sensible Democrats want to produce a product and not have an issue for the next election. I happen to think, from the comments I have heard today—all the fault that can be found with this bipartisan product—that there are still too many people on the other side of the aisle who have not learned a lesson: No. 1, how do you get anything done in the Senate? It has to be bipartisan. And, No. 2, they did not learn from the mistakes of the last election when they thought they needed an issue. Do they think if it did not work in 2002, it is going to work in 2004?

So that is why we are where we are because there are Democrats who know that you do not get anything done in the Senate if there is not a bipartisan coalition. There are Republicans who have understood that for a long period of time.

So that is background to what I want to tell the people of America and my colleagues about why this bill should be adopted. During this process, I am going to correct some of the statements made by my colleagues so far today.

I want to correct what my colleague from Iowa said earlier about this bill's impact on rural America and on our State of Iowa in particular.

The rural health provisions of this bill go further and wider than any other legislation that this Congress has ever considered. It enjoys the strong support of the Nation's doctors and hospitals, and it is also strongly endorsed by the Iowa Medical Society and by the Iowa Hospital Association, two of the strongest advocates for rural equity in my State and my colleague's State.

I will read an excerpt from each and then ask unanimous consent that both letters be printed in the RECORD.

This is from the Iowa Medical Society president, Tom Evans, M.D.: "[P]assage of the bill," meaning the bill before us, "is critical for rural states like Iowa." "He said: "In addition to providing seniors with prescription drug coverage"—and I want to emphasize this part of his statement—"this legislation fixes many of the reimbursement issues that have unfairly penalized rural States. Congress must pass this legislation before the Thanksgiving [Day] recess."

Now, I go to the Iowa Hospital Association, which in 2001 circulated statistics, already referred to, showing Iowa in last place in per-beneficiary spending. The Iowa Hospital Association: "The Iowa Hospital Association strongly endorses passage of this legislation." "In an evaluation of the per-beneficiary increase, this legislation provides Iowa hospitals with the second largest percentage increase per Medicare beneficiary of any state in the Union. This amounts to a per-beneficiary increase of $583, which is the thirteenth highest increase of any state in the Union.

Mr. President, beyond those quotes, I could give a lot of evidence, but I think those quotes speak volumes about our rural package. That package in this legislation speaks for itself. It brings real improvements and equitable payments to hospitals and doctors in Iowa and way beyond.

I ask unanimous consent to have these letters printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

IOWA HOSPITAL ASSOCIATION
Des Moines, IA, Nov. 20, 2003.

Hon. CHARLES GRASSLEY,
U.S. Senator, Hart Senate Office Building Washington, DC.

DEAR SENATOR GRASSLEY: Congratulations in reaching an agreement on a conference report that directly and significantly impacts the issue of equity and fairness for hospitals and physicians in rural America and particularly for Iowa. Just this morning, the entire Iowa Hospital Association Board was briefed on the impact of your Medicare legislation and on a unanimous vote endorsed the pending legislation.

In an evaluation of the per-beneficiary increase, this legislation provides Iowa hospitals with the second largest percentage increase per Medicare beneficiary of any state in the Union. This amounts to a per-beneficiary increase of $583, which is the thirteenth highest increase of any state in the Union.

The Iowa Hospital Association strongly endorses passage of this legislation and will today ask its entire membership to weigh-in on behalf of the legislation with the entire congressional delegation of Iowa in an effort to support your work to achieve passage of this legislation before the Thanksgiving holiday. It is our hope that when Congress completes its work and you return to Iowa for the holidays, that all Iowa providers will have an opportunity to congratulate you for successful passage of this historic legislation.

Sincerely,
KIMBERLY A. RUSSEL,
IHA Board Chair.
KIRK NORRIS,
President/CEO.

IOWA MEDICAL SOCIETY STRONGLY SUPPORTS PASSAGE OF MEDICARE REFORM LEGISLATION

The Iowa Medical Society (IMS) announced today its strong support for the Medicare Prescription Drug and Modernization Act of 2003 conference report.

IMS President Tom Evans, MD, said passage of the bill is critical for rural states like Iowa. "In addition to providing seniors with prescription drug coverage, this legislation fixes many of the reimbursement issues that have unfairly penalized rural states," he said. "Congress must pass this legislation before the Thanksgiving recess."

Evans said the bill protects Iowans' access to physicians by replacing a 4.5 percent payment cut scheduled for 2004 with two years of modest payment increases. The bill also fixes a component of the reimbursement formula that deals with geographic practice cost adjustors that causes huge reimbursement swings from state to state.

"If this legislation isn't passed, the American Medical Association estimates that a 4.5 percent cut in reimbursement will take $30 million away from Iowa's health care system in 2004," he said. "Now add to this the fact that Iowa already receives among the lowest payment rates in the country, and you can see how Medicare is threatening our ability to care for our patients."

Evans also thanked Senator Charles Grassley for his work on this bill as Chair of the Senate Finance Committee, and he urged Iowa Senator Tom Harkin and Iowa's Congressional Representatives to support the Medicare conference report.

The Iowa Medical Society is the professional association representing over 4,600 MDs and DOs. The IMS core purpose is to assure the highest quality health care in Iowa through its role as physician and patient advocate.

Mr. GRASSLEY. Now let me speak to what this bill does for Iowa's seniors. The bipartisan agreement provides all of the 485,042 beneficiaries in Iowa with access to Medicare prescription drug benefits, as I have stated previously, on a voluntary basis. It does it for the first time in the history of the Medicare Program. That begins January 2006. Beginning in 2006, the bipartisan agreement will give 142,297 Medicare beneficiaries in Iowa access to drug coverage they would not otherwise have and will improve coverage for many more.

Within 6 months after this bill is signed—in other words, during the year 2004—Iowa residents will be immediately eligible for Medicare approved prescription drug discount cards which will provide them with savings between 10 percent and 25 percent off the retail price of most drugs. Beneficiaries with incomes of less than $12,123, or $16,362 for couples, who lack prescription drug coverage, including drug coverage under Medicaid, will get up to $600 in annual assistance to help them afford their medicine along with a discount card. That is a total of $100,840,345 in additional help for 84,034 Iowa residents during these years of 2004 and 2005, as this interim program is in place, helping Medicare recipients with drugs until we get the permanent program put in place. Then beginning in the year 2006, all 485,042 Medicare beneficiaries living in Iowa will be eligible to get prescription drug coverage through a Medicare approved plan.

In exchange for a monthly premium of about $35, seniors who are now paying the full retail price for prescription drugs will be able to cut their drug costs roughly in half. In many cases, they will save more than 50 percent on what they pay for their prescription medicines. One hundred thirty-three thousand beneficiaries in Iowa who have limited savings and low incomes—and this would generally be those below $12,000 for individuals and $16,000 for couples—will qualify for even more generous coverage. They will pay no premiums for their prescription drug coverage, and they will be responsible for a nominal copayment. That copayment would be no more than $2 for generic drugs and $5 for brand name drugs.

We have 41,300 additional low-income beneficiaries in Iowa with limited savings, and incomes below $13,500 for individuals and $18,000 for couples, qualifying for reduced premiums and a reduced deductible of $50 and a Medicare that will cover 85 percent of their prescription drug costs with no gap in coverage.

Additionally, Medicare, instead of Medicaid, will now assume the prescription drug cost of 50,000 Iowa beneficiaries who are eligible for both Medicare and Medicaid. These seniors generally will pay $1 and $3 per prescription and those in nursing homes will pay zero dollars for their prescriptions. This will save Iowa $175 million over 8 years on prescription drug coverage for its Medicaid populations.

I have tried to address for my colleagues, but particularly for my residents and constituents in Iowa, how this program will impact them as individual beneficiaries of the prescription drug part of our bill. And I have tried to inform my colleagues and my residents of Iowa how the rural equity package will help provide quality care for Iowans because we are increasing the reimbursement for our hospitals and for our doctors in rural America.

Now I will address several of the most egregious misconceptions about the bill that have been spoken on the floor of the Senate today. First, I will address the issue of protecting retiree drug coverage. This would be those people who, have, for the most part, coverage from places where they used to work that also continue to cover people with health benefits and prescription drugs after they leave employment.

During the debate on S. 1, when this bill passed the Senate the first time in June of this year, it passed by a 76-to-21 bipartisan vote. At that time, even though we had that high bipartisan majority, my colleagues raised concerns about what they referred to as the high level of employers that would drop their retiree prescription drug coverage should we enact the prescription drug benefit into the Medicare Program.

At that time, the Congressional Budget Office told us that 37 percent of the seniors who have drug coverage—that is roughly one-third of the seniors under Medicare—would lose that coverage if we passed the bill. I think I ought to say that there was another group, the Employer Benefit Association, that studied the same issue and said it would be 3 percent to 9 percent who would lose coverage. So we probably have an intellectually honest difference of opinion by the Congressional Budget Office on the one hand and the Employer Benefit Association on the other hand. But we in the Congress are stuck, as we determine the cost of programs, with what the Congressional Budget Office says. We would rather—and it would be easier—if we could just go by what the Employer Benefit Association says, but we go by CBO because they are God when it comes to saying what something costs. So we had to live with that 37 percent.

Well, as we all know, however, employers have been dropping or reducing prescription drug coverage for many years. So this is really nothing new. If we were not even talking about this bill today, some board of directors of some corporation in America could come to the conclusion that they couldn't afford to cover their retirees anymore and drop them. What could Congress do about that? Nothing. But it is nice to have a program when that happens for people to fall back on. That is one of the reasons for this legislation.

Of course, we want to take care that we can do everything possible to make sure that corporation X doesn't do that. In just the past 2 years, retiree health care coverage has dropped by 22 percent. That was with this Congress not doing anything, not considering this legislation.

We know these days employers are finding it harder and harder to continue to voluntarily provide health insurance coverage. That is due to a lot of factors, including rising health care costs overall. Now, as we were in conference between the House and the Senate, we took this marketplace dynamic of company XYZ, ABC, or whatever corporation—that they could do this. This is a dynamic we had to take very seriously. So we went to great lengths to improve employer participation in drug benefits to keep employers in the game; to keep their retirees covered, as retirees would expect to be covered, but sometimes they are surprised when they are not.

Our conference report reflects this. It includes remarkably better policies for employers than those that were in either the bill that passed in the Senate 76 to 21 or that passed the House in June as well. So I am saying to you we brought back a conference report that was better in regard to employee-retiree coverage than either passed the Senate or the House in the first place.

So what happens when we do that good work? The policies in this conference report have led to major corporate plans endorsing our conference report. So the people on the other side of the aisle, with their charts, who are saying bad damage is being done by this legislation, what would they have us do? Pass nothing? If corporation X decides to drop, and there is nothing there for their employees, do you think those same people are better off if Congress does zilch? Where were they when they voted in the first place, complaining about S. 1 or H. 1, the House bill, when we passed them in June?

Here we are bringing back a conference report that is being endorsed by these corporate plans. Doesn't that mean anything to any of you? Under this conference report, employers will be given an enormous amount of flexibility and options—employers that already provide retiree benefits beyond Medicare coverage. This legislation will help make it more affordable for these employers to continue providing these benefits. We do that by a direct subsidy worth 28 percent of their drug spending between deductibles and the coverage gap.

I should add, too, this conference report makes this 28 percent completely excludable from taxation, so that instead of doing 65 percent good because of a 35 percent tax bracket that corporations are in, it does 100 percent good, bringing down the number of people who might lose coverage.

Now, some people would say, what is this corporate welfare all about—Congress giving money to corporations to do something they have been doing forever. Some people might say, well, when you buy a Chevrolet, you pay for these retirement plans. How many times do you have to pay for them? You pay for them when you buy a car and when you pay a 28 percent subsidy. We are cautious about the fact that some do that.

So I tell my colleagues over there—each of them who are complaining about this—this 28 percent subsidy is something you ought to be glad to have. Sometimes when we give corporations something, you condemn us for giving corporations something; but you cry when we do it and you cry when we don't do it because they might dump their retirees. In the final analysis, we are also doing it to protect the taxpayers and the Medicare Program because it is better to encourage these employers to keep their retirees in these plans at a 28 percent subsidy, which is about $750 per person, instead of having those corporations dump those plans on the Medicare Program, and it is going to cost about $1,250. So that is why we do that.

Now, besides this 28 percent help, we also say that employers can use the flexibility this legislation provides to structure plans that complement Medicare's new drug benefits and provide them even enhanced benefits for their retirees. They can even do better than they are presently doing because of this flexibility we have in the legislation.

These new choices and options will do much more to help and, consequently, not threaten employer-sponsored health care coverage for those who currently receive it.

In fact, the Congressional Budget Office now estimates that the so-called drop rate—in other words, the rate by which corporations will drop their retirees—is now 17 percent because of the changes that were made in conference. In other words, we listened to our colleagues over there complain about a 37 percent potential drop rate because of the way S. 1 was written. But it goes to conference and it comes back from conference with, instead of 37 percent, 17 percent, and you folks are still complaining. I don't understand it. And these 2.7 million retirees will still be better off with Medicare coverage, likely paid for by their former employees. In other words, the 2.7 million people who would have been dropped, according to CBO, because of what we did in the conference—that is better than either bill when first passed in June; 2.7 million people are still going to be in their corporate retiree plan.

So I say to my colleagues—I hope you hear this—we have come a long way since June, when 76 people, in a bipartisan way, voted for this. Half of you over there voted for it. I believe company plans have a lot to be happy about under this conference agreement.

All seniors deserve health care benefits. All seniors deserve access to prescription drug programs. This compromise between the House and Senate provides that, and it makes certain that good sources of existing coverage remain intact. I urge my colleagues to embrace the strong employer provisions we have agreed to and vote for this conference report.

We have also heard from a lot of them over there that somehow we are trying to privatize Medicare. How many times do I have to say it? This program is voluntary. Nobody has to go into anything in this bill if they don't want to. If they want to keep traditional Medicare, keep it. But this issue has been brought up. Do you know why? Because these folks over there, my colleagues over there—every one of them—like to scare seniors. You know, it is called Medicare, but you like to make Medicare into "medi-scare."

You know, it is easy to scare seniors. I have my town meetings around Iowa. I hold town meetings in each of the 99 counties every year so I can keep in touch with my constituents. There are people—the older, the more so—but seniors come up to me and they actually believe what is said on that side of the aisle when people say somebody is going to take their Medicare away from them. They believe that "medi-scare."

They are really nervous. Some of them even have tears in their eyes. I tell them, if you just knew as seniors how you have a hook on Congress, that Congress is scared to death of you, you would be laughing at me instead of being scared of something we might do. That is how the concerns of the seniors of America are taken into consideration by people in the Congress of the United States.

Maybe we ought to have a little more of an independent view than be so concerned about the electoral power of the seniors, but they have tremendous influence on Congress. Maybe some people say too much influence. Regardless, it is wrong for people over here to "medi-scare" our seniors.

I wish to address this issue of privatization, but the easiest answer is that if you are satisfied with what you have—traditional Medicare—don't worry. Also, if you like other provisions in this bill, they are voluntary. You don't have to do them.

This bill before us today brings Medicare into the 21st century practice of medicine. It does not privatize traditional fee-for-service Medicare. Overall, this conference agreement relies on the best of the private sector to deliver drug coverage, supported by the best of the public sector to secure consumer protections and important patients' rights. This combination of public and private resources is what stabilizes the benefits and helps keep costs down.

Seniors will be able to purchase prescription drug coverage on a voluntary basis as part of Medicare's traditional fee-for-service program or be part of a new Medicare-approved private plan where the drug benefit is integrated into broader medical coverage. These Medicare-approved plans have the advantage of offering the same benefits of traditional Medicare, including prescription drugs, but on an integrated, coordinated basis. This creates new opportunities for chronic disease management and access to innovative new therapies.

Let me comment on chronic disease management. That is very important if we are going to keep costs down in the future. We won't have to squeeze seniors at all. In fact, seniors will have a better quality of life under chronic disease management because 5 percent of the seniors are responsible for 50 percent of the cost of Medicare. The reason for that is that we only pay doctors to make people well after they get sick. We never pay enough to keep them well in the first place.

We can concentrate on this 5 percent in chronic disease management, and by so doing, we are going to provide a better quality of life because they will not be in and out of the hospital as much, and we save money there. But also their quality of life is going to be better, and it protects the taxpayers in the process and preserves the longevity of Medicare.

Unlike Medicare+Choice, we set up a regional system where plans will bid in a way that doesn't allow them to choose the most profitable cities and towns. Cherry-picking cannot take place. Systems like this work well for Federal employees, such as the postmaster in New Hartford, IA, my hometown. He has a choice of several plans. We want to give that same choice to his parents who today only have traditional Medicare. They have no right to choose.

We provide an alternative plan for people who want to try something new, something that is probably close to what baby boomers have for health plans where they work. We have set up preferred-provider organizations. Are they right for everyone? We give seniors the right to choose. Our bill sets up a playing field for preferred-provider organizations to compete for beneficiaries. We believe preferred-provider organizations can be competitive and offer a stronger, more enhanced benefit than traditional Medicare, assuming seniors want to choose that. They have that choice.

Let me be clear, no senior has to go into a preferred-provider organization. My policy has always been to let seniors keep what they have if they like it with no changes. All seniors, regardless of whether they choose a PPO or not, can still choose prescription drug coverage if they want to, to go along with their traditional Medicare, but it is their right to choose.

I can't mention preferred-provider organizations without correcting the record regarding the preferred-provider organization stabilization fund that the other side has called a slush fund. It is no slush fund. It is something that those of us who live in rural America know we have to have. We learned a lesson from Medicare+Choice because in 1997, I worked hard to bring greater reimbursement to rural America through Medicare+Choice so that people in Iowa would have the same options that 40 percent of the people in Miami have chosen: to go into an HMO. It is a voluntary choice. If they don't like it, they can get out tomorrow. Get in today; get out tomorrow. In rural America, we enhanced greatly the reimbursement for them, but they have not come because of cherry-picking.

We want the preferred provider organizations to serve all of America, rural as well as urban. The stabilization fund is so those of us in rural America have an opportunity to get the same benefits as people in New York City or Los Angeles or Miami.

The bipartisan agreement on a final Medicare bill establishes this stabilization fund. It was not in the Senate bill. Some people say the Kyl provisions were similar to that, but Senator KYL will tell you he had a whole different idea in mind. His idea is not even in this bill, but we did take a stabilization fund to accomplish something he wants to accomplish. He wants his entire State of Arizona to be served by PPOs, not just Phoenix. We did this in an effort to expand access to private health plans in all areas of the country and, additionally, to maintain existing health care choices in areas where health plans face particularly difficult challenges.

My colleagues on the other side who find fault with this conference report are always talking about this slush fund as benefiting some organization's profit motive.

Every one of them has rural areas. My colleagues ought to want the people in the rural parts of their State to be served the same way as people in the urban parts of the State.

The reality is that this is not a slush fund, but it is to help beneficiaries have equal services, whether they live in rural America or urban America, and that will be helped by this stabilization fund. It is targeted and its plans are held accountable. Resources will be distributed from the stabilization fund only when specific conditions are met. Moreover, in instances where these conditions are met, then health plans will be accountable for using these funds only to promote affordable health coverage to beneficiaries, not for profit. Under no circumstances will plans then be permitted to use these funds to pad their bottom line.

It expands choices and ensures access in rural areas. The fund is designed to expand and preserve beneficiary choices and benefits in areas where it is most difficult to provide private health plans and to get them to participate in this program.

The stabilization fund will ensure that millions of additional beneficiaries, including many in rural areas, will have access to health plans offering high quality, comprehensive benefits, and low out-of-pocket costs. If the stabilization fund is not successful, the worst case scenario is that the funds will be returned to the U.S. Treasury.

Now I will speak about the accurate explanation of how this bill helps low-income seniors. We did something in the conference report that the House did so the Senate receded to the House on this point, and that is where we in the Senate decided to leave dual eligibles who were covered by Medicaid. That is the way it passed the Senate. The House wanted to have one program for seniors, a totally Federal program, so dual eligibles in the House bill were taken away from Medicaid and put in Medicare. We accepted what the House wanted to do, as a matter of equality I suppose. We had other motivations for doing it in the Senate.

In fact, most of the support for doing that—that was one of the shortcomings that Democrats said about the Senate bill in June. Now we are hearing complaints from them about aspects of this dual eligible, how it impacts seniors, particularly on asset tests. That is one of the reasons we tried to avoid putting dual eligibles under Medicare in the Senate bill, because we wanted asset tests to be the same for this group. Now they are complaining, I think inaccurately, which I will prove in a minute, about it negatively impacting people with less coverage than they presently have.

We have heard from the other side how 6 million low-income eligible seniors will be worse off under this conference report. That is inaccurate. It is a lot of talk, and I want to tell the American public the truth about this issue. Beneficiaries are not hurt by this bill. They are helped. This bill provides generous predictable coverage to 6.4 million dual eligibles, but it does not stop there. It provides coverage to an additional 7.7 million low-income seniors. Madam President, 14.1 million seniors are eligible for low-income subsidy, nearly 36 percent of Medicare beneficiaries.

So who are these dual eligibles? They are the 6.4 million who are enrolled in both Medicare and Medicaid.

This conference report for the first time provides drugs to dual eligibles through Medicare rather than Medicaid. This is a great help for the States that have budget problems, and Medicaid is a growing, biggest part of State budgets.

As I said, the Senate bill left dual eligibles in Medicaid. That policy allowed the Senate to provide generous coverage for low-income seniors. S. 1 focused on providing drug coverage to seniors who did not have any coverage whatsoever, and duals did have that coverage. So in the spirit of compromise, the Senate conferees changed the policy in the Senate bill.

The conference report provides prescription drugs for dual eligibles through Medicare. It is not exactly the same, but in general policy it is the same way they were treated in the House bill. Providing drugs for dual eligibles through Medicare was a cornerstone issue for House conferees.

The conference report covers duals in the Medicare Program. The coverage is designed to benefit as many low-income seniors, including duly eligibles, as possible, given the budget constraints of $400 billion in our budget.

This bill comes out at about $395 billion. Blanket statements about the reduction of benefits for the dual eligibles in the conference report are not accurate. We have heard some of those inaccurate statements this Saturday as we have debated this bill. This bill is generous and does not leave 6.4 million seniors worse off. I will bet tomorrow those over on the other side will be putting those signs up again that say that. Well, don't do it.

For instance, unlike the Senate bill or the current Medicaid Program, the conference agreement does not have cost sharing above the catastrophic limits for the dual eligibles. That is right. There is no cost sharing. I hope my colleagues on the other side get that.

I will put this in perspective, then, from the State level. According to the Kaiser Family Foundation, the Commonwealth of Massachusetts currently charges $2 for every prescription filled by dual eligibles. There is no catastrophic limit for duals in that Medicaid Program in that State, just a requirement for beneficiaries to pay $2 for every single prescription.

Like many Medicaid Programs, this bill establishes copayments for a majority of the dual eligibles who are either equal to or less than those required by most State Medicaid Programs. So let's get that straight. These copayments are no more than, and in some cases less than, those required in most State Medicaid Programs.

More specifically, today 25 States have copayment levels for generic and brand-name drugs set at $1 or higher for dual eligibles enrolled in their Medicaid Programs. In this conference agreement, dual eligibles with incomes below 100 percent of poverty will be responsible only for a copayment between $1 and $3 for their Medicare drug benefit. Taking a step back, it seems to me that this level of cost sharing is very similar to what the duals pay for in Medicaid coverage.

In fact, in South Dakota, duals pay $2 per prescription. That policy is on par with the coverage offered through this bill. This conference report contains a generous drug benefit, then, for dual eligibles. There is no donut, or no loss of coverage, no gap in coverage, for low-income Medicare beneficiaries. But my colleagues on the other side would lead us to believe otherwise.

The bill guarantees all 6 million dual eligibles access to prescription drugs. Under the conference report, dual eligibles will have better access through Medicare than they do today, specially since State Medicaid Programs are increasingly imposing restrictions on patients' access to drugs because of budget problems that 45 of our 50 States have.

Further, States have the flexibility to provide coverage for classes of drugs, including over-the-counter medicines that might not even be covered by the Medicare Program.

This bill ensures appeal rights for dual eligibles. Under the agreement, duals will maintain appeal rights, such as those that they presently have in the Medicaid Program. The dual eligibles are a fragile population and are well taken care of in this bill. The conference report recognizes and provides generous coverage to these 6 million beneficiaries and in fact goes further by providing full drug coverage to 7.7 million more low-income seniors.

So I turn now to highlighting what this bill does to protect Medicare in the long run. I have heard some Members trying to assert that this $400 billion expansion of one of the most successful social programs in our country's history is going to destroy traditional Medicare; you have said it, "Medicare as we know it." That is another one of your "medi-scare" tactics.

I know Members are tired. I know we are nearing the closing of our first session of the 108th Congress. Many Members are using these wornout lines because they would rather not take a serious look at the bipartisan Medicare agreement we put together and really assess whether or not those scare tactics are true. I am here to tell all my colleagues and the people of this country that the allegations that this Medicare bill destroys traditional Medicare are falsehoods.

This Medicare bill strengthens and improves traditional Medicare in a number of ways. We are not talking about just Medicare as it has been for the last 38 years. We are talking about some improvements we made in traditional Medicare that seniors will have the choice, the right to choose to stay in if they want to. I will discuss just three.

First, we add new preventive program benefits. For the first time ever, every new Medicare enrollee will receive a "Welcome To Medicare" physical; they go to the doctor when they go into Medicare, get a benchmark physical. Hopefully, nothing is wrong. But if something is wrong, we know about it right away and it is part of our effort to see that we zero in on keeping people well, as opposed to waiting until they get sick and it costs a heck of a lot more. It is part of our program, of a quality of life for our seniors. It is part of our program of zeroing in on the 5 percent of the people who, because of not having chronic care management, are costing us 50 percent of the total costs.

Seniors are going to have physicals that will help them—maybe their lifestyle, like getting their weight checked, but more seriously, the heart; receive cancer, diabetes, and bone mass screenings. It is very important to have an initial physical because, as we say in Iowa, an ounce of prevention is worth a pound of cure.

Consider these statistics. In 2000, 6.2 percent of the U.S. population had diabetes. Heart disease and stroke are the first and third leading causes of death in the United States. In 2003, 1.1 million Americans will have a heart attack. Diabetes, heart disease, and other chronic conditions exact an awful toll on our seniors. By getting an initial physical, seniors can get valuable information on their health status. They can enroll in weight loss programs, start a blood pressure medicine, or know whom to call if something goes wrong.

We have also eliminated the deductibles and the copays on screening tests for heart disease and diabetes, so beneficiaries do not incur any costs. There is an extent to which that cost today may inhibit them or divert them from having needed tests, so this is an additional incentive, particularly for those with limited resources who might not otherwise access these benefits. Adding preventive benefits is just one way we have improved traditional Medicare.

A second way we have improved the fee-for-service program is by providing access to disease management. It is a common option available to younger people in health insurance. If you have a chronic health condition such as heart disease, diabetes, asthma, you can get extra help managing your condition. You may be taking a lot of medications and seeing several doctors. Disease management programs help patients take responsibility for their health care and better control of their lives, but they also involve health professionals in that process, to aid you.

When this Medicare bill becomes law, seniors with access will have access to these services. It will be a voluntary program and one that will improve the quality of life for millions of Medicare beneficiaries.

Another improvement is this bill provides an additional $25 billion for rural health care providers. That is new money to strengthen our Nation's hospitals, physicians, ambulance riders, and dialysis clinics, just to name a few. This is the biggest funding boost Congress has ever passed for our rural health care system. This is going to help fee-for-service, traditional Medicare because in some places in this country there is not an adequate number of health care providers. Providers in rural States such as mine, Iowa, practice some of the lowest cost medicine in the country. Yet health care providers in rural areas lose money on every Medicare patient they see. This Medicare bill takes historic steps toward correcting geographic disparities that penalize rural health care providers.

So when I hear people in Washington say this bill is going to destroy traditional Medicare, I suggest that each of them take a closer look at this legislation. Providing new preventive benefits, allowing seniors to access state-of-the-art disease management programs, and mending the rural health care safety net will help millions of seniors with these three important ways we are strengthening Medicare.

I would like to turn now to a subject that is important to me, to the taxpayers, and to the seniors, and that is the issue of curbing waste, fraud, and abuse. You just read in your news releases from HHS, $11.5 billion of waste, fraud, and abuse within health care. If we can save that money, we are going to make Medicare strong for a long time in the future.

When it comes to reimbursements for many of the items and services that Medicare covers, the price, historically speaking, has not been right. That goes, for instance, for doctors and hospitals in rural areas who are paid too little, and some drugmakers and equipment suppliers, to name a few, who are paid too much.

This conference agreement makes great strides toward correcting both the underpayment and the overpayment that plague the Medicare Program. I have already talked about the underpayments to rural States such as Iowa and how this bill corrects that through the $25 billion of new money we are injecting into making Medicare reimbursements equitable.

But I want to talk now about just the opposite. There are overpayments in Medicare. Overpayments eat away at Medicare's reserves, eating away at its solvency slowly, like a cancer. Overpayments are bad for taxpayers, they are bad for beneficiaries, both of whom deserve to pay a fair price. In certain areas of Medicare, in many payment systems there are few fair prices.

Fee schedules pay too much, providers play games with complex rules and regulations, and beneficiaries pay a higher copay as a result. The sad fact is that Medicare's price is often far higher than the marketplace price. This conference agreement begins to change that in significant ways.

My colleagues should read title III of the conference report, and that is entitled, "Combating Waste, Fraud, and Abuse."

Our bipartisan initiative in this bill will end overpayments, reduce fraud, and cut down on opportunities for abuse to the tune of $31.3 billion as scored by the Congressional Budget Office. That is significant.

These measures in this bill directly reduce Medicare's spending on overpriced, wasteful, fraudulent items, and services to the tune of $31.3 billion over 10 years.

Throughout my time in Congress, I have worked hard to combat fraud and waste in Federal programs. In 1986, I successfully passed False Claims Act improvements that give whistleblowers new rights and protections under Federal law. In just the last year alone, civil fraud recoveries have tallied a record $2.1 billion, the Justice Department announced just last week. This is a 75-percent increase over the prior years' recoveries of $1.1 billion, and brings total recoveries to over $12 billion since I got that bill passed. Of the $2.1 billion, $1.4 billion is associated with suits initiated by whistleblowers.

While the False Claims Act is one of our best weapons in the war on fraud and abuse, our policies in this new language of the title III conference agreement adds still more weapons to our arsenal.

First, we make important technical clarifications to existing law that strengthen and improve what is known as the secondary payer statute. The purpose of the statute is to ensure that Medicare pays first for seniors' medical needs when other sources should be, in fact, paying instead of the taxpayer paying.

These other sources include, for instance, employer coverage. In addition, when a Medicare beneficiary is injured by wrongful conduct of another entity, that entity's liability insurance or the entity itself, if it has no insurance, or it might be self-insured, is always required to pay first instead of having the taxpayers pay. The provisions in title III do not change existing law in this area but, in fact, clarify the intent of Congress in protecting Medicare's resources.

According to the Congressional Budget Office, these clarifications alone promise to restore Medicare over $9 billion out of that $31 billion.

Second, we change the way Medicare pays for durable medical equipment, first by slowing the spending growth in these areas for 3 years, and then by instituting a competitive mechanism that will deliver a fair market price for seniors.

While I have concerns about the impact of such a new system on very many small businesses across America, the supply of high-quality equipment especially in rural areas, I am confident that good protections are in this conference agreement for small business and for our seniors as well.

The Congressional Budget Office estimates that these changes will save Medicare $6.8 billion out of that $31 billion.

Next, title III institutes what we call market pricing mechanisms for drugs administered in the doctors' offices that both the Office of Inspector General and the GAO have concluded are priced far higher than their actual costs.

In addition to the financial toll these overpayments take on the taxpayers, they also affect Medicare's beneficiaries who are often required to pay dramatically higher copayments for the drugs they rely on. In some instances, these copayments can even exceed the actual prices the doctors paid for the drug.

In recommendations to Congress, the GAO urged Medicare to take steps to begin paying doctors for Part B-covered drugs and related services at levels that reflect the doctor's actual acquisition costs—not some inflated cost. And they use information about actual market transactions prices to bring that about.

I am pleased that our conference agreement accomplishes this first by reducing the so-called average wholesale price by 10 percentage points, and then instituting a new payment system based on manufacturers' reported average sale price—or ASP reporting—which will be closely scrutinized by the inspector general on an ongoing basis ensuring its accuracy.

Errors or abuse of the system will be corrected swiftly so that Medicare will never again pay an unfair price.

These changes result in Medicare savings of approximately $11 billion out of that $31 billion total.

Finally, title III takes similar steps to correct overpayments for respiratory medicine which the Office of Inspector General has said are priced far in excess of their actual costs. These drugs will be reduced by 10 percentage points in 2004, and then priced on a similar average sale price system, as others I just mentioned, and that will begin in the year 2005.

The Congressional Budget Office says that this policy alone will save Medicare $4.2 billion of that $31 billion total.

I have listed three or four examples of how you save that $31 billion.

I believe all of these changes have been carried out in a compassionate fashion with twin goals of protecting both the Medicare Program's resources and our senior citizens' access to those services. We have done both.

Our market-based improvement Part B drug payments are accompanied by sweeping changes in payments for clinical services associated with delivering them.

We worked closely with oncologists to ensure that access to cancer care was not harmed.

Similarly, we went to great lengths to ensure that seniors who rely on medical equipment supplies will be able to rely on them as they do today.

Finally, to my colleagues who talk about cost containment and the need for Medicare to curtail its spending, I say this: It starts right here. Cost containment begins by ensuring that the costs to Medicare and to the taxpayers who finance it are, in fact, fair.

The conference agreement starts us down the road. The sum total of $31.3 billion of savings, and the market prices we are imposing on future spending in this area, are in my view, the most significant cost containment policies in this conference agreement.

In the months and years ahead as Medicare spending increases with the expansion of benefits that we are going to pass here shortly, our focus on cost containment will obviously increase. The best thing that Congress can do is to be vigilant. We all need to watch Medicare's outlays closely, and to listen to whistleblowers who are patriotic citizens telling us when there is fraud and crying for government to do something about it.

We also need to pay attention to other private individuals who have inside information on wrong doing. We need to heed the warnings of the Office of Inspector General, and, most of all, insist that Medicare never pay more than market price. Taxpayers, on the one hand, and the seniors' Medicare services, on the other hand, deserve nothing less.

I want to conclude by talking about the views of very many organizations that support the conference report.

Mr. GRASSLEY. Madam President, I want to quote from some.

As you know, I have a chart up here talking about the AARP. All of you colleagues on that side of the aisle have been saying to me all day how dastardly it is that the AARP is backing this legislation. Some Members have even spoken of them becoming a political organization. They cannot become a political organization or they will lose their tax-exempt status. But you accuse them of being a tax-exempt organization.

It is funny, last year when they did not come out for the bipartisan bill that several Members brought out, that the Democrat majority did not want to let pass because they wanted an issue in the last election instead of a product, the AARP was not backing what I, Senator SNOWE, Senator JEFFORDS, Senator BREAUX, and Senator HATCH wanted to do. Ours was a bipartisan effort, or a tripartisan effort, with Senator JEFFORDS being an Independent, to get a bill through because you cannot get through anything in this body if it is not bipartisan. The AARP did not like what we were doing. They did not discourage us but they did not help us. They actually sent letters out to support what Senator KENNEDY was trying to do a year ago.

I did not accuse the AARP of being a tool of the Democrat Party like Members on the other side are accusing the AARP of being in bed with the Republicans. They are not in bed with the Republicans. They are in bed with a bipartisan group of this body who want to do something for seniors of America. It is funny how the AARP is OK when they are helping Senator KENNEDY but they are not OK if they are helping a bipartisan group led by Senator GRASSLEY and Senator BAUCUS.

I would say they are discretionary in what they do. They may not be consistent, but thank God they are not consistent because they would not be representing the diverse group they represent.

Here is what the AARP says in their endorsement:

> AARP believes that millions of older Americans and their families will be helped by this legislation.

They continue:

> This bill provides prescription drug coverage at little cost to those who need it most: People with low-incomes, including those who depend on Social Security for all or most of their income. It will provide substantial relief for those with very high drug costs and will provide modest relief for millions more.

The last sentences I will read:

> An unprecedented $88 billion will encourage employers to maintain existing health retiree benefits. The legislation will help speed generic drugs to market and add important new preventive and chronic care management services. This legislation protects poor seniors from future soaring prescription drug costs.

All the Members complaining about the AARP, put that in your pipe and smoke it.

Then we have the National Council on the Aging:

> . . . we find it too difficult to again say to millions of vulnerable seniors in need: Sorry, come back in a few years and maybe there will be some help for you then.

Another sentence:

> We urge Congress to pass the Medicare bill so that millions of seniors with greater needs will receive long-awaited and badly-needed prescription drug coverage.

Are Members trying to tell me the National Council on the Aging does not know what is good for seniors when they see it? Put that in your pipe and smoke it.

The Alzheimer's Association says:

> This is a historic accomplishment that may potentially provide meaningful relief to the 4.5 million Americans dealing with Alzheimer's disease—many of whom also suffer other health issues.

That is from Sheldon Goldberg, president and CEO of the Chicago-based national organization for the Alzheimer's Association.

Are Members telling me the Alzheimer's Association cannot make a judgment if this bill is good for their members? Go put that in your pipe and smoke it.

From the American Diabetes Association:

> . . . contains important improvements to the Medicare Program that will benefit many people living with or at risk for diabetes.
>
> . . . the prescription drug package assists seniors living with diabetes by providing coverage for insulin and syringes, a critical component for seniors that take insulin to manage their diabetes.
>
> . . . the American Diabetes Association supports passage of—and strongly urges Congress to enact—the Medicare package as a way to improve the lives of millions of seniors living with diagnosed and undiagnosed diabetes.

Are Members trying to tell me the American Diabetes Association does not know a good piece of legislation when they see it? Put that in your pipe and smoke it.

We have a statement by Advancing Health in America, AHA, saying:

> It provides prescription drug benefits to the elderly and provides needed Federal relief to hospitals, particularly rural hospitals.
>
> The legislation includes important provisions that help patients by providing hospitals the resources necessary to continue caring for America's seniors.

Tell me an organization called Advancing Health in America does not know what is good for their Members.

From the American Medical Association:

> Congress listens to America's patients and physicians who serve it.
>
> The status quo is unacceptable to patients and their physicians. The Medicare conference agreement includes numerous provisions that will improve seniors' access to medical services.

Tell me the American Medical Association does not know what is good for their members or what is good for their members' patients.

The Arthritis Foundation says:

> The Arthritis Foundation supports a Medicare Prescription Drug, Improvement, and Modernization Act for 2003 that for the first time would provide coverage for prescription drugs and biologicals for persons with arthritis.

Can Members tell me the Arthritis Foundation does not know what is good for their members, know a good piece of legislation when they see it?

We have the American Pharmacists Association:

> . . . APhA supports this as an important, long-overdue step toward providing Medicare beneficiaries greater access to medications and critical pharmacist services.
>
> The proposal creates a comprehensive benefit that provides coverage for drug products and pharmacist services, and provides seniors their choice of pharmacists and ensures any willing pharmacist can participate in a plan and incorporates important administrative efficiencies.

Those Members who oppose this bill, are you trying to tell the people of America that the American Pharmacists Association does not know a good piece of legislation when they see it and that they cannot speak for not only their membership but also their patients and clients they serve?

From the College of American Pathologists:

> This legislation will improve Medicare coverage for seniors and protect access to the physicians and services upon which they rely for quality of care.
>
> The conference agreement also preserves critical health care services provided by independent laboratories in to hospital patients, especially in smaller and rural communities.

Are Members telling me, as they criticize this legislation, that the College of American Pathologists would support legislation that is not good for their patients and the people they serve?

The Federation of American Hospitals:

> This agreement does more to improve Medicare coverage for seniors than any legislation since its program inception.

That is 38 years.

> The Federation of American Hospitals commends President Bush, the Congressional leadership, and members of the Medicare Conference Committee for their great efforts in bringing these vital improvements to the Medicare to fruition.
>
> H.R. 1 would greatly enhance the ability of hospitals to provide necessary care medical care to Medicare beneficiaries. It would make important strides in ensuring that all hospitals have sufficient funding to meet the medical needs of this nation's seniors and would particularly aids though hospitals that serve seniors in rural areas.

Every Member has rural areas in their State. And we have a major hospital association supporting this legislation because it is particularly going to serve seniors in rural America.

Now, tell me that they do not know a good bill when they see it.

Here is something that answers complaints that were heard late this morning or early this afternoon. One of the first speakers on the other side of the aisle, the Senator from Illinois, was complaining about this not doing enough for generics. But here we have the Generic Pharmaceutical Association:

> The Generic Pharmaceutical Association today called the Medicare Conference compromise on generic drugs a tremendous victory for all consumers that will ensure timely access to affordable pharmaceuticals. . . .
>
> The House and Senate conferees have met the challenge of eliminating some of the most serious barriers to generic competition by closing loopholes that have unnecessarily delayed the timely introduction of affordable pharmaceuticals—and American consumers, young and old alike, will be the winners.

Now, how many of you speaking today have complained about this legislation not doing anything about the cost of drugs? And we know that putting generics on the market sooner is one of the ways to bring down tremendous drug costs.

Now, the Generic Pharmaceutical Association supports this legislation, and yet you do not recognize that they understand a good piece of legislation when they see it.

We have the United Seniors Association:

> We commend the Senate and House Conferees on their historic step to benefit every senior in America. Partisan politics and rhetoric-without-results on prescription drugs are simply unacceptable. Years of hard work by many in Congress and years of heartache for America's seniors have led us to this point. The whole senior world is watching and Congress must not collapse so near the finish line.

Are you trying to tell me that the United Seniors Association looks at this legislation and sees it is good for their members, and yet you cannot see that?

We have The 60 Plus Association:

> The bill makes available much needed assistance to millions of seniors who lack any

> prescription drug coverage. Significantly, those who can least afford to pay will get the most help [from this legislation].

From the Rural Hospital Coalition:

> We support your efforts to modernize Medicare and give senior citizens a prescription drug benefit that they deserve. . . . [T]his bill strengthens health care in rural America.

From the National Rural Health Association:

> This bill is a big boost for the rural healthcare system. . . . A stronger healthcare system will help revitalize rural economies which will positively impact rural Americans throughout the country.

We have the National Hospice and Palliative Care Organization:

> NHPCO strongly supports these provisions and believes these changes will improve the quality and timeliness of hospice and palliative care for seniors and their families.

From the Mayo Clinic, 150 miles from my home in Iowa:

> Mayo Clinic supports the compromise Medicare reform legislation that has emerged from a congressional conference committee.

We have NAMI, The Nation's Voice on Mental Illness:

> This conference agreement does represent an improvement for Medicare beneficiaries living with mental illness. . . . NAMI feels strongly that it is time for Congress to end partisan stalemate over this issue and take advantage of the $400 billion available this year to spend on a new drug benefit.

This is kind of a partisan statement I am going to read to you, but it does represent a group of people who are impacted by what we do here with dual eligibles. It is from the Republican Governors Association:

> Medicare will provide first-time access to prescription drug coverage to many of our seniors. The agreement also assists states with the costs related to the dual eligible population. Assistance to low income persons as well as critical protection against high out-of-pocket drug costs are essential components of this legislation. . . . [T]he preventive benefits found in this measure will keep our constituents healthier.

From the Alliance For Aging Research:

> With this act the millions of Medicare beneficiaries will no longer have to wait from 15 months to 5 years for access to new state-of-the-art medicines and life-saving and life-enhancing technologies. In addition, and most importantly, it targets those with the greatest need by providing significant low-income subsidies for prescription drugs that will assist millions of Medicare beneficiaries living longer and healthier lives. . . . This will be a giant step toward expanding and modernizing Medicare, while preserving the power of science and technology to improve and enhance the lives of our people in the future:

Lastly, we have the American Benefits Council, a news release. The headline: "Medicare, prescription drug reform bill represents historic, positive achievement."

> We urge swift enactment of the legislation. . . .

I have quoted these statements from these outstanding organizations for the RECORD because they speak louder than any Member of this Senate can about what is good about this legislation.

I would hope that you folks on the other side of the aisle would take these statements into consideration, particularly tomorrow, when I am told 15 of you are going to speak, probably most of you against this legislation. I would appreciate you taking into consideration what these major groups have said.

Madam President, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Ms. MURKOWSKI. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. GRASSLEY). Without objection, it is so ordered.

Ms. MURKOWSKI. Mr. President, I realize the hour is late. This body has been discussing the issue of Medicare legislation for close to 12 hours now on this Saturday.

I want to speak briefly this evening about the legislation that is under consideration in the Senate and its impact on senior citizens in my home State of Alaska as well as around the Nation.

We have heard a great deal today on the floor about the need for reform, about what we need to provide for our senior citizens.

We must keep in perspective what we owe our seniors. This is the generation of Americans who paid most dearly to protect the freedoms we enjoy. Many of our older Americans today went through the Depression and have very personal, truly gut-wrenching memories of the hunger that they perhaps went through at the time. They were the generation who settled the frontier areas of America, including my State of Alaska. They remember the horror and the stories from Pearl Harbor. We owe this generation of Americans many things, not the least of which is honesty.

Since Medicare was enacted in 1965, it has provided health security to millions of America's seniors and people with disabilities. Medicare is that promise of health security we must always keep.

Many of my colleagues on the other side of the aisle would like Americans to believe that the bill in front of us today is designed to kill those promises made in 1965. I remind my colleagues that Americans deserve more than the rhetoric and the scare tactics we have heard saturating the airwaves from here. Earlier this evening in listening to the debate, one of my colleagues made reference to the fact that seniors are going to have to sell their wedding rings in order to meet certain levels for low-income subsidies for Medicare beneficiaries.

I thought, wait a minute, that can't be true. That is not a part of this legislation. Seniors will not have to do that. So I said: Show me. Let me know for sure that, in fact, this is not the case.

We pulled it out and looked at the application of the asset test. It very clearly states those resources that are not counted for an asset test, excluded resources, include, and No. 3 on the list is memorabilia such as a wedding ring. For us to stand here on the Senate floor and suggest to a senior citizen that in order to meet certain requirements to keep your Medicare benefits you might have to give up your wedding ring, I sure hope my 84-year-old next-door neighbor was not hearing that because I know she wouldn't sleep well knowing that that could be true.

We have to be real. We have to be honest with our statements, and we have to talk the truth about what is and is not contained in the legislation before us.

Americans deserve to know that this bill, while not perfect—I don't think any of us would suggest it is perfect—will provide good drug coverage for any senior citizen who wants to enroll. Americans deserve to know that this bill doesn't force seniors to join HMOs to get prescription drugs.

This legislation is designed to provide choice, not coercion. If seniors want to add prescription drug coverage to the Medicare plan that they have right now, they would have that option. Their benefits would not be reduced, would not be taken away. If they don't want the drug coverage or if they are happy with the coverage they have now through their retirement plan, they don't have to accept the voluntary Medicare benefit.

The incentives for employers to keep offering their own prescription drug benefits: The Employer Benefit Research Institute indicates that they expect between 97 percent and 99 percent of beneficiaries won't have any change in benefits. We need to clearly repeat these provisions.

The bottom line is this: If you like Medicare the way it is today, you can keep it that way because it is designed to be a voluntary benefit.

The problem is for many Americans, including those in Alaska, Medicare has not been living up to its promises. It will only pay for your drugs if you have been hospitalized. And for many, it does not pay for the health care professionals. Essentially, this program is still stuck in the 1960s mindset of reactive care rather than the kinds of proactive care we expect today.

Several months back I had an individual up in the State who was meeting with me and going out to senior centers. We were talking about the Medicare legislation in front of us at that time. She made the analogy that Medicare is like the telephone. In 1965, the telephones that we had in our homes were the black rotary dial. They came in one color and one style, and that was it. And that was how we talked.

Now in the year 2003, we talk on cell phones, by fax, e-mail, on colored phones. The technology has changed incredibly, but we are still doing the talking.

Medicare is essentially the rotary dial system of health care that just hasn't been ramped up.

Americans need to know that Medicare still doesn't provide full coverage for preventive care, including cancer, diabetes screenings. It doesn't offer protection against catastrophic medical costs, these things that can rob our seniors of their hard-earned savings. There has been a lot of rhetoric about the drug benefit. But if you cut all through it, if you do the number crunching, you get to the indisputable fact that the average senior citizen, after paying their premium, is going to see a savings in the cost of their drugs—we estimate about a 63-percent savings in the cost of drugs.

For those seniors with limited income and limited savings, which is about half of Alaska's senior citizens, half of Alaska's senior citizens are in this lower income bracket, they will have closer to 90 percent of their drug costs covered, and this is not a skimpy benefit.

The bill also adds important preventive benefits that are many years overdue. In order to combat our Nation's No. 1 and No. 3 killers, which are heart disease and stroke, Medicare would be required to cover screening blood tests with no cost to the senior. This bill helps the millions of Americans who struggle daily with the chronic diseases such as asthma and diabetes. The bill adds principles of disease management to Medicare which will help the seniors navigate the oftentimes confusing health care system and get them the access to vital specialty care and educational resources.

While we all seem to agree that it is important to add preventive benefits to Medicare, there has been a lot of discussion about whether to allow government-regulated private plans to offer these Medicare benefits. I have to step back a little and wonder if perhaps I am the only one who finds it ironic that we would use taxpayer-funded subsidies to give each one of us in Congress a choice of health plans, but yet we would deny our senior citizens that same choice.

The bill before us rejects this philosophy of "big Government knows best," and tells our seniors: You have the right to select a benefit that meets your needs. If you don't need drug coverage, you don't have to enroll. You can keep Medicare the way it is today. If you don't want to join a private plan, you don't have to. If you don't want to change anything about Medicare, you don't have to.

I also want to address a comment that a number of Members—primarily on the other side of the aisle—have made characterizing Medicare as good the way it is now. I have even heard a number claiming that the Medicare Program today gives seniors such things as a choice of doctors. While I agree with them that Medicare is a good program, and I believe we need to make sure it still exists for our children's children, I need to let my colleagues know that the way the current Medicare Program does business, it hurts those in my State who have been promised care.

Every week, Senator STEVENS, Congressman YOUNG, those in the Alaska delegation, and I come to work and we are faced with a huge stack of mail, e-mail, phone calls, and the like from Alaskans about the problems they are having with Medicare. I mentioned earlier that this summer, back in my State, I held a senior citizen forum in the community of Chugiak. What I learned may actually surprise some of my colleagues who seem particularly enamored with the way Medicare is today. Seniors in Alaska are not only being denied a choice of doctors, but in many cases they don't have the ability to see a doctor at all. This is because doctors, or health care providers, in Alaska are paid just about 37 cents on the dollar for the care they provide to seniors on Medicare. Medicare is a price-fixer. So what we have is somebody in Baltimore sitting in a cubical, and they are deciding how much to pay for medical care in the community of Delta Junction, in Alaska; or take the community of Bethel, not on the road system, completely cut off from the rest of the world. If the payment the folks in Baltimore have said we are going to be charging is less than the cost of actually providing the care, Medicare basically tells our doctors: Tough, you are out of luck. This price-fixing causes problems not only in the rural areas of the State—as I mentioned, in a place such as Bethel or Delta, where you would expect these problems—but the sad truth is that even seniors in the urban centers of Alaska, in Anchorage and Fairbanks, cannot find a doctor who will accept new Medicare patients.

Perhaps I need to go a little further in explaining to my colleagues how much of a problem this is in my State. When a senior in the lower 48 cannot find a doctor in their community to help them, they can hop into their car and drive to the next town and find a doctor—just go to the city. But when seniors cannot find a doctor in Fairbanks—and the whole State knows seniors in Anchorage are having the same problem—there are two options for them. The first one is that there are few things you can do. Second, there are bad things you can do.

The simple fact is that for many of my constituents, their choice for a doctor is limited to those who are practicing in the emergency room. Who is the doctor on call that night? That is their choice of doctors.

The only other choice is—and this is probably a choice only for a few—to fork over the $1,400, or whatever the price of the airplane ticket is, to make the 8-hour roundtrip flight to Seattle and try their luck with doctors there.

Just 2 weeks ago, I had a constituent in my office who told me she flies to Virginia every year to see her doctor. She lives in Alaska. She flies to Virginia to see her doctor. She does this because she cannot find one in Anchorage who will accept new Medicare patients. The cost for the ticket alone, not counting her lodging and meals while she is there, is about $1,500. Unfortunately, these situations in Alaska right now are not the exception; they are the rule.

We have somewhere between 1,000 and 2,000 senior citizens in Anchorage alone who cannot find a doctor who is willing to treat them. The situation in Fairbanks is not much better. We recently called up the State to one of the larger clinics there that accepts Medicare patients. We asked them: Are you accepting new Medicare patients, and when would the first available appointment be? We were told mid-July. This is not choice when it comes to your doctor.

How is this situation keeping the promise we made to our senior citizens in 1965 when we established Medicare? What kind of treatment are you advocating for when you keep Medicare the way it is? We can come up with grand plans here in Washington and we can talk about Medicare reform, but if we don't have doctors who can write the prescriptions, if we don't have access to physicians, we have not done anything to fix the problem with Medicare.

Keeping Medicare as we know it in Alaska means Alaskans will go to the emergency room for primary care. It means making Alaskans pay to fly across the country by themselves to go find a doctor, and it means making Alaskans go without preventive screening.

Medicare as we know it doesn't give patients a choice of providers or access to the care of their choice, as some of my colleagues have stated. Medicare isn't working perfectly and desperately needs reform. I believe the legislation we have in front of us is a good compromise. It includes provisions that will ensure that senior citizens around the Nation and in Alaska will be able to find a doctor somewhere other than in the emergency room.

We owe our seniors a little more honesty in this debate. They deserve to know clearly that the prescription drug is voluntary. They deserve to know they will not be forced to join a program they don't want to join. They deserve to know the average senior citizen who joins will save somewhere around 63 percent on the cost of their prescription drugs. They deserve to know low-income seniors will pay no deductible, no monthly premium, and have no gap in coverage; and Medicare will pay about 90 percent of their drug costs. They deserve to know the group purchasing power we are giving to seniors is going to make the drug companies work for their business.

Mr. President, those who stood defending our freedom deserve more than the partisan rancor that has been sailing around this Chamber. They deserve to know more than some of the half-truths that have been told. Medicare, as we know it, should provide seniors with access to vital health care services and the physician of their choice. I believe this bill does those things, and I believe it will meet the needs of my constituents.

We have come a long way toward making good on our promise to our senior citizens, and that is to the credit of the administration and to the leadership of this Congress, certainly to the leadership of the Senator who is presiding this evening. We do need to strengthen Medicare, and seniors do need access to vital prescription drugs.

Many who are now on Medicare fought for the freedom that we enjoy today, and Monday we will, hopefully, have the opportunity to keep our promise to seniors and to fight on their behalf by providing them with a voluntary prescription drug benefit.

I urge my colleagues to support this legislation.

ORDERS FOR SUNDAY, NOVEMBER 23, 2003

Ms. MURKOWSKI. Mr. President, on behalf of the majority leader, I ask unanimous consent that when the Senate completes its business today, it adjourn until 1 p.m., Sunday, November 23. I further ask unanimous consent that following the prayer and pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day, and the Senate then resume consideration of the conference report to accompany H.R. 1, the Medicare Prescription Drug Modernization Act, with the understanding that speakers will alternate between the sides with the order of speakers on the opponents' side, as previously requested by the assistant Democratic leader.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Ms. MURKOWSKI. Mr. President, tomorrow the Senate will continue debate on the Medicare conference report. We had an extended and vigorous debate today, but there are many others who wish to make statements on this historic bill. Because we have a large number of Senators who wish to speak tomorrow, we ask Senators to limit their remarks to 30 minutes. We will talk further tomorrow on the best way to accommodate Members as we go forward.

As a reminder, a cloture motion on the conference report was filed today. That vote will occur during Monday's session at approximately 12:30.

Finally, on behalf of the leader, I thank not only the Members who participated in the debate but also the Senators who presided throughout this session.

ADJOURNMENT UNTIL 1 P.M. TOMORROW

Ms. MURKOWSKI. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 9:33 p.m., adjourned until Sunday, November 23, 2003, at 1 p.m.

EXTENSIONS OF REMARKS

IN RECOGNITION OF THE PORT AUTHORITY EMPLOYEES WHO LOST THEIR LIVES ON SEPTEMBER 11, 2001 ON THE OCCASION OF THE DEDICATION OF A MEMORIAL AT MCMANUS PARK IN ASTORIA, NY

HON. CAROLYN B. MALONEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mrs. MALONEY. Mr. Speaker, I rise to pay tribute to the 75 employees of the Port Authority of New York and New Jersey who tragically lost their lives in the attacks on the World Trade Center on September 11, 2001. In recognition of the ultimate sacrifice they made while striving to rescue others, these fallen heroes have been honored with the dedication of a memorial in McManus Memorial Park in Astoria, New York.

I attended the dedication of the memorial and was deeply moved by the heartfelt testament to these fallen heroes by friends, family, and area residents. This park will bear witness that their courage and selflessness will never be forgotten, while offering a quiet and tranquil oasis amidst the busy city that affords an opportunity for reflection upon the terrible losses borne on that tragic day.

I ask that the following speeches given at the dedication ceremony be entered into the record:

THE UNITED COMMUNITY CIVIC ASSOCIATION

(By Rose Marie Poveromo, President)

Good evening ladies and gentleman. Tonight's memorial dedication ceremony is a joint effort shared by the United Community Civic Association and our neighbor, the Port Authority of New York and New Jersey.

This living memorial of "A Grove of Trees" is to specifically honor the 75 Port Authority employees as well as all the other innocents who so tragically lost their lives in the 9111 shattering, horrific attack on, and total collapse of, the twin towers.

PORT AUTHORITY OF NEW YORK AND NEW JERSEY

(By Bill De Costa)

I am grateful to be here to dedicate this memorial to the 75 Port Authority employees, and neighbors who lost their lives in the attacks on the World Trade Center on September 11, 2001. This ceremony also honors the memory of all the New York City police officers, firemen and all the other citizens who gave the ultimate sacrifice that day.

Any event is always more meaningful when you receive acknowledgment from your family, so we are particularly honored that our neighbors and friends represented by the United Civic Community Association have been so thoughtful and considerate in their recognition. Thank you Rose Marie!

Yes, whether we are Port Authority or New York City employees, we are all actual members of this vibrant and wonderful community.

As we stand here today and view the McManus Vietnam Memorial at one end of the park, and now this Port Authority memorial at the other end of the park, we should always be reminded of the words of President Harry Truman: "Freedom is still expensive. It still costs money. It still costs blood. It still calls for courage and endurance, not only in soldiers, but in every man and woman who is free and who is determined to remain free."

Seventy-five Port Authority employees, including 37 police officers, made the ultimate sacrifice that September morning. Always remember these people who were our neighbors, family members and friends. The greatest testimony that we can now give them is to continue our resolve for security and freedom and to continue to work and live in this spirit.

Thank you all for attending and remembering them.

Mr. Speaker, I ask my colleagues to join me honoring the Port Authority employees, the police officers and firefighters, and all those who paid the ultimate price on September 11, 2001 and to recognize those who planted a beautiful memorial grove of trees in their honor. It aptly serves as a living tribute to the brave men and women of the Port Authority and all who lost their lives on that tragic day.

BASIC PILOT EXTENSION ACT OF 2003

HON. MARK UDALL

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. UDALL of Colorado. Mr. Speaker, I rise today in support of S. 1685, the Basic Pilot Extension Act of 2003.

The Basic Pilot Verification program was created in 1997 to assist employers in verifying the eligibility of prospective employees to work in the U.S. Currently the program is only available to employers in six States. Recently I voted against a bill to expand and extend the program, H.R. 2359, because I thought an expansion of this program deserved more debate and allowance for amendments to fix some of the more problematic parts of the bill.

The Senate-passed measure that we are considering today, S. 1685, is an improvement on the House bill.

Unlike the House bill, this bill does not open up access to the databases of the Homeland Security Department and the Social Security Administration to other Federal agencies or to State and local government agencies. I had grave concerns about the infringement of civil liberties in the House bill, which would have permitted widespread sharing of employee information. I am also pleased that concerns already identified by the Department of Homeland Security about the Basic Pilot program are being addressed. I still have apprehensions that the data used in this program is not always up-to-date or accurate, specifically in regard to the visa status of employees. However, I am hopeful that the Homeland Security Department report required under this legislation will address these concerns so that they can be resolved by the time the program is expanded to all fifty states.

The Basic Pilot Verifications program provides an efficient and effective method for ensuring that employers are hiring eligible employees. I hope that through the extension and expansion provided for in this bill, this program will provide accurate information about prospective employees and continue to address the needs of American employers.

A TRIBUTE TO DAVID LOFYE

HON. NICK LAMPSON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. LAMPSON. Mr. Speaker, I rise today to wish a fond farewell to a member of my staff, David Lofye, who will be leaving Capitol Hill at the end of this calender year. David is leaving his position as my Deputy Chief of Staff, and will be moving to Austin, Texas with his wife, Andrea Lofye.

All of us who serve in Congress know how important our staff members are to us. David came to my office after completing law school nearly six years ago. His knowledge of legislative issues, his strong work ethic, and his desire to make a difference have grown exponentially during this time. I value David's council and his pragmatic and methodical approach to each task he undertook.

David has staffed me on both the Transportation and Infrastructure Committee, as well as the Science Committee. His depth of knowledge on these and other issues has been invaluable over the past six years.

I am grateful to have had the opportunity to know and work with David. I am confident that his abilities and his work ethic will continue to serve him well in the years to come.

David, thank you for your hard work over the last six years. You will truly be missed.

RECOGNIZING THE MORRIS ISLAND LIGHTHOUSE AND SAVE THE LIGHT

HON. HENRY E. BROWN, JR.

OF SOUTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. BROWN of South Carolina. Mr. Speaker, I rise today to recognize the Morris Island Lighthouse and to applaud the efforts of Save

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

the Light. Save the Light is a non-profit entity dedicated to the preservation of the Morris Island Lighthouse. The Morris Island Lighthouse, a National Historic Landmark which began operation in 1876, is a true historical treasure, playing significant roles in both the Revolutionary and Civil Wars. It was decommissioned in 1962 by the U.S. Coast Guard, but is now owned by the State of South Carolina and leased to Save the Light.

The island on which the lighthouse is situated has all but washed away, leaving the lighthouse precariously perched on a tiny sandbar that sits underwater at high tide. I want to thank Chairman Taylor and the Appropriations Committee for providing the first federal funding for this project in the recently passed Interior Appropriations Bill.

Save the Light has been coordinating monumental preservation efforts dedicated exclusively to the foundation repair of the Morris Island Lighthouse. The organization began as a grass roots effort by concerned citizens and has taken charge of the preservation of this historic site when public agencies would not. Save the Light has generated significant public support in raising funds for the project, worked with the Army Corps of Engineers and established a long-term maintenance program for the lighthouse.

The level of public support generated for its preservation underscores the importance of the Morris Island Lighthouse to the community, and I applaud Save the Light for all of their hard work and dedication. Thank you, Mr. Speaker.

CONGRATULATIONS TO THE DENTON HOUSING AUTHORITY

HON. MICHAEL C. BURGESS

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. BURGESS. Mr. Speaker, I rise today to recognize the Denton Housing Authority to commend them for receiving three National Association of Housing and Redevelopment Officials (NAHRO) Merit Awards in Tampa, Florida this year.

The Denton Housing Authority has been active in the North Texas community for years, working hard to provide quality public and affordable housing. This year at the 2003 NAHRO awards ceremony, the Denton Housing Authority was recognized for their achievements in Program Innovation for Resident and Client Services. NAHRO President Curt Creager said, "These agencies are accomplishing remarkable levels of service for their communities and their residents. They are setting up programs and establishing standards that can be duplicated by other housing authorities around the country."

The Denton Housing Authority was recognized for three of their programs. The ARTS program brings together the DHA, University of North Texas, Center for Public Service, and Greater Denton Arts Council to provide an arts program and promote social skills for disadvantaged youth in low-income neighborhoods. The New Direction of Community Oriented Policy Services (COPS) program partners with the Denton Police Department to encourage community outreach services to create and sustain safer neighborhoods. Also, the Phoenix After-School Program teams with the University of North Texas and DHA to encourage social and academic success for socially challenged youth 4–11 years old living in the Phoenix Development. These are the kind of great programs that will create a better society in the future by giving our youth a strong foundation and forming a safer environment for our neighborhoods.

Once again, I would like to express my sincere congratulations to the Denton Housing Authority for their innovation and hard work in providing community outreach services to the City of Denton and surrounding communities.

CENTRAL NEW JERSEY RECOGNIZES AND CELEBRATES MARVIN REED

HON. RUSH D. HOLT

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. HOLT. Mr. Speaker, I rise today to recognize the career of Mayor Marvin Reed, who has served the Borough of Princeton as mayor for 13 years.

A resident of the borough for 45 years, he began his career of public service in 1985 as a member of the Borough Council. Since that time the people of Princeton have chosen him as their leader for three consecutive terms.

Under his direction the town has made a deliberate and concentrated effort to make affordable housing available to all within the community. He has secured five affordable housing developments and has laid the groundwork for at least 68 units of low-income senior housing.

He has worked with the local police department to establish a strong community presence and to work hand in hand with residents. Throughout his years as mayor the borough has seen an increasingly strong community grow, one that works together to support senior programs, youth activities and growth within the community.

Through his efforts the borough has seen the renovation of Borough Hall, the reconstruction of Monument Park and the Suzanne Paterson Senior Center. His commitments to creating open space and historic preservation have made Princeton Borough a stronger community.

As an inspiration to his community and the State of New Jersey, Mayor Reed has contributed significantly to the life of his community. He has earned our heartfelt appreciation for his efforts.

HONORING WILLIE L. BROWN, JR.

HON. BARBARA LEE

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Ms. LEE. Mr. Speaker, I rise today to honor Mayor Willie Brown of San Francisco on his upcoming retirement after 40 years of dedication and spirited service to the community.

As we honor Mayor Brown, I want to thank him for being an exemplary role model, leader, and friend. I take great pride in joining his family, friends and colleagues to recognize and salute the accomplishments and contributions of Willie L. Brown, Jr.

Mayor Brown's personal story is an inspirational one. He was born into poverty on March 20, 1934, in Mineola, Texas, a small, racially-segregated Texas town, where he earned his first dollar as a shoeshine boy. Throughout his high school years, he worked as a janitor, a crop harvester and a messenger. On graduating, he moved to San Francisco, bringing with him a little more than a cardboard suitcase and hope in his heart.

He worked his way through and graduated from San Francisco State University and from the Hastings College of the Law. He was admitted to the State Bar of California and built a thriving law practice in what was then a predominantly white legal world.

Brown was elected to the California Assembly in 1964 and was re-elected 16 times, serving a total of 31 years in the Assembly. In 1980, he was elected Speaker of the Assembly, a position of power second only to that of the governor. The state's only African American Speaker, he held the position for an unprecedented 15 years.

Mayor Brown's personal experiences in the realm of racial discrimination have made him a tireless advocate for affirmative action. During his years as a state assemblyman, dozens of his bills became laws, including the passage of the most comprehensive educational reform and financing bill in 20 years. He also passed bills that requested the United States Congress to grant citizenship to Filipino veterans of WWII and eliminated criminal penalties for private sexual acts between consenting adults, a bill that was introduced before the Assembly five times before its ultimate passage.

While in the Assembly, several organizations awarded Brown for his tireless work on behalf of minority groups; he received the California Association of the Physically Handicapped Special Service Award, the ACLU Human Rights Award from the Gay Rights Chapter, the Tree of Life Award from the Jewish National Fund, the Japanese American Bar Association Award, and was honored by the California Advisory Commission on Special Education.

As mayor, he has continued his career-long commitment to civil rights and higher education, notably by designating the address of the refurbished City Hall as Dr. Carlton B. Goodlett Place after the recently-deceased San Francisco NAACP Chapter president and community activist. During the renaming ceremony and in front of a crowd of 7,000 people gathered at the 13th annual Martin Luther King Holiday rally, Mayor Brown restated his dedication for the betterment of education, his continued fight for civil rights, and his dedication to representing all of the minority groups that make up San Francisco.

Mayor Brown continues to make good on this promise. He championed and signed legislation requiring all companies doing business with the city to grant equal benefits to their workers' domestic partners. As mayor, he presided over seven domestic partner commitment ceremonies, the latest taking place in City Hall. His administration is also working toward guaranteeing universal health care for its 130,000 residents currently without medical coverage. Thanks to commitment from the City and the private sector, the University of California at San Francisco will break ground on its first new campus in over twenty years.

During his seven years at the helm of one of America's most diverse cities, Mayor Brown has shown continued leadership, creating continued vitality and economic energy in San Francisco. Respected in the ethnically diverse neighborhoods as well as in the burgeoning business community, a San Francisco Chronicle reporter said of Brown, "He's been magical in his ability to unite the city. There's been this unbelievable camaraderie between camps that have been at war for years."

As the city's first African American mayor, Mayor Willie L. Brown, Jr. continues to represent the past, present and future of civil rights and the cultural and intellectual diversity that symbolizes San Francisco's history of acceptance.

Mayor Brown has been a mentor and a friend since the early 1970's. He has been consistent in championing the rights and the plight of those shut out of the American dream, and he has never forgotten his humble roots in Mineolea, Texas.

I had the privilege to serve with Mayor Brown while in the California Legislature. As speaker of the Assembly, Mayor Brown led our state through many challenging years. He was my "shadow Governor" and made sure that communities of color, women and the poor had a seat at the table.

As a skilled legislator, Speaker Brown guided me with my very aggressive and successful legislative agenda, which I continue to embrace with pride and humility.

Mayor Brown leads with his head and his heart. His intellect, his wisdom and his spirit is something to behold.

As one whose life and work has been enriched by this giant of a man, I say thank you, and Godspeed. Enjoy this next glorious chapter of your life.

PERSONAL EXPLANATION

HON. ROB PORTMAN

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. PORTMAN. Mr. Speaker, on November 20, 2003, I was unavoidably detained and missed the vote on Roll Call Number 654 on H.R. 1828, the Syria Accountability and Lebanese Sovereignty Restoration Act of 2003.

Had I been present, I would have voted "Yes."

RECOGNIZING WORLD AIDS DAY

HON. HILDA L. SOLIS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Ms. SOLIS. Mr. Speaker, I rise today to recognize December 1, 2003, as World AIDS Day. On this day, many around the globe will celebrate the progress made in the battle against AIDS while raising awareness to the challenges that remain.

Worldwide, an estimated 42 million people are living with the disease; 11.8 million are young people aged 15 to 24. Furthermore, more than half of those newly infected with HIV are between 15 and 24 years old—six thousand new infections each day, or 4 every minute.

In Latin America, in 2001, approximately 130,000 adults and children were infected with HIV and 80,000 died of AIDS. Unfortunately, young people and women are becoming increasingly vulnerable.

As we recognize World AIDS Day and celebrate the successes achieved, let us remember that our young people are at the center of this global crisis. They are our greatest hope in fighting this deadly disease and we should do all we can to deliver effective treatments and prevent new infections.

PERSONAL EXPLANATION

HON. DANNY K. DAVIS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. DAVIS of Illinois. Mr. Speaker, I was unavoidably detained in my district had I been present, I would have voted yea on the following roll call votes:

Roll Call 650 (H.R. 1), Medicare Prescription Drug and Modernization Act—On Motion to Instruct Conferees;

Roll Call 651 (H.R. 2660), Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2004—On Motion to Instruct Conferees;

Roll Call 652 (H.J. Res. 63), Compact of Free Association Amendments Act of 2003;

Roll Call 653 (H. Con. Res. 209) Commending the signing of the United States-Adriatic Charter, a charter of partnership among the United States, Albania, Croatia, and Macedonia;

Roll Call 654 (H.R. 1828), the Syria Accountability and Lebanese Sovereignty Restoration Act of 2003; and

Roll Call 655 (H.R. 253), National Flood Insurance Reauthorization.

AMERICAN EDUCATION WEEK

HON. CIRO D. RODRIGUEZ

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. RODRIGUEZ. Mr. Speaker, this week marks the 82nd annual celebration of American Education Week, a time for us to acknowledge and praise the important role of education for our social and economic future. In the United States, the public school system provides the backbone of our youth's education, a system that deserves our active support and continued respect.

In 1919 the American Legion and the National Education Association joined together in concern over illiteracy rates among World War I draftees. The two groups agreed to support a national effort to increase awareness of the importance of education. The first American Education Week was observed from December 4–10, 1921. In many parts of our state, literacy remains a great challenge, and the need for a strong public education system is more important than ever.

Each year American Education Week focuses on a different issue; this year's theme is "Great Public Schools for Every Child-America's Promise." The week's co-sponsors include the United States Department of Education, National PTA, and various national educator associations.

Every child deserves the opportunity to attend a quality public school where he or she can learn and excel in a safe, stable environment. Students should receive an education that teaches not only practical skills and specific knowledge, but that also passes down our nation's core values. Public schools nurture American traditions such as tolerance, freedom, and equality that create productive citizens.

Public schools in Texas continue to show great progress in many areas. According to statistics compiled by the NEA, Texas ranks in the top ten states for 4th graders scoring well in math tests. More and more Texas schools are offering advanced placement courses, and Texas now ranks first in the nation for the proportion of students taking advanced math courses. Texas stands among the top four states nationally for the percentage of public primary schools offering foreign language immersion. Excellence in math and language are not only important personal education skills, but they are critical to our future economic growth.

At the same time, challenges remain. The Administration and the Congress have failed to make the financial investments needed to expand the areas of progress and provide the quality education needed by all of America's children. Elementary schools in Texas are overcrowded and many are desperately in need of major repairs. Quality teachers, our most valuable educational resources, are becoming more and more difficult to recruit and retain.

Despite the promise to leave no child behind, the current federal leadership has adopted policies that break the commitments to reform and accountability in the No Child Left Behind Act. Rural and inner city schools will suffer the most, as will children with special needs and challenges. The President's budget and congressional appropriations are underfunding the No Child Left Behind Act by as much as $8 billion. Similarly, the Individuals with Disabilities Education Act (IDEA) remains woefully underfunded, leaving states and school districts with the burden of complying with the important federal goal of providing a public education to all students.

This lack of funding contributes directly to the problems facing Texas schools and schools across the Nation: larger classes, schools closing earlier, cutting out after school and summer programs, and laying off teachers and staff. What is the response to this starvation diet by the Administration and congressional leaders? Private school vouchers . . . Blame the public schools for meeting standards without providing resources to comply . . . Failure to make the commitment to provide all students, of all backgrounds and needs, with the education they deserve and we as a society need.

The best investment in America's future is an investment in our children's education. We should take this week to give special attention to promoting quality in our nation's public schools; however, our vigilance should not end this week, but continue until every child has the chance to realize his or her educational potential.

TRIBUTE TO LARRY CORNMAN, ROBERT SHARMAN, AND PAUL POLAK

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. McINNIS. Mr. Speaker, it is with great pride that I rise today to pay tribute to three brilliant scientists from my home State. Larry Comman, Robert Sharman, and Paul Polak have an impressive grasp of the most technical aspects of science, and they are using those talents to improve the quality of life of millions of people throughout the country and the world. I would like to join my colleagues here today in recognizing these three gentlemen and their tremendous service to the global community.

Larry, Robert and Paul were recognized recently with three of the year's top fifty science and technology awards by Scientific American magazine. Larry and Robert, of the National Center for Atmospheric Research, developed a computer program that allows the Doppler radar on commercial airplanes to see turbulence at the edges of a storm. This system will serve to increase the safety and comfort for all future commercial air flights. Paul, who is the President of International Development Enterprises, helped to create a low-cost drip-irrigation system for Third World farmers. The system has the potential to aide more than 30 million rural farm families to escape poverty.

Mr. Speaker, Larry Cornman, Robert Sharman, and Paul Polak are bright, enthusiastic individuals who dedicate themselves to the noble endeavor of improving the lives of citizens around the world. These three men have demonstrated a passion for science that resonates in their extraordinary achievements. I am honored to pay tribute here today to these devoted scientists before this body of Congress. Congratulations on your awards, gentlemen. I wish you all the best in your future endeavors.

TRIBUTE TO BARBARA CARMICHAEL, FORMER NORCO CITY COUNCILMEMBER

HON. KEN CALVERT

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. CALVERT. Mr. Speaker, I rise today to honor and pay tribute to an individual whose dedication and contributions to the community of Norco, CA are exceptional. Norco has been fortunate to have dynamic and dedicated community leaders who willingly and unselfishly give their time and talent and make their communities a better place to live and work. Barbara Carmichael is one of these individuals. After 13 years of service to the city, Barbara will step down as a councilmember.

Barbara moved to Norco in 1980 and quickly became involved in the community as a 4–H leader. As an honorary FFA Chapter farmer Barbara truly fit in to the rural lifestyle of Norco. Barbara has been involved with many community organizations including the Chamber of Commerce Fair Committee, a Foundation Board Member for Corona Regional Hospital and member of the Riverside Community Hospital college advisory board. She has also represented the City of Norco as a Mosquito Abatement Trustee, on the Economic Development Advisory Council, the Ad Hoc Committee for the retention of the Naval Warfare Assessment Center. She is a member of the Corona/Norco School Advisory Board and the host of monthly Senior Town Hall meetings. She is also the current President of the Norco Seniors and Pet Relief organization and is a Charter and active member of the Norco Horsemen's Association.

Barbara was first elected to the Norco City Council in November 1990, was elected Mayor in 1992 and 1998. She has served as Mayor Pro-Tempore three times. During her tenure on the Norco City Council Barbara has accomplished an enormous amount for the residents of Norco including the construction of five low-to-moderate income homes; a pilot curbside recycling program and the Sixth Street Façade program; a Directional Sign Program for new homes was approved; a new City Hall was opened; an agreement was reached with the City of Jurupa for the purchase of desalter water; the Lake Norconian Club and central hotel were designated as historic landmarks; the second phase of senior housing was approved; a new senior center was completed; the Animal Keeping Ad Hoc Committee was formed; the proposal to purchase Hidden Valley Golf Club was rejected and barbed wire was prohibited adjacent to equestrian trails.

Barbara's tireless passion for community service has contributed immensely to the betterment of the community of Norco, California. She has been the heart and soul of many community organizations and events and I am proud to call her a fellow community member, American and friend. I know that many community members are grateful for her service and salute her as she steps down from the Norco City Council.

A RESOLUTION IN SUPPORT OF NATIONAL SURVIVORS OF SUICIDE DAY

HON. SUE W. KELLY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mrs. KELLY. Mr. Speaker, I rise today to call attention to an issue that is too often overlooked in our society: the problem of suicide

According to the Centers for Disease Control, a suicide occurs once every 18 minutes. In the year 2000, we lost 29,350 people to suicide. It is the third leading killer of children ages 10 to 14 in the U.S., causing 7.2 percent of the total deaths in that age group. For children ages 15 to 19, the percentage jumps to 12 percent. When most people are starting a family and beginning their careers, between the ages of 25 and 34, suicide is the number two cause of death.

Too often suicide has been stigmatized as a weakness or character flaw. Instead, suicide must be viewed as it truly is: a symptom of mental illness. Viewing suicide as such allows us to recognize the warning signs (including depression, reckless behavior, substance abuse, and a drastic change in attitude and behavior) and helps encourage people to seek help.

While the number of males who commit suicide is about four times higher than the number of females, it is important that we pay special attention to suicide attempts among females, especially teenage girls. It is estimated that women attempt suicide at a three-to-one margin. In the case of teenage girls, these attempts are often a cry for help at a very confusing time in their lives.

We lose one person to suicide every 18 minutes. To put this in perspective, this equates to nearly 13,000 more deaths per year than homicide. We must do more to educate people about suicide, thereby helping to prevent it. For this reason I am sponsoring a Concurrent Resolution in support of National Survivors of Suicide Day and the ideals it upholds. This resolution recognizes and praises the work that numerous public and private sector groups carry out to raise awareness about suicide and provide treatment for depression.

REINTRODUCTION OF THE CAMINO REAL DE LOS TEJAS NATIONAL HISTORICAL TRAIL ACT

HON. CIRO D. RODRIGUEZ

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. RODRIGUEZ. Mr. Speaker, today I am pleased to reintroduce the Camino Real de los Tejas National Historical Trail Act. This legislation would recognize the historical significance of the oldest highway system in Texas.

Translated, camino real means "royal road" and was used exclusively to describe roads between economically important Spanish towns and Spanish capitals. In keeping with its roots, the Camino Real de los Tejas was the first overland route from the Rio Grande to the Red River Valley in Louisiana, and contributed enormously to the settlement and development of the Texas frontier. First traveled in 1689, for the next 300 years the road was worn by traders, immigrants, mail carriers, missionaries, cattlemen and their herds, soldiers, and settlers into an early-day "superhighway".

We would not only pay homage to our ancestors by designating the Camino Real as a National Historic Trail, but also develop a positive tool for economic development and historical preservation in the many towns and cities along the route. By promoting the preservation of this historic resource, the public will gain an opportunity to learn and small, rural communities will have greater opportunity for cultural tourism.

The bill I am introducing today contains special provisions to ensure that trail designation will not impair private property rights. Unlike prior versions of the bill, this one designates the trail only on public lands. Land condemnation is prohibited, and only willing sellers will be approached for acquisition purposes. No private lands will be included in the trail designation unless the private property owner affirmatively opts in.

Spanish conquistador Cabeza de Vaca, the first European to explore Texas, ventured up and down this trail. Both Davy Crockett and General Santa Anna journeyed to battle at the Alamo by way of the Camino Real.

The trails deserve national recognition for their tremendous historical and cultural value. In marking the trail, we honor our history and heritage.

Mr. Speaker, I ask my colleagues to support and cosponsor the reintroduction of the Camino Real de los Tejas National Historical Trail Act. Join me in building up communities rich in history and economic opportunities.

IN HONOR OF CLEVELAND POLICE COMMANDER MARVIN CROSS

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. KUCINICH. Mr. Speaker, I rise today in honor and recognition of Commander Marvin Cross, upon the occasion of his retirement from the Cleveland Police Department—Following twenty-two years of dedication to the citizens of Cleveland; and twenty-two years of honor to the force and to the badge.

Commander Cross was born and raised in Cleveland, and graduated from Max Hayes High School. He earned a Bachelor of Science degree from Myers University, and later graduated from the FBI Academy. In 1981, Commander Cross joined the city of Cleveland Police Department. By 1983, Commander Cross was promoted to the position of Detective, and within ten years, he was appointed to the position of Sergeant in the 6th District. His extensive experience regarding hate crimes, combined with his passion for social justice, led Commander Cross to create the city of Cleveland's Ethnic Intimidation/Hate Crime Task Force. This Task Force has resulted in a 62 percent reduction of hate crime activities since 1998.

Commander Cross' great intellect, combined with his exceptional interpersonal skills, brought people and agencies together for the common good and protection of Cleveland citizens. He developed a Fugitive Tracking System that led to the apprehension of over 2,500 fugitives; and reduced fugitive tracking expenses by more than forty percent.

The list of Commander Cross' accomplishments and accolades is long and far-reaching. He was twice-named Police Officer of the Year; was honored with the Distinguished Service Award from the city of Cleveland Police Department; and was bestowed the Red Cross Biennial Volunteer Hero Award, among others.

These extraordinary honors reflect the extraordinary nature of Commander Cross himself, His integrity, vision, heart, and concern for others has served to uplift the lives of countless families and individuals within our community. Commander Cross in the ultimate hero and role model for our youth. His sincere concern for our children has been witnessed through his involvement in the Amateur Athletic Youth Basketball League, the Special Olympics Torch Run and the Greater Cleveland Big Brothers/Big Sisters Shadow Blue Program.

Mr. Speaker and Colleagues, please join me in honor, gratitude and celebration of Commander Marvin Cross, as we reflect on his twenty-two years of significant service to the citizens of Cleveland. Commander Cross' positive nature, personal integrity, expertise, and focus on protecting his constituents in the city of Cleveland have all served to raise the grade of safety and protection within the City limits to an exceptional level. Commander Cross' outstanding years of service has been a guiding force within our community, and is worthy of our gratitude and recognition. We wish Commander Cross and his entire family many blessings, great happiness and abundant health today and always.

PERSONAL EXPLANATION

HON. VERNON J. EHLERS

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. EHLERS. Mr. Speaker, on rollcall Nos. 626 and 627 I was absent because I was giving a major lecture on science and engineering to the American Society of Mechanical Engineers.

Had I been present, I would have voted "aye" on both issues.

ON THE DEATH OF JAMES A. GRAHAM, FORMER NORTH CAROLINA COMMISSIONER OF AGRICULTURE

HON. RICHARD BURR

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. BURR. Mr. Speaker, North Carolina lost a great friend today. For 36 years, the Old North State's agricultural interests were overseen with care, love, and passion by Jim Graham. For 36 years, Jim Graham served as Commissioner of Agriculture for my State, and he was probably the most beloved figure in public life in 20th century North Carolina.

Anyone who met the Commissioner—whether they met him once, or knew him for all of his 82 years—knew the same Jim Graham. He was affable, kind, and passionate. Mr. Graham grew up in Rowan county, was educated at State College (now North Carolina State University), and held several agriculture-related jobs before he entered public service, including managing the Dixie Classic fair in my home town of Winston-Salem. He was appointed Commissioner of Agriculture in the summer of 1964, was elected to the position that fall, and held it until his retirement in 2001.

Mr. Speaker, the Commissioner was a passionate member of the other political party. So passionate, in fact, that when introduced at political rallies, he would let out the loudest donkey bray you have ever heard. But while he brayed loudly for his party, he never spoke louder, or with more passion, than he did when preaching for the betterment of the North Carolina farmer. He always held the land, and the people who worked the land, in the highest esteem.

With all the changes that have occurred in North Carolina agriculture in the last 30 years, it is a good thing that we had Jim Graham looking out for us. When he was looking out, he was looking forward. He took the Tar Heel State from near-total dependence on the golden leaf of tobacco, to today, when tobacco income is complemented by hogs, poultry, winegrapes, soybeans, sweet potatoes, and more.

He was a positive voice for the future of North Carolina, and just as he would never forget your name, not soon will many forget his ever-present cigar and cowboy hat, his kind manner and love for his state.

No farmer anywhere had a better friend than Jim Graham. No State in the Union had a better public servant than Jim Graham. Well done, good and faithful servant.

HONORING SAMUEL HUNTINGTON AND BILL STANLEY

HON. ROB SIMMONS

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. SIMMONS. Mr. Speaker, I rise today to recognize two individuals who are genuine Connecticut treasures—Samuel Huntington and Bill Stanley.

On Monday I will attend a ceremony to re-intern Samuel Huntington. Mr. Huntington will be laid to rest in Norwich, Connecticut, a community in the Second District, which I am proud to represent.

Samuel Huntington was born in Windham, Connecticut on July 2, 1732. He did not have the benefit of a formal public education as he was the eldest son and his father needed him to help work the family farm. Possessing a fine mind, when he was finished with his farm chores he devoted himself to reading. Mr. Huntington enjoyed studying the law and when he turned 22 he left the farm to pursue his interest. Unable to afford a formal legal education, he studied on his own. The library of an attorney in a neighboring town provided him with access to the necessary books—his own determination accomplished the rest.

He did well. In 1774, he became an associate judge in the superior court. Mr. Huntington was among those who early on spoke against British tyranny. In October 1775, his wisdom and patriotism earned him an appointment by the Connecticut General Assembly to represent the colony in the Continental Congress.

In the July 1776 Mr. Huntington joined his colleagues in voting for the Declaration of Independence. In 1779, Mr. Huntington served as president of the Congress. As such, some say he was the first President of the United States. He remained a member of that honorable body until 1781, when ill health forced him to retire. Samuel Huntington died on January 5, 1796.

Recently the Norwich Historical Society embarked on a campaign to renovate the tomb of Mr. Huntington and his wife. Over time the tomb had decayed and was in danger of collapse. Our Founding Fathers deserve more, and the leaders of Norwich have responded.

The second individual I recognize is President of the Norwich Historical Society, William Stanley. He is also one of Connecticut's treasures. Bill organized the effort to renovate the tomb and I was very pleased when he called me for support. Bill is a good man and a good friend.

For five decades Bill Stanley has dedicated himself to public service. His resume shows an individual who has a profound devotion to his community and has worked to make it a better place in which to live, work and raise a family.

In 1963, Bill was chairman of the Norwich Flood Rehabilitation Drive and from 1966 to 1970 he was a state senator, representing the 19th District. Over the decades he has served as chairman of the Eastern Connecticut District of the American Cancer Society; led Eastern Connecticut Recruitment for the Boy Scouts of America; been treasurer of the Norwich Industrial Park Association; served as director of the William W. Backus Hospital, and has been vice chairman of the Southeastern Connecticut Water Authority.

Motivated by a desire to improve the lives of our senior citizens, Bill became the founder, treasurer and president of St. Jude Common, a non-profit elderly housing facility in Norwich. St. Jude's provides high quality housing. Bill has also dedicated his time to Norwich Free Academy and served as Chairman of the Norwich Charter Revision Commission.

Bill's public service has not gone unnoticed. He is the 1995 recipient of Norwich Rotary's Outstanding Citizen Award and in 1991 the Eastern Connecticut Chamber of Commerce named him Norwich's Citizen of the Year. Bill is the unofficial Norwich historian, having published several books chronicling the city's past. His "Once Upon a Time" column has appeared in both the New London Day and the Norwich Bulletin.

These are merely a few of the public citations from Bill's years of service. They do not include the many times Bill quietly helped people by making a phone call or offering good advice. Bill served in the Marine Corps. He is a Korean War veteran.

I am proud that I was able to be of some assistance to Bill Stanley in ensuring one of our nation's Founding Fathers received the honor and respect he deserves as America's first president.

IN RECOGNITION OF LILA DE CHAVES-CHRONOPOULOS

HON. CAROLYN B. MALONEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mrs. MALONEY. Mr. Speaker, I rise to pay tribute to Lila De Chaves-Chronopoulos. A remarkable woman, Lila De Chaves-Chronopoulos serves as President of the National Museum of Greek Folk Art, Lifetime Honorary Chair and Executive Global Cultural Director of the Euro-American Women's Council, and President of the Hellenic Federation of Friends of Museums. It is a pleasure to honor this ambassador of Greek folk art and culture.

Lila De Chaves-Chronopoulos has had a distinguished career as an ethnologist specializing in historical and ethnic textiles, jewelry and costumes. Among other accomplishments, she is currently professor of visual arts at American University in Athens. Ms. De Chaves-Chronopoulos is known for her participation in numerous international exhibitions of metalwork in Greece and abroad. She has also given various seminars through the American Women's Organization of Greece, as well as consulting for Hellenic organizations in Greece and the United States. In addition to her educational efforts, Ms. De Chaves-Chronopoulos has worked tirelessly to preserve Hellenic culture and promote Hellenic achievements to audiences around the world.

Granddaughter of an immigrant to America, Lila has strong ties to both the Greek and American communities. Her grandfather, Konstantin V. Chrones, came to the United States at the turn of the century and lived and worked here for 15 years prior to returning to his native Greece to raise a family. Lila's grandfather passed his American experience and his love of Greek culture on to his children and grandchildren. Lila's father, Vassilis K. Chronopoulos, was a well known doctor and revered philanthropist in Greece. The influence of her grandfather's American experience and her father's philanthropic efforts profoundly shaped Lila's life. Just as Lila has helped increase American awareness of Hellenic culture, she has also helped Europeans to understand and appreciate America's unique history, culture and way of life.

As President of the friends of the Museum of Greek Folk Art, Lila has authored numerous articles in both scholarly and mass media publications. Over the years, Lila De Chaves has shared the breadth and depth of her vast knowledge of folk art and jewelry with a wide audience. Her endless efforts to support the arts and culture, and to enlighten communities around the world are commendable.

In recognition of her outstanding achievements, I ask my colleagues to join me in honoring Lila De Chaves-Chronopoulos.

TRIBUTE TO HANK STOVALL, BROOMFIELD COUNTY AND CITY COUNCILMAN

HON. MARK UDALL

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. UDALL of Colorado. Mr. Speaker, I rise today to acknowledge the outstanding work of Hank Stovall. Hank served for 24 years on the Council for the City and County of Broomfield as a member for Ward 4 and as Mayor Pro Tempore for a number of years.

Along with his colleagues on the city council, Hank helped make Broomfield the diverse and vibrant community that it has become today. He has also helped preserve the high quality of life that citizen in this community at the foothills of the Rocky Mountains have come to expect and appreciate.

The citizens of Broomfield have benefited greatly from Hank's dedicated leadership. He helped secure a quality transportation system in the Broomfield region, including support for the Northwest Parkway, an important highway that will connect this community with the Denver International Airport and other important access roads in the region. This Parkway will also include an open space buffer that will add to the quality of the Broomfield neighborhoods as well as increase transportation efficiency and access. He also worked with coalition to improve the US 36 highway corridor and the Broomfield intersections to this important highway corridor.

He also has helped ensure that Broomfield's transition from a city to a county was smooth, effective and successful. He and his colleagues recognized the importance of establishing Broomfield as a city and county so as to better serve its citizens. Before the conversion to a county, residents were required to travel to four distant county offices as the city was spread across four separate counties. By making Broomfield a county, the citizens of this community can now enjoy the efficiencies that come with that designation as well as further develop the sense of community that he and others have sought to accomplish.

Hank has been involved in many regional and State governmental committees, authorities, task forces and coalitions. All of this work was designed to promote effective governmental function and quality services to citizens and communities in the Broomfield region.

But perhaps his most lasting legacy will be his leadership on issues related to Rocky Flats, the former U.S. Department of Energy nuclear weapons production facility just south of the city and county. He brought his knowledge of nuclear issues to the table as strategies and approaches for cleaning up this facility were being discussed and developed. He insisted that the cleanup be thorough, cost effective and protective of the health, safety and environment of the surrounding communities. He was also a strong proponent of preserving the open space resources at this site and was an early advocate of designating the site as a national wildlife refuge. His support, as well as the support of other leaders surrounding the site, helped make this a reality.

He remained very concerned with public health and safety issues related to this site and its cleanup, closure and conversion to a national wildlife refuge. He was especially concerned about the health and safety of the workers at the site and pushed for instituting a high level of safety in all facets of the work done there.

Hank leaves the Broomfield County and City Council with a long and distinguished record of accomplishment and service. The citizens of Broomfield enjoy a quality of life, a strong sense of community and a solid reputation for service and leadership on regional issues because of Hank's involvement and public service work. I ask my colleagues to join me in wishing Hank every success in his future endeavors and hope that he remains active in community and regional issues for years to come.

IN HONOR OF THE FERTITTA FAMILY 105TH ANNIVERSARY REUNION

HON. NICK LAMPSON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 21, 2003

Mr. LAMPSON. Mr. Speaker, I rise today to pay tribute to the 105th Anniversary of the highly regarded Fertitta Family in Galveston, Texas. The Fertitta family generously devotes their time, integrity, and leadership to every community their journey encounters.

This family reunion is a rare celebration of perseverance, achievement, loyalty, and love of an incredible ancestry. The Fertitta family heritage traces their roots back more than a century ago to Palermo, Sicily where a courageous young man named Joseph Fertitta made the pivotal decision to come to America in 1897.

Joseph and Olivia Fertitta have inspired hundreds of descendents to travel across the country to Galveston, Texas to celebrate the trials and joys of life together as a family. It is to he and his wife Olivia that a profound amount of respect and honor should be paid to, and upon whose base this incredible family is built upon.

Mr. Speaker, on November 29th, this family will commemorate its anniversary of over 100 years of faith and love. I ask you, and all of my colleagues, to join me in recognizing this remarkable family's triumph that has passed the test of time and remains a shining example of America's strength and unity.

H. CON. RES. 257—PRESIDENTIAL MEDAL OF FREEDOM TO HARRY W. COLMERY

HON. HENRY E. BROWN, JR.

OF SOUTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. BROWN of South Carolina. Mr. Speaker, I rise today in strong support of House Resolution 257 urging President Bush to bestow this Nation's highest civilian honor, the Presidential Medal of Freedom Award, on Harry W. Colmery, former national commander of The American Legion.

Mr. Colmery is credited with drafting the Servicemen's Readjustment Act of 1944, otherwise known as the World War II "GI Bill of Rights." The GI Bill not only enabled the successful transition of millions of World War II veterans back to civilian life, but also paved the way to create America's modern middle class.

In fact, about 7.8 million men and women were educated or trained by the World War II GI Bill, arguably our most successful domestic program ever.

With our brave service men and women currently engaged in dangerous military operations in Iraq, Afghanistan and other areas of the world in support of the Global War on Terrorism, it is so critical for Congress to continue to provide our military personnel with topnotch benefits like today's Montgomery GI Bill. As I travel throughout the first district of South Carolina, veterans and current service members always remind me of the importance of these educational benefits.

Mr. Speaker, I ask my fellow colleagues to support this Resolution to honor Harry W. Colmery, a man of extraordinary wisdom and foresight.

VETERAN TRIBUTE FOR CHIEF GUNNERSMATE WILLIAM L. WRAY

HON. MICHAEL C. BURGESS

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. BURGESS. Mr. Speaker, I rise today to recognize the contributions and sacrifices of Chief Gunnersmate William L. Wray.

Chief Gunnersmate Wray served as a United States Navy Frogman in World War II and the Korean War. Throughout his military career Chief Gunnersmate Wray earned three purple hearts, the World War II Commemorative Medal, and was a Prisoner Of War in World War II. He also received the Korean War Medal with two stars, United Nations Korean Service Medal, and numerous other accolades for his service.

At a time when we are once again at war, it is necessary to recognize the achievements of these national heroes. Due to their dedication, service, and sacrifice, they deserve our unwavering admiration and our unending gratitude.

Our country often takes for granted the freedoms and liberties our service men and women risk their lives to protect; yet by continuing to honor our veterans we preserve our nation's future by commemorating their past.

Thank you, Chief Gunnersmate Wray, for your service and sacrifice. You are a true hero.

CENTRAL NEW JERSEY RECOGNIZES AND CELEBRATES JOHN G. McCORMACK, CHIEF OF POLICE, MANALAPAN, NJ

HON. RUSH D. HOLT

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. HOLT. Mr. Speaker, I rise today to recognize the career of Chief John G. McCormack, who has served the Manalapan Police Department and the people of Manalapan for 30 years and as chief for 7 years.

In his 30 years of service he has risen through the ranks of the Manalapan Police Department, starting as a police dispatcher in 1973.

Along with his commitment to the department he has spent numerous hours serving as the Emergency Management Coordinator for the Township of Manalapan for the last seven years. He also serves as the Municipal Disaster Control Director for the town and sits on the Monmouth County Community Crisis Response Planning Committee.

His dedication to his work earned him the honor of being named Chief of the Year by the Princeton Education Research Institute and the Law Enforcement Man of the Year by the Manalapan-Marlboro Post 972 Jewish War Veterans of the United States.

Prior to serving and protecting his community, Chief McCormack served his country. He served four years in the United States Air Force, including a tour in Vietnam.

As an inspiration to police officers in his department and the state of New Jersey, Chief McCormack has contributed significantly to the life of his community. He has earned our heartfelt appreciation for his efforts.

HONORING ST. PAUL AFRICAN METHODIST EPISCOPAL CHURCH

HON. BARBARA LEE

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Ms. LEE. Mr. Speaker, I rise today to honor St. Paul African Methodist Episcopal Church, and its Bishop, John Richard Bryant. On Sunday, November 23, 2003, St. Paul AME will celebrate seventy years of serving the greater Bay Area community.

The Reverend E.N. Elliott developed the foundations for the Berkeley Mission in 1933. He was very proud to report his three members to the African Methodist Episcopal 69th Annual Conference.

Early developmental meetings were held in the home of Rev. and Mrs. Speese, but the needs of a rapidly-growing congregation led to the establishment of a temporary church headquarters at the corner of Grove Street and Russell in Berkeley. The Sunday school was set up during the very first week at that site.

Later on, the property at 1630 Fairview was purchased under the leadership of Rev. H.C. Claybrook. The name, Berkeley Mission, was changed to St. Paul AME Church, and the Seal of Incorporation was secured in early

1937. In 1953, St. Paul moved to the current location at 2024 Ashby Avenue.

The St. Paul AME family has come a long way from its humble beginning. The congregation has expanded to over 1,100 members and continues to grow today. St. Paul enjoys the distinction of being the only African Methodist Episcopal Church in Berkeley, California. Its ministries provide a wide spectrum of service, offering food, clothing, and housing referrals for those in need. Additionally, its doors are open for meetings of Narcotics Anonymous, Alzheimer's, and diabetes support groups. Children in the Berkeley community are served through education, tutorial and Saturday programs, as well as exercise classes.

Today, St. Paul AME is under the guidance of Presiding Prelate Fifth Episcopal District Bishop John Richard Bryant and Episcopal Supervisor Reverend Dr. Cecelia Williams Bryant. Reverend Dr. Vernon Steven Burroughs is the Presiding Elder and Reverend Dr. Allen Williams is the Pastor.

I take great pride in joining friends, family, and the congregation to salute St. Paul African Methodist Episcopal Church and its leader, the extraordinary Bishop John Bryant, on the seventieth anniversary of service.

DEPARTMENT OF THE TREASURY INSPECTOR GENERAL CONSOLIDATION ACT OF 2003

HON. ROB PORTMAN

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. PORTMAN. Mr. Speaker, today I am introducing legislation, the Department of the Treasury Inspector General Consolidation Act of 2003, which will promote efficiencies and improve oversight at the Department of the Treasury. The measure I am proposing will merge two existing Inspector General offices at the U.S. Treasury—the Office of Inspector General of the Treasury (OIG) and the Treasury Inspector General for Tax Administration (TIGTA)—into a new office called the Office of the Treasury Inspector General (TIG).

The Department of the Treasury is the only agency with two Inspectors General. The benefit derived by consolidating OIG and TIGTA will be better oversight for all of Treasury, including the IRS, while ensuring that the new organization has all the same powers and authority as its predecessors have under current law.

The legislation I am introducing is necessary because the creation of the Department of Homeland Security has resulted in significant reduction in agencies and personnel at Treasury. The U.S. Customs Service, U.S. Secret Service, the Federal Law Enforcement Training Center, and most of the Bureau of Alcohol, Tobacco and Firearms have been moved to the Department of Homeland Security and the Department of Justice. The current TIGTA and OIG structure does not recognize the new organizations, where IRS has 87 percent and the rest of Treasury has 13 percent of the remaining personnel resources.

A single, elevated IG will provide strong oversight to all of Treasury's current operations. The Department also will gain the efficiencies from the merger by eliminating duplication and creating a more effective and efficient operation to further the mission of both offices.

TRIBUTE TO SERGEANT FIRST CLASS KELLY M. BOLOR

HON. HILDA L. SOLIS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Ms. SOLIS. Mr. Speaker, I rise to pay tribute to Sergeant First Class Kelly M. Bolor, 137th Quartermaster Company, United States Army Reserve, located in South El Monte, California. This brave and compassionate man dedicated his life to protecting our country and the freedoms that we all enjoy. On November 15, 2003, Sergeant First Class Kelly Bolor made the ultimate sacrifice and was killed while serving our country during Operation Iraqi Freedom.

Sergeant First Class Kelly Bolor was born December 20, 1965, and raised in Hawaii with his twin brother. He graduated from Lahainaluna High School in June 1984. Shortly after graduating Sergeant First Class Bolor enlisted in the United States Army, beginning an almost 20 year military career.

In 1984, Sergeant First Class Bolor graduated from a 92Y Supply Specialist course from Fort Jackson. Subsequently, in 1986, he completed Fort Benning Airborne School. On March 1, 1998, Sergeant Bolor joined the United States Army Reserve. He rose to the rank of Platoon Sergeant for the 137th Quartermaster Company on January 10, 2002.

Sergeant First Class Bolor is a Desert Storm veteran, and served overseas duty in Fort Wainwright, Alaska in 1988, Southwest Asia in 1991, Camp Humphrey's Korea in 1993 and finally Iraqi Freedom in 2003.

Sergeant First Class Kelly M. Bolor served our country as a true patriot and defender of democracy. He leaves behind widow Kelly Bolor and son Kyle, age three. Let us preserve the memory of Kelly M. Bolor so that his son may learn about his father, who was a kind-hearted man who put the safety and well-being of his country and fellow soldiers first.

HONORING THE LIFE AND WORK OF KENNETH WILEY

HON. CIRO D. RODRIGUEZ

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. RODRIGUEZ. Mr. Speaker, I rise today to honor the life and work of Kenneth Wiley. Kenneth has been a leader in the San Antonio community, and he serves as a positive role model for future generations of labor advocates.

Born in Union Valley, Texas, Kenneth married Dorothy Sutton Wiley. He is the proud father of Sharron Kay Pacheck, Terry Marshall Wiley, and James Arthur Gross and the beloved grandfather to 11 grandchildren and 6 great-grandchildren.

Kenneth began working at Southwestern Bell Telephone Company in 1948 where he served as a lineman, an installer, a telephone repeaterman, and a central office technician. During his years of service at Southwestern Bell, he served his fellow workers as a job steward, a chief steward, legislative director, and vice president for the Communications Workers of America (CWA). He also served for 13 years as the president of the CWA, Local 6143.

A tireless advocate for labor in local, state, and national politics, Kenneth also worked for the rights of his fellow workers as a member of the State Democratic Committee and the San Antonio and Texas AFL/CIO Councils.

Kenneth has also worked to improve his local community serving on the boards of the San Antonio United Way, San Antonio's Council on Alcoholism, the USO, Goodwill Industries, and San Antonio's Centro 21 Committee.

I have had the great privilege of knowing Kenneth for many years, and I am well acquainted with his good works, his strong moral character, and his selfless dedication to his friends, families, co-workers, and community. I rise today to honor Kenneth Wiley's legacy of community service and his commitment to protect the rights of American working men and women.

RECOGNIZING COLIN A. HANNA

HON. JIM GERLACH

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. GERLACH. Mr. Speaker, I rise today to recognize Colin A. Hanna for his eight years of service as commissioner of the Chester County Board of Commissioners.

Colin Hanna was first elected Chester County Commissioner in November 1995 and ran successful races to serve as Chairman of the Chester County Board of Commissioners in 1998, 1999, 2001 and this year, 2003. After only six months, he was elected by his colleagues to represent the County on the Delaware Valley Regional Planning Commission, which he chaired for two terms spanning four years from 1996 to 2000. He was also appointed Chairman of the Housing Authority of Chester County where he saved the agency from insolvency by undertaking an extensive reorganization process. During his tenure, the nationally-acclaimed County comprehensive plan, "Landscapes," was adopted and Chester County achieved its first bond-rating increase in 28 years, bringing it to the second highest in the Commonwealth. Mr. Hanna is a two-time recipient of the Governor's Award for Local Government Excellence—once with his commissioner colleagues and once individually.

Mr. Hanna has lived in Chester County virtually his entire life and chose to attend college at the University of Pennsylvania in nearby Philadelphia where he met his wife Pricie in 1967. After graduating from the University in 1968, Colin was commissioned an officer in the U.S. Navy. When his military service ended, he became employed with the CBS network in New York before returning to Chester County in 1972. He continued his work with CBS in Philadelphia before becoming President of Industrial Advertising Incorporated, which at the time was Chester County's largest advertising agency. Eventually, he would sell his ownership in the agency and pursue work in the marketing field as a management and executive search consultant. He continued his consulting work until 1991 when he founded PC Helper, a computer support and maintenance firm specializing in small business networks. In 1996, Colin Hanna sold his firm and chose to devote his time and energy to public service and the job of County Commissioner where he has remained a tremendous asset to the community. Mr. Hanna brings with him to the Chester County Board of Commissioners years of hard work, experience and leadership that has allowed him to be a driving force in making Chester County a better place for all of its residents.

I ask that my colleagues join me today in recognizing Colin Hanna for his exemplary citizenship and service to our community. His enduring devotion and unwavering support has made him a man for which Chester County and our entire nation can be proud.

TRIBUTE TO MOUNTAIN PARK ENVIRONMENTAL CENTER'S EARTH STUDIES PROGRAM

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. McINNIS. Mr. Speaker, it is with great pride that I rise today to pay tribute to an award-winning Earth Studies Program at Mountain Park Environmental Center in Beulah, Colorado. The program provides children with the wonderful opportunity to learn about the environment while providing them an alternative to abusive lifestyles such as gangs and drugs. I would like to join my colleagues here today in recognizing the Mountain Park Environmental Center's tremendous service to the Pueblo community.

The Earth Studies Program is a yearlong outdoor-based education course that covers basic subjects in language art, math, social studies, and geography in addition to environmental sciences. Students learn firsthand about ecosystems, three identification, and stream ecology. Recently, the Earth Studies program was recognized by the Colorado Alliance for Environmental Education for excellence in environmental education. It is truly an outstanding program.

Mr. Speaker, the Earth Studies Program at Mountain Park Environmental Center is an educational organization that encourages students to develop a love for nature. The program enriches the lives of Pueblo's students and the entire Colorado community. The Earth Studies Program is a learning experience that positively affects every child who is able to participate. It is my honor today to pay tribute to this fine educational program before this body of Congress.

TRIBUTE TO RAY BECKER, PRESIDENT, BUILDING INDUSTRY ASSOCIATION

HON. KEN CALVERT

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. CALVERT. Mr. Speaker, I rise today to honor and pay tribute to an individual whose dedication and contributions to the community of Southern California are exceptional. Southern California has been fortunate to have dynamic and dedicated community leaders who willingly and unselfishly give their time and talent and make their communities a better place to live and work. Ray Becker is one of these individuals. Ray will be stepping down as President of the Building Industry Association of Southern California (BIA) and I would like to thank him for his service.

Ray originally came to the Inland Empire in the early 1980s as Vice President and Division Manager with the Lusk Company. During 20 years in Southern California real estate development, Ray has managed the construction of more than 3,000 homes and 16,000 home sites. For eight years Ray taught Light Construction and Development Management at the University of California, Riverside.

Ray is also Senior Vice President of Lennar Communities Inland, a division of Lunar Homes of California. Lunar is a national real estate company listed on the New York Stock Exchange and is one of the largest public homebuilders in the United States. Under his leadership, Lunar acquires, plans, entitles, develops, markets, sells, and manages medium and large scale communities.

Ray has been an excellent President of BIA and continually promotes the building profession. He is also involved in California BIA and the National Association of Homebuilders. He is past President of the Inland Chapter of HomeAid, an industry charitable foundation, and has held the Presidency of the Youth Service Center and Parkview Community Hospital Foundation. Ray's commitment to the community and to Southern California is exemplary.

Ray's tireless passion for the building industry has contributed immensely to the betterment of the community of Southern California. I am proud to call him a fellow community member, American and friend. I know that many BIA members and homebuilders are grateful for his service and salute him as he steps down from his position.

H.R. 1964, THE HIGHLANDS STEWARDSHIP ACT

HON. SUE W. KELLY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mrs. KELLY. Mr. Speaker, I rise today to urge the passage of H.R. 1964, the Highlands Stewardship Act.

The Highlands region is spread through parts of New York, New Jersey, Connecticut, and Pennsylvania and covers more than two million acres of pristine, undeveloped land. In studies in 1992 and 2002, the National Forest Service recognized the Highlands as "nationally significant" and estimated that 5,000 acres of land are lost to development just in the New York and New Jersey portions of the Highlands.

The Highlands also serve as an "oasis" amid the urban centers of Philadelphia, Hartford, and New York. The region, with its networks of reservoirs and aquifers, supplies clean, safe drinking water for over 11 million Americans. At the moment, only 23% of those watershed lands are protected, with almost 100,000 of those acres being immediately threatened. Without these water sources, the sprawling metropolises we know today and New York and Philadelphia would have never developed.

The tourist value of this region cannot be overlooked. Every year, over 14 million people visit the Highlands. This total is higher than the number of people who visit Yellowstone National Park every year, and we don't even have a geyser.

Twenty million people live within a two hour drive of the Highlands. With the ever-increasing rigors of city and suburban life, it is important to have a place for families to unwind and interact with the natural splendors that are too often missing from their lives. The Highlands provides that and so much more. This bill will ensure that these natural beauties survive so that future generations can enjoy them as we do now.

IN HONOR OF FATHER MARINO FRASCATI

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. KUCINICH. Mr. Speaker, I rise today in honor of and recognition of Father Marino Frascati, founding member of the Detroit Shoreway Community Development Organization—and spiritual guide, healer, and beloved mentor and friend to many in this Westside community for more than fifty years. Father Frascati, parish priest of Our Lady of Mount Caramel Church, continues to serve the Detroit-Shoreway neighborhood with integrity, compassion, and grace, and was bestowed the honorary appointment of President for Life with the Detroit Shoreway Community Development Organization. Father Frascati has been a steady and focused instrument of healing, preservation, growth and hope along the streets of this neighborhood.

When others lost hope and turned away, Father Frascati dug in, continuing his quest to improve the lives of the families, seniors and individuals who live and work within this Westside community. His rare ability to connect with others and bring people and groups together for the common good has significantly improved all aspects of this neighborhood.

Father Frascati was instrumental in renovating and developing countless commercial and residential structures along Cleveland's Westside. Due to his persistence and personal meetings with Monsignor Barone, then Undersecretary for the U.S. Department of Housing and Urban Development, the Detroit-Shoreway neighborhood was the first community in Cuyahoga County to be awarded the Urban Development Action Grant for a neighborhood project. This grant resulted in the construction of Father Caruso Boulevard and restoration of the historical Gordon Square Arcade. Despite opposition and adversity, Father Frascati remains a tireless and unwavering champion of this neighborhood. Father Frascati established Nolasco Corporation which resulted in new housing for senior citizens and low income families. Additionally, Father Frascati has created strong and enduring bonds with local business owners, bringing businesses and jobs—like Bank One at the Gordon Square Arcade—back into the neighborhood.

Mr. Speaker and colleagues, please join me in honor, recognition and gratitude of Father Marino Frascati, whose compassion, commitment and energy continues to create a haven of assistance, hope and renewal along the streets of Detroit-Shoreway and beyond. His presence, vision, leadership, and unwavering faith in the people and possibilities of this community have restored and uplifted the very foundation of this neighborhood—reclaiming the heart and soul of this community one brick, one senior citizen, one family at a time.

PERSONAL EXPLANATION

HON. VERNON J. EHLERS

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. EHLERS. Mr. Speaker, on rollcall No. 641, 642, 643, and 644, I was absent because I was receiving a major named award from and giving remarks to the national meeting of the American Society of Mechanical Engineers.

Had I been present, I would have voted "aye" on all four votes.

THE ISRAELI-PALESTINIAN CONFLICT

HON. RICHARD BURR

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. BURR. Mr. Speaker, I rise today to discuss the lack of progress in the Middle East peace process. Aside from our own Nation's ongoing military operations in the war against terrorism, the Israeli-Palestinian conflict is one of the most important foreign policy issues being discussed and debated by my constituents.

Clearly, there is a wide range of points of view on this critically important issue, and they cover the range of the political spectrum. I would like to take this opportunity, Mr. Speaker, to outline some of my own thoughts on some of these subjects.

I should state at the outset that I believe Israel has a right to defend herself against the actions of Palestinian extremists. It would be the height of hypocrisy, Mr. Speaker, for our own country—engaged in its own fight against terrorists bent our destruction—to deny Israel the right to pursue those bent on her destruction. Since obtaining independence in 1948, Israel has been engaged in a near-constant struggle for survival.

The current violence, and Israel's military response to it, is a reflection and continuation of that struggle. There are some on the Palestinian side, many of whom have close ties—if not direct connections—to Yasser Arafat and the Palestinian Authority, who desire nothing less than the destruction of the state of Israel. These are the very groups sending young Palestinians to detonate suicide bombs on buses, in pizza parlors, in sidewalk cafes, and even at Jewish religious celebrations. On that basis alone, Israel has no choice but to continue efforts to round up those responsible. Even prior to the eruption of the latest violence more than two years ago, Arafat refused to do so. He refuses to do so to this day.

It is clear, Mr. Speaker, that Arafat has abdicated his position as a responsible negotiator and representative of the best interests of the Palestinian people. On too many occasions, he has walked away from the peace table and given tacit approval to renewed violence by Palestinian extremists. Arafat remains—for better or worse—the "chosen" representative of the Palestinian people. For real progress to occur, however, the Palestinian people need a prime minister with real authority—the authority to go after the extremists, the authority to negotiate with the government of Israel, and the authority to make decisions that will not be overturned at Arafat's whim. If a lasting peace in the Middle East is the ultimate goal, and I firmly believe that it must be, the Palestinian people must have a capable, effective prime minister. I am hopeful that Ahmed Qureia, sworn in as the Palestinian prime minister earlier this month, will be permitted to take the steps necessary to end the terror attacks against Israel and return the Palestinians to the peace table.

I am not opposed to the establishment of an independent Palestinian state. Neither, for that matter, are the people and government of Israel. That state, however, can only be established if it and the larger Arab world in turn recognize Israel's right to exist. Without that recognition, there can be no lasting peace. If Israel were to accept the establishment of an independent Palestinian state that maintained its opposition to Israel's existence, the country would only be ensuring its own destruction.

I firmly believe that our country should continue providing financial and military assistance to the Israeli people. As long as the nations surrounding Israel continue to provide assistance to those trying to destroy the country, the United States should continue its efforts to support her. As the region's only democratically elected government, Israel deserves our support.

Our Nation has an important role to play in the peace process, Mr. Speaker, and we should continue to do so. We can and should continue diplomatic efforts to bring a lasting peace to the region. It remains to be seen if the Arab states, which have called on us to play a more active role, will actually respect that role. I do not believe, however, that our involvement should extend to the deployment of U.S. troops to "police" any final peace agreement. Any agreement that requires peacekeepers to be deployed is flawed to begin with—it means neither side actually expects the other to abide by the agreement's provisions. We must pursue a comprehensive agreement that both sides accept.

Having accepted Israel's right to defend herself, I also believe there must come a time for negotiations and a legitimate peace process. Israel should make every effort to limit incursions into Palestinian-controlled areas. There must be recognition, both in this country and around the world, that both sides must be willing to talk. The Israelis have shown that willingness in the past, and have made significant proposals aimed at achieving a lasting peace. What remains, however, is the need for a serious commitment on the part of the Palestinians to return to the table and actively work with the Israelis.

In order for that to happen, though, the new Palestinian leadership must denounce terrorism once and for all and make a firm commitment to restrain, arrest, detain, and destroy those militant elements in Palestinian areas that want the violence to continue. After all, there are groups who have stated that they will never accept cease-fire, nor respect any peace agreement. More than a firm commitment, however, the Palestinians must take firm action—or empower a prime minister to take firm action on their behalf.

In crisis, Mr. Speaker, there is opportunity. The only thing that remains is for both sides to accept the challenge, and take advantage of the opportunity. Peace in the region is long overdue, but it will take the active participation of both sides to achieve it.

HONORING PAUL J. SIMMERT OF NORWICH, CONNECTICUT

HON. ROB SIMMONS

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. SIMMONS. Mr. Speaker, I rise today to honor Cadet Paul J. Simmert of Norwich, Connecticut who was recently named Chief Petty Officer of the Nautilus 571 Division of the United States Naval Sea Cadet Corps.

At only 17 years of age, Paul will be in command of 50 cadets, ranging in age from 11 to 17 years. This appointment follows tremendous hard work and dedication, including the completion of regulation U.S. Navy courses and many months of training throughout the country over the past 4 years.

Having a father in the Navy inspired Paul's interest in serving his country at a very young age. At 12, he took the first steps toward what will be a very successful career in the U.S. Navy by joining the U.S. Sea Cadet Corps. Through this program, Paul has been able to take on important responsibilities and learn the ropes of the United States Navy.

Chief Petty Officer Simmert is an exemplary young man and is highly deserving of this great honor and responsibility. I am most proud to have him serving his peers in this capacity. Now more than ever, we need young men like Paul to take the lead in protecting the freedoms that this great country was founded on for future generations.

Mr. Speaker, I would encourage the Members of the House of Representatives to join me in congratulating Chief Petty Officer Paul J. Simmert in receiving this prestigious award and thanking him for the contributions he makes to his country.

IN RECOGNITION OF AN INTERFAITH CELEBRATION OF THANKSGIVING

HON. CAROLYN B. MALONEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mrs. MALONEY. Mr. Speaker, I rise today to pay tribute to a group of congregations in my district that will come together to give thanks in the true spirit of Thanksgiving. These congregations are of different faiths, different sects and different practices. Nonetheless, they have in common a love for our country and gratitude to our Creator for bringing them or their forebears to a democratic country where civil rights and individual freedoms are protected. This inspired them to plan a joint service to give thanks.

Thanksgiving is a holiday that belongs to every American. It unites our country and embodies the principles upon which our great nation was founded. The first Thanksgiving is an account of immigrants arriving on a remote continent, launching a new life, surviving dangerous conditions, encountering a different culture, and sitting down with strangers to enjoy the bounty of this land. As waves of new Americans have found welcome here, they have embraced American values and joined in celebrating Thanksgiving.

Thanksgiving symbolizes the bond that unites the very first immigrants with every subsequent generation of Americans. When we recreate the meal eaten at the first Thanksgiving, we remember the importance of sharing, kindness and tolerance, and we are grateful for the rich bounty offered us by this country. This is a land filled with plenty—fertile soil, rich resources and, most of all, liberty. We also recall, with sadness, that although the early immigrants were greeted with friendship by the native Americans, they reciprocated with hostility, greed and intolerance. Thanksgiving gives us an opportunity to be at our best, to welcome friends and family into our homes, and to recall those who are not as well off. Many Americans take time to feed the hungry in Thanksgiving celebrations at homeless shelters, soup kitchens and neighborhood civic organizations.

The Pilgrims arrived in the new world in November 1620, too late to plant crops. Of 110 men and women who arrived here from Europe, fewer than 50 survived the first hard winter. With help from a neighboring tribe, the Pilgrims learned how to cultivate local produce. In the fall they celebrated the harvest with members of the tribe. Over time, this harvest celebration became an institution. In 1817 New York State adopted Thanksgiving Day as an annual custom. By the middle of the 19th century many other states also celebrated a Thanksgiving Day. In 1863 President Abraham Lincoln appointed a national day of thanksgiving. Since then every subsequent President has issued a proclamation designating a day of Thanksgiving.

At dark times in our history the celebration of Thanksgiving has seemed especially poignant. For example, in 1942, London's Westminster Abbey held its first secular service in nine centuries, hosting a Thanksgiving event for U.S. troops stationed in England. More than 3,500 people filled the church, reveling in singing "The Star Spangled Banner" and "America the Beautiful". Everything that marked their differences—geography, religion, race—seemed insignificant in comparison to the things that united them and the liberties they had joined in battle to defend.

In times of tragedy, Thanksgiving has served to rally our nation. Six days after the assassination of President Kennedy, President Lyndon Johnson addressed the nation on Thanksgiving Day. He asked his fellow citizens to remain "determined that from this midnight of tragedy we shall move toward a new American greatness."

Mr. Speaker, I pay tribute to the congregations that honor the true spirit of Thanksgiving by setting aside the differences among their faiths and joining together to celebrate the liberties and freedoms we all treasure.

H.R. 2417, INTELLIGENCE AUTHORIZATION AGREEMENT

SPEECH OF

HON. MARK UDALL

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. UDALL of Colorado. Mr. Speaker, I rise in opposition to H.R. 2417. I voted for this bill earlier this year, but I cannot support it today.

I have concerns about a provision in the conference report that would expand financial surveillance authority of our intelligence agencies. I also had concerns about this provision in the first version of the bill that passed the House, but I supported the bill then in the hope that the language would be further clarified in the final conference report. It has not been.

Whereas currently banks, credit unions, and other financial institutions are required to provide certain financial data to authorized intelligence agencies and the Treasury Department, this legislation would expand the list of institutions to include car dealers, pawnbrokers, travel agents, casinos, and other businesses.

This expanded definition of "financial institution" may indeed be necessary for effective counterintelligence, foreign intelligence, and international operations of the United States. But since this will represent such a significant expansion of the powers of our intelligence agencies, I believe it is important that it be clear and not go further than necessary.

In particular, I am concerned that the language in the conference report only vaguely limits this expanded definition to financial information. I understand that report language makes this distinction more explicit, but that bill conferees objected to including this clarifying language in the conference report itself. The legislative intent of this provision is to expand surveillance in the area of financial—not other—information, but there are no assurances that this intent will be observed when the legislation is implemented.

Mr. Speaker, this provision in the conference report involves the privacy rights of Americans—rights that I believe strongly we must protect even as we work to combat terrorism. Because I'm concerned that this conference report does not strike the right balance, I am voting against it today.

COMMENDING BUSINESS AND INDUSTRY ON EXEMPLARY EFFORTS TOWARD THEIR MILITARY GUARD AND RESERVE EMPLOYEES

HON. HENRY E. BROWN, JR.

OF SOUTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. BROWN of South Carolina. Mr. Speaker, I rise today to commend the efforts of many in the business and industry community who far exceed current-law requirements of the Uniformed Services Employment and Reemployment Rights Act, better known as USERRA. The act simply states that when a Reserve or Guard member returns from active duty he or she is entitled to the job that they left behind.

However, USERRA not only protects Reserve and Guard members and their families, it also gives America's business and industry a chance to be part of the ongoing effort to protect our freedoms.

Companies like Schering-Plough, ExxonMobil, SCANA Corporation, Wal-Mart, W. W. Grainger, International Paper, and the McNaughton-McKay Electrical Company in South Carolina, all have added enhancements such as paying the full salary deferential, continuing health and life insurance for the servicemembers and their families, and even creating special Web sites for spouses. These are outstanding corporate citizens and I applaud them.

With more than 150,000 reserve component service members still on active duty in support of Operation Iraqi Freedom and the Global War on Terrorism, this effort is very critical. Mr. Speaker, I urge all employers to not only follow the letter of the law with respect to mobilized Reservists, but to also do their part in supporting the war on terror.

VETERAN TRIBUTE FOR STAFF SERGEANT BILLY J. WEBSTER

HON. MICHAEL C. BURGESS

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. BURGESS. Mr. Speaker, I rise today to recognize the contributions and sacrifices of Staff Sergeant Billy J. Webster.

Staff Sergeant Webster began his military service in the United States Navy during World War II, where he partook in raids on Tokyo Bay under the command of legendary Admiral Halsey. Following the conclusion of World War II, Staff Sergeant Webster joined the Air Force, and he concluded his military service with a posting at Little Rock United States Air Force Base in Arkansas. Staff Sergeant Webster received numerous awards throughout his armed services career. Some of these awards include the World War II Victory Medal, American Campaign Medal, Air Force Longevity Service Award with 2 Oak Leaves, and the National Defense Medal.

At a time when we are once again at war, it is necessary to recognize the achievements of these national heroes. Due to their dedication, service, and sacrifice, they deserve our unwavering admiration and our unending gratitude.

Our country often takes for granted the freedoms and liberties our service men and women risk their lives to protect; yet by continuing to honor our veterans we preserve our nation's future by commemorating their past.

Thank you, Staff Sergeant Webster, for your service and sacrifice. You are a true hero.

CENTRAL NEW JERSEY RECOGNIZES AND CELEBRATES THE CAREER OF HERBERT BARRACK

HON. RUSH D. HOLT

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. HOLT. Mr. Speaker, I rise today to recognize the career of Herbert Barrack, who has served the Federal Environmental Protection Agency for 32 years.

A resident of Manalapan, he has risen through the ranks of the EPA by demonstrating his commitment to the protection of public health and the environment.

Under Herb's direction as the Chief Financial Manager of the New York Regional Office of Policy and Management, the department has expanded its capacity in administrative areas such as information systems management, financial management, grants management and human resources management

Mr. Barrack was the first EPA Assistant Regional Administrator for Policy and Management, as well as the first Executive Director of the Administrator's Environmental Financial Advisory Board.

In 1994 Mr. Barrack became one of only two regional representatives on the Regulatory Policy Council, overseeing the EPA's implementation of new Executive Orders on Regulatory Development.

His dedication to his work earned him both the Silver and Gold Medal for Exceptional Service. Mr. Barrack has also received Presidential Rank Awards of SES Meritorious Executive three times in recognition of quality and efficiency in public service.

As an inspiration to his community and the state of New Jersey, Mr. Barrack has contributed significantly to the life of his community. He has earned our heartfelt appreciation for his efforts.

RECOGNIZING KAREN L. MARTYNICK

HON. JIM GERLACH

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. GERLACH. Mr. Speaker. I rise today to recognize Karen L. Martynick for her twelve years of service as Commissioner on the Chester County Board of Commissioners.

Karen Martynick has been a Chester County Commissioner since 1992 and has served as Chairman of the Board for five years. As Commissioner, Ms. Martynick oversees a budget of $450 million and a workforce of 2500 employees and is responsible for administering and funding a wide array of departments, programs and services.

Under Commissioner Martynick's leadership, Chester County implemented a new comprehensive land development plan called "Landscapes" which has received numerous awards and been cited as a model for other counties around the Commonwealth and the country. Her land use work resulted in her selection by Governor Ridge to participate on his Sound Land Use Advisory Committee. Ms. Martynick was also selected by her colleagues to chair the Sustainable Communities Task Force, a special initiative of the County Commissioners Association of Pennsylvania. In addition, she also serves on the Board of Directors of the Association and has chaired the Legislative and Community and Economic Development Committees. In 1999, Commissioner Martynick was elected to the Board of Directors of the National Association of Counties. During her tenure, she has been named to the Commonwealth of Pennsylvania's "Honor Roll of Women" and in 1998 was selected by her colleagues throughout the state as the Outstanding County Commissioner of the Year.

In addition to her duties as County Commissioner, Karen Martynick has served for ten years as a member of the Southeastern Pennsylvania Transportation Authority (SEPTA). As a SEPTA Board Member, Commissioner Martynick has been an advocate for increased public transit in the suburbs and pushed for improved service to Chester County. She has served on the Operations Committee and the Budget and Planning Committee of SEPTA and currently chairs the Administration Committee. In 2001, Ms. Martynick was named by Administrator Christie Todd Whitman as one of 15 local officials from around the country to serve on the EPA's Local Government Advisory Committee.

Karen Martynick has been active in her community for many years. She has served on the Board of Directors for the United Way of Chester County, the People's Light and Theatre Company and as President of the Friends of Historic Goshenville, where she was instrumental in raising money to preserve two historic buildings. She was active for many years with the Boy Scouts of America, most recently serving as a Merit Badge Counselor and as a member of the District Executive Search Committee. She also served on the Capital Campaign Committee for the Goshen Fire Company, the Women of Achievement Dinner Committee for the March of Dimes and has taught Sunday school at her church.

Mr. Speaker, I ask my colleagues join me today in recognizing and honoring Karen L. Martynick for the hard work and civic dedication she has demonstrated over the years in making Chester County and the Commonwealth of Pennsylvania a better place to live.

TRIBUTE TO PUEBLO MOTIVE SERVICE

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. MCINNIS. Mr. Speaker, it is my honor to rise and pay tribute to a remarkable business in my district. Pueblo Motive Service has been serving the Pueblo community since 1946, and it is my honor to rise and pay tribute to their contributions to the people of Pueblo before this body of Congress and our nation.

The employees of Pueblo Motive Service have always approached their work with the customer in mind. The current owner, Jim Ward, often spends a large portion of his day on the phone discussing mechanical problems with his many customers. The store always maintains a family atmosphere. Longtime customers can often be found discussing old times with the store's owner and staff. There is even an honor system in which the store trusts its customers to place their payment in a mailbox when they are in a hurry.

In addition to its magnificent customer service, Pueblo Motive Service is also active in the community. Past owner Ralph Simmons made a significant donation to the University of Southern Colorado in order to help students enhance their education. To this day, Pueblo Motive Service continues to support the university's automotive parts and service program, which educates students in the automotive industry.

Mr. Speaker, it is my honor to rise before this body of Congress and our nation to call attention to the contributions of Pueblo Motive Service. Over the years, Pueblo Motive Service has been dedicated to keeping the citizens of Pueblo equipped with safe and reliable transportation. The business continues to serve the people of Pueblo with dedicated and friendly customer service and I would like to join the customers of Pueblo Motive Service in thanking them for their hard work.

A PARTNERSHIP COMMITTED TO DEMOCRACY

HON. FRANK R. WOLF

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. WOLF. Mr. Speaker, I would like to commend the President for highlighting the longstanding friendship between the United States and the United Kingdom in his recent speech delivered at Whitehall Palace in London. It is encouraging that this administration is taking a strong stand against tyranny, but I am further encouraged that we are not forced to travel this road alone. The history of the United States and the United Kingdom has been forged on the belief that freedom is the natural right of all men. It is the role of governments to preserve this right, not hinder it.

The conflict in Iraq is our joint commitment to promoting democracy in the 21st century. Our countries will not idly stand by while dictators, hunger, disease, war and corruption ravage human beings across the globe. However, the United States and United Kingdom cannot combat these evils alone. I therefore support the three pillars set forth by the President in combating tyranny. International organizations that are equal to the challenges of our world, free nations willing to meet evil by force, and a commitment to the international spread of democracy.

I support the President's vision to see peace and stabilization in the Middle East. I am hopeful that the world will one day see a secure Israel and an independent Palestinian state. The people of Israel and Palestine deserve our best efforts in helping them to achieve a future that restores peace and dignity to a land rich with history and culture. I share the President's passion spreading democracy and commit my efforts to help him achieve this end.

Below is the President's speech:

[Remarks by the President at Whitehall Palace, Royal Banqueting House-Whitehall Palace, London, England]

PRESIDENT BUSH DISCUSSES IRAQ POLICY AT WHITEHALL PALACE IN LONDON

The President: Thank you very much. Secretary Straw and Secretary Hoon; Admiral Cobbald and Dr. Chipman; distinguished guests: I want to thank you for your very kind welcome that you've given to me and to Laura. I also thank the groups hosting this event—The Royal United Services Institute, and the International Institute for Strategic Studies. We're honored to be in the United Kingdom, and we bring the good wishes of the American people.

It was pointed out to me that the last noted American to visit London stayed in a glass box dangling over the Thames. (Laughter.) A few might have been happy to provide similar arrangements for me. (Laughter.) I thank Her Majesty the Queen for interceding. (Laughter.) We're honored to be staying at her house.

Americans traveling to England always observe more similarities to our country than differences. I've been here only a short time, but I've noticed that the tradition of free speech—exercised with enthusiasm—(laughter)—is alive and well here in London. We have that at home, too. They now have that right in Baghdad, as well. (Applause.)

The people of Great Britain also might see some familiar traits in Americans. We're sometimes faulted for a naive faith that liberty can change the world. If that's an error it began with reading too much John Locke and Adam Smith. Americans have, on occasion, been called moralists who often speak in terms of right and wrong. That zeal has been inspired by examples on this island, by the tireless compassion of Lord Shaftesbury, the righteous courage of Wilberforce, and the firm determination of the Royal Navy over the decades to fight and end the trade in slaves.

It's rightly said that Americans are a religious people. That's, in part, because the "Good News" was translated by Tyndale, preached by Wesley, lived out in the example of William Booth. At times, Americans are even said to have a puritan streak—where might that have come from? (Laughter.) Well, we can start with the Puritans.

To this fine heritage, Americans have added a few traits of our own: the good influence of our immigrants, the spirit of the frontier. Yet, there remains a bit of England in every American. So much of our national character comes from you, and we're glad for it.

The fellowship of generations is the cause of common beliefs. We believe in open societies ordered by moral conviction. We believe in private markets, humanized by compassionate government. We believe in economies that reward effort, communities that protect the weak, and the duty of nations to respect the dignity and the rights of all. And whether one learns these ideals in County Durham or in West Texas, they instill mutual respect and they inspire common purpose.

More than an alliance of security and commerce, the British and American peoples have an alliance of values.

And, today, this old and tested alliance is very strong. (Applause.)

The deepest beliefs of our nations set the direction of our foreign policy. We value our own civil rights, so we stand for the human rights of others. We affirm the God-given dignity of every person, so we are moved to action by poverty and oppression and famine and disease. The United States and Great Britain share a mission in the world beyond the balance of power or the simple pursuit of interest. We seek the advance of freedom and the peace that freedom brings. Together our nations are standing and sacrificing for this high goal in a distant land at this very hour. And America honors the idealism and the bravery of the sons and daughters of Britain.

The last President to stay at Buckingham Palace was an idealist, without question. At a dinner hosted by King George V, in 1918, Woodrow Wilson made a pledge; with typical American understatement, he vowed that right and justice would become the predominant and controlling force in the world.

President Wilson had come to Europe with his 14 Points for Peace. Many complimented him on his vision; yet some were dubious. Take, for example, the Prime Minister of France. He complained that God, himself, had only 10 commandments. (Laughter.) Sounds familiar. (Laughter.)

At Wilson's high point of idealism, however, Europe was one short generation from Munich and Auschwitz and the Blitz. Looking back, we see the reasons why. The League of Nations, lacking both credibility and will, collapsed at the first challenge of the dictators. Free nations failed to recognize, much less confront, the aggressive evil in plain sight. And so dictators went about their business, feeding resentments and anti-Semitism, bringing death to innocent people in this city and across the world, and filling the last century with violence and genocide.

Through world war and cold war, we learned that idealism, if it is to do any good in this world, requires common purpose and national strength, moral courage and patience in difficult tasks. And now our generation has need of these qualities.

On September the 11th, 2001, terrorists left their mark of murder on my country, and took the lives of 67 British citizens. With the passing of months and years, it is the natural human desire to resume a quiet life and to put that day behind us, as if waking from a dark dream. The hope that danger has passed is comforting, is understanding, and it is false. The attacks that followed—on Bali, Jakarta, Casablanca, Bombay, Mombassa, Najaf, Jerusalem, Riyadh, Baghdad, and Istanbul—were not dreams. They're part of the global campaign by terrorist networks to intimidate and demoralize all who oppose them.

These terrorists target the innocent, and they kill by the thousands. And they would, if they gain the weapons they seek, kill by the millions and not be finished. The greatest threat of our age is nuclear, chemical, or biological weapons in the hands of terrorists, and the dictators who aid them. The evil is in plain sight. The danger only increases with denial. Great responsibilities fall once again to the great democracies. We will face these threats with open eyes, and we will defeat them. (Applause.)

The peace and security of free nations now rests on three pillars: First, international organizations must be equal to the challenges facing our world, from lifting up failing states to opposing proliferation.

Like 11 Presidents before me, I believe in the international institutions and alliances that America helped to form and helps to lead. The United States and Great Britain have labored hard to help make the United Nations what it is supposed to be—an effective instrument of our collective security. In recent months, we've sought and gained three additional resolutions on Iraq—Resolutions 1441, 1483 and 1511—precisely because the global danger of terror demands a global response. The United Nations has no more compelling advocate than your Prime Minister, who at every turn has championed its ideals and appealed to its authority. He understands, as well, that the credibility of the U.N. depends on a willingness to keep its word and to act when action is required.

America and Great Britain have done, and will do, all in their power to prevent the United Nations from solemnly choosing its own irrelevance and inviting the fate of the League of Nations. It's not enough to meet the dangers of the world with resolutions; we must meet those dangers with resolve.

In this century, as in the last, nations can accomplish more together than apart. For 54 years, America has stood with our partners in NATO, the most effective multilateral institution in history. We're committed to this great democratic alliance, and we believe it must have the will and the capacity to act beyond Europe where threats emerge.

My nation welcomes the growing unity of Europe, and the world needs America and the European Union to work in common purpose for the advance of security and justice. America is cooperating with four other nations to meet the dangers posed by North Korea. America believes the IAEA must be true to its purpose and hold Iran to its obligations.

Our first choice, and our constant practice, is to work with other responsible governments. We understand, as well, that the success of multilateralism is not measured by adherence to forms alone, the tidiness of the process, but by the results we achieve to keep our nations secure.

The second pillar of peace and security in our world is the willingness of free nations, when the last resort arrives, to retain* (sic) aggression and evil by force. There are principled objections to the use of force in every generation, and I credit the good motives behind these views.

Those in authority, however, are not judged only by good motivations. The people have given us the duty to defend them. And that duty sometimes requires the violent restraint of violent men. In some cases, the measured use of force is all that protects us from a chaotic world ruled by force.

Most in the peaceful West have no living memory of that kind of world. Yet in some countries, the memories are recent: The victims of ethnic cleansing in the Balkans, those who survived the rapists and the death squads, have few qualms when NATO applied force to help end those crimes. The women of Afghanistan, imprisoned in their homes and beaten in the streets and executed in public spectacles, did not reproach us for routing the Taliban. The inhabitants of Iraq's Baathist hell, with its lavish palaces and its torture chambers, with its massive statues and its mass graves, do not miss their fugitive dictator. They rejoiced at his fall.

In all these cases, military action was proceeded by diplomatic initiatives and negotiations and ultimatums, and final chances until the final moment. In Iraq, year after year, the dictator was given the chance to account for his weapons programs, and end the nightmare for his people. Now the resolutions he defied have been enforced.

And who will say that Iraq was better off when Saddam Hussein was strutting and killing, or that the world was safer when he held power? Who doubts that Afghanistan is a more just society and less dangerous without Mullah Omar playing host to terrorists from around the world. And Europe, too, is plainly better off with Milosevic answering for his crimes, instead of committing more.

It's been said that those who live near a police station find it hard to believe in the triumph of violence, in the same way free peoples might be tempted to take for granted the orderly societies we have come to know. Europe's peaceful unity is one of the great achievements of the last half-century. And because European countries now resolve differences through negotiation and consensus, there's sometimes an assumption that the entire world functions in the same way. But let us never forget how Europe's unity was achieved—by allied armies of liberation and NATO armies of defense. And let us never forget, beyond Europe's borders, in a world where oppression and violence are very real, liberation is still a moral goal, and freedom and security still need defenders. (Applause.)

The third pillar of security is our commitment to the global expansion of democracy, and the hope and progress it brings, as the alternative to instability and to hatred and terror. We cannot rely exclusively on military power to assure our long-term security. Lasting peace is gained as justice and democracy advance.

In democratic and successful societies, men and women do not swear allegiance to malcontents and murderers; they turn their hearts and labor to building better lives. And democratic governments do not shelter terrorist camps or attack their peaceful neighbors; they honor the aspirations and dignity of their own people. In our conflict with terror and tyranny, we have an unmatched advantage, a power that cannot be resisted, and that is the appeal of freedom to all mankind.

As global powers, both our nations serve the cause of freedom in many ways, in many places. By promoting development, and fighting famine and AIDS and other diseases, we're fulfilling our moral duties, as well as encouraging stability and building a firmer basis for democratic institutions. By working for justice in Burma, in the Sudan and in Zimbabwe, we give hope to suffering people and improve the chances for stability and progress. By extending the reach of trade we foster prosperity and the habits of liberty. And by advancing freedom in the greater Middle East, we help end a cycle of dictatorship and radicalism that brings millions of people to misery and brings danger to our own people.

The stakes in that region could not be higher. If the Middle East remains a place where freedom does not flourish, it will remain a place of stagnation and anger and violence for export. And as we saw in the ruins of two towers, no distance on the map will protect our lives and way of life. If the greater Middle East joins the democratic revolution that has reached much of the world, the lives of millions in that region will be bettered, and a trend of conflict and fear will be ended at its source.

The movement of history will not come about quickly. Because of our own democratic development—the fact that it was gradual and, at times, turbulent—we must be patient with others. And the Middle East countries have some distance to travel.

Arab scholars speak of a freedom deficit that has separated whole nations from the progress of our time. The essentials of social and material progress—limited government, equal justice under law, religious and economic liberty, political participation, free press, and respect for the rights of women—have been scarce across the region. Yet that has begun to change. In an arc of reform from Morocco to Jordan to Qatar, we are seeing elections and new protections for women and the stirring of political pluralism. Many governments are realizing that theocracy and dictatorship do not lead to national greatness; they end in national ruin. They are finding, as others will find, that national progress and dignity are achieved when governments are just and people are free.

The democratic progress we've seen in the Middle East was not imposed from abroad, and neither will the greater progress we hope to see. Freedom, by definition, must be chosen, and defended by those who choose it. Our part, as free nations, is to ally ourselves with reform, wherever it occurs.

Perhaps the most helpful change we can make is to change in our own thinking. In the West, there's been a certain skepticism about the capacity or even the desire of Middle Eastern peoples for self-government. We're told that Islam is somehow inconsistent with a democratic culture. Yet more than half of the world's Muslims are today contributing citizens in democratic societies. It is suggested that the poor, in their daily struggles, care little for self-government. Yet the poor, especially, need the power of democracy to defend themselves against corrupt elites.

Peoples of the Middle East share a high civilization, a religion of personal responsibility, and a need for freedom as deep as our own. It is not realism to suppose that one-fifth of humanity is unsuited to liberty; it is pessimism and condescension, and we should have none of it. (Applause.)

We must shake off decades of failed policy in the Middle East. Your nation and mine, in the past, have been willing to make a bargain, to tolerate oppression for the sake of stability. Longstanding ties often led us to overlook the faults of local elites. Yet this bargain did not bring stability or make us safe. It merely bought time, while problems festered and ideologies of violence took hold.

As recent history has shown, we cannot turn a blind eye to oppression just because the oppression is not in our own backyard. No longer should we think tyranny is benign because it is temporarily convenient. Tyranny is never benign to its victims, and our great democracies should oppose tyranny wherever it is found. (Applause.)

Now we're pursuing a different course, a forward strategy of freedom in the Middle East. We will consistently challenge the enemies of reform and confront the allies of terror. We will expect a higher standard from our friends in the region, and we will meet our responsibilities in Afghanistan and in Iraq by finishing the work of democracy we have begun.

There were good-faith disagreements in your country and mine over the course and timing of military action in Iraq. Whatever has come before, we now have only two options: to keep our word, or to break our word. The failure of democracy in Iraq would throw its people back into misery and turn that country over to terrorists who wish to destroy us. Yet democracy will succeed in Iraq, because our will is firm, our word is good, and the Iraqi people will not surrender their freedom. (Applause.)

Since the liberation of Iraq, we have seen changes that could hardly have been imagined a year ago. A new Iraqi police force protects the people, instead of bullying them. More than 150 Iraqi newspapers are now in circulation, printing what they choose, not what they're ordered. Schools are open with textbooks free of propaganda. Hospitals are functioning and are well-supplied. Iraq has a new currency, the first battalion of a new army, representative local governments, and a Governing Council with an aggressive timetable for national sovereignty. This is substantial progress. And much of it has proceeded faster than similar efforts in Germany and Japan after World War II.

Yet the violence we are seeing in Iraq today is serious. And it comes from Baathist holdouts and Jihadists from other countries, and terrorists drawn to the prospect of innocent bloodshed. It is the nature of terrorism and the cruelty of a few to try to bring grief in the loss to many. The armed forces of both our countries have taken losses, felt deeply by our citizens. Some families now live with a burden of great sorrow. We cannot take the pain away. But these families can know they are not alone. We pray for their strength; we pray for their comfort; and we will never forget the courage of the ones they loved.

The terrorists have a purpose, a strategy to their cruelty. They view the rise of democracy in Iraq as a powerful threat to their ambitions. In this, they are correct. They believe their acts of terror against our coalition, against international aid workers and against innocent Iraqis, will make us recoil and retreat. In this, they are mistaken. (Applause.)

We did not charge hundreds of miles into the heart of Iraq and pay a bitter cost of casualties, and liberate 25 million people, only to retreat before a band of thugs and assassins. (Applause.) We will help the Iraqi people establish a peaceful and democratic country in the heart of the Middle East. And by doing so, we will defend our people from danger.

The forward strategy of freedom must also apply to the Arab-Israeli conflict. It's a difficult period in a part of the world that has known many. Yet, our commitment remains firm. We seek justice and dignity. We seek a viable, independent state for the Palestinian people, who have been betrayed by others for too long. (Applause.) We seek security and recognition for the state of Israel, which has lived in the shadow of random death for too long. (Applause.) These are worthy goals in themselves, and by reaching them we will also remove an occasion and excuse for hatred and violence in the broader Middle East.

Achieving peace in the Holy Land is not just a matter of the shape of a border. As we work on the details of peace, we must look to the heart of the matter, which is the need for a viable Palestinian democracy. Peace will not be achieved by Palestinian rulers who intimidate opposition, who tolerate and profit from corruption and maintain their ties to terrorist groups. These are the methods of the old elites, who time and again had put their own self-interest above the interest of the people they claim to serve. The long-suffering Palestinian people deserve better. They deserve true leaders, capable of creating and governing a Palestinian state.

Even after the setbacks and frustrations of recent months, goodwill and hard effort can bring about a Palestinian state and a secure Israel. Those who would lead a new Palestine should adopt peaceful means to achieve the rights of their people and create the reformed institutions of a stable democracy.

Israel should freeze settlement construction, dismantle unauthorized outposts, end the daily humiliation of the Palestinian people, and not prejudice final negotiations with the placements of walls and fences.

Arab states should end incitement in their own media, cut off public and private funding for terrorism, and establish normal relations with Israel.

Leaders in Europe should withdraw all favor and support from any Palestinian ruler who fails his people and betrays their cause. And Europe's leaders—and all leaders—should strongly oppose anti-Semitism, which poisons public debates over the future of the Middle East. (Applause.)

Ladies and gentlemen, we have great objectives before us that make our Atlantic alliance as vital as it has ever been. We will encourage the strength and effectiveness of international institutions. We will use force when necessary in the defense of freedom. And we will raise up an ideal of democracy in every part of the world. On these three pillars we will build the peace and security of all free nations in a time of danger.

So much good has come from our alliance of conviction and might. So much now depends on the strength of this alliance as we go forward. America has always found strong partners in London, leaders of good judgment and blunt counsel and backbone when times are tough. And I have found all those qualities in your current Prime Minister, who has my respect and my deepest thanks. (Applause.)

The ties between our nations, however, are deeper than the relationship between leaders. These ties endure because they are formed by the experience and responsibilities and adversity we have shared. And in the memory of our peoples, there will always be one experience, one central event when the seal was fixed on the friendship between Britain and the United States: The arrival in Great Britain of more than 1.5 million American soldiers and airmen in the 1940s was a turning point in the Second World War. For many Britons, it was a first close look at Americans, other than in the movies. Some of you here today may still remember the "friendly invasion." Our lads, they took some getting used to. There was even a saying about what many of them were up to—in addition to be "overpaid and over here." (Laughter.)

At a reunion in North London some years ago, an American pilot who had settled in England after his military service, said, "Well, I'm still over here, and probably overpaid. So two out of three isn't bad." (Laughter.)

In that time of war, the English people did get used to the Americans. They welcomed soldiers and fliers into their villages and homes, and took to calling them, "our boys." About 70,000 of those boys did their part to affirm our special relationship. They returned home with English brides.

Americans gained a certain image of Britain, as well. We saw an island threatened on every side, a leader who did not waver, and a country of the firmest character. And that has not changed. The British people are the sort of partners you want when serious work needs doing. The men and women of this Kingdom are kind and steadfast and generous and brave. And America is fortunate to call this country our closest friend in the world.

May God bless you all. (Applause.)

VETERAN TRIBUTE FOR CAPTAIN HENRY (HANK) SCHEIBLE

HON. MICHAEL C. BURGESS

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. BURGESS. Mr. Speaker, I rise today to recognize the contributions and sacrifices of Captain Henry (Hank) Scheible.

Captain Scheible served our country during the Vietnam War in the United States Air Force. He flew 102 combat missions with over 500 hours of navigation combat time. Captain Scheible holds the Air Medal with 9 Oak Leaf Clusters. He received the Distinguished Flying Cross. Captain Scheible is also a recipient of the Republic of Vietnam Campaign Medal and two Vietnam Service Medals.

At a time when we are once again at war, it is necessary to recognize the achievements of these national heroes. Due to their dedication, service, and sacrifice, they deserve our unwavering admiration and our unending gratitude.

Our country often takes for granted the freedoms and liberties our service men and women risk their lives to protect; yet by continuing to honor our veterans we preserve our nation's future by commemorating their past.

Thank you, Captain Scheible, for your service and sacrifice. You are a true hero.

CENTRAL NEW JERSEY RECOGNIZES AND CELEBRATES HARRY J. KLIENKAUF, CHIEF OF POLICE, CRANBURY, NJ

HON. RUSH D. HOLT

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. HOLT. Mr. Speaker, I rise today to recognize the career of Chief Harry J. Klienkauf, who has served the Cranbury Police Department and the people of Cranbury for 32 years and as chief for 12 years.

In his 32 years of service he has seen the department quadruple in size from four officers to 16. And under his leadership plans for a new police station have become a reality. The 16 officers will no longer have to work in a doublewide trailer, but will have a fully functional station to better serve the community.

Along with his commitment to the department, he has spent numerous hours in the schools teaching children the importance of safety. He established a first aid patrol for students, teaching them the fundamental skills that can save lives.

Aside from being a hardworking and dedicated police officer, Chief Klienkauf found time in his day to volunteer as a firefighter in his hometown. He also spent years serving on the local first aid squad. He remains an active member of the New Jersey State Association of Police Chiefs and the Middlesex County Association of Chiefs of Police.

As an inspiration to police officers in his department and the state of New Jersey, Chief Klienkauf has contributed significantly to the life of his community. He has earned our heartfelt appreciation for his efforts.

RECOGNIZING WALTER J. STYER

HON. JIM GERLACH

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. GERLACH. Mr. Speaker, I rise today to recognize Walter J. Styer, retiring Supervisor of Upper Uwchlan Township, Chester County, Pennsylvania, and commend him for his lifelong service to our community.

When Walter Styer first took office as Supervisor, Upper Uwchlan Township was a rural farming community with only 1,200 residents. Today, after three decades of continuing growth and development, there are now 7,000. As the community has grown, so has the job of supervisor. Mr. Styer's primary responsibility during his time in office has been to make sure that Upper Uwchlan grew responsibly and that the needs and desires of its citizens were continually met. In the beginning, his meetings would take 20 min, and would revolve around paying the bills and reading the road report. In recent years, it has not been uncommon to have multiple meetings in a single week for several hours at a time. His participation in the supervising of a rapidly growing community is a true testament to his commitment and his willingness to adapt to the increasing demands of the position. Over the years, as more and more time was required as supervisor, Walter Styer still found time to run his own businesses, remain active in his church and raise four children. What has kept him going all these years was his desire to see all of his projects and undertakings to a successful conclusion—a testament to his character and drive. His tremendous leadership and experience as been an enormous asset to Upper Uwchlan Township and has allowed it to grow responsibly and successfully for all these years.

Mr. Speaker. I ask that my colleagues join me today in recognizing and honoring Walter J. Styer for his lifetime of exemplary citizenship and civil works to make Upper Uwchlan Township a better place to live.

TRIBUTE TO JUNE VALENTINE

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. McINNIS. Mr. Speaker, it is my honor to rise and pay tribute to a remarkable woman from my district. The Southern Colorado Livestock Association recently named June Valentine Stockman of the Year. June is the first woman to receive this honor in the history of the association, and it is my privilege to call her contributions to the attention of this body of Congress and our nation today.

June has been a rancher in Las Animas County her entire life. As a rancher, June is passionate and knowledgeable. In the ranching industry, June has transcended gender stereotypes and proven herself as able as any rancher in Colorado.

June is also well known for her contributions to the community. She is an avid historian who shares her knowledge of the county's history with her many friends and neighbors. In addition, June is also involved in local government and has held many offices in service of the community.

Mr. Speaker, it is my honor to rise and pay tribute to June Valentine before this body of Congress and our nation today. June is an amazing rancher, historian, public servant and friend. Her contributions set a fine example for all Americans. Congratulations, June, on a well deserved award.

PERSONAL EXPLANATION

HON. DANNY K. DAVIS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. DAVIS of Illinois. Mr. Speaker, I was unavoidably detained in my district. Had I been present, I would have voted yea on the following roll call votes:

Roll Call 620 (S.J. Res. 22), Recognizing the Agricultural Research Service of the Department of Agriculture for 50 years of outstanding service to the Nation through agricultural research;

Roll Call 621 (S.J. Res. 18), Commending the Inspectors General for their efforts to prevent and detect waste, fraud, abuse, and mismanagement, and to promote economy, efficiency, and effectiveness in the Federal Government during the past 25 years;

Roll Call 622 (H. Con. Res. 299), Honoring Mr. Sargent Shriver for his dedication and service to the United States of America, for his service in the United States Navy, and for his lifetime of work as an ambassador for the poor and powerless citizens of the United States of America, and for other purposes;

Roll Call 623 Motion—On Hour of Meeting.

HEALTH EMPOWERMENT ZONE

HON. DONNA M. CHRISTENSEN

OF THE VIRGIN ISLANDS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mrs. CHRISTENSEN. Mr. Speaker, on March 20, 2002, the Institute of Medicine (IOM) released a landmark report entitled: Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Among other key findings, the report documented that minorities in the United States receive fewer life-prolonging cardiac medications and surgeries, are less likely to receive dialysis and kidney transplants, and are less likely to receive adequate treatment for pain. Its first and most telling finding States that "racial and ethnic disparities in healthcare exist and, because they are associated with worse outcomes in many cases, are unacceptable." The reasons for these disparities in treatment are wide and varied, and include, but are not limited to: healthcare provider prejudice or bias, the implicit nature of stereotypes, and broader historic and contemporary social and economic inequality. The report included a series of recommendations and interventions for policy changes to eliminate these unacceptable disparities.

Whether it is the recently released IOM report on Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, the Commonwealth Fund's report Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans or a recent report by Physicians for Human Rights (2003) found that many minority groups receive lower quality evaluation and treatment than white Americans for a wide range of medical conditions, even when each has health insurance.

We are continually reminded that throughout the history of our great Nation, our people have been denied access to the best that medical science has had to offer—often relegated to hospitals with outdated equipment and served by African-American health care providers who, although as capable, intelligent, and gifted as their white counterparts, often could not obtain equivalent training because of racist practices such as segregation.

This segregated health system was largely responsible for the health inequities that existed during the early and middle part of this century. Indeed, in 1951 Dr. W. Montague Cobb, editor of the Journal of the National Medical Association, stated "For nearly fifty years the retarded health status of our Negro population has been common knowledge and the object of sporadic corrective effort". With the Civil Rights came an acknowledgment came greater equality in many aspects of life for African-Americans, including greater access to quality health care.

As an effort to extend such acknowledgment I am proud to introduce the Health Empowerment Zone Act of 2003. This act directs the Secretary of Health and Human Services with the Administrator of the Health Resources and Services administration and the Directors of the Office of Minority Health, of the Office of Community Services and National Center for Minority Health and Health Disparities to establish health empowerment zone programs in communities that disproportionately experience disparities in health status and health care, and for other purposes.

To be eligible the communities must demonstrate that they experience disproportionate disparities in health status and health care, set forth a strategic plan and create a partnership, with individuals, businesses, schools, minority health associations, nonprofit organizations, community-based organizations, hospitals, health care clinics, and foundations.

The health empowerment zone designation would provide communities the ability to effectively access Federal programs (namely in the Department of Health and Human Services, the Department of Agriculture, the Department of Education, the Department of Labor, the Department of Housing and Urban Development and the Small Business Administration) to improve the health or environment of minority individuals in the community and to coordinate the efforts regarding the elimination of racial and ethnic disparities in health status and health care. Special consideration is given to community that have demonstrated expertise in providing culturally appropriate and linguistically responsive services.

The bill directs communities to establish a health empowerment zone coordinating committee that will provide technical assistance and evidence-based strategies to the zone, including providing guidance on research, strategies, health outcomes, program goals, management, implementation, monitoring, assessment, and evaluation processes.

This bill recognizes that disparities in health and health care found among minority Americans have multiple causes. Lower socioeconomic status and a higher rate of uninsurance are major contributors to the health disparities .experienced by minority Americans but non-health factors also play an important role.

The bill codifies legislatively the framework needed to implement sound public health practices such as:

Primary health promotion and disease prevention: Identifying and strengthening protective ecological conditions conducive to health; and identifying and reducing various health risks.

Secondary health promotion and disease prevention: Identifying, adopting, and reinforcing specific protective behaviors; and early detection and reduction of existing health problems.

Tertiary health promotion and disease prevention: Improving the quality of life of community members affected by health problems; and avoiding deterioration, reducing complications from specific disorders, and preventing relapse of risky behaviors.

This bill is a start to a new paradigm for health and I urge my colleagues to support this bill, so that we do what is so clearly needed to improve the health and health care for millions of minority Americans.

YOUTH ATTITUDES ABOUT CIVIC EDUCATION

HON. DIANA DeGETTE

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Ms. DEGETTE. Mr. Speaker, at the First Annual Congressional Conference on Civic Education held recently in Washington, D.C., a new report was released that deserves our highest attention and concern. The report, "Citizenship: A Challenge for All Generations," showed that young people are disengaged from the political process and lack the knowledge necessary to be effective citizens. According to the public opinion survey described in the report, more young Americans know the name of the reigning American Idol than know the political party of their state's governor.

The survey did provide a source of good news, however. It reported that courses in civics and government make a significant difference in sparking young people's interest in government and increasing their understanding of the American system of government.

Both the landmark Congressional Conference on Civic Education and this new national survey of youth civic attitudes, knowledge, and participation were products of the Representative Democracy in America Project, a new congressional initiative designed to reinvigorate Americans and educate them about the critical relationship between government and the people it serves. This national project is a collaboration among the National Conference of State Legislature's Trust for Representative Democracy, the Center on Congress at Indiana University and the Center for Civic Education. The project, which is strictly nonpartisan, is funded by the U.S. Department of Education by act of Congress. I would like to submit for the record the executive summary of the report "Citizenship: A Challenge for All Generations."

EXECUTIVE SUMMARY

This public opinion survey shows that young people do not understand the ideals of citizenship, they are disengaged from the political process, they lack the knowledge necessary for effective self-government, and their appreciation and support of American democracy is limited. The older generations have failed to teach the ideals of citizenship to the next generation. But there is hope. The report provides new evidence that civic education makes a big difference in the attitudes toward citizenship, knowledge and civic engagement of young people.

The report is based on a national public opinion survey designed to tap how the civic attitudes, knowledge and participation of young people—the DotNet generation between 15 and 26 years of age—compare to those of older generations. The poll was conducted by Knowledge Networks, a research firm that conducts scientifically based Internet surveys. The sampling error for the two age groups—15 to 26 and over 26—is approximately ±4 percentage points each.

The survey results reveal a breakdown in how older generations pass on the values of democracy to younger Americans, especially in the area of what it means to be a good citizen.

Here are some key findings regarding the qualities of good citizens:

Seventy-eight percent of those in the older generations say we need to pay attention to government and politics compared with 54 percent of the younger generation.

Less than half of the DotNets think that communicating with elected officials or volunteering or donating money to help others are qualities of a good citizen.

Only 66 percent of the DotNets say that voting is a necessary quality for being a good citizen, compared with 83 percent of those over age 26.

Among the DotNet generation, 64 percent report that they have taken a high school course on civics or American government. Those who have done so are much more likely to believe they are personally responsible for making things better for society and have a more expansive concept of the qualities of a good citizen. On the importance of voting, for example, there is a 24 point spread between those who have taken a government class and those who haven't.

In the area of civic engagement—the act of governing ourselves:

Only half of the DotNets reported that they voted in the most recent elections or that they follow politics, compared to three-quarters of those over age 26.

In many areas of civic participation, two or three times more DotNets who have taken a civics class report that they have engaged in civic activities than those who have not.

On civic knowledge—the tool that enables us to govern ourselves:

Three-quarters of the older generations correctly identified the party of their state's governor and three out of five knew the Republicans control Congress. But only one-third could correctly identify the party in control of their state's legislature.

Among DotNets, eight out of 10 know that the cartoon Simpsons live in Springfield, and the great majority know that Ruben Studdard is the reigning American Idol. But less than half know the party of their state's governor, and only 40 percent can say which party controls Congress.

On attitudes toward representative democracy—our appreciation and understanding of the complexities of the legislative process:

The majority of Americans grasp the fact that people disagree on the issues and the system has to work to resolve such disagreements.

The public is cynical about the people and processes of government. They are about equally divided on whether legislators care what people in their districts think or don't care about the opinions of ordinary people. Two in five believe that those elected to public office are out to serve their own personal interests, while only one in three thinks they are trying to serve the public interest. A majority believes that the system is run by a few big interests rather than for the benefit of all.

Americans believe the country would be better off if the people decided issues directly by voting on them. Support for representative democracy is limited.

The gap between the civic attitudes, knowledge and participation of the new generation of DotNets and the older ones is substantially greater than the gaps between previous generations. It suggests that the DotNets will never be as engaged in democracy as their elders, even as they age.

Civic education makes a big difference in the attitudes, knowledge and engagement of young people. Thirty-nine states have civics or government class requirements for high school graduation. All states will want to review their civic education requirements, standards, assessments, teacher training and course content to determine if they are delivering effective civic education that produces informed citizens.

COMBATING THE SPREAD OF HIV/AIDS IN AFRICA

HON. SCOTT GARRETT

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. GARRETT. Mr. Speaker, I rise tonight to share with this body the extraordinary work being done by a constituent company of mine, BD, the Becton, Dickinson and Company of Franklin Lakes, NJ in combating the spread of HIV/AIDS in Africa.

First, I would like to applaud the Senate's efforts in passing the McConnell-Sessions-Leahy amendment, as part of the Foreign Operations Appropriations bill for fiscal year 2004 that will provide funding to combat unsafe medical practices in Africa as a means to preventing the spread of HIV/AIDS on that continent.

This bipartisan effort directs the Bush administration to spend at least $75 million on injection and blood safety programs in 12 African countries as part of the President's overall $15 billion HIV/AIDS initiative. This funding is an important first step in addressing the issue of disease spread through unsafe medical practices in Africa, and I urge my colleagues who will be participating in the conference committee to preserve this important amendment.

Which brings me to the work of BD. In business for over a century, BD, is a global medical technology company that serves healthcare institutions, life science researchers, clinical laboratories, industry and the general public. BD manufactures and sells a broad range of medical supplies, devices, laboratory equipment and diagnostic products and employs over 25,000 people in 18 states and around the world.

BD has a long, distinguished history not only in the development of medical technologies but also in partnering with global and domestic health entities and governments to tackle some of the major public health issues of our time. An example: BD pioneered the development of sterilization technology for medical devices and provided the first mass-produced sterile disposable syringes—at cost—to Dr. Jonas Salk for his nationwide polio vaccination efforts in 1954.

BD is currently working with the WHO, UNICEF, the International Red Cross, and other organizations to provide low-cost "auto-disable" needles and syringes that are specifically designed to combat the spread of HIV/AIDS and other infectious diseases by preventing reuse in the developing world.

BD has devoted years of dedicated effort and innovation to this issue, even though BD does not manufacture the vast majority of injection devices utilized in the developing world. Still, the company's commitment to this issue has manifested in many ways, including development of low-cost technologies specifically designed to address this developing world need, collaboration with international agencies in development of appropriate safe injection policies for mass immunization programs, and substantial philanthropic commitments in support of international vaccination efforts utilizing safe injection technology for deadly diseases such as maternal and neonatal tetanus and measles.

These commitments and investments occurred because BD believes their expertise and resources can have a very positive impact on these significant global health issues. In fact, their commitment to the global health arena is part of the company's overall mission: "Helping all people live healthy lives."

As a result of BD's efforts and the leadership of international agencies, U.S. government agencies and the work of some other medical equipment manufacturers of auto-disable syringes that prevent reuse are already in broad use for childhood immunization programs in Africa and some other developing countries.

Efforts were first focused on childhood immunization because these injections are generally administered simultaneously to large groups of children, increasing the potential for disease spread. And to date there has been significant progress. It is estimated that 75 percent of immunizations in Africa are administered safely with auto-disable devices. However, immunizations represent only approximately 10 percent of all injections given in Africa. The need exists to expand reuse prevention technologies to the larger number of injections given for therapeutic purposes.

To accomplish this, BD and other manufacturers are expanding the application of low-cost reuse prevention technologies to a broad array of injection devices. These devices are designed to physically disable after a single use, preventing spread of disease from reuse. And while effective technology is critical for success, it is not enough.

To get these devices into broad use, government and non-government agencies, international aid organizations, health ministries in developing countries, and manufacturers must collaborate to ensure that these reuse prevention devices are made broadly available in developing countries. Also, healthcare providers will need to be educated about the risks of injection device reuse, and trained on the proper use of reuse prevention technologies. This will require a larger investment compared with the successful effort to ensure safe immunization of children in Africa.

Injections administered in Africa and the developing world are often unsterile and may transmit infectious disease, due to either improper reuse of disposable syringes and needles designed for single use or to ineffective resterilization of reusable glass syringes. World Health Organization (WHO) and U.S. Centers for Disease Control and Prevention (CDC) estimates indicate that approximately 40% of injections in the developing world are administered with reused, unsterile medical devices. In the year 2000 alone, WHO estimates that 500,000 new HIV/AIDS infections, 2 million new hepatitis C infections, and 21 million new hepatitis B infections resulted from improper reuse of injection devices.

The global HIV/AIDS disease burden is staggering, growing exponentially, and can no longer be ignored. Last year alone, 3.5 million people in Sub-Saharan Africa were infected with the disease. Since 1981, an estimated 20 million people worldwide have died from the disease—and another 42 million around the globe may already be infected.

The passage of the McConnell-Sessions-Leahy amendment and its preservation by the conference committee will give a tremendous boost to global efforts to further prevent the spread of HIV/AIDS in Africa and the rest of the developing world due to this unsafe medical practice. But make no mistake about it; the McConnell-Sessions-Leahy amendment is only a first step in a long journey toward resolving this issue. We need to remain steadfast in our support to improve Privileged and Confidential-DRAFT ReRelease] 113103 medical conditions in Africa, and committed to working with all of the necessary parties to ensure the outcome that we know is possible.

I am proud of BD's involvement and commitment to this issue, and I commend them for their efforts and leadership. To me it is a glowing example of what a good global corporate citizen can and should be.

HONORING THE CONFEDERATED TRIBES OF THE GRAND RONDE ON THE 20TH ANNIVERSARY OF THEIR RESTORATION TO FEDERAL RECOGNITION

HON. DARLENE HOOLEY

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Ms. HOOLEY of Oregon. Mr. Speaker, I rise to commemorate the 20th anniversary this November 22 of the restoration to federal recognition of the Confederated Tribes of the Grand Ronde Community of Oregon.

Twenty years ago, on November 22, 1983, President Ronald Reagan signed into law the Grand Ronde Restoration Act, Public Law 98–165, bringing to fruition a long and determined effort by the elders and leaders of the Grand Ronde Tribes to reverse their thirty years of termination.

The vision and perseverance that marked the Grand Ronde's triumph over that very difficult termination period has continued to guide them since restoration.

Since restoration, the Tribe has grown strong and prospered. The sense of Tribal community, severely tested but not broken during termination, has flourished among a membership that, while looking to the future, actively embraces its culture, traditions, and long history. The Tribe's home lands, once reduced to their cemetery, are now thriving with housing for elders and other Tribal members, a Tribal community center, a beautiful and modern health clinic, and new governmental offices. In the near-by hills, the Tribe sustainably manages its 9,800 acre forested reservation, secured with further legislation in 1988.

In the two decades since restoration, the Grand Ronde Tribal government has pursued its full measure of responsibility, representing and providing for the Tribal membership, and directly administering the full range of federal services. A key element is the Tribal government's efforts to provide for the economic security of its members and its own self-reliance. In twenty years, the Tribe has become a primary economic engine in the area, moving from its timber base into a gaming and hotel facility and today into more broadly diversified endeavors that keep an eye toward the future.

And throughout all of this, the Grand Ronde Tribe has sought to work cooperatively with its neighbors. This is a hallmark of the Confederated Tribes of Grand Ronde. Despite the understandable temptations to walk their own path, they have consistently reached out to their neighbors, seeking to foster understanding and cooperation. There is no better example of this in the Spirit Mountain Community Fund. This fund has given over 22 million dollars to community organizations since its creation in 1997.

For the Confederated Tribes of Grand Ronde, it has been a remarkable twenty years of progress and fulfillment. As for all the restored tribes of Oregon, restoration is a defining moment in their long history, and on the November 22, 2003 twentieth anniversary of the restoration of the Confederated Tribes of the Grand Ronde Community of Oregon, I wish to commemorate and salute their achievement.

HONORING LARRY A. MATOS

HON. DENNIS A. CARDOZA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. CARDOZA. Mr. Speaker, I rise today to honor an ambitious and hard-working businessman, Mr. Larry A. Matos. Larry was born and raised in California's Central Valley, and was working hard on his parent's dairy at a young age. While growing up, Larry attended Turlock High School, and led his Future Farmers of America team to a 6th place finish at a national dairy competition. After graduating Turlock High School in 1992, he quickly received his Real Estate license at the age of 18.

In 1994, Larry was approached by Mr. John Melo to purchase a Century 21 Real Estate office. Always ready for a new challenge, Larry and Mr. Melo formed a business partnership, and turned a three-man office into eleven office locations in four counties, four businesses, and over three hundred employees and realtors. Currently, Larry is the President/Broker of Century 21 M&M and Associates. Not only is Larry dedicated to his business ventures, but to the Real Estate industry as well. He has served as a local Board of Director for the Central Valley Association of Realtors. This past year, Larry had the distinct opportunity to serve his fellow colleagues as President of the Central Valley Association of Realtors. He was one of the youngest to ever hold that position.

If not working hard with his business investments, Larry can be found spending time on his family's dairy, and being with his friends and relatives. He also dedicates his time to the community by serving on the Holiday Can Tree, and sponsoring a number of charitable events throughout the year. Mr. Speaker, Larry is a role model for our youth in the Central Valley. His positive attitude and work ethic have helped him achieve the American Dream. It is my honor to recognize him for his achievements, and to call him my friend.

LIFE OF MAJ. GEN. GEORGE RUHLEN

HON. HENRY BONILLA

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. BONILLA. Mr. Speaker, I rise to honor the life of Maj. Gen. George Ruhlen. Maj. Gen. Ruhlen loved this country and lived a life of service protecting the freedoms we hold dear. Maj. Gen. Ruhlen was a graduate of the United States Military Academy and completed regular courses at the Field Artillery School, the Army War College and the National War College. He was a great patriot and served this country well, commanding the Third Armored Field Artillery Battalion, 9th Armored Division during World War II. His battalion participated in the defense of Luxembourg, Bastogne, and the capture of the Ludendorff Bridge over the Rhine River at Remagen. Maj. Gen. Ruhlen's actions in the capture of the Ludendorff Bridge were of extreme significance, helping to hasten the end of the war in Europe. This historic capture allowed over 25,000 American soldiers, tanks, artillery and trucks to cross the bridge safely. In addition, Maj. Gen. Ruhlen served with honor in overseas postings in Japan, Taiwan and Pakistan. He went on to serve as Commander of the 1st Armored Division, Deputy Commanding General, Fourth U.S. Army and Commanding General, Fort Sam Houston. Maj. Gen. Ruhlen received the Silver Star for Gallantry in Action during the Battle of the Bulge. He was also the recipient of the Distinguished Service Medal, the Bronze Star with Oak Leaf Cluster, the Legion of Merit and the Belgian, French and Luxembourg Croix de Guerre. His leadership and valor were an inspiration to those who knew him. He was truly a great American.

VETERAN TRIBUTE FOR SERGEANT PIERSON

HON. MICHAEL C. BURGESS

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. BURGESS. Mr. Speaker, I rise today to recognize the contributions and sacrifices of Sergeant Tom Pierson.

Sergeant Pierson served our country during the Vietnam War in the United States Marine Corps. He received the Vietnam Service Medal and the National Defense Service Medal. Sergeant Pierson is also a recipient of the Vietnam Campaign Medal and the Republic of Vietnam Cross of Gallantry.

At a time when we are once again at war, it is necessary to recognize the achievements of these national heroes. Due to their dedication, service, and sacrifice, they deserve our unwavering admiration and our unending gratitude.

Our country often takes for granted the freedoms and liberties our service men and women risk their lives to protect; yet by continuing to honor our veterans we preserve our nation's future by commemorating their past.

Thank you, Sergeant Pierson, for your service and sacrifice. You are a true hero.

RECOGNIZING THE OWEN J. ROBERTS HIGH SCHOOL GIRLS SOCCER TEAM

HON. JIM GERLACH

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. GERLACH. Mr. Speaker, I rise today to recognize the Owen J. Roberts High School Girls Soccer Team on their victory in the 2003 Pennsylvania Interscholastic Athletic Association Class AAA State Championship game on November 15, 2003.

The Owen J. Roberts Wildcats set a school record for victories in a season on their way to capturing the school's first state championship. In the seven year history of the program, all under the guidance of Coach Joe Margusity, the Wildcats have compiled an amazing 138–31–6 record. The team allowed only 11 goals in 28 games this season, which was enough to earn them gold medals by shutting out Butler High School, 1–0, in the championship game at Hersheypark Stadium.

Led by Head Coach Joe Margusity, and assistant coaches Josh Hoyt, Joe Baccille, and Chris Strango; the members of this championship team include Laura Ginnona, Becky Lesh, Brittany Bench, Julia Cupp, Jen Michener, Jess Carbo, Anna Bevan, Brooke Dotterer, Kristen Kaufman, Kim Roncase, Beth Stephens, Heather Manorak, Kristi Moltz, Kate Moltz, Ashley Nespor, Amber Cumins, Gayle Exley, Amber Hawkins, Rachel Michener, Jillian Morgan, Kristine Preski and Megan Levengood.

Mr. Speaker, I ask that my colleagues join me today in congratulating the Owen J. Roberts High School Girls Soccer Team, the 2003 PIAA Class AAA State Champions.

TRIBUTE TO ST. MICHAEL'S ORTHODOX CHRISTIAN CHURCH

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. McINNIS. Mr. Speaker, it is my honor to rise and pay tribute to Saint Michael's Orthodox Christian Church located in Pueblo, Colorado. St. Michael's recently celebrated its 100th anniversary and it is my honor to rise and recognize the contributions that this church has made to the Pueblo community.

St. Michael's was founded by a number of Pueblo's ethnic Greek families in the early 1900s. Over time, the church has been a wonderful place of worship for many Puebloans. The creation of a place of worship speaks to the very essence of what our country was founded on. As we celebrate St. Michael's 100 years of existence, it is important to call attention to the fact that the American Values which led to the church's existence continue to this day.

The 100th anniversary of St. Michael's falls at a time of great renewal and triumph for the church. Over the last five years, the church has been undergoing significant renovation under the guidance of its devoted pastor, The Reverend Chris Stanton. The small church is truly a beautiful place of worship.

Mr. Speaker, it is my honor to call the attention of this body of Congress and our nation to the St. Michael's Orthodox Christian Church. Over the last 100 years, the church has provided a great deal to its parishioners and the community of Pueblo, and it is my honor to call attention to its service here today.

SAFE HOMES: CHILD IDENTIFICATION PROGRAM

HON. ALAN B. MOLLOHAN

OF WEST VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. MOLLOHAN. Mr. Speaker, a child abduction is every parent's worst nightmare. Yet all too often, we hear chilling stories of boys and girls taken from their rightful guardians; stolen by strangers or even by members of their family. Today, I want to recognize a program in my district that is working to prevent these awful occurrences.

In Weirton, volunteers have organized an initiative that is called WINK: Watching Its Neighborhood Kids. This two-part program is bringing the community together to help keep children safe—and to help recover them if they should ever be lost or taken.

Under the WINK Program, safe houses are being established across the city. These are homes and businesses, screened by the Weirton police, that volunteer to open their doors to children who are lost, hurt or threatened. The goal is to eventually have one on every block.

The approved safe houses are given a logo sign to post in their windows. They also are given information on helping children in danger. Children are told about the program in school, and parents are encouraged to show them where safe houses can be found in the neighborhood.

Mr. Speaker, this kind of vigilance and communication is a good way to protect our children. But sometimes, no matter how careful the precautions, young people are lost or missing. That is why the second part of this program is vitally important as well.

In addition to the safe houses, WINK has established a child identification program. It sponsors free registration events across the community. Parents bring in their children for digital photos, for fingerprints or footprints, and for a DNA mouth swab. All of these items—these key identification tools—are given to parents to take home, and keep close at hand.

Experts tell us that when a child is missing, an immediate response is the best response. It helps to increase the odds of a successful recovery. Thanks to the child I.D. program, parents have up-to-date information ready to give to police should the unthinkable happen.

Mr. Speaker, the safety of children is a concern that we all share. Today, I am pleased to salute a special group of people who truly take this concern to heart, and have channeled it into real community action. I ask the House to join me in recognizing the caring volunteers who are behind Weirton's watching its neighborhood kids.

A BILL TO MAKE CHANGES TO THE MAGNUSON-STEVENS FISHERY CONSERVATION AND MANAGEMENT ACT AND TO MAKE ADJUSTMENTS TO THE BERING SEA CRAB RATIONALIZATION PROGRAM

HON. DON YOUNG

OF ALASKA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. YOUNG of Alaska. Mr. Speaker, today I am introducing a bill to make a number of changes to the Magnuson-Stevens Fishery Conservation and Management Act. I believe there are three areas of the current Act that need to be changed. While the language I am proposing may not be the best way to address these concerns, I would like these proposed changes to spark a debate in the coming months.

In addition, I am including language to amend the Bering Sea and Aleutian Islands crab rationalization program to address what I believe was an oversight in the plan. I believe this plan to rationalize the Bering Sea crab fishery is a living plan which will continue to be modified as changes are needed. I believe that the safety issues of this fishery necessitate some action, and I don't believe that no action is an option. Congress asked the North Pacific Fishery Management Council to give the Congress a proposal and they did so. We have studied this fishery for too long without doing something to make it safer. Having said that, I also believe that the plan to rationalize this important fishery needs to be dynamic and we need to be able to make adjustments as we see how the plan works. Everyone involved in this debate has good intentions, but we need to be mindful that good intentions sometimes cause unintended consequences. We need to watch the implementation of the plan very carefully.

Finally, I am asking the Secretary of State to determine whether the retired U.S. staff of two international fisheries commissions who worked in Canada were unduly harmed by exchange rates and to what extent their retirement packages have suffered as a result of the exchange rate.

THE AFRICAN GROWTH AND OPPORTUNITY ACT

HON. JIM McDERMOTT

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. McDERMOTT. Mr. Speaker, partisan divisions are common in the Congress, but a few issues regularly escape those boundaries. International trade typically is one of them. Although the votes that gave President Bush Trade Promotion Authority confirm that even international trade can be an intensely polarizing issue, it frequently garners support across the political spectrum.

I first traveled to Africa in 1961 with Operation Crossroads to build a school in Ghana. Africa in the '60s underwent a vibrant surge of optimism as independence from colonial rule spread throughout the continent. My experience in Ghana changed my view of the world, and many Members of Congress have had experiences similar to mine. Many Members also believe, as I do, that when the United States opens its markets to poor countries, we extend an enormous opportunity to create jobs and raise living standards, and also provide greater value to American consumers. The African Growth and Opportunity Act (AGOA), signed into law by President Clinton in 2000, underscores the common goals that Republicans and Democrats can share.

By any measure, AGOA is a resounding success. It is spurring economic growth and bolstering economic reforms. It is fostering stronger ties between sub-Saharan Africa and the United States, and it is reaffirming Africans' conviction that they can compete in any market.

AGOA, which provides temporary benefits, requires periodic review by the Congress to assess its effectiveness. It was designed this way in part because policy makers, like myself, did not know the precise recipe to attract the type of investment in sub-Saharan Africa we were seeking. We made a few good guesses in this regard, but we probably missed the mark in other areas.

We guessed right when we decided that we should provide sub-Saharan Africa greater access to the U.S. textile and apparel market. Over the last three years, tens of thousands of jobs were created in this industry, thanks to AGOA benefits. Expiring next year, however, is the provision in AGOA that allows Africa's poorest countries to buy fabric outside the region—where it is inexpensive and high in quality—to create finished apparel products for export to the U.S.

Today, I join several of my colleagues, like Representatives ED ROYCE, AMO HOUGHTON and CHARLES RANGEL, to introduce legislation to extend AGOA and spread its benefits to other sectors of sub-Saharan Africa's economy. The AGOA III Act, H.R. 3572, marks the beginning of another bi-partisan effort to develop a plan to improve U.S.-Africa trade.

When my colleagues and I set out to write this bill, we saw the need to address four key issues. First, the third-country fabric provision available to Africa's poorest countries through AGOA expires at the end of next year, at the very same time as worldwide quotas on apparel disappear due to the WTO's Multi Fiber agreement. Third-country fabric must be extended to allow sub-Saharan Africa to participate in a market dominated by the Asian giants. There will be robust debate about how long Congress should extend this provision. We suggest in the AGOA III Act that these benefits should last as long as four years.

Second, the United States needs to provide technical assistance to African farmers to enable them to export their products to America. To do this, the AGOA III Act places dozens of American agricultural experts throughout sub-Saharan Africa to work with farmers and their governments.

Third, the biggest barrier to investment in sub-Saharan Africa is the lack of infrastructure. But building roads, ports, energy grids, telecommunication and water systems solely to increase trade flows is simply not feasible. It is the "chicken or the egg" dilemma. We cannot increase trade flows without adequate infrastructure, yet why build infrastructure if trade capacity is not at a level that requires it? We must find ways to develop and maintain new infrastructure in sub-Saharan Africa as trade capacity improves. One way we can do this is by fostering sustainable ecotourism in sub-Saharan Africa. This industry is expected to grow 30 percent over the next decade. We can help sub-Saharan Africa position itself to take advantage of this because the region enjoys an international comparative advantage with its extensive protected areas that host a variety of ecosystems and cultures. National parks and reserves in sub-Saharan Africa can become a basis for regional development, involving the communities living within and adjacent to them. The infrastructure used to support an ecotourism industry can also be used to increase trade flow. There are several initiatives in the AGOA III Act that seek to help sub-Saharan Africa develop its infrastructure, in part by helping build a viable ecotourism industry.

Fourth, we must address AIDS, which is not just a health crisis. AIDS is an economic catastrophe. In the 1990s, AIDS reduced Africa's per capita annual growth by nearly 1 percent. In the most heavily affected countries, 2 percentage points will be sliced off per capita growth in coming years. This means that after two decades, many economies in sub-Saharan Africa will be about 20–40 percent smaller than they would have been without AIDS. That is an enormous decline that no trade policy can overcome. In addition to fully funding international programs to combat the virus, we can provide tax incentives through AGOA to leverage private-sector contributions to the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria. The AGOA III Act would provide a tax deduction to U.S. firms operating in AGOA-eligible countries when they make a cash donation to the Global Fund.

As I speak with African entrepreneurs, civil society, and the African diplomatic corps, the enthusiasm about AGOA and sub-Saharan Africa's economic possibilities remind me of the excitement of 1960s. But unless all of us work together as we did before—Democrats, Republicans, civil society, and the governments of sub-Saharan Africa—to build a consensus about extending and enhancing AGOA, I fear that this enthusiasm will go the way of our '60s optimism, as genocide, apartheid, civil war, and famine swept over Africa. We have a rare opportunity to ensure that Africa continues to share our markets. We must not let this moment pass us by. I hope that when the Congress convenes next year, addressing U.S.-African trade will be at the top of Congress's agenda.

TRIBUTE TO ROBINSON HIGH SCHOOL PRINCIPAL KEVIN McCARTHY

HON. JIM DAVIS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. DAVIS of Florida. Mr. Speaker, I rise in honor of Robinson High School Principal Kevin McCarthy, who tragically passed away this week at the age of 39. Kevin's dedication to excellence and passion for serving his students, faculty and Robinson High School family will be sorely missed.

After earning two masters degrees and a doctorate, Kevin chose to become a science teacher in 1989. In 1997, he came to Tampa to serve as the science department head at Blake High School.

Kevin's ambition, enthusiasm and record of success served him well in the Hillsborough County School District. He progressed from department head to assistant principal for student affairs at Wharton High School and assistant principal for curriculum at King High School before he became principal at Robinson.

Along the way, he touched the lives of countless students, faculty and parents and left his mark on the schools in which he served. At Robinson, with his love of science, he helped create the MacDill Aeronautical Academy, which gives students the chance to engage in hands-on aerospace training and offers internship opportunities at MacDill Air Force Base.

When gunshots at Rembrant Garden apartments, adjacent to Robinson's campus, threatened the safety of students, Kevin spearheaded community meetings including local law enforcement and Tampa housing officials to address the problem. Just three months later, a plan was in place to tear down Rembrant apartments to make way for a new, safer complex.

The Robinson family, however, will most likely remember Kevin's leadership in helping the campus come to grips with the death of Lance Cpl. Andrew Aviles, a Robinson High School graduate who was killed in Iraq.

Kevin McCarthy was what every school district in America needs—a rising star who sets high expectations for students and faculty and has the talent to help them to meet those goals. All of us who got to know him and work with him were and continue to be inspired by his integrity, energy and intense focus on his students. Kevin was one-of-a-kind and will undoubtably influence countless others to follow his example in serving the community in many ways.

On behalf of the Tampa Bay community, I would like to extend my deepest sympathies to his family.

IN MEMORY OF PFC. JONATHAN CHEATHAM

HON. MIKE ROSS

OF ARKANSAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. ROSS. Mr. Speaker, I rise today to honor Army Pfc. Jonathan Cheatham, of Camden, AR, who died on July 26, 2003, fighting for his country in Iraq. I am saddened by this tragedy. I wish to recognize his life and achievements.

Jonathan attended Camden Fairview High School where he played soccer and the trumpet in the band. Upon graduation in 2002, Jonathan immediately entered the military. Jonathan served in the 489th Engineer Battalion of U.S. Army Reserve.

Jonathan gave his life to serve our country and will forever be remembered as a hero, a terrific son, and a courageous brother. My deepest condolences go out to his mother, Barbara Porchia, his sister, Portia Cheatham, family, friends, and those in his hometown of Camden whose lives he touched. I am sure Jonathan was proud of his service to the U. S. Army and to our country. I know he will be missed by his fellow soldiers, and all those who knew him and counted him as a friend. Furthermore, his fellow soldiers also know how much he contributed to the accomplishment of his unit's mission and to the U.S. Army. I will continue to keep Jonathan and his family in my thoughts and prayers.

HONORING THE CONTRIBUTIONS OF VIRGINIA DEMMLER

HON. SHELLEY BERKLEY

OF NEVADA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Ms. BERKLEY. Mr. Speaker, I rise to honor the memory of an outstanding Nevadan who dedicated her life to the highest ideals of civic life. Virginia Demmler, served the causes of justice and equality throughout her more than 20 years as a resident of Nevada, providing boundless energy, tireless work and inspiring leadership for Washoe County's Democratic Party and other civic organizations.

At the recent memorial service that celebrated Virginia's life, former United States Senator Richard Bryan described her as "the essence of a citizen activist, totally selfless and committed." Virginia was recognized at "the heart of the Democratic Party of Washoe County," by Mary Connelly, State Director for United States Senator HARRY REID.

Virginia Demmler's service as Chairman of the County Party as its Executive Director set the standard for principled, effective activism. Washoe County's Democrats have appropriately marked their respect for Virginia's legacy by naming their annual Honor Roll Dinner the Virginia Demmler Honor Roll Dinner, where hundreds of her fellow citizens will attend in tribute to her.

As a young woman I became involved in politics and public service in Las Vegas, hundreds of miles from Reno. But Virginia reached out to me to provide guidance and vision that helped chart my course to achieve elected office and to serve all Nevadans with the passion and principle epitomized. I hope my service measures up to her example.

Virginia never shied away from helping a good cause. From Common Cause, to Planned Parenthood, to the American Civil Liberties Union, she served with distinction and was always there for people in need, to right a wrong, and to help build a better state.

Nevada is a better place, and her citizens enriched, because of the life of Virginia Demmler.

VETERAN TRIBUTE FOR STAFF SERGEANT JOSEPH PENA

HON. MICHAEL C. BURGESS

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. BURGESS. Mr. Speaker, I rise today to recognize the contributions and sacrifices of Staff Sergeant Joseph Pena.

Staff Sergeant Pena served our country during the Korean War in the United States Air Force. He received the Korean Service Medal and the National Defense Service Medal. Staff Sergeant Pena is also a recipient of the Republic of Korea War Service Medal and the United Nations Service Medal.

At a time when we are once again at war, it is necessary to recognize the achievements of these national heroes. Due to their dedication, service, and sacrifice, they deserve our unwavering admiration and our unending gratitude.

Our country often takes for granted the freedoms and liberties our service men and women risk their lives to protect; yet by continuing to honor our veterans we preserve our nation's future by commemorating their past.

Thank you, Staff Sergeant Pena, for your service and sacrifice. You are a true hero.

TRIBUTE TO ZOELSMANN'S BAKERY

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. MCINNIS. Mr. Speaker, it is my honor to rise and pay tribute to a remarkable business in my district. Zoelsmann's Bakery has been serving the community of Pueblo, Colorado for 105 years, and I am pleased to call the attention of this body of Congress to the many contributions the bakery has made to the Pueblo community.

Otto Zoelsmann and his wife immigrated to the United States from Germany in the late 1800's. In 1898, the couple moved to Pueblo, where they opened a bakery. The Zoelsmann's were expert bakers and their delicacies were immediately popular throughout the Pueblo community. Horse drawn wagons, and later Ford Model T trucks, initially delivered the baked goods to Zoelsmann's loyal customers.

Aside from technological advancements, little about Zoelsmann's Bakery has changed over the years. The bakery is still dedicated to creating and selling the best baked goods possible. The current co-owners, the Petkoseks and the Paradisos, along with their staff, always serve their customers with a kind word and a friendly smile.

The Petkoseks and Paradisos took over the store after its longtime owner Chuck Martinelli retired. Chuck was a beloved figure in Pueblo and a master chef. Chuck handpicked his successors and, before retiring, he taught them his trade and entrusted them with his famous recipes. Chuck's memory lives on with Zoelsmann's Bakery as it goes about its business each day.

Mr. Speaker, it is my honor to rise and pay tribute to Zoelsmann's Bakery. The bakery is entering its second century of dedicated service to the people of Colorado and I am pleased to call attention to Zoelsmann's contributions to the community of Pueblo.

H.R. 1813, THE TORTURE VICTIMS RELIEF REAUTHORIZATION ACT OF 2003

HON. JOSEPH CROWLEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. CROWLEY. Mr. Speaker, I rise in strong support of H.R. 1813, the Torture Victims Relief Reauthorization Act of 2003.

Torture is a horrible tool used in more than 150 countries to silence, intimidate and oppress people around the world. Many survivors of torture arrive in the United States every year. This legislation provides vital funding of support for victims of torture.

Mr. Speaker, more than 500,000 survivors of torture live in the United States today. A significant number of these survivors live in New York City. These survivors need vital support in terms of rehabilitation, medical care and psychological care. Fleeing from their persecutors, most often leaving their families behind, they arrive with no documentary evidence to prove their persecution. All they have are their scarred bodies and their stories of horror.

Once they arrive, the survivors are forced to face a culture and a system different from what they have known. They face numerous challenges in their effort to integrate into our society and become fully participating members. They have difficulty telling their stories to the immigration officers and even to their own attorneys because of the abuse they have endured by those in power in the past and thus are wary of authorities. Among the few they can turn to are the torture treatment programs. These programs, armed with experience and dedication, are instrumental in helping survivors document their stories of torture, providing them with clinical care and psychosocial support, and enabling them to embark on a new life.

The life-saving work done by these torture treatment programs should be commended and appreciated by all Americans, for they open their doors, extend their hands, and offer shoulders to the most severely wounded new Americans. It is my pleasure today to commend the indispensable work of the Safe Horizon/Solace Program for Survivors of Torture and Refugee Trauma in my district. Solace is a program of Safe Horizon; which is the nation's leading victim assistance and advocacy organization. Solace is a decentralized, citywide program, with its main offices in Jackson Heights, Queens. Since 1997, Solace has provided an array of services on behalf of torture survivors from over 70 different countries, including intensive case management, clinical, referral for medical and legal, social adjustment counseling, accompaniment, interpretation, information and referral, medical and psychological evaluations, expressive therapies such as visual and dramatic arts, dance, and somatic therapies such as massage, for survivors of torture seeking safe haven in the United States.

Furthermore, Solace has pioneered a community development approach that involves creating social healing interventions at the familial and communal levels, particularly important since torture seeks to destroy the fabric of communities, as much as it seeks to destroy individuals.

The Safe Horizon/Solace approach is also extremely cost effective, since Solace is the managing partner of the Metro Area Support for Survivors of Torture (MASST) Consortium, which includes Doctors of the World/USA, Refuge, Inc., and the International Institute of New Jersey as partners. This New York City and Northern New Jersey effort is all done on one grant from the Department of Health and Human Services, Office of Refugee Resettlement, and is the only such configuration in the United States. This past year, the MASST Consortium has reached thousands of people with a dizzying array of services.

The funds provided by the Torture Victims Relief Reauthorization Act of 2003 will enable torture treatment programs like Safe Horizon/Solace and its MASST partners to continue to provide the crucial services needed by those who have been subjected to cruel and inhuman treatment in their own countries.

Mr. Speaker, we may not have the opportunity to know when we meet the survivors of torture, to listen to first hand and understand their stories, or to appreciate the courage they exhibit in overcoming the consequences of the traumatic events they have experienced. But we do have the opportunity to assist them today. By supporting this important legislation, we can play an important part in providing care for this resilient group of people. We can give them hope for a better future. We will be instrumental in helping them break down the barriers that keep them from fully integrating into our society.

I strongly encourage all my colleagues to join me in supporting this important legislation.

PERSONAL EXPLANATION

HON. JOHN B. LARSON

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. LARSON of Connecticut. Mr. Speaker, I would like to submit this statement for the record and regret that I was unavoidably detained on my way to the floor on November 21, 2003 to vote on rollcall vote Number 636, on H.R. 3491, the National Museum of African American History and Culture Act. Had I been present, I would have voted "aye."

A BILL TO IMPROVE THE LIQUIDITY OF THE MARKET FOR INVESTMENTS IN LOW-INCOME HOUSING TAX CREDIT PROPERTIES

HON. AMO HOUGHTON

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. HOUGHTON. Mr. Speaker, today Representatives NANCY JOHNSON (R–CT), CHARLES RANGEL (D–NY) and RICHARD NEAL (D–MA) are joining me in introducing legislation to correct a problem that is impairing the liquidity of the market for investments in Low-Income Housing Tax Credit (housing credit) properties. The housing credit has been a remarkably successful incentive for encouraging investment in residential rental housing for low-income families. Under Section 42 of the Internal Revenue Code, a tax credit is available for investment in affordable housing. The credit is claimed annually over a period of ten years. Qualified residential rental projects must be rented to lower-income households at controlled rents and satisfy a number of other requirements throughout a prescribed compliance period (generally, 15 years from the first taxable year the credit is claimed).

Today, virtually all of the equity for housing credit investments comes from widely held corporations investing through housing credit funds. A significant number of corporate investors have transferred these fund interests in recent years, typically due to a change in their income tax status. An investor wishing to dispose of an interest in a Low-Income Housing Tax Credit ("housing credit") property during its 15-year compliance period is subject to a recapture of housing credits previously claimed unless a bond or U.S. Treasury securities are posted to the Internal Revenue Service (IRS). The amount of the bond to be posted is based on the amount of housing credits claimed and the duration remaining in the compliance period. The purpose of the bond is to guarantee to the IRS that it can collect the appropriate recapture amount in the event that the property is no longer in compliance with the requirements of the housing credit program.

At the time the housing credit program was enacted in 1986, the drafters of the statute were concerned that owners would claim the benefits of the tax credits and then avoid the continuing compliance requirements by transferring the credits to a straw party with minimal assets that the IRS could go after to collect recapture liability. This was a potential concern because housing credits are provided on an accelerated basis in the sense that they are claimed over a ten-year period, while the property must remain in compliance with the targeting rules over a minimum 15-year period.

However, the experience with the housing credit over the past 15 years demonstrates that this concern is no longer valid. When the housing credit program was enacted, policymakers thought in terms of previous affordable housing tax incentives that supported an aggressive tax shelter market dominated by individual investors. As it turns out, virtually all (99% today) investment capital in the housing credit program is from publicly traded corporations that pose none of the risks of noncompliance that motivated enactment of the recapture bond rules. Ironically, sales of individual partnership interests in public partnerships with more than 35 investors are exempt from the recapture rules.

There are also other provisions in Code section 42 that adequately address potential noncompliance. In 1989, Congress added the requirement that all state allocating agencies adopt "extended use agreements" to be recorded as restrictive covenants on housing credit properties, which require the property to remain in compliance. In addition, the state allocating agencies were given oversight responsibilities to ensure continued compliance through site inspections and property audits.

The requirement to purchase recapture bonds forces investors to incur unnecessary costs and has produced a complex administrative burden on the IRS. Since bond filings are done building by building, and since single sales transactions frequently involve hundreds of properties, each with dozens of buildings, bond filings may involve thousands of separate filings. Worse yet, the few remaining surety companies writing this type of business operate in an inefficient market. Recapture surety bonds are priced in a fashion that does not measure the true risk of non-compliance, but rather relies solely on the credit rating of the company requesting the bond. This is a function of the fact that surety underwriters do not understand the housing credit program in general or the risk of noncompliance in particular.

At the same time, the incidence of non-compliance with housing credit program rules is exceedingly rare. Meanwhile in the aftermath of the September 11th terrorist acts and the spate of corporate accounting scandals, the surety market is in turmoil. Recapture bond premiums, even for highly rated public companies, have more than tripled over the past two years. This has imposed dead weight costs on the housing credit program. By making it more difficult to transfer credit investments, the recapture bond rule impairs the liquidity of housing credit investments, reducing credit prices generally, and undermining the overall efficiency of the program.

The IRS recently responded to a series of questions we posed about the recapture bond requirement. According to the IRS, since just 1997, recapture bonds covering approximately $1.8 billion of tax credits have been posted—but in the 17 years since the requirement was enacted, the Service has never made a claim on a recapture bond. That works out to bond premium payments of about $150 million, to ensure against an event that has never occurred. These costs are unnecessary and are imposing a real drag on the market for investments in housing credit properties.

Our bill will solve this problem by repealing the recapture bond requirement effective for disposition of interests in LIHTC properties after the date of enactment. An owner of a building (or interest therein) (generally, a limited partnership) that has been the subject of a disposition and is still within the remaining 15-year compliance period with respect to such building would be required to submit a report to its former investors when a recapture event with respect to such building occurs. A copy of recapture event forms sent to investors would be required to be filed with the IRS in order to provide the Service with the information necessary to ensure that all recapture liabilities are timely paid. The general statute of limitations applicable to taxpayers would be modified so that investors who dispose of a building after the effective date of the legislation would remain liable for any potential recapture liability for a period extending through the compliance period for such building to provide the IRS with additional time to audit the partnership's return to ensure the building's continuing compliance with the credit's requirements. Taxpayers who disposed of a building (or interest therein) prior to the date of enactment would not be required to maintain existing recapture bonds (or other alternative security), but cancellation of existing bonds would trigger an extension of the statute of limitations provided for in the legislation.

We encourage you to join us in cosponsoring this important legislation.

A FINE SENSE OF IRONY

HON. CHRISTOPHER H. SMITH

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. SMITH of New Jersey. Mr. Speaker, Russian Foreign Minister Igor Ivanov demonstrated a fine sense of irony recently when he criticized the United States for an "excessive tendency to use force" in resolving international issues.

Let me state clearly that I do not believe my country should reach for its huge arsenal of weapons and troops every time we are faced with a difficult situation abroad. To everything there is a season.

Nevertheless, it is ironic that the Russian Government should accuse the United States of taking military action when back home in Chechnya the Russian Government has demonstrated not only an excessive tendency to use force, but also a tendency to use excessive force.

This is not meant to ignore or justify the human rights abuses of the Chechen separatist movement. The Russian Government is entitled to defend its territorial integrity and defend its citizens against civil disorder. But the fact remains that with its "anti-terrorist operation," Moscow has unleashed a massive and brutal military campaign that frequently makes no distinction between combatants and noncombatants. As Newsweek's distinguished commentator Fareed Zakaria wrote in August of this year, "Over the past ten years, Russia's military has had a scorched-earth policy toward Chechnya. The targets are not simply Chechen rebels but, through indiscriminate warfare, ordinary Chechens . . . Over time, the Chechen rebellion has become more desperate, more extreme and more Islamist."

Not only are such tactics inhumane and cynical, they lead not to peace in Chechnya, but to a more protracted conflict. In this week's National Interest online, Seva Gunitsky reports on how the tactics of the Russian military has radicalized a population that might otherwise have rejected the armed militants: "For by refusing to distinguish between fighters and civilians, the Russian army fused together the interests of previously disparate groups . . . [and] created a far more dangerous foe."

Besides the widespread civilian casualties and property destruction caused by the indiscriminate use of force by Russian military and security forces, the Chechen conflict has resulted in the displacement of hundreds of thousands of persons. Moreover, the recent presidential elections in Chechnya were so obviously flawed that they could hardly be said to reflect the will of the people.

I welcome an exchange of opinions with other government leaders and parliamentarians regarding U.S. foreign policy. Nevertheless, I hope that Moscow will reexamine its own excessive tendency to use force in Chechnya and make every effort to reach a legitimate political settlement there.

HONORING PORTUGUESE EDUCATION FOUNDATION OF CENTRAL CALIFORNIA

HON. DENNIS A. CARDOZA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. CARDOZA. Mr. Speaker, I rise today to honor the continued efforts of the Portuguese Education Foundation of Central California and their numerous contributions to our community. The Foundation works tirelessly to educate the community and to recognize individuals for such efforts.

Tonight, the Foundation is honoring members of the community for their valued contributions and achievements. In addition, the Foundation is recognizing over 30 Foundation Scholarship recipients, lending these individuals strong support in their continuing pursuit of educational goals.

It is my distinct pleasure to pay tribute to the Foundation's 2003 community honorees.

Former Congressman Tony Coelho is being honored as the 2003 Citizen of the Year. Tony, my mentor and good friend, has been an exemplary member of the Portuguese community for many years. He served with distinction as Majority Whip in the United States House of Representatives and continues to think of our San Joaquin Valley as his home.

I am delighted to also recognize the achievements of Maria de Lourdes Silva. Maria has been selected as the 2003 Student of the Year by the Foundation. She is being honored for her outstanding academic achievement and research for the Portuguese Heritage Community of California. I commend her on her dedication to the community.

Finally, it is my honor to recognize Jose Luis da Silva, who has been selected as the

2003 Professor of the Year by the Foundation for his contributions and dedication to sharing the language and culture of the Portuguese community with the many students of the San Jose High Academy. Mr. da Silva is a tireless advocate and tremendous resource for his students and our community.

The Portuguese Education Foundation of Central California continues to be a strong asset to our community. The Foundation's efforts are immense and I am honored to recognize them and their awardees this evening.

THE POLITICIZATION OF THE JUDICIAL NOMINATION PROCESS

HON. MARK E. SOUDER

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. SOUDER. Mr. Speaker, I rise to address a matter of deep concern to every Member of Congress and to every American citizen—the judicial nomination process. I am chairman of the Government Reform Committee's Subcommittee on Criminal Justice, Drug Policy and Human Resources, which has responsibility for oversight of, among other things, our federal judicial system. I am deeply concerned by the growing politicization of the judicial nomination process by a handful of left-wing groups and their advocates in Congress.

Last week, the Wall Street Journal reported on a number of memos written by Congressional staff between 2001 and 2003. They illustrate the extreme political prejudice, crass maneuvering, and pandering to special interest groups that are bringing the judicial nomination process to a standstill. One memo actually claims that "most of [President] Bush's nominees are nazis". Another shows that action on nominees was delayed to allow "the groups"—i.e., left-wing special interest groups—"time to complete their research," i.e., to dig up as much dirt as they could on the President's nominees. And shockingly, a third memo shows that action was delayed on a nominee in order to affect the outcome of a case before the Sixth Circuit.

At present, no one can say for sure how the newspaper obtained the memos. Certainly illegal theft of any confidential materials should not be tolerated. I note, however, that given the large number of the memos, the fact that the source blacked out the names of the staff members who wrote and received the memos (presumably to save them from embarrassment), and the date of the documents (most are from 2001 and 2002) strongly suggest that the source was a member of the Democratic staff, and not someone illegally stealing the memos. In any case, now that these memos have been distributed to the press, I believe that it is important for the Members of Congress and the public to see them and judge their contents for themselves. I am therefore submitting the first installment of these memos for the RECORD, and intend to submit more of them in the days to come. I hope that a full and vigorous debate of this important issue will help the process to move forward, so that the President's nominees can quickly receive the yes or no vote that they deserve.

* * * * *

Big fight early next year. Three benefits: (1) Sends message on Supreme Court; (2) Forces WH to bargain; (3) encourages more moderate nominees.

To work, need all 10 Dems on board and need commitment not to go to the floor. Query: will it be possible to get all 10 Dems to commit before a hearing? Doubtful. There is a big risk. We must choose a nominee tailored to our weakest link. E.g., Pickering is bad but is he had enough? Probably not—finish him AFTER.

Who to fight? Not Estrada—hard to beat, and don't want him on the Supremes.

Groups have 3 names: Kuhl, Sutton, and Owens. Kuhl seems like a bad idea, b/c Boxer will never return the BS. Why waste that power, freeing up another nominee to go through? Similar with Sutton—he is being held up right now. Sutton will be hard to beat—very strong paper record, impressive credentials. GOP will carp about how only criteria should be excellence ("Should Ideology Matter?" retread.) (Same problem with Estrada.) Sutton is personification of the threat the New Federalism poses to Civil Rights, but his defenders will muddle debate. Why not use someone else, show WH we mean business, then bargain to "release" hold on Sixth Circuit.

I say Owens. She is from Texas and appointed to SCT by Bush, so she will appear parochial and out of mainstream. She is definitively anti-abortion, in ways that make her look disingenuous. Pro-business. Questionable ethics. Plus can craft the message: concerted campaign to pack the Courts. Phase I: GOP blocks many well-qualified people—Johnson, Moreno, etc. Phase II: GOP picks extremists like Owen, and pushes hard. Court gets way out of wack. Focus not only on numbers, but tangible outcomes—rulings striking down VAWA, civil rights laws, environmental laws, etc.

No more hearings this year. Lay the foundations for next January/February. Schumer hearing on federalism, and the threat it poses. Coordinate media strategy, Drop hints. Schedule the hearing well in advance in January, so we don't face accusations of sandbagging,

Stress that we have cut the BS: no more anonymous holds, no more years without a hearing, no more ridiculous document requests, no more shutting down the Committee. Rather than hold a nominee up endlessly, and ruin their career, we will vote. There's a reason why they did that—most of Clinton's nominees were impeachable. There's a reason why we do what we do—most of Bush's nominees are Nazis. That doesn't mean we will roll over and play dead. Mainstream nominees will get quick turn around time. Controversial ones demand more careful scrutiny.

WHY HAVE A HEARING AT ALL?

Memorandum: June 21, 2002

To: Senators Kennedy, Schumer, Durbin, and Cantwell

From:———

Subject: Strategy on Judges

In advance of the Judiciary Democrats' meeting on Tuesday at 2:15, below is the strategy regarding judges that we recommend that you suggest to Senator Leahy.

1. Cancel or Reschedule Deborah Cook, 6th Circuit nominee. Senator Leahy is suggesting that a hearing for Deborah Cook be scheduled for August 1st, and, Senator Leahy may have promised Senator DeWine that he will hold a hearing for Cook this year. Cook is extremely controversial on labor, employee rights, and right to jury issues and should not have a hearing this year. If Senator Leahy has indeed promised DeWine a Cook hearing, we suggest that he schedule Cook for after the November elections. Given our schedule of controversial nominees (see below), it will be difficult to mount any effective challenge to Cook if she is scheduled for early August. We recommend that Reena Raggi (2nd Circuit) be scheduled for early August instead of Deborah Cook.

2. Limit the Number of Hearings. Senator Leahy has promised hearings for Priscilla Owen, Miguel Estrada, and Michael McConnell. Other than these nominees, and the two remaining noncontroversial nominees Reena Raggi (2nd Circuit) and Jay Bybee (9th Circuit), no additional judges should be scheduled.

3. Timing of Hearings:

Owen. The consensus is to make Priscilla Owen the big fight for July 18th, as Senator Leahy has suggested, with the hope that we will succeed in defeating her.

Estrada. Miguel Estrada will be more difficult to defeat given the sparseness of his record. We agree with Senator Leahy that Estrada should be scheduled for September 19th. This will give the groups time to complete their research and the Committee time to collect additional information, including Estrada's Solicitor General memos (see below).

McConnell. McConnell will also be difficult to defeat. While he has a clear anti-choice record, he has the strong support of some Democrats and progressives. McConnell's clear anti-choice record, however, makes him a good nominee to bring up before the November elections. While Senator Leahy has suggested that a hearing for McConnell be scheduled on October 3rd, we would suggest October 10th, to provide enough time for preparation after the difficult Estrada hearing.

Suggested Schedule, July 18th: Priscilla Owen—5th Circuit; August 1st: Reena Raggi—2nd Circuit (non-controversial)—instead of Cook; September 5th: Jay Bybee—9th Circuit (supported by Reid); September 19th: Miguel Estrada—D.C. Circuit; October 10th: Michael McConnell—10th Circuit.

4. Obtaining Estrada's Solicitor General's Memos. Senator Leahy took the important first step of asking for Memoranda that Estrada produced while working at the Solicitor General's Office. Unfortunately, the Department of Justice has refused to turn over the memos, and Senator Leahy has been harshly criticized for this in the Press (two pieces in the Washington Post alone). We expect the Administration will continue to fight any attempt to turn these over, but there is precedent for getting these Memos—it was done for the Bork nomination and three other lower court nominations. We suggest that you encourage Senator Leahy to continue fighting the Administration for these Memos and, if possible, that one of you help him in this fight.

U. MICHIGAN SCANDAL

Memorandum: April 17, 2002

To: Senator (Kennedy)

From: ———

Subject: Call from Elaine Jones re Scheduling of 6th Circuit Nominees

Elaine Jones of the NAACP Legal Defense Fund (LDF) tried to call you today to ask that the Judiciary Committee consider scheduling Julia Scott Gibbons, the uncontroversial nominee to the 6th Circuit at a later date, rather than at a hearing next Thursday, April 25th. As you know, Chairman Leahy would like to schedule a hearing next Thursday on a 6th Circuit nominee because the Circuit has only 9 active judges, rather than the authorized 16. (These vacancies are, as you know, the result of Republican inaction on Clinton nominees). Senator Leahy would also like to move a Southern nominee, and wants to do a favor for Senator Thompson.

Elaine would like the Committee to hold off on any 6th Circuit nominees until the University of Michigan case regarding the constitutionality of affirmative action in higher education is decided by the en banc 6th Circuit. This case is considered the affirmative action case most likely to go to the Supreme Court. Rumors have been circulating that the case will be decided in the next few weeks. The thinking is that the current 6th Circuit will sustain the affirmative action program, but if a new judge with conservative views is confirmed before the case is decided, that new judge will be able, under 6th Circuit rules, to review the case and vote on it.

LDF asked Senator Leahy's staff yesterday to schedule Richard Clifton, an uncontroversial nominee to the 9th Circuit, before moving Gibbons, but they apparently refused. The decision has to be made today (or by early Thursday morning) since the hearing will be noticed on Thursday.

——— and I are a little concerned about the propriety of scheduling hearings based on the resolution of a particular case. We are also aware that the 6th Circuit is in dire need of additional judges. Nevertheless we recommend that Gibbons be scheduled for a later hearing: the Michigan case is important, and there is little damage that we can foresee in moving Clifton first. (It should be noted that Clifton was nominated three months before Gibbons and that Clifton's seat, and not Gibbons', has been designated a judicial emergency.) Elaine will ask that no 6th Circuit nominee be scheduled until after the Michigan case is decided. This may be too much to promise: we only have three uncontroversial circuit court nominees left and two of these are from the 6th Circuit.

Recommendation: Let Elaine know that we will ask Senator Leahy to schedule Gibbons after Clifton. Given the dearth of uncontroversial nominees, however, the Committee will probably have to hold a hearing for Gibbons on May 9th even if there's yet no decision in the Michigan case.

* * *

VETERAN TRIBUTE FOR COLONEL ANDREW C. OLIVO

HON. MICHAEL C. BURGESS

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. BURGESS. Mr. Speaker, I rise today to recognize the contributions and sacrifices of Colonel Andrew C. Olivo.

Colonel Andrew C. Olivo has served our country for many years in the United States Army Judge Advocate General Reserve. He was a part of the Desert Storm Conflict and Gulf War I. He has received numerous awards and medals for his services. These awards include two National Defense Service Medals and Army Commendation Medals. Colonel Olivo is also a recipient of four Meritorious Service Medals and the Humanitarian Service Medal with one service star.

At a time when we are once again at war, it is necessary to recognize the achievements of these national heroes. Due to their dedication, service, and sacrifice, they deserve our unwavering admiration and our unending gratitude.

Our country often takes for granted the freedoms and liberties our service men and women risk their lives to protect; yet by continuing to honor our veterans we preserve our nation's future by commemorating their past.

Thank you, Colonel Olivo, for your service and sacrifice. You are a true hero.

* * *

TRIBUTE TO DON VANDERHOOF

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. McINNIS. Mr. Speaker, it is my honor to rise and pay tribute to my friend Don Vanderhoof. Don has served the community of Glenwood Springs, Colorado for many years. Over the last eight years, Don has held a seat on the City Council, the last two of which he served as Mayor. Don is a tremendous public servant, and a wonderful person, and it is my honor to call his many contributions to Glenwood Springs to the attention of this body of Congress and our nation.

Over the last eight years, Don was instrumental in providing leadership and guidance for many important City projects. During Don's tenure in city government, there were major additions to the resources available to the Glenwood Spring's Police, Fire, and Public Works Departments. In addition, the City added a new Community Center and City Hall, repaired the City's water delivery system, improved public transportation, and worked to maintain the hiking trails and beautiful wilderness areas surrounding the City. These are just a few of the many accomplishments in which Don Vanderhoof was involved for the betterment of the City of Glenwood Springs. There is no question that Glenwood Springs has become a better place as the result of Don's tireless dedication to its citizens.

The people of my hometown will miss having Don as a devoted public servant. However, Don does not intend to remain idle in his retirement. I know that he will remain very active in the Glenwood Springs community. Don will now have more time for the many volunteer and community service activities that he eagerly undertakes. In addition, Don will have the opportunity to spend more time with his lovely wife Eddie, and his many friends, neighbors and family members throughout town.

Mr. Speaker, it is my privilege to rise and pay tribute to Don Vanderhoof. He has dedicated many years of his life to improving the quality of life for the citizens of Glenwood Springs and has accomplished an incredible amount to that end. In addition to his public service, Don is a great family man and a dear friend to many. He is one of Glenwood Springs' most beloved citizens. Don's life is the embodiment of all that makes this country great and I consider it an honor to call him a friend. Thank you Don, for your service.

THE NIGHTMARE IN TURKMENISTAN

HON. CHRISTOPHER H. SMITH

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. SMITH of New Jersey. Mr. Speaker, November 25 will mark the one-year anniversary of events in Turkmenistan that turned that already bizarre autocracy into an even more nightmarish kingdom. According to the official version, opposition groups led by former high-ranking officials tried to assassinate Saparmurat Niyazov, the country's President-for-Life. The attempt failed, the plotters were found, tried and imprisoned, and in the eyes of Niyazov's regime, justice has been done.

What actually happened that day is unclear. There may well have been a coup attempt against Niyazov, who has turned himself into virtually a living god. Or, as some opposition activists in exile maintain, the whole affair may have been staged by Niyazov to crack down even harder. Since no outsider has had access to those arrested in connection with the events, the truth may never be known.

Whatever happened, it is easy to understand the desperate frustration among Turkmen. Niyazov has made Turkmenistan the only one-party state in the former Soviet space, where one man decides everything, no opposition is permitted, all media are totally censored and the populace is forced to study the "rukhnama"—a dictator's rantings that purport to be a one-stop religion, national history and morality lesson.

What is clear is that Niyazov's response to November 25 has trampled on civilized norms, even if his allegations are true. In the wake of the arrests, all opposition—real or imagined—has been crushed. Quick show trials of the accused were broadcast on television, after which they received long prison sentences with no access to relatives or international organizations. Some of the opposition leaders have already died in prison. One individual who was arrested, an American citizen named Leonid Komarovsky of Massachusetts was eventually released, as a result of pressure from Washington. Upon gaining his freedom, he told the world of the horrible tortures people suffered at the hands of Turkmen security forces. The stories rival any we used to hear from the Soviet Union or Saddam Hussein's Iraq. In addition, relatives of those deemed "enemies of the people" have been targeted for persecution. The luckier ones merely are fired and thrown out of their apartments onto the streets; others have been arrested and tortured in prison or forced to watch their loved ones being tortured.

In response to this crisis, the OSCE invoked the Moscow Mechanism, a rarely-used tool to investigate particularly appalling human rights violations. But Niyazov refused to cooperate with the OSCE, whose officially designated rapporteur was denied a visa. Nevertheless, he was able to compile a comprehensive dossier of horror, which documents as well as possible without access to prisons, the mistreatment and abuse of those arrested and the persecution of their relatives. The rapporteur also forwarded to the Government of

Turkmenistan recommendations to move towards reform. Niyazov has dismissed them as "offensive" and "interference in internal affairs."

Niyazov has also refused U.S. officials entry to his jails. Recently, Ambassador Stephen Minikes, head of the U.S. Delegation to OSCE visited Ashgabat, but despite his explicit request, was not allowed to check on the health of one of those arrested: former Turkmen Foreign Minister and OSCE Ambassador Batyr Berdiev. There are persistent rumors he has died in prison.

One year after the events of November 25, Saparmurat Niyazov remains in power. He continues his crackdown, and the country's downward spiral accelerates. Niyazov has reintroduced exit visas, a legacy of the Soviet past we thought had been definitively overcome. Just last week, he instituted new laws harshly restricting freedom of religion, which is trampled upon daily in Turkmenistan; groups brave enough to meet risk home raids, imprisonment, deportation, internal exile, house eviction and even torture. The new provisions further empower regime agents to squash religious practice. Now, individuals caught more than once in a year acting on the behalf of an unregistered community can be fined between ten and thirty months of wages, or be sent to hard labor for up to one year. Of course, registration is in effect impossible to obtain, leaving religious communities and their members in a highly vulnerable position.

A recent Niyazov decree on NGO activity makes it punishable for most Turkmen to interact with foreigners. Representatives of non-Turkmen ethnic groups, such as Uzbeks or Russians, face discrimination in education and employment. Niyazov has not only reestablished and strengthened the environment of fear, he has deliberately isolated his country from outside influences. Under his rule, Turkmenistan has no chance of developing normally.

As November 25 approaches, we recall that when a political system centralizes all power in the hands one man, offering no possibilities for participation to anyone else, people may be tempted to change that system by any means. And we have occasion to consider the eternal validity of Lord Acton's dictum: "Power tends to corrupt; absolute power corrupts absolutely."

Unfortunately, the U.S. response to Turkmenistan's blatant disregard for human rights has been shamefully weak. In August, although Turkmenistan violates freedom of emigration by requiring exit visas, the Administration made the astonishing decision to exempt Turkmenistan from Jackson-Vanik requirements on the free movement of citizens.

Our leverage on this particular dictator may be weak but we have opportunities to express our outrage about these ongoing abuses and to align ourselves with the forces of freedom and democracy. In addition to ending the Jackson-Vanik waiver, the State Department should designate Turkmenistan a "Country of Particular Concern" under the International Religious Freedom Act of 1998. The regime's well-documented record of "particularly severe violations of religious freedom" unquestionably meets the statutory threshold envisioned when we passed the Act of "systematic, ongoing, egregious violations of religious freedom."

The United States and the international community must condemn the actions of Niyazov's regime and continue working to bring Turkmenistan back towards civilized and democratic norms. Any other approach betrays our own principles.

ON INTRODUCTION OF THE AFRICAN GROWTH AND OPPORUTNITY ACT III

HON. CHARLES B. RANGEL

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. RANGEL. Mr. Speaker, Today, I am proud to join with Congressman McDERMOTT, Chairman ROYCE, Congressman JEFFERSON, Congressman PAYNE and Congressman NEAL in the House, and Senator LUGAR in the Senate, in introducing legislation to begin the third phase of the African Growth and Opportunity Act.

It has been almost ten years since a bipartisan group of Members came together to help create a trade and investment framework between our great country and the countries of sub-Saharan Africa.

It has been more than three years since the first phase of that effort became law.

In that short time, the results have been impressive:

In three years, AGOA textile and apparel exports to the United States have doubled, rising from $570 million in 1999 to $1.1 billion for 2002. This total comprises 9 percent of all AGOA exports.

AGOA exports now comprise approximately two percent of all U.S. textile and apparel imports—a 100 percent increase from 2000, when AGOA took effect.

Africa's 92 percent export growth rate in textile and apparel products is 10 times that for China, Latin America, Europe and other major textile and apparel exporters.

However, we cannot afford to sit back and admire what we have done. So much remains to be done to fulfill the promise of this important legislation and this important trade program—to fill in the gaps that still exist.

So, today, I join with my colleagues on both sides of the aisle to call upon the House, the Senate and the President to take the next important step to broaden and deepen the commercial and bilateral relationships between the United States and African countries.

We need to ensure that the benefits of AGOA

We need to do this for so many reasons—bringing Africa more and more into the mainstream of the world trading system, strengthening the bilateral ties between the United States and African countries, giving women and men in the poorest countries in the world the chance to earn a fair and decent living so that the seeds of growth and a better life and a middle class society are sewn, rather than the seeds of discontent that we see in some other regions of the world.

To do this, we need to push forward. Specifically, we need to extend the effective date of AGOA, extend the ability of AGOA least developed countries to use fabrics from third countries, and bring under the AGOA framework the important agricultural products that many countries in the region seek to produce and export.

In the agriculture area, Africa's exports have actually *decreased* by 4.5 percent (or $25 million) since 1999. While duty free treatment will not completely solve the problem caused in part by large domestic support programs in the EU and elsewhere, this step will certainly help.

In other areas, the bill encourages both responsible conservation and responsible development through a provision in support of ecotourism, an area where many African countries have an important natural and comparative advantage that they are seeking to use in a sustainable and responsible way.

I look forward to working with many others on both sides of the aisle who have been so supportive of AGOA I and AGOA II, particularly Chairman BILL THOMAS and Chairman PHIL CRANE of the Trade Subcommittee, Congressman AMO HOUGHTON in the House, and Senator BILL FRIST and others in the Senate, along with the distinguished African Diplomatic Corps, and so many in the business community to realize our goal.

Finally, we intend this bill to be a starting point, and that as we move forward, we can work with Ambassador Zoellick and his staff, and Secretary Evans and his staff, to improve the legislation to reflect best the development needs of sub-Saharan Africa.

Also hope we can work together on other initiatives to ensure that the poorest countries of the world—such as Haiti and Bangladesh and Cambodia—are not left behind after 2005.

INTRODUCTION OF A BILL TO ALLOW FOR PRIORITY IN THE ISSUANCE OF IMMIGRANT VISAS TO SONS AND DAUGHTERS OF FILIPINO WORLD WAR II VETERANS

HON. ED CASE

OF HAWAII

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. CASE. Mr. Speaker, I rise today to introduce a bill that will provide for the expedited reunification of the families of our Filipino World War II veterans who have become citizens of the United States.

This body has many times over recognized the courage and commitment of the Filipino troops who fought alongside our armed forces in the Philippines during World War II. In 1990, we provided a waiver from certain naturalization requirements for these veterans, and many thereafter became proud citizens and residents of our country. And this year we appear poised to provide one further long-delayed and long-denied measure of justice by granting them veterans benefits which were unjustly denied to them in 1946.

But a huge gap still remains, for we did not also permit naturalization in 1990 to the children of these same veterans. What my bill does is allow for the sons and daughters of those veterans that became U.S. citizens through the process established in 1990 to have priority in their respective immigration categories.

These are real-life issues, for the stories of families who have waited years to be reunited are heartbreaking. For example, a veteran and his wife living in Hawaii filed immigration petitions for two of their six adult children; they have waited over ten years for a visa to be issued to either. Another veteran petitioned successfully for his wife's immigration visa, but has not been as successful with the applications for their five adult children. Again, this family has been holding on for ten years with the hope that they will one day live in the U.S. as a complete family.

As we all know, our Filipino World War II veterans are entering the sunset years of their lives. We have done what we can to give adequate veterans benefits for their commendable service. I now urge my colleagues to recognize and provide for the reunification of these families of our Filipino World War II veterans by supporting this bill.

VETERAN TRIBUTE FOR LANCE CORPORAL CARR CAMPBELL

HON. MICHAEL C. BURGESS

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. BURGESS. Mr. Speaker, I rise today to recognize the contributions and sacrifices of Lance Corporal Carr Campbell.

Lance Corporal Campbell served in the liberation of Kuwait in Operation Desert Shield and Desert Storm. During the Gulf War he engaged in surveying borders, calling in artillery hits on scud missile sites, and gathering intelligence among Iraqi prisoners of war. Because of his stellar service in this conflict, Lance Corporal Campbell was awarded the Combat Action Ribbon, South West Asian Service Medal with three stars, Saudi Arabian Liberation of Kuwait Medal, and Kuwait Liberation of Kuwait Medal.

At a time when we are once again at war, it is necessary to recognize the achievements of these national heroes. Due to their dedication, service, and sacrifice, they deserve our unwavering admiration and our unending gratitude.

Our country often takes for granted the freedoms and liberties our service men and women risk their lives to protect; yet by continuing to honor our veterans we preserve our nation's future by commemorating their past.

Thank you, Lance Corporal Campbell, for your service and sacrifice. You are a true hero.

TRIBUTE TO DESTINAE RAE

HON. SCOTT McINNIS

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. McINNIS. Mr. Speaker, I rise before you with a solemn heart to pay tribute to a remarkable young woman. Destinae Rae passed away recently after a long and courageous battle with cancer. I knew Dusty well, she was a tremendous young woman who spread happiness and faith to every person she met and it is my honor to call her compassion and kindheartedness to the attention of this body of Congress and this nation.

Dusty grew up in Colorado and had five wonderful children and five beautiful grandchildren. The week before Dusty passed away, she was blessed with another grandchild. Dusty was a tremendous mother, grandmother, daughter, sister and friend.

Dusty was a devoted Christian and a member of the Evergreen Baptist Church in her home of Evergreen, Colorado. Dusty was also involved in volunteer work. She was active in a number of cancer associations in Colorado and dedicated a great deal of her time to comforting the victims of cancer and raising funds for medical research. I know that many cancer victims had their lives bettered by Dusty's dedication and compassion for that cause.

Dusty will also be remembered for the many lives that she touched with her amazing singing voice. Dusty used her singing talents to spread her faith, happiness and joy for life to scores of people throughout Colorado. Dusty spent her last years recording and performing Christian music. She truly had the voice of an angel.

Mr. Speaker, it is my honor to rise before you to pay tribute to Destinae Rae. Dusty's parents, my longtime friends Dan and Marty Thompson, describe her best as a woman who was beautiful on the outside, and had an even more beautiful heart. We will all miss Dusty, and my heart goes out to her loved ones in this difficult time.

THE NATIONAL FILM PRESERVATION ACT OF 2003

HON. HOWARD L. BERMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. BERMAN. Mr. Speaker, today, the distinguished gentleman from Michigan, Representative JOHN CONYERS, and I introduce "the National Film Preservation Act of 2003." Senator PATRICK LEAHY joins us by introducing identical legislation in the Senate.

This legislation reauthorizes the National Film Preservation Board (NFPB) and the National Film Preservation Foundation (NFPF) for ten years. The NFPF is an independent, nonprofit organization established in 1996 with bipartisan Congresssional support to help save America's film heritage. The NFPF is the charitable affiliate of the NFPB of the Library of Congress, which was also established in 1996.

This legislation also increases the authorized appropriations for the NFPF from $500,000 in fiscal year 2004 and 2005 up to $1,000,000 in fiscal years 2006 through 2013. It authorizes additional appropriations not to exceed $1,000,000 for cooperative film preservation and access initiatives by the NFPF for each of the fiscal years 2006 through 2013. All authorized appropriations are only to be made available to match private contributions to the NFPF.

The excellent work and strong track record of the NFPB and NFPF justify both the reauthorization and increased authorization of appropriations provided by this bill. Working with archives and others in the film preservation community, the NFPF supports activities that save films for future generations, improve film access for education and exhibition, and increase public commitment to preserving film as a cultural resource, art form, and historical record. In essence, its mission is to save America's "orphan films"—newsreels, silent films, documentaries, avant-garde works, and other independent films that are not preserved by commercial interests.

Over the past seven years, the NFPF has done great work in furtherance of this goal. Working with more than 80 organizations, it has helped preserve approximately 600 films and collections. Through its preservation efforts, the NFPF has made it possible for organizations in 34 states and the District of Columbia to use these films in education and research. Many of the films preserved provide unique windows into American history and culture. For instance, films preserved through NFPF efforts include social dramas from Thomas Edison's studio, the earliest "talkie" of an American president, and home movies clandestinely shot by Japanese Americans in World War II detention camps.

As authorization for the NFPB and NFPF expired on September 30, 2003, Congress must act quickly on this legislation. We cannot allow the important work of these organizations to lapse. Over 50% of the films made before 1950 have disintegrated, and only 10% of the movies produced in the United States before 1929 still exist. We must act to stem further losses of this rich cultural heritage. No art form is more uniquely American than film, but unfortunately, few art forms are more susceptible to degradation through passage of time and poor preservation.

All parties interested in preservation and expansion of the public domain, whether for research, education, or further commercial exploitation, must join Representative Conyers, Senator Leahy, and myself in securing passage of this legislation. While it may be intellectually stimulating to debate radical copyright revisions as mechanisms to expand the public domain, these debates should not detract from the pursuit of proven methods, like NFPF projects, to preserve and expand the public domain. The tight fiscal picture for the U.S. government indicates that this legislation will be very difficult to pass, thus all public domain advocates should focus their full attention on this effort.

TRIBUTE TO CHARLES LEWIS, III

HON. DENNIS MOORE

OF KANSAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. MOORE. Mr. Speaker, I would like to take this opportunity to commend a remarkable man who lives in Leawood, Kansas, in the Third Congressional District. Charles Lewis, III, has served as the golf pro at Mission Hills Country Club for more than 25 years, in addition to his many other services to the Kansas City community. Unfortunately, for the people of Kansas City, Charles recently announced his plans to retire.

On September 14, 1960, Charles Lewis, who was competing in his first U.S. Amateur tournament, beat Jack Nicklaus at the St. Louis Country Club, a feat which some experts have called the greatest match-play upset of the 20th century.

Since he was a child, Charles Lewis has devoted much of his time and energy to golf. In addition to perfecting his own skill through practice, Charles has spent many years at the Mission Hills Country Club helping others do the same. He also serves on the advisory board of the Junior Golf Foundation of Greater Kansas City, an organization that has introduced more than 3,000 children to the game.

I commend Charles Lewis, III on this 20th day of November 2003 for his incredible skill and dedication to sharing his passion for this exciting game, and place into the RECORD an article from the Kansas City Star detailing his achievements.

[From the Kansas City Star, June 4, 2000]

LOCAL PRO ONCE BEAT NICKLAUS

(By Howard Richman)

On a wall in his Mission Hills Country Club pro-shop office, Charles Lewis III displays one of his most prized possessions, a portrait of Jack Nicklaus.

Forty years ago this summer, Lewis stunned the golf universe when he owned Nicklaus, the man who has been called the greatest golfer in history. Nicklaus will be in town Tuesday to play in the Children's Mercy Hospital Golf Classic at Blue Hills Country Club.

But one sultry, unforgettable afternoon, Lewis knocked off Nicklaus in what some experts have called the greatest match-play upset of the 20th century.

It was Sept. 14, 1960. The site: St. Louis Country Club. In anticipation of large galleries, ropes kept the spectators on the outside looking in, which was a good thing because this U.S. Amateur tournament had taken on the feel of a major professional championship.

Lewis, who was born in Miami, Okla., and raised in Little Rock, Ark., was participating in his first U.S. Amateur. A 19-year-old unknown, Lewis seemed to handle his first major event as if it were a scramble with some friends back home at The Country Club of Little Rock.

Lewis won his first three match-play matches, rarely in jeopardy through any of them. Although he had no real big-time-event background, Lewis knew he was prepared for this moment.

"As a kid, I'd go play on my dad's course (his father was the head pro at the country club)," Lewis said. "Sometimes there wouldn't be anybody out there. I'd play a variety of shots. I'd go around trees. Under them. Over them. I had no fear of hitting shots."

Lewis had to face his fear, if he had any, in the fourth round at St. Louis Country Club. Lewis was about to go head to head with Nicklaus, the defending Amateur champion and runner-up to Arnold Palmer in the U.S. Open just a few months earlier. In the morning's third round, Nicklaus shot a 31 on the front side on the way to a 6 and 5 drubbing of Phil Rodgers. In his early match, Lewis beat Connecticut amateur champion Dick Sideowf 6 and 4.

Then it was time for Lewis to match his game against Nicklaus, who was receiving accolades in the same fashion that Tiger Woods would receive them more than 30 years later.

"He (Nicklaus) was the fair-haired boy," Lewis said. "People talked about how he did things different than anybody else, how he could hit it straighter and farther, like the way they talk about Tiger.

"Me? I was the country boy. But I was never really scared. I had played a lot of golf."

It was estimated that more than 5,000 spectators tailed Lewis and Nicklaus in their match, an impressive crowd for a non-title match. It turned out to be a match that Lewis dominated, due in part to Nicklaus' awful putting.

Lewis birdied the par-4 No. 1 and went 1-up. Nicklaus bogeyed the second hole, which Lewis won. When Lewis birdied the par-5 fifth, he went 3-up. Nicklaus 3-putted No. 6. And No. 7. By the time they made the turn, Lewis was a cozy 6-up. The upset was all but sealed.

"Jack and I didn't really talk during the match," Lewis recalled, "but I do remember his dad say something to me as I was walking along. He said, 'You're thumping my little boy.' I'd met Jack's dad before. He was a class act. Like Jack."

Nicklaus finally won his first hole at No. 10 but not because of anything spectacular on his part. Lewis 3-putted. Lewis, though, didn't swerve out of control. In fact, The New York Times reported that Lewis, "under the pressure of a huge gallery, and meeting his first big test, was cool and poised."

The match came to an early conclusion when Lewis hit his 4-wood approach at the par-5 15th onto the green. Nicklaus' second shot found the rough. Lewis birdied and closed the deal. His 5 and 3 win over Nicklaus shocked golf circles. Just last year, Golf World magazine ranked Lewis' win the greatest match-play upset of the 20th century.

Nicklaus, who won the Amateur in 1961, has the fourth-best winning percentage in U.S. Amateurs of players with at least 20 wins (24-5 record). Lewis, though, prevented him from possibly winning three in a row. The only one who has done that was Woods during 1994-96.

In his book, My Story, Nicklaus said this about his loss to Lewis: "I 3-putted six times, once from near gimme range, and never had a hope against Charlie Lewis, a good golfer from Arkansas. I learned some more about controlling the psyche and about self-pacing from that experience."

Lewis still remembers what Nicklaus said following their match.

"He said, 'Good luck. . . . I hope you win it all.' I think he meant it," Lewis said.

But Lewis couldn't win it all. He went on and won his next two matches. The sixth one was important because it earned him an invitation to the Masters. In the scheduled 36-hole semifinals, Lewis' streak was halted. He fell to Bob Gardner 2 and 1.

Lewis played in two more U.S. Amateurs. But none of them matched his achievement in 1960. After serving in Vietnam with the Marines, Lewis came back, won the 1967 Arkansas Amateur, then gave the PGA Tour a shot. He thinks his best finish was 14th place, which was worth $2,200. After two years, Lewis relinquished the idea of trying to make it out there.

"His personality wasn't made for the tour," said Lewis' wife, Marilyn, who plays more golf than her husband. She's on the golf course five times a week.

"He could play the game," Marilyn said. "But he hated going from town to town. He wanted to be somewhere where he could put his feet up and relax."

Lewis returned to Little Rock, where a friend told him about an assistant club-pro job in Kansas City. Lewis phoned Duke Gibson, the pro at Blue Hills Country Club, and Gibson hired Lewis over the phone. Twenty-eight years ago, Lewis moved on to Mission Hills.

On Tuesday, Lewis hopes to rekindle memories with Nicklaus.

"It's been years since I talked to Jack," Lewis said. "We played a practice round together when I played in the Masters. I hope I get a chance to talk to him. As I said, he's a class act. But I'm sure he would have preferred to beat me.

"But that was a day I accomplished something. I saw more media than I had ever seen. I got telegrams from people I didn't even know. Next to my marriage, that (beating Nicklaus) is the greatest thrill of my life."

INTRODUCTION OF RESOLUTION COMMENDING IRAQI WOMEN

HON. CAROLYN B. MALONEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mrs. MALONEY. Mr. Speaker, today, Representative BIGGERT, Representative HOOLEY, and I introduce legislation to commend Iraqi women for their participation in Iraqi government and civil society and to advocate for the inclusion of women's rights in the Iraqi constitution.

The women of Iraq should have a stake in the future of their country. We must support the efforts of the Iraqi women to require that the constitution of Iraq includes equal rights for women. Iraq has the opportunity to begin a new chapter by rejecting the ways of Saddam Hussein, and embracing democracy, including the right to vote for all its citizens. I believe that the United States should support these efforts in every possible way.

I look forward to working with Representative BIGGERT, Representative HOOLEY and my other colleagues to pass this resolution and to fight for the rights of women in Iraq.

TRIBUTE TO NORMAN N. BURG, MD

MAURICE HINCHEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. HINCHEY. Mr. Speaker, I rise today to recognize the distinguished career of Dr. Norman N. Burg. Through more than 40 years of medical practice in Ulster County, New York, Dr. Burg has touched the lives of countless people and has improved the delivery of regional health care services immeasurably. I am pleased to join the health care community in Ulster County in congratulating Dr. Burg on his outstanding career.

During his four decades of service in Ulster County, Dr. Burg has operated a private practice, served on staff at two local hospitals, having been president of the medical staff at both. He has also contributed his leadership skills to serving the Ulster County Infirmary, Ferncliff Nursing Home, St. Francis Hospital in Poughkeepsie and Northern Dutchess Hospital.

Throughout his career, Dr. Burg has taken great pride in sharing his accumulated knowledge of medicine and worked diligently to educate aspiring physicians. Among his many accomplishments, he was a founder and the first program director of the residency program at Family Medicine in Kingston. This program has trained more than 100 family physicians, the majority of whom continue to practice medicine in New York. It also paved the way for the creation of the Mid Hudson Family Health Institute that currently provides health care services to under-insured and uninsured residents of the Hudson Valley. The Institute stands as a testament to Dr. Burg's deeply held belief that all citizens should be afforded access to health care regardless of their economic situation.

Dr. Burg has also been extremely involved in his community since coming to Ulster County. His list of activities include serving as the school physician and football team physician for Onteora High School, president and coach of the Woodstock Little League, EMT instructor, board member of the Woodstock Volunteer Ambulance Squad and chairman of the Woodstock Narcotics Guidance Council.

Mr. Speaker, it is my privilege to recognize the outstanding accomplishments of Dr. Norman Burg. His deep commitment to improving the lives of people around him has yielded a distinguished record of service and has made Ulster County and much of New York, a better, healthier place to live.

RECOGNIZING PRESIDENT CHEN SHUI-BIAN OF TAIWAN UPON HIS RECEPTION OF THE INTERNATIONAL HUMAN RIGHTS AWARD

TOM LANTOS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. LANTOS. Mr. Speaker, on November 4, 2003 I had the privilege of entering into the RECORD the prepared remarks of President Chen Shui-bian upon his acceptance of the International Human Rights Award on October 31, 2003. It is with great pleasure, Mr. Speaker, that today I am able to enter into the RECORD President Chen's remarks as delivered.

Mr. Speaker, I would also like to take this opportunity to once again commend President Chen for his decades-long struggle for human rights and democracy in Taiwan and congratulate him upon his acceptance of the International Human Rights Award. President Chen is a freedom fighter we can all look up to, and it is with great pleasure that I enter into the CONGRESSIONAL RECORD his remarks, as delivered.

President Horton, Congressman Lantos, Congressman Ackerman, Mr. Rabaut, Mr. Wu, Executive Director Dr. Kantrow, Board Member Dr. Chen, Distinguished Guests, Ladies and Gentlemen: Good evening!

On behalf of the government and people of Taiwan, I would like to pay special tribute to the International League for Human Rights (ILHR). Over the last 62 years since its establishment, the League has worked unrelentingly in carrying out its mission of defending human rights and rights advocates who have risked their lives to promote the ideals of a just and civil society.

The Human Rights Award conferred on me this evening is an honor bestowed upon the 23 million people of Taiwan. It signifies both affirmations and expectations. The award is representative of the international validation that the people of Taiwan have received for decades of effort in pursuit of democracy, freedom and human rights. It is also a reminder that we have assumed by destiny the duty of protecting human rights and of upholding international human rights principles.

The year 2000 marked Taiwan's first peaceful transfer of power and our country's first alternation of political parties, an accomplishment unprecedented in the history of all Chinese societies. In my inaugural speech, I proposed a goal of building our nation on the principles of human rights. We are committed to abide by the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and the Vienna Declaration and Program of Action. We also pledged to bring Taiwan on par with the international human rights system despite our authoritarian past.

Over the past three and a half years, concrete actions have been taken to fulfill our commitments. In step with the institutionalization of human rights protection mechanisms, comprehensive human rights policies and implementation measures have been carefully drafted, as outlined in our Human Rights Policy White Paper, and the Organic Law of the National Human Rights Commission is currently under review in our National Legislature.

My office has established a presidential Human Rights Advisory Committee and the Cabinet has also established an Inter-Ministerial Committee. Both have been collaborating with local and international human rights NGOs for the purpose of incorporating the International Bill of Rights into a "Taiwan Bill of Rights." Furthermore, the "National Human Rights Report" will soon be published—another first for Taiwan—and work is in progress for a National Human Rights Memorial Museum responsible for social education and raising public awareness.

My friends, although our journey has not been easy, Taiwan has not stood alone. Support from the international community, particularly the United States, has played a critical role. I will never forget the watershed event—the Kaohsiung Incident—in Taiwan's democratization process. On December 10, 1979, a group of Taiwan citizens defiantly held a rally to commemorate International Human Rights Day. Because such activity was forbidden by the ruling regime of the time, rally leaders were charged with illegal assembly and conspiracy for sedition.

As a defense attorney in the Kaohsiung Incident, I personally witnessed the efforts of ILHR, who sent Professor John Kaplan to Taiwan to observe the trial at the military tribunal. The rest of the international human rights community also rendered assistance—and inspiration—to Taiwan's democratic movement.

My wife and I were both victims of human rights violation I was sentenced to prison for fighting for freedom of speech. My wife was seriously injured in what is believed to be a politically motivated accident and must spend the rest of her life in a wheelchair. However, like the brave sacrifices made by Taiwan's pioneers of democracy, our suffering only serves to strengthen the determination of the Taiwanese people in their pursuit of political and personal freedoms.

Today, there are no more blacklists, no more political prisoners, no more religious persecution. Citizens in Taiwan now enjoy full civil rights—freedom of speech, freedom of expression, freedom of assembly, freedom of press and other categories of rights. Despite our exclusion from the United Nations, Taiwan has never slowed its pace to push for human rights reform.

At a time when the international community is caught up in debates on "clashes of civilization" with regard to human rights protection, Taiwan's experience is proof that human rights are a universal value and humanity's common asset. All countries and individuals should have access to these universal rights; none should be subjected to a double-standard. As stated in the Universal Declaration of Human Rights, "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

I would like to take this opportunity to express appreciation to the government of the United States of America for its efforts to help promote human rights in Taiwan. Section II(C) of the "Taiwan Relations Act", which was passed by the U.S. Congress in 1979, stipulates that "the preservation and enhancement of the human rights of all the people an Taiwan are hereby reaffirmed as objective of the United States." We appreciate, and are always mindful of the concern and support a more established democracy has given to a fledgling one.

Taiwan's achievement in human rights and democracy so far would not have been possible were it not for the generosity of those of the international community who have stood behind us. Likewise, we would not be able to receive the affirmation and commendation of the ILHR and other international human rights organizations.

Of course, a sound and solid institutionalized system is requisite for the effective protection of human rights. Taiwan has now established a fair electoral environment with an increasingly vigorous civil society. However, much remain to be further strengthened in terms of consolidating and deepening our democracy and human rights. Whether we succeed or not would rely on the collective and continuing efforts of the people, particularly on whether we can consolidate our democracy by rectifying the inadequacies in our constitutional framework.

More than two centuries ago, the founding fathers of the United States spurred in Constitutional debate, prompting a great New Yorker, Mr. Alexander Hamilton, to criticize "the insufficiency of the present Confederation to preserve the Union." He argued in "The Federalist Papers" that the Articles of Confederation failed to address issues such as a checks-and-balances system of the government, separation of powers among agencies, fair representation of the States, and safeguarding freedom of the people. He concluded that the very design of the Articles of Confederation was insufficient to meet the needs of the American people.

As a result of extensive discussions and debates by America's founding fathers, the

Constitution of the United States of America was created and has been honored to this day. The U.S. Constitution became the pulse of American society, and allowed for amendments, including Bill of Rights, to be incorporated, thereby guaranteeing freedom and laying a strong foundation for sustainable development of the American democracy.

Taiwan now faces a similar "insufficiency" of the constitutional framework. As my country's leader, it is imperative that I shoulder responsibility for Taiwan's national development and set a clear vision for the future. I believe that a sound and sustainable constitutional framework can be created through rational debate and engendered by civic consciousness. This is the rationale upon which I have proposed the concept of "hastening the birth of a new constitution for Taiwan."

The "hastening of a new Taiwan constitution" will determine whether or not our democracy can come into full bloom. This, strengthened and supplemented by the institutions of direct democracy, such as referendums, would be a necessary step in advancing Taiwan's human rights and the deepening of its democracy. One must not be misled by the contention that holding referendums or re-engineering our constitutional framework, bears any relevance to the "Four No's plus one" pledge presented in my inaugural speech. Neither should matters concerning Taiwan's constitutional development be simplistically interpreted as a political debate of "unification versus independence." I stand before you today, appealing to the collective conscience of the world community, asking that the voice of Taiwan be heard, for ours is the voice of democracy and progress. It is my job as President, to safeguard the security, democracy, freedom and human rights of the 23 million people of Taiwan, and, in so doing, build a solid foundation for the sustainable progress of Taiwan's continuing democratization.

The progression of democracy and human rights in Taiwan not only signifies a triumph of our people in the relentless pursuit for freedom, it is also a torch of democracy for all Chinese societies and has become an indispensable asset to the United States as well as the international society. I have great confidence that by advancing our democracy, we shall show where Taiwan stands in terms of values: A veritable part of the world's democratic community.

While furthering human rights in Taiwan, I call for a joint effort among Asian governments and regional NGOs for a regional framework for the advancement of human rights, including a state-sponsored regional charter, a regional commission, and a regional court of human rights. The newly founded Taiwan Foundation for Democracy can serve as one of the channels through which we shall endeavor to make our rightful contributions and share out experience in the protection and promotion of human rights. I want Taiwan to be a positive contributing force in the international human rights movement.

On the Green Island, situated off the south-east coast of Taiwan, there used to be a concentration camp and prison for the confinement and deprivation of countless human rights defenders. On this island, the Taiwanese equivalent to the infamous Robin Island of South Africa, there stands a monument on which names of victims of human rights abuse are inscribed. The epitaph reads: "In those times, how mothers wept through long nights for their imprisoned children."

I have kept that epitaph in my heart, and tonight, I would like to share it with you as a tribute to all who support, advocate, and have stood up in the name of human rights: Let there be no more fear, let there be no more tears. Let the world take Taiwan as an example. She is emerging from her democratic metamorphosis.

While I am standing on this stage, receiving this Human Rights Award and giving this speech, out there is a group of people protesting and shouting. I must tell them clearly: You are in a wrong place and protesting to the wrong person; for you should be happy for me to receive this Award. Human rights are universal. The path towards human rights is the right path and a road of no return. The democratic achievements of Taiwan and the deepening of human rights there can serve as a beacon for others. What you should ask yourselves is: Why can Taiwan do it and we cannot? Along with the 23 million people in Taiwan, I would like to invite the people protesting out there to share my joy and pride in receiving the Human Rights Award. Do believe in democracy, in freedom and in human rights. We will make it.

Thank you.

AMENDMENT TO SUPPORT CURRENT U.S. PATENT AND TRADEMARK OFFICE POLICY AGAINST PATENTING HUMAN ORGANISMS

HON. DAVE WELDON

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. WELDON of Florida. Mr. Speaker, this summer I introduced an amendment that provides congressional support for the current U.S. Patent and Trademark Office policy against patenting human organisms, including human embryos and fetuses. This amendment was approved by the House of Representatives with bipartisan support on July 22, 2003, as Sec. 801 of the Commerce/Justice/State appropriations bill.

On November 5th of this year, I submitted to the CONGRESSIONAL RECORD an analysis of my amendment that offers a more complete elaboration of what I stated on July 22nd, namely, that this amendment "has no bearing on stem cell research or patenting genes, it only affects patenting human organisms, human embryos, human fetuses or human beings."

However, some have continued to misrepresent my amendment by claiming it would also prohibit patent claims directed to methods to produce human organisms. Moreover, some incorrectly claim that my amendment would prohibit patents on claims directed to subject matter other than human organisms. This is simply untrue.

What I want to point out is that the U.S. Patent Office has already issued patents on genes, stem cells, animals with human genes, and a host of non-biologic products used by humans, but it has not issued patents on claims directed to human organisms, including human embryos and fetuses. My amendment would not affect the former, but would simply affirm the latter. This position is reaffirmed in the following U.S. Patent Office letter of November 20, 2003.

I submit to the RECORD a letter from James Rogan, Undersecretary and Director of the U.S. Patent office, that supports the enactment of my amendment because it "is fully consistent with our policy."

U.S. PATENT AND TRADEMARK OFFICE,
November 20, 2003.

Hon. TED STEVENS,
Chairman, Committee on Appropriations, U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: Thank you for the opportunity to present the Administration's position on the Weldon amendment adopted by the House during consideration of H.R. 2799, the Commerce-Justice-State Appropriations bill FY 2004, and the effect it would have on the United States Patent and Trademark Office (USPTO) policy on patenting living subject matter. For the reasons outlined below, we view the Weldon amendment as fully consistent with USPTO's policy on the non-patentability of human life-forms.

The Weldon Amendment would prohibit the U.S. Patent and Trademark Office from issuing any patent "on claims directed to or encompassing a human organism." The USPTO understands the Weldon Amendment to provide unequivocal congressional backing for the long-standing USPTO policy of refusing to grant any patent containing a claim that encompasses any member of the species Homo sapiens at any stage of development. It has long been USPTO practice to reject any claim in a patent application that encompasses a human life-form at any stage of development, including a human embryo or human fetus; hence claims directed to living "organisms" are to be rejected unless they include the adjective "nonhuman."

The USPTO's policy of rejecting patent application claims that encompass human lifeforms, which the Weldon Amendment elevates to an unequivocal congressional prohibition, applies regardless of the manner and mechanism used to bring a human organism into existence (e.g., somatic cell nuclear transfer, in vitro fertilization, parthenogenesis). If a patent examiner determines that a claim is directed to a human life-form at any stage of development, the claim is rejected as non-statutory subject matter and will not be issued in a patent as such.

As indicated in Representative Weldon's remarks in the Congressional Record of November 5, 2003. the referenced language precludes the patenting of human organisms, including human embryos. He further indicated that the amendment has "exactly the same scope as the current USPTO policy," which assures that any claim that can be broadly construed as a human being, including a human embryo or fetus, is not patentable subject matter. Therefore, our understanding of the plain language of the Weldon Amendment is fully consistent with the detailed statements that the author of the amendment, Representative Weldon, has made in the Congressional Record regarding the meaning and intent of his amendment.

Given that the scope of Representative Weldon's amendment does not alter the USPTO policy on the non-patentability of human life-forms at any stage of development and is fully consistent with our policy, we support its enactment.

With best personal regards, I remain
Sincerely,

JAMES E. ROGAN,
Under Secretary and Director.

THE STUDENT AID STREAMLINED DISCLOSURE ACT OF 2003

HON. SAM JOHNSON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. SAM JOHNSON of Texas. Mr. Speaker, today I am introducing the Student Aid Streamlined Disclosure Act, to enhance the privacy of individuals who apply for a federal student loan or Pell Grant and to ensure the integrity of student aid programs administered by the Secretary of Education.

This year, the Department of Education anticipates that more than 13 million people will apply for federal student aid. In order to verify income information, approximately 4 million of these applicants will be selected and required to hand over detailed tax information to school administrators with few controls in place to guard against redisclosure or misuse of this highly personal information. In addition, nearly 100,000 people will be required to waive their right to taxpayer privacy as a condition of applying for an income-contingent student loan.

The current process used by the Department of Education to verify the income information supplied by students is not only unnecessarily invasive of student privacy, but it also is ineffective. Numerous studies by the Department of Education and the Education Inspector General have concluded that income information supplied by students does not match information on file with the Internal Revenue Service. In fact, a recent study of applications filed during fiscal years 2001 and 2002 found that the Department of Education had paid $602 million in Pell Grants to individuals who were either ineligible or eligible for smaller awards.

The General Accounting Office has confirmed that this substantial misallocation of resources could be corrected if Congress would redesign the law that governs sharing of information between the Department of Education and the Internal Revenue Service. I am pleased to say that the bill I am introducing today would accomplish that task in a way that enhances taxpayer privacy.

This legislation would provide for income verification for every student loan application, but it would require disclosure of information on file with the IRS only in cases where there is a discrepancy that is large enough to impact the student grant or loan. Sensitive tax information from the IRS could not be disclosed directly to schools or contractors, but could only be disclosed to Department of Education officials or to the taxpayer who filed the return.

This tax legislation is a priority of the Bush Administration and the Education and Workforce Committee has endorsed data sharing as a means of reducing waste, fraud, and abuse in programs administered by the Secretary of Education. Congress has already authorized the Secretary of Education to match data with the IRS in the Higher Education Act of 1998, but, to date, the Internal Revenue Code has not been amended to allow this matching to take place. My staff has worked closely with the Treasury Department, the Office of Management and Budget, the Joint Committee on Taxation, and the Department of Education in developing this proposal.

This proposal is the right policy and, with all of our consultations, we believe that it is the correct technical solution. I am introducing it as we hopefully close out the first session of the 108th Congress in order that it can be reviewed over the next few months by all participants in the student loan community. I ask any stakeholders—students, parents, schools, lenders and loan processors—to review this legislation to be sure that there are no unintended consequences of the bill. I welcome constructive criticism of this bill and look forward to seeing it enacted next year.

H.R. 6—ENERGY POLICY ACT OF 2003

SPEECH OF

HON. CHARLES W. STENHOLM

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mr. STENHOLM. Mr. Speaker, today, I rise in support of H.R. 6, the energy bill that America has waited so long for. Like the original House version of this legislation, I intend to support the conference report on the floor today, but not without some reservation.

Since being elected to Congress in 1978, I've carefully watched our federal spending and have advocated for a balanced budget. Under our current policies, America is facing a $400 billion budget shortfall, and we will continue to run deficits for the foreseeable future. This energy bill conference report continues on that path of fiscal irresponsibility. The Joint Committee on Taxation stated this bill will cost up to $23.5 billion dollars. I am very disappointed this conference report didn't include the offsets that the Senate version did.

However, I truly believe this legislation provides the proper framework to diversify America's fuel sources. As Ranking Member of the House Agriculture Committee, I'm glad there are greater incentives for increased production of ethanol. I'm glad to see production tax credits for wind, solar and biomass energy, as well as nuclear electricity generation. Diversification of our nation's energy sources will help us meet our goal of reducing our dependence on foreign sources of fuel.

More importantly, this energy bill provides the right tools for independent oil and gas producers to continue producing from our own fields, right here in this country. I've been fighting for these measures for years, and I'm glad Congress is finally going to implement them. The time is long overdue for Congress to recognize the importance for America to decrease our use of oil and gas from foreign countries and to capitalize on the resources beneath our own soil. And, contrary to what many groups will lead us to conclude, we can drill for oil and gas without doing damage to our environment. Former U.S. Senator Lloyd Bentsen of Texas once said that when America imported more than half of its crude and petroleum products, it would have reached a point of peril. Friends and colleagues, we have reached that point.

Although I intend to support this legislation, I must express my extreme disappointment of the process in which this bill was considered. I have worked for years in Congress to promote equality and bipartisanship in this great institution. However, this bill was written behind closed doors with no input from the public. Unfortunately, my Democratic colleagues were not given the opportunity to offer significant amendments to the legislation. This conference report isn't perfect, and it could have been improved significantly if my colleagues were allowed to bring their ideas to the negotiating table and if we were allowed to offset the cost of this legislation.

FREEDOM FOR MANUEL VÁZQUEZ PORTAL

HON. LINCOLN DIAZ-BALART

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. LINCOLN DIAZ-BALART of Florida. Mr. Speaker, I rise to speak about Manuel Vázquez Portal, a prisoner of conscience in totalitarian Cuba.

Mr. Vázquez is a 52-year-old writer, poet and founder of the independent news agency Grupo de Trabajo Decoro. Originally, Mr. Vázquez was a high school teacher and a journalist for several state-owned media outlets. However, after years of observing the constant lies and incessant distortion mandated by Castro's totalitarian regime, Mr. Vázquez began working for an independent news agency in 1995. As an independent journalist, Mr. Vázquez relentlessly chronicled the atrocities committed by Castro's machinery of repression, even going so far as to have his articles published under the pseudonym Pablo Cedeño. Eventually, Mr. Vázquez founded the independent news agency Grupo de Trabajo Decoro in 1999.

In fact, because of his ability to find and write the truth as a journalist working under Castro's stifling repression, Mr. Vázquez will receive the 2003 International Press Freedom Award from the Committee to Protect Journalists on this coming Tuesday, November 25, 2003.

Mr. Speaker, when Mr. Vázquez's fellow recipients of the International Press Freedom Award accept this high honor, Mr. Vázquez will be languishing in the Cuban totalitarian gulag next to a toilet he describes as a "hole regurgitating its stench 24 hours a day." Mr. Vázquez was arrested in the reprehensible March crackdown on those many patriots who actively opposed Castro's tyranny. Subsequently, in a sham trial held in April, Mr. Vázquez was sentenced to 18 years in the Cuban gulag.

I remind my colleagues that, under Castro's totalitarian regime, any freedom of the press, any effort to display the atrocities of the regime under the spotlight of truth, is met with swift and violent repression. Mr. Vázquez described the punishing conditions of the Cuban gulag in a diary smuggled out of prison by his wife. He said "the cell is a space of 1.5 meters wide and 3 meters long." Inside his cell, he describes an interior comprised of insects, an unstable cot, a filthy mattress and a disgusting toilet.

Mr. Speaker, a man who is about to receive the International Press Freedom Award is suffering at this very moment in those abominable conditions. Mr. Vázquez had the courage to depict the reality of Cuba under Castro's totalitarian dictatorship, and now he is locked in the gulag for the next 18 years.

My Colleagues, we can not stand by in silence while those who pursue truth languish in the gulags of repressive dictators. We must stand together and loudly demand freedom for Manuel Vázquez Portal.

PHARMACY EDUCATION AID ACT OF 2003

HON. BARBARA CUBIN

OF WYOMING

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mrs. CUBIN. Mr. Speaker, pharmacists are a vital link in this nation's health care system. Across the nation, we are seeing a shortage of pharmacists and this shortage is taking hold in Wyoming as well.

Americans of all ages will continue to take advantage of the therapeutic benefits that come from prescription medications.

Without pharmacists to distribute those drugs and educate us about their effects, we would see the downfall of our health care system. We cannot allow that to happen, and must do what we can to ensure an adequate supply of pharmacists in Wyoming, and across the country.

In addition, as Congress prepares to pass a Medicare reform prescription drug bill, seniors will have greater access to medications at a lower cost and will need qualified pharmacists to help them understand and properly use their medications.

The Pharmacy Education Aid Act of 2003 authorizes two new student-loan programs for pharmacists. The first would repay the student loans of pharmacists who agree to practice for at least 2 years in areas with a critical shortage of pharmacists.

The second would repay the loans of students who agree to serve for a least 2 years as faculty members at accredited schools of pharmacy; one of which is at the University of Wyoming.

It makes sense that if we want an adequate supply of pharmacists in the workplace then we need to ensure adequate faculty to guide them through their education.

We are seeing more of a demand for pharmacists in Wyoming, whether it be in our local Walmart and Safeway stores, or in our hospitals.

Our faculty at UW's school of pharmacy is also stretched very thin, and I want to ensure that we continue to have excellent faculty there. After all, they are responsible for providing Wyoming with the best and brightest in the way of pharmacy graduates.

This legislation is designed to encourage students to enter the pharmacy profession, both in individual practice and as university educators. We all know how expensive it is to get an education these days, and pharmacy students can face loans of up to $90,000.

This bill will not only help students in Wyoming with the financial burdens associated with education, but help Wyoming obtain the qualified pharmacists it needs.

SAY NO TO INVOLUNTARY SERVITUDE

HON. RON PAUL

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. PAUL. Mr. Speaker, the ultimate cost of war is almost always the loss of liberty. True, defensive wars and revolutionary wars against tyrants may preserve or establish a free society, as did our war against the British. But these wars are rare. Most wars are unnecessary, dangerous and cause senseless suffering with little being gained. Loss of liberty and life on both sides has been the result of most of the conflicts throughout the ages. The current war, in which we find ourselves, clearly qualifies as one of those unnecessary and dangerous wars. To get the people to support ill-conceived wars the nation's leaders employ grand schemes of deception.

Woodrow Wilson orchestrated our entry into World War I by first promising in the election of 1916 to keep us out of the European conflict, then a few months later pressured and maneuvered the Congress into declaring war against Germany. Whether it was the Spanish-American War before that or all the wars since, U.S. presidents have deceived the people to gain popular support for ill-conceived military ventures. Wilson wanted the war and immediately demanded conscription to fight it. He didn't have the guts to even name the program a military draft and instead in a speech before Congress calling for war advised the army should be "chosen upon the principle of universal liability to service." Most Americans at the time of the declaration didn't believe actual combat troops would be sent. What a dramatic change from this early perception when the people endorsed the war to the carnage that followed and the later disillusionment with Wilson and his grand scheme for world government under the League of Nations. The American people rejected this gross new entanglement reflecting a somewhat healthier age than the one in which we find ourselves today.

But when it comes to war, the principle of deception lives on and the plan for "universal liability to serve" once again is raising its ugly head. The dollar cost of the current war is already staggering yet plans are being made to drastically expand the human cost by forcing conscription on the young men (and maybe women) who have no ax to grind with the Iraqi people and want no part of this fight.

Hundreds of Americans have already been killed and thousands more wounded and crippled while thousands of others will suffer from new and deadly war-related illnesses not yet identified.

We were told we had to support this preemptive war against Iraq because Saddam Hussein had weapons of mass destruction and to confront the al Qaeda. It was said our national security depended on it. But all these dangers were found not to exist in Iraq. It was implied that those who did not support this Iraqi invasion were un-American and unpatriotic.

Since the original reasons for the war never existed, it is now claimed that we're there to make Iraq a western-style democracy and to spread western values. And besides, it's argued, that it's nice that Saddam Hussein has been removed from power. But does the mere existence of evil somewhere in the world justify preemptive war at the expense of the American people? Utopian dreams, fulfilled by autocratic means, hardly qualifies as being morally justifiable.

These after-the-fact excuses for invasion and occupation of a sovereign nation directs attention away from the charge that this war was encouraged by the military industrial complex, war profiteering, control of natural resources (oil) and a neo-con agenda of American hegemony with a desire to redraw the borders of the countries of Middle East.

The inevitable failure of such a seriously flawed foreign policy cannot be contemplated by those who have put so much energy into this occupation. The current quagmire prompts calls from many for escalation with more troops being sent to Iraq. Many of our reservists and National Guardsmen cannot wait to get out and have no plans to re-enlist. The odds of our policy of foreign intervention, which has been with us for many decades, are not likely to soon change. The dilemma of how to win an unwinnable war is the issue begging for an answer.

To get more troops, the draft will likely be re-instituted. The implicit prohibition of "involuntary servitude" by the 13th Amendment to the Constitution has already been ignored many times so few will challenge the constitutionality of the coming draft.

Unpopular wars invite conscription. Volunteers disappear, as well they should. A truly defensive just war prompts popular support.

A conscripted, unhappy soldier is better off on the long run than the slaves of old since the "enslavement" is only temporary. But on the short run, the draft may well turn out to be more deadly and degrading as one is forced to commit life and limb to a less than worthy cause—like teaching democracy to unwilling and angry Arabs. Slaves were safer in that their owners had an economic interest in protecting their lives. Life endangerment for a soldier is acceptable policy and that's why they are needed. Too often though, our men and women who are exposed to the hostilities of war and welcomed initially are easily forgotten after the fighting ends.

It is said we go about the world waging war to promote peace and yet the price paid is rarely weighed against the failed efforts to make the world a better place. But justifying conscription to promote the cause of liberty is one of the most bizarre notions ever conceived by man. Forced servitude with risk of death and serious injury as a price to live free makes no sense. By what right does anyone have to sacrifice the lives of others for some cause of questionable value? Even if well motivated it cannot justify using force on uninterested persons.

It's said that the 18-year-old owes it to his country. Hogwash. It could just as easily be argued that a 50-year-old chicken-hawk who promotes war and places the danger on the innocent young, owe a heck of a lot more to the country than the 18-year-old being denied his liberty for a cause that has no justification.

All drafts are unfair. All 18- and 19-year-olds are never needed. By its very nature, a draft must be discriminatory. All drafts hit the most vulnerable as the elitists learn quickly how to avoid the risks of combat.

The dollar cost of war and the economic hardship is great in all wars and cannot be minimized. War is never economically beneficial except for those in position to profit from war expenditures. But the great tragedy of war is the careless disregard for civil liberties of our own people. Abuse of German and Japanese Americans in World War I and World War II is well known.

But the real sacrifice comes with conscription—forcing a small number of young vulnerable citizens to fight the wars that old men and women, who seek glory in military victory without themselves being exposed to danger, promote. These are wars with neither purpose nor moral justification and too often are not even declared by the Congress.

Without conscription, unpopular wars are much more difficult to fight. Once the draft was undermined in the 1960s and early 1970s, the Vietnam War came to an end.

But most importantly—liberty cannot be preserved by tyranny. A free society must always resort to volunteers. Tyrants think nothing of forcing men to fight and die in wrongheaded wars; a true fight for survival and defense of one's homeland I'm sure would elicit, the assistance of every able-bodied man and woman. This is not the case for wars of mischief far away from home in which we so often have found ourselves in the past century.

One of the worst votes that an elected official could ever cast would be to institute a military draft to fight an illegal war, if that individual himself maneuvered to avoid military service. But avoiding the draft on principle qualifies oneself to work hard to avoid all unnecessary war and oppose the draft for all others.

A government that's willing to enslave a portion of its people to fight an unjust war can never be trusted to protect the liberties of its own citizens. The end can never justify the means no matter what the Neo-cons say.

BEST WISHES TO THOMAS J. AIKEN

HON. JOHN T. DOOLITTLE

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. DOOLITTLE. Mr. Speaker, today I wish to express warm thanks, congratulations, and best wishes to Thomas J. Aiken, upon his retirement as the Central California Area Manager of the Bureau of Reclamation (Bureau). Tom has done an outstanding job in a difficult position, and he deserves the appreciation of both his colleagues and the general public.

Born and raised in Colorado Springs, Colorado, Tom earned a Bachelor of Science degree in Business Administration from Colorado State University in 1964. At the same time, he was commissioned a Second Lieutenant in the Army. He served dutifully as a Unit Commander for the Military Advisory Corps in Vietnam.

Following his military service, Tom began his three-decade career with the Bureau. In 1974, he joined the Mid-Pacific Region as the Administrative Officer for the Auburn Dam Construction Office. After the Auburn Dam project was stalled shortly thereafter, he became the region's Budget Officer for six years. Subsequently, from 1984 to early 1993, Tom was the Assistant Regional Director for Administration, overseeing such functions as personnel, budget, finance, procurement, and computer processing.

In 1993, Tom received his final and perhaps most challenging position with the Bureau—that of Manager of the Central California Area office. The area includes the Folsom and Nimbus Dams and the Folsom South Canal on the American River, New Melones Dam on the Stanislaus River, and Lake Berryessa located between Napa and Winters.

Mr. Speaker, many of the issues relating to the facilities and watersheds in the Central California Area have been controversial, yet Tom has constantly sought to serve the public's best interest. As a veteran of California's renowned water wars, Tom has frequently had to be a facilitator amongst numerous competing interests. Despite the challenging and often unpleasant nature of this position, he has weathered it with patience and a continuing willingness to stand on principle.

One such example that has been of special importance to me has been Tom's unwavering support of the Auburn Dam. For three decades, Tom has helped promote the need to build the Auburn Dam by championing its unmatched ability to provide flood protection, water supply, hydroelectric power, recreational opportunities, and environmental benefits. Tom rightly recognizes that the Auburn Dam is the only solution to the Sacramento region's water management needs, and he has been one of the few who has stood steadfast in that position despite the misguided opposition of those in the environmental community and from within the Bureau itself. Tom's commitment to the Auburn Dam is nothing less than a testament to his dedication to faithfully uphold the Bureau's mission of providing a reliable water supply to the West in the most efficient and effective way possible.

Tom has received several honors for his good work, including the National Administrative Support Units' Annual Award for Executive Leadership in 1991, Who's Who in Government Service in 1990, and the Interior Department's Meritorious Service Award in 1984.

As he retires from public service, Tom will be free to spend more time with his family, including his wife, Linda, his children, Joe and Me'Shay, his step-daughters, Jennifer and Lisa, and his five grandchildren. Also, he will have more time to pursue his oil painting and show his 1934 Ford hot rod. His family's gain is the public's loss.

Mr. Speaker, one thing is certain—Tom Aiken's expertise, cooperative attitude, clear thinking, and toughness will certainly be missed in California's water community.

THE SPECIAL GOVERNMENT EMPLOYEES AMENDMENTS ACT OF 2003

SPEECH OF

HON. JOHN CONYERS, JR.

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. CONYERS. Mr. Speaker, I would like to submit the Department of Defense Inspector General's public report on Richard Perle, an editorial from the Wall Street Journal, and a clip from The Washington Times.

[Editorial from the Wall Street Journal]

PERLE'S VINDICATION

One obligation of editors is to distinguish phony political scandal from the genuine article. On that standard, any number of writers and editors owe Richard Perle an apology.

The noted defense intellectual voluntarily resigned in March as chairman of the Pentagon's Defense Policy Board Advisory Committee after his enemies pumped up a few anecdotes into allegations about "conflicts of interest." The Pentagon's Inspector General has been investigating those charges and last week issued a report absolving Mr. Perle of even the "appearance" of impropriety.

The accusations, fanned by Michigan Democrat John Conyers, had received especially prominent coverage in the New Yorker magazine and the New York Times. They boiled down to the all-purpose Washington smear that Mr. Perle has exploited his position for personal financial gain. But Pentagon investigator Donald Horstman concluded in a letter to Mr. Perle that "all of your activities with respect to those private entities complied with statutory and regulatory standards." There were no "quid pro" offers or attempts to leverage his (unpaid) Pentagon access.

In Washington, of course, people are often run out of office merely for the "appearance" of a conflict of interest. But Mr. Horstman says he also examined that "more elusive issue" and concluded that Mr. Perle's "activities did not create such an appearance" under the "perspective of a reasonable person with knowledge of the relevant facts." Mr. Perle's accusers knew all the facts, so the only conclusion is that they are not "reasonable persons," which will not come as news to most of our readers.

Mr. Conyers is now trying to compound his political felony by proposing to close what he claims is a "loophole" that requires someone to work more than 60 days a year before certain, more stringent Pentagon ethics rules apply. But this would essentially bar anyone with private expertise from advising Defense officials even in a voluntary, unpaid capacity. How this would enhance U.S. national security is not obvious. Then again, U.S. security was the last thing on the mind of Mr. Perle's critics.

[From the Washington Times, Nov. 20, 2003]

WASHINGTON-STYLE POLITICS

I beg to differ with Greg Pierce's recent item "All-purpose smear" (Inside Politics, Nation, Tuesday), claiming that charges levied against former Defense Policy Board Advisory Committee Chairman Richard Perle were an "all-purpose Washington smear."

A close reading of the inspector general's report would indicate that Mr. Perle's conduct raises real conflict-of-interest issues.

There is no doubt that Mr. Perle had an important role in shaping our nation's defense policy and heavily influenced the mobilization of our war machine in Iraq, along with all the defense contracts and profits that follow. The IG's report confirmed that while guiding this effort, Mr. Perle benefited financially by working for firms with major business before the Department of Defense.

The report notes that Mr. Perle appears to have represented Global Crossing and Loral in matters pending before the Defense Department, but escaped violations of the conflict-of-interest laws by virtue of the fact that he was considered to be in the board's employ less than the required 60-day period. Mr. Perle went so far as to sign an affidavit claiming that his position as chairman of the Defense Policy Board gave him a "unique perspective on and intimate knowledge of national defense and security issues." The fact that the offending language subsequently was removed from the affidavit doesn't change the reality of the assertion or the awkwardness of the conflict.

My legislation responds to the loopholes highlighted by the IG's report by merely ensuring that persons such as the chairman of the Defense Policy Board are treated as if they worked for the government for 60 days.

This would ensure that persons awarded with the public trust through prominent public positions do not use that trust to feather their own nests financially. At a time when we are asking our soldiers to make so many sacrifices, I hardly think it is too much to ask the chairman of the Defense Policy Board to refrain from representing clients with financial interests before the Defense Department.

ALL-PURPOSE SMEAR

"One obligation of editors is to distinguish phony political scandal from the genuine article. On that standard, any number of writers and editors owe Richard Perle an apology," the Wall Street Journal says. "The noted defense intellectual voluntarily resigned in March as chairman of the Pentagon's Defense Policy Board Advisory Committee after his enemies pumped up a few anecdotes into allegations about 'conflicts of interest.' The Pentagon's inspector general has been investigating those charges and last week issued a report absolving Mr. Perle of even the 'appearance' of impropriety," the newspaper said in an editorial. "The accusations, fanned by Michigan Democrat John Conyers, had received especially prominent coverage in the New Yorker magazine and the New York Times. They boiled down to the all-purpose Washington smear that Mr. Perle has exploited his position for personal financial gain. But Pentagon investigator Donald Horstman concluded in a letter to Mr. Perle that 'all of your activities with respect to those private entities complied with statutory and regulatory standards.' There were no 'quid pro' offers or attempts to leverage his (unpaid) Pentagon access. "Mr. Horstman says he also examined that 'more elusive issue' and concluded that Mr. Perle's 'activities did not create such an appearance' under the 'perspective of a reasonable person with knowledge of the relevant facts.' Mr. Perle's accusers knew all the facts, so the only conclusion is that they are not 'reasonable persons,' which will not come as news to most of our readers."

RECOGNIZING NATIONAL DIABETES MONTH

HON. JEB HENSARLING

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. HENSARLING. Mr. Speaker, this November, we recognize National Diabetes Month and renew our commitment to preventing and eradicating diabetes. Just last week, the Department of Health and Human Services announced that the number of Americans with diabetes rose to an all-time high. According to their report, an estimated 18.2 million Americans now have diabetes, more than 6 percent of the population.

Even more alarming is the fact that many Americans are unaware that they may be at risk or already have diabetes. Recent research suggests that more than five million people have the disease but have not been diagnosed.

Another major cause of concern is the number of serious diabetes related illnesses. Diabetes is the leading cause of blindness among adults between 20 and 74 years of age. People with diabetes are also at higher risk for heart disease, kidney failure, extremity amputations, and other chronic conditions.

To ensure the future health of our Nation, we can safeguard our children and our families from diabetes by encouraging good health and regular exercise. Following the guidelines for good nutrition, getting physical exercise, and maintaining proper weight can help prevent diabetes and reduce the chance of severe complications.

As the sixth leading cause of death in the United States, finding a cure for diabetes is a top priority for medical researches. As a member of Congress, this year I supported legislation that included funding for important diabetes research and clinical testing. This year the House voted to provide $1.6 billion for the National Institute of Diabetes and Digestive and Kidney Diseases, which is $47.2 million above fiscal year 2003. In addition, $150 million in mandatory funds will be made available for juvenile diabetes research.

Through increased prevention and research we will overcome this disease and free millions of Americans from the threat of diabetes and related illnesses.

ANACOSTIA WATERSHED INITIATIVE ACT OF 2003

HON. ELEANOR HOLMES NORTON

OF THE DISTRICT OF COLUMBIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Ms. NORTON. Mr. Speaker, today I am introducing the Anacostia Watershed Initiative Act of 2003. I am very pleased to be joined on the bill by several of my colleagues from the Washington region—Mr. HOYER, Mr. WYNN, Mr. MORAN, and Mr. VAN HOLLEN.

Although the beautiful Potomac, a river we also love, gets most of the attention in this region, it is the Anacostia that flows closest to the Congress and to the neighborhoods of the city and region. The Anacostia flows just 2,000 yards from the majestic Capitol Dome. The wastewater from the Capitol complex flows into the river when the ancient D.C. sewer system—built over the last century and a half—overflows on rainy days. The polluted runoff from congressional and federal parking lots and the fertilizers and pesticides from our magnificent lawns and gardens go into the Anacostia on those days as well. Many Members of Congress maintain a home in the Anacostia watershed. It is a sad fact that more than 30 years after the passage of the Clean Water Act, the Anacostia, despite its proximity to the Congress, remains badly contaminated with fecal bacteria, toxic chemicals, heavy metals, and many other pollutants. Contact with the water of the Anacostia isn't safe for human beings, there are official warnings not to eat fish caught in the river, and according to the U.S. Fish and Wildlife Service, more than half of the bottom-feeding brown bullheads in the river have cancerous tumors caused by chemicals.

We're simply not doing a good job of taking care of our home river. The Anacostia has no treatment plants and very few small industrial sites. Federal agencies are the biggest polluters of the river. Nearly all of its pollution enters the river from public streets, storm drains, and sewers. These public systems—particularly the District's combined sewer—are old and inadequate and should have been upgraded years ago.

One of the many challenges in cleaning up the Anacostia is that five-sixths of the land area that contributes polluted water to it is within the state of Maryland, about a sixth of the total is owned and managed by the federal government. The residents of the District of Columbia especially feel the effects of the pollution. The result of that geography is that neither the District of Columbia nor any other single jurisdiction can achieve the cleanup of the river by itself. If we are to envision the day that the Anacostia can be a real asset for the entire Washington region extraordinary cooperation among the federal, state, and local governments will be required.

This is the purpose of the Anacostia Watershed Initiative Act of 2003. The bill that my colleagues and I are introducing today would bring together federal, state, District of Columbia and other local governments in a joint approach to cleaning up the river. It would set up a mechanism to develop, fund, and implement a 10-year Comprehensive Action Plan for the Anacostia watershed that would address both the District's outdated and inadequate combined sewer system and the runoff from federal facilities and other properties in Maryland. It would involve all the major players in a truly unified approach to cleaning up the home river of Congress.

This legislation has broad support, not only among members of congress, but from state and local officials, environmentalists, and the business community. With regional colleagues as original co-sponsors, I will work hard for the passage of the Anacostia Watershed Initiative Act of 2003 and know that our colleagues in the other body will work for it there, too. I urge all members of the House to join me in creating a Congressional home river that we can be truly proud of.

THE EMPLOYEE FREE CHOICE ACT

HON. GEORGE MILLER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. GEORGE MILLER of California. Mr. Speaker, today I am joining with 81 of my colleagues to introduce the Employee Free Choice Act—legislation that will strengthen workers' rights in America.

Workers in America are demanding the same basic legal, labor and human rights by which we judge other nations around the world: the freedom of association and the right to collectively bargain.

These are the internationally-recognized standards our government says all workers deserve, whether in China or in Chattanooga, in Mexico or in Milwaukee, in South Africa or in South Carolina. We tell other nations that collective bargaining gives workers a voice in the workplace. It's time—in fact, it's way past time—for workers here in the United States to have the same rights and protections we demand of poorer, less developed and less democratic nations around the world.

Unfortunately, the basic labor law that Congress enacted in 1935 no longer works to protect the right of workers to form and join unions. Recent history is littered with the stories of companies that defeated their workers when they sought to exercise their legal right to organize for their mutual benefit.

Something is obviously very wrong with our nation's labor laws when one side in a dispute has so many weapons at its disposal to thwart the will of the majority.

We are all aware of the egregious record of Wal-Mart, whose vigorous anti-union activities include threats and firings to unlawful surveillance. In the last few years, Wal-Mart has been charged with well over 100 unfair labor practices and has faced at least 50 formal complaints from the NLRB. None of this has apparently deterred Wal-Mart. Current law simply does not discourage lawbreakers.

In August 2000, Human Rights Watch, which usually reviews conditions in developing nations, documented "a systemic failure to ensure the most basic right of workers [in the United States]: their freedom to choose to come together to negotiate the terms of their employment with their employers." No impartial observer of our law could reach any other conclusion.

Is this the image of democracy that we choose to show to the rest of the world?

It is no mystery why workers want unions. The wages of union workers are 26% higher than for nonunion workers. Union workers have better pensions, better health benefits, and better shortterm disability coverage. Union workers have contracts that prevent arbitrary firings.

So why do unions win only 50% of the elections? Because the deck is stacked against employees who want to form a union.

We propose a new deck. Not just a new deal.

The Employee Free Choice Act restores integrity to our labor law by ensuring that our own citizens have the same basic freedom we demand for others. The right to organize must mean more than the right to be fired for daring to propose a union, and the right to bargain collectively must mean more than the right to endlessly negotiate once a union has been selected.

Throughout my congressional career, I have fought to improve the rights of workers. With many of my colleagues I've fought for a larger minimum wage, protection for migrant workers, better education, and greater retirement security and health coverage. This fight is to enable workers to fight for themselves. It is an historic fight that I resolve to continue until the rights of working Americans are fully protected.

For the benefit of my colleagues, a short summary of the Employee Free Choice Act follows:

SUMMARY OF EMPLOYEE FREE CHOICE ACT

1. CERTIFICATION ON THE BASIS OF SIGNED AUTHORIZATIONS

Provides for certification of a union as the bargaining representative if the National Labor Relations Board finds that a majority of employees in an appropriate unit has signed authorizations designating the union as its bargaining representative. Requires the Board to develop model authorization language and procedures for establishing the authenticity of signed authorizations.

2. FIRST CONTRACT MEDIATION AND ARBITRATION

Provides that if an employer and a union are engaged in bargaining for their first contract and are unable to reach agreement within 90 days, either party may refer the dispute to the Federal Mediation and Conciliation Service (FMCS) for mediation. If the FMCS has been unable to bring the parties to agreement after 30 days of mediation the dispute will be referred to arbitration and the results of the arbitration shall be binding on the parties for two years. Time limits may be extended by mutual agreement of the parties.

3. STRONGER PENALTIES FOR VIOLATIONS WHILE EMPLOYEES ARE ATTEMPTING TO ORGANIZE OR OBTAIN A FIRST CONTRACT

Makes the following new provisions applicable to violations of the National Labor Relations Act committed by employer's against employees during any period while employees are attempting to organize a union or negotiate a first contract with the employer:

a. Mandatory Applications for Injunctions: Provides that just as the NLRB is required to seek a federal court injunction against a union whenever there is reasonable cause to believe that the union has violated the secondary boycott prohibitions in the Act, the NLRB must seek a federal court injunction against an employer whenever there is reasonable cause to believe that the employer has discharged or discriminated against employees, threatened to discharge or discriminate against employees, or engaged in conduct that significantly interferes with employee rights during an organizing or first contract drive. Authorizes the courts to grant temporary restraining orders or other appropriate injunctive relief.

b. Treble Backpay: Increases the amount an employer is required to pay when an employee is discharged or discriminated against during an organizing campaign or first contract drive to three times back pay.

c. Civil Penalties: Provides for civil fines of up to $20,000 per violation against employers found to have willfully or repeatedly violated employees' rights during an organizing campaign or first contract drive.

SENATE—*Sunday, November 23, 2003*

The Senate met at 1 p.m. and was called to order by the President pro tempore [Mr. STEVENS].

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

O God, too near to be found and too good to make a mistake, help us to trust the fact that You know us better then we know ourselves and desire for us abundant living.

Give us strength sufficient for this day and blessing that will enable us to transform hurting lives. As we rely upon Your wisdom, guide our steps and bring us safely to our desired destination. Keep us from trouble and let Your faithfulness inspire us. Lead us beside peaceful streams and renew our strength.

Guide our Senators. And Lord, give them a faith that works by love and keep them strong and steadfast in their efforts to do Your will. We pray this in Your wonderful Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable TOM DASCHLE led the Pledge of Allegiance as follows:

> I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. FRIST. Today, the Senate will resume debate on the Medicare prescription drug conference report. We had an extended and vigorous debate on this historic legislation yesterday. Again, it is unusual to have a Saturday session and even more unusual to have a Sunday session, but the historic level which this debate has reached demonstrates the importance of doing just that.

There are a number of Senators who will be on the Senate floor to discuss this matter during today's session, and in an effort to accommodate the number of Senators who are seeking floor time today, we would encourage Members to limit their statements to no more than 30 minutes. We hope to work out a schedule so that Members will have a better understanding of at what point in the day or the evening they will be able to speak. If we can lock in 30 minutes per Member, or possibly work out alternating hours, which we will do, hopefully, in a few minutes, we will then have an orderly way to move forward so that everybody will have an opportunity to address this important issue.

Yesterday, it became apparent that we would not be able to lock in a time certain for an up-or-down vote on this important legislation, and at least one Democratic Member said that a filibuster would be the road to pursue. Thus, I filed a cloture motion on the conference report. That vote on the motion to invoke cloture is expected to occur sometime around 12:30 on Monday. All Senators will be notified when that vote is set.

RECOGNITION OF THE MINORITY LEADER

The PRESIDENT pro tempore. The minority leader is recognized.

Mr. DASCHLE. Mr. President, I share the view expressed by the majority leader about the need for us to accommodate as many Senators as possible. It is my understanding that there is no objection to actually locking in a 30-minute time limit. Senators are free, of course, to ask unanimous consent to extend if they wish. So at this time I propound that request.

I ask unanimous consent that Senators be limited to no more than 30 minutes during the debate today.

The PRESIDENT pro tempore. Is there objection?

The Senator from Oregon.

Mr. WYDEN. Mr. President, reserving the right to object, and I do not intend to object, I just want to clarify one matter. My understanding is, and it is printed in the calendar, that there is already an order of speakers that has been established. I want to make clear that that will be recognized as we go forward today. I certainly will not object to the request of the distinguished minority leader. I just want to be clear that that will be the order of the speakers.

The PRESIDENT pro tempore. Is there objection to the original request?

The Senator from Massachusetts.

Mr. KENNEDY. Reserving the right to object on the order, I was referred to by my good friend, the majority leader, last evening at about 6:15 in reference to this legislation. The time-honored tradition of this body is to notify an individual when there is going to be reference made to them. I was not notified, and I heard later last evening that I was referred to. I indicated that to the leader. I would like to be able to do this in a timely way. I was listed yesterday to be either third or fourth in order, but I am not prepared right now—if there is some other previous order that has been arranged, I want to be able to reserve my rights that have been respected in this institution for 220 years, and that is when a Senator is referred to in terms of legislation, a fair opportunity is given for them to respond.

The PRESIDENT pro tempore. Is there objection to the original request?

The Senator from Nevada.

Mr. REID. Mr. President, I hope that Senators would not ask to extend beyond half an hour because it is so difficult to object. We have a lot of people. We have 17 on this side. Multiply that by half an hour and one gets the figures. I hope everyone will stick by the half hour that will be entered into, hopefully, momentarily.

I say to my friend from Massachusetts, the way the order is now set on our side, the majority leader would speak first. I would speak second. I would be happy to change places with the Senator from Massachusetts so he can go second, and I will go sixth or seventh.

Mr. KENNEDY. The Senator from Nevada, as always, is more than kind and generous. I appreciate that very much. I have no objection.

The PRESIDENT pro tempore. Is there objection to changing the order as the Senator from Nevada requested? Without objection, it is so ordered. The Senator from Massachusetts will take the place of the Senator from Nevada, and the Senator from Nevada will have the place in the order of the Senator from Massachusetts.

Is there objection to the minority leader's time limit of 30 minutes per speaker?

The Senator from Kentucky.

Mr. BUNNING. Mr. President, the list that is published in the calendar only has Democratic Senators in it. Obviously, there is an alternative list that would allow for Republican Senators to have a 30-minute block in between the Democratic Senators who speak.

The PRESIDENT pro tempore. The Parliamentarian informs me the Senator is correct, that a Republican Senator will go after each Democratic speaker if someone is here to be recognized.

Mr. FRIST. Let me also clarify that on the Republican side we are not locked into any order. The opponents to the bill are locked into an order of speakers. Ours has been just an agreement, so we are not locked into any order, but there will be a 30-minute limit, and we will be alternating back and forth.

Mr. BUNNING. I thank the Chair.

The PRESIDENT pro tempore. Is there objection to the minority leader's request? Without objection, it is so ordered.

Who seeks time?

RESERVATION OF LEADER TIME

The PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003—CONFERENCE REPORT

The PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of the conference report to accompany H.R. 1, which the clerk will report.

The legislative clerk read as follows:

> Conference report to accompany H.R. 1, an act to amend Title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare Program and to strengthen and improve the Medicare Program, and for other purposes.

The PRESIDING OFFICER. The minority leader is first on the list.

Mr. DASCHLE. Mr. President, I will certainly not exceed 30 minutes. I hope I can speak using less time because we are getting a little bit of a late start.

Let me begin by saying what an important debate this is. This is a debate the consequences of which will last for generations. This debate in many respects will be every bit as important as the debate on Medicare in 1965. One really has to go back to that year, 1965, to fully appreciate what we are debating now.

There was a debate, of course, in that period of our history, in the mid-1960s, about whether it was possible for us to address what was a national embarrassment at the time. About half of all senior citizens in the early 1960s had no health insurance—none. They were left out. There were horror stories about what they had to do in order to accommodate the health problems they were facing. It was a painful chapter. In some cases, because seniors had no health insurance, they were not living as long, the quality of their lives could not have been worse, and they were the poorest of the poor. They often had no income other than Social Security, and Social Security took them nowhere in regard to paying for the costs of health care.

Thanks to President Kennedy and then-President Johnson, the recommendation was made that we provide a national health insurance plan for seniors. Republicans, at that time, argued that it was not the role of Government, that it ought to be the private sector that provides health insurance. Democrats argued, in response, that given the group of people we were talking about, providing health insurance for senior citizens in the private sector had about as much profit in it as providing insurance for a haircut. You are dealing with the sickest, most elderly in our population. So there is not much of a profit incentive for insurers; there is not an incentive in terms of the demographics and all of the actuarial circumstances. The private sector has virtually been loath to insure seniors because of that. It is like insuring a haircut. There is an inevitability, if you are a senior, to that moment in one's life when illness becomes a serious threat. And obviously, that is when the circumstances involving the end of life become all the more real.

Medicare stepped in. Now, over the last 40 years, it has been one of the most successful programs in all of American history. Forty years of success, 40 years of providing health care with a consistency and a confidence we have never had in all of our time in this country.

My mother has benefits from Medicare. My mother benefits from Social Security. I can only imagine what it would be like today if she did not have Medicare and Social Security upon which to depend.

So Republicans, over the last 40 years, have tried to find ways to go back to that debate of 1965 and say: We still believe in the private sector. We ought to be able to find a way to provide insurance for a haircut and incentivize the private sector.

I will never forget the extraordinary statement made by the Speaker of the House, I believe it was in 1994. He addressed that very issue all over again when he said: It is still our hope and still our design to see Medicare wither on the vine.

For 40 years they have attempted to bring about an end, if not to Medicare itself, certainly to the concept of universal coverage through Medicare for all senior citizens.

That is really the backdrop that today we must recognize as we begin the debate on this bill. How is it that those very colleagues who 40 years ago argued that we really should not have a Government program for universal coverage for health care, who just 10 years ago said we ought to see Medicare wither on the vine, now in the name of Medicare are arguing we need to reform it, we need to improve it? We are not improving it with this bill. We are not reforming it with this bill.

Does Medicare need to be changed? Of course. And providing a meaningful prescription drug benefit is probably the single best reform we could enact, because medicine itself has changed. But to those who say we want Medicare to look more like the private sector, I say you don't speak for me with that assertion.

Medicare has had about a 4 percent administrative cost over 40 years; 96 percent of the money that goes into Medicare goes to benefits. Do you know how that compares with the private sector? I am told the average administrative cost in the private sector for insurance plans is not 4 percent. It is not even 10 percent. I am told the administrative cost for a private sector plan today on the average is about 15 percent—almost four times the administrative costs of Medicare.

So if you want to see the Medicare plan become more like a private plan, then count on spending almost four times more for administrative costs. At most, 85 percent of premiums go to benefits in private sector plans.

How ironic that we find our colleagues saying: We want to make Medicare more like the private sector; we want more competition.

We don't mind competition. But the kind of competition they want doesn't make a lot of sense to me. Why would we provide, instead of 96 percent of the benefits to the beneficiary, only 85 percent, and call that progress?

To make Medicare more "competitive," our colleagues want to give more than $14 billion of incentives to the private sector to get them to insure a haircut. Their notion is that somehow we can find a way to make the private sector more interested in providing meaningful health care to seniors, when Medicare is doing it so well already.

There are a lot of very grave concerns we have about this legislation. I brought some charts to the floor to talk about some of these concerns. I want to address them, if I can, in the time I have allotted to me.

I think one of the biggest concerns I have is that seniors today are very concerned about prices. They are concerned that their drug prices go up each and every year.

I will never forget talking to a woman in Sioux Falls whose name is Florence. She told me that, at 73 years old, she must work and she must use the supplemental pay she gets from her job—at 73—simply to pay for the drugs she needs. Her drug bill is about $400 a month. It goes up 10 to 15 percent every year.

She drives to Canada once every 3 months in order to save $100 a month. She figures every 3 months she saves enough to actually buy the drugs for a month with that trip to Canada. So, without question, I think most seniors are very concerned about what is going to happen to the costs of their drugs.

The answer, with all of the specific analysis done to date about the impact of this bill, the best analysis we can provide so far, is that up to 25 percent of all beneficiaries are actually going to pay more, not less, for the drugs they buy with the passage of this bill—25 percent. It could be more than that.

Many Medicaid beneficiaries are going to pay more than what they are paying right now.

And there are many in the private sector who are going to pay more. You are going to see several million Medicare beneficiarie who now have private coverage actually lose that coverage as a result of the passage of this bill. The estimate is now about 2.7 million senior citizens will lose their retiree coverage when this legislation is enacted into law.

There are a number of other concerns we have with regard to this particular bill, including the coercion of seniors into HMOs and increasing their Medicare premiums with the so-called premium support concept. Within 7 years, many seniors are going to be forced into a pilot project in at least six locations. In those locations at least, and maybe others, we are going to see not only increases in Medicare premiums, but also seniors coerced into HMOs. These are cases where seniors have never even thought about an HMO until now.

In addition, millions of seniors are going to go without drug coverage during part of the year. I will talk more about that later.

We also are going to keep drug prices high as a result of this legislation. There is very little this legislation does to reduce the cost of drugs at all, as I said just a moment ago.

And finally, we squander $6 billion needed for retiree coverage on tax shelters for the wealthy and the healthy.

For all of these reasons—the cost to beneficiaries, the coercion of seniors into HMOs, millions of seniors who are going to go part of the year without any coverage at all, the fact that drug prices don't come down but they go up, and that we squander $6 billion on tax shelters for the wealthy in the name of Medicare—it makes a mockery of the whole word "reform."

I said earlier that up to 25 percent of all beneficiaries will see more costs for drugs. There are two categories in particular. Studies have shown that 2.7 million retirees, including about 5,000 South Dakotans, will actually lose the coverage they have with the private sector when this legislation is enacted. And that 2.7 million number, I think, is actually going to be higher. For those millions of Americans and those thousands of South Dakotans, that would be the biggest blow of all. They have confidence now that they can go to the pharmacy, and they can buy their drugs. They do not have to worry about whether or not they are covered. They had better start worrying because the problems kick in just as soon as this legislation is enacted, if it is.

Up to 6.4 million low-income beneficiaries are going to pay more or lose access to drugs they are now provided. I think the 25 percent number may be a conservative figure.

When you take the number of retirees adversely affected, when you take the number of low-income beneficiaries who may be worse off under this plan, you begin to appreciate the magnitude of the problem this bill is going to create for millions of senior citizens today who are totally unaware of its negative implications.

The legislation creates a dilemma. The choice seniors will face is higher premiums on one side or an HMO on the other. How is that reform? How does that possibly relate to this widely stated goal we all have that we simply want to provide a meaningful drug benefit to senior citizens? This bill isn't a drug reform plan, this is a Trojan horse for the collapse of Medicare.

We are going to see the loss of Medicare as we know it today if this legislation passes. I think this chart describes it pretty well.

If you want to see increased premiums, support this bill. If you want to see seniors forced into an HMO, support this legislation. It leaves a question mark for a senior citizen right now: What do I do? How do I respond? How can I prepare myself for what is about to come?

What is about to come regarding drug coverage is described on this calendar. This calendar says more than any speech probably can. This calendar describes in essence the drug benefit structure. Of all the concerns I have, the benefit structure is one of the most troubling to me. I want to describe it, but then I want to use this calendar to talk about its implementation.

A senior will start paying $35 a month. We will come back to that figure in just a minute. A senior pays that $35 a month 12 months out of the year—January through December. Then the senior must pay 100 percent of all the benefits up to the deductible. That is depicted in red. Then the first dollar of protection under this plan for drug coverage would kick in, following the $250 deductible. Beneficiaries pay all of the $250. The drug coverage kicks in from $250 in spending up to $2,250. The Government pays 75 percent of the benefit. After the benefit has been paid—75 percent Government, 25 percent senior, up to $2,250—the Government says: Wait a minute. We paid all we can pay. You are on your own from $2,250 up to $5,100. You are going to pay all the costs during that period.

After the beneficiary pays $35 a month, 100 percent up to $250, and 25 percent up to $2,250, they have to pay the entire cost up to $5,100, even though they are still paying a premium, and then they have a 95 percent benefit that kicks in after that.

Basically, what this calendar depicts is the drug schedule for 2006 for beneficiaries with $400 per month in drug spending.

By the way, the benefit doesn't kick in until 2006. So there are premiums that kick in, and the benefit lasts for a period of time, during the months of February, March, April, and May. They benefit in June somewhat. But for the entire rest of the year they are on their own.

This convoluted benefit structure is scary, as I think of my own mother, and I think of all of those who are going to try to figure it out: How in the world do I know how much I owe? How much can I count on? How much of these benefits are really going to apply to me?

This period of no benefits is called a coverage gap. Some people call it a donut hole. Whatever you want to call it, it is a mistake.

Think of the myriad of administrative costs involved for every single senior citizen who is going to have to try to decide: Are they in the 25 percent category, the 100 percent category, or are they in the 95 percent category?

By the way, if you are a senior citizen with a lower income, you are entitled to a different schedule. First, they have to know what their income is. They are going to have to turn over their tax records to determine what kind of income they have and whether they are eligible or not. Once those tax records are determined, they then are presented with these different tables that they are going to have to try to figure out. Imagine a 90-year-old woman trying to figure out when she goes to the pharmacy what the coverage gap is: Do I pay the premium? Do I have to pay 100 percent? If I do, how do I pay for it? Am I breaking a law if I expect the pharmacy manager to give me the full benefit? How do I figure this out?

This convoluted, confusing, extraordinarily complex schedule is a disaster.

I will make a prediction. I will predict that within 12 months, we are going to be back fixing this so-called coverage gap. It is chasm, it is not a gap. It is a confusion chasm. It is a disaster. That, if nothing else, ought to warrant reconsideration of this legislation.

But as I say, the coverage gap widens over time. It is not just now. The premium, as I said, starts at $35. In 2013, the premium goes up to $58. The deductibles start at $250. But guess what? In 2013, the actual deductible is going to be almost $500. The coverage gap then goes from $2,850 in 2006 all the way up to $5,066 by 2013.

In other words, senior citizens are going to have to pay $5,000 even though they are paying $35, or in this case $58, a month for the benefit. Can you imagine a senior citizen coughing up these kinds of dollars in just a few short years?

It is absolutely the most reprehensible expectation for senior citizens. They can no more afford $5,000 in 2013 than they can afford it today. It is wrong. This, if nothing else, ought to be a reason we should send this legislation back to the conference to figure out a better way of doing it.

The bottom line is, when it comes to the coverage gap, seniors are going to have to pay $4,000 to be eligible for $5,000 worth of benefits. Can you imagine that in the name of reform?

First of all, we are coercing seniors into an HMO. We are telling retirees they may lose their own health benefits. Two to three million people are going to lose benefits, and the benefit they are going have instead is a $5,000 coverage gap and paying $58 a month in 2013. That, perhaps more than anything else, is disconcerting. As I talk to seniors, the concern they have the most is, of course, the high cost of drugs.

First of all, our conferees wasted no time in eliminating the reimportation of United States-made drugs from Canada. They will point to language in the bill, but the bottom line is we will not see any change in the current law with regard to reimportation of drugs from Canada. There is virtually a prohibition on drugs from Canada. South Dakotans, North Dakotans, Montanans, Minnesotans, Michigan residents have counted on Canadian relief. That has been a big part of what has been their strategy in coping with the high cost of drugs today. That is going to be gone. They will not be able to reimport unless they go to Canada themselves.

They also have a prohibition—and this is amazing to me as one of the things Medicare has been able to show is it can leverage better prices; because of the power of pooling, we can leverage, whether it is hospital prices, doctor prices, prescription drug prices—and there is actually a prohibition for Medicare in the negotiation of lower drug prices on behalf of senior citizens. Drug companies can do it, pharmacy benefit managers can do it, but there is a prohibition on the Federal Government involving itself in negotiating on behalf of senior citizens for lower drug prices today. I have never heard of such a thing. If we cannot bring about a better price, if we cannot leverage drug prices more effectively through Medicare, who in the world can do it more effectively than the Government itself and Medicare specifically?

The reason prices are going to remain high is, No. 1, there is going to be very little competition from those sources where competition is already shown to be very effective; No. 2, Medicare itself, the Government through Medicare, is actually prohibited from negotiating better prices on behalf of seniors. That is an amazing provision of law that is inexplicable.

It goes on. I said earlier one of the concerns I have is this provision that allows $6 billion to be squandered for those who are healthy, and in many cases wealthy today, money that could actually go for retiree coverage. It creates a new health savings account which is nothing more, of course, than a tax shelter for those who are wealthy and will draw off people who are healthy. Ordinary Americans cannot afford it and it undermines the employer-based coverage we already have. Six billion dollars is a tremendous pool of resources that could have gone to making this program far more cost effective and far more accessible for a lot of seniors.

Instead, even though we did not have it in the Senate bill, even though we had bipartisan support for this $6 billion going to those who need it the most, in keeping with the trend, in keeping with the philosophy of many on the other side, creating this tax shelter for the wealthy was a "must pass" piece of legislation.

The bottom line is we lost $6 billion over the next 10 years that could have gone a long way to reducing the cost of drugs to everyone else.

How is it that with all these warts, with all these problems, with all these deficiencies, with all these concerns, this legislation could be before the Senate today? This chart shows it pretty well.

The Pharmaceutical Manufacturers Association had their agenda as well. I must say, they got virtually every single thing they wanted.

They wanted an administered drug benefit in the private sector that diluted the purchasing power of Medicare. They got it.

They wanted financial incentives for HMOs, another step away from Medicare. They got it.

They wanted a prohibition on Medicare negotiating prices, as I just described a minute ago. Guess what. It is there.

They wanted a meaningless reimportation provision because they did not want the competition. Guess what. That is in the bill as well.

They wanted a watered-down generic access provision. Check that off the list.

They wanted no public scrutiny and secret kickback arrangement potential within the contracts they have with the benefit managers and the insurers. That is in there, too.

They wanted a huge windfall profit. They are going to make more money in the next 10 years than virtually any other sector within our economy. No wonder stock prices are soaring today—because they also see the writing on the wall.

PhRMA had a checklist. PhRMA got their list checked, every single item on the list.

The bottom line is, of course, Medicare beneficiaries lose, PhRMA wins, and the bill comes before the Senate with this realization. PhRMA got what it wanted. But organizations that represent seniors, organizations that represent working families, organizations that represent State governments and city governments, organizations of all kinds—liberal, conservative, name it—organizations of all kinds have come forward to say: Please do not pass this bill. Send it back to the drawing board. Recognize the damage you are going to do—not just to Medicare; recognize the damage you will do to the confidence and the security of senior citizens.

Now more than 200 organizations have said they oppose this legislation and they want the Senate to oppose it as well.

This legislation would have been killed in the House had they abided by the rules. One of the most flagrant demonstrations of abuse of the institution and rules I have seen: They took almost over 3 hours the other day to bring about the desired vote on the House floor in spite of the opposition of all these organizations.

You have all these organizations on one side. This picture depicts pretty well what is happening on the other. A meeting was called on November 13 to talk about the benefits of this plan, to convince seniors that somehow they are going to be better off. And all these empty chairs pretty well depict exactly what happened. Seniors know what is going on. They were not going to be part of a sham discussion. No one showed up.

No one ought to vote for this either. This legislation does not deserve our support. We can do better. This started out as a debate about providing meaningful help to seniors. It has turned into a debate to save Medicare.

We are going to do all we can to live up to the specific talks, to live up to the needs, the hopes and dreams of senior citizens today. We will do all we can to defeat this bill when those votes are taken.

I yield the floor.

The PRESIDING OFFICER. The Senator from California is recognized.

Mrs. FEINSTEIN. Mr. President, I listened to the distinguished Democratic leader and find that I agree with much of what he said. This may not be a perfect bill, but clearly there are positive and negative features to the bill.

I worked a year ago, and through an individual's help, was able to run the numbers with respect to a prescription drug plan and tried to make them come in within $400 billion and found it to be extraordinarily difficult. In my view, the most positive feature of this bill is that it delivers voluntary prescription drug coverage to this Nation's Medicare beneficiaries. I find the low-income benefits of this bill to be one of its biggest strengths. It is better than anything we ran that came in at $400 billion or below last year.

These benefits affect about 1.4 million Californians who have limited savings and low incomes and who will qualify for prescription drug benefits under this bill. Some of these are low-income seniors who do not qualify for Medicaid. Because of $3,000 in savings, they are ineligible to receive prescription drug coverage through the California Medicaid Program. They will now have prescription drug coverage which is much better than I had hoped. So 351,000 low-income Californians who are not eligible for Medicaid and have no prescription drug benefits now will have them under this bill. This was important to me. It is one of the strengths of the bill.

Analysis shows that this bill will increase the percentage of Medicare beneficiaries with prescription drug coverage from 79 percent to approximately 95 percent.

To begin with, this bill, as I said, expands the drug coverage to the 351,000 Californians who are not eligible for Medicaid. The reason it does that is because it has a much more relaxed assets test. So where the assets tests were so stringent for Medicaid, they are more relaxed here; and, therefore, those 351,000 people who found themselves without Medicaid coverage will now have coverage under this bill.

Secondly, the bill provides a 16-percent increase in Medicaid disproportionate-share hospital payments in fiscal year 2004. This has always been important to me. Every year we have had to fight for it because these are the payments that go to our county hospitals. In California, the county hospitals receive most of the people who have no coverage who are bereft and who are extraordinarily low income. California hospitals who qualified to receive Medicaid DSH money lost $184 million this year due to cuts enacted in the Balanced Budget Act in 1997.

This bill restores $600 million to California's hospitals over the next 10 years. I must tell you, with about 25 hospitals that have closed in my State in the last few years, this is a major item for me. The DSH money in this bill will go a long way toward protecting California's fragile health care safety net, which is dependent on a complex combination of local, State, and Federal funding.

Thirdly, the bill improves payments for indirect medical education in fiscal year 2004 and beyond. Teaching hospitals will receive a 6-percent increase in payments in the second half of fiscal year 2004 and will have their payments spelled out in future years so they can begin to plan ahead. Now, they do go down in some years. So there will be advanced knowledge of that so hospitals can begin to plan for that.

This is money that reimburses teaching hospitals. My State has some of the greatest teaching hospitals in the Nation. This money would reimburse those hospitals for costs associated with educating our Nation's next generation of physicians. That is important to me. I think it is essential funding, and it will allow our major hospitals to continue training tomorrow's caregivers.

Fourthly, the hospitals and physicians in California will benefit from this bill. Hospitals will see a full market basket update for fiscal year 2004 and have the opportunity to receive a full market basket update for the 3 years that follow. With more than 58 percent of California's hospitals losing money treating Medicare beneficiaries, and all hospitals facing Federal and State unfunded mandates, the full market basket update is vital to my hospitals as they struggle to meet staffing, seismic, and privacy compliance requirements.

I have heard overwhelming opposition from doctors in my State to the projected 4.5-percent payment cut that physicians and other health care providers would have faced in fiscal year 2004. In other words, without this bill, doctors in my State—and I do not know about elsewhere—but doctors in my State were going to face a projected 4.5-percent payment cut.

This bill prevents that payment cut from happening, and it includes an increase in payments for fiscal years 2004 and 2005 of 1.5 percent each year. This means that doctors in my State will be paid more for their services. It may not sound like a lot, but we have doctors leaving California and going to other States because they cannot meet the high cost of living in the State of California and practicing medicine. So even a small amount helps them stay in business.

In my State, approximately 33 percent of all Medicare beneficiaries get their health care coverage from Medicare+Choice. Now, Medicare+Choice has not been a positive experience in every case. I think we all know this. This bill, though, strengthens the Medicare+Choice Program, renames it Medicare Advantage, and it provides payment increases to HMOs. Some find that objectionable. I, frankly, do not, because these increased payments to HMOs and preferred provider organizations should provide some premium stability throughout the State. I intend to watch and see if, in fact, it does happen.

Now, I have many concerns about this bill. The Democratic leader pointed out some of them. This is certainly not a perfect bill. I am not on the committee. I did not write the bill. I struggled to have a little bit of input into the bill, probably much less than I would have liked.

I am deeply concerned about the number of Californians, though, who have lost their retiree health benefits as a result of rising health care costs. This is happening right now without a bill. It is projected that 10 to 12 percent of retirees who have private health care plans are losing their benefits each year. That is happening without this bill. The reality is—and I know people do not like to look at this—if we do not pass this bill, employers in my State will continue to drop coverage for their retirees at this estimated rate of 10 to 12 percent a year. Many of these employers who have chosen to retain coverage for their retirees have required their retirees to pay higher copayments and premiums—not under this bill but today.

Through direct subsidies and tax provisions, this bill actually reduces the number of seniors in California who will lose their retiree health coverage from approximately 431,420 in the Medicare bill that passed the Senate, that a majority of us voted for, to approximately 198,000 in this bill. These are California numbers, true. I cannot speak to other States. But what I am saying is, because of this bill, the number of retirees in California who would lose their retirement benefits will drop from 431,420 to 198,000.

Now, I wish the number were zero, but the point is, the bill makes it better, not worse. I think that is a good thing.

Now, I find it very difficult that this bill does not restore access to Medicaid and SCHIP for legal immigrant children and pregnant women at the State's option. The Senator from Florida, Mr. GRAHAM, authored legislation which I voted for which did do this. I intend to introduce—and I hope with him—legislation to restore Medicaid and SCHIP benefits to California's legal immigrant children and pregnant women next year.

I find it, frankly, troubling that this bill actually provides $250 million per year for 4 years to reimburse hospitals for providing emergency care services for undocumented immigrants, and California's hospitals will receive approximately $72 million a year to reimburse them for their care to undocumented immigrants, but we take away the coverage for legal immigrants.

I expressed my concern to Senator BREAUX, to Senator BAUCUS, to Senator FRIST about this issue. I was told the House would not accept this language. I hope next year the Senate will once again pass a bill to restore these benefits. This is a big item in California, and I deeply believe people who come to this country legally should be entitled to these benefits.

My State spent $3.7 billion in 2002 in uncompensated care, so the additional money that California gets for the care of illegal immigrants of $72 million a year at least will go some distance in covering that deficit.

In my role as vice chair of the National Dialogue on Cancer and cochair of the Senate Cancer Coalition, I have a very serious concern about this bill's Medicare reimbursement cuts for cancer care, particularly oncology physicians. It is my strong view that every suffering cancer patient should be able to have a so-called quarterback physician, an oncologist, someone who is with them who can go through all of the terrible choices and decisions that have to be made by a cancer patient and stay with them through it all.

I have talked to both Senators BAUCUS and BREAUX and also to Senator FRIST. They have all said this bill will leave the oncology community better off. I don't see that, candidly. In looking at this complicated Average Sales Price versus Average Wholesale Price issue, I don't see where they will be better off. I want the RECORD to reflect that I have received those assurances. I don't know whether they are true or not, but I can promise my colleagues, I intend to follow very closely the impact this bill will have on cancer care up and down the State of California. My staff and I will be watching the cancer care situation, and I am certainly prepared to introduce legislation making technical corrections to Medicare reimbursement for cancer care if the bill has the impact the oncology community predicts it will.

It is my understanding that our leadership will appoint an independent commission to be headed by my good friend, former Senator Connie Mack. The commission will monitor the impact of this bill on cancer care throughout the country and will report and make policy recommendations to Congress.

I am also concerned about the impact this bill will have on 50,000 low-income Californians who are living with HIV/AIDS. We have heard a lot from the HIV/AIDS community. My concern is with their access to drug treatment therapy under the Medicare prescription drug benefit.

What happens in AIDS/HIV treatment is that very often a cocktail of drugs, three or four different drugs, proves to be the most beneficial. The type of drugs varies with the individual, just as any drug would with any of us.

I have shared this belief, and the concern is that the formularies would limit an individual to two drugs. I spoke at length with Health and Human Services Secretary Tommy Thompson Friday night about it and asked him to put in writing exactly what would happen. Directly following my remarks, I ask unanimous consent to print in the RECORD his Department's response to my concerns.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mrs. FEINSTEIN. I will read just a couple of key points made by the Secretary in response. Let me quote the Secretary:

> The Secretary may only approve a plan for participation in the Part D program if the Secretary does not find that the design of the plan and its benefits, including any formulary and any tiered formulary structure, will substantially discourage enrollment in the plan by certain classes of eligible Medicare beneficiaries. Thus, if a plan limits drugs for a group of patients (such as AIDS patients), it would not be permitted to participate in Part D.

I also note that upon completion of this bill, Senators GRASSLEY and BAUCUS and I will enter a colloquy into the RECORD to emphasize this point.

This bill says that if a plan doesn't carry or doesn't treat a drug that is needed by a person with AIDS as a preferred drug, a simple note from a doctor explaining the medical need for that particular drug would get that drug covered at the preferred price. It cannot take more than 72 hours for seniors to get a drug under this expedited appeals process. This is my understanding based on conversations with the Secretary. I am delighted this understanding is now in the CONGRESSIONAL RECORD so that we can all follow it.

I want to say a word about something that is very controversial in the bill that I happen to support and why I support it. That is income relating the Medicare Part B premium. Let me tell you why I support it. I have a great fear that as I watch entitlement spending grow, and I have watched that happen for a decade in the Senate, our children and our grandchildren will not have access to Social Security or Medicare. Let me tell you why I believe this.

Since 1993, at my constituent breakfasts we have been using charts to illustrate outlays, meaning the money the Federal Government spends every year. I believe they are the truest way to judge Federal spending. When I began this, in 1993, entitlement spending was $738 million. About 50 percent of the outlays in a given year were entitlement spending. That was welfare, veterans benefits, Social Security, Medicare, et cetera. Interest on the debt was 13 percent. So 63 percent of the outlays in a given year could not be controlled by our budget.

This year, entitlement spending is $1.174 billion. Entitlements have risen to 54.4 percent, a 4.4 percent increase. Interest has dropped some, to 7.5 percent.

Now, if we look at the projection—and this is with the $400 billion prescription drug plan—if you look at entitlement spending in 2013, 10 years from now, you see that it is $2.048 billion. So in 10 years it has gone from $738 billion to $2.48 billion. That is the problem. Entitlements will be 58 percent of the outlays, and interest on the debt, 11.6 percent. What does that mean? That means 70 percent of everything that is spent by the Federal Government in fiscal year 2013 cannot be controlled.

The other two pieces, of course, are defense, projected at about 16.9 percent, and discretionary spending, dropping from 20 percent this year down to 13.6 percent. Discretionary spending is everything else we have to do. It is everything in the Justice Department, the Education Department, the Park Service. All the rest of the Federal Government in 10 years will be about 13 percent of what is being spent. That is the enormity of the entitlement picture.

I know it is hard for people to look at this because those people who had the dream of Medicare decades ago looked at it as a program that everyone who paid in got out the same benefit. But what the income relating in this bill talks about is just the Part B Medicare premium, the cost of which today is $3,196.80. That is the full cost of the Medicare Part B premium in 2004.

Now, what is Part B? Part B is physician care, other medical services; it is outpatient hospital care, ambulatory surgical services, X-rays, durable medical equipment, physical occupational and speech therapy, clinical diagnostics, lab services, home health care, and outpatient mental health service.

The premium is $3,196.80. The income-relating provisions in this bill are very mild, much milder than what Senator NICKLES and I presented on the Senate floor.

In this bill, beginning in 2007, individuals with incomes of more than $80,000, or couples with incomes of more than $160,000, will have, instead of 75 percent of their Medicare Part B premium subsidized, 65 percent of it will be subsidized by the Federal Government.

This goes up four tiers so that individuals with incomes of more than $200,000 a year, or a couple with an income of more than $400,000 a year, will have just 20 percent of their Medicare Part B premium subsidized by the Federal Government. Why should hard-working taxpayers pay for a millionaire's health care? That is my view.

I don't see income relating as bringing about the downfall of Medicare. I see it as making the program more solvent.

There is one significant missed opportunity in this bill that concerns me deeply, and that is the whole area of the cost of prescription drugs. I am particularly concerned about the amount of money spent on prescription drug promotion by pharmaceutical companies. Perhaps I have reached the age where I remember when there was no advertising of prescription drugs. We were just as well off then as now, and without huge costs.

Let me give you some examples. Promotional spending by pharmaceutical manufacturers has more than doubled, from $9.2 billion in 1996 to $19.1 billion in 2001. That is an annual increase of 16 percent.

Most troubling to me is the rapid spending growth of direct-to-consumer advertising of prescription drugs, which has increased an average of 28 percent.

Bottom line, Mr. President: I intend to support this bill, and not because it is perfect, but because I believe it brings substantial help to people who need that help in my State of California.

I yield the floor.

EXHIBIT 1

ACCESS TO DRUGS FOR AIDS PATIENTS UNDER THE BIPARTISAN AGREEMENT

Question: Will AIDS patients have access to all drugs within a therapeutic class under the Bipartisan Agreement? Can a PDP limit the number of drugs that are covered within a therapeutic class? Are dual eligibles in a Medicare drug plans losing coverage available to them in Medicaid?

Answer. In the Bipartisan Agreement there are significant safeguards in the development of plan formularies that will ensure that a wide range of drugs will be available to Medicare beneficiaries.

Plans have the option to use formularies but they are not required to do so. If a plan uses a formulary, it must include "drugs" in each therapeutic category and class under section 1860D–4(b)(3)(C)(i). A formulary must include at least two drugs in each therapeutic category or class unless the category or class only has one drug.

The Secretary will request the U.S. Pharmacopoeia, a nationally recognized clinically based independent organization, to develop, in consultation with other interested parties, a model guideline list of therapeutic categories and classes. How categories and classes are designed is essential in determining which drugs are included on a plan's formulary. USP is clinically based and will be cognizant of the needs of patients. We expect they will design the categories and classes in a way that will meet the needs of patients.

In designing formularies, plans must use pharmacy and therapeutic committees that consist of practicing physicians and pharmacists who are independent and free of conflict with respect to the plan, and that have expertise in care of elderly and disabled. The committee has to use scientific evidence and a scientific basis for making its decisions relating to formularies.

Further, the Secretary may only approve a plan for participation in the Part D program if the Secretary does not find that the design of the plan and its benefits, including any formulary and any tiered formulary structure, will substantially discourage enrollment in the plan by certain classes of eligible Medicare beneficiaries. If a plan complies with the USP guidelines it will be considered to be in compliance with this requirement. Thus, if a plan limited drugs for a group of patients (such as AIDS patients) it would not be permitted to participate in Part D.

Under the Bipartisan Agreement, the beneficiary protections in the Medicare drug benefit are extremely comprehensive to ensure access to a wide range of drugs and are more comprehensive than the protections now required of state Medicaid programs.

For example, there are extensive information requirements in Part D so beneficiaries will know what drugs the plan covers before they enroll in the plan.

The plans must set up a process to respond to beneficiary questions on a timely basis.

Beneficiaries can also appeal to obtain coverage for a drug that is not on their plan's formulary if the prescribing physician determines that the formulary drug is not as effective for the individual or has adverse effects. As a result, there should be access to all drugs in a category or class when needed.

Because the Medicare drug benefit will be offered through private plans, plans will have an incentive to offer multiple drugs in a therapeutic class in order to attract Medicare beneficiaries to join their plans.

Becuase of the optional nature of the Medicaid drug benefit today, states can drop their coverage entirely. According to a recent Office of the Inspector General report, states have identified prescription drugs as the top Medicaid cost driver (FY 2002, Medicaid prescription drug expenditures totaled approximately $29 billion or 12% of the Medicaid budget). From 1997 to 2001, Medicaid expenditures for prescription drugs grew at more than twice the rate of total Medicaid spending.

Pressures on state budgets have led to Medicaid coverage restrictions for drugs and the use of cost control measures that will not be used in the Part D program.

Eighteen states contain Medicaid drug costs by limiting the number of prescriptions filled in a specified time period, limiting the maximum daily dosage or limiting the frequency of dispensing a drug. Some states also limit the number of refills.

Six states have pharmacy lock-in programs, which require beneficiaries to fill their prescriptions in one designated pharmacy.

States already have the authority to limit the number of drugs that may be provided in a therapeutic class, and nineteen states are using preferred drug lists in their Medicaid programs. Thus, dual eligible beneficiaries will have the same access in Part D that they have in Medicaid, with expanded beneficiary protections and appeal rights.

Concerns have been expressed that the Medicare benefit will result in a loss of coverage for dual eligibles. This is not the case for low-income beneficiaries, the Bipartisan Agreement provides generous coverage.

The Bipartisan Agreement preserves the universality of Medicare for all eligible beneficiaries including those now dually eligible for both Medicare and Medicaid. Unlike Medicaid, the new Medicare Part D benefit will provide a guaranteed benefit to all eligible seniors—a benefit they can count on without fear of loss of benefits when state budgets become tight.

Dual eligibles, who currently have full Medicaid benefits, will automatically be given generous subsidies and pay no premium, no deductible and minimal cost-sharing regardless of their actual income (which can be higher than 135% of poverty based on states' special income rules).

In addition, full dual eligibles with incomes under 100% of the Federal Poverty Level (FPL) will pay no premiums, no deductible sand only nominal copayments of $1 for generic and other multiple source preferred drugs and $3 for all other drugs. These copayments will increase only at the rate of inflation, the same rate as the Supplemental Security Income (SSI) payments on which many low-income individuals rely.

Dual eligible nursing home patients and other institutionalized persons who only have a small personal needs allowances will be exempt from copayments altogether.

The copayment levels in the Bipartisan Agreement are similar to what dual eligibles now pay in what is an optional Medicaid benefit in their states. In fact, because of the optional nature of the Medicaid drug benefit today, states can drop their coverage entirely. Current regulations permit states to increase coinsurance to 5%, which is more than what will be permitted for dual eligibles under the new Medicare benefit.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KENNEDY. Mr. President, will the Chair please advise me when I have 5 minutes remaining?

The PRESIDING OFFICER. The Chair will do so.

Mr. KENNEDY. Mr. President, during yesterday and early today, we have had characterizations and descriptions of this legislation, which is enormously important. We are doing these debates on Saturday and Sunday, and it is anticipated that we will have a vote tomorrow, Monday, on a bill that will not go into effect until 2006, and other provisions will take effect in 2010. I have right here next to me the bill, the legislation, which was put on everyone's desk. I am still waiting for a Member to come here and indicate that he or she has read it, and describe the details of it.

We are dealing with a matter of enormous importance and consequences, as we are dealing with issues of life and death for our seniors in this country—the men and women who have brought this Nation out of the Great Depression, the ones who fought in World War II, the greatest generation. They came back and faced challenging times. We went from a 12 million, mostly man military, down to an Army of just a couple of million, with massive unemployment, and they helped to get the country back on a peaceful road. We are talking about a generation that faced down the Soviet Union and communism, and they are now in their golden years.

As the great philosophers point out so well, civilization is measured by how it treats its elderly people, whether they will be able to live in the peace, dignity, and security for their contribution to the country. I believe in that. I believe in that very deeply.

We have to ask ourselves at the end of the day whether this legislation before us, which is being rushed through with effectively 2 or 3 days of debate, is worthy of our senior citizens. I mentioned the issue of time again because my good friend, the majority leader—and he is my good friend—made reference to the fact that I believe that this legislation needed more debate than a Saturday afternoon and evening. I watched the debate going on, and the chairman of the Finance Committee and the Senator from Alaska talked up until almost 10 o'clock last night, and now we are here on Sunday afternoon.

But I wonder whether it needs more than 2 days debate. I believe it does; I do believe so. I believe that particularly after we saw what happened in the House of Representatives.

This legislation makes an enormous difference to the well-being and the security of seniors in this country. And we saw the facade that took place in the House of Representatives where the vote was called at 2 or 3 o'clock in the morning, and the vote was kept open beyond the traditional time of 15 to 20 minutes, for nearly 3 hours, in order to try to effectively coerce Members to support the proposal.

We are doing that on a measure that is supposed to benefit our senior citizens, and a measure that passed the House of Representatives by only one vote in a purely partisan proposal. Then, it passed the House of Representatives by less than a handful the second time, again, on a purely partisan proposal. It seems to me that if the House of Representatives had a full opportunity to have an open discussion and debate, and then have a reasonable vote and call them as they see them, then this process would be worth supporting. We ought to have the same here in the Senate. But, on the one hand, when we have a Republican leadership, which is effectively jamming this legislation through the House of Representatives, and then effectively wants to use the closing off of debate and discussion in order to effectively jam it through here, the Senate of the United States, we ought to take a moment or two to ask why.

I note the references of my friend, the majority leader, about who was really representing the seniors of this country and whether some were delaying this legislation. Many of us have been fighting for a prescription drug program for years. I will not take the time today to discuss the time when it was bottled up in the Republican Finance Committee, and how it only emerged on the Senate floor when we had Democratic leadership here just over a year ago. It is not worth taking up the time because I don't have it.

But this is a Senator who fought for the Medicare Program, who knows the history of the program, and knows how important the Medicare Program is. I am also mindful—with all respect to those on the other side and in the House of Representatives—that they got 12 votes in support of the Medicare. I know that they are untrustworthy of the Medicare Program, that they have a disdain for the Medicare Program. That is a very important difference. They are obviously entitled to their view.

But what we have seen is the efforts that were made on the floor of the Senate earlier this year, where we had a truly bipartisan effort for a prescription drug program. In 1964, Medicare was defeated in the Senate. It was defeated by 12 or 14 votes. Seven months later, it passed by that number. The only intervening aspect was an election. And the important aspect of that election is that the seniors understood what the stakes were in that election.

I am saying here on the floor of the Senate that the seniors are going to understand, when they know what is in this bill, how much it risks their future and the future of the Medicare system, make no mistake about it.

Make no mistake about it, no matter the outcome of this bill in the Senate, this issue is going to continue to be debated as we go into 2004, the 2004 election, 2006, 2008—all the way down the line. This issue is not going to go away.

I was here when the Senate passed catastrophic coverage. I can remember the catastrophic Medicare changes which allegedly were supposed to be so helpful to the seniors. There was a flood of Senators who left this body and rushed down to the television and radio center to indicate how they supported it. And I remember how they all crept back into this body just a couple of months later to vote to rescind that change because they got it wrong, because they rushed it through the Senate. And that is just what we are in danger of doing with this bill.

The Medicare system is a tried and tested program. It is a beloved program. The reason we have a Medicare system is that the private insurance companies failed our elderly people. They continued to fail them. Finally, in the late 1950s, we began to have a debate about a Medicare system, and when we had the debate in the 1960 campaign and 1962 campaigns, we finally found we were able to pass Medicare legislation in 1965. It took 5 years to pass that program, and we want to risk that program in a 2-day debate in the Senate when this is a lifeline to so many of our seniors, when we are seeing an effort to undermine the Medicare Program. I will get into that in one moment.

We had a chance to do something we failed to do in 1965. We passed the Medicare Program that dealt with hospitalization. We passed the Medicare Program that dealt with physician fees. But we did not pass a Medicare Program that dealt with prescription drugs. Only 3 percent of the private sector programs had prescription drugs at that time. Can you imagine that we would pass a Medicare Program today without prescription drug coverage? Those prescription drugs are as important as physician services and hospitals today.

We are on the verge of the life science century. The breakthroughs we are going to see in the next months and years are going to be breathtaking, and our seniors ought to be entitled to those programs. That is why a prescription drug program is so necessary.

We passed a good program in a bipartisan way, but that is not the proposal that is before the Senate. The bill before us is not that proposal. The bill that passed the House of Representatives is not the proposal we passed.

We have a major undermining of the Medicare system. There are those who say: You are really overstating this, Senator KENNEDY. Where in the world are you getting this idea?

I understand, as others do, that the position of the President of the United States earlier in March was that no one who was in Medicare would be entitled to a prescription drug program. I want our seniors to listen to that. In the spring of this year, this President indicated he supported the program for prescription drugs only when it was delivered by the HMOs.

He gave up that position. He said: Oh, no, let's try and see if we can figure out something else that may be related to the Medicare system. That was his position. That is the position of the majority of the people who are supporting this program. Make no mistake about it, that is their position. They believe that is what ought to happen: that we ought to dismantle the Medicare system, undermine it, privatize it. That is what they want to do.

You say: Why in the world are you saying that? How can you possibly say that? Read the paper this past week. The Washington Post, Friday, November 21:

> Bid to Change Social Security is Back.

They are going to get Medicare first. Social Security is next. Here it is:

> President Bush's aide reviving long shelved plan on Social Security. A Presidential adviser said [Bush] is intent on being able to say that reworking Social Security "is part of my mandate."

There it is, my friends, Social Security is next; Medicare now. That is why I think we ought to have some debate because, I daresay, I don't believe the Members of this body understand what is going to be done with the proposals.

There are three major provisions in this proposal that will effectively undermine the Medicare system. The first is the premium support proposal. I have listened day after day, week after week, month after month: We have to give premium support a try. My answer is: Why? Why? We know what it means even before trying it. Committed as they are on the other side of the aisle to start off with hundreds of thousands or a few million and multiply that to millions and millions of people, we understand what the results are going to be before we even try the program. They said: Let's try it; let's understand what the outcome is going to be.

Currently, everyone in the United States pays into the Medicare system. No matter where you live, you get your range of benefits. You get to pay the same premium and you get the same range of benefits all over this country. It is uniform. Not under premium support. You are going to pay in and you are going to pay more. Even the administration has recognized that the minimum you are going to pay is 25 percent more. You are going to pay more. So that every elderly person who understands premium support, this administration understands you are going to pay more at the outset.

Secondly, you are never going to know what your premium is because it is going to depend on where you live. These are not my figures, these are the figures of the Medicare actuary. Here it is: Under the premium support program—this is the Medicare actuary—

the national average under current law will be $1,205 by 2013. It is about $700 now. Their estimate is $1,205. A year and a half ago they estimated the premium support would be $1,771. The Medicare actuary estimated that every senior citizen would be paying $500 more in premiums than they would be paying under Medicare.

This year they have gone down to $1,501. They have gone down nationwide as starters, and we have to learn something more. That is not good enough.

The difference with premium support is there is no security. It depends on where you live. Do you understand that? Your premiums are going to be based not on the national standard that we have at the present time but on where you live.

In my State of Massachusetts, under premium support, it will be $1,450 in Barnstable, MA, and $1,050 in Hamden, MA; $400 more. The difference is 100 miles. In Dade County, FL, it is $2,000 and, in Osceola, FL, it is $1,000; $1,000 more.

Explain that to some senior who lived there all their life, has a house and is proud to live there, and they find that their premiums are going to be $2,000 and their neighbors in another part of Florida are paying $1,000.

It is very interesting what my friends on the other side say: Senator KENNEDY, you don't understand what we are going to do in this bill. We are only going to let it go up 5 percent a year this year. That is what they say this year. Next year in the Budget Committee, or the year after, it won't be 5 percent. We will have to recalculate. It will be 10 percent or 15 percent, or let's have a free enterprise system and let it sail off. That is what is going to happen.

That is what has happened in the Metropolitan Statistical Areas (MSAs), and the list goes on: $1,700 in Los Angeles, $775 in Yolo, CA. Medicare actuaries—every senior citizen ought to understand that premium support is written in this legislation. One can say, well, it is written in such a way that we are not going to face it for several years. Several years? But it is still there. The only way to repeal it is to come back here to the Congress.

In Yamhill, OR, premiums would be $1,325, but only $675 in Columbia, OR. It is double the amount if one lives in a different part of the State.

Why do we have to experiment with premium support? We already know what the results are going to be. That is a key element in this legislation. It was not in the Senate bill. I did not hear our majority leader make much of a case for it. To be honest about it, I do not hear the President of the United States make much of a case for it.

Nonetheless, when one is talking about the House of Representatives, they understood what this was all about. They committed to it, alright.

Now one might say: Well, Senator, what about the health delivery system? We are going to have the health delivery system delivered through the HMOs. Let us have real competition.

How many times have I heard this from our Republican friends over there: Let us have competition? We are glad to have competition, but do not suggest that this bill is competition. It is not. I see the chairman of the Finance Committee. He can correct me if I am wrong about any of these figures.

We start off with every HMO getting a 109 percent increase in the cost of living over Medicare. Is that competition? Competition? Come on. Beyond that, CMS—the governmental agency that administers the Medicare program—pays an additional 16 percent in excess of Medicare's own costs to private insurance companies because seniors who join Medicare HMOs are healthier than seniors in the traditional Medicare system.

So, under this bill, Medicare is going to pay a 25 percent advantage or bonus for every senior citizen that goes into an HMO. Our Republican friends are talking about competition, the free enterprise system. Is there a business man or woman in this country who would not want a deal such as this? The tragic part is, who is paying for it? It is our seniors who are paying for it.

And you think Medicare is going to be able to hold on when they are effectively getting a $1,936 overpayment per senior? That is what they are getting now. This is not competition with Medicare. This is a rip-off. This is a scandal. This is a payout. And that is what is happening now under our overpayment to the HMOs.

As a matter of fact, you are overpaying them almost the amount that the average person does for the prescription drugs. You could almost make a deal and say, do not even bother with the prescription drug program. The HMOs are almost paying the whole amount. That is what the seniors pay, $2,300. We are paying close to a $2,000 overpayment.

On the one hand, you have the premium support that is going to undermine it. Secondly, you have this program on the overpayment of the HMOs. Given the dramatic overpayment on this, we can see what is going to happen with the HMOs.

Look at what is going to happen with the HMOs, according to the actuaries. This year, there is $31 billion that went through the HMOs in this country. The best estimate, given the arrangement that has been made now, will be $181 billion going through the HMOs. You call this private competition? Competition with Medicare? This is outrageous. Do my colleagues think we are having that debate here on the floor of the Senate? Do my colleagues think we have time to change that 109 percent down to 102 percent or 104 percent? Absolutely not. We do not have time to do that.

Do my colleagues think we have time to change this with regard to the 16 percent advantage? Do my colleagues think we have any time to do that? Oh, no, let's stamp it. Let's close the books. Let's say to those who would like to have that kind of debate and offer amendments, this is being delayed for our senior citizens.

This is absolutely outrageous. We know what is going on. These are the payoffs to the HMOs.

Beyond that, if that is not enough, listen to this: Not only do they have the additional 25 percent, which is almost $2,000, there is also a $12 billion slush fund. What did the Senator from Massachusetts say? A $12 billion slush fund.

Well, what can they do with the $12 billion? They can give it to the HMOs as well. This is running-around money, walking-around money, $12 billion more. Who pays for that? The seniors pay for that under the Medicare system.

Do we have an opportunity to offer an amendment to strike that? Oh, no. Do my colleagues think we have an opportunity to go back to the Senate position that said let's take half of that and use it for good preventive kinds of medicine for our seniors, such case management programs? No, no. That was what we passed in the Senate. Do my colleagues think we can go back? No, no. We have to rush this proposal in.

In the meantime, we are telling our seniors all across this country that $12 billion is needed to help the HMOs. Tell that to the 10 million seniors who need Celebrex to deal with arthritis, or the 12 million to deal with osteoporosis, or the 11 million with treatments for diabetes, high cholesterol, thyroid deficiency, and depression. These are millions of our fellow citizens who could benefit from that $12 billion. Oh, no. We have to give that as a supplement to the HMOs.

I have listened to those who say: Well, at least our senior citizens are going to be better off. Let us just look what is going to happen to our senior citizens. We have the 2 to 3 million retirees who are going to be dropped. They are certainly not going to be better off. There are 6 million people worse off. Who are these 6 million? These are the Medicaid beneficiaries who, the day this bill goes into effect, are going to be worse off. These are the people who are paying the $1 to $3 copays. The States are paying for it with the Medicaid. Know what? They will not be paying anymore. Why? Because this bill prohibits it.

So one might ask whether they are better off. We start right off with 9 million beneficiaries who are going to be worse off. People say: Well, Senator, what about all of those low-income people we are all concerned about in this program? I am going to come back to that.

Let's take these 6 million people, who are the poorest of the poor, who are going to be worse off. Is that really going to make much difference, because it is only a couple of bucks a week, $3 to $5 a week, maybe $20, $25 a month? But when one is talking about the average income for seniors at about $12,000, it adds up. There are studies to show what happens to the poor when they do not pay the copays in terms of adverse health outcomes.

The PRESIDING OFFICER (Mr. ALLARD). The Senator from Massachusetts has 5 minutes remaining.

Mr. KENNEDY. Will the Chair tell me when I have 1 minute remaining, please.

This is what happens to those poorest of the poor when they do not have the copays—serious adverse events effectively double. The emergency rooms effectively double. These findings are demonstrated by research studies published in JAMA.

Of course, the sad fact is it ends up costing hundreds of millions and billions of dollars more to pay for in these circumstances. It is bad health policy and it is bad economics.

Finally, we had a good program that passed the Senate. We found our friends in the conference knocked out 3 million of the neediest elderly people in this country. We provided for up to 160 percent of poverty, they made it up to 150 percent of poverty. That is a million people. And they reimposed the asset test for those under 150 percent of poverty. As a result of reimposing it, that is a total of 2.8 million who were included for help and assistance under the Senate bill who were wiped out in this conference report. We had a good bill, but that is not the one that is before us.

Finally, the third part of the inclusions in this legislation, what they used to call Medical Savings Account, now referred to as Health Savings Accounts (HSAs), which have very high deductibles and low premiums. Who takes advantage of those programs? The most healthy people take advantage of those and the most wealthy people take advantage of those.

What is the problem with that? The problem with that is that if you are the working poor, working middle class, if you have some children, you can't afford to constantly pay the deductibles. So what happens to your premiums? Two studies—one study by the American Academy of Actuaries "Medical Savings Accounts: Cost Implications and Design Issues," May 1995, and another by tne Urban Institute, "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers," April 1996)—indicate that premiums will rise at least 60 percent. That is not just talking about the elderly people, that is across the country. That is undermining the employer-based system.

We have enough problems in this country with the uninsured. Now we have an additional proposal that is going to raise the cost of premiums for working families in this country? That has been included. Was that in the Senate bill? Absolutely not. But it has been in the House. It has been a matter of faith in the House. There you have it: Premium support, not a level playing field, a new form of health insurance that is going to raise the premiums for workers. What in the world does that have to do with the prescription drug program? It has a lot to do with ideology. That is what this bill is about, to undermine, to privatize Medicare. After they do that, coming right behind it is the Social Security Program, make no mistake about it.

We can do better. We should do better. We ought to take the time to do better. There are enough Republicans and Democrats alike in this body who have demonstrated over the period of the last year and a half that we can get a good bill. There is no reason to be stampeded with a bad bill. Why are we being stampeded with a bad bill? We ought to take our time, get a good bill, make a difference for our seniors, make a difference for our country. That is what I believe.

I hope we will have the opportunity to take the time so all of our Members understand it, and not just these Members but so our seniors, whose lives are going to be affected, who are suffering every single day and making choices between putting food on the table and paying for their prescription drugs, so they understand it. Don't we have enough respect for our seniors so we can provide some opportunity for those individuals to understand it? Or are we going to be rushed into the situation with short debates on Saturday and Sunday and then have the gauntlet come down. We saw what happened over in the House of Representatives. It took them 3 hours in order to galvanize this. I think we should demonstrate in this institution too much respect for our seniors to be stampeded into a bad bill.

The PRESIDING OFFICER. The time of the Senator has expired. The Senator from Kentucky is recognized for 30 minutes.

Mr. REID. If I could offer a unanimous consent request?

The PRESIDING OFFICER. Does the Senator from Kentucky yield for a unanimous consent request?

Mr. BUNNING. I have a unanimous consent request first to propose. Then I will.

Mr. REID. That is fine.

Mr. BUNNING. I ask unanimous consent that with the previous order standing in place, the 30-minute time limit on each Senator be considered controlled time, so that any remaining time may be yielded to another Senator, and if not yielded, the time be automatically yielded back.

The PRESIDING OFFICER. Is there objection?

Mr. REID. In layman's terms, what this means is, if there are Senators on our side or the other side who want to use the 30 minutes in any way they want—10-10-10, 15-15—that is certainly permissible. The going back and forth would be unfair otherwise because someone here would use 30 minutes and only 10 there.

So what we are going to do—I think this is totally appropriate. I ask the distinguished Senator from Kentucky to allow a modification, simply a housekeeping matter over here. The Senator from Michigan, Mr. LEVIN, and the Senator from Florida, Mr. NELSON, are going to switch places, and also that Senator EDWARDS would be listed at the end of our list as the final Democratic speaker.

The PRESIDING OFFICER. Is there objection?

Mr. BUNNING. I have no objection.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Kentucky is recognized for 30 minutes.

Mr. BUNNING. Mr. President, today I rise to talk about the Medicare prescription drug bill. First, let me commend the members of the conference committee who worked day and night for many months to reach this agreement. I know it was not easy, but they have done a good job that will finally bring Medicare into the 21st century.

Second, let me say how disappointed I am that it appears some Members may try to filibuster this bill. In fact, it seems as though there are Members in this body who want to filibuster just about everything we try to do, whether it is stopping judicial nominations, the Energy bill, or this Medicare bill. Just a few weeks ago we spent several days in continuous debate on judicial nominations. On Friday, the Energy bill was blocked. Now it looks as though some are going to try to kill this bill. I call that obstructionism.

I want to show a chart because from the beginning there have been charts shown on both sides. These are 358 different groups—358 different groups that support this bill in its present form. It is headed by the American Association of Retired People—the AARP, which represents over 35 million seniors.

Seniors have been pleading for Congress to expand Medicare to include drug coverage, and this bill will do just that. It might not be all things to all people, and I am sure every Member in here would have written a different bill if it was completely up to him or her, but that is not the way we work around here and this bill is a very large compromise. Even the AARP, as I said before, has endorsed this bill and said that, although the bill is imperfect, it is an historic breakthrough. I want to repeat that—an historic breakthrough; and that we should not let this opportunity pass us by.

Today, Medicare provides health insurance to about 40 million seniors and disabled individuals each year. The number is only expected to grow as the baby boomers begin retiring. Medicare provides important medical and health and hospital benefits for seniors. However, it is a program that is still trying to provide health care as if it were in 1965 instead of the year 2003.

When Medicare was created, prescription drugs played a small role, a very small role in medical care. Today, as we all know, that is much different. In fact, for many seniors and many Americans, prescription drugs have replaced expensive surgeries and extended their lives significantly. By tying a drug benefit to Medicare, this bill makes these lifesaving and life-enhancing drugs more available to millions of Americans.

This has been a very long process, and I kind of chuckle when I hear people say we are rushing into this. I can tell you as a member of the Finance Committee that we have been working on this bill for almost the entire year, working and crafting legislation to make the best drug bill possible for all Americans.

I was supportive of our bill as it moved through the Finance Committee and through the full Senate. Today I am supportive of the bill before us. It is time to add this benefit to Medicare. Seniors have waited too long for their benefit, and I urge my fellow colleagues in the Senate to support this bill. Talk is cheap, and it is time to act and it is time to act now.

We have $400 billion allocated for this benefit. It would be a shame if we let this opportunity pass us by. It might not come again.

This legislation provides a much needed prescription drug benefit to Medicare beneficiaries. It provides more options to seniors than just traditional fee-for-service Medicare, and it provides incentives to companies to continue offering medical benefits to their retirees.

Seniors will be able to receive prescription drug coverage under two options: Through the traditional fee-for-service Medicare and also through a new Medicare Advantage Program made up of private companies offering Medicare benefits.

Under the fee-for-service Medicare, beneficiaries will be able to enroll in Medicare drug plans. The standard drug benefit will require a $35 monthly premium and a $250-a-year deductible. Once seniors have met the deductible, they will pay 25 percent of the prescription drug cost up to $2,250. Once a beneficiary has received an out-of-pocket spending limit of $3,600, they will pay 5 percent for their prescription drugs.

I emphasize this because this is the key to the whole Medicare prescription drug benefit.

Low-income seniors will be provided with assistance paying for their drug costs depending on the level of their income. This means that seniors with the lowest income—those below 100 percent of poverty—will not pay a deductible or monthly premium and will pay either $1 or $3 per prescription drug up to the catastrophic limit. Once they reach the catastrophic limit, these seniors will have 100 percent of their drugs paid for.

These are the seniors who truly struggle to pay for their prescriptions. At 100 percent of poverty, a senior's income is $8,900 per year. Other low-income seniors below 150 percent of poverty will receive additional assistance depending upon their level of income. Personally, I believe our biggest responsibility is to low-income seniors. These are the ones who struggle the most to buy their prescriptions, and they deserve a very generous benefit.

Seniors will also be able to choose to receive their health care through a private company. I hope everybody heard that. They will be able to choose. This is a voluntary program. You can choose to stay in Medicare Part B and have no prescription drugs if you choose to do that. You can choose to take Medicare Part B and add a prescription drug benefit or you can choose to go into a private company's health care program.

Under Medicare Advantage, seniors will be able to choose whether they would like medical coverage from a preferred provider organization, known as a PPO, or a health maintenance organization, or HMO, operating in their regions.

These plans will provide beneficiaries with an integrated benefit, which means seniors will receive both medical and drug coverage under the plan. They would have a single deductible for medical benefits currently provided under Medicare Part A and B. They would also be able to receive preventive care, disease management, and chronic care under these programs.

These private plans will have much more flexibility in the type and scope of benefits they provide than traditional Medicare, and will provide many seniors with a valuable health care option.

Please notice—"option, voluntary." These are very key to this whole program.

I know some of my colleagues do not like these PPOs and HMOs because they say seniors will not be able to go to any doctor they choose. Hogwash. No one is going to force the seniors into these private plans, and they will be able to pick a plan in which their doctor participates.

Please understand that. We are not going to force any senior away from their given doctor. They will be able to choose their own doctor and stay with that doctor.

That is one of the key elements of the bill—giving seniors more choices instead of forcing them to use a health care plan created in 1965, which has changed very little since then. If these care advantage plans sound familiar, they should.

Finally, Medicare will provide seniors with a modern benefit similar to what is offered to most employees, including what the Federal Government offers to employees.

One of the biggest concerns with the legislation as it moved through the Finance Committee and the full Senate was what would happen to retirees who currently have drug coverage from their former employer. No one wants this new program to be an excuse for employers to drop their retirees' health coverage. That would be counterproductive and unfair to those seniors. To encourage companies to continue providing these benefits, this agreement sets aside almost $70 billion of our $400 billion for subsidies to help companies cover their prescription drug costs for their medical-eligible retirees. This is a substantial commitment by Congress to make sure companies do not have an excuse to drop their coverage.

The members of the conference committee have worked long and hard for many hours and in many meetings over the last year on this compromise. We have a real chance to pass this bill, and we shouldn't pass up this opportunity.

If we don't pass this bill now, it will be several years before we get another chance, and seniors have waited much too long already.

Again, I urge my fellow Senators to pass this bill and finally fulfill the promise that each and every one of us in the Senate has made either on the campaign trail or anywhere that we have spoken to senior groups. We have promised this benefit and we can deliver it.

I urge my fellow Senators, once again, to pass this bill providing prescription drug coverage to our seniors. We can talk about it for 2 or 4 more years or we can do it now.

I yield whatever time I have to the Senator from Iowa.

Mr. GRASSLEY. How much time remains?

The PRESIDING OFFICER (Mr. BUNNING). There are 14 minutes 50 seconds remaining.

Mr. GRASSLEY. Mr. President, we have heard in the Senate today and last night that the comparative cost adjustment demonstration project, which some of the Members refer to as premium support, would end Medicare as we know it. I want to be very clear, nothing could be further from the truth. I have 10 facts about this demonstration to explain why this is not the case. We are talking about the comparative cost adjustment.

Fact No. 1: It sunsets in 6 years. The demonstration will only be in existence for 6 years. It will not begin until the year 2010. During that time, there will be a 4-year phase-in period. Explicit authorization from Congress at the end of 6 years is necessary to extend the demonstration and/or expand it to other areas of the country. This proposal is significantly modified from the House of Representatives' original position. Congress weighs in before this becomes something other than a demonstration project and becomes policy for the entire country.

Fact No. 2: Very limited areas of the country will be affected in the demonstration. Under the agreement, the Health and Human Services Secretary may select no more than six metropolitan statistical areas to participate in the demonstration. It is not easy to be put in that list of six because in order to be selected, a metropolitan statistical area must have at least two local coordinated care plans offering services in the area and at least 25 percent of the Medicare beneficiaries must be enrolled in these plans. That means the private PPOs we are setting up beginning in 2006 must succeed. I hope they succeed. But we do not know if they will succeed, and if they do not succeed, at least to the tune of 25 percent in two local areas, there will not be one. If that does happen, according to the Congressional Budget Office, somewhere between 670,000 and 1 million beneficiaries will be included in this limited demonstration. It is a demonstration. It is not something that could ever, without an act of Congress, encompass all 40 million seniors.

Fact No. 3: Low-income beneficiaries are not affected at all. So if they are low-income, below 150 percent of poverty, none of them will see their Part B premiums increase.

Fact No. 4: Premium increases for beneficiaries above 150 percent of poverty will be limited to 5 percent. For everyone else, if premiums go up, there is a cap of 5 percent. As an example, if the national Part B premium was, say, $100 in 2010, the fee-for-service premiums in the demonstration areas could not exceed $105 a month. The increase, by the way, is not compounded over that 6-year period of time.

Fact No. 5: Other than the limited impact on the Part B premium calculation, the fee-for-service program is unchanged choice. Fee-for-service benefits, beneficiary cost sharings, payments to hospitals, and other health care providers are unaffected by the demonstration. The Medicare entitlement to benefits and payments to health care providers are unchanged in these same areas.

Fact No. 6: Beneficiaries are not required to enroll in these private plans. The right for a Medicare beneficiary to remain in fee-for-service programs is maintained in the demonstration areas. The fee-for-service program will remain affordable for all beneficiaries.

Fact No. 7: The prescription drug benefit is unaffected. The prescription drug benefit and the drug premiums are not changed. The demonstration only minimally affects the Part B premium, and that is the maximum of 5 percent increase.

Fact No. 8: Over the demonstration period, enhanced payments to private plans are phased out to ensure that their payments to private plans are on a level playing field with the fee-for-service program.

Fact No. 9: The preferred provider organization stabilization fund, referred to on the other side by my colleague as a "slush fund," has no relationship to this demonstration. So one cannot talk about the demonstration and talk about a stabilization fund in the same breath. If you do that, you do not know what the bill does; you have not read the bill.

Under the conference agreement, the stabilization fund may only be used to provide assistance to the newly regional PPO options. However, any enrollment in regional PPOs is not counted toward the 25 percent enrollment requirement in the metropolitan statistical areas. The extent to which beneficiaries enroll in the new regional PPO opposite will have no bearing on whether a metropolitan statistical area becomes a candidate for demonstration.

Last fact, No. 10: Strict quality monitoring is required. The Health and Human Services Secretary is required to closely monitor access to care and quality and submit a report to Congress upon completion of the demonstration to determine if the demonstration has reduced Medicare spending and/or increased cost to beneficiaries; second, access to physicians and other health care providers has declined; and lastly, whether beneficiaries remain satisfied with the program. The evaluation would be on the basis of any congressional decision to extend that demonstration.

Premium support, as has been described in the Senate numerous times in the last few days by the Senator from Massachusetts and by other Senators, is not in this bill. It is not included. This bill strengthens and improves fee-for-service Medicare.

How much time remains?

The PRESIDING OFFICER. Seven minutes.

Mr. GRASSLEY. It would be good at the start of the third day of debate on this bill to remind people of the political situation that has gotten us where we are today. That is a very positive political situation.

Last year, we were beginning to develop a bill in the Senate Finance Committee that would have had bipartisan support to get it out of the committee. Bipartisan support in the committee is a way to have a chance of success in the Senate where there can always be an extraordinary minority who can keep a bill from being passed because we protect minority interests in this body as no place else in our political system. So we must be bipartisan.

About the time that was going to happen, the majority leader—the Senator from South Dakota, last year—decided we needed to talk about this in the Senate. But the bill never came out of committee. It was brought right to the floor. When bills are brought to the floor, there is no chance of developing bipartisanship. We discussed it for 2 or 3 weeks and no one could get the bipartisan majority it takes to get pieces of legislation passed.

At that time, I surmised, and I think the outcome of the debate last year proves it, that the other side wanted more of an issue for the election rather than a product. They gambled and they lost because Republicans gained control of the Senate in that election and then we were right back to square 1 where we went to the Senate Finance Committee where there could be, even with a Republican majority, still a bipartisan working relationship that was able to report out a bill on 16-to-5 bipartisan vote. Then we brought that bill to the floor during the month of June. And it got through here 76 to 21.

We are as successful as we are because the people made a change in the Senate.

In the Senate, then, we adopted a bipartisan bill, and we were able to get through, for the first time on this issue in the history of the Senate, prescription drugs for seniors. We were able to match the House, where it had passed three times previously. We went to conference. We operated in the conference, at least from the Senate point of view, on a bipartisan basis, and we were able to produce a product where here we are doing the best improvement and the most sweeping improvement in Medicare in 38 years. We are able to do that because of bipartisanship.

Now, all of a sudden, people on the other side of the aisle, at this last minute, are filibustering. I hope they do not get away with that filibuster. But, again, they are trying to be very partisan, as they were a year ago. I hope they learned a lesson from a year ago and will not try to be partisan on this very important social issue for the seniors and the disabled of America, and that they will not repeat the mistakes of last year when they wanted an issue instead of a product.

We have a bipartisan product. I listed last night, in my closing remarks, all of the organizations that are supporting this bill. Other Senators have put charts up saying how many organizations are supporting this bill.

We have this opportunity. Let's hope partisanship—that is demonstrated by the filibuster that was announced yesterday—does not keep this bill from passing. Democrats who want to filibuster ought to consider that is not the way to go. They should learn from the lesson of the past. That lesson is that last year when they wanted an issue instead of a product, they got a defeat at the polls.

I yield the floor.

The PRESIDING OFFICER (Ms. MURKOWSKI). The Senator from Florida.

Mr. GRAHAM of Florida. Madam President, since its creation in 1965, the Medicare Program has helped millions of our Nation's elderly and disabled when they desperately needed it, after they became ill.

It has been an extremely successful and popular program, and has improved the health of countless seniors.

Now that we are in the 21st century, it is time to reap the full benefits of the advances made over the years, and shift the focus of the Medicare Program from assistance after illness to one that promotes wellness.

To achieve that, a prescription drug benefit is mandatory. Ninety percent of seniors have at least one chronic condition; drugs are often the best way to manage those conditions.

The bill we are considering is frequently divided into two parts—one part is the prescription drug benefit, and the other part is Medicare reform.

Let me state what we all ought to know by now: A prescription drug benefit is the most fundamental reform that we can make to the Medicare Program.

If we want to truly reform Medicare, we must change the approach of the program from one of sickness to one focused on wellness. This prevention approach will require access to prescription drugs.

Modern medicine has been altered fundamentally by prescription drugs, notably by improving the quality of people's lives, ending the need for surgeries and long recovery periods.

A side benefit of this change would be that the cost to the Medicare Program could be lower by reducing these procedures.

I have introduced several prescription drug bills over the past few years because I believe a reorientation toward wellness is in the best interest of our seniors, as well as the Medicare Program.

However—and this is critical—not just any prescription drug bill will do. The bills I have authored have been constructed to provide an affordable, comprehensive, reliable prescription drug benefit to our seniors and Medicare beneficiaries with disabilities.

The bill I introduced in 2001, cosponsored by Senators ZELL MILLER and EDWARD KENNEDY, was voted on in July of that year. It received 52 votes.

That bill would have made a significant, and positive, difference in the lives of the nearly 41 million older Americans and disabled citizens who are covered by Medicare—more than 2,770,000 of whom live in Florida.

The conference agreement that we are now considering would also make a significant difference in the lives of our seniors. However, that difference will not be a positive one.

I have many grave concerns about this legislation. The drug portion of the bill is deeply flawed. It includes an enormous coverage gap. When a senior has reached $2,250 in total drug expenses, all drug coverage stops. The drug benefit doesn't begin again until total drug spending reaches $5,100. That is a gap of $2,850.

And during all of the months the senior is in that "gap", the senior is required to keep paying premiums.

The bill is projected to cause 2.6 million retirees nationwide, and over 160,000 in Florida, to lost their retiree prescription drug coverage.

It will cause 6 million low-income seniors nationwide, and over 360,000 in Florida, to pay more for their drugs, and to face more restrictions on the drugs they can get.

It relies on an untested delivery system which would either herd seniors into what we know they don't like, a managed care organization, or would turn them into guinea pigs for a never previously utilized drug-only insurance plan.

Millions and millions of seniors who will not have access to drugs through the traditional Medicare Program will suffer the fate I have just described.

In addition, the legislation that was supposed to be about adding a prescription drug benefit now includes provisions that will privatize the Medicare Program beginning in the first year of implementation fragmenting the health insurance group by subsidizing health savings and increase the costs of comprehensive health insurance for our non-Medicare citizens.

I am not alone in my concern about this legislation. In a recent survey conducted by Hart Research, of voters aged 55 and older, only 19 percent said we should pass this bill. Sixty-four percent said we should go back to the drawing board. This isn't the Medicare prescription drug benefit that they need.

And although the AARP has taken the inexplicable position of supporting this legislation, the national organization may want to listen to its members. Only 18 percent of AARP members want Congress to pass the bill. Sixty-five percent have instructed us to go back to the drawing board.

The percent of seniors in favor in my State is even lower. I have received over 1,000 calls from seniors opposed to this agreement, representing about 80 percent of all calls.

Listen to what some of my constituents are saying about the bill:

Earl Dangler of Beverly Hills, FL said:

> This prescription drug benefit is going to cost my wife and I an additional $750 to $1,000 per year whether we use it or not.

Many of my constituents have expressed outrage at AARP for endorsing this conference agreement.

One constituent said:

> I'm really mad at the AARP and I am going to cancel my subscription that I've had for 20 years.

Another constituent remarked:

> I've been a member of AARP for many, many years, and I can't believe that they have sold out to the pharmaceutical industry and the insurance companies.

The real test of the reaction to this legislation is a bit down the road—but it will come. The impact of the bill won't be felt until at least 18 months after enactment.

I would predict the vote we cast on this legislation will be politically inconsequential for those running in the year 2004. The stunning impact will be felt first in the fall of 2005, when Medicare beneficiaries get the notice that it is time to enroll in the drug benefit.

What choices would the senior face in 2005 when considering whether to enroll in the new, highly touted program?

Many Medicare beneficiaries will have to consider the following:

No. 1, sign up for a prescription drug plan, PDP—a private drug-only insurance plan with no limits on the premium that may be charged, or No. 2, enroll in a managed care plan.

Given that more than 85 percent of seniors today have rejected managed care, I anticipate a "1980s"catastrophic outrage. But, that is not the end of the outrage. In fact, it may be just the beginning.

As the senior considers his choices, he will soon realize that the private plans hold all the cards. They have all the flexibility, all the options, and none of the commitments.

The plan defines the classes, or categories of drugs, then decides what drug is in the class or category, and how much the senior will be charged for the drug.

The plan doesn't even have to tell the senior prior to enrolling what the charge for the drug will be, and can change which drugs are in each category at any point in the year.

But the senior? The senior has to make an enrollment decision prior to the beginning of each calendar year, based on limited and subject-to-change information, and cannot change plans at any time during the year.

The private insurance plan can make changes during the year, but the senior cannot.

Once enrolled, in the first part of the year 2006, seniors will begin to feel the impact of the deck being stacked in favor of the private plans. They will discover that the plan can make changes to the drugs covered and the price of the drugs at any time.

They will discover that the drug prices aren't all that low, and they will discover that they have to pay the full cost for part or all of January as they struggle to meet the $250 deductible.

At this point, you may be thinking that things are bound to improve for the senior. But, hold on, because the summer of 2006 is coming. What happens then? That is when, for the first time, seniors—voters—will experience the infamous "gap." Beginning sometime after Memorial Day 2006, many seniors will reach, and fall into, the gap.

At this point the senior has been going to the drugstore for about 6 months, each month filling prescriptions for treatment of any number of chronic illnesses.

The senior has met his or her deductible, has never missed a monthly premium payment, and dutifully has been paying 25 percent of the cost of each prescription.

But when the drugstore counter is reached in July, the senior finds he is now responsible for paying 100 percent of the cost of the prescription, and yet still is responsible for paying the monthly premium.

I predict that by Labor Day of 2006, seniors will have made loud and clear their opinions about this prescription drug benefit.

And yet, there is still more ahead. In the year 2010, a vast experiment called "premium support" will be imposed on millions of seniors in several parts of the country, including Florida.

Seniors in my State, as in others, will be forced to choose between enrolling in a health maintenance organization or paying a much higher premium to stay in the traditional fee-for-service Medicare Program.

Although we are beginning to hear the outrage now, it will be nothing compared to what we will hear in the summer of 2006.

The voters have been polled and my constituents have been calling, and they all cite many concerns with the bill—many of the same issues I mentioned a few moments ago. Each of these issues should be discussed in great detail, and I hope we have the time to do so.

Today, I am going to concentrate on one of the aspects of the bill that I find to be the most troubling, and one that is shared by 64 percent of those polled: the legislation does little to contain drug costs. The legislation actually forbids Medicare from negotiating with the drug companies to reduce costs.

It doesn't seem to make much sense. A Medicare prescription drug benefit should allow the Medicare Program to do whatever it can to get the best possible prices from the drug companies. Why? Because both seniors and taxpayers would benefit.

Under this legislation, the majority of seniors would have to pay either 100 percent or 25 percent of the price of the drug—100 percent before the deductible is met, and during the time the senior is in the enormous "gap" in coverage, and 25 percent after the deductible and before reaching the "gap."

In 2001, the median income of a Medicare beneficiary was $19,688. After covering the cost of housing, food, and transportation, there isn't a lot left.

We need to make sure the prices are as low as possible so that our seniors are able to actually purchase the drugs they need to keep them well.

Of course, the taxpayers would also benefit from Medicare serving as a tough negotiator. The taxpayer is going to pay the portion not paid by the senior.

Both parties—the seniors and the taxpayers—have an interest in keeping drug prices as low as possible. The party that does not share that interest is the pharmaceutical industry.

The interests of that industry can be the only reason for a provision included at the top of page 54 of the conference report. The provision is designed to appear helpful by being called a "noninterference" clause.

What is a "noninterference" clause? According to the authors of this legislation, it is the following:

> NONINTERFERENCE.—In order to promote competition under this part and in carrying out this part, the Secretary—
>
> (1) may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors; and
>
> (2) may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs.

Let me get this straight. A provision that prohibits the Secretary of HHS from negotiating with drug manufacturers to lower the price of drugs—a provision that prohibits the Secretary from using the purchasing power of 41 million Medicare beneficiaries to lower the price of drugs—and thus lower costs to seniors and taxpayers alike—is "noninterference"?

I put my money on this being a form of "interference" that senior wouldn't mind. Saying this provision is about not interfering, and about promoting competition, is akin to the fox putting on the San Diego chicken costume and heading into the chicken coop to "protect" the chickens.

This may sound like dry stuff. But it has very real life implications. Take the case of Patricia Kittredge, a 71-year-old woman who lives in Tamarac, FL.

She takes 6 different prescription drugs to stay healthy, which add up to $409 a month, or approximately $4,908 annually. Fortunately, her former employer picks up the majority of these costs so that she pays $65 a month, or $781 annually.

A former credit analysis for a major employer in South Florida, Mrs. Kittredge has good retiree health coverage. Yet she is far from wealthy. She makes about $18,000 a year when you combine her pension and Social Security income.

Because the conference bill does not allow the Medicare Program to negotiate on her behalf—should Ms. Kittredge find herself among the 4 million Americans who will lose their retiree coverage—her out-of-pocket costs, including her premium, will explode to $3,830.

That is nearly 5 times what she currently spends, nearly 5 times what she now pays, and nearly $4,000 in out-of-pocket drug costs on an income of $18,000 a year. What kind of benefit is that?

But don't take my word for it, this is what Patricia Kittredge has to say:

> That would really hurt me. The handwriting is on the wall. The companies that have retiree coverage will be walking away from it to save money and won't feel bad about it at all.

Were Medicare able to use its bargaining power to negotiate with the drug manufacturers, our seniors would likely see drug prices more in line with the VA drug prices. Mrs. Kittredge's drug costs under the proposed plan would decrease dramatically.

Yet the conference bill strictly forbids Medicare from using its bargaining power to negotiate lower drug prices for seniors.

How good are these VA prices? Let's compare the VA prices of Mrs. Kittredge's drugs to their retail prices.

Diazepam, which Mrs. Kittredge takes to help her sleep, costs the VA $0.84 for one hundred 5 milligram tablets, while the same pills cost $16.70 at the drug store.

In addition, a month's supply of pravachol which she takes to regulate her cholesterol, costs the VA $19.80 at 40 mg per pill for the clinical equivalent, while the drug store charges $116.75 for the same amount.

Mrs. Kittredge would face similarly high prices for her other prescriptions: a 20 mg dosage of accupril, a drug to treat her high blood pressure, costs the VA $7.69 for 30 pills goes for $32.00 at the drug store.

Diltiazem, which Mrs. Kittredge also takes for her blood pressure, costs $69.20 at the drug store but only $32 through the VA.

Metrocream, which she takes for a skin disorder, costs $69.99 at the drug store compared to $25.13 through the VA.

If the Medicare bill we are now considering actively negotiated on Mrs. Kittredge's behalf, she would likely pay prices more in line with the prices available to veterans. Her total bill would be $2,188 rather than the $3,830 as she will pay under the conference agreement.

Mrs. Kittredge's example is not unusual. Look at the price differentials between the VA price and the average retail price of some common drugs.

How is the VA able to secure such good prices for veterans?

In 1992, concerned about the prices veterans were paying for drugs, Congress passed the "Veterans Health Care Act"—a Rockefeller, Simpson, Murkowski, Cranston amendment—by voice vote.

It is interesting that an issue that was and is so controversial could be passed by voice vote. We are only asking that Medicare not be prohibited from negotiating prices for seniors.

This legislation gave the VA the authority it needed to secure better drug prices for our veterans. What was the result of that legislation? In the first 5 years alone, the VA saved more than $1 billion.

VA's savings have continued to grow exponentially, as both the cost of pharmaceuticals and the number of veterans seeking prescription drugs have grown. The savings represent valuable Federal dollars that have been used to provide quality health care to our Nation's veterans.

In addition, the savings on pharmaceuticals have allowed VA to provide a long-term care benefit, including nursing home care, adult day care.

What are the implications of allowing Medicare to negotiate prices? In 1998, the Inspector General, IG, of HHS, studied 34 drugs currently covered by the Medicare program.

The IG found that Medicare and its beneficiaries could save more than $1 billion a year if the allowed amounts for just these 34 drugs were equal to the prices obtained by VA.

If the Medicare program were able to achieve similar savings on the outpatient drugs covered in this legislation, Congress would be able to provide a much richer prescription drug benefit for the same $400 billion we are proposing to spend now, reduce the costs to taxpayers, or both.

In terms of the drug benefit: we could give seniors a lower deductible and fill in the gap; we could remove the gimmicky definition of what counts toward reaching the catastrophic limit so that employers wouldn't drop their retiree drug coverage; we could remove the assets test; We could allow the Medicare Program to pay to the cost-sharing of our low-income seniors.

What would allowing Medicare to use its purchasing power do to the pharmaceutical industry?

Some would have us believe that only the proposal we are discussing today would allow the industry to thrive and continue to develop life-savings drugs.

But in June 1999, reaching to the prospect of a Medicare prescription drug benefit, Merrill Lynch advised investors that

> volume increases could overwhelm negative pricing impact. It is important to remember that a reduction in prescription drug prices, both with or without associated prescription benefit coverage, is likely to be associated with price elasticity and increased utilization.

The proposal before us fractures the Medicare market. One of the great strengths of the Medicare Program has been its universality. Seniors from Anchorage to Key West knew they would get the same benefits for the same premium.

The proposal before us also uses scarce Federal dollars in an attempt to force private insurers into a line of business they have repeatedly said they do not want to enter.

Instead, we should be using the purchasing power of the nearly 41 million Medicare beneficiaries waiting for a drug benefit to drive down prices—for their benefit, and for the taxpayers benefit.

I ask unanimous consent to print an editorial at the conclusion of my remarks.

The PRESIDENT OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. GRAHAM. I'd like to quote from the November 21st Miami Herald, which editorialized as follows:

> The problem: Instead of using the free market to drive down the costs of prescription drugs, the bill would protect pharmaceutical companies from competition and pay more than $100 billion in incentives to employers and insurers in an attempt to make its flawed logic work. The bill also threatens to cap future Medicare spending.
>
> True, the measure promises prescription-drug coverage for low-income seniors not already covered by Medicaid and would benefit seniors with extremely high prescription costs. But its coverage for middle-class seniors is modest at best.
>
> That's just not enough benefit for a 10-year price tag of $400 billion that will add to the skyrocketing Federal deficit, especially when it doesn't even contain the cost of prescription drugs.
>
> A better, more logical approach would be to harness the buying power of the 40 million Medicare seniors to drive down drug costs. But this bill actually would prohibit the government from doing so. Instead it would dissect the country into 10 regions and pay incentives to companies—$12 billion to private insurers and $1.6 billion to HMOs—so they'll offer prescription-drug coverage.

For the Record, I'd like to make one correction in the otherwise excellent editorial. Under the latest version of the bill, between 10 and 50 regions would be allowed—further dissecting the country.

The last drug benefit endorsed by the AARP was the Medicare Catastrophic Coverage Act. We all know how seniors felt about that drug benefit, and it was quickly repealed.

If we adopt the proposal before us, we will be turning a deaf ear to history, and to the seniors across the country today who are already telling us—through AARP card burnings, through the messages they are writing on the AARP "message board", and through the hundreds and hundreds of calls from seniors we've been receiving over the last week—that we need to get back to work.

This drug "benefit" is actually no such thing. It leaves millions of seniors worse off.

Along with many others, I have worked to provide an affordable, comprehensive, reliable prescription drug benefit for our seniors and citizens with disabilities for the last several years.

It is therefore with great regret that I have no choice but to vote against a conference report that does not provide the benefit seniors need, and have been promised.

If the proposal is adopted—and I sincerely hope it is not—it will not be the last chapter. Seniors won't stand for it.

I predict voters will put Congress on the hook in 2006, and we will spend many, many years attempting to fix this deeply flawed legislation—or will repeal it outright as we did with the catastrophic legislation.

Or we could have the worst of both worlds.

We could repeal the prescription drug benefit because the benefits are too meager, its subsidies of health maintenance organizations are too great, and its delivery system too confusing and disrespectful.

And what would be the price of repealing the drug benefit?

We would leave the privatization of Medicare in place and destroy one of the Federal Governments most effective, efficient and popular programs: traditional fee-for-service Medicare.

In the event the legislation before us does become law, I plan to use my last year in Congress working to fix it. Our seniors need better from us.

EXHIBIT 1

[From the Miami Herald, Nov. 21, 2003]

WHEN HALF A LOAF ISN'T NEARLY ENOUGH

OUR OPINION: REJECT THE FLAWED MEDICARE PRESCRIPTION BILL

With its $7 million ad campaign to win support for the Medicare prescription-drug bill, AARP says that the legislation "isn't perfect. But millions of Americans can't afford to wait for perfect." We agree with AARP's assessment of the bill but not its conclusion.

The proposed bill is badly flawed. It delivers too few benefits to seniors at too big a cost. Americans don't need perfect, but for $400 billion they deserve a bill that helps more people and drives down the high costs of prescription drugs. The proposed bill does little of either. Congress should reject it and try again.

The problem: Instead of using the free market to drive down the costs of prescription drugs, the bill would protect pharmaceutical companies from competition and pay more than $100 billion in incentives to employers and insurers in an attempt to make its flawed logic work. The bill also threatens to cap future Medicare spending.

True, the measure promises prescription-drug coverage for low-income seniors not already covered by Medicaid and would benefit seniors with extremely high prescription costs. But its coverage for middle-class seniors is modest at best. That's just not enough for a 10-year price tag of $400 billion that will add to the skyrocketing federal deficit, especially when it doesn't even contain the cost of prescription drugs.

Don't repeat the past

A better, more logical approach would be to harness the buying power of the 40 million Medicare seniors to drive down drug costs. But this bill actually would prohibit the government from doing so. Instead it would dissect the country into 10 regions and pay incentives to companies—$12 billion to private insurers and $1.6 billion to HMOs—so they'll offer prescription-drug coverage.

We've tried such incentives before with HMOs, and experience shows that they didn't work. Half of the Medicare Plus Choice plans provided by HMOs have folded, even though taxpayers still pay more to subsidize a senior in a Medicare HMO than a senior in traditional Medicare.

The compromise measure also guts provisions that would have allowed seniors to legally buy prescription-drugs from Canada, another concession to pharmaceutical companies, some of which now are retaliating against Canadian wholesalers who sell to Americans.

The doughnut hole

The standard coverage that the bill offers would only benefit a senior who spends more than $835 a year, or some $70 a month, on drugs. Then there's the "hole in the doughnut" coverage gap in which the government's 75-percent subsidy stops after $2,200 in out-of-pocket cash has been spent. If out-of-pocket spending reaches $3,600, the subsidy kicks in again, this time at 95 percent of drug cost. Deductibles and co-payments are complicated enough without trying to explain the "hole in the doughnut" to elderly recipients.

AARP and other supporters say that even a flawed benefit is better than nothing. They reason that once passed, bad provisions could be changed before they go into effect. But why fix later what should be fixed now?

Seniors deserve affordable prescription-drug coverage. Congress should scrap this flawed approach and come up with a plan that delivers that coverage while driving costs down.

The PRESIDING OFFICER. The Senator from South Dakota.

Mr. JOHNSON. Madam President, I ask unanimous consent to speak for 5 minutes as in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

HAPPY 90TH BIRTHDAY, DAD

Mr. JOHNSON. Madam President, today my father, Van Johnson, is celebrating his 90th birthday. He is joined by my mother Ruth, my brother and sister and their spouses, dad's sister Ardis, and a great many wonderful friends. I had long planned to be there to join in this celebration, but the Senate failed to adjourn on time, and now is staying in session through the weekend and into next week in an effort to conclude legislative business which should have been completed months ago.

The good people of South Dakota honored me by electing me to represent their interests and values in the Senate, and I simply cannot neglect those duties by leaving Washington today.

While I cannot be with dad on this very special day in his life, I rise to express my long appreciation for a father who has always been there for me. Dad taught me about the importance of family, of fatherhood, of faith, and of personal integrity. He taught me about the importance of public service—that life is more than about the collection of things, and that helping make the world a better place is, indeed, a central purpose to our lives.

Dad was there for me, whether it involved the countless family camping trips, athletic events, school work, or church activities—all at a time when he was intensely busy with his own career as a highly regarded teacher, coach, professor, and university administrator. He and mom were and are a great team, and my brother Tom and my sister Julie and I have benefited all our lives from their loving guidance and care.

As a father of three children, and now a new grandfather myself, I continue to draw from the values imparted to me from my father and find with each passing year how profoundly important they are.

But dad, although an educator all his adult life, did not teach exclusively in a pedagogical manner. Many of the greatest things I learned from dad came from observing his example—his commitment to our family, his love for mom, his dedication to professional excellence, and his willingness to assume leadership roles in the church and in our community.

Dad, it deeply disappoints me that I cannot be with you today, but know that I am with you in thought and spirit. Happy 90th birthday, dad.

I yield the floor.

Mr. REID. Madam President, Senator NICKLES is in the building. I do not know if he is going to speak.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. NICKLES. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. NICKLES. Madam President, I rise to speak on the Medicare bill that is before us. First, I compliment a couple colleagues with whom I have had the pleasure of working on this bill, particularly in the conference committee. First would certainly be Senator GRASSLEY who, in leading the Senate conferees, I think did an outstanding job. I also would echo that for the majority leader. The majority leader seldom gets involved in a conference. This majority leader, Dr. BILL FRIST, has an interest in Medicare and he was a very influential member of the conference. In addition, Senator KYL, Senator HATCH, Senator BAUCUS, and Senator BREAUX and, I would also include, Chairman THOMAS.

This was a very challenging conference between the House and the Senate. The bill that was reported out of the Senate—I did not vote for it. I thought it was very heavy on expense and very light on reforms. I did not really think it was a sustainable bill, one that we or our children could afford. So I worked very diligently, I guess, or very aggressively, trying to come up with a conference report that would meet the test, that would provide better benefits at a sustainable level.

I think the present Medicare system has crummy benefits. It does not cover a lot of things that should be covered. It is so far behind the times, I really did want to modernize it. I also wanted to add the new benefits in a way that would be affordable and sustainable.

Under the present situation in Medicare, just to give people a little thumbnail sketch—and this is without providing any new benefits—the total debt held by the public is $3.6 trillion. Social Security unfunded liabilities is about $4.6 trillion. Medicare is almost three times as much. It is $13.3 trillion, and that is without adding a new benefit, which most people would estimate to be $6 trillion or $7 trillion. So my colleagues can see we have an enormous challenge before us.

Then just look at Medicare today. There is a lot more money going out than coming in. Medicare is primarily financed by two things. One is payroll taxes; 2.9 percent of all payroll, not capped at the same amount that Social Security is up to the 80,000-something dollars. It is 2.9 percent of all payroll. That is the money going in. It is also financed by general revenue. We subsidize Part B.

If it is added all together and we take out the intergovernmental transfers, Medicare had net deficits last year—in 2002—of almost $70 billion. It gets a lot worse—by 2012 the deficit will be above $150 billion. That is present law. That is without adding a new benefit. So Medicare is in very difficult fiscal waters, a lot more challenging than even Social Security, a lot more challenging than any other program because demographically there are a lot of people who are living longer, health care expenses are exploding, and there are fewer people paying the payroll tax. So it is going to take a greater share of general revenue, money from taxpayers to pay for these obligations.

So I thought, let's provide better benefits. What do I mean by that? Medicare does not provide drug benefits. Everyone knows that. Medicare also has unaffordable deductibles. It has a deductible for the hospital of $840. I compare this to what the private sector offers. If a person buys Blue Cross or Aetna, any of the private plans, they do not have an $840 deductible to pay if they go in the hospital for one day, but Medicare does. All private plans certainly should—I think most do—have catastrophic. Medicare does not have catastrophic.

If a person is really in trouble, if they are in the hospital more than 150 days, it is all on them; they do not get any help from Medicare. I think that is pathetic. That is not a very good benefit. As a matter of fact, if someone is in the hospital more than 60 days, they have to pay $210 a day. If they are in the hospital more than 90 days, they have to pay $420 a day. So if someone is really sick, if they are really in trouble, look out, Medicare does not come through. So it is a program that has, frankly, not been modernized since its creation in 1965.

Medicare does not do enough for preventive care. It does not offer prescription drugs. It does not have catastrophic. Its deductibles are way too high for hospitalization. So I think it needs significant improvement.

I want to pass a Medicare bill that will help solve all of these problems. I want to pass a bill that will provide drug benefits. I think we are way behind the times. We should be doing it. I also want to be cognizant of the fact that Medicare is in real financial trouble, that it is not sustainable in its present form. I do not want to be adding new benefits that will just accelerate the day where it collapses, where it is not sustainable, where our kids are going to be saying: What about this tax?

Some people say: Well, this is not a tax. And that is correct, we are not creating a direct tax to pay for the new benefits, but what we are doing is incurring enormous debt to pay for benefits. Frankly, our kids are either going to be paying for that in the form of taxation tomorrow or they are going to be paying for it in an increased interest rate because debts will increase substantially under this bill.

The budget resolution we passed last year said we should strengthen and enhance Medicare. That means make it more solvent, more sustainable, more affordable. Unfortunately, I am not sure we did that under this bill. In fact, we focused too many resources in this bill to cover the covered and not improve Medicare.

What do I mean by that? If we look at this chart, we find out that 76 percent of seniors now have prescription drug coverage, but we are going to spend billions, almost $100 billion, to provide assistance to those people who already have drug coverage. For employer-sponsored plans, for example, we are going to spend $89 billion to subsidize employers so they can continue providing health care benefits, drug benefits, for their employees. We are going to bribe them to keep covering the people they have already contractually obligated to cover. This is a big bailout, in my opinion, for employer plans, union plans. It is way too high of a subsidy. I know AARP wanted these subsidies and in fact wanted more money.

Now, some people were criticizing Senator BAUCUS. Mr. Hunt in the Wall Street Journal criticized him as a negotiator. I take issue with that. He was a very successful negotiator because in the last several days of negotiating the bill—we spent months negotiating—Senator BAUCUS was a very effective negotiator. He kept winning. I kept losing. We were on opposite sides in many battles. I complimented him. I said: You just keep winning.

He got more money for the employer and union subsidy, another $18 billion in the last few days to cover the covered. It went from $71 billion to $89 billion by making it tax free. He also got an additional $18.5 billion for low-income subsidies and more benefits. That makes the bill more expensive and I think will make utilization go way up. So I compliment Senator BAUCUS for his negotiations, but I also think it makes the bill less sustainable or less affordable for future generations.

So we spend a lot of money to take care of employer sponsored. I also have issues with covering the covered in the Medicaid program. We have low-income subsidies in this bill not just for those who are higher incomes than Medicaid but for the Medicaid population that is dually eligible. We have subsidies in this bill for low-income to the tune of $190-some billion. These are subsidies for seniors which many of whom already had drug coverage. So what is the total package? Everybody says this package is a $395 billion package. In reality it is much more than that. In reality, this bill is closer to $800 billion. It nets out about $400 billion. It is $800 billion because we have $507 billion in drug benefits, but we also have low-income subsidies of $192 billion, and we have employer subsidies of $89 billion. If you add that up, it is almost $800 billion of checks that are going to be written. The Federal Government is going to be writing those checks.

The Federal Government will be receiving money back in the form of premiums from seniors, $131 billion, and a reach-back or call-back from the States. Since we are assuming Medicaid, which in my opinion is a serious mistake, one that was opposed by the administration and certainly opposed by this Senator, but we were not successful. It was not the Senate position to assume federalization of Medicaid. Medicaid is a Federal-State program. It is now an all-Federal program when this bill becomes law. Again, we are covering the covered. We are going to subsidize Medicaid to the tune of $190-some billion in this bill. That is a lot.

We recoup some of the money we were paying. Now it is all Medicare, so the offset will say we will spend less in Medicaid because we are not going to do that. In the future we will make it all Medicare. The net is—we will spend $800 billion, recoup $400 billion—so the net cost to future generations is about $400 billion. Yes, that meets the so-called budget restraint we put in, in this year's budget. But we didn't finance that, we don't pay for it, so we have benefits, frankly, that are certainly overpromised and underfunded. They are not funded. The $400 billion is not funded. That is just additional debt.

I happen to think it will be a lot more than that. I happen to think once you end up paying some benefits you will find that utilization will skyrocket. This is just what CBO has told us. People without drug coverage in this age category spend about $732 on their drugs per year. If they have drug coverage, they spend about double that, $1,337.

I think this figure will skyrocket. I asked my mother: Do you have drug coverage? She said yes. She buys it with AARP. She pays $140 or $160 a month for drug coverage. I said: How much is your drug coverage?

It is 50 percent of whatever she spends up to $1,000. She gets $500 in drug benefits from AARP. She pays almost $1,000 for that $500. Maybe there are some other benefits in there I am not aware of. My point is, a lot of people have drug coverage, but they only have a little drug coverage. The reason I say this bill may not be sustainable or affordable is because 36 percent of all Medicare seniors are going to get an enormous benefit and they pay almost nothing. They will have only $1 and $3 copays, or $2 and $5 copays; in most cases they will have no premiums, deductibles or gap in coverage.

I have heard some colleagues say we should be doing that for everybody. Let me just give you an example of who is pushing that proposition. I saw that AARP ran an ad today and is asked: Why should you vote for this bill? They had three or four reasons. If you have income less than 100 percent of the federal poverty level—for an individual, that is $9,600; for a couple it would be $13,000, this is the best deal you have ever seen because all you have to pay is $1 if you are buying a generic, or $3 if you are buying a brand-name drug, and you have unlimited drugs—no limit, no deductible, no copay other than that $1 and $3; no premiums, and no donut hole. That is unlimited. All you have to pay is $1 to $3 and all your drugs—whether they are $5,000 or $10,000—are all covered.

It is almost the same if you have an income of less than 135 percent of poverty. That would be for individuals with $13,000 and a couple with $17,600 of income. If they have less, they have the same thing, except their copay is $2 and $5. There is no donut hole, no catastrophic, no limitation. They don't have to pay premiums, no $35 a month in premiums. They have a great benefit. They should be celebrating.

I am surprised to hear some of our colleagues on the other side say they can't support this bill because it is not a very good deal. If they are so-called champions of the poor, this is the most generous federalization of a government benefit in U.S. history. Maybe they are ignoring the low-income subsidies. It is not insignificant—$192 billion according to CBO. I think it is so much more than that. I think when people find out their only copay is $1 or $3 or even $2 and $5, utilization will skyrocket. This chart will be so inaccurate.

We will find out if we have underestimated the impact of providing a federal benefit upwards of a 90 percent subsidy. In a few years we will find out. People who don't have to pay much—in other words, if the Government is paying 90-some-odd percent of it, 95 or 97 percent, which would be the case in many of these income categories, utilization will skyrocket. At least that is my opinion. Maybe I am wrong. We will find out. I am making this statement for the record because I think this benefit is going to cost a lot more than people estimate. I think utilization will skyrocket.

For individuals who have incomes less than $14,500, or as a couple, $19,500, between that 135 percent and 150 percent of poverty, their copay is 15 percent. The Government is going to pay 85 percent. Again—no donut hole. They will have a reduced sliding scale premium and a reduced deductible of $50. This too is an enormous benefit that will skyrocket.

People who have incomes above 150 percent of poverty, they have a copay of 25 percent. Then you are getting into the area where it is not quite as good as what they had in the private sector. So my point is, for low income, for that 36 percent of Medicare seniors, for about 14 million seniors, this is one great package. My guess is, it will explode in cost.

Another reason I think it will explode in cost is because a lot of our colleagues will say whatever we pass, that is just the beginning. I think Senator KENNEDY alluded to that when this passed the Senate: This is a beginning and he wants to expand upon it. I believe that is what AARP says: We will take this and expand upon it.

How do you expand upon it? Well, let's just fill the donut hole. In other words, the basic benefit after you get past the low-income subsidies, the basic again goes up to $2,250. Then above that amount you have to basically self-insure or in other words you pay the next couple of thousand dollars on your own before the Federal Government catastrophic kicks in.

A lot of people would say: Let's just fill that donut hole up. We don't have that donut hole in the private sector, we should not have it in this. If you fill that up, in other words, if Government expands its liability, the cost of this program goes up by the hundreds of billions of dollars—hundreds of billions of dollars. In fact, one does not have to predict that this will happen, it actually already did. The Conference Committee negotiated an initial benefit level of $2,200. This was an agreement. Tuesday night, armed with a CBO score that was under $400 billion the negotiators closed the donut by $50. This cost $4 billion. I have no doubt in my mind that once this passes, future Congresses will be working to fill that donut hole, and my guess is they will be successful. My guess is they will be successful in increasing the number of people eligible for these enormous low-income subsidies. It doesn't have to be 150 percent. As a matter of fact, the Senate bill passed at 160 percent of poverty. So I am sure there will be amendments year by year to increase that level up for the super government benefit. Let's make that eligible up to $30,000 or $40,000 so that will be happening.

I also think areas in which there are significant savings in the bill—and I was involved in this—the reach-back, where we try to recapture a portion of the savings going to States we will see slowly undone. My guess after this becomes law, States will be lobbying us extensively: You are taking too much back. We want that reduced. In fact the reach-back provision was reduced just this past week at a cost to the taxpayers of $4 billion.

I am afraid in many cases States will continue to be successful. So that cost will explode. As a matter of fact, I will make a prediction. Within a few years, the donut hole will be eliminated, the reach-back by States will be reduced dramatically, and the expansion of low-income definition will be enlarged tremendously, so the cost of this bill will more than double, more than double. That is just my guesstimate. I may not be in the Senate when that happens, but my guess is it will happen.

What is my other complaint about the bill? Its explosive nature in cost. I knew it would cost a lot. I knew it would explode. One of the things I really wanted to do was come up with some reforms that would help make this program more sustainable, more affordable for the future.

Presently, we have a system that is bifurcated. We have Medicare hospitalization. That is called Part A. It has Part B for doctors. It will now have a new part D for prescription drugs. The benefits are not integrated.

A lot of people also buy Medigap. Under present law they buy A and B and they buy Medigap. So it is not a very good integrated system, unlike the private sector. The private sector offers the benefits that I said that Medicare lacks. I wanted to have an integrated private-sector alternative to the present Medicare system, one that people could look at and say: Wait a minute, this works better. I think I would rather be in the everyday private sector type system, the same one Federal employees have, the same one private sector employees have.

They have better plans. They have a better package. It is more modern. It is not tied to a government-controlled fee-for-service system that does not work. Do you want the private sector to become a 1965 Medicare fee for service model? This bill is spending billions and billions of dollars to make adjustments for doctors and hospitals and providers because government is underfunding them? That is not the private market and we should not tie them to Medicare's price controls.

Senator GRASSLEY has been a champion for increasing assistance to rural areas, and he is exactly right. The present system hasn't worked very well. I wanted to come up with a more modern system with integrated benefits that integrates Part A, Part B, and Part D—hospitals, doctors, and prescription drugs—and avoid the necessity of a Medigap plan. People had to have Medigap because Medicare alone didn't pay for a lot of benefits, and it had too high of a deductible. People had to buy Medigap. They shouldn't have to do that. I was hoping we could come up with a good, reasonable integrated system. I am afraid that maybe we haven't quite attained that. I am afraid our reforms are really not adequate for the explosiveness of the benefits we are looking at today.

Let me touch on the integrated benefit. I have heard some people say this is a ripoff because we are giving money to insurance companies; that it should be done by the Government. I have already mentioned that Government doesn't do a very good job in providing the benefits today. Now we are trying to have the private sector come in after Part D, the private sector for a prescription drug package. Nobody in the real market right now offers to Medicare beneficiaries or for that matter anyone a stand-alone drug benefit. We hope and pray they will in the future. But if they do, they will have to basically offer exactly what we told them to offer, and that is the benefit structure of 75–25 up to $2,250. We are limiting the private sector to only offering a government-designed benefit.

There is this big donut hole in the government standard benefit and we have a governmental catastrophic, some call it Government reinsurance—which ties the hands of the private sector and denies seniors the best the private sector has to offer. For example, After you spend $3,600 of your own money, then Government reinsurance will kick in, and individual beneficiary will be liable for 5 percent. The Government is responsible for 80 percent of all costs above the $3,600 "true out of pocket", the health plan is covering 15 percent and the individual 5%. The private sector is not able to assume full risk and offer the benefits they want. If the private health plans did offer increased benefits they would lose or delay government subsidies. This is crazy. All they are able to offer is basically the basic benefit up to the $2,250, or the actuarial equivalent, but they are not able to offer both. They are not able to say they will take all of Part D—that they will assume all of Part D and combine it with Part A and Part B and use efficiencies between the system having an integrated benefit and maybe doing something better in hospitalization and doctors, have some savings and offer a more generous drug benefit. They are not able to do that because under this bill, they are required to maintain this true out-of-pocket cost. This bill puts the private plans in straight jacket.

I think that is very unfortunate. It really kind of locks in an inflexible structure. We are telling the private sector, which have extensive experience in offering comprehensive benefits for all types of individuals including public and private sector employee and individuals, that they have to sell a government benefit. They can not offer a plan with prescription drugs for our seniors without having a donut hole. We are mandating that they have that before they can get into catastrophic. I find that to be very unfortunate and very shortsighted and maybe even unworkable. It doesn't really transcend the movement to private sector. It doesn't trust the private sector. By doing that, I am afraid we have put in a rigidity that won't allow it to work as we would like for it to.

We did not get cost containment. We tried. Maybe I should say we have minor cost containment. We did put in a provision that says if general revenue contributions exceed 45 percent, the President shall come up with a plan to fix it, and Congress has some procedures. Nothing mandates Congress do it. We tell the President he should. That is years away. I find that to be a little hollow. I wanted real cost containment. It was opposed by many—particularly on the Democrat side—and we weren't successful in getting that in. That is unfortunate.

There are several provisions in this bill that are good. I want to compliment again Senator GRASSLEY and Chairman THOMAS. We did get health savings accounts. It is not directly related to Medicare, but I think it would help reform health care as we know it. People would actually be spending their own money. I think that is a very positive and a good significant change, and it will change people's behavior. That is about $6 billion or $7 billion. That is very positive. I compliment Senator GRASSLEY and Chairman THOMAS especially for putting that in.

We did put in income-relating Part B premiums. Senator FEINSTEIN and I worked on that amendment on the Senate floor. We included a lot of that in the bill, not exactly as we put it in the bill on the Senate floor, but I think that is a positive change. But to my regret, it puts more money in the bill, and basically we spent that money.

We did get income-related Part B. Basically, that means we are going to have less subsidies for higher income people. Part B has always been paid for. When it was created, it was 50 percent for individuals. Over the years that has been declining. Now the individual only pays 25 percent, and the Federal Government pays 75 percent.

What we said is if you have income above $80,000 up to $100,000, eventually you have to pay 35 percent. If you have individual income above $100,000, eventually you have to go up to 50 percent where it used to be. If you have incomes much higher than that, you will have to pay 65 percent, or you will have to pay 80 percent. Even very wealthy people will still get a 20-percent subsidy under this provision. I think that is good reform.

We also index Part B deductibles. It has been $100 for a long time. Now we index that to the cost of the program. Those are good changes. They will help improve it. Unfortunately, the savings to the taxpayers as a result of these changes have already been spent in this bill. As a matter of fact, in the 2 or 3 days of negotiations, we amended the benefits and the subsidies in the bill by about $40 billion. Most of the good done by the income-relating of the Part B premiums and the indexing of the deductible were undone.

I have no doubt that in future Congresses that the current 75 percent up to that $2,250 subsidy will be changed and the $2,250 is going to be climbing up. I have no doubt that people will say we need the most generous subsidies and low-income subsidies which needs to apply to a lot of other people. It will increase spending dramatically.

My point is, Yes. We made some reforms, but this program may not be affordable or sustainable. Right now, it is estimated to cost $400 billion over the next 10 years. The program doesn't even start for a couple of years; that is, over the next 8 years. The Congressional Budget Office directive said that in the next 10 years they thought this program might cost up to $1.5 trillion to $1.7 trillion. That is with the benefits structure as we have outlined it today. As it expands, it will be much more than $1.7 trillion. When the donut hole is filled—and I predict it will be—when you have the number of eligibles increase dramatically to receive the low-income subsidies, when we reduce the reach-back or claw-back from States, this $1.7 billion in the next decade will probably be much more than that.

That brings me to my final comment. Can we sustain it? I am not sure. It looks to me like we are building a brand new deck on a house with a very unstable foundation. I think we are expanding this program like it is on a solid foundation, and it is not. We are not paying for these new benefits. We are saddling our future generations with enormous liability.

I conclude by saying I have the greatest respect for the chairman of the committee. I have the greatest respect for the majority leader. I want them to be successful. I want the President to be successful, and I want senior citizens to have prescription drugs. I want them to have a modern Medicare system. This bill takes some steps in those directions, but my conclusion is that the benefits greatly exceed the reforms. Without necessary reform, I am not sure this program will be sustainable in the future. So it is my intention not to support this bill.

Also, I want to compliment some people who have worked very energetically on this bill. One is my staff, Stacey Hughes, who has just worked unbelievable hours; on Senator GRASSLEY's staff, Linda Fishman and Mark Hayes, and the Senate legislative counsel. There are a lot of people who have put in more hours than you can imagine to put forth this bill. I compliment them for their efforts. They worked in a very positive way. It is a pleasure to work with them and to work with the chairman.

I yield the floor.

Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. One minute five seconds.

Mr. NICKLES. I yield that time to the Senator from Iowa.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, I certainly think the cooperation we have had from the chairman of the Budget Committee, Senator NICKLES, helped to move this bill along. Even though he has not liked some parts of the bill, he has been cooperative all the way through the process and, more importantly, through the crucial time of conference.

There is a claim that pharmacies are concerned about beneficiary access to pharmacies, pricing transparency issues, and insurance risk.

I understand the concerns of pharmacists with regard to local access. This bill provides several provisions to ensure that Medicare beneficiaries are provided with adequate choice and easy accessibility to local pharmacies.

First, the conference report provides choice to beneficiaries by containing an "any willing provider" provision. This provision requires prescription drug plans to accept any and all pharmacies willing to agree to the terms and conditions of the plan. By adding this provision, we have given all pharmacies, big and small, the chance to participate in the modernization of Medicare.

Second, the conference report provides beneficiaries with convenient access to pharmacies by adopting the TRICARE standard for prescription drug plans. In urban areas, 90 percent of beneficiaries would have a pharmacy within two miles of their residence; 90 percent of beneficiaries in suburban areas would have access to a pharmacy within five miles of their home; In rural areas, plans would be required to provide 70 percent of beneficiaries with a pharmacy 15 miles within their residence.

By adopting this standard, beneficiaries are ensured adequate convenient access to pharmacies of their choice.

The conference report also requires that plans permit beneficiaries the ability to fill their prescriptions at a community pharmacy rather than through the mail. Again, ensuring access to local pharmacies.

In addition to providing convenient, local access to pharmacies, the conference report provides safeguards to ensure fair drug pricing and protects pharmacies from insurance risk.

Under the report, pharmacy benefit manager's, PBMs, would be required to disclose all discounts, rebates, and charge backs given to them by drug manufacturers. This places local pharmacies on a fair playing field with PBMs.

The report also prevents insurance risk to pharmacies by clarifying that pharmacies could not accept insurance risk.

This conference report adequately addresses the concerns of pharmacies and pharmacists alike. It makes sure that beneficiaries have local and convenient access to pharmacies, provides transparency pricing, and protects pharmacies from insurance risk.

REVISIONS TO H. CON. RES. 95

Mr. NICKLES. Mr. President, section 401 of H. Con. Res. 95, the budget resolution, permits the chairman of the Senate Budget Committee to make adjustments to the allocation of budget authority and outlays to the Senate Committee on Finance, provided certain conditions are met pursuant to section 401.

I hereby submit the following revisions to H. Con. Res. 95, and I ask unanimous consent to have it printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

	($ in millions)
Current Allocation to Senate Finance Committee:	
FY 2004 Budget Authority	771,171
FY 2004 Outlays	773,820
FY 2004–2008 Budget Authority	4,618,622
FY 2004–2008 Outlays	4,627,988
FY 2004–2013 Budget Authority	10,991,722
FY 2004–2013 Outlays	11,007,116
Adjustments:	
FY 2004 Budget Authority	4,800
FY 2004 Outlays	3,800
FY 2004–2008 Budget Authority	11,725
FY 2004–2008 Outlays	11,576
FY 2004–2013 Budget Authority	−5,000
FY 2004–2013 Outlays	−5,200
Revised Allocation to Senate Finance Committee:	
FY 2004 Budget Authority	775,971
FY 2004 Outlays	777,620
FY 2004–2008 Budget Authority	4,630,347
FY 2004–2008 Outlays	4,639,564
FY 2004–2013 Budget Authority	10,986,722
FY 2004–2013 Outlays	11,001,916

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Parliamentary inquiry. This, of course, has nothing to do with the legislation. It is my understanding the action of the distinguished chairman of the Budget Committee would not be in derogation of the consent order before the Senate for debate today.

The PRESIDING OFFICER. The Chair's understanding is that changes in the allocation being submitted by the Senator are just being printed in the RECORD.

The Senator from Massachusetts is recognized.

Mr. KERRY. Mr. President, I believe we ought to reject this Medicare bill. When I look at it carefully—which has been hard because there has not been a lot of time—it is clear it is a cruel hoax for seniors and a cynical giveaway to drug companies and to the insurance industry. Even as we speak, there are lobbyists scurrying around Capitol Hill working feverishly to pass a bill that has already driven up the stock of those corporations I have mentioned, the insurance industry and drug companies across the country. The rise in that stock tells the story about the windfall profits that come with this bill.

With the help of President Bush, they produced a Medicare bill that lines the pockets of the powerful moneyed interests and it leaves America's seniors out in the cold. This bill is less about prescription drug benefits and more about a prescription to benefit large drug companies. America's seniors deserve better.

As I have traveled around the country and heard from countless numbers of seniors about their health care needs, they repeat again and again how they need and they want more affordable prescription drugs. "More affordable" are key words when measured against this bill. They need and want a quality Medicare plan—I emphasize Medicare plan—that lets seniors choose their own doctors, their own hospitals, and provides prescription drug coverage.

I have met seniors across the country who have cut their medication, they have cut the dosage in half, because they cannot afford their prescription drugs. I met a woman the other day who could not even afford to start her prescription drugs because the initial bill was $100 and she did not have the cash. I met people in small businesses who have seen their health care premiums more than double because drug prices are rising so fast. And I met seniors in New Hampshire and elsewhere who have no idea how they are going to possibly pay their rent and cover the prescription drugs they need.

When we break past the advertising bought and paid for by the special interests to sell this bill as something it is not, we will notice that America's seniors are outraged by what they have seen already about this legislation. I was at a forum the other day sponsored by AARP, and when it was mentioned what was happening in the bill, seniors booed their own leadership in the AARP. It is no wonder AARP members are tearing up or burning their cards.

For Senators who are planning to vote for this bill, I ask a very straightforward question: How are you going to explain to seniors that Congress stuck them with a Medicare plan that forces those seniors into HMOs? How are you going to explain to seniors that this plan will stick them with a raw deal that raises premiums for those who do not want to go into an HMO by $56 to $200 a month? What do you say to the 2 or 3 million seniors who are actually going to lose quality retiree prescription drug coverage under this bill and they are going to get something much worse?

We have to, in future years, add a real prescription drug benefit to Medicare in order to make seniors' lives better. By now accepting a phony drug benefit, Congress literally risks making it worse for those seniors.

How do you explain to seniors that Congress was not willing to let them buy cheaper prescription drugs from Canada, but Congress was willing to hand the pharmaceutical companies new windfall profits of more than $139 billion?

How are you going to explain this bill could only be passed in the House under the cloak of darkness in the early morning hours, and only then by stretching the rules of the House beyond almost anything in history? And that the Senate then jammed through a 700-page bill with only 3 days of debate, giving seniors very little chance to understand what is involved in the biggest and most dangerous change ever made to Medicare?

I ask those Senators who are planning to support this bill why they think it is worthy to hold a prescription drug benefit hostage to a backdoor deal to privatize Medicare, a deal that will help lobbyists, help powerful Washington interests and other interests around the country and help pharmaceutical companies but will literally make the lives of a lot of our seniors worse off than they are today?

Seniors need relief from inflated prescription drug prices, and they need it now. Nearly 40 percent of Medicare beneficiaries report having no prescription drug coverage. Yet the average amount they have to pay out of their own pocket for prescription drugs is going to more than double between the years 2000 and 2006. It is on track to be $1,400 the year this bill is scheduled to go into effect. If you deduct the amount of money given by this bill from the amount seniors will be paying on average out of pocket, the benefit to most seniors in this country for being pushed into an HMO will not be worth the cost.

Congress ought to be demanding more. We ought to be demanding a real deal for seniors, a Medicare bill that does what it says instead of this phony bait-and-switch legislation. We ought to go back to the drawing board and pass a real Medicare prescription drug benefit. This bill does more harm than it does good. Seniors are not guaranteed that the price of their plan is not going to skyrocket. This bill prohibits the Government from even negotiating discounts for Medicare prescription drugs. It prohibits the Government from doing that. It denies the opportunity for seniors to import reasonable drugs from Canada and other industrialized countries. How extraordinary that the acolytes of free trade are closing down the ability of Americans to exercise free trade and import a product from another country at a lower price.

This bill is really about President Bush passing the buck on prescription drug coverage and passing the bucks from seniors to the pharmaceutical industry. And this bill is being pushed through Congress without adequate debate and exposure to the public light, with too many backroom deals, and with blatant contempt for the public interest.

The Republicans could not win a legitimate victory in the House, so they held the vote open for an unprecedented 3 hours of special interest lobbying, of almost $900 million of giveaways in exchange for votes, so they could get enough people to switch over to their side.

President Bush twisted arms, twisted facts, until he finally managed to get the vote. Time and again, the President chooses to get cozy with the lobbyists. We saw it on the Energy bill. We have read it in the newspapers in the last weeks about who gained and who lost on any particular debate each day in the debate over this bill. This administration's motto ought to be: Leave no special interest behind. This Medicare bill lays that record bare for all Americans to see.

The President goes around the country at a furious pace, fundraising at record levels. He has a group of insiders who provide his campaign with a minimum of $100,000 of campaign cash. They have a name. They are called "rangers" and "pioneers." Well, it should come as no surprise to Americans, and particularly to seniors, that 24 "rangers" and "pioneers" are executives or lobbyists for the very companies that will benefit from this Medicare bill, and they are getting a good return on their money.

This bill makes it easier for the big drug companies to gouge seniors and jack up health care costs so that top executives can walk away with millions. I am all for people who work hard to make a living, and I want people to be able to get rich in America. But when the drug companies' CEOs are making $40 million a year while the seniors they sell to are choosing between their medicine and their mortgage, I do not consider that just plain old free enterprise; I consider that plain old greed.

This bill smoothes the way for even higher drug company profits. In the past 6 months, drug companies, HMOs, and other powerful industries have spent $139 million in lobbying Congress to give them what they want. Now they have gotten a bill that will give them an estimated $139 billion over the next 8 years. A thousandfold return on an investment is not bad. You can say what you want about President Bush, but it is clear that his powerful campaign contributors got what they paid for. And it is easy to see why they make so much profit, given this bill, which does nothing to control the rising prices of prescription drugs, nothing to control the rising prices.

Without an effective means to restrain double-digit price increases, this bill does nothing to protect seniors from ever-growing out-of-pocket costs. Someone needs to explain why we are in such a rush to do this. Is someone concerned that the more this cynical bill is exposed, the less likely seniors will be to accept it? What harm would be done if the Nation took some time to look carefully at what is in this bill?

This plan does not kick in until 2006 anyway. So it is not as if seniors are going to get the relief they deserve at the stroke of a Presidential signing ceremony—no indeed. For the next 2 years, seniors are going to get a discount drug card to give them a 15-percent discount. Well, it does not take an act of Congress to do that. Ask any senior today, and he or she will show you about three or five cards they already carry in their wallets to get a discount on drugs.

Seniors deserve and expect more than a discount card with $400 billion on the table. If we were really crafting a drug benefit and allowing the Government to institute cost-saving measures in order to tame out-of-control prices, we could deliver a benefit sooner than 2006. The Government ought to be ready to do this within a matter of months.

The entire Medicare plan was set up in 11 months. Now that it is already set up, in the age of computers, are we saying we could not deliver a prescription drug benefit in a matter of months?

Why are we waiting until 2006? I will tell you why. It is for the private, for-profit companies that need to lure people into the market. And it is going to take them time to warm up to the plan. We are waiting for 2006 for those companies.

This bill sets aside a $12 billion slush fund for the Secretary of Health and Human Services to entice private HMO-style plans to come into the market in order to offer prescription drug plans to seniors. Larded up financial inducements are needed to attract these plans to the market because the risk is so high.

Insuring seniors for drugs usually makes about as much sense as trying to sell a homeowner's policy to someone whose house is burning down. In other words, you are going to lose money. But in the name of "private competition," and to prevent the Federal Government from running this program, this is what they came up with: a great big cookie jar from which to dole out public dollars to private companies to get them to do what we could do less expensively and at less cost to seniors.

On top of giving them extra payments to participate, the bill does nothing to require that private plans actually operate efficiently. The Medicare Program, in its entirety, now spends only 2 percent of total expenditures on administration. By contrast, many health plans in the private market often commit as much as 15 to 20 percent of their expenditures to administration. So every dollar that goes to administrative costs is a dollar not available to improve benefits for Medicare beneficiaries.

I think smart stewards of taxpayer dollars ought to demand that private plans be more efficient if they want to participate. Instead, they are being rewarded from the slush fund and given advantages that only their lobbying influence could get written into law.

In addition, this bill squanders another $6 billion on tax breaks for wealthy Americans that is going to harm Medicare. The legislation would create a tax-free, high-deductible catastrophic health policy known as health savings accounts. That account will undermine the traditional Medicare Program because it will result in cherry-picking. The healthiest and the wealthiest seniors will come out of the risk pool where they share the risk of coverage, and that will result in raising the premiums for everyone else—for the poorer and the sicker—and it will raise those premiums by as much as 60 percent.

The so-called cost containment provisions in the bill add insult to injury by essentially placing a cap on Medicare spending. This bill would attempt to force future Congresses to reconcile Medicare spending growth by cutting benefits, raising premiums, or increasing the payroll tax. I believe that is unacceptable.

So what do America's seniors get from this bill?

More than 2 million seniors who have good drug coverage now, through retiree health plans, are going to lose it. About 6½ million low-income seniors—the very people we need to help the most—could get less drug coverage than they have now. That is a raw deal for seniors.

Under this bill, 7 million seniors will be given this choice: Pay more for Medicare and get forced into an HMO, give up on choosing your own doctor and hospital, or watch your bills skyrocket. That is the choice for seniors.

The name of this provision in the bill is called premium support, but like Clear Skies, which means dirtier air, or Healthy Forests, which means cutting down the trees, it is an innocent-sounding name for a plan that could raise Medicare premiums from about $60 to thousands of dollars. It breaks the compact of Medicare.

In fact, what it really means is the beginning of the end of Medicare as we know it. Those are not my words, those are the proud boasts of the author of this bill, House Ways and Means chairman, BILL THOMAS. He said:

> To those who say that it would end Medicare as we know it, our answer is, we certainly hope so.

It is not surprising that Newt Gingrich is supporting this deal because he long wanted Medicare to "wither on the vine." Most Americans and most Democrats have a different hope, that Medicare remain secure and strong. I intend to fight with everything I have to make that happen.

We need a real-world, affordable Medicare prescription drug benefit for seniors, a plan that won't force seniors into an HMO, that won't undermine the coverage for seniors who are already getting help today, that will be run by Medicare instead of an insurance company in search of a buck, and that will send a real benefit to every senior, no matter whether the costs are average or high. That is a real deal for America's seniors. But as I said before, right now this bill is a bad deal for seniors and they know it.

They know that this bill provides the skimpiest of benefits, with holes in coverage and complex rules. The coverage gaps remain too high, and seniors are still charged premiums even after their benefits shut down in the so-called donut hole. I think we ought to go back to the drawing board. They know this bill does not adequately protect them with a guaranteed government fallback with a national premium. Until this bill stops slanting all the advantages toward the HMOs and private companies, I believe we have to vote it down.

I believe seniors deserve a guaranteed Government fallback plan. Seniors know that this bill will jack up the out-of-pocket costs in order to visit doctors and hospitals. This is supposed to be a bill to add a prescription drug benefit, but along the way beneficiaries got stuck holding the bill for an additional $25 billion in increased out-of-pocket costs from means testing the Part B premium and increasing the deductible and indexing it to inflation.

This revenue raiser isn't done in order to improve Medicare but to give sweet deals, slush funds, and tax accounts to corporations and to the rich. It is wrong. We should vote it down.

I believe the proponents know that this bill fails to fix protections for low-income seniors—certainly low-income seniors know that across the country—and people with disabilities that currently rely on both Medicare and Medicaid for their coverage and should be defeated. They know it and you know it. This is not a good deal for seniors.

This week in November of 1945, Harry Truman sent to Congress a proposal for health care for Americans. He said:

> Millions of our citizens do not now have a full measure of opportunity to achieve and to enjoy good health. And the time has now arrived for action to help them attain that opportunity and to help them get that protection.

But powerful interests mobilized 1945 on Capitol Hill and defeated health care for Americans, Harry Truman's proposal, and especially for our seniors.

It was almost 20 years later that a young American President took up Harry Truman's cause and called for health care for America's seniors. This week in November of 1963, the House of Representatives was considering John Kennedy's Medicare proposal. The same powerful interests were swarming through this building, but there was a spirit of hope and possibility. Now those who support this bill are breaking the promise of Truman and Kennedy that was fulfilled under President Lyndon Johnson.

This has been tried before. This week in November of 1995, 30 years after Medicare became law, Speaker Newt Gingrich and his ideological allies shut our Government down for the first time ever in order to achieve their radical objective of tearing down Medicare. Millions of seniors would have been harmed by those cuts, but we stood up and we stopped Newt Gingrich because President Bill Clinton and others stood their ground and defended Medicare.

I believe we need to stand our ground today and stand on principle again. This bill will hurt seniors more than it will help them. We should pass a bill that offers a real prescription drug benefit under Medicare. We need to rebuild Medicare, not sell it out to the highest bidders. Medicare is one of the best Federal programs we have. I don't believe it is time to shred it. It is time to strengthen it. This Congress and President Bush will be held accountable by America's seniors and American history for the decision we make now. I believe we ought to give seniors a real deal, a prescription drug benefit under Medicare that works for them, and not a phony prescription drug benefit that provides benefits only for the most powerful special interests that stand in their way.

I yield the floor.

The PRESIDING OFFICER (Mr. GRASSLEY). The Chair recognizes the Senator from Missouri.

Mr. TALENT. Mr. President, I appreciate the opportunity to speak about this landmark piece of legislation that is so necessary and has been so necessary for too long and of which we have deprived America's seniors for too long. If I may say with great respect, I had a chance to listen to the last two speakers, my friend from Oklahoma and my friend from Massachusetts. Listening to those speakers just summed up for me why we have not passed this bill in the years and years it has been necessary and that seniors have been demanding it. The last two speakers represented pretty well and eloquently, with their usual vigor, the opposite ends of the political spectrum on this bill.

For the first speaker, the bill represented too much government, too much money. For the second speaker, it represented too little government, too little money. Both speakers are terribly disappointed with President Bush. Both want more time to consider this bill and, if necessary, go back to the drawing board; if necessary, wait years more before we provide a prescription drug benefit that millions of seniors around the country need and have needed for many years.

I rise to speak in favor of the bipartisan Medicare conference agreement. I think it is necessary. Medicare is a great program. My dad passed away last October. He was 91 years old. My mom had passed away about 15 years before then in her early seventies. They both used Medicare and stayed alive as long as they did and as healthy and as happy as long as they did in part because of Medicare. It has covered tens and tens of millions of seniors, not only with good medical care but with the security of knowing that they had medical care if they got sick.

Medicare was a great program and is a great program in 1965 terms. That is when it was developed. It covers the kinds of things that good health care covered in 1965, and it doesn't cover the kinds of things that were not covered in 1965. It doesn't have very many preventive health care benefits, catastrophic coverage for long-term acute illnesses. And it does not have coverage for outpatient prescription drugs because in 1965 you didn't use prescription drugs very often, unless you had an infection or some kind of pain killer. Now they are a part of almost every ongoing medical care treatment plan. Everybody who has health insurance—and not enough do—just about everybody who does has some kind of prescription drug coverage because it helps keep you healthy.

In providing insurance to somebody, you want them to stay healthy because if they get sick, it ends up costing more money for everybody. That is the reason we haven't had this coverage in Medicare, and it has hurt people.

There was a parade I used to be in every year when I was in the House. I like parades. You get a lot of exercise, and they are fun. It is in Hazelwood, MO. I would go down the same street. I always walk parades. I remember running up this driveway and these two seniors would be sitting at the top of their driveway watching the parade every year. Every year I would stop there for 60 seconds, and they would ask me when we were going to cover prescription drugs in Medicare.

I would say: Well, we haven't done it yet.

And they would say: We know that.

Then the issue finally moved on the front burner here at the end of late 1990s and the House began passing bills, 3 or 4 years in a row. We never passed one until this year here. The sentiments we have heard today—I respect so much the Senators who uttered them—are the reasons why.

I just do not want to wait until we get a bill that satisfies every extreme in politics and the political exigencies for everybody because we will wait forever. We will never get a bill then. I would rather go ahead with this bill, which is a good bill, and take what is good about it and then see what is working and what isn't working and then go back and fix it.

That is the reason the AARP supports this. They are tired of waiting, too. I had a hearing on this. I have the honor of sitting on the Special Committee on Aging, a great committee, with a great chairman, Senator LARRY CRAIG. The hearing was in St. Louis. One of the witnesses was Audrey Vallely, a delightful lady, who attended the Route 66 Senior Center in Eureka, MO, regularly. I have been out there for lunch a couple of times. She testified about her experiences over the last 12 years. Audrey suffers from osteoarthritis, a degenerative bone disease, and she also has a sinus disease. She ought to be taking two different types of prescription drugs for these conditions, but it costs $100 a month for 15 pills. So she often cannot take the drugs. She gets some pain relief over-the-counter pills; sometimes it makes her feel better and sometimes it doesn't. She does the best she can. She has to choose between paying for those drugs or paying her rent. Having an air conditioner working in the summer is hard for her. All of these statements about the problems in this bill mean nothing to Audrey, who struggles month after month because of this gap in Medicare.

What would the bipartisan agreement mean for Missouri? We have over 888,000 beneficiaries in Missouri. They all have the opportunity to get a discount card—a 15- to 25-percent discount immediately. Better than that, low-income seniors get, in addition to that, $600 a month in annual assistance to help them afford their medicines, along with discount cards. That is a total of over $200 million in assistance for over 170,000 Missouri residents over the next 2 years, if we pass this bill—not otherwise.

Beginning in 2006, every Missouri senior in Missouri would be eligible for coverage in this bill for approximately $35 a month. They get at least 50 percent off—or approximately 50 percent off their prescription drug costs. Of the approximately 270,000 beneficiaries in Missouri who have limited savings and low income, they will qualify for even more generous coverage. Additionally, the Government will help the State pick up the cost of the Medicaid-eligible seniors. That will help Missouri, which is in a cash-strapped situation with regard to its budget.

This bill meets the conditions that I thought was important for a Medicare prescription drug bill. It has an immediate benefit, reasonable monthly premiums, strong catastrophic coverage, targeted help for low-income seniors, quality benefits for rural areas, protections for local pharmacies, choice and access to all medicine, and participation in it is voluntary. If you like what you have, you don't have to participate.

That is the reason I am supporting this. I will be pleased to vote for it on final passage. I hope a majority of the Senate does. I hope we are allowed to vote. You never know these days. This is the most important Medicare bill in a generation and maybe we will be able to vote on it and maybe we will not. I know most of the people want to have an opportunity to vote on this bill. I think most will vote for it if they get that opportunity.

I am going to close by saying what I have said on the fairly rare occasions when I have spoken on this issue on the Senate floor. In this body, everything always gets said but not everybody says it. Once in a while, I feel maybe I should deprive the Senate of my comments on something in the service of expedition. But I have said, look, if the bill is reasonable, I am going to move ahead with it. I am tired of waiting. I would like to help these people, such as the folks I saw in that parade, and like Audrey Vallely, and others, get access to prescription drugs. I think most of the people who have worked on this on both sides have done their best. As far as I can tell, they are not motivated by all the lobbyists or the special interests. I have been in a lot of meetings on this, and that hasn't come up once. They are trying to do the best they can for seniors, in a way that will work and be affordable for everybody. That is what this bill does. I am going to vote for it on that basis. I hope it passes.

I congratulate the chairman, who is presiding now, for his fine work.

How much time remains?

The PRESIDING OFFICER. There are 21 minutes remaining.

Mr. TALENT. I am pleased to yield that time to my friend from Colorado.

The PRESIDING OFFICER. The Senator from Colorado is recognized for 21 minutes.

Mr. ALLARD. Mr. President, I thank the Senator for yielding the balance of his time.

Mr. President, first I want to compliment Majority Leader BILL FRIST, from Tennessee; Chairman of the Finance Committee, CHUCK GRASSLEY; and the Conference Committee on working diligently and in good faith toward a workable prescription drug program for elderly citizens. Some have come to this floor and proclaimed it is about politics. I couldn't disagree more. President George Bush, Majority Leader BILL FRIST, and Chairman GRASSLEY have not only talked about the need for a prescription drug program but have worked hard for several years toward a workable program.

It is the Democrats who have demagoged this issue. We just have to look at last year when the prescription bill was brought to the floor by the Democrat majority leader, without having it debated and reported out of committee. I believe that it was their hope that they could embarrass Republicans in an election year. Instead, it only helped point to the failures of a Democrat-led Senate that couldn't even pass a budget because they did not want to deal with the tough votes they would have to face on this floor.

I believe this Republican-led Senate is wrapping up one of the most successful sessions since 1994. There have been long hours and a lot of hard work that has paid off, despite filibusters on judges and attempts to slow down and kill many provisions, such as the budget. But Republicans passed a budget. Republicans are still working hard to pass an energy bill that was blocked through the efforts of key Democrats, and the Republicans are now working hard to pass a description drug benefit that is facing a possible filibuster on the Senate floor by the Democrats.

Mr. President, I am very disappointed that we have had to face all this obstruction on the floor, despite the concerted effort to work responsibly and respectively through the Senate committee system, then bringing the prescription drug bill to the floor and passing it. Now, here we are again, facing a threatened filibuster by the Democrats. Mr. President, we need to have an up or down vote on this conference report. Again, I know that the conferees worked hard in a bipartisan way.

I plan on voting for cloture because I want to see the conference report on Medicare voted on the floor of the Senate. I have stated that I am undecided on final passage. That is because, as a general rule, in the process of negotiations, legislation doesn't get less expensive, it gets more expensive through spending to attract more support and votes. I hope to act as a counterbalance with the clear message that, if spending gets out of hand, I will not vote for the bill.

I am not happy with creating a new program that could lead to a monstrous program in the future. That is why I opposed the bill as it left the Senate, because it was not limited to just the most needy and I felt it broke the budget. It was later proved that I was right in the assessment that it would break the budget, and with more accurate budget figures the conference committee set to work to reduce the scope of the program to keep it below $400 billion for 10 years and within the parameters of the budget. This, in effect, forced the conference committee to means test the program and keep certain provisions that would hold the user accountable by forcing that patient to participate with a deductible and the so called "donut hole."

In my view, it is very difficult to have a third party pay system and yet maintain accountability. Users feel that they have already paid for the system and are going to utilize it to its maximum to get their just return, and providers feel that it has already been paid for and creates no particular hardship on the individual so they charge with little restraint the third party. So utilization is regulated. And we end up with regulations like we have now in the current Medicare system, which prevents a patient from paying for their own medical care if they want, and it prevents the physician from receiving cash outside the system that could reduce the burden on taxpayers. It ends up creating a system where the close patient-doctor relationship is disrupted to where the patient can't use whomever they desire to care for their medical needs. So what we have today is a Medicare system that is not actuarially sound and, if not reformed, will lead to much higher payroll taxes and huge demands on the general budget. That is why I was pleased to see some reform proposals on medicare emerge from the conference committee, such as health saving accounts.

When I served in the Colorado State Senate, I sponsored, with State Representative Phil Pankey, a bill to put in place an individual medical saving account; and Colorado became the first State to have such a program.

Unfortunately, in an effort to pass the bill, we allowed the program to become so limited that the risk pool became too small to function as insurance against future liabilities. Consequently, when Colorado moved to a modified flat tax, this program became a victim of tax reform.

This Congress puts forth a health savings account that will work. Individuals can put in $5,000 a year or a family can put up to $10,000 per year and save on their taxes. The income builds up within the health savings fund without tax liability and, finally, can be pulled out to pay for the family medical needs without paying additional taxes.

This is wonderful reform because it reestablishes the doctor-patient relationship and makes individuals responsible for their own health care with much fewer regulations, and it brings common sense to the decisionmaking process. It builds upon previously enacted medical savings accounts that have been limited to small business and the self-employed by Congress.

One other attractive feature in this bill is that the elderly are not forced to participate. It is voluntary. It also tries to prevent large businesses and local governments from dumping their current prescription programs into the Federal system to save themselves future liabilities and further burden the Federal prescription drug program.

The other side has repeatedly made the claim that this bill is full of giveaways to Republican contributors. This is simply not true. That is simply more absurd "medi-scare" tactics by the opponents of a bipartisan drug benefit for our Nation's seniors and the disabled.

The argument I find most amusing is the claim that this bill will lead to increased drug company profits. The reason this bill is so desperately needed is because our Nation's seniors and the disabled, particularly those with low incomes, are unable to afford their prescriptions today. Let me stress that again. The reason this bill is so desperately needed is that our Nation's seniors and the disabled, particularly those with lower income, are unable—unable—to afford their prescriptions today. Today they are forced to choose between food and rent and taking their medicine. We have all heard the stories of seniors cutting their pills in half to get by and in so doing taking a lower dose than their doctor prescribed.

When this Medicare prescription drug benefit goes into effect, they will be able to get their prescriptions filled. Of course, this is going to lead to increased drug sales. Surely, this is no surprise to anyone. With new technologies and new medications, invasive procedures become less likely. Any prescription drug bill that works is going to lead to increased drug sales. That is just common sense.

Where are the medicines supposed to come from except the manufacturers of those medicines? Every single medical prescription drug bill introduced by these naysayers would also increase drug sales and the bipartisan conference report has the same basic drug benefit structure that passed the Senate by a vote of 76 to 21.

The Congressional Budget Office has concluded that the competitive approach in this bipartisan drug benefit will do better at controlling drug costs than other proposals. To suggest that no one should support a Medicare drug benefit because it will lead to increased drug sales turns logic on its head. If this were our basic principle, then we should not have food stamps because this will lead to increased profits by grocery stores and farmers. How about housing subsidies? This might lead to profits by construction companies and utility companies and increased sales of lumber, bricks, and nails. This is just an absurd issue, and it is easy to see why.

I am here to tell you that this bill will strengthen and improve the Medicare Program. The spending on this bipartisan prescription drug bill goes to better benefits for America's seniors and the disabled.

As I draw to a conclusion, unfortunately, those who want universal health care and the big Government solution to drugs, making people more vulnerable to Government control, are vehemently opposed to this conference report.

The conference report lays out a plan for Medicare reform and a way to help the most needy. It is a balance that does not come easily and not without a lot of discussion on both sides of the aisle. We should at least have a vote on the bill. It is time to put partisan obstruction aside and think about what is good for America.

I ask my colleagues to join me in voting yes on cloture to stop the filibuster and to help hold down costs to within the budget limits.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. TALENT). The Senator from Oregon.

Mr. WYDEN. Mr. President, as Congress considers Medicare and prescription drugs, I keep remembering the older people whose stories spurred me to choose a career in public service. For 7 years, before I came to the Congress, I worked with seniors and spent many hours visiting with them in their homes. During those visits, seniors would often bring out shoeboxes full of health insurance policies that were supposed to fill the gaps in their Medicare. It was common for a senior then to have seven or eight of these policies, and many of them were not worth the paper they were written on. Slick, fast-talking insurance hucksters kept coming around and scaring the older folks, and it was heartbreaking to see seniors ripped off this way.

After working all their lives, seniors would go without each month because they were paying for junk health insurance policies with the precious funds they needed to pay the heating bill or buy some groceries.

When I got elected to the Congress, I vowed to stop this fleecing of America's seniors. I helped to write the first and only tough law to stop the ripoffs of private health insurance sold to the elderly. This statute has worked to drain the swamp of fly-by-night Medigap policies that used to rob seniors blind.

The days of the shoebox full of health insurance policies are gone, but the skyrocketing drug costs and lack of access to medicine—two of the problems that plagued seniors even back then—are more of a problem today.

During those home visits I made with seniors, I saw firsthand the pain they felt when they couldn't afford lifesaving medicine. Their anguish was physical, and it was emotional. They feared for their futures. They worried that the choices that financial constraints forced on them would not be the right ones.

We are very familiar with those stories today. Caseworkers in every office in the Senate hear them constantly. A senior is supposed to take four pills, but because they can't make ends meet, they take three or two. Eventually, that senior ends up in the hospital where the hospital portion of Medicare, known as Part A, covers drug treatment, but often it is too late.

I have tried to rewrite stories such as that since I came to the Congress. That is why I worked with Senator PRYOR's father so that States could bargain aggressively and get more for their Medicaid dollar when buying prescription drugs that would help the low-income elderly. I have tried to expand coverage for generic drugs. I have worked to supplement those efforts by creating new health care options for seniors, including in-home care and increased payments for providers in low-cost areas, funds that can be used to offer prescription drug benefits to some of the elderly. Because of my history, I am acutely aware that there is so much more to do. The reason the debate on this bill is so important is that Government has the obligation to do right by a generation that deserves our respect and care and not give those seniors the runaround.

My years working with the older people have governed the decision I have made on this bill. I have tried to keep the focus on determining whether this prescription drug benefit legislation would make a genuine positive difference for a significant number of older people or whether it falls short of that objective.

As part of the process, I have developed a set of criteria to evaluate this legislation. I would like to describe the questions I believed were key and the answers I have found.

The first question I asked was: Does this bill help a significant number of older people with low incomes or big prescription drug bills? In their editorial endorsing this legislation, the New York Times stated:

> The bill is strongest when it comes to the most important target groups: Elderly people with low incomes or very high drug bills.

It is not my job to take the word of editorial writers simply because they are just one voice in a chorus that comes from both sides. So I have gone to some length to examine the figures and data from all perspectives. I looked at the data that has been available from those strongly in favor of the legislation, such as the Federal Center for Medicare and Medicaid Services. I looked at the information from those strongly opposed to the bill, such as the nonprofit Center on Budget and Policy Priorities.

The critics say the legislation has significant gaps in coverage for seniors, especially those of modest income. Proponents of the bill claim that millions of seniors will have coverage they did not have before. There does seem to be truth on both counts. So I have tried to keep the focus on figures that were beyond any doubt. Using data from the 2000 Oregon census, my staff and I have determined that 78,829 older people in Oregon had prescription costs that exceeded $5,000, and under this bill these seniors would have their prescription drug costs reduced by one-half.

Using 2001 data from the nonprofit Kaiser Family Foundation, my staff determined that Oregon has 106,765 seniors on Medicare with incomes at or below $12,123 for an individual or $16,362 for a couple.

Under this legislation, this low-income group would pay no premium for their drug coverage and would be responsible for a copay of no more than $2 for generic drugs and no more than $5 for brand name drugs. The least fortunate would pay only $1 for generics and $3 for brand name drugs.

Most seniors with low incomes and high drug costs are likely to be eligible for both Medicaid and Medicare. These older people are known as dual eligibles. This legislation assures that they receive at least some measure of prescription drug coverage through Medicare so they are not left at the mercy of perennial State budget crises and so they will not have to compete against other vulnerable groups in State budget battles.

Another factor I considered was the expectations for this legislation. What I hear from seniors at senior centers and at meal sites is that expectations are very high. I know some seniors will find that this bill does not offer benefits that match their expectations. Some seniors fear this bill is going to fence them in and require that they participate in a program they do not support. So at the very least, because this program is voluntary, it strikes me as a plus that no senior will be forced to accept the terms of this legislation.

So on this particular issue, with respect to who benefits, what we found that seniors in my State with very high drug bills would have their costs reduced by half. We found a great many low-income people who would receive very significant benefits with no premium and a very modest copay for their drugs.

The second question we asked was: How does this bill affect seniors who currently get their prescription drug coverage through corporate retiree benefit packages? Almost every day now we pick up a newspaper and read about another employer dropping their retiree benefits or cutting them back significantly. There has been a dramatic reduction in corporate retiree health benefits, and it is taking place right now before the enactment or rejection of any legislation.

The percentage of large employers offering retiree health benefits over a relatively short period of time has dropped from 66 percent to 34 percent. Consistently, the employers who keep coverage have required the retirees to shell out for higher copayments and premiums. Employers say they have to make these cuts because of the rising costs of health care and the effects of a lousy economy. Now along comes the Congress with a bill that many believe will dramatically affect retiree plans in the future.

It seems to me that with legislation offering $71 billion to employers to keep their coverage, these funds can only be a plus in developing a strategy for getting more employers to retain existing coverage. This is a subsidy the companies are not going to see absent this legislation.

So I ask the Senate: Will companies not be less likely, not more likely, to drop coverage if they get the funds offered tax free under this legislation?

I would also note that corporate retiree provisions in the conference report are better than the provisions in the original Senate bill which was approved by more than 75 members of this body.

Bernstein Research says employers spend about $1,900 per year per senior on retiree drug benefits. Based on my calculations, this bill gives corporations a significant tax-free incentive to cover not only retiree drug benefits but other senior health care costs as well.

The next question I asked was: Does this bill significantly undermine traditional Medicare? Critics of the bill have focused on this issue, and I share their view that seniors believe in Medicare, want to modernize it, and do not want it undermined.

The critics seem to believe that any effort, however, to create more choices outside the basic Medicare fee-for-service program is a mistake. I disagree. I believe seniors need good quality choices beyond fee for service. I simply believe those choices must be accompanied by strong consumer protections and that it is essential to strike a balance, making sure that the new choices never, ever cut off access to traditional Medicare that seniors know so well and a program with which they feel so comfortable.

I have never been opposed to private sector involvement with Medicare. In many Oregon communities, upwards of 40 percent of the elderly get their Medicare through private plans. The law I wrote stopped the rip-offs of private health supplements to Medicare, standardized 10 private sector policies to help seniors fill the holes in Medicare, and consumer advocates across the country believe that law is working.

The key to making the private sector choices work is a combination of strong consumer protections and a level playing field between the private sector choices and health services offered by the Government. I have considerable ambivalence about how this legislation will affect that balance.

In the bipartisan prescription drug legislation I drafted with Senator SNOWE, we offered private sector options for seniors that contain strong consumer safeguards. Our bill was known as SPICE, the Senior Prescription Insurance Coverage Equity Act. It did not tilt the playing field toward the private sector the way the legislation before Congress does today with its health savings accounts and premium support. Unfortunately, the health savings accounts in this bill, which are tax breaks for purchasing health care, are structured to disproportionately benefit the healthy and the wealthy. Seven billion dollars of tax subsidies are directed to these accounts. This has gone from a demonstration project to a major expense, one that siphons away funds that could go to beef up the drug benefits.

Another drawback of the legislation is the premium support provisions, which are designed to test competition between traditional Medicare and private plans. These could drive seniors out of the fee-for-service programs they want. Premium support demonstrations could allow insurance companies to cherry-pick the healthy seniors, leaving the truly ill to go to poorly funded Government programs that are sicker than they are. Even though premium support doesn't start until 2010, I don't believe it has a responsible role to play in this legislation.

I don't believe this legislation is going to wipe out traditional Medicare. I do believe that Congress is going to have to be extraordinarily vigilant with respect to ensuring that traditional Medicare can coexist and prosper along with the new choices. Without careful management, it is certainly possible that health savings accounts and premium support could tilt the Medicare Program away from providing traditional fee for service for all the seniors who want it. If this legislation passes, it will be the job of the Congress to make sure that does not happen.

The next question I asked is especially important. Virtually every senior in America wants to know: What will this legislation do to keep their prescription drug bills down? In my mind, the key to effective containing of prescription costs is to make sure older people have bargaining power in the health care marketplace. Today, when a senior gets his or her prescriptions through a health plan with many members, that plan has significantly more bargaining power than that same senior would have by walking into a Walgreen's, a Safeway, or a Fred Meyer to buy medicine. Getting seniors more purchasing power by getting them into large buying groups is an absolute prerequisite for a long-term strategy for keeping prescription costs down for older people.

That was the principle behind the Medicaid drug rebate law that I helped author with the first Senator Pryor. That is the principle that Senator SNOWE and I have proposed in our bipartisan legislation. We looked to a market-based proposal that was built around the Federal Employees Health Benefits Plan, a program that has been proven to contain costs because of the sheer size of the group of Federal employees for which it bargains.

I think it is very unfortunate that this legislation did not put in place a model like the Federal Employees Health Benefits Plan to contain costs. But I think it has to be noted that some baby steps in the right direction have been taken with respect to cost containment. The bill begins to leverage the potential bargaining power of 30 million seniors by giving older people the opportunity to join large managed care plans and big fee-for-service plans that can use their sheer numbers to negotiate discounts for older people on their medicine. The bill also removes some of the barriers to getting cheaper generics to market faster.

It also recognizes that there is great value in comparing the effectiveness of similar drugs so seniors, providers, and the Government can spend funds on the best medicines at the lowest cost. This is very much in keeping with the way my own State has approached cost containment.

I do wish this bill went further on cost containment. There should be a way to bargain for even bigger segments of the elderly, not just the fractions of the population who end up in HMOs or various private health plans.

I am concerned that while private plans have the power to bargain under this bill, the Medicare Program is barred from giving seniors the kind of bargaining power that Senator SNOWE and I wanted them to have in our model that looked to the Federal employee program for seniors.

I am also concerned that there is not ongoing monitoring to assure that drug prices are not increased unfairly before the bill takes effect, or in the first few months after it does.

So the legislation does not contain costs the way Senator SNOWE and I would have liked. It does take some modest steps in the right direction. It borrows from the principles of our legislation, but in the end I strongly believe that more and better cost containment measures with respect to prescriptions are going to be needed in the future.

Next, I asked: Does this legislation address Medicare's broader challenges, including the large number of retirees that will join in the near future? A demographic tsunami is about to occur in our country. As the baby boomers come of age, there are going to be extraordinary pressures on our health care system. Health care advances mean that seniors will live longer, and many of those advances will come in pill form. What is exciting is that the more researchers learn about the way medicines affect individuals, the more personalized treatments, emphasizing pharmaceuticals, will become. Drugs that work one way for Bob will work differently for Mary. In the years ahead, I believe a new field known as "personalized medicine through pharmaceuticals" is going to help to increase the quality of patient care and cut down on wasteful spending.

As of now, however, baby boomers face the prospect of joining a Medicare Program that is already short of funds. That is why the $400 billion authorized in this legislation is a lifeline for the baby boomers who are going to retire in just a few years. Those funds provide some measure of security for future retirees, and some tangible evidence that Congress is laying the groundwork to support the growing Medicare population which will need both prescription drugs and the broader program.

There are several modest benefits in this bill, in addition, that sounds exciting to me for Medicare's future. One would focus on an approach known as disease management. This is going to be attractive in the years ahead because it will allow many of our country's future seniors to have better, more cost-effective care for chronic conditions. Medicare has lacked this benefit.

In addition to these direct benefits for seniors, the legislation helps gear up Medicare for the baby boomers with significant increases to many deserving health care providers. Over 10 years, hospitals in my State will receive almost $95 million. I am especially pleased that a number of medical providers, a number of our hospitals that now see a small number of patients and those that have a large share of patients who are too poor to pay for their care, would get help.

In addition, doctors across the country who are expecting decreases in Medicare reimbursements in 2004 and 2005 would find this reduction blocked in this legislation. In fact, the legislation increases Medicare provider payments in both of the years where otherwise there would be cutbacks. This is important because Government cost shifts have already cut reimbursement to doctors, many of whom have large numbers of low-income patients, to record lows.

I would also note that these benefits to providers will be especially useful in rural areas where we have the nationwide crisis with respect to declining access as a result of providers simply not being able to stay in business.

Finally, I ask one last question that looked beyond the issue of prescription drugs. I asked: Is there any way this legislation could provide a path to a health care system that works, not just for older people, but for all Americans? There is a provision in this bill that offers health care hope, not just to seniors, but for all Americans. It is a provision that I helped to write with Senator HATCH, based on our Health Care that Works for All Americans Act. This legislation would ensure that, for the very first time, the American people would be involved in the process of comprehensive health care reform. There would be a blueprint for making health care more accessible and more affordable, not just to seniors, but for all Americans.

Senator HATCH and I have been able to convince those on the Medicare conference committee that the key is to make sure that the public understands what the real choices are with respect to health care, how the health care dollar is used today, and how it might be used in the future.

In 1993, then-President Clinton announced his intention to create a health care system that worked for all Americans. But by the time that 1,390-page bill was written with no input from the public, sent to the Congress, and torn apart on the airwaves by special interest groups, the people couldn't distinguish the truth from the special interest spin, and the effort died. Without public support, the opportunity for change was lost.

The bipartisan leadership of the Senate at that time has told Senator HATCH and I that, had our bill been in effect in 1993, our country would be well on its way to implementing a system that ensured coverage for all our citizens. So I think it is of additional benefit that this legislation gives us a chance to restart the debate that died in 1994. Our legislation creates a Citizens Health Care Working Group that would take steps, through on-line opportunities, townhall meetings and other forms, to involve the public; and then there is a requirement, after that public involvement, that the Congress follow up on the views that come from the citizens' participation.

There are tough calls to be made in today's health care system, including in the Medicare Program. But it is time to make them together. I think if one lesson has been learned in the last few months of discussion about prescription drugs, it is that health care is like an ecosystem. When you make changes in one area, such as prescription drugs, it can affect many other areas, such as corporate retiree benefits, provider payments, and various other parts of the health care system.

The legislation Senator HATCH and I have put together and which is included in this conference report treats health care as an entire and a systemwide concern for the American people. Nothing is taken off the table. I believe there is in that legislation a path to making sure this Congress helps not just older people but sets out ways to ensure that all Americans have access to good quality and affordable health care.

Finally, let me note that collegiality hasn't exactly been one of the watchwords of the debate over this legislation. There have been some very cold considerations entering into this discussion. I know that some believe passage of this legislation will hand the President a great victory. Others on the other side of the aisle say Democrats who oppose this bill shouldn't dare raise questions. Those aren't the concerns that ought to drive the debate on Medicare at a time when the country has to get ready for a demographic phenomenon. Polarization and division do not do our country any good.

This legislation is a very tough call for me and I think for many others.

Congress could make a mistake by believing the $400 billion available in this legislation will still be there in February of 2005. As a member of the Budget Committee, I know how hard it has been to get funding for this benefit. When Senator SNOWE and I began in 1999 to work for funding for a drug benefit, the Senate thought we lassoed the Moon when we successfully got $40 billion in the budget. How then can you argue that Congress should walk away from $400 billion?

I wish there were a better bill. I wish it didn't include medical savings accounts and premium support and had done better in the area of cost containment.

There are going to be various procedural considerations that may come out, and I intend to weigh each of them before I vote on those procedural concerns. If it finally becomes clear that the bill, as is, represents the Senate's sole opportunity to inject $400 billion in long-sought prescription drug benefits in Medicare, I will vote yes.

At the end of the day, I will not vote to let the last train that leaves the Senate go out without $400 billion that can be used to help vulnerable seniors and those who are getting crushed by prescription drug costs. I will continue to fight to make this legislation better and for better health care for all Americans.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, the opponents of this bipartisan Medicare bill have made the claim that 6 million seniors are hurt by this bill. The other side has also claimed that 25 percent of seniors will be forced to pay more for their prescription drugs under this bill.

I want to be very clear that this is not accurate at all. I'm here to tell the American public the truth.

The truth is that 14 million lower income seniors and disabled Americans are benefited greatly by this bipartisan bill. These 14 million people will get very generous prescription drug coverage through Medicare in this bill.

First, as you can see on this chart, 7.8 million seniors and disabled Americans get full coverage with no deductible, no gap in coverage, and would pay only $2 for generic drugs and only $5 for brand name drugs. And if these seniors reach the catastrophic coverage limit, then they will get their prescriptions fully covered with no copays. That's right, no copays at all.

Next, as you can see on the chart, an additional 4.4 million lower income seniors will get even more generous coverage. These Seniors will pay only $1 for generic drugs and only $3 for brand name drugs. And if these seniors reach the catastrophic coverage limit, then they too will get their prescriptions fully covered with no copays.

In addition, some of these people are enrolled in both Medicare and Medicaid and are living in a nursing home—about 1.3 million of them. This bipartisan bill creates a special benefit for these people. For them, Medicare will cover 100 percent of the prescription costs. They pay nothing.

These groups of seniors in total represent 12.2 million seniors and disabled Americans.

The bill also provides coverage to about 2 million more lower income seniors and disabled Americans. These seniors have 85 percent of their drug costs covered after meeting a $50 deductible, and if they hit the catastrophic coverage limit, they would pay only $2 for generic drugs and $5 for brand-name drugs.

This is full coverage with no coverage gap and 85–98 percent of drug costs covered for about 14 million seniors and disabled Americans. That is about 36 percent of all Medicare beneficiaries.

That is what this bill does. It provides very generous prescription drug coverage through the Medicare program for about 14 million lower income seniors and disabled Americans. And it provides this full coverage to 8 million lower income seniors who have no coverage at all today.

On top of that, of course, this bill provides all beneficiaries with access to basic prescription drug coverage with protections against catastrophic drug costs. The average beneficiary who does not quality for the low income benefits I have just described will still have about half of their drug costs covered under this bill.

Finally, no one is forced into this drug benefit. It is a purely voluntary benefit. No one is forced to enroll and any senior or disabled American that does not see the drug coverage offered as a good deal for them does not have to enroll.

So this bipartisan bill before us does not harm seniors. That is an absurd charge to make by the opponents of this bill.

This bill provides an affordable, voluntary and universal drug benefit for all seniors and disabled Americans in this country. And it provides very generous coverage to those 14 million lower income beneficiaries.

It is time to put the partisan rhetoric aside and approve this bipartisan bill that the AARP calls "an historic breakthrough and [an] important milestone in the nation's commitment to strengthen and expand health security for its citizens.

I yield the remainder of this half hour to Senator DOMENICI.

The PRESIDING OFFICER (Mr. ENSIGN). The Senator from New Mexico is recognized. He has 23 minute 20 seconds remaining.

Mr. DOMENICI. Mr. President, today I rise in support of the Medicare Prescription Drug and Modernization Act. I thank the Senate and the House conferees, as well as the leadership of both bodies, for their work over the past few months. Their perseverance has paid off. This bill represents a major step forward for this body on behalf of the seniors of this country.

Experts and fair-minded people have known for many years that the Medicare Program must be reformed. For more than 6 years, Republicans have led efforts to overhaul the Medicare system and ensure American seniors continue to have access to high-quality, comprehensive health care in the future. First, a little history. The Budget Act of 1997, when I was chairman of the Budget Committee, created the National Bipartisan Commission on the Future of Medicare. This Commission was created to address the issue of modernization. The Commission supported changes to the program that would have provided an additional prescription drug benefit as well as modernized the Medicare system—not one without the other, but both.

Unfortunately, that Commission failed in part because of lack of support from the previous administration's appointees to address the fundamental problem of the program's design. A majority of the Commission was for it, but we structured it where 60 percent was required, and the President withheld his support after all the work that was done. The point is, clearly even back then we were tying modernization to prescriptions.

In 2001, again as chairman of the Budget Committee, the budget resolution provided $300 billion, and we are now up to $400 billion. The budget resolution said $300 billion for prescription drug benefits and it required modernization of the program. It said $300 billion way back then. DON NICKLES, as chairman, took it up to $400 billion. It did not say for prescription drugs, it said for prescription drugs and modernization. Why? Because one without the other is never going to work. If you have a prescription drug benefit for the seniors and do nothing to the underlying Medicare Program, you have taken care of one of the problems for a couple of years but you will be back with a bigger problem. That bigger problem is the Medicare system itself. With the great change in demographics this country is going to be experiencing, we will be in big trouble.

Medicare beneficiaries have waited too long for prescription drug coverage. I am pleased this year appears to be a breakthrough year. Before we are finished, there will be many Senators we will be able to thank. This will be the year we finally help millions of Medicare beneficiaries obtain affordable prescription drugs. The bill will also provide substantial relief for those with the highest drug costs. It will also provide prescription drug coverage at little or no cost to those with low incomes.

When this bill passes, we will be providing seniors with prescription drug coverage for the first time since the program's creation in 1965. Across America, there are still millions of people who do not know that Medicare provides by law not one nickel's worth of prescription benefits. It is not that the benefit is inadequate or that it is written wrong, it just did not provide for a benefit; that need was not contemplated in 1965.

It has been hard to get a bill that really has a chance. This bill has a chance. It contains new accounting safeguards that put the program on a stronger financial foundation. The legislation contains preventive care measures, including screening for diabetes and cardiovascular disease. It provides benefits for coordinated care for people with chronic illnesses. None of these benefits was provided under the 1965 act because the need was not contemplated as part of the health delivery system. These benefits are needed today, but they are excluded from the current Medicare system.

This is by far the best opportunity, speaking on behalf of my constituents in my home State, that New Mexico has had to get doctors, hospitals, home health care providers, nursing homes, and Medicare beneficiaries fair and equal treatment. Before this bill, each of these groups had been shortchanged by the health care laws of our country.

I am particularly pleased this bill contains $25 billion in initiatives aimed at providing health care in rural areas. We can thank Senator GRASSLEY for being so steadfast on that provision. The Finance Committee estimates my home State of New Mexico can expect approximately $140 million over the next 10 years in increased doctor and hospital reimbursements. That is because we are so low. This brings us to parity and fairness.

This bill includes $50 million to equalize payments between large urban hospitals and rural and small hospitals, $15 million to increase payments to disproportionate share hospitals, $1 million in payments to critical access hospitals, $50 million in increased payments for doctors, and $3 million in incentive payments to encourage physicians to practice in areas where there are shortages.

Beginning in 2006, again for my State, all 250,000 Medicare beneficiaries living in New Mexico will be eligible to get prescription drug coverage through a Medicare-approved plan. This bipartisan agreement will give 55,000 Medicare beneficiaries in New Mexico access to drug coverage they would not otherwise have. Nearly 17,000 of those beneficiaries will qualify for reduced premiums, lower deductibles, coinsurance, and no gap coverage. Unquestionably, these provisions will help improve access to health care and treatment for seniors.

We have a great opportunity, fellow Senators, to fulfill our promise to the American people and provide our seniors with high-quality prescription drug benefits. I believe prescription costs will be manageable, even with the baby boom generation that will then be retiring. Some worry about the costs of this bill, but I am confident about the future of American ingenuity and competition, America's science achievements, and America's wellness achievements.

As I said this spring when we were debating this bill, we are not living in a stagnant world. American scientists today are reaching for health care breakthroughs linked to the mapping of the human genome. Advances in nanoscience and microtechnology will change medicine and health care as we know it today. However, while that work continues, this long-awaited prescription drug plan is what we need now. I am suggesting when I talk about the future breakthroughs that we may be astonished at how much we are going to be able to do that we cannot do today that may save lives and save money.

I encourage my colleagues to put their differences aside today and, most of all, to put their politics aside, and do what is best for the American people. Overwhelmingly, my constituents have contacted me and asked that I support this legislation.

Seniors need affordable prescription drugs, and if Congress fails to act this year, it will likely be many more years before beneficiaries are able to access prescription drugs through Medicare.

It is for those reasons—all of them; the national reasons and the parochial New Mexico reasons—that I have indicated that lead me to saying I will support this bill. And I hope we do it quickly.

Now, we have an additional Senator. Mr. President, how much time do we have left in this block of time?

The PRESIDING OFFICER. Thirteen minutes fifty seconds.

Mr. DOMENICI. Mr. President, I understand we have a Senator who is coming over to use that time. Until they do, I will yield that time to Senator GRASSLEY.

Mr. REID. Mr. President, if I could just be heard briefly.

Mr. DOMENICI. Sure.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. We had a Senator who took an extra 5 minutes today because of various reasons, so it is my understanding that the distinguished Senator from Kentucky wants an extra 5 minutes. We would be happy to agree to that. So we would just add that on to what time he has.

Mr. DOMENICI. I say to the Senator, Senator GRASSLEY is in charge. I will just wait to see what he says.

Mr. REID. Is the Senator on his way down?

Mr. GRASSLEY. I say to the distinguished Democratic whip, it is my understanding the Senator is on his way to the Chamber from Senator FRIST's office right now.

Mr. REID. We would agree to give him that extra 5 minutes.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MCCONNELL. Mr. President, finally, after 38 years, Medicare will finally give our most frail citizens help in acquiring the miracle of modern medicine: prescription drugs. They save lives, but they are not cheap.

After decades of talking, while our seniors waited, tomorrow we vote yes or no on a Medicare prescription drug benefit. It is now or never for our seniors. And for their drug benefit, this is the bill and this is the time.

On one side stand 40 million seniors, the American Medical Association, the AARP, and hundreds of other citizen groups. On the other side stand some Senate Democrats itching to kill this bill. Do not be fooled by those who think we can do something better at some point later. We are already 38 years late, and this is as close as we will ever come.

So for our seniors to get a Medicare drug benefit, it is now or never. Incredibly, there are those in this Senate who say never. They plan to filibuster the Medicare drug benefit or use procedural measures designed to do the same thing as a filibuster—kill the bill.

Let me repeat that. Some of our Democratic colleagues are trying to kill this bill. For 38 years there has been no prescription drug benefit, none. Now, when it comes time to actually pass a drug benefit, some of our Democratic colleagues are filibustering. That is truly astonishing.

Now, we will hear a lot more debate about whether there is too much or too little Medicare prescription drugs. And we will hear a lot of talk that there is too much or too little reform to preserve Medicare.

Mr. President, I believe we do more for Medicare prescription drugs than most could have ever expected. We do more to preserve Medicare for the future than most presently expect.

Before I discuss the reforms to preserve Medicare, I would like to focus on the new Medicare prescription drug benefit. The facts are that we provide $400 billion for a Medicare prescription drug benefit over a decade, about a third more than our Senate colleagues proposed just 2 years ago—a third more than was proposed just 2 years ago—and one and a half times more than President Clinton proposed for a Medicare drug benefit.

This unprecedented investment in our seniors' health translates into an incredible amount of relief for our seniors.

Back home, in my State of Kentucky, for example, there are about 650,000 seniors who will share in that relief. So what does this relief mean to them? The first comfort is that all 650,000 Kentucky seniors—whether rich, poor, or in between—will never again face the fear of being wiped out—completely wiped out—by catastrophic drug costs.

Under this plan, Medicare will cover a minimum of 95 percent of all catastrophic prescription drug costs.

Next, all Kentucky seniors currently paying full retail drug prices will be able to cut their prescription drug costs by an estimated 50 percent or more once they enroll in this new plan.

For those 235,000 Kentucky seniors with low incomes—low-income seniors—they will never again have to choose between food on the table or medicine in the cabinet—never again. They will get 95 percent to 99 percent of their prescription drug costs fully covered. None of those 235,000 Kentuckians will pay more than $2 for generic drugs or $5 for brand-name drugs, and most will pay even less than that.

Another 56,000 Kentuckians, with moderate incomes, will get assistance with their premiums, deductibles, and coinsurance.

While the full drug plan will not start until 2006, all Kentuckians can benefit from an immediate helping hand thanks to the Medicare prescription drug discount card available as soon as April of next year. This prescription drug benefit card will be available by April of next year. Through group purchasing power and negotiated prices, this card can save seniors between 10 and 25 percent of their drug costs, starting, as I indicated, just next April—right around the corner.

Finally, also starting next April, about 123,000 low-income Kentucky seniors will be credited up to $600 on that same prescription drug card to help tide them over until the full plan takes effect.

So this is real relief, and it is just around the corner. But we did not just give Kentucky seniors that real relief, we also gave them real choices.

Today, Medicare offers no prescription drug benefit and few choices in health care. All that is offered is the traditional hospital and doctor benefit, with a limited managed care option called Medicare+Choice.

Tomorrow, Medicare also could provide seniors a prescription drug benefit and almost unlimited choices in health care. If we act now, every senior on Medicare will soon have the choice of two prescription drug benefit plans, along with a Federal backup.

But if not now, then when will seniors get that benefit? Or, if we act now, every Medicare senior can choose from a variety of Medicare+Choice plans, with a full drug benefit added. But if we do not offer that to them now, when will we offer it to them?

Another choice is every Medicare senior can choose from three or even more preferred provider organizations. But if we do not offer this choice now, when will we? Or, if we act now, every Medicare senior can get help to maintain their current employer-based drug plan. But if we do not offer that now, when are we going to offer it? When would be a better day than now? Or every Medicare senior can do nothing at all and keep exactly what they have today. Every senior, I repeat, can stay in exactly the same coverage they are in today, if they choose to.

That is a lot of freedom and a lot of choices—much like those which Federal employees and Members of Congress enjoy today. But if we do not offer these choices now, when are we going to offer them?

This bill provides an excellent prescription drug benefit, a great array of choices to get that drug benefit, and a host of new benefits, such as preventive care, disease management, and comprehensive chronic care.

But after all we did for prescription drugs, what did we do to secure Medicare's future, you might ask? The reforms may not have gone as far as some would have liked, but the good news—the paramount good news—is for our Medicare system, a little reform can go a long way.

So how far can it go?

When a scam artist can make $7 million by selling gauze pads that cost a penny but sell them to Medicare for as much as $7, a little reform can go a long way.

When a shakedown artist can bilk Medicare for as much as $300,000 by allegedly providing health care services to a deceased patient—I repeat, a deceased patient—a little reform can stop a real abuse. When two rented mailboxes and a beeper is all one fugitive needed to scam Medicare out of $2.1 million, a little reform can go a long way. When Medicare imposes 110,000 pages of regulations, a tower of paperwork 6 feet tall that requires a regiment of clerks to handle, a little reform can mean real savings. When estimates suggest that as much as $33 billion a year is wasted in Medicare and Medicaid—$33 billion a year in waste in Medicare and Medicaid—a little reform can do a lot of good.

When computational errors at Medicare cost $4.5 billion a year, when $2.2 billion is paid out annually to phony businesses, when $23 billion is annually overpaid to doctors, hospitals, and other health care providers, and when study after study shows not just poor business practices but rampant and outright fraud, waste, and abuse throughout Medicare, costing tens of billions of dollars a year, year after year, decade after decade, then a little reform can do enormous good.

The reform in this bill is real. We infuse real competition, market forces, and private sector dynamics to provide the best health care at the best price for our seniors. A wide array of health care providers, insurers, plans, and organizations will compete to offer the best health care at the best price, and seniors will be free to choose the best plan for themselves.

With all of these choices, with all of this competition, ordinary people providing health care across this land are soon going to do a very extraordinary thing. They are going to figure out how to provide seniors all the quality health care they want without all the waste, fraud, and abuse in Medicare that no one wants.

And who will benefit? Of course, our seniors will benefit. And so, too, will our children. When our seniors get a quadcane such as this one for $15, like the Veterans Administration pays—the VA pays $15 for this quadcane, but Medicare pays $44 for the very same cane—stopping this kind of abuse is going to save our parents and our children. When our seniors get a catheter for a dollar, as most Federal Employee Health Plans pay, instead of the $12 Medicare typically pays, our parents and children both win.

These potential savings are not conjecture. This is not guesswork. We know that under imperfect—if not hostile—rules and regulations, the health care providers in the Medicare+Choice Program were able to give our seniors all the services of traditional Medicare and wring out enough savings to provide seniors an average drug benefit of about $857 a year. With this bill, the power to convert Medicare waste into Medicare benefits, which we only saw a flash of in the Medicare+Choice plans, will now be fully unleashed.

There was always a riddle to the Medicare drug benefit. That riddle was: Could we help our parents without harming our children? Could we add a prescription drug benefit to Medicare today yet still preserve Medicare benefits tomorrow? The answer to the riddle was always reform. In this bill, we have done enough reform to rein in the waste I have touched upon earlier.

To my colleagues on this side, I would agree there could be more reform in Medicare than we have in this bill. But there can be no reform of Medicare without this bill. We could have more reform than we have in this bill, but we will have no reform without this bill. The reforms are more than a first step. They reflect a bold, new direction. That new direction for Medicare flows from the market-based incentives in this bill that I believe will do more good to reform Medicare than our colleagues can possibly imagine.

Our colleagues need to recall that every time we have placed our faith in the ability of free market forces to provide for our people, our Nation has been richly rewarded. When we infused our energy markets with market competition, the gas shortages and economic stagnation of the 1970s were replaced by energy stability and two decades of solid economic growth. When we reformed Welfare-to-Work, we relied on the private sector to provide the best welfare program man had ever devised—a job. And the welfare reform of 1996 has worked better than we could ever have imagined.

Today we tap those same forces that saved our economic security and improved the well-being of the neediest to save Medicare for our children and improve Medicare for our parents.

I believe this new drug benefit will meet the needs of our seniors. I believe the reforms will meet the needs of our children. Now is the time to act. Now is not the time to filibuster. Our seniors deserve better than that from us. Thirty-eight years of waiting is long enough. We must not filibuster and kill the bill providing a prescription drug benefit for 40 million seniors.

Doctors, hospitals, and seniors have all said this Medicare prescription drug plan is the right plan at the right time. They all strongly support this. We should support it, too. Our seniors, the greatest generation, have been there for us. Now we need to be there for them.

I yield the floor.

The PRESIDING OFFICER. The Senator from Florida.

Mr. NELSON of Florida. Mr. President, here it is, about 675 pages of a bill. I have spent the better part of this past week trying to comprehend all of the nuances in this legislation, and of course a lot of that was difficult since the conference committee was still negotiating up through Thursday night, and some of the final things that are in the legislation we didn't find out until late in the game.

But having spent a considerable bit of time, I believe I have a fairly comprehensive knowledge of it. I want to give my comments and conclusions as to why this legislation is not in the best interest of this country and is it not in the best interest of our seniors. Therefore, I am going to give my reasons why I am going to vote against this legislation.

At the end of the day, what we need in America is a health care delivery system that is organized in a logical manner. The way we organize health insurance, as it has grown up historically around employers, if the employer is large enough, then the group of people who are insured for their medical expenses, you can spread the health risk over that large group. That brings down the per-unit price or the costs, the premiums that people pay.

But all employers are not large. Indeed, in my experience for 6 years as Florida's elected insurance commissioner, what I found was that not only was it very difficult for individuals to get health insurance and pay the prohibitive costs of the premiums but there was a gaming of the system that went on by some insurance companies. By having group coverage, a group was established, a rate was set for that group. Usually the rate was a very low rate or premium in order to entice people into that group to be insured for their health care. And then, as the group got older and it got sicker, they would not expand the group, so the size of the group began to contract. Yet people in the group are getting older and sicker, and you can guess what happens to the cost of that health care; and as those costs rise, so do the premiums and those people in that group had no other choice. They could not go out and get into another group, unless they happened to join an employer who had a large one.

That is the way the system in America is organized. That is not a logical system. What we ought to do is be creating the largest groups possible, the largest pools, so that you can take the health risk and spread it over that large number of people—young and old, sick and well, geographically disbursed—so that the cost of that health care is spread over the larger number and, therefore, the cost per person, the premiums, are much lower.

One of the reasons I oppose this legislation is that it is the beginning of the violation of that principle of insurance, for what this legislation is doing is beginning to fragment the seniors as a group and beginning to create groups where well senior citizens will be encouraged to join, leaving the sicker senior citizens for the traditional fee-for-service Medicare and for the prescription drugs that go along with that Medicare.

For example, what we have in this bill is that prescription drugs will be provided in an area. I think the country is divided into 10 areas. I heard it said earlier that it may be as many as 50. But whatever it is, the whole country is divided. In that particular area, there has to be a prescription drug plan for Medicare, as the basic underpinning of fee-for-service, and also the opportunity for managed care, either a PPO or an HMO.

Now, here is what is going to happen. First of all, the PPOs and the HMOs, under this bill, are heavily subsidized by the U.S. Government. There is $12 billion in this bill that is a subsidy to PPOs, money to be released at the discretion of the Secretary of HHS. This money would be to help the PPOs, managed care, to become more competitive. And guess what. It is going to help them go out and recruit senior citizens to come into the PPOs.

So, too, there is a subsidy here for HMOs. Medicare fee-for-service is reimbursed at 100 percent. In this bill, a kicker is given to HMOs of 109 percent; they are going to be reimbursed for those medical expenses.

So, by this legislation, we are setting a policy that says we are going to encourage seniors to go into those managed care plans—managed care plans that, in fact, will then take away a lot of the choice for seniors to select their own doctor.

What is that going to leave then? As they recruit the more well senior citizens, then Medicare, with its own prescription drug plan, is going to have all others. And guess what is going to happen to that $35 premium that has been promised. It hasn't been promised that it is going to stay the same. To the contrary, that $35 premium per month is going to start escalating. It is going to be hiked. Therefore, what is going to happen to the poor and the sick among our senior citizens? It is not going to be as it has been represented here.

So I see this as a giveaway to HMOs and PPOs. I see it as pushing seniors into managed care, where they will lose their choice of doctors. That is my first objection.

Of course, there is a lot in this bill that is salutary. I voted for the bill when it came through the Senate because I believed that it was a first step in what I thought was a very important policy goal—that we modernize Medicare with a prescription drug benefit.

But what has been added has made it too onerous for me to support. Let me tell you about the second reason I am not going to vote for this legislation.

It is widely acknowledged by several very respected studies that the private sector employers who are covering the prescription drugs for their retirees, from their private employment, are going to drop that drug coverage that is now coming from the private sector. It is estimated by several, including CBO, the Congressional Budget Office—an arm of the Congress of the United States—that some 2.7 million seniors in this country are going to be dropped, which means they will only have the choice of getting prescription drugs under the deficient plan that comes under this bill. So they are going to be getting less.

You talk about being mad. You talk about being upset. When they have a very robust plan and they could go to the pharmacy and have their former employer, under that retiree plan, pay for their drugs and suddenly they get dropped because now there is an inadequate prescription drug plan, well, in my State of Florida alone, it is going to be 166,000 people who are going to be dropped. There is going to be, indeed, some increase under the bill of those who are not covered now up to 150 percent of the poverty level of senior citizens, and I salute that.

You would think that in a State such as mine, which only covers poor seniors with Medicaid, a Federal and State health care program, you would think, since our State of Florida only covers up to 88 percent of poverty level, that would be a big benefit—to go from 88 to 150 percent of poverty level. Yet, in fact, there is some help there, but it is not much because this 675 pages includes a new assets test that is going to drop a lot of those people who are not covered by Medicaid in Florida, who would be covered under the bill—they are not going to be eligible because there is now a new assets test and there is a part in this 675-page bill that will not allow them to receive all of the brands of drugs that they want because there is a limitation in here on the class of drugs, and how it is defined.

Let me tell you, Mr. President, there are going to be some upset seniors who think they are in the range of 150 percent of the poverty level and below, and they are going to get covered and then they are going to suddenly realize they are not. That is going to happen a lot in my State of Florida. This is another reason I am not going to vote for the bill.

A third reason is that there is no competition for the prescription drug plan. I happen to think if we want to have a comprehensive, overall health insurance plan in this country, it ought to be as wide as possible with the biggest possible pools, and there ought to be private sector competition so we get the efficiencies and economies through competition.

That is not what happens in this bill. What happens in this bill is if you don't have two prescription drug plans attached to Medicare in that particular region of the country, there is no competition between the two. You can't say there is just going to be competition with the PDP and the PPO or the HMO. No, they are going to siphon off the more well seniors so if you don't have two prescription drug plans competing in price and there is only one, what do you think is going to happen to the cost? What do you think is going to happen to the monthly premium that was set initially at $35 a month? It is going to go one way. It is going to go up because the cost of those drugs is going to go up.

This bill is not pro-competition. This bill is pro private plans.

Another reason 35 bucks is going to go up is the fact that right now under the Medicare system, Medicare Part B, seniors pay the same premium throughout the country, but we know in some parts of the country health care costs are higher than in other parts. The costs in South Florida are higher than the costs in Iowa. But now the country is going to be divided up, in how many regions? I thought it was 10. I heard earlier in the debate it is 50. However many regions, it is going to be divided up, it is going to more reflect the cost in that region.

You might say that is a good thing unless you come from a State such as mine which has a higher percentage of the population of seniors than any other State because, why? When they retire they want to come to the land of sunshine and enjoy the benefits of our environment.

So because there is no competition and because the universality of the Medicare premium that has been in effect since 1965 is going to be abolished for prescription drugs, what is going to happen? The prescription drug premium is going to get hiked all the way to the Moon.

A fourth reason for opposing this legislation is that $400 billion is a lot of money, indeed, and if we were getting a true comprehensive drug benefit for $400 billion, it would well be worth it because Medicare needs to be modernized. If we were doing Medicare again in 1965, would we include a prescription drug benefit? Of course we would, because of all the wonders of these miracle drugs.

So $400 billion is a lot of money, but it is not being efficiently spent in this bill. Why? Aside from all of these provisions I talked about—about splitting up all of the groups and making them inefficient and siphoning off well seniors and leaving the sick seniors for the remainder—we cannot do anything in this bill about the prices of drugs.

In this bill, there are two little paragraphs that do not allow Medicare to negotiate the price. I always thought the free market was about economies of scale, of being able to get better prices. That is the whole theory of Wal-Mart. In bulk purchasing, they bring down the price. This is an anti-Wal-Mart policy bill because it does not allow bulk buying, as has been stated many times before, which has been done with other agencies of Government, particularly the Veterans Administration.

Mr. President, I supported the bipartisan bill we crafted in the Senate earlier this year. Unfortunately, this agreement does not adequately protect seniors' retire coverage, moves too many seniors into private plans, and fails to do anything about the escalating costs of prescription drugs.

When Medicare was passed 40 years ago, we promised our seniors they would have access to medical care as they grew older. As a matter of fact, since the passage of Medicare, seniors' life expectancy has increased about 25 percent.

The agreement that we will be voting on has little to do with providing a prescription drug benefit to seniors and a lot more about enticing private insurance companies to take over for the Government.

The financial incentives to private companies and creative trappings inserted in the bill will do nothing less than limit seniors' choices—mostly because of cost. Seniors may be forced into HMOs or PPOs because it may be the only affordable way to at least have access to a prescription drug benefit. Affordable, because the bill provides a $12 billion subsidy for PPOs and a reimbursement rate of 9 percent above Medicare for HMOs.

Since 1999, in Florida alone over 260,000 seniors and people with disabilities were abandoned by their private Medicare HMOs. As Florida's former insurance commissioner, I recall having to beg these plans to stay in our State and continue providing care to our seniors.

This conference agreement, with its various incentives—from a $12 billion slush fund, to its risk buyout, is nothing more than a give-away to insurance companies.

Private health plans are in the business of making money, and have routinely blamed low profit margins as their reason to drop seniors. In comparison to Medicare, they have failed to be as effective in controlling their own costs.

HMOs have managed to lure the healthiest of our seniors in order to maximize their reimbursement from the government. Currently, they receive about 16 percent more per beneficiary than is paid out through the traditional Medicare program. If these savings aren't enough to feed their profit margins, then the increased payments included in the bill will.

The agreement proposes payments to HMOs of 109 percent of the fee-for-service rate. This cumulative effect results in our government paying private plans 25 percent more than what it would cost Medicare to provide that same care. How can that be considered competition?

I am also concerned that the agreement before us could create premium variations across the country, and even within my own State of Florida.

While we all keep hearing about this $35 monthly premium, there is nothing written in the law that limits the premium to that amount. That number is simply an average which between now and 2006 could certainly increase just as the rest of the costs of health care are.

In addition, I am envisioning a scenario where seniors who do not have access to a fallback because there is one HMO or PPO plan and one prescription drug plan are left without any real choice. Then, if the drug plan, PDP, has no competition, it can raise the annual premium at will.

Since there are no limits and the premium from a private drug plan could be hiked to the moon, they could essentially create a situation where a senior has no other choice—based on costs—but to join an HMO or PPO and give up their choice of doctors.

Again, we see an example of this bill's failure to allow true competition to take place.

Under the fallback plan included in the Senate bill there would be at least two of the same kinds of plans competing in each region. This would have created an incentive for the drug plans to keep their premiums competitive.

During a careful examination of this agreement, I also became aware that the private drug plans are allowed the greatest flexibility possible. Little consideration is given to the particular needs of the beneficiary.

For example, each Medicare drug plan could have its own list of covered drugs, or formulary. The only requirement is that the private drug plan covers at least one drug in each "therapeutic class." The definition of a therapeutic class; however, is left up to the plan itself. A plan might choose to exclude certain high-cost drugs for financial reasons, leaving seniors who depend on those drugs without coverage for them.

I am also very disappointed that this agreement prohibits Medicare from negotiating better prices from drug manufacturers.

In 2001, the cost of prescription drugs rose more than 15 percent—the seventh straight year of double-digit increases.

When we consider the fact that drug prices have been increasing by double digits in recent years, it does not make any sense to let these prices go unchecked.

In light of our limited resources, wouldn't our seniors have been better served if we had addressed the issue of drug costs? We even have a proven model for success in the Veterans Administration, which has used its bulk purchasing power to negotiate with the drug companies for dramatically reduced prices. Medicare could do the same, saving our seniors and the taxpayers billions of dollars.

Our Nation's seniors, when unable to afford their own drugs, turned to Canada for relief. This bill continues the stalemate between supporters of importation and the FDA by including the poison pill provision requiring a certification from the Secretary of Health and Human Services before medications can be legally imported.

At a Commerce Committee hearing last week on this exact issue, supporters of importation argued that in the absence of trying to control the increasing prices of drugs, importation should be at least an option to provide short-term price relief.

In making my decision to oppose this legislation, I considered who would be better off versus who would be worse off.

One-third of Medicare beneficiaries have no drug coverage at all, another one-third of them have access to prescription drugs through their retiree health care plans.

The legislation before us will cause private employers to drop 25 percent of their retirees. In the State of Florida, that could mean over 166,000 retired seniors would lose the coverage they worked all of their lives to earn.

Another group that fares worse under this agreement are those seniors who are over 65 and also eligible for Medicaid. We fought long and hard to have these duel-eligible seniors covered under Medicare. However, provisions in the agreement raise the asset tests and restrict the Medicaid program from paying the senior's copayment, and that leaves seniors worse off.

Medicaid beneficiaries in Florida have access to all classes of drugs and all drugs within those classes. Should patients have trouble getting their medications, their physicians are allowed to appeal directly to Medicaid. The limited formularies allowed under the agreement for Medicare could jeopardize a senior's access to the drugs they need.

Despite our best efforts in trying to minimize cuts to cancer care in this legislation, the agreement will result in an $11.5 billion cut. The ripple effect of these cuts and the reaction of private sector insurers will threaten community cancer centers' ability to continue treating patients.

I reiterate my support for the providers of care to America's seniors. To our doctors, our hospitals, and nursing homes—I support the provisions in this bill that will allow them to continue to serve our seniors.

For Florida's hospitals alone, this bill means almost $740 million in improved Medicare reimbursement over the next 10 years, and I am pleased about that. But these reimbursements to health care providers should not be held hostage in a 675-page bill that has many defects.

In the final analysis, this agreement fails to fulfill my promise to provide comprehensive prescription drug benefit to seniors. We can do better. Regardless of whether this bill passes or fails, I intend to keep working to provide that comprehensive benefit. Our seniors deserve nothing less.

I want to yield the rest of my time to one of my colleagues who needs some time. I wanted to state at least these reasons and try to give the comprehensive overview of the health insurance marketplace, where we need to go eventually to straighten out the mess so that all people can be insured and not just the ones who have it and the 42 million people in this country who don't have it. Indeed, this bill is not the first step toward that kind of health care reform.

I yield to the Senator from North Carolina the remaining time that I have, which should be about 13 minutes.

The PRESIDING OFFICER. It is about 10 minutes. The Senator from North Carolina is recognized.

Mr. EDWARDS. Mr. President, may I inquire how much time the Senator from Florida has remaining?

The PRESIDING OFFICER. About 10 minutes.

Mr. EDWARDS. Mr. President, I thank the Senator from Florida very much for yielding time and allowing me to speak tonight.

Medicare was created 40 years ago with the idea of giving seniors health care to allow them to live out their lives in dignity and self-respect. It was a promise that they could choose their own doctor and afford their health care.

We clearly need a real prescription drug benefit under Medicare, there is no question about that. The problem is that this bill does a great deal more harm than good. It is very good for the drug companies, it is very good for the HMOs, but it is very bad for seniors and very bad for America as a result.

Here are some of the reasons: First, it has billions of dollars in giveaways to HMOs and insurance companies, money that could be and should be used to provide a better benefit to seniors who desperately need prescription drugs.

Second, it does almost nothing to control the skyrocketing costs of prescription drugs which seniors all over America face every single day when they go to the pharmacy.

Third, it contains billions of dollars in tax breaks for millionaires, for the wealthy, which is part of a long pattern by this President of trying to shift the tax burden. The President is in the middle, as I speak, of shifting the tax burden in America from wealth to work. He wants to get rid of the dividends tax, capital gains tax, taxation of the largest estates, and shift that tax burden right on the backs of middle-class working Americans who are already struggling, already having a difficult time saving, putting money aside, having any level of financial security. And here we go again, the President of the United States is in the process of putting an additional burden on the very people who are struggling and who are so critical to getting this economy moving again.

This is just another in a long series of efforts by this President and this administration to shift the tax burden. There is no question the lobbyists all over Washington are popping the champagne corks as we speak. The drug company stocks are going up. The HMO stocks are going up. Do not the drug companies and HMOs make enough already? For all the seniors who go to the pharmacy to try to buy medicine and cannot afford it, is the really nice thing for us to do right now to help the HMOs and drug companies? Are they not doing all right?

The truth is we ought to forget the drug companies, forget about the HMOs. They are doing a terrific job of taking care of themselves. We in the Senate ought to be focused on trying to help seniors who are struggling.

Let me say a word about the giveaways to the HMOs. This bill contains something that is called a stabilization fund of $12 billion, which is nothing but a giveaway to HMOs. The idea is we have been hearing all along that it is important to have competition and the HMOs can be more cost-effective than Medicare. I am missing something. If they can be more cost effective than Medicare, why in creation are we giving them $12 billion of taxpayer money? At least where I come from, you do not have to give somebody $12 billion to be more cost effective. That is taxpayer money that could be used to help seniors who desperately need prescription drugs. But, oh, no, we are going to give them $12 billion, money that could go to the seniors, money that could give them a decent benefit. Instead, we are going to give it to HMOs. I guess they are struggling so much, they need our help.

Then on top of that, we see that the justification for this is that they need money so they can "compete"? What in the world is that all about?

On top of what is being done for the HMOs, we have the drug companies. This bill does almost nothing to control costs. We have been fighting in the Senate to bring down the cost of prescription drugs for months and years now. The battle is always uphill because the drug companies have more lobbyists in this town than people who live in my hometown where I grew up. They are all over the place.

So we are trying to bring down the cost of prescription drugs. The Wall Street Journal itself calls this a big win for the drug companies. Their stock is going up.

Why have we not been able to do the things that need to be done to bring the cost of this program under control and, more importantly, to bring the cost of prescription drugs under control? I will tell my colleagues why. Because the drug companies are against it. It is just that simple. It is the answer to everything we try to do on the Senate floor to bring down the cost of prescription drugs.

We try to do something about misleading drug company advertising on television. No, no, we cannot do it. The drug companies are against it.

We try to allow the reimportation of prescription drugs from Canada to bring down costs for everybody, but we cannot get it passed. Why? The drug companies are against it.

We try to do all of this, to allow the market power of the Government to be used to negotiate a better price to bring down the cost of prescription drugs. We cannot get it done. Why? The drug companies are against it.

We are never going to get health care costs under control in this country until we stand up to these people, stand up to the drug companies, stand up to the HMOs.

I know in Washington, DC, they are powerful, but out across America, the

American people have a great deal more power in this democracy than these lobbyists in Washington. We need to stand up to drug companies and HMOs and stand up for the American people.

In the middle of not controlling costs, billions of dollars of taxpayer money going to HMOs and drug companies, we have another effort to shift the tax burden in this country. It is not as if working, middle-class families are not struggling enough. It is not as if over the last 20 years we have not gone from them saving money, having financial security, to today not being able to save, having negative savings as a matter of fact, with one medical emergency or one layoff keeping them from going under.

Here is a good idea: Why do we not take another step to shift the tax burden away from the wealthy and to the middle class and working people? That is exactly what is happening with these medical savings accounts. The only people who are going to be able to afford to take advantage of it are the wealthy. Regular folks cannot save anyway. They are not going to be able to put money away in one of these accounts.

The bottom line is, this is a bad bill. It is not a first step; it is a misstep. It takes this country in exactly the wrong direction. We need to stand up and say so. The American people need to hear our voices loudly and clearly. They also need to know what it is we actually need to do to provide a prescription drug benefit because they deserve one.

I will tell my colleagues what we need to do—put controls on the cost of prescription drugs by allowing reimportation from Canada, by doing something about misleading advertising on television, by cracking down on some of the price gouging that is going on. We ought to provide this prescription drug benefit under Medicare. We can give people choices and still stand by the very program that has provided seniors with health care for 40 years now, that so many seniors have depended on for four decades now.

At the end of the day, the American people, seniors, want us to do something about prescription drugs. We ought to do it. We ought to give them a real benefit. We ought to bring down the costs. We ought to make it cost efficient in terms of taxpayer dollars. In order to do it, we are going to actually have to have the backbone to stand up to these drug companies and these HMOs and their armies of lobbyists all over Washington.

I, for one—and I believe some of my colleagues will join me in this—intend to stand up to these people, and I intend to stand up for the American people and fight with everything I have for a real prescription drug benefit under Medicare that does not give billions of dollars to HMOs and drug companies.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Senator BAUCUS is the next scheduled speaker. I will ask for a quorum call, but I also ask unanimous consent that the time be taken off his time. It is not fair to wait because we have 4½ hours' worth of speakers.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. Over the last couple of days there have been many assertions from my colleagues on the other side of the isle that this bill does nothing to lower the cost of prescription drugs.

I would like to take this opportunity to set the record straight.

The conference report contains a number of significant reforms to lower the cost of prescription drugs for not just Medicare beneficiaries, but for all Americans.

This bill provides immediate relief to 40 million Medicare beneficiaries by providing a discount drug card starting in April 2004.

The voluntary drug card program will save beneficiaries an average of 10 to 25 percent on the cost of their prescription drugs. Beneficiaries will have the choice of at least two Medicare-endorsed drug discount cards.

The drug discount program included in the Medicare Prescription Drug and Modernization Act also provides low-income beneficiaries with an additional subsidy of $600 to help with the costs of their prescription drugs.

This program provides immediate relief to Medicare beneficiaries now paying extremely high prices for their prescription drugs.

This bill also lowers the price of prescription drugs for Medicare beneficiaries, by eliminating the Average Wholesale Price, AWP, paid for prescription drugs.

This provision significantly reduces the prices that Medicare and many private insurers pay for physicians-administered drugs.

Under this agreement, Medicare reimbursements will now be based on actual prices paid by physicians, rather than fictitious numbers reported by manufacturers, providing a ripple effect lowering the cost of prescription drugs for not just Medicare beneficiaries but individuals in the private market.

The conference report also contains a "non-interference" provision that will protect patients and deliver lower prices through market competition.

The conference bill specifies that the Government "may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors" and "may not require a particular formulary or institute a price structure." It is right here on page 53.

Opponents claim that this provision, which originated with Democratic proposals, is a concession to the pharmaceutical industry. That is plain wrong.

The noninterference provision is at the heart of the bill's structure for delivering prescription drug coverage through market competition that gets a good deal for consumers, rather than through price fixing by the CMS bureaucracy. As CMS Administrator Tom Scully explained in the November 21, 2003 issue of the Washington Post, if Medicare negotiated prices, "I wouldn't be negotiating; I'd just be fixing the price. Let's get seniors organized into big purchasing pools that get bulk discounts and see how they fare."

Ironically, this provision was created by the Democrats and first appeared in May 2000 in a bill sponsored by Senator DASCHLE and 33 Democratic cosponsors. In June 2000, Mr. STARK included the same language in his motion to recommit H.R. 4680. That motion received the support of 203 Democrats and Mr. SANDERS.

The provision protects patients by keeping the Government out of decisions about which medicines they will be able to receive. Under this section, CMS will not be able to dictate that drugs must be excluded from a PDP formulary or subjected to reimbursement limits that effectively deny access.

The bill relies on market competition, not price fixing by CMS, to deliver the drug benefit. The bill's entire approach is to get seniors the best deal through vigorous market competition, not price controls.

CBO scores the bill's approach of relying on at-risk private sector plans to deliver the prescription drug benefit as getting a higher cost management factor for Medicare than bills where private sector competition is handicapped by Government. The noninterference provision protects this approach, by preventing politicians and bureaucrats from getting into the middle of the very negotiations that drive these savings.

Private plans have strong incentives under the bill to negotiate the best possible deals on drug prices, because they are at risk for a large part of the cost of the benefit. They also will have the market clout to obtain large discounts. By driving hard bargains, they will be able to offer lower premiums and attract more enrollees.

The alternative is a command-and-control system that would not be responsive to consumer desires or marketplace realities. Bureaucrats would swing between adding benefit requirements without a means of paying for them and restricting choices and access in an effort to contain costs. This bill wisely rejects that approach. The noninterference provision is the fundamental protection against it.

Finally, the conference report lowers the cost of drugs for all Americans by reforming the Hatch-Waxman drug pricing laws.

The agreement will speed the process of allowing generic drugs to come to market, which will significantly reduce drug prices.

The agreement will provide brand drug companies only one 30-month stay on the approval or a generic competitor.

Generics would be forced to forego their 180-day generic exclusivity if they do not bring a product to market within a specified time period.

These reforms are the most aggressive since Hatch-Waxman laws took effect in 1984.

These reforms have also earned the strong endorsement of the Generic Pharmaceutical Association and dozens of allied groups who are advocates of increased generic usage and low drug prices.

So to my colleagues who say there is nothing in this bill to lower drug prices, they are not talking about this bill.

My friend and colleague on the Finance Committee, Senator BAUCUS, has come to the floor. He is primarily responsible for the legislation that is before us because he has been very willing to work in a bipartisan way to get things done. We would not be here today if it was not for the hard work of Senator BAUCUS, the ranking Democrat on the Finance Committee, and a person with whom I can work very well.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, first I deeply thank my good friend from Iowa, Senator GRASSLEY. I know people in his home State greatly respect him. I read somewhere that he has the highest approval rating of any politician in the State of Iowa. I am sure that is true and I can understand why. It is because he is straight, down to Earth, and honest. He tells it like he sees it, no guile. I want Senators to know that this is my impression, as well. I say this because when he explains the provisions of this bill, I hope people listen. Senator GRASSLEY is not one to gild the lily, not one to indulge in inflammatory rhetoric, not one to exaggerate. He is someone who tells it like it is. This is a very important personal quality of his, and one that I revere deeply.

I thank the Senator for allowing me to work with him as the chairman of the Senate Finance Committee.

I would like to take a few minutes to discuss the Medicare conference report before us. I am sure a lot of people across the country have heard statements by many Senators and House Members and are wondering who is telling the truth. They hear a set of allegations from one side and lots of responses from the other side. It must be incredibly difficult to determine the truth.

A few days ago, Senator BREAUX and I met with 20 or 25 House Democrats. The group is known as the New Democrats. Senator BREAUX and I explained to them what was in the bill.

Over and over again, the New Democrats asked: What is going on here? Our leadership tells us one thing and you are telling us something else. Whom are we to believe?

Senator BREAUX and I explained the bill to the best of our ability. We tried to be honest and straight with the facts. It is my belief that the facts are usually controlling. Once people understand the facts of a bill or legislation, they can make up their own minds. It was our intention to just give the facts so these House Members could make up their own minds.

I suspect that a lot of them were in a difficult place: stuck between their leadership, which was pressuring them to do one thing, and the facts which were inclining them in the other direction.

I further suspect that many people watching across the country tonight are wondering the same thing. There are compelling speeches on both sides of this debate. Who is telling the truth? After all, that is what it is all about.

I am going to do the best I can to explain why I am supporting this Medicare legislation, why I personally think it is a good bill. I am going to use the facts, as opposed to rhetoric. I am not a great rhetorical speaker. As with the Senator from Iowa, I tend not to embellish. Maybe it is because we are from agricultural states. We have learned to accept that we cannot control everything—we cannot control the weather for the crops and the livestock; we cannot control the market price. We accept reality for what it is and tell it like it is because that is the way we have grown up. I will do my very best to give a fair take on facts of this bill.

Why do I support this bill? For many years, Congress has been trying to pass legislation that gives prescription drug benefits to seniors. For many years we have been talking about it. Some years we have come pretty close. Last year, for example, we were very close. I can remember a meeting I had convened in my office with the key Senators: OLYMPIA SNOWE, TED KENNEDY, CHUCK GRASSLEY, Senator GRAHAM, and four or five or six other Senators from both sides of the aisle—liberals and conservatives. We came very close.

But in the end, partisan politics dominated—I think because some wanted an issue, not a solution. We were pulled apart, and in the last moments, we were unable to pass a prescription drug bill.

Here we are again today. We are even closer this year because we have actual legislation that has passed both bodies of the Congress, and a conference report before us. It is not possible to get any closer. If we do not pass legislation this time, I do not know if we ever will. And this would be a tragedy. This bill provides $400 billion over 10 years to create a prescription drug benefits for seniors. This is what the debate comes down to.

We know the importance of this bill because drug prices are increasing rapidly, while at the same time, drugs are becoming ever-more important. They oftentimes replace expensive hospital procedures. And new medications are constantly being developed. New, so-called miracle drugs are being developed today that will help treat many different illnesses in the future.

Many of our seniors with low incomes and fixed incomes simply cannot afford the drugs they depend on. It is critical that we pass this legislation. Every other country in the industrialized world provides prescription drug benefits for their seniors. We are the United States of America. Why in the world do we not provide prescription drug benefits for our seniors?

We should.

And we now have the opportunity before us. I do not know when we are going to get this opportunity again. If we do not act now, the chances of passing prescription drug benefits for seniors in the next several years is very slim. Next year we will be faced with higher budget pressures: The national debt is increasing; our deficits are rising due primarily to uncertainties overseas—Iraq and Iran; due to terrorism; and due to greater domestic needs. If we do not pass prescription drug benefits now, we are unlikely to have another opportunity again. If we do not act today, the $400 billion will not be there next year.

I also support this legislation because of its very generous low-income subsidies for one-third of all senior citizens. These senior citizens, one-third of all senior citizens, will have 90 percent of their drug costs paid for. Under this legislation, 90 percent of their drug costs are going to be paid for by the federal government.

This is a very important measure in this bill. It provides very strong low-income protections. I do not know if we are going to have these protections again in future Medicare legislation, if we even have future Medicare bills. When are we going to again have such generous assistance for our low-income seniors?

An additional reason I support this legislation is that it contains a strong government fall-back plan. This is a technical term which means that when there are not two private drug plans available in any region, a senior is able to access a guaranteed government fall-back plan for their drug benefits.

The only question is: Are there two private plans in any given region of the country? If there are, your prescription drug benefits are covered through the private plan with all of the guarantees that are written in the legislation to ensure that seniors are not taken advantage of. If there are not two private plans in the area, then the Government fall-back plan goes into effect.

The bottom line is that all seniors in America will get a prescription drug benefit. All seniors in America are covered by this bill, whether it is in a private drug plan or through the government fall-back plan. This is what we mean by a strong Government fallback—all seniors will get the prescription drug benefit.

It is true that the House bill did not include a strong government fallback. But we are talking about the Conference report. And in this legislation, all seniors will have access to the drug benefit.

The fourth reason I support this legislation is rural payment equalization, as well as other strong provider provisions.

During the many years I have been in this body, I have worked hard to make sure that Montana and other rural States get the same payments for hospitals and doctors as urban States, as the big States.

We have been fighting for this for years. Finally this legislation addresses this inequity. If this bill does not pass, I do not know when we are going to be able to address this issue. Nothing is guaranteed in the future. Times change. Congresses changes. It is difficult to predict the future. A bird in the hand is worth two in the bush. We have a bird in the hand now.

We have strong rural provisions in this legislation. If it does not pass now, the chances of rural areas getting a square deal and a level playing field are going to be in serious jeopardy.

I say to those Senators from rural states, how can you vote against a bill and deny increased payments to your home states when you are probably not going to get them again, when you have been fighting so hard to get them for so many years?

I would now like to turn to another issue that has been discussed frequently and which is of great concern to many Senators, and well it should be.

As indicated on this chart, employer-sponsored retiree coverage is declining.

Eighty percent of companies offered retiree health care coverage in 1991. In 1996, it fell to 71 percent. In 1999, it fell to 66 percent. In 2001, it fell to 62 percent, and 2003, 61 percent. There is a steady decline of companies dropping or reducing their retiree coverage.

You might ask, Why is that happening? It is happening because of competitive pressures. Companies want to cut back on costs wherever they can to maximize their profits. Retiree health benefits is one area where they are cutting down their costs. They are reducing coverage for their retirees. It is inevitable and it is happening.

Why do I mention this? What does this bill do to address this phenomenon? This is an extremely important point, and I hope Senators and staff are listening. This bill discourages employer retiree droppage; discourages, not encourages, it. It provides tax-free subsidies for companies to discourage them from dropping their retiree benefits.

This bill provides $88 billion—$88 billion—to companies for their retiree plans. Eighty-eight billion dollars is going to companies to discourage them from dropping their retiree plans.

The Congressional Budget Office said under the Senate bill that there would be about a 37-percent droppage rate; in the House bill, about 32 percent.

But in this Conference report, we have provided additional funding. The rate is now down to about 22 percent. But that 22 percent would be higher if this additional money was not provided.

The actual number in the conference report is 17 percent. This number reflects a more accurate calculation. 22 percent is apples to apples to the 37 and 32 percent in the Senate and House bills. The 17 percent is a more accurate figure.

The net effect is the droppage rate is about 50 percent less as a consequence of the provisions in the conference report. Companies are getting $88 billion to maintain their retiree coverage.

I ask my colleagues, if you vote against this bill, what are you going to say to those employees who lose their retiree coverage when you had the opportunity to vote for a bill that would have provided funding to address this problem? What are you going to say to those retirees when you tell them you voted against a bill which would have discouraged retiree droppage? What are you going say to them? I don't know; it wasn't perfect.

This bill has the effect of discouraging—not encouraging—retiree droppage. I hope Senators pay very close attention to this point. This issue concerns many Senators.

I would like to address another issue—the impact of this bill on dual eligibles.

We have heard criticism that the effect of this bill is to make drugs more expensive than current law for dual eligible senior citizens.

This is completely inaccurate. The assumption behind this argument is that this bill has a $1 and $3 copay for drugs for dual eligibles. For seniors who are under 100 percent of poverty, this bill has a $1 copay for generic drugs, and a $3 copay for brand-name prescription drugs.

The assumption behind the argument that the 6 or 7 million dual eligibles will be worse off is that these seniors do not currently have copays under Medicaid. That is not true. Most States, at least 38 States, already have Medicaid copays. The 6 or 7 million worse off is simply a false figure.

In fact, most States are under tremendous pressure to reduce the costs of their Medicaid programs. One of the ways they decrease costs is through increasing copays.

For those Senators who have been claiming that 6 or 7 million will be worse off, please look at the Medicaid copays in many States and anticipate what will be the situation in the year 2006. It will be worse: 38 States have copays. Not all are greater than $1 in $3 now, but if States continue to cut back on Medicaid to balance their budgets, then the copays will rise.

Today, Illinois already has $1 and $3 copay. The bill does not hurt low-income seniors in Illinois. In Maryland, there is a $2 co-pay for brand-name prescription drugs. In Massachusetts, it is for all drugs. The same is true for Nevada. I see my good friend Senator REID is here. He knows more about Nevada than I hope to know. North Dakota is $3 for a prescription. South Dakota, about the same. And these are just some examples.

If you look at the facts, the 7 million figure is closer to about 1 million.

Another inaccurate criticism is premium support. There has been a lot of talk that premium support will undermine Medicare as we know it. I would never vote for a bill that I thought would undermine fee-for-service Medicare. I would not do that because I know how important it is to seniors, certainly in my State of Montana.

In the year 2010 there will be six demonstration projects. That is far better than the House bill which wanted a full-blown nationwide premium support. We have heard a lot of horror stories about premium support, but that is based upon the House bill, which had full-blown, nationwide premium support. This is not a fair criticism. People are talking about another bill, not the Conference report before the Senate.

What is before the Senate is a bill which says in the year 2010 there will be up to six MSAs, metropolitan statistical areas, that could test this concept of premium support. I might add, as I have said before, that Medicare fee for service is held harmless. People in these areas who want to stay in fee for service can. There is no requirement they get out of fee for service.

Remember, the President earlier proposed legislation that would have required people to join private plans to get a drug benefit. That was then. This is now. This bill does not say that. This bill says, if you want to stay in fee for service, that is fine. You do not have to join a private plans.

Some Senators also worry that Part B premiums might rise because the private plans will take the healthiest seniors, forcing up the fee-for-service Part B premium.

This argument is not true.

All low-income people are held harmless in Medicare fee for service. Their Part B premium cannot go up. They are held totally harmless. As I mentioned earlier, a third of America is classified as low income in this bill.

What about those who are not low income? This bill limits any premium increase to 5 percent. This is significant.

Part B premiums for next year, 2004, are going up about 13 percent for all senior citizens. Why is that? Because this Congress, using its best judgment, has decided to increase dollars to doctors. Seniors pay for 25 percent of this increase through higher Part B premiums.

In this bill, the premiums cannot go up by more than 5 percent in the premium support areas.

Another point: A maximum of 1 million beneficiaries may be affected. I mention this number because there are a lot of other figures being discussed, including that 10 million senior citizens will be affected by premium support. Ten million is not an accurate figure. It is not true. We went to an objective source to find out what is true and accurate. We went to the CBO. CBO told us that between 670,000 and 1 million people could be affected by this bill in the six areas. Even so, these people can stay in standard fee for service. They are not required to go into private plans. There is no incentive, unless a premium support plan does offer a much better package, much more in benefits, much lower in costs. That is possible. I don't think it is likely, but it is possible.

The main point is that very few people could be affected by premium support. It is not the 10 million figure we have heard. Take the figure of 10 million, cross out the zero, and you get the real figure of 1 million or fewer.

Next, this legislation limits the number of sites to six. There can be no more than six MSAs in the Nation. The Secretary has no discretion to add more.

In addition, this legislation says these demonstrations are limited to 6 years. That is in statute. That is not regulation. The Secretary cannot change that at his discretion.

It takes an act of Congress to extend or expand these six. After 6 years, the issue will be before Congress to decide what to do: Do we want to extend the premium support areas? Do we want to eliminate them? Do we want to change them? This cannot, by regulation or the Secretary's decision or by the President's decision, be changed; it takes an act of Congress to change.

I might add, as well, that there are payments in this legislation that go to preferred provider organizations to see if they can work.

But preferred provider organizations have to be regionwide. They have to serve the whole region. They cannot pick and choose individual MSAs. As we know of today, HMOs pick and choose. They go to the counties they like and avoid the counties they do not like. They cherry-pick the healthiest people. They do not go to the counties they don't like, those with the less healthy people. This is not the American way.

This legislation provides for additional funding for the regionwide PPOs which go into existence in the year 2006. There is a $12 billion fund which helps get these plans up and started. But again——

The PRESIDING OFFICER. The Senator's time has expired.

Mr. BAUCUS. Mr. President, may I ask for a few more minutes?

Mr. REID. Mr. President, we have 4½ hours of speeches still tonight, and that is why we have limited it to half an hour each.

Mr. BAUCUS. If I could just have 1 minute?

Mr. REID. Sure.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Montana.

Mr. BAUCUS. Mr. President, I will just sum up by saying, I have spent a lot of time on this legislation. I am not going to do anything to hurt senior citizens. It would be foolhardy, foolish, stupid. And this bill does not hurt senior citizens, it helps them.

There have been a lot of charges against this bill. It is very easy to be negative. It is very easy to find fault with anything.

This bill is not perfect, but it is very good.

I urge all of us to remember, this is a very good bill. It gives great assistance to our seniors. We have subsequent years to work on it, build upon it, and to make changes. But if we do not pass it now, the chances are very slim we will be able to pass prescription drug benefits for seniors again.

So I strongly urge my colleagues to support this bill and oppose procedural motions which will impede passage of this bill.

The PRESIDING OFFICER. The assistant Democratic leader.

Mr. REID. Mr. President, first of all, I want to underscore the comments about the Senator from Iowa, Mr. GRASSLEY, which were made by the senior Senator from Montana.

Senator GRASSLEY is a dedicated Senator, a gentleman, and I have great respect for him. So I appreciate the Senator from Montana saying those nice things about the senior Senator from Iowa, Mr. GRASSLEY.

But I also want to say that on our side we have two people who have been so heavily involved in getting a bill here. One is the ranking member of the Finance Committee, Senator BAUCUS, who, as he said, is my friend. I have the deepest respect for him, and I know how hard he has worked on this legislation. He has kept me apprised of his progress and slippage on occasion.

Senator BREAUX and I, of course, came to the Senate together. There is a bond of friendship between us that will last forever.

So even though I do not agree with my two friends, Senators BAUCUS and BREAUX, on this legislation, no one can take away how hard they have worked on it and how they believe they are doing the right thing.

Mr. President, the Presiding Officer knows that my father was a hard rock miner. As I look back, the best times we spent together were when I was a little boy.

My dad worked in a number of mines, but the mine that I remember is a mine called The Elvira. My dad worked underground alone, which was, of course, against the law. No one ever prevented him from doing that. The mining inspectors rarely came to Searchlight.

It was during the summertime, when I was out of school, the first summer I can remember going down with him, keeping him company.

As I look back on my father, those were times we had together underground. I had my own little hat, with a carbide lamp. I was not much help to him, but I kept him company.

My dad was a very quiet man, but he would talk to me. We had wonderful times. I would have my own lunch. My mom would pack my lunch.

But my dad taught me a lot of things. As I indicated, the finest memories of my dad are from those days we spent together underground.

As I got older and stronger there were things I did later, as I became a teenager, that I could do to help him physically other than just keep him company. But those days were not like the days I spent alone underground with my dad.

He taught me a lot of things. But one of the things he taught me how to do was to pan for gold. Of course, we never had much. He never found much for what he did. There was not much gold there.

But I knew how to pan for gold. You would take the rock and grind it up real fine into a little metal bowl. Then you would put it in like a frying pan, a pan that was made just for that, and shake it with water coming down. And gold, of course, is very heavy, and the gold would be at the bottom. You could see if there was any gold there.

The other way, of course, you could find if there was gold is you could send it to an assayer and find out. But the first preliminary thing you did was pan for gold.

Mr. President, one of the things I learned as a boy in Searchlight is there was a lot of something called iron pyrites. It is fool's gold.

I have this little rock in my hand. It is the same kind of rock I have pictured on the right side of this chart. If you were up close, you could see this glittery, gold stuff on the rock. It is all over the rock, and it looks like gold. It glistens like gold. The only way that you can find out if it is real gold is if you either pan it or assay it.

What I have shown on the left side of this chart is gold. And what is shown on the right side of the chart looks like gold, but it is fool's gold.

I say to my friends within the sound of my voice, even though this product looks like gold, I think if you examine it, if you assay it, you will find it is not gold. It is like the iron pyrites in the mines of Searchlight. It is something we call fool's gold.

This legislation started as a Medicare prescription drug benefit for seniors. Now, this large bill we have here, of approximately 700 pages—approximately 700 pages—about 150 pages of it deal with prescription drugs for Medicare. The rest of it is something that I never thought was to be part of the legislation; it is to reform Medicare.

Now, my friend, JOHN BREAUX, has spent a lot of his legislative life talking about the need to reform Medicare. And I have not talked in detail with Senator BREAUX, but I am confident he was much more involved in and concerned about reforming Medicare than the prescription drug aspect. That is not necessarily bad, but that is what he was focused on.

Senator BREAUX believes that Medicare needs reform. During the Clinton years, he was the chairman of a committee to come up with some Medicare reform. And he came up with it. He was the chairman of that committee. More than 50 percent of the people who served on that panel believed that his program was good that they had come up with. But under the rules of engagement, it took a supermajority to do that, and he could not get that.

So Senator BREAUX, as I have already said about my friend—Senator BAUCUS and Senator BREAUX, fine people, wonderful Senators, but I think this legislation, which started out as a prescription drug benefit for seniors, has gone way beyond that and is now a bill mostly dealing with Medicare reform.

This legislation is OK at first glance, but if you look at it closely, I believe, as I have indicated on this chart, it is really not the gold, shown on the left, but it is the fool's gold, the iron pyrites, shown on the right.

This summer, we passed a bipartisan prescription drug bill, which was not perfect. As it returned from the House, though, the prescription drug bill that passed the Senate has taken a step backward. It is not imperfect; it is bad. I think there are millions of people worse off. It gnaws away at the foundations of Medicare.

Seniors have trusted this program for 40 years. My position has been that we should make health care available to every American, we should cut costs, we should improve quality, and we should expand access. Upon review of this legislation, we don't have that. We have what I believe is an image, an image that looks like gold, but it isn't, it is fool's gold.

All you have to do is look at the facts. In Nevada, 20,000 low-income seniors will have to pay more when this legislation goes into effect. This bill contains an unfair and confusing assets test. Why would we charge someone negatively because they have planned ahead and have a burial plot, maybe a car, maybe some furniture? This bill contains an unfair and confusing assets test. More affluent seniors are going to be punished. That is not right.

I have been through this once before as a Member of Congress. On catastrophic, I introduced legislation in the Senate that the chairman of the Finance Committee, Lloyd Bentsen, personally criticized me for introducing. That legislation was to repeal catastrophic. I did it because the seniors of America were up in arms. I was a relatively new Senator, and I won't say my colleagues shunned me, but they weren't happy for a while. But that legislation passed. It repealed catastrophic.

Catastrophic was directed toward people who had taken care of themselves, had provided for the future. They were being punished for having done a good job, taking care of the future. They rebelled. And that is what we are going to find here.

Clearly, they will pay more in Medicare premiums. The costs of Medicare will go up for them. They already pay more than their share of payroll and income taxes. They already pay the greater share of Medicare costs.

I have received some letters from people in Nevada, constituents of the Presiding Officer and me. Let's note what some of them say.

Mrs. Betty Sweet of Las Vegas: Don't sell the seniors out to big business HMOs. The HMO plan will be a step down in our care.

Martha Pruter of Reno: This plan is only going to benefit the pharmaceutical companies. It will not benefit consumers.

Mary Ann Brim of Henderson: I oppose the Medicare bill. Has anyone done the math? I can't believe they would support this bill if they had. Certainly you can come up with something better than this.

Now, these people, Mrs. Brim in particular, actually did their homework on the math. The actual drug benefit created by this bill is confusing and offers seniors only a meager drug benefit. Someone who spends approximately $5,000 a year on drugs will be stuck with almost 80 percent of the bill.

People have come to me and said: Vote for this. Nothing is going to kick in for a couple of years. You are protected. You can talk about the benefits of this bill. Maybe they are right. But in a couple years I would look back on this vote saying, I didn't do the right thing because thousands of retirees in Nevada will lose their coverage as a result of this bill.

In Nevada, tens of thousands of seniors stand to lose their current retiree drug benefits. The Nevada senior prescription program that Governor Guinn of Nevada tried, it was one program, and nobody even signed up for it. He has one now that is good, people like it, and we don't know what is going to happen. We don't know what is going to happen to this program.

We heard the distinguished ranking member of the Finance Committee, Senator BAUCUS, talk about demonstration projects, six of them. We could get as many as three of them in Nevada. I don't think we should be used as guinea pigs in an ideological experiment that would force them to give up their doctor and join an HMO or pay higher premiums to remain in traditional Medicare. Those who opt for private plans would have to use a doctor approved by the insurance company in these areas. Over time the seniors who remained in the traditional fee-for-service Medicare would likely be the oldest, the sickest, and the poorest. They would have to pay an ever-increasing premium to maintain their coverage.

This bill would make a wide range of seniors worse off than they are today, from seniors who are eligible for Medicaid, seniors who have coverage through former employers, seniors enrolled in State pharmacy programs, to seniors who will be forced to pay higher premiums to stay in traditional Medicare. That is not the type of prescription drug coverage our seniors deserve. It is fool's gold.

Many of my colleagues support this bill because they like the concept of competition. I like competition, too. But I am in favor of competition where there is a level playing field. This bill does not provide for fair competition.

This rigs the rules in favor of private insurance companies by paying them off to serve a patient whom Medicare would also take care of without the additional incentive that these companies get. It siphons off $12 billion that should be used to help our seniors. It pushes it off into a fund for private insurance companies. That is why we have read in all of the papers around the country that the insurance industry is wild about this legislation. The pharmaceutical companies are wild about this legislation. They wiped out the reimportation we had in our bill, something that went to the House, where we could reimport drugs which are much cheaper in Canada. That is eliminated, and that is too bad. It was a concept that both the House and the Senate approved. This is something that is hard to comprehend.

This bill even says that when Medicare becomes the largest purchaser of prescription drugs, it is expressly forbidden to negotiate prices with the drug companies. That is why we want these large purchasers of pharmaceuticals, so they can go to the drug companies and get lower prices. In this legislation, they are forbidden from doing this. If we really believe in a free market, why shouldn't Medicare also be able to bargain for good prices? It is no wonder big insurance companies and big drug companies are spending millions of dollars on lobbyists and ads to support this bill.

I have to say they have done a good job. I want everyone to know that the drug companies and the insurance companies have spent their money well. Because the lobbyists have really done well by them, this bill is a dream for the insurance industry and the big drug companies. It tilts the playing field in their favor at the expense of senior citizens. That is not competition, it is corporate welfare.

This bill is not what it claims to be, and seniors are smart enough to see this bill for what it really is, fool's gold. Betty Sweet, Martha Pruter, Mary Ann Brim, they all did their homework and understand that this legislation is not good.

As I have indicated, the actual drug benefit created by this bill is confusing and offers seniors only a meager drug benefit. It is a poor trade when you spend approximately $5,000 a year on drugs and you will be stuck with 80 percent of the bill. When we talk about a pharmaceutical benefit for Medicare, people think they are going to get the drugs at a reasonable price.

The Medicare conference agreement would make fundamental changes to Medicare as we know it, changes that have nothing to do with a prescription drug benefit or building a stronger foundation for the program. It would use our senior citizens as guinea pigs to test the theories of Newt Gingrich and other ideologues.

Am I off base on this? I carry this with me because I have used it on a number of occasions, and now it is kind of withered and dilapidated. I have seen Newt Gingrich, with whom I served in the Congress—a fine person. I like him. I think he has a great mind. And he has been able, with his great mind, to do some things with which I don't agree. But I have here some statements made by leaders. I believe their whole concept is what is behind this legislation.

First of all, this is Senator Bob Dole's direct quote:

> I was there fighting the fight—

He was 1 of 12 against Medicare—

> because we knew it would not work in 1965.

He and many colleagues believed it would never work. Senator Dole was 1 of 12 who voted against it then.

Former House Speaker Newt Gingrich, said:

> Now, we didn't get rid of it in round one because we didn't think it was politically smart, but we believe Medicare is going to wither on the vine.

Former House Member Dick Armey said this:

> Medicare has no place in a free world. Social Security is a rotten trick.

He goes on to say:

> I think we are going to have to bite the bullet and phase it out over time.

Those are direct quotes. I think part of what we have behind this legislation is an effort to have Medicare wither on the vine, and it will be withering on the vine. I think we should understand that this legislation is not what it purports to be; it is not. As a result of that, I believe we should vote against this legislation.

Mr. President, how much time do I have left?

The PRESIDING OFFICER (Mr. ENZI). The Senator has 11 minutes.

Mr. REID. Mr. President, I yield that time to my colleague from Nevada, Senator ENSIGN.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. ENSIGN. Mr. President, I want to talk about one Senator's journey through this bill, trying to make a decision based on the facts and trying to get through the rhetoric, because there is a lot of that going on in any piece of legislation. So I am trying to write down the pros and the cons of this legislation and go through them in a systematic fashion and try to make a decision based on policy and not based on politics, a decision based on what is in the bill, not on what people are saying is in the bill.

As I have gone through this, I have a whole list of general principles that I believe are good. I have still not made up my mind on this final piece of legislation because it is really a balancing act. There are good things and there are things that are not so good. Just to mention a few of the things that I believe are good in this bill, probably the best thing is something called the health savings account, which has nothing to do with Medicare today. It has to do with reforming the overall insurance system in our country for health care. It is something I have been fighting for, for many years and introduced legislation on when I was in the House of Representatives on the Ways and Means Committee.

We passed it several times, but unfortunately, when we passed the final version, we had to water it down so much that we enacted a piece of legislation that did not work. So the health savings accounts in this piece of legislation, I believe, are going to be one of the most significant reforms we can possibly enact for the future of bringing the patient back into the accountability loop. When you have a third-party payer system—what I mean by that is the person receiving the care doesn't directly pay for the care; it is a third-party payer system.

So when you walk into a doctor and the doctor says we need to run this test and that test, the person doesn't even say how much do those tests cost or is there a cheaper place to go get an MRI, for instance, or is one place better or cheaper or is a certain specialist better than others or is one cheaper than others, and maybe of the same quality—none of those kinds of discussions happens because they are not paying the bill. The health savings account allows them to put money into an account tax free. It builds up in the account tax free, and when it is taken out for health care expenses, it is taken out tax free. Then that person directly pays the doctor.

Now, why is that significant? It is significant because in our current system, whether it is traditional Medicare fee for service, or even the HMOs or the PPOs, all the payments go through some kind of bureaucracy, whether it is a Government bureaucracy or a private one. Anybody that has experienced our health care system today knows that maybe companies are not trying to deny payment but it certainly seems like that in a lot of cases.

My in-laws are dealing with this right now. My father-in-law had cancer last year. They have been battling for almost a year now on whether the insurance company should pay for a large part of their coverage or not. That takes a lot of time for people to process, to answer phones, go through the whole process. If somebody is paying out of their own pocket to the doctor, none of these conversations has to take place, and that money that is saved through the bureaucratic process can go directly to health care. I believe health savings accounts are one of the most positive things in this bill.

Mr. President, will the Chair please notify me when there is 1 minute remaining?

The PRESIDING OFFICER. The Chair will do so.

Mr. ENSIGN. Second is the means testing idea of Part B, the affluence testing, as it is being called. I think it is wrong. This is not a part of Medicare where people are paid in their taxes over the year. Part B is something that younger generations—such as the pages we have here—people paying taxes out there are paying for seniors, and we should, at least for those wealthy seniors, have them pay for that benefit they are getting, instead of shifting the benefit on to middle-class taxpayers. That is also very good.

Another part that is good in the bill is this idea of a disease management pilot project. Right now in Medicare, you go to one doctor and Medicare pays, and maybe you have diabetes and you have to go to several specialists, internists, or whatever; there is nothing really coordinating care. So you get different prescriptions and different doctors. There is no real coordination of care and also not a lot is being done preventively. So we end up with poor-quality care, poor outcomes, and we spend more money.

We have a great demonstration project, a pilot project that Republicans and Democrats actually should like in this bill on the disease management part of it. In the future, I believe it will improve outcomes for seniors healthwise, and it will also save costs.

As to some of the negative parts of the bill, first of all, it does not kick in right away. A bill that I introduced would have kicked in as soon as the drug discount card kicks in. That is the only thing that really kicks in, in the next 5 or 6 months—the drug discount card. The legislation I had introduced actually would have fully kicked in. The Democrat bill and Republican bill we had debated, none of those kicked in right away, and neither does this bill.

The other problem with this bill is there is a cliff at 150 percent of poverty. After that, you kind of drop right off the cliff. So for those below 150 percent of poverty, this is too generous. With a $1 and $3 copay, we are going to incentivize people to overutilize drugs, pure and simple. You are going to see overutilization of drugs. We see it in Medicaid today because of the low copays and we are going to see it here. That was a huge mistake that we didn't once again have people receiving the drugs having anything financial at stake. And $1 and $3 copays will not change behavior in any way whatsoever.

The other thing that actually we have to consider—and we should at least go into this with open eyes—this is the largest wealth transfer since Medicare was first put into effect. We just have to know that. The $400 billion is being taken from younger people and given to older people. The older people didn't pay for it. We are giving that. So we have to go into this with open eyes.

The other thing I believe is a problem with the drug benefit we have in Medicare is that it is giving it to the wealthy. I don't believe we should be. We should be helping and putting almost all the benefit into the people who are literally having to choose between prescription drugs and rent and maybe whether they are going to eat that month or what kind of food they are going to eat that month.

Instead, this bill gives coverage for everybody on Medicare. I don't believe that is right. When Bill Gates turns 65, I don't believe he should be getting a prescription drug benefit that is paid for by some union worker who worked hard all of their life and paid taxes. I don't believe that is right. So I believe the prescription drug benefit should be means tested. That is another negative in this particular piece of legislation.

Just mentioning a couple of the things, there are some really good pieces of this bill, but there are some major negatives in this bill.

When we are going through all of the rhetoric, I think all of us have to be honest. The supporters of the bill should be honest that there are some problems with it, but the people who are against the bill should also be honest. This does not end Medicare as we know it. This is a bill incredibly generous to low-income seniors. Even if I vote against this bill, I have to say this is incredibly generous to low-income seniors. That is just being honest. All seniors pay out of pocket is a $1 copay for generics and a $3 copay for brand name prescription drugs. That is an incredibly generous benefit.

In conclusion, as I go through this next 24 to 48 hours—whenever we are going to vote on final passage of the bill—it is a 700-page document we got a couple of days ago. I think we have to take our time to go through the bill.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. ENSIGN. Taking our time to go through the bill is very wise to do because my biggest fear—and we see this happen with legislation all the time—when we have this kind of complexity in a document is the law of unintended consequences.

We enact bills all the time. When we enacted HIPAA—and the majority leader is on the floor and he knows better than anybody—the HIPAA law is a terrible piece of legislation, and we are suffering consequences today. We are driving up health care costs unnecessarily because of that legislation. That is why I am still trying to go through this legislation to make up my mind.

I thank my colleague, the senior Senator from Nevada, Mr. REID, for yielding me the time to speak tonight. I look forward to hearing the majority leader's comments on this legislation as I am still battling through what I am going to do on it.

I thank the Chair. I yield the floor.

The PRESIDING OFFICER. The majority leader.

Mr. FRIST. Mr. President, I will be speaking for about 30 minutes. I ask that the Chair notify me when I have used 25 minutes.

The PRESIDING OFFICER. The Senator will be notified.

Mr. FRIST. Mr. President, we are at a truly historic time. A lot of times we exaggerate a bit to make a point. It seems as if on every bill somebody says: This is a historic bill.

As a physician, as someone who has had a great privilege in life, a blessing in life to have served as a physician and to have taken an oath to serve humankind in such an intimate and personal way, I truly believe it is an historic time because with the action we are almost certainly going to take tomorrow night, we are going to change the lives of 40 million seniors and also 77 million baby boomers who will be seniors over the coming years by this single piece of legislation.

It is rare we can say that. It is so rare. Everybody gets sick at some point later in life—everybody. If it reaches a certain threshold, you seek medical care. This bill will affect the type of care you receive, whether or not you have appropriate access, the quality of that care, and the response of the type of care that is given to you. That is why I say it is a historic bill.

I am confident we will pass this bill tomorrow night. I know there are a lot of statements that have been made: We are going to obstruct; we are going to filibuster; we are going to use procedural moves. But at the end of the day, nobody from this body, I believe, can go home and say—when we are an eyelash away, after 6 years of hard work of trying to put together the very best bill possible—that we would go home having denied the President, with the leadership he has shown, and the House of Representatives, with the leadership they have shown, and the hard bipartisan work on this floor, and then tell seniors: It is not going to happen. Once again the promises that have been made have been denied you.

Why do I say that? That is the question I wish to answer over the next few minutes.

I want to start from afar and then come down to some of the specifics of the bill and paint a picture, paint a portrait that I think helps, at least in my own thinking, to explain to the American people why this is a pivotal time, why we have to act now, why we can't wait another year or 3 years or 5 years, why at this moment in history events have come together in conversion. There is a reason, and when we act, we will have a much more dramatic impact in improving health care and improving health care security than if we were to wait.

In 1965, Medicare began. I didn't start practicing medicine until the eighties, but through that period of time, it is just amazing. We have seen health care advances that are remarkable in terms of medicine, science, and technology. The half-life of medicine—that is a statistical way of looking at medicine and advances. It got smaller and smaller and smaller and smaller because of our knowledge and understanding. Advances have been made in both health services delivery—that is how health care is delivered and how it is organized—as well as scientific and technological advances.

I am going to show three graphs using this same format. On this Y axis is change. It is fairly arbitrary in describing change, but it is improvements, it is how things change over time. Along this X axis, it starts in 1965 when Medicare started and ending in the year 2005, as we project ahead.

We can see this change came along pretty steadily, and all of a sudden it started to go up, up, up, and I would put it way up off the chart. That is where this change is going.

The first successful heart and liver transplant was in 1965. That is a fascinating history. That is the field I ended up going into, heart transplant surgery.

Coronary angioplasty, when people have drug-eluting stents, and we hear about it all the time. It wasn't that long ago. That was just in 1977. We had the first open heart surgery cases in the 1960s.

In 1974, the HMO Act was passed in this body. Prozac, a drug many people are on today, was first used in 1988. It is interesting, when the PPOs—and I will talk more about PPOs shortly—began in 1985, 1 million people were enrolled. Within 13 years, 90 million people are enrolled in these PPOs.

We had the human genome project, a fantastic project which just finished this year. It was a successful public-private partnership. This chart shows all the advances. The point is, these advances are getting faster and faster.

The next chart uses the same format, but it shows what Medicare has done. Has it changed as well? Medicare has not changed very much. It started in 1965. It was enacted into law in 1965. It is a great program, a fantastic program. I had the opportunity to treat thousands of patients in Medicare. It has given them health care security.

But, contrast Medicare to all the health care advances, and we can see it hasn't changed much over time.

In 1972, it was expanded to include end-stage renal disease and dialysis. That was a a good advance.

There was a good advance in 1985 with prospective payments for patients who are actually in hospitals. It was pretty revolutionary at the time.

We have had people refer to catastrophic coverage. Notice line went up and went down because catastrophic coverage was repealed. A lot of people said: Is this bill going to be repealed? If I have time, I will comment on that because there is a clear answer to why that is different.

There were prospective payments for physicians 1990. In 1997, we added the Medicare+Choice Program and other prospective payments.

Now we are in 2003. And tomorrow night are we going to improve and change Medicare in a positive way. People say you can change Medicare and that is bad. That is not bad; that is good.

We are going to strengthen and improve Medicare, and that is the whole purpose. The next chart shows very clearly the advances in technology go on up, but Medicare is too rigid. It does not change. We are not capable of changing the structure of Medicare fast enough in this body and therefore that rigid structure cannot adapt to new drugs, new pharmaceutical agents, new ways to deliver health care, new types of PPOs. We just do not change.

So the gap, is what we are addressing. If we do not pass this bill tomorrow night or tomorrow afternoon—the sooner the better on my part—I think we are not going to fill this gap, and we are going to be stuck down here when all of these advances are up here and these advances are being denied seniors.

That is why when people say "filibuster," use procedural moves to stop this, do they mean they want to stay down here when we have the opportunity, to catch up and let these health advances be delivered to our seniors? So that is the way I think about things—in terms of what is at stake.

I do not think anybody can defeat this bill and go home from here. They cannot face 40 million seniors and say we are not going to give them the advances that are available to the rest of the world. It is not right, if that is the case.

Now, why today? I have heard from the other side of the aisle again and again: Let's do it next year, 2 years from now, 3 years from now.

It is because we have this earthquake, or this mountain, moving towards us, defined in 1945 by the baby boomers. This is a fertility curve. We know after the war, fertility went up 3.5 births per woman. Then it fell back down. This is moving through the system to the point that in about 2008 or 2010, this curve will begin to move through the Medicare program as these baby boomers age, beginning in about 4 to 5 years.

When they hit the system, what happens is potentially catastrophic if we have not prepared the system for that.

To explain that, I will use the following several charts. No. 1, let's say I am the Medicare system right here. I have seniors who are taken care of over here, and I have people who are paying—that is all the working people today—to support the Medicare system which takes care of these seniors. Well, what is happening is we are having a doubling of the number of seniors because of the baby boom. So the population is getting bigger because of the baby boom demographic shift. It is this point in history that it occurs. It was not 10 years ago, and it is not 30 or 40 years from now. It is beginning right now. We have a doubling of the number of seniors.

At the same time, because there is a big curve moving through, we have fewer people working to pay. So we have fewer and fewer people paying the health care of more and more people over time because it is a pay-as-you-go system. The people supporting the system today are the people working today.

I will show my colleagues graphically exactly what I said. Medicare enrollment—that is the number of seniors over 65 years of age—in 1970 it was only 20 million. What is important is that there are 40 million people today, but because of the baby boom—look at this curve going up—we are going to have twice that in 2030, right at 77 million, this chart says, but it will be right at 80 million. So we have a doubling of the number of people we are going to be taking care of over the next 30 years.

What about the people who are actually taking care of each one of those? In 1970, there were seven people over here working to take care of every senior, but because the fertility curve is moving through in the year 2000, it was about four people working. So for every person working to support one, they are having to work a lot harder. There are fewer people. Instead of seven working, four are working for each one.

What is even worse is that over the next 30 years, instead of four people, it goes to two people. So they are going to have to be working twice as hard for every one person that is benefiting. Yet we have twice as many people who are benefiting. That is the challenge that we have and that is the reason for "why now." That answers the question as to why we should do it in this Congress. We should have done it 2, 4, even 6 years ago. If we do not do it now, it is too late.

That is the reality of Medicare. So people say, why do we not give a drug card and leave it at that, take care of a group of people and give them 50 or 70 percent on the card? The point is, that does not address everything that I have said to date. It does not address the challenge of having a rigid, inflexible, outdated, antiquated Medicare Program, and that is why not just a drug card, though a drug card is important, and I will come back to that. But that is why that is not the answer.

A lot of people say we should not be spending $400 billion. They say we should spend $100 billion and take care of the people who need it the very most. But, that approach does not address the fact that we have an outdated system.

I have said on this Senate floor many times the most important tool a physician or a nurse has today to treat a patient is not the surgeon's knife that I used every day. It is not the hospital bed. It is not even the hospital. It is pills. It is medicines. It is prescription drugs.

Why today? Why are we acting today? That was not true 10 years ago. It was not true 20 years ago. But today it is the most important tool a physician has. Yet it is denied seniors in the

Medicare Program. Seniors cannot get outpatient prescription drugs through Medicare today. It is the most important part of health care. Yet we deny it to our seniors. That is why nobody can filibuster this bill in good conscience because we are denying our seniors the most important tool in medicine today.

Tomorrow, after we pass this bill, since it has been passed by the House, and the President is going to sign it, for the first time in the history of this Medicare Program we are going to have the most important part of health care as a tool. The most important tool in a physician's armamentarian is prescription drugs. It is being denied seniors today.

Now, just an example: Cancer, diabetes, rheumatoid arthritis, osteoporosis—there are drugs for all of these diseases. There are 402 drugs right now in clinical development for cancer. So whatever we do, we do not want to destroy the research that is going on in this country. If drugs are the most important part of health care today, we want to make sure that we promote research and development. That is why we do not engage in governmental price fixing, setting prices by Government, because it destroys all of this in terms of research.

NIH does a good job, and we can fund it. We fund several billion dollars through our NIH, but the private sector's contribution to research is many fold what the government provides. So we have to continue to support that private sector research.

So what do we do? Where are we today? Here we go in terms of how we modernize this system, and at the same time address the issue of prescription drugs. How do we marry it? This bill does it in a bipartisan way.

I predict this bill will pass tomorrow with a bipartisan vote. I know a lot of people are bringing partisan issues to the floor and saying we are going to stop it with such things as procedural votes, but this bill is going to pass with a strong bipartisan vote tomorrow.

Again, what are we going to do? Today, a senior right now has a choice. They can stay in traditional Medicare, just like 35 million have, with good care and a strong system. It is antiquated, it is out of date, and it is inadequate compared to other options that people have today. It does not include prescription drugs, for example. Or a senior can go into Medicare+Choice. Five million seniors have chosen to go into Medicare+Choice. They do get some prescription drugs. Prescription drugs are in green on these charts. For my colleagues who are in the Chamber tonight, they can see the green.

So seniors can get some prescription drugs, but there are no prescription drugs in traditional Medicare today.

No. 1, I mentioned the drug discount card. In this legislation, maybe 6 or 8 months from now, after we pass this bill and the President signs it, seniors will have access to a drug discount card. It will last for a 2-year period. What it says is while we are developing this system, they can get immediate relief through a card. This card will allow a senior to go to the local pharmacy and get an additional 20-percent discount. Maybe it is a 10 or 25-percent discount, but however a senior gets the drugs they might get today, they will have an additional discount.

It is voluntary. This word "voluntary" is key because everything that we put into this program today in terms of prescription drugs or giving a choice of a health care plan that might better suit a senior's needs is voluntary. They can keep exactly what they have today—and this is important for people who are listening. They can keep exactly what they have today, with no change in their benefits. They might already have prescription drugs so they would not want prescription drugs. All of this is voluntary. It is not mandatory. Nobody is making any senior even make a decision to do anything. They can keep exactly what they have if they are satisfied.

In addition to this discount, there is a $600 value if a senior is low income, less than 135 percent of poverty. The chart I just showed my colleagues was Medicare today. Remember, the senior could choose either traditional Medicare, which 35 million people have, or Medicare+Choice. After this bill passes, we are going to expand the opportunity to choose, so seniors for the first time can choose the health care plan that best suits their individual needs. If you have Alzheimer's you might choose a plan that specializes in Alzheimer's. If you have Parkinson's disease or coronary artery disease or you have had a stroke or you have seizures, there may be plans out there that can best suit your needs that for the first time you will have access to. That is not available in traditional Medicare.

So a senior can choose under new Medicare. Either the traditional Medicare, keep what you have, don't change anything. If you stay in traditional Medicare, for the first time, if you want it—you don't have to take it—you can choose from one of two and maybe three or four drug plans. They will have equal value, but you can have that choice.

People say what if the drug plans don't show up? If they don't show up, there is a fall-back Government plan there. Everybody can have this new choice, but if you don't want to, keep what you have.

In addition, you can choose Medicare+Choice, which are primarily HMOs. HMOs are maligned on the Senate floor a lot. You talk to these 5 million people who are in them, they really like them. But if you want to, you are also going to be able to choose, from a preferred provides organization or PPO or C. There may be five, there may be three, there may be two, there may be one PPO. These PPOs are integrated health care plans. They have disease management. They have this little green down there showing all of them will have access to prescription drugs.

People say sick people may stay here or they may go into here or they may go into here. You don't really know. My heart transplant patients, who are among the sickest patients going in—before they get their transplant they are all going to die. Coming out, they require a lot of medicines. I would encourage a lot of those who are among the most challenging to take care of, I would encourage them to go into these PPOs. Why? Because they can have a health care plan that is tailored to their needs, that is able to respond to infectious disease, acute care, chronic care, disease management, coordinated care, none of which is available under traditional Medicare. So this is the design. Opportunity to choose all of this. Nobody is forced to choose at any point in time.

Transformational: I won't go through all of this, but I wanted to show this because it is hard as you listen to everybody. Everybody is talking about little pieces. Using the same format, let me show some of the things we do.

In the PPOs, in the choice over here that we are going to give for the first time—I say it is FEHBP-like. What that simply means is we in the Senate have a choice among a group of plans. I happen to take the Blue Cross/Blue Shield plan. That might be one of these plans. But seniors will be able to choose, just like we choose, a plan that might best suit their needs.

These are integrated plans; that is, acute care, chronic care, preventive medicine, coordinated care. You have a choice. You can choose among these plans. There is competition in that these plans will compete one versus the other based on quality, access, and cost. They give the same benefits as traditional Medicare, but there will be competition among those plans based on any of the issues that I just mentioned.

The flexibility: What that really says is that this PPO may be different than this PPO, different than this PPO. It may give a different range of benefits, although all of them will give at least the benefits given in traditional Medicare.

If you look at the drug plans, I have down that they are risk bearing. Risk bearing means the Government itself shares the risk with the plan. That plays into the marketplace. That is the way the private sector works. It captures the dynamism of the marketplace and, over time, and with the element of competition, that can bring the cost of drugs and Medicare down. These are competitively bid. Again, they have the flexibility.

Traditional Medicare: You have heard people talking about income relating, means testing. For the first time, the very rich, the Ross Perots of the world, will no longer have their assistants or their secretaries subsidizing their Part B premiums, their health care. For the very rich, they are going to have to be responsible for more of the subsidy—not all of the Government subsidy for them but more. There is cost containment built in. There are disease management programs that are going to be part of the traditional Medicare.

Quality is going to be rewarded. This is fantastic. I will come back to this if I have time. For the first time, the hospitals, for example, if they report the quality data, they will get their full, what is called, market basket update. The important thing is if they don't report that quality data over time, they are not going to get paid as much. Quality is being rewarded.

It is amazing; as a heart specialist, 50 percent of people in this body are going to die of heart disease, probably. It is higher for women than it is for men. A lot of people don't realize that, in terms of morbidity. More women will die of heart disease than men this year.

Right now there is no screening test reimbursed. Your cholesterol level right now, as a screening test, in Medicare is not reimbursed. Once we pass this bill tomorrow, and it is implemented, cholesterol screening and lipid profiles, preventive tests will be reimbursed for the first time. People say, come on; it has got to be reimbursed today. It is not reimbursed today. That is just an example—prevention.

As to physical exams, people know that is important as a screening measure. A lot of people get to 65 years of age and have never had a physical exam. For the first time in Medicare, everybody is going to have available to them, under Medicare, an entry level physical exam. Before, it wasn't there. It is not there today, but it is going to be there under the bill.

Information technology, I mention that because it has to do with medical errors. Right now we know there are too many medical errors that are being made. We need to facilitate, and adapt information to come into the system and be handled in a way that is consistent, in which the data can be assimilated and reported back. There will be e-prescribing for prescriptions with incentives—not mandatory, but incentives to encourage physicians to be able, instead of writing each prescription and have it go through 10 or 15 different hands and come back where mistakes can be made, by computer it can go all the way through the system where the mistakes are less likely to be made.

It is a complicated chart, but it gives my colleagues the feel for everything that we are accomplishing in this bill—not everything, but how important the various elements of this bill are.

Senator Kent Conrad in this body is the person who is probably as focused as anybody on this particular issue. I agree with him 100 percent.

How much time do I have?

The PRESIDING OFFICER. The leader has 5½ minutes.

Mr. FRIST. Five and a half. OK. I will move fairly quickly.

The issue is that most people in Medicare today are not very expensive, in terms of their health care. But 6 percent are.

In this body there are 100 people. Not everybody is here right now, but 6 of the 100 people in this body would account for 50 percent of all expenditures in Medicare. That is amazing.

Wouldn't it be great if you could identify which 6 it is, and if you identified them you could focus resources, coordinate their care, get preventive medicine, give them disease management, and that would take care of 50 percent of the cost? In this bill we establish data collection to identify and begin that disease management.

This bill is good for doctors and hospitals. Physicians right now, if we don't do anything today, are going to be cut by 4.5 percent, under current law, as to what they are reimbursed. When we pass this bill, it will increase, instead of being cut, by 1.5 percent.

Hospitals, if they give us the quality data—which they should give do—will get full market basket.

Paperwork: You hear physicians all the time, and hospitals, complain about the regulations and the paperwork. We have significant paperwork reduction in this bill.

Back in Tennessee, the most common request is: What is this bill to me? What does it mean to me?

To seniors, it means a lot. To individuals with disabilities, it means a lot. But in addition, the State of Tennessee, above current law, is going to receive for hospitals, $655 million more; for doctors, $240 million more; and for our Medicaid Program, almost $700 million more, because of this bill.

We hear regarding prescription drug costs that there is nothing in this bill to control prescription drug costs. That is not true. It is simply not true. I encourage my colleagues to read that bill and continue to read it tonight.

We speed generic drugs to the market. All of us know brand-name drugs are expensive. Generic drugs are not very expensive. What we do through this bill and the work of Senator Schumer and the work of Senator Judd Gregg is speed generics to the market in this bill.

We have competition. All the competition, the marketplace dynamics—competition is the only thing we know that over time can slow the growth of, whether it is drug prices or any prices. Price fixing simply does not work. It hasn't worked in Germany, it hasn't worked in England, and it hasn't worked in this country when we tried it in health care. I am going to keep moving here.

Are we helping the people who need it the most, poor people? The answer is yes. Below 100 percent of the poverty level: If you have $100 in monthly drug spending, 95 percent of the cost of drugs is paid for through this plan.

Let's take another example. If you are below the poverty level and you have $500 a month in drug spending, you have 97 percent of all of the costs taken care of by this plan; $1,000, you have 98 percent.

These are the people who need it the most. This plan is generous to the people who need it the most.

In closing, again, I will keep it very short. Hopefully, I can speak for a couple of minutes tomorrow morning.

We are providing access to prescription drugs, the most important tool in medicine today. Seniors don't have it today. They are going to have it after we pass this bill.

This program is voluntary. If you do not want to change anything, if you like what you have today, then keep what you have. Nobody is forcing you to choose. All of this is voluntary.

Private health plan choices: Why? Because private health plans today capture the advances I showed you earlier—coordinated care, disease management, and integrated care. That is what it is in private plans today that is being denied to our seniors. Seniors don't have access to them.

Appropriate reimbursement and regulatory relief to providers, to doctors, to hospitals, to nurses—I just mentioned what the impact is for a State such as Tennessee. Payment linked to quality is not done today. It is not done today in Medicare. For the first time, reimbursement is being linked to quality care.

Lastly, preventive care, physical exam for the first time, if we pass this bill; lipid profile; improvement in mammography screening; chronic care management and disease management.

I know my time is up. Let me close by saying this bill does four things. It strengthens and improves Medicare; it offers prescription drugs for the first time in the history of our Medicare Program; it does it on a voluntary basis; and for the first time in the history of this program it gives seniors access to plans that better suit their needs.

I encourage every Member in this body to vote for this bill.

Thank you, Mr. President.

The PRESIDING OFFICER. The Senator from Washington is recognized.

Mrs. MURRAY. Mr. President, would you notify me when I have 5 minutes remaining?

The PRESIDING OFFICER. The Senator will be notified.

Mrs. MURRAY. Mr. President, I have been fighting for a real prescription drug benefit for years. In the 106th Congress, I helped draft the MEND Act, and year after year I have used my seat on the Budget Committee to set aside money for a good drug benefit. I voted for several Medicare prescription drug bills, including S. 1 last June and the Graham-Miller-Kennedy bill in the last Congress. I have written and I have introduced legislation to make Medicare more fair to the people of my home State of Washington. I have worked to improve health care for seniors on the HELP Committee, on the Labor-HHS appropriations subcommittee, and here on the Senate floor.

After all of these years of work, no one wants prescription drug benefits more than I do. But I am very troubled by the proposal that is now before us.

I am unhappy at the prospect that this plan could force seniors and the disabled into an overly restrictive health care rationing regime in which they could lose their choice of doctors just to get a pretty meager drug benefit.

I am unhappy at the prospect that this plan could tell our seniors they must give up the good retirement health plan they have worked all of their lives to earn.

I am unhappy at the prospect that this plan could leave our seniors and disabled at the mercy of ever-increasing premiums.

I am unhappy at the prospect that this plan could tell patients who have complex medical conditions they cannot get direct access to specialists they need to see.

I am unhappy at the prospect that this plan could tell patients with MS, or Parkinson's disease, or ALS they can't get the drugs they need because their plan will not cover them.

I am unhappy at the prospect that this plan could tell our rural seniors they will have to roll the dice on how they receive health care coverage because this is not a real choice in their communities.

I am unhappy at the prospect that this plan would tell disabled Americans who are fighting poverty that the drugs they get today can be off limits tomorrow.

I am unhappy at the prospect that this plan would tell seniors if their drugs cost more than $2,300, they won't get a dime of help until they pay $3,600 out of their own pockets.

I am unhappy at the prospect that this plan could break the promise that Medicare has had for our seniors and our disabled since 1965.

This isn't just about plans and formularies and medical services areas; this is about people. It is about our parents and our grandparents and generations of Americans coming behind us.

I have sat down with seniors in my State, and I have heard how badly they need a real drug benefit. Just last August, I met with more than 200 seniors in Edmonds, WA, at the South County Senior Center. They told me in their own words just how important the drug benefit is.

During this debate, I have listened to my colleagues. I have listened to seniors and the disabled in Washington State. I have heard from doctors and hospitals at home. I have read the key provisions in the package, and I have reviewed the Congressional Budget Office estimates. Without a doubt, this is one of the most complex and controversial proposals this Congress has considered.

One needs only to review what happened in the House a few days ago to see how controversial and political the vote was. What occurred during that vote speaks volumes about the failures of this bill and the lengths the majority will go to in order to pass this flawed measure.

At the end of the allocated time for that vote in the House, the bill had been rejected. But the majority leadership refused to close that vote. They held it open for many more minutes, and those minutes turned into hours, and finally at about 6 o'clock in the morning, after holding that vote open for 3 hours, the majority managed to pressure a few Members to switch their votes.

An issue this important deserves a thorough debate. I am troubled that it appears as though this bill is being railroaded through Congress on twisted arms and backroom pressure.

When I look at Social Security and Medicare, I don't just see a program, I see a promise. It is a promise from one generation to the next. It is a promise from our Government to our seniors. And it is a promise that reflects our values.

Coupled with Social Security, Medicare is the most important antipoverty program ever. In fact, before Medicare, in 1963, 44 percent of our seniors were uninsured. Today, it is just 1 percent. In 1966, 29 percent of seniors lived in poverty. Today, it is down to about 10 percent. Since 1960, life expectancy for those over 65 has increased by 25 percent.

Medicare is a success story. It promised our seniors that they will have health care security, regardless of their ability to pay, regardless of where they live, and regardless of their medical condition.

Not only has Medicare helped seniors, but it forms the foundation of all of our health care. Medicare helps train our doctors. Medicare payments help keep our rural hospitals open. And Medicare helps keep emergency rooms and neonatal units operating. Medicare is open to every doctor and every hospital. It doesn't force providers into restricted networks. It lets doctors make decisions based on what their patients need—not on some mandate from some accountant.

It is troubling to think of what rural America would be today and whether inner-city trauma centers would even be in existence today without Medicare.

Let us not forget the reason we created Medicare in the first place. The market failed our seniors.

I approach this debate with a clear understanding of the importance of Medicare to our seniors and to our entire health care system. When I look at this bill, I want to know what it means to the seniors I represent. So far, I have found five big dangers for Washington State seniors.

First, this plan jeopardizes the health benefits retirees have earned during their working years. In Washington State, 47,250 seniors could lose their retiree health benefits. In return, they get much less coverage and they will pay for more than they had planned.

This plan is an unpredictable benefit that requires huge out-of-pocket costs and has massive gaps in coverage. This bill changes the ground rules on seniors in the middle of their golden years, and that is just not right.

Second, seniors could be forced into an overly restrictive health care rationing regime if they want a drug benefit. On paper, it looks as if seniors have a choice. That is what the proponents keep repeating. When we take a closer look, we see what is going on. Supporters claim that seniors can stay in traditional Medicare, but that is only if insurance companies decide to offer drug-only plans. They could offer drug-only plans, but the affordability of those plans is unknown and unknowable. That is because there is no limit on how much a plan can charge, so seniors will not be protected from price gouging.

On paper it may look as if seniors get a choice, but in reality many will face a new system that rations their health care in exchange for a very small drug benefit. Seniors could get fewer choices and less coverage than they have today. They will face fewer choices because of an imposed system of rationing that may not let them pick their own doctor, and they will have less coverage because the plans they will be forced into do not need to cover every drug that is medically necessary.

Third, if you get a chronic, life-threatening disease such as cancer or AIDS, you are not guaranteed the drugs you need. Here is what one client of The Lifelong AIDS Alliance in Washington State had to say:

> The current bill as it is written will affect me personally as it limits the drugs I can have access to because it only allows for up to two drugs under the prescription part of the bill. Since I am on a multiple-drug regimen, I will not have access to the other lifesaving drugs that I will have to take to stay HIV healthy.

Those are the chilling words of one of my constituents who is HIV positive and understands what this bill will mean for him. That is why AIDS service providers in my State oppose this bill.

In addition, if you need access to a clinical trial, forget it. This bill does not require any plan to give you access to experimental treatments.

This plan will mean fewer choices and less coverage for millions of seniors.

Fourth, this bill is especially bad for seniors and disabled Americans who are fighting poverty. Today, about 6 million Americans are eligible for both Medicare and Medicaid. Through these two programs, they get the coverage for the drugs they need. But this new bill we are looking at strips away what is known as wraparound coverage. In Washington State, that means about 92,000 people will get less coverage than they have today. That is just in my State. Those are the most vulnerable among us, the very people Medicare and Medicaid were designed to protect.

Fifth, there is a huge gap in coverage. Many seniors will see a big hole in their coverage. Payments will not stop. What you have to pay will not stop, but your coverage will. If your drugs cost you more than $2,250 a year, you will get zero help until you spend a total of $3,600 out of your own pocket. You get no coverage, but you still have to pay the premium.

When you look at what the average Medicare beneficiary spends for drugs, this coverage gap gets even worse. According to the Kaiser Family Foundation, in 2003, the average Medicare beneficiary paid $2,322 for prescription drugs. If you spend the average, you are already in the coverage gap. Those figures were included in the Los Angeles Times article that appeared in the Seattle Times on November 21. They show that the average senior will end up with a gap in coverage from which few seniors will ever emerge.

When I ask, what does this bill mean for the seniors I represent, I am pretty troubled by the answers. I am troubled this could force 47,000 seniors in Washington State to give up the retiree health benefits they have worked for their entire lives. I am troubled this could force seniors in Washington State into overly restrictive health care rationing, to get a limited drug benefit and to lose their choice of doctor. I am troubled this could force patients with cancer, AIDS, and other life-threatening diseases into a system that will deny them the drugs they need. I am troubled this could force 92,000 low-income seniors or disabled Washingtonians out of Medicaid into a market where they lose access to the drugs they get today. I am troubled this could force millions of seniors into a coverage gap where they have to spend more than $3,600 out of their own pocket without getting coverage or benefits.

This bill is also bad for Washington State in seven ways:

It could result in unequal benefits throughout Washington.

It could force providers and seniors to reevaluate their participation every single year, and they will get very little in return for that added unpredictability.

It could encourage seniors who are healthier and financially secure to leave traditional Medicare.

It could undermine Medicaid in Washington State.

It could require my State to send to the Federal Government a very large chunk of the savings it realizes.

It could force Washington State to manage new bureaucracies to test the assets of seniors in my home State.

And it could put Washington State even further down the list in Medicare reimbursements per beneficiary.

Let me walk through how this program would work to show how it is bad for my home State. Under this plan, the country will be divided into as many as 50 regions. States such as Washington could be divided into as many as three regions. Within these new, undefined regions, private insurance plans would be able to run the Medicare Program—not just the drug benefit, but Part A and Part B of the Medicare Program as well.

Washington State will be an attractive market for the PPOs and HMOs because we have areas that are healthier and wealthier and a tradition of health care delivery.

Currently, Washington State has one of the highest Medicare+Choice participation rates in the country with 18 percent of Medicare beneficiaries receiving Medicare through a Medicare+Choice plan.

Washington State also has a long tradition of managed and efficient care, so we will be a prime target for the new PPOs and HMOs. That means Medicare benefits in my State, just within my State, will vary from region to region and county to county depending on where you live. In theory, seniors in my home State may have more choices, but they give up a guarantee of a defined benefit.

Providers in Washington State could also face the same changes and uncertainty. Every year, seniors in Washington State would have to evaluate each insurance plan to find the one that best meets their needs.

Here are some of the things seniors every year in my State will have to figure out. While not knowing what medical conditions they may confront, they will have to figure out how much they have to pay out of pocket. Without knowing what their future holds, they will have to predict what providers they will be able to see. Without knowing, they will have to figure out what doctors have dropped out of their plan or may drop out, what restrictions will be on drug coverage, what their copayments will be, what plan formulary includes expensive new drugs, what hospitals are in their network.

That is an awful lot to figure out, especially since health plans, as we all know, are never written in plain English and no one knows what medical conditions they may confront in their future.

Today, Medicare provides predictability. An 85-year-old woman in her home knows what Medicare provides. Under the Medicare+Choice plan, seniors got more than they gave up.

I do want to state there have been some managed care success stories in my home State. We have some great providers in Washington State that led the way in providing innovative, comprehensive care that puts the focus on patients, not profits. But overall, we need to think how this plan would expand the Medicare+Choice model.

Medicare+Choice has worked only in limited parts of Washington State. A total of 131,391 seniors in Washington State participate in these plans. But they are not open to all seniors and they are limited to a very few select regions. Even in this limited program, we have seen significant changes and instability just within Washington State. I am not at all convinced this is a model we should now expand for all seniors and disabled.

If these new plans that are coming in attract higher income, healthier seniors, we need to ask, what will be left of traditional Medicare? I am afraid traditional Medicare will begin to look more and more like Medicaid.

The prospects for this plan are deeply troubling. They could have a massive financial impact on Washington State.

I will turn to how this plan will affect Washington State and its Medicaid Program.

I received a letter from the Democratic Governors' Association. It is signed by three Governors, including Governor Locke of Washington.

Mr. President, I ask unanimous consent that letter be printed in the RECORD at the conclusion of my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mrs. MURRAY. Mr. President, the Governors' letter urges Congress to give the States time to determine the impact on their Medicaid programs before enacting sweeping changes in how we treat Medicaid beneficiaries and how States pay for coverage for low-income seniors and the disabled.

So under this plan, if States save money by shifting drug costs from Medicaid to Medicare, States have to give a portion of those savings that they get back to the Federal Government every year.

Many States, such as Washington, have stepped up to the plate and have tried to fill the gap in Medicare by providing affordable, comprehensive prescription drug coverage through Medicaid for people who are eligible for both programs.

Over the past 10 years, as drug costs have rapidly increased, this burden has become overwhelming. Many States are now being forced to scale back their coverage in access.

In 2002, Washington State spent an estimated $212.8 million on drug costs for people who are eligible for both Medicare and Medicaid. That was a huge strain on my State.

Under this plan we are considering, the States will see some relief by shifting Medicaid beneficiaries to Medicare for drug coverage. But, unfortunately, the plan gives with one hand and takes back with the other.

Washington State, under this plan, will be forced to surrender much of the savings it sees back to the Federal Government. That could reduce Washington State's Federal Medicaid dollars by almost $2 billion from 2006 to 2013. That could devastate the entire program and result in further Medicaid reductions for low-income children and families. It could force the State to again implement reductions in provider payments for doctors, hospitals, and nursing homes.

A $2 billion give-back, just for my State, will mean more uninsured, lower provider payments, and more children losing any health care safety net they have today.

Let's not forget that States will be handed a massive new administration burden under this plan. Washington State will now have to administer new asset tests to determine who qualifies under Medicare for low-income assistance. These tests are extremely restrictive and will result in many low-income seniors being pushed into higher income categories.

Under the conference agreement, assets will be limited to $6,000 for a single person and $9,000 for a married couple.

In order to get any additional financial assistance under this plan, many seniors and the disabled will be forced to impoverish themselves and give up almost everything they have worked so hard to earn. Even if the States want to provide a more humane benefit or assistance, they will not be allowed to do so.

Now, many of us fought to provide relief to States just this year by temporarily increasing the Federal Medicaid match. This was a critically important fight to save Medicaid and prevent massive Medicaid cuts on doctors and hospitals. Our success in achieving a small measure of relief is now being undone by imposing an even greater burden on the States.

Finally, Mr. President, this bill will punish Washington State even further in Medicare payments. For several years, I have been working to address the geographic disparities that punish providers and seniors in my State of Washington. For years, Washington State has received unfair treatment.

Today, Washington State ranks 41st in the Nation in Medicare payments per beneficiary. We are being penalized because we have a tradition of low-cost, efficient health care, and healthy seniors. Medicare should reward that. Instead, its outdated reimbursement formulas are causing doctors to leave my State or close their practices to new Medicare patients.

I have spoken at great length on the Senate floor before about this, and I have introduced legislation to correct that inequity. But under this bill, the situation would be even worse.

Washington State would fall from 41st in the Nation to 45th in the Nation. Even though there will be a slight increase in payments to Washington, because of what happens to other States, we end up falling even further behind. This is a fundamental shift in the Medicare entitlement, in exchange for a very weak benefit.

Philosophically, this plan goes in the wrong direction. We should be strengthening the foundation of Medicare, not experimenting with imposing a new health care system on seniors.

This plan undermines the role of the Federal Government in ensuring that every senior can live with the dignity and respect and stability they deserve. It could force seniors into an overly restrictive, ever-changing health system.

Let's not forget why Medicare was enacted in the first place. It was created because the private insurance market failed seniors and the disabled. Coverage was sporadic, expensive, and unpredictable. Medicare, when it was enacted, changed all of that for our Nation's seniors. Now I am afraid we are flirting with that original failed model. I believe we can do better.

During my time in the Senate, I have been proud to work on prescription drug coverage—from helping to draft the MEND Act in the 106th Congress to working on the Budget Committee over the past 4 years to fund prescription drugs.

I was proud to support the Graham-Miller-Kennedy bill in the 107th Congress that would have provided an affordable, reliable, comprehensive prescription drug benefit as part of Medicare. We had a chance to do much better.

I believe a prescription drug benefit ought to be a seamless part of Medicare. It should be treated just like a doctor's office visit or an outpatient surgical procedure.

By implementing a seamless, affordable benefit as part of Medicare, as we did when we added the Part B benefit, we would guarantee that all seniors have access to the same level of care, regardless of their health status or their age or their income or their assets or where they live. That access would be stable, and it would be predictable.

I know we can do this. Many of us in this Chamber, on both sides of the aisle, have worked to significantly boost our investment in NIH funding. We have fought to reform and modernize the FDA to ensure timely approval of new, lifesaving drugs. I want all of my seniors and disabled constituents to benefit from those kinds of investments.

Under the plan before us today, I cannot be sure they will reap the rewards of this Federal investment.

The PRESIDING OFFICER (Mr. GRASSLEY). The Chair is responding to the request that the Senator be notified when she has 5 minutes left.

Mrs. MURRAY. Thank you, Mr. President.

Mr. President, we should be on the floor today debating a prescription drug benefit package, not a proposal to radically alter Medicare. This should be a fight about providing good, affordable, stable coverage, not about experimenting with Medicare.

I do want to thank my friend and colleague, Senator BAUCUS, for his efforts. I know he worked hard to do the best he could. Senator BAUCUS understands the importance of Medicare for seniors and the disabled, and I know he fought against incredible odds. He was sitting across the table from Members of Congress who tried before to privatize Medicare, and many who still hope to turn Social Security over to Wall Street. He faced an impossible task.

I know he did all he could, and I thank him for his fight.

Mr. President, I do want to note there are some things in this bill that I fought for that are important.

It does prevent additional cuts in payments to doctors who are scheduled to take effect early next year. The scheduled reduction of 4.5 percent, as we all know, is unacceptable. I worked hard to prevent that scheduled reduction of 4 percent in 2003, and I do applaud the conferees for meeting our demands on this issue.

The package also provides additional relief for rural hospitals, home health care agencies, and rural health care providers. This relief is truly a life line for saving rural health care. I have always supported these provisions, and I will continue to fight for fair and equitable rural payments.

I can promise health care providers and patients in my home State that regardless of the outcome of this legislation, I remain committed to stabilizing Medicare payments.

Now, Mr. President, I know many organizations representing doctors and hospitals think we can come back in 2006 and correct the mechanisms in this bill that undermine Medicare.

That is a pretty dangerous gamble. Not only that, but we don't know what the people who put this bill together will demand down the road in exchange for changes—premiums support or vouchers for States; larger gaps in coverage; more copayments; more restrictions on access; more deals on the House floor in the middle of the night?

We do not know what the pricetag will be to undo the damage that this bill will impose. I assure everyone, it will not be easy.

I had looked forward to the day when the Senate would pass a Medicare prescription drug benefit. That day is upon us, but I believe that the price of this benefit is far too high.

In the coming months and years we will see the theory behind this bill put to practice. As more and more people discover what this bill and this President have done to their health care, I am confident we will hear from seniors as we have never heard before.

This is a difficult decision. The $400 billion in this bill does represent a step forward. The provider payments contained in this bill are needed in my State, and seniors deserve the prescription drug coverage they have been asking for. Passage of this bill and being signed into law is not the end of the story. A tremendous amount of work will be required to fix the deficiencies in this bill. I will be there, as I have been all these years, working the best I can to do the right thing for the people I represent in my State and the people across this country.

I yield the floor.

EXHIBIT 1

DEMOCRATIC GOVERNORS' ASSOCIATION,
Washington, DC, November 21, 2003.

MEMBERS OF THE U.S. SENATE,
U.S. Capitol,
Washington, DC.

DEAR SENATOR: As you know, the near 700-page Medicare reform bill was unveiled yesterday. As a consequence, states have not thoroughly reviewed the language or seen individual cost estimates needed to make an accurate determination of its benefits and/or costs. Late yesterday, the Congressional Budget Office (CBO) released numbers portraying a net savings to states of $17 billion over ten years. Notwithstanding this projected rosy scenario, neither CBO, nor any other independent entity has completed a state-by-state impact analysis of this legislation. Even CBO is projecting that states will be $900 million in the red in the first year of the Medicare's program implementation in 2006. States need to ensure that their reading of the legislation confirms that the projected new state costs have not been underestimated by CBO.

With this in mind, we urge you to reject any effort to vote on this legislation before you know its full content and cost impact on your state and the people we both serve. To this end, CBO estimates on Medicare reform impact and expedited state reviews of the direct and indirect cost/savings impact from this legislation must be done and fully disseminated. Any rush to judgment, without this information, may have both short and long-term consequences that could prove to be irrevocably severe.

Early in the deliberations of the Medicare reform conference, governors were advised that at a minimum, the conferees were committed to ensuring that states would face no new costs as a consequence of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This commitment was made for each and every state, for each and every year, of the ten-year budget. For this reason, we are writing to urge you to not vote on this legislation until it is absolutely clear that this assurance has been upheld.

In recent days, there have been reports that the new administrative and other indirect state costs of this program—combined with the bill's exceedingly high "claw-back" of state savings—would more than exceed any Medicare savings for many states. Such an unacceptable outcome would be in addition to another misguided policy, reportedly seeking to mandate states and the territories to permanently pay 75 percent of the current Federal prescription drug cost-shift to states. In 2006, the first year of the bill's enactment, states would have to pay 90 percent of these costs.

Some have already suggested that this is a poorly crafted bill and in the long run it would do more harm than good to the very population it was intended to benefit. Although some states are witnessing a small increase in revenues, most states will continue to experience budget shortfalls for the current fiscal year. Some analysts believe that the overall shortfall will likely be $25 to $40 billion. With the continued sluggish growth in state revenues, any increases in state costs imposed by this legislation would be yet another unfunded federal mandate, creating additional pressure on states to cut essential programs and/or raise taxes.

Similarly, any permanent continuation of the Federal government's prescription drug cost-shift to states runs counter to existing National Governors Association (NGA) policy that, "if Congress decides to expand prescription drug coverage to seniors, it should not shift that responsibility or its costs to the states and territories" and establishes a damaging precedent.

Sincerely,

GOV. GARY LOCKE,
Washington, DGA Chair.
GOV. TOM VILSACK,
Iowa, DGA Vice-Chair.
GOV. BILL RICHARDSON,
New Mexico, DGA Federal Liaison.

The PRESIDING OFFICER. The Chair recognizes the Senator from Wyoming.

Mr. ENZI. Mr. President, as we all know by now, the Medicare conferees have reached agreement on the most significant changes to the Medicare Program in history. I thank the Presiding Officer for the hours he has spent working on this, the agony he has gone through at understanding and reaching agreement with this diverse body of Senators. There are 100 of us. We usually amount to probably 150 opinions on anything. The Chair has had to put all of that together into a bill that not only the 100 Senators agree with—and not all 100 Senators do—as many of the Senators as possible, and as many of the House as possible, because a bill to go through to the President has to pass both the House and the Senate. When it gets this complicated, it is an extremely talented person who is able to put together the kind of legislation that reaches a compromise that will be able to pass.

This is a copy of the bill. If anybody thinks it is simple, they haven't looked at it. It takes a long time to wander through this. We have been working on it for a few days and now have the finalized copy, the copy that has passed the House. It is the most significant change in the history of Medicare. It may be the most significant change in medical delivery in the history of the world.

I congratulate the Presiding Officer, the Senator from Iowa, Mr. GRASSLEY, for all the hard work he put in on this bill. We will soon be voting on it.

This bill will add a prescription drug benefit to Medicare, it will offer new Medicare coverage options to seniors, and it will expand tax incentives for people who save money to pay for their own health care needs. That is quite a package.

I want to strengthen Medicare. Seniors and disabled people in Wyoming depend upon Medicare to pay for their health care needs. We have relatively few major employers in Wyoming so most of our retired seniors don't have access to health care coverage through their former employers. Medicare is critical to the health and well-being of 66,000 elderly and disabled citizens in my home State. That may not sound like a lot of people, but it is over 13 percent of Wyoming's population.

Adding a prescription drug benefit to Medicare makes sense. Medicare is the only traditional insurance plan in the United States that does not cover outpatient prescription drugs. The reason Medicare does not cover prescription medications is that pharmaceuticals were not a major part of medical care in the 1960s, when Medicare was founded. It is a different story today. Today, prescription drugs are absolutely integral to providing quality health care. All of us rely on them. It makes sense for Medicare to keep up with the times by offering voluntary prescription drug coverage to seniors.

Let me emphasize the voluntary nature of this program some more. We have heard that the AARP is going to regret supporting this Medicare bill just as they regretted supporting the catastrophic coverage bill of the 1980s. I will come back to that a little bit later. The reason seniors revolted against the catastrophic coverage bill back then was that it was mandatory. They didn't have a choice. They had to pay for the coverage even if they didn't want it.

This bill does not make that mistake. This bill is different. If seniors don't want Medicare drug coverage, they don't have to pay for it. If they have coverage through their former employer, they can keep that. Plus we provide a lot of support in this bill for employers to continue providing their retirees with drug coverage so that seniors won't be forced to buy a Medicare drug plan because they lost their retiree coverage. So this is indeed a voluntary program.

It gives seniors a chance to sign up for Medicare drug coverage or stay in the traditional Medicare and keep what they have. Choice is a great concept. America was built on the idea that people should have the freedom to choose how to live their lives, as long as their choices don't infringe on the freedom of others.

When it comes to health care, choice is also important. Today seniors don't have choices. Medicare is a one-size-fits-all program, take it or leave it. But we all know that most seniors cannot afford to leave it. So right now they are stuck with Medicare, warts and all. The fact that Congress has to pass a law to add a prescription drug benefit is part of the problem with the Medicare system. Medicare is not flexible enough to adjust and adapt to the complex nature of health care today.

As I have noted, prescription drugs play a much greater role in treating disease today than they did when Medicare was created nearly four decades ago. But unlike private health plans, Medicare has not changed with the times. Under this Medicare agreement, seniors will have the option to choose drug coverage through Medicare. They will also have options that go beyond voluntary drug coverage.

The conference agreement would allow a variety of private health plans to offer coverage of Medicare beneficiaries. I am not talking about HMOs. Despite what I have heard here on the Senate floor, this bill does not force seniors and disabled into HMOs. Medicare HMOs exist today, and no one is being forced into them. What this bill does is allow preferred provider organizations, or PPOs, to offer Medicare plans.

Most of us are familiar with PPOs. They are the type of health plans to which more Americans belong than any other type. HMOs give you a list of doctors. If your doctor is not on the list, you can't visit him. The great thing about PPOs is, you can use any doctor you choose. And if the doctor is part of the plan's network, you get a discount on the cost of his or her services. These private PPO plans will compete to serve seniors by offering new choices and benefits, choices that are currently unavailable under Medicare's one-size-fits-all structure.

To be blunt, I believe the legislation could be bolder in stimulating competition. But it represents a good step in the direction of flexibility, innovation, and here is that word again—choice.

Let's be clear on what the Medicare bill would do. It would offer security to seniors who are without drug coverage. It would provide incentives to employers to encourage them to maintain the coverage they provide to their retirees. At the same time, the bill would create new Medicare options for seniors. It also would create incentives for private health plans to innovate and compete for the businesses of today's seniors and invigorate the Medicare Program for future generations.

Let's also be clear on what the bill won't do. It won't force seniors and the disabled to pay for a Medicare drug benefit if they don't want it. It won't encourage employers to drop drug coverage for their retirees. It won't force seniors and the disabled into HMOs.

I should also point out that the Medicare bill won't pay for every dollar of a senior's prescription drug costs. A drug benefit for needy seniors is important, but it is also important that we preserve Medicare for future generations. Already 30 percent of Medicare funding comes from the general government revenues. Projected expenditures are expected to exceed projected tax and premium revenues after 2015. I will be keeping a careful eye on Medicare spending, especially now that we have passed this drug benefit. If we are going to add anything new to Medicare beyond a basic and sensible drug benefit, we need to pay for it directly.

This drug benefit isn't free, but it is responsible. We set aside $400 billion of the Federal budget over the next 10 years to pay for this benefit. That is how much the agreement is projected to cost. Actually, it comes in slightly under that. But last year when we were doing the appropriations, we set aside the $400 billion. Some people say $400 billion is not enough. They point out that seniors are expected to spend $1.8 trillion on prescription drugs over the next 10 years.

Well, nothing in life is truly free, and prescription drugs will not be an exception. We need to remember that every new Federal program comes at a price. We need to be aware of just what that price is when we ask for a new program. It is not always the people receiving the benefit that are paying the benefit. The $400 billion is the equivalent of $1,600 from every taxpayer over that 10-year period. What would taxpayers say about the need for any program if we put it into that kind of a form for them? There would be increased concern just like there is increased concern when people have to pay their own costs of medical treatment.

That is how the competition comes into the market. I suppose we could have passed a $1.8 trillion drug benefit. Of course, we would have had to raise taxes by $1.4 trillion to do it. I cannot speak for the rest of my colleagues, but I just became a grandfather this year and I am not willing to put that kind of a tax burden on my grandson.

Even the critics of this agreement acknowledge that low-income seniors would be eligible for substantial subsidies for their prescription drugs. Even the critics admit that seniors with catastrophic drug expenditures get measurable relief under this bill. There is a generous 95 percent coverage of a seniors' drug cost over $5,000.

This bill also includes important projections for which I fought on the Senate floor this summer, which protect every senior's right to visit their community pharmacy and receive the high level of service they are accustomed to receiving from them. We have put a huge burden on our pharmacists in this country, the local ones that are right there to answer your questions face to face. There is a provision in the bill that will help to keep that local pharmacist in place and operating. It gives them an equal chance under the bill to be providing prescription drugs for seniors on Medicare. It is important that we keep those small businesses and pharmacists—local people that you can talk to—in place.

This bill doesn't cover every dollar of every prescription for every senior. But that is not a reasonable expectation. What this bill does is provide help and protection for the two groups that need it the most—those who can least afford prescription drugs, and those who otherwise would be bankrupted by a serious illness that requires expensive drug therapies. These are worthy objectives and this agreement accomplishes those goals.

I want to discuss a couple of other aspects of this agreement. First, the bipartisan Medicare agreement would establish health savings accounts, HSAs. These HSAs are tax advantaged savings accounts that all people could use to pay for medical expenses. This is a huge advancement in taking care of the uninsured. Health savings accounts would be open to everybody with a high deductible health insurance plan. The higher the deductible, the less the cost to the insurance plan. The higher the deductible, the more a person is allowed to put into a HSA. Employers would also be able to contribute to the employee's health savings account, and neither the employer's nor the employee's contribution would be taxable. Tax free, you can set up this account.

If you have an HSA, your total yearly contributions to it would be as large as your health insurance plan deductible. Just like an individual retirement account, the interest and investment earnings your health savings account would generate are not taxable. Furthermore, the money you take out of HSAs to pay for medical costs are not taxable, as long as the money is used to pay for health care expenses. Let's see, you don't pay taxes on it when you put it in, you don't pay taxes on the earnings, and you don't pay taxes when you take it out. It is a little incentive to put away money to cover deductibles, or anything to do with health care later on. I hope that every young person in this country will establish a health savings account. No matter what their income level is, no matter how good their health is, it is an opportunity to put away money for when the health is not as good, and to take care of any deductibles that are necessary at any point in life with an insurance plan. It is an opportunity to be insured from the time you enter the job market, and to put a little away and perhaps have a lot for the years when 50 to 80 percent of the health care costs come up.

One of the best features of health savings accounts is they would be portable. That means that if you change jobs, the health savings account goes with you, you still have it. It is yours. Health savings accounts are a great innovation. Health savings accounts create a tax incentive for everybody—not just seniors—to save for health care expenses, plus it doesn't matter whether your employer offers health insurance or not; you can still save money in a health savings account and receive the tax benefit. This provides some tax fairness for those of you who don't have access to tax advantages of the employer-sponsored health insurance. Let me say that again. This provides some tax fairness to those who don't have access to the tax advantage of employer-sponsored health insurance. Employer-sponsored health insurance is tax free. It doesn't even show up on anything that you have to file. This would give the average person the same opportunity to have tax-free health coverage.

Health savings accounts are an idea whose time has come. Giving people more flexibility and responsibility in their health care spending will result in healthier and wiser consumers. I wholeheartedly support this part of the Medicare agreement. It is long overdue. It needs to be advertised. Young people of this country need to understand that that is their part of Medicare, that they can get into this now and it will save them costs later. It will be a part that will shore up the system.

I also want to speak to the provisions that would address a very sore subject on the frontier, the inequity in Medicare reimbursement between urban and rural areas. I am pleased that the conference agreement ensures reimbursement equity to doctors, hospitals, and other providers of health care in Wyoming and other rural States.

Right now, Medicare underpays rural hospitals, home health alleges, and other providers, as compared to urban counterparts. This limits the ability of these providers to maintain their services and their infrastructures and to recruit qualified personnel.

Some people do not understand the challenges that rural health care providers face in providing quality care to seniors and the disabled. For instance, I read a column in the Washington Post last Friday by a gentleman named Steven Pearlstein. I think it was supposed to be a semi-humorous column—I hope so—although it was in the business section. Well, to those of us in rural areas, it wasn't even semi-humorous, and it wasn't accurate either. I suppose I could ask that this column be printed in the CONGRESSIONAL RECORD, but I would not want to waste the space. I will, however, cite a paragraph from the column in which this gentleman called politicians from rural States "nothing more than welfare queens in overalls." At this point, I'll state that I still believe Senators ought to be able to bring laptops onto the floor. But I assure my colleagues I will not be petitioning them to wear overalls on the Senate floor.

Let me read one of the paragraphs that Mr. Pearlstein wrote:

> Then there is Medicare bill, which was supposed to be about providing drug benefits to seniors, but wound up being yet another chance to whine about the plight of country doctors and hospitals. Although the cost to providing medical service is actually lower out there in God's country [the God's country is true] that hasn't stopped your guys from squeezing $25 billion more from the Federal Treasury over the next decade to pad Medicare payments to rural providers.

I don't know if this gentleman has ever been to God's country or not. Maybe he has flown over God's country, Mr. President. I doubt he has ever visited the Niobrara Health and Life Center, a very small hospital in Lusk, WY. Lusk has a population of 1,500. Lusk is the county seat Niobrara County, population 2,500. That is Wyoming's least populated county. Incidentally, it is a little bigger than the State of Delaware. It has one person for every 524 acres of land.

The hospital in Lusk has been closed since May of 2000. Since then, folks in Niobrara have had to travel to Douglas and Torrington for surgery or other hospital care. Douglas and Torrington are in different directions from Lusk. They are both about 55 miles from Lusk. That is a long drive any time, but in winter—and we are having winter there now. I don't know if you saw pictures of the Bronco football game where they were scraping snow off of the field; but yesterday there was a blizzard in Colorado and in Wyoming, and the temperatures were about 16 degrees, and it gets a little tough to get around, if you can at all.

Fifty-five miles is a long drive in winter when the winds are howling and the snow blows across two-lane roads. That is an important hospital for the people of Niobrara County, and they are getting ready to reopen it. They are hoping to be able to afford it. It is also important for the State of Wyoming because there is a State prison for women in Lusk. The State tried to keep the hospital open in the 1990s, but the financial pressures were simply too great.

Hospitals across rural America are struggling, particularly the smallest hospitals, such as the one in Lusk. If it were really true that the "cost of providing medical service was actually lower out there in God's country" then why are the rural hospitals struggling to stay open?

Our Federal Government's own Medicare Payment Advisory Commission published a report in 2001 on Medicare in rural America. That report found that the Medicare "payment system does not recognize factors that have a greater effect on the cost of rural hospitals." The study also found that there are aspects of Medicare's prospective payment system for inpatient hospital care that tend to work against rural hospitals.

Every hospital has to buy a certain amount of medical equipment from hospital beds to x-ray machines. If rural hospitals get a rural discount on this equipment, it is news to me. In fact, I think there are probably some quantity discounts on which they lose out.

Rural hospitals also have to hire nurses and technicians, just as urban hospitals. It is hard enough to recruit nurses because we have a nationwide shortage. Trying to recruit nurses to come to the Wyoming frontier is even harder. So our rural hospitals have to offer a competitive wage.

Most rural hospitals also have a low patient volume compared to their urban counterparts, and this contributes to a higher cost of rural hospital care. There is a certain amount of staff and everything that has to be on hand ready for patients if they show up.

As the Medicare Payment Advisory Commission rightly points out in its study, hospitals in small and isolated communities "cannot achieve the economies of scale and service scope of their larger counterparts and thus have higher per-case costs." The current Medicare rates do not directly account for the relationship between cost and volume, potentially placing smaller providers at a financial disadvantage relative to the other facilities.

I am pleased to note that the Lusk hospital is scheduled to reopen in October 2004 after completing some important upgrades and renovations. I am confident the hospital will be able to survive this time because Congress passed a law in 1997 to allow for special payments to hospitals in rural areas that are too sparsely populated to support a full-service facility.

The Medicare conference agreement would increase payments over the 1997 law to critical access hospitals, such as the one in Lusk. Despite Mr. Pearlstein's criticisms, he ignored the fact that urban hospitals have higher Medicare margins than rural hospitals.

The additional support for rural health care providers in this bill will help close the gap between higher Medicare margins of urban hospitals and the lower Medicare margins of the rural hospitals. This additional help will not come a moment too soon for the people of Niobrara County, WY, and other counties in Wyoming and other counties throughout the United States. I hope Mr. Pearlstein will visit Lusk if he ever visits Wyoming. I have been there, and I can tell you that the Medicare payments he considers "padding" are critical to the hospital in Lusk and to the seniors who depend on it.

It is a long drive to Lusk from Yellowstone National Park or skiing in Jackson Hole, but I think it would be quite educational for him or anyone else who makes the journey.

There are a lot of good aspects about this Medicare agreement. Adding a prescription drug benefit to the program is good. Providing seniors and the disabled with new Medicare options is good. Offering all Americans new ways to save money for their health care expenses is good. Providing fair Medicare payments to rural doctors and hospitals is good. Having health savings accounts is outstanding.

For these reasons, I am going to vote for this bipartisan Medicare agreement, and I am going to work in the future to ensure that Medicare continues to offer a reasonable drug benefit for many of America's seniors, but one that does not place a huge financial burden on future generations.

Earlier the majority leader, Senator FRIST from Tennessee, the only doctor in this body, gave an outstanding speech outlining the reasons that in a bipartisan way he and others have worked on this for 6 years to bring this to fruition. A person from the other side of the aisle who has worked on that for 6 years has been Senator BREAUX from Louisiana. They served on a special task force to come up with a way to make Medicare be solvent for generations to come. This will be the first significant piece of legislation to address what they have talked about for 6 years.

Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. The Senator from Wyoming has 4 minutes 15 seconds remaining.

Mr. ENZI. I thank the Chair.

Mr. President, in the Senator's remarks he did point out there have been a lot of health care advances. Science has played a great part in health from genetically engineered vaccines, to coronary angioplasties, to heart transplants, to the human genome project that is coming up with a lot of new medicines that will take care of us. That project, incidentally, came in 2 years ahead of time, in 2003, and has led to a massive increase in the number of projects that are being done to come up with new drugs that will help us.

This is the way Medicare has advanced. It is pretty inflexible. There has not been much advancement. We have an opportunity to correct that right now. We need to get the flexibility of Medicare to increase the same way that medical advances are increasing, and those are mostly in the area of prescription drugs. So it is time we added a prescription drug benefit.

The bill also takes care of some problems we have with Medicare. I mentioned this task force that Senator BREAUX and Senator FRIST were on. The task force recognized the problem that when Medicare got underway, there were 20.4 million people under Medicare. Today there are 40.8 million people under Medicare. That is a doubling. By 2030, 77.6 million people will be under Medicare. That is another doubling. That is a huge increase in the number of people who will come under Medicare.

How is it paid for? It is paid for by people who are in the workforce, not the people who are retired—the people in the workforce.

In 1973, there were 7.3 people. That tenth of a person probably didn't feel too well. But 7.3 people were paying for every person under Medicare. In the year 2000, there were 3.9 people paying the bill for those in Medicare. By the year 2030, 2.4 people per person will be paying the bill for those on Medicare. These people have to pick up the costs of all of Medicare for those people. So it is important we have some cost containment, that we put in some reforms to make sure the system is available for those 77 million people in the year 2030.

Prescription drugs are the most important treatment factor now. They were not in 1965. We have come a long way on the issue of prescription drugs. This is where we are headed. These are the number of drugs in clinical development: Cancer, 402 different kinds in clinical development. The percentage of drugs that actual make it is very small. Is there a high cost to develop a drug? Yes. Diabetes, there are 30 different kinds of medicines; rheumatoid arthritis, 24; osteoporosis, 20; obesity, overweight, 29; depression 19; congestive heart failure, 18; Alzheimer's disease, 17; schizophrenia, 16; hypertension, 11; hyperlipidemia, 10; migraine headaches, 20, and so on.

There are a lot of drugs that are being worked on. That is a new treatment. That is a tool that has to be put in the hands of doctors.

Now, we have heard some comments, as well as different versions, about surprise that AARP has backed this bill. It is not a perfect bill. We never pass a perfect bill out of the Senate.

AARP has had some comments on it. I hope my colleagues all pay attention to them. AARP believes that millions of older Americans and their families will be helped by this legislation. AARP also endorses the Medicare bill. On November 17, they stated, "The integrity of Medicare will be protected."

These are the most significant reforms. It provides access to medical prescription drugs. It dramatically expands voluntary, private health plan choices. I hope my colleagues will look at the comments the leader made and read them in full.

I thank the President for the time, and I yield the floor.

The PRESIDING OFFICER. The Chair now recognizes the Senator from New Jersey.

Mr. CORZINE. Mr. President, I rise today to join this historical debate on health care for America's seniors. I also rise so that I can provide a perspective to the people of New Jersey on why I will regrettably be voting against this Medicare conference report.

I particularly find it unfortunate and disappointing because there are 300,000 seniors in New Jersey, out of about 1.2 million, who lack any prescription drug coverage. Those seniors make tough choices between medicine and other of life's expenses, as we have heard talked about in political debate for years.

I truly want to be a positive participant in assuring access to quality drug coverage at an affordable price for all of America's seniors. I think all of us do. That is why I voted affirmatively on a bipartisan Senate bill. I worked very closely with the senior Senator from Iowa to put together what I thought was an outstanding bill, one I would have been proud to support.

Those 300,000 seniors badly need and deserve affordable, quality coverage. But just as badly as they need it, we need to make sure their gain does not come at the expense of harming others. If the left-out seniors were the only ones impacted by this bill, I would vote for this plan we now are debating. I would vote for it because I thought it was going to provide access to those 300,000 folks and that would happen regardless of all the ideological or political arguments that have been made over the last several days.

Sadly, hundreds of thousands of other seniors in my State will be seriously and negatively impacted by this bill. The fact is, this plan harms more New Jersey seniors than it helps. I calculate that, at a minimum, 500,000 seniors will be harmed, breaking the first rule of medicine: "Do no harm."

The negative impact comes at a very high financial cost not only to my State but to the Nation at large. I believe the scarce resources we are using would be better used to make the limited and complex benefit more substantial and to reduce the harm to those who already have benefits that they will lose.

This Senator can only wonder in that context that we feel compelled to lavish $14 billion of subsidies on HMOs and other insurers to provide them profit incentives to compete with traditional Medicare as opposed to improving the benefits to uninsured seniors who are constructively a part of this bill. We could close that so-called donut hole, that gap.

With all due respect to the Herculean efforts of those on both sides of the aisle who cobbled together this compromise—and I really do want to congratulate and thank those who worked so hard. Ranking Member BAUCUS, and Senator BREAUX, the senior Senator from Louisiana, as well the senior Senator from Iowa, have done a great job of trying to get to a conclusion on which we could all agree. In my case, the cost/benefit for New Jersey seniors just does not work. It just flat out does not work.

My staff and I have done the numbers. We have worked very hard, to the best of our ability, to really scrub down these numbers and to come up with a conclusion on whether this works for our folks. Considering we are in a mad dash to absorb and analyze this 1,100-page bill, I will bet there is not a single Senator who has read it. I could be wrong. Maybe there are one or two who just did not have anything to do in the last 24, 36, 48 hours, but I doubt if there is anyone who has read this. The result is that the only certainty about this bill is that in addition to its unintended consequences, even from the well-intended, it is certain to have unfortunate consequences for many American seniors, as well as all of us who might hope to be seniors one of these days.

So my reason for opposing this legislation is that this body should be thoughtful and careful when we are spending $400 billion for a good cause, but we ought to make sure we are not doing more harm than good. That is objection 1. Objection 2 is if we do not plan to implement this bill in its broad form before 2006, I do not understand why we need to cram all of this analysis into 48 hours or 72 hours over a 3- or 4-day period.

Why before Thanksgiving? What is the hurry when we have a bill this complex, this big, and we only have 3 or 4 days to look at it? I think there are a lot of problems stuck right in here.

So let me repeat what I do know. For roughly $4,000 of out-of-pocket payments, a senior will get $5,000 worth of return, plus a catastrophic coverage for everything above $5,000 of drug spending.

Let me repeat: A $4,000 payment for $5,000 worth of coverage will come with a complex concoction of HMOs, PPOs, PDPs, premiums, deductibles, copays, formularies, annual price increases, shifts of providers, and a bevy of choices that are more to the confusion of seniors than they are to the security of seniors. In fact, the complexity of navigating this proposal for an individual senior is almost enough of a reason for me to vote no on the bill to start with.

I have stood in all kinds of townhall meetings with seniors just trying to explain the simple first steps of this bill. I think we are going to be creating a tremendous industry of opportunity out there informing seniors about what is going to be borne from this 1,100 pages, 1,200 pages of work. Somebody is going to have to tell folks how they get through this.

That said, this bill does provide favorable relief to doctors, as I have heard some talk about, serving Medicare patients. It gives some needed aid to hospitals, particularly America's rural hospitals, as the Senator from Wyoming adequately presented. Of course, in a thousand pages plus, there have to be some good things, and there are. We are spending $400 billion.

A few of the benefits I have talked about are good but, in my view, they come at too high a price, and that is before one weighs in on the serious push in this bill to get Medicare on a pathway to privatization and the dismantling of the social safety net and coverage of our seniors' health which has been so fundamental to the success of moving so many of our seniors out of poverty into longer, healthier lives.

While this bill fundamentally being debated is in the context of prescription drugs in general, spending $400 billion, one would think that might have some positive implications for the broader health care system. To that end, I believe this bill falls far short of the mark. Once again, at least from my perspective, it does more harm than good.

Cost containment through Medicare negotiating the cost of drugs with the drug industry could have led to lower prices for everybody in America. You have unbelievably strong buying power out of Medicare—if they were negotiating those prices. We are talking about reimportation? We could do a heck of a lot better if we just had Medicare go out and negotiate those prices. That would help all Americans: Children, generation Xers, juniors, seniors, corporate America. That is not happening.

Other missed opportunities? Cost containment is omitted in this bill. The only containment of costs that I see falls on the shoulders of beneficiaries with escalating copays and premium hikes.

Equally troubling, reforming reimbursement rates for cancer treatment by doctors would have strengthened Medicare, as opposed to limiting oncological drug payments that undermines cancer care. For my State, this is really a troubling and unacceptable aspect. The fact is, we have the third highest incidence of cancer in our State. I think we are putting at risk the treatment of that not only for our seniors but for the whole of the community.

Egregiously—and this is where I strongly disagree with those who would make this case—the diversion of $6 billion into these health savings accounts in this bill I think is a big mistake. It encourages the healthy and the wealthy out of the employer-based health care system, leaving the older and sicker and more poor in the system that remains or until employers drop coverage altogether. Frankly, I think this appears to be a handout to insurers. Several credible studies, including the Rand Corporation's, suggest a major reduction in employer health care coverage will follow as the likely outcome of this tax cut proposal because of adverse selection.

I don't understand this. This doesn't seem to be relevant to the purpose we are about in a $400 billion prescription drug benefit for seniors. Once again, I think this legislation in this area does more harm than good. It certainly does with respect to the U.S. Treasury because I think it has the capacity to go well beyond the $6 billion in cost over a period of time, particularly as it is more of a savings program than it is one that is going to help on health care.

That is the big picture for me. As you can tell, I don't think it is so good. But let me now illustrate the specifics, as least as I see them, in a cost-benefit analysis for New Jersey's seniors because that is what I care about. It is clear to me this is the analysis that is the most important from my perspective. It is the primary driver for how I came to my conclusion with respect to this bill.

This is not about insurers and HMOs. It is not about what the Democratic caucus would argue. It is not about what political scorekeepers think. It is not even about the pharmaceutical industry, which, by the way, in our country is most heavily concentrated in my State. It generates about 65,000 jobs and produces about $30 billion worth of business and revenues. It is really important to our State. But simply my analysis is about New Jersey's seniors and their role and participation in this program across this Nation. On that basis, I would like to talk about some of what we see.

First of all, I think from all of the independent analyses we see, approximately 94,000 New Jersey retirees will lose their employer-based prescription drug benefits. There are estimates of 2.1 to 2.7, whether it is CBO or some private estimates. The middle of the range number for New Jersey is about 94,000.

We have, in New Jersey, a substantial number of seniors, what people call dual eligible, who would receive this wraparound of their Medicaid benefits, various low-income folks, 152,000 of those who receive their benefits through Medicaid and, as we all know, will be paying copays and potentially have an accelerated rise in health costs. They certainly will be on formularies that may limit their choices of drugs. Those 152,000 seniors I think will find this difficult.

We also have 220,000 seniors who are currently enrolled in our State pharmaceutical plan. I first want to congratulate the conferees because they did provide for a wrap here around State programs. It is going to be cumbersome and anything but seamless to move from the program that has been in place for 25 years, created by a bipartisan set of Governors and legislators over that period of time, that have provided the State program. We are going to have to change it. We are going to have to have our seniors go into private programs, and then the State is going to have to fill in those gaps, to be able to make sure that our low-income seniors, who have terrific programs, probably the best in the country, are able to maintain the same coverage.

As I say, I think the facilitating language with regard to financial obligations has been very good. I am very grateful for the work of the conferees with regard to this estimate. But the seamless element, the quality of coverage with regard to this element, this particular program, is going to be very hard to implement. Each of these seniors, the lowest income seniors in our State, is going to end up being faced with formularies and be experiencing changes each year with regard to who has maximum coverage, and it will be a major impact on how they look at it. Plus they are going to end up potentially paying copays and premiums that are slightly more than what they have in current benefits. So there is another 220,000.

Finally, there are about 52,000 seniors in New Jersey's program who pay more for Part 3 premiums due to the premium test—the means testing—that is coming out. Some can argue means testing is good. That is said where you have already very high income seniors.

Now $80,000 in New Jersey, which is where this means testing begins, is not exactly superrich. We happen to have the most wealthy average population in the country. We also have the most expensive cost of living of any place in the country. We pay more in taxes; we send more to Washington than anyplace else in the country. This means testing, which is going to affect about 52,000 of our seniors, is not going to Bill Gates-like folks or Warren Buffett; it is going to middle class New Jerseyans and I think is going to have a lot more bite. I would have liked to have seen it set higher. It was cut back. I frankly wonder if this is going to be good for the overall Medicare Program because we are ultimately going to start pulling out a lot of these high-income seniors. As people know, Part B is voluntary, and we could end up again providing another adverse selection element to the overall underlying traditional Medicare Program.

We will come back to some other perspectives with regard to New Jersey. But by my calculations, it is 94,000 retirees with employer-based coverage. They are going to lose that coverage, at least that quality coverage relative to what they will get in a new prescription drug program in Medicare. There are 152,000 dual eligibles who will end up with payments that are different than what they would have had under the old program; 220,000 of our State beneficiaries will end up with a lower quality, less seamless program than what they have today, and 40,000—I talked about this earlier in my remarks—40,000 diagnosed with cancer every year are going to have a much harder time getting drug treatments that they previously had. It is going to cost about $50 million to the State over the 10-year period in payments with respect to these drugs. Those folks are going to be impacted.

Then there are the 52,000 subject to means testing. That is 558,000. I am not going to be so certain there are not some overlaps here, but we are talking in the neighborhood of about 500,000 folks who are going to be hurt. There are now only 300,000 New Jerseyans who are without drug coverage. I think that speaks for itself. There is a tough tally when you look at those who are harmed and those who are benefited. That, to me, is an important consideration.

That is an important consideration. Those are not the only considerations. With regard to New Jersey, we have certainly one that already meets the Medicare privatization approach that falls under the premium support program demonstration projects. Actually, it looks as if there will probably be two. I don't think our seniors are going to say they want that in their backyard. They like prescription drugs, but they also like traditional Medicare.

I think it is hard for me to go back to them and argue when they have had a chance—by the way, we have seen a lot of people dropping out of Medicare+Plus Choice because they haven't felt like the program is good. Plus a number of insurers dropped people who signed up for it. They thought it was going to be a good deal and it didn't turn out to be so. That is another one that a lot of folks talked about. There are approximately 1 million New Jersey Medicare beneficiaries who are going to see their Part B deductible rise at a faster rate than their Social Security benefit.

Some people will say that is not a part of this bill, that it is something else. But the fact is, we are building an escalator on Part B. It doesn't compare with what I think is going on with Social Security. At least when I go to townhall meetings, that is a real problem for me to try to deal with and explain to folks. That is the challenge.

Roughly 100,000 seniors will be negatively impacted and a lot of others will feel as if they were somehow not properly protected in it. Again, 300,000 don't now have drug coverage.

That system doesn't work. It is arithmetic. It is very straightforward. It seems to me that there is more harm than benefits. For me, the case is closed.

It would be remiss of me not to say that I have another objection that I believe is built into this package. If I could convince myself that New Jersey seniors were going to be benefitted, I would come around on this issue. But I think this package puts America on a pathway to privatization of Medicare. I suggest that is not the right direction. I think we ought to be enhancing and extending the traditional Medicare Program and have a prescription drug benefit. We ought to be using that $12 billion to $14 billion that is going to benefit the managed care industry and the insurance industry to cover up one of those donut holes that we are talking about. We ought to be putting that money to work to enhance traditional Medicare.

While others have spoken eloquently and extensively, maybe even politically about this, I think it is a very serious consideration for those of us who believe that traditional Medicare should be enhanced.

I looked at three steps that will put it on that pathway.

Fourteen-billion dollars in subsidies and protection against skyrocketing health care costs provided to health insurers in this bill doesn't seem to me to be the right place to put us into a comparative cost-benefit analysis with the private providers who I think have many incentives to cherry-pick the healthiest, the wealthiest, and the most able versus what is going to be left in the traditional Medicare program, which raises costs. I think that is step 1.

Step No. 2, this series of demonstration projects which is hardly a level playing field by comparison—and I think it is actually going to be difficult for us to make a real assessment if it—I have heard actually limits this program under 600,000 folks. I think it is also possible that it will be cherry-picked in the areas as opposed to the difficulty of looking at the wide diversity of populations that we have in the country. I am particularly troubled when I look at what I see with regard to what fits into New Jersey with regard to this program. It could be very difficult.

Then the third step is this 45-percent trigger on general fund expenditures that will cause an overall review of traditional Medicare when the breach occurs. I think all of us realize with the changing demographics and the baby boomers going into retirement, and with 40 million seniors growing to 75 million or 77 million seniors over the next 10 to 15 years, we are going to have that happen. I think that is going to lead to pretty hard choices without the kind of triggers we have here.

I think that it is just one more step, one more nail in the box that is trying to change us and move us away from traditional Government-supported and underwritten Medicare to privatization. In my view, after an inadequate analysis of this 1,100-page bill, I really think that may be the most troubling piece.

I think it is very difficult to be certain about any of the conclusions that any of us are drawing with regard to this bill. The one thing that I do know for certain as it shows up both in the marketplace and in the phone calls that we are receiving is that there are great benefits for the insurance industry and the pharmaceutical industry built into this.

By the way, as I said, the pharmaceutical industry is right smack dab in the middle of my State. I like to see them do well. I like to see them press forward in their research. But I don't think that should come at the serious expense of many of America's seniors. I can say, at least based on what I understand by my analysis, that is not the case with regard to New Jersey seniors.

Frankly, I just do not understand this mad dash to get this done before Thanksgiving. It obviously must reflect some other agenda than what seems sensible. I think we ought to slow down. We ought to be careful. We ought to be thoughtful. I know there are a lot of people who have spent a lot of time. We have heard about the 6 years of debate and discussion. But to come to a conclusion where we have to make a decision about something that is extraordinarily important to the lives of the people across this country—not only to our seniors but to the families, and the impact it has on the markets that we deal with with regard to prescription drugs—investing $400 billion is a very important issue. It ought to help our seniors as much as possible. It is a good thing. I think all of us want to be supportive. We should do our best with what we have to invest in this project. You have to think about it in the context of a very limited amount relative to how much seniors are going to spend over the next decade. I hear estimates that it may be as much as $1.8 trillion. What we are talking about here is about 20 percent of that.

We have to make tough choices. I appreciate the difficulty with which the Senator from Iowa had to work his way through these difficult areas. I think he made a lot of good choices, but there are some in here that are very difficult. I think we ought to be wise and reflect on this 1,100-page report.

I am convinced we can do better, at least in the cost-benefit analysis that I put together for my State.

As a consequence, I have to oppose this report. I hope we can slow it down and make some revisions and bring it to a positive conclusion which is not ideological and which is not political; that is, believing we are searching for the best interests of all of our seniors in America.

I yield the floor.

The PRESIDING OFFICER (Mr. ENZI). The Senator from Iowa.

Mr. GRASSLEY. Mr. President, before the Senator from New Jersey leaves, I want to speak about a couple of words which he mentioned. And I don't say it to take exception with what he said or to quibble with his description of the legislation before us. But if the President of the United States saw Senator GRASSLEY speaking right after some words that the Senator from New Jersey used about legislation, the President would be offended because I found fault with the President using those very same words back on December 10 last year when I had my first meeting with the President on the Medicare issue.

The words that the Senator from New Jersey used about the legislation before the Senate is that it is cobbled up. As everyone in this body knows, for about a year and a half I worked with five Members of this body on what was then called the tripartisan plan. The President started his lecture to me last December, something along this line: We have to have a dramatic change of Medicare. We have to provide prescription drugs for the seniors. We have to change Medicare for the future. He says: We do not want something like that cobbled-up tripartisan plan.

Obviously, the President cannot know everything that goes on in the Congress of the United States about forming legislation, but if he knew the hours and hours, not only at the staff level but at the Member level, that went into the tripartisan plan that we unfolded here a year ago in July, the President would not use the words "cobbled up." I never heard the President use the words "cobble up" after that because I tried to impress upon him there was a great deal of thought, a great deal of hard work, and most importantly, time, plus bill compromise that the word "tripartisan" implies to bring together where we were at that time.

If he had appreciated it, he would see we have to have the same sort of thought and hard work go into what he was thinking about. I never heard him say that again. I am reminded of that story now that the Senator from New Jersey said this legislation is cobbled together.

To some extent, I suppose every political compromise, for every piece of legislation, one could use those words to describe it. I know the Senator from New Jersey participates in a lot of very difficult legislation in the committees he serves on and knows what it takes to put a bill together. However, I look at this piece of legislation, the compromise it takes, the hard work it takes, all the long hours it takes, as not a perfect piece of legislation but surely not a cobbled-together piece of legislation.

From that point of view I will respond not to the Senator from New Jersey any further but to speak about some of the aspects of this legislation as we get ready to vote on it tomorrow.

Mr. CORZINE. Will the Senator from Iowa yield for just a question and a comment?

Mr. GRASSLEY. I would be glad to yield for a short question or short comment and reserve my right to the floor.

Mr. CORZINE. I appreciate the comment with regard to cobbling. It is great to be put in the same company of criticism with regard to the use of the term. I do not want to leave the impression that I don't think there was great thought and effort in putting together this extraordinary piece of legislation. It is actually a tremendous tribute to the Senator from Iowa for the ability to put together all the various interests in common and come up with something that is pretty doggone close for all Members to be able to consider.

My concern is that it is very hard to know from this Senator's point of view all the details. I wish I could say I was absolutely certain that I had analyzed this exactly the right way for those seniors in my State. But this is an incredibly complex issue, not only for the seniors themselves to be facing but also for those who are trying to decide how we are investing $400 billion.

I congratulate the Senator for his efforts. Unfortunately, as I look at it, I come out with a different perspective, but I don't think it is for lack of good intentions, hard work, and great compromise on the Senator's part.

Mr. GRASSLEY. I surely appreciate the good nature in which the Senator from New Jersey just stated his feelings about this legislation. I wanted to give equal treatment to the President, as I did the Senator from New Jersey and vice versa.

One of the aspects of this legislation that is misunderstood is the issue of health savings accounts, which is a new name for what people hear Congressmen talk about as medical savings accounts, only different in name, particularly, as it relates to people in my State, the benefit to farmers and small business people.

This bipartisan agreement includes these provisions establishing health savings accounts. I will refer to them as HSAs.

HSAs are tax-advantaged savings accounts that can be used to pay for medical expenses incurred by individuals, their spouse, or dependents. HSAs are similar to medical savings accounts. However, medical savings account eligibility has been restricted to employees of small businesses and the self-employed. HSAs are open to everyone with a high deductible health insurance plan. The only limitation on the health plan is that the annual deductible must be at least $1,000 for individual coverage, and $2,000 for family coverage. Contributions to the HSA by an employer are not included in the individual's taxable income. Contributions to an individual are tax deductible.

Total yearly contributions to an HSA can be as large as the individual's health insurance plan deductible, between $1,000 and $5,000 for self-coverage, and $2,000 and $10,000 for family coverage.

The interest in investment earnings generated by this account is also not taxable while in the health savings account. Amounts distributed are not taxable as long as they are used to pay for qualified medical expenses such as prescriptions, over-the-counter drugs, and long-term care services, as well as the purchase of continued health care coverage for the unemployed individual. That is legislation we passed a long time ago called COBRA.

Amounts distributed which are not used to pay for qualified medical expenses will be taxable, plus an additional 10-percent tax being applied in order to prevent the use of HSAs for nonmedical purposes. These accounts are portable, so an individual is not dependent on a particular employer to enjoy the advantages of having an HSA, low-income individual retirement account. The HSA is owned by the individual, not by the employer, and if the individual changes jobs, the HSA goes with the individual.

In addition, individuals over age 55 may contribute extra contributions to their accounts and still enjoy the same tax advantage.

In 2004, an additional $500 can be added to the HSA. By the year 2009, an additional $1,000 can be added to the HSA.

In regard to this legislation before the Senate beyond the health savings accounts, I point out what a great prescription drug benefit structure we have. First and foremost, it is important to point out that this is a voluntary program. If you currently have drug coverage and you like it, you can keep it or, if you do not have drug coverage and do not want it, you do not have to take it. If you are covered by Medicare fee for service today, and you are satisfied with it, you can stay right where you are.

This drug benefit also offered through Medicare will be a comprehensive benefit that will provide real relief for our seniors. Seniors that now pay full retail price could see a 25-percent reduction in their prescription spending. Additionally, these seniors' overall out-of-pocket drug spending could fall by as much as 77 percent. This is real relief for real people, not some hypothetical.

To provide relief to all seniors, the drug benefit is based upon income level. It is quite simple. Those who need more help because they are low income will receive more help under this program.

We divide this up according to the levels of poverty under the official poverty indexes of the Federal Government.

For those individuals and couples who are above 150 percent of the Federal poverty level, they can expect to see a monthly premium of $35, an annual deductible amounting to $250, a 75–25 percent cost-sharing up to a payment of $2,250, and a true out-of-pocket catastrophic cap at $3,600.

Additional benefits, including help with both the premium and initial cost-sharing, are targeted to seniors with income levels below 150 percent of the Federal poverty level. These subsidies will be available at increasing levels for those between 135 and 150 percent of the poverty index, and those between 100 and 135 percent. And then there is still another category of greater help for those below 100 percent of poverty.

I will explain how this differs for each of these categories. First, for individuals who are 135 to 150 percent of poverty, this group would have a $50 deductible, sliding-scale premium assistance, and 15 percent cost-sharing up to the benefit limit of $2,250, and $2 or $5 cost-sharing above the catastrophic level—$2 meaning for generic, $5 for brand-name drugs.

For individuals who are below 135 percent of the poverty index, they would have no deductibles, no premiums, $2 and $5 cost-sharing up to the catastrophic limit, and no cost-sharing after the catastrophic level has been reached.

Now, we go to the neediest of our seniors, the dual eligibles, those who are presently low income and getting help not only from Medicare but from the State Medicaid Program. They currently have their drug costs paid for by the Medicare Program that differs a little bit from State to State based upon the laws of those States.

Our conference report calls for Medicare to pick up the cost of their prescription drugs. Most of this population will have a $1 and $3 cost-sharing up to the cost-sharing limit, and then, after that, no cost-sharing on the catastrophic. Now, that $1 and $3, again, is generic for the $1, and $3 for the brand-name drugs.

By providing coverage to all seniors based on income levels, you can see that the number of individuals with no prescription drug coverage will fall from 24 percent in the year 2002 to 2 percent in the year 2009.

Now let's make it clear. About over half of individuals today have some prescription drug coverage—some very good, some not so good—and then 25 percent, maybe 30 percent have nothing. Now, we expect this to go down under this program to just 2 percent of our population, after 3 years of phase in.

Mr. President, 98 percent of the seniors receiving prescription drug coverage in 2009 will receive it from privately insured plans. Moreover, 33 percent of the beneficiaries will get their prescription drug coverage from integrated private plans, three times the rate in 2002.

Additionally, seniors will see immediate benefits with discount drug cards. These are going to be available in the middle of next year, and through all of the year 2005. Then, after the year 2005, the new program, in its entirety, kicks in. So the discount drug card is for an interim period of time while it takes the Department of HHS a period of time to set up what we are going to pass tomorrow. These discount drug cards will pass on between 15 and 25 percent of savings on seniors' current drug prices.

It is clear to see that the conference agreement has come a long way since we passed this bill in this body the first time in June. Many of my colleagues wanted a lower deductible. We have a lower deductible. Other colleagues were more concerned with getting the dual eligibles' drug costs out of the Medicaid Program and covering everybody by Medicare. We have done that as well.

So this is a good, solid drug benefit that will provide real relief to all seniors. Not only is this a good bill, with a good benefit, this bill provides an incentive for employers not to drop their retiree coverage.

Because there has been so much misinformation about corporations dropping employees, and since we have gone to such great strides in the conference report to overcome that problem and reduce that possibility, I want to spend some time on that and make clear that what we did in this respect—I think it is fair for me to say that the conference report, the compromise between the House bill and the Senate bill, is very much better than either the Senate bill, when it passed in June, or the House bill, when it passed the other body in June. So I would make these comments about whether or not employers are going to drop coverage of their retirees.

Now, we have heard a lot from opponents of this historic bipartisan effort alleging that this bill will cause employers to drop their retiree health coverage. But one thing these opponents do not do is tell the people the whole story.

So as Paul Harvey says, the rest of the story and the reality is that employers have been dropping retiree coverage for years.

As you can see from this chart, there has been a gradual decline in the number of corporations providing coverage for their retirees. Since 1991, the number of larger employers offering health coverage to their retirees has dropped by nearly 20 percent, from 80 percent down to 61 percent.

This chart shows what we have been seeing in our States and hearing from our constituents. So employers have been dropping coverage for their retirees, and this has already been going on for more than a decade.

We know these days employers are finding it harder and harder to continue voluntarily providing health insurance coverage for their retirees.

That is why we in the Medicare conference worked diligently—put resources behind it—to help employers continue providing coverage for retirees, not just to be nice to the retirees but to be nice to the taxpayers because it is a heck of a lot cheaper to keep these retirees in their corporate plans than have them go on our plan.

That is our goal. Let me make it very clear; we have done a very good job of accomplishing that goal.

So let me tell you the three important ways we have done it.

First, the bill provides a 28-percent subsidy for the prescription drug costs for retirees so they will continue providing this coverage. That is about $750 per retiree, but that is just on average because every corporation has a different plan.

Second, we exclude this retiree subsidy from the Federal corporate tax. This dramatically increases the value of this subsidy for retiree coverage and helps the employer continue offering this coverage.

Third, the bill provides additional flexibility for employers to structure plans that complement Medicare's new drug benefit.

Overall, the conferees agreed to put $89 billion in this bill to protect retiree health coverage.

This funding makes it more likely—obviously not less likely—that employers will continue their retiree benefits. I think I ought to emphasize what $89 billion happens to be. That is 20 percent of all the money we are putting in this bill for prescription drugs for seniors. Now the Congressional Budget Office estimates that 17 percent of the retirees will not receive supplemental drug coverage from their employers beyond what is offered by Medicare in this bill. We have a different estimate from the Employee Benefits Research Institute that is outside of our government. It is a nationally respected organization that studies retiree benefits. They estimate that that number is going to be much smaller: 2 to 9 percent of the retirees might not receive supplemental coverage from their employer in the future if Congress passes the Medicare benefit.

According to the Employee Benefits Research Institute, if Congress creates a Medicare drug benefit of any kind, some employers will want their retirees to take advantage of that new benefit. This is an important part of the rest of the story. The only way to prevent employers from putting their retirees in the Medicare drug program is if we don't pass legislation such as this, if we say we don't give a darn about the 25 to 30 percent of the people who don't now have prescription drugs and we don't care if they ever have it. That is not the attitude of Congress. That is why this legislation is before us, because we do care about people who can't afford or don't have available a plan for prescription drugs.

For those people, particularly on this side of the aisle, who have been complaining about not doing enough or that passing this bill might cause some corporations to change their health benefits and prescription drugs for their seniors, do they think we should do nothing? No, they don't think so. They are crying because we aren't doing enough. I tell you honestly, we could put $400 billion, all of this bill, into just those 30 percent of the people in this country who retire from corporations that have a pretty good prescription drug program, probably better than most people have, and I couldn't guarantee anybody in this country that some corporation, big or little, wouldn't dump their programs, just dump them, as they have been doing for 20 years.

Let me be clear, these retirees will not be left without drug coverage. Retirees are not going to lose drug coverage. Why? Because of this bipartisan bill before us. These retirees will still be better off than today, because today when their employer drops coverage, they are left with nothing—no coverage whatsoever. Because of this bill, these retirees will be getting drug coverage from Medicare, and their former employer will likely pay the monthly premium for them. They will still be better off than they would be today where there is no Medicare drug benefit to back them up.

It is also important to recognize that keeping employers in the game lowers the Federal cost of the drug benefit. That is why we are concerned about the taxpayer as well as the corporate retiree. Obviously, if it is dumped, it is going to cost the plan more than if they stay on the corporate plan. So providing this 28 percent subsidy actually lowers the cost of the Medicare benefit. This generous 28 percent subsidy for retiree coverage is good policy. And because it is good policy, it is good politics. This bipartisan bill protects retiree benefits. That has been our goal, and we have accomplished it.

Mr. GRASSLEY. Mr. President, Medicare contractor reform will not succeed if contractors are subject to unlimited civil liability in carrying out the payments, provider services, and beneficiary services functions expected of them. The conference agreement would therefore continue the past policy of limiting the liability of certifying and disbursing officers, and the Medicare administrative contractors for whom those officers serve, with respect to certain payments.

In addition, the language contained in section 911 of the conference agreement clarifies that Medicare administrative contractors are not liable for inadvertent billing errors but, as in the past, are liable for all damages resulting from reckless disregard or intent to defraud the United States. Importantly, the reckless disregard standard is the same as the standard the standard under the False Claims Act. This standard balances the practical need to shelter Medicare administrative contractors from frivolous civil litigation by disgruntled providers or beneficiaries with the Medicare program's interest in protecting itself from contractor fraud.

The False Claims Act, 31 U.S.C. §§3729–3733, applies to Medicare fiscal intermediaries and carriers under current law. This legislation makes it clear that the False Claims Act continues, as in the past, to remain available as a remedy for fraud against Medicare by certifying officers, disbursing officers, and Medicare administrative contractors alike and that, among other things, the remedy subjects Medicare contractors to administrative, as well as trust fund, damages.

ORDERS FOR MONDAY, NOVEMBER 24, 2003

Mr. GRASSLEY. Mr. President, for the leader, I would like to give what is referred to daily as the closing script, if I may.

I ask unanimous consent that when the Senate completes its business today, it adjourn until 9 a.m., Monday, November 24. I further ask that following the prayer and pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day, and the Senate then resume consideration of the conference report to accompany H.R. 1, the Medicare modernization bill, provided that the time until 12:30 p.m. be equally divided between the chairman of the Finance Committee or his designee and the minority leader or his designee. I further ask unanimous consent that the cloture vote on the conference report begin at 12:30 p.m. Finally, I ask that the last 10 minutes prior to the vote be allocated to the Democratic leader for 5 minutes, to be followed by the majority leader for 5 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. GRASSLEY. Mr. President, tomorrow morning we will resume debate on the Medicare modernization conference report. Under the previous order, there will be approximately 3½ hours of debate prior to the cloture vote on the conference report which is locked in to occur at 12:30 p.m. The cloture vote on the conference report will be the first vote of the day. It is my hope and expectation that cloture will be successful. This issue deserves an up-or-down vote. I urge my colleagues on the other side of the aisle to allow this process to move forward.

MORNING BUSINESS

THE FLORIDA CITRUS INDUSTRY

Mr. NELSON of Florida. Mr. President, this week, leaders from thirty-four countries around the Western Hemisphere gathered in Miami for the Free Trade Area of the Americas (FTAA) Ministerial and Americas Business Forum for the purposes of expanding free trade within the Western Hemisphere.

The negotiations at this and future Ministerial meetings will greatly impact my State of Florida.

This event drew large headlines in the papers across the hemisphere as leaders converged upon Miami and anti-globalization protesters gathered outside to voice opposition. In this context, I feel it appropriate to commend Miami-Dade County, the City of Miami, and all the local and Federal law enforcement officers who helped keep the peace during a tense week of negotiations, and everyone who made it a success.

But in light of these talks, I want to share my own concerns regarding the FTAA negotiations, and the path ahead.

These talks did generate positive movement forward, towards greater economic integration in the hemisphere. Trade Ministers agreed to a baseline of minimum standards for a full and comprehensive agreement that takes into account differing levels of development among nations. This framework is a step forward that gives nations flexibility.

A carefully negotiated Free Trade Area of the Americas could generate new economic opportunities for Florida, our country, and the entire Western Hemisphere.

Yet, the FTAA poses opportunities and challenges for Florida as we work to make Miami the premier U.S. candidate city for the location of the permanent FTAA Secretariat, while at the same time protecting the viability of a key part of our way of life in Florida—the domestic citrus industry.

We must be cautious about the scope of the final FTAA and consider how it affects our domestic industries. I urge U.S. negotiators to take some important concerns into account as an agreement is shaped in the months ahead. The different parties, alliances, and groups involved in the negotiations have gone back and forth on which goods and products to include in a final agreement, and the flexibility provided for in the final Miami Declaration reflects this fact.

Citrus is one product that must not be included in these negotiations. I again call upon the Administration, as I have done in the past, to give citrus special consideration; given the unique nature of the citrus fruit and juice trade.

The administration should state unambiguously that it will not agree to any reduction of the current tariff on imported orange juice in the context of the FTAA or any other trade negotiation, until Brazil ceases its monopolistic, anticompetitive trade practices. Let me explain why this is so important to the State of Florida.

This tariff is a lifeline for Florida's citrus industry and the State's economy because it helps to promote competition—and it enables us to compete in the global marketplace.

It is very clear that any reduction in the tariff would destroy Florida's citrus industry and devastate the State's economy. The citrus industry is the State's second largest, contributing over $9 billion to our economy. And the citrus industry accounts for nearly 90,000 direct and indirect jobs throughout Florida and the country.

A collapse of this industry would not only cost tens of thousands of jobs, it would also cost the State and county governments of Florida up to $1 billion in lost tax revenues.

This would mean less money for other vital public services, such as police and firefighters.

This spring, I arranged for Andrew LaVigne, Executive Vice President and CEO of Florida Citrus Mutual to testify before the Senate Foreign Relations Committee and share these arguments, for the benefit of my colleagues in the U.S. Senate so that they could be made a permanent part of the record, because they are so strong.

Orange juice consumption is concentrated chiefly in two places: the United States and the European Union. Unlike other agricultural products, production is also limited chiefly to two places: the United States and Brazil. Florida's growers provide the vast majority of U.S. citrus that is used for orange juice.

Florida's citrus industry is efficient, competitive, and environmentally responsible; it is also one of only a handful of U.S. agricultural commodities that receives no federal or state subsidies. Let me say it another way: American taxpayers do not subsidize the citrus industry, unlike many other sectors that reaped benefits in last year's farm bill.

Florida's citrus industry is composed of 12,000 growers, many of them small family-owned operations, in addition to the many tens of thousands of others around the state and country who contribute to this $9 billion industry. But, this is more than just an economic engine to Florida. It is an American way of life.

Brazil's citrus industry, in contrast, is dominated by four large producers who form large export cartels to maximize their advantage and squeeze small producers. The industry also benefits from advantages brought by years of past subsidization and dumping, lax environmental laws, weak and largely unenforced labor laws, and price manipulation. And, Brazilian orange juice already has access to U.S. markets. Their government's pronouncements to the contrary are counterproductive to advancing greater hemispheric economic cooperation.

Brazil's citrus industry also continues to rely heavily on child labor and the low wages associated with using children.

In Florida, we do not allow children to work in our orange groves.

Until Brazil whole-heartedly enforces its labor laws, putting an end to child labor and paying workers a decent living wage, there will not be a level playing field for competition.

Florida's citrus industry can compete with Brazil, or anyone else, as long as there is a fair playing field. WTO negotiations should deal with these problems. But in the meantime, the tariff on frozen concentrated orange juice imports acts to balance the anti-competitive practices of Brazil. It also acts to prevent the large Brazilian producers from overwhelming the U.S. market and driving Florida's 12,000 growers out of business.

During the Trade Promotion Authority debate in 2001, Senator GRAHAM and I offered an amendment that would have prevented tariffs from being reduced on commodities imported from other countries in violation of trade laws, such as Brazilian orange juice.

Although this amendment was defeated, we were successful in including language that required the Administration to study and report to the Congress on the economic effects that a tariff removal would have on import-sensitive commodities like frozen concentrated orange juice and citrus. I look forward to reviewing the results of these studies as the debate progresses.

Without this tariff, the Florida citrus industry could collapse, and Brazil would have a monopoly over the global market. Already, Brazil produces 53 percent of the world's orange juice and has a virtual monopoly over the European market.

Removal of this tariff would not enhance free trade—it would, rather, giver Brazil a total world monopoly and make that country the world's dominant citrus and citrus juice producer and enable them to control market supply, access and prices with no competition.

This would not only devastate Florida's citrus industry, it would also be bad for all consumers. Absent competition from Florida's growers, the large Brazilian cartels would have all consumers at their mercy.

I have worked to bring these issues to the attention of the Administration and to ensure that one of Florida's primary industries is not traded away at the negotiating table, and I will continue to do so. In fact, I plan to travel to Brazil in the coming weeks and have asked to meet with President Lula da Silva so that I can carry the message of the Florida citrus growers: free trade can only benefit American consumers if it offers free and fair competition and is not monopolistic—so Brazil must reform its monopolistic citrus industry.

It is past time for this administration to acknowledge the inequalities between the U.S. and Brazilian citrus industries, and recognizing these inequities, to treat citrus accordingly.

I would like to conclude by again urging the administration not to agree to any reduction of the current tariff on imported orange juice, because if they do, an American industry and American consumers will pay a steep price. These issues are too important to the people of Florida to be ignored, and we will all be watching closely in the months ahead.

I ask unanimous consent to have printed in the RECORD conclusions in the testimony from Andrew LaVigne, Executive Vice President and CEO of Florida Citrus Mutual, from a hearing before the House Agriculture Committee on June 18, 2003, and Squire Smith, President of Florida Citrus Mutual, before the House Agriculture Committee, Subcommittee on Livestock and Horticulture on November 5, 2003, and an Op-Ed that appeared in the Miami Herald on November 19, 2003.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

CONCLUSION

The U.S. market is by far the most significant market we have. Unlike dairy and crop commodities, which are consumed throughout the world, orange juice is consumed primarily in the highly developed market economies of the United States and Europe. With Brazilian juice firmly entrenched in Europe at rock bottom prices, it only makes sense for Florida producers to concentrate on sales at home. Our growth in exports of specialty products, such as NFC, must necessarily be incremental and secondary to the domestic market for FCOJ. While the Florida industry will continue to seek out new export markets, both for fresh and processed products, it is myopic to think that we are likely to be as large a factor in foreign markets as Brazil. We simply do not have the domestic subsidies we would need to compete with the Brazilians and Europeans in Europe. Furthermore, we cannot be there to develop those new foreign markets slowly over the many years it will take them to achieve higher disposable incomes, if the Florida industry is forced out of existence by the elimination of the tariff. We want to serve the U.S. market and we can do so without the huge government payments that other agricultural sectors receive. However, the U.S. orange juice tariff is necessary to offset the unfair or artificial advantages that lower the price of Brazilian juice.

Florida Citrus Mutual understands that free trade in many industries, including many agricultural industries, leads to increased competition, eventual price benefits to consumers, and overall global economic growth. Unfortunately, free trade cannot deliver these rewards to such a concentrated and polarized global industry, especially one in which the developing country's industry is, in fact, already the most highly developed in the world. Florida Citrus Mutual appreciated the opportunity to explain to the Committee the unique global structure of the orange juice industry and the negative economic effects that would occur as a result of U.S. tariff reduction or elimination.

DOMESTIC POLICIES AFFECTING THE SPECIALTY CROP INDUSTRY

CONCLUSION

The U.S. Government's approach to domestic policy that impacts the fruit and vegetable industry, including the citrus industry, is to a large extent driven by the U.S. trade policy as it affects the industry. Our ability to properly address issues of pest and disease interdiction and eradication, labor law reform, agricultural research and export market growth depend almost entirely upon the balancing impact of the tariff, which assures that the industry can continue to exist in an unsubsidized domestic environment alongside otherwise artificially manipulated global competition.

[From the Miami Herald, Nov. 19, 2003]

TARIFFS WOULD CONTROL OVERSUPPLY

(By Mark Ritchie)

Last September in Cancún, the Bush administration's promises of free trade's benefits ran headlong into the reality of the last ten years under the World Trade Organization and the U.S.-Canada-Mexico arrangement known as NAFTA—the North American Free Trade Agreement.

Governments from Latin America, Africa and Asia decried the loss of millions of farm jobs, and denounced a system that promotes the continued export of agricultural commodities below their cost of production price (dumping) by U.S. and European agribusiness corporations. That's why the WTO talks in Cancún collapsed.

Fortunately, a close look at the underlying conflicts at the WTO reveals the potential for a new approach that negotiators trying to create a Free Trade Area of the Americans should use as a blueprint. It would create a win-win solution to the chronic low prices that plague farmers in the United States, Brazil and elsewhere.

International trade negotiations used to be about finding solutions that were aimed at benefiting societies as a whole. In 1947, just a few miles from Miami, governments met in Havana to discuss the creation of the International Trade Organization (ITO). The stared goal for the organization was full employment and the need to global monopolies and predatory trade practices. At that time, the nations gathered knew well the ravages of war and the role that brutal trade conflicts played in creating the economic Depression of the 1930s, the breeding ground for fascism.

BALANCING NEEDS

At the talks in Havana, the U.S. Department of Agriculture brought forward a special set of agricultural trade rules that would help balance the needs of producers and consumers with an emphasis on protecting food security over the long term. In essence, U.S. negotiators, with the Great Depression still very much on their minds, developed rules that helped nations balance supply and demand.

The ITO never got off the ground, but these agricultural rules were included in the original general Agreement on Tariffs and Trade, precursor to the WTO. The rules allowed nations to use quantitative import controls as long as they were imposing supply controls. This spurred countries to address domestic oversupply, helping to bring global supply and demand into balance. This plan was key to the "golden era" for U.S. and global agriculture in the 1950s and 60s.

The WTO Agreement on Agriculture undid this important work, but now the ministers gathering in Miami have an opportunity to make improvements by returning to the work done by the pioneers back in Havana in 1947. They have to tackle global over-supply in ways that can help producers in Florida and Brazil earn a profit by restoring the balance between supply and demand that has been damaged by the "race to the bottom" results of free trade.

Negotiators must address monopoly-style business practices that dominate global trade in highly competitive products when global prices fall too far.

TARIFFS BENEFICIAL

The solution to low commodity prices in general, be it orange juice or coffee, is not that complicated. Every business knows that when supply and demand are out of balance, there is going to be trouble. In agriculture, when there is not enough supply, some people go hungry. When there is too much supply, prices drop, farmers suffer and many go out of business.

We need modern trade agreements that enable countries to restore the balancing mechanisms for supply and demand. To take that step, the Bush administration needs to unlock the "free trade" straitjacket of eliminating tariffs at all costs, and start focusing on agricultural market fundamentals.

ADDITIONAL STATEMENTS

DANIEL AND JO ANN PLATT

• Mr. BOND. Mr. President, today I rise to honor two outstanding Missourians, Daniel and Jo Ann Platt. The occasion is a special one, as they celebrate their 50th wedding anniversary.

Only a year after Jo Ann, a native of Indiana, and Dan, a New Yorker, were married on December 5, 1953, they came to the Midwest from Manhattan, where Dan—an anesthesiologist—had been asked to become chief of the Anesthesia Department at Knickerbocker Hospital and the New York Eye and Ear Infirmary.

Instead, Dan practiced at Alton Memorial Hospital, a place where the Platts believed that he could engage in a personal, patient-centered style of medicine that was impossible in a larger, more urban hospital setting. And there, he opened the first recovery room in the St. Louis metropolitan area, and established one of the first coronary care units and intensive care units in the St. Louis area, along with Barnes Hospital. Upon Dan's retirement in 2002, Alton Memorial Hospital dedicated its surgical and emergency building in his name, to commemorate his 48 years of service to the community, complete with a bust and a plaque paying tribute to Dan as "the consummate physician."

As Dan worked long hours at the hospital, Jo Ann was busy, as well. Over the years, she has served the community in many capacities, including as a member of the board of trustees of St. Louis Country Day School, on the vestry of The Church of Saint Michael and Saint George, on the board of governors of the Saint Louis Woman's Club, on the board of the St. Louis Charitable Foundation, and as a board member for both the Jennie D. Hayner Library Association and the Alton Museum of History.

Yet the bulk of Jo Ann's time was spent in supporting Dan's practice of medicine—which she considered a ministry—and being a devoted and fun-loving mother to their three children: Drew, now a commercial realtor and developer in Evansville, IN; Brett, who runs his own currency hedge fund in London, England, and recently became engaged to Mariela Ferro; and Carol, an attorney, political analyst and commentator, who lives in San Marino, CA, with her husband Jack Liebau, a portfolio manager who recently opened his own investment management firm. Carol, after surviving Harvard Law School as an overt Republican, worked faithfully on my staff in Washington for 2 years before realizing that her colleagues simply could not listen fast enough. All three children remember lives filled with the love, support and encouragement of their parents—and many, many good times.

Truly, Dan and Jo Ann's life together has been full of accomplishments and blessings—most notably, the heartfelt love and respect of their children and children-in-law. We wish them every happiness in the years to come, together with our warmest congratulations and best wishes.●

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. NICKLES (for himself, Ms. LANDRIEU, Mr. CRAIG, Mr. BINGAMAN, Mr. INHOFE, and Mr. SMITH):

S. 1934. A bill to establish an Office of Intercountry Adoptions within the Department of State, and to reform United States laws governing intercountry adoptions; to the Committee on the Judiciary.

By Mr. CORZINE:

S. 1935. A bill to amend the Public Health Service Act to require employers to offer health care coverage for all employees, to amend the Social Security Act to guarantee comprehensive health care coverage for all children born after 2001, and for other purposes; to the Committee on Finance.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. NICKLES (for himself, Ms. LANDRIEU, Mr. CRAIG, Mr. BINGAMAN, Mr. INHOFE, and Mr. SMITH):

S. 1934. A bill to establish an Office of Intercountry Adoptions within the Department of State, and to reform United States laws governing intercountry adoptions; to the Committee on the Judiciary.

Mr. NICKLES. Mr. President, today on National Adoption Day, I rise to introduce the Intercountry Adoption Reform Act along with my colleagues Senators LANDRIEU, CRAIG, BINGAMAN, INHOFE and SMITH. The primary focus of this bill is to streamline, simplify and improve the foreign adoption process for families, adoption agencies and more importantly for the foreign adopted children of American citizens.

In the last decade, there has been a significant growth in intercountry adoption. In 1990, Americans adopted more than 7,000 children from abroad. In 2002, Americans adopted almost 20,000 children from abroad. Families are increasingly seeking to create or enlarge their families through intercountry adoptions. There are many children worldwide who are without permanent homes. It is the intent of this bill to make much-needed reforms to the intercountry adoption process used by U.S. citizens and therefore help more homeless children worldwide find a permanent home here in the United States.

There are two main goals of this legislation. First, and more importantly, this bill acknowledges and affirms that foreign adopted children of American citizens are to be treated in all respects the same as children born abroad to an American citizen. Under existing law, foreign adopted children are treated as immigrants to the United States. They have to apply for, and be granted immigrant visas to enter the United States. Once they enter the United States, citizenship is acquired automatically. Had these children been born abroad to American citizens, they would have traveled back to the United States with a U.S. passport and entered as citizens. This bill provides for equal treatment for foreign adopted children.

Furthermore, these children are not immigrating to the United States in the traditional sense of the word. They are not choosing to come to our country, but rather American citizens are choosing to bring them here as part of their families. Once a full and final adoption has occurred, then the adopted child is a full-fledged member of the family and under adoption law is considered as if "natural born." As a child of an American citizen, the foreign adopted child should be treated as such, not as an immigrant.

The second goal is to consolidate the existing functions of the Federal Government relating to foreign adoption into one centralized office located within the Department of State. Currently, these functions are performed by offices within the Department of Homeland Security and the Department of State. Consolidation of these functions into one office will result in focused attention on the needs of families seeking to adopt overseas and on the children they are hoping to make part of their families.

Today, when a family seeks to adopt overseas, it has to first be approved to adopt by the Department of Homeland Security. Then, after a child has been chosen, the Department of Homeland Security has to determine if the child is adoptable under Federal adoption law. After this determination is made, the Department of State has to determine whether the child qualifies for a visa as an immediate relative of an American citizen. This bill seeks to minimize the paperwork involved and streamline the process by having these functions all performed in one, centralized office, the Office of Intercountry Adoptions, staffed by expert personnel trained in adoption practices.

The focus of this office will be on foreign adoptions and only on foreign adoptions. Officials in the Department of Homeland Security and the Department of State that currently perform the functions being transferred to this new office have many other duties, such as screening for terrorists or dealing with illegal immigrants. Adoption is frequently a low priority on the desk of such officers. By consolidating these functions into one office, with its sole focus being foreign adoption, these issues can be handled more promptly and given the priority they deserve.

Another aspect of the Office of Intercountry Adoptions that I consider extremely important is the proactive role that we intend for it to take in assisting other countries in establishing fraud-free, transparent adoption practices and interceding on behalf of

American citizens when foreign adoption issues occur. By establishing an Ambassador at Large for Intercountry Adoption, this legislation will provide a point of contact for foreign governments when issues involving foreign adoptions arise.

In the last few years there have been many examples of instances where our government has had to intercede on behalf of Americans seeking to adopt a foreign child. For example, Romania has been closed to foreign adoption for more than 2 years now. When Romania issued its moratorium on foreign adoption, hundreds of American families who were in the process of adopting Romanian orphans were unable to complete their adoptions. Fortunately, the Department of State was able to work successfully with the Romanian government to have these adoptions processed and persuaded Romania to grant exceptions to the moratorium for these American families and their adopted. Unfortunately, the moratorium is still in place leaving many orphans stuck in orphanages across Romania.

There also have been major adoption issues involving Cambodia, Vietnam, and Guatemala in the last 2 years. These issues are still being addressed by various officials within the Department of State and the Department of Homeland Security. It will be greatly beneficial to have a point person within the Federal Government to work on these issues, facilitate resolutions, and intercede on behalf of American families.

There also are some very significant procedural changes in the foreign adoption process included in this bill. Under the Child Citizenship Act of 2000, a foreign child adopted by a U.S. citizen acquires automatic citizenship upon entry into the United States to reside permanently. This bill proposes to change the point of acquisition of citizenship from entry into the United States to the time when a full and final adoption decree is entered by a foreign government or a court in the United States. Prior to citizenship attaching, the child must be determined to be an "adoption child" under U.S. law as defined in this bill. This provision is made retroactive to January 1, 1950, the year Americans began to adopt from abroad. This date also addresses the issue of children adopted during this time period whose parents failed to naturalize them under previous law.

Additionally, the Secretary of State shall issue a U.S. passport and a Consular Report of Birth for a child who satisfies the requirements of the Child Citizenship Act as amended by this Act. No visa will be required for such a child; instead it will be admitted to the United States upon presentation of a valid U.S. passport. No affidavit of support under 213A of the Immigration and Nationality Act will be required nor will the child be required to undergo a medical exam. These changes are again made to more closely equate the process of bringing a foreign adopted child home to the process of documenting and bringing home a biological child born abroad to a U.S. citizen.

When a U.S. citizen gives birth abroad, the parents simply go to the U.S. Embassy, present the child's birth certificate, their marriage license and proof of U.S. citizenship. Upon receiving this documentation, the embassy provides the parents with a U.S. passport for the child and a Consular Report of Birth that serves as proof of their child's citizenship as well as the child's birth certificate. This process takes little to no time to complete.

The process for foreign adopted children, however, is anything but quick and easy. Currently, an adoptive family may have to travel from the country where it adopts a child to another country in order to get the child's immigrant visa. Only certain embassies are able to grant such visas. On the other hand, most embassies are equipped to provide passports and Consular Reports of Birth. This will eliminate the need and expense associated with families having to travel with their newly adopted children to another U.S. Embassy in a different location prior to bringing the children home.

This bill also provides that the adoptive parents do not have to prove twice that they are financially capable of providing for their child and eliminates the immigration requirement of having the child undergo a medical exam. Before a family is approved to adopt a foreign child, the Federal Government has to be satisfied that the family is financially able to care for the child. This is part of the approval process. They should not have to repeat this process once they have fully and finally adopted a child.

In addition, prior to a family choosing to adopt a child, they should acquire and be provided as much medical information as is available on the health of the child so that it can make an informed decision on its ability to care for the child. Once that information has been provided and the child has been adopted, the child is now a member of the family. No biological child is denied entry because of medical reasons, nor should an adopted child be denied.

Another section of this bill provides for a new type of visa for children traveling to the United States for the purpose of being adopted by an American citizen who has been approved to adopt. Currently children who are not adopted overseas prior to their entry into the United States are allowed entry using an immigrant visa. As I have stated earlier, these children are not immigrants. They are being brought to the United States, at the request of a U.S. citizen, to become a member of that family. This new visa is a non-immigrant visa which authorizes admission of the child for the purposes of adoption. The authorized admission under this section terminates on the date the adoption is finalized, or 2 years after the date of admission if the adoption has not been finalized. Until the child is adopted, the child will receive temporary treatment as a legal permanent resident.

This bill also redefines the criteria used to determine a child's eligibility for adoption This is a critical piece of this legislation. The existing statutory language has not been revised since it was first written over 50 years ago. When it was written it was intended to deal primarily with war orphans and it does not permit voluntary relinquishment of children who have two living parents. The provision in this bill has been written to more fully comport with the language as agreed to in the Intercountry Adoption Act of 2000 which does permit the adoption of children whose parents have irrevocably relinquished them.

The bill also includes many safeguards such as: requirements that the Secretary of State is satisfied that the proper care will be furnished the child; that the purpose of the adoption is to form a bona fide parent-child relationship; that the biological parent-child relationships have been terminated; that the Secretary of State, in consultation with the Secretary of Homeland Security, is satisfied that the child is not a security risk; and that whose adoption and emigration to the United States has been approved by the competent authority of the country of the child's place of birth or residence.

Now that I have covered some of the significant aspects of this bill, let me tell you what this bill does not do. It does not create more bureaucracy or additional regulation. It does not increase fees for adoption. It does not slow down the adoption process. It does not add more red tape or additional paperwork. In fact, it does just the opposite.

It consolidates existing Federal processes for foreign adoptions into what is intended to be a "one stop shop"—the Office of Intercountry Adoptions. It eliminates paperwork involved in getting an immigrant visa and provides citizenship documentation up front for the child, saving the adoptive family from having to deal with this upon its return home. Instead the fully and finally adopted child enters the United States on a U.S. passport as a U.S. citizen and child of a U.S. citizen.

This bill is intended to ease the paperwork burden on adoptive parents who have already gone through extensive paperwork and documentation production to accomplish their adoption. It is intended to recognize that children adopted by American citizens are the children of American citizens and entitled to all the same rights, duties and responsibilities of biological children of U.S. citizens born abroad.

I introduce this bill with the hope that its passage will significantly improve the foreign adoption process so that more children worldwide can find loving, permanent homes. It is my prayer that someday, adoption will not be needed. That all children will be born into stable, loving homes to parents who want them and are able to care for them. However, until that day comes the foreign adoption process can be improved and should be improved. Foreign adopted children should be treated as children of U.S. citizens, not as immigrants, and should be accorded all the same rights as biological children of U.S. citizens. To that end, I introduce this bill.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1934

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Intercountry Adoption Reform Act of 2003" or the "ICARE Act".

SEC. 2. FINDINGS; PURPOSES.

(a) FINDINGS.—Congress finds the following:

(1) That a child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love, and understanding.

(2) That intercountry adoption may offer the advantage of a permanent family to a child for whom a suitable family cannot be found in his or her country of origin.

(3) There has been a significant growth in intercountry adoptions. In 1990, Americans adopted 7,093 children from abroad. In 2001, they adopted 19,237 children from abroad.

(4) Americans increasingly seek to create or enlarge their families through intercountry adoptions.

(5) There are many children worldwide that are without permanent homes.

(6) In the interest of United States citizens and homeless children, reforms are needed in the intercountry adoption process used by United States citizens.

(7) In addition, Congress recognizes that foreign born adopted children do not make the decision whether to immigrate to the United States. They are being chosen by Americans to become part of their immediate families.

(8) As such these children should not be classified as immigrants in the traditional sense. Once fully and finally adopted, they should be treated as children of United States citizens.

(9) Since a child who is fully and finally adopted is entitled to the same rights, duties, and responsibilities as a biological child, the law should reflect such equality.

(10) Therefore, foreign born adopted children of United States citizens should be accorded the same procedural treatment as biological children born abroad to a United States citizen.

(11) If a United States citizen can confer citizenship to a biological child born abroad, then the same citizen is entitled to confer such citizenship to their legally and fully adopted foreign born children immediately upon final adoption.

(12) If a United States citizen cannot confer citizenship to a biological child born abroad, then such citizen cannot confer citizenship to their legally and fully adopted foreign born child, except through the naturalization process.

(b) PURPOSES.—The purposes of this Act are—

(1) to ensure that foreign born children adopted by United States citizens will be treated identically to a biological child born abroad to the same citizen parent;

(2) to improve the intercountry adoption process to make it more citizen friendly and child oriented; and

(3) to foster best practices.

SEC. 3. DEFINITIONS.

In this Act:

(1) ADOPTABLE CHILD.—The term "adoptable child" has the same meaning given such term in section 101(c)(3) of the Immigration and Nationality Act (8 U.S.C. 1101(c)(3)), as added by section 204(a) of this Act.

(2) AMBASSADOR AT LARGE.—The term "Ambassador at Large" means the Ambassador at Large for Intercountry Adoptions appointed to head the Office pursuant to section 101(b).

(3) FULL AND FINAL ADOPTION.—The term "full and final adoption" means an adoption—

(A) that is completed according to the laws of the child's country of origin or the State law of the parent's residence;

(B) under which a person is granted full and legal custody of the adopted child;

(C) that has the force and effect of severing the child's legal ties to the child's biological parents;

(D) under which the adoptive parents meet the requirements of section 205; and

(E) under which the child has been adjudicated to be an adoptable child in accordance with section 206.

(4) OFFICE.—The term "Office" means the Office of Intercountry Adoptions established under section 101(a).

(5) READILY APPROVABLE.—A petition or certification is considered "readily approvable" if the documentary support provided demonstrates that the petitioner satisfies the eligibility requirements and no additional information or investigation is necessary.

TITLE I—ADMINISTRATION OF INTERCOUNTRY ADOPTIONS

Subtitle A—In General

SEC. 101. OFFICE OF INTERCOUNTRY ADOPTIONS.

(a) ESTABLISHMENT.—There is established within the Department of State, an Office of Intercountry Adoptions which shall be headed by the Ambassador at Large for Intercountry Adoptions who shall be appointed pursuant to subsection (b).

(b) AMBASSADOR AT LARGE.—

(1) APPOINTMENT.—The Ambassador at Large shall be appointed by the President, by and with the advice and consent of the Senate, from among individuals who have background, experience, and training in intercountry adoptions.

(2) AUTHORITY.—The Ambassador at Large shall report directly to the Secretary of State, in consultation with the Assistant Secretary for Consular Affairs.

(3) DUTIES OF THE AMBASSADOR AT LARGE.—In carrying out the functions of the Office, the Ambassador at Large shall have the following responsibilities:

(A) IN GENERAL.—The primary responsibilities of the Ambassador at Large shall be—

(i) to ensure that intercountry adoptions take place in the best interests of the child; and

(ii) to assist the Secretary of State in fulfilling the responsibilities designated to the central authority under title I of the Intercountry Adoption Act of 2000 (42 U.S.C. 14911 et seq.).

(B) ADVISORY ROLE.—The Ambassador at Large shall be a principal advisor to the President and the Secretary of State regarding matters affecting intercountry adoption and the general welfare of children abroad and shall make recommendations regarding—

(i) the policies of the United States with respect to the establishment of a system of cooperation among the parties to The Hague Convention;

(ii) the policies to prevent abandonment, strengthen families, and to advance the placement of children in permanent families; and

(iii) policies that promote the well-being of children.

(C) DIPLOMATIC REPRESENTATION.—Subject to the direction of the President and the Secretary of State, the Ambassador at Large may represent the United States in matters and cases relevant to international adoption in—

(i) fulfillment of the responsibilities designated to the central authority under title I of the Intercountry Adoption Act of 2000 (42 U.S.C. 14911 et seq.);

(ii) contacts with foreign governments, intergovernmental organizations, and specialized agencies of the United Nations and other international organizations of which the United States is a member; and

(iii) multilateral conferences and meetings relevant to international adoption.

(D) INTERNATIONAL POLICY DEVELOPMENT.—To advise and support the Secretary of State and other relevant Bureaus in the development of sound policy regarding child protection and intercountry adoption.

(E) REPORTING RESPONSIBILITIES.—The Ambassador at Large shall have the following reporting responsibilities:

(i) IN GENERAL.—The Ambassador at Large shall assist the Secretary of State and other relevant Bureaus in preparing those portions of the Human Rights Reports that relate to the abduction, sale, and trafficking of children.

(ii) ANNUAL REPORT ON INTERCOUNTRY ADOPTION.—On September 1 of each year, the Secretary of State, with the assistance of the Ambassador at Large, shall prepare and transmit to Congress an annual report on intercountry adoption. Each annual report shall include—

(I) a description of the status of child protection and adoption in each foreign country, including—

(aa) trends toward improvement in the welfare and protection of children and families;

(bb) trends in family reunification, domestic adoption, and intercountry adoption;

(cc) movement toward ratification and implementation of The Hague Convention; and

(dd) census information on the number of children in orphanages, foster homes, and other types of nonpermanent residential care;

(II) the number of intercountry adoptions by United States citizens, regardless of whether the adoption occurred under The

Hague Convention, including the country from which each child emigrated, the State in which each child resides, and the country in which the adoption was finalized;

(III) the number of intercountry adoptions involving emigration from the United States, regardless of whether the adoption occurred under The Hague Convention, including the country where each child now resides and the State from which each child emigrated;

(IV) the number of Hague Convention placements for adoption in the United States that were disrupted, including the country from which the child emigrated, the age of the child, the date of the placement for adoption, the reasons for the disruption, the resolution of the disruption, the agencies that handled the placement for adoption, and the plans for the child, and in addition, any information regarding disruption or dissolution of adoptions of children from other countries received pursuant to section 422(b)(4) of the Social Security Act;

(V) the average time required for completion of an adoption, set forth by the country from which the child emigrated;

(VI) the current list of agencies accredited and persons approved under the Intercountry Adoption Act of 2000 (42 U.S.C. 14901 et seq.) to provide adoption services;

(VII) the names of the agencies and persons temporarily or permanently debarred under the Intercountry Adoption Act of 2000 (42 U.S.C. 14901 et seq.), and the reasons for the debarment;

(VIII) the range of adoption fees charged in connection with Hague Convention adoptions involving adoptions by United States citizens and the median of such fees set forth by the country of origin;

(IX) the range of fees charged for accreditation of agencies and the approval of persons in the United States engaged in providing adoption services under The Hague Convention; and

(X) recommendations of ways the United States might act to improve the welfare and protection of children and families in each foreign country.

(c) Functions of Office.—The Office shall have the following 6 functions:

(1) Approval of a family to adopt.—To approve or disapprove the eligibility of United States citizens to adopt foreign born children.

(2) Child adjudication.—To adjudicate the status of a child born abroad as an adoptable child.

(3) Family services.—To provide assistance to United States citizens engaged in the intercountry adoption process in resolving problems with respect to that process and to track intercountry adoption cases so as to ensure that all such adoptions are processed in a timely manner.

(4) International policy development.—To advise and support the Ambassador at Large and other relevant Bureaus in the development of sound policy regarding child protection and intercountry adoption.

(5) Central authority.—To assist the Secretary of State in carrying out duties of the central authority as defined in section 3 of the Intercountry Adoption Act of 2000 (42 U.S.C. 14902).

(6) Administration.—To perform administrative functions related to the functions performed under paragraphs (1) through (5), including legal functions and congressional liaison and public affairs functions.

(d) Organization.—

(1) In general.—All functions of the Office shall be performed by officers housed in a centralized office located in Washington, D.C. Within the Washington, D.C., office, there shall be 6 divisions corresponding to the 6 functions of the Office. All 6 divisions and their respective directors shall report directly to the Ambassador at Large.

(2) Approval to adopt.—The division responsible for approving parents to adopt shall be divided into regions of the United States as follows:

(A) Northwest.
(B) Northeast.
(C) Southwest.
(D) Southeast.
(E) Midwest.
(F) West.

(3) Child adjudication.—To the extent practicable, the division responsible for the adjudication of foreign born children as adoptable shall be divided by world regions which correspond to those currently used by other divisions within the Department of State.

(4) Use of international field officers.—Nothing in this section shall be construed to prohibit the use of international field officers posted abroad, as necessary, to fulfill the requirements of this Act.

(e) Qualifications and Training.—In addition to meeting the employment requirements of the Department of State, officers employed in any of the 6 divisions of the Office shall undergo extensive and specialized training in the laws and processes of intercountry adoption as well as understanding the cultural, medical, emotional, and social issues surrounding intercountry adoption and adoptive families. The Ambassador at Large shall, whenever possible, recruit and hire individuals with background and experience in intercountry adoptions.

(f) Use of Electronic Databases and Filing.—To the extent possible, the Office shall make use of centralized, electronic databases and electronic form filing.

SEC. 102. RECOGNITION OF CONVENTION ADOPTIONS IN THE UNITED STATES.

Section 505(a)(1) of the Intercountry Adoption Act of 2000 (42 U.S.C. 14901 note) is amended by inserting "301, 302," after "205,".

SEC. 103. TECHNICAL AND CONFORMING AMENDMENT.

Section 104 of the Intercountry Adoption Act of 2000 (42 U.S.C. 14914) is repealed.

Subtitle B—Transition Provisions

SEC. 111. TRANSFER OF FUNCTIONS.

(a) In General.—All functions under the immigration laws of the United States with respect to the adoption of foreign born children by United States citizens and their admission to the United States that have been vested by statute in, or exercised by, the Commissioner of Immigration and Naturalization, the Immigration and Naturalization Service (or any officer, employee, or component thereof), of the Department of Homeland Security (or any officer, employee, or component thereof) immediately prior to the effective date of this title, are transferred to the Office on such effective date for exercise by the Ambassador at Large in accordance with applicable laws and title II of this Act.

(b) Exercise of Authorities.—Except as otherwise provided by law, the Ambassador at Large may, for purposes of performing any function transferred to the Ambassador at Large under subsection (a), exercise all authorities under any other provision of law that were available with respect to the performance of that function to the official responsible for the performance of the function immediately before the effective date of the transfer of the function pursuant to this title.

SEC. 112. TRANSFER OF RESOURCES.

Subject to section 1531 of title 31, United States Code, upon the effective date of this title, there are transferred to the Ambassador at Large for appropriate allocation in accordance with section 115, the assets, liabilities, contracts, property, records, and unexpended balance of appropriations, authorizations, allocations, and other funds employed, held, used, arising from, available to, or to be made available to the Immigration and Naturalization Service or the Department of Homeland Security in connection with the functions transferred pursuant to this title.

SEC. 113. INCIDENTAL TRANSFERS.

The Ambassador at Large may make such additional incidental dispositions of personnel, assets, liabilities, grants, contracts, property, records, and unexpended balances of appropriations, authorizations, allocations, and other funds held, used, arising from, available to, or to be made available in connection with such functions, as may be necessary to carry out this title. The Ambassador at Large shall provide for such further measures and dispositions as may be necessary to effectuate the purposes of this title.

SEC. 114. SAVINGS PROVISIONS.

(a) Legal Documents.—All orders, determinations, rules, regulations, permits, grants, loans, contracts, agreements, including collective bargaining agreements, certificates, licenses, and privileges—

(1) that have been issued, made, granted, or allowed to become effective by the President, the Ambassador at Large, the former Commissioner of the Immigration and Naturalization Service, their delegates, or any other Government official, or by a court of competent jurisdiction, in the performance of any function that is transferred pursuant to this title; and

(2) that are in effect on the effective date of such transfer (or become effective after such date pursuant to their terms as in effect on such effective date);

shall continue in effect according to their terms until modified, terminated, superseded, set aside, or revoked in accordance with law by the President, any other authorized official, a court of competent jurisdiction, or operation of law, except that any collective bargaining agreement shall remain in effect until the date of termination specified in the agreement.

(b) Proceedings.—

(1) Pending.—The transfer of functions under section 111 shall not affect any proceeding or any application for any benefit, service, license, permit, certificate, or financial assistance pending on the effective date of this title before an office whose functions are transferred pursuant to this title, but such proceedings and applications shall be continued.

(2) Orders.—Orders shall be issued in such proceedings, appeals shall be taken therefrom, and payments shall be made pursuant to such orders, as if this Act had not been enacted, and orders issued in any such proceeding shall continue in effect until modified, terminated, superseded, or revoked by a duly authorized official, by a court of competent jurisdiction, or by operation of law.

(3) Discontinuance or modification.—Nothing in this section shall be considered to prohibit the discontinuance or modification of any such proceeding under the same terms and conditions and to the same extent that such proceeding could have been discontinued or modified if this section had not been enacted.

(c) Suits.—This title shall not affect suits commenced before the effective date of this title, and in all such suits, proceeding shall be had, appeals taken, and judgments rendered in the same manner and with the same effect as if this title had not been enacted.

(d) Nonabatement of Actions.—No suit, action, or other proceeding commenced by or against the Department of State, the Immigration and Naturalization Service, or the Department of Homeland Security, or by or against any individual in the official capacity of such individual as an officer or employee in connection with a function transferred pursuant to this section, shall abate by reason of the enactment of this Act.

(e) Continuance of Suit With Substitution of Parties.—If any Government officer in the official capacity of such officer is party to a suit with respect to a function of the officer, and pursuant to this title such function is transferred to any other officer or office, then such suit shall be continued with the other officer or the head of such other office, as applicable, substituted or added as a party.

(f) Administrative Procedure and Judicial Review.—Except as otherwise provided by this title, any statutory requirements relating to notice, hearings, action upon the record, or administrative or judicial review that apply to any function transferred pursuant to any provision of this title shall apply to the exercise of such function by the head of the office, and other officers of the office, to which such function is transferred pursuant to such provision.

Subtitle C—Effective Date

SEC. 121. EFFECTIVE DATE.

This title shall take effect 180 days after the date of enactment of this Act.

TITLE II—REFORM OF UNITED STATES LAWS GOVERNING INTERCOUNTRY ADOPTIONS

SEC. 201. AUTOMATIC ACQUISITION OF CITIZENSHIP FOR ADOPTED CHILDREN BORN OUTSIDE THE UNITED STATES.

(a) Amendments of Automatic Citizenship Provisions.—Section 320 of the Immigration and Nationality Act (8 U.S.C. 1431) is amended—

(1) by amending the section heading to read as follows: "Children Born Outside the United States; Conditions Under Which Citizenship Automatically Acquired"; and

(2) in subsection (a), by striking paragraphs (1) through (3) and inserting the following:

"(1) Upon the date the adoption becomes full and final, at least 1 parent of the child is a citizen of the United States, whether by birth or naturalization, who has been physically present in the United States or its outlying possessions for a period or periods totaling not less than 5 years, at least 2 of which were after attaining the age of 14 years. Any periods of honorable service in the Armed Forces of the United States, or periods of employment with the United States Government or with an international organization as that term is defined in section 1 of the International Organizations Immunities Act (22 U.S.C. 288) by such citizen parent, or any periods during which such citizen parent is physically present abroad as the dependent unmarried son or daughter and a member of the household of a person—

"(A) honorably serving with the Armed Forces of the United States; or

"(B) employed by the United States Government or an international organization as defined in section 1 of the International Organizations Immunities Act (22 U.S.C. 288); may be included in order to satisfy the physical presence requirement of this paragraph.

"(2) The child is an adoptable child described in section 101(c)(3).

"(3) The child is the beneficiary of a full and final adoption decree entered by a foreign government or a court in the United States.

"(4) For purposes of this subsection, the term "full and final adoption" means an adoption—

"(A) that is completed under the laws of the child's country of origin or the State law of the parent's residence;

"(B) under which a person is granted full and legal custody of the adopted child;

"(C) that has the force and effect of severing the child's legal ties to the child's biological parents;

"(D) under which the adoptive parents meet the requirements of section 205 of the Intercountry Adoption Reform Act; and

"(E) under which the child has been adjudicated to be an adoptable child in accordance with section 206 of the Intercountry Adoption Reform Act.".

(b) Effective Date.—This section shall take effect as if enacted on January 1, 1950.

SEC. 202. REVISED PROCEDURES.

(a) In General.—Notwithstanding any other provision of law, the following requirements shall apply with respect to the adoption of foreign born children by United States citizens:

(1) Upon completion of a full and final adoption, the Secretary of State shall issue a United States passport and a Consular Report of Birth for a child who satisfies the requirements of section 320 of the Immigration and Nationality Act (8 U.S.C. 1431), as amended by section 201 of this Act, upon application by a United States citizen parent.

(2) An adopted child described in paragraph (1) shall not require the issuance of a visa for travel and admission to the United States but shall be admitted to the United States upon presentation of a valid, unexpired United States passport.

(3) No affidavit of support under section 213A of the Immigration and Nationality Act (8 U.S.C. 1183a) shall be required in the case of any adoptable child.

(4) The Secretary of State shall not require an adopted child described in paragraph (1) to undergo a medical exam.

(b) Regulations.—Not later than 90 days after the date of enactment of this Act, the Secretary of State shall prescribe such regulations as may be necessary to carry out this section.

SEC. 203. NONIMMIGRANT VISAS FOR CHILDREN TRAVELING TO THE UNITED STATES TO BE ADOPTED BY A UNITED STATES CITIZEN.

(a) In General.—Section 101(a)(15) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)) is amended—

(1) by striking "or" at the end of subparagraph (U);

(2) by striking the period at the end of subparagraph (V) and inserting "; or"; and

(3) by adding at the end the following:

"(W) an adoptable child who is coming into the United States for adoption by a United States citizen and a spouse jointly or by an unmarried United States citizen at least 25 years of age, who has been approved to adopt by the Ambassador at Large, acting through the Office of Intercountry Adoptions established under section 101(a) of the Intercountry Adoption Reform Act.".

(b) Termination of Period of Authorized Admission.—Section 214 of the Immigration and Nationality Act (8 U.S.C. 1184) is amended by adding at the end the following:

"(q) In the case of a nonimmigrant described in section 101(a)(15)(W), the period of authorized admission shall terminate on the earlier of—

"(1) the date on which the adoption of the nonimmigrant is completed by the courts of the State where the parents reside; or

"(2) the date that is 2 years after the date of admission of the nonimmigrant into the United States.".

(c) Temporary Treatment as Legal Permanent Resident.—Notwithstanding any other law, all benefits and protections that apply to a legal permanent resident shall apply to a nonimmigrant described in section 101(a)(15)(W) of the Immigration and Nationality Act, as added by subsection (a), pending a full and final adoption.

(d) Exception From Immunization Requirement For Certain Adopted Children.—Section 212(a)(1)(C) of the Immigration and Nationality Act (8 U.S.C. 1182(a)(1)(C)) is amended—

(1) in the heading by striking "10 years" and inserting "18 years"; and

(2) in clause (i), by striking "10 years" and inserting "18 years".

(e) Regulations.—Not later than 90 days after the date of enactment of this Act, the Secretary of State shall prescribe such regulations as may be necessary to carry out this section.

SEC. 204. DEFINITION OF "ADOPTABLE CHILD".

(a) In General.—Section 101(c) of the Immigration and Nationality Act (8 U.S.C. 1101(c)) is amended by adding at the end the following:

"(3) The term "adoptable child" means an unmarried person under the age of 18—

"(A) whose biological parents (or parent, in the case of a child who has one sole or surviving parent) or other persons or institutions that retain legal custody of the child—

"(i) have freely given their written irrevocable consent to the termination of their legal relationship with the child, and to the child's emigration and adoption;

"(ii) are unable to provide proper care for the child, as determined by the appropriate governmental authority of the child's residence; or

"(iii) have voluntarily relinquished the child to governmental authorities pursuant to the law of the child's residence;

"(B) with respect to whom the Secretary of State is satisfied that the proper care will be furnished the child if admitted to the United States;

"(C) with respect to whom the Secretary of State is satisfied that the purpose of the adoption is to form a bona fide parent-child relationship and that the parent-child relationship of the child and the biological parents has been terminated (and in carrying out both obligations under this subparagraph the Secretary of State, in consultation with the Secretary of Homeland Security, may consider whether there is a petition pending to confer immigrant status on one or both of the biological parents);

"(D) with respect to whom the Secretary of State, in consultation with the Secretary of Homeland Security, is satisfied that the person is not a security risk; and

"(E) whose adoption and emigration to the United States has been approved by the competent authority of the country of the child's place of birth or residence.".

(b) Conforming Amendment.—Section 204(d) of the Immigration and Nationality Act (8 U.S.C. 1154(d)) is amended by inserting "and an adoptable child as defined in section 101(c)(3)" before "unless a valid home-study".

SEC. 205. APPROVAL TO ADOPT.

(a) IN GENERAL.—Prior to the issuance of a visa under section 101(a)(15)(W) of the Immigration and Nationality Act, as added by section 203(a) of this Act, or the issuance of a full and final adoption decree, the United States citizen adoptive parent shall have approved by the Office a petition to adopt. Such petition shall be subject to the same terms and conditions as are applicable to petitions for classification under section 204.3 of title 8 of the Code of Federal Regulations, as in effect on the day before the date of enactment of this Act.

(b) EXPIRATION OF APPROVAL.—Approval to adopt under this Act is valid for 24 months from the date of approval.

(c) EXPEDITED REAPPROVAL PROCESS OF FAMILIES PREVIOUSLY APPROVED TO ADOPT.—The Ambassador at Large shall prescribe such regulations as may be necessary to provide for an expedited and streamlined process for families who have been previously approved to adopt and whose approval has expired, so long as not more than 3 years have lapsed since the original application.

(d) DENIAL OF PETITION.—

(1) NOTICE OF INTENT.—If the officer adjudicating the petition to adopt finds that it is not readily approvable, the officer shall notify the petitioner, in writing, of the officer's intent to deny the petition. Such notice shall include the specific reasons why the petition is not readily approvable.

(2) PETITIONERS RIGHT TO RESPOND.—Upon receiving a notice of intent to deny, the petitioner has 30 days to respond to such notice.

(3) DECISION.—Within 30 days of receipt of the petitioner's response the Office must reach a final decision regarding the eligibility of the petitioner to adopt. Notice of a formal decision must be delivered in writing.

(4) RIGHT TO AN APPEAL.—Unfavorable decisions may be appealed to the appropriate appellate jurisdiction of the Department of State, and if necessary, Federal court.

(5) REGULATIONS REGARDING APPEALS.—Not later than 6 months after the date of enactment of this Act, the Ambassador at Large shall promulgate formal regulations regarding the process for appealing the denial of a petition.

SEC. 206. ADJUDICATION OF CHILD STATUS.

(a) IN GENERAL.—Prior to the issuance of a full and final adoption decree or a visa under section 101(a)(15)(W) of the Immigration and Nationality Act, as added by section 203(a) of this Act—

(1) the Office shall obtain from the competent authority of the country of the child's residence a certification, together with documentary support, that the child sought to be adopted meets the description of an adoptable child; and

(2) within 30 days of receipt of the certification referred to in paragraph (1), the Office shall make a final determination on whether the certification and the documentary support are sufficient to meet the requirements of this section.

(b) PROCESS FOR DETERMINATION.—

(1) IN GENERAL.—The Ambassador at Large shall work with the competent authorities of the child's country of residence to establish a uniform, transparent, and efficient process for the exchange and approval of the certification and documentary support required under subsection (a).

(2) NOTICE OF INTENT.—If the Office finds that the certification submitted by the competent authority of the child's country of origin is not readily approvable, the Office shall—

(A) notify the competent authority and the prospective adoptive parents, in writing, of the specific reasons why the certification is not sufficient; and

(B) provide the competent authority and the prospective adoptive parents the opportunity to address the stated insufficiencies.

TITLE III—FUNDING

SEC. 301. FUNDS.

The Secretary of State shall provide the Ambassador at Large with such funds as may be necessary for—

(1) the hiring of staff for the Office;

(2) investigations conducted by the Office; and

(3) travel and other expenses necessary to carry out this Act.

Ms. LANDRIEU. Mr. President, two years ago, I had the distinct pleasure of spending an hour with the President of China, Jiang Jiamin. As you know, President Jiamin is tremendously busy and has numerous requests for personal meetings, but he agreed to meet with this particular U.S. delegation because of the importance of the subject we were there to discuss, international adoption. During this meeting, he shared with us that the Chinese believe every child born is born with a red string attached to their heart, the other end of which is tied to the ankle of their soul mate. It is because of this string, they believe, that soul mates eventually find each other and spend the rest of their lives together. It is his belief, that perhaps the same is true of children who are adopted. That when they are born, their hearts have a string that is tied to the ankle of their forever family, and it is because of that heartstring that they eventually find one another.

I will treasure the memory of this meeting forever. Not only because it was an extreme honor to meet with such a learned and distinguished leader, but because it reminds me of how profound adoption is. 19,237 children were adopted by American citizens last year. 18,477 children the year before that, 16,363 in 1999 and 15,744 children in 1998. That is almost 100,000 children in four years. I think it is easy for us to understand the impact that these adoptions have had on the adoptive families and the orphan children, but what I would like to focus on this morning is the impact that this has for the diplomatic relations between the United States and countries throughout the world.

In sheer numbers alone, the impact is evident. In real terms, these children are "mini-ambassadors" to 200,000 American citizen parents, 400,000 grandparents, conservatively 800,000 aunts and uncles, and 300,000 siblings. According to a recent report by the U.S. Census Bureau, 1.6 million people in the United States were adopted, fifteen percent of them from abroad. Because of this magnificent process, communities all over the U.S. are deepening this understanding and affinity for the people of the world. September 11 reminded us of the importance of continuing to build bridges with the nations of the world. International adoption is one very effective and lasting way to build these bridges.

Over this past year, I have also had the privilege of meeting with the Presidents of Kazakstan, Romania and Russia and high-ranking government officials from Cambodia, Vietnam, Guatemala, Africa, and the Ukraine. Each time the message is the same. They want to do what they can to make the Hague more than just a piece of paper with 59 signatures on it. They are looking to the U.S. to lead the way toward a system of international adoption and child welfare that is based on best practices. A system comprised of meaningful protections for the adoptive parents, the birth parents, and perhaps most importantly the children; a system that universally recognizes that a government institution is not and cannot be an adequate replacement for a family and works toward the shared mission of finding every child in this world a loving and nurturing, permanent family.

I am proud to be here today, along with my colleague, the Senior Senator from Oklahoma, to introduce legislation that will take us in that direction. What it proposes to do is simple, but what it might help us to achieve is limitless. Simply put, this bill hopes to streamline the existing international adoption process, consolidate its federal functions into one agency and to empower that agency with the staff and resources it needs to represent the United States, the largest beneficiary from international adoption. With this office in place, the United States can begin to lead the world community in forging an international system of adoption that protects the interests of all those involved.

Under current law the federal responsibility for international adoption lies with the Department of State and the U.S. Citizenship and Immigration Services. This dual jurisdiction gives rise to several problems including: lack of coordination, lack of accountability, duplication of efforts and unnecessary paperwork and fees for prospective adoptive families. It also impedes the State Departments ability to fulfill its responsibilities as the central authority under the Hague Treaty on Cooperation in International Adoption.

Now, you may be asking yourself, as I have many times, what does adoption have to do with immigration? You see, under current law children adopted by United States citizens abroad are treated as immigrants, forced to apply for an immigrant visa to enter the United States. This process is not only impractical, since these children obtain automatic citizenship upon entry into the United States, it is inequitable. Children born to U.S. citizens abroad are conferred automatic citizenship upon their birth and are therefore permitted to travel to the United

States on a U.S. passport. Children adopted by United States citizens should be afforded this same protection. This bill affords them that protection.

This bill also proposes that we update the current law definitions of an "adoptable child" to reflect the types of children in need of homes throughout the world. The current law definition of "orphan" reflects the reality for which it was created; to help U.S. citizens adopt children orphaned by the wars in Korea and Vietnam. As such, it is an extremely narrow definition that in many cases prohibits a family from bringing their newly adopted child to the United States.

In creating an Ambassador at Large for international adoption, this bill hopes to provide the leadership and high level diplomatic representation so desperately needed in international adoption. Under his or her leadership, the Office of International Adoptions will be able to take the proactive measures necessary to limit corruption and ensure that adoptions are performed in the most efficient, transparent manner possible. The Hague Treaty already gives the State Department this responsibility; this bill is designed to help them fulfill it.

Let me tell you why we need to act now to pass this legislation. Because of the lack of consistent leadership by the United States in this area, many countries around the world are in "crisis mode" and have been forced to take unilateral actions to solve perceived problems in the system. For two years, there has been a moratorium on international adoption in Romania. The second anniversary of the INS issued suspension in Cambodia is fast approaching. The governments of Guatemala and Vietnam have taken actions to limit the number of international adoptions. In each and every one of these cases, the foreign governments have expressed frustration with the lack of action on the part of the U.S. to limit corruption or close potential loopholes in the system. The end result, hundreds and thousands of children are left in orphanages. This cannot be.

I have spent the past two years talking to foreign governments, agencies, and most importantly, adoptive parents and they tell me that this legislation is needed. I urge my colleagues to join me in supporting this legislation and I look forward to seeing it passed as soon as possible.

Mr. INHOFE. Mr. President, I rise today, National Adoption Day, to join my colleagues in introducing this bill to give children everyhwere around the world a greater chance to find a loving, permanent home.

This bill, the Intercountry Adoption Reform Act (ICARE), will automatically make a child who is adopted from another country a citizen the minute the adoption is finalized.

This legislation has a personal impact for me. My granddaughter was adopted from Ethiopia a few years ago. Even though she is a vital part of our family, she was not a citizen when she arrived. We now have to do work to make the law recognize her in the same light we do—as a legal member of our family and a lawful citizen of this country—entitled to the same rights and privileges as all my other biological grandchildren.

ICARE will ensure that foreign-born children, such as my granddaughter, will be treated the same as biological children born abroad to the same parent who is an American citizen. It will help streamline international adoptions and implement best practices for all adoptions.

Situations such as one that happened in my State of Oklahoma would not have happened under this legislation. Anna Lynn Fincher was born in the Philippines and adopted by a U.S. military couple in the Philippines. Even though they adopted Anna Lynn in the Philippines, they never brought her to the United States. Sadly, both of Anna Lynn's American parents died while in the Philippines—before Anna Lynn was able to set foot on American soil and become a U.S. citizen. As a result, she had to be granted Humanitarian Parole, which is granted to people in extreme circumstances, so that she could come to the United States and be adopted by her adoptive sister.

Under ICARE, Anna Lynn would have become a citizen as soon as her adoption was finalized—eliminating the need for Humanitarian Parole and another adoption.

Providing children, such as my granddaughter and Anna Lynn, with a permanent, stable family is the most precious gift we can give a child. I am proud to lend my support to this important legislation that will help give these young people a home.

By Mr. CORZINE:

S. 1935. A bill to amend the Public Health Service Act to require employers to offer health care coverage for all employees, to amend the Social Security Act to guarantee comprehensive health care coverage for all children born after 2001, and for other purposes; to the Committee on Finance.

Mr. CORZINE. Mr. President, I rise today to introduce legislation on an issue that is of utmost importance to me, to the State of New Jersey, and to our Nation: providing universal access to health insurance.

This is an issue I talked about incessantly during my campaign, because I strongly believe it is a national outrage that we are the only industrial society on earth that does not insure the health of all its people.

I begin with a basic premise. Health care is a basic right, and neither the government nor the private sector is doing enough to secure that right for everyone.

Unfortunately, as I have traveled across the State of New Jersey, I have talked to many men and women who lay awake nights trying to figure out how to care for loved ones. I've met people who work two jobs to support their family, and end up taking their kids to the emergency room when they're sick because they are unable to afford preventive care and timely treatment for their children.

In 2002, more than 43 million Americans—or a staggering 17 percent of the total nonelderly population—were uninsured. In my State of New Jersey, 1.1 million citizens lack health insurance.

The number of uninsured grew steadily throughout the 1990's until 1999, when modest increases in employer coverage due to the robust economy, coupled with expansion and improved enrollment in the State Children's Health Insurance Program (CHIP), led to the first decline in the number of uninsured in over a decade. Unfortunately, the number of uninsured is on the rise again, as State budget deficits have forced deep cuts in public health programs and as unemployment has risen.

Unemployment, however, is not the leading cause of being uninsured. In fact, more than eighty percent of the uninsured—four out of five Americans—are in working families. Seventy-two percent live in households with a full-time worker, and 11 percent live with a part-time worker. Low-wage workers are at greater risk of being uninsured, as are unskilled laborers, service workers, and those employed in small businesses.

The consequences of our Nation's significant uninsured population are devastating for our health and our economy.

The uninsured are significantly more likely to delay or forego needed care and are less likely to receive preventive care.

Delaying or not receiving treatment can lead to more serious illness and avoidable health problems, which in turn results in unnecessary and costly hospitalizations. For example, the uninsured are more likely than those with insurance to be hospitalized for conditions that could have been avoided, such as pneumonia and uncontrolled diabetes. In addition, the uninsured with various forms of cancer are more likely to be diagnosed with late stage cancer.

Indeed, my own State of New Jersey struggles to deal with the costs of charity care provided to the uninsured. In 2002, New Jersey hospitals provided $624 million in charity care to the uninsured and underinsured, but were only reimbursed for $381 million of these costs.

In sum, health insurance coverage matters. It matters to families who don't receive adequate care, and it matters to communities. We ignore the issue of the uninsured at our peril and at a great cost to the quality of life—and to the very life—of our citizens. That is why today I am introducing legislation that will provide universal access to health care for all Americans. My legislation, the Universal Secure Access to (USA) Health Care Act has several components:

First, we must cover all children. Despite the success of the CHIP program, over nine million children are still uninsured. These children are less likely to have immunizations and receive less preventive care, which often results in health problems later in life and also leads to poor school performance. The millions of uninsured children cannot control whether they have health care coverage, and it is a measure of the failure of our politics that we do not take care of our children.

My proposal, modeled on legislation introduced by Senator ROCKEFELLER, would create a MediKids program that would provide universal health insurance for children up to age 23 through a new federal program modeled after Medicare, but with benefits tailored toward the needs of children.

Maintaining the health of our children is critical to the future of our country. Indeed, it is clear that providing health care coverage to children impacts more than just their health—it impacts their ability to learn, their ability to thrive, and their ability to become productive members of society. MediKids simplifies the confusing array of health insurance assistance programs for children today and guarantees them coverage until adulthood.

The next step is to demand that the private sector do its part. Under my bill, large employers would be required to provide health coverage for all their workers. A minimum wage in America should include with it minimum benefits, among them health insurance. But unfortunately, the current system puts the responsible employer who provides health insurance at a disadvantage relative to the employers who do not. When employers fail to cover employees, society pays their share of the bill at the emergency room. In fact, the universal health care delivered in the emergency rooms of our community hospitals is the most expensive and short-sighted approach to address the problem of the uninsured Americans.

Under my bill, small businesses, the self-employed and unemployed would be able to buy coverage in the Federal Employee Health Benefit Program. If it is good enough for Senators, it is good enough for America. Those who are between the ages of 55 and 64 would be able to buy-in to the Medicare program. My legislation would provide tax credits to the self-employed to assist them in purchasing health insurance and would allow them to buy into the FEHBP program. But although I am passionate about universal access to health care, I realize we can't get there yet. Not because the popular will is not there, but because the political will isn't.

Therefore I believe we can and should be doing all that we can to make incremental progress. So I support incremental changes, starting with the most vulnerable populations, and building on Medicaid and CHIP, success public programs. That is why I am a strong supporter of the Family Care proposal, which would cover the parents of children already enrolled in the CHIP program.

I was also pleased to be an original cosponsor of Senator BINGAMAN's bipartisan legislation, the Start Healthy, Stay Healthy Act, which would expand coverage for children and pregnant women. It is based on the common sense principle that children deserve to start life healthy and stay healthy.

Health professionals agree that one of the best ways to ensure the birth of a healthy baby is to ensure adequate prenatal care. Yet as a Nation, we do far too little to provide this type of care. This is evident by the stark statistics on the subject: the United States ranks 27th in infant mortality and 21st in material mortality—the worst among developed nations. The statistics in New Jersey are equally stark: New Jersey ranks an abysmal 44th among the States in the percentage of mothers receiving adequate prenatal care, 34th in low birth weights, and 12th in infant mortality rates.

Specifically, this important legislation would allow States to cover prenatal care services for women up to 185 percent of the Federal poverty level through the Children's Health Insurance (CHIP) Program. It would also allow States to extend coverage to children under the CHIP program through age 20, and would increase CHIP funding by $2.65 billion over four years.

I often say that we are not a Nation of equal outcomes, but we should be a Nation of equal beginnings.

Until we give all Americans access to health care, however, we cannot live up to that promise.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1935

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; FINDINGS.

(a) SHORT TITLE.—This Act may be cited as the "Universal Secure Access to Health Care Act of 2003".

(b) FINDINGS.—

(1) In 2002, 43,600,000 Americans, nearly 17.2 percent of the total nonelderly population, were uninsured.

(2) The number of uninsured has grown by nearly 10,000,000 over the past decade.

(3) While 61 percent of Americans receive health insurance coverage through their employers, millions of Americans lack access to such coverage either because their employer does not offer such coverage or the employer cannot afford to pay for such coverage.

(4) Today, fewer Americans have health insurance through their employment to cover themselves and their dependents than 10 years ago.

(5) Eighty-two percent of the individuals that are uninsured in the United States are in working families.

(6) Low-wage workers have more difficulty obtaining affordable health care coverage since such workers are less likely than high-wage workers to have such coverage offered as a benefit by an employer, and prohibitive premiums for individually purchased coverage often prevents such workers from purchasing such coverage independently.

(7) The consequences of our nation's significant uninsured population are devastating.

(8) The uninsured are significantly more likely to delay or forego needed health care.

(9) The uninsured are less likely to receive preventive health care.

(10) Delaying or foregoing health care treatment when such treatment is needed can produce unnecessarily dire and expensive results. More severe health care conditions may arise and more expensive health care treatments, such as costly hospitalizations, may be necessary even though such conditions or treatments could have been avoided by the initial provision of adequate and timely health care. The uninsured, for example, are more likely to be hospitalized for conditions that could have been avoided, such as pneumonia and uncontrolled diabetes, than the insured. The uninsured with various forms of cancer are also more likely to be diagnosed with late stage cancer than the insured.

SEC. 2. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

"TITLE XXVIII—UNIVERSAL HEALTH INSURANCE COVERAGE

"Subtitle A—Employer Mandated Health Insurance Coverage

"SEC. 2801. EMPLOYER MANDATED HEALTH INSURANCE COVERAGE.

"(a) IN GENERAL.—Each employer shall offer to enroll each of its employees and their families in a standard health benefit plan.

"(b) STANDARD HEALTH BENEFIT PLAN.—For purposes of this title, the term 'standard health benefit plan' means a plan that provides benefits for health care items and services that are actuarily equivalent or greater in value than the benefits offered as of January 1, 2000, under the Blue Cross/Blue Shield Standard Option Plan provided under the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code.

"(c) PART-TIME EMPLOYEES.—Subsection (a) shall apply to part-time employees.

"SEC. 2802. TYPE OF COVERAGE.

"(a) IN GENERAL.—Each standard health benefit plan offered by an employer under section 2801(a) shall conform to the requirements of this section.

"(b) PROHIBITION AGAINST DISCRIMINATION.—A standard health benefit plan offered by an employer under section 2801(a) shall not establish rules for eligibility of any individual to enroll under the plan or exclude or otherwise limit any individual from coverage under the plan based on—

"(1) medical history;

"(2) health status;

"(3) a preexisting medical condition, disease, or disorder; or

"(4) genetic information.

"(c) Open Enrollment.—A standard health benefit plan offered by an employer under section 2801(a) shall offer an annual open enrollment period during which an individual may change enrollment from such plan to another standard health benefit plan offered by such employer.

"(d) Medically Necessary Services.—A standard health benefit plan offered by an employer under section 2801(a) shall, if such plan provides coverage for a certain health care item or service, provide coverage for such item or service if a doctor determines that such item or service is medically necessary.

"(e) Date of Initial Coverage.—In the case of an employee enrolled in a standard health benefit plan provided by an employer under section 2801(a), the coverage under such plan shall commence not later than 5 days after the day on which the employee first performs an hour of service as an employee of that employer. No waiting period beyond this initial 5-day period may be imposed regarding such coverage.

"SEC. 2803. PREMIUMS.

"(a) In General.—Each employer shall—

"(1) contribute to the cost of any standard health benefit plan that an employee has enrolled in in accordance with this section; and

"(2) withhold from wages of an employee, the employee share of the premium assessed for coverage under the standard health benefit plan.

"(b) Contribution.—

"(1) Employer share.—

"(A) Full-time employees.—Each employer who has enrolled an employee in a standard health benefit plan shall contribute not less than 72 percent of the monthly premium for such employee.

"(B) Part-time employees.—

"(i) Pro-rated portion paid.—Each employer who has enrolled a part-time employee in a standard health benefit plan shall pay a portion of the monthly premium for such employee that is pro-rated to correspond with the number of hours of work that such employee has provided during the past month.

"(ii) Exception.—No employer contribution is required under this section with respect to an employee who works less than 10 hours per week.

"(2) Employee share.—

"(A) In general.—Each employee enrolled in a standard health benefit plan under section 2801(a) shall pay the remaining portion of the monthly premium after payment by the employer as required under subsection (a).

"(B) Part-time employees.—An employee who is enrolled in a standard health benefit plan under section 2801(a) and works for such employer for not more than 30 hours and not less than 10 hours per week shall be eligible for a subsidy to aid such employee in paying his or her portion of the monthly premium.

"(3) Low-income employees.—An employee who is enrolled in a standard health benefit plan under section 2801(a) whose family income does not exceed 250 percent of the poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)) as applicable to a family of the size involved, shall be eligible to receive a subsidy from the State as described in subtitle B to aid in payment of premiums.

"SEC. 2804. ENFORCEMENT.

"(a) State Ineligibility for Public Health Service Act Funds.—An employer that is a State or political subdivision of a State or an agency or instrumentality of a State or political subdivision that does not comply with the requirements of this title shall not be eligible to receive a grant, contract, cooperative agreement, loan, or loan guarantee under this Act.

"(b) Civil Penalty for Private Employers.—

"(1) In general.—Any nongovernmental employer that does not comply with this title shall be subject to a civil penalty of not more than 10 percent of the total amount of the employer's expenditures for wages for employees in that year.

"(2) Assessment procedure.—A civil money penalty under this section shall be assessed by the Secretary and collected in a civil action brought by the United States in a United States district court. The Secretary shall not assess such a penalty on an employer until the employer has been given notice and an opportunity to present its views on such charge.

"(3) Amount of penalty.—In determining the amount of the penalty, or the amount agreed to in compromise, the Secretary shall consider the gravity of the noncompliance and the demonstrated good faith of the employer charged in attempting to achieve rapid compliance after notification of a violation of this title.

"SEC. 2805. DEFINITIONS.

"In this title:

"(1) Employer.—The term 'employer' means, with respect to a calendar year and plan year, an employer that employed an average of at least 50 full-time employees on business days during the preceding calendar year and employs not less than 50 employees on the first day of the plan year.

"(2) Part-time employee.—The term 'part-time employee' means any individual employed by an employer who works less than 40 hours a week.

"(3) Waiting period.—The term 'waiting period' means, with respect to a plan and an individual who is a potential beneficiary or participant in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.noncompliance by the Secretary.

"SEC. 2806. EFFECTIVE DATE.

"This title shall take effect 2 years after the date of enactment of the Universal Secure Access to Health Care Act of 2003.

"Subtitle B—Individual and Employer Subsidies

"SEC. 2811. SUBSIDY PROGRAM.

"(a) In General.—The Secretary shall establish a Federal program to award grants to States for State premium assistance programs.

"(b) Federal Program.—

"(1) In general.—The Secretary shall establish a Federal program that shall set all standards for administration of State programs, receive applications from States for the establishment of such programs, and receive reports from States regarding the developments of such programs.

"(2) Regulations.—The Secretary shall promulgate regulations specifying requirements for State programs under this subtitle, including—

"(A) standards for determining eligibility for premium assistance;

"(B) standards for States operating programs under this subtitle which ensure that such programs are operated in a uniform manner with respect to application procedures, data processing systems, and such other administrative activities as the Secretary determines to be necessary; and

"(C) standards for accepting reports regarding developments of such programs.

"(3) Content.—The regulations described in paragraph (2) shall require that a State program—

"(A) enable an individual to file an application for assistance with an agency designated by the State at any time, in person, by mail, or online;

"(B) provide for the use of an application form developed by the Secretary;

"(C) make applications accessible at locations where individuals are most likely to obtain the applications;

"(D) require individuals to submit revised applications to reflect changes in estimated family incomes, including changes in employment status of family members, during the year, and the State shall revise the amount of any premium assistance based on such a revised application; and

"(E) provide for verification of the information supplied in applications under this subtitle, including examining return information disclosed to the State.

"(4) Application.—The Secretary shall develop an application form for assistance to be used by a State which shall—

"(A) be simple in form and understandable to the average individual;

"(B) require the provision of information necessary to make a determination as to whether an individual is eligible for assistance, including a declaration of estimated income by the individual based, at the election of the individual—

"(I) on multiplying by a factor of 4 the individual's family income for the 3-month period immediately preceding the month in which the application is made; or

"(II) on estimated income for the entire year for which the application is submitted; and

"(C) require attachment of such documentation as deemed necessary by the Secretary in order to ensure eligibility for assistance.

"(c) State Administration.—

"(1) In general.—A State shall have in effect a program for furnishing premium assistance in accordance with this subtitle.

"(2) Designation of State Agency.—A State may designate any appropriate State agency to administer the program under this subtitle.

"(3) Effectiveness of Eligibility.—A determination by a State that an individual is eligible for premium assistance shall be effective for the calendar year for which such determination is made unless a revised application indicates that an individual is no longer eligible for assistance.

"SEC. 2812. SUBSIDIES FOR LOW-INCOME WORKERS.

"(a) In General.—A low-income worker shall be eligible for premium assistance if such worker is eligible under subsection (b).

"(b) Eligibility.—A low-income worker is eligible for premium assistance under subsection (a) if the State determines that such worker has a family income which does not exceed 250 percent of the poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Community Services

Block Grant Act (42 U.S.C. 9902(2)) as applicable to a family of the size involved.

"(c) Amount of Assistance.—The amount of premium assistance for a month for a low-income worker determined to be eligible under subsection (b) shall be determined by the Secretary.

"(d) Payments.—The amount of the premium assistance available to a low-income worker shall be paid by the State in which the individual resides directly to the standard health plan in which the individual is enrolled. Payments under the preceding sentence shall commence in the first month during which the individual is enrolled in a standard health benefit plan and determined to be eligible for premium assistance under this subtitle.

"SEC. 2813. SUBSIDIES FOR SMALL BUSINESS EMPLOYERS.

"(a) In General.—A small business employer that offers to enroll its employees and their families in a standard health benefit plan shall be eligible for premium assistance if the State determines that such employer qualifies for such assistance under subsection (b).

"(b) Eligibility.—A small business employer is eligible for premium assistance if such employer employs an average of not more than 75 full-time employees on business days during the preceding calendar year and employs not more than 75 employees on the first day of the plan year.

"(c) Amount of Assistance.—The amount of premium assistance for a small business employer for a month shall be determined by the Secretary.

"(d) Payments.—The amount of the premium assistance available to a small business employer shall be paid by the State in which the business is located directly to the standard health benefit plan in which the employee of such business is enrolled. Payments under the preceding sentence shall commence in the first month during which the employee is enrolled in a standard health benefit plan and the employer is determined to be eligible for premium assistance under this subtitle.

"Subtitle C—Election of Coverage

"SEC. 2815. ELECTION OF COVERAGE.

"(a) In General.—A small business employer as described in subsection (b) may elect to enroll its employees in—

"(1) a plan provided under the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code; or

"(2) the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), if such employees are not less than 50 years of age.

"(b) Small Business Employer.—In this section, the term 'small business employer' means an employer that employs an average of not more than 75 full-time employees on business days during the preceding calendar year and employs not more than 75 employees on the first day of the plan year.

"Subtitle D—Community Rating

"SEC. 2821. COMMUNITY RATING.

"(a) In General.—Each State shall establish community rating areas in which standard health benefit plans shall offer a standard premium in accordance with this subtitle for enrollment for all eligible individuals.

"(b) Community Rating Areas.—

"(1) In general.—In accordance with this subtitle, each State shall, subject to approval of the Secretary, provide for the division of the State into 1 or more community rating areas.

"(2) Revision of areas.—Each State may, subject to approval of the Secretary, redraw the boundaries of such community rating areas as described in paragraph (1) if such revision is reasonable or necessary.

"(3) Multiple Areas.—With respect to a community rating area—

"(A) no metropolitan statistical area in a State may be incorporated into more than 1 such area in the State;

"(B) the number of individuals residing within such an area may not be less than 250,000; and

"(C) no area incorporated in a community rating area may be incorporated into another such area.

"(4) Nondiscrimination.—In establishing boundaries for community rating areas, a State shall not directly or through contractual arrangements—

"(A) deny or limit access to or the availability of health care services, or otherwise discriminate in connection with the provision of health care services; or

"(B) limit, segregate, or classify an individual in any way which would deprive or tend to deprive such individual of health care services, or otherwise adversely affect his or her access to health care services;

on the basis of race, national origin, sex, religion, language, income, age, sexual orientation, disability, health status, or anticipated need for health services.

"(5) Coordinating multiple community rating areas.—Nothing in this section shall be construed as preventing a State from coordinating the activities of 1 or more community rating areas in the State.

"(6) Interstate community rating areas.—Community rating areas with respect to interstate areas shall be established in accordance with rules established by the Secretary.

"(7) Coordination in multi-state areas.—One or more States may coordinate their operations in contiguous community rating areas. Such coordination may include, the adoption of joint operating rules, contracting with standard health benefit plans, enforcement activities, and establishment of fee schedules for health providers.

"(c) Open Enrollment.—Each State, based on rules and procedures established by the Secretary, shall specify a uniform annual open enrollment period for each community rating area during which all eligible individuals are permitted the opportunity to change enrollment among the standard health benefit plans offered to such individuals in such area under this Act. The initial annual open enrollment period shall be for a period of 90 days.

"(d) Standard Premium.—Each standard health benefit plan shall establish within each community rating area in which the plan is to be offered a standard premium for enrollment of eligible individuals who seek enrollment in such plan.

"(e) Uniform Premiums Within Community Rating Areas.—

"(1) In general.—Subject to paragraphs (2) and (3), the standard premium for each group health plan to which this section applies shall be the same, but shall not include the costs of premium processing and enrollment.

"(2) Application to enrollees.—

"(A) In general.—The premium charged for coverage in a group health plan which covers eligible employees and eligible individuals shall be the product of—

"(i) the standard premium (established under paragraph (1));

"(ii) in the case of enrollment other than individual enrollment, the family adjustment factor specified under subparagraph (B); and

"(iii) the age adjustment factor (specified under subparagraph (C)).

"(B) Family adjustment factor.—

"(i) In general.—The Secretary shall specify family adjustment factors that reflect the relative actuarial costs of benefit packages based on family classes of enrollment (as compared with such costs for individual enrollment).

"(ii) Classes of enrollment.—For purposes of this subtitle, there are 4 classes of enrollment:

"(I) Coverage only of an individual (referred to in this subtitle as the 'individual' enrollment or class of enrollment).

"(II) Coverage of a married couple without children (referred to in this subtitle as the 'couple-only' enrollment or class of enrollment).

"(III) Coverage of an individual and one or more children (referred to in this subtitle as the 'single parent' enrollment or class of enrollment).

"(IV) Coverage of a married couple and one or more children (referred to in this subtitle as the 'dual parent' enrollment or class of enrollment).

"(iii) References to family and couple classes of enrollment.—In this subtitle:

"(I) Family.—The terms 'family enrollment' and 'family class of enrollment' refer to enrollment in a class of enrollment described in any subclause of clause (ii) (other than subclause (I)).

"(II) Couple.—The term 'couple class of enrollment' refers to enrollment in a class of enrollment described in subclause (II) or (IV) of clause (ii).

"(iv) Spouse; married; couple.—

"(I) In general.—In this subtitle, the terms 'spouse' and 'married' mean, with respect to an individual, another individual who is the spouse of, or is married to, the individual, as determined under applicable State law.

"(II) Couple.—The term 'couple' means an individual and the individual's spouse.

"(C) Age adjustment factor.—The Secretary shall specify uniform age categories and maximum rating increments for age adjustment factors that reflect the relative actuarial costs of benefit packages among enrollees. For individuals who have attained age 18 but not age 65, the highest age adjustment factor may not exceed 3 times the lowest age adjustment factor.".

SEC. 3. TAX DEDUCTION FOR SELF-EMPLOYED.

(a) In General.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 is amended to read as follows:

"(1) Allowance of deduction.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to 100 percent of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, the taxpayer's spouse, and taxpayer's dependents.".

(b) Effective Date.—The amendment made by this section shall apply to taxable years beginning after December 31, 2004.

SEC. 4. ACCESS TO MEDICARE BENEFITS FOR INDIVIDUALS 62-TO-65 YEARS OF AGE.

(a) In General.—Title XVIII of the Social Security Act is amended—

(1) by redesignating section 1859 and part D as section 1858 and part E, respectively; and

(2) by inserting after such section the following new part:

"Part D—Purchase of Medicare Benefits by Certain Individuals Age 62-to-65 Years of Age

"SEC. 1859. PROGRAM BENEFITS; ELIGIBILITY.

"(a) Entitlement to Medicare Benefits for Enrolled Individuals.—

"(1) In general.—An individual enrolled under this part is entitled to the same benefits under this title as an individual entitled to benefits under part A and enrolled under part B.

"(2) Definitions.—For purposes of this part:

"(A) Federal or state COBRA continuation provision.—The term 'Federal or State COBRA continuation provision' has the meaning given the term 'COBRA continuation provision' in section 2791(d)(4) of the Public Health Service Act and includes a comparable State program, as determined by the Secretary.

"(B) Federal health insurance program defined.—The term 'Federal health insurance program' means any of the following:

"(i) Medicare.—Part A or part B of this title (other than by reason of this part).

"(ii) Medicaid.—A State plan under title XIX.

"(iii) FEHBP.—The Federal employees health benefit program under chapter 89 of title 5, United States Code.

"(iv) TRICARE.—The TRICARE program (as defined in section 1072(7) of title 10, United States Code).

"(v) Active duty military.—Health benefits under title 10, United States Code, to an individual as a member of the uniformed services of the United States.

"(C) Group health plan.—The term 'group health plan' has the meaning given such term in section 2791(a)(1) of the Public Health Service Act.

"(b) Eligibility of Individuals Age 62-to-65 Years of Age.—

"(1) In general.—Subject to paragraph (2), an individual who meets the following requirements with respect to a month is eligible to enroll under this part with respect to such month:

"(A) Age.—As of the last day of the month, the individual has attained 62 years of age, but has not attained 65 years of age.

"(B) Medicare eligibility (but for age).—The individual would be eligible for benefits under part A or part B for the month if the individual were 65 years of age.

"(C) Not eligible for coverage under group health plans or federal health insurance programs.—The individual is not eligible for benefits or coverage under a Federal health insurance program (as defined in subsection (a)(2)(B)) or under a group health plan (other than such eligibility merely through a Federal or State COBRA continuation provision) as of the last day of the month involved.

"(2) Limitation on eligibility if terminated enrollment.—If an individual described in paragraph (1) enrolls under this part and coverage of the individual is terminated under section 1859A(d) (other than because of age), the individual is not again eligible to enroll under this subsection unless the following requirements are met:

"(A) New coverage under group health plan or federal health insurance program.—After the date of termination of coverage under such section, the individual obtains coverage under a group health plan or under a Federal health insurance program.

"(B) Subsequent loss of new coverage.—The individual subsequently loses eligibility for the coverage described in subparagraph (A) and exhausts any eligibility the individual may subsequently have for coverage under a Federal or State COBRA continuation provision.

"(3) Change in health plan eligibility does not affect coverage.—In the case of an individual who is eligible for and enrolls under this part under this subsection, the individual's continued entitlement to benefits under this part shall not be affected by the individual's subsequent eligibility for benefits or coverage described in paragraph (1)(C), or entitlement to such benefits or coverage.

"SEC. 1859A. ENROLLMENT PROCESS; COVERAGE.

"(a) In General.—An individual may enroll in the program established under this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed by the Secretary consistent with the provisions of this section. Such regulations shall provide a process under which—

"(1) individuals eligible to enroll as of a month are permitted to pre-enroll during a prior month within an enrollment period described in subsection (b); and

"(2) each individual seeking to enroll under section 1859(b) is notified, before enrolling, of the deferred monthly premium amount the individual will be liable for under section 1859C(b) upon attaining 65 years of age as determined under section 1859B(c)(3).

"(b) Enrollment Periods.—

"(1) Individuals 62-to-65 years of age.—In the case of individuals eligible to enroll under this part under section 1859(b)—

"(A) Initial enrollment period.—If the individual is eligible to enroll under such section for July 2002, the enrollment period shall begin on May 1, 2002, and shall end on August 31, 2002. Any such enrollment before July 1, 2002, is conditioned upon compliance with the conditions of eligibility for July 2002.

"(B) Subsequent periods.—If the individual is eligible to enroll under such section for a month after July 2002, the enrollment period shall begin on the first day of the second month before the month in which the individual first is eligible to so enroll and shall end 4 months later. Any such enrollment before the first day of the third month of such enrollment period is conditioned upon compliance with the conditions of eligibility for such third month.

"(2) Authority to correct for government errors.—The provisions of section 1837(h) apply with respect to enrollment under this part in the same manner as they apply to enrollment under part B.

"(c) Date Coverage Begins.—

"(1) In general.—The period during which an individual is entitled to benefits under this part shall begin as follows, but in no case earlier than July 1, 2002:

"(A) In the case of an individual who enrolls (including pre-enrolls) before the month in which the individual satisfies eligibility for enrollment under section 1859, the first day of such month of eligibility.

"(B) In the case of an individual who enrolls during or after the month in which the individual first satisfies eligibility for enrollment under such section, the first day of the following month.

"(2) Authority to provide for partial months of coverage.—Under regulations, the Secretary may, in the Secretary's discretion, provide for coverage periods that include portions of a month in order to avoid lapses of coverage.

"(3) Limitation on payments.—No payments may be made under this title with respect to the expenses of an individual enrolled under this part unless such expenses were incurred by such individual during a period which, with respect to the individual, is a coverage period under this section.

"(d) Termination of Coverage.—

"(1) In general.—An individual's coverage period under this part shall continue until the individual's enrollment has been terminated at the earliest of the following:

"(A) General provisions.—

"(i) Notice.—The individual files notice (in a form and manner prescribed by the Secretary) that the individual no longer wishes to participate in the insurance program under this part.

"(ii) Nonpayment of premiums.—The individual fails to make payment of premiums required for enrollment under this part.

"(iii) Medicare eligibility.—The individual becomes entitled to benefits under part A or enrolled under part B (other than by reason of this part).

"(B) Termination based on age.—The individual attains 65 years of age.

"(2) Effective date of termination.—

"(A) Notice.—The termination of a coverage period under paragraph (1)(A)(i) shall take effect at the close of the month following for which the notice is filed.

"(B) Nonpayment of premium.—The termination of a coverage period under paragraph (1)(A)(ii) shall take effect on a date determined under regulations, which may be determined so as to provide a grace period in which overdue premiums may be paid and coverage continued. The grace period determined under the preceding sentence shall not exceed 60 days; except that it may be extended for an additional 30 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 60-day period.

"(C) Age or medicare eligibility.—The termination of a coverage period under paragraph (1)(A)(iii) or (1)(B) shall take effect as of the first day of the month in which the individual attains 65 years of age or becomes entitled to benefits under part A or enrolled for benefits under part B (other than by reason of this part).

"SEC. 1859B. PREMIUMS.

"(a) Amount of Monthly Premiums.—

"(1) Base monthly premiums.—The Secretary shall, during September of each year (beginning with 2001), determine the following premium rates which shall apply with respect to coverage provided under this title for any month in the succeeding year:

"(A) Base monthly premium for individuals 62 years of age or older.—A base monthly premium for individuals 62 years of age or older is equal to 1/12 of the base annual premium rate computed under subsection (b) for each premium area.

"(B) Deferred monthly premiums for individuals 62 years of age or older.—The Secretary shall, during September of each year (beginning with 2001), determine under subsection (c) the amount of deferred monthly premiums that shall apply with respect to individuals who first obtain coverage under this part under section 1859(b) in the succeeding year.

"(3) Establishment of premium areas.—For purposes of this part, the term 'premium area' means such an area as the Secretary shall specify to carry out this part. The Secretary from time to time may change the boundaries of such premium areas. The Secretary shall seek to minimize the number of such areas specified under this paragraph.

"(b) Base Annual Premium for Individuals 62 Years of Age or Older.—

"(1) NATIONAL, PER CAPITA AVERAGE.—The Secretary shall estimate the average, annual per capita amount that would be payable under this title with respect to individuals residing in the United States who meet the requirement of section 1859(b)(1)(A) as if all such individuals were eligible for (and enrolled) under this title during the entire year (and assuming that section 1862(b)(2)(A)(i) did not apply).

"(2) GEOGRAPHIC ADJUSTMENT.—The Secretary shall reduce, as determined appropriate, the amount determined under paragraph (1) for a premium area (specified under subsection (a)(3)) that has costs below the national average, in order to assure participation in all areas throughout the United States.

"(3) BASE ANNUAL PREMIUM.—The base annual premium under this subsection for months in a year for individuals 62 years of age or older residing in a premium area is equal to the average, annual per capita amount estimated under paragraph (1) for the year, adjusted for such area under paragraph (2).

"(c) DEFERRED PREMIUM RATE FOR INDIVIDUALS 62 YEARS OF AGE OR OLDER.—The deferred premium rate for individuals with a group of individuals who obtain coverage under section 1859(b) in a year shall be computed by the Secretary as follows:

"(1) ESTIMATION OF NATIONAL, PER CAPITA ANNUAL AVERAGE EXPENDITURES FOR ENROLLMENT GROUP.—The Secretary shall estimate the average, per capita annual amount that will be paid under this part for individuals in such group during the period of enrollment under section 1859(b). In making such estimate for coverage beginning in a year before 2006, the Secretary may base such estimate on the average, per capita amount that would be payable if the program had been in operation over a previous period of at least 4 years.

"(2) DIFFERENCE BETWEEN ESTIMATED EXPENDITURES AND ESTIMATED PREMIUMS.—Based on the characteristics of individuals in such group, the Secretary shall estimate during the period of coverage of the group under this part under section 1859(b) the amount by which—

"(A) the amount estimated under paragraph (1); exceeds

"(B) the average, annual per capita amount of premiums that will be payable for months during the year under section 1859C(a) for individuals in such group (including premiums that would be payable if there were no terminations in enrollment under clause (i) or (ii) of section 1859A(d)(1)(A)).

"(3) ACTUARIAL COMPUTATION OF DEFERRED MONTHLY PREMIUM RATES.—The Secretary shall determine deferred monthly premium rates for individuals in such group in a manner so that—

"(A) the estimated actuarial value of such premiums payable under section 1859C(b), is equal to

"(B) the estimated actuarial present value of the differences described in paragraph (2). Such rate shall be computed for each individual in the group in a manner so that the rate is based on the number of months between the first month of coverage based on enrollment under section 1859(b) and the month in which the individual attains 65 years of age.

"(4) DETERMINANTS OF ACTUARIAL PRESENT VALUES.—The actuarial present values described in paragraph (3) shall reflect—

"(A) the estimated probabilities of survival at ages 62 through 84 for individuals enrolled during the year; and

"(B) the estimated effective average interest rates that would be earned on investments held in the trust funds under this title during the period in question.

"SEC. 1859C. PAYMENT OF PREMIUMS.

"(a) PAYMENT OF BASE MONTHLY PREMIUM.—

"(1) IN GENERAL.—The Secretary shall provide for payment and collection of the base monthly premium, determined under section 1859B(a)(1) for the age (and age cohort, if applicable) of the individual involved and the premium area in which the individual principally resides, in the same manner as for payment of monthly premiums under section 1840, except that, for purposes of applying this section, any reference in such section to the Federal Supplementary Medical Insurance Trust Fund is deemed a reference to the Trust Fund established under section 1859D.

"(2) PERIOD OF PAYMENT.—In the case of an individual who participates in the program established by this title, the base monthly premium shall be payable for the period commencing with the first month of the individual's coverage period and ending with the month in which the individual's coverage under this title terminates.

"(b) PAYMENT OF DEFERRED PREMIUM FOR INDIVIDUALS COVERED AFTER ATTAINING AGE 62.—

"(1) RATE OF PAYMENT.—

"(A) IN GENERAL.—In the case of an individual who is covered under this part for a month pursuant to an enrollment under section 1859(b), subject to subparagraph (B), the individual is liable for payment of a deferred premium in each month during the period described in paragraph (2) in an amount equal to the full deferred monthly premium rate determined for the individual under section 1859B(c).

"(B) SPECIAL RULES FOR THOSE WHO DISENROLL EARLY.—

"(i) IN GENERAL.—If such an individual's enrollment under such section is terminated under clause (i) or (ii) of section 1859A(d)(1)(A), subject to clause (ii), the amount of the deferred premium otherwise established under this paragraph shall be pro-rated to reflect the number of months of coverage under this part under such enrollment compared to the maximum number of months of coverage that the individual would have had if the enrollment were not so terminated.

"(ii) ROUNDING TO 12-MONTH MINIMUM COVERAGE PERIODS.—In applying clause (i), the number of months of coverage (if not a multiple of 12) shall be rounded to the next highest multiple of 12 months, except that in no case shall this clause result in a number of months of coverage exceeding the maximum number of months of coverage that the individual would have had if the enrollment were not so terminated.

"(2) PERIOD OF PAYMENT.—The period described in this paragraph for an individual is the period beginning with the first month in which the individual has attained 65 years of age and ending with the month before the month in which the individual attains 85 years of age.

"(3) COLLECTION.—In the case of an individual who is liable for a premium under this subsection, the amount of the premium shall be collected in the same manner as the premium for enrollment under such part is collected under section 1840, except that any reference in such section to the Federal Supplementary Medical Insurance Trust Fund is deemed to be a reference to the Medicare Early Access Trust Fund established under section 1859D.

"(c) APPLICATION OF CERTAIN PROVISIONS.—The provisions of section 1840 (other than subsection (h)) shall apply to premiums collected under this section in the same manner as they apply to premiums collected under part B, except that any reference in such section to the Federal Supplementary Medical Insurance Trust Fund is deemed a reference to the Trust Fund established under section 1859D.

"SEC. 1859D. MEDICARE EARLY ACCESS TRUST FUND.

"(a) ESTABLISHMENT OF TRUST FUND.—

"(1) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Medicare Early Access Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and such amounts as may be deposited in, or appropriated to, such fund as provided in this title.

"(2) PREMIUMS.—Premiums collected under section 1859B shall be transferred to the Trust Fund.

"(b) INCORPORATION OF PROVISIONS.—

"(1) IN GENERAL.—Subject to paragraph (2), subsections (b) through (i) of section 1841 shall apply with respect to the Trust Fund and this title in the same manner as they apply with respect to the Federal Supplementary Medical Insurance Trust Fund and part B, respectively.

"(2) MISCELLANEOUS REFERENCES.—In applying provisions of section 1841 under paragraph (1)—

"(A) any reference in such section to 'this part' is construed to refer to this part D;

"(B) any reference in section 1841(h) to section 1840(d) and in section 1841(i) to sections 1840(b)(1) and 1842(g) are deemed references to comparable authority exercised under this part; and

"(C) payments may be made under section 1841(g) to the trust funds under sections 1817 and 1841 as reimbursement to such funds for payments they made for benefits provided under this part.

"SEC. 1859E. OVERSIGHT AND ACCOUNTABILITY.

"(a) THROUGH ANNUAL REPORTS OF TRUSTEES.—The Board of Trustees of the Medicare Early Access Trust Fund under section 1859D(b)(1) shall report on an annual basis to Congress concerning the status of the Trust Fund and the need for adjustments in the program under this part to maintain financial solvency of the program under this part.

"(b) PERIODIC GAO REPORTS.—The Comptroller General of the United States shall periodically submit to Congress reports on the adequacy of the financing of coverage provided under this part. The Comptroller General shall include in such report such recommendations for adjustments in such financing and coverage as the Comptroller General deems appropriate in order to maintain financial solvency of the program under this part.

"SEC. 1859F. ADMINISTRATION AND MISCELLANEOUS.

"(a) TREATMENT FOR PURPOSES OF THIS TITLE.—Except as otherwise provided in this part—

"(1) an individual enrolled under this part shall be treated for purposes of this title as though the individual was entitled to benefits under part A and enrolled under part B; and

"(2) benefits described in section 1859 shall be payable under this title to such an individual in the same manner as if such individual was so entitled and enrolled.

"(b) NOT TREATED AS MEDICARE PROGRAM FOR PURPOSES OF MEDICAID PROGRAM.—For purposes of applying title XIX (including the provision of medicare cost-sharing assistance under such title), an individual who is enrolled under this part shall not be treated as being entitled to benefits under this title.

"(c) Not Treated as Medicare Program for Purposes of COBRA Continuation Provisions.—In applying a COBRA continuation provision (as defined in section 2791(d)(4) of the Public Health Service Act), any reference to an entitlement to benefits under this title shall not be construed to include entitlement to benefits under this title pursuant to the operation of this part.".

(b) Conforming Amendments to Social Security Act Provisions.—

(1) Section 201(i)(1) of the Social Security Act (42 U.S.C. 401(i)(1)) is amended by striking "or the Federal Supplementary Medical Insurance Trust Fund" and inserting "the Federal Supplementary Medical Insurance Trust Fund, and the Medicare Early Access Trust Fund".

(2) Section 201(g)(1)(A) of such Act (42 U.S.C. 401(g)(1)(A)) is amended by striking "and the Federal Supplementary Medical Insurance Trust Fund established by title XVIII" and inserting ", the Federal Supplementary Medical Insurance Trust Fund, and the Medicare Early Access Trust Fund established by title XVIII".

(3) Section 1820(i) of such Act (42 U.S.C. 1395i–4(i)) is amended by striking "part D" and inserting "part E".

(4) Part C of title XVIII of such Act is amended—

(A) in section 1851(a)(2)(B) (42 U.S.C. 1395w–21(a)(2)(B)), by striking "1859(b)(3)" and inserting "1858(b)(3)";

(B) in section 1851(a)(2)(C) (42 U.S.C. 1395w–21(a)(2)(C)), by striking "1859(b)(2)" and inserting "1858(b)(2)";

(C) in section 1852(a)(1) (42 U.S.C. 1395w–22(a)(1)), by striking "1859(b)(3)" and inserting "1858(b)(3)";

(D) in section 1852(a)(3)(B)(ii) (42 U.S.C. 1395w–22(a)(3)(B)(ii)), by striking "1859(b)(2)(B)" and inserting "1858(b)(2)(B)";

(E) in section 1853(a)(1)(A) (42 U.S.C. 1395w–23(a)(1)(A)), by striking "1859(e)(4)" and inserting "1858(e)(4)"; and

(F) in section 1853(a)(3)(D) (42 U.S.C. 1395w–23(a)(3)(D)), by striking "1859(e)(4)" and inserting "1858(e)(4)".

(5) Section 1853(c) of such Act (42 U.S.C. 1395w–23(c)) is amended—

(A) in paragraph (1), by striking "and (7)" and inserting ", (7), and (8)", and

(B) by adding at the end the following:

"(8) Adjustment for early access.—In applying this subsection with respect to individuals entitled to benefits under part D, the Secretary shall provide for an appropriate adjustment in the Medicare+Choice capitation rate as may be appropriate to reflect differences between the population served under such part and the population under parts A and B.".

(c) Other Conforming Amendments.—

(1) Section 138(b)(4) of the Internal Revenue Code of 1986 is amended by striking "1859(b)(3)" and inserting "1858(b)(3)".

(2)(A) Section 602(2)(D)(ii) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)) is amended by inserting "(not including an individual who is so entitled pursuant to enrollment under section 1859A)" after "Social Security Act".

(B) Section 2202(2)(D)(ii) of the Public Health Service Act (42 U.S.C. 300bb–2(2)(D)(ii)) is amended by inserting "(not including an individual who is so entitled pursuant to enrollment under section 1859A)" after "Social Security Act".

(C) Section 4980B(f)(2)(B)(i)(V) of the Internal Revenue Code of 1986 is amended by inserting "(not including an individual who is so entitled pursuant to enrollment under section 1859A)" after "Social Security Act".

SEC. 5. ACCESS TO MEDICARE BENEFITS FOR DISPLACED WORKERS 55-TO-62 YEARS OF AGE.

(a) Eligibility.—Section 1859 of the Social Security Act, as inserted by section 4(a)(2), is amended by adding at the end the following new subsection:

"(c) Displaced Workers and Spouses.—

"(1) Displaced workers.—Subject to paragraph (3), an individual who meets the following requirements with respect to a month is eligible to enroll under this part with respect to such month:

"(A) Age.—As of the last day of the month, the individual has attained 55 years of age, but has not attained 62 years of age.

"(B) Medicare eligibility (but for age).—The individual would be eligible for benefits under part A or B for the month if the individual were 65 years of age.

"(C) Loss of employment-based coverage.—

"(i) Eligible for unemployment compensation.—The individual meets the requirements relating to period of covered employment and conditions of separation from employment to be eligible for unemployment compensation (as defined in section 85(b) of the Internal Revenue Code of 1986), based on a separation from employment occurring on or after January 1, 2001. The previous sentence shall not be construed as requiring the individual to be receiving such unemployment compensation.

"(ii) Loss of employment-based coverage.—Immediately before the time of such separation of employment, the individual was covered under a group health plan on the basis of such employment, and, because of such loss, is no longer eligible for coverage under such plan (including such eligibility based on the application of a Federal or State COBRA continuation provision) as of the last day of the month involved.

"(iii) Previous creditable coverage for at least 1 year.—As of the date on which the individual loses coverage described in clause (ii), the aggregate of the periods of creditable coverage (as determined under section 2701(c) of the Public Health Service Act) is 12 months or longer.

"(D) Exhaustion of available COBRA continuation benefits.—

"(i) In general.—In the case of an individual described in clause (ii) for a month described in clause (iii)—

"(I) the individual (or spouse) elected coverage described in clause (ii); and

"(II) the individual (or spouse) has continued such coverage for all months described in clause (iii) in which the individual (or spouse) is eligible for such coverage.

"(ii) Individuals to whom COBRA continuation coverage made available.—An individual described in this clause is an individual—

"(I) who was offered coverage under a Federal or State COBRA continuation provision at the time of loss of coverage eligibility described in subparagraph (C)(ii); or

"(II) whose spouse was offered such coverage in a manner that permitted coverage of the individual at such time.

"(iii) Months of possible COBRA continuation coverage.—A month described in this clause is a month for which an individual described in clause (ii) could have had coverage described in such clause as of the last day of the month if the individual (or the spouse of the individual, as the case may be) had elected such coverage on a timely basis.

"(E) Not eligible for coverage under Federal health insurance program or group health plans.—The individual is not eligible for benefits or coverage under a Federal health insurance program or under a group health plan (whether on the basis of the individual's employment or employment of the individual's spouse) as of the last day of the month involved.

"(2) Spouse of displaced worker.—Subject to paragraph (3), an individual who meets the following requirements with respect to a month is eligible to enroll under this part with respect to such month:

"(A) Age.—As of the last day of the month, the individual has not attained 62 years of age.

"(B) Married to displaced worker.—The individual is the spouse of an individual at the time the individual enrolls under this part under paragraph (1) and loses coverage described in paragraph (1)(C)(ii) because the individual's spouse lost such coverage.

"(C) Medicare eligibility (but for age); exhaustion of any COBRA continuation coverage; and not eligible for coverage under Federal health insurance program or group health plan.—The individual meets the requirements of subparagraphs (B), (D), and (E) of paragraph (1).

"(3) Change in health plan eligibility affects continued eligibility.—For provision that terminates enrollment under this section in the case of an individual who becomes eligible for coverage under a group health plan or under a Federal health insurance program, see section 1859A(d)(1)(C).

"(4) Reenrollment permitted.—Nothing in this subsection shall be construed as preventing an individual who, after enrolling under this subsection, terminates such enrollment from subsequently reenrolling under this subsection if the individual is eligible to enroll under this subsection at that time.".

(b) Enrollment.—Section 1859A of such Act, as so inserted, is amended—

(1) in subsection (a), by striking "and" at the end of paragraph (1), by striking the period at the end of paragraph (2) and inserting "; and", and by adding at the end the following new paragraph:

"(3) individuals whose coverage under this part would terminate because of subsection (d)(1)(B)(ii) are provided notice and an opportunity to continue enrollment in accordance with section 1859E(c)(1).";

(2) in subsection (b), by inserting after Notwithstanding any other provision of law, (1) the following:

"(2) Displaced workers and spouses.—In the case of individuals eligible to enroll under this part under section 1859(c), the following rules apply:

"(A) Initial enrollment period.—If the individual is first eligible to enroll under such section for July 2005, the enrollment period shall begin on May 1, 2002, and shall end on August 31, 2002. Any such enrollment before July 1, 2002, is conditioned upon compliance with the conditions of eligibility for July 2002.

"(B) Subsequent periods.—If the individual is eligible to enroll under such section for a month after July 2002, the enrollment period based on such eligibility shall begin on the first day of the second month before the month in which the individual first is eligible to so enroll (or reenroll) and shall end 4 months later.";

(3) in subsection (d)(1), by amending subparagraph (B) to read as follows:

"(B) Termination based on age.—

"(i) At age 65.—Subject to clause (ii), the individual attains 65 years of age.

"(ii) At age 62 for displaced workers and spouses.—In the case of an individual enrolled under this part pursuant to section 1859(c), subject to subsection (a)(1), the individual attains 62 years of age.";

(4) in subsection (d)(1), by adding at the end the following new subparagraph:

"(C) Obtaining access to employment-based coverage or federal health insurance program for individuals under 62 years of age.—In the case of an individual who has not attained 62 years of age, the individual is covered (or eligible for coverage) as a participant or beneficiary under a group health plan or under a Federal health insurance program.";

(5) in subsection (d)(2), by amending subparagraph (C) to read as follows:

"(C) Age or medicare eligibility.—

"(i) In general.—The termination of a coverage period under paragraph (1)(A)(iii) or (1)(B)(i) shall take effect as of the first day of the month in which the individual attains 65 years of age or becomes entitled to benefits under part A or enrolled for benefits under part B.

"(ii) Displaced workers.—The termination of a coverage period under paragraph (1)(B)(ii) shall take effect as of the first day of the month in which the individual attains 62 years of age, unless the individual has enrolled under this part pursuant to section 1859(b) and section 1859E(c)(1)."; and

(6) in subsection (d)(2), by adding at the end the following new subparagraph:

"(D) Access to coverage.—The termination of a coverage period under paragraph (1)(C) shall take effect on the date on which the individual is eligible to begin a period of creditable coverage (as defined in section 2701(c) of the Public Health Service Act) under a group health plan or under a Federal health insurance program.".

(c) Premiums.—Section 1859B of such Act, as so inserted, is amended—

(1) in subsection (a)(1), by adding at the end the following:

"(B) Base monthly premium for individuals under 62 years of age.—A base monthly premium for individuals under 62 years of age, equal to $1/12$ of the base annual premium rate computed under subsection (d)(3) for each premium area and age cohort."; and

(2) by adding at the end the following new subsection:

"(d) Base Monthly Premium for Individuals Under 62 Years of Age.—

"(1) National, per capita average for age groups.—

"(A) Estimate of amount.—The Secretary shall estimate the average, annual per capita amount that would be payable under this title with respect to individuals residing in the United States who meet the requirement of section 1859(c)(1)(A) within each of the age cohorts established under subparagraph (B) as if all such individuals within such cohort were eligible for (and enrolled) under this title during the entire year (and assuming that section 1862(b)(2)(A)(i) did not apply).

"(B) Age cohorts.—For purposes of subparagraph (A), the Secretary shall establish separate age cohorts in 5-year age increments for individuals who have not attained 60 years of age and a separate cohort for individuals who have attained 60 years of age.

"(2) Geographic adjustment.—The Secretary shall adjust the amount determined under paragraph (1)(A) for each premium area (specified under subsection (a)(3)) in the same manner and to the same extent as the Secretary provides for adjustments under subsection (b)(2).

"(3) Base annual premium.—The base annual premium under this subsection for months in a year for individuals in an age cohort under paragraph (1)(B) in a premium area is equal to 165 percent of the average, annual per capita amount estimated under paragraph (1) for the age cohort and year, adjusted for such area under paragraph (2).

"(4) Pro-ration of premiums to reflect coverage during a part of a month.—If the Secretary provides for coverage of portions of a month under section 1859A(c)(2), the Secretary shall pro-rate the premiums attributable to such coverage under this section to reflect the portion of the month so covered.".

(d) Administrative Provisions.—Section 1859F of such Act, as so inserted, is amended by adding at the end the following:

"(d) Additional Administrative Provisions.—

"(1) Process for continued enrollment of displaced workers who attain 62 years of age.—The Secretary shall provide a process for the continuation of enrollment of individuals whose enrollment under section 1859(c) would be terminated upon attaining 62 years of age. Under such process such individuals shall be provided appropriate and timely notice before the date of such termination and of the requirement to enroll under this part pursuant to section 1859(b) in order to continue entitlement to benefits under this title after attaining 62 years of age.

"(2) Arrangements with states for determinations relating to unemployment compensation eligibility.—The Secretary may provide for appropriate arrangements with States for the determination of whether individuals in the State meet or would meet the requirements of section 1859(c)(1)(C)(i).".

(e) Conforming Amendment to Heading to Part.—The heading of part D of title XVIII of the Social Security Act, as so inserted, is amended by striking "62" and inserting "55".

SEC. 6. PROVISIONS TO MAKE FEHBP COVERAGE AVAILABLE FOR THE SELF-EMPLOYED.

Chapter 89 of title 5, United States Code, is amended by adding at the end the following:

"§ 8915. Expanded access to coverage for the self-employed

"(a) The Office of Personnel Management (referred to in this section as the 'Office') shall administer a health insurance program for eligible individuals who are non-Federal employees in accordance with this section.

"(b) The term 'eligible individual' means a self-employed individual as defined in section 401(c)(1) of the Internal Revenue Code of 1986.

"(c) The Office shall prescribe regulations to apply the provisions of this chapter to the greatest extent practicable to eligible individuals covered under this section.

"(c) In no event shall the enactment of this section result in—

"(1) any increase in the level of individual or Government contributions required under this chapter, including copayments or deductibles;

"(2) any decrease in the types of benefits offered under this chapter; or

"(3) any other change that would adversely affect the coverage afforded under this chapter to employees and annuitants and members of family under this chapter.

"(d) The Office shall develop methods to facilitate enrollment under this section, including the use of the Internet.

"(e) The Office may enter into contracts for the performance of appropriate administrative functions under this chapter.

"(f) Each contract entered into under section 8902 shall require a carrier to offer to eligible individuals under this chapter, throughout each term for which the contract remains effective, the same benefits (subject to the same maximums, limitations, exclusions, and other similar terms or conditions) as would be offered under such contract or applicable health benefits plan to employees, annuitants, and members of family.

"(g)(1) The Office may waive the requirements of this section, if the Office determines, based on a petition submitted by a carrier that—

"(A) the carrier is unable to offer the applicable health benefits plan because of a limitation in the capacity of the plan to deliver services or assure financial solvency;

"(B) the applicable health benefits plan is not sponsored by a carrier licensed under applicable State law; or

"(C) bona fide enrollment restrictions make the application of this chapter inappropriate, including restrictions common to plans which are limited to individuals having a past or current employment relationship with a particular agency or other authority of the Government.

"(2) The Office may require a petition under this subsection to include—

"(A) a description of the efforts the carrier proposes to take in order to offer the applicable health benefits plan under this chapter; and

"(B) the proposed date for offering such a health benefits plan.

"(3) A waiver under this section may be for any period determined by the Office. The Office may grant subsequent waivers under this section.

"(h) The Office shall provide for the implementation of procedures to provide for an annual open enrollment period during which eligible individuals may enroll with a plan or contract for coverage under this section.

"(i) Except as the Office may by regulation prescribe, any reference to this chapter (or any requirement of this chapter), made in any provision of law, shall not be considered to include this section (or any requirement of this section).

"(j) This section shall take effect on the date of enactment of this section and shall apply to contracts that take effect with respect to calendar year 2002 and each calendar year thereafter.".

SEC. 7. MEDIKIDS HEALTH INSURANCE.

(a) Benefits for all Children Born After 2002.—

(1) In general.—The Social Security Act is amended by adding at the end the following:

"TITLE XXII—MEDIKIDS PROGRAM

"SEC. 2201. ELIGIBILITY.

"(a) Eligibility of Individuals Born After December 31, 2002; All Children Under 23 Years of Age in Sixth Year.—An individual who meets the following requirements with respect to a month is eligible to enroll under this title with respect to such month:

"(1) Age.—

"(A) First year.—During the first year in which this title is effective, the individual has not attained 6 years of age.

"(B) Second year.—During the second year in which this title is effective, the individual has not attained 11 years of age.

"(C) Third year.—During the third year in which this title is effective, the individual has not attained 16 years of age.

"(D) FOURTH YEAR.—During the fourth year in which this title is effective, the individual has not attained 21 years of age.

"(E) FIFTH AND SUBSEQUENT YEARS.—During the fifth year in which this title is effective and each subsequent year, the individual has not attained 23 years of age.

"(2) CITIZENSHIP.—The individual is a citizen or national of the United States or is permanently residing in the United States under color of law.

"(b) ENROLLMENT PROCESS.—An individual may enroll in the program established under this title only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed by the Secretary consistent with the provisions of this section. Such regulations shall provide a process under which—

"(1) individuals who are born in the United States after December 31, 2002, are deemed to be enrolled at the time of birth and a parent or guardian of such an individual is permitted to pre-enroll in the month prior to the expected month of birth;

"(2) individuals who are born outside the United States after such date and who become eligible to enroll by virtue of immigration into (or an adjustment of immigration status in) the United States are deemed enrolled at the time of entry or adjustment of status;

"(3) eligible individuals may otherwise be enrolled at such other times and manner as the Secretary shall specify, including the use of outstationed eligibility sites as described in section 1902(a)(55)(A) and the use of presumptive eligibility provisions like those described in section 1920A; and

"(4) at the time of automatic enrollment of a child, the Secretary provides for issuance to a parent or custodian of the individual a card evidencing coverage under this title and for a description of such coverage.

The provisions of section 1837(h) apply with respect to enrollment under this title in the same manner as they apply to enrollment under part B of title XVIII.

"(c) DATE COVERAGE BEGINS.—

"(1) IN GENERAL.—The period during which an individual is entitled to benefits under this title shall begin as follows, but in no case earlier than January 1, 2003:

"(A) In the case of an individual who is enrolled under paragraph (1) or (2) of subsection (b), the date of birth or date of obtaining appropriate citizenship or immigration status, as the case may be.

"(B) In the case of an another individual who enrolls (including pre-enrolls) before the month in which the individual satisfies eligibility for enrollment under subsection (a), the first day of such month of eligibility.

"(C) In the case of an another individual who enrolls during or after the month in which the individual first satisfies eligibility for enrollment under such subsection, the first day of the following month.

"(2) AUTHORITY TO PROVIDE FOR PARTIAL MONTHS OF COVERAGE.—Under regulations, the Secretary may, in the Secretary's discretion, provide for coverage periods that include portions of a month in order to avoid lapses of coverage.

"(3) LIMITATION ON PAYMENTS.—No payments may be made under this title with respect to the expenses of an individual enrolled under this title unless such expenses were incurred by such individual during a period which, with respect to the individual, is a coverage period under this section.

"(d) EXPIRATION OF ELIGIBILITY.—An individual's coverage period under this part shall continue until the individual's enrollment has been terminated because the individual no longer meets the requirements of subsection (a) (whether because of age or change in immigration status).

"(e) ENTITLEMENT TO MEDIKIDS BENEFITS FOR ENROLLED INDIVIDUALS.—An individual enrolled under this section is entitled to the benefits described in section 2202.

"(f) LOW-INCOME INFORMATION.—At the time of enrollment of a child under this title, the Secretary shall make an inquiry as to whether or not the family income of the family that includes the child is less than 150 percent of the poverty line for a family of the size involved. If the family income is below such level, the Secretary shall encode in the identification card issued in connection with eligibility under this title a code indicating such fact. The Secretary also shall provide for a toll-free telephone line at which providers can verify whether or not such a child is in a family the income of which is below such level.

"(g) CONSTRUCTION.—Nothing in this title shall be construed as requiring (or preventing) an individual who is enrolled under this section from seeking medical assistance under a State medicaid plan under title XIX or child health assistance under a State child health plan under title XXI.

"SEC. 2202. BENEFITS.

"(a) SECRETARIAL SPECIFICATION OF BENEFIT PACKAGE.—

"(1) IN GENERAL.—The Secretary shall specify the benefits to be made available under this title consistent with the provisions of this section and in a manner designed to meet the health needs of enrollees.

"(2) UPDATING.—The Secretary shall update the specification of benefits over time to ensure the inclusion of age-appropriate benefits to reflect the enrollee population.

"(3) ANNUAL UPDATING.—The Secretary shall establish procedures for the annual review and updating of such benefits to account for changes in medical practice, new information from medical research, and other relevant developments in health science.

"(4) INPUT.—The Secretary shall seek the input of the pediatric community in specifying and updating such benefits.

"(5) LIMITATION ON UPDATING.—In no case shall updating of benefits under this subsection result in a failure to provide benefits required under subsection (b).

"(b) INCLUSION OF CERTAIN BENEFITS.—

"(1) MEDICARE CORE BENEFITS.—Such benefits shall include (to the extent consistent with other provisions of this section) at least the same benefits (including coverage, access, availability, duration, and beneficiary rights) that are available under parts A and B of title XVIII.

"(2) ALL REQUIRED MEDICAID BENEFITS.—Such benefits shall also include all items and services for which medical assistance is required to be provided under section 1902(a)(10)(A) to individuals described in such section, including early and periodic screening, diagnostic services, and treatment services.

"(3) INCLUSION OF PRESCRIPTION DRUGS.—Such benefits also shall include (as specified by the Secretary) prescription drugs and biologicals.

"(4) COST-SHARING.—

"(A) IN GENERAL.—Subject to subparagraph (B), such benefits also shall include the cost-sharing (in the form of deductibles, coinsurance, and copayments) applicable under title XVIII with respect to comparable items and services, except that no cost-sharing shall be imposed with respect to early and periodic screening and diagnostic services included under paragraph (2).

"(B) NO COST-SHARING FOR LOWEST INCOME CHILDREN.—Such benefits shall not include any cost-sharing for children in families the income of which (as determined for purposes of section 1905(p)) does not exceed 150 percent of the official income poverty line (referred to in such section) applicable to a family of the size involved.

"(C) REFUNDABLE CREDIT FOR COST-SHARING FOR OTHER LOW-INCOME CHILDREN.—For a refundable credit for cost-sharing in the case of children in certain families, see section 35 of the Internal Revenue Code of 1986.

"(c) PAYMENT SCHEDULE.—The Secretary, with the assistance of the Medicare Payment Advisory Commission, shall develop and implement a payment schedule for benefits covered under this title. To the extent feasible, such payment schedule shall be consistent with comparable payment schedules and reimbursement methodologies applied under parts A and B of title XVIII.

"(d) INPUT.—The Secretary shall specify such benefits and payment schedules only after obtaining input from appropriate child health providers and experts.

"(e) ENROLLMENT IN HEALTH PLANS.—The Secretary shall provide for the offering of benefits under this title through enrollment in a health benefit plan that meets the same (or similar) requirements as the requirements that apply to Medicare+Choice plans under part C of title XVIII. In the case of individuals enrolled under this title in such a plan, the Medicare+Choice capitation rate described in section 1853(c) shall be adjusted in an appropriate manner to reflect differences between the population served under this title and the population under title XVIII.

"SEC. 2203. PREMIUMS.

"(a) AMOUNT OF MONTHLY PREMIUMS.—

"(1) IN GENERAL.—The Secretary shall, during September of each year (beginning with 2002), establish a monthly MediKids premium. Subject to paragraph (2), the monthly MediKids premium for a year is equal to 1/12 of the annual premium rate computed under subsection (b).

"(2) ELIMINATION OF MONTHLY PREMIUM FOR DEMONSTRATION OF EQUIVALENT COVERAGE (INCLUDING COVERAGE UNDER LOW-INCOME PROGRAMS).—The amount of the monthly premium imposed under this section for an individual for a month shall be zero in the case of an individual who demonstrates to the satisfaction of the Secretary that the individual has basic health insurance coverage for that month. For purposes of the previous sentence enrollment in a medicaid plan under title XIX, a State child health insurance plan under title XXI, or under the medicare program under title XVIII is deemed to constitute basic health insurance coverage described in such sentence.

"(b) ANNUAL PREMIUM.—

"(1) NATIONAL, PER CAPITA AVERAGE.—The Secretary shall estimate the average, annual per capita amount that would be payable under this title with respect to individuals residing in the United States who meet the requirement of section 2201(a)(1) as if all such individuals were eligible for (and enrolled) under this title during the entire year (and assuming that section 1862(b)(2)(A)(i) did not apply).

"(2) ANNUAL PREMIUM.—Subject to subsection (d), the annual premium under this subsection for months in a year is equal to 25 percent of the average, annual per capita amount estimated under paragraph (1) for the year.

"(c) PAYMENT OF MONTHLY PREMIUM.—

"(1) PERIOD OF PAYMENT.—In the case of an individual who participates in the program established by this title, subject to subsection (d), the monthly premium shall be payable for the period commencing with the first month of the individual's coverage period and ending with the month in which the individual's coverage under this title terminates.

"(2) COLLECTION THROUGH TAX RETURN.—For provisions providing for the payment of monthly premiums under this subsection, see section 59B of the Internal Revenue Code of 1986.

"(3) PROTECTIONS AGAINST FRAUD AND ABUSE.—The Secretary shall develop, in coordination with States and other health insurance issuers, administrative systems to ensure that claims which are submitted to more than one payor are coordinated and duplicate payments are not made.

"(d) REDUCTION IN PREMIUM FOR CERTAIN LOW-INCOME FAMILIES.—For provisions reducing the premium under this section for certain low-income families, see section 59B(c) of the Internal Revenue Code of 1986.

"SEC. 2204. MEDIKIDS TRUST FUND.

"(a) ESTABLISHMENT OF TRUST FUND.—

"(1) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'MediKids Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and such amounts as may be deposited in, or appropriated to, such fund as provided in this title.

"(2) PREMIUMS.—Premiums collected under section 2203 shall be transferred to the Trust Fund.

"(b) INCORPORATION OF PROVISIONS.—

"(1) IN GENERAL.—Subject to paragraph (2), subsections (b) through (i) of section 1841 shall apply with respect to the Trust Fund and this title in the same manner as they apply with respect to the Federal Supplementary Medical Insurance Trust Fund and part B, respectively.

"(2) MISCELLANEOUS REFERENCES.—In applying provisions of section 1841 under paragraph (1)—

"(A) any reference in such section to 'this part' is construed to refer to title XXII;

"(B) any reference in section 1841(h) to section 1840(d) and in section 1841(i) to sections 1840(b)(1) and 1842(g) are deemed references to comparable authority exercised under this title;

"(C) payments may be made under section 1841(g) to the Trust Funds under sections 1817 and 1841 as reimbursement to such funds for payments they made for benefits provided under this title; and

"(D) the Board of Trustees of the MediKids Trust Fund shall be the same as the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund.

"SEC. 2205. OVERSIGHT AND ACCOUNTABILITY.

"(a) THROUGH ANNUAL REPORTS OF TRUSTEES.—The Board of Trustees of the MediKids Trust Fund under section 2204(b)(1) shall report on an annual basis to Congress concerning the status of the Trust Fund and the need for adjustments in the program under this title to maintain financial solvency of the program under this title.

"(b) PERIODIC GAO REPORTS.—The Comptroller General of the United States shall periodically submit to Congress reports on the adequacy of the financing of coverage provided under this title. The Comptroller General shall include in such report such recommendations for adjustments in such financing and coverage as the Comptroller General deems appropriate in order to maintain financial solvency of the program under this title.

"SEC. 2206. INCLUSION OF CARE COORDINATION SERVICES.

"(a) IN GENERAL.—

"(1) PROGRAM AUTHORITY.—The Secretary, beginning in 2003, may implement a care coordination services program in accordance with the provisions of this section under which, in appropriate circumstances, eligible individuals may elect to have health care services covered under this title managed and coordinated by a designated care coordinator.

"(2) ADMINISTRATION BY CONTRACT.—The Secretary may administer the program under this section through a contract with an appropriate program administrator.

"(3) COVERAGE.—Care coordination services furnished in accordance with this section shall be treated under this title as if they were included in the definition of medical and other health services under section 1861(s) and benefits shall be available under this title with respect to such services without the application of any deductible or coinsurance.

"(b) ELIGIBILITY CRITERIA; IDENTIFICATION AND NOTIFICATION OF ELIGIBLE INDIVIDUALS.—

"(1) INDIVIDUAL ELIGIBILITY CRITERIA.—The Secretary shall specify criteria to be used in making a determination as to whether an individual may appropriately be enrolled in the care coordination services program under this section, which shall include at least a finding by the Secretary that for cohorts of individuals with characteristics identified by the Secretary, professional management and coordination of care can reasonably be expected to improve processes or outcomes of health care and to reduce aggregate costs to the programs under this title.

"(2) PROCEDURES TO FACILITATE ENROLLMENT.—The Secretary shall develop and implement procedures designed to facilitate enrollment of eligible individuals in the program under this section.

"(c) ENROLLMENT OF INDIVIDUALS.—

"(1) SECRETARY'S DETERMINATION OF ELIGIBILITY.—The Secretary shall determine the eligibility for services under this section of individuals who are enrolled in the program under this section and who make application for such services in such form and manner as the Secretary may prescribe.

"(2) ENROLLMENT PERIOD.—

"(A) EFFECTIVE DATE AND DURATION.—Enrollment of an individual in the program under this section shall be effective as of the first day of the month following the month in which the Secretary approves the individual's application under paragraph (1), shall remain in effect for one month (or such longer period as the Secretary may specify), and shall be automatically renewed for additional periods, unless terminated in accordance with such procedures as the Secretary shall establish by regulation. Such procedures shall permit an individual to disenroll for cause at any time and without cause at re-enrollment intervals.

"(B) LIMITATION ON REENROLLMENT.—The Secretary may establish limits on an individual's eligibility to reenroll in the program under this section if the individual has disenrolled from the program more than once during a specified time period.

"(d) PROGRAM.—The care coordination services program under this section shall include the following elements:

"(1) BASIC CARE COORDINATION SERVICES.—

"(A) IN GENERAL.—Subject to the cost-effectiveness criteria specified in subsection (b)(1), except as otherwise provided in this section, enrolled individuals shall receive services described in section 1905(t)(1) and may receive additional items and services as described in subparagraph (B).

"(B) ADDITIONAL BENEFITS.—The Secretary may specify additional benefits for which payment would not otherwise be made under this title that may be available to individuals enrolled in the program under this section (subject to an assessment by the care coordinator of an individual's circumstance and need for such benefits) in order to encourage enrollment in, or to improve the effectiveness of, such program.

"(2) CARE COORDINATION REQUIREMENT.—Notwithstanding any other provision of this title, the Secretary may provide that an individual enrolled in the program under this section may be entitled to payment under this title for any specified health care items or services only if the items or services have been furnished by the care coordinator, or coordinated through the care coordination services program. Under such provision, the Secretary shall prescribe exceptions for emergency medical services as described in section 1852(d)(3), and other exceptions determined by the Secretary for the delivery of timely and needed care.

"(e) CARE COORDINATORS.—

"(1) CONDITIONS OF PARTICIPATION.—In order to be qualified to furnish care coordination services under this section, an individual or entity shall—

"(A) be a health care professional or entity (which may include physicians, physician group practices, or other health care professionals or entities the Secretary may find appropriate) meeting such conditions as the Secretary may specify;

"(B) have entered into a care coordination agreement; and

"(C) meet such criteria as the Secretary may establish (which may include experience in the provision of care coordination or primary care physician's services).

"(2) AGREEMENT TERM; PAYMENT.—

"(A) DURATION AND RENEWAL.—A care coordination agreement under this subsection shall be for one year and may be renewed if the Secretary is satisfied that the care coordinator continues to meet the conditions of participation specified in paragraph (1).

"(B) PAYMENT FOR SERVICES.—The Secretary may negotiate or otherwise establish payment terms and rates for services described in subsection (d)(1).

"(C) LIABILITY.—Case coordinators shall be subject to liability for actual health damages which may be suffered by recipients as a result of the care coordinator's decisions, failure or delay in making decisions, or other actions as a care coordinator.

"(D) TERMS.—In addition to such other terms as the Secretary may require, an agreement under this section shall include the terms specified in subparagraphs (A) through (C) of section 1905(t)(3).

"SEC. 2207. ADMINISTRATION AND MISCELLANEOUS.

"(a) IN GENERAL.—Except as otherwise provided in this title—

"(1) the Secretary shall enter into appropriate contracts with providers of services, other health care providers, carriers, and fiscal intermediaries, taking into account the types of contracts used under title XVIII with respect to such entities, to administer the program under this title;

"(2) individuals enrolled under this title shall be treated for purposes of title XVIII as though the individual were entitled to benefits under part A and enrolled under part B of such title;

"(3) benefits described in section 2202 that are payable under this title to such individuals shall be paid in a manner specified by the Secretary (taking into account, and based to the greatest extent practicable upon, the manner in which they are provided under title XVIII);

"(4) provider participation agreements under title XVIII shall apply to enrollees and benefits under this title in the same manner as they apply to enrollees and benefits under title XVIII; and

"(5) individuals entitled to benefits under this title may elect to receive such benefits under health plans in a manner, specified by the Secretary, similar to the manner provided under part C of title XVIII.

"(b) Coordination With Medicaid and SCHIP.—Notwithstanding any other provision of law, individuals entitled to benefits for items and services under this title who also qualify for benefits under title XIX or XXI or any other Federally funded program may continue to qualify and obtain benefits under such other title or program, and in such case such an individual shall elect either—

"(1) such other title or program to be primary payor to benefits under this title, in which case no benefits shall be payable under this title and the monthly premium under section 2203 shall be zero; or

"(2) benefits under this title shall be primary payor to benefits provided under such program or title, in which case the Secretary shall enter into agreements with States as may be appropriate to provide that, in the case of such individuals, the benefits under titles XIX and XXI or such other program (including reduction of cost-sharing) are provided on a 'wrap-around' basis to the benefits under this title.".

(2) Conforming amendments to social security act provisions.—

(A) Section 201(i)(1) of the Social Security Act (42 U.S.C. 401(i)(1)) is amended by striking "or the Federal Supplementary Medical Insurance Trust Fund" and inserting "the Federal Supplementary Medical Insurance Trust Fund, and the MediKids Trust Fund".

(B) Section 201(g)(1)(A) of such Act (42 U.S.C. 401(g)(1)(A)) is amended by striking " and the Federal Supplementary Medical Insurance Trust Fund established by title XVIII" and inserting ", the Federal Supplementary Medical Insurance Trust Fund, and the MediKids Trust Fund established by title XVIII".

(C) Section 1853(c) of such Act (42 U.S.C. 1395w–23(c)) is amended—

(i) in paragraph (1), by striking "or (7)" and inserting ", (7), or (8)", and

(ii) by adding at the end the following:

"(8) Adjustment for medikids.—In applying this subsection with respect to individuals entitled to benefits under title XXII, the Secretary shall provide for an appropriate adjustment in the Medicare+Choice capitation rate as may be appropriate to reflect differences between the population served under such title and the population under parts A and B.".

(3) Maintenance of medicaid eligibility and benefits for children.—

(A) In general.—In order for a State to continue to be eligible for payments under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a))—

(i) the State may not reduce standards of eligibility, or benefits, provided under its State medicaid plan under title XIX of the Social Security Act or under its State child health plan under title XXI of such Act for individuals under 23 years of age below such standards of eligibility, and benefits, in effect on the date of the enactment of this Act; and

(ii) the State shall demonstrate to the satisfaction of the Secretary of Health and Human Services that any savings in State expenditures under title XIX or XXI of the Social Security Act that results from children from enrolling under title XXII of such Act shall be used in a manner that improves services to beneficiaries under title XIX of such Act, such as through increases in provider payment rates, expansion of eligibility, improved nurse and nurse aide staffing and improved inspections of nursing facilities, and coverage of additional services.

(B) Medikids as primary payor.—In applying title XIX of the Social Security Act, the MediKids program under title XXII of such Act shall be treated as a primary payor in cases in which the election described in section 2207(b)(2) of such Act, as added by subsection (a), has been made.

(4) Expansion of MedPAC membership to 19.—

(A) In general.—Section 1805(c) of the Social Security Act (42 U.S.C. 1395b–6(c)) is amended—

(i) in paragraph (1), by striking "17" and inserting "19"; and

(ii) in paragraph (2)(B), by inserting "experts in children's health," after "other health professionals,".

(B) Initial terms of additional members.—

(i) In general.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission under section 1805(c)(3) of the Social Security Act (42 U.S.C. 1395b–6(c)(3)), the initial terms of the 2 additional members of the Commission provided for by the amendment under subsection (a)(1) are as follows:

(I) One member shall be appointed for 1 year.

(II) One member shall be appointed for 2 years.

(ii) Commencement of terms.—Such terms shall begin on January 1, 2002.

(b) Medikids Premium.—

(1) In general.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to determination of tax liability) is amended by adding at the end the following new part:

"PART VIII—MEDIKIDS PREMIUM

"Sec. 59B. MediKids premium.

"SEC. 59B. MEDIKIDS PREMIUM.

"(a) Imposition of Tax.—In the case of an individual to whom this section applies, there is hereby imposed (in addition to any other tax imposed by this subtitle) a MediKids premium for the taxable year.

"(b) Individuals Subject to Premium.—

"(1) In general.—This section shall apply to an individual if the taxpayer has a MediKid at any time during the taxable year.

"(2) Medikid.—For purposes of this section, the term 'MediKid' means, with respect to a taxpayer, any individual with respect to whom the taxpayer is required to pay a premium under section 2203(c) of the Social Security Act for any month of the taxable year.

"(c) Amount of Premium.—For purposes of this section, the MediKids premium for a taxable year is the sum of the monthly premiums under section 2203 of the Social Security Act for months in the taxable year.

"(d) Exceptions Based on Adjusted Gross Income.—

"(1) Exemption for very low-income taxpayers.—

"(A) In general.—No premium shall be imposed by this section on any taxpayer having an adjusted gross income not in excess of the exemption amount.

"(B) Exemption amount.—For purposes of this paragraph, the exemption amount is—

"(i) $17,415 in the case of a taxpayer having 1 MediKid,

"(ii) $21,945 in the case of a taxpayer having 2 MediKids,

"(iii) $26,475 in the case of a taxpayer having 3 MediKids, and

"(iv) $31,005 in the case of a taxpayer having 4 or more MediKids.

"(C) Phaseout of exemption.—In the case of a taxpayer having an adjusted gross income which exceeds the exemption amount but does not exceed twice the exemption amount, the premium shall be the amount which bears the same ratio to the premium which would (but for this subparagraph) apply to the taxpayer as such excess bears to the exemption amount.

"(D) Inflation adjustment of exemption amounts.—In the case of any taxable year beginning in a calendar year after 2001, each dollar amount contained in subparagraph (C) shall be increased by an amount equal to the product of—

"(i) such dollar amount, and

"(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2000' for 'calendar year 1992' in subparagraph (B) thereof.

If any increase determined under the preceding sentence is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

"(2) Premium limited to 5 percent of adjusted gross income.—In no event shall any taxpayer be required to pay a premium under this section in excess of an amount equal to 5 percent of the taxpayer's adjusted gross income.

"(e) Coordination With Other Provisions.—

"(1) Not treated as medical expense.—For purposes of this chapter, any premium paid under this section shall not be treated as expense for medical care.

"(2) Not treated as tax for certain purposes.—The premium paid under this section shall not be treated as a tax imposed by this chapter for purposes of determining—

"(A) the amount of any credit allowable under this chapter, or

"(B) the amount of the minimum tax imposed by section 55.

"(3) Treatment under subtitle f.—For purposes of subtitle F, the premium paid under this section shall be treated as if it were a tax imposed by section 1.".

(2) Technical amendments.—

(A) Subsection (a) of section 6012 of such Code is amended by inserting after paragraph (9) the following new paragraph:

"(10) Every individual liable for a premium under section 59B.".

(B) The table of parts for subchapter A of chapter 1 of such Code is amended by adding at the end the following new item:

"Part VIII. MediKids premium.".

(3) Effective date.—The amendments made by this subsection shall apply to months beginning after December 2002, in taxable years ending after such date.

(c) Refundable Credit for Cost-Sharing Expenses Under Medikids Program.—

(1) In general.—Subpart C of part IV of subchapter A of chapter 1 of the Internal

Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 35 as section 36 and by inserting after section 34 the following new section:

"SEC. 35. COST-SHARING EXPENSES UNDER MEDIKIDS PROGRAM.

"(a) ALLOWANCE OF CREDIT.—In the case of an individual who has a MediKid (as defined in section 59B) at any time during the taxable year, there shall be allowed as a credit against the tax imposed by this subtitle an amount equal to 50 percent of the amount paid by the taxpayer during the taxable year as cost-sharing under section 2202(b)(4) of the Social Security Act.

"(b) LIMITATION BASED ON ADJUSTED GROSS INCOME.—The amount of the credit which would (but for this subsection) be allowed under this section for the taxable year shall be reduced (but not below zero) by an amount which bears the same ratio to such amount of credit as the excess of the taxpayer's adjusted gross income for such taxable year over the exemption amount (as defined in section 59B(d)) bears to such exemption amount.".

(2) TECHNICAL AMENDMENTS.—

(A) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period "or from section 35 of such Code".

(B) The table of sections for subpart C of part IV of subchapter A of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

"Sec. 35. Cost-sharing expenses under MediKids program.

"Sec. 36. Overpayments of tax.".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after December 31, 2002.

(d) REPORT ON LONG-TERM REVENUES.—Within 1 year after the date of enactment of this Act, the Secretary of the Treasury shall propose a gradual schedule of progressive tax changes to fund the program under title XXII of the Social Security Act, as the number of enrollees grows in the out-years.

ORDER FOR ADJOURNMENT

Mr. GRASSLEY. Mr. President, we want to make sure there is time this evening for Senators BINGAMAN and LEVIN to give their remarks. If there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment under the previous order, following the remarks of Senator BINGAMAN and Senator LEVIN.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from New Mexico.

Mr. BINGAMAN. Mr. President, I thank the chairman of the committee. I appreciate the chance to speak briefly on this bill. It is a very important piece of legislation. I congratulate the Senator from Iowa on the hard work he has put into this legislation. I do not share his conclusion about it at this stage, but I certainly admire the work he has put in and admire the good job he does as chairman of the committee on which I serve.

When the 2000 Presidential campaign was underway, I saw one of the debates between then-Governor Bush and then-Vice President Gore. Both of them in that debate endorsed the enactment of a prescription drug benefit for seniors for Medicare beneficiaries. I remember thinking when I saw that, this is one good thing that will come out of this campaign in the next few years, no matter who wins. But what I had in mind as a prescription drug benefit was a very different animal than what we have in these 1,100 pages that have been referred to repeatedly.

What I had in mind was a benefit where Medicare beneficiaries would be able to sign up for a prescription drug benefit. It would be voluntary. They could sign up or not. They could then pay a monthly premium. They would get a card. They could take that card, go to the pharmacy and get their prescription drugs. They might have to pay a copay. They might have to pay some deductible. But it was basically the adding of a prescription drug benefit to Medicare. That is what I thought both candidates were talking about.

That is not what we have in these 1,100 pages. Had we decided to enact that, it could have been done in a much smaller document.

I regretfully have to oppose the conference report for H.R. 1 as it comes before us tonight and tomorrow.

I will cite six reasons I have come to that conclusion. The first reason is that the bill, in my view, over time, will undermine traditional Medicare.

The second reason is that the bill requires the Government to overpay private health plans by tens of billions of dollars.

The third reason is that the bill actually will harm many senior citizens who are intended to benefit.

Fourth, the bill will increase drug costs rather than reducing them.

Fifth, the bill will dramatically increase the complexity and volatility of the Medicare system for many of our seniors.

Finally, the sixth point is that the bill will increase the financial burden on States and make it more difficult for each of our States to maintain the benefits they provide through their Medicaid programs to low-income patients.

Let me start with the problem that I see of this bill undermining traditional Medicare. Today, 88 percent of all of those 41 million people who are served by Medicare are enrolled in traditional Medicare. The major thrust of this bill is not to add a prescription drug benefit but instead to do what is euphemistically referred to as "modernize" Medicare.

Now, there are definitely some things we should do to modernize Medicare. I would agree with that. But as that term is used in this discussion, most of the time it is a code word, meaning that we should move people—seniors and disabled individuals—out of traditional Medicare into the private health care system. That is what is meant by a lot of our colleagues when they talk about modernizing Medicare.

There are two good reasons for moving people out of traditional Medicare into the private health care system, as I see it. I could certainly favor doing that if we could accomplish these purposes. The first, obviously, would be to make the program more efficient and save money—save some taxpayer dollars by moving these people out of the Government plan into a private plan.

The second, of course, would be if we could improve services, increase the satisfaction of Medicare beneficiaries by moving them into the private plan.

Let me just show this chart. Medicare cost growth: This relates to the first of those two points. Medicare has historically controlled costs far better than either private health care plans have, or even better than the Federal Employees Health Benefits Program, FEHBP. We all take great pride in the FEHBP program and talk about how this is a great benefit and we should extend it to others.

Between 1969 and now, Medicare's costs have increased at an annual rate of 8.9 percent a year, which stands in contrast to the 11 percent growth rate in the private health insurance arena and 10.6 percent growth rate in FEHBP. So the ideology of this drive to modernize Medicare or move people out of traditional Medicare into the private system does not match the evidence. In fact, the recent record is even more dramatic. Between 1996 and 2003, Medicare's per capita growth was 4.2 percent compared to 5.9 percent for private health plans and 5.3 percent for FEHBP.

Medicare wins the contest going away. But maybe some are willing to pay higher costs, so this chart should make that point. The red line shows the increase in costs from 1970 to the end of the century in private insurance. The blue line shows the increase in the cost of Medicare. They have both gone up, but Medicare has gone up less rapidly. We might still be willing to pay more—pay the amount required to put people on this red line if, in fact, we had greater patient satisfaction by doing so.

There is a recent study by the Commonwealth Fund, published in Health Affairs, and it is reflected on this chart. It is hard to read because the colors are too similar. What is reflected is that of those with private health insurance, there were 51 percent of those who were satisfied, and 62 percent of those in traditional Medicare were satisfied with their coverage. That is the case, despite the fact that Medicare benefits are less generous and its beneficiaries are more elderly and disabled and have higher health needs than individuals in the private health care system.

So the bill seeks to move people out of traditional Medicare into private health plans. It does so by dramatically overpaying the private health plans.

Let me move to my second point. Since managed care is not more efficient than traditional Medicare, the conference report concludes that the way to get people into these private health plans is to spend billions of dollars in overpayment to those plans.

The legislation begins by setting its benchmark for payments to private plans at 109 percent of what Medicare fee for service would have to spend for those beneficiaries. It does so in other ways as well, including giving health plans money that Medicare otherwise would pay to a disproportionate share of hospitals, to graduate medical education, and the cost of veterans retiree health care.

It makes no sense to me to subsidize and pay health plan payments that Medicare intends, or could have, for safety net hospitals or teaching hospitals or veterans retirees. These HMOs do not provide unpaid services to the poor. They do not educate our Nation's medical students. They do not provide health care to our veterans. Yet the conference report provides payment for such services.

It makes no sense, but it is intended to camouflage the fact that private health plans cannot compete with traditional Medicare if they merely receive the amount traditional Medicare spends to provide these services to beneficiaries. So that is not enough.

The other thing that is done is that we, in this bill, provide a $10 billion to $12 billion stabilization fund. That stabilization fund essentially is money that the Secretary of Health and Human Services has available to add to what private plans are receiving and further advantage them over the traditional Medicare system if he or she determines that that is necessary in order to keep them providing services to this portion of our population.

Of course, the other issue that I think is extremely important is that these private health plans, under the legislation, are fully free to engage in practices that allow them to enroll healthy Medicare beneficiaries and shift the sicker and the more costly or elderly beneficiaries into the Medicare system. They do this by adjusting their benefits. They do this by designing their benefit packages and marketing them to the healthy segments of the society.

Some might ask how do they do this. I will give you an example. Some private plans impose a higher cost share for services such as chemotherapy or renal dialysis than traditional Medicare in order to encourage those who have contracted cancer or renal failure to enroll, to leave the private plan and to go back into traditional Medicare.

Proponents of the bill say what they are trying to do by getting these private plans involved is to foster competition. Obviously, we all favor competition, but I do not see that it is particularly competitive for us to provide this kind of very major subsidy.

When you add together the 109 percent payment to the private plans and the risk selection in which they are permitted to engage, private plans will be paid an estimated 25 percent more than the cost of traditional Medicare for each enrollee, for each beneficiary. This amounts to $1,920 more per enrollee in the year 2006.

A third problem is the bill actually does harm. I mentioned what many of my colleagues have already mentioned, and that is the 2.7 million retirees who are expected to lose their prescription drug coverage once we enact this legislation.

Also, the Congressional Budget Office analysis says as to low-income beneficiaries, there are 3.4 million low-income beneficiaries who will benefit from this; there are 6.4 million low-income beneficiaries currently enrolled in Medicaid who will be worse off. It is hard for me to see how that adds up to a major benefit for a lot of those people who are expecting a benefit under this legislation.

Let me talk a minute about drug costs. What will this bill do for drug costs? When I talk with seniors in my State, the No. 1 problem they cite to me when it comes to prescription drugs is the enormous growth in the cost of those drugs.

I have concluded, reluctantly, that not only will this legislation not bring down drug costs but it will actually cause them to go up. Surveys indicate that Medicare beneficiaries cite this as their No. 1 problem. The Congressional Budget Office has concluded the conference report will actually raise the price of drugs by 3.5 percent overall.

The legislation that is before us, this 1,100 pages, delivers to hundreds of private drug companies and HMOs an insurance-administered drug benefit that vastly dilutes the purchasing power of Medicare. Rather than Medicare purchasing the drugs in bulk to achieve significant savings, the medication splits Medicare's purchasing power into hundreds of purchasing pools and eliminates the significant leverage that Medicare could have in controlled costs.

This bill expressly prohibits Medicare from negotiating for prices. People need to focus on that. Here we are setting up a program where Medicare is going to pay for prescription drugs, and we are prohibiting Medicare from negotiating as to the price it is going to pay.

Consumers Union came out with a report last week saying the proposal's modest benefits, coupled with an expected high growth of prescription drug prices, could result in major disappointments for many of these Medicare beneficiaries. Medicare beneficiaries at most prescription drug expenditure levels will actually face higher out-of-pocket costs when they have coverage in 2007—that is one year after the bill is implemented—than they do in 2003 when they have no coverage.

That is an incredible finding, in my view. For example, it only provides people with a benefit of around $1,000 for the first $5,000 in prescription drug spending. When you couple that with weak cost containment provisions, the Consumer Union finds that the average out-of-pocket spending for beneficiaries rises to $2,900 in 2000 compared to $2,300 in 2003 for beneficiaries with absolutely no prescription drug coverage.

Let me also move to this final chart to talk about the problem of complexity and volatility. I heard some of the majority leader's comments earlier this evening. He indicated that one of the great advantages of this bill is that it would reduce paperwork. I would love to understand that. How we can enact this enormous piece of legislation and see it reduce paperwork is a mystery to me.

This is a chart that was put together by the Medicare Rights Center. It tries to set out some depiction of how this is all going to work. I can't begin to explain it to you at this point, but I can tell you that you can study it for a great length of time and still not understand how it is going to work.

Most people receiving benefits through Medicare choose traditional Medicare. They like the stability of traditional Medicare.

The Washington Post today had a story about the problems beneficiaries who have enrolled in Medicare+Choice have encountered: the changing benefits that health plans offer on an annual basis; the changes in premiums and copayments; the problem of health plans coming in and out of the marketplace. We have had that problem in my State of New Mexico. Health plans come in, advertise, sign up a lot of people, and 6 months or a year later they announce they are not making money and they pull out. They send a letter to everybody and say: Sorry, we decided not to provide your benefits. Those people come to my office and say: What are we going to do?

This is a volatility in the system that most people on Medicare do not appreciate. I see that increasing dramatically under this legislation. How in the world we can see less paperwork, how in the world we can see less complexity and less volatility as a result of this bill escapes me.

A final point I want to make is the impact on States, expanding on this concept of "do no harm." This legislation has potentially major negative consequences for our States. In the first 3 years of the bill, the Congressional Budget Office estimates that the costs, or the unfunded liability of the bill to the States in their Medicaid programs, will be $1.2 billion.

We are, in effect, adding $1.2 billion in costs to the Medicaid Program at a time when States have been begging for relief from the Federal Government due to the growing Medicaid costs that States have experienced because of the slow economy and the growing beneficiary roles.

States have had to make rather dramatic cuts in their Medicaid programs because of these changes, and this $1.2 billion in additional costs to them will result in additional cuts in Medicaid.

There is a misconception, I believe, about this legislation, and that is, people think that because Medicare is taking over the payment for dual-eligibles—that is low-income individuals who are eligible for Medicaid but also old enough to be eligible for Medicare—since Medicare is going to take over that expense, people think this is going to save the States money.

First of all, until the year 2008 under this legislation, States do not receive any benefit from the Federal assumption of drug costs for dual-eligibles or low-income beneficiaries who currently get their prescription drugs from Medicaid. That is 5 years from now before they receive any benefit. States expecting to get savings from this bill, in the words of the National Conference of State Legislatures, will be "deeply disappointed."

In addition, this report contains what is called the clawback or the reverse block grant. This is a new concept to me, but it is a fascinating one. Instead of the Federal Government giving a block grant to the States, the Federal Government legislates a requirement on the States to give the Federal Government a block grant.

It is through this clawback or reverse block grant the Federal Government demands that States pay the Federal Government for any savings the Federal Government estimates the States might gain from the new Medicare Program.

When we take the period between 2004 and 2013, the amount the States will have to pay back to the Federal Government is $88.5 billion. Now, that is a big number, $88.5 billion. The conference report requires States to write checks to the Federal Government in the amount of $5.7 billion in 2006. This goes up to $14.9 billion in 2013. Over that 7-year period, that is a 261 percent increase in the amount the States have to pay the Federal Government.

One may ask how they go up that much. It goes up that much because the Federal Government has built into this a 15 percent compounded inflation rate, and that is being imposed on the States. The States have nothing to say about it. If the States want to participate in Medicaid, they will pay that amount back to the Federal Government.

State general revenues, tax revenues, will not go up 15 percent annually during those 7 years. So States are rightfully upset by this clawback. They rightfully point out that they are being required to now pay an inflation rate for something they do not control. The clawback, or the reverse block grant, is increasing by 261 percent over 7 years.

What this is going to do is to put increased pressure on State budgets which will result in cuts in Medicaid, cuts in education, cuts in transportation. This should not be an acceptable outcome for those of us in the Senate. The bill we sent to the conference from the Senate loaded a $10 billion burden on the States. Now that it has come back to us, it has an $88 billion burden that we are loading on the States as part of this legislation.

I would add one other point about this burden. There is a group of 20 States that have a cap that is imposed upon them through Medicaid's disproportionate share hospital program. That cap says they can receive no more than 1 percent of the total Medicaid spending in their State. That compares to 8 percent, which is the national average.

The 20 States I am talking about are called low-DSH States. New Mexico is one of those States. I authored legislation to increase that 1 percent to 3 percent, not to get it up to the national average, which would have been 8 percent, but to get it up to 3 percent. That would have allowed the disproportionate share hospitals in my State, instead of receiving $9 million a year, to receive a total of $45 million a year.

Unfortunately, the conference report cut the amount my State would receive from $45 million down to $10 million. Current law is $9 million. Under this bill, we would go to $10 million instead of going from $9 million to $45 million.

In sharp contrast, Louisiana's share of the Medicaid DSH funding goes from $500 million to $600 million next year. This is an unacceptable disparity, in my view. Louisiana's $100 million increase is more than the $43 million increase that is provided to all of the 20 low-DSH States combined. This precludes States such as mine from protecting their safety net hospitals and dealing with the fact that the uninsured rate in our States has increased by 4 million people over the last 2 years.

In conclusion, it is my view that Congress does its worst work under the circumstances we are being presented with tonight and tomorrow. It is late in the session. There is no time for adequate review of the 1,100 pages that have been put on each of our desks. We are being pushed up against a totally artificial deadline. This is not the end of the Congress. It is barely the middle of the Congress. There is no reason this bill has to be passed before we leave for Thanksgiving. We could either come back after Thanksgiving or we could take it up in January.

I have a letter from the Democratic Governors Association which says: We urge you to reject any efforts to vote on this legislation before you know its full content and cost impact on your State and the people we both serve.

This is to all Members of the Senate from the Democratic Governors Association. They go on to say: Any rush to judgment without the necessary information may have both short- and long-term consequences that could prove to be irrevocably severe.

We do not know the consequences of this legislation that we are being urged to pass tomorrow. We owe it to senior citizens in this country to understand what we are doing. We owe it to the taxpayers of the country to buy health care services for seniors without overpaying for those health care services. We owe it to the public to do all we can to reduce health care costs. Unfortunately, we are doing none of these things if we take up this bill and pass it tomorrow.

I hope Senators will join me in voting not to send this bill to the President in its present form.

I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan.

Mr. LEVIN. Mr. President, first, I commend the Senator from New Mexico for his analysis of this bill. I listened to the last part of it and I thought it was exactly on point. I particularly would like to emphasize his last point, which is that this is not the end of the Congress, this is just the end of a session, or nearing the end of a session.

With 4 days' notice of a bill of this complexity—now, I think the bill itself is about 700 pages and there are hundreds of pages of commentary that go with it, but the idea that we should take up a bill of this complexity, when seniors are just having the first opportunity after 4 days to try to fathom what is in it, is a terrible mistake.

The Senator from New Mexico was exactly right in urging that we not rush to consider this bill tomorrow and to adopt this bill. It took a great deal of effort to create Medicare. It was not until 20 years after Harry Truman first proposed the idea of a guaranteed health benefit for seniors that President Lyndon Johnson signed the Medicare Program into law. It was fitting that Harry Truman was the program's first beneficiary. He paid his $3 premium and he enrolled in Medicare in 1965.

We are confronting in this bill a turning away from Medicare's noble purpose. That purpose was to create an insurance pool for all seniors, where the risks and financial burdens are shared—not for the profit of insurance companies or pharmaceutical companies but for the common good. The legislation before us is a fundamental and ill-advised restructuring of Medicare under the guise of adding a prescription drug benefit to the program.

Many Members of Congress have worked for years to bring a Medicare prescription drug benefit to fruition. While the Senate-passed version of this bill had enough flaws to cause me, along with a number of colleagues, to vote against it, at least I was hopeful that some of these flaws would be corrected in the conference committee. Unfortunately, the prescription drug plan before us not only worsens the prescription drug program as adopted by the Senate, it has become a millstone dragging Medicare down with it.

The promise of a prescription drug plan is being used to begin the unraveling of Medicare. First, there are the dangers for seniors created by the prescription drug provisions themselves. The Congressional Budget Office estimates that up to 25 percent of retirees, with existing prescription drug coverage through a former employer, would lose that coverage under this bill's plan. That is about 2.7 million senior citizens who currently have good private insurance and are paying less now than they would have to under a Medicare prescription drug plan. That is 2.7 million retirees who will lose benefits, above and beyond the number of retirees who are projected to lose their benefits under the current trend of employers reducing prescription drug coverage for their retirees. The tax subsidies for employers included in this conference report are not enough to entice employers to keep their drug coverage for those 2.7 million retirees.

Another fundamental flaw with the prescription drug benefit in this legislation is the lack of a guaranteed Medicare prescription drug plan. In the Senate bill, in the absence of two competing private plans offering a senior a prescription drug benefit, Medicare was the fallback. This approach was gutted in conference. Here is what the conference report provides. If one insurance company in a region offers a prescription drug benefit, regardless of how unattractive it is to seniors in terms of its premiums and copayments, both of which are left up to the insurance company, and if an HMO offers coverage in that region as a substitute to Medicare, no matter how unattractive that HMO is to seniors, and assuming that HMO also offers a prescription drug benefit, the senior will not be offered the fallback Medicare prescription drug benefit.

Let me put that another way. We begin with the fact that private insurance companies offering a prescription drug policy under this bill could charge whatever premiums and copayments they want. If only one private prescription drug plan exists in a region, regardless of how unappealing it is, and one HMO offering a prescription drug plan also exists in that region, a senior has the choice of purchasing the bad prescription drug plan or leaving Medicare to join an HMO that he or she does not want to join, in order to get that prescription drug benefit. Forcing seniors to make the choice between staying in traditional Medicare or leaving Medicare and joining an HMO they otherwise would not join in order to get a prescription drug benefit is a thinly disguised attempt to unravel and privatize Medicare. That is a choice no senior citizen in America should have to make.

Also troubling is the fact that the private company which offers the prescription drug benefit, and the company which offers the managed care alternative to Medicare, can be one and the same under the provisions of this bill. In addition, the prescription drug benefit in the legislation before us has a large gap in the prescription drug coverage. Once a senior's total drug spending reaches about $2,500 for the year, he or she will have to pay 100 percent of the cost of their prescriptions until their total drug spending reaches $3,600. This has come to be called the donut hole. This coverage gap will leave many seniors to pay the full cost of prescriptions at a time when they most need assistance. I know of no other insurance program that is so unfairly structured in that way.

Adding insult to injury, while there is a gaping hole in coverage, there is no gap in the requirement to pay premiums. That obligation continues, even during the period that benefits are halted.

One of the most disturbing aspects of this legislation is the fact that private insurance companies can use the purchasing power of their large number of beneficiaries to negotiate lower prescription drug prices, but Medicare is prohibited from doing so. This is one of the most unacceptable ways this bill protects private insurance companies and prescription drug companies from fair competition from Medicare, all at the expense of seniors and American taxpayers.

Ask veterans how much prescription drugs cost at VA hospitals compared to their local pharmacy. Many of the drugs the VA offers are as little as half the price. The reason is the VA buys drugs in large quantities from drug manufacturers and has leverage in negotiating the prices. Instead of buying the 30-day supply of pills for someone on Medicare, why not allow Medicare to buy thousands of 30-day supplies at once for a fraction of the cost? That makes a lot of sense, but it is prohibited under this bill.

The conferees left out some other real solutions to address the high cost of prescription drugs. Both the House- and Senate-passed versions included a provision to allow seniors to buy drugs in other countries at lower prices, so-called reimportation provision. However, these provisions have been stripped from the final bill. Even though the House and Senate have voted to allow reimportation with strong bipartisan votes, the conferees ignored these votes. More important, they ignored the problem of high prescription drug costs. Americans pay more for prescription drugs than any people in the world. U.S. taxpayers' dollars help to subsidize the research and development of many prescription drugs. Yet drug companies then sell them abroad for less. Because this bill does not address the high cost of prescription drugs, needed medicine will still be inaccessible for millions of our citizens.

Unfortunately, the prescription drug benefit in this bill is what Newt Gingrich envisioned for the future of the entire Medicare Program. The former House Speaker said that he wanted Medicare to wither on a vine. To slowly chip away at the foundation of Medicare until it crumbles with a private network of managed care and drug companies eventually replacing Medicare is what he envisioned.

Apparently AARP, which once stood for preserving social insurance for America's seniors, agrees with Mr. Gingrich. The AARP executive director and CEO wrote the forward to the former Speaker's book entitled "Saving Lives and Saving Money," and later commented that "Newt's ideas are influencing how we at AARP are thinking about our national role and in our advocating for system change."

With this bill, the chief cooks of the Republican Party are following Newt Gingrich's "wither on a vine" recipe for the future of Medicare.

The six so-called premium support demonstration projects created by this bill are the opening act for the privatization of Medicare. Proponents argue that Medicare's costs won't come down without a private sector competitor. But this bill, while purporting to promote competition between Medicare and private insurers, tilts the playing field against Medicare. First, there is a $12 billion so-called stabilization fund, which is in reality a slush fund. It is a slush fund for insurance companies to subsidize their policies. The $12 billion in slush money is not available to traditional Medicare, only to the private insurance companies.

Second, the claims of the insurance industry that they will and must accept every senior who applies are disingenuous. Here is why. Private insurers will have the flexibility to alter and change their plans, to be able to cherry-pick the healthy senior. For example, if an insurance company designed a program with a very low monthly premium but with high copayments and high deductibles, this would be an incentive for a healthy senior to enroll, someone who could risk having to pay high copayments and deductibles because he or she has relatively infrequent medical treatment. Less healthy seniors, whose frequent medical treatments make it difficult or impossible for them to pay high copayments and high deductibles, would be left for the Medicare program to cover. This is privatization plus. It simply cannibalizes Medicare. Subsidizing insurance companies and allowing them to cherry-pick the beneficiary population means that insurance companies will be profiting mightily, while leaving the U.S. taxpayer to pick up the tab of insuring the less profitable population.

How did we arrive at this ill-conceived legislation? Democrats were all but shut out of the conference committee which wrote this bill. Only two Democrats were allowed to participate in the conference negotiations. This massive shift in Medicare's approach and purpose was delivered publicly to us about 4 days ago. In this bill's 700 pages are provisions to dismantle Medicare as we know it, replacing it with a network of private insurers and drug companies whose goal is making a profit.

There is a fundamental difference between private industry and government: Private companies fail if they do not make money, while government fails if we do not help citizens—especially those that cannot help themselves.

I have heard from many of my constituents in the State of Michigan who need help in getting affordable prescription drugs. Let me read you a few excerpts from letters that I have received on this issue. One constituent writes:

> I am writing for your support for the Medicare Program. Please provide a Medicare drug benefit that is comprehensive, affordable and secure. Do not undermine Medicare as a defined benefit program through privatizing it.

Another constituent writes:

> We do not want a drug bill that eliminates or reduces our current prescription plan that we now have . . . When I retired . . . this plan was part of my benefit package and we felt that it is their obligation to continue it, and the cost of our drugs should not be passed on to the tax payers.

I get hundreds of messages a week like that from constituents with concerns over the privatizing of Medicare and the possible loss of existing prescription drug benefits. It is estimated that this bill, if it becomes law, would cause 138,000 seniors in Michigan currently receiving prescription drug benefits to lose some or all of those benefits. And 90,000 seniors in my State who are Medicaid beneficiaries with a current prescription drug coverage will be worse off if this bill becomes law than they are under current law.

A fundamental restructuring of Medicare of this magnitude demands careful and thoughtful deliberation. The conference report contains a large amount of new material not included in either the House-passed or Senate-passed bills. Hastily acting on this legislation is fundamentally unfair to millions of seniors who want and deserve to be treated fairly. I predict that when seniors become familiar with this bill's details, there will be a crescendo of opposition.

The siren song you hear now principally from our Republican colleagues is that competition is necessary to drive the cost of health care down. The reality of this bill is not competition but government subsidies for insurance companies while allowing them to carve out the most profitable segment in the business—caring for the healthiest—leaving the seniors with greatest need as the responsibility of the Federal government. Privatizing the most profitable part with a subsidy is not competition; it is a huge gift to private companies at the expense of the U.S. Treasury.

Supporters of this legislation say they are harnessing the power of the marketplace to drive down prices. The reality is just the opposite. They are hobbling the Medicare program in the prescription drug program by letting the private provider use its purchasing power to drive down its drug prices, but not letting Medicare do the same; and in the dismantling of Medicare, by pushing people out of Medicare into private HMOs in order to obtain a prescription drug benefit.

The bill before us will begin undoing 37 years of progress in Medicare. It is an ill-advised assault on the one program that guarantees medical care to our most vulnerable population, our senior citizens. An historic opportunity is being squandered if we adopt this bill. Our Nation's seniors deserve better. I yield the floor.

ADJOURNMENT UNTIL 9 A.M. TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 9 a.m. tomorrow morning.

There being no objection, the Senate, at 10:45 p.m., adjourned until Monday, November 24, 2003, a 9 a.m.

EXTENSIONS OF REMARKS

H.R. 2417, THE FISCAL YEAR 2004 INTELLIGENCE AUTHORIZATION CONFERENCE REPORT

SPEECH OF

HON. BETTY McCOLLUM

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Ms. McCOLLUM. Mr. Speaker, it is with great dismay that I rise to oppose H.R. 2417, the Fiscal Year 2004 Intelligence Authorization Report.

The Republican Leadership inserted a controversial provision in the FY04 Intelligence Authorization Report that will expand the already far-reaching USA Patriot Act, threatening to further erode our cherished civil liberties. This provision gives the FBI power to demand financial and other records, without a judge's approval, from post offices, real estate agents, car dealers, travel agents, pawnbrokers and many other businesses. This provision was included with little or no public debate, including no consideration by the House Judiciary Committee, which is the committee of jurisdiction. It came as a surprise to most Members of this body.

It is of great concern that the Republican Leadership, along with the Administration and Attorney General Ashcroft, would seek to include such a non-germane, controversial provision into what should otherwise be a nonpartisan bill. Furthermore, the Republican Leadership, in the Senate defeated an attempt to "sunset" this provision when they considered it. It is clear the Republican Leadership and the Administration would rather expand on the USA Patriot Act through deception and secrecy than debate such provisions in an open forum. The freedoms and civil liberties of the American people are too important to allow such an irresponsible, abusive power play by the Majority.

The importance of our intelligence community has grown significantly in the wake of the September 11th terrorist attacks and the subsequent, continuing campaign against terrorism. The FY04 Intelligence Authorization Report includes a number of positive, beneficial provisions designed to improve our counterintelligence capabilities, strengthen our ability to share information between the federal government, local and state officials, and provide for our intelligence officers and their families. It is unfortunate that such a controversial provision had to be included.

MATT KENSETH

HON. TAMMY BALDWIN

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Ms. BALDWIN. Mr. Speaker, I rise today to recognize Matt Kenseth, a native of Cambridge, Wisconsin, for clinching the NASCAR Winston Cup Championship after placing fourth at the Pop Secret 400 at North Carolina Speedway on November 9, 2003.

Matt began working on his father's racecar when he was thirteen years old, and then he got the chance to start racing at the young age of sixteen. As a sign of his early talent for the sport, Matt was racing competitively by the age of nineteen. He moved up quickly to the ultra-competitive Wisconsin Late Model ranks, and he became the youngest winner ever in ARTGO Challenge Series history.

After driving the American Speed Association's ACDelco Challenge Series, Matt received a call from Robbie Reiser to drive his Busch Series car. In the NASCAR Busch Grand National Series, Matt excelled in his first full year by finishing second in the points battle. As a tribute to his success, he was called to substitute for Bill Elliott in the elite NASCAR Winston Cup Series at Dover Downs in September of 1998. This was his first start against the biggest names and greatest stock car drivers around, and Matt finished an impressive sixth place. The motorsports world certainly took notice of Matt in 2000, when he took the Winston Cup scene by storm winning the Raybestos Rookie of the Year Award.

This year, in his fourth season in NASCAR's top stock car series, Matt's commitment and consistency paid off because with one win, eleven top-five finishes, and twenty-five top ten finishes, he was able to take the Winston Cup title. Matt's achievements certainly have brought out the community pride and hometown spirit in Cambridge and across Wisconsin. He is a hero to countless young aspiring drivers, and he has shown why with his dedication through this long and challenging season. This December, he and his team will deservingly sit at head of the head table at the Waldorf-Astoria.

Mr. Speaker, I am proud to rise today to honor Cambridge Native Matt Kenseth for his accomplished racing career and his recent NASCAR Winston Cup Championship title.

INTRODUCTION—OFFICE OF OCEAN AND COASTAL POLICY CREATION ACT OF 2003

HON. JIM SAXTON

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. SAXTON. Mr. Speaker, I am pleased to be here today to introduce an important piece of conservation legislation, the Office of Ocean and Coastal Policy Creation Act of 2003. This bill establishes in the Executive Office of the President, an Office of Ocean and Coastal Policy. I believe this Office will serve as a valuable complement to the environmental offices and agencies that currently exist, and will provide a unique perspective on the direction we ought to be moving in with regard to comprehensive ocean policy.

An issue to which I have devoted a great deal of time and one that I feel is very important is the protection of the diverse range of fish stocks that inhabit our world's oceans, many of which are very close to disappearing forever. Given the recent release of two studies essentially stating that what I have been talking about is likely to happen, I am more convinced than ever that we need to take aggressive action immediately. Many of our oceans' fish stocks are now reportedly 90 percent depleted, meaning only 10 percent of the stocks that once existed remain. And many of these stocks are in grave danger of extinction if we proceed down the same path we are on now—that is, continue to study these stocks and do little to mitigate the damage that has already been done.

One of these two studies recently published was conducted by Dalhousie University, in Halifax, Canada, stating that the global ocean has lost over 90 percent of its large predatory fishes, such as tuna, swordfish and marlin. I have long known that the use of pelagic longline gear is one of the most, if not the most destructive, indiscriminate way to fish. A direct result of the use of this geartype, starting in the early 1960s, has provided for the almost complete disappearance of white marlin. Though not the target species of longline gear, marlin are a bycatch species, meaning that this geartype catches whatever eats the bait, and as the lines are left in the water overnight, any fish that bites onto a hook is more likely than not dead by the time the lines are pulled in, killing not only the target species, which is primarily swordfish, but also marlin or turtles or sharks or even small whales that happen to take the bait.

The U.S. Commission on Ocean Policy, created from my Oceans Act of 2000, has it's own report forthcoming on the status of our oceans, it will be interesting to see what conclusions they put forward.

The National Marine Fisheries Service, the agency tasked with the protection of these

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.
Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

species has failed to do so. The United States is a world leader on so many important and complex issues; it is hard to understand why the issue of fisheries management, and enforcement of the regulations currently in place both domestically and internationally, seems impossible to accomplish.

We need to take immediate aggressive steps to prevent the disappearance of these fish species, before it's too late. These studies should be a wake-up call that the process through which our world's fisheries is managed is broken and needs to be fixed.

This is an issue that resonates with anyone who has ever been to the beach in states like New Jersey, or watched a television program involving the deep blue sea. And given that 50 percent of the population of the United States lives within 100 miles of a coast, there are many who are personally affected by this issue. We have a unique opportunity to do something amazing and I think we owe it these wonderful resources that are our oceans to do all we can to bring them back to a healthy and sustainable level, for future generations. I look forward to working with this unique Office on Ocean Policy to preserve these magnificent resources.

HONORING THE ST. LOUIS GATEWAY CLASSIC SPORTS FOUNDATION

HON. WM. LACY CLAY

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. CLAY. Mr. Speaker, I rise today to pay tribute to the St. Louis Gateway Classic Sports Foundation for its commitment to providing academically average youth in St. Louis with the opportunity to attain a valuable college education. Since 1998, the St. Louis Gateway Classic Sports Foundation has striven to even the educational playing field by giving generously to hard-working students.

The Foundation is sending a clear, unmistakable message to urban youth that someone does care about them by believing in them and financially supporting their goals of attaining a valuable college degree.

Mr. Speaker, it is with great privilege that I recognize the St. Louis Gateway Classic Sports Foundation today before Congress. The Foundation was recently honored in an article published in the Baltimore Sun. I would like to share this article with my colleagues which further details its dedication to providing a vital contribution to our youth by helping to produce an educated society.

[From the Baltimore Sun, Nov. 9, 2003]

BLACK SCHOLARSHIP PROGRAM HELPS "PEOPLE IN THE MIDDLE"; MO. FOUNDATION REWARDS THE ACADEMICALLY AVERAGE

(By Mike Bowler)

Don't even dare dream about college, a guidance counselor warned Leonard Woodson. With your mediocre academic record, you'll be lucky to survive high school.

The counselor was wrong. It took Woodson an extra semester, but next month he'll graduate from Lincoln University in Jefferson City, Mo., with a B average—and no college debt. All his costs were covered by a St. Louis foundation that rewards academically average students in financial need.

"It took me two hours to do what my fellow students could do in an hour, but I learned to survive in the world," says Woodson, 22. Unable to keep up taking notes, he recorded lectures and played them back in his dorm room.

Woodson is one of about 50 graduates of St. Louis-area high schools who have received full scholarships to historically black colleges and universities since 1998. The foundation raises the money, in part, by sponsoring an annual football "classic" between black college teams, devoting the proceeds to scholarships and other charities.

"Average kids don't get a chance because everybody gives to the cream of the crop," says Earl Wilson Jr., a retired IBM executive who established the foundation a decade ago. "It's our way of giving back to the community."

Wilson, 71, began his IBM career as one of the company's first black salesmen. He says he understands students in the middle. "Myself and many of my colleagues were average students or worse," he says. "People at the extremes get help. People in the middle don't."

Lawrence A. Davis Jr., chancellor of the University of Arkansas at Pine Bluff, whose Golden Lions play in the annual fall classic, agrees. "The world is run by average people," he says. "We reward people who can run fast, jump high and throw balls through holes. The least we can do is help those who might not be academic stars but who are willing to work hard."

"It's the trickle-up theory," says Sylvester Brown Jr., a columnist for the St. Louis PostDispatch. Brown defends Wilson against charges from another St. Louis writer that he's "creating dumbness" by so generously supporting less-than-stellar scholars.

"I'd much rather see Earl spend $10,000 on one scholarship than give $1,000 scholarships to 10 students," says Brown. "What he's saying by doing it this way is that we have enough faith in you to support you for four years. You have no financial worries. All you have to do is focus on being great."

The foundation distributes application forms to high school guidance counselors, and uses radio and print advertising to get the word out. Winners are chosen by a committee of educators and others who review the applications and interview applicants. "I stay completely out of the selection process," says Wilson. Sixteen recipients are currently attending college through the program.

Since the foundation began giving scholarships 5 years ago, the champion recipient is Dedree Smart, 23, who went to Howard University in Washington. "I have been so blessed," she says. "There's no way I could have afforded Howard. I didn't have to worry about anything financially, so I could concentrate on my grades. I went from a low B average in high school to graduating magna cum laude."

Smart earned her degree last year and is back in Missouri, working as special events coordinator for the State's public university system. "I am so elated, so grateful and so proud of my baby," says her mother, Delores Smart.

Wilson says the foundation carefully monitors the scholarship program. "The ones who finish college almost always get better grades" than they did in high school, he says.

"These are the late bloomers," says Irving Clay, 78, a former city alderman who sits on the foundation's board. "I and Earl, we grew up in tenements about 10 blocks from here. We all know what it's like to struggle. We know late bloomers."

But the scholarship program has had its failures and setbacks. About 40 percent of recipients have washed out, and since Smart's graduation, the foundation has dropped Howard and Virginia's Hampton University because of their high, private-college tuition.

Then, too, some scholarship recipients "haven't so much as said thank you," Wilson says. "That's a real disappointment." He expects them to send him an invitation when they graduate, and he wants all recipients—and their parents—to sell tickets to the annual classic.

In addition to the football game, which Wilson estimates has generated $3.5 million in 10 years, the foundation raises money through charity golf and high school basketball events. Last year, it opened a $2.8 million sports complex near downtown St. Louis that includes a computer laboratory for after-school tutoring and a "Walk of Fame" featuring prominent local African-Americans.

About 20 percent of foundation revenue comes from corporate sponsors such as Anheuser-Busch Inc., whose brand name Budweiser is attached to the football game.

"We raise 80 percent ourselves," Wilson says. "That's extremely high for a foundation like this. We are all about self-help. We don't want anyone interfering with our independence."

That attitude has rankled some in the St. Louis business community, says Brown, the newspaper columnist.

"Earl doesn't go begging in the business community, and that rubs some people the wrong way. He says [racial] integration is a wonderful thing, but we have to take care of our own. That's his integrity. Every year, he beats his head against the wall trying to fill the [Edward Jones] dome, every year he doesn't do it, and every year he smiles and says we'll do it next year."

St. Louis' only historically black institution, Harris-Stowe State College, doesn't have a football program, so the Gateway Classic turns to regional schools for the annual competition. In recent years, Arkansas-Pine Bluff, about seven hours away by car, has become a permanent contestant, its opponents rotating among Kentucky State University and others. The Classic weekend features band competitions, street parties and lunches with African-American sports figures.

"It's all generated by Earl," says Julius Dix, 74, a retired St. Louis school administrator who sits on the selection committee. "He's a born salesman. He could sell you anything."

Davis, the UAPB chancellor, says the annual event is "really great for our university. We bring in hundreds for the game. It's great visibility for us and our students. It's like a second homecoming."

Several Gateway scholarship students have enrolled at Pine Bluff, including two with the title Miss Gateway Classic. These are young women who prevail in a pageant after their junior year in high school and preside as Miss Gateway Classic as seniors, making appearances around St. Louis at foundation-sponsored events.

The pageant is partly a beauty contest [with evening gowns but not bathing suits] and partly a contest of brains and poise, says Janell Wallace, the 2002 winner, who is attending Pine Bluff on a $40,000 Gateway Classic scholarship.

"I had to write an essay and answer questions on current events. I had to learn etiquette and how to walk and speak publicly and keep calm. That's helped a lot here," she says.

For Wallace, 18, who had never been away from St. Louis for more than two weeks, college has been "awesome and at times scary," she says. "Everything seems a lot bigger. Even the bugs are bigger. I never killed bugs; that's what you have a daddy for."

But classes at UAPB are smaller, she says, than they were at Hazelwood Central High. In the first couple of months of school she has become active in student government. She plays softball, and she has joined the modeling squad, a group that puts on fashion shows.

"There were a couple of times I wanted to give up and go home," she says. "But I'm beginning to feel complete now. I never felt that way in high school."

THANKS DIANA "TOODLES" HAUF

HON. JOHN T. DOOLITTLE

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. DOOLITTLE. Mr. Speaker, today my colleagues Mr. POMBO, Mr. OSE, and Mr. MATSUI and I wish to express warm thanks, congratulations, and best wishes to Diana "Toodles" Hauf upon her retirement as Executive Services Director and Concierge for United Airlines, at the Sacramento International Airport. With an always helpful and pleasant demeanor, Toodles went above and beyond, ensuring the utmost in customer service for those passengers so fortunate to be assisted by her.

Toodles began her 34-year career with United Airlines in Buffalo, New York, on April 28, 1969, where she began as the Station Manager Secretary. In a few short years, Toodles was given the opportunity to relocate to Sacramento, California to assist in the opening of the Red Carpet Club where she continued to serve until it closed ten years later. In 1984, Toodles was named Executive Services Director for Premium Travelers. Noted for her outstanding organization and leadership, Toodles has provided exemplary service to numerous Federal and State Representatives, State and Local Officials and Dignitaries. In addition to these responsibilities, Toodles directed the advance travel preparations for Former Governor Deukmejian, Former Governor Wilson, and Former Governor Davis. Toodles continued to facilitate superior customer service as the Executive Services Director and as a Concierge until her retirement.

Throughout her outstanding career with United Airlines, Toodles has received numerous accolades for exceptional service. Most notable, in 1988, she received the Airport Services Award, the Most Valuable Players Exemplary Service Award, and the Regional Award. In 1997, her hard work and dedication were again recognized with the Division Award. Furthermore, in addition to the above mentioned acknowledgements, Toodles received two gold medal medallions for safety and customer service.

Although Toodles' tenure with United Airlines has come to a close, her professional endeavors will continue to thrive as she embarks on a new career with Lyon Realtors in Roseville, California. We are certain that the talents and skills that allowed her to excel while at United Airlines will serve her just as well in her new career.

Toodles' vivacious and dynamic personality will truly be missed. We thank Diana "Toodles" Hauf for her outstanding service and wish her well in the future.

HONORING DOC STEWART

HON. TOM UDALL

OF NEW MEXICO

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. UDALL of New Mexico. Mr. Speaker, I am honored to have the opportunity to express my heartfelt appreciation and congratulations to Doc Stewart, one of the treasures of Eastern New Mexico. Considering all that Doc has done for Clovis and the surrounding communities, how very appropriate it is that November 21, 2003, has been designated "Doc Stewart Day." I salute Doc with great honor and respect.

It would be very difficult to mention all that Doc Stewart has done to further the success of Clovis and the smaller communities that depend on the services this eastside hub provides. In addition to the vital importance of such as the excellent public schools, the business community and the agriculture industry, of great significance is Cannon Air Force Base. Doc has worked tirelessly for many, many years to ensure the continuation of this military presence on the eastside of New Mexico. In addition, he has always been extremely aware of how critical a congenial and productive relationship is between the air base personnel and the local residents. Doc's business acumen, keen insight, delightful personality and affable manner always served the community well in this effort.

Doc knew early on that Cannon was a key player in the economic health of Clovis. His exceptional efforts as a member of the Committee of Fifty have clearly demonstrated Doc's sincere interest and concern for the betterment of his fellow residents. Even though managing his own successful business required much of his time, he always made himself available to be involved in activities that were critical in retaining the presence of Cannon Air Force Base, whether those be local, state or national.

Doc Stewart is an outstanding member of his community and our state. Not only has he been dedicated to the efforts of the Committee of Fifty, his additional involvement in community service has been invaluable. I invite my colleagues to join me in extending best wishes for a job well done and continued success in all Doc's future endeavors.

HONORING GUY D. BRIGGS

HON. DALE E. KILDEE

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. KILDEE. Mr. Speaker, I rise before you today to honor one of General Motors Corporation's (GM) finest, Mr. Guy D. Briggs, who is retiring as GM's Vice President of Manufacturing after 43 years of distinguished service on December 31, 2003. To recognize his accomplishments, Guy will be honored during a plant wide celebration to be held in his honor at the Truck and Bus Plant located in Flint, Michigan on December 1, 2003.

Guy D. Briggs received a bachelor's degree in economics and an M.B.A. from the University of Michigan in 1960 and 1961, respectively. Upon graduating he hired in at General Motors Corporation (GM) as a college graduate in training, and was assigned to the Chevrolet Manufacturing Plant located in Flint, Michigan. While working at the Chevrolet Plant, Guy held several supervisory positions. In 1969 he was selected for the Chevrolet Executive Development Training program. Once he completed the program he returned to his plant as the superintendent of manufacturing. In 1973 GM assigned Guy to the former Chevrolet Parts Plant, located in Saginaw, Michigan to assume the role of general superintendent of production, and a year later he transferred to the Saginaw Manufacturing Plant holding the same position. In September of 1975, Guy was appointed to the position of superintendent of production at the Saginaw Grey Iron Casting Plant, a position he maintained until 1976 when he was promoted to manager of the Chevrolet's Pressed Metal Plant located in Parma, Ohio. After his stint away from home, Guy returned to Flint, Michigan in 1978 to become manager of the Chevrolet Engine Plant and to complete the Dartmouth College Executive Development Program, which subsequently led to his promotion in May of 1983 to regional manufacturing manager, and then to acting general manufacturing manager for Chevrolet. In February of 1984, he became the manufacturing manager at the former Chevrolet-Pontiac-GM of Canada Group. From 1985 to 1991, he was vice president in charge of manufacturing operations for GM's Saturn Corp. subsidiary. In 1991, Guy was elected vice president of GM and appointed group director of operations for the truck group. In 1996 he was named vice president and general manager of the GM truck group until 2001 when he became vice president and general manager of vehicle manufacturing. Effective May 1, 2003 Guy was appointed GM vice president of manufacturing, his new role will allow him to continue to work with the manufacturing leadership team to provide support during the 2004 model-year product launches and the 2003 Labor negotiations. Guy is currently the Chairman of the board for the Oakland County (Michigan) Traffic Improvement Assoc., and a member of the Bishop International Airport Authority board of directors, Executive Board member for the Detroit Area Council of Boy Scouts and GM's key executive for the University of Wisconsin.

Guy Briggs has spent his entire career ensuring that GM remains the best in the world.

His loyalty to GM is evident by the number of moves he and his family have made. Aside from being an automotive enthusiast, Guy is a humble family man. He is a devoted husband to his lovely wife Karen and a devoted father to his five children. During his tenure Guy has earned the respect of his Company and its employees. He has a strong love for the Automotive Industry and Flint, Michigan.

Mr. Speaker, as a member of Congress, I ask my colleagues in the 108th Congress to please join me in congratulating my constituent and my dear friend, Guy Briggs, on his retirement, and wishing him and his family the best in future endeavors.

IN RECOGNITION OF L. JOEL MARTINEZ

HON. CHRIS BELL

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. BELL. Mr. Speaker, I rise to honor the life of L. Joel Martinez, a nationally known AIDS activist who died Wednesday, November 12, 2003. Mr. Martinez was the founding director of the Center for AIDS, a Houston-based clearinghouse for treatment and research information. The center was founded in 1995 to address the lack of treatment and research information available to the public.

Joel Martinez had a profound effect on the way pharmaceutical companies developed their drugs and the way they looked at issues relating to people with HIV and AIDS. He met with companies to help change the guidelines for clinical trials and encouraged them to do research and testing in Houston. He urged companies to test drugs not just on gay, white males, but also on minorities, women and children.

He was an excellent and articulate spokesperson for people with HIV and AIDS and a true leader in treatment advocacy issues. Mr. Martinez was a community representative for amFAR and the AIDS Clinical Trials Group. He also was a voting member of a U.S. Food and Drug Administration advisory committee that influenced the way the agency reviews drugs during the approval process.

Most recently, he was involved in the AIDS Treatment Activists Coalition, a national coalition of activists working to end HIV and AIDS by advancing research.

Mr. Martinez was born in Harlingen, Texas in 1953 to Luis and Teresa Martinez. He was salutatorian of the class of 1970 at Brownsville High School. A Rice University graduate, he earned a law degree from the Columbia University School of Law in New York in 1977.

He was an associate at Vinson & Elkins for six years before going into private practice in 1983. He re-evaluated his life after he was diagnosed with HIV in 1987. In the early 1990s, the focus of public information on HIV and AIDS was on prevention and not on treatment and research. Mr. Martinez set about to improve public information by making numerous presentations on HIV and AIDS and by writing many articles in English and Spanish on research and treatment of the disease. His significant influence on HIV and AIDS research and treatment helped so many people affected by the disease.

I know my colleagues join me in honoring Joel Martinez for his exceptional life and passionate activism. I extend my heartfelt condolences to his family and friends especially to Vann Vaughan, his life partner of twenty-two years, his mother Teresa, his sisters Rebecca and Zoe, and his brother Harry. Joel Martinez was a great American who fought tirelessly for those in need. His important work must continue until a cure for HIV and AIDS is found.

CHIEF FINANCIAL OFFICER FOR THE GOVERNMENT OF THE VIRGIN ISLANDS

HON. DONNA M. CHRISTENSEN

OF THE VIRGIN ISLANDS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mrs. CHRISTENSEN. Mr. Speaker, I rise today to introduce legislation to create the position of Chief Financial Officer for the Government of the Virgin Islands. It is my hope and intention that by temporarily placing the reins of fiscal management of the Virgin Islands government outside of the political arena we will be able to end years of crisis management and place the islands on sound financial footing for the long term.

Mr. Speaker, my beloved community, has been plagued over the years and several administrations, by one economic or fiscal crisis after another. If allowed to continue or recur, they have the potential of forcing us into total fiscal collapse.

The factors which have caused these crises are numerous and include among other things: the decline in our tourism sector due to the demographic shift from cities of the Eastern Seaboard to areas in the West and Midwest; being hit by as many as 6 catastrophic hurricanes since 1989; and the fact that the territory's geography mandates a large government workforce and necessitates the replication of many basic services.

When the current administration of Governor Charles W. Turnbull took office in January of 1999, the territory was in a fiscal state of enormous and alarming proportions.

While Governor Turnbull is to be commended for his response to that crisis and the succeeding ones he has faced, because of the special and unique burdens we face, history informs that the necessary political resolve to put measures in place to address these problems, some of which will call for public sacrifice, is best found and sustained outside of the political process.

It is for this reason that I am introducing the Virgin Islands CFO Act today. The CFO will be empowered to oversee and approve all spending of the government of the Virgin Islands and be authorized by law to disapprove items of spending which would send the government into financial deficit. The CFO position would sunset after five years and while he or she would be appointed by the Governor of the Virgin Islands from a list of names selected by a search commission, and confirmed by the Legislature, he or she will not be an "at-will" employee of the government and could only be removed for cause.

Mr. Speaker, this is not an easy bill for me to introduce, but it is a necessary one at this time. It is an action that I feel is in the best interest of all of my constituents and the responsible course of action for me to take. I ask for my colleagues support.

CONGRATULATING EDWARD ROBINSON

HON. PETER J. VISCLOSKY

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. VISCLOSKY. Mr. Speaker, it is with great sincerity and enthusiasm that I rise to congratulate Mr. Edward Robinson on his retirement from The Community Hospital in Munster Indiana, where he served as the Hospital Administrator for 37 years. Mr. Robinson has been a substantial fixture of the health care community in Northwest Indiana and he will be greatly missed.

Ed Robinson attended the University of Pittsburgh after receiving a highly competitive four-year scholarship from the American Legion. After the completion of his undergraduate college degree he was designated as a Distinguished Military Graduate by the United States Air Force in 1950, when he received his commission.

With his commission, Ed served as a Captain in the United States Air Force for three years and was stationed in Korea with the Fifth Air Force and was also a staff officer for the personnel at the headquarters of the Eighth Air Force, Strategic Air Command.

Knowledge has always been something valued by Ed. He holds a Master's Degree in Hospital Administration from the Graduate School of Public Health of the University of Pittsburgh, as well as a Master of Business Administration and a Bachelor of Arts Degree from the same institution. Mr. Robinson was awarded on Honorary Doctor of Laws Degree from Calumet College in May 1997.

Ed's career as a health care professional has been multifaceted and world-renowned. He has been published in numerous professional journals and received first prize in the "Hospital Topics" editorial National-wide competition for his thesis on "Nursing Staffing Pattern in an Intensive Care Unit." Ed is also a Fellow of the Royal Society of Health in London, England. As a member of the program committee of the Atlantic Economic Conference, an international group, he has presented papers in Paris, Rome, Puerto Rico, Scotland, and Munich on various hospital economic topics. He has been a presenter at numerous seminars with John Goodman and Associates regarding Hospital Based Heart Centers.

Nobly, Ed has committed a life of service to Northwest Indiana through his work in the health care community. He has received the Meritorious Service Award from the Munster Board of Trustees and a Special Award for Outstanding Leadership from the Munster Medical Research Foundation. He is also a founding member of the Board of Directors of Community Foundation, Inc. and the President of the Board of Directors of Hospice of the

Calumet Area. He has also shared his time with Board of the Northwest Indiana Symphony, as well as serving as Co-Chairman of the Community Veterans Memorial Park in Munster.

Mr. Speaker, Ed Robinson will be greatly missed at The Community Hospital by all of those who have served with this caring and compassionate man. At this time I ask that you and my other distinguished colleagues join me in honoring and congratulating Mr. Robinson for an outstanding career, not only in health care, but also in service to his community. Ed's leadership and passion for his career are to be commended, and his professional absence from the Northwest Indiana community will surely be missed.

TRIBUTE TO WILLIAM (BILL) LYONS, JR.

HON. DENNIS A. CARDOZA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. CARDOZA. Mr. Speaker, I rise today to pay tribute to Secretary William (Bill) Edward James Lyons, the V for his service to our Nation and to his community. Bill was born in Modesto, California to William, the IV, and Mary Lyons on July 4, 1950. He attended school at Modesto High School in Modesto, California. Bill then attended college at California State University, Chico where he received his bachelor's degree and secondary teaching credential.

Throughout his career Bill has become a well-respected leader in the field of agriculture and is consistently sought out for his expertise. Appointed by Governor Gray Davis and confirmed by the California State Senate, Bill Lyons, Jr. served as the Secretary of the California Department of Food and Agriculture, from January 1999 to November 2003. As a rancher and businessman, Bill brought nearly three decades of leadership and business expertise to the department. As Secretary, Bill was responsible for a Department of 2,300 employees, and a budget of $250 million. Secretary Lyons' key responsibilities included policy development and implementation of programs that support California's $27 billion agricultural industry. He was responsible and successful in implementing the marketing campaign of the "Buy California" program in the state. While Secretary, Bill served as president of the Western Association of State Departments of Agriculture, chair of the Specialty Crop Task Force for the National Association of State Departments of Agriculture, and chairman of the Agricultural Worktable for the U.S.-Mexico Border Governors' Conference.

In California's great Central Valley, the Lyons family has been engaged in production agriculture for more than 75 years. Secretary Lyons managed the 6,000-acre ranch located in the Modesto area from 1976 to 1999. The ranch produces a number of crop and livestock commodities.

Bill currently serves as a member of the California Water Commission and on the Board of the California Department of Food and Agriculture. From 1993 to 1999, Bill served as chairman of the USDA's Farm Service Agency state committee. Bill was also appointed by the Stanislaus County Board of Supervisors to serve from 1996 to 1998 as founding director of the East Stanislaus and Toulmne County USDA Agriculture Stabilization and Conservation Service Committee, and the Stanisulaus/San Joaquin Counties' Cattlemen's Association.

Bill is a widely respected member of his community and has greatly contributed to his state and nation. The USDA has honored Secretary Lyons on three occasions: in 1998 with a certificate of appreciation; in 1997 with an award for excellence; and in 1996 with a national environmental award. In 1995, the California Farm Bureau Federation recognized him with a service award. The United States Jaycees named him the Outstanding Young Man of American in 1984 and both the City of Modesto and Stanislaus County has awarded him with various service commendations. In addition, California State University at Chico awarded Bill in 2000 with a Distinguished Alumni Award.

Secretary Lyon's illustrious career also includes various elected office positions in Stanislaus County such as: Member of the Central Catholic High School Board of Directors, Chairman, Doctors Medical Center, and Director, Modesto Irrigation District. Bill also worked as a Religion teacher at Saint Stanislaus elementary school, in Modesto California.

Throughout his lifetime, Secretary Lyons has demonstrated a deep commitment to community service. Throughout the years, he has worked with countless community organizations such as the Salvation Army, United Way, American Cancer Society, the Modesto Chamber of Commerce, and Camp Sylvester, a local youth camp. Additionally, he has coached sports teams for nearly two decades.

It is my pleasure to join the Stanislaus community in recognizing Secretary Bill Lyons, Jr. for his commitment to his community, state and nation. I have personally known the Lyons family for over two decades. Bill Lyons, Jr. and the entire Lyons family have a passion for California agriculture and for the values of hard work and community service in the San Joaquin Valley. Bill is a trusted and dear friend. I look forward to our continued friendship and to his wise counsel, and know that Bill's future path will continue to benefit California agriculture and all of us in the San Joaquin Valley. It is a pleasure to represent Bill and the entire Lyons family in the 18th Congressional District of California.

FLAWED ELECTIONS IN THE CAUCASUS

HON. CHRISTOPHER H. SMITH

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. SMITH of New Jersey. Mr. Speaker, as we approach the end of session, I would like to take note as Helsinki Commission Chairman of a very disturbing trend in the Caucasus republics of Armenia, Azerbaijan and Georgia. At this very moment, thousands of Georgians are engaging in a campaign of civil disobedience in the wake of the November 2 parliamentary elections. Georgian and international monitors registered large-scale falsification and ballot stuffing, not to mention the exclusion of many thousands of eligible voters. When the Central Election Commission gave the largest tallies to President Shevardnadze's party and the nominally-opposition but Shevardnadze-allied Revival Party, opposition leaders organized large demonstrations in Tbilisi's main street. There, in the rain and cold, protesters spent days demanding the President's resignation and new elections.

Their efforts, born of rage and despair, have been peaceful and the authorities have so far acted with restraint. But Georgia faces a genuine crisis, make no mistake. After ten years of growing frustration at official incompetence and corruption, the country's impoverished public has begun to resist business as usual. Eduard Shevardnadze, still lionized in the West for helping to end the Cold War as Soviet Foreign Minister, has long been deeply unpopular at home. Demands by successive U.S. administrations and international financial institutions to curb pervasive corruption have gone unheeded. And the November 2 election was a harbinger of the presidential race in 2005, when Shevardnadze will not be eligible to run. All participants and analysts agree that the outcome of this year's parliamentary contest will influence the coming succession.

How the Georgian drama will play itself out is hard to predict. But it is clear that Georgia is not alone in suffering through a crisis of trust and legitimacy. On October 17, Azerbaijan held presidential elections that, according to OSCE observers, did not meet international norms. Serious clashes between opposition backers and the authorities erupted in which at least one person was killed and hundreds were injured. Law enforcement agencies arrested hundreds of opposition activists; though most have since been released, according to human rights groups, many were beaten in detention. The Azerbaijani election, moreover, marked the transfer of power from President Heydar Aliev to his son, establishing the first family dynasty in the former Soviet Union. But Ilham Aliev has begun his term under a shadow, tainted by an election seen as unfair inside and outside the country and marred by the accompanying violence.

Earlier this year, Armenia held presidential elections in February and parliamentary elections in May that also fell short of OSCE standards. In February, thousands of protesters marched in the snowy streets of Yerevan; perhaps their numbers kept President Robert Kocharian from claiming a first round victory and forced him into a runoff—a first for a sitting president in the Caucasus. Between the two rounds, however, the authorities detained some 200 opposition campaign workers and supporters. On election day, they did whatever was necessary to win in a landslide. The final judgement of the OSCE election observation mission was that "the overall process failed to provide equal conditions for the candidates. Voting, counting and tabulation showed serious irregularities, including widespread ballot box stuffing." The Armenian Assembly of America on March 18 noted that "the people of Armenia deserved nothing less than the declared aim of their government for free, fair and transparent presidential elections. As reported in depth by the OSCE, this achievable standard was not met."

There was some improvement in the May parliamentary contest, concluded the OSCE, especially in the campaign and media coverage. Nevertheless, the election "fell short of international standards . . . in a number of key respects, in particular the counting and tabulation of votes."

In sum, Mr. Speaker, a discouraging and disturbing record for all three countries, marked by a consistent pattern of election rigging by entrenched elites who have learned that they can "get away with it." The international community is prepared to register disapproval, by proclaiming these elections—in diplomatic language, to be sure—short of OSCE norms. But there have never been any other consequences for subverting the democratic process. Nor have opposition parties anywhere been able to annul or change the official results of a falsified electoral process, or even compel governments to negotiate with them.

Perhaps Georgia, where the state is relatively weak and discontent widespread, will prove the exception—although it is alarming that President Shevardnadze has sent his sometime rival Aslan Abashidze, who runs the region of Ajaria like a Central Asian potentate, north to gain Moscow's support. The prospect of Russia propping up a shaky, illegitimate Georgian Government should send shivers down the spine of any American. But until and unless an opposition movement registers some tangible success, the men in charge of the destinies of Armenia, Azerbaijan and Georgia have no reason to change course. What they are doing works and it benefits them, even if it harms their countries' chances of developing democracy.

Even worse, there is little reason to expect changes for the better. For years, optimists maintained that however discouraging things were, time and constant pressure from Washington and the international community would bring gradual change. As we approach 2004, the 13th year of independence for the former Soviet republics, that prognosis seems increasingly pollyanish. The consolidation of ruling groups, determined to remain in power, in control of the state's law enforcement and judicial agencies, and disposing of significant wealth, makes gradual evolution towards a genuinely democratic mentality and practices ever less plausible. Instead, we see evolution towards what some analysts call "semi-authoritarian" states and others, with reference to the Middle East, term "liberal autocracies."

Mr. Speaker, this admittedly depressing analysis leads to several worrisome conclusions. First, political opposition and publics in the Caucasus have concluded that electoral processes are hopelessly corrupted and offer no prospect of fairly competing for power or even trying to influence policymaking. Accordingly, they are increasingly inclined to mobilize against their leaders and governments. Even though victories have thus far eluded them, this turn to the "street" bespeaks a perennial politics of resentment instead of compromise and consensus-building. Second, the gulf between rulers and ruled has obvious implications for stability and democracy. Ruling elites will try to tamp down actual protest and curb society's organizing capability, infringing on their basic liberties; this, in turn, will upset the delicate balance between state and society. Change, when it comes, may be violent.

Steadily losing hope, many Armenians, Azerbaijanis and Georgians will likely opt out of politics altogether. Many others will emigrate if they can. This trend has been marked for years in all three countries; Armenians often try to come to the United States; while Azerbaijanis and Georgians find it easier to move to Russia. But the departure of these highly motivated individuals and their families, who often find ways to prosper in their adopted homes, weakens their homelands.

Washington has observed these tendencies with concern but little action. Democracy-building programs may help develop civil society but have little impact on leaders who pursue their own interests and are quite prepared to dismiss the State Department's criticism of yet another rigged election—even if, as happened yesterday, the Department, in unprecedentedly strong language, said the Georgian election "results do not accurately reflect the will of the Georgian people, but instead reflect massive vote fraud in Ajara and other Georgian regions." And while we are preoccupied with Iraq and the war on terrorism, Moscow has been steadily rebuilding its assets in these countries, buying up infrastructure in equity-for-debt deals and offering all possible support to those in power.

Under these circumstances, Mr. Speaker, our chances of influencing political evolution in Armenia, Azerbaijan and Georgia may not be very great. But they will diminish to zero unless we recognize the problem, and soon.

HONORING MR. FRANK M. LAMPKIN, JR.

HON. JIM McCRERY

OF LOUISIANA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. McCRERY. Mr. Speaker, October 24th of this year, Louisiana and the United States lost a fine American and a good friend. Frank Lampkin, Jr. of Bossier City passed away at the age of 79. Though he has passed away, he leaves behind a rich legacy and a community made better by his good work.

Mr. Lampkin was a giver in every sense of the word. He gave to his country as a Sergeant in the Marines. He gave his time and energy, inspiring the children of Northwest Louisiana as a teacher, a coach, and a principal for more than three decades. He raised a family. And he continued to find ways to give back even more to his community.

Over the years Mr. Lampkin was an integral member of campaigns like the Clean City Committee, the Salvation Army Food Drive and Bell Ringing, Shots for Tots, and awards programs to inspire learning in elementary school children.

His list of awards and achievements is remarkable. He was a Kiwanian of the Year and had 50 years of perfect attendance at the Kiwanis Club of Bossier. He was inducted into the Louisiana High School Athletic Hall of Fame and the Northwestern Educators' Hall of Fame. He was a recipient of the Air Force R.O.T.C. Outstanding Service Award.

Despite all of these achievements, Mr. Lampkin will best be remembered as a husband, a father, a mentor, a neighbor, and a friend.

Frank Lampkin was an inspiring member of his community and I am pleased to have had a chance today to share some of the highlights of his life with those who never had the chance to meet him.

COMMENDING BARBARA REYNOLDS FOR HER YEARS OF SERVICE ON CAPITOL HILL

HON. DAVE WELDON

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. WELDON of Florida. Mr. Speaker, I come to the floor today to pay tribute to a long-time member of my staff who is retiring this December. Barbara Reynolds has worked for me as my scheduler and executive assistant since I was elected in 1994. Barbara's career on Capitol Hill preceded mine by 13 years. This experience, along with her talent and willingness to accommodate the busy schedule of a Congressman, was invaluable.

Before coming to work on the Hill, Barbara had been a stay-at-home mom, taking care of her two children. She had never really given much thought to getting involved in the political world, but, in 1979, at the suggestion of her father-in-law, she handed a resume to a friend at the Republican Policy Committee and, in about a week, landed a job with then-Representative Carlos Moorehead from California. This, however, was not her only job at the time. Barbara often spent her weekends as a professional model—many say she looked just like Jackie Kennedy Onassis. Her modeling took her all over the world as well as provided her with many commercial advertising opportunities. As a result of this, some current House maintenance workers who were around at the time still refer to Barbara as "Jackie" when they see her in the halls.

In 1985 Barbara began working for then-Representative and eventual presidential candidate Jack Kemp. In addition to working in his personal office she also worked on his campaign in New Hampshire.

After working with Jack Kemp, Barbara moved on to work for my Florida colleague, Representative CLIFF STEARNS in 1988. Barbara spent six years working for Representative STEARNS where she established her Florida roots.

In 1995 Barbara came to work for me and has worked in my Washington office since my first day in office. I am incredibly grateful for her loyalty to my staff and me. It will be nearly impossible to replace her uplifting spirit. Her presence in my office added a touch of class and style, which are sometimes hard to find in the world of politics.

I, along with her coworkers and others outside my office whose lives she has touched, will miss her presence on Capitol Hill. Barbara

Reynolds's retirement is well earned. She plans to pursue her hobby of boating on the Chesapeake with her husband, Bob, as well as continue to be a loving mother and grandmother to her two grown children and to her grandchildren. We all wish her many blessings and much happiness in the years to come.

Thank you Barbara, for your service to my office, the people of Florida, and the many others with whom you have worked on Capitol Hill.

CONFERENCE REPORT ON H.R. 2417, INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 2004

SPEECH OF

HON. RON PAUL

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. PAUL. Mr. Speaker, I rise with great concerns over the Intelligence Authorization Conference Report. I do not agree that Members of Congress should vote in favor of an authorization that most know almost nothing about—including the most basic issue of the level of funding.

What most concerns me about this conference report, though, is something that should outrage every single American citizen. I am referring to the stealth addition of language drastically expanding FBI powers to secretly and without court order snoop into the business and financial transactions of American citizens. These expanded internal police powers will enable the FBI to demand transaction records from businesses, including auto dealers, travel agents, pawnbrokers and more, without the approval or knowledge of a judge or grand jury. This was written into the bill at the 11th hour over the objections of members of the Senate Judiciary Committee, which would normally have jurisdiction over the FBI. The Judiciary Committee was frozen out of the process. It appears we are witnessing a stealth enactment of the enormously unpopular "Patriot II" legislation that was first leaked several months ago. Perhaps the national outcry when a draft of the Patriot II act was leaked has led its supporters to enact it one piece at a time in secret. Whatever the case, this is outrageous and unacceptable. I urge each of my colleagues to join me in rejecting this bill and its incredibly dangerous expansion of Federal police powers.

I also have concerns about the rest of the bill. One of the few things we do know about this final version is that we are authorizing even more than the president has requested for the intelligence community. The intelligence budget seems to grow every year, but we must ask what we are getting for our money. It is notoriously difficult to assess the successes of our intelligence apparatus, and perhaps it is unfair that we only hear about its failures and shortcomings. However, we cannot help but be concerned over several such failures in recent years. Despite the tens of billions we spend on these myriad intelligence agencies, it is impossible to ignore the failure of our federal intelligence community to detect and prevent the September 11 attacks. Additionally, it is becoming increasingly obvious that our intelligence community failed completely to accurately assess the nature of the Iraqi threat. These are by any measure grave failures, costing us incalculably in human lives and treasure. Yet from what little we can know about this bill, the solution is to fund more of the same. I would hope that we might begin coming up with new approaches to our intelligence needs, perhaps returning to an emphasis on the proven value of human intelligence and expanded linguistic capabilities for our intelligence personnel.

I am also concerned that our scarce resources are again being squandered pursuing a failed drug war in Colombia, as this bill continues to fund our disastrous Colombia policy. Billions of dollars have been spent in Colombia to fight this drug war, yet more drugs than ever are being produced abroad and shipped into the United States—including a bumper crop of opium sent by our new allies in Afghanistan. Evidence in South America suggests that any decrease in Colombian production of drugs for the US market has only resulted in increased production in neighboring countries. As I have stated repeatedly, the solution to the drug problem lies not in attacking the producers abroad or in creating a militarized police state to go after the consumers at home, but rather in taking a close look at our seemingly insatiable desire for these substances. Until that issue is addressed we will continue wasting billions of dollars in a losing battle.

In conclusion, I strongly urge my colleagues to join me in rejecting this dangerous and expensive bill.

THE ALDER CREEK DROUGHT PROTECTION PROJECT

HON. JOHN T. DOOLITTLE

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. DOOLITTLE. Mr. Speaker, I rise today to introduce The Alder Creek Water Storage and Conservation Project Act. This legislation will authorize The U.S. Bureau of Reclamation, in cooperation with the El Dorado County Irrigation District, to conduct a study to determine the feasibility of constructing a water storage project on Alder Creek in El Dorado County, California.

The Alder Creek Water Storage and Conservation Project would include the construction of a dam and 31,700 acre foot reservoir that would yield approximately 11,500 acre feet of additional water supply per year. A major advantage of this location is the ability to deliver this water by gravity into El Dorado Irrigation District's existing water delivery system and to the American River to increase instream flows for the propagation of fallrun Chinook salmon and Steelhead trout.

Like many communities in the arid West, El Dorado County faces water supply shortages that threaten people, cities, farms and the environment. The El Dorado Irrigation District, which serves over 100,000 of my constituents, is charged with the difficult task of providing a safe and reliable water supply throughout the region for all of these competing interests. Severe drought periods, like we are experiencing now, and explosive growth rates that are occurring in portions of El Dorado County, have made this task even more arduous. EID deserves great credit for developing alternative sources of water, such as recycled water, to ease the burden of inadequate supplies. In fact, all new developments within The El Dorado Irrigation District's service area are hooked up to recycled water lines that run in the front and back of the properties which conserves precious drinking water. However, if current trends continue, which all indications say they will, other alternative sources of water will be required in order to keep up with demand. To avoid a crisis, the District is in the process of developing a comprehensive plan to protect against multiple-year drought events. The Alder project would be a key component in the Districts overall drought protection strategy that would also include water banking and intergovernmental agreements.

Mr. Speaker, I would ask that this legislation be given prompt consideration so that the benefits of this important project can be realized in a timely manner.

INTRODUCTION OF THE "NATIONAL FILM PRESERVATION ACT OF 2003"

HON. JOHN CONYERS, JR.

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. CONYERS. Mr. Speaker, I am pleased to announce the introduction of the National Film Preservation Act of 2003, which reauthorizes the National Film Preservation Act of 1996.

We all know that motion pictures are amongst this nation's cultural treasures, going beyond entertainment to represent American ideals and values to people across the world. Unfortunately, the films on which many motion pictures are created are easily susceptible to physical deterioration; in fact, over fifty percent of movies made before 1950 have deteriorated and over ninety percent of movies from before 1929 have disintegrated.

The 1996 Act was designed to ensure that we could protect the treasures we still have. It created the National Film Preservation Board and the National Film Preservation Foundation. The NFPB generates public awareness of a national film registry and reviews initiatives to ensure the preservation valued films. The NFPF issues grants to libraries and other institutions that can save films from degradation.

The program has received accolades from organizations such as the Directors Guild of America and the Academy of Motion Picture Arts and Sciences. Noted filmmakers Martin Scorsese and Ken Burns also have praised the NFPB and the NFPF.

Unfortunately, the program officially expired October 11, 2003, and was not reauthorized. The legislation being introduced today would remedy that oversight by reauthorizing both the NFPB and the NFPF. I hope my colleagues will join me in supporting this valuable effort as we move it through the House.

CONFERENCE REPORT H.R. 6

SPEECH OF

HON. W.J. (BILLY) TAUZIN

OF LOUISIANA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mr. TAUZIN. Mr. Speaker, the Energy Policy Act of 2003, among other things, would authorize the promulgation of mandatory and enforceable standards for the North American transmission system by an Electric Reliability Organization subject to FERC oversight in the U.S. Having been so recently reminded that transmission system failures and system reliability do not respect state or international boundaries, it is essential that this legislation protect consumers in one state from actions or events in another. Under the plain language of new FPA section 215 (i)(3), no state may take any action with respect to the safety, adequacy and reliability of electric service within that State if that action is determined by the Electric Reliability Organization or by the Federal Energy Regulatory Commission to be inconsistent with any reliability standard. A regional entity that satisfies the requirements of new section 215 (e)(4) may propose to the Electric Reliability Organization reliability standards that reflect regional differences, and the Electric Reliability Organization may approve such proposed standards when justified.

TRIBUTE TO PASTOR EPHRAIM AND MRS. CARRIE SUE WILLIAMS

HON. ROBERT T. MATSUI

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. MATSUI. Mr. Speaker, I rise in tribute to Pastor Ephraim and Mrs. Carrie Sue Williams as they celebrate a personal milestone. On November 22, 2003, Pastor Williams and his beloved wife will celebrate their 50th wedding anniversary. As their friends and family gather to commemorate this momentous occasion, I ask all my colleagues to join me in wishing one of Sacramento's most revered couples a happy anniversary and continued happiness in the future.

For the past 32 years, Mr. and Mrs. Williams have served with great class, dignity, and distinction as the Pastor and First Lady of the St. Paul Baptist Church in Sacramento California. As Pastor, Mr. Williams has played an instrumental role in directing and coordinating all aspects of the St. Paul Missionary Baptist Church. Pastor Williams made vital decisions related to staffing, church organization structure, finances, and the modification of facilities. Pastor Williams was the driving force behind the construction of a seventy-nine square foot edifice, which includes an administration wing, sanctuary, fellowship hall and classroom wing. Pastor Williams spearheaded a 7-year effort that liquidated a $4 million debt for the church so that it could cover the $7.7 million that was required for the construction project. Pastor Williams is currently leading the church in the building of a multi million-dollar Family Life Center that will include a gymnasium, classrooms, computer lab, dance rooms, nursery, office space, library, weight room and conference room. Pastor Williams' commitment to improve the church is great proof of his willingness to work hard to improve the lives of other people.

Mrs. Carrie Sue Williams is a former business owner and she has brought her trademark grace and dignity to her role as the First Lady of St. Paul Baptist Church. As the First Lady, Mrs. Williams regularly visits the sick and the confined. She also counsels women and couples. Mrs. Williams helped to design the St. Paul Children and Youth Reading Ministry, a program that is designed to motivate and reward children for their reading efforts.

Pastor Williams is undoubtedly one of the strongest civic leaders in the Capital Region. Pastor Williams' leadership capacities have included: President of United Pastors of Sacramento, Vice President of the National Baptist Convention, U.S.A., Inc, President of the California State Baptist Convention and President of the Northern District Baptist Association. Pastor Williams is the current President of the Oak Park and St. Paul Community Outreach Program.

Pastor and First Lady Williams are the proud parents of Gwen and Ephraim Jr., although he has since passed on. They also enjoy the love and companionship of their four grandchildren and three great grandchildren.

Mr. Speaker, I am honored to congratulate Pastor Williams and First Lady Williams on their 50th wedding anniversary. As the family and friends of the Williams family gather to celebrate this terrific milestone, I would like to especially thank Pastor Williams and First Lady Williams for all their great service to their community. I ask all my colleagues to join with me in wishing Pastor Ephraim Williams and First Lady Carrie Sue Williams continued success in all their future endeavors.

PERSONAL EXPLANATION

HON. XAVIER BECERRA

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. BECERRA. Mr. Speaker, on Monday, November 17, 2003, I was unable to cast my floor vote on rollcall numbers 620, 621, 622, and 623. The votes I missed include rollcall vote 620 on the Motion to Suspend the Rules and Pass S.J. Res. 22, Recognizing the Agricultural Research Service; rollcall vote 621 on the Motion to Suspend the Rules and Pass S.J. Res. 18, Commending the Inspectors General; roll call vote 622 on the Motion to Suspend the Rules and Agree to H. Con. Res. 299, Honoring Sargent Shriver; and rollcall vote 623, on the Hour of Meeting.

Had I been present for the votes, I would have voted "aye" on roll call votes 620, 621, 622, and 623.

HONORING MR. DANIEL MILLER OF ARLINGTON, TEXAS, TO RECOGNIZE HIS DESIGN OF THE TEXAS STATE QUARTER

HON. MARTIN FROST

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. FROST. Mr. Speaker, I rise today to honor Daniel Miller of Arlington, Texas. Daniel is the artist who designed the Texas State quarter, which will debut in 2004 and will be the 28th in the series of state commemorative quarters from the U.S. Mint. His design was picked from over 3000 entries.

Daniel has gracefully and accurately captured the spirit of our great State. The Texas State quarter will feature a Lone Star springing from the outline of a map of Texas, with a lariat featured prominently. When asked about what inspired him with the coin's design, Daniel simply said, "I toyed around with putting the Alamo in, but Texas is so much more than just the Alamo."

Indeed, Texas is much more than the Alamo. Its rich history and people can hardly be summed up in a coin, but Mr. Miller has gamely risen to the task. Although a native Minnesotan, having come to Texas only 15 years ago, Daniel's design tells me that the blood of a true Texan runs through his veins.

Daniel's inspired work will soon be familiar to millions of people across this great nation. Whether they collect or spend the Texas quarter, I believe that a little bit of the Texas spirit will rub off on everyone who encounters Daniel's work of art.

Mr. Speaker, I am proud of Daniel and his work to recognize Texas's great history. I know my colleagues will join me in congratulating Daniel Miller as we celebrate his design for the Texas State quarter. We salute him today.

INTRODUCTION OF THE MEDICARE CHRONIC KIDNEY DISEASE MANAGEMENT ACT OF 2003

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. STARK. Mr. Speaker, I rise today to introduce the Medicare Chronic Kidney Disease Management Act of 2003. My bill would expand Medicare eligibility for uninsured patients with advanced chronic kidney disease before their condition progresses to end-stage renal disease (ESRD) status. The bill would provide access to healthcare and most importantly disease management and pre-ESRD educational and counseling services. It would improve the health and quality of life for those suffering from kidney disease and could provide real savings for the Medicare program by helping chronic kidney disease patients delay costly dialysis treatments and kidney transplants associated with the end stage status of the disease.

ESRD patients are the only group of patients eligible for Medicare enrollment solely due to their medical diagnosis. ESRD is characterized by a permanent loss of kidney function, which results in the need for dialysis treatments or kidney transplantation in order to sustain life. Under current law, a physician must certify that an individual's kidney functions have deteriorated to end-stage status for a patient to be eligible for the Medicare ESRD program. Subsequently, there may be an additional waiting period of up to 3 months depending on the type of dialysis procedure chosen by the patient before the individual becomes eligible for benefits. Thus, benefits are only received after the cessation of adequate kidney functioning.

The cost to the Federal Government for providing care to an ESRD patient is very high. The average per capita expense for all ESRD patients was $33,282 in 2000, approximately 8 times the annual cost of care for the average Medicare beneficiary. The annual cost for in-center hemodialysis, the most frequent form of dialysis used, approaches $55,000.

There has been a substantial amount of research within the past several years indicating that the provision of improved medical care and disease-related pre-ESRD educational and counseling services to advanced chronic kidney disease patients prior to their progressing to end-stage renal status has multiple positive effects. The provision of these pre-ESRD services slows down the progression toward ESRD status, decreases the occurrence and intensity of related diseases and decreases overall mortality rates. By allowing uninsured patients with advanced kidney disease to access care prior to qualifying for Medicare due to an End Stage Renal Disease diagnosis, this bill wisely and appropriately addresses a critical unmet health need.

Under the Medicare Chronic Kidney Disease Management Act, uninsured, pre-ESRD chronic kidney disease patients would be eligible for full Medicare coverage and pre-ESRD counseling and educational services. To be eligible, a physician would need to certify that a chronic kidney disease patient has reached a level of kidney functioning deterioration predictive of a need for dialysis or a transplant in the next 1½ years under a widely accepted clinical standard. Individuals eligible under the bill would pay Medicare Part B premiums. Pre-ESRD educational and counseling services provided by this legislation address treatment options, disease management, and nutrition. These new services would also be available to current Medicare enrollees who become diagnosed with chronic kidney disease.

This bill also requests that the Secretary of Health and Human Services establish at least 2 demonstration projects in cooperation with recognized kidney patient organizations, to devise ways, or demonstrate means through which peer education procedures can slow progress to ESRD and improve outcomes for patients with this disease.

Today, more than 300,000 individuals are covered under the Medicare ESRD program. By 2010, it is expected that this number will more than double. This bill, which is supported by the National Kidney Association and the American Association of Kidney Patients, will help minimize the damaging impact of this chronic illness and slow the growth of individuals suffering from ESRD. By delaying the need for either dialysis or transplantation, one can also anticipate substantial cost savings to the government. I urge my colleagues to join me in supporting the Medicare Chronic Kidney Disease Management Act so we can make these vital improvements to the Medicare program for those who suffer from chronic kidney disease.

TRIBUTE TO JENNIFER DOWNEY OF CLINTON TOWNSHIP, MICHIGAN

HON. SANDER M. LEVIN

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. LEVIN. Mr. Speaker, it is with genuine pleasure that I rise to recognize one of my constituents, Jennifer Downey of Clinton Township, Michigan, for her recent promotion to Chief Petty Officer in the U.S. Naval Sea Cadet Corps.

The U.S. Naval Sea Cadet Corps was established in 1958 to develop an appreciation for the United States' naval history, customs, traditions, and its significant role in national defense. The goal of the Cadet Corps is to encourage young people to develop an interest in basic seamanship and teach cadets patriotism, courage, confidence and self reliance.

Cadet CPO Downey has been a member of the Naval Sea Cadet Corps Program's Tomcat Squadron for over 5 years. She has completed a large number of advanced training courses over her tenure in the program, including seamanship training aboard the USNSCS *Grayfox*, Coast Guard training, Master at Arms School, and Petty Officer Leadership Academy. In addition, she has completed sixty-four hours of community service and won numerous citations and ribbons.

Cadet CPO Downey's promotion to Chief Petty Officer was brought to my attention in a letter from her Commanding Officer, LTJG Lisa Stoyanovich, who writes me to say that CPO Downey "is a very personable young woman who takes pride in herself and her unit. CPO Downey's performance of her duties is always top-notch, her leadership abilities are exceptional, and her ability to motivate other cadets is finely tuned. Through her years of Navy League Cadet and Naval Sea Cadet training, she has earned the respect of her peers, and the officers in the unit."

The letter from Lieutenant Stoyanovich goes on to say that "Chief Petty Officer Downey has developed into a mature, solid leader and is a fine example of what the Sea Cadet Corps hopes to develop in young people."

I ask all my colleagues to join me in congratulating Chief Petty Officer Jennifer Downey for her achievements as a member of the U.S. Naval Sea Cadet Corps.

OPPOSING THE SYRIA ACCOUNTABILITY ACT

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. STARK. Mr. Speaker, I rise in opposition to this bill despite being one of its cosponsors and having voted for it when it came before the House on October 15th.

I strongly believe Syria's actions ought to be called into question. To say this regime is a bad actor is putting it mildly. Their actions are rightly condemned, especially when it comes to their tacit support for terrorism and ongoing occupation of Lebanon. The United States ought to use the tools at our disposal—both political and economic—to demand an end to their egregious policies.

There is, however, a reason why I am voting against this resolution. It is based on my long held reservations about the President's intentions on foreign policy. Given his belligerent declarations yesterday, I have genuine concerns that he may seek authority in this resolution to pursue aggressive military action against Syria.

After all, Mr. Speaker, this President did not need much to march to war against Iraq. At best, the evidence was soft, the intelligence was trumped up and now not a grain of proof can be found showing Iraq had any weapons of mass destruction. But, ultimately, President Bush used past declarations of Congress meant merely to reprimand Iraq for its policies to justify full-blown war against that regime.

This resolution today contains provisions that rightly admonish Syria, but do so on the basis of reasonable beliefs and assumptions, not proven facts. Most notably, there is reference to Syria's "hostile actions" in regard to the United States and our troops in Iraq. Although our suspicions are well founded, there is as yet no proven connection between the government of Syria and terrorism in Iraq.

I have concerns the President may not draw this distinction and take these words as grounds for pursuing preemptive military action.

Frankly, Mr. Speaker, I don't trust this President. His actions toward Iraq have clearly demonstrated his willingness to lie to the American people. But, they also underscore his willingness to use force indiscriminately without the burden of proof.

I cannot support a resolution that might be used as a vehicle for the President to act counter to the interest of the American people. I vote "no" on this resolution.

HONORING THE BASIC HIGH SCHOOL MJROTC UNIT

HON. JON C. PORTER

OF NEVADA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. PORTER. Mr. Speaker, I rise today to honor the Basic High School Marine Corps JROTC unit. I am proud to represent this outstanding group of young men and women and urge the entire House to join me in commending them today.

The MJROTC unit at Basic High, in Henderson, Nevada is one of the top JROTC units in the country, having been recognized as a Naval Honor School for the 2002–2003 school year. In addition, the Basic High MJROTC unit is the National Champion of the unarmed competition at the United States Air Force Academy National Invitational Drill Meet

Championship, and has won seven times in the last 9 years. The Basic High armed competition unit has won the National Championship every time it has competed.

Basic High MJROTC is not only a champion on the drill field; it is also a champion in producing young men and women of character. Basic High MJROTC has been an active part of honoring Veterans Day in Henderson, with the whole battalion presenting the colors for the City of Henderson ceremony. The unit also led the local celebrations of the 228th anniversary of the founding of the U.S. Marine Corps. I want to thank the members of the unit, and instructors Lieutenant Colonel Montgomery, Master Gunnery Sergeant Ignatz, and First Sergeant Rael for standing always faithful, "Semper Fidelis," to the best traditions of Nevada, America, and the U.S. Marine Corps.

HONORING SISTER JEANNE O'LAUGHLIN

HON. E. CLAY SHAW, JR.

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. SHAW. Mr. Speaker, I rise today in recognition of the amazing life and contributions of Sister Jeanne O'Laughlin, OP, Ph.D., as she prepares to retire from service to the Barry University community this December. Sister Jeanne is the president of Barry University, which is located in Miami Shores, Florida. Since becoming president in 1981, Sister Jeanne has worked endlessly to increase the reputation and endowment of Barry University, raise hundreds of millions of dollars for her student's aid, and create a student body and alumni that stretches 70 countries, ranking number one in diversity among southern regional universities.

Sister Jeanne O'Laughlin was born and raised in Detroit, Michigan where she first learned what it meant to love and educate. As a little girl, she realized that in order to stop hatred, crime, and injustice, education must be the first priority on any agenda. Sister recalls the story when she was a 13-year old girl riding a streetcar in Detroit, she noticed a black woman enter the car with four small children. As the streetcar lurched forward, one of the children fell into her lap. Without hesitating, young Jeanne gladly held the young child for the remainder of the ride. Later, as a man departed the streetcar, he walked by and spit on young Jeanne.

Startled by what occurred, Jeanne asked her father later that evening why the man spit on her. Jeanne's father replied, "prejudice". Innocently, Jeanne asked, "how do you stop that?" "Education" was her father's answer. This simple response began a vision. A vision we honor today.

The Adrian Dominican Sisters founded Barry University in 1940, as a university dedicated to educating women. Since then, the University has continued to be administered by women, including the last 22–years with Sister Jeanne at the helm. My first year in the people's House, was also Sister's first year as Barry president. The year was 1981, and for Sister Jeanne it was the beginning of an educational revolution. In 22 tremendous years, Barry has changed from a predominantly women's university of 2,000, into a diverse campus of 8,500. She has raised nearly $170 million for the university since she took office and has seen the university contribute nearly $200 million to South Florida's economy last year.

Under the supervision of Sister Jeanne, Barry has been able to sustain in excess of 1,000 employees, up from 340 when Sister Jeanne started in 1981. Barry's budget has also increased dramatically rising from $8.3 million to a staggering $100 million. Barry's endowment has also risen more than 2,000 percent to $22 million during the past 22 years. The university now offers seven doctoral degrees, including the only Doctor of Podiatric Medicine in the Southeast, and only seven universities in the country to offer such a degree. During her term as president, Sister Jeanne has inspired those around her to give more and more of themselves to better the lives of the students of Barry University. A tireless educator, Sister Jeanne has not only contributed greatly to Barry University, but also to many other institutions around Florida and the nation.

Sister Jeanne has served as chair of the Council of Independent Colleges from 1994–1996, the chair of the Association of Catholic Colleges and Universities also from 1994–1996, and as an Executive Council member of the Southern Association of Colleges and Schools' Commission on Colleges from 1991–1996. Just in Florida alone, Sister Jeanne has served as president of the Florida Association of Colleges and Universities and chairman of the Independent Colleges and Universities. As a testament to her dedication to education, four Florida universities: Holy Cross College, University of Miami, Rollins College, and Lynn University, have conferred honorary degrees on Sister Jeanne, making her one of the most respected and loved educators in Florida's history.

Sister Jeanne has also been an advocate of revitalizing South Florida's economy. South Florida's power elite noticed her qualities and dedication and named Sister the first female member of two exclusive groups: The Orange Bowl Committee and the Non-Group. The Orange Bowl Committee is a group of dedicated, South Florida volunteers, who are committed to bringing tourism to South Florida through the annual college football game. Now, one of the four most prestigious college football bowl games in America, the Orange Bowl festivities bring in an excess of 150,000 visitors every year, which contribute to a thriving South Florida economy.

Despite all her dedication and hard work, even Sister Jeanne is susceptible to illness and in 1996, Sister was diagnosed with lung cancer. However, even this disease could not stop her determination. Following disclosing publicly her illness, Sister helped raise awareness and funds for the American Cancer Society.

Mr. Speaker, as a fellow lung cancer survivor, I know how difficult life seems after being diagnosed with such a terrible illness. For Sister Jeanne to continue her work like this is an inspiration to every cancer patient and survivor in America. I am also grateful to Sister for her thoughts and prayers during my illness earlier this year.

Sister Jeanne is a dear friend, and someone I am truly proud to know and love. Sister Jeanne's vision continues. Her love for Barry and South Florida is evident evermore. Under Sister Jeanne's supervision, Barry University is attempting the largest construction project in Miami Shores history. Nearly $18 million will bring a new student center and residence hall to accommodate the growing student population, which Sister Jeanne has pushed to grow and expand ever since she took office.

Mr. Speaker, as Chairman of Florida's Congressional Delegation, I salute Sister Jeanne O'Laughlin for her 22 years as President of Barry University. May God bless Sister Jeanne O'Laughlin.

H.R. 2297, VETERANS BENEFITS ACT OF 2003

SPEECH OF

HON. TOM UDALL

OF NEW MEXICO

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. UDALL of New Mexico. Mr. Speaker, H.R. 2297, the Veterans Benefits Act of 2003, contains myriad benefits for our nation's veterans, many of which are long overdue. The bill builds on education benefits by expanding the Montgomery GI Bill program, a successful program that will now include educational assistance for on the job training in certain self-employment programs. It also increases monthly educational benefits for spouses and dependent children of veterans with permanent total disabilities, or who have died as a result of combat.

Among the housing benefits in the bill is a provision allowing remarried surviving spouses of veterans to be buried next to the veteran in a national cemetery, based on the original marriage. A prohibition on remarried spouses burial eligibility is unfair to many of the dedicated spouses who have faithfully supported their veterans for years. I was a cosponsor of the original bill for this measure and support its passage.

The section of the bill relating to benefits for former Prisoners of War contains a provision that will add cirrhosis of the liver to the list of presumed service-connected disabilities for former POWs. It also eliminates the unfair requirement that a POW must be held for at least 30 days to qualify for presumption of service-connection for certain disabilities, such as psychoses and states of anxiety. We owe it to our former POWs to repay them for what they have been through as much as we possibly can, and this provision is a step in that direction.

Yet another beneficial provision in this bill is the extension for six years of the Advisory Committee on Minority Veterans. As a representative in a state with over 9,000 Native American veterans, and with over 17,200 Hispanic veterans in my district alone, I fully support this provision and believe it is a necessary step to the continued service to all minority veterans.

Another provision in the bill provides federal contracting officials the discretionary authority to award sole source contracts to small businesses owned by service-disabled veterans. I am pleased that the Senate took out the "notwithstanding any other provision of law" phrase that was in the original version of H.R. 1460, from which the language for this provision of H.R. 2297 was taken. The language included in the original version of H.R. 1460 was very harmful to the 8(a) small business contract program, a program that benefits minority-owned small businesses all across this country. As a member of both the House Veterans' Affairs Committee and House Small Business Committee I worked to forge a suitable compromise that would ensure increased contracting opportunities for veteran-owned small businesses, while not harming the 8(a) program that has helped provide economic opportunity for minority entrepreneurs. With the help of the Chairmen and Ranking Members of both committees, we were able to unanimously pass an amended version of H.R. 1460.

Unfortunately the unanimously passed version of H.R. 1460 is not what is included in H.R. 2297 today, but neither is the originally damaging language of H.R. 1460 included in this bill. I do have remaining concerns about the effect of the included contracting provision on the 8(a) and other small business programs, but considering the numerous important provisions for our nation's veterans contained in this bill, I will vote in favor.

In closing, Mr. Speaker, let me say that I strongly support increased opportunities for veteran entrepreneurs. In fact, with the support of Congresswoman SUE KELLY, I recently introduced H.R. 3483, the Seeds for Soldiers Act, to establish a loan program and a vocational rehabilitation program for veterans. As a member of the House Veterans' Affairs Committee, I strongly support strengthening benefits for our Nation's veterans, who have fought so bravely to protect our country. I support the passage of H.R. 2297 and look forward to continuing work in the House Veterans' Affairs Committee to support our Nation's heroes.

LET'S GO LANCERS

HON. EDWARD J. MARKEY

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. MARKEY. Mr. Speaker, while the Boston Red Sox failed to finally capture a World Series victory that has eluded them since 1918, another group of Hardball Heroes from Red Sox Nation did achieve their ultimate goal. The Malden Catholic Lancers defied all expectations, overcame every obstacle, and defeated every opponent to finish the year as Massachusetts Division One State Champions.

While Red Sox fans will have to wait until next year yet again, the Lancers fans can rejoice and celebrate the success of this young team of schoolyard superstars.

Mr. Speaker, today I join with faculty, students, my fellow alumni, and all members of the Malden Catholic community who are saying congratulations!

It was Coach Stephen Freker's guidance and leadership that fueled these young men as they drove to the championship. The National High School Baseball Coach's Association affirmed what we knew all along by naming Coach Freker New England's Coach of the Year.

These Lancers worked hard, practiced long, and gave their hearts and souls for the blue and gold all year long. While they are great individual players, their true greatness lies in their ability to play as team.

Mr. Speaker, this was our year.

Let's Go Lancers!

IN RECOGNITION OF THE GLENDALE GENERAL RICHARD GRIDLEY CHAPTER OF THE DAUGHTERS OF THE AMERICAN REVOLUTION

HON. ADAM B. SCHIFF

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. SCHIFF. Mr. Speaker, I rise today to congratulate the General Gridley Chapter of the Daughters of the American Revolution on their 90th anniversary celebration.

Mrs. Mary Howard Gridley Braly founded the chapter on December 19, 1913. Mrs. Braly served as an organizing regent, and was later named Regent-For-Life by Chapter members. Mrs. Braly and her daughter first became members of the National Society of D.A.R. in 1983 in Highland Park, Illinois. Then recording Secretary General Miss Eugenia Washington, one of the D.A.R. founders, signed their applications.

The chapter is named for General Richard Gridley, ancestor of Mary's first husband James Conger Gridley. General Gridley was born in Boston in 1711. In 1745 he was commissioned Lieutenant Colonel of the Artillery in the expedition against the French fortress of Louisbourg of Cape Breton Island. At the outbreak of the Revolutionary War in April 1775, he was commissioned chief engineer and Colonel of Artillery and was wounded in the battle of Bunker Hill. He married Hannah Deming and had nine children. He served with General George Washington throughout the Revolutionary War. In 1798 General Gridley died in Staughton, Massachusetts at the age of 87.

Today the chapter is extremely involved in the community. It is active in veterans' services, ROTC programs, and scholarship programs with our local high schools. The chapter also presented the City of Glendale with the Department of Defense's 50th Anniversary of the Korean War flag. This flag currently flies over the Glendale War Memorial at City Hall.

I ask all Members of Congress to join me today in congratulating the General Gridley Chapter of the Daughters of the American Revolution on 90 exemplary years of service to the City of Glendale and surrounding communities.

A HERO LEAVES BEHIND A LASTING LEGACY—GOD'S LOVE: REMARKS ON BEHALF OF ROBERT HODGES

HON. WALTER B. JONES

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. JONES of North Carolina. Mr. Speaker, last Monday was a sad day for Eastern North Carolinians and America as a whole. On November 10, 2003, North Carolina lost her oldest living Veteran, Robert Hodges. When Mr. Hodges passed away, he was 115.

I had the privilege of meeting Mr. Hodges at an event in his hometown just a few years ago. Even in the brief interaction I shared with this living legend, I was struck by his sharp mind and vitality. I can still remember Mr. Hodges singing "Over There" so beautifully . . . he was so lucid, his voice so clear, you would never have believed he was celebrating his 114th birthday.

Born June 18, 1888, Mr. Hodges was not only North Carolina's oldest living veteran, he was one of America's longest living war heroes as well.

Mr. Hodges had a phenomenal story. He was born in North Carolina's first official town, Bath. The grandson of slaves, Mr. Hodges shared a three-room house with his parents and 9 siblings.

He worked the fields in rural Eastern North Carolina until 1918. At the age of 20, Mr. Hodges enlisted in the Army and went on to serve in France during World War I.

After World War I, Hodges returned to North Carolina and married Malinda. The couple enjoyed 70 years together until her death at the age of 92.

Mr. Hodges and his wife raised 7 children on their farm in Pamlico County, where Mr. Hodges worked until his poor eyesight forced him into retirement. The Hodges family still calls the Pamlico area home, with his surviving children living in Stonewall and New Bern.

He was honored in 2002 with North Carolina's Order of the Longleaf Pine, the state's highest civilian order.

While Mr. Hodges most certainly leaves behind an amazing personal and military history, I must say that in my opinion, the most significant legacy this hero left behind is a pure and stalwart love of Jesus Christ. Last year Mr. Hodges was quoted as saying, "What I figure on is anything you can do for the Lord is all right."

Despite all his honors and all the attention he had showered on him through the years, Mr. Hodges always kept his heart in check. He knew that in the end, he would take nothing with him when he left this world.

More important than all the military medals and awards was the love of Jesus.

I believe wholeheartedly that the secret of Mr. Hodges long life was love of family and love of the Lord.

That is why I'm confident that when Mr. Hodges closed his eyes to this world, he opened them in Heaven. And that, Mr. Speaker, is a reward well earned by Mr. Hodges' life lived by faith. From battlefield to his front porch, Mr. Hodges did it all for the glory of the Lord.

I stand today in remembrance of this military hero and godly man. May God bless his soul, and the family he left behind.

SIERRA NATIONAL FOREST LAND EXCHANGE ACT OF 2003

SPEECH OF

HON. GEORGE RADANOVICH

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mr. RADANOVICH. Mr. Speaker, I am pleased the House is considering H.R. 1651–The Sierra National Forest Land Exchange Act of 2003 on suspension today. I thank my colleagues, Mr. NUNES and Mr. DOOLEY, in addition to Resources Committee Chairman POMBO, for their support and assistance on this measure.

H.R. 1651 completes a land exchange between the Forest Service and a constituent of mine, Mr. Bob Glassman. Under the exchange, the Forest Service will obtain an 80 acre parcel within the Sierra National Forest from my constituent, who will in turn receive a 160 acre parcel located on Shaver Lake and also within the Sierra National Forest.

Upon completion of the land exchange with the Forest Service, my bill states that my constituent will convey the newly acquired 160 parcel on Shaver Lake to the Sequoia Council of the Boy Scouts. The Boy Scouts have operated a recreational camp on a portion of this land for over five decades. Thousands of Scouts use the camp each year to experience outdoor activities and gain leadership skills. Owning the property will allow the Sequoia Council of the Boy Scouts to make improvements to the facilities located on the land. This bill, therefore, allows the Scouts to provide continued opportunities for young men to learn the importance of and actively participate in serving their community.

Given that there is a hydroelectric facility at Shaver Lake, I have worked with the operator of that facility, Southern California Edison, to ensure it can maintain and operate its hydro project once the land exchange is completed. As a strong supporter of hydroelectric power, I am pleased to say that under my legislation—this hydro facility can continue to operate unencumbered.

Mr. Speaker, H.R. 1651 is a non-controversial piece of legislation that will benefit the lives of Boy Scouts for years to come. As such, I encourage my colleagues to support its passage.

CONFERENCE REPORT ON H.R. 2754, ENERGY AND WATER DEVELOPMENT APPROPRIATIONS ACT 2004

SPEECH OF

HON. MAURICE D. HINCHEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mr. HINCHEY. Mr. Speaker, I want to commend the Chairman of the Energy and Water Subcommittee, Mr. Hobson and the ranking member, Mr. Visclosky for their good work on this bill. This conference report deserves the overwhelming support it is about to receive.

I do want to bring attention to one provision in this bill that has not received the scrutiny it deserves. Section 115 is an affront to our nation's environmental laws. It was not included in either the House or Senate bills and was added in conference. The provision waives all environmental laws and directs the construction of a road from the village of King Cove, Alaska through the sensitive Izembek National Wildlife Refuge and right to the boundary of the fragile and internationally significant Izembek Wilderness Area.

Specifically, Section 115 directs the Corps of Engineers to build a road proposed in one Alternative from a draft Environmental Impact Statement prepared to evaluate several modes of transportation between the villages of King Cove and Cold Bay, Alaska. The Environmental Protection Agency has raised significant concerns with the alternative mandated by Section 115. The Corps of Engineers is still reviewing public comment on the draft EIS.

The King Cove Access Project first surfaced as legislation in 1998. Proponents attempted to add the provision to an appropriations bill that year but were not successful. A compromise was reached later that year with the King Cove Health and Safety Act which was included as Section 353 of Public Law 105–277, the Department of Transportation and Related Agencies Appropriations Act. The measure appropriated $40 million to address the access needs of the communities of King Cove and Cold Bay; however, the Act did not approve a road through the Izembek refuge or the Izembek Wilderness. In fact, the legislation specifically required that expenditure of the funds allocated in the bill "must be in accordance with all other applicable laws."

Five years after a satisfactory compromise was agreed upon, this rider inappropriately short-circuits the public process. An administrative decision on a project to enhance marine-road access for the community of King Cove is proceeding in a timely manner and does not require intervention by Congress. However, the King Cove Access Project mandates one alternative in the EIS, thereby effectively ignoring the advice of the U.S. Fish & Wildlife Service, other federal agencies and the American public.

Section 115 is an affront not only to public process, but also to our nation's environmental laws. Unlike the King Cove Health & Safety Act, which is subject to national environmental laws, the King Cove Access Project is "notwithstanding any other provision of law." It is inappropriate to exempt the Izembek refuge from federal environmental laws in this manner.

The Izembek National Wildlife Refuge, on the Alaska Peninsula, is internationally recognized as one of the most important wetland reserves in the Northern Hemisphere. Home to threatened and endangered species, as well as millions of migratory birds, the Izembek National Wildlife Refuge and Izembek Wilderness are keys in the fight to conserve the natural diversity of wildlife populations and habitats. A road through the refuge will inevitable damage the refuge's critically important habitat.

The King Cove Access Project ignores environmental laws, threatens important wildlife habitat and sets a dangerous anti-wilderness precedent. The 17-mile road proposal is not compatible with the purposes of the refuge, as established by ANILCA, or with the Wilderness Act. The King Cove Access Project rider is terrible policy and terrible process.

FAIRNESS TO CONTACT LENS CONSUMERS ACT

SPEECH OF

HON. F. JAMES SENSENBRENNER, JR.

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 19, 2003

Mr. SENSENBRENNER. Mr. Speaker, I rise today in support of H.R. 3140, "The Fairness to Contact Lens Consumers Act of 2003," which provides contact lens wearers with important new rights. This bill ensures that unscrupulous eye doctors will no longer be able hold consumers' contact lens prescriptions hostage, forcing them to purchase lenses solely from their doctor's office. In addition, this legislation will make shopping for lenses simpler and cheaper.

Currently, eye doctors are only required to give patients their prescriptions for eyeglasses. Eyeglass wearers have had this right since 1978, when the Federal Trade Commission issued a regulation granting eyeglass wearers the right to automatically receive a copy of their prescription following an exam. Contact lenses were understandably not included in this regulation because, at the time, most contacts were hard lenses, which were custom-made to fit each patient. Today, most contact lenses are mass produced, soft lenses that do not require manipulation by eye doctors. As a result of this improvement, today's contact lens wearers should have the same right as eyeglass wearers to obtain their prescription, at no additional charge. That is why I am proud to be an original cosponsor of the Fairness to Contact Lens Consumers Act.

Approximately 36 million Americans wear contact lenses. Each year, these Americans spend an estimated $3.5 billion on contact lenses. Providing consumers with an automatic right to their prescriptions will allow them to shop around for contact lenses based on price, service, and convenience. It is estimated that H.R. 3140 could save consumers approximately $350 million annually, thanks in large part to increased competition. Competition among contact lens companies will result in lower prices, a greater choice of lens providers, and more convenient ways to fill contact lens prescriptions.

H.R. 3140 is bipartisan legislation supported by both optometrists and retailers. I have been working on this issue for a number of years, and am pleased to "see" it pass the House in a bipartisan manner. I encourage the Senate to take up this bill and help contact lens wearers receive this right.

HONORING MR. SARGENT SHRIVER

SPEECH OF

HON. PATRICK J. KENNEDY

OF RHODE ISLAND

IN THE HOUSE OF REPRESENTATIVES

Monday, November 17, 2003

Mr. KENNEDY of Rhode Island. Mr. Speaker, I am proud to join my colleagues in support of H. Con. Res. 299, a resolution honoring Mr. Sargent Shriver for his dedication and service to the United States of America, for his service in the United States Navy, and for his lifetime of work as an ambassador for the poor and powerless citizens of the United States of America. Growing up with a role model like my uncle, Sargent Shriver, doesn't allow much room for failure. He has served our nation in countless ways and on multiple fronts. When he retired from the Navy as a Lieutenant Commander, he could have ended his public service career then, and been proud of his accomplishments. But he chose to continue to serve our nation when President Kennedy appointed him the first Director of the Peace Corps. Sargent Shriver exceeded expectations for the initiative by developing volunteer programs in more than 50 countries around the world.

Sargent Shriver and his wife, Eunice Kennedy Shriver, went on to establish the Special Olympics during the 1960's, when those with mental retardation were often institutionalized because of a lack of understanding of their needs and abilities. The Shrivers recognized the importance of challenging these individuals with physical activities, when others simply cast them aside. The Special Olympics brought courage to their lives and taught them the value of teamwork, and proved that people with mental retardation were strong and caring individuals who could be successful and independent. The Special Olympics has grown exponentially under the Shrivers direction. When given the position of president of the Board of Directors of the Special Olympics, Sargent Shriver, again, reached out to other nations to bring together people of all nationalities to compete in the games. In 1985, athletes from 14 countries were represented at the Special Olympics Winter Games in Utah, and today, more than 1 million athletes participate in the Special Olympics in over 150 countries.

I hesitate to end my remarks with this short list of what Sargent Shriver has accomplished in his life. Unfortunately, I am not sure if there is anyway to accurately reflect the number of lives he has touched as our nation's ambassador, through Head Start and the Special Olympics, to name a few. But I am sure that even at the age of 88, he will continue to add accomplishments to this list of public service, and he will continue to touch the lives of people around the world.

OXYCONTIN CONTINUES TO DESTROY LIVES

HON. FRANK R. WOLF

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. WOLF. Mr. Speaker, over the past year I have been writing to Health and Human Services Secretary Tommy Thompson and Food and Drug Commissioner Mark McClellan urging their action to curb the continuing abuse of the powerful prescription painkiller, OxyContin. In many of those letters I have enclosed newspaper articles about another life destroyed by this drug.

Their inaction is perplexing. The death toll continues to rise and thousands of lives continue to be ruined because of the abuse of this drug. When will they do something to stop this tragedy?

I want to submit the letters I have been sending to Secretary Thompson and Commissioner McClellan over the past six months.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC, March 28, 2003.

Hon. TOMMY THOMPSON,
Secretary, Department of Health and Human Services, Independence Ave, SW., Washington, DC.

DEAR SECRETARY THOMPSON: In December 2001, the Commerce-Justice-State and the Judiciary appropriations subcommittee held a hearing on the illegal diversion of the prescription drug OxyContin, a pain-killing Schedule II narcotic manufactured by Purdue Pharma L.P. One of the witnesses, the father of recovering OxyContin addict, told a gripping story of the devastating impact the drug has had on his family and his son, who was in his early 20s. He proudly told the committee how his son had just finished rehab and had kicked his addiction. Sadly, a few months after appearing before the subcommittee, the son died as a result of abusing the drug.

When used properly, OxyContin is considered a wonder drug, especially for the terminally ill cancer patients. I know what it is like to see people suffer from cancer. Both my mother and father died of cancer. I can remember my mother constantly asking the nurses for more morphine but being told she couldn't have any more. My mother was in a great deal of pain. OxyContin, if it had been available when she was dying, probably would have made her a lot more comfortable at the end.

When used illegally, however, OxyContin destroys families and communities. It also can lead to death. This powerful painkiller has increasingly become a drug of choice for people who choose to abuse it by chewing it or grinding it up. By disabling the time release mechanism in OxyContin, abusers get a heroin-like high.

Initially, cases of abuse and illegal diversion occurred primarily in poor, rural communities in Virginia, Kentucky, West Virginia and Ohio. Abuse is no longer limited to Appalachia. The drug has found its way to urban areas and there are now reports of widespread abuse as far away as Arizona. Florida, I am told, has been hit extremely hard.

Several pharmacies in my congressional District have been robbed at gun point in recent months for OxyContin. No money was taken; the robbers only demanded the drug. Earlier this month, a prominent defense lawyer in northern Virginia who twice served as a local prosecutor in Prince William County pleaded guilty to Federal drug charges linked to a large-scale investigation into the illegal distribution of OxyContin and other painkillers.

Communities where the illegal drug has taken hold are being completely destroyed. I am told there is one county in southwest Virginia where no one isn't either using the drug, knows someone using the drug or been the victim of a crime by someone needing the drug.

When a professional baseball player recently died after taking the dietary supplement ephedra, your agency immediately issued fact sheets regarding potential serious risks of dietary supplements containing ephedra. You were even quoted as cautioning all Americans about using dietary supplements that contain ephedra.

According to fact sheets produced by the FDA, two deaths, four heart attacks nine strokes and five psychiatric cases involving ephedra have been reported. More than 240 people have died from the abuse of OxyContin and countless numbers of families and communities have been torn apart by this drug.

Your agency has done a good job educating the public about the dangers of ephedra and other dietary supplements. I urge you to initiate a similar public information campaign about the dangers of abusing OxyContin.

I have previously written to your department asking for a review of the marketing of OxyContin and its classification for treatment of moderate to severe pain. The Food and Drug Administration did change the warning label on OxyContin but more needs to be done. The drug should not be marketed to treat moderate pain. I urge you to no longer allow OxyContin to be prescribed for moderate pain.

Too many people have died, too many families have suffered and too many communities have been devastated by the improper use of this drug.

Sincerely,

FRANK R. WOLF,
Chairman, Subcommittee on Commerce-Justice-State and the Judiciary.

HOUSE OF REPRESENTATIVES,
Washington, DC, April 7, 2003.

Dr. MARK MCCLELLAN,
Commissioner, Food and Drug Administration, Fishers Ln., Rockville, MD.

DEAR DR. MCCLELLAN: I want to share two newspaper articles about OxyContin that I came across since our meeting Thursday. One is from a paper in my District; the other is from a paper in Florida. Both are very troubling.

I trust you will give this issue the attention it deserves.

Sincerely,

FRANK R. WOLF,
Member of Congress.

HOUSE OF REPRESENTATIVES,
Washington, DC, April 11, 2003.

Hon. TOMMY G. THOMPSON,
Secretary, Department of Health and Human Services, Independence Ave., SW., Washington, DC.

DEAR SECRETARY THOMPSON:

As a follow up to my March 28 letter on OxyContin, I want to share with two recent newspaper articles that I recently came across. One is from a paper in my District; the other is from a paper in Florida. Both are extremely troubling.

OxyContin, when used properly, is a wonder drug. When abused, it is destroying families and communities.

Please look at this issue.

Sincerely,

FRANK R. WOLF,
Member of Congress.

HOUSE OF REPRESENTATIVES,
Washington, DC, May 16, 2003.
Hon. TOMMY G. THOMPSON
Secretary, Department of Health and Human Services, Independence Ave., SW., Washington, DC.

DEAR MR. THOMPSON: Here's another news article from my District and another death.

I am waiting to hear what you are going to do.

Sincerely,
FRANK R. WOLF,
Member of Congress.

HOUSE OF REPRESENTATIVES,
Washington, DC, April 29, 2003.
Dr. MARK MCCLELLAN,
Commissioner, Food and Drug Administration, Fishers Ln., Rockville, MD.

DEAR DR. MCCLELLAN: I want to share with you two news articles I recently came across concerning the marketing of OxyContin. The articles stem from the investigation undertaken in 2001 by the Florida Attorney General. Several sensitive company documents were initially sealed but two Florida papers have successfully sued to make the information public. I have highlighted some extremely troubling sections in the articles.

Please take action.

Sincerely,
FRANK R. WOLF,
Member of Congress.

HOUSE OF REPRESENTATIVES,
Washington, DC., April 30, 2003.
Dr. MARK MCCLELLAN,
Commissioner, Food and Drug Administration, Fishers Ln., Rockville, MD.

DEAR DR. MCCLELLAN: I wanted to be sure you saw this letter by Pennsylvania State Senator LISA BOSCOLA. This is tragic.

The FDA needs to address this issue.

Sincerely,
FRANK R. WOLF,
Member of Congress.

HOUSE OF REPRESENTATIVES,
Washington, DC., May 13, 2003.
Hon. TOMMY G. THOMPSON,
Secretary, Department of Health and Human Services, Independence Ave., SW., Washington, DC.

DEAR MR. THOMPSON: The attached article ran in a newspaper in my District on Monday. Please step in and do something to prevent OxyContin from being allowed to be prescribed for moderate pain. The drug is destroying communities, families and careers.

Sincerely,
FRANK R. WOLF,
Member of Congress.

HOUSE OF REPRESENTATIVES,
Washington, DC., May 13, 2003.
Dr. MARK MCCLELLAN,
Commissioner, Food and Drug Administration, Fishers Ln., Rockville, MD.

DEAR DR. MCCLELLAN: The attached article ran in a newspaper in my District on Monday.

The FDA needs to step in and do something OxyContin should not be allowed to be prescribed for moderate pain. Too many families, communities and careers are being destroyed.

Please take some action.

Sincerely,
FRANK R. WOLF,
Member of Congress.

HOUSE OF REPRESENTATIVES,
Washington, DC., May 21, 2003.
Dr. MARK MCCLELLAN,
Commissioner, Food and Drug Administration, Fishers Ln., Rockville, MD.

DEAR DR. MCCLELLAN: Enclosed is another news story from my District and another death.

I am waiting to hear what FDA is going to do.

Sincerely,
FRANK R. WOLF,
Member of Congress.

HOUSE OF REPRESENTATIVES,
Washington, DC, June 5, 2003.
Dr. MARK MCCLELLAN,
Commissioner, Food and Drug Administration, Fishers Ln., Rockville, MD.

DEAR DR. MCCLELLAN: The enclosed article is from today's Washington Post. When are you going to take some action? Please do something.

Sincerely,
FRANK R. WOLF,
Member of Congress.

HOUSE OF REPRESENTATIVES,
Washington, DC, June 25, 2003.
Hon. TOMMY G. THOMPSON,
Secretary, Department of Health and Human Services, Independence Ave., SW., Washington, DC.

DEAR MR. THOMPSON: See the enclosed article from today's Post.

You have to do something before things get worse.

When a professional baseball player died after taking the dietary supplement ephedra, your agency took immediate action to warn the public about the dangers of taking such supplements. Sadly, the same cannot be said when it comes to your agency's efforts on OxyContin.

Sincerely,
FRANK R. WOLF,
Member of Congress.

HOUSE OF REPRESENTATIVES,
Washington, DC, June 25, 2003.
Dr. MARK MCCLELLAN,
Commissioner, Food and Drug Administration, Fishers Ln., Rockville, MD.

DEAR DR. MCCLELLAN: The enclosed article from today's Post speaks for itself.

Please take some action. What are you waiting for.

Sincerely,
FRANK R. WOLF,
Member of Congress.

HOUSE OF REPRESENTATIVES,
Washington, DC, July 10, 2003.
Dr. MARK MCCLELLAN,
Commissioner, Food and Drug Administration, Fishers Ln., Rockville, MD.

DEAR DR. MCCLELLAN: The enclosed brief was in today's Post. You have to do something. What more evidence do you need that there is a problem?

Sincerely,
FRANK R. WOLF,
Member of Congress.

HOUSE OF REPRESENTATIVES,
Washington, DC, July 10, 2003.
Hon. TOMMY G. THOMPSON,
Secretary, Department of Health and Human Services, Independence Ave. SW., Washington, DC.

DEAR MR. THOMPSON: I wanted you to see this brief in today's Post. As you can see the OxyContin problem has no boundaries.

Thank you for your response to my earlier letters. I hope we can come up with some solutions.

Best wishes.

Sincerely,
FRANK R. WOLF,
Member of Congress.

HOUSE OF REPRESENTATIVES,
Washington, DC, October 28, 2003.
Hon. TOMMY G. THOMPSON,
Secretary, Department of Health and Human Services, Independence Ave. SW., Washington, DC.

DEAR MR. THOMPSON: The enclosed article describes another tragic account of OxyContin abuse.

How many more stories do we have to read about this problem before you take more action?

Sincerely,
FRANK R. WOLF,
Member of Congress.

HOUSE OF REPRESENTATIVES,
Washington, DC, October 28, 2003.
Dr. MARK MCCLELLAN,
Commissioner, Food and Drug Administration, Fishers Ln., Rockville, MD.

DEAR DR. MCCLELLAN: The enclosed article describes another tragic account of OxyContin abuse.

How many more stories do we have to read about this problem before action is taken?

Sincerely,
FRANK R. WOLF,
Member of Congress.

HONORING THE CIVIC LEADERSHIP OF ROBERT SIDNEY AND GAIL PHELAN

HON. JOHN S. TANNER

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. TANNER. Mr. Speaker, today I rise in honor of Robert Sidney and Gail Phelan, fine public servants who have dedicated themselves throughout their lives as loyal citizens to our community.

The couple married in 1958, months after Gail had been crowned Miss Trenton. They are members of the 1st United Methodist Church of Trenton and the proud parents of Robert Sidney Phelan, Jr., Paul Edmund Phelan, and Mary LeAnn Phelan. Robert and Gail also have three grandchildren and two step-grandchildren.

Robert operated the family business, a Ford automobile dealership, for 50 years, before selling it. He has since started a smaller independent dealership. In 1963, Robert became the acting Postmaster while continuing to run his auto dealership. He also served in the Tennessee National Guard, from which he retired as a First Lieutenant. With the help of U.S. Senator Jim Sasser, Robert was instrumental in establishing a new National Guard Armory in 1991.

He has served as Exalted Ruler of the Trenton Elks Lodge and President of the Trenton Chamber of Commerce. Robert also served on the Trenton Rotary Club, the Gibson County Election Commission, the Trenton Housing Authority Board and the Trenton Industrial Board. He served on the board of Citizen

State Bank, spending some of that tenure as Chairman. Robert worked diligently to form Citizen City and County Bank, where he now serves as Chairman of the Board.

The Phelans have always been devoted to the Democratic Party on local, state and national levels, including involvement with generations of Tennessee governors, Members of Congress and Vice President Al Gore. Their son Paul served for 10 years as a State Representative.

The family was instrumental in the formation of the Trenton Special School District and years later helped replace the aging school building with a new high school. Believing that Gibson County could support a satellite community college, Robert and Gail also helped raise money to fund Dyersburg State Community College in Trenton.

Gail has dedicated much of her life to the education of her children and others in our community. She has always been very involved in school parent organizations and takes an active role in making our schools better, including beautiful murals in school hallways.

Gail has not limited her helpful involvement to working with children, however. A cancer survivor, she has been an active participant in Relay for Life efforts of the American Cancer Society and has helped counsel others who are also battling cancer, using her own experiences to help comfort those around her.

Mr. Speaker, please join Robert and Gail's friends and family as we recognize their dedication and service to our community.

IN HONOR OF MAYOR DAVID PENDERGRASS OF SAND CITY, CALIFORNIA

HON. SAM FARR

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. FARR. Mr. Speaker, it is with great honor and pleasure that I am able to rise today to recognize Mayor David Pendergrass, a dedicated public servant of Sand City, California. Mayor Pendergrass has served Sand City for 25 years, where throughout his tenure as a Mayor-Councilmember, Mayor Pendergrass has distinguished himself as a strong leader.

Under Mayor Pendergrass' leadership, the City of Sand City has been enhanced in many different ways. He has overseen the establishment of an active redevelopment program and agency, the organization of a modern city government with a City Administrator-Council administrative structure, and maintained an ongoing forum to receive and respond to citizens' concerns. Furthermore, Mayor Pendergrass has been able to keep Sand City's focus on its primary goals with diplomacy, patience, and consideration.

Mayor Pendergrass' committed public service has improved the quality of life at Sand City, California. He has made great contributions, and his lifelong dedication to public service is commendable. His achievements are truly honorable, and I along with the City of Sand City, honor this great man.

WRITING BY VICKI WILSON

HON. ZOE LOFGREN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Ms. LOFGREN. Mr. Speaker, I am honored to share with my colleagues this editorial written by my courageous friend Vicki Wilson. In it she describes her very personal story about her pregnancy and a procedure that was required to save her life. As Vicki rightly points out, the ban on so-called "partial birth abortion" prevents women—along with their families and doctors—from making private decisions about saving their own lives and protecting their right to future pregnancies.

A short while ago, the House debated the so-called "Partial Birth Abortion" ban. Several members who supported the ban tried to deny Vick's story.

Those Members didn't know what they were talking about. Here is the truth as printed in the San Jose Mercury News.

[From the San Jose Mercury News]

HEARTBREAK AND A CHOICE: I HAD AN ABORTION AT EIGHT MONTHS

(By Vicki Wilson)

The right to end a pregnancy is frighteningly precarious, something I didn't understand until I had an abortion at eight months. The new abortion ban covers what is not actually a recognized medical procedure; "partial birth" was coined by the anti-choice lobby to rile public sensibilities and distort the truth.

At 36 weeks of pregnancy, an ultra-sound showed what all my previous prenatal testing failed to detect—an encephalocoele. Two-thirds of my daughter's brain had formed outside her skull. What felt to be strong, big, healthy baby movements were in fact seizures.

My doctor sent me to several specialists in a desperate attempt to find a way to save her. Everyone agreed she would not survive outside my body. As the pregnancy progressed before I went into labor, she would probably die from the increased compression of her brain.

Our doctors explained our options. Let "nature take its course." But how could I let my daughter suffer the ongoing seizures? Second: Abortion. My God! I thought. Here I am at the end of a planned and very much wanted pregnancy: Her name is Abigail. How can one even utter the word "abortion" now? Despite being a nurse, I'd never heard of any abortion in the eighth month. I asked about a Caesarean section. Doctors perform C-sections only to save babies lives. Mine couldn't be saved so they didn't want to risk the possibility of hurting my future fertility. It was a risk I wasn't willing to take either.

We agonized over our options, which doesn't convey the heartbreak and rage we felt. It was hard even to think of these "choices." I wanted my daughter to be born with a brain—period. We decided to make our choice based on what was best for Abigail.

As health-care professionals, my husband and I understood the medical risks of each alternative. We understood that it wasn't "is she going to die"—a higher power had decided that—but "how?" To this day, I thank God that this decision, at least, was ours.

I continue to battle the anti-choice hardliner machine from banning the very procedure that saved my health and ended Abigail's suffering. When will politicians understand: The decision about terminating a pregnancy should be between women, their family and their doctors—not politicians. While I was struggling with the most wrenching choice I have ever made, it never occurred to me to confer with a lawyer or a judge or a politician.

Those opposed to abortion for any reason declare that women are selfishly choosing to end their pregnancies late. They deny medical necessity; they'd rather see Abigail suffer and me lose my fertility than allow us to choose the most decent path for our family.

They state that Americans are opposed to their politically motivated "partial birth" abortions. They don't acknowledge that Americans believe the choice should remain with my family.

Almost nine years have passed since we lost Abigail, and not a day passes that I don't think of her. In my heart I know I did the right thing for me and my family.

EXPLANATION OF VOTE ON CONFERENCE REPORT ON FY 2004 DEFENSE AUTHORIZATION BILL

HON. RUSH D. HOLT

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. HOLT. Mr. Speaker, the final version of this legislation continues our shared bipartisan commitment to boost the income for all of our military personnel with a 4.15-percent average increase in base pay. This is an important testament to the brave men and women who risk their lives to defend America's freedom.

In addition, this conference report extends several special pay provisions and bonuses for active duty personnel through December 31, 2004. It reduces the average amount of housing expenses paid by service members from 7.5 percent to 3.5 percent in FY 2004 and eliminates the out-of-pocket expense completely by FY 2005. It increases the family separation allowance for service members with dependents, worldwide, from $100 per month to $250 per month for the period beginning October 1, 2003 and ending December 31, 2004. Finally, it increases the rate of special pay for those subject to hostile fire and imminent danger, worldwide from $150 per month to $225 per month for the period beginning October 1, 2003 to December 31, 2004.

While I am not satisfied with the provisions in this conference report regarding concurrent receipt for military retirees, it does provide some, overdue redress for this out-of-date policy.

But on balance, I am opposing this final conference report because I fundamentally disagree with key aspects of its policy presumptions and prescriptions. On balance, it will make America less safe in an increasingly unstable world.

First and most importantly, the growing reliance upon nuclear weapons that this legislation encourages makes our nation and the world less safe, not more so. Accordingly, I strongly disagree with the funding in this bill to continue work on high yield, burrowing nuclear "bunker-busters" that target underground military facilities or arsenals. I am equally opposed to the language in this bill that lifts the ban on research leading to low yield "mini-nuclear weapons" of 5 kilotons or less.

Last April, I sent a letter to President Bush that was co-signed by 34 of my colleagues to convey our grave concern that he is weakening long-standing U.S. policy governing the use of nuclear as opposed to conventional weapons. I regret that we have never received a substantive reply from the President. That congressional action coupled with the examples I've cited and other provisions in this conference report further undermine the U.S. nonproliferation efforts of Republican and Democratic Presidents alike and heighten growing international fear that Bush Administration's policies are fueling a new nuclear arms race.

Second, I am opposed to the blanket exemptions from our nation's environmental protection laws for the Pentagon in this bill. There is no convincing evidence that environmental laws like the Clean Air Act and the Endangered Species Act hinder our military's capacity to defend our nation.

But you don't have to take my word for it. Former EPA Administrator, Christine Whitman, testified to the Congress that she does not "believe that there is a training mission anywhere in the country that is being held up or not taking place because of environmental protection." Furthermore, the U.S. General Accounting Office (GAO) has reported to the Congress that the Pentagon has failed to produce any evidence that environmental laws have significantly affected our military readiness.

I do not think the Pentagon or any other federal agency should be above the law. Moreover, current law already allows case-by-case environmental exemptions for the Pentagon, when they are determined to be in the national interest.

Finally, this conference report also contains provisions that will be very harmful to hundreds of thousands of dedicated civilian men and women who make our Defense Department work.

Last year saw the largest government reorganization in more than 3 decades with the creation of the U.S. Department of Homeland Security, affecting 170,000 federal employees. Following extensive congressional debate, Secretary Ridge was granted authority to establish a more flexible that attempted to protect basic worker rights.

But this legislation will give Defense Secretary Rumsfeld broad authority to rollback worker protections for hundreds of thousands of Pentagon employees. There will be nothing to prevent agency managers from abusing their power for political advancement or engaging in discriminatory practices. Allowing managers the ability to waive such protections under the guise of national security and the need for greater flexibility is wrong. It will not make us safer.

Thanks to this legislation, Secretary Rumsfeld will be able to do away with the current personnel system in the Pentagon. I am unwilling to give the Bush Administration a blank check to undo, in whole or in part, many of the civil service laws and protections that have been in place for nearly a century to safeguard against the return of an unfair patronage system.

I want to be very clear. I support a strong national defense. I support modernizing our military. I support giving our troops the resources and training they need to keep our nation secure. But I cannot support this conference report which contains provisions that will take our military backwards, rather than forwards. I cannot support legislation that will re-ignite a global nuclear arms race, even as our troops in Iraq and elsewhere risk their lives every day to stop the spread of nuclear weapons. I cannot support legislation that takes away the rights of hundreds of thousands of hard-working Pentagon employees Finally, I cannot support legislation that disingenuously claims that stripping away important environmental protections here at home will somehow bolster our national security.

IN MEMORY OF KESH

HON. JIM McDERMOTT

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. McDERMOTT. Mr. Speaker, his full name was Nayaran Dilip Keshavan Ayyangar, but everyone simply knew him as Kesh. Kesh was a journalist, a Hill staffer, a community activist and a friend to anyone who cared passionately about the political, economic and cultural relationship between his adopted country, the United States, and his native country, India.

Last Thursday, November 13th, Kesh was doing what he had done for the past 2 decades. He was advocating that India's interests were in confluence with the United States'. He had just finished taping an appearance on Lou Dobbs's Moneyline on CNN. Ten minutes after leaving the studio, Kesh was dead of a massive heart attack at the young age of 53.

Mr. Speaker, as a former Chairman of the Congressional Caucus on India and Indian Americans, I know first hand the gravity of the loss both countries have suffered. Not only was Kesh's knowledge of U.S. India relations comprehensive, the breadth and depth of his contacts, here in Washington and back in Delhi, was truly amazing.

A review of Kesh's career will give our colleagues an idea of why Kesh was such a critical player in the U.S India dialogue. For the past 2 years Kesh served as President of the New York City Chapter of the Indian American Forum for Political Education. Prior to that he was the Executive Director of the India Caucus here in this body. And for more than 15 years before coming to Capitol Hill, Kesh was a distinguished journalist, serving as Editor in Chief of the India Post, as the Washington Bureau Chief of the Indian American, as a reporter for the Washington Times and as the Chief Diplomatic Correspondent for the New York City Tribune. Kesh was educated here in the U.S. at the School of Journalism at Syracuse University and also in India at Osmanis University in Hyderabad, where he obtained a journalism degree, and at Andhra University, where he was awarded a degree in pharmacy.

Mr. Speaker, I am certain all members of this body join me in expressing our condolences to his father, a former head of the Indian Geological Survey, his sister, and his many friends, both here in the United States and back in India. We have all lost a devoted public advocate. Kesh's loss will be felt for many years.

HONORING SARGENT SHRIVER

HON. SAM FARR

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. FARR. Mr. Speaker, I rise today to honor the dedication, spirit, and accomplishments of my good friend Sargent Shriver who celebrated his 88th birthday last week. I met Sarge while I was in Peace Corps Training in Questa, New Mexico in 1963. He was a hero figure: handsome, smart, engaging, and the President's brother-in-law. We were all so proud of being chosen to be in one of the early waves of the Peace Corps. President John F. Kennedy asked our nation's citizens to "ask not what this country could do for you, but what you can do for your country." Sargent Shriver was a living demonstration of the way to serve and the spirit it took to launch the new and bold idea of the Peace Corps.

Peace Corps began under Sargent Shriver's directorship on March 1, 1961. Today, over 170,000 Americans, including six members of Congress, have served in 136 countries. Many volunteers who served under Sargent Shriver have become Ambassadors, Presidents of Universities, and Chairmen of major corporations.

Sargent Shriver began his public service in the United States Navy where he earned the rank of Lieutenant Commander. Following his naval career, Sargent Shriver dedicated himself to the societal problems facing the youth of the country—organizing the National Conference on Prevention and Control of Juvenile Delinquency in Washington and serving as the President of the Chicago Board of Education. He continued to foster quality social programming through the creation of VISTA, Head Start, Community Action, Foster Grandparents, Job Corps, Legal Services, Indian and Migrant Opportunities and Neighborhood Health Services. In addition, Sargent Shriver has served on the Board of many humanitarian organizations, including as President of the Special Olympics

Sargent Shriver's dedication to living his ideals, and making them a reality has inspired subsequent generations to do the same. His invaluable contributions to the formation and longevity of the Peace Corps has brought hope to people around the world and has educated generations of Returned Peace Corps Volunteers, such as myself, in the necessity and value of public service. The Peace Corps continues to be a means for understanding the cultures, and languages of the world while recognizing the differences between different countries.

The vision of peace that Director Shriver has committed so much time and energy to has only become more important during this time of war. Director Shriver once wisely said, "I say what our nation needs now is a call to peace and service—peace and service on a scale we have scarcely begun to imagine." Mr. Speaker, today I honor Sargent Shriver and wish him the very best in the coming year.

RECOGNIZING THE CONTRIBUTIONS OF BOB SINCLAIR TO SAVING LIVES IN TENNESSEE

HON. JOHN S. TANNER

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. TANNER. Mr. Speaker, I rise today to recognize the accomplishments of a tireless public servant, Mr. Bob Sinclair. The service he has provided over the years through the Henry County Ambulance Service has touched—and saved—many lives in our community.

Mr. Sinclair is a decorated veteran of World War II and a former employee of the Tennessee Valley Authority, but it is his dedicated work for the Henry County Ambulance Service that makes him stand out among the rest.

He started his service on January 1, 1969, the first day of operation for the ambulance service, which was one of the first countywide ambulance services in Tennessee to also offer an emergency medical technician training program. Sinclair volunteered for rotating shifts so his workers could get the training they needed to become paramedics. The service was originally based in the Paris Fire Department, and hearses purchased from the Ridgeway Morticians were used as ambulances.

Mr. Sinclair remained diligent, however, and helped the ambulance service grow, becoming director in 1970 and remaining there until 1985, when the service was assigned to the Henry County Medical Center. Mr. Sinclair is now a member the HCMC Board of Trustees and has also been a longtime member of the Henry County Commission.

Mr. Sinclair continued to give his time and devotion to the Henry County Ambulance Service and overcame many obstacles, such as funding and vehicle replacement issues. He helped make the ambulance service what it is today.

Time and time again, Mr. Sinclair has given his time and dedication to his community, and this will continue to be appreciated. Mr. Speaker, please join me in honoring the accomplishments and dedication of a fine leader, Mr. Bob Sinclair.

PERSONAL EXPLANATION

HON. LUIS V. GUTIERREZ

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. GUTIERREZ. Mr. Speaker, I was unavoidably absent from this chamber on September 3, 2003. I would like the record to show that, had I been present, I would have voted "yea" on rollcall votes 460, 461 and 462. On September 4, 2003, I missed rollcall vote 467 and would like the record to show that, had I been present, I would have voted "nay."

INTRODUCTION OF THE "METROPOLITAN CONGESTION RELIEF ACT"

HON. EDDIE BERNICE JOHNSON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I am pleased to introduce legislation that strengthens our commitments to the public and their local decision-makers in both urbanized and rural areas of this nation.

The "Metropolitan Congestion Relief Act" proposes a number of simple adjustments to the TEA–21 law, which as you know is now under discussion in the House Transportation Infrastructure Committee. Two days ago, the leaders of the Committee introduced legislation setting forth a six-year reauthorization plan for TEA–21, legislation that I am proud to cosponsor.

My legislation compliments the Committee legislation and proposes key adjustments to current congestion-related programs. This legislation would ensure that our national policy more fully engages and supports local elected leaders and the communities they represent. We need to engage the public and local decision-makers to address the nation's many transportation challenges.

The proposals in this legislation include two initiatives that follow the basic thrust of the Committee's TEA–21 renewal package.

First, this legislation invests more in our local decision-makers, those who now lead our nation's very important metropolitan economies and those in non-urbanized areas. Secondly, it further strengthens the partnership set forth in the 1991 ISTEA law that began devolving resources and decision-making to the nation's larger metropolitan areas. Finally, this legislation continues to place more responsibility where it belongs, with local community leaders and metropolitan planning organizations. These are the entities most challenged by pressing transportation needs, be it traffic congestion, air quality degradation or the rising demands of global competition.

These selected reforms and adjustments will yield results for all areas of our states. In those provisions targeted to metropolitan areas, all taxpayers and areas will benefit as these additional commitments will improve the performance of our existing assets and help us use available transportation dollars more efficiently.

Mr. Speaker, let me talk for a minute about the key features of this legislation and what it does and does not do.

First, it does not affect the allocation of resources from any of TEA–21's formula highway programs to the states, which is to say that it is policy neutral on the donor/donee issue. For the record, I am one member who has an interest in seeing more equity among the states, and this legislation does not disrupt any of these important efforts.

Second, the law this legislation amends is the Transportation Equity Act for the 21st Century. As we make progress on equity among the states, we should also make some greater strides in providing some modest assurances of equity to local areas and local taxpayers within our states. Here in this chamber and in the Transportation Committee we talk often about "fair share" among the states, and yet there is nothing in current law that addresses how equity is assured at the sub-state level.

Let me illustrate this point further from the perspective of my district and the Dallas-Fort Worth region. As each new fiscal year arrived under TEA–21, local decision-makers in my region were certain that they would determine the fate of about 2½ cents of every highway formula dollar coming to the State of Texas. This is an inadequate commitment to a region that accounts for nearly one out of every five Texans and, in recent years, more than one out of every three new jobs in the State. By the donor/donee yardstick, this amounts to my local decision-makers having the certainty and direct control over about 10–12 cents on every federal highway dollar that is generated from local taxpayers and returned to the state. This is simply inequitable and can no longer be justified.

My legislation proposes to deliver more certainty to all areas of the state, both large and small, helping make some modest gains in ensuring more funding equity for the public in their local areas.

The legislation directs that Surface Transportation Funds provided to each of the states, either through the STP or indirectly through the unprogrammed share of the Minimum Guarantee program, be directed to local areas, following existing law using the fair share distribution to urbanized and non-urbanized areas. All areas within the states will have more funding certainty as a result.

Third, the Metropolitan Congestion Relief Act enhances our federal surface transportation policies by enlisting local decision-makers and their substantial transportation assets under their control more fully into the TEA–21 partnership.

In addition to directing more STP and Minimum Guarantee resources to metropolitan planning organizations and other local areas under ongoing state-directed programs, the legislation specifically directs states to work more directly with local decision-makers, particularly in the larger urban areas, in deciding on investments in the National Highway System. This is a critical asset for all of us and one where local governments either own a share of these facilities or where locally-owned facilities are substantially affected by NHS facility investments.

Let me provide some additional background on this and related points. One of the weaknesses of the current Federal policy is that it relies too heavily on overburdened State transportation agencies. Overall, States own the smallest share of the Nation's transportation facilities relative to local governments and yet are given direct control over an overwhelming share of Federal transportation dollars. On average, for each highway dollar that a State receives, only six percent is guaranteed to reach local decision-makers, those in metropolitan areas of 200,000 or more where more than one out of every two Americans live.

Let me explain further. Presently, local governments—cities, towns and counties—directly or indirectly through regional agencies own and/or operate more than three-quarters of the

Nation's roads and streets, about one-half of the Nation's bridges, more than ninety percent of all transit systems and about the same share of the Nation's airports, most of the train stations, port facilities, traffic signals, public parking structures, sidewalks and trails, and so on. Let us not forget that 63 percent of urban area highways in the Federal Aid System, which includes those facilities generally eligible under Federal TEA–21 programs, are owned by local governments. Yet, existing policy directs virtually all of the resources to State highway and transportation departments.

In aviation, Congress rightly directs resources to the agencies, be it the State, region or local government who own and operate airports. In transit, Congress rightly directs resources to the level of government who delivers these services. In flood control, the State, region, or local agency responsible for the improvements receives the funding. And so on.

As this Congress seeks to address the burdens of congestion the need for smarter and more balanced transportation investments to give taxpayers more for their dollars, we must recognize that we have reached the point where it is impossible to achieve these outcomes without more fully involving our local transportation partners. This means bringing local elected officials—mayors, city council members, county executives and commissions, and others—more fully into this partnership. This legislation makes some modest adjustments and empowers these critical officials in the transportation partnership.

Finally, this legislation specifically addresses the needs of local areas with the most air quality and congestion problems. It does so by directing States to allocate Congestion Mitigation and Air Quality Improvement program (CMAQ funds to local areas that are in nonattainment or maintenance of applicable national ambient air quality standards. Specifically, it requires States to pass these funds to local areas on a fair share basis where metropolitan planning organizations are in place. Simply put, States earn CMAQ funds based on local air problems and the legislation makes sure that funds are passed through to these areas. Recently, this chamber debated the extension of the compliance deadlines in some Texas cities and other places, all the while my own State of Texas had piled up more than $270 million in unspent CMAQ funds that could have helped improve air quality in my area and others in the State. This provision will make sure that the local areas that carry these-requirements under Federal law are certain to receive their fair share of the resources that are provided.

There are also two new initiatives in the legislation that address congestion. One is a new $2 billion annual formula program aimed at the Nation's most congested metropolitan markets, as analyzed by the Texas Transportation Institute. This program will target resources to areas of the Nation with clear congestion needs. The other program will provide modest resources of $500 million annually to local governments to support incident management programs.

Let me speak to the need for these targeted programs. Every taxpayer and every community in our States benefits if we make some selected investments that improve the performance of our Nation's most productive economic centers. All of our economic data shows that our metropolitan areas are truly the economic engines of our State economies and help drive overall U.S. economic growth. They now account for the overwhelming and disproportionate share of the Nation's new jobs, personal income and total economic output. This legislation speaks directly to the pressing needs of these city and county metropolitan areas by investing immediately in congestion relief strategies and programs that will pay substantial dividends to the economic bottom lines of our State and the Federal Government. These initiatives, coupled with other provisions in this legislation, will help us extract more economic output from these areas.

This investment in our regional economic engines will also position our Nation more favorably in the global competition of world trade. For instance, consider my own district, the Dallas Metro area, not including the adjoining Fort Worth Metro area. The Dallas Metro area produced more goods and services—about $170 billion in 2001—than 29 States. This output exceeded that of many countries, such as Denmark or Hong Kong. This legislation is about recognizing the importance of the role local decision-makers play in steering these vital economic units and the value of tapping the vast range of our Nation's broadest asset base. In the end, our Federal policy needs to go beyond the Federal/State partnership of the 1950s that was built around the Interstate era. The 1991 ISTEA made some strides to update our institutional arrangements, and this legislation builds on those improvements.

Mr. Speaker, this legislation is nonpartisan. It represents an effort to establish a fair and equitable distribution of our Federal transportation dollars.

HONORING C.K. WILLIAMS

HON. RUSH D. HOLT

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. HOLT. Mr. Speaker, this week C.K. Williams was honored with the National Book Award in Poetry for his book "The Singing: Poems".

The National Book Award, established in 1950, has become one of the most significant literary prizes in the country and comes with a $10,000 cash award. A creative writing professor at Princeton University since 1995, C.K. Williams has authored 14 books of poetry over his long and distinguished career and in 2000 he received the Pulitzer Prize in poetry for his work "Repair".

Charles Kenneth Williams was born in Newark, New Jersey in 1936. He started writing poetry at the age of 19 and has said that "Poetry didn't find me, in the cradle or anywhere else near it: I found it. I realized at some point—very late, it's always seemed—that I needed it, that it served a function for me—or someday would—however unclear that function may have been at first."

Mr. Speaker we all are very lucky that C.K. Williams found poetry and its clear to me that he has served a function to those of us who have had the pleasure to read his wonderful poetry. At times his poetry delves in to the dark areas of despair and our eventual mortality. As such his poetry is thought provoking, deeply moving, and at times extremely personal.

Again, I congratulate Mr. Williams on his award, and I deeply thank him for the contributions he has made through his poetry to enrich our society. C.K. Williams continues in the long great tradition of other New Jersey poets such as Walt Whitman, William Carlos Williams, Alan Ginsburg, and Robert Pinsky, and he is certainly one of the best poets that New Jersey has to offer today. And as the National Book Selection Committee, The Pulitzer Committee, and other juries make clear, C.K. Williams is one of the best. I am so pleased to have a poet of such talent and mettle both writing and teaching in my district.

Mr. Speaker I would like to include in the RECORD a copy of the title poem of C.K. Williams's award winning book, which is entitled The Singing.

THE SINGING

I was walking home down a hill near our house on a balmy afternoon under the blossoms
Of the pear trees that go flamboyantly mad here every spring with their burgeoning forth
When a young man turned in from a corner singing no it was more of a cadenced shouting
Most of which I couldn't catch I thought because the young man was black speaking black
It didn't matter I could tell he was making his song up which pleased me he was nice-looking
Husky dressed in some style of big pants obviously full of himself hence his lyrical flowing over
We went along in the same direction then he noticed me there almost beside him and "Big"
He shouted-sang "Big" and I thought how droll to have my height incorporated in his song
So I smiled but the face of the young man showed nothing he looked in fact pointedly away
And his song changed "I'm not a nice person" he chanted "I'm not I'm not a nice person"
No menace was meant I gathered no particular threat but he did want to be certain I knew
That if my smile implied I conceived of anything like concord between us I should forget it
That's all nothing else happened his song became indecipherable to me again he arrived
Where he was going to a house where a girl in braids waited for him on the porch that was all
No one saw no one heard all the unasked and unanswered questions were left where they were
It occurred to me to sing back "I'm not a nice person either" but I couldn't come up with a tune
Besides I wouldn't have meant it nor he have believed it both of us knew just where we were

In the duet we composed the equation we made the conventions to which we were condemned
Sometimes it feels even when no one is there that someone something is watching and listening
Someone to rectify redo remake this time again though no one saw nor heard no one was there

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INTRODUCTION OF BIPARTISAN RESOLUTION ON JUÁREZ

HON. HILDA L. SOLIS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Ms. SOLIS. Mr. Speaker, I rise today to introduce this bipartisan resolution with my colleagues Ms. SLAUGHTER, Mr. REYES, Mr. RAMSTAD, Mr. RODRIGUEZ, and Ms. CAPITO. We are deeply concerned about the murders and violence against women that has occurred in the state of Chihuahua, Mexico. Since 1993 over 300 women have disappeared from this area. Oftentimes their mutilated bodies are found in the abandoned or desert areas. This resolution expresses our sincerest condolences and deepest sympathy to the families of the victims, and encourages increased U.S. involvement in bringing an end to these heinous crimes that for the most part have gone unsolved.

SMALL BUSINESS BANKRUPTCY VENUE RELIEF ACT

HON. RICHARD H. BAKER

OF LOUISIANA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. BAKER. Mr. Speaker, the recent bankruptcy of a large chemical company in Louisiana has alerted me to the difficulties that small businesses can face in bankruptcy proceedings. In the wake of this chemical company's bankruptcy, a number of small businesses in Louisiana found themselves defendants in preferential payment lawsuits brought by the bankruptcy trustee. Many of these companies were shocked that they would be accused of receiving preferential payments when they had had a long history of consistent business dealings with the chemical company. Not only were these businesses surprised by the lawsuits, but they were dismayed that they were forced to defend these lawsuits in Delaware. The burden of hiring an attorney in Louisiana and Delaware was significant and a number of these small businesses were forced to settle these meritless lawsuits to avoid the costs associated with a legal defense.

I believe that we are placing these small businesses in an unacceptable position. Asking small businesses to pay several thousand dollars in legal fees or settlement fees is a significant burden for many of these businesses. It appears that in a number of cases, bankruptcy trustees realize the leverage they have on these small businesses and exploit this leverage. It costs little for the trustees to file suit against these small businesses and then the trustees have the luxury of adjudicating the lawsuits in the State they are working in. Authorizing penalties for frivolous lawsuits and changing the venue for preferential payments cases that fall below a meager $5,000 threshold has done little to improve the situation for small businesses. I believe that we must force bankruptcy trustees to take a harder look at the merits of these preferential payments cases and we need to allow small businesses the courtesy of defending these lawsuits in the State in which they reside.

For this reason, I have introduced the "Small Business Bankruptcy Venue Relief Act." This legislation will allow small businesses of under 25 full-time employees to defend preferential payments claims in the State where they reside. In addition to lowering legal costs for these small businesses, this legislation will force bankruptcy trustees to give greater consideration to the merits of preferential payment claims against small businesses.

Mr. Speaker, I hope that members will consider the plight of small businesses and cosponsor the "Small Business Bankruptcy Venue Relief Act."

PERSONAL EXPLANATION

HON. LUIS V. GUTIERREZ

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. GUTIERREZ. Mr. Speaker, I was unavoidably absent from this Chamber on July 8, 2003. I would like the RECORD to show that, had I been present, I would have voted "nay" on rollcall vote No. 334 and "yea" on rollcall votes Nos. 335 and 336. On July 10, 2003, I was absent from this Chamber for a journal vote No. and I would like the RECORD to show that, had I been present, I would have voted "yea" on rollcall vote No. 346.

On July 14, 2003, I was absent from this Chamber and I would like the RECORD to show that, had I been present, I would have voted "yea" on rollcall votes Nos. 354, 355, 358 and 359 and "nay" on rollcall vote No. 356. I was also absent from this Chamber on July 17, 2003, and would like the RECORD to show that, had I been present, I would have voted "yea" on rollcall vote No. 387. Furthermore, on July 18, 2003, I was unavoidably absent from this Chamber and I would like the RECORD to show that, had I been present, I would have voted "yea" on rollcall vote No. 396 and "nay" on rollcall vote No. 397.

On July 21, 2003, I was absent from this Chamber and I would like the RECORD to show that, had I been present, I would have voted "yea" on rollcall votes Nos. 398, 399 and 400. I was unavoidably absent from this Chamber on July 24, 2003 and would like the RECORD to show that, had I been present, I would have voted "yea" on rollcall vote No. 441. I missed rollcall vote No. 452 on July 25, 2003, and would like the RECORD to show that, had I been present, I would have voted "nay."

IN RECOGNITION OF BANQUET HONORING THE HEROES OF THE MONTGOMERY, ALABAMA BUS BOYCOTT

HON. MIKE ROGERS

OF ALABAMA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. ROGERS of Alabama. Mr. Speaker, I rise today to join the Montgomery, Alabama Transportation Coalition in recognizing the heroes of the 1955 Montgomery Bus Boycott.

On December 4, 2003, the Coalition will hold its annual awards dinner, and the theme for this year's banquet is "Reclaiming the Dream." They have chosen this occasion to honor the heroes of the Montgomery Bus Boycott. These heroes are former Pastor Robert Graetz, Mrs. Inez Jessie Baskin, Mrs. Johnnie Carr, Mrs. Daisy Childrey, Mrs. Thelma Glass, Mrs. Hazel Gregory, Mrs. Vera Harris, Mr. Bobby Jackson, Mrs. Zecozy Williams, and posthumously, Mrs. Aurelia Browder, Mrs. Virginia Durr and Mr. Eddie Posey.

INTRODUCING THE AUDITOR INDEPENDENCE AND TAX SHELTERS ACT

HON. RAHM EMANUEL

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. EMANUEL. Mr. Speaker, today, I am proud to introduce bipartisan legislation to stop the unethical, and in certain cases, criminal conduct by some of our Nation's most respected accounting firms that market abusive tax shelters under the guise of "non-audit services" to the public companies whose books they audit—in effect auditing their own work. The Auditor Independence and Tax Shelters Act, cosponsored by Representatives MARK FOLEY, BART STUPAK, DAVE CAMP, and TOM LANTOS, will eliminate this irreconcilable conflict of interest that fuels the engine of an ever-expanding tax shelter industry.

Ongoing Senate hearings and the General Accounting Office investigations reveal that tax revenue lost from known shelters totaled $33 billion over the past decade, and that losses from undetected shelters could total another $52 billion. Last year, for example, an abusive tax shelter known as "Slapshot" was expected to produce tax breaks exceeding $120 million for Enron. It was based on a $1 billion loan and concealed by a highly intricate combination of loans and stock transactions occurring within minutes of each other that were designed to prevent tax regulators and authorities from discovering what really happened.

As William McDonough, Chairman of the Public Company Accounting Oversight Board recently said, major accounting firms have suffered a "complete ethical collapse." Chairman McDonough added during recent testimony before Congress that the willingness to sell faulty tax shelters and hide them from the IRS is "immensely and immorally repugnant." Moreover, David Clay Johnston of the New York Times and author of Perfectly Legal, reports that tax avoidance among corporations and upper-income individuals is far outrunning the audit capacity of the IRS. He estimates that a $113 billion gap exists between what corporations should be paying and what they actually pay. Clearly, the burden of this gap in tax receipts is being shouldered by middle-class families.

In response to this costly and unethical practice, our legislation prohibits auditors from providing those tax shelter services for which a significant purpose is the avoidance or evasion of federal income tax to the publicly traded corporations they audit. The bill also prohibits auditors from offering tax shelter services to the corporation's officers and directors. Additionally, guiding principles under this bill will clarify how audit committees decide whether the corporation's auditor may provide certain non-audit services to the corporation. If the audit committee finds that a proposed service would reasonably result in an impairment of the auditor's independence by violating one of these principles, the audit committee would be unable to approve the proposed service.

Under our legislation, auditors would still be able to market tax reduction strategies to other companies and individuals, but not to the companies that they are responsible for auditing. This is a common sense approach to protecting our investors and American middle-class families from the increasing cost and the expanding prevalence of tax shelters, which should be exposed for what they really are—unfair and unpatriotic corporate behavior, and which should be stopped once and for all.

COMMENDING LAFARGE CONSTRUCTION MATERIALS

SPEECH OF

HON. BOB BEAUPREZ

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. BEAUPREZ. Mr. Speaker, I would like to take this opportunity to commend Lafarge Construction Materials on their exceptional contribution as a corporate member of the Golden community.

Lafarge West operates the Specification Aggregates Quarry on Colfax Avenue in Golden, Colorado. I am proud to serve Golden as their Congressman, especially after watching this tremendous effort put forth by all parties involved to create a win-win situation for Lafarge, the city of Golden, concerned environmental groups and, of course, the citizens of Jefferson County.

In fact, I recently received a letter from the mayor of Golden, Charles Baroch where he said, "Lafarge has for many years been a good neighbor, being very concerned about the impact of the mine and crushing plant on the neighborhood. Lafarge listens to citizens concerns and takes action to correct the problem. Most everyone in Golden is proud to have this business a part of Golden."

The partnership began when Lafarge realized it's basic need to increase the reserves of the quarry to serve the growing Denver market. A market, I hope, that will be even stronger soon with the passage of a new transportation re-authorization bill.

So, in the spirit of cooperation, Lafarge began a 2-year process of meeting with local citizens, businesses, community leaders and environmental groups to learn what concerns may be out there regarding a quarry expansion. In the end, after many presentations, many meetings and many late nights, they did find that win-win solution. Scott Gudahl put it simply when he said, "We kept addressing expectations and concerns until there were none left—and that's what you basically have in the final proposal."

That final proposal was an innovative land swap. The quarry will be able to expand by 60 acres and Jefferson County will receive more than 500 acres of added scenic open space. Even the quarry itself, once reclaimed, will be donated as additional open space for the enjoyment of Jefferson County citizens.

Mr. Speaker, you know as well as I that all too often, good honest businesses are painted with unfair labels by those who do not understand the process of making the roads and highways that keep our economy moving. I applaud the people at Lafarge for putting forth the extra effort not only to create a better company, but also create a better community. I am proud of their efforts and I am proud to represent their employees in this Congress.

IN RECOGNITION OF THE 125TH ANNIVERSARY OF THE CITY OF HURTSBORO, ALABAMA

HON. MIKE ROGERS

OF ALABAMA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. ROGERS of Alabama. Mr. Speaker, I rise today to pay tribute to the City of Hurtsboro, Alabama, on its 125th anniversary of its incorporation on December 4, 2003.

Hurtsboro, Alabama, located in Russell County, Alabama, was originally station Number 4 on the Mobile and Girard Railroad. In 1857, Joel Hurt, Sr. came to the site of Hurtsboro and with a partner, William Marshall, bought land and established a sawmill by a creek now called Hurtsboro Creek. Mr. Hurt had moved from Eatonton, Georgia, to Olivet, Alabama, a thriving farm community about 3 miles from Hurtsboro. However, when Olivet was bypassed in the survey to the Mobile and Girard Railroad, Mr. Hurt moved to the railroad site. In 1858, when the railroad reached the place, the mill company laid out the town, with the mill in the center. It was called Hurtsville for the principal founder.

On November 8, 1878, a petition was filed with the Russell County Judge of Probate Simeon O'Neal by more than 20 of the male inhabitants of the town laying out the boundaries of the town and the name to be given if incorporated and requesting that an election be held for incorporation. Judge O'Neal then set the election for December 3, 1878, and on that day, no votes were cast against incorporation. Therefore, on December 4, 1878, Judge O'Neal made entry in the record that inhabitants of the town of Hurtsville were incorporated under the name of "Hurtsville" with such boundaries to extend one half mile in every direction from the present public crossing at the depot of the Mobile and Girard Railroad. On March 24, 1883, a petition was filed by more than 10 of the male inhabitants of Hurtsville that the name of the town be changed to "Hurtsboro" (to avoid confusion with the town of Huntsville, Alabama). An election was held on April 11, 1883, and based on the results, Russell County Judge of Probate Simeon O'Neal entered into the record that the town's name be changed to "Hurtsboro."

I congratulate Hurtsboro, Alabama, on its 125th anniversary of incorporation and join its residents in recognizing their proud history.

COMMENDING PENNINGTON ELEMENTARY IN WHEAT RIDGE

HON. BOB BEAUPREZ

OF COLORADO

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. BEAUPREZ. Mr. Speaker, I rise today to add to the RECORD a story of true leadership and determination occurring in the very place that it should, our school system.

I recently had the honor of visiting Pennington Elementary, a small school located back home in my great Colorado district. Not only was I impressed by the moral this house of education puts forth to its visitors, I was amazed at the progress I learned of that these young minds are making and the dedication of their instructors and administrators.

Four years ago Pennington Elementary was considered to be the school to which no one wanted to send their children. The children in the community were known to be impolite and irresponsible. Now if you ask neighbors of this accomplished school about the little ones' demeanor in and out of the school setting, they will tell you the children are intelligent, delightful and always polite and courteous to those around them.

This school of only 248 students has risen to the top of the pile and now begins their day with a "Pennington Pledge" as a daily reminder of what they stand for; a good motto for any upcoming citizen. It reads:

> We the students of Pennington agree to have a drug free school, a safe and orderly learning environment, to be big brothers and big sisters to any little student. As a responsible citizen I will follow the rules of Pennington.

Because the school has changed the outlook of the staff, community and parents, success is a regularly heard word within the walls of Pennington Elementary. The school's standardized state test scores have risen from 28 percent proficient or better in 1998–1999 to 56.7 percent during the 2002–2003 school year and continue to rise. Their fourth grade reading scores alone have gone from 35 percent proficient or greater to 82 percent during the same span of time, gaining them the recognition for the largest improvement in reading scores for the state of Colorado.

I would also like to make mention that Pennington has achieved these great strides by adopting a "no excuses attitude." The students and faculty of Pennington believe that there is no reason that their school should not be a school of excellence, and that very attitude is what has placed them as such in my eyes.

Pennington illustrates pride in education and excitement for the learning process. Mr. Speaker, I am proud to have such a school of excellence back home in my district. Pennington has truly shown that they are an excellent educational institution that strives daily to deliver on their goals and dedication to their children and the futures that await them. I am truly proud of the students, staff and community surrounding and supporting Pennington Elementary.

COMMEMORATING FIRST ANNIVERSARY OF TERROR ATTACK ON MOUNT SCOPUS

HON. ERIC CANTOR

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. CANTOR. Mr. Speaker, I had the great opportunity to return to Israel during this past August. Every visit to Israel brings forth so many emotions, some happy, some sad, but always inspirational. My visit was approximately a year after one of the most senseless and brutal attacks that has taken place since the beginning of the so-called second Intifada. On July 31, 2002, a terrorist placed a bomb in the cafeteria at Hebrew University. Nine young people were killed and many more wounded. Of the nine, five were Americans. I mourn the loss of all innocent lives, but this particular attack stands out for two main reasons.

First, of course, the attack underscores the close relationship of Hebrew University to the United States. This goes beyond the tragic deaths of the five Americans. The fact that so many Americans were there and that so many are still going there to study underscores the close relationship between this university and the people of the United States. Thousands of Americans have studied at Hebrew University, particularly in their exceptional "year-abroad" program and in their graduate schools. Many are there still and many more will follow. Many scientists from Hebrew University are also recipients of research grants from the American government and American institutions. Their work has been and continues to be of the highest quality. Second, targeting Hebrew University for such an attack was truly heinous. Throughout its long and distinguished history, Hebrew University has reached out to students and scholars of all religions and races.

The Hebrew University of Jerusalem, the "flagship" of Israeli universities, was first conceived in the 19th century against the background of discrimination and persecution in Europe. Jews were barred from higher education in Russia and Romania, and there were similar restrictions in many other countries. Also, there was an increasing demand from high school graduates in pre-state Israel for higher education.

The idea of a university in the Holy Land was proposed by Chaim Weizmann, Israel's first president. Among those backing the idea and assisting in raising financial support for the future university was Albert Einstein. The university's foundation stones were dedicated on Mount Scopus overlooking Jerusalem in 1918. Even before the university officially opened its doors in 1925, there was an inaugural lecture given by Einstein in 1923.

From its core of three institutes in the exact sciences and Jewish studies, the university expanded rapidly to eventually include all areas of higher education—the social sciences, law, medicine, dental medicine, agriculture, social work and education. The War of Independence, with its division of Jerusalem, caused the loss of the Mt. Scopus campus to the university in 1948 and its subsequent dispersal to various sites in West Jerusalem.

After the Six-Day War of 1967 and the reunification of Jerusalem, the university returned to Mt. Scopus, which again became the main campus. Today the university operates from four campuses—three in Jerusalem and one in Rehovot and has a total enrollment of some 23,000 students and an academic staff of about 1,200.

The Hebrew University of Jerusalem is an institution of international renown and is a beacon of open inquiry and academic freedom in the Middle East. The key point is that the university is open to all, regardless of nationality, ethnic origin, religion or race. Its Rothberg International School hosts students from dozens of countries, and its Jewish National and University Library is an unparalleled research source used by scholars from around the world.

The following is a copy of a speech delivered by Menachem Magidor, President of the Hebrew University, on the occasion of the first anniversary of the attack on the school.

PRESIDENT MAGIDOR'S SPEECH AT THE CEREMONY COMMEMORATING THE FIRST ANNIVERSARY OF THE TERROR ATTACK ON MOUNT SCOPUS

Just one year ago.at exactly this moment, this was the scene of a ghastly event, a scene of broken glass, overturned tables, blood and the cries of the injured and dying.

"Desolation, devastation and destruction!"

One year has passed—the murdered have been laid to rest, and among the injured, there are those who have recovered fully, and there are those who will never return to their former selves. The blood has been washed away, the blackened walls have been repainted, students rush to classes, and young people gather at the new tables in the cafeteria, engaged in lively and friendly conversations.

Has life simply returned to the way it was before? Of course not, because of those who are no longer with us.

Because Marla Bennett and Benjamin Blutstein will never continue on their marvelous journey of discovery of their roots and traditions;

Because David Gritz will never continue with his unique combination of philosophy, Jewish Studies and music;

Because David Diego Ladowski will never serve society and the country as he had aspired to, and to promote the peace in which he believed despite the forces of darkness exemplified by those who murdered him;

Because Revital Barashi will no longer share her pleasant manner with her colleagues in the corridors of the Faculty of Law;

Because Dina Carter will never continue with her dedicated work in the Library and Janis Ruth Coulter will never continue to devote herself to the University in America.

Because we will never again see the wonderful smile that lit up the face of Levina Shapira,

Because the intelligence and the wisdom which Daphna Spruch personified has gone and will never return.

And even those amongst us who were not here last year, or who arrived after the dreadful explosion, cannot return to being how they were before. Because we all understand that this University, which is so dear to us all, is hated by the forces of darkness, and that it was not by chance that the University was chosen as a target because we are Israeli or Jewish, but dafka because we are dedicated to openness and tolerance, because we are part of the free and enlightened world and the wicked spared no effort to strike at the University, dafka because our Campuses are oases of wisdom, of dialogue between people of different faiths and backgrounds, of different beliefs and religions.

And then, you realize that this Campus is part of the war zone in the war for the rebirth of the Jewish people in its land, part of the war zone in the war of the free world against the forces of hate, intolerance and tyranny.

The year that has passed has not been an easy one. Those who lost their dear ones have found it difficult to accept their loss; the wounded have fought to rebuild their lives again, but the emotional and physical scars will forever be with them.

The Hebrew University family gritted their teeth, and returned to the sacred work of research and teaching. We were faced with almost impossible decisions. The threats against this University, its principles and all that it represents haven't disappeared.

We have had to make painful compromises between security considerations and maintaining a free and dynamic Campus. The economic situation and the budgetary burdens have not made it any easier, but the year that has passed has proved to us all, as has happened so many times during the 78 years of the existence of the Hebrew University, that this living and growing tree, called the Hebrew University, is difficult to uproot.

Because the University's existence draws its life's breath from the never-ending struggle for truth; because it aspires to help the advancement of humanity; because it is rooted deep in the essence of our traditions while its branches stretch forth to the winds of tolerance, openness and respect for one another; because despite the forces of darkness that tried to destroy it, it has not lost its aspirations for peace.

May the memory of the nine be blessed.

CONFERENCE REPORT ON ENERGY POLICY ACT OF 2003

SPEECH OF

HON. W.J. (BILLY) TAUZIN

OF LOUISIANA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 20, 2003

Mr. TAUZIN. Mr. Speaker, I rise to explain for the record the role of the FERC in regulating public utility holding companies following repeal of the Public Utility Holding Company Act. The repeal contains several savings clauses. In essence, the savings clauses state that none of them give the FERC any new authority. They confirm that once PUHCA repeal takes effect, the FERC will continue to apply existing utility rate regulation to public utilities within formerly registered holding companies under PUHCA of 1935.

Particularly, Section 1275(a) states if a state commission disagrees with the allocation of costs of non-power goods or services provided by an affiliate organized specifically for that purpose, typically a service company, either the state commission or the holding company system may ask the FERC to resolve the allocation issue. The FERC will then make a determination of the proper allocation of such costs under the standards contained in the section, but only at the request of a State commission or a holding company system. The FERC has no authority to review or approve such cost allocations absent such a request. Section 1275(b) merely states that both the FERC and the State commissions retain whatever rights they now have to review cost allocations from service companies among public utilities for rate-making purposes.

H.R. 1964 THE HIGHLANDS CONSERVATION ACT

HON. STEVEN R. ROTHMAN

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. ROTHMAN. Mr. Speaker, I rise today in strong support of H.R. 1964, the Highlands Conservation Act, introduced by my colleague, Mr. RODNEY FRELINGHUYSEN.

I am very pleased to be an original cosponsor of the Highlands Conservation Act, which is an important step forward in our ongoing effort to save New Jersey's precious open space and enhance the quality of life for residents. New Jersey is the most densely populated State in the Nation, which is why it is so important that we think ahead and recognize the importance of preserving our remaining acres of open space. By protecting the 2 million acres of the Highlands, which extend through our neighboring states as well, we are creating an environmental legacy for future generations, safeguarding our area's drinking water, and ensuring that our children and our children's children have places to explore and opportunities to enjoy the great outdoors.

The Highlands Conservation Act is a testament to the foresight of the bill's author, Congressman RODNEY FRELINGHUYSEN, who recognizes the importance of saving New Jersey's open space. I have seen Congressman FRELINGHUYSEN's commitment to the preservation of undeveloped acres firsthand as a colleague of his on the House Appropriations Committee. He worked in a bipartisan fashion to garner support for his measure. Congressman FRELINGHUYSEN's leadership to protect the Highlands will truly help New Jersey live up to its namesake as the Garden State.

Getting Congress to authorize $100 million for the preservation of the Highlands would be a victory for our quality of life and the environment, but also a victory for New Jersey's taxpayers who will be spared from having to pay for the full cost of these preservation efforts. I am pleased that I was able to help get this bill onto the floor today and I look forward to working with Congressman FRELINGHUYSEN on the Appropriations Committee to preserve New Jersey's open space.

HALF A LOAF FOR AMERICA'S DISABLED VETERANS IN ELIMINATING DISABILITY TAX

HON. RUSH D. HOLT

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. HOLT. Mr. Speaker, earlier this session I signed the discharge petition to force a vote on legislation that I co-sponsored (H.R. 303) which would have repealed altogether an antiquated law from the 1890s that prevents disabled veterans from receiving concurrently both military retirement and veterans' disability benefits. In response to that parliamentary procedure, the Republican Leadership finally relented and included a plan in the FY 2004 Defense Authorization Conference Report that will be phased in over ten years and would provide greater benefits for approximately 245,000 disabled veterans—only half of those who see their retirement benefits reduced or eliminated under current law.

This is a good step forward and I surely would have voted in favor of this plan had it been brought to the House floor as a freestanding bill. Unfortunately, the Republican Leadership folded it into the $400 billion Defense Authorization Conference Report, which I voted against for several other reasons. Now that this legislation has been enacted, it is incumbent upon this Congress to do more than provide half a loaf. We need to pass additional legislation in the next session of Congress to cover the remainder of our nation's disabled veterans who are unfairly left in the predicament of having to pay this de facto "disability tax".

On January 21, 2001, President Bush said, "America's veterans ask only that government honor its commitments as they honored theirs. . . . In all matters of concern to veterans—from health care to program funding — you have my pledge that those commitments will be kept. My Administration will do all it can to assist our veterans and to correct oversights of the past."

I couldn't agree more. I will actively support additional legislation in the next session of this Congress to ensure that none of the 4,263 veterans in New Jersey who currently receive military retirement benefits will have their disability payments reduced commensurately because they remain subject to the so-called concurrent receipt prohibition.

ON THE OCCASION OF THE RETIREMENT OF NAVAL CRIMINAL INVESTIGATIVE SERVICE SPECIAL AGENT ROD MILLER

HON. JOHN N. HOSTETTLER

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. HOSTETTLER. Mr. Speaker, I rise to express my appreciation to Special Agent Rodney Miller of the Naval Criminal Investigative Service for his 32 years of service to his country, and to salute him on the occasion of his retirement from the ranks of federal law enforcement.

Special Agent Rod Miller was born and raised in Linton, Indiana, which is in the heart of Indiana's 8th Congressional District. The son of an Army veteran who was awarded the Purple Heart during World War II and who himself worked as a Navy employee for some 30 years thereafter, Rod spent time as a lifeguard and paperboy in Linton before graduating from Linton High School in 1966. He enrolled at Indiana State University in Terre Haute, and completed two years of study before enlisting in the U.S. Air Force in 1969. After a four-year stint in the Air Force, including over a year spent in Vietnam, Rod returned to Terre Haute and completed his undergraduate studies, earning a Bachelor of Science degree in Criminology in 1974. Shortly thereafter, he began coursework at the same school to obtain a Master of Science degree, also in Criminology.

In May 1975, Rod commenced what would become a long and illustrious career as a Special Agent with the Naval Investigative Service (NIS)—the predecessor of today's Naval Criminal Investigative Service—at NIS Resident Agency Great Lakes. There he learned the basics of criminal investigation, and proved himself to be a talented and driven law enforcement professional.

In 1978, Rod opened a new NIS office in Crane, Indiana, where the Navy conducts some of its most important research, development, and engineering of surface ship combat systems. He also took this opportunity to conclude his studies at Indiana State University, finishing his thesis and earning his Master's degree in 1979.

Following his NIS service in his home state of Indiana, Rod was assigned to the NIS Resident Agency in Guam from 1980 to 1982. He demonstrated continued leadership and investigative acumen in Guam, where he received a meritorious award from the Drug Enforcement Administration for his role in a significant international drug smuggling investigation, and was made an honorary Police Officer with the Guam Department of Public Safety for the support he provided to that department. He was rewarded with a supervisory role at the NIS Resident Agency in Portsmouth, Virginia, where he was appointed to the position of Assistant Special Agent in Charge in 1982.

For the next 21 years, Rod served with distinction in supervisory roles at a host of critical Navy locations—from 1984 to 1985, as the Special Assistant to the NIS Regional Director in Norfolk; from 1985 to 1986, as the Assistant Special Agent in Charge of the fraud unit at NIS Resident Agency Norfolk; and from 1987 to 1988, as the first Special Agent in Charge of the new NIS Mid-Atlantic Regional Fraud Unit.

In 1988, Rod was appointed to be the first Special Agent in Charge of Operation Ill Wind, one of the most significant defense procurement fraud investigations in our nation's history. This joint investigation ultimately resulted in the conviction of 46 individuals and six defense corporations, and yielded fines and penalties in the amount of some $190 million.

Rod's professional success continued in the wake of his involvement in Operation Ill Wind. In 1989, he was appointed the Special Agent in Charge of the new NIS Regional Fraud Unit based in Los Angeles, California. And, when the decision was made to open a new NIS Field Office in Los Angeles in 1992, Rod was the natural choice to be the first Special Agent in Charge there, as well.

In 1993, in the aftermath of the Tailhook investigation, the then-acting Secretary of the Navy disestablished the Naval Investigative Service and established the Naval Criminal Investigative Service (NCIS) in its stead. This change, and the reforms associated with it, had profound and dramatic effects across the organization.

Among other developments, in 1997 NCIS created a new Office of Special Projects, or OSP, representing the vanguard of the agency's counterespionage efforts. The following year, Rod was named the Special Agent in Charge of OSP, and set about to make his impact felt. He applied his vision and leadership to the OSP mission, ultimately evolving the unit far beyond original expectations. In addition to enjoying success in several significant espionage cases, Rod's unit applied its specialized training to a broad range of other investigative and operational activities, including counterterrorism operations, counternarcotics initiatives, and "cold case" homicide efforts. The successes achieved in these endeavors have earned OSP accolades from across the law enforcement and counterintelligence communities.

Mr. Speaker, Rod Miller has served our nation with distinction for 32 years—first in the uniform of an Air Force airman, and then in the ranks of federal law enforcement with NCIS. His is a record to be admired. I hope that the occasion of Rod's retirement from NCIS this November will give all of us pause to consider the many contributions and sacrifices of our nation's law enforcement professionals. On behalf of all Americans, I wish him "fair winds and following seas" as he pursues the next stage in his life—returning to Linton with his wife of 34 years, to join his three children and three grandchildren there—after a long, successful, and distinguished career in service to the United States of America.

THE MANUFACTURING TECHNOLOGY COMPETITIVENESS ACT OF 2003

HON. VERNON J. EHLERS

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. EHLERS. Mr. Speaker, I rise today to introduce "The Manufacturing Technology Competitiveness Act of 2003."

While Congress, the Administration and the American people have discussed the many challenges facing our nation's manufacturers, such as international trade, China policy, tax policy and health care costs, I believe that a fundamental issue has been generally left out of the debate—innovation. For decades innovation has underpinned American's dominance in the world economy. If our manufacturing sector is to remain competitive in the global marketplace, we must foster innovation within this sector.

As Chairman of the House Science Subcommittee on Environment, Technology and Standards, I oversee many of the federal government's manufacturing-focused research and development programs. I have met with manufacturers from around the country and specifically spoken to manufacturers both large and small about their problems. They all agree that innovation is one of the keys to ensuring our manufacturers remain competitive and it is crucial to the development of new industries. Funding research and development underpins innovation.

Based on these discussions and a hearing I held earlier this year, I am proud to introduce the Manufacturing Technology and Competitiveness Act of 2003. This bill will help our nation's manufacturers maintain and improve their technological edge. This legislation will stimulate innovation through collaborative research and development, and broaden and strengthen the Manufacturing Extension Partnership (MEP) program, which provides small- and medium-sized manufacturers with the tools to compete better. More importantly, it will bring together a variety of partners in the public and private sectors, building relationships that encourage and foster technological development and the ability to bring these developments to the marketplace.

Our global competitors are eagerly supporting investments in manufacturing research and development because they know it is the key to sustained economic development. If we are to continue to be the world's technological leader, we need to rise to this new global challenge and make the investments envisioned by this legislation.

More specifically, the bill:

Ensures that all federal manufacturing programs and related funding are coordinated and focused on solving these important problems. The bill requires a strategic plan and improved budget process to ensure these programs work together efficiently;

Designates the current Under Secretary for Technology within the Department of Commerce, as the Under Secretary for Manufacturing and Technology, to be the federal government's point person on manufacturing R&D policy, and outlines new duties focused on fostering innovation within the manufacturing sector for this position;

Establishes a new collaborative research and development program for manufacturing technology to build partnerships among higher education institutions, businesses, states and other partners. This program will provide $184 million over four years;

Helps to develop future leaders in manufacturing technology through a fellowship program in applied manufacturing research. Fellows will get to work with world-class leaders in technology and engineering at the National Institute of Standards and Technology (KIST). The fellowship program will provide $7.5 million over four years;

Reauthorizes and reforms the Manufacturing Extension Partnership (MEP) program by increasing competition among the centers. MEP is funded at $120 million for the first year, increasing to $137 million by year four; and,

Creates a new competitive, peer-reviewed grant program within the Manufacturing Extension Partnership (MEP) program to develop new tools to help small businesses innovate and compete. Funding for this program will come from the total MEP funding.

Mr. Speaker, while I am pleased that we are on the road to economic recovery, we must still address underlying concerns about the future of U.S. manufacturing. This bill will help address some of those concerns and put our Nation's manufacturers in a better position to compete today and in the future.

I look forward to working with my colleagues in the House and Senate, and with the manufacturing and research communities, to pass this important legislation.

IN RECOGNITION OF OUTSTANDING CONTRIBUTIONS OF AUBURN, ALABAMA CITY MANAGER DOUG WATSON TO THE AUBURN COMMUNITY

HON. MIKE ROGERS

OF ALABAMA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. ROGERS of Alabama. Mr. Speaker, I rise today to join the residents of Auburn, Alabama, in recognizing the contributions of Doug Watson to the City of Auburn, Alabama.

Doug Watson has been City Manager for Auburn for 21 years. During this time, he has gained the respect of the entire community for his loyal and dedicated service. To demonstrate their appreciation, the City of Auburn, Auburn University and the Auburn Chamber of Commerce are hosting a community-wide reception on December 10, 2003. The reception will immediately follow the dedication ceremony of the Douglas J. Watson Municipal Complex, consisting of the Development Services building, the Public Safety Administration building, and the Municipal Court. The naming of this complex after Doug Watson is an indication of the high esteem in which he is held.

I salute Doug Watson for his service to the Auburn community and wish him well as he takes on the new position of tenured professor at the University of Texas at Dallas.

CONFERENCE REPORT ON H.R. 6, ENERGY POLICY ACT OF 2003

SPEECH OF

HON. W.J. (BILLY) TAUZIN

OF LOUISIANA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mr. TAUZIN. Mr. Speaker, offshore oil and gas production in the Gulf of Mexico provided nearly $6.6 billion in royalty, bonus and rent revenues to the federal government in 2001. The coastal states which supported this production received approximately $130 million combined—a royalty sharing rate of less than two percent. Yet onshore oil and gas production revenues on federal lands is shared 50/50 between the federal government and the state in which the production occurs. In the case of Alaska, the state gets 90 percent of these onshore revenues produced on federal lands.

The disparity between the onshore and offshore royalty sharing programs and their contribution to our domestic energy security is striking. Federal lands within the United States generated an estimated $2 billion in royalties from the production of oil, gas and coal in

2001 with about $1 billion of these revenues going to the states for "hosting" these energy production activities. In contrast, offshore production in Louisiana's waters of oil and gas contributed over $5 billion in royalties to the U.S. Treasury in 2001 yet Louisiana received royalties of less than $30 million, a 0.6% return. The Gulf of Mexico produces more energy and associated revenues to the U.S. Treasury than any other area of the federal domain. Nearly $130 billion has been provided to the federal government as a result of oil and gas production in the Gulf of Mexico.

States receive 100 percent of the royalties they charge and collect in state waters. Louisiana's waters extend to only three nautical miles, compared to 9 miles for Texas and Florida. Therefore, if Louisiana had waters equal to these states, the significant revenues produced in these waters would have been wholly received by the state, not the US Treasury.

Section 1412 of the Energy Policy Act of 2003, the Secure Energy Reinvestment Fund (SERF), recognizes the significant contribution coastal states provide by supporting offshore development to decrease our nation's dependence on foreign oil and gas. The SERF program shares a small portion of Outer Continental Shelf (OCS) revenues with states that host offshore oil and gas production. As included in the conference report, section 32(a) of the Outer Continental Shelf Lands Act defines the terms used in the section, including 'coastal energy state'. It is the intention of the conferees that the Secretary of Interior (Secretary) reevaluate the eligibility of each coastal energy state's participation in the SERF program annually.

Section 32(b) provides $35 million annually, as well as OCS royalties and bonuses above the CBO baseline (in some cases, royalties and bonuses will have to reach levels hundreds of millions or over a billion dollars above the baseline before additional revenues will be shared with coastal energy states). This subsection authorizes up to $500 million for each Fiscal Year through 2013, and after 2013, 25 percent of qualified OCS revenues are to be shared with coastal energy states. Section 32(b) also includes a provision to protect deposits into the Land and Water Conservation Fund and Historic Preservation Fund.

Section 32(c) establishes a distribution formula comparable to those used in other federal royalty sharing programs. It also recognizes the historical contribution that some states provided by hosting offshore oil and gas production for decades, despite unfulfilled promises of royalty sharing by the federal government. The conferees have confirmed the document referred to in subsection 32(c)(2)(A)(iii). This section also provides 35 percent of a state's share directly to the political subdivisions that are within the state's coastal zone. When determining criteria for the "relative level of OCS oil and gas activities" in a state, the Secretary shall seek to direct the majority of this portion to the most impacted, or two most impacted, political subdivisions. In the case of Louisiana, the conferees have determined activities in Port Fourchon/LA1 should be recognized as OCS oil and gas activities and the conferees direct the Secretary to provide funds from the relevant portion of the formula in subsection 32(c)(2)(B)(iii) to address these impacts before any other activities in the state.

Section 32(c) specifies that only coastal energy states that have an approved plan as described under section 32(d) are eligible to receive funds. Section 32(c) also gives the Secretary authority to hold a state's funds in escrow (within the fund) if necessary and establishes a reallocation provision if states fail to have an approved plan. Finally, the section ensures coastal energy states will receive a minimum share of revenues.

Section 32(d) requires states to submit plans to the Secretary for approval. The Governor of each eligible state must include the plans prepared by the political subdivisions in the state plan. It is not the intention of this section to allow the Governor of a state to disapprove the plans of a political subdivision. In preparation of the plans, the conferees strongly urge the Secretary to ensure that states and political subdivisions carefully evaluate and coordinate with other regions. Further, states and political subdivisions should seek to use existing federal and state programs that advance the goals of the state plans. States and political subdivisions should leverage SERF resources to other federal programs to the maximum extent practicable.

Subsection 32(d)(2)(A)(v) is designed to ensure that any state with significant offshore oil and gas operations will address impacts that are "significant" or "progressive". This subsection requires that any state producing more than 25 percent of qualified OCS revenues spend not less than 30 percent of funding received annually from the SERF program (together with appropriate political subdivisions) to address "significant" or "progressive" impacts identified in the most recent EIS. For the first ten Fiscal Years of this program, the term "significant" means only infrastructure supporting "focal points of impact" (LAI) as identified in a relevant EIS. The term "progressive" means only coastal wetlands restoration. It is the conferees intent that greater than 15 percent of the funding received by the state and appropriate political subdivisions be used equally for each of these items. Further, it is the conferees intent that these monies shall be in addition to those provided to a political subdivision under subsection 32(c)(2)(B)(iii) (25 percent discretionary portion).

Section 32(e) specifies that the funds should be used in a manner that is consistent with federal environmental laws and all relevant state laws. Additionally, this section provides the eligible use of funds by states and political subdivisions. The SERF program is designed to ensure that mitigation and natural resource protection are top priorities of the eligible states. The Secretary should work with states and political subdivisions to establish reasonable administrative costs and keep these costs to a minimum. It is not the intent of this program to fund any otherwise required function of local or state government unless that function was designed to mitigate OCS activities or improve the coastal environment. Should any state propose a program or expenditure that would be authorized under subsection 32(e)(5), the Secretary shall not approve this use of funds unless there is a clear and direct link to OCS activities.

Section 32(f) requires the Secretary to withhold funding to any state or political subdivision that spent funds provided under this section in a manner inconsistent with the approved plan of such state or political subdivision.

Section 32(g) allows the Secretary to require arbitration to resolve disputes among any combination of coastal political subdivisions, states and the Secretary.

Section 32(h) provides for an administrative cost to be retained by the Minerals Management Service to implement this program. It is the intent of the conferees the Secretary will designate only the Minerals Management Service as the agency to administer and provide oversight to the SERF program. Since the majority of the coastal energy states and nearly all the federal offshore production is located in the Gulf of Mexico, the conferees expect the current Gulf of Mexico OCS Region office to play a significant role in the administration of this program.

Section 32(i) directs that two percent of the SERF fund be provided to the CREST program which has an existing relationship with the National Oceanographic and Atmospheric Administration. This payment shall be without limit and consist of two percent of all revenues available in the fund annually. It is the intent of the conferees that the funds provided under this section be used in a manner that is largely consistent with the goals of the existing CREST MOU and the current relationship with NOAA. In addition, the consortium may perform any activity authorized in section 1412(c) of this act. It is the intent of the conferees that Nicholls State University act as the fiscal agent for this section. The conferees expect CREST to retain its primary facilities at their existing location at CCEER.

Section 32(j) requires that any expenditure by a state or political subdivision using funds provided under section 32 must be in compliance with authorized uses specified in subsection 32(e). Section 32(j) also provides that these funds may be used for any payment that is eligible under section 35 of the Mineral Leasing Act. So as to create parity with other federal revenue sharing programs, it is the intent of the conferees that any funds provided under section 32 may be used for any purpose that is in an approved plan. The conferees expect the Secretary to work with other federal agencies, if appropriate, to ensure that states and coastal political subdivisions be permitted to use SERF monies in accordance with this section.

Section 32(k) requires states and political subdivisions to submit an annual joint report to the Secretary describing the expenditure of funds for the preceding fiscal year.

Section 32(l) requires that the otherwise established signs at projects or programs receiving funds under this section identify the source of revenue as being from the "Secure Energy Reinvestment Fund (SERF) program" or other common name established by the Secretary. The signage should also identify the source of funding as being from revenues generated from offshore oil and gas production.

Section 1412(b) amends section 31 of the OCSLA to reauthorize the program.

Section 1412(c) authorizes the CREST consortium through the Secretaries of Interior and

Commerce. It is the intent of the conferees that the consortium will focus their work on coastal wetlands loss in the lower Mississippi River delta and adjacent estuaries. Further, as a condition of funding, the conferees expect the Secretaries to require the consortium to establish an online library of existing information and findings on coastal wetlands restoration, the interaction between the Mississippi River and Gulf of Mexico, and other similar information. The agencies should use CREST as a tool to coordinate the various coastal activities, research and development, and programs of the various federal agencies that have existing authority over coastal activities or programs that affect coastal use. It is not the intent of the conferees that, as a condition of funding, the Secretary or Secretaries require the consortium to conduct operations outside the region in which it currently operates.

CONFERENCE REPORT ON H.R. 6, ENERGY POLICY ACT OF 2003

SPEECH OF

HON. MAX SANDLIN

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mr. SANDLIN. Mr. Speaker, I rise to express my support for the long-overdue energy conference report, while at the same time sharing my disappointment with the process by which the House leadership has brought this legislation to the floor.

As we all know, one of the greatest problems facing the United States today is our lack of national energy independence. The United States' dependence upon foreign sources of oil is simply unacceptable for a country rich in natural resources and equipped with the capability to develop these resources as a means of increasing our national security. At the height of the energy crisis during the 1970s, the United States imported 46 percent of our oil supply. Today, it is estimated that we import approximately 55 percent of all energy used in this country. As America's energy consumption increases, our need to produce more energy rises as well. Unfortunately, supply is not meeting demand, and our increased reliance on foreign sources of energy has potentially disastrous consequences for our economy and national security. The energy conference report contains significant incentives for the exploration and production of oil and gas and represents an important step toward increasing our national energy independence.

At the same time, energy independence cannot be attained through production alone. Though Congress should strongly encourage the production of energy sources such as oil, gas, and nuclear power, Congress should also incentivize businesses and consumers to produce energy with wind and solar power and conserve energy through innovative technologies.

When used effectively, the Internal Revenue Code ["the Code"] can help to stimulate both the production and conservation of energy. Provisions in the Code such as section 29 and section 45 have stimulated the production of nonconventional fuels and wind energy, respectively, and the tax title of the energy conference report will extend these credits and encourage continued production from these sources for years to come.

Further, the report's funding authorizations and tax incentives for investment in clean coal technology will benefit both consumers and the environment in the state of Texas. Texas consumes more coal for electricity generation than any other state in the country, with a significant amount of that coal mined in Texas. Unfortunately, while generation facilities must burn coal to provide the electricity that so many people take for granted, burning coal inevitably releases some pollutants into our atmosphere. Together with private industry, the Department of Energy's clean coal technology program is working to develop cleaner-burning technologies that will decrease emissions of nitrogen dioxide, sulfur dioxide, and other airborne pollutants.

Additionally, I am pleased that the conference report seeks to decrease our over-reliance on foreign sources of oil by repealing the current sunsets for the qualified electric vehicle credit and clean fuel vehicles deductions. Further, I appreciate the inclusion of a credit for the purchase of hydrogen fuel cell motor vehicles. I included a similar provision in my energy tax legislation, H.R. 1436, the Energy Independence and Security Act, and believe strongly that fuel cell technology holds enormous potential for the future. The federal government has an important role to play in the development and use of this clean, renewable energy source.

Any balanced energy plan must acknowledge that Americans need to increase our conservation efforts in an attempt to move closer to energy independence. To that end, I appreciate the inclusion of incentives to homeowners to make energy efficient home improvements that decrease their consumption of energy.

As well, the energy conference report's increased funding authorization for the Low Income Home Energy Assistance Program [LIHEAP] will directly benefit low-income Texans in my district who rely on LIHEAP aid to pay their utility bills. Last yeas, Texans received $50.1 million through this federal grant program, and this legislation should increase the amount of federal aid that Texas receives in the future.

Further, I believe that the electricity provisions contained within the conference report will encourage the improvement of our country's transmission infrastructure by reducing the depreciable lives for transmission assets from twenty to fifteen years. Accelerating the depreciation period will provide additional resources for electric utilities to modernize their transmission systems, which should increase the reliability, safety, arid security of the national grid system.

I am, however, extremely disappointed with the process by which the Republican leadership has brought this measure to the floor. It is well known by now that the Republican leadership and energy conferees in both Houses drafted the conference report without Democratic participation. Democratic legislators who, in some cases, have been involved in drafting complex energy legislation for several decades were prohibited from taking part in this process. Mr. Speaker, the Republicans' behavior throughout this process has been outrageous and inexcusable, and their actions demonstrate a contempt both for the democratic process and the constituents of the legislators who have been denied a voice over the past several months.

SUPPORTING POISON PREVENTION AND CONTROL CENTERS

HON. RAHM EMANUEL

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. EMANUEL. Mr. Speaker, I rise today in strong support of S. 686, which strengthens poison prevention in America and guarantees funding for our nation's 74 poison control, information and treatment centers. Each year these centers save countless lives, and it is critical that we ensure the financial stability and public awareness they need to best serve the American people.

As our nation's primary line of defense against poison-related injuries and deaths, these centers provide physicians and the general public with direct access to life-saving information. Health care professionals rely on these centers for immediate, around-the-clock assessments and treatment recommendations for many types of poisonings, overdoses and drug interactions affecting people of all ages. Parents who find their child has consumed a toxic substance can receive immediate professional help with one phone call, any time, day or night.

Over 90 percent of all accidental poisonings take place in the home. More than 50 percent of these accidents involve children under the age of six, with more than one million young children exposed to toxins annually. When a child's life is potentially in danger, parents need to know immediately where to go for help. Too often parents are unaware of the services provided by poison control centers and turn to costly and time-consuming options such as rushing to emergency rooms at distant hospitals. In response to this situation, this bill provides for both a nationwide toll free number connected to local poison control centers, and a new media campaign to call the public's attention to services available through this number.

My home state of Illinois is served by the nation's oldest poison control, information and treatment center, the Illinois Poison Center. The IPC has expertly served the needs of metropolitan Chicago since 1953, and handles approximately 100,000 cases throughout the state of Illinois each year. In 1985, my state was served by five regional poison control centers, but only IPC remains after deep budget cuts over the years. We must ensure that our nation's remaining centers receive the support they need to continue serving the public.

Our nation's Poison Control and Information Centers also play a vital role in managing public health crises, environmental disasters, and the threat of weapons of mass destruction. In July of 2000, the Illinois Poison Center was the first to respond to a nitric acid leak at a Chicago factory. In December of that same year, the IPC was again the first to respond, this time to an anthrax threat at the British-American Chamber of Commerce in Chicago. And, in August of 2001, the IPC responded to a toxic chemical spill on the Dan Ryan Expressway.

The Illinois Poison Center has developed protocols for response and notification of proper governmental agencies when these events occur, and it is also a participant in regional disaster drills throughout the metropolitan Chicago area. Poison control and information centers like the IPC are a critical part of our nation's emergency response and disaster preparedness systems.

Poison centers represent a cost effective investment that benefits the public health. In 1998, the U.S. Department of Health and Human Services estimated that every dollar spent on a poison center saves seven dollars in unnecessary medical costs.

Mr. Speaker, I commend our colleagues on both sides of the aisle for their hard work on this legislation. This bill is good for the health, safety and security of the American people. I strongly encourage my colleagues to vote for S. 686.

CONFERENCE REPORT ON H.R. 6, ENERGY POLICY ACT OF 2003 REGARDING TITLE VIII—HYDROGEN

SPEECH OF

HON. W.J. (BILLY) TAUZIN

OF LOUISIANA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, November 18, 2003

Mr. TAUZIN. Mr. Speaker, as Co-Chairman of Conference Committee on H.R. 6, the Energy Policy Act of 2003, as well as Chairman of House Energy and Commerce Committee which has jurisdiction over national energy policy as well as the production, storage, supply, marketing, pricing and regulation of energy resources, including unconventional energy resources, I am taking this opportunity to elaborate on and clarify both the legislative provisions and Statement of Managers that is contained in the conference report on H.R. 6 regarding Title VIII, Hydrogen.

On April 1, 2003 and April 2, 2003, the Energy and Commerce Committee met in mark up session to consider a committee print, the Energy Policy Act of 2003. On April 2, 2003, the Energy and Commerce Committee voted to approve the committee print and report this legislation to the full House of Representatives. This committee print contained, among other provisions, Title V, Vehicle and Fuels, Subtitle B, FreedomCar and Hydrogen Fuel Program.

H.R. 6, the Energy Policy Act of 2003, was subsequently introduced in the House of Representatives on April 7, 2003. H.R. 6 contained the legislative work product of the Committee on Energy and Commerce as well as other committees. Hydrogen provisions in H.R. 6 concerning the "FreedomCar" and hydrogen fuel and infrastructure program were consolidated in Division F—Hydrogen. The conference report on H.R. 6 contains Title VIII, Hydrogen, which is based on Division F of H.R. 6, incorporating several elements of S. 14.

The program established under Title VIII of the committee print provides for the production of hydrogen from diverse energy sources, including conventional and renewable energy sources. It also provides for the use of hydrogen in electric power generation and the safe delivery of hydrogen and hydrogen-carrier fuels. The program additionally encompasses advanced vehicle technologies, including automobile materials, energy storage, propulsion and hybrid systems.

Although Title VIII contains necessary appropriations to the Secretary of Energy to fund the activities authorized by the Title, central to the operation of this federal program is the public/private partnership required under Section 803(a). This partnership is reflected within the section 803(b)(1)(A) programmatic goal, specifically the directive to "enable a commitment by automakers no later than year 2015 to offer for sale" hydrogen fuel vehicles. Section 803(b)(2) contains a corresponding programmatic goal of obtaining a private sector commitment, not later than 2015, for necessary hydrogen infrastructure. Under sections 803(b)(1)(A) and 803(b)(2), both the vehicle and infrastructure commitments are followed, by five years, with availability, in the mass consumer market, of vehicles and safe and convenient refueling capacity.

Title VIII, therefore, incorporates the public/private partnership regarding the production of hydrogen fuels, associated hydrogen vehicles and necessary support infrastructure at a basic structural level. Section 803(a)(7), in particular, indicates that the development of necessary codes and standards needed to implement the program take place "after consultation with the private sector." This statutory directive applies to the production, distribution, storage and use of hydrogen, hydrogen-carrier fuels, and related products. Statutory authority conveyed to the Secretary of Energy for the promulgation of "necessary codes and standards" is to be interpreted by the Department of Energy in conformance with the ordinary and regular practice concerning these legislative terms.

The concept of public/private partnership in implementation of the program established through Title VIII is additionally reflected in section 803(d) requiring the conduct of activities to deploy hydrogen energy and energy infrastructure, fuel cells and advanced vehicle technologies. It should be noted that this deployment activity is separate and apart from section 803(c) which requires the Secretary of energy to fund a limited number of demonstration projects. This separation of demonstration and deployment activities is intentional and reflects the fact that such required elements of the hydrogen program are distinct entities.

IN REMEMBRANCE OF GUSTAVO MONTEJANO

HON. GENE GREEN

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. GREEN of Texas. Mr. Speaker, I rise today to extend my deepest sympathies to the family and friends of my constituent Gustavo Montejano (Mon-tay-HAH-no) and his two daughters, Katia and Esmerelda.

Gustavo Montejano is a true hero. When his family's home caught fire early on Monday morning, Gustavo rushed his wife and 2-year-old son out of the house. He then went back to rescue his two daughters, who were still asleep inside. Unfortunately, the second story collapsed, and the smoke and flames overtook him before he could get his girls to safety. As the headline from the Houston Chronicle reads, "He died hugging his two girls."

While we are all deeply saddened for the Montejano family's loss, I know that those girls were comforted by their father's presence, and that they died together knowing that he loved them so much that he was willing to sacrifice his own life trying to save them.

Gustavo's family remembers him as a kind and generous man, who took in his sister and her eight children when they needed a home.

Despite the fact that he had been laid off from his job, he helped support his sister's family as well as his own, helping to pay bills and care for the children.

I know his wife, Maribel, and 2-year-old son are devastated by this loss, but they should be proud of the great man Gustavo was, and that he died a hero's death.

His loss will be felt by all of Galena Park, and I ask that you remember the Montejano family in your thoughts and prayers.

TRIBUTE TO SPC JEREMY DiGIOVANNI

HON. CHARLES W. "CHIP" PICKERING

OF MISSISSIPPI

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. PICKERING. Mr. Speaker, I rise this evening to pay tribute to Specialist Jeremy DiGiovanni who was killed in action Saturday, November 15, in Iraq. Along with seventeen other American soldiers, including another Mississippian, PFC Damien Heidelberg, Jeremy was killed in the collision of two Black Hawk helicopters.

Jeremy was a member of the A Company, 4th Battalion, 101st Airborne based in Fort Campbell, Kentucky, and he served as crew chief on one of the Black Hawks. Jeremy hailed from Pike County, Mississippi, and he served his country proudly and with honor.

Specialist DiGiovanni made the ultimate sacrifice defending our Nation and helped free millions of men, women, and children from the tyrannical grasp of an evil and brutal dictator. We Mississippians are so proud of the men and women we have serving in Iraq and appreciate their dedication to defending freedom and democracy.

I ask my fellow Members of the U.S. House of Representatives to remember Jeremy and his family during this difficult time. To his family, our prayers are with you, and we are grateful for Jeremy's courage and service to the United States of America.

PROTECTING THE VULNERABLE, ENSURING FOOD SAFETY

HON. JANICE D. SCHAKOWSKY

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

MS. SCHAKOWSKY. Mr. Speaker, I rise today to address a danger that threatens every one of us—food-borne illnesses. Each year, 76 million people suffer from food-borne illness. Of those individuals, approximately 325,000 will be hospitalized and more than 5,000 will die. Our children, the elderly, and those with weakened immunity systems face an even greater danger. Of the deaths caused by food-borne illness nearly every year, children comprise nearly 40 percent of the victims. I know parents who have lost their children to this threat.

Today, I am introducing legislation, the National Food Safety Database Act, that will give officials charged with caring for our children and our other vulnerable loved ones the information they need to make safe food purchasing choices. My bill will create a national database containing information that documents whether a company has a history of providing safe food—food that has been produced and packaged under sanitary conditions and is properly branded. It will also document any outbreaks of food-borne illness that have originated from the provider and any enforcement actions that have been taken against the provider. Officials at hospitals, nursing homes, schools, and child care facilities can access this database from a secure website and use that information to ensure that they are serving those in their care the safest food possible. The final authority over the information included in this database will be granted to the Secretary of Health and Human Services who will work in consultation with the Secretary of Agriculture. A task force consisting of anticipated users, representatives of food manufacturers, processors, packers, transporters, and representatives of consumer groups will also advise the Secretary as to what information needs to be included to ensure our loved ones' safety. The Secretary will also have the authority to make grants to states to help them access and use the database.

The information that will be provided by the database is critical to public health. We need to prevent outbreaks of food-borne illness in our schools. Earlier this year a school in Illinois received ammonia-tainted food and did not receive adequate notification that the product had been contaminated. Luckily, no one died, but a number of teachers and students suffered. Currently the ability of hospitals, nursing homes, schools, and child care providers to provide quality care is compromised by their inability to get adequate and timely food safety information. Safety histories of the companies are not shared with the officials who purchase the food. Due to a complex web of food manufacturers, distributors and brokers, if the USDA or FDA announces that a manufacturer has produced tainted food, officials often have no way to determine if affected foods are in their kitchens and being served to our loved ones.

A person fed tainted food can experience diarrhea, nausea, vomiting, and abdominal pain. Those in hospitals, nursing homes, schools, and child care centers are by far the most vulnerable among us. Their immune systems are not as strong; their bodies are just not as sturdy. They can become very ill and can even die from food-borne illness, as far too many already have.

Food manufacturers also stand to gain from this bill. Companies that have a history of providing safe food will have that fact known. Should an accident occur and there is an outbreak, it will be much easier for companies to know where the tainted food has gone. The company will be able to stop the outbreak faster and reduce their liability.

I urge my colleagues to cosponsor this legislation that will increase the safety of the most vulnerable in our society. Our loved ones deserve to know that someone is looking out for their safety while they can't do it themselves. Without this bill, we can't make that guarantee.

EDUCATION FUNDING

HON. ADAM B. SCHIFF

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. SCHIFF. Mr. Speaker, I rise today to express concern over the failure to fund and adequately implement the No Child Left Behind Act (NCLB).

This bipartisan legislation attempted a comprehensive approach to reforming our schools by refocusing our national education policy on helping states and local school districts raise academic achievement for all children, while providing more funding and flexibility to states and local districts.

The legislation passed with overwhelming support because it included tough accountability requirements aimed at closing the achievement gap between students of different economic backgrounds; stronger professional development standards and training for teachers; additional resources do turn around low performing schools; allowances for an unprecedented level of flexibility for local school districts; and rewards and sanctions for States based on the academic performance of students.

Despite the bill's good intentions and tremendous support in Congress, the legislation has become largely a hollow promise to our children because of inadequate funding. The Administration's budget request this year provided only $22.7 billion for these important education efforts—$9.7 billion less than what Congress agreed was necessary.

The commitment of significant federal funding to assist local schools in meeting the new testing, achievement and training requirements was a solemn promise made to all the children of our nation. NCLB imposes strict standards on our school districts with considerable penalties if they do not comply. But how can our schools be expected to meet these new standards without adequate federal funding to meet these challenging mandates?

For this reason, I have cosponsored legislation, the Keeping Our Promises to America's Children Act of 2003, to suspend application of NCLB until the funding that was promised to our schools is actually delivered to our schools. The alternative merely sets up our schools for failure.

Implementation of this important law has also been unduly harsh. Award-winning science teachers who have excelled at teaching for decades are deemed unqualified because their bachelor's degree was in a different subject. As someone who supported passage of NCLB, I am alarmed by its poor funding and implementation.

Passing the NCLB was only one step in the lawmaking process. To enact real education reform and to implement the new education standards within NCLB, we must appropriate the full funding required, and not blind ourselves in its application. We must not shortchange our children's education.

I ask my colleagues today to reaffirm the Congress's commitment to the No Child Left Behind Act and support full funding authorized by the legislation.

CONGRATULATING BROWNSVILLE PORTER COWBOYS FOOTBALL TEAM

HON. SOLOMON P. ORTIZ

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. ORTIZ. Mr. Speaker, I rise today to congratulate the Porter Cowboys on their incredible season, as they just completed their first-ever winning record and were one win away from a perfect regular season record.

In the almost 30 years of the school's history, the Cowboys football team has endured many tough seasons and constant criticism to their program.

However, last week they won their first-ever playoff game beating PSJA 45–8 and advanced to the second round of the Texas high school playoffs where they now face Gregory Portland. I wish them the best as they continue their amazing playoff run and season.

The Porter Cowboy story is one that has everyone in the community and in the Rio Grande Valley extremely excited and energized. Guided by Coach Jim Helms and his exceptional staff, this talented group of players exceeded virtually all expectations that many had for them coming into the season. Of course, the players and coaches had something else in mind when they were preparing in the off-season and now they are in the middle of a dream season; a season that the faculty, students and families, along with the players, will never forget.

As these Porter players make history on the football field they are now only opening the doors to the future in which they will be part of a generation that will make positive changes to the lives of many living in the community. The same determination and commitment they possess on the football field every Friday night will prepare them to respond accordingly when faced with life's challenges and obstacles.

The Porter Nation as they have come to be known were led by their star quarterback and he was surrounded by a cast of gifted athletes that contributed to the success of the stellar season. The arsenal in the passing game, complemented with a tremendous defense and an excellent kicking game enabled them to truly dominate their opponents.

I am so proud of these guys and wish them the best as they continue to achieve their goals both on the field and in the classroom.

Mr. Speaker, I respectfully ask that the roster with the names of each player, coach, and trainer be inserted in the CONGRESSIONAL RECORD of the United States House of Representatives.

2003 PORTER COWBOYS FOOTBALL VARSITY ROSTER

Chris Walker, Evy Chavez, Emmanuel Gutierrez, Rick Monsivais, Jason Bernard, Chris Vasquez, Billy Garza, Ivan Villarreal, Michael Verduzco, Mike Salazar, Manuel Hernandez, Steve Garcia, Jimmy Gutierrez, Benny Salazar, Moises Salinas, Ivan Iglesias, and Louie Pineda.

Rogelio Camarillo, Ben Gomez, Jesus Chapa, Carlos Lozano, Angel Ramirez, Jesus Ferrer, Luis Cruz, Jose Izaguirre, Thomas J. Rios, Joe Espinoza, Juan Leal, Javier Ruiz, Josh Burguete, Eli Perez, Ernesto Olivarez, Isaac Almaguer, and Omar Avila.

David Pallares, Emmanuel Lopez, Eliseo Balderas, Christian Lara, Stephen Cisneros, Eber Flores, David Diaz, Julian Mendez, Oscar De Los Santos, Juan Peña, Julius Williams, Frankie Ramirez, Danny Palacios, Juan Perez, Jose Guerra, Will Jaramillo, and Gilbert Flores.

Athletic Director: Joe A. Rodriguez.

Athletic Coordinator: Jim Helms.

Football Assistants: Art Cantu, Ruben Cortez, Bill Deen, Luis Garza, Benny Gonzalez, James Kizer, Abel Moreno, Danny Pardo, Armando Rangel, Tom Rios, Jeffrey Rodriguez, and Jose Luis Zarate.

Trainers: John Prosek and Jerry San Pedro.

HONORING WILLIAM THOMAS (BILL) POWERS

HON. MARY BONO

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mrs. BONO. Mr. Speaker, I rise to honor one of the most distinguished and remarkable individuals in the Coachella Valley, a region of southern California which I have the privilege of representing.

Mr. William Thomas (Bill) Powers has established an impressive record of achievement and service, both in his professional career and charitable activities. Since moving to the Palm Springs region in 1986, after a long and successful career in banking in Los Angeles, Bill Powers dedicated himself to enhancing our community's economy and improving the lives of its residents.

Now, our community joins to honor this most deserving individual with the Desert Samaritans for the Elderly naming Bill Powers Good Samaritan of the Year 2003.

A native Californian, Bill is renowned in our community for his many good works and strong stewardship of numerous worthwhile causes. At the same time, Bill has used his keen judgment and extensive professional experience to establish one of the leading financial institutions in California's Inland Empire, Pacific Western Bank.

In Bill's own words he "believes in the community and the people who live here. The best way I know how to give back to the community is through excellent service; I extend that philosophy in both my professional and personal life" and our community is better for his commitment to this code.

Bill and his wife, Anita, have raised a wonderful family. Their children, David and Christie, and their grandchildren, Jessica, Teddy, Tommy, and Hunter are a great source of pride to both Bill and Anita.

Bill has distinguished himself in our area through his ability to combine his love of family with his desire to work tirelessly in both business and community causes. The list of charitable and civic causes that Bill has participated in over the years is literally to vast to list in total, however, it is worth noting that he has served as both President and Tournament Chairman of the Bob Hope Chrysler Classic, a professional golf tournament that has provided immense financial support to those in need in this region. In addition, Bill has served as President or board member for the United Way of the Desert, the American Cancer Society, the John F. Kennedy Memorial Foundation, the Coachella Valley Economic Partnership, Desert Samaritans for the Elderly Board of Governors, the John F. Kennedy Memorial Hospital, College of the Desert Foundation, Yucca Valley Economic Partnership, founding director of the Desert Town Hall Speakers Forum, and as a member of the McCallum Theatre's Board of Trustees, to name a few.

Mr. Speaker, I consider it a privilege to call Bill Powers my friend, and ask that this brief tribute to this accomplished individual be placed permanently in the RECORD. I yield back the balance of my time.

IN HONOR OF GARY SCHLANSKER, CEO OF THE GREENVILLE YMCA

HON. JIM DeMINT

OF SOUTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. DEMINT. Mr. Speaker, today I take privilege in honoring Gary Schlansker's 11 years as the President of the Greenville YMCA. Gary has recently accepted the position as the President of the Greater St. Louis YMCA, the 8th largest YMCA system in the country. Gary started his relationship with the YMCA back in 1956 when he was first enrolled in a YMCA program in St. Louis. Gary has indicated that the St. Louis position is the only job that would take him out of Greenville, as Gary grew up in St. Louis and has family in the Show Me State.

The Greenville YMCA has been a model of stability and success for the YMCA system. Since the founding of the Greenville YMCA in 1876, only six people have served as President of the Greenville YMCA.

During Gary's 11 years at the Greenville YMCA, the annual operating budget increased from $4 million annually to in excess of $10 million annually. The Greenville YMCA grew from five branches serving 35,000 community members annually to seven branches with three additional outreach centers serving a total of 55,000 people annually. The annual scholarships campaign increased by over 200 percent and collaborations with the greater community now number in excess of 85 annually. Program highlights for the Greenville YMCA include Camp Greenville, Youth in Government, and outreach services through schools and churches. The Youth in Government program of South Carolina is sponsored exclusively through the Greenville YMCA, and is one of the most successful Youth in Government state programs in the country.

Gary's stewardship of the Greenville YMCA is accurately reflected by the tremendous growth and success of the Greenville YMCA. Not only is the growth of the Greenville YMCA impressive, but very importantly the kind and caring manner that Gary has conducted himself on a daily basis will be greatly missed by those who he has served in the Greenville area.

I sincerely wish Gary all the best for a nice start to his new job leading the St. Louis YMCA, as they are getting a wonderful workhorse of a leader to guide their YMCA. Thank you Gary for your 11 great years in Greenville, and we will miss you.

TEMPORARY AGRICULTURAL LABOR REFORM ACT OF 2003

HON. BOB GOODLATTE

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. GOODLATTE. Mr. Speaker, I rise today to introduce the Temporary Agricultural Labor Reform Act of 2003, a bi-partisan bill to reform the H–2A guest worker program. As Chairman of the House Agriculture Committee, I have traveled across the Nation and seen first-hand that the H–2A temporary visa process is not working. I have talked face to face with producers who have to deal with participating in a costly, time-consuming and flawed program. Employers have to comply with a lengthy labor certification process that is slow, bureaucratic and frustrating. In addition, they are forced to pay an artificially inflated wage rate. My bill will streamline the labor certification process while also creating a wage standard that is more fair and realistic.

Likewise, as a long-time Member of the House Judiciary Committee, I understand the immigration problems that currently face our country. Illegal immigration penalizes those legal immigrants and citizens who play by the rules. It is estimated that there are between 8 and 11 million illegal aliens currently living in the United States. This population grows by over 350,000 each year. Clearly, this situation has reached crisis proportions and cannot be allowed to continue.

Some believe that the only way to reform the guest worker program is by including amnesty provisions and allowing illegal aliens to adjust to Legal Permanent Resident (LPR) status. However, this would create the wrong incentive by encouraging foreign nationals to come into the country illegally in the hopes that they, too, will be rewarded for their illegal actions. Amnesty is not the answer to our Nation's illegal immigration problem.

My bill would not grant blanket amnesty. Instead, it would allow the large population of illegal farm workers one chance to come out of hiding and participate legally in the guest worker program. Potential workers would be required to return to their home countries and apply for the program legally from there.

In addition, this legislation would address a troublesome wage issue. Employers are required to pay an inflated wage called the Adverse Effect Wage Rate or AEWR. The AEWR was designed to protect similarly situated domestic workers from being adversely affected by guest workers coming into the country on a seasonal basis and being paid lower wages. However, the shortage of domestic workers in the farm workforce forces employers to hire foreign workers, and thus, is also forcing them to pay an inflated wage. My bill abolishes this unfair wage and creates a prevailing wage standard, under which, all workers are paid the same wage as workers doing similar work in that region.

The facts are simple. Agriculture needs a reliable guest worker program. Workers need access to stable, legal, temporary employment. It is in our national security interest to create a sensible way for workers to come in on a temporary basis, work, and go back to their home countries. My bill addresses the problems in the current guest worker program, and I look forward to working with all of the Members in this body to reform this program and make it a more viable process for everyone involved.

ARSENIC-TREATED WOOD PROHIBITION ACT

HON. JANICE D. SCHAKOWSKY

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Ms. SCHAKOWSKY. Mr. Speaker, I rise today to address the dangers posed to the public health by arsenic-treated wood. Most of the lumber sold for outdoor use in our schools' playgrounds and in our own private backyard decks is pressure-treated and injected with toxins to preserve the wood and prevent insect infestation. The most common wood preservative and pesticide used is chromated copper arsenate (CCA), which is 22 percent pure arsenic. The inorganic arsenic used in CCA-treated wood is a known carcinogen and has been linked to skin, bladder, liver and lung cancers. The arsenic in CCA-treated wood has been shown to leach out, ending up in the soil in our back yards and playgrounds, rubbing off onto our clothing, and wiping off onto our hands.

Today, I am re-introducing a bill to begin to remove this threat, the Arsenic-Treated Wood Prohibition Act. This bill will prohibit the use of CCA treated lumber once and for all. This legislation will protect children and families by mandating the phase out of arsenic in pressure treated lumber and will ensure that arsenic treated lumber is disposed of safely. Specifically, my bill will: phase-out the use of arsenic-treated wood in residential settings; require the disposal of arsenic-treated wood in lined landfills to prevent contamination of groundwater; require the Environmental Protection Agency (EPA) to finally complete its risk assessment regarding arsenic-treated wood; provide monetary assistance to schools and local communities to remove arsenic-treated wood from their playgrounds; and direct the Consumer Product Safety Commission (CPSC) to complete its mitigation studies to determine the effect of sealants in preventing exposure to residues of CCA on treated wood. This bill would save lives and protect our environment.

Recent actions by the CPSC and preliminary findings released by the EPA make it even more important that we in Congress pass this legislation. Despite their own findings found that of every 1 million children exposed to the treated wood three times every week for five years, two to 100 of them might develop lung or bladder cancer later in life, the CPSC recently decided to deny a petition to ban the use of arsenic-treated wood in playground equipment and to recall existing playground structures using CCA-treated wood (HP–01–3). In their statements denying the petition, the CPSC Commissioners cited that a voluntary agreement between the EPA and CCA-treated wood manufacturer's to voluntarily phase-out the production of the product. The Commissioners reasoned that rulemaking on the subject would be both unnecessary and redundant. They further cited that the CPSC did not have the authority to initiate a recall before the risk assumptions made in the Commission's staff study could be verified.

On November 13, a draft probabilistic exposure assessment released by the EPA confirmed the CPSC's earlier findings. The study concluded that the cancer risk for children who repeatedly come in contact with commonly found playground equipment and decks made of arsenic-treated wood is considerably greater than EPA officials indicated last year. The agency's preliminary findings show that 90 percent of children repeatedly exposed to arsenic-treated wood face a greater than one-in-1 million risk of cancer. The risk associated with exposure to arsenic-treated wood appears to be up to 100 times greater in the warmer climates of southern States than in the general population since children tend to spend more time playing outdoors. This risk passes the EPA's historic threshold of concern about the effects of toxic chemicals.

In light of these facts, I believe that we must take immediate action. I believe that a voluntary phase-out of this potentially harmful product is not adequate. Initiating a ban on CCA-treated wood would greatly increase public awareness of the dangers that existing arsenic-treated wood presents. By failing to ban CCA-treated wood, we are ignoring the responsibility to protect and promote the best interests of consumers. I strongly believe that a legislative mandate permanently banning its use and providing for its safe removal is critical to ensuring the safety of children and their families.

The effect of arsenic in our environment is undeniable: it kills. Arsenic-treated wood is a danger to the future health of America's families. I encourage my colleagues to join me in this very important effort to remove this threat.

TRIBUTE TO PFC DAMIEN L. HEIDELBERG

HON. CHARLES W. "CHIP" PICKERING

OF MISSISSIPPI

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. PICKERING. Mr. Speaker, I rise this evening to pay tribute to Private First Class Damien Heidelberg who was killed in action Saturday, November 15, in Iraq. Along with seventeen other American soldiers, including another Mississippian, Specialist Jeremy DiGiovanni, Damien was killed in the collision of two Black Hawk helicopters.

Damien was a member of the First Battalion, 187th Infantry Regiment, 101st Airborne based in Fort Campbell, Kentucky. The little town of Shubuta, Mississippi was home to Damien. He was the ninth Mississippian to die in Iraq since the war began, and he served his country proudly and with honor.

PFC Heidelberg made the ultimate sacrifice defending our Nation and helped free millions of men, women, and children from the tyrannical grasp of an evil and brutal dictator. We Mississippians are so proud of the men and women we have serving in Iraq and appreciate their dedication to defending freedom and democracy.

I ask my fellow Members of the U.S. House of Representatives to remember Damien and his family during this difficult time. To his family, our prayers are with you, and we are grateful for Damien's courage and service to the United States of America.

THE LIMITS AND LIABILITY OF POWER: LESSONS OF IRAQ

HON. JAMES A. LEACH

OF IOWA

IN THE HOUSE OF REPRESENTATIVES

Friday, November 21, 2003

Mr. LEACH. Mr. Speaker, the issue of our engagement in Iraq demands that we as a society probe the question of the limits of a superpower's power and the possible anomaly that there are severe liabilities to power, particularly for a superpower.

Does, for instance, overwhelming military might protect us from terrorism or, if used unwisely, increase our vulnerability to terrorism?

Likewise, does overwhelming economic power ensure loyalty or buy friendship even from the countries most indebted to the U.S.?

In other words, can military and economic might ever become a substitute for sensible and sensitive foreign policy?

And given the dilemma of Iraq, could it indeed be that the most important "multibillion" problem America faces is not deficits measured in dollars, fiscal or trade, but the antagonism of billions of people around the world who object to our current foreign policy?

Here, let me say that I strongly believe in the need for clarification of thought as it applies to policy, and anyone who wishes to review the reasoning I have applied to the Iraq issue, ranging from a floor explanation of a "no" vote on the Congressional resolution authorizing war last year to calls for internationalizing the civil governance in Iraq last month, to a vote in favor of generosity in reconstruction efforts last week, can find the explanatory statements on my Congressional web site: www.house.gov/leach.

What I would like to do today is summarize the dilemma we face and make the following points about where we might go from here:

(1) There are no certitudes. Anyone who was not conflicted on the original decision to approve intervention or who does not see a downside to all courses of action today is not approaching the problem with an open mind. America and the world are in a strategic pickle. In an era of anger, of divisions in the world based on economics, on color of skin, on ethnicity, on religious belief, on happenstance of family and place of birth; in a world made smaller by technological revolutions in communications and transportation, those who have causes—good or bad—have possibilities of being heard and felt around the globe that never existed before. Great leaders like Gandhi and Martin Luther King appealed to the higher angels of our nature and achieved revolutionary change with non-violence. Mendacious leaders like Hitler, Saddam Hussein and Osama bin Laden have sought to impose their wills on others through appeals to hate and reliance on increasingly wanton instruments of oppression.

As the world's only superpower, the U.S. has no choice but to display firmness of purpose and resolve in deterring inhumane breaches of order. Yet, firmness and resolve must be matched by compassionate understanding of the reasons people of the world lash out. We have the world's greatest armed forces. But these forces cannot successfully be deployed to counter international misconduct if we don't also seek to undercut the causes of such conduct.

Reviewing the causes of World War I, historians quickly concluded that there was not enough flexibility in the European alliance system and that this allowed a rather minor event, the assassination of an Austrian archduke, to precipitate a cataclysmic war. With this example in mind, political leaders in the 1930s erred on the side of irresolution, which led them to Munich and the partition of Czechoslovakia. Too much inflexibility caused one war; too little spine a greater one.

The problem today is not whether we should meet problems with firmness or compassion. We need both. The problem is determining when and how to respond with firmness, when and how to express compassion. As in all human conduct, the challenge is wisdom.

(2) We must listen as well as assert. Four decades ago the British author Lawrence Durrell wrote a series of novels called the Alexandria Quartet, in which he describes a set of events in Alexandria, Egypt, preceding World War II. An experiment in the relativity of human perception, each of the four books views the same events through the eyes of a different participant. While the events described are the same in each book, the stories as told by each of the participants are surprisingly different. The reader comes to the realization that a broad understanding about events that transpire can only be developed by synthesizing the singularly different perceptions of various protagonists.

To understand the Middle East today, we need to listen to everyone's story.

(3) To shape or deter an opponents' actions, we need to understand how they think. American policy makers, at their best, reason in a pragmatic, future-oriented manner. In much of the rest of the world, on the other hand, people reason by historical analogy. Events dating centuries back, especially umbrages, dominate thinking about today. People in the Middle East, like the Balkans, are oriented to the past and are driven by ideas of honor of a different shape and emphasis than those we derive from American culture.

(4) No country can go it alone for long and expect to be respected as an international leader. Doctrines of American exceptionalism—the precept that we should not be bound by legal or procedural norms that bind others—which are now fashionable in certain Washington ideological circles have led to intervention in Iraq without full UN sanction. Ironically, prior to 9/11 these same notions led to rejection of a Comprehensive Test Ban Treaty and of upgraded verification provisions for the 1972 Biological Weapons Convention—agreements that would have stood in the way of WMD production in Iraq and provided a legal basis for possible armed intervention if violations occurred. The world is crying out for leadership in restraining weapons development. We are not providing it because Washington policy makers prefer that restraint on others not apply to ourselves.

(5) When Washington policy makers speak on foreign policy they must understand that their audience is more than one party's political base. While Saddam Hussein is widely perceived to be the worst sort of tyrant, many people around the world view us as bullies for attacking a sovereign country without prior armed provocation. That is why it is so critical that a case for intervention should be based on concern for the well-being of others as well as the U.S. national interest.

For foreign policy to be effective, it must be clearly articulated and convincing in those parts of the world most affected by it.

(6) We must rededicate ourselves to building up an intelligence capacity that better understands the Middle East and the Islamic world and is less susceptible to being politicized. Our inability to understand Islamic culture resulted in the greatest intelligence failure of our era. It is, however, not the sole intelligence failure. In one of the greatest judgmental errors of our time we appear to have attempted to combat the ideological posturing of others by slanting our own intelligence. Based on what is known today, policy makers not only erred in assessing Saddam Hussein's WMD capacities, but put too much faith in a narrow cadre of ideologues who suggested the U.S. would be welcomed as a liberating rather than conquering or, worse yet, colonizing force in Iraq. Estimates of the costs of war, of the ramifications of involvement, of the expected reaction of the population and of the likelihood of foreign support were dead wrong.

(7) It is the responsibility of public officials to ensure that no American soldier is deployed as a defenseless magnet for terrorist attack—or in such a way as to incite foreign radicals to commit terrorist acts in America itself.

American soldiers have been trained to withstand the heat of battle in defense of America and American values. For two and a quarter centuries no country has been more effectively or more courageously served by a citizen soldiery than the United States. In Iraq, our armed forces could not have performed more professionally or valiantly than in the initial engagement. But the difference between service in combat and service in occupation of a foreign land, especially an Islamic society, is profound. In Iraq, which is fast becoming for us much like Algeria was for the French in the 1950s, our men and women in uniform are increasingly facing hit-and-run terrorist assaults, which are much more difficult to defend against than traditional military confrontations.

The challenge of policy makers is to recognize that there is a distinction between three endeavors: warfare, reconstruction and occupation. Our armed forces are trained to prevail in the first; they can be helpful in the second; but in the Islamic world no outside power is ever going to be well received as an occupying force. Hence, strategies that emphasize the first two endeavors and don't lead to long-term reliance on the third should be the goal of U.S. policy makers.

(8) Responses to terrorism often lead to escalating action/reaction cycles. When our forces become subject to terrorist assaults and the perpetrators disappear into their neighborhoods, we, like Israel, will inevitably be tempted to retaliate in ways that may intensify rather than restrain future violence.

Calls will be made not only to use air power in urban areas but to double or triple troop deployments, perhaps without adequate assessment of what such troops will be assigned to do. In conventional warfare, the case for overwhelming superiority (sometimes referred to as the Powell Doctrine) is compelling. In a terrorist setting, as in modernist design, less can often be more. There may be cases where deploying a large force to combat terrorism is appropriate. There may also be cases—and I believe Iraq is one—where additional soldiers simply become additional targets, and a different mix of strategies is both preferable and more effective.

(9) To defend against terrorism, especially when it is fueled by an explosive mixture of religious and nationalist sentiments, requires frank acknowledgment of the nature and depth of the problem.

For months, the administration has suggested the problem in Iraq is limited to 5,000 dissidents. This is a 5-digit miscalculation. At least half the Muslim world—over 500,000,000 people—are outraged by the U. S. government's attitudes and action. Long simmering resentment of American policies in Muslim countries like Indonesia has in recent months metastasized into hatred. And in Europe, including what the defense secretary called the "new Europe," as well as in South and East Asia, respect for American policy is in steep decline.

In the Vietnam War we gave a great deal of attention to the notion of "winning the hearts and minds" of the people. We didn't succeed in convincing the Vietnamese or world opinion of our good intentions despite the horrendous tactics of the Vietcong and the Communist North. Today, Americans must understand that in the battle for the minds of men, particularly in the Moslem world, we are doing less well than even in the most difficult days of the Vietnam War. In this context, we would be well-advised to remember America's original revolutionary commitment to a decent respect for the opinions of mankind.

(10) While, for the time being, security in Iraq must remain the responsibility of U.S. military commanders in the field, we would be wise to put an international face on civil governance in the country and ask Secretary General Kofi Annan to immediately appoint a top civilian administrator to whom Ambassador Bremer and his staff would report.

Transfer of interim civil authority to the UN would provide greater legitimacy to the formation of a new Iraqi government and encourage other countries to help with economic reconstruction and security requirements. We should also work to transfer, as soon as practicable, responsibility for internal security to troops of other nations or the Iraqis themselves. Transferring the police function to others is a way to build up Iraqi's own postwar internal security infrastructure and make evident that the U.S. does not desire long term control.

(11) We should also move forthwith to transfer more political control to the Iraqi Governing Council and press for immediate elections and constitution writing. Some argue that stability is more likely to be achieved with a long U.S. occupation. I believe the reverse is true. The longer we are in Iraq, the greater the instability there and the greater the likelihood that terrorism will spread to other countries, including the United States.

(12) America cannot cut and run politically, economically or militarily, but we would be wise to announce a timetable for troop withdrawal, by the end of next year at the latest. Some experts in and out of government believe that American troops should stay in and control Iraq at least as long as we did in Japan and Germany after World War II. Such a time table (a minimum of 5 years) is out of sync with the times and the mood in the Islamic world.

The world is more impatient today and Muslims in particular are more history sensitive than ever before. While we assume the Iraqi populace should accept the American presence because of our good will, the Muslim world sees our forces as a compounding of grievances dating back to the crusades and, more recently, to American support of Israel. The imagery AlJazeera projects of Baghdad is that of another West Bank. In this context, American commitments to "slog on" interminably play into the hands of extremists. All extremists have to do is continue blowing up a vehicle or two every day, thereby eliciting a military reaction that we might view as reasonable but that the Islamic world is likely to see as heavy-handed, angering the populace and emboldening further dissent.

The longer we stay, the greater the opportunity for al Qaeda and radical Baath party supporters to claim that the war is continuing and that they are prevailing. To prevent this and to keep control of events we would be wise to announce a withdrawal timetable that we, not they, control. Setting such a timetable has the effect of asserting that the war itself is over and we prevailed, and that Iraqis cannot dither in establishing a legitimate, elected government.

A drawn out occupation plays into the hand of radicals. It gives them a rallying cry to keep up resistance in Iraq and expand terrorist assaults around the world. It gives them the chance to suggest that America is bent on continuing the crusades and, when we eventually withdraw, the prospect of claiming that they won the war. On the other hand, if we set a firm schedule for drawing down our troops, we define the war as being over in its 3rd week, not in its 6th year. An announced time table can later be modified to allow, for instance, a small force to remain briefly in northern Iraq to maintain sovereign cohesion. Timetables can also be abbreviated. But the point is that they underscore our reluctance to become an imperial power and, perhaps more importantly, our determination to control our own destiny.

(13) It is critical to the security of our troops, as well as Iraqi security, that we create an Iraqi police force as soon as possible. Responsibility for domestic security is an internal not external matter. We can't be their policemen and if we persist in trying, we will make it harder for stability to be established and maintained.

Students of international politics have for the past generation questioned the capacity and moral authority of any country to be policeman for the world. But little academic attention was devoted to the challenge of being policeman within a country after the conclusion of a conflict. We have little experience with such a responsibility. In Japan, MacArthur relied on indigenous Japanese police; in Germany, we quickly reconstituted a German constabulary at most local levels.

Common sense would indicate that trying to police a country the size of France with soldiers unfamiliar with the language and culture of the society, untrained in the art of policing, and unwelcome and resented in critical cities and towns must be a nearly impossible task. Hence the need to expedite the training of an indigenous Iraqi police force.

(14) We should announce that we have no intention of establishing permanent military bases in Iraq. Some Washington policy makers want such bases but they would be a political burden for any new government in Baghdad and a constant struggle for the U.S. to defend. Defense of American bases in Iraq from terrorism in the 21st century is likely to be far more difficult than the challenge we foresaw of maintaining U.S. sovereignty over the Panama Canal in the 20th century. The reason the Department of Defense concluded in the Carter administration that it was wise to transfer control over the Panama Canal to Panamanians was the estimation that the Canal could be defended against traditional aggression but not sabotage or acts of terrorism. It seemed wiser to respect nationalist sentiment and provide for a gradual transfer of the canal to local control than to insist on quasi-colonial assertions of power.

There are many reasons why Europeans are so smugly opposed to our policy in Iraq. One is historical experience with colonialism. The French were chased out of Algeria, the Russians, and earlier the British, out of Afghanistan. U.S. intervention in Iraq is seen in Europe as not too dissimilar to the British and French effort to re-establish control over the Suez Canal in 1956. It is noteworthy that the Islamic world deeply appreciated President Eisenhower's refusal to back the British and French intervention in Egypt. Europeans now think that the shoe is on the other foot. We appear insensitive to history.

(15) Credit will remain the dominant economic issue until Iraq's foreign debt is reduced or canceled. Neither significant private nor large scale public credit will be made available to Iraqis until the burden of old debt is lifted. Accordingly, we should press vigorously for Saddam-era debt—which went largely to build palaces for Saddam's family and to buy weapons of aggression—to be written off. We should also press to establish community-centered banks and credit unions where micro credit can be offered. Oil wealth has its advantages only if revenues are used for the benefit of society rather than political insiders. Increasing petroleum production is not enough. Oil is not a labor intensive industry. Jobs matter, and Iraq needs bankers and small business entrepreneurs far more than oil barons. We have no choice except to help rebuild Iraq's oil infrastructure, but we must make clear that we have no intention of controlling Iraq's oil reserves. The natural resources of Iraq must be treated as the patrimony of the Iraqi people.

(16) Economic assistance to Iraq should be front-loaded and generous. War has been a constant of history, but the concept of reconstruction is relatively new. The 20th century gave us two vastly different models. At the end of World War 1, the victors imposed retributive terms on Germany, which so angered German society that it turned to fascism. World War II was the result.

The allies took a different approach at the end of World War II. Generosity was the watchword. The Marshall Plan was adopted to rebuild Europe and Gen. MacArthur directed the reform and modernization of Japan. Model democracies emerged. The world was made more secure. The economic plan for Iraq should be two-pronged: debt forgiveness coupled with institution building. A better world is more likely to emerge if the American agenda places its emphasis on construction rather than destruction.

Here a note about the other reconstruction model in American history is relevant. With his call for malice toward none, Lincoln's second inaugural address set the most conciliatory tone in the history of war. His successor once removed, U.S. Grant, proved to be a more proficient soldier than President and countenanced carpet bagging conflicts of interest. Our government today would be well advised to recognize that neither history nor the American public approves of war or post-war profiteering. Great care has to be taken to ensure transparency and integrity in government contracts and common sense would indicate that the more Iraqis are involved in rebuilding their own society, the more lasting such efforts are likely to be.

(17) Terrorism affects world economics as well as politics. Markets depend on confidence and nothing undercuts confidence more than anarchist acts. Policies designed to deter terrorism can be counter-productive. International disapproval of our actions may jeopardize our

economy and diminish the credibility of our political leadership in the world. Increased terrorism could well have the dual effect of precipitating new U.S. military engagements and, ironically, strengthening isolationist sentiment—which, in turn could degenerate into a disastrous spiral of protectionism.

(18) The measure of success in reconstruction is not the sum of accomplishments. In the Vietnam War the Pentagon gave progress reports that came to be symbolized by its body counts. One of the most liberal critics of that war, I.F. Stone, once commented that he accepted the validity of the body counts but thought that they did not reveal the big picture. It would be as if, Stone suggested, he were to be walking down the street and bump into a man running out of a bank waving a gun and carrying a satchel full of money, and were to ask the man, "What are you doing?" If the man responded, "I'm waiting for a car," the man would be telling the truth but not revealing the big picture.

Good things are being accomplished in Iraq, particularly in the North where an American general has won a measure of popularity through progressive stabilization initiatives. Yet terrorism cannot credibly be contained in the arms-infested Iraqi environment. American civilians as well as armed services personnel who have been posted to Iraq deserve to be commended for their commitment and sacrifices, but prudence suggests that brevity of service is preferable to a long standing presence. Otherwise, in a world where terrorism is a growth industry even extraordinary sacrifice and significant accomplishments could be for naught.

(19) We must respect Iraqi culture and work to ensure that the art and artifacts of this cradle of civilization are preserved for the Iraqi people. There are few umbrages more long lasting than cultural theft. Cultural looting must be stopped and the market for stolen antiquities squelched. For our part we should ensure that Iraqi cultural sites are protected and that our laws are upgraded. Any stolen antiquities brought to America must be returned.

(20) The war in Iraq should not cause us to forget Afghanistan. While the center of our military attention may at the moment be Baghdad, we must remember that no Iraqi was involved in hijacking the planes that struck the World Trade Center and Pentagon on 9/11. Few countries are more distant physically or culturally from the United States than Afghanistan, yet it is there where the plotting for that terrorist act began. The Taliban have been removed and a new, more tolerant government has been established, but the world community has not fulfilled its commitments to raise that country out of poverty and warlordism. The U.S. cannot continue to be complacent about economic and social development in that country, where foreigners have never been welcome. Failure of the Karzai government and a return of the Taliban would be a major setback in the battle with terrorism.

(21) Lastly, and most importantly, U.S. policy makers should never lose sight of the fact that events in Israel and Iraq are intertwined and that no challenge is more important for regional and global security than resolution of the Israeli-Palestinian dilemma.

Extraordinarily, administration after administration in Washington seems to pay only intermittent attention to this issue. There should be no higher priority in our foreign policy than a resolution of the Arab-Israeli conflict. Attention in Washington should be riveted at all times on this singular issue. The current status quo is good neither for Israel nor for the Palestinians. Now, for the first time lack of progress in establishing a mutually acceptable modus vivendi between the parties may be even more damaging to countries not directly involved in the conflict. The need for U.S. leadership in pressing for peace has never been more urgent. It would be a tragedy if, focussed on making war in one part of the Middle East, we neglected to promote peace in another.

In conclusion, the world is noting what we are saying and what we are doing. Many are not convinced by our words; many are appalled by our actions. Yet nothing would be worse for the world than for us to fail. We must not. The key at this point is to recognize the limits as well as magnitude of our power and emphasize the most uplifting aspects of our heritage: democracy, opportunity, freedom of thought and worship. Differences we must respect; intolerance we must reject. But America does better as a mediator and multi-party peace maker than as a unilateral interventionist. This is the great lesson of the past year.

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